Dedicated to Promoting Economy and Efficiency in California State Government

The Little Hoover Commission, formally known as the Milton Marks “Little Hoover” Commission on California State Government Organization and Economy, is an independent state oversight agency.

By statute, the Commission is a bipartisan board composed of five public members appointed by the governor, four public members appointed by the Legislature, two senators and two assemblymembers.

In creating the Commission in 1962, the Legislature declared its purpose:

...to secure assistance for the Governor and itself in promoting economy, efficiency and improved services in the transaction of the public business in the various departments, agencies and instrumentalities of the executive branch of the state government, and in making the operation of all state departments, agencies and instrumentalities, and all expenditures of public funds, more directly responsive to the wishes of the people as expressed by their elected representatives...

The Commission fulfills this charge by listening to the public, consulting with the experts and conferring with the wise. In the course of its investigations, the Commission typically empanels advisory committees, conducts public hearings and visits government operations in action.

Its conclusions are submitted to the Governor and the Legislature for their consideration. Recommendations often take the form of legislation, which the Commission supports through the legislative process.

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Dear Governor and Members of the Legislature:

Last year, the Little Hoover Commission initiated a review of the impacts of the COVID-19 pandemic to better understand the challenges facing California and identify how state government can support those impacted. The following report, the last in our series, focuses on the pandemic’s impact on the mental and emotional well-being of children and adolescents, especially those under the age of 18.

The Commission learned that the COVID pandemic has had a major impact on young people’s mental well-being and has been a source of stress, anxiety, and trauma. The Commission also learned that chronic stress and traumatic experiences during childhood can have a life-long impact on individuals’ psychological and physical health, with substantial social and economic costs. However, the Commission found that California has long struggled to support children’s mental and emotional health adequately.

In this report, we examine ways in which California can improve the state’s system for supporting child mental health. Governor Newsom and the Legislature, together with state agencies, local governments, health plans, care providers, and stakeholders, are taking critical steps to overhaul and improve California’s system for supporting child mental health, especially through the Children and Youth Behavioral Health Initiative. These ambitious and expansive efforts promise to transform California’s child mental health system, but strong leadership and clearly defined outcome goals will be needed to ensure that they achieve their potential. To create lasting improvements in children’s mental health care, the Commission recommends that the state establish centralized leadership to promote sustained and sustainable coordination, collaboration, and accountability around mental health.

While the pandemic has exacerbated an ongoing crisis in children’s mental health, the Commission recognizes that it also presents a once-in-a-generation opportunity to improve children’s mental health care. The Commission respectfully submits this work and stands prepared to help you address the impacts of the COVID-19 pandemic.

Sincerely,

Pedro Nava, Chair
Little Hoover Commission
COVID and Children’s Mental Well-Being

COVID confronts California with two pandemics of public health: the viral pandemic and a pandemic of mental health that has fallen most heavily on children and youth.

COVID created a perfect storm of stress, anxiety, and trauma, exacerbating a preexisting crisis in children’s mental health. Many young people experienced social isolation and disconnection; some endured economic dislocation and the illness or loss of loved ones. There have been notable increases in anxiety, depression, and mental health-related emergency room visits. Experts further warn of a looming “tsunami” of unmet mental health needs among young people and suggest that some children and adolescents will need time, support, and investment to bounce back.

The pandemic’s effect on children’s mental well-being is likely to be uneven. It is probable that the pandemic will disproportionately impact the mental and emotional well-being of children from communities of color and low-income communities, which have borne the brunt of the pandemic’s economic and physical health effects. Unless California responds robustly, trauma and sustained stress may also have long-term psychological and physiological impacts on some children.

Barriers to Addressing Children’s Mental Health Needs

Early intervention and treatment can help to address COVID’s impact on young people’s mental well-being, but California has long struggled to meet the mental health needs of young people. Too few children receive care, and when they do, it often is too late. Children of color and children from low-income families, moreover, access mental health services at lower rates than their peers.

Systemic and structural barriers can prevent children from accessing mental health services. More than half of children and adolescents in California are on Medi-Cal and thus receive care through the state’s public mental health system. That system is, however, decentralized and fragmented. It contends with capacity and workforce shortages, complicated and administratively burdensome funding mechanisms, and challenges around providing preventive and timely care. There is also considerable variation in school districts’ focus on student mental well-being and in the availability of school-based services.

Addressing the Crisis

To address COVID’s impact on children’s mental health, California needs to build a larger, more diverse mental health workforce, establish a genuine continuum of care for children, emphasize prevention and early intervention, and center schools as hubs of mental well-being.

California is poised to facilitate access to mental health services through two major initiatives that have potential to transform children’s mental health care:

CalAIM. The California Advancing and Innovating Medi-Cal (CalAIM) proposal reforms Medi-Cal service delivery and financing, reducing administrative burdens and removing diagnostic requirements that can prevent children from accessing timely mental health services.

Children and Youth Behavioral Health Initiative. The Behavioral Health Initiative provides more than $4 billion over the next five years to develop a comprehensive system of mental health for children and youth. It will create a statewide virtual platform for behavioral health services and invest in expanding school-linked mental health services, developing a larger, more diverse mental health workforce, building a continuum of care, and promoting public awareness.
Steps Forward

California also needs strong structures to administer the Behavioral Health Initiative and achieve lasting improvement in children's mental health care. The Commission finds that there are three key elements for coordinating California's response to COVID's impact:

- California needs stronger, more coherent, and more cohesive state leadership around children's mental health, including common outcome goals and a single point of overall leadership.
- California must build capacity for statewide approaches to children's mental health, especially by expanding the ability of state government to provide support and technical assistance to health plans and local providers.
- Centering schools as hubs of mental wellness means bringing together systems of health and education and forging partnerships among entities that may have little experience working together. To foster effective partnerships, state government must support careful planning around intersystem collaboration, coordination of services, and use of data.

Recommendations

To improve the state's system for supporting child mental health, California needs leadership that promotes sustained and sustainable coordination, collaboration, and accountability around mental health.

**Recommendation 1:** The state of California should identify a central point of leadership for children's mental health. The Governor and Legislature should also initiate a review process to examine the creation of a new and robust Department of Behavioral and Mental Health, with coequal focus on child and adult mental health, which could exercise statewide leadership over mental health care and services.

**Recommendation 2:** In consultation with stakeholders, the Secretary of the Health and Human Services Agency should set statewide goals for child mental health based on key metrics related to overall mental well-being, access to care, and quality of services.

**Recommendation 3:** The Governor and Legislature should reserve a portion of Behavioral Health Initiative funding to provide a future tranche of additional funding to be competitively awarded to counties and health plans that effectively and efficiently implement successful reforms/programs and reach identified benchmarks.

**Recommendation 4:** The Department of Health Care Services should work with stakeholders to identify ways to increase the support and technical assistance it provides to counties, health plans, and other mental health providers.

**Recommendation 5:** The Governor and Legislature should leverage the Behavioral Health Initiative to encourage local educational agencies and their partners to develop comprehensive approaches to student mental wellness, including requiring grantees to establish actionable plans for coordinating services, for using and sharing data, and for integrating funding to create sustainable programs.

**Recommendation 6:** The Governor should establish a clear timeline for the development, testing, and piloting of the behavioral health services virtual platform, with vigorous oversight at every stage of development.
Introduction

COVID has confronted California with two pandemics of public health. The first is the viral pandemic, which has sickened millions and, at the time of this report, had led to the death of nearly 65,000 Californians.\(^1\) The second is a pandemic of mental health that has hit children and adolescents especially hard. Surveys and reports suggest substantial increases in anxiety, depression, suicidal ideation, and mental health-related emergency room visits among young people. California and Californians are likely to feel the effects of the sustained anxiety and stress brought on by the pandemic for years to come.

COVID appears to have exacerbated and amplified what many experts call an ongoing crisis in children’s mental health. Rates of adolescent suicide and self-harm were increasing even before the pandemic. Between an existing crisis in young people’s mental health and COVID’s impact, experts speak of a looming “tsunami” of unmet need.\(^2\)

California has long struggled to support children’s mental and emotional health adequately. Many young people with mental health needs do not receive any services; by some estimates, a majority of youth with some serious mental health conditions, like major depression, do not receive consistent care. Moreover, Ken Berrick, Founder and CEO of Seneca Family of Agencies, and Robin Detterman, Seneca’s Chief Program Officer of Education Services, observed, “Too often, struggling students and families are not met with services until their needs rise to a crisis level.”\(^3\) California’s child mental health system is extremely fragmented and suffers from severe capacity shortages. Additional demand for care and services as a result of COVID will further stress and strain this system.

Yet the COVID pandemic also presents a once-in-a-generation opportunity to improve children’s mental health care. The pandemic’s broad impact on Californians’ mental and emotional well-being has raised awareness of the importance of mental health. Federal stimulus funding, together with an unexpected rebound in California’s fiscal situation, will enable California both to make historic one-time investments in children’s mental health and support ongoing work to improve coordination in delivering support and care.

State government must seize this moment. More than half of children and adolescents in California are on Medi-Cal and thus receive care through the state’s public system of mental health. These young people come from the low-income families and the communities of color that have disproportionately

Impacts of the COVID-19 Pandemic

This report is the last in the Commission’s series on the impacts of the COVID pandemic. The first two reports, First Steps toward Recovery: Saving Small Businesses and First Steps toward Recovery II: Job Training and Reskilling, examined the immediate economic impacts of the pandemic on small businesses and workers, focusing on how California can support small business recovery and job training opportunities for impacted workers.

This report studies the pandemic’s impact on the mental and emotional well-being of children and adolescents, especially those under the age of 18. Literature around adverse childhood experiences suggests that chronic stress and traumatic experiences during childhood can have a substantial and life-long impact on individual’s psychological and physical health, with substantial social and economic costs. This report examines how state government can respond to the pandemic’s impact and better support children’s mental well-being into the future.
borne COVID’s economic and physical health impacts, and they are likely to be at higher risk to stress, anxiety, and trauma due to the loss of family income or the illness or death of family members. They have also historically been less likely to receive mental health services. California is, however, now poised to respond to young people’s need for a stronger mental health system with the new Children and Youth Behavioral Health Initiative, which promises to build capacity, encourage new partnerships and collaborations, support prevention and early intervention, and expand access to care and services.

Still, key structural and systemic barriers remain. In previous reports, the Little Hoover Commission emphasized that California needs leadership that promotes sustained and sustainable coordination, collaboration, and accountability around mental health. In order to ensure that new initiatives achieve their potential and that California truly addresses the mental health needs of children, state government needs to take steps to institutionalize and sustain that leadership. State government also needs to set clear outcome goals that center on child wellness and that promote coordination around children’s mental health care and services.

Section I: COVID and Children’s Mental Well-Being

Dr. Tom Insel, former director of the National Institute of Mental Health, observed that the COVID pandemic has impacted populations differently depending on their age. Mortality from the pandemic is largely concentrated among adults beyond the age of 50. The pandemic’s psychological consequences, however, have fallen most heavily on children and youth under the age of 25. Children have endured long periods of social isolation and disconnection as measures to control the pandemic, including social distancing and remote learning, separated them from their friends, limited opportunities to make new friendships, and deprived them of their social routines. They missed out on major life events and milestones like graduations, birthday parties, and family reunions. They lost access to the sports, clubs, activities, and pastimes that connected them with friends and mentors, shaped their identities, and gave their lives meaning—and that let them be kids.

The COVID pandemic’s impact on young people’s mental health is multifold. Children have endured long periods of social isolation and disconnection as measures to control the pandemic, including social distancing and remote learning, separated them from their friends, limited opportunities to make new friendships, and deprived them of their social routines. They missed out on major life events and milestones like graduations, birthday parties, and family reunions. They lost access to the sports, clubs, activities, and pastimes that connected them with friends and mentors, shaped their identities, and gave their lives meaning—and that let them be kids.

The pandemic created a perfect storm of stress, anxiety, and trauma. Some children grappled with stress stemming from economic dislocation and parents’ loss of jobs or income. Those whose parents or relatives are essential workers confronted daily anxiety over the safety of family members. Some also faced the illness or loss of family and loved-ones due to COVID. On top of all these stresses, young people dealt with the challenges of remote education, potentially struggling to log onto classes or to concentrate in shared rooms and crowded homes. Many coped with isolation through social media and increased screen time, which researchers link to disruptions in sleep patterns that can impact mental health. In addition, the pandemic coincided with a significant and emotionally challenging national reckoning around racial justice.

Meanwhile, COVID affected the ability of young people to receive care and of the mental health system to deliver that care. For some children and adolescents receiving mental health services, the pandemic disrupted treatment. At the same time, it pushed care givers to their limit. California’s Surgeon
Defining Children’s Mental Health and Mental Health Disorders

According to the Centers for Disease Control and Prevention, “Being mentally healthy during childhood means reaching developmental and emotional milestones and learning healthy social skills and how to cope when there are problems.” Mental health disorders, in turn, “are serious changes in the way children typically learn, behave, or handle their emotions, which cause distress and problems getting through the day.” Mental health exists on a continuum: children who do not have a mental health disorder may not be equally well; children with a mental health disorder can vary in how they are coping with that disorder.

The term “mental health disorder” is a broad term that encompasses mood and anxiety disorders, including depression, neurodevelopmental disorders like ADHD and autism, and mental illnesses like schizophrenia. Studies suggest that approximately 13-20 percent of children experience a diagnosable mental, emotional, or behavioral disorder in a given year; prevalence of mental health disorders among children and adolescents appears relatively similar around the world. Estimates further suggest that 7-8 percent of children in California are likely to have a serious mental or emotional heath disorder, one which substantially interferes with their functioning in family, school, or community activities. Approximately half of mental illnesses appear by a child’s mid-teens.

Studies suggest that low-income children are probably at higher risk of mental health disorders. According to the California Health Care Foundation’s review of 2014 data, 10 percent of children whose families fall below the federal poverty line have a serious emotional disturbance, compared to a California average of 7.6 percent of children.

On the other hand, studies suggest that young people of color and White young people generally appear to experience mental health disorders at similar rates. The California Health Care Foundation reports that approximately 8 percent of Black and Latino children have a serious emotional disturbance, compared to about 7 percent of White children. The Public Policy Institute of California, meanwhile, finds that approximately 4 percent of both Black and White teens and 5 percent of Latino teens suffer from severe psychological stress, which correlates with severe mental health conditions like depression; the prevalence of suicidal thoughts was highest among White teens at 6 percent, compared to 4 percent for Black teens and 5 percent for Latino teens. Studies generally show that children and adolescents who are foreign-born immigrants tend to have lower rates of mental health disorders than children born in the United States. There are, however, significant disparities in access to mental health services based on race, ethnicity, and immigration status.
The effect of pandemic-induced stress and anxiety on children’s mental and emotional health is still unclear. The CDC reported that the number of pediatric mental-health related emergency department visits during the first six months of the pandemic, between March and October 2020, was largely the same as it was for the same period in 2019. Mental-health related emergency department visits constituted, however, a substantially greater proportion of all pediatric emergency department visits, probably reflecting both the impact of pandemic-related stress and anxiety and a decline in visits for other reasons, perhaps as a result of less time spent outside or participating in team sports.¹⁶ More recently, the CDC reported that emergency department visits for suspected suicide attempts began to increase among adolescents in May 2020. Between February 21 and March 20, 2021, emergency department visits for suspected suicide attempts were almost 51 percent higher among girls aged 12-17 than they were for the same period in 2019. Emergency department visits for suspected suicide attempts were almost 4 percent higher for boys aged 12-17.¹⁷

Demand for services appears to be increasing and child mental health providers report increases in referrals for anxiety and depression. Reporting suggests that at least some hospitals have seen spikes in mental distress among children. UCSF Benioff Children’s Hospital Oakland saw a 77 percent increase in children seeking emergency mental health services between May and December in 2020, compared to the same period in 2019—651 children in 2020, up from 368 in 2019.²⁰

**COVID and the Existing Crisis in Children’s Mental Health**

Child advocates and children’s mental health experts argue that COVID amplified a preexisting crisis in children’s mental health. Suicide is now the second leading cause of death among people aged 10-24 and is responsible for more childhood and adolescent deaths than cancer and heart disease combined. In California, mental illness is also the leading reason for hospitalization among children.²¹ “We were,” Dr. Tom Insel observed, “in a bad way even by 2019, and with COVID we have gotten to an even worse point.”²²

Although data on rates of mental and emotional distress among young people can vary among surveys, studies consistently point to deterioration in child and adolescent mental and emotional health:²³

- The State Auditor reported in September 2020 that the number of youth suicides in California increased by 15 percent from 2009 through 2018 (from 163 to 188). Incidents of youth self-harm requiring medical attention increased by 50 percent during the same period (from 10,861 to 16,314).²⁴
- The federal Substance Abuse and Mental Health Services Administration reports that the average annual percentage of youth aged 12-17 in California who experienced a major depressive episode increased from 8.1 percent in 2004-2007 to 14 percent in 2016-2019.²⁵
The most recent iteration of the California Healthy Kids Survey, conducted between fall 2017 and spring 2019, found that the percentage of 7th graders reporting chronic sadness increased from 25 percent in 2011/13 to 30 percent in 2017/19. The percentage of 11th graders reporting chronic sadness increased from 33 percent to 37 percent. The sources of increasing rates in depression, self-harm, and suicide, as well as in the incidence of conditions like autism and ADHD, are still unclear. The United States has, however, faced a broad crisis in behavioral health for several decades. “Deaths of despair”—deaths from suicide, drug overdose, and alcoholism—have doubled nationally since the mid-1990s, leading to the first drop in American

Social Media, Children’s Mental Health, and the COVID Pandemic

Although studies associate heavy social media use with poor teen mental health, social media has also proved to be a “lifeline” for many teens and adolescents during the pandemic, one that allowed them to remain in contact with friends and combat loneliness and isolation. One national survey found that more than half of young people aged 14 to 22 reported that social media has been very important to them for staying connected with friends and family. This same survey also found that social media has played a supportive role for some with mental health challenges: nearly 30 percent of young people with moderate to severe depression reported that social media was very important for helping them feel less alone, compared to 13 percent of young people without depression.

Studies suggest that social media’s relationship to young people’s mental health varies with the amount and type of use. Although the relationship between causation and correlation is not certain, researchers find that teenagers who spend more time on social media—three hours a day or more—are more likely to display symptoms of depression. Conversely, moderate and “active” use of social media to connect and interact with friends and peers, as opposed to compulsively scrolling through content, may be protective for mental well-being. More generally, social media can also expose young people to racist, sexist, homophobic, or bullying comments and content.

Several social media companies have taken steps to help users protect their mental health, like offering them the option to hide “like” counts or filter out abusive replies to posts, as well as linking users to mental health resources. Collaboration with social media companies will probably also be essential for facilitating access to the Behavioral Health Services Virtual Platform that will be developed as part of the Children and Youth Behavioral Health Initiative.

Much appears still unknown, however, about social media’s impact on children’s mental health, what measures can most effectively help to mitigate potentially negative effects, and how social media can best be used to support young people’s mental well-being. Studies observe, for example, that it can be hard for some teens to take a break from streams of personalized contact, even when they use apps that prompt them to do so. Education and awareness for young people and parents around healthy social media use and habits will probably continue to be critical.
life expectancy in a century and taking a heavy
toll on less well-educated Americans and their
communities. Some researchers further point
to technology and social media as contributing to
decline in mental well-being among children and
youth, observing that rise in youth suicide and
self-harm appears to coincide with the expansion
of social media. Although the relationship between
social media and mental health is debated, studies
correlate heavy social media use, decreased
face-to-face interactions, and cyberbullying with
increased risk of depression. Environmental factors,
including parental age at conception and exposure
to pollutants, can impact children’s mental and
emotional development and may also contribute
to increasing prevalence of certain mental health
conditions.

Yet, beyond the economic, social, and technological
developments that are driving anxiety and
depression, witnesses emphasized that the crisis in
mental health is also the result of failure to support
mental and emotional well-being and to deliver
care to those in need. According to Dr. Insel, “We
should think of this as a crisis of care, manifested
as high rates of incarceration, homelessness, and
mortality.” This point holds for children and youth,
as well. Increasing rates of suicide, self-harm, and
mental distress among children and youth indicate
that they are not getting the support they need or
the care they require for treatable mental health
conditions.

Understanding COVID’s Impact

COVID likely exacerbated the preexisting and
ongoing challenges around children’s mental and
emotional well-being. Moreover, it is probable that
the pandemic will disproportionately impact the
mental and emotional well-being of children from
communities of color and low-income communities,
which have borne the brunt of the pandemic’s
economic and physical health effects. It is also
probable that the pandemic will have a significant,
long-term impact on the well-being of some children
and adolescents.

AN UNEQUAL IMPACT

As with its physical health and economic impacts,
COVID’s effect on children’s mental well-being is
likely uneven. There is considerable variation in how
children experienced the pandemic and additional
variation in how they responded to it based on
family circumstance and social environment. The
presence of trusted caregivers and stable, supportive
environments, for example, can buffer the impact
of adversity and has probably helped many young
people cope with the pandemic’s challenges.

It is probable that the pandemic will disproportionately impact the mental and emotional well-being of children from communities of color and low-income communities, which have borne the brunt of the pandemic’s economic and physical health effects.

Although the pandemic led to widespread feelings of depression and loss among children, most children will probably ultimately recover. For many children whose mental and emotional health have been impacted by the pandemic, return to school and social reopening likely will bring substantial improvement.

Other children, however, may need more time,
support, and investment to bounce back. The
pandemic’s physical health impact has fallen most
heavily on communities of color, with the result
that children from those communities were most likely to have had family members sickened by COVID and to have lost family members to the pandemic. Children of color were also most likely to endure anxiety over the loss of employment and income. Job losses fell most heavily on low-income workers, who are disproportionately Black and Latino, and this economic impact will probably affect children's mental health, as well. One study found that a 5 percentage-point increase in the national unemployment rate during the Great Recession increased the probability of “clinically meaningful child mental health problems” by 35 to 50 percent, as a result of household stress, as well as material impacts from income loss.44

For many children from low-income families and communities of color, as well as children in rural communities, COVID has exacerbated social, economic, and environmental factors that increase risk of mental health challenges. Currently, only limited data exists on COVID's impact on young people's mental health that is disaggregated by location, race and ethnicity or by family income level. Nevertheless, initial surveys suggest the young people who have had family members sickened by COVID, whose family members lost jobs as a result of COVID, and who worry that their families will not have enough to eat are indeed more likely to have symptoms of depression than those young people whose families were less directly affected by the pandemic.45 Meanwhile, the pandemic, remote education, and social distancing also intensified isolation for rural and mountain communities.46

**LONG-TERM CONSEQUENCES**

There is reason to believe that initial indications of COVID's toll on young people's mental well-being will ultimately manifest as mental and emotional health challenges. Toby Ewing, Executive Director of the Mental Health Services Oversight and Accountability Commission, observed that the mental health impacts of natural disasters and traumatic events usually play out over a three-to-five year trajectory.47 Moreover, the pandemic's sustained and often severe impact on children's mental and emotional health may have even longer-term ramifications, which California will be living with for years to come. Prolonged exposure to stress and adversity can have significant consequences for children. “An overwhelming scientific consensus,” explains Surgeon General Dr. Burke Harris, “demonstrates that cumulative adversity, particularly during critical and sensitive developmental periods, is a root cause to some of the most harmful, persistent and expensive health challenges facing our nation.”48
Studies of the impact of adverse childhood experiences (ACEs) show that severe or chronic adversity and stress can have lasting and severe psychological and physical impacts. Research suggests that individuals who experience multiple ACEs are less likely to be employed and are at increased risk of heart disease, stroke, and suicide.\textsuperscript{49} Chronic stress can further disrupt child development around executive functioning, affecting children’s ability to regulate emotions and behaviors, pay attention, and start and complete tasks. This can contribute to subsequent mental or behavioral health conditions, as well as to challenges in the classroom.\textsuperscript{50}

Although COVID is not one of the traditional adverse experiences included in ACEs screenings, it has become a significant stressor for many children and it has further disrupted access to sources of mental and emotional support. Dr. Burke Harris observed that the pandemic, “has been unique in its effect of acting as a major stressor while simultaneously cutting off access to many of the usual sources of buffering care necessary to help children and parents regulate their stress responses, such as grandparents, teachers, coaches, faith leaders and, in some cases, child care providers.”\textsuperscript{51} Evidence that incidents of domestic abuse have risen during the pandemic and that rates of substance abuse have increased further suggests that the pandemic may also have heightened some children’s risk of exposure to other adverse experiences.\textsuperscript{52} Dr. Burke Harris warned of the long-term consequences of the toxic stress and trauma stemming from the COVID pandemic: “Unless we

### ACEs and ACEs Aware

Adverse childhood experiences refer to potentially traumatic events that occur during childhood and may include: experiencing physical, sexual or emotional abuse, neglect, parental separation or divorce, substance abuse by a household member, witnessing domestic violence, having an incarcerated household member, or having a household member with mental illness.

ACEs can have lasting psychological and physical impact. Trauma and chronic stress can lead a child’s physiological stress response, which includes the release of stress hormones, increase in heart rate and blood pressure, and changes in brain activity, to activate too intensely or for too long. This toxic stress response can impact how genes are read, how the body’s immune and metabolic systems function, and lead to changes in brain development, affecting attention, learning, and decision-making.\textsuperscript{53} Exposure to four or more categories of adverse childhood experience is associated with a doubling of risk of heart disease, cancer and stroke. Exposure to ACEs is also associated with greater likelihood of experiencing mental health conditions, including depression, anxiety, and eating disorders, and of engaging in risky behaviors.

The ACEs Aware Initiative is a first-of-its-kind statewide effort to promote screening for childhood trauma and treat the impacts of adverse childhood experiences. The initiative offers Medi-Cal providers training in screening for ACEs and for providing trauma-informed care. Under ACEs Aware, California offers qualified providers a $29 payment for conducting screenings for ACEs for Medi-Cal patients; providers must have completed ACEs training in order to qualify for payment.\textsuperscript{54} The initiative has already trained more than 17,000 providers.
intervene robustly, the consensus of scientific evidence suggests that we are very likely to see an unprecedented increase in toxic stress. Some of this will likely manifest in the short term through behavioral health, mental health, and learning challenges. Some of it may manifest later in terms of higher incidents of cardiovascular disease, incarceration, cancer, stroke, and other health conditions.55 Early detection and early intervention can prevent and mitigate the impact of toxic stress and promote healing. The social and economic costs of failing to address COVID’s impact, on the other hand, will likely be significant. Research suggests that prior to the pandemic, the annual cost of ACEs in California exceeded $100 billion as a result of health care spending and lost years of productive life due to death, disability, and incarceration.56

Section II: Barriers to Addressing Children’s Mental Health Needs

Even before the pandemic, California’s mental health system failed to fully serve children and youth with mental and emotional health needs. Based on its analysis of data from 2018, the Commonwealth Fund found that only 70 percent of California children aged 3-17 received mental healthcare when needed, compared to 82 percent of children nationally. California ranked 48th nationally in terms of children receiving needed treatment or counseling for mental health.57 Levels of treatment for specific conditions, meanwhile, can be even lower, with Mental Health America reporting that only a quarter of youth in California with severe depression receive consistent treatment.58 The percentage of eligible children who access mental health services in California also appears to be well below the level expected based on estimates of the number of children with mental health conditions who would benefit from treatment and care.59

Too few children receive care, and when they do, too often it occurs too late. In the absence of early intervention and treatment, mental health needs and conditions can intensify and potentially metastasize into mental health crises. Limited availability of mental health providers and thus limited access to timely care probably contributes, for example, to higher rates of child suicide and self-harm in California’s rural and northern counties, compared to coastal and more urban counties.60

Moreover, children of color and children from low-income families, who, as noted above, have been disproportionately impacted by COVID, tend to access mental health services at lower rates than their peers.61 Nationally, the Substance Abuse and Mental Health Services Administration reports that about half of White youth aged 12-17 with depression received care in 2019; conversely, only about 36 percent of Black or Latino youth with depression received care.62 Within California, meanwhile, the Department of Health Care Services reports that Latino and Black beneficiaries under the age of 21 access mental health services from Medi-Cal managed care plans at substantially lower rates than White beneficiaries, with Black beneficiaries accessing services at only half the rate of White beneficiaries and Latinos accessing services at less than 60 percent the rate of their White peers.63

A number of factors contribute to young people not receiving needed mental health services. Children of color and children from low-incomes families can confront linguistic, cultural, and social barriers to accessing mental health care.64 A number of systemic and structural barriers, which are discussed below, can also prevent children in need from accessing mental health services.

In addition, child advocates and health experts identified a key, foundational reason for challenges around children’s mental health care: California, like many states, has historically treated mental
health as different from physical health, a product of traditional stigma and misunderstanding around mental health. Ted Lempert, President of Children Now, observed that there is a broad social and political understanding around the importance of children's physical health such that when a child breaks an arm, care is available to set the arm. There is also a general understanding that children should receive vaccines and physical wellness checks, even if application is uneven. Yet, no such common understanding around the significance of mental and emotional health for children's well-being exists.65

This situation began to change before COVID as a result of concern about increasing rates of child and adolescent suicide and self-harm; the pandemic further raised awareness around the importance of mental health, especially children's mental health. California is poised to make historic investments in children's and young people's mental well-being. Systemic and structural weaknesses in California's child mental health system may, however, impede efforts to address the pandemic's impact on children's mental health.

California’s Child Mental Health “System”

California's mental health system is not really a single system; rather it is a “mosaic” or “patchwork” of systems, plans, agencies, and programs.66 It is decentralized, fragmented by provider, and bifurcated based on the severity of an individual’s condition.

The majority of Californians under the age of 21 who need mental health services are treated through the public mental health system. Although only a third of Californians overall are covered by Medi-Cal, more than half of California's children and adolescents are covered by the program.67 In addition, the federal Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) entitlement provides federally-supported mental health screening and treatment for Medicaid-eligible children under 21 years of age.71

California splits responsibility for mental health services for Medi-Cal eligible children between 24 managed care plans (MCPs) and 56 largely county-based mental health plans (MHPs) (See Figure 1). Both MCPs and MHPs contract with the Department of Health Care Services (DHCS) to provide services to Medi-Cal beneficiaries. Managed care plans provide a limited set of mental health services for screening and treating “mild to moderate” mental health conditions. Mental health plans, meanwhile, provide specialty mental health services (SMHS), which cover a wider range of mental health services, and are responsible for treating more severe mental health conditions.

This report focuses on this public system of mental health, which serves the lower income children

Substance Use Disorders and Child Mental Health

Mental health and substance use disorders are often co-occurring. Research suggest as many as 60-to-75 percent of adolescents with substance use disorders also have mental health conditions.68 Children who have experienced a major depressive episode are twice as likely to begin using alcohol or an illicit drug.69 For children and adolescents with mental health conditions, substance abuse may be a coping mechanism or may begin as an attempt to self-medicate.

A challenge for meeting child and adolescent mental health needs is that addressing those needs often means also treating issues of substance abuse. Yet fewer than 10 percent of adolescents with substance use disorders receive treatment.70
Figure 1: California’s Youth Mental Health System is a Mosaic

PUBLIC SYSTEM

Over 50% of young people are covered by Medi-Cal.

Schools may bill Medi-Cal for eligible school-based mental health services.

School Districts/Local Educational Agencies

The Department of Health Care Services (DHCS) administers California’s Medicaid program—Medi-Cal. DHCS contracts with MHPs and MCPs to deliver Medi-Cal mental health services.

56 Mental Health Plans (MHPs)

24 Medi-Cal Managed Care Plans (MCPs)

Community Agencies

Mental health plans and managed care plans may contract with community agencies to deliver services.

PRIVATE SYSTEM

Under 50% of young people are covered by private insurers.

Level of services and coverage can vary among commercial insurers.

Schools may partner with MHPs and MCPs to provide school-based mental health services.

Schools may contract with community agencies to deliver school-based mental health services.

50+ Commercial Insurers

Note: This is a simplified illustration of the basic structure of California’s child and youth mental health system. It does not include fee-for-service delivery options, which, as of 2018, served about 10 percent of children enrolled in Medi-Cal, including slightly under half of children in foster care or with a probation placement. It also does not reflect that managed care plans may subcontract to other health plans to deliver services.
who are likely to be disproportionately impacted by COVID.

Children who are not eligible for Medi-Cal are generally covered by one of more than 50 commercial insurers, which provide varying levels of mental health services and coverage. Witnesses noted that mental health is an unusual case in American health care—publicly supported mental health services can be more comprehensive than those provided by commercial insurers, though legislative efforts have sought to expand commercial plans’ coverage of conditions and services. Commercial plans also generally do not cover school-based mental health services. The Children and Youth Behavioral Health Initiative includes legislative language that would establish parity across the public and private systems in supporting mental health services in school settings, which child mental health advocates and providers suggest is important for more fully meeting children’s mental health needs.

### Barriers to Care and Services

Witnesses testifying before the Commission emphasized that addressing COVID’s impact will require attending to existing weaknesses in California’s system for supporting young people’s mental health.

#### DECENTRALIZATION

Mental health experts and advocates repeatedly observed that a critical weakness in California’s child mental health system lies in the highly decentralized character of the system and in the absence of consistent central leadership. “Unlike almost any other state,” Dr. Tom Insel observed, “California does not have strong central leadership around behavioral health. There is no person, there is no department, there is no group that is setting outcome goals for the mental health systems in California. There is no one trying to integrate this; we do not have a central data repository to even begin to provide accountability for the state.”

There is, witnesses observed, no “common framework” in California for children’s mental health that links the various public and commercial systems and providers through shared goals, standards, and approaches. Instead, there is considerable variation in support and care for children’s mental health. Lishaun Francis, Associate Director for Health Collaborations at Children Now, observed that California has invested in full-service clinics, community schools, school-county mental health partnerships, and youth-led mental health approaches, in addition to other evidence-based strategies for supporting children’s mental health. Yet, while there are highly innovative and notably successful programs for children’s mental health around the state, state government has generally failed to commit to particular models: “California’s focus constantly shifts in its approach to implementing policy—rather than doubling down on any of the initiatives we create, we move on to the next, spreading out our resources in a way that becomes untenable and ultimately less impactful for California’s kids.”

Counties vary, moreover, in the resources they have available for supporting mental health systems and in the extent to which they prioritize children’s mental health services, with the result that availability of particular services and programs can differ depending on where a child lives. Meanwhile, state government has struggled to develop a consistent mechanism for identifying, scaling, and replicating demonstrated models of care.

#### FRAGMENTATION

In addition to the challenges of decentralization, child mental health providers reported that California’s fragmented mental health system creates barriers to providing and accessing care. Mental health practitioners observed that counties employ
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program

The federal Early and Periodic Screening, Diagnostic, and Treatment program entitles children and young adults up to 21 years of age covered by Medicaid to a broad range of diagnostic and treatment services as may be necessary to “correct or ameliorate defects and physical and mental illnesses and conditions.” The entitlement has its origins as a Great Society program, one which recognized that children from low-income families are more likely to have health conditions and developmental delays and that early identification and intervention can help address those health issues. In addition to services related to identifying and treating mental health issues, the EPSDT mandate covers a range of health services, including well-child visits, oral health, and vision care.

Although the EPSDT mandate constitutes a broad entitlement to medically necessary health services, many eligible young people in California who would benefit from mental health care do not appear to receive services to which they are entitled. Young people in California access EPSDT services at rates that are below the national average—in 2017, 49 percent of eligible children in California accessed at least one preventive service covered by EPSDT, compared to a national average of 58 percent. Several factors, as discussed in this report, contribute to relatively low rates of access for EPSDT mental health services, including: diagnostic requirements for accessing services; capacity and workforce shortages; challenges in coordinating services between managed care plans and mental health plans; as well as, lack of awareness on the part of families of children’s entitlement to EPSDT services.

Funding and Medi-Cal financing further complicate the provision of EPSDT services. EPSDT is an uncapped mandate—children are entitled by federal law to services if they are determined to be medically necessary. Yet, while the EPSDT program provides federal reimbursement for preventive and treatment services, a certified public expenditure is necessary to generate that reimbursement. Effective implementation of EPSDT thus requires non-federal dollars, but funding streams may be inadequate to meet rising need, as in the case of some counties’ funding for EPSDT services provided under 2011 Realignment, or subject to competing demands, as in the case of MHSA funding. Advocates nevertheless observe that there are opportunities for more fully leveraging expenditures to drawdown federal dollars, including by increasing managed care plans’ provision of EPSDT services and by maximizing reimbursement for school-based mental health services.

different screening instruments, require different forms of documentation, and adopt different approaches to contracting with providers, creating significant administrative burdens and barriers to delivering needed services. Christine Stoner-Mertz, CEO of the California Alliance of Child and Family Services, observed that this complexity imposes a substantial burden on providers. The California Children’s Hospital Association estimates that between 30 and 50 percent of providers’ time is required for administrative purposes, with variation in requirements and documentation contributing significantly to this burden.

The bifurcation of services between managed care plans and mental health plans adds another hurdle
that can act as a barrier to timely care. Dr. Brian Distelberg of Loma Linda University Children’s Hospital noted, “even within a county services are disjointed because different levels of mental health care get allocated to different resources. It’s very complicated for a patient to understand that; it’s very complicated for providers who are professionals to execute this complicated process.”

“Unlike almost any other state, California does not have strong central leadership around behavioral health. There is no person, there is no department, there is no group that is setting outcome goals for the mental health systems in California.”
- Dr. Tom Insel, Chair of the Steinberg Institute Board of Directors

For example, a managed care plan might recommend a patient for specialty mental health services, but county mental health plans have no obligation to accept that patient for service if their own evaluation does not indicate that the individual’s needs meet diagnostic thresholds. Although managed care plans and mental health plans enter into MOUs to define their interactions, the challenges of information sharing and of case management across systems can limit effective collaboration.

FAIL FIRST
Providers and advocates observe that California’s approach to children’s mental health has historically rested on a “fail first” model: the system of children’s mental health is structured to respond when a child’s mental health has deteriorated to a particular level of severity, rather than to support good mental and emotional health. Indeed, the State Auditor recently found that nearly half of children served by managed care plans did not access EPSDT preventive health services, including those for mental health.84

According to providers and experts, one key manifestation of the fail first quality of mental health care in California is its diagnosis-driven character—a child must be diagnosed with a specific mental illness or condition in order to access specialty mental health services. Advocates argue that this requirement contravenes the EPSDT mandate, which entitles children on Medicaid to treatment that is medically necessary for their health and well-being. As a result of the diagnosis requirement, at-risk children may be unable to access needed services until their condition deteriorates to the point that they can be diagnosed with a specific condition.85

CAPACITY
Experts, witnesses, and providers universally agreed that there are not enough mental health counselors or psychiatrists trained to work with children and youth. Dr. Bryan King, Vice President for Child Behavioral Health at University of California, San Francisco Benioff Children’s Hospitals, reported that while significant demand for services exists, there is a “breathtaking lack of providers.”86 Shortages in the child mental health workforce are a national—and international87—challenge. The number of child psychiatrists in California in proportion to population—10 per 100,000 children, as of 2016—corresponds to the national average, but is half that of Connecticut, Massachusetts, New York, and Rhode Island, states which have lower percentages of children with untreated mental health conditions.88

More broadly, Christine Stoner-Mertz described the challenges facing California’s child mental health workforce: “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.”89
The mental health workforce is unrepresentative of the populations it serves and unequally distributed by geography. The Healthforce Center at University of California, San Francisco, reports, based on its analysis of American Community Survey data from 2011-2015, that only 8 percent of psychologists, 23 percent of counselors, and 24 percent of social workers in California are Latino. In addition, only 4 percent of psychiatrists are Latino and only 2 percent are Black. Critically, lack of diversity and representation in California’s mental health workforce can create challenges around building trust and delivering culturally-competent care. Moreover, many clinicians do not accept Medi-Cal, raising further barriers to access for low-income communities. In addition, per capita ratios for psychiatrists, psychologists, and social workers in the San Joaquin Valley and Inland Empire are half statewide ratios, or lower.

Inadequate physical capacity for care and treatment exacerbates these workforce shortages, especially for children with severe needs. Dr. Brian Distelberg reported that the number of inpatient psychiatric beds in California is approximately a third of the number that SAMHSA recommends. Moreover, there are no inpatient psychiatric beds in 42 counties or in any county north of Napa County, meaning that many children with severe mental health conditions may have to wait to access inpatient services or may not be able to access those services close to home. Dr. Distelberg related that COVID has made this bad situation even worse: residential units have had to close if a patient were diagnosed with COVID, exacerbating the shortage of inpatient facilities. Hospitals resorted to “emergency room boarding,” wherein children remained in emergency departments, potentially for more than 10 to 15 days, until an inpatient bed became available, with negative impact on their treatment and recovery.

**FUNDING**

Most child mental health advocates and providers emphasized the need for more substantial investment in children’s mental health. Some, however, also argued that while additional investment is needed, the structure and deployment are as important as the amount.

Multiple funding streams support California’s system of public mental and behavioral health, including federal Medicaid dollars, funding from the Mental Health Services Act, and funding from 1991 and 2011 Realignment, as well as state and federal grants (See Figure 2). In addition to funding for the public mental health system, many local education agencies (LEAs) may deploy their funding, as well as state and federal grants, to support mental health services for their students. Schools providing mental health care can also bill Medi-Cal for a limited range of services through the Local Education Agency Medi-Cal Billing Option Program (LEA-BOP), though less than half of school districts participate in this program, and can further bill Medi-Cal for costs associated with administering Medi-Cal through the School-Based Medi-Cal Administrative Activities program (SMAA).

Witnesses and child mental health experts identified two key ways in which current structures of mental health funding can act as barriers to meeting children’s mental health needs and expanding services:

- First, supporting child mental health and providing mental health services depends on braiding and blending a range of funding sources, especially with the goal of leveraging state and local funding to maximize federal Medicaid draw-downs. The complexity and administrative burdens of maximizing reimbursements can prevent counties from doing so, as well as dissuading school districts from seeking to reimburse eligible mental health expenditures.
- Second, child mental health advocates and providers point to specific challenges arising out of the 2011 Realignment of EPSDT funds. They observe that distribution of Realignment revenues...
Figure 2: Funding Streams in the Public System of Mental Health

Public Community Mental Health Services Funding
2017-18 LAO Estimates

Total Funds ($9.8 Billion)

- Federal Funds (Primarily Through Medi-Cal) $4.3 Billion
- State General Fund $0.8 Billion
- Mental Health Services Fund (Prop 63) $2.0 Billion
- Local Realignment Revenues $2.7 Billion

County Mental Health Services $7.9 Billion

- Medi-Cal Specialty Services
  - Care coordination and case management
  - Therapy
  - Day treatment and rehabilitation
  - Crisis intervention and stabilization
  - Psychiatric inpatient services
  - Residential treatment

- Mental Health Services Act Programs
  - Mental health programs including intensive and wraparound services, prevention and early intervention activities, and innovative projects

- Safety Net Services
  - Mental health services for low-income residents, including the uninsured

Medi-Cal Managed Care and Fee-for-Service $1.9 Billion

- Psychotropic Drugs
- Outpatient Services
  - Individual and group therapy
- Psychiatric Inpatient Services

Note: This figure shows total mental health services funding, for both children and adults. It is not possible to determine what percentage of this funding goes to children.

was determined largely based on historical county spending and thus tends to provide more funding for counties that spent heavily on mental health services at the time of Realignment, and less funding for those that spent less. Providers further observed that Realignment can essentially cap county EPSDT expenditures, putting pressure on the community agencies that contract with county mental health plans to deliver services.

What Is the Role of Schools?

Child mental health advocates and educators emphasized that schools are essential to addressing children's mental health needs. Alex Briscoe, Principal of the California Children’s Trust, observed, “Children 8-to-18 go to the doctor the least frequently, but that is when about 60-to-70 percent of mental illness manifests.” Yet those same children go to school, so bringing mental health care to schools may significantly expand access to services. Schools play an important role in identifying mental and behavioral health issues, since schools are where there are eyes on children. Students are also much more likely to seek mental health services when those services are offered at a school site and studies further suggest that school-based mental health services can improve student mental health and academic outcomes. Moreover, multi-tiered systems of support (MTSS) frameworks provide a promising model for developing comprehensive school mental health systems.

For all these reasons, the Mental Health Services Oversight and Accountability Commission recently recommended that California establish schools as “centers of wellness.”

An emphasis on schools as places of healing and wellness is especially important as California addresses COVID's unequal impact. Studies suggest that children who have experienced trauma are more likely to be subject to disciplinary action at schools. In addition, students of color, who often have higher rates of exposure to trauma and ACEs, have also historically been more likely to be suspended from school than White students, though California has recently made important steps to address disparities in school discipline. Looking forward, Pia Escudero, Executive Director of the Division of Student Health and Human Services at Los Angeles Unified School District, suggested that a focus as students return to school in the fall will be to create “healing” school environments that support students’ mental health and to catch students who may be at risk before they need higher levels of care.

Multi-Tiered Systems of Supports

MTSS is a framework for deploying evidence-based interventions and supports in school settings. With respect to supporting student mental health through a MTSS framework, a school might provide preventive services and social emotional learning to all students (Tier 1); targeted interventions and supplemental support, like social skills groups, for at-risk students (Tier 2); and intensive services, including therapy or wraparound services, for students with the greatest mental health needs (Tier 3).

California has supported the implementation of MTSS approaches for creating inclusive and positive learning environments that meet the needs of all students through funding for the Scale Up MTSS Statewide (SUMS) Initiative, which is administered by the Orange County Department of Education. This initiative has provided grants to approximately 400 local educational agencies to implement integrated multi-tiered systems that support student academic learning, social emotional learning, and mental health.
School-based mental health resources and approaches take a range of forms. Pupil personnel services (PPS) professionals—school counselors, school psychologists, and school social workers—provide services that support student well-being and development, including, in the case of school psychologists, providing psychological counseling. Many schools and local educational agencies are also working to establish more positive school climates and to develop or introduce curricula that build social emotional learning among students. For example, as of 2019-2020, more than 2,500 schools in California have implemented the Positive Behavioral Interventions and Support (PBIS) approach, a data-based MTSS framework for reducing disciplinary incidents and improving school culture.

Some school districts operate significant, specialized student mental health programs. Los Angeles Unified School District, for example, makes mental health services available through 15 wellness centers, operated by federally qualified health centers, as well as additional school-based health clinics, and employs more than 400 school mental professionals. The district is working to hire an additional 500 psychiatric social workers in order to respond to COVID’s impact. In Alameda County, a longstanding partnership exists between the Health Care Services Agency and school districts around student health; Alameda County’s School-Based Behavioral Health Initiative reaches more than 40 percent of schools in the county. Other districts have entered into partnerships with county behavioral health departments or community agencies to provide school-based services.

There is, however, considerable variation in the depth of services contained in school mental health programs and in districts’ focus on student mental well-being. Ken Berrick and Robin Detterman from Seneca Family of Agencies commented on the importance of providing a continuum of care at schools. They observed that whole school approaches help to equip every student to succeed, while also providing opportunities for prevention and early intervention, as well as more intensive services for students who need them. Yet building out a full, effective MTSS framework and continuum of care can be challenging and administratively burdensome. Schools with programs around social emotional learning and positive school climate may not have linkages to more intensive clinical services. Conversely, community agencies working with schools noted that school-based mental health programs can sometimes focus on the most intensive and expensive interventions, without fully building out more universal supports.

Overall, fewer than half of California’s elementary students have access to school-based mental health services, though access improves substantially with grade level. Nearly 90 percent of high schools offer mental health services, at least through school counselors and school psychologists. Yet schools see the same workforce challenges as the mental health system. As of 2018-19, California’s K-12 schools employed one school counselor for every 626 students, one school psychologist for every 1,041 students and one school social worker for every 7,308 students. In each case, California does not meet recommended ratios, with the result that the ability of pupil personnel services professionals to meet individual student’s needs may be highly limited. In part, this is the result of schools and districts making decisions about how to allocate scarce resources and balancing different priorities; small and rural districts face especially severe capacity constraints around providing mental health services. On the other hand, leadership in some districts and schools may not see supporting students’ mental health as part of their school’s educational mission.

Partnerships with county behavioral health departments or with community agencies can expand the availability of clinicians and counselors at
together with federal recovery and stimulus funding, gives state government the resources to address COVID’s impact on children’s mental and emotional well-being, address many of the long-standing barriers that prevent children from receiving care and support, and implement preventive programs to alleviate the triggers for mental health conditions.

In the course of this study, witnesses identified a number of steps that California can take to address COVID’s impact on children’s mental health, including:

Section III: Addressing the Crisis

In recent years, the Governor’s Office, the Legislature, and state agencies, including the Department of Education, the Department of Health Care Services, and the Mental Health Services Oversight and Accountability Commission, have taken a variety of steps to better support child mental health. This has included funding through the Mental Health Student Services Act for partnerships between county behavioral health departments and schools to support school-based mental health services, efforts to raise awareness around the impact of adverse childhood experiences and childhood trauma on individuals’ well-being, and proposed reforms to Medi-Cal to remove barriers to services.

California is now poised to build meaningfully and substantially on this work. The state budget surplus, together with federal recovery and stimulus funding, gives state government the resources to address COVID’s impact on children’s mental and emotional well-being, address many of the long-standing barriers that prevent children from receiving care and support, and implement preventive programs to alleviate the triggers for mental health conditions.

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In the course of this study, witnesses identified a number of steps that California can take to address COVID’s impact on children’s mental health, including:

### Telehealth

There has been a dramatic shift to telehealth as a result of COVID. Practitioners report that they are now providing a majority of services via telehealth and that they find that telehealth can be equally effective as in-person consultations. According to Dr. Brian Distelberg, this shift has increased access and utilization, including increasing the likelihood that patients participate in follow-up appointments and decreasing the number of appointments for which the patient does not show-up. Some providers further observed that telehealth makes it possible to speak with entire families, facilitating whole family care. Studies suggest, moreover, that most young people report being very or somewhat satisfied with their telehealth experiences.

Yet experts also observed that challenges around telehealth remain, including around the digital divide, trust, and privacy. For example, while telehealth can allow clinicians to interact with whole families, children who wish to speak with a clinician privately may have a hard time doing so via telehealth.
Establishing a larger, more diverse mental health workforce. Witnesses emphasized that training peer support specialists, mental health workers who have lived experience of mental health conditions and who can serve as mentors and models, and community health workers has potential to grow the mental health workforce quickly while expanding access to culturally competent care. They also suggested that telehealth approaches can further help to mitigate some challenges of access and capacity.

Expanding the mental health system’s capacity to support those with high levels of need. Witnesses encouraged the development of a genuine continuum of care for children in need of intensive care, featuring crisis response mobile units, expanded inpatient facilities, and crisis residential services.

Supporting mental wellness. Witnesses observed that while California must expand its capacity to support children with severe mental health conditions, state government should also put greater emphasis on prevention and early intervention by addressing the social determinants of mental health, especially the impact of poverty and social inequality on mental well-being, and by encouraging health promoting interventions, like support for new mothers and children at risk. Witnesses agreed that eliminating the diagnosis requirement for accessing specialty mental health services is a key step toward enabling early intervention.

Establishing schools as centers of mental wellness. Although other points of access will also be critical to supporting children and families, schools are likely to be “ground zero” for supporting the mental and emotional health of children who have experienced an extended period of stress, anxiety, and trauma. Mental health supports will also be critical to addressing learning loss and helping vulnerable children and those most impacted by COVID re-engage with school. Witnesses noted that partnerships between schools and mental-health oriented community-based organizations, including as part of community school models, can help provide students with access to wraparound and comprehensive services.

Collaborative Health Models/UCSF Benioff Children’s Hospitals Child Psychiatry Access Portal

One approach to mitigating the workforce and capacity challenges in children’s mental health care lies in psychiatric telehealth consultations for primary care providers, which give pediatricians essential tools to address basic issues of mental and emotional health. These programs help to bridge the gap between physical and mental health care, assist with early identification and treatment of mental health needs, and incorporate pediatricians into the broader continuum of mental health care. Psychiatric consultation programs for pediatricians in Washington State and Massachusetts appear to have facilitated access to mental health care and allowed child psychiatrists to focus on patients with more complex mental and behavioral health issues.

University of California, San Francisco Benioff Children’s Hospital has recently launched a new Child Psychiatry Access Portal wherein child psychologists and clinicians work with pediatricians to help address common mental health issues. Through support from philanthropic donations, this program has grown to include more than 70 pediatric practices in the San Francisco Bay Area; it has also entered into agreements with health care providers to expand into the Central Valley.
In addition, the Newsom administration has launched two major initiatives that have potential to fundamentally transform California's system of supporting and treating children's mental health: the California Advancing and Innovating Medi-Cal (CalAIM) proposal and the Children and Youth Behavioral Health Initiative. These initiatives incorporate many of the proposals listed above. Together they can reshape how California approaches child mental health, transforming a system that focuses on treating diagnosed mental and behavioral health conditions into one that more fully supports children's mental and emotional well-being, even prior to conditions developing.

**CAL AIM**
The California Advancing and Innovating Medi-Cal (CalAIM) proposal is an ambitious and far-reaching plan to reform and transform Medi-Cal service delivery and financing. According to Dr. Tom Insel, CalAIM is, “the most substantial change to mental or behavioral health in California for the public system in four decades.” Although children's mental health is not the focus of CalAIM, the initiative nevertheless includes key features that address the structural and systemic issues discussed above, including:

- Eliminating the requirement for diagnosis to access specialty mental health services. The Department of Health Care Services intends to reform criteria for establishing medical necessity, shifting from requiring a specific diagnosis to instead basing medical necessity on level of impairment. This is designed to lower the bar for establishing that treatments are medically necessary under the EPSDT mandate. DHCS further intends to develop standardized, statewide assessment tools to determine eligibility for services.
- Streamlining reimbursement for county mental health plans and for specialty mental health services with the goal of reducing administrative burden and providing opportunity to reimburse based on the quality of services and not just their cost. This will include expanded opportunities to reimburse for care delivered through value-based care models, which could, for example, support an expanded role for community health workers in the delivery of children’s mental health.
- Encouraging closer coordination and cooperation between managed care plans and mental health plans in delivery of mental health services.
- Encouraging administrative and clinical integration of specialty mental health services and substance use disorder treatment services at the county level.

CalAIM is a complex initiative that consists of renewing with amendment the federal Medicaid waivers under which California administers specialty mental health services, updating state contracts with managed care plans, and revising county monitoring and reporting standards. Development and implementation of CalAIM are ongoing, with the Department of Health Care Services submitting its application for waiver renewal to the federal Centers for Medicare & Medicaid Services in June 2021. DHCS aims to make revisions to medical necessity criteria for specialty mental health services effective in early 2022, following approval of the relevant waivers. Some elements of CalAIM, including integration of specialty mental health services and substance use disorder treatment services, will take several years to implement fully.

**CHILDREN AND YOUTH BEHAVIORAL HEALTH INITIATIVE**
The Children and Youth Behavioral Health Initiative aims to develop a comprehensive system of mental health care for Californians from birth to 25 years of age. The Newsom Administration proposed the Behavioral Health Initiative as part of the May Revision to the 2021-22 state budget; the Legislature subsequently established the initiative through Assembly Bill 133 (Committee on Budget, 2021). The 2021-22 state budget allocates approximately $4.4 billion in funding for the initiative over the next
five years, including about $1.5 billion in both 2021-22 and in 2022-23 and more than $400 million in ongoing funding in 2023-24 and thereafter.

The Children and Youth Behavioral Health Initiative is a capacious program that aims to transform California’s child mental health system. In the words of Health and Human Services Secretary, Dr. Mark Ghaly, this ambitious initiative seeks to remake California’s child mental health system “into one that is a world-class, innovative, up-stream-focused, early intervention-focused ecosystem where we can promise all of our young people that we will be looking out for their emotional and mental health needs, that we will be able to screen them and assess them in a timely way, and support them with emerging and existing best practices, in a culturally competent and equitable fashion.” The Behavioral Health Initiative includes the following components:

- **Behavioral Health Services and Supports Virtual Platform.** The budget allocates $750 million for the development and implementation of a virtual platform that integrates behavioral health services with around the clock access to screening, clinic-based care, and app-based support services. This platform will build on a new Department of Health Care Services project, the CalHOPE Program, to create a responsive platform designed for children, youth, and their families that provides tiered resources and treatment, while also helping to connect users to community-based organizations, wellness programs, and more intensive in-person services. In addition, the platform will support Pediatric Primary Care and Other Healthcare Provider eConsult services, which will facilitate consultation between primary care providers and behavioral health specialists. An outside vendor will develop and manage the platform; a portion of funding is delayed until the project achieves appropriate milestones from the California Department of Technology’s Project Approval Lifecycle.

- **School-Linked Behavioral Health Services.** The Children and Youth Behavioral Health Initiative will build partnerships and capacity statewide around school-based and school-linked mental health services through more than $1 billion in incentive and grant funding for schools, counties, health plans, and community-based organizations. Of this funding, $400 million is directed specifically to incentives for Medi-Cal managed care plans to partner with schools and county systems of behavioral health to provide school-linked and school-based mental health services to students and families. This collaboration could ease access to EPSDT mental health services and support greater provision of mental health services in school settings. Partnerships between schools, health plans, and community agencies can also facilitate Medicaid reimbursement for school mental health services. The Behavioral Health Initiative will require that commercial plans support school-based mental health services.

- **Workforce Development.** The budget allocates more than $1 billion in funding to support expansion of the behavioral health workforce. In the Newsom Administration’s original proposal for the Behavioral Health Initiative, this funding would support the training of 10,000 culturally and linguistically proficient behavioral health counselors, at varying levels of specialization and certification, as well as psychiatric nurse practitioners, community health workers, and peer support specialists. The initiative will further expand training program capacity and models and also leverage the existing workforce through training for pediatric and primary care providers.

- **Developing and scaling age-appropriate, evidence-based programs.** The budget provides grant funding of $430 million to health plans, county systems of health, and community-based organizations to support evidence-based practices. Priorities will likely include programs that support individuals following a first episode.
of psychosis, drop-in wellness centers, and both in-person and telehealth services oriented around prevention and early intervention.

- **Building Continuum of Care Infrastructure.** The budget provides $310 million in grant funding to build continuum of care infrastructure targeted at individuals age 25 and younger, with $205 million of that funding directed toward supporting mobile crisis support teams.

- **Dyadic Service Benefits.** The Behavioral Health Initiative will add dyadic behavioral health visits as a Medi-Cal benefit. Dyadic services refer to care that treats children and their parents/families together. The budget includes $800 million in funding support for these benefits over the next five years.

- **Public Awareness.** Finally, the Behavioral Health Initiative includes funding for a public awareness campaign around mental health, adverse childhood experiences, and toxic stress. The campaign will include measures to support culturally specific engagement and outreach, as well as youth involvement.

The Behavioral Health Initiative aims to simultaneously and comprehensively address the various systemic and structural barriers that can prevent young people from accessing and receiving mental health services. It aims to facilitate access by providing virtual services that both help to make care more available in rural parts of the state and that meet young people where many are—online. It also aims to expand the mental health workforce, center schools as hubs of wellness, develop a fuller continuum of care, and expand awareness around the importance of mental health. In addressing different issues at once, the initiative tackles the interrelated nature of barriers to care. For example, school-based mental health services can facilitate access to care, but making those services genuinely available requires creating a larger mental health workforce that can provide culturally competent care and reducing the stigma that can deter children and adolescents from visiting a school-based clinician.

Yet addressing an array of structural weaknesses and barriers simultaneously also creates an initiative that will be administratively complex. At the state level, the initiative calls for the participation of the Health and Human Services Agency, Department of Health Care Services, Department of Managed Care, Mental Health Services Oversight and Accountability Commission, Office of Statewide Health Planning and Development, Department of Public Health, Office of the Surgeon General, and the Department of Education.

The state budget surplus, together with federal recovery and stimulus funding, gives state government the resources to address COVID’s impact on children’s mental and emotional well-being, address many of the long-standing barriers that prevent children from receiving care, and implement preventive programs to alleviate the triggers for mental health conditions.

Several initiative components will involve third-party vendors, raising challenges of contract management. Putting the initiative into practice will further depend on collaboration and cooperation among county behavioral health offices, managed care plans, commercial insurers, community agencies, and school districts. Secretary Ghaly was upfront regarding the challenges facing implementation:
“It will not be easy; it will take a lot of innovation, a lot of rolling up sleeves.” It will also take strong structures for governing, coordinating, and administering the initiative, together with consistent leadership at the state level.

**Section IV: Steps Forward**

Given the complexity and urgency of the Behavioral Health Initiative, it is critical that the Governor’s Office and leadership of relevant state agencies work with local agencies, health plans, and stakeholders to establish a compact of relevant actors that clearly defines the work to be done, by whom, and when. The first year of the Behavioral Health Initiative focuses on planning, needs assessment, and stakeholder engagement, including creating a Youth Advisory Council and an advisory committee for expanding the mental health workforce.

The Commission understands that significant consultation and negotiation will be necessary to build the initiative’s component programs and develop concrete plans for implementation, but urges an efficient process so resources are primarily utilized for critical engagement with children. The following are key steps that state government may take that can help to structure and coordinate its response to COVID’s impact on children’s mental health and ensure that the Behavioral Health Initiative achieves sustainable improvements in California’s child mental health system.

**ESTABLISHING STATE LEADERSHIP AND OUTCOME GOALS**

In its 2015 and 2016 reports on the Mental Health Services Act, the Commission called for stronger, more coherent, and more cohesive state leadership over the mental health system and urged the Governor and Legislature to identify a mental health leader within state government that is able to ensure accountability for outcomes. Witnesses similarly emphasized the need for greater state leadership in addressing children’s mental health needs. Dr. Tom Insel recommended creating a new, more robust Department of Behavioral Health that would provide a single point of state leadership over mental health care and could consolidate state mental health programs and funding streams.

Witnesses and advocates generally agreed that the state of California needs to establish outcome goals for children’s mental and emotional well-being, especially for vulnerable children and youth. Christine Stoner-Mertz observed, “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... Setting clear statewide measures so that all delivery systems have increased transparency and accountability to children’s well-being is essential.” Dr. Insel further suggested mapping managed care plans and county systems onto a common regional template in order to begin centralizing standards.

“Setting clear statewide measures so that all delivery systems have increased transparency and accountability to children’s well-being is essential.” - Christine Stoner-Mertz, CEO, California Alliance of Child and Family Services

The Children and Youth Behavioral Health Initiative provides a foundation for a truly statewide approach to children’s mental and emotional well-being. Strong planning around implementation and governance will be needed to coordinate the initiative’s different branches and to ensure that it produces lasting and sustainable results, rather than producing more one-time pilot projects. Establishing a single person or entity with overall leadership—and accountability—
for the initiative, with capacity to oversee initiative elements and ensure that these elements have complementary outcome goals, is also likely to be essential to its success. Clear metrics and goals can further help to guide implementation and focus the initiative’s intersystem and interagency partnerships on common objectives both in the short- and long-term.

Moreover, the funding contained in the Behavioral Health Initiative is a potential lever for establishing outcome goals relative to children’s mental health and enforcing accountability for outcomes. The Behavioral Health Initiative includes planning around evaluation and data reporting; the portion of the initiative around behavioral health evidence-based programs, for example, would include the requirement that grantees share standardized data in a statewide behavioral health dashboard.

Addressing COVID’s impact on children’s mental health will require shared accountability, with state government assuming responsibility for ensuring that the various health plans and providers achieve goals.

Yet the Behavioral Health Initiative is also an opportunity to require entities receiving funding to collect and report data relative to more general outcome goals. In order to encourage accountability, the California Health and Human Services Agency and relevant agencies could make access to portions of initiative funding contingent on meeting metrics linked to established outcome goals.

BUILDING CAPACITY FOR STATEWIDE APPROACHES

Several witnesses and experts testified to the importance of metrics and accountability in structuring a more coordinated and strategic approach to children’s mental health; witnesses also emphasized, however, that state government must take responsibility for the ability of health plans and providers to meet outcome goals.

Toby Ewing explained, “Part of the reason we do not have a mental health system from a statewide perspective, is the state is not in the business of helping counties build out their systems.” Mr. Ewing observed that the Mental Health Services Oversight and Accountability Commission has recently made progress encouraging counties to reduce the amount of unspent MHSA funds, not by seeking to punish counties for failing to expend funds, but by working with them to address the risks that cause counties to accumulate excess reserves and to identify ways to spend the funds more effectively. “We need,” Mr. Ewing suggested, “to be equally responsible for success together.”

Alex Briscoe made the same point, suggesting that the relationship between state government and county systems needs to be reworked around collaboration and support. According to Mr. Briscoe, the state’s approach to counties and health plans needs to be predicated on the understanding, “our job is to help you to do your job better.”

Addressing COVID’s impact on children’s mental health will require shared accountability, with state government assuming responsibility for ensuring that the various health plans and providers achieve goals. The Children and Youth Behavioral Health Initiative is potentially a major step in the direction of establishing greater state leadership around children’s mental health and toward developing a culture of collaboration between state government and health plans. Secretary Ghaly noted that the proposed virtual platform is a “bold step to say
that we will have something statewide, that we do not expect every county to come up with their own version.”

In addition, technical assistance is likely to be instrumental for the success of the Behavioral Health Initiative, especially by enabling health plans, providers, and schools to learn from existing models rather than reinventing the wheel. The Health and Human Services Agency and participating departments may need to build out or identify sources of technical assistance; they can also establish learning collaboratives and communities of practice, as the Oversight and Accountability Commission has done for its early psychosis intervention program. In addition, there is opportunity to leverage the resource and knowledge base of California’s university systems. New York State’s Department of Education, for example, supports three university-based, regional technical assistance centers for community schools.

California could similarly work with universities and relevant non-profit organizations to institutionalize technical assistance around children’s mental health, including school-based mental health, evidence-based practices, and approaches around prevention and early intervention.

Separately, witnesses and providers called for the Department of Health Care Services to dedicate resources around capacity building. They suggested that DHCS expand its ability to provide technical assistance around reimbursement and take steps to simplify and streamline state processes around documentation. Although providers were hopeful that CalAIM will ultimately help address and reduce the paperwork burden associated with billing Medi-Cal, they also suggested that more assistance is needed in addressing challenges around documentation and drawing down reimbursements.

BUILDING SCHOOL-LINKED PARTNERSHIPS

School-based and school-linked partnerships will be critical for responding to COVID’s impact at scale. It is important, however, to appreciate the complexity and difficulty of what will be involved in creating partnerships around school-based mental health. Centering schools as sites for supporting child mental wellness requires bringing together California’s systems of education and mental health. Putting the Behavioral Health Initiative into practice further depends on forging new and deeper partnerships between entities that have little experience working together, like schools and managed care organizations. Moreover, schools will need to develop and expand partnerships with health plans and community agencies while also confronting the significant challenges associated with fully reopening, addressing uncertain risk around COVID, attending to

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**Seneca Family of Agencies and Coordination of Services**

Seneca Family of Agencies is a statewide non-profit that provides school and community-based services addressing children’s well-being through an innovative whole child model called Unconditional Education. This model provides a highly developed and integrated example of a MTSS framework that equips school districts with supports to educate all students at local schools. At each school site, an Unconditional Education “coach” guides implementation of the model. This coach works with school leadership to help improve school culture and climate and provides professional development and coaching for school staff and teachers to help them meet students’ needs. The coach also supports a coordination of services team that manages referrals and ensures students receive the engagement and supports they may need.
learning loss, and managing the immediate impacts of the pandemic on students’ well-being.

Careful planning and coordination at both the district and at the school level is critical. Most importantly, there needs to be clarity around the roles that teachers, pupil services personnel, administrative staff, outside clinicians, and other mental health professionals will play in providing mental health services:

- This does not mean training teachers to be social workers or mental health clinicians. Instead, it means better connecting teachers and educators with resources and helping them understand signs that indicate that a student may be struggling and how to help direct that student to sources of support. It can also mean building awareness around social emotional learning and providing teachers, administrators, and staff with training in trauma-informed approaches, so that they respond to behavioral issues through restorative practices, rather than disciplinary actions.

- Clearly defining the respective roles of pupil services personnel professionals (i.e., school counselors, school social workers, and school psychologists) and outside clinicians and further developing clear understanding regarding care coordination and information sharing, so as to ensure that there is both a “warm hand off” and continued coordination when a student needs more intensive or specialized services. Establishing coordination of services teams can support effective cooperation among the various people and entities involved in providing different levels of care and services. School counselors can also play a key role in managing MTSS frameworks, identifying students who need more intensive services and coordinating with mental health clinicians.

- Developing data-driven approaches to coordinating and delivering care and measuring the effectiveness of interventions. Attendance and academic data can be powerful indicators of student emotional or mental issues. Yet, many schools do not employ this data to identify students who may need support or disaggregate data to identify where there may be issues. With regard to the use of data systems in delivering and tracking school mental health services, Pia Escudero observed, “We’re in the infancy stages because of the lack of funding.” The Behavioral Health Initiative makes funding available to develop and integrate data systems around student mental health, but connecting and integrating data systems across educational and health agencies will pose administrative and technical challenges.

Technical assistance is likely to play a critical role in supporting the development of viable and effective partnerships around school-based and school-linked mental health services. Existing partnerships between schools and county mental health plans can offer models and lessons that new collaborations can learn from, as can previous state programs that provided technical assistance around school climate and student well-being. For example, the Scale Up MTSS Statewide (SUMS) Initiative administered by Orange County Department of Education also included leadership from Butte County Office of Education and featured technical assistance oriented towards the needs of small and rural districts, as well as creating a community of practice that bridged large and small districts. This initiative could potentially hold lessons for helping small and rural school districts address their unique constraints and challenges in delivering mental health services.

In addition, the 2021-22 State Budget allocates $3 billion in funding to expand implementation of community school models, including $140 million to support regional technical assistance centers for community schools. These centers could potentially also support technical assistance around school-linked mental health.
Recommendations

Governor Newsom and the Health and Human Services Agency are taking critical steps to overhaul and improve California’s system for supporting child mental health. Taken together, CalAIM and the Children and Youth Behavioral Health Initiative have potential to transform California’s child mental health system and address many of the longstanding structural weaknesses of that system.

Yet these ambitious and expansive proposals may not fully address some of the root causes of these weaknesses. California’s child mental health system has long suffered from lack of clear and consistent leadership—leadership that can overcome fragmentation, define the roles of the system’s various actors, establish metrics to evaluate success, and hold agencies and providers accountable for outcomes.

California cannot afford to waste the current moment. Meeting children’s mental health needs requires clear state leadership and clearly defined goals and expectations.

1. Establish state leadership. The Commission reiterates its recommendation from earlier reports for the state of California to identify a central point of leadership for children’s mental health. In the short term, the Governor should establish a clear plan for coordinating the constituent parts of the Children and Youth Behavioral Health Initiative, including developing governance and implementation plans. The Commission suggests that this plan include the creation of a staffed coordinating council for children’s mental health that would be charged both with implementing the Behavioral Health Initiative and with overall oversight of the children’s mental health system. This council should be chaired by the Secretary of the Health and Human Services Agency. It should also include leadership from relevant agencies, including the Department of Health Care Services, Department of Managed Care, Department of Public Health, Office of the Surgeon General, the Mental Health Services Oversight and Accountability Commission, Office of Statewide Health Planning and Development, and the Department of Education.

In the longer run, the Governor and Legislature should initiate a review process, to be completed no later than October 2022, to examine the creation of a new and robust Department of Behavioral and Mental Health that would be capable of statewide leadership over mental health care and services, with coequal focus on child and adult mental health. This review process would include examination of how other states structure departments of mental health, of the lessons that can be learned from California’s previous Department of Mental Health, and of how the department may be best organized to ensure that children’s mental health receives equal attention to adult mental health, as well as consideration of whether a distinct Department of Behavioral and Mental Health would impede or support whole person approaches to care that address both mental and physical health.

2. Establish outcome goals. The Commission commends the Newsom Administration for incorporating evaluation as a core component of the Children and Youth Behavioral Health Initiative. However, the Commission also finds that California needs to establish overarching and unifying goals and metrics around child mental health.

In consultation with stakeholders, the Secretary of the Health and Human Services Agency should set statewide goals for child mental health based on a limited number of key metrics related to overall mental well-being, access to care, and quality of care, which could include: increasing attendance and graduation rates for students with behavioral or mental health disorders; increasing recovery after first episode of psychosis; increasing the percentage of children reporting severe depression who receive counseling; decreasing wait time to access care;
increasing the percentage of children being screened for mental wellness and for ACEs, and, if at risk, receiving appropriate interventions; and, increasing the percentage of children with access to school mental health programs. These data should be released publicly each year and, where appropriate, should further be disaggregated by race, gender, and age.

In order to guide local implementation and encourage local accountability, each county, managed care plan, and commercial plan should also be required to establish equivalent goals that would contribute to reaching statewide goals.

3. Support accountability around outcome goals.
The Governor and Legislature also need to use the new funding associated with the Children and Youth Behavioral Health Initiative as an opportunity to expand accountability and oversight in the provision of mental health services.

The Commission recommends reserving a portion of Behavioral Health Initiative funding to provide a future tranche of additional funding that would be awarded on a competitive basis to counties and health plans that efficiently and effectively implement successful reforms/programs and that reach identified benchmarks or improvements with respect to outcomes, data collection, data sharing, and care coordination. Within this “race to the top” style competition, entities would compete with like-situated entities.

4. Build shared accountability. In establishing outcomes goals, California needs also to reset the relationship between the state and county systems with regard to accountability and technical support. Currently, accountability around children’s mental health centers on audits that focus on how money is spent, rather than on outcomes for children’s mental health. CalAIM promises to reduce the burdens associated with Medi-Cal payments, but more is needed to change the culture that exists between state and local government around child mental health services. The Governor and Legislature need to take steps to establish a culture within the relevant state agencies that says to counties and providers, “How can we work together to learn together,” and “How do we help you increase capacity?”

The Department of Health Care Services should work with stakeholders to identify ways to increase the technical assistance it provides to counties, managed care plans, and other mental health providers, including local educational agencies. In addition, the review process for the creation of a new Department of Behavioral and Mental Health should include consideration of what changes would potentially be required to expand the capacity of the Department of Health Care Services to provide greater technical assistance to local departments of mental health and to others providers. It should also include consideration of where technical assistance for school-based Medi-Cal payments should reside.

5. Center schools. In addition to funding school-linked mental health partnerships and services, the Governor and Legislature should also use this opportunity to encourage school districts and local education agencies to develop coordinated and comprehensive approaches to student mental and emotional wellness.

The 2021-22 State Budget includes major investments in the development of community schools. Schools can further draw on existing federal and state funding sources to support their counselor and mental health workforces, as well as on significant one-time funding. It is critical that the Governor, Legislature, and associated departments and agencies encourage districts to approach these funding sources in an integrated and strategic fashion so as to position schools as hubs of mental well-being.

School-linked behavioral health services grants within the Children and Youth Behavioral Health Initiative should require the following of recipients:
Every district and school receiving funding should develop a coordinated plan for how it will deliver multi-tier mental health supports, including clear identification of the roles of teachers, of school support and counseling staff, and of partner organizations. This should be a concise, actionable plan that promotes clear and efficient cooperation, and care should be taken to ensure that developing the plan is not administratively burdensome.

Every district and its partners should develop a plan detailing how they will use available data to identify students who may need support, how they will share data and information, and how they will coordinate services in an equitable and balanced manner.

Every district and its partners should specify how they will integrate grant funding with funding from other sources to create sustainable programs around student mental health.

In order to further highlight the importance of school climate and student mental health, the Superintendent of Public Instruction should also create a program that recognizes schools that are leaders in creating and maintaining positive school climate and in supporting student mental well-being.

6. Strengthen the behavioral health services virtual platform. The Commission commends the Newsom Administration for building on the momentum and innovation surrounding telehealth services for mental health. The proposed virtual platform has potential to expand availability of telehealth options while “meeting children where they are.” Yet the ongoing challenges surrounding IT systems at the Employment Development Department and Fi$Cal, as well as with the MyTurn and MyTurn Volunteer websites, should also urge caution as the state proceeds to support the development of a complicated technology system, and one that must be accessible and inviting to children and youth of different ages and backgrounds.

In order to mitigate risks associated with platform development, the Governor should provide specifications on the bidding and contracting process for the virtual platform. The Governor should also establish a clear timeline for the development, testing, and piloting of the platform, with vigorous oversight at every stage of development.

In addition, in developing and rolling out the virtual platform, the Governor and relevant agencies should address how they will ensure that the virtual platform does not exacerbate the digital divide. The design and development of the platform should include consideration of how this platform can be made available to children and youth who do not have broadband and may also have limited internet access. Development should also include identification of strategies to provide equivalent in-person services for those children who are unable to access the platform.
Notes


5. Dr. Tom Insel, Chair of the Steinberg Institute Board of Directors and Former Director of the National Institute of Mental Health, Testimony to the Commission, April 22, 2021.


11. California Health Care Foundation, Mental Health and Substance Use, p. 8, see endnote 10.


13. California Health Care Foundation, Mental Health and Substance Use, p. 7, see endnote 10.


15. Dr. Nadine Burke Harris, California Surgeon General, Testimony to the Commission, May 27, 2021.

17. Ellen Yard et al., “Emergency Department Visits for Suspected Suicide Attempts among Persons Aged 12-25 Years Before and During the COVID-19 Pandemic – United States, January 2019-May 2021,” Morbidity and Mortality Weekly Report (June 2021), https://www.cdc.gov/mmwr/volumes/70/wr/mm7024e1.htm?s_cid=mm7024e1_w&fbclid=IwAR3-mKwFWvscJkKd1XGy0vcR0lwvW5rS-SpsVSj04HnohYMqplTYrAGmhsc.


22. Dr. Tom Insel, see endnote 5.


27. Dr. Bryan King, Interview with Commission staff, July 7, 2021.


37. Dr. Tom Insel, see endnote 5.


39. Christine Stoner-Mertz, CEO, California Alliance of Child and Family Services, Written Statement to the Commission, April 22, 2021; Dr. Rebecca Dudovitz, Associate Professor in General Pediatrics, UCLA School of Medicine,
Conversation with Commission staff, May 4, 2021.


47. Toby Ewing, Executive Director, Mental Health Services Oversight and Accountability Commission, Testimony to the Commission, May 27, 2021.

48. Dr. Nadine Burke Harris, see endnote 43.


50. Ken Berrick and Robin Detterman, see endnote 3.
51. Dr. Nadine Burke Harris, see endnote 38.


55. Dr. Nadine Burke Harris, see endnote 38.

56. Dr. Nadine Burke Harris, see endnote 43.


60. California State Auditor, *Youth Suicide Prevention*, pp. 7-10, see endnote 24.


63. Preliminary data contained in testimony to the Commission by Michelle Cabrera, Executive Director, County Behavioral Health Directors Association of California, May 13, 2021. According to these data, White beneficiaries under 21 years of age received managed care plan mental health services at a rate of 10,739 per 100,000; in comparison, Black beneficiaries accessed services at a rate of 3,525 per 100,000 and Latino beneficiaries accessed services at a rate of 4,000 per 100,000.

64. Hodgkinson, “Improving Mental Health Access for Low-Income Children and Families,” see endnote 42.


66. Toby Ewing, see endnote 47.

67. California State Auditor, *Department of Health Care Services: Millions of Children in Medi-Cal Are Not Receiving Preventive Health Services*
DHCS reports that, as of early 2021, more than 5.4 million children aged 0-20, out of a total population of approximately 10.775 million, were enrolled in Medi-Cal, see Medi-Cal Children's Health Dashboard (June 2021), https://www.dhcs.ca.gov/services/Documents/Childrens-Health-Dashboard-June-2021.pdf, and State of California, Department of Finance, Projections, Total Estimated and Projected Population for California by Single Year of Age: July 1, 2010 to 2060, https://www.dof.ca.gov/Forecasting/Demographics/Projections/.


70. California Health Care Foundation, Mental Health and Substance Use, p. 18, see endnote 10.


72. Christine Stoner-Mertz, see endnote 39.

73. Dr. Tom Insel, see endnote 5.

74. Alex Briscoe, Principal, California Children’s Trust, Testimony to the Commission, April 22, 2021; Jessica Cruz, Executive Director, National Alliance on Mental Illness – California, Conversation with Commission staff, April 20, 2021; Dr. Tom Insel, see endnote 5.

75. Lishaun Francis, see endnote 46.


77. California State Auditor, Department of Health Care Services, pp. 14, 17, see endnote 67.

78. Lewis and Hults, Meeting the Moment, p. 16, see endnote 71.

79. Children Now and California Children’s Trust, The California Children’s Trust Initiative, pp. 6-7, see endnote 67.

80. Christine Stoner-Mertz, see endnote 39.

81. California Children's Hospital Association (CCHA),
Dr. Brian Distelberg, Director of Research, Loma Linda University Behavioral Medicine Center, Testimony to the Commission, May 13, 2021.

Lewis and Hults, *Meeting the Moment*, pp. 15, 17, see endnote 71.

California State Auditor, *Department of Health Care Services*, p. 17, see endnote 67.

Lewis and Hults, *Meeting the Moment*, p. 15, see endnote 71.

Dr. Bryan King, see endnote 2.


As of July 20, 2021.

Christine Stoner-Mertz, see endnote 39.


CCHA, *Improving Behavioral Health Care for Children*, p. 15, see endnote 81.

Dr. Brian Distelberg, see endnote 82. According to Dr. Distelberg’s testimony, SAMHSA recommends a ratio of one psychiatric bed for every 2,000 residents in a community; in California, the number is one bed for every 5,834 individuals.

CCHA, *Improving Behavioral Health Care for Children*, pp. 10-11, see endnote 81.


Gardner, *California's Children and Youths' System of Care*, pp. 24-5, see endnote 59.
97. Debra Manners, President and CEO, Hathaway-Sycamore, Conversation with Commission staff, March 24, 2021; Lewis and Hults, Meeting the Moment, p. 16, see endnote 71.

98. Dr. Brian Distelberg and Dr. Amy Young, Director, Resiliency Institute for Childhood Adversity, Loma Linda University Children’s Hospital, Conversation with Commission staff, March 16, 2021. Tracy Mendez, Executive Director, California School-Based Health Alliance, Conversation with Commission staff, March 29, 2021.


105. Pia Escudero, Executive Director, Division of Student Health and Human Services, Los Angeles Unified School District, Testimony to the Commission, May 13, 2021.

106. MHSOAC, Every Young Heart and Mind, p. 23, see endnote 101.

108. Pia Escudero, Conversation with Commission staff, March 29, 2021, and see endnote 105.


110. Ken Berrick and Robin Detterman, see endnote 3.

111. Dr. Bryan King, see endnote 2.

112. Rebeck, *Investments in Student Health and Mental Health*, pp. 9-10, 15, 20, and Figures 3, 7a, 7b, and 7c, see endnote 99.

113. MHSOAC, *Every Young Heart and Mind*, p. 36, see endnote 101.


115. Michelle Cabrera, see endnote 63.


117. Dr. Brian Distelberg, see endnote 82.


119. Dr. Tom Insel, see endnote 5.

120. Dr. Tom Insel, see endnote 5; Christine Stoner-Mertz, see endnote 39; Dr. Brian Distelberg, see endnote 82.

121. Dr. Tom Insel, see endnote 5; Dr. Brian Distelberg, see endnote 82; Ken Berrick and Robin Detterman, see endnote 3.

122. Dr. Tom Insel, see endnote 5; Lishaun Francis, see endnote 46.

123. Dr. Tom Insel, see endnote 5; Alex Briscoe, see endnote 74.

124. Christine Stoner-Mertz, see endnote 39.

125. Ken Berrick and Robin Detterman, see endnote 3.


127. Dr. Bryan King, see endnote 2.


129. Dr. Tom Insel, see endnote 5.

131. Dr. Mark Ghaly, Secretary, California Health and Human Services Agency, Testimony to the Commission, May 27, 2021.


134. Secretary Mark Ghaly, see endnote 131.

135. Jessica Cruz, see endnote 74.

136. Dr. Tom Insel, see endnote 5.

137. Christine Stoner-Mertz, see endnote 39.

138. Toby Ewing, see endnote 47.

139. Alex Briscoe, see endnote 95.

140. Secretary Mark Ghaly, see endnote 131.


142. Ken Berrick and Robin Detterman, see endnote 3.

143. Ken Berrick and Robin Detterman, see endnote 3.

144. Jessica Cruz, see endnote 74.

145. Jessica Cruz, see endnote 74; Mara Madrigal Weiss, Executive Director of Student Wellness and School Culture, San Diego County Office of Education, and Toby Ewing Conversation with Commission staff, April 7, 2021.

146. Dr. Loretta Whitson, Executive Director, California Association of School Counselors, Conversation with Commission staff, April 27, 2021; *Connecting the Dots: The School Counselor Role in Student Mental Health*, see endnote 116.

147. Pia Escudero, see endnote 105.

148. Tim Taylor, see endnote 114.


150. Toby Ewing, see endnote 47.
Little Hoover Commission Members

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Appointed to the Commission by the Senate Rules Committee in February 2013. Elected in November 2012 to represent the 31st Senate District. Represents Corona, Coronita, Eastvale, El Cerrito, Highgrove, Home Gardens, Jurupa Valley, March Air Reserve Base, Mead Valley, Moreno Valley, Norco, Perris, and Riverside.

CATHY SCHWAMBERGER | Calistoga
Appointed to the Commission by the Senate Rules Committee in April 2018 and reappointed in January 2019. Retired associate general counsel for State Farm Mutual Automobile Insurance Company. Former board member of the Civil Justice Association of California and the Capital Political Action Committee.

JANNA SIDLEY | Los Angeles
Appointed to the Commission by Governor Edmund G. Brown Jr. in April 2016 and reappointed in February 2020. General counsel at the Port of Los Angeles since 2013. Former deputy city attorney at the Los Angeles City Attorney’s Office from 2003 to 2013.

Full biographies are available on the Commission’s website at www.lhc.ca.gov.
“DEMOCRACY ITSELF IS A PROCESS OF CHANGE, AND SATISFACTION AND COMPLACENCY ARE ENEMIES OF GOOD GOVERNMENT.”

By Governor Edmund G. “Pat” Brown, addressing the inaugural meeting of the Little Hoover Commission, April 24, 1962, Sacramento, California