

Strategies for Addressing California's Rural Behavioral Health Workforce Shortages

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Overview

This brief is designed to provide California decisionmakers with a high-level overview of strategies and available resources to address rural behavioral health (BH) workforce shortages. Drawing on the literature and evidence base, it focuses on practical strategies that rural communities can use to strengthen their BH workforces. Broader implementation factors such as organizational capacity and health system infrastructure are also critical considerations; while beyond the scope of this brief, they are explored further in [“Strengthening the Primary Care Workforce in Rural California”](#). The [accompanying decision guide](#) helps readers consider which approaches may best fit their community's needs and resources.

Rural behavioral health workforce shortages and needs

Like many states, California's rural areas are experiencing significant BH workforce shortages.^{1,2} Recent modeling from the California Department of Health Care Access and Information (HCAI) shows that while the state as a whole lacks sufficient BH professionals, shortages of BH professionals are particularly severe in rural areas and projected to worsen in the coming years.¹

Simultaneously, many rural areas of California experience greater BH needs than urban areas, including higher rates of mental illness, alcohol use, opioid use, youth binge drinking

and depression, and suicide.³ These needs cut across populations, with systemically minoritized populations, people with limited English proficiency, older adults, members of the LGBTQ community, Native Americans, migrant workers, and women at especially high risk.^{3,4,5} Together, these high levels of need and limited workforce capacity leave many rural Californians facing significant access barriers to BH care and services.

Reasons for shortages

These shortages are due to a range of factors. Workers are often dissuaded from practicing in rural areas for financial reasons including lower salaries, lower reimbursement rates, and lack of affordable or desirable housing in rural areas.^{4,5,6} Burnout is another challenge, as rural practitioners often carry higher caseloads and patient panels, and have more complex patients, many of whom enter BH care later and in more distress than their urban counterparts.⁵ Rural health workers also have fewer treatment options for patients and fewer colleagues to consult for support. Additionally, California's existing BH workforce is aging, meaning that many will leave the profession in coming years, and fewer professionals are entering many BH roles, further constraining the future workforce.^{6,7}

Policy initiatives supporting behavioral health workforce development

Several policy initiatives in California have elements designed to address BH workforce challenges, making this a strategic time for communities to pursue solutions. These include the [Behavioral Health Services Act \(BHSA\)](#), [BH-CONNECT](#), the [Children and Youth Behavioral Health Initiative \(CYBHI\)](#), [CalAIM](#), and the state's [Rural Health Transformation Program \(CalRHT\)](#), among others. Numerous strategies highlighted in this brief can be supported through funding, technical assistance, or other opportunities created by these initiatives.

Strategies to increase rural behavioral health capacity

Rural communities can draw on a range of evidence-based and emerging strategies to address BH workforce shortages. The following sections summarize four of the most common approaches: **(1)** expanding who can help address BH needs; **(2)** expanding where BH services are delivered; **(3)** developing the future workforce; and **(4)** recruiting and retaining BH professionals to rural areas. These approaches are not always mutually exclusive and may overlap or reinforce one another in practice. Together, they offer a flexible set of options that can be tailored to local needs and resources to address BH workforce gaps.

Strategy #1: Broadening the workforce

Rural communities can expand BH capacity by drawing on a wider range of health workers and finding new ways to extend the reach of existing BH professionals. The following section highlights several of these strategies.

Enhancing the broader workforce’s behavioral health capabilities

Many rural areas have developed approaches that allow health workers who do not specialize in BH to play a greater role in addressing individuals’ mental health and substance use disorder (SUD) needs. The table below provides examples of this approach.

Table 1: Strategies to Enhance the Broader Workforce’s Behavioral Health Capabilities

Strategy	Description	Considerations
Integrating BH services into primary care teams	Allows primary care teams to deliver an expanded range of BH services such as screening, treatment, medication management [including prescribing medications for opioid use disorder (MOUD)],	Best suited for mild-to-moderate BH conditions; licensed BH expertise recommended for more complex patients. ⁷ Opportunities for training and implementation support for primary care teams include Advanced BH Prevention

Strategy	Description	Considerations
	and collaborative care with remote or co-located BH specialists (e.g. Collaborative Care Model).	California , UC-Irvine's Advanced Training in Primary Care Psychiatry Fellowship and forthcoming BHSA workforce and CalRHT initiatives.
Growing clinicians' BH capabilities through connections to remote specialists	Evidence-based remote support approaches include eConsults, which provide BH specialist consultation on individual cases, and Project ECHO , which grows clinicians' capabilities through education and case-based support from specialists. ^{8,9}	Medi-Cal reimburses eConsults [Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) not eligible]. Increases equitable access to care and may alleviate clinician burnout, but also time- and resource-intensive to implement. ^{8,10}
Leveraging pharmacists to provide BH-supportive services	Pharmacists can provide a range of services that support BH needs and improve outcomes (e.g. patient education, medication management and monitoring, supporting MOUD access). ^{11,12,13}	May be most effective when paired with primary care team collaboration and strong data tools, but current CA pharmacy reimbursement policies create barriers for collaboration in FQHC and RHC settings. ¹⁴
Training existing workers as lay counselors	Provides individuals already serving in helping roles (e.g. case managers, first responders, etc.) with BH counseling skills, allowing them to better support people with BH needs. ^{15,16}	Not currently reimbursable through Medi-Cal or most commercial insurance. California-based Lay Counselor Academy trains a broad range of individuals in mental health counseling approaches and strategies.

Leveraging community-connected roles

Many rural communities have also prioritized going beyond traditional BH workforce roles and developing new ones that can be filled locally and require less extensive training. Individuals in these roles often have deep community roots that allow them to form trusting relationships with patients and are more diverse and representative of the communities they serve than the

traditional BH workforce. The table below summarizes some of these key roles and considerations for utilizing them in rural contexts.

Table 2: Examples of Community-Connected Roles

Role	Description	Considerations
Peer support specialists	Individuals who have lived experience with mental health and/or SUD. Support clients through activities such as teaching self-management skills, advocacy, and navigation support. Can work in a range of clinical and non-clinical settings.	Medi-Cal and Medicare reimbursable; statewide certification required. Support opportunities include HCAI's Peer Personnel Training and Placement Program and the Medi-Cal BH Community-Based Provider Training Program .
Community health workers/promotores/representatives (CHW/P/Rs)	Typically members of the communities they serve, can connect with patients through shared culture and values. Services include patient education, navigation, screenings and assessments, support and advocacy.	Medi-Cal reimbursable. California's statewide CHW/P/R Initiative is investing in expansion of this workforce through training and implementation supports . CalRHT also proposes an extensive focus on growing the CHW/P/R workforce.
Certified wellness coaches (CWCs)	New certified, non-clinical workforce established to support youth BH through services such as wellness promotion, screening, care coordination, individual/group support, and crisis referral. Operate in schools and other youth-serving organizations.	Reimbursable through Medi-Cal and commercial insurance. Scholarships, grants for community colleges available to support development of CWC workforce.

Role	Description	Considerations
Care coordinator/ manager/navigator	Can provide a range of supportive services, including help addressing social needs, coordinating linkages to clinicians and resources, health literacy education, etc.	No certification required, and many community colleges in California offer applicable certificate/associate degree programs in human services or social work. Can be financially supported through a range of pathways, including Enhanced Care Management .

Expanding behavioral health access via telehealth

Telehealth is another widely used and evidence-based strategy to expand BH capacity in rural areas.¹⁷ Medi-Cal reimburses telehealth [at parity](#) with in-person services, and [CalRHT's](#) 'Transformative Care Model' aims to further enhance its role in rural care. However, limited internet and phone connectivity remains a barrier in some rural areas, and telehealth use is lower among some groups (people with limited English proficiency, Asians, Latinos, etc.).¹⁸

Extending the reach of existing behavioral health professionals

Examples of how rural communities can maximize the reach and impact of their existing BH workforce include:

- **Improving access to supervision to support the hiring and licensure of associate-level BH professionals** (e.g., social workers, marriage and family therapists, professional clinical counselors).¹⁹ Evidence in this space is still emerging, but approaches include a recent pilot in a rural California county of [virtual supervision](#) to address the supervision bottleneck, and using HCAI's [Medi-Cal BH Recruitment and Retention Program](#) (MBH-RRP) funds to cover supervision support and certification/licensure costs. This is also a focus area of the [BHSA Workforce Education and Training \(WET\) Plan](#), meaning that additional policy and financial support opportunities in this space may continue to evolve.
- **Leveraging psychiatric mental health nurse practitioners.** [Recent changes](#) to California law now grant these individuals the opportunity to practice without

physician supervision after completing a multiyear transition period. This may remove a barrier that has often kept rural communities (where a local supervising psychiatrist may not exist) from fully using this workforce.²⁰

- **Providing behavioral health professionals with cross-training.** Recognizing that many individuals have co-occurring mental health and SUD conditions, the BHSA WET Plan notes the importance of developing a BH workforce that is cross-trained in both these areas, and signals the state's intention to explore support opportunities in this space. More research on this strategy is needed, but programs such as Project ECHO may offer current avenues for doing so.²¹

Strategy #2: Offering behavioral health services in settings that routinely see people with these needs

Rural communities can also expand access to BH care by offering services in settings that routinely reach people with mental health and SUD needs. Examples include:

- **FQHCs and RHCs.** Co-locating BH specialists and services within FQHCs and RHCs is a widely adopted strategy that allows patients to receive care in settings that are more frequently accessed in rural areas and increases the ability for primary care teams and BH specialists to collaborate and co-manage patients. However, [with a few exceptions](#), California FQHCs and RHCs are only permitted to bill Medi-Cal for *either* a physical health or mental health visit (not both) per member per day.
- **Hospitals and emergency departments (EDs).** These serve as important access points for individuals with (often untreated) BH needs. ED [Bridge Programs](#) equip ED clinicians to initiate MOUD and rapidly connect patients to ongoing SUD treatment. Evidence suggests these are most impactful when they are accompanied by patient navigation and timely access to follow-up treatment.²² Implementation support opportunities include [CA Bridge](#), which offers training and technical assistance to California-based hospitals.
- **Correctional settings.** These are increasingly recognized as a key partner in the BH ecosystem, with particularly strong evidence supporting the provision of MOUD during

incarceration.^{23, 24, 25} CalAIM's [Justice-Involved Reentry Initiative](#) creates a Medi-Cal financing pathway for eligible incarcerated individuals to receive mental health and SUD services and care management for up to 90 days before release, as well as a 30-day supply of medications upon release.

- **Schools.** California's CYBHI creates new opportunities to expand youth access to BH care by providing a statewide reimbursement pathway for services including screening, psychoeducation, counseling/therapy, and care management.

Strategy #3: Developing the future workforce

Developing a sustainable rural workforce also requires investing in the next generation of BH professionals. Strategies in this area seek to grow and strengthen the future workforce through educational, career advancement, training, and work-based opportunities. These approaches may be particularly valuable in rural areas, as individuals who live or train locally are often more likely to practice in these communities after completing their education.^{26,27}

The [BHSA WET Plan](#), [BH-CONNECT Workforce Initiative](#), and CalRHT's proposed 'Workforce Development Initiative' all include components designed to strengthen these workforce pathways.

Examples of strategies to cultivate the future workforce include:

- **Creating educational pathways into BH careers** through partnerships with high schools, community colleges, local universities, and employers to introduce students to BH careers and build the educational credentials needed to enter the field. Examples include [HCAI's Designated Educational Programs](#), which support community colleges in developing certified wellness coach curricula, and regional partnerships in the San Joaquin Valley that connect high schools, technical education programs, and community colleges with local BH employers.^{4,28} Additionally, California may develop future BHSA opportunities to support training programs for licensed BH professionals.
- **Promoting career advancement for existing workers** through opportunities that build skills and support movement into higher-level roles. These strategies are often referenced as particularly valuable for community-connected roles and can also support retention efforts. Examples include creating supervisory and management

pathways, providing mentorship, providing paid time off for staff to pursue further education and training, and providing financial assistance to associate-level clinicians and SUD counselors to complete licensure requirements.^{4,28}

- **Expanding community-based training opportunities, apprenticeships and job placements** to build skills and strengthen connections to local employers. Training support opportunities include BH-CONNECT's [Medi-Cal Behavioral Health Community-Based Provider Training Program](#), which supports training for peers, CHW/P/Rs, and SUD counselors. Apprenticeships allow individuals to receive paid, work-based training while completing educational requirements, while placement programs help ensure those with relevant skills are connected to jobs in rural areas. Support opportunities include HCAI's forthcoming [CWC apprenticeship program](#); CalRHT similarly has proposed both apprenticeship and job placement support initiatives.

Strategy #4: Recruiting and retaining the rural behavioral health workforce

Rural communities often use a variety of financial and professional incentives to recruit and retain a broad range of health care workers, many of which can also be used to strengthen the BH workforce. Many of these tie incentives to commitments to serve in rural areas for a minimum amount of time.

Approaches include:

- **Scholarships and loan repayment programs** to cover educational costs in exchange for serving in urban or rural shortage areas for a set duration. A range of [federal](#) and [state](#) programs exist for this, but there are also examples of [foundation](#), [managed care plan](#), and [local college](#)-supported scholarships in California.
- **Salary incentives** such as higher pay, stipends, and signing and retention bonuses to improve recruitment and reduce turnover.⁴
- **Relocation supports** that reduce the financial barriers to moving to rural communities.

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- **Recruiting international medical graduates for psychiatry positions** through programs such as the [J-1 visa](#) (which prioritizes rural practice sites) and [Licensed Physicians from Mexico](#) programs.

While these types of incentives have benefits, the literature shows that many health workers leave rural areas once their commitment is met, leaving turnover and disruptions in continuity of care as an ongoing challenge in these communities.²⁹

These strategies also do not resolve some of the key underlying factors that make rural workforce retention a challenge, such as high workloads, patient complexity, lack of peer collaborators and limited career advancement opportunities. To strengthen retention, many organizations have invested in strategies such as creating career ladders and lattices (particularly for community-connected roles), professional development and upskilling opportunities, mentorship, and educational supports.^{4,28}

Conclusion

As California continues to invest in BH transformation, strengthening the rural workforce will remain essential to improving access to mental health and SUD care. The strategies highlighted in this brief, including making expanded use of existing workers and resources, bringing BH services into new settings, developing the future workforce, and strengthening recruitment and retention, provide practical opportunities for communities to build workforce capacity. Together, these approaches can help communities improve access to BH services in ways that reflect their local needs, resources, and priorities.

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References

1. Department of Health Care Access and Information. Supply and Demand Modeling for California's Behavioral Health Workforce. Accessed August 2, 2026. [https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-](https://hcai.ca.gov/visualizations/supply-and-demand-modeling-for-californias-behavioral-health-workforce/)
2. Substance Use in California Almanac 2025 Edition. California Health Care Foundation. September 30, 2025. Accessed August 2, 2026. <https://www.chcf.org/resource/2025/09/30/substance-use-in-california-almanac/>
3. California Center for Rural Policy. *California's Rural North: Exploring the Roots of Health Disparities*. Cal Poly Humboldt; 2024. Accessed August 2, 2026. <https://www.humboldt.edu/sites/default/files/ccrp/2026-02/californiasruralnortheexploringtherootsofhealthdisparitiesfinal0.pdf>
4. San Joaquin Valley Regional Market Report 2025. California Health Care Foundation. January 5, 2026. Accessed August 2, 2026. <https://www.chcf.org/resource/2026/01/05/san-joaquin-valley-regional-market-report-2025/>
5. Gale J, Janis J, Coburn A, Rochford H. *Behavioral Health in Rural America: Challenges and Opportunities*. Rural Policy Research Institute; December 2019. Accessed August 2, 2026. <https://rupri.org/wp-content/uploads/Behavioral-Health->

-
- in-Rural-America-Challenges-and-Opportunities.pdf
6. Coffman J. *Building the Future Behavioral Health Workforce: Needs Assessment*. Healthforce Center at UCSF for the County Behavioral Health Directors Association of California; February 2023. Accessed August 2, 2026.
https://static1.squarespace.com/static/5b1065c375f9ee699734d898/t/63e695d3ce73ca3e44824cf8/1676056025905/CBHDA_Needs_Assessment_FINAL_Report_2-23.pdf
 7. Davis JR, Lambert D, Sinha S, Dalton H, Perkins D, Mohatt D. *Rural Mental Health in the United States 2006–2022: An Overview and Annotated Bibliography*. Western Interstate Commission for Higher Education; 2024. Accessed August 2, 2026.
https://www.wiche.edu/wp-content/uploads/2024/05/WCE_RuralMentalHealth_050824_FullDoc.pdf
 8. Thielke A, King V. Electronic Consultations (eConsults): Promising Evidence and Policy Considerations for Implementation. Milbank Memorial Fund; June 2020. Accessed August 2, 2026.
https://www.milbank.org/wp-content/uploads/2020/06/eConsults_Milbank_Report_v3.pdf
 9. Kopelovich SL, Blank J, McCain C, Hughes M, Strachan E. Applying the Project ECHO model to support implementation and sustainment of cognitive behavioral therapy for psychosis. *J Contin Educ Health Prof*. 2024;44(2):137-142.
doi:10.1097/CEH.0000000000000511
 10. Lee MS, Nambudiri VE. Electronic consultations and clinician burnout: an antidote to our emotional pandemic? *J Am Med Inform Assoc*. 2021;28(5):1038-1041.
doi:10.1093/jamia/ocaa300
 11. Cheetham A, Grist E, Nielsen S. Pharmacist-prescriber collaborative models of care for opioid use disorder: an overview of recent research. *Curr Opin Psychiatry*. 2024;37(4):251-257.
doi:10.1097/YCO.0000000000000943
 12. Feng L, Wei G, Lei Z. Pharmacists' contributions to the management of mental health conditions: a comprehensive review. *Ann Pharm Pract Pharmacother*. 2024;4:125-139. Accessed August 2, 2026.
<https://galaxypub.co/storage/files/article/b04d82c2-d9f9-4af1-972b->

28b76e4c9774-

pyRAHUOggM752pGD/sLF9Fo2g2
eyOSJ5.pdf

13. Kono M, Deller S. Rural pharmacies an overlooked piece of the rural health care milieu. *Choices*. 2023;38(2). Accessed August 2, 2026.
https://www.choicesmagazine.org/UserFiles/file/cmsarticle_869.pdf
14. Gustafson DH, Molfenter T, Kunes T, et al. Delivering MOUD to the underserved: how can pharmacies really help? *J Stud Alcohol Drugs*. 2024;85(5):759-764.
doi:10.15288/jsad.24-00150
15. Connolly SM, Vanchu-Orosco M, Warner J, Seidi PA, Edwards J, Boath E, Irgens AC. Mental health interventions by lay counsellors: a systematic review and meta-analysis. *Bull World Health Organ*. 2021;99(8):572-582.
doi:10.2471/BLT.20.269050
16. Strengthening the Behavioral Health Workforce: Evaluation of the Lay Counselor Academy. California Health Care Foundation. April 18, 2025. Accessed August 2, 2026.
<https://www.chcf.org/resource/2025/04/18/strengthening-the-behavioral-health-workforce-evaluation-of-the-lay-counselor-academy/>
17. Substance Abuse and Mental Health Services Administration. *Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders*. SAMHSA Publication No. PEP21-06-02-001. National Mental Health and Substance Use Policy Laboratory, Substance Abuse and Mental Health Services Administration; 2021. Accessed August 2, 2026.
<https://library.samhsa.gov/sites/default/files/pep21-06-02-001.pdf>
18. Tan S. *Telehealth and the Future of Health Care Access in California*. Fact Sheet. UCLA Center for Health Policy Research; October 2023. Accessed August 2, 2026.
<https://healthpolicy.ucla.edu/sites/default/files/2023-09/telehealth-fact-sheet-october-2023.pdf>
19. Buche J, Wayment C, Buckland S, Doyle M, Tibbits M. Reducing behavioral health licensure barriers through supervision incentives. *J Rural Ment Health*. 2026;50(3):157-170. doi:10.1037/rmh0000331
20. DePriest K, D'Aoust R, Samuel L, Commodore-Mensah Y, Hanson G, Slade EP. Nurse practitioners' workforce outcomes under implementation of full practice authority. *Nurs Outlook*.

-
- 2020;68(4):459-467.
doi:10.1016/j.outlook.2020.05.008
21. Votaw VR, Rudolf M, Dragoi I, et al. The use of learning collaboratives to support integrated mental health and opioid use disorder services: lessons from the HEALing Communities Study. *Front Psychol*. 2026;17:1698589.
doi:10.3389/fpsyg.2026.1698589
22. CA Bridge. *Rapid Implementation of Opioid Use Disorder Treatment in the Hospital: Nationwide Toolkit*. CA Bridge; June 2025. Accessed August 2, 2026.
https://bridgetotreatment.org/wp-content/uploads/CA_Bridge_TOOLKIT_Rapid-Implementation-of-Opioid-Use-Disorder-Treatment-in-the-Hospital-Nationwide_June_2025.pdf
23. Jannetta J, Nayak S. Challenges and Opportunities in Jail Reentry: Insights from the Transition from Jail to Community Initiative Expert Advisory Panel: Behavioral Health. National Institute of Corrections; 2026. Accessed August 2, 2026.
<https://nicic.gov/resources/digitalpub/challenges-and-opportunities-in-jail-reentry-insights-transition-jail-0>
24. Friedmann PD, Wilson D, Stopka TJ, et al; MassJCOIN Research Hub. Medications for opioid use disorder in county jails: outcomes after release. *N Engl J Med*. 2025;393(10):994-1003.
doi:10.1056/NEJMsa2415987
25. Evans EA, Wilson D, Friedmann PD. Recidivism and mortality after in-jail buprenorphine treatment for opioid use disorder. *Drug Alcohol Depend*. 2022;231:109254.
doi:10.1016/j.drugalcdep.2021.109254
26. MacQueen IT, Maggard-Gibbons M, Capra G, et al. Recruiting rural healthcare providers today: a systematic review of training program success and determinants of geographic choices. *J Gen Intern Med*. 2018;33(2):191-199.
doi:10.1007/s11606-017-4210-z
27. Henning-Smith C, Fritsma T, Olson AP, Woldegerima S, MacDougall H. Decisions to practice in rural areas among mental health care professionals. *JAMA Netw Open*. 2024;7(6):e2421285.
doi:10.1001/jamanetworkopen.2024.21285
28. Healthforce Center at UCSF. *Paraprofessionals in California's Behavioral Health Workforce*. Healthforce Center at UCSF; February 2023. Accessed August 2, 2026.

<https://healthforce.ucsf.edu/sites/g/files/tkssra14981/files/Paraprofessionals%20in%20California%E2%80%99s%20Behavioral%20Health%20Workforce%20Feb.2023%20revised.pdf>

29. Last BS, Zhu JM. State policy strategies to promote the recruitment and retention of the behavioral health workforce. *Milbank Q.* 2025;103(S1):50-74. doi:10.1111/1468-0009.70013