Training for Transformation

Presentation to MHSA Steering Committee, January 30,2009

What We'll Do Today

- Today
  - Overview of the proposed plan
  - followed by breakout groups
- You have:
  - Document 1 – those portions of Training Plan that will be used to apply for MHSA funding
  - Document 2 - Copy of the actual funding request we will send to the State
- We expect both documents to change as a result of our work
- The next steps:
  - Open for public comment
  - Present to MHB
  - Documents can change based on feedback during period of comment
  - Pubic comment closed at Mar MHB meeting and Public Hearing is held. Then submit to State.

Background

- Planning goes back to 7/06 (p. 47-48 of Doc 2)
- Identified areas of “foundational knowledge”
  - cultural competence, stigma reduction, consumer and family training and support
- Identified core areas of “skills & competencies”
  - motivational interviewing, WRAP planning, integrated treatment of co-occurring disorders
- Identified populations needing special attention in training
  - LGBTQ, victims of trauma, gender-responsive treatment
- Identified treatment approaches essential to sustaining EBP
  - cognitive-behavioral therapy, trauma-focused interventions, ACT, FFT
- Stakeholder groups included: MH Leadership, line staff, consumers, family members, MHB, community based agencies.

Recent Planning – E&T Workgroup

- Met from 11/07-12/08 to develop our submission of training initiatives to the State
- Integrated key aspects of previous planning
- Defined guidelines that would help ensure that trainings provided in county would realize goal of transformation as envisioned by MHSA (p. 49 of Document 2)
  - This led to check off list that will be used by BHRS Training Committee when reviewing proposals
- 12/08 approved the portions of the Training Plan that will be our funding request to State (Document 1)
- Stakeholder groups included: BHRS Leadership, line staff, consumers, family members, MHB representatives, community based agencies

BHRS Training Committee

- Met to incorporate comments of E&T Workgroup and flush out specific BHRS Training Plan
- Defined duties of Training Director, including
  - Oversee implementation of Training Plan
  - Ensure Training Plan adheres to guidelines
  - Evaluate the effectiveness of trainings in leading to change in how services are delivered
- Stakeholder groups included: BHRS Leadership, line staff, consumers, family members, community based agencies

Staff Surveys

- Survey of county and contracted MH staff (p. 49-50 of Document 2)
  - Top Priorities: working with trauma, working with clients we have not been able to engage successfully, working with depression and complicated families
  - Preferred trainings that are small team-based consultation or seminar that can be directed to specific cases
- Survey of county and contracted AOD staff
  - Top priorities: working with trauma, relapse prevention, and AOD counseling
- Survey of admin staff
  - No strong findings of perceived training needs (e.g., less than 50% felt a need for more training in cultural competence or creating a welcoming environment)
  - May indicate we need to do more to outreach to admin staff in all training efforts

How Consumers and Family Members Are Reflected in Training Plan

- Numerous trainings are proposed that will be provided by consumers and family member
- Consumer and family members working as staff will be able to attend **all** training activities
- The perspective of consumers and family members will be included in training series by including them as part of the training team
- The training committee will review all training proposals for how the training will include consumers and family members and values associated with cultural competence, wellness, recovery, and resilience

Targeted Training For & By Consumers & Family Members (p. 1-2)

- In this proposal, we commit to expand the role of consumers and families in all parts of training
- Done in a number of ways:
  - Trainings support consumers and family members who assume county positions
  - Trainings provided by consumers and family members that expose providers to their culture and their point of view about the treatment experience and
  - Trainings that emphasize the value of creating partnership between providers, consumers, and families
  - Trainings that support consumer and family members assuming policy and advocacy roles
- Examples of programs we hope to support and fund
  - Paving the Way
  - Stamp Out Stigma
  - NAMI sponsored Provider Training
  - In Our Own Voice
  - Voices of Recovery

Wellness & Recovery (p. 3)

- In this proposal, we increase our commitment to W&R by providing intensive WRAP training
  - Uses a train-the-trainer model, which we hope to use to support developing
    - WRAP plans for 100 consumers by next FY
    - 5 WRAP support groups by next FY

Cultural Competence (p. 3)

- In this proposed Plan, we increase our commitment to reducing health disparities by developing trainings:
  - Providing an intensive assessment of our system's cultural competence
  - Expand the availability of culturally focused clinical consultation
  - Addressing cultural issues affecting trauma, AOD problems, and domestic violence
  - Support initiatives developed by the Health Disparities Manager including
    - Pacific Islander Summit
    - African-American Summit
    - Latino Initiative
    - Outreach to LGBTQ community

Evidence-Based Practices (p. 4-5)

- In this proposal, we increase our commitment to EBP in our system by developing trainings in:
  - Integrated treatment co-occurring problems
    - Motivational interviewing
    - Integrated treatment planning
  - Trauma-focused treatment
  - Pro-social skills
  - FFT
  - DBT
- All EBP selected for emphasis support our values of developing strength-based, consumer-focused approaches to care

Site-Based Training Experiences (p. 6)

- This proposal responds to emphasis in the planning process on adult learning and to survey results by supporting the use of consultants and other topic experts
- We hope this will help to integrate global, one-time trainings into actual practice
  - Model used successfully in co-occurring initiative

Residency & Internships (p. 6-7)

- This proposal responds to the chronic shortage of child psychiatry by developing a child psychiatry fellowship
- Also promotes cultural competence by expanding our ability to award special stipends to trainees who help to increase the cultural and linguistic diversity of our workforce

Staff to Implement Training Plan (p 7-8)

- The proposal includes provisions for a Training Director, .5 of Community Program Specialist III, & consultant to the planning process for Workforce Development
- Their duties are specified under the “Training Experiences” column for each staff

Summary

- Over 60% of non-personnel, non-fellowship costs in proposal will result in trainings:
  - By consumers and family members,
  - Focusing on wellness and recovery, and
  - Focusing on cultural competence
- Over 30% of non-personal, non-fellowship costs will result in trainings:
  - To support EBP and
  - To develop consultants to provide team-based, case-specific trainings
- We hope this proposal speaks to the training experiences that will support the transformation of our system as envisioned by MHSA

Document #1
MHSA Workforce Education & Training Plan Summary

Note: The summary below captures those portions of the Training Plan for BHRS that we will list as "actions" in our proposed MHSA WET budget request to be submitted to the State.

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
TRAINING & TECHNICAL ASSISTANCE				0	0
Targeted Training For & By Consumers and Family Members	Range of training delivered by and for consumers and family members to include: ☐ Training and support for consumers and family members joining the workforce of BHRS. Examples include: o *Paving the Way* ▪ Train and support new consumers and family members joining workforce ▪ Support existing staff to welcome new consumer / family staff ▪ Hope Awards – helping to educate consumers, families, staff, and public about recovery and to reduce stigma o *Inspired at Work* which provides a framework for consumers and family members to get support and to explore issues involved with entering and remaining the workforce. ☐ Trainings provided by consumers to providers and the public designed to increase understanding of mental health issues and to reduce stigma. Examples include: o *Stamp Out Stigma* ☐ Trainings provided by consumers and family members to increase understanding of mental health issues, recovery and resilience, and available treatments and supports. Examples include: o *Provider Education* – NAMI sponsored intensive training to providers led by consumers, family members, and experts o *In Our Own Voice* – NAMI sponsored consumer to consumer presentations about their experiences. Presented in a number of locations, including hospitals. o *Family to Family* – NAMI sponsored 12 wk course family-	☐ Increase training opportunities for consumers and family members designed to prepare them for entry into the workforce, to advocate for reforms, and to play leadership and advisory roles in the behavioral health system. ☐ Increase the number of training sessions delivered by consumer and family organizations ☐ Increase the ability of treatment teams to successfully engage consumers and families we have failed to engage in the past ☐ Increase understanding among treatment providers of the consumer/ family perspective on treatment and supports. ☐ Increase understanding among treatment providers of the different cultural perspectives of consumers and family members.		20,000 40,000 5,000 8,000	115,000

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
	taught to families of consumers about mental health, treatments, and how to take care of one's self o *Peer to Peer* – NAMI sponsored 9 wk course taught by consumers to consumers about mental health, treatments, and recovery o *Voices of Recovery* – a client and family driven advocacy and support effort for those who have been affected by addiction. Voices of Recovery is committed to supporting recovery by providing consumer/client and family member advocacy and support. ☐ Send selected consumers and family members to leadership training to support increased involvement of consumers and family members in various committee, commission, and planning roles ☐ Trainings by consumers, families, and experts in the field in strategies to improve engagement of consumers and family members ☐ Send selected consumers, family members, and staff to conferences and training experiences o CMHCY Conference - Send selected consumers, youth, family members, and staff for training in the delivery of services for youth and families o Village – Send selected consumers, family members, and staff for training in wellness and recovery concepts o NAMI conferences and trainings – send selected consumers, family members, and staff for training in family-focused approaches to service delivery ☐ Trainings for the community to reduce stigma and increase the understanding of the community about behavioral health consumer and family issues o *Crisis Intervention Training (CIT)* – provides training to police officers in local communities about the nature of behavioral health issues and problems and is designed to increase understanding, reduce stigma, and lay the ground work for more appropriate responses to consumers and family members by local police.			10,000 12,000 10,000		

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
Trainings to Support Wellness and Recovery	San Mateo County BHRS will engage in training to extend and support consumer wellness and recovery. Examples include: ☐ *Wellness Recovery Action Plan Training* o Self-help approach to achieve & maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorder o Following a train the trainer approach, BHRS will send selected staff from county and contracted providers, consumers, and family members to become "Master Trainers." o The "Master Trainers" will then provide training and support to consumers and staff throughout our system in developing WRAP plans.	☐ 100 consumers in BHRS with WRAP plans by end of 09/10 ☐ Establish 5 WRAP support groups in the county by end of 09/10	40,000	40,000	80,000
Cultural Competence Training	Training in the area of cultural competence is designed to reduce health disparities in our community, to provide instruction in culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities will be available to consumers, family members, providers, and those working and living in the community. The Training Plan has identified a number of components designed to address these issues. Examples include: ☐ Use of the CA Multi-Cultural Scale to assess our system of services ☐ Trainings to increase the effective use of interpreters in service delivery ☐ Creation of a clinical consultation resource for providers working with Filipino consumers ☐ Addressing cultural issues when providing services to consumers suffering from co-occurring disorders and domestic violence Trainings will also be used to help support key initiatives launched by BHRS' Health Disparities Manager. Examples include, ☐ Pacific Islander Summit ☐ African American Summit ☐ Latino Initiative Summit ☐ Outreach to the LGBTQQI community	☐ Improved capacity to utilize interpreters with consumers who are not English-speaking; ☐ Expanded incorporation of a variety of alternative and culturally specific strategies as part of ongoing treatment efforts; ☐ Incorporation of culturally-informed engagement strategies; ☐ Increased satisfaction with services by historically under-served and poorly served cultural populations; ☐ Improved access and service delivery to historically under-served communities		50,000	50,000

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
Evidence-Based Training for System Transformation	The Training Committee will schedule an ongoing series of training designed to support transformation of the BHRS system by increasing utilization of evidence based treatment practices that better engage consumers and family members as partners in treatment and have contributed to improved consumer quality of life. Recommendations for training can come from consumers, family members, or public or private agency staff by submitting a form to the Training Director who will submit the request to the Training Committee. Criteria for training includes: consistency with the values of the MHSA, contribution to creation of a more culturally competent system, and that the training is based upon evidence-based practices. Among training to be offered in 08-09/09-10: ☐ Improve family functioning, parenting, communication and help parents and youth to reduce problem behaviors through evidence-based and promising practices such as o *Functional Family Therapy* ▪ Family-based intervention with at-risk youth in the criminal justice system ▪ Focus on using family and consumer strengths to help youth gain control of their behaviors ▪ Has been found to be effective with clients of diverse cultural backgrounds o *Teaching Pro-Social Skills* ▪ Strength-based approach for at-risk youth designed to increase pro-social behaviors ▪ Involve educational and criminal justice partners in coordinated delivery of TSP-related services ☐ Training in interventions designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, or war trauma. Examples include: o *Trauma Focused Cognitive Behavioral Therapy* o *Seeking Safety* ▪ EBP focused on harm reduction for adult and	☐ Increase the use of effective recovery-oriented, strength-based treatment approaches for youth and adult clients ☐ Increase involvement of other service providers in treatment partnerships to ensure the consistency and effectives of evidence-based interventions ☐ Increase the use of interventions that involve consumers enrolled in programs to also help deliver service ☐ Increase the use of interventions that are relevant to clients seeking help for co-occurring disorders ☐ Increase the use of interventions found effective with diverse cultural populations		8,000 17,000 30,000	113,000

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
	youth consumers severely impacted by trauma ▪ Strength-based approach designed to improve the ability of consumers to make safe, effective choices in their lives ▪ It is an integrated, co-occurring approach to treatment ☐ Training to help clinicians teach coping skills for individuals with serious, self-harming personality disorders, such as o *Dialectical Behavior Therapy* ▪ Promising practice focused on reducing self-harming behavior in adolescents and adults ▪ Focuses on developing skills to more effectively deal with distress ▪ Many elements of this approach have been successful in integrated treatment for co-occurring clients ☐ Training in delivery of integrated treatment for clients suffering from co-occurring disorders. Examples include: o *Motivational Interviewing and Enhancement* o *Development of integrated treatment planning for clients suffering from co-occurring disorders.* o *Trainings to promote a welcoming environment for clients suffering from co-occurring disorders* The Training Director will routinely contact participants in various EBP (and other) training activities six-months after training has been completed to assess the degree to which the training has resulted in changed treatment practice.			8,000 50,000	

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
Expanded Site-Based Clinical Consultation	Staff surveys indicated that the preferred means of training was through clinical consultation on specific treatment challenges. San Mateo County has piloted this approach with the hiring of a Coordinator of Integrated Dual Disorder Treatment who meets with treatment teams to reinforce principles and practices introduced through the intensive training practicum introduced by Minkhoff and Kline. This model will be replicated with training being offered in EBP (as per above) being reinforced with contracted clinical consultants retained to meet with treatment teams implementing the EBPs. An example, Quarterly consultations on working with individuals with co-occurring mental health and developmental disabilities; The Training Director will receive requests from both CBO and County treatment teams and will compile an inventory of expert practitioners available to provide time-limited clinical consultations. The Director will present requests to the Training Committee for approval. Criteria for approval will include: ☐ Extent to which consultation will reinforce use of EBP; ☐ Extent to which consultation supports the vision and values of the MHSA; ☐ The degree to which consultation includes plans for disseminating learning to other treatment teams.	☐ Increased ability of treatment staff to implement EBPs as evidenced from annual staff survey; ☐ Increased consumer satisfaction with services and supports introduced in training and reinforced through clinical consultations; ☐ Increased dissemination of effective implementation of EBP beyond the treatment teams directly involved in clinical consultations. ☐ Provide consultations on complex co-occurring cases in which there are issues associated with developmental disability		25,000	25,000
RESIDENCY & INTERNSHIPS					
Child Psychiatry Fellowship	The Child Psychiatry Fellowship was initiated in 2007-08 and 08-09 utilizing 'one-time' MHSA funding. It will be sustained in 2009-10 with MHSA WET funds. The Child Psychiatry Fellowship responds to a critical, historically hard to fill position within the San Mateo County BHRS system. The Fellowship is a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. It is also designed to provide education to a new generation of psychiatrists about recovery-based, strength-based service delivery.	☐ Increase the availability of psychiatric services to youth consumers of BHRS ☐ Increase the knowledge and understanding of psychiatric fellows of the values and commitments of recovery-based, strength-based services offered in BHRS	183,598	192,778	376,376
Expanded Internships to Create More	This program provides stipends to trainees from local universities who help to expand the diversity and linguistic and cultural competence of our workforce. This program will be sustained in 08/09 and 09/10 with	☐ Increase the availability of culturally and linguistically competent services to all consumers and	60,000	60,000	120,000

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
Culturally Competent System	MHSA WET funds.	family members of BHRS ☐ Increase the knowledge and understanding of trainees of the values and commitments of recovery-based, strength-based services offered in BHRS			
STAFFING & SUPPORT					
Training Director	Director will serve as lead staff to the Training Committee and will be responsible for: implementing Three-Year Training Plan and MHSA WET Plan; organize and schedule training events, including identifying trainers and consultants; collaborate with consumer and family members staff to expand availability of consumer-family focused training; developing new strategies and modalities to provide training to staff, including use of team-based training experiences, the use of consultants, and electronic training resources (video/web) to expand access to training; managing intern recruitment, placement, and training; collaborate with regional and State training resources to expand availability of training resources available locally; participate in local mental health pipeline workforce development strategies; and supervise .5 FTE Community Program Specialist responsible for scheduling and coordinating training events.	☐ Provide research, data, and communication to the Training Committee to assist them in oversight of the WET MHSA annual budget and work plan; ☐ Recruit members to ensure that the Training Committee includes both consumers and family members and represents the cultural composition of the population served; ☐ Develop, maintain and strengthen relationships with a wide range of regional stakeholders in education and training and workforce development, as well as among the provider, consumer and family communities and the cultural communities; ☐ Evaluate the impact of WET actions and report on this impact to the Training Committee; ☐ Develop an annual report for staff, clients and family members to determine the extent to which training and workforce development activities are contributing to transformation of the BHRS system of services and supports. ☐ Prepare and submit periodic reports to the California Department of Mental	133,065	133,065	266,130

Proposed Action	Training Experiences	Objectives	2008-09	2009-10	Total
		Health, as per DMH guidelines; and ☐ Manage the budget of WET initiative.			
Community Program Specialist III	Provide administrative, communication, coordination and data collection support to the Training Director in support of efforts to implement the Three-Year Training Plan and MHSA WET Plan and to manage intern recruitment, placement, and training.	See above.		54,392	54,392
Plan Consultant	Provide research on effective mental health pipeline models and partnerships, engage stakeholders in a facilitated process to develop a pipeline designed to expand interest in pursuing careers in the behavioral health field, create opportunities to develop interest and prepare for such a career, and offer supports, internships, tutorials, and other interventions designed to increase the cultural diversity of those participating in pipeline activities.	☐ Prepare a written Workforce Development Plan describing specific actions, budget amounts, strategies, and partners involved in a full range of mental health pipeline and workforce development activities. ☐ Cultivate pipeline partnerships among local stakeholders designed to create greater cultural diversity in the local behavioral care system of care. ☐		29,500	29,500
WORKFORCE DEVELOPMENT		San Mateo County BHRS will extend WET planning in the spring with a focus upon developing as well as to expand workforce development strategies in residency and internships.			
			426,663	802,735	1,229,398

PART IV: REQUIRED EXHIBITS

EXHIBIT 1: WORKFORCE FACE SHEET

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

County: Date:

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 include individuals with client and family member experience who are capable of providing client- and family-driven services that promote wellness, recovery, and resiliency, leading to measurable, values-driven outcomes. This Workforce Education and Training component has been developed with stakeholders and public participation. All input has been considered, with adjustments made, as appropriate.

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

County Mental Health Director
Printed Name:

Signature:

Street Address (or, PO Box):
City, ZIP Code:
Phone #: Fax #:
E-mail address:

Contact Person' Name: Phone #: Fax #: E-mail:

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EXHIBIT 2: STAKEHOLDER PARTICIPATION SUMMARY

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

San Mateo County's local Mental Health Services Act (MHSA) Workforce Education and Training planning built upon a number of important local planning initiatives.

San Mateo County Mental Health MHSA Community Services & Supports Plan: This planning process was designed to facilitate meaningful participation from a broad range of stakeholders including members of historically un-served and under-served communities. The information collected through an ambitious outreach process was integrated within a more structured planning process involving the Mental Health Board (MHB), a MHSA Steering Committee, and Child and Youth, Transition Age Youth, Adult and Older Adult Work Groups. Each Work Group was co-chaired by a consumer and a mental health services manager with membership from criminal justice, housing, primary care, community-based providers, family members, and consumers, with consultants serving as facilitators. Throughout over a year of planning, Work Groups considered research, data on types and levels of services delivered, input from the community (see below), and testimony by Work Group members. Through this process, a set of high-priority services were identified and forwarded to the Steering Committee which was charged with prioritizing the recommended strategies and approving the final budget and plan. The CS&S Plan was approved by the MHB in December 2006 the County Board of Supervisors in January 2007 and the State Department of Mental Health. The plan identified areas in which the system needed to be transformed and expanded to better meet the needs of the community, both those being served and under-served populations. In addition, the Work Groups identified historically hard-to-fill positions, cultural groups who are historically under-served, and Evidence-Based Practices that should be expanded. This knowledge base created an important foundation from which the Workforce Education & Training (WET) planning emerged.

MHSA CS&S Communication Plan for Transforming the System: As part of the MHSA, CS&S planning process the Mental Health Services Division also conducted an intensive community outreach process to ensure there would be substantial, meaningful input from consumers, family members, and representatives of populations that have been historically un-served or under-served by the Mental Health Services Division and would be unlikely to participate in formal planning meetings. The design for the Communication Plan for Transforming the System: Sources of Input to Mental Health Services Act (MHSA) Planning evolved from an initial meeting of over 20 consumers, family members, providers, and MHB members in early February, 2006 and by the time it was approved by the Steering Committee, it contained a plan for outreach to dozens of community-based agencies, cultural organizations, community centers, regional leaders, and other institutions that serve populations and communities that are historically un/under-served by the Mental Health Services Division. The Mental Health Services Division partnered with numerous community stakeholders to conduct over 100 focus groups and community meetings targeting un/under-served populations, which were held in all communities in the County between March and June, 2006 through which input from over 1,000 individuals was received. This input not only informed the character and scope of the CS&S Plan, it provided invaluable insights into how consumers, family members, and historically under-served populations wanted to be served and how they wanted a more prominent role in treatment planning and treatment itself.

Meetings and focus groups were held in all regions of the County in venues where un/under-served populations reside or are served including juvenile hall, jail, group homes, senior centers, community centers, schools, homeless shelters, and other venues. Some focus groups were conducted in Spanish, Tagalog, Chinese, and Tongan. Results were recorded, posted on the Mental Health Services Division's Network of Care

website http://sanmateo.networkofcare.org, coded and assembled into a data base that facilitated analyzing perceptions by age group, culture or language, region, as well as by provider, consumer or family member. Written reports and visual slide presentations summarizing findings were generated for each Work Group and reviewed prior to prioritizing issues, target populations and strategies. As a result of this outreach effort, the County achieved a far more personal and tangible understanding of both the cultural dimensions to transformation and the need to strengthen the degree to which services and supports are consumer and family friendly.

Joint Labor/Management Initiative: The Joint Labor/Management Initiative was a County-wide initiative that spanned multiple County departments, included representation from labor and management, and focused on developing a shared labor-management framework that addressed both the conditions of employment and the approach to providing staff development.

Workforce Development Group Planning (WFD Group): Beginning on July 14, 2006, a Workforce Development Group began planning to develop a vision and set of values and principles designed to ensure that workforce development and education and training initiatives were consistent with the vision and values that had been established through the Community Services & Supports planning process. The WFD Group was comprised of County Mental Health leadership, managers, line staff, consumers, and representatives from community-based agencies. Over a series of meetings spanning many months, a Workforce Development Framework was developed that included a WFD vision, mission, and set of values. It also identified core foundational knowledge that was felt to be the essential competence required from all treatment staff. Foundational knowledge included a wide range of competencies that were viewed as central to supporting system transformation. Foundational knowledge included:

- ☐ Cultural competence
- ☐ Stigma reduction
- ☐ Customer service
- ☐ Consumer and family training and support
- ☐ HIPAA and confidentiality
- ☐ Self Care and
- ☐ a dozen other areas central to developing a consumer-centered system.

In addition, the Group identified *core skills and competencies* that reflected the intent to expand the use of Evidence Based Practice and client-centered services throughout the system. Among the *core skills and competencies* identified:

- ☐ Motivational Interviewing
- ☐ Integrated treatment of co-occurring disorders
- ☐ Cultural competence in clinical assessment
- ☐ Supporting informed consent and choice
- ☐ Wellness Recovery Action Planning
- ☐ Illness management and recovery

The WFD Group also identified specific populations where population-specific training and staff development was needed, including:

- LGBTQ
- Gender-responsive treatment
- Infants and early childhood
- Developmental disabilities
- Abused children
- Family law participants
- Adult survivors of abuse
- PTSD
- Geriatrics
- Cognitive disorders
- And victims of domestic violence

Finally, the WFD Group identified a number of specific treatment practices deemed critical to ensuring the reliance upon Evidence Based Practices and consumer-focused treatment that is consistent with principles of wellness and recovery. These interventions included:

- Cognitive Behavioral Therapy
- Trauma-focused CBT
- Family Psycho-Education
- Supported Employment
- Assertive Community Treatment
- System of Care and Wraparound
- Dialectical Behavioral Therapy
- Functional Family Therapy
- Aggression Replacement Therapy

The WFD Group also identified a number of initiatives that were important to advance using either CS&S funding or 'one-time' MHSA money advanced by DMH to enable counties to launch important processes and interventions in advance of WET plan approval. This included the retaining of a Training Director, funding a year of intensive training in integrated treatment of co-occurring disorders, and the creation of a partnership with Stanford University establishing a Child Psychiatry Fellowship. The WFD Group also achieved a core understanding of how workforce development and education and training can support, expand and sustain system transformation.

The Behavioral Health & Recovery Services Training Committee (BHRS Training Committee): During the months of December 2007 through March 2008 the BHRS Training Committee, which includes representation from management and direct service staff, consumer and family members, community-based agencies -among other stakeholders, discussed how to best address the educational and training needs of the Behavioral Health and Recovery Services Division. The intent was to develop a three year training plan that identified the full-spectrum of BHRS staff education and training needs, including those that would be funded through MHSA WET funding and those funded through other resources. The Training Committee used the work of the WFD Group as its starting point, creating a clear timeline for implementation of a wide range of training activities that were fully aligned with the vision, mission, values and principles developed through the CS&S and WFD Group planning. In

the course of the discussions, the need emerged to delineate a framework that would set the philosophical foundation for the work of this group, which in turns guides the Training Plan and the elements included in it. The guidelines below grew out of the WFD's vision, values and principles.

The training plan has been developed based on the feedback received by stakeholders regarding educational and training needs of our workforce. The plan was informed by staff survey, deliberations by the BHRS Training Committee, and by input from a broad based Education and Training Committee (below) that encouraged input from community members, family members, and consumers.

The plan includes a set of foundational or core trainings, specialized yearly trainings in different areas focused on a few priorities each year, ongoing co-occurring training, yearly required trainings for licensure and re-licensure, consultation, collaborative trainings with other agencies/organizations, support for off-site trainings and conferences, among others as identified. It also delineates the role of the Training Director responsible for implementing the plan, the role of the Training Committee responsible for monitoring the plan's implementation and the criteria by which a training would be approved and evaluated.

GUIDELINES FOR EDUCATION AND TRAINING

1. Consumers and family members are equal partners in the decision-making process around education and training.
2. Cultural and linguistic competence (fluency) are embedded in all phases of educational and training initiatives.
3. Our education and training initiatives increase the ability of all staff to provide wellness and recovery-based services.
4. Our initiatives support the education and training needs of staff and rely on staff input in the development of an education and training plan, with a broad definition of what constitutes education and training.
5. Best practices are at the core of our education and training plan in every aspect, including the type of training models used, the content of the training provided, and the evaluation tools to monitor the long-term effectiveness of the education and training activities.
6. Our education and training plan maximizes the effective use of resources –including, but not limited to, staff's time.
7. Partnerships and collaboration with the community and contract agencies in the planning and implementation of education and training initiatives is encouraged and prioritized.
8. All the above guidelines are in the service of providing effective and quality care to the individuals and families we serve.

BHRS Training Committee, January 2008.

Behavioral Health & Recovery Services MHSA Education and Training Work Group Planning (E&T WG): The E&T WG was specifically charged with developing the WET plan for submission to DMH. It was comprised of BHRS leadership, managers, line staff, consumers, family members, and representatives of community-based agencies. It began meeting in November 2007 with additional meetings occurring on January 11th, 2008, February 22, 2008, and March 22, 2008. It focused upon education and training issues leaving workforce development issues to be considered in the spring of 2009 with an expanded committee or work group that will include representation from K-12, community colleges, California State University, Stanford, and other community stakeholders. This group will develop a second MHSA WET submission covering the workforce development components to the overall WET plan.

At the November meeting, the work of the CS&S and WFD Group were shared with the Work Group and a summary was presented that showed the alignment of MHSA WET values established by the State and San Mateo County BHRS values established in the CS&S planning process and extended and applied to workforce development by the WFD

Group. The term 'guidelines' was used to replace the terms "values and principles" and revisions to the guidelines were made to reflect the views of the E&T WG.

At the November meeting, a presentation was given summarizing months of research into adult learning theory and organizational change that had been conducted by one of the County's consultants. The presentation anticipated what was later learned from staff surveys, that adults learn best through coaching, consultation, and site/practice-based training. The presentation also highlighted the critical importance of changes in administrative structures and policies to encourage coaching and collaboration and to support new practices and treatment strategies that are introduced to support system transformation. At the November meeting, the E&T WG also approved a training survey to be administered with county and CBO staff. The survey sought input from staff as to the areas in which training was needed, the ways in which training would best be delivered and the kinds of treatment challenges they typically face.

The survey results were shared at the January 11th meeting. Among the most important findings from the survey:

- The highest priority training needs included working with dually diagnosed individuals and with multi-problem individuals; in assessment of individuals with multiple problems; in motivational interviewing; in working with treatment resistant clients and in cultural issues. Specific areas where training was sought included:

  - PTSD
  - Working with clients we haven't been able to engage
  - Depressive disorders
  - Working with complicated families
  - Anxiety disorders
  - Substance use / abuse by age group
  - Trauma assessment & interventions
  - Psychotic disorders
  - ADHD
  - Immigration law
  - Family therapy
  - Autism spectrum and developmental disabilities
  - Sustaining family commitment
  - Family psychosocial rehabilitation
  - Eating disorders
  - Affective Disorders

- The survey also queried how staff most wanted to learn and here findings were very instructive, as the highest prioritized training delivery methods were:

  - Hands-on Interactive workshop
  - Ongoing case consultation
  - Ongoing seminar
  - In-house expert consultation
  - Team consultation

  Very few staff indicated an interest in didactic lectures or large group training or seminars. This finding led the E&T WG and the Three-Year Training Plan to incorporate more strategies that fostered consultation, site or practice-based training and team consultation and training.

- Finally, the survey queried staff to identify what treatment situations were most challenging. Staff identified the following as the most challenging situations:

- Multiply diagnosed clients, particularly clients with complex diagnoses compounded by multiple life challenges (housing, criminal justice, immigration) (21)
- Working with clients we haven't been able to engage (13)
- Eating disorders (8)
- Developmental disabilities, autism, Asperger's (8)
- Homeless/housing
- Dual diagnosis (6)
- Trauma (6)

Staff also indicated that the kind of support that would have most helped in these situations was more of a specific consultation than an article or web url or a seminar.

The survey played an important part in shaping both the MHSA WET plan and the three-year training plan described above.

In February 2008, the E&T WG met again and developed a set of criteria by which the Training Committee would approve specific trainings and the criteria to be used to evaluate each training and in March 2008, the E&T WG outlined some additional priorities to guide the Training Committee and BHRS leadership as it crafted the Three-Year Training Plan and the MHSA WET Plan. These priorities included an emphasis upon site and practice-based training, collaboration within BHRS and across systems, and the development of cross-training and train the trainer approaches that built a long term, sustainable capacity to foster the use of culturally competent, client/family-focused treatment consistent with the framework of system transformation outlined in the MHSA.

After its March 2008 meeting, the E&T WG ceased meeting while the Training Committee developed its three year plan and while BHRS leadership focused on completion of its Prevention and Early Intervention Plan. Beginning in September 2008, staff leadership and consultants began meeting to take the input from the processes described above and developed an initial draft of the Exhibits required by DMH to obtain MHSA WET funding. An initial draft was completed in mid-December and the E&T WG met on December 19th to review the draft and provide input. At this meeting the E&T WG made several minor suggestions, but with those incorporated, approved the planned actions and budget.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

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

(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals Only)

(*Unlicensed* Mental Health Direct Service Staff; Sub-Totals and Total Only)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 2

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

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 3

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

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers):										
CEO or manager above direct supervisor.....				(Managerial and Supervisory; Sub-Totals Only) ⬇						
Supervising psychiatrist (or other physician)										
Licensed supervising clinician.....										
Other managers and supervisors.....										
Sub-total, D (County)										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
CEO or manager above direct supervisor.....				(Managerial and Supervisory; Sub-Totals and Total Only) ⬇						
Supervising psychiatrist (or other physician)										
Licensed supervising clinician.....										
Other managers and supervisors.....										
Sub-total, D (All Other)										
Total, D (County & All Other):										
E. Support Staff (non-direct service):										
County (employees, independent contractors, volunteers):										
Analysts, tech support, quality assurance.....				(Support Staff; Sub-Totals Only) ⬇						
Education, training, research										
Clerical, secretary, administrative assistants										
Other support staff (non-direct services).....										
Sub-total, E (County)										
All Other (CBOs, CBO sub-contractors, network providers and volunteers):										
Analysts, tech support, quality assurance.....				(Support Staff; Sub-Totals and Total Only) ⬇						
Education, training, research										
Clerical, secretary, administrative assistants										
Other support staff (non-direct services).....										
Sub-total, E (All Other)										
Total, E (County & All Other):										

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 5

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

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casian	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	# FTE filled **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E).....**										
***All Other (CBOs, CBO sub-contractors, network providers and volunteers)* (A+B+C+D+E) .....**										
GRAND TOTAL WORKFORCE (County & All Other) (A+B+C+D+E)										

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

				Race/ethnicity of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	Hispanic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islander	Native Ameri-can	Multi Race or Other	All individuals **(5)+(6)+ (7)+(8)+ (9)+(10)**
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**									

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

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

III. LANGUAGE PROFICIENCY

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

Language, other than English	Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)	(2)	(3)	(4)
1. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
2. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
3. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
4. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____
5. _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____	Direct Service Staff _____ Others _____

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

A. Shortages by occupational category:

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

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

D. Language proficiency:

E. Other, miscellaneous:

EXHIBIT 4: WORK DETAIL—Page 1

A. WORKFORCE STAFFING SUPPORT

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

Action #1 – Title: WET Plan Coordination & Implementation

Description:

The WET Plan will be overseen by a full time Training Director who will supervise a .5 FTE Community Resource Specialist. This team will serve as staff to the Training Committee and will be responsible for:

- Managing implementation of the Three-Year Training Plan and MHSA WET Plan;
- Providing research, data, and communication to the Training Committee to assist them in oversight of the WET MHSA annual budget and work plan;
- Recruiting and orienting Training Committee members to ensure that the Training Committee includes both consumers and family members and represents the cultural composition of the population served;
- Organizing and scheduling training events, including identifying trainers and consultants;
- Collaborating with consumer and family members staff to expand availability of consumer-family focused training;
- Developing strategies and modalities to provide training to staff, including use of team-based training experiences, the use of consultants, and electronic training resources (video/web) to expand access to training; managing intern recruitment, placement, and training;
- Collaborating with regional and State training resources to expand availability of training resources available locally;
- Participating in local mental health pipeline workforce development strategies;
- Developing, maintaining and strengthening relationships with a wide range of regional stakeholders in education and training and workforce development, as well as among the provider, consumer, family and cultural communities;
- Evaluating the impact of WET actions and reporting on this impact to the Training Committee;
- Developing an annual report for staff, clients and family members to determine the extent to which training and workforce development activities are contributing to the transformation of the BHRS system of services and supports.
- Preparing and submitting periodic reports to the California Department of Mental Health, as per DMH guidelines; and
- Supervising a .5 FTE Community Program Specialist responsible for scheduling and coordinating training events.

Objectives:

- Training Coordinator and Community Program Specialist will be hired and oriented within six months of receipt of funding;
- Within three months of being hired, the Training Coordinator will submit a Training Calendar for 2009-10;
- On a quarterly basis, the Training Coordinator will submit an updated calendar and summary of training activities that have been implemented;
- Prepare an annual report to the Training Committee, Steering Committee and California Department of Mental Health summarizing activities conducted and funds expended;

Budget justification:

Budgeted Amount: **FY 2008-09: $** **FY 2009-10: $**

EXHIBIT 4: WORK DETAIL—Page 2
A. WORKFORCE STAFFING SUPPORT

Action #2 – Title: WET Plan Research & Development
Description:

San Mateo County Behavioral Health and Recovery Services (BHRS) will extend WET planning in the spring 2009 with a focus upon developing mental health pathways as well as expanding workforce development strategies in residency and internships. BHRS will contract with an independent consultant to facilitate a comprehensive research and planning process focused upon developing a plan for a model mental health pipeline. The purpose of the pipeline is to create a wide range of integrated strategies and opportunities that:

1) Stimulates greater interest in careers in mental health among communities of color and historically under-served population and
2) Prepares individuals interested in mental health careers with the skills and preparation necessary to filling historically hard-to-fill positions.

In support of this purpose, the planning consultant will:

- ☐ Identify and summarize research on effective mental health pipeline models and partnerships;
- ☐ Engage stakeholders from state and private universities, the community college system, K-12 districts, as well as other training and educational institutions, as well as representatives from under-served populations in a facilitated process through which stakeholders consider research, data, and the availability of local resources to create a comprehensive mental health pipeline plan;
- ☐ Create a plan and budget that describes a system of integrated opportunities that increase interest in the mental health field and that offers supports, internships, tutorials, and other interventions designed to increase the cultural diversity of those participating in pipeline activities.

Objectives:

- ☐ Creation of an effective partnership of local stakeholders committed to sustaining a mental health pipeline.
- ☐ Completion of a Pipeline Plan and budget delineating strategies, timeline, roles and responsibilities of partners and funding necessary for plan implementation
- ☐ Submission of Pipeline Plan and budget to the Training Committee, Steering Committee and California Department of Mental Health.

Budget justification:

120 hours @ $125/hour

Budgeted Amount: **FY 2008-09: $___$15,000_____ FY 2009-10: $29,500**

EXHIBIT 4: WORK DETAIL—Page 3

B. TRAINING AND TECHNICAL ASSISTANCE

Action #3 – Title: Targeted Training For & By Consumers and Family Members

Description:

Provide a range of training delivered by and for consumers and family members to include:

- ☐ Training and support for consumers and family members join the workforce of BHRS. Examples include:
  - o *Paving the Way which:* Trains and supports new consumers and family members joining workforce; supports existing staff to welcome new consumer / family staff; and recognizes excellence by providing Hope Awards to those who have excelled in helping to educate consumers, families, staff, and public about recovery and to reduce stigma
  - o *Inspired at Work* which provides a framework for consumers and family members to get support and to explore issues involved with entering and remaining the workforce.
- ☐ Trainings provided by consumers to providers and the public designed to increase understanding of mental health issues and to reduce stigma. Examples include:
  - o *Stamp Out Stigma*
- ☐ Trainings provided by consumers and family members to increase understanding of mental health issues, recovery and resilience, and available treatments and supports. Examples include:
  - o *Provider Education* – NAMI sponsored intensive training to providers led by consumers, family members, and experts
  - o *In Our Own Voice* – NAMI sponsored consumer to consumer presentations about their experiences. Presented in a number of locations, including hospitals.
  - o *Family to Family* – NAMI sponsored 12 wk course family-taught to families of consumers about mental health, treatments, and how to take care of one's self
  - o *Peer to Peer* – NAMI sponsored 9 wk course taught by consumers to consumers about mental health, treatments, and recovery
- ☐ Leadership training to support increased involvement of consumers and family members in various committee, commission, and planning roles
- ☐ Trainings by consumers, families, and experts in the field in strategies to improve engagement of consumers and family members
- ☐ Send selected consumers, family members, and staff to conferences and training experiences
  - o CMHCY Conference - Send selected consumers, youth, family members, and staff for training in the delivery of services for youth and families
  - o Village – Send selected consumers, family members, and staff for training in wellness and recovery concepts
  - o NAMI conferences and trainings – send selected consumers, family members, and staff for training in family-focused approaches to service delivery

The findings from this survey will be reviewed by the Training Director to identify areas in which training has improved consumer experience of the system and to identify needs for additional training.

Objectives:

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

- ☐ Increase the number of training sessions delivered by consumers and consumer organizations.
- ☐ Increase the number of consumers and family members in policy, planning and advocacy roles.
- ☐ Increase the ability of treatment teams to successfully engage consumers and families we have failed to engage in the past

Budget justification:

Budgeted Amount:		**FY 2008-09: $10,000**	**FY 2009-10: $105,000**

EXHIBIT 4: WORK DETAIL – Page #

B. TRAINING AND TECHNICAL ASSISTANCE –

Action # 4 – Title: Wellness Recovery Action Plan Training

Description:

San Mateo County BHRS will engage in training to extend and support consumer wellness and recovery. Self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. Following a train the trainer approach, BHRS will send selected staff from county and contracted providers, consumers, and family members to become "Master Trainers." The "Master Trainers" will then provide training and support to consumers and staff throughout our system in developing WRAP plans.

Objectives:

- ☐ Ten selected staff, family members and consumers will be trained to become "Master Trainers."
- ☐ 100 consumers in BHRS will complete WRAP plans by end of 09/10
- ☐ Establish 5 WRAP support groups in the county by end of 09/10

Budget Justification:

Budgeted Amount:		**FY 2008-09: $__40,000_____**	**FY 2009-10: $__40,000____**

EXHIBIT 4: WORK DETAIL—Page 3

B. TRAINING AND TECHNICAL ASSISTANCE –

Action # 5 – Cultural Competence Training

Description:

Training in the area of cultural competence is designed to reduce health disparities in our community, to provide culturally and linguistically competent services, and to increase access, capacity, and understanding by partnering with community groups and resources. Educational and training activities will be available to consumers, family members, providers, and those working and living in the community. Our Three-Year Training Plan has identified a number of components designed to address these issues. Examples include:

- ☐ Use of the CA Multi-Cultural Scale to assess our system of services
- ☐ Trainings to increase the effective use of interpreters in service delivery
- ☐ Creation of a clinical consultation resource for providers working with Filipino consumers
- ☐ Addressing cultural issues when providing services to consumers suffering from co-occurring disorders and domestic violence

Trainings will also be used to help support key initiatives launched by BHRS' Health Disparities Manager. Examples include:

- ☐ Pacific Islander Summit
- ☐ African American Summit
- ☐ Latino Initiative Summit
- ☐ Outreach to the LGBTQQI community

The scheduling of training modules will be coordinated by the Training Director in consultation with the Health Disparities Manager of BHRS. San Mateo County BHRS administers an annual consumer satisfaction survey.

Objectives:

- ☐ Improved capacity to utilize interpreters with consumers who are not English-speaking;
- ☐ Expanded incorporation of a variety of alternative and culturally specific strategies as part of ongoing treatment efforts;
- ☐ Incorporation of culturally-informed engagement strategies;
- ☐ Increased satisfaction with services by historically under-served and poorly served cultural populations;
- ☐ Increased proportion of consumer population comprised of historically under-served populations.

Budget Justification:

Budgeted Amount:		**FY 2008-09: $ 50,000**	**FY 2009-10: $ 50,000**

EXHIBIT 4: WORK DETAIL—Page #

B. TRAINING AND TECHNICAL ASSISTANCE –

Action # 6 – Title: Evidence-Based Training for System Transformation

Description:

The Training Committee will schedule an ongoing series of training designed to support transformation of the BHRS system by increasing utilization of evidence based treatment practices that better engage consumers and family members as partners in treatment and have contributed to improved consumer quality of life. Recommendations for training can come from consumers, family members, or public or private agency staff by submitting a form to the Training Director who will submit the request to the Training Committee. Criteria for training includes: consistency with the values of the MHSA, contribution to creation of a more culturally competent system, and that the training is based upon evidence-based practices. Among training to be offered in 08-09/09-10:

- ☐ Improve family functioning, parenting, communication and help parents and youth to reduce problem behaviors through evidence-based and promising practices such as
  - o *Functional Family Therapy*
    - Family-based intervention with at-risk youth in the criminal justice system
    - Focus on using family and consumer strengths to help youth gain control of their behaviors
    - Has been found to be effective with clients of diverse cultural backgrounds
  - o *Teaching Pro-Social Skills*
    - Strength-based approach for at-risk youth designed to increase pro-social behaviors
    - Involve educational and criminal justice partners in coordinated delivery of TSP-related services
- ☐ Training in interventions designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, or war trauma. Examples include:
  - o *Trauma Focused Cognitive Behavioral Therapy*
  - o *Seeking Safety*
    - EBP focused on harm reduction for adult and youth consumers severely impacted by trauma
    - Strength-based approach designed to improve the ability of consumers to make safe, effective choices in their lives
    - It is an integrated, co-occurring approach to treatment
- ☐ Training to help clinicians teach coping skills for individuals with serious, self-harming personality disorders, such as
  - o *Dialectical Behavior Therapy*
    - Promising practice focused on reducing self-harming behavior in adolescents and adults
    - Focuses on developing skills to more effectively deal with distress
    - Many elements of this approach have been successful in integrated treatment for co-occurring clients
- ☐ Training in delivery of integrated treatment for clients suffering from co-occurring disorders. Examples include:
  - o *Motivational Interviewing and Enhancement*
  - o *Development of integrated treatment planning for clients suffering from co-occurring disorders.*
  - o *Trainings to promote a welcoming environment for clients suffering from co-occurring disorders*

The Training Director will routinely contact participants in various EBP (and other) training activities six-months after training has been completed to assess the degree to which the training has resulted in changed treatment practice.

Objectives:

- ☐ Increase the use of effective recovery-oriented, strength-based treatment approaches for youth and adult clients
- ☐ Increase involvement of other service providers in treatment partnerships to ensure the consistency and effectives of evidence-based interventions
- ☐ Increase the use of interventions that involve consumers enrolled in programs to also help deliver service
- ☐ Increase the use of interventions that are relevant to clients seeking help for co-occurring disorders
- ☐ Increase the use of interventions found effective with diverse cultural populations

Budget Justification:

2008-09: $3,000 for Co-occurring

2009-10:

$8,000 FFS;

$17,000 Teaching Pro-social Skills,

$3,000 Co-Occurring

Budgeted Amount:		**FY 2008-09: $_____**	**FY 2009-10: $113,000**

EXHIBIT 4: WORK DETAIL—Page #

B. TRAINING AND TECHNICAL ASSISTANCE –

Action # 7 – Title: Expanded Site-Based Clinical Consultation

Description:

Staff surveys indicated that the preferred means of training was through clinical consultation on specific treatment challenges. San Mateo County has piloted this approach with the hiring of a Coordinator of Integrated Dual Disorder Treatment who meets with treatment teams to reinforce principles and practices introduced through the intensive training practicum introduced by Minkhoff and Kline. This model will be replicated with training being offered in EBP (as per above) being reinforced with contracted clinical consultants retained to meet with treatment teams implementing the EBPs. An example, Quarterly consultations on working with individuals with co-occurring mental health and developmental disabilities.

The Training Director will receive requests from both CBO and County treatment teams and will compile an inventory of expert practitioners available to provide time-limited clinical consultations. The Director will present requests to the Training Committee for approval. Criteria for approval will include:

- Extent to which consultation will reinforce use of EBP;
- Extent to which consultation supports the vision and values of the MHSA;
- The degree to which consultation includes plans for disseminating learning to other treatment teams.

Objectives:

- Increased ability of treatment staff to implement EBPs as evidenced from annual staff survey;
- Increased consumer satisfaction with services and supports introduced in training and reinforced through clinical consultations;
- Increased dissemination of effective implementation of EBP beyond the treatment teams directly involved in clinical consultations.

Budget Justification:

$2400 per consultation with three consultations in 08-09 and ten in 09-10. Estimate is based upon history with dual disorder consultations that cost $2400 per consultation.

Budgeted Amount:		**FY 2008-09: _____**	**FY 2009-10: __$25,000_____**

EXHIBIT 4: WORK DETAIL –

C. MENTAL HEALTH CAREER PATHWAY PROGRAMS

Action # – Title: **Description:** **San Mateo County intends to conduct a separate planning process focused upon developing a model pipeline program. This process will build upon the one that has produced this plan.** **Objectives:** **Budget justification:**			
Budgeted Amount:	**FY 2006-07: $_____**	**FY 2007-08: $_____**	**FY 2008-09: $_____**

EXHIBIT 4: WORK DETAIL – page

D. RESIDENCY, INTERNSHIP PROGRAMS --

Action # 8 – Title: Child Psychiatry Fellowship

Description:

The Child Psychiatry Fellowship was initiated in 2007-08 and 08-09 utilizing 'one-time' MHSA funding. It will be sustained in 2009-10 with MHSA WET funds. The Child Psychiatry Fellowship responds to a critical, historically hard to fill position within the San Mateo County BHRS system. The Fellowship is a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. It is also designed to provide education to a new generation of psychiatrists about recovery-based, strength-based service delivery.

Objectives:

- ☐ Increase the availability of psychiatric services to youth consumers of BHRS
- ☐ Increase the knowledge and understanding of psychiatric fellows of the values and commitments of recovery-based, strength-based services offered in BHRS

Budget Justification:

Budgeted Amount:		**FY 2008-09: $___183,598____**	**FY 2009-10: $_____192,778**

EXHIBIT 4: WORK DETAIL – page

D. RESIDENCY, INTERNSHIP PROGRAMS --

Action # 9 – Title: Expanded Internships to Create More Culturally Competent System

Description:

This program provides stipends to trainees from local universities who help to expand the diversity and linguistic and cultural competence of our workforce. This program will be sustained in 08/09 and 09/10 with MHSA WET funds.

Objectives:

- ☐ Increase the availability of culturally and linguistically competent services to all consumers and family members of BHRS
- ☐ Increase the knowledge and understanding of trainees of the values and commitments of recovery-based, strength-based services offered in BHRS

Budget Justification:

Budgeted Amount:		**FY 2008-09: $___60,000_____**	**FY 2009-10: $___$60,000____**

E. FINANCIAL INCENTIVE PROGRAMS

Action #10 – Title: Stipends for Consumers
Description:

Stipends for consumers to support their efforts to advance in the County-CBO career ladder, obtain AS degrees, CADAC certification, and other community college, state college and university degrees, and accreditation.

Objectives:

- ☐ Increased number of consumers in peer counseling, case manager, and other treatment positions.
- ☐ Increase upward mobility of current consumers in County-CBO positions.

Budget justification:

Budgeted Amount:	**FY 2006-07: $_____**	**FY 2008-09: $_____**	**FY 2009-10: $_____**

EXHIBIT 5: ACTION MATRIX

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

Actions (as numbered in Exhibit 4, above)	Promotes wellness, recovery, and resilience	Promotes culturally competent service delivery	Promotes meaningful inclusion of clients/family members	Promotes an integrated service experience for clients and their family members	Promotes community collaboration	Staff support (infrastructure for workforce development)	Resolves occupational shortages	Expands postsecondary education capacity	Loan forgiveness, scholarships, and stipends	Regional partnerships	Distance learning	Career pathway programs	Employment of clients and family members within MH system
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action # 1 : WET Plan Coordination & Implementation	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**	**X**
Action # 2 : WET Plan Research & Development	**X**	**X**	**X**	**X**	**X**		X	X		X		X	
Action # 3 : Targeted Training For & By Consumers and Family Members	**X**	**X**	**X**	**X**	**X**		X						X
Action # 4 : Wellness Recovery Action Plan Training	**X**	**X**	**X**	**X**	**X**								X
Action # 5 : Cultural Competence Training	**X**	**X**	**X**	**X**	**X**								
Action # 6 : Evidence-Based Training for System Transformation	**X**	**X**	**X**	**X**	**X**								
Action # 7 : Expanded Site-Based Clinical Consultation	**X**	**X**	**X**	**X**	**X**								
Action # 8 : Child Psychiatry Fellowship	**X**	**X**	**X**	**X**	**X**		X						
Action # 9 : Expanded Internships to Create More Culturally Competent System	**X**	**X**	**X**	**X**	**X**								
Action # 10 : Stipends for Consumers	**X**	**X**	**X**	**X**	**X**								X

EXHIBIT 6: BUDGET SUMMARY

Fiscal Year: 2006-07			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:			
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	

Fiscal Year: 2007-08			
Activity	**Funds Approved Prior to Plan Approval (A)**	**Balance of Funds Requested (B)**	**Total Funds Requested (A + B)**
A. Workforce Staffing Support:			
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 2007-08	

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:			
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 2008-09	

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

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

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