

Policy Analysis:  
Workforce Education and Training Component  
Of the Mental Health Services Act-Proposition 63

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## **Background: Mental Health Services in California**

According to the Center for Mental Health Services Research website (2006), during the 1970s, in an effort to cut costs, California began the process of deinstitutionalization. At this time, people with severe mental illnesses were released from large operated hospitals onto the streets of the community for services. Fagin explains that some of the historical factors underlying this massive change included: (1) the emergence of psychoanalytic thought and the notion that those suffering from mental health illness could be helped through a supportive, therapeutic relationship, (2) the World War II lesson that brief, intensive care on the front could ensure a soldier's rapid return to duty, (3) societies' concern for cramped conditions in Veterans Administration and state hospitals along with an increasing demand to improve the care of their residents (4) and the 1960's social justice movement (p. 112).

While, the goal was to provide better care for those with mental health illnesses, many communities lacked the infrastructure and resources needed to provide sufficient care once people were released from hospitals. In fact, money saved from reduced hospitalization was not reinvested into other community mental health services as had been envisioned. Instead, many of those released from institutions did not succeed and thrive in the community. To the contrary, a good number of the mentally ill became homeless and only received treatment when they came into contact with law enforcement.

As a result of deinstitutionalization and the lack of community-based infrastructure for mental health services, the state of California now faces the challenge of millions of people going without mental health services. According to the Mental Health Services Act (MHSA) "in any year between 5% and 7% of adults and 5% and 9%

of children are affected by serious mental health illness. Approximately, two million children, adults, and seniors in California are affected by a potentially disabling mental illness every year. Untreated mental illness is the leading cause of disability and suicide and imposes high costs on the state and local government. Many people left untreated or with insufficient care see their mental illness worsen. Yet, for too many Californians with mental illness, the mental health services and supports they need remain fragmented, disconnected, and often inadequate, frustrating the opportunity for recovery (p.1).”

In the early 1990’s, through new legislation California began to build a more effective community oriented and county-based mental health system. According to Felton “In 1991, through AB 1288 the California legislature initiated a realignment of both administrative and fiscal responsibility for health, social, and mental health services from the states to counties to increase flexibility, stability of funding and local control. By consolidating sources of mental health funds into a single dedicated sales tax, funding across counties was equalized through redistribution while overall costs decreased.” In addition, MHSA (2004) describes how AB 34 was recognized in 2003 as a model program by the President’s Commission on Mental Health. This program combines prevention services with a full range of integrated services to treat the whole person, with the goal of self sufficiency. These programs, including prevention, emphasized client centered, family focused and community based services that are culturally and linguistically competent and provided in an integrated system (p.1).

Building off this legislation and effective programs, the state of California introduced and passed in 2004 MHSA, Proposition 63. The purpose and intent is the following: (1) To define serious mental health illness among children, adults, and seniors as a condition deserving priority attention, including prevention and early intervention

services and medical and supportive care, (2) To reduce the long-term adverse impact on individuals and families and state and local budgets resulting from untreated serious mental illness, (3) To expand the kinds of successful, innovative service programs for children, adults, and seniors begun in California, including culturally and linguistically competent approaches for underserved populations (4) To provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under the pressure (5) To ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to tax payers and to the public. In addition, to provide an equitable way to fund these expanded services while protecting other vital state services from being cut, funding for MHSA comes from very high income individuals who pay an additional one percent of that portion of their annual income that exceeds one million dollars.

The Department of Mental Health has identified the following components or program areas that will receive MHSA funding: Community Services and Supports for children, transition age youth, adults, and older adults, Workforce Education and Training, Capital Facilities and Technical Needs, Prevention and Early Intervention, and Innovative Programs. Given the scale of each component, DMH is implementing each component through a sequential or phased-in approach with five-year plans.

The focus of this policy analysis is on the Workforce Education and Training (WET) component. According to Dr. Mayberg, WET addresses the serious shortage of mental health service providers in California. California was already facing a shortage of public mental health workers prior to the passage of MHSA. Chapter 814, Statutes of 2000 (SB 1748, Perata) required that a Task Force be formed and identify and address

options for meeting the mental health staffing needs of state and county health, human services, and criminal justice agencies. The task force found that for core occupations, such as psychiatrists, psychologists, licensed clinical social workers, registered nurses, and psychiatric technicians, vacancy rates were approximately 20-25 percent statewide. In rural parts of the state, vacancy rate were far higher (p. 4).

Mayberg goes on to explain that due to a history of under-funding, the mental health system has historically suffered from a lack of diversity in the workforce, poor distribution of existing mental health workers, and under-representation of individuals with client and family member experience in the provision of services and supports. Particularly severe shortages exist for mental health practitioners with skills to work effectively with such groups as children, transition aged youth, and older adults and other diverse ethnic/cultural populations heretofore un-served or underserved (p. 4).

### **Intended Outcomes of WET**

The intended outcomes of the Workforce Education and Training (WET) component of the of the Mental Health Services Act (MHSA) revolve around the need to increase the number, skills and diversity of the mental health workforce in order to bring greater and better services to children, as well as an aging and diversifying population.

Unfortunately as the populations in need of mental health services increase, the number of mental health providers with the special skills and credentials required to adequately treat these populations is failing to rise along with the demand; and some specialties are actually seeing a decline. Providers note dissatisfaction with mental health profession for a variety of reasons including low pay, having to spend too much time filling out paperwork rather than treating patients, a lack of access to good training, huge

workloads, a lack of job security, and a deficiency in advancement opportunities. These factors are also translating to a decline in the number students pursuing graduate degrees in mental health professions. As a result, providers are aging faster than new graduates are entering the system. The Annapolis Coalition (2007) reports that over half of clinically trained professionals are older than 50 years of age. The fear is that as these providers retire out of the system, there will be no one available to fill their positions.

America's rural areas are suffering the greatest effects of the mental health worker shortage. More than 85% of areas experiencing a lack of mental health services are rural. The mental health needs of minority populations are also not being fully addressed due to the scarcity of providers with skills in cultural diversity. Non-Hispanic whites make up the majority of mental health professionals – 94.7% of psychologist, 75.7% of psychiatrist, 91.5% of marriage and family therapist, 95.1% of school psychologists, 85.1% of social workers and 90.2% of psychiatric nurses (Anapolis Coalition, 2007). The lack of diversity and cross-cultural training amongst mental health workers has resulted in lack of understanding, and sometimes a misunderstanding, of the mental health needs of America's growing immigrant and minority populations.

Additional factors that account for the pertinence of the Workforce Education and Training component of the MHSA include the necessity to address the needs of seniors as well as children, and individuals with dual diagnosis (i.e. substance abuse and mental health issues). The Workforce Education and Training (WET) piece of the Mental Health Services Act was devised by the California Department of Mental Health (CDMH) to specifically address all of the aforementioned issues, which have impacted California, just as they have the rest of the country. For example, in California alone, the vacancy rate for mental health workers is estimated to be between 20-25% (CDMH, 2008).

WET was developed by CDMH in collaboration with various stakeholders to achieve a number of key outcomes. In order to increase the number of qualified public mental health workers, WET seeks to provide financial incentives such as loans, loan repayments, scholarships and stipends to help current mental health professionals and students gain or maintain employment in the public mental health system. Moreover, to increase diversity and cultural competence amongst the workforce, and improve access to education and training, the plan will establish partnerships between the mental health system and educational system, fund mental health career pathway programs, and utilize distance learning technology and develop culturally competent mental health courses in colleges. An added strategy to attract more workers to the profession includes establishing mental health career development programs in high schools, community colleges and adult education programs (CDMH, 2008).

Another desired goal of MHSA/WET is to attract more mental health clients and family members to the mental health profession. Methods to achieve this outcome involve establishing entry-level mental health employment preparation programs and developing a technical assistance center for clients and families so as to advance employment in the public mental health field. WET also calls for improving the skills of those in the field by conducting ongoing statewide assessment of training needs. Stakeholder and community involvement in the public mental health system is also a vital outcome of the plan, as is ensuring that cultural competence training be included in all aspects of mental health training programs. Cultural and linguistic experts will be recruited to assist in devising training strategies to achieve this goal (CDMH, 2008).

### **Structure and Current Status of the Programs**

Currently, California counties are submitting plans called, “Mental Health Services Act (MHSA) Workforce Education and Training Component Three-Year Program and Expenditure Plans” to the CA state Department of Mental Health (CA DMH) for consideration for MHSA Workforce Education and Training (WET) funding. Each county develops their own WET plan for new programs, tailored to their county’s needs and scaled to proportionate sizes. And although each county’s plan will differ, they all complete the same plan template created by CA DMH. The plan template has six sections; 1-Workforce Face Sheet, 2-Stakeholder Participation Summary, 3- Workforce Needs Assessment, 4-Work Detail (which is where all implementation actions are described in detail), 5-Action Matrix (a cross reference of actions outlined by the county and the goals of WET funding), and a Budget Summary detailing the costs of the proposed plans and the total amount the county is requesting from the WET funds.

This process, while fair and objective, still faces some significant challenges. Each county’s implementation of WET programs will be different and will not have common outcomes. This makes measurement of statewide progress towards WET’s goals difficult, if not impossible. Another challenge is the equity of resources available to individual counties. Smaller counties do not have the same amount of resources on their end to assist them in creating a comprehensive plan. Larger counties like San Francisco and LA have greater abilities to involve more people in a more complex process.

There are three categories of county plans available for review, “Plans Posted for Public Review and Comment”, “Plans Submitted to the state department”, and “Approved Plans”. There are 14 approved plans so far, 7 with submitted status and 5 currently posted for public review

(<http://cmhda.org/go/MentalHealthServicesAct/WorkforceEducationandTrainingWET.as>

px). Of those plans submitted, and even of those approved, it is clear that some counties are better equipped to develop, implement and monitor new programs with WET funds. Larger counties, who usually have more resources, tend to have more complex plans as in the cases of LA (submitted) and San Francisco (approved). While smaller counties seem to have simpler programs planned that cost less. Even among less populated or more rural counties, some plans are more ambitious than others. As we see in the case of Plumas County, a simple plan involving few people will have a minimal impact, compared to more complex and comprehensive plans like San Francisco.

Key to San Francisco's exemplary plan was the involvement of a highly representative group of stakeholders. A committee led the planning process for San Francisco that included county employees, consumers, family members of consumers, and representatives from community-based organizations and higher education institutions. This planning committee held eight meetings and designated time for public comment in each. They also held an entire meeting dedicated to public comment. These meetings were publicly announced and the community was actively invited to join. San Francisco's plan also included formal input from the San Francisco Mental Health Board and the Mental Health Association of San Francisco, which was noted and incorporated where appropriate. The integration of WET programs into the existing mental health community, the interest in public comment and the diversity of the planning committee, all reflect the city's genuine interest in creating an effective plan and are hopefully indicators of a successful plan.

Other aspects of San Francisco's plan that point to successful implementation are the completeness of their data collection and data analysis. Although data collection is outlined in the plan template, some counties, like Plumas, had trouble collecting all the

data requested. Plumas County also chose not to submit any data analysis from the Workforce Needs Assessment, as opposed to San Francisco and LA County who described details about what they found in their respective Workforce Needs Assessments. San Francisco utilized 5 pages for the “Remarks” section following the Needs Assessment. LA used 6 pages; both counties included charts to better explain the data they collected. Plumas County only included 3 sentences in this same section, and those statements described data Plumas county staff thought was important but was not requested.

Another important difference between San Francisco’s plan and the Plumas plan are the definitions and degree of involvement from stakeholders. While San Francisco’s stakeholder group is a diverse array of staff, consumer and community representatives working together to create a comprehensive and effective plan, Plumas County falls very short of this standard. Plumas County’s plan includes a vague list of staff positions involved in the planning process, including program and administrative staff from the county mental health department, (county directors of social services and Human Resources were consulted with). Other stakeholder staffs were sent a written survey for their input, (including client employees, office support, paraprofessionals, therapists, and administrators).

LA County, like San Francisco included an extensive list of stakeholders in their plan, this list also includes what commissions/advisory councils stakeholders participate in, as well as the entity the represent. A stakeholders group led the LA planning process and included representatives from all facets of the system, government staff of all levels, consumers, non-profits, community advocates, etc. LA and San Francisco demonstrate the capacity to include all stakeholders in the planning process.

LA, San Francisco and Plumas all engaged in similar planning processes before the WET planning process, and all counties built on previous planning experiences. But unlike LA and San Francisco, Plumas limited the number of people involved in this process. They probably did this because a smaller planning group can move quicker and they requested a much smaller amount than the larger counties. However, the lack of a diverse and representative stakeholder group could lead to ineffective programs that serve few people. San Francisco spent more time and resources managing a larger stakeholder group and inviting the public into the planning process. But because of their efforts, San Francisco has a much higher probability of successfully implementing meaningful programs.

## **Conclusion and Recommendations**

This paper is an analysis of a legislative experiment that is just beginning to take flight. Workforce, Education, and Training (WET) plans for the counties have only just become approved and programs will just begin to be implemented over the next year.

One challenge of the MHSA legislation is that MHSA carves out money for its own program but does not support DMH as a whole. In the “findings” section of the law it sights the growing problems faced by DMH California. While all of the ideas seem good it does very little to support the already existing under funded programs of the State. The law finds that cause cutting in the 70’s crippled the system but the act itself does little to replace the money disparity needed by hospitals and pre-existing programs (Keefer).

WET is the most important part of MHSA because it contributes to the Mental Health services programs as a whole and provides the expertise upon which all mental

health programs rest. Those that become mental health professionals as a result of the pathways provided by WET will strengthen the field as a whole. Though some educational stipends may be directly linked to MHSA projects their career will undoubtedly broaden with time.

This piece of the MHSA is a clear and direct action towards the dwindling and majority white workforce in the mental health services field. Without the WET programs the quality of mental health services would be seriously compromised in the years to come. These programs are essential to the success of the field in California. In order to insure the success of this program and the industry as a whole we must look critically at the possible problems that the program faces.

There are questions about the usefulness of community involvement in the current structure of the WET programming. MHSA calls for an immense amount of community involvement in decision making for every program designated by the legislation. The community involvement provides each program with guidance to insure they will address the self assessed needs of the stakeholders rather than the perceived need as determined by the state. The local of the community input however may not be effective (Keefer).

The WET division of California is now receiving plans from the counties. The counties themselves are not going to be delivering most of the services directly but rather hiring non-profit agencies to provide the service. Those who administer the services are in no way connected to the involved planning process and therefore marginalizes the community involvement piece. Further the service provider on the individual level may have no connection to the mission as determined by the many focus groups that designed the programs. Stakeholder groups don't have the access and energy to provide true community level accountability to the MHSA programs.

The recent State audit of MHSA found problems with the MHSA programs. Primarily, they found the community involvement process cumbersome and lengthy. They found the communication between agencies and the accountability systems not well defined. They also found the program inefficient overall. This government analysis does shed some light on the important problems to look at. First if community involvement is recourse and time intensive we need to make sure that is useful. Also the MHSA structure needs to be tightened so that the limited mental health resources can be stretched to the maximum.

Outcomes measures are difficult to track in the short term. Each county invents its own proposal and there are no established outcomes measure that is uniform. Each county is developing its own ways of collecting data. Further, each non-profit agency will have its own way of collecting the data. As the goals are long-term, outputs can be measured and not outcomes the success of the program will be challenging to report with accuracy (Keefer).

Industry recruitment programs are anything but new. The health care industry has had career track high schools, educational stipend programs, technical programs, and other successful methods of moving people to choose the field. The health care industry is years ahead of the mental health industry in its recruitment in general as well as its recruitment of people from diverse backgrounds. Using models that work for other industries are likely to work so it is OK that short -term data is not available. Because these programs cannot control outcomes the best way to test WET to wait for the long term results.

The California mental health planning council recently recommended the following multi tiered approach. First a Short-term Approach to Local and Statewide Evaluation

that includes development of a survey of each type of program to self report output. A Mid-term approach to identify a convenient cohort to do an extensive hands on evaluation by WET. And the long term approach of evaluating the workforce demographic of the county after 5 years and use outcomes to inform the next five year plan strategy.

The program success will be shown by the change in the workforce 5 years after program implementation. Statewide analysis of the number of workers in the field and the demographic of the workforce will determine if the efforts of WET have been a success. However it is important to keep good jobs in state so our efforts are not undermined by another state offering better wages after California has provided pathways to education. If just 30% of the programs developed this year survive the program will be a success and the future of mental health services in California will look brighter than ever.

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