

# The California Children's Trust Initiative: Reimagining Child Well-Being

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California  
Children's  
Trust

CH1LDREN NOW

# Reimagining Well-Being for California's Children

Whether measured against developmental benchmarks, epidemiological estimates of the prevalence of need, or the timeliness of access to quality interventions, California's child-serving systems are failing to support healthy development, alleviate suffering, and unlock the potential of individual children and youth<sup>1</sup>. There is an immediate need for systems change to redefine the scope and nature of behavioral health—including the procurement, financing, and delivery mechanisms that translate healthcare coverage and policy into actual services and supports for children's social, emotional, and developmental health. While the challenge is stark, the current moment is defined by extraordinary possibility.

**The California Children's Trust (CCT)** is a broad-based initiative to capture unique opportunities in the state to conceive, fund, administer, deliver, and measure a comprehensive system of social, emotional, and behavioral health supports to all of California's children. The Trust aims to bring existing groups together under a shared agenda to:

**CONCEIVE:** Shift from a reactive, pathology-oriented behavioral health infrastructure to one that integrates proactive, preventative approaches to advancing child well-being

**FUND:** Leverage and create mechanisms to finance a more expansive and responsive array of behavioral health services and supports

**ADMINISTER:** Simplify and integrate behavioral health administration and funding

**DELIVER:** Expand access to a broad array of supports that allow children's and families' needs—not simply their diagnoses—to drive system quality, delivery and utilization

**MEASURE:** Create shared child well-being outcomes and systems of measurement to increase accountability and coordination across child-serving systems

This brief reviews the history and complexity of California's policies related to the delivery of children's behavioral health services, highlighting the limitations of existing approaches. It focuses on the current performance and most significant challenges facing California's mental health delivery system for children and outlines new fiscal and programmatic opportunities for the state to improve child well-being.

## CCT Definition of Terms

**Behavioral Health Supports:** clinical and non-clinical interventions that support children's social, emotional, mental, developmental and cognitive health and prevent and treat substance use disorders.

**Child Health Equity:** Child health is equitable and just when every child has a fair and intergenerational opportunity to attain their full health and developmental potential, free from discrimination.

**Child Well-Being:** Refers to the health of the whole child and includes physical health and safety; psychological, social, emotional, and cognitive development; and educational achievement.

## Who is responsible for child well-being in California?

In California, multiple public systems share responsibility for ensuring the mental and behavioral health needs of children and youth are met. This includes, but is not limited to: Department of Social Services (DSS), Department of Health Care Services (DHCS), California Department of Education (CDE), Department of Developmental Disabilities (DDS), Department of Juvenile Justice (DJJ), First 5, Department of Managed Health Care (DMHC), and the Department of Public Health (DPH). These agencies, plus the departments of 58 counties implement programs to address aspects of child well-being. However, each agency has different rules guiding what they can pay for, different definitions and measurements for child well-being, and difficulties sharing interagency information, resulting in a lack of accountability to each other, and to the children and families they serve.

The largest payer of mental health services, Medicaid (Medicaid and the Children's Health Insurance Program are combined to be "Medi-Cal" in California) provides services to children through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. EPSDT requires that states provide youth under the age of 21 with all the medically necessary services to "correct or ameliorate defects, physical and mental illnesses, and conditions discovered by the screening services."<sup>2</sup> While "medical necessity" under EPSDT is defined broadly, until recently California state law included a confusing definition that resulted in more restrictive applications of the broad federal standard.

As a result, many California children have not been deemed eligible to receive crucial services.

## How are children doing?

### CHILDREN ACROSS CALIFORNIA ARE NOT GETTING THE SUPPORT THEY NEED.

This is in part because the current mental health system does not account for exposures to poverty, racism, or adverse childhood experiences in how it assesses behavioral health needs, dispenses behavioral health supports and services, or defines behavioral health outcomes. That means the gap between children who would benefit from a behavioral health support, including prevention, and those who receive a behavioral health support is large.

Current estimates suggest 7-8% of California's children have a serious emotional disorder and Black and Latino children and children who live below the federal poverty line have the highest rates, ranging from 8-10%.<sup>3</sup> Yet, fewer than 5% of youth eligible for specialty mental health services (SMHS) under Medi-Cal receive a service, and less than 3% receive ongoing services<sup>4</sup>. What is more, these estimates do not account for children who are at risk of other social, emotional, or behavioral impairments, or who may benefit from a support other than a specialty mental health service, including the more than 60% of California's children exposed to at least one adverse childhood event.<sup>5</sup>

Troubling access disparities also exist across the state, as the regions with the greatest need also have the fewest providers<sup>6</sup> and the populations with the greatest need face continued access challenges. For example, in some California counties, only 33% of children in foster care receive any SMHS, and statewide only 50% receive such a service.

### ALL CALIFORNIA CHILDREN SHOULD RECEIVE DEVELOPMENTAL SCREENINGS THAT ARE CRITICAL TO EARLY INTERVENTION.

- About **25% of California children are at risk for developmental, behavioral or social delays.**<sup>7</sup>

- Only **22% of California parents report that their child received a developmental screening** during a pediatric well child visit, and Black, Latino and Asian children have the lowest screening rates largely because fewer providers ask these families about their child's development.<sup>8</sup>

### RATES OF YOUTH MENTAL ILLNESS, SUICIDALITY, AND SUBSTANCE USE ARE ON THE RISE.

- The rate of **mental health-related hospitalizations for youth in California has increased 50%** since 2007.<sup>9</sup>

- Nationally, inpatient visits for **suicide, suicidal ideation, and self-injury increased by 104%** for children ages 1 to 17 years, and by 151% for children ages 10 to 14 years between 2006-2011.<sup>12</sup>

- The rate of self-reported **mental health needs among California adolescents has increased by 61%** since 2005.<sup>10</sup>

- Nationally, **70% of youth involved in juvenile justice have a diagnosable mental illness.**<sup>13</sup>

- Substance use and abuse starts early—by 11th grade, **half of all California students have used alcohol or drugs and over 10% report heavy use.**<sup>15</sup>

- Nationally, since 2005, there has been a **30% increase in suicide rates, including a 200% increase among girls 10-14.** Suicide is now the second leading cause of death for all youth and young adults 10-24.<sup>11</sup>

- Over **30% of California adolescents report feelings of depression and over 10% have considered suicide,** with Native Hawaiian/Pacific Islander, American Indian/Alaska Native, and LGBTQ students reporting dramatically higher rates.<sup>14</sup>

## The Evolution of California's Mental Health Policies and Financing

The mental health system is a product of its history—a history that reflects changing values and inconsistent financial commitments. After the closure of its state psychiatric hospitals, California shifted to treating individuals in the community. The following timeline shows the foundational national and state legislative programmatic and fiscal changes that have shaped children's behavioral health care in California for over six decades:

# The Evolution of California's Mental Health Policies and Financing

Events in blue represent law suits.

- **Pre-1957-State Hospitals**—state funding for mental health services was concentrated on eight state hospitals that served approximately 36,000 mental health patients, including children.
- **1957- Short-Doyle Act**—established that mental illness could and should be treated in the community.
- **1965-Medicare and Medicaid amendments to the Social Security Act**—Medicaid allows states to receive a federal match on certain healthcare expenses for covered individuals. The federal government had the authority to waive certain provisions of Medicaid law to give states flexibility to meet the goals of their Medicaid programs. For example:
  - Section 1115(a) of the Social Security Act gave states the ability to plan, negotiate, and implement experimental, pilot, or demonstration projects that promote the objectives of Medicaid and the Children's Health Insurance Program (CHIP).<sup>16</sup>
  - Section 1915(b) of the Social Security Act gave states the ability to restrict enrollees' freedom of choice.
- **1968-Lanterman-Petris-Short Act**—established that for an individual to be involuntarily committed to an institution, a judicial hearing must first be held to ensure their rights were not being circumvented. LPS also required that most counties<sup>17</sup> implement mental health programs.
- **1978-Proposition 13**—capped property taxes across the state, decreasing government revenues dramatically and impacting locally-delivered programs, including community mental health services.
- **1984-AB 3632**—required counties to provide students with disabilities, as designated by their Individualized Educational Plan, any necessary mental health services.
- **In 1995-1915(b) Waiver**—California uses its Section 1915 (b) waiver to implement its Specialty Mental Health Services program (SMHS) through Local Mental Health Plans.<sup>18</sup>
- **1991- The California Realignment Act**—required counties to take on new responsibilities for mental health, social service, and health programs and in exchange, counties received a dedicated funding stream from the state.<sup>19</sup>
- **1998-Healthy Families Program (HFP)**—created California's children's health coverage program, expanded eligibility for the existing Access for Infants and Mothers (AIM) program, and expanded Medi-Cal's Federal Poverty Level for children.
- **1995-TL v Belshe**—**resulted in funding to ensure compliance with and implementation of an expanded EPSDT mental health services benefit with counties assuming responsibility for service provision.**
- **2000-AB 88**—California's mental health parity law required health plans to provide coverage for the diagnosis and treatment of severe mental illness 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-Emily Q v. Belshe**—**resulted in the creation of a new type of intensive mental health service for children called therapeutic behavioral services**
- **2003-Proposition 63 (the Mental Health Services Act or MHSA)**—imposed a 1% tax on those who report income of at least \$1 million, and directs revenues to fund programs focused on prevention and early intervention, workforce development, technology, and treatment.
- **2008-The Mental Health Parity and Addiction Equity Act**—required health insurers, including Medi-Cal Managed Care plans, to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care.
- **2010-Patient Protection and Affordable Care Act**—established reforms including that children cannot be denied coverage for pre-existing conditions.<sup>20</sup>
- **2011 Realignment**—While similar to 1991 realignment, 2011 realignment moved some juvenile justice responsibility from the state to counties and increased funding for community mental health.
- **2011-AB 114**—rendered AB 3632 inoperative and transferred that funding to California school districts requiring them to assume responsibility for ensuring that students with qualifying disabilities, as designated by their Individualized Educational Plan, be offered the mental health services necessary to benefit from their educational programs.
- **2011 Katie A. v. Bontà**—**required statewide implementation of new home and community-based mental health services to meet the mental health needs of youth in foster care and those at risk of removal from their families. The state later clarified that these services are available to all Medi-Cal eligible children who meet medical necessity for the services (not just foster children or those at risk of removal).**
- **2013-HFP Ends**—eliminated the HFP and AIM: children covered by these programs were absorbed into Medi-Cal, resulting in more children being eligible for the EPSDT benefit.<sup>21</sup>
- **2015 Continuum of Care Reform**—overhauled California's child welfare system to reduce the state's dependence on institutional care and ensure that all foster children are raised in stable family homes.<sup>22</sup>
- **2018-SB 1287**—clarified the state's definition of "medical necessity" under EPSDT to align with the broader federal definition.

# The Time for Change is Now

California's current patchwork of policies, siloed funding streams, lack of coordination among agencies and levels of government, burdensome administrative complexity, and diagnosis-driven treatment models hinder California's state and local systems from delivering on the promise of child well-being. **California can and must do better for children.**

Advocates, families, and policymakers agree that it will take dramatic changes to establish a stronger foundation for the health of all Californians. Policymakers are now in a position to understand the science behind the persistence of negative health outcomes across generations and populations, the drivers and implications of health inequities, and the need for a new approach. Today, the current confluence of financial, programmatic, and administrative opportunities make now the right time to reimagine how to create a responsive continuum of services to improve the well-being of California's children.

**Financial Opportunities.** Federal Medicaid waivers draw billions in federal matching funds into the Medi-Cal program. Both California's 1115(a) and 1915(b) waivers were approved for a five-year term in 2015 and are up for renewal in 2020. This impending negotiation provides an opportunity for the state to revisit and restructure the financing and delivery system of behavioral health services. Additionally, the Medi-Cal program provides the state with federal matching funds for allowable expenditures. By maximizing qualified expenditures, the state can generate significant additional federal funds.

Despite amassing approximately \$2 billion in annual revenue, the MHSA has not yet significantly transformed children's mental health outcomes and child well-being. There are approximately \$230 million in MHSA revenues stored in county accounts, which may be subject to reversion to the state. These unspent dollars demonstrate the need for new strategies and present an opportunity to create a system that could more efficiently and effectively deploy resources.

Finally, as the economy continues to thrive, California can expect continued growth in 2011 Realignment revenues, a portion of which counties are required to use to fund children's programs.<sup>23</sup>

**Programmatic Opportunities.** There have been multiple recent attempts at reform to better address child wellness. Programs like the Department of Health Care Services' Care Coordination Assessment project and the Whole Person Care Initiative show a strong desire to address the multiple needs of adults and children. Additionally, California's education system has begun to focus on the whole child, seeking to provide students the skills they need to set and achieve positive goals, maintain positive relationships, feel and show empathy for others, and make responsible decisions. With Continuum of Care Reform, the state seeks to revamp the way foster youth receive care, including mental health supports. Unfortunately, most of these efforts are distinct and uncoordinated, and could benefit from stronger, more effective partnership and shared accountability across agencies.

**Workforce Development Opportunities.** California continues to struggle with providing a consistent and adequate pipeline of doctors, nurses, behavioral health providers, community health workers, resource navigators and public health professionals who are trained to support child well-being, particularly in underserved, rural, and ethnically and linguistically diverse communities. Peer-based, caregiver led, and community-oriented models of support have the ability to expand our workforce. The California Children's Trust sees an opportunity to employ new strategies to ensure that a broader workforce can better meet the needs of California's diverse population.

## Conclusion

California is facing a crisis in the health and welfare of children, just as current science highlights the need to focus holistically on social, emotional, and developmental well-being. Behavioral health is a tool that supports healthy development and is a means to achieve health equity. Effective behavioral health services must provide the supports that children and their families need to heal, be resilient, and thrive.

The California Children's Trust presents a unique collaborative opportunity to redesign the current system through policy, programs, and fiscal reforms. A new system will ensure that all California's children are safe, educated, and healthy, with a sense of purpose and belonging and the opportunity to achieve their aspirations.

## About California Children's Trust

The California Children's Trust is committed to working together to reinvent our state's approach to children's social, emotional, and developmental health. We are a statewide initiative that seeks to improve child well-being through policy and systems reform. Learn more at [www.cachildrenstrust.org](http://www.cachildrenstrust.org)



## About Children Now

Children Now is dedicated to ensuring every California child, regardless of race or socioeconomic status, can reach his or her full potential. The organization conducts nonpartisan, whole-child research, policy development, and advocacy to improve children's health, education, and well-being in California. Learn more at [www.childrennow.org](http://www.childrennow.org).

## CHILDREN NOW

## Acknowledgments

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## Endnotes

1. In this brief, when we say children we are referring to children, youth, adolescents and transitional age youth.
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