



San Mateo County
Mental Health Services Act (MHSA)

Workforce Education and Training (WET) 10-Year Impact and Sustainability Report



Office of Diversity and Equity

San Mateo County Behavioral Health and Recovery Services



February 2018

Table of Contents

Introduction	3
Background	3
San Mateo County WET Program	3
Summary of Recommendations	4
Overview	5
WET Planning	5
WET Plan Components	6
Evolution of WET Priorities.....	10
Fiscal Investments	15
Overall Distribution of WET Investments (2014-17).....	15
Stakeholder Input	17
Survey Results - Priority Training Areas.....	17
Workforce Development and Education Committee Priorities.....	19
WET Impact	21
Challenges	23
Vision for WET Moving Forward.....	23
Lived Experience Education Workgroup and Lived Experience Academy	26
Overview	26
Methods Results.....	26
Challenges	33
Recommendations for LEEW and LEA	35
Cultural Competency Stipend Internship	36
Overview	36
Methods	37
Results	38
Challenges	42
Recommendations for CCSIP	43
Sustainability Recommendations	45
Recommendation 1: A Systemic Approach to Workforce Education and Training	45
Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation.....	46
Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff.....	47
Conclusion	48

Introduction

Background

The Mental Health Services Act (MHSA) was approved by California voters in November 2004 and provided dedicated funding for mental health services by imposing a 1% tax on personal income over \$1 million dollars. MHSA emphasizes transformation of the mental health system while improving the quality of life for individuals living with mental illness. It provides funding for treatment, prevention and early intervention, outreach, support services, family involvement, and programs to increase access to services for underserved communities.

Workforce Education and Training (WET) received a total one-time \$3,437,600 funding allocation in FY's 2006-07 and 2007-08, with a reversion period (timeframe for expending the allocated funds) of 10 years. With MHSA WET funding ending in 2017-18, BHRS is preparing to sustain the most effective and impactful elements of these investments. Continued investment in WET is critical to supporting BHRS' strategic initiatives and priorities, and for creating a system of care that is responsive to MHSA core values of building community collaboration, cultural humility, consumer and family driven services, a focus on wellness, recovery, and resilience, and an integrated service experience.

This report provides an overview of the impacts of MHSA WET investments in the 10 years of implementation by San Mateo County Behavioral Health and Recovery Services (BHRS), stakeholder priorities, and BHRS' vision for WET as a commitment to building knowledge, skills, and core values.

San Mateo County WET Program

After two years of stakeholder engagement and plan development, the San Mateo County WET Plan was approved and enacted in 2009. Current components of the WET Plan include:

1. **Workforce staffing support** – A WET coordinator, a Community Program Specialist, and an Administrative Assistant provide system wide responsibility for managing implementation, reporting and evaluation of all BHRS training activities.
2. **Training, technical assistance, and capacity building** – Trainings to increase the capacity of providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. Additionally, use of evidence-based and community-defined promising practices has increased as a result of training.
3. **Behavioral health career pathways programs** – Strategies that are necessary to address ongoing vacancies in positions which are difficult to fill.
4. **Financial Incentives** – to create a more culturally competent system, this program provides stipends to trainees from local universities who contribute diversity as well as the linguistic and cultural humility of BHRS.

Summary of Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained, total of \$500,000 per year, through the following three strategy recommendations:

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS. Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation.

- **Sustainability strategy** – a transfer from MHSA CSS will sustain foundational knowledge and training that supports system transformation (\$100,000) and the workforce staffing (\$260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce and, providing knowledge and skills in the area of stigma reduction and advocacy, empowering and inspiring participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence. Creating pathways for individuals with lived experience requires a systemic and integrated approach.

- **Sustainability strategy** – consolidation of the peer and family partners strategies (\$60,000) currently funded by MHSA, CSS General Systems Development component.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level. More has to be done to recruit, hire and retain diverse staff.

- **Sustainability strategy** – a transfer from MHSA CSS (\$80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Overview

In the spring of 2017, San Mateo County Behavioral Health and Recovery Services' Office of Diversity and Equity hired independent consultant Sean Kirkpatrick to assess the impact of WET and identify priorities that would shape the future landscape. Engagement included the following:

- WET Survey for Staff, CBO Partners, Contractors
- Survey for Cultural Competency Stipend Intern Program Participants
- Interviews of Cultural Competency Stipend Intern Program Participants
- Listening Session with the Lived Experience Education Workgroup
- Survey for Lived Experience Academy Participants
- Interviews of Lived Experience Academy Participants
- World Café with the Workforce Development and Education Committee
- LEEW Enhancement report (prepared separately by another contractor)

Materials reviewed in preparation of this report also included training logs, pre/post-tests for trainings, evaluations collected during trainings, reports developed, WET Plans and annual updates, etc.

WET Planning

WET planning has always been built on stakeholder input and feedback. The planning process has targeted a diverse group of San Mateo County community members, clients/consumers of BHRS and their family members, BHRS and contract agency staff (including peer and family workers), and community-based organizations and partners, including Health Equity Initiatives. Online surveys, focus groups, in-person group dialogue and key informant interviews have been deployed to capture the input of over 800 stakeholders.

The foundation for the first WET Plan (FY 2009-10) was based on several planning efforts: 1) the MHSA Community Services and Supports (CSS) planning, which engaged a wide range of stakeholders including members of historically unserved and underserved communities; 2) the Joint Labor/Management Initiative, which was formed to create a framework for addressing both the conditions of employment and the approach to providing staff development; and 3) a planning workgroup, which began developing a vision and set of values and principles to ensure that workforce development, education and training initiatives within BHRS were consistent with the vision and values established through the CSS planning process. For the second planning phase (FY 2011-13), a Training Survey based on the priorities of the previous plan was added. The original planning workgroup was comprised of BHRS leadership, managers, line staff, consumers, family members, and representatives of community-based organizations. The group identified foundational knowledge, a wide range of competencies that are viewed as central to supporting system transformation and core of the WET Plan.



Currently, the formal governing and advisory bodies ensure that workforce development, education and training initiatives meet the needs of BHRS' clients/consumers, family members and the community.

- **Workforce Development and Education Committee (WDEC)** meets bi-monthly to ensure training and workforce development plan implementation; identify barriers to the training and workforce plans, create strategies to address the barriers, and accountability. The WDEC is facilitated by the WET Coordinator.
- **Lived Experience Education Workgroup (LEEW)** meets monthly to focus on building workforce development, training, and advocacy opportunities within BHRS for clients/consumers and family members, and planning and supporting the Lived Experience Academy Trainings. LEEW is composed of people who have completed the Lived Experience Academy and other people with Lived Experience. The content of the meetings includes discussion of member participation in speaking engagements, BHRS-related committees and commissions, and sharing their Lived Experience stories. Additionally, members discuss announcements, other peer-led organizations and peer-focused conferences.

WET Plan Components

Over the course of WET implementation, the strategies and investments for WET have shifted to meet the evolving training needs of BHRS. A Child Psychiatry Fellowship was initiated in 2007-08 in response to a critical, historically hard-to-fill position within the San Mateo County BHRS system and as part of the It was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings, as well as provide education to a new generation of psychiatrists about recovery- and strength-based service delivery.

Workforce Staffing Support

As each phase of WET implementation brought about increases in scale and need, the WET Team expanded to include a Coordinator, a Community Program Specialist, and an Office Specialist. The WET Coordinator is generally tasked with oversight of the WET Programs and their implementation, the WET Team, and related WET workgroups/committees; evaluation of WET Programs; facilitation of the Workforce Development and Education Committee (WDEC) and the Practice Evaluation Committee; and participation in several BHRS Workgroups. The WET Community Program Specialist implements and facilitates the WET Programs, including BHRS Training Plan trainings; and oversees internship recruitment, the Cultural Competency Stipend Internship Program, the Lived Experience Academy, the Lived Experience Education Workgroup (LEEW), and the Cultural Humility Trainers. Lastly, the WET Office Specialist provides administrative support and documentation for all WET Programs and trainings. The WET Team members are also the administrative staff responsible for administering the Learning Management System for all BHRS trainings. Currently, WET operates under the Office of Diversity and Equity (ODE), and is supervised by the ODE Director. This shift happened three years ago and has enhanced the focus of WET to embed cultural humility, as well as to support the core values of MHSA.

Training, Technical Assistance, and Capacity Building

Training opportunities have greatly increased the capacity of community members and providers to respond to behavioral health issues, as well as address public perception on such issues as stigma and suicide in a culturally sensitive manner. The strategy also supports system transformation by providing training and technical assistance on utilizing evidence-based practices (EBPs) and community-defined treatment practices (CDPs). Sub-categories for training, technical assistance and capacity building are:

1. **Trainings to support wellness and recovery** – San Mateo County BHRS offers trainings to extend and support consumer wellness and recovery, examples include:
 - *Wellness Recovery Action Plan (WRAP)* trainings. WRAP is an evidence-based, self-help approach to achieve and maintain wellness that has been used successfully with mental health consumers and consumers with co-occurring disorders. With a train-the-trainer approach, consumers, family members, contracted providers, and County staff are trained as Master Trainers. The Master Trainers then provide training and support in developing WRAP plans for consumers and staff throughout the system.
 - *WISE Recovery 101 and Peer Support 101* Two separate trainings that have been designed for supervisors and peer workers to support understand and support the participation of Peer Workers in the BHRS provided programs and services.
 - *Trainings for Peer Support Workers/Family Partners* a series of trainings designed to address topics and concerns encountered by Peer Support Workers/Family Partners in managing their roles and responsibilities within BHRS.

2. **Training and technical assistance for and by consumers and family members** – these have included a range of trainings activities, for example:
 - Trainings delivered by and for consumers and family members.
 - *Paving the Way*, a San Mateo model that provides training and supports for consumers and family members joining the BHRS workforce
 - *Hope Awards*, which highlights personal stories while educating consumers, families, staff, and the general public about recovery and stigma; and
 - *Inspired at Work*, a program that provides a framework for consumers and family members to get support for entering and remaining in the workforce.
 - Trainings provided by consumers and family members to reduce stigma.
 - *Stamp Out Stigma*, a community advocacy and educational outreach program in which individuals with mental illness share their personal experiences with the community at large
 - *Breaking the Silence*, a training activity designed to address issues of gender identification in youth and the effects of community violence; and
 - *Consumer-led trainings* by transitional age youth for audiences of all ages.
 - Trainings provided by consumers and family members to increase understanding of mental health issues and substance use/abuse issues, recovery and resilience, and available treatments and supports.
 - *NAMI's Provider Education Training*, an intensive training for providers led by consumers, family members, and experts;
 - *Peer to Peer*, a NAMI-sponsored nine-week course taught by consumers to consumers about mental health, treatments, and recovery; and
 - *Voices of Recovery*, a client and family-driven advocacy and support program for those who have been affected by addiction.

- Trainings for consumers and family members on leadership skill development to support increased involvement of consumers and family members in various committee, commission, and planning roles:
 - *California Mental Health Advocates for Children and Youth Conference*
 - *The Village* educational visits; and
 - *NAMI, Heart & Soul*, and other community-based training activities to help perfect the leadership skills of consumers and family members.
3. **Cultural humility trainings** – trainings in the area of cultural humility are designed to reduce health disparities in the community; 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 are made available to consumers, family members, providers, and those working and living in the community. Examples include:
- *Working Effectively with Interpreters in Behavioral Health Settings*
 - *Culturally Responsive Supervision*, and
 - *Building Bridges to Diversity and Inclusion: Cultural Humility for Non-Clinical Staff*.

The Health Equity Initiatives work with the WET team to create and support trainings to address special populations and appropriately serve marginalized communities, examples include:

- *Native American Mental Health: Historical Trauma and Healing Practices*
 - *Working with Filipino Youth*, and
 - *Understanding Issues in the Queer Experience (UNIQUE)*.
4. **Evidence-based practices (EBPs)** – for system transformation are supported through an ongoing series of trainings that increase utilization of EBPs. Such practices aim to engage consumers and family members as partners in treatment, and thus contribute to improved consumer quality of life. The WET Coordinator facilitates the Practice Evaluation Committee which carries out the selection of evidence-based and community-defined practice policy. Examples include:
- *Functional Family Therapy*, a family-based intervention with at-risk youth in the criminal justice system that focuses on using family and consumer strengths to help youth gain control of their behaviors
 - *Trauma-Focused Cognitive Behavioral Therapy*, a model that integrates cognitive and behavioral interventions with traditional child abuse therapies and focuses on enhancement of interpersonal trust and empowerment; and
 - *Dialectical Behavior Therapy*, a practice focused on developing skills to more effectively deal with distress.

Behavioral Health Career Pathways Programs

The Behavioral Health Career Pathways Programs aim is to recruit, hire, support, and retain diverse staff in behavioral health careers. After the first WET Plan (FY 2009-10) established core program areas, subsequent WET Plans refined strategies. Some program areas were not retained in subsequent plans including the Behavioral Health and Human Resources Forums and the specific Behavioral Health Career Pathways Program with high school students.

1. **Attract prospective candidates to hard-to-fill positions** (including child/adolescent psychiatrists, psychiatric mental health nurses, and *promotores*/navigators) by addressing application barriers and providing incentives. Programs San Mateo County participated in included:
 - *Mental Health Loan Assumption Program (MHLAP)* – provides student loan forgiveness for BHRS and contractor staff who work in hard-to-fill positions and exhibit cultural and linguistic competence and/or experience working in underserved areas. Trainees receive up to \$10,000 to repay educational loans in exchange for a 12-month service obligation. In fiscal year 2015-16, 25 BHRS awardees received stipends totaling \$197,383.
 - *Behavioral Health and Human Resources Forums* – hosted by the Greater Bay Area Mental Health & Education Workforce Collaborative, the purpose of these forums was to influence county behavioral health human resources practices and priorities toward hiring staff who reflect the composition of the community being served. This program was discontinued.
 - *Child Psychiatry Fellowship* – was initiated in 2007-08 and responded to a critical, historically hard-to-fill position within the San Mateo County BHRS system. The Fellowship was a partnership of San Mateo County BHRS and Stanford University designed to serve high-risk youth in inpatient, outpatient, and community settings. This program was discontinued.
2. **Promote the mental/behavioral health field in academic institutions** where potential employees are training in order to attract individuals to the public mental health system in general, and to hard-to-fill positions in particular.
 - *Intern/Trainee Program* – BHRS partners and contracts with graduate school in the Bay Area to provide education, training, and clinical practice for their students at various behavioral health worksites in the County to provide training opportunities for psychology interns, masters-level trainees, alcohol and drug certificate program students, and psychiatric residents each year. Students are welcome to attend any of the five didactic training seminars throughout the county. There are bi-monthly psychiatric grand rounds that are open to all staff and students. Regular in-service training and specialized staff training are also available for students to attend. Additional skills training in wellness and recovery; crisis response, suicide and trauma; cultural humility; integrated care; and co-occurring mental health and substance use disorders were added to the internships.
3. **Promote interest among and provide opportunities for youth/Transition Age Youth (TAY)**
 - *Behavioral Health Career Pathways Program* – Encourages San Mateo County high school students to explore future careers in behavioral health, increases students' understanding of individuals with behavioral health challenges, and reduces stigma. This program was discontinued in FY 15/16.
4. **Create new career pathways and expand existing efforts for consumers and family members** in the workforce to allow for advancement within BHRS and in other parts of the County system.
 - *Lived Experience Education Workgroup/Lived Experience Academy* – Prepares clients/consumers and family members for workforce entry, advocacy roles, participation on committees and commissions, etc.
 - *BHRS New-Hire Orientation* – Starting in 2014-15, BHRS employees receive a 3-session orientation designed in part to help new staff understand how BHRS works and connects to other agencies and departments, to meet and learn from BHRS managers, to explore possibilities for career advancement, and to feel invested in and supported.
5. **Increase diversity of staff to better reflect our client population and retain diverse staff.**
 - *Cultural Competency Stipend Internship Program* – this program shifted to Financial Incentives Program defined below to provide interns with school expense support.

Financial Incentive Programs

The Financial Incentive Program goal is to **increase the availability of culturally and linguistically competent services to all consumers and family members of BHRS**, and to increase trainees' knowledge and understanding of the values and commitments of recovery- and strengths-based services offered.

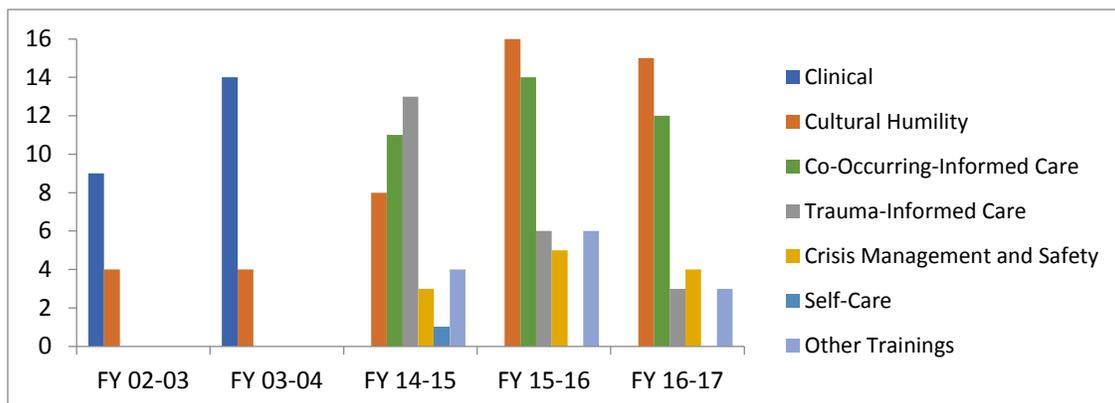
1. *Lived Experience Scholarship* – provides up to \$500 for clients/consumers or family members to pursue their academic goals toward a clinical, administrative, or management career in behavioral health. Applicants must be current or former BHRS clients/consumers or family members, residents of San Mateo County, and registered for at least six units in a vocational, 2-year college, 4-year college, credential, or graduate program.
2. *Cultural Competency Stipend Internship Program (CCSIP)* – created to support behavioral health graduate students who contribute to the cultural humility/responsiveness of BHRS through linguistic capability, cultural identity and/or experience working with and advocating for special populations represented in San Mateo County. Up to 10 trainees are selected based on their bicultural/bilingual capabilities, with preference given to those who identify or have experience working with special populations. As the program evolved interns were required to interact with and learn from members of the Health Equity Initiatives and other systems-change initiatives. Stipend amounts average \$5,000 per participant.

Evolution of WET Priorities

Prior to implementation of the MHSA WET strategy, the landscape was far less robust, with fewer trainings offered annually. Furthermore, topics skewed toward direct clinical training due to norms and an emphasis on medical intervention. For example, 60% of the trainings offered in FY 2002-03 had a clinical focus (e.g. Methadone, Antipsychotics, Risk Management, etc.); in FY 2003-04, 78% had a clinical focus. Cultural humility-focused trainings at this time included Latinos and Mental Health, Cultural Values and End of Life, and a Cultural Competence and Mental Health Summit.

In more recent years, the number and variety of trainings offered have increased significantly. Between 2014 and 2017, BHRS invested \$1,308,920 of MHSA funding in WET, providing 95 trainings to over 3,000 people in the same timeframe. In addition to cultural humility trainings spearheaded by the Office of Diversity and Equity, these trainings focused on co-occurring-informed care, trauma-informed care and crisis management and safety, a shift visible in the graph below.

Types of Trainings Offered by Fiscal Year



Overall, this increase in diversity of training offerings reflects BHRS' intentionality to invest in training. While it is possible that data collection on training type was lacking prior to the implementation of MHSA, this investment also reflects a response to shifts in training needs, either from the providers or the clients. Additionally, the annual training participant numbers have been relatively stable from year to year; however, there has been an increase in the number of trainings offered. This may signify that more people are being trained across more topics. Throughout the initial planning of WET and iterations of the plan, diverse stakeholders have been engaged to help shape future training topic priorities in four areas (Foundational Knowledge, Special Populations, Clinical Competencies and Skills and Treatment Practices) as described below.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values of San Mateo County behavioral health programs that all employees, regardless of position, should know and understand. Topics for Foundational Knowledge trainings have evolved and expanded in various iterations of WET Plans.

Table 1. Foundational Knowledge Trainings Prioritized

Topic	FY 2009-10	FY 2011-14	FY 2014-17
Cultural competence/humility	X	X	X
Stigma reduction	X	X	X
Self-care	X	X	X
Consumer and family training and support/support and integration of families in treatment	X		X
Customer service	X		
HIPAA and confidentiality	X		
Developing consumer-centered system	X		
Crisis management and safety		X	X
Legal and ethical issues		X	X
Partnering and Collaboration		X	X
Integration of Primary Care and Behavioral Health		X	X
Knowledge of BHRS and Partner Programs		X	X
Spirituality and Behavioral Health		X	X
Managing Assaultive Behavior		X	
Trauma/trauma-informed care			X
Co-occurring-informed care			X
Wellness and Recovery			X
Quality Improvement/Documentation			X
Welcoming and Engagement			X
Inclusion of Indigenous Healing Practices in Tx			X

Special Populations

WET Plans also identified special populations for whom behavioral health staff should receive tailored trainings to effectively treat and serve these special populations. Language used to identify these communities changed over time. The 2014-17 WET Planning stakeholder groups and surveys identified certain cultural groups as special populations, evidence of increased awareness that culture and community-specific trainings help improve quality of services for these groups.

Table 2. Special Populations Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
LGBTQQI	LGBTQQI	The LGBTQQI – emphasis on the transgender community
Gender-responsive treatment	Survivors of domestic violence	The Chinese Community
Infants and early childhood	Chinese	The Pacific Islander Community
Developmental disabilities	Filipino	The African-American Community
Abused children	Pacific Islander	The Latino/Hispanic Community
Family law participants	African American	“At-risk” Youth and Transitional Age Youth
Adult survivors of abuse	Latino	Individuals in the Criminal Justice System
PTSD	Co-occurring Disorders	The Aging and Older Adult Population
Geriatric		Individuals with Co-Occurring Mental Health and Substance Use Conditions
Cognitive disorders		Individuals with developmental disabilities – Pervasive Developmental Disabilities
Victims of domestic violence		

The 2014-17 WET Plan identified only 4 cultural communities as special populations (the Chinese Community, Pacific Islander Community, African-American Community and Latino/Hispanic Community). A more recent survey in 2017 identified 10 cultural communities meriting training attention (the African American Community, Arab Community, Asian American Community, Black Community, Chinese Community, Filipino Community, Indigenous Community, Native American Community, Latina/a/x Community [including youth and families], and Pacific Islander Community). Survey respondents additionally indicated need for trainings that address the experiences of marginalized communities, newly immigrated communities, the LGBTQ community (with a focus on transgender people), and spiritually-based communities.

Clinical Competencies and Skills

In addition to Foundational Knowledge, stakeholder groups and surveys identified key areas of clinical competency that should be prioritized for staff training. In various WET Plans, these areas included:

Table 3. Key Areas of Clinical Competency Identified by Stakeholders

FY 2009-10	FY 2011-14	FY 2014-17
Motivational Interviewing	Culturally appropriate responding	Assessing and Treating Suicide Risk/Harm
Integrated treatment of co-occurring disorders	Working with complicated families	Trauma-Informed Care
Cultural humility in clinical assessment	Assessment and Diagnostic skills for substance abuse	Assessment and Diagnosis of MH and SU Conditions
Support of informed consent and choice	Motivational enhancement	Working Effectively with Complicated Families
Wellness Recovery Action Planning	Assessment and Diagnostic skills for mental health	Self-Care
Illness management and recovery	Personality Disorder	Client-Centered Treatment Planning and Documentation
	Relapse Prevention	Crisis Management/Safety
	Assessing Strengths and needs	Working Effectively with Undocumented Families
	Mindfulness Skills	Assessing/Managing Assaultive Behavior
	Client Centered tx planning and documentation	Professional Ethics
		Motivational Enhancement/Engagement in Treatment
		Relapse Prevention
		Cultural Humility
		Partnering and Collaboration
		Co-occurring Informed Care
		Wellness and Recovery
		Mindfulness Skills
		Group Treatment Skills
		Clinical Supervision
		Integration of family partners/peers support workers in Tx
		Clinical Case Management
		Integration of Spirituality
		Integration of non-traditional healing practices

Treatment Practices

Stakeholders including consumers and their family members, administrative and managerial staff, and direct services staff identified a number of specific treatment practices to include in the FY 2009-10 WET Plan. Over time, the Specific Treatment Practices became more aligned with State- and Federal-level interventions and requirements, as well as such emerging trends as mindfulness-based interventions.

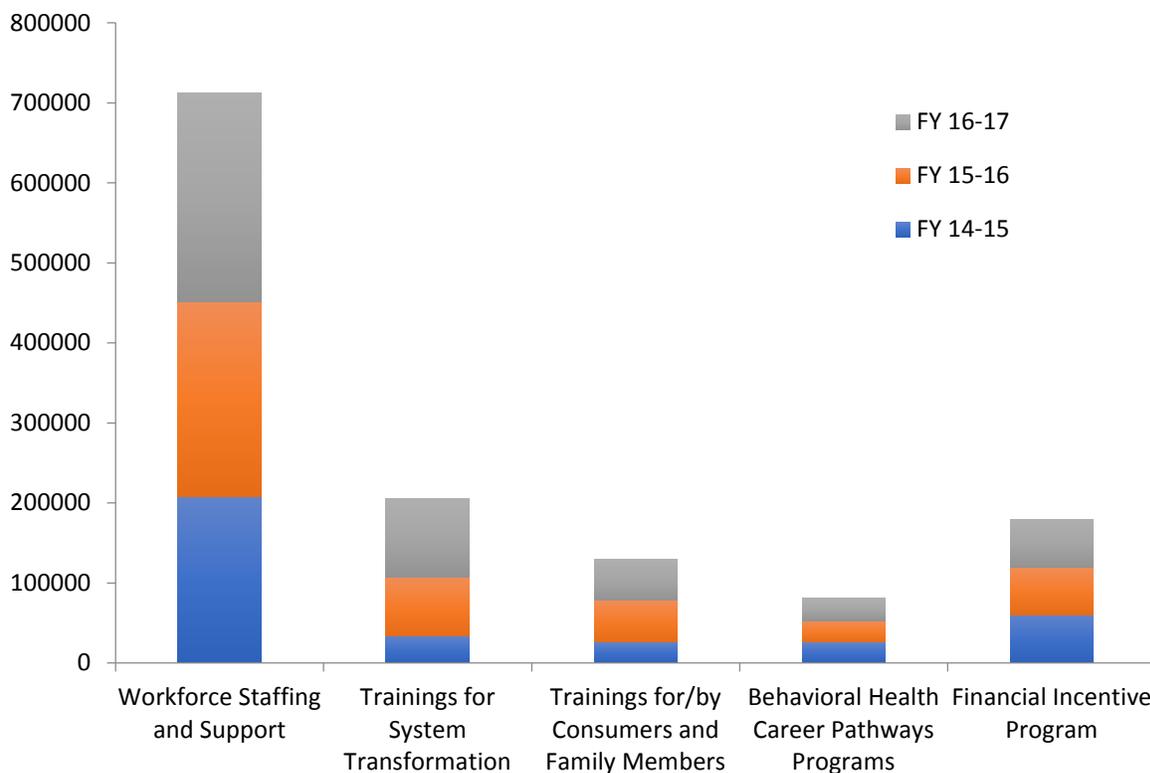
Table 4. Treatment Practices

FY 2009-10	FY 2011-14	FY 2014-17
Cognitive Behavioral Therapy (CBT)	Trauma Focused CBT	Trauma-Informed Care
Trauma-focused CBT	Advanced CBT	DBT/ DBT Informed Treatment
Family Psycho-Education	Solution focused Treatment	Seeking Safety
Supported Employment	Trauma Recovery and Empowerment Model	CBT for Psychosis
Assertive Community Treatment (ACT)	Seeking Safety	Motivational Interviewing
System of Care and Wraparound	Group Treatment Methods	Brief Family Therapy Models
Dialectical Behavioral Therapy (DBT)	Relapse Prevention	Mindfulness-Based Interventions
Functional Family Therapy (FFT)	DBT	Attachment-Based Therapy Models
Aggression Replacement Therapy (ART)	Brief and Strategic Family Therapy	Wellness Recovery Action Plan
	Family Therapy	Solution Focused Therapy
		Cultural Humility
		Relapse Prevention Therapy
		EMDR
		Brief Psychodynamic Therapy
		Group Treatment
		Somatic Therapy
		NMT
		CBT for Insomnia
		Peer Support/Peer Counseling
		Outcome Informed Services

Fiscal Investments

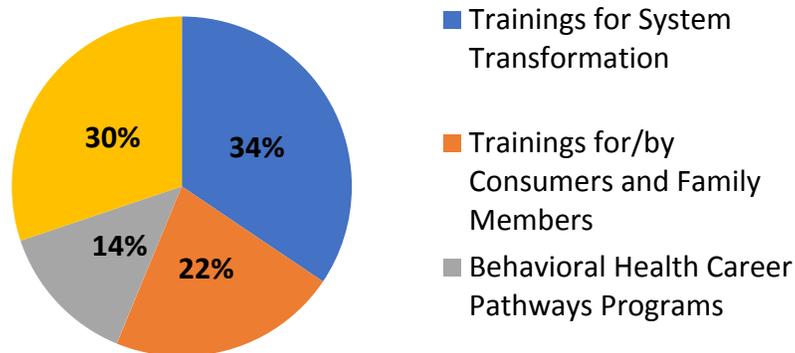
Workforce Education and Training (WET) received a total \$3,437,600 funding allocation in FYs 2006-07 and 2007-08. In FYs 2014-17, BHRS invested \$1,308,920 of the total allocation to WET activities. Following is a snapshot of the funding distribution by year and categories based on the WET Plan. There are six categories that reflect the components of the WET Plan, with Training, Technical Assistance and Capacity Building divided into two subcategories, Trainings for System Transformation and Trainings for/by Consumers and Family Members.

Overall Distribution of WET Investments (2014-17)



- Workforce Staffing and Support**, which accounted for over 50% of the total investment (\$712,316). Prior to the 2014-17 WET Plan, the WET team had the equivalent of 1.5 full-time staff (referred to as 1.5 FTE), but MHS funding allowed the team to increase to 2.0 FTE in FY 2014-15 and currently, 3.0 FTE. This additional staffing proved crucial to sustaining the 2014-17 WET Plan, particularly to support trainings, which also received substantial increases in funding.

WET Investments (non-staffing) FY 2014-17



- Trainings for System Transformation** represented 34% of non-staffing WET investments. From FY 2014-15 to FY 2016-17, funding in this category increased nearly three-fold, from \$34,150 to \$98,650. With this funding, BHRS was able to offer substantially more trainings designed to reduce health disparities in the community, provide instruction in culturally and linguistically competent services, and increase access, capacity, and understanding of mental health issues; as well as more trainings on evidence-based practices. This funding also enabled BHRS to partner with community groups and offer educational and training activities to consumers, family members, providers, and those working and living in the community.
- Trainings by and for Consumers and Family Members** nearly doubled between FY 2014-15 and FY 2016-17, from \$26,354 to \$51,900, and accounted for 22% of total non-staffing investments from 2014-17. These trainings aimed to increase understanding of mental health issues and reduce stigma among consumers, family members, and the general public. Trainings also increased consumers' and family members' knowledge of substance use/abuse issues, recovery and resilience, and available treatments and supports. This funding also enabled consumers and family members to attend leadership trainings to support their increased involvement in various committee, commission, and planning roles. Taken as a whole, these substantial increases in training investments represent BHRS' commitment to reducing health disparities, providing culturally and linguistically competent services, increasing understanding of mental health issues, and empowering consumers and family members.
- The Behavioral Health Career Pathways Program** investments remained relatively stable and included the Intern/Trainee Program and Behavioral Health Career Pathways Program to encourage San Mateo County high school students to explore future careers in behavioral health. Together, they accounted for 14% of total non-staffing investments from 2014-17. The Intern/Trainee Program increased by only \$1,000 per year between FY 2014-17, while funding for the Behavioral Health Career Pathways Program remained at a stable \$25,000 annually and was discontinued FY 2016-17.
- Financial Incentive Program** consisted of the Cultural Competency Stipend Internship Program (CCSIP) and the Lived Experience Scholarship Funds and represented 30% of non-staffing investments. CCSIP funding remained at a consistent \$50,000 annually and The Lived Experience scholarship remained at a consistent \$10,000 annually between FY 2014-17.

Stakeholder Input

The stakeholder engagement process included the WET Survey for staff, community-based partners, and contractors, and the Workforce Development and Education Committee World Café. The data collected during this process is being used to develop staff training priorities for the next three years of WET Planning (2017-20). As with the previous WET plan, there are four major areas/topics of training: Foundational Knowledge, Special Populations, Clinical Competencies and Skills, and Treatment Practices.

Survey Results - Priority Training Areas

The WET Survey for staff, community-based partners, and contractors was administered to all BHRS and contract agency staff in all positions (i.e. clinical, administrative, managerial, peer positions, etc.). The survey asked respondents about priority areas and training topics; specifically, areas/topics in which they would like their providers to be trained, and in which they would like to receive training.

Overall Training Priorities

All survey respondents were asked to identify BHRS' top training needs as a free response; this allowed us to see whether responses clustered around similar themes without providing options that would bias responses. Given that many respondents have direct contact with clients/consumers, it is unsurprising that the most frequently identified training were related to treatment modalities and clinical interests:

- **Evidence-based practices (EBPs)** – such as Cognitive Behavioral Therapy, Dialectical Behavioral Therapy (DBT), and Eye Movement Desensitization and Reprocessing, Motivational Interviewing.
- **Required trainings** – such as for the Board of Behavioral Sciences (AIDS/HIV training, Law & Ethics training) and Alcohol and Other Drugs contractor required trainings (EBPs, Title 22, CLAS).
- **Other Treatments/interventions** – including psychosocial interventions, peer support integration models, sexual abuse prevention and interventions, and non-verbal modalities such as art therapy and play therapy.
- **Cultural humility** – free responses included trainings on cultural differences, white privilege and systemic oppression, cultural humility/diversity conversations, social equity trainings
- **Career development** – several other responses mentioned topics related to career development, including peer training for certification, culturally informed supervision training, and training on becoming a clinical supervisor.

Foundational Knowledge

Foundational Knowledge areas represent the practices and values that all employees, regardless of position, should know and understand. Staff, community-based partners, and contractors identified the following top training areas, in order of priority:

- Trauma-informed care
- Self-care
- Co-occurring-informed care
- Welcoming and engaging all clients/consumers
- Cultural humility/responsiveness

Clinical Competencies and Skills

Staff who have direct contact with clients/consumers were asked about their priorities with regards to training in clinical competencies. These staff provide direct assessment and treatment-related services, including intake/assessment, counseling, advocacy, and education for consumers and/or family members. The following top clinical areas were identified, in order of priority:

- Trauma-informed care
- Co-occurring-informed care
- Self-care
- Alcohol and other substance use
- Assessing/treating suicide risk/harm
- Assessment and diagnosis of mental health and substance abuse conditions

Clinical staff were also interested in receiving more training in the following priority EBPs:

- Neurosequential Model of Therapeutics (NMT)
- Mindfulness-based interventions
- Attachment-based therapy models
- Motivational Interviewing (MI)
- Eye Movement Desensitization and Reprocessing (EMDR)

Clinical staff were asked about specific mental health conditions/diagnoses for which they would like more training. This question received fewer responses overall, most were interested in:

- Personality disorders (e.g. narcissistic personality disorder, borderline personality disorder, etc.).
- Psychotic disorders
- Co-occurring conditions with mental health, substance use, and physical health issues
- Trauma and trauma-focused care

Administrative Staff Training Priorities

Administrative staff included front office, reception, fiscal/billing, support, contracts, quality management, and information technology staff. Their top five training priorities were:

- Managing crisis phone calls
- Engagement and welcoming
- De-escalation of conflict
- Self-care for administrative staff
- Roles and responsibilities when engaging with consumers/family members

Managers/Supervisors Training Priorities

Managers and supervisors oversee staff performance, as well as programmatic and clinical operations. Their top five training priorities were:

- Creating safety and trust among teams
- How to give and receive feedback in a culturally sensitive/responsive way
- How to facilitate dialogues on racism, sexism, etc.
- Increasing staff motivation
- Documentation for supervisors of interns and trainees

Training Modality and Structure

Hands-on interactive/experiential workshops were the most preferred training modality, followed by in-house expert consultations. Case presentations/consultations, didactic lectures, ongoing seminars, and coaching were also preferred by many respondents. In their free responses, respondents also recommended mentoring, videos for training (separate from Webinars), and in-person “behind the mirror” trainings with real clients as other training modalities to consider.

The most preferred structure and length of trainings were half-day trainings (starting in the morning) and full-day trainings. Half-day trainings (starting in the afternoon), two-hour trainings, and one-hour trainings were preferred half as frequently.

Other recommendations related to modality and structure included offering more trainings in general, offering trainings more than once to provide more opportunities to attend, offering small group trainings, and incorporating more group interaction within trainings. Some of these recommendations clearly complement each other; for example, small group trainings can accommodate more group interaction within each training. An example of how WET has already responded to such recommendations is the “Becoming Visible” training on Sexual Orientation and Gender Identity: this training is being offered twice a month in FY 17-18 in order to reach a broad audience, including BHRS staff, community partners, and contractors.

Workforce Development and Education Committee Priorities

On April 28, 2017, a World Café-styleⁱ session was facilitated for the Workforce Development and Education Committee (WDEC). Six BHRS staff members and four representatives from community-based partners (Caminar, Daly City Youth Health Center, Edgewood and Your Strength to Heal) participated; all participants are current members of WDEC. The session focused on three topics: Training Priorities, the Impact of WET, and the WDEC’s Vision for WET moving forward.

WDEC Identified Training Priorities

Participants identified the following training priority areas: data collection and management using a health equity frame, alcohol and other drugs, certification tracks for individuals with lived experience, trauma-informed systems, self-care, and specific trainings.

- **Data Collection and Management Using a Health Equity Frame** – the group recommended that there be trainings on performing community assessments and data collection to inform equitable quality services. These trainings should use CLAS requirements as a core principle for providers, and not only for prevention staff. One participant also recommended using process evaluations to assess the efficacy of training implementation.
- **Alcohol and Other Drugs** – several training priorities in the area of alcohol and other drugs (AOD) were identified, including substance use, co-occurring-informed care, and including more people with substance use lived experience on training panels. One participant observed that AOD treatment is different from mental health treatment, and that more training specific to AOD would improve this understanding.

ⁱ <http://www.theworldcafe.com/key-concepts-resources/world-cafe-method/>

- **Certification Tracks for Individuals with Lived Experience** – several participants indicated that there is a need for certification tracks, especially for peer support workers. Certification tracks would allow individuals with lived experience to find new career paths within clinical/support fields without needing to complete a graduate school track. An example of such a program was the AOD Training Academy held in FY 2017-18.
- **Trauma-Informed Systems** – the group felt that BHRS needs to move beyond trauma-informed care to deeper trainings that support the development of a trauma-informed system. Participants noted that this effort should be staged across three to five years and monitored at each step so that the transformation to a trauma-informed system is carried through. Related trainings should also include the importance of culturally-informed care. Training administrators would also be needed to evaluate the utility of trauma-informed principles in their work. A Bay Area initiative, Trauma Transformed, focused on developing trauma-informed systems was mentioned as a potential resourceⁱⁱ.
- **Self-Care** – continued attention to self-care should be a priority, as the group felt that it was “not happening” with consistency and clarity of purpose. One recommendation was to use trainings as settings for self-care and processing, with the goal of creating a culture where staff build more self-care into their daily work.
- **Specific Training Topics** – in addition to the training areas described, participants identified the following specific trainings and training topics as priorities:
 - Acuity and risk increase
 - Cult abuse
 - Culturally appropriate trainings, especially on suicide
 - Harm reduction
 - Human trafficking
 - Practical skills, especially for people in direct service
 - How to use community resources and free support services
 - Suicide among specific population (e.g. Dr. Joyce Chu’s suicide among Chinese adolescents)
 - Recovery oriented clinical services
 - CBT
 - CBT for Psychosis
 - Child Management techniques
 - Collaborative Problem-Solving for Clinicians and Social Workers
 - DBT
 - EMDR
 - Motivational Interviewing
 - NMT
 - Positive Parenting Program
 - Psychoeducational
 - Substance use prevention
 - Relapse Prevention
 - Crisis/suicide/assault intervention (i.e. Crisis Intervention Training)
 - Tobacco Cessation
 - Clients’ stories

ⁱⁱ <http://traumatransformed.org/>

WET Impact

Both survey respondents and the WDEC were asked about how WET has shaped the culture of BHRS, as well as how trainings have impacted them individually. Overall, stakeholder input was positive and majority of stakeholders acknowledged how WET trainings are able to shape BHRS' culture and enhance services by providing opportunities for all to learn and practice cultural humility, igniting much needed system transformations, allowing for new insight and awareness, promoting dialogue, increasing understanding, and ultimately better serving clients.

There were specific programs/trainings that were mentioned as being particularly impactful including the Lived Experience Academy, Neurosequential Model of Therapeutics (NMT), Seeking Safety, the Health Ambassador Program, Mental Health First Aid, Health Equity Initiatives, anti-stigma work, and the internship program. The following themes capture the comments from the perspective of survey respondents and WDEC participants:

Improving Cultural Humility

The most commonly mentioned accomplishments of WET in shaping the culture of BHRS were related to improving cultural humility, multiculturalism, and cultural sensitivity. Many respondents also felt that they had been personally impacted by cultural humility-related trainings, with one writing that such trainings gave them "greater awareness and better practice methods on how to work with specific populations." Leanna Lewis' trainings and consultations on cultural humility were mentioned specifically, but culturally informed trainings in general have also made a difference.

Increasing Focus on Trauma-Informed Care

WET trainings have had an impact on increasing focus on trauma-informed care. Participants observed that cultural humility and trauma are the "big platforms" for BHRS/ODE's WET investments. It was noted that people continue to ask for more trainings, it is a constant request. It was also noted that because trainings are left to individual choice versus being a requirement for all, it may not be sufficient to laying the groundwork for trauma-informed systems change.

Cultural Humility and Trauma Informed

"Cultural Humility gave me a helpful frame for addressing a microaggression I experienced, which was empowering."

[trainings on cultural humility] "open the door for difficult and important conversations amongst staff."

"become very sensitive to the impact trauma has on myself and others. I am aware that there is so much I don't know and need to learn as I interact with others."

Creating a Culture of Learning

BHRS' 20-hour training requirement was identified as having an impact on the institutional culture of learning and growing. Several respondents felt that having more trainings available was helpful to their work. Other clinicians stated that trainings related to licensing and opportunities to earn CEUs were valuable.

Improving the Standard of Care

The impact of WET on cultural humility was even more poignant in relation to how trainings affected providers. Exposure to cultural humility-related trainings permeates into providers' work and interactions with clients/consumers. Additionally, several respondents felt that trainings helped enhance providers' clinical skills.

Valuing Lived Experience

The Lived Experience Academy (LEA) and Lived Experience Education Workgroup (LEEW) were especially important for increasing peer support and training. The establishment of LEEW was cited by many respondents as crucial to welcoming staff with lived experience into BHRS, impacting BHRS' culture. Other respondents felt that incorporating lived experience into trainings increased their level of support for the work of lived experience staff, as well as enhanced connections among different staff.

Building Capacity for Co-occurring Care

While systems for co-occurring AOD and mental health capability have developed, participants felt that resources were still needed. There are greater interactions and integration of services between substance abuse providers and mental health treatment providers, and more interaction with other systems such as health and criminal justice, towards an Organized Delivery System. Additionally, these efforts have helped to identify change agents from all agencies, giving people within the system a place for networking, cross-training and cross-pollination, resulting in a significant shift in the work and moving the work out of prior silos.

Increasing Awareness of the Importance of Self-Care

Participants noted the importance of self-care and trainings related to it yet, awareness of the importance of self-care is not sufficient to creating a system that supports it across all staff levels. It was noted that lots of workers burn out, and they have no ability or mechanism to refresh within their current work environment. Additionally, there are still legal obstacles and limitations in place because of the union. There is still very little preventive care for this workforce, and employees have to fight for their self-care needs to be honored.

Culture of Learning

"I have appreciated being exposed to dialogue that I can bring back and apply directly."

"Hearing a perspective of the people I work with in words that resonate with me so that I can listen to people better."

"[Trainings have] encourage[d] ongoing learning to better serve clients at BHRS."

"Learning empowers me to keep fighting the good fight!"

Standard of Care

[trainings] "have allowed providers of treatment to explore new possibilities and promote insight and awareness."

"Ongoing education is so important for a clinician. It really raises our standard of care."

Lived Experience

"incorporating lived experience at trainings has help[ed] me and others put a face to the training...very important...please keep this up."

Focusing on Client Centered Services

Participants acknowledged that WET investments have helped impact the focus on client outcomes. All decisions (clinical and non-clinical) should be made through the lens of how they will benefit clients and families. “Client-centered” is more than clinical, and involved continuous quality improvement, not just quality assurance. Efforts should be made such that all decisions should derive from client- and family-centered perspective, and that we are present for them and coming from a place of love vs. judgment.

Challenges

Need to Focus on Systemic Changes

WDEC participants noted that they feel that there needs to be more conversation about how to perpetuate systemic changes fostered by trainings so that they result in systems transformation. These transformations need to be seen in policies and qualities of leadership. There is a need to create ways of measuring the impacts of workforce education and training that are aligned with the goals of systems change. This was also mentioned by survey respondents on a number of occasions as they discussed trauma informed care and self-care for example and the feeling that there is still not a system that can support full implementation.

Systemic Transformation

“The goal should be a systemic transformation that includes everyone, from janitor to judge.”

Additional Comments

A small number of survey respondents were “not sure” or felt that they had not been impacted by trainings. One respondent noted that the WET investments have tended to privilege mental health over AOD, noting how this “shapes what staff perceive as priorities; because most training are focused on mental health, it is perceived as a priority over substance use.”

Vision for WET Moving Forward

Cultural Humility

Stakeholders were also asked about what areas of training should receive ongoing investments. Cultural humility (multiculturalism, social equity, power/privilege, etc.) and culturally informed trainings received the most responses, with one respondent writing, “Cultural Humility is an entry point, but we need to dig deeper!” At least one respondent also noted that the Health Equity Initiatives have an important role to play as trainers and providers of key information and perspectives, stating that they would like to see ongoing investment in trainings from such teams as the Native American Initiative, Latino Collaborative, and PRIDE Initiative.

Trauma-Informed System and Self-Care

Trainings on trauma-informed care and NMT received the second-highest number of responses followed by Self-Care. Specifically, continuing to invest in building a *trauma-informed system* – moving beyond trauma-informed care – built on social determinants of health as a foundation with the vision of building a permanent culture within BHRS’ network of providers and organizations. Participants connect this vision to a system that supports *self-care* as well. Specifically, there needs to be a greater focus on self-care to prevent burnout in the workforce and continued investment in WRAP trainings.

Youth Career Path Development

Another vision is connected to workforce development through a focus on *youth career path development* in behavioral health fields. One participant pointed to youth training being done in the Filipino community as an example. Participants also would like to see greater youth representation in regional meetings.

Lived Experience-Focused Trainings

WDEC participants see a continued investment in *lived experience-focused training*, with a goal of honoring lived experience people by making trainings more inclusive and welcoming. WDEC would also like to see more lived experience people in trainings as a goal moving forward. *Certification courses* were mentioned as a vision.

Alcohol and Other Drugs (AOD)

Several participants would also like to emphasize AOD moving forward. Recommendations include addressing *the needs of AOD treatment providers* who often face barriers to training due to the nature of their work (such as evening hours, financial constraints, long commutes, etc.) that limit their ability to participate in, and benefit from, training opportunities. There is a wish for AOD providers and interns to collaborate more. Lastly, there is a vision is to create and support a culture that recognizes that “sobriety does not equal wellness,” and that being sober is just the beginning of the journey to recovery.

Specific Trainings

The group would like to see *guiding principles for all trainings/programs* developed by BHRS/ODE, and that these be a focus of future trainings. Other program ideas include:

- Service learning projects
- Training focused on long-term recovery such as Voices of Recovery
- Human trafficking training
- Family treatment models
- Training to SOGI standards (it was noted that San Francisco Department of Public Health makes training on gender orientation mandatory, and that this should be considered).
- Trainings from the Bay Area Regional Health Inequities Initiativeⁱⁱⁱ (County of San Mateo Public Health, Policy and Planning Department is a member of the initiative)
- Grant writing and organizational development

ⁱⁱⁱ <http://www.barhii.org>

Other Comments

- **System Change** – Focusing the work of the WET Coordinator on system change priorities
- **Decentralized Training System** – Developing policies and structures for training that can be developed in house
- **System Orientation for Contractors** – using BHRS College for contractors to learn about BHRS. Related to this, the group suggested that there be a survey to identify who can offer specific trainings and experiences within BHRS in order to maximize internal resources as well as acknowledge strengths that are untapped within the system.
- **Improved Communications of Trainings** – there was a request for improved communications so that training opportunities are seen earlier, and for a more integrated communication system that is connected to calendaring.
- **Intern Training Manual** –that can be used system-wide towards improving clarity of goals, tracking of outcomes, and continuity in order to level the field of practice. Should include an interview process for interns.
- **Crisis Intervention Team (CIT) Shared Curriculum** –develop a strategy for sharing curriculum across the system with providers.
- **Online Training** – it was observed that the system is not meeting its goals for providing webinars, while also noting that face-to-face training is a preference that might be impacting this outcome.



Lived Experience Education Workgroup and Lived Experience Academy

In addition to the surveys and dialogues conducted with staff and providers as described above, it was important to delve deeper into WET funded programs.

Overview

The **Lived Experience Education Workgroup (LEEW)** engages clients, consumers, and family members and prepares them for workforce entry, advocacy roles, participation in public committees/commissions, and other empowering activities. In addition to those with lived experience, BHRS and contractor staff also participate in the LEEW, which oversees the **Lived Experience Academy (LEA)**. Graduates of LEA train to share their stories as a tool for self-empowerment, stigma reduction, and public education about behavioral health issues through the LEA Speaker's Bureau. Speakers are compensated at a rate of \$35 per hour to speak at BHRS trainings and events throughout San Mateo County.

As of Spring 2017, there were approximately 40 LEEW members, with 20 active members. The Enhancement of Lived Experience Workgroup Report, submitted to ODE/BHRS in March 2017, found that this is less than what is needed for clients/consumers with lived experience to be fully represented throughout the system of care. Specifically, additional consumers and family members would enhance the work of the Community Service Areas (CSAs) and Health Equity Initiatives (HEIs), as well as increase participation in competitive employment. In 2016, LEEW members participated in the Mental Health and Substance Abuse Recovery Commission; BHRS Quality Improvement/Quality Management; Workforce Development Meetings; Housing, Operations & Planning meetings; CSA committees; and various ODE HEIs.

Participating in LEA had positive and far-reaching impacts on BHRS consumers. As one Listening Session participant described it:

*"Empowering.
Non-shameful.
A supportive journey.
I felt that I was not just a consumer, but part of the team. My mentally ill children have a different experience of me now. We all have our individual stories. This helped me with my children, moving them from street drugs to taking their meds, and they are now open to seeing the psychiatrist."*

Methods

"I've gone from a really good life to nothing to starting to build my life back up again...If not for LEA and other classes offered by BHRS, I would not be where I am today."

- LEA participant

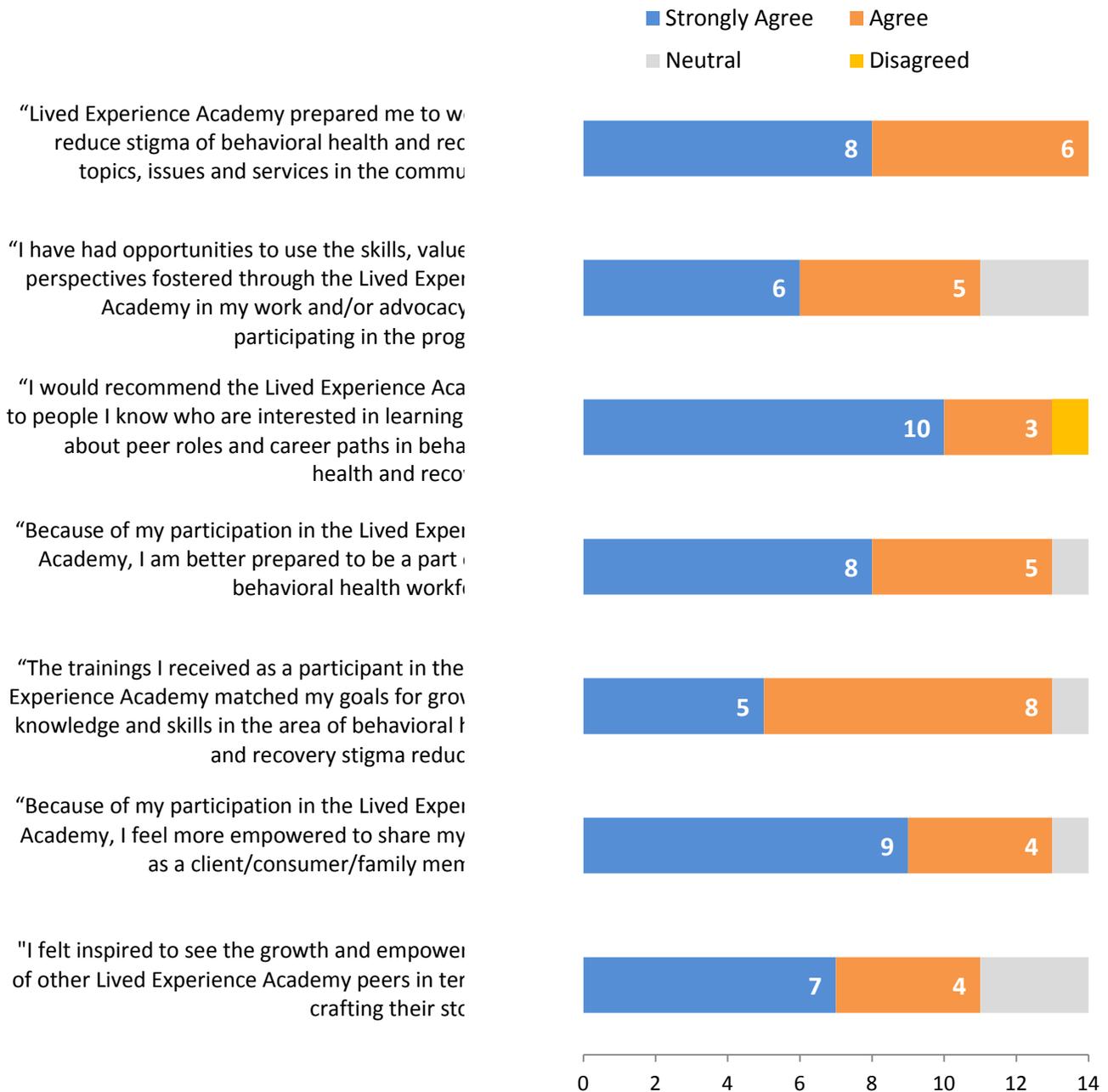
In the Spring 2017, three methods of data collection were used in this evaluation conducted:

- **LEA Survey** – current and former LEA participants were surveyed about their perceived outcomes and level of agreement to a series of statements.
- **LEEW Listening Session** – current and former LEA participants were invited to attend the Listening Session held on April 4, 2017. The focus of was LEA's impact on community involvement and personal and professional development.
- **LEA Interviews** – former LEA participants were interviewed for a deeper perspective of LEA's impacts.

Results

Lived Experience Academy Survey

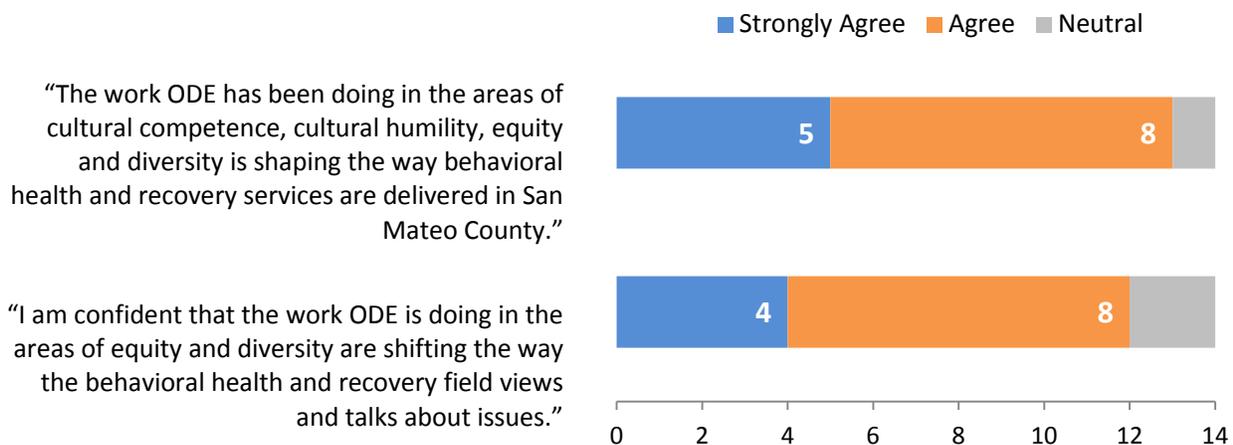
A total of 14 current and former LEA participants responded to the WET Survey. Almost all respondents felt that LEA met its goal of preparing graduates for workforce entry, providing them with knowledge and skills necessary to work in behavioral health. Almost all survey respondents also felt empowered to share their stories as a result of their participation in LEA.



Survey respondents identified two main areas of impact on their current work and/or professional development: (1) improved ability to participate in the behavioral health workforce, and (2) increased comfort and confidence in sharing their own story.

Open-ended responses to the survey indicated that participation in LEA helped trainees process their feelings and support others, “Initially, LEA helped me process my own feelings about the experience, and I went on to become increasingly effective at supporting other family members in learning effective advocacy skills.” Another participant wrote, “I am advocating more for people who are either not aware of the opportunities for them to speak up or unable to because of the severity of their condition.”

Furthermore, survey responses highlighted the value of LEA’s close partnership with ODE, as respondents expressed confidence in the positive impacts of ODE’s work. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.



In their open-ended responses, survey respondents also identified at least two areas of improvement for LEA: (1) increasing the number of speaking opportunities, and (2) having ongoing, additional training, with more cohorts of LEA annually. Some examples of responses include the following:

“I wish there were more opportunities for me to be able to use the new capabilities I achieved through the Lived Experience Academy.”

“I had a great experience going through the LEA...I wish there were more opportunities for speaking.”

“There should be more training so people can have more tools in the box.”

“Keep supporting this important group, INCREASE number of academies each year. Use your contract agencies to leverage your capacity to teach this.”

Taken as a whole, these survey responses indicate that LEA is a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. Not only does LEA arm graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and support others. Additional training opportunities and speaking engagements would help increase the presence and inclusion of individuals with lived experience in the behavioral health workforce.

Lived Experience Education Workgroup Listening Session

A total of 16 LEEW members participated in the Listening Session, including ODE/BHRS staff and LEA participants who are currently employed within BHRS or with partner CBO's. The Listening Session focused on LEA's impact on personal and professional development, as well as community involvement. Among the strongest outcomes of LEA identified by the Listening Session participants were **empowerment**, increased **confidence** and **reduced shame**, and **reduced isolation**.

"My story is empowering, I can now sit comfortably with diverse clients, they tell me that I am of service. There is a life after hospitalization. LEA helped me with my story, which I share."

"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."

"I am no longer ashamed about my condition."

With specific regards to motivational interviewing training, participants noted, "[it] bolstered my self-confidence," and, "The program teaches us to fight against self-stigma."

Community-building aspects of LEA were also noted, with Listening Session participants speaking specifically to how LEA helped **reduced feelings of isolation**:

"I was isolated from my family. The LEA Speakers Bureau helped me to talk to my family and get through to them about what triggers me and what helps."

"We all shine because of the program. It is like family – non-judgmental, reduces loneliness, very therapeutic."

"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."

"I'm homeless but I don't feel homeless."

Listening Session participants also shared that LEA was intimately connected to their **healing**, with one participant saying that they, "Found it very healing and liberating...telling your story lifts you." Another noted the **transformative** nature of the process, saying, "To be able to look in the mirror and say 'I forgive myself' has been transformed into acceptance, 'I accept myself.'" In the realm of professional development, Listening Session participants noted increased **empathy** and improved **communication**.

Empathy

"I've been part of the County system for the past 20 years. Through LEA, I saw that I was more like clients than I had acknowledged."

Communication Skills

"The experience of going through LEA has helped my communications skills, I am amazed at myself that I could share without crying."

Greater confidence

"My life has changed dramatically, now I see myself, how I allow others to see me, more confident than I ever thought I could be. I am free because of LEA."

Reduced Isolation

"I felt lots of self-guilt, family and peer guilt. I am part of my community, part of something, because of LEA."

Lived Experience Academy Interviews

“Without LEA, many of us would not be where we are today. We wouldn’t feel like we have the support of the public or BHRS or the Health System of San Mateo County at all.”

- LEA participant

Three former LEA participants were interviewed. The interviewees represented participation across the timeline of LEA program implementation, with participants from the 2012, 2013, and 2015 cohorts. They represented ethnic/racial diversity, with one African American, one Latino/a, and one Asian (Chinese) American participant. Two were male and one was female.

All three have sustained their involvement with LEEW: two have participated in facilitating the most recent LEA training, and two have additionally trained as presenters for BHRS. All three are also involved in the work of related efforts (e.g. participation in HEIs, specific committees, and other mental health consumer-led organizations such as NAMI and California Clubhouse).

The interviewees identified three key areas in which LEA made a discernable impact: at the **individual/personal level, the community level, and the systemic level**. The interviewees also expressed some disappointments, which revolved mainly around changes to the program.

- **Individual/Personal Level** – all three interviewees identified specific areas for skills and awareness that they gained through participation in the LEA, and similar to the Listening Session offered examples including increased **confidence** and a sense of **empowerment**, while feeling reduced shame and stigma.

“LEA helped shape my participation and contribution, boosted my confidence and how I carry myself.”

“LEA helped take away the shame, and gave me confidence to share my story.”

“A lot of weight was lifted off of me once I could share my story. I was really ashamed of many things.”

“For many years, I felt so much shame, which prevented me from doing so many things. I felt weird and that I didn’t belong. I used to pray that God would send me something awful so I can finally appreciate what I have. Shame, self-hate, guilt about mom, dad, little brother’s experience of my illness.”

“A big challenge for us is stigma, most importantly self-stigma. When we feel that there is something wrong with us, it is difficult for us. When we tell our stories, it helps us to shed our self-stigma. It helps normalize things for us.”

Empowerment

“I had never shared my story with anyone before... It felt really empowering, I wanted to share my story with a larger audience.”



"I was nervous when I first spoke about my story, I was only comfortable in meetings where I knew everyone. To talk to others, doctors, classrooms, nursing school students, etc., was difficult for me. I've spoken through NAMI and other orgs. The training really helped me learn to speak more confidently."

The interviewees also echoed that LEA helped with their **recovery**:

"To have this training to help tell our stories, it has helped me with my recovery process also."

"The more we feel that we have support from others, the more it helps with our recovery process."

Beyond personal gains and healing, the interviewees also spoke of the importance of sharing their stories. They recognized the **value** of speaking with confidence about their experience in supporting and educating others and a sense of **validation** that allowed participants to reach beyond themselves, be part of the wider community, and help others:

"To be able to go through the training was exhilarating for me, being able to present to different groups, hear feedback, being able to provide support and advice for people. Hearing the feedback and responses was something I had not expected. People were genuinely interested in learning more, and this helped dispel some of the internalized shame I felt. I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

"I feel valued that I can help other people."

Confidence

"I was more able to talk about my story with family, friends and acquaintances. It really boosted by confidence and self-esteem. This is my story and I am an expert on my story."

Recovery

It's when we feel it is ok internally to have a mental health issue and that we are not going to be treated as a leper of some sort, we begin to be more of an advocate."

Validation

"The more we are validated for our feelings, the more comfortable we are in speaking out for our needs. We have a better ability to attend BHRS committee meeting to give our input about what is missing or overlooked or could be more helpful for us."

Similar to the Listening Session participants, interviewees also noted an increased sense of community through the LEA and reduced isolation:

“LEA has the feeling of community that other trainings I have been through don’t – community, genuine compassion and love.”

“I am definitely excited about the prospects of bringing my consumer perspective to this work in the future. It really feels like a family and community.”

- **Community Level** – the interviewees expressed an eagerness to **participate** in participation in public committees/commissions, and other empowering activities:

“If it wasn’t for lived experience and advocacy trainings...I have been able to do so much more than before. I have participated in the Spirituality Initiative, Youth and Children’s Services Committee (my son has mental health issues so I am a consumer and a family member), the Chinese Health Initiative...I attended the symposiums on Spirituality.”

Furthermore, the importance of sharing their stories, as well as the boost in confidence to do so, was best expressed by the interviewees’ newfound ability to advocate for themselves and others. **Advocacy** and an eagerness to give voice to others were brought up several times:

“[LEA] helped me learn how to advocate for others with tact.”

“[LEA] helped me advocate for myself when my rent was being raised with the Housing Authority and my landlord.”

“As I took advantage of more opportunities, I had more capacity to help.”

“The way I see it, we who have mental health issues do not speak out for ourselves (the majority of us), so those of us who can have a responsibility to speak out for those who cannot.”

Advocacy

“My goal is always to give a voice to others who are silenced or feel that they have to hide due to stigma. I hope my voice can help give voice to others.”

“I not only advocate for myself, but try to advocate for others to benefit their situation.”

Areas of advocacy need included decriminalization of the mentally ill, disability benefits, regulations that limit income for those receiving the benefit, and loss of life insurance policy due to it being seen as an “asset.” This respondent further noted that the income limits and benefit amounts are not realistic given the cost of living in the Bay Area.

- **Systemic Level** – the interviewees identified three areas of systemic impact due to the investment made in the LEA. These impacts fall broadly into the following areas: *Lived Experience Voices, Workforce Diversity, and Movement-Building & Advocacy Opportunities.*

All three interviewees shared how their LEA training made it possible for them to present their stories in an array of settings, and how their voices made an impact on the way behavioral health professionals viewed people with lived experience:

“I was able to do presentations last year for the psychology interns coming into the hospital, 10-12 students working on their doctorates, through the Spirituality Initiative.”

“Since the course, I have spoken to middle and high school age children, to MFT trainees, pharmacology students, etc. It helps them understand what we go through, what are the challenges, and also how to work with us better. I have also spoken with people who run the 24-hour suicide prevention hotline, their feedback is that it helps them understand our mindset so they can do their job better.”

The interviewees also spoke to how LEA training made a difference in their own professional development, allowing them to enter and be successful in the behavioral health workforce.

“I work with CA Clubhouse, Heart and Soul, Stamping Out Stigma, the Peer Association we just started. ... None of the things, awards, recognition, etc., plus my own desire to share my story, none of that would have happened without LEA.”

Significantly, the interviewees also discussed how LEA training and empowerment could build toward a collective movement. One interviewee shared a vision of shared advocacy paving the way to make bigger and more meaningful impacts.

“I have overcome a lot in the past 8 years, but I am at the point of wanting to have a bigger impact. People with insurance and/or money, they are living on the island of themselves. NAMI and CA Clubhouse are on their own islands. How do we get them to come together to coalesce and speak with a shared voice to make meaningful legislative changes? State, federal, local Board of Supervisors.”

Challenges

LEA interviewees shared some of their disappointments in the recent direction of LEA and LEEW. Many of these disappointments were related to changes in **program structure**, while others were related to the limited **opportunities available** for LEA graduates:

“I don’t think the program is the same. Only one of their [recent] 8 graduates came to LEEW meeting. The curriculum has changed, no longer using the 7 elements of public speaking training. There are only 5 sessions now. They didn’t use the seasoned facilitators from previous classes [this last round]. I have some dissatisfaction with LEEW group and how it is being held. They are doing only one LEA per year now, and we only have stuff to do during MH Awareness Month and Recovery Month/Suicide Prevention Initiative events.”

Lived Experience Voices

“Before the advocacy group training, they didn’t have consumers attending these meetings to give them direct feedback. It is tremendously helpful to them to hear from us.”

Movement Building

“By training people with lived experience to share their stories, it builds a grassroots movement to help voice our concerns in a public arena.”

“The class size has been cut in half - only one group, and only 5 classes, and smaller group going through the LEA. We had 12-15 per group go through the whole thing in the past, with 25 people going through each year, now only 6-7 in the past year. There should be LEA in Spring and Fall, and Advocacy training in the summer.”

“We used to have a lot more opportunities to speak, more happens in May which is mental health awareness month and in September which is suicide prevention month, but other months there are fewer opportunities. After the sessions and graduating, we were part of a Speakers Bureau, but not sure if I am still on the list. I wonder whether it is really active and actively managed by anyone. We used to have more opportunities to speak, was very active at one point.”

“I want more speaking engagements. There are opportunities through Heart and Soul and NAMI, [and] LEA participants need to be connected.”

“I would do more year-round advocacy, not enough opportunities for LEA participants currently.”

“If the right opportunities come up, I would be interested. I have volunteered a lot - I’ve looked at RFPs, offered IT background to gather data, looking at data when it is related, they haven’t taken me up on it. Even if they don’t have funds, they could create volunteer opportunities for us that help with our sense of self-worth and recovery. I don’t see people open to having volunteers in BHRS. I know of a handful of LEA participants who are working with BHRS as family partners or peer supports, there are a few of us, but few and far between.”

Interviewees also expressed dissatisfaction with the **stipend levels**, a concern echoed in the WET Survey and Listening Session. While LEA Speakers Bureau participants previously received a stipend of \$35/hour for speaking engagements, more recent LEA participants have been paid only \$25. In a separate report,^{iv} LEEW members also shared that the process of getting merited stipends appeared inconsistent. For some LEEW members, lack of clarity on whether ODE or the Office of Consumer and Family Affairs is responsible for distributing stipends led to significant delays in receiving stipends. In addition, LEEW members raised questions about whether LEEW members who are employed by BHRS or community-based contractors are eligible to receive stipends. From these accounts, it seems that changes in stipends – both amount and policy – have not been **clearly communicated**.

Perhaps one of the most revealing ways in which former LEA participants expressed their appreciation for the skills and community gained from their participation was in their desire for BHRS to support high-quality programming for people with lived experience, which stems from their belief that LEA helped them. Their hope is for programs like LEA to be available in order to help others.

“My vision is that BHRS starts taking care of this because it helps people, not just to do it.”

“I just want it to be the same high quality it was in the past. Nothing bad to say about LEA in and of itself, it has helped a lot of people. Don’t kill it, take care of it. We want it to be around for other people to enjoy and benefit from. It has helped a lot of people in different ways.”

^{iv} Enhancement of Lived Experience Workgroup Report by Ellie Dwyer, March 2017

Recommendations for LEEW and LEA

The following recommendations for LEEW and LEA are based on the results of the WET Survey and stakeholder feedback from the LEEW Listening Session and LEA Former Participant Interviews.

More trainings for leaders with lived experience

LEEW members would like to see more investments in training for leaders with lived experience, including more LEA cohorts, with more sessions. Refresher trainings were deemed useful, with particular interest in advocacy training (Advocacy Academy).

More opportunities to use skills learned from LEA

Noting that “sharing your story takes practice,” LEEW members voiced interest in having more speaking engagements. Because of the empowerment, confidence, and value LEA graduates experience through sharing their stories, having such opportunities on a regular basis would greatly benefit LEEW members. Hearing the voices of people with lived experience would help clients and clinical trainees better understand the population they serve as well.

Integrate LEA into all consumers’ recovery

Many Listening Session participants and interviewees said that LEA was integral to their recovery. They suggested that, for consumers who are ready, being able to go through a program that builds skills and confidence in sharing their stories should be an opportunity available to all. One former LEA participant stated, “If I had the ability, I would use my magic wand to make those who are at a level of readiness and recovery to take the LEA. It would be a formal part of peoples’ recovery.”



Cultural Competency Stipend Internship

Overview

The goal of the **Cultural Competency Stipend Internship (CCSIP)** is to provide more culturally responsive services to clients and the community. Up to 20 stipends are awarded annually to interns who are providing mental health and alcohol and other drug services within the Older Adult, Adult, and Youth systems of care, or interns who are providing coordination and logistical support in the Office of Diversity and Equity (ODE). Stipends are awarded based upon the trainees' ability to add to the cultural competence of services BHRS provides. Recipients of the stipend are required to participate in a Health Equity Initiative (HEI) project/program by attending the monthly initiative meetings and helping organize events and activities. They also conduct a cultural competence project during the year that is aimed at improving the cultural responsiveness of our services and educating our staff as negotiated between the trainee/intern and the HEI co-chair.

Participating in CCSIP was a valuable experience. As one respondent wrote:

"This was a wonderful experience and I am so thankful for the opportunity. I would like to return to the Latino Collaborative once I return to the Bay Area after internship next year."

Highest priority is given to applicants who are bilingual and/or bicultural and whose cultural background and experience is similar to the clients he or she will serve or to an identified underserved population in the community for whom we would like to have more outreach. It is also a priority to award stipends to students who have personal or previous experience serving marginalized populations including:

- Gay/lesbian/bisexual/transgender/queer/intersex/two-spirit or gender-nonconforming clients
- Individuals or family members of individuals with lived experience
- Individuals with physical disabilities
- Individuals with lived experience as inmates in correctional settings

In FY 2015-16 CCSIP participants conducted projects in support of the Spirituality Initiative, the Filipino Mental Health Initiative, the Latino Collaborative, the Native American Initiative, the African American Community Initiative, the PRIDE Initiative, the Arab Community Workgroup, the Diversity and Equity Council, and the Chinese Health Initiative. Their projects included:

Surveys and Assessments:

- Two county-wide surveys that assessed clinician comfort in addressing spirituality in treatment in order to determine the impact of spirituality training and advocacy efforts on clinician practices. The surveys also sought to understand client perspectives on spirituality in treatment.
- An assessment of why African American males receive longer and harsher sentencing than European American males who have committed similar crimes through an examination of the role of psychological assessments in the sentencing process.
- Focus groups with African American/Black consumers and clients of BHRS to better understand how African Americans feel about and perceive access to care, welcoming at clinics and service points of entry, information provided and its relevance, treatment options and opportunities, experiential perceptions regarding Cultural Humility, and thoughts about what could be done better to improve their treatment experiences and outcomes.

Community-Specific Workshops and Presentations:

Example of past CCSIP Projects:

A survey-based assessment of clinician comfort in addressing spirituality in treatment

Workshop on mental health and socio-emotional issues for a Filipino Barkada student group

Monthly newsletter with mental health information for the Latino Community

- Creation and facilitation of a workshop on mental health and socio-emotional issues at Westmoor High School for the Filipino *Barkada* student group.
- A presentation on mental health issues and services at the Moonridge facility in Half Moon Bay, which offers affordable housing through Mid-Peninsula to agriculture workers.
- A presentation to San Mateo County providers and the community on Native American mental health and strategies for working with the Native American community to improve health outcomes in this population. This project was part of a larger workshop that integrated various aspects of Native American healing practices, as well as experiential activities involving drumming.
- A presentation at the Mills High School Wellness Panel on childhood development and parent-child-teen communication in Mandarin Chinese.
- A three-day PhotoVoice workshop for older adult (age 60 and older) clients of BHRS.

Outreach Efforts:

- Creation of a subscription-based monthly newsletter to increase access to mental health information for the Latinos.
- Development of an up-to-date and sustainable social media presence and Website for the PRIDE Initiative that provides LGBTQQI2S individuals in San Mateo County with information about events, groups, and services for the community
- Direct outreach from the PRIDE Initiative to other HEIs in order to facilitate a conversation about the issues faced by the LGBTQ subpopulations of their respective communities.
- An outreach event and presentation to Arab communities in San Mateo County on behavioral health and recovery resources, services and issues.

Methods

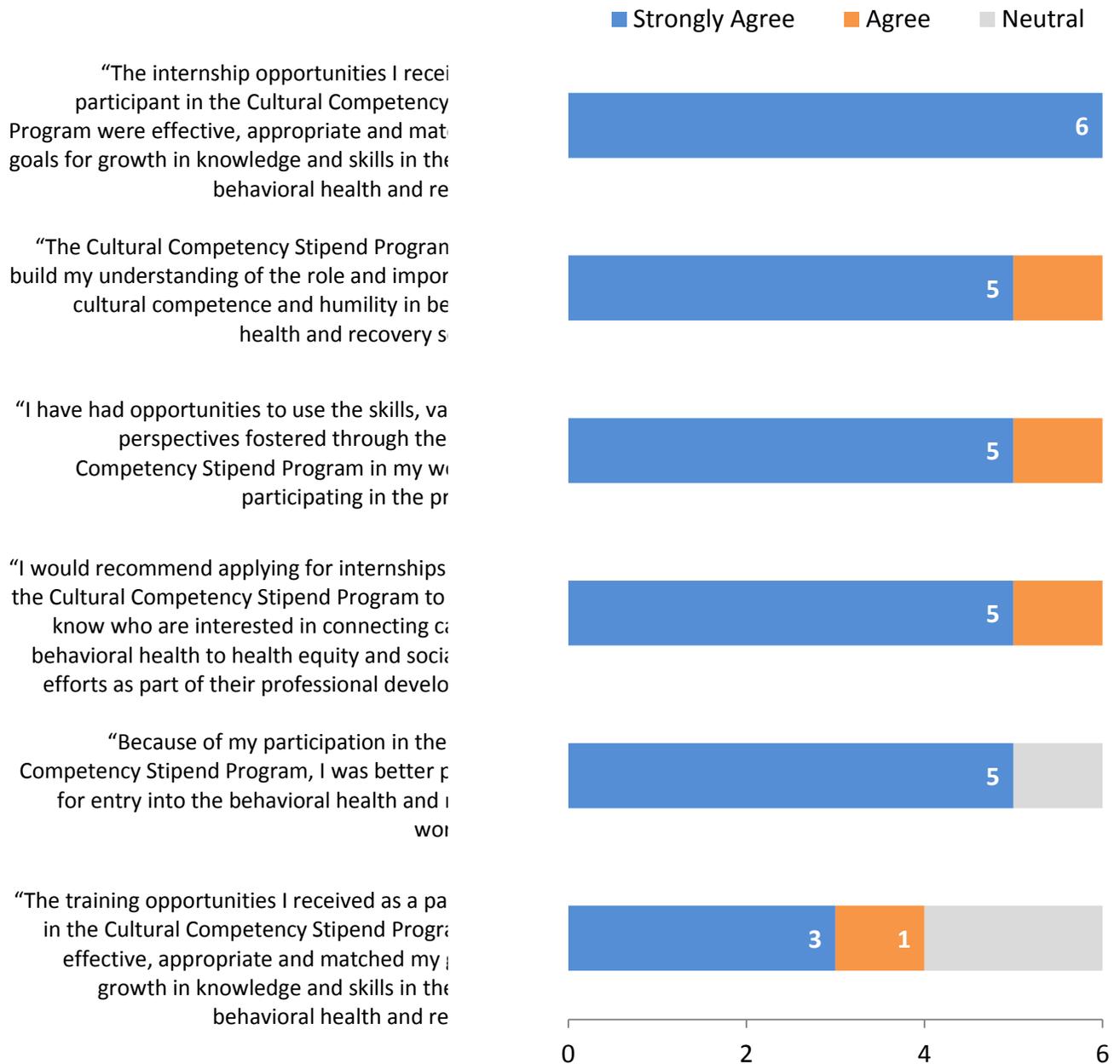
Two methods of data collection were used for the CCSIP evaluation:

- **CCSIP Survey** – current and former CCSIP participants were surveyed about their experiences in CCSIP, and level of agreement on a series of statements.
- **CCSIP Interviews** – former participants were interviewed for a deeper perspective of impacts.

Results

WET Survey for Cultural Competency Stipend Internship Program Participants

A total of six current and former CCSIP participants responded to the WET Survey. All respondents strongly agreed that CCSIP matched their goals for growth in knowledge and skills in the area of behavioral health and recovery, and all agreed that CCSIP helped build their understanding of the role and importance of cultural competence and humility in behavioral health and recovery settings.



In their open-ended responses, survey respondents also spoke of how CCSIP increased their awareness of diversity-related issues, including privilege and power differentials:

“I have become very involved in the various events that various initiates have offered after seeing the tremendous amount of work that goes into hosting an event. These events have truly developed my awareness and understanding of other cultures, which has allowed me to be more mindful and culturally sensitive when providing treatment to someone of a different race/ethnicity/ spiritual community.”

“[I am] more aware of diversity related concerns and needs assessment.”

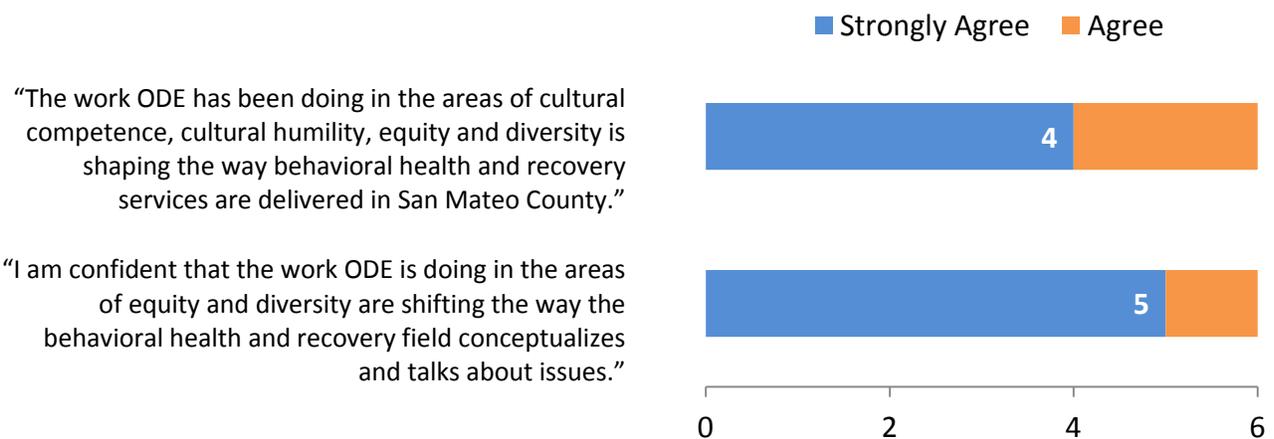
“I am thinking about issues of privilege and power in the therapy room in deeper ways.”

“I have realized how fortunate I am to have attended a Master’s program that places such a strong emphasis on cultural humility. Much of the information presented through the initiative was not new to me, but I was glad to be involved in raising awareness in the county.”

“It has allowed me to gain a deeper understanding of the Latino community and the services that the entire county (outside of just BHRS) has for this population. It has also allowed me to see where the areas of strength/deficit are when providing mental health services to this community, therefore giving me an idea of how I may be able to improve this system when I complete graduate school.”

Thus, the main areas of impact on CCSIP trainees’ work were (1) **increased knowledge and skills** in behavioral health and recovery, including the roles of cultural competence, cultural humility, health equity, and social justice; and (2) **deeper understanding and awareness of diversity**, including how specific communities view mental health services.

Furthermore, survey responses highlighted the value of housing CCSIP within ODE, as respondents expressed **confidence in the positive impacts of ODE’s work**. Respondents also indicated that ODE is a key player in equity and diversity in San Mateo County.



In their open-ended responses, survey respondents spoke about the challenges of participating in CCSIP, which were primarily logistical in nature.

1. The HEI schedule and the schedule for the regular intern program should be aligned. For at least one intern, the regularly scheduled meeting of the assigned HEI coincided with the intern seminar, leading to the intern to nearly drop out of CCSIP. Moreover, they “did not receive any support or assistance from CCSIP regarding this issue.”
2. The time constraints for the internship project were not realistic. While interns are expected to devote 10 hours per week to CCSIP, much more work occurred toward the end of the year, when data had to be compiled and final papers written. One intern who wrote about this challenge suggested two possible solutions: 1. It was very challenging to get approval for their project, and had the project been approved sooner, they would have had more time to implement it. 2. CCSIP interns can work together to make the project more manageable.

Taken as a whole, the survey responses indicate that CCSIP is a valuable resource for preparing future clinicians to better understand issues related to diversity, marginalized communities, privilege, and power. Its emphasis on cultural humility and cultural competence helped foster skills, values, and perspectives that participants found useful. Some logistical coordination would improve the interns’ ability to contribute to their assigned HEI’s during an already busy and stressful intern year. Nonetheless, feedback from CCSIP participants was overwhelmingly positive.

Cultural Competency Stipend Internship Program Former Participant Interviews

Three former CCSIP participants were interviewed. Two interviewees participated in the 2015-16 cohort, and one participated in 2013-14. They represented ethnic/racial diversity, with one African American, one Asian (Chinese), and one Middle Eastern (Egyptian) participant. All three were female. Two interviewees worked on projects that supported specific HEIs (African American Community Initiative and Chinese Health Initiative), while the third supported the work of the Arab Community Workgroup.

All three have sustained some level of involvement with BHRS and/or the County. One continued supporting the African American Community Initiative past their intern year. Another was hired as the Chinese community outreach worker for ODE to host events, connect clients and consumers to services, and participate in the Chinese Health Initiative’s work around stigma reduction, mental health awareness, and help-seeking in the Chinese community. The third is currently a provider in the BHRS system of care, and is a member of the Bay Area Muslim Therapists group. As part of her CCSIP project, she gave a presentation to the Arab community; after her intern year, she reached out to high schools in Daly City with a plan of doing presentations and support groups in the next year. While the former participants who were interviewed may thus be somewhat self-selecting, they and the internship supervisor felt that their experiences were representative of the average intern’s participation in CCSIP.



The interviewees identified two key areas of impact: at the **individual/personal level** and the **community level**. The interviewees also gave feedback on the program, particularly around the level of support they received, and made recommendations.

- **Individual/Personal Level** – broadly, the interviewees felt that they gained a better understanding of **working with marginalized communities**, new **connections** and networks, and **professional development** and growth as therapists as a result of their participation in CCSIP. Some specific examples they offered included:

“All those connections I made with the County through the internship have helped my work with clients now. Exposure to classes and workshops and digital storytelling, the network I have now.”

“I will be going back to get my PsyD, my CCSIP experience will be helpful in my career later. I want to work with Chinese families as a therapist, there is a large population in the Bay Area, might intern at RAMS at some point.”

Understanding of Marginalized Communities

“I appreciated working in the community...I now understand the challenges of working with monolingual Chinese speakers better.”

Another significant impact of participation in CCSIP was the opportunity to **serve communities** with which the interviewees identified:

Commitment to Serving Own Community

“Without CCSIP, I would not have had as strong a feeling about wanting to work with my community.”

“I think the internship solidified my want and need to work in the Arab community, address stigma, identify resources. Being able to present on mental health was amazing, a lot of people shared their fears, experiences of being discriminated against, fears of seeking services. Being able to offer a space to do that was very impactful. It has given me more of a drive to work with this population... without CCSIP, I would not have had as strong a feeling about wanting to work with my community. The experience helped open the door to work with the Arab population.”

“When I was an undergraduate, I was in a different state, so this was a great opportunity for me to work in my community for the first time, the other state was not diverse. Great to meet other people with similar interests.”

“It really helped me personally to be more motivated to help my own community. I would not have stepped into community mental health if I had not participated in the CCSIP program.”

- **Community Level** – for the interviewees, working within the County system was a powerful way to make a **broad impact**; the County brought greater visibility and legitimization of their work:

Making Broad Community Impact

“I think the opportunity to have an impact, to be involved in health equity initiatives or work groups, doing PhotoVoice or presentations in a specific community, was incredible. Doing it on a County-wide level is special. Having support and funding from the County, food provided by BHRS, etc. ... Because it was through the County, this holds more meaning. A lot of the attendees of our presentation were recent immigrants, they didn’t know the structure or the meaning, but having the County behind the work is really important. More access, resources, partnership.”

“...having the County behind the work is really important. More access, resources, partnership.”

“I think the thing I appreciate the most is that San Mateo County has this kind of opportunity. I was exposed to lots of different ways to interact with the community through ODE, also being able to do the mental health work at the same time. I feel that San Mateo County is the leader in having these conversations about equity and diversity.”

“I feel that San Mateo County is the leader in having these conversations about equity and diversity within the County.”

Another interviewee noted the work still to be done:

“I would like to think that the work we did made some progress. Having honest and open conversations about mental health is a success. I hope for more. I hope the community is able to access more resources. There are more amplified needs now due to the current context.”

Challenges

When asked about what they found challenging about participating in CCSIP, the majority of the interviewees’ comments revolved around the support they received. While one interviewee found CCSIP support to be “just right,” others would have preferred more **guidance**. Many of the former participants’ comments indicated that the trainees would have liked more **clarity on expectations**, especially with regard to splitting their time between clinical hours and completing their CCSIP projects. They struggled with balancing the **expectations of their various supervisors**, who had differing levels of support for interns’ projects (one comment suggested that some supervisors did not take CCSIP seriously). Some comments indicated that there was room for ODE to work more closely with clinical supervisors in order to better integrate CCSIP and clinical training. For example, one interviewee was able to limit her clinical caseload in order to accommodate the CCSIP project, but this appears to be a rare exception.

Additional comments indicated that CCSIP participants would have benefitted from **basic skills training** such as project coordination, community outreach, and time management. The interviewees expressed a need for general help, but beyond additional training, they were not specific about what kind of help was needed. One interviewee had knowledge of a coordinator who was later hired to “help interns get the support that they need”, and she seemed to view this support from ODE positively.

The interviewees found the CCSIP **time allotted overwhelming**, yet insufficient. Many interns were required to devote as many as 20-24 hours on clinical training on top of school commitments and other responsibilities, so the additional hours for the CCSIP project were often difficult to incorporate into

their usual work day. At the same time, the interns were very enthusiastic about the cultural competence work, and wanted to be actively involved with ODE's work as well as the HEIs. For example, the intern who worked with the African American Community Initiative (AACI) worked on three different projects during her intern year, and found that untenable. Reflecting on her year with CCSIP, she stated that she "I could have easily spent all 20 hours with the African American Community Initiative."

When the interviewees were asked about the **stipend amount** (\$5000), their responses were mixed. While they felt that it was helpful, especially in terms of not having to take out as much in loans, the amount "could have been more," and ran out quickly for most. Suggestions included having fewer interns, each of whom would receive a larger stipend; splitting extra funding among CCSIP participants; and splitting the stipend into two separate checks. Some interviewees thought that the offered amount was less than what other organizations were offering, while others felt that it was more. The fact that the County covered mileage was helpful.

In addition to sharing the views expressed above, the intern who worked with the Arab Community Workgroup had some specific concerns about the **continuity** of the Workgroup. While her work with the Arab Community Workgroup was impactful, she expressed disappointment that it did not continue, nor did it lead to the establishment of a formal HEI. She has attempted to reconnect and help with this effort; but it is not realistically possible for her to carry her CCSIP work forward outside of her current role without some form of compensation. She also expressed a desire for opportunities to provide feedback and stay connected with the County. Her comments indicated that she would have liked to see some plan for sustainability, as well as some formal network for staying involved.

These final thoughts reflect how uniquely devoted CCSIP participants are to serving their communities. By rooting their work in cultural competence and cultural humility, CCSIP interns help the program meet its goal of providing more culturally responsive services to clients and the community. As this last interviewee stated:

"many choose to be part of CCSIP for personal and professional reasons, [to be] part of the community."

Recommendations for CCSIP

The following recommendations for CCSIP are based on the results of the Survey and Interviews.

Basic skills training

Only two-thirds of the survey participants felt that CCSIP training opportunities were effective and appropriate, and matched their goals for growth in knowledge and skills. As we are unable to follow up with the one-third of respondents who did not agree, we use the responses of the former participant Interviews to inform us on what was missing. These responses indicate that CCSIP interns could benefit from training on such basic skills as project coordination, community outreach, and time management. While this additional training may seem excessive at first, the responses indicate that some upfront investment in these ancillary skills may help set CCSIP participants up for success during the rest of their intern year. These trainings could be provided or coordinated by ODE, a strategy that could also help CCSIP participants feel more supported by and connected to ODE's work. Another suggestion could be to let the interns choose a number of skills workshops, and get feedback at the end of the year on which trainings were most useful during their internship.

Better coordination between CCSIP and clinical supervision

The former participant interviews indicated that major challenges throughout the year were understanding the expectations of various supervisors and, often, lack of support from clinical supervisors. The interviewees also noted that there was room for ODE to work more closely with clinical supervisors in order to clarify expectations and time commitments with regard to CCSIP and clinical training. Better coordination between the two programs might strengthen clinical support for trainees' participation in CCSIP, and help legitimize the CCSIP projects in the eyes of the clinical staff. It could, in some cases, also help CCSIP participants limit their clinical caseload in order to balance the time with their CCSIP projects.

Sustainability of CCSIP projects

One former participant interviewee noted that once an intern's year is over, their relationship with the County essentially ceases, and their project might not continue. While this is not necessarily a widely held view, it makes sense to invest in the sustainability of the CCSIP projects. One way that ODE does this is by ensuring that the CCSIP interns' work supports the work of the HEI's, which have more consistency in terms of membership and participation from year to year. ODE could also encourage or require interns to incorporate a sustainability plan or component into their project proposals. Another way might be to actively encourage new interns to continue the work of previous projects; however, that could be challenging because much of the interns' work hinges on the relationships they build with County staff and community members.



Sustainability Recommendations

WET investments are crucial to creating and sustaining a transformed behavioral health care system that is client-centered and provides high quality accessible services. The most impactful elements will be sustained through the following three strategy recommendations: 1) A Systemic Approach to Workforce Education and Training; 2) Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation; and the 3) Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff.

WET sustainability (\$500,000 per year) was prioritized through the planning process for the FY 2017-2020 Three Year Program Plan as vetted by the MHSA Steering Committee, presented to the Mental Health and Substance Abuse Recovery Commission and opening of a 30-day public comment period and public hearing process.

Table 5. WET Sustainability - Recommended Components and Cost

WET Recommended Components	Sustainability Amount
Workforce Staffing and Support	\$260,000
Trainings for System Transformation	\$100,000
Trainings for/by Consumers and Family Members including LEA, LEW and LE stipends	\$60,000
Behavioral Health Career Programs including MHLAP, Internship, BHRS Career Orientation, CCSIP, and MCOB recruitment/ hiring/ retention strategies	\$80,000
TOTAL	\$500,000

In 2008, counties received guidance^y regarding the continuation and funding of WET approved projects through other MHSA components. The two relevant options for BHRS are transferring MHSA Community Services and Support (CSS) funding (not to exceed 20% of the average amount of MHSA funds allocated for the previous five years) and consolidating programs across other MHSA components.

Recommendation 1: A Systemic Approach to Workforce Education and Training

MHSA investments in workforce, education and training have significantly broadened the continuum of topics covered and the transformation of BHRS as demonstrated by stakeholder perceived key benefits of WET including; Improving Cultural Humility, Increasing Focus on Trauma-informed Care, Creating a Culture of Learning, Improved Standard of Care, Valuing Lived Experience, Building Capacity for Co-occurring Service, Increased Awareness on Importance of Self-Care and Client-Centered Services. Additionally, expansion to include those with lived experience, community partners, contract providers, and interns, which were not supported with much intentionality prior to MHSA WET.

Moving forward, a systemic approach to foundational knowledge and BHRS transformation goals (cultural humility, trauma-informed care, standard of care, co-occurring and other integrated care, lived experience integration, self-care, etc.) should be the standard. Trainings initiate dialogue, personal level impacts, and the beginning of culture shifts. Policies, leadership qualities, and intentional linkages to quality improvement goals advance sustainability and genuine system transformation. Additionally,

^y Department of Health Care Services Information Notice #08-16, published April 4, 2008

measuring the impacts of workforce education and training in alignment with systems change goals, will ensure meaningful activities and appropriate investments.

An example of a systemic approach to transformation is BHRS investments to cultural humility. Championing cultural humility was held as a primary responsibility of the state-mandated Ethnic Services Manager and a cultural competence committee (the Diversity and Equity Council) within the Office of Diversity and Equity (ODE). With MHSA WET investments, resources were made available to develop a training infrastructure for cultural humility priorities. ODE worked with the Quality Improvement Committee to develop policies that reinforced the importance of cultural humility as a standard of quality care; staff with direct client contact are required to participate in the Working Effectively with Interpreters training. Additionally, ODE's Health Equity Initiatives have brought valuable perspectives, insights and liaisons into the BHRS system. HEIs provide critical community voices to the shaping of BHRS' vision and programming rooted in the communities. Most recently, BHRS Leadership' commitment to Multi-Cultural Organizational Development (MCO) engaged BHRS supervisors and managers in monthly dialogues needed to help BHRS realize the potential of cultural humility and inclusion through strategies aimed at personal, interpersonal, and organization levels; setting goals to address implicit bias, power and privilege and around recruitment and hiring, leadership development and training (including making Cultural Humility a required training of all staff), and engaging in challenging topics about race and culture.

Sustainability strategy

A transfer from MHSA CSS will sustain foundational knowledge and other training that supports system transformation (\$100,000) and the workforce staffing (\$260,000) needed to manage, implement, and evaluate WET across the BHRS system of care.

Recommendation 2: Creating Pathways for Individuals with Lived Experience in Behavioral Health Careers and Meaningful Participation

The Lived Experience Academy (LEA) has demonstrated to be a valuable resource for preparing clients/consumers and family members with lived experience to participate in the behavioral health workforce. And, the LEA has not only does LEA provided graduates with knowledge and skills in the area of stigma reduction and advocacy, it empowers and inspires participants to share their stories and supporting their recovery, reduced shame, isolation and increased confidence.

Creating pathways for individuals with lived experience requires a systemic and integrated approach. Moving forward, Training By/For Consumers and Family Members will include the Lived Experience Academy (LEA) and Speakers' Bureau (\$15,000), Lived Experience Stipends (\$10,000) and other trainings such as Recovery and Peer Support 101, Inspired at Work trainings for BHRS Peer Support Workers/Family Partners, Wellness Recovery Action Plans, etc. (\$35,000).

Currently, Peer Support Workers and Family Partners employed throughout the BHRS Youth and Adult Systems are funded through MHSA CSS and supported by the Office of Consumer and Family Affairs (OCFA), a team of diverse consumers and family members with lived experience. It makes sense for OCFA to oversee this strategy with support from WET staff to help coordinate the system-wide trainings. An additional consideration would be for OCFA to contract the Lived Experience Academy, Speakers' Bureau and Stipends to a collaboration of consumer and family member agencies, linking this strategy to

other similar efforts in the community and create a more integrated system. Furthermore, this would provide participants access to the full array of resources held by partner organizations, while at the same time giving an opportunity for leadership development to clients and family members receiving supports and services at or through their specific organization.

Sustainability strategy

Consolidation of the peer and family partners strategies currently funded by MHSA, which also includes the California Clubhouse among other programs will not only sustain but better integrate this programmatic strategy. The recommendation (\$60,000) will be funded through CSS General Systems Development component of MHSA.

Recommendation 3: Promotion of Behavioral Health Careers to Recruit, Hire, and Retain Diverse Staff

The WET internships, and specifically the Cultural Competence Stipend Internship Program (CCSIP), are valuable resources for preparing future clinicians to better understand issues related to both promote the mental/behavioral health field and increase diversity of staff to better reflect our client population and retain diverse staff. CCSIP invaluable outcomes included providing a better understanding of marginalized communities, reinstating participants' commitment to working with their community and being able to have a broad impact on the community not just at the clinical level.

The WET team will continue promoting/monitoring the Mental Health Loan Assumption Program (awards are provided by the State) supporting and strengthening the internship programs (\$55,000) including the CCSIP stipends and specifically paying attention to the challenges in terms of greater support, communication and basic skills training identified by former participants.

More has to be done to recruit , hire and retain diverse staff. The recent MCOG goals include strategies aimed at recruitment, hiring and retaining diverse staff. Currently there is a committee, led by the Director of Adult System of Care and made up of diverse staff looking at specific strategies. A review of the original WET approved plan indicates funding was set aside (\$25,000) for development of targeted materials, outreach and recruitment efforts at schools and cultural/ethnic specific organizations (Historically Black Organizations, etc.), mentoring and developing specific training "promotion readiness" for staff, among other strategies.

Sustainability strategy

A transfer from MHSA CSS (\$80,000) to MHSA WET will sustain internship and outreach strategies currently managed by the WET Coordinator.

Conclusion

This report provides a documentation of the perceived impact that WET funded trainings and programs have had on staff, community-based partners, and contractors over the past 10 years. The interviews with former participants of two programs, LEA and the CSIP allowed for a deeper look into longer-term impacts these programs have had on clients/consumers, family members and behavioral health graduate students.

Throughout the 10 years WET priorities evolved, programs were discontinued, priority efforts (specifically, cultural humility, trauma-informed care, co-occurring care and lived experience integration) were refined. While most of these priorities require a more integrated and systemic approach for meaningful transformation, there is undoubtedly positive impacts, culture shifts and appreciation by stakeholders across the system including staff, partner agencies and clients/consumers and family members. This report has shed light on some areas of further development and improvement and it is expected that strategies will continue to evolve. Given this and the fact that WET funding is now directly tied to service components of MHSA, it will be crucial that the community program planning process incorporate workforce training and development assessment and prioritization where needed.

The Behavioral Health and Recovery Services, Office of Diversity and Equity, Workforce Education and Training look forward to another 10 years of meaningful trainings, programs and most importantly system transformation to better serve the San Mateo County community and especially clients/consumers and family members.

Lived Experience Academy Participants

- *“It made me more confident to present to people who have no idea what it is like to have a serious mental illness, to be able to see me. That is very empowering.”*
- *I have emerged a more compassionate person, the experience has paved the road for what I want to do, what I am passionate about. I want to be a MFT*

Behavioral Health System of Care Staff

- *“[trainings] helped me see my clients in a new light and really, really show respect to them and support them.”*