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2020-2025 Mental Health Services Act Workforce Education and Training Five-Year Plan

OSHPD
Office of Statewide Health Planning and Development

California Behavioral Health Planning Council

Advocacy • Evaluation • Inclusion

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Executive Summary

The Office of Statewide Health Planning and Development (OSHPD) improves access to quality healthcare for Californians. OSHPD ensures hospital buildings are safe, offers financial assistance to individuals and healthcare institutions, and collects and publishes healthcare data.

California's public mental health system (PMHS) has serious workforce shortages and maldistribution in nearly all professions. There is a recognized lack of workforce diversity, underrepresentation of professionals with consumer and family member experience, and of racial, ethnic, and cultural communities providing services and support. These shortages are particularly severe for public mental health practitioners with adequate competencies to work effectively with individuals with serious mental illness (SMI) or serious emotional disturbance (SED) across the lifespan of age groups, as well as diverse racial, ethnic, and cultural populations.

The passage of Proposition 63, the Mental Health Services Act (MHSA), in November 2004 provided a unique opportunity to expand and improve the workforce that supports PMHS programs. To address the public mental health workforce issues, the MHSA included a component for Workforce Education and Training (WET) programs.

As provided for by Welfare and Institutions Code (WIC) Section 5820, OSHPD, in coordination with the California Behavioral Health Planning Council (CBHPC), is charged with the development of the WET Plan every five years. The 2020-2025 WET Five-Year Plan provides a framework for strategies that state and local government, community partners, education institutions, and other stakeholders can pursue to further efforts to remedy the shortage of qualified individuals who provide services.

The WET Plan provides a mission, vision, and values for state and local implementation. It promotes planning toward an integrated mental health service delivery system that encompasses both substance use services and primary health care. The WET Plan also supports an ongoing dialogue between state partners, consumers, family members, and other stakeholders to increase the capacity of California's current and prospective public mental health workforce.

The WET Plan carries forth the MHSA vision to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of infants, children, adolescents, transition age youth, and older adults. The WET Plan includes the elements required in state statute (WIC Section 5822) and the results of a robust stakeholder engagement process.

Introduction

The 2020-2025 WET Plan provides a guide for WET programming in Fiscal Year (FY) 2020-21 through FY 2025-26. Unlike the first ten years (2008-2018), there is no funding associated with this WET Plan. The WET Plan has been specifically designed to be programmatically flexible based on the level of funding provided.

Upon approval of the WET Plan every five years by the CBHPC, OSHPD is tasked with developing programs that create, enhance, and grow the PMHS workforce. This is necessary to ensure access to services to meet the needs of Californians with serious mental health needs. The WET Plan envisions that OSHPD could use FY 2019-20 to develop state and local programs based on the level of funding committed for FY 2020-21 through FY 2024-25.

Purpose of Plan

The purpose of the WET Plan is to guide efforts to improve and expand the PMHS workforce throughout California.

The WET Plan includes the vision, values, mission, measurable goals, objectives, funding principles, performance indicators, a statewide needs assessment, and career pathway recommendations. In accordance with Welfare and Institutions Code (WIC) sections 5820 through 5822 of the MHSA, the WET Plan covers the period of 2020-2025.

The WET Plan carries forth the MHSA vision to create a transformed, culturally-competent system that promotes wellness, recovery, and resilience across the lifespan of infants, children, adolescents, transition age youth, and older adults. The WET Plan includes the elements outlined in WIC Section 5822, providing a framework for strategies that state and local government, community partners, education and training institutions, and other stakeholders can enact to further public mental health workforce education and training efforts.

Background

In November 2004, California voters approved Proposition 63, the MHSA. The MHSA imposes a one percent tax on personal income greater than $1 million to support the PMHS. The MHSA provides funding to support county- and state-administered public mental health programs and to monitor progress toward statewide goals. The MHSA aims to prevent and reduce severe and disabling outcomes for adults with SMI and children and adolescents with SED through early identification and access to treatment.

California's PMHS suffers from a shortage of qualified mental health personnel to meet the needs of California's diverse population. In addition to an overall shortage, there is a PHMS workforce maldistribution throughout the state, with a shortage of providers who reflect the state's cultural and linguistic diversity. This includes individuals with lived experience to provide consumer- and family-driven services that promote wellness, recovery, and resilience.

California WIC Sections 5820 through 5822 require OSHPD, in partnership with the CBHPC, to develop a statewide MHSA WET Five-Year Plan to address California's PMHS workforce needs every five years. In addition, the Legislature appropriated nearly $445 million in MHSA funds over ten years to support WET programs, allocating $234.5 million to the state to support two state-administered WET Five-Year Plans. Counties received $210 million to support local WET programs over a ten-year period. State and county authority to expend these WET program funds ended June 30, 2018. The FY 2018-19 budget provided $11 million in one-time MHSA support to continue some state WET programs.

The WET Plan is based on an analysis of demand for mental health providers, stakeholder input, evaluation of past state-administered WET programs, and an assessment of mental health provider educational capacity.

Vision

OSHPD envisions a public mental health workforce, which includes persons with lived experience, including consumers, family members, and caregivers, sufficient in size, diversity, skills and resources to deliver successful and innovative services to individuals most severely affected by or at risk of an SMI or SED.

Strength-based mental health service delivery that embodies the principles of wellness, recovery, and resilience is essential to preventing costly, inappropriate, and often involuntary treatment across healthcare systems and settings. It also enables individuals to live, work, learn, and fully participate in the communities of their choice.

Expanding the role of individuals, families, and communities in the recovery process is an accepted strategy to effectively address workforce shortages. This approach shifts the focus to competencies that can be learned and utilized by many individuals who can then serve as non-licensed professionals in the PMHS.

MHSA resources present the potential for new and expanded services to enable a full spectrum of care that includes an integrated mental health, substance use, and primary healthcare service delivery across multiple systems, settings, and regions.

Through the WET Plan, resources promote multi-disciplinary and interprofessional training that considers the diverse needs of racial and multicultural communities and other unserved, underserved, and inappropriately served populations across the lifespan of age groups. To bring the MHSA vision to fruition, mental health, substance use, and primary healthcare systems must develop a full range of strategic alliances and structures. These collaborations are necessary to benefit mental health consumers and accommodate an ever-changing service needs landscape that can quickly respond to current and future opportunities, such as those presented by state and federal healthcare reform.

Mission

OSHPD, with input from its partner agencies, persons with lived experience, including consumers, family members, and caregivers, and other stakeholders, developed the following mission statement to guide all WET activities:

> California's PMHS will develop and maintain a robust and diverse public mental health workforce capable of addressing mental health disparities by providing treatment, prevention, and early intervention services to persons with SED or SMI. Services need to be consumer- and family-driven, equitable, compassionate, culturally and linguistically appropriate, and gender responsive, across the lifespan. Effective methods are those that promote wellness, recovery, and resilience and lead to positive mental health, substance use, and primary care outcomes across healthcare systems in community-based settings.

Values

Develop a diverse licensed and non-licensed professional workforce that includes, but is not limited to, those from:

- Underrepresented racial, ethnic, and cultural communities.
- Disabled and the deaf and hard-of-hearing communities.
- Lesbian, Gay, Bisexual, Transgender, Questioning/Queer, Intersex, and Asexual (LGBTQIA) community members.
- Persons with lived experience as mental health consumers, families, and caregivers.

PMHS professionals must have the skills to:

- Provide treatment, prevention, and early intervention services that are culturally and linguistically responsive to California's diverse and dynamic needs.
- Promote wellness, recovery, and resilience and other positive behavioral health, mental health, substance use, and primary care outcomes. PMHS agencies need to extend these same values to their workforce.
- Work collaboratively to deliver individualized, strengths-based, consumer-and family-driven services.
- Use effective, innovative, community-identified, and evidence-based practices.
- Conduct outreach to and engage with unserved, underserved, and inappropriately served populations.
- Promote inter-professional care by working across disciplines.
- Include the viewpoints and expertise of persons with lived experience, including consumers and their families and caregivers, in multiple healthcare settings.

Goals and Objectives

The development of the following goals and objectives were informed by elements outlined in statute (WIC Section 5822) and a robust stakeholder engagement process that involved diverse stakeholder groups. The goals and objectives provide a framework for strategies that state and local government, community partners, educational institutions, and other stakeholders can enact to remedy the shortage of qualified individuals to provide services to those who are at risk of or have a severe mental illness.

Goals

1. Increase the number of diverse, competent licensed and non-licensed professionals in the PMHS to address SMI.

2. Expand the capacity of California's current public mental health workforce to meet California's diverse and dynamic needs.

3. Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.

4. Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.

5. Support delivery of PMHS services for consumers within an integrated health system that encompasses physical health and substance use services.

Objectives

1. Expand awareness and outreach efforts to effectively recruit racially, ethnically, and culturally diverse individuals into the PMHS workforce.

2. Identify and enhance curricula to train students at all levels in competencies that align with the full spectrum of California's diverse and dynamic PMHS needs.

3. Develop career pathways for individuals entering and advancing across new and existing PMHS professions.

4. Expand the capacity of postsecondary education to meet the identified PMHS workforce needs.

5. Expand financial incentive programs for the PMHS workforce to equitably meet identified PMHS needs in underrepresented, underserved, unserved, and inappropriately served communities.

6. Expand education and training programs for the current PMHS workforce in competencies that

align with the full spectrum of PMHS needs.

7. Increase the retention of PMHS workforce identified as high priority.

8. Evaluate methods to expand and enhance the quality of existing PMHS delivery systems to meet California's PMHS needs.

9. Develop and sustain new and existing collaborations and partnerships to strengthen recruitment, training, education, and retention of the PMHS workforce.

10. Explore stakeholder-identified policies that aim to further California's efforts to meet its PMHS needs.

11. Provide flexibility to allow local jurisdictions to meet their unique needs.

12. Standardize PMHS workforce education and training programs across the state.

13. Promote care that reduces demand for high-intensity PMHS services and workforce.

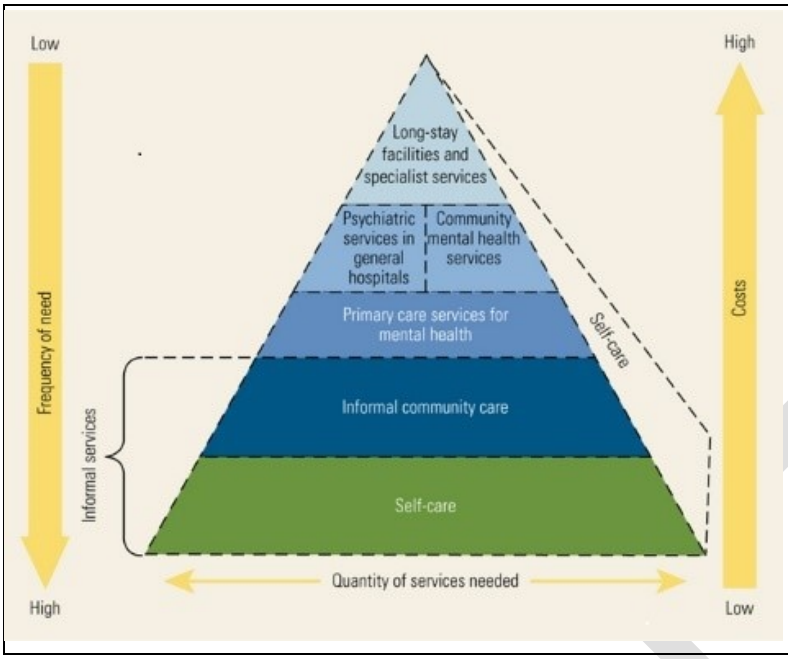
Actions that Support Goals and Objectives

The following actions support the implementation the WET Plan's goals and objectives:

- Continue to partner with stakeholders to develop and implement WET strategies.
- Include target populations across all WET programs, including persons with lived experience, culturally diverse communities, disabled communities, deaf and hard of hearing communities, LGBTQIA communities, rural and frontier communities, and underrepresented, underserved, unserved, and inappropriately served populations across the life span of age groups that include infants, children, adolescents, transition age youth, and older adults.
- Continue focus on MHSA values, principles, and priorities.
- Promote innovative, evidence-based, and community-identified strategies.
- Continue MHSA WET evaluation activity that is well-designed, data driven, and outcomes-based.
- Continue evaluation and assessment of mental health workforce needs to guide priority WET strategies.

Public Mental Health System of Care

The WET Plan places an emphasis on supporting PMHS services that provide care at the lowest level of intensity and promote the use of non-licensed personnel throughout the delivery system. The chart below depicts this system of care and identifies the professions associated with each level of care.



Psychiatrists, Psych Techs, PMHNPs, non-licensed personnel, including peer specialists

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Psychiatrists and PMHNPs; Licensed clinicians; Non-licensed direct service personnel

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Primary Care doctors, NPs, PAs with psychiatric training

Non-licensed personnel, including:
Certified Peer Personnel
Certified Case Managers
Certified Community MH Workers

NP: nurse practitioner
PA: physician assistant
PMHNP: psychiatric mental health nurse practitioner

The WET Plan is poised to support a comprehensive system of programs and services, across the state, to meet the needs of California's diverse populations. Additionally, the strategies set forth in the plan support inter-system collaboration to address the mental health needs of multi-system users and ultimately to achieve positive outcomes and reduced costs.

Proposed 2020-2025 WET Five-Year Plan Framework

The following WET Plan framework reflects and responds to findings from the WET evaluation, academic capacity and workforce needs studies, key literature reviews, and a robust stakeholder engagement process. Summaries of these findings appear in Appendices 4 through 8. The WET Plan framework proposes two categories.

1. Supporting Individuals
2. Supporting Systems

To implement this proposed strategy, OSHPD would contract with the Regional Partnerships to carry out the proposed activities under Supporting Individuals, and OSHPD would directly administer the proposed activities under Supporting Systems.

Supporting Individuals

There are four components in this category.

- Pipeline development
- Undergraduate college and university scholarships
- Clinical master and doctoral level graduate education stipends
- Educational loan repayment

There is an emphasis on supporting individuals throughout their undergraduate and graduate education to achieve their desired degree in exchange for working in the PMHS. Should an individual complete their education with student loans, then he or she would be eligible to receive loan repayment assistance while working in the PMHS as a hard-to-fill, hard-to-retain professional.

If this strategy is implemented, OSHPD would make local allocations based on the identified needs of the 59 local MHSA jurisdictions, also taking into consideration historical local MHSA support awarded for other MHSA activities (e.g., Prevention and Early Intervention, Community Support Services, and Full Support Services) for expenditure by OSHPD and the Regional Partnerships.

The Regional Partnerships created by the MHSA would administer the series of programs supporting individuals to promote the leveraging of resources to best serve individual local jurisdictions. OSHPD would contract with each of the Regional Partnerships for activities supporting individuals. OSHPD would assist with the administrative execution of educational scholarships, clinical graduate student stipends, and educational loan repayments.

The strategy is two-fold. First, identify individuals in the early stages of considering and deciding on their career trajectory. Once an individual decides on a PMHS career, the Wet Plan envisions that the full range of programs would support them over the course of their education and securing PMHS employment, from scholarship to stipend, and/or to loan repayment.

Second, allow individuals to receive support at any point along the career development pathway: as an undergraduate receiving a scholarship, in a clinical graduate program receiving a stipend, or as a PMHS professional receiving loan repayment assistance with education debt. Selecting candidates from underserved communities and local jurisdiction would also support grow-your-own workforce development strategies.

Pipeline Development

Introduce the PMHS to kindergarten through 12th grades, community colleges, and universities. Ensure that these programs incorporate developmentally appropriate concepts of mental health needs, self-care, and de-stigmatization. Resources should be targeted at educational institutions with underrepresented communities. The Regional Partnerships would conduct pipeline activities to identify students as potential scholarship and stipend candidates.

Undergraduate College and University Scholarships

Provide scholarships to undergraduate students in exchange for service learning received in a PMHS agency. The scholarship level would depend on the student's academic aspirations (including certificate, associate degree, and bachelor's degree), pre-placement training and education received, lived experience, and/or other possible factors.

Clinical Master and Doctoral Graduate Education Stipends

Similar to the previous Stipend program, this program would provide funding for post-graduate clinical master and doctoral education service performed in a local PMHS agency. Regional Partnerships would select students in advance of their final year of education and provide funds after completing the service obligation, giving priority to applicants who previously received a scholarship.

Loan Repayment Program

The loan repayment program would provide financial assistance to PMHS professionals that the local jurisdiction identifies as serving in hard-to-fill and hard-to-retain positions, giving priority to applicants who previously received a scholarship and/or stipend. The amount awarded would be based on educational attainment, the level of unmet need in the community being served, and years of service in a local PMHS agency.

Supporting Systems

OSHPD would directly administer the following four components of this program category.

- Peer Personnel Preparation
- Psychiatric Education Capacity Program
- Train New Trainers Psychiatry Fellowship
- Research and Evaluation

Peer Personnel Preparation

Expand peer personnel preparation to include employee development and outreach for persons with lived experience as consumers, family member, and care giver employees and volunteers. The program would support the selection, training, placement, and support of prospective peer personnel, as well as develop and prepare county and county-contract agencies for peer personnel employment.

Psychiatric Education Capacity Program

Establish a Psychiatric Education Capacity Program for psychiatrists and psychiatric mental health nurse practitioners (PMHNPs). This program would expand the number of psychiatry residency and PMHNP student programs across the state.

Train-New-Trainers Psychiatry Fellowship

Extend and expand the Train-New-Trainers Psychiatry Fellowship for primary care practitioners. The Train-New-Trainers Psychiatry Fellowship would provide funds to primary care physicians, family practice nurse practitioners, and physician assistants who participate in a curriculum that provides advanced training in primary care psychiatry.

The chart that appears in Appendix 1 lays out the structure for the WET Plan framework.

Research and Evaluation

If funded, the WET Plan would provide resources to government and non-government stakeholders throughout California to enhance and expand the PMHS workforce. Evaluating the impact of these investments is critical to assess the effectiveness of the activities undertaken, determine whether the WET Plan is meeting goals and objectives, and re-evaluate future priorities and actions.

This work would include developing and implementing refined evaluation metrics for each WET program component. This will enable OSHPD and the Regional Partnerships to ensure funds are used efficiently and effectively. Research would also carefully analyze available information to evaluate the supply of and demand for qualified PMHS workforce.

In addition, OSHPD would contract with entities to carry out a range of studies:

1. Identify successful program pipeline models for kindergarten through 12th grades, community colleges, and universities that include de-stigmatization and mental health wellness components. This study would also evaluate WET Program funded pipeline activities.

2. Identify and design specialized training curricula that community colleges and non-profit organizations can implement for:
   a. peer personnel
   b. health and social services case management
   c. community mental health worker

3. Identify evidence based and promising practices for the use of technology and distributed learning for PMHS workforce education and training.

Innovations for Further Consideration

The following policy and program recommendations would improve efforts to expand and retain the PMHS workforce with little or no cost.

1. Explore applying a portion of time of supervised clinical field work performed during the final year of graduate school in the PMHS toward licensure.

2. Improve collection and sharing of employment and licensure data gathered, including the administration of special surveys that identify licensed professionals working in the PMHS.

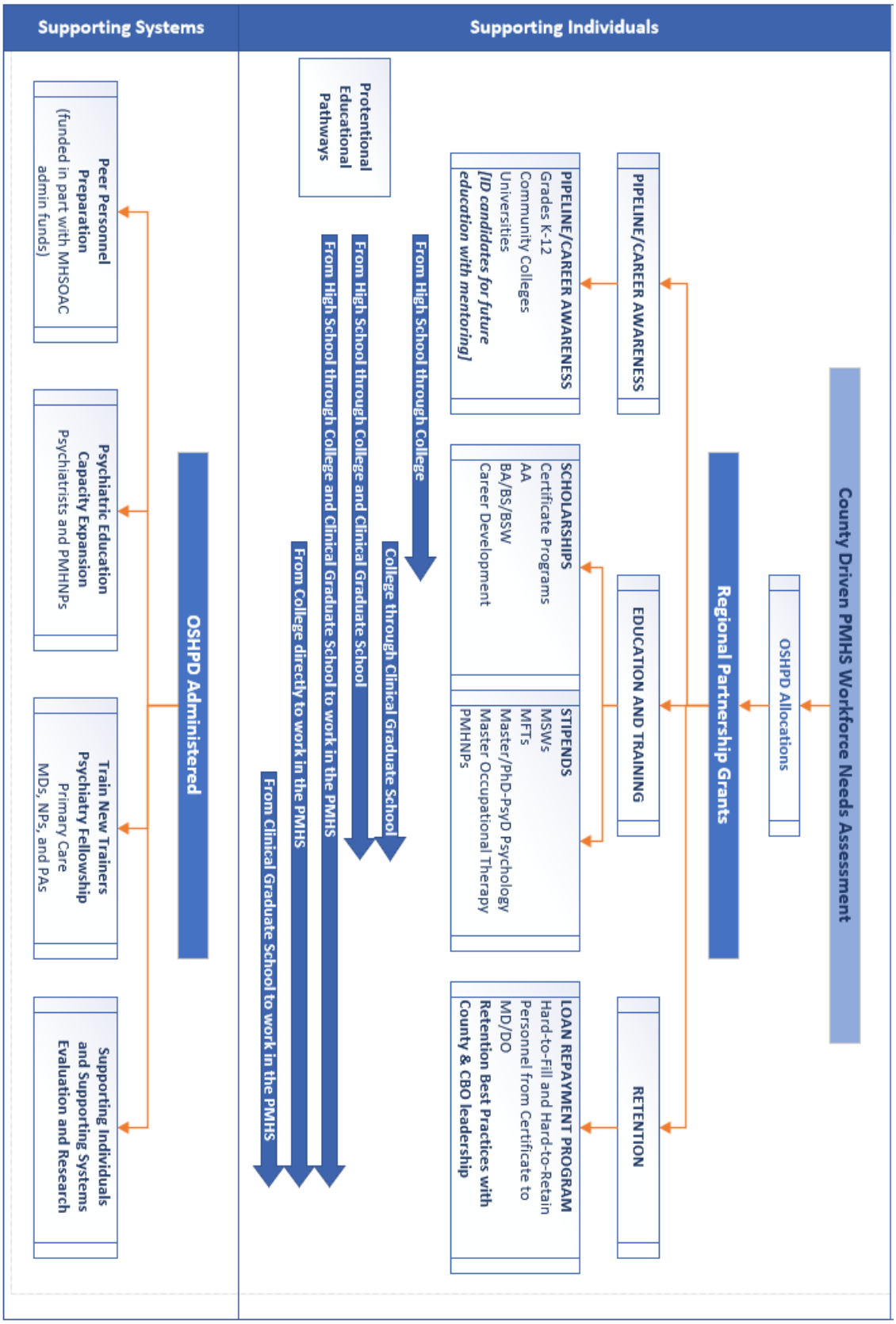
3. Use the Health Workforce Pilot Projects Program to test changes in scope of practice of licensed clinicians.

4. Promote adoption of a standardized curricula by community colleges and non-profit organizations for:
   a. peer personnel
   b. case management personnel
   c. community mental health workers

5. Collaborate with other agencies and stakeholders to maximize SMHS Medi-Cal reimbursement to specifically include services provided by licensed, certified, and non-licensed staff.

6. Collaborate with other agencies and stakeholders to explore possible changes in SMHS Medi-Cal billing documentation to reduce paperwork burden.

Appendix 1: Plan Framework



Appendix 2: Definitions

Across the Lifespan includes infants, children, adolescents, transition aged youth, transition aged adults, adults, and older adults.

Caregivers are grandparents and their partners, adoptive parents and their partners, guardians and their partners, and foster parents and their partners, who are now or have in the past been the primary caregiver for a child, youth, or adolescent with a mental health challenge who accessed mental health services.

Consumer, referred to as Client in *Title 9, CCR, Section 3200.040,* is an individual of any age who is receiving or has received mental health services. The term "client" includes those who refer to themselves as clients, consumers, survivors, patients, or ex-patients.

Community-Identified are strategies that have been identified as being effective by cultural and ethnic communities but that have not been demonstrated by empirical evidence.

Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies in a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross cultural situations. *Title 9, CCR, Section 1810.211*.

Diversity includes dimensions of race/ethnicity, gender, sexual orientation/identity, socio-economic status, age, religion, physical and/or mental/neurological abilities, language, geographical location (i.e. urban/rural), veteran, and/or other pertinent characteristics.

Distributed Learning is an instructional model that involves using various information technologies to help students learn such as video or audio conferencing, satellite broadcasting, and multimedia formats.

Evidence-Based are strategies that have produced empirical evidence of their successful outcomes to address an identified issue.

Family Member are parents and siblings and their partners, kinship caregivers, friends, and others as defined by the family who is now or was in the past the primary caregiver for a child, youth, adolescent, or adult with a serious mental health challenge who accessed mental health services.

Grow-Your-Own Model are strategies used to recruit individuals from within diverse communities to pursue professions in the PMHS which involves engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care.

Health Workforce Pilot Projects is an OSHPD-administered program that allows organizations to test, demonstrate, and evaluate new or expanded roles for health professionals or new health delivery alternatives before changes in licensing laws are made by the Legislature.

Inappropriately Served are populations that are not being provided appropriate culturally responsive and/or culturally appropriate services and are provided services often inconsistent with evidence-based and/or community-identified practices.

Interprofessional are health providers from different professions working together to provide care.

Lived experience refers to consumers of PMHS services and their family and caregivers.

Local jurisdictions include the 58 counties (with Sutter and Yuba counties operating as a single entity), the City of Berkeley, and the Tri-City area (Pomona, Claremont, and La Verne) in Los Angeles County.

Persons with Lived Experience include consumers, family members, and caregivers.

Prevention and Early Intervention are services to prevent mental illnesses from becoming severe and disabling.

Public mental health system (PMHS) is the publicly-funded mental health programs/services and entities that are administered, in whole or in part, by state departments or counties. It does not include programs and/or services administered, in whole or in part by federal, state, county, or private correctional entities or programs or services provided in correctional facilities. *Title 9, CCR, Section 3200.253*

Public mental health workforce is the current and prospective personnel, county contractors, volunteers, and staff in community-based organizations, who work or will work in the PMHS. *Title 9, CCR, 3200.254*

Regional Partnerships are five geographic regions designated by the California Mental Health Directors Association. The designations are Superior, Central, Greater Bay Area, Southern, and Los Angeles. The Superior Region is comprised of Butte, Colusa, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, and Trinity counties. The Central Region is comprised of Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Placer, Sacramento, San Juaquin, Sutter, Stanislaus, Madera, Mariposa, Merced, Mono, Tulare, Tuolumne, Yolo, and Yuba. The Greater Bay Area Region is comprised of Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, San Benito, Santa Clara, Solano, Santa Cruz, Sonoma, and the City of Berkeley. The Southern Region is comprised of Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara Ventura, and the Tri-City (Pomona, Claremont, and La Verne) area of Los Angeles County.

Serious Emotional Disturbance (SED) is infants, children, and youth up to age 18 who have

a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. These can include, but are not limited to, pervasive developmental disorder, childhood schizophrenia, schizophrenia of adult-type manifesting in adolescence, conduct disorder, affective disorder, other disruptive behaviors, or other disorders with serious medical implications such as eating disorders. *WIC 5600.3.*

Serious Mental Illness (SMI) is a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. *WIC 5600.3 (b)(1)*

Stackable Credential is part of a sequence of credentials that can be accumulated over time to build up an individual's qualifications and help them move along a career pathway or up a career ladder to different jobs and potentially higher paying jobs. *Source: U.S. Department of Labor*

Stakeholder is an individual or entity with an interest in mental health services in California, including but not limited to: individuals with serious mental illness and/or serious emotional disturbance and/or their families; providers of mental health and/or related services such as physical health care and/or social services; educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with serious mental illness/ and/or serious emotional disturbance and/or their families. *Title 9, CCR, Section 3200.270*

Underrepresented refers to populations and communities that are underrepresented in the mental health professions relative to their numbers in the total population.

Underserved means clients of any age who have been diagnosed with a serious mental illness and/or serious emotional disturbance and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience. When appropriate, it includes clients whose family members are not receiving sufficient services to support the client's recovery, wellness, and/or resilience. These clients include, but are not limited to, those who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences; members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services; and those in rural areas and Native American rancherias and reservations not receiving sufficient services.

Unserved means those individuals who may have serious mental illness and/or serious emotional

disturbance and are not receiving mental health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the county may be considered unserved. *Title 9, CCR, 3200.310*

Appendix 3: Welfare and Institutions Code (WIC) Sections 5820-5822 Governing the WET Program

WIC Section 5820

(a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.
(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.
(c) The Office of Statewide Health Planning and Development, in coordination with the California Mental Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and develop a five-year education and training development plan.
(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.
(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

WIC Section 5821

(a) The California Mental Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development.
(b) The Office of Statewide Health Planning and Development shall work with the California Mental Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

WIC Section 5822

The Office of Statewide Health Planning and Development shall include in the five-year plan:
(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, masters degrees, or doctoral degrees.
(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.
(d) Establishment of regional partnerships between the mental health system and the educational

system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.
(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.
(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.
(g) Promotion of the employment of mental health consumers and family members in the mental health system.
(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).
(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

Appendix 4: Literature Review on the Epidemiology of Mental Illness

As part of developing the 2020-2025 Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan planning, OSHPD contracted with Healthforce Center at University of California, San Francisco to produce a report summarizing literature on incidence and prevalence of mental illness, use of mental health services, and unmet need for mental health services. The report describes racial/ethnic disparities and other demographic and socio-economic disparities identified in the literature and differences across regions within California to the extent data are available.

What follows is the executive summary of this report. The terminology used for communities of color (e.g., Black and African-American) comes from the source documents referenced in the full report.

Methods

The authors searched databases of peer-reviewed literature and websites of organizations engaged in monitoring incidence and prevalence of mental illness, use of mental health services, and unmet need for mental health services. The literature search and summary of findings focus primarily on literature published since OSHPD and CBHPC released the 2014-2019 MHSA WET Five-Year Plan.

Limitations of the Literature for Drawing Inferences about Californians' Mental Health Needs

The literature is limited on the epidemiology of serious mental illness (SMI) and serious emotional disturbance (SED) in California. Most of the studies that have been published only report state level estimates and do not report regional or county level estimates. In addition, little literature has been published about how implementation of the Affordable Care Act (ACA) has affected use of mental health services and unmet need for services among persons with SMI or SED.

Findings

Incidence and Prevalence of Mental Illness

- Studies have used several different indicators and several different data sources to estimate the percentage of Californians with mental illness.
- During the most recent years for which estimates are reported in the literature (2014-2016):
    - 15.4 percent to 17.2 percent of Californian adults had any mental health condition within the past year and 3.6 percent to 4.2 percent had an SMI.
    - 5.9 percent of California adults had a major depressive episode within the past year.
    - 12.3 percent of California children and adolescents had a major depressive episode within the past year and 7.6 percent had an SED.
    - Major depressive episode is the only mental health condition for which the literature reported trends over time in California. The percentage of adults with a major depressive

episode decreased between 2011-2012 and 2014-2015, but the percentage of children and adolescents with a major depressive episode increased.
    - Rates of any mental illness and SMI among California adults were similar to rates in the U.S. overall.

Use of Mental Health Services

- During 2011-2013 (the latest year for which these data are available), 9.1 percent of California adults visited a psychiatrist or other mental health specialist within the past year and 7.2 percent visited a primary care physician for treatment of a mental health condition or substance use disorder.
- The ratio of emergency department (ED) discharges to inpatient psychiatric facilities per 10,000 persons in California increased from 18.7 to 24.5 between 2010 and 2015.
- Among Californians enrolled in Medi-Cal who used Specialty Mental Health Services between fiscal year 2012 and fiscal year 2015:
    - The vast majority of both children and adults received mental health therapy (72 percent of adults and 93 percent of children and adolescents).
    - Adults were more than twice as likely to obtain medication support than children and adolescents.
    - Less than 20 percent of adults and less than 10 percent of children received crisis intervention services, crisis stabilization services, or inpatient mental health care.
- Findings from national studies suggest that, among children and adolescents, rates of use of psychotropic medications and use of psychotherapy increased substantially from the late 1990s to the early 2010s, as did ED visits and inpatient admissions for mental health conditions.

Unmet Need for Mental Health Services

During the most recent year for which estimates are reported in the literature (2011-2015 survey data):

- Only 37.2 percent of California adults who had any mental illness received any mental health treatment during the past year.
- Only 32.1 percent of California adolescents who had a major depressive episode within the past year received treatment.
- Among California adults who sought treatment for a mental health condition, 17 percent were not able to obtain treatment.
- Among California adults who had severe psychological distress or needed help with an emotional/mental or alcohol/drug problem, nine percent were not able to receive treatment.
- The percentage of California adults with any mental illness and the percentage of California adolescents with major depression who received treatment within the past year were lower than the percentages in the U.S. overall.

Geographic Differences

- Estimates of the prevalence of SED, SMI, and serious psychological distress (an indicator that is highly correlated with SMI) vary across regions of California.
- A study that used the WET regions to identify differences within California found that the Bay Area had the lowest rate of serious psychological distress among adults (3 percent) and the Superior region had the highest rate of serious psychological distress among adults (4.6 percent).
- Rates of mental health services utilization varied by region. People in the Bay Area were the most likely to see a mental health specialist (10.8 percent). People in the Superior region were the most likely to see a primary care provider for a mental health condition (9.4 percent).
- The Bay Area had the highest percentage of adults with unmet need for mental health services (9.2 percent) and the Central region had the lowest percentage (8.2 percent).

Racial and Ethnic and Socio-economic Disparities

Race/Ethnicity

- The prevalence of SMI and SED vary substantially across racial and ethnic groups in California:
  - African-American, Latino, Native American, and multi-cultural (non-Latino) Californians had higher rates of SMI than whites, Pacific Islanders, and Asians.
  - The prevalence of SED also varied across racial and ethnic groups, but the differences were not as large as the differences in SMI prevalence among adults. African-American and Latino children had the highest rate of SED and white children had the lowest rate of SED.
- White adults in California were more likely to visit a mental health specialist or a primary care provider for a mental health condition than Asians or Latinos.
- Black and Latino adults in California were more likely to report unmet need for mental health services than whites.

Gender

Women in California were more likely than men to have SMI, visit a mental health specialist or a primary care provider for a mental health condition, and report unmet need for mental health services.

Age

- California adults aged 35 to 44 years had the highest rate of SMI in 2014 and adults age 65 years or older had the lowest prevalence.

- California adults aged 18 to 24 years were less likely than older adults to visit a mental health specialist or a primary care physician for a mental health condition and more likely to report unmet need for these services.

Income

The percentages of adults with SMI and children with SED in California increase as income decreases. The rate of SMI among adults with incomes below 100 percent of the federal poverty level was 4.7 times the rate among adults with incomes at or above 300 percent of poverty and the rate of SED was 1.7 times higher among children.

Conclusion and Implications

The findings from this literature review suggest that during the years for which data are available:

- Rates of any mental illness and SMI in California were similar to rates in the U.S. overall but Californians with mental health conditions were less likely to obtain treatment.
- Substantial percentages of adults with any mental illness and adults with SMI had unmet need for mental health services.
- Rates of mental illness, use of mental health services, and unmet need for services vary substantially across California WET regions.
- There are significant disparities in prevalence of mental illness, use of services, and unmet across racial/ethnic groups and income levels. There are also differences between men and women and between young adults and older adults.

These findings have several implications for California's mental health workforce.

- There is a need to investigate whether shortages, maldistribution, and lack of racial/ethnic diversity among mental health professionals in California contribute to unmet need for mental health services or lead people to obtain mental health services from primary care providers instead, or delay seeking care until they need inpatient treatment.
- Disparities in prevalence of mental illness and unmet need for care indicate a need for mental health professionals who are prepared to work with young adults, low-income persons, and communities of color—specifically Blacks, Latinos, and Native Americans.

Policymakers should commission additional research with subsequent years of data from the datasets discussed in this report to assess the impact of the ACA on use of mental health services and unmet need for services.

Appendix 5: 2014-2017 WET Program Evaluation

The purpose of WET is to improve the PMHS' ability to improve and retain mental health professionals. As part of developing the 2020-2025 Mental Health Services Act Workforce Education and Training (WET) Five-Year Plan planning, OSHPD researchers analysed data for state-administered WET programs.

This section summarizes the evaluation findings from Fiscal Year (FY) 2014-15 through FY 2016-17 and describes the seven statewide WET programs. This report addresses the following research topics:

1. What workforce preparation and development services were provided and to whom?

2. Did each WET program adhere to their proposed project plan?

3. What impact has each WET program had on the PMHS statewide healthcare workforce?

WET Program Background

Programs

The state-administered WET programs fall into one of two groups:

Programs Serving Individuals

- Educational Stipend: Provide stipends to graduate students in certain mental health professions agreeing to practice in the PMHS following graduation.
- Mental Health Loan Assumption Program (MHLAP): Increase the number of PMHS providers hired and retained by the PMHS by repaying loans of mental health professions and personnel in exchange for working in the PMHS.
- Peer Personnel Preparation: Support the training and job placement of individuals with lived experience in the PMHS.
- CalSEARCH: Increase the recruitment and retention of culturally competent staff.

Programs Serving Groups

- Educational Capacity: Expands training capacity and provide clinical rotations for psychiatry residents and psychiatric mental health nurse practitioners in the PMHS.
- Consumer and Family Member Employment (CFME): Increase the number of consumers and family members employed in the PMHS.
- Mini Grants: Strengthen educational foundational knowledge of the PMHS by providing underrepresented and/or disadvantaged individuals with program support for exploring and pursing healthcare careers.
- Retention: Increase the continued employment of PMHS personnel identified as high priority by county behavioral health agencies, by developing and enhancing evidence-based and community-identified practices.

Personnel

WET personnel who participated in state-administered WET programs fell into three categories:

- Prescribing Clinicians
- Non-Prescribing Licensed Clinicians
- Non-Licensed Personnel

Evaluation Findings

Research Topic One: What workforce preparation and development services were provided and to whom?

OSHPD staff gathered the following data from individual program progress reports and annual summary reports:

- Context (WET program, program type)
- The volume of individuals served
- Participant demographics (race/ethnicity, non-English languages spoken, lived experience)
- Counties served

Volume of Individuals Served

The tables below summarize the participation counts for each program from FY 2014-15 to FY 2016-17:

Program Type	WET Program	Participants by Fiscal Year			Total
		2014-15	2015-16	2016-17	
Individuals	MHLAP	1,085	1,528	1,514	**4,127**
	Stipends	293	325	339	**957**
	Peer Personnel	522	933	1,207	**2,662**
	CalSEARCH	66	30	0	**96**
Groups	CFME	600	4,736	4,510	**9,846**
	Education Capacity	63	106	111	**280**
	Mini Grants	0	10,858	7,416	**18,274**
	Retention	0	5,293	7,616	**12,909**
	All Programs	**2,629**	**23,809**	**22,713**	**49,151**

Demographics: Race/Ethnicity

The analysis revealed that the percentages for each race/ethnicity group of prescribing clinicians, with the exception of Latino/Hispanic clinicians, surpassed their respective population percentages.

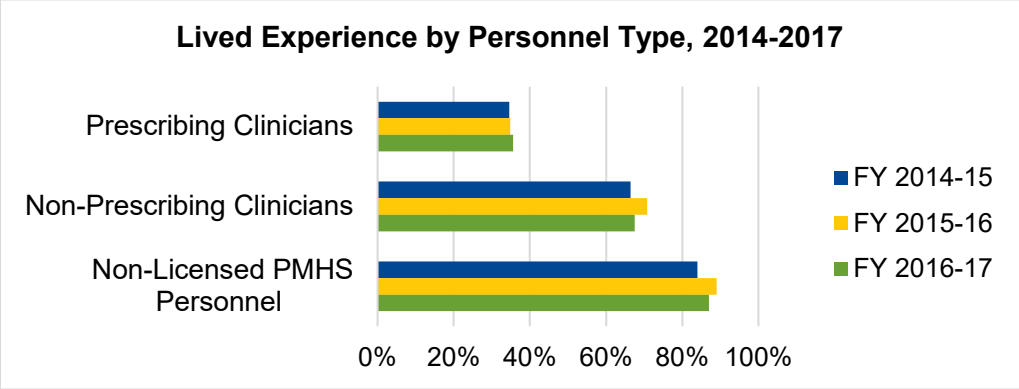
Caucasian/White and Asian personnel make up a majority of prescribing clinicians (71 percent), while Latino/Hispanic personnel make up a majority of non-prescribing licensed clinicians (41 percent) and non-licensed PMHS personnel (39 percent).

Demographics: Non-English Languages Spoken

Spanish was the most commonly spoken non-English language for all individuals and personnel types served. More than 70 percent of non-prescribing licensed clinicians and non-licensed PMHS personnel spoke a non-English language. Overall, the number of WET state-administered program participants in all personnel types spoke at least one non-English language increased each year, with the largest increases occurring in FY 2016-17.

Demographics: Lived Experience

Lived experience refers to refers to consumers of PMHS services and their family and caregivers. Non-licensed PMHS personnel showed the highest percentage of individuals with lived experience.



Counties Served

WET programs operated in nearly every county (57 out of 58). Non-prescribing clinician participants were from the greatest number of counties (54 out of 58), with the greatest number of clinicians participating from Southern California. The fewest number of participants were prescribing clinicians, who were also located in the lowest number of counties (23 out of 58).

Research Topic Two: Did each WET program adhere to their proposed project plan?

OSHPD research staff compared the observed participation numbers with the proposed numbers outlined in each programs' grant proposal. OSHPD research staff obtained data from individual grant agreements, grantee-provided progress reports, and annual grantee summary reports.

The data show that six out of seven state-administered WET programs met or exceeded their proposed outcomes. The percentage of MHLAP recipients who completed their service obligations increased each year, from 84 percent in FY 2014-15 to 96 percent in FY 2016-17. individuals in almost all counties (57 out of 58) participated in state-administered WET programs. A greater number of community-based organizations (CBOs) participated in WET programs than the minimum number proposed.

Research Topic Three: What impact has each WET program had on the PMHS statewide healthcare workforce?

MHLAP/Stipend Recipients

OSHPD administered the MHLAP and Stipend Tracking Survey to determine the proportion of recipients who completed their service obligations, and how long they stayed in the PMHS after their obligation was completed. Of those who graduated and completed their service commitments, 91 percent continued working in the PMHS. The table below summarizes the average time spent in the PMHS after graduating and completing their service commitments:

Program Type	**Time in PMHS After Service Obligation Completion (Months)**	
	Currently in PMHS	**Exited PMHS**
Stipend Recipients	14.35 (n=65)	17.00 (n=11)
MHLAP Recipients	24.35 (n=850)	24.75 (n=270)
MHLAP and Stipend Recipients	24.98 (n=60)	23.20 (n=21)
All Recipients	**23.69 (n=975)**	**24.33 (n=302)**

Respondents also reported reasons for why they stayed or left the PMHS workforce. Happiness with their job (59 percent) and advancement opportunities (35 percent) were the most common reasons for staying. Leaving for positions with better salaries/benefits (30 percent) and experiencing burnout (29 percent) were the most common reasons for leaving.

Respondents who received both Stipend and MHLAP awards, compared to those only receiving one category of these awards, stayed an average of two years after completing their service obligation. These awardees were also more likely to report:

- The awards helped them to secure employment after graduation.
- The funding was important to their decision to continue working in the PMHS after completing their service commitments.

OSHPD researchers also asked counties and CBOs under contract with counties to provide PMHS services how helpful WET programs were to increase and improve the PMHS workforce (on a scale of 1 to 5 with 1 being not at all helpful and 5 being very helpful). Counties and CBOs reported, on average, the WET programs were between helpful and very helpful (3.5). County and CBO response to the question, “How effective have the state-administered WET programs been increasing the PMHS workforce diversity and cultural/linguistic competency?” averaged 3.2, or helpful. This compares to the response to the question, “How effective have the state-administered WET programs been in helping your county increase the number of persons employed by or volunteering in the PMHS since 2014?”, which averaged 3.9, or very helpful.

Appendix 6: Stakeholder Engagement Outcomes (CSUS)

Public Engagement Process

The current Mental Health Services Act (MHSA) Workforce Education and Training (WET) Plan will be expiring in April 2019. Welfare and Institutions Code (WIC) Section 5820 (c) requires OSHPD) to develop a WET Plan every five years. OSHPD, which oversees the state WET Program, is developing the 2020-2025 WET Five-Year Plan in partnership with the California Behavioral Health Planning Council (CBHPC). The WET Plan will articulate the workforce needs for the county-based public mental health system (PMHS).

Through a comprehensive stakeholder engagement, OSHPD sought to obtain varying perspectives to ensure a comprehensive and inclusive process. OSHPD solicited input through focus groups, a survey, and regional community events.

CBHPC Workforce and Employment Committee and CBHPC WET Steering Committee

Throughout the WET Plan development process, OSHPD provided the CBHPC updates and solicited the CBHPC Workforce and Employment Committee and WET Steering Committee member input on the stakeholder engagement process. OSHPD presented to the CBHPC Workforce and Employment Committee and WET Steering Committee in June, July, October, and December 2018.

Focus Groups

Purpose

- Solicit input from key statewide stakeholders for developing the WET Plan to ensure a comprehensive and inclusive planning process.
- Identify key themes and content for the subsequent statewide survey and community forums to further solicit information for the WET Plan development.

Schedule

Focus group meetings were held between August 27, 2018 and September 7, 2018.

Locations: Sacramento, Riverside, and Redding.

Stakeholder Participation

- CBHPC Workforce and Education Committee and WET Steering Committee
- PMHS providers
- Professional associations and educators
- Southern and Northern California rural communities

- California rural communities
- State government partners
- Consumers, family members, and underserved communities

Key Takeaways

- Update the WET plan values and principles by explicitly:
  - Expanding the definition of diversity
  - Reorienting the PMHs around recovery and behavioral health
  - Emphasizing cultural humility and cultural sensitivity
  - Integrating trauma informed care philosophy
- Expanding existing workforce capacity requires a closer look at addressing systemic challenges such as:
  - Billing
  - Funding disbursements
  - Lack of data to support capacity building efforts
- Strategies for recruitment should focus on:
  - Grow your own approach to identifying workforce in communities that are hard to serve
  - Building career paths from Junior High school forward
  - Improving outreach for PMHS careers
  - Leveraging lived experience.
- Strategies to support the workforce and promote retention should focus on:
  - Improved supervision and mentoring opportunities
  - Standardized education and certification of non-licensed workforce
  - Work-life balance
  - Use of tele-psychiatry and other web-based education and training support

Community Forums

Purpose

- Provide information about the developing WET plan and solicit input from diverse participants.
- Validate information gathered through the focus group meetings and fill potential gaps.

Schedule

Community forum meetings were held between October 30, 2018 and November 14, 2018.

Locations

Sacramento, Eureka, Santa Ana, Pasadena, San Jose, and Fresno

Stakeholder participation: There were a total of 107 participants at the six meetings.

Key takeaways

- Suggested additional values and principles:
  - Openness toward non-conventional methods of healing.
  - Emphasize the importance of establishing rapport in the therapeutic relationship.
  - Incorporate and integrate family feedback and support in a transparent systemic response.
  - Incorporate systemic issues and solutions to complement individualized efforts.
- Pipeline Priorities:
  - Provide financial incentives.
  - Offer pathway programs to expose students to careers in public mental health.
  - Grow-your-own and recruit locally to take advantage of community connections.
- Workplace Career Paths:
  - Develop opportunities for providers to continue their education while working; allow workers to achieve incremental gains in training and experience.
  - Invest in developing personalized career growth pathways with each staff member Create career pathways for consumers/family members who are interested in the PMHS.
  - Establish statewide standards and certifications for non-licensed workforce.
- Retention Strategies: It would be helpful to have a toolbox of retention strategies from which diverse workplaces could choose those best suited to their needs.
- Career Development:
  - Develop well-defined career pathways that allow workers to progress through incremental training and experience.
  - Maintain bridges between academia and public mental health providers to prevent a disconnect between theory and practice.
  - Expand the professional capacity of non-licensed staff.
  - Create structures that allow licensed providers to work at the top of their scope of practice.
  - Provide training for management in how to effectively support peer staff.
- Partnerships and collaboration across organizations and agencies are important ways to improve and incorporate the various strategies.

Statewide survey

Purpose

- Provide information about the developing WET plan and solicit additional input.
- Validate information gathered through the focus group meetings and fill potential gaps.

Schedule

The survey was available from October 16, 2018 through November 15, 2018

Stakeholder participation

The survey was sent to over 6,000 individuals, and 635 responses were received.

Key Takeaways

Survey findings affirmed most of the suggestions made during the focus group meetings, and reaffirmed some key themes that emerged throughout the stakeholder engagement process:

- Broaden and be explicit about the definition of diversity.
- Respondents perceive their workplace as generally responsive to language, accessibility, cultural competency issues, and peer support needs.
- Respondents were divided on the question of how well the workforce represents the population being served regardless of race/ethnicity or where they work.
- Provide opportunities for training and capacity building for both providers and their supervisors.
- Develop well-defined career pathways that allow workers to progress after incremental training that also takes work experience into account.
- Financial incentives (e.g., loan forgiveness, stipends) continue to be an important approach to encouraging and retaining providers who are working in the PMHS.
- Develop statewide standards and/or certifications for peer support specialists, community health/mental health workers, and case managers to promote the non-licensed workforce.
- Important strategies to retain and support the workforce include schedule flexibility, promoting work-live balance, providing financial incentives, and streamlining bureaucratic requirements.
- Supervisors and managers emphasized the importance of ongoing supervision skills training to better support the workforce.

Appendix 7: Academic Institution Capacity Survey Findings

As part of the planning process, OSHPD contracted with Healthforce Center at the University of California, San Francisco to produce reports on several mental health workforce topics. This executive summary presents findings from a survey of California educational programs that train mental health professionals conducted in fall 2018. The survey addressed educational programs' ability to admit qualified applicants and their plans for expansion. Assessing the ability of educational programs to admit additional qualified applicants is important because studies of California's mental health workforce suggest that the state is facing shortages of multiple types of mental health professions.[1] Policymakers need to know whether mental health professions education programs need additional resources to expand to meet the projected increase in demand. What follows is the executive summary from this report.

Conclusion and Implications

Findings from this survey suggest that 61 percent of mental health professions education programs in California are at capacity (i.e., they are enrolling the maximum number of students they can accommodate). The majority of psychiatry residency programs, psychiatric mental health nurse practitioner (PMHNP), and master's of social work (MSW) programs that responded are at capacity as are the only occupational therapy and community mental health worker programs that responded. The majority of these programs are also rejecting qualified applicants because they lack sufficient faculty or capacity for clinical education. These findings suggest that educational programs for psychiatrists, PMHNPs, and social workers (BSWs and MSWs) do not have adequate capacity to meet demand among qualified applicants. Inability to admit all qualified applicants is a cause for concern because forecasts of demand for mental health professionals in California suggest that the state is facing shortages in multiple mental health professions.

Methods

In October 2018, the Healthforce Center distributed an online survey to 204 educational program directors in the following mental health disciplines located in California:

- Psychiatry
- PMHNP
- Clinical and counseling psychology (LPCC and PhD/PsyD)
- Marriage and family therapy (MFT)
- Occupational therapy
- Social work (BSW and MSW)
- Community mental health

For all professions except community mental health workers, the Healthforce Center used lists of

[1] Janet Coffman, Timothy Bates, Igor Geyn, and Joanne Spetz, *California's Current and Future Behavioral Health Workforce*, Healthforce Center at UCSF, February 2018, https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce.

educational programs approved by California licensing boards and lists of accredited educational programs in California to identify programs and obtain contact information for their directors. Since community mental health workers are neither licensed nor accredited, the Healthforce Center relied on OSHPD staff to identify training programs in this field for inclusion in the survey.

The Healthforce Center conducted descriptive analyses to determine the proportion of mental health professions education programs that are rejecting qualified applicants or plan to expand. Findings were compared by profession and type of educational institution (e.g., public vs. private).

Results

Description of Respondents

Thirty-eight of the 204 mental health professions education programs surveyed provided usable responses to the survey (response rate = 19 percent). Table 1 lists the numbers of program that responded and response rates by discipline. Directors of PMHNP programs had the highest response rate followed by directors of MSW programs and psychiatry residency programs. Doctoral programs in clinical or counseling psychology and master's degree programs in MFT had the lowest response rates.

Table 1. Response Rate by Type of Mental Health Professions Education Program

Program Type	# of Programs	# of Responses	Response Rate
Psychiatry – residency	28	6	21%
PMHNP – doctoral and master's	10	7	70%
Clinical Counseling Psychology - doctoral	31	2	6%
Clinical Counseling Psychology – master's	72	6	8%
Marriage and Family Therapy – master's	85	5	6%
Occupational Therapy – master's[2]	12	1	8%
Social Work – master's		7	29%
Social Work – bachelor's	17	3	17%
Community mental health worker	5	1	20%
All types of programs	**204**	**38**	**19%**

Twenty-three respondents (61 percent) were from public higher education institutions, including community colleges, California State University, and the University of California. Fifteen respondents (39 percent) were from private colleges or universities.

[2] Although there are doctoral programs in occupational therapy in the U.S., at present all accredited occupational therapy programs in California are master's degree programs. https://www.aota.org/Education-Careers/Find-School.aspx

The WET Southern region accounted for the largest proportion of respondents (39 percent). Twenty-six percent of respondents are located in the Greater Bay Area, 26 percent in the Los Angeles region, and 8 percent in the Central region (the total is less than 100 percent due to rounding). There were no respondents from the WET Superior region.[3]

Findings: Capacity to Accept Additional Students

Respondents were asked two questions to assess their current capacity to admit qualified applicants. One question asked whether their programs are "at capacity," meaning that they have admitted as many qualified students as they can admit. The second question asked respondents to indicate whether their programs turn away qualified applicants.

Twenty-three respondents (61 percent) indicated that their programs are enrolling the maximum number of students that they can enroll. As the data in Table 2 indicate, the percentage of respondents who indicated that their programs are enrolling the maximum number of students possible varied across mental health disciplines. Bachelor's degree programs in social work and master's degree programs in clinical or counseling psychology were the least likely to be at capacity (33 percent) and occupational therapy and community health worker programs were the most likely to be at capacity (100 percent).

Table 2. Number and Percentage of Respondents Enrolling the Maximum Number of Students They Are Able to Enroll

Program Type	# of Respondents	# At Capacity	% At Capacity
Psychiatry – residency	6	4	67%
PMHNP – doctoral and master's	7	5	71%
Clinical Counseling Psychology - doctoral	2	1	50%
Clinical Counseling Psychology – master's	6	2	33%
Marriage and Family Therapy – master's	5	2	40%
Occupational Therapy – master's[4]	1	1	100%
Social Work – master's	7	6	86%
Social Work – bachelor's	3	1	33%
Community mental health worker	1	1	100%
All types of programs	38	23	61%

Mental health professions education programs that are not enrolling the maximum number of students that they can enroll (39 percent) were asked to indicate the reasons why their programs are not at capacity. The most frequently reported reasons were that some students

[3] See https://www.cibhs.org/southern-region for a list of WET regions and counties in each of the WET regions.

[4] Although there are doctoral programs in occupational therapy in the U.S., at present all accredited occupational therapy programs in California are master's degree programs. https://www.aota.org/Education-Careers/Find-School.aspx

admitted to the program did not enroll (33 percent of programs not at capacity) and that the program was unable to offer sufficient financial aid to applicants (27 percent).

Twenty-three respondents (61 percent) reported that their programs reject qualified applicants. The one community mental health worker program that responded does not reject qualified applicants. Among disciplines in which programs reject qualified applicants, doctoral programs in clinical or counseling psychology and occupational therapy were the most likely to reject qualified applicants (100 percent). MFT programs were the least likely to reject qualified applicants (20 percent).

Educational programs that are rejecting qualified applicants were asked to indicate the reasons why they do so. The most frequently reported reasons for rejecting qualified applicants were lack of sufficient funds to increase the number of faculty members (61 percent of programs that reject qualified applicants), limited space at clinical training sites (35 percent), and insufficient classroom space and numbers of clinical preceptors (22 percent each).

Mental health professions education programs located at public colleges and universities were more likely to report that they have enrolled the maximum number of students they can enroll than programs at private colleges and universities. Programs at public colleges and universities were also more likely to report that they reject qualified applicants.

Findings: Plans for Expansion

Twenty-one respondents (55 percent) plan to expand their programs. Marriage and family therapy and PMHNP programs were the most likely to plan to expand (80 percent and 71 percent, respectively). Occupational therapy and community mental health worker programs were the least likely to plan to expand.

Educational programs at public colleges and universities were less likely to plan to expand than programs at private colleges and universities. For example, only two of the four PMHNP programs at public universities that responded (50 percent) indicate that they plan to expand, whereas all three programs at private universities that responded plan to expand (100 percent). Similarly, only two of the six MSW programs at public universities that responded (33 percent) plan to expand, whereas the only program at a private university that responded plans to expand (100 percent).

Respondents were also asked to indicate how many additional students they plan to enroll. The number of additional students that programs plan to enroll varied widely. Psychiatry residency programs, doctoral programs in clinical or counseling psychology, and bachelor's degree programs in social work plan to add 1 to 5 students. In contrast, master's degree programs in social work that plan to expand plan to add 16 to 20 students or more than 20 students.

Respondents indicated that they plan to use a variety of strategies to expand enrollment listed all strategies they plan to use. Recruiting additional qualified applicants was the most frequently mentioned strategy (52 percent of respondents that plan to expand). The second most frequently

mentioned strategies were increasing the number of students their existing programs can accommodate and developing a hybrid or fully online program. Twenty-four percent of respondents that plan to expand anticipate using one or both of these strategies.

Findings: Requirements for Expansion among Respondents Not Planning to Expand

Respondents who indicated that their educational programs do not plan to expand were asked to indicate the conditions under which they would consider expanding their programs. Many respondents cited multiple conditions. Securing sufficient funds to hire additional faculty and/or staff was the most frequently mentioned condition (71 percent of respondents not planning to expand). Other frequently mentioned conditions include obtaining funds to expand classroom space (47 percent), obtaining funding to establish additional clinical training sites (41 percent), and receiving assurances from employers that job opportunities would be available for additional graduates (24 percent).

Limitations

This survey had several important limitations. First, respondents may not be representative of the population of mental health professions education programs in California because the response rate is low (19%). Low response rates are a particular concern for clinical and counseling psychology doctoral and master's degree programs, marriage and family therapy programs, and occupational therapy programs because less than 10 percent of programs in these disciplines responded to the survey. Second, the survey responses are self-reported data that were not validated against official records. Third, a single respondent was surveyed for each educational program. Some respondents may not have complete information about their programs or may have different perspectives than their colleagues on the reasons why their programs reject qualified applicants or conditions that would need to be met for their programs to expand.

Only 55 percent of respondents plan to expand their educational programs. The percentage of respondents that plan to expand varies widely across disciplines. Marriage and family therapy and PMHNP programs were the most likely to plan to expand and programs that train occupational therapists and community mental health workers were the least likely. The numbers of students that programs plan to add vary widely, ranging from 1 to 5 students to over 20 students. Programs that do not plan to expand indicated that multiple conditions would need to be met for them to expand. The most frequently cited conditions were funding to hire additional faculty, acquire additional classroom space, and establish additional clinical training sites.

The survey identified important differences between mental health professions education programs at public and private colleges and universities. Programs at public colleges and universities were more likely to be at capacity and to reject qualified applicants. They were also less likely to plan to expand. These findings suggest that public colleges and universities have greater need for additional resources to meet demand for mental health professionals than private colleges and universities. Investment in mental health professions education programs at public colleges and universities would help decrease educational debt among all mental health professions students.

Expanding educational opportunities at lower cost public institutions would be especially helpful to students from disadvantaged backgrounds who are disproportionately members of racial/ethnic groups that are underrepresented in mental health professions.

Appendix 8: Public Mental Health System (PMHS) Workforce Needs

OSHPD conducted a PMHS workforce needs assessment. OSHPD surveyed counties and community-based organizations (CBOs) to assess the gaps between current workforce employed and unfilled positions. Information collected directly from counties and CBOs under contract with counties provides first-hand descriptions of current workforce shortages.

OSHPD researchers surveyed counties and CBOs to assess their current need for PMHS workforce, by profession. Respondents included staff at county PMHS agencies, CBOs under contract with the county PMHS, and other similar organizations. The breakdown of respondents is as follows:

Respondent Type	Total Respondents	Percent Respondents
CBO under contract with the county PMHS	73	42%
County PMHS agency	71	41%
Other	28	16%

The respondents were based in 52 different counties, providing a good representation of the many diverse regions of California. The table below shows respondents (for counties and county-contract CBOs only) by region:

Region	Total Respondents	Percent Respondents*
Central	75	44%
Greater Bay Area	29	17%
Los Angeles	24	14%
Superior	24	14%
Southern	20	12%

*Total exceeds 100% due to rounding.

Hard-to-Fill and Hard-to-Retain Professions

County and county-contract CBO respondents report the top seven positions as hard-to-fill and hard-to-retain:

1. General Psychiatrist
2. Licensed Clinical Social Worker
3. Child and Adolescent Psychiatrist
4. Licensed Marriage and Family Therapist
5. Psychiatric Mental Health Nurse Practitioner
6. Case Manager/Social Worker
7. Executive and Management Staff

In general, the race/ethnicity of staff at these county agencies and CBOs mirrors that of the clients served, although there are some gaps. The table below shows average percentages across the state for race and ethnicity.

Race/Ethnicity	Percent in PMHS	
	Staff	Clients
White	46%	39%
Hispanic	29%	33%
Asian	9%	5%
Black	14%	12%
Other	17%	14%

Peer Personnel

There is also high demand for peer personnel in the PMHS. Sixty-one percent of respondents reported that they employ peer personnel. Peer personnel fill many roles in PMHS agencies, including client support (44 percent of their working hours), case management (18 percent), family support (17 percent), and clerical work (12 percent).