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: San Francisco Date: March 16, 2008

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

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

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

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

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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.

Description of Working Committee

The Planning Process for the County of San Francisco's Workforce Development, Education and Training (WDET) component of the Mental Health Services Act was led by a working committee comprised of county employees, consumers, family members, representatives from community-based organizations and educational institutions. This committee was tasked to build upon the workforce development, education and training sub-committee issues identified during the 2005 Community Services and Supports planning process. The goal was to develop programs that would: 1) actualize the recommendations of the 2005 committee; 2) provide mental health educational opportunities to existing and potential employees; 3) address cultural and linguistic gaps in the mental health system; 4) encourage high school students and young adults to pursue careers in the mental health field; 5) provide support for implementation of recommended programs and activities; and 6) leverage existing resources such as CSS programs and activities and State initiatives.

The working committee was co-chaired by Toni Rucker, Director of Grants, Training & Development for Community Behavioral Health Services, and Dina Redman, MPH, PhD., LCSW, Assistant Professor of School of Social Work at San Francisco State University. Karen Strickland of Golden Bear Associates facilitated the meetings. Chandreve Clay and Tim Tabernik of Hatchuel Tabernik & Associates (HTA) conducted the workforce analysis and wrote the WDET Plan.

The working committee was comprised of:

- Andrea Canaan, California Institute for Mental Health and the Bay Area Mental Health Education Workforce Collaborative
- Belinda Lyons, Director of the Mental Health Association of San Francisco, Past Co-Chair of the Prop 63 Education and Training Committee
- Benito Casados, Peer Case Manager, Family Services Agency and Consumer
- Dale Milfay, Vice President, National Alliance for Mental Illness in San Francisco and Family Member
- Daniel Michael, Director of Vocational Services, RAMS (Richmond Area Multi-Services)
- Eduardo Morales, Professor and Director of the Doctorial Program, Alliant International University
- Helaine Weinstein, Assistant Director, Children's Mental Health Services/Department of Public Health
- James Peavey, Department of Public Health
- Janey Skinner, Director of the Regional Health Occupations Resource Center/Instructor, City College of San Francisco
- Joseph Subbiondo, President, California Institute of Integral Studies
- Juliet Valerio, Community Behavioral Health Services/Department of Public Health
- Kevin McGirr, Quality Management Office, Community Behavioral Health Services/Department of Public Health
- LaVon King, Family Member Representative on the Mental Health Board
- Lisa Fineberg, Vocational Counselor, Volunteer Center
- Lorna Jones, Community Vocational Enterprise

- Michael Smith, Policy Coordinator, Adolescent Health Working Group
- Michael Wise, MHSA Implementation Specialist, Community Behavioral Health Services/Department of Public Health and Consumer
- Roy Crew, Director, Office of Self Help
- Sandy Robison, Co-Coordinator Peer Internship Program at Community Behavioral Health Services/Department of Public Health and Consumer
- Susan Scheidt, Director of Training for Psychology Interns, University of California at San Francisco and San Francisco General Hospital

Summary of Meetings

The Working Committee met eight times between April and December 2007 and held one meeting entirely devoted to public comment to develop WDET recommendations. The co-chairs described how committee members were selected and how they would be the primary group to develop the county plan. The co-chairs provided guiding questions to focus on during meetings that adhere to the State requirements. The committee made a conscious effort to inform all Community Behavioral Health Services (CBHS) clinicians and providers and advocacy groups of the scheduled meetings by distributing flyers through various email groups and posting on the Department of Public Health (DPH) and MHSA websites and at community sites. In addition, consumer MHSA Implementation Specialists personally invited staff and consumers at primary care, mental health and substance abuse treatment sites, and distributed meeting announcements in neighborhoods disproportionately represented in our treatment system.

Each Working Committee meeting was open to the public and ended with a public comment period. Public comments were also solicited during course of the meeting. The co-chairs maintained email contact with the Working Committee and regularly emailed drafts and supporting materials between meetings as appropriate. All Working Committee Meetings and the Public Meeting were audio recorded and transcribed. Transcripts along with agendas and any other documents provided at the meetings were posted to the County MHSA webpage at: http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/WorkforceDevEducTrain/default.asp. Each meeting announcement included information about interpreter services that would be available upon request.

The public meeting drew an ethnic and linguistically diverse group from across San Francisco's many neighborhoods. A sampling from the public comments is listed below:

> *"Unfortunately, some providers feel that people with severe psychiatric issues cannot be rehabilitated and become an integral part of society. Case in point, when I had my first psychotic break in my early twenties and was hospitalized, I was told that I should, in essence, disown my family and live in an SRO. What the provider didn't realize was my family had been my sense of hope and support…."* ***From a consumer employed at Mental Health Association of San Francisco***
>
> *"I'm also a member of the Mission Health Clinic. Currently I'm on the board of directors of the Youth Training, Media Training Program called Conscious Youth Media…. So one of the reasons why I came here today is to ask you to prioritize service-providers that work with gangs in the Mission community…. So I come to help them become more like, get certifications, you know, get some perks for their work because they're professionals, just as much as LCSWs, teachers, lawyers and doctors, because they're, they are young people*

that were perpetrators of violence and are now case managers. They are young people, young adults, that were victims of violence that now are working and serving in the community." ***An advocate from the Mission District***

"I would recommend training that would be in an ongoing series, so fewer kind of one-shots…. Training that's hands on or, and case based and skills based…." ***Clinician and consumer***

"…we do workforce development in our training programs for individuals who often have mental health or co-occurring diagnoses or problems… we have really struggled to find peer placements, placements where people can do an internship. And because of confidentiality everybody is very reluctant to take our students as a placement. So that's something we'd like to really figure out." ***A Program Manager in a Supportive Housing Organization***

"…I'm concerned about the total black community. Because of the gang violence and the violence in the community…I think you definitely need to start in the high school and maybe the middle school…." ***Resident of Visitacion Valley***

"…I would like to see definitely like more seminars and maybe workshops in the community…. But it would be good if we could like maybe put on seminars and forums where the community could come and even be a part of…." ***Case manager at San Francisco General Hospital – Crisis Resolution***

"…hire these young people that are at one time are perpetrators and victims of violence to be advocates and case managers for their own peers?… And the funding, I'd prefer that you fund existing programs to do that training…. " ***A representative from the Legal Response Network***

"…those consultants help me to release a lot of my immigration stress and allow me to serve my family better. That's why I'm here to advocate for the mental health consulting education training programs, in particular for bilingual Chinese speaking consultants…." ***A representative from the Fu Ya Project***

"African-American men in mental health are missing. It's a big, big hole. They're not in the pipeline and there needs to be some encouragement for that to occur. Also we know the college rates for Latinos throughout the country is extremely low, like 10%. In terms of the workforce in California we're in a particular crisis in terms of getting into higher education, and if you're talking about master's and doctoral level students who are expert in the Latino community, it's extremely small…." ***Professor of Psychology at Alliant International University***

"And so in speaking specifically to this funding and perhaps and tie in with the prevention and early intervention funding that's to come, is thinking about how do you train high level school administrators to

create school climates that are actually, you know, places of peace and calm and where the academics don't create anxiety because the students aren't necessarily matched properly or the special education and the mental health issues are blended too differently. But how do you create a school culture that's accepting of mental health, promotes positive mental health and also strives to keep students in school?" ***Adolescent Health Work***

"I wanted to know, maybe there could be more programs for mental health, people interested in providing mental health services, and who better like the substance abuse counselors, who better to treat someone else if they've already walked in their moccasins a thousand miles?" ***Mental health consumer***

WDET Plan Approval

County Staff and Hatchuel Tabernik & Associates turned the Working Committee recommendations and Needs Assessment data into the final WDET Plan. The WDET Plan was then presented to and approved by the Community Behavioral Health Services/Department of Public Health Executive Committee. Subsequently, the Mental Health Board held a public hearing of the WDET Plan on April 9, 2008. The WDET Plan was posted on the CBHS/DPH public website for a 30 day public comment period from April 15, 2008 to May 14, 2008. Public comments were sent by email and included the following:

San Francisco Mental Health Board

- In addition to ethnicity and language capacity look at the balance of gender and LGBT in the workforce, including the balance at different skill levels.
    - The State guidelines for all county plans only require ethnicity and language data. The cultural competency survey used for this analysis does not include gender or sexual orientation of staff or clients. However, the department is working with the Cultural Competency unit to redesign the Fiscal Year 08-09 survey to include sexual orientation, gender and experience as a consumer of mental health services or family member of a consumer of mental health services.
- Focus more recruitment and education opportunities on consumers in the system than on high schools and colleges.
    - Recruitment and education opportunities will be open to all consumers and family member, whether they are currently in the system or in the general San Francisco community. It has been indicated by some committee members that there is a significant proportion of current community college and state university enrollees who are consumers or family members who are involved in or seek out mental health education programs.
    - There will be significant efforts to recruit consumers with varying severity levels and preparedness to embark on educational goals and employment opportunities, with the goal of having a transitional progression for everyone participating in these programs
- Insure that workforce development, education and training as well as housing opportunities are extended to the Southeast Sector of the County as well as other underserved and/or underrepresented areas.
    - The department is opening these opportunities for all consumers and family members throughout the City and County of San Francisco. Recognizing that the needs assessment results and committee recommendations highlighted the workforce gap for certain racial and ethnic community groups, there will be efforts to ensure that these under-represented groups are aware of opportunities for continuing education and career development. There will be trainings and recruitment efforts throughout the City and the Southeast

sector will be one of the neighborhoods for these outreach efforts. In addition, selection criteria such as under-represented centers and diversity would be considered in the RFP process.

- Process for people applying for permanent housing should be thoroughly vetted so that those who are homeless or near homeless have access to permanent housing.
    - While this is a worthwhile endeavor it is not relevant to the WDET funding. It is addressed by other funding initiatives.
- Training should be provided to smaller nonprofits to write grants and respond to RFP's
    - While this is a worthwhile endeavor it is not a mandate for the WDET funding. There are other resources that exist to help smaller nonprofits apply for competitive RFPs. In addition, selection criteria such as participation of underrepresented centers and diversity are considered in RFP responses.

Mental Health Association of San Francisco

- There is a lack of funding for one-time and on-going funding for consumers to serve as trainers to educate providers about the recovery model.
    - Many initiatives that are being recommended for funding will utilize consumers as trainers. In addition, in the existing budget, there are several funding categories wherein consumers could be trained as trainers. Although there are many worthwhile activities that will engage consumers and increase the diversity of the providers' service teams, not all of these could have been funded with the initial allocation. This is an area for expansion or for increased funding should the Committee deem them to be a priority for the augmented funding.
- No funds have been included to provide cultural sensitivity trainings for Native Americans.
    - A cultural sensitivity training for Native Americans is included in the workplan and budget for $10,000. An RFP will be awarded to respondents to address the need for either enhancing existing services for the Native American community or for implementation of a new program initiative. Again, this could be an area for increased funding or expansion with the augmented allocation.
- Why is a Crisis Intervention training included in the budget and plan? Isn't the WDET funding for workforce development?
    - The intent of the Crisis Intervention training is to provide on-site training to help community-based organizations to better address crises that might surface in the workplace, particularly when working with a community with complex needs and challenges. Employers will be trained in stabilization and de-escalation best practices as well as other supervisory practices that help them address behaviors that are inappropriate in the workplace.
- Include funds for a designated consumer based staff person to work with and address the concerns of consumers about the possible loss of SSI/SSDI benefits if they begin employment. This potential loss of benefits would be addressed as a barrier to consumers returning to or entering the mental health workforce.
    - While this is an important consideration, it falls outside the mandate of WDET funding which is focused on ensuring that consumers enter and are successful in the workforce. There are existing resources that should be able to address the consumers' concerns about potential loss of SSI/SSDI benefits.

Public comments were incorporated into the final plan submitted to and approved by the County Board of Supervisors on June 10, 2008 under resolution number 263-08. The final approved plan is hereby submitted to the State for review.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions	Estimated # FTE authorized	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/ Caucasian	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	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	5.5	0	0							
Case Manager/Service Coordinator	15.3	0	0							
Employment Services Staff	3.5	0	0							
Housing Services Staff	3.8	0	0							
Consumer Support Staff	5.0	0	0							
Family Member Support Staff	15.8	0	0							
Benefits/Eligibility Specialist	2.5	0	0							
Other *Unlicensed* MH Direct Service Staff	55.1	0	0	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, A (County)	106.3	**0**	0	19.7	11.0	40.8	24.5	1.0	4.9	101.8
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	14.2	0	0							
Case Manager/Service Coordinator	88.5	0	0							
Employment Services Staff	24.5	1	.5							
Housing Services Staff	116.0	1	1							
Consumer Support Staff	23.2	0	0							
Family Member Support Staff	3.0	0	0							
Benefits/Eligibility Specialist	4.7	0	0							
Other *Unlicensed* MH Direct Service Staff	278.3	1	32.87	(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Sub-total, A (All Other)	552.3	**3**	34.87	226.5	70.1	108.8	91.2	2.5	21.1	520.2
Total, A (County & All Other):	658.7	**3**	34.37	246.2	81.1	149.6	115.7	3.5	25.9	622.0

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*

I. By Occupational Category - page 2

Major Group and Positions	Estimated # FTE authorized	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-American / Black	Asian/ Pacific Islander	Native American	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	57.4	0	0							
Psychiatrist, child/adolescent	1.5	1	3							
Psychiatrist, geriatric	1.3	1	2.6							
Psychiatric or Family Nurse Practitioner	9.8	0	0							
Clinical Nurse Specialist	3.0	0	0							
Licensed Psychiatric Technician	65.9	0	0							
Licensed Clinical Psychologist	23.1	0	0							
Psychologist, registered intern (or waivered)	0.0	0	0							
Licensed Clinical Social Worker (LCSW)	72.1	0	0							
MSW, registered intern (or waivered)	37.0	0	0							
Marriage and Family Therapist (MFT)	31.4	0	0							
MFT registered intern (or waivered)	21.3	0	0							
Other *Licensed* MH Staff (direct service)	0.0	0	0	(*Licensed* Mental Health Direct Service Staff; Sub-Totals Only) ⬇						
Sub-total, B (County)	323.5	**2**	5.6	142.9	46.0	43.0	77.9	2.0	5.8	317.6
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	32.9	1	1							
Psychiatrist, child/adolescent	0.6	1	.8							
Psychiatrist, geriatric	3.3	1	.63							
Psychiatric or Family Nurse Practitioner	6.9	0	0							
Clinical Nurse Specialist	0.0	0	0							
Licensed Psychiatric Technician	28.5	0	0							
Licensed Clinical Psychologist	7.5	1	.35							
Psychologist, registered intern (or waivered)	11.7	0	0							
Licensed Clinical Social Worker (LCSW)	50.5	1	6.88							
MSW, registered intern (or waivered)	29.8	0	1.1							
Marriage and Family Therapist (MFT)	62.7	1	11.25							
MFT registered intern (or waivered)	62.9	1	1	(*Licensed* Mental Health Direct Service Staff; Sub-Totals and Total Only) ⬇						
Other *Licensed* MH Staff (direct service)	0.0	0	0							
Sub-total, B (All Other)	297.2	**7**	**23.01**	173.6	28.1	18.4	50.2	0.4	18.0	288.6
Total, B (County & All Other):	620.6	**9**	**28.61**	316.4	74.0	61.4	128.1	2.4	23.8	606.1

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*

I. By Occupational Category - page 3

Major Group and Positions	Estimated # FTE authorized	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/ Caucasian	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	Multi Race or Other	# FTE filled **(5)+(6)+(7)+(8)+(9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers):										
Physician	0.0	0	0							
Registered Nurse	93.9	0	0							
Licensed Vocational Nurse	17.8	0	0							
Physician Assistant	0.0	0	0							
Occupational Therapist	0.9	0	0							
Other Therapist (e.g., physical, recreation, art, dance)	1.5	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	69.6	0	0	(Other Health Care Staff, Direct Service; Sub-Totals Only) ⬇						
Sub-total, C (County)	183.6	0	0	61.8	13.6	24.7	79.8	0.0	2.9	182.7
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	0	0	0							
Registered Nurse	34.4	0	.5							
Licensed Vocational Nurse	10.9	0	0							
Physician Assistant	0.0	0	0							
Occupational Therapist	1.0	1	.9							
Other Therapist (e.g., physical, recreation, art, dance)	0.3	0	0							
Other Health Care Staff (direct service, to include traditional cultural healers)	60.8	0	0	(Other Health Care Staff, Direct Service; Sub-Totals and Total Only) ⬇						
Sub-total, C (All Other)	107.5	**1**	**1.4**	41.7	5.6	9.2	48.4	0.9	1.7	107.5
Total, C (County & All Other):	291.1	**1**	**1.4**	103.4	19.2	33.9	128.2	0.9	4.6	290.2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*

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-American/ Black	Asian/ Pacific Islander	Native American	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	17.4	0	0	(Managerial and Supervisory; Sub-Totals Only) ↓						
Supervising psychiatrist (or other physician)	6.2	0	0							
Licensed supervising clinician	16.8	0	0							
Other managers and supervisors	31.1	0	0							
Sub-total, D (County)	71.5	0	0	28.9	13.4	13.9	9.3	0.0	3.0	68.5
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	72.2	1	.65	(Managerial and Supervisory; Sub-Totals and Total Only) ↓						
Supervising psychiatrist (or other physician)	6.5	0	0							
Licensed supervising clinician	14.4	0	0							
Other managers and supervisors	105.7	1	2.5							
Sub-total, D (All Other)	198.8	**2**	**3.15**	110.7	20.8	22.9	29.2	1.5	7.0	192.1
Total, D (County & All Other):	270.3	**2**	**3.15**	139.6	34.2	36.8	38.5	1.5	10.0	260.6
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	7.5	0	0	(Support Staff; Sub-Totals Only) ↓						
Education, training, research	0.0	0	0							
Clerical, secretary, administrative assistants	71.8	0	0							
Other support staff (non-direct services)	3.0	0	0							
Sub-total, E (County)	82.3	0	0	12.5	17.4	19.0	27.2	1.0	1.0	78.1
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	13.4	0	0	(Support Staff; Sub-Totals and Total Only) ↓						
Education, training, research	28.9	0	0							
Clerical, secretary, administrative assistants	74.5	1	4.1							
Other support staff (non-direct services)	46.5	0	0							
Sub-total, E (All Other)	163.4	**1**	**4.1**	69.6	22.9	32.7	35.0	0.3	2.5	162.9
Total, E (County & All Other):	245.7	**1**	**4.1**	82.1	40.3	51.7	62.2	1.3	3.5	241.0

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*
I. By Occupational Category - page 5

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

Major Group and Positions	Estimated # FTE authorized	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-American/ Black	Asian/ Pacific Islander	Native American	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).....**	767.2	2	5.6	265.8	101.4	141.3	218.8	4.0	17.5	748.7
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) .....**	1319.1	14	66.53	622.0	147.5	192.0	253.9	5.6	50.2	1271.2
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	2086.3	0	72.13	887.8	248.9	333.3	472.7	9.6	67.7	2019.9

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-American/ Black	Asian/ Pacific Islander	Native American	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**			34.7%	14.4%	22.8%	19.2%	0.7%	8.2%	**100%**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*

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	17.5		
Family Member Support Staff	0.0		
Other *Unlicensed* MH Direct Service Staff	12.7		
Sub-Total, A:	30.2		
B. *Licensed* Mental Health Staff (direct service)	6.0		
C. Other Health Care Staff (direct service)	0.0		
D. Managerial and Supervisory	5.7		
E. Support Staff (non-direct services)	18.2		
GRAND TOTAL (A+B+C+D+E)	60.0		

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 229 Others 64	Direct Service Staff 0 Others 0	Direct Service Staff 229 Others 64
2. Cantonese	Direct Service Staff 110 Others 25	Direct Service Staff 33 Others 23	Direct Service Staff 143 Others 48
3. Russian	Direct Service Staff 34 Others 2	Direct Service Staff 28 Others 18	Direct Service Staff 62 Others 20
4. Vietnamese	Direct Service Staff 18 Others 2	Direct Service Staff 6 Others 6	Direct Service Staff 24 Others 8
5. Filipino Dialect	Direct Service Staff 0 Others 1	Direct Service Staff 15 Others 5	Direct Service Staff 15 Others 6
6. Mandarin	Direct Service Staff 37 Others 5	Direct Service Staff 0 Others 0	Direct Service Staff 37 Others 5
7. Tagalog	Direct Service Staff 150 Others 30	Direct Service Staff 0 Others 0	Direct Service Staff 150 Others 30
8. Chinese	Direct Service Staff 2 Others 0	Direct Service Staff 8 Others 2	Direct Service Staff 10 Others 2

9. Korean	Direct Service Staff 8 Others 1	Direct Service Staff _____ Others 2	Direct Service Staff 8 Others 3
10. Cambodian	Direct Service Staff 4 Others 0	Direct Service Staff 5 Others 2	Direct Service Staff 9 Others 2
11. Arabic	Direct Service Staff 7 Others 0	Direct Service Staff 23 Others 8	Direct Service Staff 30 Others 8

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT – *Continued*

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.

San Francisco County hired Hatchuel Tabernik and Associates, an independent consultant, to conduct a needs assessment of the mental health workforce. Workforce data from the 2005-2006 Cultural Competency Survey and the CCSF Mental Health Data Warehouse was provided by County staff and additional US Census data was collected between August and September 2007. Data was processed, matched to the State workforce categories and analyzed by position, credentialing/education, ethnicity and language in October 2007. Findings were reported to the Working Committee in December of 2007 and used to develop final recommendations.

A. Shortages by occupational category:

Our findings indicate that the county experiences significant challenges recruiting, hiring and retaining Child and Geriatric Psychiatrists.

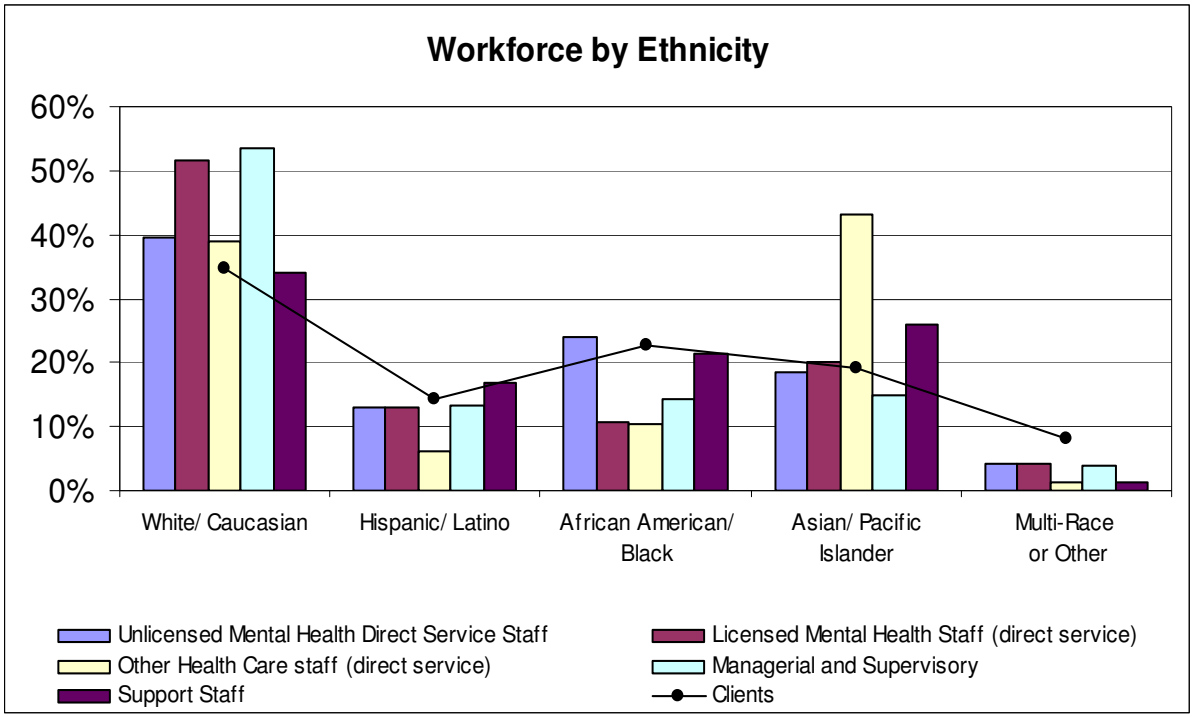
CBOs also appear to have difficulty filling psychiatric positions – including child, geriatric, medical director, and general psychiatric positions. There are also quite a few openings for LCSW and MFT licensed positions. These numbers are drawn from a point in time survey in 2005-06 and should, therefore, be considered generally reflective of the vacancies in the CBO provider community but should not be assumed to be completely accurate for the current timeframe. In addition, there are substantial openings among "other" unlicensed direct service staff such as residential counselors.

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

San Francisco County has made significant efforts to align its mental health workforce to the cultural and linguistic composition of the consumers of mental health services in the county. The table below outlines the congruence of the overall workforce (including county staff, CBO staff and the provider network) and consumers.

	White	Latino	Black	Asian/PI	Native American	Multi-Race or Other
Workforce	44.0%	12.3%	16.5%	23.4%	0.5%	3.4%
Consumers	34.7%	14.4%	22.8%	19.2%	0.7%	8.3%
County Population	44.3%	14.1%	6.6%	32.2%	0.2%	2.7%

Overall, therefore, White and Asian/PI workforce representation exceeds the consumer population by ethnicity. Latino, African American and multi-race workforce representation is correspondingly lower than their consumer populations. The largest disparity is that the White workforce is about 26% higher than the consumer population. However, if we consider the overall county population, it seems that the White population is somewhat underrepresented in the public mental health system – perhaps reflecting the relative affluence of the White population in the city. The Black population, however, represents another picture altogether. African Americans are 3.5 times more likely to be a consumer of mental health services than their population would predict. Their representation in the workforce is more than twice that of the overall city population and 28% lower than in the consumer population. Asian/PI populations are much less likely to be consumers of public mental health services than their population would predict, and they are slightly more likely to be represented in the workforce than as consumers. Finally, Latino populations are reasonably representative in the consumer population as would be predicted by their overall community population, and they are slightly underrepresented in the workforce.



However, if we consider the **categories** of workforce – that is, Unlicensed Direct Service, Other Health Care, Support Staff, Licensed Direct Service, and Managerial staff – compared to consumer populations, the picture is somewhat different. The graph to the left demonstrates that the White workforce is more heavily represented in the managerial and licensed mental health staff categories. Latinos are relatively proportionately represented in all categories with a slightly higher proportion in support staff and a lower representation in other health care staff. African Americans are represented most heavily in the unlicensed and support staff categories and underrepresented in licensed, managerial, and other categories. Asian/PI workers are most likely to be in the other health care and support staff categories, but their overall representation in other categories is reasonably proportionate. Multi-race and Other are generally underrepresented in all staff categories.

These data reinforce the need to ensure that the African American workforce is recruited, trained and educated to fill positions that require licensure and to fill managerial and health care positions. This echoes the community input that the African American community in San Francisco is facing serious traumatic challenges from ambient violence, poverty and other assaults and that efforts should be made to provide African American mental health practitioners to better serve the community.

Based on needs assessments conducted during the CSS process and other demographic data from the 2000 Census, it is clear that there are barriers to diversifying the mental health workforce in San Francisco. As mentioned above, it is clear that African Americans are underrepresented among licensed staff and management staff, while their representation among support and unlicensed staff is much higher. While this is only one example, it is clear that there are barriers to African Americans moving into the ranks of licensed and management staff. One of the obvious barriers is economics – with African Americans being among the lowest income residents of San Francisco. Lack of financial resources may well impact the ability of individuals who are interested in entering the mental health field or those who wish to get the education necessary to become licensed providers. Another barrier is the relatively low educational attainment of African American students in San Francisco's public schools. There is a 12.2% dropout rate among African Americans, and of the students who do graduate, only 32.2% of them have completed high school with the admission requirements to enter the UC or CSU systems.

Poverty and educational attainment are also likely to be barriers that are reflected in the relatively lower rate of Latino/as who are in licensed or managerial positions as compared to support services. In San Francisco Latino students are also more likely to experience high dropout rates (11%) and low levels of qualification for the UC/CSU systems (36.6%).

The twin barriers of poverty and low educational attainment must be addressed in order to further diversify the San Francisco Mental Health workforce.

Another barrier to diversifying the Mental Health workforce in San Francisco is cultural and attitudinal issues such as stigma and lack of belief in western medicine. As we have mentioned elsewhere these barriers militate against certain cultural groups utilizing the public mental health system, and they also act as barriers to young people selecting a career in the mental health field. As a result better outreach and community education are necessary to overcome these barriers. Only when our workforce is truly representative of the community we serve will we begin to break down the barriers to access and ensure that affected individuals will receive early assessment and intervention.

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

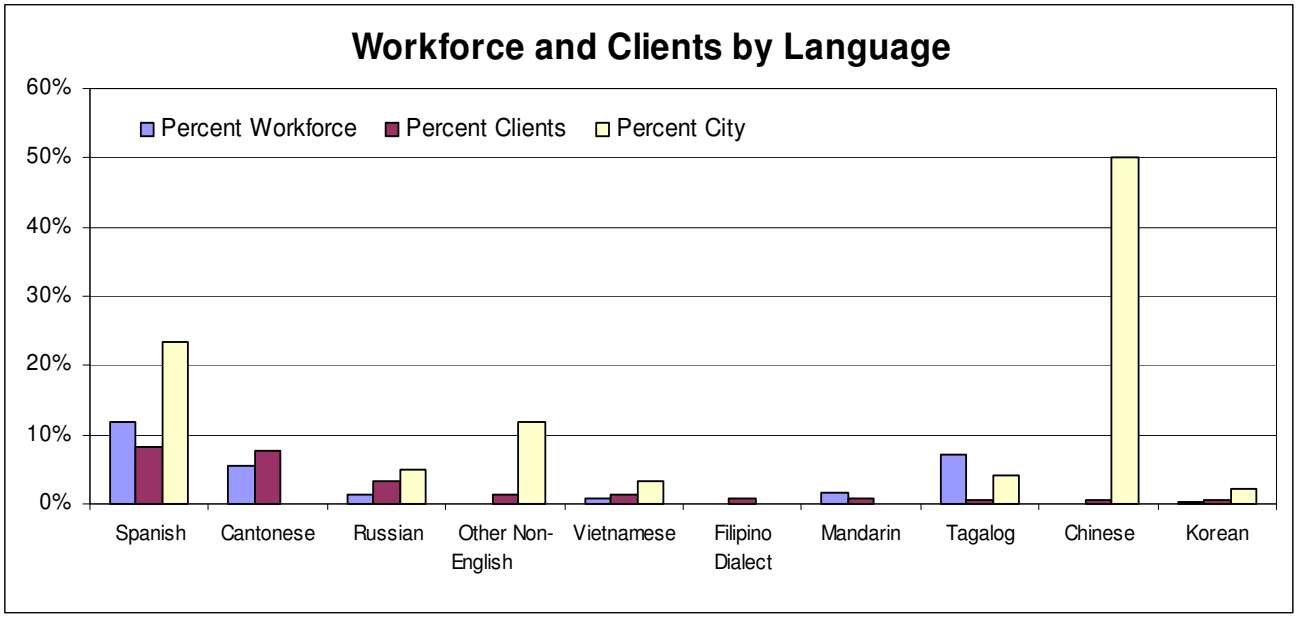
San Francisco County does not discriminate in hiring. This includes limiting positions to persons designated as consumer and family members Rather San Francisco County makes being a consumer or family member a desirable qualification for all potions in CBHS. San Francisco County does, however, track consumer/family member status on its biannual cultural competency questionnaire. The limitation of this questionnaire is that the respondents (both County staff and CBO/Contractor staff) self-determine whether they are considered a consumer or a family member. Because there has been no clear definition of these designations, we expect that there is a high likelihood that underreporting is the norm. The County will set a definition for consumer/family member designation and encourage County and CBO/Contractor staff to self identify on the confidential questionnaire.

	County	CBO
Unlicensed Mental Health Direct Service Staff		
Consumer Support Staff	5.2	12.3
Family Member Support Staff		
Other *Unlicensed* MH Direct Service Staff	6.7	6.0
Licensed Mental Health Staff (direct service)	0.6	5.4
Other Health Care Staff (direct service)		
Managerial and Supervisory	3.0	2.7
Support Staff (non-direct services)	4.9	13.3
GRAND TOTAL	**20.4**	**39.6**

It is also important to note that the last Cultural Competency Questionnaire was conducted for the 2005-06 fiscal year, prior to significant efforts to increase the employment of consumers as a result of the MHSA CSS implementation

process. That said, the chart to the left provides information from the Questionnaire, with consumer designation. There was no category for self-report as a family member in this Questionnaire. Because of the limitations inherent in the 2005-06 Questionnaire we do not consider the data above to be particularly accurate, and, as mentioned, we expect a dramatic increase in these self-report numbers in the current Cultural Competence Questionnaire.

Language proficiency:



The graph to the left provides a snapshot of the language capacities of the San Francisco County and CBO/Contractor workforce in comparison to the languages of the consumers and the City as a whole. These are the 9 most frequently cited languages among consumers, and the composite "other non-English" languages which are many.

The criteria for representing the workforce as possessing the language in question is that they are able to either "interpret" or "provide therapy" in that language. These criteria, therefore, exclude many individuals who may be conversant with a language but do not feel they have high enough skills to provide this standard of fluency.

That said, the workforce is highly fluent in Spanish, Korean, Mandarin and Tagalog relative to the ***consumer*** population (and presumed demand). Somewhat less well represented are languages such as Russian, Vietnamese, and some Filipino and Chinese dialects. There are also a number of low-incidence languages (other non-English) that are not at all well represented in the workforce. It is important to note that, since San Francisco is so diverse from a cultural and language perspective, there are community providers who are drawn upon to provide interpretation and direct services in a wide variety of languages. We believe that there is always potential for improvement, and the County of San Francisco acknowledges that language barriers (often in combination with stigma, cultural mores and practices) can reduce the use and usefulness of mental health services for specific ethnic/language minority groups. To this end, a continued emphasis on hiring, training and educating language and cultural minority groups will factor into this WDET Plan.

If, however, we consider the linguistic representation of the workforce relative to the ***overall*** linguistic profile of San Francisco, the picture is quite different. In this context, the workforce under-represents Chinese, Other non English, Spanish, Russian, Vietnamese, and Korean populations. Clearly the Chinese disparity is enormous. We see in this context that both language and cultural issues may act as barriers to participation as consumers of public mental health services and as members of the workforce. Chinese speakers represent 50% of the non-English speaking

population of the city, but Chinese speakers represent a small fraction of the consumer population and an even smaller proportion of the workforce. While less dramatic, this disparity is also true of the Spanish speaking population where the overall population is twice the size of the workforce. The consumer population is proportionately even lower, which is likely to be a consequence of linguistic and cultural barriers to service as mentioned above.

E. Other, miscellaneous:

Geographic Distribution:

The map to the right indicates the geographic distribution of consumers of public mental health services by census tract. Clearly there are some areas of the city with high densities of consumers. These concentrations are generally in lower income neighborhoods, largely communities of color. As the WDET plan unfolds there will be efforts made to provide trainings in these communities, especially focusing on CBOs with roots in these neighborhoods and the cultural and linguistic competence to reach underserved populations. The distribution of interns (via the internship coordination effort) will also take these geographic realities into consideration.

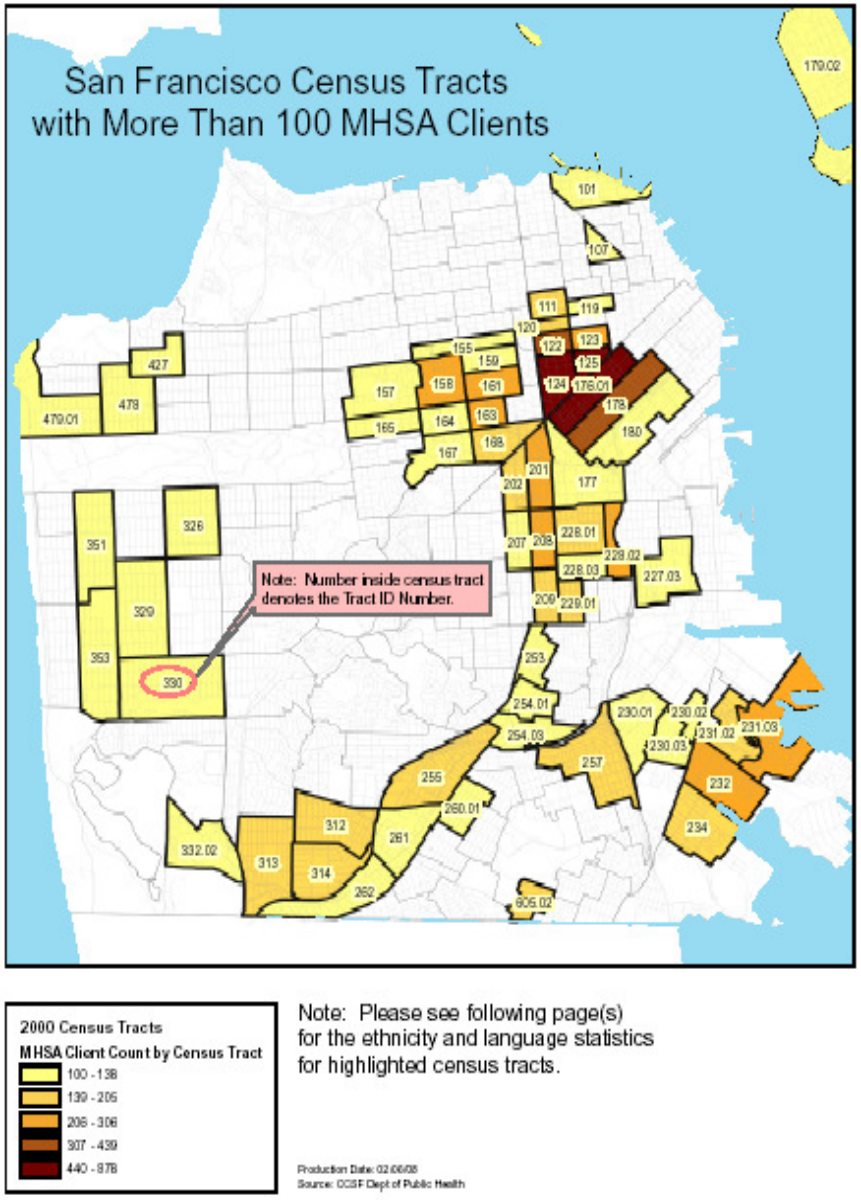


EXHIBIT 4: WORK DETAIL

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

A. WORKFORCE STAFFING SUPPORT

Action #1 – Title: Workforce Staffing and Support

Description:

Implementation Activities: Hire a Workforce Education and Training (WDET) Coordinator (1 FTE) for a salary of $80,626 plus a 3% annual COLA for year three, with the first year costs funded through the CSS component. The WDET Coordinator will:

- Support and coordinate training and technical assistance efforts for CBHS clinicians, providers, consumers, and family members;
- Support CBO training efforts that address and adhere to the principles of MHSA;
- Provide leadership, coordination and support for selected educational institutions, including SFUSD high schools, to develop a career pathway that supports underrepresented populations to prepare for employment in the behavioral health field;
- Work with CBHS administrative staff and civil service clinics to develop and implement supervision protocols for staff and interns; coordinate all implementation activities with state and local partners;
- Coordinate certification and licensing credits for training participants in topics relevant to MHSA;
- Supervise Health Worker staff and volunteers;
- Coordinate with Community Services and Supports (CSS) and Prevention/Early Intervention (PEI) MHSA coordinators;
- Oversee WDET activities to ensure MHSA principles are integrated into all strategies and interventions.

Hire a Health Worker II (.5 FTE) employee based on a full time compensation rate of $51,350, with the first year costs funded through the CSS component. The Health Worker II will assist the WDET Coordinator by:

- Providing coordination and support for the high school program and other educational institutions;
- Reaching out to support internal CBHS educational and training efforts;
- Reaching out to community providers to help them access WDET staff development and other resources through MHSA.

Objectives: To provide staffing and support to the WDET component and to enhance San Francisco's training infrastructure by:

- Improving the coordination and streamlining of training efforts throughout the mental health system.
- Designing training interventions to meet the needs of a multidisciplinary workforce, including mental health, substance abuse, and primary care.
- Designing trainings to cut across various "tiers" of the workforce, including licensed providers, unlicensed, health care, etc. – providing consistent messages and skill development for all.
- Enhance collaboration between Community Behavioral Health Services (CBHS) and community-based organizations (CBOs) and
- Ensure that consumers, family members, and underserved and underrepresented communities are included as both trainers and participants.

Budget justification: These positions are necessary to build a pipeline of education and training to help underrepresented populations to enter the behavioral health workforce and/or to advance within the system to licensed and/or managerial roles, as desired. Significant coordination is necessary to create and/or strengthen alliances with the K-16 educational systems, local colleges, and graduate schools to ensure that SF CBHS has an increasingly representative workforce and that consumers are better served by way of a culturally and linguistically competent staff. WDET staff will coordinate with the San Francisco Unified School District (SFUSD) and youth focused community-based organizations to provide information to youth on job and career opportunities in the public mental health system and information about the Summer Bridge Program. In addition, the team will work together to coordinate trainings for CBHS to improve cultural competence and incorporation of a recovery model principles throughout the SF system of services. WDET staff will also work with the selected Career Pathways colleges, universities, and/or community-based organizations to implement Career Pathway Programs. They will also work closely with the hired Coordinator to enhance the development and implementation of the CBHS Internship Program. Moreover, the WDET Coordinator will interface with the Coordinators of other service components of MHSA such as Community Services and Supports and Prevention and Early Intervention. This is no small task and requires the positions proposed.

There will be a full time WDET Coordinator @ $80,626 in Year Two plus fringe benefits calculated at 35% of salary for a total of $108,845. In Year Three, a 3% COLA will be added for a total of $112,111. There will be a 50% FTE Assistant @ $25,675 in Year Two plus fringe benefits calculated at 35% of salary for a total of $34,661. In Year Three, a 3% COLA will be added for a total of $35,701.

Budgeted Amount:	**FY 2006-07: $____**	**FY 2007-08: $143,506**	**FY 2008-09: $147,812**

B. TRAINING AND TECHNICAL ASSISTANCE

Action #2 – Title: CBHS Training Initiatives

Description:

Implementation Activities: Provide training to staff from CBHS and community-based agencies over a three-year period on such topics as wellness and recovery, family support, intensive case management, and the integration of primary care and mental health services. These trainings should be culturally and community-appropriate.

Implementation Activities: Have subject matter experts, some who may be consumers, family members, and members of underserved communities, provide system-wide trainings to administrators and staff from CBHS and CBO partners on the hiring and integration of consumers, family members, and members of underserved and underrepresented communities into the behavioral health system. Topics to be addressed include stigma, job performance standards, supporting professional development, reasonable accommodations, boundaries, ethical decision making, as well as effective strategies for providing supervision, support, and the enhancement of professional development and vocational success.

Implementation Activities: Offer mental health service providers small-group, hands-on, skills-based follow-up consultation in recovery-based methods with an emphasis on the inclusion of individuals who would be most instrumental in implementing organizational and service provision change. One avenue for providing this follow-up would be conducting quarterly case reviews using a grand rounds approach within organizations. Other follow-up processes could be written into the RFPs for the above-mentioned trainings.

Implementation Activities: Over the three-year period, provide on-site technical assistance and training to behavioral health organizations (10 agencies annually; 4x/wk for 2 months per agency). CBHS recognizes that beyond knowledge dissemination efforts, more in-depth assistance is needed for concrete knowledge adoption/implementation and practice change at the individual and clinic level. To assist with a more comprehensive system and clinical practice transformation, WDET funds will be used over the three-year period to identify a best practice model, have subject matter experts provide on-site assistance, observation, and support to assist the agency in effectively adopting this model and thereby enhancing a core intervention/clinical practice.

Budget:

Trainings	Year One Budget	Year Two Budget	Year Three Budget
Recovery Model training systemwide	$9,000		
Quarterly Case Review systemwide (Recovery Model)	$ 5,000	$15,000	$15,000
Family Support training	$ 3,000		
Supervision of Consumer Employee trainings	$ 5,000	$ 5,000	
Stigma trainings		$ 5,000	$ 5,000
Boundaries and Ethical Decision Making training	$ 2,500	$ 2,500	$ 5,000
Other professional development (identified by staff)		$ 5,000	$ 5,000
On-site technical assistance for agencies		$40,000	$40,000
TOTAL	$24,500	$72,500	$70,000

Objectives: Train existing and newly hired CBHS and CBO staff in an effort to shift the "center of gravity" in the service structure to a recovery model of mental health service provision, as follows:

- Train at least 150 new and 300 existing CBO and CBHS employees in the principles of recovery-based approaches
- Provide 32+ hours of on-site technical assistance for 10 agencies per year
- Identify and adopt a best practices model (year one) and then provide comprehensive, agency-wide training in this strategy for 80% of all direct services and management/supervisory staff.
- Build internal agency capacity by providing technical assistance that would give participating staff the ability to train other staff within their agencies – resulting in at least 50 CBHS and CBO staff being trained as trainers in the adopted best practice model(s) over the three year period.

Budget justification: The itemized budgets above are estimates based on standard consulting costs for trainers (e.g., $125/hr for local trainers). In addition to trainer fees, the budget will cover the costs for securing a venue, processing continuing education fees, and support staff time. These training and technical assistance activities will be contracted via an RFP process which will follow approval of this WDET plan by the State Department of Mental Health. Contracts will be let to providers that have the required technical and cultural competence and that propose realistic scopes of work at cost beneficial rates.

Budgeted Amount:	**FY 2006-07: $24,500**	**FY 2007-08: $72,500**	**FY 2008-09: $70,000**

Action #3 – Title: Community-Based Organization Training: Educational Empowerment, Support, and Cross-Training

Description:

Implementation Activities: Provide grants over a three-year period to community-based organizations and other qualified trainers to provide cross-training between agencies as well as reciprocal training between licensed and unlicensed providers (including older adults and youth). Protocols would be developed on culturally competent and innovative mental health practices consistent with the values and principles of MHSA, including traditional and natural healing approaches. These trainings would address the topics in the table below.

Budget:

Trainings	**Year One Budget**	**Year Two Budget**	**Year Three Budget**
Family Support		$13,500	$13,500
Crisis Intervention		$11,250	$11,250
Consumers in the Workplace:Professional Development and Etiquette		$30,000	$30,000
Training Consumers/Family Members to be trainers		$25,000	$25,000
Community Violence/Vicarious Trauma & Impact of Violence on Families		$20,000	$20,000
Community-Based Cultural Sensitivity Trainings			
African Americans		$7,000	$7,000
Latinos		$7,000	$7,000
Asian/Pacific Islander		$7,000	$7,000
Native Americans		$5,000	$5,000
Russians		$5,000	$5,000
LGBTQQ		$4,500	$4,500
Transitional Age Youth		$4,500	$4,500
Older Adults		$4,500	$4,500
TOTAL	$0	$144,250	$144,250

Funds are set aside in year three for hospitality and other miscellaneous expenses related to cultural training ($1,382).

Implementation Activities: Hire consultant who will develop the Requests for Proposals for each of these activities ($5,000). Funding will come from planning funds, which has been pre-approved prior to this plan.

Objectives: Build community capacity through training that promotes understanding and improved service of specific cultural and ethnic groups and that promotes understanding and collaboration between licensed and unlicensed providers, as follows:

- Engage community-based and outside experts to train at least 1,000 staff/providers over three years regarding cultural literacy and competence in serving the needs of the array of ethnic/minority groups and populations within a recovery-based framework
- Engage at least 150 licensed and 200 unlicensed providers over three years in reciprocal training that builds effective dialogue, understanding and collaboration between these groups of staff.
- Train at least 500 CBHS and CBO providers over three years regarding the impact, prevention and treatment of violence-related trauma on vulnerable communities.
- Train at least 1,000 CBHS and CBO providers over three years regarding cultural issues related to different ethnic communities.

Budget justification: The itemized budgets above are estimates based on standard consulting costs for trainers (e.g., $125/hr for local providers). In addition to trainer fees, the budget will cover the costs for securing a venue, processing continuing education fees, and support staff time. These training and technical assistance activities will be contracted via an RFP process, which will follow approval of the WDET plan by the State Department of Mental Health. Contracts will be let to providers that have the required technical and cultural competence and that propose realistic scopes of work at cost beneficial rates. Special efforts will be made to ensure that community residents are engaged in the process of addressing the needs of particular groups and the consequences of violence in the community. To this end a small fund for stipends is set aside ($1,382) so that individuals can be compensated for personal testimony given in support of the plan (in addition to contracts with community trainers).

Budgeted Amount:	**FY 2006-07: $5,000**	**FY 2007-08: $144,250**	**FY 2008-09: $145,632**

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS

Action #4 – Title: Summer Bridge Program

Description:

Implementation Activities: In order to develop a new generation of mental health workers, the San Francisco CBHS will work in collaboration with the SFUSD and the local higher education community to identify, recruit, train and educate cadres of high school students to fill positions in the Behavioral Health Care System. Students selected will be reflective of the diversity of the San Francisco consumer population and serious about pursuing a mental health career. Over a three-year period, MHSA funding will provide these high school students with a mental health oriented Summer Bridge Program in preparation for their entry into postsecondary education. Costs include a Project Coordinator ($12,000/year) and stipends for 20 students a year at $600 per student. We project to enroll a total of 40 students by the end of the third year.

Budget:

Description	Year One Budget	Year Two Budget	Year Three Budget
Project Coordinator – 3 months	$12,000	$12,000	$12,000
Stipends (20 students x $600/student)		$12,000	$12,000
TOTAL	$12,000	$24,000	$24,000

Objectives: Provide training and educational opportunities for a diverse cadre of engaged high school students as well as disengaged community youth who are at-risk for not completing high school. Assist these students to pursue careers in the mental health field, as follows:

- 20+ students per year will be recruited to enter the Summer Bridge program by enrolling in a health-oriented career path in their high school, adult school, or other alternative program.
- Over a two year period at least 40 students will complete the Summer Bridge program and enter a postsecondary program that leads to a certificate or diploma.

Budget justification: The Summer Bridge program will leverage the institutional resources and commitments of the K-12 and postsecondary systems and community-based organizations in San Francisco who provide human and behavioral health services to youth to disseminate information about jobs and careers in the public mental health system and recruit and educate two cadres of 20 students for Summer Bridge Program. The MHSA WDET funding will be used for a part time Coordinator ($12,000/year x 2 years = $24,000) and for twenty $600 stipends for students who complete the Summer Bridge program on their way to postsecondary education. In the first year, the coordinator will develop the curricula and coordinate with the SFUSD and community-based organizations to disseminate information about jobs and careers in public mental health systems and the ensuing requirements for eligibility. In addition, the Coordinator will work with the WDET coordinator to facilitate the placement of students at appropriate sites for the Summer Program.

$12,000 of fiscal year 2006-07 will come from planning funds prior to plan approval.

Budgeted Amount:	FY 2006-07: $12,000	FY 2007-08: $24,000	FY 2008-09: $24,000

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS – *Continued*

Action #5 – Title: Peer Specialist Mental Health Certificate Program

Description:

Implementation Activities: Provide consumers, who are in early recovery but are not ready for continuing education or not yet able to work in higher sectors of the labor force, with basic skills and knowledge for entry-level employment in the behavioral health care system. The program will offer a series of foundational trainings on topics such as effective negotiation and communication skills, teamwork, a basic understanding of mental health diagnoses, and professional etiquette. The funding will cover program cost for a project coordinator, curriculum developer, staff coordination and client stipends.

Implementation Activities: Provide support to establish a 12-week community college mental health certificate program. One-time costs would include a curriculum developer.

Budget:

Year 1: $50,000 for curriculum development
Year 3: $75,000 for implementation costs

Objectives: Increase participation of consumers, family members, and members of underserved and underrepresented communities in the mental health field through preparation for entry level positions in mental health service as well as continuing education with a community college-level mental health certificate. Successful transition to public or private 4-year universities would also be addressed.

- A Peer Specialist mental health certificate program at the community college level will be developed in year one
- The certificate program will be fully funded for two subsequent years
- 10 students per year will be recruited and complete the certificate program

Budget justification: Year one costs will include faculty release time to develop the curriculum and pilot it with a small cadre of consumer staff to test its effectiveness. Year three will begin full implementation with operating costs, including teachers, facilities and operational costs such as texts and other materials. An RFP will be let for this project and the applicants will supply more detailed budgets for development and implementation costs.

$50,000 of fiscal year 2006-07 will come from planning funds prior to plan approval for curriculum development

Budgeted Amount:	**FY 2006-07: $50,000**	**FY 2007-08: $0**	**FY 2008-09: $75,000**

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS – *Continued*

Action #6 – Title: Mental Health Certificate Program

Description:

Implementation Activities: Develop curricula for the Mental Health Certificate Program for consumers and family members who are ready to pursue higher educational goals. The certificate will allow individuals to obtain skills and training necessary for providing clinical and other supportive services for those impacted by serious mental illness. With this certificate, they would be able to have the proper credentials that will support employment advancement and higher salaries, and an opportunity for career advancement within the public mental health system.

Budget:

Description	Year One Budget	Year Two Budget	Year Three Budget
Curriculum Development, Administration & Recruitment	$100,313		
Teachers, Facility and Program Costs		$100,000	$100,000
Tuition Assistance for 10 enrollees at $960/student		$ 4,800	$ 4,800
Childcare and transportation for 10 enrollees: Childcare = $15/hr x 8 hrs x 36 wks x 10 students Transportation = $5 x 3 days x 36 wks x 10 students		$ 48,600	$ 48,600
Release time for Project Coordinator at .50 FTE		$ 20,157	$ 20,157
TOTAL	$100,313	$173,557	$173,557

Objectives: Increase the enrollment and graduation rates from post-secondary institutions of consumers, family members, and members of underserved and underrepresented communities whose education is focused on service in the public mental health system.

- 10 consumers/family members per year will enroll in post-secondary institutions to pursue a certificate program in mental health services
- Of the above enrollees at least half will be underserved/underrepresented community members
- 80% of consumers and/or family members and/or underserved/underrepresented community members will express satisfaction with the support and education they are receiving in the certificate program

Budget justification: Significant faculty time will be required in year one to develop the certificate program and to gain approval through faculty senate and administrative processes. During years two and three the program will be in full operation, but due to the small number of enrollees anticipated state reimbursement will not be sufficient to cover the costs of the program which will require intensive faculty/staff involvement to recruit and retain appropriate students, for this reason the costs of faculty and other institutional costs will be partially subsidized by WDET funds. In addition, we anticipate that tuition costs, childcare, and transportation may be barriers to participation for consumers/family members, therefore these costs will be picked up by WDET funds. Finally, a part time Project Coordinator will be provided released time during years two and three.

$100,313 of fiscal year 2006-07 will come from planning funds prior to plan approval.

	FY 2006-07: $100,313	**FY 2007-08: $173,557**	**FY 2008-09: $173,557**

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS – *Continued*

Action #7 – Title: Supportive Services for Consumers Enrolled in Public Universities or Private Colleges

Description: In order to overcome barriers to advancement in the behavioral health care field, it is necessary to build pathways beyond the certificate or AA degree level. In order to move existing consumer staff in the public mental health system to higher levels of employment (e.g., licensure and management) it is necessary to provide baccalaureate degree and graduate degree assistance. This strategy addresses both the baccalaureate and graduate degree pathways. An RFP will be let for two institutions of higher education to build these pathways for consumer advancement. Beyond building the pathways, it is necessary to provide "high touch" support for enrollees to be successful. We anticipate that the institutions involved will require, depending on the size of their programs, a full or part time coordinator and administrative staff to create and manage this program within their institutions and to provide the support for participants that will be necessary to ensure that they are successful in these challenging programs. Based on data provided by Institutions of Higher Education (IHEs), there are many existing consumer and family member enrollees in these institutions. However, their success rates are not optimal, especially among underrepresented minority groups.

Objectives: Increase the enrollment in and graduation rates of consumers, family members, and members of underserved and underrepresented communities from post-secondary institutions – with concentration on service in the public mental health system.

- Two IHEs will develop and develop provide supportive services to increase the enrollment, retention, and graduation rates from post-secondary institutions of consumers, family members, and members of underrepresented communities whose education is focused on service in the public mental health system. In this way, service penetration to targeted populations will be increased.
- By year three, enrollment of the above-mentioned populations in both baccalaureate and graduate programs will be increased by at least 30%. As undergraduate programs generally take four years and graduate programs two years to complete, often longer for the above-mentioned populations due to a range of economic, environmental, and psychosocial challenges, and graduate programs take at least two years, substantial increases in graduation rates may not be apparent until the end of year five but in the meantime data will be collected on retention, grade point average, and student satisfaction among other outcomes with substantial increases anticipated in all areas.
- Outreach will be conducted to recruit student applicants having consumer and family member experience and/or who are members of underrepresented communities identified as such in the Workforce Needs Assessment.
- Transitional services from the High School Bridge and community college programs will be provided, as well as between undergraduate and graduate levels of education.
- Group training and individual consultation will be provided to faculty and staff to set up structures, policies, procedures, and curricula to more effectively meet the needs of students with consumer and family member experience with a culturally competent, recovery focus.
- These institutions will serve as training sites for interns and peers in recovery-oriented mental health practices.
- Job placement assistance will be provided as students are nearing graduation thus increasing the employment rates of consumers, family members, and members of underrepresented communities in the mental health system.

Budget:

Description	Year One Budget	Year Two Budget	Year Three Budget
Release time for 2 Project Coordinators at .75 FTE each		$120,000	$120,000
Family and Consumer Consultants at .50 FTE for 2 sites		$ 35,000	$35,000
Release time for 2 Administrative Assistants at .50 FTE each		$ 40,000	$40,000
TOTAL	$0	$195,000	$195,000

Budget justification:
Each site will have a project coordinator who will be responsible for coordinating the outreach to students, support services for students and their families, providing individual consultation and assistance; interfacing with faculty and other academic staff; scheduling tutorials; referrals to on-campus or community based mental health services; coordinating job placements for students nearing graduation and providing pre-employment counseling services. Family and consumer consultants will be hired to provide emotional and life-skills supports to students and families, including occasional support groups, time management, group study sessions, assistance with enrollment and financial aid, and other needs identified by these students. The Administrative Assistants will keep track of student requirements and performance; assist the coordinator in referral services and scheduling of counseling and support services; assist with scheduling of child care services; track support services provided to these students.

	FY 2006-07: $___	**FY 2007-08: $195,000**	**FY 2008-09: $195,000**

D. RESIDENCY, INTERNSHIP PROGRAMS

Action #8 – Title: Internships for Hard-To-Fill Positions and Underrepresented Populations

Description:

Implementation Activities: Hire an Internship Program Coordinator who will develop the protocols, policies, and procedures for recruitment and placements of students in graduate programs at CBHS and provider sites. This program is expected to be implemented in the second year due to time needed to hire the WDET Coordinator, a civil service employee, who will supervise the Intern Coordinator.

Budget:

Description	Year One Budget	Year Two Budget	Year Three Budget
Internship Coordinator at .50 FTE; 3% COLA in Year 3		$38,312	$39,461
Stipends for 14 students at $2,500/student		$ 35,000	$35,000
TOTAL	$0	$73,312	$74,461

Objectives: Address mental health workforce shortages and diversity needs by creating a more comprehensive workforce that is culturally competent and staffed by professionals from the targeted service communities:

- Create for a coordinated and centralized effort for recruiting and placing graduate students at various sites. Graduate students may be from the following disciplines : MSW; Counseling/Psychology; Nurse Practitioner; Mental Health Certificate
- Provide stipends for 14 interns who meet the cultural competency needs of CBHS

Budget justification: Current internship processes are quite decentralized and placements are not necessarily meeting the needs of the CBHS system to diversify the workforce in a way that best meets consumer needs. In addition, interns are not provided the breadth of options that would enhance their cultural competence as a part of their training experience. Therefore, we are proposing to create a centralized resource for both interns and agencies so that this lack of information and coordination can be mitigated. In addition, low-income (and often, therefore, ethnically diverse) interns would benefit from stipends that would encourage them to take internship placements in low-income communities where stipends are often not available for interns.

Budgeted Amount:	FY 2006-07: $0	FY 2007-08: $73,312	FY 2008-09: $74,461

EXHIBIT 5: ACTION MATRIX

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

Actions (as numbered in Exhibit 4, above)	Promotes wellness, recovery, and resilience	Promotes culturally competent service delivery	Promotes meaningful inclusion of clients/family members	Promotes an integrated service experience for clients and their family members	Promotes community collaboration	Staff support (infrastructure for workforce development)	Resolves occupational shortages	Expands postsecondary education capacity	Loan forgiveness, scholarships, and stipends	Regional partnerships	Distance learning	Career pathway programs	Employment of clients and family members within MH system
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action # 1: Workforce Staffing and Support	✓	✓	✓	✓	✓							✓	✓
Action # 2: CBHS Training Initiatives	✓	✓	✓	✓	✓								
Action # 3: Community-based Organization Training	✓	✓	✓	✓	✓	✓							✓
Action # 4: Summer Bridge Program	✓	✓	✓	✓	✓	✓			✓			✓	
Action # 5: Peer Mental Health Certificate Program	✓	✓	✓	✓	✓	✓		✓	✓			✓	✓
Action # 6: Mental Health Certificate Program	✓	✓	✓	✓	✓	✓	✓	✓	✓			✓	✓
Action # 7: Supportive Services for Consumers enrolled in Public Universities or Private Colleges	✓	✓	✓	✓	✓	✓	✓	✓				✓	✓
Action # 8: Internships for Hard-To-Fill Positions and Underrepresented Populations	✓	✓	✓	✓	✓	✓			✓			✓	✓
Action # 9:													
Action # 10:													

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	0	0
B. Training and Technical Assistance	5,000	24,500	29,500
C. Mental Health Career Pathway Programs	162,313	0	162,313
D. Residency, Internship Programs	0	0	0
E. Financial Incentive Programs	0	0	0
		GRAND TOTAL FUNDS REQUESTED for FY 2006-07	**191,813**

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	143,506	143,506
B. Training and Technical Assistance	0	216,750	216,750
C. Mental Health Career Pathway Programs	0	392,557	392,557
D. Residency, Internship Programs	0	73,312	73,312
E. Financial Incentive Programs	0	0	0
		GRAND TOTAL FUNDS REQUESTED for FY 2007-08	**826,125**

Fiscal Year: 2008-09			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:	0	147,812	147,812
B. Training and Technical Assistance	0	215,632	215,632
C. Mental Health Career Pathway Programs	0	467,557	467,557
D. Residency, Internship Programs	0	74,461	74,461
E. Financial Incentive Programs	0	0	0
		GRAND TOTAL FUNDS REQUESTED for FY 2008-09	**905,462**