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ADVANCING BRAIN HEALTH POLICY & INSPIRING LEADERSHIP

Little Hoover Commission on Covid-19 and Child Well-Being
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Comments from Thomas R. Insel, MD,
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Dear Commissioners,

Thank you for inviting me to share some perspectives as you explore the state of child well-being in California during this pandemic and, we hope, early post-pandemic period. My name is Thomas R. Insel, MD. I am a psychiatrist and neuroscientist who served as Director of the National Institute of Mental Health until 2015. I currently serve as Chair of the Steinberg Institute Board as well as working in the private sector. In 2019 I volunteered to assist Governor Newsom and Secretary Ghaly as a Special Advisor on Behavioral Health. My comments today are based on my experiences during that year as well as my understanding of the impact of the pandemic on behavioral health needs in California.

Covid and Behavioral Health

As you know, the state and the nation faced a behavioral health crisis before the Covid-19 pandemic. In contrast to recent infectious disease outbreaks, this behavioral health crisis was not due to a sudden surge in prevalence of a new disorder. The behavioral health crisis was decades in the making, due to our failure to help people with disorders that are entirely treatable. We should think of this as a crisis of care, manifested as high rates of incarceration, homelessness, and mortality – all increasing steadily over the past four decades. A few numbers help to define this crisis of care. People with serious mental illness who need to be treated in an institution are ten times more likely to be in a jail or prison than in a public hospital. As many as 25% of the homeless in California are people with untreated serious mental illness. And the life expectancy for people with serious mental illness in the public sector (ie. Medicaid or Medicare covered) is more than 20 years below the life expectancy of those without mental illness. Even before Covid, deaths of despair (deaths due to suicide, drug overdoses, and alcohol-related illness) had doubled in the previous decade and were dropping overall life expectancy in the U.S. for the first time since 1918.

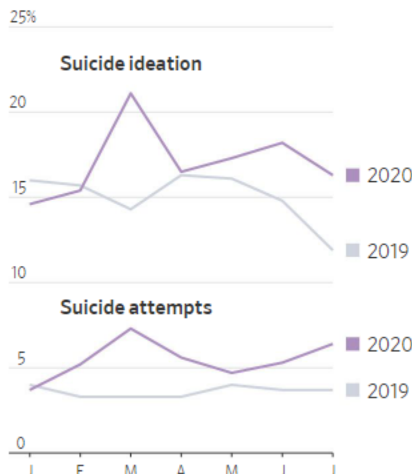
On this background of high morbidity and mortality from behavioral disorders, Covid-19 added significant woe. Social isolation, job loss, uncertainty, and inequity all contributed to a surge in mental health and substance abuse problems. In contrast to the virus which had most impact on those over age 65, the behavioral issues were greatest in those under age 24. A Kaiser Family Foundation report found that 56.2% of Americans between ages 18 and 24 reported symptoms of anxiety and depression (vs. 29.3% of adults over 65). (https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/) In this 18 – 24 age cohort, roughly 25% described an increase or onset of substance abuse and 26% reported

serious thoughts of suicide (compared to 11% of older adults). Overdose deaths surpassed 81,000 in 2020 (https://www.cdc.gov/media/releases/2020/p1218-overdose-deaths-covid-19.html), with 10 Western states reporting nearly a 100% increase in synthetic opioid-related deaths. A recent Wall Street Journal report provided the graphic below. (https://www.wsj.com/articles/pandemic-toll-children-mental-health-covid-school-11617969003?mod=searchresults_pos7&page=1)

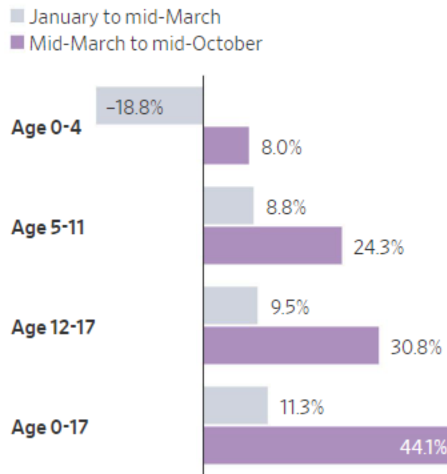
Dark Times

The mental health of young people has suffered during the pandemic.

Percentage of screens positive for recent suicidal thoughts and suicide attempts among people age 11 to 21*



Change in mental-health-related emergency department visits per 100,000 visits, 2020 from 2019



*Study was conducted in an unnamed pediatric emergency department in a major metropolitan area in Texas.
Sources: Study published online in the journal Pediatrics in December 2020 (suicide); Centers for Disease Control and Prevention (mental-health related emergency department visits)

With every natural disaster, the behavioral health complications tend to be a lagging indicator, with mood and anxiety disorders as well as suicide increasing in the subsequent months and years, often with a long tail. Early in the pandemic, the Meadows Mental Health Policy Institute modelled this impact to suggest roughly 10,000 additional deaths due to suicide and drug overdoses in the years following the economic upheaval caused by Covid-19.(https://mmhpi.org/topics/policy-research/covid-impact-series-volume1/) We do not have better data at this point, but it will be important to track behavioral health outcomes, particularly in young people who have seen the greatest emotional impact of this pandemic. There is an unfortunate tendency for relief teams mobilized for a natural disaster or health challenge to move on to the next crisis just as behavioral health consequences are beginning to emerge.

Behavioral Health in CA

California spends more on behavioral health than any other state. (https://openminds.com/intelligence-report/) The MHSA, providing over $2.4B for county behavioral health departments, is a unique resource. And realignment funds, surpassing $2B, are a dedicated tax base that few states have matched. Yet, Mental Health America's latest State of the State survey ranks California as 25th overall and 33rd for youth behavioral health services. (https://www.mhanational.org/issues/ranking-states)

Why does the state that spends the most rank in the lower half in terms of performance? It's not for lack of resources. Beyond California's unique funding streams of MHSA and realignment, this state

enjoys several advantages: a brain trust for psychiatry and psychology at our universities, entrepreneurial talent from the private sector, and leadership that has prioritized behavioral health. Fully 50% of California children are covered by Medicaid. And with recent increases in federal support of families and, specifically, the Certified Community Behavioral Health Centers (CCBHCs), there should be even greater investment in children and youth.

Countering all of these advantages, there are several systemic impediments to creating an optimal behavioral health system for children and youth in California. Many of these have been the focus of previous Little Hoover Commission reports, so I will not dwell on some of these issues. And most of these are not specific to children and youth, yet their consequences are most evident in vulnerable populations, meaning that children and youth are at risk. Below I note three areas that need to be addressed to improve outcomes for children and youth.

Decentralization

California does not have a behavioral health system. It has 58 different systems defined by its diverse counties. The absence of a state department of behavioral health is another exceptional feature of California, created by the realignment process. Our county-based behavioral health approach has the advantage of locally-informed services but decentralization means that there are no state-wide goals, standards, or approaches. While this concern has been noted in previous Commission reports, there are some newly consequential issues. First, without a state department of behavioral health, California has not been competitive for the federal government's new investment in this area, such as the CCBHC program for whole person care. Second, there are populations with significant behavioral health needs that fall outside the county system. For instance, the 3 million students in California's colleges and universities are under-served by county behavioral health services. As noted above, this population may be the most affected psychologically by Covid, but we are not organized to support this new need. And finally, as noted in previous reports, the absence of state-wide data on outcomes means that California is not learning and not innovating from its huge investment in behavioral health. By contrast, New York's capacity to innovate and iterate in areas such as first episode psychosis and school mental health demonstrate what we are missing in California. Note that there are pockets of excellence in California. We have some of the best services for first episode psychosis (UC Davis and UCSF) and school mental health (Alameda County), but these are truly in pockets and not leveraged across the state.

Fragmentation

In addition to the county-based decentralization, California has a highly fragmented service delivery system with separate providers for serious mental illness and mild to moderate mental illness, mental health and substance abuse, behavioral health and primary care. Most of this fragmentation is driven by reimbursement streams, but some results from creating artificial silos of care. As a result, individuals cannot navigate the public system and different members of a family may need to seek care from different providers.

Although much of the population is covered by private insurance, there is essentially no bridge or coordination between the public and private systems of care. As we learned with the Covid vaccines, public-private partnerships can accomplish major public health goals quickly. In this case, a public-private partnership could solve problems of workforce (imagine Coach for California

created on the Teach for America model, as done with the IAPT program in the UK), early detection (imagine engaging small or large digital mental health companies to create tools for school mental health, as done with Future Proofing in Sydney, Australia), and crisis services (imagine implementation of the Crisis Now model, as done in Phoenix, AZ).

Health is More than Healthcare

Increasingly, healthcare policy experts are distinguishing health from healthcare. If healthcare is the repair shop, health is the highway. Our mental healthcare system for children lacks capacity. There are too few beds and too little access. Building capacity for healthcare is critical but insufficient. The health lens moves the focus upstream to social determinants and lifestyle factors as well as downstream to long-term outcomes and recovery goals. This distinction is particularly true when the topic is behavioral health in children and youth. We need to remember that some of the most important interventions for children are not healthcare but health promoting. For instance, the Nurse Family Partnership program to support new mothers is not a traditional healthcare intervention, yet the impact of this program on both short-term and long-term outcomes surpasses nearly every medication or therapy that we use in behavioral healthcare. Focusing on health also addresses housing, social inequities, and criminal justice issues, which are central to success in behavioral health, yet are too often outside of healthcare policy or reimbursement.

Camelot for California

How can we optimize behavioral health for children and youth in California? Here are five proposals for the Commission's consideration:

1. **Leadership.** Re-establish state leadership with a robust Department of Behavioral Health as a component of Health and Human Services. Ultimately, California will need to follow other states, like New York, Oregon, and Texas, by consolidating reimbursement and care. This will require statutory change to realignment and MHSA. In the meantime, there are steps that will be helpful. The managed care program for mild to moderate mental illness is regionalized to 14 providers across the state. Many of the counties could be mapped on to this regional template to begin a process of centralizing standards and improving quality. Most important, the state via DHCS, could begin to establish outcome goals for vulnerable children and youth. As examples: increasing graduation rates for high school and college students with behavioral health disorders, increasing recovery after first episode of psychosis, decreasing crisis in children in foster care. The state must take responsibility for outcomes of its citizens with behavioral disorders.
2. **Workforce.** Enhance the workforce for children and youth behavioral health. There are large numbers of individuals in the behavioral health workforce, but few have the training to provide evidence-based care and fewer are culturally competent for the diverse population in California. We need a workforce trained to deliver services where and when they are needed; a workforce that reflects the populations we are trying to serve. In the UK, the workforce was transformed by a national program (IAPT) training 7,000 new therapists, much as Teach for America has provided a new educational workforce to underserved school districts. California could do this specifically for (a) school mental health, ensuring that every school has access to a trained provider and tools for mental health; (b) support to new mothers, giving at risk women the preventive interventions that have been proven to reduce depression and increase child well-being; (c) management of children at risk, following up on those children who have more than 4 ACEs.
3. **Capacity.** Build out a continuum of crisis services. This is not specifically for children and youth but it will serve them as well as the adult population. The federal 9-8-8 authorization mandates updated

crisis services by 2022, with 9-8-8 replacing 9-1-1 for behavioral health crisis calls. We need more than a new number. The crisis continuum includes the new phone hub; crisis mobile units staffed by a nurse, a social worker, and a peer; psychiatric emergency centers for 23-hour stabilization; and crisis residential services for those who need longer care. Building out the capacity for intensive outpatient and inpatient services for children and young adults will be critical in the near term. We know this approach solves the problems of incarceration, ER boarding, and criminal justice involvement. LA County already has a plan for this continuum, but most counties will not be able to develop the full range of services necessary.

4. **Early Intervention.** Ensure that CalAIM includes a full range of services for children and youth. The CalAIM proposal is the most significant change in California's mental health commitment in decades. This whole person care approach will seek reimbursement for a range of services that we know are effective but have not been previously covered via Medicaid. Vital to the needs of children, CalAIM must not be constrained by a list of diagnostic categories, because ideally we should be providing services to children "at risk" not waiting until children are symptomatic and in crisis.
5. **Partnership.** Create a public-private partnership for behavioral health, piloting a single payer system. With the ACA's extension of commercial insurance coverage to dependents up to age 26 and with the new parity law in California, we need to realize that mental healthcare is not simply the responsibility of the public system. In this area of healthcare, particularly for children and youth, California can lead the nation with a public-private partnership, potentially modelled on Operation Warp Speed.

Conclusion

California should have the premier behavioral health care delivery system and the best rates of recovery and prevention in the nation. We do not. The pandemic has revealed the inequities and inefficiencies in our healthcare system broadly and in behavioral health specifically. The pandemic has also revealed the opportunity to solve difficult problems when we commit ourselves to an urgent goal. Now is the time to focus on the needs of children and families for better care and better outcomes.

With gratitude,

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