Little Hoover Commission
Public Hearing on COVID-19 and Children's Mental Health (Part 1)
April 22, 2021

Testimony by Christine Stoner-Mertz, LCSW, CEO of the California Alliance of Child and Family Services

I am Chris Stoner-Mertz, the CEO of the CA Alliance of Child and Family Services. We are a 150+ member organization that provides policy, advocacy, training, and technical assistance to those working with California's children, youth and families served through its public systems. Our member organizations are providing behavioral health services to children and youth in the state's Medicaid (MediCal) system through contracts with their County Mental Health Plans (MHPs), MediCal Managed Care Organizations (MCOs), or funding through the Mental Health Services Act. As such, these nationally accredited nonprofits organizations represent an essential part of the behavioral healthcare system for children and youth.

We are pleased that the Commission has invited our testimony and is spending significant time to review the state of California's children's mental health and the impacts of COVID19 on our youth. Prior to the pandemic, there were clear barriers in access to care, and the pandemic has only exacerbated these as well as created additional barriers. Prior to the pandemic, the crisis in children's mental health was already clear. National estimates put the prevalence of behavioral health disorders among children at between 13 and 20 percent.[i] And we have seen a 75% increase in teen suicides in California since 2015.[ii] Yet, fewer than 5% of California youth eligible for specialty mental health services (SMHS) under Medi-Cal received a service, and less than 3% received ongoing services.[iii] This percentage also varies significantly from county to county, based on local decision-making regarding spending due to the realignment of mental health funding.

It is difficult to fully assess the short and long-term impact of social isolation, lack of school engagement, and increased family stressors such as unemployment, COVID related deaths and caregiver mental health issues on California children and youth. However, survey and research data available suggest that the nature and extent of this impact depend on several vulnerability factors such as the developmental age, educational status, pre-existing mental health condition, being economically underprivileged or being quarantined due to infection/fear of infection.[iv] Mental Health America reported that in September 2020, over half of 11-17-year-olds reported having thoughts of suicide or self-harm more than half or nearly every day of the previous two weeks. Further, from Jan. to Sept. 2020, nearly 78,000 youth reported experiencing frequent suicidal ideation, including nearly 28,000 LGBTQ+ youth[v]. Based on our understanding of brain development and children's social-emotional needs, along with the multiple family stressors created by the pandemic, it is safe to say that California children's mental health is more at risk than ever before. For youth of color – Black, Latinx, Native American – the risks are

even greater given the lack of culturally responsive practices, and dearth of mental health professionals that are racially diverse.

The impact of school closures will be felt for years, with some students unlikely to recover without targeted interventions. And even as we spend billions on learning loss, without the mental health supports in place to re-engage students in school and address the trauma experienced through the pandemic, the most vulnerable children – those with special education needs, English learner, and foster youth – will fall further behind.

Structure of Behavioral Health Systems in California

It important to understand the landscape of our public and private mental health systems as we look to reduce the stigma of reaching out for help, as well as understand the ways in which our systems limit access. Our public system has been divided into 56 public mental health plans (MHPS) run by County Behavioral Health Agencies. Each of these MHPs, under contract with the state Department of Healthcare Services (DHCS), is expected to provide Specialty Mental Health Services to anyone meeting the income eligibility and medical necessity for these services. For children and youth, there is a specific federal entitlement known as Early, Periodic Screening, Diagnosis and Treatment (EPSDT) within the Medicaid (MediCal) system that was designed to be proactive in spotting physical and behavioral health needs and addressing these as early as possible. Unfortunately, this entitlement and the vision of prevention and early intervention have eluded us thus far, as evidenced by the most recent penetration rates for these services across California counties.

There are 24 MediCal Managed Health Plans (MCOs), and over 50 Commercial Health plans, in California, all of whom are responsible for providing access to behavioral healthcare for their beneficiaries. This complex web of plans, and the accompanying contracting, authorization, and documentation requirements for services, create a multitude of challenges for providers and patients alike. While our focus today is on the public system, it is critical to remember that the issue of parity in the private plans must be addressed to ensure all children and youth have timely access to services when they need them, where they need them.

The experience of providers working in California's public systems reflects the fragmentation that has been created by a realigned system. To provide specialty mental health services to children and youth, a contracted provider must win a request for proposal, often based on providing the lowest bid. In spite of the entitlement embedded in federal law, EPSDT-funded services are limited through the current contracting approach due to contract limits. Additionally, the significant variation in rates, the administrative burdens associated with 56 different approaches to contracting, credentialing of staff and documentation, all combine to create barriers to providing the right level of intervention that meets a child's service needs at the right time and in the right place. With two different delivery systems – the MHP and the MCOs – that do not allow providers the ability to provide and bill for the same services at the same rates, it is not possible to ensure that children and youth have true access to the range of services to which they are entitled. Finally, our current children's mental health system does not ensure that substance use services are available through the EPSDT benefit – in spite of our knowledge that adolescence is regarded as the critical risk period for initiation of alcohol and drug use[vi].

Current Initiatives

There are several current initiatives impacting the structure of how services are delivered to children and youth, and have the possibility to reduce barriers to care, improve continuity, and create networks of care that support the stability of children and their families. **CalAIM** is DHCS's multi-year effort to improve the health outcomes of MediCal beneficiaries by improving delivery system and payment reform. CalAIM promises to increase access to children and youth mental health services by redefining medical necessity, the threshold that determines a child's eligibility for services. Allowing access to services for children who are at risk of foster care placement, are homeless, or have experienced trauma are among some of the proposes changes that provide hope for our most vulnerable children. Additionally, CalAIM proposed changes to how children in the foster care system access and receive mental health services. We have provided recommendations on the Foster Care Model of Care that focus on the importance of whole family care, presumptive eligibility for services, continuity of care, and the critical need to create a statewide approach to serving youth with the most complex behavioral needs.

California's Surgeon General has led the state's ACES Aware Initiative, which has an ambitious goal of training healthcare providers in screening for Adverse Childhood Experiences, and creating local networks of care that can support the health and behavioral health needs of individuals that have been impacted by ACES. This initiative, funded through Prop 56 in the state budget, aligns with many of the elements of CalAIM, and emphasizes the impact of trauma and the social determinants of health. The impact of racism on health and mental health cannot be ignored, and all of these initiatives must stay alert to ways that health inequities impact children's opportunities to thrive.

The **Family First Prevention Services Act**, a federal child welfare law enacted in 2018 and set to be implemented by all 50 states by October, 2021, creates opportunities to use foster care funding to support prevention services and increase supports to families before children are placed in foster care, and works to reduce the number of children placed in group care. While California's Continuum of Care Reform (CCR) has significantly reduced both the number of youth in group care, as well as the length of stays, FFPSA further emphasizes the importance of family search and engagement and offers aftercare to ensure that children and youth are stable as they move from short term residential therapeutic programs to family-based care. An essential component of our success in stabilizing children's mental health is to ensure the widespread use of high fidelity Wraparound services, a home-based, highly individualized service that addresses the supports and services needed to stabilize children in their homes and communities.

Finally, the combined efforts of the administration and DHCS to increase one-time and ongoing funding for school-based mental health partnerships between county behavioral health, school districts, managed care organizations and community-based organizations are highlighting the role that schools can play in identifying children's mental health needs, as well as being a service hub through which they are provided.

To be successful at using every dollar wisely to increase access to services, all of these initiatives must work together, with a focus on increasing MediCal spending by matching every local and state dollar possible. We must also ensure that services go beyond the traditional approaches, using community-

based organizations that provide culturally and linguistically appropriate services, and peer counselors and culture brokers.

Where Do We Go From Here:

1) Use a statewide approach that ensures consistent funding, access and measures the progress in children's wellbeing – California's public mental health system does not currently measure the well-being of children (both eligible and those served) and report out on this. This is despite the statewide expectation that children and youth go through a comprehensive assessment process when receiving Specialty Mental Health services using the Child and Adolescent Needs and Services assessment (known as CANS). Setting clear statewide measures so that all delivery systems have increased transparency and accountability to children's wellbeing is essential. Measuring the investment in, access to, and performance of our children's mental health system will maintain the important focus on their well-being.

2) Focus one-time investments available on children and youth's behavioral health needs to mitigate the impact of the pandemic – the current one-time funding available through the American Rescue Plan, as well as state allocations to schools, provides opportunities to build infrastructure and create pathways to expand children's mental health services. Partnerships with community-based organizations that have the capacity to work across MHPS, MCOs and schools can support the immediate and longer-term needs of children and youth.

3) Use CalAIM as a vehicle for sustained change in the MediCal system – while there are some substantial changes outlined in the vision for CalAIM, the true impact will not be seen for children and youth unless there are certain elements built into the system as the vision is implemented through waivers, the state plan, and the contracts between the state and MCOS and MHPs. Building in statewide consistency for contracting, documentation and other administrative functions like staff credentialing are key elements that must be included in implementation. Developing rates for providers that support the real costs of services delivery and ensuring that all six million children who are MediCal eligible can access the services they need in through any delivery system must be built into the fabric of CalAIM. Finally, we must ensure that substance use services are truly integrated and available to all youth, and that prevention services are funded.

4) Workforce Investments – the children's mental health system in California continues to struggle with low wages, high turnover, and limited racial and ethnic diversity in the workforce. Through increased investment in support for students interested in this field, and continued focus on the reimbursement for services that improve wages, the state can expand the workforce available to serve children and youth. We have been very engaged in the peer certification efforts, which will further expand the behavioral health workforce. Integrating the use of telehealth, which has been such a critical element to keeping children and youth engaged through COVID19, offers yet another avenue for accessing services and supports.

5) Maintain and Expand Investment in Current Systems and Providers – Nonprofit providers that have struggled to stay afloat throughout the pandemic have continued to serve children, youth and their families as essential workers. Limited state and federal funds have been made available for children's

mental health providers, and some are still facing potential cuts to their programs and services. As we focus on the implementation of the initiatives outlined, there must be a commitment to maintaining and expanding the investment in the state's current community-based provider network. Expanded investments in crisis mobile teams and specialized services for youth in foster care and juvenile justice who have previously required out of state placements is vital to stabilizing our most vulnerable populations.

6) Ensure parity for children and youth across public and private systems – As we look to ensure that all of California's children and youth have their mental health needs addressed, we must attend to the wide variation of services available between public and private systems. For example, home and school-based mental health services are not available to children with private health insurance, even if the primary drivers of a mental health or substance use issue are due to family or school issues. We must carefully assess our delivery approaches and be willing to take bold steps toward changing how services are accessed, delivered and paid for if we wish to truly meet the needs of all of our children and youth with the hope for a healthier future for all of them.

We are grateful for this opportunity to address the commission, and for your attention on the state of children's mental health.

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[i] "Mental Health Surveillance Among Children – United States, 2005-2011." U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. MMWR Supplement/ Vol.62/No.2, May 17, 2013.

[ii] https://www.americashealthrankings.org/explore/health-of-women-and-children/measure/teen_suicide/state/CA

[iii] Department of Health Care Services. Performance Outcomes and System Reports and Measures. March 2018. Retrieved from https://www.dhcs.ca.gov/provgovpart/ pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx

[iv] Singh, Roy, Sinha, Parveen, Sharma, and Joshi. August 24, 2020. Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. Published online. National Center for Biotechnology Information. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7444649/#bib0031

[v] https://www.mhanational.org/number-people-reporting-anxiety-and-depression-nationwide-start-pandemic-hits-all-time-high

[vi] https://www.samhsa.gov/data/sites/default/files/WebFiles_TEDS_SR142_AgeatInit_07-10-14/TEDS-SR142-AgeatInit-2014.pdf