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Health Policy Brief

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Nearly 2 Million California Adults Not Getting Needed Public Mental Health Services

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"The Mental Health Services Act (MHSA) paves a path toward a 'help first' approach with prevention and early intervention."

SUMMARY: Studies of unmet mental health service needs have typically focused on populations requiring intensive services, such as individuals with serious psychological distress (SPD). Such efforts are critical, as these are often individuals with severe mental health challenges. At the same time, that focus inadvertently misses the vision behind Prevention and Early Intervention (PEI) efforts, mandated in Proposition 63, to intervene early and prevent mental health problems from becoming more severe and disabling. In addition to examining the unmet mental health service needs for adults with SPD who are eligible (definition on page 2) for services through the Mental Health Services Act (MHSA), this policy brief presents the first analysis that identifies and examines the unmet service needs among adults who have moderate psychological distress (MPD) —a group that may benefit from MHSA's PEI services. Based on data from the 2018 California Health Interview Survey (CHIS), approximately 11 million California adults were MHSA eligible due to their insurance status. Over one-quarter of these (3 million) reported psychological distress, with the majority (1.8 million) reporting unmet needs for services. Policies that could reduce this unmet need include expanding the breadth and reach of PEI programs and increasing efforts to develop a robust, culturally and linguistically competent workforce across all MHSA services.

Proposition 63, the Mental Health Services Act (MHSA) of 2004, has altered the view and vision of what public and community mental health care services can be in California. Rather than a reactive system that provides services only after individuals have developed a severe mental illness—a "fail first" approach, which is how public mental health services have historically been provided—the MHSA paves a path toward a "help first" approach. It does so by committing 20% of Proposition 63 funds for prevention and early intervention programs and services in order to prevent mental health problems from becoming severe and disabling.[1] In fiscal year 2018-19, Proposition 63 generated $2.4 billion in dedicated revenue. In general, it accounts for about 25% of all sources of revenue for public mental health services in the state.[2, 3]

MHSA direct services are primarily provided through two statewide component activities. The first, Community Services and Supports (CSS), serves individuals who have the most complex needs and most severe mental health challenges through Full-Service Partnerships (FSP) and Outreach and Engagement Activities (OEA). The second component, Prevention and Early Intervention (PEI), serves individuals who are at risk or who show early signs of mental illness or emotional disturbance, providing programs and services to prevent mental illness from becoming severe and disabling. Both component activities aim to improve timely access for underserved populations.[3]

"Three million [MHSA-eligible adults] have symptoms associated with clinically relevant psychological distress."

Efforts to identify the extent of unmet mental health service needs have typically focused on populations needing more intensive services, like those provided through CSS programs. Such efforts are critical, as these are individuals with the most severe mental health challenges. At the same time, by focusing solely on identifying the population with the most severe mental health challenges, these efforts inadvertently prioritize the "fail first" approach and do not effectively help California move forward with MHSA's commitment to the PEI "help first" vision.

This policy brief evaluates data from the 2018 California Health Interview Survey to investigate the potential of CSS and PEI programs to reach MHSA-eligible adults with serious or moderate psychological distress. The study findings show that 1.7 million California adults exhibit symptoms associated with serious psychological distress, and an additional 1.3 million have symptoms associated with moderate psychological distress. All of these individuals may benefit from CSS and PEI services. Compared to adults with serious psychological distress, adults with moderate psychological distress reported higher rates of unmet need, with statistically significant differences by race and ethnicity, citizenship status, English proficiency, and family type. These findings highlight a need to reevaluate the reach of prevention services, including MHSA PEI programs and services, since the aim of Proposition 63 was for these services to offer early intervention for mental health problems, and in so doing prevent these problems from becoming severe and disabling.

(For definitions of serious and moderate psychological distress and unmet need, see sidebar, this page. For measurements, see Data Source and Methods.)

Definitions

MHSA eligible—Based on self-reports for type of insurance coverage in the past year, estimates of adults who were uninsured or who were covered by Medi-Cal or other public insurance programs in the past year.

Serious Psychological Distress (SPD)—Based on the number and frequency of symptoms reported in the past year, an estimate of adults with serious, diagnosable mental health disorders that warrant mental health treatment within a population.[4]

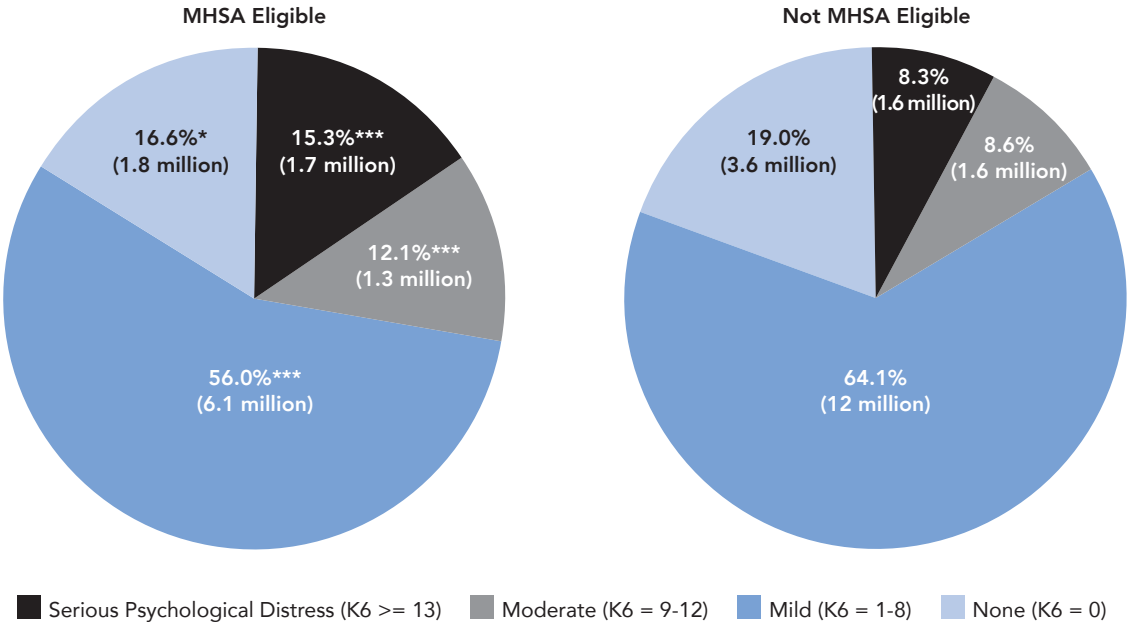
Moderate Psychological Distress (MPD)—Based on the number and frequency of symptoms reported in the past year, an estimate of adults with moderate mental distress – that is, distress that is clinically relevant and warrants mental health intervention within a population.[5]

Need for mental health services—Based on the number and frequency of symptoms reported in the past year, an estimate of adults with serious or moderate psychological distress who may benefit from mental health treatment or intervention.[6]

Unmet need for mental health services—Based on the estimate of adults with an identified need for mental health services who have not accessed mental health services in the medical or mental health sectors in the past year.[7]

Psychological Distress by MHSA Eligibility, Adults Ages 18 and Over, California, 2018

Exhibit 1



Note: Difference between MHSA eligibility groups for each distress category is statistically significant at *p<.05; **p<.01 (not used in this chart); ***p<.001.

Data Source: California Health Interview Survey (CHIS), 2018

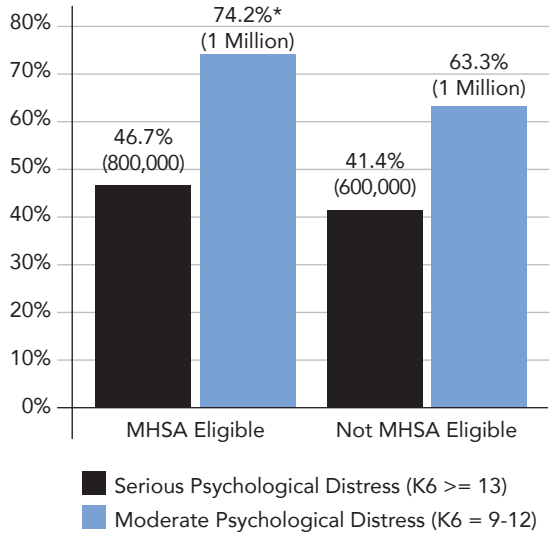
Need and Unmet Need for Mental Health Services Higher Among MHSA-Eligible Adults

In 2018, California adults eligible for MHSA were nearly twice as likely as adults who were ineligible to report symptoms associated with serious psychological distress (SPD) (15.3% vs. 8.3%), and 1.5 times more likely to report symptoms associated with moderate psychological distress (MPD) (12.1% vs. 8.6%) (Exhibit 1).

Adults eligible for MHSA with serious psychological distress have slightly higher unmet needs (46.7%) compared to similar adults who are not eligible for MHSA (41.4%). Unmet need for adults with moderate psychological distress was higher for MHSA-eligible adults compared to adults not eligible for MHSA (74.2% vs. 63.3%) (Exhibit 2). These data demonstrate that there are gaps in access to mental health care for both populations. Moreover, the data show that there is a critical need for the services provided by the MHSA-funded CSS and PEI programs.

Unmet Need for Mental Health Services Past Year, Adults Ages 18 and Over, by Level of Psychological Distress and MHSA Eligibility, California 2018

Exhibit 2



Note: *p<.05 – difference between MHSA eligibility groups for each psychological distress category

Data Source: California Health Interview Survey (CHIS), 2018

"Those ages 18-25 were more than twice as likely to report having had MPD than the oldest adults."

The following two sections highlight sociodemographic variations in need and service use for MHSA-eligible adults with either moderate or serious psychological distress.

Who Has a Need for Mental Health Services?

Younger age groups disproportionately report symptoms associated with SPD and MPD compared to older age groups. Overall, SPD and MPD decline with age among adults. The youngest adults, ages 18-25, were five times more likely to report having had serious psychological distress in the past year (23.8%) than the oldest adults, those ages 65 and over (4.7%). In addition, those ages 18-25 were more than twice as likely to have experienced MPD in the past year (16%) than those ages 65 and over (7.3%).

Non-Latino white adults are more likely to have SPD and MPD than adults of other races and ethnicities. Non-Latino white adults were almost twice as likely to report having had SPD in the past year (23.3%) than Latino adults (12.7%). In addition, non-Latino white adults were more than twice as likely as Asian adults to report experiencing MPD in the past year (14.7% vs. 6.7%).

Adults born in the United States are more likely to report symptoms associated with SPD and MPD than foreign-born adults. U.S.-born adults are four times more likely to have SPD than foreign-born adults who are not U.S. citizens (21.7% vs. 5.8%), and 2.5 times more likely than naturalized foreign-born adults (8.2%). In addition, U.S.-born adults are twice as likely to experience MPD than naturalized foreign-born adults (14.1% vs. 7.2%).

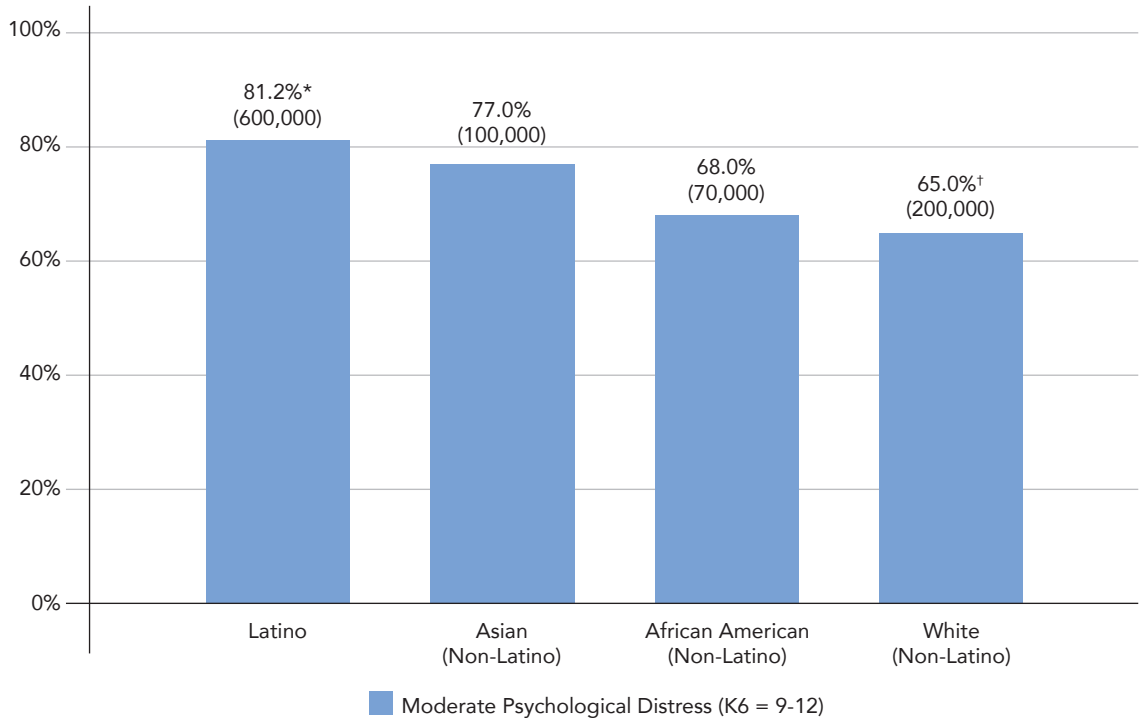
Adults who speak only English are more likely to have SPD and MPD than adults who may or may not speak English in addition to another language. Adults who speak only English were more than four times as likely to report SPD as adults who have limited English proficiency or do not speak English at all (22% vs. 5%), and almost 1.5 times more likely than adults who speak English very well or well (16.2%). In addition, adults who speak only English were more than1.5 times as likely to report MPD as adults who have limited English proficiency or do not speak English at all (14.9% vs. 8.8%).

Single adults are significantly more likely than married adults to have SPD and MPD. Single adults with or without children were equally likely to report SPD in the past year (20% and 18.4%, respectively). Both groups of single adults were about three times more likely than married adults without children (6.3%) and those with children (7.6%) to have experienced SPD in the past year. In addition, single adults without children were more than 1.5 times as likely to have experienced MPD in the past year than married adults without children (14% vs. 8.9%).

Adults with some college education report SPD more often than adults with higher and lower educational levels. Adults with some college education were twice as likely as adults with less than a high school education to report experiencing SPD in the past year (21.7% vs. 10.6%), and 1.5 times more likely to report this than both adults with a high school education (14.7%) and adults with a graduate or higher level of education (13.4%). (Not all socioeconomic data are presented here. To see all data, please see Exhibit 1A in the online Appendix (*https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-appendix.pdf*).

Unmet Need for Mental Health Services Past Year, MHSA-Eligible California Adults With Moderate Psychological Distress, Ages 18 and Over, by Race and Ethnicity

Exhibit 3



Note: † Reference Group: Difference from reference group is statistically significant at *p<.05.

Data Source: California Health Interview Survey (CHIS), 2018

Who Has Unmet Need for Mental Health Services?

Adults with MPD are more likely than adults with SPD to have unmet needs. Among adults with MPD, 7 out of 10 have unmet needs for mental health services, compared to nearly 5 out 10 adults with SPD (Exhibit 2). Morever, examining socioeconomic differences showed that some groups of adults with SPD may have had more unmet needs than other groups, while some groups of adults with MPD had disproportionately more unmet needs than other groups.

Foreign-born adults who are not citizens and have SPD may be more likely than U.S.-born adults with SPD to not access the mental health care they need. Nearly 7 out of 10 foreign-born noncitizen adults with SPD have unmet needs, compared to nearly 5 out of 10 U.S.-born adults with SPD.

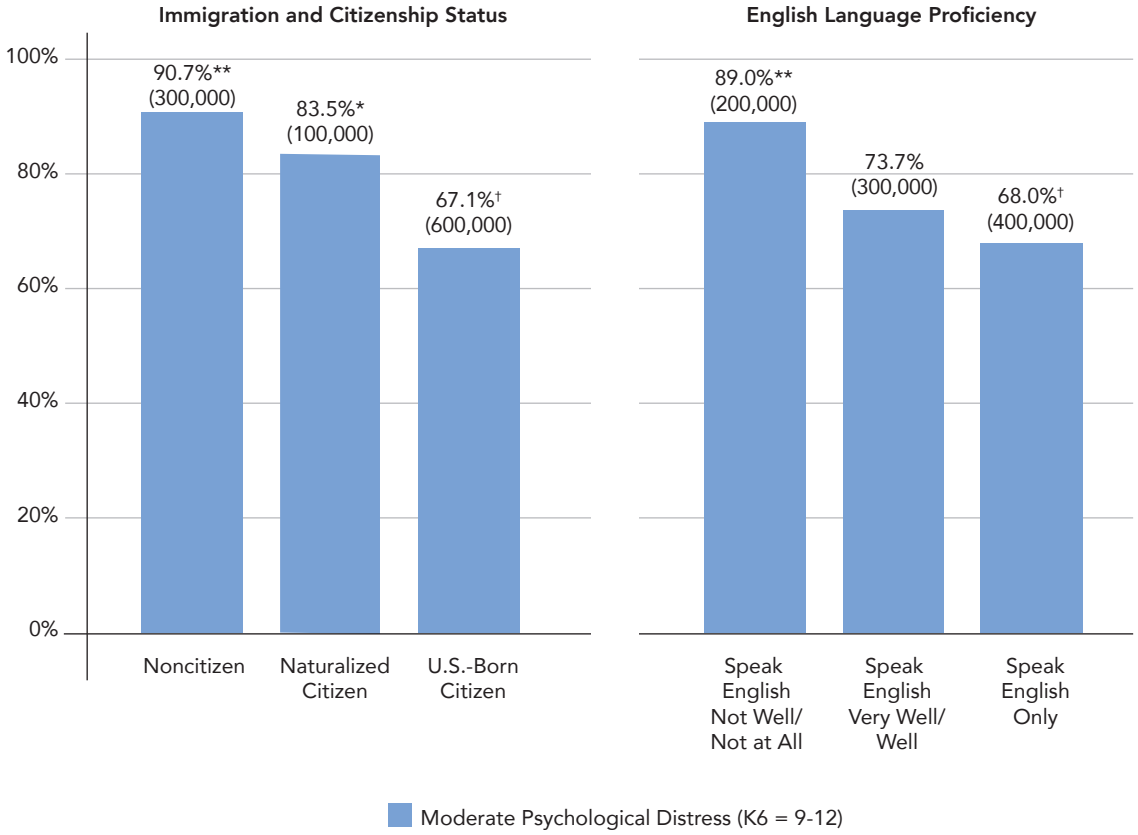
Adults with SPD who have limited or no English proficiency may be more likely to have unmet needs than adults with SPD who speak only English. Among adults with SPD who speak limited or no English, 6 out of 10 do not access the mental health care they need, compared to 4 out of 10 adults who speak only English. (Not all socioeconomic data for adults with SPD are presented here. To see these data, please see Exhibit 1B in the online Appendix (*https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-appendix.pdf*).

Latino adults with MPD are more likely than their white counterparts to not access the mental health care they need. Among Latino adults with MPD, 8 out of 10 have unmet needs, compared to 7 out of 10 non-Latino white adults with MPD (Exhibit 3).

"Latino adults with MPD are more likely than their white counterparts to not access the mental health care they need."

Exhibit 4

Unmet Need for Mental Health Services Past Year, MHSA-Eligible California Adults with Moderate Psychological Distress, Ages 18 and Over, by Immigration and Citizenship Status and by English Language Proficiency



Note: † Reference Group. Difference from reference group is statistically significant at *p<.05, **p<.01.

Data Source: California Health Interview Survey (CHIS), 2018

"Noncitizen adults with MPD are more likely than U.S.-born citizens with MPD to have unmet mental health care needs."

Noncitizen adults with MPD are more likely than U.S.-born citizens with MPD to have unmet mental health care needs. Among adults who are noncitizens and have MPD, 9 out of 10 have unmet needs, compared to nearly 7 out of 10 U.S.-born adults with MPD (Exhibit 4).

Adults with MPD who have limited or no English proficiency are more likely than similar adults who have MPD but speak only English to not have accessed needed mental health care in the past year. Nearly 9 out of 10 adults with MPD who have limited or no English-speaking proficiency have unmet needs, compared to nearly 7 out of 10 similar adults who speak only English (Exhibit 4).

Married adults with MPD are more likely to face unmet needs than single adults with MPD. Nearly 9 out of 10 married adults with MPD, whether with or without children, have unmet needs, compared to nearly 7 out of 10 single adults without children and with MPD. (Not all socioeconomic data for adults with MPD are presented here. To see all data, please see Exhibit 1B in the online Appendix (*https://healthpolicy.ucla.edu/publications/Documents/PDF/2020/mentalhealth-appendix.pdf*).

Policy Recommendations

The intent of the Mental Health Services Act includes reducing the long-term adverse impacts on individuals and families resulting from untreated or undertreated serious mental illness. While efforts are made to address the unmet mental health needs of individuals with severe and debilitating mental disorders, improvements can be made to expand the development of and access to prevention and early intervention programs and services for individuals experiencing moderate to serious psychological distress. These efforts could help reduce the severe and debilitating effects of mental disorders and psychological distress, leading to better mental health outcomes in California. The following policy recommendations would help more fully reach the goals of the MHSA.

Expand access to CSS and PEI programs and services for the 1.8 million California adults with unmet needs. According to the 2020-21 *Mental Health Services Act Expenditure Report–Governor's Budget*, counties have over $500 million in MHSA funds in local reserves, and they must move at least $161 million of these funds to their CSS and PEI components by June 30, 2020.[5] MHSA funds from these reserves must be used to increase the number of CSS and PEI programs and services to address the unmet needs of 1.8 million MHSA-eligible California adults.

Given that these data were collected prior to the COVID-19 pandemic, it is reasonable to assume that the need for mental health services will be much greater during the 2020-21 fiscal year. In a Kaiser Family Foundation poll conducted at the end of March, 45% of adults in the U.S. reported that the pandemic had affected their mental health,[8] and 19 percent reported a major impact on their mental health. The increasing need could be short-term and consist of crisis counseling due to fears raised by the pandemic; however, the increasing need could be more long-term, for several reasons, among them the emotional and mental toll of significant financial hardship from job loss. It is estimated that 2.6 million California workers and their dependents are at risk of losing job-based insurance coverage, and a majority of them will be eligible for Medi-Cal or subsidized insurance through Covered California.[9] Legislation may be needed that requires counties to move over even more funds from their reserves to meet this impending demand for public mental health services.

> *"The need for mental health services will be much greater during the 2020-21 fiscal year."*

Increase, promote, and protect a culturally and linguistically competent mental health workforce. Given the rich and diverse population that makes California unique, findings from this brief highlight a large gap in ensuring that resources are equally distributed for racial, ethnic, and multicultural groups and communities. These findings suggest that a culturally and linguistically competent staff and mental health workforce may be needed for outreach, programs, and services for adults who are noncitizens and who have limited or no English proficiency. Decision-makers from the 59 local MHSA jurisdictions and the Regional Partnerships could also prioritize Workforce, Education, and Training (WET) funds for a PEI mental health workforce that can address the unmet needs of the racial, ethnic, multicultural, and multilingual populations with moderate psychological distress in their local areas.[10] Lay health care workers or other staff who can provide cultural and linguistic translation services need to be encouraged and supported to obtain a higher level of education and become part of California's mental health workforce. In addition, a robust peer-support workforce that comes from these communities and is developed by counties would also be essential for providing culturally competent and linguistically appropriate mental health services.

"Identifying individuals who could benefit from prevention and intervention services would avoid the need for more intensive and costly services."

Prioritize evaluation and statewide monitoring of impact from Prevention and Early Intervention programs. For example, a two-year evaluation of existing PEI programs shows promising positive outcomes in stigma and discrimination reduction, suicide prevention, and improvements in student mental health.[11] As decision-makers consider expanding existing PEI programs or implementing new ones, it is imperative that they consider having standardized evaluation tools to measure outcomes for individuals in these programs—outcomes that capture both short-term and long-term impacts to help inform evidence-based programs and planning. Moreover, for PEI programs designed to reach a wider audience in which individual data cannot be collected, it would be essential to have a system in place to monitor statewide population mental health outcomes. Lastly, to inform policymakers and stakeholders, the impact data collected from all PEI program evaluations could then be added to the Mental Health Services Oversight and Accountability (MHSOAC) Transparency Suite.[12]

To fulfill the vision behind Proposition 63's PEI—to intervene early and prevent mental health problems from becoming severe and disabling for individuals—efforts to identify the extent of unmet need for PEI programs and services are warranted. Individuals reporting clinically relevant symptoms associated with moderate psychological distress may be a population that could benefit from PEI services, which would avoid the need for more intensive and costly services. This would be of benefit not only to the individuals, but also to the counties and the state as a whole.

Data Source and Methods

This policy brief presents data from the 2018 California Health Interview Survey (CHIS), conducted by the UCLA Center for Health Policy Research. We used data collected in interviews with 21,177 adults, sampled from every county in the state. Interviews were conducted in English, Spanish, Chinese (both Mandarin and Cantonese), Vietnamese, Korean, and Tagalog. CHIS is designed with complex survey methods requiring analysts to use complex survey weights in order to provide accurate variance estimates and statistical testing. All analyses presented in this brief include replicate weights to provide corrected confidence interval estimates and statistical tests.

For analyses in this brief, serious psychological distress in the past year (SPD) was measured by using a cutoff score of 13 to 24 on the Kessler-6 (K6), a validated measure designed to estimate the prevalence of diagnosable mental disorders within a population.[4] Moderate psychological distress in the past year was measured by using a K6 score of 9 through 12—a conservative cutoff on the lower score, as one validation study found a cutoff of 5 or 6 to be a clinically relevant level.[5] A K6 score of 9 to 24 was used as an objective measure of need for mental health services.[4,5] Unmet need for mental health services was measured with this question: "In the past 12 months, have you seen your primary care physician or mental health professional for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?" A "no" response was coded as having an unmet need for mental health services. To measure MHSA eligibility, adults who were uninsured or covered by Medi-Cal or other public insurance (does not include Medicare) in the past year were coded as eligible, and adults with private insurance were coded as not eligible.

Author Information

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Endnotes

1 Mental Health Services Oversight and Accountability Commission. 2012. *Prevention and Early Intervention (PEI) Fact Sheet: What Is Prevention and Early Intervention? https://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf*

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6 This is distinct from a subjective measurement of need for mental health services, in which individuals self-report that they need mental health services.

7 This definition of unmet need has limitations, as it does not include all of the important MH programming that is provided by laypeople, peers, and nonprofessionals; for some, these services may be all that they need.

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12 Mental Health Services Oversight and Accountability Commission. *MHSOAC Transparency Suite. https://mhsoac.ca.gov/resources/mhsoac-transparency-suite*

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