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May 29, 2026

Libby Abbott
Deputy Director of Workforce Development
Department of Health Care Access and Information
2020 West El Camino Avenue, Suite 800
Sacramento, CA 95833

Re: Comments on Draft 2026-2030 Workforce Education and Training Five-Year Plan

Dear Deputy Director Abbott:

On behalf of the California Psychological Association (CPA), the largest statewide association of licensed psychologists and others affiliated with delivering psychological services across California representing over 21,000 psychologists, we appreciate the opportunity to comment on the draft 2026-2030 Workforce Education and Training (WET) Five-Year Plan. CPA supports the WET Plan's overall goal of strengthening California's county behavioral health workforce and appreciates HCAI's recognition that workforce shortages, training capacity, geographic maldistribution, and retention challenges are limiting access to care for Californians with serious mental illness, substance use disorders, and co-occurring conditions.

CPA offers the following comments and recommendations to ensure the final Plan more fully supports the licensed behavioral health workforce, strengthens the public behavioral health pipeline, and addresses barriers specific to psychology trainees and psychologists.

Licensed SUD Provider Type

CPA urges caution regarding the Plan's proposal to "explore strategies for establishing a licensed-level SUD professional qualified to lead SUD care teams and direct the provision of SUD services" (page 27). The need for more SUD expertise is clear, but the creation of a new licensed provider type should not proceed without a careful assessment of scope, training requirements, supervision structures, consumer protection standards, and potential overlap with existing licensed behavioral health professions. We believe the focus should be on funding graduate preparation in existing Behavioral Health disciplines and recruiting these licensed clinicians into California's Medi-CaL specialty SUD system.

Psychologists, LCSWs, LMFTs, LPCCs, physicians, and other licensed professionals already provide care to individuals with SUD and co-occurring conditions. Rather than creating a new license with a more limited scope of practice than existing master's level behavioral health providers, fragment the workforce or create confusion for counties and consumers, HCAI should first evaluate whether existing licensed professionals can be better trained, incentivized, and deployed to meet SUD workforce needs. Any exploration of a new licensed SUD provider type should include meaningful engagement with existing licensing boards, professional associations, counties, providers, and consumer representatives.

CPA does support focus training in SUD for the existing workforce to increase capacity to provide co-occurring mental health and substance use disorder services, as this is likely the most cost-effective and integrative approach to meeting California's complex behavioral health needs.

Evaluate Prescribing Psychologists as a Strategy to Address the Prescriber Gap

The WET Plan identifies severe psychiatrist shortages across nearly all counties and projects that the shortage will worsen. CPA recommends that HCAI evaluate and launch a demonstration project for prescribing psychologists, often referred to as RxP, as one potential strategy to reduce the prescriber gap, particularly in underserved and rural communities.

Prescriptive authority for appropriately trained psychologists would be a significant step forward in creating a new pathway for California, similar to that adopted in other states, (Two states, Illinois and New Mexico, each after decades of implementation, have recommended and passed legislation to now expand medications that can be prescribed by such specialty trained licensed psychologists.)to help address the prescriber shortage in behavioral health. This policy can be pursued in parallel to HCAI's initiatives to expand the psychiatry and mid-level medical provider workforces and is not in conflict with those approaches. Rather, it is a workforce model that merits serious evaluation as part of a broader strategy to expand access to medication evaluation and management. Psychologists are already embedded in behavioral health systems, have extensive training in diagnosis and treatment, and, with additional specialized education and supervised clinical training in psychopharmacology, could help address access gaps in appropriate settings, where it can be very difficult to find a psychiatrist and primary care physicians do not have the mental health training to provide necessary specialty care. The available evidence from states with established prescribing psychologist programs supports further evaluation of this model. A large study of privately insured patients in New Mexico and Louisiana from 2005 to 2021 found that, compared with patients treated by psychiatrists, patients treated by prescribing psychologists had lower rates of adverse drug-event visits and psychotropic polypharmacy, with similar rates of psychiatric emergency department utilization and medication nonadherence. Additional research on deprescribing found that prescribing

psychologists' practices were generally within the range of psychiatrists and primary care physicians. Prescriptive authority for appropriately trained psychologists has now been approved in eight states (New Mexico, Louisiana, Illinois, Iowa, Idaho, Colorado, Utah, and Vermont) as well as in the Department of Defense and Indian Health Service. Moreover, there are now over 400 licensed psychologists in California that have completed the Master of Science in Clinical Psychopharmacology Program (MSCP), the degree that in states that have passed prescriptive authority, is the necessary prerequisite degree for Licensed Psychologists to pursue supervised prescriptive practice prior to completing necessary examination and licensing requirements for independent or supervised prescriptive practice.

The final WET Plan should commit to a formal evaluation and launching a demonstration project of prescription authority for appropriately trained psychologists (also referred to as RxP) as part of California's prescriber workforce strategy, including assessment of training requirements, safety standards, supervision and implementation models, and the potential for prescribing psychologists to improve timely access to medication evaluation and management in county behavioral health systems.

County Behavioral Health Positions and the Role of Psychologists

The WET Plan appropriately identifies shortages among licensed non-prescribing clinicians and psychiatrists, but CPA recommends that HCAI conduct a more detailed evaluation of county behavioral health position classifications. Many counties do not maintain a separate psychologist classification or do not utilize psychologists in a manner that reflects their full scope of training. As a result, psychologist supply, vacancies, recruitment barriers, and retention needs may be obscured within broader "licensed clinician" categories. Medi-Cal Specialty Mental Health Services (SMHS) and Drug Medi-Cal Organized Delivery System (DMC-ODS) pays different rates based on different provider type, so we do not view this as an issue of funding.

Psychologists bring specialized training in diagnosis, psychological assessment, evidence-based treatment, supervision, program evaluation, behavioral health integration, and services for individuals with complex and co-occurring conditions. The final WET Plan should direct HCAI to evaluate county job classifications, vacancy data, and compensation structures for psychologists specifically, including whether the absence of distinct psychologist positions limits county recruitment and the effective use of doctoral-level expertise. By creating psychologist specific classifications that reflect the full scope of services that this doctoral level of training brings to behavioral health services would incentivize more psychologists to join the County Behavioral Health Systems (CHBS).

Clinical Pipeline Sites

CPA strongly supports the WET Plan's focus on education and clinical training opportunities, but the final WET Plan should more explicitly invest in practicum and internship sites as a core

pipeline strategy. For psychology trainees, the pathway into public behavioral health does not begin at licensure. It begins during practicum, internship, and postdoctoral training.

The WET Plan recognizes that limited exposure to county behavioral health settings can steer new clinicians toward private or non-public employment. For psychology, this issue is especially acute because doctoral training requires multiple years of supervised clinical experience before licensure. HCAI should dedicate funding to expand clinical psychology practicum placements, APA-accredited and APPIC-member internship sites, postdoctoral placements, and supervisory capacity within county and county-contracted behavioral health settings. Funding postdoctoral training is when early career psychologists choose their career path while acquiring these necessary hours for licensure. As the WET plan notes, clinicians often choose to work in settings that they have trained in. This includes funding that goes to counties and training programs to cover the cost of supervision and training aspects, not solely stipend-based funding directly to students. One model that is successful is HRSA's Graduate Psychology Education (GPE) Program. These investments would help create a direct, structured pipeline into the public behavioral health system. Additionally, internship sites are a noted area of need for psychologists. Nationally, there was a shortage of 561 APPIC Internships from the internship Match Statistics for 2026.[1] Creation of these internship and postdoctoral training positions would make County Behavioral Health System an attractive option for early career psychologists.

One barrier that exists is that in DMC-ODS plans, counties cannot bill for psychological associates or waivered psychologists. DMC-ODS can bill for services provided by clinical trainees, students that are in their practicum, or fully licensed psychologists but not for individuals that are in the process of earning their clinical hours for licensure.

CPA supports loan repayment and scholarship investments that the state has made under BH-CONNECT, but the final WET Plan should recognize that existing loan repayment and scholarship timelines often do not align with the psychologist trainee pathway. For example, the timeframe for the existing Medi-Cal Behavioral Health Scholarship announcement does not align with decisions for doctoral students to hear if they were matched with an APA internship. APPIC decisions generally are announced in late February and March, while the application which requires supervisor and placement sponsorship information was due in February this year. Psychology graduate students participate in different placements for each of their three to four years of practicum, their internship year, and then post-doctoral training. Flexibility would be helpful so that students can take advantage of the opportunity and create a pipeline into the public behavioral health system.

[1] Match Statistics - 2026 - Combined

HCAI should consider reallocating a portion of individual behavioral health stipend funding to accredited training programs that can distribute financial support more broadly, equitably, and efficiently across trainees. Such an approach may increase outreach, reduce administrative burden, standardize distribution processes, and strengthen the behavioral health workforce pipeline by supporting trainees earlier in their professional development, including during psychology internship and postdoctoral training.

Recruitment and Retention Funding Should Not Be Zero

CPA is concerned that the draft WET Plan allocates no BHSA WET funding to recruitment and retention at this time, despite identifying recruitment and retention as one of the Plan's five investment objectives. The Plan states that HCAI intends to rely on the BH-CONNECT Medi-Cal Behavioral Health Recruitment and Retention Program and later assess whether BHSA WET funds should complement, enhance, or sustain those efforts.

CPA supports coordination with BH-CONNECT, but recruitment and retention cannot be treated as a future or optional investment. Counties and county-contracted providers are facing immediate staffing shortages, high turnover, and competition from private sector and health plan employers. A zero-dollar allocation risks undermining the Plan's stated goal of stabilizing the workforce. The final Plan should include a dedicated BHSA WET recruitment and retention allocation, even if modest, to support targeted strategies such as retention bonuses, supervision support, salary supplements, early-career incentives, and hard-to-fill classification incentives.

Core Competencies and Licensed Provider Training

CPA appreciates the WET Plan's intent to identify shared core competencies for the county behavioral health workforce. However, the final WET Plan should be careful not to suggest that licensed behavioral health providers are broadly undertrained or interchangeable across disciplines. Licensed psychologists and other licensed professionals already meet extensive education, supervised experience, examination, ethics, and continuing education requirements.

Specific training may be useful for system-specific training, such as Medi-Cal documentation, county behavioral health operations, serving BHSA priority populations, integrated SUD and mental health care, and working with justice-involved or unhoused populations. However, that training should supplement, not supplant or dilute, discipline-specific licensing standards. Core competency standards are developed by the American Psychological Association (APA) Council on Accreditation (COA) and Western Association of Schools and Colleges (WASC), with individual graduate programs having limited flexibility in how they meet these standards. This is true across graduate programs for behavioral health disciplines (e.g. Social Work, Marriage and Family Therapy, etc). Additionally, reviewing each graduate program's curriculum across all behavioral health disciplines would be time consuming and, in our perspective, not yield the

results to better prepare future clinicians in working in the public behavioral health system. We believe this is best accomplished by on-the-job training supported by graduate programs through investments in establishing additional practicum, internship, and post-doctoral sites in county behavioral health and county-contracted organizations.

HCAI should ensure that any core competency framework is role-specific, scope-specific, and developed with professional associations and licensing boards. The framework should recognize differences in training, scope of practice, and clinical responsibility across psychologists, social workers, marriage and family therapists, professional clinical counselors, psychiatrists, peers, SUD counselors, and other workforce members.

Federal Student Loan Caps

CPA appreciates that the draft WET Plan recognizes that changes in federal graduate loan eligibility may create additional barriers for underrepresented and underserved communities pursuing behavioral health careers. This issue should be elevated in the final WET Plan. Recent federal changes will eliminate Grad PLUS loans and establish new annual and aggregate borrowing limits for graduate and professional students beginning July 1, 2026. The U.S. Department of Education states that new borrowers will be limited to $20,500 annually and $100,000 aggregate for graduate programs, and $50,000 annually and $200,000 aggregate for professional programs.

These caps are particularly concerning for psychology because doctoral education is lengthy, clinically intensive, and costly. While clinical psychology is treated as a professional degree for higher borrowing limits, the caps may still be insufficient for students, particularly in PsyD programs. Without state-level mitigation, these changes may reduce the diversity of the psychology pipeline, discourage students from lower-income backgrounds from pursuing behavioral health careers, and worsen shortages in public behavioral health settings and will likely have a longer-term impact on the professional psychology training programs throughout the state

The final Plan should include a specific strategy to respond to federal loan caps, including expanded state scholarships, stipends, paid training placements, loan repayment, and institutional partnerships that reduce out-of-pocket costs for students entering public behavioral health careers.

Conclusion

CPA appreciates HCAI's commitment to strengthening California's behavioral health workforce. To better meet the needs of Californians with serious mental illness, SUD, and co-occurring conditions, the final 2026-2030 WET Plan should more directly invest in the licensed workforce

pipeline, recognize the role of psychologists, support practicum and internship infrastructure, fund recruitment and retention, evaluate county classifications, avoid overbroad competency frameworks, assess RxP as one strategy to address prescriber shortages, and respond to federal student loan caps.

CPA looks forward to continued engagement with HCAI, CBHPC, counties, and stakeholders to ensure the final Plan supports a strong, diverse, clinically competent, and sustainable behavioral health workforce. If you have any questions, please do not hesitate to reach out to me at trinde@cpapsych.org.

Sincerely,



Tyler Rinde
Director of Government Affairs

cc: Stephanie Welch, Deputy Secretary, California Health and Human Services Agency
Jenny Bayardo, Executive Officer, California Behavioral Health Planning Council
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