CARS CENTER FOR APPLIED RESEARCH SOLUTIONS

2021 CALIFORNIA

BEHAVIORAL HEALTH WORKFORCE ASSESSMENT

EXECUTIVE SUMMARY

Prepared by Center for Applied Research Solutions (CARS) for Advocates for Human Potential and California Department of Health Care Services

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AHP Advocates for Human Potential, Inc.

DHCS California Department of Health Care Services

EXECUTIVE SUMMARY

California's behavioral health workforce is comprised of a broad range of mental health and substance use prevention, treatment, and recovery professionals and paraprofessionals. In Fall 2021, more than sixteen hundred (1,602) members of the behavioral health workforce responded to the California Behavioral Health Workforce Assessment (BHWA) survey, and 66 representatives of peer-run organizations participated in small-group listening sessions.

Respondents represented a wide array of behavioral health workforce settings; professional and educational backgrounds; and racial, ethnic, and cultural communities. Many have lived experience: 35.4% have been a family member or caregiver of a person with behavioral health needs, 32.0% have experienced a personal mental health challenge, 11.9% have experienced a substance use disorder (SUD). In response to the current focus on expanding peer support services and developing peer specialist certification in California, the project had a special emphasis on the peer support community.

Together, the rich data and perspectives gathered from the survey and listening sessions yielded valuable information about the strengths, challenges, and needs of California's behavioral health workforce today—and opportunities for tomorrow.

This assessment is part of the **California Department of Health Care Services (DHCS) Behavioral Health Workforce Development Project (BHWDP)**. The goals of the BHWDP are to expand, elevate, enhance, and empower the behavioral health workforce in every California community. The BHWDP supports multiple peer organization grant initiatives that are funded by DHCS and administered by Advocates for Human Potential (AHP). AHP partnered with the Center for Applied Research Solutions (CARS) for the workforce assessment.

RECOMMENDATIONS & REPORT FINDINGS

Below are key findings and abbreviated recommendations from this data collection effort, as well as relevant policy spotlights. These recommendations are based on the survey responses and focus group data, and they are described in greater detail in section M of this report. Note: DHCS does not endorse or advocate for any particular legislation, funding, or expenditure that is discussed in this section.

» **Recommendation 1.** Support data-driven decision-making and policy by collecting nuanced behavioral health workforce data.

Over the last decade, California has implemented several large-scale, nuanced statewide behavioral health workforce assessments to analyze existing data and expand the data collected. These and other states' workforce assessments have

POLICY AND FUNDING SPOTLIGHT

With the 2021-2022 California state budget, the former Office of Statewide Health Planning and Development (OSHPD) has been expanded and modernized as the Department of Health Care Access and Information (HCAI). This transition includes creating a new California Health Workforce Research Data Center as a central hub of the state's workforce information, updating data programs, and establishing a California Health Workforce Education and Training Council to provide guidance (Department of Health Care Access and Information, 2021).

pointed to significant gaps in the public data about the behavioral health workforce, available services, and quality of services, particularly regarding SUD professionals.[1] Building on this process can yield value and insights to support California's workforce development efforts in the long term.

- Implement the BHWA on a two- to three-year cycle to allow for tracking trends over time. Allocate more time for the BHWA planning, implementation, and analysis process.
- Collect data from provider members and make it publicly available. Consider demographic information, years of experience, employment setting, etc.

» **Recommendation 2.** Create, expand, and strengthen career pathways for racially, ethnically, linguistically, and culturally diverse behavioral health providers.

The majority of respondents are cisgender women (64.4%). There is significant cultural, racial, and linguistic diversity overall: 14.3% of respondents are Black or African American, nearly triple the proportion of adult Californians who are Black (5.3%)[3]; 11.3% identify as LGBQ; and 31.6% are Hispanic or Latino/a/e. Nearly one-third (30.1%) of respondents provide services in a language other than English, predominately Spanish. However, White respondents were more likely than other races to be in counselor, psychologist, physician, or psychiatrist roles, which were the highest-paid professions, while Black respondents were more likely to be in peer or recovery support positions, which were the lowest-paid roles. Additionally, many respondents say that people with Limited English Proficiency were underserved in their community, and few respondents indicate that their organization serves this group.

To reduce health disparities, workforce development strategies should increase the number and proportion of behavioral health providers who are representative of the communities they serve.

- Fund career pipeline programs that support lower-income and racially diverse students and early professionals to join higher-paid behavioral health professions.
- Use focused recruitment, training, and retention efforts to increase the number of non-traditional and community-based behavioral health service providers.
- Provide incentives for providers who offer multilingual services.

POLICY AND FUNDING SPOTLIGHT

As part of California Advancing and Innovating Medi-Cal (CalAIM), DHCS is currently negotiating to authorize Traditional Healers & Natural Helpers for SUD treatment services under DMC-ODS (Drug Medi-Cal Organized Delivery System).[4]

Governor Newsom's 2022-2023 proposed budget includes an investment of $1.7 billion in care economy workforce development.[5] This includes:

- **$350 million for 25,000 new Community Health Workers by 2025**
- **$210 million for social worker training programs, stipends, and scholarships to "create a new pipeline of diverse social workers"**
- **$130 million to support healthcare-focus vocational pathways for English language learners, and $60 million for multilingual health and social work programs**

» **Recommendation 3.** Increase pay and benefits for the behavioral health workforce. Address disparities between peer and non-peer staff.

Across all major behavioral health occupational groups, the most commonly cited negative factor motivating employment plans was wanting or needing higher pay. Among the peer workforce, fewer than half (48.9%) agreed or strongly agreed that their pay is consistent with that of others in the organization who do not have lived experience. During the listening sessions, participants repeatedly called for better pay and benefits, noting that it was hard to recruit peer supporters when people had better pay from retail jobs or were afraid of losing Medi-Cal insurance.

Focus group and survey responses suggest that strategies to raise compensation, such as the following sample strategies, may help address workforce shortages:

- Increase compensation for existing behavioral health staff, raise salary caps in county and state contracts, and increase reimbursements to allow for ongoing wage increases.
- Utilize American Rescue Plan Act (ARPA) funds for both immediate and long-term workforce development needs.
- Ensure parity of benefits, particularly health care, between clinical and peer staff.

POLICY AND FUNDING SPOTLIGHT

California's Children and Youth Behavioral Health Initiative (CYBHI) represents an historic investment of $4.4 billion over five years, initiated in 2021-2022. Funding is spread across multiple California Health & Human Services (CalHHS) agencies, including DHCS. Under the Department of Health Care Access and Information (HCAI), $448 million will be used for Broad Behavioral Health Workforce Capacity projects such as peer support, earn-and-learn (apprenticeship) programs, and pipeline programs. These activities also include recruitment and retention activities that include recruitment incentives, loan repayment, and stipend programs.[6]

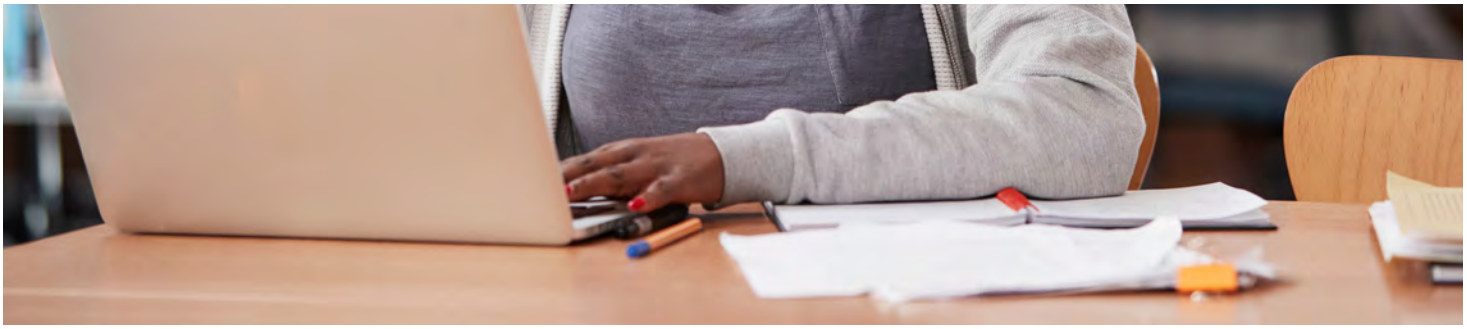
The proposed $1.7 billion investment in the care economy workforce referenced above includes $120 million for psychiatric resident programs and $26 million to build out the SUD workforce, with an emphasis on opioid treatment.

» **Recommendation 4.** Address provider burnout and compassion fatigue. Support parents and caregivers.

Common negative factors motivating employment plans include a lack of support from the organization (need for better pay or benefits, staffing, or family time) as well as burnout or compassion fatigue. Respondents plan to increase their hours, advance their careers, and pursue training or education in the near term (12-month and five-year plans), but many are looking to decrease their hours or retire in the longer term (five to ten years). More than one-third of peers (34.9%) have more than one behavioral health position, compared to 25.9% of survey respondents overall.

- Build awareness about the signs and symptoms, impacts, and mitigating factors of burnout, compassion fatigue, and secondary traumatic stress.

- Implement self-care and wellness supports, connecting spaces, and incentives.
- Offer Employee Assistance Programs (EAP) to connect employees to more intensive supports.
- Implement policies such as flexible scheduling and mental health days.



» **Recommendation 5.** Prioritize supports for unserved, underserved, and inappropriately served communities. Invest in equity-driven strategies and wraparound supports.

Considering community needs, survey respondents selected many of the same groups when asked who their organization focuses on and who is underserved in their community: people experiencing homelessness; Hispanic or Latino/a/e, Black or African American, and LGBTQ people; people with disabilities; and youth and young adults with foster care involvement. Listening session participants identified several needs that were unmet in their community: housing, case management services, harm reduction strategies, services for people who are incarcerated or in reentry, and services for youth and young adults of transition age.

- Continue to fund implementation, evaluation, and replication of culturally responsive and community-defined evidence (CDE) practices; e.g., programs such as the California Department of Public Health initiative, the California Reducing Disparities Project (CRDP).
- Invest in innovative programs to support affordable housing supports and infrastructure. Ensure that “housing first” strategies do not prevent people with behavioral health needs from accessing services.
- Interrupt the cycle of hospitalization and incarceration by supporting affordable housing and reentry supports for individuals experiencing homelessness or justice system involvement.

POLICY AND FUNDING SPOTLIGHT

With the establishment of CalAIM, DHCS is strongly encouraging counties to use Medi-Cal funding for in lieu of services (ILOS) that include housing transition navigation services, housing deposits, and housing tenancy and sustaining services, among others.[7]

CalAIM includes care coordination, SUD treatment services and medication, and other Medi-Cal services for youth and adults transitioning out of incarceration. DHCS is currently negotiating this component of CalAIM with the Centers for Medicare & Medicaid Services.[8]

» **Recommendation 6.** Provide additional training and technical assistance to expand telehealth.

Nearly half (47.8%) of respondents currently use telehealth as a service delivery mechanism. Survey respondents and listening session participants like that telehealth makes services more accessible for many. Three out of five telehealth users (62.8%) even feel that telehealth improves service delivery. However, only 42.0% of current users were confident that they plan to continue utilizing telehealth after the pandemic. Concerns cited include limited access to technology (especially for older adults and people experiencing homelessness) and low comfort with technology.

- Provide clear guidance about telehealth billing parity policies and how they may shift post-pandemic.
- Create learning opportunities for counties and providers to learn about innovative and resource-effective ways that others are engaging communities with limited access to telehealth.
- Educate providers and service recipients about how to use telehealth.

POLICY AND FUNDING SPOTLIGHT

DHCS has committed to permanent Medi-Cal reimbursement parity for an array of services at both video and audio visits. Medi-Cal is unique among state Medicaid programs for its commitment to audio visit payment parity.[9]

In December 2021, the DHCS Medi-Cal Telehealth Advisory Group released a report with policy recommendations to inform the Governor's 2022-2023 budget. These included supporting patients' choice of telehealth and in-person modalities; documentation of patients' consent to telehealth services; and other billing, coding, and monitoring protocols to align telehealth with DHCS' guiding principles.[10] Similarly, California's AB 457 (Protection of Patient Choice in Telehealth Provider Act, under review) would implement a "Telehealth Patient Bill of Rights."

» **Recommendation 7.** Invest in training initiatives and programs that support integration of peers. Include and promote peer voice and leadership.

Both survey respondents and listening session participants identify a lack of awareness of what is unique and valuable about peer support, and how clinicians and peers can effectively collaborate, as barriers to peer integration. Listening session participants stressed the importance of ongoing training and cross-training for both peer support providers and their non-peer colleagues. One in three members of the peer workforce (32.5%) report having a peer specialist or peer supervisory certification. Further, over sixty percent (61.8%) currently hold, are working toward, or plan to pursue certification. Listening session participants expressed excitement about SB 803, under which DHCS is developing peer support specialist certification program and requirements; however, they also expressed concerns, including how and whether peers are being engaged in the planning process.

Similar to focus group participants in Assessing the Continuum of Care for Behavioral Health Services in California, another recent DHCS-funded report, BHWA listening session respondents are strongly interested in integrating peer services across different levels of care (e.g., crisis services, faith-based organizations).[11]

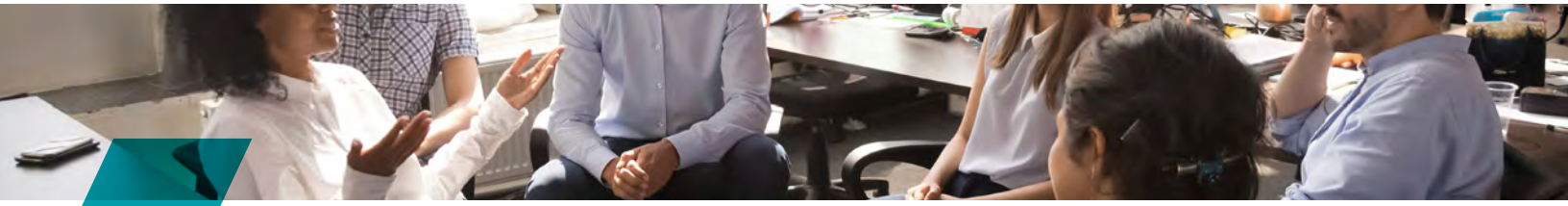
- Continue to authentically engage a broad community of peers in the planning and implementation of SB 803 certification requirements, at both the state and county levels.
- Market and promote widespread awareness of peer support services, training programs, and certification/SB 803.
- Promote cross-training between peers, non-peer clinicians and leadership, and non-peer staff within behavioral health organizations (e.g., on recovery-oriented language for clinicians, on mental health topics for peers).
- In organizations that employ peers, align workplace training, professional development, and responsibilities with certification requirements. Ensure there are career advancement and leadership opportunities for peer specialist and peer support supervisor staff.

POLICY AND FUNDING SPOTLIGHT

Effective July 2022, the new Peer Support Services benefit in Medi-Cal will allow people with lived experience to provide specialty mental health and SUD treatment services in counties that opt-in. Expanding peer support services through increased county funding options may increase not only the size but also the diversity of the peer support workforce.[12]

At the federal level, multiple bills are currently under review that would support the integration of peers in traditional behavioral health services or expand virtual peer support services (Promoting Effective and Empowering Recovery Services in Medicare Act of 2021, PEERS Act; Virtual Peer Support Act of 2021). Vermont, Florida, North Carolina, and Washington have all recently introduced bills to support peer specialist certification as a strategy to expand the behavioral health workforce. [13]

ARPA authorizes an 85% federal funds matching benefit for a Medicaid mobile crisis services benefit, which DHCS will incorporate as soon as January 2023. Additionally, DHCS' new Crisis Care Mobile Units (CCMU) Program is releasing $205 million from county and city behavioral health agencies to expand behavioral health crisis and non-crisis services. This is important because DHCS strongly encourages grant recipients to integrate peers in their crisis response system;[14] peer support is considered an essential component of SAMHSA's best practices for comprehensive crisis care.[15]



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[12] Page 14. Ibid.

[13] See Vermont HB 560, An act relating to the certification of mental health peer support specialists; Florida SB 282, Mental Health and Substance Use Disorders; North Carolina HB 732, Peer Support Specialist Certification Act; and Washington HB 1865, Addressing the behavioral health workforce shortage and expanding access to peer services by creating the profession of certified peer specialists.

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