The Mental Health Services Act Stipend Program for MSW Students

A Retrospective Study of Program Outcomes and Impact

April 2022

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Created in 1990, CalSWEC is the nation's largest consortium of social work and social welfare degree programs, public human service agencies, and related professional organizations. Hosted by the School of Social Welfare at the University of California, Berkeley, CalSWEC's partners and stakeholders include 22 California universities, the California Department of Social Services, the Office of Healthcare Access and Information, the County Welfare Directors Association, the County Behavioral Health Directors Association, California's Regional Training Academies, and the California Chapter of the National Association of Social Workers. With the goal of supporting effective, culturally competent delivery of public services to the people of California, CalSWEC works with its partners throughout the state to support social work education and training in child welfare, behavioral health, and aging and adult services. CalSWEC's training programs for social work students, in-service training for social workers, and workforce development-focused evaluation and research projects are funded through private, local, state, and federal contracts and grants.

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INTRODUCTION

The Mental Health Services Act

In November of 2004, California's Mental Health Services Act (MHSA) was passed through ballot initiative as Proposition 63. Widely known as "the Millionaire's Tax," this measure created a novel 1% tax on annual personal incomes over $1 million and established the Mental Health Services Fund. Revenue collected was directed to five mandated components; Community Services and Supports (CSS), Prevention and Early Innovation (PEI), Innovation (INN), Capital Facilities and Technological Needs (CF/TN), and Workforce Education and Training (WET) for the purpose of enhancing the state's public mental health services.

Grounded by a core emphasis on applying the recovery model to all aspects of service delivery, the MHSA provided a directive and roadmap for revamping the approach of California's public behavioral health systems to serving the state's diverse population around a range of mental health needs and across the lifespan. The MHSA thus mandated the development of new models for in-service training of staff and pre-service education of future providers. WET funding, specifically, was to be used to develop the current and future mental health workforce. Through the WET funding stream, training and education programs were developed with the goal of expanding the licensed mental health workforce.

The MHSA Stipend Program for MSW students

In academic year 2005-06, the MHSA Stipend Program for Masters of Social Work (MSW) students became the first statewide MHSA WET-funded stipend and training program. Its central goal was to ameliorate existing and projected MSW shortages in California's public behavioral health workforce. In addition, it was formulated to address the dual goals of recruiting students from groups historically underrepresented among MSWs in California's public behavioral health system and training those students to apply the recovery model and other core MHSA principles to practice in public behavioral health settings.

Recruitment prioritized students at accredited MSW programs who reflected California's racial/ethnic diversity, could provide services in high demand languages other than English, and had lived experience in the public behavioral health system, either as consumers or as family members of consumers. Selection prioritized students who expressed commitment to the recovery model and other MHSA principles and practices, and to working in California's public behavioral health system after graduation. Finally, the program sought to meet target goals for enrolling students who would complete MHSA training in counties identified as having the most severe shortages of MSWs in their public systems.

MSW students accepted to the MHSA Stipend Program were awarded stipends of $9,250 if enrolled part-time and $18,500 if enrolled full-time, in order to defray educational expenses during their final year of MSW study. All MHSA trainees were required to complete advanced-year field training at public behavioral health sites, advanced-year clinical courses focused on applying the recovery model and other MHSA principles in clinical practice, and specialized symposia, capstone projects, and other consumer-focused learning experiences designed by their MSW programs. After graduation, all MHSA trainees were required to complete either six or 12 months (depending on stipend amount) of full-time paid or volunteer service in public behavioral health settings in California. Graduates who failed to

complete this service obligation and who were not entitled to a waived repayment were required to repay stipend funding in cash, prorated to reflect any service fulfilled.

The Evolution of the MHSA Stipend Program

At its inception in academic year 2005-06, the MHSA Stipend Program was administered by the California Department of Mental Health (DMH) and directed by CalSWEC. In 2012, when DMH became a division of the Department of Health Care Services (DHCS), the Office of Statewide Health Planning & Development (OSHPD) took over its administration. In 2013, OSHPD initiated changes to program funding and structure that were executed through new contracts with CalSWEC and guided program implementation from 2014-15 through 2018-19. Funding to CalSWEC and participating MSW programs for specialized training, on campus coordination and program management was cut by roughly two thirds, and participating MSW programs were newly required to assume fiscal liability for any cash repayment obligations unfulfilled by program graduates.

The MHSA Stipend Program was initially implemented at 17 MSW programs across the state. Between 2010-11 and 2013-14, four additional MSW programs joined the program and in 2016-17, the newly accredited MSW program at CSU San Marcos joined as well. However, in 2014-15 and 2015-16, three of the original 17 MSW programs, including, of note, the two largest CSU campuses in California's central region, withdrew from the program due to the inability to fund required specialized training or assume graduates' fiscal liability as was required by new contract agreements.

Finally, from its outset the Workforce, Education and Training (WET) funding stream was the only component of MHSA funding with a legislated sunset date. Because WET funding was allocated for only ten years, the MHSA Stipend Program was initially funded only through fiscal year 2015-16. The carryover of unobligated balances enabled its continuation in academic years 2016-17 and 2017-18, and a final allocation of additional funding enabled funding for a final training cohort of reduced size and scope in academic year 2018-19.

STUDY PURPOSE AND METHODS

Development and Design of the Study

Despite mandating the collection and reporting of descriptive program data, neither DMH nor OSHPD initiated or funded program evaluation procedures designed to assess the MHSA Stipend Program's achievement of its stated goals, or broader impact on California's public behavioral health workforce development needs over time. As such, in 2016 CalSWEC requested funding from OSHPD to conduct a retrospective evaluation of the MHSA Stipend Program for these purposes. In 2018, CalSWEC secured such funding and developed the evaluation plan, key questions, and survey items for the MHSA Stipend Program Retrospective Study, in consultation with OSHPD.

The MHSA Stipend Program Retrospective Survey was created in Qualtrics as a web-based survey, and included 63 items focused on participants' descriptions of and reflections on their MHSA training experiences, the program's impact on their employment decisions and career trajectories, and their commitment to MHSA principles and practices over time. It asked participants to provide information about their employment histories after completion of the MHSA service obligation and to reflect on ways to improve the retention of MHSA graduates in California's public behavioral health system.

Participant Recruitment and Data Collection

With the approval of UC Berkeley's Institutional Review Board, the MHSA Retrospective Study began in September 2018. The MHSA Stipend Program trainee database was used to identify potential study participants and program graduates were recruited by email to participate. Initial and follow-up recruitment messages explained the purpose of the study, outlined data that would be collected using a web-based Qualtrics survey, and provided a link to the survey. These messages also offered $20 virtual VISA gift cards as an incentive for completing the survey.

Between September and December of 2018, recruitment and data collection focused on the 2014-15 through 2017-18 trainee cohorts associated with OSHPD-administered program years. From February to June of 2019, recruitment and data collection focused on the 2005-06 through 2013-14 trainee cohorts associated with the DMH-administered program years. Participants who opted to receive the incentive were asked to provide an email address at survey completion and were then sent instructions and a link for accessing $20 virtual VISA gift cards.

Data Analysis Procedures

An initial goal of the study was to provide data for stakeholder consideration during the WET five-year planning process that began in 2018, and preliminary study data was summarized for that purpose in early 2019. Data from the MHSA Stipend Program database and quantitative survey data were exported to Statistical Package for the Social Sciences (SPSS, version 26), in which they were cleaned and analyzed. Descriptive statistics were generated for all relevant demographic, process, outcome-related items for the final survey sample.

Once all data collection was complete, a comprehensive analysis was conducted that juxtaposed the complete MHSA Stipend Program Retrospective Study dataset against MHSA Stipend Program data. Chi square analysis was conducted to assess the distribution of key variable values in the study sample versus in administrative program data, in order to identify any significant differences between the study sample and the population of program graduates. Significant differences between the study sample and the program database were accounted for in all multivariate analyses through the control of the relevant variables.

A series of multiple regressions, logistic regressions, and analyses of covariance (ANCOVA) were conducted to identify statistically significant relationships between a variety of data points and key outcome variables related to key training outcomes and historical and current graduate employment in California's public behavioral health system after completion of MHSA service.

The design of the MHSA Stipend Program Retrospective Study data and the analysis of survey and program data were guided by key questions about program impact on trainees and identified workforce development goals. This report presents findings related to those eight key questions.

Key Questions

1. Did the MHSA Stipend Program achieve its recruitment goals in relation to racial/ethnic diversity, language fluency, and consumer experience among trainees?
2. Did the MHSA Stipend Program achieve its training goals in relation to statewide dispersion of training efforts and resources?
3. How do MHSA Stipend Program graduates assess the value and quality of their MHSA training, especially in relation to its fidelity to MHSA principles and practices?

4. How do MHSA Stipend Program graduates assess the impact of their MHSA training, especially in relation to employment in California's public behavioral health system?
5. After completing MHSA training and over time, are MHSA Stipend Program graduates committed to applying MHSA principles and practices to their work?
6. What do MHSA Stipend Program graduates' careers look like over time, in terms of their fields of practice, employment settings, professional roles, and pursuit of licensure?
7. Are MHSA Stipend Program graduates employed and retained in California's public behavioral health system after completing required MHSA service?
8. What factors best predict the employment and retention of MHSA Stipend Program graduates in California's public behavioral health system?

STUDY SAMPLE

MHSA Stipend Program Data

MHSA Stipend Program records provided the study team with baseline information essential to the design of the MHSA Retrospective Survey, the recruitment of study participants, and the analysis of survey data. Administrative program data provided demographic information about many trainees that included age, gender, race/ethnicity, language capacity, and lived consumer and/or family member experience, as well as sexual orientation, disability status, former foster youth status, and veteran status for trainees in later cohorts. Program data for individual graduates also included stipend year and amount, MSW program, enrollment type (part-time vs. full-time), field placement site, agency type and location, and service employment site, agency type, location, and graduation date.

Through the MHSA Stipend Program 2,373 advanced-year students at 22 MSW programs in California received specialized training and stipend support as members of 14 training cohorts between academic years 2005-06 and 2018-19. Of these 2373 trainees, 89.1% received stipends of $18,500 as full-time students while 10.9% received $9,250 as part-time students. Fully 99.2% of all trainees completed the MSW degree, yielding 2,353 program graduates from 14 training cohorts. MHSA Stipend Program graduate data presented here reflects all available program data about those 2,353 MHSA Stipend Program graduates, outlined in **Appendix A**.

MHSA trainees' mean age at entry into training was 30.7 years (SD = 8.0; range = 19–69). Consistent with MSW program enrollment, 81.4% of trainees identified as female, 17.8% as male, and 0.7% identified as genderqueer, transgender, or nonbinary. In addition, 83.3% identified as heterosexual, 16.2% as lesbian, gay, or bisexual, and 0.5% as questioning. Consistent with California's population, 38.3% identified as white, 33.1% as Latinx, 11.4% as Asian, and 8.9% as African-American. Fully 62% indicated they could provide services in at least one language other than English, with 72.9% of multilingual trainees fluent in Spanish. In addition, 26.8% identified as having lived experience as consumers of public behavioral health services and 48.6% identified as family members of consumers. Finally, 13.4% of trainees identified as visibly or invisibly disabled, 1.9% as former foster youth, and 1.8% as military veterans.

MHSA Retrospective Study Participant Data

Because of available program data, the study team was able to focus the survey design on items intended to gather follow-up information not previously collected from program graduates. Once survey data collection was complete, initial analysis focused on aligning administrative program data

with survey responses in order to verify time frames for participants' completion of MHSA training and MSW graduation. Through data cleaning, incomplete survey responses were eliminated from the dataset, which yielded a final survey dataset of 1,086 unique cases.

Summary and analysis of survey data presented in this report is based on this final study sample of 1,086 participants, which represents 46.2% of all MHSA Stipend Program graduates, and includes graduates of all 22 MSW programs. Because study timing did not enable recruitment of graduates from the final 2018-19 MHSA Stipend Program cohort, only 13 of 14 training cohorts are represented. Of these 1086 graduates, 90.8% received stipends of $18,500 as full-time students while 8.7% received $9,250 as part-time students, and all completed the MSW degree.

Survey participants' mean age when surveyed was 38.7 years (SD = 8.5; range = 25–75). Again, consistent with MSW program enrollment, 79.0% identified as female, 17.2% as male, and 1.9% as genderqueer, transgender, or nonbinary. In addition, 79.0% identified as heterosexual, 14.9% as lesbian, gay, or bisexual, and 0.5% as questioning. Also consistent with California's population, 38.2% of survey participants identified as white, 30.8% identified as Latinx, 12.2% as Asian/Asian-American, and 7.6% as African-American/Black/African. Fully 53.3% indicated they could provide services in at least one language other than English, with 70.7% of multilingual trainees fluent in Spanish. In addition, 23.9% identified as having lived experience as consumers of public behavioral health services and 49.2% identified as family members of consumers. Finally, 12.4% of survey participants identified as visibly or invisibly disabled, 2.3% as former foster youth, and 1.6% as military veterans.

73.4% of MHSA graduates earned their bachelor's degrees from UC and CSU campuses

The MHSA Retrospective Survey enabled the collection of data about MHSA graduates' pre-MSW educational, volunteer, and employment experiences never previously collected. Through these items, we learned that survey participants earned their bachelors' degrees between 1968 and 2017, with a mean of 5.9 years (SD = 5.0; range = 1–39) between earning that degree and the MSW. The majority (73.4%) earned their bachelor's degrees from campuses of either the California State University system or the University of California system, and another 10.6% graduated from private universities in California. Of note, 72.9% earned undergraduate degrees in fields other than social work or social welfare, with 79.3% earning a BA or BS degree, and only 20.0% earning a BSW or BASW.

When asked about their pre-MSW experiences in behavioral health settings, 39.2% of survey participants reported engaging in volunteer work, 28.5% reported completing undergraduate field training, and 53.7% reported paid employment in behavioral health settings, prior to pursuing the MSW. Overall, 39.7% had experience in one of these three domains, 34% had experience in two or three domains, and only 26.2% had no pre-MSW experience in behavioral health settings. Of note, those with pre-MSW behavioral health volunteer or internship experience typically reported experiences of less than one year's duration. However, among those with pre-MSW paid behavioral health employment, 60.3% reported employment durations of one to four years and 26.7% reported employment duration of more than four years.

Most MHSA graduates were full-time students focused on Mental/Behavioral Health

The MHSA Retrospective Survey also enabled the collection of data about MHSA graduates' MSW studies not previously collected. This data revealed that among the 1086 survey participants, 83.9% completed full-time MSW programs, 10.9% completed part-time MSW programs, and 5.3% completed advanced standing MSW programs. As highlighted in **Figure 1**, 69.5% of participants identified their advanced-year specialization area as Mental Health, Behavioral Health, or Integrated Behavioral Health and 10.6% reported focusing on generalist practice, indicating their MSW programs did not offer advanced-year specializations. The remaining 19.9% identified a variety of advanced-year specializations through which they completed MHSA requirements for advanced-year coursework, seminars, and field training.

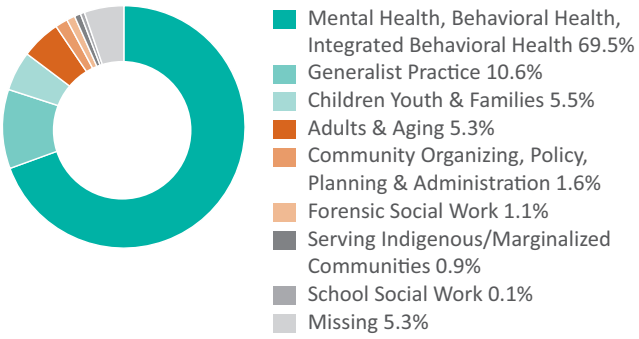


Figure 1 | MSW Options/Tracks/Concentrations (N=1028)

Table 1 | MHSA Stipend Program Graduates (N=2353) and MHSA Retrospective Survey Participants (N=1086) by Training Cohort

MHSA Training Cohort	MHSA Program Graduates Frequency (%)	Survey Participants Frequency (%)	MHSA Program Graduates in Survey Sample (%)
2005/2006	172 (7.3%)	41 (3.9%)	23.8%
2006/2007	182 (7.7%)	55 (5.1%)	30.2%
2007/2008	184 (7.8%)	61 (5.6%)	33.2%
2008/2009	182 (7.7%)	72 (6.6%)	39.6%
2009/2010	180 (7.6%)	60 (5.5%)	33.3%
2010/2011	196 (8.3%)	72 (6.6%)	36.7%
2011/2012	188 (8.0%)	78 (7.2%)	41.5%
2012/2013	196 (8.3%)	104 (9.6%)	53.1%
2013/2014	192 (8.2%)	117 (10.8%)	60.9%
2014/2015	143 (6.1%)	101 (9.3%)	70.6%
2015/2016	156 (6.6%)	95 (8.8%)	60.9%
2016/2017	150 (6.4%)	119 (11.0%)	79.3%
2017/2018	149 (6.3%)	111 (10.2%)	74.5%
2018/2019	83 (3.5%)	0 (0%)	0%
Total	**2353 (100%)**	**1086 (100%)**	**100%**

Comparison of MHSA Stipend Program Data and MHSA Survey Participant Data

As outlined in **Table 1**, comparison of the MHSA Stipend Program database and MHSA Retrospective Survey data reveals that, with the exception of the 2018-19 training cohort that was not included in study recruitment efforts, more recent training cohorts (2012-13 through 2017-18) are better represented in the study sample than earlier ones (2005-06 through 2011-12). These two factors created a somewhat different distribution of training cohorts in the study sample as compared to the program database.

Some significant differences between program data and survey data were identified in relation to MSW program representation. As seen in **Table 2**, for the most part, between 40% and 60% of the graduates of each participating MSW programs are included in the study sample. However, one MSW program (California State University Northridge) is overrepresented in the study sample, most likely because its participation in the MHSA Stipend Program did not begin until academic year 2012-13 and thus all of its graduates are concentrated in the later training cohorts that are better represented in the study sample.

In addition, three MSW programs are under-represented in the study sample. Most notably, as seen in **Table 2**, graduates from two of the larger

MSW programs in California's central region, Fresno State University and Sacramento State University, are significantly underrepresented in the study sample. This reflects the greater difficulty recruiting survey participants from those MSW programs, which is likely due to the greater number of years elapsed since those MSW programs participated in the MHSA Stipend Program and the related reduced availability of current and complete program records.

This is significant because the underrepresentation of graduates from these specific MSW programs in the study sample means that the sample also includes significantly smaller numbers of graduates who completed field training and MHSA service in California's central region, as compared to program data. Specifically, while 13.5% of all MHSA Stipend Program trainees completed field training in the Central region, only 9.0% of survey participants did so. Similarly, while 12.5% of MHSA Stipend Program graduates' service episodes were completed in the Central region, only 9.4% of survey participants' service episodes were completed in that region.

Chi square analysis confirmed that graduates who completed field training in the central region appear to be significantly underrepresented in the study sample as compared to MHSA Stipend Program data (X^2 [2, 1086] = 21.182, $p < .001$), as do graduates whose service episodes were completed in the central region (X^2 [2, 1264] = 12.419, $p = .014$).

Finally, **Appendix B** presents a comparison of some key characteristics of MHSA Stipend Program graduates and study participants. Chi square analysis also revealed a few significant areas of variance between individual characteristics. For example, genderqueer/nonbinary graduates appear to be overrepresented in the study sample as compared to all MHSA graduates (X^2 [2, 1062] = 12.366, $p = .002$). Graduates with lived experience as consumers of public behavioral health services appear to be underrepresented in the study sample as compared to all MHSA graduates (X^2 [2, 1086] = 11.734,

Table 2 | MHSA Stipend Programs Graduates (N=2353) and MHSA Retrospective Survey Participants (N=1086) by MSW Program

MSW Programs	MHSA Program Graduates Frequency (%)	Survey Participants Frequency (%)	MHSA Program Graduates in Survey Sample (%)
CSU Bakersfield	74 (3.1%)	34 (3.1%)	45.9%
CSU Chico	117 (5.0%)	54 (5.0%)	46.2%
CSU Dominguez Hills	40 (1.7%)	24 (2.2%)	60.0%
CSU East Bay	166 (7.1%)	81 (7.5%)	48.8%
CSU Fullerton	51 (2.2%)	25 (2.3%)	49.0%
CSU Long Beach	200 (8.5%)	104 (9.6%)	52.0%
CSU Los Angeles	98 (4.2%)	42 (3.9%)	42.9%
CSU Monterey Bay	41 (1.7%)	21 (1.9%)	51.2%
CSU Northridge	36 (1.5%)	26 (2.4%)	72.2%
CSU San Bernardino	170 (7.2%)	71 (6.5%)	41.8%
CSU San Marcos	24 (1.0%)	12 (1.1%)	50.0%
CSU Stanislaus	60 (2.5%)	31 (2.9%)	51.7%
Fresno State University	80 (3.4%)	19 (1.8%)	23.8%
Humboldt State University	79 (3.4%)	38 (3.5%)	48.1%
Loma Linda University	109 (4.6%)	41 (3.8%)	37.6%
Sacramento State University	163 (6.9%)	43 (4.0%)	26.4%
San Diego State University	172 (7.3%)	95 (8.8%)	55.2%
San Francisco State University	119 (5.1%)	48 (4.4%)	40.3%
San Jose State University	97 (4.1%)	44 (4.1%)	45.4%
UC Berkeley	132 (5.6%)	67 (6.2%)	50.8%
UC Los Angeles	123 (5.2%)	74 (6.8%)	60.2%
University of Southern California	202 (8.6%)	92 (8.5%)	45.5%
Total	**2353 (100%)**	**1086 (100%)**	**100%**

p = .003). Graduates who reported speaking English only appear to be overrepresented in the sample as compared to all MHSA graduates (X^2 [2, 1086] = 36.663, p < .001). These differences were all carefully controlled for in multivariate analyses.

ACHIEVEMENT OF TRAINEE RECRUITMENT GOALS

MHSA graduates are more racially diverse than the existing MSW workforce in California

The MHSA Stipend Program sought to recruit and train MSW students who reflected California's racial and ethnic diversity better than the existing MSW workforce. As highlighted in **Figure 2**, 38.3% of MHSA Stipend Program graduates identified as white, 33.1% as Latinx, 11.4% as Asian, 8.9% as African-American, and 8.3 % as multiracial or other ethnicities. As such, program data confirms that MHSA Stipend Program graduates reflect California's racial/ethnic diversity and bring significant diversity to the provision of public behavioral health services in California.

62% of MHSA graduates are able to provide services in languages other than English

The MHSA Stipend Program also sought to recruit and train MSW students who were able to provide behavioral health services in high demand languages other than English. Again, program data suggests that MHSA graduates bring significant linguistic diversity to their work in California's public behavioral health system. As shown in **Figure 3**, 62.0% of MHSA Stipend Program graduates reported being able to provide services in at least one language other than English. In total, 45.2% reported fluency in Spanish and 16.8% reported fluency in non-English languages other than Spanish. As shown in **Figure 4**, among program graduates fluent in languages other than English, the most common second languages were those spoken by significant numbers of consumers in the public behavioral health system in various parts of the state, including Spanish, Vietnamese, French, Mandarin, and Cantonese.

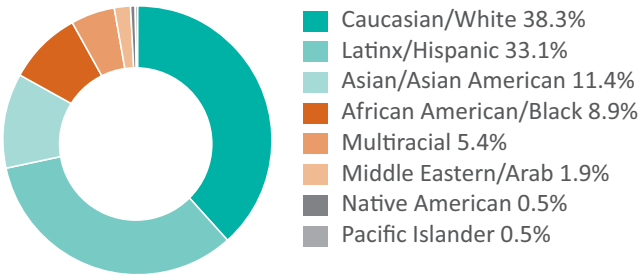


Figure 2 | Race/Ethnicity of MHSA Stipend Program Graduates (N=2124)

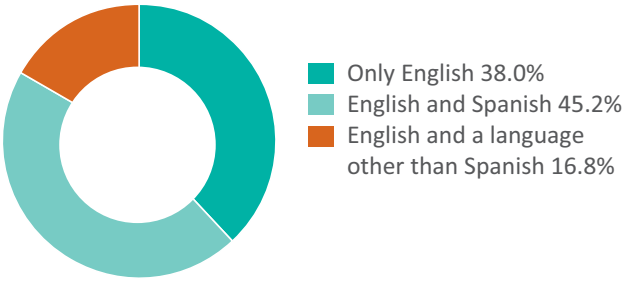


Figure 3 | Language Fluency among MHSA Stipend Program Graduates (N=1863)

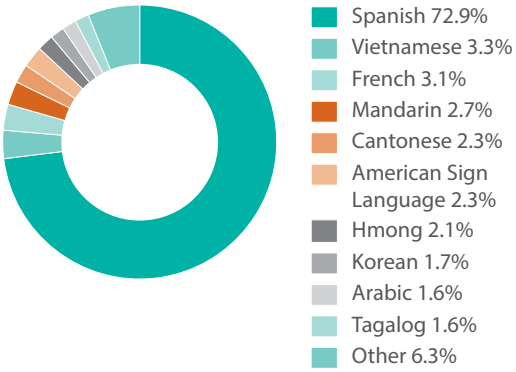


Figure 4 | Second Languages among MHSA Stipend Program Graduates (N=1155)

Most MHSA graduates have lived experience with public behavioral health services

Finally, the MHSA Stipend Program sought to recruit and train greater numbers of MSW students with lived experience as consumers of public behavioral

health services and/or as family members of consumers. Once again, MHSA graduates appear to bring significant levels of lived experience to their work in California's public behavioral health system. As highlighted in **Figure 5**, program data shows that 7.3% of MHSA graduates reported lived experience as consumers, 29.1% reported lived experience as family members of consumers, and 19.5% reported both. In total, 55.9% of MHSA graduates reported some sort of lived experience in the public behavioral health system (as consumers, family members of consumers, or both) and only 44.1% reported no such lived experience at all.

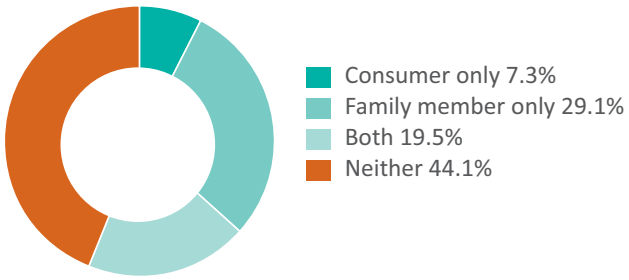


Figure 5 | Lived Experience as Behavioral Health Consumers/Family Members (N=1350)

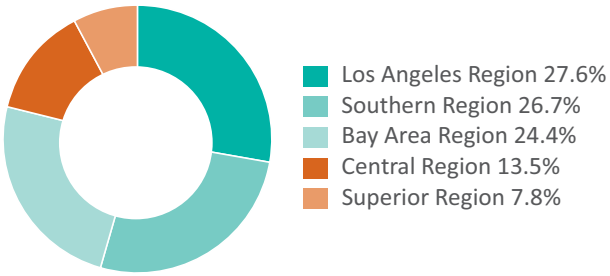


Figure 6 | MHSA Field Training Sites by Service Region (N=2299)

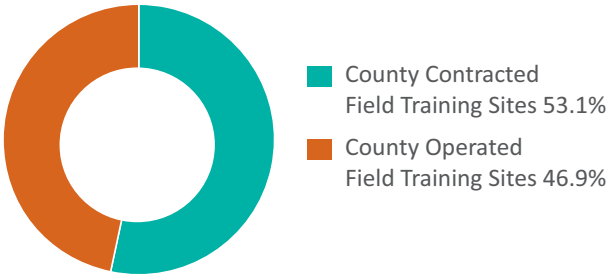


Figure 7 | MHSA Field Training Sites by Agency Type (N=2297)

ACHIEVEMENT OF GOALS FOR GEOGRAPHIC DISPERSION OF EFFORTS AND RESOURCES

MHSA trainees completed field training at public behavioral health sites across CA

MHSA Stipend Program administration and planning were structured around the goal of ensuring statewide distribution of training efforts and resources. MHSA Stipend Program data indicates that across 14 program years, MHSA graduates completed field training in public behavioral health service sites in all five of California's behavioral health service regions and in 50 of its 59 city/county behavioral health systems. As highlighted in **Figure 6**, of 2299 MHSA Stipend Program graduates with complete field training records, 27.6% completed field training in the Los Angeles region, 26.7% in the Southern region, 24.4% in the Bay Area region, 13.5% in the Central region, and 7.8% in the Superior region. As highlighted in **Figure 7**, 53.1% MHSA Stipend Program graduates completed field training at county-contracted sites and 46.9% completed training at county-operated sites.

Data outlining the field training locations and site types for all MHSA Stipend Program graduates is provided in **Appendix C**, and data outlining the field training locations and site types for all MHSA Retrospective Survey participants is provided in **Appendix D**.

MHSA trainees completed field training in Central and Superior region target counties

In program years 2014-15 through 2018-19, OSHPD established additional goals for the geographic dispersion of training efforts to specific counties.

CalSWEC and participating MSW programs together made best efforts to ensure that 15% of MHSA trainees completed field training at sites in target counties, identified as having the most dire shortages of MSWs. The identified counties were largely rural and mostly located in California's Central and Superior service regions. As shown in **Appendix E**, 39 target counties were identified for program years 2014-15 and 2015-16 and 41 were identified for program years 2016-17 through 2018-19.

MHSA Stipend Program data for all program years (2005-06 through 2018-19) reveals that 13.4% of all MHSA trainees completed field training in OSHPD-identified target counties and 14.7% of all MHSA graduates provided MHSA service in these counties. Program data also reveals that between 2014-15 and 2018-19, the OSHPD-administered program years during which target goals for trainee disbursement were in effect, 10.6% of MHSA trainees completed field training in these target counties and 14.1% of MHSA graduates provided MHSA service in these counties.

Of note, between 2005-06 and 2013-14, there were only five counties in which no MHSA trainees completed field training or MHSA service. These were Alpine, Inyo, Mono, and Tuolumne Counties in the Central region and Trinity county in the Superior region. However, during the five OSHPD-administered program years, there were 14 target counties in which no MHSA trainees completed field training or MHSA service. These include Alpine, Amador, Calaveras, Inyo, Kings, Madera, Mariposa, Mono, and Tuolumne Counties in the Central region, Lassen, Modoc, Sierra, and Trinity Counties in the Superior region, and Solano County. The reduced program footprint from 2014-15 forward appears to reflect the non-participation of key Central region MSW programs after changes to the program contract.

GRADUATE FULFILLMENT OF THE MHSA SERVICE OBLIGATION

93.8% of MHSA graduates fulfilled the MHSA service obligation after graduation

The service obligation associated with the MHSA Stipend Program required graduates to secure MSW positions in California's public behavioral health system within 180 days of graduation and complete the equivalent of either 12 months (for stipends of $18,500) or six months (for stipends of $9,250) of full-time service in eligible positions. Available program data indicates that 93.8% of MHSA Stipend Program graduates fulfilled some or all of the MHSA service obligation through paid or volunteer service. Survey data indicates that at the point of survey completion, 96.5% of survey participants had fulfilled at least some of their required service, 78.2% at a single site, 16.5% at two sites, and 1.8% at three sites.

Only 3.5% of survey participants had no history of paid or volunteer MHSA service. Among those graduates, 64.5% reported that they had applied for positions in the public behavioral health system but were either never interviewed or never offered positions. Among those who had not completed any service, the most common reasons provided were (1) that it was too difficult to find a position in a preferred location, (2) that it was too difficult to find a position in any location, and (3) that salaries for eligible positions were too low. In addition, 5.4% of participants had engaged in cash repayment of stipend funding for at least some period of time, although over half of those graduates had also completed some paid or volunteer service.

MHSA graduates completed MHSA service at public behavioral health sites across CA

It was also a goal of the MHSA Stipend Program to encourage the completion and statewide geographic

distribution of MHSA graduates' required service. MHSA program data indicates that after earning the MSW degree, MHSA graduates completed MHSA service in public behavioral health agencies and contract sites across the state. MHSA graduates completed 2582 episodes of paid and volunteer service in all five of California's behavioral health service regions and 54 of its 59 city/county behavioral health systems. As highlighted in **Figure 8**, of 2582 episodes of MHSA service, 30.3% were completed in the Los Angeles region, 25.2% in the Bay Area region, 23.7% in the Southern region, 12.5% in the Central region, and 8.3% in the Superior region. As highlighted in **Figure 9**, 68.9% of documented service episodes occurred at county-contracted sites and 31.1% occurred at county-operated sites.

Data outlining the service employment locations and site types for all MHSA Stipend Program graduates is provided in **Appendix F**, and data outlining the service employment locations and site types for MHSA Retrospective Survey participants is provided in **Appendix G**.

GRADUATE ASSESSMENTS OF MHSA TRAINING EXPERIENCES

MHSA graduates assign high value to most core components of MHSA training

The MHSA Retrospective Survey provided a unique opportunity to learn more about MHSA Stipend Program graduates' perspectives on their MHSA training experiences. By design, MHSA training involved specialized field training and supervision, advanced-year coursework, stipend program-specific seminars and colloquia, and specialized guest speakers, symposia, events, agency visits, immersions, and community projects focused on the use of the recovery model in service delivery.

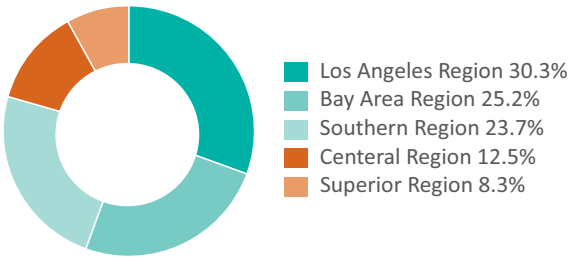


Figure 8 | MHSA Service Obligation Employment Episodes by Service Region (N=2582)

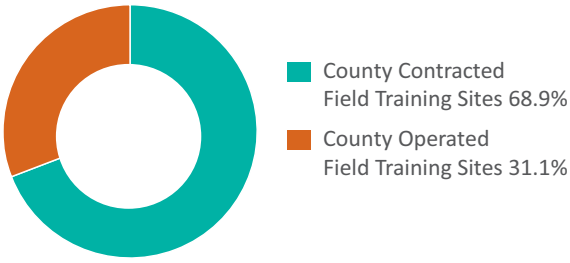


Figure 9 | MHSA Service Obligation Employment Episodes by Agency Type (N=2562)

As such, MHSA survey participants were asked to assess the value of each component of their MHSA training in relation to several points.

The training component endorsed most enthusiastically by survey participants was specialized field training and supervision in public behavioral health settings, which 82.5% of survey participants identified as very or extremely valuable. In addition, 67.7% of survey participants endorsed the specialized coursework required for MHSA trainees as very or extremely valuable, and 66.7% endorsed agency visits, immersions, and community projects focused on behavioral health as very or extremely valuable. Finally, 63.8% endorsed the specialized seminars and colloquia required of MHSA trainees as very or extremely valuable, and 63.8% endorsed guest speakers, symposia, and events focused on behavioral health as very or extremely valuable.

Graduates report MHSA training effectively emphasized core MHSA principles and practices

MHSA training was intended to help reshape California's public behavioral health workforce and service delivery system by emphasizing the application of core MHSA principles and practices to service delivery. As such, survey participants were asked to assess the degree to which their MHSA training did, in fact, emphasize core MHSA principles and practices. The majority of survey participants reported that their MHSA training significantly or extensively emphasized all of the identified foci.

Fully 87.4% reported that their training significantly or extensively emphasized wellness, recovery and resilience in service delivery, 86.7% reported the same degree of emphasis on the importance of racial, ethnic, and cultural diversity among providers, and 86.6% reported the same degree of emphasis on the importance of racial, ethnic, and cultural, competence among providers. In addition, 84.1% reported that their training significantly or extensively emphasized the use of the recovery model in behavioral health care, 83.3% reported significant or extensive emphasis on the importance of consumer and family input into service plans and interventions, 79.4% reported significant or extensive emphasis on the importance of consumer and family member participation as service providers, and 75.8% reported significant or extensive emphasis on the importance of linguistic diversity among providers.

Graduates described MHSA training as solid preparation for only some aspects of practice

The need to prepare trainees for real-life practice in the public behavioral health system was also central to the design of MHSA training. However, when asked about the degree to which MHSA training prepared them for practice in public behavioral health settings, survey participants' responses were somewhat mixed. Most reported that MHSA training prepared them well for key aspects of clinical practice in the public system, including 78.5% who felt well prepared to address legal and ethical challenges, 77.8% who felt well prepared to engage in clinical interventions, 68.9% who felt well prepared for case management duties, and 68.8% who felt well prepared to manage documentation requirements. However, only 58.4% of survey participants felt well prepared for the self-care required to work in the public system, and only 58.2% reported feeling well prepared for team leadership and/or management responsibilities.

GRADUATE ASSESSMENTS OF MHSA TRAINING IMPACT

75% of graduates say MHSA training motivated them to seek public behavioral health positions

A central goal of the MHSA Stipend Program was to increase the numbers of new MSWs joining the public behavioral health workforce. This survey data clearly suggests that participation in the MHSA Stipend Program served as a significant motivator for trainees to pursue employment in the public behavioral health system after earning the MSW. Fully 75.0% of participants reported that receiving the MHSA Stipend was an extremely strong motivator for them to pursue such employment. In addition, only 28.7% reported that they would have been extremely likely to pursue such employment had they not completed MHSA training. Thus, it seems likely that without the MHSA Stipend Program, far fewer of these individuals would have entered positions in the public system after graduation.

63.8% of graduates say MHSA training helped them secure public behavioral health positions

Because of this overarching goal, it was also hoped that participation in the MHSA Stipend Program would assist graduates in securing positions in the public behavioral health system after graduation. Survey responses about the transition from MHSA training to MHSA service were mixed. 63.8% of survey participants indicated that being an MHSA Stipend Program graduate was very or extremely helpful to them in securing such employment. However, only 46.2% indicated that their MSW programs offered significant levels of support for these efforts, and qualitative data suggest that there may be a great deal of variation among various MSW programs' practices and resources for supporting graduate employment searches.

GRADUATE CAREER TRAJECTORIES

94.9% of MHSA graduates worked as MSWs after completing MHSA training and service

The MHSA Retrospective Survey also provided a unique opportunity to learn more about MHSA Stipend Program graduates' career trajectories after completing MHSA service. On average, survey participants had earned the MSW degree 6.0 years prior to being surveyed (SD = 3.6; range = 0–13) and 94.9% reported some history of social work employment since earning an MSW. As highlighted in **Table 3**, those participants had been employed as social workers for an average of 5.3 years since degree completion (SD = 3.4; range = 0.3–13).

80.1% of graduates practiced in public behavioral health agencies after MHSA service

With regard to professional setting, the MSW employment histories provided by survey participants were dominated by work in public behavioral health settings. Indeed, these MHSA graduates were more likely to have worked in public behavioral health than in any other type of service setting. Since completing the MSW degree, 80.1% had worked in publicly funded behavioral health settings and 42.2% had worked in private non-profit, religious, for profit, and university-based behavioral health settings. Only 14.1% had ever worked in private non-profit, religious, for profit, and university-based social work settings focused on practice areas other than behavioral health and only 13.5% had ever worked in publicly funded social work settings focused on areas other than behavioral health.

Table 3 | Years of MSW Employment by MSW Graduation Year (N=1031)

Graduation Year	N	Mean (SD)
2006	40	10.6 (3.2)
2007	53	10.9 (2.3)
2008	62	9.4 (2.0)
2009	70	9.0 (1.6)
2010	61	7.7 (1.8)
2011	68	7.2 (0.8)
2012	77	6.0 (1.1)
2013	103	5.2 (0.8)
2014	116	4.2 (0.7)
2015	98	3.3 (0.6)
2016	95	2.3 (0.5)
2017	107	1.3 (0.4)
2018	81	1.0 (0.1)
Total	**1031**	**5.3 (3.4)**

As highlighted in **Figure 10**, survey participants reported average of 4.4 years of MSW employment in public behavioral health settings, more time than in any other setting type.

78.4% of graduates provided clinical care in public behavioral health after MHSA service

Similarly, survey participants were more likely to have provided clinical services in public behavioral health settings than to have performed any other

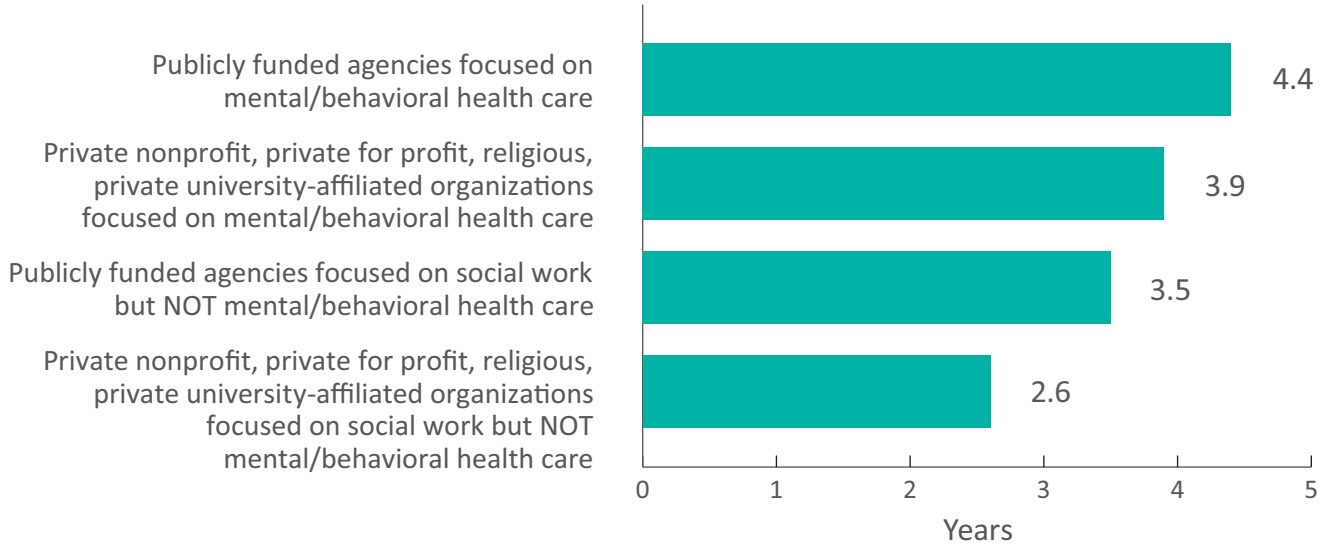


Figure 10 | Mean Years of MSW Employment in Specified Service Settings (N=1086)

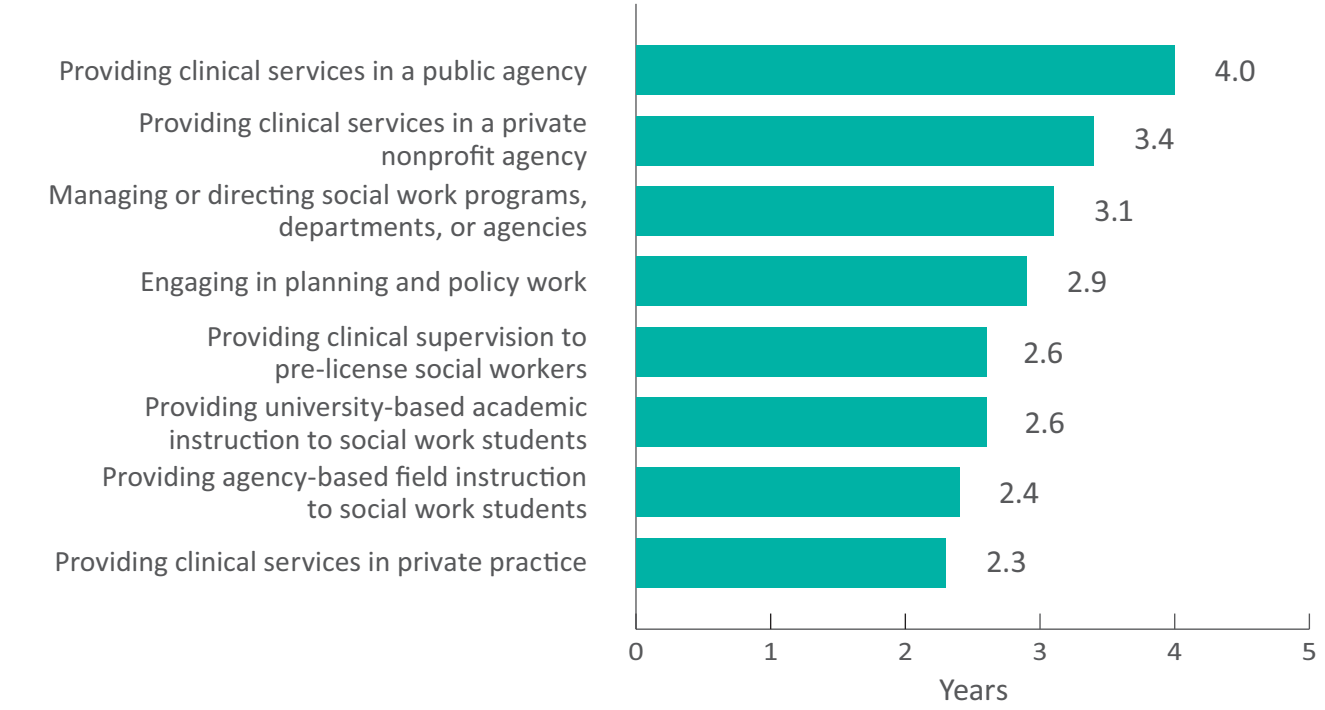


Figure 11 | Mean Years of MSW Employment in Specified Professional Roles (N=1086)

professional role as MSWs. Since completing the MSW degree, 78.4% had provided clinical services in public behavioral health settings, 46.9% had provided clinical services in private nonprofit agencies, and 22.8% had managed or directed social work programs, departments, or agencies, while only 12.5% had provided clinical services in private practice. As highlighted in **Figure 11**, survey participants reported an average of 4.0 years spent providing clinical services in public agencies since graduation, more time than in any other professional role.

97% of MHSA graduates pursued or planned to pursue LCSW licensure in California

Social work licensure is an important credential that enables social workers to contribute to the development of the next generation of social workers by providing field supervision to MSW students, clinical supervision to MSWs seeking licensure, and teaching direct practice classes in MSW programs. MSHA trainees were uniformly encouraged to pursue clinical social work licensure after graduation and survey participants appear to have largely committed to doing so.

At the time of survey completion, 54.6% of survey participants reported having already obtained clinical social work licensure, 38.0% reported that they were currently actively pursuing licensure (completing supervised clinical hours), and 4.4% reported that they had plans or intentions to pursue licensure in the future. In sum, only 3.0% reported that they had no current plans or intentions to pursue licensure. Of those already licensed, 96.1% reported being licensed in California and 3.9% reported being licensed in other states.

MHSA graduates make a variety of professional contributions to the field of social work

Of note, many survey participants also reported fulfilling roles that involved making professional contributions to the field of social work beyond the scope of direct practice. Notably, 30.4% reported providing agency-based field instruction to MSW students, 17.4% reported providing clinical supervision to MSWs in pursuit of LCSW licensure, 17.3% reported engaging in policy and planning work related to social work practice, and 5.2% reported providing university-based academic instruction to social work students.

GRADUATE COMMITMENT TO THE RECOVERY MODEL AND OTHER MHSA PRINCIPLES AND PRACTICES

Trainee commitment to the recovery model increased significantly during MHSA training

MSW programs clearly played the most influential role in helping MHSA Stipend Program achieve its core training goals. Arguably, the most ambitious of those goals was to shape MSW graduates who would enter California's public behavioral health system trained in and committed to applying the recovery model and other core MHSA principles and practices to their work in that system. Program applicants' commitment to MHSA principles and practices was prioritized during selection, and emphasized and encouraged during all aspects of MHSA training. As such, survey participants were asked to reflect on their level of commitment to the recovery model and other core MHSA principles and practices when they applied to the program, when they completed the MHSA training, and on the day they completed the retrospective survey.

At highlighted in **Figure 12**, survey data reveals that participants entered MHSA training with high levels

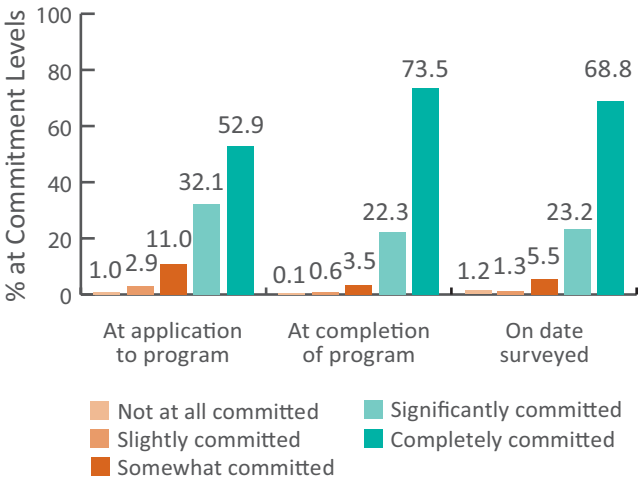


Figure 12 | MHSA Retrospective Study Participant Levels of Commitment to MHSA Principles and Practices (N = 1086)

of commitment to MHSA principles and practices; 85.0% described themselves as very or extremely committed to these principles when they applied to the MHSA Stipend Program. A paired-samples T-test conducted to compare self-reported levels of commitment to MHSA principles and practices at application to the stipend program versus after completing it, however, revealed a significant difference in commitment levels before MHSA training (M = 3.33, SD = .860) and after training (M = 3.69, SD = .574), indicating that this commitment was strengthened significantly during MHSA training; t (1083) = -16.013, $p < .001$.

Survey data also indicates that participants' increased levels of commitment to MHSA principles and practices are sustained after training completion, at least up to the date of survey completion, which was an average of 6.0 years (SD = 3.6; range = 0–13) later for survey participants. Another paired-samples T-test was conducted to compare self-reported levels of commitment to MHSA principles and practices when applying to the MHSA Stipend Program and on the day of survey completion. It revealed a significant difference in commitment levels before MHSA training (M = 3.33, SD = .860) and at survey completion (M = 3.57, SD = .760), suggesting that a significant increase in commitment was sustained for some period of time after MSW graduation and the completion of MHSA training; t (1084) = -8.367, $p < .001$.

Training factors predict increased and sustained commitment to MHSA principles and practices

In order to explore what factors might predict survey participants' increased levels of commitment to MHSA principles and practices and the sustenance of those increases over time, the study team sought to measure the influence of a variety of training-related variables on those outcomes through hierarchical multiple regressions.

The model for training-related predictors of survey participants' increased levels of commitment to MHSA principles and practices between application to and completion of the MHSA Stipend Program was significant overall ($R^2_{change} = .16$, F_{change} (7, 1061) = 29.42, $p < .001$). The most influential training factor was the perceived degree to which MHSA training emphasized wellness, recovery, and resilience in service delivery, for which a single unit of increase yielded a .16 increase in level of commitment to MHSA principles and practices at the end of training.

The second most influential training factor was the perceived degree to which MHSA training emphasized the use of the recovery model in practice, for which a single unit of increase yielded a .12 increase in level of commitment to MHSA principles and practices at the end of training.

The model for training-related predictors of survey participants' increased levels of commitment to MHSA principles and practices between application to the MHSA Stipend Program and date of survey completion was also significant overall ($R^2_{change} = .12$, F_{change} (7, 1061) = 18.39, $p < .001$). In this model, too, the most influential training factor was the perceived degree to which MHSA training emphasized wellness, recovery, and resilience in service delivery, for which a single unit of increase yielded a .16 increase in level of commitment at survey date.

The second most influential training factor was the perceived degree to which MHSA training emphasized the use of the recovery model in practice, for which a single unit of increase yielded a .14 increase in level of commitment at survey date. In addition, a single unit of increase in perceived training emphasis on linguistic diversity yielded a .13 increase in level of commitment to MHSA principles and practices at survey date.

Table 4 | Years of Post MHSA Service Obligation Employment in Public Behavioral Health System by Graduation Year (N = 964)

MSW Graduation Year	Number of Graduates	Graduates Employed in Public System Since Service Completion	Mean Years Post Service Public System Employment	Graduates Currently Employed in Public System
2006	40	34 (85.0%)	7.1 (4.2)	11 (27.5%)
2007	55	51 (92.7%)	8.1 (3.2)	28 (50.9%)
2008	62	61 (98.4%)	6.7 (3.1)	23 (37.1%)
2009	71	62 (87.3%)	6.4 (2.6)	28 (39.4%)
2010	61	53 (86.9%)	6.0 (1.8)	28 (45.9%)
2011	70	63(90.0%)	5.2 (1.6)	28 (40.0%)
2012	77	69 (89.6%)	4.1 (1.7)	29 (37.7%)
2013	104	98 (94.2%)	3.7 (1.0)	57 (54.8%)
2014	118	107 (90.7%)	2.8 (1.0)	71 (60.2%)
2015	98	90 (91.8%)	2.0 (0.8)	66 (67.3%)
2016	96	91 (94.8%)	1.3 (0.5)	74 (77.1%)
2017	91	87 (95.6%)	0.4 (0.4)	77 (84.6%)
2018	21	17 (81.0%)	0.1 (0.1)	16 (76.2%)
Total	**964**	**883 (91.6%)**	**4.1 (2.9)**	**536 (55.6%)**

GRADUATE EMPLOYMENT AND RETENTION IN PUBLIC BEHAVIORAL HEALTH AFTER MHSA SERVICE

91.6% of graduates surveyed kept working in the public system after completing MHSA service

The most concrete workforce development goal of the MHSA Stipend Program was undoubtedly to train MSW students who would make significant ongoing contributions to service provision in California's public behavioral health system through sustained employment in that system. Of the 1086 survey participants included in this analysis, 964 had completed the MHSA service obligation prior to completing the survey, and thus were able to provide data about employment after completion of MHSA service. As highlighted in **Table 4**, 91.6% of these graduates reported employment in California's public behavioral health system after completion of MHSA service.

Graduates work in public behavioral health an average of 4.1 years after MHSA service

The 964 graduates who completed the MHSA service prior to survey participation completed the MSW degree an average of 6.6 years (SD = 3.3; range = 1–13) prior to being surveyed. Thus, at survey completion they had a potential MSW employment history of between 5.1 and 5.6 years after completing MHSA service. On average, these graduates reported having been employed in California's public behavioral health system for 4.1 years (SD = 2.9; range = 0.1–12) after the completion of MHSA service.

Up to 13 years later, 55.6% of MHSA graduates still work in the public behavioral health system

As highlighted in **Table 4**, the duration of post-service employment in California's public behavioral health system was directly linked to MSW graduation year. But in the aggregate this data suggests that between 73.2% and 80.4% of all possible months of MSW employment after the completion of MHSA service included employment in the public system. Even more encouraging, up to 13 years post MSW graduation, 55.6% of these MHSA graduates

reported that they were currently employed in California's public behavioral health system.

MHSA graduates are employed in public behavioral health systems throughout the state

Although not an identified MHSA Stipend Program goal, the study team also examined whether or not MHSA graduates' post-MHSA service employment in California's public behavioral health system appeared to have statewide impact. The 91.6% of eligible survey participants who reported MSW employment in the public system after completing MHSA service reported 915 discrete episodes of public employment. As highlighted in **Figure 13**, these employment episodes occurred in all five of California's behavioral health service regions and included employment in 43 of California's 59 city/county behavioral health systems. As highlighted in **Figure 14**, 54.9% of these post-MHSA service employment episodes took place in county-contracted sites, while 45.1% of them took place in county-operated sites.

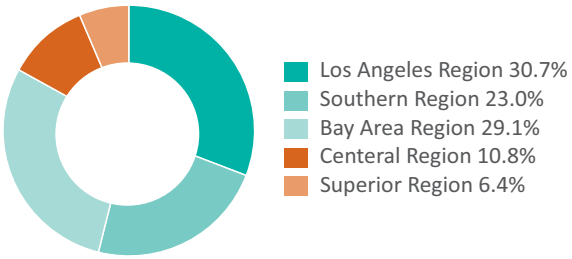


Figure 13 | Post Service Obligation Public Employment Episodes by Service Region (N=915)

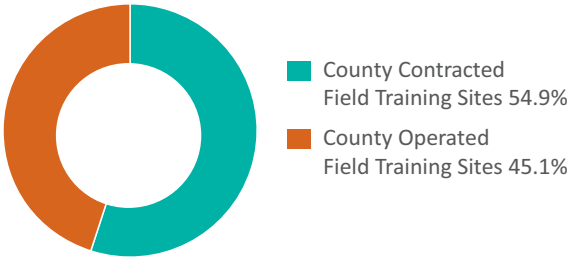


Figure 14 | Post Service Obligation Public Employment Episodes by Agency Type (N=915)

GRADUATE MOTIVATIONS FOR EMPLOYMENT IN PUBLIC BEHAVIORAL HEALTH SETTINGS

In order to understand how to maximize the effect of the MHSA Stipend Program on workforce development goals, it is critical to gain greater insight into MHSA graduates' motivations to work in the field of public behavioral health and in specific positions within that field. As such, survey participants who reported employment in the public behavioral health system after completing MHSA service were asked to identify their key motivators for remaining in and for leaving public behavioral health as a field of practice. They were also asked to identify their reasons for leaving their most recent former positions in that system, even if they continued to work in the public behavioral health field after leaving those positions.

Graduates named intrinsic and interpersonal factors as motivators to remain in public service

Survey participants most frequently identified six factors as their strongest motivators to remain in public behavioral health as a field of practice. Of note, these factors all focus on intrinsic or individual drives and preferences and on interpersonal dynamics and relationships in the workplace, only some of which can be effectively modified by employers. First and foremost, 85.3% identified the mission or meaning of their work as a strong motivator to remain in the field, while 76.7% identified relationships with colleagues and 74.1% identified their pursuit of clinical licensure. In addition, 73.9% identified their level of personal satisfaction with their work, 69.2% identified the quality of their professional colleagues, and 60.7% identified the quality of their supervision.

Graduates identified workplace factors as their primary motivators to leave public service

Survey participants also identified five factors most consistently as their strongest motivators to leave public behavioral health as a field. Of note, all of these factors focus on more structural, workplace-driven issues and dynamics that, unlike intrinsic motivations, can be effectively modified by employers. Heading this list, 59.4% identified their strongest motivator to leave the field as general stress levels, 54.9% identified the amount of paperwork required, and 52.3% identified general productivity demands. Finally, 45.4% identified the sizes of their caseloads and 41.6% identified their salary levels.

Graduates identified workplace factors as their primary motivators to leave specific positions

Similarly, survey participants most frequently identified more structural, workplace-driven factors as their strongest motivators to leave their most recent former positions in the public behavioral health system. In this instance, these graduates identified six motivators most frequently: Heading the list, 43.5% identified salary level as a motivator to leave their most recent public behavioral health position, 43.4% identified general stress level, and 35.0% identified overall agency climate or culture. In addition, 34.1% identified general productivity demands, 32.7% identified (lack of) available opportunities for career advancement, and 31.6% identified the amount of paperwork required.

PREDICTORS OF MHSA GRADUATE RETENTION IN CALIFORNIA'S PUBLIC BEHAVIORAL HEALTH SYSTEM

In order to explore actual predictors of the employment and retention of MHSA graduates in California's public behavioral health system, the study team sought to verify the measurable influence of survey participants' self-reported motivators in relation to three key outcomes; (1) any post-MHSA service employment in the public behavioral health system, (2) current post-MHSA service employment in the public behavioral health system, (3) duration of post-MHSA service employment in the public behavioral health system. To examine these relationships, multiple hierarchical logistic regressions were conducted on all motivation variables. These regressions revealed that the actual influence of many motivators identified by survey participants on the key outcomes differs significantly from their perceived influence.

Graduates motivated by salary were 6.18 times more likely to have been employed post service

First, this analysis revealed that survey participants' likelihood of ever having been employed in the public behavioral health system after completing MHSA service was most strongly predicted by motivation related to a single workplace factor: salary. Those who identified salary as a motivator to stay in the field were 6.18 times more likely to have been employed in California's public behavioral health system since completing MHSA service than those who did not ($\beta = 1.821$, $p = .023$).

Graduates driven by personal satisfaction were 3.3 times more likely to be currently employed

The strongest predictor of survey participants' being employed in the public behavioral health system at the point of being surveyed, however, was an intrinsic motivation: Those who identified their level of personal satisfaction with their work as a motivator to stay in the field of public behavioral health were 3.3 times more likely to be employed in the public system when surveyed that those who did not ($\beta = 1.183$, $p = .001$).

Other reported motivations that significantly predicted current employment in the public behavioral health system related to concrete

workplace factors: Participants motivated by work-related travel requirements (indicating a desire to minimize travel) were 2.6 times more likely to be employed in the public system when surveyed than those who were not (β = 0.974, *p* = .022), and participants motivated by salary were 1.9 times more likely to be employed in the public system when surveyed than those who were not (β = .635, *p* = .003).

In addition, motivations related to the interface of workplace and intrinsic factors significantly predicted current employment in the public system: Participants motivated by their level of personal influence in the workplace were 1.8 times more likely to be currently employed in the public system than those who were not (β = .603, *p* = .003). Participants motivated by available opportunities for career advancement were 1.7 times more likely to be currently employed in that system than those who were not (β = 0.526, *p* = .006), and participants motivated by pursuit of licensure were 1.6 times more likely to be currently employed in the public system than those who were not (β = .441, *p* = .024).

Graduates motivated by personal satisfaction were employed an average of 8.4 months longer

Many of the same motivations also appear to predict the longevity of graduate employment in the public behavioral health system: Participants who identified level of personal satisfaction with their work as a motivation to stay in the field of public behavioral health were employed an average of 8.4 months longer in the public behavioral health system than those who did not (β = .098, *p* = .001). In addition, graduates who identified level of personal influence in the workplace as a motivator were employed an average of 4.8 months longer in that system than those who did not (β = .063, *p* = .016). Of note, graduates who identified the quality of their professional colleagues as a motivator to stay in the field were employed an average of 4.8 fewer months in the public system than those who did not (β = -.07, *p* = .016).

Multiple trainee characteristics predict MHSA graduate employment and retention

To identify all possible predictors of employment and retention of MHSA graduates in California's public behavioral health system, the study team explored the influence of a variety of factors beyond those identified by survey participants. They were explored in relation to the three key outcomes of; (1) any post-MHSA service employment in the public behavioral health system, (2) current post-MHSA service employment in the public behavioral health system, and (3) duration of post-MHSA service employment in the public behavioral health system. After initial exploratory analysis, logistic regressions, multiple regressions and ANCOVA analyses enabled the identification of five general areas of significant influence on these outcomes.

Language fluency, ethnicity, and gender all predict the retention of MHSA graduates

Multiple logistic regression revealed that survey participants able to provide services in English and Spanish were 3.3 times more likely than those who spoke only English to report any post-service employment in the public behavioral health system (β = 1.201, *p* = .004), and were 1.7 times more likely to report current employment in that system (β = .557, *p* = .006). In addition, a one-way ANCOVA revealed that after controlling for years since graduation, there were significant differences in post-service employment duration between participants with different language capacities (F (2, 879) = 5.33, *p* = .005). Specifically, graduates able to provide services in both English and Spanish were employed in the public behavioral health system an

average of 6.0 months longer after MHSA service than graduates who spoke only English (p = .004).

Logistic regression analysis also revealed that Latinx graduates were 1.8 times more likely than white graduates to be currently employed in the public behavioral health system (β = .578, p = .009), and that graduates of all other ethnicities were 1.6 times more likely than white graduates to be currently employed in that system (β = .500, p = .031). ANCOVA analyses revealed that Latinx graduates were employed an average of 6.0 months longer in the public behavioral health system after MHSA service than white graduates (p = .010). To some degree, these differences likely reflect differentials related to salaries, signing bonuses, and other opportunities offered to MSWs who are able to provide services in Spanish.

Finally, logistic regression revealed that male graduates were employed an average of 4.8 months longer in the public system after MHSA service than female graduates (p = .020). This may reflect gender-based differences in needs related to parenting, and aligns with gender-based patterns in survey participants' comments about the difficulties of balancing work and family responsibilities in public behavioral health positions that do not enable part-time employment, flexible work schedules, or remote work.

Consumers are more likely–but family members less likely–to have been employed post service

Logistic regression analysis revealed that graduates with lived experience as consumers were 2.1 times more likely than graduates with no such lived experience to report a history of post MHSA service employment in the public behavioral health system (β =.756, p = .009). However, graduates with lived experience as family members of consumers were only 50% as likely than those with no such family members to have been employed in the public system after completing MHSA service (β = -.693, p = .012). This seems concerning, given that recruiting and training students with lived experience both as consumers and as consumer family members were central priorities for the program.

Education and experiential factors predict the retention of MHSA graduates post service

Logistic regression analysis revealed that graduates of two-year full-time MSW programs were only 39% as likely as graduates of one-year advanced standing MSW programs to be currently employed in the public behavioral health system (β = -.949, p = .011). In addition, graduates of three-year part-time MSW programs were only 37% as likely as graduates of one-year advanced standing MSW programs to be currently employed in the public system (β = -.994, p = .017). Thus, graduates of one-year advanced standing programs were 2.6 times more likely than graduates of full-time programs and 2.7 times more likely than graduates of part-time programs to be employed in the public system when surveyed. In addition, graduates who reported any duration of volunteer, internship, or employment experience in behavioral health settings prior to entering their MSW programs were 1.5 times more likely than graduates who reported no such experience to be currently employed in the public behavioral health system (β = .384, p = .016). Those graduates were also employed an average of 3.6 months longer in the public system than graduates who reported no such experience (β = .289, p = .048).

Factors related to MHSA training predict the retention of graduates post service

Logistic regression analysis revealed that graduates who identified specialized MHSA field training and field supervision as very or extremely valuable were 2.3 times more likely to have been employed in the

public behavioral health system after completing MHSA service than graduates who did not (β = .843, *p* = .023). In addition, graduates who reported that their MHSA training emphasized the importance of linguistic diversity among providers were employed an average of 4.8 months longer in the public system than those who did not (β = .42, *p* = .034).

Graduates motivated by stipends were 2.5 times more likely to have been employed post service

Multiple regression analysis revealed that graduates who indicated that receiving the stipend associated with the MHSA Stipend Program motivated them to pursue employment in California's public behavioral health system were 2.5 times more likely to have been employed in that system since completing MHSA service (β = .93, *p* = .006). In addition, those graduates were 2.3 times more likely to be currently employed in California's public behavioral health system when surveyed (β = .828, *p* = .001).

Graduates more committed to MHSA values were 2.4 times more likely to be employed

Finally, multiple regression analysis revealed that with each unit of increase in graduates' reported level of commitment to MHSA principles and practices at the conclusion of MHSA training, they were 2.4 times more likely to have been employed in California's public behavioral health system after completing MHSA service (β = .882, *p* = .001). In addition, with each unit of increase in graduates' reported level of commitment to MHSA principles and practices at survey completion, they were 1.5 times more likely to be currently employed in that system (β = .397, *p* = .001).

In addition, with each unit of increase in graduates' reported level of commitment to MHSA principles and practices at the conclusion of MHSA training, these graduates were employed an average of 3.6 months longer in California's public behavioral health system after completing MHSA service (β = .311, *p* = .036). Finally, with each unit of increase in graduates' reported level of commitment to MHSA principles and practices at survey completion, they were employed an average of 2.4 months longer in the public system after completing MHSA service (β = .191, *p* = .049).

SUMMARY AND CONCLUSIONS

Between 2005 and 2019, the MHSA Stipend Program successfully recruited a diverse, multilingual population of new MSWs and provided them with specialized training to provide public behavioral health services guided by the recovery model and other key MHSA principles. These graduates were trained through cooperative partnerships between CalSWEC and 22 MSW programs and completed field training and service employment in every service region and most counties within the state. Survey data confirms that program graduates remain strongly committed to MHSA principles and practices, and that a notable proportion of them have been and continue to be retained in California's public behavioral health system over a significant number of years.

The MHSA Stipend Program successfully achieved its workforce development goals

This retrospective study of the MHSA Stipend Program for MSW Students was intended to provide data for stakeholder consideration during the WET five-year planning process that began in 2018. CalSWEC offered preliminary data in an effort to demonstrate the positive and important impacts of the program. However, the five-year plan approved in 2019 for MHSA spending from 2020 to 2025 eliminated all funding for statewide behavioral health workforce development projects, and thus for all MHSA-funded statewide stipend programs.

The analysis presented here represents the only juxtaposition of complete data from the MHSA Stipend Program Retrospective Study against comprehensive MHSA Stipend Program data. As such, these findings are critically relevant to ongoing efforts to recruit, train and retain MSWs who are prepared for and committed to work in California's public behavioral health system. They are also uniquely valuable in relation to efforts to develop new programs intended to address workforce needs in that system.

These findings can be used to design and implement future training programs

This analysis highlights a number of influences on both training outcomes and public system hiring and retention that can be applied to the development and implementation of new specialized training programs. These include factors that can be addressed by MSW programs, by public behavioral health employers, and collaboratively by educators, employers and other workforce development stakeholders through advocacy around legislative and program funding decisions.

Training program structure, content and quality all influence graduate retention in public service

This analysis suggests that California's MSW programs can impact the employment and retention of new MSWs in the public behavioral health system in a number of ways. Centrally, it is clear that both the availability of stipend support and the quality, structure and content of specialized training offered in conjunction with that support influence the employment and retention of newly graduated MSWs in California's public behavioral health system.

Structurally, the development of more one-year advanced standing MSW programs has the potential to enhance both the diversity of the MSW workforce and the retention of newly trained MSWs in public service settings. In addition, participation in one-year advanced standing programs is associated with a number of other demographic and experiential factors, some of which can be prioritized in the admissions and selection procedures for all MSW program formats.

MSW programs can identify students most likely to remain committed to public service

Specifically, MSW programs can help shape the MSW workforce by giving priority consideration to applicants who have some history of pre-MSW internship, volunteer and/or paid work experience in behavioral health settings, applicants who have lived experiences as consumers and consumer family members, and applicants who are committed to public service, during both MSW admissions and selection for specialized training. MSW programs might also explore ways to clearly identify applicants whose motivation to pursue the MSW degree is linked to the personal satisfaction they have derived from internship, volunteer and/or paid work experiences.

MSW programs can enhance training content linked to graduate retention in public service

In this analysis, graduates' assessments of the quality of their field training experiences are clearly linked to training and employment outcomes. As such, MSW programs can focus on enhancing the quality of students' field training experiences in all types of public behavioral health settings, and on specific supports for university-based field instruction and agency-based field supervision in those settings. Related to this, MSW programs can work to enhance collaborations with public agencies and other university-based resources and supports for new graduates seeking employment in such settings.

This analysis also suggests that MSW programs can better prepare graduates for public behavioral health employment by expanding emphasis on the unique self-care needs of social workers in public behavioral health care during specialized training, and by enhancing training focused on helping students recognize and address their self-care needs. Finally, MSW programs might also consider ways to help trainees develop baseline competency in high demand languages during MSW study.

MSW programs can cultivate student commitment to key values and practices

Critically, this analysis suggests that MHSA Stipend Program graduates' level of commitment to MHSA values and practices is clearly and directly shaped by their experiences during specialized training, and that the intensity of this commitment significantly influences their employment and retention in public systems of care. As such, in designing and implementing future specialized training programs, MSW programs might expand the use of specific instructional approaches and training content focus on enhancing trainee commitment to key values and practices associated with program goals.

Salary is likely the most critical factor in retaining new MSWs in public service

This analysis also suggests that county-operated and county-contracted agencies in California's public behavioral health system can influence the employment and retention of new MSWs in public settings in a number of ways. First and foremost, they can prioritize increasing social worker salaries. These findings demonstrate not only that MHSA graduates report being motivated to remain in public service by salaries, but that they are actually significantly more motivated by salary than their direct responses alone would indicate.

Flexibility in the structure of MSW positions and responsibilities can enhance retention

This analysis highlights the fact that over 70% of new MSW graduates are women of childbearing age, many of whom delay developing their families until finishing their graduate degrees. As such, public behavioral health employers should explore ways to structure MSW positions and job responsibilities that are responsive to that reality. Minimizing requirements for work-related travel and enhancing flexibility around time/effort basis, work schedules, and opportunities for remote work in these positions has the potential to significantly enhance MSW retention. These same changes may also address the failure to retain consumer family members, who likely face other significant caregiving responsibilities at home.

Proven ways to attract and retain specific MSWs can be applied to other groups of MSWs

This analysis reflects the success that California's public behavioral health system has had using salary incentives for those who can provide services in Spanish to hire and retain Latinx and other Spanish-speaking MSWs. Public agencies may be able to use these same methods to recruit and retain new MSWs who offer other critically sought-after linguistic competencies, as well as those with lived experience as family members of consumers.

This analysis also suggests that public behavioral health employers can support the successful retention of specially trained MSWs by attending to the quality and nature of their experiences in the workplace in specific ways. First, it suggests that employers can enhance retention by enhancing opportunities and resources for self-care at work exploring ways to increase MSWs' perceptions of the quality of their professional colleagues. It also suggests that employers should consider increasing

MSWs' perceived level of personal influence in the workplace and working to enhance their opportunities for career advancement. Finally, it suggests that employers should work to support and enhance resources for MSWs pursuing LCSW licensure in both county-operated agencies and county-contracted workplaces, where necessary supervision infrastructure and resources may be more scarce.

MSW programs and public employers must work together to achieve workforce goals

Many of these suggestions require collaboration and joint advocacy by stakeholders in MSW education and behavioral health service provision to collaborate with one another and with advocates in the policy-making sphere. MSW programs and public behavioral health employers will likely need to work together to advocate for enhanced funding and for evidence-driven policy making in California's behavioral health workforce development efforts. These stakeholders must jointly and clearly communicate that in order to enhance the employment and retention of new MSWs in the public behavioral health system, future training programs must offer both high-quality specialized training and adequate stipend funding.

Future training programs must offer both high-quality training and stipend support

The findings presented here support the MHSA Stipend Program's significant achievements in relation to its specialized training and workforce development goals, and suggest ways in which those goals can be even better addressed in the future. In light of the significant current and projected deficits in the numbers of MSWs and LCSWs needed to meet consumer demand in California's public systems of care, it is hoped that this evidence will be used to support the planning and implementation of a renewed statewide MSW training program and associated supports in the public behavioral health system.

MHSA Stipend Program graduates' feedback and reflections about the value of the specialized MHSA training they received and its impact on their careers over time can be used to inform planning for the structure and content of future training programs. The identification of the most significant measurable influences on the retention of MHSA graduates in California's public behavioral health system can be used to help public behavioral health employers identify the best methods for recruiting and retaining newly trained MSWs in that system and to enhance and expand the application of those methods in strategic ways.

CalSWEC remains committed to behavioral health workforce development

This successful model of workforce development demonstrates the impact of CalSWEC and its partner universities and agencies in addressing critical needs for behavioral health workforce capacity building. It also demonstrates CalSWEC's ability to plan, develop, implement and evaluate workforce strategies that can effectively translate statewide policy initiatives into viable and robust programs. CalSWEC has extensive experience with the implementation of successful and sustainable publicly funded stipend and training programs for MSW students and social workers in other fields of practice, most notably Title IV-E funded pre-service and in-service training child welfare-focused projects. Based on that experience, it is essential to point out that the key feature that enables the ongoing success of those programs is the stable ongoing investment of public funding, and that this will also be critical to the success of future efforts to grow and develop California's public behavioral health workforce.

As always, additional evaluation is needed to explore how the experiences, motivations and decision-making of MHSA graduates highlighted here can be used to improve the retention of MSWs in California's public systems of care. With that in mind, CalSWEC continues to track the employment and related outcomes of the 2,353 graduates of the MHSA Stipend Program for MSW Students. We encourage social work scholars to collaborate with public agencies to demonstrate both the feasibility of documenting program outcomes and impact, and the need to use such data to inform evidence-based policy decisions. CalSWEC's stakeholders share the common goal of ensuring the success of practice, planning, and policy for behavioral health workforce development.

REFERENCES

Buckles, B. J., Ryan, J., Black, J., Alemi. Q. & Riggs, M. (2011). *California Social Work Education Center mental health program curriculum implementation and continuous quality improvement report* [White paper]. California Social Work Education Center, U.C. Berkeley School of Social Welfare. https://calswec.berkeley.edu/sites/default/files/mh_cqi_issbrf_final_10-13_1.pdf

California Future Health Workforce Commission. (2019). *Meeting the demand for health: Fact sheet on California's looming workforce crisis* [Research Report]. California Future Health Workforce Commission. https://futurehealthworkforce.org/2019/02/04/ca-looming-workforce-crisis/

Coffman, J, Bates, T., Geyn, I & Spetz, J. (2018). *California's current and future behavioral health workforce* [Research Report]. Healthforce Center, U.C. San Francisco. https://healthforce.ucsf.edu/publications/california-s-current-and-future-behavioral-health-workforce

Council on Social Work Education Commission on Accreditation. (2021). *2022 Educational policy and accreditation standards for baccalaureate and master's social work programs - draft #2 – Fall 2021*. Council on Social Work Education, Commission on Educational Policy. https://www.cswe.org/Accreditation/Information/2022-EPAS/Draft-2-of-2022-EPAS

Foster, G., Morris, M.B. & Sirojudin, S. (2013). Mental health workforce change through social work education: A California case study. *Journal of Social Work Education, 49* (3), 490-505. https://www.tandfonline.com/doi/abs/10.1080/10437797.2013.796771

National Center for Health Workforce Analysis. (2017). *Behavioral health workforce projections, 2017-2030*. Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/bh-workforce-projections-fact-sheet.pdf

National Center for Health Workforce Analysis. (2017). *Sex, race and ethnic diversity of U.S. health occupations (2011-2015)*. Health Resources and Services Administration. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/diversity-us-health-occupations.pdf

Salsberg, E., Quigley, L., Richwine, C., Sliwa, S., Acquaviva, K. & Wyche, K. (2019). *From social work education to social work practice: Results of the survey of 2018 social work graduates* [Research Report to CSWE]. George Washington University Health Workforce Institute. https://www.cswe.org/CSWE/media/Workforce-Study/2018-Social-Work-Workforce-Report-Final.pdf

Zittel, K. M., Lawrence, S. & Wodarski, J. S. (2002). Biopsychosocial model of health and healing. *Journal of Human Behavior in the Social Environment, 5*(1), 19-33.

APPENDIX A: MHSA STIPEND PROGRAM TRAINING COHORTS BY MSW PROGRAM AND ACADEMIC YEAR (N=2353)

MSW Programs	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	Total
CSU Bakersfield	3	4	4	5	5	5	5	5	5	7	7	7	7	5	74 (3.1%)
CSU Chico	8	6	8	9	9	9	9	9	9	8	9	9	10	5	117 (5.0%)
CSU Dominguez Hills	0	0	0	0	0	3	1	1	1	8	9	6	7	4	40 (1.7%)
CSU East Bay	10	15	15	15	15	15	15	15	15	9	9	7	7	4	166 (7.1%)
CSU Fullerton	8	8	10	9	7	9	10	10	9	0	0	0	0	0	80 (3.4%)
CSU Long Beach	0	0	0	0	0	3	3	3	3	8	12	7	7	5	51 (2.2%)
CSU Los Angeles	13	20	20	20	20	20	17	17	17	2	8	9	12	5	200 (8.5%)
CSU Monterey Bay	7	7	7	7	7	8	7	7	7	7	8	7	7	5	98 (4.2%)
CSU Northridge	0	0	0	0	0	0	0	4	4	6	7	7	8	5	41 (1.7%)
CSU San Bernardino	0	0	0	0	0	0	1	1	1	7	9	7	7	3	36 (1.5%)
CSU San Marcos	15	14	15	12	15	15	15	15	15	8	13	7	7	4	170 (7.2%)
CSU Stanislaus	0	0	0	0	0	0	0	0	0	0	0	8	10	6	24 (1.0%)
Fresno State University	5	4	4	4	2	4	5	5	4	7	3	7	6	0	60 (2.5%)
Cal Poly Humboldt	2	5	3	3	4	5	5	5	5	8	9	10	10	5	79 (3.4%)
Loma Linda University	16	8	6	4	5	6	10	10	10	7	7	9	7	4	109 (4.6%)
Sacramento State University	13	17	20	20	18	20	14	17	16	8	0	0	0	0	163 (6.9%)
San Diego State University	13	15	14	15	15	15	15	15	14	7	10	10	9	5	172 (7.3%)
San Francisco State University	10	10	9	10	10	10	9	9	10	8	9	8	4	3	119 (5.1%)
San Jose State University	10	10	10	10	10	10	10	10	10	7	0	0	0	0	97 (4.1%)
UC Berkeley	9	9	10	10	10	10	10	11	10	7	9	10	10	7	132 (5.6%)
UC Los Angeles	10	10	10	9	10	10	10	10	10	7	9	7	7	4	123 (5.2%)
University of Southern California	20	20	19	20	18	19	17	17	17	7	9	8	7	4	202 (8.6%)
Total	**172 (7.3%)**	**182 (7.7%)**	**184 (7.8%)**	**182 (7.7%)**	**180 (7.6%)**	**196 (8.3%)**	**188 (8.0%)**	**196 (8.3%)**	**192 (8.2%)**	**143 (6.1%)**	**156 (6.6%)**	**150 (6.4%)**	**149 (6.3%)**	**83 (3.5%)**	**2353 (100%)**

APPENDIX B: COMPARISON OF KEY CHARACTERISTICS OF MHSA STIPEND PROGRAM GRADUATES (N=2353) AND MHSA RETROSPECTIVE SURVEY PARTICIPANTS (N=1086)

	MHSA Stipend Program Graduates	MHSA Retrospective Survey Participants
Total Number	2,353	1,086
MSW Programs Included	22	22
Training Cohorts Included	14	13
Two Year Full-time Students	89.4%	71.2%
Part-time Students	10.6%	23.6%
Advanced Standing Students	-	5.3%
$18,500 Stipends	89.9%	90.8%
$9,500 Stipends	10.1%	9.2%
Mean Age	30.7 years	38.7 years
Female	81.4%	79.0%
Male	17.8%	17.2%
Genderqueer/Nonbinary	.7%	1.6%
Heterosexual	83.3%	79.0%
LBGQ	16.7%	15.4%
White	38.3%	38.2%
Latinx	33.1%	30.8%
Asian/Asian American	11.4%	12.2%
African American/Black	8.9%	7.6%
All Other Ethnicities	8.3%	11.2%
English Only	38.0%	46.7%
Multilingual	62.0%	53.3%
Lived Experience as Consumers	26.8%	23.9%
Lived Experience as Family Members	48.6%	49.2%
Disabled	13.4%	12.4%
Former Foster Youth	1.9%	2.3%
Military Veterans	1.8%	1.6%

APPENDIX C: MHSA STIPEND PROGRAM GRADUATE FIELD TRAINING SITES BY COUNTY AND AGENCY TYPE (N=2299)

	MHSA Field Training Sites			
County	Number of Sites	% of All Sites	County Agencies (% Within County)	Contract Agencies (% Within County)
Alameda	136	5.9%	47 (34.6%)	89 (65.4%)
Alpine	0	0.0%	0	0
Amador	1	0.0%	1 (100.0%)	0 (0.0%)
City of Berkeley	19	0.8%	19 (100.0%)	0
Butte	75	3.3%	41 (54.7%)	0.0%
Calaveras	0	0.0%	0	33 (44.0%)
Colusa	3	0.1%	3 (100.0%)	0
Contra Costa	41	1.8%	11 (26.8%)	0 (0.0%)
Del Norte	1	0.0%	1 (100.0%)	30 (73.2%)
El Dorado	1	0.0%	1 (100.0%)	0 (0.0%)
Fresno	46	2.0%	31 (67.4%)	0 (0.0%)
Glenn	12	0.5%	11 (91.7%)	15 (32.6%)
Humboldt	65	2.8%	48 (73.8%)	1 (8.3%)
Imperial	4	0.2%	4 (100.0%)	17 (26.2%
Inyo	0	0.0%	0	0 (0.0%)
Kern	60	2.6%	30 (50.0%)	0
Kings	8	0.3%	6 (75.0%)	30 (50.0%)
Lake	4	0.2%	2 (50.0%)	2 (25.0%)
Lassen	0	0.0%	0	0
Los Angeles	635	27.6%	209 (32.9%)	424 (66.8%)
Madera	8	0.3%	8 (100.0%)	0 (0.0%)
Marin	10	0.4%	7 (70.0%)	3 (30.0%)
Mariposa	1	0.0%	1 (100.0%)	0 (0.0%)
Mendocino	2	0.1%	0 (0.0%)	2 (100.0%)
Merced	4	0.2%	3 (75.0%)	1 (25.0%)
Modoc	0	0.0%	0	0
Mono	0	0.0%	0	0
Monterey	36	1.6%	27 (75.0%)	9 (25.0%)
Napa	6	0.3%	4 (66.7%)	2 (33.3%)
Nevada	2	0.1%	0 (0.0%)	2 (100.0%)
Orange	82	3.6%	40 (48.8%)	42 (51.2%)
Placer	15	0.7%	14 (93.3%)	1 (6.7%)
Plumas	1	0.0%	0 (0.0%)	1 (100.0%)
Riverside	152	6.6%	141 (92.8%)	11 (7.2%)
Sacramento	114	5.0%	13 (11.4%)	100 (87.7%)

	MHSA Field Training Sites			
County	Number of Sites	% of All Sites	County Agencies (% Within County)	Contract Agencies (% Within County)
San Benito	1	0.0%	1 (100.0%)	0 (0.0%)
San Bernardino	99	4.3%	52 (52.5%)	47 (47.5%)
San Diego	199	8.7%	57 (28.6%)	142 (71.4%)
San Francisco	167	7.3%	58 (34.7%)	108 (64.7%)
San Joaquin	18	0.8%	15 (83.3%)	3 (16.7%)
San Luis Obispo	4	0.2%	4 (100.0%)	0 (0.0%)
San Mateo	42	1.8%	40 (95.2%)	2 (4.8%)
Santa Barbara	3	0.1%	1 (33.3%)	2 (66.7%)
Santa Clara	63	2.7%	31 (49.2%)	32 (50.8%)
Santa Cruz	16	0.7%	9 (56.3%)	7 (43.8%)
Shasta	8	0.3%	5 (62.5%)	3 (37.5%)
Sierra	0	0.0%	0	0
Siskiyou	2	0.1%	2 (100.0%)	0 (0.0%)
Solano	13	0.6%	4 (30.8%)	9 (69.2%)
Sonoma	10	0.4%	10 (100.0%)	0 (0.0%)
Stanislaus	44	1.9%	27 (61.4%)	17 (38.6%)
Sutter	8	0.3%	5 (62.5%)	3 (37.5%)
Tehama	5	0.2%	5 (100.0%)	0 (0.0%)
Tri-City	1	0.0%	1 (100.0%)	0 (0.0%)
Trinity	0	0.0%	0	0
Tulare	20	0.9%	11 (55.0%)	9 (45.0%)
Tuolumne	0	0.0%	0	0
Ventura	9	0.4%	7 (77.8%)	2 (22.2%)
Yolo	17	0.7%	7 (41.2%)	10 (58.8%)
Yuba	6	0.3%	0 (0.0%)	6 (100.0%)
Total	**2299**	**100.0%**	**1075 (46.8%)**	**1219 (53.2%)**

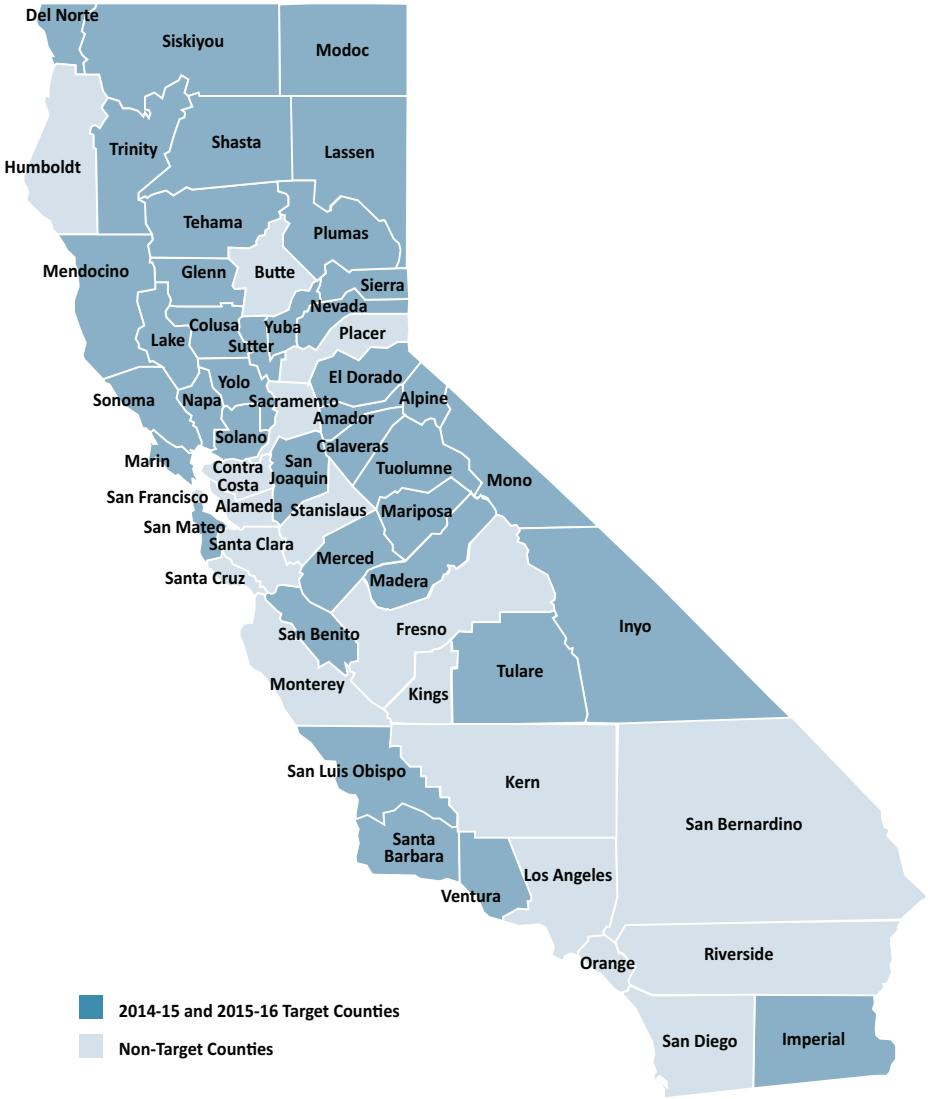
APPENDIX D: MHSA RETROSPECTIVE SURVEY PARTICIPANT FIELD TRAINING SITES BY COUNTY AND AGENCY TYPE (N=1086)

	MHSA Field Training Sites			
County	Number of Sites	% of All Sites	County Agencies (% Within County)	Contract Agencies (% Within County)
Alameda	81	(7.4%)	33 (40.7%)	48 (59.3%)
Butte	34	(3.1%)	16 (47.1%)	18 (52.9%)
Colusa	1	(0.1%)	1 (100%)	0 (0%)
Contra Costa	19	(1.7%)	5 (26.3%)	14 (73.7%)
Del Norte	1	(0.1%)	1 (100%)	0 (0%)
El Dorado	1	(0.1%)	1 (100%)	0 (0%)
Fresno	11	(1.0%)	7 (63.6%)	4 (36.4%)
Glenn	8	(0.7%)	7 (87.5%)	1 (12.5%)
Humboldt	29	(2.7%)	23 (79.3%)	6 (20.7%)
Imperial	3	(0.3%)	3 (100%)	0 (0%)
Kern	26	(2.4%)	11 (42.3%)	15 (57.7%)
Kings	2	(0.2%)	1 (50%)	1 (50%)
Lassen	0	(0.0%)	0 (0%)	0 (0%)
Lake	1	(0.1%)	0 (0%)	1 (100%)
Los Angeles	338	(31.0%)	119 (35.2%)	219 (64.8%)
Madera	3	(0.3%)	3 (100%)	0 (0%)
Marin	6	(0.6%)	5 (83.3%)	1 (16.7%)
Mariposa	0	(0.0%)	0 (0%)	0 (0%)
Mendocino	2	(0.2%)	0 (0%)	2 (100%)
Merced	2	(0.2%)	2 (100%)	0 (0%)
Monterey	18	(1.7%)	15 (83.3%)	3 (16.7%)
Napa	3	(0.3%)	2 (66.7%)	1 (33.3%)
Nevada	2	(0.2%)	0 (0%)	2 (100%)
Orange	41	(3.8%)	26 (63.4%)	15 (36.6%)
Placer	4	(0.4%)	3 (75.0%)	1 (25.0%)
Plumas	1	(0.1%)	0 (0%)	1 (100%)
Riverside	66	(6.1%)	61 (92.4%)	5 (7.6%)
Sacramento	33	(3.0%)	4 (12.1%)	29 (87.9%)
San Benito	1	(0.1%)	1 (100%)	0 (0%)
San Bernardino	43	(3.9%)	25 (58.1%)	18 (41.9%)
San Diego	108	(9.9%)	30 (27.8%)	78 (72.2%)
San Francisco	78	(7.2%)	27 (34.6%)	51 (65.4%)
San Joaquin	10	(0.9%)	9 (90.0%)	1 (10.0%)
San Luis Obispo	1	(0.1%)	1 (100%)	0 (0%)
San Mateo	20	(1.8%)	19 (95%)	1 (5%)

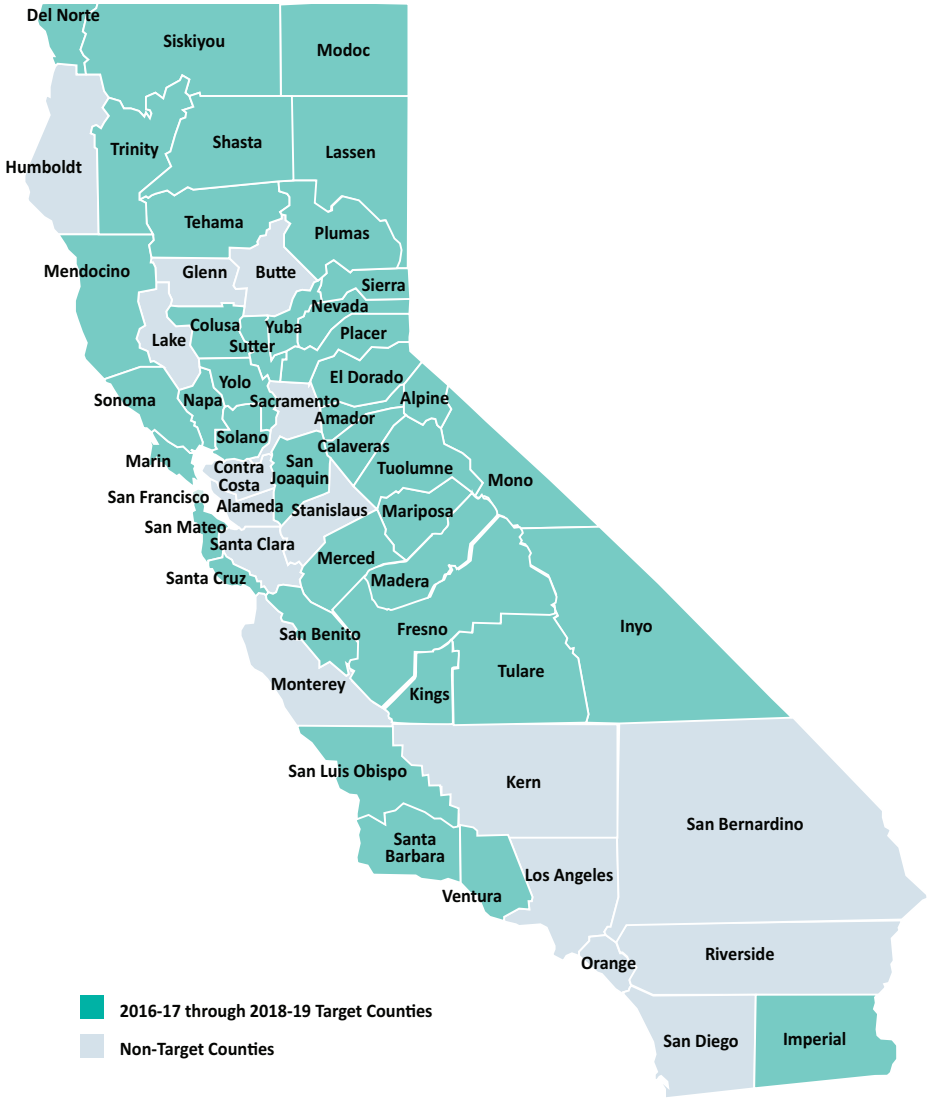
	MHSA Field Training Sites			
County	**Number of Sites**	**% of All Sites**	**County Agencies (% Within County)**	**Contract Agencies (% Within County)**
Santa Barbara	2	(0.2%)	1 (50%)	1 (50%)
Santa Clara	25	(2.3%)	11 (44%)	14 (56%)
Santa Cruz	9	(0.8%)	6 (66.7%)	3 (33.3%)
Shasta	2	(0.2%)	2 (100%)	0 (0%)
Sierra	0	(0.0%)	0 (0%)	0 (0%)
Siskiyou	2	(0.2%)	2 (100%)	0 (0%)
Solano	5	(0.5%)	2 (40%)	3 (60%)
Sonoma	3	(0.3%)	3 (100%)	0 (0%)
Stanislaus	19	(1.7%)	10 (52.6%)	9 (47.4%)
Sutter	1	(0.1%)	1 (100%)	0 (0%)
Tehama	3	(0.3%)	3 (100%)	0 (0%)
Tri-city	0	(0.0%)	0 (0%)	0 (0%)
Tulare	6	(0.6%)	5 (83.3%)	1 (16.7%)
Ventura	6	(0.6%)	5 (83.3%)	1 (16.7%)
Yolo	3	(0.3%)	1 (33.3%)	2 (66.7%)
Yuba	3	(0.3%)	0 (0%)	3 (100%)
Total	**1086**	**(100%)**	**572 (52.7%)**	**514 (47.3%)**

APPENDIX E: OSHPD-IDENTIFIED TARGET COUNTIES, ACADEMIC YEARS 2014-15 TO 2015-16 AND 2016-17 TO 2018-19

Target Counties for 2014-15 and 2015-16



Target Counties for 2016-17 through 2018-19



APPENDIX F: MHSA STIPEND PROGRAM GRADUATE SERVICE EMPLOYMENT SITES BY COUNTY AND AGENCY TYPE (N=2582)

	MHSA Service Episodes			
County	Number of Episodes	% of All Episodes	County Agencies (% Within County)	Contract Agencies (% Within County)
Alameda	182	7.0%	20 (11.0%)	160 (87.9%)
Alpine	0	0.0%	0	0
Amador	1	0.0%	0	1 (100.0%)
City of Berkeley	2	0.1%	2 (100.0%)	0 (0.0%)
Butte	66	2.6%	33 (50.0%)	33 (50.0%)
Calaveras	2	0.1%	1(50.0%)	1 (50.0%)
Colusa	9	0.3%	9 (100.0%)	0 (0.0%)
Contra Costa	34	1.3%	3 (8.8%)	31 (91.2%)
Del Norte	6	0.2%	2 (33.3%)	4 (66.7%)
El Dorado	3	0.1%	3 (100.0%)	0 (0.0%)
Fresno	47	1.8%	16 (34.0%)	30 (63.8%)
Glenn	19	0.7%	19 (100.0%)	0 (0.0%)
Humboldt	75	2.9%	49 (65.3%)	25 (33.3%)
Imperial	8	0.3%	7 (87.5%)	1 (12.5%)
Inyo	0	0.0%	0	0
Kern	57	2.2%	14 (24.6%)	43 (75.4%)
Kings	2	0.1%	0 (0.0%)	2 (100.0%)
Lake	4	0.2%	3 (75.0%)	1 (25.0%)
Lassen	2	0.1%	2 (100.0%)	0 (0.0%)
Los Angeles	783	30.3%	269 (34.4%)	508 (64.9%)
Madera	6	0.2%	5 (83.3%)	1 (16.7%)
Marin	15	0.6%	4 (26.7%)	11 (73.3%)
Mariposa	3	0.1%	3 (100.0%)	0 (0.0%)
Mendocino	11	0.4%	2 (18.2%)	9 (81.8%)
Merced	15	0.6%	6 (40.0%)	9 (60.0%)
Modoc	1	0.0%	1 (100.0%)	0 (0.0%)
Mono	0	0.0%	0	0
Monterey	41	1.6%	27 (65.9%)	14 (34.1%)
Napa	15	0.6%	3 (20.0%)	12 (80.0%)
Nevada	3	0.1%	0 (0.0%)	3 (100.0%)
Orange	74	2.9%	22 (29.7%)	52 (70.3%)
Placer	14	0.5%	6 (42.9%)	8 (57.1%)
Plumas	1	0.0%	0 (0.0%)	1 (100.0%)
Riverside	103	4.0%	83 (80.6%)	20 (19.4%)
Sacramento	134	5.2%	11 (8.2%)	123 (91.8%)

	MHSA Service Episodes			
County	Number of Episodes	% of All Episodes	County Agencies (% Within County)	Contract Agencies (% Within County)
San Benito	5	0.2%	3 (60.0%)	2 (40.0%)
San Bernardino	111	4.3%	46 (41.4%)	65 (58.6%)
San Diego	227	8.8%	11 (4.8%)	212 (93.4%)
San Francisco	215	8.3%	29 (13.5%)	183 (85.1%)
San Joaquin	19	0.7%	11 (57.9%)	8 (42.1%)
San Luis Obispo	7	0.3%	2 (28.6%)	5 (71.4%)
San Mateo	28	1.1%	10 (35.7%)	18 (64.3%)
Santa Barbara	7	0.3%	2 (28.6%)	5 (71.4%)
Santa Clara	70	2.7%	4 (5.7%)	65 (92.9%)
Santa Cruz	13	0.5%	4 (30.8%)	9 (69.2%)
Shasta	11	0.4%	5 (45.5%)	6 (54.5%)
Sierra	1	0.0%	1 (100.0%)	0 (0.0%)
Siskiyou	2	0.1%	1 (50.0%)	1 (50.0%)
Solano	8	0.3%	2 (25.0%)	6 (75.0%)
Sonoma	23	0.9%	6 (26.1%)	16 (69.6%)
Stanislaus	33	1.3%	5 (15.2%)	28 (84.8%)
Sutter	8	0.3%	3 (37.5%)	5 (62.5%)
Tehama	3	0.1%	3 (100.0%)	0 (0.0%)
Tri-City	6	0.2%	6 (100.0%)	0 (0.0%)
Trinity	0	0.0%	0	0
Tulare	18	0.7%	6 (33.3%)	11 (61.1%)
Tuolumne	0	0.0%	0	0
Ventura	11	0.4%	7 (63.6%)	4 (36.4%)
Yolo	13	0.5%	4 (30.8%)	9 (69.2%)
Yuba	5	0.2%	0 (0.0%)	5 (100.0%)
Total	**2582**	**100.0%**	**796 (30.8%)**	**1766 (68.4%)**

* 0.8% of all placements were categorized as “other.”

APPENDIX G: MHSA RETROSPECTIVE SURVEY PARTICIPANT SERVICE EPISODES BY COUNTY AND AGENCY TYPE (N=1264)

	MHSA Service Episodes			
County	Number of Episodes	% of All Episodes	County Agencies (% Within County)	Contract Agencies (% Within County)
Alameda	98	(7.8%)	9 (9.2%)	89 (90.8%)
Butte	34	(2.7%)	16 (47.1%)	18 (52.9%)
Colusa	3	(0.2%)	3 (100%)	0 (0%)
Contra Costa	17	(1.3%)	2 (11.8%)	15 (88.2)
Del Norte	5	(0.4%)	1 (20.0%)	4 (80.0%)
El Dorado	2	(0.2%)	2 (100%)	0 (0%)
Fresno	14	(1.1%)	3 (21.4%)	11 (78.6%)
Glenn	12	(0.9%)	12 (100%)	0 (0%)
Humboldt	26	(2.1%)	21 (80.8%)	5 (19.2%)
Imperial	8	(0.6%)	7 (87.5%)	1 (12.5%)
Kern	26	(2.1%)	7 (26.9%)	19 (73.1%)
Kings	1	(0.1%)	0 (0%)	1 (100%)
Lassen	1	(0.1%)	1 (100%)	0 (0%)
Lake	1	(0.1%)	0 (0%)	1 (100%)
Los Angeles	406	(32.1%)	149 (36.7%)	257 (63.3%)
Madera	0	(0.0%)	0 (0%)	0 (0%)
Marin	8	(0.6%)	3 (37.5%)	5 (62.5%)
Mariposa	1	(0.1%)	1 (100%)	0 (0%)
Mendocino	6	(0.5%)	1 (16.7%)	5 (83.3%)
Merced	11	(0.9%)	5 (45.5.7%)	6 (54.5%)
Monterey	21	(1.7%)	13 (61.9%)	8 (38.1%)
Napa	2	(0.2%)	0 (0%)	2 (100%)
Nevada	1	(0.1%)	0 (0%)	1 (100%)
Orange	37	(2.9%)	10 (27.0%)	27 (73.0%)
Placer	5	(0.4%)	1 (20.0%)	4 (80.0%)
Plumas	1	(0.1%)	0 (0%)	1 (100%)
Riverside	45	(3.6%)	37 (82.2%)	8 (17.8%)
Sacramento	45	(3.6%)	4 (8.9%)	41 (91.1%)
San Benito	4	(0.3%)	3 (75.0%)	1 (25.0%)
San Bernardino	55	(4.4%)	24 (43.6%)	31 (56.4%)
San Diego	136	(10.8%)	5 (3.7%)	131 (96.3%)
San Francisco	105	(8.3%)	14 (13.3%)	91 (86.7%)
San Joaquin	10	(0.8%)	8 (80.0%)	2 (20.0%)
San Luis Obispo	2	(0.2%)	0 (0%)	2 (100%)
San Mateo	13	(1.0%)	5 (38.5%)	8 (61.5%)

	MHSA Service Episodes			
County	**Number of Episodes**	**% of All Episodes**	**County Agencies (% Within County)**	**Contract Agencies (% Within County)**
Santa Barbara	6	(0.5%)	2 (33.3%)	4 (66.7%)
Santa Clara	28	(2.2%)	1 (3.6%)	27 (96.4%)
Santa Cruz	10	(0.8%)	4 (40.0%)	6 (60.0%)
Shasta	4	(0.3%)	1 (25.0%)	3 (75.0%)
Sierra	1	(0.1%)	0 (0%)	1 (100%)
Siskiyou	1	(0.1%)	1 (100%)	0 (0%)
Solano	2	(0.2%)	0 (0%)	2 (100%)
Sonoma	9	(0.7%)	4 (44.4%)	5 (55.6%)
Stanislaus	13	(1.0%)	3 (23.1%)	10 (76.9%)
Sutter	4	(0.3%)	1 (25.0%)	3 (75.0%)
Tehama	3	(0.2%)	3 (100%)	0 (0%)
Tri-city	1	(0.1%)	1 (100%)	0 (0%)
Tulare	7	(0.6%)	1 (14.3%)	6 (85.7%)
Ventura	7	(0.6%)	5 (71.4%)	2 (28.6%)
Yolo	4	(0.3%)	2 (50.0%)	2 (50.0%)
Yuba	2	(0.2%)	0 (0%)	2 (100%)
Total	**1264**	**(100%)**	**396 (31.3%)**	**868 (68.7%)**

APPENDIX H: MHSA SURVEY PARTICIPANT POST-SERVICE PUBLIC BEHAVIORAL HEALTH SYSTEM EMPLOYMENT BY RACE/ETHNICITY AND LANGUAGE CAPACITY (N=964)

Table H1 | MHSA Survey Participant Post-Service Public Behavioral Health System Employment by Race/Ethnicity (N=964)

Race/Ethnicity	% of All Graduates	% of Graduates Ever Employed in Public System	% of Graduates Currently Employed in Public System
African American/Black/African	77 (8.0%)	71 (8.0%)	40 (7.5%)
Asian American/Asian	117 (12.1%)	108 (12.2%)	66 (12.3%)
Latinx/Hispanic	288 (29.9%)	274 (31.0%)	199 (37.1%)
Middle Eastern/Arab	15 (1.6%)	13 (1.5%)	9 (1.7%)
Multiracial	59 (6.1%)	53 (6.0%)	34 (6.3%)
Native American/American Indian/Alaska Native	5 (0.5%)	5 (0.6%)	4 (0.7%)
Pacific Islander	4 (0.4%)	4 (0.5%)	4 (0.7%)
White/European/Caucasian	373 (38.7%)	333 (37.7%)	169 (31.5%)
Decline to state	26 (2.7%)	22 (2.5%)	11 (2.1%)
Total	**964 (100.0%)**	**883 (100.0%)**	**536 (100.0%)**

Table H2 | MHSA Survey Participant Post-Service Public Behavioral Health System Employment by Language Capacity (N=964)

Language Capacity	% of All Graduates	% of Graduates Ever Employed in Public System	% of Graduates Currently Employed in Public System
English Only	456 (47.3%)	404 (45.8%)	216 (40.3%)
English and Spanish	355 (36.8%)	339 (38.4%)	237 (44.2%)
English and a Language Other than Spanish	153 (15.9%)	140 (15.9%)	83 (15.5%)
Total	**964 (100.0%)**	**883 (100.0%)**	**536 (100.0%)**

APPENDIX I: MHSA SURVEY PARTICIPANT POST-SERVICE PUBLIC BEHAVIORAL HEALTH SYSTEM EMPLOYMENT BY CONSUMER AND CONSUMER FAMILY MEMBER STATUS (N=964)

Table I1 | MHSA Survey Participant Post-Service Public Behavioral Health System Employment by Consumer Status (N=964)

Consumer Status	% of All Graduates	% of Graduates Ever Employed in Public System	% of Graduates Currently Employed in Public System
Lived Experience	219 (22.7%)	192 (21.7%)	111 (20.7%)
No Lived Experience	703 (72.9%)	651 (73.7%)	402 (75.0%)
Decline to state	42 (4.4%)	40 (4.5%)	23 (4.3%)
Total	**964 (100.0%)**	**883 (100.0%)**	**536 (100.0%)**

Table I2 | MHSA Survey Participant Post-Service Public Behavioral Health System Employment by Consumer Family Member Status (N=964)

Consumer Family Member Status	% of All Graduates	% of Graduates Ever Employed in Public System	% of Graduates Currently Employed in Public System
Lived Experience	472 (49.0%)	437 (49.5%)	273 (50.9%)
No Lived Experience	450 (46.7%)	406 (46.0%)	243 (45.3%)
Decline to state	42 (4.4%)	40 (4.5%)	20 (3.7%)
Total	**964 (100.0%)**	**883 (100.0%)**	**536 (100.0%)**