



"Equitable Healthcare Accessibility for California"



**Workforce Education and Training (WET)  
Five-Year Plan Advisory Sub-Committee**

**February 27, 2013  
1:00 PM to 4:00 PM**

**400 R Street, Suite 471  
Sacramento, CA 95811  
Teleconference Number: 866-390-1828  
Participant Code: 1197648#**

**Webinar Link:** <https://connect4.uc.att.com/calnet/meet/?ExEventID=81197648>

Item	Subject	Contact
1	Welcome and Introductions	Lupe Alonzo-Diaz
2	Overview of Five-Year Plan Sub-Committee Responsibilities and Process	Inna Tysoe
3	Overview of MHSA WET Programs and Five-Year Plan	Linda Onstad-Adkins
4	Presentation and Discussion on MHSA WET Five-Year Plan Stakeholder Engagement Process <ul style="list-style-type: none"> <li>Review and Discuss Community Forum Meeting Locations</li> <li>Review and Discuss Questions for Stakeholder Engagement Process</li> </ul>	Sergio Aguilar
5	Presentation and Discussion on Revised Draft MHSA WET Five-Year Plan Vision, Mission, and Values	Sergio Aguilar
6	Presentation and Discussion on Draft Scope of Work for Mental Health Workforce Needs Assessment Contractor <ul style="list-style-type: none"> <li>Review and Discuss Scope of Work for Mental Health Workforce Needs Assessments</li> </ul>	Sergio Aguilar
7	Presentation and Discussion of Career Pathways Sub-Committee Scope and Process	Sergio Aguilar
8	Public Comment	Lupe Alonzo-Diaz
9	Adjournment	Lupe Alonzo-Diaz

The meeting facility is accessible to people with mobility impairments. Please contact Elvira Chairez at (916) 326-3635 at least 5 working or 7 calendar days in advance of the meeting to make arrangements for persons who need additional reasonable accommodations or have special needs.



**Mental Health Service Act Workforce Education and Training  
Five-Year Plan Advisory Sub-Committee  
Roles and Responsibilities**

The Mental Health Service Act (MHSA) Workforce Education and Training (WET) Five-Year Plan Advisory Sub-Committee (WET Five-Year Plan Advisory Sub-Committee) is comprised of experts and stakeholders in the California Community Public Mental Health System which advise the Foundations' MHSA WET Advisory Committee (WET Advisory Committee) on all aspects related to the development of the MHSA WET Five-Year Plan including:

- Activities pertaining to stakeholder engagement process including:
  - Stakeholders to engage
  - Methods to engage stakeholders
  - Vetting of stakeholder input; and
- Activities pertaining to the development of a statewide needs assessment;
- Development of WET Five-Year Plan vision, values, and mission;
- Development of WET Five-Year Plan goals, objectives, and actions;
- Development of WET Five-Year Plan workforce needs assessment;
- Development of WET Five-Year Plan governance and funding; and
- Development of WET Five-Year Plan evaluation (performance indicators and measurements);

The WET Five-Year Plan Advisory Sub-Committee is also encouraged share feedback from stakeholders at Advisory Committee meetings and share WET activities with constituents. The commitment for WET Five-Year Plan Advisory Sub-Committee members will be for one-year until the completion of the Five-Year Plan in January 2014.



## Mental Health Services Act Workforce Education and Training Five-Year Plan Development Process Overview and Key Dates

Proposition 63 – the Mental Health Services Act (MHSA) – funds Workforce Education and Training (WET) programs. Per Welfare and Institutions Code Section 5822, the Office of Statewide Health Planning and Development (OSHPD) is accountable for the development of the MHSA WET Five-Year Plan.

The Five-Year Plan provides a framework for the advancement and development of mental health workforce programs at the state and local level. Specifically, the MHSA WET Five-Year Plan provides the vision, values, mission, measurable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for mental health workforce.

To ensure the development of a comprehensive plan, OSHPD is employing a robust stakeholder engagement process to engage diverse stakeholder groups through different strategies including but not limited to Advisory Committee meetings, community forums, focus groups, county site visits, surveys, and key informant interviews. OSHPD will also engage in a process to evaluate current WET programs and develop a statewide needs assessment for mental health workforce. The MHSA WET Five-Year Plan requires final approval by the Mental Health Planning Council.

Below are key dates for the MHSA WET Five-Year Plan Development Process. For more information, please contact Sergio Aguilar at [Sergio.Aguilar@OSHPD.ca.gov](mailto:Sergio.Aguilar@OSHPD.ca.gov) or (916)326-3699.

Action	Date
WET Advisory Committee Meeting	December 3, 2012
Begin Evaluation of Current WET Programs	January 2, 2013
WET Advisory Committee Meeting	January 29, 2013
WET Five-Year Plan Advisory Sub-Committee Meeting	February 27, 2013
Begin Phase 1 Stakeholder Engagement Process (community forums, county site visits, surveys, interviews, etc.)	March 4, 2013
WET Five-Year Plan Advisory Sub-Committee Meeting	April 18, 2013
WET Advisory Committee Meeting	June 20, 2013
Needs Assessment Begins	July 1, 2013
Finalize First Draft of WET Five-Year Plan	July 24, 2013
WET Five-Year Plan Advisory Sub-Committee Meeting	August 8, 2013
WET Advisory Committee Meeting	September 5, 2013
Finalize First Draft of Five-Year Plan	September 20, 2013
Contractor Provides Statewide Needs Assessment Data	September 25, 2013
Begin Phase 2 of Stakeholder Engagement Process (key stakeholder forums, surveys, interviews, etc.)	September 30, 2013
WET Five Year-Plan Advisory Sub-Committee Meeting	November 13, 2013
Government Partners Meeting	December 4, 2013
WET Advisory Committee Meeting	December 18, 2013
Planning Council Meeting to Review WET Five-Year Plan	January 2014
WET Five-Year Plan Submitted to Administration for Approval	March 2014
Finalize and Submit Five-Year Plan to Legislature	April 1, 2014



## Mental Health Services Act (MHSA) Workforce Education and Training (WET) Program Overview

### Background

Passed in November 2004 by California voters, Proposition 63 – the Mental Health Services Act (MHSA) – imposes a one percent tax on personal income in excess of \$1 million to support the public mental health system (PMHS) via prevention, early intervention and services. Historically underfunded, the PMHS suffers from a shortage of mental health providers in addition to maldistribution, lack of diversity, and under-representation of practitioners with client experience.

The MHSA included a component for Mental Health Workforce Education and Training (WET) programs. The Welfare and Institutions Code (WIC) 5892(a) (1) specifies that a “trust fund” be created and that money within the trust fund “be expended consistent” with the WET Component in MHSA. WIC Section 5892(e) (1) states that in Fiscal Year (FY) 2004-05, 45% of the total MHSA revenues shall also be deposited in to that fund. WIC Section 5892(a) (1) states that in FYs “2005-06, 2006-07, and in 2007-08, 10 percent shall be placed in the trust fund to be expected for education and training programs”. WIC Section 5892(b) also allows counties to deposit up to 20 percent of their funds into the education and training fund. Although this fund was never established, a total of \$444.5 million was made available for the education and training fund at the State level with the Department of Mental Health (DMH).

### Five-Year Plan: 2008-2012

Pursuant to WIC Section 5820, in 2008, DMH, in concert with stakeholders, developed the Five-Year Workforce Education and Training Development Plan (Five-Year Plan), April 2008-April 2012 which provides a framework for the advancement and development of mental health workforce education and training programs at the County, Regional, and State levels. Specifically, the Five-Year Plan provides the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for the use of MHSA WET funds.

The Five-Year Plan developed by DMH was approved by the California Mental Health Planning Council in 2008 and covers the period from April 2008 to April 2013 ([http://www.oshpd.ca.gov/HPEF/Text\\_pdf\\_files/WET/MHSA\\_FiveYearPlan\\_5-06-08.pdf](http://www.oshpd.ca.gov/HPEF/Text_pdf_files/WET/MHSA_FiveYearPlan_5-06-08.pdf)). To supplement the Five-Year Plan, DMH also developed a ten-year budget projection for the administration of the \$444.5 million that were deposited for the WET component of MHSA. The ten-year budget set aside \$210 million to be distributed to counties for local WET program implementation, and \$234.5 million to be set aside for the administration of WET programs at the State level.

State level WET programs that were budgeted in the ten-year budget include:

- Stipend Programs
  - Stipend Programs are administered through contracts with ten higher educational entities, for graduate students who plan to work in the PMHS. The goals of the stipend programs are to increase the number of licensed mental health professionals in public mental health, and to incorporate the MHSA principles into graduate level curriculum. The graduate degrees funded in the WET stipend program include: Masters of Social Work; Marriage and Family Therapist; Clinical Psychologist; Psychiatric Mental Health Nurse Practitioner; Psychiatric Residency; and Physician Assistant. A total of \$100 million was authorized for Stipend Programs over 10 years.
- Mental Health Loan Assumption Program (MHLAP)
  - MHLAP offers loan assumption to mental health providers in hard-to-fill and/or hard-to-retain positions in the PMHS in exchange for a 12-month service obligation. A total of \$75 million was authorized for MHLAP over 10 years.
- Song-Brown Residency Program for Physician Assistants in Mental Health
  - Adds a mental health track to the Song-Brown Residency Program for Physician Assistants (PA) as a strategy to address the shortage of Pas that can sign mental health treatment plans and prescribe and administer psychotropic medications. PA programs that train second-year residents to specialize in mental health are eligible to apply for augmented funding. A total of \$5 million was authorized for Song-Brown over 10 years.
- Psychiatric Residency Program
  - The Psychiatric Residency Program ensures that psychiatric residents receive training in the County public mental health system, working with the populations prioritized by that community. Further, psychiatric residents are encouraged to continue working in the California PMHS after their rotations end. A total of \$13.5 million was authorized for Psychiatric Residency Programs over 10 years.
- Client and Family Member Statewide Technical Assistance Center
  - The Client and Family Member Statewide Technical Assistance Center promotes the employment of mental health clients and family members in the mental health system. A total of \$8 million was authorized for the Technical Assistance Center over 10 years.
- Regional Partnerships
  - Five Regional Partnerships (RPs) have formed across the state to promote building and improving local workforce, education and training resources. The RP collaboratives represent Bay Area counties; Central Valley counties; Southern counties; Los Angeles County; and Superior Region counties. RPs include representation from mental health, community agencies, educational/training entities, consumers, family members, and other partners to plan and implement programs that build and improve local workforce education and training resources.

Each RP focuses on projects and goals specific to their regional needs. A total of \$27 million was authorized for Regional Partnerships over 10 years.

### **MHSA WET Program Transfer**

In July 2012, following the elimination of DMH, the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD). OSHPD received budget authority to expend remaining MHSA WET State funds. An additional one-time \$6 million in unallocated WET funds were transferred to OSHPD, to be appropriated after stakeholder engagement for purposes of WIC Sections 5820, 5821, 5822 in a manner subject to requirements set forth in WIC Section 5820(a) (e) and WIC Section 5848.

### **MHSA WET Five-Year Plan: 2014-2019**

Per WIC Section 5820, OSHPD is accountable for the development of the next Five-Year Plan that will be in effect from April 2014 – April 2019. To ensure the development of a comprehensive plan, OSHPD is employing a robust stakeholder engagement process to engage diverse stakeholder groups through different strategies including the WET Advisory Committee and WET Five-Year Plan Advisory Sub-Committee, community forums/focus groups, key-informant interviews, webinars and surveys, and county site visits.

The Five-Year Plan will provide the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for the use of MHSA WET funds for the period from April 2014 to April 2019. Per WIC Section 5822, the next Five-Year Plan shall incorporate the following elements:

- A. Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.
- B. Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, master's degrees, or doctoral degrees.
- C. Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.
- D. Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increases the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.
- E. Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.
- F. Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with

Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division.

- G. Promotion of the employment of mental health consumers and family members in the mental health system.
- H. Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).
- I. Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
- J. Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

The Five-Year Plan will be accompanied by a five-year budget that will allocate remaining State MHSA WET program funding for the next five years. This five-year budget will allow the opportunity provide changes to the funds remaining from the prior ten-year budget developed in 2008. Per WIC Section 5820 (e), the Five-Year Plan requires final approval from the Mental Health Planning Council by April 2014.



## Mental Health Services Act - Workforce Education and Training Five-Year Plan Phase-1 Stakeholder Engagement Process Overview

Proposition 63 – the Mental Health Services Act (MHSA) – funds Workforce Education and Training (WET) Programs. Per Welfare and Institutions Code Section 5822, the Office of Statewide Health Planning and Development (OSHPD) is accountable for the development of the MHSA WET Five-Year Plan (WET Five-Year Plan).

The WET Five-Year Plan provides a framework for the advancement and development of mental health workforce, education and training programs at the State and local level. Specifically, the WET Five-Year Plan provides the vision, values, mission, measureable goals and objectives, proposed actions and strategies, funding principles, and performance indicators for mental health workforce funding.

To ensure the development of a comprehensive plan, OSHPD is employing a robust stakeholder engagement process to engage diverse stakeholder groups through different strategies that include:

### Focus Groups/Community Forums

OSHPD will engage stakeholders through 14 focus groups/community forums throughout the different regions of the State. The focus groups/community forums will inform stakeholders on MHSA WET programs and solicit feedback on the elements and priorities that should be included in the next WET Five-Year Plan. OSHPD will engage regions used by the MHSA WET Regional Partnerships which include Superior, Bay Area, Central, Southern, and Los Angeles regions. A County breakdown of each region and the number of proposed meeting to be set can be found below:

- *Superior Region* (Counties: Modoc, Siskiyou, Del Norte, Humboldt, Trinity, Shasta, Lassen, Sierra, Nevada, Plumas, Butte, Glenn, Tehama, Lake, Mendocino, Colusa)
  - 3 focus groups/community forums
- *Bay Area Region* (Counties: Alameda, City of Berkeley, Contra Costa, Marin, Napa, San Francisco, Santa Clara, San Mateo, Solano, Sonoma, Monterey, San Benito, Santa Cruz)
  - 3 focus groups/community forums
- *Central Region* (Counties: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter/Yuba, Tulare, Tuolumne and Yolo)
  - 3 focus groups/community forums

- *Southern Region* (Counties: San Luis Obispo, Santa Barbara, Ventura, Kern, Tri-City Mental Health, San Bernardino, Riverside, Imperial, Orange, San Diego)
  - 3 focus groups/community forums
- *Los Angeles Region* (County: Los Angeles)
  - 2 focus groups/community forums

There are numerous MHSA WET stakeholder organizations that meet regularly. To the extent possible, OSHPD will also request time at regularly scheduled stakeholder meetings to conduct mini-focus groups. (For example: State Mental Health Planning Council meetings, Song-Brown Commission meeting, Healthcare Workforce Development Council meeting, WET Contractor's Board meetings...etc.).

### **Key-Stakeholder Interviews**

OSHPD will engage key stakeholder groups through phone and in-person interviews. The interviews will be used to solicit feedback from key stakeholder groups on elements that should be included in the WET Five-Year Plan.

### **WET Advisory Committee and WET Five-Year Plan Advisory Sub-Committee**

OSHPD will engage experts and stakeholders through the WET Advisory Committee (Committee) and WET Five-Year Plan Advisory Sub-Committee (Sub-Committee) meetings. Committee and Sub-Committee members will be able to provide their feedback and their stakeholder's feedback when discussing the WET Five-Year Plan elements during the meetings. Additionally, there will be time set aside for public comment at every Committee and Sub-Committee meeting, which allows public members attending in-person or by-phone to provide input on the different elements discussed during the meetings.

### **Webinars and Surveys**

There are numerous stakeholders that may not be able to attend the focus groups/community forums, WET Advisory Committee meetings, and/or be involved in the key-stakeholder interviews. OSHPD will engage these stakeholders through webinars and surveys and will utilize these webinars to inform stakeholders about MHSA WET Programs and the WET Five-Year Plan. The webinars will be available online to allow stakeholders who do not have the opportunity to attend in person, to watch at their own leisure. OSHPD will subsequently send out surveys to engage stakeholders to solicit their feedback on what should be included in the WET Five-Year Plan.

### **County Site Visits (To Be Determined)**

As there are funding limitations, OSHPD is evaluating the possibility of engaging county site visits, and the total number of site visits conducted.



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## WET Five Year Plan Stakeholder Engagement Community Forums

OSHPD will engage stakeholders through 14 focus groups/community forums throughout the different regions of the State. The focus groups/community forums will inform stakeholders on MHPA WET programs and solicit feedback on the elements and priorities that should be included in the next WET Five-Year Plan. OSHPD will engage regions used by the MHPA WET Regional Partnerships which include Superior, Bay Area, Central, Southern, and Los Angeles regions. A County breakdown of each region and proposed locations for meetings can be found below:

- *Superior Region* (Counties: Modoc, Siskiyou, Del Norte, Humboldt, Trinity, Shasta, Lassen, Sierra, Nevada, Plumas, Butte, Glenn, Tehama, Lake, Mendocino, Colusa)
  - Butte County
  - Shasta County
  - Humboldt
- *Bay Area Region* (Counties: Alameda, City of Berkeley, Contra Costa, Marin, Napa, San Francisco, Santa Clara, San Mateo, Solano, Sonoma, Monterey, San Benito, Santa Cruz)
  - Napa County
  - Alameda County
  - Monterey County
- *Central Region* (Counties: Alpine, Amador, Calaveras, El Dorado, Fresno, Inyo, Kings, Madera, Mariposa, Merced, Mono, Placer, Sacramento, San Joaquin, Stanislaus, Sutter/Yuba, Tulare, Tuolumne and Yolo)
  - Sacramento County
  - Modesto County
  - Tulare County
- *Southern Region* (Counties: San Luis Obispo, Santa Barbara, Ventura, Kern, Tri-City Mental Health, San Bernardino, Riverside, Imperial, Orange, San Diego)
  - San Diego County
  - San Bernardino County
  - Ventura County
- *Los Angeles Region* (County: Los Angeles)
  - Los Angeles, North
  - Los Angeles, South



## Office of Statewide Health Planning and Development

**Draft Questions for WET Five-Year Plan Stakeholder Engagement**Broad Questions

1. What are the most significant mental health workforce development challenges in your region?
  - What actions are needed to address the most significant mental health workforce development challenges in your region?
2. What successful models of mental health workforce education and training currently exist to supply the mental health workers necessary to meet the region's needs?
3. What partnerships are you involved in that you believe will be necessary at the state and regional level to meet the mental health workforce needs of this region? (e.g., local workforce investment boards, Counties, one-stop career centers, community colleges, adult education, private training institutions)
  - What actions are necessary to strengthen existing partnerships and/or form new partnerships?
4. What resources are currently being invested or utilized in the region to recruit, educate, train or retain the mental health workforce and strengthen partnerships?
  - Where is additional investment needed?
5. What elements are key to the development and expansion of mental health providers and included in the MHSA WET vision, values and mission?

Questions Specific to the Statutory Elements that must be in the Five-Year Plan

6. What are the barriers to expanding the capacity of postsecondary education for mental health workforce programs?
  - What actions are needed to expand the capacity of postsecondary education in order to meet the mental health workforce needs?
7. What are the barriers to utilizing and/or expanding stipend, forgiveness, and scholarship programs offered in return for a commitment to employment in California Public Mental Health System?
  - What actions are needed to utilize and/or expand stipend, forgiveness and scholarship programs offered in return for a commitment to employment in California Public Mental Health System?
8. What are the barriers to expanding outreach to multicultural communities, increasing the diversity of the mental health workforce, reducing stigma associated with mental illness; and promoting web-based technologies/distance learning techniques?

- What actions are needed to expand outreach to multicultural communities, increasing the diversity of the mental health workforce, reducing stigma associated with mental illness; and promoting web-based technologies/distance learning techniques?
9. What are the barriers to recruiting high school students for mental health occupations, increasing the mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation center programs, and increasing the number of human service academies?
    - What actions are needed to increase the recruitment of high school students for mental health occupations, increasing the mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation center programs, and increasing the number of human service academies?
  10. What are the barriers to train and retain staff to provide appropriate prevention, early intervention, and service needs for mental health consumers?
    - What actions are needed to train and retain staff to provide appropriate prevention, early intervention, and service needs for mental health consumers?
  11. What are the barriers to employing mental health consumers and family members in the mental health system
    - What actions are needed to increase employment of mental health consumers and family members in the mental health system?
  12. What are the barriers to including mental health consumer and family member, and their viewpoints and experiences in the training and education programs
    - What actions are needed to include mental health consumer and family member, and their viewpoints and experiences in the training and education programs?
  13. What are the barriers to include diverse, racial, and ethnic community members in the mental health provider networks?
    - What actions are needed to include diverse, racial, and ethnic community members in the mental health provider network?
  14. What are the barriers to including cultural competency in the mental health workforce training and education programs?
    - What actions are needed to include cultural competency in the mental health workforce training and education programs?

#### **Questions for WET Five-Year Plan Advisory Sub-Committee Members**

1. Are we missing questions on elements relevant to WET that we should be collecting in the stakeholder engagement process?
2. How can we best word/frame these questions to make them understandable and get the most feedback?
3. What type of questions would be most relevant to ask during open community forums?



## Draft Changes to WET Five-Year Plan Vision, Values AND Mission Statement

This draft WET Five-Year Plan Vision, Values, and Mission statement is intended for discussion and is not a final document. This draft was developed from the first WET Five-Year Plan and has received changes from initial WET Advisory Committee input. This draft will be presented at various venues for discussion by experts and stakeholders. If you would like to provide feedback on the draft vision, values, and mission please email Sergio Aguilar at [Sergio.Aguilar@oshpd.ca.gov](mailto:Sergio.Aguilar@oshpd.ca.gov)

### VISION

***We The Office of Statewide Health Planning and Development (OSHPD) envisions a public mental health workforce, which includes consumers clients and family members, sufficient in size, diversity, skills and resources to deliver equitable and compassionate, culturally and linguistically responsive, safe, timely and effective mental health services to all individuals across the lifespan who are in need and their families and caregivers in multiple healthcare systems and settings, and contributes to increased prevention, wellness, recovery and resilience for the people of California.***

Strength-based mental health service delivery that embodies the principles of wellness, recovery and resilience is being recognized as essential to preventing costly, inappropriate, and often involuntary treatment across healthcare systems and settings. It also enables individuals to live, work, learn, and fully participate in the communities of their choice.

Significantly expanding the role of individuals, families and the community in the recovery process is an effective strategy to address workforce shortages, as the focus shifts to competencies that can be learned and utilized by many individuals who can serve as non-licensed professionals in the public mental health system. ~~do not have advanced degrees, credentials or licenses.~~

The additional resources provided by the passage of the Mental Health Services Act (MHSA) present the potential for new and expanded services to enable a full spectrum of care that includes an integrated behavioral health, mental health, substance abuse, and primary care service delivery across multiple healthcare systems and settings. Through the Five-Year Plan, resources may be utilized to facilitate the expansion of multi-disciplinary and interdisciplinary training which takes into account the diverse needs of racial and ethnic minorities and other unserved, and underserved, and inappropriately served populations such as children and youth, transition-aged youth, adults and older adults across the lifespan. To bring the full vision of the MHSA to fruition, behavioral health, mental health, and substance abuse and related systems must be able to develop a full range of strategic alliances and structures that can accommodate an ever-changing service needs picture landscape and quickly respond to current and future opportunities, such as those presented by State and Federal healthcare reforms.

## VALUES

In collaboration with its stakeholders, the Department OSHPD has developed a set of core values that guide all activities included in the Five-Year Plan:

- **Develop a diverse workforce, *that includes diverse, racial and ethnic community members underrepresented in the public mental health provider networks, and mental health consumers and including clients and families/ caregivers, with the skills to:***
  - **Promote wellness, recovery and resilience and other positive *behavioral health, mental health, substance abuse, and primary care* outcomes**
  - **Work collaboratively to deliver individualized, *client consumer- and family-driven* services**
  - **Use effective, *innovative, community-identified, and where possible, evidence-based* practices**
  - **Conduct outreach to *and engagement with* unserved and underserved *and inappropriately served* populations**
  - **Provide *preventative and treatment* services that are *linguistically and culturally competent and relevant* *culturally and linguistically responsive to diverse needs***
  - **Promote ~~multi-disciplinary~~ and interdisciplinary care *by working across disciplines***
- **Include the viewpoints and expertise of ~~clients~~ *consumers* and their families/caregivers *in multiple healthcare settings***

The Department OSHPD, again with input from its partner agencies, ~~clients~~ *consumers* and family members and other stakeholders, *will* utilize the vision and values to develop the following Mission Statement to guide all *mental health* Workforce Education and Training activities:

## MISSION STATEMENT

**California's public mental health system will develop and maintain a sufficient *and diverse public mental health* workforce capable of providing ~~client~~ *consumer* and family-driven, *equitable and compassionate, culturally competent and linguistically responsive* services, *across the lifespan* using effective methods that promote wellness, recovery and resilience and other positive *behavioral health, mental health, substance abuse, and primary care* outcomes *across healthcare systems and settings.***

### Text Color Legend

~~Black Text~~=Original Five-Year Plan language

~~Black Strikeout Text~~= Original Five Year Plan Language Deleted

**Red Text**= Changes proposed by OSHPD

**Green Text**= Changes proposed at the WET Advisory Committee Meeting 1/29/2013

"Access to Safe, Quality Healthcare Environments that Meet California's Diverse and Dynamic Needs"



## **Mental Health Workforce Needs Assessment Background and Draft Scope of Work**

Per Welfare and Institution Code Section 5820, Office of Statewide Health Planning and Development (OSHPD) is engaged in the process of developing the next Five-Year Workforce Education and Training (WET) Development Plan (Five-Year Plan) which provides a framework for the advancement and development of the mental health WET programs at the local, regional, and state level. To ensure the development of a comprehensive plan, OSHPD is conducting a mental health workforce needs assessment that identifies and evaluates mental health workforce needs.

Per WIC Section 5820 (b) OSHPD will work with the counties to collect needs assessment data identifying shortages and supply of workforce needed to provide mental health services.

### **Draft Contractor Mental Health Needs Assessment Scope of Work**

Contingent on funding approval, OSHPD is going to contract an expert to compile and analyze the Counties needs assessment data and develop a statewide mental health workforce needs assessment report. The Contractor will provide to the department:

1. An analysis of information currently available on public mental health workforce shortages and corresponding educational and training capacity;
2. An analysis of current mental health workforce and educational/training capacities and shortfalls;
3. Estimates of long-term mental health workforce needs and recommendations for meeting those needs; and
4. Mental health workforce outcomes benchmarks and the means to evaluate progress towards meeting these benchmarks.

Specifically, the contractor will:

1. Outline workforce shortages by occupational classification, geographical region, race/ethnicity, and language proficiency.
2. Analyze ethnic diversity/language proficiency needs by occupation and geographical need.
3. Identify the workforce needs of individuals with consumer and family member experience to enter and retain employment at all levels of the public mental health system.
4. Analyze service provider training, technical assistance, and support needs.
5. Analyze vacancy and turnover rates to identify workplace retention variables.
6. Address geographic imbalances in the distribution of licensed and unlicensed mental health professionals.
7. Compare the needed growth of the workforce to the growth of the population over time.

8. Assist in the establishment of personnel to population ratio benchmarks for various occupational classifications.
9. Compare the current admissions/graduation rates of educational programs to that which is feasible over time to address various occupational shortfalls and imbalances.

**California’s Public Mental Health Workforce: A Needs Assessment**

Table 7. Authorized FTE (Col. 2) and Additional FTE needed to meet current needs (Col. 4) (extrapolated from size/density totals)

Major Group, Position	Authorized FTE	Additional FTE Needed to Meet Current Needs	
		Number	As % of Authorized
<b>A. Unlicensed Mental Health Direct Service Staff:</b>			
Mental Health Rehabilitation Specialist.....	3,560	1,201	33.7%
Case Manager/Service Coordinator.....	3,817	815	21.4
Employment Services Staff.....	363	483	133.1
Housing Services Staff.....	427	306	71.7
Consumer Support Staff.....	1,293	1,368	105.8
Family Member Support Staff.....	680	645	94.9
Benefits/Eligibility Specialist.....	285	171	60.0
Other Unlicensed MH Direct Service Staff.....	4,451	890	20.0
<i>Sub-total (or, Avg.), Major Group A</i>	<b>14,876</b>	<b>5,879</b>	<b>39.5%</b>
<b>B. Licensed Mental Health Staff (direct service):</b>			
Psychiatrist, general.....	1,067	336	31.5%
Psychiatrist, child/adolescent.....	323	241	74.6
Psychiatrist, geriatric.....	53	112	211.3
Psychiatric or Family Nurse Practitioner.....	116	124	106.9
Clinical Nurse Specialist.....	713	157	22.0
Licensed Psychiatric Technician.....	666	234	35.1
Licensed Clinical Psychologist.....	1,201	162	13.5
Psychologist, registered intern (or waived).....	576	152	26.4
Licensed Clinical Social Worker (LCSW).....	2,175	971	44.6
MSW, registered intern (or waived).....	2,046	401	19.6
Marriage and Family Therapist (MFT).....	2,316	878	37.9
MFT registered intern (or waived).....	3,105	623	20.1
Other Licensed MH Staff (direct service).....	354	55	15.5
<i>Sub-total (or, Avg.), Major Group B</i>	<b>14,711</b>	<b>4,448</b>	<b>30.2%</b>
<b>C. Other Health Care Staff (direct service):</b>			
Physician.....	116	36	31.0%
Registered Nurse.....	1,137	343	30.2
Licensed Vocational Nurse.....	496	108	21.8
Physician Assistant.....	14	28	200.0
Occupational Therapist.....	128	120	93.8
Other Therapist (physical, recreation, art, dance).....	149	95	63.8
Other Health Care Staff (direct service).....	687	180	26.2
<i>Sub-total (or, Avg.), Major Group C</i>	<b>2,727</b>	<b>910</b>	<b>33.4%</b>
<b>D. Managerial and Supervisory:</b>			
CEO or manager above direct supervisor.....	1,924	403	20.9%
Supervising Psychiatrist (or, other physician).....	183	89	48.6
Licensed supervising clinician.....	1,845	804	43.6
Other managers and supervisors.....	2,464	378	15.3
<i>Sub-total (or, Avg.), Major Group D</i>	<b>6,416</b>	<b>1,674</b>	<b>26.1%</b>
<b>E. Support Staff:</b>			
Analysts, tech support, quality assurance.....	1,653	580	35.1%
Education, training, research.....	404	125	30.9
Clerical, secretary, administrative assistants.....	5,290	1,571	29.7
Other support staff (non-direct service).....	2,446	562	23.0
<i>Sub-total (or, Avg.), Major Group E</i>	<b>9,793</b>	<b>2,838</b>	<b>29.0</b>
<b>Total (or, Avg.), all Major Groups and Positions.....</b>	<b>48,512</b>	<b>15,749</b>	<b>32.5%</b>



## Office of Statewide Health Planning and Development



*"Equitable Healthcare Accessibility for California"*

## **Career Pathway Sub-Committee- Background and Phase III Process**

### Background

In April 2011, the California Workforce Investment Board (State Board), in concert with the Office of Statewide Health Planning and Development (OSHPD), convened a sub-committee of its Health Workforce Development Council called the Career Pathway Sub-Committee (Committee). The Committee was comprised a cross-section of educational system representatives, employers, workforce development professionals, advocacy and professional associations, and researchers. The Committee was charged with developing statewide planning recommendations that address the following six areas:

- Existing and potential health career pathways that may increase access to primary care
- Existing education and training capacity and infrastructure to accommodate the career pathways needed to increase access to primary care
- Academic and healthcare industry skill standards for high school graduation, entry into postsecondary education, and various credentials and licensure
- Availability of career information and guidance counseling to existing and potential health professions students and residents
- Big picture issues around recruitment, retention, attrition, transfer, articulation and curricular disconnects, and the identification of policies needed to facilitate the progress of students between education segments in California
- Need for pilot/demonstration projects in eligible health personnel categories, or new health personnel categories

For purposes of the Committees charge and process, “career pathways” were defined as a coordinated set of components which, when aligned correctly, provide a “pathway” to achieve a sufficient supply, distribution and diversity of qualified candidates for a specific health profession. The Committee adopted a common framework for pathway development (Appendix One) and used the framework to develop the pathways for 12 professions in two different phases. The Committee engaged experts in the various occupations analyzed for the initial development of the career pathways that were subsequently presented to the Committee for review and approval.

For Phase I, the Committee developed pathways for primary care physicians, primary care nurses, clinical laboratory scientists, medical assistants, community health workers, public health professionals, and social workers (Appendix Two (Sample)). For Phase II, the Committee developed pathways for home health aides and certified nurse assistants, physician assistants, oral health, imaging technologists, and military veterans. The full report that includes Phase I and II can be found through the following

link: <http://www.oshpd.ca.gov/Reform/CareerPathwaySubCommitteePhase2FinalReport.pdf>

### Phase III

OSHPD in concert with the State Board is re-convening the Committee for Phase III which will focus solely on Behavioral Health, Mental Health, and Substance Abuse occupations. The development of

career pathways for Behavioral Health, Mental Health, and Substance Abuse occupations will be part of the development of the next Workforce Education and Training (WET) Five-Year Plan. For Phase III, the Committee will be comprised of experts and stakeholders that include a cross-section of educational system representatives, employers, workforce development professionals, advocacy and professional associations, and researchers including members from the Health Workforce Development Council and WET Advisory Committee.

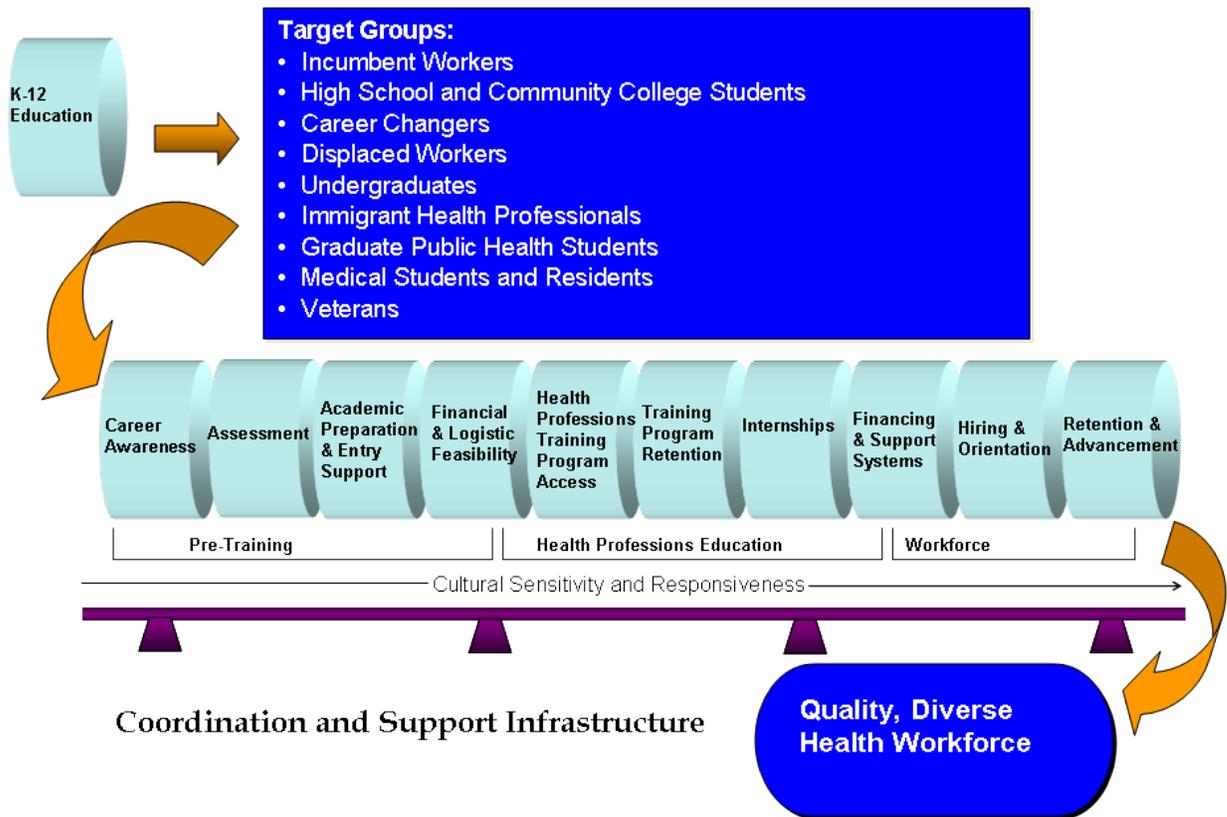
For Phase III, OSHPD and the State Board are proposing to develop pathways for the following disciplines:

- Clinical Psychologist;
- Marriage and Family Therapists;
- Licensed Professional Clinical Counselors
- Peer Counselors;
- Psychiatrists;
- Psychiatric Mental Health Nurse Practitioner/Clinical Nurse Specialists; and
- School Psychologist

The Committee will meet at most, four times between July 1 and September 30 to develop the career pathways via the same framework that was used during Phase I and II of the Committee process (Appendix 1). The Committee will engage experts in each discipline examined to aid in the development of the career pathways. A report for Phase III of the Committee’s work will be developed and subsequently integrated with the work completed during Phase I and II.

**Appendix One**

**Coordinated Health Workforce Pathway**



## **Appendix Two Social Workers (Sample of Completed Pathway)**

### ***Background Information***

#### ***CURRENT SITUATION AND FUTURE NEED***

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Social workers practice in community and institutional settings ranging from physical health care facilities and mental health settings to schools. They reflect the populations served culturally and ethnically. In these venues social workers perform the following functions: Screening and assessment of clients/consumers (93%); information and referral services (91%); crisis intervention (89%); individual therapy (86%); and, health and mental health casework/planning (86%). Parentheses indicate percentage of social work activities in venues listed above.

California has a need for an estimated 22,000 social workers, factoring in expected growth in the insured health population due to the PPACA. This need is projected through 2015. Specifically, 17,000 are needed in urban areas throughout the state and 5,000 are needed in rural areas (regarding rural areas, see Superior Regional Workforce Education and Training Study). According to the National Association of Social Workers and Federal Labor Board, there are approximately 60,000 social workers in California out of a needed 82,000. Unfortunately 20 to 25% of these workers call themselves social workers, but have neither a BSW nor MSW.

California's social worker shortage crosses all service areas, including: child welfare, mental health, physical health, developmental disabilities, aging, and adult protective services. Specifically, social workers work and are needed in these areas in these proportions: 37% mental health, 20% health, 15% children and family public services, 10% aging, and 18% other (BBS and NASW).

Social workers practice as part of health care teams, and are specifically trained to address the psychosocial implications of acute and chronic illnesses. They practice across the continuum of care including community and public health clinics, hospitals, nursing homes, home health care, primary care, prisons, veteran service networks, and hospices (Asua Ofosu, JD, Manager, Government Relations National Association of Social Workers). The new health care law requires health plan benefits to include mandatory mental health, substance use, and preventive services. Many times social workers are often the only providers delivering these services in rural and underserved areas (Asua Ofosu). In fact, the Patient Protection and Affordable Care Act provides the opportunity for a radical shift in the way patients and their families are cared for. It recognizes that the *patient* should be at the center of medical care. Meeting this challenge requires improved coordination of care over time and across multiple settings provided by professionally educated social workers (Robyn L. Golden, LCSW, Rush University Medical Center).

Pilot studies done in community based health care settings, the VNA home hospice, and Kaiser's Tri-Central Region demonstrated that social workers on inter-disciplinary teams were effective in reducing hospital admissions and emergency room visits (Cherin, 1998; Enguidanos, 2003). In these studies as in social work practice, social workers perform using a focus on person-in-environment/ecological perspective with regard to psychosocial assessments, diagnosis, interventions and outcomes evaluation. Practice in these cases leads to development of patient advocacy in the form of policy practice among care teams and within systems. Social workers in

direct service meet with patients develop a psychosocial assessment, develop plans of action for given circumstances, represent patients/clients/consumers with the care team, provide onsite visits and connect clients with services, (discharge planning), and provide team coordination and training both for teams and clients/consumers/patients.

Some of the primary areas in which social workers are critical include mental health, aging, and substance abuse. Mental health and substance abuse social worker professionals represent the largest sector of these types of providers in California's mental health workforce with an estimated current employment of 14,010. In the next several years demand for social workers in this arena is expected to increase by 35.4% (Center for the Health Professionals, University of California, San Francisco, 2009). As defined by HRSA, social workers will represent a critical force working on behavioral health in the affordable care act, working with consumers on mental health issues as well as the broader aspects of lifestyle and management of chronic illness (HRSA email on PPACA and Social Work, 2011). In fact, California's community-based, public mental health resources groups indicated in surveys that positions that were the hardest to fill or retain by order of difficulty and need were first, general psychiatrists, and second, licensed clinical social workers (LCSW) (California Department of Mental Health, 2009). In particular, the Bureau of Labor Statistics in 2008 found that the median average salary for health and mental health social workers was approximately \$46,000, and projected growth in new positions in these areas alone would be 34% between 2008 and 2018.

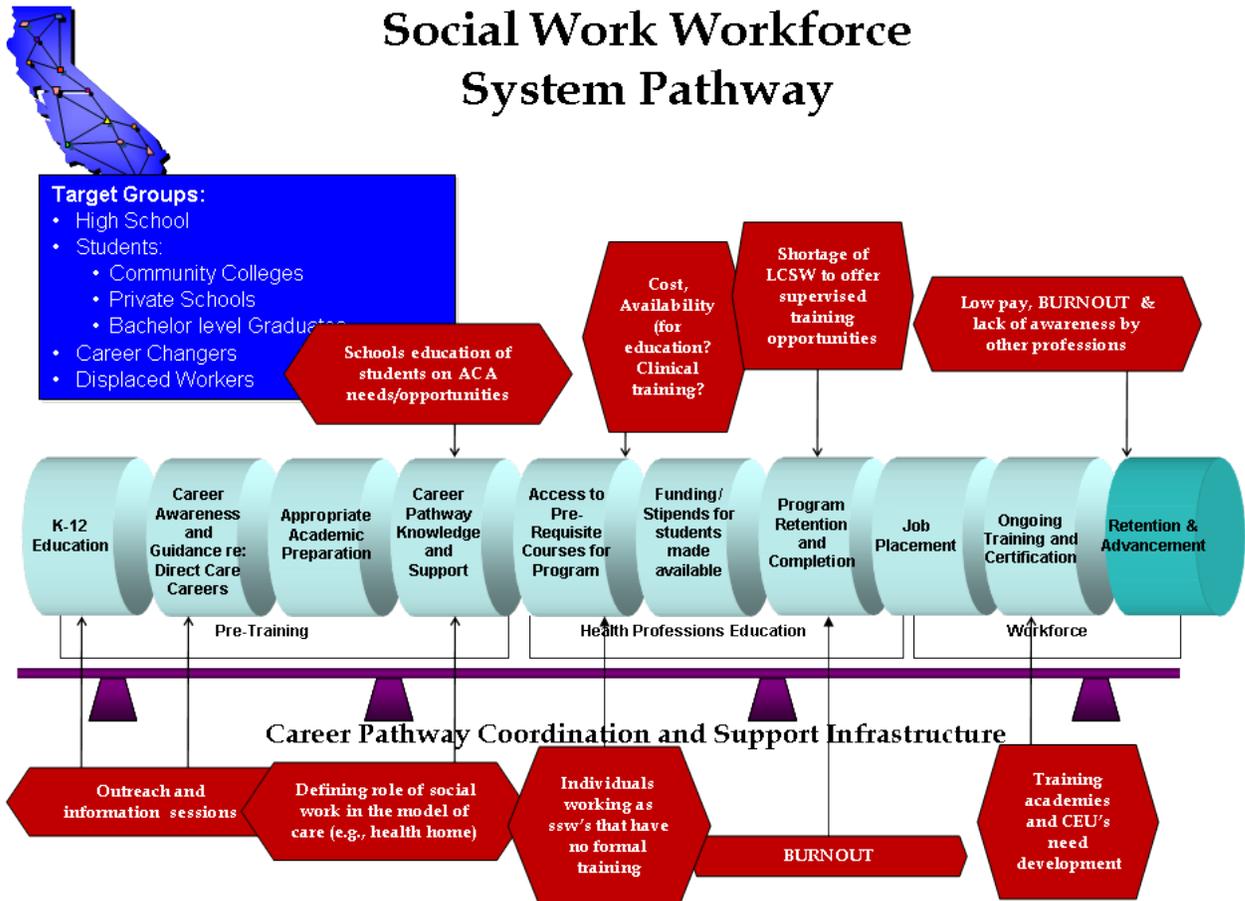
The PPACA will have a major impact on California's health workforce needs because it will substantially increase the number of Californians with health insurance. In particular, as many as up to 3 million Californians will be newly eligible for Medi-Cal, the state's Medicaid program (Cabezas and Laverreda). This Medi-Cal population is currently served in county social service and mental health systems throughout California by trained social workers. Social workers will continue to provide an array of services to this population as well as a growing number of senior citizens. In sum, this will require additional social workers in these public venues.

Dr. David Cherin and the California Social Work Education Center (CalSWEC) developed the pathway and recommendations for the Committee. Below are the Committee's recommendations to the Council for Social Work.

## Pathway and Components

### VISUAL DEPICTION

The pathway below represents the final system pathway developed for social workers in California. The barriers and recommendations developed are detailed in the following section.



### BARRIERS AND RECOMMENDATIONS

**Table H-1. Social Workers Pathway Barriers and Recommendations**

BARRIER	RECOMMENDATION
<ul style="list-style-type: none"> <li>• Outreach to Target Groups needs to be improved</li> </ul>	<ul style="list-style-type: none"> <li>• Marketing and ongoing information sessions need to be developed at Schools and Departments of Social Work with local high schools and community colleges and out of state institutions. This can be accomplished through use of CalSWEC's infrastructure and articulation committee designed to meet needs of students moving between high school, community colleges and four year colleges.</li> <li>• Develop a better articulated career pathway from high school through the MSW degree working with Secondary</li> </ul>

**Table H-1. Social Workers Pathway Barriers and Recommendations**

BARRIER	RECOMMENDATION
	<p>educational experts and CalSWEC, using concepts such as a service learning model and certificate requirements.</p>
<ul style="list-style-type: none"> <li>• Programs in social work need to create awareness on the part of incoming students of PPACA and opportunities. Without placements and stipends interested students will not have incentives to pursue careers</li> </ul>	<ul style="list-style-type: none"> <li>• Develop placements related to PPACA through California Fieldwork consortiums and training academies.</li> <li>• Develop stipend programs through CalSWEC infrastructure to model mental health and child welfare funding streams. Possibly expand the use of Title-IV-E and Mental Health Service Act.</li> <li>• Advertise social work as a job avenue for recent college graduates from other disciplines entering the work world.</li> </ul>
<ul style="list-style-type: none"> <li>• Establish role of social work among health professionals to convey value of social work</li> </ul>	<ul style="list-style-type: none"> <li>• Continue evidenced based pilot studies of social work in health teams that validate effectiveness, e.g., Kaiser Tri-Central Study and VNA/HRSA study.</li> <li>• Continue to define role of the social worker in health teams, including complementary role with other team members such as substance abuse counselors.</li> <li>• Use CalSWEC infrastructure to fund statewide research initiatives and coordinate overall recommendations.</li> <li>• Work with State and Board of Behavioral Sciences to support social work title protection so that skills levels and education that are required for offering social work services are clearly identified and protected. This will provide stronger incentives to enter the field and enhance recruitment.</li> <li>• Explore a requirement for formalized training for individuals working in social work capacity that have no formal social work education.</li> </ul>
<ul style="list-style-type: none"> <li>• Retention of students and professionals in practice (e.g., overwhelmed by heavy caseload, lack of clear career pathway)</li> </ul>	<ul style="list-style-type: none"> <li>• CalSWEC funded studies and curriculum have identified factors causing burnout. Workload continues to be the major problem. Increasing the number of social workers will alleviate some of the problem. Reconfiguring delivery through community teams as delineated in Superior Northern California Study.</li> <li>• Use distance education to upgrade skills of existing staffs, especially in rural areas, to develop newly educated social workers that are trained and upgraded in place</li> <li>• Examine whether compensation is a barrier for practitioners.</li> </ul>
<ul style="list-style-type: none"> <li>• In order to maintain currency CEU courses related to PPACA will have to be developed</li> </ul>	<ul style="list-style-type: none"> <li>• CalSWEC has regional training academies to develop ongoing education and delivery mechanisms.</li> <li>• Schools of Social Work will have to incent faculty to develop ongoing training material and deliver same through CEU certifications that belong to each school.</li> </ul>
<ul style="list-style-type: none"> <li>• Shortage of LCSW to offer supervised training opportunities</li> </ul>	<ul style="list-style-type: none"> <li>• Address shortage by increasing training opportunities.</li> <li>• Explore other ways to meet need for supervision in training programs (e.g., other methodologies for</li> </ul>

**Table H-1. Social Workers Pathway Barriers and Recommendations**

BARRIER	RECOMMENDATION
	supervision such as tele-supervision).

**INDIVIDUAL PATHWAYS**

In their 2004 Master Plan, the Deans and Directors of Social Work programs in California created a ladder of learning delineating individuals' social work career pathway.

**Table H-2. Social Work Ladder of Learning**

LADDER LEVEL	DESCRIPTION	CURRENT GRADUATES PRODUCED	FUTURE GRADUATES NEEDED	WORK SKILL SETS GRADUATE WILL HAVE	JOB CLASSIFICATIONS
1	<ul style="list-style-type: none"> <li>High School Certificate</li> </ul>	<ul style="list-style-type: none"> <li>Unknown (survey needed)</li> </ul>	<ul style="list-style-type: none"> <li>Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>Interactive skills, introductory knowledge of theory and practice</li> </ul>	<ul style="list-style-type: none"> <li>Apprentice Social Worker</li> </ul>
2	<ul style="list-style-type: none"> <li>AA degree</li> </ul>	<ul style="list-style-type: none"> <li>Unknown (survey needed)</li> </ul>	<ul style="list-style-type: none"> <li>Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>Introductory intervention skills, some basic assessment.</li> </ul>	<ul style="list-style-type: none"> <li>Assistant Social Worker</li> </ul>
3 (optional)	<ul style="list-style-type: none"> <li>Certificate</li> </ul>	<ul style="list-style-type: none"> <li>Not yet fully developed</li> </ul>	<ul style="list-style-type: none"> <li>Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>As above, plus knowledge of service delivery systems and community assets and services</li> </ul>	<ul style="list-style-type: none"> <li>Trainee Social Worker</li> </ul>
4	<ul style="list-style-type: none"> <li>BSW</li> </ul>	<ul style="list-style-type: none"> <li>300 per year</li> </ul>	<ul style="list-style-type: none"> <li>Need 18,700 combined MSW and BSW</li> </ul>	<ul style="list-style-type: none"> <li>Casework, community assessment and knowledge of policy</li> </ul>	<ul style="list-style-type: none"> <li>Social Worker One</li> </ul>
5 (optional)	<ul style="list-style-type: none"> <li>Certificate</li> </ul>	<ul style="list-style-type: none"> <li>Not yet fully developed</li> </ul>	<ul style="list-style-type: none"> <li>Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>Advanced case management and community intervention skills</li> </ul>	<ul style="list-style-type: none"> <li>Social Worker Two</li> </ul>
6	<ul style="list-style-type: none"> <li>MSW</li> </ul>	<ul style="list-style-type: none"> <li>1,200 per year</li> </ul>	<ul style="list-style-type: none"> <li>Need 18,700 combined MSW and BSW</li> </ul>	<ul style="list-style-type: none"> <li>Sophisticated individual and group skills as well as casework</li> </ul>	<ul style="list-style-type: none"> <li>Social Worker Three</li> </ul>

**Table H-2. Social Work Ladder of Learning**

LADDER LEVEL	DESCRIPTION	CURRENT GRADUATES PRODUCED	FUTURE GRADUATES NEEDED	WORK SKILL SETS GRADUATE WILL HAVE	JOB CLASSIFICATIONS
				expertise, supervisory and leadership skills, ability to evaluate practice and understand research	
7a Practice	<ul style="list-style-type: none"> <li>• Various Licenses</li> </ul>	<ul style="list-style-type: none"> <li>• At present only one kind of license: a clinical license. Currently 300 per year pass oral exam.</li> </ul>	<ul style="list-style-type: none"> <li>• Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>• As above but specialized</li> </ul>	<ul style="list-style-type: none"> <li>• Licensed Social Worker</li> </ul>
7b Education and Research	<ul style="list-style-type: none"> <li>• Doctorate</li> </ul>	<ul style="list-style-type: none"> <li>• 30 per year?</li> </ul>	<ul style="list-style-type: none"> <li>• Need to do workforce study and analysis</li> </ul>	<ul style="list-style-type: none"> <li>• Practice, research and teaching skills</li> </ul>	<ul style="list-style-type: none"> <li>• Social Work Educator and Researcher</li> </ul>

**Ladder of Learning.** Source: California Association of Deans and Directors of Schools of Social Work and the California Social Work Education Center (CalSWEC), 2004).

In addition the detailed provided in the above ladder of learning, Committee members recommended further refining the ladder to more clearly specify specific titles, compensation, core prerequisites, and licensure requirements at each level.

**EDUCATION AND TRAINING CAPACITY AND INFRASTRUCTURE**

California has 25 social work programs in schools/departments across the state. These programs currently graduate approximately 5,500 students annually. In terms of ethnic statistics on these students, the graduates fall within the following categories (CADD, 2003; validated 2011):

- African American/Other Black, Non-Hispanic (10%);
- Native American/Alaskan/American Indian (1%);
- Asian American (10%);
- Latino/Hispanic (32%);
- Pacific Islander (1%);
- White/Non Hispanic Caucasian (36%);
- Multiple Race/Ethnic (0.1%);
- Other (5%); and,

- Unknown (6%).

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### ***ACADEMIC AND HEALTHCARE INDUSTRY SKILL STANDARDS***

Over the past 18 months, CalSWEC and the Deans and Directors of Social Work programs in California have developed a set of competencies that frame both the foundation and advanced years of a social work education in California. These competencies are aligned with the accrediting group's Educational Policy and Accreditation Standards (EPAS) guidelines and delineate the Knowledge, Skills and Attitudes which are explicitly a part of the social work curriculum and frame social work practice. These competencies link social work program goals to measurable program objectives. Through CalSWEC's infrastructure, these competencies are being implemented in all member schools and departments of social work in California.

Competencies in foundation social work education and advanced practice in aging, child welfare and mental health were provided to Committee members as sample competency documents. The Committee recommended further refining these by incorporating linguistic competencies.

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### ***AVAILABILITY OF CAREER INFORMATION AND GUIDANCE COUNSELING***

Career information and guidance counseling is available in California from many sources. However, given the limited time of this project it was not summarized.

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### ***ADDITIONAL RESOURCES***

Additional information can be found in the following resources. These resources were provided to the Committee.

- California Association of Deans and Directors of Schools of Social Work and the California Social Work Education Center (CalSWEC). Master Plan for Social Work Education in the State of California (July 2004).
- Integrated Foundation and Advanced Competencies Draft for Social Work: Mental Health (March 2011).
- Integrated Foundation and Advanced Competencies Draft for Social Work: Child Welfare (March 2011).
- Integrated Foundation and Advanced Competencies Draft for Social Work: Aging (April 2011).
- California Social Work Education Center (CalSWEC). Competency Integration and Revision Project Summary (April 2011).
- Elizabeth J. Clark, National Association of Social Workers. Letter to Donald Berwick re: Proposed Rule on Medicare Shared Savings Program and Accountable Care Organizations; CMS-1345-P (June 6, 2011).
- Pamela Brown, Donna Jensen, Tene Kremling, and Meredith Ray. Distance Education Feasibility Study (October 2009). Funded by Superior Region Workforce, Education and Training Collaborative.