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2026-2030 Workforce Education and Training: Five-Year Plan

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HCAI expands access to quality, equitable, affordable health care for all Californians by supporting high value delivery systems, resilient health facilities and workforces, and actionable health information and strategies.

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Executive Summary

The Department of Health Care Access and Information (HCAI) has developed the 2026–2030 Five-Year Workforce Education and Training (WET) Plan pursuant to Welfare and Institutions Code section 5820, subdivisions (c)–(e). The Plan identifies behavioral health workforce needs across California and establishes a framework for the strategic allocation of the Behavioral Health Services Act (BHSA) funds to support workforce education, training, and development within the County Behavioral Health System (CBHS).

Plan development was informed by community engagement focused on the service and workforce needs of individuals with significant behavioral health conditions, in collaboration with the California Behavioral Health Planning Council (CBHPC). HCAI will conduct a public comment period to solicit feedback on proposed investments, and the CBHPC will review and approve the final Plan.

The 2026–2030 BHSA WET Plan guides California's strategy to strengthen, expand, and sustain the behavioral health workforce by aligning investments with BHSA goals and priority populations. Guided by HCAI's mission to expand equitable health care access for all Californians, the Plan prioritizes an adequate supply of behavioral health professionals in areas of greatest need, a workforce that reflects the diversity and lived experience of the communities served, and providers equipped to support individuals with serious mental illness, substance use disorders, and co-occurring conditions.

To advance these priorities, HCAI developed five investment objectives in response to stakeholder-identified workforce challenges:

1. Expand existing workforce skills
2. Educate and train future licensed professionals
3. Scale and optimize deployment of non-licensed workforce
4. Enhance career pathways and advancement
5. Recruit and retain workforce

Together, these objectives translate stakeholder priorities into a coherent investment framework for a stable, capable, and sustainable CBHS workforce.

California Behavioral Health Landscape

California's Growing Behavioral Health Demands

Behavioral health needs in California are substantial and increasing. Demand for services has grown due to the COVID-19 pandemic, economic stressors, and increased awareness of behavioral health needs, and these conditions disproportionately affect BHSA priority populations, including individuals experiencing homelessness, justice involvement, and children and youth in the child welfare system. California's diversity in terms of race, ethnicity, language, culture, immigration status, and socioeconomic conditions creates both opportunities and challenges for delivering equitable behavioral health services, contributing to uneven access to care, particularly in rural and inland areas and among historically underserved communities.

The section below details population-based needs across priority populations in California.[1]

Children and Youth

- Between 2021-2023, approximately 19 percent of adolescents aged 12 to 17 experienced at least one major depressive episode.[2]
- Between 2019 and 2021, suicide was the second leading cause of death among youth between the ages of 10 to 25.[3]
- As of 2023, up to 70 percent of youth in the juvenile court system have a diagnosable mental health condition. More than half of system-involved youth have a co-occurring substance use disorder. [4]

Adults and Older Adults

- Among adults experiencing homelessness, 48 percent have complex behavioral health needs that require robust services and support. These individuals have at least one of the following: regular illicit drug use; heavy episodic alcohol use;

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[1] Demographic Report Health and Mental Health Equity in California. Reporting Data through July 2024.
[2] Behavioral Health Barometer, California, Volume 8: Indicators as Measured in the 2021-2023 National Surveys on Drug Use and Health.
[3] California Department of Public Health. (2024, April 8). *Youth Suicide Prevention Program highlights* [Fact sheet].https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Suicide%20Prevention%20Program/YouthSuicideHighlight-04082024.pd
[4] Judicial Council of California. (2024, November). *Juvenile mental health funding briefing series 1: The need for treatment*. California Courts. https://courts.ca.gov/system/files/2024-11/Juvenile-Mental-Health-Funding-Briefing-Series-1-The-Need-for-Treatment.pdf

and/or a recent psychiatric hospitalization, with 51 percent experiencing anxiety and 48 percent experiencing depression.[5]

- As of June 2023, more than 53 percent of incarcerated individuals in county jails have a mental health condition;[6] and over the last decade, the proportion with an identified mental health need increased by 63 percent.[7]
- Among older adults, approximately 45 percent report symptoms of depression.[8] In 2021, individuals between the ages of 65-84 accounted for 18 percent of all suicide deaths.[9]
- Between 2022 and 2023, nearly one in five Californians age 12 and older met criteria for a substance use disorder.[10]

As behavioral health needs increase in both prevalence and complexity, these populations often require more intensive, coordinated, and cross-county service delivery approaches.

The County Behavioral Health System

California's County Behavioral Health System (CBHS) is responsible for serving Medi-Cal members and other eligible individuals with the most significant and complex behavioral health needs. All 58 counties administer specialty mental health and substance use disorder services for Medi-Cal members and also serve other individuals who need publicly funded services. Counties deliver services directly, and/or through contracted community-based organizations, resulting in variation in service delivery models, infrastructure, and workforce capacity across the state.

The populations served by the CBHS include children and adults with complex and/or significant behavioral health needs, inclusive of mental health and substance use disorders. These populations are disproportionately Medi-Cal members and are more likely to experience housing instability, justice system involvement, and other adverse

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[5] University of California, San Francisco, Benioff Homelessness and Housing Initiative. (2023). *Toward thriving: Understanding health and homelessness—Findings from the California Statewide Study of People Experiencing Homelessness*.
[6] California Department of Health Care Services. (2026). From incarceration to care: California's Medi-Cal reentry initiative – Impact report (March 2026). https://www.dhcs.ca.gov/CalAIM/Justice-Involved-Initiative/Documents/CA-Reentry-Initiative-Impact-Report-March-2026.pdf 1

[7] California Department of Health Care Services. (n.d.). *Transformation of Medi-Cal: Justice-involved* [Justice Involved Sheet]. https://www.dhcs.ca.gov/CalAIM/Documents/CalAIM-JI-a11y.pdf
[8] Mbaku, V. (2026, March 10). *Behavioral Health Services Act Advocacy for Older Californians*. Justice in Aging. Retrieved April 22, 2026, from https://justiceinaging.org/behavioral-health-services-act-advocacy-for-older-californians/
[9] California Department of Public Health. (2021). *Suicide and self-harm emergency department visit trends in California, 2021* [Slide deck]. Office of Suicide Prevention.
[10] California Health Care Foundation. (2025). *Substance Use in California Almanac: 2025 edition*. https://www.chcf.org/wp-content/uploads/2025/02/SubstanceUseAlmanac2025.pdf

social determinants of health. Their needs are often complex and ongoing, requiring intensive, coordinated, and long-term support. As a result, the CBHS workforce must be equipped not only to deliver services and supports, but to operate effectively within systems that address high acuity needs, structural inequities, and pathways to sustained recovery.

California's Constrained Behavioral Health Workforce

As the demand for behavioral health services grows and evolves in California – placing unique pressures on the CBHS, there are ongoing challenges related to the availability of an appropriately skilled and distributed workforce able to provide services to individuals with significant behavioral health conditions.

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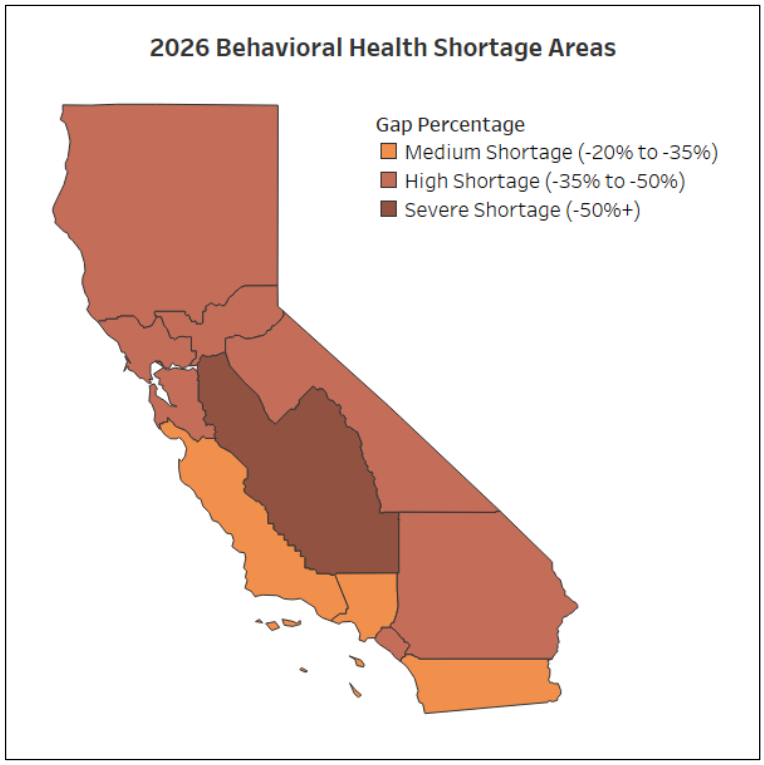
Figure 1: Behavioral Health Shortage Areas



Statewide Gaps by Region

In 2026, HCAI's behavioral health workforce supply and demand model[11] estimates statewide gaps for licensed behavioral health professionals, with the most severe gaps concentrated in the Inland Empire (49 percent) and San Joaquin Valley (54 percent).

By 2033, some regions are projected to see little to no change in their workforce gaps,[12] including the Inland Empire (51 percent) and the San Joaquin Valley (51 percent), while others are expected to see shortages

[11] Supply and Demand Modeling for California's Behavioral Health Workforce - HCAI
[12] These projections do not specifically account for planned investments through BH-CONNECT, BHSA, or other funding streams that are expected to increase training capacity and enrollment, and therefore contribute to workforce expansion.

worsen, such as Orange County, where gaps are projected to increase from 41.9 percent (2026) to 45.3 percent (2033). These gaps reflect both limited overall supply and ongoing geographic maldistribution.

Statewide Gaps by Professional Type

HCAI's supply and demand model can estimate gaps for licensed professionals, including psychiatrists, licensed non-prescribing clinicians (licensed clinical social workers [LCSWs], licensed marriage and family therapists [LMFTs], licensed professional clinical counselors [LPCCs] and psychologists), and associate non-prescribing clinicians (associate clinical social workers, associate marriage and family therapists, associate professional clinical counselors, and registered psychological associates).

Non-Licensed Workforce Supply and Demand: HCAI's behavioral health supply and demand model uses licensing data and care delivery trends broken down by role or role group to create supply projections. California can track licensed workforce shortages more easily because state-regulated licensing boards collect consistent, mandatory data on license holders, while non-licensed behavioral health professionals do not have a unified registry or reporting structure, making their supply more challenging to enumerate.

Modeling shows that currently, 22 counties face severe shortages of licensed non-prescribing clinicians with about 58,856 additional providers needed statewide. This gap is projected to widen slightly by 2033 (just over 42 percent), requiring an additional 171,413 professionals statewide—double the current supply.[13]

Psychiatrist shortages are acute across nearly all counties and projected to deepen. As of 2026, psychiatrists are in critically short supply across all counties, with 40 counties facing severe shortages; there is a statewide need for 4,126 additional psychiatrists. This gap is expected to increase to over 6,200 by 2033.[14]

While it is harder to quantify and project gaps for non-licensed behavioral health professionals, shortages in these roles are consistently recognized by implementation partners and broader system stakeholders, including counties and their contracted service providers. These groups emphasize both the seriousness of the shortages and the critical importance of non-licensed professionals in delivering high-quality care as well as enabling licensed clinicians to practice at the top of their licenses.

Statewide Gaps in Workforce Diversity

In addition to overall supply gaps, the composition of the behavioral health workforce does not reflect the diversity of California's population, particularly in terms of race,

[13] Supply and Demand Modeling for California's Behavioral Health Workforce - HCAI
[14] Supply and Demand Modeling for California's Behavioral Health Workforce - HCAI

ethnicity, and language (e.g., many providers do not speak the languages of the communities they serve). For example, HCAI data show that 28.2 percent of California's population speaks Spanish, but only 19.4 percent of licensed behavioral health professionals statewide can provide services in Spanish. This picture varies by region (see image). In the Northern and Sierra region, for example, only 7.7 percent of licensed behavioral health professionals speak Spanish compared to 28.2 percent of the statewide population. This mismatch contributes to cultural and language barriers to care, further limiting access for many communities.[15]

The racial and ethnic composition of the behavioral health workforce also does not reflect the diversity of the populations served. Though data are only available for licensed behavioral health professionals, representation gaps are reported across the behavioral health workforce and in the CBHS.

[15] Coffman, J., & Fix, M. (2023, February). *Building the future behavioral health workforce: Needs assessment*.
Healthforce Center, University of California, San Francisco. Retrieved from https://healthforce.ucsf.edu/publications/building-future-behavioral-health-workforce-needs-assessment

Figure 2. Linguistic Concordance for Behavioral Health in California

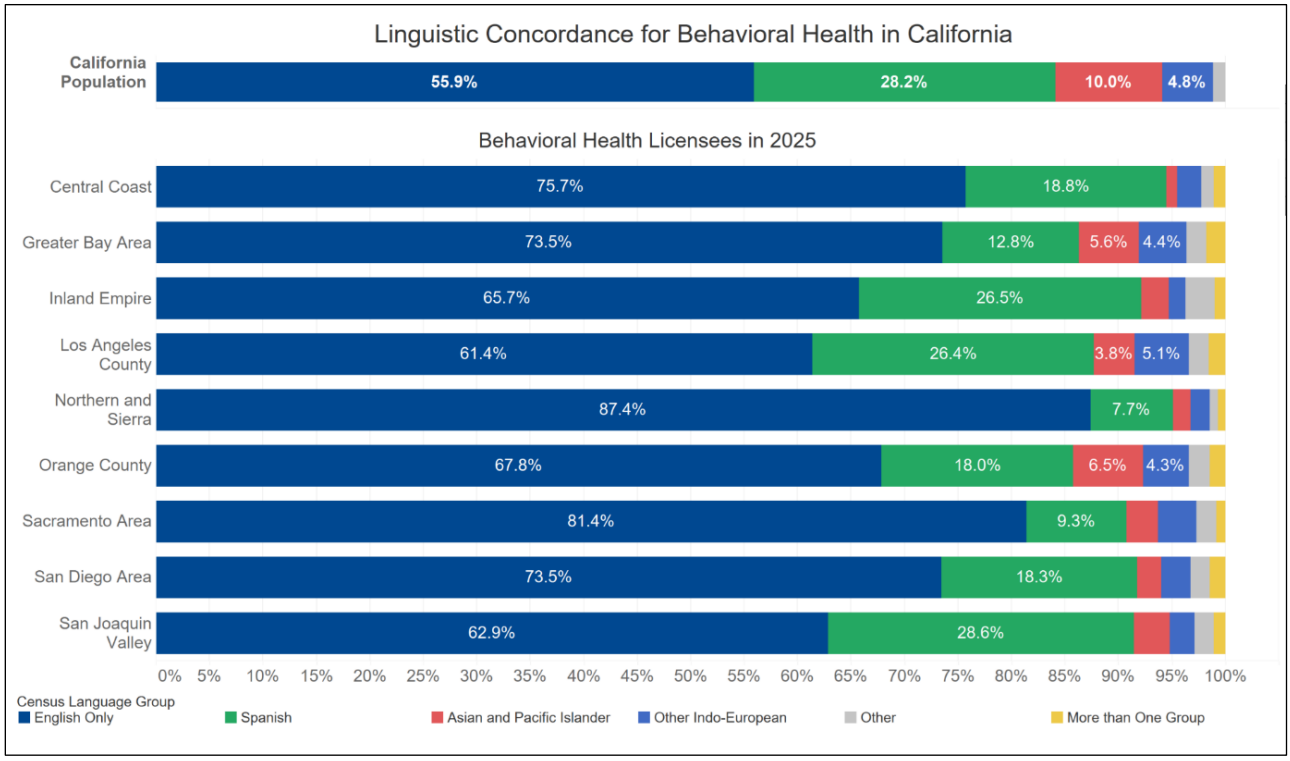
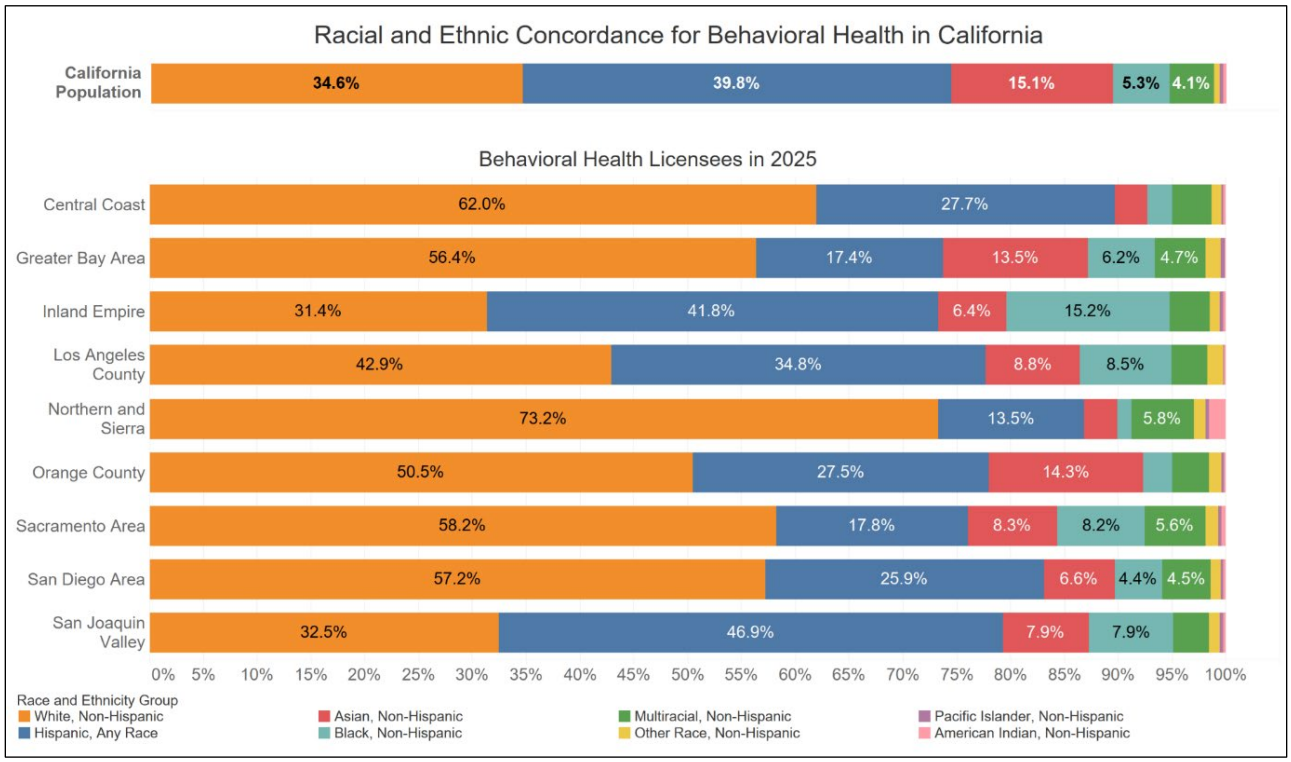


Figure 3. Racial and Ethnic Concordance for Behavioral Health in California



Gaps in the CBHS workforce

Statewide gaps in the behavioral health workforce mask setting or market-based gaps. Although ongoing data regarding the CBHS workforce are limited, one study[16] found that between 2019 and 2022, the number of professionals delivering Medi-Cal specialty mental health services declined by more than 3,000, with over one-third of the workforce leaving within one year and fewer than half remaining beyond three years. That same study found that rural counties were more likely to cite location as a major barrier to recruitment, and urban counties were more likely to report high cost of living as a significant obstacle to hiring. Retention challenges further strained the system, as county behavioral health agencies reported that mitigating high staff turnover required significant investment in training and supervision of less experienced staff, while also noting that many new graduates were not adequately prepared to provide specialty behavioral health services.

A separate 2023 assessment of the county behavioral health networks[17] identified significant workforce gaps across the system, including persistent shortages of core licensed clinicians, such as LCSWs, LMFTs, LPCCs, psychiatrists, registered nurses, and certified SUD counselors, with more than 70 percent of counties reporting difficulty filling these roles. Counties reported that—as is the case statewide—the behavioral health workforce also lacks sufficient racial, ethnic, and linguistic diversity, leaving many counties unable to meet the needs of Spanish-speaking patients and communities of color.

Specialized expertise is hard to find, including expertise related to treating people with co-occurring conditions and justice-involved populations, and counties struggled to staff high need programs like crisis services and Full-Service Partnerships. Retention challenges, including burnout, heavy documentation requirements, and more competitive compensation in other sectors, contribute to high turnover, while lengthy hiring processes and delays in licensure processing slow recruitment. These issues are compounded by a constrained education pipeline, with declining numbers of SUD counselors and MSW (Master of Social Work) graduates and an aging workforce in key professions.[18]

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[16] California Institute of Behavioral Health Solutions analysis of Network Adequacy Certification Tool data for 2019-2020, 2021-2022, and 2022-2023. Unpublished study.
[17] Coffman, J., & Fix, M. (2023, February). *Building the future behavioral health workforce: Needs assessment*.
Healthforce Center, University of California, San Francisco. Retrieved from https://healthforce.ucsf.edu/publications/building-future-behavioral-health-workforce-needs-assessment
[18] Coffman, J., & Fix, M. (2023, February). *Building the future behavioral health workforce: Needs assessment*.

California's Response: Behavioral Health Transformation

Behavioral Health Transformation is a central component of California's statewide effort to build a stronger, more equitable behavioral health system. Coordinating policy reform and substantial public investment to ensure individuals with the most significant needs receive timely, culturally responsive care, through cross-sector partnerships among counties, health plans, providers, community-based organizations, and people with lived experience.

A central pillar of Behavioral Health Transformation is Proposition 1, a two-part reform package approved by voters in March 2024 to modernize the behavioral health delivery system.

- The Behavioral Health Services Act (BHSA), formerly the Mental Health Services Act (MHSA), refocuses the state's behavioral health funding framework to prioritize individuals with the most significant needs while strengthening investments in treatment, housing, and workforce development. Notably, BHSA expands the scope of prior mental health investments to explicitly include SUD, enabling a more integrated, whole-person approach to workforce development, service delivery, and system planning across the Medi-Cal behavioral health continuum.
- The Behavioral Health Infrastructure Bond Act provides $4.4 billion to expand behavioral health treatment capacity through new and renovated facilities, supportive housing, and community-based settings, with targeted investments for priority populations. These funds are being administered through the Behavioral Health Continuum Infrastructure Program (BHCIP). In addition, $2 billion has been allocated to the Department of Housing and Community Development for supported housing.

Behavioral Health Services Act Priority Populations

BHSA directs resources toward individuals and communities with the highest need and greatest risk of adverse outcomes across the behavioral health continuum, with the goal of improving outcomes, closing equity gaps, and ensuring the most vulnerable Californians receive timely and effective support.[19]

HCAI will address BHSA priority populations across all workforce strategies and investments while also considering other important populations with specific behavioral needs as identified during stakeholder engagement, including LGBTQIA+ individuals, limited English proficient individuals, people of color, veterans, and older adults.

Priority populations under BHSA include:

[19] Welfare and Institutions Code Section 5892(d).

- Eligible adults and older adults who are:
  - Chronically homeless, experiencing homelessness, or are at risk of homelessness
  - In, or are at risk of being in, the justice system
  - Reentering the community from prison or jail
  - At risk of conservatorship[20]
  - At risk of institutionalization or conservatorship [21]
- Eligible children and youth who are:
  - Chronically homeless or experiencing homelessness or are at risk of homelessness
  - In, or at risk of juvenile justice system involvement
  - In the child welfare system[22]
  - At risk of institutionalization

Behavioral Health Transformation Related Initiatives

Behavioral Health Transformation aligns with, and is an integral component of, several major statewide initiatives that are driving policy changes and shifts in funding priorities to improve access, coordination, and quality of care. These include the following:

- California-Advancing and Innovating-Medi-Cal (CalAIM): Redesigns the Medi-Cal delivery system to create more coordinated, person-centered, and equitable care
- Children and Youth Behavioral Health Initiative (CYBHI): Enhances prevention, early intervention, and system coordination for children and youth
- Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT): Strengthens community-based capacity and expands access to evidence-based community services.
- Medi-Cal Mobile Crisis: Expands access and shortens response times to deliver care where it is needed most.
- Community Assistance, Recovery and Empowerment (CARE) Court: A court-based process that provides intervention for individuals experiencing severe impairment, to prevent avoidable hospitalizations, incarcerations, and Lanterman-Petris-Short Mental Health Conservatorship.
- 988 Suicide and Crisis Lifeline: Simplifies access to immediate behavioral health crisis support.

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[20] Welfare and Institutions Code Section 5350 et. seq.
[21] I.e., Welfare and Institutions Code Section 5150 and 5250.
[22] Welfare and Institutions Code Sections 300, 501, and 502.

- California Mental Health Parity Act: Requires all commercial health plans provide coverage for medically necessary treatment of mental health and substance use disorders (behavioral health) at the same cost as physical health conditions.
- Behavioral Health Continuum Infrastructure Program (BHCIP): Strengthens crisis response and treatment capacity across the continuum of care.

HCAI is collaborating with state partners across these initiatives. BHSA and BH-CONNECT work together to strengthen California's behavioral health workforce, building on investments in the workforce made through CYBHI. BH-CONNECT delivers a major one-time surge of funding to rapidly attract and retain professionals in Medi-Cal settings. BHSA provides the ongoing, flexible resources needed to fill gaps, expand pipeline and scholarship supports, and sustain or evolve successful BH-CONNECT strategies over time. More details about the related aspects of BH-CONNECT are described in the table below.

Together, these initiatives represent a comprehensive and coordinated strategy to transform California's behavioral health system by expanding infrastructure, strengthening community-based services, and investing in the workforce to create a more integrated, equitable, and accessible system of care.

Behavioral Health Community-Based Organized Networks of Equitable Care and Treatment (BH-CONNECT)

California's Medicaid Section 1115 Demonstration—BH-CONNECT—is a Medi-Cal initiative designed to strengthen the behavioral health delivery system by expanding community-based services and building the workforce needed to support them. By aligning workforce strategies with service expectations, the program aims to ensure Medi-Cal members and uninsured individuals receive timely, high-quality behavioral health care in community settings.

Within this framework, HCAI administers the BH-CONNECT workforce initiative—an opportunity to invest up to $1.9 billion through 2030—to expand and strengthen the behavioral health workforce through five programs. BH-CONNECT funds are intended to work alongside BHSA resources, which may be used to sustain successful efforts after BH-CONNECT concludes.

BH-CONNECT Programs

The Medi-Cal Behavioral Health Student Loan Repayment Program (MBH-SLRP) pays student debt for behavioral health professionals working in Medi-Cal safety net settings in exchange for the commitment to continue serving Medi-Cal members and uninsured individuals.

The Medi-Cal Behavioral Health Residency and Fellowship Training Program (MBH-RTP) funds increased positions in psychiatry residency and in fellowship programs in child and adolescent psychiatry, addiction psychiatry, and addiction medicine, in exchange for residents and fellows serving Medi-Cal members and uninsured individuals in safety net settings after having completed their residency and fellowship.

The Medi-Cal Behavioral Health Scholarship Program (MBH-SP) provides scholarships to support individuals pursuing behavioral health degrees or certifications in exchange for a service commitment in a setting that serves Medi-Cal members and uninsured individuals.

The Medi-Cal Behavioral Health Community-Based Provider Training Program (MBH-CBPTP) funds individuals to receive training to become AOD/SUD counselors, community health workers, and peer support specialists, with a commitment to later serve Medi-Cal members and uninsured individuals.

The Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP) supports hiring and retaining behavioral health providers serving Medi-Cal through bonuses, supervision, and licensure and training assistance, tied to service commitments in Medi-Cal settings.

BHSA Workforce Investment Allocation

The BHSA both expands funding for workforce development and provides an updated behavioral health funding framework. The BHSA establishes a dedicated and sustained investment in California's behavioral health workforce, allocating 3 percent of total

funding to workforce initiatives.[23] Statute requires HCAI to develop and implement a Five-Year BHSA Workforce Education and Training (WET) Plan as the primary vehicle for identifying workforce priorities and guiding investments.[24]

Per statute, the Plan must be informed by meaningful input from a broad range of partners, including behavioral health professionals, counties, education and training programs, community-based organizations, and individuals with lived experience. Statute also indicates that the plan must include:[25]

- **Workforce Development and Retention**: Supporting strategies to train, recruit, and retain county and county-contracted behavioral health professionals, with an emphasis on expanding access in underserved areas and strengthening workforce diversity.
- **Technical Assistance and System Support**: Provision of technical assistance to county-contracted providers to improve workforce stabilization and retention.
- **Peer Workforce Expansion**: Strategies to support counties and providers in maximizing the use of peer support specialists as part of the behavioral health workforce.

HCAI's Previous Workforce Education and Training Plans

As part of its mission to expand access to quality, equitable, and affordable health care for all Californians, HCAI has a longstanding role in supporting Workforce Education and Training (WET) initiatives, starting with the Mental Health Services Act (MHSA) WET Plan in 2015–2020.

The subsequent 2020–2025 WET Plan was shaped by extensive community and stakeholder engagement and developed in accordance with statutory requirements (California Welfare and Institutions Code §§ 5820–5822). The 2020-2025 MHSA WET Plan secured a total of $70 million in funding over five years[26] and outlined a vision for a culturally responsive, recovery-oriented behavioral health system serving individuals across the lifespan—from infants and children to transition-aged youth, adults, and older adults. It prioritized diversity, particularly increasing culturally and linguistically diverse professionals and those with lived experience. See Appendix III for further description of previously funded programs.

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[23] Welfare and Institutions Code Section 5892 (f)(1)(D)(i)
[24] Welfare and Institutions Code Sections 5820 and 5822.
[25] Welfare and Institutions Code Sections 5892 (f)(1)(D)(ii)
[26] This includes an original allocation of $60 million for the WET Plan, plus an annual allocation of $2 million from the Mental Health Services Fund for HCAI's Peer Personnel Training and Placement Program.

2026-2030 BHSA WET Plan Development

Community and Stakeholder Engagement: Key Insights, Findings

BHSA statute requires HCAI to develop the BHSA WET Plan in consultation with numerous stakeholders, including behavioral health consumer advocates, behavioral health professionals, behavioral health education and training programs, county, and county-contracted organizations.[27] In addition to acting in accordance with statute, HCAI is also committed to embedding equity and accountability across all workforce initiatives.

The BHSA WET Plan stakeholder engagement process was conducted in three phases, beginning with statewide community convenings, progressing to targeted deep dive discussions with subject matter experts, and ending with public meetings and a public comment period. During each phase, participants were invited to share insight into community workforce needs within the CBHS and ensure alignment with proposed funding priorities outlined in the BHSA WET Plan.

Phase One

Between July and August 2025, HCAI held 21 convenings with nearly 300 participants. Participants were invited to provide input on fifteen key workforce related themes, including education and training, significant behavioral health conditions, innovation, recruitment and retention, diversity and equity, workplace wellbeing, consumer perspectives, work-based learning, and technology and telehealth. Participants included representatives from counties, universities, community-based organizations, professional organizations, and state agencies, as well as key populations, including CBHS service users, older adults, veterans, and LGBTQIA+ individuals. The feedback from these sessions informed the preliminary development of HCAI's proposed investment objectives.

Across all fifteen topics, communities consistently describe a behavioral health workforce that is underprepared, under-resourced, and constrained by structural barriers. Key challenges included inadequate education and training, professionals not equipped for real world complexity (e.g., co-occurring conditions, psychiatric rehabilitation), and gaps in culturally responsive practice. Additional concerns included limited or inconsistent supervision structures, unclear career pathways, and a lack of cross training that further limit workforce readiness.

[27] Welfare and Institutions Code Section 5892(d)(D).

Participants also described severe recruitment and retention challenges, driven in part by low wages, high living costs, limited advancement opportunities, and heavy caseloads, barriers that are even more pronounced in rural and underserved regions. Additional structural inequities (e.g., high educational costs, limited paid training opportunities) disproportionately affect students of color, low-income individuals, rural residents, LGBTQIA+ individuals, and justice impacted youth. Overall, the challenges shared reflect a workforce stretched thin, insufficiently supported, and misaligned with today's behavioral health needs.

Participants collectively called for sustained investments in workforce development, including expanded education, graduate-level clinical training, high-quality supervision, and stronger cross-training in co-occurring mental health and SUD conditions. They emphasized that the workforce must also be equipped with the specific skills needed to effectively serve individuals with significant behavioral health conditions.

Additional recommendations included flexible, stackable training pathways; and paid internships, apprenticeships, mentoring, and earn-and-learn models. Participants also highlighted the importance of improving recruitment and retention through financial support (e.g., loan repayment, stipends, bonuses) paired with clearer career mobility and leadership development. There was broad agreement on the need for culturally responsive, trauma-informed, equity-centered training and supervision, along with targeted efforts to diversify the workforce. This feedback informed the preliminary development of HCAI's proposed investment objectives, which were further refined during phase two.

Phase Two

Between January and April 2026, HCAI conducted phase two of its engagement process, holding more than 30 virtual meetings with over 60 subject matter experts. During these convenings, participants provided direct feedback on preliminary investment objectives and proposed programming, focusing on feasibility, effectiveness, and alignment with community and county needs.

The table below outlines the number of organizations, by organization type, who participated in phase two.

Phase Two: Summary of Stakeholder Engagement	
Type of Organization	**Number of Organizations**
Provider Associations	5
California State Departments	9
Community-Based Organizations	3
County Partners	6
Education and Training Partners	5
Education and Training Consultation	2
Health Plans	1
Organized Labor	1
Public Policy and Advocacy	1
Total Number of Organizations	**33**

Phase two feedback underscored the need to expand the behavioral health workforce, better align training to population needs, differentiate strategies for licensed vs. non-licensed workforce, strengthen supervision capacity, and address recruitment and retention challenges (compensation, administrative burden, burnout) in the CBHS.

Phase Three

Between April and June 2026, HCAI will complete phase three of its stakeholder engagement process by presenting at four public meetings followed by publishing the draft BHSA WET Plan online for a public comment period. HCAI presented an in-depth overview of the proposed workforce strategies and investments at the following public meetings in April 2026: The California Health & Human Services Agency Behavioral Health Task Force, California Behavioral Health Planning Council (CBHPC), and CBHPC Workforce Education Committee. In addition to public meetings, HCAI also presented this plan at several other stakeholder convenings. During these meetings, HCAI received both written and verbal feedback from members of the council and/or committee as well as members of the public.

Once the public comment period is complete, we will summarize the findings in the table below.

Phase Three: Summary of Stakeholder Engagement	
Written and verbal feedback was received during phase three.	
Organization or Individual Type	**Number of Comments Received**
Consumer/Family Member	
Provider Association	
Total Number of Comments/Feedback	

Phase three feedback will inform the final refinements to the BHSA WET Plan. BHSA WET Plan Objectives and Strategies

Key Outcomes

The BHSA identifies 14 statewide goals[28]:

HCAI envisions that its BHSA investments will contribute most directly to improvements in the care experience and access to care by supporting the expansion and development of the workforce. Specifically, the BHSA WET Plan targets three primary outcomes:

1. A sufficient supply of behavioral health professionals within the CBHS, particularly in geographies and communities with the greatest need.
2. A workforce that has the skills required to serve individuals with significant behavioral health conditions, including complex co-occurring needs.
3. A workforce that is diverse and reflects the lived experiences, cultural backgrounds, and languages of the communities served.

These outcomes were identified based on thematic analysis of phase one stakeholder feedback and subsequently refined and validated during phase two engagements.

Design Principles

HCAI developed and shared the following principles to guide BHSA investment development:

1. **Evidence-backed**
   Grounding workforce investments in evidence ensures BHSA resources are directed toward strategies proven to improve behavioral health outcomes and workforce capacity. This includes a commitment to using evidence to target and prioritize gaps, and to leveraging efforts that have been demonstrated to be successful.
2. **Community-informed**
   Community-informed strategies are developed as a result of significant engagement and iteration with the broad community of stakeholders connected to BHSA, including people with lived experience, behavioral health professionals, and advocates. Aligning investments with community input supports services that are culturally relevant and responsive.

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[28] These efforts will contribute to the 14 statewide BHSA goals: **improve** care experience, access to care, prevention and treatment of co-occurring physical health conditions, quality of life, social connection, engagement in school, and engagement in work; and **reduce** suicides, overdoses, untreated behavioral health conditions, institutionalization, homelessness, justice-involvement, and removal of children from home.

3. **Experience-based**
   Experience-based strategies will prioritize lessons learned from programs that HCAI or its partners have previously funded, developed, and/or implemented.
4. **Co-designed where appropriate**
   Co-designing strategies with stakeholders fosters shared ownership and more tailored solutions and improves program feasibility, relevance and long-term sustainability. HCAI proposes several specific co-design exercises in the BHSA WET Plan.
5. **Aligned with and complementary to other investments**
   All workforce strategies and investments are intended to be in alignment with and complementary to other behavioral health and workforce programs, including BH-CONNECT programs and the Behavioral Health Continuum Infrastructure Program. See chart below.

Figure 4. Chart of Behavioral Health Workforce and Funding Streams by Program Area

Workforce Development Strategy	BH-CONNECT	BHSA WET Plan
Pipeline development and career pathways	Not funded	Funded; up to ~$75M
Scholarship	For licensed and non-licensed professionals in exchange for a service obligation in a Medi-Cal setting; up to ~$200M	For licensed prescriber and licensed non-prescriber professionals, bundled with clinical placement support and post-grad stipend, in exchange for a service obligation in the County Behavioral Health System; ~$130M
Education capacity expansion	For psychiatry residency and select fellowships *only*; up to ~$70M	For multiple licensed prescriber and licensed non-prescriber programs, conditioned on implementation of curriculum aligned to the County Behavioral Health System; ~$50M
Loan repayment	Funded; up to ~$450M	Not funded
Recruitment and retention	Funded; up to ~$820M	Not funded

Core Workforce Strategy | Expanded Scope | Limited Scope | Not Funded

*BHSA Recruitment and Retention will not duplicate BH-CONNECT Recruitment and Retention.

These design principles ensure that the workforce strategies and investments are thoughtfully designed, take into consideration stakeholder feedback, and do not duplicate or contradict efforts from other stakeholders and agencies.

BHSA WET Plan Investment Objectives

Extensive community and stakeholder engagement reinforced the need for strategies to build, support and maintain a robust behavioral health workforce in the CBHS In response, HCAI has identified five workforce investment objectives, each designed to strengthen the CBHS workforce and improve services for individuals with significant behavioral health needs:

- Objective 1: Expand existing workforce skills
- Objective 2: Educate and train future licensed professionals
- Objective 3: Scale and optimize deployment of non-licensed workforce
- Objective 4: Enhance career pathways and advancement
- Objective 5: Recruit and retain workforce

Each objective has its own series of tailored investments and programs to ensure that HCAI can achieve the goals of each objective.

Equity as a Cross-Cutting Objective

HCAI values an equitable approach to strengthening California's behavioral health workforce. As BHSA-funded investment strategies and programs are being implemented, equity will be embedded across all objectives. HCAI's approach prioritizes developing and supporting a diverse workforce and prioritizing funds for historically underserved communities and geographic regions. Establishing a diverse and reflective workforce has been shown to lead to improved health outcomes[29] and expanding the number of providers who speak a non-English language is critical to serving Limited English Proficient health consumers. Detailed descriptions on how equity will be considered and embedded can be found under the equity section of each objective.

HCAI also recognizes that changes in federal policy can impact efforts to build an equitable workforce. For example, recent revisions to graduate loan eligibility at the federal level may limit access to higher education, creating additional barriers for underrepresented and underserved communities pursuing behavioral health careers. To counter these effects, HCAI is proposing workforce strategies and investments that continue to provide scholarships, stipends, loan repayment programs, and comprehensive wraparound supports.

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[29] Kottek, A., Rogers, T., Coffman, J., & Mertz, E. (2025, July). *Diversity Matters: Evidence to Diversify California's Health Care Workforce* [Issue brief]. Healthforce Center at UCSF. https://healthforce.ucsf.edu/document/policy-issue-briefdiversitypdf

Objective 1: Expand Existing Workforce Skills

Problem Statement

The current behavioral health workforce within the CBHS, including county behavioral health agencies, facilities, and its contracted providers, may not have sufficient training and support to meet the demands of an evolving public behavioral health landscape in serving individuals with significant behavioral health conditions. Individuals with significant behavioral health conditions also receive health care in other settings—such as hospital emergency departments, carceral settings, and federally qualified health centers (FQHCs)—where providers may lack training in mental health and SUD.

As service models, client needs, and policy requirements continue to evolve in the CBHS, and as individuals with significant behavioral health conditions engage with other service settings, community stakeholders report that the existing workforce may not have sufficient training to meet the demands of serving individuals with complex and co-occurring behavioral health needs. This lack of adequate training affects workforce readiness across roles and disciplines and limits the system's ability to consistently deliver high-quality, equitable care to individuals with significant behavioral health conditions and to the statutorily identified priority populations targeted by the BHSA.

Detailed Objective

First, HCAI seeks to expand on-the-job training opportunities for recently graduated and existing behavioral health workforce in the CBHS, to enable professionals at all levels to develop the knowledge and skills necessary to serve individuals with significant behavioral health conditions more effectively. Second, HCAI seeks to fund training for primary care and emergency services professionals who interact frequently with individuals with significant behavioral health conditions to be able to appropriately care for and manage the behavioral health needs of these individuals. Across both priorities, HCAI aims to build durable, scalable training infrastructure by funding training models that can be reused, adapted, and expanded over time as licensed and non-licensed workforce needs evolve and new service and policy demands emerge. This approach supports the CBHS workforce and the workforce supporting individuals with significant behavioral health conditions in being responsive to changing conditions while building long-term system capacity.

Investment Strategies and Programs

A central focus of this approach is defining shared core competencies specifically related to serving individuals with significant behavioral health conditions and working within the CBHS. These competencies apply across the CBHS workforce, including licensed prescribers (e.g., psychiatrists), licensed non-prescribers (e.g., Licensed

Clinical Social Workers), and non-licensed professionals (e.g., peer support specialists), as well as to professionals that routinely provide care to individuals with significant behavioral health conditions, such as in hospital emergency departments and carceral settings. Establishing a shared set of relevant core competencies that, regardless of role or discipline, all workforce members possess the foundational knowledge and skills necessary to effectively serve individuals with significant behavioral health needs and BHSA priority populations. An example of this includes the growing number of individuals who have both intellectual or developmental disabilities, such as autism spectrum disorder, and co-occurring serious emotional disturbance or serious mental illness, such as major depressive disorder.

HCAI will first identify—and define, where necessary—these core competencies through a systematic, stakeholder-informed process. Once the core competencies are defined, HCAI will conduct a statewide skills gap analysis by role and setting to identify where the most significant needs for skills development exist within the workforce.

To achieve this objective, HCAI is proposing a phased approach that builds intentionally from pre-existing workforce assessments to avoid unnecessary duplication or over-assessment, while strategically informing future training investments. This approach prioritizes making use of existing data, tools, and findings wherever possible, and filling gaps only where needed. For example, HCAI may leverage existing competencies that have been defined such as core competencies for peer support specialists established by the Substance Abuse and Mental Health Services Administration (SAMHSA).[30]

Once the core competencies have been defined and a gap analysis performed, HCAI will then map existing state level training programs and platforms to identify opportunities to leverage existing assets, avoid duplication, and support the development of a cohesive and sustainable training infrastructure. This analysis will allow HCAI to target investments toward skills that are both most needed and most impactful across the CBHS.

Building on the results of the skills gap analysis and locally identified training needs, HCAI will then fund the development of prioritized, work-based training and continuous professional development modules aligned with the defined core competencies. Training content will be designed specifically to address identified gaps by competency, role and setting. These training assets are intended for broad deployment across the CBHS, supporting skill development at scale.

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[30] Core Competencies for Peer Workers: Behavioral Health | SAMHSA

Finally, HCAI will explore and establish mechanisms to support the delivery of these trainings to county and county-contracted agencies. Where feasible, HCAI seeks to align training delivery with continuing education units or formal continuing professional development requirements to reinforce sustainability and ongoing workforce engagement. Collectively, these investments are intended not only to address immediate skills gaps, but to establish long-term, adaptable training models capable of responding to emerging needs.

In addition, HCAI will fund trainings designed to enhance the skills of existing primary care and emergency services providers who interact frequently with individuals who have significant behavioral health conditions. Scholarships for behavioral health training will be offered to primary care and emergency services health professionals who serve individuals with significant behavioral health conditions and work in settings where these individuals receive care and cross-referrals to the CBHS.

Equity

Objective 1 centers equity by providing training on how to effectively meet the needs of people with significant behavioral health conditions–an underserved group–and how to do so with cultural humility. Moreover, HCAI's equity approach for this objective includes developing and scaling training programs that meet diverse learning needs (such as in person and virtual formats), offering accessible and ADA compliant content, and offering training materials in languages that reflect the communities being served, such as Spanish. HCAI will continue to engage trusted community organizations and incorporate co-design practices whenever possible to ensure solutions reflect the lived experiences of the communities served.

Objective 2: Educate and Train Future Licensed Professionals

Problem Statement

California faces critical shortages of adequately trained licensed behavioral health professionals, with the most severe gaps concentrated in the Northern & Sierra, Inland Empire, and San Joaquin Valley regions. Based on HCAI's supply and demand modeling, the greatest gaps by volume for licensed behavioral health professionals are with psychiatrists and non-prescribing licensed clinicians like social workers. Shortages are reported to be more severe in the CBHS and constrain the system's ability to meet growing service demands and to effectively serve individuals with significant behavioral health conditions, including BHSA priority populations. As much-needed investments in behavioral health infrastructure are made through BHCIP, demand for licensed professionals may increase.

In addition, some stakeholders note that even as the number of individuals experiencing a substance use disorder (SUD) continues to rise, there is currently no licensed-level professional role focused primarily on SUD care, contributing to observed gaps in specialized clinical expertise, supervision capacity, and clearly defined career pathways for the SUD workforce.

Several systemic factors contribute to these workforce challenges. Limited academic training capacity as well as economic barriers (e.g., the cost of graduate programs) constrain the number of new clinicians entering the workforce, while existing academic and clinical training programs often do not adequately prepare graduates for practice in county behavioral health settings. Clinical supervision and placement barriers further exacerbate this issue, as shortages of qualified supervisors in the CBHS specifically restrict access to required field placements and post-graduate supervision hours. Because clinical training experiences strongly influence where graduates ultimately practice, limited exposure to CBHS settings steers many new clinicians toward private or non-public employment, reducing the pipeline into county systems.

Detailed Objective

To address these challenges, HCAI's objective is to expand affordable, academic-based education and clinical training opportunities that prepare future licensed behavioral health professionals to serve effectively within the CBHS This will be done in five ways:

- Scale education to attend to known workforce gaps, by role and geography; this includes efforts to align with training output and workforce supply with staffing demand created by BHCIP facilities
- Incentivize curricula modifications to education and training so that future professionals are better prepared and motivated to work in the CBHS
- Provide financial support to students in exchange for service commitments
- Expand placement opportunities in the CBHS that can offer clinical supervision to graduates while they are fulfilling their service obligations
- Explore strategies for establishing a licensed-level SUD professional qualified to lead SUD care teams and direct the provision of SUD services

This objective focuses not only on increasing the overall number of licensed clinicians, but on ensuring that new graduates are well trained, well supported, and motivated to work in county behavioral health settings. Together, these strategies are intended to strengthen the licensed workforce pipeline and improve access to care for Californians with complex behavioral health needs.

Investment Strategies and Programs

HCAI's approach is intentionally multidimensional and targeted. The goal is not only to increase the number of licensed professionals, but to ensure that new graduates are prepared for and willing to work in CBHS settings. To support this outcome, HCAI will first invest in strengthening the infrastructure that underpins licensed workforce development. Building on core competencies and skills gap analyses developed for the existing workforce under Objective 1, HCAI will conduct curriculum gap analyses across licensed-level degree programs in all relevant disciplines, building on existing analyses where available. These analyses will identify where current curricula fall short in preparing students for CBHS practice. Using these findings, HCAI will partner with education institutions and representatives of the CBHS to support the development of evidence-based, CBHS-focused academic curricula tailored by discipline and aligned with the needs of individuals with significant behavioral health conditions and BHSA priority populations.

Clinical placement and supervision represent a central challenge in expanding the licensed workforce. Counties and their contracted providers often lack the supervisory capacity to support associate-level clinicians who must complete thousands of postgraduate supervision hours to achieve licensure. Because clinicians frequently practice in the settings where they complete their field placements, rotations, or residencies, limited access to placements in CBHS settings significantly reduces long-term workforce supply. To address this barrier, HCAI will explore creative and scalable supervision solutions, including virtual supervision models and incentives to encourage experienced clinicians to become supervisors within the CBHS. HCAI will finance supervision in county and county-contracted settings and offer financial assistance to graduates during clinical training. Counties and their contracted providers. In addition, HCAI will invest in the development of an integrated clinical supervision and placement tool or platform to help associate-level clinicians secure placements in county and county-contracted settings and receive appropriate supervision.

Beyond these foundational investments, HCAI will design and implement multiple funding mechanisms to directly expand education capacity and support trainees. This includes a bundled approach that combines institutional funding, student financial support, and supervision assistance. Educational institutions will receive grants to expand training capacity, conditioned on the requirement that they offer curricula that explicitly prepare students for CBHS practice. These educational opportunities will include support for placement and training capacity in contract organizations.

All students participating in these programs will be eligible to receive annual scholarships, and wraparound support, including exam preparation and licensure costs.

In exchange, students commit to serve in the CBHS, with clinical supervision and placement support provided during their service obligation.

This includes helping students secure placements in CBHS through the newly developed placement platform. To support the expansion of available sites, HCAI will finance supervision in county and county-contracted settings and offer financial assistance to graduates during clinical training.

The programs supporting this objective include the Psychiatric Education Capacity Expansion Program for prescribing clinicians (psychiatrists and psychiatric mental health nurse practitioners) and the Graduate Education Capacity Expansion Program for licensed non-prescribing professionals. To ensure continuity of education capacity expansion for a portion of this workforce, bridge funding will be provided to continue the Social Work Education Capacity Expansion Program for increasing MSW enrollment, paired with the Public Behavioral Health Training (PBHT) Program, which provides these MSW students with stipends of up to $25,000 in exchange for service in the CBHS. The importance of the PBHT Program is the requirement of these students to participate in specialized curriculum preparing them to work in the CBHS.

Finally, HCAI will fund a focused study to explore options for establishing licensed level SUD expertise. While many licensed clinicians receive some training in substance use treatment, there is no designated licensed profession focused primarily on SUD care. This absence creates challenges for supervision quality and effective team-based care; limits specialized expertise and restricts career advancement pathways for SUD counselors. Through this exploratory effort, HCAI will assess potential models for a licensed-level SUD specialization that could strengthen care quality and create clear progression pathways within the behavioral health workforce.

Equity

To advance equity across the workforce, HCAI will address geographic inequities in access to care and training by aiming to award dollars in areas of greatest shortages, supporting historically underserved communities. Academic and clinical training pathways will be designed and implemented in partnership with communities and HCAI will expect that trauma-informed and culturally responsive approaches be embedded into curriculum development.

Additionally, by taking a bundled, holistic approach rather than relying on standalone interventions, HCAI aims to provide financial support throughout the full workforce development journey, including tuition assistance, wraparound support, and support during clinical training. This approach is intentionally designed to promote equitable opportunities and contribute to a more diverse behavioral health workforce by addressing the full range of barriers faced by underrepresented, rural, and low-income

students across California. By expanding supervised clinical training opportunities in high-need areas, partnering with trusted educational and community institutions, and embedding equity criteria into funding decisions, HCAI supports students not only in entering the pathway, but in progressing through training and into the workforce.

Objective 3: Scale and Optimize Deployment of Non-Licensed Workforce

Problem Statement

The CBHS relies heavily on a large non-licensed and certified workforce, including SUD counselors, peer support specialists and related roles, to deliver a substantial share of behavioral health services. These professionals play a critical role in providing accessible, community-based care and supporting individuals with complex and co-occurring behavioral health needs. There is significant opportunity to further strengthen and scale this workforce to improve service quality, expand access, and support delivery across the full behavioral health continuum.

At the same time, persistent challenges limit the effectiveness and sustainability of the non-licensed workforce. These include gaps in overall workforce availability, uneven geographic distribution, variability in readiness and performance upon entry into practice, and inconsistent or ineffective deployment within care teams. These challenges stem from a combination of factors across the workforce ecosystem, including limited career pathways, uneven training capacity and content, certification and supervision barriers, high attrition rates, and payer and employer incentives and billing constraints.

On the employer side, many counties and county-contracted organizations report uncertainty around appropriate role definition, supervision expectations, documentation, billing, and how to fully integrate non-licensed professionals into team based and Medi-Cal funded care models. As a result, limited uptake of these roles persists even where workforce supply exists, and some stakeholders—including organizations training peer support specialists—indicate that the peer support specialist workforce supply may exceed jobs available.

Detailed Objective

Addressing these workforce gaps requires a comprehensive, ecosystem-based approach that goes beyond increasing supply alone. To fill these gaps, HCAI aims to strengthen the non-licensed workforce by providing education training, job placement, and transition-to practice support, while also offering targeted technical assistance to employers to improve workforce integration and deployment. Specifically, HCAI will scale training for SUD counselors and peer support specialists to close workforce gaps

by geography and profession, aligning with BH-CONNECT evidence-based practice expansion and BHCIP investments to support recently certified professionals as they enter practice. HCAI will also provide technical assistance aimed at enabling counties and county-contracted organizations to more effectively integrate non-licensed professionals to enhance care delivery teams, including care for those with co-occurring conditions.

Investment Strategies and Programs

To fulfill this objective, HCAI proposes a coordinated set of programs designed to both expand the non-licensed workforce and strengthen the infrastructure needed to ensure that these professionals are properly placed, supported, and retained within the CBHS. These strategies intentionally address both supply and demand side barriers and are designed to align training pipelines with local workforce needs.

HCAI will scale training for SUD counselors and peer support specialists to address workforce gaps by region and profession. The proposed approach builds upon successful elements of HCAI's existing Peer Personnel Training Program and Placement Program emphasizes integrated training models that combine instruction, certification support, and job placement. HCAI will fund training organizations with the expectation that they will provide culturally and linguistically appropriate training at no cost to participants, support certification and certification fees, and assist with job placement. By linking training directly to employment opportunities, this model is intended to strengthen workforce entry and reduce attrition between training and practice. HCAI aims to fund training scale-up in areas with noted workforce gaps in these specific roles, including communities where new infrastructure funded through BHCIP programs will create additional workforce demand.

HCAI also intends to fund programs designed to address variability in readiness and performance among newly trained workers and to improve early career retention. Transition to practice supports for non-licensed behavioral health professionals may focus on skill development, mentorship, and practical integration into care teams during initial employment. As these programs are implemented, HCAI will refine models based on participant and employer feedback, including addressing specialty needs for peer support specialists and SUD counselors and evaluating opportunities to strengthen preparation for roles serving individuals with complex and co-occurring needs.

To maximize the impact of non-licensed professionals, HCAI proposes funding a jointly designed technical assistance package for counties and county-contracted organizations to address demand-side challenges such as unclear role definitions, limited supervision capacity, and reimbursement or regulatory barriers that constrain effective deployment of the non-licensed workforce. To develop the specifics of the

technical assistance mechanism and scope, HCAI will fund a co-design process that will empower both county and county-contracted providers to define their technical assistance needs. That said, through consultation, some potential domains for the technical assistance package have emerged, such as clarifying and standardizing non-licensed roles within care teams; supporting partnerships between counties, employers, and local training institutions to create placement opportunities; defining appropriate scopes of supervision. HCAI will also coordinate closely with the Department of Health Care Services (DHCS) to ensure alignment and avoid duplication with existing DHCS technical assistance efforts, particularly those related to billing and program compliance.

Equity

These strategies are grounded in a commitment to advancing equity within both the behavioral health workforce and the systems that support it. HCAI's approach prioritizes reducing barriers to entry through no-cost, culturally and linguistically responsive training, expanding access for individuals from underserved communities to enter, scaling training in the areas where it is needed the most, and advancing within the workforce.

Across these investments, equity is further strengthened by incentivizing training organizations to provide comprehensive support, including certification assistance and job placement, helping to reduce drop-off between training and employment. Community feedback also highlighted challenges in transitioning from registered to certified roles; in response, transition-to-practice programs are designed to provide structured support, mentorship, and early career stabilization for new professionals.

HCAI recognizes that advancing equity requires intentional investment in the people who deliver services, and as part of the proposed technical assistance package, HCAI is committed to supporting county and county-contracted providers in developing reflective, culturally competent workforces that are better equipped to meet the diverse needs of the communities they serve.

Objective 4: Enhance Career Pathways and Advancement

Problem Statement

For young people and prospective workers, behavioral health careers are often poorly understood or perceived as inaccessible, reducing early interest and entry into the field. Persistent stigma further discourages many from considering these careers or openly pursuing related training opportunities. For those already within the behavioral health workforce, career progression opportunities may be limited or unclear, which can contribute to stagnation, burnout, and attrition. Together, these challenges weaken

workforce stability and limit the system's ability to recruit, retain, and advance a diverse workforce that reflects the communities served.

Detailed Objective

To address these two issues, HCAI seeks to develop and implement early pathway programs and standardized career pathways within the CBHS that increase awareness of behavioral health professions, support upward mobility, and promote a diverse and sustainable workforce. This objective is designed to strengthen the workforce pathway/pipeline at multiple entry points while also filling gaps in career advancement structures for existing workers. By also clarifying career ladders, supporting transitions across roles, and creating visible and attainable advancement opportunities, HCAI aims to both diversify the workforce and improve long-term retention, supporting individuals to enter, grow, and remain in behavioral health careers. Development of career ladders is especially important for non-licensed professionals.

Investment Strategies and Programs

To advance this objective, HCAI will pursue a set of complementary investments focused on increasing awareness, strengthening career progression pathways, and supporting workforce diversification at all stages of the career continuum. This work begins with expanding early exposure to behavioral health careers among youth and young adults, particularly those in underserved communities.

HCAI will design early pathway programs, including K-12 and college-level initiatives, informed by findings from an ongoing assessment. This study combines formative evaluation of HCAI's previous pathway programs with a national review to identify attributes of successful behavioral health pathway programs. Findings are expected in 2026 and will inform the design and implementation of early pathway programs and help identify effective strategies for engaging diverse participants. During design and implementation, HCAI will also consider linkages to existing programs with potential candidate pools, such as CalWORKs and Career Technical Education programs, to broaden outreach and recruitment and contribute to overall workforce development and economic opportunity in California.

To address career progression, HCAI—in partnership with education and training partners—will fund analyses of behavioral health career pathways and support the collaborative design of career advancement solutions that promote workforce retention and mobility. These efforts may include the development of stackable credentials (education or training designed to build on previous experience, to support progression along a career pathway), bridging programs, or certificate pathways that enable workers to progress across roles and educational levels without unnecessary barriers. This approach is particularly important for recruiting and advancing individuals from

underserved communities into the behavioral health workforce, many of whom begin their careers in entry-level, non-licensed positions and may benefit from clearly defined, supported pathways to advancement.

The intent is to align these advancement models with training and educational opportunities offered through community colleges and universities, and to encourage adoption by both higher education institutions and employers. An example includes structuring continuing education units earned through workforce training to convert into academic credit, thereby supporting formal degree completion and advancement.

Equity

HCAI will pursue strategies that promote workforce diversification across all points of the behavioral health career pathway by aligning early exposure programs with clear career ladders and advancement opportunities to strengthen entry, retention, and progression in a coordinated way. HCAI aims to address longstanding financial, structural, and informational barriers that contribute to limited training and career opportunities for marginalized communities by supporting no cost, culturally responsive early pathway programs in underserved communities and expanded opportunities for youth, young adults, and current workers.

By increasing exposure at an early age and connecting students to accessible entry points, these investments are designed to build interest early and expand who sees behavioral health as a viable and attainable career path. Additionally, by prioritizing investments in diverse and underserved areas, increasing early exposure, and developing stackable credentials and accessible training, this approach is designed to reduce barriers, broaden participation, and build a more equitable, supportive behavioral health workforce ecosystem.

Objective 5: Recruit and Retain Workforce

Problem Statement

The CBHS continues to experience significant challenges in recruiting and retaining behavioral health professionals. Persistent vacancies and high turnover rates affect both licensed and non-licensed roles, undermining service continuity and placing additional strain on remaining staff. These conditions also weaken the return on earlier workforce investments, as gains achieved through education, training, and pathway programs are diminished when workers leave the system shortly after entry.

Stakeholders consistently report that these recruitment and retention challenges are driven not only by workforce shortages, but also by structural and financial factors within the CBHS, including workload pressures, supervision constraints, compensation

disparities, limited workplace support, as well as workplace burnout and moral injury that is often experienced when serving individuals with significant behavioral health conditions. As a result, even well-prepared clinicians and practitioners may opt to leave county or county-contracted settings for alternative employment, compromising long-term workforce stability.

Detailed Objective

To address these systemic challenges, HCAI's objective is to stabilize and strengthen the behavioral health workforce by supporting recruitment and retention within county and county-contracted organizations, while also addressing market inequities that contribute to workforce shortages in public behavioral health settings. This objective recognizes that workforce sustainability requires more than training alone and that targeted structural supports are necessary to ensure behavioral health professionals are able to work and remain in the settings that serve individuals with significant behavioral health needs. By reinforcing recruitment and retention strategies, HCAI aims to protect existing workforce investments, strengthen continuity of care, and support a stable, experienced workforce appropriately distributed across systems that treat high-need and priority populations.

Investment Strategies and Programs

HCAI's approach to meeting this objective is informed by, and closely coordinated with, significant workforce investments already underway outside of the BHSA WET Plan. Most notably, HCAI is implementing the BH-CONNECT Workforce Initiative, which includes the Medi-Cal Behavioral Health Recruitment and Retention Program (MBH-RRP). Through MBH-RRP, HCAI will invest up to $821 million to support recruitment and retention in Medi-Cal safety net settings by funding hiring bonuses, retention bonuses, clinical supervision support, and other workforce incentives. The first funding cycle for MBH-RRP is expected to launch in June 2026.

Rather than duplicating these efforts, HCAI intends for BHSA WET investments to be strategically informed by the outcomes of the BH-CONNECT initiative. Over the course of the BH-CONNECT Workforce Initiative, through 2030, HCAI will conduct ongoing evaluation to assess the effectiveness of MBH-RRP in improving recruitment, retention, and workforce stability. These evaluations will generate important insights into which strategies are most effective, for which roles and regions, and under what conditions.

Based on evaluation findings, HCAI will assess whether and how BHSA WET funds should be used to complement, enhance, or sustain successful recruitment and retention strategies initiated under BH-CONNECT. This approach allows HCAI to remain flexible and data-driven, ensuring that BHSA resources are deployed where they can

add the most value and support long-term workforce stabilization. By aligning BHSA WET investments with demonstrated recruitment and retention strategies, HCAI aims to strengthen the CBHS workforce in a coordinated, efficient, and evidence informed manner that supports both immediate workforce needs and long-term system sustainability.

Equity

Through a coordinated, data-driven approach, HCAI will assess how recruitment and retention investments are distributed across regions, roles, and populations, ensuring resources are directed to communities with the greatest need. By aligning BHSA WET investments with evidence-based strategies and strengthening workforce conditions in county and county-contracted settings, HCAI aims to support a diverse, community-rooted workforce and improve continuity and quality of care for populations most impacted by behavioral health disparities.

Program Funding

Although the BHSA WET Plan is structured as a five-year plan, HCAI's budgeting approach focuses on forecasting priorities and associated costs for the first three years to support effective implementation, learning, and course correction. In Year 3, HCAI intends to conduct a midline evaluation, the results of which will inform future decision-making and help assess whether funding allocations should be adjusted for the remaining years of the plan. Accordingly, the budget allocations outlined below reflect a phased implementation approach designed to support smooth execution, learning, and scaling over time. Because several objectives will roll out in stages, funding is distributed to align with each phase and remains intentionally flexible to allow for adjustments based on program uptake and evaluation findings. Notably, no funding is allocated to recruitment and retention at this time; see Objective 5 for an explanation of HCAI's approach to addressing recruitment and retention.

Budget Principles

The following budget principles guide the strategic allocation of BHSA resources to ensure meaningful, lasting impact across California's behavioral health workforce.

6. **Maximize and Leverage Funding:** The BH-CONNECT Workforce Initiative funds up to $1.9 billion for scholarships, loan repayments, recruitment and retention, community-based provider training programs, and

residency/fellowship.[31] BH-CONNECT funds will be maximized, while BHSA will fill critical gaps and sustain successful programs to ensure long-term impact.

7. **Balanced Investment:** HCAI recognizes that the CBHS requires both licensed and non-licensed professionals to advance access to quality care. Substantial educational cost differences exist between licensed and non-licensed behavioral health workforce pathways, with licensed roles requiring greater investment due to longer training and supervision needs. A balanced approach allocates resources across both sets of roles to support team-based care across the continuum.
8. **Up Front Investments to Drive Systems Change:** Fund the up-front work needed to inform thoughtful approaches to systems change (e.g. definition of core competencies for serving in CBHS, analysis of gaps in career lattices). Where appropriate, provide targeted short-term funding to address immediate needs while long-term systems change is being designed.
9. **Sustainability:** Prioritize strategic up-front ("kickstart") investments that enable long-term, self-sustaining change to establish systems, build capacity, and demonstrate effectiveness, with the expectation that reforms will be absorbed and sustained by sector partners (e.g., education institutions and other stakeholders) over time. Specific sustainability expectations will be developed for funded programs.

Budget Allocations

The following table provides an overview of proposed budget allocations, by objective. The proposed allocations are approximate and may shift. Specific amounts by objective and program will vary based on annual BHSA allocations to HCAI. Depending on the total allocation, additional prioritization may be required.

[31] See Appendix for detailed information on BH-CONNECT funding allocations

Proposal	Funding Allocations			
	FY 2026-27	FY 2027-28	FY 2028-29	TOTAL
1. Expand Existing Workforce Skills	27%	15%	8%	**16%**
2. Educate & Train Future Licensed Professionals	46%	49%	44%	**46%**
3. Scale & Optimize Deployment of Non-Licensed Workforce	10%	25%	36%	**25%**
4. Enhance Career Pathways and Advancement	17%	11%	12%	**13%**
5. Recruit & Retain Workforce*	0%	0%	0%	**0%**

* Funding for Objective 5: Recruitment and Retention has not yet been determined. In alignment with HCAI's budget principle regarding maximizing and leveraging existing funding, HCAI proposes to first assess the success and reach of the mid-2026 BH-CONNECT Medi-Cal Behavioral Health Recruitment and Retention Program. Pending findings from that first cycle, HCAI will determine whether BHSA funds should be allocated to fill gaps not addressed by the BH-CONNECT program. HCAI will continue to assess complementarity of BH-CONNECT and BHSA funds throughout the five-year period.

The allocations outlined above are flexible and can be shifted depending on need and performance of the BHSA WET Plan (see "Monitoring and Evaluation" and "Accountability").

Monitoring and Evaluation

Introduction and Purpose

To ensure responsible stewardship of BHSA WET funds, HCAI is committed to robust monitoring and evaluation (M&E) of funded programs over the course of the five-year plan. M&E enables evidence-based decision-making, supports continuous improvement, and enables accountability to stakeholders, including the California Behavioral Health Planning Council, HCAI Health Workforce Education and Training Council, the Behavioral Health Task Force, and the Commission for Behavioral Health.

M&E activities will verify appropriate use of funds, support transparent reporting, and demonstrate accountability for outcomes. Findings will inform reflections on what is working and what is not, and how to prioritize or modify investments. These processes are integral to the BHSA WET Plan, supporting performance tracking, evidence-based decision-making, and timely course corrections.

Routine Monitoring

Monitoring Frequency and Process

- HCAI will conduct routine program monitoring and learning over the five years
- Data will be collected on an annual basis, at minimum
- HCAI will manage program data, report actionable information, and identify program adjustments as needed
- HCAI will identify and recommend opportunities for continuous improvement, where they arise

Key Indicators

Result[32]	Indicator(s)*[33]	Frequency
Objective 1: Expand Existing Workforce Knowledge and Skills	Number of behavioral health professionals who complete prioritized trainings, by professional type, content type, and setting	Annual
	Increase in workforce competencies	Baseline, midline, endline
Objective 2: Educate & Train Future Licensed Professionals	Number of schools that adopt CBHS curricula and CBHS placements/rotations, by degree type and geography	Annual
	Number and demographics of trainees graduating from institutions with CBHS curricula, by degree type and geography	
	Number of enrolled trainees benefiting from: • Education/ training • Scholarships and wrap-around services • (during school) • Stipends (post-graduation) • Clinical supervision placement	

[32] BH-CONNECT provides a major recruitment and retention lever through the Recruitment and Retention program (MBH-RRP). Following the launch of this program, we will evaluate its success and identify potential gaps. We anticipate that BHSA funds may complement BH-CONNECT if gaps remain; however, those BHSA funding decisions will be contingent on MBH-RRP program performance.

[33] For all indicators, data should be collected, analyzed, and reported using sub-categories for profession, type (licensed/ non-licensed), role, demographics, and geography (including county designation), where applicable.

Result[32]	Indicator(s)*[33]	Frequency
	Number and percentage of trainees supported who achieve licensure	
	Number and percentage of trainees who complete service agreements	
	Number or percentage of trainees who remain practicing in CHBS 1 and 3 years after completion of service agreement	Endline and post-endline
Objective 3: Scale & Optimize Deployment of Non-Licensed Workforce	Number of individuals participating in: • Training/scholarship • Stipend or wrap-around supports • Job placement support • Transition to practice support	Annual
	Number and percentage of individuals trained who: • Achieve certification • Get a job placement in CBHS within 6 months or 12 months of graduating • Are working in the CBHS 1 and 3 years after placement	
	Number of counties participating in Technical Assistance	
	Change in team composition and use of non-licensed behavioral health professionals in participating counties	Midline and endline
Objective 4: Enhance Career Pathways and Career Advancement	Number of (new) career pathway programs developed	Annual
	Number of individuals participating in: • Pipeline/Pathway programs • Career advancement programs	

Objective 5 is being implemented through BH-CONNECT and the effectiveness of those programs will be assessed separately.

Learning and Evaluation

Baseline Assessment

HCAI proposes a baseline assessment of workforce availability and skills in CBHS. The assessment will employ mixed methods and, if feasible, may include a sample-based survey of quantitative measures including vacancy rates, turnover rates, and use of non-licensed behavioral health professionals, as well as qualitative measures reflecting the experiences of both employers and behavioral health professionals in the CBHS. To the extent possible, HCAI aims to reduce measurement fatigue and leverage pre-existing data sources such as County Integrated Plans to assess the workforce landscape.

Annual Reviews

HCAI will conduct annual reviews of progress against output and outcome targets. Findings will be shared with HCAI's BHSA Workforce Panel (see "Accountability" section below) as well as stakeholders through HCAI's Health Workforce Education and Training Council, as well as other bodies upon request. Reflection will inform operational planning and resource allocation for the following year.

Mid-line Review

A comprehensive mid-line review will be conducted in 2028, roughly halfway through the five-year 2026–2030 BHSA WET Plan period. Using a mixed-methods approach, the review will assess progress, identify challenges, and recommend course corrections. The timing of the proposed mid-line review aligns roughly with the end of the BH-CONNECT implementation period (the BH-CONNECT program is authorize through 2029, but as a result of service obligation requirements, most BH-CONNECT programs will have run their final cycles by the time of the proposed BHSA mid-line review), as well as the completion of the first County Integrated Plan cycle. Drawing on data related to uptake, reach, and early outcomes from BH-CONNECT programs as well as workforce-related information included in the County Integrated Plan, HCAI will reassess county and county-contracted workforce needs, highlight county and state successes, and determine how remaining BHSA funds should be allocated, including whether and how to sustain BH-CONNECT programs. Findings will be shared through the same venues as the annual reviews to support community engagement and collective reflection.

Endline Review

HCAI will conduct a comprehensive endline review, including a summative evaluation of findings from M&E activities across the BHSA WET Plan's five-year period. This mixed

methods evaluation will identify what worked, what did not, and key considerations to inform the next five-year plan.

Evaluation Questions

HCAI will design a robust outcome evaluation to assess the extent to which its BHSA WET Plan investments have contributed to progress on its three primary outcomes:

- The behavioral health workforce has the skills needed to effectively serve individuals with significant behavioral health conditions.
- There is a sufficient supply of behavioral health professionals across the county behavioral health system, including in geographic areas and service settings with the greatest need.
- The workforce is diverse and reflects the lived experiences and backgrounds of the communities served, supporting culturally responsive and equitable care delivery.

Evaluation will be mixed methods and will draw from secondary data sources – including County Integrated Plans – as well as primary data sources, including surveys of awardees and qualitative data collection where appropriate.

Evaluation questions may include:

1. To what extent has the BHSA WET Plan increased the supply of behavioral health professionals in the CBHS with the skills needed to serve individuals with significant behavioral health conditions?
    a. How effective are WET-funded programs in preparing professionals for CBHS roles?
    b. To what degree is the CBHS workforce equipped to meet the needs of the clients/ populations they serve?
    c. Do county and county-contracted organizations have the workforce they need to serve their clients? If not, what gaps persist and what are root causes?
    d. To what extent do individuals trained and supported through WET-funded activities (education, scholarships, clinical placement) remain in the CBHS over time including one and three years after placement?
2. What is the impact of WET-funded programs on workforce sustainability?
    a. How did new career pathways contribute to workforce sustainability?
    b. How did advancement opportunities contribute to workforce sustainability?
    c. How did technical assistance impact the capacity of county and county-contracted agencies to integrate non-licensed roles within care teams, and better attract, manage and retain their behavioral health workforce?
3. What is the impact of WET-funded programs on workforce diversity?

   a. How did new career pathways contribute to workforce diversity in the CBHS? Who benefitted and who did not?
   b. How did career advancement opportunities contribute to workforce diversity in the CBHS?
   c. To what degree does the CBHS workforce reflect the diversity of California and the diversity of patients/populations served in the CBHS, specifically regarding race/ethnicity and language?
   d. To what extent does the distribution of funds by role and geography reflect known gaps?
4. To what extent did BHSA funds address geographic and setting-based workforce inequities?
5. What larger learnings can inform future workforce development initiatives?

Accountability

Accountability Framework

To ensure transparency, effectiveness, and long-term sustainability, the BHSA WET Plan is supported by an accountability framework organized around three core pillars:

1. Program Monitoring and Evaluation
2. Community Engagement
3. Cross Department Alignment and Public Oversight

Together, these pillars establish a structured approach to responsible management of public resources, informing and transparent decision-making, and maintaining alignment with the broader behavioral health system and policy environment.

Program Monitoring & Evaluation

Program M&E serves as the first pillar of accountability. See above for a description of the proposed M&E approach for the BHSA WET Plan.

Community & Stakeholder Engagement

Community and stakeholder engagement serve as a second pillar of accountability, grounding implementation in the lived realities of the behavioral health workforce and the communities it serves.

As part of our commitment to stakeholder engagement, HCAI has convened a BHSA Workforce Panel. The panel includes implementation partners, representatives from

state agencies, organized labor, provider associations, educational institutions, community-based organizations, health plans, individuals with lived experience, and county departments. The panel will be convened two to three times per year throughout the five-year period, and will review M&E findings, interpret program performance data, and identify emerging challenges and opportunities across the field. This forum will provide structured opportunities for feedback and thought partnership, helping to ensure that WET investments remain responsive to changing system conditions and stakeholder input.

HCAI will also be responsive to requests to share findings and engage with communities and key stakeholders, including but not limited to opportunities through public meetings hosted by the California Behavioral Health Planning Council, Commission for Behavioral Health, and the CalHHS Behavioral Health Task Force.

Cross Department Alignment and Public Oversight

The third pillar of accountability focuses on aligning BHSA WET Plan implementation with broader behavioral health system efforts and ensuring transparency through established public oversight structures. HCAI will maintain ongoing coordination with key state partners, including California Health and Human Services Agency (CalHHS), the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), the California Department of Aging (CDA), the Department of Social Services (DSS), the Department of State Hospitals, the Office of Youth and Community Restoration (OYCR) and other entities such as the California Department of Veterans Affairs. through regular check-ins to align on BHSA implementation, identify emerging challenges, and explore opportunities for continued partnership. This coordination is essential to ensuring that workforce investments are integrated with complementary initiatives, including Medi-Cal behavioral health reforms and public health workforce efforts.

Through sustained interagency coordination and ongoing public engagement, HCAI will ensure that BHSA WET Plan implementation remains aligned with statewide Behavioral Health Transformation efforts and is accountable to both stakeholders and the public. Following implementation, lessons learned and key findings from the evaluation process will be shared to support a dynamic and evolving policy landscape and service delivery system.

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1. Glossary

988 Suicide and Crisis Lifeline is a nationwide, 24/7, free and confidential service connecting individuals in crisis with trained counselors for mental health, substance use, and emotional support.

Across the Lifespan refers to infants, children, adolescents, transition-aged youth, transition-aged adults, adults, and older adults.

Behavioral Health Continuum Infrastructure Program (BHCIP) is a California initiative to construct, acquire, and rehabilitate real estate assets or to invest in needed mobile crisis infrastructure to expand the community continuum of behavioral health treatment resources.

Behavioral Health Services Act (BHSA) was passed by California voters in March 2024 as Proposition 1. It is a major overhaul of the state's behavioral health system. It replaces the 2004 Mental Health Services Act (MHSA).

Behavioral Health Infrastructure Bond Act was passed by California voters in March 2024 as part of Proposition 1. It is a $6.4 billion state bond program created to expand behavioral health treatment capacity and supportive housing for people with serious mental illness (SMI), substance use disorder (SUD), and other behavioral health needs

Behavioral Health Community-Based Organization Networks of Equitable Care and Treatment (BH-CONNECT) is California's initiative to expand access to community-based behavioral health services for Medi-Cal members with significant mental health or substance use needs.

California Advancing and Innovating Medi-Cal (CalAIM) is a statewide initiative to transform Medi-Cal by improving health outcomes, addressing social determinants of health, and implementing system-wide delivery, program, and payment reforms.

California Mental Health Authority (CalMHSA) is a Joint Powers Authority (JPA) formed in 2009 by counties throughout the state to work on collaborative, multi-county projects that improve behavioral health care for all Californians.

California Mental Health Parity Act ensures all commercial health plans provide coverage for medically necessary treatment of mental health and substance use disorders (behavioral health) at the same cost as physical health conditions.

Caregivers are grandparents and their partners, adoptive parents and their partners, guardians and their partners, and foster parents and their partners, who are or have previously been the primary caregiver for a child, youth, or adolescent with a mental health challenge who accessed mental health services.

Children and Youth Behavioral Health Initiative (CYBHI) is a comprehensive $4 billion program in California aimed at improving the behavioral health and well-being of children and youth and their families through accessible behavioral health services and support.

Consumer or **client** is an individual of any age who is receiving or has received public behavioral health services. The term client includes those who refer to themselves as clients, consumers, survivors, patients, or ex-patients.

Community-Identified are strategies that have been identified as being effective by cultural and ethnic communities but that have not yet been demonstrated through empirical evidence.

Cultural Competence is a set of congruent practice skills, behaviors, attitudes, and policies within a system, agency, or among those persons providing services that enables the system, agency, or those persons providing services to work effectively in cross-cultural situations. **Community Assistance, Recovery and Empowerment (CARE) Court** provides intervention for individuals experiencing severe impairment to prevent avoidable hospitalizations, incarcerations, and Lanterman-Petris-Short Mental Health Conservatorship.

Co-occurring Conditions applies to an individual who is experiencing a serious mental illness or serious emotional disturbance and substance use disorder.

County Behavioral Health System (CBHS) is the constellation of county-owned and county-contracted organizations in a local jurisdiction that, under the administration and leadership of the county, serve individuals with significant and/or complex mental health conditions, substance use disorder, and/or co-occurring conditions.

County Behavioral Health System (CBHS) Workforce is the current and prospective personnel, county contractors, volunteers, and community-based organization staff who work or will work in the CBHS.

Diversity includes dimensions of race/ethnicity, gender, sexual orientation/identity, socioeconomic status, age, religion, physical and/or mental/neurological abilities, language, geographical location (e.g., urban, rural), veteran, and/or other pertinent characteristics.

Distributed Learning is an instructional model that involves using various information technologies to help students learn such as video or audio conferencing, satellite broadcasting, and multimedia formats.

Department of Health Care Access and Information (HCAI) is California's state department dedicated to expanding equitable access to quality, affordable, and safe healthcare for all residents.

Evidence-Based are strategies that have produced empirical evidence of their successful outcomes to address an identified issue.

Family Member includes parents and siblings, and their partners; kinship caregivers; friends; and others as defined by the family who are or have previously been the primary caregiver for a child, youth, adolescent, or adult with a serious mental health challenge who accessed mental health services.

Graduate Education Capacity Expansion (GECE) an HCAI program that, when fully developed and launched, will provide educational institutions with resources to support graduate students seeking to become behavioral health clinicians in the County Behavioral Health System (CBHS), including loan repayments or comprehensive scholarships, specialized curricula that will prepare them to work in the CBHS, clinical supervision, and mentoring during their two-year service obligation period.

Grow-Your-Own Models are strategies used to recruit individuals from within diverse communities to pursue professions in the public mental health system, which involves engaging local residents in entry-level positions and promoting their long-term professional growth, development, and advancement within the organization or system of care.

Inappropriately Served are populations that are not being provided culturally responsive and/or appropriate services and often receive services inconsistent with evidence-based and/or community-identified practices.

Interprofessional refers to behavioral health providers from different professions working together to provide care.

Local jurisdictions include the 58 counties (with Sutter and Yuba counties operating as a single entity), the City of Berkeley, and the Tri-City area (Pomona, Claremont, and La Verne) in Los Angeles County.

Long-term disability refers to a condition that prevents an individual from working for an extended period due to illness or injury, often qualifying them for income replacement through insurance or government programs.

Medi-Cal Mobile Crisis services are community-based, behavioral health interventions designed to provide de-escalation, stabilization, and crisis relief to individuals experiencing a behavioral health crisis, wherever they are — at home, work, school, or in the community

Mental Health Services Act (MHSA), Proposition 63 passed in California in 2004, aimed to transform and expand mental health services through dedicated funding from a 1% tax on personal income over $1 million.

Peer Support Specialist is a trained individual with lived experience of mental health or substance use challenges who provides guidance, mentoring, and support to others facing similar issues.

Psychiatric Education Capacity Expansion (PECE) is an HCAI initiative designed to address critical shortages in mental health care by expanding training opportunities for psychiatrists and psychiatric mental health nurse practitioners.

Persons with lived experience include consumers, family members, and caregivers.

Prevention and Early Intervention are services to prevent mental illnesses from becoming severe and disabling.

Psychiatric rehabilitation is a therapeutic process aimed at helping individuals with behavioral health conditions regain independence, improve their quality of life, and reintegrate into society.

Public Behavioral Health Training (PBHT) offers specialized training for Master of Social Work (MSW) students to enhance their skills in providing behavioral health services in publicly funded settings.

Regional Partnerships (RPs) (are five geographic regions designated by the California Behavioral Health Directors Association). The designations are:

1. **Superior**: Butte, Colusa, Glenn, Humboldt, Lake, Lassen, Mendocino, Modoc, Nevada, Plumas, Shasta, Sierra, Siskiyou, and Trinity counties.

2. **Central**: Alpine, Amador, Calaveras, El Dorado, Fresno, Kings, Placer, Sacramento, San Joaquin, Sutter, Stanislaus, Madera, Mariposa, Merced, Mono, Tulare, Tuolumne, Yolo, and Yuba counties.
3. **Greater Bay Area**: Alameda, Contra Costa, Marin, Monterey, Napa, San Francisco, San Mateo, San Benito, Santa Clara, Solano, Santa Cruz, and Sonoma counties, and the City of Berkeley.

4. **Southern**: Imperial, Kern, Orange, Riverside, San Bernardino, San Diego, San Luis Obispo, Santa Barbara, and Ventura counties, and the Tri-City (Pomona, Claremont, and La Verne) area of Los Angeles County.

5. **Los Angeles**: Los Angeles County.

Serious Emotional Disturbance (SED) is infants, children, and youth up to age 18 who have a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. These can include, but are not limited to, pervasive developmental disorder, childhood schizophrenia, schizophrenia of adult-type manifesting in adolescence, conduct disorder, affective disorder, other disruptive behaviors, or other disorders with serious medical implications such as eating disorders. WIC 5600.3.

Serious Mental Illness (SMI) is a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. WIC 5600.3 (b)(1).

Social Work Education Capacity Expansion (SWECE) is an HCAI initiative designed to expand postsecondary social work education to meet the state's growing demand for clinical behavioral health professionals.

Stackable Credentials is part of a sequence of credentials that can be accumulated over time to build up an individual's qualifications and help them move along a career pathway or up a career ladder to different jobs and potentially higher paying jobs. Source: U.S. Department of Labor.

Stakeholder is an individual or entity with an interest in mental health services in California, including but not limited to individuals with SMI and/or SED and/or their families; providers of mental health and/or related services such as physical health care and/or social services, educators and/or representatives of education; representatives of law enforcement; and any other organization that represents the interests of individuals with SMI and/or SED and/or their families.

Substance Use Disorder (SUD) is a chronic, treatable condition characterized by the compulsive use of substances despite harmful consequences, affecting brain function, behavior, and daily life.

Underrepresented refers to populations and communities underrepresented in the mental health professions relative to their numbers in the total population.

Underserved refers to clients of any age who have been diagnosed with a SMI and/or SED and are receiving some services but are not provided the necessary or appropriate opportunities to support their recovery, wellness, and/or resilience. It can include clients whose family members are not receiving sufficient services to support the client's recovery, wellness, and/or resilience. These clients include, but are not limited to:

- Those individuals who are so poorly served that they are at risk of homelessness, institutionalization, incarceration, out-of-home placement or other serious consequences
- Members of ethnic/racial, cultural, and linguistic populations that do not have access to mental health programs due to barriers such as poor identification of their mental health needs, poor engagement and outreach, limited language access, and lack of culturally competent services
- Those individuals in rural areas and Native American rancherias and reservations not receiving sufficient services.

Unserved means those individuals who may have SMI, SED, SUD, or COC and are not receiving needed behavioral health services. Individuals who may have had only emergency or crisis-oriented contact with and/or services from the county may be considered unserved.

Workforce Education and Training (WET) refers to organized instruction, training, and learning programs designed to prepare individuals for current and future careers. It connects education directly to the labor market, equipping people with the skills, knowledge, and credentials needed to enter, advance in, or transition within the workforce

2. BHSA WET Plan / HCAI-Related State Statutes

SECTIONS OF THE BEHAVIORAL HEALTH SERVICES ACT

Enacted March 2024

HUMAN RESOURCES, EDUCATION, AND TRAINING PROGRAM[34]

Part 3.1 (commencing with Section 5820) is hereby added to Division 5 of the Welfare and Institutions Code, to read:

5820. (a) It is the intent of this part to establish a program with dedicated funding to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

(b) Each county mental health program shall submit to the Office of Statewide Health Planning and Development a needs assessment identifying its shortages in each professional and other occupational category in order to increase the supply of professional staff and other staff that county mental health programs anticipate they will require in order to provide the increase in services projected to serve additional individuals and families pursuant to Part 3 (commencing with section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850) of this division. For purposes of this part, employment in California's public mental health system includes employment in private organizations providing publicly funded mental health services.

(c) The Office of Statewide Health Planning and Development, in coordination with the California Behavioral Health Planning Council, shall identify the total statewide needs for each professional and other occupational category utilizing county needs assessment information and

[34] Originally included in the Mental Health Services Act that was enacted by Proposition 63 of 2004.

develop a five-year education and training development plan.

(d) Development of the first five-year plan shall commence upon enactment of the initiative. Subsequent plans shall be adopted every five years, with the next five-year plan due as of April 1, 2014.

(e) Each five-year plan shall be reviewed and approved by the California Mental Health Planning Council.

5821. (a) The California Behavioral Health Planning Council shall advise the Office of Statewide Health Planning and Development on education and training policy development and provide oversight for education and training plan development. enacted

(b) The Office of Statewide Health Planning and Development shall work with the California Behavioral Health Planning Council and the State Department of Health Care Services so that council staff is increased appropriately to fulfill its duties required by Sections 5820 and 5821.

5822. The Office of Statewide Health Planning and Development shall include in the five-year plan:

(a) Expansion plans for the capacity of postsecondary education to meet the needs of identified mental health occupational shortages.

(b) Expansion plans for the forgiveness and scholarship programs offered in return for a commitment to employment in California's public mental health system and make loan forgiveness programs available to current employees of the mental health system who want to obtain Associate of Arts, Bachelor of Arts, master's degrees, or doctoral degrees.

(c) Creation of a stipend program modeled after the federal Title IV-E program for persons enrolled in academic institutions who want to be employed in the mental health system.

(d) Establishment of regional partnerships between the mental health system and the educational system to expand outreach to multicultural communities, increase the diversity of the mental health workforce, to reduce the stigma associated with mental illness, and to promote the use of web-based technologies, and distance learning techniques.

(e) Strategies to recruit high school students for mental health occupations, increasing the prevalence of mental health occupations in high school career development programs such as health science academies, adult schools, and regional occupation centers and programs, and increasing the number of human service academies.

(f) Curriculum to train and retrain staff to provide services in accordance with the provisions and principles of Part 3 (commencing with Section 5800), Part 3.2 (commencing with Section 5830), Part 3.6 (commencing with 5840), and Part 4 (commencing with 5850) of this division.

(g) Promotion of the employment of mental health consumers and family members in the mental health system.

(h) Promotion of the meaningful inclusion of mental health consumers and family members and incorporating their viewpoint and experiences in the training and education programs in subdivisions (a) through (f).

(i) Promotion of meaningful inclusion of diverse, racial, and ethnic community members who are underrepresented in the mental health provider network.
(j) Promotion of the inclusion of cultural competency in the training and education programs in subdivisions (a) through (f).

WIC Section 5892[35]

…

(d) The programs established pursuant to subdivision (a) shall prioritize services for the following populations:
(1) Eligible adults and older adults, as defined in subdivision (k), who satisfy one of the following:
(A) Are chronically homeless or experiencing homelessness or are at risk of homelessness.
(B) Are in, or are at risk of being in, the justice system.
(C) Are reentering the community from prison or jail.
(D) Are at risk of conservatorship pursuant to Chapter 3 (commencing with Section 5350) of Part 1 of Division 5.
(E) Are at risk of institutionalization.
(2) Eligible children and youth, as defined in subdivision (k), who satisfy one of the following:
(A) Are chronically homeless or experiencing homelessness or are at risk of homelessness.
(B) Are in, or at risk of being in, the juvenile justice system.
(C) Are reentering the community from a youth correctional facility.
(D) Are in the child welfare system pursuant to Section 300, 601, or 602.
(E) Are at risk of institutionalization.

…

(f) (1) (D) (i) The costs of the Department of Health Care Access and Information to implement a behavioral health workforce initiative. The cost for this initiative shall be a minimum of 3 percent of the total funds allocated pursuant to this subdivision.
(ii) This initiative shall be developed in consultation with stakeholders, including, but not limited to, behavioral health professionals, counties, behavioral health education and training programs, and behavioral health consumer advocates. The initiative shall focus on efforts to build and support the workforce to meet the need to provide holistic and quality services and support the development and implementation of strategies for training, supporting, and retaining the county behavioral health workforce and noncounty contracted behavioral health workforce, including efforts to increase the racial, ethnic, and linguistic diversity of behavioral health providers and increase access to behavioral health providers in geographically underserved areas.
(iii) A portion of the workforce initiative may focus on providing technical assistance and support to county contracted providers to implement and

[35] Added by the Behavioral Health Services Act enacted in March 2024.

maintain workforce provisions that support the stabilization and retention of the broad behavioral health workforce.

(iv) A portion of the workforce initiative may focus on providing technical assistance and support to county and contracted providers to maximize the use of peer support specialists.

…

(k) For purposes of this section, the following definitions shall apply:

…

(5) "Workforce education and training" includes, but is not limited to, the following for the county workforce:

(A) Workforce recruitment, development, training, and retention.

(B) Professional licensing and/or certification testing and fees.

(C) Loan repayment.

(D) Retention incentives and stipends.

(E) Internship and apprenticeship programs.

(F) Continuing education.

(G) Efforts to increase the racial, ethnic, and geographic diversity of the behavioral health workforce.

For the reader interested in reading the full BHSA and Bond statutes, these are available at:

- Behavioral Health Services Act: SB 326
- Behavioral Health Bond Act: AB 531

3. 2020-2025 MHSA WET Plan Funded Programs

The 2020-2025 MHSA WET Plan funding supported the following programs:

- Regional Partnerships[36]
- Psychiatric Education Capacity Expansion (PECE) Program[37]
- Peer Personnel Training and Placement (PPTP) Program[38]

Regional Partnership Program

The Regional Partnership Program supported workforce development and retention in the Public Mental Health System (PMHS), now called the County Behavioral Health System (CBHS), through coordinated strategies across the career pathway. The

[36] Regional Partners Grant Guide
[37] 2023-24 PMHNP Training Program Grant Guide
[38] For example, 2026-27 Peer Personnel Grant Guide

program was organized into five multi-county regions: Superior, Central, Greater Bay Area, Southern, and Los Angeles. Each region had to implement at least one of the following:

- Pathway Development
- Undergraduate Scholarships
- Graduate Stipends
- Loan Repayment
- Retention Strategies

To support analysis and fair investment, HCAI developed a centralized system to collect key demographic and workforce data. Regional grants were administered through designated host counties, which managed implementation, data collection, and reporting on behalf of participating counties. The Regional Partnership Program ends in June 2026.

Early findings show implementation challenges, especially the time needed for counties approve agreements and get Board of Supervisors' approval. In some cases, no county was able to serve as the host for the region, requiring alternative arrangements with the California Mental Health Authority (CalMHSA). These processes took up to two years to finalize, delaying program launch and limiting timely deployment of funds.

Psychiatric Education Capacity Expansion (PECE) Program

HCAI administered the Psychiatric Education Capacity Expansion (PECE) Grant Program, which supported the expansion of postsecondary education and training, particularly in underserved regions.

The program provided funding to medical institutions and programs to develop and expand training programs for psychiatrists (including general psychiatry, child and adolescent, and addiction specialties) and psychiatric mental health nurse practitioners (PMHNPs). These programs prepared providers to work in team-based settings, serve underserved communities, and apply PECE principles in coursework and clinical training.

The program was successful at recruiting 139 psychiatry residents and 414 new psychiatric mental health nurse practitioners.

Peer Personnel Training and Placement (PPTP) Program

HCAI contracts with Peer Personnel Training Programs to support individuals with lived experience as a mental/behavioral health services consumer, family member, or caregiver placed in designated peer positions with local county agencies and CBOs. The grantees must provide training to peer support personnel that meets the 80-hour

training requirements under the California Department of Health Care Services (DHCS) Medi-Cal Peer Support Specialist Certification Program. Between 2020 and 2025, MHSA funding supported about 2,000 individuals to complete training for certification as a peer support specialist. This program is ongoing.

4. Phase One: 2025 Community Engagement Invitees[39]

State Associations

Addiction Counselor Certification Board of California
Association of Regional Center Agencies
California Association of Alcohol and Drug Educators
California Association of DUI Treatment Programs
California Association of Local Behavioral Health Boards and Commissions
California Association of Marriage and Family Therapists
California Association of Mental Health Peer-Run Organizations
California Association of School Counselors
California Association of School Psychologists
California Association of Social Rehabilitation Agencies
California Behavioral Health Association
California Consortium of Addiction Programs and Professionals
California Hospital Association
California LGBTQ Health and Human Services Network
California Primary Care Association
California Psychological Association
California State Association of Psychiatrists
Mental Health America of California
National Association of Social Workers, California Chapter
Psychiatric Physicians Alliance of California

California State Departments, Agencies, and Commissions
California Behavioral Health Planning Council
California Board of Behavioral Sciences (Department of Consumer Affairs)
California Commission on Aging
California Correctional Healthcare Services

[39] Representatives of these organizations responded to a January 2025 HCAI survey indicating a desire to participate in development of the 2026-2030 BHSA WET Plan and were later invited by Sacramento State to community engagement sessions.

California Department of Aging
California Department of Health Care Services
California Department of Public Health
California Department of State Hospitals
California Office of the Surgeon General
California Commission for Behavioral Health (formerly the Behavioral Health Services Oversight and Accountability Commission)
California Labor & Workforce Development Agency
Council on Criminal Justice and Behavioral Health

Community-Based Organizations

Addiction Counselor Certification Board of California
AltaMed Health Services
Aging and HIV Institute
Alameda Health Consortium
Alzheimer's Los Angeles
Amity Foundation
Bill Wilson Center
Bridge Center
California Alliance of Child and Family Services
Center for Caregiver Advancement
Cal Voices
California Consortium for Urban Indian Health, Inc
Cambodian Family Community Center
Capital Adoptive Families Alliance
CenCal Health
Centro Medico Community Clinic
Chinatown Service Center
Choice In Aging
Chychy Gilgal Care, Inc
Clarvida Oasis Clubhouse
Community Health Group
Compassion Outreach (Homeless Outreach)
Compatior Counseling Center
Creating Conscious Communities Coalition
Diversity in Health Training Institute
El Sol Neighborhood Educational Center
Elite Family systems
Family Health Centers of San Diego, Inc.

FREED Center for Independent Living
Glenn Medical Center
Healthy Rural California
Hill Country Community Clinic
Inland Caregiver Resource Center
Inland Empire Behavioral Health
Inland Empire Health Plan
Institute on Aging Friendship Line
John Muir Health Family Medicine
Korean Community Center of the East Bay
La Clinica de La Raza
Liberty Hill Foundation
LifeLong Medical Care
Lift Off Recovery
Los Angeles Centers for Alcohol and Drug Abuse
Los Angeles Recovery Connect
Medmark Los Angeles
Mendonoma Health Alliance
Mental Health Association of San Francisco
Mental Health Connections, Inc.
Mental State Foundation
Mineral Baths Community Gardens
NAMI Greater Los Angeles County
Norooz Clinic Foundation
Northern Valley Catholic Social Service
Partners in Care Foundation
Pacific Asian Counseling Services
Peer Recovery Art Project
Plumas District Hospital
Project Return Peer Support Network
Public Health Institute FACES for the Future Coalition
Richmond Area Multi-Services, Inc.
St. Mary Medical Center Families in Good Health
San Fernando Valley Community Mental Health Center, Inc.
Santa Rosa Community Health
Self-Help And Recovery Exchange
Self-Help for the Elderly
Senior Care Network at Huntington Health
Sierra County Behavioral Health
Sierra View Medical Center

Southern California Counseling Center
Southern Humboldt Community Healthcare District
SSG Weber Community Center
Special Service for Groups
The Happier Life Project
The Meeting Place Clubhouse, Inc.
The Public Works Alliance
The Race and Gender Equity Project
The Veterans Art Project
Toiyabe Indian Health Project
Trauma-Informed Montessori In Home Care
Turning Point of Arnold, LLC
Tyson Medical Foundation
United Parents
Victor Community Support Services
Voices Of Recovery
Voices of Recovery San Mateo County
Weimar University
West Coast Children's Clinic
Wise and Healthy Aging
Worker Education and Resource Center
Youth Empowerment Finest Inc.
Youth for Change
Youth Forward

County/Local Jurisdiction Agencies

Agency on Aging, Area 4
Alameda County Behavioral Health Services
Amador County Behavioral Health
Behavioral Health Board of Santa Clara County
Butte County Behavioral Health Services
Calaveras County Behavioral Health Services
City of Berkeley Behavioral Health Program
Colusa County Behavioral Health Services
Contra Costa Behavioral Health Services
County Behavioral Health Directors Association of California
County of San Luis Obispo Behavioral Health Department
County of Santa Clara Behavioral Health Services Department
Del Norte County Department of Health and Human Services

Del-Norte County Office of Education
Fresno County Behavioral Health Board
Fresno County Department of Behavioral Health
Glenn County Behavioral Health Advisory Board
Glenn County Health and Human Services Agency- Behavioral Health
Glenn County Office of Education
Humboldt County Behavioral Health Board
Humboldt County Department of Health and Human Services- Behavioral Health
Humboldt County Office of Education
Kern Behavioral Health and Recovery Services
Kern Health Systems
Los Angeles County Mental Health Commission
Lassen County Behavioral Health
Los Angeles County Department of Mental Health
Los Angeles County Department of Public Health- Substance Abuse Prevention and Control
Marin County Behavioral Health & Recovery Services
Mariposa County Health and Human Services Agency
Mendocino County Health and Human Services Agency
Merced County Behavioral Health Recovery Services
Modoc County Behavioral Health
Monterey County Behavioral Health
Napa County Behavioral Health Board
Nevada County Behavioral Health Department
Orange County Health Care Agency Behavioral Health Services
Placer County Health and Human Services
Plumas County Behavioral Health
Riverside University Health System- Behavioral Health
San Benito County Behavioral health
San Benito Healthcare District
San Bernardino County Department of Behavioral Health Workforce Education and Training Program
San Diego County Behavioral Health Advisory Board
San Joaquin County Behavioral Health Services
San Mateo Behavioral Health and Recovery Services
Santa Barbara County Behavioral Wellness Commission
Santa Barbara County Department of Behavioral Wellness
Santa Cruz County Health Services Agency Behavioral Health Division
Santa Cruz County Behavioral Health Board
Stanislaus Behavioral Health and Recovery Services

Southern Counties Regional Partnership
Sutter-Yuba Behavioral Health
Tehama County Health Services Agency Behavioral Health Division
Tri-City Mental Health Authority
Tulare County Behavioral Health
Tulare County Behavioral Health Board
Tuolumne County Behavioral Health Plan
Tuolumne County Behavioral Health Advisory Board
Ventura County Behavioral Health, Office of Health Equity
Yolo County Local Behavioral Health Board

Education

Azusa Pacific University Department of Clinical Psychology
California Baptist University Division of Social Work
California School of Professional Psychology (Alliant International University)
California State University (CSU), Office of the Chancellor
CSU Chico-Passages
CSU Chico School of Social Work
CSU Dominguez Hills, College of Health - Human Services and Nursing
CSU Fullerton School of Social Work
CSU Long Beach School of Social Work
CSU Los Angeles School of Social Work
CSU Monterey Bay School of Social Work
CSU Northridge Department of Social Work
CSU Stanislaus Social Work Department
California Community Colleges
Chabot-Las Positas Community College District
Diversity in Health Training Institute
Fuller Seminary
Futuro Health
Loma Linda University School of Behavioral Health - Psychology Department
Loyola Marymount University
Mt. San Antonio College
Payment for Placements at University of California (UC) Berkeley
Samuel Merritt University School of Social Work
Sacramento State School of Social Work Public Behavioral Health MSW Training Program
San Diego State University School of Social Work
San Jose State University School of Social Work

San Francisco State University - Department of Counseling
San Francisco State University School of Social Work
Touro University California
UC Berkeley School of Public Health
UC Berkeley School of Social Welfare, Ctr of Excellence for Behavioral Health Equity
UC Davis Betty Irene Moore School of Nursing at
UC Davis Health Office for Health Equity
UC Irvine School of Medicine, Medical Education
UC Irvine School of Medicine, TNT Primary Care Fellowships
UC Los Angeles Fielding School of Public Health
UC Los Angeles Prevention Center of Excellence
UC Los Angeles- UC San Francisco, ACEs Aware Family Resilience Network
UC Office of the President
UC Office of the President, Academic Health Sciences
UC Riverside School Psychology Program
UC San Francisco, Division of Geriatrics
UC San Francisco School of Nursing PMHNP Program
University of Massachusetts Global
University of Redlands Inland Empire Mental Health Training and Integration Center
University of Southern California Keck School of Medicine - Department of Family Medicine
Western University of Health Sciences
Wright Institute, Integrated Health Psychology Training Program
Wright Institute, PsyD Program

Policy and Advocacy

California Health Policy Strategies
California Health Care Foundation
Center for the Study of Latino Health and Culture
Chapman Consulting
Healthforce Center at UCSF
HealthImpact
HealthRIGHT 360
LMT and Associates
Steinberg Institute
The Children's Partnership
Western Institute for Social Research

State Entities

Medical Board of California

Health Plans

Adventist Health
Adventist Health Clearlake
Blue Shield of California
Common Spirit Health/Dignity Health
Kaiser Permanente
LA Care Health Plan
Local Health Plans of California
Managed Health Care
Partnership HealthPlan of California
Promise Health Plan

Organized Labor

California Teachers Association

Service Employees International Union - United Health Workers and Joint Employer Education Fund

5. Phase Two: 2026 Stakeholder Engagement Partners

State Associations
California Alliance of Child and Family Services
California Association of Alcohol and Drug Prevention Executives, Inc.
California Association of Social Rehabilitation Agencies
California Association of Mental Health Peer-Run Organizations
California Behavioral Health Association

California State Department Partners
California Board of Behavioral Sciences (Department of Consumer Affairs)
California Commission for Behavioral Health
California Department of Corrections and Rehabilitation
California Department of Health Care Services
California Department of Housing and Community Development
California Department of Public Health
California Department of State Hospitals
California Labor and Workforce Development Agency

Community-Based Organization Partners
MARU Center (formerly the Korean Community Center of the East Bay)
Santa Rosa Treatment Program, Inc.
The Happier Life Project

County Partners
Alameda County Behavioral Health – Office of Peer Support Services
California Mental Health Services Authority
County Behavioral Health Directors Association
Fresno County Department of Behavioral Health
Los Angeles County Department of Public Health – Substance Abuse Prevention and Control

Education and Training Partners
California Community Colleges Chancellor's Office
California State University (CSU) Chancellor's Office
CSU Long Beach School of Social Work
CSU Sacramento School of Social Work
Deans, Directors, and Chairs from public and private university programs in:

- Master of Social Work
- Marriage and Family Therapy
- Professional Clinical Counseling
- Psychology (PhD/PsyD)

University of California Office of the President

Education and Training Consultation
Futuro Health
George Washington University

Health Plans
Partnership HealthPlan of California

Organized Labor
Service Employees International Union

Public Policy and Advocacy
Steinberg Institute