The Impact of California's Mental Health Service Provider Shortage: Inequitable Access to Infant and Early Childhood Mental Health Services

BRIEF

July 2024

FIRST 5 CENTER FOR CHILDREN'S POLICY

Executive Summary

The first five years of life mark a critical time for early childhood development. Early experiences and relationships with caregivers shape the architecture of a developing brain and lay the foundation for mental health across an individual's life. Despite the importance of mental health in the early years, the mental and behavioral health needs of infants, toddlers, and young children are often overlooked.

Only in recent years has California and our state leaders started to acknowledge that very young children can suffer from mental health concerns, that their wellness is dependent on their caregivers' wellness, and looked for ways to treat mental health concerns in the first years of life.

As California has started to more prominently acknowledge infant and early childhood mental health (IECMH) it has also made significant strides in increasing investments and launching initiatives in mental health for children. However, many of these investments are focused on older children. Furthermore, recent changes in mental and behavioral health funding through Proposition 1 and the Mental Health Services Act may soon impact the availability of community-based prevention and early intervention services for young children. **State and local governments must do more to ensure we meet the mental health needs of California's youngest.**

An important component of improving access to mental health services for young children is addressing the mental health provider workforce shortage impacting the nation and our state. This shortage is particularly acute for providers serving specific sub-populations of California children, such as children in Medi-Cal, infant and toddlers, and for providers that are cultural and linguistically relevant for the diverse population of children in the state. This workforce faces many of the same challenges leading to the broader mental health workforce provider shortage, including:

1. Low reimbursement rates and high administrative burden for Medi-Cal providers
2. High levels of provider attrition
3. Aging workforce
4. Insufficient investment in IECMH training

The cost of these challenges is borne by our most vulnerable children, exacerbating existing health disparities and putting them at an even greater disadvantage.

TO ADDRESS THESE CHALLENGES AND PRIORITIZE THE MENTAL HEALTH NEEDS OF INFANTS, TODDLERS, AND YOUNG CHILDREN, THIS BRIEF POSES SEVERAL KEY RECOMMENDATIONS FOR STATE LEADERS:

1. Embed basic training of IECMH for all individuals who have contact with children, such as early care providers and community health workers, through grants to employers and educational institutions.
2. Collect more robust data on IECMH providers across the state to more accurately assess the shortage of licensed and non-licensed IECMH providers.
3. Increase Medi-Cal reimbursement rates for all IECMH providers, especially for non-licensed community-based supports such as community health workers.
4. Expand investments in IECMH to increase the ways Medi-Cal members with toddlers and young children can access IECMH services, including but not limited to creating new Medi-Cal benefits focused on IECMH providers.
5. Proactively invest in mental health programs specifically for the birth to 5 population and the providers who serve them.

These recommendations aim to address the critical shortage of IECMH providers, improve access to mental health services for families with young children, and reduce the inequitable impacts of the current system. The success of California's mental health investments for infants and young children rests on having a culturally relevant workforce who can meet this population's needs.

By investing in the IECMH workforce and prioritizing the mental health needs of infants and young children, California can take significant steps towards building a more equitable and supportive mental health system that sets kids up for success during their most vulnerable time.

ACKNOWLEDGEMENTS

This brief was developed by the First 5 Center for Children's Policy and is the result of a research project on the current mental health service provider shortage in California and the inequitable impacts the shortage has on supporting the mental health of families with children ages birth to 5, particularly those on Medi-Cal, conducted by Sarah Kang, Berkeley Goldman School of Public Policy Graduate Student. The sources for this brief include a review of the available literature and stakeholder interviews with subject matter experts. Interviews, background research, and authorship of this paper were conducted by Sarah Kang and Jaren Gaither. Research supervision and editing support were provided by Sarah Crow, Alexandra Parma, and Jaren Gaither. Design support was provided by Melanie Flood and Tiana Cameron. The First 5 Center would like to thank the following individuals for their valuable insights, feedback, and recommendations:

Alan Ellis, assistant professor at North Carolina State University

Angela Vazquez, policy director at The Children's Partnership

Barbara Ivins, clinical director early intervention services at the University of California San Francisco's (UCSF) Benioff Children's Hospital

Janet Coffman, professor of health policy at Institute for Health Policy Studies at UCSF

Caryn Rizell, deputy director of health workforce development at the Department of Health Care Access and Information

Dulce Petty, senior director of early childhood mental health consultation at Kidango, Inc.,

Laurel Lucia, health care program director at the UC Berkeley Center for Labor Research and Education

Lishaun Francis, senior director of behavioral health at Children Now

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Table of Contents

Introduction

In 2004, California voters passed Proposition 63, known as the Mental Health Services Act (MHSA). Twenty years later, in 2024, Californians were once again tasked with going to the polls to vote on overhauling the MHSA. Proposition 1 (Prop 1) is a ballot initiative to amend the MHSA to fund additional behavioral health services and create $6.3 billion in bonds to build mental health treatment facilities. In March of 2024, Prop 1 narrowly passed. The passage of Prop 1 means counties will now need to update how they provide mental and behavioral health services with an expanded focus on housing and personalized support services.

While the passage of Prop 1 promises to bring in more funding for mental and behavioral health services for adults, there is concern that the expanded focus could mean less funding for infant and early childhood mental health (IECMH). Historically, the MHSA has been a vital source of funding for key prevention and early intervention services for California's youngest children. Much of this funding has gone to non-clinical community-based providers.

As California works to transform its Medi-Cal system, the state intends that more services that were once funded by the MHSA will now be funded by Medi-Cal. However, as families navigate various challenges with accessing these crucial Medi-Cal-covered services, including a dwindling IECMH provider workforce, it is important that children and their families do not get lost in the conversations around the distribution of MHSA funding.

Since the onset of the COVID-19 pandemic in 2020, the demand for mental health services has increased.[i] Despite increased demand, the supply of mental health service providers has sharply declined.[ii] The ever-widening gap between the need for mental health providers and its dwindling supply has become impossible to ignore as individuals struggle to find a mental health service provider who is able to meet their needs. The supply of providers is even more acute among specific populations, such as infants, toddlers, and young children, especially those on Medi-Cal.[iii,iv]

Although often overlooked in discussions about mental health needs, infants, toddlers, and young children suffer from mental health challenges like adolescents and teens. Yet, the mental health needs of infants, toddlers, and young children look different when compared to their older counterparts.

This population's mental health needs are unique and are closely linked to both early behavioral and cognitive development, and the relationship with their caregivers.

Attending to their mental health is critical to setting them up for a wide range of improved outcomes as they get older. This brief discusses the current infant and early childhood mental health (IECMH) landscape in California, attempts to quantify the number of IECMH service providers in the state, and offers an estimate of the number of licensed and unlicensed providers needed to mitigate the current mental health provider shortage.

This brief presents policy solutions to address the IECMH workforce shortage and, more broadly, presents how California can better support access to behavioral and mental health services for infants, toddlers, and young children.

Mental Health Service Demand Among Young Children

The mental health service needs of children as a general category are well documented. According to data collected by the Commonwealth Fund, 21 percent of California children who required treatment for mental health issues were unable to receive it.[v]

California's diverse population raises important issues about access to and availability of culturally responsive care.

Nationally, research shows that children and adolescents in racial, ethnic, and other minority groups experience inequities in access to care and disparities in outcomes for mental and behavioral health conditions.[vi]

In 2021, California ranked 38 out of 50 states for children's mental health care access.

Additionally, the CDC found that the percentage of children who had received any mental health treatment was highest among non-Hispanic White children and that this group was almost twice as likely to receive mental health services than Hispanic and non-Hispanic Black children.[vii]

The needs of young children – especially those ages birth to 5 – are a specific sub-category of all children that merits its own consideration. Children's brains develop connections faster in their first five years than at any other time in their lives, making early experiences during this time critical in shaping the brain.

During these early experiences, children learn to relate to others and manage and express emotions verbally and non-verbally. Positive early experiences help lay the foundation for brain development, behavioral, social and emotional development, and a child's lifelong health.

NO OTHER PERIOD IN A CHILD'S LIFE DEPENDS MORE ON THE EXTERNAL ENVIRONMENT FOR GROWTH AND DEVELOPMENT. BECAUSE OF THIS, IT IS CRUCIAL TO NOTICE THE WARNING SIGNS OF POOR INFANT AND TODDLER MENTAL HEALTH AND SEEK SUPPORT WHEN THEY DO ARISE.

Intervention during the first five years of a child's life can have a more powerful and lasting effect than interventions at other stages of development.

Infant and early childhood mental health is defined as the developing capacity of the child from birth to five years of age to form close and secure adult and peer relationships, experience, manage and express a full range of emotions, and explore their environments and learn – all in the context of family, community, and culture.[viii]

Factors that affect IECMH include their relationship with their caregiver, genetics and the environment they grow up in. Adverse childhood experiences (ACEs) such as neglect, abuse, or poverty can significantly impact the building blocks for positive IECMH. According to the Health Resources and Services Administration's National Survey of Children's Health, at least one in five children ages birth to 5 have experienced at least one ACE.[ix] Moreover, the social determinants of ACEs are not evenly distributed across all children.

Children across all races/ethnicities and socioeconomic backgrounds experience ACEs. However, multiple studies have shown that children of color, immigrant children, and children of lower socioeconomic backgrounds experience adverse childhood events at higher rates compared to their White and more well-off counterparts.[x,xi] With over half of children under age five in California being considered low-income and eligible for Medi-Cal, there is a large contingent of children who might require IECMH services.[xii]

Despite the need to prioritize IECMH, the number of young children who go undiagnosed with a mental health disorder and may benefit from mental health services far exceeds the number of children with a diagnosis. According to a 2016 study, approximately 1 in 6 U.S. children (17.4 percent) aged 2 to 8 had a diagnosed mental, behavioral, or developmental disorder. [xiii]

More recently, the American Academy of Pediatrics estimates that about 16 percent of children under age six have clinically significant mental problems requiring clinical care early in life.[xiv] Furthermore, the need for mental health support and services stretches beyond just those infants, toddlers, and young children who have received an official diagnosis. Many additional young children could benefit and are eligible to receive services but are not identified or connected to the appropriate resources.

The Infant and Early Childhood Mental Health Service Landscape for Children on Medi-Cal

As part of federal Medicaid requirements, the state must provide Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits to all children under the age of 21.

The EPSDT benefit requires Medicaid programs to cover comprehensive screening, diagnosis, treatment and preventative health care services, including behavioral health services, when they are necessary to correct or ameliorate any physical or behavioral conditions or to prevent disease, disability and other health conditions or their progression, to prolong life, and to promote physical and mental health and efficiency.[xv]

Per the Centers for Medicare and Medicaid Services, the goal of EPSDT is to ensure that individual children get the right care they need at the right time in the right setting.[xvi]

With over half of all children ages birth to 5 relying on Medi-Cal for their health coverage, the Medi-Cal program plays a significant role in ensuring these children receive the mental health support they need.

For children on Medi-Cal who require EPSDT mental health treatment, services are delivered through two concurrent systems. County Mental Health Plans (MHPs) are responsible for providing Specialty Mental Health Services (SMHS), including therapy, crisis intervention, and targeted case management.[xvii] A child is eligible for SMHS if they meet one of the following criteria:

- **CRITERIA 1:** has a condition placing the youth at high risk for a mental health disorder due to experiencing trauma evidenced by scoring in the high-risk range under a trauma screening tool, involvement in the child welfare system, juvenile justice involvement, or experiencing homelessness.
- **CRITERIA 2:** (a) has "a significant impairment, a reasonable probability of significant deterioration in an important area of life functioning, a reasonable probability of not progressing developmentally as appropriate, or a need for SMHS regardless of the presence of an impairment, that are not included as NSMS required to be provided by the MCP, and (b) has a diagnosed mental disorder, a suspected mental disorder not yet diagnosed, or a significant trauma placing the beneficiary at risk of a future mental health condition, based on the assessment of a licensed mental health professional. A mental health diagnosis is not required.[xviii]

In fiscal year 2021-2022, the SMHS program served approximately 23,000 children from birth to age 5.[xix]

On the other hand, Medi-Cal managed care plans (MCPs) or fee-for-service (FFS) providers are responsible for providing non-specialty mental health services (NSMHS), including mental health evaluation and dyadic services.[xvii] In 2021, DHCS updated its provider manual for all NSMHS to broaden eligibility.

The 2021 update affirms a child is eligible to when services are medically necessary as defined by EPSDT, regardless of level of distress or the presence of a diagnosis.[xx] These changes recognized the importance of attachment, family wellbeing, and caregiver mental health and bonding on early childhood development and mental health.[xxi]

Even with federal EPSDT mandates and the state's recent clarification of mental health service eligibility, children still face challenges receiving the mental health services they are entitled to. According to data from the 2022 National Survey of Children's Health, over 56 percent of children ages 3 to 17 experienced difficulty obtaining needed mental health treatment or counseling.[xxii] Furthermore, a 2019 audit by the Department of Health Care Services found that California ranked 40th in the nation for all states providing preventative services to children, which includes services such as EPSDT.[xxiii]

Among other difficulties families with children on Medi-Cal face as they navigate to services, a lack of providers focused on treating children on Medi-Cal was also cited as a key reason these children often do not receive the services to which they are entitled.[xxiv]

Since the 2019 audit, California has taken significant strides to address the challenges families and children on Medi-Cal face when accessing the mental and behavioral health services they need. One such initiative aimed at transforming the way California supports children, youth and families with mental and behavioral health needs is the **Children and Youth Behavioral Health Initiative (CYBHI)**. The CYBHI is a multi-year, multi-department, $4.7 billion initiative focused on promoting social and emotional wellbeing, preventing behavioral health challenges, and providing equitable, appropriate, timely, and accessible services for emerging and existing behavioral health (mental health and substance use) needs.[xxv]

In addition to the CYBHI, the state has also launched new Medi-Cal benefits focused on strengthening the caregiver-child relationship to improve the mental health and development of the family. In June of 2020, DHCS launched the **family therapy benefit**. Family therapy is covered under NSMHS, and its primary purpose is to approach children's health from a whole-family wellness lens. Family therapy focuses on improving family relationships and behaviors in the family and between individual family members, such as between a parent and child, two parents or other adult family members.[xxvi] Mental health providers can bill Medi-Cal for family therapy to treat a caregiver and child together based on family risk factors.

DHCS also created the **dyadic care benefit**, which launched in January 2023. Within the dyadic care model, the caregiver and infant or toddler are treated as a unit, which allows the healthcare team to understand and address developmental or behavioral health concerns in the infant or toddler and caregiver more quickly and comprehensively. Unlike the family therapy benefit, the child and parent/caregiver receive simultaneous treatment during a child's medical visit through the dyadic care benefit.[xxvii] Eligible services under the dyadic care benefit include integrated behavioral health services, screening, assessment, evaluation, and case management. [xxviii] Dyadic services can help identify behavioral health interventions and other behavioral health issues, provide referrals to services, and help guide the parent-child or caregiver-child relationship. By treating children and parents or caregivers together as a dyad, families on Medi-Cal can receive targeted treatment to support healthy child development and mental health.

The CYBHI, family therapy benefit, and dyadic care benefit represent a significant policy shift within Medi-Cal to prioritize the health and wellbeing of parents/caregivers with infants, toddlers, and young children. However, challenges still exist to accessing these crucial services—namely, workforce challenges. **As Medi-Cal MCPs and providers work on implementing these new initiatives and benefits, mental health workforce provider shortages create new challenges for families trying to access these services.**

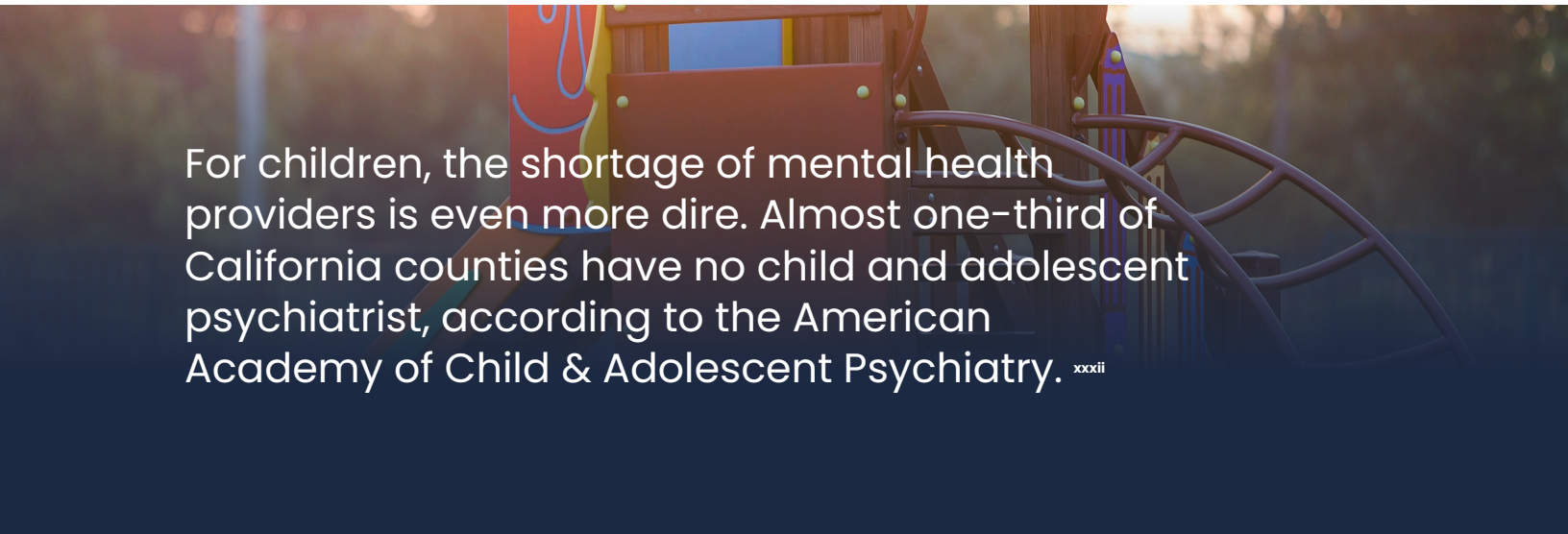
California's Mental Health Service Provider Shortage

While the state has made a concerted effort to prioritize a whole-child approach to improving the landscape of infant and early childhood mental health, families with young children still face barriers to accessing timely and appropriate services. As mentioned previously, limited access to providers is one of the most pressing barriers to accessing services.

A primary driver behind limited access to providers is the current mental health service provider shortage. According to a report by Definitive Healthcare, of the 145,000 healthcare providers who left the national workforce in 2021 and 2022, over 11,000 were psychologists and psychiatrists.[xxix] Moreover, per the Health Resources and Services Administration (HRSA), the country has seen a two percent decrease (roughly 2,500 providers) in the total supply of mental and behavioral health providers from 2021 to 2023.[xxx] This gap is only expected to increase through 2036, according to HRSA's workforce projections.[xxx] The decline of the child-serving mental health workforce has significantly impacted the ability of children to receive the treatment they need. Approximately half of children nationally who have a mental health disorder do not receive treatment in part because of the workforce shortages, the uneven distribution of providers, and increased demand for mental health services amongst this population post-COVID-19. [xxxi, xxxii]

The shortage of mental health providers is nothing new. In 2018, the University of California, San Francisco (UCSF) released a report detailing the critical shortage of licensed mental health professionals for all patients within the state. The report found that 23 of 58 California counties had fewer than one psychiatrist per 10,000 residents, and six counties had no psychiatrist at all.[xxxi]

The authors predicted that by 2028, the shortage of mental health providers would be even more severe.[xxxi]



For children, the shortage of mental health providers is even more dire. Almost one-third of California counties have no child and adolescent psychiatrist, according to the American Academy of Child & Adolescent Psychiatry. [xxxii]

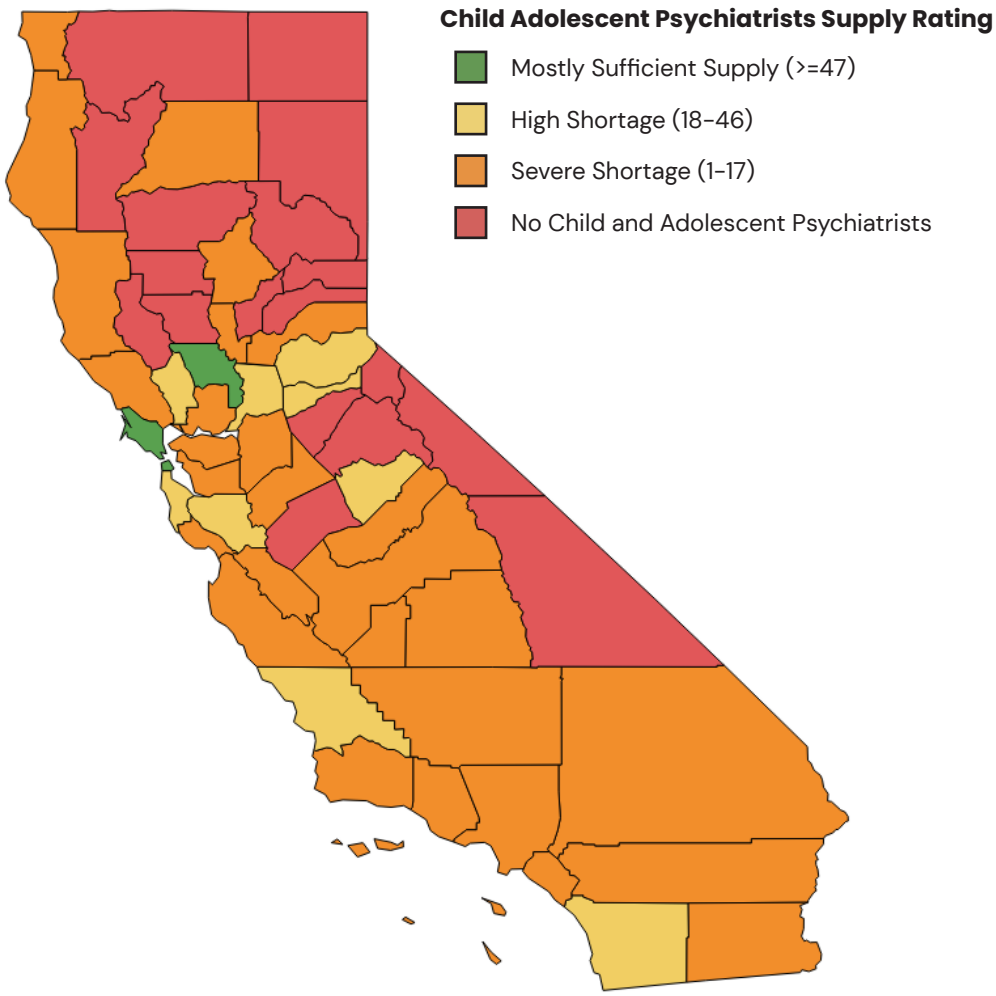


FIGURE 1: HEAT MAP OF THE SUPPLY OF CHILD AND ADOLESCENT PSYCHIATRISTS 2022[1]

The American Academy of Child & Adolescent Psychiatry's data for child and adolescent psychiatrists is a helpful starting point to ground our understanding of the mental health provider shortage facing infants, toddlers, and young children. However, their data is not generalizable to the rest of the IECMH workforce.

Few data points exist to provide additional context to the IECMH provider shortage. Moreover, this brief recognizes that licensed clinical providers like psychiatrists are not the only IECHM providers available and that unlicensed providers play a crucial role in providing IECMH services.

[1] Poolman, I. (2024, April 12). Workforce Maps by State: 2022 CAPs. American Academy of Adolescent and Child Psychiatry. **https://www.aacap.org/aacap/Advocacy/Federal_and_State_Initiatives/Workforce_Maps/Home.aspx**

What accounts for the mental health service provider shortage?

The lack of pediatric psychiatrists and other mental health professionals who specialize in caring for infants and toddlers' mental health is attributable to many factors that are the same as the reasons for the overall mental health provider shortage and some factors that are distinct. Research indicates that low reimbursement rates, high levels of attrition, and an aging workforce are all holding back the supply of mental health providers.

LOW REIMBURSEMENT RATES AND HIGH ADMINISTRATIVE BURDEN FOR MEDI-CAL PROVIDERS

According to interviews, providers are increasingly able to attract clients without having to accept insurance.[xxxiii] This trend makes treatment less accessible to all clients, especially for those who qualify for Medi-Cal. Mental health providers cite low reimbursement rates and administrative burdens as reasons for not accepting Medi-Cal insurance.[xxxiv] Data from 2017 indicate that the median rate for a therapy session in California was $120, far above the $98 paid by Medi-Cal fee-for-service.[xxxv, xxxvi]

HIGH LEVELS OF ATTRITION

Another contributing factor to the mental health service provider shortage is the incredibly high attrition rates among mental health providers. According to the National Union of Healthcare Workers, which represents mental health service providers for Kaiser in California, Kaiser's rate of attrition for mental health clinicians doubled to 16 percent in 2022.[xxxvii] Nationally, one survey of behavioral health facilities found that turnover among mental and behavioral health service providers was approximately 27 percent in 2022.[xxxviii] The literature suggests that burnout, emotional exhaustion from excessive workloads, and work-life conflict affect turnover intention for mental health service providers.[xxxix] No information was available specifically about the mental health workforce that serves young children.

AN AGING WORKFORCE

According to 2022 data from the California Department of Health Care Access and Information (HCAI), 19 percent of clinical social workers, 29 percent of marriage and family therapists, and 10 percent of professional clinical counselors are 60 years or older.[xl] Additionally, UCSF's behavioral health workforce report states that 31 percent of psychiatrists are 65 or older.[xli] This research predicts that the current shortage will be exacerbated once this cohort of providers retires within the next five to ten years, and it is likely that the COVID-19 pandemic accelerated this timeline.

INSUFFICIENT INVESTMENT IN IECMH TRAINING

According to experts, California's IECMH provider base is further reduced because of a lack of systemic support for IECMH, a lack of IECMH specific training within degree granting programs, and the complexity of California's mental health service system.

How many mental health service providers do we need for California's infants and toddlers?

There is no uniform standard for the number of mental health providers that constitutes a sufficient workforce supply for a population. The Department of Health and Human Services' (HHS) Health Professional Shortage Area (HPSA) designation and the American Academy of Child and Adolescent Psychiatry's standard for child and adolescent psychiatrists are two common measures of a sufficient workforce of mental health service providers. The HPSA designations identify areas and population groups within specific geographies experiencing a shortage of health professionals.[xliii]

There are three categories of HPSA designations based on the health discipline experiencing the shortage: 1) primary care, 2) dental, and 3) mental health. Although the HPSA designation is helpful in getting an overall picture of the current mental health provider shortage in California, the available data does not enable us to drill deeper into the child provider shortage. Currently, the HPSA designations data for mental health providers cannot be stratified by the providers' population of focus. Therefore, using the HPSA designations data only provides a high-level picture of the current mental health provider workforce shortage and does not enable us to delve deeper into the specific workforce shortages facing providers who focus on the children and youth populations. Because of this, for this brief, we opt to use the American Academy of Child and Adolescent Psychiatry's standard for child and adolescent psychiatrists as our baseline measure for an adequate supply of IECMH providers; it is the only measure of need for licensed mental health providers for children.

According to the Academy, a "mostly sufficient supply" of child and adolescent psychiatrists is 47 per 100,000 children.[xxxii] Currently, California has 1,358 registered child and adolescent psychiatrists.[xlii] This equates to a ratio of 15 child and adolescent psychiatrists per 100,000 children. California would need approximately 2,900 additional child and adolescent psychiatrists to meet the "mostly sufficient" standard set by the American Academy of Child and Adolescent Psychiatry.

While this standard is helpful for understanding the current shortage of psychiatrists, it does not tell the whole story of infant and early childhood mental health providers.

HOME VISITING is one way families can receive mental health support outside a clinical setting. Home visiting connects caregivers-to-be and caregivers of infants and toddlers with a designated support person — typically a nurse, early childhood specialist, or other trained professional — who guides them through the early stages of raising a family. Home visitors support overall family wellbeing and can provide referrals and resources directing families to mental health services, when needed. However, home visitors typically are not trained or credentialed to provide clinical mental health services.

The insufficient supply of pediatric mental health providers results in significant impediments for children and youth in need of mental and behavioral health services. However, community-based mental health supports and care outside of the traditional clinical setting are often the first access points for families whose children have mental health needs.

Community-based providers and programs that also support infant and early childhood mental health include home visiting, IECMH consultation (IECMHC), and more.

Although home-visiting programs vary considerably in their approaches and primary goals, research shows the services they provide result in improved parenting and family outcomes, and as a byproduct, child outcomes.[xliii] Evaluations of home-visiting programs have shown evidence of improving outcomes in maternal and child health, child maltreatment, parenting, and child mental health.[xliv]

Furthermore, home visiting programs like Nurse Family Partnership, Healthy Families America, and Parents as Teachers include routine screening for depression, modules educating clients about a variety of mental health and parenting issues, and recommend home visitors receive mental health endorsements to demonstrate basic skills and knowledge in mental health principles and practices.[xlv,xlvi,xlvii]

There have also been models specifically developed to target behavioral and mental health challenges. SafeCare is one such model. SafeCare is a short-term home visiting model that provides behavioral skills training to families with histories of abuse and neglect.[xlviii] The model includes one-on-one home visits between community-based home visitors and families/caregivers focused on three modules: (1) infant and child health, (2) home safety, and (3) parent-infant/parent-child interactions. Evaluations of SafeCare and similar infant mental health home visiting models show their effectiveness in promoting optimal child mental health and social-emotional wellbeing.[xlix]

The services offered by home visiting programs enable families with infants and toddlers who may otherwise be unable to receive support through traditional health services, to obtain earlier recognition and intervention for their mental health needs.

Home visiting services are also often provided by culturally congruent providers. In 2021, First 5 California (F5CA) conducted a home visiting workforce study with over 900 home visitors to better understand the landscape of California's home visiting workforce.[l] F5CA found that the majority of California's home visiting workforce identifies as Hispanic or Latinx and speaks Spanish fluently. The demographics of the state's home-visiting workforce closely mirrors the families being served, with most families comprising home visitor caseloads also identifying as Hispanic or Latinx and reporting Spanish as their second most commonly spoken language behind English.

Furthermore, the report found that almost all home visitors (90 percent) reported sharing racial, ethnic, or cultural traits with at least some of the clients that their program serves, with the majority (67 percent) reporting that they share these traits with most of the clients they serve.[lvi] This is an important finding because California's children of color have unique needs that our traditional healthcare system cannot always meet.

Having providers who can deliver culturally congruent services in the home or other community-based settings who share the same language, cultural values, or lived experiences contributes to building a stronger relationship and improves the quality of care delivered.

IECMH CONSULTATION is another way to provide community-based mental health support outside traditional clinical settings. IECMH consultation is evidence-based and prevention-focused. It pairs mental health professionals, such as IECMH mental health specialists or clinicians, with other professionals and systems working in the community who are involved in the care and support of young children's mental health. IECMH consultants support early childhood educators, childcare providers, CBOs, and other professionals and organizations working to improve IECMH.

The benefits of IECMH services include helping families overcome access barriers to mental health care and connecting families and educators with more intensive mental health or early intervention services; building organizational capacity to support healthy social and emotional development of children; and reaching families from historically marginalized communities, including low-income families of color, through community-based IECMH programs and services.[lii]

ADDRESSING THE MENTAL HEALTH PROVIDER SHORTAGE

California has implemented several programs with the goal of addressing the current mental health provider shortage, specifically focusing solely on providers serving young children, adolescents, and young adults. As discussed earlier, California's CYBHI has been the key policy initiative aimed at mitigating the current provider shortage.

As of January 2023, CYBHI initiatives have awarded over $100 million in grants, loan repayment programs, scholarships, training programs, and career pathway programs to increase the number of mental and behavioral health professionals to improve children and teen's ability to access high quality mental and behavioral health services. Investments through programs such as the Psychiatric Education Capacity Expansion grant and the Peer Support for Transition-Aged Youth have supported the training of over 700 psychiatric mental health nurse practitioner students and over 2,500 peer support specialists, respectively, to address the mental health needs of children and youth ages 0 to 25.

These programs represent a strong foundation for continuing funding investments to support child-serving providers. However, CYBHI programs currently lack an intentional focus on building the workforce provider capacity focused on early childhood. Future CYBHI investments and other investments focused on supporting the child-serving mental and behavioral health workforce should intentionally focus on building pipelines, specifically for early childhood providers.

The following table lists CYBHI programs focused on creating a more prominent and representative workforce.

PROGRAM NAME	AMOUNT AND DESCRIPTION
Psychiatric Education Capacity Expansion Grant (PECE)	$37.6 million in grants to support psychiatric mental health nurse practitioner training programs and psychiatry residency programs.
Scholarship and Loan Repayment Programs	$10.25 million between August and October 2022 was awarded for scholarship and loan repayment for behavioral health professionals in California.
Peer Support for Transition-aged Youth	$9.5 million in Peer Personnel Training & Placement grants to support the workforce development of 18–25-year-olds.
Behavioral Health Career Pathways	$23 million in Health Professions Pathway Program (HPPP) grants for "career pipeline programs, summer internships, and fellowships for students from underrepresented regions and backgrounds who are interested in behavioral health careers."
Community-Based Organization (CBO) Behavioral Health Workforce Grant Program	Unspecified amounts for scholarships, stipends, loan repayments, recruitment support, and retention payments for current and future behavioral health professionals.
Social Work Education Capacity Expansion	Unspecified amount to go towards grants to develop bachelor's and master's level social work programs within educational institutions.
Justice-and-System-Involved Youth	Unspecified amount to develop behavioral health training for non-behavioral health professionals working with this population.
Trauma-Informed Training for Educators	Unspecified amount towards developing a voluntary training for childcare providers, educators, and school personnel to support students experiencing ACEs.
Early Talents	Unspecified amount to developing and implementing a program to incentivize a diverse group of high school students to choose a career in behavioral health.

Source: Children and Youth Behavioral Health Initiative[iii]

A range of policy solutions for California to continue prioritizing the mental health needs of infants, toddlers, and young children.

Recommendations for California

California has rallied around the need to address the state's mental health provider shortage. From Governor Newsom's commitment to improved behavioral health initiatives to the CYBHI and new Medi-Cal benefits directed at strengthening the family unit, the state has made significant progress in developing programs and initiatives supporting IECMH. Yet, there are still areas presenting significant challenges to families with young children in need of mental and behavioral health services.

1. EMBED BASIC TRAINING OF IECMH.

Interviewees for this report highlighted the need for everyone who has contact with children, such as teachers and community health workers, to be trained on the basics of IECMH. The state should provide grants to employers, community colleges, and community-based organizations to fund this training. Additionally, there is an opportunity to train existing mental health professionals to provide IECMH services. Through state and county funding sources, including the CYBHI, the state could fund a certificate program for existing mental health professionals to become certified in providing IECMH services.

2. COLLECT MORE AND BETTER DATA ON INFANT AND EARLY CHILDHOOD MENTAL HEALTH SERVICE PROVIDERS.

Though several news articles and studies have been published on the mental health provider shortage, most of them focus on the number of psychiatrists per 100,000 of the population as an indicator of a sufficient or insufficient mental health provider workforce. This measure does not capture the complete scope of IECMH providers. Child and adolescent psychiatrists make up only a fraction of the workforce providing IECMH services. The IECMH workforce is multidisciplinary. There is a large contingent of non-licensed service providers who fall outside of the traditional healthcare setting whose needs have not been studied as intently. Better data needs to be collected to understand the scope and severity of the IECMH workforce shortage. Data collected must include traditional clinical providers like psychologists and psychiatrists and community-based providers such as home visitors and CHWs to assess the IECMH provider needs more accurately.

3. RAISE MEDI-CAL RATES FOR MENTAL HEALTH PROVIDERS AND COMMUNITY-BASED PROVIDERS THAT SUPPORT IECMH.

The Medi-Cal program provides essential healthcare services to low-income Californians, including mental health services. Unfortunately, many mental health service providers are reluctant to accept Medi-Cal patients because the reimbursement rates are so low, exacerbating the state's shortage of mental health providers. This is particularly problematic as it leaves vulnerable populations, including young children and people experiencing homelessness, without access to necessary healthcare.

In May of 2023, the California legislature passed the 2023 – 2024 health budget trailer bill which renewed the state's Managed Care Organization (MCO) Tax. As part of this bill, rates for certain Medi-Cal services saw their largest increase to date. Included in the Medi-Cal rate increases was non-specialty mental health services. These rate increases took place January 1, 2024. It is too early to determine the affect these rate increases will have on the delivery of non-specialty mental health services for families/caregivers with children prenatal to age 5, but given the existing reimbursement disparities between private pay and Medi-Cal, and the lack of workforce investments in CalAIM, more must be done to attract IECMH providers to shore up the current workforce shortage.[liii]

Community-based providers, such as CHWs, face similar challenges as mental health providers when attempting to receive reimbursement through Medi-Cal. Current CHW reimbursement rates are low and do not reflect the full range of services CHWs provide. Their work includes looking for families and traveling to and from engagement with families which is not reimbursable. Given low reimbursement rates and complications billing for Medi-Cal, CHWs can be dissuaded from attempting to access the CHW benefit for the services they provide.

For more details about the essential services CHWs provide to families and caregivers with children, and for additional information on advocacy opportunities to boost California's CHW workforce, read the brief **"Community Health Workers Advancing Child Health Equity: Part II"** co-authored with The Children's Partnership.

By raising Medi-Cal rates for mental health service providers and other community-based providers, the state can incentivize more providers to participate in the program and expand access to critical mental health services and supports. This policy has the potential to improve mental health outcomes, reduce healthcare costs associated with untreated mental illness, and improve the overall quality of life for individuals struggling with mental health challenges. Additionally, investing in mental health services can have ripple effects, including reducing homelessness, improving school performance, reducing crime rates, and increasing cost-effectiveness.[liv]

4. INCREASE INVESTMENTS IN COMMUNITY-BASED PREVENTION.

In addition to raising the rates Medi-Cal pays for mental health services, the state could also create new benefits to expand the ways Medi-Cal members can access mental health services. For example, California could create a home visiting Medi-Cal benefit to dramatically expand access to home visiting services for low-income California families. As mentioned above, home visiting is one way families and caregivers with infants, toddlers, and young children can improve overall wellbeing and get support in accessing needed mental and behavioral health services.

Community-based organizations fund essential IECMH programs and infrastructure within their local communities. However, many organizations, including First 5s, are running up against challenges in finding sustainable financing for the programs they operate. The state should also provide sustained investments in community-based prevention and early intervention programs with a proven efficacy of supporting healthy child mental health development and/or programs that identify mental and behavioral health problems early. The state should look for ways to create evergreen funding sources for these organizations and programs.

5. PROACTIVELY INVEST IN MENTAL HEALTH PROGRAMS SPECIFICALLY FOR THE BIRTH TO 5 POPULATION AND THE PROVIDERS WHO SERVE THEM

Approximately 20 percent of California's children are ages birth to 5. Despite representing a large proportion of the state's children and youth population, this group receives only a fraction of the child-focused mental health funding compared to their older counterparts. While treating mental health challenges is critical at any age level, investing in early

childhood mental health ensures children receive the care they need during their most formative years. To ensure the unique mental health needs of children ages birth to 5 are met, the state should dedicate a proportion of future mental health funding for children specifically for the birth to 5 population and the providers who serve them. By strategically allocating funds for these groups, the state has an opportunity to recognize the importance of early identification and treatment in addressing mental health challenges now and its role in promoting overall well-being and resilience later in life.

Conclusion

Timely mental health support helps children build positive social, emotional, behavioral, and cognitive skills necessary to build a good foundation for better mental health and wellbeing later in life. While California has begun implementing policies focused on improving the IECMH workforce, more policies and initiatives focused on providers serving the infant and early childhood population must be explicitly implemented. Having providers and the requisite support systems in place to identify and treat the mental health needs of infants, toddlers, and young children is critical.

Ultimately, if California is serious about addressing the mental health disparities of the infant and early childhood population, more research is required to accurately assess the IECMH workforce in the state. Currently, data is limited for obtaining an accurate estimate of California's IECMH workforce shortage; however, we know that there are not enough to fulfill the needs of California's young children.

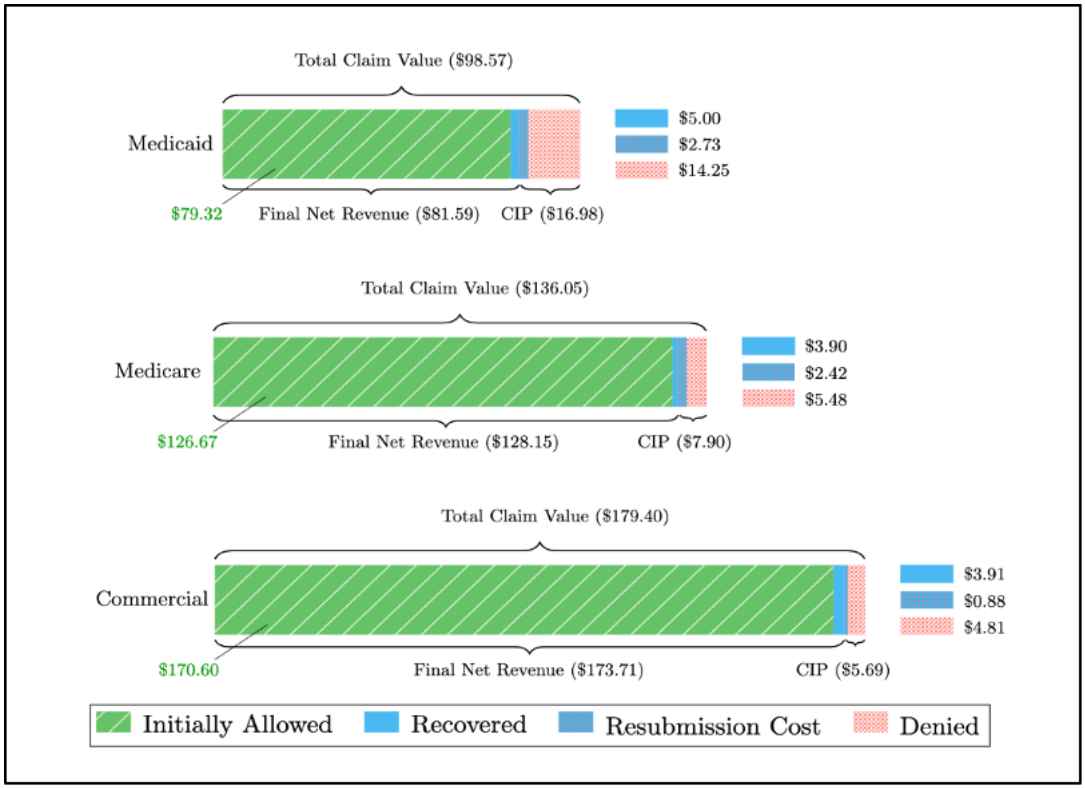
Moreover, insufficient financial incentives undermine Medi-Cal care provision, which is inherently inequitable for California's most vulnerable babies. Future policies must be implemented with this population in mind to reduce the inequitable impacts of the current IECMH provider shortage.

Appendices

Appendix A: Examples of Medi-Cal reimbursement rates from California, New York, and Alaska.

	CALIFORNIA[lv,lvi]	NEW YORK[lvii,lviii]	ALASKA[lix]
Family Psychotherapy with patient present	$89.65	$70.70	$130.76
Individual Psychotherapy, 60 minutes	$98.02	$105.07	$127.96
Group Psychotherapy, 30 minutes	$14.48	$21.47	$25.59

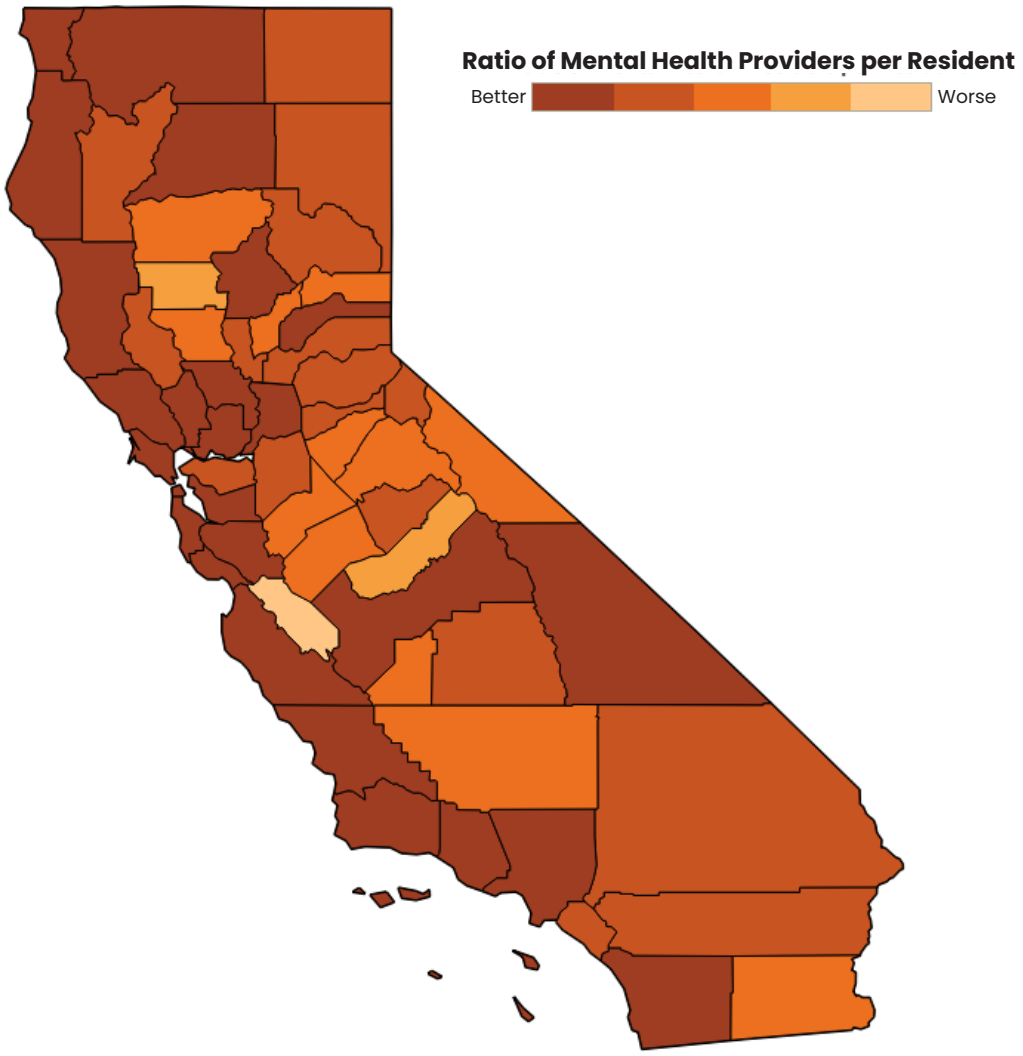
Appendix B: Average loss on a claim for Medicaid, Medicare, and Commercial insurance plans.



This figure visualizes the average loss on a claim for Medicaid, Medicare, and Commercial insurance plans. These data are collected from doctor's offices across the country.

Source: Dunn et al.[lx]

Appendix C: County Health Rankings Report – Ratio of Mental Health Providers per Resident using National Provider Identification (NPI) Registry data 2023[lxi]



Appendix D: Actively Licensed Behavioral Health Professionals per 100,000 Population by Region, 2020

Region	Psychiatrists	Psychologists	LCWs	LMFTs	LPCCs	Psych Techs
Central Coast	14.7	47.0	61.7	144.2	5.2	52.5
Greater Bay Area	25.2	72.4	82.6	134.9	6.8	17.8
Inland Empire	9.4	16.1	39.4	61.5	3.8	41.3
Los Angeles	15.6	48.8	81.3	106.5	4.0	8.8
Northern & Sierra	7.8	21.5	64.3	98.8	5.4	12.6
Orange	11.0	40.0	56.6	105.9	5.6	15.1
Sacramento Area	14.9	37.1	71.6	97.0	5.6	12.3
San Diego Area	17.1	55.6	65.6	95.2	7.4	3.1
San Joaquin Valley	7.0	16.0	35.1	47.7	2.5	57.7
California	15.2	44.2	65.9	100.8	5.0	22.7

Sources: *Medical Board of California Mandatory Survey, 2020, private tabulation; Department of Consumer Affairs, Public Information Licensee List; U.S. Census Bureau, Annual Estimates of the Resident Population for Counties in California: April 1, 2020 to July 1, 2021.*

California's behavioral health professionals are not evenly distributed across the state. Appendix D displays ratios of psychiatrists, psychologists, LCSWs, LMFTs, LPCCs, and psychiatric technicians per 100,000 population by region in 2020. The regions are defined by county and reflect the regions used by the California Health Interview Survey. Ratios per 100,000 population are displayed so that supplies of licensed behavioral health professionals can be compared across regions that have populations of different sizes. Ratios in green indicate the region with the highest ratio per capita, and ratios in red indicate the region with the lowest ratio per capita.[lxii]

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