Mental Health Services Act

WORKFORCE EDUCATION AND TRAINING PLAN

Public Hearing on

November 14th, 2012

EXHIBIT 1: WORKFORCE FACE SHEET

MENTAL HEALTH SERVICES ACT (MHSA) WORKFORCE EDUCATION AND TRAINING COMPONENT
THREE YEAR PROGRAM AND EXPENDITURE PLAN, Fiscal Years 2012 – 13, 2013 – 14, 2014 – 15, 2015 – 16

County: Tri-City Mental Health Center Date: October 11, 2012

This County's Workforce Education and Training component of the Three-Year Program and Expenditure Plan addresses the shortage of qualified individuals who provide services in this County's Public Mental Health System. This includes community-based organizations and individuals in solo or small group practices who provide publicly funded mental health services to the degree they comprise this County's Public Mental Health System workforce. This Workforce Education and Training Component is consistent with and supportive of the vision, values, mission, goals, objectives and proposed actions of California's MHSA Workforce Education and Training Five-Year Strategic Plan (Five-Year Plan), and this County's current MHSA Community Services and Supports component. Actions to be funded in this Workforce Education and Training component supplement state administered workforce programs. The combined Actions of California's Five-Year Plan and this County's Workforce Education and Training component together address this County's workforce needs as indicated in Exhibits 3 through 6.

Funds do not supplant existing workforce development and/or education and training activities. Funds will be used to modify and/or expand existing programs and services to fully meet the fundamental principles contained in the Act.

All proposed education, training and workforce development programs and activities contribute to developing and maintaining a culturally competent workforce, to include individuals with client and family member experience who are capable of providing client and family driven services that promote wellness, recovery, and resiliency, leading to measurable, values driven outcomes. This Workforce Education and Training component has been developed with stakeholders and public participation. All input has been considered, with adjustments made, as appropriate.

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

County Mental Health Director
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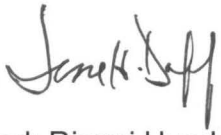
Signature: 

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EXHIBIT 2: STAKEHOLDER PARTICIPATION SUMMARY

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

Tri-City Mental Health Center (TCMHC) has a long track record of engaging in expansive community engagement and stakeholder processes throughout its MHSA planning and implementation efforts. We included more than 6,000 people in the development of our Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) plans.

As a demonstration of our commitment to engaging community stakeholders, TCMHC created a permanent Delegates structure in July 2011. This sixty-member TCMHC Delegates Group ensures that broad stakeholder and community engagement takes a deep hold in our transformed mental health system. A current roster is provided as Attachment A.

The Delegates began developing this Workforce Education and Training Plan in June 2012, although TCMHC staff and consultants began collecting data on workforce education and training needs starting in April 2012 in order to prepare for the planning process. The group began by reviewing a variety of data regarding the workforce, mental health needs, and community-wide demographics. That data was supplemented with information on trends and emerging issues gathered through interviews with key leaders outside of TCMHC, as well as through an internal staff survey that included contractors. More detail on the process used to develop our Workforce Needs Assessment can be found in Exhibit 3.

The Delgates used the following matrix to assist their planning efforts:

Tri-City WET Plan

Where should we invest?

	Engagement continuum					
	Increase interest	Preparation	Recruitment	Hiring/ engagement	Retention	Improve effectiveness
Intensive Tx						
Treatment						
Transition support						
Early Intervention						
Prevention						
Wellbeing						

There are several important perspectives to note about this matrix that informed the perspective of the Delegates and others involved in the planning process:

- TCMHC is aimed at creating a system of care with the community at the center of the system, and TCMHC as one influential part of the system.
- The system includes supports and services that range from intensive forms of mental health interventions to wellbeing activities.
- The public mental health workforce of this system of care is not limited to professional, clinical staff providing treatment services; rather, it also includes staff who provide wellbeing supports, volunteers and caregivers, both paid and unpaid.

Therefore, a key question for TCMHC's WET plan to answer was: "How will we support those who provide support?" Rather than simply focusing our efforts in growing the numbers available to provide support, workgroup participants also concerned themselves with the retention of current staff and volunteers and supporting their initiative and intrinsic motivation for this work. Our expansive perspective on both the system of care and the workforce that comprises it is a critical factor towards understanding the context in which Exhibit 4's Actions were developed.

Beginning in July and working through August, smaller workgroups formed around specific areas for potential workforce investment:

- Workgroup A: Improving the effectiveness of people providing support for treatment
- Workgroup B: Retaining people providing support for treatment
- Workgroup C: Recruiting and preparing people who will provide and support treatment
- Workgroup D: Increasing interest among, recruiting, and preparing people to become volunteers or future staff who can support wellbeing and prevention efforts
- Workgroup E: Improving the retention and effectiveness of people providing support for prevention, early intervention, and wellbeing activities.

These workgroups included Delegates, TCMHC staff, volunteers, consumers and many others. A total of 23 participated in the workgroup process.

After all of the groups brainstormed action steps, it became clear that there was meaningful overlap in the ideas of the workgroups. TCMHC, with the assistance of facilitator consultants, re-organized the workgroups' ideas into two comprehensive proposals: 1) Actions that would apply a systemic approach to learning and improvement, and 2) Actions

that engage volunteers and future employees. Workgroups unanimously approved these proposals and forwarded them to the Delegates for consideration.

In September 2012, the Delegates agreed by consensus to endorse the two proposals which constitute the Workforce Education and Training Plan as submitted here. Both Delegates and other stakeholder participants developed this Innovation Plan.

Delegates and their alternates represented stakeholder perspectives including individuals who receive services; family members; community providers; leaders of community groups in unserved and underserved communities; representatives from the three cities of Claremont, La Verne and Pomona; representatives from the local school districts; primary health care providers; law enforcement representatives; faith-based community representatives; representatives from the LGBTQ community; representatives from LACDMH and other county agencies; and many others. Attachment B contains a roster of individuals in attendance at these meetings.

The Public Hearing for this plan was held on November 14, 2012, and the WET plan was adopted. A summary of comments and a list of outreach efforts are included as Attachments G and H.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category - page 1

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11) White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
A. *Unlicensed* Mental Health Direct Service Staff:										
County (employees, independent contractors, volunteers)										
Mental Health Rehabilitation Specialist	18.0	1	0.0							
Case Manager/Service Coordinators	3.0	1	0.0							
Employment Services Staff	1.0	0	0.0							
Housing Services Staff	2.0	0	0.0							
Consumer Support Staff	12.0	0	0.0							
Family Member Support Staff	0.0	0	0.0							
Benefits/Eligibility Specialist	0.0	0	0.0							
Other *Unlicensed* MH Direct Service Staff	1.0	0	0.0							
Sub-total, A (County)	37.0	2	0.0	4.0	23.0	6.0	5.0	0.0	0.0	38.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Mental Health Rehabilitation Specialist	0.0	0	0.0							
Case Manager/Service Coordinators	0.0	0	0.0							
Employment Services Staff	0.0	0	0.0							
Housing Services Staff	0.0	0	0.0							
Consumer Support Staff	0.0	0	0.0							
Family Member Support Staff	0.0	0	0.0							
Benefits/Eligibility Specialist	0.0	0	0.0							
Other *Unlicensed* MH Direct Service Staff	2.0	0	0.0							
Sub-total, A (All Other)	2.0	0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	2.0
Total, A (County & All Other)	39.0	2	0.0	4.0	25.0	6.0	5.0	0.0	0.0	40.0

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers)										
Psychiatrist, general	2.5	1.0	0.0							
Psychiatrist, child/adolescent	1.0	1.0	0.0							
Psychiatrist, geriatric	0.0	0.0	0.0							
Psychiatric or Family Nurse Practitioner	0.0	0.0	0.0							
Clinical Nurse Specialist	0.0	0.0	0.0							
Licensed Psychiatric Technician	8.0	1.0	0.0							
Licensed Clinical Psychologist	0.0	0.0	0.0							
Psychologist, registered intern (or wiavered)	3.0	1.0	0.0							
Licensed Clinical Social Worker (LCSW)	3.0	1.0	0.0							
MSW, registered intern (or waivered)	3.0	0.0	0.0							
Marriage and Family Therapist (MFT)	4.0	1.0	0.0							
MFT registered intern (or wiavered)	19.0	1.0	0.0							
Other *Licensed* MH Staff (direct service)	0.0	0.0	0.0							
Sub-total, B (County)	43.5	7.0	0.0	11.0	14.0	4.0	10.5	0.0	5.0	44.5
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Psychiatrist, general	1.0	1	0.0							
Psychiatrist, child/adolescent	0.0	0	0.0							
Psychiatrist, geriatric	0.0	0	0.0							
Psychiatric or Family Nurse Practitioner	0.0	0	0.0							
Clinical Nurse Specialist	0.0	0	0.0							
Licensed Psychiatric Technician	0.0	0	0.0							
Licensed Clinical Psychologist	0.0	0	0.0							
Psychologist, registered intern (or wiavered)	0.0	0	0.0							
Licensed Clinical Social Worker (LCSW)	0.0	0	0.0							
MSW, registered intern (or waivered)	0.0	0	0.0							
Marriage and Family Therapist (MFT)	2.5	0	0.0							
MFT registered intern (or wiavered)	0.0	0	0.0							
Other *Licensed* MH Staff (direct service)	0.0	0	0.0							
Sub-total, B (All Other)	3.5	1	0.0	1.4	1.0	0.0	0.6	0.0	0.0	3.0
Total, B (County & All Other)	47.0	8	0.0	12.4	15.0	4.0	11.1	0.0	5.0	47.5

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers)										
Physician	0.0	0	0.0							
Registered Nurse	0.0	0	0.0							
Licensed Vocational Nurse	0.0	0	0.0							
Physician Assistant	0.0	0	0.0							
Occupational Therapist	0.0	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)	0.0	0	0.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0.0	0	0.0							
Sub-total, C (County)	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Physician	0.0	0	0.0							
Registered Nurse	0.3	0	0.0							
Licensed Vocational Nurse	0.0	0	0.0							
Physician Assistant	0.0	0	0.0							
Occupational Therapist	0.0	0	0.0							
Other Therapist (e.g., physical, recreation, art, dance)		0	0.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	0.0	0	0.0							
Sub-total, C (All Other)		0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.3
Total, C (County & All Other)	0.0	0	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.3

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers)										
CEO or manager above direct supervisor	6.0	0	0.0							
Supervising psychiatrist (or other physician)	0.0	0	0.0							
Licensed supervising clinician	7.0	0	0.0							
Other managers and supervisors	8.0	0	0.0							
Sub-total, D (County)	21.0	0	0.0	8.0	8.0	1.0	4.0	0.0	0.0	21.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
CEO or manager above direct supervisor	0.3	0	0.0							
Supervising psychiatrist (or other physician)	0.0	0	0.0							
Licensed supervising clinician	0.0	0	0.0							
Other managers and supervisors	0.0	0	0.0							
Sub-total, D (All Other)	0.3	0	0.0	0.0	0.0	0.0	0.4	0.0	0.0	0.4
Total, D (County & All Other)	21.3	0	0.0	8.0	8.0	1.0	4.4	0.0	0.0	21.4
E. Support Staff:										
County (employees, independent contractors, volunteers)										
Analysts, tech support, quality assurance	7.0	0	0.0							
Education, training, research	0.0	0	0.0							
Clerical, secretary, administrative assistants	11.0	0	0.0							
Other support staff (non-direct services)	8.0	0	0.0							
Sub-total , E (County)	26.0	0	0.0	6.0	13.0	3.0	4.0	0.0	0.0	26.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Analysts, tech support, quality assurance	0.0	0	0.0							
Education, training, research	0.0	0	0.0							
Clerical, secretary, administrative assistants	0.5	0	0.0							
Other support staff (non-direct services)	0.0	0	0.0							
Sub-total , E (All Other)	0.5	0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5
Total, E (County & All Other)	26.5	0	0.0	6.0	13.0	3.5	4.0	0.0	0.0	26.5

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

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTEs currently in the workforce -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
***County (employees, independent contractors, volunteers)* (A+B+C+D+E)**	127.5	9	0.0	29.0	58.0	14.0	23.5	0.0	5.0	129.5
***All Other (CBOs, CBO sub-contractors, network providers, and volunteers* (A+B+C+D+E)**	6.3	1	0.0	1.4	3.3	0.5	1.0	0.0	0.0	6.1
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	133.8	10	0.0	30.4	61.3	14.5	24.5	0.0	5.0	135.6

F. TOTAL PUBLIC MENTAL HEALTH POPULATION

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of individuals planned to be served -- Col. (11)						
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	All indivi-duals (5)+(6)+ (7)+(8)+ (9)+(10)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
F. TOTAL PUBLIC MH POPULATION	**Leave Col. 2, 3, & 4 blank**			286	703	308	37	8	51	1393

NOTE: Detail may not add to total, due to rounding.

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated for Individuals with Consumer an

Major Group and Positions	Estimated # FTE authorized and to be filled by consumers or family members	Position hard to fill with consumers or family members? 1=Yes; 0=No	# additional consumer or family member FTEs estimated to meet need
(1)	(2)	(3)	(4)
A. *Unlicensed* Mental Health Direct Service Staff:			
Consumer Support Staff	12.0	0	0.0
Family Member Support Staff	0.0	0	0.0
Other *Unlicensed* MH Direct Service Staff	0.0	0	0.0
Sub-total, A:	12.0	0	0.0
B. *Licensed* Mental Health Staff (direct service)	0.0	0	0.0
C. Other Health Care Staff (direct service)	0.0	0	0.0
D. Managerial and Supervisory	0.0	0	0.0
E. Support Staff (non-direct services)	0.0	0	0.0
GRAND TOTAL (A+B+C+E+E)	12.0	0	0.0

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

Language, other than English		Number who are proficient	Additional number who need to be proficient	**TOTAL (2)+(3)**
(1)		(2)	(3)	(4)
1. Spanish	Direct Service Staff	47	8	55
	Others	1	0	1
2. Vietnamese	Direct Service Staff	6	5	11
	Others	0	0	0
3. Cantonese	Direct Service Staff	2	3	5
	Others	1	0	1
4. Hmong	Direct Service Staff	1	0	1
	Others	0	0	0
5. Farsi	Direct Service Staff	0	0	0
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	56	16	72
	Others	2	0	2

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

Introduction

TCMHC conducted its Workforce Needs Assessment during the spring and early summer of 2012 to provide the Delegates with an expanded data set to consider during their WET planning process. In addition to Exhibit 3, the Delegates were provided the following four documents:

- A collection of charts comparing various demographic attributes relevant to our communities (provided as Attachment C);
- "Maps" of current resources and programs available for workforce needs, as well as trends in the field (provided as Attachment D);
- "Maps" that summarize the current Tri-City system of care and gaps and emerging needs that were identified through qualitative interviews with key stakeholders (provided as Attachment E); and,
- Results of a survey of TCMHC staff that was conducted specifically for the WET planning process (a summary of themes from that survey is provided as Attachment F).

Two clear needs emerged out of the workgroup discussions that formed the basis of the Actions proposed in this plan. The first is a need for a systematic and sustained approach to training and learning within TCMHC. TCMHC has grown dramatically over the past five years, and we now manage complex and diverse programs that have outpaced our current informal methods of training and learning.

The second need is for a deeper pool of volunteers and future employees who also have a realistic understanding of community mental health. While there are very limited opportunities for employment available, there are significant volunteer opportunities that can be harnessed to support the wellbeing efforts in the three cities. Additionally, TCMHC sees a long-term benefit in beginning to focus on the training and education of young people going into careers in mental health, as the shift toward community mental health may require time to take hold.

A. Shortages by occupational category:

Exhibit 3 asks for FTEs needed to fill need *by job category;* however, we believe that what Exhibit 3 wants to know generally is the number of additional staff that would be needed in order to meet public mental health needs. Towards that end, we respectfully offer the following macro-level calculation instead:

- The estimated unmet need of public mental health population in the Tri-City area not currently receiving services in formal clinical public settings is 5,846 people.[1]
- The number of additional clinical staff needed to serve those additional 5,846 people would be 365.[2]

In other words, TCMHC is currently serving 20% of the public mental health needs, so to serve 100% of the need we would need to have five *times* the number of current clinical staff.

TCMHC and the Delegates realized early in the MHSA planning process that the need for services will always exceed the resources available to meet that need if we assume that the need can only be met by clinical services. Therefore, TCMHC and the Delegates adopted a model of looking at the system of care from the perspective of a community that supports the wellness of its whole population, and from there considered what role TCMHC could play in providing services and strengthening the community's capacity to care for itself. So where Exhibit 3 requests the number of FTEs needed to fill the need by job category we have marked them all as 0, because we do not anticipate the significant resources required to fill those positions and have decided to focus our MHSA resources on investments in building the community's capacity to create a system of care consistent with MHSA principles.

That said, there are specific areas where we would like to meet particular occupational shortages. In particular, we have found Mental Health Rehabilitation Specialists and Case Manager/Service Coordinator positions to be hard to fill. While there are many applicants, few are well-prepared for the realities and challenges of community mental health. Action #8 detailed in Exhibit 4 is designed specifically to help better prepare students in local college and university programs to address this situation.

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[1] This figure was calculated by taking the population at or below 200% of poverty for the cities of Claremont, Pomona and La Verne (estimated to be 91,962 based on the US Census 2010 data) and multiplying it by the SMI/SED prevalence rate for SPA 3 (7.88% according to LACDMH 2008). The result is 7,247 people in the public mental health population. Then we subtracted the number of people currently receiving clinical services through TCMHC (1,401 people based on 2011-12 actual counts).

[2] This figure was calculated by taking the number of people currently receiving TCMHC clinical services (1,401) and dividing it by the number of clinical staff (87 according to 2011-12 actual count) and applying that ratio to the number of public mental health population not currently receiving services (5,846).

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

The following is a chart from the Ethnic Diversity Analysis of the data packet reviewed by the Delegates during the WET planning process, which is provided as Attachment C, page 1. The numbers for TCMHC come from our own internal tracking sources and include all staff positions and contractors as of June 30, 2012.

	Tri-Cities	200% Poverty	SMI/SED	TC Consumers	TC Staff
White	26.2%	12.4%	22.1%	21.5%	22.4%
Latino	56.6%	63.8%	48.7%	49.4%	45.2%
African American	5.9%	9.0%	4.5%	21.6%	10.7%
American Indian	0.3%	1.6%	0.2%	0.6%	0.0%
API	9.0%	6.8%	25.2%	3.0%	18.0%
Multi-Race/Other	2.0%	6.4%	0.0%	3.9%	3.7%
Total	100.0%	100.0%	100.7%	100.0%	100.0%

Based on this analysis, TCMHC ideally would like to hire six more clinical staff members of African American heritage.

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

Under the category of Consumer Support Staff, TCMHC has listed 12 FTE Community Support Workers, the role designated for people with lived experience with mental illness. TCMHC actually has a greater number of people in these roles, but they work on a part-time basis. In addition, a significant number of staff *across all positions in the organization* has direct lived experience with mental illness and are not limited to this position.

D. Language proficiency:

Below are the data presented to the Delegates for their WET planning process (pages 3 and 4 of Attachment C).

	Total Population			Relative %		
	La Verne	Claremont	Pomona	% La Verne	% Claremont	% Pomona
English	23,571	26,572	52,163	75.9%	76.1%	35.0%
Spanish	4,547	3,310	83,136	14.6%	9.4%	55.8%
API	782	2,696	12,120	2.5%	7.7%	8.1%
Other	2,163	2,347	1,639	6.9%	6.7%	1.1%

	Tri-Cities population primary language spoken at home	TC staff language capacity in addition to English	# of TC staff
Monolingual English	47.6%	42.4%	53
Spanish	42.3%	38.4%	48
API	6.7%	12.0%	15
Other*	3.5%	7.2%	9
Total	100.0%	100.0%	125

* TCMHC has a high degree of diversity and capacity to serve its communities. We would like to note that:

- Three direct service staff speak Tagalog;
- One manager who also does some direct service speaks Japanese;
- Two direct service staff speak Kutchi, a dialect of Sindhi;
- Three direct service staff speak Hindi;
- One manager speaks Punjabi;

- Two staff speak Urdu; and,
- One supervisor (who also provides direct services) speaks Mandarin and Taiwanese.

We have found it hard to fill clinical positions with staff who speak Vietnamese or Spanish. In addition, TCMHC would ideally like to have a total of 15 staff members who speak Vietnamese, Cantonese or Mandarin.

E. Other, miscellaneous:

Staff turnover was an issue that appears to now be stabilizing. In FY 2009-10, TCMHC had a turnover rate of 8.33%. It spiked during FY 2010-11 to 32%, which was during a time of significant changes in how we conducted and documented our work. This past fiscal year (FY 2011-12) TCMHC was at a 16% turnover rate, however several staff members moved from direct service provision to non-billable MHSA programs. The recent decline in turnover is an indication to us that there is now more stability in staffing thanks to improved matches of staff to positions and the investments we have made in training.

Thanks to the Inter-Faith Collaborative Project at Tri-City, we have several religious denominations represented at TCMHC which allows us to use spirituality with clients in treatment and recovery. Our staff includes those who practice Christianity, Catholicism, Mormonism, Islam, Buddhism, Sikhism, Hinduism and Judaism.

EXHIBIT 4: WORK DETAIL

Please provide a brief narrative of each proposed Action. Include a title, short description, objectives on an annualized basis, a budget justification, and an amount budgeted for each of the fiscal years included in this three-year plan. The amount budgeted is to include only those funds that are included as part of the County's planning estimate for the workforce education and training component. The following is provided as a format to enable a description of proposed Actions.

Introduction

TCMHC is creating a system of care that acknowledges that communities already support each other's mental health. Further, TCMHC plays an influential role in both providing services and strengthening the community's ability to support their members and each other in seeking and maintaining mental health and wellbeing.

Towards this holistic model, TCMHC considers the system of care to run along a continuum of services that ranges from intensive forms of mental health interventions (such as full service partnerships and other clinical services) to wellbeing activities (such as peer support groups and self-care activities).

Thinking of the system of care broadly also requires us to reconsider what is meant by the "public mental health workforce." Therefore, for this WET Plan, TCMHC considers the public mental health workforce to include professional, clinical staff providing treatment services, staff who provide wellbeing supports, and volunteers and caregivers, both paid and unpaid.

A key question for TCMHC's WET plan to answer was: "How will we support those who provide support?" Two themes emerged in answer to that question:

- TCMHC needs to develop a systemic approach to learning and improvement that furthers the goals and principles of MHSA; and
- TCMHC needs to increase the interest, preparation and recruitment of volunteers and future employees along the entire continuum of care.

The Actions that address the need for a systemic approach to learning and improvement are listed under the Training and Technical Assistance section, and the Actions that address increasing the interest, preparation and recruitment of volunteers and future employees are detailed under Mental Health Career Pathways. Staffing for both efforts are included as Action items under Workforce Staffing Support.

No Actions will be taken in the areas of Residency, Internship Programs nor Financial Incentives. Instead, TCMHC will utilize existing regional and state programs in these areas.

Please note that TCMHC is providing a four-year budget plan rather than a three-year plan as instructed, because according to MHSA, all WET funding needs to be expended by Fiscal Year 2015-16.

A. Workforce Staffing Support

Action #1 – Title: Hire a Learning Ally (a.k.a. the WET Coordinator)

Description: As part of creating a systemic approach to learning within the system of care, TCMHC will hire a Learning Ally who will oversee the development of the strategic learning plan and be responsible for the development of the infrastructure to implement the learning plan, as detailed in the Actions listed under the Training and Technical Assistance section of this Exhibit.

The Learning Ally will be hired during fiscal year 2012-13.

Objectives: The Learning Ally will help design and implement an on-going learning management system to strengthen MHSA values, leverage learning resources across the system of care, and make learning opportunities and resources more readily accessible.

Budget justification: A total of $300,800 over four fiscal years is allocated to cover salary and benefits for this full-time position.

Budgeted Amount: FY 2012-13: $70,400 FY 2013-14: $76,800 FY 2014-15: $76,800 FY2015-16: $76,800

Action #2 – Title: Assign a presentation coach to support staff and volunteers

Description: One theme among the Actions included in the Training and Technical Assistance section is that TCMHC draw upon the skills and knowledge base of current staff and volunteers as a source of internal expertise that can be shared more broadly among colleagues. This Action is proposed as a way to support current staff and volunteers to be able to do so.

TCMHC already has identified current staff who can fill this role, therefore this Action can be completed during fiscal year 2012-13.

Objectives: The presentation coach will support staff and volunteers who wish to share their knowledge and experience but who lack the ability to create and deliver effective learning materials.

Budget justification: No costs are associated with this Action. The responsibilities will take up minimal amounts of time, so no costs are foreseen.

Budgeted Amount: Not applicable.

Action #3 – Title: Hire a Volunteer and Future Career Coordinator

Description: As part of the Actions listed under Mental Health Career Pathways, TCMHC will hire a Volunteer and Future Career Coordinator who will oversee the development of a map of volunteer opportunities, build a system for identifying priority needs for volunteers, recruit and prepare volunteers, and support the building of relationships with area high school and college leaders.

The Volunteer and Future Career Coordinator will be hired by January 2013.

Objectives: Volunteer and Future Career Coordinator will build systems and relationships that will create a stronger pool of interested volunteers and potential staff member in ways that can sustain themselves beyond the period of this initial WET investment.

Budget justification: A total of $210,000 over four fiscal years is allocated to cover salary and benefits for this full-time position.

Budgeted Amount: FY 2012-13: $30,000 FY 2013-14: $60,000 FY 2014-15: $60,000 FY 2015-16: $60,000

B. Training and Technical Assistance

Action #4 – Title: Draft and implement a strategic learning plan

Description: TCMHC in collaboration with community partners will draft and implement a strategic learning plan to support the emerging system of care over the next 3 years and beyond. This plan will build upon the work already done for WET planning, the emerging Results Based Accountability performance measures for each program, and other unfolding developments.

The steps to develop this plan will include work to:

1. Catalog existing learning resources across the system of care—e.g., the Mental Health Toolkit for teachers, MHFA training and materials, NAMI and Pacific Clinics programs and materials, Wellness Center programs, Family Wellbeing programs and materials, role-play based training for Integrated Services programs, and others;
2. Conduct periodic surveys of staff, providers, and volunteers, including individuals with lived experience of mental illness and family members, to identify gaps and priority learning focus areas; and,
3. Develop strategic learning activities based on identified priorities that expand upon and do not supplant current efforts.

Learning activities will likely include:

- Formal courses and training sessions led by current staff, volunteers, and/or consultants to meet an identified learning priority;
- Informal learning sessions to focus on particular practices or topics in a more relaxed way—e.g., one-time workshops, drop in periodic activities, ongoing “Lunch and Learn” sessions for staff and volunteers;
- On-line learning activities—e.g., self-guided and interactive tutorials focusing on particular skill sets and practices; and,
- Periodic Learning Summits for staff, volunteers, and/or the larger public to educate, share resources and best practices, recognize outstanding contributors, and celebrate successes through story-telling and other activities.

All topics for learning covered by the WET Plan will help to further the intent of MHSA. Examples of topics to be addressed through one or more learning activities include:

- Cultural competency awareness, skills about the specific ethnic and cultural groups in the Tri-City area, and foreign language instruction;
- Evidence based practices, best practices, and promising practices grounded in recovery and resiliency;

- Coping skills for people who are in treatment;
- Co-occurring disorders and advanced skills needed for developing treatment plans and strength-based engagement, particularly for TAY;
- Effective engagement of communities, especially underserved groups to reduce stigma and support wellbeing;
- Essential skills for working effectively within diverse groups such as presenting and group facilitation; and,
- Sharing “stories from the field” by seasoned clinicians and volunteers, including individuals with lived experience and family members to deepen understanding about effective engagement and recovery processes.

Staff and volunteers will be relied upon whenever possible. If a priority learning need cannot be met through currently available resources and personnel, TCMHC will engage consultants to develop the necessary content and processes. The Learning Ally will work with presenters and use the learning management system (see Action #5) to systematically assess the effectiveness of learning activities and improve future activities.

TCMHC is using the RBA framework to develop performance measures across all TCMHC programs. As we track trends across these performance measures, we foresee a need for staff and volunteers to master the capacity to hold learning conversations to reflect on data and improve the impact of their efforts.

In addition, the strategic learning plan will also develop and implement a leadership development curriculum. This curriculum will include content such as: inspiring oneself and others, listening with genuine openness, soliciting feedback and making it safe for others to share ideas and feel valued, offering supportive critique instead of criticism, expressing frequent appreciation, strength-based problem solving and engagement, and building strong relationships. These skills can be developed through small group discussions, experiential exercises, 1-1 coaching and mentoring sessions, and others activities.

Lastly, TCMHC will support a self-care initiative led by a voluntary committee of staff and volunteers from across TCMHC to identify and organize a variety of no-cost or very low-cost self-care activities.

Objectives: This Action intends to increase the effectiveness of staff and volunteers, and by creating a learning environment that supports the delivery of higher quality, more consistent, and cost-effective services as well as supports for recovery and wellbeing activities.

This Action also creates opportunities for staff to develop and enhance their own learning and professional development in ways that increase their intrinsic motivation and satisfaction. By creating and delivering content that they enjoy and

excel at, staff and volunteers will have opportunities to strengthen their own skills, contribute to the overall work environment, and be recognized for their expertise.

The leadership development curriculum, in particular, aims to support and strengthen the leadership capacity of all staff and volunteers, regardless of formal authority, to better fulfill the intentions and spirit of MHSA.

As part of the development of a strategic learning plan, staff and consultants will develop performance measures to regularly assess: How much did we do? How well did we do it? Is anyone better off? These performance measures will be tracked within the ongoing Results Based Accountability system evolving within TCMHC. In addition, every learning activity will be assessed for positive impact and to guide judgments about how to improve the activity in subsequent iterations.

Budget justification: Budget includes anticipated expenses for course materials, the creation of custom curriculum, learning summits, and other materials as needed.

Budgeted amount: FY 2012-13: $60,000 FY 2013-14: $70,000 FY 2014-15: $75,000 FY 2015-16: $75,000

Action #5 – Title: Develop a learning support infrastructure within TCMHC

Description: TCMHC will develop an infrastructure to support the implementation of the strategic learning plan. A major component of this infrastructure will be an on-line learning management system to facilitate the development, coordination, tracking, and assessment of system-wide learning activities.

TCMHC plans to engage an e-learning consulting firm to help assess software options, identify priorities, and develop this on-line management system. The consultant(s) will work with TCMHC staff to:

- Research available learning management system software options and determine the optimal software for Tri-City's existing information technology and learning needs;
- Conduct a survey of TCMHC staff members and volunteers, as needed, to assess preferred learning styles and preferences related to electronic learning delivery options - e.g. videos, on-line instruction, webinar, and other technology; and,
- Purchase and install a learning management system software package, including cameras and other equipment needed to capture, deliver, and facilitate learning activities.

In addition, TCMHC will create a learning resource library with books, papers, audio and video resources, and other materials related to the public mental health workforce and community mental health. The learning resource library will be available to staff, volunteers, and possibly the larger public.

TCMHC will also explore the possibility of offering incentives to encourage staff and volunteers to actively engage in learning activities. Incentives may include informal and formal recognition processes, continuing education units (CEUs), and others to be developed.

Objectives: The activities in this Action are designed to create an infrastructure for systematically coordinating and extending efforts to implement the strategic learning plan and successfully address the identified learning priorities for staff and volunteers.

As part of the development of a strategic learning plan, staff and consultants will develop performance measures to regularly assess: How much did we do? How well did we do it? Is anyone better off? These performance measures will be tracked within the ongoing RBA system evolving within TCMHC. In addition, every learning activity will be assessed for positive impact and to guide judgments about how to improve the activity in subsequent iterations.

Budget justification: Budget includes anticipated expenses for the purchase, development and training in an online learning management system; the development of a learning resource center; and learning incentives.

Budgeted amount: FY 2012-13: $75,000 FY 2013-14: $15,000 FY 2014-15: $15,000 FY 2015-16: $15,000

C. Mental Health Career Pathway Programs

Action #6 – Title: Increase pool of diverse, engaged and effective volunteers

Description: The need and demand for mental health services in the Tri-City area far exceeds the current and projected availability of services. Given this reality, the more effective we can become at recruiting and using volunteers to augment recovery and wellbeing supports provided by staff, the greater the positive impact we can have for people struggling with mental health issues.

In addition, recruiting and supporting volunteers in the mental health system is an effective anti-stigma strategy, not only for the volunteers themselves, but for the people they are in relationship with as well.

First, TCMHC will develop a map of existing and projected volunteer opportunities to provide tangible support to program staff and the people they serve across TCMHC programs and our partners.

Next, we will develop and implement a plan to identify, recruit, train and match volunteers to existing and projected volunteer opportunities. Activities conducted through this plan will likely include:

- Health and wellbeing fairs coordinated as appropriate with other partners and community offerings;
- Community presentations;
- Inspirational videos; and,
- Other culturally-appropriate means to attract diverse and effective volunteers.

Objectives: Given the expanding gap between available services and need, TCMHC seeks to expand the pool of volunteers who can engage with the community to help extend the impact of currently funded mental health and wellbeing programs across the three cities.

Budget justification: Budget includes anticipated expenses for identifying volunteer opportunities and implementing plans to increase the pool of volunteers.

Budgeted amount: FY 2012-13: $5,000 FY 2013-14: $10,000 FY 2014-15: $10,000 FY 2015-16: $10,000

Action #7 – Title: Increase the pool of local public and private high school students informed about and interested in careers in community mental health, particularly in the Tri-City area.

Description: While currently there is little demand for new staff members, either within TCMHC or our partners, this will not always be the case. Turnover and the evolution of the system will generate need for new staff members over time. Developing a more systematic approach to encouraging high school and college students to realistically consider a career in the community mental health field in the Tri-City area will have long-term benefits for TCMHC and our partners.

TCMHC will conduct the following activities towards increasing this pool of high school students:

- Cultivate relationships with area high school Regional Occupational Program (ROP) faculty and administrators in the three school districts;
- Facilitate the expansion of existing Health Careers program with curriculum about careers in community mental health;
- Develop and coordinate opportunities for Tri-City staff, volunteers, and partners to present to high school students about career and volunteer opportunities; and,
- Connect interested students with community service, internship, or shadow-for-a-day opportunities related to community mental health.

Objectives: This Action aims to develop a more systematic approach to encouraging students to realistically consider a career in the community mental health field in the Tri-City area. It builds upon existing programs already in operation.

Budget justification: Budget includes anticipated expenses for cultivating needed relationships within school faculty and administration and implementing programs.

Budgeted amount: FY 2012-13: $1,250 FY 2013-14: $2,500 FY 2014-15: $2,500 FY 2015-16: $2,500

Action #8 – Title: Increase the pool of local college students informed about and interested in careers in community mental health, particularly in the Tri-City area.

Description: Local college and university programs offer degrees in Marriage and Family Therapy (as opposed to Masters of Social Work) which are not oriented towards consideration of community mental health as a career choice. However, new state law SB33 now mandates that MFT programs incorporate community mental health delivery into their

curricula beginning with the fall semester 2012. This legislative change is an opportunity for TCMHC to help students consider a career in community mental health and prepare them for success.

Activities that TCMHC will pursue to increase the pool of local college students informed about and interested in careers in community mental health include the following:

- Cultivate relationships with mental health counselors, career counselors, faculty, deans, and administrators at local area colleges and universities.
- Develop and coordinate opportunities for Tri-City staff, volunteers, and partners to impact curriculum in related courses to better prepare college students for careers in community mental health, particularly in the Tri-City area. This work can build upon the momentum created by the passage of SB 33.
- Develop and coordinate opportunities for Tri-City staff, volunteers, and partners to serve as guest lecturers and/or instructors to ground students in the realities of community mental health practice and to encourage them to consider these fields of service and support.
- Develop and coordinate opportunities for undergraduate and graduate programs to include on-site learning opportunities at the Wellness Center and/or clinic.
- Develop and coordinate internship and volunteer opportunities for local area students.
- Develop and coordinate opportunities for Tri-City staff, volunteers, and partners to participate in career day fairs and related activities.

Objectives: This Action aims to develop a more systematic approach to encouraging students to realistically consider a career in the community mental health field in the Tri-City area.

Budget justification: Budget includes anticipated expenses for cultivating needed relationships within school faculty and administration and implementing programs.

Budgeted amount: FY 2012-13: $1,250 FY 2013-14: $2,500 FY 2014-15: $5,000 FY 2015-16: $5,000

EXHIBIT 5: ACTION MATRIX

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

Actions (as numbered in Exhibit 4)	Promotes wellness, recovery and resilience	Promotes culturally competent service delivery	Promotes meaningful inclusion of clients/family members	Promotes an integrated service experience for clients and their family members	Promotes community collaboration	Staff support (infrastructure for workforce development)	Resolves occupational shortages	Expands postsecondary education capacity	Loan forgiveness, scholarships, and stipends	Regional partnerships	Distance learning	Career pathway programs	Employment of clients and family members within MH system
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Action # 1: Hire a Learning Ally (WET Coordinator)	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐
Action # 2: Assign a presentation coach to support staff and volunteers	☑	☑	☐	☐	☑	☑	☐	☐	☐	☐	☐	☐	☐
Action # 3: Hire a Volunteer and Future Career Coordinator	☐	☐	☐	☐	☑	☑	☐	☑	☐	☐	☐	☑	☐
Action # 4: Draft and implement a strategic learning plan	☑	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☐
Action # 5: Develop a learning support infrastructure within TCMHC	☑	☑	☐	☐	☐	☑	☐	☐	☐	☐	☑	☐	☐
Action #6: Increase pool of diverse, engaged and effective volunteers	☑	☑	☑	☐	☐	☐	☐	☐	☐	☐	☐	☑	☐
Action # 7: Increase the pool of local public and private high school students informed about and interested in careers in community mental health, particularly in the Tri-City area	☑	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐
Action # 8: Increase the pool of local college students informed about and interested in careers in community mental health, particularly in the Tri-City area	☑	☑	☐	☐	☐	☐	☐	☑	☐	☐	☐	☑	☐

Note: All of the actions affect most of these criteria, but we have selected the top four criteria as instructed.

EXHIBIT 6: BUDGET SUMMARY

Fiscal Year 2012-13			
Activity	Funds Approved Prior to Plan Approval (A)	Balance of Funds Requested (B)	Total Funds Requested (A+B)
A. Workforce Staffing Support	$0	$100,400	$100,400
B. Training and Technical Assistance	$0	$135,000	$135,000
C. Mental Health Career Pathway Programs	$0	$7,500	$7,500
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$0	$0	$0
Indirect Costs (15% of direct costs)	$0	$36,435	$36,435
	GRAND TOTAL FUNDS REQUESTED for FY 2012-13		$279,335

Fiscal Year 2013-14			
Activity	Funds Approved Prior to Plan Approval (A)	Balance of Funds Requested (B)	Total Funds Requested (A+B)
A. Workforce Staffing Support	$0	$136,800	$136,800
B. Training and Technical Assistance	$0	$85,000	$85,000
C. Mental Health Career Pathway Programs	$0	$15,000	$15,000
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$0	$0	$0
Indirect Costs (15% of direct costs)	$0	$35,520	$35,520
	GRAND TOTAL FUNDS REQUESTED for FY 2013-14		$272,320

Fiscal Year 2014-15			
Activity	Funds Approved Prior to Plan Approval (A)	Balance of Funds Requested (B)	Total Funds Requested (A+B)
A. Workforce Staffing Support	$0	$136,800	$136,800
B. Training and Technical Assistance	$0	$90,000	$90,000
C. Mental Health Career Pathway Programs	$0	$17,500	$17,500
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$0	$0	$0
Indirect Costs (15% of direct costs)	$0	$36,645	$36,645
	GRAND TOTAL FUNDS REQUESTED for FY 2014-15		$280,945

Fiscal Year 2015-16			
Activity	Funds Approved Prior to Plan Approval (A)	Balance of Funds Requested (B)	Total Funds Requested (A+B)
A. Workforce Staffing Support	$0	$136,800	$136,800
B. Training and Technical Assistance	$0	$90,000	$90,000
C. Mental Health Career Pathway Programs	$0	$17,500	$17,500
D. Residency, Internship Programs	$0	$0	$0
E. Financial Incentive Programs	$0	$0	$0
Indirect Costs (15% of direct costs)	$0	$36,645	$36,645
	GRAND TOTAL FUNDS REQUESTED for FY 2015-16		$280,945

TRI-CITY MENTAL HEALTH CENTER
PERMANENT DELEGATES STRUCTURE - BEGINNING 06/2011

DELEGATES LISTING
ALPHA BY ORGANIZATION
Updated: 01/30/2012

Delegate / Alternate		Last Name	First Name	Agency/Business	City
1	Delegate	Hinton	Rick	American Recovery Center	Pomona
2	Alternate	Cockrell	Carolyn	Bonita Unified School District	La Verne
3	Delegate	Sifter	Nancy	Bonita Unified School District	La Verne
4	Delegate	Brown	I.R.F.	Brown Memorial Temple	Pomona
5	Alternate	Brown	Cynthia	Brown Memorial Temple	Pomona
6	Delegate	Willingham PsyD	Michele	Cal Poly Pomona	Pomona
7	Delegate	Goldwater	Helaine	City of Claremont Committee on Aging	Claremont
8	Alterate	Rosenthal	Karen	City of Claremont Committee on Aging	Claremont
9	Alternate	Bloom	Arny	Claremont Unified School District	Claremont
10	Delegate	Geske	Judy	Claremont Unified School District	Claremont
11	Alternate	Wolfrom	Jennifer	Claremont Unified School District	Claremont
12	Delegate	Cerda	Tony	Costanoan Rumsen Tribe	Pomona
13	Alternate	Barela	Daniel	Costanoan Rumsen Tribe	Pomona
14	Alternate	Derrick	Victoria	East Valley Community Health Center, Inc.	Pomona
15	Delegate	Mardini	Alicia	East Valley Community Health Center, Inc.	Pomona
16	Delegate	French	Anitra	Hope Resource Group	Pomona
17	Alternate	Shaw	Carina	Hope Resource Group	Pomona
18	Alternate	Keo (Dr.)	Sam	LA County Department of Mental Health	LA County
19	Delegate	Larios	Alfredo	LA County Department of Mental Health	LA County
20	Delegate	Gordon	Andrea	LA County Probation Department	LA County
21	Delegate	Taylor	Ellen	League of Women Voters	Claremont
22	Delegate	Bonodie	Heidi	NAMI Pomona Valley	Tri-Cities
23	Delegate	Watkins	Tim	NAMI Pomona Valley	Tri-Cities
24	Alternate	Bunce	Dick	NAMI of Pomona Valley	Tri-Cities
25	Alternate	Fay	Michael	NAMI of Pomona Valley	Tri-Cities
26	Alternate	Cheng	C. Rocco	Pacific Clinics	Pomona
27	Delegate	Reyes	Kathy	Pacific Clinics	Pomona
28	Delegate	Rambaran	Sham	Pomona First Baptist	Pomona
29	Delegate	Ellis	Michael	Pomona Police Department	Pomona
30	Delegate	Azevedo	Patricia	Pomona Unified School District	Pomona
31	Alternate	Meza	Fernando	Pomona Unified School District	Pomona
32	Alternate	Garcia M.D.	Jamie	Pomona Valley Hospital Medical Ctr	Pomona
33	Delegate	Pavlov	Anna	Pomona Valley Hospital Medical Ctr	Pomona
34	Delegate	Boynton	Julie	Project Sister Family Services	Pomona
35	Delegate	Garcia	Robert	TAY (Cal Poly Student)	Pomona
36	Delegate	Corona	Nicholas	TAY (Damien High School)	La Verne
37	Alternate	Tran	Lisa	TCMCH Staff - Adult	Tri-Cities
38	Delegate	Baron	Mary	TCMCH Staff - Adults	Tri-Cities
39	Delegate	Crane	Paul	TCMCH Staff - Adults	Tri-Cities

TRI-CITY MENTAL HEALTH CENTER
PERMANENT DELEGATES STRUCTURE - BEGINNING 06/2011

DELEGATES LISTING
ALPHA BY ORGANIZATION
Updated: 01/30/2012

40	Delegate	Polanco	Gamaliel	TCMCH Staff - Wellness Center	Tri-Cities
41	Delegate	Lyons	Joseph M	TCMHC Governing Board	Claremont
42	Alternate	PENDING	PENDING	TCMHC Governing Board	
43	Delegate	Garcia	Maria Elena	TCMHC MH Commission	Pomona
44	Alternate	Whitlock, Ph.D.	Sylvia	TCMHC MH Commission	La Verne
45	Alternate	Garcia	Patricia	TCMHC Peer-to-Peer Seniors	Claremont
46	Delegate	Lee	Bob	TCMHC Peer-to-Peer Seniors	Claremont
47	Alternate	Murillo	Christian	TCMHC Peer-to-Peer TAY	Pomona
48	Alternate	Blackshear	Keisha	TCMHC Staff - Childrens	Tri-Cities
49	Alternate	Chandler	Terri	TCMHC Staff - Childrens	Tri-Cities
50	Delegate	Mintie	Nancy	Uncommon Good	Claremont
51	Delegate	Martin	Luci	University of La Verne	La Verne
52	Alternate	Nakamura	Nadine	University of La Verne	La Verne
53	Delegate	Céspedes-Knadle Ph.D	Yolanda	University of La Verne	La Verne
54	Alternate	Chavez	Naomi	Veterans Wellness Collaborative	Pomona
55	Delegate	Henderson	Anne	Youth & Family Master Plan (Pomona)	Pomona
56	Delegate	Barry	Candace	Community member	Pomona
57	Delegate	Gonzales	Eduardo	Community member	Pomona
58	Delegate	Holstrom	Geoffrey	Community member	Claremont
59	Delegate	McNicoll	Sandra	Community member	Claremont
60	Delegate	Montesion	Noelle	Community member	La Verne
61	Delegate	Sanchez	Laura	Community member	Pomona
62	Delegate	Schuman	Evelyn	Community member	Claremont
63	Delegate	Watson	Toni Lynn	Community member	Pomona
64	Delegate	Byers	Jonathan	DCFS - Pomona	Pomona
65	Alternate	Nancy	Urquilla	DCFS - Pomona	Pomona

TRI-CITY Mental Health Services

MHSA Delegates Meeting - WET
Ganesha Park Community Center
1575 N White Avenue - Pomona CA 91767
September 20, 2012 5:30 p.m.

Name	Affiliation / Agency	Phone Number	Email Address
[illegible]	[illegible]	—	—
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NOELLE MONTESION	TRI-CITY	909-971-3656	NOELEMONTESION@YAHOO.COM
Toni Lynn Watson	Tri city	909 730-2683	lynnkitty1@yahoo.com
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Anny Bloom	Claremont Unified	909-[illegible]-0806	annybloom@mac.com
Chris Ucatzo	NAMI PV	909.920.0905	frank.vendai@gMail.com
Cathy Winkelen	Cal Poly Pomona		
Kimmie Hundal	Tri-City.		
Lisa Tran	TCMH		

TRI·CITY
Mental Health Services

MHSA Delegates Meeting - WET
Ganesha Park Community Center
1575 N White Avenue - Pomona CA 91767
September 20, 2012 5:30 p.m.

Name	Affiliation / Agency	Phone Number	Email Address
Denise Gatlin	TRI-City	909-618-6142	
Joseph Lyons	Tri-City Board		
Cindy Cockrell	BUSD	909-971-8207 x7713	
Nancy Sifton	BUSD	" "	
Ruth Bonn	NAMI	on file	
Jesse Dutt	Tri-City		
Sham Rambaran	Poma First Baptist	on file.	
Karen Krogstad	Claremont COA	9096262045	
GILBERT SALDATE	TCMHS	909 772-8551	

TRI-CITY Mental Health Services

MHSA Delegates Meeting - WET
Alexander Hughes Center
1700 Danbury Rd Claremont, CA 91711
June 11, 2012 5:30 p.m.

Name	Affiliation / Agency	Phone Number	Email Address
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Carolee Rose		909 218 0988	karlynrose@aol.com
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Lori Lyn Walson	Tri city	(909) 730-2683	lynnkiHy1e@yahoo.com
Evelyn Schuman	Tri-City	(909) 461-7835	spunkeeevy@msn.com
Ileen Armstrong	Tri City	909-623-6131	[illegible]
Army Bloom	Claremont Unified Schools	909-896-2371	armybloom@mac.com
Nancy Orquilla	Pomona DCFS	909-[illegible]-1522	urquina@dcfs.lacounty.gov
Jesse Duff	Tri-City		
Kathy Reyes	Pacific Clinics	626-335-5980	kreyes@pacificclinics.org
Heidi Bohadie	NAMI PV	(909) 625-2383	ed.namipv@verizon.net
Carolyn Cockrell	BUSD	909-971-8201	carolyn.cockrell@gmail.com
Nancy Sifter	BUSD	" " "	sifter@bonita.k12.ca.us

TRI-CITY Mental Health Services

MHSA Delegates Meeting - WET
Alexander Hughes Center
1700 Danbury Rd Claremont, CA 91711
June 11, 2012 5:30 p.m.

Name	Affiliation / Agency	Phone Number	Email Address
Ellen Taylor	Tri-V	(909) 626-1801	EllenstayCrC@yahoo.com
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Sylvia Whitlock	TRICITY		
Toni Navarro	TC		
Lisa Tran	TCMH	909 623 6131	LTRAN@TRICITY MHS.ORG
Patti Azevedo	PUSD	909397-4491 x3894	patricia.azevedo@pusd.org
Michele Willingham	Cal Poly Pomona	Same	
Alfredo B. Lacson	LAC/DMH	213 739-5455	alacson@dmh.lacounty.gov

Attachment C

TCMHC Workforce Education and Training Data Analysis July 2012

An emerging map of what is

	People receiving support	People offering support	Resources for people offering support
Intensive Tx **Treatment**	**1,244** people in treatment (2011/12 YTD), including: ▸ Full service partnerships (FSP) ▸ Adult treatment ▸ Child treatment ▸ Supplemental crisis services ▸ Services for older adults ▸ Cognitive Enhancement Therapy (CET) begins Aug 2012	**47 licensed staff**—e.g. psychiatrists, psychologists, MFT and MSW interns, psychiatric technicians, including: ▸ 21.5 in Full Service Partnerships ▸ 25.5 in non-FSP clinical services (16.5 adult services; 9 child services) **19 unlicensed staff**—e.g., MH rehab specialists, case managers, and MH workers including: ▸ 14 in Full Service Partnerships ▸ 5 non-FSP clinical services (3 adult services; 2 child services) **Substance abuse** provider staff	**Training resources:** Pacific Clinics Training Institute; Mental Health Association of LA; California Association of Social Rehabilitation Agencies (CASRA); CIMH; online trainings **Education resources:** Local colleges and universities offer: BA in psychology, Masters in psychology or MFT, PhD in psychology **Financial resources:** Loan Assumption and Stipend Programs, focused at Masters level and above
Transition support	**7,161** wellness center visits (2011/12 estimated) **1,813** people linked to supports by navigators (2012/13 estimates) **110** people receiving housing support services	**12 unlicensed staff** **6 FTE consumer and family member** support staff	**Training resources:** CASRA; online trainings
Early Intervention **Prevention**	**119** in peer-to-peer counseling (2011/12) **Many** engaged by MH first aiders and NAMI activities **959** total visits to Family Wellbeing (2011/12) **Many** reached through untracked community-based efforts	**3 licensed staff** including 1 each for Peer-to-Peer counseling, Urban Farming and Family Wellbeing **3 unlicensed staff** including: ▸ 2 for Prevention & Early Intervention ▸ 1 for Wellness & Recovery Public **school counselors**, **interns** **1,039 MH first aiders** trained to date (2011/12)	**Training resources** ▸ For **Peers:** NAMI training for family members; Tri-City training for peer counselors ▸ For **Community members:** NAMI Parents and Teachers as Allies training; Mental Health First Aid training ▸ **Online resources**—e.g., HeartMath
Wellbeing	**2000+** reached through Community Wellbeing Program **Many** reached through community-based efforts	**1 unlicensed staff** **Community leaders** trained in CWB program **Untracked networks of support**—e.g., family, friends, neighbors, faith communities, traditional healers	**Training resources:** Leadership development for community leaders through CWB program; parenting courses **Funding resources:** Grants through the CWB program **Untracked community resources**

A beginning map of needs and gaps

	People receiving support	People offering support	Resources for people offering support
Intensive Tx **Treatment** **Transition support**	**Gaps and emerging treatment needs** ▸ Unmet need: general population SMI/SED about 13,000; 200% of poverty SMI/SED about 6,600 ▸ Increasing numbers of people without insurance ▸ School-aged children with unaddressed chronic stress; noted increases in self-inflicted violence ▸ Many adults and TAY who receive treatment do not have networks of support to help sustain recovery. ▸ TAY receiving services require substantial support ▸ Increases in intimate and intra-family violence ▸ Perceived shortages of inpatient and residential treatment programs ▸ Populations identified as needing more and/or more appropriate care: TAY, Veterans, African Americans, Asians, Working poor ▸ Treatment services through TCMHC and other providers restricted by eligibility requirements—e.g., medical necessity	**Identified needs for professionals** ▸ Staff who speak Spanish, Vietnamese, other Asian languages, Farsi, Arabic. **Note:** Tri-City MHC has made good progress on this need in the last year. ▸ African American professionals ▸ Staff with experience in dual diagnosis treatment ▸ Significant turnover of staff providing treatment and intensive treatment services	**More training resources needed** to strengthen cultural competence of staff **Barriers to staff recruitment:** Stigma and cultural norms are barriers that prevent people from considering the profession **Education institutions not keeping up** ▸ Graduates lack preparation for trauma care, dual diagnosis care, prevention, and other emergent aspects of mental health system ▸ Many applicants from on-line colleges/ universities not qualified **Few applicants** for TCMHC staff positions coming **from local colleges/universities**
Early Intervention **Prevention**	**Gaps and emerging treatment needs** ▸ Prevention and Early Intervention services in the schools have been cut repeatedly ▸ Challenges within the school districts have made it difficult to initiate programs with MHSA funding ▸ Stigma affects people accessing services up and down the continuum	**Documented demand for people who can educate others** about mental health issues, including but not limited to: ▸ Autism, developmental delays, and ADHD ▸ Substance abuse ▸ Suicide prevention ▸ Intimate violence ▸ Parenting ▸ Stress reduction and resiliency **Significant reductions in school-based staff and resources**	**Gaps in training** Additional resources needed to prepare people as coaches, behavior therapists, community navigators, and/or peer supporters **Documented demand** for training in alternative therapies—e.g., art, play, others
Wellbeing	**Challenge of community-based training:** People most likely to access training—e.g., parenting classes—are typically higher educated and demonstrating skills already		

SUMMARY OF THEMES FROM
TCMHC STAFF SURVEY REPORT
CONDUCTED JULY/AUGUST 2012

What staff enjoy most about work and career in public mental health:

- Intrinsic rewards of helping people;
- Knowledge they are making a difference in the lives of individuals and within the community;
- Learning and growing from clients, colleagues and supervisors;
- Supportive relationships of colleagues;
- Diversity of their clients and the opportunities the job provides to respond in creative ways to daily challenges; and,
- Working with diverse communities.

Challenges related to work:

- Necessity to complete documentation and other paperwork while still serving the clients;
- Time or the perceived lack of it;
- The flip side of staffers' enjoyment of helping people (frustration, etc.);
- Staff interactions with one another; and,
- Taking adequate care of themselves given the demands on their time.

Resources staff currently access to deal with challenges:

- Coworkers, colleagues and staff;
- Supervisor and family support;
- Self-care such as exercise, therapy, faith, and relaxation techniques;
- Internet for gathering information; and,
- Trainings offered through TCMHC.

Resources staff identified could help them deal with challenges:

- Training, ranging from more information on severe mental illness, to computer skills, to time management;
- More supervisorial support; and,
- Support for more self-care.

Background on Survey:

- 66% response rate, 59 responded;
- 10 questions: 3 multiple choice, 7 open ended;
- Respondents included staff and contractors;
- 85% of respondents had worked at TCMHC 5 years or fewer; and,
- 53% of respondents worked with families, 29% with communities.

ATTACHMENT G
Written and Oral Feedback from November 14, 2012 Public Hearing

SUMMARY OF WRITTEN FEEDBACK FROM NOVEMBER 14, 2012 PUBLIC HEARING ON WORKFORCE EDUCATION AND TRAINING PLAN

Participants in the public hearing

- Hearing about MHSA plans for the first time: 11
- Have gone to a few meetings about MHSA plans: 24
- Have been substantially involved in the MHSA planning efforts: 24

What we like about the proposed WET Plan:

- Education inspires growth and is stimulating
- Good idea to train volunteers for maximum engagement
- Encouragement to students to explore mental health careers
- Staff has opportunity to create something new
- Good dynamic learning support system to identify resources, curriculum and sharing
- Sustainability of the plan
- Engaging the community in the volunteer opportunities
- We agree that not going with option # three, the complexity and legal aspects of that area won't bog this opportunity down
- The ongoing training of professional staff, support staff and community leaders and professionals
- Nice that they give support for the folks that are employees and are helping clients and recognizing that they too need help and support sometimes.
- Outreach and engagement
- Information sharing
- The creation and identification of resources being shared with families, clients, staff and volunteers
- Lunch and Learn – staff and volunteers, informally addresses issues
- More opportunities to outreach to community
- High school teachers and college professors being engaged gives a chance for volunteers and careers in the mental health field to the students
- The effectiveness of staff's ability to work well being leveraged and then passing the knowledge on
- Uses staffs' strengths and expertise to train other staff and volunteers
- The idea of learning better
- Helps keep peer-to-peer volunteers engaged and stay
- Volunteer recruitment needs far greater than what we can do
- Keep them enjoyed and motivated
- Helping community become aware of mental health opportunities
- Education for parents to understand role of mental health careers -- reduce stigma -- keeps people out of the field

- Having key people in community know options so they can tell their neighbors
- Get mental health incorporated into ROP
- Volunteer work force
- Developing of leadership
- Current reality – not reinventing the wheel
- Systematic learning captured and made available to TC staff and others in community
- Focus on adapting and responding effectively to evolving needs
- Volunteer mapping, development
- The help that will be given to support the growth of learning for employees, volunteers and families that help the community. The good news is this will prepare students of high school and college to find work in the area of mental health. (translated from Spanish)

Questions or concerns we have about the WET Plan

- What happens after 2012 when recurring allocation has been expended?
- Explain sustainability in plan – will it impact resources of other programs?
- How are programs evaluated?
- Will requirements be posted for recruits?
- Concern about the long-term plan for sustaining volunteer recruitment
- When the program is successful how do we get more funds?
- Concern to use the money effectively
- Is it really going to happen?
- How will we recruit and match volunteers and find more passionate and committed volunteers
- Why is someone hired for implementation of plan before the plan is approved? Interested in keeping process clean, don't want political fallout
- Mobilizing people in these ways is a significant effort, challenging
- Project #2 – having enough volunteer opportunities and resources to work on the education and matching interests and knowledge
- Supplanting
- What does implementation look like
- Inherent difficulty in organizing community volunteer efforts
- Sustainability
- How will you promote in the schools? (translated from Spanish)

Other comments we want to share

- Sharing of knowledge and experience contributes to motivation of staff and volunteers
- Volunteer training from Tri City has been helpful, all under one entity, know across departments
- Hard as workshop participant to find our work in here – just got this summary tonight and haven't had a chance to read it.

- Like seamless system of care and integration of intensive to recovery and the flow, how all things are brought into the effects
- I participate as peer counselor and I think the Wednesday meetings are very productive, we learn so much of other organizations that come to share their area of specialty. I imagine that with the WET Plan approved, Prevention and Early Intervention programs will be enhanced. (translated from Spanish)

SUMMARY OF ORAL FEEDBACK FROM
NOVEMBER 14, 2012 PUBLIC HEARING ON
WORKFORCE EDUCATION AND TRAINING PLAN

What we liked about the proposed WET Plan:

- Lunch and Learn concept
- Doing outreach to the community
- Engaging professors
- Plan is well thought-out
- Systematic learning
- Education will inspire growth
- Plan will be sustainable
- Likes all the connections between TCMHC and the colleges, would like to see even more Tri City presence on campuses

Questions and concerns we have:

- Will there be online forums or communities created for questions as this may be more convenient for some
- Will the sustainability of this plan have an impact on other programs?
- Will requirements be posed for recruited positions?
- What will be done with regard to evaluation?
- If we rely on student volunteers, how will be keep continuity?

ATTACHMENT H
Roster of Participants Engaged in Planning Process

Roster of Participants Engaged in the Planning Process and Public Hearing Outreach

Assistance League
Church of Breth
DPSS
East Valley Health Center
Emerson Village
Havenly Homes
Hillcrest
Inland Valley Hope Partners
Joslyn Senior Center
La Casita Teen Center
La Verne mobile homes
La Verne Senior Center
La Verne City Hall
NAMI support group
Pacific Clinics
Palomares Park Senior Center
Palomares Dance Class
Palomares Exercise Class
Pomona City Hall
Pomona Community Clinic
Project Homeless Connect
Prototypes
Public Health
Sowing Seeds
Tri-City Lobby
United Methodist
Volunteers of America
Washington Park
YMCA

Public Hearing Outreach by Various Demographics

Gender:

- Male: 227
- Female: 349

Ethnicity:

- Hispanic: 259
- White: 168
- African American: 98

- Native American: 4
- Asian Pacific Islander: 36
- Other: 11

Age:

- Children, 0-15: 0
- Transition Aged Youth, 16-25: 67
- Adults, 26-59: 255
- Older Adults, 60+: 254