Addressing California's Behavioral Health Workforce Shortage

Simon Vue

Master of Public Policy & Administration

California State University, Sacramento

Spring 2022

EXECUTIVE SUMMARY

I. Introduction

California is facing a behavioral health workforce shortage. There are not enough mental health and substance use disorder (SUD) providers to meet the needs of an increasingly growing and diverse population. Addressing workforce shortages in behavioral health is critical for the delivery of care and necessary treatment. This policy brief analyzes what has caused the shortage, reviews recent efforts to address it, and provides three options to strengthen and expand the state's workforce.

II. Drivers of Workforce Shortages

California's behavioral health workforce shortage is driven by a variety of factors affecting recruitment and retention of mental health and SUD providers. They include: 1) low reimbursement rates, 2) excessive paperwork requirements, and 3) lack of resources for the SUD system.

III. Workforce Development Efforts

Workforce development refers to the policies, programs, and practices designed to upskill employees and enrich the work environment through education, skills training, and recruitment and retention strategies. This section highlights the recent behavioral health investments in California.

IV. Policy Options

California has already taken a variety of steps to better support behavioral healthcare and bolster its workforce. In this section, I describe three policy options to further address workforce shortages, focusing on 1) the expansion of peer-to-peer programs to youth and 2) Certified Community Behavioral Health Clinics in California, and 3) additional funding for the 988 Crisis Hotline.

V. Conclusion

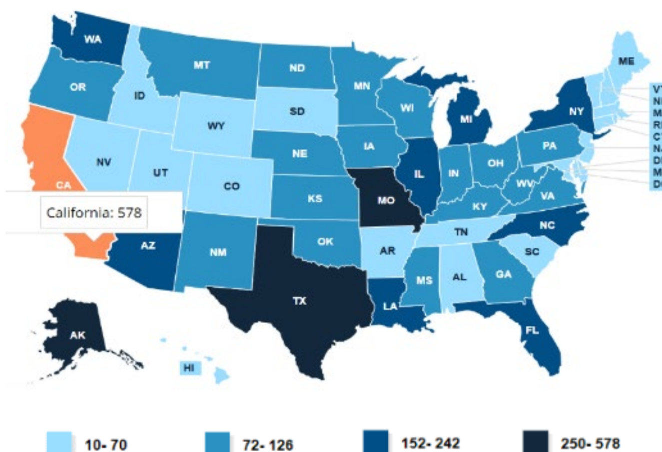
The COVID-19 pandemic has significantly increased the incidence of behavioral health challenges among children, youth, adults, and older adults, making access to services and care more important than ever. All three proposed workforce solutions are important and should be considered.

INTRODUCTION

Background

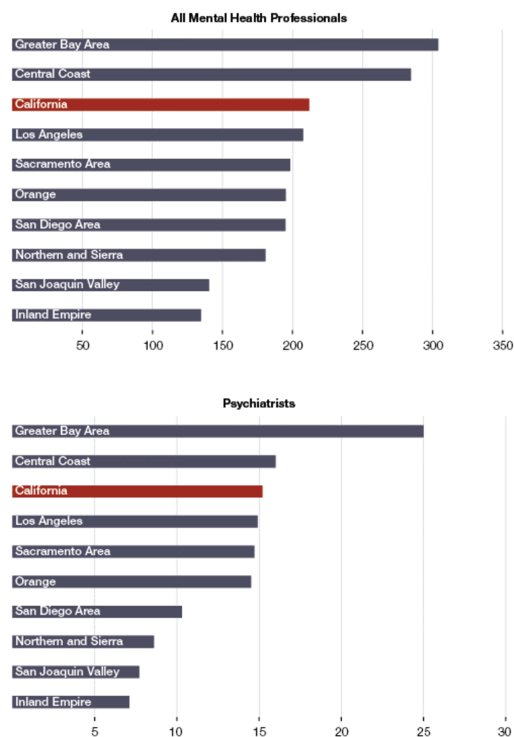
California is facing a behavioral health (mental health and substance use disorder) workforce shortage. Research conducted by the Healthforce Center at the University of California, San Francisco shows that statewide shortage is projected to grow, leaving the state with fewer providers than needed to meet demand by 2028.[i] Today, roughly eight million Californians, the majority of whom are Latino, Black, and Native American, live in Mental Health Professional Shortage Areas (MHPSAs), a federal designation for geographic regions, populations, or facilities experiencing a shortage of mental health professionals.[ii] To be considered as a MHPSA, an area must have a population-to-provider ratio of at least 30,000 to one.[iii] Currently, 31 counties with a high need for mental health services report a shortage [iv] Altogether, California has the most MHPSAs in the country, with 578 regions receiving this designation, as shown in Figure 1.[v]

Figure 1. Mental Health Care Health Professional Shortage Areas (HPSAs)



Workforce shortages are especially acute in some regions than others as providers are not distributed evenly across the state. For example, as indicated in Figure 2, the San Joaquin Valley and Inland Empire regions have the lowest ratios of behavioral health professionals to population than the Bay Area, which has more than three times as many psychiatrists by population as those two regions.[vi]

Figure 2. Mental Health Professionals Are Unequally Distributed Across the State



Furthermore, there are severe shortages of substance use disorder (SUD) providers statewide. In California, fewer than 20,000 alcohol and drug abuse counselors are certified, and fewer than 700 of the nearly 140,000 licensed physicians have an addiction specialty

certification.[vii] SUD programs often cited the "lack of qualified staff" as their primary concern in the past decade, and this shortage is expected to grow if the current trends continue.[viii]

Purpose of the Report

This policy brief provides the California State Legislature and Governor Gavin Newsom with an analysis of various policy alternatives, that have been presented, to expand and sustain the state's behavioral health workforce. This brief begins by describing current behavioral health trends and key facts, including rates of untreated mental health and SUD conditions and workforce composition. Next, I describe why retaining a qualified workforce is important. Then, I outline some of the major drivers that are behind workforce shortages in the state: low reimbursement rates, paperwork burden, and a historically underfunded system of SUD. I then discuss recent workforce investments by the State Legislature and Newsom's Administration before considering the policy options of 1) the expansion of peer-to-peer programs to youth and 2) Certified Community Behavioral Health Clinics in California, 3) additional funding for the 988 Crisis Hotline. I conclude by recommending that the state prioritize all three options to achieve the goals for a sustainable and diverse workforce.

Prevalence of Behavioral Health Conditions

Today, nearly one in six California adults has a mental health condition, and one in ten has a substance use disorder (SUD).[ix] One in 20 adults suffers from a serious mental illness that impacts their daily activities.[x] In children, the rate is even higher with one in every 13 suffering from a serious emotional disturbance, disproportionately impacting low-income children and those who are Black or Latino.[xi] Between 2007 and 2018, suicide rates among children, adolescents, and young adults ages 10-24 increased over 56 percent[xii], and as of 2020 suicide was the second leading cause of death for people ages 10-14 and 25-34.[xiii]

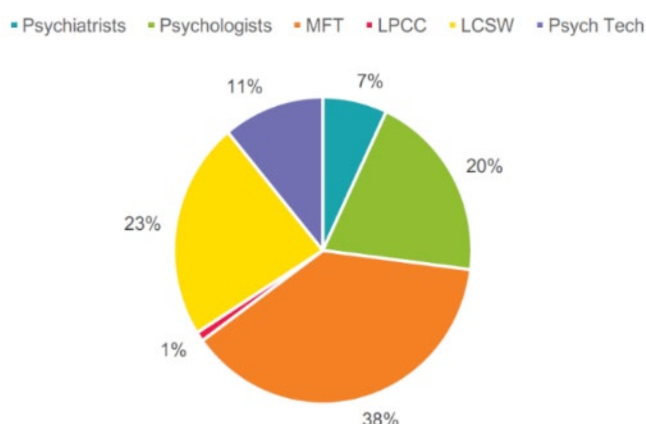
Despite access to insurance coverage for healthcare through the Affordable Care Act since 2010, research shows that many Californians with a mental health or SUD condition do not receive services. Just one-third of Californians who live with a mental health condition received the care they need and a tenth of the nearly three million people with a diagnosable SUD received treatment. [xiv] [xv] The COVID-19 pandemic has only exacerbated the state's behavioral health crisis and placed enormous strain on its healthcare delivery system and workforce capacity.[xvi]

California Behavioral Health Workforce

California's behavioral health workforce is comprised of a broad range of professions with different scope of practice and training requirements delivering prevention, treatment, and recovery services for mental health and SUD conditions.[xvii] While some occupations require a license to practice (psychiatrists, psychiatric nurse practitioners, licensed marriage and family therapists, licensed clinical social workers, and licensed addiction counselors), others do not but may require certification (peer support specialists, certified addiction counselors, and community health workers).[xviii] Due to limited data on the state's non-licensed, non-certified, and SUD workforce, Figure 3 shows the percentage breakdown of only actively licensed mental health providers in 2016, where there were more than 83,000 professionals in the workforce.[xix]

Licensed, certified, and non-certified and/or non-licensed providers play a critical part of the behavioral health workforce. For example, whereas a psychiatrist can diagnose and prescribe medications to a patient, a non-licensed or non-certified peer provider can provide culturally competent services that promote engagement, recovery, self-sufficiency.[xx] Therefore, it is important that the state invest in and support all types of providers in any workforce development initiatives.

Figure 3. Actively Licensed Behavioral Health Professionals, 2016



So What?

Addressing workforce shortages in behavioral health is critical for the delivery of care and necessary treatment. Without an adequate supply of qualified professionals, individuals with mental health, SUD, or co-occurring conditions will continue to have limited access to the care they need and deserve. According to the National Alliance on Mental Illness – California, without appropriate treatment, these individuals are at a higher risk for severe illnesses, disability, substance abuse, homelessness, suicide, and hospitalization.[xxi] Untreated behavioral health conditions also have serious economic effects, costing the United States more than 100 billion dollars per year.[xxii] Furthermore, the cost of lost productivity and crime spending related to youth mental illness is $202 billion. Thus, the state's mental health and SUD workforce shortage should be an extremely pressing concern for government officials and policymakers.

DRIVERS OF WORKFORCE SHORTAGES

California's behavioral health workforce crisis is driven by a variety of factors affecting recruitment and retention of mental health and SUD providers. Chief among these factors is the low Medi-Cal reimbursement rates for behavioral health services, with providers indicating that payment does not account for the full cost of delivering services. Furthermore, community organizations that contract with counties to provide mental health services to Medi-Cal beneficiaries have cited excessive paperwork requirements as a major deterrent to retention, often leading to burnout and turnover. A historically underfunded system for SUD services has also contributed to workforce issues in the state.

Driver #1: Low Reimbursement Rates

Reimbursement is the payment made by a health insurer to a provider for services rendered to a patient. In California and much of the nation, low reimbursement rates for health and social services have been well documented as a key driver of the health care workforce shortage.[xxiv] [xxv] For example, providers may be reluctant to accept insurance because of poor payment rates, an issue that may be especially severe in Medicaid, which pays significantly less than Medicare or private insurance.[xxvi] The issue is particularly acute in the public behavioral health systems. On average, the amount behavioral health providers receive for delivering services is lower than that received by primary care physicians. A recent Milliman report shows that behavioral health providers were paid on average more than 20 percent less than primary care physicians in 2017.[xxvii] In California, the average mental health professional is paid $80 to $85 per session.[xxviii]

The California Council of Community Behavioral Health Agencies (CBHA) is a statewide association of more than 70 community nonprofit organizations and businesses that provide mental health and SUD services and programs to nearly 800,000 Californians across the state. According to CBHA, low rates of reimbursement remain a significant concern, as these payments are not enough to cover the actual cost of caring for patients.[xxix] In her public testimony on the state's healthcare workforce during the March 14th, 2022 joint hearing with Assembly Budget Subcommittee #1 on Health and Human Services and Assembly Budget Subcommittee #4 on State Administration, CBHA's CEO Dr. Le Ondra Clark Harvey explained, *"Community based organizations are competing with private health plans…even Amazon, that is paying up to $40 hourly. Imagine getting your SUD certificate or Master's degree in Social Work to work in the public behavioral health system only to be met with low pay and administrative burden such as onerous paperwork…"*[xxx]

Driver #2: Excessive Paperwork Requirements

Another driver of the workforce crisis is the excessive paperwork requirements. In behavioral health care, reporting and documentation are critical to receiving reimbursement for services. However, studies show that excessive paperwork can create an undue burden leaving behavioral health staff feeling detached from clients and resentful with state and federal oversight.[xxxi] Studies also show that excessive paperwork is among the greatest stressors among mental health professionals and is associated with greater emotional exhaustion and job satisfaction.[xxxii]

These findings hold true in California. In 2016, CBHA commissioned a study of required documentation in six counties and compared it to requirements of other states. [xxxiii] In their study, CBHA found that documentation varies from county to county for providers, which means a nonprofit that serves patients from multiple counties must navigate many different sets of forms, and spend even more time being trained to complete the paperwork properly. Not only are the forms different, but there is an excessive amount of paperwork associated with the California's Medi-Cal billing process. For example, CBHA estimated that paperwork consumes 40-50 percent of providers' time to complete, requires many hours of training to complete properly, and is a major driver of provider burnout and attrition.[xxxiv] Nationwide, it takes about six minutes for providers to fill out Medicaid paperwork. In California, providers have the undue burden of about four times the amount of paperwork.

To address the issue of paperwork burden, in 2021, CBHA co-sponsored Senate Bill 293 by Senator Limon. The legislation would require the Department of Health Care Services (DHCS) to convene a stakeholder workgroup to streamline and standardize intake and assessment forms that mental health providers must complete when serving children in the Medi-Cal program. In their June 2021 sponsor letter to the Chair of the Assembly Health Committee, they explained, "*California is suffering from a mental health provider shortage, particularly for pediatric providers, and simply cannot afford to have the providers it does have spending half of their time filling out forms instead of providing clinical services*."[xxxv]

Many "closed-door" discussions took place among county representatives, DHCS leadership, key legislators, and the bill sponsors to determine the future of SB 293, which later died in committee. While DHCS acknowledged the importance of the issue, they believed their California Advancing and Innovating Medi-Cal (CalAIM) initiative would address the provider paperwork burden.[xxxvi] County officials expressed similar views that the bill was unnecessary as upcoming documentation relief proposed under

CalAIM would alleviate the issue.[xxxvii] For more information on Cal-AIM, see the following section, "Workforce Development Efforts."

Driver #3: An Underfunded System for SUD Services

Robust and reliable funding for mental health and SUD services is critical for closing the workforce gap. However, unlike the mental health workforce, the SUD workforce has been historically underfunded, according to the California Council of Community Behavioral Health Agencies (CBHA).[xxxviii] For example, in November 2004, California voters approved Proposition 63, the Mental Health Services Act (MHSA), which imposes a one percent tax on personal income of over $1 million to support the public mental health system.[xxxix] While MHSA funding may be used for mental health issues, the funding cannot be spent on SUD-specific services. Furthermore, in 2009, Medi-Cal spending for mental health was $3.4 billion compared to $167.2 million for substance use treatment.[xl] In addition, Governor Newsom's 2019-2020 state budget included $50 million for mental health workforce development with no specific allotment for the SUD workforce.[xli]

One third of patients receiving treatment for serious mental illnesses in the public mental health system also have a co-occurring SUD and are about six times more likely than those without these conditions to attempt suicide.[xlii] In response to the dire need for SUD services, in 2020 Governor Newsom signed Assembly Bill (AB) 2265, which authorizes counties to use MHSA funds to treat people with co-occurring mental health and SUD.[xliii] Introduced by Assemblymember Quirk-Silva, the bill acknowledges that mental healthcare and SUD treatment are interconnected and critical to an individual's health and wellbeing. However, it is important to note that, unless a mental health patient has a co-occurring disorder, MHSA funds cannot be used.[xliv] This means individuals who have a drug or alcohol addiction problem but without a diagnosed mental health disorder are ineligible for MHSA services.

WORKFORCE DEVELOPMENT EFFORTS

Workforce development refers to the policies, programs, and practices designed to upskill employees and enrich the work environment through education, skills training, and recruitment and retention strategies. As California works to address shortages in the behavioral health workforce, there is consensus among county and state officials and stakeholders that solutions must address all facets of workforce development.[xlv] [xlvi] [xlvii] This section will highlight the recent behavioral health investments in California. The section will also discuss recent legislation and initiatives designed to bolster the workforce and increase access to care.

Mental Health Services Act

Table 1: MHSA Components

MHSA Components
Community Services & Supports (CSS) Outreach and direct services for children, transition age youth (TAY), adults and older adults with the most serious mental health needs
Prevention & Early Intervention (PEI) Prevention services to promote wellness and prevent the development of mental health problems, and early intervention services to screen and intervene in early signs of mental health issues
Capital Facilities & Technology Needs (CFTN) Infrastructure development to support the implementation of the technological infrastructure and appropriate facilities to provide mental health services
Workforce Education & Training (WET) Support to build, retain, and train a competent public mental health workforce
Innovation (INN) New approaches that may improve access, collaboration, and/or service outcomes for all mental health consumers, with a focus on unserved, underserved, and inappropriately served populations

Since its passage by state voters in 2004, the MHSA has provided more than $18 billion to strengthen California's mental health infrastructure and support community mental health services for children, transitional age youth, adults, and older adults.[xlviii] Also known as Proposition 63 or Prop 63, the MHSA places a one percent tax on personal income over one million dollars per year. The purpose of the Act is to address prevention and early intervention while providing the necessary infrastructure, technology, innovation, and training to support the public mental health system.[xlix] As shown in Table 1, these five components together create the MHSA.

Workforce Education and Training Plan

A key component of the MHSA is Workforce Education and Training (WET), which aims to address shortages of skilled professionals serving community mental health. The purpose of WET programs is to build a more diverse mental health workforce that is culturally and linguistically competent, delivers client/family-centered services, and promotes wellness, recovery, and resilience.[l] In 2008, the WET component provided $444.5 million to counties and state departments over a 10-year period to support workforce development programs that provide scholarships, student loan repayment, and training assistance for mental health professionals.[li]

2019 Workforce Expansion

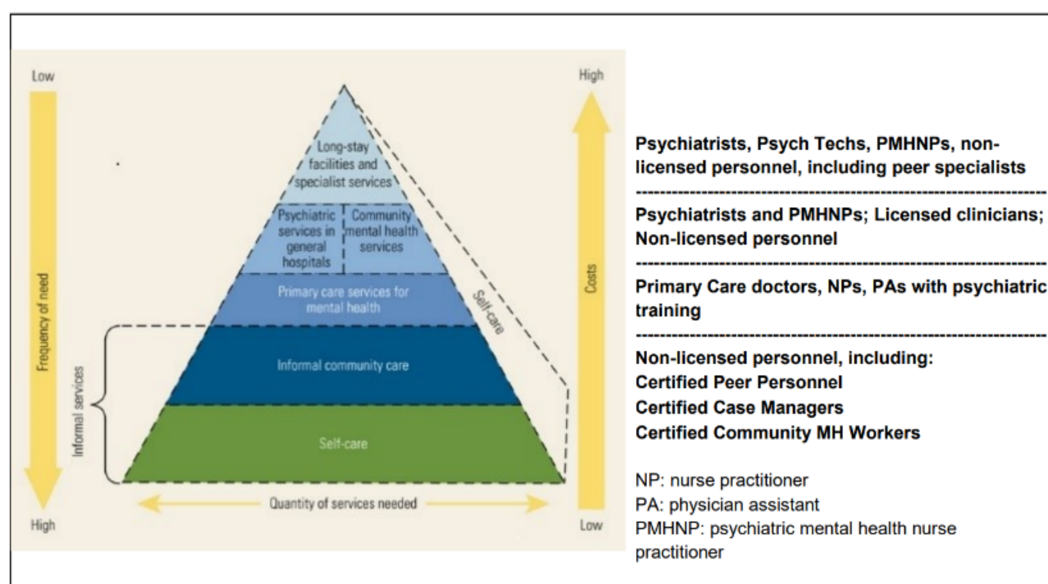
The MHSA mandates the California Department of Health Care Access Information (HCAI) (formerly known as the Office of Statewide Health Planning and Development) to develop a statewide WET Plan to guide efforts every five years to strengthen and expand the public mental health workforce.[lii] However, funding for the first two plans was only allocated for 10 years. Before 2012, the former Department of Mental Health administered the first Five-Year Plan for the program. In the following year, the State Legislature transferred program responsibility to HCAI, which developed the second

Five-Year Plan for 2014-2019 in partnership with the California Behavioral Health Planning Council.[liii] To support implementation of the third Five-Year WET Plan for 2020-2025, Governor Newsom allocated a one-time $60 million in his 2019 Budget Act to HCAI to support and grow the workforce. Through a stakeholder engagement process, the new Plan establishes the following five goals:

1) Increase the number of diverse, competent licensed and non-licensed professionals in the public mental health system to address the needs of persons with serious mental illness.
2) Expand the capacity of the current public mental health workforce to meet California's diverse and dynamic needs.
3) Facilitate a robust statewide, regional, and local infrastructure to develop the public mental health workforce.
4) Offer greater access to care at a lower level of intensity that enables consumers to maintain and maximize their overall well-being.
5) Support delivery of public mental health system services for consumers within an integrated health system that encompasses physical health and substance use services.[liv]

Two key components of the new Plan are its emphasis on supporting efforts that provides care at the lowest level of intensity and investment in utilizing non-licensed professionals throughout the delivery system. Figure 4 depicts this system of care and lists the professions associated with each level of care.[lv]

Figure 4: Public Mental Health System of Care



SB 803 (2020): Peer Support Specialist Certification Program Act

Non-licensed professionals, such as peers, play a vital role in delivering behavioral health services. Peer support has long been recognized as an evidence-based model of care.[lvi] Peers are a growing workforce that mirrors the cultural and linguistic diversity of communities they serve and use their lived experience with recovery from mental health and/or SUD conditions, coupled with specialized training, to assist others on their journey toward recovery. Research has shown that peer support specialists reduce hospitalizations, increase client satisfaction, and alleviate depression and other behavioral health symptoms.[lvii, lviii] In 2007, the federal Centers for Medicare and Medicaid Services authorized states to bill Medicaid (Medi-Cal in California) for peer support services upon the adoption of statewide training and certification standards.[lix]

To expand California's behavioral health workforce, in 2020 Governor Gavin Newsom signed Senate Bill (SB) 803, joining 48 other states in establishing a statewide certification program for peer support specialists.[lx] This means that individuals who are 18 years of age or older are now able to be certified as peer providers. Authored by then state Senator Jim Beall, SB 803 allows the state's 58 counties to invest in peer support services for Medi-Cal patients and seek federal reimbursement to partially cover the cost of hiring peers. SB 803 recognizes the value and benefit of peer support by legitimizing peer support specialists as a critical part of the state's behavioral health workforce.

AB 666 (2022): SUD Workforce Needs Assessment

To address the shortage and lack of diversity within the state's behavioral health workforce that treats substance use disorders (SUD), in March of 2022 Governor Newsom signed Assembly Bill (AB) 666.[lxi] Authored by Assemblymember Quirk-Silva, AB 666 requires the Department of Health Care Services (DHCS) to issue a statewide SUD workforce needs assessment report that evaluates the current state of the SUD workforce, determines barriers to entry into the SUD workforce, and assesses the state's systems for regulating and supporting the SUD workforce.[lxii] In addition, the bill authorizes the Department of Health Care Access and Information (HCAI) to create a SUD workforce development program that includes several program elements, including stipends to cover costs related to testing, registration, and certification and tuition reimbursements for undergraduate and graduate students who complete SUD-related coursework.[lxiii]

Two Key California Initiatives

There are two major state-led initiatives in California that have the potential to significantly improve the behavioral healthcare delivery system and strengthen the behavioral health workforce.

Children and Youth Behavioral Health Initiative

Governor Newsom and the State Legislature have taken crucial steps to improve and expand the state's behavioral health system for children and youth, particularly through the Children and Youth Behavioral Health Initiative (CYBHI). The 2021-22 state budget allocates more than $4 billion over the next five years to transform the system so that all children and youth are regularly screened, supported, and served for mental health and SUD needs.[lxiv] Some key features of the initiative include creating a statewide virtual platform for mental health and SUD services and expanding school-based mental health services.[lxv] Most notable is the component on workforce development, which would expand the workforce including behavioral health counselors and coaches. In the initial behavioral health initiative proposal, this funding would support the training of 10,000 culturally and linguistically competent providers to serve children and youth.[lxvi]

The California Advancing and Innovating Medi-Cal (CalAIM)

Medi-Cal, the state's Medicaid program, provides free or low-cost health coverage for more than 14 million low-income Californians, including people with disabilities, children and their parents, adults, and older adults.[lxvii] Through the California Advancing and Innovating Medi-Cal (CalAIM) initiative, Governor Newsom and the California Department of Health Care Services (DHCS) are taking ambitious steps to improve access to mental health and SUD services. CalAIM is a multi-year effort designed to reform the Medi-Cal program and build a more integrated system of care between physical and behavioral health, and between mental health and SUD. Two key components of the initiative are the goals of reducing administrative burden and aligning reimbursement for behavioral health with physical health.[lxix] DHCS plans to reduce administrative burden and provider burnout by streamlining documentation requirements for mental health and SUD services and developing standardized, statewide assessment tools.[lxx]

POLICY OPTIONS

In its 2018 report, the Healthforce Center at UCSF defines four areas that California should prioritize when addressing its behavioral health workforce shortage: increase supply, reduce geographic maldistribution, increase racial and ethnic diversity, and increase collection and analysis of workforce data.[lxxi] As mentioned in the last section, California has already taken a variety of steps to better support behavioral healthcare and bolster its workforce. In this section, I describe three policy options to further address workforce shortages, focusing on 1) the expansion of peer-to-peer programs to youth and 2) Certified Community Behavioral Health Clinics in California, and 3) additional funding for the 988 Crisis Hotline.

Alternative #1: Expansion of Peer Providers on School Campuses

Under current law (Senate Bill 803), individuals who wish to become peer support specialists must be 18 years of age or older. While SB 803 does not apply to students ages 17 and under, the new law has paved the way for the expansion to adolescents and youth, according to the California Children's Trust (CCT).[lxxii] CCT is a statewide initiative to achieve health equity and healthy development for children, youth, and families in California. In its 2022 report, "*Youth Supporting Youth Expanding Peer-to-Peer Programs in Schools to Address the Growing Youth Mental Health Crisis*," CCT advocates for the expansion of peer-to-peer programs to children and youth ages 14 to 17. Peer-to-peer programs provide many benefits, including but not limited to the following:

- Meet youth where they are, which is in schools,
- Minimize transportation barriers that may exclude students from seeking services,
- Provide a trusted and safe environment,
- Provide culturally and linguistically relevant services,
- Leverage shared experience to foster trust and decrease stigma,
- Provide immediate access to support and personal connection to help better manage stress and mental health concerns.[lxxiii]

New legislation introduced by Assemblymember Cristina Garcia (AB 2124) seeks to achieve many of the goals in the CCT's report. Sponsored by the California Council of Community Behavioral Health Agencies (CBHA), AB 2124 would establish the Pupil Peer Support Training Program to be implemented by the California Department of Education (CDE) and the Superintendent of Public Instruction (SPI) as a competitive

grant program.[lxxiv] Specifically, the bill would encourage school districts, county offices of education, and charter schools to apply for grants to fund peer support training programs at schools for students in grades 9 to 12.[lxxv]

AB 2124 would also require CDE to compile and upload on their website a list of evidence-based peer support programs that applicants may adopt for purposes in compliance with this Program.[lxxvi] The bill would require training and ongoing supervision of any program be conducted by school staff with a Pupil Personnel Services credential. As of the month of April 2022, AB 2124 was heard in the Assembly Committee on Appropriations, which estimated that the bill would cost "at least several million dollars" to provide funding for the grant program.[lxxvii] Because AB 2124 has an annual cost of more than $150,000, the committee ordered the bill to the suspense file. If the bill does not make it out of the suspense file, the bill is considered dead.[lxxviii] Bill sponsors and authors who have strong relationships with the Chair of the Assembly Appropriations Committee may see their bills alive for another day. This is because the chair, to some extent, has the final say on which bills pass and which ones remain on suspense.[lxxix]

Alternative #2: Expansion of Certified Community Behavioral Health Clinics

Figure 5. Nine Required CCBHC Services

Another policy option is the expansion of Certified Community Behavioral Health Clinics (CCBHCs) in California. Established by the 2014 Excellence in Mental Health Act, CCBHCs are a new provider type in MediCaid designed to deliver comprehensive services to individuals with primary care, mental health, and SUD needs, regardless of insurance coverage or ability to pay.[lxxx] As nonprofit clinics, CCBHCs must provide or contract with community-based organizations to deliver nine types of services, as displayed in Figure 5.[lxxxi] This healthcare model addresses financing shortfalls, which have long been a top driver of workforce shortages, by paying clinics at a rate based on the real costs of expanding services to meet demand.[lxxxii] In other words, when behavioral health clinics are properly funded, they can provide more treatment to more patients, particularly those from low-income communities. Today, there are over 430 CCBHCs operating in 42 states, and California is home to 15.[lxxxiii]

The National Council for Mental Wellbeing (National Council) is the unifying voice of over 3,100 mental health and SUD organizations serving more than 10 million children, adults, families across the country.[lxxxiv] Since 2017, National Council has conducted periodic surveys of CCBHCs to better understand their impact. According to their 2021 Impact Report, CCBHCs have supported communities and states in reducing unmet need for care, diverting people in crisis from hospitals, emergency departments, and jails, and expanding the behavioral health workforce. Across all clinics, an estimated 9,000 staff were hired representing an average of 41 new jobs per clinic. Additionally, CCBHCs have improved access to medication-assisted treatment, the gold standard for treating opioid use disorder.

Expanding the CCBHC demonstration program so that any California health center or behavioral health organization can apply to be a CCBHC may be an interest to California policymakers in their efforts to close the workforce and treatment gaps. Despite CCBHCs' positive impacts on the one million lives they serve, the federal grants providing these critical services are set to expire this year. However, Congress has the opportunity to continue and expand CCBHCs by passing the Excellence in Mental Health and Addiction Treatment Act of 2021. Sponsored by California Congresswoman Doris Matsui, the Act would allow every state the option of joining the CCBHC Medicaid demonstration program and authorize investments for current and new CCBHCs.[lxxxviii] The downside is that California will have to wait for Congress to make their decision on the bill. As of July 2021, the Excellence in Mental Health and Addiction Treatment Act was last heard in the House Committee on Energy and Commerce and has been referred to the Subcommittee on Health.

Alternative #3: Additional Funding for the 988 Crisis Hotline

In 2020, then-President Donald Trump signed the National Suicide Hotline Designation Act, establishing "988" as the new three-digit alternative to 911 for suicidal and mental health crisis response.[xc] 988 launches on July 16th, 2022 and will allow Californians to easily access care over the phone from trained mental health professionals at any of the state's 13 call centers.[xci] Before the launch date, California and other states must build the infrastructure to receive and respond to calls.[xcii]

Last year, the California Department of Health Care Services (DHCS) designated $20 million to fund critical infrastructure for the 988 Crisis Hotline.[xciii] However, this amount fell short of what was originally proposed by $30 million that is needed to expand the workforce and provide training.[xciv] California could provide additional funding to fully support and fund its call centers as they prepare for the launch this summer. This funding could help with staffing, technology, and planning. Without a fully funded

infrastructure in place to handle the anticipated tripling of call volume, individuals in crisis may not receive the care they need in a timely appropriate manner that could result in preventive tragedies.[xcv] Five of the 13 call centers in California have membership with the California Council of Community Behavioral Health Agencies (CBHA). According to Dr. Clark Harvey, CEO of CBHA, call centers have seen a 67 percent increase in call volume in recent years, and the COVID-19 pandemic has only exacerbated the mental health crisis.[xcvi]

CONCLUSION

The COVID-19 pandemic has significantly increased the incidence of behavioral health challenges among children, youth, adults, and older adults, making access to services and care more important than ever. At the same time, California struggles to meet the increasing demand for mental health and SUD services due to a shortage of behavioral health professionals. Research shows that by 2028 California will have 41 percent fewer psychiatrists and 11 percent fewer psychologists, licensed marriage, and family therapists (LMFTs), licensed professional clinical counselors (LPCCs), and licensed clinical social workers (LCSWs) than needed to meet the state's behavioral health needs.[xcvii] Solutions for addressing this problem should be multi-faceted and will require strong partnerships and support from the State Legislature, the Office of Governor Gavin Newson, elected officials from all levels of government, and key stakeholders. Additionally, these solutions must place an emphasis on recruiting and retaining workers from racial and ethnic communities as well as lesbian, gay, bisexual, transgender, and queer (LGBTQ) communities because they represent the largest segment of the state's population. Workforce strategies must also consider and uplift other categories such as non-English speaking communities, immigrant and refugee communities, and other communities with the highest needs.

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