California's Behavioral Health System

The LTC Fundamentals series is produced by The SCAN Foundation to outline the organization and financing of long-term care (LTC) in California. This LTC Fundamentals brief provides background on California's behavioral health system, changes under parity requirements and the Affordable Care Act, and integration initiatives that are re-shaping current delivery systems with the intention of expanding access and improving services.

Introduction

California's behavioral health system seeks to support individuals with mental health and/or substance use disorders, involving both public and private payers and providers. The current public system has evolved from primarily a state-run, institution-based system to a community-based system with local (county) control. Recent changes at both the federal and state levels aim to better connect behavioral health care with medical services. Yet fragmentation remains, leaving individuals to navigate a complex system. This *LTC Fundamentals* brief provides background on California's behavioral health system, services provided, who provides and who receives services, as well as policy challenges and opportunities.

Background

Behavioral health refers to a continuum of services for individuals who have or who are at risk of mental illness and/or substance use disorders.[1] Mental illness is a health condition that affects a person's ability to cope with everyday life. It is characterized by changes in mood, thinking, and behavior, and may affect one's ability to interact with others and complete ordinary tasks.[2] The most commonly diagnosed mental illnesses are anxiety and depression, while severe mental illness (SMI) includes a broader array of conditions including: severe depression, obsessive compulsive disorder, bipolar disorder, schizophrenia, etc.[3] Substance use disorder (SUD) refers to a dependence on alcohol and/or drugs that may be detrimental to one's physical or mental health.[2] In this brief, we also include the detection and treatment of dementia as a part of behavioral health as those with dementia may also exhibit anxiety, agitation, depression, and other behavioral conditions affecting one's ability to function and interact with others effectively.[4] The duration of behavioral health conditions can be short- or long-term.[2]

Over time, federal and state policies and the respective funding streams have transitioned behavioral health treatment from institutional settings, such as state mental hospitals,

to community-based providers. Two key laws – California's *Lanterman-Petris-Short Act* passed in 1967, and the federal *Americans with Disabilities Act* (ADA) passed in 1990, protect the rights of individuals with behavioral health conditions to receive services in the community. The *Lanterman-Petris-Short Act* established the standards regulating involuntary commitment, including the right to due process.[5] The ADA established a person's right to choose where they receive services.[6] In 1999, the U.S. Supreme Court's *Olmstead* decision established the right of people with disabilities to live in the least restrictive environment.[7] These legal precedents are often cited by people with disabilities, including those with behavioral health needs, as the basis for obtaining necessary services in the community.

Population Description

Approximately 16 percent of California adults have behavioral health needs, and prevalence among those 65 and older is four percent.[8] Within this population are those with mental health conditions and SUD separately, as well those with co-occurring disorders (both mental health and SUD). It is estimated that baby boomers have three to four times higher rates of depression, anxiety, SUD, etc. than the current older adult population. This prevalence of behavioral health conditions is expected to carry through as the baby boomer generation ages, placing even more demand on the current system.[9] In this section, we describe prevalence of these conditions separately. While California counties provide services to people age 60 and older congruent with Older American's Act services, most available data sources limited data to 65 and older. There are significant challenges to measuring prevalence of mental health conditions and SUD in older populations[8-10]; however, where data are available, we provide description of the population age 65 and older.*

Prevalence of Mental Illness

Eleven percent of all older Californians (age 65+) reported they experienced challenges to completing daily tasks due to emotional problems such as depression or anxiety, which are the most prevalent behavioral health conditions among adults overall.[11] This rate is almost double (20 percent) for older Medi-Cal (California's Medicaid program) beneficiaries. The prevalence of SMI in the state is approximately 4.3 percent among all adults and 1.6 percent among older adults.[8] In addition, 10 percent of older Californians (age 65+) experience some form of dementia, increasing to 47 percent for adults over age 85. Approximately half of the people with dementia also experience treatable symptoms of behavioral health conditions (e.g., delusions, severe depression, etc.).[12]

Prevalence of Substance Use

Two percent of older Californians (age 65+) have a substance use disorder diagnosis. SUD is often overlooked by health care providers as the symptoms are mistaken for dementia, depression, delirium.[13] Older adults are vulnerable to SUD due to physical changes that occur with age, alcohol and/or illicit drug interactions with chronic illness, poor nutrition, and prescription medication use. Compounding the issue, people with behavioral health needs can have a SUD in addition to a SMI, referred to as co-occurring

*Challenges remain with collecting surveillance data on adults with behavioral health needs as information is gathered through multiple processes with various foci and measurement. Compiling data on older adults is further complicated as older adults are not consistently identified and measured as a separate population group, especially in relation to SUD. Finally, older adults are typically under-diagnosed for behavioral health conditions, which may result in undercounting the prevalence of behavioral health issues in the older adult population. With these challenges in mind, a review of multiple sources helps to build a more complete picture.

disorders. Nationally, eight million adults live with co-occurring disorders.[1,14]

The abuse of prescription painkillers (e.g., opiates) is a growing problem with the highest abuse rate between ages 35-54.[15] However, with the high incidence of chronic pain among older adults, it is expected to be an increasing problem with the aging of baby boomers. Interactions between alcohol and drugs (prescription or otherwise) are anticipated to become a larger problem as approximately 50 percent of older Americans are light or moderate drinkers.[9] The baby boom generation exhibits a higher level of alcohol consumption than previous generations, which is expected to carry over as they age, placing more demand on both the medical care and behavioral health systems.[9]

Complex Health and Behavioral Health Needs

Individuals with behavioral health needs often experience complex health problems due to a variety of factors (impact of psychotropic medications on health status, limited access to primary care, etc.). In addition to managing behavioral health issues, older adults with SMI have higher rates of comorbid chronic conditions (heart disease, diabetes, etc.) than those without. Over 50 percent of older adults with one or more SMI also have three or more chronic conditions.[16]

People with co-occurring SMI and chronic health conditions are at higher risk for increased healthcare costs and reduced life expectancy. Forty-six percent of Medicare beneficiaries with SMI and 88 percent with SMI and SUD were hospitalized as compared to 17 percent of those without SMI.[17] On average, people with SMI die 25 years sooner than the general population. For those with co-occurring SMI and SUD, the reduction in life expectancy is 30 years. In 2010, suicide was the tenth leading cause of death in the US.[18] Older adults are more likely to commit suicide than teenagers, with the highest suicide rate among older white men.[12,19] While suicide rates are elevated in this population, the shorter life expectancy is largely due to exacerbations of health conditions that are preventable.

Implications for an Aging California

Older Californians are increasing as a proportion of the total California population at a faster rate than the rest of the U.S., reaching 12.5 million people by 2040.[12] The population age 80 years and older is the fastest growing segment of older adults, increasing by nearly 600 percent while the rest of the older population only doubles in size.[12] In light of the behavioral health needs described above, these demographic trends will create a greater demand on California's behavioral health system, and require a greater understanding among providers of older adults' needs and how they access services.

Behavioral Health Care Settings and Providers

Behavioral health services are provided across multiple sectors and settings – medical, behavioral health, and human services – by a variety of providers including physicians, psychiatrists, psychologists, social workers, certified nurses, technicians, and peers. Behavioral health services for older adults are provided in various institutional or community settings including: physician offices, community mental health centers, senior housing, group homes, adult day centers, nursing homes, outpatient and residential SUD programs, hospitals, psychiatric hospitals, state mental hospitals, and Veterans' Health Administration facilities.[4] Treatment for behavioral health needs for older adults may include pharmaceutical intervention, geropsychiatric services, dementia care, home-and community-based long-term care

services, residential and family support services, intensive case management, psychosocial rehabilitation services, crisis intervention, and inpatient hospitalization. However, older adults residing in the community most commonly seek pharmaceutical interventions to treat their behavioral health care needs.[4]

Institutional Services

Behavioral health services are provided in a variety of institutional settings depending on scope of care, supervision, and diagnosis. Institutional settings include state hospitals, psychiatric hospitals, nursing homes, mental health rehabilitation centers,[†] and corrections facilities.[19] State hospitals represent 38 percent of psychiatric inpatient beds (6,094), predominately serving incarcerated persons with SMI. Acute psychiatric beds are located in general hospital psychiatric units, acute psychiatric hospitals, and psychiatric health facilities.[‡] California has nearly 6,000 acute psychiatric beds, 2,000 beds in the special treatment program provided in certified skilled nursing facilities, and 1,500 beds in mental health rehabilitation centers.[19] Notably, 25 counties do not have psychiatric beds. There are 812 beds licensed for inpatient detoxification treatment for Californians with SUD.[8] Additionally, an estimated 31,400 persons with behavioral health needs reside in state prisons.[20]

Although on the decline, the proportion of older adults with behavioral health needs residing in institutions still remains high. Almost 90 percent of older adults with SMI getting services in an institution receive them in a nursing facility.[4] This is due in part to the high proportion of this population receiving services funded by Medicaid that mandates coverage for institutional services but not home- and community-based services. Often nursing facilities do not have the appropriate systems in place to meet the needs of residents with behavioral health needs, which may lead to excessive use of physical and chemical restraints.[21,22]

Community-Based Services

The vast majority of individuals with behavioral health needs live in and seek treatment options in community settings.[4] Older adults with behavioral health needs prefer to receive treatment in a primary care setting rather than in specialty mental health or substance use treatment settings.[4] People who do not qualify for SMI or SUD services through Medicare or Medicaid may receive behavioral health services through federally qualified health centers (FQHCs) and rural health clinics (RHCs). These providers traditionally address the needs of underserved populations such as homeless individuals, and in areas with limited resources like rural communities. In 2010, California's 118 FQHCs provided mental health services to over 108,000 people and substance use treatment services to almost 22,000.[8] Other traditionally utilized community-based services include support groups; limited behavioral health in-home support through home health agencies; and Community-Based Adult Services (CBAS)[§], which offers assessment, supervision, and social/recreational services.[4] California has 244 CBAS centers, with a high concentration of providers in Los Angeles County. Notably, almost half of CBAS participants have a psychiatric diagnosis, and 30 percent are diagnosed with dementia.[23]

[†]Mental health rehabilitation centers provide intermediate and long-term care.

[‡]Acute psychiatric hospitals are typically free-standing, locked facilities used for short-term acute treatment. A psychiatric health facility is licensed for inpatient treatment and provides acute short-term treatment in a non-hospital setting.

[§]Community-Based Adult Services, or CBAS, is a Medi-Cal managed care benefit that provides adult day health care services.

California's Behavioral Health System

In California, counties are responsible for providing over 90 percent of behavioral health services for people with SMI and SUD.[20] While services are mostly provided through county mental health departments (often identified as county mental health plans) and county alcohol and drug programs, the state also contracts directly with providers in counties that do not have established departments. County behavioral health programs predominantly serve the general adult population and children, yet serve a small percentage of older adults and often do not serve those with dementia.[8] Older adults who do not meet narrow criteria for specialty mental health services have access to limited mental health services, resulting in those with co-occurring disorders (mental health and SUD) receiving treatment through the county alcohol and drug programs.[24-26] California's behavioral health system is made up of providers and programs funded through a variety of sources with varying requirements.

California Behavioral Health Workforce

California's behavioral health system relies on a large and varied workforce. Table 1 below provides a detailed description of the broad range of providers, the primary focus of their work in treating behavioral health needs, a count of those present in California, and the entity responsible for licensing/certification.

California Behavioral Health Programs

The state offers a variety of programs to address the behavioral health needs of Californians. Table 2 provides information on key public behavioral health programs. Following this table is further discussion of the funding mechanisms and oversight.

TABLE 1 California Behavioral Health Workforce [8,19,27-30]

Provider	Size	Credentials and Customary Practice	Licensing/Certification Entity
Physician (MD/DO)	130,440 (1,559 geriatric)	MD/DO with general licensure. Provide diagnosis, treatment planning, medication prescription, and referral for behavioral health services.	Medical Board of CA
Psychiatrist	4,260	MD/DO with general licensure and specialty in psychiatry. Provide diagnosis, medication prescription, treatment planning, and therapy.	Medical Board of CA
Psychologist	17,645	PhD in clinical psychology with general licensure. Provide psychological testing, treatment planning, and therapy.	CA Board of Psychology
Mental Health and SUD Social Worker (LCSW)	18,633[a]	MSW with general licensure. Provide treatment planning, therapy, case management, rehabilitation and support.	CA Board of Behavioral Sciences
Marriage & Family Therapist (MFT)	13,563[a]	MA in Counseling or related degree with general licensure. Provide treatment planning, therapy, case management, rehabilitation and support.	CA Board of Behavioral Sciences
Psychiatric Nurse	357	Advanced practice nurse with a masters or doctorate specializing in psychiatry. Provide treatment planning, therapy, and medication prescription if a nurse practitioner with a furnishing number.	CA Board of Registered Nursing
Psychiatric Technician	9,855	Licensed vocational nurse equivalent. Medication administration, treatment planning, case management, rehabilitation and support.	CA Board of Vocational Nurses and Psychiatric Technicians.
Substance Use Counselors	8,850	Typically have personal experience with addiction, and must be certified within 5 years of hire date. Some may be licensed, but California does not require licensure.[c] Provide intake, assessment, treatment planning, recovery planning, and counseling.	Certified by one of nine organizations approved by the California Department of Health Care Services (DHCS).[b]
Psychiatric Rehabilitation Counselor	8,140[d]	Behavioral health workers with a bachelor's degree. Work to maximize the independence and employability of persons coping with personal, social, and vocational difficulties by providing treatment planning, case management, rehabilitation and support.	No licensure or certification.

[a] Forty percent are in private practice.

[b] For a list of approved Substance Use Counselor certification organizations, please see: http://www.adp.ca.gov/Licensing/LCBhome.shtml.

[c] Substance Use Counselor certification is based upon the *Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice*, provided by the Center for Substance Abuse Treatment. More information is available at http://www.adp.ca.gov/Licensing/LCBhome.shtml.

[d] This number represents the total number of rehabilitation counselors in California including psychiatric rehabilitation counselors. No data were available identifying rehabilitation counselors by specialty.

TABLE 2 Public Behavioral Health Programs[19,23,31-41]

Program	Population Served	Services	Funding
Specialty Mental Health Services (SMHS)	Medi-Cal eligible with SMI[a]	Crisis residential services, residential treatment services, crisis intervention and stabilization, day rehabilitation, day treatment intensive, medication support, psychiatric health facility services, psychiatric inpatient hospital services, and targeted case management and therapy.	Medi-Cal, through a 1915(b) waiver (federal and state/local)[b]
Medi-Cal Health Plans and Medi-Cal Fee-for-Service	Medi-Cal eligible with mild and moderate behavioral health needs	Outpatient mental health services, crisis intervention, psychiatry, inpatient mental health care.	Medi-Cal (federal and state)
SMI Indigent Services	Uninsured with SMI	Outpatient mental health services, crisis intervention, psychiatry, short- and long-term inpatient mental health, rehabilitative and support services, and prevention.	County funds, realignment funds, and Mental Health Services Act
Medi-Cal Alcohol and Drug Program (Drug Medi-Cal)	Medi-Cal eligible with SUD	Medically necessary substance use disorder treatment services including outpatient, narcotic treatment programs, narcotic replacement therapy, day rehabilitation, Naltrexone, and counseling in residential facilities for pregnant and post-partum women.[c]	Medi-Cal
SUD Indigent Services	Uninsured with SUD	Outpatient treatment, residential treatment, and residential detoxification programs.	Substance Abuse Prevention and Treatment block grant, realignment funds, and other county funds
Community-Based Adult Services (CBAS)	Adults with chronic medical, cognitive, or behavioral health needs who are at risk for institutional care	Assessment, professional nursing services, therapies (physical, occupational and speech), mental health services, therapeutic activities, social services, personal care, meals, nutritional counseling, and transportation to and from the program.	Medi-Cal[d] Not part of the county mental health program

TABLE 2 Public Behavioral Health Programs[19,23,31-41]

Program	Population Served	Services	Funding
Institutions of Mental Disease[e]	Adults with SMI who are a danger to themselves or others	Short-term services (transition from an acute-care setting) and long-term services provided in state hospitals, nursing homes specializing in behavioral health services, and Mental Health Rehabilitation Centers.	Medi-Cal (< age 22, and age 65+); County realignment funds (ages 22-64)[f]
Projects for Assistance in Transition from Homelessness (PATH)	Homeless individuals with behavioral health needs	Community-based outreach, mental health and substance use referral and treatment, and case management, in addition to limited housing services.	Federal grant administered by DHCS to counties
Regional Caregiver Resource Centers (CRCs)	Caregivers of people with chronic or degenerative cognitive diseases (e.g., Alzheimer's, stroke, Parkinson's, traumatic brain injury) resulting in physical and cognitive limitations	Eleven regional Caregiver Resource Centers (CRCs) throughout the state provide information, assessment of caregiver needs, long-term care planning and consultation, support groups, counseling, training, respite care, etc.	General Funds through a contract with DHCS; private pay based on income

[a] Medically necessary criteria consist of specific covered diagnoses, functional impairment, and meeting intervention criteria.[42]

[b] A description of Medicaid waivers, including 1915(b) waivers can be found in the LTC Fundamental entitled: "What is a Waiver?" See, http://www.thescanfoundation.org/what-medicaid-waiver.

[c] While SUD programs are primarily provided by the counties, they are not required to provide SUD treatment programs. All counties contract with DHCS to provide substance use treatment programs, but not all counties include Drug Medi-Cal. In 2012, nineteen counties did not participate in Drug Medi-Cal; in four of those counties, the state contracted directly with providers to provide Drug Medi-Cal services.[8]

[d] In most counties where CBAS providers are available, CBAS is a managed care benefit although in counties with no Medi-Cal managed care contracts, CBAS is still a fee-for-service benefit . As of September 2013, DHCS has begun to expand Medi-Cal managed care into rural counties. As rural managed care expands, CBAS will transition from a fee-for-service benefit in these counties to a managed care benefit.

[e] California provides long-term behavioral health care services in twenty-seven Institutions of Mental Disease (IMDs) in twelve of the fifty-eight counties for people with SMI.[8]

[f] DHCS oversees the licensing and funding of the IMDs, but counties manage admissions and utilization.[35]

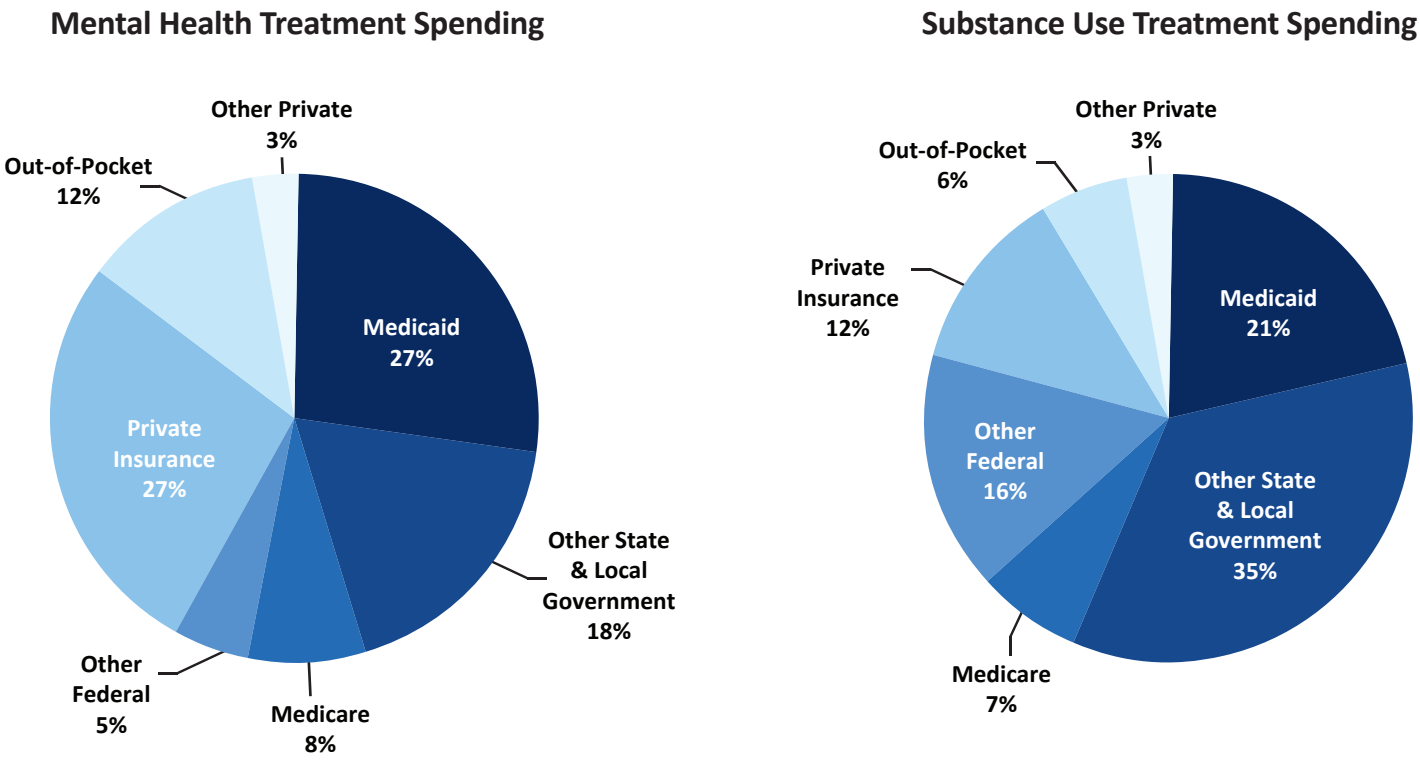
Financing for Behavioral Health

Funding for behavioral health services comes from a variety of sources, including Medi-Cal, Medicare, state and local sources, private insurance, as well as individual out-of-pocket payments. Nationally, behavioral health services accounted for $135 billion across public and private funding sources in 2005, or 7.3 percent of all health spending. Public funding sources account for almost 60 percent of behavioral health expenditures, with the remaining coming from private sources.[43] In California, public spending on behavioral health services (excluding Medicare) totaled $7.76 billion in fiscal year 2012-2013.[20]

California Public Sources of Funding

Public programs currently covering long-term behavioral health services for individuals with SMI and SUD are limited to only those individuals who meet the established eligibility criteria. In California, these include Medi-Cal, County-State Partnerships, and Mental Health Services Act Funds. In addition, the federal government provides public funding for behavioral health services primarily through Medicare, Community Mental Health Block Grants, Substance Abuse and Treatment Block Grants, and the Veterans Health Administration.

FIGURE 1 **Percentage of national behavioral health spending per funding source in 2005.**



Source: Substance Abuse and Mental Health Services Administration. National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2005.

Medi-Cal: Medi-Cal is the primary public funder of behavioral health services in California.[20] In addition to general health and long-term care services, Medi-Cal primarily funds community-based behavioral health services such as psychiatric and counseling services, personal assistance, rehabilitative services, outpatient mental health services, community support services, substance use treatment, and targeted case management.[44] Regarding institutional care, Medi-Cal pays for behavioral health services in Institutions of Mental Disease (IMDs)[44], and nursing homes (regardless of age) for Medi-Cal-eligible residents.[45]

Total Medi-Cal spending for behavioral health services in FY 2012-13 is estimated to be $3.34 billion.[20] California's portion of this amount (50 percent of the total) came from state general funds, a portion of Mental Health Services Act (MHSA) funds, and county realignment funds (see below). As a portion of the behavioral health spending, the California Department of Health Care Services (DHCS) paid out an estimated $205 million in FY2012-2013 general funds for Medi-Cal psychiatric prescriptions.[20]

County and State Partnership: The state and county programs share fiscal responsibility for behavioral health services. This partnership began in 1957 with the *Short-Doyle Act*[45] and has grown through the years with administrative and fiscal responsibilities allotted to the counties through realignment initiatives in 1991 and 2011.[46,47] The 1991 realignment established a portion of the state sales tax and vehicle licensing fees as funding sources. The funding structure was updated in 2011, with services being funded through the Local Revenue Fund sales tax. Realignment funds are estimated to reach $1.94 billion in FY 2012-2013.[20] In order to receive these funds, counties must meet a pre-determined maintenance of effort (MOE). Counties fund their portion of behavioral health services through property taxes, patient fees, and some payments from private insurance.[8] The estimated total county spending on mental health services for FY 2012-2013 was $150 million, with $25 million attributed to MOE.[20]

Community Mental Health Block Grant: Another source of federal funding for behavioral health services is provided through a community mental health block grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). These block grants provide comprehensive community mental health services to adults with SMI. States must also maintain a Mental Health Planning Council, which reviews the state's mental health plan and implementation.[48] DHCS must submit a state plan as part of an application for the funds. DHCS distributes these funds to the county mental health plans.[48] California's SAMHSA block grant funding totaled nearly $70 million in FY 2011-2012.[20]

Substance Abuse Prevention and Treatment Block Grant: The Substance Abuse Prevention and Treatment Block Grant from SAMHSA funds prevention, treatment, recovery supports and other SUD services. Funding is used to provide services to the uninsured and for services not covered by Medi-Cal, Medicare, or private insurance. DHCS applies for the grant by submitting a state plan, and distributes the funds to the county alcohol and drug abuse programs.[41] California was awarded nearly $249 million for FY 2012-2013.[49]

Mental Health Services Act: *The Mental Health Services Act* (MHSA), passed in 2004, created a one percent income tax on individuals earning over $1 million annually to fund innovative community behavioral health services for prevention and treatment of SMI for children, adults, and older adults. MHSA also funds integrated treatment programs for people with

co-occurring mental health needs and SUD. [50] MHSA, estimated to total $1.34 billion in FY 2012-2013[51] is the largest funding source for county, non-Medi-Cal services.[20]

Other Funding Sources

Medicare: Medicare is a federal health insurance program available to adults age 65 and older and select younger populations with disabilities.[52] Medicare Part A covers psychiatric hospital care up to 190 days with a deductible that varies depending on length of stay.[53] Medicare Part B covers outpatient services such as professional services provided by a psychiatrist or other doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, or physician's assistant. Services may include individual and group psychotherapy, family counseling, psychiatric evaluation, medication management, occupational therapy, patient training and education, and diagnostic tests. Medicare Part B may also cover outpatient partial hospitalization/outpatient active psychiatric treatment through hospital outpatient departments or community mental health centers. Most Medicare beneficiaries have co-payments, deductibles, and up to 40 percent co-insurance depending on the service. Medicare Part D is a prescription plan that covers medications under a formulary. The formularies and the co-pays vary between plans and can change.[53] Medicare spending for older adults with SMI and/or SUD was $43,792 per beneficiary in 2010, while spending for the average beneficiary age 65 and older was $8,649.[54]

Veterans Health Administration: The Veterans Health Administration (VHA) provides behavioral health services for qualified veterans using a recovery-based, integrated approach to care.[55] Services include inpatient care, outpatient care in psychosocial rehabilitation and recovery centers, residential rehabilitation treatment programs, primary care, residential care, supported work settings, psychotherapy, medications, SUD treatment, and intensive case management for people with SMI.[56]

Private Insurance: Private insurance plans may provide behavioral health services such as hospitalization, psychotherapy, medications, etc., but these services vary by plan along with cost sharing.[4,43] Historically, private insurers have denied coverage for behavioral health services on the basis of the underlying diagnosis being a pre-existing condition.[57] In instances where coverage was provided, insurers charged higher premiums preventing individuals from accessing the necessary services.[57] In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA) requiring that the cost and coverage of behavioral health services not be any more restrictive than the plan's coverage for medical services. MHPAEA requires equal coverage between mental and physical health services, often called "parity," but only for plans that offer behavioral health services coverage.[58]

Administrative Oversight

In recent years, California's behavioral health system has undergone administrative realignment. The Department of Mental Health (DMH) was dismantled in 2012 resulting in responsibilities being distributed to various agencies.[59] Administrative functions for the Medi-Cal specialty mental health managed care program and other federal Medicaid requirements were reassigned to DHCS' Mental Health Services Division. As of July 1, 2013 the Department of Alcohol and Drug Programs was also dismantled and program responsibilities were reassigned to DHCS' Substance Use Disorder Services Divisions.[60] There were no changes to behavioral health services or eligibility.[61] While individual counties are responsible for most behavioral

health services, DHCS oversees the Medi-Cal-related behavioral health functions in partnership with the federal Centers for Medicare and Medicaid Services (CMS) in compliance with state and federal laws.[62]

California's behavioral health system also incorporates stakeholder input into oversight and accountability through the California Mental Health Planning Council and Mental Health Services Oversight and Accountability Commission (MHSOAC). The California Mental Health Planning Council is a required provision of the Community Mental Health Block Grant from SAMHSA.[48] The council is mandated through federal and state statute to advocate for people with SMI, provide oversight of the public mental health system, and provide feedback and recommendations on the implementation of the state mental health plan.[63] MHSOAC is a state-mandated commission and was established as part of the implementation of the *Mental Health Services Act*. The commission is comprised of various community professionals involved in the behavioral health system, legislators, family members, and individuals with behavioral health conditions. The commission works to provide oversight, accountability, and leadership in an advisory role to work toward eliminating disparities and promoting mental wellness and positive outcomes for people with SMI.[64]

Recent Developments

Patient Protection and Affordable Care Act

With the passage of the *Patient Protection and Affordable Care Act* (ACA) in 2010 came several opportunities to build and strengthen California's behavioral health system. People with SMI are often uninsured or underinsured and the individual cost of treatment can also be prohibitive. It is estimated that over 500,000 uninsured Californians with behavioral health needs will gain access to health coverage through expansion of Medi-Cal eligibility and the new health insurance exchanges.[65]

Beginning in 2014, health insurance plans in the small group and individual market will be required to comply with the *Mental Health Parity and Addiction Equity Act,* as will health plans in the health insurance exchanges in each state by including mental health and SUD services as essential health benefits.[58] In addition, stronger parity requirements will require behavioral health services to be provided on equal footing with physical health services, meaning insurance companies cannot deny coverage, charge higher premiums, or require higher cost-sharing for behavioral health.[66]

The Coordinated Care Initiative

The ACA also included opportunities for states to develop demonstration projects coordinating the care of individuals who are dually eligible for Medicare and Medicaid. California will implement the Coordinated Care Initiative (CCI) in eight counties** that 1) mandates that selected long-term care benefits be available only through managed care; 2) requires all individuals dually eligible for Medi-Cal and Medicare to enroll in managed care for their Medi-Cal benefits; and 3) establishes Cal MediConnect, an integrated managed care program for dual eligibles.[67]

Under the CCI, dual eligibles with behavioral health needs will have access to medically necessary behavioral health services currently funded by Medi-Cal and Medicare through the Cal MediConnect health plans. However,

**The eight CCI counties include: Alameda, Los Angeles, Orange, Riverside, San Bernardino, San Diego, San Mateo, and Santa

individuals with SMI and SUD will continue to access services through the county agencies, requiring these individuals to navigate multiple systems of care. In order to mitigate barriers to accessing services between the two systems, Cal MediConnect plans will be required to have agreements with county mental health agencies and county alcohol and drug agencies in an effort to ensure seamless access to targeted case management and rehabilitative services provided by the counties.[67]

Medi-Cal Behavioral Health Services Benefit

Beginning January 1, 2014 California will provide new Medi-Cal mental health and SUD benefits to all eligible Medi-Cal populations. Covered behavioral health benefits will be expanded to include individual and group psychotherapy; psychological testing; outpatient drug therapy monitoring; outpatient laboratory, drugs, supplies, and supplements; and psychiatric consultation on non-specialty benefits. Medi-Cal substance use benefits available to all eligible populations include intensive outpatient treatment, residential substance use disorder services, and elective inpatient detoxification services in addition to existing benefits of outpatient counseling, naltrexone, and narcotic treatment program.[26]

System Challenges

The behavioral health system faces a number of challenges that create barriers to accessing and providing services. It is estimated that approximately 43 percent of adult Californians with SMI and 90 percent of those needing substance use treatment do not receive any type of behavioral health services, with service gaps more pronounced for the state's racial/ethnic populations.[8] While California's behavioral health system contains a variety of programs, benefits, and providers to address the needs of individuals with behavioral health issues, the system is not sufficient to meet the needs of those already engaged, nor does the system have the capacity to expand to serve others with behavioral health needs.

Workforce Capacity & Training

Capacity: The size and availability of the necessary workforce directly influences access to services. The workforce and services provided are unevenly distributed across the state, with the majority of providers in the Bay Area, Los Angeles County, and the San Diego Area. For example, rural communities have a limited number of behavioral health providers creating a void where services are needed.[19] In addition, the behavioral health workforce does not reflect the diversity of the population, which can create cultural and linguistic barriers to service.[8]

It is estimated that over 5,000 new behavioral health clinicians will be needed statewide by 2019 to meet the behavioral health needs of the growing older adult population.[24] Recent policy changes such as Medi-Cal expansion, mental health and SUD parity, and care coordination for dually eligible individuals will place additional strain on the behavioral health system.[8]

Training: Current and future health care providers need to be able to recognize and treat the unique needs of older adults with behavioral health conditions as symptoms present themselves differently in older adults than in younger adults. Medication interactions can mask behavioral health symptoms or may be the cause of behavioral health issues. Co-occurring physical, mental health and substance use issues also create challenges to identifying causes and treatments for symptoms. In addition, older adults often face stereotyping inhibiting appropriate assessment and treatment; e.g., the

misguided belief that depression is a normal part of aging.[4] Overuse of psychotropic medications can complicate health issues and lead to death or other injury. Since the majority of older residents in nursing homes are diagnosed with a behavioral health disorder, appropriate use and management of medications is important to ensure residents are functioning at their highest capacity.[68]

System Fragmentation

Older adults with behavioral health needs often have to navigate multiple systems of care to ensure their total needs are met. A recent survey of county behavioral health staff revealed only 12.5 percent reported a fully integrated system of care where primary care and behavioral health providers are part of the same team.[69] Integration of services is fundamental to effective behavioral health service delivery.[70] California's behavioral health services have evolved into a more coordinated system, with some counties making strides to integrate health care and behavioral health systems. However, while there is good coordination of services within the behavioral health system, limited coordination between the behavioral health and health systems remain.

Conclusion

California's behavioral health system has evolved to better serve people with behavioral health needs through an array of providers, funding streams, and programs; however, challenges remain, particularly for older adults. While significant focus on coordinating care within the behavioral health system exists, systems need a stronger emphasis on coordinating care for the person as a whole, incorporating behavioral health with physical health and community supports. California should build from the substantial evidence that a well-coordinated, integrated care system for individuals with behavioral health needs can enhance quality of life while creating more efficiency in the behavioral and physical health care systems. California should also develop further strategies to build the size of the workforce in order to meet future demand, with needed emphasis on creating an awareness and knowledge of older adult behavioral health issues within the existing health care workforce in order to fully understand and meet the needs of the growing older adult population.

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