# COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH

SYSTEM LEADERSHIP TEAM (SLT) MEETING
Wednesday, May 15, 2013 from 9:30 AM to 12:30 PM
St. Anne's Auditorium, 155 N. Occidental Blvd., Los Angeles, CA 90010

## REASONS FOR MEETING

1. To provide feedback to the Office of Statewide Health Planning and Development (OSHPD) on the next 5-Year Plan for the Statewide Work Force, Education, and Training (WET) Program.

## MEETING NOTES

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| **Meeting Opening** | The Office of Statewide Health Planning and Development (OSHPD) conducted the May 15, 2013 SLT meeting. Information from these sessions will inform the next five-year plan for the Statewide Work force, Education, and Training (WET) programs. This meeting was open to the public. The comments and feedback contained in the notes are from SLT members and the public. |
| **OSHPD Five-Year Plan for Statewide WET Program** | **Sergio Aguilar, Project Manager, Mental Health Workforce Five-Year Plan, Office of Statewide Health Planning and Development.**<br><br>A copy of Sergio Aguilar's presentation was included in the May 2013 SLT meeting packet.<br><br>**FEEDBACK**<br><br>1. **Question**: On page two, the slide indicates a shortage of mental health providers. Is there a shortage of mental health providers for children and older adults?<br>**Response:** That statistic is not available. OSHPD is rolling out the data clearinghouse on providers from primary care to mental and behavioral health. In the future, we can gather more detailed information. The available data and breakdowns can be accessed via the link on the page.<br><br>2. **Question:** Does the website list the people who are on the WET 5 year plan advisory committee and subcommittees?<br>**Response:** Yes. We have both rosters on the website<br><br>3. **Question:** Will your organization include those in the mental health capacity as well as co-occurring treatment? Is this where this funding comes from?<br>**Response:** The funding develops the workforce that will provide services, not the services. |

4. **Question:** Many children and PEI mental health providers come out of school ill prepared to deal with some of the newer initiatives including models such as IHBS and ICC models. The WET plans do not appear to have anything preparing newly minted graduates or students to work under these models which are becoming the standard practice.
   **Response:** No plan has been developed yet. We are here for recommendations.

5. **Question:** Are you planning specifics? It is important to find out the hiring priorities for those working with dual diagnosis, children, and older adults.
   **Response:** We will do a 'needs assessment' that looks at how many providers in different professions are we needed. We will look at more detailed needs assessment of the actual numbers by county.

6. **Question**: How would the state plan interact with or be part of the local WET plan?
   **Response:** The counties have the option to use some of what the state develops, based on our plan, and take those recommendations for themselves. There is no mandate that says the counties must use the strategies the State develops.

7. **Question:** Is OSHPD discussing whether or not WET will be a component of that integrated plan with DHCS?
   **Response:** For the statewide WET, we only focus on the $130 million. It is separate because we only work on programs we administer at the state level.
   **[Note- The county's WET plan will be incorporated into the county's next 3 Year Integrated Plan]**

8. **Question:** Over the past couple years there has been stagnation of certified counselors, peer advocates in these facilities.
   **Response:** We want to hear about those things today.

GROUP DISCUSSION ONE

1. **Report Out One:**
   The first highlight of our discussion is increasing statewide certification of peer and family employees so there are more than twenty-nine certifications statewide. Second, the budget for WET should be large and not shrink over time. The budget needs to be higher to support ongoing work in education, public relations on recovery and mental health issues and modern mental health. Third, there more peers and families in the workforce and increased focus on recovery are needed.

2. **Report Out Two:**
   The group discussed the lack of psychiatrists, especially those trained specifically for children, nurse practitioners and psychiatric nurses, as well as bilingual staff who are culturally sensitive and culturally sensitive staff in

general. In addition, the need to focus on professionals specializing in 0-5 services, COD services, PEI population, and increasing the number of peer advocates and health care navigators in our system is important. Second, the group discussed Evidence Based Practices (EBPs) in LA County. The overall theme was increasing the number of EBP's, and other practices that provide trainings for individuals for clinicians and non-clinical staff to improve services that the work force provides to clients. Second, the group discussed using health care navigators to assist in reducing the silos that exist amongst departments across the state; as well as creating a data system which tracks the successes and issues faced in the public mental health system by looking at more anonymous / confidential and community based collection of data. Finally, the group discussed the system in place in San Diego County, which gives mental health funding to primary care clinics directly to establish integrated behavioral health care systems rather than having separate mental and physical health clinics. They were given the money based on per capita and per case rate, and established their own treatment teams.

3. <u>Report Out Three:</u>
   First, the group asked who needs training? The previous WET plan looked at professional schools. Professional schools should not be overlooked, but there is need for individuals who are not necessarily trained professionals to work in the mental health system. Creating programs in community colleges could recruit and train people interested in the mental health field for employment. The second was looking at using the state plan to influence the curriculum in professional schools so graduates of those programs are better prepared to work in the community. Third, 'community' means multiple communities. Each community has specific needs for culturally competent, and linguistically competent people. It is important in the planning process to learn how to evaluate and train individuals going into the community.

4. <u>Report Out Four:</u>
   Finding individuals with the skill sets and the competency to provide integrated care that encompasses mental health, behavioral health, physical health, and substance use. That also includes working with the nursing profession, advanced practice nurses, nurse practitioner—who are more cost effective than psychiatrists. Developing a comprehensive mental health worker certification specifically for individuals with lived experiences to obtain credentials recognized by the state and provide billable services under Medi-Cal. Focusing on engaging more multilingual and culturally competent individuals within the underserved communities is important. For number 2, tapping into the work force that are not billable to Medi-Cal, individuals who are experts in mental health, with lived experiences, reducing financial barriers and, the lack of true collaboration within our communities. Substance use, mental health community partners, and educational institutions need to collaborate. Recommended actions include: increasing collaboration across partners and develop educational incentives that introduce community services in exchange for education.

5. <u>Report Out Five:</u>
   There is a need for professionals who understand clients from their cultural perspectives. Increasing peer

advocates as part of the integration. Our group had a heated discussion about how some professionals are not welcoming the integration of peer advocates and volunteers into the work force. For section 2, challenges included an uneven ratio between clinical and support staff. This needs to be balanced to create the integration of peers into the work force. There is a need to hire more peer advocates and case managers or paraprofessional levels and integrate them into service delivery. For number 3, what has worked: the integration between mental health, physical health, substance abuse, via the various innovation programs that are currently being piloted county wide. The idea of looking at the client as a whole versus the symptom oriented model--focusing treatment; hiring employees who work collectively, collaborate, and develop partnerships.

6. Report Out Six:
   The group discussed how diversity shapes service delivery. We need to emphasize prevention. There is an absence of males in the field--particularly who work with youth. With respect to the second question we focused a lot on challenges in training programs. Tuition costs are high. Stipend programs often come toward the end of people's training. Another identified need area is the shortage of qualified supervisors in public mental health settings who can supervise people coming into the pipeline. It is important to create pipelines for younger people to enter the field. With respect to successful programs one example was CalSWEC—which has a wraparound program for trainees with training and integration into the community.

7. Report Out Seven:
   In addition to previously discussed plans, our group encourages alternative therapies and promoting these alternatives in education. This includes: music therapy, art therapy, and creative type therapy--either clinical or non-clinical therapy. In terms of substance abuse our group discussed several different types of certifications in California and the possibility of creating an overarching substance abuse certification to improve supervision and competency. The third are public benefit experts that go into the community and more mobile service providers including peers.

8. Report Out Eight:
   Our group discussed changing the cultural drought that exists in our field. Need to start outreaching early to address youth dropping out of high schools. It is important to choose mental health as a career pathway. It is important to define what cultural diversity is addressing linguistic opportunities. We want to create stipends for high school students and community service hours to include in our CBO's. Second, the disconnection between universities and community based organizations. Training and preparing students to work in a community mental health model. Need to address, bridge and create more opportunities for practicum for young professionals entering the field. Lastly creating a peer work force and getting ready for the health integration model; really incorporating a peer work force that embraces the substance abuse, health, and mental health models.

9. Report Out Nine:

There is a disconnection between what happens in the professional world and the academic world. Need to reinforce what is learned in the community college and universities and its relevance in the professional world. Outside of workload and pay, need to discuss the importance of increasing and sustaining the public health work force. Need to promote the mental health fields as a viable profession from a young age. There are a lot of silos and a lot of organizational barriers that do not allow for promotion of the mental health field. How do we retain employees? Current professionals must be trained on how to deal with workload and stress. Need to strengthen the alliances and programs that bridge the gap in between the students and work force. What incentives do current employers have to promote and retain employees? What about new companies? What is out there to promote the mental health field?

GROUP DISCUSSION TWO

1. Report One - Supporting Training and Education:
   The group talked about community inclusion and outreach--implementing an oversight committee for quality assurance. Annual conferences with visibility for under-represented groups needed. Flexibility, collaboration between schools and community based organizations, especially high schools and community colleges.

2. Report Two - Support, Recruitment, and Retention:
   One idea was to develop and promote a coordinated incentive plan across the systems including the education system. Identify school programs that specifically focus on social work, health and human services, and work with those individual schools to focus on behavioral health and schools as an important component to building prevention and early intervention strategies.

3. Report Three - Recruitment and Retention:
   Our group focused on developing a stipend and loan forgiveness program. There is a need for evaluation and assessing the competency of people who receive those programs to insure dedication and commitment to continue service to organizations. Mentorship was a reoccurring theme. Need to have good clinical supervision for young professionals in the mental health field to make sure they grow and are aware of the different programs available to them. Finally, it's critical in developing the public mental health work force to be relevant and understand messaging and framing of mental health issues that are used to address stigma in different cultures.

4. Report Four - Recruitment and Retention:
   Our group narrowed down retention to two key issues, "needing more money" and “more support for staff.” The group discussed the need to develop a workforce with passion for working in a very difficult field. Need to make funding available for stipends, loan forgiveness, and, if possible, rearrange the funding so that there are higher allocations for stipends. Examination of recruitment strategies is needed. Our group emphasized the need to make it more community based; particularly at the community college level where there is a rich source of people

who are not yet committed to mental health but have the capability because of their experience in and knowledge of the community. Lastly, it is important for a statewide commitment to fund identified agencies at a local level that could identify and mentor people, particularly, residents or community people.

5. Report Five:
   To increase recruitment it is important to eliminate the stigma by public and private sector employers of hiring behaviorally challenged people. Need to decrease the stigma within the community for those transitioning into the work force. Many people are terrified of losing the benefit, even replacing it with a salary that is larger then what they receive from the public benefit source. HR Departments must be included in these efforts so that in collaboration to make sure that they understand the outcomes we want to achieve by recruiting people with lived experience--the people that have been in the mental health system as consumers and now want to transition back into that workplace. I'm going to reemphasize the stigma and also the cultural competencies and the competencies and the sensitivities that are involved with the communities we serve. For instance, linguistic, cultural, ethnic, gender, sexual orientation and even economic competencies. Educating both employers and consumers about what those disparities is important.

6. Report Six - Supporting Consumer and Family Employment:
   Out of 4000 directly operated employees in LA County Dept of Mental Health 100 are peers. That is 2.5%. That needs to be increased by a magnitude of at least 10. There is no line item on the work force education and training budget for peer and family employment. That needs to be changed. Workplace wellness programs need to be implemented for advocates and other staff. That can reduce some of the stigma. Lastly, there is a real lack of opportunity and jobs available for peers. We need training for supervisors, management, and all staff that are going to be working with peer and families on clarity of role--on what the positions are for actually.

7. Report Seven - Support, Training, and Education:
   Our first goal was addressing how to expand the capacity of education in training programs. It is important to increase the number of students going into community mental health by creating a stronger bridge between practice and teaching. Additionally, promoting cultural competencies in training and education not only to students but to staff of agencies and consumers and families. Education must be continuous and integrated into clinical supervision and in the families. The final point is that we need to start doing work within the community colleges down to the middle school level that mental health is a career path.

8. Report Eight - Training and Education:
   Our group emphasized the need for partnerships between educational institutions, community based organizations, and DMH to determine what should be in curriculum, what students and new professionals need to work effectively in public mental health and the need for financial support for those kinds of partnerships. Another theme that emerged was a psycho-educational model that could be used to train staff at organizations to do early

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| | intervention and prevention but also as a model to support consumers. Using a "train the trainer" model could be used to support consumers going into the community to teach about mental health.<br><br>9. <u>Report Nine - Consumer and Family Education:</u><br>Our group discussed supporting consumer and family member employment. The first question was, "Is there an adequate number of health consumers and family members being employed?" Our answer, "No." The reasons stigma not only just as a general issue but also in the work place itself and mental health organizations. There are challenges to integrating workers with professionals who are not consumers. The roles are limited and the opportunities for advancement are not always there, and the skills are not always properly matched. To reduce stigma we thought about a state subsidized project for private sectors to support hiring. To support diversity, our group thought a policy paper that makes a strong statement from several organizations could clearly promote diversity and include a detailed plan and principles. |
| **Public Comments & Announcements** | N/A |