SAN MATEO COUNTY HEALTH
BEHAVIORAL HEALTH & RECOVERY SERVICES

San Mateo County Behavioral Health & Recovery Services | Mental Health Services Act **Workforce Education and Training Plan Fiscal Years 2023-2026**

Overview

The San Mateo County Behavioral Health and Recovery Services (BHRS) Mental Health Services Act (MHSA) Three-Year Workforce Education and Training (WET) Plan will **guide implementation of WET strategies for fiscal years 2023-2026**. The WET Plan aligns with California Department of Health Care Access and Information (HCAI) 2020-2025 WET Five-Year Plan and Regional Partnership guidelines for implementing WET programs statewide.

The WET Plan is divided into two sections:

1. Workforce Recruitment and Retention Plan
2. Workforce Training Plan

Stakeholder Engagement Process

The WET Plan was developed during the comprehensive Community Program Planning (CPP) process for the County's MHSA Three-Year Plan, which involved diverse groups of BHRS staff, contracted agencies, and peers and family members in identifying needs, recommending strategies to meet the needs, and prioritizing those strategies. **BHRS sought input on WET needs and strategies in two phases**:

1. BHRS gathered input on behavioral health workforce needs and strategies in community input sessions for the County's broader three-year MHSA plan. See the MHSA Three-Year Program and Expenditure Plan, FY 2023-26 for a list of the community input activities.

2. BHRS contracted a consultant to carry out **five virtual input sessions on workforce recruitment and retention** and an **online survey on workforce training priorities**. These methods offered an opportunity for in-depth conversation and feedback to shape the WET Plan.

WET Implementation

As part of the CPP, **the MHSA Steering Committee selected Behavioral Health Workforce as the top priority for MHSA investment**. As a result, BHRS will dedicate funding for workforce strategies, using the WET Plan as a guide. BHRS recognizes that some strategies require system-level changes—

comprehensive change or innovation that may require involvement and decision-making from multiple partners, including unions—while some are low-hanging fruit—changes within the current system (e.g., a new program or process) that would have immediate, positive impact on the workforce. The WET Plan includes a range of short-term to long-term strategies, understanding that some strategies will require a multi-phase implementation timeline.

The WET team currently includes three positions: WET Director, WET Internship Program Coordinator, and Community Program Specialist – Training Support. WET operates under the BHRS Office of Diversity and Equity (ODE) and is supervised by the ODE Director. This organizational structure enhances the focus of WET to embed cultural humility, apply an equity lens, support the core values of MHSA, and allow for a systemic approach to behavioral health workforce strategies.

Workforce Recruitment and Retention Plan

Stakeholder Engagement

WET input sessions (see table below) focused on **two primary questions** related to workforce recruitment and retention:

- What strategies would support people of diverse backgrounds to *enter* the behavioral health workforce?
- What would encourage staff to *remain* in the behavioral health workforce?

WET Input Session	Stakeholder Representation
1. Adult Leadership	• BHRS leadership and management of treatment programs for adults
2. AOD Providers Group	• BHRS Alcohol and Other Drug (AOD) staff and contracted providers
3. Diversity and Equity Council (DEC)	• Health Equity Initiative co-chairs • BHRS staff • Contracted providers • Peers
4. Lived Experience Education Workgroup (LEEW)	• Clients and family members, many who have participated in the County's Lived Experience Academy, supported by the Office of Consumer and Family Affairs (OCFA)
5. Youth Leadership	• BHRS leadership and management of early intervention and treatment programs for children and youth

Input session participants were invited to offer comments verbally, in the meeting chat, or on an anonymous feedback document. Comments were also gathered via an online WET survey to invite feedback from a broader audience—while the survey focused on training priorities, there was an optional section for staff to share suggestions about workforce recruitment and retention.

Strategy Prioritization

Input session and open-ended survey comments were organized into 11 categories (shown below alphabetically) based on topics raised by stakeholders and research on factors that influence behavioral health workforce retention.[1]

1. Career advancement
2. Compensation and benefits
3. Hiring process and requirements
4. Financial incentives
5. Organizational culture and management
6. Peer engagement and leadership
7. Pipeline
8. Staff wellness, support, and engagement
9. Training and experience
10. Workload
11. Work flexibilities

Next, strategies in each category were consolidated from stakeholder suggestions. Based on this analysis, **BHRS combined the categories as follows and put forward 11 strategies for the MHSA Steering Committee to prioritize**.[2]

1. Compensation and benefits
2. Financial incentives
3. Peer engagement and leadership
4. Pipeline, hiring, and career advancement
5. Staff wellness, support, and engagement
6. Workload and work flexibilities

The MHSA Steering Committee met on May 4, 2023, and **23 members each selected three strategies for BHRS to implement over the next three years**. The table below shows the WET strategies in order of priority from the MHSA Steering Committee. Next, there is a description of stakeholder input in each category and more detail about the components of each strategy.

[1] MHSA Stipend Program Retrospective Study Highlights: Retention; California's Children's Mental Health Workforce

[2] Note: "Training and experience" was designated as a separate section of the WET Plan and was therefore not included in the six priority areas. Feedback related to "organizational culture and management" was routed to the ODE team in charge of the department's Multicultural Organization Development (MCOD) Action Plan.

Summary of MHSA Steering Committee Priorities

WET Strategy *(Number of Selections as a Priority Strategy)*	**Category**
Implement recruitment and retention financial incentives for staff and contracted providers *(7)*	Financial incentives
Invest in support, retention, and leadership development of peers and family members *(7)*	Peer engagement and leadership
Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff *(6)*	Pipeline, hiring, and career advancement
Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties *(4)*	Compensation and benefits
Create a pipeline program focused on increasing Asian/Asian American and Black/African American behavioral health staff *(4)*	Pipeline, hiring, and career advancement
Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities *(4)*	Pipeline, hiring, and career advancement
Explore opportunities for alternative and flexible schedules and remote work *(4)*	Workload and work flexibilities
Create more entry-level positions and internships for students of diverse backgrounds; streamline process to hire interns *(2)*	Pipeline, hiring, and career advancement
Streamline BHRS hiring process to enhance recruitment[3]	Pipeline, hiring, and career advancement
Examine and adjust caseload size and balance, particularly for bilingual staff *(2)*	Workload and work flexibilities
Expand type, flexibility, and access to staff wellness and engagement opportunities *(2)*	Staff wellness, support, and engagement
Address extra help and contracted positions, especially for those that interface with the community *(1)*	Pipeline, hiring, and career advancement

[3] Note: This was pulled out from the above strategy after the Steering Committee meeting in order to distinguish between improvements to the overall hiring process and improvements in the intern hiring process.

Category 1: Compensation and Benefits

Summary of stakeholder input

Staff,[4] contractors, and peers highlighted competitive salaries that enable them to afford living in San Mateo County as a core issue affecting both retention and recruitment. They noted pay differentials between San Mateo County BHRS and neighboring counties, between BHRS and other large healthcare employers in the county such as Kaiser, between BHRS and community-based organizations (CBOs), and between mental health and alcohol and other drug (AOD) counselors. Staff called attention to the need for higher pay for bilingual staff, observing that retention of bilingual staff is particularly challenging. In addition to increasing compensation, staff suggested that strengthening benefits such as retirement plans and providing vouchers to assist with the cost of housing could support staff recruitment and retention.

"It's about wages and benefits—we need to be able to pay our staff living wages and benefits, or we won't be able to support our staff."

Strategy	Components
1.1 Research, plan, and implement compensation and benefits that are aligned with competing agencies and neighboring counties.	• Increase cost of living adjustments (COLAs) • Increase pay for bilingual staff (and explore adding languages that qualify to receive bilingual pay) • Strengthen retirement/pension plans • Increase equity between disciplines (e.g., mental health clinicians, AOD counselors, nurses, medical doctors) • Increase contract amounts for contracted providers to pay higher wages • Provide and/or support BHRS staff with housing, below market rate housing, and/or housing vouchers

Category 2: Financial Incentives

Summary of stakeholder input

After compensation, financial incentives (monetary benefits that encourage staff to enter or remain in the workforce) were a frequent suggestion for improving both retention and recruitment. Bonuses were the most commonly mentioned type of financial incentive, including bonuses upon hire and retention bonuses for staff who have worked for a certain number of years. Loan repayment was also commonly mentioned as an attractive incentive. Staff also suggested funding for undergraduate and graduate education, credential renewal, and other trainings. Staff emphasized the importance of providing financial incentives for individuals from diverse backgrounds, particularly Black, Indigenous, and other people of color (BIPOC) and those who are bilingual to enter and advance

"There seems to be more organizations providing starting bonuses, which are an attractive strategy for recruitment."

[4] Note: To be concise, the term "staff" is used throughout to refer to all levels of staff, including leadership, managers, supervisors, and direct service staff.

in the field. They also raised a need to improve communication, promotion, and support for existing County-run and federal financial incentives (e.g., ensuring staff know how to apply, simplifying application processes, and building time into staff meetings to apply).

Strategy	Components
2.1 Implement recruitment and retention financial incentives for staff and contracted providers.	• Offer starting bonuses, including higher bonuses for bilingual staff • Offer retention bonuses • Expand educational loan repayment programs • Promote and support staff in applying for existing loan repayment opportunities

Category 3: Peer Engagement and Leadership

Summary of stakeholder input

"There is a need for mentoring and coaching for peers and family members to fully participate in BHRS operations, program development, and oversight."

Peers and staff underscored that engaging people with lived experience in the workforce is critical to effective service delivery. At the same time, they observed that stigma and lack of information prevent BHRS and contractors from integrating peers consistently and to their full potential. They recommended training for BHRS and contractors on consumer culture, implicit bias, and hiring and working with peers—this is included in the Workforce Training Plan below.

Other recommended strategies included increasing support for peers who may be interested in entering or advancing their careers in the behavioral health field and ensuring that peers can meaningfully engage in BHRS advisory and decision-making spaces. On a system level, supporting CBOs to set up their infrastructure to align with CalAIM reform and bill Medi-Cal for peer specialists was suggested—this was included in another component of the MHSA Three-Year Plan and is therefore not included as a WET strategy.

Strategy	Components

3.1 Invest in support, retention, and leadership development of peers and family members.	• For peers who have engaged with the County through the Lived Experience Academy (LEA), Advocacy Academy, and/or LEEW:
	  ○ Support peers to meaningfully engage in BHRS advisory and decision-making spaces (e.g., mentoring to meaningfully participate in committees and workgroups)
	  ○ Enhance career development support (e.g., scholarships and support for peer certification, shadowing/volunteer opportunities, "peer career track" cohort with hiring workshops and

	support, social emotional support for employed peer workers) ○ Provide opportunities for networking and relationship building • Ensure financial viability of working as a peer or family support worker (e.g., competitive pay, training/benefits counseling related to working while receiving supplemental security income, financial incentives for career advancement) • Engage new peers through peer-led outreach in clinic and community spaces

Category 4: Pipeline, Hiring, and Career Advancement

Summary of stakeholder input

Staff, contractors, and peers highlighted the need to create pathways for people with diverse backgrounds and lived experience to enter and advance in the behavioral health field.[5]

- **Pipeline**: Stakeholders commonly suggested pipeline programs to engage high school and undergraduate students in school and non-academic settings (e.g., mentorship programs, summer programs, bilingual or Spanish language pipeline programs, and expanding the County's existing Health Ambassador Program for Youth). Pipeline programs could also include outreach to adults who might be interested in a career change. There was an emphasis on programs for individuals who identify as Asian/Asian American or Black/African American, as these groups are underrepresented among BHRS staff.
- **Hiring**: Efficient hiring processes are critical to workforce recruitment. Staff reflected that the hiring and onboarding process (e.g., background checks, hiring contracts) is often lengthy, which disincentivizes staff who may have other job offers or cannot afford to be unemployed for the length of the hiring process. Staff observed that the use of limited term and extra help contracts has been a barrier to both recruitment and retention and there is a need for greater job stability. They also emphasized that creating more entry-level positions and internships, and reducing barriers to hiring interns immediately after graduation, would improve recruitment of staff from diverse backgrounds.

  "If I was looking for a job, I can't wait 30 days to be hired. I have an 8-year-old to feed."
- **Career advancement**: Staff recommended providing supports for direct service staff, specifically BIPOC staff, to pursue advanced degrees/licensure/credentials while working and to receive mentorship and support to enter leadership positions.

[5] To be successful, these strategies should incorporate financial incentives such as scholarships and stipends and be implemented in the context of competitive pay.

Strategies	Components
4.1 Create a pipeline program focused on increasing Asian/Asian American and Black/African American behavioral health staff.	• Develop partnerships and programs with local and neighboring academic and non-academic programs (e.g., high schools, community colleges, universities, adult schools, local wellness centers, nonprofits, places of worship, promotores programs) • Consider outreach to mature workers interested in a career change • Expand the Health Ambassador Program for both youth and adults *(included in the MHSA Three-Year Plan under Youth Needs)*
4.2 Target recruitment activities to reach black, indigenous, people of color (BIPOC) communities.	• Ensure racial equity lens is used in job postings • Partner with BIPOC-focused communities and student organizations and networks
4.3 Create more entry-level positions and internships for students of diverse backgrounds; streamline process to hire interns.	• Research, plan, and implement new entry-level positions and internships • Integrate processes to enable BHRS to hire trainees/interns immediately after graduation
4.4 Streamline BHRS hiring process to enhance recruitment.	• Expedite hiring and onboarding process • Explore hiring a recruiter • Allow for hiring clinicians with alternative licenses (e.g., licensed professional clinical counselors—LPCC) • Ensure job postings include a salary range and benefits • Include staff/team members in hiring interviews to ensure a good fit to the team
4.5 Address extra help and contracted positions, especially for those that interface with the community.	• Explore permanent, benefited positions for community-facing work • Explore other means for creating consistency and leadership for community-facing work
4.6 Implement supports for direct service staff, including peers, to advance in their careers, specifically BIPOC staff.	• Offer incentives (e.g., scholarships) to pursue advanced degrees/licensure/credentials • Increase mentorship and support for BIPOC staff to enter leadership positions

Category 5: Staff Wellness, Support, and Engagement

Summary of stakeholder input

Staff and contractors reflected that along with the financial and administrative factors influencing retention, staying in a job long-term requires feeling appreciated and supported. They suggested that BHRS increase formal and informal opportunities for staff recognition, mentoring, and relationship building. They called attention to the need to address pandemic trauma and prevent burnout through team-based

"One thing that's made me stay is I've had opportunities to build a lot of relationships."

wellness activities and easy-to-access behavioral health services, treatment, and trainings (e.g., trauma stewardship, mindfulness, and sensory/movement modalities).

"People need to feel safe and heard as well as knowing this may be a place where personal development is possible."

Staff highlighted the importance of feeling heard, respected, and trusting that leadership will support and advocate for them. They recommended strategies to increase diversity at all levels of the organization and support trauma-informed and culturally responsive leadership. Because these strategies point to agency-wide culture and management, this feedback was elevated to the ODE team leading the BHRS Multicultural Organization Development (MCOD) plan.

Strategy	Components
5.1 Expand type, flexibility, and access to staff wellness and engagement opportunities.	• Provide flexible team wellness budgets for staff appreciation and wellness activities • Offer staff mentoring programs, particularly for BIPOC staff • Improve availability and access to behavioral health supports for staff, including Employee Assistance Programs (EAP) and other supports • Increase opportunities for relationship building (e.g., cohorts of new employees, welcome events for interns, mixer events across teams, contracted provider networking events)

Category 6: Workload and Work Flexibilities

Summary of stakeholder input

A key component of employee wellbeing is having a manageable workload. Staff shared that they are frequently required to take on more work than one person can reasonably do well. For direct service staff, this is often driven by caseloads—not only caseload sizes, but also the intensity of those caseloads. Staff acknowledged that bilingual staff often carry higher caseloads.

"Stress and burnout is the most important issue. Until you create an environment that helps, instead of giving high caseloads, I don't see people staying very long—it's stressful, compassion fatigue sets in."

In addition to addressing workload issues, staff recommended flexible work schedules including part-time opportunities and continuation of remote work schedules as appropriate (e.g., for staff who do not interface with clients), and noted that several competing agencies offer these types of flexibilities. Staff also suggested that having greater flexibility to take time off for mental health and/or family reasons would promote wellbeing and retention.

Strategies	Components

6.1 Examine and adjust caseload size and balance, particularly for bilingual staff.	• Develop caseload standards and methods for monitoring caseloads, with special attention paid to those providing bilingual services • Analyze and improve workflows
6.2 Explore opportunities for alternative and flexible schedules and remote work.	• Offer opportunities to work less than 40 hours/part-time • Offer options to work at different times/days as appropriate • Continue telework schedules as appropriate • Increase flexibility in offering time off for staff experiencing stress or burnout

Workforce Training Plan

Stakeholder Engagement

The online WET training survey **sought feedback from staff, contractors, and peers about training priorities**. Specifically, the survey asked what BHRS does well and areas for improvement, training topics of interest, and how BHRS can support staff to access trainings and apply knowledge in practice.

BHRS emailed the survey to over 500 staff and contractors and promoted it in BHRS staff meetings from late March to late April 2023.

- **96 responses** were received.
- **Half of respondents (50%) were direct service staff**, about a quarter (24%) were program managers/supervisors, 14% were administrative staff, 8% were executive leadership, and 4% were in a peer/family support role.
- Of the 75 respondents who reported their race/ethnicity, **the largest group identified as White (47%),** followed by Latino/a/x or Hispanic (32%), and Asian (20%). Black/African American staff made up 8% of responses, 7% identified as another race or ethnicity, 4% identified as Native American, American Indian, or Indigenous, and 3% identified as Native Hawaiian or Pacific Islander.
- Respondents were **evenly split between 0-3 years, 4-9 years, and 10 or more years** in their role.

Strategy Prioritization

Training is a key factor both for staff retention and maintaining a high-quality workforce. The Workforce Training Plan includes overarching strategies to improve training availability, experience, and application, as well as priority training topics. BHRS developed workforce training strategies based on common barriers and suggestions for improvement from staff in the WET training survey and WET input sessions. BHRS identified priority training topics based on the proportion of survey respondents that selected them.

Summary of Stakeholder Input

- **Training topics.** Staff suggested increasing the variety of trainings, including training on serving clients with complex needs for clinical, non-clinical, and administrative staff. Direct service staff most commonly voiced a need for more clinical training, particularly training in a variety of evidence-based practices that goes beyond introductory level courses and provides continuing education unit credits (CEUs). Several staff praised the strong focus on cultural humility training, and some requested more in-depth trainings in this area. Some also noted they appreciated having trainers from diverse backgrounds and suggested incorporating more trainers with lived experience. Peers and staff also emphasized the need to train BHRS staff and contractors on consumer culture and hiring/working with peers. Trainings in the categories of "behavioral health crisis management, assessment, and prevention" and "areas of specialization" had the most training topics that were prioritized by more than 50% of survey respondents.

- **Training access.** Survey responses suggest that not all staff learn about BHRS trainings with enough advance notice. Many survey respondents reported difficulty finding time to attend trainings given their workloads and schedules. To address these barriers, staff suggested advertising trainings farther in advance, offering trainings on multiple days and times, creating a structured training calendar, and introducing more self-paced trainings. Staff appreciated the existing support for educational leave and reimbursement for external trainings and suggested helping staff apply for approval and extending this benefit for contractors. They also recommended increasing opportunities for staff and contractors to be invited to trainings run by BHRS and CBOs. Several staff commented that they appreciated the transition to virtual training; moving forward, about two-thirds of survey respondents preferred a combination of remote and in-person training options, while about a quarter preferred all remote trainings.

  "Even when trainings are advertised in advance, the slots fill up quickly. If or when a space is opened up it is difficult to get supervisor approval for the training if the training is the next day or within the next few days because the request is short notice."

- **Application of knowledge and skills**. Staff preferred ongoing consultation/coaching, follow-up/refresher trainings, and interactive trainings to help them apply skills taught in trainings. Other suggestions were to assign staff "buddies" or mentors, particularly for self-paced trainings, and to allot time during the workday for staff to review and study concepts learned in trainings.

Training Strategies

Strategies	Components
1. Strengthen scheduling and communication about BHRS trainings.	• Inform staff and contractors of trainings farther in advance • Offer trainings on multiple days and times • Compile and share a structured training calendar • Consider productivity standards when scheduling trainings • Add self-paced trainings to help with scheduling conflicts
2. Increase the type, level, and frequency of training offered.	• Increase topics and variety of clinical trainings • Increase upper-level (beyond introductory) trainings on clinical and cultural humility topics • Increase training opportunities for administrative staff • Support staff in accessing external trainings or conferences
3. Increase the number of trainings that offer CEUs.	• Certify existing trainings to provide CEUs • Create a set schedule for trainings required for licensure (e.g., semi-annual Law and Ethics trainings)
4. Enhance support for staff in applying knowledge and skills from trainings.	• Enhance clinical consultation and coaching (e.g., consultation with clinical experts, including consultation groups led by BIPOC clinicians) • Increase the number of follow-up/refresher trainings • Prioritize interactive trainings
5. Enhance BHRS and contractors' capacity to hire and work with peers.	• Train supervisors responsible for hiring and supervision of peer and family support workers • Train all staff on the role of peer and family support workers • Involve peers in developing, reviewing, and presenting content for these trainings

Training Topics

The priority topics below represent the **top three selections** in each training category on the WET survey. See the Appendix for the full data on training priorities. The WET team will use the priority topics, survey data, and write-in responses to inform its training calendar for fiscal years 2023-26.

Training category	Priority topics
Areas of specialization	• Integrated care for complex clients • Treating eating disorders • Human trafficking
Behavioral health crisis management, assessment, and prevention	• Deescalating a crisis • Advancing suicide prevention and management for diverse clients • Assessing and managing risk of suicide
Culturally informed practices	• Movement therapy • Drumming • Storytelling

Training category	Priority topics
Evidence-based practices	● Trauma-focused cognitive behavioral therapy (CBT) ● Motivational interviewing ● Dialectical behavior therapy (DBT)

Peer trainings	● *Training for individuals with lived experience* [6]
	  ○ Working with people who are unhoused
	  ○ Peer work in crisis care
	  ○ Peer work with justice-involved individuals
	● *Training for BHRS staff and contractors* [7]
	  ○ Implicit bias and behavioral health stigma
	  ○ Hiring and working with peers
	  ○ Supervision of peer workers
	  ○ Consumer culture

Multicultural organization development, diversity, equity, and inclusion (DEI)	● Supporting diverse staff engagement ● Facilitating dialogue on DEI ● Giving and receiving responsive feedback

[6] The San Mateo County Office of Consumer and Family Affairs (OCFA) oversees training and leadership development for peers/family members. The survey received only four responses from individuals who identified as being in a peer/family support role, therefore there is a need to enhance input from peers/family members to inform training priorities. BHRS will route input from peers/family members to OCFA for consideration and for them to continue engaging peers/family members in prioritizing training topics.

[7] These recommendations are from the WET input session discussions, as this was not asked on the survey.

Appendix

Data on Training Priorities

Areas of specialization (83 total responses)	Number	Percent
Integrated care for complex clients	62	75%
Treating eating disorders	52	63%
Human trafficking	44	53%
Other	24	29%
Write-in responses and input session feedback: Supporting undocumented individuals/families and immigration trauma (several mentions); language training if a need is identified (e.g., improving Spanish language skills for staff who already have some proficiency); how to assist unhoused clients utilizing county resources, public benefits for unhoused clients; working with clients on the autism spectrum (2 mentions); training on the new DSM; training for addressing PTSD, personality disorders (2 mentions), psychotic symptoms, bipolar disorder, co-occurring disorders (2 mentions) and substance use disorders (several mentions); emotion regulation; opiate crisis training and Narcan; smoking cessation; medication management with a focus on new medication options; mental health in older adults; impacts of social media.		

Behavioral health crisis management, assessment, and prevention (85 total responses)	Number	Percent
Deescalating a crisis situation	62	73%
Advancing suicide prevention and management for diverse clients	52	61%
Assessing and managing risk of suicide (for clinicians)	48	56%
Postvention support	31	36%
Access to lethal means counseling	13	15%
Other	7	8%
Write-in responses and input session feedback: suicide and violent behavior risk assessment and documentation for all staff; managing risk with clients who are actively self-harming; management of verbally abusive clients, family members, community members; 5150 process; training in firearm safety and working with clients on lethal means restriction; laws and ethics related to suicidal ideation and danger to self and others.		

Culturally informed practices (75 total responses)	Number	Percent
Movement Therapy	51	68%
Drumming	36	48%
Storytelling	34	45%
Healing Circles	32	43%
Medicinal Plants	21	28%
Other	14	19%
Write-in responses and input session feedback: relaxation techniques such as yoga, meditation, breathing, and progressive muscle relaxation; tai-chi; sound healing; art therapy such as painting,		

drawing, clay; singing; dance therapy; pow wow, sweat lodge, and spiritual practices; African-American and Latinx specific practices.

Evidence-based practices (82 Total responses)	Number	Percent
Trauma Focused CBT (TF-CBT)	47	57%
Motivational Interviewing (MI)	39	48%
Dialectical Behavior Therapy (DBT)	37	45%
Mindfulness-Based Substance Abuse Treatment (MBSAT)	28	34%
Eye Movement Desensitization and Reprocessing (EMDR)	25	30%
Acceptance and Commitment Therapy (ACT)	23	28%
Brief Strategic Family Therapy (BSFT)	9	11%
Other	18	22%
Write-in responses and input session feedback: CBT for psychosis; CBT for insomnia; DBT, family-based treatment (FBT); Internal Family Systems (IFS) (2 mentions); WRAP (2 mentions); attachment-based therapies such as interpersonal psychotherapy (IPT); polyvagal theory; emotional freedom techniques (EFT); family systems therapy; Brain spotting; other evidenced-based trauma therapies for complex clients; expressive arts therapy; harm reduction; PITH family therapy; Youth Acceptance Project-Family Builders;); contingency management; recovery/resiliency model of care components.		
There was a collection of write-in responses and input session feedback related to clinical processes and tools: telehealth and options for interventions; web tools and apps for therapy or notetaking; clinical documentation training such as how to improve progress notes; treatment planning (e.g., incorporating CANS and other tools into practice; new laws and legislation that govern mental health; processes for accessing BHRS services; referring clients to assistance with health insurance and public benefits.		

Peer trainings (70 total responses)	Number	Percent
Working with persons who are unhoused	47	67%
Peer work in crisis care	38	54%
Peer work with justice-involved individuals	28	40%
Supervision of peer workers	27	39%
Other	11	16%
Write-in responses and input session feedback: Community inclusion; Recovery 101; creating opportunities for families to engage in supported creative experiences; parenting, family support; support for peer certification; working with youth on the autism spectrum; working with CPS; Motivational Interviewing; non-violent communication; working with human trafficking victims; clinical trainings		

Multicultural organization development, diversity, equity, and inclusion (DEI) (78 total responses)	Number	Percent
Supporting diverse staff engagement	36	46%

Facilitating dialogue on diversity, equity, and inclusion	35	45%
Giving and receiving responsive feedback	35	45%
Creating trust among teams	28	36%
Other	20	26%
Write-in responses and input session feedback: Training for supervisors on supervising staff; supporting undocumented individuals and families; training on how to support LGBTQ+ clients in coming out to their families, friends, etc.; hiring practice that attract multi-cultural staff; humility as a whole; community inclusion; how to be anti-racist; advanced cultural humility training (e.g., "calling in"); communication and addressing conflict; working with multi-generational staff; embracing diversity beyond ethnicity, gender and sexual orientation; guidance for practicing MCOD goals alongside other providers when working with clients involved in the legal system (like CFS); trainings with outside trainers (such as Dr. Ken Hardy, Dr. Joy DeGruy, and Tim Wise).		

Additional Survey Data

Ensuring knowledge and skills are applied (82 total responses)	Number	Percent
Learning collaboratives	61	74%
Follow-up/refresher trainings	58	71%
Ongoing consultation/coaching	46	56%
Interactive trainings (e.g., scenario based, role plays)	26	32%
Technical assistance for implementation	26	32%
Other	8	10%
Write-in responses and input session feedback: experiential training; mentoring; one-way mirror in-vivo coaching; breakout room/small group discussions; role-plays; case study reviews; time allotted during the regular work day to read/study/process the newly learned skills		

Barriers (84 total responses)	Number	Percent
It is hard to fit in trainings with existing workload	54	64%
Trainings do not provide Continuing Education Unit (CEU) credits	42	50%
Trainings are not advertised far enough in advance	32	38%
Trainings are not offered at times of day that fit with my schedule	26	31%
Training slots fill up	17	20%
It is difficult to get approval to attend trainings	6	7%
I have not experienced barriers	12	14%
Other	22	26%
Write-in responses and input session feedback: difficult to get supervisor approval for training slots that open up with short notice; tech issues with trainings in LMS; trainings that get canceled if enough people do not show up; meeting productivity standards of the county for days when training is under 4 hours (i.e., 3.5 hours is almost half the work day, but not considered productive by county standards)		