Marin County Community Mental Health

Seeking public comment on the Mental Health Services Act (MHSA) Workforce Education & Training Plan (WET)

October 3, 2008
30-day Public Comment Period begins

Marin County Community Mental Health Services (CMHS) is seeking public comment regarding the MHSA Workforce Education & Training Plan.

The full WET Plan follows this page. The second document posted is the summary document of the WET Plan that includes the budget and short descriptions of each program.

If you would like to provide input to the document, please send your comments to:

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San Rafael, CA 94903
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The required 30-day comment period begins on Friday October 3, 2008 and will end on Wednesday November 5, 2008.

PART IV: REQUIRED EXHIBITS

EXHIBIT 1: WORKFORCE FACE SHEET

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

County: Marin County Date: [**Insert date of submission]**

County Mental Health Director

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Signature:

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EXHIBIT 2: STAKEHOLDER PARTICIPATION SUMMARY

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

The Marin County Community Mental Health Services (CMHS) planning process for Workforce Education & Training (WET) had two important antecedents:

- A year-long, comprehensive county-wide, interdisciplinary Workforce Planning Initiative research and planning process focused upon staff development, workforce development, and personnel recruitment and retention strategies; and
- Marin County's Mental Health Services Act Community Services and Supports (CSS) planning process.

Marin County's MHSA WET planning process built upon the work conducted in each of these processes and will continue to connect with both of these efforts in important ways. Throughout 2007, the county's Workforce Planning Initiative Research Team gathered and analyzed County-wide demographic data to identify systemic areas of strength and vulnerability and presented the data to the Board, Department Heads and Assistants. In the second phase, the team conducted extensive interviews with each department in order to more fully understand the complexity of public workforce issues facing Marin County. The report described recruitment challenges posed by a local cost of living that far outstrips other neighboring regions. The report also pointed to the dire need to develop strategies to prepare for the impending retirement of a high proportion of its workforce as 26% of the County's current workforce could retire today and 47% could retire within five years.

Findings and recommendations from this report also identified the need to diversify the workforce, expanding both its cultural and linguistic capacities. The Workforce Planning initiative (WFI) identified a need for diversity that extended beyond cultural dimensions to include recruitment of older adults and younger adults. During the WFI planning process, some departments saw the value in marketing to these underrepresented candidate pools, such as the older worker, through increased part-time and limited term opportunities. They also advocated relationships with colleges and universities to promote internship and trainee programs and increased focus on career development to enhance the career opportunities of younger County employees, strategies that have also been incorporated into this WET plan. The Health and Human Services Department has created a Cultural Competency Committee to focus attention on the issue of diversity in the workplace and provide solutions. The EEO Office has identified several hundred new recruitment sites for diversity, sites that will be utilized by the WET Coordinator funded by the MHSA. Finally, the WFI report points to the challenge of finding new ways to create career ladders and utilize local educational institutions as partners in workforce development efforts. The WFI process has engaged leadership from throughout the County employment and education and training systems. This leadership commitment to collaboration, resource sharing and transforming the entire workforce system creates a policy and partnership context in which MHSA WET transformative efforts will be welcomed and supported.

The CMHS MHSA Community Services and Supports (CSS) process is the second relevant local community planning process from which the WET planning has emerged. CSS planning began in the fall of 2004, resulting in a plan being approved by the County in February 2006. The CSS process involved over 1000 individuals, included over 20 focus groups with over 300 representatives of under-served cultural populations, parents and consumers. Over 500 individuals returned a community survey with 42% of respondents identifying as consumers. Surveys were made available in Spanish, English and Vietnamese and more than 10% of those responding indicated that they had never been successful in engaging county mental

health services. Town hall community meetings were held and eight Special Topic Workgroups were formed to conduct ongoing meetings. Overseeing all of this planning activity is a 28 member Steering Committee that includes 9 clients and family members as well as representatives from under-served populations, criminal justice, the Mental Health Board, National Alliance for the Mentally Ill, First Five Commission, County Division of Social Services, County Office of Mental Health, and criminal justice system.

Marin MHSA WET Planning Team	
Member	**Affiliation**
Ann Stoddard	Consumer
Barbara Coley	Consumer Provider
Eileen Becker	Consumer Provider
Beverlee Kell	President of NAMI Marin/Mental Health Board
Bob Brown**	Project Manager, Buckelew Programs
Bobbie Wunsch	Consultant to WET
Carolina Rosales-Wyman	Bilingual/Bicultural Spanish MHP Therapist
Donna Garske	Director, Marin Abused Women's Services
Mary Donovan**	Program Manager, County Employment and Training
Elberta Eriksson	Citizen, Mill Valley
Nan Heflin	Clinician, Older Adult HOPE Program
Holly Byers	Clinician, Youth and Family Services
Kim Denn	Consumer, Mental Health Board Member
Leah Fagundes	Consumer Provider
Carol Kerr	Contract Psychologist Intern Program
Julie Kaplan	Novato Unified School District
Margaret Hallett**	CEO Family Service Agency
Rebecca Smith	Planner/Evaluator Division of Health
Ricardo Moncrief	Citizen, Novato
Robin Buccheri**	Nurse Practitioner/Educator UCSF
Judy Kendall**	Marin Community Mental Health Services
Hutton Taylor**	County Mental Health Services
Kathy Kipp**	County Mental Health Services
Paul Gibson**	Consultant to WET
Members listed above were involved in meetings throughout 2007 to set the priorities and focus for WET planning. Individuals with double asterisks continued to participate in meetings throughout 2008 to generate specific 'actions' and budgets that would support them.	

The CSS process generated significant input from family members, consumers, and representatives from under-served populations resulting in a vastly improved understanding of how these groups felt the system must be transformed to meet their needs. With this as a basis, the WET process then engaged staff, consumers, and family members to achieve a better understanding of how MHSA WET funding could support system transformation, diversify the workforce, fill hard-to-fill positions, train family members and consumers to play important roles in the system and better address the needs of consumers, particularly those who historically have been under-served.

The MHSA WET planning process was initiated in July 2007 and a WET committee has been meeting continuously since then.

The Planning Team met five times in 2007 to obtain initial input and establish the parameters for future planning. Focus groups were held with consumers and family members as part of the WET planning process. The summary below presents themes from these groups. There were more sessions with family members than with consumers, hence the larger number of themes identified. It is also worth noting how often comments revolve around system issues rather than specific training issues.

Input from the focus groups with consumer and family members resulted in planned use of MHSA WET funds to support special scholarship funds devoted to support consumer and family members' advancing their education and to create a pool of funds specifically dedicated to developing career ladders and training opportunities to be delivered for **and by** consumers and family members.

A survey seeking input both into areas in which training was needed and the ways in which staff preferred to learn was administered with both community based agencies and County Mental Health Services staff. This survey was also used to obtain demographic and linguistic capacity data for the county's mental health workforce. Over 270 surveys were returned.

Just as the focus groups informed the WET plan actions, the staff survey was also central to the WET Planning Team's deliberations. Survey respondents indicated that they strongly preferred targeted consultation, clinical supervision and peer 'expert' support that responded immediately to specific treatment challenges. As a result, the WET Planning Team constructed a number of new and highly transformative structures that will be supported with MHSA funding including a peer support network, a framework for a clinical practices forum, and a flexible training fund that can be used to target training to specific needs identified by providers. High priority training needs identified by staff are listed below. Once WET funding is received, staff and programs will be able to submit requests to the WET Coordinator and the WET Committee to generate various forms of training that meet MHSA WET criteria, criteria developed by the WET Committee during the planning process. Criteria includes:

- ☐ Is the training evidence-based?
- ☐ Does the training increase the degree to which treatment is client or family driven?
- ☐ Is training either delivered by consumers or family members or intended to benefit them directly?
- ☐ Will the training increase the cultural competence of participants?
- ☐ Will the training contribute to the transformation of the system?
- ☐ Is it clear how training participants will be

Consumers	Family Members
☐ Better understanding of WRAP planning process ☐ Consumers should be able to train treatment staff in consumer perspective. ☐ Training to help staff be more 'welcoming', this and the need for training to be more sensitive to consumer needs were the two main 'training' needs identified. ☐ More entry level jobs for consumers ☐ Consumer advocates who "float" at the new campus and provide educational and other forms of support. ☐ Work with CBO's to foster inclusion of consumers and family members on boards and advisory committees. ☐ Pay for consumers in CBO's is below Marin 'living wage'	☐ Consistently identified the need for better family orientation about status of family member, diagnosis and resources available. ☐ Significant criticism of the necessity to go through CJ system to access services. ☐ Family members feel that staff do not understand the full PES/CJ/CIT processes or the full range of options for access to services and supports. ☐ Sense that staff should be more welcoming and consumer friendly. ☐ Better training in working with and communicating with families and engaging them in the treatment process and not to limit questions about family to the 'emergency contact' person. ☐ Better protocols in relation to PES with notification of family members before release so they can be there to help client. ☐ Increase opportunities for family member to have input upon diagnosis. ☐ Develop getter ties with NAMI. ☐ There were many concerns that the only entry point to CMHS is through the Criminal Justice system and that this process results in a permanent record and an unnecessarily long time in jail, etc. ☐ Training is needed in relation to PTSD. ☐ Training is needed in relation to working with TAY. ☐ More training is needed in relation to self-care, education, employment and living skills. ☐ There is a need to achieve a better understanding of holistic health practices. ☐ Increase/improve family partnership practices and better understanding of recovery. ☐ Medication management training is needed. ☐ Dual diagnosis training is needed. ☐ Motivational interviewing training is needed.

able to share what is learned with other colleagues?

Training topics identified as high priority in the staff survey include:

- ☐ Evidenced-based models of treatment such as cognitive behavioral therapy (CBT), dialectical behavioral therapy(DBT), parent-child interaction therapy(PCIT), family therapy, motivational interviewing, best practices for home visits by paraprofessionals for the 0-5 age group. All training should be supported with ongoing consultation.
- ☐ Integrated dual diagnosis treatment, stage-wise treatment and motivational treatment.
- ☐ Illness management and recovery.
- ☐ Training for: attachment disorder with incarcerated parents, sexual abuse, differential diagnosis and substance abuse, crisis diversion for children and adolescents.
- ☐ Training for schools on how to manage crisis situations without calling police.
- ☐ Additional training in building language skills, particularly in Spanish to assist with family engagement and parenting skills.
- ☐ Employment support and retention for consumer employees.
- ☐ Training on motivational treatment.
- ☐ Training about local resources for adult children of aging parents.
- ☐ Training on age-associated cognitive impairments for the community.
- ☐ Training on crisis diversion for community organizations.
- ☐ Training, education and support for families through local agencies for families of children with severe emotional disturbance.
- ☐ Training, education and support for families through local agencies for families of adults with mental illness.
- ☐ Training for mental health workers about trauma and mental illness, physical health care issues, weight, smoking, diabetes, and dental issues.
- ☐ Ongoing training on Family Partnership using the New Zealand model.
- ☐ Leadership training for managers of mental health programs and future managers of mental health programs.
- ☐ Training on collaborating with physical health care organizations and providers.

The staff survey also revealed a surprising lack of understanding of integrated dual disorder treatment, as many staff indicated that many of their clients were difficult and needed to receive substance abuse treatment *prior to* entering mental health services. In part, as a result of the prevalence of these comments, the WET Planning Team prioritized the delivery of Integrated Dual Disorder Training as a high priority need. It was scheduled for 2009-10 because of the anticipation of final approval from DMH not occurring until January and the need to seek bids and plan thoughtfully for the IDDT. No funds are identified in Exhibit 6 (budget) as the time period for the budget only extends through 2008-09, however, this action is described in Exhibit 4 because of the importance of the training need.

The WET plan also includes strategies that directly respond to workforce demographic data that illustrated significant differences in culture and spoken languages between the client population and the current staff. This discrepancy was noted both in the MHSA CSS plan and the Workforce Planning Initiative and as a result, the WET plan includes significant resources to provide stipends for interns who specifically address hard-to-fill positions and / or to increase the cultural diversity and language capacity of the system.

Finally, a second survey of CBO directors and county mental health program managers was used to get input into the scope of consumer and family member employment throughout the system and to achieve a better, more specific understanding of the precise positions that managers found 'hard-to-fill.' This survey was used to help complete sections of Exhibit III.

As this summary indicates, Marin County has conducted a thoughtful and comprehensive outreach effort that engaged consumers, family members, providers, and partners in a thoughtful planning process designed to use MHSA WET Funds to fuel system transformation and increase the cultural diversity and competency of the system.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers):										
Mental Health Rehabilitation Specialist	12									
Case Manager/Service Coordinator	12									
Employment Services Staff	4									
Housing Services Staff										
Consumer Support Staff		1	3							
Family Member Support Staff		1	1							
Benefits/Eligibility Specialist										
Other *Unlicensed* MH Direct Service Staff	34	1		(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	**62**	**3**	**4**	**44**	**4.0**	**4.0**	**1.75**	**0**	**8.25**	**62**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	19									
Case Manager/Service Coordinator	8		2							
Employment Services Staff	9									
Housing Services Staff	32									
Consumer Support Staff	5	1	5							
Family Member Support Staff	0	1	1							
Benefits/Eligibility Specialist	13									
Other *Unlicensed* MH Direct Service Staff	21	1		(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	**107**	**3**	**8**	**71.5**	**11.5**	**17.5**	**1**	**0**	**5.5**	**107**
Total, A (County & All Other):	**169**	**6**	**12**	**115.5**	**15.5**	**21.5**	**2.75**	**0**	**13.75**	**169**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11) White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	10		1							
Psychiatrist, child/adolescent	3	1								
Psychiatrist, geriatric	0									
Psychiatric or Family Nurse Practitioner	6	1	1							
Clinical Nurse Specialist	3									
Licensed Psychiatric Technician	5									
Licensed Clinical Psychologist	13									
Psychologist, registered intern (or waivered)	30	1								
Licensed Clinical Social Worker (LCSW)	26	1	2.5							
MSW, registered intern (or waivered)	3									
Marriage and Family Therapist (MFT)	76		2.5							
MFT registered intern (or waivered)	18	1								
Other *Licensed* MH Staff (direct service)	2									
				(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, B (County)	**195**	**5**	**7**	**127.5**	**28.5**	**5**	**15**	**0**	**19**	**195**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	6		1.2							
Psychiatrist, child/adolescent		1								
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner		1	2							
Clinical Nurse Specialist										
Licensed Psychiatric Technician										
Licensed Clinical Psychologist		1								
Psychologist, registered intern (or waivered)	9	1								
Licensed Clinical Social Worker (LCSW)	5	1	3.5							
MSW, registered intern (or waivered)	8		1							
Marriage and Family Therapist (MFT)	29	1	3.5							
MFT registered intern (or waivered)	55	1								
Other *Licensed* MH Staff (direct service)	3			(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, B (All Other)	**115**	**7**	**11.2**	**81**	**11**	**0**	**8**	**0**	**15**	**115**
Total, B (County & All Other):	**310**	**12**	**18.2**	**208.5**	**39.5**	**5.0**	**23**	**0**	**34**	**310**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes' 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician										
Registered Nurse	12	1	1							
Licensed Vocational Nurse										
Physician Assistant	7									
Occupational Therapist										
Other Therapist (e.g., physical, recreation, art, dance)	0									
Other Health Care Staff (direct service, to include traditional cultural healers)		1		(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	**19**	**2**	**1**	**10**	**0**	**0**	**3.5**		**5.5**	**19**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician										
Registered Nurse		1	1							
Licensed Vocational Nurse										
Physician Assistant										
Occupational Therapist										
Other Therapist (e.g., physical, recreation, art, dance)	4.0									
Other Health Care Staff (direct service, to include traditional cultural healers)	13.0	1		(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	**17.00**	**2**	**1**	**9.00**	**3.5**	**2.0**			**2.5**	**17.00**
Total, C (County & All Other):	**36.00**	**4**	**2**	**19.00**	**3.5**	**2.0**	**3.5**		**8.0**	**36.00**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....	5									
Supervising psychiatrist (or other physician)										
Licensed supervising clinician.....	2									
Other managers and supervisors.....	15									
				(Managerial and Supervisory; Sub-Totals Only) ⬇						
Sub-total, D (County)	**22**	**0**	**0**	**12.0**		**3.25**	**3.25**		**3.5**	**22.00**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....	15									
Supervising psychiatrist (or other physician)		1								
Licensed supervising clinician.....	13.5	1	1							
Other managers and supervisors.....	25.5									
				(Managerial and Supervisory; Sub-Totals and Total Only) ⬇						
Sub-total, D (All Other)	**54**	**2**	**1**	**43.5**	**.75**	**3.25**	**0**	**0**	**6.5**	**54**
Total, D (County & All Other):	**76**	**2**	**1**	**55.5**	**.75**	**6.5**	**3.25**	**0**	**10.0**	**76**
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....	**9.25**									
Education, training, research	**0**									
Clerical, secretary, administrative assistants.....	**37.5**		**1.5**							
Other support staff (non-direct services).....	**13.25**									
				(Support Staff; Sub-Totals Only) ⬇						
Sub-total, E (County)	**60**	**0**	**1.5**	**30**	**13**	**0**	**4.75**	**0**	**12.25**	**60**
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....	**8.25**	**1**								
Education, training, research	**10.5**									
Clerical, secretary, administrative assistants.....	**28.25**		**1.5**							
Other support staff (non-direct services).....	**5**									
				(Support Staff; Sub-Totals and Total Only) ⬇						
Sub-total, E (All Other)	**52.25**	**1**	**1.5**	**20.25**	**13.25**	**6.5**	**7.25**	**0**	**5.0**	**52.25**
Total, E (County & All Other):	**112.25**	**1**	**3**	**50.25**	**26.25**	**6.5**	**12**	**0**	**17.25**	**112.25**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category –

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

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).....**	**358**	**10**	**13.5**	**223.5**	**45.5**	**12.25**	**28.25**	**0**	**48.5**	**358**
All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)	**345.25**	**15**	**22.7**	**209.5**	**50**	**29.5**	**14.25**	**0**	**41.75**	**345.25**
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	**703.25**	**25**	**36.2**	**433 64%**	**95.5 12%**	**41.75 5.9%**	**42.5 6.33%**	**0**	**90.25 11.8%**	**703.25**

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			**2655 67.8%**	**600 15.3%**	**379 9.7%**	**138 3.5%**	**19 0.5%**	**127 3.2**	**3918**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Major Group and Positions	Estimated # FTE authorized and to be filled by clients or family members	Position hard to fill with clients or family members? (1=Yes; 0=No)	# additional client or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff.....	6.30	1	6
Family Member Support Staff	3.0	1	2
Other *Unlicensed* MH Direct Service Staff.....	5.0	1	
Sub-Total, A:	**14.30**	**3**	
B. *Licensed* Mental Health Staff (direct service).....	**0**	**1**	
C. Other Health Care Staff (direct service)	**1**	**1**	
D. Managerial and Supervisory.....	**4**	**1**	
E. Support Staff (non-direct services).....	**5**	**1**	
GRAND TOTAL (A+B+C+D+E)	**10.0**	**4**	**8**

III. LANGUAGE PROFICIENCY

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

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. Spanish	Direct Service Staff 79 Others 35	Direct Service Staff 11 Others 9	Direct Service Staff 90 Others 44
2. French	Direct Service Staff 18 Others 5	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
3. Cantonese	Direct Service Staff 9.25 Others 3.0	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
4. Thai	Direct Service Staff 6.25 Others 0	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
5. Farsi	Direct Service Staff 5.25 Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

A. Shortages by occupational category:

An analysis of surveys of Marin CMHS managers and Marin CBO directors revealed that there are a number of specific occupational categories that are historically hard to fill. The most frequently identified positions include: child psychiatrist, child psychologist, psychiatric nurse practitioner, consumer / peer counselor, and family support counselor. In addition, CMHS managers and CBO directors identified a challenge in recruiting bilingual Spanish or bilingual Vietnamese direct service staff in all positions, especially therapists. Focus groups with managers and dialog with WET Planning Committee representatives amplified upon findings from this survey. In these meetings the following positions were identified as difficult to fill:

- ☐ Therapists with expertise treating PTSD, especially with people of color
- ☐ Early childhood, 0-5 treatment staff, particularly males
- ☐ African American therapists
- ☐ Psychiatrist
- ☐ Nursing in general
- ☐ Night shift personnel in all positions
- ☐ Peer counselors and especially bilingual peer counselors
- ☐ Planning analyst and/or data analyst

The research conducted as part of Marin County's Workforce Planning Initiative revealed that the major barriers to recruiting individuals in these occupations are the competition with surrounding counties and the extremely high cost of living resulting in large part from a housing market that is among the highest priced in the nation. High housing costs create a significant impediment to recruiting interns, staff of color, and hard-to-fill positions outlined above.

As will be described below, across virtually all occupational categories, the workforce for Marin County's public mental health system is largely Anglo and while it may be roughly representative of the population it serves, this is largely because the system significantly under-serves its Latino and Asian population while African Americans are over-represented in the system largely due to being over-identified by the criminal justice, social service and educational systems. As a result, within each occupational category, there is a critical need to diversify and to build both cultural and linguistic competence.

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

A comparison of totals represented in Tables E and F reveals that CMHS and CBO staff are surprisingly representative of the cultural composition of the clients served by the public mental health system. However this comparison doesn't account for several factors. First, Table E understates the extent of this under-representation as it aggregates direct service, supervisory and support staff. As the table at left reveals, the clerical support staff is significantly more diverse than direct service staff masking the lack of diversity among direct service staff. Second, the system significantly under-serves the Latino and Asian population and over-serves the African American community. For example, Latino's represent roughly approximately 35% of the population living in poverty and eligible for CMHS services, yet Latinos represent only 15% of the clients served by the public mental health system. Asian Americans represent 5.8% of the general population and 7% of the population living in poverty, yet only represent 3.5% of the clients served by the system. The challenge in relation to African Americans is not so much an inadequate number of African American staff as it is the large number of African Americans who are inappropriately served by the mental health system due to the over-identification of African Americans by the criminal justice, social / child welfare, and educational systems. Focus groups conducted during the Community Services and Supports planning process indicated that people of color preferred to be served by a diverse system and the lack of both cultural diversity and linguistic capacity undoubtedly contributes to the degree to which the system under-serves Latino and Asian populations. In short, if the mental health system was effective in identifying and engaging Latino and Asian populations, it would expect that its client population would be 30-35% Latino and 7% Asian Pacific Islander. In that context, the system's staffing should be significantly more diverse. Further, the absence of more bilingual/bicultural staff is an important reason why the system is not fully engaging communities of color.

Population	Unlicensed Table A	Licensed Table B	Indirect Table D
African American	13%	2%	6%
Latino	9%	13%	23%
API	2%	7%	7%

Marin County's Workforce Planning Initiative found a similar cultural imbalance throughout the public sector workforce and has made diversification of the workforce a significant goal of the WPI. Marin CMHS will work closely with the County WPI to utilize the scores of employee candidate resources where a more diverse workforce can be engaged and recruited. The MHSA WET plan includes numerous strategies to use internships and scholarships to attract a more diverse workforce.

C. Positions designated for individuals with consumer and/or family member experience:

In interviews with managers and directors, there was a consensus that trying to recruit consumers and family members is an ongoing challenge. More specifically, managers and directors identified the even greater need to recruit family members and consumers who are African American, or bilingual / bicultural Latino, Chinese, or Vietnamese. Further, the absence of a clear career ladder for consumers limits their opportunities for employment in the system. The WET Coordinator will be responsible for working with Human Resources to encourage the use of life experience alternatives to degrees or work experience so as to facilitate consumers entering and advancing in the workforce.

D. Language proficiency:

As would be expected, the under-representation of people of color in the public mental health workforce contributes to a significant need for more bilingual staff. The Exhibit 3 table summarizing language proficiency of direct service staff and of other staff depicts the critical need for expanding the pool of direct and indirect service staff proficient in all non-English languages spoken by the client population. By way of illustration, there are only four staff who are bilingual Vietnamese or Tagalog and two bilingual Russian staff while all three of these populations are growing among the population served by the public mental health system. While there are almost 80 direct service staff who identified as being Spanish-speaking the system is not designed to fully identify and use these individuals bilingual skills effectively. Further, even this number is inadequate to serve the current level of Latino clients, let alone those that should be served if the system were fully serving that population.

As in the discussion of cultural diversity (Section B, above) one must be cautious when considering the number of the workforce who are bilingual and the need for a more linguistically competent workforce. As noted above, the Latino population is significantly under-served by the system and to a lesser degree so are Marin's Asian populations. While the 7.93% of direct service staff that is bilingual in Spanish is higher than the percent of Latino clients served and the nine Cantonese speaking direct service staff (1.88%) roughly matches the proportion of API clients served by the system, the Community Services and Supports plan pointed out that both of these populations are significantly under-served. For example, only 15% of clients served by Marin's public mental health system are Latino, while according to the 2000 census data 11.1% of Marin's population is Latino and 35% of County's population living in poverty is Latino. It can be assumed that the extent to which the County is under-serving these populations is the degree to which a lack of cultural diversity and linguistic capacity limits engagement efforts. In short, a significant increase is needed in the number of bilingual public mental health staff in Spanish and Cantonese. What's more, bilingual staff are needed to serve populations that are increasing in the County, primarily Vietnamese.

E. Other, miscellaneous: N/A

EXHIBIT 4: WORK DETAIL

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

A. **WORKFORCE STAFFING SUPPORT**

Action #1 – Title: Training Coordinator

Description: The Training Coordinator will perform a number of key functions in coordinating the delivery of training, consultations, internships, and other workforce related capacity-building efforts, including:

- *Staffing of the Training Committee*: Coordinator will serve as staff to the Training Committee with duties including developing a system for requesting training and consultation services, providing data on satisfaction and impact of training activities, and reporting on other MHSA related training, internship, and consultation efforts.
- *Developing Peer Consultation Network (PCN, described below)*: Duties include marketing the opportunity to become a peer expert in the *PCN*; managing the system through which applicants for expert status apply to the Training Committee for approval; managing the framework for ensuring equitable use of the system; and providing satisfaction data from users of the system.
- *Clinical Practice Forums (CPF)*: Marin's WET plan includes the creation of a system of *Clinical Practice Forums* on topics identified by providers as areas where ongoing clinical conversations, review of research, and shared learning can occur. The Training Committee will establish a set of criteria defining eligible topics for a CPF and procedures for nominating and approving a CPF and for monitoring and evaluating their implementation. The Training Coordinator would manage this process, collect data on CPF implementation and report to the Committee.
- *Managing Evidence Based Training for Transformation: One* key function of the Training Coordinator will be to analyze the results of staff, consumer and family surveys to identify training needs necessary to effecting the kind of system transformation envisioned in the MHSA. Once the analysis is complete, the Coordinator will work with staff, consumers and family members to identify training resources responsive to those needs. Resources may include local experts from the *PCN*, family members and consumers or family/consumer organizations like NAMI Marin, Community Action Marin, and the Network of Mental Health Clients. Other resources may be Community Mental Health, or other Health and Human Services divisions, as well as other experts in cultural competence services, delivery of consumer-driven services, and strategies for working more effectively with families. With specific amounts targeted to support training in treatment issues, family issues and consumer issues, the Training Coordinator will be responsible for managing these budgets and ensuring that each component of the Training for Transformation actions are being implemented effectively and utilizing the budget available.
- *Internship Development:* The WET plan calls for the development of a system for recruiting interns meeting very specific criteria related to increasing the cultural composition of the workforce, the degree to which hard-to-fill positions are being filled (and filled with a more culturally diverse individuals) and to increase internship opportunities for consumers and family members. The Coordinator will be responsible for managing the recruitment system, processing applications, and submitting recommendations to the Training Committee. The Coordinator will also work with CBO's and the County to expand clinical supervision options enabling more agencies to engage interns supported through this initiative. These activities will require ongoing relationship building with universities and colleges, CBOs and County

administration. The Coordinator will be the key facilitator responsible for building the relationships and managing an infrastructure that monitors implementation and the impact of this system.

- ☐ *Scholarships for Consumers, Family Members, & Interns Filling Hard-to-Fill Positions*: The WET plan calls for the provision of scholarships to individuals who can expand the involvement of consumers, family members, and under-served populations in the public mental health system. The implementation of this system will require someone to develop consensus about priorities, market and accept applicants, and manage the review and approval of applications. The Coordinator will serve in this capacity.
- ☐ *Coordination with Human Resources Department:* A key responsibility of the Coordinator will be to work with a Training Committee Sub-committee for Consumer and Family Member Training and to work with the County Human Resources Department to encourage changes in hiring policies that will recognize life experience as comparable with work or educational experience. The Training Coordinator will be one of the key staff responsible for fostering the development of a career ladder for consumers and family members working in the mental health system. In addition, the Coordinator will work with Human Resources to identify ways to create release time for staff and to provide either compensation for staff who devote significant levels of time to WET activities (e.g. CPF and/or PCN) or to their agencies who are providing release time for their involvement in these activities.

Taken together, the Coordinator serves as a critical central coordinator for a variety of workforce-related system transformation functions. Without the capacity to coordinate the above actions, these transformative activities would not be implemented effectively and would not be monitored and evaluated for each action's impact.

Objectives:

The following objectives apply to the work of the Training Coordinator. Specific measurable performance measures and timelines will be developed for each of the objectives below. This timeline and the performance measures will be monitored by Marin CMHS Director and reported to the Marin Mental Health Services Act Implementation Committee.

- ☐ Provide research, data, and communication to the MHSA WET Training Committee to assist them in oversight of the MHSA WET annual budget and work plan;
- ☐ Develop a system of performance measures and a time line for the WET Coordinator function;
- ☐ Recruit members to ensure that the WET Training Committee includes both consumers and family members and represents the cultural composition of the population served by the public mental health system;
- ☐ Develop, maintain and strengthen relationships with a wide range of regional stakeholders in workforce development, as well as among the provider, consumer and family communities and the cultural communities served by the public mental health system;
- ☐ Evaluate the impact of WET actions and report on this impact to the WET Training Committee;
- ☐ Prepare and submit periodic reports to the California Department of Mental Health, as per DMH guidelines.

Budget justification: WET Coordinator @ $80,000 to include salary and benefits.

Budgeted Amount:	**FY 2006-07: $ 0**	**FY 2007-08: $ 0**	**FY 2008-09: $ $80,000**

Action #2 – Title: Workforce Education & Training Plan Facilitation

Description: Consultant will develop surveys, conduct focus groups, review required DMH regulations related to WET plan requirements, facilitate WET planning team, conduct necessary research to support plan development and prepare written plan and budget for review by the WET Planning Team and the Marin MHSA Implementation Committee.

Objectives:

- ☐ Develop survey to obtain data on workforce demographics, language capacity, and training priorities;
- ☐ Conduct focus groups with consumers and family members;
- ☐ Develop data collection tools to identify hard-to-fill occupational positions;
- ☐ Prepare all Exhibits I-VI for submission, review and approval by the Marin MHSA Implementation Committee and the California Department of Mental Health.

Budget justification: Consultant contract for $20,000 (funding from one-time monies so it is not included below)

Budgeted Amount:	**FY 2006-07: $ 0**	**FY 2007-08: $ 00**	**FY 2008-09: $ 0**

B. TRAINING AND TECHNICAL ASSISTANCE

Action # 3 – Title: Peer Consultation Network

Description: The Peer Consultation Network will create a system for identifying staff working in the public mental health system, either County staff or CBOs, who have a specific expertise in a variety of high priority treatment issues. These peer 'experts' would be available for phone, email and/or personal consultation on specific treatment challenges. Experts would develop a brief profile outlining their expertise and experience in a variety of areas and post this on a system intranet or interactive website. Other treatment providers would be able to key in a description of their treatment challenge into a search engine which would then identify a list of experts.

The Marin County Training Committee would identify and post the need for specific expertise and then screen individuals who apply for expert status. Funding in Year I would be used to conduct research and planning to create a system that would allow for PCN experts either to be compensated for their work or to receive release time. In subsequent years, funding would be used either to compensate PCN experts and/or to fund agencies whose expert personnel were being utilized by other agencies, thereby reimbursing them for the lost productivity of their 'expert' staff.

This action responds to the staff survey that identified peer consultation as the most preferred form of training or support. It also fosters the development of 'in-house' expertise that is immediately responsive to specific treatment challenges. Initially, the Training Committee will prioritize approving applicants with expertise in treatment areas related to wellness and recovery, WRAP planning, peer and family-related issues, and other topics related to system transformation and MHSA priorities, but over time the system will be used to develop a comprehensive consultation expertise in a wide range of treatment issues.

This is an example of an action that would be developed and coordinated by the MHSA Training Coordinator who will be responsible for staffing the Training Committee, overseeing the development of the system, marketing it to the workforce, coordinating the application and approval process, and managing the budget.

Objectives: Objectives for the first year of planning include:

- ☐ Develop of a system for managing the delivery of technical support to be provided by a cadre of local experts available for consultation in high priority areas identified by treatment staff;
- ☐ Develop a system for identifying experts and criteria for selecting them; and
- ☐ Develop tools for evaluating the effectiveness of the system once it is in place.
- ☐ Create a system of rewards/compensation for teams/agencies that supply trainers.

Budget justification: Consultant contract to research and design the PCN system in consultation with the Training Coordinator. Up to $15,000 maximum.

Budgeted Amount:	**FY 2006-07: $_____0_____**	**FY 2007-08: $_____0_____**	**FY 2008-09: $_15,000_____**

Action # 4 – Title: Targeted Training in Evidence-Based Practice that Support System Transformation

Description: Targeted Training is a flexible fund designed to support the delivery of a range of training in evidence-based practices. Requests for training will be accepted from individual staff or from county managers and CBOs, as well as from organizations representing consumers and family members. The Training Committee will review all requests for training and use criteria aligned with the MHSA WET priorities to determine if and when training will occur. Applications for training will include a description of the purpose of training, documentation that it is an evidence-based practice; description of how it responds to MHSA priorities; description of how it can contribute to system transformation, and how training participants would share what is learned with staff who do not attend.

A survey was conducted of County and CBO staff and focus groups and interviews were conducted to identify an initial list of areas in which training would be desirable. Over 125 staff, consumers and family members responded to this survey. There was a general consensus that the highest priority areas for training were in relation to serving consumers with multiple challenges, differential and/or dual diagnoses, and / or resistant to engagement and treatment compliance. Among training identified by staff as a high priority: WRAP plan development, culturally competent treatment strategies, evidenced-based models of treatment such as cognitive behavioral therapy(CBT), dialectical behavioral therapy(DBT), Integrated Dual Disorder Treatment, PTSD treatment, parent-child interaction therapy(PCIT), family therapy, motivational interviewing, best practices for home visits by paraprofessionals for the 0-5 age group and other training needs identified by the Training Committee.

The logistics of securing trainers and scheduling training activities will be the responsibility of the Training Coordinator, as will it be the Coordinator's responsibility to ensure that all training includes a survey for participants to evaluate the quality of the training and the degree to which what was learned will influence future service delivery. The Coordinator will also follow-up with participants 3-6 months later to assess the degree to which what was learned in the training has been applied as intended and if and how what was learned was shared with other colleagues who could not attend.

Objectives:

- ☐ Organize delivery of a range of training, consultations, coaching, and educational offerings that are responsive to consumer, family and staff identified needs and requests.
- ☐ Develop a Targeted Training system for enabling staff, consumers and family members to request funds to support delivery of specific evidence-based training, consultation, coaching and educational supports that support system transformation, increase cultural competency, increase the degree to which services are consumer and family focused and contribute to the transformation of the public mental health system.
- ☐ Develop a set of criteria to be used by the Training Committee to evaluate and approve Targeted Training activities.
- ☐ Develop a system for evaluating the immediate and longer-term benefits of each Targeted Training activity and of the Targeted Training action as a whole.

Budget justification: $60,000 pool of funds available for training, coaching, consultation and education activities identified by staff, consumers, and family members, and approved by the Training Committee.

Budgeted Amount:	**FY 2006-07: $_____**	**FY 2007-08: $_____**	**FY 2008-09: $ 50,000**

Action # 5 – Title: Consumer-Focused Training

Description: In focus groups and as represented in WET planning meetings by staff from consumer organizations, consumers indicated a desire for training that might enable them to qualify for employment in the public mental health system. To ensure that the perspective of consumers is integrated into ongoing training priorities, two consumers will be on the Training Committee and a Consumer and Family Member Training Sub-committee will be charged with developing recommendations to the full committee in how best to integrate the perspective of consumers (and family members) in all training and to ensure that a career pipeline evolves that targets consumers and family members and facilitates their entry into and advancement within the public mental health system. A key responsibility of the Coordinator will be to work with this Sub-committee and to work with the County Human Resources Department to encourage changes in hiring policies that will recognize life experience as comparable with work or educational experience.

Among the possible training options are: WRAP plan development, consumer-driven treatment strategies, and culturally competent treatment strategies. There was also a strong desire expressed by both consumers and family members for training in a range of areas focusing upon helping providers better understand the perspective, priorities and needs of consumers and family members. It was felt that this kind of training might be best delivered by consumers and family members themselves.

Objectives:

- ☐ Increase understanding of treatment providers in relation to the consumer perspective on treatment and supports.
- ☐ Increase understanding among treatment providers of the different cultural perspectives of consumers.
- ☐ Increase training opportunities for consumers that are designed to prepare consumers for entry into the workforce and to advocate for consumer-driven reforms, and to play leadership and advisory roles in the mental health system.
- ☐ Increase the number of training sessions delivered by consumers and consumer organizations.

Budget justification: Flex fund for delivery of series of consumer-focused trainings at an average cost of $5,000-$10,000.

Budgeted Amount:	**FY 2006-07: $ 0**	**FY 2007-08: $ 0**	**FY 2008-09: $** 25,000

Action # 6 – Title: Family-Focused Training

Description: In focus groups and as represented in WET planning meetings by staff from family organizations, family members indicated a desire for training designed:

- To enable family members to qualify for employment in the public mental health system
- To increase the capacity of family members to serve in policy, oversight, and planning roles within the system;
- To improve family members' capacity to support their relative in treatment and maintaining independence; and
- To increase the capacity of treatment providers to work effectively with family members, to engage them in treatment planning, and to utilize them as a resource in supporting the consumer.

Among the possible training options are: understanding consumer and family member rights as relates to confidentiality and increasing provider understanding of how to work with families and procedures related to AB 1424. There was also a strong desire expressed by both consumers and family members for training in a range of areas focusing upon helping providers better understand the perspective, priorities and needs of consumers and family members. Family members felt that this kind of training would be best delivered by family members or organizations with a history of advocating for the rights of family members, e.g. NAMI.

Objectives:

- Increase understanding of treatment providers in relation to the family perspective on treatment and supports.
- Increase understanding among treatment providers of the different cultural perspectives of families.
- Increase training opportunities for family members designed to help them better support their family member, to advocate for consumer and family-driven reforms, and to play leadership and advisory roles in the mental health system.
- Increase the delivery of training delivered by consumers and consumer organizations.

Budget justification: Flex fund for delivery of series of family-focused trainings at an average cost of $5,000-$10,000.

Budgeted Amount:	**FY 2006-07: $_____**	**FY 2007-08: $____0____**	**FY 2008-09: $ 25,000**

Action # 7 – Title: System Wide Integrated Dual Diagnosis Training

Description: During FY 2008-09, the county will identify an expert trainer who in 2009-10 will provide a year-round series of Integrated Dual Disorder Treatment (IDDT) trainings, phone consultations, and train the trainer trainings designed to build a stronger system-wide understanding of integrated dual disorder treatment. This was an area of training identified by treatment staff as being of very high priority. In addition, the most challenging cases identified in open-ended survey questions indicated that many staff felt that individuals with dual disorders should first seek/obtain substance abuse treatment prior to receiving mental health services, an indication of a need to expand understanding of Integrated Dual Disorder Treatment.

At a minimum, the training would: 1) include a series of intensive trainings (12 sessions in multiple sites), 2) involve weekly consultation calls throughout the year, 3) incorporate a train the trainer approach resulting in the expansion of capacity to conduct ongoing training and capacity building in this area, and 4) monthly training and consultation. Training will be focused on stage wise treatment, motivational interviewing, and CBT. It is anticipated that training would occur during 2009-10 at a cost of approximately $108,000. While both CBO and county treatment staff identified this as a critical training need, Marin County feels it is imperative that this training be organized in such a way as to maximize its impact. To ensure this, Marin County would prefer to schedule the training after a Training Coordinator has been in place for several months and is able to effectively manage the logistics for such a system-wide training. Anticipating submission of the WET plan in November 2008 and approval no sooner than January, we have elected to include this Action as part of the 2009-10 fiscal year. As such no funding is included in Exhibit 6.

Objectives: Objectives will be revised once a training provider is identified and a precise scope of work developed, however, the training will be designed to:

- ☐ Increase knowledge of the principles of integrated dual disorder training among treatment providers system-wide.
- ☐ Increase capacity of treatment providers to deliver evidence-based integrated dual disorder treatment throughout the system.
- ☐ Increase system capacity to renew skills in integrated dual disorder treatment by developing an expanding core of local experts who can be available in the Peer Consultation Network (Action 3) and to facilitate Clinical Practice Forums (Action 9).

Budget justification: Precise budget to be negotiated in 2009. Detailed scope of work will be developed at that time.

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

Action # 8 – Title: Clinical Practice Forums

Description: Clinical Practice Forums would be learning forums facilitated by a forum sponsor. Sponsors would submit an application for funding and a list of individuals who are interested in participating in the forum. This application would be submitted to the Training Coordinator who would bring the request to the Training Committee for approval. Each forum would focus on a specific treatment topic where practitioners had identified the need to participate in ongoing dialog on the topic and possibly to involve expert practitioners from within and from outside the county system. Forums will be comprised of small groups (max. of 12) of service providers who will commit to attendance and will be granted release time for 2 hours a month for 6 months to participate. In year I four to six forums will be offered. Emphasis will be on creating learning communities that generate support and networking as well as acquiring new information. Groups will maintain waiting lists and monitor attendance so that should members drop out, others could join or if the waiting list becomes very long, a new forum on the same topic could be established. Priority will be for groups that:

- ☐ Are formed across treatment teams or sites (eg: County / CBO)
- ☐ Include or emphasize topics relevant to peers, consumers, and family members or that focus on topics directly related to system transformation and reinforcement of the principles of the MHSA.
- ☐ Include family members and/or consumers as members of the forum;
- ☐ Increase cultural competence or improve services to under-served populations.
- ☐ Describe in their proposal a clear, specific plan for sharing and/or extending the learning from the forum to other staff and/or other sites.

As part of their proposal to the Training Committee, groups could apply for funds to bring in an outside "expert" when specific consultation needs were defined and an appropriate consultant was identified. Groups could also apply to send members to attend a conference with a requirement that they present what they learn in the context of an ongoing forum. Each Forum will have required reading/homework, written confidentiality agreements, and a structured design to monthly sessions. Designated group leaders will have brief facilitation training prior to group start date as part of the plan. Group self-evaluations will happen pre, mid, and post group to assess learning and monitor utility of group structure and focus. Groups will be asked to give a "learning outcomes" report at the conclusion of the group and/or before seeking an extension for an additional 6 months. Groups may be invited to develop "Grand Rounds" presentations for the broader community that could be credited with CE units.

Objectives:

- ☐ Increase participant and system understanding of effective approaches to addressing high priority treatment challenges.
- ☐ Increased collaboration and collegiality across treatment sites.
- ☐ Increased reliance upon research and evidence-based practice to inform clinical practice and support services.

Budget justification:

Delivery of 4-6 Clinical Treatment Forums at an average cost of $5,000 per forum with funds used to compensate the facilitator of the forum.

Budgeted Amount:	**FY 2006-07: $____0____**	**FY 2007-08: $____0____**	**FY 2008-09: $___21,000____**

Action # 9 – Title: CIMH Mental Health Directors Leadership Institute Training

Description: One, three-day and several two-day California Institute of Mental Health (CIMH) sessions for the training of mental health leaders to address issues of leadership in system transformation. Sessions will focus upon issues related to MHSA and managing system transformation. Individuals interested in attending would submit an application to the Training Committee outlining why they would be a good candidate for leadership institute training and how they would utilize what they had learned in their current position and in possible advanced positions. Marin would send one person each year to strengthen leadership in the public mental health system with the intent of building leadership.

Objectives:

- ☐ Build broader strength in leadership of Marin County Mental Health Services
- ☐ Increase system readiness to address succession issues.

Budget justification:

Budgeted Amount:	**FY 2006-07: $_____0____**	**FY 2007-08: $_____0_____**	**FY 2008-09: $_$5,000_____**

EXHIBIT 4: WORK DETAIL

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS

No Mental Health Pathways programs were identified as part of Marin's WET plan.

D. RESIDENCY, INTERNSHIP PROGRAMS

Action #10 – Title: Intern Stipend System

Description: The Intern Stipend System would expand County/CBO support for interns and focus that expansion upon interns who would address MHSA principles. Agencies and county managers will submit requests for stipend support to the Training Committee who will decide upon which requests to approve. Priority would be given to interns who:

- would fill hard-to-fill positions as identified in Exhibit 3 of Marin County's MHSA WET plan,
- have family member or consumer experience, and/or
- would contribute to diversifying the cultural composition and competence of the public mental health system.

Funding in 2008-09 would provide $80,000 for stipends for interns serving either within a CBO or working directly for the County with the funding level sustained at this level through 2012 at which point it would likely be reduced. This initiative would build the capacity of CBO's while maintaining the commitment to interns serving the county. A key part of this initiative will be performed by the Training Coordinator who will be responsible for building relationships with surrounding educational institutions in order to recruit individuals who meet the priorities outlined above. The table below outlines some of the intern options that will be considered by the Training Committee. The Training Coordinator and Training Committee will explore a range of compensations other than pure stipends. These alternatives are outlined under Action # 11 that follows.

Time Commitment in Internship	Time Span	Proposed Stipend	License Track/Status
40-44 hrs./5 day/week (250 days/2000 hours)	12 Months	$12,000-15,000	FT PhD/PsyD, MFTI, ASW, OT, FNP, PA
24-30 hrs /3+ day/week (120 days/1000 hours	10	6,000-8,000	MSW-2nd yr ,MFTT, MFTI,)OT, .5 PsyDPhD,
20-24 hrs /2+ days (90 days/720-750 hours)	9	3,000-5000	MSW-2nd year, MFTT, RehabMA
16-20 hrs /2 days (50 days/480-500 hours)	8	1,500-2,500	MSW-1st year, MFTT, BSW, CADAAC
Add 8% differential for language proficiency to Deliver services in a second language			

Objectives:

- Increase cultural diversity of the treatment system
- Fill critical hard-to-fill positions identified in the WET plan

Budget justification: $80,000 in stipends will be available annually and the Training Committee will be responsible for working with the Training Coordinator to manage that budget using the stipend structures outlined in the table above. It is expected that this fund will support at 2-4 FT PhD/PsyD, MFTI, ASW, OT, FNP, PA; 2-4 second year interns, and 5 first year interns annually.

Budgeted Amount:	FY 2006-07: $ 0	FY 2007-08: $ 0	FY 2008-09: $ $80,000

D. RESIDENCY, INTERNSHIP PROGRAMS

Action #11 – Title: Psychiatric Nurse Practitioner Internships

Description:

Psychiatric Nurse Practitioners were identified as a hard-to-fill position in the needs assessment process that has informed the development of the MHSA WET plan. What's more, this position was identified as one that could significantly improve the quality of care, ensure the early identification of medical needs, facilitate access to primary care to address those needs, and improve monitoring, compliance and support for medication routines. While it is extremely expensive to recruit and fund psychiatrists, stakeholders felt that the expansion of the number of Psychiatric Nurse Practitioners was a cost-effective means of extending the impact of psychiatrists.

The Training Coordinator would be responsible for establishing and maintaining relationships with UCSF, UC Davis, and other educational institutions that train Psychiatric Nurse Practitioners and to implement recruitment efforts that target candidates from historically under-represented populations, especially individuals who are African American or bicultural and bilingual Spanish. Students often have $50,000 in loans and are seeking loan forgiveness, as they don't quality for the typical traineeship programs. In consultation with UCSF, it was advised that $7,000 in loan forgiveness would be a strong incentive for these students and that it could be modeled after the Kaiser Loan Forgiveness Program that is $5,000-7,500/year for 2 years. Leadership from UCSF also thought that a long-term solution would be for the county to become part of the National Health Service Corp (loan repayment of up to $50,000) or the State Loan Repayment Program that provides matching funds for loan forgiveness. The Training Coordinator would be responsible for exploring these options further.

Funding would support two interns annually.

Objectives:

- ☐ Expand number of Psychiatric Nurse Practitioners serving Marin County.
- ☐ Increase cultural diversity of nurse practitioners serving Marin County.
- ☐ Improve quality of medication management and access to primary care services for Marin County consumers.

Budget justification: $7,000 in stipends or loan forgiveness for each of two psychiatric nurse practitioner interns.

Budgeted Amount:	**FY 2006-07: $_____0_____**	**FY 2007-08: $____0_____**	**FY 2008-09: $__14,000____**

EXHIBIT 4: WORK DETAIL

E. FINANCIAL INCENTIVE PROGRAMS

Action # 12 – Title: Scholarships for Consumers, Family Members, and to Diversify the Workforce

Description: A fund will be established and administered by the Training Committee for the purpose of providing scholarships for consumers, family members and members of under-represented populations. The purpose of the fund will be to subsidize the cost of these individuals' education when the educational program will result in possible entry to or advancement within the public mental health system. The Training Committee will establish criteria for the kinds of educational programs it will consider and priorities for populations to be served. The Coordinator will receive applications and provide summaries to the Committee so that it can consider the applications, interview applicants who meet a threshold and award scholarships.

Objectives:

- ☐ Increase the number of consumers, family members, and under-represented populations working within the public mental health system.
- ☐ Facilitate consumers, family members and members of under-represented populations to advance in their careers in the public mental health system.

Budget justification: Provide a minimum of 12 scholarships to support consumers, family members and representatives of under-represented minorities. Scholarships will range from $2,500-$5,000 annually.

Budgeted Amount:	**FY 2006-07: $__0_____**	**FY 2007-08: $___0_____**	**FY 2008-09: $_30,000**

EXHIBIT 5: ACTION MATRIX

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

Actions (as numbered in Exhibit 4, above)	Promotes wellness, recovery, and resilience	Promotes culturally competent service delivery	Promotes meaningful inclusion of clients/family members	Promotes an integrated service experience for clients and their family members	Promotes community collaboration	Staff support (infrastructure for workforce development)	Resolves occupational shortages	Expands postsecondary education capacity	Loan forgiveness, scholarships, and stipends	Regional partnerships	Distance learning	Career pathway programs	Employment of clients and family members within MH system
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action # 1: Training Coordinator					X	X				X			
Action # 2: Planning Facilitation					X	X				X			
Action # 3: Peer Consultation Network	X	X			X								
Action # 4: Targeted Training in Evidence-Based Practices that Support System Transformation				X									
Action # 5: Consumer-Focused Training	X	X	X	X									X
Action # 6– Title: Family-Focused Training	X	X	X	X									X
Action # 7 – Title: System Wide Integrated Dual Diagnosis Training	X			X	X								
Action # 8 – Title: Clinical Practice Forums	X	X		X	X								
Action # 9 – Title: CIMH Mental Health Directors Leadership Institute Training	X			X									
Action #10 – Title: Intern Stipend System	X	X					X	X	X	X			
Action #11 – Title: Psychiatric Nurse Practitioner Internships	X	X					X	X	X	X			
Action #12 – Title: Scholarships for Consumers, Family Members, and to Diversify the Workforce	X	X	X	X			X		X			X	X

EXHIBIT 6: BUDGET SUMMARY

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

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

Fiscal Year: 2008-09			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:		$80,000	$80,000
B. Training and Technical Assistance			$141,000
C. Mental Health Career Pathway Programs			0
D. Residency, Internship Programs			$94,000
E. Financial Incentive Programs			$30,000
		GRAND TOTAL FUNDS REQUESTED for FY 2008-09	**$345,000**

EXHIBIT 7: ANNUAL PROGRESS REPORT (NOTE: This exhibit is for information purposes only, and does not need to be submitted with the Plan.)

List any objectives from any of the Actions that have been met during the period being reported, any issues that significantly impact on the accomplishment of objectives, and any positive accomplishments. Events, milestones, products, or outcomes are to be reported as measurable activities that can be quantitatively compared for the duration of the contract period.

ANNUAL PROGRESS REPORT County:_____ Component: **Workforce Education and Training**	Fiscal Year: _____ Period Covered: _____
Progress on Objectives (short narratives, below)	
Workforce Staffing Support:	
Training and Technical Assistance:	
Mental Health Career Pathways Programs:	
Residency, Internship Programs:	
Financial Incentive Programs:	
Form completed by: Name:_____ Title or position:_____ Phone#:_____ Email:_____ Date:_____	