CALIFORNIA LEGISLATURE

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Joint Informational Hearing:

Assembly Health and Assembly Budget Sub. 1 Committees
Wood and Arambula, Chairs
Subject: Status Hearing on California Mental Health Initiatives
Tuesday, February 28, 2023 - 1:30 to 5:00 p.m.
1021 O Street, Room 1100

Background

INTRODUCTION

The Assembly Health Committee and the Assembly Budget Subcommittee 1 on Health and Human Services are convening this joint hearing to examine the current status of the many, new mental health initiatives established by the State of California to address the mental health crisis occurring throughout the state. The convergence of mental health, homelessness, and substance use disorders has evolved into a humanitarian crisis. This crisis, coupled with the Covid-19 pandemic and the documented affects the pandemic has had on the mental health of Californians, has resulted in an unprecedented demand for mental health services. In response, over the past two to three years, the state has undertaken numerous initiatives to address each of these areas – collectively and individually. While mental health and substance use disorders are both included within the state's definition of behavioral health, the purpose of this hearing is to provide an overview on the status of the newly enacted initiatives aimed specifically at mental health, mental health equity, services, workforce expansion, and treatment capacity.

As previously mentioned, the nexus of mental illness, homelessness, substance abuse, and Covid-19 has raised public awareness of and concern for individuals suffering from mental illness. Public perceptions have changed and continue to change. According to a Harris Poll conducted on behalf of the American Psychological Association in 2019, most Americans harbor positive views about mental health disorders and treatment. A total of 87% of American adults agreed that having a mental health disorder is nothing to be ashamed of while 86% said they believe that people with mental health disorders can get better, and 84% felt that people with

mental illness can lead a normal life. Eighty-six percent also felt that the term "mental illness" carries a stigma with it.

In February 2023, the California HealthCare Foundation (CHCF) released its California Health Policy Survey (survey), conducted for 2022. The survey, conducted annually since 2019 by the CHCF in collaboration with NORC (a nonprofit, public opinion, research center) at the University of Chicago, represents a statewide survey of residents' views and experiences on a variety of health care topics. The survey asked respondents how important they felt it was for the California Governor and Legislature to work on various health care issues. Some key findings of the survey reflected that Californians' top health policy priorities are making sure people with mental health problems get the treatment they need (83%), making sure state and county public health departments have the resources they need (85%), and making sure there are enough doctors, nurses, and other health care providers across California to meet those needs (85%). Further, one in five Californians (21%) report trying to make an appointment for mental health care in the last 12 months. Of those, more than half (53%) report waiting longer than they thought reasonable.

As Californian's have become more aware of the prevalence of mental illness and the status of available treatment, concerns over the societal response to the issue, either because of a lack of readily available services and support systems or the inability to ensure individuals receive the care they need either through voluntary or involuntary means, have escalated.

In response to the growing awareness of the plight of those with mental illness and concerns surrounding the mental health care delivery system, beginning in approximately 2020, the Legislature and Governor responded by investing significant resources to improve the mental health system in California. These initiatives are mostly multi-faceted, multi-year efforts and are currently in the development and implementation phases. As such, it is too soon to assess the effectiveness of these initiatives or to determine whether the comprehensive investment of several billions of dollars and thousands of person-hours across the many initiatives has been "money well spent" and if they have and will improve the mental health status of Californians.

As the Legislature begins a new two-year session, it is important to examine the landscape of ongoing mental health initiatives and assess the impact of these efforts on the agencies, departments, local governments, and stakeholders as they navigate implementation. The intent of this hearing is to level set for members of the Assembly by examining the breadth and scope of ongoing efforts. Speaker Rendon perhaps described the goal of this hearing best when he was quoted in the *Orange County Register*, "I want to make sure that we slow down, and we don't pass reforms on top of reforms without knowing [whether] the stuff we've been doing is effective or not."

PREVALENCE OF MENTAL HEALTH DISORDERS IN CALIFORNIA

In another CHCF publication issued in July 2022 entitled, "Mental Health in California: Waiting for Care, (report)" CHCF reported that nearly one in seven adults (an estimated 4.4 million individuals) statewide experiences a mental illness of some kind. One in 26 (an estimated 1.2 million individuals) has a Serious Mental Illness (SMI) that makes it difficult to carry out daily activities. Additionally one in 14 (an estimated 621,000) children has a Serious Emotional Disturbance (SED) that limits functioning in family, school, or community.
Additional major findings from CHCF's report include:

- California's statewide suicide rate was slightly below the national average, although rates varied in the state by gender, race/ethnicity, and county;
- Close to two-thirds of adults with a mental illness and two-thirds of adolescents with major depressive episodes did not get treatment;
- The prevalence of SMI varied by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% of the federal poverty level.
- The prevalence of SMI among adults ranged by region from highs in Northern and Sierra (4.9%) and San Joaquin Valley (4.8%) to a low in the Greater Bay Area (2.9%). The rate of SED among children in California regions did not vary much by region and hovered between a low of 6.8% (Greater Bay Area) and a high of 7.8% (San Joaquin Valley);
- Rates of SMI among California adults varied considerably among racial and ethnic groups, American Indian and Alaska Native adults experienced the highest rates (6.8%) followed by Blacks (5.3%) and Multiracial (4.9%);
- Females were slightly more likely than males to experience SMI and Californians aged 35-44 had the highest rate of SMI and those 65 and over the lowest rate;
- Adult females were more likely than males to experience serious psychological distress (SPD) (a measure of psychological distress occurring in the past year using a standardized screening tool) with rates for females increasing by 60% from 2015 to 2019; and,
- Rates of SPD for adults who are bisexual gay, lesbian, or homosexual were higher than for adults who are straight or heterosexual.

In perhaps the most recent and damning release of data, the federal Centers for Disease Control and Prevention (CDC) released a "*Youth Risk Behavior Survey 2011-2021*," in which federal researchers characterized teen girls across the United States as being "engulfed in a growing wave of violence and trauma." The survey reflects that nearly one in three high school girls reported in 2021 that they seriously considered suicide – up nearly 60% from a decade ago. Almost 15% of teen girls said they were forced to have sex, an increase of 27% over two years. Moreover, almost three in five teenage girls reported feeling so persistently sad or hopeless

almost every day for at least two weeks in a row that they stopped regular activities – a figure that was double the rate for boys.

The CHCF report demonstrates that people of color, those with low socio-economic status, and the LGTBQI+ community not only have a higher prevalence of mental health disorders but also suffer from the lack of access to and receipt of appropriate mental health treatment. The importance of addressing this inequity is not lost on 64% of respondents to the CHCF survey who indicated that it was extremely or very important for the Governor and the Legislature to reduce differences in health care quality between racial and ethnic groups.

Mental health equity can be defined as the state in which everyone has a fair and just opportunity to reach their highest level of mental health and emotional well-being. According to the CDC's Office of Minority Health and Health Equity's July 12, 2022 report entitled "Prioritizing Minority Mental Health," "Mental health care is important for mental wellbeing, yet many people from racial and ethnic minority groups face obstacles in accessing needed care. These obstacles may include lack or insufficient health insurance, lack of racial and ethnic diversity among mental healthcare providers, lack of culturally competent providers, financial strain, and stigma." These or similar obstacles are also present for the LGTBQIA+ communities and result in higher incidences of mental health issues than for the general population.

BACKGROUND

Systems of Care: Mental health disorders are among the most common chronic illnesses that people face, both in the United States and in California. Mental health treatment and services within California may be provided to individuals either voluntarily or involuntarily. Most mental health services are received voluntarily within community-based settings. Regardless of whether the services occur in an in-patient (hospitalization) or outpatient (community based) setting (group therapy, counseling, etc.), patients who enter treatment voluntarily are more inclined to experience improvement in their mental health condition than those admitted involuntarily. Voluntary hospital admissions are often shorter than involuntary admissions, primarily because the patient is fully engaged in their treatment, more motivated and more cooperative.

Unlike voluntary treatment where the patient is often self-directed to seek treatment and highly motivated to get better, involuntary care is almost always initiated by someone other than the patient and oftentimes against the patient's will. More often than not, a law enforcement officer or a designated mental health professional initiates a 5150 hold (72 hours) under the Lanterman-Petris-Short Act. However, it is not uncommon for family members or friends to seek help for their loved ones by asking they be involuntarily held for purposes of a mental health assessment and treatment if warranted.

The focus of this hearing is voluntary care, the systems providing care, and the new efforts underway to ensure availability and access to appropriate and necessary care.

Regardless of whether an individual is receiving mental health treatment voluntarily or involuntarily, the delivery systems remain the same. As with physical health, there are three primary delivery and payment systems, private insurance (including Covered California), Medicaid (Medi-Cal within California), and private pay (uninsured).

Under California law, behavioral health services are considered essential health benefits and all health plans are required to provide coverage for behavioral health services, including substance use disorders. Additionally, under both Federal and California law, behavioral health services must be offered in such a way as to achieve parity with medical services, ensuring they are covered under the same terms and conditions as other medical conditions – meaning that behavioral health services must achieve parity with medical conditions in areas such as, but not limited to, network adequacy, geographic (time of travel and distance to treatment) and timely access standards (appointment availability), and financial requirements such as copayments and deductibles.

Private Coverage: If an individual has private coverage whether through an individual plan purchased by themselves or a group plan through their employer, they have access to mental health services. Either the individual or the employer pays premiums directly to the plans. Under private pay insurance, beneficiaries access mental health services in much the same way they would regular medical care. They would seek out a mental health provider either directly or through a referral from their primary care provider. These services may be offered through a mental health provider that contracts with the health plan as part of their provider network or through a specialized mental health plan that the primary health care plan has sub-contracted with to provide behavioral health services, (examples of specialized mental health plans include Beacon and Managed Health Network (MHN)). Unlike Medicaid (described below) where care is provided via a two-prong approach based on severity of mental illness, individuals insured under private coverage receive the all their behavioral health benefits through their single plan regardless of the severity of their mental illness.

Medicaid/Medi-Cal: Medicaid is a joint, state and federal program that operates under both federal and state laws and regulations. Federal Medicaid law sets broad requirements for the program and mandates coverage of some populations and benefits, while inclusion of other populations and benefits are optional for the states. States make the operational and policy decisions to determine who is eligible for enrollment, which services are covered, and how payments are set. In California, the state Medicaid program is Medi-Cal. As the primary payer of mental health services, and the program entity responsible for the coverage of nearly one-third of

Californians, the mental health coverage provided under Medi-Cal is a fundamental component of the state's mental health delivery system. California operates its Medi-Cal mental health programs as two separate systems of care - managed care (MCMC) and county special mental health plans (MHPs). MCMC plans provides care to individuals with mild-to-moderate mental illness while the MHPs have responsibility for the SMI and SED populations.

MHPs provide a broad range of specialty mental health services (SMHS) to individuals with a level of mental illness classified as SMI. The delivery of SMHS through MHPs is commonly referred to as a "carve-out." A "carve out" is when services covered by the Medi-Cal program are delivered outside of managed care.

MHPs are responsible for providing SMHS to Medi-Cal beneficiaries who meet SMHS medical necessity criteria. SMHS are delivered through 56 county MHPs (Placer and Sierra counties and Yuba and Sutter counties operate two separate dual-county combined MHPs.) Medi-Cal beneficiaries who meet medical necessity criteria for SMHS are entitled to receive medically necessary SMHS from the county MHP, regardless of whether or not they are enrolled in a MCMC plan. Counties are essentially responsible for providing mental health services to children on Medi-Cal, adults on Medi-Cal with SMI, the bulk of programs provided under the Mental Health Services Act (MHSA) and low-income residents without health insurance coverage (indigent care).

MCMC plans deliver their scope of mental health coverage in different ways and to a population that experiences what is referred to as mild to moderate mental illness. For example, some MCMC plans use a specialized healthcare service plan to administer the mental health benefit, while other plans manage the benefit directly, and one plan contracts with its county behavioral health department.

This two-method delivery system is oftentimes difficult for consumers to maneuver because mental illness is not linear. Individuals may move from a diagnosis of a mild-to-moderate level illness to SMI and back again. For example at any given time, an individual may be managing their illness with the aid of medications and counselling. However, that same individual may also experience a psychotic episode, cease their medication and require hospitalization and as a result, their illness may be reclassified as a SMI. Navigating the two systems to ensure ongoing treatment and care can be burdensome and does not always result in well-coordinated care. Providers within the MCMC and MHP plans may also be different, coordination of treatment may be non-existent and fiscal accountability may or may not be assumed by the appropriate entity.

This lack of fiscal accountability also occurs between private insurance coverage and the county's responsibility to provide care for SMI patients whether they are a Medi-Cal beneficiary or not. A patient may experience the need for care; the county provides it and then later learns there is private insurance. However, recouping the treatment costs from the private insurer is oftentimes difficult with counties eventually bearing the full cost of treatment for individuals with private coverage.

Funding Streams for Public Community Mental Health Services: The funding of community mental health services in California is quite complex and involves multiple, distinct funding streams. To further compound this complexity, each of those funding streams may have specific objectives and requirements tied to its use.

In a report dated August 21, 2019, entitled an "Overview of Public Community Mental Health Services Funding and the MHSA," the Legislative Analyst's Office estimated that in 2017-18, community mental health services funding was approximately $9.8 billion. The source of these funds were provided primarily through the following:

- Federal Funds (primarily Medi-Cal) $4.3 Billion
- MHSA $2.0 Billion
- Local Realignment Revenues $2.7 Billion
- State General Fund $0.8 Billion

Of those funds, approximately $7.9 billion went to county mental health services and $1.9 billion to MCMC and fee-for-service. Thus, about 80% of total funding for community mental health services went to county mental health agencies and the remaining 20% of funding is either paid out directly by the Department of Health Care Services for specific benefits such as psychotropic medications or goes to MCMCs to pay for outpatient therapy for Medi-Cal enrollees (primarily adults) with mild-to-moderate mental illness.

With the exception of some MHSA funding within specific allocations of the MHSA (i.e., prevention and early intervention and innovation) most of these monies support direct patient care.

Infrastructure and Workforce Challenges: The increasing demand for mental health services is not only challenging the existing delivery systems and payment models, but is presenting significant challenges in the area of physical infrastructure and availability of behavioral health workforce.

Despite the growing numbers of individuals experiencing mental illness, few resources were earmarked for infrastructure buildout or behavioral health workforce development over the past 20 plus years. The shortage of available psychiatric facilities, beds and behavioral health workers has reached crisis proportions. Much of the money allocated within the newly enacted mental health initiatives is aimed at remedying these issues in order to improve availability and access to appropriate mental health services.

The CHCF report stated that the number of psychiatric beds per 100,000 population decreased 31% from 1998 through 2017 as 35 facilities either closed or eliminated their psychiatric units. These facilities have not been replaced despite the growing prevalence of mental illness. Additionally, there was significant geographic variation in the availability of beds for psychiatric inpatient care. Twenty-five counties had no adult acute psychiatric beds, and 43 counties had no acute psychiatric beds for children.

Community based housing for those suffering with mild-to-moderate mental illness as well as in-patient beds have reached all-time lows prompting efforts like Project Roomkey and the most recent Behavioral Health Continuum Infrastructure program that are available to cities, counties, tribes, nonprofits, and corporations that offer grant funding which can be used to construct, acquire, or renovate behavioral health facilities.

The availability of a qualified, culturally competent and diverse workforce is a critical factor in ensuring that individuals receive the care and treatment they require. Unfortunately, there is a significant shortage of behavioral health workforce in both mental health and substance use disorder treatment. In a 2018 report commissioned by the CHCF and conducted by the University of California's Healthforce Center entitled, "California's Current and Future Behavioral Health Workforce," a review of extensive data from numerous sources revealed:

- Ratios of behavioral health professionals to population vary substantially across California's regions—the lowest ratios persist in the Inland Empire and San Joaquin Valley.
- African-Americans and Latinos are underrepresented among psychiatrists and psychologists relative to California's population; and Latinos are underrepresented among counselors and clinical social workers.
- Forty-five percent of psychiatrists and 37% of psychologists are over age 60 years and are likely to retire or reduce their work hours within the next decade.
- Wages vary widely across behavioral health occupations, as do the settings in which people are employed. Psychiatrists have the highest mean annual earnings and substance abuse and addiction counselors have the lowest mean annual earnings.
- California's behavioral health trainees are not distributed evenly across the state. There are no residency programs for psychiatrists and no educational programs for psychiatric

mental health nurse practitioners or psychologists north of Sacramento. There are no doctoral programs in psychology in the Central Coast and San Joaquin Valley regions.

- If current trends continue, California will have 41% fewer psychiatrists than needed and 11% fewer psychologists, licensed marriage and family therapists, licensed professional clinical counselors and licensed clinical social workers than needed by 2028. Additional behavioral health professionals will be needed to care for Californians with unmet needs for behavioral health services.

Top recommendations from the report to address this critical shortage included increasing the supply of workers, reducing geographic misdistribution; increasing racial/ethnic diversity; and increasing collection, analysis and dissemination of workforce data. Today, between the Governor's commitment of $1.7 billion specifically for health care economy workforce development, the Children and Youth Behavioral Health Initiative workforce commitment, and other workforce related efforts, over $2 billion has been earmarked for workforce development and expansion with a focus on ethnic/racial and gender equity and the development of community health workers (peer workers).

FOCUS ON MENTAL HEALTH

The focus of the Legislature over the past two to three years has increasingly been on addressing the mental health crisis in California. Numerous new initiatives have been adopted aimed at addressing specific aspects of the crisis including:

- School based mental health services;
- Educational campaigns;
- Provision of housing for individuals suffering from mental illness;
- Requiring mental health services for specific populations;
- Building out the facilities infrastructure to ensure there are sufficient treatment beds; and,
- Increasing the behavioral health workforce; and many more.

Billions of dollars have been committed to improving and transforming the mental health system in California. The following represents a sample of some major (and lessor) efforts across health, housing and education. This is not by any means a comprehensive list but demonstrates the breadth and scope of efforts all envisioned as pieces of the solution. While some of the funds allocated for these programs are ongoing, some programs provide one-time funding with specific goals and timelines for completion in order to create the appropriate support necessary to ultimately provide greater access for those individuals in our state requiring services and supports to live safe and meaningful lives.

- Mental Health Student Services Act (MHSSA)

- Children and Youth Behavioral Health Initiative (CYBHI)
- School Behavioral Health Infrastructure Grants
- Behavioral Health Continuum Infrastructure Program (BHCIP)
- Expansion of the Incompetent to Stand Trial Diversion Program
- Development of Mental Health and Wellness Instructional Resources and Training
- Behavioral Health Workforce Development
- Community Assistance, Recovery, and Empowerment (CARE) Court
- Behavioral Health Bridge Housing
- CalAIM (Medi-Cal) Behavioral Health Initiatives
- 988 Behavioral Health Emergency Crisis Phone Line
- Creation of an Office of Suicide Prevention
- Enhanced Funding for Behavioral Health Oriented Teacher Training
- School Health Demonstration Project
- Community Schools
- Project Cal-Well
- Project Cal-Stop

CONCLUSION

The existing mental health care system in California is an extremely complex and oftentimes difficult system to navigate, making it cumbersome for individuals and the families of those with mental illness to avail themselves fully of the services and benefits offered. It is also a challenge to provide Legislative oversight of a mental health system that lacks integration and clear fiscal and programmatic reporting lines.

It is appropriate for the Legislature to focus its attention on untangling the web of the mental health system and given the many efforts aimed at improving, enhancing and expanding the system to ensure seamless access to comprehensive, appropriate and equitable mental health services for all Californians requiring care.

Because so many Californians demand it, the Legislature has a duty to evaluate the current mental health initiatives not only to modernize the system but most importantly to address the many issues faced by consumers as described in this briefing paper and create a mental health system that is consumer-centered.