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Analysis of California Assembly Bill 1451: Behavioral Health Crisis Treatment

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Abbreviated Analysis

California Assembly Bill 1451: Behavioral Health Crisis Treatment

Report to the 2023–2024
California State Legislature
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Prepared by
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SUMMARY

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[1] complete a limited background analysis of the policy issues related to California Assembly Bill (AB) 1451, Behavioral Health Crisis Treatment.

For a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, AB 1451 would:

1. Require coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition.
2. Authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care.
3. Require the treatment to be provided without preauthorization, and authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured.
4. Require a health care service plan to provide reimbursement for services in compliance with the requirements for timely payment of claims.

Background on Behavioral Health Conditions

There are multiple definitions of a "behavioral health crisis" used in the behavioral health field, with the definitions included in this report being inclusive of situations where care is needed on an urgent basis or on an emergency basis.

Behavioral health conditions are common. Individuals can have a mental health condition, a substance use disorder (SUD), or if they have both, this is referred to as co-occurring disorders. As examples, more than 40 million Americans (19.1% of the population) have anxiety and about 21 million (8.4%) have major depressive disorder. Among people aged 12 years or older in 2021, more than 46 million had a substance use disorder.

Although any person can experience a behavioral health crisis, people with mental health and substance use conditions are at increased risk of having a behavioral health crisis. Despite notable gains in stigma reduction over the past century in relation to gender, race, sexual orientation, religion, and medical diagnoses, behavioral health–related stigma is still prevalent. Behavioral health crises may be more likely to occur if stigma associated with having a mental health or substance use disorder means that people are less likely to seek care that would help them manage their condition.

Results from a national survey provide detailed information on the prevalence of mental health conditions in the United States in the past year. Among adults, 57.8 million had any mental illness (AMI) in the past year; of these, 14.1 million people (5.5%) had a serious mental illness (SMI). In California, 6.8 million adults had AMI and 1.8 million had an SMI in 2021. This translates to almost 1 in 7 California adults experiencing AMI, and 1 in 26 with an SMI that makes it difficult to carry out daily activities. Among children in California,1 in 14 has an emotional disturbance that limits functioning in family, school, or community activities. The prevalence of SMI in California in 2019 varied by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% of the federal poverty level.

Among adults aged 18 years or older in the United States, 14.5 million experienced a major depressive episode (MDE) with severe

[1] Refer to CHBRP's full report for full citations and references.

impairment in 2021. For adolescents aged 12 to 17 years, 3.7 million had an MDE with severe impairment in 2021.

In 2021, 6.4 million adults aged 18 years or older had both a serious mental illness (SMI) and an SUD; 935,000 adolescents aged 12 to 17 years had both an MDE and an SUD.

In 2021, less than half (47.2%) of the 57.8 million U.S. adults aged 18 or older with any mental illness in the past year received mental health services. Among California adults with AMI, about one-third reported receiving mental health services during the past year in 2019; this was lower than the national rate. Adults in California with an SMI were more likely to receive treatment, but 40% did not receive any treatment. Of people aged 12 or older in 2021, 43.7 million people (15.6%) were defined as needing substance use treatment in the past year.

Of the adults who had an MDE with severe impairment in 2021, 64.8% received treatment, whereas 44.2% of adolescents who had an MDE with severe impairment received treatment. In California, one in seven adolescents and 7% of adults reported experiencing an MDE between 2018 and 2019. Between 2016 and 2019, about one in three adolescents in California who reported experiencing symptoms of MDE during the past year received treatment.

In terms of treatment settings, in 2021, 4.7 million adolescents aged 12 to 17 years received mental health services in a specialty setting and 3.7 million in a nonspecialty setting such as a school or general medical provider. Of the 46.5 million adults aged 18 years or older who received mental health services, 34.4 million took prescription medication, 28.1 million received virtual services, 20.1 million received outpatient services, and 2.5 million received inpatient services.

In 2021, among the 14.1 million adults aged 18 years or older with serious mental illness (SMI) in the past year, more than half (51.5%) perceived an unmet need for mental health services; of those, 39.7% (or 2.8 million people) did not receive any mental health services in the past year. Amongst the 40.7 million people aged 12 years or older with an illicit drug or alcohol use disorder who did not receive treatment at a specialty facility in 2021, 1.3 million people (3.2%) felt they needed substance use treatment.

Nationwide, the prevalence of anxiety, depression, and substance use has accelerated since the COVID-19 pandemic began in early 2020. Unmet need for behavioral health services has also increased during the pandemic. More than 66% of adolescents and 64% of adults perceived that COVID had a negative effect on their mental health, with 19.2% of adolescents and 14.4% of adults saying it affected their mental health “quite a bit or a lot.” Among adults with SMI, almost half (48.9%) said it affected their mental health “quite a bit or a lot.”

Factors including level of education, immigration status, race/ethnicity, and language contribute to disparities in access to behavioral health services. Drug- and alcohol-induced death rates also differed considerably by race/ethnicity; in 2019, American Indian and Alaska Native Californians had the highest rates and Asian, Native Hawaiian, and Pacific Islander Californians had the lowest. The number of amphetamine-related ED visits in California increased nearly 50% between 2018 and 2020. While Black Californians had the highest rate of nonfatal ED visits for amphetamines, Latino Californians accounted for 40% of those visits. In 2019, more than 3,200 Californians died from an opioid-related overdose. The death rate from fentanyl increased 10-fold from 2015 to 2019 in California. In 2019, American Indian and Alaska Native Californians had the highest rate of opioid overdose deaths, followed by White and Black Californians.

The range of factors discussed above contribute to disparities in prevention, access to care, and treatment of behavioral health crises. Even when infrastructure including facilities, providers, and insurance are in place, there are social determinants of health that can affect health equity and access to behavioral health services.

Treatment Pathways for People Experiencing a Behavioral Health Crisis

Federal policy that shifted funding and services from institutionalized settings to community-based behavioral health services has been accompanied by a persistent gap in outpatient

treatment services, which often leaves those in a behavioral health crisis to receive treatment in hospital emergency departments (EDs).

Individuals experiencing a behavioral health crisis may need care on an urgent or emergency basis. There may be somewhat different pathways to treatment based on urgency and whether the person has primarily a mental health condition or a substance use disorder.

Type of insurance coverage or the lack of insurance may affect where an individual who is having a behavioral health crisis will seek care. There is substantial variation across counties in the types of providers and facilities that are available to assist an individual having a behavioral health crisis, and this also may affect where they seek care.

Those with *urgent* needs for care who are covered by Medi-Cal or who are uninsured may seek outpatient treatment from a primary care clinic or a federally qualified health center (FQHC), a public or county clinic, or a mental health crisis center if there is one in their community. Those with commercial insurance may seek care from a private practice medical care provider or behavioral health provider.

If a person has a behavioral health crisis during a visit for a physical health issue and needs behavioral health care *urgently*, a medical care provider may provide a warm handoff to a behavioral health provider onsite, if those services are available, or they may refer the person to an external behavioral health provider if such services are not available onsite.

Individuals who need care on an *emergency* basis may self-refer to a mental health crisis center or a sobering center if one is available in the community or to a hospital ED. Alternatively, they may contact emergency services or someone else may call on their behalf. After 911 is called, first responders (i.e., emergency medical technicians [EMTs]/paramedics, law enforcement personnel) or a mobile crisis response team, if available in the community, will be summoned. The individual will be assessed and potentially transported to a hospital ED, psychiatric facility, mental health crisis center, sobering center, or other care facility. Mobile crisis teams, which may include a behavioral health clinician, medical professional, and peer support specialist, also would assess the person's needs, provide them with resources or referrals for needed care and other services, and potentially transport them to needed care/services.

Mobile crisis response teams offer an alternative to traditional first responders. In 2022, the California Department of Health Care Services (DHCS) announced that it planned to seek federal approvals to provide qualifying community-based mobile crisis services to eligible Medi-Cal beneficiaries experiencing a behavioral health crisis. Similar programs in California predate DHCS' mobile crisis care initiative. As one example, San Francisco's first Street Crisis Response Team was launched in November 2020 as a pilot project; it operates citywide, 24 hours per day throughout the year. Designed to assist people in crisis who do not necessitate a law-enforcement response, teams consist of a specially trained community paramedic, a behavioral health clinician, and a peer support specialist.

Major Gaps Impacting Behavioral Health Crisis Response

Throughout California, communities are facing multiple barriers to behavioral crisis response including a shortage and maldistribution of facilities and providers. In both public and private settings, the supply and distribution of the state's behavioral health workforce affects the ability to provide necessary and competent services to patients facing behavioral health crises.

There is particular concern about the capacity of California's county behavioral health safety net to provide care to those with behavioral health needs. This safety net includes county behavioral health agencies, city behavioral health authorities, and community-based organizations (CBOs) with which they contract to provide behavioral health services. The county behavioral health safety net primarily serves low-income people with mental health conditions, SUDs, and co-occurring disorders who require a range of specialty behavioral health services. Additionally, federally qualified health centers (FQHCs) and FQHC lookalikes play significant roles in providing behavioral health services to people with low-incomes who have SUD or mild to moderate mental health

conditions. The majority of people served by the county behavioral health safety net and FQHCs are uninsured or enrolled in Medicaid.

With 6,702 inpatient psychiatric beds available across the state, California has a shortage of beds as well as high bed occupancy rates and long waitlists for placements. There were 17.05 psychiatric inpatient beds for every 100,000 California residents (1 psychiatric bed per 5,856 people) in 2016, substantially below a recommended ratio of 1 per 2,000 people. Of the 58 California counties, 25 have no inpatient psychiatric services at all, 25 do not have any inpatient adult psychiatric beds, 42 do not have child/adolescent beds, 56 do not have geriatric psychiatric (long-term) beds, 48 do not have chemical dependency beds, and 55 do not have psychiatric intensive care beds.

As noted above, mobile crisis services are intended to provide community-based crisis response and reduce unnecessary first responder involvement and ED utilization. Limited crisis intervention services are currently covered by a specialty mental health benefit service under Medi-Cal and are provided by some counties. While DHCS is pursuing federal approval for mobile crisis services, they are not yet a statewide Medi-Cal benefit. As of 2021, approximately two-thirds of the 58 California counties have mobile crisis teams of varying design and utilization. Of the 35 counties with mobile crisis services, most (73%) did not provide 24/7 coverage but prioritize services during peak hours.

First responders and primary care providers generally have limited training in dealing with behavioral health crisis management and treatment. Inconsistent training, complexity of procedures, and stigmatization make this a very challenging task, and many first responders report feeling unfit to respond to behavioral health crises because they lack the knowledge, resources, and training to handle these situations.

Recent studies have reported a shortage and maldistribution of psychiatrists and other behavioral health providers, including addiction specialists, that are authorized to diagnose behavioral health conditions. California's behavioral health professionals are not evenly distributed across the state. As examples, the Greater Bay Area had the highest ratios per capita for psychiatrists, psychologists, and licensed clinical social workers (LCSWs) and the second highest ratios for licensed marriage and family therapists (LMFTs) and licensed professional clinical counselors (LPCCs), while the San Joaquin Valley had the lowest ratios per capita for these professions.

A recent needs assessment on the behavioral health workforce in California reported that county behavioral health agencies are facing challenges with recruiting personnel who specialize in treating the clients they serve. Difficulties were reported in recruiting staff for specific programs such as crisis care (especially 24/7 care), forensic services, full-service partnership programs, and narcotics treatment programs. Among California county agencies, 86% had difficulty recruiting staff to work in these specific mental health programs and 43% experienced difficulty with recruitment of staff for specific SUD programs.

The distribution of California's behavioral health professionals across racial/ethnic groups does not reflect the state's population. As an example, while Latino persons make up 39% of California's population, they comprise only 12% to 32% of behavioral health professions and are most underrepresented among psychiatrists and psychologists, comprising only 5% and 12% of these professionals, respectively. The linguistic diversity of behavioral health professionals also does not reflect the linguistic diversity of California's population, with 41% of behavioral health professionals speaking only English. The lack of access to racially/ethnically and linguistically concordant providers makes it more difficult for people to obtain treatment that can help them manage their behavioral health condition(s) and reduce the risk of experiencing a behavioral health crisis.

The shortage and maldistribution of behavioral health professionals is compounded because many of these professionals do not accept health insurance. No entity regularly collects and reports data on participation of California's behavioral health professionals in commercial health insurance, Medicare, or Medi-Cal. Psychiatrists' low rate of participation in Medi-Cal compounds the demand for psychiatrists' services in the county behavioral health safety net.

OVERVIEW

The California Assembly Committee on Health has requested that the California Health Benefits Review Program (CHBRP)[2] complete a limited background analysis of the policy issues related to California Assembly Bill (AB) 1451, Behavioral Health Crisis Treatment.

Bill-Specific Analysis of AB 1451, Behavioral Health Crisis Treatment

Bill Language

For a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, AB 1451 would:

1. Require coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition.
2. Authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care.
3. Require the treatment to be provided without preauthorization, and authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured.[3]
4. Require a health care service plan to provide reimbursement for services in compliance with the requirements for timely payment of claims.

The full text of AB 1451 can be found in Appendix A.

To provide context on behavioral health crises, potential treatment pathways, and gaps impacting behavioral health crisis response, this abbreviated analysis includes information organized into three sections:

- Background on Behavioral Health Conditions
- Treatment Pathways for People Experiencing a Behavioral Health Crisis
- Major Gaps Impacting Behavioral Health Crisis Response

[2] CHBRP's authorizing statute is available at www.chbrp.org/about_chbrp/faqs/index.php.
[3] Same-day billing is an issue that is relevant only for Medi-Cal beneficiaries treated in federally qualified health centers (FQHCs), and this has been the topic of many legislative proposals over the past 10+ years. Several resources on this topic were shared with the Assembly Health Committee staff, including the California Health Care Foundation webpage on Modernizing Payment to California's Community Health Centers (available at: https://www.chcf.org/collection/modernizing-payment-californias-community-health-centers) and a California Department of Health Care Services (DHCS) resource on CalAIM/alternative payment models for FQHCs (available at: https://www.dhcs.ca.gov/services/Documents/DirectedPymts/FQHC-APM-September-2022-Overview.pdf).

BACKGROUND ON BEHAVIORAL HEALTH CONDITIONS

Behavioral Health Crisis Definitions

There are multiple definitions of a "behavioral health crisis" used in the behavioral health field. Two ways of defining a behavioral health crisis, used by a behavioral health treatment membership organization and a patient advocacy organization, respectively, are:

- "Any event or situation associated with real or potential disruption of stability and safety as a result of behavioral health issues or conditions. Crisis, as used here, does not only refer to situations that require calling 911 or 988.[4] A crisis may begin at the moment things begin to fall apart (e.g., a person runs out of psychotropic medication and cannot obtain more, or is overwhelmed by urges to use substances they are trying to avoid) and may continue until the person is safely re-stabilized and connected or re-connected to ongoing supports and services" (National Council for Mental Wellbeing, 2021). This definition was incorporated into the California Department of Health Care Services (DHCS) Behavioral Health Information Notice No.: 22-064 on Medi-Cal Mobile Crisis Services Benefit Implementation (DHCS, 2022).
- "Any situation in which a person's behavior puts them at risk of hurting themselves or others and/or prevents them from being able to care for themselves or function effectively in the community" (NAMI, 2018).

Any person can have a behavioral health crisis, which may be triggered by a stressful event but also can occur without a clear cause. The definitions above are inclusive of situations where care is needed on an urgent or emergency basis. According to the California Department of Managed Health Care (DMHC), timely access requirements for urgent care are two days if prior authorization *is not* required by the health plan and four days if prior authorization *is* required by the health plan (DMHC, 2023). As described in more detail in the *Treatment Pathways* section, for care on an *urgent* basis, individuals can seek care on their own from a medical or behavioral health provider, or they can contact their health plan/insurer for assistance in obtaining care. For care on an *emergency* basis, such as when a person is a danger to themselves or others, individuals can seek care directly from an emergency medical services provider or be transported to such a provider by first responders (e.g., emergency medical technicians [EMTs]/ paramedics, law enforcement personnel).

Prevalence of Behavioral Health Disorders

Although any person can experience a behavioral health crisis, people with mental health and substance use conditions are at increased risk of having a behavioral health crisis. Behavioral health crises may be more likely to occur if stigma associated with having a mental health or substance use disorder means that people are less likely to seek care that would help them manage their condition. Despite notable gains in stigma reduction over the past century in relation to gender, race, sexual orientation, religion, and medical diagnoses (e.g., HIV), behavioral health–related stigma is still prevalent. A systematic review (Sharac et al., 2010) reported that stigma reduces quality of life by creating additional issues including housing and employment difficulties and barriers to access and quality health care (e.g., delayed treatment, early treatment discontinuation).

Use of the term behavioral health to encompass both mental health conditions and substance use disorders (SUDs) is increasing. Historically, however, funding, workforce, and service delivery for mental health and SUD have been separate, and data continue to be collected and reported separately; therefore, information is shown separately for each below.

[4] As of 2022, people experiencing behavioral health emergencies can dial 988 as an alternative to 911. 988 is a new suicide and mental health crisis hotline that is available nationally, including in California.

Mental Health

Table 1 shows the percentage of people in the United States with various mental health conditions, the two most common of which are anxiety (affecting 19.1% of the population) and major depressive disorder (affecting 8.4% of the population) (NAMI, 2023). In addition, in the United States, about 100,000 young people experience psychosis[5] each year, and as many as 3 in 100 people will have a psychotic episode at some point in their lives. The exact prevalence of schizophrenia is difficult to measure, but estimates range from 0.25% to 0.64% of U.S. adults.

Table 1. Prevalence of Select Mental Health Conditions, United States

Mental Health Condition	Percentage Affected
Anxiety	19.1%
Bipolar Disorder	2.8%
Borderline Personality Disorder (BPD)	1.4%
Major Depressive Disorder	8.4%
Obsessive-compulsive disorder (OCD)	1.2%
Post-traumatic Stress Disorder (PTSD)	3.6%

Source: NAMI, 2023.

Results from a national survey provide detailed information on the prevalence of mental health conditions in the United States in the past year (SAMHSA, 2022). Among adults, 57.8 million had any mental illness (AMI)[6] in the past year; of these, 14.1 million people (5.5%) had a serious mental illness (SMI).[7] In California, 6.8 million adults had AMI and 1.8 million had an SMI in 2021. This translates to almost 1 in 7 California adults experiencing AMI, and 1 in 26 with an SMI that makes it difficult to carry out daily activities. Among children in California,1 in 14 has an emotional disturbance that limits functioning in family, school, or community activities (CHCF, 2022a). The prevalence of SMI in California in 2019 varied by income, with much higher rates of mental illness for both children and adults in families with incomes below 100% of the federal poverty level (CHCF, 2022a).

Major depressive episode

Table 2 shows the percentage and number of adolescents aged 12 to 17 years and adults aged 18 years and older who experienced a major depressive episode (MDE)[8] in 2021. Among adolescents aged 12 to 17 years in 2021, 5.0 million people had an MDE in the past year, of whom 3.7 million had severe impairment. Among adults aged 18 years or older in 2021, 21.0 million had an MDE in the past year, of whom 14.5 million had severe impairment. In California, 2.5 million adults had an MDE in 2021.

[5] Psychosis is characterized by disruptions to a person's thoughts and perceptions that make it difficult for them to recognize what is real and what isn't. These disruptions are often experienced as seeing, hearing, and believing things that aren't real or having strange, persistent thoughts, behaviors, and emotions.
[6] SAMHSA defines AMI as a mental, behavioral, or emotional disorder. AMI can vary in impact, ranging from no impairment to mild, moderate, and even severe impairment.
[7] SAMHSA defines SMI as a mental, behavioral, or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one or more major life activities, and notes that these estimates are based on a predictive model and are not direct measures of diagnostic status.
[8] Survey respondents were classified as having an MDE in the past year if (1) they had at least one period of 2 weeks or longer in the past year when for most of the day nearly every day, they felt depressed or lost interest or pleasure in daily activities, and (2) they had problems with sleeping, eating, energy, concentration, self-worth, or having recurrent thoughts of death or recurrent suicidal ideation.

Table 2. Individuals Experiencing a Major Depressive Episode (MDE), United States, 2021

	Adolescents Aged 12-17	Adults Aged 18+
Experienced an MDE in the past year	20.1% (5.0 million)	8.3% (21.0 million)
Experienced an MDE with severe impairment in the past year	14.7% (3.7 million)	5.7% (14.5 million)

Source: SAMHSA, 2022.

Key: MDE = major depressive episode.

Suicide

Suicide is the second leading cause of death for people aged 10 to 34 years and the fifth leading cause of death for those aged 35 to 54 years (SAMHSA, 2022). Among adolescents aged 12 to 17 years nationally in 2021, 3.3 million people had serious thoughts of suicide, 1.5 million people made a suicide plan, and 892,000 people attempted suicide in the past year. Among adults aged 18 years or older in 2021, 12.3 million people had serious thoughts of suicide in the past year, 3.5 million made a suicide plan, and 1.7 million people attempted suicide. Among California adults in 2021, 1.5 million people had serious thoughts of suicide in the past year, 439,000 made a suicide plan, and 212,000 people attempted suicide. The overall rate of suicide in California was below the national rate, but rates of suicide vary by gender, race/ethnicity, and county (CHCF, 2022a).

Substance Use Disorder

Among people aged 12 years or older in 2021, 46.3 million people (16.5% of the population) had an SUD in the past year (SAMHSA, 2022). Of these, 29.5 million people had an alcohol use disorder (of which 19.5% had a severe disorder), 24.0 million people had a drug use disorder, and 7.3 million had both an alcohol use disorder and a drug use disorder. Among people aged 12 years or older in California in 2021, 5.4 million people had an SUD in the past year, including 235,000 adolescents aged 12 to 17 years (SAMHSA, 2022). Of these 5.4 million, 3.7 million people had an alcohol use disorder and 2.7 million people had a drug use disorder.

Co-occurring Mental Health and SUD Conditions

Individuals can have a mental health condition, an SUD, or both, referred to as co-occurring disorders. Table 3 shows the percentage and number of adolescents aged 12 to 17 years who had an MDE and/or an SUD in the past year; it also shows the number of adults aged 18 year or older who had an SMI and/or an SUD in 2021. Among adolescents, 6.3 million people experienced either an MDE or SUD in the past year and 935,000 experienced both (SAMHSA, 2022). Among adults, 51.7 million people experienced either an SMI or SUD in the past year and 6.4 million experienced both.

Table 3. Prevalence of Mental Health, Substance Use, and Co-occurring Conditions, United States, 2021

Adolescents Aged 12-17		Adults Aged 18+	
Experienced an MDE or SUD in the past year	25.2% (6.3 million)	**Experienced an SMI or SUD in the past year**	20.4% (51.7 million)
Experienced an MDE but not an SUD in the past year	16.4% (4.1 million)	**Experienced an SMI but not an SUD**	3.0% (7.7 million)
Experienced an SUD but not an MDE in the past year	4.8% (1,200,000)	**Experienced an SUD but not an SMI**	14.8% (37.7 million)
Experienced both an MDE and an SUD in the past year	3.7% (935,000)	**Experienced both an SMI and an SUD**	2.5% (6.4 million)

Source: SAMHSA, 2022.

Key: MDE = major depressive episode; SMI = serious mental illness; SUD = substance use disorder.

Treatment of Behavioral Health Disorders

Mental Health

In 2021, less than half (47.2%) of the 57.8 million U.S. adults aged 18 or older with AMI in the past year received mental health services (SAMHSA, 2022). Among California adults with AMI, about one-third reported receiving mental health services during the past year in 2019; this was lower than the national rate (CHCF, 2022a). Adults in California with an SMI were more likely to receive treatment, but 40% did not receive any treatment (CHCF, 2022a).

Substantial numbers of adolescents and adults with an MDE do not receive treatment, with smaller percentages of adolescents than adults receiving treatment (44.2% vs. 64.8% for those having a MDE with severe impairment). Table 4 shows the percentage and number of adolescents aged 12 to 17 years and adults aged 18 years and older nationally who had an MDE and received depression treatment in 2021. In California, one in seven adolescents and 7% of adults reported experiencing an MDE between 2018 and 2019 (CHCF, 2022a). Between 2016 and 2019, about one in three adolescents in California who reported experiencing symptoms of MDE during the past year received treatment (CHCF, 2022a).

Table 4. Individuals Experiencing a Major Depressive Episode (MDE) and Received Depression Treatment, United States, 2021

	Adolescents Aged 12-17	Adults Aged 18+
Had an MDE and received treatment for depression in the past year	40.6% (2.0 million)	61.0% (12.6 million)
Had an MDE with severe impairment and received depression treatment in the past year	44.2% (1.6 million)	64.8% (9.2 million)

Source: SAMHSA, 2022.

Key: MDE = major depressive episode.

Substance Use Disorder

In the United States, of people aged 12 or older in 2021, 43.7 million people (15.6%) were defined as needing substance use treatment in the past year; individuals were so classified if they had an illicit drug or alcohol use disorder or if they received substance use treatment at a specialty facility in the past year.

Treatment Types and Settings

Mental health

In 2021, 18.3% of adolescents aged 12 to 17 years (4.7 million people) in the United States received mental health services in a *specialty* setting, including 4.5 million people who received mental health treatment in an outpatient setting and 629,000 people who received mental health treatment in an inpatient setting; 3.7 million adolescents received mental health services in a *nonspecialty* setting, such as a school, general medical provider, child welfare, or juvenile justice setting (SAMHSA, 2022). Among adults aged 18 or older, 46.5 million people (18.8%) received treatment in the past year for a mental health condition, including 34.4 million people who took prescription medication, 28.1 million who received virtual services, 20.1 million people who received outpatient services, and 2.5 million people who received inpatient services.

Substance use disorder

Among people aged 12 years or older with a past-year SUD in 2021, 4.1 million people received any substance use treatment in the past year. Of these, 2.0 million obtained care from a self-help group, 1.9 million received virtual services, 1.8 million received outpatient care at a rehabilitation facility, 1.5 million received outpatient care at a mental health facility, 1.3 million received inpatient care at a rehabilitation facility, 1.1 million received care in a private doctor's office, and 1.1 million received inpatient hospital care.

Co-occurring mental health and SUD conditions

Of the 842,000 adolescents aged 12 to 17 years in 2021 with a co-occurring illicit drug or alcohol use disorder and MDE in the past year, 471,000 (56.1%) received either substance use treatment at a specialty facility or mental health services in the past year. Of the 5.8 million adults aged 18 years or older with a co-occurring illicit drug or alcohol use disorder and SMI, about 3.9 million (66.9%) received either substance use treatment at a specialty facility or mental health services in the past year. For both adolescents and adults, most received only mental health services. Table 5 shows the types of treatment received by adolescents aged 12 to 17 years and adults aged 18 years or older who had co-occurring illicit drug or alcohol use disorder and mental health conditions (MDE for adolescents and SMI for adults).

Table 5. Types of Treatment Received for Mental Health, Substance Use, and Co-occurring Conditions, United States, 2021

	Adolescents Aged 12-17 with Co-occurring SUD and MDE	Adults Aged 18+ with Co-occurring SUD and SMI
Received substance use treatment at specialty facility or mental health services in past year	56.1% (471,000 people)	66.9% (3.9 million people)
Received only mental health services in the past year	52.4% (440,000 people)	54.6% (3.1 million people)
Received only substance use treatment at a specialty facility in the past year	--	1.4% (84,000 people)
Received both substance use treatment at a specialty facility and mental health services in the past year	3.6% (31,000 people)	10.7% (620,000 people)

Source: SAMHSA, 2022.

Key: MDE = major depressive episode; SMI = serious mental illness; SUD = substance use disorder.

Unmet Needs

Among the 57.8 million adults aged 18 years or older who had any mental illness in 2021, 15.5 million (27.6%) perceived an unmet need for mental health services in the past year (SAMHSA, 2022). Of the 14.1 million adults with SMI in the past year, 7.2 million (51.5%) perceived an unmet need for mental health services; of those, 39.7% (or 2.8 million people) did not receive any mental health services in the past year. The most common reason given for not receiving care was that the person could not afford the cost of care; other reasons included not knowing where to go for services and believing they could handle the problem without treatment. Approximately 6% of California adults reported needing mental health treatment or counseling in 2019 but not being able to get it (CHCF, 2022a).

Of the 40.7 million people aged 12 years or older with an illicit drug or alcohol use disorder who did not receive treatment at a specialty facility in 2021, 1.3 million people (3.2%) felt they needed substance use treatment. The following were the top three reasons given for not receiving treatment: not being ready to stop using, having no health insurance/unable to afford treatment cost, and not knowing where to go for treatment.

Impact of COVID-19

Nationwide, the prevalence of anxiety, depression, and substance use has accelerated since the COVID-19 pandemic began in early 2020 (Breslau et al., 2021; Czeisler et al., 2020; Czeisler et al., 2021; Ettman et al., 2020; Ettman et al., 2022; Vahratian et al., 2021). Unmet need for behavioral health services has also increased during the pandemic (Coley and Baum, 2022; Nagata et al., 2021; Vahratian et al., 2021).

Results from the 2022 SAMHSA report show that 66.2% of adolescents aged 12 to 17 years perceived a negative effect of the COVID-19 pandemic on their mental health, with 19.2% saying it negatively affected their mental health “quite a bit or a lot.” Similar findings were reported for adults aged 18 years and older, with 64.2% perceiving a negative effect of the pandemic on their mental health, including 14.4% who said it negatively affected their mental health “quite a bit or a lot.” Among adults with SMI, almost half (48.9%) said it negatively affected their mental health “quite a bit or a lot.”

Disparities and Behavioral Health

Studies have shown that factors such as level of education, immigration status, race/ethnicity, and language contribute to disparities in access to behavioral health services (Tran and Ponce, 2016; Ortega et al., 2018; Salem et al., 2021). In one study, people whose highest level of education was a high school diploma or less were more likely to have unmet need for behavioral health services (Tran and Ponce, 2016). This study also reported that people who did not speak English or did not speak it well were more likely to have unmet need for behavioral health services than people who only speak English (Tran and Ponce, 2016). Other studies have reported that immigration status affects the ability to access behavior health services. In one study, undocumented Latino persons were more likely than other Latino persons to be unable to obtain mental health services due to concerns about cost (Ortega et al., 2018). Another study found that women who experienced severe psychological distress and did not have a green card were more likely to have unmet need for behavioral health services than U.S. born citizens (Salem et al., 2021). Other studies have reported that race and ethnicity can affect access to care. In two studies, Asian and Latino persons were more likely to have unmet need for behavioral health services and Asian and Latina women were more likely to have unmet need for behavioral health services than White women (Tran and Ponce, 2016; Salem et al., 2021).

Drug- and alcohol-induced death rates[9] also differed considerably by race/ethnicity. In 2019, American Indian and Alaska Native Californians had the highest rates (39.2 drug-induced and 34.4 alcohol-induced deaths per 100,000 population) and Asian, Native Hawaiian, and Pacific Islander Californians had the lowest (4.1 drug-induced and 2.5 alcohol-induced deaths per 100,000 population). Black (28.4 drug- deaths and 10.7 alcohol-induced deaths per 100,000 population) and White Californians (23.2 drug-induced and 14.1 alcohol-induced deaths per 100,000 population) had drug-induced death rates that were more than twice as high as Latino Californians (11.1 drug-induced and 14.7 alcohol-induced deaths per 100,000 population) (CHCF, 2022b).

The number of amphetamine-related ED visits in California increased nearly 50% between 2018 and 2020. While Black Californians had the highest rate of nonfatal ED visits for amphetamines (26.7% per 100,000 population; 656 visits), Latino Californians accounted for 40% of those visits (7.1% per 100,000 population; 1,162 visits) (CHCF, 2022b).

In 2019, more than 3,200 Californians died from an opioid-related overdose. The death rate from fentanyl increased 10-fold, from 0.3 deaths per 100,000 population in 2015 to 3.8 deaths per 100,000 population in 2019. The rate of deaths from heroin increased steadily from 2011 to 2019, while the rate of prescription overdose deaths decreased by 30% over the same period. In 2019, American Indian and Alaska Native Californians had the highest rate of opioid overdose deaths (15.7 deaths per 100,000 population), followed by White (12.6 deaths per 100,000 population), and Black Californians (12.3 deaths per 100,000 population). Among opioid overdose deaths, the highest rates were from fentanyl, and this finding was consistent across all racial and ethnic groups (CHCF, 2022b).

The range of factors discussed above contribute to disparities in prevention, access to care, and treatment of behavioral health crises. Even when infrastructure including facilities, providers, and insurance are in place, there are social determinants of health that can affect health equity and access to behavioral health services.

TREATMENT PATHWAYS FOR PEOPLE EXPERIENCING A BEHAVIORAL HEALTH CRISIS

As stated above, individuals experiencing a behavioral health crisis may need care on an urgent or emergency basis. There may be somewhat different pathways to treatment based on urgency and whether the person has primarily a mental health condition or a substance use disorder. An overview of potential treatment pathways for these situations is described below.

Historical Context

The Community Mental Health Act of 1963 was the first federal policy that shifted funding and services from institutionalized settings to community-based behavioral health services (Erickson, 2021). Shifting resources and funding from institutionalized care to community-based care has shown promise for improving care for people experiencing behavioral health crises, but community-based care has been underfunded historically.

Following this shift, there has been a persistent gap in outpatient treatment services, which often leaves those in a behavioral health crisis to receive treatment in hospital emergency departments (EDs), culminating in an increase in overall healthcare expenditures. Providing behavioral health crisis assessment and treatment in busy EDs often means a long wait for care, and the ED can be a difficult environment for those in need of immediate treatment for a behavioral health crisis.

[9] *Drug-induced deaths* are drug poisonings (overdoses) with ICD-10 codes that cover unintentional, suicide, homicide, and undetermined poisoning. *Alcohol-induced deaths* include accidental or intended poisoning in addition to other conditions directly induced by use of alcohol.

Potential Treatment Pathways

In many communities, behavioral health crisis response consists of a variety of fragmented services rather than a single, cohesive system (Gulley et al., 2022). People experiencing a crisis may interact with several separate systems (e.g., law enforcement, EMTs/paramedics, EDs, jails) and not receive adequate behavioral health treatment (Gulley et al., 2022). In many communities, law enforcement personnel are the default first responders, but few are extensively trained in how to assist a person having a behavioral health crisis. Police interaction with people experiencing a behavioral health crisis increases the likelihood of traumatic and adverse outcomes (e.g., being arrested, handcuffed, imprisoned, involuntarily hospitalized, injured, killed) (Gulley et al., 2022).

Type of insurance coverage or the lack of insurance may affect where an individual who is having a behavioral health crisis will seek care. There is a great deal of variation across counties in the types of providers and facilities that are available to assist an individual having a behavioral health crisis, and this also may affect where an individual will seek care.

Mental Health: Urgent Care Needed

Those with a *mental health* condition who need care urgently but not on an emergency basis may seek *outpatient* care from providers as shown below:

- Medi-Cal or other public insurance, or uninsured: go to a primary care clinic or a federally qualified health center (FQHC), a public or county clinic, or a mental health crisis center if there is one in their community.
- Commercial insurance: go to a private practice medical care provider or behavioral health provider (e.g., social worker, psychologist), or a mental health crisis center if there is one in their community.

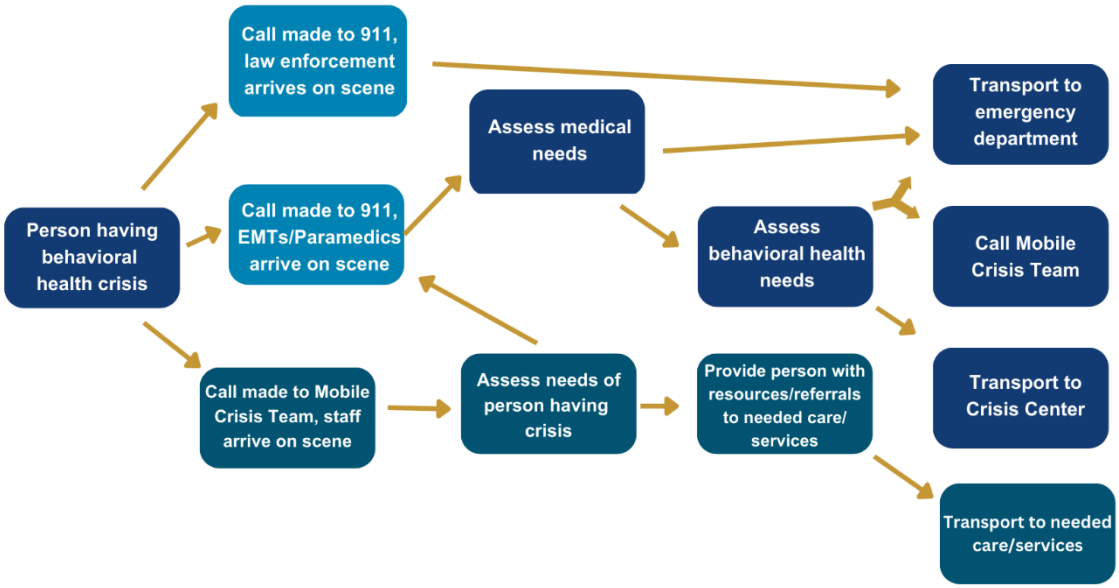
If a person with a mental health condition has a behavioral health crisis during a visit for a physical health issue and needs behavioral health care urgently, a medical care provider may provide a warm handoff to a behavioral health provider onsite, if those services are available, or they may refer the person to an external behavioral health provider if such services are not available onsite.

Mental Health: Emergency Care Needed

Individuals with a mental health condition who need care on an *emergency* basis may call 988 or a county behavioral health department 24/7 crisis hotline,[10] or self-refer to a mental health crisis center if one is available in the community or to a hospital ED. Alternatively, they may contact emergency services (i.e., 911) or someone else may call on their behalf. After 911 is called, first responders (i.e., law enforcement personnel, EMTs/paramedics) or a mobile crisis response team, if available in the community, will be summoned. EMTs/paramedics would assess the person for medical and behavioral health needs, and based on the patient's needs, may transport them to a hospital ED (where they may be treated and either admitted for inpatient care or discharged), mental health crisis center, or inpatient psychiatric facility, depending on what facilities are available in the county (see Figure 1); law enforcement personnel typically transport directly to the ED. EMT/paramedic transport of a person directly to a mental health crisis center currently occurs in two California counties — Fresno and Los Angeles.[11] Mobile crisis teams are available in some California counites and are described in more detail at the end of this section. These teams may include a behavioral health clinician, medical professional, and peer support specialist, and also would assess the person's needs, provide them with resources or referrals for needed care and other services, and potentially transport them to needed care/services.

[10] DHCS, *County Mental Health Plan Information*, available at: https://www.dhcs.ca.gov/individuals/Pages/MHPContactList.aspx.
[11] Authorized by AB 1544, Community Paramedicine or Triage to Alternate Destination Act. https://leginfo.legislature.ca.gov/faces/billPdf.xhtml?bill_id=201920200AB1544&version=20190AB154491CHP

Figure 1. Example of Behavioral Health Crisis, Emergency Response



For individuals with a mental health condition who are having a behavioral health crisis and have been assessed and stabilized, treatment pathways may include one or more of the following: inpatient hospitalization, outpatient/day treatment programs, outpatient psychotherapy, and prescription medications.

Substance Use Disorder: Urgent Care Needed

Similar to what is described above for mental health, individuals with a substance use disorder (SUD) who need care urgently but not on an emergency basis may seek *outpatient* care from providers as shown below:

- Medi-Cal or other public insurance, or uninsured: primary care clinic or a FQHC, a public or county clinic, or support group.
- Commercial insurance: private practice medical care provider or behavioral health provider, or support group.

If a person with an SUD has a behavioral health crisis during a visit for a physical health issue and needs behavioral health care urgently, a medical care provider may provide a warm handoff to a behavioral health provider onsite or refer the person to an external behavioral health provider if such services are not available onsite.

Substance Use Disorder: Emergency Care Needed

Similar to what was described above for emergency situations, individuals with an SUD who are having a behavioral health crisis and need care on an *emergency* basis may call 988 or a county behavioral health department 24/7 crisis hotline, or self-refer to a hospital ED or sobering center if there is one in their community. Alternatively, they may contact emergency services (i.e., 911) or someone else may call on their behalf. After 911 is called, first responders or a mobile crisis response team, if available, will be summoned. EMTs/paramedics would assess the person for medical and behavioral health needs, and based on these needs, may transport them to an appropriate facility, potentially including an ED (where they may be treated and either admitted for inpatient care or discharged), a sobering center, or a detoxification facility, depending on what facilities are available in the county and whether EMTs/ paramedics are allowed to transport a person to a destination other than an ED); law enforcement personnel typically transport directly to the ED. Alternatively, mobile crisis teams would assess the person's

needs, provide them with resources or referrals for needed care and other services, and potentially transport them to needed care/services.

For individuals with an SUD who are having a behavioral health crisis and have been assessed and stabilized, treatment pathways may include one or more of the following: inpatient hospitalization, inpatient detoxification, outpatient/day treatment programs, outpatient psychotherapy, and prescription medications.

Mobile Crisis Services

In 2022, DHCS announced that it planned to seek federal approvals to provide qualifying community-based mobile crisis intervention services to eligible Medi-Cal beneficiaries experiencing a "behavioral health crisis." These services are designed to provide relief to individuals experiencing a behavioral health crisis, including through de-escalation and stabilization techniques; reduce the immediate risk of danger and subsequent harm; provide warm handoffs to appropriate settings and providers when needed; coordinate with and make referrals to needed health, social, and other services and supports; and offer short-term follow-up support to help ensure the crisis is resolved and the individual is connected to ongoing care (DHCS, 2022). This may reduce ED use, psychiatric inpatient hospitalizations, and law enforcement involvement.

Similar programs in California predate DHCS' mobile crisis care initiative. As one example, San Francisco's first Street Crisis Response Team was launched in November 2020 as a pilot project; it operates citywide, 24 hours per day throughout the year.[12] Designed to assist people in crisis who do not necessitate a law-enforcement response, teams consist of a specially trained San Francisco Fire Department Community Paramedic, a behavioral health clinician, and a peer support specialist.

MAJOR GAPS IMPACTING BEHAVIORAL HEALTH CRISIS RESPONSE

Throughout California, communities are facing multiple barriers to behavioral crisis response including a shortage and maldistribution of facilities and providers. In both public and private settings, the supply and distribution of the state's behavioral health workforce affects the ability to provide necessary and competent services to patients facing behavioral health crises. There is particular concern about the capacity of California's county behavioral health safety net to provide care to those with behavioral health needs. This safety net is composed of county behavioral health agencies, city behavioral health authorities, and community-based organizations (CBOs) with which they contract to provide behavioral health services. The county behavioral health safety net primarily serves low-income people with mental health conditions, substance use disorders (SUDs), and co-occurring disorders who require a range of specialty behavioral health services. Additionally, federally qualified health centers (FQHCs) and FQHC lookalikes play significant roles in providing behavioral health services to people with low-incomes who have SUD or mild to moderate mental health conditions. The majority of people served by the county behavioral health safety net and FQHCs are uninsured or enrolled in Medicaid.

Shortage and Maldistribution of Psychiatric Facilities

As discussed, the emergency department (ED) often is the initial contact point for patients experiencing behavioral health crises. However, there is evidence that the ED is neither appropriate nor effective in responding to people in behavioral health crises, and psychiatric patients must wait in the ED until there is a bed where more appropriate psychiatric care is available (Zhu et al., 2016).

[12] City and County of San Francisco Street Crisis Response Team, available at https://sf.gov/street-crisis-response-team. Accessed April 16, 2023.

Across California, there are 6,702 hospital beds available for individuals in need of short-term, acute level of care, psychiatric inpatient services (CHA, 2018).[13] However, the state has a shortage of psychiatric beds that includes high bed occupancy rates and long waitlists for placements. Leading psychiatrists estimate that the absolute minimum ratio of psychiatric beds per capita required to meet the current needs in California is 50 public psychiatric beds per 100,000 individuals (1 psychiatric bed per 2,000 people) (McBain et al., 2022). Despite this need, California had 17.05 psychiatric inpatient beds for every 100,000 California residents (1 psychiatric bed per 5,856 people) in 2016. The need for California psychiatric beds is expected to grow 1.7% from 2021 to 2026 at all levels of inpatient and residential care (McBain et al., 2022). Additionally, researchers predict this shortage of psychiatric beds will vary significantly by region, with the largest needs in the Northern and Southern San Joaquin Valley (McBain et al., 2022). Of the 58 California counties, 25 counties (45% of the state) have no inpatient psychiatric services at all, 25 counties do not have any inpatient adult psychiatric beds, 42 counties (72% of state) do not have child/adolescent beds, 56 counties (97% of state) do not have geriatric psychiatric[14] (long-term) beds, 48 counties (83% of state) do not have chemical dependency beds, and 55 counties (95% of state) do not have psychiatric intensive care beds.

Limited Availability of Mobile Crisis Services

As described above, mobile crisis services are intended to provide community-based crisis response and reduce unnecessary first responder involvement and ED utilization. Limited crisis intervention services are currently covered by a specialty mental health benefit service under Medi-Cal as a carveout of comprehensive managed care and are provided by some counties (Gulley et al., 2022). While DHCS is pursuing federal approval for mobile crisis services, they are not yet a statewide Medi-Cal benefit. As of 2021, approximately two-thirds of the 58 California counties have mobile crisis teams (MCTs) of varying design and utilization (Gulley et al., 2022). Of the 35 California counties with MCTs, approximately 37% dispatch MCTs directly from a police/sheriff's office, 22% through a county access line, and 18% from a dedicated crisis line. Based on a survey conducted by the California County Behavioral Health Directors Association (CBHDA), of the 35 counties reporting that they have mobile crisis services, most (73%) did not provide 24/7 coverage but prioritize services during peak hours. In many areas without 24-hour coverage, individuals with lived experience reported that law enforcement was the only option.

Limited Training of First Responders and Primary Care Providers

First responders and primary care providers generally have limited training in dealing with behavioral health crisis management and treatment (Osborn et al., 2015). A systematic review reported that inconsistent training, complexity of procedures, and stigmatization make this a very challenging task and that many first responders report feeling unfit to respond to behavioral health crises because they lack the knowledge, resources, and training to handle these situations (Xanthopoulou et al., 2022).

Shortage and Maldistribution of Behavioral Health Workforce

Recent studies have reported a shortage and maldistribution of psychiatrists and other behavioral health providers, including addiction specialists, that are authorized to diagnose behavioral health conditions. Psychiatrists can also prescribe medications to patients experiencing behavioral health conditions. A recent report (Coffman and Fix, 2023) found that California's behavioral health professionals are not evenly distributed across the state. Table 6 displays ratios of psychiatrists, psychologists, licensed clinical social

[13] This includes 32 hospitals licensed as freestanding acute psychiatric hospitals providing 2,650 beds and 26 county-based psychiatric health facilities, which provide care only to individuals with acute behavioral health needs, with 468 beds, along with 79 general acute care hospitals in California with dedicated psychiatric units, providing 3,584 beds.
[14] Geriatric-psychiatric consists of medical care, nursing and auxiliary professional services, and intensive supervision of the chronically mentally ill, mentally disordered, or other mentally incompetent geriatric persons. Patients must be diagnosed with a severe mental illness other than or in addition to diseases with organic origins such as Alzheimer's or dementia.

workers (LCSWs), licensed marriage and family therapists (LMFTs), and licensed professional clinical counselors (LPCCs), per 100,000 population by region in 2021. The regions are defined by county and reflect the regions used by the California Health Interview Survey. Ratios in green indicate the region with the highest ratio per capita and ratios in red indicate the region with the lowest ratio per capita.

The Greater Bay Area had the highest ratios per capita for psychiatrists, psychologists, and LCSWs and the second highest ratios for LMFTs and LPCCs while the San Joaquin Valley had the lowest ratios for psychiatrists, psychologists, LCSWs, LMFTs, and LPCCs per capita. The Inland Empire had the second lowest ratios per capita for these professions except for psychiatrists.

Ratios per 100,000 population are displayed below in Table 6 so that supplies of licensed behavioral health professionals can be compared across regions that have populations of different sizes.

Table 6. Actively Licensed Behavioral Health Professionals per 100,000 Population by Region, 2021

Region	Psychiatrists	Psychologists	LCSWs	LMFTs	LPCCs
California	**15.2**	**44.2**	**65.9**	**100.8**	**5.0**
Central Coast	14.7	47.0	61.7	144.2	5.2
Greater Bay Area	25.2	72.4	82.6	134.9	6.8
Inland Empire	9.4	16.1	39.4	61.5	3.8
Los Angeles	15.6	48.8	81.3	106.5	4.0
Northern & Sierra	7.8	21.5	64.3	98.8	5.4
Orange	11.0	40.0	56.6	105.9	5.6
Sacramento Area	14.9	37.1	71.6	97.0	5.6
San Diego Area	17.1	55.6	65.6	95.2	7.4
San Joaquin Valley	7.0	16.0	35.1	47.7	2.5

Source: Coffman and Fix, 2023.

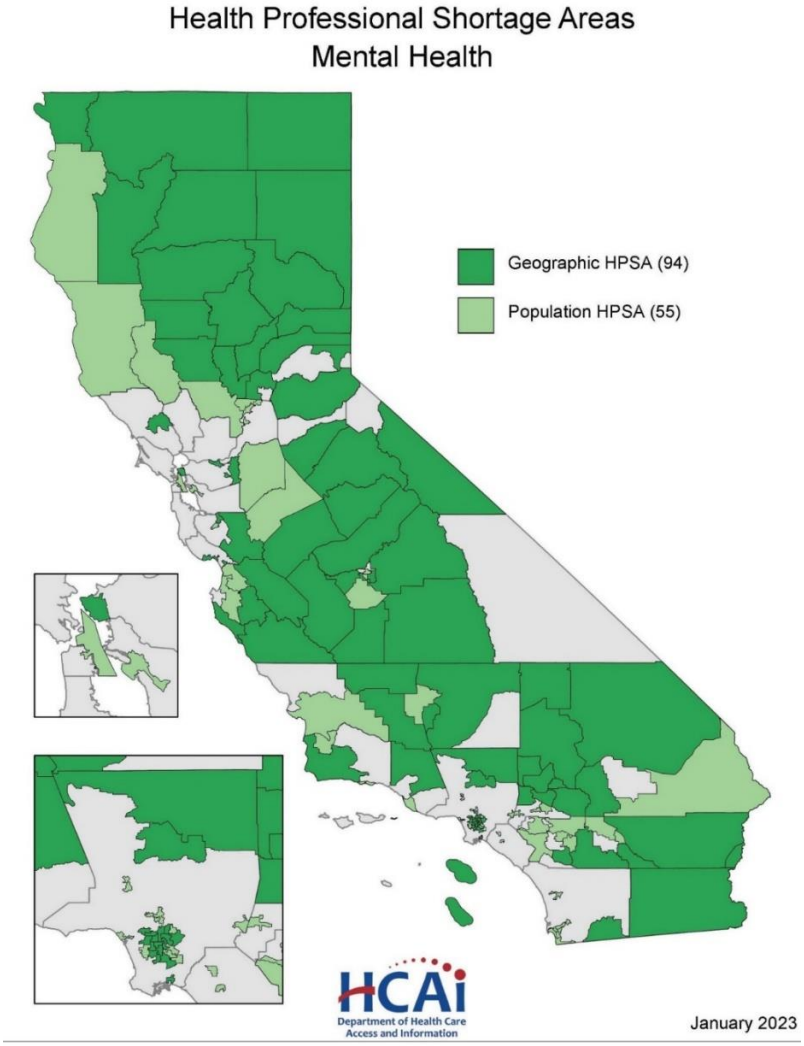
Note: Table displays ratios per 100,000 population so that supplies of licensed behavioral health professionals can be compared across regions that have populations of different sizes.

Key: LCSW = licensed clinical social worker; LMFT = licensed marriage and family therapist; LPCC = licensed professional clinical counselor.

Figure 2 shows areas of California that the Health Resources and Services Administration designates as Mental Health Professional Shortage Areas. Health Professional Shortage Area (HPSA) designations are used to identify areas and population groups within the United States that are experiencing a shortage of health professionals. *Population* HPSAs have a shortage of services for a specific population subset within an established geographic area. *Geographic* HPSAs have a shortage of services for the entire population within an established geographic area. This figure illustrates the maldistribution of health professionals across the state, as most rural and agricultural areas are designated as mental health HPSAs, along with some lower-income urban areas.

A recent needs assessment on the behavioral health workforce in California (Coffman and Fix, 2023) reported that county behavioral health agencies are facing challenges with recruitment of personnel who specialize in treating clients they serve. Difficulties were reported in recruiting staff for specific programs such as crisis care (especially 24/7 care), forensic services, full-service partnership programs, and narcotics treatment programs. Among California county agencies, 86% had difficulty recruiting staff to work in these specific mental health programs and 43% experienced difficulty with recruitment of staff for specific SUD programs. Findings for CBOs were similar to findings for county behavioral health agencies.

Figure 2. California Health Professional Shortage Areas (HPSAs), Mental Health



Source: HCAI, 2023.

Limited Diversity of Providers

Racial and Ethnic Diversity

The distribution of California's behavioral health professionals across racial/ethnic groups does not reflect the state's population (Coffman and Fix, 2023). Latino persons are underrepresented in almost all behavioral health professions relative to their share of California's population. While they make up 39% of California's population, they comprise only 12% to 32% of behavioral health professions and are most underrepresented among psychiatrists and psychologists, comprising only 5% and 12% of professionals, respectively. The exception is SUD counselors, where they comprise 39% of this profession. Black persons are also underrepresented among psychiatrists and psychologists but are represented at or above parity among marriage and family therapists, mental health counselors, social workers, and SUD counselors. By contrast, Asian persons are well-represented among psychiatrists but underrepresented in other behavioral health professions, where they constitute 8% to 12% of professionals versus 15% of the population.

Linguistic Diversity

The linguistic diversity of behavioral health professionals also does not reflect the linguistic diversity of California's population, with 41% of behavioral health professionals speaking only English: 12% speak Spanish and 8% speak one of the four most frequently spoken Asian languages in California (i.e., Cantonese/Mandarin, Vietnamese, Tagalog, and Korean). With the exception of psychologists, the percentage of Spanish speakers is higher among all types of nonprescribing behavioral health professionals than among psychiatrists. The percentage of Spanish speakers ranges from 17% of marriage and family therapists to 28% of SUD counselors. Percentages of nonprescribing behavioral health professionals that speak any other non-English language range from 7% of mental health counselors to 12% of psychologists (Coffman and Fix, 2023).

The lack of access to racially/ethnically and linguistically concordant providers makes it more difficult for people to obtain treatment that can help them manage their mental health and/or substance use conditions and reduce the risk of experiencing a behavioral health crisis (Cooper et al., 2003; Fernández and Pérez-Stable, 2015; Thornton, et al., 2011; Street et al., 2008).

Role of Insurance Status

The shortage and maldistribution of behavioral health professionals is compounded because many of these professionals do not accept health insurance. Multiple national studies have found that psychiatrists are less likely to participate in health insurance plans' provider networks than physicians in other specialties (Benjenk and Chen, 2020; Benson et al., 2020; Bishop et al., 2014; Zhu et al., 2017). The most recent estimates available indicate that in 2014 through 2016, 26% of psychiatrists nationwide did not bill health plans. Their patients had to pay out-of-pocket and submit their own health insurance claims, if their health plans covered out-of-network psychiatrists (Bocutti and Neuman, 2017). Many psychiatrists also do not accept patients enrolled in Medicare or Medicaid (Anand et al., 2021; Bishop et al., 2014; Bocutti and Neuman, 2017). Limited evidence suggests that many nonphysician behavioral health professionals also do not participate in health insurance networks (Zhu et al., 2017).

At present, no entity regularly collects and reports data on participation of California's behavioral health professionals in commercial health insurance, Medicare, or Medi-Cal. A one-time survey of psychiatrists conducted in 2015 found that 77% of psychiatrists had patients with commercial health insurance, 55% had Medicare patients, and 46% had Medi-Cal patients (Coffman and Fix, 2017). The survey found that psychiatrists were also less likely to accept Medi-Cal patients than physicians in other specialties. For example, 46% of psychiatrists accepted Medi-Cal patients versus 63% of family physicians. Psychiatrists' low rate of participation in Medi-Cal compounds the demand for psychiatrists' services in the county behavioral health safety net.

A recent article (Zhu et al., 2023) reported findings from analyses of Medicaid fee-for-service reimbursement rates for common psychiatric services (e.g., psychiatric diagnostic evaluations), showing rates for each state relative to each other and to Medicare rates. Nationally, reimbursement rates for frequently billed psychiatry services were 81% of Medicare rates, with a sizable variation in payments across states, differing by more than fivefold between the lowest- and highest-paying states. In both comparisons, California was on the low end of reimbursement rates. The article presented information on psychiatrist participation in Medicaid, also finding that California is on the low end relative to other states.

APPENDIX A TEXT OF BILL ANALYZED

On February 21, 2023, the California Assembly Committee on Health requested that CHBRP analyze AB 1451 as introduced on February 17, 2023.

ASSEMBLY BILL **NO. 1451**

Introduced by Assembly Member Jackson

February 17, 2023

An act to add Section 1374.725 to the Health and Safety Code, and to add Section 10144.58 to the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

AB 1451, as introduced, Jackson. Behavioral health crisis treatment.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law requires a health care service plan or health insurer that provides hospital, medical, or surgical coverage shall provide coverage for medically necessary treatment of mental health and substance use disorders, under the same terms and conditions applied to other medical conditions, as specified. Existing law also includes requirements for timely access to care, including mental health services, including a requirement that a health care service plan or health insurer provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's or insured's condition consistent with good professional practice.

This bill would require a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, to provide coverage for treatment of a behavioral health crisis that is identified during an appointment at a contracted facility where an enrollee or insured is receiving treatment from a contracted provider for a medical condition, as specified. The bill would authorize treatment for the behavioral health crisis to be provided at the contracted facility, if the facility has the appropriate staff to provide that care. The bill would require the treatment to be provided without preauthorization, and would authorize the provider or facility to use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee or insured. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

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THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1374.725 is added to the Health and Safety Code, to read:

1374.725. (a) A health care service plan contract issued, amended, or renewed on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders shall cover treatment for a behavioral health crisis as provided in this section.

(b) During an appointment at a contracted facility, at which an enrollee is receiving treatment from a contracted provider for a medical condition, and it is the provider's medical judgment that the enrollee also shows signs of a behavioral health crisis, treatment for the behavioral health crisis may also be provided at the contracted facility, if the facility has the appropriate staff to provide that care.

(c) Treatment for a behavioral health crisis pursuant to this section shall not require preauthorization. The provider or facility may use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the enrollee.

(d) A health care service plan shall provide reimbursement for services provided pursuant to this section in compliance with the requirements for timely payment of claims, as required by this chapter.

SEC. 2. Section 10144.58 is added to the Insurance Code, to read:

10144.58. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2024, that provides coverage for medically necessary treatment of mental health and substance use disorders shall cover treatment for a behavioral health crisis as provided in this section.

(b) During an appointment at a contracted facility, at which an insured is receiving treatment from a contracted provider for a medical condition, and it is the provider's medical judgment that the insured also shows signs of a behavioral health crisis, treatment for the behavioral health crisis may also be provided at the contracted facility, if the facility has the appropriate staff to provide that care.

(c) Treatment for a behavioral health crisis pursuant to this section shall not require preauthorization. The provider or facility may use same-day billing to obtain reimbursement for both the medical and behavioral health services provided to the insured.

(d) A health insurer shall provide reimbursement for services provided pursuant to this section in compliance with Section 10123.13.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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ABOUT CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

A group of faculty, researchers, and staff complete the analysis that informs California Health Benefits Review Program (CHBRP) reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at www.chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at www.chbrp.org.

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Please direct any questions concerning this document to: California Health Benefits Review Program; MC 3116; Berkeley, CA 94720-3116, info@chbrp.org, or www.chbrp.org