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Behavioral Health
Planning Council
ADVOCACY • EVALUATION • INCLUSION

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Libby Abbott, Deputy Director, Health Workforce Development

Department of Health Care Access and Information

2020 West El Camino Avenue, Suite 800

Sacramento, CA 95833

RE: **Feedback for Development of 2026-2030 Workforce Education and Training (WET) Plan**

Dear Ms. Abbott,

The California Behavioral Health Planning Council (CBHPC) serves as an advisory body to the Department of Health Care Services and the Legislature on behavioral health policies and priorities, as outlined in Welfare and Institutions Code §§ 5771 and 5772. Under the Behavioral Health Services Act (BHSA) and Welfare and Institutions Code Section 5820 (c)-(e), the Department of Health Care Access and Information (HCAI) must coordinate with the CBHPC to review and approve the Workforce Education and Training (WET) Plan every five years.

The CBHPC's Workforce and Employment Committee (WEC) relays pertinent information about WET Plan activities to the full Council. The WEC would like to thank and acknowledge HCAI's responsiveness to the committee's feedback during the CBHPC April 2026 Quarterly Meeting. In this letter, CBHPC provides additional feedback for consideration in the development of the 2026-2030 WET Plan. This feedback is a result of input we have received based on the information that was presented during CBHPC's April 2026 Quarterly Meetings.

Feedback for Objective 1: Expand Existing Workforce Skills

The CBHPC appreciates efforts from HCAI for the revision of Problem Statement 1. In an effort to recognize the systemic pressures from the evolving state and federal landscape and impact of health disparities in marginalized communities that leads to higher acuity needs, we ask that HCAI further revise the language for Problem Statement 1 to remove

statements that the current workforce lacks skill and sufficient training, and acknowledge the challenges that the existing well-trained workforce is currently facing. Additionally, we encourage Problem Statement 1 to clarify whether Objective 1 applies to the licensed and/or non-licensed workforce, and state what competencies are believed to be lacking. Clarification on these items can help support efforts to direct resources to the appropriate channels.

Furthermore, we recommend that HCAI use existing data for the gap analysis to help inform the priority populations, as gap analyses can be a lengthy and costly process. The use of existing data may effectively inform training needs in a timely and cost-effective manner.

We recognize that Master of Social Work (MSW) students and other behavioral health providers need more training on substance use disorder populations, adults with Serious Mental Illness (SMI), and children with Serious Emotional Disturbances (SED). It is important to define what entities support and train behavioral health providers.

Additionally, we encourage more information-sharing regarding the sources used for the core competencies in the WET Plan. The CBHPC recommends that HCAI draw on the Substance Abuse and Mental Health Administration's (SAMHSA) documents for core competencies for peer support services.

The CBHPC encourages HCAI to consider integrating housing and justice partners to better support populations currently living in facilities where probation departments, sheriffs, and correctional officers have authority. We recommend adding language to the WET Plan to encourage coordination between behavioral health and entities that maintain authority over justice-involved facilities.

There is also a great need for LGBTQIA+ cultural competence training for affirming care, given the fact that there are so few providers who are members of the LGBTQ community. The committee recommends the inclusion of cultural competence provider training for LGBTQIA+ affirming care in the gap analysis and core competencies in the WET Plan.

To support behavioral health interns with gaining world experience with the treatment of psychosis and substance use disorders (SUD) in a variety of settings, we recommend the following:

- Expansion of internships to agencies such as the California Department of Corrections and Rehabilitation (CDCR), psychiatric hospitals, and community mental health sites.
- Include continuing education in the WET Plan to address training gaps that address issues in local regions, particularly in rural settings.

Feedback for Objective 2: Education and Training for Future Licensed Professionals

We would like to acknowledge HCAI for linking training needs to the BHSA priority populations. Historically, HCAI has been focused on geographic disparities. The CBHPC recommends that HCAI build on lessons learned from the previous WET Five-Year Plans and their outcomes to fund best practices in the current WET Plan. This includes the utilization of existing competencies and established workforce needs to date. One recommended best practice to consider is the Mental Health First Aid for Older Adults Program.

The CBHPC discussed the proposal to implement a distinct educational track for substance use disorders, as well as the development of licensed professionals possessing specialized expertise in SUD. We would like to note that the BHSA supports integration for both mental health and SUD. There are licensed and non-licensed professions that serve the substance use disorder population, and it is crucial to support the entire mental health and SUD workforce with education pathways and retention. Additionally, our system currently requires supervision at levels that do not address the needs of Certified SUD Specialists. We support the use of training and cross-training in this area.

To support primary care providers that interface with behavioral health clients and individuals with co-occurring health conditions, we recommend that the WET Plan include community education and efforts to train and equip primary care providers working with individuals who experience serious mental illness or substance use disorders on a continuous basis. The Train New Trainers (TNT) program may help inform licensed professionals in the WET Plan. Focused and booster training efforts such as the TNT training for medical professionals have shown success and could be replicated for both primary care and other allied fields.

Many small and rural communities are not aware of the scholarships provided by HCAI.

To increase providers in rural communities, we need to recruit people who already come from those communities. Therefore, we ask that HCAI improve outreach in rural communities, and we recommend that the WET Plan includes a statement regarding the importance of recruitment efforts directed to rural and/or underserved communities. Continuing education would also help address the training needs in the rural behavioral health workforce.

We also request that HCAI establish training that prepares students to work in public mental health settings. Academic programs, as currently designed, may not fully equip graduates to work with high-needs individuals served by the county behavioral health system. We encourage HCAI to work with entities that set standards for academic institutions to ensure that graduates understand and can deliver services in public behavioral health settings. One way to do this is to provide internships for students to work in the field. Another is to implement pipeline education in educational system, so graduates understand and are equipped with the skills to work with clients who have severe acuity. We also suggest that the WET Plan outline HCAI's efforts to work with licensing boards to ensure that educational requirements support future behavioral health providers with the education and skills needed to effectively serve individuals with severe mental health and substance use disorders.

To support immediate training needs for Bachelor of Science in Nursing (BSN), Master of Science in Nursing (MSN), Nurse Practitioner (NP) and potential Doctorate of Nursing Practice (DNP), we recommend that HCAI contacts California State University (CSU) Dominguez Hills, Fullerton, or Long Beach for CSU public entities and include these resources directly in WET Plan or in the HCAI planning pipeline. We also recommend that HCAI include training for peers that are specific to the Children System of care in the WET Plan.

The CBHPC believes it would be helpful for the WET Plan to recognize that a major contributing factor to workforce shortages beyond academic training capacity is the pay differential between the public behavioral health system and other settings. We would also like to see investments for internship and practicum programs that offer scholarships, loan repayments, and stipends to students to help address the workforce shortage in the public behavioral health system.

Feedback for Objective 3: Scaling and Optimizing the Non-Licensed Workforce

The CBHPC recommends that HCAI provide support for training, hiring, and retaining the non-licensed workforce in the WET Plan. This is critical given the current workforce shortages and great impact that Peer Support Specialists, Community Health Workers, and Wellness Coaches have on individuals served in the public behavioral health system. Peer Support Specialists need training in basic job skills, and these skills should be integrated into their required 80-hour training. Training in basic skills such as note-taking is also needed. On-the-job shadowing and mentoring can help peers and non-licensed staff obtain job skills required. We recommend that HCAI include internships and mentorships for peer roles within the WET Plan, with continuity of support and funding to ensure that trained people have long-term career prospects in their field.

Additionally, Medi-Cal billing is complicated, so we recommend providing peers with separate training on this topic. To assist with the complexities of administrative requirements, we suggest the addition of administrative assistants in agencies to help non-licensed workers manage documentation and billing.

The CBHPC would like to highlight that many Peer Support Specialists are losing their jobs due to shifting Behavioral Health Services Act program priorities and loss of funding from critical areas where peers work, such as Community-Based Organizations that operate prevention and early intervention programs and agencies that rely on Behavioral Health Services and Supports funding, which has been reduced. We request that the WET Plan acknowledges the need for more Peer Support Specialist jobs across the state in different sizes and located counties, as there are currently more certified peers than there are positions to fill in county behavioral health departments and county-contracted agencies. It would also be helpful for the WET Plan to include information on how peers are utilized in the public behavioral health system.

The CBHPC and additional stakeholders have also raised issues regarding the lack of sufficient peer staff working in the children's system of care. The Council will further explore this issue and provide feedback during the 2026-30 WET Plan public comment period.

We also ask HCAI to consider Program 3A implemented only in the geographic areas with the most need as this practice would help reduce

these disparities. Additionally, we recommend that HCAI focus on retention issues of non-licensed workforce and meet directly with peer stakeholders and individuals that work on multi-disciplinary teams to clarify the issues that should be addressed to retain trained personnel. It would also be helpful to consult with county behavioral health departments and provider organizations for the system perspective regarding obstacles faced with non-licensed workforce retention. We recommend that HCAI conduct a time-limited focus group to support these efforts.

The idea of transition-to-practice programs for recently certified providers seems promising, however, the CBHPC seeks more clarification on how transition-to-practice programs will be implemented. It would be helpful to work with community colleges on this item, as these are spaces that have potential to attract diverse college students. The California Community College Chancellor's Office has funded a Behavioral Health Pipeline Project in the past, which would be a helpful resource for HCAI to consider in the development of the WET Plan in addition to consultation with the public universities and community colleges. There is more work to be done to understand whether existing educational pipeline is preparing graduates to work in the real world of current behavioral health realities.

Regarding the proposed technical assistance package, we recommend that HCAI consider including contracts with technical assistance organizations with subject-matter expertise to assist small peer-run organizations with business operations such as Medi-Cal billing and programmatic requirements.

Feedback for Objective 4: Enhancing Career Pathways and Advancement

The CBHPC appreciates and supports HCAI's plan to work with high school students for workforce pipeline efforts. We recommend that HCAI build on best practices shown to be effective and incorporate such practices in the WET Plan. One model to consider is a program in the San Fernando Valley co-designed with the students and includes a food distribution and clothing center. We also recommend partnering with community colleges, public universities, licensing boards, Community-Based Organizations, and Regional Centers to broaden outreach for high school pipeline programs.

Non-licensed, but credentialed providers, such as SUD certified providers, are not currently able to leverage their training and/or experience to

replace course work in graduate therapy/counselor programs. We recommend that the WET Plan includes a specific workforce project to address this issue.

Another issue is that recipients of tuition support funds cannot move into other positions until 10 years or payback time expires, because there are some instances where individuals lose their eligibility for financial support if they switch from direct practice to administration. This impacts career advancement. Therefore, we ask that HCAI consider solutions to this career pathways barrier.

We also hope that the WET Plan contains programs that contribute to meaningful career growth through training. We recommend that entities implement performance improvement plans and collect data on career outcomes through the WET Plan implementation period.

Feedback for Objective 5: Recruitment and Retention

The CBHPC and our partners express concern about the lack of Behavioral Health Services Act (BHSA) funding for recruitment and retention in the WET Plan. Utilizing BH-CONNECT dollars as part of recruitment and retention strategies is an understandable approach; however, their application is restricted to Medi-Cal environments. Thus, improvements to recruitment and retention will look different in every county as some counties are not opting into some or all BH-CONNECT programs. There are non-Medi-Cal settings that are also worthy of investment such as wellness centers or recovery and respite programs. There are also roles that cannot be funded by BH-CONNECT that are vital to the public behavioral health system, such as those who are not full-time or serve in roles that are considered not fully direct service such as program administrators and managers. We recognize that scholarships and loan repayments in the earlier objectives may address some recruitment and retention efforts, however, there are challenges with how this funding is distributed based on the BH-CONNECT Special Terms and Conditions (STCs). Many Community Based Organizations (CBOs) are not equipped with the capacity to engage in these efforts. While it can be helpful for smaller CBOs to contract with counties, they may not have the administrative infrastructure to meet the BH-CONNECT requirements. Therefore, there is a need for immediate dollars under the Behavioral Health Services Act for recruitment and retention efforts. We recommend that BHSA dollars be considered to be used for recruitment and retention

efforts and the State not solely rely on BH-CONNECT, which is a time-limited option.

As the WET Plan is developed, the CBHPC would like HCAI to consider that the salaries for behavioral health providers and staff are not competitive compared to private and for-profit settings. We recommend that the WET Plan explore different ways that salary structures can be created to retain providers, as many providers are moving to private practice and out of settings with the pay differential as a factor of the shortage of providers in the public behavioral health system. We would also like HCAI to consider including subsidies or support for childcare and housing in the WET Plan as strategies to improve recruitment and retention efforts.

There is also a lack of student slots available for clinical placements. More clinics are closing so more student slots are lost as a result. This becomes a barrier to recruitment and retention in the behavioral health workforce. We recommend that HCAI focus on addressing these challenges and strengthening the workforce pipeline, especially in small and rural communities. This includes implementing mentorship programs in addition to clinical placements.

We also recommend creating more opportunities for growth for peers and the non-licensed workforce to support recruitment and retention efforts. Incorporating Peer Support Specialists, Community Health Workers, and Wellness Coaches in the behavioral health workforce can help meet the broader needs of clients and families and help address the current workforce shortages. Emergency departments are one example of peer workplace settings. We also recommend the WET Plan fund counties to hire more non-licensed staff.

Feedback on Evaluation and Accountability

The CBHPC requests that HCAI clearly define what ‘baseline’ means in the WET Plan and provide greater transparency about how progress is measured and what specific metrics are being used.

The measurements should be based on the WET Plan’s goals and whether we are moving towards meeting those goals. We recommend that HCAI look towards academic institutions that have done this work to effectively evaluate outcomes.

The CBHPC would like to point out the need to expand training to conduct competent virtual engagements for Medication-Assisted Treatment (MAT). We ask HCAI to consider what is needed to do this and to prioritize the goals in a way that is tied to consumer outcomes. We believe HCAI must have the capacity and expertise to do in-house program monitoring and support including this in the plan.

Regarding accountability, we request that HCAI include CBHPC and key stakeholders in a meaningful way from the outset. We also ask that stakeholders be given ample time to participate in early planning discussions, as well as to stay informed about ongoing progress and outcomes related to the plan. Listing all stakeholders present at various phases of the accountability process increases buy-in, support and advocacy for this important initiative.

Feedback on Stakeholder Engagement

We encourage HCAI to continue engaging with communities and individuals with lived experience and local organizations and providers throughout the WET Plan implementation process, including but not limited to representatives for older adults, children and youth, Black, Indigenous, and People of Color (BIPOC), LGBTQIA+, Deaf and hard of hearing, and other vulnerable communities. We also recommend that HCAI engage with peer-run organizations, the National Alliance for Mental Illness (NAMI), crisis response groups, psychiatric hospitals, housing partners, and the organizations mentioned throughout this letter for stakeholder engagement. It is helpful to continuously clarify terminology and technical concepts and acronyms used in the behavioral health industry that do not translate well plain language so that communities can provide meaningful feedback. We recommend that HCAI offer a primary session for each stakeholder group and then invite each group to a secondary session to share input that they have had time to reflect on from the first session. To strengthen these efforts, we also recommend that HCAI connect with providers to ask clients if they are willing to participate in these stakeholder sessions and share their experiences or whether they are willing to participate in surveys.

We ask that the WET Plan state the specific community and stakeholder groups that HCAI received input from representing the Special Populations identified on Slide 7 of the presentation. We recommend that HCAI speak to groups that represent each community that is served by

the WET Plan. We also encourage consultation with California Department of Aging, the Commission on Aging, the California Association of Area Agencies on Aging, or older adult county advisory groups for the older adult priority population on an ongoing basis.

The committee asks that HCAI involve the WEC throughout implementation of the WET Plan, as has been done in previous years, with quarterly updates from the Workforce Education and Training (WET) Training Council while ensuring that the WET Council follows Bagley-Keene public notice rules. There may be value in stating this activity in the plan so stakeholders are also aware of this opportunity to engage with HCAI throughout the process.

Additional Feedback for the 2026-2030 WET Plan Development:

- BHSA Priority Populations: To ensure stakeholders and the public better understand how Behavioral Health Services Act (BHSA) priority populations are defined within the WET Plan, the CBHPC encourages HCAI to expand on the information regarding the unique needs and circumstances of these individuals, which shape the workforce and training priorities. Stating the challenges and vulnerability of the BHSA priority populations would enhance the Plan's clarity and strengthen public understanding of how these designations support statewide workforce goals.

- Prevention and Early Intervention (PEI): We ask HCAI to consider the reduced investment of funds for prevention and early intervention (PEI), which are critical programs that rely on BHSA funding. This impacts the high burnout rate for providers as acuity increases. Therefore, we recommend that the WET Plan include workforce programs that support programs that during the MHSA period were known as PEI and include them under BHSA planning.

- Building Workforce Capacity: We ask that HCAI include plans to build workforce capacity to serve the priority populations identified on Slide 19 of the presentation.

- Supplemental Supply and Demand Tool: The CBHPC requests that the WET Plan contain detailed information on the supplemental supply and demand tool to clarify and help stakeholders interpret the meaning of the chart that was presented.

- BHSA Budget Principles:
    - We request that HCAI refrain from using WET funds on activities that have already been done such as defining core competencies. Please refer to our feedback on Objective 1 regarding this matter.
    - We recommend clarifying expectations for sustainability, as these expectations must also be adopted by the partners that HCAI is planning to work with.
    - We ask that HCAI prioritize investments based on the greatest need for staffing.
- Objectives Allocation by Year: We recommend investments for recruitment and retention include funding beyond BH-CONNECT dollars, especially for those counties most impacted by geographic disparities.
- Statewide Reforms: We recommend that HCAI invest in the workforce that can staff facilities and spaces based on the statewide reforms. For example, it would be helpful for HCAI to make investments in workforce to staff facilities funded by the Behavioral Health Continuum Infrastructure Program (BHCIP). It is important to note that not all BHCIP facilities directly tie to BH-Connect but are part of the large continuum of care including housing and in-patient settings.
- Funding Field-Based Roles: Fewer service providers are incentivized to continue face-to-face field work opposed to virtual services and other settings. While virtual services are beneficial, many individuals with SMI and severe SUD with co-occurring socioeconomic burdens require in-person services. Therefore, we recommend that funding opportunities be made available that reward and incentive field-based roles.

In closing, the CBHPC thanks HCAI for the opportunity to provide feedback on the information presented that will inform the development of the 2026-2030 Workforce Education and Training (WET) Plan. We will continue to monitor the development and implementation of this program.

Due to the time constraints for our members to discuss the presented WET Plan objectives in depth at CBHPC's April 2026 Quarterly Meetings, we will investigate specific topics and will provide responses during the WET Plan comment period. We urge HCAI to share a draft of the 2026-2030 WET Plan with the CBHPC, as soon as possible. We also ask that you prioritize individuals with lived experience throughout every stage of this process. We are very invested in all Council members having sufficient time to review with the goal of approving this important five-year plan within the established timeline.

If you have any questions regarding our recommendations, please contact the Council's Executive Officer, Jenny Bayardo, by email at Jenny.Bayardo@cbhpc.dhcs.ca.gov or by phone at (916) 750-3778.

Sincerely,

William Stewart

Chairperson, Workforce & Employment Committee

Cc: Stephanie Welch, Deputy Secretary, Behavioral Health, CalHHS
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