MENTAL HEALTH SERVICES ACT

WORKFORCE EDUCATION AND TRAINING PLAN

FY 2006-07 TO 2008-09

COUNTY OF LOS ANGELES
DEPARTMENT OF MENTAL HEALTH

Marvin J. Southard, D.S.W.
Director

October 15, 2008

COUNTY OF LOS ANGELES

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http://dmh.lacounty.gov

Reply To: Dennis Murata, M.S.W.
Angelita Diaz-Akahori, Psy.D.
Fax: (213) 738-6455

October 15, 2008

Mr. Warren Hayes
Education and Training Division
Department of Mental Health
1600 Ninth Street, Room 250
Sacramento, CA 95814

Dear Mr. Hayes:

The Los Angeles County Department of Mental Health in collaboration with the Workforce Education and Training (WET) Ad Hoc Committee (consisting of representatives from contract agencies, various academic institutions, professional disciplines, labor unions, consumers, family members, parent advocates, and stakeholders) is submitting its Mental Health Services Act WET Plan. One year's funding for the plan in the amount of $5,039,719 is being requested.

The plan was available for public review and comment for 30 days from August 29, 2008 through September 28, 2008, and a public hearing was held on September 25, 2008.

If you have any questions regarding the WET Plan, please feel free to contact Dennis Murata, Deputy Director, at (213) 738-4978 dmurata@dmh.lacounty.gov or Angelita Diaz-Akahori, at (213) 639-6307 adiaz@dmh.lacounty.gov.

Sincerely,

Marvin J. Southard, D.S.W.
Director of Mental Health

MJS:DM:ADA

Enclosure

c: Executive Management Team (memo only)
Mental Health Commission

Los Angeles County Mental Health Commission

550 South Vermont Avenue, 12th Floor
Los Angeles, California 90020
TEL: (213) 738-4772 ~ FAX (213) 738-2120
Email: mentalhealthcommission@dmh.lacounty.gov
Website: http://dmh.lacounty.info/mhc

September 25, 2008

Marvin J. Southard, DSW
Director, Department of Mental Health
550 S. Vermont Ave., 12th Floor
Los Angeles, CA 90012

Dear Dr. Southard,

MENTAL HEALTH SERVICES ACT
MANDATED PUBLIC HEARING OF THE
LOS ANGELES COUNTY MENTAL HEALTH COMMISSION

On Thursday, September 25, 2008, the Los Angeles County Mental Health Commission hosted a mandated public hearing. The purpose of the public hearing was to inform the public of the current status of the following MHSA plan and to provide a forum for open comments:

- **Workforce Education and Training (WET)** – The plan provides the means for developing and maintaining a culturally competent workforce that includes clients, family members, and parent advocates capable of providing client-and family-driven services that promote wellness, recovery and resilience, and leads to measurable value-driven outcomes.

The hearing was attended by over 200 constituents, including clients, family members and local political activists. Spanish translators were available to ensure that Latino constituents could actively participate in the hearings, as well as American Sign Language services. Supervisor Michael Antonovich sponsored outreach transportation for constituents residing in the remote areas of Palmdale and Lancaster.

After hearing the public comments, the Mental Health Commission unanimously passed a motion that approved the process for the WET plan.

Sincerely,

Jerry Lubin
Chair

JL:TGLN:tgln

ch/mhsa/approval-WET

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EXHIBIT 1:

WORKFORCE FACE SHEET

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: **LOS ANGELES** Date: **October 15, 2008**

This 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 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 integrating treatment of co-occurring disorders, to including 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.

County Mental Health Director
Printed Name: **Marvin J. Southard, D.S.W.**
Signature: 
Contact Person' Name: **Dennis Murata, M.S.W.**

Street Address (or, PO Box): **550 South Vermont Avenue, 12th Floor**
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Phone #: **(213) 738-4601** Fax #: **(213) 386-1297**
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E-mail: **dmurata@dmh.lacounty.gov**

EXHIBIT 2:

STAKEHOLDER PARTICIPATION SUMMARY

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.

In August, 2008, Los Angeles County Department of Mental Health (LACDMH) completed its process to develop the plan for the Workforce Education and Training (WET) component of the Mental Health Services Act. The Plan that follows strongly utilizes recent stakeholder input and builds upon the initial community planning processes which began in 2005. All required exhibits are included in this Plan as well as a full description of the methodology we used for the Workforce Needs Assessment (Attachment I). There are 22 action plans and all funding categories include at least one action plan. Each action in the Plan addresses one or more of the gaps identified in the Workforce Needs Assessment. The overarching goal of this plan will be to further MHSA essential elements throughout the existing workforce and to expand capacity to implement all other components of MHSA. We believe the Plan establishes a starting point as well as a structure that delivers us to a future with a public mental health workforce with expanded capacity to be an integrated service system that delivers recovery-oriented, culturally-competent, consumer-driven and family member-driven services through collaboration with community partners. This exhibit briefly summarizes how the plan was developed.

In light of the goal of developing a mental health workforce to support the Mental Health Services Act, a brief description of the County's population and demographics provides some context for the stakeholders' considerations while developing the Plan.

With an estimated 9.9 million residents, Los Angeles County is the most populous county in the state of California and is larger in population than 42 states in the country. Los Angeles County is home to nearly a third of all California residents, and the County's population grew by nearly 4.5% between 2000 and 2006. A third (36%) of the residents are foreign born and 57% speak a language other than English at home. Nearly 38% of the population speaks Spanish at home and 6% speak Tagalog, Chinese or Korean. While Latinos are a majority followed by non-Latino Whites, the County also has the largest Asian population in the country at 1.3 million. In terms of age, the largest proportion of our population is adult. Nevertheless, almost one in four are in the 15 years of age or younger category, and in some ethnic groups the proportion in this category is believed to be much larger.

The median household income in the County is lower than the State average, as nearly 12% of the families and 15% of individuals live below the Federal Poverty Threshold. Approximately 38% of the population is dependent upon public assistance. Half the population consists of homeowners, and the other half rents. Per capita income is $24,544, and the

median value of housing is $574,100. Many economists argue that wages have not kept up with Los Angeles' higher cost of living expenses such as energy, housing, and food; thus traditional estimates of economic poverty may underestimate the actual need for public assistance, particularly as it relates to mental health.

The County of Los Angeles Department of Mental Health was established in 1960. It currently serves over 200,000 Los Angeles residents who are chronically mentally ill and often have no other source of assistance and treatment. Its services are provided through a network of directly-operated, contractor and fee-for-service resources across the County. Our providers vary considerably in terms of size, scope and target group. Because of the geographic expanse of the County, the public mental health system is configured into eight service areas each of which has its own unique combination of population, resources, geography and community make-up. The service areas are as follows:

Service Area	Communities	Population
1	Lancaster, Palmdale, North County Rural areas	347,823
2	San Fernando and Santa Clarita Valleys	2,146,515
3	San Gabriel Valley, Pasadena/Altadena, Pomona, Eastern County Area	1,868,116
4	Downtown/Metro Los Angeles, Hollywood, Pico-Union	1,260,196
5	West Los Angeles, Santa Monica, Culver City, Malibu, Brentwood, Venice and Bel Air	636,309
6	South Los Angeles, Compton, Watts, Paramount	1,041,685
7	East Los Angeles, Bell Gardens, Bell, Whittier, Downey	1,379,540
8	South Bay areas, Inglewood, Gardena, Long Beach, Carson	1,605,621

Brief History of Workforce-related Planning within Los Angeles County

Since the approval of the Mental Health Workforce Act, LACDMH has been planning and preparing for changes in its workforce to meet the requirements and spirit of the Act. A process chart and detailed timeline are included as Attachments A and B, and we briefly summarize the history of workforce-related activities here.

In 2005, LACDMH convened a smaller subset of the larger, system-wide MHSA Stakeholders Delegates, the forum that the county uses for its MHSA planning and implementation process (a full list of the members of the Stakeholder Delegates is included as Attachment C). This subgroup, later known as the "Workforce Education, Development and Training Consortium" (Consortium), made recommendations to the Delegates on the proposed expenditure of $10 million

of one-time funds available through CSS for workforce needs. By summer of 2006, the Consortium and Delegates identified and the State approved three priority groups to benefit from these one-time funds as follows:

- to people who are not yet working in the mental health system and are committed to getting a job working somewhere in the system
- to people who are currently working in the mental health system or in partnering organizations, agencies and departments
- to people who are in degree-granting programs for whom there is a documented urgent need.

To date, approved funds were allocated towards Mental Health Rehabilitation Specialist Training, College Faculty Immersion Training, DMH Staff Immersion Training, MFT stipends, Social Work stipends and Peer Advocate training. In addition, the Consortium developed a list of "Design Principles" to guide the development of further priorities for workforce education and training (included as Attachment D). Among other things, these principles highlighted the emphasis on training and workforce development opportunities that focused on proficiency with recovery-based models, consumer and family member participation and outcomes, bilingual skills and cultural competence.

In the summer of 2007, LACDMH reconvened the Consortium group to determine priorities for the Planning and Early Implementation Activities funds available through the Workforce Education and Training Plan. The workgroup's discussion was open to other interested parties as well, not just the original members of the Consortium. In fall of 2007, California Department of Mental Health or State Department of Mental Health (SDMH) allowed counties to request funds for planning and early implementation for WET. SDMH approved LACDMH's $2,450,147 request to support infrastructure expansion and consulting services required to address the various components of LACDMH's plan. The same workgroup identified specific training needs for early implementation and these recommendations have been incorporated into the actions in Exhibit 4. LACDMH included representation from as many stakeholder interests as possible while maintaining a manageable workgroup size that could efficiently execute its tasks.

Current Workforce Education and Training Plan Process

LACDMH convened a Workforce Education and Training Ad Hoc Committee to serve as the primary advisory group to develop the three-year Workforce Education and Training Plan for LACDMH and ensure that the Plan meets its intent of wellness, recovery, and resilience, cultural competency, client/family driven mental health systems, integrated service experience and community collaboration. Many of the original Consortium members continued to be active in this group, thus providing the continuity needed from LACDMH's ongoing workforce plan integration. In addition, LACDMH sought out

representatives from a wide variety of academic institutions (from high schools and community colleges up through university graduate programs), from various disciplines (such as MFTs, Psychiatry, and Social Work) and other nonprofit organizations with mental health workforce development programs. Also represented in the group were programs with experience in developing career ladders for clients and family members/parents, private foundations, and labor unions (a full list of members and representation is included as Attachment E). Just as with the Consortium, the size and membership of the group had to be balanced against the need to accomplish this task efficiently and the need to ensure that the process was as inclusive as possible. Towards this end, the System Leadership Team, a smaller subgroup of our Stakeholder Delegates, maintained a list of interested parties who wanted to join the Ad Hoc Committee and were available to fill any gaps found in representation. The Ad Hoc Committee's meetings were also open to visitors.

To set the stage for this next round of workforce education and training planning, LACDMH and CiMH held a Roundtable event on November 14, 2007 at the Center at Cathedral Plaza to showcase the state's best practices. Approximately, 220 people attended this full-day event that included Warren Hayes (Chief, MHSA Workforce Education and Training Division, CA DMH), Sharon Kuehn (from Santa Barbara County Mental Health Department), Catherine Bond (from Project Return), Gina Perez (Pacific Clinics), Chris Coppola (San Mateo County), Herb Hatanaka (University of Southern California), Ambrose Rodriguez (Latino Behavioral Health Institute) and others. After the Roundtable event, consultant Toni Tullys conducted inventories of Los Angeles County's internal (LACDMH) and external (community) assets from which the Ad Hoc Committee could consider as it prioritized needs and strategized the County's capacity to utilize Workforce Education and Training funds. Twenty-nine LACDMH representatives and 53 representatives from stakeholders external to LACDMH participated in these inventories. Full copies of both inventories are included as Attachments F and G.

The Ad Hoc Committee met monthly since November 2007 and reviewed and prioritized the large amount of data and input gathered. LACDMH conducted the needs assessment during the months of October 2007 – May 2008. The approach had to take into account the scope and unique nature of the Los Angeles mental health system and the County itself and use both qualitative and quantitative data. The qualitative analysis relied upon the input of more than 450 participants in focus groups from each of the County's eight service areas (Service Area Advisory groups or SAACs) and constituent groups such as consumers, underserved ethnic populations and unions, as well as key expert interviews with identified mental health experts. The full qualitative analysis is provided as Attachment H. The quantitative analysis consisted of a compilation and aggregation of raw data from existing human resources, provider and client utilization information, including a contractors survey conducted specifically for the development of the WET Plan. The quantitative analysis included data from all directly operated entities and more than 60% of contractors. It employed a multi-dimensional or convergent analysis methodology for collecting and analyzing the required data. A full copy of the quantitative data analysis is provided as Attachment I. Lastly, LACDMH also convened an Internal Work Group comprised

of representatives from various departments within LACDMH to develop concepts and ideas for the Ad Hoc Committee to review related to data collection, retention and training of workforce, cultural competency, and client/consumer employment and empowerment within the mental health system. A list of represented groups in included in Attachment J.

While LACDMH conducted the needs assessment, the WET Ad Hoc Committee met monthly to receive updates and share white papers and other information about effective models and strategies. LACDMH set up a public website during April 2008-June 2008 to brainstorm, collect and share ideas about workforce development needs and strategies. This webpage was set up as a wiki page, thus allowing any constituent or stakeholder to post his or her ideas and comments for the Committee's review. The Ad Hoc Committee, key experts, Stakeholder Delegates and anyone participating as an observer in those processes were explicitly invited to contribute to the site. While the site was only available in English, LACDMH offered assistance to anyone who desired translation or technical assistance. Once these ideas were collected, LACDMH began to draft potential Exhibit 4 Actions for the WET Ad Hoc Committee to consider after reviewing the results of the needs assessment.

By the end of June 2008, LACDMH presented both the qualitative and quantitative data findings to the WET Ad Hoc Committee. The Committee met almost weekly through the summer to complete its recommendations. In these meetings, the Committee sought to develop a plan consistent with the goals of the Mental Health Services Act. In addition, the Committee aimed to maximize the strengths of the current workforce and increase its capacity over time; diversify the workforce as a means to reducing health disparities; build upon current co-occurring services; and integrate consumer culture within the workforce.

After the Ad Hoc Committee developed its recommendations, they were reviewed by LACDMH executives and the System Leadership Team and finally brought to review to the larger Stakeholder Delegates. The Stakeholder Delegates approved the recommendations on August 22, 2008. A complete draft of the Workforce Education and Training Plan that included all exhibits was posted on the County's website for public review and comment on August 29, 2008; comments were received during the website posting of the Plan and are provided in Attachment K. A public hearing was held on September 25, 2008, a summary of hearing questions, responses, and general comments are likewise provided in Attachment K.

EXHIBIT 3:

WORKFORCE NEEDS ASSESSMENT

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. BY OCCUPATIONAL CATEGORY - page 1

Major Groups and Positions	Estimated # FTE authorized	Position hard to fill? 1 = Yes; 0 = No	# FTE estimated to meet need in addition to # FTE	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	20.0	1								
Case Manager/Service Coordinators	321.5	0								
Employment Services Staff	9.0	1	90.0							
Housing Services Staff	25.0	1	61.0							
Consumer Support Staff	54.0	1	107.0							
Family Member Support Staff	16.0	1	20.0							
Benefits/Eligibility Specialist	117.8	0								
Other ***Unlicensed*** MH Direct Service Staff	118.0	0	15.0							
Sub-total, A (County)	681.3	5	293.0	108.1	212.5	184.7	58.2	1.0	0.0	564.5
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Mental Health Rehabilitation Specialist	556.8	0								
Case Manager/Service Coordinators	908.4	0								
Employment Services Staff	43.7	1	131.0							
Housing Services Staff	19.3	1	58.0							
Consumer Support Staff	264.0	0	500.0							
Family Member Support Staff	186.6	0	200.0							
Benefits/Eligibility Specialist	14.8	1	44.0							
Other ***Unlicensed*** MH Direct Service Staff	763.2	0	15.0							
Sub-total, A (All Other)	2,756.8	3	948.0	679.8	981.9	453.2	100.7	0.0	302.1	2,517.7
Total, A (County & All Other):	3,438.0	8	1,241.0	787.9	1,194.4	637.9	158.9	1.0	302.1	3,082.2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. BY OCCUPATIONAL CATEGORY - page 2

Major Groups and Positions	Estimated # FTE authorized	Position hard to fill? 1 = Yes; 0 = No	# FTE estimated to meet need in addition to # FTE	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)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers):										
Psychiatrist, general	156.2	1								
Psychiatrist, child/adolescent	27.0	1	7.0							
Psychiatrist, geriatric	7.0	1	10.0							
Psychiatric or Family Nurse Practitioner	22.0	1	18.0							
Clinical Nurse Specialist	254.6	1								
Licensed Psychiatric Technician	73.5	1								
Licensed Clinical Psychologist	254.8	0								
Psychologist, registered intern (or waivered)		0	25.0							
Licensed Clinical Social Worker (LCSW)	584.0	1								
MSW, registered intern (or waivered)		0								
Marriage and Family Therapist (MFT)	2.0	0	38.0							
MFT registered intern (or waivered)		0								
Other ***Licensed*** MH Staff (direct service)	12.9	0	2.3							
Sub-total, B (County)	1,394.0	7	100.3	435.2	216.3	143.0	211.5	7.1	0.0	1,013.1
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Psychiatrist, general	62.9	1	50.0							
Psychiatrist, child/adolescent	102.0	1	50.0							
Psychiatrist, geriatric	0.5	1	25.0							
Psychiatric or Family Nurse Practitioner	1.9	1	10.0							
Clinical Nurse Specialist	50.0	1	25.0							
Licensed Psychiatric Technician	54.4	1	50.0							
Licensed Clinical Psychologist	321.9	1								
waivered)	162.6	0								
(LCSW)	190.4	0	150.0							
MSW, registered intern (or waivered)	374.9	0								
Marriage and Family Therapist (MFT)	416.2	0								
MFT registered intern (or waivered)	1,034.7	0								
service)	104.6	0								
Sub-total, B (All Other):	2,876.9	7	360.0	959.7	1,013.1	213.3	160.0	26.7	293.3	2,666.1
Total B (County & All Other):	4,270.9	14	460.3	1,394.9	1,229.4	356.3	371.5	33.8	293.3	3,679.2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. BY OCCUPATIONAL CATEGORY - page 3

Major Groups and Positions	Estimated # FTE authorized	Position hard to fill? 1 = Yes; 0 = No	# FTE estimated to meet need in addition to # FTE	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	10.3	1	4.0							
Registered Nurse	21.0	1								
Licensed Vocational Nurse		0								
Physician Assistant		1	8.0							
Occupational Therapist	16.0	1								
Other Therapist (e.g., physical, recreation, art, dance)	22.0	1								
Other Health Care Staff (direct service, to include traditional cultural healers)		0								
	69.3	5	12.0	21.8	14.0	11.0	7.4	0.0	0.0	54.2
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Physician	3.1	1								
Registered Nurse	92.0	1	50.0							
Licensed Vocational Nurse	105.0	0	25.0							
Physician Assistant	3.9	0								
Occupational Therapist	14.0	1	42.0							
Other Therapist (e.g., physical, recreation, art, dance)	18.7	0	40.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	18.8	1	38.0							
Sub-total, C (All Other)	255.3	4	195.0	72.6	73.5	54.5	20.0	0.9	21.8	243.3
Total C (County & All Other)	324.7	9	207.0	94.4	87.5	65.5	27.4	0.9	21.8	297.5

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. BY OCCUPATIONAL CATEGORY - page 4

Major Groups and Positions	Estimated # FTE authorized	Position hard to fill? 1 = Yes; 0 = No	# FTE estimated to meet need in addition to # FTE	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)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor	131.5	0								
Supervising psychiatrist (or other physician)	26.3	0								
Licensed supervising clinician	137.0	1	63.8							
Other managers and supervisors	132.0	0	29.0							
Sub-total, D (County)	426.8	1	92.8	170.8	105.0	108.0	81.0	2.0	0.0	466.8
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor	399.8	1	100.0							
Supervising psychiatrist (or other physician)	57.1	1	50.0							
Licensed supervising clinician	384.2	1	200.0							
Other managers and supervisors	484.3	0								
Sub-total, D (All Other)	1,325.4	3	350.0	542.9	337.5	218.6	125.7	8.8	57.0	1,290.5
Total, D (County & All Other)	1,752.2	4	442.8	713.7	442.5	326.6	206.7	10.8	57.0	1,757.3
E. Support Staff: (non-direct service):										
County employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance	293.0	0								
Education, training, research	39.0	0	5.0							
Clerical, secretary, administrative assistants	664.8	1								
Budget/Fiscal	125.0	1								
Human Resource	36.0	0	2.0							
Other support staff (non-direct services)	101.5	0	6.7							
Sub-total , E (County)	1,259.3	2	13.7	159.0	235.0	289.7	288.0	1.0	0.0	972.7
All Other (CBs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance	249.6	0								
Education, training, research	130.8	1	100.0							
Clerical, secretary, administrative assistants	800.1	0								
Other support staff (non-direct services)	647.9	0								
Sub-total , E (All Other)	1,828.4	1	100.0	309.1	795.5	437.6	175.6	13.4	43.9	1,775.1
Total E (County & All Other):	3,087.7	3	113.7	468.1	1,030.5	727.3	463.6	14.4	43.9	2,747.8

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT
I. BY OCCUPATIONAL CATEGORY - page 5

Major Groups and Positions	Estimated # FTE authorized	Position hard to fill? 1 = Yes; 0 = No	# FTE estimated to meet need in addition to # FTE	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)
County (employees, independent contractors, volunteers) (A+B+C+D+E)	3,830.7	20.0	511.8	894.9	782.8	736.4	646.1	11.1	0.0	3,071.3
All Other (CBOs, CBO sub-contractors, network providers and volunteers) (A+B+C+D+E)	9,042.9	18.0	1,953.0	2,564.1	3,201.5	1,377.2	582.0	49.8	718.1	8,492.7
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)	12,873.5	38.0	2,464.8	3,459.0	3,984.3	2,113.6	1,228.1	60.9	718.1	11,564.0

Major Groups 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)
F. TOTAL PUBLIC MENTAL HEALTH POPULATION	**Leave Col. 2, 3, & 4 blank**			**42,525**	**79,176**	**51,851**	**9,627**	**1,139**	**5,589**	**189,907**
(January 1, 2007-December 31, 2007				(22%)	(42%)	(27%)	(5%)	(1%)	(3%)	

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. POSITIONS SPECIFICALLY DESIGNATED FOR INDIVIDUALS WITH CONSUMER AND FAMILY MEMBER EXPERIENCE -- COUNTY TOTALS - page 1

Major Group and Positions	Estimated # FTE authorized and to be filled by consumers or family members	Position hard to fill with consumers or family members? (1=Yes; 0=No)	# additional consumer or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	318.0	1	607.0
Family Member Support Staff	202.6	1	220.0
Other *Unlicensed* MH Direct Service Staff	60.0	0	50.0
Sub-total, A:	**580.6**	**2**	**877.0**
B. *Licensed* Mental Health Staff (direct service)	20.0	1	20.0
C. Other Health Care Staff (direct service)	10.0	1	8.0
D. Managerial and Supervisory	20.0	1	5.0
E. Support Staff (non-direct services)	40.0	0	10.0
Sub-total (B+C+D+E):	90.0	3	43.0
GRAND TOTAL (A+B+C+D+E):	**670.6**	**5.0**	**920.0**

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

LANGUAGE PROFICIENCY

Directly Operated and Contract Agencies

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT				
III. Language Proficiency - Page 2				
Language, other than English		**Number who are proficient**	**Additional number who need to be proficient**	**TOTAL (2)+(3)**
(1)		**(2)**	**(3)**	**(4)**
Spanish	Direct Service Staff	3,489.0	2,638.0	**6,127.0**
	Others			
Mandarin	Direct Service Staff	55.0	10.0	**65.0**
	Others			
Other Chinese	Direct Service Staff	86.0	233.0	**319.0**
	Others			
Cantonese	Direct Service Staff	96.0	0.0	**96.0**
	Others			
Korean	Direct Service Staff	77.0	234.0	**311.0**
	Others			
Tagalog	Direct Service Staff	145.0	224.0	**369.0**
	Others			
Vietnamese	Direct Service Staff	52.0	96.0	**148.0**
	Others			
Russian	Direct Service Staff	44.0	33.0	**77.0**
	Others			
Cambodian	Direct Service Staff	60.0	0.0	**60.0**
	Others			
Armenian	Direct Service Staff	64.0	175.0	**239.0**
	Others			
Arabic	Direct Service Staff	20.0	53.0	**73.0**
	Others			
Farsi	Direct Service Staff	89.0	29.0	**118.0**
	Others			
Others	Direct Service Staff	339.0	2,509.0	**2,848.0**
	Others			
TOTAL, all languages other than English:	**Direct Service Staff**	**4,616.0**	**6,234.0**	**10,850.0**
	Others	**0.0**	**0.0**	**0.0**

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

IV. REMARKS: Provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. Include any subsets 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.

INTRODUCTION:

The goals of the needs assessment were to: 1) satisfy state requirements with respect to developing a plan for expanding, training and educating the workforce; and 2) inform the planning and decision-making of the County in how best to transform Los Angeles' system as intended by MHSA. LACDMH's needs assessment derives data from three main sources: 1) an inventory or asset map of the strengths and opportunities available in the County; 2) a qualitative data analysis that utilized input from various stakeholders through focus groups and key expert interviews; and 3) a quantitative data analysis that combined data from existing departmental information system sources and the results of a survey of LACDMH's contractors in order to complete the required tables of Exhibit 3. More than 450 LACDMH providers, contractors, consumers, family members, community representatives and many other stakeholders participated in the inventories and qualitative analysis; and all of LACDMH's providers and more than 64% of the contractors contributed to the quantitative analysis. As each phase of the needs assessment was completed, LACDMH provided the information to the WET Ad Hoc Committee for review and consideration.

The size, scope and diversity of Los Angeles' existing mental health service delivery system represents a large field to capture in a relatively short data collection process. A number of caveats to Exhibit 3's tables need to be mentioned:

- The staffing patterns in Exhibit 3 more likely reflect positions that were responsive to funding and billing streams, a system-wide adaptation to long periods of cumulative curtailments in mental health budgets and other unavoidable civil service constraints.
- The "occupational categories" stipulated by the State did not easily match the staff categories maintained within the system's directly operated and contractor agencies. Occupational titles between the State and the County of Los Angeles were not always comparable but every effort was made to match system job titles to the specified categories requested.
- The standard broad classifications for ethnic comparisons in Exhibit 3 obscure important differentiations in a county as ethnically and linguistically varied as Los Angeles. Key differences *within* each ethnic category in terms of language and culture are important considerations, for which we relied heavily on the focus groups and key expert interviews to reveal such differences. The subsets and detail in this narrative portion of Exhibit 3 attempt to highlight any significant distinctions that the standard broad classifications would otherwise mask.

- Staff language capacity in Exhibit 3 does not necessarily describe a match between language groups and ratios between staff and clients that speak a specific language. Rather, it is based on bilingual bonus information for all staff. To better assess workforce language proficiency needs, our needs assessment disaggregated the available data into the thirteen threshold languages for Los Angeles County and made recommendations based on those findings.
- The hiring and identification of consumers and family members within the system is made more difficult by stigma, isolation, voluntary disclosure rights and low expectations. Individuals who could be identified as consumers and are hired within the system may decline to acknowledge their consumer or family status.
- The following "Hard to Fill" criteria was used: lack of career ladder, pay and/or benefits insufficient to recruit/retain sufficient qualified individuals; difficulty attracting sufficient numbers of individuals to meet ethnic/racial/linguistic diversity needs; difficulty finding sufficient numbers of individuals with needed specialized skills, i.e., foster care, geriatric mental health, child psychiatry, TAY, etc.; and geographic or less desirable site assignment issues.

The full needs assessment analyses are provided as Attachment H (qualitative assessment) and Attachment I (quantitative assessment). In addition, LACDMH conducted Internal and External Inventories to assess the systems current capacity for workforce investments; while the relevant parts of the Inventories' summaries and recommendations are incorporated into this narrative, the full Inventories can be found as Attachments F and G.

Below are highlights of the needs assessment's findings and recommendations:

A. Shortages by occupational category:

The overall ratio of mental health provider to client is 1:28. Focus groups indicate that additional staffing is needed across the workforce, but particularly for those with bilingual skills and/or cultural competency skills. Unlicensed staff reflects second lowest number of authorized to filled positions (-10 difference); while support staff is the lowest number of authorized to filled positions. Data suggest that LACDMH take steps that both increase the numbers of new people entering the workforce and retain and retrain current workforce staff.

The needs assessment suggests that LACDMH take actions that reduce the gap between filled and authorized positions in unlicensed, licensed and other health care segments. These positions include clinical positions and key recovery/resiliency positions such as Community Employment Specialists, Peer Advocates and Housing Specialists. It also suggests that LACDMH should address the actual numbers and proportions of licensed positions in the system

compared to unlicensed and other health care segments (i.e. transformation to a recovery model may call for adjustments or rebalancing of types of positions in the system).

The data also suggest that LACDMH expand options for career movement from all segments to manager positions and develop more representative leadership and transform career movement/mobility to manager's positions. Focus group comments support this analysis as many participants discussed the perception of a "glass ceiling" – that there are not opportunities to promote or move up, especially for consumers and families.

In addition to the State-provided tables, our needs assessment looked more specifically at the distribution of filled positions by ethnicity (Table 3 of Attachment I – Quantitative Needs Assessment). These data demonstrate that:

- Native American employees represent the lowest proportion in every segment of filled positions; less than 1%
- Hispanic/Latino employees are one-third of filled positions in four of the five segments
- Non-Hispanic White employees represent the largest proportion of two segments; licensed (37.9%) and management (40.6%)
- Hispanic/Latino employees represent almost 40% of filled Unlicensed positions
- Notable difference for African American/Black between representation in Licensed positions (9.7%) and client population (27%); a difference of approximately 17%
- Difference for Hispanic/Latino between representation in Licensed positions (33.4%) compared to client proportion (41.%); approximately 7.6%
- Licensed White clinicians represent almost 40% of the total and white clients are 22% of the total client population

The above data suggest that LACDMH needs to: 1) increase diversity within the ranks of the Licensed workforce; 2) address the actual numbers and proportions of licensed positions in the system compared to Unlicensed and Other Health Care segments; 3) explore possible adjustments or rebalancing of types of positions in the system; and 4) examine more closely the County's Human Resources' hiring practices, criteria, and eligibility rules especially in segments that reflect important disparities or gaps.

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

The highest ratio of provider to client is with the Hispanic/Latino population (1:50), and the second highest ratio of provider to client is for Asian/Pacific Islanders population (1:38). The lowest proportion of providers is Native American (0.53%), and second lowest proportion of providers is Multi Race or Other (6.19%). These figures indicate a need to increase

diversity within the ranks of licensed segment of the workforce. In terms of ethnicity, the largest negative difference between representation in provider pool and client population is for the Hispanic/Latino ethnic group. There is a 12.41% difference between their proportion of the licensed provider's population (29.27%) and their representation in the client population (41.68%). LACDMH sees the need to reduce the ratio of clients to providers for all groups, especially for the Hispanic/Latino and Asian/Pacific Islanders populations, as well as a need to increase the proportion or representation of providers from Hispanic/Latino, Native American and African American/Black populations to better match their client proportions.

One focus group was conducted at a meeting of the Under-Represented Ethnic Populations (UREP), which provided additional valuable qualitative data. While the UREP focus groups made recommendations very similar to those made in the SAACs, they focused on issues related to providing culturally competent services. For example, they emphasized the importance of understanding both the cultural and historical contexts of the different ethnic groups and offered more community-based solutions such as placing therapists and mental health services staff within community based organizations or churches which have more direct and trusting relationships with the community. In addition to emphasizing the importance of culturally competent services, representatives from the Hispanic/Latino and Asian/Pacific Islanders groups shared a common struggle to find bilingual services in the languages that they need and finding the staff to fill critical service positions.

A consistent message that emerged from the ethnic populations in particular is the need for mental health positions to be immersed within the community that is being served. African American, Hispanic/Latino, Native American, and European American communities all mentioned the importance of collaborating with local churches, spiritual bases and community organizations in order to reach out to the community.

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

Only a total of 443 directly-operated and contracted positions were considered to have consumers or family members employed in them, representing only 4% of all positions overall in the system. While we suspect that there are more consumers and family members working in the system than can be determined by our data analysis, the largest negative difference between authorized and filled positions are in the directly operated category. DMH contractors show the "best effort" in terms of filled positions in this category with only a 13% difference between authorized and filled.

In focus groups and key expert interviews with consumers and family members, participants repeatedly focused on the need to transform the culture of the mental health service system in order to truly embrace a recovery-based model of

service delivery and to include consumers and family members as employees of the system. There was a shared frustration that “the stigma of mental health illness permeates all provider/consumer interactions.” Consumers described providers as patronizing, having low expectations of consumers' abilities, exerting minimal effort, and reinforcing learned helplessness and dependency within an unresponsive uncaring system. All consumer and family discussion groups focused on the importance of stigma reduction training. These data reinforce the need to Increase the proportion of positions in this category and develop career pathways for consumers and family members.

D. Language proficiency:

LACDMH must develop a public mental health workforce that is able to meet the linguistic needs of the unserved and underserved population in thirteen different threshold languages. The assessment of workforce needs in terms of language proficiency and staff for Los Angeles County compared target population and available human resources against a suggested standard for staff-to-consumer ratio. Our supplementary needs assessment presented data in terms of population, staff and capacity by threshold language for the purposes of WET planning and goal setting. Proportional differences between existing staff in each language category and the optimal staffing standard or ratio were calculated to identify gaps in resource availability (see quantitative needs assessment as Attachment I).

The needs assessment recommended that language groups with 50% or greater difference between available staff and the workforce standard should be the highest priority for workforce development. It also suggested that consideration should be given to expanding the “interpreter” segment of the workforce particularly in the categories with the highest discrepancies between available staff and the recommended standard, and that the languages that comprise the “Other” category should be elucidated further.

Focus group data echo the need for staff who are culturally and linguistically competent across all positions and categories. It emphasized the need for more trained bilingual and bicultural staff in the threshold languages – Spanish being the dominant among them. Existing bilingual and bicultural staff, in particular, said that they are feeling pinched because they are often called in to help translate when necessary, but that these services are not only financially uncompensated but also create a backlog in their formal job responsibilities.

E. Other, miscellaneous:

Focus group data indicated some need for training for “first responders” such as fire department and law enforcement to create a more integrated service experiences in alignment with MHSA principles. In particular, many noted how consumers and family members’ experience could provide significant contributions to training these community partners.

The needs and priorities that emerged from the focus groups were largely consistent throughout all of the age groups and in each of the SAACs. SAAC 1, however, has needs unique to its location, and thus their comments, while consistent with the other SAACs, discussed workforce development and training within a context of accessibility and transportation issues (i.e. trainings physically held in Palmdale or Lancaster or more satellite offices in the Antelope Valley).

One key recommendation from our Asset Inventories indicated that there is a priority need for Los Angeles County Human Resources to be more responsive/supportive of mental health’s transformational workforce needs. It suggests that the Plan work to improve communication and collaboration across the system to support and strengthen WET efforts.

EXHIBIT 4:

WORK DETAIL

EXHIBIT 4: WORK DETAIL – page 1
A. WORKFORCE STAFF AND SUPPORT

Action #1
Title: Workforce Education and Training (WET) Coordination

Description:
Workforce Education and Training (WET) early implementation funding supported the staffing for the planning and development of Los Angeles County's Workforce Plan. The staff included a WET Coordinator, a Program Head, an administrative staff, a secretary and four consultants. This team led the planning process by coordinating and developing a Roundtable event, conducting monthly meetings with the Ad Hoc Committee, providing regular updates and presentations at Stakeholder and System Leadership Team meetings, conducting focus and key expert groups, drafting Action Plans and submitting the plan to local approval bodies.

Implementation of the WET plan requires on-going coordination and monitoring to ensure that all administrative and clinical functions at the county and contractor levels are achieved. This team will include additional staff to support all of the new activities required during the implementation phase of the plan.

Objectives:
1. To coordinate, monitor and evaluate the implementation of the WET Plan.
2. To ensure meaningful inclusion of consumers, family members, and parent advocates in the implementation process.
3. To continue to support stakeholder involvement at all levels of the implementation process.
4. To develop and evaluate a data collection plan that meets State guidelines.
5. To ensure the WET planning process meets DMH State requirements.
6. To consolidate stakeholder input into the implementation of the WET Plan.
7. To continue to promote MHSA principles and values and ensure they are incorporated during the implementation phase.

Budget Justification:

Develop a team of staff responsible for implementation of the County of Los Angeles Workforce Education and Training Plan. This team will direct and manage the development of the WET program protocols and procedures, monitor implementation and ensure that WET outcomes and objectives are met. Costs also include services and supplies needed to effectively run the Plan. Administrative figures are based on 12.5% of the total allocated budget. Cost: $559,969.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $559,969

EXHIBIT 4: WORK DETAIL – page 2
A. WORKFORCE STAFF AND SUPPORT

Action # 2
Title: County of Los Angeles Oversight Committee

Description: A WET Oversight Committee will be created for the purpose of guiding and supporting the implementation of the County's plan. The committee will comprise of representatives from entities including:

MFT Consortium	Medical Schools-Residency Program
MSW Consortium	Under Represented Ethnic Populations (UREP)
Southern CA Assoc. of Psychology Training Programs	Age Group Leads
Los Angeles Unified School District	Labor Unions
Community Colleges	Consumers
Mental Health Commission	ACHSA
Vocational Rehabilitation	NAMI
Mental Health Contracts	Other Social Services Partners
CiMH	Co-Occurring Disorders Expert

The representatives who serve on the Oversight Committee will reflect the cultural and linguistic community of the County of Los Angeles. Appointment to the WET Oversight Committee will be determined by the County of Los Angeles Director of Mental Health.

Objectives:
1. To provide oversight and direction to the County of Los Angeles' WET Plan.
2. To track the County's workforce implementation and outcomes goals.
3. To ensure the County's compliance with WET protocols and review how the ethnic minority and linguistic staffing needs of the County are being met.
4. To monitor trends and adjust accordingly to meet the needs of the system's workforce capacity.
5. To monitor the County's WET budget.
6. To advocate at the County, State and Federal levels on behalf of the County's workforce needs.
7. To explore ways in which other funds could be leveraged with the goal of maximizing WET funds.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 3
B. TRAINING AND TECHNICAL ASSISTANCE

Action #3
Title: Transformation Academy Without Walls

Description: The Transformation Academy Without Walls will become a uniform and comprehensive resource for all mental health workforce that provides specific training to the mental health workforce. It will set standard curricula for courses in core competencies and will be tailored to the individual's particular entry point as a consumer, family member, and parent advocate, clinician, line staff, supervisory and manager. The Transformation Academy Without Walls also will incorporate coaching and mentoring as important supports and reinforcements that apply learned concepts to concrete experiences. A variety of approaches will be considered in consultation with established authorities in recovery/resilience including web-based technologies and a "promotoras" model. A forum of stakeholders that includes consumer, family members and parent advocates, contract agencies, DMH administration, labor unions, underrepresented ethnic groups, emancipated youth and academic institutions will define the value-based learning and skill building in evidence-based and community-based practices. All curricula will include a focus on cultural competency. The purpose of the Transformation Academy Without Walls is to support the transformation of the mental health system by enhancing the implementation of the MHSA model. Action #4, the Learning Management System will be an integral part of the Transformation Academy Without Walls implementation.

Objectives:
1. To establish a Transformation Academy Without Walls that will set standards and specific training curricula targeting the integration of services in a context of hope, recovery/resilience and wellness.
2. To provide programs recognized for recovery focus such as Immersions.
3. To introduce new and current staff to recognized leaders in the field of recovery/resilience and wellness, including consumers, family members and parent leaders through multi-media consultations and guided discussions of their methods and approaches.
4. To support the retention and re-training of existing staff.
5. To perform Recovery Assessments with follow up onsite coaching and training for staff at various agencies and programs, particularly with non-traditional staff that come from diverse cultures and provide unique contributions to the work place.

Budget Justification:
For FY 2008-09 allocated funds for training to update the knowledge and skills of both directly operated and contract agencies clinical staff and supervisors who are engaged in the transformation of the public mental health system that focuses on recovery-oriented services. Cost $225,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $225,000

EXHIBIT 4: WORK DETAIL – page 4
B. TRAINING AND TECHNICAL ASSISTANCE

Action #4
Title: Learning Management System --The Learning Net

Description: The Learning Management System (LMS), or the Learning Net, is a web-based tool that will enable the County of Los Angeles' Transformation Academy Without Walls to manage, report and deliver various types of learning content and resources to all mental health county and contract employees. This web-based tool will be an essential infrastructure to the Transformation Academy Without Walls. It will manage and track MHSA trainings which focus on recovery, resilience and wellness topics. In addition, consumers, family members and parent advocates will have access to information and training through the system. LMS will provide learning assistance to employees as standards are set for practice and services in the mental health workforce. As an important tool for implementing and managing the Transformation Academy Without Walls, the LMS could also include benefits such as online e-learning, self-registration and interface with other web-based training that will be accessible to all mental health employees and other stakeholders.

Objectives:
1. To provide a comprehensive web-based tracking system of training of the mental health workforce.
2. To monitor employee training and compliance.
3. To access employee training records for various authorized levels.
4. To implement a web-based system that will interface with other local, State and national training networks.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 5
B. TRAINING AND TECHNICAL ASSISTANCE

Action #5
Title: Recovery-Oriented Supervision Trainings

Description: Competent and qualified front line supervisors are critical to the effectiveness and delivery of MHSA programs. With the system's transformation, supervisors assume important leadership roles to teach, support, and elevate the recovery and resilience philosophies. The focus of the Supervisory trainings would be to immerse supervisors into the basic tenets of MHSA, provide updated information on issues related to recovery and wellness, and teach how to successfully integrate consumers, family members, and parent advocates into the mental health workforce. A key component will be the incorporation of cultural competency topics such as how one's cultural perspective affects service delivery.

Objectives:
1. To promote the core values of the MHSA philosophies and the shift of embracing the recovery, resilience and wellness philosophies through supervision and to incorporate cultural competency in the process.
2. To support and assist in the integration of consumers, family members and parent advocates in the mental health workforce.
3. To increase skills for effective supervision of staff-including individuals in recovery and/or family members who perform jobs other than advocate in order to effectively support them in delivering services congruent with the principles of the MHSA Recovery Model to multi-cultural mental health clients and families.
4. To create a network of recovery oriented supervisors.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 6
B. TRAINING AND TECHNICAL ASSISTANCE

Action #6
Title: Interpreter Training Program

Description:
With thirteen threshold languages in Los Angeles County, it is often difficult to secure sufficient numbers of bilingual mental health staff to handle requests for service. In an attempt to increase linguistic access in the short term, the system will use interpreter services. While this is not the most ideal approach, it can serve as a bridge to services until our workforce has more internal capacity to meet linguistic need. Trainings will be implemented in the following phases: Phase I: Training of interpreters for mental health settings; Phase II: Training of mental health providers on how best to use interpreters; and Phase III: Technical assistance and follow-up support to all participants. Each phase of the training will include cultural competency topics that may prevail about mental illness and treatment within different ethnic populations.

Objectives:
1. To define interpreter role within the therapeutic relationship including dual relationships (e.g., when the interpreter may also be a staff member providing support or case management services).
2. To develop techniques for managing the therapeutic triad among interpreter, client and professional staff.
3. To identify cultural differences including the variant beliefs concerning mental illness in various cultures, especially in areas related to treatment and family participation.
4. To teach ways of interpreting objectively, especially when dealing with taboo subjects (e.g. incest, child abuse or when topics are uncomfortable to the interpreter).
5. To discuss the importance of briefing and de-briefing with the interpreter.
6. To determine legal and ethical implications of problematic communication.
7. To facilitate communication of ideas, concerns, and rationales beyond the translation of words (e.g., body language).

Budget Justification:
Develop a series of trainings with an estimate of 30 participants in each training session. Participants will include individuals interested in providing interpreter services as well as individuals interested utilizing interpreters. Trainings will cover didactic classroom as well as consultation and technical support (after completion of the training for participants). One time allocation for FY 2008-09. Cost $70,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $70,000

EXHIBIT 4: WORK DETAIL – page 7
B. TRAINING AND TECHNICAL ASSISTANCE

Action #7
Title: Training for Community Partners

Description: Training will be developed and implemented with community partners including law enforcement, probation department, child protective services department, and community agencies (e.g., regional centers, schools, faith-based organizations, Katie A., health clinics, and day care centers). Curriculum would train the staff of these organizations on recognizing basic mental health symptomatology, how to access mental health services, how to work with monolingual and/or LEP (limited English proficient) individuals, and provide an overview of the MHSA recovery and resiliency philosophies. Training will be culturally sensitive to the communities where these presentations will be held and will include consumer, family member, and parent advocate presenters familiar with these communities. These trainings also will help community partners understand the MHSA elements that guide mental health workforce development in Los Angeles County.

Objectives:
1. To introduce principles of hope, recovery/resilience and wellness through examples from presenters' experiences and teach staff from community partner agencies to explore the application of these principles in their own work.
2. To train community partners to recognize the signs of mental illness and how to access care for the individual in a culturally appropriate manner.
3. To train people who work in community partner agencies about new developments in the public mental health system, including consumer support programs and Wellness/Client-Run Centers and how individuals could be linked to such services.
4. To increase the knowledge of how staff at these agencies can utilize public mental health services, specifically in communities where these innovative services are now becoming available through MHSA.
5. To identify issues of concern to community partners and develop training specific to these concerns through systematic outreach.

Budget Justification:
A "Train the Trainer" model will be selected and individuals representing the different geographic areas in the County will be trained. Consumers family members and parent advocates will be included in the training. One time allocation. Cost $100,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $100,000

EXHIBIT 4: WORK DETAIL – page 8
C. CAREER PATHWAYS

Action #8
Title: Intensive Mental Health Recovery Specialist Training Program

Description: The proposed Intensive Mental Health Recovery Specialist Training Program will play a crucial role in the creation of a transformed mental health workforce by increasing the number of MHSA-trained entry-level professionals who represent the linguistic and cultural diversity of those receiving services in Los Angeles County and/or who have the lived experience of receiving services or of being a family member of a person receiving services. The training program should include didactic and experiential portions, be taught by a variety of experts and leaders in the mental health field and include significant support for the students to help them adjust to the challenging role of Mental Health Rehabilitation Specialist in the public mental health system. The training program should also include a simultaneous field placement portion where participants will be able to experience working in the field while continuing to learn skills to improve their practice in the classroom.

Objectives:
1. To increase training programs for individuals with Bachelor degrees to support their efforts to enter into the mental health field.
2. To recruit and attract ethnically and linguistically diverse individuals to be trained in MHSA philosophies and practices.
3. To train through a combination of classroom lectures, activities and field placements, individuals to be able to fill the demand for entry level staff in the public mental health system in Los Angeles County.
4. To match trainees with ideal field placements and support them in their placements to increase the likelihood of acquiring jobs in the public mental health system.

Budget Justification:
FY 2008-09 funds allocated to train consumers, family members, parent advocates and any individuals interested in pursuing a mental health career. The intent is to train up to 220 participants with 25% consumers/family members and 50% from unserved and/or underserved ethnic communities. Design and implement a 15 week didactic course work that incorporates field experience/placement in the public mental health agency. Cost $1,086,750.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $1,086,750

EXHIBIT 4: WORK DETAIL – page 9
C. CAREER PATHWAYS

Action #9
Title: Expand Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System

Description: Given the importance of consumer employment in service delivery, this action is intended to support increased training and employment of consumers in our public mental health system and decrease barriers to employment. Consumer training could consist of topics such as how to apply and succeed in employment in the public mental health system. Curriculum could target specific populations that include older adults and transitional age youth (TAY). Recruiting consumers in ethnically diverse communities and who represent one of the 13 threshold languages would be a priority.

Objectives:
1. To identify models that train consumers in the delivery of mental health services, with particular emphasis on increasing employment of consumers from underserved communities representing the 13 threshold languages.
2. To provide training in the specific models which assist in the delivery of direct and indirect mental health services in the public mental health field.
3. To monitor consumers who successfully complete the identified training programs and acquired employment in the public mental health field.
4. To create a career pathway for consumers in the public mental health system and address issues which may negatively impact consumers' movement along this career pathway.
5. To educate contract agencies and County operated programs as to the benefits of hiring and advancing consumers.
6. To ensure appropriate County HR classifications for consumer hiring and work to significantly speed up the hiring process.

Budget Justification:
FY 2008-09 funds have been allocated to sponsor consumer training that prepare them for employment in the public mental health system. Up to 60 consumers participating in the certificated training program(s) will be enrolled. Cost $180,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $180,000

EXHIBIT 4: WORK DETAIL – page 10
C. CAREER PATHWAYS

Action #10
Title: Expand Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System

Description: Parents of children, child advocates and caregivers serviced in the public mental health system are important stakeholders, and this action is intended to increase training and employment opportunities for them and decrease barriers to employment. The training will focus on developing skills needed to perform community outreach, advocacy and leadership duties which promote MHSA resilience and wellness principles. Often public speaking and community presentations are essential duties performed. Other valuable skills needed to effectively support their roles include developing and facilitating parent and child advocate and caregiver groups. Such trainings would not only address those areas, but also focus on teaching them to navigate systems like mental health, schools, regional centers, and child protective services. These types of trainings have been requested and considered potentially beneficial for those advocates already employed in the public mental health system. Taking into consideration the County of Los Angeles ethnic communities, all trainings would be culturally relevant and in the language of the respective communities.

Objectives:
1. To identify models that train parent advocates, child advocates and caregivers in the delivery of mental health services and support the MHSA principles of resilience and wellness.
2. To provide training in the delivery of services in the public mental health field.
3. To monitor parent advocates, child advocates and caregivers who successfully complete the identified training programs and apply for acquired employment in the public mental health field.
4. To assist in accessing entry for parent advocates, child advocates and caregivers in the public mental health system with particular emphasis on increasing the number of parent advocates, child advocates and caregivers from underserved ethnic communities representing the 13 threshold languages.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 11
C. CAREER PATHWAYS

Action #11
Title: Expand Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System

Description: Family Member's concern, commitment and support of wellness and resiliency for loved ones are an important part of the recovery process. The proposed trainings would prepare family members of consumers to develop or augment skills related to community outreach, advocacy and leadership and decrease barriers to employment. These trainings would include such topics as public speaking, navigating systems, and resource supports for consumers and families. Priority will be given to those family members coming from targeted communities particularly those culturally and linguistically underserved in the County of Los Angeles (i.e., Spanish speaking, Asian Pacific Islanders, etc.). Upon completion of the training, family member advocates would be eligible to apply for employment in the public mental health workforce.

Objectives:
1. To identify models that train family member advocates in the delivery of mental health services.
2. To provide training in the delivery of services in the public mental health field.
3. To monitor family member advocates who successfully complete the identified training programs and apply for employment in the public mental health field.
4. To assist family member advocates to access employment in the public mental health system with particular emphasis on increasing advocates to serve currently unserved and underserved communities representing the 13 threshold languages.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 12
C. CAREER PATHWAYS

Action #12
Title: Mental Health Career Advisors

Description: Many barriers exist for those attempting to become employed in the mental health field, most particularly consumers, parents and family members. These barriers include financial constraints, competing responsibilities, a lack of support and encouragement, poor information, and a lack of advocacy in general. Most organizations are unable to offer constant, coordinated career guidance and support due to cost constraints, competing priorities and frequent turnover. Although it may be true that increased skills and education make an individual more attractive to a competitor, upward mobility will lead to a higher overall retention rates in the overall mental health system. In an effort to help the mental health system employ a more global approach when it comes to workforce retention, we propose developing a group of advisors who will work with newly entering and/or existing mental health staff to help them as they enter and remain in the mental health workforce. Through the provision of ongoing advice, coordination of financial assistance, job training, mentoring, tutoring, information sharing and advocacy, the Mental Health Career Advisors will essentially function as a one-stop shop for upward career mobility.

Objectives:
1. To increase the rate of retention of existing mental health staff through skill development in current positions and advancement into higher level positions.
2. To assist participants in accessing MHSA funded workforce development programs/efforts.
3. To extend the reach of MHSA funded workforce education and training efforts by assisting participants in accessing non-MHSA funded scholarships, stipends, and other means of financial assistance.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL -– page 13
C. CAREER PATHWAYS

Action #13
Title: High School through University Mental Health Pathways

Description: The County of Los Angeles will focus on promoting mental health careers to high school, community college and university students, particularly in communities or areas of the County where ethnically diverse populations reside. A High School Academy, community college AA program, and university BA/BS model program have been successfully implemented and target students in ethnic communities where a greater likelihood for recruiting bilingual/bicultural individuals into the workforces exists. Expanding such academic programs promotes the education and preparation of the next generation of ethnically diverse mental health workers, while normalizing individual and family attitudes about mental illness. The High School Academy - University track ensures that a significant number of students are identified, selected, supported and mentored through the process. In addition, a Cohort Model, where participates enter into an academic training program as a group and are followed from pre-entry to graduation to licensure/certification would be considered as part of this career pathway. Success rates for program completion for participants increase when there is camaraderie and a shared sense of group support.

Objectives:
1. To establish partnerships with interested school districts, community colleges, and universities in the County of Los Angeles to establish an academic pathway for individuals to ultimately become employed within the mental health system.
2. To align curriculum that reflects helping skills and essential concepts related to mental health services with core academic curriculum.
3. To identify and support a minimum of 1 mentor per academic institution to assist students with applying for financial aid and transitioning into higher education in mental health programs and to provide on-going guidance to keep students focused on a career pathway in the mental health field.
4. To identify and support a minimum of 1 field placement specialist/ job developer per academic institution to increase the effectiveness of the field placement experience and increase the number of graduates who become employed in the mental health system.
5. To increase graduation rates for students enrolled in the pipeline programs.
6. To create replicable curriculum and consult with potential and existing academic programs to improve the overall system.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 14
C. CAREER PATHWAYS

Action #14
Title: Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System

Description: Given the severe shortage in the County of Los Angeles' public mental health workforce and the significant need for professionals to service the seriously mental ill population, recruitment is a priority. Market research and advertising strategies can assist in defining ways of attracting and targeting new professionals into the public mental health field. To this date, no formal market research has been completed to address these issues. This action would establish a collaboration with an academic institution, research institute or think tank to conduct market research and then formulate advertising strategies based on that research. Studies would include designing research to target attracting more bilingual staff, as well as staff to serve ethnic minority communities, addressing cultural variances and access factors. Indirectly, these efforts may also support the retention of current staff or encourage their further professional development.

Objectives:
1. To collaborate with an academic institution, research institute or think tank to conduct market research and then formulate advertising strategies based on that research to attract more mental health professionals.
2. To implement advertising strategies countywide with the outcome of increasing the public mental health workforce.
3. To identify strategies to target bilingual staff and staff serving ethnic minority communities.

Budget Justification:
Develop a process for identifying academic institutions, research institutes or think tanks to conduct research in future workforce trends and provide advertising strategies to recruit mental health professionals into the public mental health system. One time allocation for FY 2008-09. Cost $200,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $200,000

EXHIBIT 4: WORK DETAIL -– page 15
C. CAREER PATHWAYS

Action #15
Title: Partnership with Educational Institutions to Increase the Number of Mental Health Professionals in the Public Mental Health System

Description: The County of Los Angeles will work with educational institutions currently producing, or that may in the future produce, mental health professionals in key high need disciplines (e.g., Psychiatric Nurse Practitioners) to expand the capacity for developing additional mental health professionals in the discipline areas that are currently most deficient.

Objectives:
1. To establish partnerships with interested educational institutions to expand the current number of mental health professionals they produce.
2. To establish partnerships with new, potentially interested, educational institutions to expand the number of mental health professionals produced.
3. To target the following disciplines: Psychiatrists, Psychiatric Nurse Practitioners, MSWs, MFTs, LVNs, RNs, and OTs.

Budget Justification:
For FY 2008-09 allocated funds for immersion training services with post-secondary faculty and teaching staff currently engaged in preparing adults for joining the public mental health workforce in Los Angeles County. This type of training updates college and graduate school faculty on current best practices and requirements for human services workforce in real-world jobs. Institutions specializing in recruiting, teaching and developing human services professionals with an emphasis on the needs of the unserved and underserved ethnic minority populations are likewise being supported with this action plan. Cost $100,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $100,000

EXHIBIT 4: WORK DETAIL – page 16
D. RESIDENCY AND INTERNSHIP PROGRAMS

Action #16
Title: Recovery Oriented Internship Development

Description: A wide range of quality internships and placements must be available to students and interns to gain the maximum benefit from these experiences. Ideally, these placements include supervision that is both welcoming and supportive of recovery based services. Unfortunately, many potential quality placements cannot be utilized because they lack a supervisor with a degree that meets the standards of the academic institution and/or their accrediting body. At the same time, many of the supervisors who meet academic standards in qualified placements are not well versed in recovery and at times are wholly opposed to recovery centered service philosophies and practice. This latter problem leads to situations where students are receiving recovery oriented instruction in the classroom, only to have it not practiced in the field.

The proposed Recovery Oriented Internship Development Program will address these problems by working with degree granting institutions providing recovery oriented classroom instruction to develop relationships with nontraditional providers, amend restrictive policies related to supervision of interns, employ a supervisor(s) who can provide supervision to interns across multiple agencies, and work with existing providers to increase the number of internships available through in-house supervisor recruitment and support.

Objectives:
1. To increase the connection between the recovery oriented lessons learned in the classroom and the recovery oriented skills learned in the field.
2. To increase the number of recovery centered placements for interns at the BA and Masters levels.
3. To increase the number of recovery oriented supervisors in existing and new internship/field placements.
4. To provide interns with a more cohesive experience based in recovery principles and practice.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 17
D. RESIDENCY AND INTERNSHIP PROGRAMS

Action #17
Title: Psychiatric Residency Program

Description:
The demand for psychiatrists throughout Los Angeles far outweighs the existing number of psychiatrists, particularly those specializing in children/adolescents and geriatrics. Additionally, the demographics of Los Angeles County reflect a dramatic need for psychiatrists that are both bilingual and bicultural. This need compels us to explore the potential duplication of existing psychiatric residency programs, such as that developed in Kern County or other successful models.

Objectives:
1. To investigate the psychiatric residency program developed in Kern County and other locations to expand the number of psychiatrists.
2. To determine if the development of such a residency program is feasible in Los Angeles County.
3. If feasible, develop an implementation plan to duplicate a similar program in Los Angeles County.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 18
D. RESIDENCY AND INTERNSHIP PROGRAMS

Action #18
Title: Trainings Pursuant to the Mental Health Services Act for Student Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians Certificate Program

Description: Promoting MHSA philosophies and values of recovery, resilience and wellness is essential in the training and mentoring of all licensed clinicians. Trainings for students are a way of promoting these important values while also preparing the students to embrace a recovery-based model of service delivery. Many graduate degree programs have already implemented this type of training; e.g., graduate social work students concentrating in public mental health are offered a curriculum embracing a comprehensive range of competencies consonant with the MHSA including recovery, wellness, culturally and linguistic services, etc. Existing partnerships among the universities, field placement faculty, and internship training site personnel will continue to be utilized while others would be established as necessary to accomplish such expectations.

Objectives:
1. To promote MHSA philosophies and values to students through trainings.
2. To utilize existing partnerships among the universities, field placement faculty and internship training site personnel to reinforce existing MHSA recovery-based training.
3. To develop new partnerships to reinforce MHSA recovery-based training, as needed.
4. To capitalize on existing expertise among university faculty and internship training site personnel to expand the number and content of curricula on recovery, resilience and wellness for delivery to students as necessary.
5. To assure that trainings for student incorporate consumer/family members/parent advocates experiences.
6. To prepare students for the public mental health workforce.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 19
E. FINANCIAL INCENTIVE PROGRAMS

Action #19
Title: Tuition Reimbursement Program

Description: The County of Los Angeles' needs assessment revealed significant occupational shortages of licensed and unlicensed mental health professionals and paraprofessionals. This action specifically targets individuals interested in pursuing careers in the mental health field including AA, BA and graduate level degrees. This tuition reimbursement program will provide up to $5,000 dollars per year for tuition expenses for those individuals interested in entering or enhancing skills for the mental health field who meet certain criteria designed to fill gaps of greatest need. This program will include consumers, family members and parent advocates and professionals from both directly operated and contract agencies. Tuition reimbursement students will be expected to make a commitment to work in the public mental health system. Additionally, those candidates who are bilingual/bicultural and/or willing to commit to working with unserved and underserved communities in the County will be given priority for the program.

Objectives:
1. To fund TBD slots per year with priority given to bilingual persons and/or persons committed to work with unserved and underserved communities in the County.
2. To target 50% of the slots to consumers, family members and parent advocates interested in increasing mental health skills.
3. Upon successful graduation the individuals will be given priority/placed in hiring band I for positions in directly operated and contract agencies. 50% of the slots will be allocated to directly operated program and 50% to contracted agencies.
4. Priority will be given to students in Recovery Based Mental Health academic programs.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 20
E. FINANCIAL INCENTIVE PROGRAMS

Action #20
Title: Associate and Bachelor Degree 20/20 and/or 10/30 Program

Description: This action specifically targets individuals currently working in public mental health who are interested in advancing their career in mental health by obtaining either an AA or a BA level degree. The program will pay for a portion of their salaries in order to allow students to meet academic responsibilities by combining hours of work with hours of education (20 hours school/20 hours work or 10 hours school/30 hours work). Participating students must commit to a minimum number of employment years in public mental health (comparable to the number of years financially supported by the program) after successful completion of the respective program. Priority will be given to staff that are bilingual and/or willing to work with underrepresented communities in the County.

Objectives:
1. To fund TBD slots per year with priority given to bilingual staff and/or staff willing to work with underrepresented communities in the County.
2. To allocate 50% of the slots to directly operated program and 50% to contracted agencies.
3. Upon successful graduation, individuals will be eligible to apply for such positions in directly operated and contract agencies.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 4: WORK DETAIL – page 21
E. FINANCIAL INCENTIVE PROGRAMS

Action #21
Title: Stipend Programs for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians

Description: Striving to meet MHSA expectations of a linguistically and culturally competent workforce, Los Angeles County has identified through its needs assessment, focus groups, key informants, and stakeholders a significant occupational shortage of licensed mental health professionals. This action is specifically targeted at expanding the number of Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians in the County by offering stipends in the respective programs that represent the underserved ethnic groups within our community. Expectations for stipend students might include working in hard-to-fill or special need areas/programs and/or serving bilingual/bicultural populations in the County of Los Angeles.

Objectives:
1. To fund stipends for Psychologists.
2. To fund stipends for MSWs.
3. To fund stipends for MFTs.
4. To fund stipends for Psychiatric Nurse Practitioners.
5. To fund stipends for Psychiatric Technicians.
6. Once graduated the stipend students would be eligible to apply for employment in directly operated and/or contract agencies.
7. It is expected that 50% of the stipend students will be providing services to communities with bilingual and/or bicultural special needs.

Budget Justification:
For FY 2008-09 funded stipends for MSW and MFT students committed after graduation to work in hard to fill positions (Forensic Adult and Juvenile Programs) and geographic areas (Service Area 1-Antelope Valley, Service Area 6-South Los Angeles) in unserved and underserved ethnically diverse communities. Up to 52 MSWs 2nd year at $18,500. Up to 140 MFTs with a 3tier funding category criteria. 1) $10,000 tuition (speaks threshold language and works in high need area); 2) $8,000 tuition (works in high need area); 3) $6,000 tuition (speaks threshold language and works in a non-designated high area of need); 4) additional monies for completing internship in contract or directly operated public mental health agency. Cost $2,518,000.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009** $2,518,000

EXHIBIT 4: WORK DETAIL – page 22
E. FINANCIAL INCENTIVE PROGRAMS

Action #22
Title: Loan Forgiveness Programs

Description: Striving to meet MHSA expectations of a linguistically and culturally competent workforce, Los Angeles County will explore loan forgiveness programs as a supplement to the State's loan forgiveness programs to be developed. Based on specific geographic, cultural and linguistic needs unique to Los Angeles County, the Oversight Committee will review the need and efficacy for such a program, for which classifications of workers, and how best to complement and not supplant existing loan forgiveness strategies.

Objectives:
1. To increase retention and recruitment of needed mental health workers in the Public Mental Health System.
2. To explore the need and efficacy of loan forgiveness programs supported with Los Angeles County funds.
3. To meet the need for a linguistically and culturally competent workforce.

Budget Justification: No budget allocation being made at this time.

BUDGETED AMOUNT:	**FY 2006-2007**	**FY 2007-2008**	**FY 2008-2009**

EXHIBIT 5:

ACTION MATRIX

EXHIBIT 5: ACTION MATRIX

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

Actions	Promotes wellness, recovery and resiliency	Promotes culturally competent service delivery	Promotes meaningful inclusion of client/family members	Promotes and 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 Partnership	Distance Learning	Career pathway program	Employment of clients and family members within the Mental Health system
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action #1: Workforce Education and Training (WET) Coordination	X	X	X	X	X	X	X	X	X	X		X	X
Action #2: WET County of Los Angeles Oversight Committee	X	X	X	X	X		X	X	X	X		X	X
Action #3: Transformation Academy Without Walls	X	X	X	X	X			X			X	X	X
Action #4 Learning Management System-The Learning Net	X	X	X	X	X		X				X	X	X
Action #5: Recovery Oriented Supervision Trainings	X	X	X	X	X		X		X			X	X
Action #6: Interpreter Training Program	X	X	X	X	X		X	X				X	X
Action #7: Training for Community Partners	X	X	X	X	X								X
Action #8: Intensive Mental Health Recovery Specialist Training Program	X	X	X	X	X		X	X	X			X	X
Action #9: Expand Employment and Professional Advancement Opportunities for Consumers in the Public Mental Health System	X	X	X	X	X		X	X				X	X
Action #10: Expand Employment and Professional Advancement Opportunities for Parent Advocates, Child Advocates and Caregivers in the Public Mental Health System	X	X	X	X	X		X	X				X	X
Action #11: Expand Employment and Professional Advancement Opportunities for Family Member Advocates in the Public Mental Health System	X	X	X	X	X		X					X	X

EXHIBIT 5: ACTION MATRIX

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

Actions	Promotes wellness, recovery and resiliency	Promotes culturally competent service delivery	Promotes meaningful inclusion of client/family members	Promotes and 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 Partnership	Distance Learning	Career pathway program	Employment of clients and family members within the Mental Health system
Action #12: Mental Health Career Advisors	X	X	X	X	X	X	X	X	X			X	X
Action #13: High School through University Mental Health Pathways	X	X	X	X	X		X	X				X	X
Action #14: Market Research and Advertising Strategy for Recruitment of Professionals in the Public Mental Health System	X	X	X	X	X	X	X			X			
Action #15 Partnership with Educational Institutions to Increase the Number of Professionals in the Public Mental Health System	X	X	X	X	X		X	X	X			X	
Action #16 Recovery Oriented Internship Development	X	X	X	X	X		X	X				X	
Action #17 Psychiatric Residency Program	X	X	X	X	X								
Action #18 Trainings Pursuant to the Mental Health Services Act for Students Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners, and Psychiatric Technicians Certificate Program	X	X	X	X	X		X	X	X			X	X
Action #19 Tuition Reimbursement Program	X	X	X	X	X		X		X			X	X
Action #20 Associate and Bachelor Degree 20/20 and/or 10/30 Program	X	X	X	X	X		X		X			X	X
Action #21 Stipend Programs for Psychologists, MSWs, MFTs, Psychiatric Nurse Practitioners and Psychiatric Technicians	X	X	X	X	X		X	X	X			X	X
Action #22 Loan Forgiveness Programs	X	X	X	X	X		X		X				

EXHIBIT 6:

BUDGET SUMMARY

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:			**$ -**
B.Training and Technical Assistance			**$ -**
C.Mental Health Career Pathway Programs			**$ -**
D.Residency, Internship Programs			**$ -**
E. Financial Incentive Programs			**$ -**
GRAND TOTAL FUNDS REQUESTED for FY 2006-07			**0**

Fiscal Year: 2007-08 (See Note Below)			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A.Workforce Staffing Support:	$834,537		$834,537
B.Training and Technical Assistance	1,148,973		1,148,973
C.Mental Health Career Pathway Programs	215,919		215,919
D.Residency, Internship Programs	125,359		125,359
E. Financial Incentive Programs	125,359		125,359
GRAND TOTAL FUNDS REQUESTED for FY 2007-08			**$2,450,147**

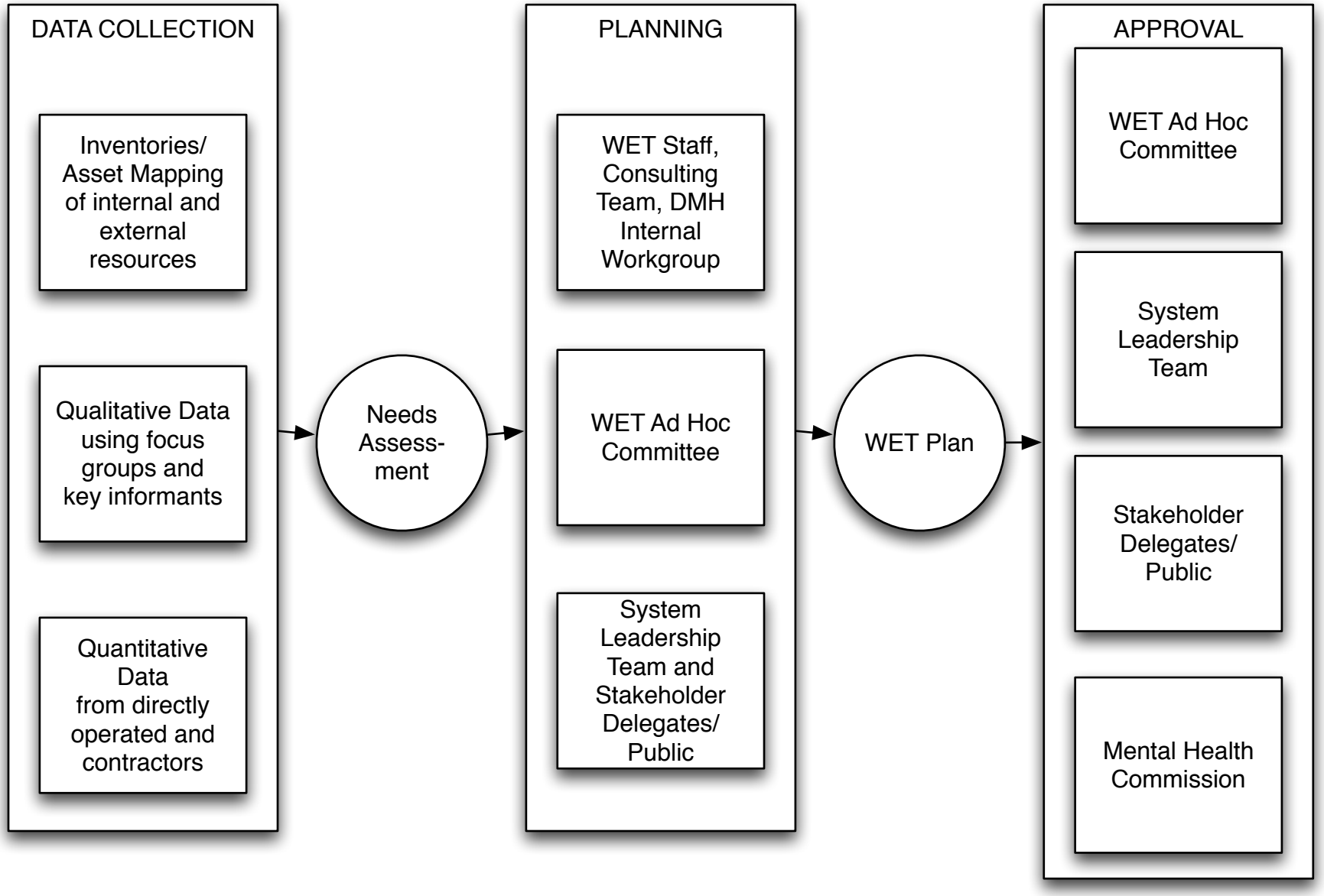
Fiscal Year: 2008-09			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A.Workforce Staffing Support:		$559,969	$559,969
B.Training and Technical Assistance		395,000	395,000
C.Mental Health Career Pathway Programs		1,566,750	1,566,750
D.Residency, Internship Programs		-	-
E. Financial Incentive Programs		2,518,000	2,518,000
GRAND TOTAL FUNDS REQUESTED for FY 2008-09			**$5,039,719**

Note: The funds listed for FY 2007-08 are dollars approved for Workforce Education and Training Planning and Early Implementation.

ATTACHMENT A

LACDMH's Workforce Education & Training Plan Process

Attachment A



ATTACHMENT B

Attachment B

Workforce Education and Training Planning Timeline

					2007							2008				
		Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept
Early Implementation Planning																
	Convened Workgroup on Use of WET Planning and Early Implementation dollars	X	X	X												
	Submission of Planning and Early Implementation Request			X												
Data Collection																
	Conducted Focus Groups				X	X	X		X	X	X					
	Conducted Quantitative Data Assessment								X	X	X	X	X	X		
	Convened Internal DMH Workgroup								X	X	X					
	Conducted Contract Provider's Workforce Assessment Survey									X	X	X	X			
	Conducted Key Informant Interviews									X	X					
Workforce Plan Development																
	Hosted Roundtable Event					X										
	Convened WET Ad Hoc Committee					X	X	X	X	X	X	X	X	X	X	
	Conducted web-based brainstorming process										X	X	X			
	Provided updates to Stakeholder Delegates								X		X	X		X	X	X
	WET Ad Hoc Committee makes recommendations													X	X	
WET Plan Approval																
	Reviewed by Executive Management Team														X	
	Submitted Plan for 30-day Public Comment Period														X	
	Collected and reviewed comments; revised Plan													X	X	X
	Mental Health Commission Hearing															X
	Submitted Plan to State DMH															X

ATTACHMENT C

Attachment C

Mental Health Services Act (MHSA) Stakeholder Delegate Roster

Representation	Delegate or Alternate Name	Entity
Commissions/Advisory Councils-C/AC		
Children's Planning Council	Cheryl Mendoza, CEO	LA County Children's Planning Council
	Alt: Lilian Coral	LA County Children's Planning Council
Commission for Children & Families	Helen Kleinberg	Commission for Children and Families
	Alt: Trish Curry	Commission for Children and Families
Co-Occurring Joint Action Council	Jim O'Connell, CEO	COJAC / Social Model Recovery Sys.
	Alt: Vivian Brown, PhD, Pres./CEO	COJAC / Prototypes
First 5 LA	Deanne Tilton, First 5 LA Commissioner	First 5 LA
	Alt: TBD	First 5 LA
Mental Health Commission	Jerry Lubin, Chair	AICP / MH Commission
	Alt: Larry Gasco, Vice-Chair	MH Commission
Narcotics and Dangerous Drugs Commission	Lauraine Barber, 2nd Vice Chair	Narcotics and Dangerous Drugs Commission
	Alt: Jack Kearney, 1st Vice Chair	Narcotics and Dangerous Drugs Commission
Service Area Advisory Committees (SAAC)	3 delegates and 3 alternates each	
SAAC I	JoEllen Perkins	DMH
	Alt: TBD	
	Bill Slocum	Project Return
	Alt: TBD	
	Natalie Ambrose	Community Resident
	Alt: TBD	
SAAC II	Ron Klein	DMH
	Alt: Beth Briscoe	DMH
	Jim Randall	DMH
	Alt: William Lemley	San Fernando Valley Community MHC
	Emma Oshagan	Pacific Clinics
	Alt: Eddie Viramontes	El Centro de Amistad
SAAC III	Alfredo Larios	DMH
	Alt: TBD	
	Anne Wrotniewski	SAAC III
	Alt: David K. Gaffield	San Gabriel Children's Center
	Bertha Washington	NAMI Pomona
	Alt: Earsel Laskey	DMH/Arcadia MHC

Representation	Delegate or Alternate Name	Entity
	Ed Vidaurri	DMH
	Alt: Larry Hurst	DMH
SAAC IV	Elvie Soldevilla	APCTC
	Alt: Don Edmondson	CA DMH
	Don Parrington	IMCES
	Alt: K. Albert Thompson	DMH
	Karen Wiliams	DMH
	Alt: Patrice Grant	DMH
SAAC V	Ruth Hollman	SHARE
	Alt: Kate McCauley	Consumer Advocate
	Roland Moses	N/A
	Alt: Michi Okano	Pacific Asian Counseling Services
	Yolanda Whittington	DMH
	Alt: Carol Vernon	DMH
SAAC VI	Ray Hernandez	USC School for Early Childhood Education
	Alt: TBD	
	Eddie Lamon	Community Advocate
	Alt: TBD	
	Ana Suarez	DMH
	Alt: Carol Sagusti	DMH
SAAC VII	Dwyane Clements	DMH/Rio Hondo MHC
	Alt: Carmen (Fatima) Baldizon	DMH
	Kathy Salazar	MELA Counseling Services Center
	Alt: Lourdes Caracoza	ALMA Family Services
	Cathy Warner	DMH
	Alt: Youngsook Kim Sasaki	Long Beach Mental Health Clinic
SAAC VIII	Cathy Williamson	DMH/Long Beach South Bay GI
	Alt: Romanda Harmon	Community Advocate
	Erika Hainley-Jewell	The Children's Clinic
	Alt: Kimberly Woods	Center for Long Beach

Representation	Delegate or Alternate Name	Entity
Community Advocates - CA		
Advocate for Homeless and Mentally Ill	Garrison Smith, LA County Homeless Coordinator	Shelter Partnership, Inc.
	Alt: Michael Castillo, Program Specialist	LA County Chief Executive Office
Client Stakeholder Group	Catherine Bond	Project Return, Peer Support Network
	Alt: Andrew Posner	Division Director BACUP
Client Stakeholder Group (incl. CA Network)	Gaines Lyons, CNMHC Board Director	CA Network of Mental Health Clients
	Alt: Ursula Sims	CA Network of Mental Health Clients
LAC Client Coalition	Audrey Hall	Los Angeles County Client Coalition
	Alt: Ana Swett	Los Angeles County Client Coalition
	Maria Tan	Los Angeles County Client Coalition
	Alt: Darla Baker	Los Angeles County Client Coalition
Mental Health Advocacy Services, Inc.	Jim Preis, Executive Director	MHAS, Inc.
	Alt: Nancy Shea, Senior Attorney	MHAS, Inc.
National Alliance on Mental Illness	Stella March	NAMI
	Alt: Keris Myrick	NAMI
Division of Empowerment and Advocacy	Eduardo Vega, Division Chief	DMH
	Alt: Gwen Lewis-Reid, Assistant Director, OCA	DMH
Older Adult	Cynthia Jackson	Heritage Clinic, Center for Aging Resources
	Alt: Holly Kiger	Wise and Healthy Aging
	Carey Temple	DMH
	Alt:TBD	
Parent Advocate	Carmen Diaz, Board President/UACF	United Advocates for Children and Families
	Alt: Ruth Tiscareno, Lead Parent Partner/Advocate	United Advocates for Children and Families
TAY Representatives	Ms. Heather Carmichael, LCSW	My Friend's Place
	Alt: Nick Taylor, Health Education Coordinator	My Friend's Place
	Ronnie E. Thomas, Medical Case Worker II	DMH
	Alt: D. J. Achtermann	Daniel's Place/Step Up on Second
Veteran Rep	Steven Peck	Community Development Director, US Veterans
	Alt: Bill Wallace	Clinical Director, US Veterans
Community Based Organizations/Foundations - CBO/F		
Association of Community Human Service Agencies (ACHSA)	Bruce Saltzer, Executive Director	ACHSA
	Alt: Wendy Wang, Mental Health Policy Director	ACHSA
	Tim Ryder, Executive Director	Amanecer Community Counseling Services
	Alt: Lynn Brandstater, Executive Director	Verdugo Mental Health

Representation	Delegate or Alternate Name	Entity
Faith Community Representative	Calvin Hsi, Director Charity Development Department	Taiwan Buddhist Tzu Chi Foundation, U.S.A.
	Alt: Eugene Taw, M.D.	Taiwan Buddhist Tzu Chi Foundation, U.S.A.
	Ruthie Grey	Faith Community
	Alt: TBD	Faith Community
	Rev. Paul Lance	Southern California Ecumenical Council
	Alt: TBD	
Foundation Community Representatives	Mary Rainwater	Integrated Behavioral Health Project
	Alt: Beatriz Solis	The CA Endowment
	Bonnie Armstrong	Casey Family Program
	Alt:Rebecca Medina, Deputy Director, LA Field Office	Casey Family Program
Education/Schools - E/S		
Education Coordinating Council (ECC)	Carrie D. Miller, PhD, Program Director	ECC
	Alt: Sharon G. Watson, PhD Team Leader	ECC
Los Angeles County Office of Education	Madeline Hall, Chief Grants Officer	LACOE
	Alt: Ray Vincent	LACOE
Los Angeles Unified School District	Rene Gonzalez, Assistant Superintendent	LAUSD
	Alt: John DiCecco, Director	LAUSD
Other School Districts	Laurel Bear, PhD, Director, Pupil Services	Alhambra Unified School District
	Alt: Rosalie Finer, Director Psychological Svcs Ctr	Alliant University, California School of Professional Psychology
Government - GOV		
Alcohol and Drug Admin.	Yolanda Cordero, Prevention Coordinator	LA County Alcohol and Drug Programs Admin.
	Alt: Sandy Song, Planner, Planning Division	LA County Alcohol and Drug Programs Admin.
City of Los Angeles Representative	Paul Freese, Director of Litigation and Advocacy	Public Council
	Alt: Leslie Wise	City of Los Angeles
Community and Municipal Services Cluster	Lari Sheehan, Deputy CEO, Chief Executive Office	LA County CEO
	Alt: TBD	LA County CEO
Los Angeles County Department of Children and Family Services	Harvey Kawasaki, Division Chief	LA County DCFS
	Alt: Michael Rauso, Division Chief	LA County DCFS
Los Angeles County Department of Community & Senior Services	Lorenza Sanchez	LA County DCSS
	Alt: Roseann Donnelly	LA County DCSS
Los Angeles County Department of Health Services	Vicki Nagata, Mental Health Liason	LA County DHS
	Alt: Karen Bernstein, Director, Special Programs	LA County DHS
Los Angeles County Department of Probation	Andrea Gordon, Director	LA County Probation
	Alt: Joseph Delfin, Deputy Probation Officer II	LA County Probation

Representation	Delegate or Alternate Name	Entity
Los Angeles County Department of Public Social Services	Judith Lillard, Program Director	LA County DPSS
	Alt: Ken Krantz	LA County DPSS
Los Angeles County Sheriff	Director Karen Dalton	LA County Sheriff
	Alt: Commander Detta Roberts	LA County Sheriff
Los Angeles Police Department	Lt. Lionel Garcia	LAPD
	Alt: Det. Charles Dempsy	LAPD
Los Angeles County Public Defender's Office	Joanne Rotstein, Special Assistant	LA County Public Def.
	Alt: Robert Fefferman	LA County Public Def.
Public Health Representative	Cynthia Harding	Los Angeles County of Public Health
	Alt: Jeanne Smart, Director Nursing Family Partnership	Los Angeles County of Public Health
Other Cities	Bonnie Lowenthal, Vice Mayor	City of Long Beach
	Alt: Dora Hogan, Manager Employee Benefits	City of Long Beach
Superior Courts	Tim Dowell	Superior Courts
	Alt: Richard Luckham	Superior Courts
Health Care - HC		
Community Health Clinics	Gloria Rodriguez, President/CEO	Community Clinic Association of LAC
	Alt: Louise McCarthy	Community Clinic Association of LAC
Hospital Representative	Mara Pelsman, CEO	Gateways Hospital
	Alt: TBD	
L.A. CARE	Cheryl Garcia, R.N., UM Liaison	L.A. CARE
	Alt: Rus Billimoria, MBBS, MPH	L.A. CARE
Disabled Community Rep	Jennifer Olson	Greater Los Angeles Agency on Deafness, Inc. (GLAD)
	Alt: TBD	
Gay/Lesbian Community Representative	Mark Dennis	GLASS
	Alt: Forest Colstrom	GLASS
UREP Representative (At Large)	Tara Pir	IMCES
	Luis Garcia	Pacific Clinics
African / African American	Ron Hasson	NAACP
	Alt: Beckelech Woude	Community Advocate
American Indian	Benjamin Hale	Community Advocate
	Alt: Elton Naswood	AIDS Project Los Angeles, Native American Programs
Asian American and Pacific Islander	Mariko Kahn, Executive Director	Pacific Asian Counseling Services
	Alt: Terry Gock, Director	Asian Pacific Family Center

Representation	Delegate or Alternate Name	Entity
Eastern European / Middle Eastern	Maral Yeranossian	Alex Pilibos Armenian School
	Alt: Sherif Toma	IMCES
Latino	Ambrose Rodriguez	LBHI
	Alt: Maria Elana Juarez	The Latino Coalition
Workforce - WF		
Academic Partnerships Representative/Universities and Research Representative	Karl Burgoyne, M.D., Professor	Department of Psychiatry, Harbor UCLA
	Alt: Mary Read, M.D., Medical Director	Department of Psychiatry, Harbor UCLA
Academic Partnerships Representative/Universities and Research Representative	Micki Gress, Director, Assistant Dean	USC School of Social Work
Academic Partnerships Representative/Universities and Research Representative	Alt: Ferol Mennen, Associate Professor	USC School of Social Work
AFSCME Union	Teddy McKenna	AFSCME
	Alt: Brad Stevens, President	DMH/Harbor UCLA
SEIU Union	Jane Jose	SEIU
	Alt: Michael Alba, Clinical Psychologist	SEIU
Staff Advisory Council	Heidi Rotheim	DMH
	Alt: Hector Garcia	DMH/West Valley MHC
Training Workgroup	Martie Drinan	TQID
	Alt: Tammy Blair	TQID
Other		
At Large	C. Rocco Cheng, Corporate Director	Pacific Clinics
	Richard Van Horn	Mental Health Association in LA County
	Deborah Tull	Los Angeles Community College District
	Alt: Bonnie Burstein	Los Angeles Community College District
	Areta Crowell	Retired Director, County of Los Angeles, DMH
	Miguel Santana	Deputy Chief Executive Officer, Children & Families Well Being
	Alt: Jenny Serrano	Chief Executive Office Srvc. Integration Branch

ATTACHMENT D

Attachment D

COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH
MENTAL HEALTH SERVICES ACT
Workforce Education and Training (WET)

Design Principles

1. Provide training to workforce providing Mental Health services.

2. Provide training to participants in public Mental Health system (consumers, family members, etal).

3. Provide training consistent with MHSA fundamental concepts.

4. Develop expertise in delivering services, training and working in diverse communities.

5. Develop positive outcomes and lasting impact from previous trainings.

6. Create individual professional development plans to ensure that training ***transform*** work habits and effectiveness rather than merely ***inform*** participants.

7. Develop awareness of constraints to learning experienced by certain groups and address there needs in program development.

8. Contribute to community capacity building via training and development.

9. Provide extended access to learning tools and programs (CBT[1], IBT[1], DVDs, ect.)

10. Develop reasonable cost/benefit and cost/participant structure.

[1]Computer-based training; Internet-based training

ATTACHMENT E

COUNTY OF LOS ANGELES-DEPARTMENT OF MENTAL HEALTH

Attachment E

Workforce Education and Training (WET) Ad-Hoc Representation

Category	Number of Representatives	Representative(s)
MFT Consortium	1	Mariko Kahn, MFT Jose Luis Flores, MFT (Alternate)
MSW Consortium	1	William Donnelly, Ph. D. Director Inter-University Consortium
Southern California Association of Psychology Training Programs (SCAPTP)	1	La Tonya Woods, Ph. D. Wayne Aoki, Ph. D. (Alternate)
LAUSD	1	Rene Gonzalez, LAUSD Assistant Superintendent
Community Colleges	1	Deborah Tull, Ph. D. LA Harbor College Coordination Special Program & Services
Medical Schools-Residency Program	1	Dr. Karl Burgoyne, Harbor UCLA Psychiatry
UREP	1	Luis Garcia, Corporate Director Emma Oshagan (Alternate) UREP Pacific Clinics
Age Groups Leads	1	Debbie Innes-Gomberg, District Chief Adult Systems of Care
Labor Unions	1 2	Teddy McKenna, LCSW American Federation of State, County, and Municipal Employees Karen Morris, SEIU Local 721 Kathleen Austria,SEIU Local 721
Consumers/Parent Advocates and Partners	4	Carmen Baldizon, Parent Advocate Cathy Williamson, Parent Advocate Eduardo Vega, Chief Empowerment Advocacy Division Catherine Bond, Executive Director Project Return Peer Support Network
Mental Health Commission	2	Vicki Sofro, Mental Health Commission Larry Gasco, Vice Chair Mental Health Commission (Alternate)
ACHSA	1	Bruce Saltzer, ACHSA Executive Director Wendy Wang (Alternate)
Health/Social Services Partners	1	Mary Rainwater, MSW Project Director California Endowment
Family Members	3	Stella March Eddie Siberman Sharon Dunas
Mental Health Contractor	1	Richard Van Horn, President MHALA Chad Costello, MHALA (Alternate)
DMH Vocational Services	1	Rhonda Gunderson
Total	**24**	

ATTACHMENT F

Attachment F

California Institute for Mental Health

Los Angeles County Department of Mental Health

Workforce, Education and Training Division

Internal Inventory
Summary and Recommendations

Submitted by Toni Tullys, MPA

CiMH Project Director for Regional Workforce Development

December 19, 2007

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Los Angeles County Department of Mental Health
Internal Inventory

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INTERNAL INVENTORY

Los Angeles County Department of Mental Health Strengths

- Administrative Leadership – the System Leadership Team and the Delegates Group

- Consumer leadership at the Administrative level and the Division of Empowerment and Advocacy, fully staffed by peers and family members.

- Office of the Medical Director's existing relationships with all of the psychiatric residency programs and their ability to provide rotations in public mental health and to develop curriculum. Los Angeles County Department of Mental Health (LAC DMH) is uniquely positioned to advance psychiatric curriculum that focuses on public mental health practice and the principles of wellness and recovery.

- Support from DMH Human Resources (HR) - while there are many challenges with County HR, the DMH HR staff worked within the system to create opportunities to hire new Master's in Social Work (MSW) graduates.

- Focus on Cultural Competency and development of the Under-Represented Ethnic Population Groups (UREP) – while the UREP groups are in the early stages, this effort is strategic and focused. Gladys Lee and her team have a clear sense of what needs to take

place to support ethnic communities – interpreter training, understanding client culture in UREP communities, on-the ground training, and mentoring. The UREP effort is an innovative approach and can contribute vital information to the WET team as they work to increase he diversity and cultural competency of the workforce

- Mentoring program for DMH Program Heads with former deputy directors to develop future leaders.

- Emerging opportunities for collaboration among DMH, Department of Public Health and Department of Social Services.

Needs/Recommendations

- Priority need is for County HR to be more responsive/supportive of mental health's transformational workforce needs.
    - Identify ways to influence County HR to support transformation of mental health workforce. Research and identify potential levers of change through the Director's office, CEOs office, and the Board of Supervisors.

- Improved communication and collaboration across the system to support and strengthen Workforce, Education and Training (WET) efforts. There is limited knowledge of WET, given the limited staff capacity and size of DMH.
    - Increase infrastructure and communication capacity to support WET initiatives across DMH, in service areas, and with community partners. (This could be funded by the DMH Regional Partnerships process.)
    - Convene quarterly meetings with the WET partners invited to the Internal Inventory meeting to share information, strengthen collaboration and identify opportunities for joint efforts.
    - Create an internal email listserve of WET partners to support ongoing communication.
    - Integrate workforce discussions/agenda items at the various departmental meetings to increase understanding and importance of workforce development.

- Extensive training demands across the system, offered by different divisions and departments.
    - Integrate trainings and training efforts across DMH through the further development of the Transformation Academy.
    - Link trainings together and create a menu of training options. Link trainings with workforce development efforts to retain staff.

- A critical need for increased cultural and linguistic competency and representative diversity in the mental health workforce.
    - Working with the UREP groups, identify culturally congruent language and approaches that respect cultural beliefs on mental illness and will

engage/encourage diverse communities to explore mental health careers. LA County could create a model in this area, given the county's tremendous diversity.

Summary of Findings

Administration/Leadership

Systems Leadership Team

- Led by Dr. Southard
- More than MHSA; an evolving process
- Advisory to DMH
- Monitors MHSA implementation
- Tracks and advises on system transformation
- Helps DMH with difficult issues/deficit
- 25 + members

County-Wide Delegates Group

- Members are representatives from each stakeholder group
- Guides/participates in MHSA initiatives
- Meets monthly or more often
- 90 + 1 alternate member

Leadership Development

- Clear desire to increase skill set of leaders within DMH administratively and clinically
- Dr. Robin Kay, Chief Deputy Director, brings Program Heads together in monthly meetings; retired deputy directors provide mentoring
- Fledgling program for middle to higher managers
- Staff would like to see mentoring throughout the system
- DMH Learning Academy –expand model
- System of supervision/support for supervisors/large caseloads for supervisors
- Leadership development skills needed for UREP groups

Service Area Advisory Committees

- Ad Hoc group – 2 chiefs and 2 consultants
- For the first time, there is dedicated staff for PEI and Outreach and Engagement
- Developed a map – "road map" – for service area development; long-term effort
- Uneven representation across all 8 service areas
- Key partners: education, UREP groups, clients, family members, law enforcement

Finance

1. Budget – currently $24 million deficit; expect this amount to increase due to decrease in realignment/sales tax funds
2. In FY 2005/06 – DMH prevented closing clinics by transforming vs. supplanting services
3. Crisis can be seen as an opportunity or a danger – Gladys Lee
4. Impact of budget cuts:

a. Clinics caseloads are increasing
b. Staff are leaving current positions and moving into MHSA programs

5. Gap exists – consumers who are not part of the system are "problematically displaced"
6. UREP groups – more stressed – large numbers of monolingual clients; ethnic staff assume the work and need to work side-by-side with consumers
7. Workforce impact:
    a. Centers – ceasing to take interns, due to decreasing budget
    b. Need to increase internships to expand career path and recruit more staff

Human Resources (HR)

County Human Resources ("Big HR")

1. Decisions/changes must be approved at county HR level
    a. Civil service
    b. Unions
2. Very slow pace of developing new classification specifications
3. Continuum – gaps – slow process – county HR culture which limits hiring practices and recruitment
4. Job classifications – applicants must meet the county requirements for education and experience; limited flexibility
5. Limited information dissemination
6. County needs to recruit more RNs – workforce development
    a. County requires RNs to have 5 years experience and mental health experience to work in DMH
    b. Developed Health Services RN program
    c. Mental health is not a participant in this program
7. "Grow Your Own" Training
    a. Medical Record Coders

DMH HR

1. DMH HR has limited decision-making authority within county HR structure
    a. HR needs are unique in mental health
    b. 800 vacancies for directly operated DMH positions
2. Broad range of disabilities exist within county employees (who do not disclose)
3. Bulk of consumer positions are for peer advocates
4. Hiring of peers – don't have sufficient supervisory staff
5. More consumers "coming out" now
6. Problem for staff to disclose when they are not in designated consumer positions
7. Peer advocates – can become a subclass of community workers, limiting opportunity for promotion
8. Innovative approach to hiring of MSW students:
    a. County civil service banding is based upon seniority and experience.
    b. Applicants who are right out of school fall into the lower bands, with little chance of being hired by the county.

    c. DMH HR created and opened an exam for social worker students on stipends (CalSWEC students), allowing them to be hired by DMH, rather than falling into the lower civil service bands.
9. DMH HR will provide a report on job descriptions/classifications and vacancies

Office of the Medical Director

1. Focus is on training and education of psychiatrists/curriculum development.
2. Work with psychiatric residency programs at Cedars-Sinai, UCLA and USC.
3. Organize rotations that provide hands-on experience/increase exposure to public mental health.
4. Recruitment challenges:
    a. State Corrections – more funding; offers higher salaries; pulls psychiatrists from DMH
    b. No current stipend $ (top scale $)
    c. No competitive salaries
    d. No raise until November 08
5. Limited success in recruiting psychiatrists for:
    a. Geriatrics
    b. Children and Adolescents
    c. Addiction
6. Focus on multi-ethnic MDs to serve diverse communities.
7. Developed a parameter on roles of consumers in the system; website is a challenge; need to distribute information.

Planning, Outreach and Engagement Division

1. Division needs additional funding and time to manage projects (1 planning staff; 2 outreach staff).
2. Geo-mapping available; data team is under-resourced.
3. Under-Represented Ethnic Populations (UREP)
    a. 5 workgroups representing 5 populations; each group is co-chaired by a community advocate
    b. African and African-Americans (serve a large number of Ethiopians)
    c. Latino
    d. American Indian
    e. Asian-Pacific Islander (translators needed for 5 languages)
    f. Eastern European/Middle Eastern
4. Additional communities needing outreach and engagement:
    a. Deaf and physically disabled
    b. Lesbian Gay Bisexual Transgender (LGBT)
5. Provide outreach and engagement to all 8 service areas.

6. Cultural competency efforts
    a. Serve over 400 providers
    b. Responsive to state requirements
    c. Auditor
    d. EQRO

Empowerment and Advocacy Division

1. Entirely peer and family run
2. Strong executive leadership support; division chief is a member of the executive team
3. 11-17 staff in division; with current hiring, anticipate 21 full-time staff
4. Divided into 5 key areas:
    a. Office of Family Advocate
    b. Policy and Advocacy Unit
    c. Client Office of Recovery and Empowerment
    d. Peer Clinical Recovery
    e. Office of Community Outreach
5. Focus is on consumers and family members to encourage/support their involvement with the system.
6. Key focus is on training/education.
7. Need the portals/entry points
8. Want to work with more county divisions.
9. Work with Client Coalitions – grass roots, free standing entities; culturally specific
    a. LA CCC
    b. API and Latino CCC are sub-affiliates of LACCC
    c. BLACCC – nonprofit, NAACP

Consumer and Family Member Employment

- Consumer and family member operating coalitions are not yet a pathway; functionally part of DMH; represent an extensive volunteer program
- Georgia model – consumers able to bill for services under Medi-Caid
    - Lower pay rate for peers under this model
- Consumer positions
    - Thoughtful, strategic
    - Empowerment
    - Meaningful opportunities to contribute
    - Value lived experience

Career Ladder Concerns

- Peer and family member advocate positions fall under the Community Worker classification
- Concern about developing an underclass of Peer Advocate workers; working at the lowest level of system pathway
- Clients need support for skill development, as well as the right supports for transition into employment

- Many clients are not workforce ready
- Need a process that will help people move along the pathway
- Need clear expectations for staff (low expectations – fail to meet)
- Shift from volunteer to paid positions
- Trainings should include internships/mentorship

Health Care Coverage/Benefits Planning for Consumers

- Limited mental health benefits offered/some systems have augmented mental health care
- Low salaries for Peer Advocates
- County benefits counseling is not consistent and client needs are complicated
- Project Return (MHALA) offers 1 staff for benefits counseling
- Need Human Resources support/understanding of benefits planning

UREP Consumer Employment Needs

- Language
- Stigma in communities/exploited
- Do not want to work in mental health system
- Peer advocate role can be stigmatizing
- Need entry into other fields

Key Question: Hiring people in a place where they have been clients - – does this give a person a real opportunity?

- Complex issue
- Office of the Medical Director
    - Parameter on working with consumers in the system
- The Village model
- Need to design a supportive model that is flexible, offers mentoring and serves as the foundation for integration.

Pilots

- Wrap Wellness Centers
    - Performance-based contracting will begin 1/08
    - Integrating consumers into survey process
- Computer kiosks
- Latino Access Study
- Interpreter Training

Key Points

- It is hard being a professional consumer
- Often consumers choose to move away from their disability
- Want meaningful, rather than remedial work and to be treated like regular employees
- Existing pool of consumers with BA/BS – can go on to graduate and professional schools, but will need a supportive education model
- Need support for the transition to full-time jobs and to leave DMH; traineeships

Training Division

1. DMH directly operates all trainings, including Human Resources trainings
2. Key training questions:
    a. How much training capacity in-house vs. contracted out?
    b. How to transform recruiting/training?
3. Lack the ability to hire various classifications, i.e. health educators, and bring them into DMH
4. Need to train staff for different roles
    a. Specialists/vocational rehabilitation counselors
    b. Different skills needed for MHSA programs, i.e., working with the homeless
    c. Specialization important – training needed on core competencies
    d. Targeted skill areas for peers/paraprofessionals
    e. Managers need training in time management, stress management and meeting management.
5. Collaborate with Department of Health Services, Department of Public Health and Department of Social Services re: sharing services
6. Need to increase capacity for parent/family advocacy trainings
7. Incubate trainings – released within fiscal year
8. Older Adult – specialization for consumers and family members who have experience/background with this population
9. Substance Abuse offers 4 month peer/advocate training; graduates 8-10/yr
10. For clinical staff – COD trainings will be offered in March '08
11. Staff development – need more Train the Trainer programs

SOC Trainings – Dr. Innes-Gomberg

- In adults, starting trainings with full service partnerships (FSPs) but plan to expand beyond that.
- Organized a regional 9 month training for clinical staff on cognitive behavioral therapy (CBT). Over 100 staff will be trained and will have the opportunity to receive ongoing consultation from a group of psychologists at Harbor-UCLA.
- Through the Training Division, purchased on-line Dialectical Behavior Therapy (DBT) training for 27 staff.
- Plan to expand the pool of trained DBT clinicians within the next 6 months with a 2nd round of on-line training.

Learning Academy

- County-wide
- Offers workplace English and computer classes
- Sometimes participants are pulled due to workload

Cultural Competency Training

- Training – 3.5 hour course
- LAC DMH - Multi-Cultural Competency for all county departments
- Need more advanced trainings on cultural competency, interpreter training, client culture
- UREP communities:
    - Individuals do not have the time to do training
    - How do we free up time on the ground level?
    - Looking at training needs – not reaching numbers for FSPs – lower Hispanic enrollment than anticipated
- Geography – trainings offered downtown/metro; need to expand trainings into service areas

Translation Needs

- Need native speakers to serve clients; limited capacity
- Have a directory of staff who are bilingual, but it is challenging to access
- Phone-based interpreter services available, not always ideal

DMH/Department of Rehabilitation Cooperative Program

- Designed for consumers
- Offers consultants/trainings

Information Technology

1. Managed in house (~200 staff)
2. Electronic Medical Record – phasing in over a 2 year period
3. Implementing countywide Learning Management System (LMS)
    a. Departments
    b. CBOs
    c. Consumers/Family Members

Communications

1. MHSA website managed by Communications
2. Intranet – Chief Information Office
3. Internet – Public Information Office – limited staff; Diana Hui is the only staff person

Other Departments

Social Services: CalWorks

1. Students in business office
2. Opportunity for exposure to work environment
3. Occupational Therapy (OT) working with the Department of Rehabilitation (DOR) on training and assessment

Children and Family Services

1. Collaborating with DMH

Parks and Recreation

2. Successful partnerships - activities, kids, recreation
3. Could offer sites for training

Community Partners: Contractors/CBOs

1. 2/3 of DMH services are provided by CBO's; many offer consumer empowerment positions.
2. Geography is a challenge – CBO's/clients and family members/UREP groups can't get to the downtown Metro Service Area to participate in meetings; transportation is needed.
3. Larger organizations have sufficient capacity to participate in meetings
4. Smaller agencies don't have the funds/forces the issue of building capacity
5. Incubating – small consumer run organizations
6. Need resources/means to increase capacity
7. Mainstream consumer groups and UREP groups
8. Increase dialogue between the two on self help/cultural competence

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Los Angeles County Department of Mental Health
Workforce, Education and Training Inventory Framework

1. Resources within LAC-DMH

- Leadership
- Team Members
- Staff
- Contractors
- Consultants
- Service Area Efforts
- Communications
- Planning

- Outside Funding

2. County Partnerships

- Human Resources
- Labor
- Auditor's Office
- County Counsel
- Economic/Workforce Development
- Finance
- Vocational Services

3. Training

- Training Categories, Target Audiences and Key Contacts
- Training and Evaluation Plan
- New Opportunities
- Certificate Programs for Specific Content Areas
- Internship Programs
- Supervisory, Management, and/or Leadership Training

4. Educational Partnerships/ Career Pathways

- Junior High Schools
- High Schools
- Community Colleges
- Baccalaureate Programs
- Graduate and Professional Schools
- Medical Schools

5. Consumer & Family Member Employment/Career Pathways

- Job Descriptions, Recruitment, Hiring Practices, Retention
- Workplace Readiness
- Financial Incentives
- Benefits Counseling
- Supportive Employment Practices
- PEER Support network/affiliations

6. Workforce Diversity & Cultural Competency

- Bilingual, Bicultural Staff
- Interpreter Program(S)
- Outreach and Engagement Efforts (UREP Groups)
- Financial Incentives
- Workplace Readiness/ Preparation

7. Financial Incentive Programs

- Stipends
- Scholarships
- Loan Assumption
- Internships/Residencies

8. Community Partnerships

- Community-based Organizations
- Labor
- Constituency Organizations
- Education and Training Entities
- Under-represented Ethnic Populations (UREP Groups)
- Vocational Services
- Workforce Development Organizations

ATTACHMENT G

Attachment G

California Institute for Mental Health

Los Angeles County Department of Mental Health

Workforce, Education and Training Division

External Inventory
Summary and Recommendations

Submitted by Toni Tullys, MPA

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January 15, 2008

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Los Angeles County Department of Mental Health
External Inventory

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Los Angeles County Department of Mental Health

Community-Based Strengths

- Through Mental Health America Los Angeles (MHALA), a well defined career pathway program exists from high school to a baccalaureate program. MHALA's Mental Health Pipeline is the most formalized mental health career pathway in the state.

- Community agencies have existing, collaborative relationships with multiple LA County educational institutions.

- Numerous consumer and family member trainings are offered by local agencies and constituency organizations.

- Long standing, community-based consumer and family member employment programs.

- Community-based training and consumer employment programs that serve as statewide models.

- Existing models for culturally specific career pathway programs.

- Recognized mental health workforce leadership at MHALA, Pacific Clinics and the Inter-University Consortium (IUC).

- An emerging relationship with Los Angeles County's Community College District, through Dr. Deborah Tull, who serves on the Los Angeles County Department of Mental Health (LACDMH) Workforce, Education and Training (WET) Advisory Group.

- LACDMH partnerships with IUC graduate social work programs at California State University (CSU) Long Beach, CSU Los Angeles, CSU Northridge, CSU Dominguez Hills, University of California Los Angeles (UCLA), and University of Southern California (USC).

- LACDMH partnership with Marriage and Family Therapy (MFT) Consortium of Southern California through Phillips Graduate Institute.

- LACDMH partnerships with Cedars-Sinai, UCLA and USC medical schools.

Needs/Recommendations

- Expand opportunities for collaboration with community agencies through joint trainings and strategic workforce initiatives.

- Invite community-based leaders and educational partners to participate in trainings and workforce discussions specific to their areas of expertise.

- Convene groups of culturally specific providers and professional associations to learn about their mental health workforce and training efforts, develop culturally appropriate recruitment strategies and partner in outreach and recruitment efforts in their communities.

- Develop and increase the capacity of culturally specific mental health career pathway programs in the Latino, Asian Pacific Islander, African American, African, Armenian, Russian and American Indian communities.

- Provide employment opportunities, offer consumer training and utilize consumers and family members to do outreach in the African, African American communities. Additional recommendations include ensuring that programs address the needs of the many African, African Americans on the streets today; improving Safe Havens and Urgent Care; and providing financial incentives to mental health workers in order to create competitive positions in the mental health profession and to recruit culturally competent professionals to manage mental health programs.

- Convene groups of age specific providers and professional associations to learn about their mental health workforce and training efforts and to develop outreach and recruitment strategies.

- Develop and increase the capacity of age specific mental health career pathway programs, including transitional age youth (TAY) and older adult programs.

- Partner with MHALA and Pacific Clinics to develop an operations and financial model for career pathway programs that could be replicated in other county service areas.

- Develop financial incentive programs that would be available to DMH and community based organization (CBO) staff, designed to meet critical workforce needs identified through the needs assessment process.

- Convene a meeting of educators, mental health providers, consumers and family members to discuss co-teaching academic courses, making presentations to students and/or employees, and developing curriculum that supports wellness, recovery and resiliency.

- Identify and target high schools with health academy programs to determine their interest in developing a mental health strand as part of their health curriculum.

- Identify mental health-related programs at the community college and 4 year college levels and explore opportunities for developing specific educational partnerships with the public mental health system.

- Develop articulation agreements with high schools, colleges and universities to create a formal career pathway program, modeled after MHALA's Mental Health Pipeline Program. This effort represents a longer term workforce development strategy.

- Promote long-term social work workforce development through stable and reliable long-term funding of stipends, curriculum development, and field education. There are four components: (A) Stipend and Scholarship Program, (B) Organized Student Unit Model, (C) Expand Outreach to Multicultural Communities to Increase Diversity of the Mental Health Workforce, (D) Curriculum to Develop and Support Staff (ref: *IUC and L.A. County DMH Proposition 63 Mental Health Services Act Concept Paper: Social Work Education and Training Program*).

Staff Training

Mental Health America of Los Angeles (MHALA)
Website: http://www.mhala.org/training.html

Theory	Techniques
Recovery Orientation	Orientation (on-going)
Collaborative Psychiatry/how to practice medicine in collaboration with consumers	Outside staff (consulting, TA)
Transforming Clinics	Faculty Immersion (new)
Recovery Leadership - concept informs managers/leaders (and increases knowledge all over the state)	Immersion Trainings at the Village
Turning Point	Train the Trainers to be peer supporters/advocates and learn how to get more peer advocates in their program week long program
Faculty Leadership Training (can be brought to other places in state for 2 day trainings)	High School Academies
	Community Colleges
	Cal State University Dominquez Hills
	Outreach to tap faculty at all educational levels: • 2-4 year programs in Nursing, Psychology, Social Work, Occupational Therapy • Certificates and CEUs

Pacific Clinics
Website: http://www.pacificclinics.org/training_institute.html

Pacific Clinics Institute
1. Dedicated training institute
2. Provides courses/catalogue
3. Provides training for DMH
4. Provides training for family members/consumers

Supervisor Training

1. How to manage/supervise front line and other staff
2. Coaching model
3. Conduct assessment
4. Pull together curriculum
5. Look at supervision goals

United Advocates for Children and Families (UACF)
Website: http://www.uacc4families.org/training/statewide.cfm

1. Parent – Parent Certified Training
2. Grief courses
3. Workforce Connection- offered statewide and nationally; includes mentoring and coaching
4. Offers a Speakers Bureau
    a. How to work with parent advocates
    b. Speak to classes/students about parent experiences
    c. Lived experience as a parent is a key component of trainings
    d. Parents serve as experts, in addition to sharing their stories
    e. Providers need training on empathy
5. Annual Parent Provider Partnership Conference
    a. Includes a parent partner/professional on every panel

National Alliance for Mental Illness (NAMI)
Website: http://www.nami.org/MSTemplate.cfm?Site=NAMI_Los_Angeles
NAMI Education Courses - train trainers for the following:

Provider Education Program:

1. A 10-week course that presents a subjective view of family and consumer experiences with serious mental illness to line staff at public agencies who work directly with people with severe mental illnesses.
    a. The program emphasizes the involvement of consumers and family members as faculty to provide staff training.
    b. The teaching team consists of the following five people: two family members trained as Family-to-Family Education Program teachers; two consumers who are knowledgeable about their own mental illness, have a supportive relationship with their families, and are dedicated to the process of recovery; and a mental health professional who is also a family member or consumer.

Parents and Teachers as Allies:

1. An inservice mental health education program for school professionals.
2. This two hour program helps school professionals and families within the school community to recognize and better understand the early warning signs of mental illnesses in children and adolescents and how best to intervene so that youth with mental health treatment needs are linked with services.

3. It also covers how schools can best communicate with families about mental health related concerns.

NAMI Internal and External Presentations:

1. In Our Own Voice
    a. A one-and-a-half hour interactive, multimedia presentation by consumers offering hope and insight with the recovery process now possible for people with mental illness.
    b. Includes a video that shows how mental illnesses strike individuals of all ages, races, genders, cultures and socio/economic backgrounds.

Los Angeles Child Guidance Clinic
Early Intervention Training Institute
Website: http://www.lachild.org/programs_eiti.htm

1. Provides trainings to "gatekeepers' in the mental health provider community who have limited expertise in the emerging fields of "0-5" mental health including: mental health professionals, social service providers, childcare and day care providers, primary care staff, public health nurses, and preschool teachers.
2. Trainings focus on effective interventions and practices which can improve at-risk children's social and emotional development.
3. Offers 4-6 hour weekly or monthly trainings for mental health staff to equip them to work with the "0-5" population of at-risk children and their families.
4. Sponsors half day and day long trainings on topical issues which can accommodate 50-250 participants.

Contract Agency Professional Training

1. Many contract agencies provide didactic trainings and MSW, MFT, Psychologist and RN graduate student clinical training including the Center for Aging Resources' Heritage Clinic WISE-Healthy Aging; Didi Hirsch and San Fernando Valley CMHC, Inc.

Center for Aging Resources' Heritage Clinic
Website: http://www.centerforagingresources.org/in-home.html

1. The Heritage Clinic and WISE-Healthy Aging conduct four 48 hour Certificated Older Adult Mental Health Services courses, and an Older Adult Service Extender Training program.
2. The Heritage Clinic provides a weekly didactic seminar on gero-psychology.

Campus Ministry

1. Ask faculty to endorse training (offering extra credit encourages people to attend)
2. In educational institutions, the Academic Senate must endorse curriculum changes or additions.

Specific Training Recommendations

1. Train new graduates – this is a significant provider issue.
    a. Emphasis is on training for new graduates to provide community mental health.

b. Issue is compounded when working with diverse populations; requires labor intensive training.
c. Need to understand what wellness means culturally.
d. New graduates often lack experience with the collaborative model, cultural competency, later life issues and complexity of family needs. Need to bring them up to speed, so that they can practice effectively in the system.
e. Providers need to balance training for new staff with training for existing staff.

2. Help young clinicians increase their collaboration skills.
    a. Didactic training
    b. Professional development/coaching
    c. Focus on strengths-based (resilience) approach and real life experiences, especially with children.

3. Provide continuing education for staff.
    a. Provide CEUs.
    b. Teach new ideas.
    c. Invite the community to attend.

4. Offer trainings on LACDMH billing and paperwork
    a. Does LACDMH have guidelines on staff requirements for billing?

5. Determine what training exists for school psychologists, teachers, pastors and other first-time responders, so that they can refer individuals to the right resources.

6. Expand community mental health curriculum in schools.
    a. Need to change curriculum towards wellness and recovery.
    b. Include wellness and recovery oriented books/texts in reading lists.
    c. Offer/increase student field placements in community mental health.

7. Add modules to curriculum to encourage positive perspective on working with older adults.
    a. Ageism, or distaste for later life, interferes with the willingness and skills of young clinicians to work with older adults.
    b. Need more opportunities in high school, college and graduate school for students to be exposed to positive experience of working with older adults.

8. Increase collaboration with community colleges to train mental health workers.
    a. Varying levels of training at different colleges
    b. Community college faculty/staff training
    c. Can download free materials from websites
    d. Life Skills Centers – faculty can go and ask questions
    e. Use approach of wellness/healing

Comments/Suggestions:

1. One-to-one training is inefficient; new employees often leave.

2. Need to reimburse for costs of developing new training curriculum.
3. Need to coordinate trainings and develop distance education programs.
4. Organize a menu/buffet of trainings offered by LACDMH.
5. Explore partnership opportunities with NAMI and UACF:
    a. Assessment
    b. Pathways to success
    c. Address fear factors
6. Explore the possibility of sharing/collaborating on internal staff training:
    a. The Network of Mental Health Clients
    b. Inventory of expertise/training abilities
    c. Partner on trainings
7. In San Fernando Valley, building collaboration between two agencies.
    a. Crisis intervention
    b. Homicidal/suicidal adolescents

Consumer/Family Member/Parent Partner Employment

UACF

- EQUIP Training
- Workforce Connection – statewide and national; includes mentoring and coaching
- Offer advice and support for parents vs. crisis intervention (billable through licensed staff)

- Parent partners/primary caregivers
    - Often child is still with them
    - Need flexible work schedule
    - Some parents have encountered finger-printing issues (LA County Human Resource requirements)
    - Some may not have high school diplomas, but could serve as parent advocates

- TAY – youth-oriented trainings
    - Youth-oriented advocacy
    - Use plain language
    - Include anger management for parents/need retraining

- Distinctive job duties for parent partners
    - 24/7 outreach/support on the phone
    - Cross training with staff
    - Are not licensed for crisis intervention
    - Parent partner does not want to be case manager; their role is to provide support to parents
    - Unique and important role for family member and parent partner advocates, just like consumer and peer advocates
    - Need to articulate roles on teams
- Identify other options available within mental health system

NAMI

Training for Consumers:

- Peer-to-Peer Training
    - A course for consumers including individual relapse prevention planning, a debriefing/storytelling week, and an advance directive for psychiatric care.
    - Training goal: recovery and resilience.
- NAMI Connection Recovery Support Group
    - A 90 minute weekly recovery support group for people living with mental illness in which they learn from each others' experiences, share coping strategies, and offer each other encouragement and understanding.
- Hearts & Minds

- A multimedia program about healthy, accessible, and affordable lifestyle changes designed to reduce cardiac risk among people with mental illness, a good life style for all.

Training for Families and Caregivers:

- Family-to-Family Training
  - A 12-week course for family caregivers of individuals with severe mental illnesses that discusses the clinical treatment of these illnesses and teaches the knowledge and skills that family members need to cope more effectively with their loved ones.
- NAMI Basics
  - A new signature education program for parents and other caregivers of children and adolescents living with mental illnesses; developed around elements extensively tested and found to be highly effective in the field.
  - Goals of the NAMI Basics program:
    - Provide the parent/caregiver the fundamental information necessary to be an effective caregiver.
    - Help the parent/caregiver cope with the traumatic impact that mental illness has on the child living with the illness and the entire family.
    - Help the parent/caregiver take the best care possible, make the best decisions possible for the entire family, especially themselves.

California Network of Mental Health Clients – Office of Self-Help
Website: http://www.californiaclients.org/office/index.cfm

- Offers peer training
- Focus on individual choice and self-determination
- Mental Health Planning Council created a Peer Specialist DACUM (a curriculum for a specific occupation, based upon the skills and competencies that are required to do the work)
- Need to address advocacy issues and differences with other constituency groups

MHALA Project Return Peer Support Network
Website: http://www.mhala.org/project-return.htm

Program:

- 3 week intensive and fieldwork
- Builds skills and offers work experience in public mental health
- Focus is on peer support
- Participants have a desire to give back
- Provides opportunity to learn the realities of job requirements
- Some people want to work a limited time, maybe 10 hours a month; can work through financial stipends

Client Outcomes:

- 60% full and part time employment
- 40% - (estimate by Catherine Bond, Interim Director)
    - 20%- looking for work
    - 20% - do not want to work in field

Friendship Line:

- "Warm line" for consumers; has been in existence for the past 8 years
- Housed in the administrative offices in Commerce, near downtown Los Angeles
- Toll free number is (888) 448-9777
- Open from 6 – 10 pm weekdays and from 2 – 10 pm weekends and holidays
- Someone is available on each shift who can answer calls in Spanish
- The calls are confidential and are answered by trained peer supporters. Although the line can provide referrals to local services or organizations, most callers are interested in having someone who will listen to them respectfully and be there for them as caring peers.
- Occasionally, someone calls the line in a crisis, and the Friendship Line staff has the capacity to link callers to the local suicide hot line on a three-way hook-up.
- Lynnette Peraza is the supervisor and she can be reached at (323) 346-0960, Ext. 217 or by email at lperaza@mhala.org.

Advanced Peer Support Training:

- Motivational interviewing
- 1:1 Peer Counselors

Project Return Comments:

- "SHARE" – volunteer to work program
- Offer life coaching in Antelope Valley
    - Coaches provide support/charge hourly rates for services
- Opportunities exist as IHSS workers – different revenue stream; funding does not come from mental health

The National Association of Peer Specialists
Website: http://www.naops.org/

- Advocates in states for peer advocate certificates
- Advocates for Medi-Cal billing
- Developing national standards

The Victory Clubhouse Peer Support Training
Website: http://www.sfvcmhc.org/html/the_victory_clubhouse.html

- Sponsored by the San Fernando Valley Community Mental Health Center
- Provides a place to learn new social skills, to engage in a wide range of educational and recreational activities, to relax and to give and receive support
- Intensive – 2 month program – 23 graduates
- Connected with the community

Westside Center for Independent Living (WCIL)
Website: http://www.wcil.org/index.html

- Offers peer counseling classes
- Peer Support and Employment Project – offers internships
- High success rate

ENKI Health & Research Systems, Inc.
Website: http://www.ehrs.com/

- Peer to Peer Wellness Center in Commerce, CA opening in Spring 2008.

LACDMH

- Peer advocates training with Dr. Bradley; work with co-occurring disorders (COD)
- Up to 20 participants per year
- Eduardo Vega, Director, Empowerment and Advocacy– bringing more into focus with recovery model

Comments/Suggestions:

- Move towards retention in the mental health field
- Decrease work stress
- Don't isolate peer workers –everybody has stress in their jobs
- Focus on efficacy/outcomes
- Value structure is critical – especially with the Mental Health Services Act (MHSA)

Educational/Career Pathways

MHALA
Mental Health Pipeline Program
Website: http://www.mhala.org/human-services-academy.htm

- Developed a career pathway program beginning with a high school, to Cerritos Community College and on to California State University Dominguez Hills.
- In 1998, MHALA started working with two high schools to create **Human Services Academies**
  - Focus on basic skills; beginning of the educational pipeline
  - At Huntington Park High School, students had reading partners to increase their literacy skills
- Working with Crenshaw High School, through funding from the Urban League and California Endowment, to develop a Regional Occupational Program (ROP)
- Looking at expanding the Life Skills Center concept
- To prevent juvenile offenders, we've learned that we need to start interventions early

- **Cerritos College** offers a Mental Health Worker Program
  Website: http://cms.cerritos.edu/browse/browse.asp?WID=20060008
  - People can come in without experience, as well as students from the high school academies

- **Cal State University Dominguez Hills**
  Human Services Program Website: http://www.csudh.edu/hhs/hd/index.htm
  - People with a BA degree can enroll or those who have been involved in the pipeline programs

- Pipeline Program's focus is on high school and community college retention
- Intro to college class is important as we develop education and training piece
  - Target goal-oriented students
- Community college experience/partnerships are central to success
  - Working with the community college system and TAY
- Interns, MFT interns, MSW interns and nursing students are part of this pipeline, as well as psychiatrists

Jumpstart Training Program

- Offers internships
- Provides a very intense feel of what it would be like to come to work
- Offers an introduction to Peer Specialist at the entry level
- Some of the participating individuals may enter other MHA pipeline programs
- A career pathway can emerge for participants
- Outcomes are good – strength in keeping this cohort going
- Important to plug into CalWorks when possible

Pacific Clinics
Pasadena City College Partnership
Website: http://www.pasadena.edu/

- Program replicated in Orange County at Santa Ana College
- Need to consider flexibility to build up experience and comfort level
- Life time experience can count towards units
- Focus on cultural and linguistic competency
- Not everyone interested in the mental health field
- Work with private business partners
    - Subsidize – offer a trial period to increase comfort of business/employers
    - Offer internships

Inter-University Consortium
Graduate social work programs at California State University (CSU) Long Beach, CSU Los Angeles, CSU Northridge, CSU Dominguez Hills, University of California Los Angeles (UCLA), and University of Southern California (USC).

- Forty (40) statewide CalSWEC mental health stipends annually
- Forty-five (45) LACDMH stipends (2008) to bilingual students committing to work in SPAs 1 or 6 and/or to do forensics work throughout LA County; sixty-five (65) LACDMH stipends to bilingual students (2005); eighty-eight (88) LAC DMH stipends (2001).
- Students at all IUC schools understand the need for alternative policies that enhance human dignity and promote social justice as being fundamental to the social work profession.
    - In addition to policy courses, practice courses address culturally responsive strengths/needs assessments and commensurate interventions.
    - Materials focus on all members of oppressed groups, including ethnic minorities, women, the disabled, and sexual minorities who continue to be denied equal access to resources and opportunities.
    - Children and the frail elderly also suffer because of their inability to advocate for themselves on both practice and policy levels. Advanced courses move the discussion of public policy issues to advocacy strategies.
- Practice courses focus on special mental health issues, including alcohol and other drug use, death and dying, family violence, especially as they relate to social work's clients.
    - Courses are responsive to statewide CalSWEC mental health competencies and the Mental Health Services Act, with advanced courses at different schools offered in forensics, wellness and recovery practice models.
- By the second year of graduate school, students are required to complete 900 hours of agency-based fieldwork, in a variety of settings where they combine observation of agency functions with participation in specific agency tasks and roles.
    - They are supervised individually for at least one hour per week by an agency-based field instructor, and a university-based faculty member provides oversight and consultation.
    - The IUC partners require field instructors to complete a course in field instruction, and completion of a course from one school is accepted by all the

others. Students also are supervised in groups through field seminars which are part of the academic program.

Asian Pacific Policy and Planning Council (A3PCON)
Website: http://www.a3pcon.org/
Specific educational/career pathway and training needs that might be more common among the Asian Pacific Islander (API) agencies:

- We need to be able to hire HB-1 Visa applicants as they have the language capacity.
  - Many of our Asian American college graduates are not bilingual but there are a number of college graduates from foreign countries who come to the US to study social work.
  - It costs an agency at least $1500 to "sponsor" these individuals to work in our agencies.
  - A corollary to this is the ability to seek trained professionals in their country of origin. This is especially true with Pacific Islander populations like Tonga or Samoa where many people travel back and forth.
  - We could advertise or seek connections with schools there to educate the young people to seek jobs in the mental health professions.
- API agencies need ongoing classes in skillful and ethical interpretation for their staff as well as ESL advanced classes with a special emphasis on mental health terminology.
  - Much of the MHSA verbiage does not translate directly from English to an Asian language.
- We need career incentives, especially in the CBOs, for the current staff to pursue higher degrees while working.
  - For example, incentives to move our brighter, more ambitious case managers to clinician level positions. This also holds true for our finance staff who might want to get a higher accounting degree but have the knowledge of DMH billing, etc. We want to find ways to keep them at our agencies.
- Many of our API consumers have expressed that they want job training but not in the mental health field as peer advocates, etc. They want job training in other fields.
  - One recommendation from our groups has been a way to subsidize small businesses to hire consumers for a trial period while encouraging them to hire them at their cost down the road. Their self-esteem is enhanced by what they perceive (culturally perhaps) as "real" work.

Los Angeles County Department of Mental Health (LACDMH)

- LACDMH has a training center for Asian Pacific Islander (API) workers in collaboration with the Special Services for Group (SSG)
- Looking at strategies to work with diverse communities in LA and to catch students at a young age; plan to develop/expand culturally specific career pathways into mental health
- Supported education is an important safety net for consumers
- There are many private schools in ethnic communities which offer intern programs; LACDMH doesn't have a connection with them.
- Collaboration with Cal State Northridge's Behavioral Science programs
  - 20-25 students working on their BA degree
  - DMH organizes field placements during the academic year

Comments:

- Need more instructors who are knowledgeable about community mental health; need to bring experience back into classroom
- Regional workforce efforts will need funding for educational institutions
- Nova Southeastern University in Florida offers a community mental health track Website: http://cps.nova.edu/programs/MastPrCounsel01.htm
- Richard Van Horn, CEO of MHALA, raised issues about the level of commitment from LACDMH towards the CBOs in workforce development and training. He commented that CBOs are integral to the workforce development process and voiced the following concerns:
    - Limited CBO voice
    - Quality control
    - Background of LACDMH training staff
    - Decision-making process
    - Vast mistrust exists
- The Association of Community Human Services Agencies (ACHSA) has provided their Workforce, Education and Training (WET) recommendations to LACDMH in which they discussed internal and external trainings, workforce development and funding.

Financial Incentive Programs

MHALA

College of the Canyons, Santa Clarita

- Offers a Spanish Immersion Program – 30 hours/week
- Teaches beginning level Spanish; goal is for participants to become bilingual
- MHALA supports salary and cost of program for participants
- If participants test out – they receive a bilingual bonus/year

MHALA Training Committee

- Meets 2x/year to review applications and disburse funds
- $20,000 year available to support staff training which pushes career ahead
- Staff can apply for books, courses
- $500 amount

Community Colleges

- College work-study (15 hrs/week) helps build resume
- Financial aid available

Seminaries

- Offer examples/models
- Students can request financial aid for education
- Can request loan forgiveness assistance if an individual stays committed to the program

Military (formerly G.I. Bill)

- 4 years commitment to military service to receive financial support for education

Stipends for Master's Degrees in Social Work

- The Mental Health Services Program requires "…scholarship programs offered in return for a commitment to employment… and…creation of a stipend program modeled after the federal Title IV-E program". The federal Title IV-E stipends are $18,500 per year in California per student per year. Work commitments equal one year for each year that a student receives a stipend.
- Federal Title IV-E – Foster Care children's services; public child welfare organizations, with public universities providing 25% match, claim Title IV-E funding for in-service staff training and pre-service graduate student stipends.
- CalSWEC mental health stipends are one element of an overall strategy for workforce training and development pursuant to the Mental Health Services Act.
- LACDMH offers mental health stipends for ~45 graduate social work students with target priorities for bilingual capabilities committing to forensics work in SPAs 1 or 6 and/or to do forensics work throughout LA County (2007-08).

Drawbacks to Financial Incentives

- Incentives won't bring in new people/employees if they are only focused on existing staff
- Need to work with consumers and their benefits (so that consumers do not exceed income limits)
- Commitment requirements are too short – not enough time working in agency
- Need to have a % of payback as long as a person works with the agency

What are the Financial Incentive models across the state?

- Existing stipend programs – CalSWEC and Title IV-E; the state Department of Mental Health has also proposed stipends for MFTs, Psychologists, Advance Practice RNs and Physician Assistants.
- Financial support for 2 year programs (i.e., case workers to complete a BA)
- Could target consumers from diverse communities with a work-study program
- Consumers could be paid to get on-the-job experience; programs must pay a living wage
- Federal incentive programs (funding streams to fund career pathways in designated health care shortage areas)

Comments:

- There are a limited number of 20/20 programs in the state due to limited funding
  - How do we expand these programs in LA?
- Need stop-gap programs, i.e., interpreters in LA County
  - 2 counties are training interpreters
  - National Asian Interpreting Agency has curriculum
    For information: http://www.nlbha.org/PDFs/InterpreterOverview2006.pdf
  - How is this program funded? (Area for research.)
- Need to retain/support experienced staff, not just students fresh out of graduate school who need training. What incentives could be used?
  - CEU's
  - Loan forgiveness/assumption

Suggestions:

1. Make loan forgiveness programs gradual, i.e., 1st year pay back $4000, 2nd year pay back $4500 and increase the amount over time to retain staff.
2. Provide adequate loan forgiveness amounts so as to appeal to licensed staff and to retain clinical staff once they become licensed.
3. Fund the lending institution directly (payback for loans after graduation).
4. Look at an equitable approach for incentives for both existing and new staff.
5. Provide incentives for bilingual employees to encourage them to stay within the organization.
6. Provide incentives for special needs populations (e.g., older adults).

WET EXTERNAL INVENTORY ~ 12/06/07 ~ SIGN IN				
Name	**Organization**	**attended**	**email**	**commented**
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Bloomgarden, Dena	MHALA	✓	dbloomgarden@mhala.org	
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Calkins, Matthew	ENKI	✓	mcalkin@ehrs.com	Yes
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Lee, Gladys	DMH Planning	✓	GLLee@dmh.lacounty.gov	
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Rodriguez, Gloria	Community Clinic Association of LAC		grodriguez@ccalac.org	
Ryder, Tim	Amanecer		tryder@ccsla.org	
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Van Horn, Richard	MHA	✓	rvanhorn@mhala.org	
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Wall, Lt. Rick	LAPD		23255@lapd.lacity.org	
Wang, Wendy	ACHSA		wwang@achsa.net	

Inventory comments and additions were also received from the following individuals:

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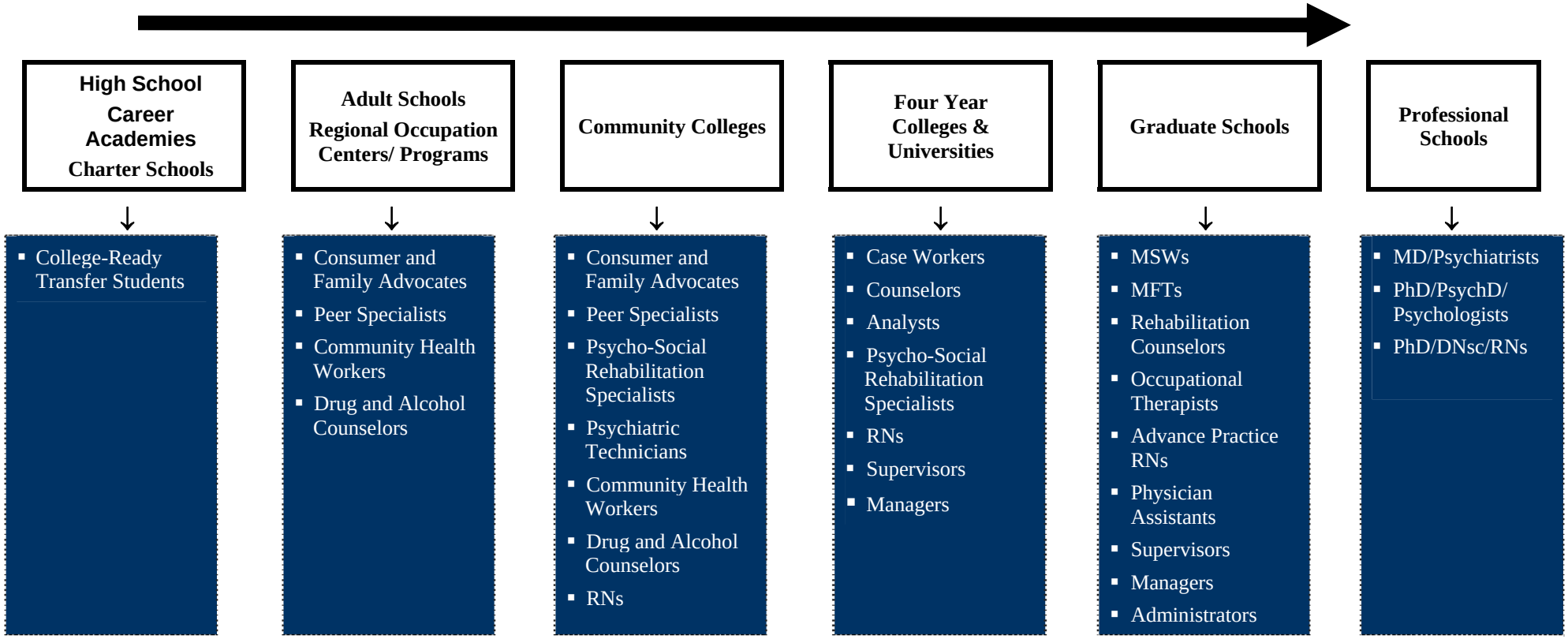
Yang, Janet Anderson	Center for Aging Resources		jyang@cfar1.org	

Public Mental Health System

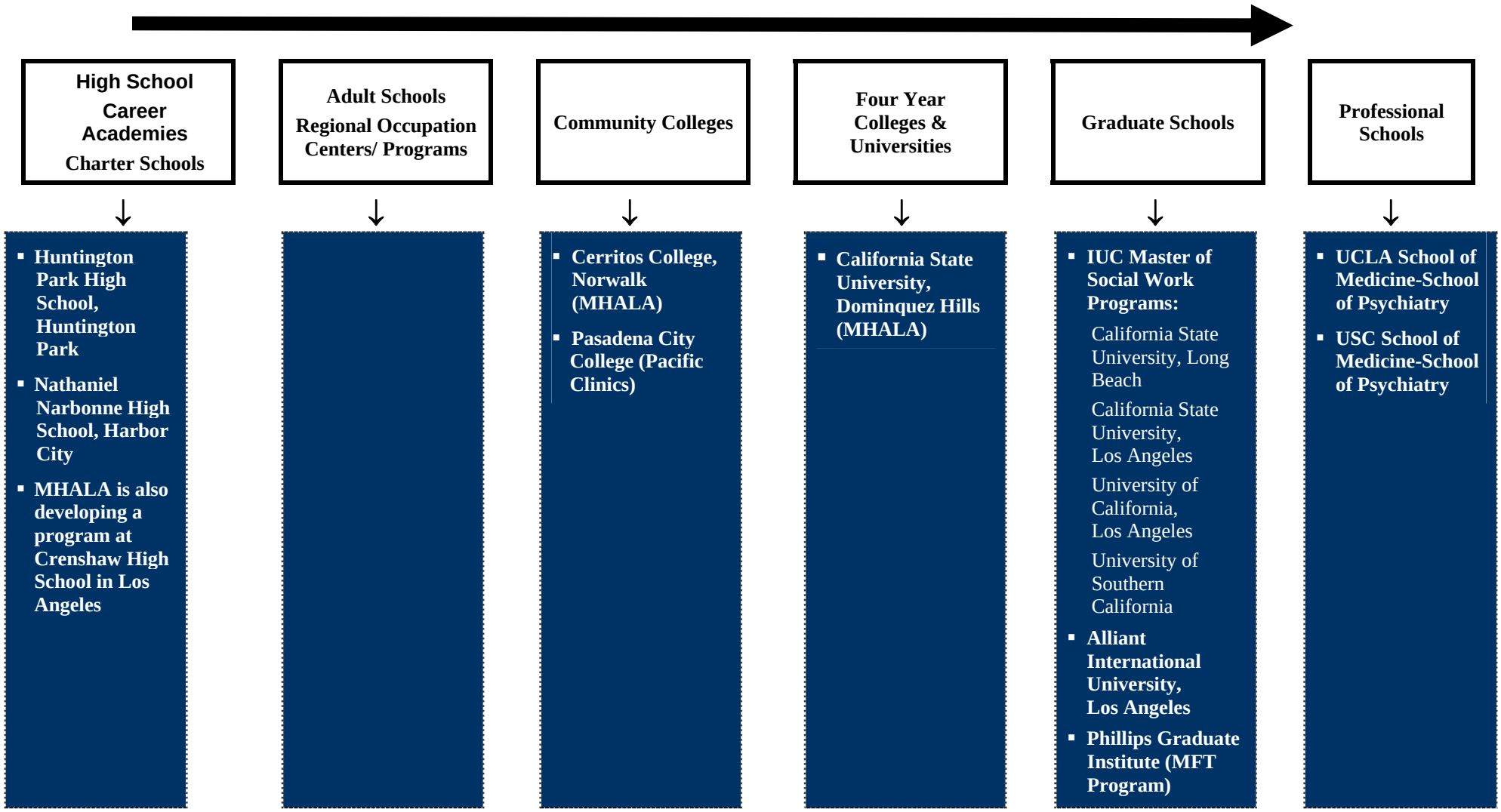
Educational/Career Pathway



MHSA Workforce Essential Elements

- **Integrate the principles of wellness, recovery and resiliency into all training and education programs.**
- **Provide consumer and family member employment and supports at all levels of the public mental health system.**
- **Increase cultural and linguistic competency to support the diversity of local communities.**
- **Address shortages identified by the needs assessment process.**
- **Establish outreach strategies and develop career pathway programs to recruit and retain individuals in the public mental health field.**

Los Angeles County Department of Mental Health
Educational/Career Pathway



ATTACHMENT H

Attachment H

COUNTY of LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
Mental Health Services Act
Workforce Education and Training (WET)

Focus Group Report

From October – December 2007, the LADMH Workforce Education and Training (WET) team conducted focus group discussions in each of the eight service areas (SAAC's) and with participants of the "Under Represented Ethnic Population" councils. Focus groups were designed to elicit creative ideas and strategies that would be used to inform the development of Los Angeles Workforce Education and Training proposal.

From February – April 2008, additional focus groups were organized to ensure opportunities for feedback from groups that were not well represented during the initial discussions in the SAACs. These groups included NAMI, consumers, peer advocates, family advocates, and front line staff. In addition, key expert interviews were scheduled with leaders from the ethnic population groups.

Results Overall

The needs and priorities that emerged were largely consistent throughout all of the age groups and in each of the SAACs. SAAC 1, however, has needs unique to its location, and thus their comments, while consistent with the other SAACs, discussed workforce development and training within a context of accessibility and transportation issues (i.e. trainings physically held in Palmdale or Lancaster; more satellite offices in the Antelope Valley)

The UREP focus groups had recommendations very similar to those in the SAACs, but added extra emphasis on the importance of culturally competent services. The UREP groups, for example, stressed the importance of linking the cultural and historical contexts when working with different ethnic groups and suggested more "community based" solutions such as placing therapists and mental health services staff within nonprofit agencies or churches which have more direct and trusting relationships with the community. In addition to the importance of culturally competent services, representatives from the Latino and Asian Pacific Islander groups share a common struggle to find bilingual services and the staff to fill critical service positions.

Consumers and family member discussions repeatedly focused on the need to transform the culture of the mental health service system in order to truly embrace a recovery-based model of service delivery and to include consumers and family members as employees of the system. There was a shared frustration that "the stigma of mental health illness permeates all provider/consumer interactions. All consumer and family discussion groups focused on the importance of stigma reduction training.

COUNTY of LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
Mental Health Services Act
Workforce Education and Training (WET)

Themes by WET Category

Workforce Staffing Support
By and large, focus group participants believed that the mental health system in Los Angeles county needs more of almost every kind of position ranging from clerical staff to psychiatrists just in order to keep up with the current workload. They emphasized the importance of having staff who are both culturally and linguistically competent. They also stressed the need for more trained bilingual and bicultural staff in the threshold languages – Spanish being the dominant among them.

LICENSED POSITIONS	UNLICENSED POSITIONS
Psychiatrists (especially children)	Case Managers
Psychologists/therapists	Parent advocates
Licensed clinicians – all types (LCSW, MFT, LPT, RN)	Physical therapists
School based counselors/clinicians	TAY staff
Social workers	Nurses (gerontologists, public health)

"New" positions designed to accommodate a transformed mental health system were described infrequently. Among the suggestions listed below, most of them focused on the TAY age group.

NEW POSITIONS (any age group)	NEW POSITIONS FOR CHILDREN/TAY
Vocational rehab	Youth service coordinators
Community Advocates (culturally/ethnically specific)	
Faith counselors	Education advisors/advocates
"Life Experience Counselors"	Trainers -- Drama, art therapy, sports, media
Autism/Aspergers specialists	
Prevention/Intervention specialists	

Training & Technical Assistance

The number one training need identified in *every group* is "cultural competency training." The most consistent definition for cultural competence was summarized by the focus group facilitator team as: "The ability to understand me within the context of my culture, language, history, gender, sexual orientation, what mental health means to my culture, generation, ethnicity, biculturalism, etc. without judgment."

Key expert interviews, as well as feedback from WET Ad Hoc Committee members, and Stakeholders, agree that cultural competency training needs to break out of the mold of classroom-based workshops. Cultural competency training as envisioned by the various key expert leaders is "in the field" and requires "immersion" with regular opportunities for debriefing and supervisorial interaction in order to explore how learnings gained in the field apply to actual work experiences.
There were suggestions for the creation of a centralized training academy, from which participants can receive CEU's, take the necessary coursework for re-licensure, and can identify clear pathways of trainings that lend itself to a "career lattice where staff enter and can grow from within."

Top Trainings Requested

1. Cultural Competency (immersion, not classroom-based format)
2. Recovery Model Training – all staff
3. Stigma Reduction
4. Peer Advocates/Peer Leadership training
5. Alcohol/Substance Abuse
6. Co-Occurring Disorder
7. First Responder training (for partners such as law enforcement, faith community, educators, etc
8. How to Access Services
9. TAY/Youth Issues and Culture
10. How to work with consumers/parents

Mental Health Career Pathway Programs

Noting the staff shortages in the mental health care system and the need to retain quality staff, focus group participants and key experts were largely consistent in their recommendations.

Top Recommendations to Improve Career Pathways

1. Create and cultivate pipelines by partnering more with high schools, community colleges, and universities
2. Collaborate with high schools, colleges, and universities to create curriculum with public mental health focus
3. Address infrastructural issues that inhibit consumers/families (i.e. benefit loss, inflexible schedules, lack of consideration of 'life experience.

Residency & Internship Programs

On the whole, focus groups did not spend a lot of their time addressing residency and internship programs. The shortage of bilingual, culturally competent licensed staff is particularly acute for the Latino and Asian Pacific Islander communities. The problem is so challenging that one API contract agency explained that they have adapted their hiring practices to concentrate on cultural and language needs first, and then look to see if the staff person is "compassionate" and "trainable." Then the agency invests in extensive one-on-one training, mentorship, and job shadowing in order to groom staffers to fill service needs. Another contract organization serving Asian Americans has turned to the growing population of foreign exchange students interested in social work and psychology. The agency "sponsors" the students throughout their graduate school education in the United States and then brings them into their organization.

Financial Incentive Programs

The suggestions to improve recruitment and retention for positions recognize that while the public mental health care system may not be able to compete with the salaries offered at private institutions, there are other ways to attract and retain quality staff. Financial incentives were also considered a key method for attracting students and professionals to the mental health field.

The recommended financial incentives were consistent across all of the focus groups and key expert interviews and included:

Financial Incentive Recommendations

1. Loan forgiveness (also for employees who are trying to move up in the system; "grow your own.")
2. Stipends (perhaps targeted for hard to place communities)
3. Signing bonuses
4. Review current salary structure – i.e. psychiatrists in the county make twice what they would at a CBO, but less than what they can make in private practice

Financial incentives, however, do have their limitations and there were some cautionary messages during discussions about loan forgiveness and stipend programs. The concern is that loan forgiveness and stipend programs are currently designed to attract students who are already – or who were already planning to be – a part of the public mental health system. Thus, when designing these programs, we need to think about how we can use these incentives to attract <u>new</u> prospects.

Retention

With regards to supporting and retaining mental health staff, there was widespread agreement that there is a need to provide incentives for staff to continue to stay within the public mental health system, as well as the need to reduce common stressors that impede work --- most notably, it was repeatedly mentioned in the focus groups that the paperwork required of DMH caseworkers is burdensome and redundant and prevents them from doing their jobs as effectively as they would like. Others said that the workload – particularly for caseworkers – is too overwhelming and that there needs to be "a better balance between the number and types of cases" that are assigned, as well as a redefinition of "billable time," because much of what caseworkers do today falls outside of their job description. Bilingual and bicultural staff, in particular, said that they are feeling pinched because they are often called in to help translate when necessary, but that these services are not only financially uncompensated, but create a backlog in their real job.

Top Retention Issues

1. Reduce workload
2. Salaries are not competitive (contract agencies pay less than county; county pays less than private practice)
3. Create career pathways for current employees
4. Job satisfaction (more than salaries – low morale, lack of leadership, lack of transparency contribute to poor work satisfaction)

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COUNTY of LOS ANGELES-DEPARTMENT OF MENTAL HEALTH
Mental Health Services Act
Workforce Education and Training (WET)

Focus Group Questions

Below, please find the questions that will be used during the group discussion portion of the meeting. If you prefer, you may write your answers below and return your responses to the discussion facilitator.

1. If we are going to attain our vision of having culturally competent services that are focused on wellness, resilience, and recovery, what kinds of staff positions do you think we need to have in place?
   - Where are the greatest shortages that currently exist in the system?

2. For the positions described above, what strategies would you recommend for:

   a. Recruitment

   b. Placement

   c. Support

3. What strategies would you recommend to include consumers and families on a career path in the mental health care system? What positions might need to be created to include more consumers and families?

4. What types of training do you think is needed for individuals who provide support services in the LA County mental health system? This can include DMH staff, community first responders, families, consumers, volunteers, etc.

5. Of the topics discussed above, what are the top 3 priorities?

ATTACHMENT I

Attachment I

County of Los Angeles – Department of Mental Health
MHSA/Workforce, Education and Training Needs Assessment

Submitted by Karen S. Gunn, Ph.D.
Gunn Consultant Group

I. PURPOSE AND BACKGROUND

The purpose of the Mental Health Services Act (MHSA) – Workforce, Education and Training (WET) effort and needs assessment is to develop a plan that addresses MHSA's "essential state requirements:"

- Wellness Focus, Recovery and Resiliency
- Culturally Competent
- Client and Family Driven System
- Integrated Service Experience
- Community Collaboration

The State of California's mission statement with respect to WET states that the ". . . public mental health system will develop and maintain a sufficient workforce capable of providing client-and family-driven, culturally competent services using effective methods that promote wellness, recovery and resilience and other positive mental health outcomes."

The State Department of Mental Health has established five components for funding programs for workforce development. They are:

- Workforce Staffing
- Career Pathways
- Training and Technical Assistance
- Residency and Internship Programs
- Financial Incentive Programs

The State of California, in an effort to achieve these goals, expects each county to develop a specific plan for *Workforce Education and Training.* The WET needs assessment should involve the following objectives:

- Addressing and assessing identified shortages in occupations, skill sets and consumer/family involvement in terms of unique cultural and linguistic competencies
- Identifying education and training needs for those who provide services and assistance in the public mental health services sector
- Identification of strengths, opportunities (i.e., gaps, deficiencies) for system transformation or growth

The results of the needs assessment are intended to inform the planning and decision-making of each county to transform their system as intended by the MHSA. through the collection of quantitative and qualitative data and engagement of key

stakeholders and constituent groups, each county should be able to gauge current capacity and plan for relevant changes in staff and services.

II. GOALS AND OBJECTIVES OF COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH WET NEEDS ASSESSMENT

The purpose of the needs assessment is to satisfy state requirements with respect to developing a plan for expanding, training and educating the workforce. The format and content for the needs assessment is stipulated in the *Workforce Education and Training: Plan Preparation and Program Development* (December 17, 2007).

The Guiding Principles for the County of Los Angeles WET Needs Assessment and Plan

Assess and address existing workforce and occupational shortages, consumer and family inclusion, linguistic competencies, ethnic representation

Identify education, training and development needs for mental health services capacity-building that will benefit Los Angeles County residents

Identify strengths, opportunities and priorities for training and education programs, career options, partnerships and financial incentive opportunities

Establish relevant baseline database and framework for measuring the implementation of a *wellness, resiliency and recovery model*

METHODOLOGICAL REQUIREMENTS

The format, process and content for the needs assessment are dictated by the State Department of Mental Health in the specific areas and terms below:

Counties should provide information on their target population, underserved and unserved, and geography.

Counties are to complete a count and extrapolated estimates of all segments of the workforce.

Counties should provide a short summary of their planning process . . . identifying stakeholder entities involved and the nature of the planning process.

The process should utilize a "defensible methodology for projecting WET needs that correspond to the program being developed and assist the county in selecting training needs and identifying support."

WET NEEDS ASSESSMENT ISSUES AND CHALLENGES

The importance of the WET planning process is acknowledged and the challenges and issues for completing it and building to a plan should also be articulated. For Los Angeles

County, the following issues and challenges presented themselves in the course of meeting this requirement.

- The size and scope of the existing mental health service delivery system, with 93 directly-operated sites, 124 contracted legal entities with 443 sites, numerous constituent and advisory groups represents a very large field to capture in a relatively short data collection process

- The "occupational categories" stipulated by the state did not easily match the staff categories within the local system, directly-operated and contractor agencies, compromising the ability to present the most accurate picture of current staff. Occupational titles, between state and county (including directly operated, contractor and fee for service providers), are not always comparable and might not reflect similar hiring and eligibility criteria or job duties.

- Funding and billing streams, long periods of cumulative curtailments and historical traditions regarding staffing patterns have created a constricted system of care focused on clinical intervention and aftercare rather than prevention and wellness.

- The expectation for ethnic comparisons and their implications for staff and client diversity, client-staff match (and other considerations) can only be assessed in terms of broad categories that actually obscure important differentiations in a county as ethnically and linguistically mixed as Los Angeles. More specifically, key differences *within* each ethnic category in terms of language and culture are extremely important and, no doubt, are obscured when using the standard broad classifications employed in this process. A few examples regarding diversity include:
    - Cultural and linguistic diversity among "Whites/Caucasians" reflect important differences in terms of U.S. vs. foreign born, native language, religion, economic status
    - The existence of over 28 sub-groups within the "Asian/Pacific Islander" category reflects generational, immigration, language, religious and economic differences
    - The masking of important distinctions within the "African-American/Black" that relate to U.S.-born vs. African-American/Black origin, language, educational achievement and economic status
    - The existence of numerous sub-groups within the "Hispanic/Latino" who differ in terms of land of origin (U.S., Mexico, Latin-Central- South America, Europe), ethnic identification, language, educational achievement and economic status.
    - Tribal memberships and alliances, economic and health status differences characterize differences among the Native American population
    - The category of "Multi-Race or Other" incorporates a vast *unknown entity* in terms of culture, language and other socio-demographic factors.

- Capacity in terms of staff language capability, as well as match between language groups and ratios between staff and clients that speak a specific language is misleading, at best. For example, some Hispanic/Latino staff speak Spanish and others in the category don't speak Spanish fluently.

Some who identify as African- American/Black speak Spanish and others don't speak the languages of those from African-American/Black nations. Staff who speak specific languages may serve many others that fall outside their native language fluency.

- Capturing a picture of the current workforce and consumer population (quantitative and static) does not, alone, provide a complete bridge to the program plan the WET needs assessment had in mind without using qualitative data and input.

- The hiring and identification of consumers and family members within the system is made more difficult by the impact of stigma and, unfortunately, cases of isolation and low expectations. Individuals who choose and are hired in those categories face those obstacles and those that are hired in all positions may decline to acknowledge their "consumer" or "family" status.

- The criteria for determining "hard to fill" positions is dependent upon a combination of factors that variously apply depending upon the specific area of the 4,752 square foot county in question, type of provider and target group.

- The access, in terms of language, for obtaining a portion of our data favored English speakers and formats.

III. DESCRIPTION OF THE COUNTY OF LOS ANGELES– Geography, Population, Socio-Economic, Educational Resources

Geography

Los Angeles is the most populous County in the state of California with 4,752 square miles. The County's population is larger than 42 states in the country, has a population density of 2,497 persons per square mile and is home to nearly a third of all California residents. The coastal and southern portions of the County are the most heavily urbanized. Public transportation systems are disconnected and poorly configured for effective movement by those dependent upon public mental health services.

Population

Los Angeles County population grew by nearly 4.5% between 2000 and 2006. In 2006, an estimated 9,948,081 people resided in the County. A third (36%) of these are foreign born and 57% speak a language other than English at home. Nearly 38% of the population speaks Spanish at home and 6% speak Tagalog, Chinese or Korean. While Hispanic/Latinos are a majority followed by non-Hispanic/Latino Whites/Caucasians, the County also has the largest Asian/Pacific Islander population in the country at 1.3 million.

In terms of age, the largest proportion of our population is adults. Additionally, almost one in four are in the 15 years of age or younger category. In some ethnic groups the proportion in this category is believed to be much larger, e.g., Hispanic/Latino.

Socio-Economic Factors

Median household income in the County is lower than the State average. Nearly 12% of the families and 15% of individuals live below the Federal Poverty Threshold. About 37.7% of the population is dependent (upon public assistance). Approximately one quarter of the population has a college degree or higher. Half the population are homeowners and the other half are renters. Per capita income is $24,544.00 and the median value of housing is $574,100. Many economists argue that wages have not kept up with cost of living expenses for the area where higher prices are paid to cover energy, housing, food and other costs. These quality of life characteristics have important implications for the application of State estimates of prevalence and “population under 200% poverty” as it relates to mental health needs.

Educational Resources

In light of the WET plan’s goal of elucidating career and educational strategies to change the mental health workforce, a brief description of the existing educational system in the county is important. The Los Angeles Unified School District serves the largest portion of K – 12 students, 681,903, followed by the Los Angeles County Office of Education system with 10,904. A number of Charter Schools have been established over the last five years to also serve the K – 12 population. Post-secondary educational resources include 22 community colleges, four CSU schools (Northridge, Long Beach, Los Angeles and Dominguez Hills) and one UC school, UCLA. A number of public and private schools exist that educate students for careers in mental health care including UCLA, USC, Biola, Claremont, Alliant, Pepperdine and Loyola Universities. Others include Phillips Graduate Institute, California Graduate Institute, University of Phoenix and National University.

IV. GENERAL DESCRIPTION OF COUNTY OF LOS ANGELES DEPARTMENT OF MENTAL HEALTH SYSTEM

The County of Los Angeles Department of Mental Health was established in 1960. It currently serves over 200,000 Los Angeles residents who are chronically mentally ill and often have no other source of assistance and treatment. Its services are provided through a network of directly-operated, contractor and fee-for-service resources across the County. Our providers vary considerable in terms of size, scope and target group. Because of the geographic expanse of the County, the public mental health system is configured into eight service areas each of which has its own unique combination of population, resources, geography and community make-up. The service areas are as follows:

Service Area	Communities	Population
1	Lancaster, Palmdale, North County Rural Areas	347,823
2	San Fernando and Santa Clarita Valleys	2,146,515
3	San Gabriel Valley, Pasadena/Altadena, Pomona, Eastern County Area	1,868,116
4	Downtown/Metro Los Angeles, Hollywood, Pico-Union	1,260,196
5	West Los Angeles, Santa Monica, Culver City, Malibu, Brentwood, Venice and Bel Air	636,309
6	South Los Angeles, Compton, Watts, Paramount	1,041,685
7	East Los Angeles, Bell Gardens, Bell, Whittier, Downey	1,379,540
8	South Bay Areas, Inglewood, Gardena, Long Beach, Carson	1,605,621

V. COUNTY OF LOS ANGELES METHODOLOGY

The County of Los Angeles Department of Mental Health employed a multi-dimensional or convergent analysis methodology for collecting and analyzing the required data. The approach had to take into account the scope and unique nature of the Los Angeles mental health system and the County itself. *The methodology also recognized the value of quantitative and qualitative data.* Quantitative data would certainly answer the stipulated Exhibit 3 and describe the system. Qualitative data was equally important because it could move beyond the baseline, quantitative data to pinpoint program ideas and issues to serve the WET planning process.

COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
MHSA/Workforce, Education and Training Needs Assessment

Data Sources

QUANTITATIVE – compilation and aggregation of raw data from existing human resources, provider and client utilization information
SOURCES:

Workforce and Consumer Population Data – Data from County and Department records as it relates to Occupational Positions and Clients for the period of January 1, 2007 to December 31, 2007. Additionally, the County of Los Angeles Department of Mental Health conducted a "Contractors Survey – Questionnaire" to obtain Occupational Positions according to Exhibit 3 between April 2008 and June 11, 2008. The response rate for the survey was 56% and the responding agencies represented 64% of our total contractor pool. This data accomplishes the following:

Provides description of existing workforce and expressed need as reflected in client demand or utilization

Provides data for comparison of service delivery to estimated population needs and prevalence in terms of ethnicity, age and language

QUALITATIVE INTERVIEWS

Key Expert Interviews – Eight individual interviews conducted with identified and representative mental health experts between January 2008 and May 2008.

Focus Groups - Guided group discussions structured to address WET needs assessment and planning objectives. Specific questions can be found in Attachment H. Forty two groups were completed in the period from October 2007 to February 2008. Participant groups represented important constituents and advisory groups to the mental health system. These included the following: Each of the 8 Service Area Advisory groups in the DMH system Specific constituent groups: African-American/Black, Asian/Pacific Islander, White/Caucasian, Hispanic/Latino, Native American, Clergy, Consumer, Labor Union, NAMI

Ad-Hoc Committee and Stakeholder Review and Comment – The WET Needs Assessment and Plan Review obtained input over a nine-month period from members of the Ad-Hoc WET Committee and Stakeholder advisory groups. These groups are composed of individuals who are contractors, educators, activists, family members, volunteers and consumers. This feedback process accomplishes the following:

Provides description of perceived needs, recommended programs and priorities relevant to WET needs assessment and planning framework and objectives from identified stakeholders, advisers, constituents and community partners.

CONSTITUENT AND STAKEHOLDER INPUT

Electronic collection of plan comment ideas (WIKI) Survey – Web-based, electronic program to allow stakeholders to contribute ideas and feedback regarding the potential WET plan components. This was an English language software program and required computer access and skills for submission. Options were also available to accommodate those with unique requirements or restrictions related to access and language. Submissions were made from April 8, 2008 to May 30, 2008.

RELEVANT RESULTS AND ANALYSIS

Table 1 – RENDERING PROVIDERS AND CLIENT CHARACTERISTICS By ETHNICITY

Ethnicity	Providers Licensed-Unlicensed (note: this count includes Management and Support Staff)	DMH Clients	Difference Provider-Client Proportion	Ratio of Providers to DMH Clients	Prevalence	Ratio of Providers to Population in Need of MH Services
White/Caucasian	3,466	42,542		1:11	46,462	1:12
	30.00%	22.39%	+7.61%			
Hispanic/Latino	3994	79,176		1:19	209,907	1:50
	29.27%	41.68%	-12.41%			
African-American/Black	2,124	51,851		1:31	32,020	1:19
	18.32%	27.30%	-8.98%			
Asian/Pacific Islander	1,228	9,627		1:12	31,080	1:38
	10.59%	5.06%	+5.53%			
Native American	62	1,139		1:21	572	1:11
	.53%	.59%	-.06%			
Multi-Race or Other	718	5,589		1:4	10,226	1:18
	6.19%	2.94%	+3.25%			
TOTAL	11,592	189,924		1:16	330,268	1:28

Discussion: Ethnicity of Providers, Clients and Population in Need
I. Provider to Population in Need of Mental Health Services

- The overall ratio of mental health provider to client is 1:28
- Highest ratio of provider to client is with Hispanic/Latino population; 1:50
- Second highest ratio of provider to client is for Asian/Pacific Islander group; 1:38

II. All Providers

- Largest proportion of all providers are Non-Hispanic/Latino White/Caucasians – 30%
- Second largest proportion of all providers are Hispanic/Latino – 29.27%
- Lowest proportion of all providers are Native American - .53%
- Second lowest proportion of all providers are Multi-Race or Other– 6.19%

III. All Providers compared to Client Population

- In terms of ethnicity, the largest negative difference between representation in provider pool and client population is for Hispanic/Latino ethnic group. There is a difference of 12.41% between their proportion of the provider population (29.27%) and their representation in the client population (41.68%).

Conclusions

- Reduce ratio of providers to population need for all groups, especially for Hispanic/Latino and Asian/Pacific Islander populations
- Increase provider levels (i.e., programs and staff) for groups with the highest population to provider ratios; i.e., Hispanic/Latino and Asian/Pacific Islander groups
- Increase proportion or representation of providers from African-American/Black, Hispanic/Latino and Native American to better match their client proportions. The data suggest that increases of 50%, 42% and 11%, respectively, should be considered.
- Focus Group priorities suggest need for more staff across all segments of staffing – Licensed, Unlicensed, bilingual in all Service Areas

TABLE 2 – COMPARISON: AUTHORIZED – FILLED POSITIONS by TYPE OF POSITION AND ETHNICITY

Type of Position	Authorized FTE's	Filled FTE's	Difference Filled vs. Authorized (%)	Highest Filled by Ethnicity	Lowest Filled by Ethnicity
Unlicensed	3,438	3,112 (90%)	-10	Hispanic/Latino 38% (1,204)	Native American .06% (2)
Licensed	4,270	3,679 (86%)	-14	White/Caucasian 37.9% (1,394)	Native American .92% (34)
Other Health Care	325	297 (91.0%)	-9	White/ Caucasian 31.6% (94)	Native American .3% (1.0)
Managers	1,752	1,757 (100.0%)		White/Caucasian 40.6% (713)	Native American .63% (11)
Support Staff	3,087	2,748 (89.0%)	-11	Hispanic/Latino 37.49% (1,030)	Native American .37% (14.37)
TOTAL	12,873.55	11,593.00 (90.01%)	-10		

KEY: Row values represent total number of positions in the category.

Discussion: Authorized, Filled Positions and Ethnicity

- Largest proportion of filled positions in 3 of 5 staff segments (Licensed, Other Health Care, Managers) are Non-Hispanic/Latino White/Caucasian employees
- Smallest proportion of filled positions in all segments are represented by Native American employees
- Support staff reflect the lowest number of authorized to filled positions, (-11 difference)
- Unlicensed staff reflect second lowest number of authorized to filled positions, (-10 difference)

Conclusions

- Need to increase hiring to reduce disparities in licensed and support segments
- Need to increase hiring of employees from Native American, African-American/Black and Asian/Pacific Islander populations across all segments
- Reduce gap between filled and authorized positions in Unlicensed, Licensed and Other Health Care segments. These position include clinical positions and key recovery/resiliency positions such as Community Outreach, Peer Advocates, Housing Specialists, Prevention that are relevant to WET goals
- Expand options for career movement from all segments to manager positions [Need to develop more representative leadership and transform career movement/mobility to manager's positions]
- Examine criteria and eligibility for various positions to assure broader diversity and ethnic representation and work experience
- Provide cultural competency training and increase translation services to address existing disparities and improve workforce
- Develop educational programs, career pathways that move qualified people into positions in segments with biggest disparities
- Focus groups priorities suggest a need to increase (i.e., fill) Licensed and Unlicensed positions with bilingual and bicultural staff

TABLE 3 – FILLED POSITIONS by ETHNICITY
All Providers

Type of Position	Filled FTE's	White/ Caucasian	Hispanic / Latino	African American/ Black	Asian/Pacific Islander	Native American	Multi-Race or Other
Un- License	3,112	796 **25.6**	1,204 **38.7**	649 **20.9**	159 **5.1**	2.0 **.06**	302 **9.7**
License	3,679	1,395 **37.9**	1,229 **33.4**	356 **9.7**	372 **10.1**	34 **.92**	293 **8.0**
Other Health Care	297	94 **31.6**	88 **29.6**	65 **21.9**	27 **9.1**	.91 **.3**	22 **7.6**
Management	1,757	714 **40.6**	442 **25.1**	326 **18.5**	207 **11.8**	11 **.6**	57 **3.2**
Support	2,748	468 **17.0**	1,031 **37.5**	727 **26.4**	464 **16.9**	14 **.5**	44 **1.6**
TOTAL % of total	11,593	3,467 **22.2**	3,994 **25.6**	2,124 **13.6**	1,228 **7.9**	62 **.39**	718 **4.6**

KEY: Row values represent total number and/or proportion of positions in category

DMH Client Proportion	White/ Caucasian	Hispanic/ Latino	African American/Black	Asian/Pacific Islander	Native American	Multi-Race or Other
	22%	**41%**	**27%**	**5%**	**.59%**	**2.9%**

Discussion: Filled Positions by Ethnic Representation

- **Native American employees represent the lowest proportion in every segment of filled positions; less than 1%**
- **Hispanic/Latino employees are one-third of filled positions in four of the five segments**
- **Non-Hispanic/Latino White/Caucasian employees represent the largest proportion of two segments; licensed (37.9%) and management (40.6%)**
- **Hispanic/Latino employees represent almost 40% of filled Unlicensed positions**
- **Notable difference for African-American/Black between representation in Licensed positions (9.7%) and client population (27%); a difference of approximately 17%**
- **Difference for Hispanic/Latino between representation in Licensed positions (33.4%) compared to client proportion (41.%); approximately 7.6%**
- **Licensed White/Caucasian clinicians represent almost 40% of the total and White/Caucasian clients are 22% of the total client population**

Conclusions

- **Need to increase, (through hiring, career pathways, training programs) diversity within the ranks of Licensed segment**
- **Address the actual numbers and proportions of licensed positions in the system compared to Unlicensed and Other Health Care segments; transformation to a recovery model may call for adjustments or rebalancing of types of positions in the system**
- **Examine hiring practices, criteria, eligibility especially in segments that reflect important disparities or gaps**
- **Focus group priorities suggest cultural competency training and more career opportunities that may need to occur in this area**

TABLE-4 – CONSUMER and FAMILY SUPPORT POSITIONS - PROVIDER BY STAFF ETHNICITY

Provider	Authorized FTE's	Filled	Difference	Highest % by Ethnicity	Lowest % by Ethnicity
Directly-Operated	70	41 58%	-42%	Hispanic/Latino 19 46%	Native American 0%
Contractors Proportion Filled	450	394 87%	-13%	Hispanic/Latino 153.5 39%	Native American 0%
Total – All Providers	520	435 83%	-16%	Hispanic/Latino 172 39.5%	Native American 0%
All DMH Positions	12,873	11,593			

KEY: Row percentages represent total number and/or proportion of positions in the category.

Discussion: Consumer and Family Positions by Provider and Ethnicity

- **Total of 520.4 Consumer and Family positions represents 4% of all positions overall in the system**
- **All providers show a negative difference between authorized and filled positions for these two categories**
- **Largest negative difference between authorized and filled positions are in the directly-operated category**
- **DMH contractors show the "best effort" in term of filled positions in this category, 87%, only a 13% difference between authorized and filled**
- **The positions of Consumer and Family represent a small proportion of overall positions in the system**

Conclusions:

- **Increase the proportion of positions in this category to achieve the goals of the WET plan in terms of representation of consumers and family members/advocates in the system**
- **Improve the number of filled positions in these categories for directly operated providers**
- **Develop career pathways and training to advance this segment of the workforce**
- **Focus groups identified this as a key area for development of the workforce**

Subset Table: Providers by Language

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT				
III. Language Proficiency - Page 2				
Language, other than English		**Number who are proficient**	**Additional number who need to be proficient**	**TOTAL (2)+(3)**
(1)		**(2)**	**(3)**	**(4)**
Spanish	Direct Service Staff	3,489.0	2,638.0	**6,127.0**
	Others			
Mandarin	Direct Service Staff	55.0	10.0	**65.0**
	Others			
Other Chinese	Direct Service Staff	86.0	233.0	**319.0**
	Others			
Cantonese	Direct Service Staff	96.0	0.0	**96.0**
	Others			
Korean	Direct Service Staff	77.0	234.0	**311.0**
	Others			
Tagalog	Direct Service Staff	145.0	224.0	**369.0**
	Others			
Vietnamese	Direct Service Staff	52.0	96.0	**148.0**
	Others			
Russian	Direct Service Staff	44.0	33.0	**77.0**
	Others			
Cambodian	Direct Service Staff	60.0	0.0	**60.0**
	Others			
Armenian	Direct Service Staff	64.0	175.0	**239.0**
	Others			
Arabic	Direct Service Staff	20.0	53.0	**73.0**
	Others			
Farsi	Direct Service Staff	89.0	29.0	**118.0**
	Others			
Others	Direct Service Staff	339.0	2,509.0	**2,848.0**
	Others			
TOTAL, all languages other than English:	**Direct Service Staff**	**4,616.0**	**6,234.0**	**10,850.0**
	Others	**0.0**	**0.0**	**0.0**

STAFF LANGUAGE PROFICIENCY AND AVAILABILITY

The assessment of workforce needs in terms of language proficiency and staff for Los Angeles County compares target population and available human resources against a suggested standard for staff-to-consumer ratio. Data is presented in terms of "threshold language" which is defined as a primary (or, first) language for at least 3,000 beneficiaries or 5% of the beneficiary population in our target area. Target population is based upon prevalence rates for the severely mentally ill(SMI) in Los Angeles County. Staff *proficiency* is defined as verbal fluency in a particular threshold category. Thirteen linguistic categories are described in Exhibit 3 excluding English. Optimal staff levels and existing gaps are based on a standard of 1:40 (staff-population) language match.

Table 5 is based on Exhibit 3 data and presents a more useful comparison of population, staff and capacity for the purpose of WET planning and goal setting. Proportional differences between existing staff in each language category and the optimal staffing standard or ratio are calculated to identify gaps in resource availability. The determination of workforce development goals can focus on the specific gaps identified as "**Availability Difference"** in each of the language categories (Column 4 – Table 5). **These values could range from positive (+) where capacity is above the standard, even (--) when current capacity meets the standard or negative (-) when capacity is below the recommended level.**

TABLE 5
Threshold Language, Staff Proficiency and Availability

Language Group	1 Staff Standard	2 Available Staff	3 Available Staff Proportion of Standard	4 Proportional Availability Difference
SPANISH	6,127	3,489	56.95%	-43.05
MANDARIN	65	55	84.62%	-15.38
OTHER CHINESE	319	86	26.96%	-73.04
CANTONESE	96	96	100.00%	--
KOREAN	311	77	24.75%	-75.24
TAGALOG	369	145	39.29%	-60.71
VIETNAMESE	148	52	35.14%	-64.86
RUSSIAN	77	44	57.14%	-42.86
CAMBODIAN	60	60	100.00%	--
ARMENIAN	239	64	26.78%	-73.22
ARABIC	73	20	27.40%	-72.60
FARSI	118	89	75.43%	-24.57
OTHERS	2,848	339	11.90%	-88.10

DISCUSSION

Discrepancies are identified for eleven of the thirteen language categories. Two languages, Cantonese and Cambodian, currently have the staff that fully meet the recommended standard. For the other eleven categories, negative differences or gaps ranged from -15.38 (Mandarin) and -43.05 (Spanish) to -88.10 (Other). A number of languages associated with Asian/Pacific Islander subgroups (e.g., Korean, Vietnamese, Tagalog) have considerable differences between the desired standard and existing workforce. Similarly high rates of
difference exist in the Arabic and Armenian language categories. The largest gap found in the “Other” category requires further scrutiny to specifically identify which languages are reflected in this segment of the population.

CONCLUSIONS

- Staff availability gaps can be targeted for eleven of thirteen threshold language groups as it relates to workforce development
- Language groups with 50% or greater difference between available staff and the workforce standard may be the highest priority for workforce development
- Consideration should be given to expanding the “interpreter” segment of the workforce particularly in the categories with the highest discrepancies between available staff and the recommended standard
- The languages that comprise the “Other” category should be elucidated given the large raw numbers and the discrepancy rate between staff and the recommended standard

HARD-TO-FILL: Exhibit 3 – Occupational Categories

Exhibit 3 of the WET Needs Assessment provides the identification of positions deemed "hard-to-fill" (Column 3 – Exhibit 3). Data for the five workforce segments is presently for DMH directly operated and contract/community based organizations separately. The criteria for Los Angeles County reflects the influence of such factors as labor market availability, minimum (or sufficient) levels of training and experience as well as hiring goals to achieve ethnic, linguistic or cultural diversity. Additionally, factors that affect recruitment and retention such as salary levels and promotional opportunities were taken into consideration. The specific hard to fill defining criteria are provided on the last document of this report.

DISCUSSION

Three occupational segments; Licensed, Unlicensed, Other Health Care, have the greatest number of positions considered hard to fill. All three are important in terms of WET planning and MHSA mission because, collectively, they represent the full complement of services for those with mental illness. Licensed staff provides direct clinical intervention and the system finds it hard to find and hire psychiatrists, social workers and psychiatric technicians. A number of positions in the Unlicensed and Other Health Care categories are also difficult to fill and they are essential components of a full spectrum of care. These jobs include Rehabilitation Specialist, Family Member Support Staff and Employment Services (Unlicensed segment) and Registered Nurses, Physician Assistants and Occupational Therapists (Other Health Care segment). Positions in the Management/Supervisory and Support Staff segments do not reflect the same degree of difficulty in recruitment and hiring as the other three.

CONCLUSIONS

- The value, contribution and satisfaction of mental health-related occupations needs to be articulated and marketed
- Key relationships with professional, academic and consumer groups should be cultivated to market, recruit and encourage interest in these positions
- Opportunities to partner with academic and training institutions should be pursued that will invigorate the educational pipeline and increase the local labor pool of potential applicants
- Financial streams of support, in the form of student stipends, better salaries and other incentives, require strategic exploration and growth
- Promotional criteria and options merit reconsideration in terms of relevance and unintended consequences (i.e., prevailing or perceived "ceilings")
- Mental Health training and education programs for existing staff may need to focus on key components of culturally competent skills and professional growth strategies.

County of Los Angeles-Department of Mental Health

Hard to Fill Criteria

1. Individuals do not meet minimum requirements
2. Pay and/or benefits are insufficient to attract or retain sufficient qualified individuals
3. Difficulty attracting sufficient numbers of individuals to meet ethnic/racial/linguistic diversity needs
4. No promotion opportunities (lack of career ladder)
5. Difficulty finding sufficient numbers of unlicensed and licensed staff with needed specialized skills.

Additionally, there is a need to explore possible bonus structures for specialty and geographic areas.

ATTACHMENT J

INTERNAL WORK GROUP REPRESENTATION	
Category/Subject	**Groups and Programs Represented**
AGE GROUPS LEADS	√
CHIEF INFORMATION OFFICE BUREAU	√
CONSUMERS Empowerment and Advocacy Division	√
CULTURAL COMPETENCY	√
DATA MHSA Data Team	√
HUMAN RESOURCES Recruitment/Classification Unit	√
PLANNING DIVISION	√
RECRUITMENT Office of the Medical Director	√
TRAINING DIVISION Training and Quality Improvement	√

ATTACHMENT K

ATTACHMENT K

County of Los Angeles Department of Mental Health
Mental Health Services Act (MHSA)
Workforce Education and Training (WET) Plan
30 day Review and Comment Period
August 29, 2008-September 28, 2008

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Eduardo Vega

Agency/Organization: County of Los Angeles-Department of Mental Health
Empowerment and Advocacy Division

E-mail address: evega@dmh.lacounty.gov

Mailing Address: 659 S. Vermont Ave. 8th Floor, Los Angeles, CA 90005

Comment

In order to pursue the stated purpose and goals and maximize the funds available, I suggest more funds be used to improve and increase the educational partnerships in Action Plan 15. In order to train the intended populations, it is best to do local to the communities which helps to address the needs for diversities and the needs for convenience because of transportation and time burdens on the intended populations. For example, community colleges are spread throughout the Los Angeles County , have experience with the local communities, are used to dealing with diverse populations in there areas and have workforce development offices that can assist in establish partnerships and are familiar with workforce training. As often the first break comes during the college years, many NAMI families are interested in the persons with the mental illness returning to college and the college could use this interest to reach out to families, consumers and mental health professionals. The Regional Occupational Programs and Skill Centers along with Adult Education Programs are also connected with local communities and could work with the community colleges on providing training programs. Disabled Student Programs at the colleges, regional occupation programs and universities could work together to be a center for this training. Further the community colleges and others have online and distance education that could offer hybrid (online and in-person) classes which would probably be attractive to the intended

population to provide content online and in person and to provide networking in class setting. These are some of possibilities and other educational partners as mentioned in the study may present similar opportunities. However, I know that NAMI members are interested in having more locally based programs that provide for better trained staff in the local area and for possibilities for their loved ones. The $100,000 allocated seems like a small amount in order to fund the exploration, development and establishment of these partnerships across the county. Finally, I assume the

2008-2009 plan is for the fiscal year July 1, 2008 –June 30, 2009. I am not sure about this and could find nothing in the plan indicating the exact dates. If this is correct or approximately correct, then I don't' understand how the approximately $2.5 million could be spent on stipends by the end of the fiscal year with the plan still needing to go through the approval process. Some of this money which seems likely to be unexpended by end of the fiscal year could be reallocated to educational partnerships. I regret I have not been able to spend time on review of the MHSA plans until recently and was only able to view the plan this weekend. I will attempt on behalf of NAMI South Bay to have our members more involved in the review of these plans.

RESOURCES MUST BE ADDED TO THE ACTION PLAN FOR PEER SUPPORT TRAINING IMMEDIATELY IN ORDER TO ACHIEVE PROGRESS IN THE WORKFORCE AND SYSTEMS CHANGE GOALS OF THE MHSA.

For over four years Los Angeles County has been preparing to meet the transformed systems needs through Peer Support trainings funded on an ad-hoc basis. However, the Accelerated and other ad-hoc trainings currently funded were always conceived as a stop-gap measure until a fully-constructed Peer Support training program including the baseline internship requirements could be implemented. At this point these offer minimal training to less than 120 individuals per year. Of these less than half qualify upon completion of these courses for full-time employment as a Peer Supporter.

From April 2006 through October of that year Los Angeles' leading training agencies met with experts in peer advocacy and peer support at LAC-DMH headquarters to establish the parameters for this complete training program in a colloquium format. The resultant Core Competencies for Peer Support training were accepted by all the training colloquium participants as an effective format that would ensure that trainees emerge with the right combination of skills, knowledge and experience (through a 96-hour internship requirement) to begin work and make substantive contributions to the mental health service system across the county.

To date trainings based on this established need analysis have not been funded and the explanation given was that such would be initiated with WET funds. At this point, all is in preparation and the workforce cannot wait.

It simply does not make sense for the 08-09 funding level for peer support training to be held at the substandard minimum it has been in the past as we waited for MHSA and then WET funds to be available.

The need across Los Angeles for effective, fully-trained peer advocates is extreme and cannot be met with current training numbers. The process and mechanism for implementing these resources is ready and waiting. Also, qualified consumers and former clients have been waiting and waiting while social work trainees and psychologist receive stipends in excess of $2 million per year. **The bare minimum that should be added to the Workplan Action item for Peer Support/Advocacy training in this and subsequent years is $488,000 (in addition to the $170,000 projected). As soon as these funds are allocated Los Angeles can act on its commitment to developing this essential and immediate workforce component.**

Thank you for your attention.

Any member of the public may submit written comments on or before September 28, 2008. Written comments can be submitted on this form by e-mail to MHSAWETPlan@dmh.lacounty.gov, or by letter addressed to:

County of Los Angeles Department of Mental Health
Program Support Bureau
Attention: Eva Carrera
550 South Vermont Ave, 3rd Floor
Los Angeles, CA 90020
Fax # (213) 736-5802

County of Los Angeles Department of Mental Health
Mental Health Services Act (MHSA)
Workforce Education and Training (WET) Plan
30 day Review and Comment Period
August 29, 2008-September 28, 2008

PUBLIC REVIEW

Personal Information (OPTIONAL)

Name: Paul Stansbury

Agency/Organization: NAMI South Bay E-mail address: pstans5@aol.com

Mailing Address: 1652 10th Street Manhattan Beach, CA 90266

Comment

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County of Los Angeles Department of Mental Health
Program Support Bureau
Attention: Eva Carrera
550 South Vermont Ave, 3rd Floor
Los Angeles, CA 90020
Fax # (213) 736-5802

County of Los Angeles Department of Mental Health
Mental Health Services Act (MHSA)

Workforce Education and Training (WET) Plan
Mental Health Commission- Public Hearing
September 25, 2008

Public Hearing Questions, Responses and General Comments on the WET Plan

Question: Will there be a separate training commitment for contract agencies as compared to the Department of Mental Health (DMH)?
Response: Training will be inclusive of both systems.

Question: Will you assist/navigate consumers and families to obtain a higher education and DMH employment?
Response: Yes, action plan #12 Mental Health Career Advisors provides ongoing support for potential new and existing mental health workers which include consumers, family members, and parent advocates.

Question: What is meant by the expanded workforce action plan #15?
Response: This action plan supports collaborations with educational institutions to increase the number of psychiatrists, psychiatric nurse practitioners, MSWs, LVNs, RNs and OTs; it provides immersion training with post secondary faculty and teaching staff currently engaged in preparing individuals for joining the public mental health workforce in Los Angeles County.

Question: Can DMH create a program to provide jobs for consumers that are not in the mental health field? DMH could collaborate with other County Departments to provide a job training program.
Response: MHSA-Workforce Education and Training (WET) funds are exclusively to increase workforce capacity in the mental health system.

Comment: While legislation includes “clinical psychologist,” and while this proposal, presented today, includes clinical psychology in several places, the document, on page 21 of Work Detail (Exhibit 4) (and page 39 of entire document) omits clinical psychology students from participating in the stipend program (See Section #2) in this area. I respectfully submit that clinical psychology students be included in the current year funding for student stipends.
Response: Clinical psychology interns were not included in the stipend program for FY 2008-2009; a commitment was made to continue the allocation of stipends made during FY 2007-2008. The stipend allocation issue, for certain occupational categories, could be reconsidered by the Oversight Committee (will oversee the needs of the public mental health workforce) for FY 2009-2010.

Question: I noticed there were references to the health department needing more bilingual trained servants in MHS. I did not notice any references to ASL (American Sign Language). I suppose the solution typically has been to hire an interpreter as with other medical situations, however, I know so many deaf clients don't feel comfortable divulging their therapeutic issues in the presences of an interpreter who is a stranger. Has there been any discussion about incorporating sign language deaf culture trained therapists and psychiatrists in the MHS?
Response: Threshold language designation is set by the State. The criteria are as follows: need to have at least 3000 beneficiaries or 5% of the total beneficiary population identifying a language other than English as a primary language. DMH has listings of therapists and other staff who have American Sign Language capabilities; such bilingual staff are available to provide mental health services.

Question: Who are the system navigators to help guide interested consumers, family members in choosing a career and finding the funding for advanced education? Overall I think the Plan is excellent because of the emphasis of 50% consumer involvement and the opportunities in the field. It treats the consumer as any other person trying to better themselves. It is not a handout.
Response: Action plans #9 - #12 address the needs and support the expansion of employment opportunities for consumers, family members, and parent advocates; this would include assisting in navigating the educational system (i.e., looking at career options, financial resources, etc.).

Question: Will current (DMH employees) psychiatric social workers II (PSWIIs) qualify for assistance in paying back student loans?
Response: The State will put forth a plan for loan deferment for Psychiatrists. Likewise such a plan will be available to other professionals by the year 2010.

Question: In working with the regional center system we are seeing an increasing number of individuals who have both a developmental disability and a mental illness diagnosis. Our resource providers and our staff are largely unequipped to work with the mental illness component. What types of partnership have you considered or already developed with the Regional Centers (7 in Los Angeles County) to look at meeting the needs of those individuals who have both a DP and MI diagnosis? Will someone who represents the needs of DD individuals be on the oversight committee?
Response: Workforce Education and Training Plan addresses the needs for increasing the public mental health workforce and the incorporation of consumers, family members and parent advocates. Advocates for consumers or consumers that are developmentally disabled will be considered along with other stakeholders for membership on the oversight committee.

Question: How does the plan include an active partnership with those consumers that are diagnosed with mental and developmental disability specifically Regional Center consumers?
Response: The plan targets all consumers who meet the criteria for mental health services, including developmentally disabled consumers.

Question: Will professionals who receive a mental health stipend (now) prior to the plan and continue to work in the mental health field qualify for the loan forgiveness program?
Response: It is difficult to say at this point since the specifics have not been defined with regard to the loan forgiveness program. Having individuals take advantage of both the stipend program and loan forgiveness at the same time may not be allowed.

Question: I took the Mental Health Staff Training for 10 weeks and field work for 6 weeks. Before the training started, orientation personnel said that the training provider would provide our stipend if we got a 70% on the course, but I didn't. Can MHSA help to pay the trainee stipend $200 for the course as promised?
Response: You will need to contact your contract provider staff (case manager) who helped enroll you in the training.

Question: If 1:40 is ideal staff ratio,, what is it now?
Response: Caseloads vary according to adult vs. children populations. Caseloads can likewise depend on the geographic area. Adult caseloads can vary from 100 to 200 or more while child caseloads can be up to 40.

Question: Who will be on the Oversight Committee?
Response: Representative from stakeholders such as local universities, community colleges, contract providers, Unions, are just a few of the entities that may be represented. Action plan #2 outlines additional details about the Oversight Committee.

Question: Why are occupational therapists excluded from Item #21: stipends?
Response: Previous commitments for FY 2007-2008 were honored. The Oversight Committee will have the option to review and decide on the stipends to be offered for FY 2009-2010.

Question: The Workforce Education and Training Plan look terrific but seem to rely on many factors falling into place to ensure success. One being buy-in by students/trainees/etc. as well as current workforce. If that does not happen, are there any plans to reach out to retired professionals with experience in the mental health field e.g. MSWs, MFTs, psychologists, psychiatrists? Or professionals from other states?
Response: Action plan #14 addresses the need to conduct market research and develop strategies for attracting new professionals to the public mental health workforce.

Question: (In Spanish) The participant asked about the Early Prevention and Intervention budget and inquired about the proposed budget cuts, if any.
Response: The Workforce and Education Plan deals with increasing the capacity of the public mental health workforce. For additional information, you can contact us at 213-738-3090, and we can direct you to the Early Prevention and Intervention Staff who can assist you with your interest and concern.

Comment: This forum is about education and training healthy people, nothing addresses jobs for consumers.
Response: Emphasis on employment of consumers, family members and parent advocates is noted throughout the plan, in particular action plans #9 – #12.

Comment: I work with the community in Lancaster. I feel the community needs to be outreached and oriented on the different programs available specifically to the Hispanic community. Many parents are dealing with the uncertainty of their children. Many children and cultures seem to be constantly discriminated against, and they are aren't finishing nor seeking further education; this to me is a mental health issue.
Response: There is a specific Plan. There is a mandate in the act which would bring students in the 9th grade to begin thinking and moving ahead. The idea is to take at risk kids and help them find their special skills. So your point is on target. We're working with Belmont to develop a comprehensive program.

Comment: With regards to the budget and the budget development, at some point, it's going to be important for the public to understand the division of monies between the children's programs and the adult programs. Part of the history of DMH and the children's programs has not gone (inaudible).
Response: Children's programs took a huge jump and are better funded at the service level. It is a matter of how we are going to search out with stipends to encourage children's specializing professionals.

Question: As it relates to workforce development, to what extent do these plans relate to children?
Response: They don't breakdown that way. We find that out as we recruit people into the programs. Hopefully, there were many devoted moving ahead to child and adolescent programs.
2nd Response: I wanted to add with the involvement of MFTs who specialize with child and family, you are bringing in another segment of the workforce that understand working with children, and you will notice in our psychiatric residency funding we will be interested in finding child psychiatrists. That is a well-identified need.
3rd Response: The oversight committee is something, if you are interested, you could ask Dr. Southard to be considered for the committee; he will appoint the representatives. There should be representatives who speak to these age groups issues. The intent is to cover over 10 years and adjust, and provide training targeted to where the need is.

Question: With the change in hiring patterns, do you feel there are going to be problems with Human Resources, for example in job descriptions? How do you plan to deal with the issue and roadblocks?
Response: There are two areas of human resources. One is when you think of CBO's, they have different criteria in terms of hiring. I think DMH can speak to the County hiring issues.
2nd Response: I know the consumers and families have been advocating for announcements for all positions. They can simply add the line "consumers and family

members encouraged to apply." Agreement on the part of human resources will be critical.
3rd Response: In terms of the County, it has to happen….yes. If you take a look at the human resource classifications now, it was for another time.
4th Response: It has to change. The requirements, the classifications, the duties and responsibilities. If you take a look at the current DMH, it was based on a medical model.
5th Response: Maybe somebody from human resources could be on the oversight committee. Keep in mind, what we want to do is going to take time.

Question: I'm an intern with DMH, in reviewing the plan, it is great. We want to include the consumers and family members, but it didn't say who and how they would be nurtured. I think it is important because families and consumers are there to meet the needs of the people who are engaged in services. How are you going to nurture them and tell them the avenues and how to navigate the system?
Response: There is a plan that deals with career advisors number 12 and we are hoping we can find a way particularly to have support groups and support processes so folks that come in with life experience will get the encouragement they need to make the transition and find a pathway if they wish to progress.
2nd Response: The high school pathway which is now in state policy will apply and make it easier for people to move ahead.

Question: I'm concerned with the consumers and family members, and more so the people who had life experiences. What are the various plans? How does the WET plan help those that are consumers?
Response: Consumers start in year 2. There is some funding this year. Basically it is $300,000 each year for consumers and parent advocates and can be expanded as we move ahead which depends on the level of desire people what to do.
2nd Response: If you look at action plan number 5, when we start talking about career pathways for consumers, it is the supervisors who will provide the support and encourage consumers to pursue career ladder opportunities.

Comment: One of the things I saw missing from the plan was the incubation academy, part of the philosophy of the incubation and rationale was we were going to bring people on board through training providers who have a client center focus to integrate them into the plan. We could take care of the issues of career paths and sensitivity and burn out.
Response: I'm not familiar with the academy. We need to look at PEI funding. We will research it, and respond to this issue. However, the initial plan for the incubation academy was to fund prevention and early intervention---mainly…Organizations that apply for early intervention funds would be new agencies coming into our system.

Question: I notice there are no interpreter references for more bilingual services. I wonder if you thought about it?
Response: That is within the plan.

Question: I wanted to get more information about item 19, the tuition reimbursement program. In particular it mentions colleges, primarily public colleges, community colleges and state colleges. Would private colleges be able to offer proposals to programs that develop linguistic and community mental health professionals?
Response: Yes, as a matter of fact, the psychiatric nurse practitioner programs in this part of the state are being started at Azusa Pacific. The biggest problem is that tuition is high. It is difficult to get stipends that will cover private schools, but they are not excluded.

Question: I am a mental health advocate with San Fernando Valley Community Health. I don't want to make it seem like it is all bad. My friend here is concerned with what consumers are worried about. If he can't make it, is he out in the cold forever? I wanted that addressed.
Response: If people are coming into the system from life experience, there has to be a support mechanism. That is anticipated in the consumer training piece and parent advocate training pieces. There are several places this must happen. This is planned for.

Comment: I represent the California Psychological Association, chair of the Board of APEC and represent Southern California Psychology Training Programs. I'm here to discuss our concerns. Our concern stems from years ago. We corresponded in writing to the office to ask for participation for our groups in the proposal; the purpose was to have stipends for the interns. We did not hear back and made phone contact and again did not hear back. Recently, we sent inclusion of psychology concerns including the stipend for psychology students. There are $2.5 million for social worker interns and MFT interns. We understand this is in a planning phase; we request the committee include us in the planning commission. We would be happy to discuss it in some other forum as to who may participate.
Response: If you look at action plan number 2, psychologists will be represented.
2nd Response: I also wanted to add that the Ad Hoc, as a group, discussed the importance of psychologists.
Comment: They submitted a report that was not allowed to be integrated.
Response: I want to assure you our goal has been to include psychologists in the stipend programs because we recognize it is a very important field.
2nd Response: There is $200 million being spent at a state level and psychologists will receive some stipend monies over a 10 year period.

Comment: I am from the Asian Pacific Islander NAMI Parents Group. My son is getting treated by a doctor and getting counseling too. I believe it is a great idea that you will provide certain educational programs and technical skills for clients to obtain jobs. However, for most clients, it's going to be very difficult to perform these jobs. It is also going to take a very long time. So rather than wait, can the Department of Mental Health Services give these clients simple tasks? They are in the stage of recovery. If they can do something every single day (some simple jobs), it will help them to develop social skills; this will be for their betterment. Also, people do apply for different jobs, but they don't get the jobs.

Comment: My son is here with his friends, and they spend a lot of time wandering around and going to Target, Beverly Hills and different places wasting their time. My son and many clients are in the recovery stage. If you provide them with simple jobs, they can do every day, they will be very grateful.

Comment: I am from Asian Pacific Counseling Treatment Center, on Page 11 on your presentation, I noticed that the language section did not include Southeast Asian or Indo-Chinese languages such as Vietnamese. I appreciate that Korean is recognized, but there is a need for Cambodian speaking staff too.
Response: We want to assure you those language groups were not left out. The ones sited were examples. We have 18 languages within our agency. In my experience, if you use examples, Tagalog and Vietnamese are more critical and hard to hire.

Comment: There are so many mental health peer counselors that are certified that are not being utilized/employed. They could help act as bridges. They could guide the consumers to the areas they need to go to. They are underutilized. It was disheartening to not have them certified in this county.

Comment: I belong to the Latino community. The comment this table selected was we need more information directed to 8th grade students. We need these students to have more information, more knowledge regarding careers in mental health. The second point is we need more bilingual doctors in the community.

Comment: Thank you for letting me participate in this forum. We are concerned about this plan which is for 10 years. The crisis is right now. We have 5 million Latinos in the County. Our comment is that there is a need for more training for consumers and families in the universities; this has to be done in Spanish. This will benefit a cultural exchange. It would help us with the current problems. We need a large number of therapists and bilingual individuals to provide quality services in our community and clinics.

Comment: I am with the Latino Institute. First of all, I would like to congratulate you for recognizing the purpose of the plan. The importance of cultural competency and the needs analysis is to look at the demographics. As you know, LA County is considered to be one of the most diverse counties in the country. Fifty percent of the population is Latino. When you look at the workforce and look at the people that provide services, It is somewhere around 15% of the people that will provide face to face contact with consumers. We need to take this opportunity to make sure that situation is addressed. Thank You.

Comment: I'm a parent and retired educator. This year we are much more proactive. It is important to work with them at the local level and make sure we get the word out as fast as possible.

Comment: There is a study that came down from the Bazelon Center in cooperation with the University of Pennsylvania dealing with the fact that self help.

Comment: On paper regarding critical language need, I want to share with you that Southeast Asia or Indo Chinese languages are critically needed, for example Vietnamese and Cambodian.

Comment: Nowhere did I see certified peer counselors mentioned. We could assist the consumers by acting as system navigators and provide peer support in helping them face challenges as they progress and return to the community.

Comment: I think that we clients definitely need support and accommodations from the government in finding work. I believe that we clients can work and live a successful life like regular people.

Comment: The meeting was very nice and interesting, food was good too. I liked the session; people were nice. I definitely need support and help, and also accommodations.

Comment: I'd like to volunteer on the committee to address the career ladder. There is a large population in LA County, particularly in DMH, who are stuck in the secretarial or clerical capacities who need the support of a program that is open to other career choices. What is needed is to rename the class, increase or reword the job specifications.

Comment: This plan seems to be a well organized strategic plan. I hope all the things that were mentioned will get the well deserved attention and become an asset to LA County productively and economically, and make it a better world.

Comment: Presentation clearly presented. Handouts appropriate. Provisions for follow-up questions provided.

Comment: Great Forum! Great job done by the committees.

Comment:

1. We need to educate people on eating better:
    a) Balanced diets (from birth to death)
    b) Supplementation (less drugs-beware of the side effects of medications).
    c) Eight glasses of purified water/day
    d) Regular cardiovascular exercise
2. Promote being helpful to others
3. Deal better with discrimination and stigma (consider someone else more important than yourself).
4. Overactive kids, changed their behavior when their diet was improved
5. Stop smoking and limit the coffee intake

Comment: It was a wonderful lunch and great program. However, I would like to say about bathroom issue. It was/is very important for mental patients, family members and all of the public. I really recommend that the DMH building open the bathroom to the public during office hours to anyone including the homelessness. It is a matter of human respect. The Metro (MTA) is going to have the redline extended to Santa Monica, but they don't build bathrooms. Again, bathrooms are important to the elderly disabled, consumers, and family members. It is related to human dignity. A mental health issue is most of time related to physical problems. Basic human needs are significant and an essential public matter. We heard that Augustus Hawkins Mental Health Department which is located at 120th Street and Wilmington Avenue has a new restroom for everyone during office hours. DMH should prepare the human basic needs to the public. It is part of the recovery and healing process of consumers and family member and all citizens. And if the homeless people are naked in the bathroom, call the police or others. The bathrooms should continue to be opened to the diligent consumers, family members and good citizens. It should not be closed to the public. This is a comment, and we look forward to the positive results.

Comment: What happens to those that are mentally ill and homeless and have been locked up and then released to mental health clinics? But, the programs have been dropped from underneath them. There are wellness centers, but they are still left homeless with jail records and no way of support to get trained and jobs due to a record; this adds to their illness and they ask "where's my hope."

Comment: I think that it is a step in the right direction to offer employment opportunities to the mentally ill. I have a desire to return to the workforce but I am hesitant to do so due to my illness; I am afraid due to my dual disorder (mental, physical) that I will not be given the same opportunity(ies) as my co-workers. Also if I am offered a position, I will be in danger of losing my source of income.

The following is a summary of written comments submitted during the Public Hearing in Spanish:

- Acknowledged the need for more bilingual staff particularly Latinos/as in all aspects of mental health services (i.e., professionals, mental health specialists).
- Suggested students to be educated about the mental health field and need to assist the teachers in such an endeavor.
- Recommended mental health career opportunities be targeted to Jr. High School students.
- Asserted the need for more sensitive, caring bilingual doctors in the community.
- Recommended more outreach be conducted not only to Latinos/as but to the general public about mental health services particularly to the homeless and disabled.