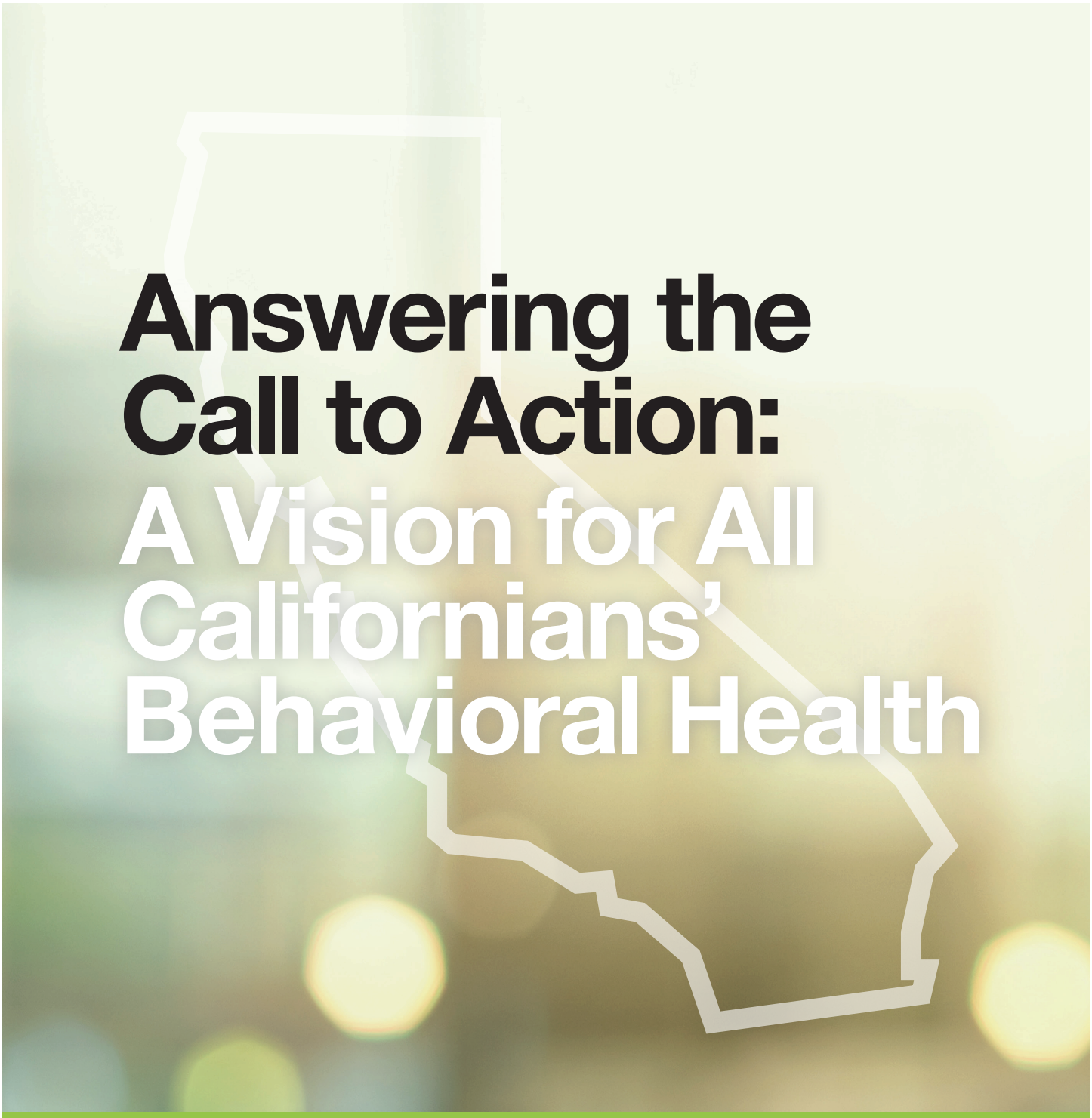


Answering the Call to Action:

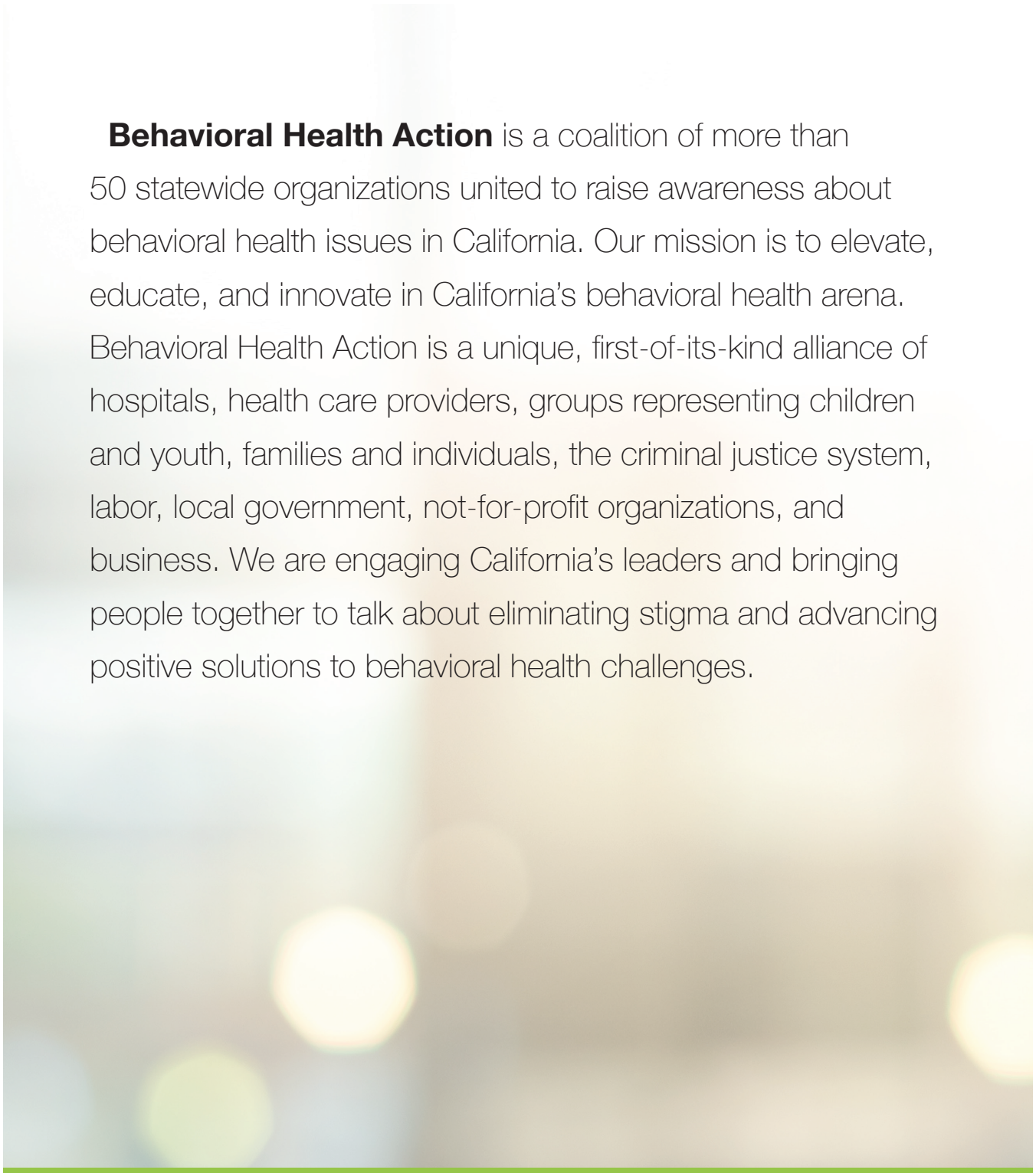
A Vision for All Californians' Behavioral Health

Prepared by

Behavioral Health Action

2021

Behavioral Health Action is a coalition of more than 50 statewide organizations united to raise awareness about behavioral health issues in California. Our mission is to elevate, educate, and innovate in California's behavioral health arena. Behavioral Health Action is a unique, first-of-its-kind alliance of hospitals, health care providers, groups representing children and youth, families and individuals, the criminal justice system, labor, local government, not-for-profit organizations, and business. We are engaging California's leaders and bringing people together to talk about eliminating stigma and advancing positive solutions to behavioral health challenges.



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Introduction

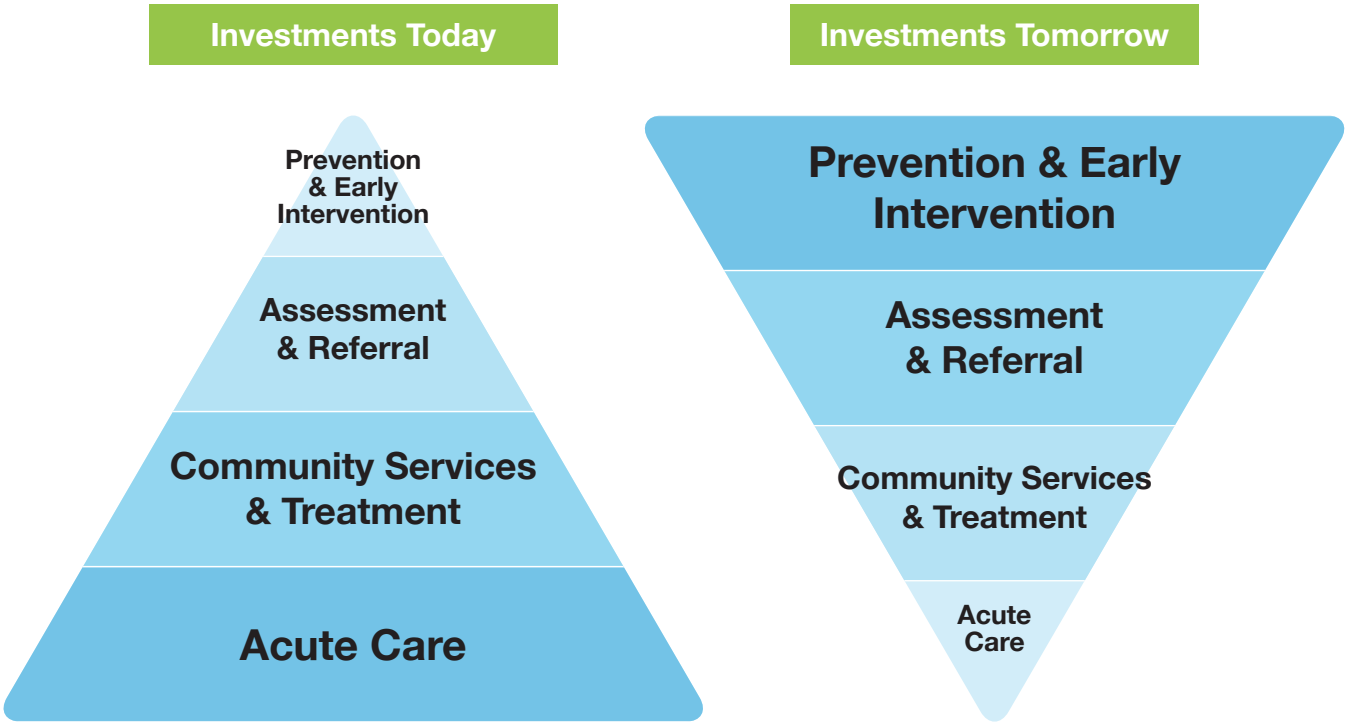
In the early months of 2019, dozens of California's behavioral health leaders — through a coalition of more than 50 organizations known as Behavioral Health Action — began to develop a roadmap to improve behavioral health care in California. This document is the result. It includes:

- A vision for behavioral health care (Page 6)
- Guiding principles to ensure the vision best serves those in need (Page 9)
- A description of a recommended standard of community-based behavioral health care that should be available to all Californians (Pages 11-26)

Underpinning all this work is the fact that California has, to date, invested heavily in reactive responses to behavioral health challenges rather than in prevention and intervention at the earliest opportunities.

To be successful in addressing California's behavioral health crisis, strategies must mirror those made in primary health care, where the goal is to prevent illness and detect early warning signs as soon as possible. By investing in prevention, early intervention, and a continuum of services available in every community, Californians with behavioral health needs can avoid the need for acute care, hospitalization, incarceration, and institutionalization. The graphic below depicts the shift in investments California must make to successfully meet the behavioral health needs of today and tomorrow.

INVERTING THE TRIANGLE



Prologue: The Lessons of COVID-19

Over the past year, Behavioral Health Action has been working to develop a model for behavioral health in California. As this report was prepared for release in early 2020, the COVID-19 public health emergency changed the world — including exacerbating behavioral health challenges by creating new obstacles for those already in distress and increasing the ranks of those who need care.

Across the board, behavioral health needs have skyrocketed.

Having lived with COVID-19 for the better part of a year, we now know that, both statewide and nationally, the number of people who need mental health and substance use disorder care has increased at an alarming rate. Economic insecurity, social isolation, health concerns, the strain of caring for others or working on the front lines — all have taken their toll. Behavioral health care needs have never been greater — for health care workers, families, and children, and those in ethnic and minority communities that have been disproportionally hard hit by the COVID-19 public health emergency.[1]

Families and children are also experiencing a new range of stressors threatening their physical and mental well-being. Job losses, school closures, and caring for loved ones recovering at home are contributing to higher levels of stress, anxiety, and depression. Families who would normally be able to see loved ones in the hospital are now being isolated and disconnected, causing additional levels of anxiety and fear. Finally, losing a family member or friend due to COVID-19 is putting people at a higher risk for prolonged grief.

It is against this backdrop that one in four Americans continues to require behavioral health care, and many more are now experiencing that same need. Nationally, a recent study found that 13.3% of adults reported new or increased substance use as a way to manage stress due to COVID-19. In July, nearly half of Californians reported symptoms of generalized anxiety disorder or major depression since the start of the public health emergency.[2]

For some, the risks are even greater.

While COVID-19 has drastically changed life for nearly everyone, factors such as life stage, socioeconomic and employment status, and family roles have intensified the behavioral health implications for many. Consider:[3]

- More than half of people who lost income or employment report negative mental health impacts. Black and Hispanic adults are more likely than others to say they or someone in their household has lost a job or taken a cut in pay due to the outbreak.[4]
- Lower income people report higher rates of major negative mental health impacts compared to higher income people. More than one-third of adults earning less than $40,000 annually say worry or stress related to COVID-19 has had a major negative impact on their mental health.
- People over 65 report increased anxiety, and parents with children in K-12 schools report concern for their children's social and mental wellness.
- Front-line workers are experiencing high rates of burnout and increased anxiety. A poll in mid-April found that 64% of households with a health care worker said worry and stress caused them to experience at least one adverse effect on their mental health, compared to 56% of the total population.
- For Black Americans, the recent, frequent images and viral videos of police brutality against Black people have compounded the disproportionate impacts of COVID-19. Racial trauma — the distress experienced because of the accumulation of racial discrimination, racial violence, or institutional racism — is having a real effect on Black and Hispanic adolescents and adults.[5]

Change cannot be delayed.

The ideas presented in this report should be understood in tandem with the public health emergency and racial trauma and how significantly they have complicated California's behavioral health care landscape. Demand for care has increased during a time when the number of providers has decreased, and the challenges in delivering care have never been more complex.

We must learn from the 2020 public health emergency, begin the change that will improve peoples' lives — and in the process, better prepare ourselves for future crises that unexpectedly derail the behavioral health of millions of Californians.

Vision

The vision Behavioral Health Action has crafted is ambitious, yet it must be to truly address the decades-old, systemic barriers that currently inhibit strong behavioral health care for all Californians. Our vision:

> *Californians will attain wellness, hope, resilience, and recovery through timely access to a strong continuum of prevention services and behavioral health care that is person-centered, culturally competent, and evidence based.*

To measure our progress in achieving this vision, California should establish a baseline and monitor the goal to improve by at least 10% per year in several key community-level indicators:

- Reduce the delay from the onset of symptoms to engagement in treatment for mental health and substance use disorder needs.
- Reduce the disparities in behavioral health service utilization among racial, ethnic, and sexual orientation/gender identity populations.
- Reduce the proportion of individuals with mental health and substance use disorder needs in jails and prisons.
- Reduce the rate of re-hospitalization following a psychiatric hospitalization.
- Increase the number of children and youth receiving screenings for behavioral health needs.
- Improve the satisfaction of consumers and families with the behavioral health care services they receive.

The Need for a California Behavioral Health Care Standard

In early 2018, Behavioral Health Action members committed to a momentous task: to develop a better way to provide behavioral health care in California. We began to convene a series of meetings to develop recommendations on an ideal continuum of care, crisis services, and ways to address finance and delivery system issues. When the full Behavioral Health Action coalition met to review this work from 2018 and set priorities for 2019, coalition members heard a presentation on a paper published in 1981 that inspired us: "A Model for California Community Mental Health Programs."

That project had been initiated by now retired Assemblymember Thomas H. Bates, who chaired the California Assembly Permanent Subcommittee on Mental Health and Development Disabilities. Following a 1979 subcommittee hearing on the future of mental health in California, Bates and subcommittee members unanimously voted to ask a coalition of mental health providers and consumers to develop a consensus on appropriate mental health care in California. During the two years that followed, a workgroup determined the basic needs for care, which were developed into standards, resulting in a "Model for California Community Mental Health Programs."

After hearing the presentation on the paper, Behavioral Health Action members saw our overdue need to articulate a modern, ideal continuum of care that includes both mental health and substance use disorder services. In this document, we detail a standard of care for behavioral health that should be available to promote the health and well-being of all Californians.

To develop this proposed model, Behavioral Health Action held numerous workgroup meetings and closely reviewed the benefits currently provided through health plans and public programs. We identified numerous areas where coverage varies widely — depending on where an individual resides and the source of their health coverage, rather than on what people need. While many perceive that behavioral health services are primarily the responsibility of state and local government providers, the reality from both from a legal and practical perspective is that the responsibility for Californians' health and well-being is shared by private insurers, health plans, and government.

One in every four Americans experiences a behavioral health challenge in any given year, and half of us will care for someone living with a mental health issue during our lives. However, far **too many Californians still struggle to access a full array of behavioral health care and supports.** According to a 2017 report by the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA):[6]

- **18%** of all adults in California had some level of diagnosable mental illness in the past year and 3.9% had a serious mental illness that caused functional impairment. However, only 11.7% received any mental health services.
- **13.3%** of young Californians ages 12 to 17 had a major depressive episode in the past year and 4.6% had a substance use disorder in the past year.
- **13.2%** of young adults ages 18 to 25 had a substance use disorder in the past year. While 8% of people ages 12 or older needed substance use treatment in the past year, only 10.8% who needed treatment received it.

Despite major improvements in health care coverage over the past decade, substantial discrepancies persist in available behavioral health care among commercial health plans and public programs. Under the Affordable Care Act, Medicaid coverage, individual market plans, and plans offered by small employers are required to offer 10 categories of essential health benefits. These benefits include preventive care, mental health

care, emergency and urgent care, rehabilitation therapy, home health or nursing home care after a hospital stay, prescription drugs, and substance abuse treatment. However, people insured by large employers are not guaranteed these essential health benefits.

Even when commercial plans cover mental health and substance use disorder treatment, they fail to meet many basic quality standards. The California Office of the Patient Advocate's 2020-21 Report Card gave "excellent" five-star ratings to only two of the top 10 health plans for their quality of their behavioral and mental health care.[7] Only three of the 16 plans in the report card met or exceeded the national average percentage of adolescent and adult patients who started treatment services within 14 days of an alcohol or other drug dependence diagnosis. Only two of 16 plans met or exceeded the national average percentage of patients who were seen within seven days after being discharged from psychiatric hospitalization.

For individuals covered by Medi-Cal, federal block grants and state tax revenues fund counties to deliver public behavioral health services to specific target populations. Medi-Cal enrollees whose mental health needs do not severely impair their functioning can access certain outpatient mental health treatment from their Medi-Cal managed care plans. If they need "specialty care," Medi-Cal enrollees access it through counties. With at least two separate health systems to navigate — each which offers different types of care — consumers, families, and health and social service partners can be easily confused, frustrated, and discouraged. And while a wide variety of mental health and substance use disorder treatment services are "covered" in the Medi-Cal program, each service type is not required to be made available on a statewide basis. As a result, some of the most effective outpatient services that reduce hospitalization and incarceration rates are not delivered everywhere in the state.

The importance of addressing disparate, fragmented care for people with behavioral health needs is substantial. As stated in the California Health Care Foundation's *Behavioral Health Integration in Medi-Cal: A Blueprint for California,* "People with behavioral health conditions —mental illness and/or substance use disorder — often experience poor health overall. They are less likely to receive preventive care, have higher rates of major chronic illnesses, and often experience a lower quality of care for their physical health needs. **Those with a diagnosis of serious mental illness or substance use disorder die on average over 20 years earlier than those without such a diagnosis, often from preventable physical illnesses."**

California must turn longstanding practices and investments on their head. **California needs to create a statewide minimum standard for behavioral health care, one that emphasizes prevention and early intervention.** These investments will reduce our state's rates of hospitalization, law enforcement involvement, emergency department visits, out-of-home care, involuntary detention, and conservatorship for people with behavioral health needs.

Guiding Principles

The behavioral health services anyone might receive must be individualized to address each person's unique needs and preferences — but the way services are experienced by clients should be high-quality, appropriate, and effective. The guiding principles below emphasize what is important to Behavioral Health Action as the continuum of services described in this document are delivered.

All services offered should:

1. Prioritize prevention and early intervention strategies to prevent the need for higher levels of care, particularly with children and youth
2. Be provided in a timely manner and in the least restrictive setting possible. For children and youth, this includes services provided to prevent their treatment in out-of-state programs
3. Embrace recovery, resilience, and wellness principles and practices, with a focus on strengthening the individual
4. Involve family members, caregivers, parents, and other natural supports, when appropriate, in treatment decisions and as a critical source of support
5. Be provided in culturally and linguistically competent ways to reduce disparities in access and quality of care
6. Use evidence-based practices when available, but also include "practice-based evidence" of programs and interventions with proven outcomes whether they were part of a formal study or research protocol
7. Respect and promote individuals' rights, including the rights to be treated with respect, dignity, and independence, and to be fully informed
8. Be provided in a trauma-informed way by providers at all levels who have received training and education about trauma's role in behavioral health
9. Be easy to navigate and access, with information readily available through the telephone, internet, and among health insurers and providers

Providers and leaders working as a system should adopt a standard of care for behavioral health, and in doing so they should:

1. Actively seek and utilize input from individuals and families from diverse communities with lived experience, as well as consult with cultural brokers and leaders from underserved communities, when developing behavioral health services and supports
2. Utilize peer providers and community health workers as a key component of the behavioral health workforce and utilize their support throughout the continuum of care
3. Recognize the critical role that families play in the support, recovery, and development of children and adults
4. Overcome and eliminate barriers to providing an integrated care experience for individuals with mental health, substance use disorder, and primary care needs
5. Require collaboration and coordination among the many state-level agencies, commissions, and councils involved in the administration of behavioral health
6. Monitor providers and plans and measure performance to assess the quality of care provided to individuals and families

7. Embrace non-stigmatizing language and practices and make investments in educating and training others in the community to reduce the stigma experienced by individuals and families with behavioral health needs

8. Prioritize and actively seek to coordinate among the local-level governmental health, social service, and justice systems to maximize limited resources

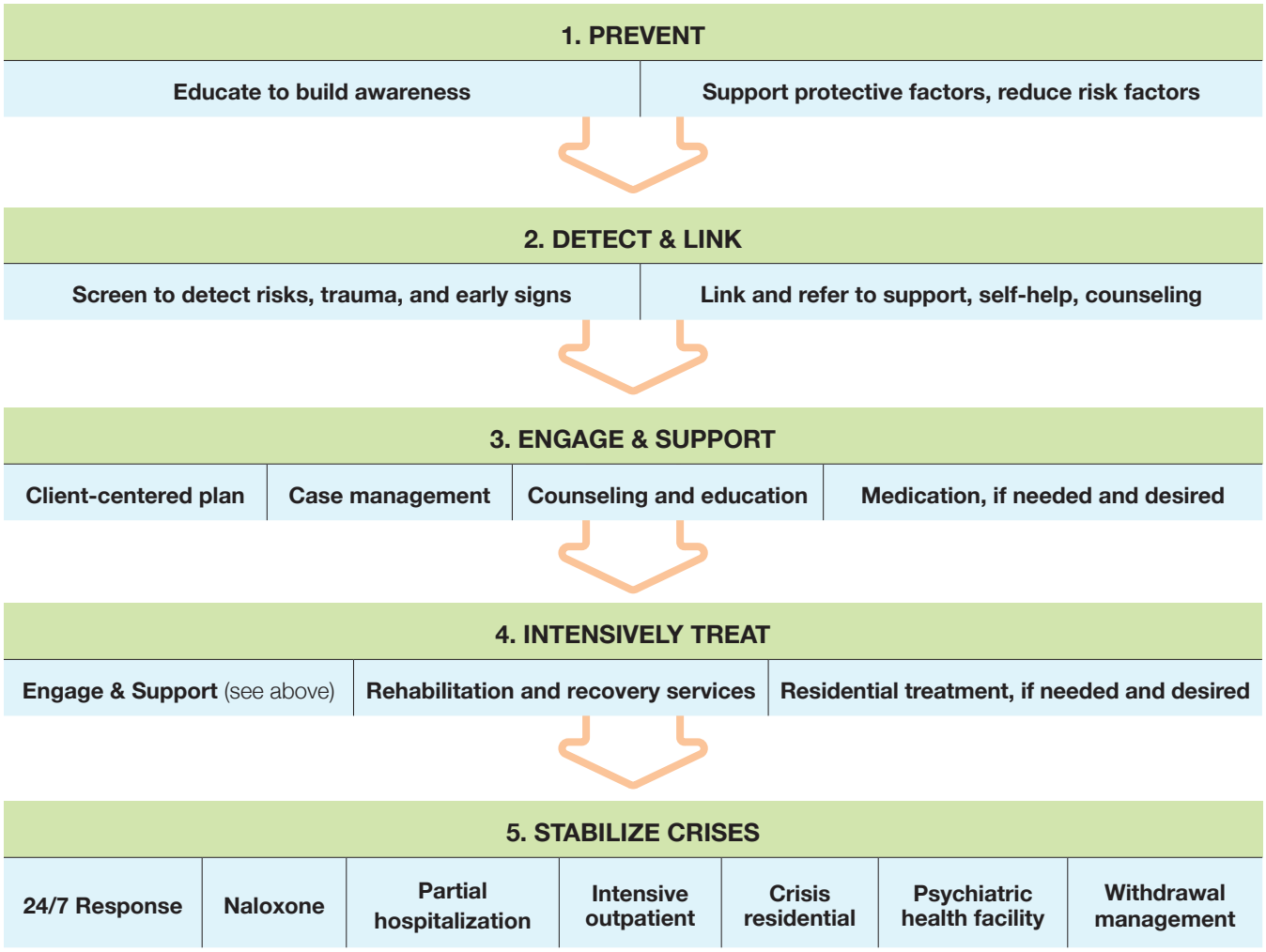
9. Increase opportunities for public and private partnerships, including in designing innovations for behavioral health care, improving data sharing, streamlining referrals, and investing in workforce development

A New Standard for Behavioral Health Care in California

Our proposed standard for behavioral health care gives equal access to a variety of inter-related elements of prevention and care — regardless of where individuals reside and who insures them. This continuum of care is not intended as a menu of optional services from which a health plan or county might choose, but rather a full continuum we should strive to build in every part of the state. This document provides a coherent set of community-based prevention and early intervention strategies, outpatient care, and a range of 24-hour services that reduce hospitalization, institutional and long-term care, and incarceration.

These interlinked strategies share the common goal of promoting recovery so that all Californians achieve health and wellness, live self-directed lives, and strive to reach their full potential. The five core action areas of this community-based standard of behavioral health care are presented below and each component is further described in the rest of this document.

CONTINUUM OF BEHAVIORAL HEALTH INVESTMENTS



1. PREVENT

Whether mental illness or substance use disorders develop depends on a variety of social, biological, and neurological factors. However, since many of those factors are malleable, they can be targeted for prevention and health promotion efforts. Additionally, the Affordable Care Act included prevention as one of the 10 essential health benefits that must be covered by health plans, giving us the opportunity to engage the private sector to invest in behavioral health prevention and early intervention.

Unfortunately, these covered essential health benefits for prevention are currently limited to alcohol misuse and depression screening for adults, postpartum women, and adolescents; developmental screenings for infants and youth; and behavioral assessments for infants and youth. The bulk of behavioral health prevention and early intervention efforts in California have been provided and financed only by county behavioral health departments under the federal Substance Abuse Prevention and Treatment Block Grant (SABG), Drug Medi-Cal Organized Delivery System pilots, and the Mental Health Services Act (Proposition 63 of 2004).

A range of prevention strategies could be implemented statewide in California, with diverse financial support that is broader than the current county behavioral health programs. After all, the savings generated by prevention investments can be enjoyed in both the private and public sectors. By providing public education about behavioral health and addressing key protective and risk factors in every community of the state, California can save lives, reduce suffering, and see a substantial return on its investment. According to 2018 state report on California's use of federal SABG funding, evidence-based prevention strategies have returns on investment of up to 18:1, meaning for every $1 invested in prevention, $18 are saved due to reduced medical costs, increased productivity in work and school, reduced crime, and generally better quality of life.[8]

A. EDUCATE TO BUILD AWARENESS

Educating the public about the early signs of mental health and substance use disorder conditions and how to seek help is an effective public health approach to behavioral health prevention and promotion. Helping individuals learn about the early signs of behavioral health problems, the benefit of receiving treatment, and how to get treatment can help California shorten the time between the first sign of a problem and accessing help. Learning about behavioral health conditions and how common they are can also help reduce stigma and discrimination. However, providing information is not effective as a singular tactic and should be accompanied by additional prevention strategies, such as mentoring and skill building, to reduce risk and foster protective factors discussed next in this document.

Public education about behavioral health can be provided by a variety of entities, including schools, primary care providers, and providers in systems serving vulnerable individuals (e.g., child welfare, probation). Media campaigns that reach millions of people and can change attitudes and behavior are effective when thoughtfully designed and delivered. For instance, a RAND Corporation evaluation of county-funded mental health prevention campaigns in California demonstrated the potential we have to change actions and beliefs in our state.[9] Participants in educational training programs conducted by the National Alliance on Mental Illness reported immediate improvements in knowledge about mental health and attitudes toward people with mental health challenges, including greater willingness to socialize with, live next door to, and work closely with individuals with mental illness. Distressed individuals who were exposed to their "Each Mind Matters" campaign were more likely to seek treatment. The counties' "Know the Signs" campaign reached over half of all adults in California and raised their confidence in intervening with people at risk of suicide.

RAND evaluators suggested that California's progress toward broader goals — including reducing suicide,

improving early receipt of needed services, reducing discrimination, and avoiding some of the negative social and economic consequences associated with mental illness — will require a long-term commitment to a coordinated prevention and early intervention strategy that is continuously informed by population needs, evidence regarding promising and best practices, and indicators of program performance and quality.

In the case of substance use disorder prevention strategies using educational methods, the National Institute on Drug Abuse recommends that prevention programs for elementary school children target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout.[10] For middle or junior high and high school students, prevention programs should increase academic and social competence. Prevention education can include resisting pressure to use drugs, looking at the intent behind advertising about drugs and alcohol, or developing other skills used in making healthy choices.

B. SUPPORT PROTECTIVE FACTORS & REDUCE RISK FACTORS

The evidence for prevention in behavioral health emphasizes how important it is to invest in reducing risk factors and boosting protective factors. According to the U.S. Office of Disease Prevention and Health Promotion:

> *"Health starts in our homes, schools, workplaces, neighborhoods, and communities. … Our health is also determined in part by access to social and economic opportunities; the resources and supports available in our homes, neighborhoods, and communities; the quality of our schooling; the safety of our workplaces; the cleanliness of our water, food, and air; and the nature of our social interactions and relationships. The conditions in which we live explain in part why some Americans are healthier than others and why Americans more generally are not as healthy as they could be."*[11]

Research shows that the risk for mental health problems and substance abuse increases as the number of risk factors increases, and that protective factors may reduce the risk.[12] Risk factors make behavioral health problems more likely to occur, while protective factors reduce their likelihood. Evidence-based strategies to increase protective factors and reduce risk factors in behavioral health are numerous. Fortunately, national databases describe specific programs and service approaches that have been rigorously reviewed and found to be efficacious.[13] Selecting which program or service approach to implement is based on collecting data to understand the needs of the target population and community priorities, and determining readiness and resources needed for organizations that will be involved to establish and sustain an organized prevention effort.

Based on research evidence, the tables below describe the youth risk and protective factors California should target to reduce the incidence of mental health problems and substance use disorders. They are organized by the domain in which they occur — the individual, family, and community levels.

KEY PROTECTIVE AND RISK FACTORS: **MENTAL HEALTH**

	PROTECTIVE FACTORS	RISK FACTORS
INDIVIDUAL	• Positive physical development • Academic achievement/intellectual development • High self-esteem • Emotional self-regulation • Good coping skills and problem-solving skills • Engagement and connections in two or more of the following contexts: school, with peers, in athletics, employment, religion, culture	• Low self-esteem, perceived incompetence, negative explanatory and inferential style • Anxiety • Low-level depressive symptoms and dysthymia • Insecure attachment • Poor social skills: communication and problem-solving skills • Extreme need for approval and social support • Shyness • Emotional problems in childhood • Conduct disorder • Rebelliousness • Early substance use • Antisocial behavior • Head injury • Marijuana use • Childhood exposure to lead or mercury (neurotoxins)
FAMILY	• Family provides structure, limits, rules, monitoring, and predictability • Supportive relationships with family members • Clear expectations for behavior and values	• Parental depression • Parent-child conflict • Poor parenting • Negative family environment (may include substance abuse in parents) • Child abuse/maltreatment • Single-parent family (for girls only) • Divorce • Marital or family conflict • Parent with anxiety or depression • Parental unemployment • Lack of adult supervision • Poor attachment with parents • Family member with schizophrenia • Sexual abuse
SCHOOL, NEIGHBORHOOD, AND COMMUNITY	• Presence of mentors and support for development of skills and interests • Opportunities for engagement within school and community • Positive norms • Clear expectations for behavior • Physical and psychological safety	• Peer rejection • Poor academic achievement, school failure • Community-level stressful or traumatic events • School-level stressful or traumatic events • Community violence • School violence • Poverty • Low commitment to school • Not college bound • Aggression toward peers • Associating with drug-using or deviant peers • Societal/community norms favor alcohol and drug use • Urban setting • Loss of close relationship or friends

KEY PROTECTIVE AND RISK FACTORS: **SUBSTANCE USE DISORDERS**

	PROTECTIVE FACTORS	RISK FACTORS
INDIVIDUAL	• Emotional self-regulation • Secure attachment with parents • Mastery of communication and language skills • Ability to make friends and get along with others • Mastery of academic skills (math, reading, writing) • Following rules for behavior at home, at school, and in public places • Good peer relationships • Positive physical development • High self-esteem • Good coping skills and problem-solving skills • Engagement and connections in two or more of the following contexts: at school, with peers, in athletics, employment, religion, culture	• Difficult temperament • Poor attachment with parents • Poor impulse control • Low harm avoidance • Sensation seeking • Aggressiveness • Anxiety • Depression • Hyperactivity/ADHD • Antisocial behavior • Early persistent problem behaviors • Early substance use • Behavioral disengagement coping • Negative emotionality • Conduct disorder • Favorable attitudes toward drugs • Rebelliousness
FAMILY	• Responsiveness • Protection from harm and fear • Opportunities to resolve conflict • Adequate socioeconomic resources for the family • Language-based, rather than physical, discipline • Extended family support • Family provides structure, limits, rules, monitoring, and predictability • Clear expectations for behavior and values • In early adulthood, balance of autonomy and relatedness to family • In early adulthood, behavioral and emotional autonomy	• Prenatal alcohol exposure • Permissive parenting • Parent–child conflict • Inadequate supervision and monitoring • Low parental warmth • Lack of or inconsistent discipline • Parental hostility • Harsh discipline • Low parental aspirations for child • Child abuse/maltreatment • Substance use among parents or siblings • Parental favorable attitudes toward alcohol and/or drugs • Leaving home in early adulthood

KEY PROTECTIVE AND RISK FACTORS: **SUBSTANCE USE DISORDERS**

	PROTECTIVE FACTORS	RISK FACTORS
INDIVIDUAL	• Support for early learning • Access to supplemental services such as feeding, and screening for vision and hearing • Stable, secure attachment to childcare provider • Low ratio of childcare caregivers to children • Regulatory systems that support high quality of childcare • Healthy peer groups • School engagement • Positive teacher expectations • Effective classroom management • Positive partnering between school and family • School policies and practices to reduce bullying • High academic standards • Presence of mentors and support for development of skills and interests • Opportunities for engagement within school and community • Positive norms • Clear expectations for behavior • Physical and psychological safety • In early adulthood, opportunities for exploration in work and school • Connectedness to adults outside of family	• School failure • Low commitment to school • Peer rejection • Deviant peer group • Peer attitudes toward drugs • Interpersonal alienation • Extreme poverty for those children antisocial in childhood • Associating with drug-using peers • Not college bound • Aggression toward peers • Laws and norms (e.g., advertising) favorable toward substance use • Accessibility/availability of substances

2. Detect and Link

Complementary to the previous section on prevention, screening at the individual level to identify risk factors and then intervening can have long-lasting benefits. Services should be offered as early as possible to children, youth, and adults who are at risk or are showing early signs of a behavioral health need. Intervening early (before high school) is critical, given that patterns of substance abuse become worse in the high school years and individuals who begin using alcohol or tobacco when they are very young are more likely to abuse them later in life, when it becomes much more difficult to quit.[14]

Half of all cases of mental illness begin by age 14, and 75% by age 24. Sometimes decades elapse, unnecessarily, between the first appearance of symptoms and when people get help. According to the National Institute of Mental Health, the average delay between onset of symptoms and intervention is between eight and 10 years.[15]

Trauma can have lasting impacts that affect behavioral health and well-being. A recent study of the impacts of trauma found that childhood trauma is associated with a two- to threefold increase in risk of psychotic experiences.[16] Furthermore, trauma that involves neglect or interpersonal violence appears to be associated with a greater risk of psychotic experiences compared with exposure to unintentional injury, parental loss, or economic adversity. Adolescence is the time when exposure to trauma is most strongly associated with risk of psychotic experiences. According to the World Health Organization, severe mental health disorders often result in increased risk of poverty, unemployment, social isolation, and social stigma. These factors can increase psychological stress and unhealthy behaviors (such as smoking), which in turn increase the risk of chronic illness.

A. SCREEN TO DETECT RISKS, TRAUMA, AND EARLY SIGNS

Substance Misuse

The U.S. Surgeon General's 2016 report on substance use disorders states:[17] "Because substance misuse has traditionally been seen as a social or criminal problem, prevention services were not typically considered a responsibility of health care systems and people needing care for substance use disorders have had access to only a limited range of treatment options that were generally not covered by insurance. Effective integration of prevention, treatment, and recovery services across health care systems is key to addressing substance misuse and its consequences and it represents the most promising way to improve access to and quality of treatment."

Unhealthy Alcohol Use

Excessive alcohol use is one of the most common causes of premature mortality in the United States; in fact, unhealthy alcohol use is the third-leading preventable cause of death in the United States. Alcohol use during pregnancy is also one of the major preventable causes of birth defects and developmental disabilities.[18] These alarming figures present an immense opportunity for California to educate the public, screen individuals of all ages, and provide interventions and referrals at the earliest possible time.

The U.S. Preventive Services Task Force (USPSTF) recommends screening for unhealthy alcohol use in primary care settings in adults 18 or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use. The U.S. Surgeon General, Centers for Disease Control and Prevention, and American Society for Addiction Medicine (ASAM) all recommend routinely screening adults for unhealthy alcohol use and providing them with appropriate interventions, if needed.[19] ASAM and the American College of Preventative Medicine urge all insurers to cover services that target early detection of and intervention for substance use and to do so without burdensome utilization management oversight.[20]

Depression

Depression is now the leading cause of disability worldwide. For children and adolescents with depression, difficulties in performance at school and in interactions with families and peers is common. Additionally, major depressive disorder in children and adolescents is strongly associated with recurrent depression in adulthood, other mental health disorders, and increased risk of suicide.[21]

The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women, citing convincing evidence that treatment using antidepressants, psychotherapy, or both decreases clinical morbidity.[22] Furthermore, USPSTF recommends depression screening in ages 12 to 18 years. The American Academy of Pediatrics' Bright Futures program recommends annual screening in child and adolescent patients for emotional and behavioral problems. Medicaid's child health component, the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, recommends screening to detect physical and mental conditions at periodic, age-appropriate intervals and — if risk is identified — follow up with diagnostic and treatment coverage.

Early Psychosis

Early treatment for adolescents and young adults displaying early symptoms of psychosis increases their chances of a successful recovery and can avert other psychotic episodes from occurring altogether. These signs include, for example, a worrisome drop in grades or job performance, new trouble thinking clearly or concentrating, suspiciousness, paranoid ideas or uneasiness with others, or withdrawing socially. The

National Institute of Mental Health reports that "studies have shown that many people experiencing first episode psychosis in the United States typically have symptoms for more than a year before receiving treatment. It is important to reduce this duration of untreated psychosis because people tend to do better when they receive effective treatment as early as possible."[23] While numerous programs have been shown through rigorous research to be effective, they are not widely available in California. About half the counties have early psychosis programs available to their residents that are typically funded by the Mental Health Services Act; commercial coverage of early psychosis intervention services varies widely.[24]

Trauma and Adverse Childhood Experiences

Trauma-informed screenings for mental health, alcohol, and other substance use concerns for all children, adolescents, and adults with referrals to treatment when needed. Screenings for children and youth should begin early, including during routine pediatrician well-child visits. Screening and identification should also include children's parents, as behavioral health conditions among parents have been shown to increase risk in children.

Screening for adverse childhood experiences (ACEs) should be widely conducted. ACEs describe 10 categories of adversities in three domains (abuse, neglect, household challenges) that individuals may experience by age 18 that can have a long-standing impact on their health and well-being. While protective factors (e.g., trusted and nurturing caregivers, safe and stable environment) can reduce their likelihood, ACEs can trigger toxic stress in the body and affect brain development, hormone and immune systems, and genetic regulatory systems.

The U.S. Centers for Disease Control and Prevention acknowledges that ACEs are common and are associated with many poor health and life outcomes in adulthood. ACEs, such as violence victimization, substance misuse in the household, or witnessing intimate partner violence, have been linked to leading causes of adult morbidity and mortality. Therefore, reducing ACEs is critical to avoiding multiple negative health and socioeconomic outcomes in adulthood. Leading researchers on ACEs and trauma have found:[25]

> *"Exposure to (ACEs) can be traumatic, evoking toxic stress responses that have immediate and long-term adverse physiologic and psychologic impacts. These (experiences) can derail optimal health and development by altering gene expression, brain connectivity and function, immune system function, and organ function. (ACEs) can also compromise development of healthy coping strategies, which can affect health behaviors, physical and mental health, life opportunities, and premature death. (ACEs) have been linked to increased risk for alcohol and substance use disorders, suicide, mental health conditions, heart disease, other chronic illnesses, and health risk behaviors throughout life. (ACEs) have also been linked to reduced educational attainment, employment, and income, which directly and indirectly affect health and well-being. At least five of the 10 leading causes of death have been associated with exposure to adverse childhood experiences, including several contributors to declines in life expectancy."*

Once trauma and/or ACEs are identified, providing appropriate support and treatment can lower long-term health costs and support individual and family wellness and healing.[26] Over the past year, California's Surgeon General, Nadine Burke Harris, MD, and the California Department of Health Care Services (DHCS) have launched the "ACEs Aware" initiative, which includes paying Medi-Cal providers to screen all Medi-Cal enrollees for ACEs .

B. LINK AND REFER TO SUPPORT, SELF-HELP, AND COUNSELING

Once risk factors are detected or screenings reveal the presence of a mental health problem or substance use disorder, it is critical that care providers take swift action.

With children and youth, efforts must include the active engagement of their parents and caregivers. Effective school and community support models, such as high school wellness centers, school-based health centers, on-site school counseling staff, and drop-in centers, can also reach youth as mental health needs arise and prevent them from worsening — particularly for children who have experienced trauma. To ensure a low barrier of access to care, behavioral health services should be fully considered at all points throughout health care systems, particularly in primary care where issues can be discovered early, and interventions can begin early. Additionally, supports to prevent relapse among individuals in recovery from a substance use disorder, such as self-help groups, can prevent the need for higher levels of service.

There is also increasing evidence of the effectiveness of behavioral health interventions delivered by non-specialists in community platforms delivered outside primary care or health care settings. Non-specialist could include leaders of social/recreational venues, libraries, self-help groups, faith-based organizations as well as technology-aided delivery where individuals may have better accessibility, acceptability, affordability, and scalability of services compared to health care facilities. Activities could include awareness raising, psychoeducation, and skills training. Moreover, community services can play a crucial role in promoting mental health awareness, reducing stigma and discrimination, supporting recovery, and social inclusion.

3. Engage and Support

For individuals who have developed a mental health need or substance use disorder that requires engagement in treatment services, this continuum of behavioral health care includes essential elements of effective, outpatient care. It is critical that behavioral health services consider active strategies to engage their clients so that they participate in and return for care.

In a report focused on mental health care engagement, the National Alliance on Mental Illness wrote, “The failure to effectively engage a person early can cause the person to turn away from mental health services and supports. Lack of effective engagement can have serious consequences when a condition gets worse: hospitalization, incarceration, homelessness, and early death. The failure to get timely, effective help often also harms relationships and traumatizes families. Watching a loved one spiral downward leaves those left on the sidelines feeling helpless, powerless and terrified.”[27]

Consider that less than half of people who enter substance use disorder treatment complete it, even as research has shown that engagement in treatment improves treatment outcomes. At the provider level, tackling obstacles to treatment engagement must be a priority. This includes wait times, ease of use, efficacy of treatment used, cost of treatment, outreach, and provider knowledge, attitude, and care coordination capacity.[28]

A. CLIENT-CENTERED PLAN

Treatment plans developed at the start of care should be individualized, culturally congruent, and client centered. To be client centered, the plan should be driven by the goals of the individual (and his or her family members, when appropriate) to address their health care, education, housing, recovery, or wellness services, and social and community supports needs and preferences. More than ever, the health care industry is recognizing the importance of providing “whole person” and integrated care to address the biopsychosocial aspects of an individual’s health. Individuals should receive biopsychosocial assessments and treatment plans that identify and address the multitude of factors that impact overall health.

Treatment plans done in isolation cannot successfully help clients reach their goals. Since treatment plans specify which community resources will be employed to assist clients with their needs and goals, the full continuum of outpatient behavioral health options described in this document must be locally available to draw upon. Case managers — described next — are critical in this respect.

B. CASE MANAGEMENT

The importance of case management cannot be understated. At a minimum, case managers serve as a single point of contact to assist individuals and their families in accessing needed services. They help develop and monitor the client's treatment plan, and they coordinate with the services and other treatment plans that may be underway in other systems (e.g., primary care, school, child welfare, criminal justice).

When clients' needs change, case managers provide encouragement, consistency, and service coordination. Case managers are often the one "constant" in the care experience as individuals navigate different services and systems, and as individuals' needs and goals change over time. They help ensure more intensive treatment is avoided whenever possible.

For children and youth with serious emotional or behavioral health conditions enrolled in Medi-Cal, Intensive Care Coordination services are available to help facilitate collaboration and coordination among mental health and other child-serving systems (e.g., mental health, child welfare, juvenile justice, education).[29]

A dynamic and intensive model of case management called the Full Service Partnership (FSP) provides an augmented set of supports to clients. Expanded in California after passage of the Mental Health Services Act (Proposition 63) in 2004, an FSP provides individuals with a serious mental illness a "whatever it takes" approach to keeping clients healthy and living in the community. With low staff-to-client ratios, FSP case managers are available to clients on a 24/7 basis and can accommodate clients with complex conditions being treated by multiple systems. FSP case managers also have access to flexible funding to support critical aspects of their clients' lives that prevent hospitalization or homelessness, such as rental subsidies and employment support.

Under any case management model, case managers must be able to access the broad array of community-based services articulated in this document to effectively advocate for their clients. For instance, if a client in recovery needs help dealing with a substance use disorder relapse, case managers draw upon their knowledge of available local services that can meet the client's need. When individuals transition from a temporary residential treatment episode, case managers help ensure a safe home is available for their return and arrange for any ongoing support a client may need to stay well. Case managers are the glue that holds a comprehensive treatment system together.

C. COUNSELING AND EDUCATION

Therapy and counseling can help people living with a behavioral health condition manage symptoms and improve their ability to cope. It can help individuals and their families to acquire greater personal, interpersonal and community functioning, and can help them make changes to challenging feelings, thought processes, attitudes, or behaviors. Provided in an individual, family, or group setting, counseling can be provided by licensed or certified therapists or counselors, as well as by peers.

Individualized counseling not only focuses on coping with a mental health condition or reducing drug or alcohol use, but also addresses life areas that may be affected (employment, legal problems, family, and social relationships). In group counseling, the support of peers and the social reinforcement of others modeling how they overcome challenges can be uniquely effective.

Client and family education about behavioral health conditions and how to successfully manage them can also be helpful and empowering. Well-designed "psychoeducational programs" for individuals and families facing mental illness have been shown to reduce relapse and hospital readmission rates, improve involvement in and adherence to treatment, and produce positive outcomes for caregivers, including improved morale, better knowledge of mental illness, enhanced feelings of empowerment, and reduced worry and displeasure about their loved ones.[30]

Since an individual's substance use disorder can affect the entire family, family members benefit from getting educated about addiction and recovery, including how to effectively assist their loved ones through the recovery process. Particularly when provided by people with lived experience or family members, education about behavioral health conditions can be mutually beneficial; it can reduce the sense of being on one's own and diminish feelings of guilt and shame.

D. MEDICATION, IF NEEDED AND DESIRED

Psychiatric medications

Psychiatric medications (also called "psychotropic" medications) affect chemicals in the brain that regulate emotions and thought patterns. These medications are typically more effective when combined with therapy, rather than taken in isolation of other supports. The most common psychiatric medications are antidepressants, anti-anxiety, stimulants, antipsychotics, and mood stabilizers. For some individuals, psychiatric medication might only be taken on a short-term basis (a few months). For others, taking medication can be a long-term or lifelong strategy for maintaining their mental health. As with other prescribed medications, some psychiatric medications cause unpleasant side effects that must be considered when part of a treatment plan.

Medication Assisted Treatment (MAT)

The term "MAT" means utilizing U.S. Food and Drug Administration (FDA)-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. According to SAMHSA, medications commonly used include methadone, buprenorphine, and naltrexone, which reduce or prevent cravings and withdrawal symptoms, and reduce the risk of overdose.[31] MAT is primarily used for the treatment of addiction to opioids (heroin and prescription pain relievers that contain opiates). Additionally, acamprosate may be used to reduce cravings for individuals with alcohol use disorder, and disulfiram deters drinking because combining it with alcohol causes physical illness. Naltrexone is also used for alcohol use disorder since it blocks the euphoric effects and feelings of intoxication. Bolstered by SAMHSA grant funding, California recently initiated a variety of MAT expansion projects and made additional MAT services available to Medi-Cal enrollees in counties participating in Drug Medi-Cal Organized Delivery System pilot projects.[32]

4. Intensively Treat

If prevention and early intervention efforts are unsuccessful in preventing the development of a serious mental health condition or substance use disorder, we must offer an array of intensive treatment services that are available in every community to stem the tide of hospitalizations, arrests, homelessness, and institutionalization for people in need of community-based care.

A. REHABILITATION AND RECOVERY SERVICES

Rehabilitative and recovery services assist individuals (and family members, when appropriate) with a range of needs that impact behavioral health. Rehabilitative and recovery services can be provided anywhere in the

community, including in an individual's or family's residence or at a young person's school. Unfortunately, these services are typically only available to Medi-Cal enrollees and are not commonly included in commercial health plan benefits. These include the following:

- Coaching and life skills training, peer-to-peer services, and relapse prevention support
- Linkages to and support with employment, training, education, and housing
- Family support, linkages to childcare, parent education, child development support, and family/marriage education
- Self-help and community support groups, including activities and programs at cultural and community centers
- Parent and family coaching to build resiliency and help families learn to effectively interact and manage children's behavior, such as Parent-Child Interaction Therapy
- Therapeutic Behavioral Services, which provide short-term and intensive, behaviorally focused services for youth and their family to help build skills to effectively manage challenging behaviors (e.g., aggression, self-injury)
- High-Fidelity Wraparound Services, designed for children with serious emotional or behavioral health diagnoses whose family needs assistance keeping them in their home, school, or community; these services provide a structured, team-based, care-coordination approach.

B. RESIDENTIAL TREATMENT, IF NEEDED AND DESIRED

Residential treatment can be an effective method for treating both mental health and substance use disorders, as well as co-occurring disorders. Residential programs provide a non-institutional, non-medical program in which individuals live on the premises and are supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. However, residential treatment programs cannot effectively help their clients in isolation — they rely heavily on the availability of a continuum of services and supports in the communities to which their clients return.

Transitional Residential Mental Health Treatment for Adults

Transitional residential treatment programs include a range of mental health treatment services and activities, with staff present 24 hours per day, seven days per week. Residential treatment can be an effective alternative to psychiatric hospitalization and involuntary, institutional placements. The length of stay for transitional residential treatment programs ranges from 90 days to one year, depending on the target client population of the program. The programs are licensed by the California Department of Social Services as "Social Rehabilitation" programs. To participate in Medi-Cal, these programs must also be certified by the Department of Health Care Services (DHCS).

Transitional residential treatment is particularly effective intervention for individuals who are "dually diagnosed" with both a severe mental illness and substance use disorder who would benefit from 90 days to six months of structured treatment to address these complex challenges. Transitional residential treatment programs are most effective when they are part of a broader continuum of care, based on recovery principles, and linked to crisis residential treatment (see next section, "Stabilize Crises") and supported housing resources.

Additionally, short-term respite care can be provided by peers in a residential setting. According to the National Empowerment Center, a peer respite is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move

forward. They operate 24 hours per day in a homelike environment. “Peer respites are staffed and operated by people with psychiatric histories or who have experienced trauma and/or extreme states.”[33]

Residential Mental Health Treatment for Children and Youth

When services and supports at home are not possible or have been ineffective, residential treatment can be an effective method for treating both mental health and substance use disorder needs, as well as co-occurring needs, among youth. The primary types of licensed home- and community-based residential treatment for children and youth with mental health conditions in California are briefly described below.

- Short-Term Residential Therapeutic Programs (STRTPs) are licensed residential facilities operated by a public agency or private organization. They provide specialized and intensive care and supervision, services and supports, treatment, and short-term 24-hour care and supervision to children with the most complex and profound needs.
- Children’s Crisis Residential Programs (CCRPs) are licensed by the California Department of Social Services as STRPs and have a mental health program approved by DHCS. CCRPs serve children experiencing an acute mental health crisis as an alternative to psychiatric hospitalization.
- In the Medi-Cal program, Therapeutic Foster Care provides intensive support to foster parents of youth with complex emotional and behavioral needs. Parents meet with a mental health professional regularly and receive a variety of outpatient mental health services. While very limited in California, Community Treatment Facility Services are secured residential facilities providing mental health services to adolescents who are diagnosed as Severely Emotionally Disturbed.

Residential Treatment for Substance Use Disorders

Available to adolescents and adults, residential treatment for substance use disorders can be beneficial to individuals who are at a high risk of experiencing drug or alcohol withdrawal, have experienced a relapse, or have tried a less intensive level of drug or alcohol treatment but were unable to stay sober.

While they can vary in intensity and duration, residential treatment typically provides a 24-hour living support and structure with trained personnel that provide individual and group counseling services. Short-term residential treatment stays are typically 30 days or less, giving individuals a safe and supportive environment to better manage their addiction and make plans to stay sober in the future. In contrast, long-term models, such as the therapeutic community, have planned lengths of stays between six and 12 months. These programs focus on “re-socializing” the individual and use the community of other residents and staff as part of treatment. Treatment is highly structured and focuses on developing personal accountability and responsibility.

Unfortunately, this critical service is unevenly available to Californians who need it: According to DHCS data,[34] close to 80% of California’s 7,713 residential substance use disorder treatment beds are in Southern California and Los Angeles counties – leaving the rest of the state’s residents to compete for scarce local or regional residential treatment capacity.

As with mental health residential programs, it is critical that individuals who leave substance use disorder residential treatment programs stay engaged in outpatient services along the continuum described in this document. Participating in aftercare is effective in reducing the risk of relapse.

5. Stabilize Crises

At times, even individuals with no prior history of a serious behavioral health condition can experience an emotional or behavioral health crisis. A mental health crisis is described as a non-life-threatening situation during which an individual exhibits extreme emotional disturbance or behavioral distress, is disoriented or out of touch with reality, has a compromised ability to function, or is otherwise agitated and unable to be calmed. In the case of substance use disorders, a crisis may occur if an individual has a relapse, or if an unforeseen event or circumstance presents an imminent threat of relapse. The range of services described in this document are effective — sometimes lifesaving — for individuals in crisis and can often avert the need to treat an individual in a more costly and restrictive inpatient hospital setting.

According to SAMHSA, "The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes."[35]

The services described below are critical to make available on a statewide basis if California is to be successful in preventing unnecessary hospitalization, arrests, overdose deaths, and suicide.

A. 24/7 RESPONSE

Crisis response services available on a 24-hour, 365-days-a-year basis are provided through a variety of mechanisms, including crisis hotlines, mobile crisis teams that may include specially trained law enforcement, or simply a process for making urgent treatment appointments. These services offer important opportunities to safely divert individuals to stabilizing treatment, rather than hospitalization or arrest. Currently, they are primarily offered and financed through government programs and not covered by commercial health plans.

Crisis intervention services can be provided by clinicians anywhere in the community (e.g., at home, at school, on the street) when an immediate response is needed. As part of crisis intervention services, a clinician provides an assessment of an individual to determine if there is a need for inpatient psychiatric hospitalization or if they can safely remain in the community with access to appropriate outpatient care.

Crisis intervention services can be delivered in conjunction with law enforcement who encounter individuals with behavioral health needs to develop and implement alternatives to arrest and incarceration. Many crisis intervention services can also be used as an alternative to a law enforcement response. Additionally, crisis stabilization services provide mental health care in a licensed health care facility to avoid hospitalization. Some communities have established Crisis Stabilization Units to offer residents, ambulances, and law enforcement a safe alternative to hospital emergency departments or to avoid making a criminal arrest.

The National Suicide Prevention Lifeline is a long-standing resource providing suicide prevention and mental health crisis assistance (800-273-TALK/8255) and also offers support through online chats. Recent federal legislation was enacted to establish "988" as the new, nationwide, three-digit phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors. By July 16, 2022, all phone service providers must direct 988 calls to the existing National Suicide Prevention Lifeline.[36]

B. NALOXONE

Naloxone is a medication approved by the FDA to prevent overdose by opioids such as heroin, morphine, and oxycodone. It blocks opioid receptor sites, reversing the toxic effects of an overdose. Naloxone is administered when

a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or intravenous injection. A doctor can prescribe naloxone to patients who are in MAT, especially if an individual is taking medications used in MAT or is considered at risk for opioid overdose. Naloxone is effective if opioids are misused in combination with other sedatives or stimulants. It is not effective in treating overdoses of benzodiazepines or stimulant overdoses involving cocaine and amphetamines.

C. PARTIAL HOSPITALIZATION

Partial hospitalization services are for individuals with a psychiatric diagnosis and/or substance use disorder as well as co-occurring mental health needs, and are an effective alternative to inpatient hospitalization. They provide 20 or more hours of clinically intensive programming per week. These programs assign a multi-disciplinary team with direct access to psychiatric, medical, and laboratory services, and are designed to meet needs that warrant daily monitoring or management and can be addressed in a structured outpatient setting. Individuals typically attend the program five or more days per week for six hours per day. Services consist primarily of group therapy and education about mental health recovery and addiction-related coping and strategies, and/or addiction-related problems, as well as family intervention, medication management, and discharge services. Currently, partial hospitalization is a covered service only in Medicare and commercial plans.

D. INTENSIVE OUTPATIENT TREATMENT

Intensive outpatient treatment provides an alternative to inpatient hospitalization by providing structured programming for adolescents and adults with a psychiatric diagnosis or substance use disorder with a co-occurring mental health need. Individuals typically attend three days per week for three hours per day. Services consist primarily of group therapy and education about mental health recovery and addiction-related coping skills and strategies, as well as help to alleviate a crisis, prevent a relapse, treatment planning, and discharge assistance to link individuals and families to essential community supports. Currently, intensive outpatient treatment is a covered service only in Medicare and commercial plans.

E. CRISIS RESIDENTIAL

Crisis residential treatment services are therapeutic or rehabilitative services in a non-institutional residential setting that provides a structured program as an alternative to hospitalization for individuals experiencing an acute psychiatric episode or crisis who do not have medical complications requiring nursing care. Crisis residential treatment services are typically provided for 90 days or less. The service includes a range of activities and services that support individuals in their efforts to restore, maintain, and apply interpersonal and independent living skills, and to access community support systems. The service is available 24 hours a day, 365 days a year.

Currently, crisis residential treatment facilities are licensed as “social rehabilitation” facilities by the California Department of Social Services. Unfortunately, this service is not available in every community. Of the approximately 1,580 mental health crisis residential beds in California, almost half (46%) are in the Bay Area and close to one-third are in Southern California (excluding Los Angeles). While over one-quarter of the state’s population resides in Los Angeles County, only 9% of the state’s 1,580 crisis residential beds are located there.[37]

F. PSYCHIATRIC HEALTH FACILITY

Psychiatric Health Facility (PHF) services are provided in a multidisciplinary model as an alternative to psychiatric inpatient hospitalization for individuals who need acute psychiatric care, but do not require services to treat a

physical health condition in an inpatient setting. Currently, PHFs are licensed by DHCS. While PHF services are an important part of a care continuum that strives to prevent psychiatric hospitalization, their availability is uneven in our state. Of the 520 PHF beds[38] available statewide, 40% are in central region counties, which only represent 15% of the state's population. The Southern California region and Los Angeles represent 61% of the state's population, and yet have only 25% of all the state's licensed PHF beds.

G. WITHDRAWAL MANAGEMENT

"Withdrawal management" has replaced the term "detoxification" in the treatment guidelines published by the ASAM. Withdrawal management refers to the medical and psychological care of patients who are experiencing withdrawal symptoms as a result of ceasing or reducing use of a drug or alcohol for which they are physiologically dependent. The symptoms, management practices, use of medications, and follow-up care depend on the substance from which an individual may experience withdrawal symptoms, as well as the acuity of the withdrawal symptoms.

Supervised withdrawal management can prevent potentially life-threatening complications that might result if an individual is left untreated. Detoxification is a form of palliative care (reducing the intensity of a disorder) for those who want to become abstinent or who must observe mandatory abstinence as a result of hospitalization or legal involvement. Finally, for some individuals, withdrawal management may be a point of first contact with treatment and the first step to recovery. These services may be provided on an inpatient basis in a general acute care hospital or in an outpatient setting, when safe and appropriate.[39]

Important Additional Considerations

While the proposed standard of behavioral health care in this document is comprehensive, there are several important intersecting issues and challenges that must be tackled alongside our development of a robust continuum of community behavioral health care in California.

Workforce Development

Successful implementation of a robust continuum of care rests heavily on the availability of a sufficient workforce. According to the California Health Care Workforce Commission's 2019 report:[40]

> *"As demand grows for quality health care, California does not have enough of the right type of health workers, with the right skills, in the right places to meet the needs of our state's growing and increasingly diverse population. Despite everything California has done in recent years to improve health care delivery, the state will face a shortfall in the next decade of 4,100 primary care clinicians and 600,000 home care workers and will only have two-thirds of the psychiatrists we need."*

Other findings by the commission include that millions of Californians still don't have access to quality health care because of where they live, how much they earn, or the health conditions they face.

- Seven million Californians, the vast majority of them Latino, Black, and Native American, live in Health Professional Shortage Areas — a federal designation for counties experiencing shortfalls of primary care, dental care, or mental health care providers.
- Some of the fastest-growing regions of the state, such as the Inland Empire and San Joaquin Valley, have half as many doctors per resident as major metros like the Bay Area.
- In the Northern and Sierra regions, one in five adults say they find it difficult to get the care they need.
- For people who rely on the safety net, these challenges are even greater — with just over half as many doctors accepting Medi-Cal as those who accept private insurance.
- Access to care is a major obstacle for those living with mental illness or drug and alcohol issues.

Additionally, today's health workforce doesn't currently reflect the diversity of our state's population. Given the cost associated with training, it's no surprise that the majority of medical students in California come from families with incomes in the top 20%. Latinos are now nearly 40% of California's population, but only 7% of doctors. More than 7 million patients are limited English proficient and could benefit from access to multilingual providers. Yet, the state has only 20% as many Spanish-speaking doctors as it needs.

The workforce gaps for professionals trained to treat children and adolescents is especially acute. According to the American Academy of Child and Adolescent Psychiatry, there are only 1,135 child and adolescent psychiatrists in California — a state with over 9 million children and adolescents.[41] In addition to psychiatrists, other professionals who work with children and adolescents are needed. According to the Behavioral Health Workforce Research Center at the University of Michigan School of Public Health, "psychiatric mental health nurse practitioners can provide many of the same services that psychiatrists provide, including the ability to prescribe medications. Research shows that patient satisfaction with their care has been high."[42]

A recent University of California, San Francisco Center for Health Force study states:[43]

> *"Persons working in some behavioral health occupations are required to obtain a license from the state in*

which they practice. Other occupations, such as addiction counselors and peer providers, do not require licensure but may require certification. For example, California requires addiction counselors who work in substance use disorder treatment facilities that are licensed or certified by the state to be certified by one of two certifying bodies accredited by the National Commission for Certifying Agencies. Certification is voluntary for peer providers."

Most studies of the behavioral health workforce focus on the shortfall of licensed providers, and some also discuss peer providers as an important part of meeting California's behavioral health needs. Expansions are needed in psychiatry residency, nurse practitioner, master's in social work, marriage and family therapists, licensed professional clinical counselor, and other graduate and doctoral programs to increase the licensed workforce. However, nearly all these programs are already running at capacity and cannot keep pace with the anticipated growth in the need for qualified behavioral health staff. In addition, these programs are not equally distributed throughout the state, with many rural areas lacking any graduate or doctoral programs, compounding the workforce challenges in rural areas.

Behavioral health systems should take full advantage of other capable individuals who can meet clients' needs. For example, too little attention is currently paid to the value of expanding employment opportunities to non-licensed, college educated individuals who hold associate's, bachelor's, or master's degrees in a wide range of disciplines. Additionally, county behavioral health systems should take full advantage of the existing, broad range of provider types eligible to provide billable services to Medi-Cal beneficiaries while working to increase the number of non-licensed individuals and peer providers available to work in behavioral health. These efforts could include creating specialized certifications offered at community colleges, and post-bachelor's intensive training programs, as well as taking further advantage of existing certification opportunities, such as the Certified Psychiatric Rehabilitation Practitioner credential. These examples would be especially helpful to rural areas given the wider distribution of community colleges and bachelor's degree granting institutions throughout California.

Housing and Homelessness

The critical role of affordable, safe, and stable housing cannot be overstated. Approximately one quarter of California's 130,000 homeless individuals are chronically homeless (homeless at least a year or repeatedly). According to the National Alliance to End Homelessness:[44]

"People experiencing chronic homelessness typically have complex and long-term health conditions, such as mental illness, substance use disorders, physical disabilities, or other medical conditions. Once they become homeless — regardless of what immediately caused them to lose their housing — it is difficult for them to get back into housing and they can face long or repeated episodes of homelessness."

Housing costs and income levels are critical factors. Close to 2 million low-income households in California are spending more than half of their income on housing costs, according to the California Department of Housing and Community Development. While the individuals who are homeless and living with a behavioral health condition have a variety of health care, social service, and income support needs, most current programs and funding streams are not integrated. As a result, accusations among health and social service sectors ensue about which entity has the responsibility to help individuals and "end homelessness."

Housing challenges and homelessness also affect substantial numbers of children in California. Between 2015 and 2016, 8% of all children under age 6 experienced homelessness. Families experiencing homelessness, whether chronic or episodic, often face other barriers to affordable housing. In California, close to half (44%) of families with children under 18 had a high-cost burden for housing, and one in four (25%) of children under age 6 live in low-income working families.[45]

Availability of Hospital-Based Care for Those Who Need It

Behavioral Health Action is well aware that in rare cases, individuals living with a behavioral health condition will experience acute episodes that require hospitalization. Whether due to not accessing timely and appropriate outpatient, community-based care, or due to the nature and severity of the illness, some individuals do require the safety and care available only in a hospital setting. While Behavioral Health Action emphasizes again that in most cases, access to a robust continuum of services in the community can prevent the need for hospitalization, we do believe sufficient access to hospitalization is necessary and critical.

In California, psychiatric inpatient hospital services may be provided in a freestanding acute psychiatric hospital or within a psychiatric unit of a general acute care hospital . Both types of hospitals are licensed and certified by the California Department of Public Health and may be certified by the Centers for Medicare & Medicaid Services. Individuals may be admitted to psychiatric inpatient care on a voluntary basis, or on an involuntary basis under the Lanterman-Petris-Short Act of California.

Unfortunately, hospital-level inpatient care for mental illness and substance use disorders is not evenly distributed throughout the state and some counties have no inpatient beds for their residents. In total, there are over 6,700 inpatient psychiatric beds licensed in California — a per capita rate falls below the national average. Close to half (25) of California's 58 counties have no inpatient psychiatric services available locally.[46] Chemical dependency recovery hospital beds are in even shorter supply (only 667 beds) and 97% of them are located in Southern California and Los Angeles counties.[47]

Quality of Care

Behavioral Health Action recognizes the importance of the quality of care that is provided. Merely making each service type available through both private insurance and public programs will not necessarily result in consumer and family satisfaction with and improved functioning from the care they receive. In a journal article summarizing findings on health care quality by the Institute of Medicine, the authors state:

> *"Despite the availability of outstanding health care in the United States, several independent reports, including the Institute of Medicine's quality chasm report, found that the gap between the care that patients could receive and do receive is greater than a fissure; it is a chasm. Problems include the underuse, overuse, and misuse of interventions and other errors in care. These problems are found in all types of services (i.e., preventive, acute, and chronic), patient age groups, treatment settings, managed and unmanaged care, and somatic and behavioral health services."*

The Institute of Medicine identifies the following "10 Rules to Guide the Redesign of Health Care":[48]

1. **Care based upon continuous healing relationships**. Patients should receive care whenever they need it and, in many forms, not just face-to-face visits. This rule implies that the health care system should be responsive at all times (24 hours a day, every day) and that access to care should be provided over the internet, by telephone, and by other means in addition to face-to-face visits.
2. **Customization based on patient needs and values.** The system of care should be designed to meet the most common types of needs but have the capability to respond to individual patient choices and preferences.
3. **The patient as the source of control.** Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over health care decisions that affect them. The health system should be able to accommodate differences in patient preferences and encourage shared decision making.

4. **Shared knowledge and the free flow of information.** Patients should have unfettered access to their own medical information and to clinical knowledge. Clinicians and patients should communicate effectively and share information.
5. **Evidence-based decision making.** Patients should receive care based on the best available scientific knowledge. Care should not vary illogically from clinician to clinician or from place to place.
6. **Safety as a system property.** Patients should be safe from injury caused by the care system. Reducing risk and ensuring safety require greater attention to systems that help prevent and mitigate errors.
7. **The need for transparency.** The health care system should make information available to patients and their families that allows them to make informed decisions when selecting a health plan, hospital, or clinical practice or choosing among alternative treatments. This should include information describing the system's performance on safety, evidence-based practice, and patient satisfaction.
8. **Anticipation of needs.** The health system should anticipate patient needs rather than simply reacting to events.
9. **Continuous decrease in waste.** The health system should not waste resources or patient time.
10. **Cooperation among clinicians.** Clinicians and institutions should actively collaborate and communicate to ensure an appropriate exchange of information and coordination of care.

According to SAMHSA, the five questions to be asked to determine the quality of substance use disorder treatment include:[49]

1. **Accreditation:** Has the program been licensed or certified by the state? Is the program currently in good standing in the state? Are the staff qualified?
2. **Medication:** Does the program offer FDA-approved medication for recovery from alcohol and opioid use disorders?
3. **Evidence-Based Practices:** Does the program offer treatments that have been proven to be effective in treating substance use disorders including medication management therapies, such as motivational therapy, cognitive behavioral therapy, drug and alcohol counseling, education about the risks of drug and alcohol use, and peer support?
4. **Families:** Does the program include family members in the treatment process?
5. **Supports:** Does the program provide ongoing treatment and supports beyond just treating the substance issues? Quality programs provide treatment for the long term which may include ongoing counseling or recovery coaching and support and helps in meeting other basic needs like sober housing, employment supports, and continued family involvement.

Ease of Navigation

It is critical to ease the navigation of behavioral health services. Regardless of their health care coverage, individuals and families have a very difficult time finding the type of care they need when they need it. This results in unnecessary stress and frustration, as well as delays in treatment access. It can also discourage individuals and families from seeking help. The stigma surrounding mental health and substance use disorders compounds the difficulties in access because people may be reticent to seek assistance in the first place. While a variety of phone numbers and web sites exist to provide information and resources to individuals seeking behavioral health care, no single place exists for individuals, families, and providers to obtain help navigating the web of behavioral health care available in each community/county.

Outcomes Evaluation

Efforts to evaluate the effectiveness of California's behavioral health services are sorely lacking in statewide infrastructure, investment, and technical expertise/assistance. Establishing a select number of standard client-level outcomes for measurement by all behavioral health care systems and providers would assist with accountability and public transparency, as well as helping facilitate better treatment and policy decision making.

Current state law already requires several state agencies to evaluate mental health and substance use disorder services. However, none of the existing efforts provide a clear conclusion about whether individuals being served are getting healthier. Most of the data currently collected are reported in a program-by-program fashion and are not assembled at the state level to reach conclusions about the point-in-time or long-term performance trends of programs, counties, Medi-Cal managed care plans, health plans, or the state.

Special Populations

Finally, Behavioral Health Action recognizes there are a number of important special populations that should be considered by policy makers based on their high risk factors and difficulties accessing adequate behavioral health and primary care services. Examples include, but are not limited to:

- Older adults, including individuals with dementia or Alzheimer's disease
- Individuals with traumatic brain injuries
- Individuals receiving conservatorship, guardianship services, or who are detained involuntarily for evaluation due to danger to self or others or grave disability due to a mental disorder
- Individuals with co-occurring intellectual/developmental disabilities
- Youth and families involved in the child welfare or juvenile justice systems
- Immigrants, refugees, and their children
- Infants and young children, birth to 5 years of age
- People from unserved/underserved/inappropriately served communities including racial, ethnic, and LGBTQ communities

Participating Organizations of Behavioral Health Action

American Federation of State, County, and Municipal Employees

California Alliance of Child and Family Services

California Ambulance Association

California Association of Alcohol and Drug Program Executives

California Association of Health Plans

California Association of Local Behavioral Health Boards and Commissions

California Association of Mental Health Peer-Run Organizations

California Association of Public Administrators, Public Guardians and Public Conservators

California Association of Public Hospitals and Health Systems

California Association of Social Rehabilitation Agencies

California Behavioral Health Planning Council

California Board of State and Community Corrections

California Children's Hospital Association

California Council of Community Behavioral Health Agencies

California Department of Education

California Department of Health Care Services

California Health and Human Services Agency

California Hospital Association

California LGBTQ Health and Human Services Network

California Medical Association

California Mental Health Advocates for Children and Youth

California Mental Health Services Authority

California Police Chiefs Association

California Primary Care Association

California Professional Firefighters

California Psychological Association

California Public Defenders Association

California School-Based Health Alliance

California State Sheriffs' Association

California State Association of Counties

California Workforce Development Board

Chief Probation Officers of California

Children Now

Children's Partnership

Civil Justice Association of California

Coalition for Whole Health

Council of State Governments Justice Center

Council on Criminal Justice and Behavioral Health

County Behavioral Health Directors Association of California

Disability Rights California

District Hospital Leadership Forum

Forensic Mental Health Association of California

Garrett Consulting Group

Health Access California

Jewish Family Service

Judicial Council of California

League of California Cities

Los Angeles County Department of Mental Health

Los Angeles County District Attorney's Office

League of California Cities

Mental Health America of California

Mental Health Services Oversight and Accountability Commission

National Alliance on Mental Illness California

National Association for the Advancement of Colored People

National Association of Social Workers – California

Open Minds

Peace Officers Research Association of California

Planned Parenthood Affiliates of California

Private Essential Access Community Hospitals

Racial and Ethnic Mental Health Disparities Coalition

Sacramento Area Congregations Together

Service Employees International Union California

Steinberg Institute

Union of American Physicians and Dentists

Urban Counties of California

University of California Office of the President

Western Center on Law and Poverty

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