Background on Mental Health in California

In California, about 16% of the adult population – an estimated 4 million individuals – have mental health care needs. Of these, approximately 1 million adults have what qualifies as severe mental illness (SMI). More than 7% of California children and adolescents – an estimated 714,000 individuals – suffer from a serious emotional disturbance that limits their ability to participate in daily life activities.\(^1\)

The prevalence of mental health needs among children and adults in California varied by income, with much higher rates of mental health needs at lower income levels. Among children living in households below poverty level (<100% FPL), 1 in 10 suffered from SED.\(^2\)

The prevalence of adults with SMI and children with SED also varied across California counties. In 2013, the highest rates of mental health needs were seen in San Joaquin Valley counties and the lowest rates were seen in the Bay Area.\(^3\) The counties with highest rates of adult SMI (Kings, 6.9%; Madera, 7.0%) tended to also report the highest poverty rates statewide. The inverse was also true: counties with the lowest rates of adult SMI (San Mateo and Santa Clara, 3.0%) usually had the lowest poverty rates.\(^4\) Regions with the highest reported SMI and SED and the highest poverty levels also tended to have the fewest number of licensed mental health providers – psychiatrists, psychologists, clinical social workers, and marriage and family therapists—per capita.\(^5\)

Approximately one half of California adults with mental health needs received some kind of treatment in the past year. However, among the uninsured, mental health treatment was reported by less than one third, suggesting that lack of health coverage remains a fundamental barrier in accessing mental health care.\(^6\) Among California adolescents (0-17 years old) with mental health needs, less than one third reported receiving psychological or emotional counseling.\(^7\) Among younger California children between the ages of 4 and 11, the rate was even lower: 70.8% of children with mental health needs went without treatment despite the fact that 95% reportedly had health insurance and 96% had a usual source of health care.\(^8\) Based on this data, insurance coverage is only one of the many factors impacting access to mental health care. Other obstacles to seeking or receiving care may include limited English proficiency, fear of social stigma associated with mental illness, and limited access to health care providers or lack of culturally and linguistically competent providers.
California’s Public Mental Health Services: Funding and Delivery

California’s public mental health services are funded by three streams of revenue: (1) sales tax from the Realignment ix, (2) Medi-Cal, comprised of federal, state, and county dollars, and (3) revenue from Proposition 63 x. California’s fifty-eight counties also each collect a small amount of revenue from local property taxes, patient fees, and private insurance company payments (totaling $150 million in Fiscal Year 2012-13) to use towards mental health services. xi For FY 2012–13, public spending on mental health services in California was estimated to be $7.76 billion. 90% of these state funds were administered by the counties. xii

Under state law, counties are required to deliver mental health services to individuals with and without Medi-Cal, either through county-owned and operated facilities or through outside contracts with hospitals, clinics, community-based organizations, and private health care providers. In particular regards to individuals without Medi-Cal coverage, counties are required to provide safety-net mental health services targeted towards adults with SMI and children with SED. Despite this state provision, counties are legally permitted to limit access to mental health services among the Medi-Cal ineligible, or provide services only to extent that resources are available after serving Medi-Cal beneficiaries. As a result, there are great disparities across counties in terms of the number of patients without Medi-Cal served, spending per individual, and availability and quality of services provided. (In the past fiscal year, Santa Cruz County spent approximately $8,000 per patient while the San Joaquin Valley counties spent, on average, $2,500—$4,499 per patient. xiii) MHSA revenue continues to be the largest funding source for non-Medi-Cal mental health services delivered at the county level.

Another weakness within California’s mental health service system is the flexible interpretation of “medical necessity” across counties. Under state law, counties are not required to provide Medi-Cal mental health services for individuals who don’t meet the county’s medical necessity criteria. Essentially, even individuals covered under Medi-Cal may be barred from care if their symptoms or mental health needs do not qualify them as sufficiently functionally impaired or disabled.

This coverage gap is partially mitigated by services provided by community health centers (federally qualified health centers and rural health centers) and safety-net services provided by the county. Again, the limitations of safety-net mental health services are many. Lastly, emergency departments are the “safety net of the safety net”—federally mandated to provide necessary treatment to all patients who seek care. However, this is generally a highly-avoided, last resort option for the uninsured, who are often billed for the full cost of their ED visits.

1 Realignment, a term for the transfer of administrative and financial control from the state to counties, was first established in California in 1991 and revamped in 2011. The 2011 Realignment diverted a portion of a 1.0625% state sales tax towards each county’s behavioral health subaccount and
protective services account, increasing county funding for substance abuse programs, the Medi-Cal Mental Health Managed Care Program, Medi-Cal’s Early and Periodic Screening, Diagnosis, and Treatment program, foster care, child abuse prevention and intervention, and adoption services.

Proposition 63, also known as the Mental Health Services Act (MHSA), was passed by California voters in November 2004 and imposed an additional 1% tax on taxpayers’ taxable personal income above $1 million to provide dedicated funding for expansion of mental health services and programs. MHSA revenue provides funds to counties to expand services and develop integrated service plans and innovative programs including prevention, early intervention, education, and training programs. Since 2004, MHSA has generated more than $8.5 billion.

Background on Mental Health Parity Law

The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health plans and health insurers that provide group coverage for mental health/substance use disorders to maintain parity between such benefits and their medical/surgical benefits. Specifically, MHPAEA:

- Provides that financial requirements (such as copays and deductibles) and quantitative treatment limitations (such as visit limits) applicable to mental health or substance use disorder benefits can be no more restrictive than the requirements or limitations applied to medical/surgical benefits
- Expands on the Mental Health Parity Act of 1996 by banning lifetime or annual dollar limits on mental health or substance use disorder benefits that are lower than the lifetime or annual dollar limit imposed on medical/surgical benefits

When it was passed, MHPAEA aimed to ensure that when coverage for mental health and substance use conditions was provided, it was generally comparable to coverage for medical and surgical care. However, it’s important to note that the law never mandated that an insurance plan provide MH/SUD benefits and that under MHPAEA, individual and small group (50 or fewer employees) health insurance policies remained exempt from parity requirements.

The Patient Protection and Affordable Care Act (ACA) aims to significantly expand mental health/substance use disorder coverage and is expected to extend federal parity protections to 62 million Americans. Specifically, ACA:

- Beginning in 2014, the ACA will require that all non-grandfathered small group and individual market plans offer coverage of mental health and substance use disorder services as one of the Essential Health Benefits. Under this provision, 3.9 million Americans currently covered in the individual market and 1.2 million currently covered in the small group market are expected to gain either mental health or substance use disorder coverage or both.
- In addition, the ACA will extend federal parity protections to include the individual and small group markets. This provision will benefit the 7.1 million Americans in the individual market and
23.3 million Americans in the small group market who currently have some mental health and substance use disorder benefits by ensuring that their MH/SUD benefits abide by federal parity law.\textsuperscript{xv}

• Finally, the ACA will extend health insurance coverage to 27 million previously uninsured Americans through private health insurance, the Exchanges, and Medicaid. This newly covered population will have access to Essential Health Benefits, including mental health and substance use disorder services subject to parity requirements.\textsuperscript{xvi}

• In California, four out of five uninsured adults with mental health needs will become eligible for health insurance under the ACA. Of this newly eligible population—approximately half a million individuals—42.2\% (228,500) will gain private coverage through the Exchange and 47.0\% (254,400) will gain public coverage through Medi-Cal.\textsuperscript{xvii}

**Foreseeable Gaps in Coverage under the Affordable Care Act**

As of May 2014, twenty states have chosen to opt out of Medicaid expansion under the ACA, and four states are still debating the decision.\textsuperscript{xviii} In states that do not expand Medicaid, nearly five million uninsured adults will fall into a “coverage gap”—earning too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits. All but locked out of the healthcare system, most of these individuals will remain uninsured and will therefore lack access (or have very limited access) to mental health services.\textsuperscript{xix}

Recent immigrants to the U.S. and undocumented immigrants will also face barriers to accessing mental health care coverage despite the newly outlined provisions of the ACA. Both undocumented immigrants and immigrants with less than 5 years residence in the U.S. remain ineligible under the ACA for Medicaid or Exchange subsidies. This is of particular concern in states like California, in which an estimated 11\% (58,600) of uninsured adults with mental health needs will remain uninsured in 2014 due to immigration status.\textsuperscript{xx}

**Mental Health Workforce Current Legislations and Strategic**

The key measurement of success will be the flow of incoming Mental Health Professionals to ensure the equity and diversity of the service providers. As we prepare this overview of Mental Health the most passion issue is the training mental health workforce. To better understand what at stake following information is review of Mental Health Professionals in California.

The Mental Health Services Act (MHSA) was passed by voters in 2004 to create a transformed, culturally-competent system that promotes wellness, recovery and resilience across the lifespan of age groups such as infants, children, adolescents, transition age youth, and older adults. California’s public mental health system (PMHS) suffers from a critical shortage of qualified mental health personnel to meet the needs of the diverse populations they serve. There are critical issues such as the mal-distribution, lack of diversity, and under-representation of practitioners across disciplines with cultural competencies including consumers and family members with lived experience to provide consumer and family-driven services that promote wellness, recovery,
and resilience.

To address the workforce issues, the MHSA included a Workforce Education and Training (WET) component to develop programs that create a core of mental health personnel that would support the transformation of the public mental health system. In July 2012, following the reorganization of the former California Department of Mental Health (DMH), the MHSA WET programs were transferred to the Office of Statewide Health Planning and Development (OSHPD) which coincided with the completion of the first WET-Five Year Plan (April 2008 to April 2013)

The Office of Statewide Health Planning and Development (OSHPD) formed as Advisory Committee of Mental Health Professionals, Advocates, Academic and Consumer to begin the development of strategic plan to add the questions of Mental Health Workforce.

After a number of Sacramento meetings, Webinars and Focus Groups Forum in Central Valley, Southern and Northern California OSHPD and Advisory Committee analyzed the report and develop a list of key findings. (OSHPD September 2014 Report)

• **Overall, most professions in the public mental health workforce grew from 2006 to 2013, and are anticipated to continue growing from 2014 to 2019.** Observed trends from 2006 to 2013 showed that the total number of mental health workforce increased each year from 2006 to 2013. These trends were forecasted to continue through the next five years for all professions in the public mental health workforce.

• **Rates of growth varied by profession and by provider class.** The number of Registered Nurses was estimated to increase by 50% over the next five year period, corresponding to the highest growth rate of all professions. Conversely, the number of Psychiatrists was estimated to increase by 14% over the same period, corresponding to the lowest growth rate of all professions.

*Of the 19 different types of providers in the public mental health workforce, Marriage and Family Therapists (MFT) comprise the largest share, both in 2013 and for 2019 estimates.* MFTs constituted 46% of the licensed, non-prescribing, clinical class of providers, which was the largest group of providers in 2013. This distribution is forecasted to continue through 2019.

• **Among the Licensed, Prescribing class, Psychiatrists and Physician Assistants comprise the largest share, while Psychiatric Mental Health Nurse Practitioners comprise the smallest share of providers.** Psychiatrists comprised 47% of the licensed, prescribing providers, while Physician Assistants were 51% of the provider class. The highest counts of each profession are located in the Bay Area region, followed by the Southern and Los Angeles regions. Providers in both professions were located mostly in California’s large counties. However, it should be noted that most Physician Assistants practice in non-public mental health settings.
While retirement is a key concern discussed in the literature and identified by counties, reliable estimates about retirement for all mental health professions were difficult to obtain. In the supply projections, the notion of retirement was adjusted for by using proxy indicators to estimate approximate providers’ duration of practice from education to retirement. Based on the supply projections, retirement will not seriously affect the supply of Psychiatrists, MFTs or Licensed Clinical Social Workers (LCSW).

While the Bay Area, Los Angeles, and Southern regions had the largest concentrations of providers in the state, the highest provider-to-population ratios for some professional categories occurred in the Central and Superior regions. This implies that when considering the number of providers relative to the populations of those regions, the Bay Area, Los Angeles, and Southern regions have fewer providers relative to their populations. However, both the Central and Superior regions have counties with rural populations; a rural community will have greater difficulty accessing providers even if they are available.

Federal Policies

The Affordable Care Act (ACA) will spur a significant expansion of mental health services. Title V of the ACA makes provisions for “mental and behavioral health education and training grants to schools for the development, expansion, or enhancement of training programs in social work, graduate psychology, professional training in child and adolescent mental health, and training of non-licensed professionals in child and adolescent mental health.” ACA funding will provide scholarships and loan repayment programs incentivizing pursuit of careers in mental health and entry into the public mental health system. Additionally, ACA funding will support scholarships and loan repayments for disadvantaged students who commit to working in medically underserved areas of the country. Many of these programs are currently scheduled to be administered by the National Health Service and the Health Resources and Services Administration (HRSA). With its many postsecondary educational institutions, California is poised to benefit greatly from ACA provisions encouraging the development and expansion of the public mental health workforce.

Contact Information:
Perfecto Muñoz
Email: perfecto.munoz@berkeley.edu
Phone: (510) 643-5205