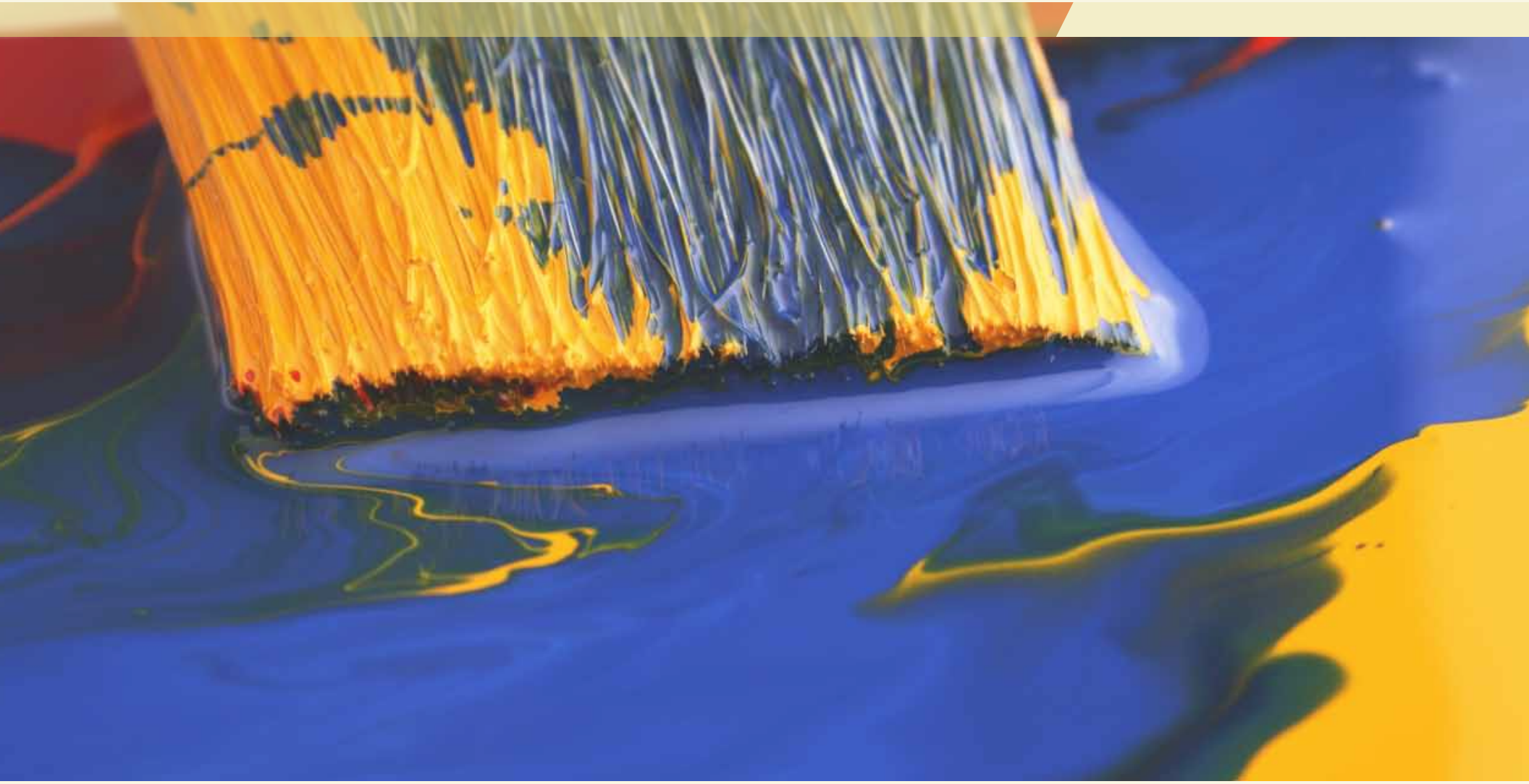
CALIFORNIA

HEALTH CARE ALMANAC

CALIFORNIA HEALTHCARE FOUNDATION



Mental Health Care in California: Painting a Picture

JULY 2013

Introduction

Nearly 1 in 6 California adults has a mental health need, and approximately 1 in 20 suffers from a serious mental illness that makes it difficult to carry out major life activities. The rate among children is even higher: 1 in 13 suffers from a mental illness that limits participation in daily activities.

In mental health care, counties play a large role in financing and care delivery, and outpatient settings for care dominate. However, less is known about the mental health system — from prevalence of individual disorders to statewide costs of care to quality of care delivery — than about the medical system. This report uses the most recent data available — from 2009 and 2010.

Mental Health Care in California: Painting a Picture provides an overview of mental health in California: disease prevalence, suicide rates, the state's care delivery system, supply and use of treatment providers, and access to care. The report also highlights available quality data and the most recent data on national mental health care spending.

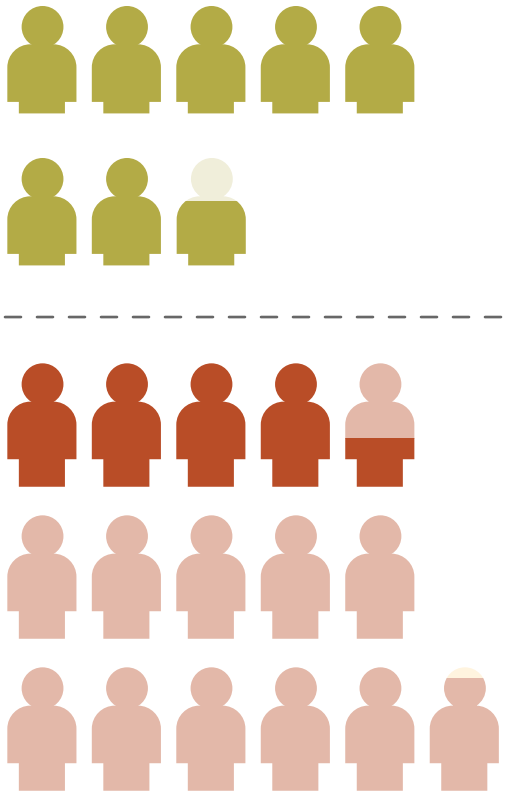
KEY FINDINGS INCLUDE:

- About half of adults and two-thirds of adolescents with mental health needs did not get treatment.
- For children and adults, the prevalence of serious mental illness varied by income, with much higher rates of mental illness at lower income levels.
- There were significant racial and ethnic disparities for incidence of serious mental illness among adults: Native American, multiracial, and African American populations experienced the highest rates.
- Compared to the US, California had a lower overall suicide rate, although it varied considerably within the state by gender, age, race/ethnicity, and region.
- The distribution of spending on mental health care in the US has changed dramatically over the last 20 years, with inpatient and residential care spending decreasing, and outpatient care and prescription drug spending increasing.
- Recent policy changes, including the Mental Health Parity Act and the Affordable Care Act, are expected to increase access to treatment for insured and uninsured Californians with mental health needs.
- The supply of acute psychiatric beds has declined over the last 15 years in California. The state's bed-per-capita ratio was much lower than the nation's.

CONTENTS

State of Mental Illness
California, 2009

PERCENTAGE OF POPULATION



7.6% Children with Serious Emotional Disturbance

4.3% Adults with Serious Mental Illness

15.9% Adults with Any Mental Illness

About 1 in 20 adults in California suffered from a serious mental illness making it difficult to carry out major life activities. The rate for children was higher.

Notes: Serious emotional disturbance (SED) is a categorization for children age 17 and under. Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations.

Source: Technical Assistance Collaborative and Human Services Research Institute (February 2012), California Mental Health and Substance Use Needs Assessment.

Mental Illness Defined

There are a wide variety of mental health disorders. Some are acute and short-lived. Others are persistent and can lead to difficulty with functioning to the point of disability. States define a serious mental illness in adults and a serious emotional disturbance for children based on mental illness diagnosis and level of difficulty with functioning.

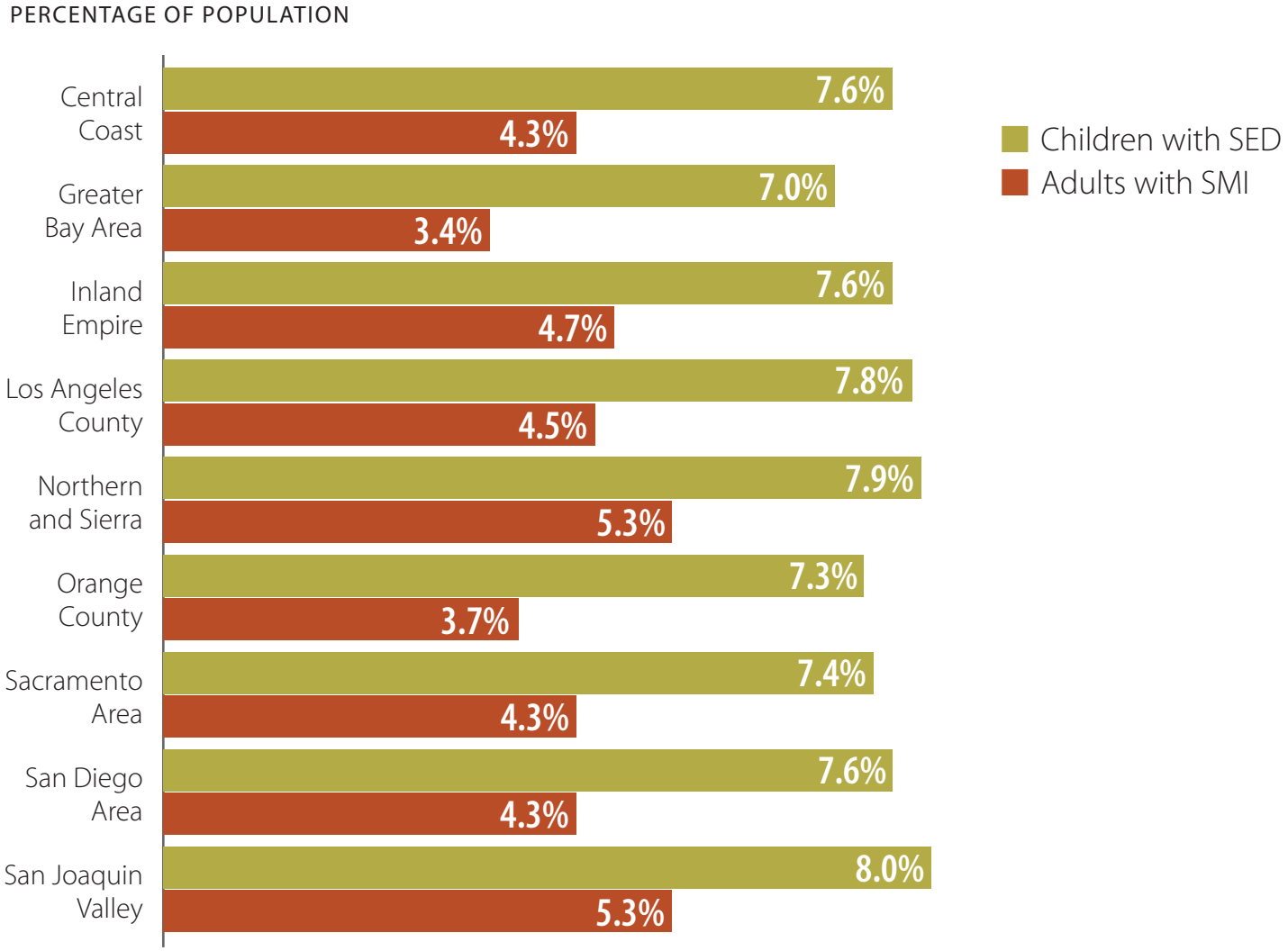
An adult with any mental illness is a person 18 or older who currently has, or at any time in the past year had, a diagnosable mental, behavioral, or emotional disorder, regardless of the level of impairment in carrying out major life activities. This category includes people with serious, moderate, or mild functional impairment.

Severe mental illness (SMI), a categorization for adults age 18 and older, is any mental illness that results in substantial impairment in carrying out major life activities. Mental illnesses encompass a wide range of diagnoses. Examples include: depression, anxiety, schizophrenia, bipolar disorder, attention deficit hyperactivity disorder, and post traumatic stress disorder.

Severe emotional disturbance (SED), a categorization for children age 17 and under, is defined as a mental, behavioral, or emotional disorder that is currently present, or has presented within the last year, that meets diagnostic criteria for a mental illness and has resulted in functional impairment that substantially limits participation in family, school, or community activities.

A major depressive episode (MDE) is a period of at least two weeks when a person has experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of specified depression symptoms.

Adults with SMI and Children with SED, by Region
California, 2009

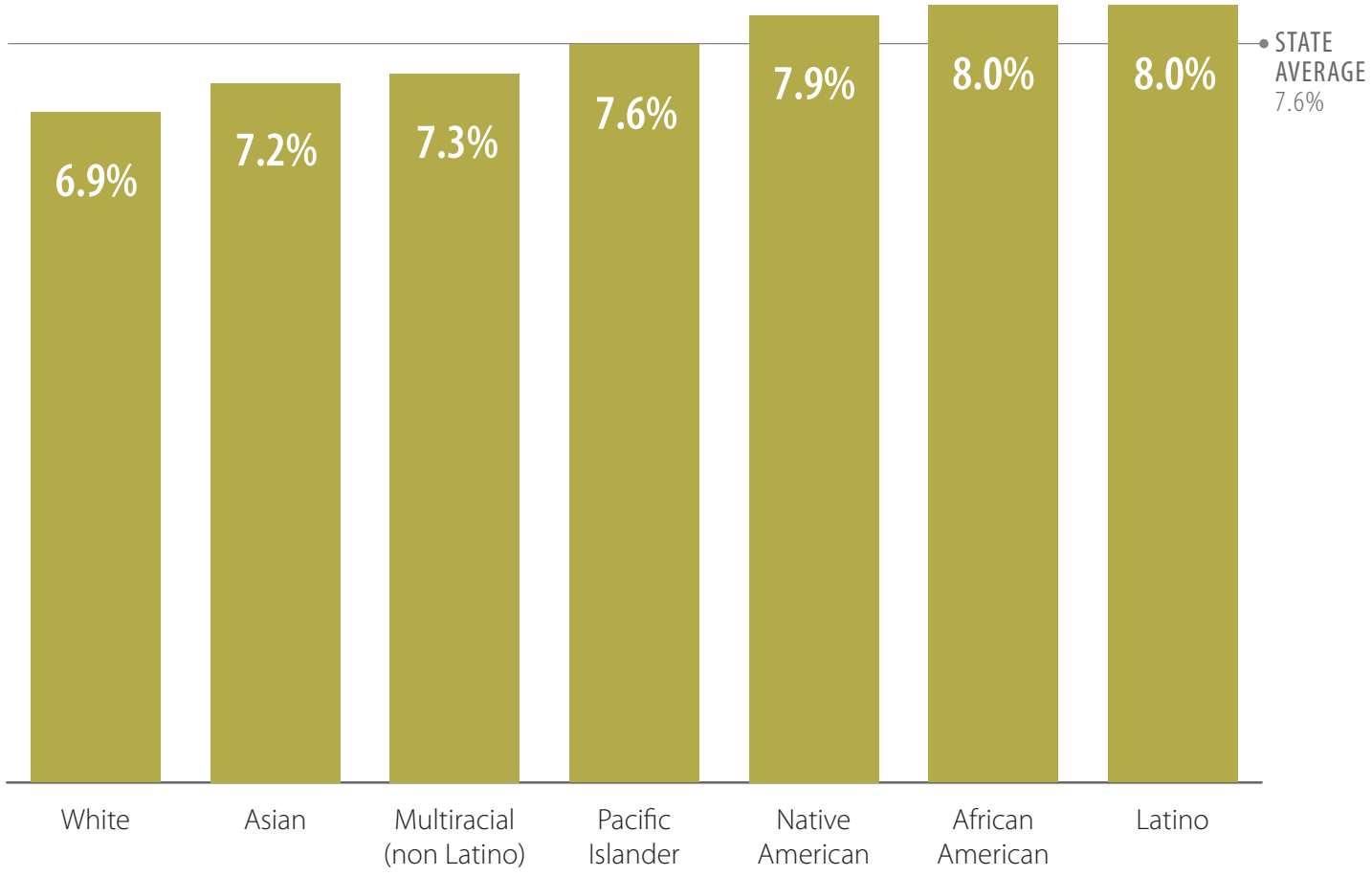


Notes: Serious emotional disturbance (SED) is a categorization for children age 17 and under. Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations. See Appendix A for a map of counties included in each region.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

The rate of serious emotional disturbance among children in California varied slightly by region, from a high of 8.0% in the San Joaquin Valley and 7.9% in the Northern and Sierra region, to a low of 7.0% in the Bay Area. The prevalence of serious mental illness among adults ranged from a high of 5.3% in the San Joaquin Valley and in the Northern and Sierra region, to a low of 3.4% in the Bay Area.

Children with SED, by Race/Ethnicity
California, 2009



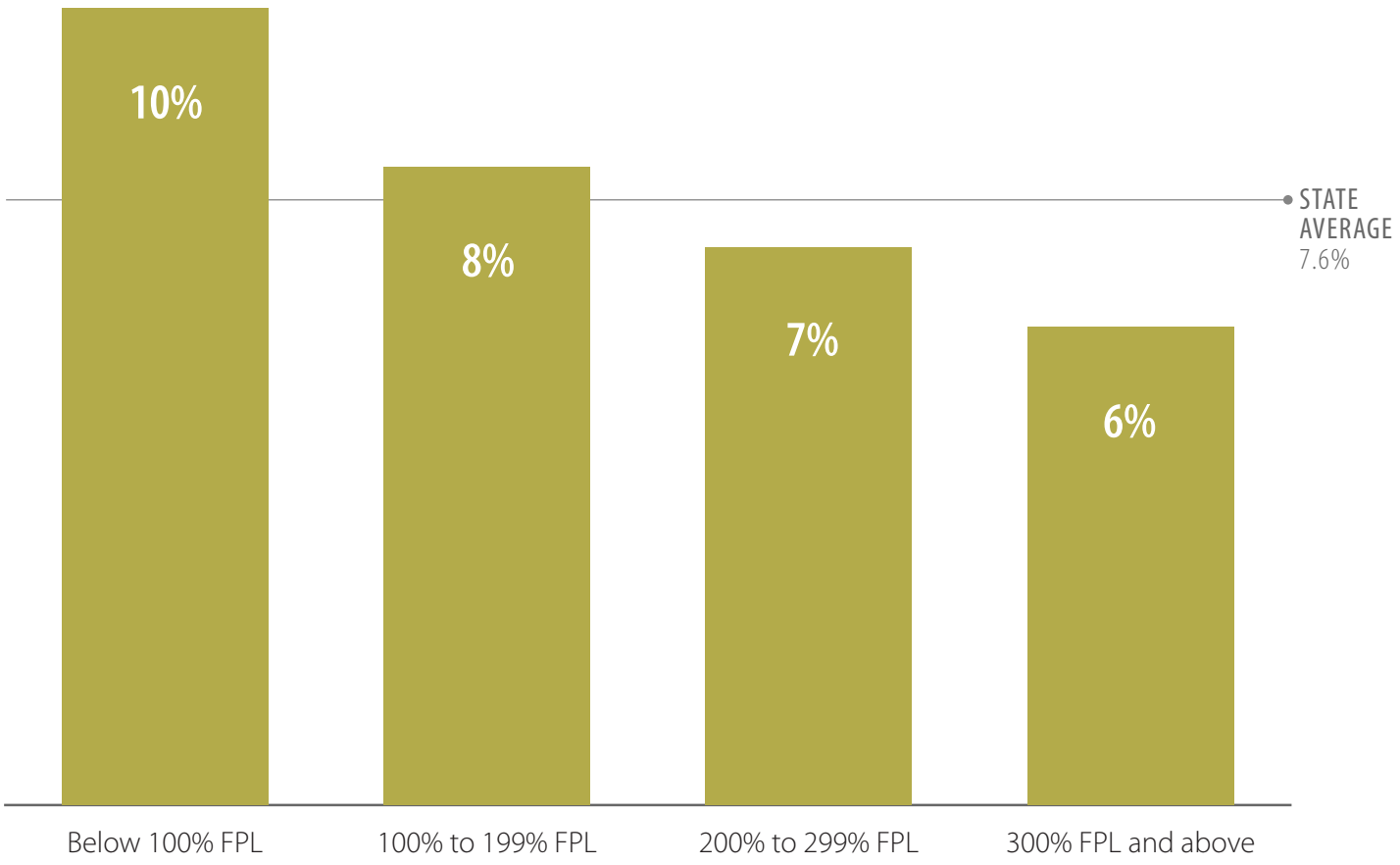
Notes: Serious emotional disturbance (SED) is a categorization for children age 17 and under. See page 4 for full definitions of mental illness categorizations.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

Rates of serious emotional disturbance in California children showed slight variation among ethnicities: Latino, African American, and Native American children experienced rates of SED at or close to 8%, and rates for White, Asian, and multiracial children were close to or below 7%.

Children with SED, by Income
California, 2009

PERCENTAGE OF CHILD POPULATION

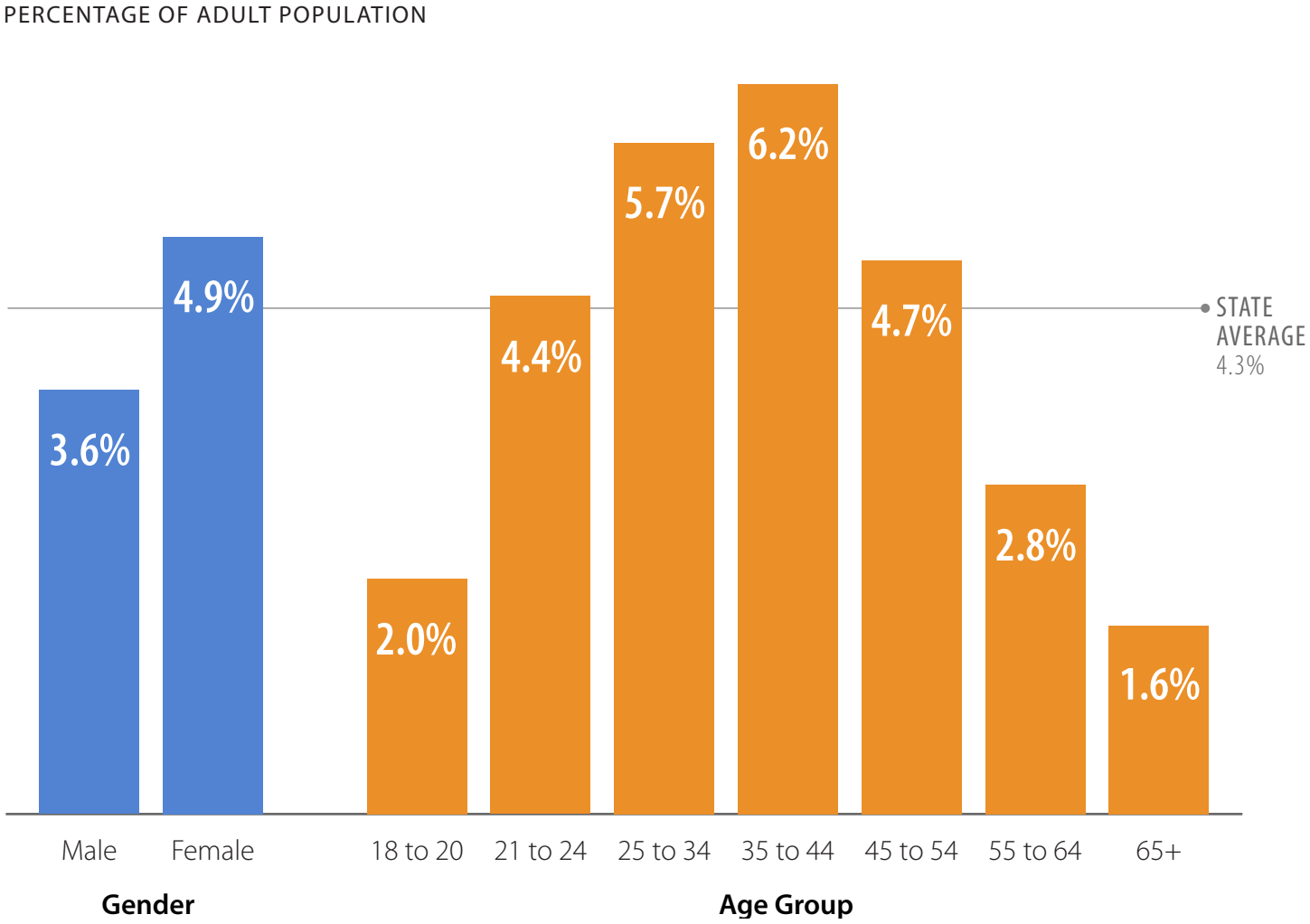


Notes: Serious emotional disturbance (SED) is a categorization for children age 17 and under. See page 4 for full definitions of mental illness categorizations. FPL is federal poverty level; 100% of FPL was defined in 2009 as an annual income of $10,830 for an individual and $22,050 for a family of four.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

Rates of serious emotional disturbance in California children showed more variation across income levels than across gender, age groups, and race and ethnic groups. One in 10 children below the poverty level suffered from a serious emotional disturbance.

Adults with SMI, by Gender and Age Group
California, 2009



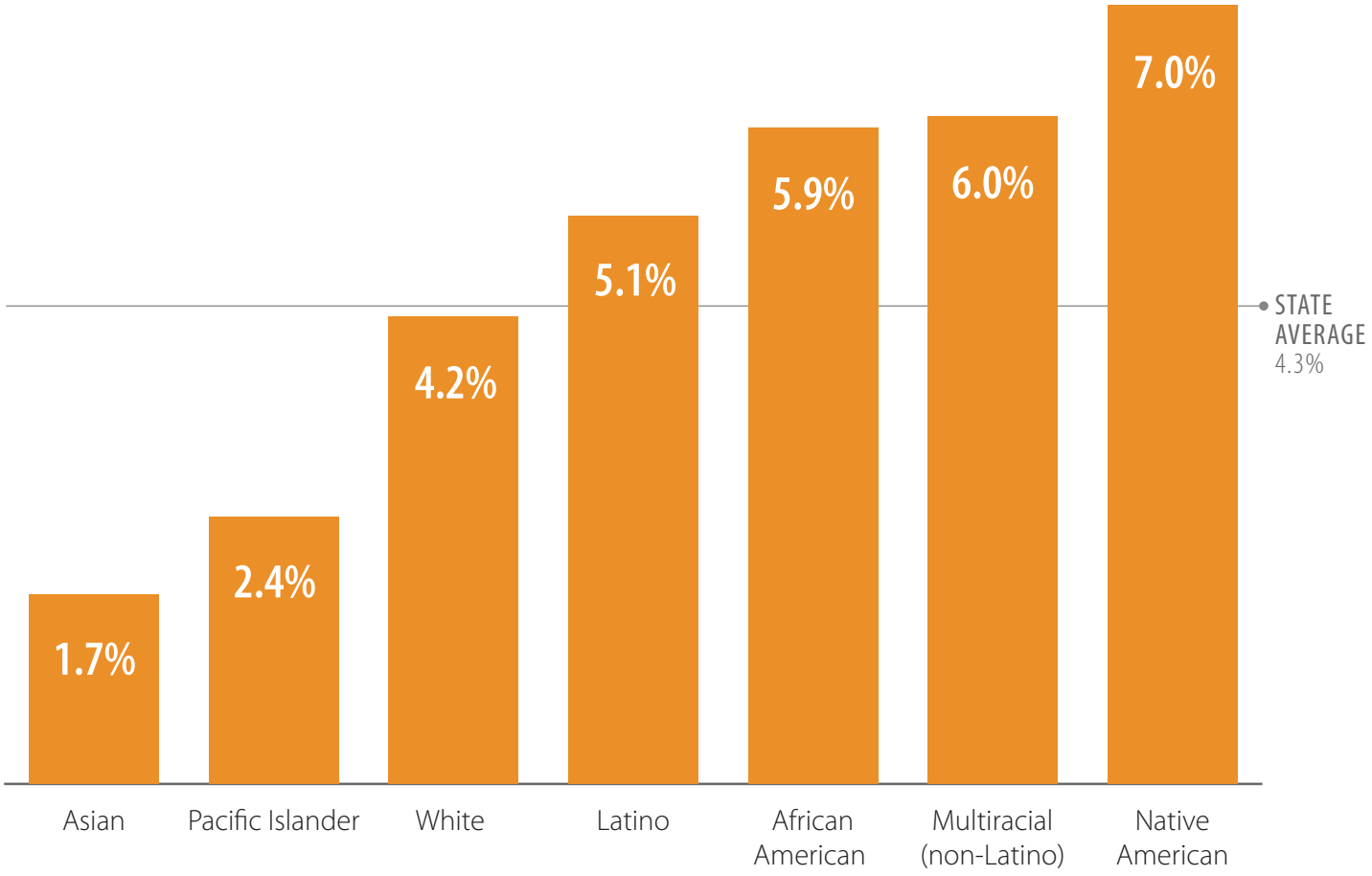
Notes: Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

Adult California women were more likely than men to experience serious mental illness. Rates of serious mental illness increased steadily by age group, from 2% (18 to 20) to a peak of 6.2% (35 to 44). Rates fell to a low of 1.6% among those age 65 and over.

Adults with SMI, by Race/Ethnicity
California, 2009

PERCENTAGE OF ADULT POPULATION



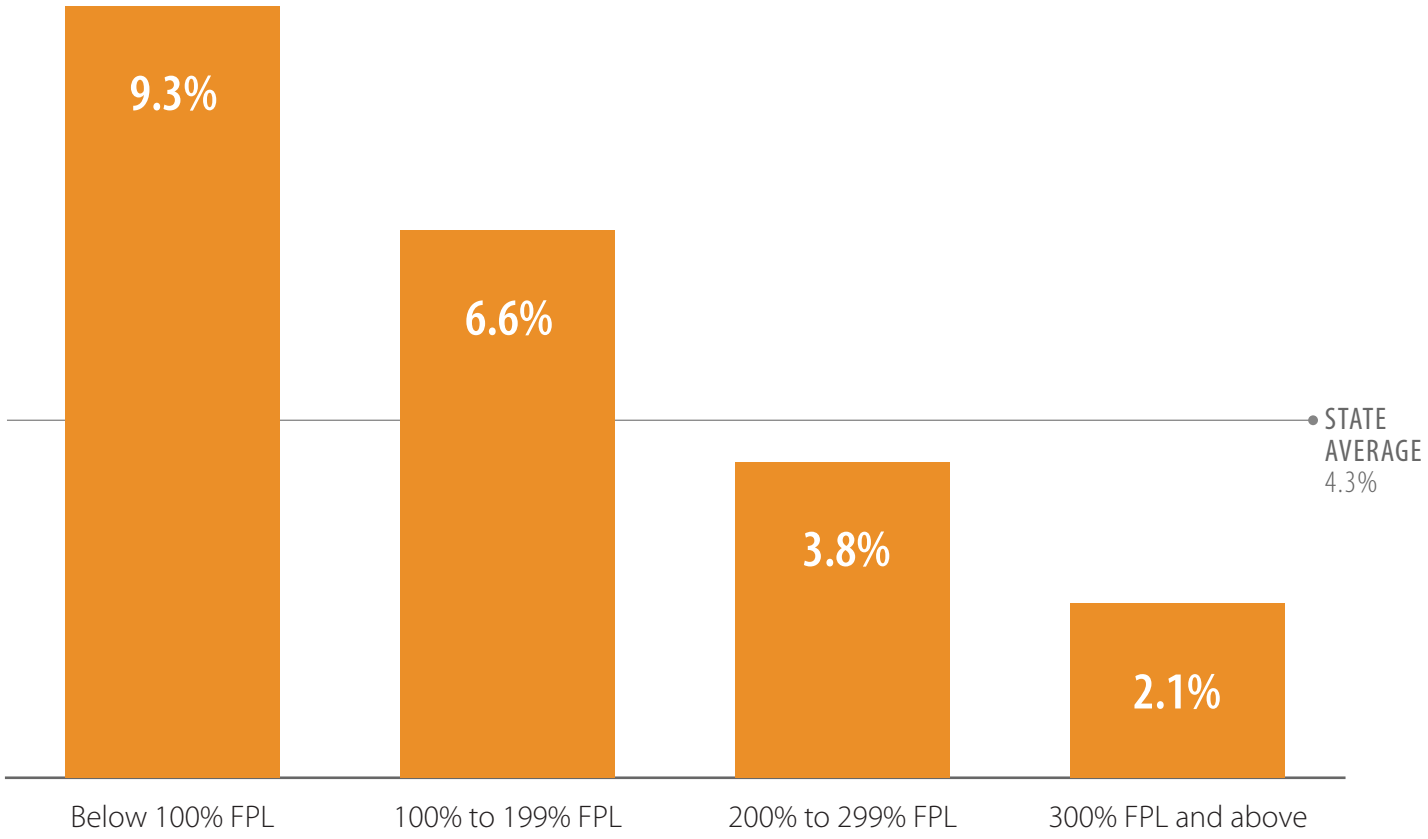
Rates of serious mental illness in California adults varied considerably among racial and ethnic groups. Native American, multiracial, and African American populations experienced the highest rates, and Asians and Pacific Islanders had the lowest.

Notes: Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

Adults with SMI, by Income
California, 2009

PERCENTAGE OF ADULT POPULATION



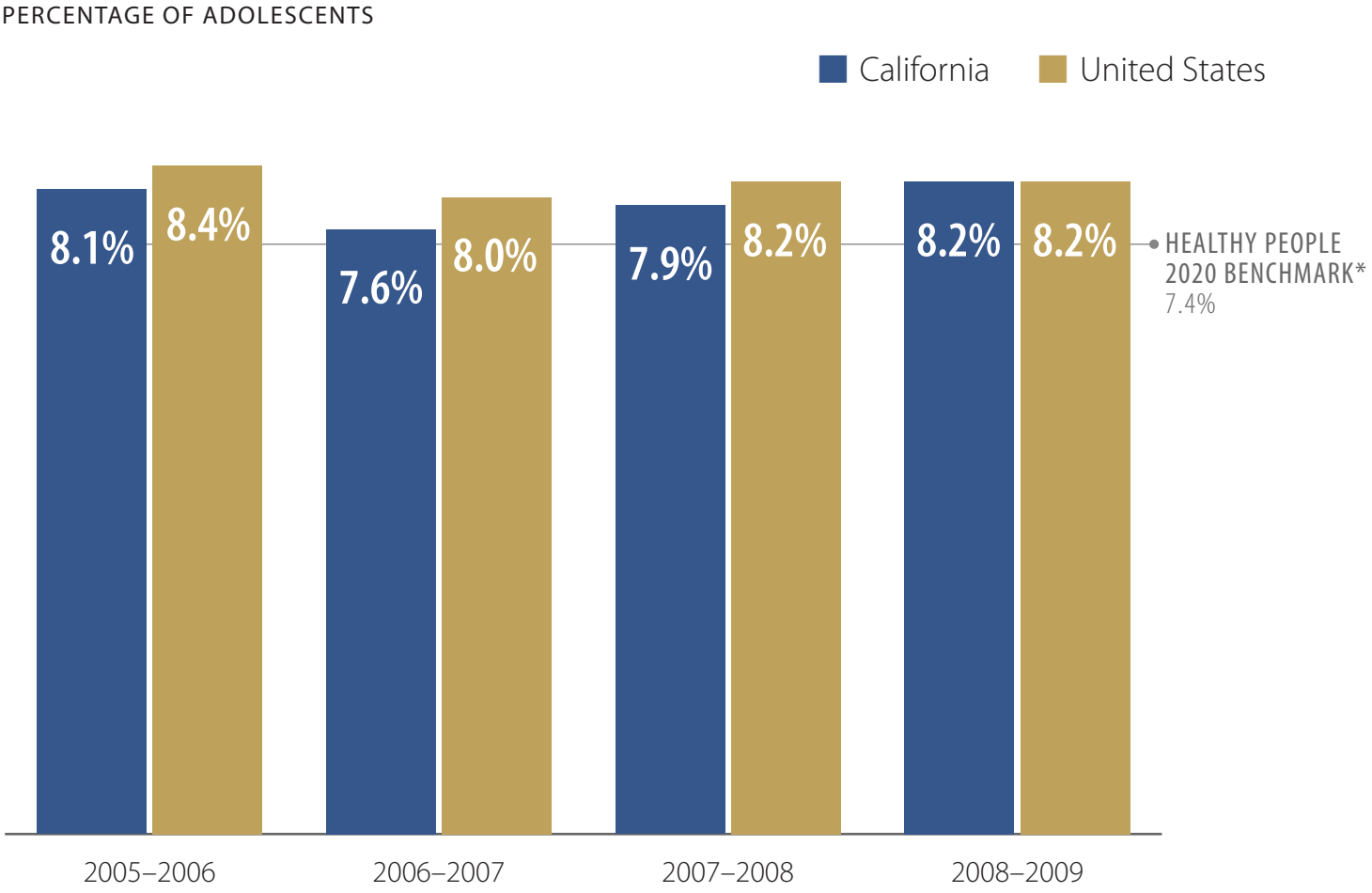
The rate of serious mental illness was highest among the poorest Californians.

Notes: Serious mental illness (SMI) is a categorization for adults age 18 and older. See page 4 for full definitions of mental illness categorizations. FPL is federal poverty level; 100% of FPL was defined in 2009 as an annual income of $10,830 for an individual and $22,050 for a family of four.

Source: HSRI, TAC, and Charles Holzer, *California Mental Health Prevalence Estimates* (Sacramento, CA: Department of Health Care Services), accessed January 31, 2013, www.dhcs.ca.gov.

Adolescents who Reported Having an MDE in the Past Year

California vs. United States, 2005 to 2009



*Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts released by the US Department of Health and Human Services.

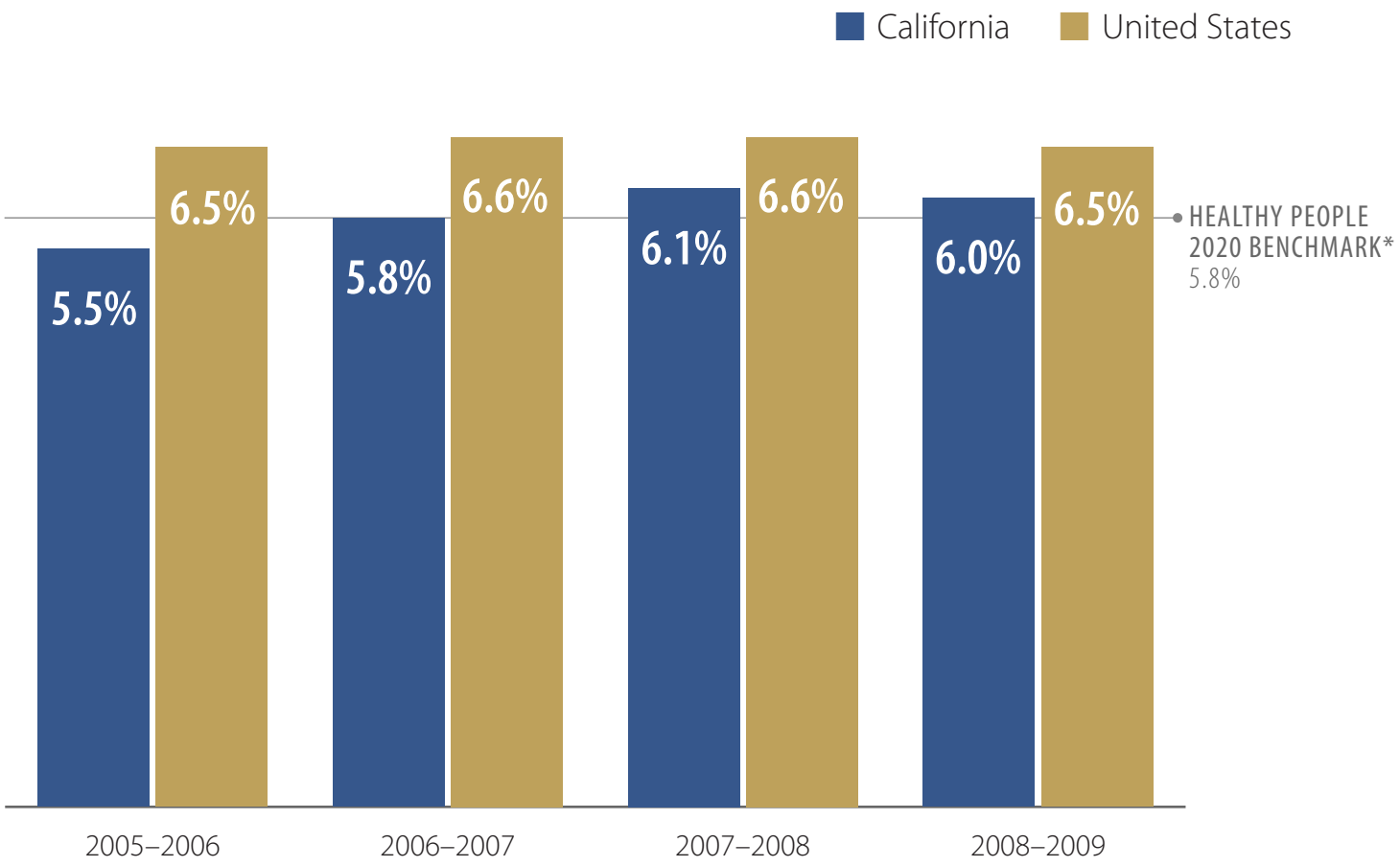
Notes: Adolescents are age 12 to 17. The National Survey on Drug Use and Health is a nationally representative survey of the civilian, noninstitutionalized population of the United States age 12 and older. The survey interviews approximately 67,500 people each year. Data from more than one year were combined to ensure statistically precise estimates. MDE is major depressive episode. See page 4 for full definitions of mental illness categorizations.

Source: *Mental Health, United States, 2010, HHS Publication No. (SMA) 12-4681* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012).

Depression is one of the most prevalent mental health disorders among adolescents. Between 2005 and 2009, approximately 8% of teens in California and the US reported that they had experienced an episode of major depression in the previous year.

Adults who Reported Having an MDE in the Past Year

California vs. United States, 2005 to 2009



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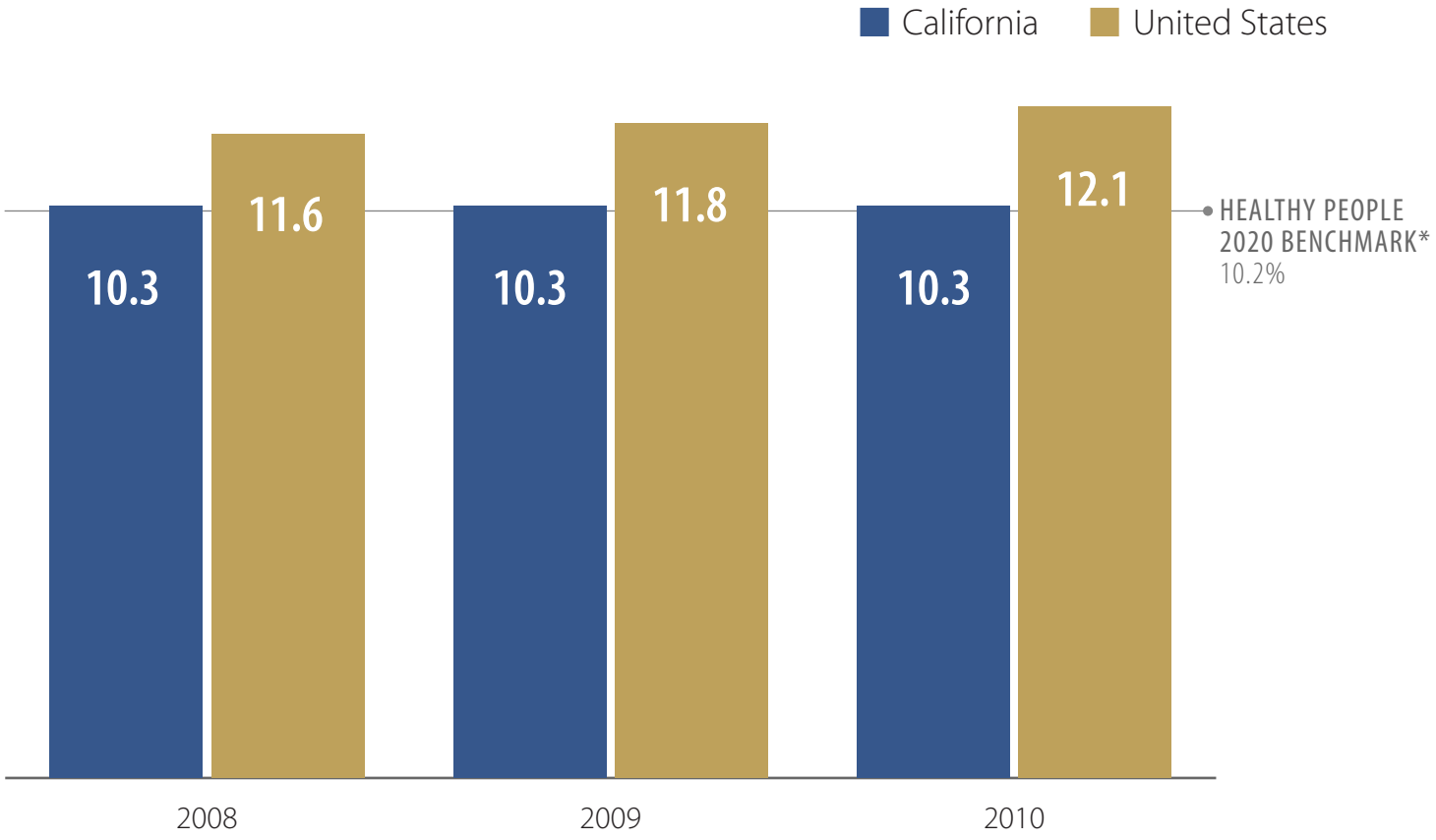
Source: *Mental Health, United States, 2010, HHS Publication No. (SMA) 12-4681* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012).

Rates of major depressive episodes among California adults remained relatively stable between 2005 and 2009. National rates of major depressive episodes were slightly higher and remained constant throughout the same period.

Suicide Rate

Adults and Children, California vs. United States, 2008 to 2010

PER 100,000 POPULATION, AGE ADJUSTED



*Healthy People is a set of goals and objectives with 10-year targets designed to guide national health promotion and disease prevention efforts released by the US Department of Health and Human Services.

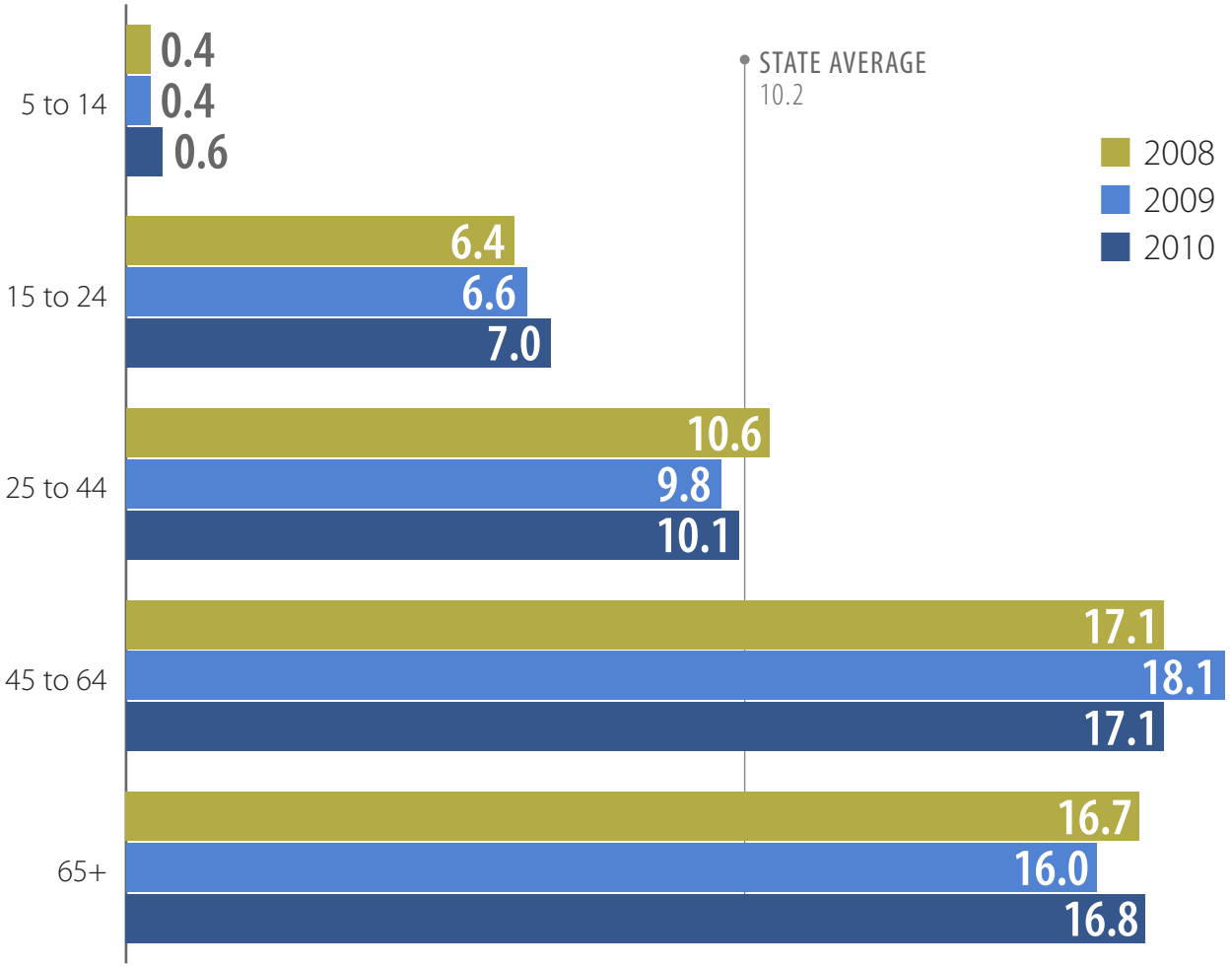
Notes: Suicide is death from a self-inflicted injury. California data come from registered death certificates. National data are collected from death certificates filed in state registration offices. Statistical information is compiled in a national database through the Vital Statistics Cooperative Program of the Centers for Disease Control and Prevention's National Center for Health Statistics.

Sources: Arialdi M. Miniño et al., "Deaths: Final Data for 2008," *National Vital Statistics Reports 59,* no. 10 (Hyattsville, MD: National Center for Health Statistics, 2011), www.cdc.gov/nchs; Kenneth D. Kochanek et al., "Deaths: Final Data for 2009," *National Vital Statistics Reports 60,* no, 3 (Hyattsville, MD: National Center for Health Statistics, 2011), www.cdc.gov/nchs; Sherry L. Murphy et al., "Deaths: Final Data for 2010," *National Vital Statistics Reports 61,* no. 4 (Hyattsville, MD: National Center for Health Statistics, 2013), www.cdc.gov/nchs. Estimates for 2008 and 2009 as of July 1, estimates for 2010 as of April 1.

California's suicide rate remained stable from 2008 to 2010 and consistently lower than the national rate.

Suicide Rate, by Age Group
California, 2008 to 2010

PER 100,000 POPULATION



In California, the suicide rates for those age 45 and over were significantly higher than the rates for younger age groups.

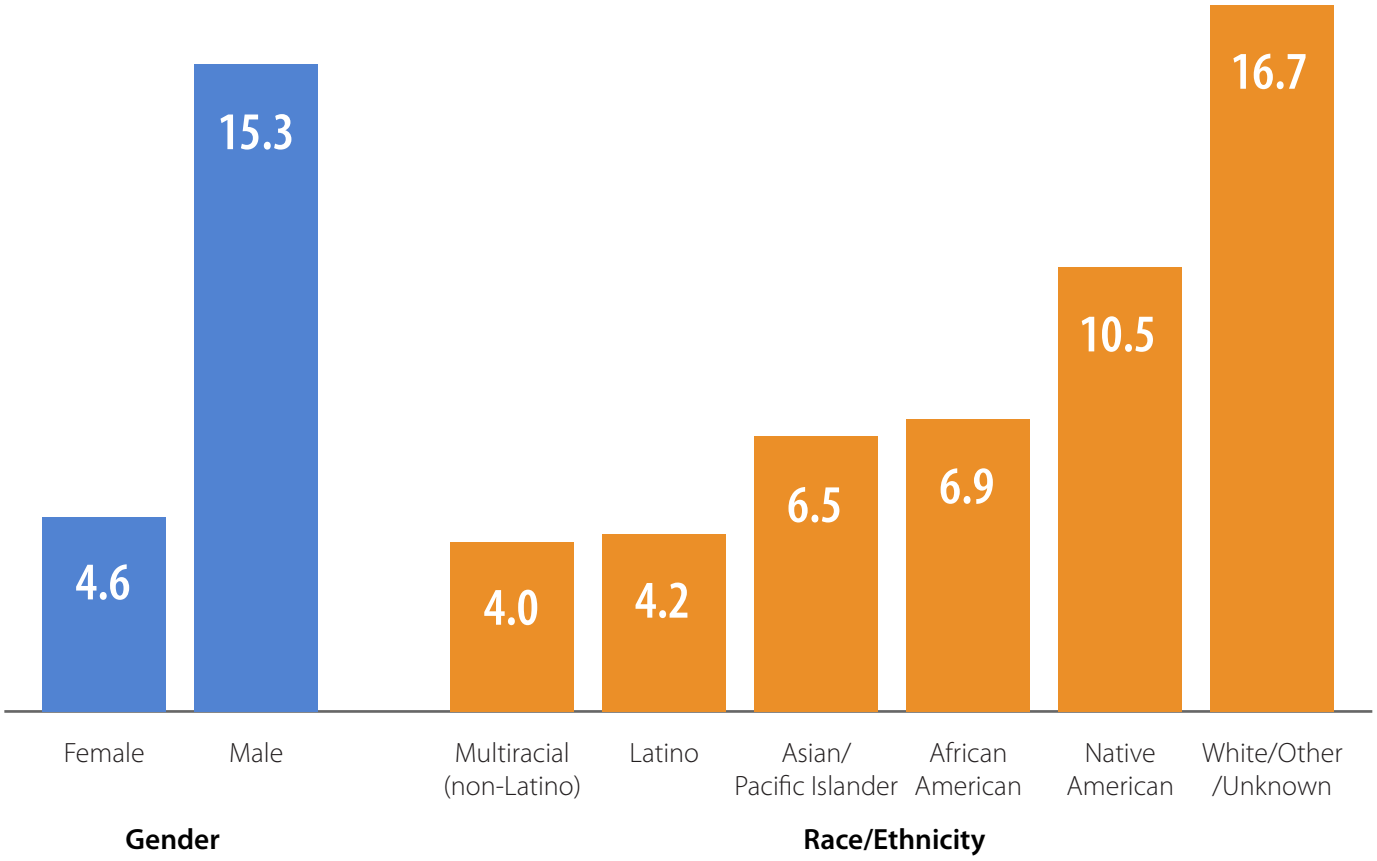
Note: Suicide is death from a self-inflicted injury.

Sources: "California Injury Data Online," California Department of Public Health, epicenter.cdph.ca.gov. "American Community Survey, County Estimates, 2008, 2009, and 2010," US Census Bureau. Census Bureau estimates for 2008 and 2009 as of July 1, estimates for 2010 as of April 1.

Suicide Rate, by Gender and Race/Ethnicity

Adults and Children, California, 2008 to 2010

PER 100,000 POPULATION, THREE-YEAR AVERAGE



Notes: Suicide is death from a self-inflicted injury. Data are from registered California death certificates.

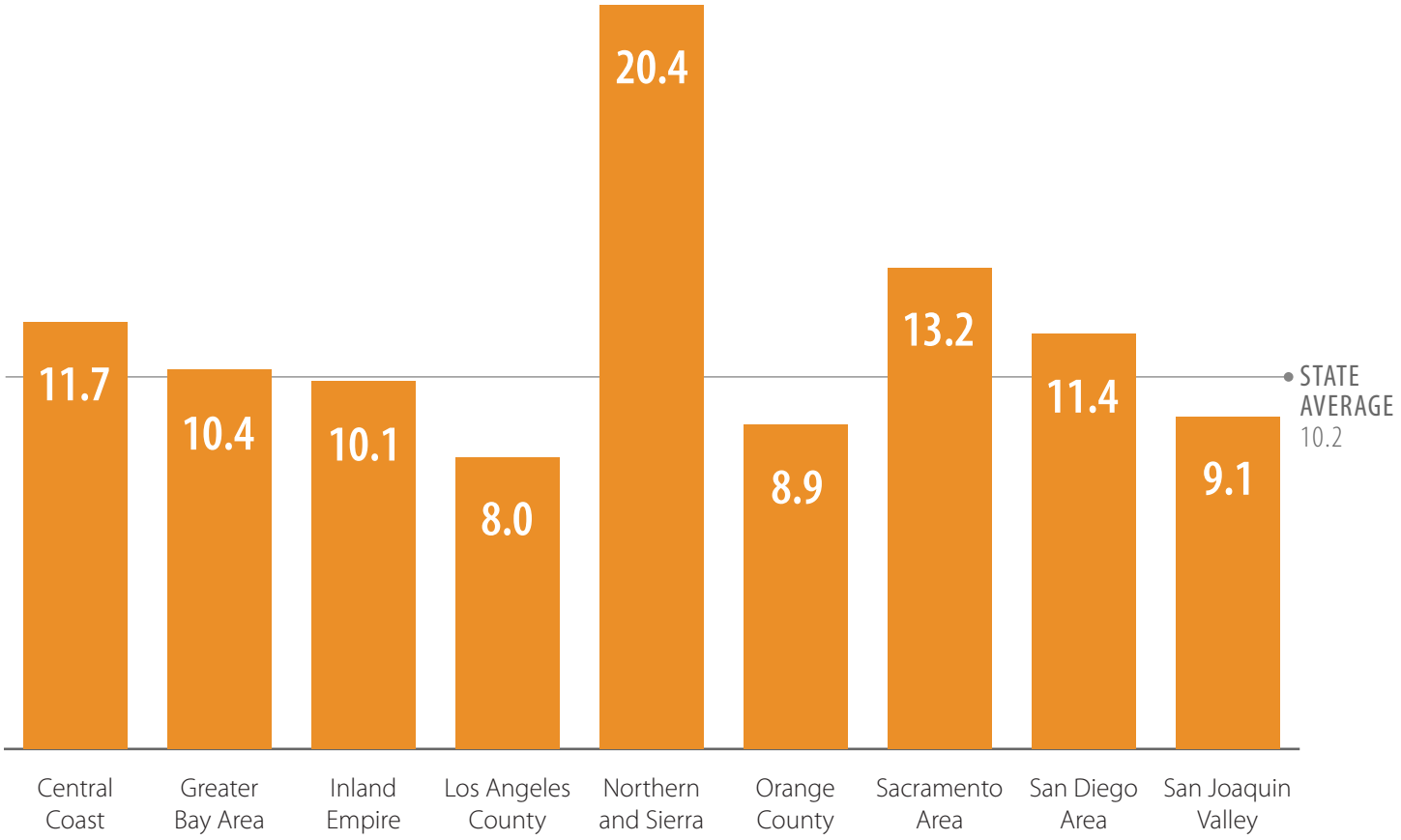
Sources: "Vital Statistics Query System," California Department of Public Health, Center for Health Statistics. "Race/Ethnic Population with Age and Sex Detail, 2000–2050," California Department of Finance.

Suicide rates in California differed dramatically by gender and race. The rate of suicide for men was three times as high as the rate for women. Among all of the race and ethnic groups, Whites had the highest suicide rate.

Suicide Rate, by Region

Adults and Children, California, 2008 to 2010

PER 100,000 POPULATION, THREE-YEAR AVERAGE



Notes: Suicide is death from a self-inflicted injury. Data are from registered California death certificates. See Appendix A for a map of counties included in each region.

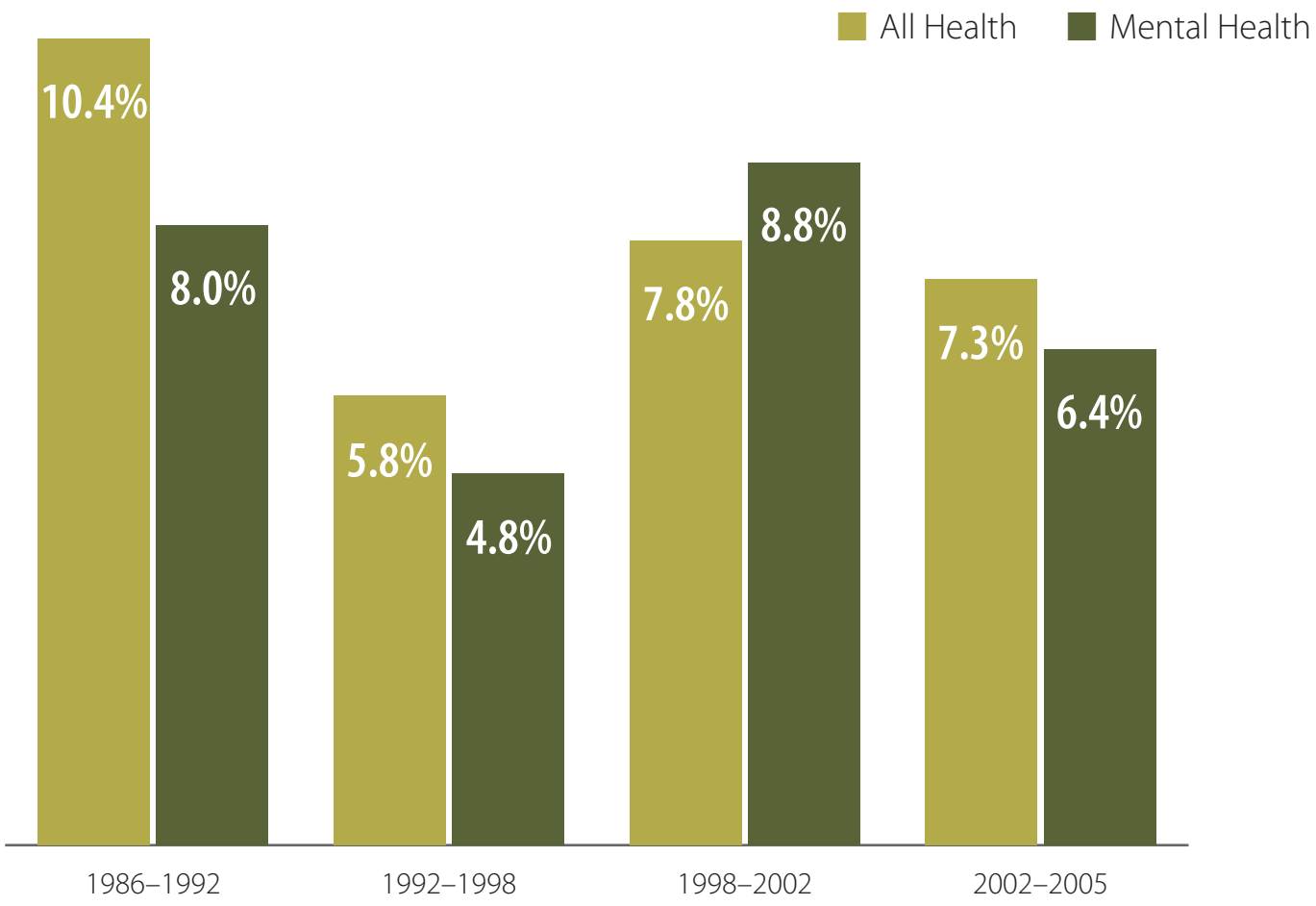
Sources: "California Injury Data Online," California Department of Health, epicenter.cdph.ca.gov. "American Community Survey, County Estimates, 2008, 2009, and 2010," US Census Bureau.

Northern and Sierra counties stand out among California regions, with suicide rates that were twice the state average. The Sacramento area also had a high rate of suicide, while Los Angeles County's rate was well below the state average of 10.2.

Total Estimated Expenditures for Health and Mental Health

United States, 1986 to 2005

ANNUAL PERCENTAGE INCREASE

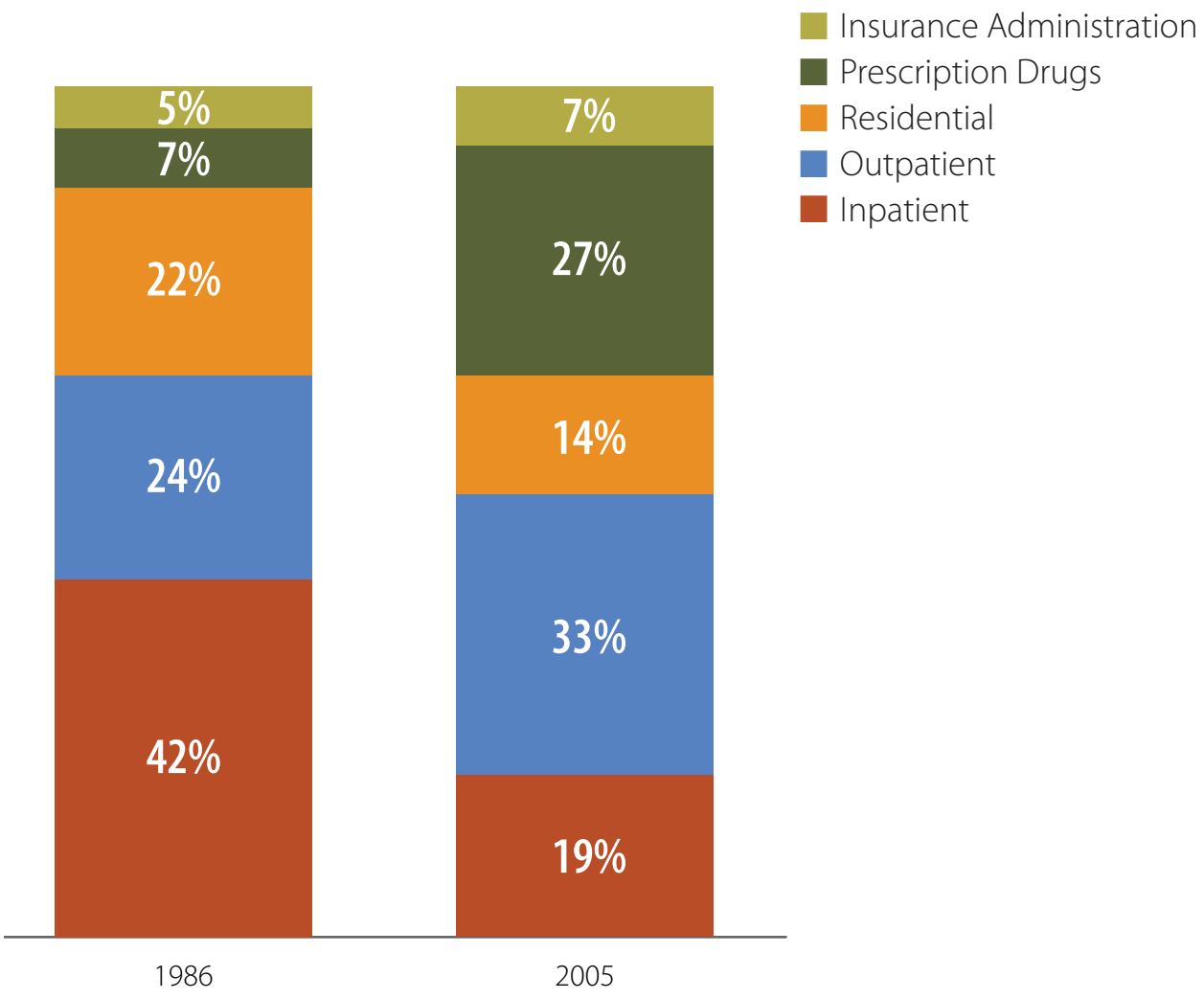


Source: *National Expenditures for Mental Health Services and Substance Abuse Treatment: 1986–2005* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011).

Nationally, estimated expenditures for mental health have not increased as fast as those for general health care, except from 1998 to 2002.

Mental Health Expenditures, by Service Category

United States, 1986 and 2005

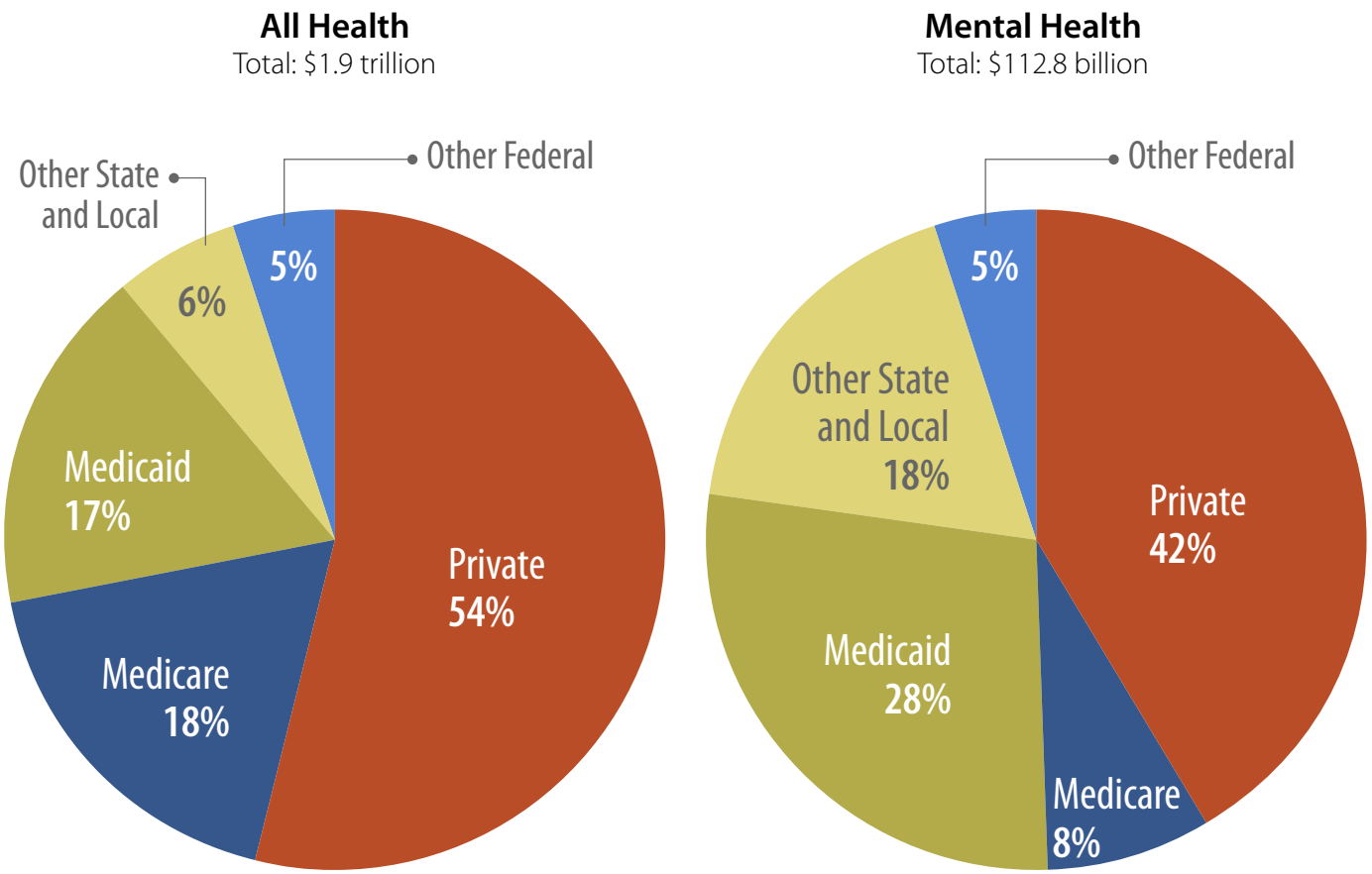


The delivery of mental health services has evolved over the past 20 years, resulting in significant changes in expenditures for mental health treatment. Between 1986 and 2005, expenditures for inpatient and residential treatment declined as expenditures for prescription drugs and outpatient care increased as a percentage of total expenditures.

Source: *National Expenditures for Mental Health Services and Substance Abuse Treatment: 1986–2005* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011).

Expenditures for Health and Mental Health Services, by Payer
United States, 2005

PERCENTAGE OF TOTAL SPENDING



Notes: Private includes private health insurance, out-of-pocket payments, and spending from philanthropic and other nonpatient revenue sources. May not total 100% due to rounding. Mental health expenditures are estimates.

Source: *National Expenditures for Mental Health Services and Substance Abuse Treatment: 1986–2005* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011).

In 2005, total US mental health expenditures were estimated at $112.8 billion, or 6% of total health care expenditures. Private payers and Medicare paid for close to three-quarters of all health care expenditures, but only half of mental health expenditures. Medicaid, state, and local sources made up the difference.

California's Public Mental Health Delivery System

	MEDICAID HEALTH PLANS AND MEDICAID FEE-FOR-SERVICE	LOCAL SPECIALTY MENTAL HEALTH PLANS	COUNTY-BASED MENTAL HEALTH SAFETY-NET PROVIDERS
Payer	Medi-Cal (federal and state)	Medi-Cal (federal and state/local)	County, Mental Health Services Act, realignment funds,* and other funding sources
People Served	Medicaid eligibles with mild and moderate mental health conditions	Medicaid eligibles with SED or SMI	Uninsured with SED or SMI
Services Provided	Outpatient mental health services, crisis intervention, psychiatry, inpatient mental health care	Same as Medicaid, plus specialized rehabilitative and supportive care	Outpatient mental health services, crisis intervention, psychiatry, short- and long-term inpatient mental health, as well as rehabilitative and supportive services and other services as resources allow

California's public mental health system provides services to many low-income individuals with mental illness. Various county entities provide specialized services to Medi-Cal enrollees and uninsured individuals with SMI or SED.

*Realignment is the transfer of administrative and financial control from the state to counties. California underwent two major mental health system realignments: in 1991 and in 2011.

Notes: Serious emotional disturbance (SED) is a categorization for children age 17 and under. Serious mental illness (SMI) is a categorization for adults age 18 and older.
See page 4 for full definitions of mental illness categorizations.

Source: California Welfare and Institutions Code § 5600–5623.5.

Timeline of Mental Health Policy in California, 20th Century

1957 State legislature enacts the Short-Doyle Act, which provides financial assistance for local governments to establish locally administered community mental health programs.

1966 Medi-Cal is created.

1968 The Lanterman-Petris-Short Act (LPS) changes the law by requiring a judicial hearing procedure prior to involuntary hospitalization of an individual.

1971 Traditional Medi-Cal benefits expand to include Short-Doyle community mental health services.

1974 Legislature requires all counties to have mental health programs.

1984 Assembly Bill 3632 assigns county mental health departments the responsibility to provide special education students with mental health services guaranteed under the Individuals with Disabilities Education Act.

1985 The Bronzan-Mojonnier Act enacts provisions relating to the identification of the shortage of services resulting in the criminalization of people who are mentally disabled, and the provision of community support and vocational services for individuals who are homeless and mentally disabled and for seriously emotionally disturbed children.

1988 The Wright-McCorquodale-Bronzan Mental Health Act establishes demonstration projects to test the effectiveness of community-based, integrated service systems of care for adults with serious mental illness.

1991 The Bronzan-Wright-McCorquodale Realignment Act of 1991 shifts authority from state to counties for mental health and other health programs.

1993 California adopts the Medicaid Rehabilitation Option to expand community mental health services.

1995 California institutes Medicaid Early and Periodic Screening, Diagnosis, and Treatment by providing increased state matching funds to counties.

Medi-Cal Mental Health Managed Care program is implemented. Inpatient and various specialty services became the responsibility of the Mental Health Plan in each county.

1998 Medi-Cal fee-for-service and Short-Doyle programs merge into one mental health managed care program administered by counties.

1999 Assembly Bill 34 authorizes grants totaling $9.5 million for pilot programs in Los Angeles, Sacramento, and Stanislaus Counties to provide services for severely mentally ill adults who are homeless, recently released from jail or prison, or at risk of being homeless or incarcerated in the absence of services. The program is expanded to all counties the next year.

Sources: Michael Doss, "Mental Health Laws over the Years," *The Orange County Register,* December 9, 2011 (updated: March 27, 2013). Sara Watson and Alison Klurfeld, "California's Mental Health System: Aligning California's Physical And Mental Health Services To Strengthen The State's Capacity For Federal Coverage Expansion," Insure the Uninsured Project, August 2011.

California's mental health system, and its public mental health system in particular, has undergone significant changes in financing and organization over the past 50 years.

Timeline of Mental Health Policy in California, 21st Century

2000 Assembly Bill 88 (mental health parity law) requires health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age and for the serious emotional disturbances of a child under the same terms and conditions applied to all other covered medical conditions.

2001 Assembly Bill 1424 modifies the Lanterman-Petris-Short Act of 1968, mandating mental health departments, law enforcement agencies, and court systems to consider a patient's psychiatric history.

2003 Assemby Bill 1421, "Laura's Law," permits court-ordered, assisted outpatient treatment for severely mentally ill people.

2004 Voters approve the Mental Health Services Act (Proposition 63), providing significant funding for mental health services based on a 1% tax on annual incomes of more than $1 million.

2008 The US Mental Health Parity and Addiction Equity Act of 2008 requires group health insurance plans to offer coverage for mental illness and substance use disorders in no more a restrictive way than all other medical and surgical procedures covered by the plan.

2010 The Patient Protection and Affordable Care Act includes measures to expand affordable forms of health insurance coverage and identifies mental health and substance abuse as one of 10 essential areas of coverage.

2011 Realignment 2011 gives counties more money and more responsibility for a range of mental health, substance abuse, and criminal justice services.

Assembly Bill 114 transfers responsibility and funding for educationally related mental health services from county mental health departments to county education departments.

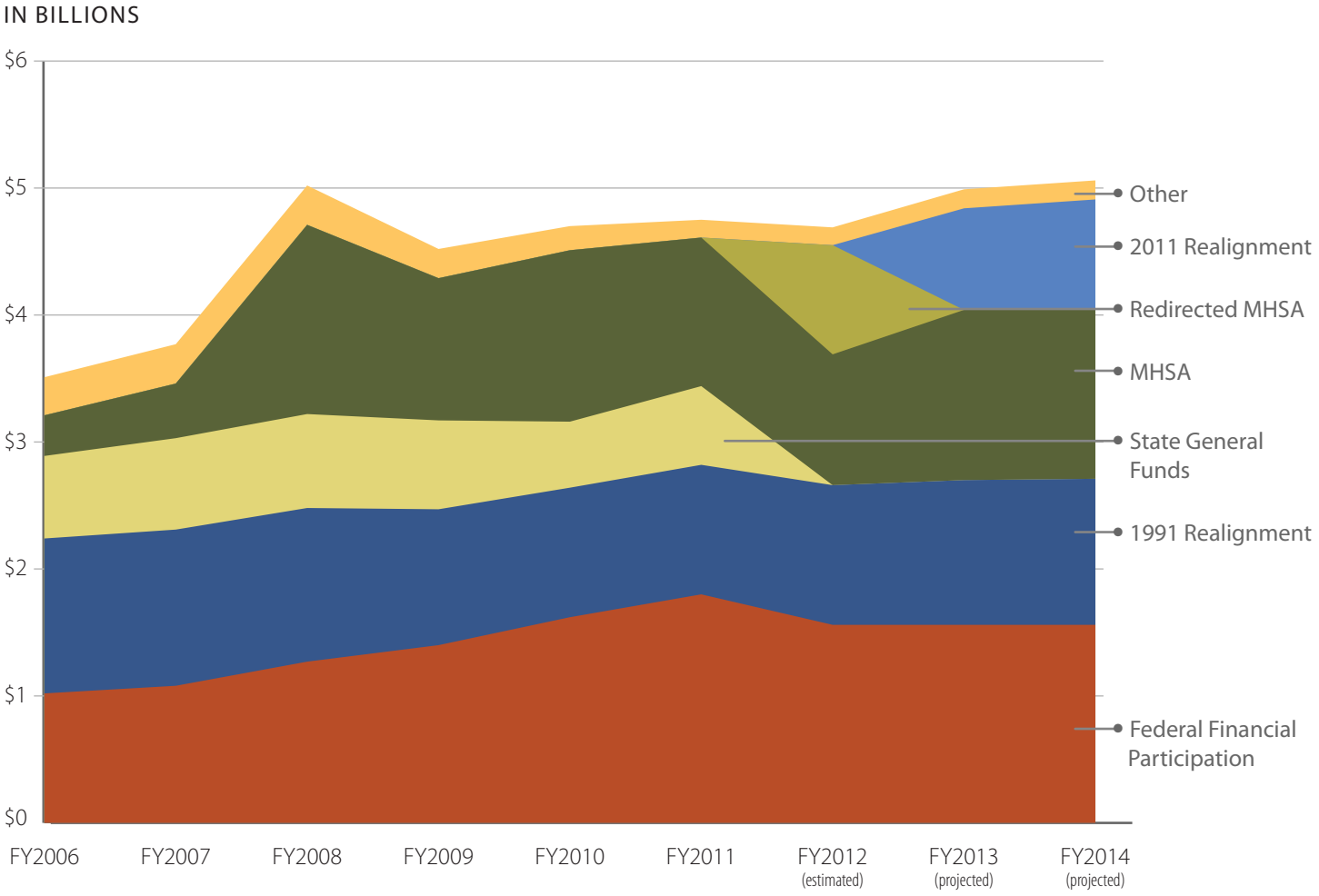
2012 Legislature eliminates the Department of Mental Health, creates the Department of State Hospitals, and transitions responsibility for managing all community mental health services functions to the Department of Health Care Services.

Since 2000, California and national parity laws have taken effect, Affordable Care Act provisions have started to be implemented, and a state reorganization eliminated the Department of Mental Health.

Sources: Michael Doss, "Mental Health Laws over the Years," *The Orange County Register,* December 9, 2011 (updated: March 27, 2013). Sara Watson and Alison Klurfeld, "California's Mental Health System: Aligning California's Physical And Mental Health Services To Strengthen The State's Capacity For Federal Coverage Expansion," Insure the Uninsured Project, August 2011.

California's Public Mental Health System

Financing Trends, FY2006 to FY2014



Notes: These figures encompass revenues received or projected to be received by counties in support of the Medicaid and safety-net mental health services they provide. Other public mental health services, such as forensic services in state hospitals and mental health services and medications provided by Medicaid health plans and Medi-Cal fee-for-service, are not included. See Appendix E for a detailed description of each funding source.

Sources: *Financial Report* (Sacramento, CA: Mental Health Services Oversight and Accountability Commmission, January 24, 2013), accesssed April 17, 2013, www.mhsoac.ca.gov. Actual, estimated, and projected amounts from these sources: FY2013 Governor's Budget, DOF, DMH (DHCS after June 30, 2012) MHSA Summary Comparison (posted July 21, 2011), MHSOAC Fiscal Consultant Projections, and California Department of Health Care Services.

From 2006 to 2011, spending on California's public mental health system increased 36%. During that time, federal contributions increased significantly. The sources of funding for public mental health services are expected to continue to shift, with the implementation of federal health reform and the subsequent expansion of Medi-Cal, and the increasing role of Mental Health Services Act (MHSA) funds raised by a tax on incomes over $1 million.

Medi-Cal Expansion Population

Adults with Mental Health Needs, 2014

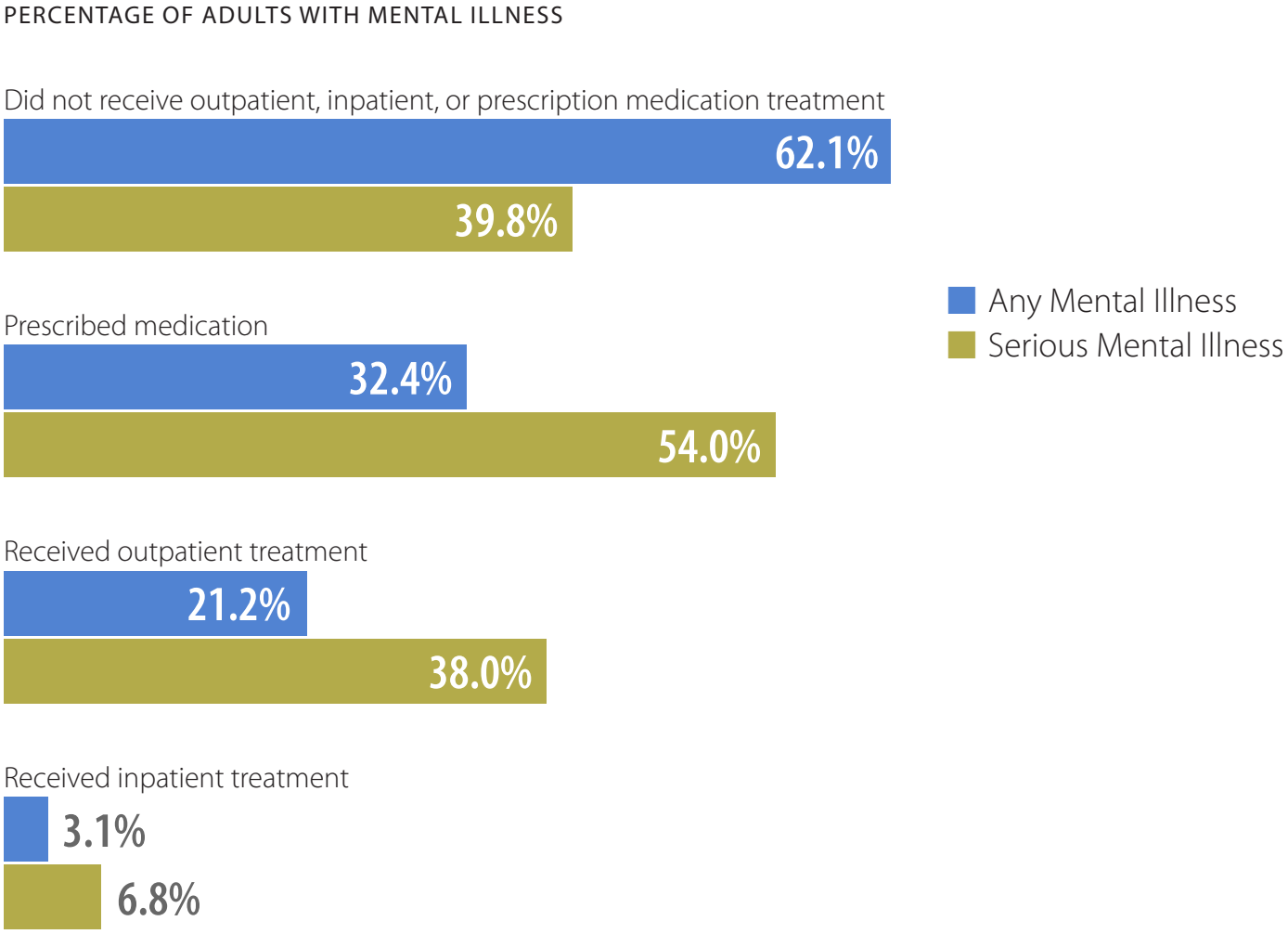
	PREVALENCE RATES	LOW RANGE ESTIMATES	HIGH RANGE ESTIMATES
Estimated Mental Health Need			
Upper limit	15.9%	237,750	317,000
Lower limit	8.3%	124,500	166,000
Total Medi-Cal Expansion Population		**1.5 million**	**2.0 million**

Notes: The upper limit of mental health need is based on the estimated prevalence rate of mental illness among adults with incomes less than 200% of the federal poverty level. The lower limit is based on the California Health Interview Survey estimate of mental health need, which includes adults who have symptoms of mental illness and experience discomfort or disruption from these symptoms. The lower limit estimates are believed to be more representative of the actual experience in Medi-Cal. The number of adults is estimated by applying the prevelance rates to the estimated Medi-Cal expansion population.

Source: *California Mental Health and Substance Use System Needs Assessment* (Boston, MA: Technical Assistance Collaborative and Cambridge, MA: Human Services Research Institute, February 2012).

Implementation of the Affordable Care Act will expand eligibility for Medi-Cal by an estimated 1.5 to 2 million individuals beginning in 2014. It is estimated that more than 124,000 adults in this expansion population will need mental health services.

Adults Receiving Mental Health Treatment
by Mental Illness Status, United States, 2009



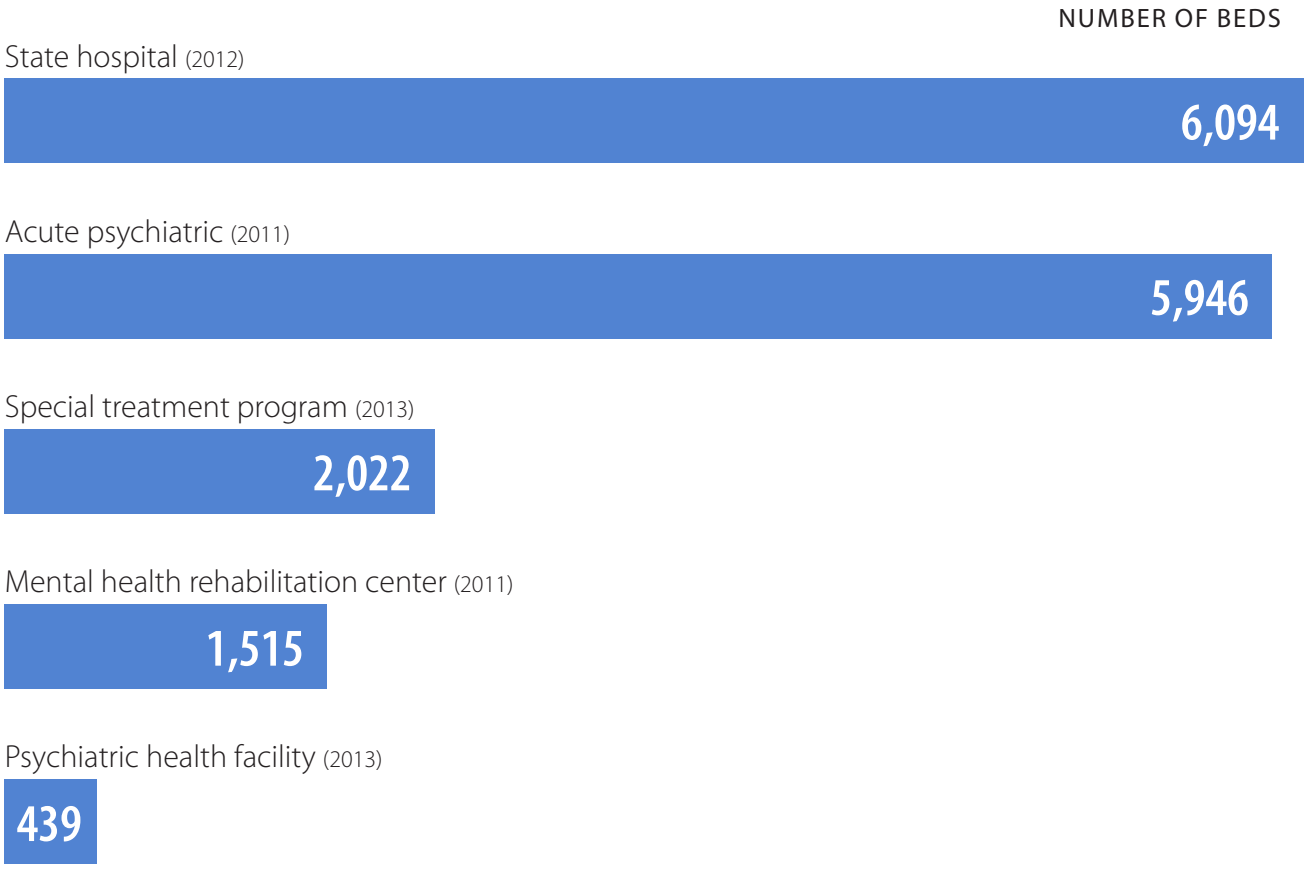
Notes: Those with a serious mental illness are a subset of adults with any mental illness. See page 4 for full definitions of mental illness categorizations. Data exclude respondents with unknown treatment information. Respondents could be counted as participating in more than one form of treatment. Respondents were asked about treatment of their mental illness in the year prior to the survey.

Source: *National Survey on Drug Use and Health* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2009).

Many people with mental illnesses do not receive treatment. More than 60% of adults with any mental illness and 40% of those with a serious mental illness did not receive outpatient care, inpatient care, or medication treatment to address their condition. Prescription medication was the most common treatment received by both groups.

Psychiatric Inpatient Beds, by Type

California, Varying Years (2011, 2012, or 2013)

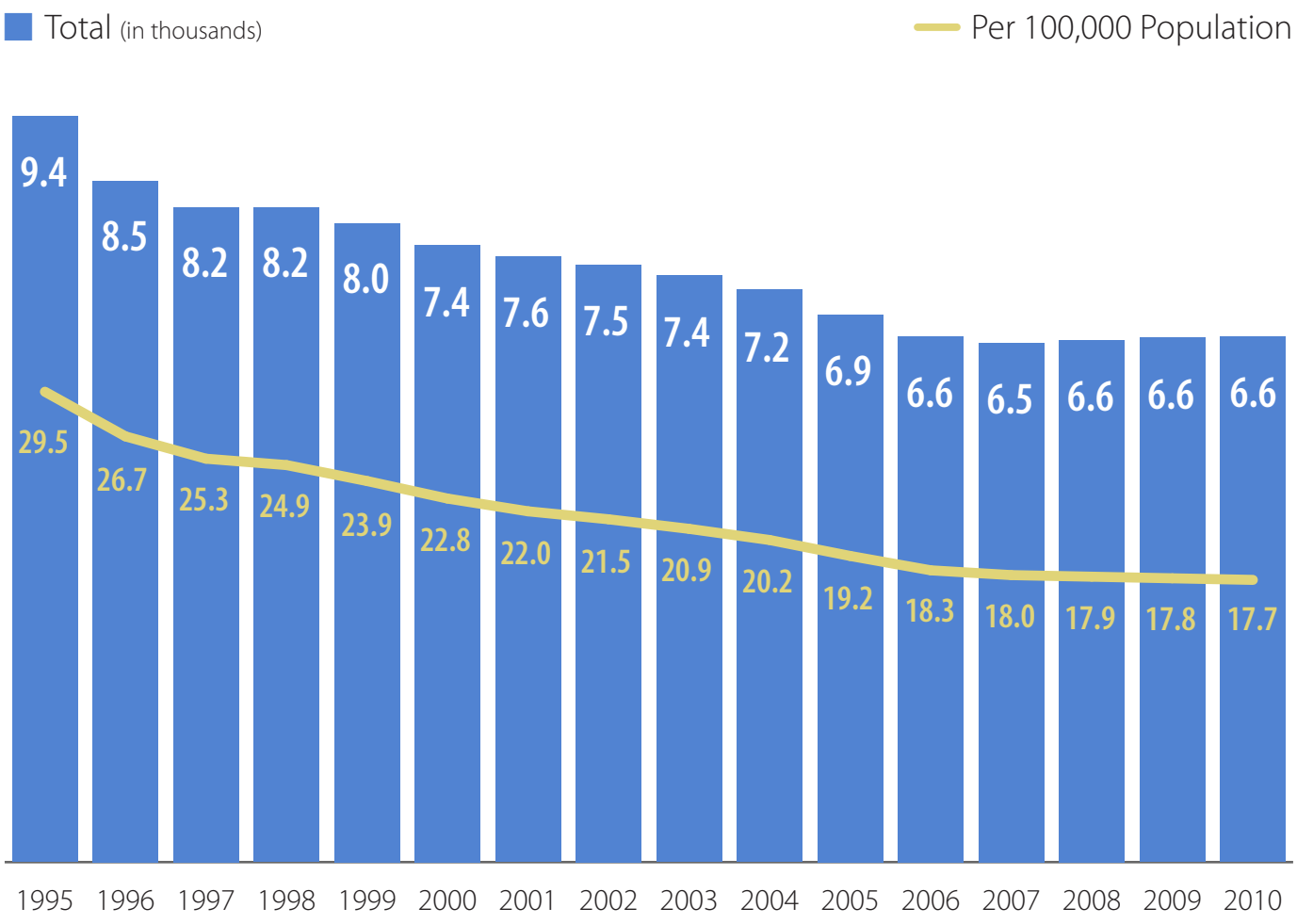


Notes: Acute psychiatric beds are those in general hospital psychiatric units or in facilities licensed as acute psychiatric facilities. Psychiatric health facilities also provide acute inpatient care. Mental health rehabilitation centers are licensed by the Department of Mental Health (DMH) and provide intermediate and long term care. Special treatment programs are beds in skilled nursing facilities (SNFs) that are certified by the DMH to provide intermediate and long term inpatient care. State hospitals provide intermediate and long term care, primarily for forensically involved patients.

Sources: "Hospital Annual Financial Data Profile, 2011," Office of Statewide Health Planning and Development (OSHPD), accessed February 13, 2013, www.oshpd.ca.gov. Automated Licensing Information and Report Tracking System (ALIRTS) for listing of open SNFs with Special Treatment Programs and Psychiatric Health Facilities, OSHPD, accessed January 22, 2013. "California Mental Health Rehabilitation Centers (MHRC)," Department of Mental Health, accessed January 22, 2013, www.dmh.ca.gov, with bed numbers from Facilities and Programs Defined as Institutions for Mental Disease (IMDs) 2011, accessed Feburay 13, 2013, www.dmh.ca.gov, supplemented by web search and phone calls. State hospital beds from Department of State Hospitals, special data request, received December 19, 2012.

California's three major types of psychiatric facilities provide inpatient care for mental health patients. State hospitals, accounting for nearly 38% of beds, primarily provided care for incarcerated patients with mental illness. Acute psychiatric beds accounted for 37% of the state's total psychiatric beds. Special treatment programs in skilled nursing facilities accounted for much of the remainder of beds.

Acute Psychiatric Inpatient Beds
California, 1995 to 2010



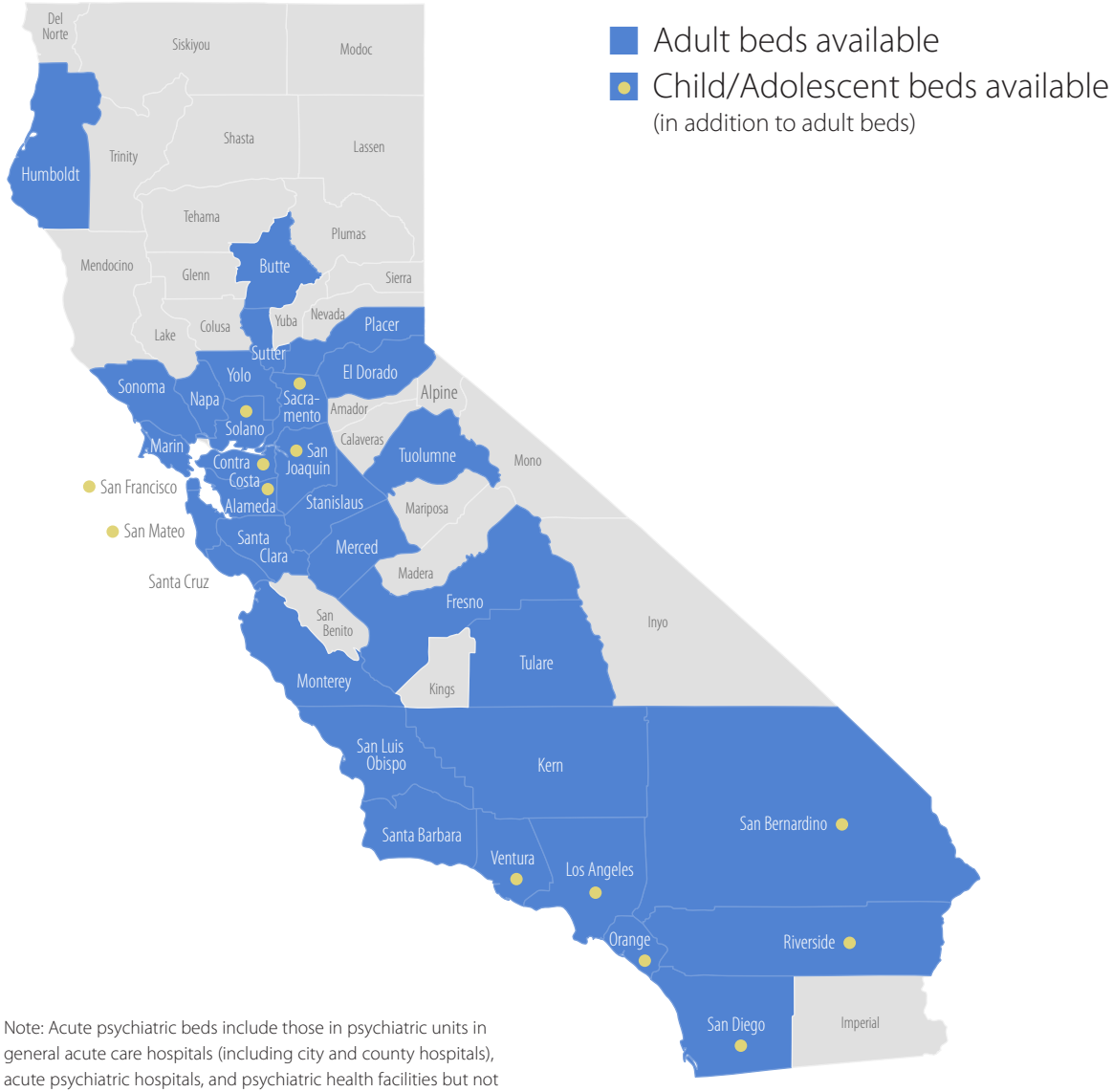
Notes: Psychiatric acute beds include those in psychiatric units in general acute care hospitals (including city and county hospitals), acute psychiatric hospitals, and psychiatric health facilities but not those in California state hospitals.

Source: California's Acute Psychiatric Bed Loss (Sacramento, CA: California Hospital Association), accessed January 31, 2013, www.calhospital.org.

The number of acute psychiatric beds per capita in California decreased by 40% in the 15 years from 1995 to 2010. During this time, the number of facilities with psychiatric beds decreased, either due to the elimination of psychiatric units or complete hospital closure. California would need an additional 1,029 beds to reach the national average of 20.5 beds per 100,000 population.

Acute Psychiatric Inpatient Beds, by County

Adults and Children/Adolescents, California, 2010



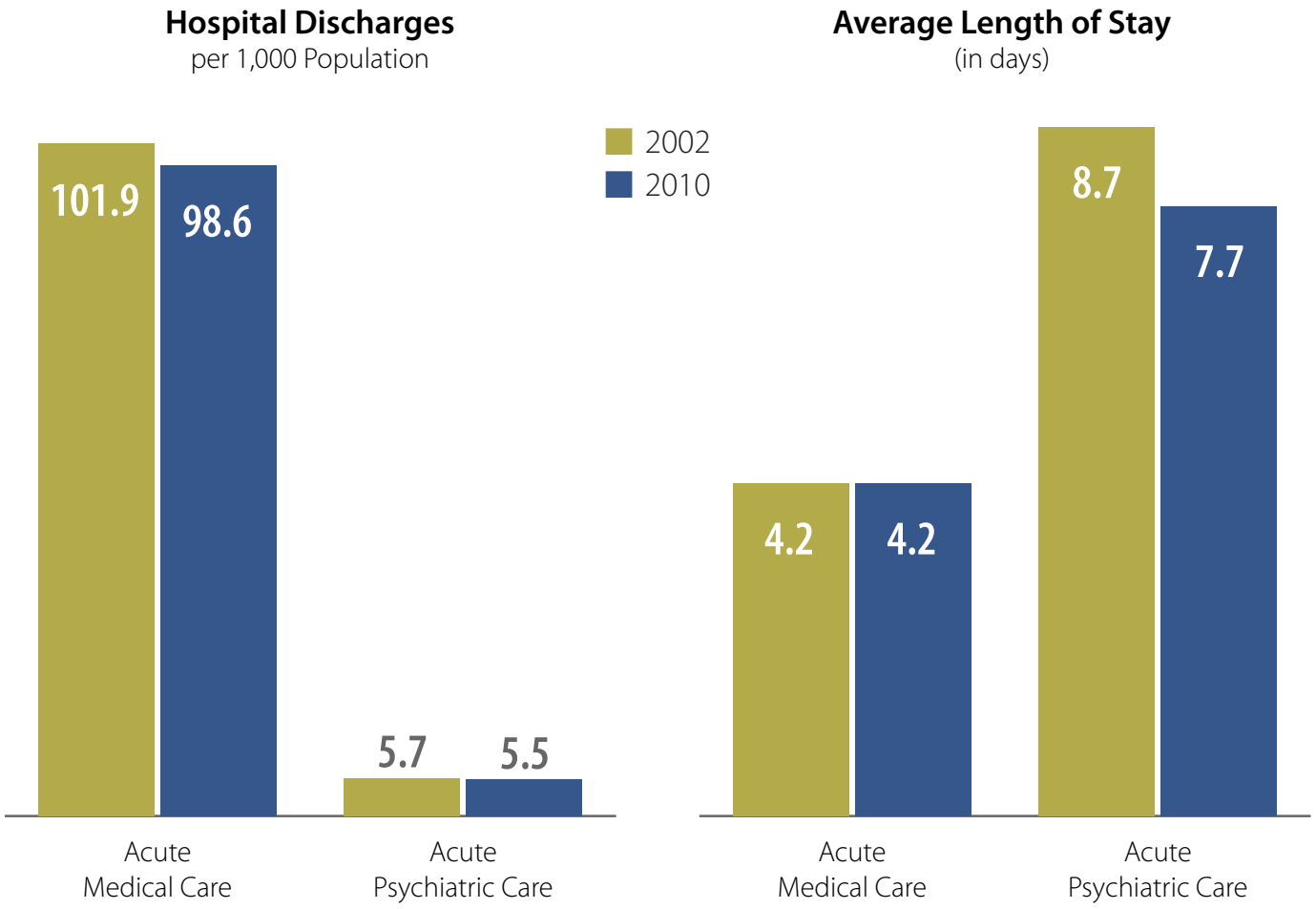
Note: Acute psychiatric beds include those in psychiatric units in general acute care hospitals (including city and county hospitals), acute psychiatric hospitals, and psychiatric health facilities but not those in California state hospitals.

Source: *California's Acute Psychiatric Bed Loss* (Sacramento, CA: California Hospital Association), accessed January 31, 2013, www.calhospital.org.

In California, there is significant geographic variation in the availibility of acute psychiatric beds. Twenty-five counties had no adult beds, and 45 counties had no beds for children. When inpatient facilities are far from where people live, it is difficult for family members to participate in treatment and for facilities to plan for post-discharge care. Rural counties are particularly affected by this lack of beds.

Hospital Discharges / Length of Stay

Acute Medical vs. Acute Psychiatric, California, 2002 and 2010

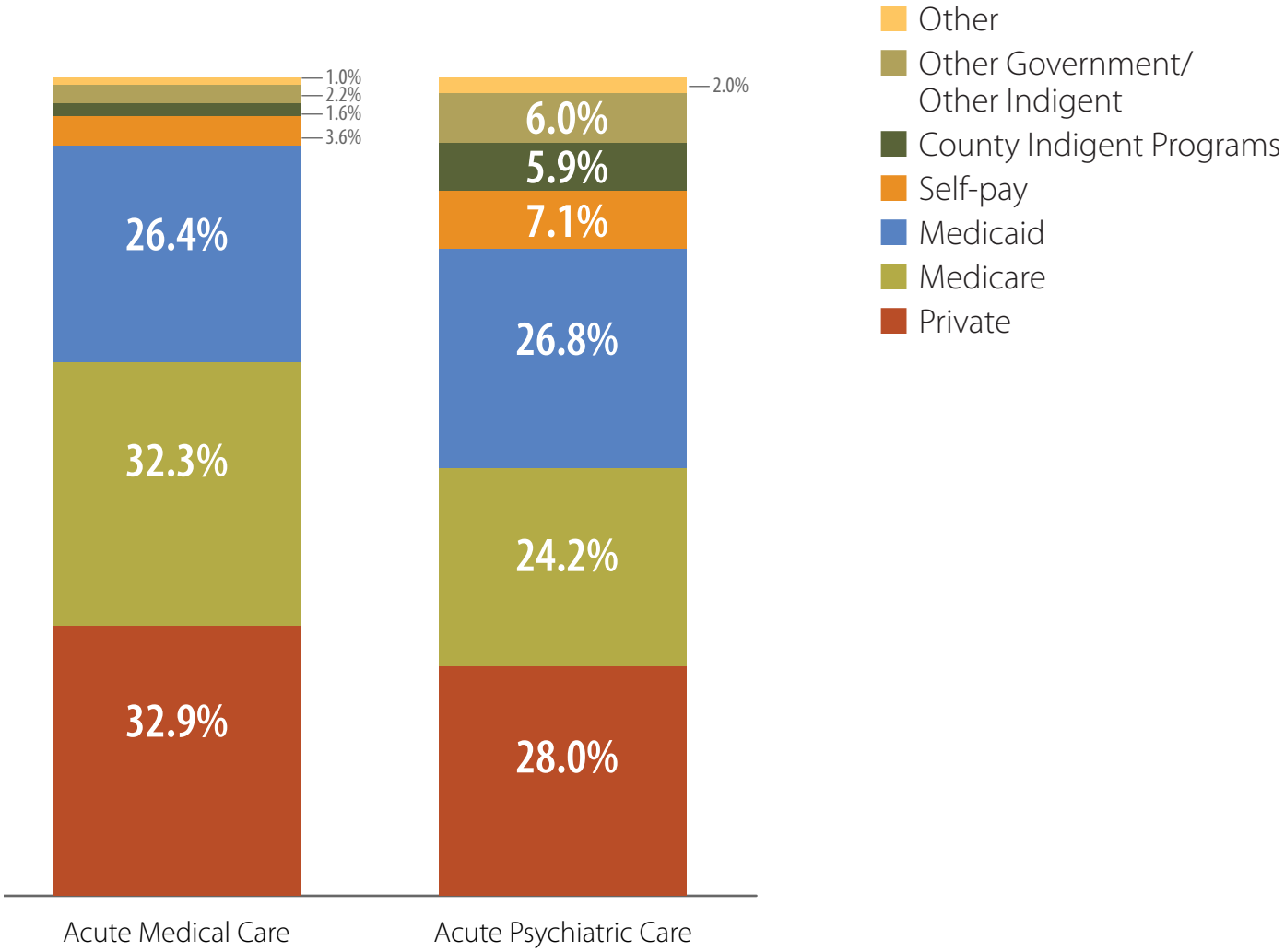


Notes: Includes discharges from general acute beds, acute psychiatric beds, and psychiatric health facilities. Discharges from chemical dependency recovery care, physical rehabilitation care, and skilled nursing/intermediate care are not shown. Psychiatric hospital facilities were designed as a cost-effective way to deliver acute psychiatric inpatient care. They do not have to meet the same facility regulations as hospitals, and they provide medical care through arrangements with other providers.

Sources: "Type of Care by County of Residence, 2002," Office of Statewide Health Planning and Development (OSHPD), www.oshpd.ca.gov. "Type of Care by County of Residence, 2010," OSHPD, accessed January 21, 2013, www.oshpd.ca.gov. "State Population Estimates: April 1, 2000 to July 1, 2002," US Census Bureau, www.census.gov. "Annual Population Estimates as of July 1, 2010," US Census Bureau.<NOTE TO AUTHOR: Please check links.>

The number of discharges from general acute care beds and from acute psychiatric beds dropped slightly between 2002 and 2010. The average length of stay in acute psychiatric care was almost twice as long as the average stay in general acute hospitals, and grew shorter.

Acute Medical vs. Acute Psychiatric Hospital Discharges
by Payer, California, 2010



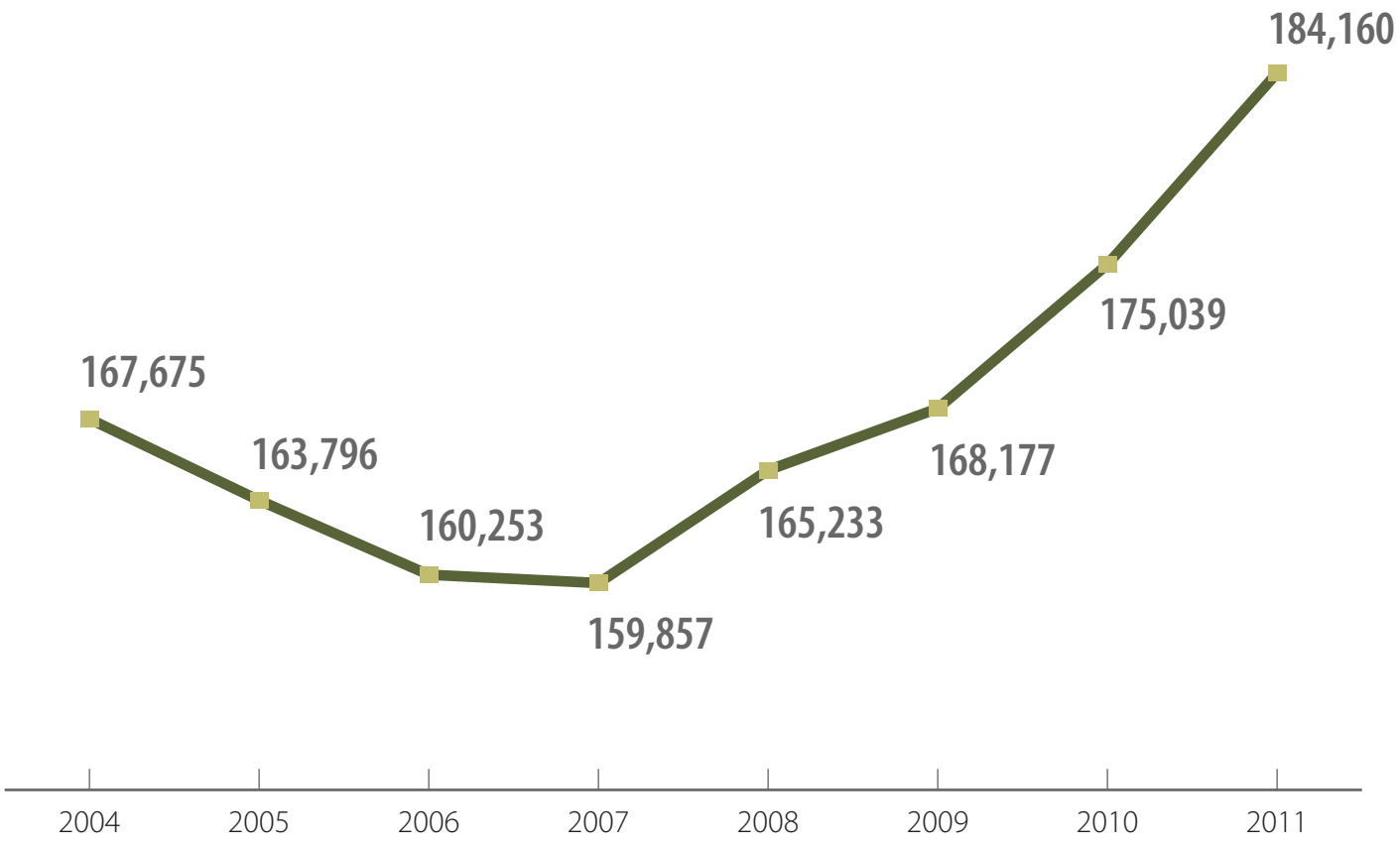
Notes: Includes discharges from general acute beds, acute psychiatric beds, and psychiatric health facilities. Discharges from chemical dependency recovery care, physical rehabilitation care, and skilled nursing/intermediate care are not shown. Other includes workers compensation and other payers.

Source: "Expected Payer by Patient County of Residence and Type of Care for 2010" (Sacramento, CA: Office of Statewide Health Planning and Development), accessed January 21, 2013, www.oshpd.ca.gov.

Psychiatric acute hospital care and other acute hospital care had very different payment sources. Patients discharged from acute psychiatric hospital stays were less likely to have their care paid for by private payers or Medicare than those discharged from other acute hospital care, and were more likely to have their stay paid for by self-pay, county indigent programs, or other government sources.

Psychosis Treatment Discharges
California, 2004 to 2011

NUMBER OF DISCHARGES



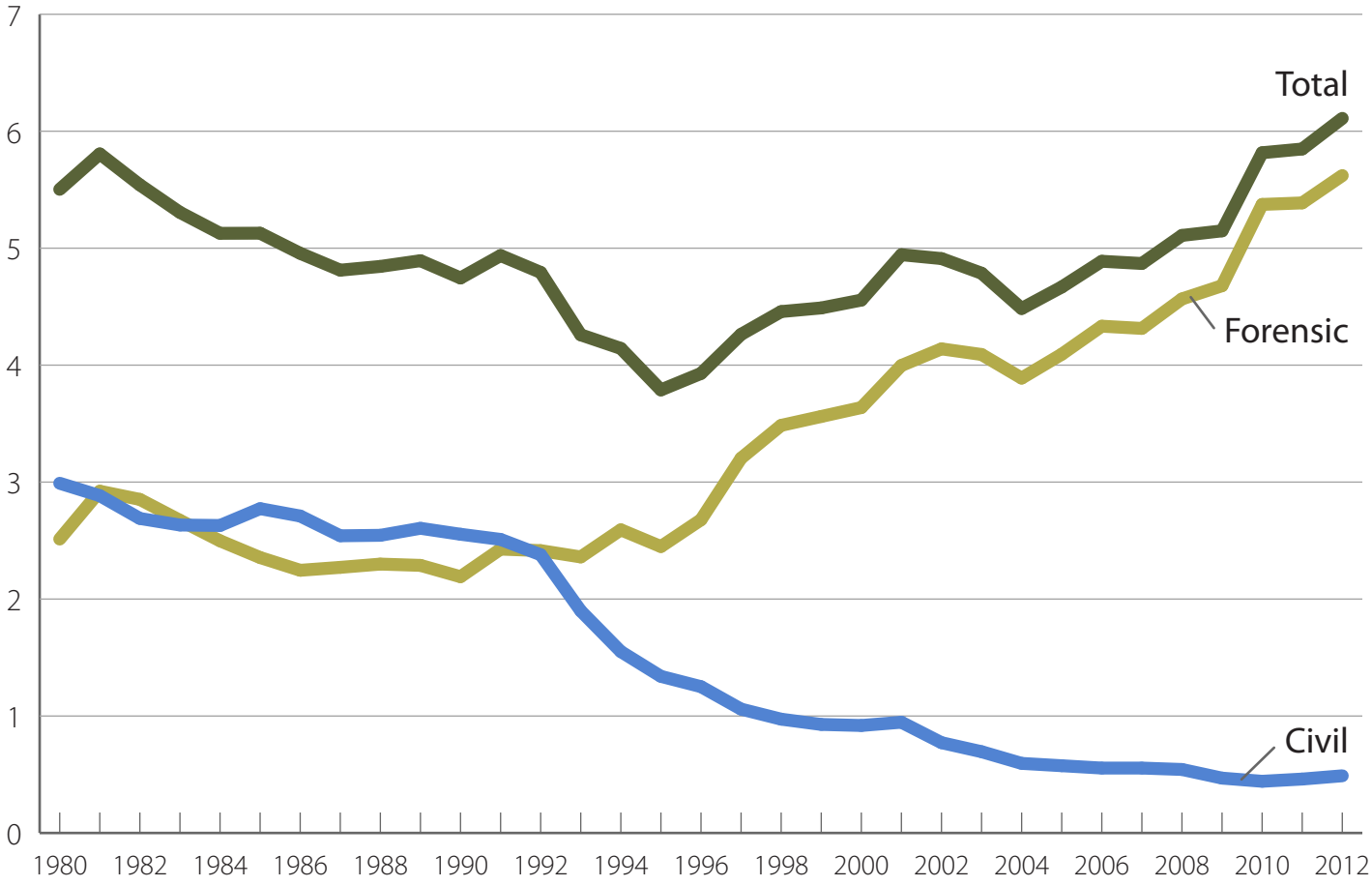
Psychoses were among the most frequent diagnoses for discharges from California acute care hospitals. Only childbirth-related discharges (not shown) exceeded those for psychoses.

Notes: Includes discharges from general acute beds, acute psychiatric beds, and psychiatric health facilities. The years measured cover the period October through September.

Source: "Average Charges for the Top 25 Statewide MS-DRGs, 2004–2011," Office of Statewide Health Planning and Development, www.oshpd.ca.gov.

California State Hospital Patients
1980 to 2012

NUMBER OF PATIENTS (IN THOUSANDS)



Notes: Data for each year are a count of state hospital patients as of June 30 (except 2006, when the count was taken on May 31). Civil clients are individuals committed to the hospital under provision of the California Welfare and Institutions Code that allows for conservatorship for up to one year. Forensic clients are persons committed to the state hospital under various provisions of the California Penal Code.

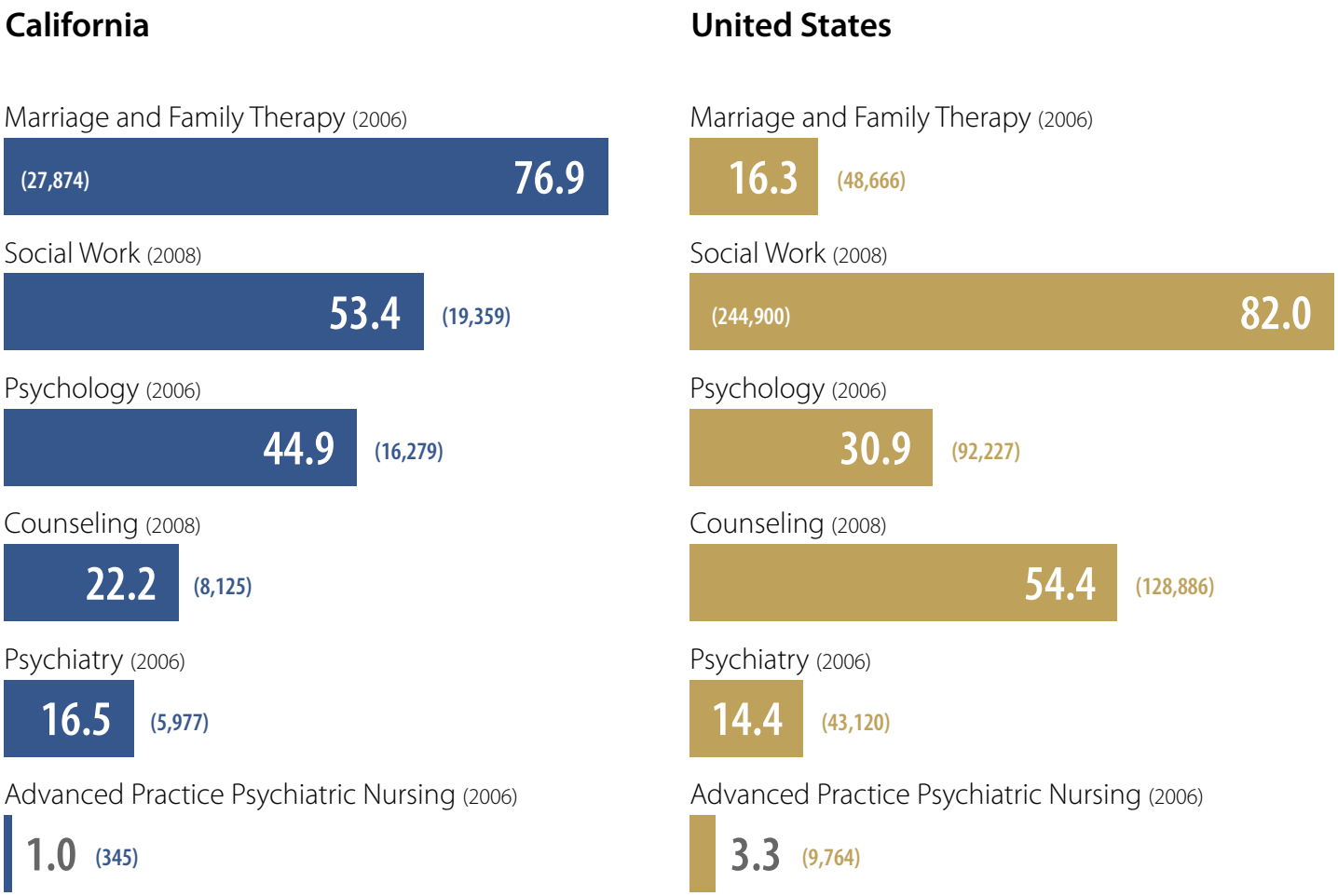
Source: Department of State Hospitals, special data request, received January 4, 2013.

Use of state hospital beds has changed dramatically over the past 30 years. In 1986, the occupation of state hospital beds was almost evenly split between civilly committed patients needing intermediate or long term hospital care, and forensic patients — those involved with the criminal justice system — with a serious mental illness. By 2012, state hospital beds were used almost exclusively by forensic patients, with less than 10% being occupied by patients on civil commitments.

Mental Health Professionals, by Discipline

California vs. United States, Varying Years (2006 or 2008)

PER 100,000 POPULATION (TOTAL NUMBER)



Note: See Appendix C for more details about mental health professionals.

Source: *Mental Health, United States, 2010, HHS Publication No. (SMA) 12-4681* (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2012).

The composition of California's mental health workforce differed from that of the US overall. California had more psychiatrists and fewer nurses with psychiatric prescribing privileges, and more marriage and family therapists (MFTs) than social workers and counselors. State law prohibits MFTs from participating as Medi-Cal or Medicare providers unless they are members of county clinic staff. This restriction prevents a large percentage of the mental health workforce from serving Medi-Cal and Medicare enrollees.

Licensed Mental Health Professionals, by Region
California, 2012

PER 100,000 POPULATION

	PSYCHIATRISTS	PSYCHOLOGISTS	LICENSED CLINICAL SOCIAL WORKERS	MARRIAGE AND FAMILY THERAPISTS
Central Coast	20	45	46	117
Greater Bay Area	32	71	69	123
Inland Empire	9	16	27	40
Los Angeles County	20	45	52	81
Northern and Sierra	10	25	46	91
Orange County	16	41	43	83
Sacramento Area	19	36	57	76
San Diego Area	22	53	53	72
San Joaquin Valley	8	17	25	34
State Average	**19**	**43**	**48**	**81**

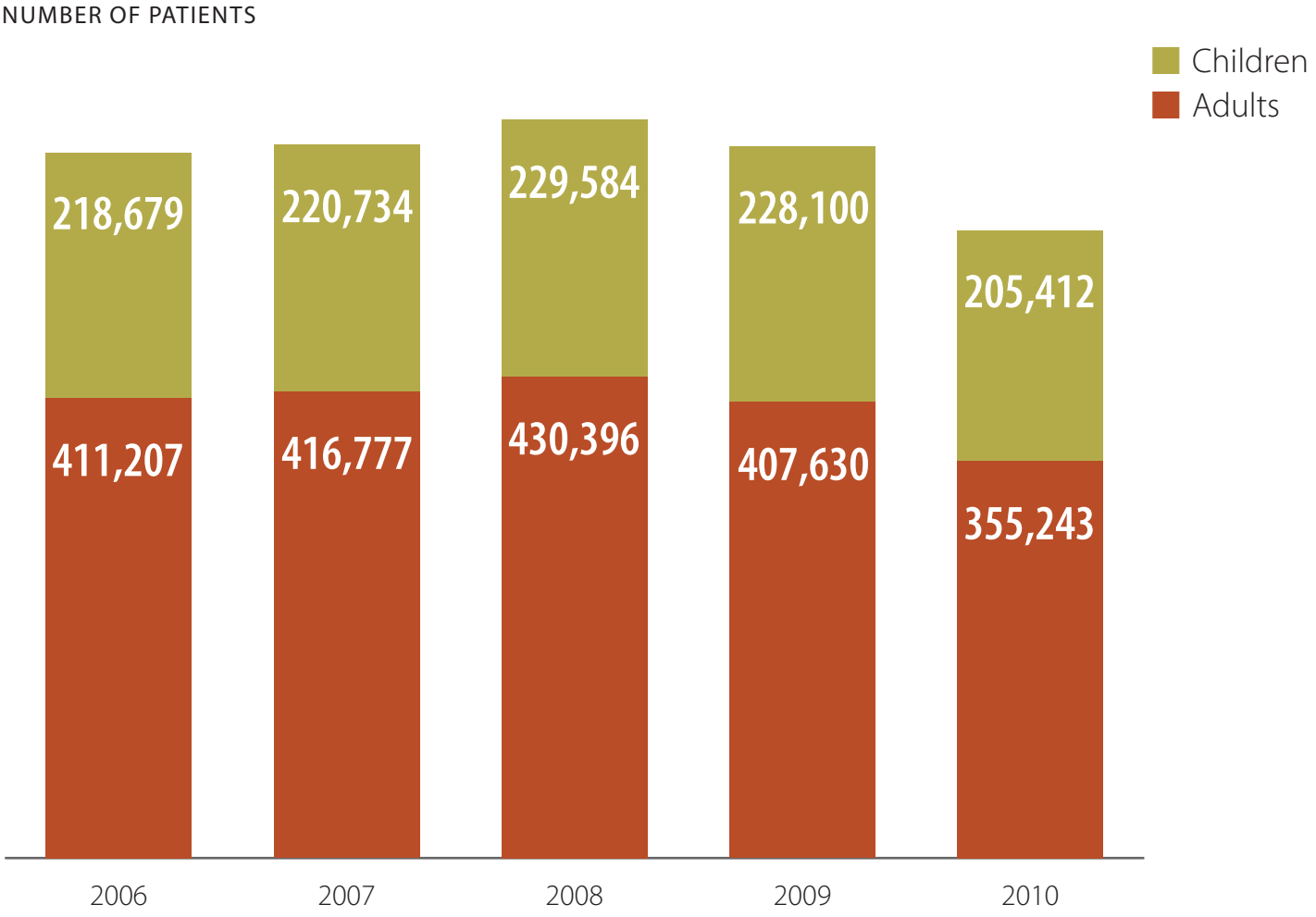
Notes: Psychiatrists may be counted twice if they have more than one type of license. Count includes psychiatrists whose primary or secondary specialty is psychiatry, regardless of board certification. See Appendix A for a map of counties included in each region.

Sources: "Supply of Health Care Providers," California Office of Statewide Health Planning and Development, accessed October 22, 2012, www.oshpd.ca.gov. "Licensed Psychologists by County as of February 5, 2012," California Board of Psychologists. Public Information Request to the California Department of Consumer Affairs, Bureau of Behavioral Health, received October 24, 2012. US Census 2011 population, current residents as of April 1.

The distribution of licensed mental health providers varied considerably among California regions. The Bay Area had the greatest concentration of licensed mental health professionals, far exceeding the state average. The Inland Empire and San Joaquin Valley fell well below the state average for all mental health professions. The Northern and Sierra region was below average in the numbers of psychiatrists and psychologists, but above average for marriage and family therapists.

Use of County Mental Health Services

Children and Adults, California, 2006 to 2010



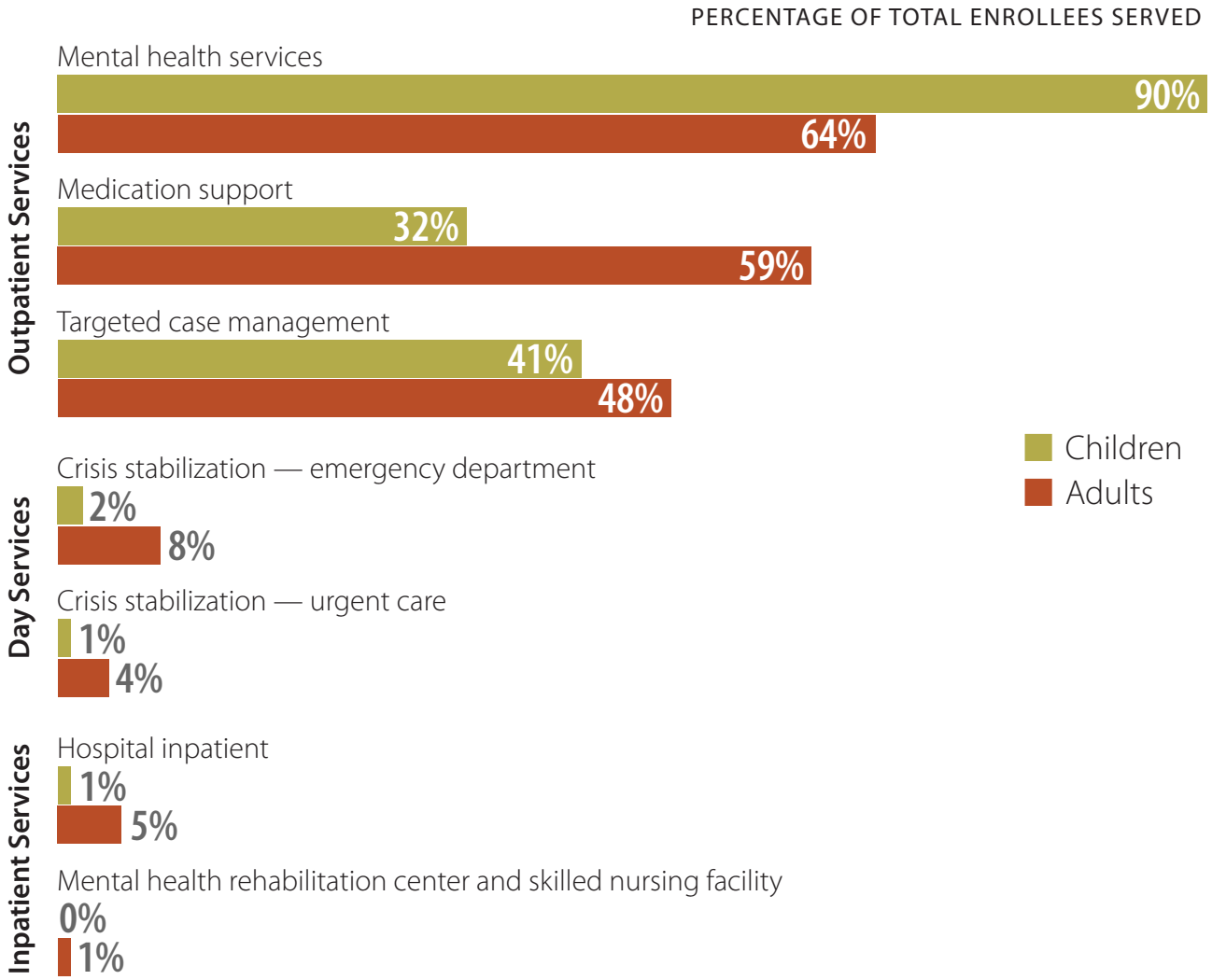
Notes: County mental health programs serve both Medicaid enrollees and people who are uninsured, focusing on those with serious mental illness and serious emotional disturbance. Children are age 17 and under. See page 4 for full definitions of mental illness categorizations.

Source: *California Mental Health and Substance Use Needs Assessment* (Boston, MA: Technical Assistance Collaborative and Cambridge, MA: Human Services Research Institute, February 2012).

California county mental health programs are responsible for managing Medi-Cal mental health services and for providing safety-net mental health services for those who are uninsured. These services are paid for by a combination of state, county, and federal funds. The number of Californians served by this system fell 11% between 2006 and 2010.

Use of County Mental Health Services, by Type

Children and Adults, California, 2010



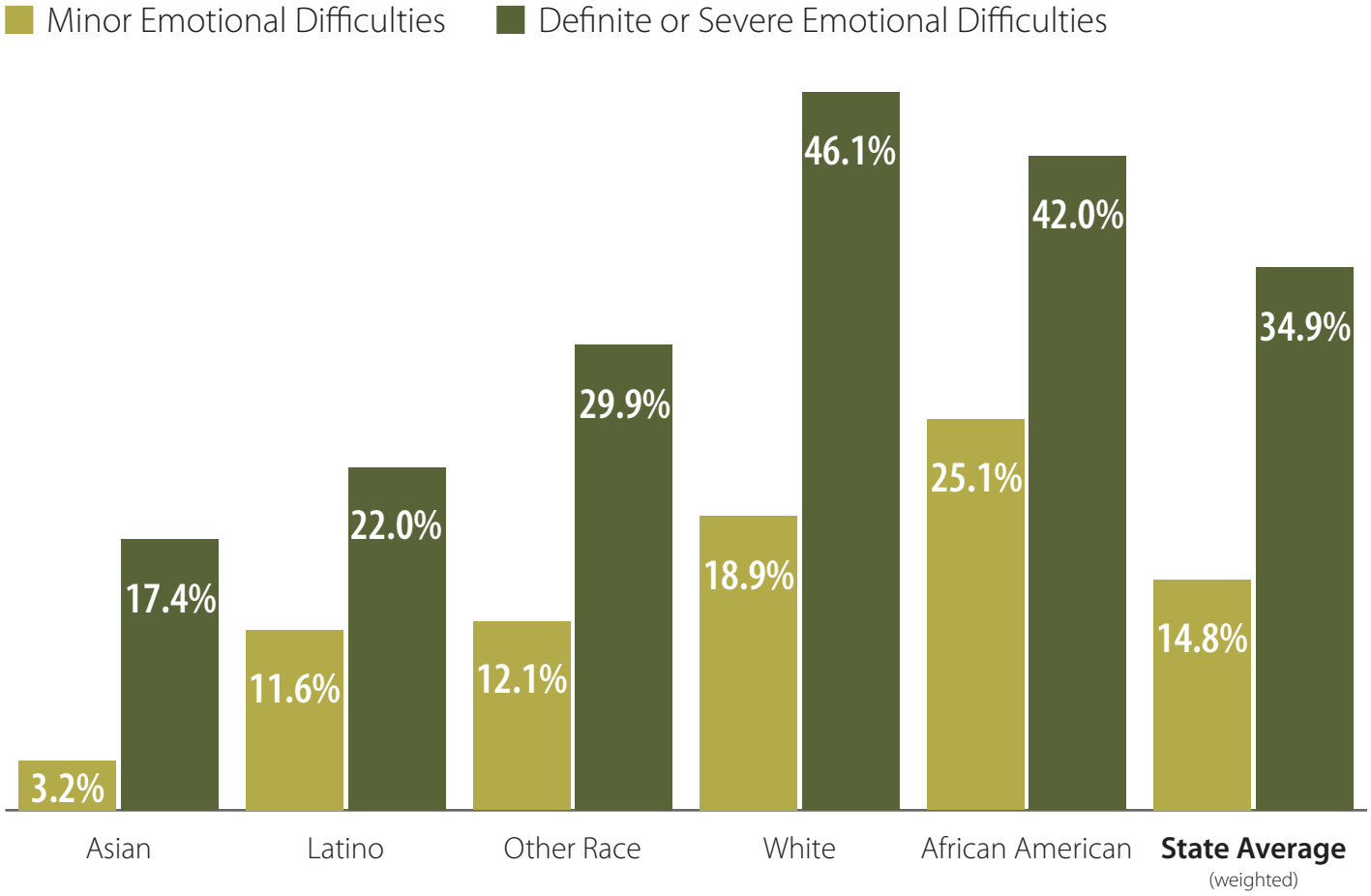
Notes: Outpatient mental health services includes counseling and therapy. Medication support is the prescription and management of psychotropic medications. Hospital inpatient includes psychiatric health facilities. Targeted case management assists clients in coordinating and accessing needed community services. Children are age 17 and under.

Source: *California Mental Health and Substance Use Needs Assessment* (Boston, MA: Technical Assistance Collaborative and Cambridge, MA: Human Services Research Institute, February 2012).

Outpatient mental health services were the most frequently used services among both children and adult county mental health program enrollees. Compared to adults, children were more likely to receive outpatient mental health services and less likely to receive medication support. Day and inpatient services were infrequently used by all patients.

Treatment for Children with Emotional Difficulties,
by Severity and Race/Ethnicity, California, 2005, 2007, and 2009 (combined)

PERCENTAGE WITH AT LEAST ONE MENTAL HEALTH VISIT IN THE PAST YEAR



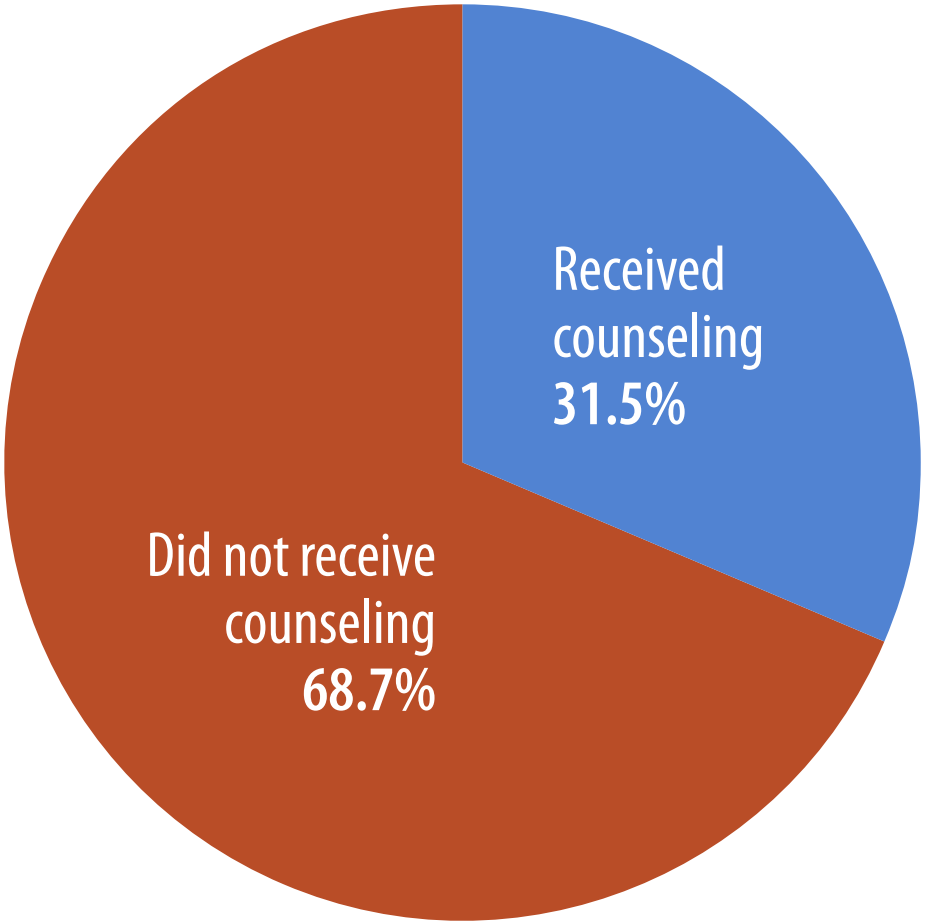
Notes: In the California Health Interview Survey, parents or primary caregivers are asked if a child had difficulties with emotions, concentration, behavior, or interaction with other people in the past six months. Those who answered affirmatively were asked to rate those difficulties as minor, definite, or severe. In the study from which these data were drawn, ratings of definite and severe were combined. Parents also reported whether their child had one or more mental health visits in the past year. Children are age 17 and under.

Source: Jim E. Banta et al., "Race/Ethnicity, Parent-Identified Emotional Difficulties, and Mental Health Visits Among California Children," *Journal of Behavioral Health Services and Research* 40, no. 1 (January 2013): 5–19, doi:10.1007/s11414-012-9298-7. Based on data from the California Health Interview Survey.

Only one-third of children whose parents rated their emotional difficulties as definite or severe had a mental health visit in the past year. Rates varied dramatically by race. White and African American children were considerably more likely to have had a mental health visit than Asian or Latino children. Children with minor emotional difficulties were much less likely to have had a mental health visit. For these children, there was even more variation in mental health treatment among racial groups.

Counseling for Adolescents with Mental Health Needs
California, 2009

PERCENTAGE WHO…



More than two-thirds of adolescents who said they needed help for emotional or mental health problems reported that they had not received psychological or emotional counseling.

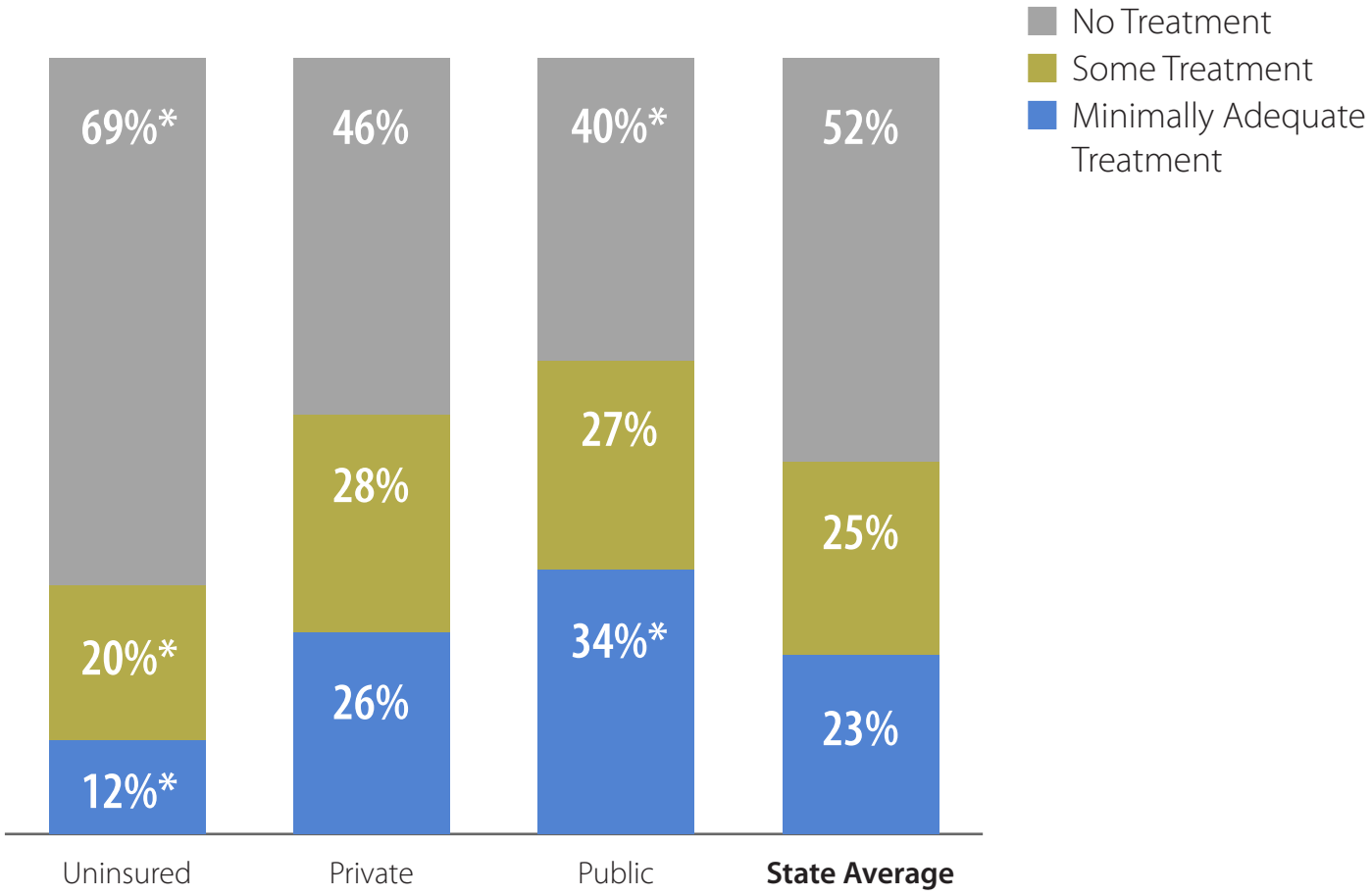
Notes: Adolescents, age 12 to 17, were surveyed. Segments don't add to 100% due to rounding.

Source: 2009 California Health Interview Survey.

Mental Health Treatment Among Adults

by Insurance Coverage, California, 2007 and 2009 (combined)

PERCENTAGE WITH MENTAL HEALTH NEEDS WHO HAD...



*Difference from state average is statistically significant at p<.05.

Notes: Based on data from the 2009 California Health Interview Survey. Mental health need during the past 12 months was assessed based on determination of serious psychological distress using the Kessler 6 scale and at least a moderate level of impairment using the Sheehan Disability Scale. Minimally adequate treatment was defined as four or more visits with a mental health professional in the past 12 months and prescription medication for mental health, an evidence-based guideline for the treatment of serious mental illness. Segments don't add to 100% due to rounding.

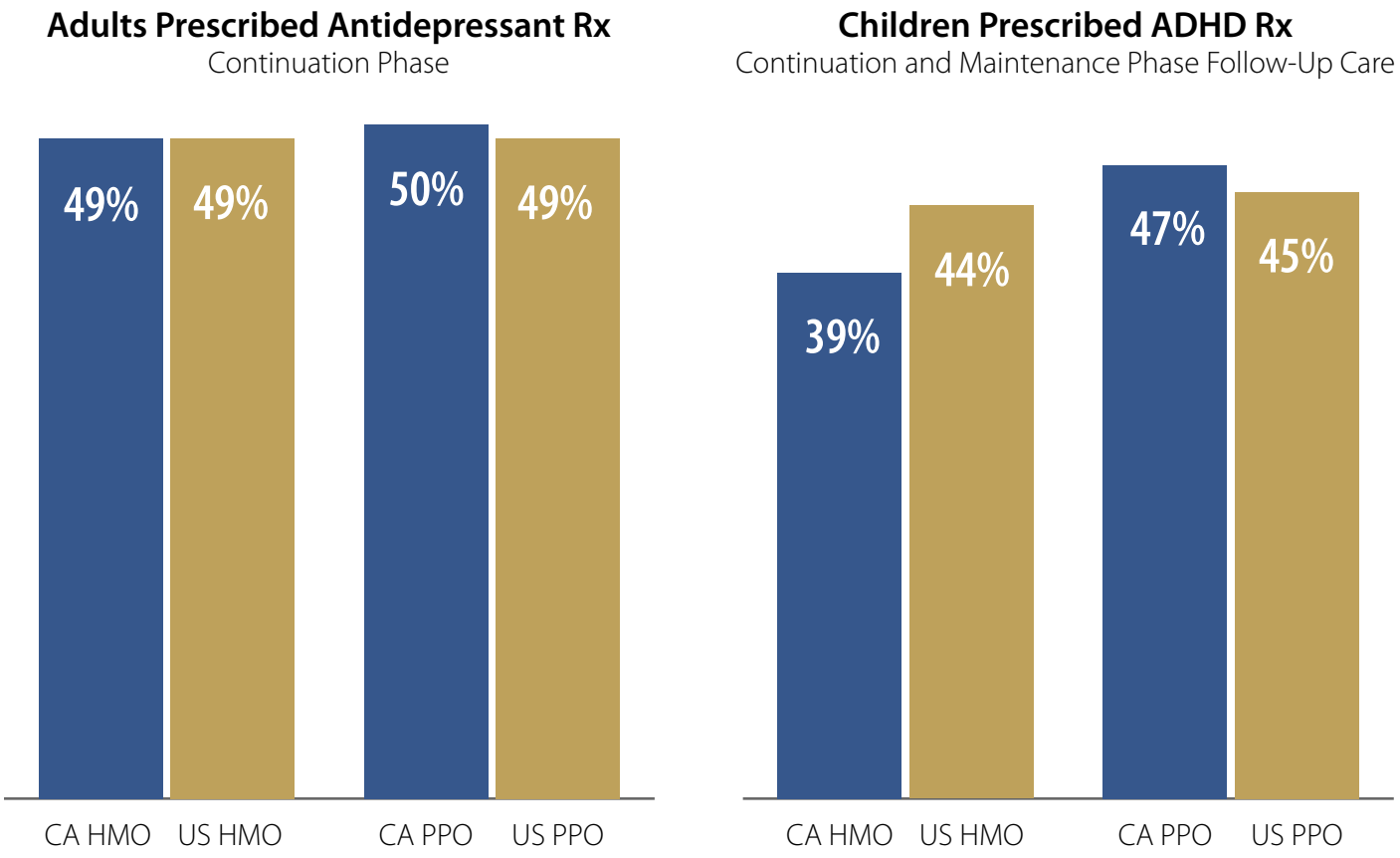
Source: D. Imelda Padilla-Frausto et al., *Half a Million Uninsured California Adults with Mental Health Needs Are Eligible for Health Coverage Expansions* (Los Angeles: UCLA Center for Health Policy Research, November 2012).

About half of California adults with mental health needs did not get any mental health treatment during the past year. Less than a third of the uninsured got treatment.

Medication Treatment for Selected Mental Health Conditions

Commercial Health Plans, California vs. United States, 2010

PERCENTAGE WHOSE TREATMENT MET STANDARDS OF CARE



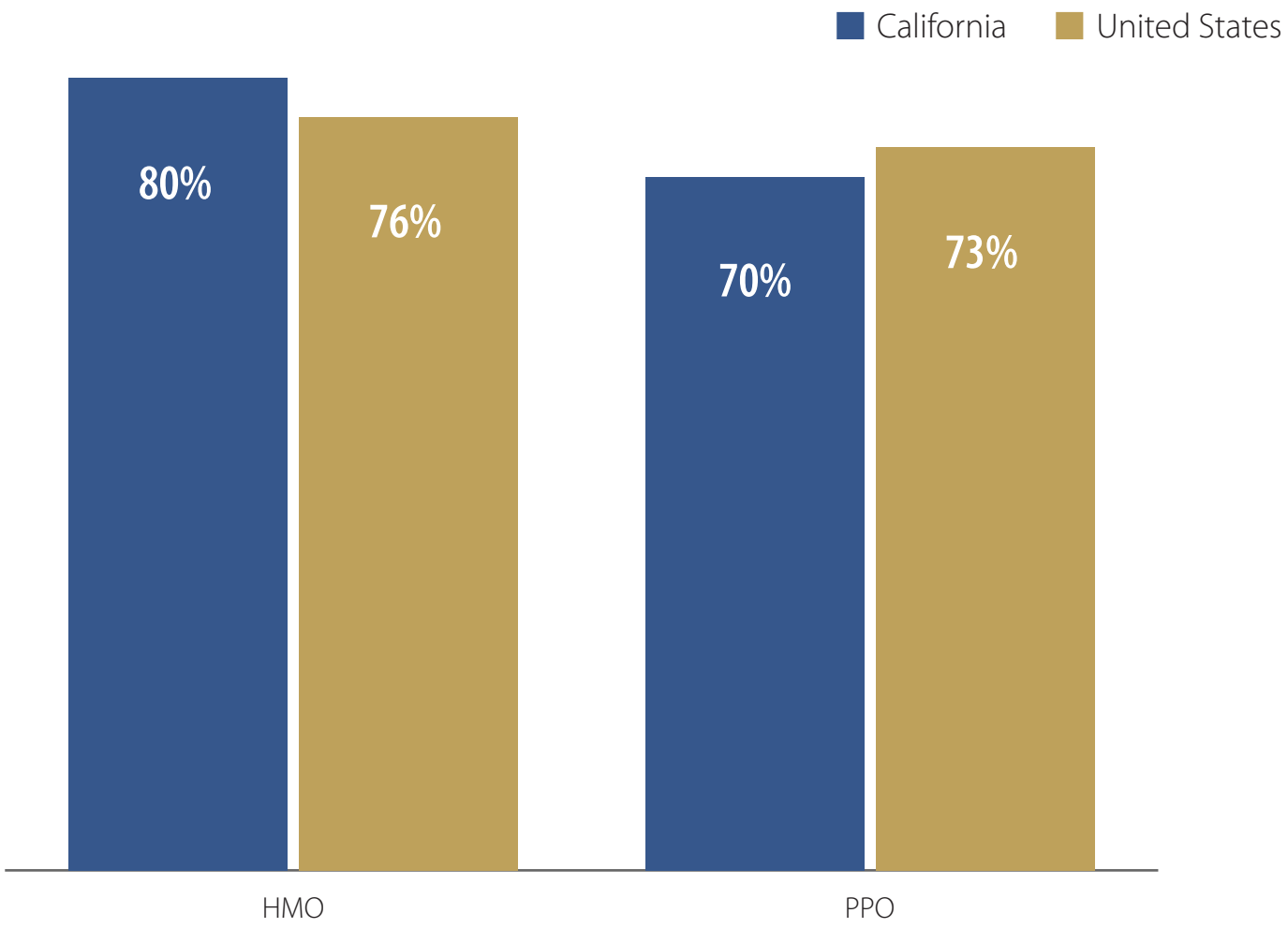
Notes: A widely accepted standard for effective management of adults who iniate treatment with an antidepressant medication calls for them to remain on the medication for six months. An accepted measure of the appropriateness of continued care for children (age 6 to 12) prescribed attention deficit hyperactivity disorder (ADHD) medication and remain on it for at least 210 days is to have at least two practitioner visits between the second and ninth months on the medication. Continuation phase care aims to prevent recurrence of the episode. California scores are the average of the state's largest HMOs and the average scores of six of the largest California PPOs. Nationwide results are from PPO health plans throughout the US and were calculated giving equal weight to each plan's score regardless of its enrollment. HMO is health maintenance organization; PPO is preferred provider organization. Read more: "Continuation-Phase Treatment: Strategies and Tactics in the Treatment of Depression," Armenian Medical Network (March 6, 2006), www.health.am.

Source: "NCQA Quality Compass, 2011," Office of the Patient Advocate, accessed April 19, 2013, reportcard.opa.ca.gov.

Almost half of adults and less than half of children in HMOs and PPOs who were prescribed medications for their mental health conditions received care that met quality standards.

Follow-Up After Hospitalization for Mental Illness

HMO vs. PPO Plans, California vs. United States, 2010



Notes: HMO is health maintenance organization; PPO is preferred provider organization. California HMO scores are the average of the state's largest HMO. California PPO scores are the average across six of the largest California PPOs. The nationwide results are from PPO health plans located throughout the US and were calculated giving equal weight to each plan's score regardless of its enrollment.

Source: "NCQA Quality Compass, 2011," Office of the Patient Advocate, accessed April 19, 2013, reportcard.opa.ca.gov.

Prompt follow-up with an outpatient mental health provider after discharge from a psychiatric hospital is important to maintain continuity of care and to prevent relapse or rehospitalization. A widely accepted measure of quality follow-up care is whether a patient keeps an outpatient appointment within 30 days of discharge. California HMOs exceeded national counterparts on this measure while PPOs fared slightly worse.

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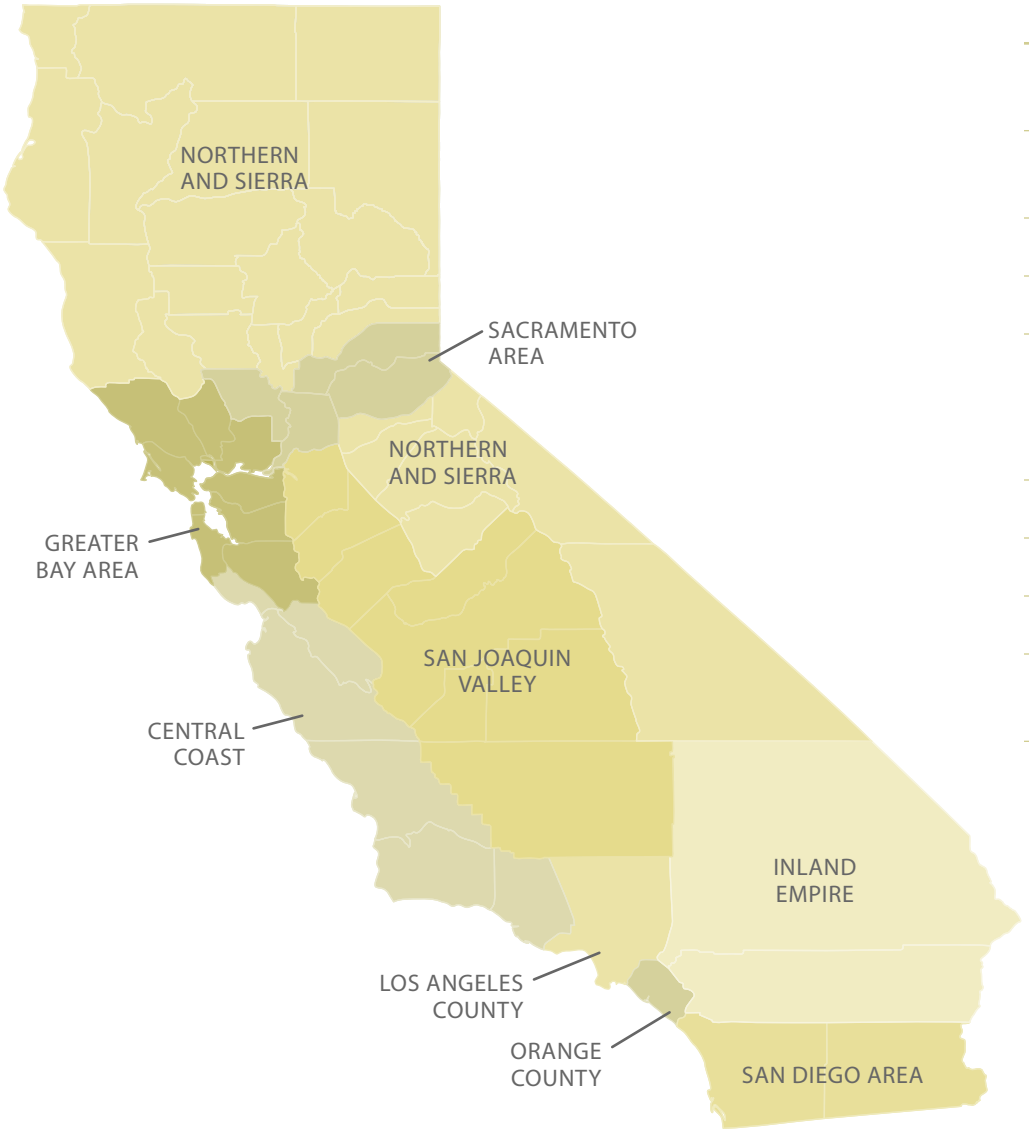
Appendix A: California Counties Included in Regions



REGION	COUNTIES
Central Coast	Monterey, San Benito, San Luis Obispo, Santa Barbara, Santa Cruz, Ventura
Greater Bay Area	Alameda, Contra Costa, Marin, Napa, San Francisco, San Mateo, Santa Clara, Solano, Sonoma
Inland Empire	Riverside, San Bernardino
Los Angeles County	Los Angeles
Northern and Sierra	Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Inyo, Lake, Lassen, Mariposa, Mendocino, Modoc, Mono, Nevada, Plumas, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tuolumne, Yuba
Orange County	Orange
Sacramento Area	El Dorado, Placer, Sacramento, Yolo
San Diego Area	Imperial, San Diego
San Joaquin Valley	Fresno, Kern, Kings, Madera, Merced, San Joaquin, Stanislaus, Tulare

Appendix B: Mental Health Care Service Continuum, California

There is a continuum of mental health treatment that offers a wide variety of types and intensities of treatment and degrees of supervision.

The scope of practice that is allowed for different types of providers and organizations determines what kinds of services they can provide.

PROVIDER TYPE OR LEVEL OF CARE	OUTPATIENT MENTAL HEALTH SERVICES	INTERMEDIATE/ INTENSIVE COMMUNITY SERVICES	ROUND-THE-CLOCK SERVICES		
			ACUTE INPATIENT CARE	INTERMEDIATE OR LONG TERM INPATIENT CARE	RESIDENTIAL
Therapists and psychiatrists in independent and group practice	X				
Mental health clinics	X	X			
Community mental health centers	X	X			X
Specialized community providers (e.g., assertive community treatment)		X	X		X
Psychiatric units in general hospitals		X	X		
Acute psychiatric hospitals		X	X		
Psychiatric health facilities			X		
Nursing home specialized treatment programs				X	
Mental health rehabilitation centers				X	X
State hospitals				X	

Sources: Welfare and Institutions Code, § 5670–5676.5; California Community Care Facilities Act, Chapter 3 (commencing with § 1500) of Division 2 of the Health and Safety Code; and Business and Professions Code, Chapters 5, 6, 13, and 14.

Appendix C: Mental Health Professionals, by Discipline

Licensed mental health practitioners of all kinds are qualified to conduct assessments, determine diagnoses, develop treatment plans, and provide therapies for individuals, couples, families, and groups. Only psychiatrists and psychiatric clinical nurse specialists may prescribe and monitor medications, and only psychologists can administer various forms of psychological testing and assessment. Nonlicensed mental health staff provide important case management, rehabilitation, and support services for people with serious mental illness.

PROFESSION	CREDENTIALS, QUALIFICATIONS, AND CUSTOMARY PRACTICE	PSYCHOTROPIC MEDICATIONS	PSYCHOLOGICAL TESTING	TREATMENT PLANNING	THERAPY	CASE MANAGEMENT	REHABILITATION AND SUPPORT
Physician	MD/DO with general licensure as physician and surgeon	X		X			
Psychiatrist	MD/DO with a specialty in psychiatry, some with a second specialty in child and adolescent psychiatry	X		X	X		
Psychiatric clinical nurse specialist	Advanced practice nurse with masters or doctorate degree who specializes in psychiatry	X		X	X		
Nurse	RN and LVN, some with specialty psychiatric training, plus licensed psychiatric technicians	X*		X		X	X
Psychologist	Clinical psychologist licensed at the doctoral level, perhaps specializing in psychological or neuropsychological assessment, including diagnostic test administration, assessment, and treatment recommendations		X	X	X		
Licensed independent clinical social worker (LICSW), mental health counselor, and marriage and family therapist	Master's level clinicians licensed by the state to provide therapy, case management, and treatment planning, with only LICSWs eligible for reimbursement under Medi-Cal and MediCare			X	X	X	X
Occupational therapist (OT)	Licensed OT			X		X	X
Unlicensed mental health workers qualified under the California Medi-Cal Rehabilitation Option	Mental health workers with high school, associates, or bachelors degrees providing (under supervision) care management, rehabilitation, behavior management, mentoring, milieu support, respite, and other supportive roles			X		X	X

*Administer/monitor only.

Sources: California Welfare and Institutions Code, Business and Professions Codes, MediCal Regulations.

Appendix D: County-Based Public Mental Health System, Financing Detail FY2006 to FY2014 (in millions)

	1991 REALIGNMENT[1]	FEDERAL FINANCIAL PARTICIPATION[2]	STATE GENERAL FUNDS[3]	MHSA[4]	REDIRECTED MHSA[4]	2011 REALIGNMENT[5]	OTHER[6]	TOTAL
Actual FY2006	$1,217.1	$1,019.9	$653.5	$316.9	n/a	n/a	$295.4	**$3,502.8**
Actual FY2007	$1,230.9	$1,076.8	$721.8	$426.3	n/a	n/a	$306.8	**$3,762.6**
Actual FY2008	$1,211.5	$1,266.4	$738.5	$1,488.2	n/a	n/a	$313.3	**$5,017.9**
Actual FY2009	$1,072.4	$1,404.6	$701.0	$1,117.0	n/a	n/a	$233.9	**$4,528.9**
Actual FY2010	$1,023.0	$1,619.2	$518.0	$1,347.0	n/a	n/a	$187.6	**$4,694.8**
Actual FY2011	$1,023.0	$1,799.9	$619.4	$1,165.1	n/a	n/a	$139.4	**$4,746.8**
Estimated FY2012	$1,097.6	$1,562.5	$0.1	$1,029.9	$861.2	n/a	$139.4	**$4,690.7**
Projected FY2013	$1,144.1	$1,562.5	$0	$1,340.0	$0	$801.2	$150.0	**$4,997.8**
Projected FY2014	$1,145.7	$1,562.5	$0	$1,340.0	$0	$861.3	$150.0	**$5,059.5**
% change FY2006 to FY2014	−6%	+53%	−100%	+323%	n/a	n/a	−49%	**+44%**

Notes: These figures encompass revenues received or projected to be received by counties in support of the Medicaid and safety-net mental health services they provide. Other public mental health services, such as forensic services in state hospitals and mental health services and medications provided by Medicaid health plans and Medi-Cal fee-for-service, are not included.

1. 1991 Realignment is the shift of funding and responsibility from the state to the counties to provide mental health services, social services, and public health, primarily to individuals who are a danger to themselves and/or others or who are unable to provide for their immediate needs. Two revenue sources fund realignment: 1/2 percent of state sales taxes and a portion of state vehicle license fees. Realignment is the primary funding source for community-based mental health services, state hospital services for civil commitments, and Institutions for Mental Disease, which provide long term care services. It includes $14 million in vehicle license fee collections. The FY2012 estimate and FY2013 projection are from the governor's proposed FY2014 budget.
2. Federal Financial Participation (FFP) is the federal reimbursement that counties receive for providing specialty mental health treatment to Medi-Cal and Healthy Families Program beneficiaries. The amount of federal reimbursement received by counties is based on a percentage established for California called the Federal Medical Assistance Percentage (FMAP). Managed Care and Early and Periodic Screening Diagnosis Treatment (EPSDT) share of 2011 Behavioral Health Subaccount only. FY2013 growth estimated on percentage of growth in Behavioral Health Subaccount from the governor's proposed FY2014 budget.
3. The State General Fund includes revenues from personal income tax, sales and use tax, corporation tax, and other revenue and transfers. Prior to the governor's FY2012 Budget Proposal and Realignment II, these funds primarily supported specialty mental health benefits of entitlement programs including Medi-Cal Managed Care, EPSDT, and Mental Health Services to Special Education Pupils (AB 3632).
4. The MHSA (Proposition 63) is funded by a 1% tax on personal income in excess of $1 million. The primary obligations of the MHSA are for counties to expand recovery based mental health services; to provide prevention, early intervention services, and innovative programs; and to educate, train and retain mental health professionals.
5. 2011 Realignment, initiated in 2011, gives counties the funding responsibility for Medicaid EPSDT and Mental Health Managed Care.
6. Other revenue is from county property taxes, patient fees and insurance, grants, etc. The primary obligation of counties is to fund mental health services sufficiently to meet maintenance of effort requirements to qualify to receive realignment funds.

Sources: *Financial Report* (Sacramento, CA: Mental Health Services Oversight and Accountability Commmission, January 24, 2013), accesssed April 17, 2013, www.mhsoac.ca.gov. Actual, estimated, and projected amounts from these sources: FY2013 Governor's Budget, DOF, DMH (DHCS after June 30, 2012) MHSA Summary Comparison (posted July 21, 2011), MHSOAC Fiscal Consultant Projections, and California Department of Health Care Services.