Minding the Future:

A report on workforce challenges in youth behavioral health

California Alliance

Empowering lives. Enriching futures.

Catalyst Center

Executive Summary

Children and youth in California have been subject to some of the largest increases in depression and anxiety over the last several years. The annual number of suicides among youth ages 12 to 19 have increased by 15% from 2009-to 2018, and incidents of self-harm increased by 50% during the same time period.[1] Yet 65% of the youth in California do not receive appropriate behavioral health services due to lack of access.[2] Meanwhile, California's community-based nonprofit behavioral health providers are facing a dire workforce crisis which is rapidly diminishing their ability to provide adequate services to children and youth. Providers are reporting unprecedented job vacancy levels of 30-40% that were spurred by the COVID-19 pandemic. Just as we are working to combat the impact on children's and youth's mental health, we are faced with the most severe staffing shortages in a century.[3]

The CA Alliance and its partner organizations, through a workforce convening and interviews, have identified the below strategies and recommendations to address the current crisis effectively.

Strategies & Recommendations

Investing in Worker Wellbeing, Sustaining Entry Points for the New Generation of Professionals, Diversifying Workforce Pipeline, and Increasing Compensation and Other Incentives

1. **Address the lack of uniformity in statewide MediCal standards of documentation and other cumbersome administrative processes.**

- Reduce burdens in documentation and service requirements related to treatment planning and align with standard medical care, which has been a goal of the CalAIM Initiative.
- Pass legislation to address standardized protocol for required documentation used by county mental health plans.

2. **Address backlog of Board of Behavioral Sciences (BBS) registrations.**

- Establish a panel of reviewers.
- Allow a 90-day grace period for MSW and MA registration candidates to bill MediCal for therapy services.

3. **Address the lack of supervisory staff available to provide clinical supervision.**

- Waive the 2-year Post Licensure Requirement for Community Based Organizations.
- Change supervision requirements for ACSW to align with AMFT and APCC.

4. **Align California's standards for BBS registration with national standards.**

- Pass legislation to reduce regulatory barriers by initiating participation in interjurisdictional acts such as PSYPACT, Interstate Licensure Compact, and Counseling Compact.
- Address observed racial disparities in licensing exam performance across various behavioral health professional licenses.

5. **Maximize community-initiated care, other non-traditional community workers, and rehabilitative specialists.**

- Develop Community Initiated Care and Promote Individual Level Supports.
- Revision of MHRS Requirements.
- Increase the Use of Other Qualified Providers for Service Provision.

6. **Implement strategies to meaningfully increase and diversify the pipeline of students.**

- Fund a robust public campaign targeted at young people to increase awareness and early exposure to the field.
- Invest in early professional development and exposure programs starting at secondary and post-secondary level.
- Fund partnerships to develop apprenticeship programs that provide paid positions for community college students.
- Address racial disparities in licensing exam performance across various behavioral health professional licenses.

7. Collaborate with colleges and universities to design options that will reduce the length of time it takes to receive a Master's degree.

- Design an option for 16-month MSW/MFT programs to reduce the length of study.
- Design an accelerated program that allows students to complete their BSW and MSW in 5 years, and design similar programs for MA Psychology and Counseling students.
- Create/Increase paid traineeship/internships.

8. Increase opportunities for accessible quality training, professional collaboration, and shared experience.

- Create Regional Training Centers encouraging multisite collaboration to develop practice, training, and supervision competencies, and shared resources.
- Create spaces for consultation, professional development, and support for new supervisors and newly licensed staff.

9. Increasing Competitive Compensation and Incentivization.

- Increase funding for post-baccalaureate level behavioral health staff to obtain professional training.
- Expand and utilize loan forgiveness programs for staff working in Community-Based Organizations (CBOs).
- Utilize funding opportunities through MHSA/WET and CBO Behavioral Health Workforce Grant Program to recruit and build a dynamic workforce. (Please see Appendix I for related grant announcements/resources).
- Explore legislation for Rural Health Practitioner Tax Credit to facilitate hiring and retention practitioners in rural areas with high need.
- Create provider and CBO engagement in Requests for Proposal (RFP) development processes and other future initiative rollouts to reduce logistical barriers in accessing funding.
- Fund and implement Certified Community Behavioral Health Clinics (CCBHCs) as a supplemental framework to enhance service capacity, higher salaries, and provide alternative payment structures through such models.
- Address high preparation and testing and re-testing costs that disproportionally impact marginalized groups.

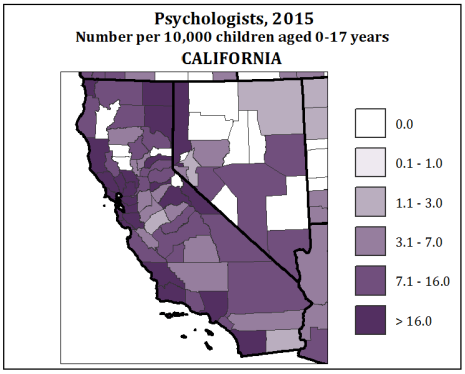
Global & National Mental Health Crisis

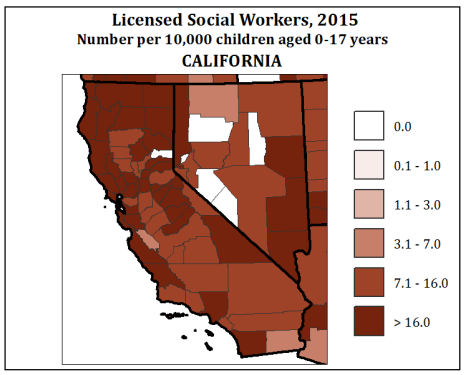
Communities have found themselves struggling to survive a global pandemic, economic devastation, and social injustices tormenting our country over the past three years. There is consensus that COVID-19 highlighted and exacerbated the mental health crisis facing this nation, and that our children and youth have been particularly impacted. On October 19th, 2021, the American Academy of Child and Adolescent Psychiatry (AACAP), the American of Pediatrics (AAP), and the Children's Hospital Association (CHA) declared a national emergency in child and youth mental health[4] as the already soaring rates of mental health challenges were accelerated by the COVID-19 pandemic.

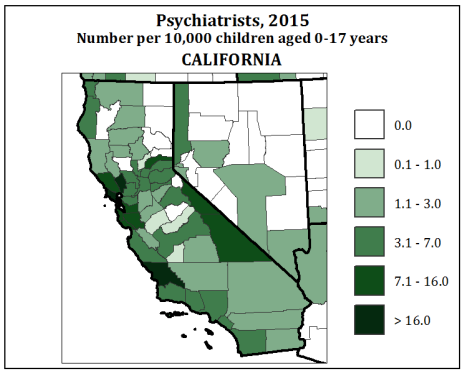
While rates of mental health challenges in children and youth had already been rising steadily throughout the past decade, the physical isolation, loss and grief, and fear of uncertainty brought on by the pandemic further exacerbated pre-existing mental health challenges unmatched by any previous years of record. Physical and social distancing, including but not limited to stay-at-home orders, made it increasingly difficult and, at times. impossible to access in-person mental health and peer support services. From March to October of 2020 alone, emergency department visits for children with mental health emergencies increased by 24 percent for children ages 5-11 and 31 percent for children ages 12-17. In early 2021, we saw a sharp 50% increase in suspected suicide attempts leading to emergency department visits among girls ages 12-17.[5] More than 175,000 U.S. children experienced the death of a primary or secondary caregiver during the COVID-19 pandemic with children of color disproportionately impacted.

Currently, California only meets 23.57% of the mental health needs across the state.[6] Approximately 17% of Californians have mental health needs while 1 in 20 suffers from serious mental illness. Approximately 66% of California adults with a mental illness and 64.5% adolescents with major depressive episodes do not receive treatment.[7] The soaring opioid crisis and increasing homelessness across the state will continue to surpass a pre-existing high demand for behavioral health services.

Figure I: Distribution of Behavioral Health Service Providers Per 10,000 Children Aged 0-17 years.







Unfortunately, the pandemic has also continued to amplify the socio-economic determinants of poor health and has unveiled the profoundly entrenched inequities in access to health care - particularly in communities of color.[8] Based on a 2018 study, communities of color have substantially lower access to mental health and substance use treatment services. Compared with 56.7% of the overall US population,[9] 69.4% of Black adults and 67.1% of Hispanic adults with any mental illness reported receiving no treatment. This lack of access to behavioral health services will continue to result in grave consequences for Californians with both acute and chronic mental health struggles.

Pre-Existing Shortage of Workforce Exacerbated by Pandemic Stress

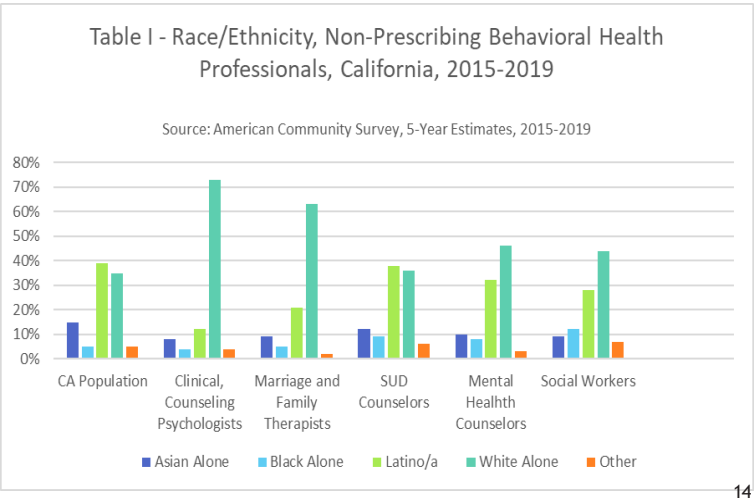
In 2022, approximately 55 Short Term Residential Therapeutic Programs were forced to permanently shut down, with workforce shortages and capacity being significant factors.

Data for CA Dept. of Social Services

The public behavioral health workforce comprises a wide range of professionals, including but not limited to psychiatrists, psychologists, psychiatric nurses, social workers, professional counselors, psychiatric/behavioral technicians, and addiction counselors. Additionally, the behavioral health workforce employs non-clinical professionals, such as case managers, peer support specialists, and recovery coaches. A third arm of the public behavioral health workforce includes individuals trained in early intervention, prevention, and those who work with specific populations such as individuals who interface with the justice system.

While the emotional wellness of children and youth is crucial to their development, we would be remiss to ignore the emotional wellness of the adults who work with children. In 2016, California had over 80,000 licensed behavioral health professionals, yet California only met 30% of its overall need for a professionally trained behavioral health workforce.[10] As highlighted by the Truth Student Survey, the availability of supportive adults on campus fell from 46% pre-pandemic to 39% in 2021. Simultaneously, the percentage of students reporting feeling depressed, stressed, or anxious rose from 39% in 2020 to 49% by 2021. [11]

The evidence is abundant and compelling that mental health and substance use issues continue to grow in conjunction with the behavioral health workforce struggling with deteriorating staff wellness and organizational capacities. While staffing, recruitment, and retention challenges within the behavioral health workforce precede the global pandemic, such challenges are indisputably being intensified by the continued impact of COVID-19.



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Inequitable representation. Systemic, racial, and structural oppression have chronically grim impacts on communities of color. Like most other health professions in the U.S, there is a troubling gap in racial and ethnic diversity within the behavioral health workforce. According to the UCSF 2018 Behavioral Health workforce report, African Americans and Latinos are severely underrepresented among psychiatrists, psychologists, counselors, and social workers relative to California's population Limited educational and training opportunities further continue to constrict the workforce pipeline, including but not limited to, social workers who currently make up approximately 17% of the behavioral health workforce.[12] It is estimated that by 2030, while communities of color will make up over 65% of California's population, representation in the health workforce and educational pipeline will continue to decline if we continue to use the same approaches in educating, training, licensing, and hiring our workforce.[13]

Geographical Limitations to Provider Access. Geographical accessibility to mental health care remains a standing and an uncompromising barrier to access,[15] specifically for rural communities and communities of color. While the Bay Area and LA have more providers, these are also the least affordable places in California. Community providers report struggling to pay for housing and other needs with their current salaries. The incomparable variation in reimbursement rates for Medical versus commercial and private pay further continue to negatively impact community providers.[16] According to the UCSF Report, 2018, of the providers available, the following statistics represent an unequal distribution across the state:

San Joaquin Valley & Inland Empire have the lowest ratios of BH professionals	46% of psychiatrists serve MediCal patients and by 2028 there will 41% fewer psychiatrists	No residency or training programs for mental health NPs north of Sacramento	No Doctoral Programs in Central Coast and San Joaquin Valley

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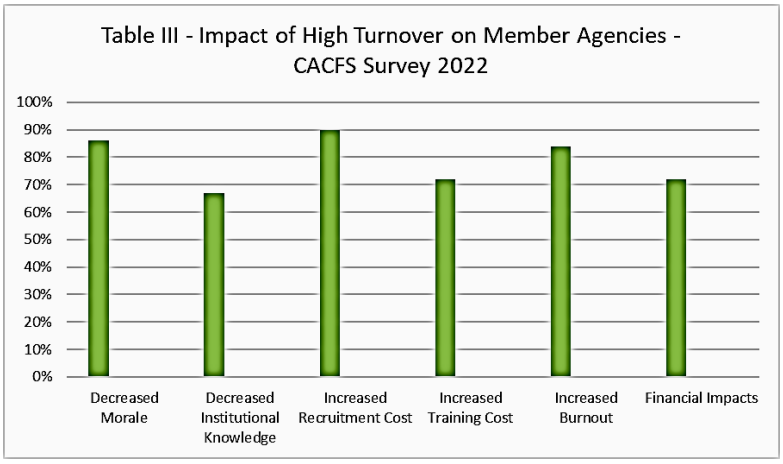
Causes of Workforce Shortage

A. Administrative burdens result in turnover and burnout of behavioral health providers. Over the last two decades, our systems of care have taken the well-intentioned but misguided approach of trying to improve the quality of care by requiring staff to document activities extensively and in more complex ways. Administrative burdens have continued to result in burnout and turnover of behavioral health providers. An estimated 40% of a behavioral health providers' time is spent completing documentation and paperwork associated with service delivery. These paperwork requirements are time-consuming, redundant, and are subject to frequent changes. This often results in unforeseen errors leading to MediCal claims being rejected. The lack of standardized documentation protocols and requirements across counties impacts professionals serving clients in multiple counties. This can lead to errors, confusion, and a severe cognitive burden for the professionals, which directly impacts the quality of care for their clients. As a result, practitioners tend to leave nonprofit CBOs for settings where they spend more time with clients and less on paperwork.

B. Secondary Trauma, Burnout and Lack of Support, and Turnover. Burnout existed before COVID-19 as one of the major barriers to retention for behavioral health care providers. Burnout is a direct result of ongoing, increased, and unmanaged workplace stress[18]. A recent study found a strong association between burnout and insufficient staffing, high turnover, and large patient panels.[19] Many CBO staff work with high-acuity clients who present severe mental health symptoms and concurrent behavioral issues. Combined with limited resources and unmanageable caseloads, secondary trauma exponentially increases the likelihood of staff burnout. COVID-19 continues to exacerbate the pre-existing challenges with vicarious trauma and burnout,[20] significantly impacting practitioners' health, intent to stay, and ability to effectively deliver services.



Source – CACFS Member Survey 2022

C. A Generational Shift Widening the Vacancy Gaps. The impact of an aging workforce and the growing need for psychiatric services are leading causes for the decrease in available psychiatrists in California. This puts additional pressure on an already struggling workforce pipeline, as the increasing demand continues to outpace new professionals entering the field. According to a study published by the University of California San Francisco, more than 45% of practicing psychiatrists and 37% of psychologists are 60 or older. In just 10 years, California is projected to face a shortfall of more than 4,100 primary care clinicians, 600,000 home care workers, and will have only two-thirds of the psychiatrists it needs. [21]

D. Burdensome Licensing Procedures – Educational Cost, Time Investment, & Lack of Supervisory Opportunities. One of the biggest challenges impacting the workforce is that the rigorous educational and training requirements unnecessarily impede our ability to build and maintain a robust workforce. A lack of streamlined career pathways and training opportunities continue to aggravate this issue. Per state requirements, a clinical license for social workers and counselors requires a master's degree, 3000 hours of supervised practice, and passing multiple examinations. Due to a shrinking supply of licensed professionals, the growing need for supervision for new professionals in training remains unmet. Rising, debt-inducing educational and continuing education costs, low wages, and the inflated cost of living in California continue to hinder the recruitment and retention of professionals in the field. For Black, Indigenous, People of Color (BIPOC) communities, these issues are of even greater concern: a new report published by the Association of Social Work Board revealed troubling details around the racial disparities in the 2022 licensing exam pass rate[22]. With fewer clinicians of color entering the field, community members seeking services continue to experience challenges with finding clinicians who share their racial and other identities.

E. Lack of Adequate and Equitable Education, Training, and Practice Opportunities. A report by Children Now[23] highlights that one of the rising concerns within the existing mental health force is the lack of adequate training and education. For non-clinical staff, the gaps in education and training in suicide prevention, behavior management, crisis intervention, and behavioral health basics are significant. Having staff trained in programs like Mental Health First Aid[24] may aid in filling some of those gaps. Additionally, implementation of non-evidence-based protocols. and failure to incorporate trauma-informed and culturally responsive training for both clinical and non-clinical staff pose significant concerns. Most educational and training programs are in major metropolitan areas that fail to serve the needs of professionals situated in rural or Health Professional Shortage Areas. The cost of commuting or relocation, prohibitive educational and training costs, coupled with the prohibitive cost of living in California have further increased barriers to education for professionals, which disproportionately impact students of color. In addition, while the demand for social workers has risen, the educational opportunities presented have dramatically decreased since 2017[25], with programs citing the expensive costs of running the programs as a major concern. Criminal background checks and records continue to pose barriers to having a career in mental health services. The Ban the Box Act now requires employers to remove criminal-history questions from employment applications has been implemented in 33 states, including California[26]. The recent study evaluating Ban the Box implementation[27] showed that there was an increase in racial discrimination with the implementation of this act. Researchers found that the presumed African American applicants were four times less likely to get a callback when the criminal background questions were removed.

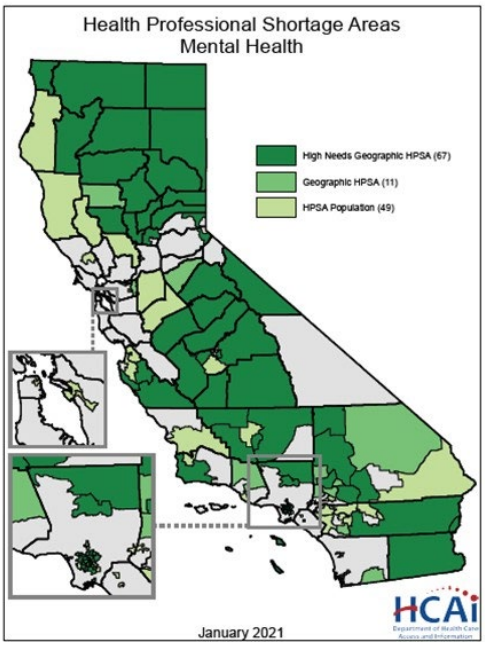


Figure III - HPSAs in California[1]
HPSAMentalHealthMap.pdf (ca.gov)

F. Inadequate Compensation and Incentivization. In a recent CACFS member survey, over 90% of the respondents reported limited and restricted funding as one of the biggest barriers to employee retention and incentivization programs. The most prominent hiring disadvantage for CBOs is the salaries, which lag far behind salaries offered by county employers and private pay providers. CBOs contracting with county MHPs typically have reimbursement rates that are between 60-70% of the counties' rates. This directly impacts the salary levels that providers can pay their staff. Furthermore, reimbursement rates for MediCal versus commercial insurance carriers vary vastly. In 2017, the Milliman report revealed that reimbursements for primary care services were 24% higher than behavioral health services. For example, in 2018 the Bay Area cost of living rose 4.5%[28], however the past Cost of Living Adjustment (COLA) increases (or a lack thereof) for CBOs have failed to adequately protect workers from these rising costs. In Alameda County, where the average price of a home is nearly $1 million[29], the prohibitive cost of living and lack of COLAs for prevention staff, peer providers, crisis support, and MHSA (Mental Health Services Act) service providers in the past fiscal year are forcing workers to prioritize competitive salaries to make ends meet. In San Diego County, behavioral health workers at every level are considerably underpaid compared to other major metropolitan areas within the state.[30] Currently, MediCal only covers 46%[31] of California's psychiatrists with a vast majority of them serving the private health insurance sector. CBOs serving children, youth, and families in the public systems (behavioral health, social services) experience the lowest rates of reimbursement, do not consistently get COLAs, and therefore have the highest turnover rates.

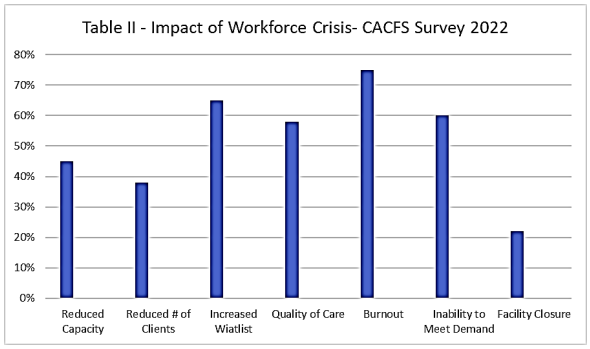
Community Based Organizations: The Gateway to Community Health and Prosperity

"CBOs provide 70% of the services in Santa Clara County. However, we are underpaid/outpaced on average by $20K/licensed clinician. We have a systemic disaster on our hands across the mental health system. State needs to intervene and increase rate on the contracts so that we can meet NACT requirements for the betterment of our communities."

CACFS Member Survey

An inadequate professional behavioral health workforce results in significant impediments for children and youth in need of access behavioral health services. Community-based organizations (CBOs) are the "boots on the ground" forces that, oftentimes, stand as the first line of defense against mental health disparities and crises. CBOs provide prevention and early intervention services that decrease the chances of developing more significant mental health and substance use issues, inevitably reducing the burden on the treatment side.

Source – CACFS Member Survey 2022



Most urgent treatment options, such as the emergency room and in-patient facilities, are far more expensive interventions and are also more limited. CBOs fill in these service gaps and provide a range of interventions, such as outpatient and peer support services that are far more cost-effective than hospitals or longer-term treatment facilities.

Challenges for CBOs. CBO staff are underpaid and experience extensive administrative burdens, increased secondary trauma, and demanding caseloads. These factors create a deep sense of underappreciation and significantly increase the likelihood of staff burnout. In addition, these factors have historically played a crucial role in putting CBOs at a greater disadvantage when they seek to hire and retain staff. Consequentially, CBOs experience higher than average vacancy and turnover rates, leading to increased wait times for services and service interruption. The national average wait time for behavioral health services is 48 days, which has continued to increase over the course of the COVID-19 pandemic.[32] The ongoing pandemic, coupled with worsening economic disenfranchisement and social injustices and inequities, have only added fuel to this growing fire. It is imperative to acknowledge both the crucial role that CBOs play in providing service access and prevention, and how to adequately redress the impacts of the current crisis.

Over 80% of our member survey respondents reported having the most difficulty in hiring and retaining direct care staff.

Community, Equity, and Social Justice Oriented Access. CBOs are well situated within the communities they serve to identify systems of oppression and the need for appropriate and culturally responsive care within those specific communities. CBOs also benefit from the trust and rapport within their service areas to identify and provide appropriate and trauma responsive services. With a deep understanding of the individualized needs of children, youth, and families in the communities they serve, CBOs are uniquely positioned to deliver an array of dynamic and culturally responsive services.

Larger Access, Cross-Systems Collaboration, and Enhanced Service Capacity. In Sacramento County, 90% of services are contracted to CBOs. CBOs, many of which operate 24/7 year-round, provide timely access to critical care services that schools and other institutions cannot feasibly provide. The around-the-clock availability of evidence-based, trauma-responsive care reaches children, youth, and families when they are most in need, which does not always coincide with "business hours." Most CBOs are embedded in cross-sector partnerships, collaborating with entities in the juvenile justice, behavioral health, education, and child welfare sectors. Cross-sector collaboration better situates CBOs and their partners to improve child and youth outcomes, carry out effective and comprehensive care coordination, and catalyze prevention-oriented services.

Reliance on CBOs is predicted to grow alongside continued implementation of initiatives such as CalAIM and the Children and Youth Behavioral Health Initiative (CYBHI). These initiatives aim to expand community-based supports and services, crisis and mobile support units, enhanced care management, and other efforts to integrate behavioral health services in traditionally non-behavioral health settings (i.e., education, justice, medical, etc.). However, CBOs do not have the proper resources to carry out these initiatives and the most significant barriers - workforce recruitment, development, and retention - continue to be overlooked.

Opportunities & Proposed Recommendations

"In 2022, the U.S. Surgeon General called for a whole-of society approach to address health worker burnout at the systems level and to build a thriving health workforce. This approach, in part, highlights the need to reevaluate financial incentives, create more human-centered health information technology, and rebuild trust through public-private collaborations and increased social support programs for health workers." **SAMHSA**[33]

Opportunity I – Pursuing Administrative Relief and Sustaining Entry Points for the New Generation of Professionals

Currently, there is no uniform statewide standard for documentation and reporting of Medi-Cal reimbursable services. SB (Senate Bill) 293 (Limón), which failed to gain traction in the legislative process, would require the California Department of Health Care Services (DHCS) to develop a standardized protocol and documentation requirements that would be used by county MHPs and their contracted providers to simplify Medi-Cal reimbursement paperwork.

Additionally, expansion of mental health resources, advocacy efforts, peer support for both clinical and non-clinical staff, and a more manageable distribution of caseloads would improve challenges for current staff as well as entice a new generation of workforce to commit to CBOs long term. The overall distribution of clients with acute mental healthcare needs could also be addressed through increased systemic emphasis on prevention-based strategies. For example, over half of the Californian population seeking psychiatric care do so through their primary care physicians Efforts including Mental Health First Aid[34] suicide prevention training, and implementation of screening protocols should be a part of primary care practice with suitable strategies in place to make appropriate referrals when needed. This will continue to help alleviate pressure from the increasing demand for behavioral health practitioners. Investment in the new generation of behavioral health workers also requires addressing rising educational and licensing demands (solutions will be discussed in later sections).

Strategies for Increasing and Sustaining Entries of New Professionals

1. **Address the overly burdensome and ununiformed standards of documentation, along with other cumbersome administrative processes.** Reduce burdens in documentation and service requirements related to treatment planning and align with standard medical care. Continue to pursue legislation to address standardized protocol for required documentation used by county MHPs. CA Alliance has provided continued feedback to the state with regards to accreditation and CalAIM Documentation Reform.[35]

2. **Address backlog of Board of Behavioral Sciences (BBS) registrations** to get ASW, MFT and LPCC interns into the workforce expeditiously. It often takes 3-6 months for applicants to become registered and they cannot bill for therapy services under MediCal. This continues to impact the entry points for new clinicians and overall service capacity and delivery.
   A. **Panel of Reviewers.** We recommend that BBS create, train, and certify a panel of qualified professionals that can serve as backup reviews of applications. This panel could provide the same review as BBS staff on an as-needed basis and recommendations to improve the review process. This system would help develop and maintain a more efficient application process.
   B. **Allow a 90-day grace period for MSW and MA registration candidates to bill MediCal for therapy services.** The BBS has a 90-day rule that enables clinicians to retroactively count their licensing hours from the date of their graduation until their approved registration. (Business and Professions Code (BPC) § 4996.23(b)). A corresponding 90-day rule for clinician billing of therapy is recommended. DHCS could direct MHPs to approve the billing of therapy services retroactively back to the date of the original BBS application. This would enable a seamless transition of services and employment from intern to associate.
3. **Address the lack of supervisory staff available to provide clinical supervision towards licensure hours for ASW and MFT interns.** Current regulations require that supervisors have a license plus two years of experience and 15 hours of supervision training.
   A. **Waive the 2-year Post Licensure Requirement for Community Based Organizations.** A waiver of the requirement for the additional two-year post-licensure for clinical supervision provided in nonprofit settings is recommended The existing requirement of 15 hours of clinical supervision will retain a level of quality and fidelity to the licensure process.
   B. **Change requirements for ASW to align with AMFT and APCC**. Current requirements for ASWs are for 13 weeks of individual supervision and a minimum of 1700 hours under the supervision of an LCSW. This creates a barrier for ASWs who may not be able to count all hours provided/accrued, if under the supervision of an LMFT or LPCC. Other disciplines have less restrictions on supervision, and there is no evidence that this requirement impacts an ASW's success at obtaining licensure.
4. **Align California's standards for BBS registration with national standards.** Currently, unlicensed individuals moving from out of state must complete additional coursework before registration with the BBS. We should not require more than the other states at the outset of registration since this further delays mental health professionals entering the field and discourages potential applicants from coming to California. We recommend exploring legislation to reduce regulatory barriers by initiating participation in interjurisdictional acts such as PSYPACT, Interstate Licensure Compact, and Counseling Compact that allow professionals to work across state borders without the need for additional training, multiple licenses, or educational requirements. These compacts will allow multiple states to collaborate and develop standardized laws to increase practice beyond state borders, reduce barriers to access while regulating practice, and improve continuity of care. States must enact compact legislation within their state to become a member. We recommend exploring and introducing compact legislation within California, which will attract and retain new and unlicensed professionals from out of state.

Opportunity II – A Call to Create an Innovative and Accessible Workforce Framework

"I would love to see more ROP programs in high schools for behavioral health options. These ROP programs also provide community college credit when they graduate from high school."
CACFS Workforce Summit 2022

Pipeline, advising, mentorship, and professional development programs help first-generation, low-income, and underrepresented students of color explore careers in behavioral health care and social services. Subsidized and tiered educational programs should begin as early as post-secondary education and incorporate more sophisticated certifications throughout the undergraduate and post-graduate years. For example, the Child & Youth Care Certification Board[36] is an international organization that works to advance professions within the youth services arena. These programs instill a sense of motivation and passion in students to take on meaningful career trajectories in behavioral health care. Despite the lack of educational and training opportunities, a consensus within the field supports hiring paraprofessionals with lived experience and supporting peer-based initiatives to facilitate workforce expansion - especially within CBOs. Additionally, continuing to foster exposure and interest in behavioral health careers among underrepresented minority students remains a vital solution towards expanding the behavioral health workforce pipeline.

Strategies to Strengthen the Workforce Pipeline, Creating Innovative and Accessible Education Pathways

1. **Maximize community-initiated care, other non-traditional community workers, and rehabilitative specialists.** Community initiated care focuses on existing community relationships and multidisciplinary wraparound services through assuming shared responsibility. These supports establish pathways to empower members of the community by training stakeholders to appropriately respond to behavioral health needs in their communities. While this does not replace the service providers within the behavioral healthcare system, it serves to strengthen the system with active community involvement. Empowering communities to assume an active role may also encourage an increased entry for positions such as mental health rehabilitation specialists (MHRS) that can provide adjunct services such as behavioral support, individual and group rehabilitation, support groups, and crisis intervention. Furthermore, empowering community members to play an active role in the mental and behavioral wellbeing of their peers will instill trust in individuals who would otherwise resist or refuse mental and behavioral health treatment.
   A. **Develop Community Initiated Care.** In addition to making continued and sustained efforts towards expanding the clinical workforce, it is vital to shift and share care with the communities. This includes, but is not limited to, investing in training and compensation for community health workers, public health professionals such as contact tracers to aid in mental health screening processes, and individual members of the public to deliver low-intensity interventions. CBOs are best situated to expand these types of positions and can play a vital role in facilitating community-initiated care.
   B. **Revision of MHRS Requirements.** Current regulations require that MHRS staff have either an associate degree plus 6 years of relevant experience, a bachelor's degree plus 4 years' experience, or a master's degree plus 2 years of experience.

We recommend amending the Medicaid State Plan to reduce the required years to BA or master's plus 2 years' experience and AA plus 4 years' experience. Additionally, because there are highly effective staff with HS diplomas who do not yet have their AA, we strongly urge the expansion of this credential to include those with a high school diploma plus 6 years of experience. (Medical State Plan, Section 3, Supplement 3 to Attachment 3.1-A, p. 2o.).

C. **Increase the Use of Other Qualified Providers for Service Provision.** DHCS can direct MHPs to allow for the use of Other Qualified Providers, defined as, "an individual at least 18 years of age with a high school diploma or equivalent degree determined to be qualified to provide the service,"[37] to provide services within their scope (rehabilitation, plan development, case management, etc.) thereby facilitating the expansion of the workforce. While this is currently available under California's State Plan, there are county MHPs that do not allow CBOs to hire and train staff in this category.

2. **Develop more strategies to meaningfully increase and diversify the pipeline of students** entering the field of Behavioral Health by encouraging, motivating, and engaging students, particularly BIPOC and those with lived experience, to enter the field.

   A. **Fund a robust public campaign targeted at young people.** Develop a robust public campaign aimed at recruiting young students and creating awareness and excitement about joining the field using youth-centered platforms and social media. Engaging youth in these campaigns should expand the space for and engage young people with lived experience to design, develop, and produce the campaign.

   B. **Invest in Early Professional Development Programs.** Programs starting at the secondary and post-secondary levels focused on providing applied and other learning opportunities within the behavioral health field expose students to opportunities in behavioral healthcare. These may include vocational training programs and professional internship opportunities for students interested in behavioral health professions. Programs like Faces for the Future have successfully developed strategies to engage and encourage diverse youth to enter healthcare professions through their applied internships and vocational and professional mentorship opportunities at both secondary and post-secondary level.

   C. **Fund partnerships to develop apprenticeship programs that provide paid positions for community college students**. Apprenticeships within the behavioral health field remain an untapped resource. Twenty-eight percent (28%) of CACFS survey respondents reported having less than 5% of staff who had gone through prior pipeline training. Partnerships between Community Colleges and CBOs with CACFS and its Catalyst Center serving as sponsor will provide a certification program for students and apprenticeships with CBOs in which students will be trained in topics such as trauma-informed care, crisis intervention, restorative justice, and evidence-based/community-defined practices. These apprenticeships coupled with added support such as scholarships and tuition reimbursement will expand and diversify the pipeline for mental health staff. In addition, maximizing on programs like Foster2SocialWork[38] and other innovative programs that focus on paid work experience, vocational training and development, career planning, and utilizing mentorship models for systems-involved youth will foster continued interest and entry points in the field for young people with lived experience. (Please see Appendix for related grant announcements). Address racial disparities in licensing exam performance across various professional behavioral health licenses for new professionals. We recommend initiating additional research and analysis by a third party to understand the contributing factors to exam pass rate disparities and to establish routine publication of disaggregated exam data by race, gender, and age on an annual basis.

3. **Work with Colleges and Universities to design options that will reduce the length of time it takes to receive a Master' degree.** Developing more options for students to have in their educational experience, and moving through their programs while obtaining the necessary curriculum will help to increase and diversify the workforce.

   A. Design a 16-month MSW/MFT program option to reduce the length of study. This would include a full year and a half program with a year-long traineeship and increasing responsibility. This program design currently exists at the University of Michigan Social Work School.

   B. For BSW students, design an accelerated program that allows students to complete their BSW and MSW in 5 years, reducing the completion time by one year. A similar approach could be created for students studying Psychology at universities that provide MA in Psychology or MA in Counseling programs.

   C. Create pathways and opportunities for paid traineeships. Currently, traineeships typically must happen outside of a trainee's paid employment. In certain cases, students also may have to pay to acquire internship practice and credit.

4. **Increase opportunities for accessible quality training, professional collaboration, and shared experience.** To create better retention and recruitment strategies addressing professional development, we must acknowledge the gaps in standardized and accessible quality training programs, especially in rural areas that lack proper infrastructure. Creating consistent best practices by encouraging local and regional partnerships amongst CBOs, clinical programs, and academic institutions, and applied practice will aid in catalyzing access to services and training opportunities.

   A. Create Regional Centers of Excellence. San Diego County proposes establishing Regional Centers of Excellence and Training with multisite collaboration (including but not limited to local training programs, academic institutions, and CBOs) that help develop training and supervision competencies.[39] Multisite collaborations will be established within existing programs that provide a multitude of behavioral health services. These training hubs would provide technical assistance and other necessary supports for CBOs to effectively develop and expand their own robust training and applied practice models. The regional centers can provide training for all levels of direct care staff to fulfill their supervision and training needs towards certification/licensure. Furthermore, these collaborations will not only provide spaces for shared learning and resources but also support for working professionals. Lastly, leveraging academic partnerships to research effective strategies that reduce gaps between education, practice and training, supervision, use of clinical best practices, and evaluating successful client outcomes will continue to help move the needle forward.

   B. Create spaces for consultation, professional development, and support for new supervisors and newly licensed staff. We recommend funding professional development, consultation, and support programs for newly licensed clinicians, clinicians pursuing licenses, and new supervisors. These spaces will not only enable professionals to share ideas and resources, but offer professional support, supervision, and consultation opportunities to assist providers in training new clinical supervisors, newly licensed clinical staff, and other (unlicensed) clinical staff. These services may help alleviate burnout, aid in retention, and expand supervision and training opportunities that are otherwise impacted by the current shortage of professional supervisors in the field.

"State and Counties need to empower CBOs more because they can serve as training agencies for new professionals. This can really help curb the lack of existing training/clinical programs across the state" – CACFS Workforce Summit 2022

Opportunity III - Competitive Reimbursement and Incentivization

As the CalAIM initiative moves forward and the changes in payment methodology between the state and counties are put in place, it is imperative that the rates paid to CBOs are competitive enough to maintain a stable and effective workforce. This means not simply replicating the current rate structures but providing enough funding for contracted providers to pay staff competitive wages.

Expanding parity requirements to encourage commercial insurance plans to provide direct reimbursement for all levels of licensure and certification among behavioral health professionals can also help curb some of the compensation challenges. Incentivizing paraprofessional staff with growth opportunities, such as educational support and reimbursement, certification programs, and childcare services, can further address some of the challenges with lower pay rates.

Strategies for Competitive Compensation and Incentives

Increase Funding to Improve Compensation and Implement Legislation to Reduce Barriers. The following strategies can further increase and diversify the behavioral health workforce.

- **A.** Fund post-baccalaureate level behavioral health staff to pursue professional training and degrees.
- **B.** Expand and utilize loan forgiveness programs, such as Title IV-E used for social services, but for behavioral health careers and for staff working in CBOs.
- **C.** Utilize funding opportunities through MHSA/WET funding and the Community-Based Organization Behavioral Health Workforce Grant Program[40] to recruit and build a dynamic workforce within the CBOs. (Please see Appendix for related grant announcements/resources).
- **D.** Explore legislation for Rural Health Practitioner Tax Credit to incentivize hiring and retaining practitioners in rural areas with high need.
- **E.** Increase provider and CBO engagement in the RFP development process at both county and state level and other future initiative rollouts to reduce logistical barriers faced by providers in accessing funding.
- **F.** Embrace Certified Community Behavioral Health Clinics and expanding access to federal funding that allows organizations to enhance service capacity, offer higher salaries, and provide alternative payment structures through the CCBHC models. These models can serve in tandem with CalAIM and continue to address the needs of populations not being adequately served under the initiative.
- **G.** Address high preparation and testing and re-testing costs that disproportionally impact marginalized groups. We recommend waiving licensing exam re-testing fees for test-takers who have already paid for their initial exam.

78% of the respondents shared having access to more funding would help with retention by investing in better pay, employee training and educational costs, wellness and development programs, and yearly bonuses - CACFS Survey 2022

Answering the Call

California's vision for the CalAIM and CYBHI Initiatives requires that the behavioral health system works diligently to ensure easy access to high quality care. Increasing efforts and resources for the development and retention of dedicated, qualified, diverse, and passionate professionals serving within CBOs is paramount in combating the rapidly increasing demand. Unless directly addressed, workforce challenges associated with low compensation, prohibitive education and training costs, cumbersome regulations, and a professional pool trending toward retirement will continue to hinder California's ability to respond to the current and future demands.

The current workforce shortage requires immediate action to ensure that the state can meet the growing demand, provide quality services, and maintain access to a robust continuum of care. The strategies outlined in this report provide promising opportunities towards creating both short- and long-term pathways that will lead to widening, strengthening, and sustaining the workforce pipeline. Let us work together towards the larger vision of ensuring that all children, youth, and their families have access to high quality behavioral health services when and where they need them, regardless of their insurance coverage.

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Appendix

Behavioral Health Workforce Funding Opportunities
There are numerous funding opportunities available through the California Department of Health Care Access and Information (HCAI) intended to increase and diversify California's healthcare workforce. This document contains a summary of the eligibility criteria and deadlines for several programs for behavioral health professionals and organizations. Please use the HCAI Funding Eligibility tool to check eligibility and visit the HCAI Funding Portal to apply.

A} Scholarships

Advanced Practice Healthcare Scholarship Program (APHSP)
Application Deadline: February 24, 2023 at 3:00 p.m.

Allied Healthcare Scholarship Program (AHSP)

B} Loan Repayment Programs

Licensed Mental Health Services Provider Education Program (LMH)
Application Deadline: Applications will be accepted from May 1, 2023 at 3:00 p.m. to July 31, 2023, at 3:00 p.m.

State Loan Repayment Program (SLRP)
Application Deadline: Applications will be accepted from July 17, 2023, 3:00 p.m. to September 15, 2023, 3:00 p.m.

C) Grants for Organizations

Community-Based Organization Behavioral Health Workforce Grant Program
Application Deadline: Applications were accepted from September 30, 2022, to November 30, 2022

Workforce Education and Training (WET) Peer Personnel Training and Placement Program
Application Deadline: Applications will be accepted from January 31, 2023, at 3:00 p.m. to March 31, 2023, 3:00 p.m.

D} Pipeline Programs

Health Careers Exploration Program (HCEP)

Application Deadline: Applications will be accepted from April 26, 2023, to June 26, 2023

Health Professions Pathways Program (HPPP)
Application Deadline: Applications will be accepted from April 26, 2023, to June 26, 2023

E} Other HCAI Workforce Initiatives

Children and Youth Behavioral Health Initiative (CYBHI) Wellness Coach Model