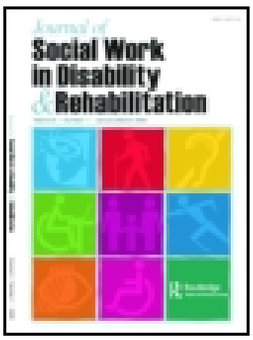

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Educational Collaboration in Psychiatric Disability, Rehabilitation, and Recovery: Developing Transformative Solutions

Janet Black
Teresa Morris
Anita Harbert
Christine Mathias

ABSTRACT. This article describes an innovative statewide collaboration between schools of social work and public mental health departments to transform social work curriculum and address the workforce crisis in public mental health service systems. The collaborative partnership has fostered the development of a Mental Health Initiative that has developed a set of mental health competencies offered in each of the participating master's in social work (MSW) programs in California. These competencies identify critical skills and knowledge necessary to support recovery, resiliency, evidence-based practice, and psychosocial rehabilitation principles. A statewide stipend program to support

Janet Black, MSW, is Professor Emeritus in the Department of Social Work California State University, Long Beach, CA. Teresa Morris, PhD, MSW, is Chair and Professor in the Social Work Department, California State University, San Bernardino, CA. Anita Harbert, PhD, is Director and Professor of the School of Social Work, San Diego State University, San Diego, CA. Christine Mathias, MSW, is Director of the California Social Work Education Center, Berkeley, CA.

Address correspondence to Janet Black, P.O. Box 8597, Fountain Valley, CA 92728. E-mail: jbblack@earthlink.net

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final-year MSW students in their graduate study and a requirement for a year of employment payback in the public mental health system is also presented, as well as a brief discussion of the organizational and structural principles supporting the collaborative organization. Current successes, future challenges, and strategies for the partnership collaborative in their task of developing a workforce are addressed.

KEYWORDS. Collaboration, curriculum implementation strategies, mental health curriculum competencies, Mental Health Services Act, recovery and resilience, transformation of mental health services, workforce development

THE NATIONAL PERSPECTIVE

After decades of little or no attention to the ravages of psychiatric disability, current thinking and recent legislation have proposed a new level of support to this population group and a concentrated focus on rehabilitation and recovery. The disrepair and fragmentation of the nation's mental health service delivery system and supportive rehabilitation services has been identified, and a new focus on a fundamental transformation of the nation's approach to mental health care has been defined. The President's New Freedom Commission indicates that "this transformation must ensure that mental health services and supports actively facilitate recovery and build resilience to face life's challenges" (President's New Freedom Commission on Mental Health, 2003, p. 1). Mental health and mental illness are part of the mainstream of health, and they are a concern for all people (Daniels & Adams, 2003; U.S. Public Health Service, Office of the Surgeon General, 1999). The commitment of the mental health workforce to the recovery process and the belief that people with psychiatric disabilities can and do recover is a critical factor in effectively providing services in this new model. The transformed mental health system must include a strong focus on consumer- and family-driven services, the recovery process, a commitment to psychosocial rehabilitation, and the utilization of evidence-based practices to guide interventions for individuals in need of psychiatric rehabilitation.

Testimony from consumers, families, advocates, and public and private providers has clearly identified a workforce crisis in mental health care. This crisis extends across the country, affecting both urban and rural areas, and across all ethnic and social strata. Rural areas are affected more significantly, and additionally, there is a major shortage in mental health providers who specialize in services to children, adolescents, and older adults (Bird, Dempsey, & Hartley, 2001; Peterson, West, Tanielian, & Pincus, 1998; President's New Freedom Commission on Mental Health, 2003).

Existing educational programs in the United States are frequently outdated in terms of evidence-based and best practice technology, and have not updated curriculum to reflect the current focus of psychiatric disability and rehabilitation treatment (Hoge & Morris, 2002). In addition, models of education are frequently used that support didactic instruction that might not be the most effective method. Existing psychiatric rehabilitation systems have not addressed the unique needs of culturally diverse groups, resulting in not only less care, but a poorer quality of care for these populations (U.S. Public Health Service, Office of the Surgeon General, 2001). Substantial numbers of adults and older adults with severe psychiatric disabilities and children and adolescents with serious emotional disorders have cooccurring psychiatric disabilities and substance abuse disorders, complicating the treatment and intervention approach significantly (Center for Mental Health Services, 2004; Harwood, Kowalski, & Ameen, 2004; Substance Abuse and Mental Health Services Administration, 2002; Watkins, Burnam, Kung, & Paddock, 2001).

The aforementioned issues and the anticipated "new look" to psychiatric rehabilitation and recovery service delivery presents an additional set of challenges: (a) providing a new cadre of adequately trained providers, who are knowledgeable about the new focus of psychiatric rehabilitation and recovery services, and exposed to evidence-based and best practice principles, and (b) retraining existing staff and practitioners to new ideas and knowledge. There must be a change in practice expectations so that mental health practitioners value each of the components of the process of recovery, including self-direction individualized and person-centered intervention, empowerment, use of a strengths-based approach, peer support, respect, responsibility and hope (Ragins, 2005).

The Annapolis Coalition on Behavioral Health Workforce Education is a not-for-profit organization that has taken a leadership role

in building a national consensus on the nature of the mental health workforce crisis, and promoting improvements in the quality and relevance of education and training by identifying and implementing change strategies. They have identified critical concerns about the ability of the current workforce to effectively provide psychiatric rehabilitation and recovery services within the resilience- and recovery-oriented practices, and within a perspective of collaboration with consumers, family members, and the local community as equal service providers (Annapolis Coalition, 2007).

The Annapolis Coalition (2007) has been involved in a multiphase project to support improvement in the education and training of the behavioral health workforce for students in professional training programs, working professionals, nondegreed and bachelor-degreed direct care staff, as well as persons in recovery and their families (Hoge, Morris, & Paris, 2005). Their activities have included national invitational conferences bringing together key leaders in the field to identify education and training needs, disseminating conference presentations and recommendations, and a strong consultative presence in the development of the President's New Freedom Commission on Mental Health. The critical work of this organization has been instrumental in guiding national efforts in building relevant training systems to provide the necessary education to produce the needed workforce,

DEVELOPING COMPETENCY MODELS IN PSYCHIATRIC REHABILITATION AND RECOVERY ORIENTATION FOR THE BEHAVIORAL HEALTH WORKFORCE

Over the past decade, several forces have emerged that have driven a move toward the development of competency-based thinking. The onset of managed care, with an increased attention to effectiveness of interventions and the qualifications of those providing services to constituency groups has led this thinking (Hoge, Tondora, & Marrelli, 2005). Additional critical influencing factors include the development of professional practice guidelines and standards for a variety of professional groups, and the emphasis on development and implementation of evidence-based practice models (American Psychiatric Association, 2000; Drake et al., 2001; Hoge, Tondora,

& Marrelli, 2005). The importance of a common definition of competencies is critical to the development effort, and is provided by Hoge, Tondora, and Marrelli (2005):

> A competency is a measurable human capability that is required for effective performance. It is comprised of knowledge, a single skill or ability, or personal characteristic—or a cluster of these building blocks of work performance. Successful completion of most tasks requires the simultaneous use of sequenced demonstration of multiple competencies. (p. 517)

A comprehensive overview of efforts to develop competencies in behavioral health care has been completed by Hoge et al. (2005). They found competency development efforts underway in several distinct areas including substance abuse, interdisciplinary, discipline specific (including Marriage and Family Therapists (MFT), psychology, psychiatric mental health nurse practitioners, psychosocial rehabilitation practitioners, psychiatry and social work), population focused groups (including children's mental health, serious and persistent mental illness) and in special approaches to care (including recovery oriented, cultural competency and peer specialists). Developmental efforts among these groups were uneven but were characterized by recent onset; the effort to identify core knowledge, skills and attitudes required for practice; and an effort to develop some clusters of like competencies (Hoge et al., 2005). Some work has been identified to date that addresses issues of implementing the developed competencies in an organized training program for students or existing workforce members, but many efforts reviewed have not included consumer and family involvement in the competency identification or development process (Hoge et al., 2005; O'Connell, Morris, & Hoge, 2004).

MENTAL HEALTH REHABILITATION AND RECOVERY WORKFORCE: PROGRAM NEEDS IN CALIFORNIA

The mental and behavioral health care workforce in California numbered nearly 63,000 licensed professionals at the time of the most recent statewide workforce study (McRee et al., 2003). The majority of this workforce (59%) was marriage and family therapists (MFTs) and licensed clinical social workers (LCSWs), with 19% psychologists

and 15% psychiatric technicians. Less than 1% was advanced practice nurses in psychiatric and mental health (PMH) and about 8% were psychiatrists (American Medical Association, 2000; McRee et al., 2003). California is experiencing severe shortages in available mental health providers that mirror those reported in national reports (President's New Freedom Commission on Mental Health, 2003; Substance Abuse and Mental Health Services Administration, 2003). Additionally, statewide workforce studies have reported a critical shortage in individuals appropriately trained to provide services to individuals from the wide variety of cultural and ethnic groups residing in the state. It appears certain from the most recent workforce surveys that non-White providers are not represented in proportion to their numbers in the general population, and the growing ethnic and immigrant population groups in the state are reflected in disproportionate numbers as consumers of mental health services, at all age levels of service: children, adolescents, adults, and older adults (McRee et al., 2003). Additionally, the majority of licensed mental health workers in the state are concentrated in urban areas. The majority of the 58 counties in the state are designated as small or medium-sized counties, and have higher levels of vacancy in available licensed positions, as well as increased difficulty recruiting individuals to the more remote and rural environments. During fiscal year 2001–2002, a total of 595,405 individuals were served through California's public-sector mental health agencies, including more than 197,000 adults with serious mental illnesses, and more than 106,000 children with serious emotional disturbances (McRee et al., 2003). Many of these individuals have treatment complications because they are dually diagnosed, or have cooccurring disabilities that include debilitating mental illness and involvement with alcohol and other drugs. These consumers are frequently shifted between mental health facilities and drug treatment programs as the systems continue to be fragmented.

According to McRee et al. (2003), the overall demand for mental and behavioral health care workers in California between 2001 and 2010 can be expected to grow from 63,000 to between 73,000 and 80,000 (or between 16% and 30%). In 2001, there were 13,000 LCSWs providing social services in the state across all service areas. The statewide report concluded that there was a current shortage of social workers in the mental health and behavioral health area, and that the current supply of social workers was inadequate for the state's growing needs (McRee et al., 2003).

Pasztor, Saint-Germain, and DeCrescenzo, in their 2002 study *Demand for Social Workers in California*, identified several important trends that provide impetus for the Mental Health Initiative activities described in this article. The study was commissioned by the California Assembly through the Faculty Fellows Research Program at the Center for California Studies, California State University, Sacramento. Their findings indicate that social work is one of the faster growing sectors of employment, and documented an increasing need for social workers across program areas of mental health, child welfare, disabilities, and school social work. Taking into consideration the growth of ethnic minority populations, an aging population group, and the special needs of children and adolescents, the mental health workforce needs in terms of social work are astronomical.

A RESPONSE TO THE WORKFORCE SHORTAGE IN PSYCHIATRIC REHABILITATION AND RECOVERY

The California Public Mental Health System

The various members of the California Mental Health constituency groups have a long history of working together and share a clear vision of the mission of the public mental health system. In 2003, the California Mental Health Planning Council developed and published the California Mental Health Master Plan. This document states that

> "The mental health constituency envisions a society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent and effective services from the mental health system. As a result of the services, support and rehabilitation they receive, these persons are able to lead happy, productive and fulfilling lives.
>
> The mission of California's public mental health system is to enable all individuals, including adults and older adults with serious mental illness and their families and children with serious emotional disturbances and their families, to access services from a seamless system of care. These services will assist them in a manner tailored to each individual to achieve their personal

> goals and optimal recovery, and to develop skills that support living the most constructive and satisfying lives possible in the least restrictive environment. The mental health system shall help children achieve optimal development." (California Mental Health Planning Council, 2003, p. 8)

The California public mental health system has been on a financial roller coaster for the last 20 years. In good financial years, mental health would get an incremental increase in its budget. Never would the increase enable the system to meet the need that existed in the state. Many times there would be promises of more in the future that rarely materialized. In bad years, mental health would always get its budget reduced. In the last two budgets, the Children's System of Care funding was totally eliminated.

The Planning Council estimates that there are "600,000 adults, older adults and children and youth in need of mental health treatment who are not receiving services" (California Mental Health Planning Council, 2003, p. 19). The Planning Council further states that to meet this need, the public mental health system would need to double in size and scope of services.

THE MENTAL HEALTH SERVICES ACT: A PATHWAY TO THE WORKFORCE CRISIS

In early 2003, the Mental Health Constituency Group, given leadership by California State Assemblyman Darrell Steinberg, placed Proposition 63 on the state election ballot. The intent of the proposition was to expand mental health care for children and adults in an effort to meet the unmet need that exists in the state. It was estimated that if the proposition passed, an additional $750 million would be added to the mental health budget in 2006–2007. The proposition places a 1% tax on taxable personal income over $1 million. The monies generated from this tax are restricted and can only be spent on mental health services. The proposition passed by a margin of 53.4% on the November 2004 ballot.

The passage of Proposition 63, called the Mental Health Services Act (MHSA) defines a critical and historic undertaking for public mental health care in California. The Vision Statement and Guiding Principles for Department of Mental Health (DMH) implementation

of the MHSA state that "The California DMH will dedicate its resources and energies to work with stakeholders to create a state-of-the-art, culturally competent system that promotes recovery/wellness for adults and older adults with severe mental illness and resiliency for children with serious emotional disorders and their families" (California Department of Mental Health, 2004, p. 1). The MHSA builds on principles, goals, and strategies identified in the President's New Freedom Commission on Mental Health (2003), Institute of Medicine (2001), and the SAMHSA (2002, 2003) reports and provides a blueprint to fundamentally transform how mental health care is conceptualized and delivered in California.

Development of a Collaborative Partnership

In an effort to support the growth of a social work workforce for the public mental health services system in its redesign efforts, it was natural to turn to an innovative collaboration between academic institutions and the community agency system serving public child welfare, which had been developed 18 years earlier to address child welfare staffing and redesign issues.

With visionary leadership and a strong commitment to the mission of producing professionals for careers in the previously abandoned publicly supported social services (Specht & Courtney, 1994), deans and directors of the schools of social work in California, the local National Association of Social Workers (NASW) chapter and the Child Welfare Directors Association came together for strategy discussions. The California Social Work Education Center (CalSWEC) was conceptualized and initiated in 1990 and was institutionalized as part of the University of California, Berkeley, School of Social Welfare. It was funded by a grant from the Ford Foundation with matching grants from eight California foundations, which supported its early activities focusing primarily on child welfare issues (Clark, 2003; Grossman, Laughlin, & Specht, 1991; Ringuette, 2000).

CalSWEC reached a milestone in 1993 with the implementation of Title IV-E child welfare training programs in the 10 schools of social work in California, focusing on reprofessionalizing the child welfare workforce. The subsequent years involved an extensive expansion of CalSWECs involvement in child welfare training in the state and nation. CalSWEC is now the nation's largest state coalition of social work educators and practitioners. It has developed five Regional

Training Academies throughout the state that provide training activities to child welfare staff at all levels. It was also instrumental in supporting the legislation that brought about the Master Plan for Social Work Education.

The plan suggested an integrated response that relies on both educational initiatives and workforce development. This response, known as the Ladder of Learning, identifies the stages of education that can be followed by individuals who want to become social workers. Beginning with high school certificates, the Ladder of Learning systematically demonstrates how one could move through community college certificates or degrees, to baccalaureate education and on to graduate education, including postgraduate certificates, licensure, and attainment of a doctoral degree. At each of the educational rungs are the associated employment opportunities (CalSWEC, 2004). This model has important ramifications for assisting in the transformation of mental health services, as it provides a pathway for consumers and family members to reach educational goals that will support their employment in the mental health service system.

Expansion of a Successful Collaboration

Historically, CalSWEC had primarily focused on preparation of social work professionals for the public child welfare services and was originally funded solely for this purpose. Over the years dialogue occurred with other fields of social work that wished to affiliate with the Center. In 2003, the CalSWEC Board of Directors adopted a strategic plan that outlined several new initiatives including the Mental Health Initiative, which was designed to expand on the successful workforce and educational development activities that had taken place over the prior 12 years in the child welfare arena through the efforts of the CalSWEC collaborative.

Organizational Change to Accommodate Success

It is important to understand that CalSWEC in its early formative years did not legally exist, but was a voluntary collaborative partnership between organizations and entities. It had been surprisingly successful simply because of the goodwill of those involved and a common focus area. In 2003, with the growth of social work educational initiatives to include mental health, it became clear that organizational change and a structured set of operational policies

and procedures to accommodate an increasing number of funding agencies and respond to multiple requests for new programs and expansion of social work education was needed. It was critical that any new structure allow maximum flexibility and creativity while providing consistent principles of guidance, support, and accountability. A hybrid model with a combination of centralized and decentralized, formalized and informal organizational principles was adopted as the structure that would most effectively meet the needs and challenges for the organization. The basic principles of collaboration and inclusion of partners from across the state continue to play a critical role in the organization. The new model is being phased in over time and appears to be satisfactory at this point.

Social Work's Response to the Challenge: Development of the CalSWEC Mental Health Initiative

In July 2003, the California Wellness Foundation and the Zellerbach Family Foundation awarded grants to CalSWEC to begin the Mental Health Initiative. This project has as its primary goal developing a culturally competent corps of trained social workers through the creation of a continuum of social work education and training programs, to respond to the mental health workforce crisis in California. The Mental Health Initiative has created a partnership between the education and mental health provider community to achieve this goal.

The CalSWEC Mental Health Initiative was formally developed in December 2003. The selection of two cochairs of the committee was a critical step. One individual representing the educational arena and one representing a local county public mental health agency was a good match, and modeled the type of collaboration and partnership development that was a cornerstone of the initiative. An individual with experience in mental health, the social work educational arena, and organizational systems was brought on as a consultant to the project, providing expertise and assisting with some administrative functions. During the early development of the committee, efforts were made to follow the key concepts for successful collaboration: shared vision, skilled leadership, process orientation, diversity, member-driven agenda, multiple sectors, and accountability (National Assembly of National Voluntary Health and Social Welfare Organizations, 1991; Prince & Austin, 2005).

The Mental Health Initiative Committee includes faculty members from member schools of social work throughout the state, as well as directors of county mental health departments, and other key stakeholders in the mental health arena. The membership is representative of multiple cultural and ethnic identities, rural and urban settings, and the full social and economic strata that exemplifies the state.

The committee is linked to the wider CalSWEC governance structure as described earlier. Additional members are added to the committee on an ongoing basis, to assure full representation of all of the stakeholders who will bring expertise to the effort. The committee meets three times per year in various locations throughout the state, and has developed a regional network of university–agency partnerships that meet more frequently to address local issues and develop implementation strategies. The committee has functioned well as a "committee of the whole," encouraging active participation by all members; as the need has arisen, subcommittees have been formed with volunteer membership, to complete a particular task or represent a specific perspective. A philosophy of inclusion has given latitude for a variety of individuals to attend and participate in meetings, and the active mailing list includes over 140 people.

The initiative has three major objectives:

1. Development of core skills and competencies in mental health practice that will guide the curriculum in schools and departments of social work in California to produce a cadre of MSW-level graduates for employment in the public mental health arena.
2. The creation of a partnership between the education and provider community for the planning, coordination, and development of Mental Health Workforce Development Projects that recruit and deploy more social workers into the mental health system.
3. A collaborative effort to seek funding from private and public resources to support the implementation of a training and educational continuum for social workers in public mental health services.

Mental Health Initiative Competency Development

The primary work of the Mental Health Initiative Committee since its inception in February 2004 has focused on the curriculum development objective building on earlier work efforts. Early in 1992,

under the auspices of CalSWEC, faculty from schools of social work and professionals from county mental health agencies throughout California embarked on a collaborative project to develop a curriculum of mental health competencies to prepare MSW-level students to meet the workforce crisis in the public mental health service arena. A series of joint work sessions were held resulting in a document entitled "Guiding Philosophy and Principles of Graduate Social Work Education in Community Mental Health" that was produced in mid-1993, which included a set of 45 competencies. Although there continued to be very strong support for the completion of the entire collaborative effort in mental health curriculum, funding streams and infrastructure support were not available and the project was put in abeyance for a time.

The work of the Annapolis Coalition described earlier, and the 2005 MHSA legislation underscored the reemergence of the need for a set of curriculum competencies in mental health, and thus became a primary objective of the Mental Health Initiative Committee. The Annapolis Coalition has been involved in the Mental Health Initiative activities described in this article, and we are involved in monthly conference calls to assess common issues and strategies that are being developed to address the needs.

The result of the curriculum development work by the Mental Health Initiative Committee is a set of Mental Health Competencies at both the first-year (Foundation) and second-year (Advanced or Specialization) levels that can be implemented at each of the 17 schools of social work in the state, and in each of the county Department of Mental Health agencies who are involved in collaborative training agreements with these schools. Multiple stakeholders in the public mental health and educational partnership arena have developed the Mental Health Competency document through input and review. Many of these stakeholder groups included consumers and families who were provided an opportunity for inclusion in the development and revision process The document underwent five revisions, each time integrating newly suggested content areas, revising concepts, and adjusting presentation style to show consistency throughout the document. The competencies are designed to reflect the emphasis in mental health treatment on recovery, resiliency, evidence-based practices, and consumer- and family-driven treatment and psychosocial rehabilitation principles. They are delivered in classroom and agency-based fieldwork settings (Annapolis Coalition, 2007; President's New Freedom Commission

on Mental Health, 2003; U.S. Public Health Service, Office of the Surgeon General, 1999). A series of regional technical assistance meetings with education and agency participants were held to develop implementation strategies to deliver the curriculum with the opening of the 2005–2006 academic year.

A Curriculum Implementation Survey has been completed for the 2005–2006 and 2006–2007 academic year periods. The survey identified a variety of strategies being utilized by schools to strengthen existing curriculum offerings and develop new courses or concentration specialties in mental health to assure that the Mental Health Competencies are being delivered to students. The most frequently used strategies include the following:

1. Development of specialized electives and courses reflecting the recovery process, principles of psychosocial rehabilitation, resilience, and utilization of consumers, family, and community resources in developing intervention strategies.
2. Inclusion of consumers and family members in curriculum development and course presentations.
3. Regional meetings and collaboration with local mental health and community-based mental health contract agencies.
4. Inclusion of evidence-based and promising practices in mental health in both classroom and fieldwork assignments (Segal & Riley, 2003).
5. Infusion of the mental health competencies into the entire curriculum to expose all MSW students to practice in the public mental health system.

Introducing the newly developed Mental Health Competencies has presented a number of challenges and some background about the philosophy and practice of social work education is important to understand these issues.

Social work education is deeply rooted within the context of agency practice. As such, it is guided by an educational philosophy that emphasizes preparing a workforce that is competent to meet the needs of individuals, families, groups, organizations, and communities (Dinerman & Geismar, 1984). Although the relationship between social work education and practice has been long and usually productive, it has not always been easily maintained. For generations, social work educators and practitioners have grappled with

and often lamented the challenge of keeping education current with practice. Likewise, the struggle associated with the rise and fall of workforce resources adequate to meet population dynamics and agency needs continues as a recurring theme.

The need to maintain strong linkages between social work education and practice, although natural, is not new or accomplished without ongoing intentionality. In fact, in some ways the current efforts of social work education in California to respond to the workforce shortage affecting public mental health is reminiscent of early workforce studies from the 1950s that documented the severe shortfall of properly trained social workers and propose interventions to strengthen curricula and improve linkages to practice (Dinerman & Geismar, 1984). However, despite the appearance of cyclical themes, social work education California is much better prepared to engage in a partnership with practice than was possible even a decade ago. Much has been done and continues to be done to understand and enhance the capacity of social work education to effectively respond to the needs of mental health services in California.

One of the factors that has significantly affected the capacity of social work education in California has been the number of programs available to meet population needs. The growth of social work programs in California can best be described as sporadic, rather than planned. Like in many other parts of the country, social work programs emerged first in urban areas. In California, this meant that Los Angeles (USC in 1922; UCLA in 1949) and San Francisco (UC Berkeley in 1928) were the first areas to develop graduate social work programs. It would be nearly another 20 years before additional programs would begin appearing around the state, and then only three were added (San Diego State, CSU Sacramento, and CSU Fresno). Over the next 20 years, four more programs would appear. However, not until the late 1990s (Barr & Neustrom, 2001; CalSWEC, 2000; Theriot, 2001) was there shared acknowledgment that the number of social work programs was inadequate to meet the needs of California's citizens and honor the requirements of a strong partnership with practice.

Today, although the 17 social work programs in California vary in how each articulates the conceptual framework that guides the structure of its independent curricula, all are organized and thus unified by the educational standards, procedures of accreditation, and the foundations of generalist social work practice. Supporting this common ground are the revised (July 2003) Council on Social Work

Education (CSWE) accreditation standards, which further support individualized institutional articulation of collective principles.

These foundations, along with the communication mechanism that is unique to California vis-à-vis CalSWEC, positions social work education in California to be aptly responsive to the challenges facing the public mental health services. As a part of this response, a set of curriculum competencies (foundation and advanced) have emerged from the collaborative efforts of the Mental Health Initiative. This being said, it should be understood that these competencies do not in any way replace, but rather rely and build on CSWE accreditation standards. Rather, similar to the standards for practice that have been articulated by NASW for work with specific populations and systems, the mental health curriculum competencies respond to the need to prepare and retain committed, competent, and confident social workers for responsive practice in public mental health. Initiatives like this one are increasingly being recognized and encouraged by CSWE as the addressing the requirements for preparing social workers for the workplace of the future (Mizrahi & Baskind, 2003).

Collaboration between schools of social work and their community partners is an integral component in all programs. The delivery of social work education curriculum is dependent on strong community partnerships and relationships, to support the fieldwork and internship model of learning, bringing together the academic community and the practice world to train students for entry into the professional social work world. Although each of the 17 schools of social work in California have specific concentration or specialization areas and particular perspectives of the educational experience, a common theme among all of the schools has been attention to the issues of social justice and service provision to the underserved and underrepresented populations. Schools vary in their view about private practice and the public service environment, but have come together to embrace the need for training for the public social services within the framework of CalSWEC.

TRAINING IMPLEMENTATION AND CONTRIBUTIONS TO THE MENTAL HEALTH WORKFORCE

In 2005, CalSWEC entered into a 1-year contract with the California Department of Mental Health to provide stipends to full-time

second-year MSW students enrolled in one of the 17 accredited schools of social work throughout the state. It was modeled after the Title IV-E stipend program in which students who receive stipend funds are required to complete an employment payback period with a county public mental health agency or a community-based organization under contract to a county public mental health agency. The contract provides a stipend of $18,500 to each student, provides funding for a mental health stipend project coordinator at each of the schools, and has a minimal funding amount for administrative and clerical support for each school. Stipend coordinators are full-time or part-time positions, dependent on the number of students enrolled in the program, and there is a maximum of 20 students per school. Students participating in the program receive classroom and field-related instruction and experiences that deliver the Mental Health Competency curriculum developed by the Mental Health Initiative, supporting and promoting recovery, wellness, and resiliency. Since the original contract, two additional 1-year contracts have been implemented, and negotiations have been completed for an additional 3 years of statewide support for this project.

The contract is funded through MHSA dollars, and inherent in the funding acceptance is a commitment to support concepts of the recovery process, consumer family- and community-driven interventions, and involvement of mental health consumers and family members in the educational process in as many ways as possible. A number of consumers are participating as MSW students, and consumers, family members, and advocate agencies are involved with the schools in developing and delivering curriculum to the students.

Research results for the first three student cohorts, (2005–2006, 2006–2007, and 2007–2008) have been collected, analyzed and reported by Dr. James Midgley, Principal Investigator for the CalSWEC. Mental Health Stipend Program, and indicate that the stipend program is indeed having an impact on developing the workforce for both county-operated mental health programs and community-based organizations having a contract with a county agency. Although there was some attrition for the first cohort group, it was much less of an issue with the second cohort, and there were fewer students who were taking additional time to complete all MSW degree requirements in the second year of the project. In the 2005–2006 cohort, a total of 172 students successfully completed

the MSW degree and at the time of this writing, 80% have successfully completed their payback employment. It is anticipated that this number will increase to 88% to 90% within the near future. In the 2006–2007 cohort, only 1 student withdrew prematurely from the program. Of those enrolled in the program in Fall 2006, 179 students (96%) have completed their MSW degree. As of August 2007, 99% of those who enrolled in the MSW program and 96% of those who completed their degrees have either found employment or are on track to do so, and it is anticipated that they will complete their payback employment commitment by the summer of 2008.

These are very encouraging results, and data about the third cohort (2007–2008) are currently being collected and analyzed. The target number of stipends for this cohort was 196 students, which exceeds the two previous years. Tables 1 and 2 identify the diversity of each of the first two student cohorts, and the variety of languages other than English that are spoken by the students, with nearly 60% speaking a second language. These data underscore the early success of the CalSWEC Mental Health Stipend program and the commitment to creating a mental health workforce that will meet the needs of the diverse population of California.

A more complete evaluation is planned for the next year, with a particular focus on retention issues. It will be important to identify why students have continued with employment in the public mental

TABLE 1. Ethnic Self-Identification of Mental Health Stipend Students

	Academic Year 2005–2006		Academic Year 2006–2007	
Ethnic Self-Identification of Students	Number	%	Number	%
American Indian	2	1	0	0
Asian or Asian Pacific Islander	25	14	35	19
Black or African American	17	10	19	10
Hispanic, Chicano, or Latino	41	23	47	25
White or Caucasian	84	48	78	41
Declined to state and other (self-reported) includes Jewish, Ethiopian, Iranian, Pakistani, Israeli, Armenian, and multicultural	8	4	9	5
Total	177	100	188	100

TABLE 2. Languages Spoken by Mental Health Stipend Students: Academic Year 2006–2007

Language Spoken	Number	%
English language only	77	38
Asian and Pacific Island languages (e.g., Mandarin, Cantonese, Vietnamese, Tagalog, Korean, Hindi, Urdu, Farsi, Arabic, etc.)	37	18
Native North American language	0	0
Spanish or Spanish Creole language	65	32
European languages (e.g., French, Russian, Italian, Portuguese, etc.)	17	8
African languages (e.g., Ethiopian, Swahili, Zulu, etc.)	2	1
American Sign Language	4	2
Total	202	100

Note. The total number of languages spoken exceeds the total number of students enrolled because many students speak more than one language.

health system beyond the payback employment period. Conversely, it is equally important to identify those factors that influenced students to leave mental health employment either during or immediately after their payback employment period. The collaborative partnership with the mental health system will be an important factor as this evaluation evolves.

The importance of providing support and curriculum resources to faculty and agency-based field instructors cannot be underestimated (Styron, Shaw, McDuffie, & Hoge, 2005). In April 2007, the CalSWEC Mental Health Initiative applied for and received a grant from the Zellerbach Family Foundation, entitled "A Model for Implementation of the Mental Health Competency Curriculum." The grant activities were designed to support delivery of several curriculum development and infusion seminars to university partner faculty, directors of field education, and mental health stipend coordinators, as well as county mental health agency field instructors and MHSA coordinators. The first infusion seminar focused on the topic of recovery, and provided participants with an introduction to the recovery process, and the critical importance of emphasis on wellness, resilience, and consumer- and family-driven interventions. The presentation team of a social work professional and a consumer brought the recovery process to life and provided an excellent training opportunity.

The project will also develop four curriculum modules in identified priority areas for use in school and agency settings (recovery, cooccurring disorders, older adult mental health issues, and child mental health issues) and support a statewide mental health summit at the end of the funding period. Additional efforts to support faculty and field instructors in the development and delivery of mental-health-related curriculum have included posting of mental health course syllabi on the CalSWEC Web site, development of a Web site devoted to curriculum resources, and a listserv for stipend coordinators to discuss critical issues and common concerns.

We are encouraged by the rapid growth and development of the Mental Health Initiative collaboration, the positive results it has achieved, and the significant commitment that CalSWEC, the participating schools of social work, and the 58 county mental health departments have made to this effort. Based on this early experience, we expect continued success in workforce development, and look forward to maintaining this newly nurtured workforce in the mental health system. Although we are encouraged with the efforts to date, a number of challenges remain to be addressed during the coming years.

How can the Mental Health Initiative effectively support faculty in redesigning their curriculum to reflect current practice and thinking in mental health and embrace recovery-oriented care and a psychosocial model of rehabilitation? How can we support our agency-based field instructor faculty in delivering the curriculum competencies, particularly those that reflect the recovery process and an interdisciplinary perspective? Many mental health agencies are struggling with the transformation efforts. Although new MHSA money is available for innovative community-based and recovery-focused programs, budget cuts are cruelly slashing existing programs and leaving consumers lost and confused, even as the system is attempting to more appropriately address their needs.

How can we support the coordinators of the Mental Health Stipend program at each of the schools to develop collaborative partnerships with their local mental health providers, and extend that partnership to a regional focus within the state? It seems very clear that a regional approach to workforce development and workforce retention is necessary to address the unique needs and priorities of various areas. Collaboration is a time-intensive activity and needs support from multiple entities to be successful.

The MHSA not only requires that the service system transform to a responsive and recovery-oriented focus, but mandates the inclusion of consumers in educational programs funded by these funds. Some academic institutions have done an excellent job in developing supported education models assisting individuals with psychiatric disabilities to successfully complete their educational goals and degree programs. It seems likely that collaborating with these institutions around these critical issues will not only provide important services for individuals in need, but will provide important insights for faculty and academic administrators into the realities of severe and persistent mental illness and the societal, cultural, and professional stigma that impede them in their quest for independence and a productive life. Challenges also equal opportunity and we look forward to moving forward to continued collaboration and strategy development to meet the mental health workforce needs in California.

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ADDITIONAL WEB SITE RESOURCES

http://calswec.berkeley.edu
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001–06000&file=5801–5802
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001–06000&file=5830
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001–06000&file=5840-5840.2
http://www.leginfo.ca.gov/cgi-bin/displaycode?section=wic&group=05001–06000&file=5850–5851.5
http://www.dmh.cahwnet.gov/
http://SAMHSA/evidencebasedpractices