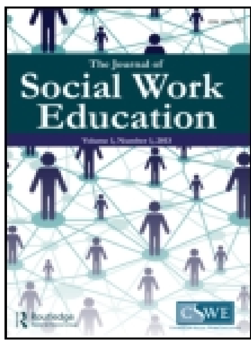

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Mental Health Workforce Change Through Social Work Education: A California Case Study

Gwen Foster, Meghan Brenna Morris, and Sirojudin Sirojudin

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The 2004 California Mental Health Services Act requires large-scale system change in the public mental health system through a shift to recovery-oriented services for diverse populations. This article describes an innovative strategy for workforce recruitment and retention to create and sustain these systemic changes. The California Social Work Education Center Mental Health Program provides stipends to master's of social work students at 17 California universities. In return, students must work for 1 year postgraduation in community mental health practice. Results of a 5-year study show that stipend recipients closely mirror the diverse demographics of the state, and 94% have remained in community mental health practice. The article also discusses lessons learned and implications for social work education in California and other states.

California, like many other states throughout the nation, has mental health workforce needs that have largely gone unmet: a shortage of mental health professionals exists across disciplines, and the diversity of the workforce is an ongoing concern. Retention of professionals in public and contract mental health agencies throughout their careers is a factor in meeting quantitative and qualitative workforce needs. The Mental Health Services Act (MHSA), a 2004 California ballot initiative (referred to in other states as a referendum), includes dedicated funding for workforce development that supports systemic shifts to recovery-oriented services. Workforce education and training dollars have been made available to create career pathways for consumers and their family members, staff development for existing staff in county mental health systems, and stipend programs for selected mental health disciplines, including social work. Since 2005 the California Social Work Education Center (CalSWEC) Mental Health Program (MHP) has coordinated a stipend program through 17 schools of social work for almost 200 full-time 2nd-year MSW students. In return for their $18,500 stipend, students work for 1 year postgraduation in a county mental health agency or contract community-based organization (CBO). The stipend

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program, along with a set of core competencies taught at each school of social work, attempts to specifically address social work workforce shortages, diversity needs, and preparation for careers in recovery-centered systems of care.

CalSWEC has gathered data on the stipend recipients pre- and postgraduation and postpayback. The study examines the demographic characteristics of the stipend recipients in the first 5 years of the program, their bilingual and multilingual abilities, their payback employment locations, and their postpayback employment. The study is longitudinal, following the same group of students throughout time (although they are graduates, during their payback and postpayback periods), as well as a cohort analysis, assessing students from different graduation years. This article presents those findings as a case study for workforce development that may have implications for other interested jurisdictions.

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THE NEED FOR MORE DIVERSITY AND INCREASED RETENTION AMONG MSWs IN COMMUNITY MENTAL HEALTH

California represents one of the most ethnically, racially, and linguistically diverse states in the country. Using 2009 data, the U.S. Census Bureau (2010) estimates that California has a population of nearly 40 million people with 41.7% non-Hispanic Whites, compared to 65.1% nationally, and 58.3% minorities, compared to 41.8% nationally.

Many studies have pointed out the critical role of diversity in the mental health workforce in improving access to services for mental health consumers and their families. *Mental Health: Culture, Race, and Ethnicity. A Supplement to Mental Health: A Report of the Surgeon General* (U.S. Department of Health and Human Services, 2001) highlights the importance of understanding the effects of culture and society on mental health, mental illness, and mental health services.

> With a seemingly endless range of subgroups and individual variations, culture is important because it bears upon what *all* people bring to the clinical setting. . . . the cultures of the clinician and the service system also factor into the clinical equation. These cultures most visibly shape the interaction with the mental health consumer through diagnosis, treatment, and organization and financing of services. (p. 25)

In his seminal text, *Social Work Practice and People of Color*, Lum (1996) lists employment of bilingual/bicultural social workers as crucial for multicultural service delivery.

Mental health disparities of need and access to treatment are significant issues for California's highly diverse population. The California Health Interview Survey (CHIS) is a telephone survey that is conducted for the purposes of measuring health and mental health needs and disparities and informing public policy. In the 2007 survey, approximately 2.2 million Californians reported having mental health needs for serious mental distress. Native Hawaiian/Pacific Islander and multiracial groups comprised the largest group (15%) of those with mental health needs; next were American Indians (12%), followed by White (11%), African American (9%), Latino (8%), and Asian (7%). Overall, 50% of the respondents received no mental health treatment, but the disparities are striking: 63% of Asians reported receiving no treatment; 60% of African Americans; 55% of Latinos; 52% of American Indians; 47% of Native Hawaiian/Pacific Islander and multiracial respondents; and 43% of Whites. Unmet treatment needs were also associated with English proficiency; those who did not speak English well reported higher rates of need (Grant et al., 2011).

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Clinical social workers constitute about 22% of the mental and behavioral health workforce in California (McRee et al., 2003). In their report, McRee and colleagues forecasted that the first decade of 2000 would initiate a demand for mental and behavioral health workers, with an expected growth from 63,000 workers to perhaps 80,000 workers in the state by 2010. They identified factors affecting this rate of growth, such as coverage of more mental health costs by insurance companies, practice model changes, changes to primary medical care practice models, and increased and improved integration of mental and behavioral health services (McRee et al., 2003, pp. ii–iii).

According to national statistics, the majority of all psychologists and social workers in community mental health are non-Hispanic Whites, and are women (McRee et al., 2003). In 2006, 43.1% of MSW graduates in the state of California were White, a decline from 51.9% in 2000. Hispanic and Latino MSW graduates were the second-largest group in 2006 with just over 30%. African Americans hovered at slightly more than 10% of MSW graduates, and Asian/Pacific Islanders at around 12% (Integrated Post-Secondary Education Data System, 2006). The Council on Social Work Education reported that in 2006, there were 17,209 MSW graduates from social work programs in the United States. Of these, 62% were White, 31% were from minority groups, and 7% were foreign, multicultural, or of unknown race/ethnicity. Eighty-six percent of MSW graduates were women in 2006. To meet the increasing diversity of service consumers, schools of social work need to recruit and graduate MSWs who reflect the diversity of the population and who are skilled in culturally competent practice (Johnson, 2002; Lok & Chapman, 2009).

National studies (e.g., Cheng & Snowden, 1990; Chow, Jaffe, & Snowden, 2003) have shown lower usage of mental health care services by limited-English-proficient speakers and minorities In California and elsewhere, language barriers particularly affect usage of mental health services by Latinos and Asians; the need to increase access to bilingual/bicultural health and mental health professionals is well documented (Bloom, Masland, Wallace, & Snowden, 2005; Fiscella et al., 2002; Kaiser, Barry, & Kaiser, 2002; Li & Browne, 2000; Sue, Fujino, Hu, Takeuihi, & Zane, 1991; Vidal de Haymes & Kilty, 2007). Other studies suggest that ethnic matching of clients and providers increases return rates and leads to the greater likelihood that clients will stay in and adhere to treatment (Takeuchi, Sue, & Yeh, 1995).

The surgeon general's report (U.S. Department of Health and Human Services, 2001) defines culturally competent services as "the delivery of services that are responsive to the cultural concerns of racial and ethnic minority groups, including their language, histories, traditions, beliefs, and values" (p. 36). The President's New Freedom Commission on Mental Health called for a transformation of mental health care in the United States in 2003 and identified equally critical needs for (a) diversifying the mental health workforce and (b) ensuring that the workforce can provide culturally competent services. The commission's recommendations to address the workforce crisis in mental health services for racial and ethnic minority populations include recruiting and retaining racial and ethnic minority and bilingual professionals and developing curricula that "address the impact of culture, race, and ethnicity on mental health and mental illness, help-seeking behaviors, and on service use" (p. 52).

The California Board of Behavioral Sciences (2007) acknowledges that many of California's diverse residents face barriers to effective care such as racism, poverty, lack of access to services in languages other than English, and clinician bias. Therefore, the members of the board state that taking "steps to address the demographic differences between California's mental health consumers and its providers will improve future and current licensees' ability to treat diverse

consumers and attract more diverse people into the professions" (p. 18), and they specifically cite the MHSA as crucial to that process.

In California, the majority of social work positions in community mental health agencies and private practice require licensure, which social work graduates are eligible for after completing 3,200 hours of supervised practice and passing a state-administered examination (Board of Behavioral Sciences, 2009). A trend over the past few decades affecting workforce availability for the public mental health system has been an increasing number of licensed clinical social workers choosing to establish private practices along with or instead of working in public mental health agencies (Specht & Courtney, 1994).

Although social workers have been practicing psychotherapy since the 1920s, private practice did not become as prevalent until the decade of 1975 to 1985. By 1985 the number of social workers engaged in full-time private practice was five times what it was in 1975 (Jayaratne, Siefert, & Chess, 1988). By 1990 more than one third of National Association of Social Workers (NASW) members were engaged in private practice of some kind (Brown, 1990). The latest national survey of 2,000 NASW members, conducted in 2000, revealed that 39% worked in mental health agencies (NASW, 2000). A similar survey of 1,560 NASW members revealed that about 38% of them were in private practice (NASW, 2003). Thus, it seems that over a third of NASW members are in private practice, and virtually the same number work in agency-based mental health and in private practice.

Another national survey of community mental health workers (848 participants) specifically engaged in psychosocial rehabilitation found a significant relationship between age and intent to leave the field: younger workers were less likely to stay in public mental health. Additionally, a statistically significant relationship existed between the numbers of years of work at an agency and intent to leave: more recent hires were more likely to express their intent to leave in the following 2 years (Blankertz & Robinson, 1997). Because of their concern over losing these social workers early in their careers to other fields, particularly private practice, state agencies and some scholars have focused significant attention on the importance of retention, and even on social work students' intentions to enter private practice (Green, Baskind, Mustian, Reed, & Taylor, 2007; Specht & Courtney, 1994). However, very little data currently exists that examines retention factors specifically for social workers in community mental health. Because retention of social workers in community mental health throughout their careers is a critical aspect of workforce development and remains an ongoing concern, CalSWEC has made analyses of longitudinal data on retention of the MHP's graduates a critical part of its study.

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MHSA AND CALSWEC

In 2004 the voters of California approved a ballot initiative mandating that a new 1% tax on income over $1 million be dedicated to enhancing the state's community mental health services. Nearly $1 billion has been raised to date; the funding is being used to expand and transform California's public mental health system. The MHSA (2004) calls for the development of a comprehensive system of care that includes prevention, early intervention, and recovery-oriented, client-centered treatment services across the lifespan. Large-scale change in 60 county mental

health systems and jurisdictions requires extensive retooling of skills among existing staff and preparation of incoming professionals to sustain new ways of serving highly diverse populations with a wide range of mental health needs. A portion of this significant public revenue source has been allocated to workforce development for mental health professionals, including psychiatrists, psychologists, clinical social workers, marriage and family therapists, nurse practitioners, and physician assistants.

Created in 1990 at the School of Social Welfare at a prestigious California University, CalSWEC is a consortium of the state's accredited schools of social work, the county departments of social service and mental health, the California Department of Social Services (CDSS), the California Department of Mental Health, and the California Chapter of the NASW. It is the nation's largest coalition of social work educators and practitioners.

This consortium has a long history of effective collaboration in preparing graduate social workers for practice in the public child welfare system. The cornerstones of the child welfare program are funding for stipends and operating costs through Title IV-E of the Social Security Act, a set of core competencies that are taught at each participating school, partnerships with child welfare agencies as placement providers and employers, and program evaluation. In 2003 the CalSWEC Board of Directors decided to develop additional programs that were modeled after the CalSWEC child welfare program that would train social workers for the mental health and aging systems. A task force comprising faculty, field instructors, county mental health directors, and CalSWEC staff developed a set of core competencies that students planning careers in public mental health services would be expected to demonstrate by the time they graduated. The competencies were approved by the CalSWEC board in 2005.

When the MHSA (2004) became law, CalSWEC offered a well-organized infrastructure for new workforce development, and in fall 2005 an interagency agreement was signed between the California Department of Mental Health and the Regents of the University of California, Berkeley to provide funding for stipends and basic operating costs incurred by CalSWEC and participating schools. The CalSWEC MHP provides stipends (five to 20 stipends of $18,500 each per school) and operational support, determined by the number of stipends, to each school of social work to prepare culturally and linguistically competent graduate social workers for professional practice in California's community mental health system.

Stipends are awarded to students who are in their final year and are expected to graduate within one academic year of enrolling in the program. The program then requires that graduates work in the community mental health system for 1 year in return for the stipends they received, although they may appeal for an extension of time if they are unable to meet the graduation or employment requirements. If graduates do not meet their employment obligation, they must pay back the stipend in cash.

Each school implements curricula to teach the core competencies in the classroom and in field placements in county mental health or contract nonprofit agencies during the foundational and advanced years. The competencies are designed to be integrated into existing social work classes or addressed in specialized course work or field placement experiences. In the foundational year, these competency clusters include Culturally and Linguistically Competent Generalist Practice, Foundations of Social Work Practice, Human Behavior and the Social Environment, and Workplace Management. In the advanced/final year, competencies are clustered into Culturally and Linguistically Competent Mental Health Practice, Advanced Mental

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Health Practice, Human Behavior and the Mental Health Environment, and Mental Health Policy, Planning, and Administration.

A series of studies led by Loma Linda University assesses how the core competencies are being implemented in the schools and whether they transfer satisfactorily to the field after graduates are employed in community mental health settings. The final results of the studies were not yet public when this article was submitted. However, innovative examples of implementation strategies have been described in other reports to the MHP. One school addresses one of the MHP cultural and linguistic competency practice indicators—"student demonstrates understanding of the importance and necessity of using the consumer's and community's native language on all forms of communication . . . and its importance in health treatment" (Herrera, 2011)—by offering an elective course, Spanish Language Development for Social Workers. The goal of the course, taught in Spanish, is to strengthen students' ability to interact with monolingual and limited-English-speaking Latino clients and families by using culturally grounded practice modalities (Herrera, 2011). Another school has developed a hybrid (online and in person) course that covers topics such as recovery and wellness, consumer movements in mental health, working as part of a recovery team, involving families in recovery, and stigma and discrimination as barriers to recovery. One assignment in this course requires each student to visit two mental health clinics, sit in the waiting rooms, observe whether and how each experience is welcoming and culturally sensitive, and write a short paper comparing and contrasting settings (Jensen, 2010).

The implementation of the MHP relies upon ongoing collaboration among CalSWEC, the schools, community mental health providers, and project coordinators (PCs) in the participating schools. The PC, usually a faculty member, leads recruitment, selection, and stipend award activities. The PC also functions as a liaison within the school and with others outside the school, maintaining contact with other faculty, field instructors, potential employers, and other community stakeholders. PCs are also a valued resource for students and graduates who need assistance with problems they may encounter throughout the academic program or in seeking payback employment. Administrative staff helps with financial aid processes and maintains budgetary and demographic records.

Between 2005 and 2009, the MHP enrolled a total of 911 students as stipend recipients. The vast majority of the students in these first five cohorts completed the program requirements, graduated, and secured employment in California's community mental health system within the required time frame. Most have also completed their 1-year employment obligation. This article presents data collected through a 5-year study of the outcomes of this unique mental health workforce development program. Results indicate the program has been effective in increasing the numbers of multicultural and multilingual social workers at the MSW level to enter the mental health field. They also demonstrate that the majority of these social workers have stayed in county- or community-based mental health agencies after completing their payback obligations.

California often is the locus of policy and practice innovation. This case study is presented for consideration by other states and counties as a potential model for similar programs. The following sections address two main questions: Has the MHP contributed to the development of diverse and culturally competent community mental health workforce in California? What proportion of former stipend recipients has been retained in California's mental health system?

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METHODOLOGY

To address these questions, this study uses two main sources of data. First, administrative data was collected on a quarterly basis from the participating schools. CalSWEC regularly collects this data from PCs directly responsible for program implementation at each participating school. The data include demographic characteristics of MHP recipients; changes in enrollment, graduation rates, progress toward the required year of employment in a county or contracted CBO; and the completion of payback employment. This regular collection of data allows each school to monitor the progress of its MHP stipend recipients toward graduation and employment. CalSWEC is able to track progress toward contractual goals of producing a larger and more diverse social work workforce that is prepared to serve individuals and families in California's public mental health system.

Information regarding ethnic and language diversity is gathered from the administrative data. The total number of stipend recipients from the first 5 years of the MHP is 911. All these students self-reported their ethnic backgrounds. However, language diversity information is not available for the first cohort (2005–2006), so the total for the language diversity portion of the study comes from all the stipend recipients from 2006 to 2009. The total number is also affected by multilingual students for the language section; some students reported speaking two or more languages besides English, which resulted in slightly higher totals for languages being spoken than for the number of students in the four cohorts.

The second source of data is based on an outcome study, which is specifically designed to explore participants' employment status after completing their payback employment upon graduation. The data address several questions: (a) Are the MHP stipend recipients still employed in the California mental health system? (b) In what types of agencies are they currently employed? (c) Are they employed by the same agencies where they worked during their 1-year required payback? The study began in 2008 by tracking employment status of MHP stipend recipients in the first cohort of 2005–2006; subsequently, the same procedures were used in 2009 for the 2006–2007 cohort and in 2010 for the 2007–2008 cohort.

Data collection was conducted through collaboration with PCs, who have prolonged contact with stipend recipients, beginning with recipients' recruitment into the program until they complete their 1-year payback requirement. Through informally maintained systems, PCs provided contacts and alumni information, including current employment information, for graduates beyond the payback period.

An interview protocol was developed to record information from the PCs about the graduates. Telephone interviews were conducted during 2008, 2009, and 2010 with each PC. PCs were asked, to the best of their knowledge, whether 2005–2006, 2006–2007, and 2007–2008 cohort graduates at their school were still employed in California and working in a community mental health agency, or whether they had moved into another field of practice. Data from these three cohorts were collected in three batches: August–December 2008 for the 2005–2006 cohort, August–December 2009 for the 2006–2007 cohort, and January–May 2010 for the 2007–2008 cohort. Former students from these three cohorts who completed their 1-year required payback employment and found subsequent employment after May 2010 were not included in this report.

At least one interview was conducted with each PC, and often several follow-up contacts via phone calls or e-mails were necessary for the PC to gather additional information to respond to the protocol questions. Through this data collection method, PCs reported that a total of 543 stipend recipients from the first three cohorts graduated with an MSW; of these, only 502 completed the required payback employment. Additionally, PCs were able to collect information about postpayback employment from 85% of those 502.

Although the information collected was routinely administrative in nature, the data were aggregated. Information about particular graduates has remained confidential. A descriptive analytical procedure was conducted to analyze graduation rates, ethnic and language diversity, payback completion, and employment retention in public mental health.

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LIMITATIONS TO RESEARCH METHODS

The MHP evolved in its first 5 years without a specific theoretical framework that explicitly guided its development. A theory of change or a logic model would assist in determining research questions in the future.

The data were collected from administrative sources, that is, reports completed by staff at each school and interviews of PCs. As such, these provide a general picture about the progress of the MHP implementation. Therefore, although these data are reliable in obtaining a general descriptive understanding, the current data do not allow for inferences about the relationships of the variables. It is important to note that because the interviews were conducted with the same PCs who supplied the administrative data, the sources were, in effect, the same. There may have been some social desirability bias on the part of the PCs, but because the data discussed were well documented, the researchers believe the possibility for bias was minimized.

At this point, the researchers draw only descriptive conclusions about program outcomes and note that a study with a more rigorous statistical analysis is necessary to better understand the relationships between variables. Finally, it is important to recognize that neither the data collection method nor the analytical procedure provide a detailed picture about factors that affect graduation, selection of certain payback methods, and retention in the community mental health field. Further research is needed to explore those areas.

RESULTS

Results of this study are summarized in two parts: (a) ethnic and language diversity and (b) payback completion and postpayback employment (retention). Tables are provided to illustrate the data and analysis.

Ethnic and Language Diversity

In addition to addressing the shortage of professionally qualified social workers able to practice effectively in California's community mental health system, as previously noted, the MHP also seeks to increase the number of ethnically and linguistically diverse social workers. This

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shortage in the state's community mental health system has been viewed with concern for many years, since a strongly held value in community mental health settings is that an ethnically and linguistically diverse workforce is fundamental to quality care for consumers and their families. Accordingly, the MHP schools have made a determined effort to ensure that each student stipend cohort is diverse; an important achievement of the program is the graduation of significant numbers of students from underrepresented ethnic minorities.

From 2005 to 2010, over half the students receiving stipends have been from minority groups. Whereas about 43% of students have been White/Caucasian, a quarter of the recipients have been Hispanic/Latino/Chicano; 14% Asian or Pacific Islanders; 10% African American; and 1% American Indian. Two students (0.2%) have declined to state their ethnicity in the first 5 years of the program, and 6% have self-identified as "other," which includes various religious, linguistic, or multiethnic backgrounds (see Table 1). These percentages roughly mirror California's diverse population. If MHP continues to diversify the clinical social work workforce, it will help to improve the penetration rates described earlier in which all ethnic groups except African Americans are underserved in the public mental health system.

The MHP has also sought to address the linguistic workforce needs of California. The majority of students enrolled in the MPH are bilingual or multilingual, speaking English as well as at least one other language. Because no information about language competency was obtained in the 1st year of the program, only data for the cohorts from 2006 to 2007 to 2009 to 2010 are provided in Table 2.

Tables 2 and 3 document the languages spoken by the four latest MHP cohorts in six categories, including American Sign Language. Table 2 illustrates that a majority of the stipend recipients were bilingual (57%), and 43% spoke English only. As shown in Table 3, the most commonly spoken language besides English across all four cohorts was Spanish (265 students, 34%). The next category of languages most commonly spoken (103 students, 13%) were the Asian/Pacific languages, including Tagalog, Chinese, Vietnamese, Korean, and Hindi. European languages were spoken by 56 students (7%), followed by African languages, including Amharic,

TABLE 1
Ethnic Background of Students

	2005–06		*2006–07*		*2007–08*		*2008–09*		*2009–10*		*Subtotal*	
Ethnic Groups	N	%	N	%	N	%	N	%	N	%	N	%
Minority students												
American Indian	2	1	0	0	2	1	3	2	1	1	8	1
Asian/Pacific Islander	24	14	35	19	23	13	20	11	24	13	126	14
African American	17	10	19	10	18	10	21	11	19	10	94	10
Hispanic/Latino/Chicano	40	23	47	25	45	24	49	27	50	27	230	25
Other	9	5	8	5	16	9	12	7	12	6	57	6
Declined to state						0	0	1	1	2	0.2	
Total minority students	92	53	109	59	104	57	105	57	107	58	517	57
White/Caucasian	82	47	78	41	80	43	78	43	76	42	394	43
Total	174	100	187	100	184	100	183	100	183	100	911	100

Zulu, and Swahili (1%). The wide range of languages spoken by the students enrolled in the MHP is indicative of the program's success in recruiting students from diverse ethnic and linguistic groups who are able to serve California's multicultural population. It also demonstrates the program's efficacy in meeting counties' needs for MSWs who speak very specific languages that are historically underrepresented.

Payback Completion

As mentioned in the previous section, participation in the MHP is conditional. Upon graduation from their MSW programs, recipients are required to work for 1 year at a county or contracting mental health agency in California. Tables 4 and 5 track the first three cohorts and document their postpayback employment.

The study found that the vast majority of MHP students (543) successfully graduated with their MSW degrees, and 502 (92.4%) of the graduates completed the required 1 year of payback employment (see Table 4). Only 41 (7.6%) of the recipients did not meet the terms of their agreement because they did not demonstrate a good faith effort to find employment at mental health agencies, or they chose to work in a non-mental health agency or to pay back the stipend in cash. It should also be noted that 51% of MHP recipients completed the payback at county agencies, whereas 41% completed their payback at contracting CBOs.

Postpayback Employment (Retention)

Table 5 documents the results of efforts to track the stipend recipients after they completed their payback employment. It was possible to track only 427 of the 502 students who completed the payback employment. PCs were not able to locate the remaining students; thus, information on their employment is not available. Of those tracked, the vast majority, 295 (69.1%), of the stipend recipients remained in the same agency where they completed their payback employment, whereas 132 (30.9%) moved to different agencies. About 93.7% (400) remain employed in the mental health field in California. County agencies continue to employ more MHP graduates (53.2%) than CBOs (46.8%).

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TABLE 2
Comparison of English and Bilingual Students

	2006–07		*2007–08*		*2008–09*		*2009–10*		*Total*	
Language	N	%	N	%	N	%	N	%	N	%
English only	77	38	91	47.9	83	44.1	77	41.2	328	43
Bilingual	125	62	99	52.1	105	55.9	110	58.8	439	57
Total	202	100	190	100	188	100	187	100	767	100

TABLE 3
Languages Spoken by Students

Language Groups	2006–07 N	2006–07 %	2007–08 N	2007–08 %	2008–09 N	2008–09 %	2009–10 N	2009–10 %	Total N	Total %
English only	77	38.0	91	48	83	44	77	41	328	43
Asian or Asian Pacific (Tagalog, Chinese, Vietnamese, Korean, Hindi)	37	18.3	23	12	21	11	22	12	103	13.4
Native North American	0	0.0	0	0	0	0	0	0.0	0	0
Spanish	65	32.2	56	29	69	37	75	40	265	34.4
European (Russian, Italian, Portuguese)	17	8.5	15	8	12	6	12	6	56	7.2
African (Amharic, Zulu, Swahili)	2	1.0	3	2	3	2	1	1	9	1.2
American Sign Language	4	2.0	2	1	0	0	0	0	6	0.8
Total	202	100	190	100	188	100	187	100	767	100

Note. The total number of languages spoken by the students from the four cohorts is different from the total cohort numbers because some of the students speak more than one language (English and their native language).

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TABLE 4
Employment (Payback) Record

	Cohorts						Total	
	2005–06		2006–07		2007–08		2005–08	
Employment Record	N	%	N	%	N	%	N	%
A. Number of graduating students	174	100	187	100	182	100	543	100.0
B. Entered employment payback								
1. Payback requirement								
a. Met payback requirement	154	88.5	177	95	171	94	502	92.4
b. Dropped out and paid back stipend	20	11.5	10	5	11	6	41	7.6
2. Field of services (completed)								
a. Mental health	154	100	175	99	171	100	500	92.1
b. Non-mental health	0	0	2	1	0	0	2	0.4
3. Type of agency								
a. Public	98	63.6	90	51	89	52	277	51.0
b. Contracting community-based organization	56	36.4	87	49	82	48	225	41.4

DISCUSSION

The aggregated demographic totals for the students closely mirror the ethnic and racial demographics of the state of California. In fact, with close to 10% African American MHP students, the program surpasses the demographic diversity of the state (6.6%). Since it began, the MHP

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TABLE 5
Postemployment Retention 2005–2006, 2006–2007, and 2007–2008 Cohorts (as of May 2010)

	Cohorts						*Total*	
	2005–06		*2006–07*		*2007–08*		*2005–08*	
Employment Progress	N	%	N	%	N	%	N	%
Total traced	139	100	145	100	143	100	427	100.0
Current employment								
Employer (agency)								
a. The same agency where initially employed	103	74	109	75	83	58	295	69.1
b. Different agency	36	26	36	25	60	42	132	30.9
Field of services								
a. Mental health	128	92	133	92	139	97	400	93.7
b. Non-mental health	11	8	12	8	4	3	27	6.3
Type of agency								
a. Public	82	60	78	54	67	47	227	53.2
b. Contracting community-based organization	57	40	67	46	76	53	200	46.8
Place of employment								
a. California	136	98	145	100	143	100	424	99.3
b. Out of state	3	2	0	0	0	0	3	0.7

has provided over 900 new social workers to help address California's mental health workforce shortage, with a majority of students continuing their employment in county agencies and contracting CBOs. The majority of graduates are members of ethnic minority groups, strengthening workforce diversity. Moreover, with social workers graduating from schools throughout the state, the program is also addressing urban-rural workforce disparities.

The social work profession has long placed a high value on the diversity and cultural and linguistic competence of the workforce. Although diversity refers to individual attributes (e.g., race, ethnicity, native language, gender, sexual orientation), cultural competence is a set of skills that can be learned and used consciously by individual providers or service programs. Efforts to address diversity alone may be based on the assumption that providers of the same racial or ethnic background as their clients are also culturally competent to serve them. They may or may not be prepared to deliver culturally competent services that are responsive to clients' particular experiences (e.g., urban/rural, subculture, socioeconomic status, linguistic nuances, immigration history, and status).

The MHP addresses diversity and cultural competence through the recruitment of underrepresented minorities to the stipend program and the inclusion of core competencies to ensure that students, regardless of their ethnic backgrounds, gain knowledge and skills for culturally and linguistically competent service delivery. Although the MHP is tracking diversity and cultural competence alike, this study focuses on describing the racial and linguistic diversity of the workforce.

Mental health staff's linguistic capability is one of the most frequently mentioned skills identified by counties in an assessment they conducted for MHSA Workforce, Education, and Training

funding (CalSWEC, 2010). Among MHP graduates, 34% speak Spanish, which the counties identified as the language besides English that staff needs most to serve clients (CalSWEC, 2010). Another 13% speak Asian languages like Tagalog, Chinese, and Vietnamese, which counties also commonly mentioned as needed for their mental health staff.

When these outcomes are directly compared to counties' stated workforce needs, a strong case can be made for the efficacy of the MHP, which meets workforce needs through the provision of stipends, selection of diverse cohorts, academic preparation, and requirements to find employment in a public mental health system at the start of one's professional career. Furthermore, early indications are that the MHP may contribute to workforce retention of social workers. At the time of the study, the older cohorts (2005–2008) had been out of school for 2–4 years, during which time they have completed the payback obligation and many, if not all, of the requirements for clinical licensure in California. Registering as an associate social worker preparing for licensure and obtaining a clinical social worker license are job requirements in most county and contract mental health agencies in California. Although the license also qualifies a social worker to work outside the community mental health system (e.g., employee assistance programs, solo or group private practice, noncontracting mental health agencies), 94% of the graduates contacted have continued to work in the mental health field, and all are working in public or contract agencies.

It is important to note that the 2008 and 2009 cohorts entered the employment sector during a major global recession. Uncertainty about job retention (e.g., potential layoffs) and job availability may be factors influencing decisions among these and subsequent graduates to stay or leave positions in public mental health agencies. What appears to be a baseline retention level now may prove not to be completely accurate when comparing retention patterns among cohorts that graduate after the recession runs its course. Thus, actual long-term retention rates may become apparent with continued research after the recession has ended.

IMPLICATIONS FOR SOCIAL WORK EDUCATION

CalSWEC is a consortium of workforce development stakeholders: universities, state agencies, county employers, and in-service training providers. Leaders of schools of social work and mental health agencies are collaborative partners in the development of competency-based curricula for graduate education, as well as in the active advocacy for the establishment and maintenance of the stipend program under the auspices of a university.

Schools of social work already play critical leadership roles in preparing new social workers to deliver services that match the rapidly changing demands of client populations. CalSWEC's structure of a board of directors made up of social work deans/directors and local and state-level agency leaders, and its record of developing a successful Title IV-E stipend program for training MSWs for child welfare positioned it well to jump-start a new program for the mental health field when the opportunity was presented through the MHSA (2004). However, this apparent success begs the question: Can CalSWEC's mental health stipend program be replicated?

Lack of funding and supportive public policy might be seen as obvious barriers to replication. However, in this California case study, the passage of the MHSA (2004)—which includes funding for workforce development as a component of systems change and expansion—happened after the CalSWEC collaborative developed the core competencies for public mental health. Curriculum development is not as costly as financial aid and may be a starting point for school

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administrators interested in developing a program. The passage of the Patient Protection and Affordable Care Act of 2010 presents some significant potential national funding opportunities for stipends and loan forgiveness that will produce behavioral health providers capable of meeting the health care needs of a growing patient population. Some federal programs, such as the National Health Services Corps and the State Loan Repayment Program, already exist and will be expanded; others, such as the Mental Health and Behavioral Health Education and Training grant program, are authorized but without financial allocation at the present time.

Social work education and advocacy organizations such as the Council on Social Work Education and the NASW are working to ensure passage of the Social Work Reinvestment Act, introduced in Congress in 2008. The act would provide long-term funding for social work workforce development across many fields, including mental health. The formation of the Congressional Social Work Caucus in 2011 provides additional opportunities for improved workforce development funding and supportive public policies.

The key components of the CalSWEC MHP are collaboration among universities, public mental health agencies, and other key stakeholders; core competency development as a framework for curriculum development and implementation; financial aid in the form of stipends; a payback requirement that exposes new MSWs to careers in the public mental health sector; and research for program evaluation. Some of these components are likely already in place in other states, and if so, they may serve as cornerstones for replication.

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CONCLUSION

California's MHP serves as an informative case study for designing and implementing innovative programs to increase mental health workforce diversity and retention among MSWs. This case study may prove helpful for other states that are facing similar workforce needs related to diversity as well as an exodus of workers from community mental health programs. Currently, no comprehensive demographic data exist about social work interns in California by field, their placement types, and academic/field concentrations. This information would be helpful in comparing and examining the differences in demographics between MHP and non-MHP students statewide.

California has historically piloted social service and education programs that can become national models, and this program may eventually follow this pattern. The documented results from the first 5 years of the program demonstrate its success in approaching its goals. However, ongoing evaluation will prove whether this holds true over time. For example, what are the motivations of the graduates who have remained in the community mental health system? Do they feel the current mental health competencies in the MSW curriculum are adequate to prepare them for successful careers in community mental health? How has payback employment affected the retention of MHP alumni in community mental health systems? Does a more diverse workforce contribute to improved quality of care, and if so, in what ways? All these questions will be beneficial to understanding the impact of the MHP program and are goals for future research.

Although the program has contributed to meeting the demonstrated mental health workforce needs of California, the needs still exist, and the MHP in no way offers a broad solution to the multidisciplinary workforce demands of the public mental health sector. Funding for stipends and

building capacity among schools of social work will be a major policy issue requiring strategic and collaborative advocacy on the part of educators, social workers, and state and county mental health agencies to implement models like this stipend program and to create other models that address this issue. Researchers and educators can examine workforce needs assessments conducted in their own states and counties, and critically assess how their educational institutions and state governments are going to address these gaps. More information about workforce needs and promising workforce development strategies will become available as health care reform begins to be implemented. Further research and advocacy could provide timely solutions to increased workforce needs.

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