San Joaquin County Behavioral Health Services

1212 N. California St.
Stockton CA 95202

Mental Health Service Act

Workforce Education and Training Component

Three-Year Program & Expenditure Plan

Fiscal years 2006-07, 2007-08, 2008-09

ACKNOWLEDGEMENTS

San Joaquin County Behavioral Health Services wishes to thank the many consumers and their family members who gave their time and energy to this process. Their words of wisdom and stories of optimism, wellness, resiliency and recovery have shaped every component of this plan.

In addition, BHS wishes to recognize the contributions of the members of the Stakeholder Steering Committee who helped guide the development of the planning process and the creation of this plan.

Prepared by Resource Development Associates

Project Team:

Jennifer Susskind, RDA, Project Lead
Kayce Rane, RDA
Frances Hutchins, BHS, Deputy Director
Becky Smith Gould, BHS, Deputy Director, MHSA
Vic Singh, BHS, Director

EXHIBIT 1: WORKFORCE FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA) WORKFORCE EDUCATION AND TRAINING COMPONENT
THREE-YEAR PROGRAM AND EXPENDITURE PLAN, Fiscal Years 2006-07, 2007-08, 2008-09

County: San Joaquin Date: XXX

This County's Workforce Education and Training component of the Three-Year Program and Expenditure Plan addresses the shortage of qualified individuals who provide services in this County's Public Mental Health System. This includes community based organizations and individuals in solo or small group practices who provide publicly-funded mental health services to the degree they comprise this County's Public Mental Health System workforce. This Workforce Education and Training component is consistent with and supportive of the vision, values, mission, goals, objectives and proposed actions of California's MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan), and this County's current MHSA Community Services and Supports component. Actions to be funded in this Workforce Education and Training component supplement state administered workforce programs. The combined Actions of California's Five-Year Plan and this County's Workforce Education and Training component together address this County's workforce needs as indicated in Exhibits 3 through 6.

Funds do not supplant existing workforce development and/or education and training activities. Funds will be used to modify and/or expand existing programs and services to fully meet the fundamental principles contained in the Act.

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes. This Workforce Education and Training component has been developed with stakeholders and public participation. All input has been considered, with adjustments made, as appropriate.

Progress and outcomes of education and training programs and activities listed in this Workforce Education and Training component will be reported and shared on an annual basis, with appropriate adjustments made. An updated assessment of this county's workforce needs will be provided as part of the development of each subsequent Workforce Education and Training component.

County Mental Health Director
Printed Name: Vic Singh

Signature: Sign here

Street Address (or, PO Box): 1212 N. California St.
City, ZIP Code: Stockton, CA 95202
Phone #: 209-468-8750 Fax #: 209-468-2399
E-mail address: vsingh@sjcbhs.org

Contact Person' Name:
Becky Smith Gould, Deputy Director, MHSA Phone #:209-468-8859 Fax #:209-468-2399E-mail: bgould@sjcbhs.org

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EXHIBIT 2: STAKEHOLDER PARTICIPATION SUMMARY

Counties are to provide a short summary of their planning process, to include identifying stakeholder entities involved and the nature of the planning process; for example, description of the use of focus groups, planning meetings, teleconferences, electronic communication, use of regional partnerships.

In March 2008, San Joaquin County Behavioral Health Services (BHS) and the MHSA Planning Stakeholder Steering Committee, with assistance from Resource Development Associates, a consulting firm specializing in community-based strategic planning processes, launched the Workforce Education and Training (WET) component planning process. This "Planning Team" sought to incorporate stakeholder participation to:

- Identify workforce strengths, challenges and needs;
- Develop strategies for leveraging strengths and mitigating needs; and
- Prioritize the strategies.

The Planning Team's objective was to build upon the initial MHSA Community Services and Supports (CSS) planning process by reviewing the CSS plan and supplemental CSS stakeholder participation notes and by drawing on the expertise of the newly-formed MHSA consortium of community community-based organizations (CBO). In addition, the Planning Team sought to draw upon the knowledge and expertise of an exceptionally diverse range of stakeholders, including consumers and their families, representatives from underserved ethnic and cultural communities, public and community-based service providers at all occupation levels, educators and workforce developers. We sought to provide opportunities for intimate, focused discussions and to reach out to the broadest possible number of stakeholders through interactive community meetings.

The WET and Prevention and Early Intervention (PEI) planning processes occurred simultaneously, which enabled the Planning Team to leverage planning resources and attract an unusually wide range of stakeholders. For example, early childhood development experts primarily interested in prevention and university professors interested in career pathways participated in a broader discussion about public mental health than they may have otherwise engaged in. We hope that this broadening of the discussion helps reduce stigma and increases understanding of the multi-faceted needs of the community.

The following proposed Workforce Education and Training Plan is the result of a planning process that included the following participatory elements:

- Increased membership on the MHSA Planning Stakeholder Steering Committee
- Community education and outreach
- Key informant interviews
- Focused discussion groups
- Strategy roundtables
- Community meetings

Oversight and Recommendations: Planning Stakeholder Steering Committee

The joint WET and PEI Planning Stakeholder Steering Committee was charged with establishing a shared vision, overseeing the planning process, ensuring community participation, and approving the draft plan. The Committee was made up of members from the Mental Health Board, many of whom were involved in the CSS Planning Process. BHS and the Mental Health Board also sought to include people with workforce expertise, such as job developers and educators, and people with PEI expertise, such as criminal justice and early childhood experts. Additionally BHS and the Board sought to ensure diverse ethnic and life stages representation and recruited individuals with strong consumer and family member advocacy backgrounds. The intention of BHS and the Board was to include individuals who were not afraid to speak up and advocate for consumers, family members and underserved individuals.

The Planning Stakeholder Steering Committee included the following members:

Cynthia Gustafson	Chair, Mental Health Board, family advocate
Stephanie Bays	Deputy Chief Probation Officer
Ken Cohen	Director, Health Care Services
Mary Ellen Cranston-Bennett	NAMI Representative/Parent Advocate
Mick Founts	Deputy Superintendent, Office of Education
Kathleen Gutierrez	BHS Employee/Labor Representative
Robert Hart	Medical Director, Behavioral Health Services
Monica Madrigal	Power and Support Team/Consumer Advocate
Jennie Montoya	NAMI Representative/Outreach Worker
Jane Riddle	Family Advocate
Chris Rose	Senior Deputy, County Administrator's Office
Daphne Shaw	Older Adult Advocate
Vic Singh	Director, Behavioral Health Services
John Solis	Executive Director, WorkNet
Margaret Szczepaniak	Assistant Director, Health Care Services
Cheryl Torres	BHS Consumer Outreach Coordinator
Curt Willems	Manager, Substance Abuse Services
Stella Williams	Children's Advocate

All Planning Stakeholder Steering Committee meetings were open to the public and the public was provided opportunity for comments during each meeting. Between May 2008 and January 2009, the Planning Stakeholder Steering Committee met monthly to oversee the planning process.

General Outreach:

During the initial stage of the WET planning process, the Planning Team developed an outreach list with phone and email contact information based on sign-in sheets from the earlier CSS planning process, consumer and family member staff and volunteers, staff supervisors and a brainstorm of other WET stakeholders such as university instructors, workforce development experts, and public education representatives. This list continued to grow during the planning process, and by the end, included over 500 names. Prior to the community meetings, Planning Team members made phone calls and email invitations to all on the list.

Additionally, the Planning Team posted notices and personally invited stakeholders to participate in focused discussion groups and community meetings. Full-color MHSA newsletters and the County MHSA website announced upcoming meetings and discussion groups as well. Our success in attracting consumers and family members reflected the powerful advocacy and commitment of BHS and Community-Based Organization (CBO) Outreach Workers. Our success in attracting participants from underrepresented communities reflected the extensive outreach conducted by the MHSA community-based organizations.

Community Education: MHSA Consortium Meeting & Communitywide WET/PEI Kickoff Meeting

All community meetings and discussion groups included a community education component, specifically a PowerPoint presentation, which explained MHSA goals, principles, activities and findings to date, and opportunities for future involvement. The Planning Team was committed to ensuring all participants understood the WET component so that they could contribute to the planning process in an informed manner.

On May 7, 2008, the Planning Team introduced the WET and PEI planning process to the MHSA Consortium. The Consortium is made up of representatives of the MHSA funded programs in San Joaquin County, including ethnic and culture-based CBOs. Consumers, family members and BHS staff also attend and participate in the Consortium. Most of 50-plus attendees at the May 7th meeting were engaged in the initial MHSA-CSS planning process, were invested in programmatic continuity, and wanted to stay involved to ensure a broad-based, community-driven plan.

On May 19, 2008, the Planning Team kicked off the community-wide planning process with a meeting attended by 103 participants. During both the Consortium and the Community Kickoff meetings, participants were informed about the WET component goals, principles, potential funding opportunities, and plan for involving stakeholders throughout the planning process. During the Kickoff Meeting, the Planning Team distributed commitment forms that asked how participants would be willing to outreach for future meetings. In addition, the Planning Team distributed confidential demographic forms during the Community Kickoff Meeting and all other participatory meetings. Participation rates, based on the demographic forms, are described in the text boxes to the right.

Communitywide WET/PEI Kickoff Meeting Participation
103 sign-ins; 82 demographic forms submitted
19 consumers of mental health services
23 family members of consumers
6 transitional age youth (18-25 years)
15 older adults (60+)
63 female and 19 male
43 Caucasian/White, 9 African American/Black, 4 Hispanic/Latino, 11 Southeast Asian, 2 other Asian, 1 Native American, 9 mixed-race, and 3 other

Information Gathering and Needs Assessment: Key Informant Interviews & Focused Discussion Groups

The Planning Team conducted a qualitative needs assessment prior to initiating detailed discussions about funding opportunities and strategies. Our objective was to reach the widest range of stakeholders as possible, and also to provide opportunities for meaningful and extended conversations about the County's workforce strengths, challenges and needs *prior* to deeply investigating funding opportunities. To accomplish these objectives, we used two participatory methods: Key Stakeholder Interviews and Focused Discussion Groups.

The Key Informant Interviews, conducted by RDA between April and May 2008, were intended primarily to provide a broad overview of workforce needs. Interviewees were given a brief overview of the WET component, its goals, MHSA principles and funding opportunities, and were asked to identify and describe:

- Workforce development priorities that were identified during the CSS planning process;
- Critical workforce shortages, including those pertaining to underserved populations;
- Difficulties associated with recruiting, hiring and training the public mental health workforce;
- Challenges associated with transforming the public mental health system;
- Systems in place and strategies currently being implemented that are addressing these challenges;
- Current opportunities for partnerships and leveraging resources;
- Initial thoughts on strategies for addressing these challenges.

Stakeholder Interviewee Participation
16 interviews; 14 demographic forms submitted
2 consumers of mental health services
7 family members of consumers
4 older adults (60+)
12 female and 2 male
8 Caucasian/White, 1 African American/Black, 2 Hispanic/Latino, 1 Southeast Asian, 1 other Asian, 0 Native American, 0 mixed-race, and 1 other

Formal, confidential interviews were conducted by Resource Development Associates with the following stakeholders:

Susan Eggman, Stockton City Councilmember, Professor of Social Work, CSU Stanislaus

Mick Founts, Deputy Superintendent, San Joaquin County Office of Education

Cynthia Gustafson, Mental Health Board Chairperson

Jennifer Goodman, Recruitment Manager, **Holly Nguyen**, Personnel Analyst and **Kathy Harris**, Deputy Director, San Joaquin County Human Resources Division

Roseann Hannon, Chair, Psychology Department, University of the Pacific

Hazel Hill, Dean of Workforce and Economic Development, San Joaquin Delta College

Karen Ippolito, Instructor, Nursing Department, San Joaquin Delta College

Michelle Salter, Chief Mental Health Clinician, Black Awareness Community Outreach Program/ Multicultural Services, San Joaquin County Behavioral Health Services

Daphne Shaw, older adult advocate, former member of Mental Health Board for 30 years
Vic Singh, Director, San Joaquin County Behavioral Health Services
Kim Suderman, Deputy Director, Children and Youth Services, San Joaquin County Behavioral Health Services
Margaret Szczepaniak, Assistant Director, San Joaquin County Health Care Services Agency
Margaret Tynan, Department Chair, Social Work, CSU Stanislaus
Lita Wallach, Coordinator, Community Health Forum

On behalf of the Planning Team, Resource Development Associates facilitated 7 Discussion Groups that focused on workforce needs. The groups were deliberately kept small (between 5 and 20 participants) and focused on a specific workforce sector. During each of the Discussion Groups, participants were asked similar questions as those posed during the key informant interviews. In addition, the discussions also reflected the unique composition of each group--for example, the Consumer and Family Member Discussion Groups focused on the experiences of consumers and family members in the workforce and the CBO focus groups led to more in-depth discussions on the needs of underserved communities.

Focused Discussion Group Participation
94 sign-ins; 92 demographic forms submitted
19 consumers of mental health services
19 family members of consumers
2 transitional age youth (18-25 years)
8 older adults (60+)
62 female; 30 male
51 Caucasian/White, 11 African American/Black, 12 Hispanic/Latino, 4 Southeast Asian, 4 other Asian, 3 Native American, 5 mixed-race, 2 other

The size and composition of the Discussion Groups were designed to promote a safe environment for honest discussion (for example, managers were not invited to participate in the employee group) and to provide enough time for participants to express complex thoughts and experiences. The Planning Team, including Program Supervisors, the MHSA Program Manager and Mental Health Outreach Coordinator, conducted targeted and general outreach to ensure that meetings were well-attended.

The Discussion Groups included:

- **Two groups of CBO contractors**: (June 10 & June 16, 2008) The participants of these groups were primarily directors of CBOs that serve specific ethnic and cultural populations. These discussions were over 3 hours in length and piggybacked technical assistance in completing the quantitative needs assessment
- **Two BHS manager groups** (June 19 & June 26, 2008) Discussion Groups were conducted after management meetings in order to include the perspectives of all BHS managers.
- **Two discussion groups exclusively for consumers and family members** (July 1, 2008) These meetings were open to all consumers and family members. Almost all who participated were employees and volunteers of BHS and CBOs. Outreach was conducted primarily by the Consumer Outreach Coordinator and MHSA Consortium Program Manager.

- **One non-supervisory group for CBO and BHS employees** (July 25) All BHS or CBO employees in good standing were permitted to sign up ahead of time to participate in a Discussion Group. There was sufficient interest for one group.

Findings from the Key Informant Interviews and the Discussion Groups, in addition to the quantitative needs assessment are presented in Exhibit 3 -- Workforce Needs Assessment.

Strategy Development: Strategy Roundtables

The Planning Team was committed to identifying realistic strategies that would help address San Joaquin's County's unique workforce needs. Resource Development Associates facilitated four Strategy Roundtables to develop a list of potential WET strategies. Each of these Roundtables focused on a different set of workforce needs and opportunities. Each was attended by between 11 and 14 participants with interest and experience commensurate with the topic:

- **Strategy Roundtable I: Workforce Training and Technical Assistance.** Participants included BHS staff and managers, and consumer and family member representatives.
- **Strategy Roundtable II: Entry-Level Pathways & Support**. Participants included consumer and family members, consumer advocates, BHS managers, BHS and CBO staff, K-12 school representatives, and workforce and economic development specialists
- **Strategy Roundtable III: Clinical Career Pathways.** Participants included mental health clinicians, BHS managers, social work instructors from CSU Stanislaus and Sacramento, and consumer and family member representatives
- **Strategy Roundtable IV: Medical Career Pathways.** Participants included nursing and psychiatric technician and psychiatrist staff, BHS managers, as well as nursing instructors from Delta College and CSU Stanislaus, and consumer and family member representatives.

Strategy Roundtable Participation
49 sign-ins; 43 demographic forms submitted
9 consumers of mental health services
12 family members of consumers
9 older adults (60+)
26 female; 17 male
25 Caucasian/White, 2 African American/Black, 7 Hispanic/Latino, 1 Southeast Asian, 3 other Asian, 0 Native American, 3 mixed-race, and 2 other

Prior to the Strategy Roundtable, in order to ground the discussion, the Planning Team emailed participants: 1) a summary of specific findings from the Needs Assessment that related to the roundtable topic and 2) a list of potential strategies that were proposed in other California counties. A copy of the emailed documents is included in Attachment A. During the meeting, participants reviewed the findings, brainstormed potential strategies, and developed a list of 5 to 6 possible strategies that could be presented at community meetings. Attachment B includes a complete list of strategies that were developed in each of the Strategy Roundtables.

Strategy Prioritization: Community Meetings

The Planning Team embarked on an extensive outreach campaign to invite community members to attend one of six WET Community Meetings designed to review the potential strategies. The team posted meeting logistics on the County MHSA website and emailed invitations and flyers to all previous participants and to representatives from community-based organizations. Mental Health Outreach workers posted notices and encouraged peers to attend community meetings. Flyers were posted in most prominent civic places including county libraries, civic buildings and health facilities. BHS staff and consultants made over 450 phone calls to an ever-expanding MHSA contact list. In order to ensure maximum attendance, meetings were planned during business hours, on a Saturday and on a weekday evening. Meetings were held throughout the County, in Stockton, Lodi, Manteca and Tracy. Each of the WET meetings was three hours in length. The WET Community Meetings were held in the morning, followed by an hour break for lunch, and then three-hour PEI Community Meetings. Some participants stayed for the whole day, while others participated in only the WET or PEI portion.

WET Community Meeting Participation[1]
126 sign-ins; 121 demographic forms submitted
32 consumers of mental health services
36 family members of consumers
11 transitional age youth (18-25 years)
15 older adults (60+)
83 female and 38 male
36 Caucasian/White, 17 African American/Black, 35 Hispanic/Latino, 14 Southeast Asian, 4 other Asian, 3 Native American, 10 mixed-race, and 2 other

Each of the six WET Community Meetings began with an overview of MHSA principles, WET goals, and a summary of the needs assessment. Participants were asked to respond to the needs assessment and add additional input (which has been incorporated into Exhibit 3). After completing the Needs Assessment portion of the meeting, the facilitator described each of the strategies developed in Roundtable. In addition, participants were given a narrative description of each of the strategies to review.

Participants broke into groups of 4 – 6 persons and were given a response sheet to collectively and by consensus answer a series of questions:

- What are your top two strategies?
- Why did you select these strategies?
- What needs do the strategies address?
- Is there anything else you would like us to consider about these strategies?

See Attachment C for an example of a response sheet. This process repeated for each of the four sets of strategies: 1) Training and Technical Assistance; 2) Entry Level Pathways and Support; 3) Clinical Career Pathways; and 4) Medical Career Pathways. At the end of each of the six meetings, each of the participant groups reported their prioritized strategies in each of the categories and why they were chosen.

The Planning Team chose to utilize this community prioritization activity, anticipating that small group discussions would allow for a greater degree of participation, dialogue, and consensus building. Discussions proved to be very deep, with many participants initially advocating for their own interests, but through dialogue, recognizing the needs of other stakeholders and the community as a whole. During these meetings, as well as all

[1] Includes only those participants that attended the WET portion of the Community Meeting.

discussion groups and community meetings, the planning team distributed feedback cards to solicit confidential and/or anonymous feedback and suggestions.

After collecting input from the group discussions during each of the six Community Meetings and tallying results, the Planning Team compiled a list of *prioritized* WET strategies. The prioritized strategies are listed and described in Attachment D. Following the Community Meetings, the Planning Team presented the prioritized strategies to an open meeting of the Mental Health Board, and again at a Planning Stakeholder Steering Committee. Resource Development Associates then researched the feasibility and costs associated with each of the strategies. In addition, Resource Development Associates broadened the strategies to reflect additional comments from participants and incorporated some of the good ideas that were not prioritized, but nonetheless supported by the community. The final plan reflects the prioritized strategies as well as an in-depth analysis of financial feasibility and institutional capacity.

Stakeholder Participation Totals

The following is a final tally of planning participants. This number reflects participants engaged in the Planning Stakeholder Steering Committee Meetings, Consortium and Community Kickoff Meetings, Key Informant Interviews, Focused Discussion Groups, Strategy Roundtables, and Community Meetings. This number does not reflect those that participated in the public hearings following the drafting of the plan. Demographic forms were not distributed at the Consortium Meeting nor at several of the Planning Stakeholder Steering Committee Meetings, though Sign-In Sheets were collected.

The following is a list of agencies and organizations whose membership participated in at least one meeting. This list was compiled from sign-in sheets at the meetings described above.

Total WET Participation
487 sign-ins; 402 demographic forms submitted
100 consumers of mental health services
111 family members of consumers
20 transitional age youth (18-25 years)
54 older adults (60+)
281 female and 121 male
192 Caucasian/White, 42 African American/Black, 71 Hispanic/Latino, 31 Southeast Asian, 15 other Asian, 8 Native American, 31 mixed-race, and 12 other

Agencies and Organizations that Participated in WET Planning

Access Managed Care (BHS)
ANKA Behavioral Health
Asian Pacific Self Help and Residential Association (APSARA)
BACOP/ Multi Cultural FSP (BHS)
Behavioral Health Services of San Joaquin County
California State University Sacramento
Manteca Unified School District
Mental Health Board
MHSA-Consortium (BHS)
National Alliance on Mental Illness (NAMI)
Native Directions, Three Rivers Lodge
Pacific Valley Recovery Center

California State University Stanislaus
Catholic Charities Senior Center
Center for Positive Prevention Alternatives
Central Valley Low Income Housing Corporation (CVLIHC)
Charterhouse School
Child Abuse Prevention Council
City of Stockton
Commission on Aging
Crisis Community Response Team
Community Health Forum
Community Partnerships for Families
Community Re-Entry Program-University of the Pacific
El Concilio-Council for the Spanish Speaking
Crestwood
CUFF Family Resource Center

Delta College
Department of Aging and Community Services
District Attorney
Family and Youth Services of San Joaquin County
Family Intervention and Community Support (FICS)
Family Resource and Referral Center (FRRC)
Fathers and Families of San Joaquin
First Five San Joaquin
Golden Acres Home Care
Human Services Projects Inc
La Familia(BHS)
Lao Family Community of Stockton, Inc
Lodi Police Department
Martin Gipson Mental Health Center
Mary Magdalene Community Services

Parent Partners
Psychiatric Health Facility(BHS)
Power and Support Team

Prevention Services
Probation Department of San Joaquin County
Project Hope
San Joaquin AIDS Foundation
San Joaquin County Health Care Services
San Joaquin County Human Resources
San Joaquin County Office of Education
San Joaquin County WorkNet
San Joaquin General Hospital
Service Employees International Union (SEIU)
Southeast Asian Recovery Services (SEARS)
St. James African Methodist Episcopal church
Stanislaus County Behavioral Health and Recovery Services
Stockton Shelter for the Homeless
Sutter Tracy Health Connection
Sutter Tracy Hospital
University of the Pacific
Valley Community Counseling Services
Valley Mountain Regional Center
Victor Community Services and Supports
Victor Treatment Centers
Vietnamese Voluntary Organization (VIVO)
Wallach and Associates
Wellness Center (BHS)
Wellness Works!
Women's Center
Youth Moving On

Public Comment, Draft Review and Public Hearing

San Joaquin County's Mental Health Board reviewed the draft plan on January 21, 2009. On January 26, 2009, the plan was posted on the County website for a 30-day public comment period. After the close of the 30-day period, the Planning Team reviewed public comments and made a number of adjustments to the plan. Planning Team wishes to thank those who diligently reviewed the document and corrected several budget and narrative inconsistencies. In addition, public comments also clarified the fact that contracting CBOs that receive funding from MHSA provide expanded services. The earlier draft suggested that community-based services replaced those that were provided by BHS staff. Another comment had to do with the Planning Team's analysis of staff language proficiencies. We estimate that approximately 21% of staff should be proficient in Spanish to meet the needs of the Spanish speaking community. One commenter correctly pointed out that a smaller proportion of community members need Spanish language interpretive services (approximately 6%). Therefore, we wish to clarify that our assessment of language proficiency needs is based on a desire to provide the most culturally competent services as possible (i.e. services provided by those who linguistically resemble the County population). The following draft includes corrections based on public comments.

On March 18th, 2009 the county held a final public hearing on the Draft WET Plan. Several substantive comments were made during public hearing. The comments and responses are described below:

- The Wellness Center should offer classes on the Mental Health Service Act
    - Response: The WET plan supports a wide range of classes and workshops to be determined by an ongoing team of volunteers and the WET Coordinator. Potential classes and workshops are described in Action #7 – Title: Entry-Level Employee Support.
- The WET plan should support aggressive outreach to help reduce stigma associated with mental health, and should support a community campaign to inform voters about MHSA.
    - Response: The WET plan supports a culturally competent consumer and family member Speakers' Bureau designed to help reduce stigma and provide vital insight into the experiences of people living with mental illness. The Speakers Bureau will articulate how communities experience and respond to psychological crises in unique ways, and will illustrate how cultural biases and misunderstandings affect how first responders and other community partners treat those they perceive as "different". The Speakers' Bureau is described in greater detail in Action #4 – Title: Mental Health 101 for Community Partners. No funding will specifically be used to lobby for specific causes/campaigns, but the Speakers' Bureau will inform the public about the Mental Health Service Act.
- There needs to be more accountability to consumers that are hired by CBOs. BHS needs to monitor their challenges and successes in job placement.
    - Response: The following language was added to Action #1 – Workforce Education and Training Coordination: "In regards to evaluation and ensuring accountability, a special emphasis will be placed on tracking the success and wellbeing of BHS consumers who enter the public mental health workplace, including those who work for CBOs. The WET Coordinator and evaluation consultant will monitor staff turnover rates, compensation, progress along career pathways, and workplace policies related to the employment of consumers and family members. Findings from these evaluations will help BHS develop additional policies promoting consumer

and family member employment and career pathways designed to support consumer-driven services throughout the County mental health system."

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT:

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11) White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	3.00	0	0							
Case Manager/Service Coordinator	54.55	0	7							
Employment Services Staff	1	0	0							
Housing Services Staff	0	0	0							
Consumer Support Staff	14.75	0	4							
Family Member Support Staff...........................	6.00	0	0							
Benefits/Eligibility Specialist	4.75	0	1	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only)						
Other *Unlicensed* MH Direct Service Staff	50.20	0	6							
Sub-total, A (County)	**134.25**	**0**	**18**	**36.65**	**30.75**	**18.25**	**23.55**	**0**	**13.05**	**122.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	25.5	0	3							
Case Manager/Service Coordinator	38.30	0	5							
Employment Services Staff	3	0	0							
Housing Services Staff	3.5	0	0							
Consumer Support Staff	41.5	0	7							
Family Member Support Staff...........................	21.5	0	5							
Benefits/Eligibility Specialist	1	0	0							
Other *Unlicensed* MH Direct Service Staff	110.45	0	13	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)						
Sub-total, A (All Other)	**244.7**	**0**	**33**	**58.9**	**55.9**	**71**	**23.3**	**3**	**10**	**222.1**
Total, A (County & All Other):	**378.95**	**0**	**51**	**95.55**	**86.65**	**89.25**	**46.9**	**3**	**23.05**	**344.35**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	12.75	1	4							
Psychiatrist, child/adolescent	2	1	2							
Psychiatrist, geriatric	1.25	1	2							
Psychiatric or Family Nurse Practitioner	1	1	2							
Clinical Nurse Specialist	0	1	2							
Licensed Psychiatric Technician	41.7	1	5							
Licensed Clinical Psychologist	0	0	2							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	4	1	0							
MSW, registered intern (or waivered)	27	0	3							
Marriage and Family Therapist (MFT)	5.05	1	1	(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only)						
MFT registered intern (or waivered)	39	0	5							
Other *Licensed* MH Staff (direct service)	.5	0	0							
Sub-total, B (County)	**134.25**	**8**	**28**	**46.8**	**22.75**	**15.45**	**26.25**	**0**	**10**	**121.25**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	2.8	1	1							
Psychiatrist, child/adolescent	4	1	1							
Psychiatrist, geriatric	2.2	1	1							
Psychiatric or Family Nurse Practitioner	0	0	1							
Clinical Nurse Specialist	0	0	0							
Licensed Psychiatric Technician	2.5	1	0							
Licensed Clinical Psychologist	3	1	0							
Psychologist, registered intern (or waivered)	0	0	0							
Licensed Clinical Social Worker (LCSW)	12.75	1	2							
MSW, registered intern (or waivered)	6.5	0	1							
Marriage and Family Therapist (MFT)	37.5	1	5							
MFT registered intern (or waivered)	13.5	0	2	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)						
Other *Licensed* MH Staff (direct service)	1.5	0	0							
Sub-total, B (All Other)	**86.25**	**7**	**14**	**48.2**	**9.5**	**6.5**	**10.5**	**3.6**	**5**	**83.3**
Total, B (County & All Other):	**220.5**	**15**	**42**	**94.95**	**32.25**	**21.95**	**36.75**	**3.6**	**15**	**204.5**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0	0	0							
Registered Nurse	17.05	0	2							
Licensed Vocational Nurse	0	0	0							
Physician Assistant	1	0	3							
Occupational Therapist	2	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)........	14.75	0	2	(Other Health Care Staff, Direct Service; Sub-Totals Only)						
Sub-total, C (County)	**34.85**	**0**	**7**	**13.05**	**4.5**	**0**	**10.5**	**0**	**.75**	**28.8**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0	0	0							
Registered Nurse	0	0	0							
Licensed Vocational Nurse	2	1	0							
Physician Assistant	0	0	0							
Occupational Therapist	1	1	0							
Other Therapist (e.g., physical, recreation, art, dance)	0	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)........	1	0	0	(Other Health Care Staff, Direct Service; Sub-Totals and Total Only)						
Sub-total, C (All Other)	**4**	**2**	**0**	**1**	**0**	**0**	**1**	**0**	**0**	**2**
Total, C (County & All Other):	**38.85**	**2**	**7**	**14.05**	**4.5**	**0**	**11.5**	**0**	**.75**	**30.8**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor..........	29	1	3	(Managerial and Supervisory; Sub-Totals Only)						
Supervising psychiatrist (or other physician)	1	1	1							
Licensed supervising clinician...........................	14.4	1	2							
Other managers and supervisors......................	24.75	1	3							
Sub-total, D (County)	**69.15**	**4**	**9**	**35.15**	**8**	**3**	**10**	**0**	**5**	**61.15**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.........	10.75	1	1	(Managerial and Supervisory; Sub-Totals and Total Only)						
Supervising psychiatrist (or other physician)	0	0	0							
Licensed supervising clinician.........................	10	1	1							
Other managers and supervisors.....................	16	1	2							
Sub-total, D (All Other)	**36.75**	**3**	**4**	**19**	**6**	**5.35**	**3**	**0**	**0**	**33.35**
Total, D (County & All Other):	**105.9**	**7**	**13**	**54.15**	**14**	**8.35**	**13**	**0**	**5**	**94.5**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance..........	**18.75**	**1**	**2**	(Support Staff; Sub-Totals Only)						
Education, training, research	**0**	**1**	**0**							
Clerical, secretary, administrative assistants.....	**140.6**	**0**	**17**							
Other support staff (non-direct services)...........	**24.25**	**0**	**3**							
Sub-total, E (County)	**183.60**	**2**	**22**	**68.15**	**45**	**14**	**23.7**	**2**	**13.75**	**166.6**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance..........	**2**	**1**	**0**							

Education, training, research	**1**	**1**	**0**			(Support Staff; Sub-Totals and Total Only)				
Clerical, secretary, administrative assistants	**20.3**	**0**	**2**							
Other support staff (non-direct services)...........	**24.4**	**0**	**3**							
Sub-total, E (All Other)	**47.7**	**2**	**5**	**10.5**	**16.15**	**7.15**	**8**	**2**	**0**	**43.8**
Total, E (County & All Other):	**231.3**	**4**	**27**	**78.55**	**61.15**	**21.15**	**31.8**	**4**	**13.75**	**210.4**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

GRAND TOTAL WORKFORCE (A+B+C+D+E)

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11) White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E)......**	**556.1**	**14**	**84**	**199.8**	**111**	**50.7**	**94**	**2**	**42.55**	**500.05**
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) ....**	**419.4**	**14**	**56**	**111.55**	**83.55**	**88**	**41.8**	**8.6**	**12**	**345.5**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**975.5**	**28**	**140**	**311.35**	**194.55**	**138.7**	**135.8**	**10.6**	**54.55**	**845.55**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau- casion	Hispanic/ Latino	African- Ameri- can/ Black	Asian/ Pacific Islander	Native Ameri- can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**6121**	**2514**	**2087**	**1670**	**483**	**274**	**13,149**

II. Positions Specifically Designated for Individuals with Consumer and Family Member Experience:

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff..	56.25	0	41
Family Member Support Staff	27.50	0	30
Other *Unlicensed* MH Direct Service Staff	0	0	
Sub-Total, A:	**83.75**		**71**
B. *Licensed* Mental Health Staff (direct service).............	**0**	**0**	**0**
C. Other Health Care Staff (direct service)	**1**	**0**	**1**
D. Managerial and Supervisory...	**1**	**0**	**1**
E. Support Staff (non-direct services).............................	**24.8**	**0**	**21**
GRAND TOTAL (A+B+C+D+E)	**110.55**		**94**

III. LANGUAGE PROFICIENCY

For languages other than English, please list (1) the major ones in your county/city, (2) the estimated number of public mental health workforce members currently proficient in the language, (3) the number of additional individuals needed to be proficient, and (4) the total need (2)+(3):

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish (threshold)	Direct Service Staff 58 Others 19.9	Direct Service Staff 100 Others 0	Direct Service Staff 158 Others 19.9
2. Cambodian (threshold)	Direct Service Staff 9 Others 1	Direct Service Staff 18 Others 0	Direct Service Staff 27 Others 1
3. Vietnamese	Direct Service Staff 8 Others 2	Direct Service Staff 1 Others 0	Direct Service Staff 9 Others 2
4. Hmong	Direct Service Staff 12 Others 3	Direct Service Staff 0 Others 0	Direct Service Staff 12 Others 3
5. Lao	Direct Service Staff 9 Others 1	Direct Service Staff 0 Others 0	Direct Service Staff 9 Others 1
6. Thai	Direct Service Staff 2 Others 0	Direct Service Staff 0 Others 0	Direct Service Staff 2 Others o
8. Tagalog/Filipino	Direct Service Staff 14.5 Others _9.5	Direct Service Staff 0 Others 0____	Direct Service Staff 14.5 Others __9.5__

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

IV. REMARKS: Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

Needs Assessment Methodology

This Needs Assessment Narrative is the result of a two-pronged information gathering process. The first was a Quantitative Analysis of all 845 full-time equivalent (FTE) volunteer and paid positions funded with public mental health dollars in San Joaquin County. This analysis included an account of all BHS, CBO and network provider occupations, a race/ethnicity and language analysis, and a count of positions specifically designated for consumers and family members. The results of this analysis precede this narrative and are referred to in this narrative as well.

Additionally, this narrative is based on a number of participatory information gathering activities conducted between March and August 2008, including:

- Key informant interviews
- Focused discussion groups
- Community meetings.

A summary of these activities is included in Exhibit 2.

A. Shortages by occupational category:

Community stakeholders, including staff and management of Behavioral Health Services (BHS) and contracting community-based organizations, and consumers and family members, consistently reported a current shortage of qualified candidates for the following occupations in San Joaquin County:

- **Psychiatrists, particularly child psychiatrists—**During a consumer and family member focus group, one participant stated: "*I wanted to see my psychiatrist and was told that they wouldn't be able to see me unless I was having a crisis. But by the time I'm in crisis, it's too late*." Another participant stated, "*We have only one child psychiatrist. We have people in crisis and huge waiting lists. This puts a lot of responsibility on the individual doctor*." Another consumer, who requested a new psychiatrist, reported having to wait a year for an appointment. This shortage extends beyond the County. According to one BHS administrator, there are only about 20 child psychiatrists in the entire Central Valley. Currently, County public mental health and contract agencies employ 25FTE psychiatrists (15.5 FTE general, 6 FTE Child/ Adolescent and 3.5 FTE geriatric). In 2006, BHS and contract agencies served 13,149 clients. This means that each psychiatrist has a potential caseload of approximately 525 patients (not all clients receive psychiatric services). The shortage of psychiatrists (as well as other psychiatric providers) will certainly grow in the coming years as additional state and regional facilities open doors in San Joaquin (see description of such facilities below).

- **Nurses and psychiatric technicians—**San Joaquin County's BHS currently has a 12% vacancy rate for psychiatric technicians and a 6% vacancy rate for nurses. The general perception among BHS employees, contractors and management is that the County cannot compete compensation-wise with the private sector or State institutions. Recently, State facilities increased nurse and psychiatric technician salaries. This not only affects the pool of qualified job candidates, but also makes retention of qualified candidates particularly challenging.

- **Licensed Clinicians—**According to BHS managers, the supply of qualified unlicensed MSW and MFT candidates fluctuates. Currently, there is no severe shortage. Once hired as interns, however, many entry-level clinicians never advance to licensure. For example, there are currently 20 licensed clinicians working for BHS and 58 unlicensed clinicians. Some unlicensed clinicians reported feeling discouraged after having failed the exam multiple times; others, according to one manager, may not feel that they have enough incentive to get their license. One of the biggest challenges associated with a shortage of licensed clinicians has to do with insufficient capacity to supervise unlicensed clinicians. Many of the most qualified licensed clinicians end up advancing up the career ladder and beyond the role of supervisor, thus adding additional pressure to the shortage of qualified supervisors.

- **High End Office Workers--**In addition to the direct service occupation categories listed above, several stakeholders described shortages of candidates for specialized public mental health administrative and office jobs. For example, there is currently a 20% vacancy rate for accountants, and these vacancies are predominantly for high-end positions such as Accountant III.

- **Managers and Deputy Directors—**San Joaquin County has a severe shortage of non-supervisory management staff due to recent retirements and professional advancements. Correspondingly, there is a shortage of local qualified candidates available to fill vacant positions. There is currently an 18% vacancy rate at BHS for managers above direct supervisor.

BHS is not alone in demanding skilled labor. The shortage of qualified candidates in these occupations is mirrored by similar shortages throughout the County in a variety of industries requiring highly trained and/or educated workers. Local industries in San Joaquin County, including health care, are having trouble attracting high-end workers. According to a Deputy Superintendent from San Joaquin's Office of Education, the school districts are consistently receiving requests from industry leaders for graduates with a variety of vocational skills and interests. While promoting career pathways is a local priority, there are a variety of challenges: "*State and Federal educational guidelines support a basic and generic type of education that does not generally allow high school students the opportunity to explore and train for specific occupational areas such as those found in health careers. The lack of State and Federal funding needed to provide these types of educational/occupational training opportunities is also greatly lacking*."

Several other factors impact the County's ability to hire and retain qualified job candidates across all occupation categories. Numerous BHS stakeholders described the challenge of hiring within civil service guidelines. Staffing shortages, for example, are exacerbated by long lag times between job posting and hiring; desirable candidates are hired by community based organizations and the private sector long before the County has

completed its process. The pay differential between County and State employees further exacerbates BHS's ability to hire and retain qualified employees. Furthermore, there is currently a hiring freeze for San Joaquin County.

The regional job market poses an additional challenge for BHS, its contractors, and the private sector. San Joaquin County has no medical school or University of California campuses. Few professionals are attracted to the County who are not from the region. Once local talent leaves the area for college or graduate school, they are further drawn away from the County by higher wages, attractive internships and residencies, and other amenities.

BHS is deeply concerned about plans to develop a 1,800-bed State Prison Healthcare Facility in the County. This facility will have a tremendous impact on the job market in the region, since the new facilities will draw already scarce employees from BHS and other health care service providers. BHS estimates that costs associated with salary escalation (based on a 10% wage increase) will total $4.0 million annually. Additionally, Stockton is slated to be the site of a regional reentry facility that will provide mental health and substance abuse services to up to 500 inmates prior to their release to Calaveras, Amador and San Joaquin Counties. Based on current state salaries, it is expected that the healthcare and reentry facility will place further pressure on the department to recruit and retain qualified, skilled employees. To date, there are no additional educational or training programs within the region to help offset the demand for licensed workers.[2]

Estimating Additional Staffing Needs

Our analysis of the number of additional FTEs needed to meet current estimated mental health needs is based upon the following analysis: In Fiscal Year 07-08, Medi-Cal approved 8,412 claims for mental health services in San Joaquin County. Each month, 148,682 individuals during this fiscal year were eligible for such services. The penetration rate of mental health services therefore equals 5.66%. In order to match similarly-sized mental health programs in other counties, BHS would want to achieve a penetration rate of 6.34%[3]. This would mean that an average of 9,423 beneficiaries would need to be served each month--an increase of 1011 individuals. Currently there are 975.5 authorized FTE mental health positions in the County. If services were provided at the same ratio of authorized positions to beneficiaries, with the increase in beneficiaries, there would need to be an increase of 117.2 authorized positions—a total of 1092.7 positions. These 117.2 FTEs, distributed among current occupation categories, represent the number of additional FTEs needed to meet current estimated mental health needs.[4] 6) In addition to evenly distributing these 117.2 positions across all occupation categories, several occupation categories could be reinforced; specifically, with additional capacity, BHS could hire more psychiatrists, nurse practitioners and physician assistants to help reduce psychiatric caseloads. Additionally, BHS would like to increase the number of outreach and peer positions dedicated to consumers and family members. While this analysis is intended to bring BHS staffing ratios to

[2] The quantitative needs assessment in this document does not include the number of additional positions that will be needed for these proposed facilities.

[3] The figures for this analysis are based on San Joaquin County MHP CAEQRO Report for Fiscal year 07-08.

a level commensurate with counties of a similar size, these figures should not be seen as sufficient to meet the needs of our entire target population of residents falling below the 200% poverty threshold with SMI and SED.

Section A: Summary of Needs

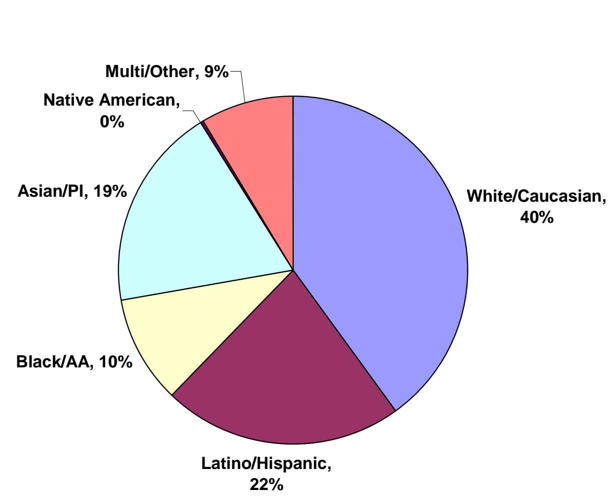
- San Joaquin County is experiencing a shortage of the following public mental health service providers:
  - Psychiatrists, especially child psychiatrists;
  - Nurses and psychiatric technicians;
  - Licensed clinicians; and
  - High-end office workers such as Accountant III.
- In order to achieve a penetration rate equal to that of other similar mental health programs, San Joaquin's public mental health system would have to employ an additional 117 FTES." evenly distributed over the occupation categories, with additional positions for those capable of providing routine psychiatric care and peer support.
- Factors that impede hiring and retention include:
  - Lag time between application and hiring date;
  - The State pays significantly higher salaries for many positions;
  - New facilities will increase the demand for qualified job candidates; and
  - General shortages of educated and trained community members throughout County and Region; fewer undergraduate and graduate programs than in other parts of the State.

B. Comparability of workforce, by race/ethnicity, to target population receiving public mental health services

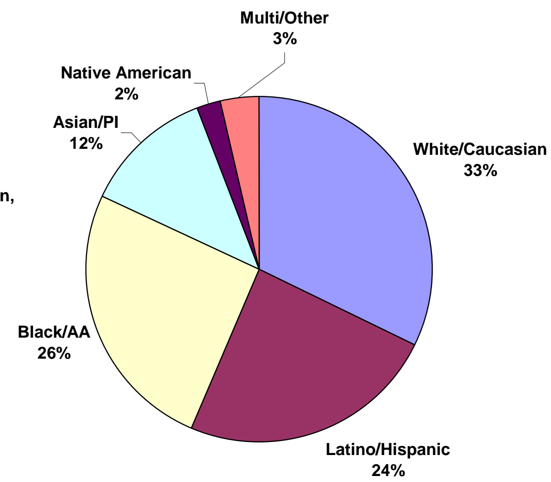
San Joaquin County's public mental health workforce, in general, is fairly diverse. And through implementation of the MHSA Community Services and Supports (CSS) Plan, BHS has made recent strides in increasing its diversity. The CSS Plan funded twelve community-based organizations--most of which represent traditionally underserved constituencies including Latinos, Southeast Asians, African Americans, Native Americans, Muslims, lesbian, gay, bisexual and transgender populations, and the homeless—to provide community based mental health services. In turn, these CBOs have hired providers who are representative of their communities. These public mental health service providers, many of them with consumer or family member experience, have added to the diversity of San Joaquin's public mental health system. Particularly, as the pie charts indicate below, African Americans are more widely represented within the CBOs than in the Department.

Comparison of Ethnic/Racial Composition of BHS Staff to CBO Mental Health Staff, San Joaquin County

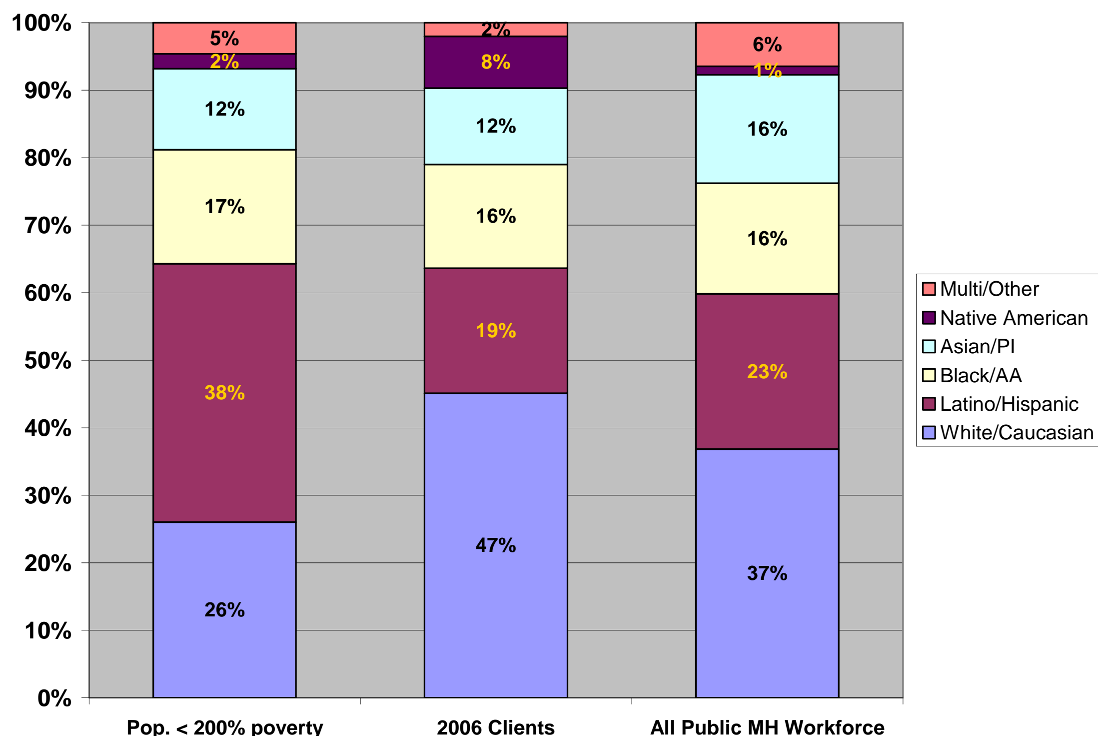
BHS Workforce



CBO MH Provider Workforce

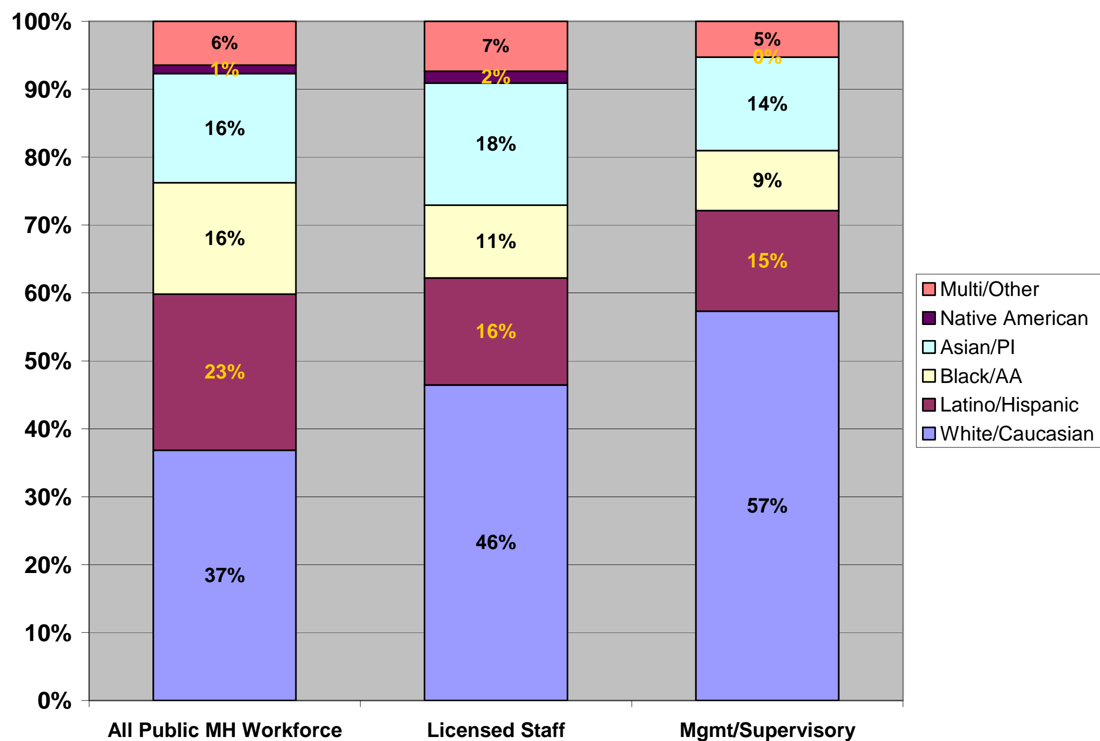


The following analysis of workforce diversity compares the ethnic makeup of San Joaquin County's population with income below the 200% poverty rate; the ethnic makeup of BHS clients[5]; and the ethnic makeup of BHS and contractor staff. Note that Latinos are underrepresented as clients (19% of clients vs. 38% of eligible populations) and underrepresented as staff (23% of staff). Note too that while Native Americans represent only 2% of the eligible population, they represent 8% of the 2006 BHS clients. Only 1% of the public mental health workforce identifies as Native American. The current staffing is very representative of African Americans and the workforce has a proportional overrepresentation of Asians. (Note that the Asian category includes many different ethnic and language groups and does not address any shortages of specific Asian subpopulations).



[5] 2006 unduplicated count.

The ethnic/racial composition of the public mental health workforce is not consistent across the board; licensed staff and management are more likely to be white/Caucasian and less likely to be Latino or African American than unlicensed, non-supervisory staff. The following chart compares the ethnic/racial composition of all staff, to licensed staff and management:



During each focus group and key informant interview, participants were asked to identify shortages of culturally representative staff. Participants consistently reported a shortage of Latino staff, particularly clinicians and direct service staff. According to numerous planning participants,

particularly BHS managers, another challenge associated with hiring Latino and other underrepresented constituents has to do with civil service requirements and the length of time it takes to hire within the public sector. For example, several years ago, BHS made an effort to recruit Latino clinicians by providing MSW stipends. In spite of the fact that Latino candidates were in high demand, these particular students were not as competitive according to civil service standards, and were not hired by the County. Additionally, the length of time between job posting and hiring can be quite lengthy. Several participants stated that the most competitive candidates--those with cultural or linguistic competency—often accept jobs in the private sector rather than wait to complete the County's hiring process.

Stakeholders involved in the planning process recognized workforce shortages of the following cultural and other target groups:

- African American, particularly male, with bachelors in social work and clinicians: "*In Children and Youth Services, there are a lot of boys who request African American counselors. There hasn't even been anyone to interview.*"
- Latino, particularly Spanish-speaking
- Hmong, Laotian, Vietnamese, Cambodian and Chinese staff.
- Native American clinicians. "*There are not many Native American personnel in California. We need to recruit and employ traditional healers specifically that serve the Native American community.*"

Stakeholders across the board recognized an ongoing need for cultural competency and diversity training for all staff, from psychiatrists to clerical workers, regardless of their background. Cultural representation is critical to providing competent services, but there are diversity issues even within recognized cultural groups. Gender, age and life experience all impact an individual's reception to mental health services. During a focus group with contracting CBOs, several providers of services to Southeast Asians explained the complexity of providing services in their community. They explained that cultural competency is not just about representation, but also about taking advantage of culturally relevant evidence based practices and treatment modalities. "*For Asians, mental health is a sensitive issue. People hide their problems. We need cultural training and training in good approaches to working with Asians. We need to raise awareness in the Asian community and provide training for family members of Asians.*" Another participant explained, "*We need training on how to develop a Vietnamese support group.*" And one Southeast Asian focus group participant expressed, "*Cultural competency isn't just about language and culture. In my culture, the younger generation doesn't have the capacity to approach the older generation.*"

Cultural competency in relation to age, sex and gender are also of particular interest to the workforce in San Joaquin County. Several planning participants remarked about a shortage of recognizable lesbian, gay, bisexual and transgendered (LGBT) clinicians: "*There are only one or two clinicians that focus on the LGBT population. People need to know that LGBT providers exist.*" During an employee focus group, there was a major difference in perception about services available to the LGBT population. One participant reported that there are a limited number of providers that can relate to LGBT clients, which has resulted in fewer LGBT referrals and follow-through. Another employee focus group participant responded, "*Where we work has nothing to do with gender.*" This exchange suggests a very disparate understanding of the service needs of the LGBT population. According to another employee, when it comes to shifting staff perceptions about the LGBT community, a small amount of sensitivity

training is not enough. "*People get trained, but they don't take it to heart. They just go back to what they were doing before*." Comments such as these suggest a need for continuous sensitivity and diversity training, not just related to LGBT issues, but related to all underserved communities. Additionally, several stakeholders noted the gender-specific nature of their professions, and the challenge within the clinical professions to diversify, "*We don't have many African American males, but we don't have many males, period. We should be encouraging males. There are male nurses, but not a lot of clinicians*."

Section B Summary of Needs:

- There are a shortage of Latino workers across occupation categories;
- There are a shortage of African American clinicians, particularly male clinicians;
- Licensed staff and management are more likely to be Caucasian;
- There are shortages of Southeast Asian and Chinese and Native American staff; and
- Cultural competency requires more than cultural representation. There needs to be additional sensitivity and diversity training for all staff about race, ethnicity, gender, sexual orientation and stages of life.

C. Positions Designated for Individuals with Consumer or Family Member Experience

San Joaquin County BHS is in the process of a system-wide transformation that reflects the core principles of MHSA. Included in this transformation is a shift toward consumer and family member-driven services. While BHS has created staff positions designated for individuals with consumer and/or family member experience, we are also in the process of building our capacity to support, train, and educate the entire workforce so that consumers and family members can participate in all aspects of public mental health services without having to contend with stigma and discrimination. The department leadership, staff and community stakeholders are poised for the challenge of transformation, and the CSS Plan (adopted in 2006) reflects the first step of their resolve.

BHS has embraced MHSA's goal of providing community-based services. Since adoption of the CSS plan, BHS has designated approximately 20 FTE direct service positions to be filled by persons with consumer or family member experience. These are client and family peer outreach positions that include training, and are appropriate for individuals with minimal employment experience.

Of the 20 FTE positions, 15 are Mental Health Outreach Workers, who have had a minimum of one year paid work experience, 4 are Mental Health Outreach Trainees who have had no paid work experience and 1 is a more experienced Mental Health Outreach Coordinator. Additionally, the CSS plan designated funding for 90 FTE positions within 10 San Joaquin community-based organizations. Of these 90 positions, 32 are for consumer support, 32 are for family member support and 25 are for non-direct services support staff. While 13% of public mental health positions in the County

are now designated for workers with consumer or family member experience, 24% of the community based public mental health positions are now designated for such individuals. All of the BHS and CBO consumer and family member positions are entry level except one management-level position in a CBO and one supervisory position at BHS.

Candidates with Consumer and Family Member Experience

BHS and CBO managers report little difficulty recruiting and hiring for designated consumer and family member positions. On the contrary, during consumer and family member focus groups, a number of participants reported wanting to work additional hours, and consumers, in particular, felt that in spite of what they understood as low pay, there was competition for positions. Consumer-stakeholders referred to the prerequisite paid work experience as a barrier to many who may have had volunteer but not paid experience. Additionally, several felt that because the County job classification requires either consumer *or* family member experience, they could not compete against family members, who they believe were likely to have had more consistent paid experience. In addition to perhaps limiting the number of candidates with consumer experience, some consumers expressed a belief that the combined job classification creates a competitive atmosphere between consumers and family members even as BHS tries to reduce such conflicts as part of its recovery model.

Preparation, Training and Support of Entry Level Consumers and Family Members

Entry-level workers and those with intermittent employment histories need job preparation, training and support. Lack of such support can lead to high turnover and a corresponding loss of institutional knowledge. Even if there is no shortage of entry-level candidates with consumer and family member experience, high turnover rates can result in insufficiently trained staff.

BHS management and administration is conscious of the need to provide job preparation, training and other supports and has developed a special classification for consumer and family member trainees. Additionally, BHS has embraced MHSA's goal of providing community-based services; recovery coaches with consumer and/or family member experience recently hired by CBOs are charged with providing peer support to community members who share similar cultural and life experiences. While receiving support and training about mental health from BHS, the Recovery Coaches/Outreach Workers also provide reciprocal educational opportunities about cultural competency and recovery to the staff at BHS. The CBO Recovery Coach positions, too, are designed to provide support to workers with little or irregular work experience. One Recovery Coach described his experience working for a CBO: "*This is an opportunity for me, disabled, with only a 9th grade education, no job experience, and a criminal record, to make a difference. How can I complain?*"

Consumer input during the planning process revealed a range of perspectives on available job preparation, training and other employee support for consumer and family member positions within CBOs. In spite of the powerful cross-training model described above, concern was expressed during a consumer focus group having to do with accountability towards the consumer employees of CBOs. One BHS consumer employee expressed:

> *"We need to make sure that as consumers are hired by the CBOs that there is accountability to the consumers, that the consumers are supported. Are we taking a vulnerable population and putting them in a place where we don't monitor them? Are they resilient? What are they*

doing with their life? We are not hiring them through the County, so how are we accountable to the clients who are taking risks? This County has been active in recruiting CBOs. We have 12 new contracts, most with clients as recovery coaches. These numbers are substantial. Yet, there are differences in the amount of pay each CBO offers. Some make $8 per hour and others $12."

Another focus group participant also expressed concern about the experience of consumer and family members working for CBOs; "*We have a 60% turnover rate of consumers. We are only paid minimum wage. This is like saying we are not valued."*

Stakeholders, including consumers and family members, CBO and BHS managers and supervisors, recognize the need for additional training and support for entry level staff with consumer and family member experience. One BHS manager stated, "*CBO outreach workers are very green. Some CBOs have done extensive training; others are relying on us. It is a challenge; we could use some assistance in this area*." Several managers in a CBO focus group expressed frustration about insufficient training resources. One manager stated that a lot of their funding can't be used for training. Another stated that they lacked time to train entry-level employees. During an interview, a BHS manager expressed frustration about insufficient training for entry level consumers and family members: *"There is a shortage of trained consumers and family members. By the time people are hired, there is a workload and people are desperate. We should have something that trains them, helps them complete their resume and certifies them first."* Currently, there are no such certificate or community college programs in San Joaquin County.

Across-the-Board Training for Staff: Recovery Model and Consumer and Family Member-Driven Services

Ultimately BHS management is responsible for increasing consumer and family member participation in the workforce, maintaining a stigma-free environment and ensuring that the recovery model is embraced by the whole workforce. For the most part, consumer and family participation is valued throughout BHS, but stakeholders in the WET planning process consistently recognized a need for ongoing management training, across-the-board staff education and support for transition. Specifically, some stakeholders recognized that while the workforce wants to embrace transformation, some consumers and family members continue to experience stigma within BHS.

Numerous stakeholders in the WET planning process referred to the challenge of unifying traditional medical models with client empowerment principles. Several participants stated that some of the more experienced staff, perhaps because they were not originally trained in recovery models, have had a harder time embracing client-driven services. Others reported that the medical staff have had the most trouble embracing the recovery and empowerment model. One supervisor engaged in the planning process concurred that some medical staff are ill-prepared for recovery and empowerment: "*Medical nursing is a subculture. We still think they are practicing in the previous, medical culture. In nursing schools, they discourage nurses from going into psychiatry. There is a gap*."

Other planning participants reported that the psychiatrists, in particular, have had fewer opportunities for training and education about the recovery model. This may be true because the psychiatrists are so understaffed that they have not had opportunities for in-depth training in the new recovery

models. While current psychiatrists, nurses and psychiatric technicians are leaving educational programs with a greater understanding of the recovery model, many of the more experienced professionals have had less exposure to such training.

During the WET planning process, numerous CBO and BHS administrators, management and supervisors expressed what they perceived as practical concerns about transformation toward more client and family member-driven services. One supervisor asked the following questions:

> *"As you involve and hire more clients to be part of the workforce, how do we deal with recovery issues in the workplace? What happens when someone you hire decides not to take their medications? What if they say, I can't work in a stressful environment? By nature, this is a stressful environment."*

Some employees with consumer and family experience also expressed dissatisfaction with the transition towards client-driven services. One consumer, during a focus group said, "*I feel like a paperclip, a stapler.*" Another: "*Our participation is trivialized. We are seen as one step above clients.*" Another consumer expressed, *"They think that we will take more time, but in reality, all we need is a support system outside the work day where we can vent. In my opinion, this support could go for everyone."*

On a positive note, San Joaquin County consumers and family members are developing informal and formal support and advocacy networks that help to develop a sense of shared interest and shared voice. One consumer expressed, "*We are now designing our own goals and collaborating as a team.*" Several participants in the consumer and family member focus group expressed interest in facilitating trainings for other staff on their experience. "*We feel we are ready to give back. We have diversity. We bring our own experiences to the table and professionals can learn from us. We could educate ourselves too."* The CSS planning process provided an opportunity to share experiences as consumer and family members, and this WET process has empowered consumers and family members to share experiences as workers and employees of the public mental health system.

Nonetheless, the frustration expressed by some consumers and family members entering the workforce and some of the supervisors clearly indicate a need for across-the-board workforce education and training on MHSA principles concerning consumer involvement in the workplace. During periods of transition, all staff members need an opportunity to ask questions and share strategies. One manager explained the need for open dialogue about the transformation of public mental health. "*We need to have more conversations so that staff understand client and family-driven mental health, so that we aren't resistant. We need to help staff maneuver the transformation.*" Without such opportunities, resentment builds up and opportunities for discrimination and stigmatization arise, even within the very institution that wishes to transform.

The need for such training is particularly critical at this time because BHS seeks to increase meaningful participation of consumers and family members in the workplace. Additionally, there is a general sense of urgency and excitement about transformation in San Joaquin County at this time. One manager explained, "*We are excited about learning strategies for bringing more consumers and family members on board, about boundary issues, competencies, and breaking through stereotypes and barriers.*"

The following are other needs expressed by BHS and CBO employees with consumer and family member experience:

- Leadership training
- Support systems
- Education opportunities
- Fairness and equity in pay and resources
- A position called "Patient Navigator" that can help navigate other consumers and family members through the public mental health system
- Additional WRAP training
- Recognition of our achievements
- Opportunities to work more hours
- Business cards and other expressions of worth

Section C: Summary of Needs

- Lack of paid work and intermittent employment experience is a barrier to consumers entering the workplace.
- Clients & family members report varying experiences participating in workforce. Many want additional hours, educational opportunities, training, support, accountability, & recognition. There is a high turnover rate amongst entry-level consumer employees.
- While BHS embraces the recovery model and consumer and family member involvement in service delivery, there needs to be management training, across-the-board staff education and support for transition in order to reduce stigma.

D. Language Proficiency

San Joaquin County Behavioral Health Services seeks to develop a mental health workforce linguistically reflective of its clients and reflective of County residents with SMI or SED living below the 200% poverty rate threshold.

The US Census provides data on the proportion of residents over the age of five who speak languages other than English in the home. In 2000, the following languages were spoken by greater than one percent (1%) of San Joaquin's population:

- Spanish: 21%
- Tagalog: 2.1%
- Cambodian: 1.8%
- Miao, Hmong: 1.1%
- Vietnamese: 1.1%

While representing the County population in general, these figures are not necessarily indicative of the target population—specifically, individuals living below the 200% poverty rate threshold with SED or SMI. There are no accurate figures to estimate the language proficiencies of this target population. However, according to the California Health Interview Survey (CHIS), 18.7% of San Joaquin residents living below the 200% poverty rate threshold speak Spanish at home and approximately 1% speaks Vietnamese. There are no such figures for any other specific languages. These figures are closely aligned to the 2000 Census figures illustrated above, and therefore, our objective is to develop a workforce with language capacities reflective of the US Census.

The Department's objective is also to develop a workforce with language proficiency to meet the needs of our current clients. The following languages are spoken by over one percent (1%) of BHS clients[6]:

- Spanish: 5.1%
- Cambodian: 3.3%
- Vietnamese: 2.1%

The following table compares the language proficiencies of BHS staff and contractors to BHS clients in 2006, and San Joaquin County residents in 2000. The final column in this table shows the number of additional staff that would need to be proficient in these languages to meet the current client or County linguistic needs, whichever is greater.

	Total BHS FTEs	% of Workforce	2006 Clients	2000 Census	Additional FTEs needed (current staffing)
Spanish	78	9%	5%	21%	100
Tagalog	24	3%	<1%	2%	0
Cambodian	10	1%	3%	2%	18
Hmong	15	2%	<1%	1%	0
Vietnamese	17	2%	2%	1%	1

Note that while 9% of the workforce speaks Spanish and only 5% of the clients were Spanish-speakers, 21% of the entire population in San Joaquin County is Spanish speaking. These figures suggest that Spanish speakers are dramatically underutilizing BHS services. Increasing the number of Spanish-speaking clinicians and other professionals to the BHS staff will make it easier for monolingual Spanish speakers to access services.

[6] BHS and contractor clients, 2006.

The need for Spanish-speaking staff far outweighs the need for staff who speak any other language. One supervisor expressed frustration about not having a sufficient pool of bilingual clinical staff in her department. *"We haven't been able to interview a Spanish speaking therapist that we would consider in the last 3 to 4 hiring rounds. We need Spanish speaking clinicians."* The shortage of bilingual Spanish-speaking staff does not pertain only to clinicians, but to the full range of occupations. The same supervisor explained, "*In clerical services, Spanish is very important. I would like to see one-third Spanish-speaking in clerical. It isn't the kids who call for services, it is their parents, and they don't speak English*."

Another language capacity deficit has to do with a shortage of bilingual supervisory staff and management. According to one Spanish-speaking provider, "*There is a conflict of interest when we translate for management. Clients can't talk confidentially to management [if they are having problems with their provider*].

Finally, the US Census does not provide data on those who use sign language as their primary means of communication. No BHS or CBO staff currently report fluency in American Sign Language, however, 9 BHS employees report some basic proficiency.

Section D Summary of Needs

- In order to serve the County's population, the Department needs 100 more FTEs who speak Spanish and 18 more who speak Cambodian

E. Other, Miscellaneous

During the WET planning process, stakeholders consistently identified challenges associated with developing a more cohesive and seamless service delivery system. Particularly participants recognized a need for:

- Increased community understanding of mental health,
- Cross-systems training and communications,
- Consistent therapeutic models and treatments,
- Across-the-board training on co-occurring disorders,
- Improved communications between centrally-located BHS providers, and those in the community and outside Stockton, and
- More effective and supportive supervision and management.

Increased community understanding of mental health/Cross-systems training and Communication

San Joaquin County is in the midst of a socio-economic crisis that has had and will continue to have an impact on the mental health of our community. Educators, primary care providers, police, probation, faith-based leaders, and other service providers are likely to have first and most

consistent contact with people with early symptoms or serious mental illnesses. One educational representative described the socio-economic landscape within which private and public service providers must operate:

> *"San Joaquin County is the seventh-most dangerous community in the United States, according to the FBI. We have huge methamphetamine use in the outlying areas, and the poverty is unbelievable. We are top-ten in the nation for foreclosures. Adult stress levels are off the charts, but the kids suffer the most. You put all those things together, and it doesn't take a rocket scientist to see that there are people in need. One of the major needs is mental health. We are a violent community and violence speaks to overall frustration and the lack of mental health services."*

In spite of these challenging circumstances, one significant community strength is that health and social service providers are committed to working together to develop strategies. This public education stakeholder explained, "*Our office, mental health, probation, police, WorkNet programs are all friends and we will do whatever we can for each other and do it with limited resources.*"

The commitment to working together provides an excellent environment to cross-train between disciplines. Planning participants expressed the strongest need to cross train with criminal justice and policing, especially in light of incidents of mentally ill people being shot by police. One manager explained: "*They didn't understand the client, couldn't deescalate, and didn't have a contact with mental health. When police have a domestic violence crisis, they call women's services. We need this same relationship with the police*." Cross-training is not a one-way street. BHS recognizes a need to train mental health staff in basic law enforcement and criminal justice as well. One manager expressed, "*We need to understand gang activity and other criminal activities. We need to deal with what the data is telling us about crime in this County*." Cross-training with law enforcement and criminal justice is particularly critical at this time, because the State is currently in the process of opening up a community reentry program, and many more staff will need to serve people with criminal backgrounds.

Additionally, several stakeholders reported the need to increase training to primary care medical providers. One medical administrator explained, "Most family physicians see a lot of mental illness, but their background doesn't allow them to effectively treat and manage those diseases." Due to stigma, many people experiencing early signs of mental illness, and even those with severe mental illness or emotional disturbances, resist going to public providers of mental health services. Doctors, teachers and clergy are often their first contact, and need to have a basic understanding of signs and symptoms and available supports and services.

Primary care doctors, physician assistants and nurse practitioners have the additional capacity to prescribe and monitor psychiatric medicine. But these medical providers do not necessarily have psychiatric training and may end up inadvertently causing harm, especially if they are not in communication with psychiatric providers. On the other hand, given the shortage of psychiatrists and the corresponding potential delay in psychiatric services, by prescribing medications, primary care providers may prevent a psychiatric crisis from occurring. With comprehensive training and improved communication, however, they can help mitigate the severe shortage of psychiatrists by monitoring stable clients and prescribing routine medications.

Consistent messaging and therapeutic models

San Joaquin County BHS has recently gone through a series of transformations that have affected its ability to provide consistent services. Since implementation of the CSS plan, twelve CBOs have received MHSA funding to provide mental health services. Increasing the number and diversity of institutions that provide mental health services has created a number of challenges, particularly in maintaining consistent services. Some CBOs, for example, do not have a history of providing mental health services, and some employees may lack basic "Mental Health 101" training. Additionally, even within BHS facilities, stakeholders recognize the need for trainings to ensure clients receive consistent information, therapies and treatments.

Both managerial and non-managerial staff involved in the WET planning process requested additional training and technical assistance to address perceived inconsistencies between involuntary programs, such as conservatorship, with programs that emphasize consumer empowerment and wellness. One conservator explained, *"The wellness, recovery, family and client driven models are in direct polarization to my work. We need training on how to begin the process, so that when the clients get off conservatorship, it isn't a black and white shift."* Because involuntary and voluntary services are provided under the same roof, the Department recognizes the need for developing a unified message to present to consumers, their families and the community at large about the transformations toward wellness, recovery and consumer empowerment.

Several stakeholders expressed the opinion that the inpatient program has not yet reconciled involuntary services and the medical model with the values expressed within MHSA. One manager expressed, *"The quality of our inpatient staff training needs to be improved in terms of sensitivities to working with mentally ill. They have a reputation of being too aggressive with restraints."* One of the nurses who participated in the planning process expressed the belief that there were few consistent therapeutic interventions offered within inpatient services. Particularly, nurses are not likely to have psychiatric certification, which would help enhance therapeutic opportunities. "*If we had a solid therapeutic model, like CBT*[7]*, and everyone was educated and on board, and the clients were on board, then the clients would have more power. If they weren't being treated according to the CBT model, then they could advocate to their therapists and doctors and each other*." Clinicians and their supervisors, too, requested ongoing and consistent training in therapeutic models and evidence based practices. Across all occupation categories, planning participants reported interest in department-wide, ongoing and comprehensive trainings on evidence-based practices, treatment modalities and therapeutic interventions that are consistent with MHSA principles.

Across-the-board training on co-occurring disorders

Consistent with MHSA principle of *integrated service experience*, both substance abuse and mental health services are provided within the Behavioral Health Services department of San Joaquin County. To date, however, managers, supervisors, staff, and consumers do not believe that the workforce shares a common understanding of both mental health and substance abuse service provision. Nor do they feel that co-occurring

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[7] Cognitive Behavioral Therapy

disorders are widely understood by service providers. The result has led to instances where people have fallen through the cracks (e.g. psychiatrists have refused to provide services to current substance users, others are reluctant to prescribe medications that may be addictive to persons with co-occurring disorders, clients have been improperly diagnosed, substance abuse services have not been sufficiently available to youth receiving mental health services, etc.). One manager explained that because of the particular nature of the client population in San Joaquin County, co-occurring disorder training is particularly critical: *"We need co-occurring training as a requirement, given the mix of folks we see on a daily basis. We need a common language that we can all speak."*

Additionally, some of the Substance Abuse Services (SAS) staff involved in the planning process report feeling left out of the integration process. To date, they believe that they have not had sufficient incentives to cross-train in mental health. Additionally, some SAS staff report feelings of stigma associated with being perceived only as former drug and alcohol users, and not as qualified service providers. The mental health staff, too, report that there are limited institutional incentives to receive substance abuse credentials. In order to develop a fully integrated service model, BHS will need to deal with these staff-related issues.

The lack of integration also means that best practices for treating co-occurring disorders have not yet fully been explored and adopted. While newer providers are more likely to receive training in co-occurring disorders, the more experienced providers, particularly those involved in selecting treatment modalities, do not have as much training.

One participant who engaged in the planning process brought up the importance of providing training on co-occurring disorders that are unrelated to substance abuse. Particularly, one provider mentioned the possibility of adult clients falling through the cracks because of an inability to identify diagnoses related to co-occurring mental health and cognitive disorders. While these services are provided to school-age children, the Department employs only one Doctorate in Psychology who is able to administer cognitive tests. During one employee focus group, several clinicians reported interest in attaining a doctorate, but felt that there were no financial incentives within the Department to do so.

More effective and supportive supervision and management

The majority of managers and supervisors at BHS have a clinical or medical background rather than a managerial or business background. In order to oversee clinical staff, supervisors need to be licensed. Clinical experience and skill, however, does not automatically translate to effective business, managerial or supervisory skills. Both managers and non-supervisory staff who were engaged in the planning process reported a need for additional managerial training for supervisors and managers. Another concern, but perhaps more difficult to mitigate, has to do with the shortage of licensed clinicians. Those with the most experience frequently are promoted out of positions that allow them to supervise interns. Supervisors with a clinical background are also now supervising the SAS staff, which adds to the shortage of licensed clinicians who supervise interns and who provide experienced services to clients. There continues to be a need for increased supervisory and management skill building within the Department.

Participants in the WET planning process, when asked about the strengths of the mental health workforce, almost unanimously reported that staff, particularly line staff, really care about the client population. One participant summarized, "*They are here because they believe in this population. They believe in the consumers even before they believe in themselves*." Additionally, participants recognized that the BHS management really want to provide excellent services and are embracing MHSA principals, teamwork and providing up-to-date training. Equally true, many who participated in the planning process reported admiration for the CBO providers. "*As we have added more contractors, the passion and caring I've seen in the CBO staff is amazing. They are committed, even if they are inexperienced.*" Such comments suggest that the process of transforming public mental health services in San Joaquin County is more a matter of identification of best practices, financial feasibility, prioritization and coordination, rather than a lack of will on the part of management and staff.

Section E Summary of Needs

- Community partners with frequent access to mental health consumers—e.g. education, law enforcement and primary care medical providers, and clergy-- need Mental Health 101 training in signs, symptoms, supports, services and de-escalation.
- Recent transformations in mental health services have led to some inconsistencies in service delivery. CBOs and BHS providers outside 1212 feel disconnected. All direct service providers need consistent trainings on evidence based practices and therapeutic models.
- Wellness, recovery & resiliency; cultural competency; and client & family-driven mental health are not universally embraced by all workforce.
- There is a shortage of workers trained in recognizing and treating clients with dual diagnoses.
- Clinical and managerial skills are not interchangeable; managers and supervisors who have been promoted from clinical positions need additional management training.

EXHIBIT 4: WORK DETAIL

Please provide a brief narrative of each proposed *Action*. Include a Title, short description, objectives on an annualized basis, a budget justification, and an amount budgeted for each of the fiscal years included in this Three-Year Plan. The amount budgeted is to include only those funds that are included as part of the County's Planning Estimate for the Workforce Education and Training component. The following is provided as a format to enable a description of proposed Action(s):

A. WORKFORCE STAFFING SUPPORT

Action #1 – Title: Workforce Education and Training Coordination

Description:

Some of the strategies described in this work detail are labor intensive, requiring coordination, assessment, evaluation and management skills. This strategy provides the person power necessary for successfully accomplishing our WET objectives.

BHS will fund a full-time WET Coordinator in order to manage MHSA-funded workforce development activities. The WET Coordinator will be supported during the first year by a consultant, who will help set up policies and procedures for implementation of workforce development activities, and measurable objectives and data collection protocols for evaluation of such activities.

The WET Coordinator will be responsible for recruiting, developing and maintaining a variety of advisory counsels and volunteer groups that will help manage workforce activities. These advisory counsels will include Mental Health Board Members, BHS and contracting CBO management and staff, consumers and family members and individuals from underserved communities. Such advisory counsels will include:

- A **WET Steering Committee** that will help: 1) identify and prioritize core competency training needs; 2) identify and prioritize ongoing staffing shortages; 3) evaluate WET activities and recommend policy and program changes; and 4) award educational and career incentives.
- A **Committee of Change Agents** to help integrate substance abuse and mental health services for individuals with co-occurring disorders.
- A **Speakers' Bureau** that will provide Mental Health 101 trainings to community partners.
- A **Team of Volunteers** that will lead vocational support groups and workshops.

One of the primary responsibilities of the WET Coordinator will be to oversee the implementation of strategies intended to further *Culturally and Linguistically Appropriate Services* (CLAS) standards. The WET Coordinator will facilitate meetings with the Human Resources Department and other management staff to develop a formal diversity plan that supports cultural and linguistic objectives for recruitment, retention, and promotion. In addition, s/he will work to ensure that WET activities, including trainings and educational incentives, are consistent with CLAS standards.

The WET Coordinator will also be responsible for coordinating and managing staff trainings to ensure all staff receive training in core-competencies and that particular occupations and departments receive trainings in accordance with specific needs. The WET Coordinator will be aided by an on-line training management system that helps track course participation, completion and continuing education units. Additionally, the WET Coordinator will help select trainers and provide logistical support for trainings.

The WET Coordinator will be responsible for outreaching to underserved communities to inform them about occupational shortages and educational opportunities. Particularly, the WET Coordinator will network with community colleges and high schools to identify bilingual students (particularly Spanish-speaking), Latino, Native American, Southeast Asian, African American and bicultural students and encourage them to pursue mental health careers and apply for career incentives.

The WET Coordinator will also outreach to and develop relationships with partner organizations to ensure high-level support for Mental Health 101 trainings and that such knowledge is incorporated into practice.

The WET Coordinator will also develop relationships with local and regional educational institutions to encourage curriculum is consistent with core MHSA principles. S/he will help local colleges develop specific educational programs that respond to the staffing need of the department and the interests of consumers, family members, those from underserved communities, and current staff, and s/he will participate in regional and statewide partnerships aimed at reducing staffing shortages and increasing staff diversity. In addition, the WET Coordinator will work with local educational institutions to develop internships for students and recent graduates with unique skills, knowledge of evidence based practices, and credentials. For example, the University of the Pacific prepares students locally in Applied Behavioral Analysis. We will seek to develop internships for such students and recent graduates that they may help add to the richness of our service delivery systems.

The WET Coordinator will manage the WET budget and will make sure that funding is utilized according to the WET Plan and within the time periods specified. S/he will manage the distribution of financial incentives and payments to professional trainers and group facilitators. S/he will work with other County MHSA coordinators and DMH to develop a single, unified MHSA plan that is consistent with County needs and local and state guiding principles.

BHS is committed to ensuring that the WET plan meets the stated objectives described in each of the actions below, and to identifying additional goals and objectives as new challenges arise. While the WET Coordinator will work with the WET Committee and BHS management to continuously analyze the impact of WET-related activities, and each year the WET Coordinator will assist the MHSA Coordinator to complete all annual updates, s/he will also facilitate a comprehensive evaluation of WET activities after the first three years of implementation. The Coordinator will be assisted by an evaluation consultant with expertise in both qualitative and quantitative evaluation methodologies. The consultant will develop evaluation tools, including surveys, focus groups and interviews, and will conduct a cost/benefit analysis to determine if funds are used efficiently. This evaluation will include the participation of a wide range of stakeholders, similar to those who participated in this planning process. Based on findings, BHS may

make changes to the current plan and post such changes for public comment. Our goal is to ensure that WET funds are used in the most efficient and effective manner, and that they continue to address the challenges of the coming decade.

In regards to evaluation and ensuring accountability, a special emphasis will be placed on tracking the success and wellbeing of BHS consumers who enter the public mental health workplace, including those who work for CBOs. The WET Coordinator and evaluation consultant will monitor staff turnover rates, compensation, progress along career pathways, and workplace policies related to the employment of consumers and family members. Findings from these evaluations will help BHS develop additional policies promoting consumer and family member employment and career pathways designed to support consumer-driven services throughout the County mental health system.

Stakeholder Comments:

- *We need someone to help recruit people to work in the County.*
- *Please, please make sure there is someone to do all this work. Make sure it is a full-time position.*
- *This should be a management-level position.*

Objectives:

- Hire a full-time coordinator to implement all WET activities.
- Hire a part-time consultant during the first year of implementation to assist in developing the infrastructure for ongoing implementation of WET activities.
- Establish policies, procedures and selection criteria for WET advisory councils.
- Coordinate, oversee and evaluate all WET activities, as described in this plan.

Budget Justification:

- One-time cost: $75,000 for a first-year implementation consultant to help develop the organizational infrastructure, relationships, curricula, and financial incentive payment system based on prior contract history.
- One-time cost: $50,000 for technical assistance with evaluation activities based upon estimate from evaluator.
- Ongoing costs[8]: $105,000 for 8 years to fund a full-time WET Coordinator. Costs are based on the salary and benefits for a Management Analyst II or Mental Health Clinician II position. Total ongoing costs = $105,000 x 8 years = $840,000.
- Total request: $965,000

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $186,000**	**FY 2008-09: $779,000**

[8] All ongoing costs are estimated for 8 years unless otherwise noted. BHS is requesting the entire portion of available funds and assumes that funds set aside for future years will accrue value proportional to the rate of inflation.

Action #2 – Title: Medical Staff Development

Description:

Stakeholders identified two critical needs that led to the Medical Staff Development strategy:

- San Joaquin County has a severe shortage of psychiatrists willing and able to serve the public mental health needs; there is a particular shortage of child and geriatric psychiatrists and recovery-oriented psychiatrists.
- The principles of *Wellness, recovery & resiliency* and *client & family-driven mental health* are not universally embraced by the entire workforce, particularly the medical staff have not received sufficient training in MHSA principles.

BHS seeks to hire a Medical Director whose job will be, in part, to attract and retain qualified medical providers (psychiatric techs, nurses, psychiatric nurses, nurse practitioners, physician assistants and psychiatrists) and who will work to eliminate stigma by ensuring that the medical staff have the necessary training, education and background to appropriately serve the diverse client population. To accomplish these goals, a portion of the Medical Director Salary will be paid for with WET funding.

The Medical Director will be responsible for the following activities:

- Ensure that all medical staff are trained in MHSA principles and in core competencies, including the medical and relevant clinical aspects associated with treating co-occurring disorders.
- Oversee mental health trainings provided to primary care medical providers throughout the county (See strategy entitled Mental Health 101 for Medical Providers below) and facilitate the development of cross-communication protocols between primary medical and behavioral health providers.
- Develop positions, job descriptions and policies for the hiring of Nurse Practitioners and Physician Assistants in order to reduce the shortage of qualified medical providers who can assess, diagnose, and manage the prevention and treatment of psychiatric disorders and mental health problems.
- Explore the development of a psychiatric rotation site for psychiatric residents from UCSF or UC Davis. Work with UC Merced to develop BHS as a location for future rotations or residencies. Participate in Central Region Partnership to address regional shortages of psychiatrists.
- Work with the WET Coordinator to ensure that local college and university curriculum is geared toward BHS needs and to the principles of MHSA.
- Coordinate in-house psychiatric nurse certification training or explore other methods to encourage psychiatric certification for nursing staff.
- Recruit qualified candidates for difficult-to-fill medical positions. Encourage community members, particularly youth and people with experience as consumers and family members and people from underserved communities to pursue psychiatric nursing and technician credentials.
- Develop and coordinate with local hospitals and private providers' Continuing Medical Education (CME) Programs to enhance knowledge of mental health, medication management, recovery, co-occurring disorders and anti-stigma initiatives.

Stakeholder Comments[9]:

- *Because we don't have enough psychiatrists, we have to look to other avenues to get more prepared people.*
- *This strategy helps bring more people into the medical field.*
- *We need multicultural doctors; more people who can identify with their culture.*
- *We need more specialty trained nurses.*
- *Nurse practitioners enable more time with patients. They can address cultural diversity directly and more immediately.*

Objectives:

- Designate a portion of a Medical Director's position to WET related activities.
- Integrate MHSA principles, particularly wellness and recovery and client-driven services, and cultural competency into the provision of medical services through educational curriculum, training, effective recruitment and supervision.
- Develop innovative strategies to recruit and retain employees for hard-to-fill medical positions.

Budget Justification:

- Ongoing costs: $25,000 per year (10%) to fund a portion of BHS Medical Director's annual salary of $250,000. The Medical Director is a new position and this funding would be allocated to the provision of WET related activities only. Total ongoing costs: $25,000 x 8 years = $200,000.
- Total Request: $200,000

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $0**	**FY 2008-09: $200,000**

[9] Comments from here on out are from the small-group prioritization worksheets that were filled out during the August 2008 WET community meetings.

B. TRAINING AND TECHNICAL ASSISTANCE

Action #3 All Workforce Training in Co-Occurring Disorders and other Core Competencies

Stakeholders expressed extensive interest in promoting system-wide competencies in co-occurring disorders, and in unifying mental health and substance abuse services to provide a welcoming, culturally competent, evidence-based and seamless service delivery model. Based on this interest, BHS will provide workforce training in treating individuals with co-occurring mental health and substance disorders in a culturally competent manner to staff and volunteers of BHS and contracting CBOs, and to consumers and family members. BHS will seek the assistance of professional consultants who will help create a system-wide integration of services that address the needs of un-served, underserved and inappropriately served individuals with co-occurring substance and mental health disorders. Our intention is to ensure that we are able to integrate the skills and knowledge gained through trainings into consistent practice by all providers of public mental health services. To do so, we recognize that a single training session will not be sufficient; rather, we will need to develop a multi-modal technical assistance and training program and a team of "Change Agents" who will help guide knowledge into practice.

Stage 1: Change Agents—BHS will support a team of Change Agents, made up of stakeholders who share an interest in system transformation. The team will include BHS administrators, departmental managers, and direct service providers, including clinicians, medical staff and outreach workers. The team will also include representation by consumers and family members and individuals from underserved cultural and linguistic backgrounds

Stage 2 System-wide assessment—BHS will contract with Zia Partners, a professional consulting firm founded by Kenneth Minkoff, MD and Christie A. Cline, MD, MBA to conduct a co-occurring needs assessment. The team of Change Agents will work collaboratively with Zia Partners to ensure broad-based stakeholder participation. The result of this needs assessment will be to develop a strategy for integrating services, developing the infrastructure needed to support universal dual diagnosis capability, clinical training and competency development.

Stage 3: E-Learning—The entire workforce, including new hires, will take an e-learning introductory course on co-occurring disorders. The course will be tailored to the specific needs of the department and the strategies developed with Zia Partners, and will take advantage of best practices in on-line instruction methods.

Stage 4: Workforce trainings--Trainings in co-occurring disorders will be provided to all staff and volunteers and will be tailored to specific occupations and service departments. They will focus on improvements in access, wraparound services for adults and children, infrastructure development, inter/intradepartmental communications, regulations, funding, program standards and design, clinical practice and treatment interventions, prevention and early intervention. A central objective of training will be to develop a universal understanding and a common language of service delivery. Trainings will be initially delivered by Zia Partners with additional train-the-trainer sessions for Change Agents, so that they can provide continuous in-house trainings in future years.

Stage 5: Other Core Competencies and Evidence Based Practices---BHS hopes to replicate the transformative nature of all-workforce training for a variety of core competencies and evidence-based practices. While stakeholders in the WET planning process prioritized training in co-occurring disorders, a number of other training needs were repeatedly referred to. They include:

- Cultural competency, for working with diverse race and ethnicities, genders, sexual orientations, ages, abilities, etc., including Brief Multi-Cultural Competency Training Program (CBMC);
- Supervision, including clinical supervision and leadership training;
- Effective language interpretation for bilingual staff;
- CBO capacity building;
- Conflict de-escalation;
- Clinical Incident Stress Debriefing;
- Medication 101;
- Wellness Recovery Action Plan (WRAP) Train the Trainer;
- Psychosocial Rehabilitation and Wellness and Recovery;
- Applied Behavioral Analysis; and
- Family member and patient rights.

The intention of the WET planning process was to develop training and workforce development strategies that remain true to the interests of the community stakeholders, and are flexible enough to respond to new challenges as they arise. The intent of this strategy is to develop a replicable method of transforming new knowledge into effective practice across the entire spectrum of public behavioral health services through the use of Change Agents. We have created a workforce development infrastructure that enables the identification of training needs as they arise.

Stage 6: Needs assessment and evaluation--On an ongoing basis, the WET Coordinator, in partnership with the WET Steering Committee, will survey staff and/or management to identify and prioritize training needs. The WET Coordinator will also be responsible for developing a set of outcome measures and data collection protocols for an outcome evaluation of training-related activities. At regular intervals, the WET Coordinator will administer pre- and post-surveys to training recipients to identify what is being learned, by whom, and how knowledge is being applied. BHS will use WET funds to support professional trainers, e-learning modules, and technical assistance for transforming core competencies into effective practice.

Stakeholder Comments:

- *The issues of mental health and substance abuse are very connected; often we can't address one without the other. Staff need to be better equipped.*
- *There are a large proportion of substance abusers in this community.*
- *We must get support at the administrator/supervisor level for implementing evidence based practices in dual diagnosis.*
- *We need to focus trainings on transitional age youth and underserved populations.*

- *Training should be on-going. We should train everybody, not just a few.*
- *Tie in e-training (e-learning) to broaden the knowledge base.*
- *[E-learning]: We like to be able to get training at home with 24-hour access.*

Objectives:

- Train all BHS and contracting CBO staff and volunteers in co-occurring disorders and develop the infrastructure for system-wide integration of services for dually diagnosed individuals.
- Train the entire workforce in at least one core competency each year, with curriculum tailored to specific occupations and departments.
- Develop a practice of prioritizing ongoing competency training needs and transforming knowledge of core competencies into effective practice through the use of train-the-trainers and Change Agents.
- Assign all-workforce and occupation-specific and workplace-specific web-based courses to BHS and CBO staff. Establish a training management system that assigns specific courses and tracks course completion.
- Evaluate training outcomes.

Budget Justification:

- One-time cost: A maximum of $54,333 per year for three years for staff and volunteer training and technical assistance by Zia Partners per quote for system-wide integration of mental health and substance abuse services. Funding totaling $163,000 will be used during the next three years to develop core competencies and effective practice in co-occurring disorders.
- Ongoing costs: $35,000 per year for the next 4 years for e-learning contracts for BHS/CBO employees and volunteers based on proposed contract. Total ongoing costs for e-learning: $35,000 x 4 = $140,000.
- Ongoing costs: A maximum of $15,000 per year for training of BHS and CBO employees and volunteers. Funding will be used to pay for professional trainers and technical assistance, curricula and other educational materials. Total ongoing costs for staff training: $15,000 x 8 years = $120,000.
- Total request: $423,000.

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $7,500**	**FY 2008-09: $415,500**

Action #4 Mental Health 101 for Community Partners

Description

BHS will provide basic training in mental health signs and symptoms, crisis intervention and de-escalation, and how to best access mental health services and supports to those of our partner organizations and agencies that may have first or ongoing contact with individuals experiencing the onset of severe emotional disturbances (SED) or with serious mental illness (SMI).

In light of shootings that resulted in the injury and death of community members living with a mental illness, community stakeholders repeatedly brought up the need to train first-responders, particularly County law enforcement officers. Stakeholder understanding is that these tragedies may have been prevented had officers been trained to recognize mental illness, de-escalate emotional crises and understand the range of emergency mental health services.

Law enforcement and probation officers who participated in the planning process demonstrated enthusiasm for Mental Health 101 trainings, and the WET Coordinator will be responsible for continuing to develop and maintain relationships with first responders and other community partners. Such collaborative relationships will ensure requisite leadership buy-in, because, without high-level commitment, such trainings will not be integrated into coordinated programmatic and policy change.

Implementation: A Mental Health 101 Training Team, made up of a professional trainer and a Speakers Bureau will convene approximately 20 half-day trainings annually. The professional trainer will be widely familiar with available supports and services and will have credentials in Crisis Intervention Training (CIT). The Speakers Bureau will include individuals with consumer and family member experience, and from underserved or inappropriately served communities (e.g. Middle Eastern/Muslim, African American, Latino, Southeast Asian, Native American, LGBT, non-native English Speakers, transitional age youth, etc.). Consumer and family members who participate in the Speakers Bureau will receive a stipend in appreciation for their participation. Consumers and family members will help reduce stigma and provide vital insight into the experiences of people living with mental illness. A culturally diverse Speakers Bureau will articulate how communities experience and respond to psychological crises in unique ways, and will illustrate how cultural biases and misunderstandings affect how first responders and other community partners treat those they perceive as "different". Culturally competent Mental Health 101 trainings will be critical to ensuring that prevention and early intervention activities by first responders are successful.

The following is a list of agencies that will be trained during the first year, based on planning participant prioritizations. The list of agencies and organizations that receive training each year will depend on ongoing needs assessments and relationship building:

- 6 half-day trainings for law enforcement officers (San Joaquin County Sheriff's Department and Lodi, Stockton and Tracy police departments)
- 2 half-day trainings for County Probation Department
- 4 half-day trainings for educators (Lodi, Tracy, Manteca & Stockton School Districts)

- 2 half-day trainings for small school districts, or police precincts
- 6 half-day trainings for clergy, pharmacists, CBOs, private medical providers[10], emergency responders, board and care providers or other community partners

This is a combined Prevention and Early Intervention (PEI) and Workforce Education and Training (WET) strategy because it addresses the PEI goal of reducing stigma and discrimination and the WET goal of providing training not only to County and contracting CBO staff, but also to community partners, such as criminal justice, law enforcement, medical, pharmacological, social services, education, cultural centers, faith-based organizations and other "first responders". Such training will focus on the fundamental MHSA principles of community collaboration, wellness, recovery and resiliency and integrated services, and will reflect the diverse cultural experiences of providers and the people they serve.

Stakeholder Comments:

- *Now we work with many more community partners. There are glaring deficiencies in the knowledge base.*
- *When mental health workers are not on duty, law enforcement officers are the first responders to a crisis. They are not trained to meet the need.*
- *Educators (teachers) are not trained to deal with teenagers' mental health/substance abuse issues.*
- *[Mental Health 101] will increase the capacity of the system to identify customers with mental health issues. Will increase knowledge of staff who deal with customers who have mental health issues.*
- *Difficult and tragic interactions with law enforcement will be reduced.*
- *This would help break down stigma.*

Objectives:

- Offer 20 half-day trainings to "first responders" and other community partners to help them appropriately respond in a culturally competent manner to individuals experiencing SMI and SED.
- Reduce the number of accidental injuries and deaths resulting from insufficiently trained professionals dealing with individuals experiencing SMI and SED.
- Reduce stigma and discrimination and encourage a unified message throughout the County that seeking mental health services is a safe and satisfactory course of action for any individual in need of services.
- Increase the capacity of consumers and family members to articulate their experiences in a safe and welcoming environment and provide opportunities for such individuals to gain valuable and meaningful volunteer experience.

[10] May be eligible for Continuing Medical Education Credits

Budget Justification:

- This strategy will be jointly funded with PEI and WET support. A one-time cost of $20,000 from PEI will fund CIT curriculum, train the trainer and technical assistance.
- Ongoing costs: $19,000 annually. Annual cost is based on:
    - 20 half-day professional stipends @ $750/day = $15,000 ($4,738 from WET and $10,262 from PEI).
    - 20 trainings @ $50 per training for up to four volunteer speakers = $4,000 ($1,262 from WET and $2,738 from PEI).

  The WET component will contribute $6,000 per year. (PEI or other funds will contribute $13,000 per year). Total ongoing costs: $6,000 x 8 = $48,000 from WET funds.
- Total request: $48,000

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $0**	**FY 2008-09: $48,000**

<u>Action #5</u> – Title: Mental Health 101 for Primary Care Providers

Description

Health Care Services Health Department leadership and participants in the planning process prioritized the need to further integrate the services provided by primary care medical providers and behavioral health providers. Primary care medical providers (PCP) often have first and frequent contact with community members who exhibit signs of emotional disturbances or mental illness. Additionally, due to stigma, many individuals and family members resist seeking services from BHS facilities, and rather, look to their doctors for consultation and psychiatric medications. Stakeholders from underserved communities, particularly Asian and Hispanic immigrants, stated that their community members were much more likely to seek services at primary care medical clinics.

BHS proposes to use a portion of PEI funds to support a full-time LCSW or MFT clinician and a part time psychiatrist at primary medical sites to provide specific consultations related to assessments and early interventions. For two years, a small portion of their salaries will be paid for out of WET funds, specifically to offset the costs associated with hours spent in the training of primary care providers and interns. The trainings provided by the psychiatrist and clinicians will focus on developing an understanding in the medical community of:

- The values of wellness, recovery and resiliency;
- The provision of prevention, early intervention, psychiatric and psychological services in a culturally competent, welcoming manner;
- The recognition of signs and symptoms of mental illness, including co-occurring disorders;
- Effective early interventions for first break and the onset of SMI and SED;

- The prescription of medications for routine care and the risks associated with over-prescription by multiple providers, misdiagnosis and other improper treatments;
- When it is necessary/appropriate to refer a patient to BHS and other mental health service providers;
- The rights of patients receiving psychological and psychiatric services;
- The proper use of psychiatric telemedicine;
- Effective communication strategies between BHS and primary care medical providers; and
- The relationship between physical and mental health.

Through cross-training and more effective communication methods it will be possible to provide additional quality routine mental health care in primary care settings and reduce overall psychiatric caseloads.

Stakeholder Comments

- *Broadens treatment capacity. Reserves psych time for problem cases. Increases earlier discharge and transfer to PCP. Lowers stigma.*
- *It would give mental health access to a huge population, especially the underserved, low income or diverse populations.*
- *Psychiatrist and PCP can work together to assist clients and decrease psychiatrist case load.*
- *Psychiatric prescriptions can be given by medical providers.*
- *Addresses psychiatrist shortage.*
- *Reduces medicine overdose, allows treatment of dual diagnoses and recognition by both parties.*
- *This could prevent traumatic first-break occurrences.*

Objectives:

- Provide approximately 100 hours each year, for two years, of mental health training in PCP settings to doctors, pharmacists, interns, nurses and support staff.
- Demonstrate increased knowledge among primary care medical staff of routine psychiatry and psychiatrics, focusing on MHSA principles and help them recognize their role in mental illness prevention, early intervention and treatment.
- Increasingly integrate behavioral health and physical health services so that clients are seen as whole persons with a wide range of personal assets and challenges. Prevent improper treatment, misdiagnosis and over-medication, due to patients receiving uncoordinated services.
- Reduce routine psychiatric caseloads so that psychiatrists can focus attention on clients with chronic mental illness and more difficult to treat conditions.

Budget Justification:

- This strategy will be jointly funded with PEI and WET support.

- Ongoing funds: WET funds will pay $100.00 per hour for 100 hours to a maximum of $10,000 per year for 2 years for a small portion of new mental health clinician and psychiatrist positions. The $20,000 will cover a portion of hours dedicated to primary care medical provider training in mental health. Additional hours will be dedicated to training and technical assistance as well, and will be covered by PEI funds.
- Total request: $20,000.

Budgeted Amount:	FY 2006-07: $0	FY 2007-08: $0	FY 2008-09: $20,000

EXHIBIT 4: WORK DETAIL
C. MENTAL HEALTH CAREER PATHWAY PROGRAMS

Action #6 – Title: Entry-Level Career Pathways

Description
Stakeholders involved in the WET planning process spoke of the need to apply multiple strategies to reduce barriers to employment and create opportunities for consumer and family member participation in the public mental health workforce. Additionally, the quantitative needs assessment, focus groups, and interviews shed light on the need for similar opportunities for individuals from underserved ethnic and linguistic backgrounds, particularly for increasing the number of Spanish-speaking service providers.

The recommended overarching methods for addressing these needs include:
1. Additional opportunities to gain entry-level education and training, and incentives for consumers/ family members/people from underserved cultural and linguistic backgrounds.
2. Available jobs for those who participate in such workforce development opportunities.
3. Incentives for BHS and contracting CBO entry-level employees to gain additional education and training so that they can advance up the career ladder.
4. The development of peer support networks that support consumers and family members as they proceed along career pathways and that help to reduce stigma and discrimination in the workplace.

This strategy focuses on the first two methods described above by supporting collaboration between BHS and Delta Community College to design flexible entry-level certificate programs that respond to workforce staffing needs and the interests of potential students. Additionally, this strategy supports candidates for entry level positions by providing educational scholarships and stipends.

Prospective employees, Mental Health Outreach Workers and Mental Health Outreach Worker Trainees will receive incentives for completing one of the following certificate programs: CASRA Certificate, Psychiatric Technician Certificate, Mental Health Specialist Certificate or Behavioral Health Specialist Certificate. For each full-time semester of courses, they will receive a $500 stipend (in addition to the stipend provided to BHS employees from human resources). Completion of these certificate programs will qualify individuals for positions at BHS (Individuals who are not already employees of BHS will still need to go through the civil service application process, but these certificates will provide all the prerequisite experience and education necessary for entry into the occupation.)

Completion of the 15-unit CASRA Curriculum (which can be completed through e-learning), will promote Mental Health Outreach Worker I or Trainees to Mental Health Outreach Worker II. In addition to a $500 stipend upon completion of the coursework, students will be able to apply the CASRA units towards a Mental Health Certificate or Behavioral Health Certificate. The CASRA curriculum is intended to further infuse the department with the values of wellness and recovery and consumer driven mental health services. Our intention is that elements of the CASRA curriculum will eventually be required training for all BHS and contracting CBO staff.

The proposed development of the Behavioral Health Specialist Certificate program is an effort by BHS and Delta College to encourage the integration of substance abuse and mental health services. A Mental Health Specialist Certificate requires 3 full-time semesters of coursework (or two, with completion of the CASRA curriculum). Substance Abuse Counselor Certificate requires two semesters. The Behavioral Health Certificate will combine some of the coursework so that students can complete the program in 4 semesters. The Behavioral Health Certificate will prepare candidates for proposed Behavioral Health Specialist positions. These positions will be similar in scope to the existing Mental Health Specialist Positions but will include a proposed pay differential (not funded with WET resources).

In an effort to further integrate substance abuse and mental health services, and to build career pathways for substance abuse counselors, BHS will provide incentives for substance abuse counselors to complete a Behavioral Health Certificate program. Certified substance abuse counselors will need two additional semesters of coursework to complete the Behavioral Health Certificate. They will also receive $500 per semester of coursework and be eligible for a Behavioral Health Specialist Position.

The diagram that follows illustrates the career pathways that will be supported by this strategy:

Entry Level Career Pathway Chart

	Semester 1	Semester 2	Semester 3	Semester 4	
Prospective Employee, Mental Health Outreach Worker I or Mental Health Outreach Worker Trainees	CASRA Certificate	$500 + MH Outreach Worker II			
	Psychiatric Technician Certificate			$1500 + Psych Tech I	
	Mental Health Specialist Certificate			$1500 + MH Specialist I	
	Behavioral Health Specialist Certificate				$2000 + Behavioral Health Specialist I
Mental Health Outreach Worker II	Psychiatric Technician Certificate			$1500 + Psych Tech I	
	Mental Health Specialist Certificate		$1000 + MH Specialist I		
	Behavioral Health Specialist Certificate			$1500 + Behavioral Health Specialist I	
Substance Abuse Counselor or Mental Health Specialist I	Behavioral Health Specialist Certificate		$1000 + Behavioral Health Specialist I		

During the first year of funding, the WET Coordinator will work with Delta College's Workforce and Economic Development Dean, Zia Partners, CASRA consultants, and other curriculum developers to develop or restructure the certificate programs. Additionally, it will be the responsibility of the WET Coordinator to recruit potential candidates for these certificate programs and counsel them about their interests, options and current workforce needs. One of the WET Coordinator's primary responsibilities will be to outreach to local high schools and community colleges to recruit students from un-served, underserved and inappropriately served populations. Ongoing evaluation activities, including a survey administered to community college students enrolled in the certificate programs, will measure the impact of such outreach activities.

In conjunction with the County's Human Resource Department, The WET coordinator will manage the distribution of stipends and establish priorities in the event that there is greater demand for stipends than supply. Finally, the WET coordinator will recruit BHS employees to teach Delta college courses, if necessary.

Stakeholder Comments:

- *Encourages existing staff to return to school.*
- *Raises quality of service to the community from the ground up.*
- *Increases skills for co-occurring disorders.*
- *Encourages students to look forward to higher education.*
- *Is important to get an incentive to go back to school because it puts your foot in the door to start as entry level and move forward to continue education in the mental health field.*
- *Provides incentives to succeed in life, job security and free training.*
- *Helps meet the need for a trained, more diverse workforce.*
- *Implement this ASAP! Target audience for consumers aged 55-65.*
- *We are also speaking in regards to all ethnic Asian Pacific Islanders, and don't forget the Native Americans. Must reach out to CBO to recruit the people from Asian communities.*
- *Add CASRA curriculum to the program!*

Objectives:

- Develop educational opportunities for entry-level job candidates. At least 2 new certificate programs will be developed.
- Encourage individuals with consumer and/or family member experience and/or individuals from underserved linguistic or cultural backgrounds to participate in such educational activities. At least 20 students per semester will receive financial incentives.
- Transform BHS services from the ground up by encouraging knowledge of psychosocial rehabilitation. An average of 20 individuals will complete the CASRA curriculum each year.

- Further integrate mental health and substance abuse services by providing incentives for entry level employees and substance abuse counselors to receive proposed Behavioral Health Certificates. An average of 5 students will take courses aimed at attaining a proposed Behavioral Health Certificate each semester

Budget Justification:

- One-time cost: A total of $50,000 for CASRA curriculum and Delta College curriculum development. Costs based on a quote of $7,000 from CASRA for consulting to integrate curriculum into community college courses. Additional $43,000 for professional curriculum and certificate development to Delta College and/or consultant.
- Ongoing costs: $20,000 maximum per year for student incentives. Total ongoing costs for student incentives: $20,000 x 8 years = $160,000.
    - Assumption is that 20 students per semester will request incentives (40 x $500 = $20,000 incentives per year).
- Total request: $210,000.

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $0**	**FY 2008-09: $210,000**

<u>Action #7</u> – Title: Entry-Level Employee Support

Description:

This strategy addresses the interest of consumer and family member employees and volunteers who described a need for additional peer networks that support consumers and family members as they progress along career pathways and that help to reduce stigma and discrimination in the workplace. It also addresses the interest of BHS and contracting CBOs to retain skilled and experienced staff who have valuable experience as consumers and family members.

This strategy will leverage existing vocational services offered by BHS, University of the Pacific's Community Re-Entry Program (CRP) Program and the Martin Gipson Center. These services are geared primarily toward individuals employed or seeking employment in a wide array of careers. The overarching goal of the WET component of MHSA is to develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public. As such, this strategy will add vocational supports for those individuals *specifically seeking employment or currently employed in mental health related fields*.

The following additional vocational support activities will be funded and services will be provided by BHS, Martin Gipson Center or CRP:

Behavioral Health Vocational Support Groups

Planning participants reported that working in mental health services can be incredibly rewarding, and it can also be stressful and challenging. These challenges can be mitigated through the development of safe and welcoming therapeutic environments. These weekly peer-led support groups will be for people who are employed or are currently attending classes to become employed in the public mental health system. They will focus on building resiliency and self-confidence, reducing stress, identifying triggers and decreasing troubling feelings and behaviors.

Behavioral Health Vocational Workshops:
These peer-facilitated empowerment workshops will be open to anyone working, volunteering or preparing to work in behavioral health settings. Topics will cover building a WRAP plan, navigating mental health career pathways and incentive programs, understanding how employment might affect disability benefits, methods of reducing stress, employee rights and responsibilities, developing mentor relationships; conflict mediation and effective communication strategies.

Benefits Counseling
This strategy will provide funding for a portion of an Outreach Worker position to provide benefits counseling to prospective and current employees who receive SSI and SSDI. This worker will be trained to help consumers calculate their benefits using the California on-line Disability Benefits 101--Benefits to Work Calculator.

Consumer & Family Educational Scholarships:
These scholarships are intended to pay for consumers and family members to attend workshops and brief courses on behavioral health related topics with the intention of encouraging those thinking about careers in public mental health to get their feet wet, and those already working in public mental health to broaden their knowledge base. Workshop topics will vary, but topics may include cross-cultural communications and cultural competency, peer counseling, leadership development, policy forums, legislative advocacy, WRAP train the trainer, anger management and domestic violence, crisis management, self care, stigma reduction, suicide prevention, trauma recovery, computer, basic math, English and literacy classes.

E-Learning Community Access Site (CAS), On-Line Courses, Resource Library, Build Your Own WRAP
In order to advance community knowledge and topics related to careers in Mental Health, BHS will purchase a CAS contract with Essential Learning. CAS will be open to all consumers, family members and community members interested in pursuing careers in public mental health. Courses offered through Essential Learning's CAS include: depression, mood problems, panic disorders, anxiety disorders, coping with ADD, brain basics, dealing with trauma, suicide prevention, OCD, bipolar disorder, substance abuse, HIV and AIDS, smoking cessation. Essential Learning also offers an on line Build Your Own WRAP tool. In addition to the courses already available on the CAS web-site, the department may offer its own courses on mental health, self care, and topics related to employment in the mental health field.

BHS will also use the CAS on-line resource to develop a library of resources available throughout the County so that consumers and family members can inform themselves and peers about available supports and services. Essential Learning also maintains a community reference and newsfeed library with health education, wellness news, self-help instructions, videos, questionnaires, essays, advice columns, weblogs, book reviews, etc. The WET Coordinator will be responsible for development and coordination of CAS offerings.

In order to ensure that consumers, family members and other community members without access to computers have an opportunity to access CAS resources, BHS will purchase and maintain two additional computers with the priority purpose of providing access to the CAS website.

Stakeholder Comments:

- *This strategy will increase consumer self esteem.*
- *Consumers can be most effective staff in transforming mental health services.*
- *Corresponds with current emphasis on wellness and recovery, provides critical support to identifying and encouraging consumers ready for this big step.*
- *Adds services to what's already there. Inexpensive.*
- *Helps build coping skills for on-the-job stressors, symptom management at worksite.*
- *We would like them to consider the e-learning company and have CASRA certification, and be able to use WRAP plans.*
- *Implement immediately!*

Objectives:

- Offer weekly vocational support groups and quarterly workshops that help retain skilled and experienced behavioral health staff with critical experience as consumers and family members and that support consumers and family members as they advance along behavioral health career pathways.
- Reduce the stigma associated with seeking support by offering quarterly peer-facilitated, voluntary vocational support workshops to all staff, volunteer or prospective employees.
- Provide 25 scholarships per year for mental health related workshops and on-line community access courses in order to educate consumers and family members and other prospective employees about mental health and encourage them to pursue careers in public mental health.

Budget Justification:

- One-time cost: E-Learning Community Access Site startup fee = $2,245 based on actual cost. Purchase and maintenance of two computers = $6,483 based on actual cost. Total one-time costs = $8,728.
- Ongoing costs: E-Learning Community Access Site = $5,934 for a year-long contract based on quote. Total ongoing costs for E-Learning Community Access: $5,934 x 8 years = $47,472.

- Ongoing costs: Vocational Support Groups and Workshops: $7,000 per year for stipends for volunteer peer facilitators. $3,000 per year for refreshments/supplies. Total ongoing costs for support groups and workshops: $10,000 x 8 years = $80,000.
- Ongoing costs: Benefits Counseling: $8,500 per year to cover training and peer staffing. Total ongoing costs for benefits counseling: $8,500 x 8 years = $68,000.
- Ongoing costs: Educational Scholarships: A maximum of 70 per year @ $125 each. Total ongoing costs for educational scholarships: 70 x @ $125 x 8 years = $70,000.
- Total request = $274,200

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $7,500**	**FY 2008-09: $266,700**

EXHIBIT 4: WORK DETAIL
D. RESIDENCY, INTERNSHIP PROGRAMS

(No funding requested.)

EXHIBIT 4: WORK DETAIL
E. FINANCIAL INCENTIVE PROGRAMS

Action #8 – Title: Career Incentives

Description:

The main purpose of this strategy is to ensure that there are sufficient qualified and culturally competent candidates to fill vacant positions within BHS and contracting CBOs. This strategy encompasses a variety of methods for recruiting and retaining employees for positions that are deemed hard to fill. It is also designed to be flexible so that as an increasing number of candidates are recruited and trained for specific positions, financial incentives can be redirected to supporting students to fill other positions that have been identified as difficult to fill.

This strategy depends on a WET Steering Committee with membership appointed by the Mental Health Board and the WET Coordinator. The committee will have representation from BHS, contracting CBOs, consumers and/or family members and underserved cultural communities. On an annual basis, the WET Steering Committee will identify staffing shortages and set criteria for selecting candidates for financial incentives. Awards will be provided on to applicants scoring the highest number of points on a formally agreed upon point scale. The following considerations will help to prioritize who is awarded the incentives:

- Those who are preparing to fill positions for which there are chronic vacancies or insufficiently skilled or qualified employees. (Current difficult to fill positions include: psychiatrists, psychiatric nurses, registered nurses, nurse practitioners, physician assistants with expertise in psychiatrics, child and geriatric psychiatrists and psychiatrists with expertise in wellness and recovery, psychiatric technicians, psychologists, MSWs, MAs in psychology, counseling or related fields, analysts, tech support, and highly skilled administrators and managers.)
- Those with experience as consumers and family members.
- Those with critically needed language proficiencies. (Currently, there are specific shortages of Spanish and Cambodian speakers, but other language speakers are also in demand.)
- Those from culturally underserved, un-served or inappropriately served communities and those with extensive experience providing services to such community members. (There are currently shortages of Hispanic, African American, Asian and Native American employees in many positions, particularly positions that require master's degrees. There is also a shortage of candidates with experience serving the LGBT community.)
- Those with demonstrable longstanding family or community ties in San Joaquin County and an interest in working within the County for the foreseeable future.

BHS and CBO employees will be eligible to submit applications to BHS for financial incentives. The WET Steering Committee will review applications semi-annually. The application will include an interview process that will, in part, assess the candidate's capacity to complete the educational programming and commitment to returning to the public mental health field in San Joaquin County. The number and amount of awards will vary annually according to demand for qualified staff and the strengths of the applications received. In some years no funding may be awarded and funding will "roll-over" for allocation in future years.

The WET Review Committee will award candidates for the following financial incentives, depending on merit and/or need:

Stipends: Stipends will be awarded to full or part-time students at a full-time student equivalent rate of $18,000 per semester. Stipends may be awarded to employees or to people not yet employed in public mental health. All recipients of stipends will sign a contract stating their intent to work for BHS or a contracting agency for a minimum of 2 years following graduation. Stipends for MSW students can be used for first year students in conjunction with the State's second year MSW stipend.

Scholarships: Scholarships will be awarded for specific educational costs such as tuition, textbooks, etc. Scholarships will be available to part-time and full-time regular employees of BHS and contracting CBOs.

20/20 Program: BHS employees will be awarded the opportunity to work half-time at full salary (up to $72,000 a year in salary and benefits; a cost of $36,000 per employee) in order to further their careers. Candidates must be enrolled in school full-time to be eligible for this incentive.

Loan Assumptions: BHS will further explore the possibility of awarding loan assumptions to prospective and current employees of BHS and contracting CBOs. Assuming that Loan Assumptions are feasible, candidates will be eligible for up to $10,000 per year for up to 6 years in loan assumptions. Loan assumptions are a method of recruiting candidates who have already completed their studies. These incentives are in addition to any loan assumption offered by the State.

All recipients of stipends, scholarships, loan assumptions, and 20/20 benefits will be contractually obligated to work for Behavioral Health Services or contracting community-based organizations after completing studies for a period of time equal to the period in which they received support, and with a minimum commitment of two years. Therefore, a recipient who receives a yearly stipend of $18,000 will commit to two years of employment following graduation. A recipient who receives three years of assistance will commit to three years of employment following graduation. Those who do not meet their obligations will be required to reimburse the County for the full amount of assistance, plus interest.

Stakeholder Comments:

- *This strategy will help bring folks with cultural/language skills to our county.*
- *Southeast Asians and most all of us cannot afford to pay for our school. Any resources or funds that become available could encourage people to participate in the field.*
- *Earning a masters degree is a priority to ethnic community.*
- *Prioritize underserved communities and those with language proficiency.*
- *Students are able to keep their job and benefits while still going to school [20/20].*
- *This will give CBO employees great future opportunities for jobs with the County.*
- *Personally I'm interested in [the 20/20 program] as well.*
- *Encourages those students, clients, family members to excel in the field of mental health services without having to incur the full cost of obtaining their degree.*
- *Need to promote and outreach.*
- *There is no real value in this unless this county becomes competitive in salary/retirement/ benefits.*
- *There's a need 4 years of service/support.*
- *Increase the commitment from 2 to 3 years upon graduation.*

Objectives:

- Offer approximately $100,000 annually in financial incentives to attract and retain qualified job candidates.
- Award incentives to between 3 and 10 individuals annually, depending on dollar amount of each grant.
- Increase the number of employees from underserved backgrounds.
- Increase the number of employees with critical linguistic proficiencies.
- Provide advanced educational opportunities to individuals with experience as consumers and family members.
- Ensure that prospective and current employees who have received incentives remain employed in the County's public mental health system for up to 2 years.

Budget Justification:

- Ongoing costs: A maximum of $125,000 annually. Total ongoing costs for stipends, scholarships, 20/20 compensation and loan assumptions: $125,000 x 8 years = $1,000,000.
- BHS will award between 3 – 10 awards annually, depending on selection criteria cited above. The number of awards will be determined by a not-to-exceed total of $125,000 per year. However, the WET Steering Committee may choose to fund a greater number of awards for hard to fill positions during the initial years, in order to promote an up-front development of staffing capacity.
- Award amounts will vary, depending upon the type of program: 20/20 programs may result in an award of up to $36,000 annually (based on a salary of $72,000). Stipends may be awarded at a rate of up to $18,000 per semester. Loan assumptions will be awarded at a rate of up to $10,000 per year. Scholarships will be in an amount equivalent to the cost of tuition, textbooks and other specific school-related expenses. Our intention is to remain flexible in order to allow for the adjustment of selection criteria based on changes in hard to fill positions, linguistic and cultural needs, and an ongoing interest in providing career pathways for persons with experience as consumers and family members.
- Total Request: $1,000,000

Budgeted Amount:	**FY 2006-07: $0**	**FY 2007-08: $36,000**	**FY 2008-09: $964,000**

EXHIBIT 5: ACTION MATRIX

Please list the titles of *ACTIONS* described in Exhibit 4, and check the appropriate boxes (4) that apply.

Actions (as numbered in Exhibit 4, above)	Promotes wellness, recovery, and resilience	Promotes culturally competent service delivery	Promotes meaningful inclusion of clients/family members	Promotes an integrated service experience for clients and their family members	Promotes community collaboration	Staff support (infrastructure for workforce development)	Resolves occupational shortages	Expands postsecondary education capacity	Loan forgiveness, scholarships, and stipends	Regional partnerships	Distance learning	Career pathway programs	Employment of clients and family members within MH system
(1)	(2)	(3)	(4)	**(5)**	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action #1: Workforce Education & Training Coordination	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**		**x**	**x**
Action #**2:** Medical Staff Development	**x**	**x**	**x**	**x**	**x**	**x**	**x**	**x**		**x**		**x**	
Action #3: All Workforce Training in Co-Occurring Disorders and Other Core Competencies	**x**	**x**	**x**	**x**	**x**						**x**		
Action #4: Mental Health 101 for Community Partners	**x**	**x**	**x**	**x**	**x**								**x**
Action #5: Mental Health 101 for Primary Care Providers	**x**	**x**	**x**	**x**	**x**		**x**						
Action #6: Entry-Level Career Pathways	**x**	**x**	**x**	**x**	**x**		**x**	**x**	**x**	**x**		**x**	**x**
Action #7: Entry-Level Employee Support	**x**	**x**	**x**	**x**	x	**x**			**x**		**x**	**x**	**x**
Action #8: Career Incentives	x	**x**	**x**	x	x		**x**	**x**	**x**	**x**		**x**	**x**

EXHIBIT 6: BUDGET SUMMARY

Fiscal Year: 2006-07			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:			
B. Training and Technical Assistance			
C. Mental Health Career Pathway Programs			
D. Residency, Internship Programs			
E. Financial Incentive Programs			
		GRAND TOTAL FUNDS REQUESTED for FY 2006-07	**0**

Fiscal Year: 2007-08			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:	$186,100	$0	$186,100
B. Training and Technical Assistance	$7,500	$0	$7,500
C. Mental Health Career Pathway Programs	$7,500	$0	$7,500
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$36,000	$0	$36,000
		GRAND TOTAL FUNDS REQUESTED for FY 2007-08	**$237,100**

Fiscal Year: 2008-09			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:	$0	$1,165,000	$1,165,000
B. Training and Technical Assistance	$0	$491,000	$491,000
C. Mental Health Career Pathway Programs	$0	$484,200	$484,200
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$0	$1,000,000	$1,000,000
		GRAND TOTAL FUNDS REQUESTED for FY 2008-09	**$3,140,200**

Attachment A

Strategy Roundtable I: Workforce Training

MHSA-WET Goal:

To develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the public.

Training and Technical Assistance:

Events and activities to assist all individuals who support the public mental health system in better delivering services consistent with the fundamental principles of MHSA. All trainers must be knowledgeable of MHSA principles. Clients and family members should participate as part of the team that develops curricula and provides training.

Summary of WET Needs Related to Workforce Training:

- The MHSA principles of Wellness, Recovery & Resiliency and Client & Family-Driven Mental Health are not universally embraced by all workforce.
- Cultural competency requires more than cultural representation. There needs to be additional sensitivity and diversity training for all staff about race, ethnicity, gender, sexual orientation and stages of life.
- There are a shortage of workers trained in recognizing and treating clients with dual diagnoses.
- Clients & family members report varying experiences participating in workforce. Many want additional hours, educational opportunities, training, support, accountability, & recognition. There is a high turnover rate among entry-level consumer employees.
- Recent transformations in mental health services have led to some inconsistencies in service delivery. Some CBOs and BHS providers outside 1212 feel disconnected. All direct service providers need consistent trainings on evidence based practices and therapeutic models.
- Clinical and managerial skills are not interchangeable; mangers and supervisors who have been promoted from clinical positions need additional training.
- Community partners with frequent access to mental health consumers—e.g. education, law enforcement, primary care medical providers, clergy--need Mental Health 101 training in signs & symptoms, de-escalation, and available supports & services.

Questions:

- What types of trainings are currently available to BHS and CBO mental health staff?
- What mental health trainings are available to other community partners?
- What administrative/coordination activities are being performed by BHS?
- Based on your understanding of workforce needs, what training topics, methods and systems should be offered to all BHS & CBO staff? Is there a particular curriculum or trainer that you recommend?
- In what other evidence-based practices should we consider training the BHS & CBO workforce?
- What administrative/coordination activities are necessary for ensuring successful staff trainings?

Possible Actions/Strategies:

All Workforce

- New Employee Welcoming: E-learning or other training covering wellness and recovery, customer service, cultural competency, career development for new employees (Riverside)
- Training on consumer experience of service delivery for all staff (Colusa)
- All-staff training in wellness, recovery and resiliency (Colusa)
- On-site Spanish language training (Merced); Adult School to provide language courses to staff (Monterey)
- Training and TA to implement full service partnerships (Mono)
- Increasing staff cultural competency using California Brief Multi-Cultural Competence Scale [CBMCS] Self Assessment Tool (Monterey, Riverside, San Bernardino)
- Cultural competency and diversity education provided by trained *Promotores De Salud Mental* [Health Outreach Workers] (Riverside)
- Patient's rights education and training (Santa Barbara)
- All-staff training on assessment, diagnosis, treatment and level of care for co-occurring disorders (Monterey)
- Training in stigma reduction
- Training on consumers and family members as providers and partners
- Training on basic psychopharmacology

Supervisors/Management

- Professional development for supervisors & managers (Santa Cruz, Riverside)
- Mental health supervisors Academy (Kern)
- Leadership development for select employees (Plumas)
- California Association of Social Rehabilitation Agencies (CASRA) training on hiring consumers

Consumers/Family Members

- (Discussed in Roundtable II)

Community Partners

- *In Our Own Voice* public education program given to consumers, students, law enforcement, educators (San Bernardino)
- Mental health training for foster parents and others working with foster children (Orange)
- Mental health training for law enforcement—Crisis Intervention Training (CIT) (Orange, Riverside, Santa Barbara)
- Integrated Services Resource Education to improve community collaboration in service delivery (Riverside)
- Training on consumer experience of service delivery for community partners such as education, law enforcement, colleges, ethnic groups (Orange)
- Psychiatric training for primary care medical providers

Other

- Language interpretation training (San Bernardino)
- Survey staff on specific training needs (Merced)
- Distance Learning Management Systems & E-learning: allows for clinical training, CEUs, tracking of staff training, uploading local trainings, training for community partners (Merced, Monterey, Riverside, San Bernardino, El Dorado)

Clinical Competency w/ Evidence Based Practices

- Dialectic Behavioral Therapy (Monterey, Orange, Riverside)
- Assessing/treating trauma: Seeking Safety (Monterey)
- Assessing/treating co-occurring, etc (Monterey)
- Suicide prevention (Plumas)
- Parent-Child Interactive Therapy (Plumas)
- Functional Family Therapy (Plumas)
- Cognitive Behavioral Therapy (Orange, Riverside)
- Behavioral Parent Training, (Orange)

- Geriatric Psychopharmacology, (Orange)
- Trauma-Peer-Mentoring (Orange)
- Aggression Replacement (Riverside)
- Parent-Child Interaction (Riverside)
- Multidimensional Treatment Foster Care (Riverside)
- Multidimensional Family Therapy, (Riverside)
- Illness Mgmt & Recovery (Riverside)
- Bartels Assessment for Older Adults (Riverside)
- C-Disc Assessment for Children (Riverside)
- Riverside's own manualized group treatment curriculum for co-occurring based on SAMSHA toolkit
- Motivational Interviewing (Riverside)
- Training in working with transitional age youth

Possible WET Coordination Roles and Responsibilities:

- Provide ongoing analysis of workforce training needs, consistent with MHSA principles;
- Convene WET planning, implementation and oversight meetings with relevant stakeholders;
- Identify evidence-based curriculum and appropriate trainers;
- Design appropriate trainings for all occupations; for BHS, CBO and community partner employees;
- Provide logistical support for trainings;
- Evaluate trainings;
- Develop relationships with community partners for community MH trainings;
- Outreach and engage with underrepresented communities, consumers and family members to ensure inclusion in trainings and other WET opportunities;
- Attend local, regional and statewide WET meetings;
- Monitor contracts funded by WET and submit progress reports.

Strategy Roundtable II: Entry-Level Pathways & Support

MHSA-WET Goal:

To develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the community.

Mental Health Career Pathway Programs:

Educational, training and counseling programs designed to recruit and prepare individuals for entry into a career in the public mental health system. Should address lack of equal opportunities and access for underserved communities and preparation of clients and family members.

Summary of WET Needs related to Entry-Level Pathways and Support:

- In order to reach the 60% service target, San Joaquin's public health system would have to employ 714 additional FTEs.
- There is a shortage of Latino, Asian, African American and Native American workers across occupation categories.
- In order to serve the County's population, we need 100 more FTEs who speak Spanish and 18 more who speak Cambodian.
- Lack of paid work and intermittent employment experience is a barrier to consumers entering the workplace.
- Clients & family members report varying experiences participating in workforce. Many want additional hours, educational opportunities, training, support, accountability & recognition. There is a high turnover rate amongst entry-level consumer employees.
- While BHS embraces the recovery model and consumer and family member involvement in service delivery, there needs to be management training, cross-the-board staff education and support for transition in order to reduce stigma.

Questions:

- What types of entry-level career pathway programs are available to consumers, family members and representatives from underserved communities?
- What support services are available to consumers, family members and underserved community members who are employed or volunteering within the public mental health system?
- Based on your understanding of workforce needs, what career pathway programs should be offered by BHS and/or contracting CBOs?
- What support services should be offered to entry level employees and volunteers who have critical experience as consumers or family members or come from underserved communities?
- What administrative/coordination activities are necessary for ensuring successful career pathway and entry-level support programs?

Possible Actions/Strategies:

- **Recruitment Programs**
  - Develop a high school Mental Health Professions Academy (Stanislaus)
  - Develop mental health career track for high school that has existing Health & Human Service Academy (El Dorado)
  - Outreach to high schools, adult schools, community college and employment programs (San Bernardino, Santa Cruz, Stanislaus)
  - Hire a Youth Coordinator to recruit among high school counselors, workforce development agencies and youth clients (Colusa)
  - Summer Bridge Program for high school students (San Francisco)
  - Develop personnel policies that encourage consumers and Latinos to apply (Santa Cruz)
- **Certification & Other Education Programs**
  - Develop a local *CASRA Psychosocial Rehabilitation Practitioner* training by community colleges for certificate. Certificate helps student qualify for national Certified PSR Practitioner. Different than Peer Specialist training because it is appropriate for high school graduates without consumer experience, too. (Merced, Orange, Monterey, Ventura, Contra Costa).
  - 30-hour in-house training using CASRA curriculum. (Madera)
  - *Peer Specialist Mental Health Certificate* Program: a 12-week basic employment skills training, for consumers, offered at community college. *Mental Health Certificate* Program: A more comprehensive program for those consumers & family members ready to pursue higher educational goals (San Francisco)
  - Develop *Mental Health Recovery Certificate* program (Riverside)
  - Develop *Human Services AA Degree* program (Orange)
  - In-house *Recovery Specialist Academy* (Kern)
  - Development of an in-house, county-specific curriculum, *Inspire to Work*, that is particular to the consumer entry-level positions offered at the county. Individuals can choose to go to community college and take two additional courses to receive their PSR Certificate (San Mateo)
  - Two new community college programs at Columbia Community College: *Peer Support* Certificate and *Psychosocial Rehabilitation and Recovery* Certificate. Each 12 units at community college (Tuolumne, similar programs also offered in San Mateo, Solano, Riverside)
  - Recovery Education Institute for those not ready for AA or certificate-level programs, operated by consumer/family members. Offering basic skills, illness management, medication, interviewing skills, computer literacy, communication skills, literacy. (Orange, Riverside, Kern)

- Combine Human Service (60-units) and Substance Abuse Service (30-unit) Credential Program. Provide incentives.

- **Consumer/Family Member Support**
  - Expand WRAP training for consumer/family member employees.
  - Supportive services provided by colleges for consumers enrolled in public universities and private colleges (San Francisco)
  - Job Club at a CBO: sharing success stories, learning new strategies, facilitated by consumers who have successfully gained employment (Trinity)
  - Consumer & family member employee support groups (Colusa)
  - Employment & educational support by a team including clinician, health education assistant, peer support specialist (Riverside)
  - Employment Support position for employee with consumer experience (Orange, Colusa)
  - NAMI trainings: *Peer to Peer* aimed at consumers and contains individual relapse prevention planning, debriefing/storytelling, advance directive for psychiatric care. *Family to Family* is for family caregivers on clinical treatment and coping. (Monterey, San Bernardino)
  - Mentorship Project provides support to new consumer employees by providing trained mentors with employment and recovery experience (Alameda)
  - Benefits Counseling and Transitions Training, run by consumers to teach people in recovery how to transition off benefits (Alameda)

- **Educational incentives for entry-level employees**
  - Scholarship fund available to any employee to pay for fees, books, supplies (Colusa)
  - Consumer/family member internship program w/ weekly stipends (Santa Barbara)
  - Financial incentives to increase workforce diversity: AA & BA stipends & 20/20 & 30/10 program (Orange, Kern, Stanislaus)
  - High school, bachelor and associate internship program w/ stipends (Orange)
  - Tuition reimbursement of paraprofessional staff (Mono)

- **Other**
  - Develop pool of consumer and family members (Pool of Champions) who are trained as trainers and facilitators so that all mental health trainings can include presenters who speak from personal experience. Consumer Champions also participate in campaign to combat stigma and discrimination and participate on panels, taskforces, evaluation and planning (Alameda)
  - Recovery Opportunity Center (ROC) 3-day training called METAmersions to help build recovery-based delivery systems. Send team of staff and volunteers to Phoenix for initial training. Those trained will work with consultant to train staff in learning value of consumer employees and a cohort of consumers seeking employment (Kern, San

Bernardino) Also offers a 72-hour Peer Employment Training and an Advanced Peer Employment Training.

- CASRA preparation for and training on hiring consumers
- County-developed training for supervisors on how best to support consumer employees (Alameda)
- Leadership development program, contracted through community college, for management transition and succession planning (San Bernardino)
- Consumer and family member volunteer program (Stanislaus)
- Consumer Employment Liaison. Promotes educational opportunities for consumers, works with management teams HR office, workforce development agencies, develops trainings for consumer providers and supervisors, works with self help organizations, develops Consumer Employment Strategic plan (Alameda, Colusa)
- Workforce Development Specialist to promote employment of clients and family members in public mental health system. Job functions include recruitment, job analysis, training, coaching, benefits counseling, negotiations for reasonable accommodations (Monterey)

Leveraging Existing San Joaquin Programs:

- **Strength Based Wellness Recovery & Vocational Preparation Program:** A model program that offers a Vocational Rehabilitation Community Skill-Building Group, Literacy Program, Strength-Building Peer Support Group, Post-employment support and counseling. Wishes to fortify and expand program to reach more consumers, increase tutoring to Spanish-speakers, provide additional stipends to consumer participants and volunteers.
- **Community Health Forum:** A partnership between County Board of Supervisors, colleges, hospitals, health departments to develop career pathways for young people interested in careers in healthcare. Offers Healthcare Field, Elementary Adopt-A-School, Job Shadow Projects and more.
- **Delta College Entry Level Programs:** *Mental Health Specialist Certificate* & *Human Services AA Degree*.
- **Wellness, Gibson, Power & Support Center**

Possible WET Coordination Roles and Responsibilities:

- Convene WET planning and implementation meetings with relevant stakeholders;
- Convene WET oversight committee meetings;
- Work with HR staff to develop recruitment strategies and policies;
- Work with HR staff to revise existing job descriptions, including minimum qualifications, to reduce barriers to hiring consumers, family members and underrepresented community members;

- Outreach and engage with underrepresented communities, consumers and family members
- Develop career pathway programs with educational institutions;
- Attend local, regional and statewide WET meetings;
- Monitor contracts funded by WET and submit progress reports.

Strategy Roundtable III: Clinical Career Pathways

MHSA-WET Goal:

To develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the community.

Clinical Career Pathway Strategies

Internship Programs Designed to increase the number of licensed professionals and clinicians from underrepresented racial/ethnic and cultural groups. Counties encouraged to partner with graduate mental health programs. Funding can be used to provide clinical supervision leading to licensure. Funding should be used to influence graduate school programs to better reflect the needs of the public mental health system

Financial Incentive Programs Stipends, scholarships and loan assumption to recruit and retain prospective and current employees who can address workforce shortages. Stipends and scholarships are provided to enrolled students in exchange for a commitment to work in public mental health. Counties can establish programs that include sharing of costs with an employee, such as a 20/20 program, where an employee receives full salary while pursuing an advanced degree.

Summary of WET Needs related to Clinical Career Pathways

- While there is currently no shortage of MSWs and MFTs, there is a shortage of licensed clinicians.
- In order to reach the 60% service target, San Joaquin's public health system would have to employ 714 additional FTEs.
- There is a shortage of Latino workers across occupation categories.
- There are shortages of Southeast Asian and Chinese and Native American staff.
- There is a shortage of African American clinicians, particularly males.
- In order to serve the County's population, we need 100 more FTEs who speak Spanish and 18 more who speak Cambodian.
- Recent transformations in mental health services have led to some inconsistencies in service delivery. CBOs and BHS providers outside 1212 feel disconnected. All direct service providers need consistent trainings on evidence based practices and therapeutic models.
- Wellness, recovery & resiliency; cultural competency; and client & family-driven mental health are not universally embraced by all workforce.
- There are a shortage of workers trained in recognizing and treating clients with co-occurring mental health and substance and/or developmental disabilities.
- Clinical and managerial skills are not interchangeable; managers and supervisors who have been promoted from clinical positions need additional training.

Questions

- What types of clinical career pathway programs or supports are available in San Joaquin County? What programs can be expanded or leveraged?
- Based on your understanding of workforce needs, what clinical career pathway programs, including internships and financial incentives, should be available to residents in San Joaquin County?
- Who should have priority for these programs?
- Can you think of any other strategies to encourage underserved community members to pursue clinical careers?
- What types of specific career development and/or training can be offered to unlicensed or licensed clinicians, in house, to help further career opportunities?
- What administrative and coordination activities and partnerships are necessary for ensuring successful career pathway?

Possible Actions/Strategies

Clinical Supervision and Internships

- Supervision of clinical interns (King, Merced, Colusa, Plumas, Orange, San Bernardino, San Francisco)
- Supervision of clinical interns at CBO sites (El Dorado)
- Support for licensure, ie. tutoring, study guides (Riverside)
- Centralized case conferencing (Riverside)
- Professional development for clinical supervisors (Riverside)
- Stipends or per-diems to licensed staff for supervising interns (Kern, Riverside)
- Develop interagency internships and group supervision (El Dorado)
- E-Learning for CEUs (El Dorado)

Financial Incentives

- Financial incentive or scholarship fund program for any employee to pay for tuition, fees, books, supplies directly linked to addressing occupational shortage (Colusa, King, Merced, Monterey, Orange, Riverside, San Bernardino)
- 30/10 employment/education plan (Kern)
- 20/20 employment/education plan (Orange, Riverside)
- Tuition reimbursement for paraprofessional staff interested in increasing their education (Mono)
- Application and Review Committee to select recipients of financial incentives for continued education (Riverside)
- Seek to obtain *Mental Health Professional Shortage Area* designation (San Bernardino)

- Loan assumptions for commitment to working in public mental health (Mono, Riverside, El Dorado)

College & University Partnerships

- Combine Human Service (60-units) and Substance Abuse Service (30-unit) Credential Program. Provide incentives.
- Develop or enhance CSU program to provide training specific to county need or MHSA principles; offer weekend courses (El Dorado)
- Explore development of local MSW program (Monterey)

Potential WET Coordination Roles and Responsibilities:

- Convene WET planning and implementation meetings with relevant stakeholders.
- Liaison to regional workforce and educational partnerships.
- Convene application review committee to select candidates for scholarships, loans, 20/20 programs, stipends.
- Develop career pathway programs with educational institutions.
- Develop course practicum for local colleges and universities.
- Purchase e-learning and telemedicine contracts.
- Accounting for scholarships, loan repayment, stipends.
- Recruiting from local universities and colleges.
- Work with HR staff to develop recruitment strategies and policies.
- Outreach and engage with underrepresented communities, consumers and family members.
- Monitor contracts funded by WET and submit progress reports.

Strategy Roundtable IV: Medical Career Pathways

MHSA-WET Goal:

To develop and maintain a competent and diverse workforce capable of effectively meeting the mental health needs of the community.

Medical Career Pathway Strategies

Internship Programs Designed to increase the number of licensed professionals willing and able to serve the public mental health system. Counties encouraged to partner with colleges, universities and medical schools. Funding can be used to provide supervision leading to licensure. Funding should be used to influence educational programs to better reflect the needs of the public mental health system

Financial Incentive Programs Stipends, scholarships and loan assumption to recruit and retain prospective and current employees who can address workforce shortages. Stipends and scholarships are provided to enrolled students in exchange for a commitment to work in public mental health. Counties can establish programs that include sharing of costs with an employee, such as a 20/20 program, where an employee receives full salary while pursuing an advanced degree.

Summary of WET Needs related to Medical Career Pathways

- San Joaquin County has a shortage of psychiatrists.
- There is a particular shortage in child, geriatric and psychiatrists with a recovery focus in San Joaquin County.
- There is also a shortage of nurses with psychiatric training and a periodic shortage of psychiatric technicians.
- Factors that impede hiring and retention include lag time between application and hiring date, significantly higher salaries paid by the private sector and state institutions, a lack medical school programs in the region.
- There is a shortage of medical practitioners of Latino, Native American, African American and some Asian communities.
- Cultural competency requires more than cultural representation. There needs to be additional sensitivity and diversity training for all staff about race, ethnicity, gender, sexual orientation and stages of life.
- In order to serve the County's population, we need 100 more FTEs who speak Spanish and 18 more who speak Cambodian
- Wellness, recovery & resiliency and client & family-driven mental health are not universally embraced by all workforce.
- There are a shortage of workers trained in recognizing and treating clients with co-occurring mental health and substance and/or developmental disabilities.

Questions

- What types of medical career pathway programs or supports are available in San Joaquin County? What programs can be expanded or leveraged?
- Based on your understanding of workforce needs, what medical career pathway programs, including internships, residencies and financial incentives, should be available to residents in San Joaquin County?
- Who should have priority for these programs?
- What other strategies can you think of to address the shortage of psychiatrists and other medical providers?
- What types of specific career development and/or training can be offered to psych techs, nurses, physicians, in house, to help further career opportunities?
- What administrative and coordination activities and partnerships are necessary for ensuring successful career pathway?

Possible Actions/Strategies

Internship Programs

- Internship program for psych techs, registered nurses, psychiatric nurses, nurses with mental health specialty, psychiatrists (Plumas, Orange, Kern)
- Psychiatry residencies (Orange)
- Develop psychiatry fellowship program with local medical school to train in community psychiatry. (Orange, San Bernardino)
- Bachelor nursing and nurse practitioner internship program (San Bernardino, San Francisco
- Eligibility of Federal Workforce Funding for loan repayment program through designation as Mental Health Professional Shortage Area (El Dorado)
- Develop internships with CSU Stanislaus, UCSF, UC Davis for physician assistants and nurse practitioners (Stanislaus)
- Develop practicum opportunities with community colleges and CSUs for undergraduate nursing and Licensed Vocational Nursing students (Stanislaus)
- Develop Interagency Internships and Group Supervision (El Dorado)
- Regional Partnership for Residency for Child Psychiatry and Nurse Practitioner (Kings)

Incentive Programs

- Student loan repayment program (Mono, Riverside)
- Stipends & scholarships for existing employees willing to commit to working in public mental health (Monterey, Orange, Riverside, Colusa, Kern, Kings, Merced)
- 20/20 Programs with commitment to remain in mental health system for 5 years after graduation (Orange, Riverside)

Other

- Telemedicine
- Professional development of clinical supervisors (Kern)
- Medical Staff (Psychiatrist & Nurse Practitioner) Training that includes five fundamental elements of MHSA (Santa Cruz)
- Psychiatric training to primary care providers, specifically to doctors, physician assistants and nurse practitioners on monitoring and prescribing psychiatric medications.
- E-Learning for nursing CEUs (El Dorado, Merced)
- Develop nurse practitioner training program partnership in Central Valley (Fresno)

Possible WET Coordination Roles and Responsibilities:

- Convene WET planning and implementation meetings with relevant stakeholders
- Liaison to regional workforce and educational partnerships
- Convene application review committee to select candidates for scholarships, loans, 20/20 programs, stipends
- Develop career pathway programs with educational institutions
- Develop course practicum for local colleges and universities
- Purchase e-learning and telemedicine contracts
- Accounting for scholarships, loan repayment, stipends
- Recruiting from local universities and colleges
- Work with HR staff to develop recruitment strategies and policies
- Outreach and engage with underrepresented communities, consumers and family members
- Monitor contracts funded by WET and submit progress reports

Attachment B

Potential WET Strategies for San Joaquin County

A. Training & Tech Assistance

1	*Immersion Training in Principles of Recovery Based Service Delivery*	These are multi-day, off-site trainings designed to help agencies transform towards recovery-oriented service provision. This strategy would fund a team made up of program managers, administrators and front line staff to travel to an immersion training at a location that has successfully transformed services. Trainings would include tours of successfully transformed service centers, participatory activities and opportunities to network. The participating team would be encouraged to meet regularly to promote transformation within San Joaquin County Behavioral Health Services (BHS).
2	*Training in Fidelity to Evidence Based Practices*	Planning participants identified interest in implementing a variety of Evidence-Based Practices (EBPs), particularly for children and transitional age youth and. Conforming to EBPs requires formal training for clinicians and other practitioners. Trainings are often best delivered in regional partnership in order to share costs. BHS will explore the development of partnerships with other county mental health providers to identify EBPs to train and implement. Funding will be used to: • Educate all staff on the importance of using EBPs, and their relationship to outcomes; • Research and identify most appropriate EBPs for San Joaquin County; and • Train staff in one or two such practices. This funding is contingent upon a commitment to fully fund EBP implementation, through CSS or PEI resources.
3	*All Workforce Training in Co-Occurring Disorders (And other Core-Competencies)*	Based on extensive stakeholder interest in unifying mental health and substance abuse services, this strategy would provide: • Cross training for all staff and volunteers by a range of experts, including participants. This is designed to ensure mutual understanding of various approaches to working with populations with co-occurring disorders. • Additional follow-up team trainings will take place within each program or for each occupation. For example, clinicians may follow-up with Integrated Dual Diagnosis Treatment (IDDT). • A core group of train-the-trainers will receive enhanced training by an appropriate provider in order to ensure new hires are trained. • New hires will be required to participate in co-occurring

		trainings that occur on an annual or biannual basis. This model of training, which includes large all-staff trainings with smaller team follow-up trainings and new hire training modules, can be duplicated for other core-competencies that the department wishes to share with the entire workforce. This model could be used with WRAP training, Seeking Safety, cultural competencies, psychosocial rehabilitation, patient rights, etc.
4	*Mental Health 101/Crisis Intervention Training for Law Enforcement & Other Community Partners*	Provide basic training in mental health signs and symptoms, crisis intervention, available services and supports to law enforcement officers. Recent tragic shootings by police officers that have resulted in the injury and death of community members with severe emotional disturbances could have been prevented had officers been trained to recognize mental illness and recognize when to call in crisis response teams. Other community partners, such as preschools, K-12 teachers, social service providers and clergy could benefit from such trainings as well. Training could be provided to BHS clerical staff and other non-direct service staff as well. Develop a speakers' Bureau to conduct these trainings that includes consumers and family members and people from underserved cultural groups.
5	*Distance Learning/ E-Learning*	Enables the development, delivery and management of training opportunities for BHS and CBO staff, consumers and family members. Trainings can be videotaped for use by 24-hour facility staff and by staff from home or an available internet source. Interactive training modules can be purchased from a variety of providers such as CiMH Network of Care. Can be used to meet licensing requirements and continuing education units. Can be used to ensure that all workforce has achieved core subject area competencies. Examples of training modules offered through e-learning include suicide prevention, anger management, psychopharmacology, ethics, diversity, co-occurring disorders, and many others.

B. Entry Level Career Pathways & Support

1	*Incentives for Mental Health & SAS Certificate at Delta College*	Delta College currently offers separate *Human Service Worker Certificate* and *Substance Abuse Counselor Certificate* programs. Work with Delta to develop a dual certificate program that combines mental health and substance abuse counseling. Encourage entry-level consumers, family members and high school students to obtain a dual certificate. Encourage those with one certificate to take additional courses to receive second certificate.

		Work with Human Resources to develop a position that requires both certificates with a pay differential. Provide stipends to students.
2	*"Grow Our Own" High School Outreach*	Work with County Health to set up an annual High School Health Fair for high school students. Link interested high school seniors to internships at BHS and CBOs where they receive counseling about ongoing educational opportunities in mental health. Encourage entry into dual certificate program described above. Provide stipends to interns.
3	*Billboards Advertising Need for Psych Techs, etc.*	In order to inform the community that there are opportunities to work in the mental health arena, BHS will contract with a marketing company to advertise the need for psych techs and nurses, and portray the positions in a positive light. Additionally, billboards will promote Delta College's psych tech program.
4	*Vocational Preparation & Support for Consumers*	This program will leverage existing vocational services offered by BHS. Currently the department offers a Vocational Rehabilitation Community Skills Building Group twice a year. For those who are not yet ready for Vocational Rehabilitation, BHS offers Strength Building Peer-Support Groups. In addition, BHS is partnering with a local Public Library to provide a Literacy Program for consumers with below 6th grade education. This strategy calls for supplementing existing BHS programs with: • Multilingual literacy tutoring; • Math and computer classes; • A pre-employment volunteer program for consumers; • A consumer empowerment support group for those who are working or attending school [run by consumers]; and • Vocational & benefits counseling. To implement this strategy, the department needs participant and volunteer stipends, office equipment and training materials. Volunteer opportunities could include peer tutoring or staffing an on-site mental health library and resource center to be available for staff, volunteers, interns, clients and family members.
5	*Clubhouse Model of Psychosocial Rehabilitation*	An entirely consumer-run method of providing vocational preparation, similar in scope to #4, but offers no clinical services; i.e. no therapists or psychiatrists are on staff. Program is voluntary and "member" oriented, rather than "client" oriented. This model will adhere to *International Standards for Clubhouse Programs*.
6	*Job Development Specialist*	The role of the Job Development Specialist is to provide supportive services to consumers, family members and other underserved populations working, re-entering or preparing to work in public

		mental health. S/he will work with Human Resources to develop consumer and family member employment opportunities and coordinate stipends or other incentives. S/he will network with CalWORKS, Dept of Rehabilitation, the Gipson Center, and the Wellness Center to develop a full spectrum of entry-level employment support services for consumers and family members.
7	*CASRA (California Association of Social Rehabilitation Agencies) Curriculum*	Staff education and training in-house using CASRA's Psychosocial Rehabilitation Curriculum. Can be used for entry-level and/or all staff. Based in recovery-oriented values, CASRA offers a 5-course curriculum or individually tailored curricula. The CASRA curriculum can help participants qualify for National Psychosocial Rehabilitation Certificate. BHS could also develop a relationship with community colleges to use CASRA coursework as a basis for community college certificate.

C. Clinical Pathways

1	*Intensive In-House Licensing Support*	BHS will implement an intensive effort to help unlicensed MSWs and MA/MSs pass licensing exams. BHS will offer a one-time award to clinicians who receive their license (in addition to a promotion to Clinician II). Licensed clinicians will be encouraged to mentor an unlicensed clinician from an underserved community to provide one-on-one tutoring. A licensed clinician will facilitate ongoing study group sessions and provide one-on-one counseling to unlicensed staff to help reduce barriers to licensure. BHS will adopt a standardized curriculum and purchase additional materials for the provision of supervision in order to ensure all clinical interns receive high quality support for licensure. Support would be offered to unlicensed clinicians working within the department or at contracting CBOs.
2	*Clinical Enrichment*	BHS will develop an in-house enrichment program for clinicians that includes: • Rotational trainings to learn about other programs at BHS and contracting CBOs, business administration, different client populations, etc. • Cross-training in counseling, psychology, family therapy, behavioral analysis and social work. (CSU

		Stanislaus will provide support for cross-training). • Peer-to-peer training in therapeutic practices. A Clinician III will coordinate the enrichment program with support from the WET coordinator.
3	*Managerial/Supervisory Training*	To retain experienced and licensed clinicians and ensure high quality supervision of clinical interns and other staff, BHS will provide ongoing leadership development opportunities related to mentoring and supervision. All licensed clinicians will receive management training. Topics will include how to motivate staff, employee rights, ADA compliance, business management, cultural competency, and hiring and supervising consumers and family members. Supervisors who go through managerial/supervisory training will be encouraged to develop a mentoring relationship with an unlicensed clinician in order to help them pass licensing exam. Training will be offered to supervisors at BHS and CBOs.
4	*Stipends to First Year MSWs*	BHS will award candidates a one year-scholarship to attend CSU Stanislaus or Sacramento's MSW program full-time. Priority will be given to candidates: • Representing underserved communities; • With needed language proficiencies; or • With experience as consumers or family members of public mental health. A second year stipend is currently available from the State to full-time students who commit to working in California's public mental health. This stipend would require a commitment to work at San Joaquin County BHS for 2 years after graduation. This program would fully fund a two year MSW program. BHS will outreach to CBOs and bachelors students at CSU. Students cannot be employed at BHS while participating in this program.
5	*20/20 Program*	A number of employees of BHS and contracting CBOs will be awarded the opportunity to work half-time at full salary for two years, in order to further their careers. Eligible employees will include those receiving a master's degree in social work, counseling, psychology, behavioral analysis and nursing, and those completing coursework for a doctorate in psychology. Candidates will be expected to commit to working at BHS for two years upon graduation. Priority will be given to candidates from underserved ethnic communities, to those with needed language capacity, and to those with experience as consumers or family members.
6	*Master's Level Co-*	BHS will encourage Substance Abuse Counselors with

	Occurring Incentive	Bachelor's degrees to get their Master's degrees in Social Work, Psychology or other mental health-related field. The goal is to further integrate mental and substance abuse services. Additionally, BHS will encourage clinicians to return to school to receive Substance Abuse Counselor Certificates. Those clinicians with dual MSWs and Substance Abuse Counseling Certificates will receive a pay differential.

D. Medical Pathways

1	*Cross-Training and Increased Coordination of Services Between Primary Care Medical Providers and Mental Health*	Primary care medical providers often have first and frequent contact with community members who exhibit signs of emotional disturbance or mental illness. Primary care medical providers can help prevent trauma, intervene at first break or treat less complex mental illnesses. In order to reduce the risk of over-prescription or improper treatment and diagnosis, primary care physicians and public mental health psychiatrists should develop more immediate and efficient communication pathways. Through cross-training and more effective communication (possibly using telemedicine infrastructure), it is possible to provide additional quality routine mental health care in community settings and reduce psychiatrist caseloads. Training will also be offered to insurance providers to ensure reimbursement for psychiatric prescriptions and services by primary care providers.
2	*Psychiatric Rotation at San Joaquin BHS*	UC Davis and UCSF are the closest medical schools with psychiatric programs. UCSF has a residency program in Fresno. UC Merced is in the process of planning its medical school programming. This strategy calls for the initial establishment of BHS as a rotation site for psychiatric residents from UCSF or UC Davis. Additionally BHS will work with UC Merced to develop BHS as a location for future rotations or residencies. This strategy also calls for the development of Central Valley WET Partnerships to establish a long-term plan to develop sufficient psychiatric capacity in the region.
3	*Telemedicine Training*	BHS is in the process of purchasing infrastructure for telemedicine. This tool will enable psychiatrists to provide services from outside the region and will eliminate the time it takes for psychiatrists to travel to community clinics. Telemedicine also allows psychiatrists and patients to have face-to-face interactions with language interpreters. Psychiatrists and clinical support staff need

		comprehensive training in order to successfully implement a Telemedicine service approach. Telemedicine training for primary care physicians will enable more effective communications with BHS psychiatrists, which will result in more effective consultations and fewer over-prescriptions.
4	*Medical Career Pathway Incentives*	BHS will develop appropriate incentives for current mental health workforce to further educational goals and simultaneously help reduce shortages of qualified psych techs, nurses and specialized nurses. Current interested staff of the department and contracting CBOs will apply to BHS for educational stipends, scholarships, and 20/20 contracts with an agreement that they will work at BHS or contracting agency for at least 2 years after graduation. Priority will be given to candidates from culturally underrepresented communities, clients, family members and those with needed linguistic proficiencies. The following educational career pathways will be supported by BHS: • Mental Health Specialist → Psychiatric Technician. • Psychiatric Technician→ Registered Nurse • Nurses → Certified Psychiatric Nurse • Nurse → Nurse Practitioner
5	*Psychiatric Nurse Practitioner Positions*	In order to mitigate the extreme shortage of psychiatrists, BHS will develop positions for Nurse Practitioners. Nurse Practitioners can prescribe psychotropic medications and work with supervising physicians to provide routine care, thus enabling psychiatrists to work more intensively with patients with complicated or severe illnesses.
6	*In- House Psychiatric Nurse Certification Training*	Nursing programs do not specifically train students to work in psychiatric facilities. Psychiatric nursing requires advanced skills including working with restraints, developing a wellness and recovery approach, understanding psychotropic medications, etc. Nurses with psychiatric training will be better equipped to provide a safe and supportive environment, as well as proper medical services. BHS will offer in-house training for nurses seeking psychiatric certification. A one-time incentive will be provided to all nurses who are certified. Training can be offered on a one-time or ongoing basis for new nurses working at BHS.

E. Coordination

1	*Training Coordinator*	This is a mid-management or analyst position. Works with an advisory team to identify potential participants and develop appropriate training methods. The Training Coordinator will ensure that all staff are trained in core competencies. S/he will work to include consumers and family members as trainers and participants. S/he will survey staff and volunteers to identify skills and training capacities and identify other outside trainers. The Training Coordinator will work with partner agencies and CBOs to develop appropriate cross-training opportunities, will formalize e-learning contracts and evaluate trainings and trainers.
2	*Academic Program Coordinator*	The Academic Program Coordinator will provide ongoing analysis of staffing shortages and coordinate educational opportunities that address such shortages. The position will help manage internships and coordinate financial incentives; will work with colleges and universities to develop psychiatric residency rotations, other academic programs, and curriculum enhancements. S/he will coordinate clinical and medical internships and ensure availability of supervisors and preceptors. The Academic Program Coordinator will develop regional partnerships and outreach to community based organizations to attract candidates for career pathway, financial incentive or internship programs.
3	*WET HR Analyst*	This strategy will fund a full-time analyst to work with the county's Human Resources Department to develop appropriate job classifications such as Nurse Practitioner or Co-occurring Specialist. Will help HR develop strategies to increase the participation of clients, family members and staff from underrepresented communities. S/he will work with HR to review job classifications and prerequisites, propose salary incentives for those with linguistic or other competencies that are in short supply. Will also work to ensure that all staff receives required training in core competencies.

Attachment C

MHSA Community Input Forms
WET Priorities

Strategy Breakout Group (Please check appropriate box):

- ☐ Training
- ☐ Entry Level Pathways & Support
- ☐ Clinical Pathways
- ☐ Medical Pathways

List your top two strategies here:

1) ____

2) ____

Strategy 1

Please explain why you selected this strategy?

What needs does this strategy help address?

Is there anything else you would like us to consider about this strategy?

Strategy 2

Please explain why you selected this strategy?

What needs does this strategy help address?

Is there anything else you would like us to consider about this strategy?

Other Considerations

Attachment D

San Joaquin County Behavioral Health Services
MHSA Workforce Education and Training Planning Process

MHSA Stakeholder Steering Committee

Responses to Community Meetings

A. Training and Tech Assistance

1. Immersion Training in Principles of
Recovery Based Service Delivery — 4

2. Training in Fidelity to Evidence Based Practices — 6

3. All Workforce Training in Co-Occurring Disorders — 9.5

Reason Why:

Prevalence of co-occurring disorders in mental health population.

Co-occurring- issues of mental health and substance abuse are very connected, often can't address one without the other, need staff better equipped.

It is well voiced that there is a lack in this training. Large percent of substance abusers in the community.

4. Mental Health 101/Crisis Intervention Training for
Law Enforcement and Other Community Partners — **17**

Reason Why:

Great need to provide training to partners and others that may need to recognize customers with mental health issues for appropriate referral.

Now we work with many more community partners. Glaring deficiency in knowledge base re: services. Train as to which services are appropriate.

We need awareness. Early detection is early direction. Lack of awareness and signs. Have the knowledge to understand the difference between learned behavior and illness.

When mental health workers are not on duty, 1st responders to a crisis are Law enforcement officers who are not trained to meet the need. Educators (teachers) are not trained to deal with teenagers metal health/substance abuse issues.

5. Distance Learning/E-learning — 3.5

B. Entry Level Career Pathways

1. Incentives for Mental Health and SAS Certificates at Delta College **13.5**

Reason Why:

High percentage of mental health consumers with substance abuse concerns and vice versa. Encourage existing staff to return to school. Encourage entry-level education- base of knowledge and skills.

Is important to get incentive to go back to school because it puts your foot in the door to start as entry level and move forward to continue education in the mental health field.

To increase dual diagnosis knowledge. More potential for advancement of knowledge level and jobs.

9. Provide stipends to pay for tuition to work at mental health services.

2. "Grow Our Own" High School Outreach 6

3. Billboards Advertising need for Psych Techs 1

4. Vocational Preparation and Support for Consumers **11.5**

Reason Why:

Continued and expanded services based on already existing program and DOR collaboration, to support consumers return to working. Powerful effect of consumer/consumer support and mentoring.

This plan will prepare consumers for jobs and life skills, becoming good citizens. Increase knowledge of support for consumers.

Offers services (interacts) with most people. Not having to recreate wheel- like Gibson Center- ISCP already developed- ready to go. Already have the CSB program. Close relationship with department of Rehab (state).

Consumers can be most effective staff in transforming mental health services.

5. Clubhouse Model of Psychosocial Rehabilitation 1.5

6. Job Development Specialist 4

7. CASRA Curriculum 2.5

C. Clinical Pathways

1. Intensive In-House Licensing Support	7
2. Clinical Enrichment	4
3. Managerial/Supervisory Training	0
4. Stipends to First Year MSWs	4
5. 20/20 Program	**10.5**

Reason Why:

Student is able to keep their job while still going to school. Maintain all your benefits as a part-timer

Tuition for school and increased the number of bilingual clinicians.

We believe it is a good incentive for employees to further their careers at the same time providing our county with committed staff.

Included CBOs- the opportunity to go to school and work is a great idea. Personally I'm interested in it as well.

6. Master's Level Co-Occurring Incentive	7.5

D. Medical Pathways

1. Cross Training and Increased Coordination of Services between Primary Care Providers and MH	5
2. Psychiatric Rotation at San Joaquin BHS	4
3. Telemedicine Training	2
4. Medical Career Pathway Incentives	5
5. Psychiatric Nurse Practitioner Positions	6
6. In-House Psychiatric Nurse Certificate Training	0