Evaluation Report

Greater Bay Area Mental Health and Education Workforce Collaborative

UC San Francisco School of Nursing

Center for the Health Professions

Susan Chapman PhD, RN, FAAN, Principal Investigator

Lisel Blash, MS, MPA, Senior Research Analyst

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EXECUTIVE SUMMARY

Overview

The Greater Bay Area Mental Health & Education Workforce Collaborative (the Collaborative), is a regional partnership of mental health providers, educators, advocacy and consumer groups, and other stakeholders who are engaged in a collaborative process to improve the mental health workforce in the Bay Area and throughout the state. The Collaborative began a decade ago and has undertaken many different programs and initiatives to reach its overall goals and objectives. The Collaborative addresses workforce shortages and the need for greater workforce diversity by fostering initiatives such as increased training opportunities for existing public mental health workers, enhanced educational pipelines from high school through graduate school, and improved career opportunities within the field of public mental health for consumers and family members.

Methodology

Considering its long history of accomplishment, the Collaborative determined that a systematic externally conducted program evaluation would serve to highlight and assess the Collaborative's accomplishments and impact, as well as serve as a guide for future program planning and development. The evaluation was conducted between February 2012 and January 2013.

The two-phase evaluation began with a planning phase that included the development of a logic model to guide the evaluation process and identify focus areas. Collaborative staff commented on the evaluation plan prior to phase two. In the second phase, researchers examined the Collaborative's many activities, selecting four for in-depth investigation. The researchers looked at the broader impact of the Collaborative from the perspective of stakeholders, including long-term contributors, founders, consultants, grantees, and meeting attendees.

Researchers conducted site visits at two educational programs that the Collaborative had a substantial role in launching, and gathered data from students, faculty, and administrators. Researchers also examined program documentation, conducted key informant interviews, and gathered information on the Collaborative's meetings and website usage. An online survey was sent to recent meeting participants and Bay Area Mental Health Directors to obtain perspectives on the Collaborative's broader impact. In order to provide a context for the evaluation findings, the researchers also used publicly available workforce data to assess mental health workforce employment, demographics of the workforce, and trends in recent graduates of mental health professional training programs in California and the Bay Area.

Key Findings

The Collaborative has supported a wide variety of efforts, from convening employers and educators to share best practices, to training members of the existing workforce in cultural competency skills, to providing student support in specific educational programs. The Collaborative sponsors these activities to achieve a set of overarching goals: 1) developing regional training resources and promoting training to integrate the MHSA philosophy and values, 2) increasing civil service support of public mental health employment needs, 3) strengthening and expanding partnerships that support the mental health workforce pipeline, 4) increasing quality employment for consumers and family members, 5) increasing diversity and cultural competence in the public mental health workforce, and 6) increasing public awareness of and interest in public mental health careers.

The Collaborative has been particularly effective at disseminating the MHSA recovery model, infusing it into many activities and initiatives – from pipeline programs to training for existing workers. Survey respondents and interviewees indicated that the recovery model had become the dominant paradigm, both in the workplace and especially in educational programs.

Pipeline Programs

The researchers explored three educational programs in-depth: High School Mental Health Pathways programs, the Contra Costa College Psychosocial Rehabilitation (CCC PSR) program, and the California State University Monterey Bay Master's in Social Work program (CSUMB MSW).
The Collaborative effectively addressed a number of its goals by sponsoring pipeline programs. For example, by sponsoring local public high school, community college, and state college programs, the Collaborative reaches a diverse group of students who may help to meet the need for mental health workers who better reflect the diversity of the state's population. By sponsoring community college programs, the Collaborative is also providing job training to many individuals who are themselves consumers of mental health services. By providing mental health pathway programs for high school students who are still undecided about their careers, the Collaborative helps disseminate information about public mental health careers to the general public. Finally, the Collaborative helps address mental health care worker shortages in Monterey County by supporting the CSUMB MSW program. This program has attracted a diverse group of local students, many of them bilingual, and has developed a unique partnership between stakeholders in the local community.

Improving Capacity of Public Mental Health Employers

The Collaborative has sponsored a number of initiatives intended to assist in improving human resources practices around recruitment and retention of adequately trained mental health workers. This includes sponsoring a project exploring job descriptions and competencies for mental health workers in county employment, convening a Bay Area Mental Health-Human Resources Directors Forum, assisting with the development and maintenance of internship programs, and other activities. The Collaborative sponsored trainings for the existing mental health workforce with sessions focused on enhancing cultural and linguistic competency (California Brief Multi-Cultural Scale (CBMCS), Mental Health Interpretation). In the survey conducted as part of this evaluation, respondents rated the CBMCS and internship support high in terms of usefulness. Respondents also rated the impact of the Collaborative relatively high in the area of "Improving the quality and accessibility of staff and intern training for Bay Area County m personnel & CBO personnel". The Collaborative's online community bulletin board on jobs and internships was accessed 590 times between 2011 and 2012, an increase of 19% over the prior year.

Increasing Consumer and Family Employment

The recent economic recession made it more difficult for the Collaborative to pursue the goal of increasing consumer and family member employment by creating and maintaining positions designated for them. Nonetheless, the Collaborative continued to promote this goal through workshops, conferences, and advocacy. Counties took the lead in developing their own employment programs. Two such programs in San Mateo and Alameda counties were explored. Both took somewhat different approaches to implementation, and each achieved success in increasing employment for those with lived experience. Both counties emphasized that preparing consumers/family members, co-workers, and supervisors, *in advance,* to welcome consumers/family members as colleagues was vital to the success of these efforts. San Mateo focused on creating civil service positions for consumers and family members within the county system, while Alameda focused more on obtaining employment within community-based organizations, which provide 85% of the mental health services via public contracting.

Increasing Public Awareness

The Collaborative's website is growing as a resource, as evidenced by an increasing number of visitors each year. However, increasing the number of visitors and enhancing viewer engagement should continue to be a priority. The Collaborative's efforts seem focused on developing resources for existing constituents, not on general outreach to interest the public in mental health careers.

The High School Pathways programs exemplify an innovative strategy for interesting newcomers to the field of public mental health through presenting compelling information on mental health and mental health careers in high school classrooms.

Secondary Data

Secondary data analysis provides a reflection of workforce trends and a framework for considering the Collaborative's efforts. The data indicate that California's mental health care workforce is not reflective of the state's population in race and ethnicity. However, the demographics of education pipeline programs indicate growing diversity. While some pipeline programs, such as doctoral programs in clinical psychology and MFT programs, are still composed primarily of white students, other pipeline programs, such as those for MSWs, substance abuse counselors, and psychiatric technicians, include a majority of under-represented racial and ethnic groups. There has been a notable increase in Latino students in MSW training programs. While most of the Greater Bay Area is well-supplied with mental health professionals according to worker-to-population ratios, parts of San Monterey County and Contra Costa Counties are Mental Health Professional Shortage Areas. Nearly half of Bay Area residents, particularly African Americans, Latinos, those with limited English proficiency, and the uninsured, report they have unmet needs for mental health services.

Conclusions and Recommendations

The Collaborative's many achievements are due, in part, to the strength of its human resources; resources include a Project Manager, support staff at CiMH, a pool of consultants, and volunteers. The Collaborative's capacity to achieve high-level goals appears to have grown over the years, especially with the advent of MHSA funding. The reach of the Collaborative is broad and includes a wide array of initiatives.

Recommendations

1. Consider focusing on fewer programs or on selected initiatives within each overall objective.
2. Consider soliciting funding for more staff support in order to support a broad agenda of initiatives.
3. Consider a formal strategic planning process to revisit goals and objectives for the future.

The Collaborative has a diverse and shifting constituency of participants. Those who are paid to attend meetings as part of their job responsibilities are a more steady pool of participants. Participants from the northern and southern counties are at a geographic disadvantage in accessing some Collaborative events and resources.

Recommendations

1. Continue to explore ways of addressing shifting constituency and fluctuating levels of involvement of collaborative members.
2. Improve website navigation, interactive features, and utilize newsletter email capture to engage and retain new constituents.
3. Continue to explore more effective ways to promote the Collaborative's other resources
4. Continue to find ways to make the Collaborative's meetings and activities accessible to participants from counties outside the core, urbanized Bay Area counties.

The Collaborative supports numerous initiatives, educational programs, and develops resources and programs in a variety of areas to support the mental health workforce. These initiatives are driven by the Collaborative's mission, goals, and objectives. The next step might be to consider development of an ongoing evaluation framework these various activities.

Recommendations

1. Provide sessions on self-monitoring, how to access outcomes "as you go", and how to use data to make program changes.
2. Provide funded programs with expectations in regards to reporting outcome data.
3. Focus documentation and data collection on key outcome measures (as well as process measures) that illustrate the Collaborative's progress at meeting key goals and objectives.

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INTRODUCTION

The Greater Bay Area Mental Health & Education Workforce Collaborative (the Collaborative), is a regional partnership of mental health providers, educators, advocacy and consumer groups, and other stakeholders who are engaged in a collaborative process to improve the mental health workforce in the Bay Area and throughout the state. The Collaborative began about a decade ago and has undertaken many different programs and initiatives to reach its goals and objectives. The Collaborative has addressed workforce shortages and the need for greater workforce diversity by fostering initiatives to a) increase training opportunities for existing public mental health workers, b) enhance the educational pipeline from high school through graduate school, and c) improve career opportunities within the field of public mental health for consumers and family members.

The Collaborative determined that a systematic, external program evaluation would serve to highlight and assess the Collaborative's accomplishments and impact as well as serve as a guide for future program planning and development. The evaluation was conducted between February 2012 and January 2013.

The key research questions for this evaluation include the following:

1. What impact has the Collaborative had on public mental health workforce development in the Greater Bay Area?
2. What value has the Collaborative's resources added to specific mental health workforce initiatives?
3. What changes in policy have resulted from the Collaborative's work?
4. How have the Collaborative's work products and funding supported public mental health workforce development?

This report provides answers to the research questions. It also includes a brief history of the Collaborative; a review of publicly available data on mental health workforce employment and the educational pipeline in California and the Bay Area; a review and analysis of the Collaborative's programs and activities based on interviews, focus groups, surveys; and a review of program documentation and materials. The final section of the report summarizes the findings and provides a set of recommendations for the future.

METHODOLOGY

The methodology for this evaluation was conducted in two phases--planning and implementation. This mixed method evaluation included key informant interviews, group interviews, site visits, surveys, and a review of program data, workforce and educational data, and program materials.

Phase I included:

1) A review of program material and an environmental scan.
2) A series of key informant interviews with stakeholders to understand the history of the Collaborative and target the evaluation.

Out of these initial activities, a logic model and detailed evaluation plan was developed to guide the project.

Phase II was the implementation of the evaluation plan developed in Phase I. Phase II included the following activities:

1) Site visits with Contra Costa College's Human Services Department to profile its Psychosocial Rehabilitation certificate program, and with California State University at Monterey Bay to profile its Master's in Social Work program.
2) Additional key informant interviews to better understand various initiatives of the Collaborative, including high school pathways programs and consumer and family member employment programs.
3) An analysis of secondary data on the mental health workforce and education pipeline.
4) A survey of attendees of the Collaborative's meetings and a survey of Bay Area County Mental Health Directors to better understand the impact of the Collaborative on local workforce planning and training.
5) A review of the Collaborative's data on website usage and meeting attendance to understand the Collaborative's outreach and audience.

MISSION AND GOALS OF THE COLLABORATIVE

The mission of the Greater Bay Area Mental Health & Education Workforce Collaborative (the Collaborative) is:

> *… to promote the growth and support of a public mental health workforce in the Bay Area that is wellness, recovery and resiliency-oriented and culturally and linguistically competent; and employs consumers, family members, and people of ethnic and cultural diversity at all levels of the public mental health system.*

This mission is operationalized in the following goals, which structure the Collaborative's efforts.

1. *Develop regional training resources that integrate MHSA philosophy and values: promoting education, training and re-training of the mental health workforce to increase the practice of culturally competent, recovery oriented services.*
2. *Increase County Human Resources/Civil Service responsiveness to and operational support of public mental health employment needs.*
3. *Strengthen and expand educational partnerships to increase the viability and accessibility of the mental health workforce pipeline.*
4. *Increase the number of consumers and family members hired, retained, and offered opportunities for career pathway development throughout the public mental health system.*
5. *A diverse and culturally and linguistically competent public mental health workforce serving un-served, underserved and inappropriately served consumers and their families.*
6. *Increase public awareness of and interest in pursuing public mental health careers.*

ORGANIZATIONAL STRUCTURE OF THE COLLABORATIVE

The Collaborative's structure is described in more detail on its website: **www.mentalhealthworkforce.org**.

The Collaborative is a project of the Greater Bay Area Mental Health Directors (GBAMHD) and the California Institute for Mental Health (CiMH).

Membership: The Collaborative is a "voluntary convening of interested partners dedicated to furthering the mission and goals of the group." This membership is made up of partners who attend various meetings and participants in workshops, committees, and workgroups. Open meetings include bimonthly Collaborative meetings in the Oakland area, and bimonthly Southern Regional Partnership meetings in

Salinas or other locations in the southern region, including Monterey, Santa Cruz, and San Benito Counties.

While a plurality of meeting attendees have traditionally come from county mental health departments (about 45% between 2008 and 2011), these meetings also attract large numbers of participants from educational institutions (25%), CBO's (7%), consumers and family members (3%), and other participants (25%).

Fiscal Agent: The California Institute for Mental Health (CiMH) serves as the fiscal agent for the Collaborative. For State Regional Partnership Funding, Alameda County has served as the host count and contracts with CiMH.

Funding: The Collaborative receives most of its funding from the Zellerbach Family Foundation and Regional Partnership funds through the Mental Health Services Act. The Mental Health Services Act (MHSA) specifies program components to be developed, along with funding formulas. This includes funding for Workforce Education & Training (WET) for local county, regional and statewide initiatives. In 2008, funding for state administered programs was budgeted for 10 years. This included several financial incentive programs, including stipends and loan forgiveness, consumer & family member employment technical assistance, and regional programs. Funds have been distributed in three-year allocations. Five Regional Partnerships were developed based on the geographic regions of the California Mental Health Directors Association (CMHDA). Each region determines which county acts as the fiscal agent for their Regional Partnership dollars. Alameda County is the fiscal agent for the Collaborative and contracts with CiMH for carrying out the program. Regional Partnerships are funded at $600,000 per year for 10 years. All five regional partnerships have been building capacity over the past few years and are ramping up their programs and use of state dollars. The Zellerbach Family Foundation provides funding for key projects.

One-half of the total MHSA funding for workforce development is allocated to statewide programs and the other half is allocated to counties. The partnership receives approximately $600k per year for programming and staffing.

Staff: The Collaborative has a Program Director, who is employed by the CiMH and supervised by the CiMH Director of Adult Services in consultation with the Chair. The Program Director provides leadership and administrative support for the Collaborative. The director also coordinates with the membership to advance the work plan, manages the budget, submits grants and budget reports, establishes meeting agendas, facilitates meetings, and works with the Steering Committee to establish priorities, project budget, grant review and approval and oversight.

Steering Committee: The Collaborative has a 12- to 13-member Steering Committee and is composed of volunteers from the larger Collaborative group, each of whom serves a staggered 3-year term. The steering committee is convened by the Chairperson, a local mental health director appointed by the

Greater Bay Area Mental Health Directors (GBAMHD), who works with the project director and serves as a liaison to the GBAMAHD. There is also a vice-chair appointed by the steering committee. The steering committee meets quarterly in person or by phone or video-conferencing.

The steering committee provides oversight of work plan activities and priorities, approves the work plan, reviews outcomes, reviews grants and funded projects, and assists in providing direction to the project director.

Executive Committee: An executive committee composed of the Chair, Vice Chair, CiMH Director of Adult Services, and the Project Director provides oversight for staff and decision making authority for operational decisions as needed.

Nominating Committee: A nominating Committee, which includes the Chair, Project Director and one other steering committee members services to recruit steering committee members to three-year terms.

BRIEF HISTORY

The Collaborative emerged out of a growing recognition of current and projected shortages in the mental health workforce. These shortages exist across all mental health professional disciplines as well as for peer and bilingual providers and have a significant impact on the quality of care in public mental health systems.

An important element of the Collaborative's origin lies in the social movement of the 1970's through the 1990's to recognize the civil and human rights of mental health patients, or "consumers". That movement included self-help centers where consumers in recovery provided peer counseling services and often achieved results not obtained by mental health professionals. Consumers and their family members were also demanding a voice in the planning and design of services, or a "seat at the table."

California's increasing diversity also required providers with new skill sets, both linguistic and cultural. In addition to severe shortages in the number of bilingual professionals, trained community workers or "cultural brokers" were needed to engage people in underserved communities and assist them in accessing care.

California, like some other states, responded by enacting a series of legislative measures meant to address identified inefficiencies and injustices in mental health service provision. These initiatives included the landmark Lanterman Petris Short Act (LPS) in the 1960's, which started the process of converting a hospital-based mental health system in California to a community-based system. LPS also radically changed the standard by which individuals could be involuntarily hospitalized in California and became the national model for civil commitment laws. At that time, there were approximately 30,000 persons with mental illnesses housed in California's state mental hospitals. These numbers were dramatically reduced over the next five years and patients were sent back to their communities. The advent of new psychiatric medications, civil rights concerns, public advocacy, new legislation, and rising

costs, all laid the groundwork for a new model of mental health service provision based on the idea that those with mental illnesses could recover and live outside of hospital walls.

Unfortunately, state hospital deinstitutionalization was driven more by cost-containment than quality improvement and commensurate funding did not follow these individuals to community settings. The dominant service model remained hospital and crisis-based, but responsibility was transferred to counties and local communities with inadequate resources. As a result of this trend and other social and economic forces, the number of homeless people with serious mental illnesses skyrocketed in the next few decades, along with a rapidly growing census of people with mental illnesses untreated in the county jails.

Realignment in 1993 attempted to address some of these problems by allocating a dedicated portion of state sales tax and vehicle license fees to the counties for community mental health services. This provided, for the first time, a secure funding source for mental health that could grow in the 1990's. Realignment also gave counties new flexibility in the use of these funds to support local program innovation that was responsive to changing local needs. Unfortunately, realignment growth did not ultimately keep pace with inflation, and began lagging in the early 2000's long before the recession began.

Realignment II in 2011, shifted fiscal responsibility for the majority of mental health programs to counties. It was not until the first part of the 21st century that a new funding source for mental health was developed. This source provided a comprehensive framework for consumer-driven, culturally competent services. Proposition 63, or the Mental Health Services Act, was passed by California voters in November 2004[1] and imposes a 1% income tax on the personal incomes of those earning more than $1 million a year. This money goes largely to fund county mental health programs. The MHSA not only provided additional and sorely needed funding for the state's mental health programs, it radically altered the approach to the provision of mental health services. The act was the culmination of a number of historical factors changing the focus of mental health services from a treatment and hospitalization model to a prevention, intervention, and rehabilitation model. Since 2004, the MHSA has yielded about $1 billion annually in new revenue for the mental health system.

The MHSA is prescriptive about the necessary components of a transformed mental health system. Developing a new model of mental health services based in the community necessitated a re-examination of the mental health workforce that would provide these services. The system was already experiencing shortages in many job classifications; historically, the mental health workforce was not ethnically or culturally diverse. Existing professional staff needed to be re-trained in emerging evidence-based practices and re-educated about a new vision that included welcoming former consumers as new colleagues and partners.

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[1] http://www.dmh.ca.gov/Prop_63/mhsa/

Historically, California had both a State Department of Mental Health (DMH)[2] and an independent statewide advisory board, the California Mental Health Planning Council. The Planning Council was instituted in 1993 as part of Realignment I to meet federal statutory requirements for public input into mental health policy development and planning and to provide oversight of the state mental health system.

In the late 1990's, the Planning Council began studying the mental health workforce, assessing current and future mental health workforce needs in the state.[3] The findings of this research suggested that the workforce was inadequate to meet current needs in terms of supply, diversity, and distribution, and unlikely to be able to meet future needs unless strategic action was taken. These findings mirrored national findings, including those of The President's New Freedom Commission on Mental Health (2002).

The Planning Council worked with the DMH, the California Mental Health Directors Association (CMDHA) and others to convene a Human Resources Summit in March 2000. One result was the Mental Health Planning Council's Human Resources Project, which was intended to implement the action plan to address workforce shortages developed from this summit.[4]

In the Bay Area, the Institute for Mental Health and Wellness Education at California State University (CSU) East Bay (then known as CSU Hayward) responded by appointing a committee on mental health education and workforce. An administrator at Alameda County Behavioral Healthcare Services initiated a series of meetings with local educators and mental health staff to explore workforce issues. It soon became clear that workforce development was a major long-term endeavor and the idea of a standing committee was proposed. Alameda County Behavioral Healthcare Services provided staff release time to convene and support the committee, which was largely focused on building the mental health workforce pipeline from high school to community college. The committee worked with the Mental Health Directors of the 13 Greater Bay Area Counties to broaden the geographic scope of the committee, and it eventually became a subcommittee of the Greater Bay Area Mental Health Directors. Berkeley's mental health director agreed to chair the subcommittee with continued staff support from Alameda County. It is out of this committee that the Greater Bay Area Mental Health & Education Workforce Collaborative (the Collaborative) eventually emerged in 2000.[5]

Until 2003, the group was largely supported by Alameda County in-kind resources, including staff time and office space. Support grew among the Bay Area Mental Health Directors as they saw their human resources challenges increasing. After the Alameda County administrator retired, Bay Area

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[2] The DMH was eliminated in 2012 and its various functions re-allocated to other state departments, notably the State Department of Health for many services, and the Office of Statewide Health Planning and Development (OSHPD) for workforce planning.
[3] http://mentalhealthworkforce.org/about/history
[4] Ibíd.

county mental health departments provided small contributions to fund a part-time consultant to facilitate meetings and conduct planning activities. These funds were augmented by a small grant from the Zellerbach Family Foundation to provide Collaborative infrastructure and to support small work projects. In 2003, the City of Berkeley assumed fiscal sponsorship and managed the initial Zellerbach grant. In 2004, fiscal sponsorship shifted from local government to the California Institute of Mental Health (CiMH) in order to provide more infrastructure to support grant writing and grants management.

The MHSA Workforce, Education and Training (WET) component described "regional partnerships" as a potential vehicle for MHSA workforce development with the Bay Area Collaborative as a model. There was potential funding for regional partnerships to assume a much larger role in the state's regional WET implementation. The Collaborative started with a strong focus on providing a forum for educators and county mental health department employers to learn from one another. As many early participants noted, the two groups, although vital to one another, seldom communicated or coordinated prior to this time. The Collaborative started out with a strong focus on providing these groups with a place to network, and on efforts to provide consumer and family member employment.

2004: A Turning Point

The year 2004 was a watershed year for the Greater Bay Area Mental Health and Workforce Collaborative. First, with the previous fiscal sponsorship of the City of Berkeley Mental Health Division and then the California Institute for Mental Health (CiMH), the nascent Collaborative was able to apply for additional funding from the Zellerbach Family Foundation. This ongoing support was vital to the development of the new organization, and continues today to play an important role in project implementation. Early Collaborative members felt the Collaborative was well positioned to address the workforce components funded by the MHSA. They formed a steering committee, also chaired by the mental health director and developed a work plan that outlined a clearer set of goals and objectives that were measurable. The Collaborative was in transition from a convening, networking and problem-solving group to a project-driven working group.

Growing as it did out of the consumer and family advocacy movement, the MHSA's core philosophy of empowerment postulated that individuals with serious mental illnesses can recover. Implementing this philosophy requires a culturally competent and recovery oriented-system, and a properly trained workforce who are responsive to California's increasing diversity.[6] This included creating positions for consumers and family members within the mental health care delivery system.

The Collaborative continued to promote consumer and family member employment, but also broadened its scope to emphasize and support workforce diversity on its agenda.

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[6] California's Mental Health Services Act and Regional Partnerships. http://www.cpca.org/cpca/assets/File/Policy-and-Advocacy/Active-Policy-Issues/MHSA/MHSAandRegionalPartnershipsDescription2007.pdf

Recognition, Sustained Funding, and Replication: 2006-2008

By 2006, the Collaborative had long included a wide range of stakeholders, from county mental health directors, community-based organizations, educational institutions from high schools to universities, consumer and family member organizations, the California Department of Rehabilitation, and the California Association of Social Rehabilitation Agencies (CASRA). The Collaborative was holding monthly stakeholder meetings, and working to develop and coordinate employment and education strategies across the greater Bay Area.

In 2006, the Collaborative hired its first full-time project manager with Zellerbach funding and launched its first website.

In 2007, the Annapolis Coalition praised the organization in its report "Innovative Practices in Behavioral Health Workforce Development". The Annapolis Coalition is the national non-profit organization responsible for developing the federal behavioral health care workforce plan.[7] Because of its successes, the Collaborative was chosen as the model for regional partnerships specified in the California's Five-Year Workforce Education and Training Development Plan for implementing the Mental Health Services Act.

The Advent of Regional Partnerships

Part of the MHSA legislation called for county mental health directors to identify their employment needs and submit them to the state's Department of Mental Health (DMH). From these local plans the DMH developed a Five-year Workforce Education and Training (WET) Plan to address statewide needs and allocate funding. This Five-Year Plan was developed over time and was released in 2007. This was part of a larger strategy to fund both local and statewide/regional workforce development projects. At the beginning of MHSA program development, $450 million in WET funding was set aside for ten years, with half for local county efforts and half for statewide and regional efforts. This funding included stipend programs, loan forgiveness and other strategies (including regional partnerships).

Regional partnerships were a required element of the Five-Year Plan and were to provide the statewide infrastructure for the implementation of the Plan. Beginning in 2008, DMH funded five regional partnerships based on the geographic structure used by the California Mental Health Directors Association (CMHDA). The directors in each region decided which county would be the fiscal agent for the funds. The first three years of funding were released in 2008, at $600,000 per year for three years.

Around 2009, the Collaborative applied for Regional Partnership (RP) funding from the DMH through Alameda County Behavioral Health Care Services. The GBAMHD agreed to continue contracting with CiMH to manage the project. This freed up funding for program implementation, and provided an element of sustainability for the Collaborative. DMH released a second round of funding in 2011.

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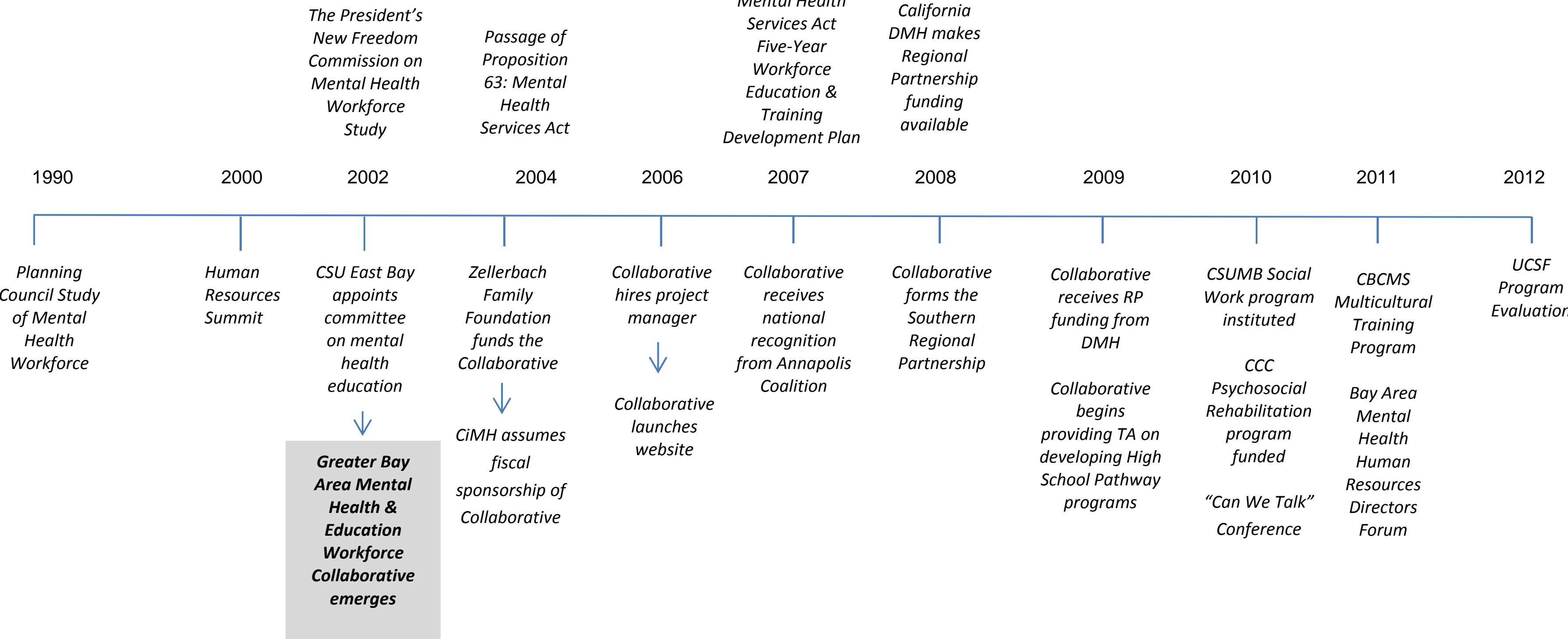
[7] ibid

There are now five Regional Partnerships in California. The California Institute for Mental Health (CiMH) serves as the contractor for three of the regional partnerships, including the Greater Bay Area group. CiMH is a non-profit corporation involved with mental health training and technical assistance for public mental health systems in California.

As noted previously, the Collaborative was the model on which other regional partnerships were based. In 2008-2009, the Greater Bay Area Mental Health & Education Workforce Collaborative began working with mental health directors in its Southern Region to develop a three-county sub-regional partnership for the Monterey, Santa Cruz, and San Benito counties. The original focus of this partnership was to develop a new MSW Program at CSU Monterey Bay. With the successful establishment of that program, the Southern Region's focus has shifted more to regional development.

Figure 1. Timeline of Collaborative's History



THE MENTAL HEALTH WORKFORCE: SUPPLY, DEMAND, AND PROJECTIONS

The following section utilizes several sources of data to describe the mental health workforce in California, and the mental health workforce specific to the Bay Area where data are adequate and reliable. These descriptive data include workforce demographic and employment characteristics; educational data indicating the pipeline, or incoming supply of new graduates; current employment data; and employment projections for the next decade. This information is intended to frame the discussion about the mental health workforce by providing background on the makeup and size of the workforce the Collaborative has been tasked with developing.

Data Collection and Sources

The data used in this section come from several sources.

1. The Integrated Postsecondary Education Data System (IPEDS). These data are from a system of interrelated surveys conducted annually by the National Center for Education Statistics. These nationwide surveys collect data on postsecondary organizations that receive federal student financial aid. Data include enrollments, completions, graduation rates, and other institutional data.
2. California Health Interview Survey (CHIS). CHIS is a telephone survey of individuals conducted on a continuous basis on a range of health topics. The CHIS is the largest state health survey and collects data on California's residents, including adults, teenagers, and children.
3. American Community Survey (ACS). The American Community Survey (ACS) is an ongoing national survey of households that uses a series of monthly samples to produce annually updated data for the same small areas formerly surveyed with the census long-form sample. Data are collected primarily by mail.
4. U.S. Department of Labor, Bureau of Labor Statistics (BLS), Occupational Employment Statistics survey (OES), May 2011. The OES survey is a national semiannual mail survey of a sample of nonfarm business establishments. Survey data are used to produce employment and wage estimates for over 800 occupations. These estimates are available for the nation, states, and for metropolitan and non-metropolitan areas within states.
5. U.S. Department of Labor, BLS, Employment Projections Program, 2010-2020. This program uses regional, state, and national data on occupational turnover and new job openings to project trends in employment in 10-year cycles.

Demographic Characteristics of the Mental Health Workforce in California and the Bay Area

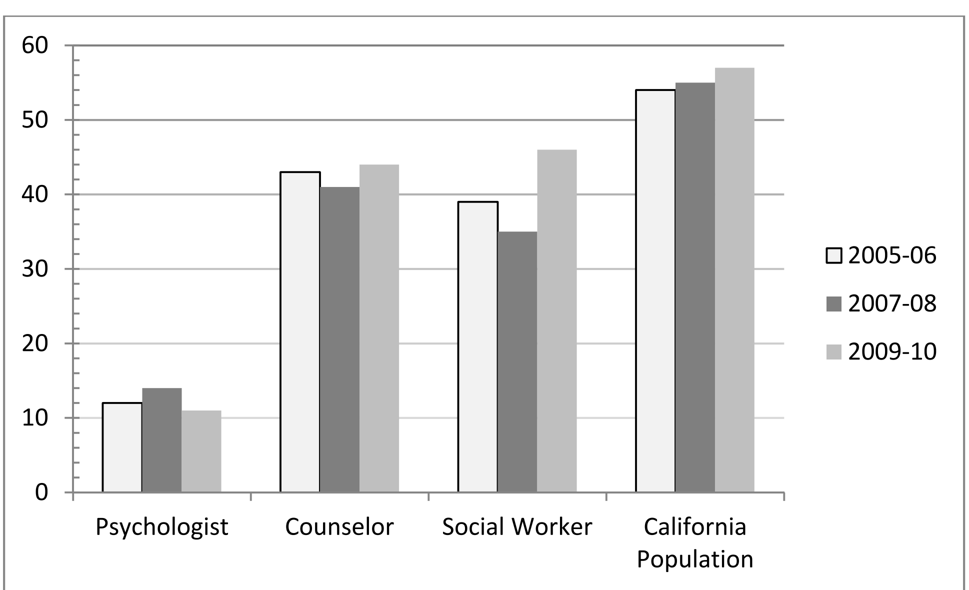
Race and Ethnicity

Diversity in the mental health workforce is one of the goals of the MHSA and the Collaborative.

displays information on trends in the non-white mental health workforce from 2005 to 2010. The American Community Survey data are only available for the three categories of workers included in the tables. Psychology and social work were selected at the master's degree level or higher. Data are compared to the proportion of the employed population in California.

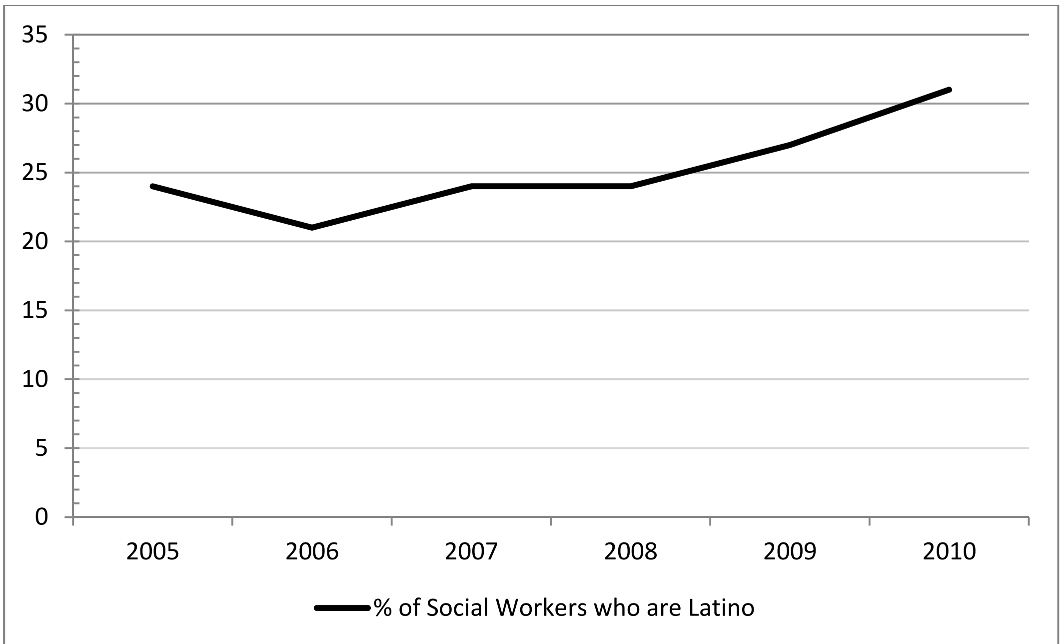
These data show that in the Bay Area, gains have been made in the diversity of social workers and counselors, particularly in recent years. However, the proportion of non-white psychologists has not changed over the past 5 years and remains low compared to California's overall employed population. These data do not reflect MHSA or Collaborative program efforts begun after 2010.

Figure 2. Non-white share of Bay Area workforce by occupational title & by race and ethnicity



Perhaps the largest trend in the diversification of the mental health workforce is the growth in the number of Latino social workers, displayed in *Figure 3*.

Figure 3. Latino share of California social worker workforce



Age

The key finding regarding age data is that the proportion of psychologists age 65 and over has steadily increased from 2005-2010, about 20% in California and the Bay Area.

Gender

Data from the ACS indicate that the vast majority of psychologists, counselors, and social workers in the Bay Area are female. More than 70% of psychologists, 60% of counselors and 70% of social workers in the Bay Area are female. Data not shown indicate that these trends have changed very little over the past 5 years and are essentially the same as statewide data.

Workforce Supply and Demand: Data on Current Employment and Projected Job Openings

The Bureau of Labor Statistics (BLS) Occupational Employment Statistics survey data include current levels by job category for the U.S., California, and by county. The data for the Bay Area are insufficient to report by county, thus data in the table are for the state. Data in *Table 1* include occupations according to BLS Standard Occupational Codes (SOC) and differ somewhat for mental health occupational codes used by the census in the previous demographic data and tables.

Table 1 Mental Health Workforce Employment in California, 2011; Projected Annual Job Openings 2010-2020.

Occupation	***Total Employment California***	***Employment per 100,000 Pop: CA***	***Employment per 100,000 Pop: U.S.***	***Projected Annual Job Openings, 2010-2020***
Clinical, Counseling, and School Psychologists	*15,990*	*42.4*	*32.4*	*770*
Substance Abuse and Behavioral Disorder Counselors	*8,660*	*23.0*	*24.6*	*380*
Mental Health Counselors	*8,610*	***22.8***	*36.6*	*390*
Marriage and Family Therapists	*10,010*	*26.6*	*10.9*	*650*
Child, Family, and School Social Workers	*25,050*	***66.5***	*88.7*	*1,030*
Healthcare Social Workers	*12,300*	*32.6*	*43.0*	*690*
Mental Health and Substance Abuse Social Workers	*10,280*	***27.3***	*37.0*	*440*
Psychiatrists	*4,070*	*10.8*	*7.4*	*170*
Psychiatric Technicians	*8,730*	*23.2*	*22.4*	*340*

Source: U.S. Department of Labor, U.S. Bureau of Labor Statistics, Occupational Employment Statistics survey, May 2011 Occupational Employment Projections
California Employment Development Department, Labor Market Information Division

These data on the current supply of the mental health workforce present a mixed picture of current employment and projected job openings across the mental health disciplines included. It is difficult to assess the "right" number of workers needed to deliver services in the state or in any geographic area. The number of workers per 100,000 can be considered a benchmark for comparison with other states or the U.S. overall. These data show that California exceeds U.S. ratios for some professions but lags behind in others. Employment of mental health counselors, social workers, and substance abuse counselors is below the average ratio in the U.S.

Projected job openings include new positions as well as expected turnover due to separation and retirement. These data indicate a significant opportunity for mental health professionals in California in the future. The data were not sufficient to analyze for the Bay Area only. However, data found in

APPENDIX A. CALIFORNIA LICENSING DATA Licensing Data, from the ACA report indicate that many of the jobs will likely be outside the immediate Bay Area. Professionals trained in the Bay Area may need incentives to work in mental health shortage areas around the state.

Workforce Supply: The Mental Health Workforce Pipeline

Data from IPEDs indicate the pipeline, or incoming supply, of mental health workers. Because IPEDS data use different categories to define professions than the employment and demographic data, it is difficult to compare supply to demand. However, IPEDS offers important information on trends in the student population. IPEDS data on diversity are presented below because one of the efforts of the Collaborative is to diversify the mental health workforce. One should view these data with caution because the year-to-year percentage changes often represent a small number of individuals and therefore, small changes in the trend.

Figures 4-8 display information on race and ethnicity reported for graduates of six mental health professions as coded in IPEDs data. These data include the reporting years 2007-2011.

Trends in race and ethnicity of graduates show that the percentage of graduates from underrepresented groups has not increased dramatically over the time period 2007-2011. In doctoral programs in clinical psychology, there appears to be a decrease in graduates from underrepresented groups. In other professions, there is movement up and down over the years. These changes represent small changes in numbers of students from year to year rather than significant trends. The one profession showing a clear trend toward increasing diversity is Latinos in social work.

Figure 4. California: Doctoral Programs in Clinical Psychology: graduates per year, by race and ethnicity

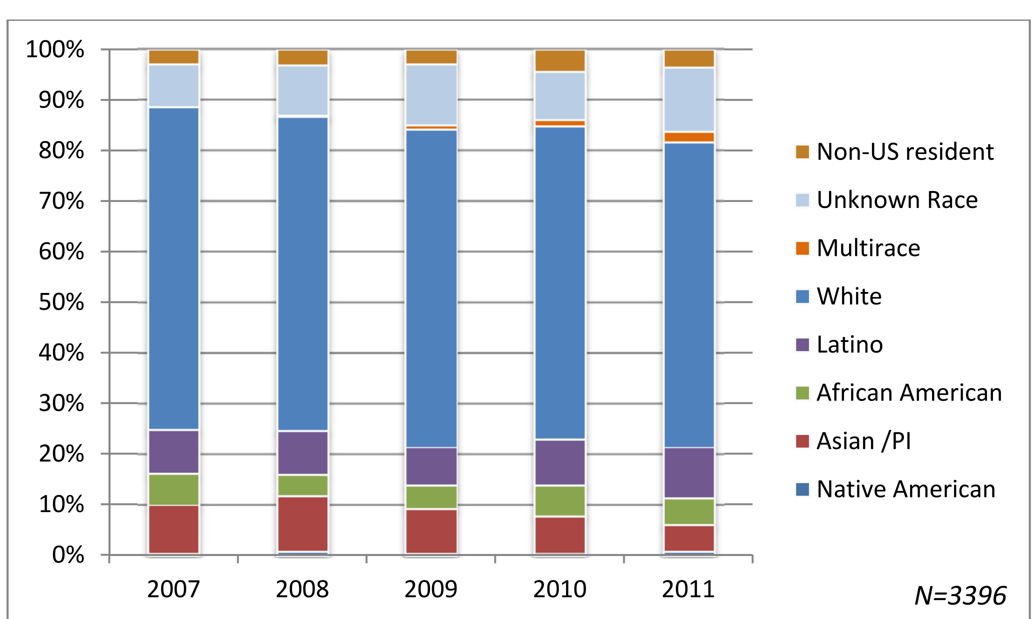


Figure 5. California: Masters Programs in Marriage and Family Therapy: graduates per year, by race and ethnicity

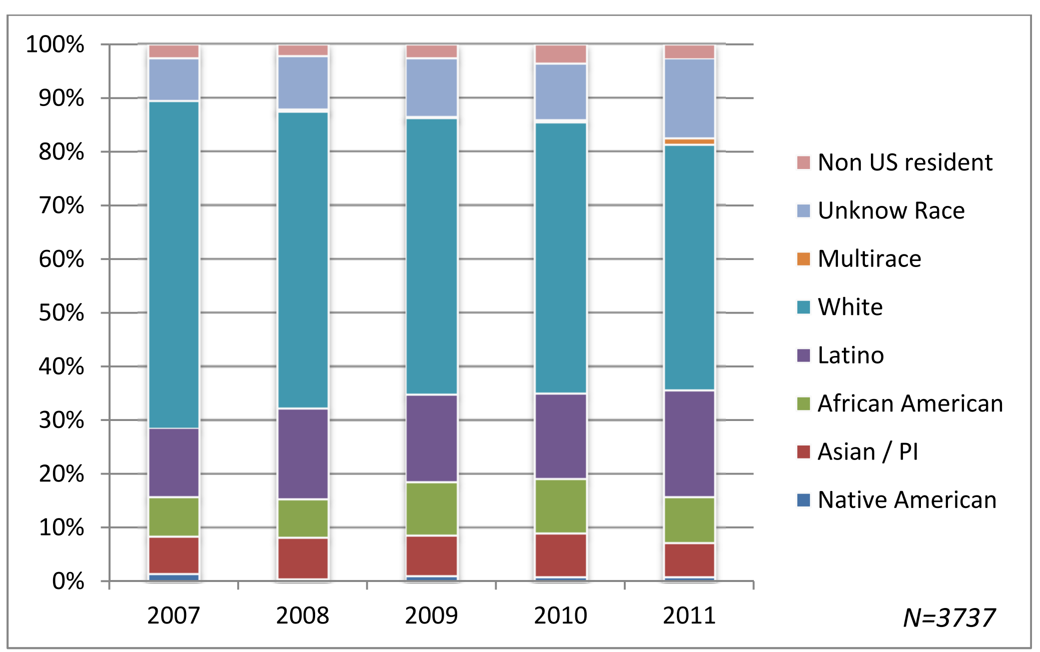


Figure 6. California: Masters Programs in Social Work: graduates per year, by race and ethnicity.

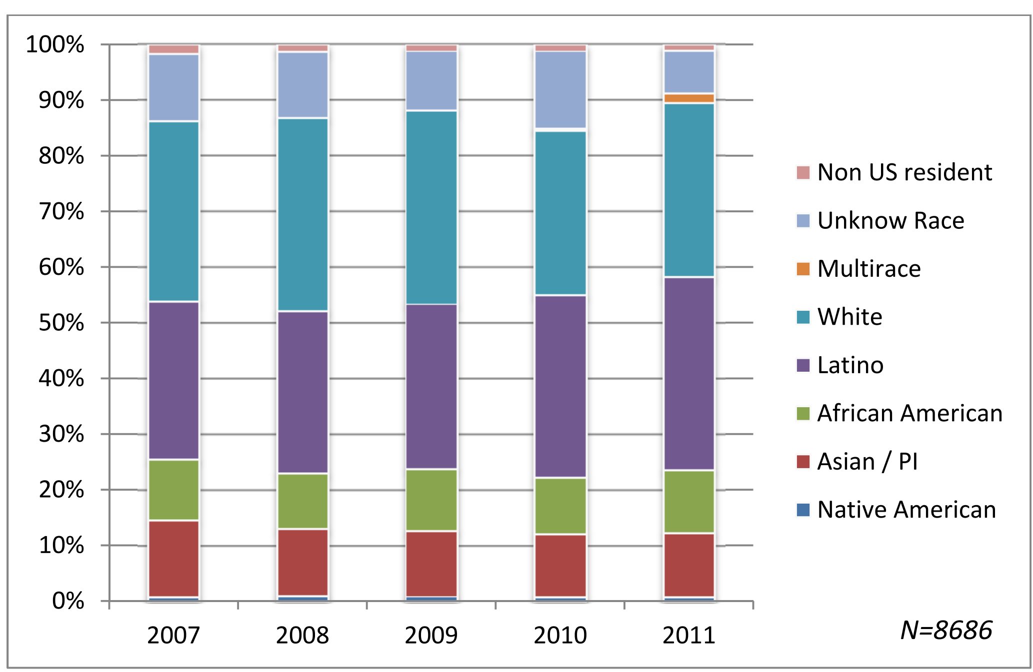


Figure 7. California: Psychiatric Technician Programs: graduates per year, by race and ethnicity

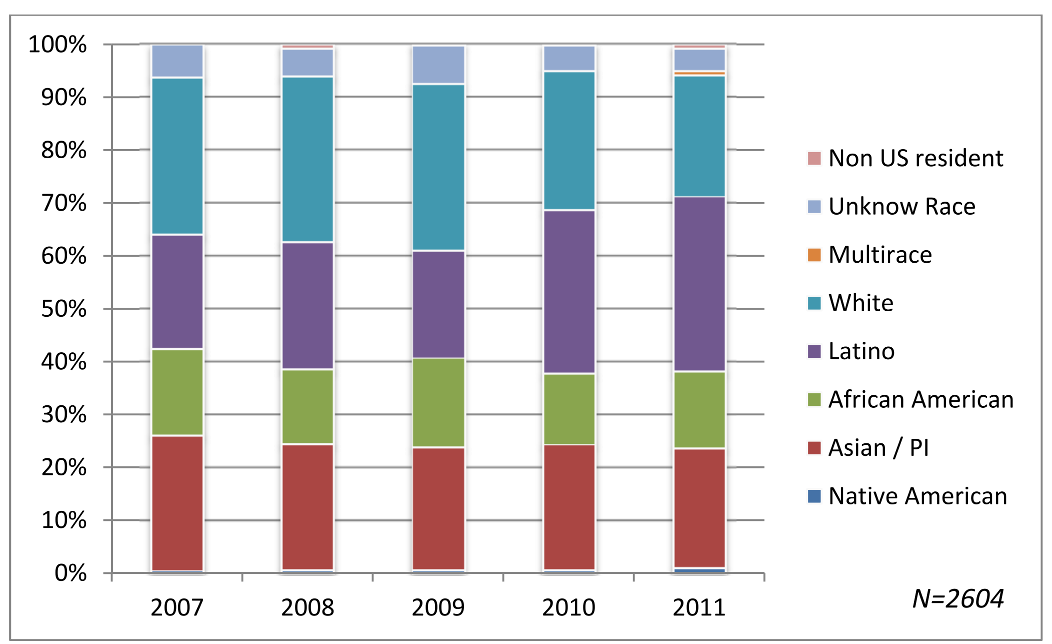
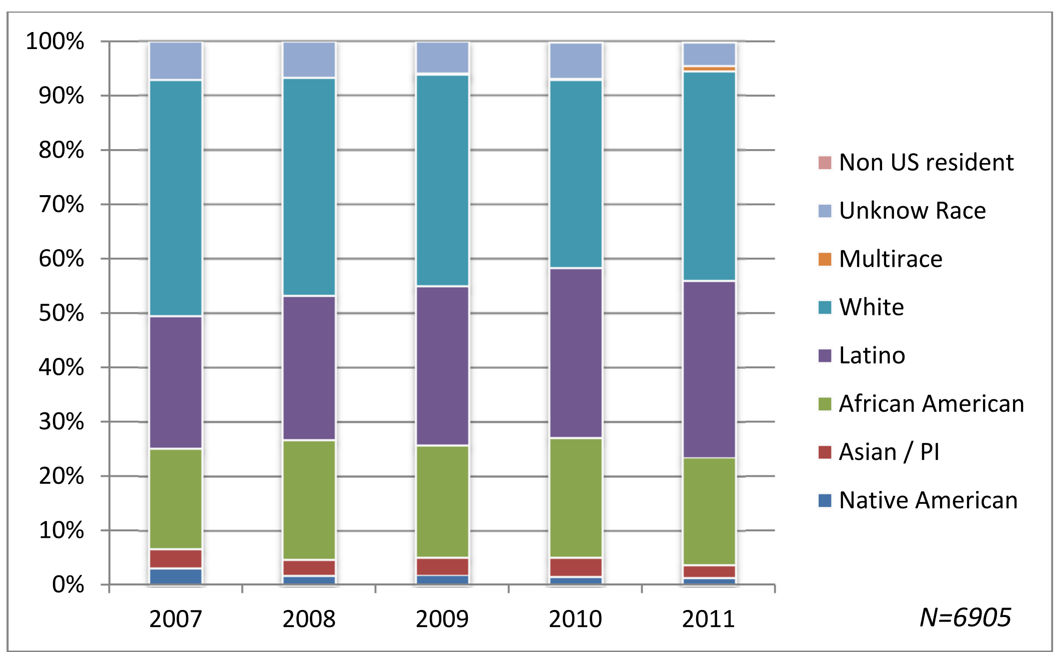


Figure 8. California: Substance Abuse Counselors: graduates per year, by race and ethnicity



Workforce Demand: The Need for Mental Health Services

Another way to look at the demand for mental health workforce is self-reported unmet need for mental health services. The 2009 California Health Interview Survey (CHIS) asked a statewide sample of adults whether they 'sought help for self-reported mental/emotional and/or alcohol-drug issue(s)'. In the 12-county Bay Area, 42.7% of respondents reported that they "needed help but did not receive treatment." Counties with the highest reported level of need (over 50%) were Santa Clara, San Mateo, and San Benito. Need was highest among the uninsured (70.8%), and lowest among those with Medicare and Medicaid.

Need was lowest among Whites and Asians (below 40%), and highest among Latinos, African Americans, and Native people (50%+). Language spoken was also related to unmet demand. Thirty-nine percent of those who spoke English well needed help but did not receive treatment compared 48% of those who spoke English less well.

Large sections of Monterey County and some areas of Contra Costa and Solano Counties are designated as mental health professional shortage areas, or HPSAs.[8] The CHIS data on unmet demand, and HRSA provider-to-population ratios, suggest that most of the Bay Area is well-served compared to much of the rest of the state, with pockets of unmet need. As with many types of health care workers, the supply of mental health professionals is not evenly distributed geographically. Even where the supply appears to be adequate in regards to numbers, need appears to be higher amongst certain groups, including the uninsured, those who do not speak English well, and among Latinos, African Americans, and Native Americans.

[8] Health Resources and Services Administration (HRSA), http://hpsafind.hrsa.gov/HPSASearch.aspx

ACTIVITIES AND PROGRAMS OF THE COLLABORATIVE

The Collaborative has sponsored a large and diverse number of initiatives, research projects, resources, and convenings.

Table 2 shows of a summary of how each these activities addresses CiMH goals. The compendium that follows describe recent activities and programs and provides an overview of these activities organized by the Collaborative's specific objectives. For each activity listed in the compendium, we provide a brief summary, date, funding source, and outcomes, if available. Each activity is also coded by activity type and goals adapted from the CiMH's evaluation typology, with some cross-referencing to other objectives the activity addresses. Table 2 shows a summary of how each of these activities addresses CiMH goals.

Funding Key

RP = Regional Partnership funds

ZFF = Zellerbach Family Foundation

Table 2. Simplified CiMH Activity Typology

Goals ⟹ Activities ⇓	Information Dissemination	Changing Attitudes & Beliefs	Improving Systems & Informing Policy	Changing Practices	Determining System Operation & Effectiveness of Practices
Trainings	X	X			
Publications/Multimedia Products	X	X			
Convening	X	X			
Planning & problem solving processes	X	X	X		
Technical assistance	X	X	X	X	X
Implementation activities	X	X	X	X	X
Research and Evaluation	X	X			X

(This table does not include CiMH's three levels of evaluation: person, project, and system.)

vities and Programs

raining resources that integrate MHSA philosophy and values: promoting education, training and re-training of the mental o increase the practice of culturally competent, recovery oriented services

	Duration	Funding	Outcomes	Activity	Goals
tings to bring together stakeholder ssist with governance. Includes: ***ater Bay Area Mental Health & on Workforce Collaborative*** *meetings e in Oakland every other month. pen meetings are generally attended / mental health staff, educators from ipeline programs, advocates, non- ff, and others. County WET staff s occasionally following regular to discuss county-to-county issues.* ***Bay Area Mental Health Directors*** *nthly in Oakland. The Collaborative anager participates in these meetings standing agenda items on workforce This group approves Collaborative final ns, represents the Regional hip with the County Mental Health Association and other stakeholders.* ***Committee****: The Collaborative has a ber steering committee comprised of aff, providers, university/college staff, consumer leaders, funders and This group oversees development of borative's work plan and advises on activities. The Collaborative's project leads these meetings and conveys endations to the Greater Bay Area ealth Directors.* ***n Bay Regional Partnership*** *take place in Salinas every other*	*Ongoing, (Southern Bay Regional Partnership Meetings since 2008)*	*RP (Regional Partners hip Funding)*	*The Steering Committee and Greater Bay Area Mental Health Directors meetings provide the Collaborative with guidance on mission and budget, and confer legitimacy in regional workforce development. The Greater Bay Area Mental Health & Education Workforce Collaborative and Southern Bay Regional Partnership meetings attract more than 100 participants annually representing many different perspectives.* ***Website:*** *http://mentalhealthworkforce.org/meetings* *a) Increased access and new resources for technical assistance and problem-solving for: Bay Area internship programs, consumer employment, educational pathways, county WET Plans, evidence-based practices;*	*Convening, Technical Assistance (TA), planning & problem solving*	*Information Dissemination* Changing Attitudes & Beliefs *Improving Systems & Informing Policy* *(Infrastructure)*

Program	Description	Duration	Funding	Outcomes	Activity	Goals
	(continued) *month (see below)*			*b) Ongoing needs assessment and planning for regional in-service trainings;* *c) Increased knowledge and expertise of educators re: integration of the recovery model and public mental health competencies in curricula at all levels.*		
Southern Bay Regional Partnership	*The Greater Bay Area Mental Health & Education Workforce Collaborative began working with mental health directors in its Southern Region to develop a three-county sub-regional partnership for the Monterey, Santa Cruz, and San Benito counties. While the original focus of this partnership was to develop a new MSW Program at CSU Monterey Bay, with the successful establishment of that program, the Southern Region's focus has shifted more to regional development. Meetings take place every other month between the GBA Collective meetings in Oakland.*	*2008- Ongoing*	*RP*	*Bi-monthly meetings of the partner groups; T.A., program development and support of CSUMB Master's in Social Work Program; Collaborative funding for feasibility study and core course faculty for MSW program; TA for CalSWEC scholarship program; scholarships for MSW students, WET plan collaboration among southern region partners;*	*Convening, TA, planning & problem solving*	*Information Dissemination* *Improving Systems & Informing Policy* *(Infrastructure)*
County WET Plans TA	*One-time technical assistance (TA) to all 13 Bay Area counties as needed/requested to support the development and implementation of county MHSA Education and Training Plans. (Ongoing regional updates through 2011).*	*2008-2011*	*RP*	*All 12 counties and 1 city submitted WET plans, which guide Mental Health workforce development in each county/city.*	*Technical Assistance*	*Improving Systems & Informing Policy*

Program	Description	Duration	Funding	Outcomes	Activity	Goals
Conference on Behavioral Health/ Primary Care Integration – Emerging Best Practices	The Collaborative is planning a one-day Bay Area Conference on Primary Care & Behavioral Health Integration for June 2013 in partnership with CalSWEC's (California Social Work Education Center's) Mental Health Initiative. The target audience includes: • Students and faculty in graduate training programs • County mental health/behavioral health systems and providers.	June 2013	Zellerbach Family Foundation (ZFF)	Completed	***Convening***	***Improving Systems and informing Policy; Information Dissemination; Changing Attitudes & Beliefs;*** ***Changing Practices***
Supporting Bay Area County Mental Health Systems Implementing AB109	*Research and produce a report highlighting evidence-based practices serving the Bay Area Post-Release Community Supervision (PRCS) population with a focus on individuals with mental health/behavioral health needs who are parents.*	*2012*	*ZFF*	*Report in process.*	*Research & Evaluation*	*Information Dissemination;* *Changing Practice;* *Improving Systems;*
MFT Curriculum Development Project	*This grant supports local graduate programs in making state-mandated changes to MFT curriculum that become effective in 2012. The objective of this project is to update training requirements for MFTs to reflect the values and workforce needs of the public mental health system under the Mental Health Services Act.*	*October 2010 – September 2011; 2012-2013*	*ZFF*	*The Collaborative supported several of curriculum development trainings and other educational materials to help prepare students pursuing MFT licenses for the public mental health sector. Materials posted online*	*Planning and Problem Solving*	*Improving Systems and Informing Policy; promoting a recovery-oriented workforce;*

II. Increase County Human Resources/Civil Service responsiveness to and operational support of public mental health employment needs						
Program	**Description**	**Duration**	**Funding**	**Outcomes**	**Activity**	**Goals**
Bay Area Mental Health Human Resources Directors Forum	*Educational and problem-solving forum including Bay Area Mental Health Directors, HR Directors and key HR managers that identified challenges and barriers as well as evolving best practices and commitments for future collaboration and mutual consultation. Disseminate findings.* • *Creating a Labor Pool* • *Recruiting a Diverse Workforce Including Consumers and Family Members* • *Creating a Welcoming Environment* • *Retaining a Diverse Workforce* • *Promoting a Diverse Workforce* • *Risk Management: Risks, Perceived and Real, and their Management*	*April 2011*	*ZFF*	*Positive evaluations re: sharing/ learning.* *Materials posted online*	*Convening and Publications / Multimedia*	*Information Dissemination* *Improving Systems and Informing Policy*
Public Mental Health Core Competencies Project	*Research and identify the core competencies direct service and supervisorial staff require to meet the needs of individuals seeking mental health services in California's public mental health system*	*2010 - 2012*	*ZFF*	*TBD—basic competencies to be developed after a comprehensive review of existing job descriptions; core competencies are intended to upgrade skills, knowledge and practices of existing staff, to educate and train new staff, to standardize job descriptions and to better integrate contemporary approaches and evidence based practices.*	*Planning and Problem Solving; Technical Assistance*	*Improving Systems & Informing Policy*

III. *Strengthen and expand educational partnerships to increase the viability and accessibility of the mental health workforce pipeline*						
Program	***Description***	***Duration***	***Funding***	***Outcomes***	***Activity***	***Goals***
CSUMB Social Work Program	*In response to community need and years of advocacy by both the County of Monterey Behavioral Health and CSUMB, the university instituted a 3-year, evening MSW program in March 2010. The primary objective of this program is to develop local residents with bilingual, bicultural capacity to serve as social workers for the local community.*	*August 2010-present*	*RP*	*Increased system capacity for bilingual/bicultural professional level services; the program has started three cohorts of students. Students have been primarily from the Central Coast region—a large proportion is Hispanic and bilingual.*	*Implementation*	*Changing practices* *Information Dissemination* *Growing the mental health workforce; Increasing access to culturally competent services;*
CCC Psychosocial Rehabilitation Program	*Contra Costa College, a community college located in San Pablo, California, offers a certificate of Psychosocial Rehabilitation through its Health and Human Services program. This program was started by the Mental Health Division of Contra Costa Health Services and the Contra Costa Community College Health and Human Services program, with substantial consulting assistance from the California Association of Social Rehabilitation Agencies (CASRA).*	*August 2010-present*	*RP*	*Expanded the labor pool and increased diversity for county and CBO entry-level employment; Improved skills of existing personnel; Collaborative funds instructor for two psychosocial rehabilitation courses; Collaborative funds instructor for two psychosocial rehabilitation courses; legitimized and made the role of non-licensed staff more visible;* *The program started its first class in August 2010 with 69 students. Fewer students have enrolled and completed the program in recent years.*	*Implementation*	*Changing practices* *Information Dissemination* *Increasing number of trained consumer and family providers; Increasing diversity of entry level workforce;*

Program	Description	Duration	Funding	Outcomes	Activity	Goals
	(continued)			*The majority of students in the certificate program have been female, and many are older than traditional college age, Many are already working in the field, and many have lived experience with mental illness.*		
High School Pathways Development	*The Collaborative is providing technical assistance and consultation to 5 counties who are interested in developing high school mental health curriculum and pathways. The Collaborative is now involved in developing curriculum, putting on webinars and workshops as well as consultation.*	*2009 - present*	*RP*	*6 of the 12 counties currently sponsor a high school program focused on mental health career pathways. 4 of these are new or in development as a result of Collaborative sponsored consultation and T.A. Evaluation data suggests positive changes in student attitudes and aspirations, knowledge about mental illness, and knowledge about mental health careers.*	*Technical Assistance; Implementation*	*Changing practices* *Information Dissemination* *(Increase public awareness of and interest in pursuing public mental health careers)*
Community College Convenings	*The Collaborative—in partnership with the Health Workforce Initiative of the California Community Colleges—has convened Bay Area community colleges that offer Human Services (or similar) programs at Berkeley City College in March 2010, at City College of San Francisco in November 2010, and at the offices for Alameda County Behavioral Health Care Services in May 2013.. The goal of these convenings is to share resources and offer information on curriculum.*	*Spring 2010 - Present*	*RP*	*The March 2010 convening included ten representatives from six different community colleges, including a representative from the Regional Health Occupations Resource Center.*	*Convening*	*Information Dissemination* *Improving Systems and Informing Policy;* *Expanding the entry level workforce and pipeline*

Program	*Description*	*Duration*	*Funding*	*Outcomes*	*Activity*	*Goals*
Support efforts to increase capacity to accept interns, including sharing resources on best practices for clinical supervision.	*The Collaborative has offered support on graduate intern programs including: presentations on best practices; developing a matrix of intern/trainee supervision requirements—posted on the website—followed by a presentation facilitated by a local trainer; posted links to county intern training programs on the website; facilitated discussions/sharing of sample intern policies and university contracts/ MOUs with training staff.*	*2009 - present*	*RP*	*The Collaborative disseminates information on financial incentive programs, educational loan assumptions, stipends, etc.* *Increased diversity of internship and future staff applicant pool through strategic use of stipends; increased efficiencies and improved training through standardized internship policies and practices.*	*Technical assistance, Convening, Publications / Multimedia products*	*Changing Practices* *Information Dissemination;* *Expand recovery-oriented workforce*
Supporting Internship Capacity	*The Collaborative has offered support of undergraduate, community college and high school internships in public mental health in order to help expand the mental health workforce by providing necessary experience to students seeking to enter the field.*	*2010*	*ZFF*	*Information, resources and tools posted online*	*Publications/ multimedia*	*Information Dissemination;* *Changing Practices;* *Expanding pipeline opportunities;*

IV. ***Increase the number of consumers and family members hired, retained and offered opportunities for career pathway development throughout the public mental health system***

Program	***Description***	***Duration***	***Funding***	***Outcomes***	***Activity Type***	***Goal***
Consumer and Family Member Employment Conference and Follow-Up	*The Collaborative planned and hosted a one-day conference, "Can We Talk?" to bring together representatives from county mental health systems and their partners in the Greater Bay Area to address the progress and barriers to successful consumer and family member employment. This conference was developed in collaboration with San Mateo County BHRS. The Collaborative has continued to work with the group "Working Well Together," an organization dedicated to developing consumer and family member employment, and has posted many of its resources online on the Collaborative's website.*	*Oct 2010 - present*	*RP, ZFF*	*Over 170 people attended in 2010; expansion of consumer and family employment is underway although hindered by effects of recession; conference helped reduce resistance to consumer employment among existing staff; promoted best practices in establishing effective supports to improve recruitment and retention of consumer/family providers.*	*Convening, TA*	*Information Dissemination* *Improving Systems and Informing Policy* *Changing Attitudes & Beliefs* *Expanding consumer and family employment*
Increase consumer and family member participation in the Collaborative.	*There is regular consumer and family member participation in Collaborative meetings, and linkages with consumer groups including: Alameda County's Pool of Consumer Champions, PEERS and others. Consumer leaders are regular participants in collaborative meetings and WET Coordinator meetings. The Project Manager offers a 30-minute orientation prior to monthly meetings open to all new participants.*	*Ongoing*	*RP*	*The number of consumer and family member positions on the 13 member Steering Committee was increased. The Collaborative website now has a "Consumer and Family Member Employment Resources" section on its website.*	*Convening*	*Information Dissemination;* *Changing Practices;* *Promoting a recovery-oriented mental health system*

V. ***A diverse and culturally and linguistically competent public mental health workforce serving unserved, underserved and inappropriately served consumers and their families***						
Program	***Description***	***Duration***	***Funding***	***Outcomes***	***Activity Type***	***Goal***
CBMCS training	California Brief Multi Cultural Scale (CBMCS) Multicultural Training Program is a tool used to assess and train mental health practitioners to enhance cultural competence and retain a diverse workforce. The target audience for the Collaborative's 4-day 2011 training session was Greater Bay Area county mental health managers, administrators, supervisors, direct service providers, clinicians, case managers, contractors, administrative and support staff and community partners.	February 9-10 and March 3-4, 2011	*RP*	*Approximately 21attendees participated in the Oakland training. This was a train-the trainer event. Training received positive evaluations. Additional training is planned for the Southern Region in 2013-14.*	*Training*	*Information Dissemination* *Changing Attitudes & Beliefs* *(Promoting a culturally competent workforce)*
Analysis of WET Plans	*Analyze County WET Plans for common elements and training needs*	*2010-2012*	*RP*	*Completed*	*Research & Evaluation*	*Determining effectiveness of system operation and practices; system improvement*
Mental Health Interpreter Training to Southern Bay Region	*Training for mental health interpreters, and staff who work with interpreters. Target area is the Southern Bay Region. To be expanded and improved based on initial pilot.*	*June 2012*	*RP*	Completed. Additional training under consideration for 2013-14	*Implementation*	*Changing Practices* *(Promoting a culturally competent workforce; increasing linguistic diversity and access)*

VI. ***Increase public awareness of and interest in pursuing public mental health careers***						
Program	***Description***	***Duration***	***Funding***	***Outcomes***	***Activity***	***Goal***
Collaborative's Website	*The Collaborative has a comprehensive website at* ***www.mentalhealthworkforce.org****.* *It has expanded and improved as a result of RP funding; the website has been well received and well utilized. A job board was added recently that is receiving many hits. A new logo was also developed as part of this process*	*2009-present*	*RP*	From Jan 1, 2011 to Dec 31, 2011 the website received 2,699 visits from 1,764 different individuals. During the same period the prior year, the site received 1,883 visits by 1,133 different individuals, representing a 69% increase in overall number of visits during 2011. The Collaborative is investigating ways the site could be made more interactive to allow users to share information	Publications / Multimedia	Information Dissemination
Newsletter	*Publish quarterly online newsletter through the Collaborative's website.*	*2012-present*	*RP*	*Two newsletters published*	*Publications / Multimedia*	*Information Dissemination*

KEY INITIATIVES

The Collaborative has sponsored a large number of initiatives, research projects, and convenings. The following section reviews four key initiatives fostered by the Collaborative. These four key initiatives were selected because they exemplify major goals of the Collaborative. These goals include development of pipeline educational programs, from high school, to community college, to four-year institutions, and development of consumer and family member employment programs. Some of these programs are directly funded by the Collaborative, and others are influenced by the work of the Collaborative if not directly funded by it.

Contra Costa College Psychosocial Rehabilitation Program

Contra Costa College, a community college located in San Pablo, California, offers a certificate of Psychosocial Rehabilitation through its Health and Human Services program. The college is located in West Contra Costa County, a very diverse area that includes a number of low-income communities.

This program was started by the Mental Health Division of Contra Costa Health Services and the Contra Costa Community College Health and Human Services program, with substantial consulting assistance from the California Association of Social Rehabilitation Agencies (CASRA). Funding from the Greater Bay Area Mental Health and Education Workforce Collaborative allows the College to pay for faculty to teach core courses integral to this certificate program.

Role of the Collaborative

Implementation: the Collaborative is involved in direct funding of this program.

Methods

In order to prepare this profile, we conducted a site visit in October 2012. This visit included:

- key informant interviews with 2 program faculty, 1 senior administrator, and 1 outside stakeholder;
- a group interview with 8 students; and
- a Review of available program documents and data.

Definition

Psychosocial rehabilitation is an approach to mental health counseling that engages persons with severe and persistent mental illness in four service domains: 1) systematic skill building through cognitive-behavioral and other interventions, 2) vocational services, 3) consumer-community resource

development, and 4) peer support. The primary goals of these activities are characterized as empowerment, competency, and recovery.[9]

History

The Contra Costa College Psychosocial Rehabilitation certificate program was developed to meet the needs of local public mental health services. These included mental health workforce shortages in general, the need for more staff reflective of the ethnic and linguistic diversity of the community, and the need for staff trained in the rehabilitation and recovery model identified in the MHSA.

The program was a joint effort between the Contra Costa County Mental Health Department and Contra Costa College, a local community college. Around 2006, Contra Costa College hired a new faculty member tasked with developing and expanding the College's nascent Health and Human Services program. The Program Director applied for grant funding that allowed the college to hire more adjunct faculty and develop additional offerings in Health and Human Services. She was approached by a consultant who had developed a psychosocial rehabilitation certificate program for College of San Mateo, another Bay Area community college. The program seemed like a good fit for what the new program director was trying to develop in Contra Costa County, so she began working with the consultant from the Department of Mental Health/Department of Rehabilitation Cooperative Program to develop a program.

In 2009, Contra Costa County provided funds to hire the California Association of Social Rehabilitation Agencies (CASRA) to facilitate the project. CASRA conducted a needs assessment via an employer survey to determine the demand for graduates and required competencies. CASRA helped to develop the curriculum for two new courses and provided a series of in-service trainings for faculty and staff. Consultants also helped to develop a 24-member advisory council to help guide the project.

By August of 2009, the consultants presented the curriculum to the Contra Costa College Committee on Instruction. With approval of the curriculum, the consultants identified key groups for recruitment as potential students. These included staff currently working in Contra Costa County Mental Health without a degree in this field, staff with degrees but no training in PSR, people with lived experience who wanted to become providers, and the general student body at Contra Costa College.

The first PSR class was offered in August of 2010. Classes were initially taught by the Program Director. As her responsibilities expanded, she sought funding from the Greater Bay Area Mental Health and Education Workforce Collaborative to hire adjunct faculty to teach the two core courses.

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[9] *Barton, R. (1999) "Psychosocial Rehabilitation Services in Community Support Systems: A Review of Outcomes and Policy Recommendations." Psychiatric Services, VOL. 50, No. 4.*

Program

Two entirely new 3-unit courses were developed, and together with two existing courses, formed the basis for the 12-unit Certificate of Specialization in Psychosocial Rehabilitation.

The two existing courses were *Introduction to Case Management* and *Introduction to Counseling*. The new courses were *Introduction to Psychosocial Rehabilitation,* and *Rehabilitation and Recovery*.

Students were not required to complete an internship as part of their certificate program because most of them already worked in the field and/or completed additional certificate programs within Health and Human Services to gain field experience in that way.

The two psychosocial rehabilitation courses are currently taught by a public health program manager with Contra Costa County. Courses are offered in the evening because they are aimed at working professionals.

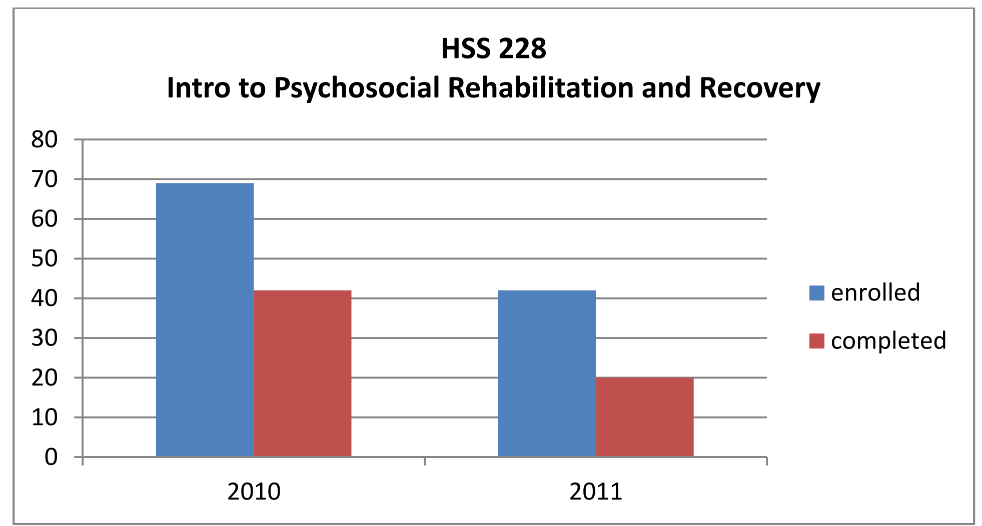
Peer Support Services Center

Since spring of 2010, the Health and Human Services program has also run a Peer Support Services Center on campus. This center is staffed by interns from the Health and Human Services program who are supervised by licensed professionals, including faculty and a staff member from the county mental health department. Interns provide mental health counseling and referral services to both students and people from the surrounding community. The Center has also become a meeting place for Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) groups.

Student Enrollment, Completion, and Characteristics

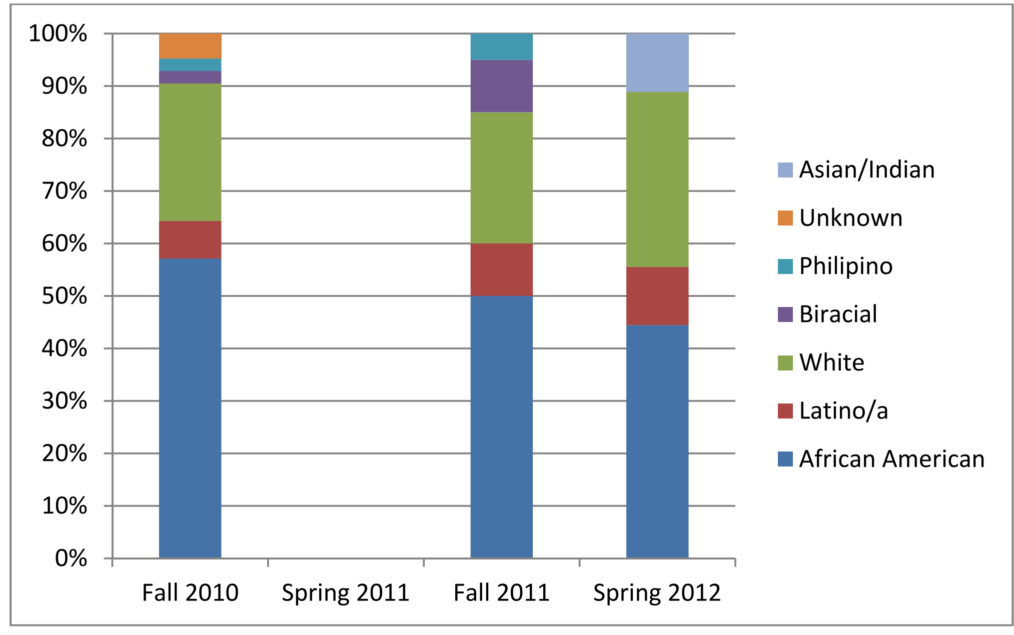
The program started its first class (HHS 228 Introduction to Psychosocial Rehabilitation and Recovery) in August 2010 with 69 students. In the following year, fewer students enrolled in the course and a smaller proportion (48% vs. 61%) completed the course. (See *Figure 9*.) Students and faculty had varying perspectives as to why this drop-off occurred. The program may have reached a certain saturation point having addressed and accommodated a pent-up demand. Students may be more likely to drop due to the reported increase in academic demands in the course. Finally, students may just be facing more barriers to attending college due to the continued economic recession.

Figure 9. Contra Costa College PSR Program: Enrollments and Completions, HHS 228



The courses appear to have attracted students from diverse backgrounds, including African American, White, Latino, Filipino, and Southeast Asian, with the plurality (54%) being African American. Courses have attracted relatively few Latino students (13%), who make up close to a third of students at Contra Costa College, and Asian students (4%), who make up approximately 13% of the students at the college.

Figure 10. Contra Costa College PSR Program: Student Race and Ethnicity



The majority of students in the certificate program have been female, and survey data suggest that many are older than traditional college age, with many over the age of 40 (range 17 to 70 years of

age). Many are already working in the field. Some also have lived experience with mental illness and/or substance abuse.

Because of the average age of students, and the fact that many are working professionals, there appears to be relatively little direct connection between this program and high school programs, including a growing High School Pathways Program funded by Contra Costa County and operating in three county high schools.

Faculty and Administrative Perspectives

Student characteristics and experiences provide both advantages and disadvantages, according to program faculty and administrators. The fact that many are working in the field and have experience with recovery issues adds relevant depth to class discussion. They bring their own experience to their work in the field, which may help them be better at understanding their clients' experience. However, lived experience can also be a challenge—many students are reportedly fresh out of their recovery programs when they start courses and eager to make a difference, but lack in basic academic skills. Students also face significant life challenges, often working, parenting, and attending school at the same time. Both faculty and students noted that instructors provide extensive extra-curricular support to help students improve their skills, set education and employment goals, and access resources to help them succeed. Faculty also noted that students brought a great deal of resiliency and understanding of client populations.

> *"They come in with some tools others don't come in with…They are strong students and strong helpers too. They stick to things and do not get easily discouraged because they have lived a life that was very discouraging, so, compared to that, they can get through this."*

The program and department have changed over time, partially due to the recession economy. Funding from the Collaborative has allowed the department to hire a new instructor to teach the PSR courses and free up the director's time for other duties. However, enrollment numbers for the PSR program are down and administrators are concerned about the causes for the decline, especially because the classes need to fill enough seats to continue being scheduled.

Student Perspectives

A group discussion with students revealed interesting insights. Students felt that this class *was* hard compared to other classes they had taken. Most felt the textbook was difficult and "boring" with small print that was hard to read. Many students traveled from great distances to attend, most were working, and many had children. Nonetheless, they expressed satisfaction with the class. They did not think the material should be taught online because they felt that the interaction between students and with the instructor was vital to their learning process. The instructor kept them engaged and the class discussions and subject matter were "eye-opening".

> *"These classes are very different…English was not comforting like this. Students that are in these courses are very alive; it is not like your regular academic course. Get in there and get it done because it won't be that difficult. You will feel like this is where you are supposed to be."*
>
> *-CCC PSR Student-*

While one student thought it possible that some students dropped because they found the class "more than they signed on for," others noted that this was the trend in all of their courses—and nearly all attributed this phenomenon to economic circumstances and the difficulty of obtaining financial aid. Students in general expressed admiration for their instructor and pride in their ability to get through what they viewed as a challenging but very stimulating course of study. They also indicated that all the faculty were very willing to help, noting: "You don't' have to be perfect—probably because there are so many people with lived experience—they will find you help," and "If someone is going through life struggles there is always a lot of support from peers and instructors."

Impact of the Collaborative

> *"With the psych class we took, we got into various mental illness issues, but not how it is dealt with. This goes over not just how they are hospitalized, but how they recover. This was a huge awakening for me… I would have thought I had a good working knowledge, but now I know that I did not!*
>
> *-CCC PSR Student-*

The Collaborative currently provides approximately $9,000 per class, or about $18,000 per school year to cover the cost of the instructor for the two PSR courses. Because of the current recession and state budget crisis in California, this funding is vital to the survival of this programming. As school administrators noted, since 2008, the college has been losing faculty through attrition and cutting programs. The fact that this program has grown in this era is unusual and entirely attributable to grant funding.

Community College programs like this one are an important link in the public mental health workforce pipeline. They allow non-licensed professionals working in the field to acquire further education and certification to work in county, church-based, and non-profit mental health programs. Community college students are more likely to be

reflective of the cultural and ethnic diversity of California, and more similar to the consumers served by public mental health organizations. The implementation of the Affordable Care Act and the push to integrate behavioral health and primary care is projected to increase the demand for mental health workers who are already in short supply. Unlicensed and peer staff can help meet this demand, although the recession has hurt county budgets and dampened hiring.

California State University, Monterey Bay, Master's in Social Work Program

California State University, Monterey Bay (CSUMB), opened in 1995, is one of the newest CSU campuses. The college was developed on a former military base in Seaside, CA and is co-located with a Veteran's Administration hospital that was a part of that base. In response to community need and years of advocacy by both the County of Monterey Behavioral Health and CSUMB, the university instituted a Master's in Social Work (MSW) program in March 2010.

Role of the Collaborative

Implementation: From 2009-2012, funding from the Greater Bay Area Mental Health and Education Workforce Collaborative allowed the College to pay for faculty to teach core courses integral to this program. Starting in 2012, funding shifted from direct operational support to student scholarships.

Methods

In order to prepare this profile, we conducted a site visit in October 2012. This visit included:

- key informant interviews with 4 program faculty/administrators and 3 county staff associated with the program;
- a group interview with 12 students; and
- a review of available program documents and data.

Definition

Social workers may work in private practice, or in public practice in settings such as schools, state and local agencies, community-based organizations, and hospitals.[10] A social worker helps individuals solve and cope with life problems. A licensed clinical social worker is qualified to diagnose and treat mental, behavioral, and emotional issues. Work as a clinical social worker requires a master's degree and licensure.

The Master's in Social Work, or MSW, qualifies an individual to practice as a social worker. In California, in order to become an LCSW (licensed clinical social worker), an individual must have graduated from an accredited program and have completed 104 hours of supervision and 3,200 hours of

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[10] Bureau of Labor Statistics, Occupational Outlook Handbook, Social Workers, accessed 12/13/2012. http://www.bls.gov/ooh/Community-and-Social-Service/Social-workers.htm#tab-1

supervised work experience. Once a candidate has completed the required education and work experience, he or she can apply to take the LCSW Standard Written Examination.[11] While an individual is completing his or her supervised work experience, he or she is an associate clinical social worker (ASW).

History

The CSUMB MSW program was specifically developed as a "grow-your-own" program intended to meet the mental health workforce needs of the southern bay region counties (Monterey, San Benito, and Santa Cruz). Parts of Monterey county, particularly southern parts of the Salinas Valley, are classified as mental health provider shortage areas, or mental health HPSAs. There is a particular need for bicultural Spanish-speaking mental health practitioners reflective of the underserved population in the county. While coastal areas of Monterey County are scenic and attract both tourists and wealthy residents, inland agricultural areas are home to many low-income individuals. Some of these individuals are agricultural workers and many of them are Spanish-speaking.

> *There are a lot of Spanish speaking people here, but hardly any Spanish-speaking interns or staff. You can see the expression on the faces of the clients when there is someone who speaks their language and understands their culture.*
>
> *-MSW Student-*

Prior to the institution of this program, the nearest MSW program was at San Jose State University (SJSU), a 60-mile drive from Salinas, and 107 miles from King City in South County. SJSU ran a satellite MSW program in the Monterey Bay area, but when that program closed, there was no nearby program for local residents. The new MSW program was the result of a great deal of planning and advocacy from the CSUMB, Monterey County Behavioral Health, and members of the local community who wanted to see bicultural, bilingual local residents trained in this field. The development of a local MSW program was written into the county's Workforce Education and Training (WET) plan as an action item. The program was instituted after three separate attempts. What made the final attempt successful was the availability of funding from the Mental Health Services Act. The Monterey County Mental Health Director spearheaded this initiative and the county provided $200k in startup funding from the county's MHSA WET allocation. Because of the commute, the county could not send existing employees to San Jose for further education as social workers. As is true in many rural and agricultural areas, once an employee or resident leaves the area for an extended length of time for further education, the probability that he or she will return to work in the local community diminishes. The CSUMB Health and Human Services Dean and various faculty developed a feasibility study for an MSW program, and worked with

[11] California Department of Consumer Affairs, Board of Behavioral Services, LCSW license requirements, accessed 12/13.2012, http://www.bbs.ca.gov/app-reg/lcs_requirement.shtml

the County to get buy-in from the local community and institutions, including social services, schools, probation departments, and prisons and from local community members via open forums. The University hired the founding director to develop the program in 2008. After a long planning process, the program was able to start recruiting students in March of 2010.

Program

While the MSW degree typically requires two years of full-time study, the CSUMB MSW program is unusual in that it is a three-year evening program aimed at working adults. The program is also unusual in that due to the three-year extended schedule, students do not take part in a field placement until their second year in the program.

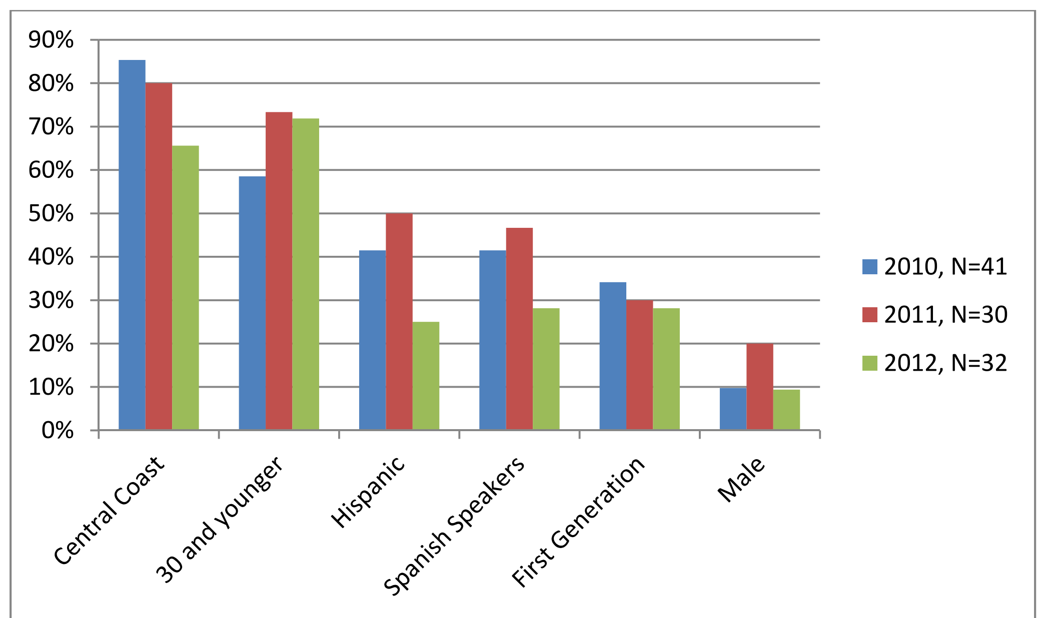
The program currently has six faculty including the director and the field coordinator. The program offers two concentrations: Behavioral Health and Children, and Youth and Family. The program may add concentrations in aging and in veterans' issues in conjunction with the neighboring Veteran's Administration hospital.

During their first year in the program, students take courses in basic social work foundations, research, and policy analysis. They are required to draft an Individual Learning Plan (ILP) and map out how they will achieve a list of Social Work Learning Outcomes. They complete two internships, one in year two, and one in a different setting in year three. Students can complete their first internship in an agency in which they are currently employed, but the second internship must be elsewhere. This allows students that are being sponsored by their agency to continue working and getting paid for fieldwork while enrolled.

Student Enrollment, Completion, and Characteristics

The program started its first cohort in March 2010. The program has been successful in recruiting a high proportion of Hispanic students over the years, meeting or exceeding the 2012 college-wide average of 26%. Compared to the first cohort, the 2012 program has fewer Hispanic and bilingual Spanish speakers, fewer students from the Central Coast, fewer first generation students, and more traditional-age college students. Gender balance has remained virtually the same with the majority of students being female.

Figure 11. CSUMB MSW Program Student Characteristics 2010-2012



Source: MSW Students: Building Diversity. CSU Monterey Bay College of Professional Studies; Department of Health, Human Services and Public Policy

Student Perspectives

Most students participating in a group interview indicated that they were from the local area and would not have been able to attend this program were it not located on the Central Coast. Even so, some traveled extensive distances within the county to attend classes. Students liked the 6-8 pm time slot for the courses and expressed concern that it might be changed in the future to an earlier or later time, both of which would be less convenient for full time working adults. One student noted that the late slot would be hard because the distances many students were driving after work meant they would be getting home very late on a work night, stating, "*and if you think of it, it's mostly women on these winding dark roads...I could not do it if I got home at 11 pm and then had to get up at 5 am the next morning to get to my internship.*"

> *"I looked at the social work program in San Jose and just decided the commute would be too much. I have three small children at home."*
>
> *-MSW Student-*

Students clearly understood the goals of the program in terms of the "grow-your-own" philosophy and imperative to serve the underserved in local communities. They expressed a great deal of commitment to the program and its goals, but noted that the program needed some fine-tuning. There was some sequencing and content of first-year courses that frustrated students. For instance, some felt that the content in some classes was thin or irrelevant and did not prepare them for future coursework. Others felt that assignments were sometimes unclear. Students also felt that some clinical

coursework offered online should have been offered in-class. Other courses, such as Conflict Resolution, and Leadership, should perhaps have been online. However, one student noted that these were just "growing pains". Overall the students were very satisfied with the program, content, and faculty.

Students indicated that they felt that their concerns were heard by program administrators and faculty and seemed confident that these concerns would be addressed. One of the benefits of this program is that instructors "make themselves available" and because the program is so small, there is an intimacy to it that is "very beneficial". One student commented, "They really work with us to make it better for us."

Faculty/Administrator Perspectives

> *"There is a huge need out there for social workers that know the community and the needs of the community...it makes a big difference."*
>
> *-MSW Student-*

Faculty noted that they were making changes to the program due to student comments. One faculty member noted, "We have received feedback from the students it is time to change. Some elements work, some don't work, some work well…It has been 3 years, so it is probably time to change a little, we have had student representatives on the curriculum committee." One change is that the fieldwork coordinator has started organizing a bus tour of local agencies to give first-year students the opportunity to visit agencies offering internships. This helps students become more engaged and helps them make informed decisions about field placement since the program is entirely didactic during the first year.

Faculty noted that they were pleased with the students they have recruited; however, like administrators in the Contra Costa College PSR program, faculty found that recruiting from local, underrepresented communities also brought challenges. On one hand, many of these students were bilingual and understood the needs of the community. However, some students were underprepared academically and it was often difficult to get students to participate in program activities outside of regularly scheduled classes due to their complex work and family responsibilities, as well as the distances many had to drive to campus.

The program is facing some potential changes due to university-wide budget concerns. There is concern on the part of the administration that the program may not remain viable as a part-time evening program; that it may have reached a saturation point in terms of demand for a program for local working adults. The administration is concerned that students may not continue to choose this program because it is part time and takes three years. Program faculty and administrators may be required to revise the program into a traditional 2-year program or a hybrid program and change the overall structure of the program by the middle of 2014. This is difficult because the program is going through accreditation (Fall 2012) as it is currently structured. Program staff feels that accreditation alone may attract more students in future years.

It is vital that the program become accredited so that its graduates can apply for licensure as clinical social workers. However, accreditation may change the program and the nature of its students in key ways. The lack of accreditation may have discouraged potential students from applying to the program. This has probably given local students working in the field an advantage since they are already employed and willing to stay in the area. Once the program is accredited, it may become more competitive as students from outside the area start to apply, as this has been the experience of other MSW programs upon accreditation. How this will impact the program's "grow-your-own" mandate is yet to be seen.

Impact of the Collaborative

The Greater Bay Area Mental Health and Education Workforce Collaborative was instrumental in assisting with start-up costs, allowing the program to hire its first faculty, and paying for a feasibility study. The Collaborative provided sustained funding that allowed the program to continue, and continues to provide CalSWEC student scholarships. The Collaborative worked with the program's scholarship committee to develop scholarship criteria and produce a recruitment flyer. The CALSWEC scholarship is paid through County Mental Health and provides about $5k per student in the behavioral health track.

The CSUMB MSW Program Director, the County Mental Health Director, and the County WET Coordinator regularly attend southern bay region meetings of the Collaborative and work closely with the Collaborative's Program Director to coordinate and sustain the program.

High School Mental Health Pathways Programs

The Collaborative has been involved in fostering a number of programs intended to interest high school students in working in public mental health. These programs serve at least three purposes: 1) to provide information and training that allows students to make an informed choice about further education and a career in the field of mental and behavioral health, and 2) to reduce stigma against persons with mental illnesses and substance abuse issues. 3) to provide a resource to students who may be facing mental health issues in their own lives.

Role of the Collaborative

Technical assistance and convening: the Collaborative has provided technical assistance for several counties and continues to convene workshops and webinars that bring together interested parties to learn from consultants and from each other. The Collaborative has disseminated materials on best practices in implementing these programs.

Methods

For the profiles of the high school pathways programs, we used the following methodology:

a. Key informant interviews with 3 administrators/consultants
b. Review of available program documents and data
c. Information from a 2012 workshop on this topic sponsored by the Collaborative

Definition

A high school career pathway is a sequence of courses from introductory to advanced instruction that allows students to explore a cluster of related career possibilities. Pathways programs encourage students to apply what they are learning in academic courses to a particular area of career interest, linking academic learning with real-world applications. Traditional academic courses like English, Math, and Science are embedded in these courses so that students meet graduation requirements, but learn these disciplines in the context of a career area of interest. The goal of mental health career pathways programs is to build enthusiasm and core competencies in behavioral and mental health.

History and Background

One of the earliest and most well developed high school mental health pathway programs in the Bay Area was developed in 2001 by the principal of the Life Academy of Health and Bioscience in Oakland. The Life Academy is a small public high school with a unique approach to education. This program was intended to interest underrepresented minority students in the health professions. The program was developed in conjunction with the Oakland Children's hospital and incorporated a mental and behavioral health strand into what had been a biosciences pathway. Students participated in a two-year sequence that included a year of psychology-related courses and internships in child development at local elementary schools. During their second year, students took human services classes through concurrent enrollment at Merritt College, a local community college, and participated in broader-based internships.

Although no longer with the school district, this key leader of the high school pathways program in mental health continues to work as a consultant with the Collaborative, leading annual workshops and a number of webinars on high school pathways development and providing coaching and technical assistance to Bay Area County Mental Health Departments implementing these programs in collaboration with local school districts. Three counties, Alameda, San Mateo, and Monterey, work with the consultant on a regular basis for technical assistance on their high school programs. Other counties have been involved at various levels. The consultant has led two workshops and at least two webinars for the Collaborative on this topic in 2011/2012. At these events, WET coordinators and other county staff and high school staff have the opportunity to learn from the presenter and to network and learn from one another.

Overview of Programs

Six of the twelve Bay Area counties and one city currently sponsor a more or less defined high school program focused on mental health career pathways. These include:

- Alameda County
- **Contra Costa County (profiled in this report)**
- Monterey County
- **San Mateo County (profiled in this report)**
- Santa Clara County
- Santa Cruz County

Alameda is planning to pilot a county-wide school behavioral health pathway based on the Life Academy curriculum.

Santa Clara is working intensively with one high school using an adapted version of the Life Academy curriculum. In 2011, the county held a successful career summer institute for high students exploring the field of public mental health.

Santa Cruz is developing a partnership between local high schools and the community college to start a health academy and to make presentations about mental health careers and stigma at high schools.

Monterey is working with the Collaborative's consultant to develop programming to insert into existing high school health academies. Monterey County is unusual in that the County sponsors public mental health internships for high school students as well as for MSW students.

San Mateo County

San Mateo County Behavioral Health & Recovery Services (BHRS) has a very developed high school pathways program. Participation was initiated by the San Mateo County Mental Health Department via a request-for-proposal process. This process resulted in two very different high schools offering unique programs in partnership with community-based organizations (CBOs).

The high school component was an agenda item in the county's WET plan. County mental health leadership and key stakeholders were very supportive of this idea, especially because it addressed the need of developing a diverse workforce and engaging high school students.

These programs were funded through Workforce Education and Training (WET) funds at the cost of approximately $25k per school in 2011/2012, and $50K in 2010/2011. While it was originally anticipated that the high schools would apply, applications were actually initiated by the CBOs, possibly because they have better infrastructure for constructing and submitting grant proposals.

Program

In 2010/2011, **Daly City Youth Health Center (DCYHC)** partnered with **Terra Nova High School** in Pacifica to add three to four hours of material per month to existing curricula in sociology, psychology and peer-helping. The goal of this program is to reduce stigma and increase interest in behavioral health careers.

A total of 133 high school juniors and seniors in four classes participated in this programming. The curriculum was divided into monthly modules integrated into the classes based on a rotating schedule. Modules include guest speakers, career exploration, and field trips to human services agencies and organizations such as South County Mental Health in Redwood City, and Drug Court at the South San Francisco Courthouse. Students attended sessions with guest speakers from groups such as the National Alliance for the Mentally Ill (NAMI), El Centro de Libertad, Rape Trauma Services, and the Daly City Peninsula Partnership.

A similar program was implemented at **Westmoor High School** in Daly City during the in 2011/2012 year. Approximately 120 students, primarily juniors and seniors, participated in this program, which was offered in conjunction with DCYHC.

The County also funded another effort in a different part of the county. **One East Palo Alto** (a CBO) assisted in creating a behavioral health care career pathways course at **East Palo Alto Academy High School** during school year 2010/2011. The high school had an existing health-focused career curriculum. The new course, "Behavioral Health Career Pathways" was an elective within the existing program which included two other health care professions courses. This course was intended to help students develop career awareness through exploration of careers, community service, and education on topics in behavioral health care. Students were expected to complete community projects, attend field trips, and complete a career assessment. Initially, all grades were welcome to participate, but the program eventually shifted to more of a focus on juniors and seniors. About 25 students took part in the formal classroom segment, but over 200 made contact through a career fair sponsored by the program.

Outcomes

The East Palo Alto program was very ambitious, but it was more difficult to sustain than the Daly City and Pacifica programs because of the amount of energy required to develop and maintain an entirely new class. However, both programs were successful, reportedly because of the interactive elements, including field trips and guest speakers. Pre- and post-assessment surveys suggested that the courses did indeed help students understand career paths available to them, better understand mental illness, and reduced stigma, particularly stigma around mental health and illness issues.

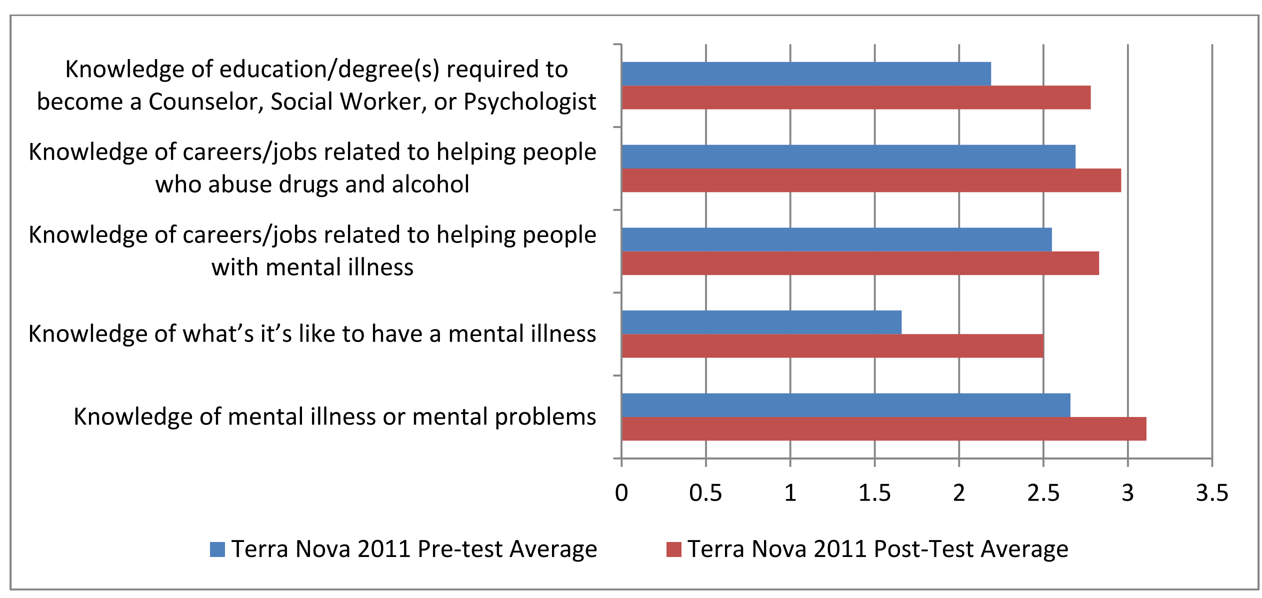
Students appeared to gain knowledge about mental illness and alcohol and other drug use (AOD), and indicated greater understanding of the types of mental health careers available and the education necessary to obtain these careers. Those in the Pacifica program did not necessarily exhibit greater interest in working in mental health or AOD fields, although evaluators noted that the students were still in high school and had some time to make career decisions. Students in the East Palo Alto program were much more likely to agree during the post-test that they could imagine themselves working with persons with mental illness (from 47% in the pretest to 100% in the posttest).

Stigma did not decrease in a significant way except in that students were less likely to agree that "It is easy to recognize someone who has a mental illness".

The WET coordinator brought some of the students to speak at one of the county's monthly leadership meetings for county mental health managers and contracted providers. This was reportedly very successful and inspiring to staff, who were impressed by the students' presentations.

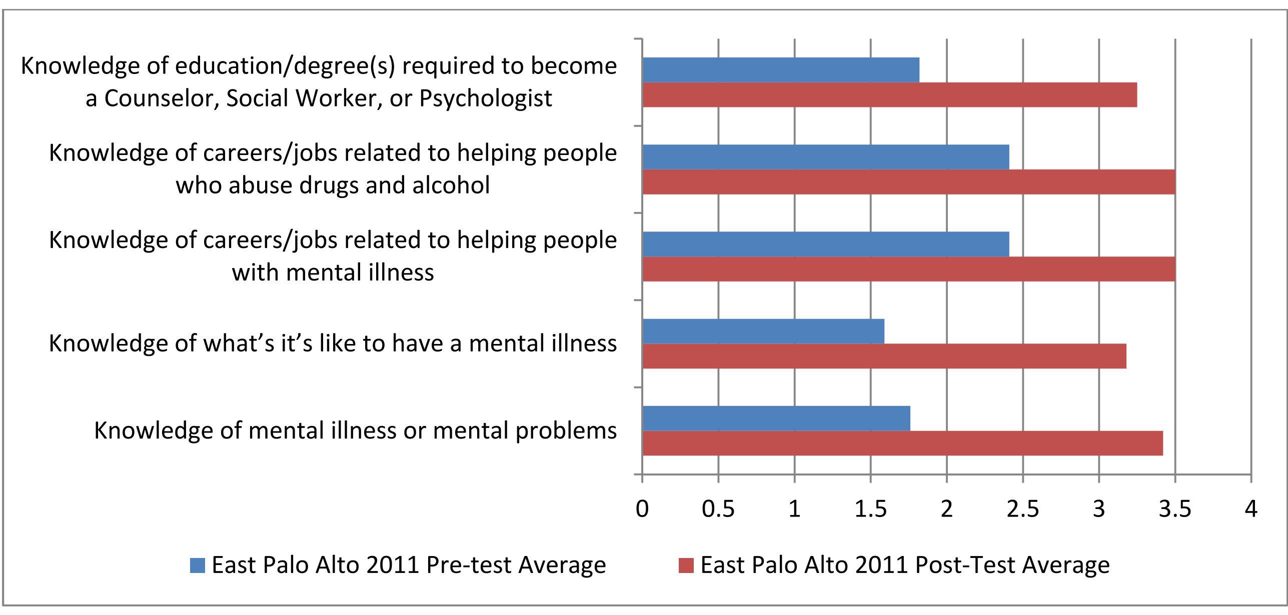
The following charts highlight some of the outcomes of the assessments during program year 2010/2011.

Figure 12. Terra Nova High School Pre/Post Test Results



("How much you know" 1= None, 2= A little, 3= Somewhat, 4= A lot)
Pre-test N=123; Post-test N=119)

Figure 13. East Palo Alto Academy High School Pre/Post Test Results



("How much you know" 1= None, 2= A little, 3= Somewhat, 4= A lot)
Pre-test N=17; Post-test N=12

Contra Costa County

Contra Costa County has developed a mental health concentration in high school academies as a strategy to develop a career ladder into the public mental health system. The county is using the Mental Health & High School Curriculum Guide from the Canadian Mental Health Association (CMHA), as the framework in for this course. The overall goal of this program has been "to engage and prepare economically and educationally disadvantaged students for careers in the public mental health system."[12]

The development of a high school collaborative for a mental health pathway in the Contra Costa career academies was part of the county's WET plan. In order to implement the curriculum in the high schools, they hired a retired psychologist who had worked in children's mental health to pilot the program at New Leaf, a continuation high school in Martinez. The pilot was conducted in the 2010-2011 school year.

Program

Students in the program at New Leaf generally came from difficult backgrounds, and for many, the subject matter was very compelling because it addressed issues they had experienced in their own lives or with family members. The program was designed for career development, but the New Leaf program included funding for supportive services for students. This ten-week course entails 6 modules of 12-14 hours each. The program was extremely popular with students. Approximately 25 students participated in the program in the first year, although they were also told they could bring anyone else who was interested, so the programming may have affected many more students than the core cohort.

Table 3. Contra Costa HS Pathways Student Demographics, 2012

Male	59%
Female	41%
Total	100%
Multi-racial	34%
Hispanic/Latino	23%
White	17%
Asian	11%
African American	10%
Native Hawaiian/ PI	2%
AI/AN	1%
Other/refused	2%
Total	100%

After its success at this first school, the program was implemented with a very different population at Dozier-Libbey Medical High School in Antioch (fall 2011) and at Pinole Valley High School in Brentwood (spring 2012; two class sessions). The program was also implemented again at the New Leaf Academy in winter of 2011.

[12] Contra Costa County Mental Health Services Research and Evaluation Unit. July 2012. *Developing a Mental Health Curriculum in High School Health Academies-Summary Report*. Pg. 3

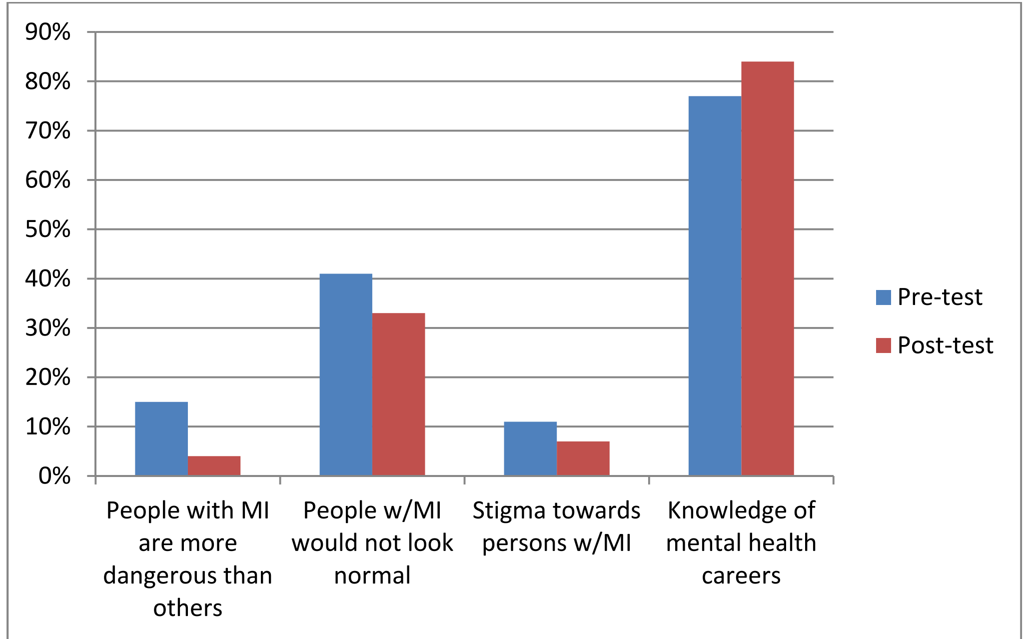
Outcomes

In the second year, the program reached approximately 102 students, although at Dozier-Libby and Pinole Valley, participation was limited to the formally enrolled students.

While the program was paid for out of WET funds, the county also received a small grant from the Office of Statewide Health Planning and Development (OSHPD) in order to expand it. The program conducted a fairly rigorous evaluation with pre and post surveys based on tools such as the **California Healthy Kids Survey**, the **Ohio Mental Health Consumer Outcomes System** instruments, and the point scale found in the **Youth Outcomes Questionnaire Self-Report** developed by Lambert & Burlingame. The surveys assess participant changes in the following domains—all goals of the program:

- Increased knowledge of mental health and mental illness
- Stigma reduction as it relates to mental illness
- Increased interest in mental health careers, preparation and readiness, system navigation, and knowledge of existing resources

Figure 14. Selected pre/post test results



Source: Contra Costa County Mental Health Services: Research and Evaluation Unit. July 2012. *Developing a Mental Health Curriculum in High School Health Academies – Summary Report.*

The program was overall successful, despite some challenges, including disparate multi-media resources across school sites. The project team found that the newer pool of students had a higher base level of knowledge about mental health than originally anticipated, possible because they were enrolled in health academies (see Figure 14). This made it a little more difficult to document an extensive increase in knowledge about general mental health issues. The county would like to spread implementation to

more high schools and offer summer internships and a summer institute modeled on Santa Clara's efforts.

Impact of the Collaborative

Both Contra Costa and San Mateo included high school programming in their WET plans, and both became more inspired to develop these programs through contact with the Collaborative and its consultant. Both continue to work with the consultant on an ongoing basis.

The Collaborative continues to sponsor workshops and webinars on this topic. These events are well attended and participants share ideas and resources for their own programs.

Lessons Learned

Both San Mateo and Contra Costa County programs were successful with decreasing stigma towards persons with mental illness, and in increasing knowledge of mental health careers among high school program participants. Both found that students were often attracted to these programs because they had questions about issues in their own lives and within their own families. Providing support and information on stigma was as important as the career information. Students were particularly inspired by the interactive elements of these programs such as field trips and guest speakers.

Overall, these programs serve as early outreach to high school students by addressing issues important in their lives and then providing information about career paths and preparation. These programs have been implemented in high schools that are "minority majority" and may help to produce the culturally and linguistically competent and concordant workforce the Collaborative hopes to foster.

Consumer and Family Member Employment Programs

The goal of consumer and family member employment has been a major component of the Collaborative's formation and focus. Founding members report it was perhaps the major imperative of early planning efforts. However, several key informants noted that this was one of the more difficult goals to achieve.

Role of the Collaborative

Convening and advocacy: The Collaborative sponsored a conference on consumer and family employment, and incorporated this topic in a number of Collaborative meetings, workshops, and trainings. The counties have taken the lead in developing and implementing these programs. The Collaborative provided a forum for counties and CBOs to share their experience implementing these programs, and disseminated materials on best practices.

Methods

For the profiles of the consumer and family employment programs, we used the following methodology:

a. Key informant interviews with 2 administrators
b. Review of available program documents and data

Definition

Consumer and family member employment is defined specifically as employment in public mental health agencies. Supported employment programs help place consumers in jobs not directly related to public mental health functions. In the former, consumers and family members are often hired because their lived experience is anticipated to make them uniquely qualified to help other consumers and family members recover and develop resiliency. Another anticipated outcome of consumer and family employment is transformation of a historically unresponsive mental health system into one that promotes wellness and recovery through the inclusion of consumer and family voices and perspectives.

Developing a definition of consumer and family member employment has initially hinged around the question of determining exactly who is a consumer and/or relevant family member. Medical privacy laws preclude many employers from asking for or verifying mental health status or history. Employers must decide what it is about lived experience as either a consumer or a family member that uniquely qualifies an individual for a particular position in public mental health.[13] Community-based organizations, which are often contracted by counties to provide mental health services, may be at something of an advantage in this respect in that they are not bound by the same civil service rules that county agencies must follow.

History and Background

One of the central tenets of the MHSA is providing consumers with the tools to lead independent and productive lives, which includes meaningful employment. However, approximately 40-70% percent of adults with a serious mental disorder are unemployed.[14]

A 2000 survey by the California Mental Health Planning Council documented a total of 1,471 consumer and 211 family members employed by 36 county mental health systems in California. The majority was hired by community-based organizations (75%) and a quarter was employed by county mental health departments. The bulk of hiring was concentrated in 8 counties (Contra Costa, San Mateo,

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[13] Working Well Together. 2009. Defining Consumers and Family Members of Mental Health Services: issues to consider in promoting California's consumers and family members as employees.

[14] Mechanic, D., Bilder, S., and McAlpine, D. 2002. "Employing Persons with Serious Mental Illness." *Health Affairs. 2:5. 242-253.*

Santa Clara, Fresno, Sacramento, Los Angeles, Orange County, and Mendocino). The plurality of consumers (37.48%) were employed as unlicensed mental health workers, while 16.2% were employed as administrative technicians, and another 11.2% were employed in janitorial/maintenance positions. Slightly more than half were employed full-time.[15]

All counties were required to include details of consumer and family member employment initiatives in their WET plans. However, this goal became more difficult to achieve as the economic recession, which began roughly in 2008, resulted in budget cuts for most county mental health programs. Since consumers and family members were often among the most recent hires, their jobs were also often among the first to go when the economy worsened.

This section entails a description of two Bay Area county consumer and family member employment programs. These examples highlight the different approaches counties can take in developing successful programs.

Alameda County Behavioral Health Services

Alameda County has a history of consumer and family member activism and advocacy. The county is home to Sally Zinman, one of the founders of the consumers' movement. There are a number of consumer advocacy groups and consumer-run organizations in Alameda County, and over 85% of the county's mental health services are provided by community-based organizations (CBOs).

In the County's Workforce Education Training (WET) Plan, the first listed goal is "Increasing consumer, family member and parent partner employment and retention rates within the Alameda County Behavioral Health Care Services (ACBCHS) workforce." Early in the development of the WET plan (2008-2009), two work groups, the Consumer Employment Work Group and the Family Employment Work Group, were formed to create strategies to facilitate employment and training opportunities. The resulting initiative was called the Peer Employment Toolkit or Consumer and Family Toolkit.

In 2010, (ACBCHS) demonstrated its commitment to this goal by creating a position for a fulltime, benefited Consumer and Family Employment Liaison to help coordinate implementation of this toolkit. The Toolkit is based around the following goals:

1. Prepare the existing workforce to welcome consumers and family members
2. Train consumers and family members for successful recruitment and retention
3. Develop hiring practices and opportunities for consumers and family members
4. Provide ongoing supports for consumers and family member employees to increase job success and retention

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[15] California Mental Health Planning Council. October 2003. Consumer and Family Member Employment in the Public Mental Health System.

In addition to hiring a Consumer and Family Employment Liaison, ACBHCS budgeted to contract out a number of training and education positions to Consumer and Family operated organizations. These positions are paid out of the county's MHSA funds.

ACBHCS is addressing goal 2 by sponsoring the BEST Now program offered through the Alameda County Network of Mental Health Clients. The Network is a consumer-run agency serving mental health consumers. The training program was initially called "Jobs Now" and was started by a number of mental health clients interested in finding jobs through the existing system of care.

The County supports this program through funding and technical support. BEST Now provides peer specialist training, and through its resource center, family advocate training. The program has been in place for more than 12 years and has expanded to include a Spanish-speaking co-facilitator to train Spanish-speaking consumers to work in the mental health system.

Program

The BEST Now program incorporates elements of the best training programs across the country in order to align with certified peer training requirements so that participants will be eligible for certification when it is introduced. The trainings include eight weeks of classroom instruction followed by a six-month internship. There is an initial orientation session, after which attendees are invited to apply for the program. At the end of the didactic sessions, there is a placement fair where agencies interested in having an intern attend, collect resumes, and set up interviews. Trainees receive a stipend for participating. The training takes place twice a year with 25-30 participants.

The County has also held three annual job fairs for consumers. The most recent job fair included 165 participants and 22 organizations. These fairs focus on slightly different content each year. In 2012, the job fair provided a resource room with computers and technical assistance to help participants set up email accounts and access job and service resources online and a vocational program to help with resume writing and interviewing skills. The Department of Rehabilitation provided orientation sessions to help participants learn about services available from the department of rehabilitation, including how to plan for employment by obtaining the necessary training and further education.

ACBHCS has started a training program and support network for supervisors and employers working with consumers and family members. After two years of development, this first training on welcoming and partnering with consumer and family member employees took place on November 1-2, 2012. The county hired Inspired at Work to create a curriculum and facilitate. The audience for this training was 29 supervisors and managers supervising at least one person with lived experience of mental illness. The training covered accommodation, hiring practices, and family issues. Eventually this training will be offered to other staff.

Outcomes

It has been difficult to track outcomes for this program. Civil service and HIPAA regulations preclude asking employees directly if they are consumers, so there are potentially many more consumers in the workforce than those who have openly claimed this identity. The Consumer and Family Liaison called and informally surveyed offices within the ACBHCS and contracted vendors and estimated that they had hired 144 consumer employees and contractors and 30 family designate employees. She noted that while many of their contractors and departments had maybe one or two consumer employees, certain consumer-run agencies like PEERs, the Alameda County Mental Health Network, and CHOICES each had more than 20 consumer employees each.

San Mateo County

San Mateo County Behavioral Health and Recovery Services has developed consumer and family member employment and development programs, including hiring these community workers directly into the county system, providing training for a speakers' bureau on lived experience, and partnering with the non-profit organization Caminar to provide college support services and scholarships for consumers pursuing higher education.

In the early 1990's, the mental health consumer movement in San Mateo County advocated for supportive services at community colleges for persons with mental illnesses. This led to a grant from the California Community College Chancellor's Office to support innovative new programming at the College of San Mateo, and a change in state categorical funding policies to include students with psychological disabilities.[16] This early activism laid the ground work for future collaboration between San Mateo County Community College District, local community-based organizations, and San Mateo County Behavioral Health and Recovery Services (BHRS) around consumer employment and education issues

When additional funding became available for consumer education and employment at the start of the MHSA implementation in 2006, BHRS developed job descriptions and hired about 20 consumers and family partners as fulltime, benefited staff. Some of the contractor organizations working with San Mateo County did the same. Prior to this time, the county had hired some peer counselors and support staff through vocational rehabilitation, but the MHSA mandate and funding increased its investment in consumer and family employment.

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[16] Stringari, T. 2003. Community Partnerships Increase Services and Outcomes for Students with Psychological Disabilities. iJournal: Insight into Student Services. Available at: **http://collegeofsanmateo.edu/ttc/journal_article.asp** Accessed January 2013.

Program

In 2006, San Mateo County contracted with Inspired at Work, the same consultants that worked with Alameda County. The two consultants held community meetings and skill-building workshops to prepare applicants to apply and interview for the new positions, resulting in 87 applications for the new Peer Community Worker positions in San Mateo County BHRS. Youth services received 60 applications for Family Partner community workers, many of them from Spanish-speaking applicants.[17] Reviewers were impressed by the quality of the applicants. Through their lived experience, community workers provide assistance and peer support services to clients and staff. There are two career steps: Community Worker I and II, with a graduated pay scale.

Additional employment services for consumers are offered by a community-based organization called Caminar. Caminar's Jobs Plus program prepares consumers for employment, vocational counseling, assessment, skills building, resume and interview preparation, job coaching, social security benefits counseling, and competitive employment referrals. This supported employment program, which is funded through a grant from the Department of Rehabilitation, helps consumers prepare for all types of jobs.

BHRS also works with Caminar and other community-based organizations (CBOs) in a unique partnership with the College of San Mateo to implement supported education for consumers through the Transition to College Program, which has been operating since spring of 1991. This program provides peer support, specialized classes and study labs, educational accommodations, and counseling and support for students with psychiatric disabilities. Partner agencies provide staff to support students as educational case managers, co-instructors for career classes, consultants to the college staff implementing the program, and as trainers and supervisors for peer counselors. Students in the program are individuals who have severe mental illnesses.

San Mateo BHRS funds a scholarship with MHSA money to provide students $500 per semester to attend college. There are currently 25 students receiving this scholarship, which can be repeated on a semester-by-semester basis. This scholarship program was set up to fund 12-120 students, depending on their level of need.

The San Mateo Workforce Education and Training (WET) Coordinator worked with consumers, family, and others to develop a speakers training academy for consumers to share their stories with employers and others. This eight-hour program trains participants to tell a focused story about their lived experience as a consumer. This effort resulted in a Lived Experience Speakers Bureau that grew from 10

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[17] Coppola, C. and Torres, D. Hiring Community Workers—Peers and Family Partners. Heads Up. (A newsletter for San Mateo BHRS). July 2006.

to as many as 30 people by 2012. Most recently it graduated a group of transitional-age youth speakers. Speakers from this group presented at BHRS leadership meetings and in conjunction with San Mateo County's High School Mental Health Pathways Project.

San Mateo County also co-sponsored the October 2010 one-day conference--"Can We Talk?"—in collaboration with the Collaborative.

Outcomes

BHRS staff reported that hiring overall was down due to the recession. Nonetheless, BHRS efforts have resulted in greater hiring of consumers and family members. BHRS has created 20 county positions, of which 8-9 are family partners. Employees hired through this initiative have an 85% retention rate. Contracted vendors also hire consumers and family members. There is now staff with lived experience at each of the county's regional centers.[18]

The partnership between BHRS, College of San Mateo, Caminar, and other community partners in providing Transition to College programming has been very successful. Traditionally, the attrition rate for students with psychological disabilities was very high—90-95%. The attrition rate for students in the Transition to College program has been only 17-20%. Students complete 90% of the courses in which they enroll, and certificate, degree, and transfer rates among program participants are identical to the general college population. Approximately 51% of students are employed after graduation—69% of them in the mental health field.[19] Thus far the Transition to College program has served more than 1,000 individuals over a period of ten years. Approximately 100 students are presently active in the program each semester.[20]

Impact of the Collaborative

The Collaborative encourages consumer and family member participation in Collaborative meetings, and maintains linkages with consumer groups. A number of Collaborative meetings have focused on best practices in consumer and family employment. Consumers and family members have made up about 3% of attendees over recent years, although the number fluctuates by meeting topic.

In 2009 two Collaborative meetings were dedicated to this topic. In addition, the Collaborative sponsored a one-day conference--"Can We Talk?"— in collaboration with San Mateo County BHRS in

[18] Gale, L. Consumers and Family Members: A journey towards inclusion. Wellness Matters: An E-journal of San Mateo County's Behavioral Health and Recovery Services. March 2012.

[1919] Robinson, C. and Shocket, M. Caminar's Blended Model – Jobs + Education. Wellness Matters: An E-journal of San Mateo County's Behavioral Health and Recovery Services. March 2012.

[20] Stringari, T. 2003. Community Partnerships Increase Services and Outcomes for Students with Psychological Disabilities. iJournal: Insight into Student Services. Available at: **http://collegeofsanmateo.edu/ttc/journal_article.asp** Accessed January 2013.

October 2010. The goal of the conference, which was targeted to county mental health systems and partner organizations, was to assess progress and address barriers to successful consumer and family member employment. The conference had over 170 attendees. The Collaborative's website also has a "Consumer and Family Member Employment Resources" section on its Workforce Development page.

Coordinators from both counties noted that the opportunity to share with and learn from other counties in Collaborative meetings, workshops, and conferences was particularly helpful in developing programming. The Collaborative's program manager was helpful in working with the counties and in keeping the consumer and family employment issue on the agenda with different stakeholder groups.

> *"When the economy crashed, that was huge. There was a shortage of resources. New hires were laid off and a lot of the Collaborative's work was undone. There has been a lot of denigration of public employment in general. It is a hard sell to get people into public employment."*

Lessons Learned

Both counties worked closely with existing staff to decrease stigma against their consumer co-workers. Some employees worried about how to maintain boundaries with consumers who became co-workers; and consumers worried about what it would be like to work as peers with therapists and doctors. San Mateo County decided not to hire consumers into the clinic where they had received services. The county also had to prepare consumers in assertiveness so that they could work with doctors and therapists as peers.

Program coordinators made sure that consumer and family staff members were being valued and utilized for their lived experience, and were not just being shunted into lower-end jobs. An important lesson learned from this initiative is that employers of consumers need to build in flexibility to accommodate the needs of workers with lived experience, keeping in mind that some people may need more time off, or that there might need to be different job expectations. Capitalizing on existing skills and lived experience requires thoughtful preparation.

It was noted that early advocates of consumer employment, in their zeal to address the injustices of the past, sometimes neglected to prepare both consumers and employers for some of the challenges they might face, resulting in unsuccessful experiences. Both programs highlighted here tried to lay the groundwork for successful employment by providing consumers and family members with the skills and preparation they need to succeed, and by providing employers with the information and support they need to create a successful employment experience.

Finally, contracted CBOs provide a significant opportunity for consumer and family employment in both counties because they often provide the bulk of services, and because they are not bound by civil service rules. Civil service rules are based on the merit system, in which the fitness of a candidate for employment is judged by his or her score on a written examination judged by a panel in an anonymous process. The goal of this system is to avoid favoritism, bias, and nepotism in government employment.

In the merit system, qualifications such as identity and lived experience are specifically excluded from consideration.

PERSPECTIVES OF COLLABORATIVE PARTICIPANTS

The following section summarizes key informant interviews and a survey of Collaborative stakeholders and participants. The researchers solicited stakeholder feedback on the challenges, successes, and impact of the collaborative.

Interviews

The following section is based on key informant interviews with eight stakeholders interviewed by phone over the course of this study. Interviewees were asked about the history of the Collaborative, developmental milestones, key challenges and successes, and recommendations for future collaborative work. Information on history and key milestones of the Collaborative are incorporated earlier in this report.

> *"Those people came together in the Collaborative, and there was all this networking; that used to be the energy. But then it kind of got taken over by managing the MHSA, and people got burned out."*

Challenges

The Collaborative has overcome many challenges. It was a pioneer in coalescing regional planning for the mental health workforce—the model on which all other regional partnerships in the state were based. Hence it started from scratch with no template.

Interviewees stated that early on, it was difficult to get busy county mental health departments, often working in crisis mode, to invest in long-term workforce planning. The Collaborative had to overcome stigma against consumers and family members, and a system that did not value workforce diversity. The passage of the MHSA provided both opportunity and challenge for the Collaborative. The MHSA brought in vital funding, new legitimacy, and engaged new set of stakeholders, but also changed the dynamics of the group as constituents vied for funding. In promoting the MHSA recovery model of care and consumer/family employment, the Collaborative encountered provider resistance. Some interviewees felt that the MHSA funding and CiMH sponsorship directed the Collaborative more towards civil service employment and decreased its attention to community-based organizations that provide the bulk of consumer and family member employment.

Interviewees stated that changes in leadership over time have been somewhat challenging for the Collaborative, but the constantly changing nature of its constituency has been more so. Individuals come and go as interest, energy, and opportunity ebb and flow. Participants find it hard to get the time off work to come to meetings and contribute in addition to their regular work, and the recession has resulted in layoffs that have created more work for remaining employees. The Collaborative has developed an

extensive orientation and slideshow that is presented to new attendees prior to the start of every meeting to get newcomers up to speed. It also moved to a bi-monthly meeting schedule to accommodate members' busy schedules.

Interviewees stressed that the economic recession has undone some of the gains of the early years as counties froze employment and discontinued or cut back on consumer and family employment programs and other training initiatives.

> *"It was so resisted by professionals. The level of discrimination was and still is appalling. There is not a lot of political or financial support for consumer and family employment. The Collaborative said "no"—this is our future—this is here to stay, it is not just the flavor of the month."*

Successes

Interviewees noted the many successes of the Collaborative, despite challenges along the way and the differing perspectives of advocates.

One of the most successful aspects of the Collaborative is its ability to create a neutral place for educators and the public mental health workforce to learn from one another in order to better coordinate the education pipeline. As one interviewee noted, "These two cultures were just not talking to each other. It was good for employers to know what it takes to get a course going at a community college or CSU; and it was good for educators to know that what is being taught in schools is not always what is needed in the real world. We needed to learn about each other's needs and build respect."

The opportunity for employers and educators to network among themselves as well as across disciplines was also noted as extremely positive. This took place in both Collaborative meetings and in various workshops and conferences organized by the Collaborative. For instance, one interviewee noted that bringing human resources departments together to think about civil service rules and how they helped or hindered public mental health employment was invaluable. As one interviewee noted, the Collaborative can do this because it is a neutral party and not inside of any governmental agency.

> *"In 2000 most educators, (if you mentioned the MHSA recovery model) their eyes just glazed over—now if you don't do it, you are ostracized—"how could you not provide this hopeful aspect?" It has made a tremendous impact. The last holdout is psychiatrists, and even they are getting it. Graduating social workers really get it. "*

The Collaborative has also been extremely successful at promoting the MHSA recovery model among educators and those working in the field, despite early resistance. The MFT curriculum project was cited as a major victory along these lines. It has provided coordination and support for consumer employment.

A number of interviewees lauded the success of the Collaborative in helping with the development of the CSUMB MSW program. As one noted, developing a new social work program is a major achievement, as is facilitating work between a county mental health department, local community, and a California State University.

The high school mental health pathways also received much praise from interviewees as being successful in building the educational pipeline and introducing the idea of mental health careers early to students, as well as safely introducing information about mental health, illness, and stigma to high school students.

One interviewee felt that community colleges were the weakest link in the pipeline, noting that there were few exemplary community college programs focusing on public mental health. However, several noted that the Collaborative had made strides in fostering Contra Costa College Psychosocial Rehabilitation program and in reaching out and organizing with community colleges to promote public mental health workforce development. Through its support of programs like these, the Collaborative has made the role of non-licensed staff, particularly peer workers, more visible and more legitimate

The Collaborative's role as founder of the regional partnership model has received national recognition and inspired legislation and replication. This is all the more remarkable in that it is largely a volunteer effort with one paid full-time staff member. CiMH provides administrative support and consultants handle some aspects of programming.

Survey of Collaborative Participants

An online, email-based survey was conducted with recent attendees of Collaborative meetings (approximately 168 people) and Bay Area Mental Health Directors (13) about the overall impact of the Collaborative. Those emailed did not include those who attended trainings or events outside of the bi-monthly meetings. There were a total of 30 respondents to these online surveys (25 meeting participants and 5 mental health directors). Due to the relatively low response rate (17%), care must be used in interpreting results, which are unlikely to be representative of the entire group.

Respondents (both Collaborative meeting attendees and mental health directors) were asked to identify Collaborative resources they had used, and how useful those resources were to their work. These resources are listed below in order of mean usefulness ratings from highest to lowest. Ratings were on a scale of 1 to 5, with 1 being "not useful" and 5 being "very useful".

The item rated most useful was support for developing and maintaining internships, while the least useful resources were the newsletter and website. These latter items were rated around the middle of the scale.

Table 4. Usefulness of Collaborative resources

Resource	Mean	N
Internship Support	4.58	12
Early Psychosis & Intervention	4.43	7
CBMCS Training	4.33	6
Can We Talk	4.14	7
Steering Committee	4.00	11
Community College Convening	4.00	6
HS Pathways Workshops	4.00	8
Technical Assistance	4.00	16
Human Resources Convening	3.86	7
Website	3.55	20
Newsletter	3.20	10

Respondents were asked an open-ended question about what additional resources they might need from the Collaborative. The following are some representative quotes.

- *More tangible resources, tools, and trainings that can be shared by educators, counties, and employers. Develop a framework for a career pathway within mental health.*
- *Affordable Care Act: how insurance exchanges and other new product lines will impact county Mental Health and the behavioral health workforce.*
- *More information and training regarding community-defined evidence and practice based evidence.*
- *Guidelines for creating new field placements or field training for both graduate students in mental health programs and for interns. How can employers and educators work together to create new field training opportunities?*
- *Need more time in order to attend more meetings. Would like to make better use of the website and doing this has inspired me to look into that in more depth.*
- *Strategies to increase the diversity of our public mental health workforce and retain desirable staff. Emphasize community-defined practices and move away from only the traditional evidence-based practices that are tailored to serve the mainstream population. More training on approaches to work with the ethnically and regionally diverse client populations.*
- *The Collaborative has supported the training needs of counties. Would like additional collaboration to provide trainings that support Practice Informed Treatments with a strong cultural competence framework. In order to continually improve the public mental health system service delivery and outcomes, we need practices that meet the clients' multicultural needs.*

Meeting attendees were also asked to rate the success of the Collaborative meetings in providing a number of resources and activities. These Collaborative resources are listed in Table 4 in order of mean rating from highest to lowest. Both mental health directors and meeting attendees were asked to rate how successful the Collaborative

was at promoting use of its resources. The three most highly rated items related to providing a forum for educators and employers to share within and across disciplines.

Table 5. Ratings of Collaborative's Convening and Dissemination Activities

Collaborative functions	*Mean*
Providing a forum for public mental health employers to learn from one another.	*4.18*
Providing a forum for educators to learn from one another.	*4.05*
Providing a forum for mental health educators and employers to learn from one another.	*4.04*
Providing a forum for educators at different stages in the educational pipeline to coordinate mental health workforce activities together.	*3.91*
Providing an opportunity for educators and employers to coordinate activities together.	*3.88*
Providing practical tools for educators to develop the mental health workforce	*3.77*
Providing practical tools for employers to develop the mental health workforce	*3.73*
Promoting use of its resources (website, toolkits, and curriculum)	*3.58*

Ratings were on a scale of 1 to 5, with 1 being "not at all effective" and 5 being "extremely effective".

Respondents were asked to rate the Collaborative's impact in reaching a number of objectives, most of which are a component of the Collaborative's work plan. Respondent's rated promotion of the MHSA recovery model the highest, along with integrating or coordinating workforce development efforts with other components of the MHSA. The highest rated impact in terms of the Collaborative's impact was fostering partnerships between employers and educators. The lowest ratings of Collaborative impact were increasing in civil service operational support of public mental health employment; increasing public interest in, and increasing public awareness of, mental health careers; and increasing the number of family members hired.

Table 6. Impact of the Collaborative

Goals	Impact	N
Fostering educational partnerships between educators and public employers to strengthen the mental health workforce pipeline	4.21	28
Integrating or coordinating workforce development efforts with other components of MHSA, (e.g., WET and PEI, Innovation or CSS**?**)	4.20	25
Promoting/disseminating the MHSA recovery model among mental health educators and academic institutions	4.07	28
Promoting/disseminating the MHSA recovery model among public mental health personnel (including non-profits/CBOs)	4.04	28
Improving the quality and accessibility of staff and intern training for Bay Area County MH personnel & CBO personnel	3.79	24
Promoting a diverse public mental health workforce reflective of populations served	3.78	27
Promoting a culturally competent public mental health workforce	3.78	27
Promoting a public mental health workforce prepared to serve unserved and underserved consumers and their families	3.75	24
Providing support for consumer and family member employment	3.63	24
Reducing public stigma about mental health careers	3.52	23
Increasing the number of consumers and/or family members offered opportunities for career pathway development throughout the public mental health system	3.52	21
Promoting a linguistically competent public mental health workforce	3.48	25
Increasing the number of consumers members hired in the public mental health system	3.48	21
Increasing public awareness of public mental health careers	3.42	24
Providing coordination for consumer and family member employment	3.41	22
Increasing the number of family members hired in the public mental health system	3.32	19
Increasing public interest in pursuing public mental health careers	3.30	23
Increasing County Human Resources (Civil Service) operational support of public mental health employment needs	3.29	21
Ratings were on a scale of 1 to 5, with 1 being "no impact" and 5 being "greatest impact".		

SUMMARY AND POLICY RECOMMENDATIONS

The Collaborative is to be commended for having achieved great success in addressing the main objectives identified on its website, in its goal statements, and in work plans over the years. We summarize those achievements in the following section by objective and make recommendations for future Collaborative efforts and self-monitoring of the outcomes related to those efforts.

I. Develop regional training resources that integrate MHSA philosophy and values: promoting education, training and re-training of the mental health workforce to increase the practice of culturally competent, recovery oriented services.

Our review of Collaborative activities over the past several years suggests that the Collaborative has clearly integrated the MHSA philosophy and values into its many initiatives. Survey responses and interviewee observations support this finding. The Collaborative Director has worked closely with WET coordinators to enhance coordination and training opportunities. Various workshops and trainings have allowed staff from many organizations and agencies to build skills and knowledge.

For example, the Collaborative sponsored the MFT curriculum project to update education and training requirements for MFTs to reflect the new values and workforce needs expressed in the MHSA. The Collaborative also partnered with the MFT Educators Consortium of the Bay Area to support MFT educators in developing curriculum and other educational materials to help prepare students pursuing Marriage and Family Therapist and counseling licenses to work in the public mental health sector. The curriculum project was reported to have had a wide impact in the field.

The Collaborative has made the resources developed from these efforts available on its website.

II. Increase County Human Resources/Civil Service responsiveness to and operational support of public mental health employment needs.

The Collaborative sponsored an educational and problem-solving forum including Bay Area Mental Health Directors, HR Directors, and key HR managers to identify challenges and barriers as well as evolving best practices. The Collaborative has also worked with counties to develop and share job descriptions for various positions, including those for consumers and family members.

The Collaborative sponsored a project examining core competencies for various positions within the mental health workforce. This should assist in future work with County Human Resources in hiring a diverse workforce within the civil service system. As noted above, the Director works closely with WET coordinators on an ongoing basis.

III. Strengthen and expand educational partnerships to increase the viability and accessibility of the mental health workforce pipeline.

This has been a strong component of the Collaborative's work. Interviewees cited the CSUMB program, the Contra Costa College PSR program, and the high school pathways work in particular as valuable and successful. Stipends and support for internship programs were also viewed positively. As one survey respondent commented, "*The establishment of the graduate program at CSUMB is a major asset that the Collaborative has been instrumental in achieving."* Survey respondents who utilized the Collaborative's assistance in developing and maintaining internships rated this resource highly as well.

A weakness identified by interviewees is in linking the community college programs to high school and CSU programs. The Collaborative held two community college convenings in 2010, but changes in the leadership structure within the community colleges' regional health workforce programs, and budget constraints, challenged sustained efforts. The Collaborative's director has remained actively involved with community college workforce development activities. In May 2013, the Collaborative held a joint meeting with the Community College Health Workforce Initiative to explore the role of community colleges in in mental/behavioral health workforce development and career pathways.

IV. Increase the number of consumers and family members hired, retained, and offered opportunities for career pathway development throughout the public mental health system.

As noted previously, this may have been one of the most challenging objectives to address and measure. The Collaborative has promoted consumer and family employment initiatives, but the economy has made it more difficult to start and maintain these types of programs. Even if progress has been made, actual employment numbers are difficult to track due to challenges in data collection at the county level.

The Collaborative has dedicated meeting sessions to sharing best practices, and has sponsored workshops on consumer and family employment. Some interviewees reported that over time, the focus on civil service employment has taken on too much priority and that more attention to the role of CBOs would allow more emphasis and fostering of consumer and family member employment programs. Others feel the Collaborative has done a good job in this respect: One interviewee praised the Collaborative for diligently keeping this topic on the agenda in numerous forums with different partners.

The Collaborative has worked with the organization Working Well Together, which has taken on the role of advocate and clearinghouse for this type of program. More research on the structure and outcomes of these programs would be useful.

V. **A diverse and culturally and linguistically competent public mental health workforce serving unserved, underserved, and inappropriately served consumers and their families.**

The Collaborative sponsored a comprehensive workshop on the California Brief Multi Cultural Scale (CBMCS), Multicultural Training Program, for Greater Bay Area county mental health managers, administrators, supervisors, direct service providers, clinicians, case managers, contractors, administrative, and support staff and community partners. The Collaborative also sponsored a mental health interpreter training in the Southern Region, which is planned to be refined and repeated. These trainings were intended to increase cultural and linguistic competency skills in the existing mental health workforce.

The Collaborative has also sponsored several educational initiatives that have successfully recruited and graduated individuals from underserved communities. The Contra Costa College Psychosocial Rehabilitation program and the California State University Monterey Bay Social Work Programs have both recruited large numbers of African American and Latino students. Many of the students from the schools served in the High School Pathways programs are from underrepresented groups. These efforts help prepare a culturally and linguistically competent and racially and ethnically diverse workforce for future employment in public mental health.

The Collaborative also presented information on promoting and retaining a diverse workforce in its Human Resources Convening in April 2011. These materials are posted on the website.

Two survey respondents specifically mentioned the need for continued training and support in this area. One survey respondent noted that a major need was, "*Increasing our ability to attract LCSW bilingual/bicultural Spanish speaking clinicians in today's labor market. Qualified LCSWs have other employment opportunities, and are compensated at higher, more competitive rates in non-public mental health settings. Since economic times do not allow for salary increases, and potentially salary decreases, additional grants with a public mental health service obligation component could assist our workforce needs.*"

VI. **Increase public awareness of and interest in pursuing public mental health careers.** The Collaborative's website appears to have an increasing number of visitors. The Collaborative's staff and consultants are redesigning the site to address changing demands and to incorporate new technology to make the site more interactive—this will include improving the jobs and internship section and improving search functions. Media groups working with nonprofits suggest that developing a blog and other strategies will help to keep content fresh and interesting. .

In terms of outreach to the general public to increase awareness and interest, the High School Pathway programs are perhaps the most effective vehicle for reaching the non-professional public. While these programs may interest youth in mental health careers, many adults also enter the workforce at a later stage in their employment history, often after lived

experience as a consumer or family member. Programs like Contra Costa College's Psychosocial Rehabilitation Program also provide an entrée point for older adults to enter the field without extensive background education.

The goal of educating the public about public mental health careers, outside of interested parties at educational institutions and employer groups, should be a continued focus.

RECOMMENDATIONS

There are numerous strategies that the Collaborative may pursue in the next decade as it continues to pursue its goals and objective to strengthen the public mental health workforce. We distill these many options in to a few recommendations from the evaluation team that perhaps may help to set the course. The Collaborative's strategic planning process may want to consider other options as well as the organization reviews past progress and future opportunities with a scan of the environment.

The Collaborative's many achievements are due, in part, to the strength of its human resources; resources include a Project Manager, support staff at CiMH, a pool of consultants, and volunteers. The Collaborative's capacity to achieve high-level goals appears to have grown over the years, especially with the advent of MHSA funding. The reach of the Collaborative is broad and includes a wide array of initiatives.

Recommendations

4. Consider focusing on fewer programs or on selected initiatives within each overall objective.
5. Consider soliciting funding for more staff support in order to support a broad agenda of initiatives.
6. Consider a formal strategic planning process to revisit goals and objectives for the future.

The Collaborative has a diverse and shifting constituency of participants. Those who are paid to attend meetings as part of their job responsibilities are a more steady pool of participants. Participants from the northern and southern counties are at a geographic disadvantage in accessing some Collaborative events and resources.

Recommendations

5. Continue to explore ways of addressing shifting constituency and fluctuating levels of involvement of collaborative members.
6. Improve website navigation, interactive features, and utilize newsletter email capture to engage and retain new constituents.
7. Continue to explore more effective ways to promote the Collaborative's other resources
8. Continue to find ways to make the Collaborative's meetings and activities accessible to participants from counties outside the core, urbanized Bay Area counties.

The Collaborative supports numerous initiatives, educational programs, and develops resources and programs in a variety of areas to support the mental health workforce. These initiatives are driven by the

Collaborative's mission, goals, and objectives. The next step might be to consider development of an ongoing evaluation framework these various activities.

Recommendations

4. Provide sessions on self-monitoring, how to access outcomes "as you go", and how to use data to make program changes.
5. Provide funded programs with expectations in regards to reporting outcome data.
6. Focus documentation and data collection on key outcome measures (as well as process measures) that illustrate the Collaborative's progress at meeting key goals and objectives.

a.

Conclusion

This report serves as an overall evaluation of the last ten years of the Collaborative's activities. The document provides an overview of the large number of one-time and ongoing initiatives across goals, an overall assessment of impact, and a more detailed look at some key initiatives. The scope and ambition of the Collaborative's projects has grown over the years as additional state funding became available, and as the Collaborative gained experience and credibility across counties, organizations, and sectors (educators and employers; county mental health departments, non-profits, community colleges, county education departments, state universities, and others).

The Collaborative has been very successful at facilitating discussions among diverse stakeholders to share best practices across programs and across counties. Educational programs have been especially successful in achieving multiple workforce development goals. Training of the existing workforce is a critical effort of the collaborative and is well regarded by the provider community. Reaching out to high school students to teach about careers in mental health and address the stigma of mental illness has also been a key component of the Collaborative's efforts. In addition, the Collaborative has supported multiple efforts to foster consumer and family employment in the mental health sector.

APPENDIX A. CALIFORNIA LICENSING DATA

The following section explores licensing Data from the California Department of Consumer Affairs (DCA) Professional License Masterfile. The DCA Masterfile includes licensing data for nearly all of the licensed, certified, or registered health care occupations in the state. State licensing boards report these data to the DCA monthly, and every month a new, updated masterfile is created. The file used for this report was current as of February, 2011. The DCA Masterfile includes nearly, but not all, of the licensed, certified, or registered health care occupations in the state.

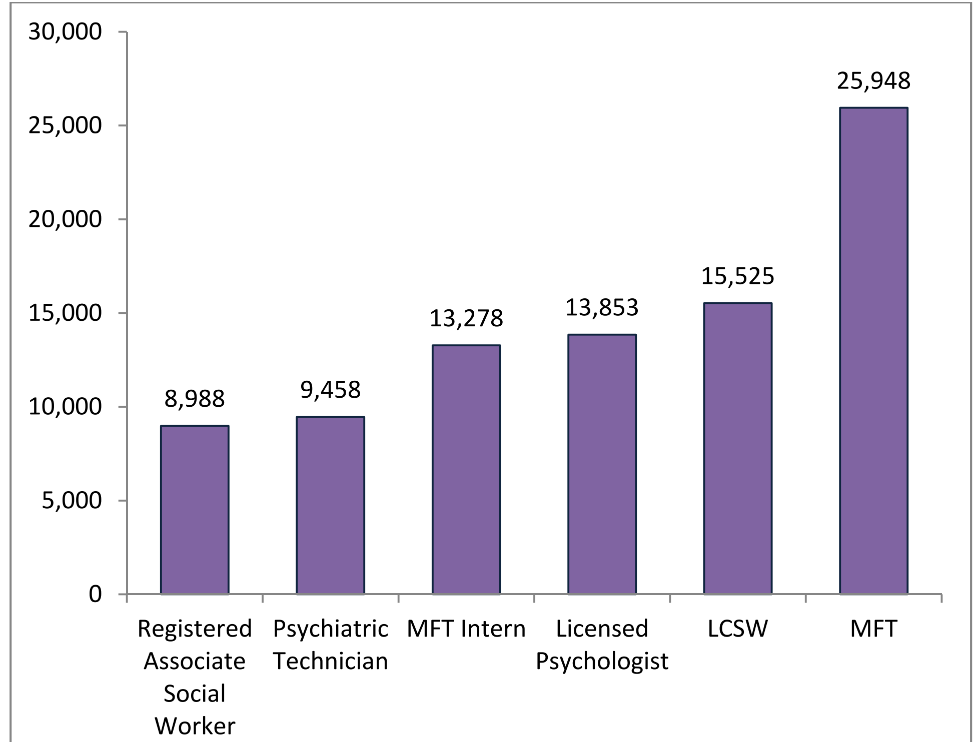
In the maps below, the Greater Bay Area is circled in blue.

These sections are excerpted from:

California's Health Care Workforce: Readiness for the ACA Era
Lisel Blash, Susan Chapman, Catherine Dower, Ed O'Neil
November 09, 2011
http://futurehealth.ucsf.edu/Content/29/2011_11_California_Healthcare_Workforce_ACA_v2.pdf

Figure 9 below is included as a point of reference. Licensed clinical social workers, registered associate social workers, marriage & family therapists, and marriage & family therapist interns, and licensed educational psychologists are all regulated by the California Board of Behavioral Sciences. Figure 9 shows the number of current licenses and registrations by type.

Figure 15. California Board of Behavioral Sciences – current licenses & registrations by type

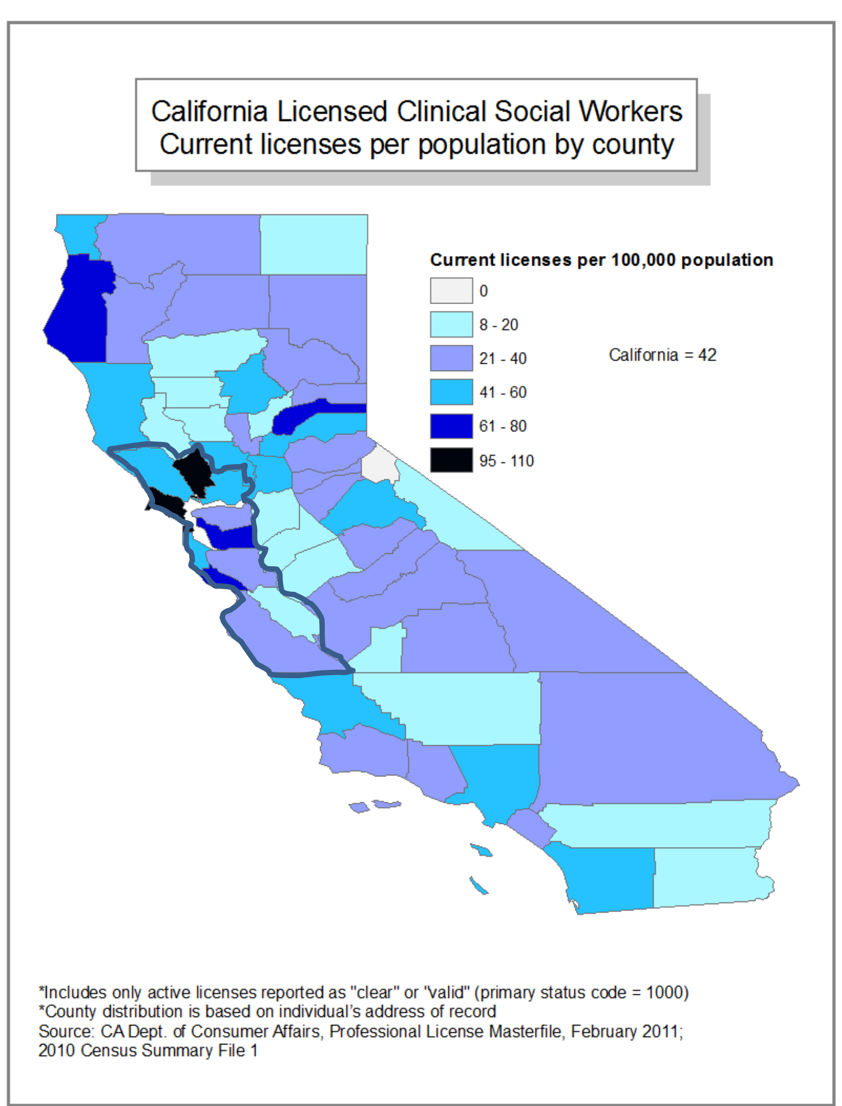


Source: CA Dept. of Consumer Affairs, Professional License Masterfile, February 2011

California Licensed Clinical Social Workers (LCSW) & Registered Associate Social Workers

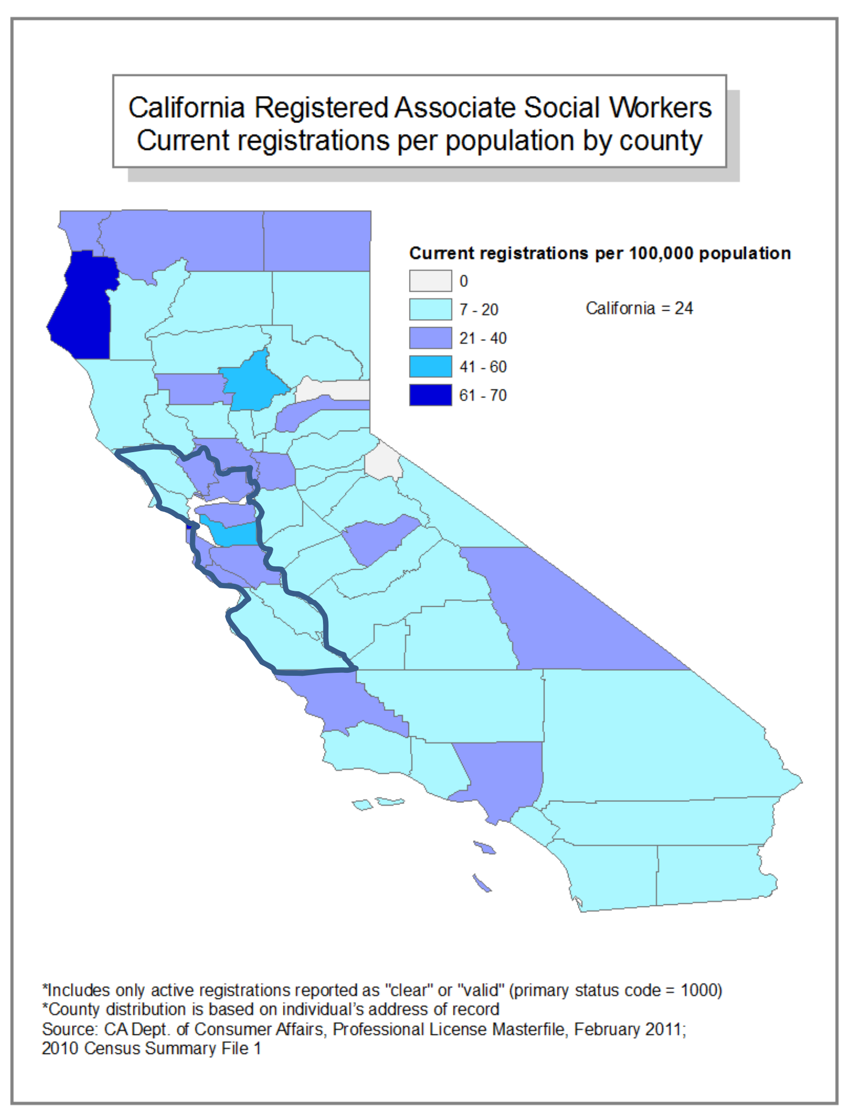
As of February 2011, there were 15,525 individuals with a California address in possession of a current and valid license to practice as a licensed clinical social worker in the state. These data show LCSWs are concentrated in several coastal counties, as well as a band of counties stretching east from the Bay Area. Approximately one-quarter of the state's counties have a LCSW per population ratio that is less than one-half the state-wide ratio, and no practitioners have an address of record in Alpine County.

Figure 16. Current California clinical social worker licenses per population by county



As of February 2011, there were 8,988 individuals with a California address and a current and valid registration to work as a registered associate social worker in the state. The distribution of registered associate social workers may reflect proximity to graduate programs in social work, with the result that two-thirds of the counties in California have very low per population ratios.

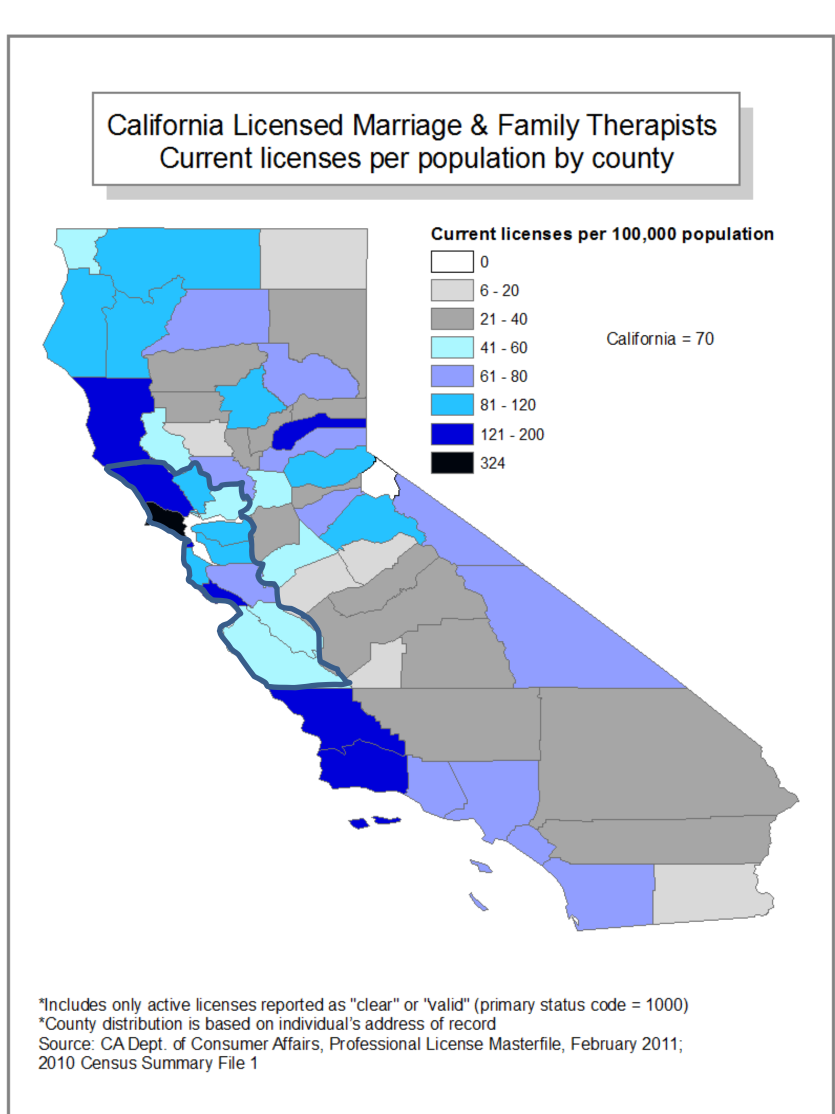
Figure 17. Current California associate social worker registrations per population by county



California Licensed Marriage & Family Therapists (MFT) and MFT Interns

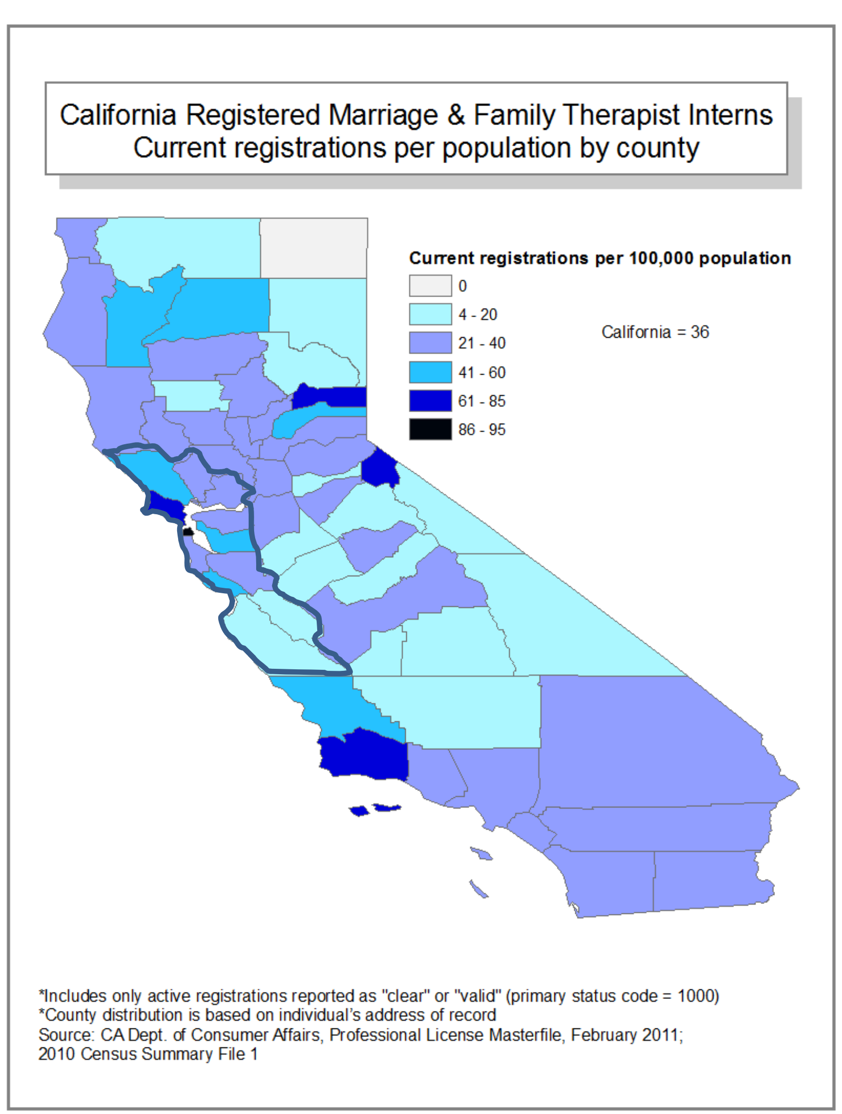
As of February 2011, there were 25,948 individuals with a California address in possession of a current and valid license to practice as a marriage & family therapist in the state. These data show marriage & family therapists are concentrated along the coast, to a greater extent compared with licensed clinical social workers. Counties in the Central Valley and parts of north-central and north-eastern California have per population ratios less than one-half the state-wide ratio, raising concerns about access to mental health services.

Figure 18. Current California MFT licenses per population by county



As of February 2011, there were 13,278 individuals with a California address and a current and valid registration to work as a marriage & family therapist intern in the state. Per population ratios for marriage & family therapist interns are generally largest in those counties that also have large MFT per population ratios. Many counties in the Central Valley and along the eastern and north-eastern borders have per population ratios less than one-half the state-wide ratio, underscoring the possibility of limited access to mental health care services.

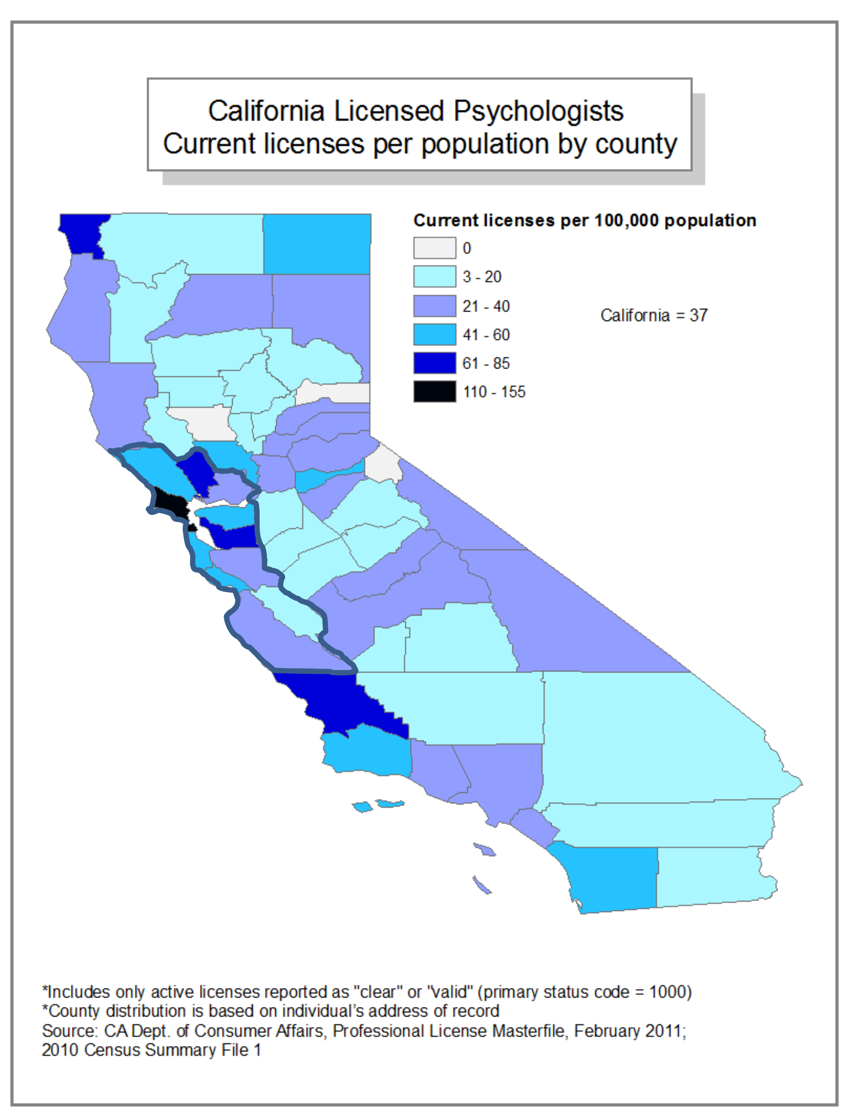
Figure 19. Current California MFT intern registrations per population by county



California Licensed Psychologists

As of February 2011, there were 13,853 individuals with a California address in possession of a current and valid license to practice as a licensed psychologist in the state. Licensed psychologists are concentrated in several coastal counties, in particular the Bay Area. Approximately 40 percent of California's counties have a licensed psychologist per population ratio that is less than one-half the state-wide ratio, including many counties in the Central Valley, those in the southern border region, and the northern-central region of the state. Three counties have zero practitioners with an address of record in those counties.

Figure 20. Current California licensed psychologist licenses per population by county



California Licensed Psychiatric Technicians

As of February 2011, there were 9,458 individuals with a California address in possession of a current and valid license to practice as a psychiatric technician in the state. The map indicates that psych techs are concentrated in just a few counties. Their geographic distribution of employment likely reflects the location of state psychiatric hospitals, or correctional facilities.

Figure 21. Current California psychiatric technician licenses per population by county