DATA BRIEF

SEP 2023

A RIGHT TO HEAL

MENTAL HEALTH IN DIVERSE COMMUNITIES

BEHAVIORAL HEALTH AND HEALTH CARE BY THE NUMBERS, CALIFORNIA

California Pan-Ethnic HEALTH NETWORK

Statewide Partners

California Black Health Network

California Consortium for Urban Indian Health

California Pan-Ethnic Health Network

LCHC Latino Coalition for a Healthy California

SEARAC

Local Partners

Year 1

Bakersfield American Indian Health Project

Cultural Center of Butte County CA

Painted Brain

Restorative Justice for Oakland Youth

Visión y Compromiso

Year 2

El Sol Neighborhood Educational Center

On Track Program Resources

The Cambodian Family

True North Organizing Network

Vista Community Clinic

Year 3

AltaMed Your community health network

Be Smooth, Inc. Heal. Grow. Change.

Fresno Interdenominational Refugee Ministries FIRM

Indian Health Center of Santa Clara Valley

Mixteco Indigena Community Organizing Project

Funded By

MHSOAC

Mental Health Services Oversight & Accountability Commission

Introduction

In 2020, the Mental Health Services Oversight and Accountability Commission (MHSOAC) contracted CPEHN (California Pan-Ethnic Health Network) for three years to engage and uplift diverse voices to influence what local programs and services are funded in their communities under "A Right to Heal: Mental Health in Diverse Communities." [1]

This data brief provides context for the Right to Heal project as well as the current challenges and opportunities facing California's behavioral health system and the care available to BIPOC (Black, Indigenous, and People of Color) communities.

Are mental health and behavioral health the same?

Mental health and behavioral health are sometimes used interchangeably. Behavioral health has been defined to capture substance use disorders (SUD; e.g., alcohol misuse and addiction) **and** mental health conditions such as anxiety, depression and schizophrenia including the prevention, diagnosis, and management of these conditions. Given data sources often use this categorization, this distinction is made. [2]

California's Diverse Communities

A majority of the 39 million people residing in California belong to a community of color (64%). This diversity is broadly represented by 39.4% Latinx/e, 14.6% Asian, 5.5% Black, 3.1% multi-racial, 0.4% American Indian and Alaska Native, and 0.4% Native Hawaiian and Pacific Islander populations. California continues to be home to a vibrant intergenerational immigrant community. More than one in four Californians (27%) are immigrants, with nearly half (46%) of all California children having at least one parent who was born in a country other than the U.S. Moreover, 44% of Californians (age 5 years and older) speak a language other than English at home. [3]

Medi-Cal, Emergency Department Visits, and Behavioral Health Diagnoses

One out of three Californians receive health insurance coverage through Medi-Cal (public program for persons with low income), but while communities of color represent 64% of the total population, they are 80% of Medi-Cal enrollees. [4], [5]

In 2021, patients with a behavioral health diagnosis accounted for one out of five emergency department visits. Whether the diagnosis was a mental health disorder (43%), substance use disorder (44%), or both (48%), Medi-Cal was the single largest payer. [6] As a result, the Medi-Cal program is a crucial lever to advance racial health equity.

Is health care utilization a reflection of need?

Health care utilization is a measure of access to services **and** need. Many barriers prevent access to appropriate high-quality behavioral health care. These include, but are not limited to: stigma, racism, lack of insurance coverage, high cost-sharing, health literacy, language and cultural barriers, and long wait times. In addition, measures of disease prevalence based on a health care diagnosis may be inaccurate for the same reasons. [7]

For example,

- Low levels of behavioral health diagnoses among Asian/Pacific Islanders likely reflect barriers such as stigma and lack of linguistically and culturally appropriate services.
- Data aggregation may be masking health disparities within broad categorizations like Latinx/e and Asian. [8], [9]
- Use of high-quality outpatient services (e.g., therapy, recovery treatment) can keep patients out of the emergency department, something likely to be more common among those who are housed, have generous private insurance coverage, or have the ability to pay out-of-pocket. [10]
- Persons experiencing homelessness represent a much higher percentage of behavioral health diagnoses when compared to patients with housing. [11], [12]
- Schizophrenia has been overdiagnosed among Black Americans. [13], [14]

Assembly Bill (AB) 470

Assembly Bill (AB) 470 was signed into law in 2017 after extensive efforts by community advocates, including CPEHN and network partners. AB 470 identifies two fundamental objectives:
(1) The provision of high-quality, culturally and linguistically competent, and accessible mild-to-moderate and specialty mental health services for all eligible Medi-Cal beneficiaries, consistent with federal law. And
(2) The development of strategies to reduce mental health disparities.

The following charts are drawn from AB470 data focusing on the most recent year of data available. [15] The definitions used in this brief were previously defined in an analysis of AB470 data and are reproduced from that source here: [16]

➤ SPECIALTY MENTAL HEALTH SERVICES (SMHS) [17]

These are services for Medi-Cal enrollees with serious mental illness. For adults, medical necessity criteria for these services include having a listed diagnosis and meeting specified impairment and intervention criteria. Specialty mental health services include but are not limited to, rehabilitative mental health services, crisis intervention, targeted case management, intensive care coordination, outpatient residential treatment, and inpatient psychiatric hospitalization. County mental health plans are responsible for providing specialty mental health services.

➤ "MILD-TO-MODERATE" MENTAL HEALTH SERVICES [18]

These services are for adults enrolled in a Medi-Cal managed care plan who have a "mild-to-moderate" impairment of mental, emotional, or behavioral functioning. "Mild-to-moderate" mental health services include but are not limited to, individual and group psychotherapy, psychological testing, outpatient services, medication management, and psychiatric consultation. Managed care plans are responsible for providing "mild-to-moderate" mental health services.

➤ ACCESS RATE

The access rate (also called penetration rate) is the percentage of people eligible for a Medi-Cal mental health service who receive one or more such services in a given time period. This is one of several measures that can be used to evaluate access to services in both the specialty and managed care Medi-Cal systems.

➤ CONTINUED ENGAGEMENT

The California Department of Health Care Services defines continued engagement as five or more Medi-Cal mental health visits in a year. In this document, the continued engagement rate is the percentage of eligible enrollees who received five or more mental health services in that year. This is a measure of ongoing access to care.

All years in figures presented on the following pages represent fiscal years (FY), where 2022, for example, represents data beginning in July 2021 and ending in July 2022.

While the majority of Medi-Cal enrollees receive care through a managed care plan (88%), some enrollees remain in the fee-for-service (FFS) system (12%), so they are excluded from the analyses restricted to managed care. [19] In contrast, specialty mental health services, which are delivered through county plans, include persons enrolled in either managed care plans or the FFS system, because they are identified only by their county of residence as recorded on the Medi-Cal eligibility file.

From 2019-2022, access rates to managed care “mild-to-moderate” mental health services are relatively unchanged at ~12% of Medi-Cal enrollees with approximately 9-10 million persons eligible for services in any year. While continued engagement rates are expected to be lower, less than 4% of enrollees received five or more mental health services each year (**Figure 1A**).

FIGURE 1A. MANAGED CARE, FY 2019-2022
ACCESS AND CONTINUED ENGAGEMENT RATES OVERALL

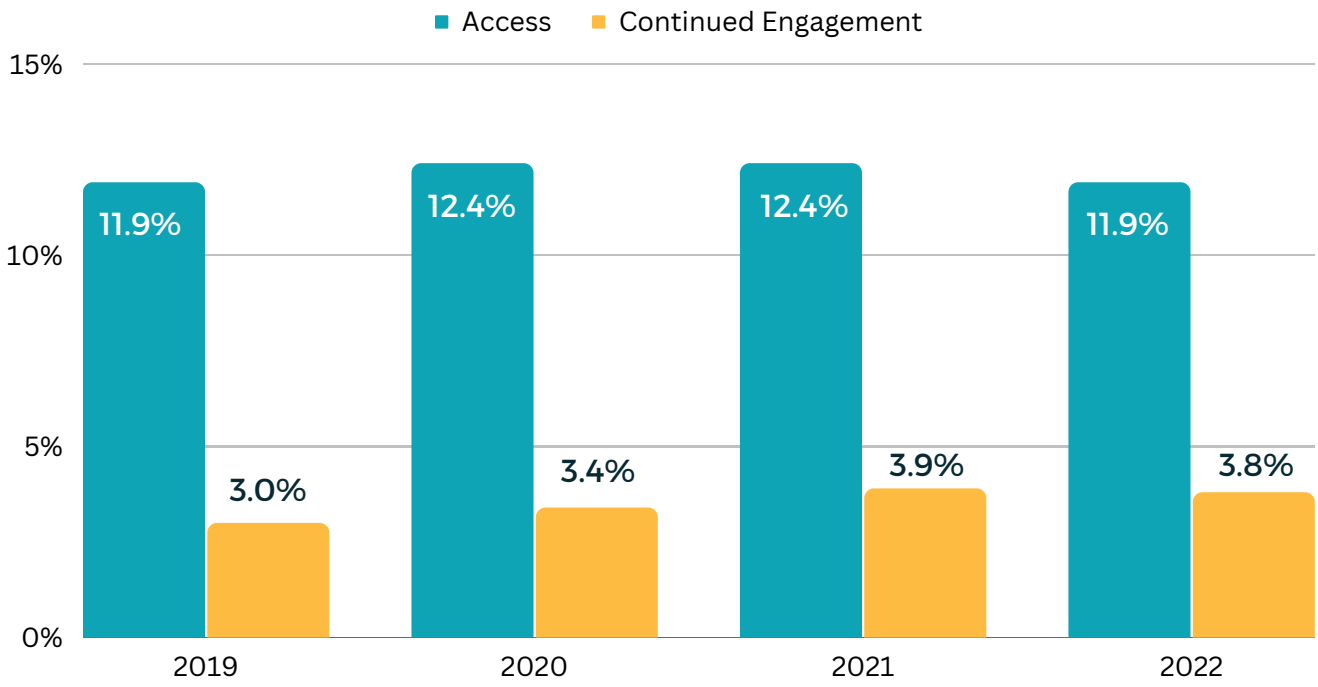
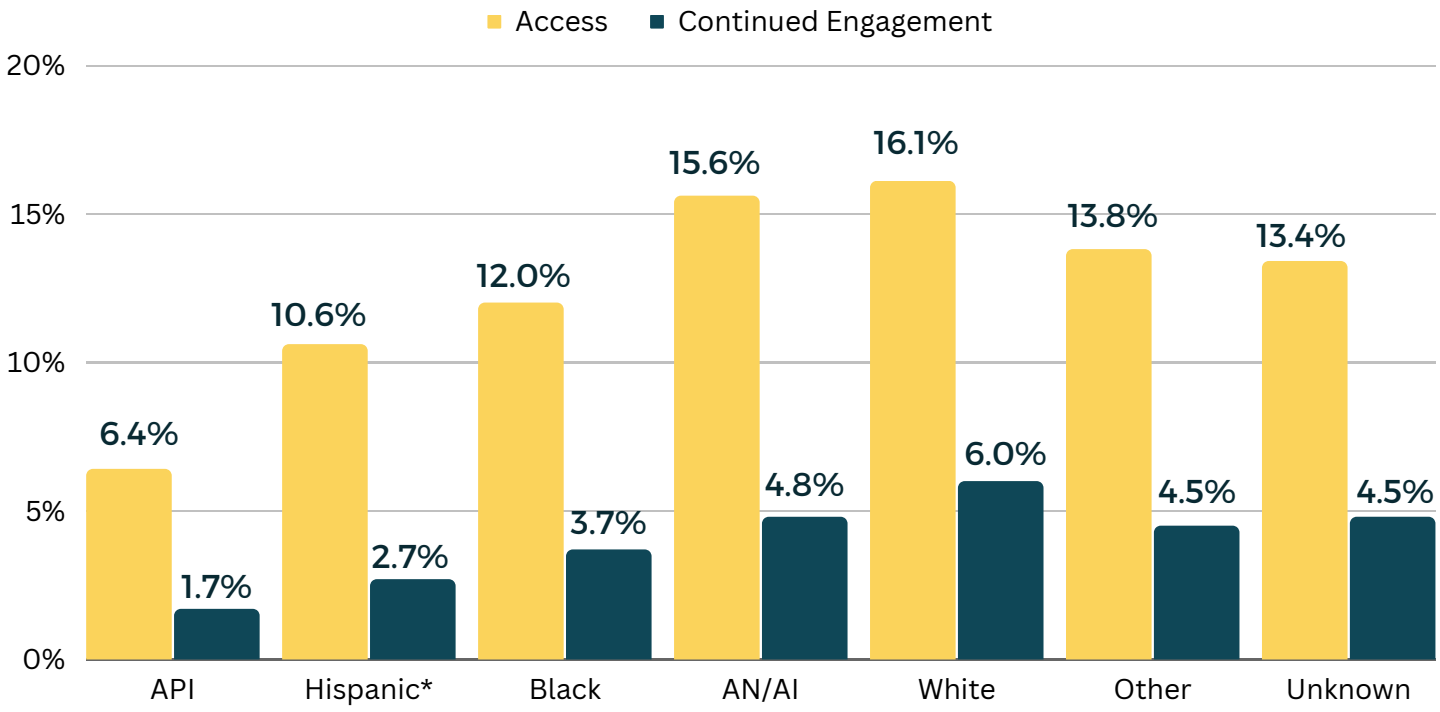


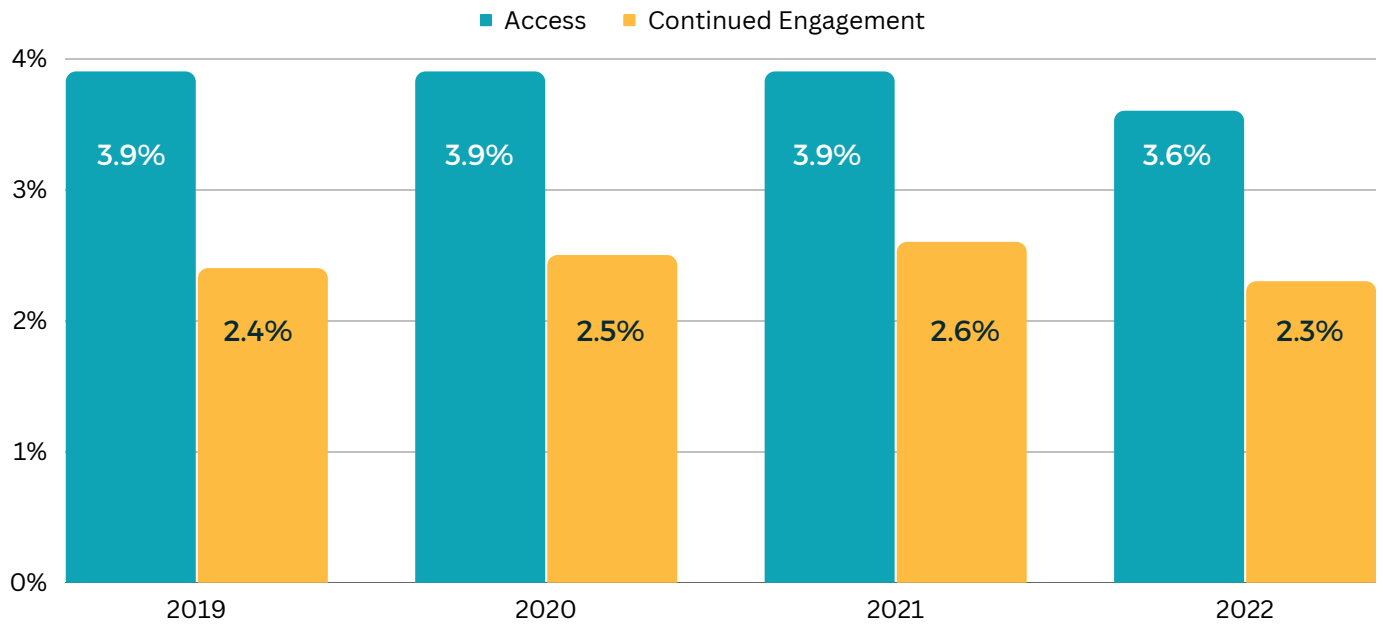
FIGURE 1B. MANAGED CARE, FY 2022
ACCESS AND CONTINUED ENGAGEMENT RATES BY RACE/ETHNICITY



*Hispanic is the terminology used in data collection, in text Latinx/e is used when describing this community.

The overall statewide access and continued engagement rates (**Figure 1A**) mask racial/ethnic disparities (**Figure 1B**). White Medi-Cal enrollees experience the highest access and continued engagement rates (16.1%, 6.0%, respectively), followed by Alaskan Native/ American Indian (AN/AI) enrollees (15.6%, 4.8%, respectively). Asian/Pacific Islander (API) enrollees have the lowest rates (6.4%, 1.7%, respectively), likely reflecting barriers to care. Moreover, as previously noted, communities of color are disproportionately enrolled in Medi-Cal (80%) compared to their representation within the total California population (64%). In 2022, while 1.7 million enrollees identified as white (22% of total enrollment), 3.1 million identified as Latinx/e (40%), nearly 950,000 as API (12%), about 620,000 as Black (8%) and nearly 33,000 individuals as part of the AN/AI community (0.4%). In addition, 17% of enrollees had other or unknown race/ethnicity recorded, hampering interpretation. [20]

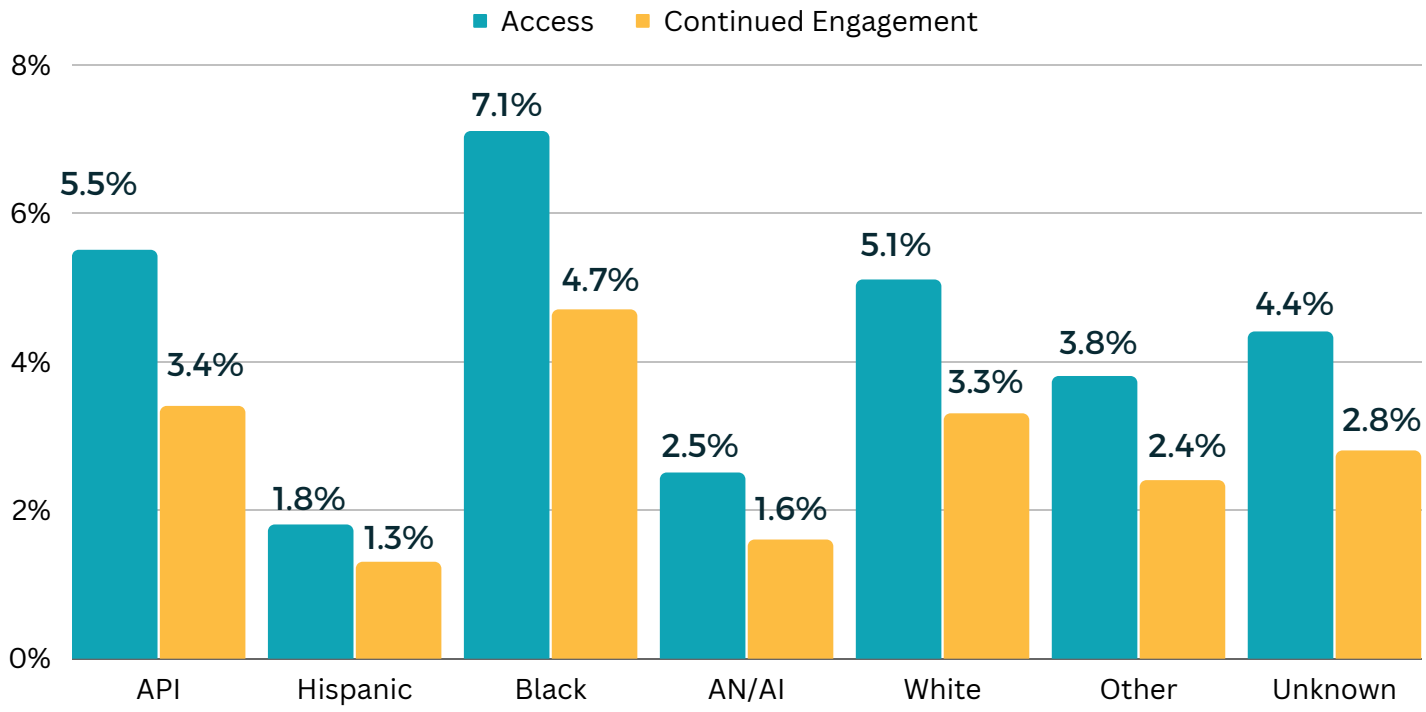
FIGURE 2A. COUNTY SPECIALITY MENTAL HEALTH SERVICES, FY 2019-2022 ACCESS AND CONTINUED ENGAGEMENT RATES OVERALL



From 2019-2022, access rates to county specialty mental health services are relatively unchanged at ~4% of Medi-Cal enrollees, with continued engagement rates just over half that rate (**Figure 2B**). Estimated rates of diagnosis of serious mental illness are relatively rare at 3.9% of Californians, but highest for AN/AI Communities (6.8%) and Black communities (5.3%). Again, these rates may also reflect access to care and discrimination in diagnosis, which could result in over or under-diagnosis (e.g., 1.5% for Asian communities). [21] In addition, the California Health Interview Survey (CHIS) indicates poor behavioral health among Californians exacerbated by the COVID-19 pandemic, with 19% of adults with lower income reporting serious psychological distress in 2020. [22]

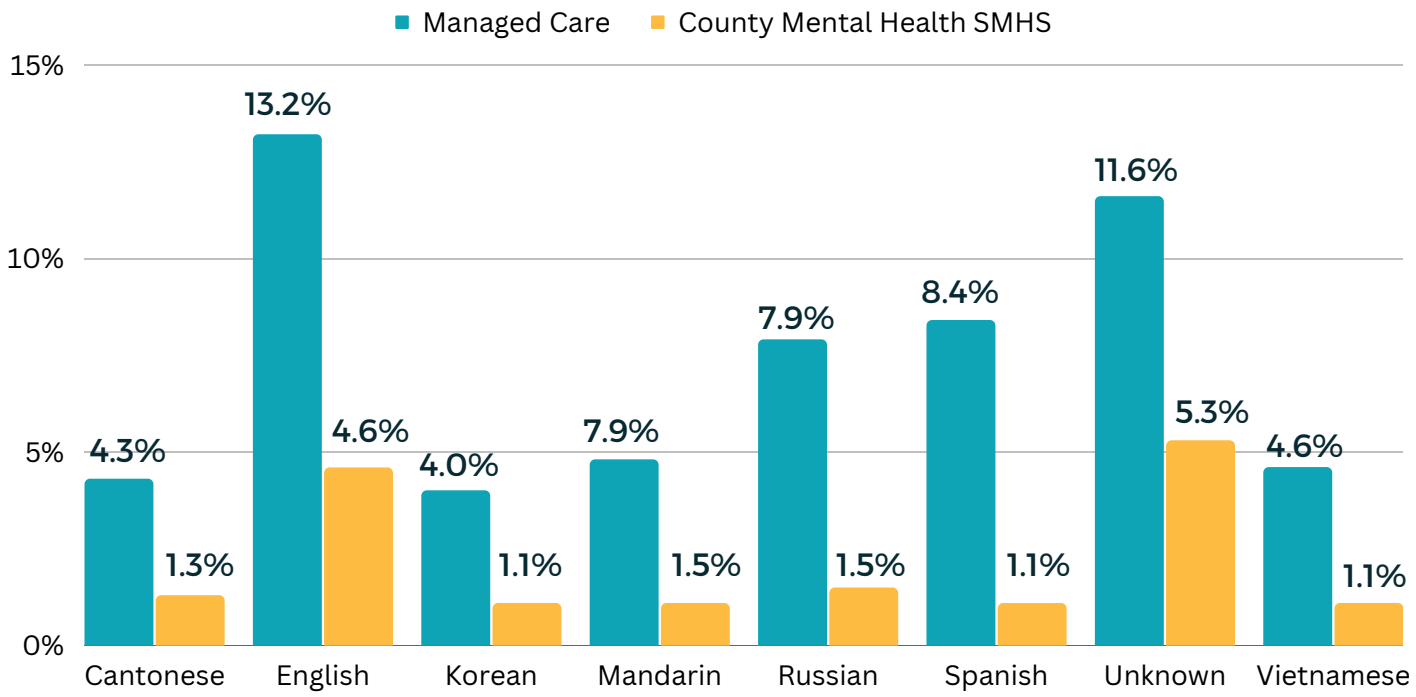
The overall statewide rates again mask racial/ethnic disparities. For reasons previously mentioned, it is difficult to know what the exact access rate should be, but there are no biological reasons to expect serious mental illness rates to differ by race/ethnicity. In addition, serious mental illnesses are chronic conditions that benefit from continuous care management, yet every community experiences continued engagement rates that are lower than their access rates, with the most pronounced drops for AN/AI (5.5% Access and 3.4% Continued Engagement) and Latinx/e communities (2.5% Access and 1.6% Continued Engagement, **Figure 2B**). In 2022, while 1.9 million enrollees identified as white (20% of total enrollment), 4.1 million identified as Latinx/e (43%), 1.1 million API (11%), about 706,000 as Black (7%) and nearly 39,000 individuals as part of the AN/AI community (0.4%). These statistics reinforce the disproportionate effect Medi-Cal has on communities of color. As with mild-to-moderate services delivered by Medi-Cal managed care plans, 17% of enrollees eligible for specialty mental health services through a county plan had other or unknown race/ethnicity recorded. [23]

FIGURE 2B. COUNTY SPECIALITY MENTAL HEALTH SERVICES, FY 2022
ACCESS AND CONTINUED ENGAGEMENT RATES BY RACE/ETHNICITY



The access and continued engagement rates for Medi-Cal enrollees who indicated English as their preferred written language (13.2%, 4.6%, respectively, **Figure 3**) are slightly higher but comparable to the overall statewide rates (11.9%, 3.8%, respectively, **Figure 1**). Access and continued engagement rates are considerably lower for the next seven most commonly preferred languages, especially among Asian languages such as Cantonese, Korean, Mandarin, and Vietnamese (~4 to ~5% and ~1%, respectively, **Figure 3**).

FIGURE 3. ACCESS RATES BY WRITTEN LANGUAGE (TOP 8), FY 2022



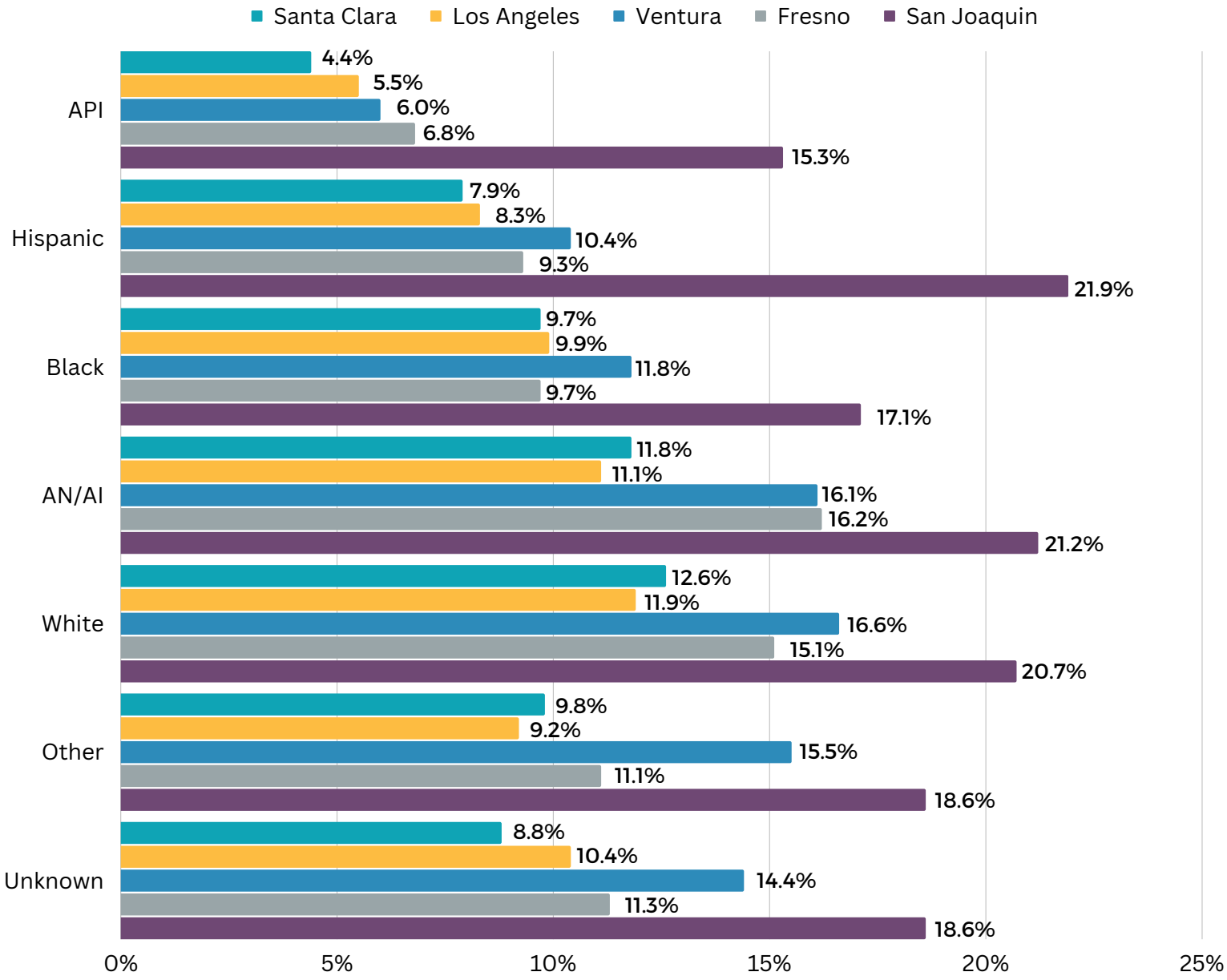
The next two figures focus on mental health access rates in the five counties (see table below) where the community-based organizations that participated as local-level entities for the 3rd and last year of the Right to Heal project were located. Given that this is a county-level analysis, the sample sizes for some race/ethnicity populations were relatively small. To not exclude data, we focus on the access rates (initial mental health encounter) to mild-to-moderate services as delivered by managed care plans and access rates to specialty mental health services as delivered by county plans for each of the race/ethnicity categories for which data is available.

County	Santa Clara	Los Angeles	Ventura	Fresno	San Joaquin
Population [24]	1,870,945	9,721,138	1,870,945	734,131	793,229
% Communities of Color [24]	73%	76%	73%	70%	74%
Local Level Entity	Indian Health Center of Santa Clara Valley	AltaMed	Mixteco Indígena Community Organizing Project	Fresno Interdeno-minational Refugee Ministries	Be Smooth, Inc
Statewide Partner	California Consortium for Urban Indian Health, Inc	Latino Coalition for a Healthy California	California Pan-Ethnic Health Network	Southeast Asia Resource Action Center	California Black Health Network

Local Level Entities

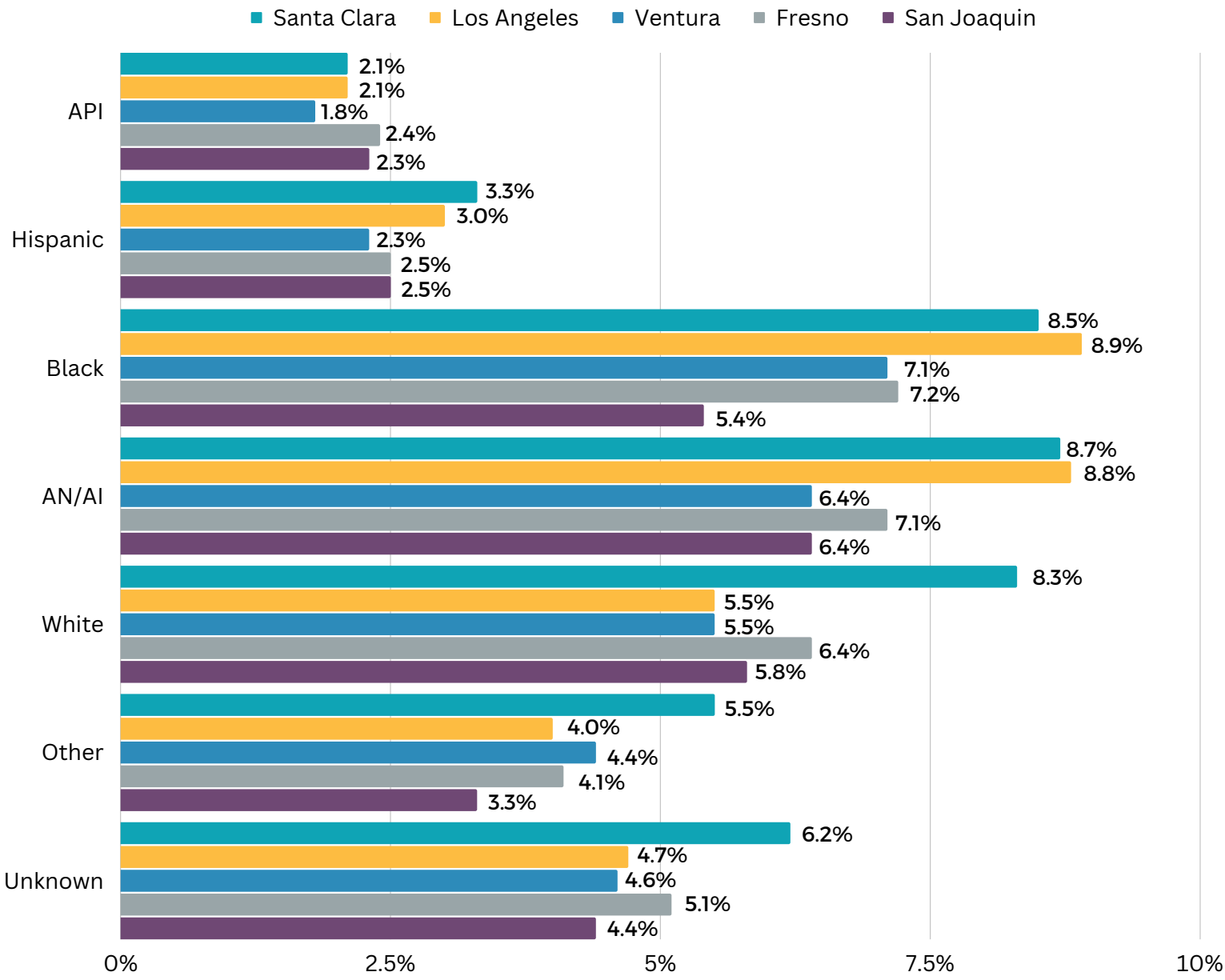
1. Indian Health Center of Santa Clara Valley
2. AltaMed
3. Mixteco Indígena Community Organizing Project
4. Fresno Interdenominational Refugee Ministries
5. Be Smooth, Inc

FIGURE 4. MANAGED CARE ACCESS RATES BY RACE/ETHNICITY, FIVE COUNTIES, FY 2022



There are clear racial/ethnic disparities in access rates to mild-to-moderate services as delivered by managed care plans within each of the five counties, with Asian/Pacific Islander and Latinx/e and then Black communities having the lowest access rates. What is most striking is the much higher rates of access in San Joaquin among all communities, even though disparities still persist (**Figure 4**). Future research should investigate whether specific characteristics (e.g., rideshare vouchers, translation services) of the managed care plan(s) available within San Joaquin and/or specific efforts such as outreach and education programs or other drivers of health (e.g., flexible employment arrangements, childcare availability) are contributing to the increase in access rates.

FIGURE 5. COUNTY SPECIALTY MENTAL HEALTH SERVICES ACCESS RATES BY RACE/ETHNICITY, FIVE COUNTIES, FY 2022



Interestingly, access rates for specialty mental health services to treat serious mental illness do not follow the same county pattern as access rates to mild-to-moderate care offered through managed care plans (**Figure 5**). Possible explanations include not only that the services are different, but the delivery system is as well (county plans vs. managed care plans). In addition, access to mild-to-moderate services has the potential to reduce the need for specialty mental health services. This pattern is seen in **Figures 4 and 5**. San Joaquin demonstrates high access rates for mild-to-moderate services but lower access rates for specialty mental health services meant to treat serious mental illness. In contrast, access rates

for mild-to-moderate care were relatively low in Santa Clara County, but access rates for serious mental illness care were relatively high in Santa Clara County. Again, future research and analysis should look more closely at this link and whether specific plans and/or programs are missing opportunities to help communities of color maintain their mental health.

Racial and ethnic disparities in mental health care within California continue to persist. Looking forward, the imperative to collect accurate, complete, and fully disaggregated data to monitor disparities is ever apparent. Comprehensive data provides insight into how policies and systems are working and how they can be improved in order to close the gap and advance racial health equity. This includes targeted resource allocation to those who need it most.

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Esther Lee, Policy Coordinator

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For more about CPEHN's work mobilizing communities of color to advocate for public policies that advance health equity and improve health outcomes, visit www.cpehn.org.

Endnotes

[1] A Right to Heal: Mental Health in Diverse Communities. Reports and related materials from 2021, 2022 and 2023 are available at: www.cpehn.org.

[2] American Medical Association, What is behavioral health? August 22, 2022. Accessed June 19, 2023.

[3] California Pan-Ethnic Health Network. Landscape of Opportunity. July 2023. Accessed September 28, 2023.

[4] Ibid.

[5] For more about Medi-Cal, see the California Department of Health Care Services (DHCS). Medi-Cal Resources. Accessed September 28, 2023.

[6] California's Department of Health Care Access and Information. Inpatient Hospitalizations and Emergency Department Visits for Patients with a Behavioral Health Diagnosis in California: Patient Demographics. Accessed September 28, 2023.

[7] U.S. Office of Disease Prevention and Health Promotion. U.S. Department of Health and Human Services. Healthy People 2030: Access to Health Services. Accessed September 28, 2023. Tong, M and Artiga S. "Use of Race in Clinical Diagnosis and Decision Making: Overview and Implications." December 9, 2021. Accessed September 28, 2023.

[8] Latino Coalition for a Healthy California. California bill that would disaggregate LatinX and Indigenous Mesoamerican data awaits Newsom's signature. September 22, 2023. Accessed September 26, 2023.

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[13] Kennedy, B. Pathologizing Bias: Racial Disparities in The Diagnosis of Schizophrenia. May 3, 2022. Writing Program at Brandeis University. Accessed September 28, 2023.

Endnotes (continued)

[14] Schwartz, R.C. and D.M. Blakenship. "Racial disparities in psychotic disorder diagnosis: A review of empirical literature. World Journal of Psychiatry. 2014 December 22; 4(4):133-140.

[15] AB470 data sets and charts are available at: DHCS Behavioral Health Reporting and MHS Dashboard Adult Demographic Datasets. Accessed September 28, 2023.

[16] California Pan-Ethnic Health Network (published by the California Health Care Foundation). "Mental Health Disparities by Race and Ethnicity for Adults in Medi-Cal." November 2020. Accessed September 28, 2023.

[17] Lewis, K. and A. Coursolle. Issue Brief: Mental Health Services in Medi-Cal, National Health Law Program, January 12, 2017. Accessed September 28, 2023.

[18] Ibid.

[19] California Department of Health Care Services (DHCS). Medi-Cal Enrollment and Renewal Data. Accessed September 28, 2023.

[20] Data not shown, but available upon request or at: DHCS Behavioral Health Reporting and MHS Dashboard Adult Demographic Datasets. Accessed September 28, 2023.

[21] California Pan-Ethnic Health Network. Landscape of Opportunity. July 2023. Accessed September 28, 2023.

[22] Panchal, N. et al."A Snapshot of Mental Health and Access to Care Among Nonelderly Adults in California." March 17, 2022. Accessed September 28, 2023.

[23] Data not shown, but available upon request or at: DHCS Behavioral Health Reporting and MHS Dashboard Adult Demographic Datasets. Accessed September 28, 2023.

[24] U.S. Census Bureau (2022). American Community Survey 1-year estimates. Census Reporter Profile page for Santa Clara County, Los Angeles, Ventura, San Joaquin and Fresno Counties of California. Accessed September 28, 2023.

California Pan-Ethnic HEALTH NETWORK