Tools for Completing *Workforce Needs Assessment,* Exhibit 3, in *Proposed Guidelines for Developing the County Education and Training Component of the Three-Year Program and Expenditure Plan*

Prepared for:

California Department of Mental Health (DMH),
Mental Health Services Act (MHSA) Education and Training Unit,
as part of a Comprehensive Needs Assessment of California's Public Mental Health Workforce

Prepared by:

Allen, Shea & Associates
1780 3rd Street, Napa, CA 94559
Ph: 707-258-1326 • Fax: 707-258-8354
Email: allenshea@sbcglobal.net • Website: www.allenshea.com,

NOTE on this *Revision*

This is a *revision* of a document by the same name, dated July 25, 2007. This *revision,* based on feedback at four Roundtables conducted in September and October, changes who and how to count the publicly-funded mental health workforce at *geographically-based* programs (e.g., residential and hospital/institutional) serving more than one county. In July it was *OPTIONAL.* Now, the expectation is that the *host county* will include the workforce for geographically-based services. See pages 18-19. In no case, however, should state hospital personnel be counted. They will be counted through DMH Headquarters in Sacramento.

December 10, 2007

Using this Handbook

The *purpose* of this handbook is to assist counties in completing Exhibit 3, *Workforce Needs Assessment,* in *Proposed Guidelines, Workforce Education and Training Component of the Three-Year Program and Expenditure Plan.* A companion Excel Spreadsheet **<WorkforceAssessment1.xls>** contains *tools* for gathering, totaling up, and reporting workforce information. The EXCEL document can be found alongside this handbook at the Department of Mental Health (DMH) website. The URL is: http://www.dmh.cahwnet.gov/Prop_63/MHSA/Workforce_Education_and_Training/default.asp

We describe various ways of developing accurate estimates. Methods will vary by county size and the extent to which a county contracts out services. Very small counties (especially if they contract out very little) will often be able to report *complete counts*, based largely on existing administrative data, plus a few phone calls. Larger counties (especially those that contract out extensively) will likely use complete-count (or, occasionally sample) surveys and/or develop estimates from known information in contracts, budgets, billings, and payments, using extrapolation procedures to *blow up* sample numbers to universe estimates where complete-count information is not available. Many counties will use a combination of approaches, including recent special studies (e.g., of individuals with consumer or family experience in paid positions).

The *Contents* of this handbook are listed on the next page. Here are a few questions, and where you will find answers:

Q1. How can I best get started, developing a plan to get the work done? Answer: See pages 10 to 13 for ideas and suggestions on planning the work.

Q2. If I want to do a survey of contract agencies, where can I get the information I need? Answer: See pages 10 to 21 for factors to consider, and Appendix C, pages 51 to 59 about conducting surveys.

Q3. How can the EXCEL spreadsheets help me put together accurate estimates? Answer: See pages 22 and 23 of this handbook, along with the spreadsheets themselves in the accompanying document ***<WorkforceAssessment1.xls>.***

Q4. Can I get some state-funded technical assistance on completing Exhibit 3 by phone or email? Answer: Yes, you may call John Shea of Allen, Shea & Associates, at 1-707-258-1326, or email him at allenshea@sbcglobal.net. He will try to help.

Feedback

We anticipate updating and revising this *Handbook* and the EXCEL document, as needed. If you see ways to make these documents more helpful, please email your suggestions to Warren Hayes, Chief, MHSA Education and Training Unit, at DMH <Warren.Hayes@dmh.ca.gov> and/or to John Shea <allenshea@sbcglobal.net>. Thank you.

Contents

Glossary

Extrapolation: The process of extending values beyond what is known (or, reported) to encompass what is not known (or, not reported).

Heterogeneity: The quality of being diverse and not comparable in kind.

Homogeneity: The quality of being similar or comparable in kind.

Law of Large Numbers (sometimes called *law of averages)*: This is the first fundamental theorem of probability. In repeated coin tosses (or, repeated samples, or repeated times at bat as in baseball), the larger the number of trials, the more accurate will be the probability of occurrence in the long-run (e.g., a proportion or arithmetic mean).

Non-response Bias: This kind of bias occurs when a significant number of sample members (e.g., contract agencies) fail to respond to a survey and have relevant characteristics (e.g., occupational composition of workforce; number of non-English speakers; individuals with consumer or family member experience in specifically designated positions) that differ from the characteristics of sample members who have responded.

Sample (or, sampling): In statistical practice, the selection of individual observations (e.g., among Network Providers, contract agencies) intended to yield knowledge about a population (or, universe of interest).

Convenience (or, judgment) sample. – A nonrandom sample in which one or more members of a population are selected, because they are accessible and it is convenient to do so. Judgment is involved, because the convenience sample is selected to represent a larger universe of interest (e.g., all members of a particular stratum).

Random sample. – Each member of the sample has an equal and known chance of being selected. This is the purest form of probability sampling.

Representative sample. – A generic term that encompasses different approaches to sampling, where the emphasis is either on probability or judgment as to sample characteristics being a close approximation to characteristics of the underlying population (or, universe of interest).

Stratified sampling. – A commonly used probability method that is superior to random sampling because it reduces sampling error. Strata should be *mutually exclusive* and *exhaustive* of all members of the population (or, universe of interest).

Systematic sampling. – In statistical practice, a procedure often used instead of random sampling. It is also called the *Nth* list member technique. As long as the list does not contain any hidden order, this technique is as good as the random sampling method. It is simpler than random sampling. If the initial list member is picked at random, each pick has an equal and known chance of being in the sample.

Sampling error (sometimes called *margin of error*): When using sample data to estimate a population parameter (e.g., arithmetic mean, proportion), there is inevitably some difference between the two. Sampling error (e.g., a statistic from repeated samples) gives us some idea of the precision of an estimate of the underlying value in the population (or, universe of interest). Generally, two standard deviations on either side of a sample mean yields a range that will encompass the underlying parameter value 95 times out of 100.

Stratum (plural: Strata): A stratum is a subset of the population that share at least one common characteristic (e.g., relative budget size; target clientele). Stratified sampling is often used when one or more of the strata in the population have a low incidence relative to the other strata.

Weighted average: A method of computing an arithmetic mean of a set of numbers in which some elements of the set carry more importance (weight) than others. For example, in computing a student's course grade, let's assume homework counts 10%, quizzes 20%, and a final examination, 70%. If a student had a homework grade of 92, a quiz grade of 68, and a final examination grade of 81, the student's course grade would be = (0.10)(92) + (0.20)(68) + (0.70)(81) = 79.5.

Tools for Completing *Workforce Needs Assessment,* Exhibit 3, in *Proposed Guidelines for Developing the County Education and Training Component of the Three-Year Program and Expenditure Plan*

Introduction

In completing Exhibit 3, *Workforce Needs Assessment,* the task is to come up with reasonably accurate *estimates* of the of the county's publicly-funded mental health workforce, in terms of:

1. Size (FTE) -- both authorized (or, budgeted) and actual;
2. Occupational composition;
3. Race/ethnicity;
4. Numbers proficient in languages other than English;
5. Number in specifically designated positions for individuals with consumer and/or family member experience in the Public Mental Health System;
6. Whether an occupation is *hard to fill*;
7. Additional workforce (FTE) needed to meet current estimated public mental health needs;
8. Additional clients and family members (FTE) in specifically designated positions needed to meet current public mental health needs; and
9. Additional number of individuals who need to be proficient in various non-English languages to meet current needs.

Counties are to provide workforce information on the county's entire workforce providing publicly-funded mental health services.[1] There are three **segments**: (1) county workers; (2)

[1] Clients assisting one another, family members supporting individuals within the family and community, and other *natural supports* (at work, within religious or other groups) – while often very important in achieving results – are not included within the *operational definition* of *workforce* here. On the other hand, those volunteering within the *public mental health system* (e.g., some interns, outreach workers,

contract agency workers; and (3) *network providers and all other (n.e.c.),* especially solo or small group practitioners who accept county referrals for services, plus local hospitals, some local residential service providers, and others (e.g., projects with colleges and universities, pharmacies, transportation services, etc.). Across the three segments, the workforce includes (1) employees, full- or part-time, long-term or temporary, (2) independent contactors, and (3) selected volunteers, such as interns, and some clients and family members performing roles within the public mental health services system.

Sources of Information

There are two main sources of information needed for Exhibit 3: (1) existing administrative data and (2) complete-count or sample survey data. Table 1, on the next page, lists offices and people who are likely to have certain kinds of administrative data for Exhibit 3. As for county employees, independent contractors, and volunteers, CMH management and support staff should have personnel rosters, organizational charts, and approved budget information that will be helpful in developing quantitative estimates for this segment of the workforce. Relatively current quantitative information on those working in contract agencies may be available from contract administrative staff and/or leaders (or, HR personnel) of contract agencies. But, it is likely that certain information beyond occupational composition of the workforce, such as positions *hard to fill,* employment of individuals with consumer or family member experience in specifically designated positions, will necessitate asking a supplemental set of questions (perhaps over the phone) of at least a representative sample of such agencies. Some information on *Network Providers,* and other contractors in the All Other (n.e.c.) category may be available through CMH accounting personnel (paid claims) and contract administrators.

Some counties may have sufficient information to complete Exhibit 3, without doing a survey. Counties that contract out very few services, may have all the information they need from County budgets, organizational charts, personnel rosters, and the like. Some (if not all) counties will be able to get occupational composition (quantitative) information on *Network Providers* from existing sources (e.g., paid claims, based on certain productivity standards and FTE assumptions). If some information is incomplete (e.g., racial/ethnic composition of

and so forth) are included. Counties may, of course, prioritize addressing education and training needs within all categories.

the workforce; employment of clients and/or family members in specifically designated positions; proficiency in languages other than English), it may be possible to fill in these gaps by talking with managers within public mental health and/or getting such information from HR personnel or special studies. To collect some of this information (e.g., on language proficiencies), some counties may want to do a telephone survey of *Network Providers* or hold a meeting to develop estimates.

Table 1. Common Sources of Workforce Information at County Level

Segment	Source(s)
County (employees, independent contractors, volunteers)	1. CMH Director and Mid-level Managers (e.g., Children's Services, Adult Services, MHSA Coordinator) 2. County Personnel, Intermediate Unit HR Personnel (e.g., Health & Human Services), and/or CMH HR Personnel 3. Other (e.g., Research Analyst, Language Proficiency and/or Cultural Competency Officer)
Contract agencies and their sub-contractors and volunteers	4. CMH contract administrators 5. Leaders and HR personnel in contract agencies
Network Providers (solo and small group practices) and All Other (n.e.c.)	6. CMH contract administrators and accounting (e.g., for paid claims information) 7. Solo (and, small group) and other local providers providing services to Mental Health clients of the county.

NOTE: In very small counties *informal* sources of information of both a quantitative and qualitative nature (known by leaders who have been in the "system" for many years) are likely to be important, as well.

Doing a survey by mail/email with telephone follow-up is a sensible approach, especially where workforce information (expressed in FTEs) of contractors is out-of-date and significant changes have occurred in project (or, program) size. A survey instrument can be found in Appendix C, and the instrument is repeated in the EXCEL spreadsheets in the accompanying document, **<WorkforceAssessment1.xls>**, at the DMH website. *Directions* for completing the Workforce Needs Assessment Survey can be found in Appendix A. Most counties of any size that use the services of several local contract agencies will want to do a survey (typically complete count) to get information on the occupational composition of their workforces and related matters, unless contract administrators can provide good estimates from timely documents (and reports) on file in their offices. Even then, as already noted, selected *gaps* in the information required in Exhibit 3, may necessitate at least a telephone survey of a representative sample of providers.

Getting Started, Planning the Work

In planning the work of getting and reporting information called for in Exhibit 3, here are some steps to take:

1. Study carefully the Department of Mental Health's (DMH) *Proposed Guidelines for Developing the County Education and Training Component of the Three-Year Program and Expenditure Plan*, which is posted at the same website as this handbook and the accompanying EXCEL document **<WorkforceAssessment1.xls>.**

2. Develop a list of all community (local) agencies that have projects (or, programs) that are publicly-funded for your county's mental health clients. For segment members included in Exhibit 3, put down key information related to services, clientele, budget size, and the like, so as to judge likely homogeneity (or, heterogeneity) in occupational composition of the workforce and related matters. (See Table 2, on page 11, for row and column headings that can be extended.)

3. Determine what information is available and who has it. – HR personnel within CMH (or, an intermediate unit, like Health Services) may have a lot of the information needed to complete Exhibit 3, for county personnel. Mid-level managers (and those they supervise) may also have good information on the workforce of county employees, and the county's independent contractors and volunteers. This is likely to include specifically designated positions for those with consumer or family experience; race/ethnicity of staff (and volunteers); and language proficiencies of staff (and volunteers). They are also a good source of information (along with HR Personnel) as to what jobs have been *hard to fill.* MH contract administrators typically have (1) lists of contractors that include project size (e.g.. annual budget) and contact information. Original project proposals often have workforce information (FTEs, by occupation; compensation). As projects unfold over time, some counties update such workforce information.

Table 2. List of Contract Agencies, Network Providers, and All Other (n.e.c.) Contractors

#	Category, agency, address	Contact (name), Ph#, email	MH program or services (C&F, TAY, A, E, Other)*	Current *annual* contract budget (or, paid claims)	Any specifically designated positions? (Y/N/DK)	Estimated % of target clientele who use/prefer non-English	Receiving MHSA funding under CSSP? (Y/N)	Involved in full-service partner-ship(s)? (Y/N)
	Contract agencies:							
	Network Providers:							
	All other (n.e.c.) contractors:							

*** C&F=Children & Families; TAY=Transition-age-youth; A=Adults; E=Elders (or, Older Adults); and Other are contractors not elsewhere classified.**

NOTE: n.e.c. stands for *not elsewhere classified.*

4. Decide whether you can get much (if not all) of the information you need from existing sources (e.g., HR and contract office), and/or whether you should do a mail/email survey with telephone follow-up. – In all but the largest counties, you may want to do a complete-count survey. *Non-response bias* may be a factor, and may need to be addressed.[2] Extrapolation of sample numbers to *population (i.e., universe) estimates* is discussed on pages 20 and 21 of this handbook.

5. Develop a plan to obtain and report the information requested in Exhibit 3. (See Table 3 on page 13 for an action planning worksheet, which may be adapted for use.) Decide on the *best use* of resources available to develop the County's Three-Year Workforce Development, Education and Training Component. Existing administrative information – if up-to-date and relatively complete – may be sufficient without inviting people to bring needed data to a meeting, or doing a formal mail/telephone survey. A few phone calls with a representative sample of providers in some categories may pin down answers to a few questions (not in any administrative database), such as occupations *hard to fill* and language proficiencies of staff, and employment of individuals with consumer and/or family member experience in specifically designated positions. Alternatively, or in addition (as a double-check), one may want to convene a group of experienced managers (and, perhaps, other stakeholders) and ask each one to share his/her *best estimate* for certain missing information (e.g., additional FTE to meet existing needs). Expression of subjective estimates may result in some convergence of opinion among experienced, knowledgeable people. Taking an average of subjective estimates may yield a plausible result.

County Size and Strata

Existing administrative data (e.g., budgets, personnel rosters, organizational charts, contracts, billings, paid claims) are helpful in developing workforce *estimates* for the segments. If basing

[2] *Non-response bias* occurs if non-respondents differ in key ways from respondents in terms of the things measured and reported. For example, if contractors working with children and families, led by clients, or with leaders specializing in languages other than English were less likely to respond than other contractors, generalizing from respondents would yield faulty estimates. Assuring a high response rate (e.g., with telephone follow-up) across all strata will reduce *non-response bias.*

Table 3. Action Planning Worksheet for Completion of Exhibit 3

***Who?* will do . . .**	***What?***	**by *When?***

universe (or, population) estimates on a *representative sample,* the typical extrapolation factor will be **Total Budget (or, Paid Claims) for the Segment (or, Stratum)** divided by **Total Budget (or, Paid Claims) for Responding Sample Members in the Segment (or, Stratum).** For example, if the former were $5,400,000, and latter were $3,150,000, the extrapolation factor would be 1.7143, which is $5,400,000 divided by $3,150,000. One would multiply each number from the *sample* respondents by 1.7143 to get an estimated total for the segment (or stratum).

About the only reason this would result in some inaccuracy would be differences in average (mean) compensation of workers across the service providers in the segment (or, stratum).

In some counties, compensation (wage, salary, employer payroll taxes and benefits) per hour of work by county employees will be higher than compensation per hour among those in contract agencies. *Network providers* will typically be paid a contractual rate per *unit of service* (e.g., a therapy visit). Contract administrators may know proportions: compensation for agency staff (and volunteers and sub-contractors) working for county clients as a percentage of fee-for-service revenues from the County. They may also know *average compensation* – for example, based on proposed (or, actual) budgets. These pieces of information are linked together this way:

1. Yearly Budget = Compensation of Workers + Other Costs (e.g., operating expenses; administrative overhead)
2. Compensation of Workers / FTE of Workers = Average Compensation per FTE

In the absence of more precise information, we suggest that 75% be assumed if trying to determine Compensation of Workers (including employer payroll taxes and benefits) with only information about Yearly Budget (or fee-for-service revenues for services to county clients).

County Size

Approaches to collecting, refining, and reporting the information called for in Exhibit 3 will vary by county. Population size matters for several reasons, including but not limited to (1) degree of specialization and division of labor; (2) the nature and extent of contracted services; (3) the ability of Human Resource (HR) personnel and contract administrators to provide needed information; and (4) where large numbers of non-English speakers live. CMH Directors with extensive local experience in very small counties may have considerable workforce information at their *fingertips*. These *informal* sources are typically less available to CMH Directors and staff in larger counties.

Twenty-two counties (or 38%) have populations under 100,000; 27 (or 47%) between 100,000 and 1,000,000; and nine (or 16%) over 1,000,000.[3] The largest county, Los Angeles, has a population that tops 10,000,000, approximately three times larger than the second most populated county, and more than 100 times larger than the largest of the 22 counties with populations under 100,000.

Counties vary in how they arrange provision of publicly-funded mental health services. Some counties provide virtually all (local) services through county employees. Other counties use contract agencies and *network providers* – sometimes sparingly, sometimes extensively. One county, for example, provides virtually all of its (local) services through a single contract agency. The County directly employs only four workers in mental health, including the CMH Director. Most counties, regardless of size, contract with some out-of-county (sometimes out-of-state) providers for some needed services not available locally. Psychiatric hospitalization and residential services are examples.

Local services in a very small county (typically rural) will often focus on the *basics* of medication management, talk therapy (supportive counseling), case management, and the like, and there will be relatively little differentiation of adult clients in comparison with large, urban counties. In the latter, the array of services (and, therefore, of occupations) will tend to be greater, reflecting greater specialization and division of labor and other factors (e.g., difference in resource base). To illustrate, a small county may reach out to a few older adults, primarily with volunteers, while a large county may have a team of professionals (and others) in full-service partnerships, working with older adults with psychiatric disabilities who are homeless. Specialized vocational services for those with psychiatric disabilities is another example. Some 20 to 25 counties, with about 80% of the State's population, provide DMH Cooperative Programs with the Department of Rehabilitation.

Small counties. -- If the County Mental Health Director (or other managers) have been working within the county in community mental health for several years, such individuals are likely to have a lot of the information called for – without necessarily going to administrative data sources – at least for county employees and volunteers. Contractors may be relatively few in number and similar in the kinds of services provided. A few telephone calls or a meeting may suffice in getting the information called for in Exhibit 3.

[3] Percentage detail does not add to total, because of rounding.

Or, one might ask invitees to bring (1) rosters of staff, sub-contractors, and any volunteers; (2) information about race/ethnicity (self-reported); (3) information about specifically designated positions for individuals with consumer and/or family member experience; (4) information about language proficiencies aside from English (perhaps alongside names on a staff roster); (5) judgments regarding additional FTE to meet existing needs; and (6) experience over the past year or so in filling various positions. Based on who attends (and who does not), and what is known about the workforces of the latter, partial information can be extrapolated in developing universe estimates for Exhibit 3. Or, rather than a few telephone calls or a meeting, small counties may want to do a mail/telephone survey along the lines laid out in the Appendix C, especially if asking additional questions about workforce development, education and training needs and opportunities.

Medium-size and large counties. -- Rather than attempting a complete count within all strata, one may be able to develop quality estimates by focusing limited resources on *representative samples* within some strata. For example, if several agencies provide similar services, conducting a survey with a representative sample within this stratum could yield estimates nearly as good as a complete count. With limited resources for planning, one might be able to improve telephone follow-up and generally spend more time on each sample member, helping get good information that can be extrapolated to totals required in Exhibit 3. There will, of course, be some unavoidable *sampling variation (or, error),* which is understood and Okay for purposes of this assessment. It makes sense to sample relatively large numbers whenever possible (e.g., N=30) in a category with (say) 50+ members. Other things the same, the larger the sample, the more precise the estimate. This follows from the *Law of Large Numbers.* Very large counties may want to sample within several strata with members known to be roughly similar in occupational composition and related matters (e.g., use of clients and family members, language proficiencies), especially if the underlying population numbers (e.g., of agencies or network providers) are quite large.

Strata

Table 4, on the next page, shows the number of contracts by type (e.g., contract agencies, provider network), relative budget size, and program/service emphasis for a hypothetical

county considerably larger than the hypothetical county in Appendix B. Each stratum has been given an identification number (e.g., **2C,** bottom 1/2 in budget size, community agencies serving adults). Table 5, below, presents hypothetical total annual budget data for

Table 4. Stratification of the Population (or, Universe) Aside from County Personnel: Number of Contracted Providers in Each Numbered Cell or Stratum

Community agencies – top 1/2 in budget: **1**	Children & Families **1A** 7	TAY **1B** 2	Adults **1C** 14	Older Adults **1D** 3
Community agencies – bottom 1/2 in budget: **2**	Children & Families **2A** 7	TAY **2B** 1	Adults **2C** 14	Older Adults **2D** 3
Network and All Other (n.e.c.) providers: **3**	Psychiatrists **3A** 2	Clinical Psychologists **3B** 5	LCSWs (25), MFTs (9) **3C** 36	All Other (n.e.c.) **3D** 18

Table 5. Stratification of the Population (or, Universe) Aside from County Personnel: Total Budget (Annual) for *All* Providers in Each Cell or Stratum

Community agencies – top 1/2 in budget: **1**	Children & Families **1A** $9,600,000 [$1,371,429]	TAY **1B** $900,000 [$450,000]	Adults **1C** $21,000,000 [$1,500,000]	Older Adults **1D** $1,200,000 [$400,000]
Community agencies – bottom 1/2 in budget: **2**	Children & Families **2A** $3,500,000 [$500,000]	TAY **2B** $300,000 [$300,000]	Adults **2C** $4,600,000 [$328,571]	Older Adults **2D** $300,000 [$100,000]
Network and All Other (n.e.c.) providers: **3**	Psychiatrists **3A** $135,000 [$67,500]	Clinical Psychologists **3B** $41,500 [$8,300]	LCSWs, MFTs **3C** $150,000 [$4,267]	All Other (n.e.c.) **3D** $6,500,000 [$361,111)

all contractors in each stratum. (For Network Providers, the data are annual claims rather than budget.) Annual outlays for outside contractors in this hypothetical county amount to over $48 million. In brackets, below each total, is the average (arithmetic mean) budget (or, claims) figure per contractor.

We will assume that FTE within the three Network Provider strata in Segment 3 (**3A, 3B, & 3C,** in Tables 4 & 5), along with other information (Sections II and III) are available in administrative data bases on a *complete count* basis:[4] (1) paid claims over the past year; (2) profession (e.g., psychiatrist, psychologist, LCSW, MFT); (3) any employment by network providers of individuals with consumers or family experience (e.g., Parent Partners; Consumers checking-in with clients to see whether there are any medication problems; etc.); and (4) capacity of each solo or small group practitioner to conduct business in a language other than English. Indeed, the use of some *network providers* is often predicated on capacity to provide services in languages other than English. The "All Other (n.e.c.)" stratum in Segment 3 (**3D** in Tables 4 & 5) in this example is more diverse, involving two in-county psychiatric hospitals, several augmented residential care facilities, and projects with nearby colleges and universities.

We suspect that in many counties, certain strata will need further refinement. For example, if some of the 28 contract agencies in **1C** and **2C** (1) were consumer-run, (2) provided specialized employment services, (3) served individuals who are homeless, and/or (4) focused on adults who prefer languages other than English, then it would be important to include at least one fairly typical agency in these and other categories as *representative samples,* and to use extrapolation procedures if more than one agency (or program) exists in any such category.

Multi-County Programs and Services

Non-Residential, Non-Institutional Services

When two or more counties use non-residential, non-institutional services of a particular contract agency (CBO), be sure to explain to the CBO that each county seeks workforce information limited to services for its clients, typically provided in its county. There would be double-counting, if the CBO reported its TOTAL mental health workforce to each county. If the services are identical (or, very similar) for clients of different counties, one can accept TOTAL workforce information, so long as the CBO is able to report budget, revenues, or

[4] We suggest that *productivity standards* be used to translate units of service into FTEs.

paid claims for (1) each county and for (2) all counties, combined, using the identical (or, very similar) services.

Here is an example. County X used services to the extent of $210,000 over the past year. All counties (including, but not limited to County X) used the services to the extent of $1,650,000 over the same period. Because $210,000 divided by $1,650,000 equals 12.7% (or, 0.1273), one can multiply the CBOs TOTAL workforce information (FTEs, etc.) for identical (or, very similar) services by 0.1273 to estimate the CBO's workforce data in the service of County X's clients. Other counties can do the same, with estimates based on each county's *shared* use of the services provided by the contract agency.

Geographically-Based Services (Residential, Institutional)

Many institutions (e.g., psychiatric hospitals), residential treatment centers, group homes, and the like, provide geographically-based services to clients from more than one county. In such cases, subject to the exception noted below (i.e., state hospitals), CMH for the county where the institution (or, residence) is located (the *host* county) is to include in their Exhibit 3 the workforce information for services to all of the counties' clients. If the provider also serves private pay clients, or clients not paid through public mental health (State or county), be sure to factor that in your estimates. For example, if 70% of a psychiatric hospital's services are provided to CMH clients from various counties, be sure to adjust your estimate by multiplying the hospital's total workforce by 0.70. Host counties should not count the workforce at state hospitals, because this information will be provided by DMH Headquarters. Host counties should not count the workforce at Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), or Indian Health Centers (IHCs), except to the extent that their county (and perhaps, other neighboring counties) contract for some services there.

Sampling and Response Rates

If the number of contract agencies and/or *Network Providers* is large or quite diverse in terms of what is being measured, decide on *strata* within which to draw (or, find) *representative samples*. [If sampling], be sure sample selection is *representative* of the underlying population of providers. *Convenience sampling,* involving *judgment,* is Okay, if the criteria are clear (has

workforce and experiences like those of providers in the underlying universe of interest). *Random sampling* within strata may also be used. This means each and every potential sample member on a list has an equal chance of entering into the sample. An easy way is to do *systematic sampling with a random start.* Because the first pick is *random* (say, by tossing a coin, with 1=heads and 2=tails), each agency on the list has an equal chance of being in the sample. In this case either the first provider on a list is selected (if heads) or the second (if tails), and from there one may be picking every other provider on the list. If there were 55 providers on the list, and one were picking half, then the following members on the list would be chosen: 1 (if the coin toss were heads), 3, 5, 7, 9, 11, 13, 15, 17, 19, 21, . . . , 53, 55. The larger the sample -- in absolute number, not as a proportion of the population -- the more accurate the sample estimate will be of values in the underlying population.

If sampling is involved, one wants to sample within strata where there is homogeneity in the services and supports provided (and therefore in composition of the workforce), and in the other matters of interest (e.g., *hard to fill* positions; additional FTE; individuals with consumer and family member experience in specifically designated positions; language proficiencies of staff).[5] There may be so much heterogeneity (diversity) involved that complete counts would make for best estimates, unless the county is very, very large and/or resources for planning purposes are quite limited.

Regardless of the number of contract agencies and/or *Network Providers*, consider sending out a survey to every provider in every stratum. Be sure to follow-up by telephone to get a high response rate. If non-respondents are similar to respondents, extrapolate the information provided by respondents to make population estimates. If non-respondents are atypical on some (or all) matters under investigation, make appropriate adjustments in the population estimates.

[5] In *stratified sampling,* an underlying population is divided into a set of *mutually exclusive and exhaustive* categories called *strata,* within which providers have at least one thing in common. All providers are in the universe, and each provider is assigned to one (and only one) stratum (group). A sample is then drawn within each stratum (group). For a given sample size, a stratified sample is more *representative* of the underlying population than a non-stratified random sample, because the latter runs the risk of leaving out an important group (stratum). See Australian Bureau of Statistics at: http://www.abs.gov.au/Websitedbs/D3310116.NSF/4a255eef008309e44a255eef00061e57/116e0f93f17283eb4a2567ac00213517!OpenDocument.

Extrapolation Procedures

If there were no *variation* in the underlying population

If each provider had precisely the same workforce and experience (race/ethnicity, vacancies, *hard to fill* positions, employment of individuals with consumer or family member experience, needed additions to meet existing needs of clients, and numbers of individuals proficient in languages other than English), ***a sample of one would be sufficient to describe that segment's (or, stratum's) total workforce!***

Variation in size and composition of the workforce, employment of clients and family members, and language proficiencies of staff are important, across contract agencies, *Network Providers,* and other contractors across the county. If each contract agency had precisely the same workforce, a *sample of one* would be sufficient to describe that segment's total workforce. One would *blow up* (extrapolate) the sample estimate to come up with a segment total. One way to do this would be to multiply numbers from the *sample of one* by:

$$\frac{\text{Segment total budget (STB), or Segment total paid claims (STPC)}}{\text{Responding Sample agency budget (SAB) or paid claims (SAPC)}}$$

Calculating a *Weighted* Average

Counties are asked to add up (either numbers or percentages) the race/ethnicity breakdown of the public mental health population, so that baseline comparisons can be made. To do this may involve calculating a *weighted average.* Let's say, for example, that Medi-Cal clients represent 75% of public mental health clients in a county, while non-Medi-Cal clients are 25% of the total. If the race/ethnicity pattern is different for these two groups, a *weighted average* can be reported. Weighting percentage distributions (75% Medi-Cal; 25% Non-Medi-Cal) is one way to do this. In the example on the next page, in Table 6, the *weighted average* is shown in Column 6.

Using the EXCEL Spreadsheets

The EXCEL spreadsheets in the accompanying document **<WorkforceAssessment1.xls>** can be used for (1) an email survey, (2) to make estimates from less-than-complete-count data, and (3) to sum up information across segments for reporting purposes (in Exhibit 3). The EXCEL document has six spreadsheets, labeled as follows:

1. Directions
2. **County**
3. **CBOs** (shorthand for *contract agencies)*
4. **Network & Other**
5. Summary
6. Survey

Table 6. Calculating a *Weighted* Average (Arithmetic Mean)

Race/ethnicity	Medi-Cal clients (%)	Col (2) x 0.75	Non-Medi-Cal clients (%)	Col. 4 x 0.25	Weighted avg (%) – Cols (3)+(5)
(1)	(2)	(3)	(4)	(5)	(6)
White/Caucasian	37%	27.75	55%	13.75	41.5%
Hispanic/Latino	20	15.00	12	3.00	18.0
African-American/Black	8	6.00	5	1.25	7.3
Asian/Pacific Islander	10	7.50	15	3.75	11.3
Native American	5	3.75	7	1.75	5.5
Multi Race or Other	20	15.00	6	1.5	16.5
Total (Average)	100%	75.00	100%	25.00	100.0%

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

If doing an email survey, we suggest that an email message be developed and electronically signed by the county's CMH Director, and that there be two attachments: (1) a copy of the Survey (the sixth spreadsheet) in EXCEL; and (2) a copy of *Directions* for completing the survey in Microsoft WORD. *Directions* can be found in Appendix A, on pages 26 to 31 of this handbook.

The three named spreadsheets in boldface and underlined (#2, #3, and #4) have been designed to facilitate the recording of information, and the *extrapolation* of information for the three segments, if some (or, all) are based on representative samples. Column A, in the top half of each of these spreadsheets, is for the ***Extrapolation Factor***. If the information is based on a complete count, use 1.0000. Then, as data are entered, one will see that the same numbers will appear (by formula) in the bottom half of the spreadsheet. Every number entered in the top set of tables is multiplied by 1.0000, yielding the same number for the segment total in the bottom set of tables. Where data is partial (as with samples, or when there are non-respondents), enter the appropriate extrapolation factor, which will be larger than 1.0000. It will be the *quotient*, where the *dividend* is typically **TOTAL BUDGET (or, PAID CLAIMS)** for a

segment, and the *divisor* is **TOTAL BUDGET (or, PAID CLAIMS)** for the representative sample members providing data. Express the quotient to four decimal places (e.g., 1.7143). A quotient this size suggests that information was provided by more than half the providers in the segment. In large counties, especially, one may want to create additional spreadsheets, one for each **stratum,** and first calculate extrapolated totals for each **stratum.** Then, adding those totals, one will have a segment estimate, and one can proceed to use Spreadsheets #2, #3, and #4 to get GRAND TOTALS for reporting purposes. Spreadsheet #5, Summary, has formulas that take information from the bottom set of tables in Spreadsheets #2, #3, and #4. The resulting information can then be reported when the County's Workforce Education and Training Component is submitted to the State.

Appendix A.

Directions for Completing the

Workforce Needs Assessment Survey

Directions for Completing the *Workforce Needs Assessment Survey*

This exhibit enables a County's, and subsequently the Public Mental Health System to:

- Establish a current, standardized baseline set of workforce data that depicts personnel shortages and the needs of ethnic/racial and culturally underrepresented populations;
- Perform a functional analysis of workforce capacity to service needs; and
- Appropriately apply workforce education and training strategies.

This establishment of baseline data will also enable measurement of change in numbers as well as workforce composition over time, and enable subsequent adjustment of strategies and resources.

Specifically, this exhibit will depict:

- A listing of occupations within the occupational categories of Unlicensed Mental Health Direct Service Staff, Licensed Mental Health Staff (direct service), Other Health Care Staff (direct service), Managerial and Supervisory, and Support Staff.
- The total number of positions (FTE) that are approved to be filled in each occupation and occupational category.
- The occupations that are deemed by the County to be hard to fill or retain.
- The number of estimated additional individuals needed in order to meet the current estimated Public Mental Health System personnel needs in the County by occupation and occupational category.
- For each occupational category an estimated number of personnel by race/ethnicity as voluntarily self-reported by the employee.
- The estimated number of individuals by race/ethnicity the County plans to serve annually.
- The number of positions by occupation and occupational category in the County that are specifically designated by title and/or job description to be filled by individuals who have experienced services in the Public Mental Health System.
- A listing of the languages other than English in which there is a need for workers to demonstrate sufficient proficiency to ensure access and quality services are provided to individuals whose primary language is other than English. For each language listed the number of workers who are proficient in that language and the number of additional workers needed to meet the need.
- A description of significant workforce shortfalls that have surfaced in the Workforce Needs Assessment, to include issues of workforce sufficiency and access to populations and communities that have not been identified in a countywide analysis of aggregated data. Populations and communities may include unserved or underserved urban and rural communities, immigrant and Native American populations, and special populations, such as at-risk youth and older adults.

For planning purposes a County is to count the Public Mental Health System workforce that is administered by the County, to include individuals, groups and agencies that contract with the County. The focus is on persons working, either full- or part-time, or volunteering (for example, some interns or individuals with consumer and/or family member experience) in the Public Mental Health System. Include in the count County employees and volunteers, community based organizations contracting with the county, and individuals in solo or small group practices contracting with the county. For staff who support direct service staff, such as administrators, clerical, analysts, and information technology (IT) staff, count only those positions if they are employed by a county mental health department or division, or directly provide support to the direct service staff of an agency contracting with county mental health to provide public mental health services.

This exhibit has four sections:

I. By Occupational Category

This enables the establishment of a quantitative baseline by occupation and occupational categories. It identifies those positions that are *hard to fill*, and provides an opportunity to estimate additional positions that the county projects as needed to meet the county's present service needs. It also provides the opportunity to compare the racial/ethnic makeup of the county's workforce to that of the mental health population planned to be served. In addition, the exhibit enables a quantitative comparison of the workforce that is employed by the County or supervised by county employees, versus community based organizations and network providers.

Note. The MHSA Prevention and Early Intervention component, when implemented, will provide additional programs, and generate additional workforce needs. Upon implementation of the Workforce Education and Training Component, Counties will have the opportunity to make changes, through updates to their Plans, which may be reflected in their performance contracts through an amendment.

The directions for completing this exhibit are to develop a defensible methodology for projecting as quickly and efficiently as possible a set of estimated data in order to quantify the differences between capacity and need. For example, acceptable methodologies might include using existing data and studies in order to extrapolate projected data, and/or conducting a survey. This data is intended for the planning and allocation of resources, and not to conduct rigorous research.

Suggested methodologies, formulas or approaches for developing and projecting estimated data are posted at http://www.dmh.ca.gov/mhsa/EducTrain.asp.

The following is guidance to assist with completing this section of the Exhibit:

Column (1) Positions

This is a list of occupations divided into major categories, such as *Managerial and Supervisory.* In Section D, count positions for licensed and non-licensed managerial and supervisory personnel if 50% of more of the person's time is managerial/supervisory. In order to develop consistency of position descriptions across Counties please use the following occupational classification system and translate each organization's job titles into occupational positions listed below. This is based upon primary tasks performed. For example, if a job title, such as Case Manager, is being used for a Family Member Support Staff, put the person under the latter category. Count an individual only once.

Each Occupational Category and classification is to be sub-totaled as **County**, meaning employees and independent contractors and volunteers directly supervised by County employees, and **All Other**, meaning community based organizations (CBOs) and *Network* and All Other (n.e.c.) providers contracting with a County, and any individuals performing in a volunteer capacity under the supervision of a CBO or other service provider.

A. *Unlicensed* Mental Health Direct Service Staff

Mental Health Rehabilitation Specialist. – This is a category for individuals typically with an Associate of Arts or Science bachelor's degree, and sufficient experience to meet the regulatory definition of Mental Health Rehabilitation Specialist. Titles could include Behavior Specialist and Psychosocial Rehabilitation Worker.

Case Manager/Service Coordinator. – Other case managers or service coordinators belong in this category if they are not listed elsewhere.

Employment Services Staff. – Job titles include those whose primary duties are to provide career and employment services. Titles may include Job Developer, Employment Consultant, Employment Specialist, Vocational Assistant, Employment Coordinator, Consumer Vocational Activities Coordinator, Educational Support Specialist, Employment Aide and Job Coach, among others.

Housing Services Staff. – Job titles include Housing Specialist, Peer Housing Counselor, Consumer Housing Activities Coordinator.

Consumer Support Staff. – Job titles include Peer Specialist, Consumer Advocate, Peer Mentor, Peer Advocate, Peer Support Aide, Peer Guide, Peer Coach, and Peer Counselor, among others. Mental Health Worker is a common job title.

Family Member Support Staff. – Job titles include Parent Partner, Family Member Provider, Family Advocate, Family Partner, Family Member Manager, Family Services Worker, and Family Liaison, among others. Mental Health Worker is a common job title.

Benefits/Eligibility Specialist. – Job titles in this category include Benefits Planner or Coordinator, Health Services Representative, Benefits Advocate, Substitute Payee Specialist.

Other Unlicensed MH Direct Service Staff. – Job titles in this category may include Mental Health Worker, Co-occurring Disorders Specialist, Forensic Mental Health Specialist, among others.

B. *Licensed* Mental Health Staff (direct service)

Psychiatrist, general. – self-explanatory.
Psychiatrist, child or adolescent. – self-explanatory.
Psychiatrist, geriatric. – self-explanatory.
Psychiatric or Family Nurse Practitioner. – self-explanatory.
Clinical Nurse Specialist. – self-explanatory.
Licensed Psychiatric Technician. – self-explanatory.
Licensed Clinical Psychologist. – self-explanatory.
Psychologist, registered intern (or, waivered). – self-explanatory.
Licensed Clinical Social Worker (LCSW). – self-explanatory.
MSW, registered intern (or, waivered). – self-explanatory.
Marriage and Family Therapist (MFT). – self-explanatory.
MFT, registered intern (or, waivered). – self-explanatory.
Other licensed MH Staff (direct service). – self-explanatory.

C. Other Health Care Staff (direct service)

Physician. – self-explanatory.
Registered Nurse. – self-explanatory.
Licensed Vocational Nurse. – self-explanatory.
Physician Assistant. – self-explanatory.
Occupational Therapist. – self-explanatory.
Other Therapist (e.g., physical, recreation, art, dance). – self-explanatory.
Other Health Care Staff (direct service). – Job titles in this category can include such titles as traditional cultural healers and credentialed pupil personnel services staff, such as school nurse, social worker, counselor and psychologist.

D. Managerial and Supervisory

CEO or manager above direct supervisor. – This category is for the County or contract agency Mental Health Director and mid-level managers. Job titles may include Program Manager, Service Chief, Health Care Program Manager, Program Director, Assistant Program Director.

Supervising psychiatrist (or other physician). – In larger counties, a supervising psychiatrist or other physician may oversee psychiatric and other medical services.

Licensed supervising clinician. – Job titles may include Nursing Supervisor, Supervising Psychiatric Social Worker, Team Leader, Unit Supervisor. A supervisor who is a licensed

clinician may supervise other licensed professionals, interns, and is sometimes responsible for some *Unlicensed Direct Service Staff* as well.

Other managers and supervisors. – All other first-line supervisors (for example, Supervising Case Manager, Supervisor of Clerical Staff) belong here.

E. Support Staff (non-direct services)

Analysts, tech support, quality assurance – To be included here are positions such as Mental Health Planning Analyst. This category includes Information Technology support, with titles such as Information Systems/Performance Measurement Staff. Quality assurance includes quality improvement, compliance, and related job titles where the individual's primary duties are in quality assurance.

Education, training, research. – Job titles may include Staff Development Officer, Training Coordinator, Training Officer, Research Analyst, and the like.

Clerical, secretary, administrative assistants. – Job titles here include Secretaries, Clerks, Administrative or Office Assistants, Intermediate Typist Clerk, Billing Clerk, Medical Records Specialist.

Other support staff (non-direct services). – Job titles in this category include Security Guard, Driver, Grant Writer, and Public Information Officer, among others.

F. Total Public Mental Health Population

Enter the estimated number of individuals planned to be served by race/ethnicity this year. Again, these are estimated numbers that could be based on factors such as recent history, population trends, ending programs, and starting new programs, such as MHSA funded services. These estimates will enable the planning and allocation of workforce education and training resources at both the state and County levels to address any relatively low numbers of individuals from certain racial/ethnic groups working in the Public Mental Health System.

Column (2) - Estimated Number FTE authorized

For each occupation, enter the number of full-time-equivalent (FTE) positions authorized, whether or not all positions are filled. The term "authorized" here means that a position is approved to be filled by the County and the funding is available. For agencies contracting with the County, authorized positions could mean positions budgeted or funded. Enter the Sub-Total number for each occupational category.

Column (3) - Positions hard to fill (Yes/No)

Mark 1 for "Yes," and 0 for "No," indicating which occupational positions are deemed *hard to fill* because of a shortage of qualified individuals who apply for positions approved to be filled. Reasons could include that there are not enough individuals with the minimum qualifications, or that pay and/or benefits are insufficient to attract or retain sufficient qualified individuals, or that there is difficulty attracting sufficient individuals to meet ethnic/racial diversity needs. Do not mark this column "1=Yes" if the position is hard to fill because of organizational barriers, such as personnel or human resource policies and procedures that interfere with the timely filling of positions.

Note. This column will be key in linking proposed funding for *Actions* to address challenges in recruiting and/or retaining staff. Positions may be deemed hard to fill in only a designated part of a county, or may pose a challenge only in agencies that contract with a county. In this instance it is recommended to mark these positions as deemed *hard to fill*, and provide explanatory remarks in Section **IV. Remarks**.

Column (4) – Number additional FTE estimated to meet need

For each Occupation, enter the estimated number of additional full-time-equivalent (FTE) workers needed in order to meet current estimated public mental needs of the county. This number includes the number of positions that are either approved to be filled but not funded, or funded but not approved to be filled. This is a planning estimate that quantifies current unmet need as it is

determined in each County. This planning estimate is to assist in establishing a baseline in assessing workforce capacity versus need over time, and to assist in long term planning of workforce development resources for specific occupations.

Columns (5) through (10) – Race/ethnicity
For each occupational category, such as *Managerial and Supervisory*, based on voluntary self-identification, provide number of FTEs currently filled by the following race/ethnicity: White/Caucasian (column 5), Hispanic/Latino (column 6), African American/Black (column 7), Asian/Pacific Islander (column 8), Native American (column 9), and Multi-Race or Other (column 10). Be sure the totals from columns 5 through 10 equal the total in Column 11.

Note. Counties may have specific underserved and/or unserved communities or groups of individuals that are small but significant subset populations within the six race/ethnicity categories provided. In this instance it is recommended to provide explanatory remarks in Section **IV. Remarks** that speak to the need for increasing the diversity of the workforce to serve more effectively these identified populations. These columns will be key in linking proposed funding for Actions to address challenges in recruiting and/or retaining staff.

Columns (11)
Column 11 should equal the total filled FTEs in the county by occupational category.

Analysis. The difference between the number of filled FTEs (column 11) and number of FTEs approved and funded to be filled (column 2) provides the County a vacancy rate with which to gauge the degree of difficulty recruiting and retaining a person within a position or occupational category.

II. Positions Specifically Designated for Clients and Family Members

The Act promotes the employment of individuals with consumer and/or family member experience in the Public Mental Health System. This section enables a quantification and analysis of those positions which the county and its community based organizations have specifically designated as positions for which experience as a consumer and/or family member is either designated in the title, or is described as desirable or encouraged in the statement of qualifications.

The Community Services and Supports Component identified new client and family member positions funded through MHSA. The completion of this section represents the entire Public Mental Health System. This section is a sub-set of section I, and the numbers are to be included in the numbers entered in Section I.

III. Language Proficiency

Counties are to report those languages other than English in which there is a need for staff to demonstrate sufficient oral and written proficiency to ensure access and quality services are provided to individuals whose primary language is other than English. This enables an analysis of current capacity versus need.

Column (1) - Language other than English
List languages, other than English, for which some public mental health workforce members need oral and written proficiency. This can include both languages designated by the Department as threshold languages as well as languages where a significant number of clients and family members compel a reasonable accommodation.

Column (2) - Number who are proficient
For each language listed, enter the number of individuals by the occupational categories of staff who are available in the workforce who are proficient in each language.

Column (3) - Additional number who need to be proficient
If the number in Column (2) is inadequate to meet the need, indicate how many additional individuals by category who need to be proficient to meet current needs.

Column (4) - TOTAL (2)+(3)
For each language listed, add the number in Column (2) to the number in Column (3) and record the sum in Column (4). Column (4) represents the total language proficiency needs of the County.

IV. Remarks

This section is to provide a brief listing of any significant shortfalls that have surfaced in the analysis of data provided in sections I, II, and/or III. It is important to include any sub-sets of shortfalls or disparities that are not apparent in the categories listed, such as sub-sets within occupations, racial/ethnic groups, special populations, and unserved or underserved communities.

Appendix B.
Hypothetical County Example

Hypothetical County Example

On pages 35 to 49, we present tables for a hypothetical county with numbers (and comments) that are made-up as well.

County Personnel

Table B-1, on pages 35 to 37, is information on *county workers,* including a few independent contractors and volunteers working within Community Mental Health. This information was obtained internally from HR people, and from conversations with key management personnel. Some Medi-Cal data was used, along with what we know of the characteristics (race/ethnicity) of those non-Medi-Cal clients now being served through MHSA and other mental health funding streams.

Contract Agencies

Table B-2, on pages 38 to 40, has information on the *contract agency* workforce. We did a survey of all contract agencies via email, and got information from all but two agencies. Knowing budget sizes – and the strata within which the two agencies fell (families and children, and a self-directed adult consumer agency) – we extrapolated the reported information so as to add in likely quantitative information for the two non-respondents. We then made adjustments in (1) the composition of employment and (2) consumers in specially designated positions based on existing project proposals responding to earlier RFPs, plus *informal* information from the contract administrator for these two agencies and their CMH programs serving our county's clients.

Network Providers and All Other (n.e.c.)

Table B-3, on pages 41 to 43, has information about *Network Providers* (individual and small group practitioners), along with selected All Other (n.e.c.) contractors. We have included one proprietary psychiatric hospital within our county, along with about seven augmented residential service providers within our county. We have excluded all contractors operating outside our county on grounds that comparative labor market conditions are difficult to judge, and it is unlikely that our Workforce Development, Education and Training Component will serve people outside our county. We used *paid claims* and our *Network Provider* database to get much of the information needed for Exhibit 3 for this segment. We included targeted providers in the "All Other (n.e.c.)" category in the email survey, mentioned above. Again, we extrapolated numbers, and adjusted the data for non-respondents.

Summary: All Segments

Table B-4, on pages 44 to 49 tallies up complete-count data (county workers) and the *estimates* for the other two segments mentioned above. Section IV, REMARKS, on page 49, is a concise summary of observations made by some (but not all) respondents to the email survey, and by selected Network Providers who met as a group with our County's CMH Director and senior staff.

Table B-1. Hypothetical County Workforce Information: County Employees, Independent Contractors, and Volunteers

COUNTY (employees, independent contractors, volunteers)

TABULATION SET #2 (TOTALS)

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category

COUNTY TOTAL

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:										
Mental Health Rehabilitation Specialist	3.0	0.0	1.0	2.0	0.5	0.0	0.0	0.0	0.0	2.5
Case Manager/Service Coordinators	6.0	0.0	2.0	3.0	1.0	1.0	1.0	0.0	0.0	6.0
Employment Services Staff	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Housing Services Staff	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Consumer Support Staff	4.0	0.0	4.0	2.0	0.5	1.0	0.0	0.0	0.0	3.5
Family Member Support Staff	6.0	1.0	4.0	2.0	1.5	0.0	0.5	0.0	0.0	4.0
Benefits/Eligibility Specialist	2.0	1.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	2.0
Other *Unlicensed* MH Direct Service Staff	9.0	1.0	1.0	4.5	1.5	2.0	0.5	0.0	0.0	8.5
Sub-total, A	30.0	4.0	17.0	15.5	5.0	4.0	2.0	0.0	0.0	26.5
B. *Licensed* Mental Health Staff (direct service):										
Psychiatrist, general	4.6	1.0	2.0	2.5	1.0	0.0	0.0	0.0	0.0	3.5
Psychiatrist, child/adolescent	2.0	1.0	1.0	1.5	0.0	0.0	0.0	0.0	0.0	1.5
Psychiatrist, geriatric	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Psychiatric or Family Nurse Practitioner	2.0	1.0	2.0	0.0	0.0	0.0	2.0	0.0	0.0	2.0
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Licensed Psychiatric Technician	6.0	1.0	4.0	3.0	1.0	1.0	0.5	0.0	0.0	5.5
Licensed Clinical Psychologist	6.0	0.0	2.0	4.0	1.0	1.0	0.0	0.0	0.0	6.0
Psychologist, registered intern (or wiavered)	2.0	0.0	1.0	0.0	2.0	0.0	0.0	0.0	0.0	2.0
Licensed Clinical Social Worker (LCSW)	17.0	1.0	8.0	9.0	4.0	1.0	2.0	0.0	0.0	16.0
MSW, registered intern (or waivered)	4.0	1.0	4.0	2.0	1.0	0.0	0.0	0.0	0.0	3.0
Marriage and Family Therapist (MFT)	6.0	1.0	2.0	4.0	1.0	0.0	1.0	0.0	0.0	6.0
MFT registered intern (or wiavered)	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other *Licensed* MH Staff (direct service)	5.0	0.0	2.0	2.0	1.5	0.5	0.5	0.0	0.0	4.5
Sub-total, B	56.6	8.0	30.0	28.0	12.5	3.5	6.0	0.0	0.0	50.0
C. Other Health Care Staff (direct service):										
Physician	2.0	0.0	1.0	2.0	0.0	0.0	0.0	0.0	0.0	2.0
Registered Nurse	5.0	1.0	1.0	2.0	1.0	0.0	1.0	0.0	0.0	4.0

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 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)
Licensed Vocational Nurse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Physician Assistant	1.0	1.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0
Occupational Therapist	1.5	0.0	1.0	1.5	0.0	0.0	0.0	0.0	0.0	1.5
Other Therapist (e.g., physical, recreation, art, dance)	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Health Care Staff (direct service, to include traditional cultural healers)	3.0	0.0	1.0	0.0	1.0	1.0	1.0	0.0	0.0	3.0
Sub-total, C	12.5	2.0	6.0	6.5	2.0	1.0	2.0	0.0	0.0	11.5
D. Managerial and Supervisory:										
CEO or manager above direct supervisor	9.0	1.0	4.0	7.0	0.0	0.0	0.0	0.0	0.0	7.0
Supervising psychiatrist (or other physician)	1.0	1.0	1.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5
Licensed supervising clinician	6.0	1.0	3.0	5.0	1.0	0.0	0.0	0.0	0.0	6.0
Other managers and supervisors	4.0	0.0	1.0	0.0	1.5	1.0	0.5	0.0	0.0	3.0
Sub-total, D	20.0	3.0	9.0	12.5	2.5	1.0	0.5	0.0	0.0	16.5
E. Support Staff:										
Analysts, tech support, quality assurance	5.0	1.0	2.0	3.5	0.0	0.0	1.0	0.0	0.0	4.5
Education, training, research	3.0	1.0	1.5	3.0	0.0	0.0	0.0	0.0	0.0	3.0
Clerical, secretary, administrative assistants	8.0	1.0	4.0	5.0	1.0	1.0	1.0	0.0	0.0	8.0
Other support staff (non-direct services)	4.0	0.0	2.0	2.0	0.0	0.0	0.0	0.0	0.0	2.0
Sub-total , E	20.0	3.0	9.5	13.5	1.0	1.0	2.0	0.0	0.0	17.5
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	139.1	20.0	71.5	76.0	23.0	10.5	12.5	0.0	0.0	122.0

Major Group and Positions				**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**			41.5%	18.0%	7.3%	11.3%	5.5%	16.5%	100.1%

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

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated . . .

COUNTY TOTAL

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	4.0	1	6.0
Family Member Support Staff	4.0	1	2.0
Other *Unlicensed* MH Direct Service Staff	10.0	1	4.0
Sub-total, A:	18.0	3	12.0
B. *Licensed* Mental Health Staff (direct service)	0.0	0	1.0
C. Other Health Care Staff (direct service)	0.0	0	0.0
D. Managerial and Supervisory	1.0	1	1.0
E. Support Staff (non-direct services)	0.0	0	2.0
GRAND TOTAL (A+B+C+E+E)	19.0	4	16.0

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

COUNTY TOTAL

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	10	6	16
	Others	2	1	3
2. Vietnamese	Direct Service Staff	2	1	3
	Others	1	1	2
3. Cantonese	Direct Service Staff	2	1	3
	Others	1	1	2
4. Hmong	Direct Service Staff	2	1	3
	Others	1	1	2
5. Farsi	Direct Service Staff	2	1	3
	Others	1	1	2
TOTAL, all languages other than English:	Direct Service Staff	18	10	28
	Others	6	4	10

Table B-2. Hypothetical County Workforce Information: Contract Agency Employees, Sub-contractors, and Volunteers

CONTRACT AGENCIES (employees, sub-contractors, volunteers)

TABULATION SET #2 (EXTRAPOLATED TOTALS)
EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category

ALL, or STRATUM ALL (extrapolated)

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 FTE 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:										
Mental Health Rehabilitation Specialist	22.9	0.0	8.6	7.1	5.7	1.4	1.4	0.0	4.3	20.0
Case Manager/Service Coordinators	42.9	2.9	8.6	20.0	8.6	2.9	2.9	0.0	1.4	35.7
Employment Services Staff	1.4	0.0	4.3	1.4	0.0	0.0	0.0	0.0	0.0	1.4
Housing Services Staff	0.9	0.0	4.3	0.0	0.0	0.9	0.0	0.0	0.0	0.9
Consumer Support Staff	51.4	2.9	21.4	24.3	5.7	1.4	1.4	0.0	7.1	40.0
Family Member Support Staff	15.7	2.9	2.9	7.1	2.9	0.0	0.0	0.0	0.0	10.0
Benefits/Eligibility Specialist	3.4	2.9	2.9	2.9	0.6	0.0	0.0	0.0	0.0	3.4
Other *Unlicensed* MH Direct Service Staff	34.3	0.0	17.1	14.3	11.4	2.9	4.3	0.0	0.0	32.9
Sub-total, A	172.9	11.4	70.0	77.1	34.9	9.4	10.0	0.0	12.9	144.3
B. *Licensed* Mental Health Staff (direct service):										
Psychiatrist, general	10.0	2.9	5.7	7.1	0.0	0.0	0.0	0.0	0.0	7.1
Psychiatrist, child/adolescent	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Psychiatrist, geriatric	1.4	2.9	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Psychiatric or Family Nurse Practitioner	1.4	0.0	1.4	0.0	1.4	0.0	0.0	0.0	0.0	1.4
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Licensed Psychiatric Technician	0.0	0.0	2.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Licensed Clinical Psychologist	11.4	0.0	1.4	8.6	1.4	0.0	0.0	0.0	0.0	10.0
Psychologist, registered intern (or wiavered)	2.9	0.0	0.0	1.4	0.0	1.4	0.0	0.0	0.0	2.9
Licensed Clinical Social Worker (LCSW)	31.4	2.9	8.6	11.4	7.1	1.4	2.9	1.4	0.0	24.3
MSW, registered intern (or waivered)	5.7	0.0	0.0	2.9	1.4	0.0	1.4	0.0	0.0	5.7
Marriage and Family Therapist (MFT)	15.7	2.9	2.9	7.1	2.9	1.4	1.4	0.0	0.0	12.9
MFT registered intern (or wiavered)	4.3	0.0	0.0	2.9	1.4	0.0	0.0	0.0	0.0	4.3
Other *Licensed* MH Staff (direct service)	1.4	0.0	0.0	0.0	0.0	1.4	0.0	0.0	0.0	1.4
Sub-total, B	85.7	11.4	25.7	41.4	15.7	5.7	5.7	1.4	0.0	70.0
C. Other Health Care Staff (direct service):										
Physician	1.4	0.0	1.4	1.4	0.0	0.0	0.0	0.0	0.0	1.4

Major Group and Positions	Esti-mated # FTE author-ized	Position hard to fill? 1=Yes; 0=No	# FTE estimated to meet need in addition to # FTE authorized	**Race/ethnicity** of FTE currently in the workforce -- Col. (11)						# FTE filled (5)+(6)+ (7)+(8)+ (9)+(10)
				White/ Cau-casion	His-panic/ Latino	African-Ameri-can/ Black	Asian/ Pacific Islan-der	Native Ameri-can	Multi Race or Other	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Registered Nurse	10.0	2.9	2.9	4.3	2.9	0.0	1.4	0.0	0.0	8.6
Licensed Vocational Nurse	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Physician Assistant	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Occupational Therapist	2.9	0.0	1.4	2.9	0.0	0.0	0.0	0.0	0.0	2.9
Other Therapist (e.g., physical, recreation, art, dance)	1.4	0.0	1.4	0.0	1.4	0.0	0.0	0.0	0.0	1.4
Other Health Care Staff (direct service, to include traditional cultural healers)	1.4	0.0	1.4	0.0	0.0	0.0	1.4	0.0	0.0	1.4
Sub-total, C	17.1	2.9	10.0	8.6	4.3	0.0	2.9	0.0	0.0	15.7
D. Managerial and Supervisory:										
CEO or manager above direct supervisor	10.0	2.9	0.0	5.7	1.4	0.0	0.0	0.0	0.0	7.1
Supervising psychiatrist (or other physician)	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Licensed supervising clinician	4.3	0.0	5.7	4.3	0.0	0.0	0.0	0.0	0.0	4.3
Other managers and supervisors	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Sub-total, D	14.3	2.9	7.1	10.0	1.4	0.0	0.0	0.0	0.0	11.4
E. Support Staff:										
Analysts, tech support, quality assurance	1.4	0.0	2.9	1.4	0.0	0.0	0.0	0.0	0.0	1.4
Education, training, research	0.6	0.0	1.4	0.0	0.6	0.0	0.0	0.0	0.0	0.6
Clerical, secretary, administrative assistants	21.4	2.9	5.7	8.6	5.7	2.9	1.4	0.0	0.0	18.6
Other support staff (non-direct services)	1.4	0.0	0.0	1.4	0.0	0.0	0.0	0.0	0.0	1.4
Sub-total , E	24.9	2.9	10.0	11.4	6.3	2.9	1.4	0.0	0.0	22.0
TOTAL WORKFORCE (A+B+C+D+E)	314.9	31.4	122.9	148.6	62.6	18.0	20.0	1.4	12.9	263.4

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated . . .

ALL, or STRATUM_____ ALL (extrapolated)

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	51.4	3	21.4
Family Member Support Staff	15.7	3	2.9
Other *Unlicensed* MH Direct Service Staff	44.3	3	17.1
Sub-total, A:	111.4	9	41.4
B. *Licensed* Mental Health Staff (direct service)	0.0	0	0.0
C. Other Health Care Staff (direct service)	2.9	3	1.4
D. Managerial and Supervisory	2.9	3	1.4
E. Support Staff (non-direct services)	8.6	3	2.9
GRAND TOTAL (A+B+C+E+E)	125.7	17	47.1

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

ALL, or STRATUM_____ ALL (extrapolated)

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	86	43	129
	Others	14	6	20
2. Vietnamese	Direct Service Staff	9	3	11
	Others	0	0	0
3. Cantonese	Direct Service Staff	6	6	11
	Others	0	0	0
4. Hmong	Direct Service Staff	3	3	6
	Others	0	0	0
5. Farsi	Direct Service Staff	3	1	4
	Others	0	0	0
TOTAL, all languages other than English:	Direct Service Staff	106	56	161
	Others	14	6	20

Table B-3. Hypothetical County Workforce Information: Network & All Other (n.e.c.) Providers

NETWORK PROVIDERS & ALL OTHERS (Principals, partners, (employees, independent contractors, sub-contractors, volunteers)

TABULATION SET #2 (EXTRAPOLATED TOTALS)
EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

I. By Occupational Category

Provider (or, set of providers):_____Network & All Other (n.e.c.)

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:										
Mental Health Rehabilitation Specialist	1.5	0.0	0.0	1.0	0.5	0.0	0.0	0.0	0.0	1.5
Case Manager/Service Coordinators	3.3	0.0	0.0	1.0	1.0	0.0	1.0	0.0	0.0	3.0
Employment Services Staff	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Housing Services Staff	0.8	1.0	0.0	0.0	0.0	0.5	0.0	0.0	0.0	0.5
Consumer Support Staff	4.0	0.0	0.0	2.5	0.8	0.0	0.0	0.0	0.0	3.3
Family Member Support Staff	1.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0
Benefits/Eligibility Specialist	1.5	1.0	0.0	1.3	0.0	0.0	0.0	0.0	0.0	1.3
Other *Unlicensed* MH Direct Service Staff	6.0	1.0	0.0	3.0	1.0	0.5	0.8	0.3	0.0	5.5
Sub-total, A	18.0	4.0	0.0	9.8	3.3	1.0	1.8	0.3	0.0	16.0
B. *Licensed* Mental Health Staff (direct service):										
Psychiatrist, general	3.0	1.0	0.0	1.8	0.3	0.5	0.0	0.0	0.0	2.5
Psychiatrist, child/adolescent	1.0	1.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5
Psychiatrist, geriatric	0.5	1.0	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.5
Psychiatric or Family Nurse Practitioner	2.3	1.0	0.0	1.3	0.5	0.0	0.5	0.0	0.0	2.3
Clinical Nurse Specialist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Licensed Psychiatric Technician	12.0	1.0	0.0	6.5	2.5	0.5	1.5	0.0	0.0	11.0
Licensed Clinical Psychologist	5.5	0.0	0.0	4.0	0.5	0.8	0.3	0.0	0.0	5.5
Psychologist, registered intern (or wiavered)	1.0	0.0	0.0	0.5	0.5	0.0	0.0	0.0	0.0	1.0
Licensed Clinical Social Worker (LCSW)	10.5	1.0	0.0	8.0	0.8	0.0	0.8	0.0	0.0	9.5
MSW, registered intern (or waivered)	2.0	1.0	0.0	0.8	0.8	0.3	0.3	0.0	0.0	2.0
Marriage and Family Therapist (MFT)	6.0	1.0	0.0	4.5	0.8	0.0	0.3	0.0	0.0	5.5
MFT registered intern (or wiavered)	1.5	0.0	0.0	0.5	0.5	0.0	0.5	0.0	0.0	1.5
Other *Licensed* MH Staff (direct service)	7.5	0.0	0.0	3.0	1.5	0.0	2.5	0.0	0.0	7.0
Sub-total, B	52.8	8.0	0.0	31.8	8.5	2.0	6.5	0.0	0.0	48.8
C. Other Health Care Staff (direct service):										
Physician	3.3	0.0	0.0	2.5	0.5	0.0	0.0	0.0	0.0	3.0

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)
Registered Nurse	8.0	1.0	0.0	3.5	1.5	0.8	2.0	0.0	0.0	7.8
Licensed Vocational Nurse	3.0	0.0	0.0	1.0	0.8	0.0	0.8	0.0	0.0	2.5
Physician Assistant	1.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0
Occupational Therapist	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Therapist (e.g., physical, recreation, art, dance)	1.3	0.0	0.0	0.8	0.3	0.0	0.3	0.0	0.0	1.3
Other Health Care Staff (direct service, to include traditional cultural healers)	12.0	0.0	0.0	3.5	2.5	3.5	2.0	0.3	0.0	11.8
Sub-total, C	28.5	2.0	0.0	12.3	5.5	4.3	5.0	0.3	0.0	27.3
D. Managerial and Supervisory:										
CEO or manager above direct supervisor	4.0	1.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	1.0
Supervising psychiatrist (or other physician)	3.0	1.0	0.0	1.5	0.8	0.0	0.0	0.0	0.0	2.3
Licensed supervising clinician	4.5	1.0	0.0	3.5	0.5	0.0	0.3	0.0	0.0	4.3
Other managers and supervisors	2.0	0.0	0.0	0.8	0.3	0.3	0.3	0.0	0.0	1.5
Sub-total, D	13.5	3.0	0.0	6.8	1.5	0.3	0.5	0.0	0.0	9.0
E. Support Staff:										
Analysts, tech support, quality assurance	0.8	1.0	0.0	0.8	0.0	0.0	0.0	0.0	0.0	0.8
Education, training, research	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Clerical, secretary, administrative assistants	4.5	1.0	0.0	2.5	0.5	0.3	0.5	0.0	0.0	3.8
Other support staff (non-direct services)	2.0	0.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	2.0
Sub-total , E	7.3	3.0	0.0	4.3	1.5	0.3	0.5	0.0	0.0	6.5
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	120.0	20.0	0.0	64.8	20.3	7.8	14.3	0.5	0.0	107.5

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated . . .

Provider (or, set of providers):_____Network & All Other (n.e.c.)

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	4.0	0	2.5
Family Member Support Staff	1.0	1	2.0
Other *Unlicensed* MH Direct Service Staff	1.5	1	1.0
Sub-total, A:	6.5	2	5.5
B. *Licensed* Mental Health Staff (direct service)	1.0	1	1.5
C. Other Health Care Staff (direct service)	0.8	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)	8.3	3	7.0

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

III. Language Proficiency

Provider (or, set of providers):____Network and All Other (n.e.c.)

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	32	3	35
	Others	4	1	5
2. Vietnamese	Direct Service Staff	11	2	13
	Others	2	1	2
3. Cantonese	Direct Service Staff	8	2	10
	Others	1	1	2
4. Hmong	Direct Service Staff	7	2	9
	Others	1	1	2
5. Farsi	Direct Service Staff	2	1	3
	Others	1	1	2
TOTAL, all languages other than English:	Direct Service Staff	60	10	69
	Others	8	4	12

Table B-4. Hypothetical County Workforce Information: SUMMARY, ALL SEGMENTS COMBINED

SUMMARY OF COMPLETE COUNT AND EXTRAPOLATED NUMBERS: ALL SEGMENTS

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	3.0	0	1.0							
Case Manager/Service Coordinators	6.0	0	2.0							
Employment Services Staff	0.0	0	2.0							
Housing Services Staff	0.0	1	2.0							
Consumer Support Staff	4.0	0	4.0							
Family Member Support Staff	6.0	1	4.0							
Benefits/Eligibility Specialist	2.0	1	1.0							
Other *Unlicensed* MH Direct Service Staff	9.0	1	1.0							
Sub-total, A (County)	30.0	4	17.0	15.5	5.0	4.0	2.0	0.0	0.0	26.5
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Mental Health Rehabilitation Specialist	24.4	0	8.6							
Case Manager/Service Coordinators	46.1	3	8.6							
Employment Services Staff	1.4	0	4.3							
Housing Services Staff	1.6	1	4.3							
Consumer Support Staff	55.4	3	21.4							
Family Member Support Staff	16.7	4	2.9							
Benefits/Eligibility Specialist	4.9	4	2.9							
Other *Unlicensed* MH Direct Service Staff	40.3	1	17.1							
Sub-total, A (All Other)	190.9	15	70.0	86.9	38.1	10.4	11.7	0.3	12.9	160.3
Total, A (County & All Other)	220.9	19	87.0	102.4	43.1	14.4	13.7	0.3	12.9	186.8
B. *Licensed* Mental Health Staff (direct service):										
County (employees, independent contractors, volunteers)										
Psychiatrist, general	4.6	1	2.0							
Psychiatrist, child/adolescent	2.0	1	1.0							
Psychiatrist, geriatric	0.0	1	1.0							
Psychiatric or Family Nurse Practitioner	2.0	1	2.0							
Clinical Nurse Specialist	0.0	0	0.0							
Licensed Psychiatric Technician	6.0	1	4.0							
Licensed Clinical Psychologist	6.0	0	2.0							

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)
Psychologist, registered intern (or wiavered)	2.0	0	1.0							
Licensed Clinical Social Worker (LCSW)	17.0	1	8.0							
MSW, registered intern (or waivered)	4.0	1	4.0							
Marriage and Family Therapist (MFT)	6.0	1	2.0							
MFT registered intern (or wiavered)	2.0	0	1.0							
Other *Licensed* MH Staff (direct service)	5.0	0	2.0							
Sub-total, B (County)	56.6	8	30.0	28.0	12.5	3.5	6.0	0.0	0.0	50.0
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Psychiatrist, general	13.0	4	5.7							
Psychiatrist, child/adolescent	1.0	1	1.4							
Psychiatrist, geriatric	1.9	4	1.4							
Psychiatric or Family Nurse Practitioner	3.7	1	1.4							
Clinical Nurse Specialist	0.0	0	0.0							
Licensed Psychiatric Technician	12.0	1	2.9							
Licensed Clinical Psychologist	16.9	0	1.4							
Psychologist, registered intern (or wiavered)	3.9	0	0.0							
Licensed Clinical Social Worker (LCSW)	41.9	4	8.6							
MSW, registered intern (or waivered)	7.7	1	0.0							
Marriage and Family Therapist (MFT)	21.7	4	2.9							
MFT registered intern (or wiavered)	5.8	0	0.0							
Other *Licensed* MH Staff (direct service)	8.9	0	0.0							
Sub-total, B (All Other)	138.5	19	25.7	73.2	24.2	7.7	12.2	1.4	0.0	118.7
Total, B (County & All Other)	195.1	27	55.7	101.2	36.7	11.2	18.2	1.4	0.0	168.7
C. Other Health Care Staff (direct service):										
County (employees, independent contractors, volunteers)										
Physician	2.0	0	1.0							
Registered Nurse	5.0	1	1.0							
Licensed Vocational Nurse	0.0	0	0.0							
Physician Assistant	1.0	1	1.0							
Occupational Therapist	1.5	0	1.0							
Other Therapist (e.g., physical, recreation, art, dance)	0.0	0	1.0							
Other Health Care Staff (direct service, to include traditional cultural healers)	3.0	0	1.0							
Sub-total, C (County)	12.5	2	6.0	6.5	2.0	1.0	2.0	0.0	0.0	11.5

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)
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Physician	4.7	0	1.4							
Registered Nurse	18.0	4	2.9							
Licensed Vocational Nurse	3.0	0	0.0							
Physician Assistant	1.0	1	1.4							
Occupational Therapist	2.9	0	1.4							
Other Therapist (e.g., physical, recreation, art, dance)	2.7	0	1.4							
Other Health Care Staff (direct service, to include traditional cultural healers)	13.4	0	1.4							
Sub-total, C (All Other)	45.6	5	10.0	20.8	9.8	4.3	7.9	0.3	0.0	43.0
Total, C (County & All Other)	58.1	7	16.0	27.3	11.8	5.3	9.9	0.3	0.0	54.5
D. Managerial and Supervisory:										
County (employees, independent contractors, volunteers)										
CEO or manager above direct supervisor	9.0	1	4.0							
Supervising psychiatrist (or other physician)	1.0	1	1.0							
Licensed supervising clinician	6.0	1	3.0							
Other managers and supervisors	4.0	0	1.0							
Sub-total, D (County)	20.0	3	9.0	12.5	2.5	1.0	0.5	0.0	0.0	16.5
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
CEO or manager above direct supervisor	14.0	4	0.0							
Supervising psychiatrist (or other physician)	3.0	1	1.4							
Licensed supervising clinician	8.8	1	5.7							
Other managers and supervisors	2.0	0	0.0							
Sub-total, D (All Other)	27.8	6	7.1	16.7	2.9	0.3	0.5	0.0	0.0	20.4
Total, D (County & All Other)	47.8	9	16.1	29.2	5.4	1.3	1.0	0.0	0.0	36.9
E. Support Staff:										
County (employees, independent contractors, volunteers)										
Analysts, tech support, quality assurance	5.0	1	2.0							
Education, training, research	3.0	1	1.5							
Clerical, secretary, administrative assistants	8.0	1	4.0							
Other support staff (non-direct services)	4.0	0	2.0							
Sub-total , E (County)	20.0	3	9.5	13.5	1.0	1.0	2.0	0.0	0.0	17.5
All Other (CBOs, CBO sub-contractors, network providers, and volunteers)										
Analysts, tech support, quality assurance	2.2	1	2.9							

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)
Education, training, research	0.6	1	1.4							
Clerical, secretary, administrative assistants	25.9	4	5.7							
Other support staff (non-direct services)	3.4	0	0.0							
Sub-total , E (All Other)	32.1	6	10.0	15.7	7.8	3.1	1.9	0.0	0.0	28.5
Total, E (County & All Other)	52.1	9	19.5	29.2	8.8	4.1	3.9	0.0	0.0	46.0
***County (employees, independent contractors, volunteers)* (A+B+C+D+E)**	139.1	20	71.5	76.0	23.0	10.5	12.5	0.0	0.0	122.0
***All Other (CBOs, CBO sub-contractors, network providers, and volunteers* (A+B+C+D+E)**	434.9	51	122.9	213.3	82.8	25.7	34.2	1.9	12.9	370.9
TOTAL COUNTY WORKFORCE (A+B+C+D+E)	574.0	71	194.4	289.3	105.8	36.2	46.7	1.9	12.9	492.9

Major Group and Positions				**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**			41.5%	18.0%	7.3%	11.3%	5.5%	16.5%	100.1%

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

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

II. Positions Specifically Designated . . .

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	59.4	4	29.9
Family Member Support Staff	20.7	5	6.9
Other *Unlicensed* MH Direct Service Staff	55.8	5	22.1
Sub-total, A:	135.9	14	58.9
B. *Licensed* Mental Health Staff (direct service)	1.0	1	2.5
C. Other Health Care Staff (direct service)	3.6	3	1.4
D. Managerial and Supervisory	3.9	4	2.4
E. Support Staff (non-direct services)	8.6	3	4.9
GRAND TOTAL (A+B+C+E+E)	153.0	24	70.1

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	128	52	180
	Others	20	8	28
2. Vietnamese	Direct Service Staff	21	6	27
	Others	3	2	4
3. Cantonese	Direct Service Staff	16	8	24
	Others	2	1	3
4. Hmong	Direct Service Staff	12	6	18
	Others	2	2	4
5. Farsi	Direct Service Staff	7	3	10
	Others	2	1	3
TOTAL, all languages other than English:	Direct Service Staff	183	75	258
	Others	29	13	42

Exhibit 3, IV. REMARKS – ***see next page.***

EXHIBIT 3: WORKFORCE NEEDS ASSESSMENT

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

A. Shortages by occupational category:

We struggle to recruit and retain adequate psychiatry, especially for children and adolescents. Having enough therapists (e.g., LCSWs, MFTs) with the ability to provide services in Spanish is a problem. With respect to some non-English languages, such as Farsi, we are able to accommodate the language by using our Provider Network.

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

We have a small Native American population, but they have been reluctant to seek services, for the most part.

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

Some contract agencies are far ahead of the County in having designated positions for consumers and family members. There are many county leaders (in HR and elsewhere) who wonder why anyone would employ a consumer or parents of severely emotionally disturbed children.

D. Language proficiency:

Nothing to report.

E. Other, miscellaneous:

Nothing to report.

Appendix C.

Conducting Surveys

Conducting Surveys

There are several methods of conducting surveys: (1) snail mail; (2) email; (3) in person (individual or group); (4) by telephone, and (5) over the Internet. If doing a full (or, complete) survey, we recommend email with telephone follow-up to prompt response (with assistance, as needed). If doing a partial survey, especially where questions focus on *qualitative* information, a telephone or in-person interview is likely to work best.

Complete Survey

Figure 1, on page 54, is a sample letter (or, email message) that can be adapted for use in conducting a complete survey.

Especially in small counties, one may want to get information through a face-to-face process. If so, Figure 2, on page 55, is a sample letter calling for an individual (or, group) meeting with some (or, all) providers. The Workforce Needs Assessment Survey itself is on pages 54 to 57. The Survey is also in EXCEL, as Spreadsheet #6 in the accompanying document **<WorkforceAssessment1.xls>**. If sending out the Survey, be sure to copy the *Directions* in Appendix A, and send these along as hard-copy or as a Microsoft WORD or PDF document, attached to your email message.

Partial Survey

In some instances, certain key workforce information is likely to be available in *administrative sources* (e.g., recently funded MHSA projects), but additional information can only be obtained by going to the contract agency or other provider. There are a couple of ways of handling this. One is to send out the Survey, indicating only those sections that need to be completed. Another is to structure a set of questions into a separate survey (or, Interview Schedule). For example, one might call on the telephone, and ask:

Q1. How many FTE do you have in the following major occupational categories (*Unlicensed* Mental Health Direct Service Staff; *Licensed* Mental Health Staff (direct service); Other Health Care Staff (direct service); Managerial and Supervisory; Support Staff)? How many are White/Caucasian? Hispanic/Latino? African-American/Black? Asian/Pacific Islander? Native American? Multi-Race or Other?

Q2. Which positions (occupations) are *hard to fill?*

Q3. Beyond positions budgeted, how many additional FTE do you need to meet existing service needs?

Q4. Do you have any jobs specifically designated for individuals with consumers or family experience? o **Yes;** o **No;** o **DK** If "Yes," how many FTE are *Unlicensed* Mental Health Direct Service Staff? Consumer Support Staff? Family Support Staff? Other *Unlicensed* Direct Service Staff? Do you have designated positions in any of the other major occupational categories listed in Q1? o **Yes;** o **No;** o **DK** If "Yes," how many FTE in the other major occupational categories?

Q5. Are any of these specifically designated positions *hard to fill*? o **Yes;** o **No;** o **DK** If "Yes," which positions?

Q6. How many more consumers or family members (FTE), if any, are needed to meet existing needs of the mental health clients you serve?

Q7. In what languages, other than English, do you have Direct Service and/or Other Staff who are proficient? How many in each group (Direct Service; Other Staff) are proficient in each language? How many additional individuals (Direct Service; Other Staff) need to be proficient in each language?

Q8. Are there any significant *shortfalls* (or, *disparities*) in any of the areas we have talked about, such as occupational shortages, racial/ethnic groups, special populations, unserved or underserved communities? o **Yes;** o **No;** o **DK** If "Yes," please describe.

Figure 1.
Sample *Cover Letter* (or, email message) Accompanying Survey
County Mental Health Letterhead Stationery

(date)

(addressee)
(street address)
(city, state, ZIP)

(salutation)

As part of our County's Three-Year Workforce Development, Education and Training Component, we have been asked to provide information about our County's publicly-funded mental health workforce, focusing on occupational composition, positions *hard to fill*, unmet staffing needs, race/ethnicity of the workforce, employment of clients and family members in specifically designated positions (e.g., Consumer or Family Support jobs, or other jobs with descriptions that contain qualification statements that consumer or family experience with Public Mental Health is *required* or *preferred*), and language proficiency.

Enclosed (or, attached in Microsoft EXCEL) is a *Survey* we would like you to complete, following Survey Directions, also enclosed (or, attached in Microsoft WORD or PDF). Please gather the information requested of your organization's mental health services being provided our county's clients, and return the completed survey to us by _____.

Information from your organization and other community agencies will be totaled up and reported to Department of Mental Health in Sacramento. No community organization or individual provider will be separately identified.

If you have any questions, or need assistance, please contact (name), my liaison for the survey, who can be reached at (phone#) or (email address). Thank you for taking the time to complete the survey and returning it to us via email or the Post Office. We have enclosed a self-addressed, postage-paid envelope for your convenience. As a token of our appreciation for completing the Survey, we will (have a drawing for _____) (send you a summary of what we learn from the survey).

Cordially,

(CMHD's name)
Community Mental Health Director

Enclosures: Survey;
Directions for completing the survey;
Self-addressed, postage-paid return envelope

Figure 2.
Come-to-a-meeting letter (or, email message)
County Mental Health Letterhead Stationery

(date)

(addressee)
(street address)
(city, state, ZIP)

(salutation)

As part of our County's Three-Year Workforce Development, Education and Training Component, we must submit to DMH Headquarters in Sacramento a *Workforce Needs Assessment* for our county. Besides county personnel, the *Needs Assessment* must include contract agencies and other providers. I'm enclosing (or, attaching) a copy of Exhibit 3 (in WORD or EXCEL), along with Survey Directions (in Microsoft WORD or PDF).

Would you kindly come to a group meeting, to be held (place, date, time). Please bring the following for your agency or group:

- Roster of staff, sub-contractors, and volunteers doing work that is publicly-funded under contract or agreement with our county, and FTE involved;
- Information about race/ethnicity of this workforce;
- List of positions not filled (but budgeted);
- List of positions *hard to fill;*
- Your considered judgment as to how many additional FTE are needed to meet existing public mental health needs in our county;
- Information about specifically designated positions for individuals with consumer and/or family member experience; and
- Information about proficiencies of staff in languages other than English.

We will spend some time talking about priority education and training needs. If you would prefer to provide your workforce information privately, please call (or, email) _____, ph: _____; email: _____, my liaison for this work.

Information from your organization and other community agencies will be totaled up and reported to Department of Mental Health in Sacramento. No community organization or individual provider will be separately identified. Thank you for taking the time to meet with us. As a token of our appreciation, we will (have a drawing for _____) (send you a summary of what we learn from the survey).

Cordially,

(CMHD's name)
Community Mental Health Director

Workforce Needs Assessment Survey

Explanation: Using the accompanying *directions*, please fill in the tables below. Include employees, independent contractors, sub-contractors, and volunteers (e.g., interns, others) with your agency.

I. By Occupational Category Name of contract agency:_____

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 authoirzed	**Race/ethnicity** of FTE 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:										
Mental Health Rehabilitation Specialist										
Case Manager/Service Coordinators										
Employment Services Staff										
Housing Services Staff										
Consumer Support Staff										
Family Member Support Staff										
Benefits/Eligibility Specialist										
Other *Unlicensed* MH Direct Service Staff										
Sub-total, A										
B. *Licensed* Mental Health Staff (direct service):										
Psychiatrist, general										
Psychiatrist, child/adolescent										
Psychiatrist, geriatric										
Psychiatric or Family Nurse Practitioner										
Clinical Nurse Specialist										
Licensed Psychiatric Technician										
Licensed Clinical Psychologist										
Psychologist, registered intern (or wiavered)										
Licensed Clinical Social Worker (LCSW)										
MSW, registered intern (or waivered)										
Marriage and Family Therapist (MFT)										
MFT registered intern (or wiavered)										
Other *Licensed* MH Staff (direct service)										
Sub-total, B										

I. By Occupational Category -- *continued*											
				Race/ethnicity of FTE currently in the workforce -- Col. (11)						
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 authoirzed	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):										
Physician										
Registered Nurse										
Licensed Vocational Nurse										
Physician Assistant										
Occupational Therapist										
Other Therapist (e.g., physical, recreation, art, dance)										
Other Health Care Staff (direct service, to include traditional cultural healers)										
Sub-total, C										
D. Managerial and Supervisory:										
CEO or manager above direct supervisor										
Supervising psychiatrist (or other physician)										
Licensed supervising clinician										
Other managers and supervisors										
Sub-total, D										
E. Support Staff:										
Analysts, tech support, quality assurance										
Education, training, research										
Clerical, secretary, administrative assistants										
Other support staff (non-direct services)										
Sub-total, E										
TOTAL COUNTY WORKFORCE (A+B+C+D+E)										

Remarks (if any):

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

Remarks (if any):

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.	Direct Service Staff			
	Others			
2.	Direct Service Staff			
	Others			
3.	Direct Service Staff			
	Others			
4.	Direct Service Staff			
	Others			
5.	Direct Service Staff			
	Others			
TOTAL, all languages other than English:	Direct Service Staff			
	Others			

Remarks (if any):

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

A. Shortages by occupational category:

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

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

D. Language proficiency:

E. Other, miscellaneous:

Survey completed by (name, title):_____ Date:_____
Phone #, including area code:_____
Email address:_____ Best time to call:_____

Please email as an attachment or otherwise return completed survey to: (name, title, street address or PO number; city, state, ZIP code).