ADVANCED POLICY ANALYSIS

Better Training For Mental Health Paraprofessionals: Why, How and Who's Going To Pay For It

A Study Conducted for the Service Employees International Union, Public Services Division Oakland, California

by

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Executive Summary

Paraprofessional workers are a crucial part of the mental health delivery system. They are an estimated 25% of the mental health workforce and make up as much as 60% of the workforce in psychiatric institutions. Their roles and responsibilities vary widely. They do anything from providing socialization and drug and alcohol counseling to caring for activities of daily living such as bathing and feeding. Still, as a whole this is an invisible workforce. With lower pay and low education than other health professionals, they are largely ignored by regulators, politicians and the academic community. There is little or no standardization for their training.

The only time they seem to get any attention is when they do something wrong. Investigative journalism has highlighted some of the most tragic cases of the failings of mental health paraprofessional training—deaths due to incorrectly placed restraining holds. These stories ignore the larger issues at play in this workforce. These are highly empathetic workers who, at the rate of pay they get, could just as easily work at McDonald's. Instead they chose to work with severely mentally and emotionally disturbed adults and children. At the core of these tragedies underlies a lack of investment in the mental health paraprofessional workforce.

With the increasing use of technologies and innovative approaches to mental health delivery the need for consumer and worker-friendly paraprofessional training clearly exists. Employers, who otherwise must pay for training out of their general budgets, should welcome offers of available training. But disincentives embedded in health care financing create barriers to their being able to access even free training sources.

There are several different pots of government and private foundation money which could be leveraged to finance training programs. These programs could take place at community colleges, through the State apprenticeship program, at the workplace or out of a free-standing union center. Despite the existence of training infrastructure and funding most of the key players in paraprofessional training and employment have yet to access the resources available to them. The union has the resources, clout and expertise to link these disjointed parts. The union has much to gain as creating these high road partnerships will bring in new members.

Benjamin Halfacre, 37
Died: May 6, 1997
Cause: Respiratory and cardiac arrest
Patient at: Hummer Lake Group Home, Michigan

Andrew McClain, 11
Died: March 22, 1998
Cause: Traumatic asphyxiation
Patient at: Elmcrest psychiatric hospital, Connecticut

Melissa Neyman, 19
Died: July 24, 1997
Cause: Asphyxiation
Patient at: Judith Young Adult Family Home, Washington

Sandra Gordon, 45
Died: Jan. 6, 1998
Cause: Strangulation, blunt trauma
Patient at: Rosewood Terrace Care Center, Utah

> Andrew McClain was having a good Sunday morning at Elmcrest psychiatric hospital. He had helped staff rearrange the furniture to prepare for breakfast. He was one of the first children to line up to eat….Little more than an hour later, at 10:15 a.m. March 22, Andrew McClain was pronounced dead, suffocated in a restraint hold administered by the aide responsible for his care. The official cause of death would be listed as "traumatic asphyxia, chest compression." (Megan and Blint, 1998)
>
> Andrew was restrained March 22 after disobeying an aide's instructions, triggering what child welfare officials called a fatal "power struggle." (Weiss, Oct. 14, 1998)
>
> Had workers known more about Andrew, had Parasco [the mental health aide] been better-versed in ways to calm him, the boy would not have died, a state investigation concluded. (Megan and Blint, 1998)… "What's most disturbing is that the restraint hold was not precipitated by anything that Andrew did, but by the actions of the mental health aide," said Kristine Ragaglia, commissioner of the Department of Children and Families. (Weiss, May 8, 1998)

The 1998 Hartford Courant series on Andrew McClain reveals the tragic story of an entirely predictable death caused by an incorrectly placed restraining hold. Andrew's story prompted the Hartford Courant to do an investigative report on the use of restraints and seclusion. Six months later they concluded that what happened to Andrew was not an isolated incident but rather one of many unnecessary deaths from restraints. The newspaper found 142 confirmed restraint-related deaths in 10 years in the United States. It estimated the real number

of deaths to be much higher anywhere from 50 to 150 per year (most restraint-related deaths are unreported). (Weiss, October 11, 1998).

In 2001, the Dallas Observer documented similar tragic stories from restraint-related deaths in Texas. There was 9-year old Randy Steele who died of asphyxiation in 2000 in Nashville. After he choked on his own vomit, aides did not know CPR and could not revive him. Fifty-one year old Macie Stafford died after being placed in a hold, face-down, by a team of mental health aides. The newspapers pointed to inadequate aide training as the common denominator in all these deaths. According to the Dallas Observer:

> Maloney [attorney representing the victim's parents] says a lack of adequately trained workers contributed to Steele's death. … Staffing is the scandal of these places." Maloney's arguments echo what most mental health advocates, including health care providers, say is the root of problems relating to restraints: Facilities can't or won't keep enough quality workers on the job. (Farley, 2001).

The Courant echoed the problems of paraprofessional training:

> Most people, when they heard about Andrew McClain, wondered "How could this happen in a hospital?"…but those who know how the system works, knew it was just a matter of time…Aides need to have more training and a deeper background.
>
> The state Department of Public Health which licenses Elmcrest hospital does not require [mental health] aides to be licensed or certified. The same department requires hairdressers in the state to have 1,500 hours of in-class study and to pass a written test in order to be licensed. "Why? That's a good question," department spokesman Kevin Sullivan said. (Farley, 2001)

The Problem with Mental Health Paraprofessional Training

Investigative journalism highlights the most tragic consequences of undertrained mental health paraprofessionals. Yet outside of these high profile media stories, there is very little attention given to the underlying problems in the mental health care system that allowed for these incidents to occur. How much do these tragic incidents signal a need for systemic reform? Are these deaths exceptions to the rule? One of the stories that emerged from these deaths was the failure of the United States healthcare system to adequately train the workers who perform these restraints. What else are these workers not prepared to do? If training deficits only surface

in the extreme case of patient death what other adverse outcomes are overlooked, less extreme but still highly damaging?

Part I: The Mental Health Paraprofessional

What is a Mental Health Paraprofessional Worker?

The workers in the mental health care system who perform manual restraints are commonly known as paraprofessional workers. They are the frontline workers of the mental health system who spend more time with patients than anyone else. (Mueller 2003). Paraprofessional job responsibilities are in many ways dependent on the type of facility they work at and the population served. They can be found anywhere that mental health services are provided including: home health programs, in private juvenile treatment facilities, in community-based outpatient facilities, in day care for the elderly or in homecare. They work with clients of all ages including: children, adolescents, adults and the elderly.

They are responsible for day-to-day patient care—whatever that may entail. A psychiatrist may design a patient's treatment plan but it is often carried out by a paraprofessional. While they get the most attention for administering restrains, some paraprofessionals may never use them. Actual job responsibilities vary widely. Technically, the work they do is not called treatment, because they are not trained for it. However, in many instances they provide informal counseling such as: alcohol and drug treatment, socialization, setting up meetings, bringing people together for support groups or even intervening with two residents who are angry at each other. (Thomas, 2003; Mueller, 2003). Othertimes, they perform more mundane concrete task such as food preparation, showering or escorting patients. They often fill the lowest entry-level position at a mental health facility. (Gerhart 1990; Kimmel, 2003).

Standardization for mental health paraprofessionals is so lacking they do not even have one name that everyone calls them. Technically, these are the direct care staff, without advanced degrees who are most likely unlicensed and the lowest paid staff member in any institution.

They are sometimes called mental health aides, nonprofessionals or direct service staff. (Perls, 1978)

Who are the Mental Health Paraprofessional Workers?

As it turns out, this nameless group represents the largest proportion of the mental health workforce. By some estimates, in 1994, there were 145,000+ non-degreed paraprofessional staff representing 25% of the total mental health workforce in the United States. Registered nurses were a distant second at 14.3%, followed by social workers at 7.2%. Paraprofessional workers represent 40.9% of the total staff at state and county mental hospitals. (Morris and Stuart, 2002). Others estimate that direct care staff (including psychiatric technicians) represent as much as 40% of active patient staff in behavioral health organizations and more than 60% of patient care staff in state and county psychiatric hospitals. (Hoges, 2002).

In spite of their large numbers, data documenting the demographics of this workforce is few and far between. While there is a wide body of literature surrounding professional mental health workers, the nonprofessional workforce is virtually invisible to the research community. A recent ground-breaking study of the mental health workforce in California failed to document paraprofessionals, focusing only on professionals. The authors recognized this as a weakness of their study, saying:

> Working alongside these professionals are many other certified or non-specialized providers including nurses, pharmacists, therapists (e.g., occupational, recreational), ***paraprofessionals*** [emphasis added], and numerous others whose roles in providing care are essential. Wherever possible in this report these roles in providing mental or behavioral services are acknowledged, yet are so diverse that is impossible to include comprehensive information about them. Categorization and study of these workers merits further attention. (McCree, 2003).

Despite the lack of available data, there are certain aspects of the paraprofessional workforce that can be identified. One can surmise that these workers are low income even

welfare-eligible; the average wage for paraprofessional workers is $8-10 per hour or $24,000 per year. (Dalquist, 2003; Mueller, 2003). In a national study of mental health direct care workers, 29% have only a bachelor's degree while as many as 25% do not have any college degree. (Gill KJ, Pratt CW and Barrett N 1997). There is little to no data on the average age of these workers, however, it seems that, at least in the Alameda County public system, many of these workers are approaching retirement age. (Majak 2003).

In one survey 48% of employers in New Jersey reported hiring inadequately educated and trained staff because of a lack of qualified applicants. (Gill KJ, Pratt CW and Barrett N 1997). Other employers say despite or aside from little education and experience among recent hires, one key quality desired of these workers is an empathetic nature. The fact that many of these workers are considered empathetic and able to relate well to others is not to be undervalued. Early literature from the sixties and seventies on mental health paraprofessionals sometimes referred to them as "indigenous workers". This emphasizes one of the strengths that these workers can have over clinical professionals. Coming from similar communities as the clients, they play a special role in the socialization of the clients; offering more holistic and less disease-centered approach to care. (Zinman 2003). Above average emotional intelligence is crucial for the work they do. Many paraprofessionals work with clients with severe mental illness or children who are emotionally disturbed. As one curriculum designer noted, "[They] don't get the respect they deserve for the work that they do. You don't go into this line of work unless you care about people. This is not what you have to do as a job." (Dalquist 2003).

There is a small but significant proportion of these workers who are known as "consumer-providers", individuals who have recovered from their own mental illness and re-enter the system as paraprofessional workers. (Kuehn 2003; Thomas 2003). Oftentimes,

employers count time spent in the mental health system as a client as work experience when the same individual applies for a job. (See Appendix 2, Interviews with Providers). These workers bring a valuable perspective both to their individual workplaces and to the larger mental health policy arena.

A Brief History of Mental Health: The Creation of the Modern Day Paraprofessional

The lack of standardization among the paraprofessional workforce can be traced back to the evolution of their role within the larger framework of mental health in the United States.

Early mental health system reformers in the United States were dismayed at the high numbers of mentally ill persons living on the streets or in the prison system. This led to the creation of a system of asylums or homes for the mentally ill. Later, there was a move to a more scientific movement in mental health. This next wave of reformers, recognizing the medical basis of mental illness, created large psychiatric hospitals specifically designed to care for the mentally ill. (U.S. DHHS 1999). Paraprofessional work during these time periods was well-defined and contained literally within the confines of the hospital walls. "The daily direct care, feeding and personal supervision of patients was the responsibility of poorly educated, poorly paid and often poorly motivated attendants, an often temporary, mobile 'working class'". (Karno and Schwartz 1974).

In the mid-1950s several high profile stories of neglect and abuse in these facilities ushered in the era of Community Mental Health. This was further facilitated by the introduction of Thorazine in 1955, the first anti-psychotic drug perceived as sufficiently effective to stabilize institutionalized persons, enabling them to live in the community. At the core of the Community Mental Health movement was massive deinstitutionalization coupled with legislation severely

restricting involuntary hospitalization. The success or failure of these two items remains a hotly contested controversy to this day. Prior to deinstitutionalization 97% of individuals committed to psychiatric hospitals were put there involuntarily. In response to this and the abuse found within the institutions, the states moved people out of institutions and then created laws making it very difficult to reinstitutionalize them. Each state created its own legislation, in California the law was known as the Lanterman-Petris-Short Act. This law limited involuntary hospitalization to instances where the state could demonstrate an individual to be in danger of harming themselves or others. In 1963, the Mental Retardation Facilities and Community Mental Health Centers Construction Act was passed providing initial funding for the transition of taking people out of institutions and moving them into the community. (Torrey 1997; Little Hoover 2000)

With the move to community health came a "nonprofessional revolution." (Sobey, 1970) Mental health planners envisioned new and innovative roles for nonprofessionals in the community. Sometimes called "indigenous workers" they were thought to have an added advantage of coming from the community and having a better understanding of the socio-cultural needs of the patients. Literature from the late sixties and early seventies is rife with debate surrounding how and where to train these nonprofessionals, the political ramifications of what name to give them, how professional psychiatric nurses and physicians perceived their more proactive role in the treatment process. (See Appendix 4, Training Programs for Special Populations).

Prior to the Community Mental Health movement, institutionalized mental health provision was characterized by, "the psychiatrist playing a dominant clinical and administrative role…much of whose time was devoted to administrative work, coupled with a large work staff with little education and training." (Karno and Schwartz 1974). The decades following the sixties and seventies saw the creation of a range of mid-level allied health professionals in mental health (See Table 1). Accompanying the creation of these mid-level professions were standardized curriculums, certifications and licensures. While it was thought that these requirements for certification and licensure would eventually trickle down to the original nonprofessional aides, they never did. Despite the anticipation of mental health planners like Dr. Perls below to the contrary, the roles of paraprofessionals in the community remains essentially unchanged today from when they worked primarily in institutions.

Table 1: Mental Health Professionals in California in 2001 (McCree et al 2003)

- Counseling Professions
  - Marriage and family therapists, 23,000
  - Rehabilitation counselors
  - Human development counselors
  - Substance abuse counselors
- Licensed clinical social workers (clinical mental health social workers); 13,000
- Psychologists; 11,000
- Psychiatrists; 4,900
- Advanced practice psychiatric and mental health nurses*; 419
- Psychiatric technicians and other allied health professionals;
  - Psychiatric technicians; 9,200
  - Occupational therapists and assistants
  - Recreational therapists
  - Industrial-Organizational psychologists; 100
  - Consumer-Providers; 1,700**

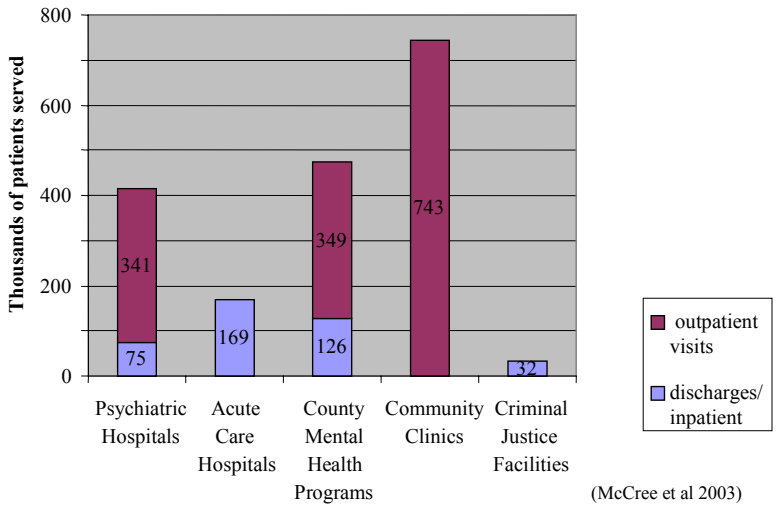
* Nurses include: staff nurses in mental health setting, clinical nurse specialists (CNS), and psychiatric nurse practitioners
** Estimate

> It is likely that in another decade we will no longer be concerned with what they [mental health paraprofessionals] are called because their identity will be solidified as a result of competency-based training, implementation of certification and licensure requirements and ever-increasing demand for human services that are relatively economical to sustain." (Perls 1978)

The Legacy of Deinsitutionalization

The materialization of paraprofessional standards seems to have been lost in the "non-system" mental health system that came out of deinstitutionalization. From 1980 to 1998, the number of patients in state and county mental hospitals decreased almost 60 percent—by the end of 1998 about 57,000 people were institutionalized. (GAO, 2000). Today mental health care in California is provided through a "vast patchwork quilt of services". (Keefer 2003). In California, in 2000, 67% of patients passed through the over 700 clinics in the community-based mental health system. At the same time 23% of patients were served by 4 state and 28 non-state psychiatric institutions. (See Figure 1). The resulting system is highly dependent on decentralized private community based non-profit and for-profit mental health providers. (Zhang et al, 2000) Service provision once cleanly contained literally and conceptually within the walls of large state-funded psychiatric hospitals has since become widely dispersed. Persons in today's mental health system are exposed to multiple tiers of professions and institutions which represent a wide spectrum of levels of independence from hospitalization, to "half-way houses", to day care, to living independently in the community with public benefits, to full independence with self-sufficiency. (See Figure 2). With such a decentralized system it is far more difficult to track the quality of care provided than in the years before deinstitutionalization. What heretofore

Figure 1. Persons Cared for by California's Mental Health System, 2000
1,218,000 (67%) by Community Agencies
416,000 (23%) by Psychiatric Hospitals



(McCree et al 2003)

has been impossible is to track the quality of care, training or even numbers of the unlicensed paraprofessionals working within this community-based system.

Financing Mental Health Services in California

The success or failure of deinstitutionalization has proved to be one of the most controversial issues in mental health today. Some say the high rates of violence, homelessness and incarceration among the mentally ill are proof of the failure of deinstitutionalization and the community based mental health movement. (Torrey 1997) Others argue that assessment as being uninformed and misplaced. They say that deinstitutionalization never really happened. Instead of deinstitutionalization we have had trans-institutionalization, *devolution*-- a movement from state and county hospitals to privately run nursing homes or board and care homes. (Hudson and Cox, eds 1991). They argue that state and federal governments were so taken with the cost savings associated with closing down institutions that they lost sight of the need for continual investment community based mental health centers and the personnel who staff them. (Hogan, 1999; Kirk and Einbinder, eds 1994).

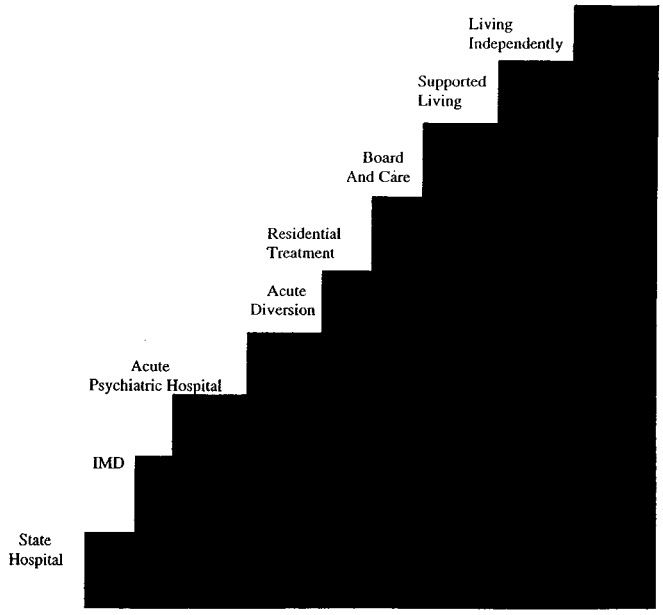


Figure 2. Mental Health Steps to Independence (SEIU 2002)

This failure of money to flow back into the community mental health system has meant that there is little to no investment in the paraprofessionals whose role in mental health care delivery has increased dramatically in recent years.

According to a National Institute of Mental Health public information packet: "Deinstitutionalization presupposes that a great many essential resources are placed in the community, including housing, access to entitlement programs, the availability of ongoing treatment for psychiatric treatment and opportunities for meaningful work or vocational rehabilitation…where necessary supports are still missing, a common result is homelessness." (Hudson and Cox, eds. 1991). A recent GAO report concludes that these necessary resources never came to be. The federal government provided states with initial funding under the 1963 Community Mental Health Centers Act to create the infrastructure needed to support deinstiutionalization. Eight years later the states were expected to develop alternative funding sources to replace the federal funds. However, the states were never able to successfully find funds to match federal dollars and in 1981 the federal government replaced state community mental health center funding with block grants.

In the ensuing years, states have attempted to shift the costs back to the federal government by tailoring service provision to meet federal reimbursement policies. From 1987 to 1997 state funding of mental health dropped 4.2% while federal funding rose 7.8%. (GAO 2000) The result of this cost-shifting is a system of misaligned incentives where care is provided in a disjointed, uncoordinated manner through a spider web of funding sources. (See Figure 3).

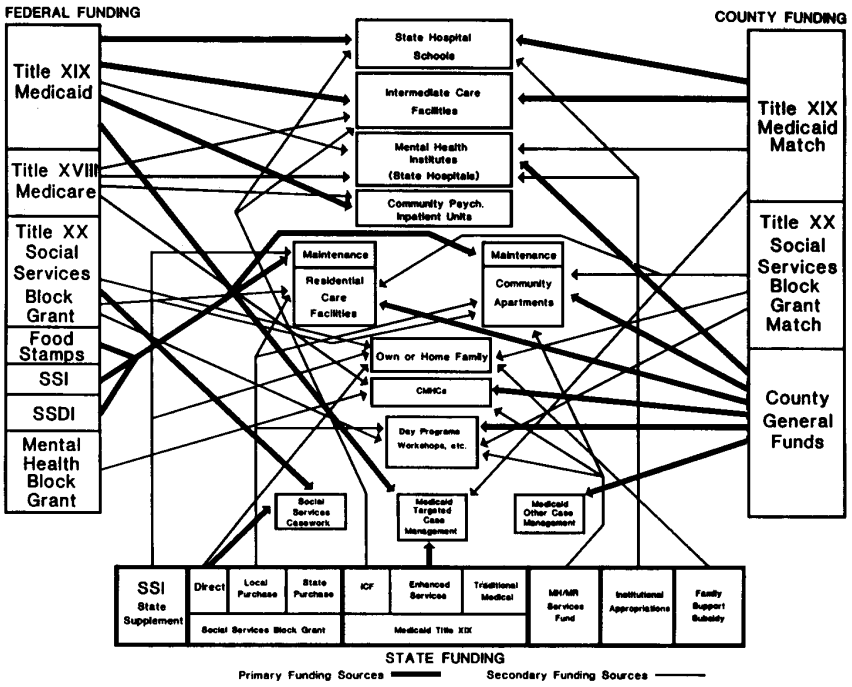


Figure 3. Funding Sources for Mental Health Programs in Iowa (Torrey 1997)

Factors Contributing to Increased Roles and Responsibilities for Paraprofessionals

1. Mental health financing increases the use of paraprofessionals while creating a disincentive to invest in them.

In order to access dispersed public funds individual employers must be extremely strategic in how they invest in personnel. There is an obvious incentive to substitute less expensive paraprofessional workers for more costly professionals. At the same time, Medi-Caid, Medicare and other major funders of mental health services often do not reimburse for unlicensed workers, such as paraprofessionals. This creates a disincentive for agencies to invest in these workers' wages and training. Community providers must balance a delicate ratio between using less expensive unlicensed workers while maintaining the numbers of billable hours from professional staff. As one administrator put it, in the county facilities where there are

higher "performance requirements" and "more fat in their schedule" the percentage of billable hours out of all direct service hours is approximately 50%; in the community agencies where "everyone is working for a living" the percentage is more like 80%. (Dalquist 2003).

2. Private Insurers: Managed Care and Mental Health Parity Issues

Mental health is in no way immune to the general trend of managed care and insurance cost controls that have entered into the fore of American health policy since the nineties. In short, managed care utilization reviews and government financing patterns have created an incentive for providers to replace highly trained workers with cheaper labor. (McCree et al, 2003, p38). As physicians are the only mental health professionals who can prescribe, they are used far less in the mental health system then lower cost social workers who can provide similar counseling services. Patients in facilities requiring 24-hour supervision are similarly cared for by lower cost paraprofessionals.

Alongside managed care are issues of mental health parity whereby all insurers offer greater cover for physical ailments than for mental illness. These restrictions on mental health payment often come in the form of limited number of coverage days. These limits on private insurer payment have led to an increasing provider dependence on fickle government sources of funding.

3. Shortages in the mental health workforce create a greater dependence on paraprofessionals.

The failure to invest in the mental health worker training does not affect paraprofessionals alone. The lack of money in the mental health system means that at all levels

healthcare professionals make more money outside of mental health. Yet, while there are loan forgiveness programs for many health professionals there are few to none for those in mental health. (Mandel 2003). A February 2003, study of the mental health workforce in California conducted by the UCSF Center for the Health Professions reveals large workforce shortages at many levels of the mental health professions. A 1999 California Mental Health Planning Council study found 2,500 vacancies in county programs and state hospitals alone. The highest vacancies were reported among psychiatrists, social workers, registered nurses and psychiatric technicians. The report forecast an increase in the overall demand for mental and behavioral heath care workers from 63,000 in 2001 to between 73,000 and 80,000 in 2010 (an increase of between 16 and 30 percent). At the current rate of mental health professional training, the report forecast the gap between the under-supply of workers and the increasing-demand for their services to increase in the future. (McRee et al, 2003)

As mentioned above, though considered a crucial part of the workforce the paraprofessional population was not included in the UCSF study. However, it can be assumed, that if cost-shifting pushes agencies to substitute paraprofessionals for more expensive professional workers, that shortages will do so as well. This means increased roles and responsibilities for paraprofessionals workers who have low pay, little education and training and little standardization. The biggest example of this is Early and Periodic Screening, Diagnosis and Treatment (EPSDT) under Medi-Cal. It is designed to keep child or adolescent out of facility. Much of this program consists of shadowing where the mental health worker accompanies the client through their daily activities. “It is all done by paraprofessionals. It doesn’t have to be, could be done by an MD but paraprofessionals spend anywhere from 4 to 5 to 8 to 10 hours a day with children and adolescents with serious behavioral problems. They are providing specific

behavioral interventions. They create a plan with the family. All within the scope of not prescribing drugs." (Mandel 2003).

4. Blurring of roles among mental health professionals in the community care setting.

The clear roles played by each mental health professional that existed prior to deinstitutionalization have become blurred in recent years. One example of this is the conflating identities of psychiatrists and psychologists. Both are called doctor and provide very similar types of counseling services and treatment plan design. Yet, only psychiatrists who are physicians have prescribing privileges. (Kirk and Einbinder, 1994). Mental health social workers and marriage and family counselors (who have Masters degrees) are referred to as therapists in the same way that psychologists are commonly called therapists.

This blurring of roles continues all the way through the spectrum of workers down to paraprofessionals. The increased dependence on paraprofessionals means that more and more these workers are key components of the treatment process. Yet, unlike the others there is no standard training for them to fill these roles. As one administrator noted: "Paraprofessionals provide counseling [in the form of helping clients with] day-to-day living skills. How do you define the difference between what a license psychiatrist and psychotherapist does from what a paraprofessional does if they are not doing intensive psychotherapy? This is about skill building. You frequently have paraprofessional case managers helping a client manage their symptoms. That's tough work." (Mandel 2003).

5. The medicalization of mental health and increasing use of technology.

The issue of prescribing privileges is particularly salient with the medicalization of mental health treatment. "Listening to Prozac," Peter Kramer's novel of 1993, christened a generation free of the stigma attached with mental illness treated by medication, bringing it into the mainstream. The children of baby boomers are no strangers to this medicalization with Attention Deficit Disorder as much a household word as its prescription drug solution, Ritalin. The resulting increased use of medications means that more and more paraprofessionals are dealing with increasingly technical service delivery, but, unlike the professionals, there is no guarantee that they receive continuing education to keep up with new technologies.

As one administrator put it, "Every year we do more and more with less and less." (Mueller 2003). Said another, "Professionals all need training because advances in knowledge about mental illness are so explosive you have people who don't know the state of the art. There is a gross lack of training…If [paraprofessionals were] better educated about techniques they would know about things to watch for, things to report, side effects of drugs…legal issues." (Mandel 2003). One example of this is early intervention with schizophrenia. Recent studies have shown that if the signs of schizophrenia are recognized in time for early intervention it can radically change the course of an individual's disease. As paraprofessionals spend the majority of time with clients they are the best candidates to observe changes in behavior. At the current level of paraprofessional training, such early intervention is for the most part contingent on the innate qualities of a given worker as opposed to the implementation of proven evidence-based medicine.

Part II: Evidence of a Need for Better Training

As mentioned earlier, there is little or no data collection on mental health paraprofessionals by federal government, state regulators, academics or accreditation agencies. For all intents and purposes, in the eyes of regulators and researchers, this is an invisible workforce. In regards to restraint related deaths: "Right now we don't have those numbers," said Ken August of the California Department of Health Services, "and we don't have a way to get at them." (Weiss, October 11, 1998). Additionally, there are no regional or national standards for mental health paraprofessional training. (Morris and Stuart, 2002):

> Less apparent, however are the qualifications of these mental health workers as well as the nature of any programs or standardized training offered or received by these individuals. One fears that many may find themselves, in the words of a field leader in rehabilitation counseling, "Well trained but unprepared" (Kress-Shull, 2000), or worse yet, neither well trained nor prepared.
>
> A review of the literature found no reports of any aggregated data on their qualifications for employment, nor were there any standardized training programs that have been adopted on a regional or national level.
>
> Even where entry-level staff can be recruited, retention is undermined by the absence of career paths through competency-based training that leads to a valued credential, and other forms of recognition as well as opportunities for higher wages (Taylor, 1999).

What is known about their training needs is mostly anecdotal and empirical. For example, as was mentioned in the Hartford Courant, these workers, who work with often severely disturbed individuals, have less stringent training requirements than hairdressers. (Farley 2001). Or as one mental health administrator and educator put it, "These people are learning about mental health the way teenagers learn about sex—from their coworkers. What's a conservatorship? Learn from a coworker. If they have it wrong, okay, now you have two people who have the wrong information." (Mueller, 2003).

The limited studies on what types of training these workers do get concludes that it is minimal and often limited to the topics required by accreditation bodies. (Hoges, 2002)

Paraprofessional workers themselves are not required to be licensed. However, in order for the facilities that employ them to retain their licensing there are training requirements for these workers. For the agency to receive credit for the training it must be on paid work-time. Some agencies consider this requirement a form of an unfunded mandate--the training is required in order for them to get their funding from the state but providers to not receive any additional monies to provide it. This creates an incentive to provide only training that will receive credit in a state audit. As one Bay Area training director at a community-based non-profit noted, "I am not going to say I won't provide the training [to a worker] if we don't get credit for it, but there are fiscal consequences of not doing so." (Kellogg, 2003).

Paraprofessional Training Regulatory Requirements

There are general requirements of on-the-job training or related work experience for all workers at community care facilities. There are no hour requirements for this training and no assessment mechanism. The training centers around knowledge and skill in the following areas:

1. Principles of nutrition, food preparation and storage and menu planning.
2. Housekeeping and sanitary principles.
3. Client care and supervision, including communication.
4. Assistance with medications that are self-administered
5. Recognition of early signs of illness and the need for professional assistance.
6. Availability of community services and resources.
7. Universal Precautions[1]

[1] California Code of Regulations, Title 22, Division 6, Chapter 1: "'Universal Precautions' means an approach to infection control that treats all human blood and body fluids as if they are infectious. Generally, Universal Precautions consist of regular handwashing after coming into contact with another person's body fluids (mucous, saliva, urine, etc.) and includes the use of gloves when handling blood or body fluids that contain blood." Universal precaution training is only required for adult community care facilities.

There are then more specific requirements for the different facilities under Community Care Licensing jurisdiction. (Table 2). Paraprofessionals who work in group homes serving children have the highest training requirements. They must do 44 hours of training per year. However, outpatient workers and those who work with adults have far less training required. Social Rehabilitation facilities, which provide 24-hour a day nonmedical care and supervision and training in a group setting, require 20 hours continuing education per year for "direct care staff". In addition, staff must have graduated from high school or possess a GED and 1 year full-time experience or part-time equivalent working in a program serving persons with mental disabilities. Adult Residential Facilities, which provide 24-hour non-medical care for adults who are unable to provide for their own daily needs, have training requirements only for direct service workers who are night supervisory staff. (California-DSS-Manual-CCL, 2003).

Table 2. Title 22 Training Requirements for Paraprofessional Workers

	Children: Group Homes	**Adults: Social Rehabilitation Facilities**	**Adult: Residential Facilities**
Before working independently with patients	• Initial 8 hours • Maximum 4 hours consisting of shadowing • Assessment: supervisor's observations documented in worker's record	• None	• Night supervisory staff: Training in the facility's emergency procedures and first aid
Within 90 days of hire	• Additional 16 hours • Assessment: Proof of completion signed by educational institutions… or qualified individuals	• None	• None
Continuing Education	• 20 hours addition annual training • At least 5 hours of training from outside entity	• 20 hours	• None (above general requirements for all workers at all facilities)

California-DSS-Manual-CCL, Effective 6/28/99

Perceived Need for Training: Conversations with Community-Based Mental Health Providers[2]

The scope of this analysis did not allow for a comprehensive assessment of the training needs mental health worker. However, a qualitative analysis was undertaken in the form of a series of telephone interviews with 15 Bay Area community-based mental health centers that employ mental health paraprofessionals. Among those interviewed were heads of human resource departments, directors of training or executive directors. (See Appendix 2 for Summary of Provider Interviews). A range of facilities was chosen, both large (approximately 400 employees) and small (under 10 employees) in five of the Bay Area counties.[3] They provide care to the elderly to adults and to children; whose needs ranged from high-level inpatient care. to day care, to outpatient care. Providers were asked questions on the following topics: the type of training direct service workers have before they are hired by the agency; the type of training they receive on the job; the type of training the employer would like to offer but cannot because of time, budget and other barriers; and their opinions on alternative training structures. (See Appendix 5 for provider interview questions).

[2] I believe it very important to point out the problems I faced during my interviews. In the course of calling these employers I became increasingly aware that their responses to my questions about the content of their training programs was contingent upon who they believed was asking the questions, i.e., their perceptions of me as an interviewer. Respondents who perceived me as a student tended to be more forthcoming about the limited degree to which they trained their paraprofessional workers. Those who saw me as a "UC Berkeley researcher" seemed to obfuscate the frequency and duration of paraprofessional training. For example, one interviewee described a highly comprehensive list of training provided. When I asked more specifically the number of hours a month that paraprofessionals attending the trainings they recanted and said that it was the professionals who attended the trainings and later told the paraprofessionals about them in staff meetings. As a result, much of the conclusions on the current state of paraprofessional training are as much my impressions of what providers told me as what they actually told me.

[3] Cities and counties agencies were located in: San Francisco County (San Francisco), Santa Clara County (San Jose), Alameda County (Oakland, San Leandro), Marin County (San Rafael), Contra Costa County (El Cerrito).

Prior work experience:

It appears that the majority of these workers are hired with very little education or work experience. Their credentials range from high school diploma with no work experience at all to some college and some counseling experience but not necessarily with the population in question, to at most a Bachelors degree and 2-3 years related work experience. Relevant work experience included counseling and work with special populations such as: children, adults and the severely mentally ill. There is a small group of workers who may have had training in a health profession in another country but their degree is not recognized in the United States.

Employers cited personal qualities they looked for in prospective workers. They hire people who, "have both feet on the ground, deal well with people, have a willingness to listen and tolerate whatever clients are expressing." There is also a small but increasingly important group of paraprofessionals known informally as "consumer-providers". These are individuals in recovery from mental illness who re-enter the workforce as peer counselors and paraprofessionals in community-based agencies. Often these workers experience as consumers in the mental health system is credited as relevant work experience when hired as a paraprofessional.

The community-based paraprofessional position was once filled more widely by Bachelor's level workers after college and before graduate school. The undergraduate education that these workers had gave them an academic base to build off of in learning mental health concepts. However, the phenomenon of these individuals working as paraprofessionals is more so a phenomenon of the past. More and more those with Bachelor's degrees do clinical training at community-based agencies as part of the field work for their graduate degree program.

Training received on the job:

True to the literature the majority of training received appears to be done in fulfillment of accreditation requirements. This is particularly true of juvenile facilities, where in order for the facility to retain its licensing the direct service staff must fulfill specific training requirements, including offering 24 hours of training within the initial 90 days of hiring. (See section above on Title 22 regulations). In the adult facilities the majority of training appears to occur on the job as part of shadowing, it does not seem as though the workers are required to have any training before working with patients. Training for paraprofessionals working with either adults or children is usually assessed by a supervisor's documentation in a worker's record.

Training is for the most part is provided by on site provider staff. Though in some instances, as required for accreditation or by union contract, outside training was provided. Several agencies reported accessing county-sponsored training sessions for little or minimal cost. Some of these trainings focused on issues of cultural competency, documentation and dual diagnosis. Table 3 below summarizes the manner in which different training topics were covered by the community-based agencies. The majority of agencies covered issues of documentation, agency mission, mandated reporting requirements and case management very soon after hiring a paraprofessional. Three of the ten agencies with results posted in Chart X serve children in residential settings. These agencies reported fulfilling nearly all of the statutory training requirements in structured sessions provided before a paraprofessional begins work.

In contrast, agencies providing outpatient services and those serving adults in residential settings were much more informal. Many of these employers trained workers the job, as part of informal supervisor feedback or covered topics in case reviews as part of weekly staff meetings.

Outside of staff meetings, paraprofessionals at these agencies appeared to receive training once a month. These monthly trainings ranged in duration from one hour to half a day. Many of the agencies said they did not provide training on restraint and seclusion, as they did not work with a severely emotionally disturbed population.

Table 3. Summary of Mental Health Provider Interviews[4]

	Currently Offered	On-the-job	Don't offer, would like to	Not Applicable
Documentation (internal/external)	7/10	2/10		1/10
Mission of the Agency	6/10	3/10		
Mandated Reporting[5] Requirements	6/10	3/10		
CPR, First Aid	5/10	2/10		2/10
Client Rights	7/10	1/10		1/10
Case Management	6/10	2/10		1/10
De-escalation*	5/10	1/10		3/10
Restraint/Seclusion	2/10			7/10
Symptom Management	5/10	3/10	1/10	
Treatment Plan Development	3/10	4/10		2/10
Informal Counseling	4/10	5/10		
Substance Abuse	5/10	5/10		
Dual Diagnoses[6]	4/10	4/10		1/10

Other training topics covered:

Medication (5/10), medical issues, diversity/cultural competency (3/10), OSHA, PART*[7](2/10), nature of mental illness (4/10), ethics, counter-transference, sexual harassment, domestic violence, advocacy/navigating bureaucracies

Soft skills: Active listening skills, communication, skill building, time management, taking care of yourself

Population-specific: Parenting skills, adolescent suicide prevention (2/10)

Perceived need for training: All interviewees stated they would like to offer more training but are limited by time and budget restraints. All but one employer said that monies to pay for training came from the agency's general budget and they did not access specialized training

[4] Values are expressed as the fraction of employers who replied.
[5] Mandated reporting requirements state that health providers must report incidents of child or elder abuse.
[6] Dual diagnosis is training for individuals with combination mental illness and substance abuse issues.
[7] PART stands for Professional Assault Response Training. It is a two day course in assault geared for those working in an in-patient setting that is taught by certified PART trainers.

funds. As such it was more difficult to pay for training of paraprofessionals as in many cases their work is not "revenue-generating" for the agency. Some agencies mentioned that the need to maintain a high number of hours of "productivity" undermined their ability to do training on work time. Others said that even if training were free it would be difficult to offer, as it had to be on paid time in order to receive "credit" in regulatory audits. The one agency which state time as less an issue than money had a large agency and felt they had more staff to cover for those workers in training than would a smaller agency. However, even this large agency mentioned the difficulty of residential staff taking time off for training. In terms of what extra they would offer the general theme was more hours of training. Some agencies mentioned not being able to keep up with innovations in care delivery because of the cost of training. Early intervention was cited as a desired training topic, one agency specifically mentioned training around early intervention in schizophrenia.

Part III: Options for Paraprofessional Training

In sum, paraprofessional roles and responsibilities have increased while funding for them has decreased. Being widely dispersed, with an undefined professional status these workers and their needs are statistically lost to regulators and academics. Employers themselves recognize the need for more training, but due to insurer reimbursement policies have a disincentive to invest in this training. Operating under the assumption that there is a need for a better and more standardized mental health paraprofessional training, the question becomes how to go about accomplishing this.

Community College Mental Health Paraprofessional Worker Training Programs

Table 4. Community College Mental Health Paraprofessional Training Programs

Pasadena City College, Southern California
- Intensive 16-week long course
- 160 hours of classroom work, 48 hours of field practice
- Topics covered: roles and responsibilities of mental health workers, client rights, delivery of mental health services, signs of abuse, human development, implications of substance abuse, case-management, effective communication skills and appropriate behavioral interventions
- Workers must pay tuition

California Association of Social Rehabilitation Agencies (CASRA), Martinez California
- Psychosocial Rehabilitation Program (PSR)
- 7 courses leading to a certificate in PSR at Statewide community colleges
- In development

Mt. San Antonio College (Mt. SAC), Walnut, California
- Mental Health Worker Certificate Program
- 60 credit hours
- Collaboration between industry providers and Regional Health Occupations Resource Centers

Community colleges have a long history of providing vocational training. As such they are uniquely positioned to fill the gap in paraprofessional training. In California and nationwide there are a handful of community colleges that offer courses to train mental health paraprofessionals. (Table 4).

Pasadena City College (PCC) in conjunction with the nearby Pacific Clinics, one of the state's largest employers of

mental health paraprofessional workers, created one such program in Southern California. The PCC program has posted four graduating classes of around 30 students each. It is an intensive 16-week long course. Among the goals of the course is the training of consumer providers and to attract "appropriate members of the community into the mental health workforce. The curriculum has a clinical focus, increasing the paraprofessional's understanding of mental health as well as principles of case management. (Pasadena City College and Pacific Clinics Collaborative 2002). This is an example of a large employer, who has the resources to work with a local community college to increase the pool of qualified applicants to fill the agency's paraprofessional needs.

Mt. San Antonio College has in development a less intensive paraprofessional training program fashioned after training programs for certified nurse assistants (CNAs). The CNA program is designed to be highly accessible. It is often provided by provider staff in the workplace or by instructors at adult vocational schools. The manual for teaching the curriculum includes prompts for the instructor to do role-playing scenarios. It assesses student learning through the use of a pre-test and a post-test. (Mueller 2003). The analogous mental health worker program is to be a competency-based certificate program for entry-level workers. The goal of its creators is that it be adopted and distributed widely through Regional Health Occupations Centers, a partnership of local government agencies, schools and employers, to community colleges throughout California. (UCSF 2003).

The California Association of Social Rehabilitation Agencies (CASRA) is a statewide association of private, non-profit agencies providing rehabilitation and support services for clients of the public mental health system. CASRA is centered on a holistic, psychosocial approach to mental health delivery **as opposed to** "a strictly medical model with, with an

emphasis on pathology and medication." (Borgfeldt 2002). CASRA provides training to approximately 1,000 California paraprofessionals working for community-based mental health providers who are CASRA members. (Dalquist 2003). Several of the employers interviewed for this analysis reported contracting out with CASRA to provide seminars and attending CASRA conferences. CASRA recently developed a curriculum, through interviews with experts and staff, to be used in community colleges to lead to a psychosocial rehabilitation certificate. (CASRA 2001).

A related community college training course for paraprofessionals is the general program in human services. These programs at community colleges are often certificate granting and developed in cooperation with State and County Departments of Mental Health, Rehabilitation, Vocational Rehabilitation, and Human Services. Their curriculum emphasizes ethics, communication skills, accessing community resources, human development, working in small groups with elective courses in such topics as substance abuse. (Merritt College 2003). They are designed to prepare students for paraprofessional positions in human services, such as mental health case manager, job coach/employment specialist, social service intake specialist, or community health worker. (College of San Mateo 2003). Human services training programs exist out of Merritt College, San Mateo Community College, Solano County, La Canada and Riverside Community College to name a few. (Keffer 2003; Mahler 2003).

Mental Health Paraprofessional Training for Special Populations

There are pockets of research documenting experimental training programs for mental health paraprofessionals serving specialized populations. The majority of these studies were done in the seventies and eighties in the wake of the "nonprofessional revolution." More recent studies have focused on consumer trainers or training special populations to work as mental

health aides such as college students or older adults. For a review of proposed curriculums, training program structures and lessons learned see Appendix 4 "Training Programs for Special Populations."

Consumer-Provider Training

There are several training program designed specifically for consumer-providers, those individuals who have gone through the mental health system first as consumers and then re-enter as paraprofessional workers. Many of these programs are provided out of county departments of mental health who recruit former clients. Initially these workers were to become peer counselors. Eventually the programs "blossomed into 'if you want to enter into the mental health field, here's what you have to learn." (Thomas 2003). Through the course of their careers many of these workers find themselves migrating into the mainstream paraprofessional workforce in clinics that are part of the general community-based mental health system.

As these programs often work exclusively with those individuals who have seen the mental health system from a consumer's perspective their curriculums take a departure from the clinical model. (Kuehn 2003; Thomas 2003). These programs have an emphasis on client empowerment and recovery through such topics as: self-help, history of the mental health patients' rights movement, and overview of public mental health, knowing and accessing community resources, peer support, recovery action plan, housing, accessing public benefits such as SSI, ethics and roles, and helping people to manage their own symptoms. (Mahler 2003).

The Consumer Perspective on Paraprofessional Training

The California Network of Mental Health Clients (CNMHC) is a statewide advocacy organization run for and by mental health clients/survivors. CNMHC has been involved in

planning meetings of the California State Mental Health Council's Select Committee on Mental Health and Developmental Disability. CNMHC provides an important consumer voice in the Council's plans for developing California's mental health workforce. They have been particularly active in guiding the state in the use of restraints and seclusion. In a series of discussions with the Service Employees International Union (SEIU) CNMHC established an agreement on the following set of guiding principles in the use of seclusion and restraints (SEIU and CNMHC 2003):

> ***WE HEREBY SUPPORT*** *a goal of reducing the use of seclusion and restraints. In order to achieve this goal, we propose the following five principles:*
>
> 1. The mental health system must undergo a fundamental change in culture throughout the whole system, from top to bottom, in its attitude toward the use of seclusion and restraints;
> 2. New training must be established for workers, especially in de-escalation techniques;
> 3. There must be an increased in the number of personnel in order to provide for more opportunities for clients to benefit from one-to-one connections with staff;
> 4. There must be an added emphasis on the importance of peer support; and,
> 5. Crisis plans must be developed by clients prior to crisis situations in order to more effectively diffuse potential for escalation.

From a consumer perspective the fact that paraprofessionals are similar to lay persons in their lack of a clinical approach means they bring a "human, holistic approach" to the mental health system. Consumers may prefer that mental health paraprofessionals not have the same clinical perspective on mental health disease and diagnosis as do their professional counterparts. As explain by Sally Zinman, psychiatric survivor and Executive Director of CNMHC:

> In the mental health system, the idea of not seeing people as their diagnosis and not carrying a clinical approach is good…People need a human touch. The amount of people that can give them that is a good thing. [Paraprofessionals] can add to the real life needs and touch someone as human beings, not always looking for signs. [The] number one concern [for consumers] is seeing someone as a whole person. The human side of psychic pain is being ignored when it's "what's the biological source and take a pill", it's all being ignored. There is a medicalization of human suffering. (Zinman 2003).

Union-Sponsored Training

Historically, unions have not had a reputation of training disadvantaged populations. Labor's past of practicing exclusionary policies in the craft and building trades often kept women and minorities away from some of the best paying jobs. However, more recently unions have been involved in creating partnerships with employers to create worker-training programs. (Takahashi and Meléndez, 2002). Training is seen as a source of common ground where the interests of unions, workers, and employers often coincide.

For the union training is seen as an opportunity to do both internal as well as external union-building. Internal union-building means increased opportunities for already unionized workers to play larger roles at their workplace. External union-building is an opportunity to increase the number of union members at a worksite. In addition, training is an area where it is possible to find common ground with employers even in cases where labor-management relations are contentious. (Zabin and Autler, unpublished) In addition, in instances where the union is seen as a source of employer recruitment of qualified workers, training can increase the union's leverage over employment in the industry and in the local labor market. (Rogers, 1996).

In working with broad-based partnerships, unions are often able to leverage training funds not otherwise eligible to individual employers trying to sponsor training out of their general budget. A review of existing union-sponsored training programs reveals that many of them receive funding from a diverse source of funders including: employers, private foundations, federal and state and local government training funds, federal agency grants and contracts, union

negotiated funds, and at times, the workers themselves. (See Appendix 6: Matrix of Partnership Funding). Union-sponsored training programs are found in a wide array of worksites including the 1199 health care workers' training program in New York and the Shirley Ware training center from Local 250 in California.

Case Study I: Hospital League 1199 SEIU Employment Training and Job Security Program (Working For America Institute 2003)

The Hospital League-SEIU 1199 Employment, Training and Job Security Program (ETJSP) is one of the oldest and largest sector-based labor-management partnerships in the nation. ETJSP generates more than $20 million annually and covering more than 300 employers and 85,000 health care workers in the New York City region. It is considered one of the largest health care staff training institutions in the nation.

ETJSP was created 30 years ago when the National Health and Human Services Employees Union, SEIU 1199 in New York City, negotiated the creation of three interlocking funds with the Hospital League, an association of 50 private non-profit hospitals, nursing homes, mental and health care facilities.

1. <u>The Joint Training and Upgrading Fund</u>

   Created in 1969 to upgrade the skills of health care workers it offers workers opportunity to acquire skills, ranging from basic literacy and GED to college degrees. They can acquire specialized occupational skills, earn certifications, attend conferences, obtain continuing education credits, take classes or receive tuition reimbursement.

2. The Job Security Fund

   Begun in 1992, it assists laid-off union members with training and placement services as well as health and unemployment benefits. Services include: counseling, skills assessment, training placement, and up to two years of health and supplemental employment benefits while in training or awaiting placement.

3. Employment Center

   Created in 1994 from a negotiated Planning and Placement fund the center is a primary source of referrals for employers and placements for workers. It also tracks industry trends, technology and job skill changes to assist members, employers and the ETSJP. In 1999, the center had more than 150 employers participating in a placements system for laid off 1199 members as well as other workers referred by the center. More than 1,100 workers were placed in new jobs through the job security fund.

ETJSP owes its longevity and success to the fact that it is able to simultaneously benefit workers, employers and the union. Through its three training funds 1199 has assumed direct responsibility for keeping up with developments in the health care industry and providing employers with skilled employees. This allows it to exercise control over a significant share of the labor market in New York City. By making its training programs accessible to non-members 1199 was able to bring new members into their union as well as "salt" non-unionized workplaces where trainees get employed. The key strategies that 1199 used to create a union-building infrastructure include:

- Bargaining with employers for training funds;
- Raising millions of dollars in additional public investments;

- Designing union-driven, worker-centered training and placement programs that take in to account the interests of the union and its members;
- Offering training to community members outside of the union (e.g. welfare recipients).

At the same time, the union has become known to both workers and employers as a primary link to high quality training and jobs. The training that is offered is worker-friendly, accessible to their schedules and circumstances (on-site training, training during working hours, child care provided). In addition, ETJSP has developed and advocated for training programs that build on workers' existing skills and knowledge. For example, workers who might otherwise have been excluded from training because they do not meet required math or literacy skills are offered support such as basic skills tutoring. For the workers, the skills-building, retraining and job placement offered by 1199 ETJSP helps them retain good jobs, build career ladders and avoid layoffs. (Zabin and Autler Unpublished).

Case Study 2: Local 250 Shirley Ware Training Center

Representing over 85,000 workers in nearly 300 facilities in Northern California, Health Care Workers SEIU 250 in Northern California is the largest local union in California and the second largest health care workers union in the United States. In 1998 SEIU 250 founded the Shirley Ware Education Center (SWEC) to train both new and incumbent health care workers in response to the health care staffing crisis. Since then, it has trained hundreds of workers. The goals of the center are: to educate health care workers in workplace safety; create career pathways for health care workers; and provide a means of entering the health care field. Though it is located at the SEIU Local 250 Headquarters in Oakland, SWEC is considered a free-standing non-profit organization and all of its programs are funded by grants. Funding

organizations have included the U.S. Occupational Safety and Health Administration, The California State Employment Development Department, the U.S. Department of Labor, and the Oakland Private Industry Council. (Braconi 2003; SEIU 250 2003).

Shirley Ware Center Programs:

1. **Career and Education Counseling**
   Career counseling is available to both members and non-members includes: brush up to aid individuals with college placement tests; counseling individuals about healthcare careers and pathways to achieve them; connecting individuals to available supportive services and financial resources; developing a career track to help people achieve their occupational goals.

2. **Kaiser Permanente Upgrade Training**
   In 2000, SWEC in partnership with Kaiser Permanente, Contra Costa Community College, the Workforce Investment board and SEIU Local 250 received a $2.2 million H-1B skills upgrade training grant from the Department of Labor to train SEIU 250 Kaiser employees and SEIU 250 represented Certified Nurse Assistants.

   The program provides on-the-job, paid training for entry-level workers to upgrade their skills and move them into nursing where there is a staffing shortage. It includes Acute Care Nursing Assistant, Medical Assistant, Unit Assistant and LVN to RN training programs for Kaiser Permanente and Local 250 members. In addition, the Shirley Ware Education Center has also received an Allied Health Workforce Project grant in partnership with Kaiser to examine the development of career ladders for existing workers in the health care field.

3. **Health & Safety**
   Provides training to prevent on-the-job injuries. Paid for through the US Occupational Health and Safety Department.

4. **GED Classes**
   Free GED assistance provided by SEIU 250's Education Department for all members and their families.

5. **Citizenship and Immigration**
   In partnership with the International Institute of San Francisco, Santa Clara County Citizenship Project and SEIU 250 are sponsoring citizenship and immigration assistance for SEIU 250 members and their families in the Oakland and San Francisco offices

(SEIU 250 2003)

Part IV: Economic Feasibility and Political Will for Increased Training

Funding Sources Available to Fund Mental Health Paraprofessional Training Programs

Funding sources available to fund a future paraprofessional training program are available from both Federal and State government sources as well as from private foundations.

California Job Training Programs

Table 5 shows a select list of job training programs in California that paraprofessionals would likely be eligible for. Below the table is an explanation of the eligibility requirements of each program and the likelihood of accessing each source.

Table 5- Job Training Programs in California – FY 2000/01 Funding in Millions (CRB 2001)

State Agency	Program	Total Funding (millions)	State General Funds	Federal Funds	Other Fund Sources	Persons Enrolled (in whole numbers)[a]
Employment Development Dept.	Job Agent Program	2.7	2.7			2,364
	Job Services - Labor Exchange-Wagner Peyser-90%	105.7	1.2	80.1	24.4[d]	625,415[e]
	Wagner Peyser-10% Governor's Discretionary Projects	9.0		9.0		Included in item e above.
	Workforce Investment Act	801.4		801.4	-	Included in item e above.
	Intensive Services Program	11.9		8.4	3.5[f]	50,536
	Special Veterans Services	18.3		18.3		Included in item e above.
	School-to-Career	17.9		17.9		Included in item e above.
	One-Stop Career Center System	1.2		1.2		Included in item e above.
	Welfare-to-Work	.624		.624		Included in item e above.
	NAFTA	4.7		4.7	-	135
	Trade Adjustment Assistance	6.1		6.1	-	1548
Employ. Training Panel	Training & Economic Dev. Prog.	97.2			97.2[g]	51,731
Dept of Ind. Relations	Apprenticeship Training	5	1.8	.1	3.1[h]	66,000[i]
Dept. of Rehabilitation	Rehabilitation Services	316.5	46.1	259.7	11.1	76,516
	Habilitation Services	115.5	101.5	1.0	13.0	16,401
Dept. of Social Services	Food Stamp Emp. & Training	69.5	1.3	47.2	21.4[j]	162,091
	CalWORKs	890.1	152.2	735.1	2.8[k]	178,560
	Refugee Assistance Services	19.3		19.3	-	Not provided
CA Community Colleges	Vocational Education	565	505	55	5[l]	2,502,159
	Adult Education (Non Credit	279	279			341,192
	CalWORKs	81.76	73.389	8.389		118,746
	Economic Development	45,172	45,172			114,172
	Apprenticeship	11.895	11.895			43,227
Dept. of Education	Adult Education	473.23	417.23	56.0		706,167
	Adult Vocational Education	168.67	120.37	48.3		423,248

Workforce Investment Act:

With a total of $801.4 million in 2000/01 the largest source of federal workforce development monies came from funds made available under the Workforce Investment Act (WIA). Of this $801.4 million, $629.8 million were new federal funds (the remaining $171.6 million carried forward from the year before). The new monies break down into the following categories: Adult training $160.7 million, Youth $171.4 million, and Dislocated Workers $297.7 million. Youth funds, among other services, will pay for qualified apprenticeship programs. The adult monies are most likely the funds that could be used to train paraprofessionals. They provide services to all adults, with specialized training and other services to economically disadvantaged adults facing serious barriers to employment. (CRB 2001).

The large sum of money available under WIA is somewhat deceiving. A large majority of WIA monies are devoted to individual workers. As such, funding to set up group training programs is actually quite limited. For example, in California there has been a push to distribute a large portion of WIA monies through local WIB "One-Stop-Centers". At these counseling centers individuals qualify for training monies only after they have gone through job placement services and demonstrated that they cannot find work through labor-exchange and need retraining. It is then that they are given vouchers in the form of Individual Training Accounts that may then use to purchase training of their choice. (Barron 2003).

Aside from this money devoted to individuals most WIA funds flow through local Workforce Investment Boards (WIBs). The process by which these local WIBs distribute money to fund employer-based training programs tends to vary widely. This distribution, which must be negotiated at a county level with local WIBs (Dawson 2003), is inherently political and highly dependent on the preferences of the local WIB members. These monies are likely to be the least useful of available funds. Most WIBs have established relationships with a specific set of

employers and they tend to continue working with these same employers from year to year. As such, much of the funding governed by local WIBs is in "someone else's hands already, so to get it, you have to take it from someone else." To have an opportunity of accessing these monies it you must familiarize yourself with the interests of the local WIBs before applying for funds. (Waldstein 2003).

Due to these types of restrictions a significant proportion of WIA funding goes unused each year. The fact of the matter is, training is made far less of a priority under WIA than it did under its predecessor program JPTA. Under JPTA it was mandated that 50% of funds go to training. By some estimates only 15% of WIA funds go towards training, with the majority of monies going to infrastructure such as buildings and plants. (Barron 2003). In State Fiscal Year 2000/01, California spent only 38.6% of the federal funds for the WIA, Youth, Adults, and Dislocated workers fund. (CRB 2001).

There is a separate pot of WIA funds whereby the Governor takes 15% off the top of the WIA funds as a discretionary training fund. This "slushfund" is the most likely WIA funding source. While competitive, it is "soft enough at the edges". (Waldstein 2003; Barron 2003) The Governor tends to prefer to train incumbent workers with this money, to train new workers with this money there are a "couple of extra hoops". (Wise 2003). In the recent past the governor has chosen to fund health care training programs so it is certainly an area of interest for him. The governor tends to fund very large programs from this pot, spending $31 million dollars on health care in past years. (Wise 2003)

TANF (CalWORKs) and Welfare-to-Work:

TANF and welfare-to-work monies are known for having some of the greatest regulatory flexibility among the available training funds. (Dawson 2003; Waldstein 2003; CRB 2001). The

welfare-to-work program is intended for the most at risk welfare recipients. In California it is a small pot of money, $624,000 in 2000/01, distributed on a county-level (Dawson 2003). However, the advantage of these funds is that they can pay for the type of on-the-job training that mental health paraprofessionals currently receive. Temporary Assistance to Needy Families (CalWORKs in California) is a larger fund of $890.1 million in FY 2000/01. CalWORKs provides education and training for welfare recipients, former welfare recipients, and now some working poor. Pre-employment education and training is relatively short-term, but long-term support is available for employed workers. (Working for America Institute 2002). To access them the population being trained must meet criteria on income thresholds. (Wise 2003). However, given the low income of mental health paraprofessionals, it is likely that some part-time workers in this population will be eligible for these funds. CalWORKs has separate funding under California Community Colleges program, providing $81.76 million for welfare recipients attending a community college as part of their welfare-to-work plan. In 2000/01 community colleges served 11% of CalWorks caseload, including 9,176 students in workstudy programs. (CRB 2001).

Employment Training Program (ETP):

ETP, with $97.2 million in 2000/01 is a large pot of money geared towards training incumbent workers. (Waldstein). Traditionally, ETP is a program for private employers who pay into the State's unemployment insurance fund. As such, the non-profit providers where mental health paraprofessionals are employed would not qualify for this program. ETP funds require an employer match; meaning employers wishing to access these funds to train their workers must put up 50% of the cost of the training. In order to get the federal match, the workers must stay on the job 90 days after the training is completed. The strength of ETP funds for setting up a

paraprofessional training program is that, unlike WIA, ETP tends to fund projects not individuals. (Waldstein 2003). There is a separate section of ETP funds called the Special Employment Training (SET), which allows ETP to fund up to 10 percent of available funds on training for employers not eligible under standard criteria. These are the ETP funds most likely to be accessed for training the mental health paraprofessional group. These ETP funds are available for "frontline" workers who can be in one of the following categories: (1) Earn at least the minimum wage; (2) in industries with demonstrated career paths; (3) in high unemployment areas; (4) with multiple barriers to employment; (5) small business owners. In the previous year, there was a special joint EDD[8]-ETP program to fund career ladders, however recently there was a moratorium put on that program. (State of California 2003).

Adult and Vocational Education:

The Community College System and the California Department of Education host adult and vocational education monies to fund programs at local high schools. These monies have already been accessed by one mental health paraprofessional training program in California to start up initial classes. (Mueller 2003). The programs are designed to provide vocational and technical training/instruction for credit to interested students enrolled in community colleges. (CRB 2001). After the community colleges receive these funds they set their priorities in terms of which type of vocational programs they want to fund. Much of how these decisions are made is based on the demand in the labor market for workers with a specific type of training. (Barron 2003). One strategy for accessing these funds would be to create a certificate-granting program at a community college. If workers were required to have this certificate, this would carve out a labor market demand among employers to have workers thus trained at the community colleges.

[8] EDD is the Employment Development Department of the State of California.

Community college monies would then flow to meet this demand. In order to create the certification you need to decide who would certify the program—consumer affairs or a mental health board; find political support within the state legislature to create the certification; and find funding to pay for the cost of the state to test and certify workers. Champions of mental health in the California State Legislator include Senators Perata and Chesboro. In the past the Governor's 15% fund under WIA has been used to create such certification programs. An advantage of creating a certification program through the community colleges is that recently community colleges have shown a great deal of interest in career ladders. As such, program which gives entry-level workers a transferable credential would have an advantage over other programs in terms of accessing community college monies. (Sherriff 2003).

Apprenticeship Programs:

The apprenticeship program out of the California State Employment Development Department (EDD) supplements on-the-job training with classroom and laboratory instruction. In order to access these apprenticeship program monies the training program must apply to be on a statewide eligible provider list. (Barbara 2003). Traditionally this program has been used in building and craft trades. More recently, the EDD has begun to explore apprenticeships in "low-tech" positions. They have started with apprenticeship program for certified nursing assistants. (Bernick 2000).

Apprenticeships are a preferred training program because sustainable also training linked to employers and what employers want and what jobs are available. (Zabin 2003). Another advantage of apprenticeship funds is that they lend themselves to the creation of group training programs. Customarily with educational monies there is a narrow route to access, each individual

must apply for the funds. This is not true if the program is an apprenticeship program. (Wise 2003).

The Politics Behind Workforce Development Funding

The real story of workforce development funding is not so much the specific eligibility requirements but much more so that the distribution of monies is inherently political.

Gain Access to Decision-makers. Many of these funds are distributed by elected government officials or government-appointed boards. It helps to have representation on these boards or access to political decision-makers. The union has an advantage in this arena, as there is union representation among many workforce development funders.

Form Partnerships. As mentioned earlier, many funders have pre-existing relationships with favored employers. It helps to fit yourself into the available spaces, if you have a training entity within available partners have everything set up as a partnership. Many agents would have incentive to partner with the union because of its access to decision-makers. Partnerships are what are what most WIA decision-makers are looking for. These can be soft partnerships, whereby one entity provides the training, another houses it and a third coordinates the funding and owns the training. (Waldstein 2003). One particularly strategic partnership would be with a faith-based entity. There are large sums of money available for faith-based organizations. In these circumstances the administration is "desperate to spend money." (Wise 2003).

Create a Persuasive Strategy: Tell a Good Story. Even with this access to the decision-makers it is important to have a persuasive strategy as to how your training program is a priority over others. You need a compelling story in terms of whom the training will benefit and what specifically it will accomplish.

Benefits to workers: If the argument is that training will benefit workers you need to demonstrate why these workers are an important population to train. You must be able to show the tangible benefit of additional training for these workers. The answer cannot be that the training makes workers better able to do their jobs at current low wages. If there is not enough money in the health care system because reimbursement rates are too low, it would not be the responsibility of workforce development monies to remedy that. This training must benefit the workers in a very specific and measurable way. Will it increase their wages, offer them certification or transferable skills? If the tangible benefit to workers is certification, you need to determine who will be sponsoring the certification.

Patient advocacy: One argument for additional training and or certification could potentially come from a patient advocacy perspective. However, to be convincing you would need to make a strong case for the need for increased quality of care. You will need to relate the program to allies in the patient advocacy world. In addition, you need to show how training these workers will contribute to the state. (Waldstein 2003).

Federal Agencies

In addition to federal workforce development monies it is possible to access grant funding of discretionary funds from various federal agencies such as: the Department of Education, NIH, the Department of Health and Human Services and the Department of Labor. (CFDA 2003). Currently, there are many possible proposals which a paraprofessional training program could be eligible for. The Shirley Ware Education Center, for example, accesses Department of Labor funding to pay for its health worker training. (SEIU 250 2003; Braconi 2003). Many of these agencies are looking for projects that offer partnerships across interested

parties, such as unions, employers, consumers and educational organizations. These discretionary funds are a solid source of funding, however, the current administration is less friendly towards unions than the past administration. Therefore, a labor-led partnership is less likely to receive funding than per se a faith-based agency led-partnership. (Barron 2003).

Foundation Funding

California has many large foundations, many of which have mental health as an area of interest. The California Wellness Foundation and California Endowment have areas of interest in mental health although nothing specific to paraprofessionals. As there is little known about the mental health paraprofessional workforce much of this funding is likely to come in the way of policy research and advocacy rather than direct service programs. (Dawson 2003). In the past year the California Endowment has shown interest in culturally competent programs--funding mental health paraprofessional training to serve Hispanic populations. (Table 6). Other foundations to consider include: the Robert Wood Johnson Foundation (healthcare); the San Francisco and Hewlitt Foundations (regional); and the Ford, Rockefeller and the Anne Casey Foundations (workforce development). (Barron 2003). One challenge to accessing foundation monies could be producing quantifiable and measurable results from the training program, particularly in the short term, which many foundations require in order to approve applications. (Mandel 2003). One possible use of foundation money could be to fund a pilot project with an evaluation component embedded into it in order to access larger funds later on. It will be difficult to show measurable results in terms of increased wages to workers and certification during the course of time that a pilot project would fund. Still, you could demonstrate such measurable

results as sustained relationships with partners, employer satisfaction and success with meeting goals set at the beginning of the project. (Teegarden 2003).

Table 6. California Endowment- Special Opportunity in Mental Health Funding Request for Proposals (RFP)- 2001		
National Latina Health Organization	Mental Health Lay Health Workers Project: To improve the mental health of Latinas by recruiting and training community health workers to facilitate peer support groups and provide social support services in Contra Costa County.	**$399,300**
Instituto Familiar de la Raza, Inc.	CALMECAC: To provide an interactive cultural competency training curriculum for mental health professionals and paraprofessionals in the Chicano/Latino community in the San Francisco Bay Area.	**$400,000**

The Political Will to Increase Mental Health/Behavioral Paraprofessional Training

Prior to the nation turning away from domestic to foreign policy the three focal points of national health politics were Medicare prescription drug coverage, patient's bill of rights and mental health parity legislation. Patient's rights legislation has been repeatedly shelved. However, the debates surrounding prescription drug coverage and mental health parity legislation remain politically viable.

As evidenced by Table 7 below, it is clear that mental health legislation is on the political radar screen. As of January 2003, a bipartisan group in Congress was primed to reintroduce mental health parity legislation in the name of former Senator Paul Wellstone. The bill already has the support of the President making passage that much more likely. (NMHA 2003). Representative Patrick Kennedy introduced legislation in July 2002, to increase the supply of children's mental health workers. The Kennedy bill specifically called for increased monies to training paraprofessional workers.

In California, Assembly member Wiggins introduced a bill in February 2003 to create worker centers for those who work with the developmentally disabled. Other California legislators with a demonstrated interest in mental health include Senator Perata, Senator Chesboro and Assembly member Yee. The question is how much of this political will for general mental health improvements will filter its way down to providing mental health paraprofessional training. (See Appendix 7 for expanded list of California legislators with mental health interest).

Table 7. Federal and State Mental Health Legislation, 2003			
Bill #	**Author**	**Summary**	**Status**
US H.R. 1359	Rep Kennedy, Patrick J. [RI-1]	**The Child Healthcare Crisis Relief Act** ▪ To increase the number of well-trained mental health service professionals (including those based in schools) providing clinical mental health care to children and adolescents, and for other purposes ▪ Includes monies for paraprofessional training	▪ Mar. 19, introduced, Referred to the Com. on Energy and Commerce, and to the Comm. Ways and Means. ▪ April 10, referred to Subcom. on Health.
US H. R. 953	Rep Kennedy, Patrick J. [RI-1]; 232 Cosponsors	**Senator Paul Wellstone Mental Health Equitable Treatment Act of 2003** ▪ To provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits.	▪ Feb. 27, introduced ▪ March 10, referred to the Subcom. on Health
CA S.B. 428	Perata	**Adult Day Health Care** ▪ Revises certification and licensing standards for Adult Day Health Care facilities ▪ Includes establishing training requirements for certification.	▪ Feb. 20, introduced ▪ May 1, referred to Com. on Appr.
CA A.B. 649	Wiggins	**Workforce Service Centers** ▪ To establish 13 regionally based Workforce Service Centers for the purposes of bringing improvements in services to people with developmental disabilities and the workforce that provides those services.	▪ Feb. 19, introduced ▪ Apr. 29, in com. on Hum. Svcs., Set, first hearing. Held under submission.
CA S.B. 130	Chesboro	**Psychiatric and medical facilities: use of seclusion and restraints** • To reduce the use of seclusions and restraints	• Feb. 5, introduced • April 28, re-refer to Com. on Appropriations
CA A.B. 1370	Yee	**Mental Health: community treatment facilities: seclusion and restraints** • To prohibit the Department of Social Services from adopting regulations relating to the use of seclusions and restraints that are in addition to regulations currently in group homes • Prohibits DSS from requiring 24 hour on site nursing	• Feb. 21, introduced. • April 29, hearing at Com. on Health
CA S.B. 938	Yee	**Mental Health Professions: scholarships and loans: funding** • Funding for licensed mental health providers in public settings.	• Feb. 20, introduced. • April 24, re-referred to Com. on Health

(California Government website, http://www.leginfo.ca.gov/bilinfo.html; US Library of Congress, Thomas, http://thomas.loc.gov/)

Part V: Lessons Learned: Homecare and Developmental Disability Workers

In considering the implementation of mental health paraprofessional training it is helpful to look at lessons that can be learned from the experiences of related paraprofessional groups. Homecare paraprofessionals were at one point a similiarly invisible workforce and then through coalition building were able to harness political will and gain greater funding and attention from researchers and regulators increasing the standardization of their workforce. Research on paraprofessionals working with developmentally disabled individuals offers insight into the paths to involuntary turnover among direct service workers.

Funding for Homecare Workers

That they are nonprofessionals alone cannot explain what makes mental health paraprofessionals such an illusive workforce. A similar group of paraprofessionals are California's homecare workers. Both are groups are low-income human service workers who work in the community. They share similar workforce issues: high turnover, low wages, stressful work and little respect. However, the passage of key legislation in California in the 1990s led to a restructuring of the homecare workforce bringing greater standardization and money into the homecare system. Homecare workers received this attention from legislators through the mobilization of organized labor in coalition with consumer advocacy groups. (Delp and Quan 2002).

In the 1970's, after pressure from senior and disabled advocacy groups, California created the In-Home Supportive System (IHSS) to provide homecare services to elderly and disabled persons. In the late 1980s and early 1990s the Service Employees International Union (SEIU) and the United Domestic Workers (UDW) simultaneously began organizing homecare

workers. In homecare, the hiring and supervision of workers is done by individual consumers but they receive their paychecks from IHSS. As such, it became clear to the unions that they had no employer of record with whom to negotiate. Union researchers realized they needed to create an employer of record in order to organize these workers. In the 1990s the unions worked towards passing legislation to create County-based Public Authorities to serve as employers of record for homecare workers. The Public Authorities provided homecare workers a central source for payroll, benefits and training as well as a central venue for collective bargaining. (Heinritz-Canterbury 2002; Grundy 2003). In some cities, such as San Francisco this has led to a large increase in wages and benefits associated with decreased turnover for workers and increased quality of care for consumers with fewer hospitalizations and improved health outcomes. (Reif & Howes 2003).

Homecare workers received attention from the union when the union came upon the policy strategy of creating the Public Authorities. This idea allowed them to more easily organize the workers. (Grundy 2003). However, it was the "coalition between the union and consumer groups that built a consumer social movement and provided the public voice that influenced policymakers to effect change." (Delp and Quan 2002). As explained below:

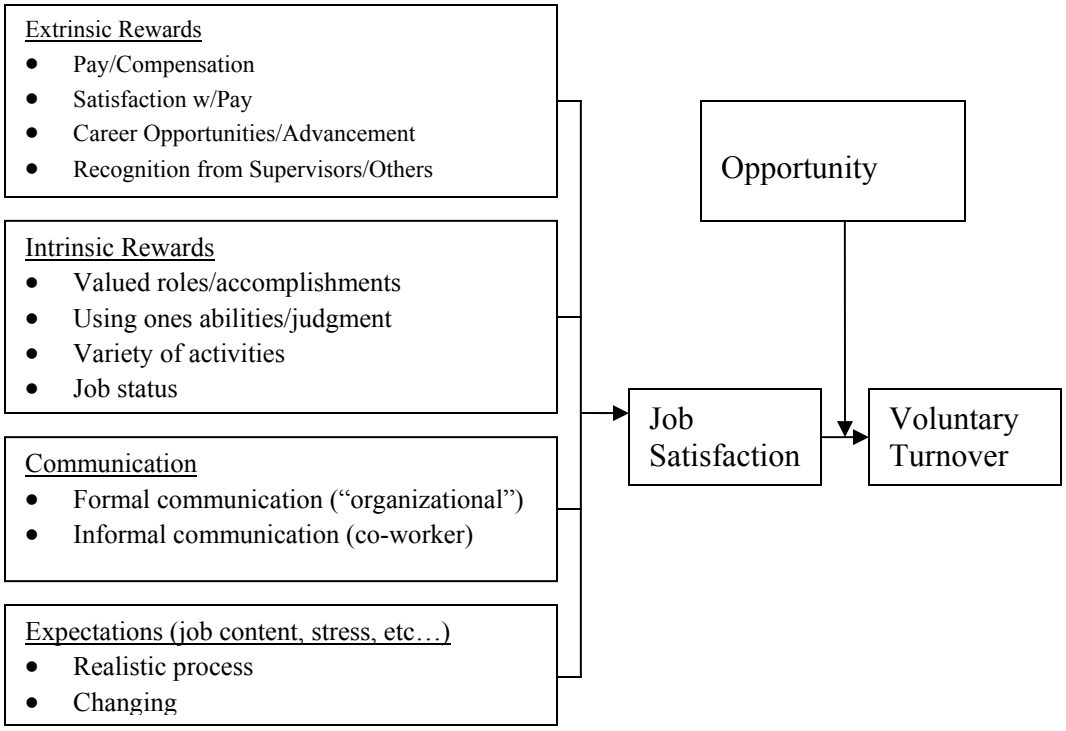
> Changing policy at the state and local level was dependent upon a strong coalition of labor and community groups, which could not have been built without the organized voice of the workers. On the other hand, the workers could not have succeeded in unionizing without legislative changes and the support of consumers. Finally, the strength of the coalition was based upon an active rank and file joining with consumers, as well as policy provisions that guaranteed a role for consumers in the public authorities. (Delp and Quan 2002).

Turnover in the Mentally Retarded/Developmentally Disabled Workforce

An even more similar worker to the mental health paraprofessional is the developmentally disabled worker. Again, there are differences between the two, particularly in the population served; the developmentally disabled can have either mental of physical

disability. Charlie Lakin, a researcher at the University of Minnesota's Research and Training Center for Community Living has done a series of studies on the needs of the developmentally disabled workforce. In Diagram 2 below, Lakin offers up the variety of paths that lead to turnover. It has been long known that low wages are a major source of turnover and that pay is seen to be the most predictable cause of turnover. However, turnover is not just about pay. There are other more intangible deficits, related to the professionalism, such as career advancement, recognition and using one's abilities and judgment that lead to high turnover. An increasingly important issue in the developmentally disabled workforce is the decreasing size and quality of the applicant pool. In a survey of heads of provider agencies, 56% of those interviewed cited a decreased quality of applicant pool. At the same time, 70% of respondents reported increased behavioral problems of "clients". (Lakin, 2003).

Diagram 2. Paths to Voluntary Turnover



(*Lakin 2003)*

Part VI: Criteria for Choosing Among Proposed Training Structures

Factors to consider in deciding what type of training structure would be best suited to train mental health paraprofessionals in California include:

Practical criteria

Funding: Depending on how the program is structured and which population it serves it could access different funding sources. Apprenticeship programs and community college programs are more tailored to new workers. ETP funding is more geared toward incumbent workers. Other funds such as welfare to work and vocational monies are geared toward low income and disabled workers. Larger scale training programs could be more expensive but if they are more likely to meet funder eligibility requirements could actually be more feasible than programs which make only incremental changes from the status quo.

Political Acceptability: As mentioned in the earlier section on funding sources, the distribution of many of these funds is inherently political. Different training program structures may be more politically palatable than others. For example, politicians prefer training programs which can demonstrate tangible benefits such as increased wages or certification. These types of measurable outcomes are difficult to produce from training programs geared to incumbent workers. Both community colleges and politicians are very interested in career-building ventures. In this way training for new workers may be more politically feasible than training for incumbent workers. At the same time, certified community college programs or apprenticeship programs, require a large investment of time

and resources. It is possible that the more politically feasible program will take much longer to get off the ground. It is also worth considering who would be the political champions of a given training program, their different agendas and conversely which interests might rise up in opposition. While not necessarily vital to the internal workings of a given program, structures created through partnerships with consumer groups, educators and employer groups may be more politically viable.

Robustness, Improvability: "Great in theory, what about practice?" To what extent is a given training program sustainable one year, five years, and ten years after implementation? One major robustness issue will be the sustainability of any funding sources that are marshaled to create the training program. For example, an apprenticeship program added to the list of state apprenticeship programs could possibly be around longer than a community college class whose funding depends on the whims of local school administrators. In addition, much of the robustness of these training programs will center on whether or not they "work" for the workers and employers. Issues important to likelihood of workers' attendance and completion of a given program include accessibility, availability and cost. The closer that programs are located to the workplace and the less that they disrupt regular work the more worker-friendly. From an employer's point of view the less investment required of them the more sustainable the program.

Efficiency

"Maximize the sum of individual utilities." Efficiency would be described as the most people benefit for least cost. This would consist of benefits and costs to the workers, the consumers and the providers.

Consumers: Certain training structures will offer more in the way of conferring benefits to consumers. More comprehensive curriculums which offer a non-clinical, client empowering emphasis will be favored by consumers. As will programs which improve consumer quality of care. Program that offer opportunities for consumer-providers will more likely to be favored by consumer advocacy groups.

Workers: Workers stand to benefit both professionally as well as financially from increased training. A program which offers career paths for workers who are interested in eventually moving on from an entry-level position gives a worker opportunity to increase their wages. Still, as evidenced by the Lakin's work on developmental disabled paraprofessionals, training that does not offer immediate financial investment can still benefit workers. Programs that create greater professionalism amongst paraprofessionals or provide workers a meaningful identity are seen to benefit workers and reduce turnover. The degree to which a given program increases worker skills and knowledge is likely to offer greater benefits to workers and consumers than to employers. Workers could benefit from the portability of the training provided in the manner of certification. At the same time, some workers could see a requirement of certification without a guaranteed job after taking the certification program as

a barrier to entry into the workforce. In this way different training programs can be seen as either entry points or barriers to entering the workforce.

Providers: Providers are unlikely to welcome having their workers attend a training program unless they see that it offers some benefit to them. Providers are already required to provide training for these workers so they will welcome a training program which takes some of this burden off of them. New worker training programs will require less investment from employers both financially and in terms of staff time than incumbent worker training. Apprenticeship programs tend to be employer-positive because their curriculums are by definition linked to the needs in the workplace. Community college programs will need to keep up to date not just on new approaches to mental health but also to changing employer needs. Employers might also favor a program that offers certification because it has recognizable currency that they can feel secure that a given worker is well-trained. For incumbent worker training the greater autonomy offered to employers the more likely they are to support a program. A program which reduces turnover rates and increases the pool of eligible workers will expand the size of the eligible workforce will speak to the primary needs of employers.

Equity

Equality, fairness, and justice; among the three groups: employers, workers and consumers, who bears the most concentrated costs for each solution? Who gets the most concentrated benefits?

Degree of Union Involvement

In what ways are given structure offer opportunities for internal union–building (increasing participation of already organized workers) and external union-building (increasing opportunity for organizing non-union workers)? The union benefits when (Zabin and Autler, unpublished):

- Unions are involved in all details of a training program from the big picture to the small details. This includes: initiation of training, application process for training program, planning process, provision of training and evaluation of training;
- Unions identify training needs of their members in the context of industry trends;
- Jobs are retained; more work is brought into the bargaining unit;
- Training leads to concrete jobs and career advancement opportunities for both members and in some cases, non-members;
- Training is worker-centered, based on input and active participation by members;
- Training increases the union's leverage in the local labor market, when the union is known to both employers and workers as a primary link to high quality training and jobs;
- The union gets credit for the training—its role in training is acknowledged by workers and employers.

Part VII: Alternative Training Structures

Caveats: (1) Recommended alternative structures are not mutually exclusive. However, some options are more long-term strategies whereas others are short-term fixes. The long-term strategies make take more time and effort to get off the ground, but in the end are the most sustainable. The short-term options will be difficult to sustain as most funders require measurable benefits to workers (wage increases, certification), which in training are difficult to achieve for many incumbent workers. (2) Whichever training structure you go forward with it is important to keep in mind the possibility of using training videos, online courses and teleconferencing to both offset the costs of training where possible as well as reach a widely dispersed workforce. Many employers are averse to using educational technology in the human service field. However, individuals at the forefront of health educational feel strongly that technology holds great potential to educate a hard to reach audience.

Option 1: Union Spearheads Certificate Granting Community College Programs

One option would be for the union to train new workers in consumer-friendly community college mental health paraprofessional programs. There are several pre-existing curriculums to work with including: the California Association of Social Rehabilitation Agencies (CASRA), Mt. San Antonio College and consumer-provider programs

.

Strengths: (1) *Community college programs provide "the most bang for your buck".* The union can take advantage of the existing infrastructure provided at the college. This keeps costs much lower than creating a free-standing training academy. (2) *Portable credential.* Many community colleges have certificate-granting programs in human services. It is a natural progression to have a certificate-granting program in mental health paraprofessional training. A certificate would give the worker greater portability in the workforce, increase sense of accomplishment and increase professionalism—factors known to reduce turnover rates. (3) *Standardization*. Having a centralized training program would allow for standardization within a very diffuse and poorly understood workforce. This would allow for both better data collection to understand future training needs as well as guarantee that all workers have a minimum level of training. If the union arranges this program and acts as a college career center for these workers this creates a centralized place for the union to locate future workers. The union benefits as rather than going out and trying to organize the highly decentralized system of community-based clinics the workers will essentially come to the union. This benefits employers as knowing ahead of time that they are bringing in high quality workers reduces the possibility of turnover and the resulting costs of turnover. In addition, a standardized certificate program offers the type of tangible benefit that funders and politicians are seeking. In the end, the union is seen as providing a tangible benefit to workers and employers creating good will among the parties.

Weaknesses: (1) *Disruptive to work schedule.* Most existing mental health paraprofessional training programs at community college programs are sixteen weeks long, several days a week and offered off-site. One reason they are not better accessed is that it is difficult for paraprofessional workers to take extended leave from the worksite. It is expensive for employers to pay not only for the training but also for extra coverage for employees off at training. As it turns out this expense is prohibitive for small employers. Any successful community college program would have to be well-integrated into the workday. The Mt. SAC program, modeled after the CNA training programs is one example of how this could work. Still, the shorter the community college program the greater the sacrifice in terms of comprehensiveness of the curriculum content. (2) *Perceived barrier to entering the workforce*. Attaching a certification program to the paraprofessional position without guaranteeing a job could be construed as creating a barrier to entry to the profession. The size of the applicant pool will be reduced if potential applicants perceive increased education as a barrier to entry into the workforce. Almost as crucial a problem in this workforce as high turnover rates is the fear of recruiting problems due to a decreased applicant pool to fill the spots of an aging and retiring current workforce. It is a weakness of community college vocational program in general that they are out of touch with the training that employers are looking for; this program would have to work hard to keep abreast of changing needs in the workplace.

Opportunities: (1) *Funding for new workers.* Creating a certified mental health paraprofessional program would drive demand in the labor market for these kinds of workers. This demand in the labor market would cause community college funding to flow to support the

training program. The major funding investment therefore, would not be to pay for the training but rather the initial creation of the certification. (2) *Funding for incumbent workers*. There exist several state programs designed to send disadvantaged, welfare to work and disabled workers to community colleges. These types of workers make up much of the current mental health paraprofessional workforce. Therefore, it is likely that funding could be accessed to increase the training of incumbent workers. Furthermore, funders look more favorably towards partnerships across sectors including: labor, industry and academic institutions. Despite restrictions on some workforce development money, the money is there, it's a matter of finessing funder eligibility requirements. Most importantly, while the funding is limited, the union is well-represented on local and state-level Workforce Investment Boards. This creates an incentive for employers and academics institutions to partner with the union to create this type of a program. (3) *Union-building.* If the union were to connect workers to standardized community college training they would be viewed very positively among workers and possibly even providers. Many providers wanted more training but had no idea how to fund them. When asked whether they would be open to a union-sponsored training program, employers with unionized workers said, "well our workers are unionized but the union hasn't done any training programs. With this option, the word would be, "my union sent me to college. (4) *Politically viable.* The certification offers funders and politicians a measurable outcome of the training. These types of tangible benefits play favorably both to legislators and funders.

***Threats*:** (1). *Other potentially viable actors.* The union is not necessarily an essential part of connecting workers to government funded community college programs. Workers, employers or community colleges can and have created these linkages in the past. The point is this has only

been done on a very limited scale. Among, tens of thousands of workers, only a couple of hundred, maybe, have accessed the programs. Therefore, the union role is a bit of the "twenty dollar test"; if this is such a great idea why hasn't anyone else done it. Other people haven't done it because there is a market failure. Everyone is too busy taking care of day-to-day operations to improve the status quo. In order for the union to lead the way in community college training it must position itself in such a way that it is a critical part of the solution. (2).

California's budget crisis. The recent economic downturn has hit the California community college program hard. Millions of dollars have been cut from the community college budgets. Still, according to the funders behind the creation of the CASRA and Mt. SAC programs, as long as enrollment is up, the classes will be offered. The union will need to create a demand for these courses driven by employer need in the labor market. The best way to do this would be to make them certification granting. This would require a great deal of political motivation, but in the long run it would guarantee the sustainability of the programs.

Option 2: Union Apprenticeship Program

Like a community college program, an apprenticeship program would allow the union to train new workers. The California Employment Development Department has an already established apprenticeship program which links eligible vocational classes with employers in the community. The union could be the facilitator in applying for and creating an apprenticeship program which links courses with employers in the community, something no one has yet to do for this population.

Strengths: *(1) Sustainable.* This will create a pipeline of new workers into a workforce with large vacancies. Employers who have no special resources will welcome trained workers who can provide coverage for other paraprofessionals with lower incoming skill sets who need additional training. (2). E*ntry point for workers to come into the workforce.* By linking coursework with jobs in the community apprenticeships are able to raise the standards of the workforce while at the same time creating an entry point for unskilled workers. This type of pipeline is what educators and large employers say is key to relieving workforce shortages in the long term. (Mandel 2003; Majak 2003; Mueller 2003). *(3). Education responsive to employer's needs.* In a field where employers have such specified needs contingent upon their client population it is invaluable to have an academic training program with such 1close links to needs in the workforce.

Weaknesses: *(1). Application process.* There is a large degree of coordination required to link employers and schools together on an application submitted by the union. This requires good will with employers and an understanding of the apprenticeship application process. (2*) Does not address needs of incumbent workers.*

Opportunities: *(1). Partnerships.* If the employers see this as a way to save on training skills and bring skilled workers into their worksite they should be willing partners in making this happen. Including a consumer-friendly, holistic course in the training part of the apprenticeship program would likely bring consumer advocacy groups on board. *(2). Union-building*. Having the union coordinate the apprenticeship program and link employers with well-trained workers creates good will towards the union.

Threats: *(1). Funding.* Coming from a single funding source the apprenticeship program is vulnerable to fluctuations in yearly State budget priorities.

Option 3: Union-Sponsored Employer Training Program

In this option the union would access Federal Discretionary Funds and Workforce Development Monies to increase training. These can be at the worksite, at a free-standing non-profit or even at community colleges. The union does not necessarily need to be the entity providing the training, but it should the entity which owns the training.

Strengths: *(1). Union has experience with this type of training.* In some ways, you would not be breaking new ground. This type of training has been done before on a large scale for the long term by other unions such as 1199 in New York and Philadelphia. It has also been done more locally by the Shirley Ware Center in Oakland. There are lessons that can be learned by those who have gone before and made this type of training happening. *(2). Offers solutions that can be done in the here and now.* Much of the infrastructure need to train incumbent workers is already in place through existing community college programs. Funding sources that can be accessed in the short term include discretionary funds from federal agencies and possible foundation funding. *(3). Training for both incumbent and new workers.* Unlike the previous two options, this training structure would allow the union to address the needs of both incumbent as well as new workers.

Weaknesses: *(1). Lack of tangible benefits to workers.* The main effect of incumbent training is that workers will do a better job and provide higher quality care. Unfortunately, in the short run, without certification-granting courses there is no tangible way to measure these gains. It will not necessarily lead to higher wages or a transferable degree. This limitation is a serious obstacle to accessing workforce development monies. To overcome this, the union will need to create partnerships particularly with consumer groups which demonstrate a real need for this training

from a quality of care perspective. *(2). Lack of tangible benefits to employers.* For employers, it will not remove their need to invest in training; it will only increase their ability to provide training. Yet, many providers replied that even if training were free, they might not offer it to their workers as they would need coverage at the worksite. In addition, if public funds were accessed there would be the creation of the extra work that comes with being accountable to government money such as auditing and evaluation. Employers are likely to respond at first: "Why should I do this, how does this benefit me?" The union will need to carefully package this so that there is employer incentive to get involved in more training. *(2) Exacerbates interest group politics.* The main benefactor group in this arrangement is in fact consumers. They will likely get the disproportionate share of benefits in this type of arrangement. This is great for quality of care but creates interest group politics, pitting one group with concentrated benefits against another group which bears concentrated costs.

Opportunities: *(1). Need exists for training.* There is a definite need for additional training of this workforce. Nearly all the employers surveyed said they would offer more training if they had the time and/or the money. The fact of the matter is that these employers must offer training one way or another. Most have full-time staff who coordinate training both on site and in the community and would welcome any additional resources brought to the table. *(2). Room for union to play a role.* While there are many separate actors addressing different parts of the paraprofessional training problem, no one is really coming together on this. For example, two of the members of the California Mental Health Planning Council were simultaneously designing training curriculums and didn't know. Employers need more training and offer similar training to workers, but few employers collaborate on joint training which would reduce inefficiencies.

Employers could access public training monies but do not do so. The union has the resources, expertise and political clout to link these disjointed parts. (3*). Union-building*. Unions have leverage when an employer is relying on public funds and can withhold union endorsement if its concerns about the proposed training are not being addressed.[9] (Zabin and Autler 2003). In addition, if the union as seen as being a training resource the union could demonstrate to workers and management that it offers things to workers. *(4). Potential for future high road partnerships.* If employers have a positive experience in these short term training programs it might establish positive labor management relationships that could lead to high road solution later on. Of course, there is also the counterfactual. Problems in employer-based training programs could jeopardize potential future high road collaborations.

Threats: *(1) Culture clash between union and providers.* Training where the union is working with incumbent workers at the worksite is the most threatening option to employers, particularly in instances where there is not full cooperation between labor and management. In these cases the union will need to work extra hard to overcome resistance from within the agencies. Many of these employers are small non-profits who like the union have strong missions and cultures of their own. In order to get past resistance and fears in the community the union will need to demonstrate that it understands the unique culture and workings of non-profits. *(2). Union irrelevance.* Technically, unions do not have to be involved for employers to access federal training money. However, in most instances individual employers do not have the influence to access much of these political funds, as they are not organized across sectors. Still, once the union gets things off the ground the potential for union irrelevance could increase. The union has to position itself so that its presence in this training structure is institutionalized.

[9] One such fund is State ETP money.

Part VIII: Recommendation

In the long term I would recommend that the union access high road partnerships to create a certified mental health paraprofessional training program at a community college. This can be done in conjunction with state apprenticeship programs. In the shorter term the union can get involved in enrolling individuals in pre-existing community college programs. In the more immediate terms the union could involve itself in incumbent worker training.

The most financially and politically feasible structure which would offer the most benefits to the most parties involved would be for the union to sponsor a certified community college program. A curriculum which incorporates the principles of consumer-provider programs would be more in line with new and innovative approaches to patient care. In creating the program the union should play a lead while still seeking input from workers and employers to assure that it meets their needs as well. There are several legislators at the State level known to champion mental health issues. In order to access the certification the union would need to partner with a wide array of key stakeholder groups and approach these legislators with a persuasive story. This story should demonstrate the need for training this population as well as how the training will benefit all involved. Funding for the certification itself could come from the Governor's discretionary 15% of annual WIA funds. Funding for the community college program would flow in from the community college system itself, driven by employer demand for workers with this certification.

Creating a certified training program at a community college is certainly a long term solution and could take a great deal of time and resources to get off the ground. As such, one shorter term alternative to this suggestion would be to for the union to spearhead community college programs without certification. It would be more difficult to access community college

monies without certification and as such the union would have to rely on separate pots of monies specific to special populations such as welfare-to-work eligible workers, workers with multiple barriers to employment who qualify for ETP SET money, and disabled workers who qualify for vocational rehabilitation funding. As many of these programs need to be accessed by workers on an individual level the union could serve as a link between workers, funding sources and community colleges. In this type of partnership, the union could serve as owner and coordinator of the training.

A secondary and not necessarily mutually exclusive recommended course of action would be for the union to apply to put mental health paraprofessional training programs on the list of California apprenticeship programs. This is also a more long terms training option which would exclude incumbent workers.

An option that does not score as well as the previous two but is more doable in the short terms would be for the union to train incumbent workers in programs which build off existing employer training. This option benefits workers less. Though it does address non-financial paths to turnover, it does not raise their wages or give them transferable credentials. It only partially benefits employers. While it relieves them of some of their training burden, it is disruptive to the workplace, requiring workers to take time off to attend classes. It is not as politically or financially feasible because politicians and funders favor training that can demonstrate measurable benefits to workers, consumers and the state. Consumers would be the main beneficiaries of this type of training. There are multiple funding sources that could possibly fund this type of patch-work training. This includes: welfare-to-work, CalWORKs, foundation funding for pilot programs and federal discretionary funding from such agencies as the Departments of Labor, Education and Health and Human Services.

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Appendix 1: Interviews Conducted

Linda Barbara, Alameda County, One-Stop Center, April 14, 2003

Mike Barnette, Office of Representative Patrick Kennedy (D-RI), April 14, 2003

Babara Barron, Training and Economic Development Consultant, Former Head of Massachusetts Workforce Development Department, April 29, 2003

Joan Braconi, Director, SEIU Local 250, Shirley Ware Training Center, April 17, 2003

Susan Chapman, UCSF Center for the Health Professions, April 17, 2003

Betty Dalquist, California Association of Social Rehabilitation Agencies, April 23, 2003

Steve Dawson, Paraprofessional Institute, April 15, 2003

Lea Grundy, Labor Specialist, UC Berkeley, Center for Labor Research and Education, May 13, 2003

Brain Keeffer, California Department of Mental Health, April 29, 2003

Sharon Kuehn, Contra Costa Mental Health Concerns, California Mental Health Planning Council, April 23, 2003

Jay Mahler, Psychiatric Survivor Activist, Program Director, Mental Health Division, Contra Costa County, May 2, 2003

Barbara Majak, Deputy Director, Behavioral Health Care Services, Alameda County, March 14, 2003

Susan Mandel, Pacific Clinics, California Mental Health Planning Council, April 18, 2003

Dale Mueller, California Mental Health Planning Council, April 18, 2003

Rhona Sherriff, Senate Office of Research, April 24, 2003

Suzi Teegarden, Workforce Learning Strategies, April 22, 2003

Nancy Thomas, Alameda County Network of Mental Health Clients, April 22, 2003

Weezy Waldstein, Working for America Institute, AFL-CIO, Director of Labor Market Participation, April 21, 2003

Pat Wise, Executive Director, Workforce and Economic Development Programs, California Labor Federation, AFL-CIO, April 23, 2003

Carol Zabin, UC Berkeley Center for Labor Research and Education, April 23, 2003

Sally Zinman, Psychiatric Survivor Activist, Executive Director, California Network of Mental Health Clients, April 30, 2003

Appendix 2: Summary of Provider Interviews

Provider, County	Population Served & Services Provided	City	Officer	Position	Organized?/ Attitude Towards Union Training
Bayview Hunters Point Foundation, SF	A; Outpatient	San Francisco	Nat Jordan		Local 790; No pp's
Westside Community Mental Health Center, SF	C, Y, A, F; Outpatient, Drug and Alcohol Counseling, Intensive Community Support	San Francisco	Kari	Human Resources	Local 790; No pp's
Alliance for Community Care, SC	Y, A, F; Outpatient, Day Programs, Residential	San Jose	Michael Hollingshead	Training Coordinator	Local 715; "Might be fine."
Lincoln Child Center, Ala.	C; Residential	Oakland	Sandra Kapsiotis	Assistant Director of Campus Services	Local 535; "Sure, that would be interesting."
St Vincent's School, Marin	Y; Residential	San Rafael	Christopher Kellogg	Employment and Training Coordinator	Local 535; "Complicated, see if they wanted to pay employee."
Progress Foundation, SF	A; Residential, Supportive Housing	San Francisco	Bernadette	Clinical Director	Local 535; "Union offers several different things… could be duplicative."
Pathways to Wellness, Ala.	C, A; Outpatient, Medication management	Oakland	James Jordan	Executive in charge of Outpatient and Inpatient Services	Not organized; "Just a matter of time [available for workers to do training]."
Anonymous, Ala.	E; Intensive community support		Anonymous		Partially organized; "Contentious, not good feelings, relationship"
West Coast Children's Center, CC	C; Outpatient, Day Programs, School-Based	El Cerrito	Adam Weiner	Assistant to the Training Director	Not organized; No pp's
Bucklew Programs, Marin	A; Residential	San Rafael	Alice Thomas	Project Director	Not organized; "If a [worthwhile] training were available, sure…certainly."
Family Insitute of Marin, Marin	C, A, F; Outpatient, Drug and Alcohol Counseling	San Rafael	Suzanne Magio-Hucek	Executive Director	Not organized; "Fine."
Jewish Family Services, SF	C, Y, A, E, F; Outpatient, Day Programs	San Francisco	Amy Rassen	Associate Exectutive Director	Declined interview, "we're too complicated"
Richmond Area Multi-Services Inc., SF	C, A, F; Outpatient, Partial hospitalization, Residential	San Francisco	Alla Volovich	Director of Training	Has very few pp's, unable to interview, re: training

Legend: C = Children; Y = Youth; A= Adults; E = Elderly; F = Families
No pp's = Doesn't employ unlicensed workers

Appendix 3: Expansion on Title 22 Training Requirements for Group Homes

	Children
Before working independently with patients	• 8 hours initial training, "training plan appropriate to needs" • Maximum 4 hours consisting of shadowing (working alongside supervisor), "shall promote the development of specific activities." • Assessment: supervisor's observations documented in worker's record
Within 90 days of hire	• 16 hours, topics include: overview of client population, facility policies and mission, discipline, disaster response, CPR, teamwork-with facility and with family members, medication, children's adjustment to milieu, Title 22, community services, recreational activities • Requires successful completion of course work, conducted in workshop, seminar, classroom, individual or group setting • Assessment: Proof of completion of coursework limited to official grade slips or transcripts or certificates signed by educational institutions… or qualified individuals (w/ Masters degree or 3+ years relevant experience)
Continuing Education	• 20 hours annual training in addition to initial 24 hours of training • At least 5 hours of training consists of course work from an entity other than the group home • Training may include but is not limited to: Neglect/abuse issues, attachment, behavior problems/psychological disorders, mental health/behavioral interventions, substance abuse, developmental disabilities, cultural diversity.

Appendix 4: Training Programs for Special Populations

1: Cowen EL, Leibowitz E, Leibowitz G. Utilization of retired people as mental health aides with children. Am J Orthopsychiatry. 1968 Oct;38(5):900-9.

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Appendix 5: Provider Interview Questions

Interview of Mental Health Providers on Direct Service Workers Training

Agency Name
Person Interviewed
Title
Primary Responsibilities (if not Executive Director)

What training/education is required for direct service workers (non-licensed staff who work with clients) before coming to work?

Education level:

Years of Experience

Other training:

What training is given to direct service workers after they start work?

Frequency of training: How much time (hours per week, weeks per month, months per year)—currently? Ideally?

	Currently Offered?	Would like to Offer
Documentation (internal/external)		
Mission of the Agency		
Mandated Reporting Requirements		
CPR, First Aid		
Client Rights		
Case Management		
Deescalation		
Restraint/Seclusion		
Symptom Management		
Treatment Plan Development		
Informal Counseling		
Substance Abuse		
Dual Diagnoses		
Other		

Is this training given on paid time when it is at the agency site?

When training is outside the agency, re direct service workers given paid time off to attend training?

Are trainings outside the agency paid for by the employee or the employer?

For training on site: Who does the training? Provider staff, contracted, public educational institution (UC Extension, community college)?

For training off site: does the training? Provider staff, contracted, public educational institution (UC Extension, community college)?

Do you work in conjunction with any other employers to provide joint training?

What special funding, if any, does the agency use for training direct service workers?

What training would you like to offer/require but cannot due to funding or other barriers?

What do you see as the barriers to providing more training?

If the county (ex: County Department of Mental Health) sponsored a training program for example: as part of it's current training for public employees, but expanded it to non-public employees, would you be interested. What if you had to pay for the additional marginal cost to the county of training your workers – but no "sunk costs"

Private Foundation offered in-service training?

If a mental health organization and union training program was available to address direct service training needs, would you be interested in utilizing it?

Would you be interested in training programs at:
Community College? High school, vocational school?

Would you use… if they were made available to you?
Online courses?
Satellite teleconferencing?
Training videos

Appendix 6: Matrix of Partnership Funding

Sources of Partnership Funding	CWE	Culinary 226	E-Team	GIDC	GAI	1199 SEIU	LMCER	1199C Phil.	SF Hotels	Carpenters	SVA	WRTP	Workers Ctr.	WPUSA
Private Funds														
Negotiated Joint Fund		■		■	■	■		■	■	■		■		
Company Contributions			■	■			■		■			■		
Union Contributions			■	■	■		■				■	■	■	
Foundations			■				■	■			■	■	■	■
Fees for service				■	■	■	■	■			■	■	■	■
Federal Funds														
USDOL/JTPA														
JTPA II Adults								■				■		
JTPA III Federal Demonstration			■					■				■		
JTPA III Rapid Response						■		■			■	■		
JTPA State	■							■				■		
JTPA Local	■							■				■	■	
Welfare-to-Work	■						■	■	■			■		■
Workforce Investment Act														
WIA Dislocated Worker												■		
WIA Adult								■				■		
WIA Youth												■		
WIA State Rapid Response												■		

Appendix 4: Matrix of Partnership Funding

Other Federal Training	CWE	Culinary 226	E-Team	GIDC	GAI	1199 SEIU	LMCER	1199C Phil.	SF Hotels	Carpenters	SVA	WRTP	Workers Ctr.	WPUSA
Department of Education								■						
Department of Energy														
HHS/TANF	■							■				■		
HUD														
ICTEA(Transportation)												■		
School-to-Work								■				■	■	
Skill Standards				■										■
Other Federal														
CDBG														
NIST/Manufacturing Extension				■							■	■		
FMCS	■					■	■		■			■		
State Funds														
Incumbent Worker Training	■		■	■	■	■			■			■		
Dislocated Worker Training			■									■		
Department of Education	■		■					■						
Community College					■				■			■	■	
School-to-work												■	■	
Skill Standards														
Labor-Management	■						■							
Manufacturing Extension				■								■	■	■
Economic Development				■							■		■	
Feasibility studies											■		■	
Research											■			
Loan funds											■			

Appendix 4: Matrix of Partnership Funding

Local Funds	CWE	Culinary 226	E-Team	GIDC	GAI	1199 SEIU	LMCER	1199C Phil.	SF Hotels	Carpenters	SVA	WRTP	Workers Ctr.	WPUSA
Incumbent Worker Training														
Dislocated Worker Training														
School District														
Community College														
School-to-work														
Skill Standards														
Labor-Management														
Manufacturing Extension														
Economic Development														
Feasibility studies														
Research														
Loan funds														

Consortium for Worker Education, a multi-union collaborative of more than 40 New York City unions representing 800,000 members, dedicated to union- and worker-focused education, training and re-employment services.
Culinary Union Training Center, a single-union, multi-employer labor-management partnership of Culinary Workers Local 226 of the Hotel Employees & Restaurant Employees (HERE) and the Las Vegas hotel industry, covering nearly 50,000 workers in America's fastest-growing city.
E-Team Machinist Training Program, a young partnership in which a union and a community group—Electrical Workers Local 201 and the Essex County Community Organization—joined forces to retain and expand good jobs in their community.
Garment Industry Development Corp., a single-union, multi-firm labor-management partnership of UNITE and the New York garment industry, covering hundreds of employers and 30,000 union members.
Graphic Arts Institute of Northern California, a single-union, multi-employer labor- management partnership of the Graphic Communications International Union and San Francisco's graphic arts industry, which is challenged by rapid and radical technological change.
Hospital League-1199 SEIU Employment, Training and Job Security Program, one of the largest and oldest sector-based labor-management partnerships in the nation, made up of SEIU 1199 New York and the New York region's health care industry. The partnership covers more than 300 employers and 85,000 health care workers in the New York region.
Labor-Management Council for Economic Renewal, a sector-focused, multi-union labor- management partnership in a southeastern Michigan industry made up of small and mid-sized firms.
Philadelphia Hospital and Health Care-District 1199C Training and Upgrading Fund, a sector-focused, single-union, multi-firm labor-management partnership of Hospital and Health Care Workers Union 1199C and the Philadelphia-area health care industry, covering 17,000 unionized health care workers in the Philadelphia area.
San Francisco Hotels Partnership, a labor-management partnership of HERE Local 2 and the San Francisco hospitality industry—the largest private-sector employer in the city. It covers nearly 5,000 workers at 11 Class A hotels.
Southern Nevada Carpenters Journeymen's and Apprentice Training Program, a traditional construction sector labor-management partnership of the Southern Nevada Regional Council of Carpenters and the Las Vegas construction industry that has undergone dramatic restructuring to address the changing workforce and industry.
Steel Valley Authority, a public authority created by the City of Pittsburgh and 11 nearby mill towns, with union and community representatives, to retain and expand the base of manufacturing jobs and revitalize communities in western Pennsylvania.
Wisconsin Regional Training Partnership, a multi-union, multi-employer sectoral effort to improve training and preserve manufacturing jobs in Greater Milwaukee.

Worker Center, AFL-CIO, a labor-community organization fighting economic decline and working to retain good jobs in the Seattle area.
Working Partnerships USA, a research, policy and advocacy institute with a focus on economic development and contingent work issues in the Silicon Valley/Greater San Jose area, initiated by the South Bay (California) Labor Council.

Appendix 7: Expanded List of California Legislators with Interest in Mental Health

(California Mental Health Directors Association 2003)

Bill	Author	Summary	Hearing Date	Last Amended	Last Action
AB 37	Yee, Leland (D)	Would require a health care service plan and a health insurer to contract with a county department of mental health to provide all medically necessary treatment to an enrollee or insured suffering from a serious emotional disturbance, if that treatment is not available through a contracting provider.	3/18/03 at 1:30 p.m.	Hasn't been amended	Awaiting first hearing.
AB 183	Nation, Joe (D)	Would include licensed marriage and family therapist and licensed clinical social workers services within the scope of Medi-Cal covered benefits, to the extent that federal matching funds are available for those services.	3/18/03 at 1:30 p.m.	Hasn't been amended	No action yet.
AB 271	Nunez, Fabian (D)	**Would establish the state community augmentation and resource enhancement account, or CARE account, containing specified funds attributable to costs saved by moving individuals from developmental centers to community-based care, or deflecting individuals from admission to developmental centers, to be distributed to the regional centers for the purpose of enhancing the services and programs provided by the regional centers. Would require each regional center to establish an account for its CARE funds, and would specify the funding sources and intended uses for CARE accounts. Would authorize the department to establish state-owned, state-operated, or state-staffed residential facilities or services, as specified, to meet the needs of persons with a developmental disability whose needs otherwise cannot be met. Would require the department to prepare an annual report to the Legislature, with specified components, to address issues relating to the implementation of the bill. Would require that state developmental lands and buildings, when feasible and appropriate, be leased or sold at fair market value, and would also establish the Lanterman Trust Fund in the State Treasury in order that funds generated from the sale or lease of existing state facilities for the treatment of the developmentally disabled may be redirected to provide housing and other specified services and supports to members of the developmentally disabled community, upon appropriation by the Legislature. Would provide that the trust shall be administered by a board of trustees, and would specify the membership of the board of trustees, including, among others, the Director of Developmental Services. Would also specify the sources and intended uses of the funds in the trust.**		Hasn't been amended	2/14/03, Referred to Com. on HUM. S.

AB 348	Chu, Judy (D)	**Would provide that a psychologist who is directly responsible for the treatment of a patient who has been confined involuntarily, may also make determinations about evaluation and release of any person subject to the Lanterman-Petris-Short Act. Provides that the bill's provisions shall not be construed to revise or expand the scope of practice of psychologists.**		Hasn't been amended	2/18/03, Referred to Com. on HEALTH.
AB 376	Chu, Judy (D)	**Would require that the California Mental Health Planning Council include representatives who are members of labor organizations representing both public and private employees who work in mental health settings.**		Hasn't been amended	2/20/03, Referred to Com. on HEALTH.
AB 380	Steinberg, Darrell S. (D)	**Would establish statutory outcome measures for the children's system of mental health care programs by requiring each county that enters a performance contract to provide services pursuant to the children's system of care program to collect and maintain locally, data that demonstrates the outcomes of the children's system of care program in that county based on outcomes achieved for individual enrollees.**		Hasn't been amended	2/20/03, Referred to Com. on HEALTH.
AB 441	Matthews, Barbara (D)	**Would authorize a juvenile court to order an evaluation at an outpatient mental health site if the court is in doubt as to whether the minor is mentally disordered or mentally retarded. Provides that if the court determines, based on the outpatient evaluation, that the person is mentally retarded or mentally disordered, specified provisions of law concerning treatment or commitment would apply.**		Hasn't been amended	2/18/03, From printer. May be heard in committee March 20.
AB 652	Leno, Mark (D)	Would revise the definition of marriage and family therapy to include the diagnosis, treatment, prognosis, prevention, and treatment of mental, nervous, and emotional disorders within the context of marriage and family systems.		Hasn't been amended	2/20/03, From printer. May be heard in committee March 22.
AB 776	Matthews, Barbara (D)	**Would authorize a court to order a mental health evaluation and assessment for treatment needs by a mental health provider certified by the county mental health department in order to determine the mental condition of a person, if the court is in doubt as to whether such minor is mentally disordered or mentally retarded. Provides that if the court determines that the person is retarded, specified provisions of law concerning treatment would apply.**		Hasn't been amended	2/20/03, From printer. May be heard in committee March 22.
AB 938	Yee, Leland (D)	**Would require the California Medical Board, the Board of Psychology, and the Board of Behavioral Sciences to charge licensees, at the time of license renewal, an additional $5 assessment. Requires the boards to transfer the fee amounts to the Mental Health Practitioner Education Fund established under the bill. Establishes the Licensed Mental Health Provider Education Program.**		Hasn't been amended	2/21/03, From printer. May be heard in committee March 23.

AB 939	Yee, Leland (D)	**Would provide that mental health providers that provide services to Medi-Cal beneficiaries under a contract with a provider of psychiatric inpatient hospital services, and mental health providers that provide mental health services to Medi-Cal beneficiaries through telemedicine, shall be reimbursed in the same manner as providers of acute psychiatric inpatient hospital services.**		Hasn't been amended	3/3/03, Referred to Com. on HEALTH.
AB 1102	Yee, Leland (D)	**Would require the Commission on P.O.S.T. to include in the regular basic training course 4 10-hour consecutive days, for a total of 40 hours, of training for law enforcement officers in the handling of persons with mental illness. Provides that the goal of the training would be to enable law enforcement personnel to deal more effectively with situations involving mentally ill persons.**		Hasn't been amended	3/6/03, Referred to Com. on PUB. S.
AB 1328	Simitian, Joe (D)	**Would require the State Department of Mental Health, in consultation with affected parties, to examine problematic reporting requirements for various mental health programs. Convenes a workgroup to make recommendations to modify these requirements to reduce unnecessary paperwork.**		Hasn't been amended	3/6/03, Referred to Com. on HEALTH.
AB 1370	Yee, Leland (D)	**Would prohibit the State Department of Social Services from adopting and enforcing regulations regarding the use of emergency interventions in community treatment facilities that are in addition to specified regulations applicable to the use of emergency interventions in group homes. Prohibits the department from requiring 24-hour onsite nursing staff at community treatment facilities that use emergency restraints.**		Hasn't been amended	2/24/03, Read first time.
AB 1693	Wolk, Lois (D)	**Would require the State Department of Developmental Services to conduct a pilot program, until January 1, 2009, to provide residential and outpatient services to eligible clients. Authorizes the participation in the pilot program for the State Department of Mental Health if that department chooses to participate, based on specified circumstances.**		Hasn't been amended	2/24/03, Read first time.
SB 372	Margett, Bob (R)	**Would revise the definition of "gravely disabled" under the Lanterman-Petris-Short Act to include, in addition to situations in which an indictment or information is pending against the defendant, situations in which a complaint is pending against the defendant at the time of commitment, and the complaint has not been dismissed.**		Hasn't been amended	3/6/03, To Coms. on H. & H.S. and JUD.
SB 816	Perata, Don (D)	Would authorize a marriage and family therapy intern or trainee to gain experience in any lawful work setting where a trainee provides services that meet certain requirements.		Hasn't been amended	2/24/03, Read first time.
SCA 8	Vasconcellos, John (D)	Would require the director to cause each person incarcerated in state prison, within 90 days of entry, to be evaluated, as specified, with respect to his or her educational and vocational level of development and capacity and with respect to his		Hasn't been amended	3/6/03, To Coms. on PUB. S. and C.A.

		or her psychosocial level of development and ability to lead a constructive life. Based on these evaluations, the measure would require that a program be prescribed and implemented for the inmate that addresses his or her deficient levels of educational, vocational, and psychosocial development, as specified, so as to better equip him or her to lead a constructive life upon release from prison. The measure would also require the Director of Corrections to make a parenting education course available to every inmate incarcerated in the state corrections system who is serving a sentence for a crime involving his or her child or a child formerly under his or her care. This measure would require the parenting course to be susceptible of completion within the sentences of these inmates, as specified, and would provide that there could be no reduction in sentence for one of these inmates who failed to complete an available parenting course. The measure would provide that it would become operative on January 1, 2005.			