California Children's Trust

HEALING CENTERED SCHOOLS:

FINANCING AND SUSTAINING SCHOOL MENTAL HEALTH SERVICES AND STRATEGIES IN SANTA CLARA COUNTY

Santa Clara Office of Education Training Series:

A Deeper Dive Into The Financing and Sustainability of School Health Services in Public Education

DRINKING FROM A FIRE HYDRANT

45 MINUTES TO COVER….

- The Crisis is Real and Why School's Matter
- MediCal By The Numbers
- How MediCaid Works and What It Means for Schools: The 7 Essential MediCal Payors and The Need To Know Them All.
- A Deeper Dive Into The Big Three:
  - Mental Health Plans
  - MediCal Managed Care Organizations in Santa Clara
  - Understanding the LEA Program: Direct Billing and Administrative Claiming
- How To Make It Work: Bubble Gum, Shoestring, Federal Matching Funds, and a Culture of Collaboration:

THERE IS A CRISIS IN YOUNG PEOPLE'S MENTALHEALTH

Consider the facts before COVID-19:

Increase in inpatient visits for suicide, suicidal ideation, and self injury for children ages 1-17 years old, and 151% increase for children ages 10-14

Increase in mental health hospital days for children between 2006 and 2014

Increase in the rate of self-reported mental health needs since 2005

California ranks low in the country for providing behavioral, social, and development screenings that are key to identifying early signs of challenges

SCHOOLS CAN (and must) BE ESSENTIAL ACTORS IN OUR RESPONSE:

Schools are ground zero for the youth mental health crisis, and our collective failure at supporting them has contributed to the marginalization of vulnerable children. We can and must do more.

The Health Care System Needs Schools: Children ages 8-18 have the lowest rate of primary care utilization of any demographic in MediCal—and 75% of mental illness manifests in adolescence. Not only are schools essential actors in a reformed mental health system that overtly addresses healing, justice, and structural racism, but they are also essential service setttings for children with clinical needs.

The Finances are Aligning: Schools have what the publicly funded Medicaid system needs….access to kids and the nonfederal dollars to claim against (CPE). Unprecedented investment from state and federal sources is creating new and expanded opportunities for schools to support the social and emotional well being of children and families.

WE HAVE A ONCE-IN-A-GENERATION OPPORTUNITY TO ADDRESS THE CRISIS

Public opinion and policymaker agendas are aligned

Political Will: New administration has a stated focus on children's well-being and has expressed interest and willingness to engage.

Community Support: Half (52%) of all Californians say their community does not have enough mental health providers to serve local needs.

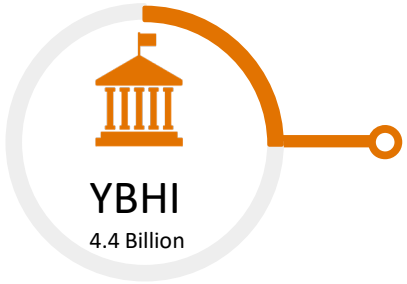
Emerging Consensus and Consciousness: Of the impact of adversity, structural racism, and the pandemic on the social and emotional health of children.

TO TAKE ADVANTAGE OF THIS MOMENT IN TIME WE MUST:

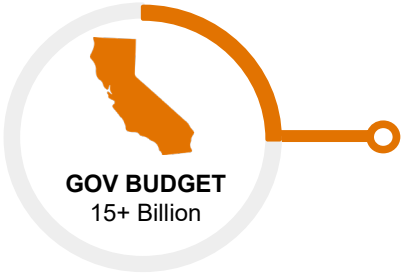
- Embrace the critical need to reform our financing and delivery models in schools so that they are healing and relationship centered.
- Adopt a concurrent but aligned paradigm shift across child serving systems, with particular focus on the role of MediCal in schools.
- Use a signigiant investment of one time funds to build sustainable programs and supports

UNPRECDENTED INVESTMENT
IS COMING TO SCHOOLS

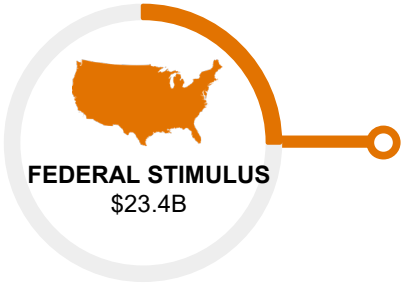
FUNDING OPPORTUNITIES FOR SOCIAL, EMOTIONAL AND MENTAL HEALTH IN SCHOOLS



- Managed Care Plans ($400 million)
- Competitive Grants Program ($550 Million)
- MHSA SSA funding ($250 million)
- Workforce including BH Coaches ($800 Million)
- BH Virtual Platform: ($750 Million)
- Expanding Evidence Based Programs (429 Million)



- Expanded Learning Opportunity Grant Program (4.6 Billion)
- Expanded Learning Program (1 Billion Ongoing, 753 Million One Time)
- Learning Loss Mitigation (5.3 Billion)
- Community School Partnership Grant Program ($3B)
- Educator Effectiveness Grant (1.5B)
- HCSB/Special Ed/Other....(1.5 Billion))



- ESSER I (CARES Act) - $1.6 billion
- ESSER II (CRRSA Act) - $6.7 billion
- ESSER III (ARP Act) - $15.1 billion

4.4 Billion Dollar Youth BH Initiative Centers Schools:

01 **Behavioral Health Service Virtual Platform:** DHCS, $749.7 M

02 **School-Linked Behavioral Health Services:** DHCS/DMHC, $550M

03 **Develop and Expand Age-Appropriate, Evidence-Based Behavioral Health Programs:** Agency/DHCS, $429M

04 **Building Continuum of Care Infrastructure:** DHCS, $310M

05 **Plan Offered Behavioral Health Services:** DHCS, $800M

06 **School Behavioral Health Counselor + Behavioral Health Coach Workforce:** OSHPD, $352M

07 **Broad Behavioral Health Workforce Capacity:** OSHPD, $448M

08 **Pediatric, Primary Care And Other Healthcare Providers:** DHCS, $50M

09 **Comprehensive And Culturally And Linguistically Proficient Public Education And Change Campaign:** CDPH + OSG, $100M

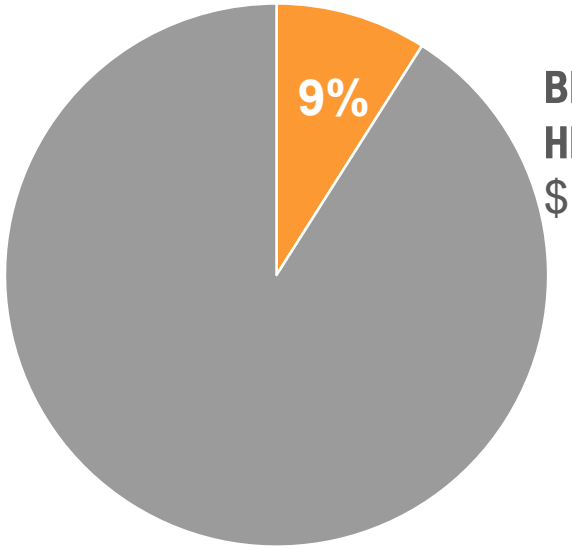
10 **Oversight, Coordination, Convening, And Evaluation:** DHCS, $70M

MEDI-CAL BY THE NUMBERS

MEDICAID BY THE NUMBERS

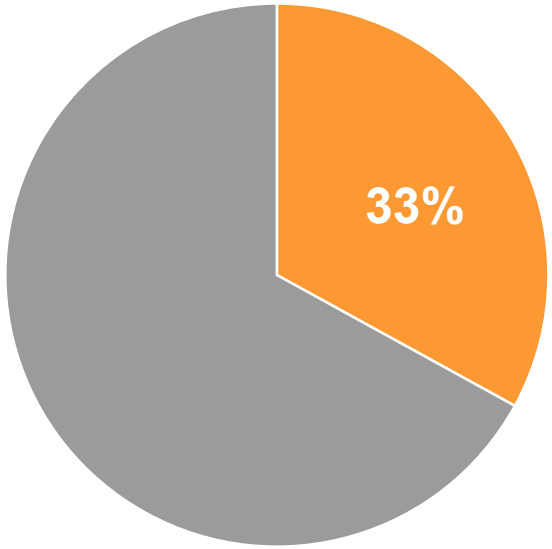
1/3 of Californians are covered by Medi-Cal (California's version of MEDICAID), which underinvests in their mental and behavioral health. Children are historically the most underfunded.

Total Dollars: $105.2 Billion



BEHAVIORAL HEALTH:
$12 BILLION

Total Californians: 39 Million



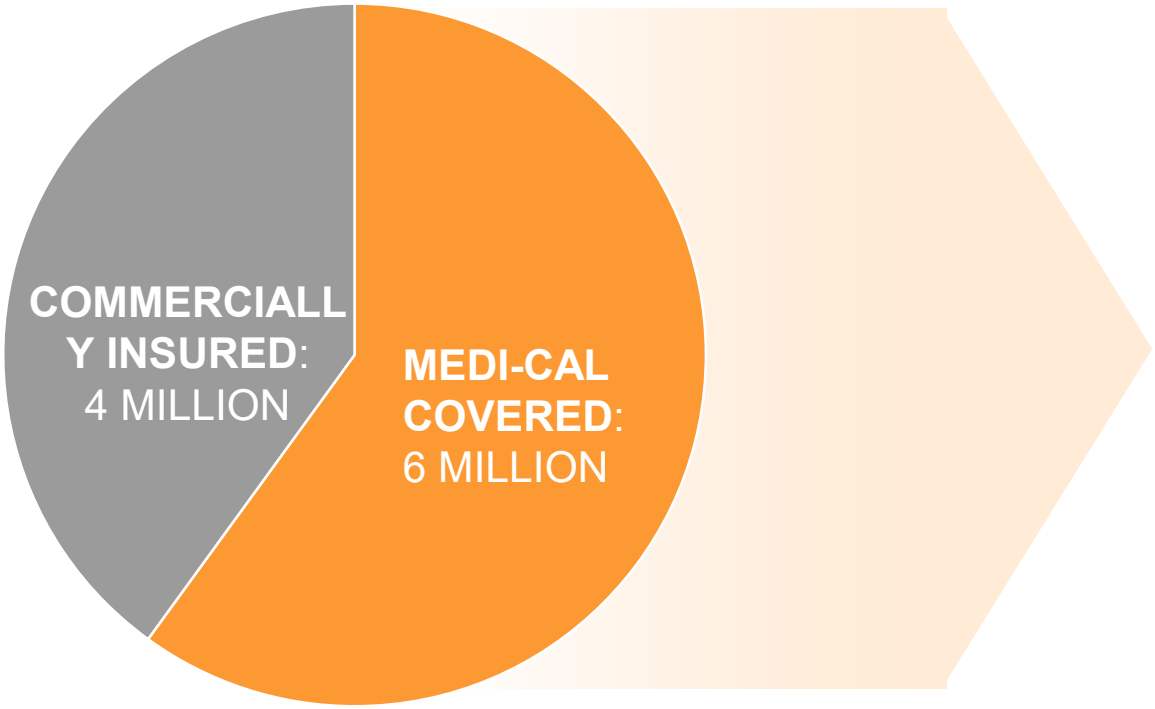
MEDI-CAL COVERED:
13 MILLION

**Current budget estimates show a 25% increase in Medi-Cal enrollees due to COVID-19*

MEDICAID BY THE NUMBERS – CALIFORNIA'S KIDS

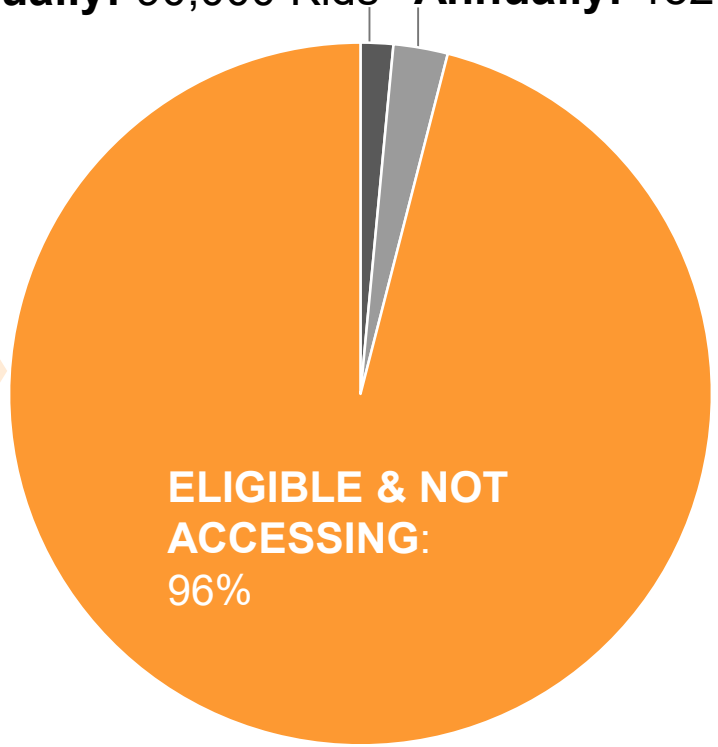
Almost 6 out of 10 children are covered by Medi-Cal. They are served by county administered Specialty Mental Health Plans (MHP) and Medi-Cal Managed Care Organizations (MCO'S)

Total California Children: 10 Million

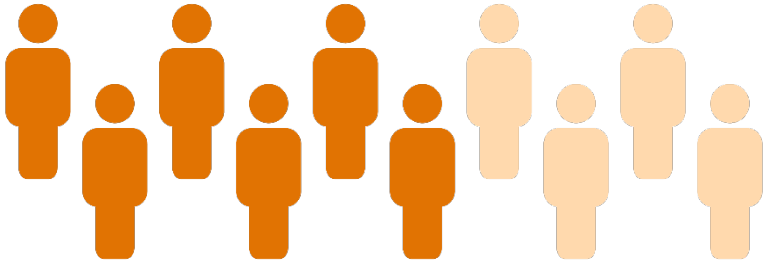


MCO Total Served Annually: 90,000 Kids

MHP Total Served Annually: 152,409 Kids

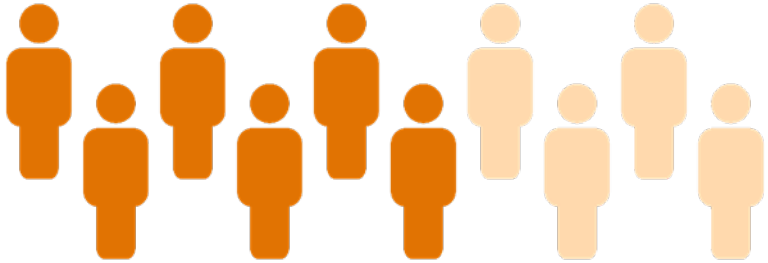


AND ALTHOUGH ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED....



6 million of California's 10 million children
are now covered by Medi-Cal and the EPSDT entitlement
(a 30% increase over last five years)

Everyone under 21 living in a family that makes less than 250%FPL qualifies for MediCal



CALIFORNIA IS GROUND ZERO FOR INCOME INEQUALITY:

7 OUT 10 CHILDREN BORN INTO POVERTY WILL NEVER GET OUT

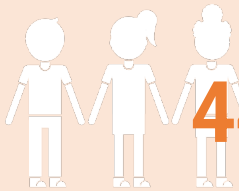
ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED, BUT ACCESS REMAINS LIMITED:

Less than 6% get access to any care in Santa Clara, and only 4% are in ongoing care.

(Santa Clara MHP Data per POS)

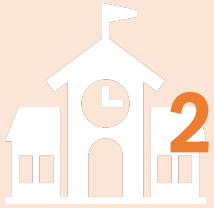
SANTA CLARA DASHBOARD AND DEMOGRAPHIC DATA

CHILD POPULATION IN COUNTY



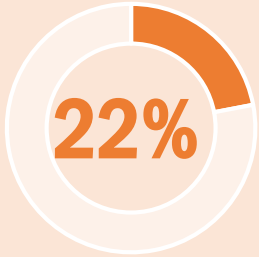
441,591

PUBLIC SCHOOL ENROLLMENT

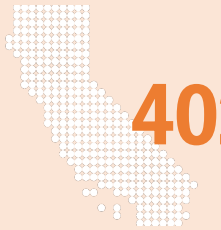


263,449

KIDS ENROLLED IN MEDI-CAL



MEDI-CAL TOTAL ELIGIBLES



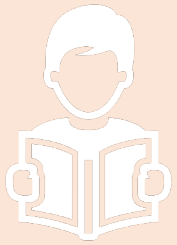
402,540

STUDENTS ELIGIBLE FOR FREE/REDUCED PRICE SCHOOL MEALS

34.70%

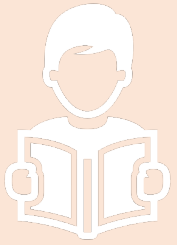
HIGH-NEEDS STUDENTS
(Unduplicated Pupil Count)

44%



1-3 ACEs

42%



CHILDREN/YOUTH AGES 0-20 IN FOSTER CARE
(Per 1000)

2.1
Santa Clara

Vs.

5.3
CA

HOSPITALIZATIONS FOR MENTAL HEALTH ISSUES AGES 5-19
(Per 1000)

4.4
Santa Clara

Vs.

5.3
CA

ALL HOUSEHOLDS WITH 1-3 ACEs

42%
Santa Clara

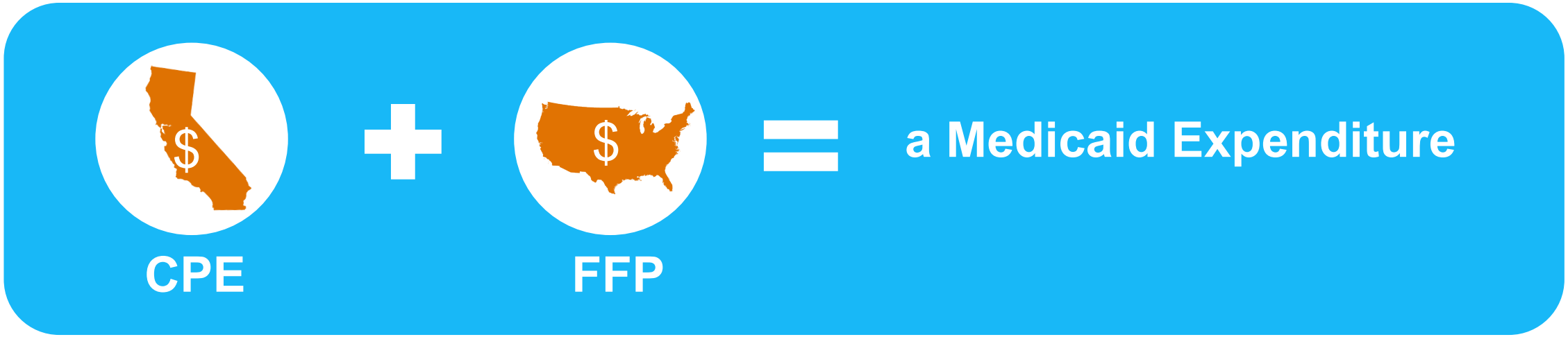
Vs.

45.1%
CA

HOW MEDICAID WORKS AND WHAT IT MEANS FOR SCHOOLS:

THE 7 ESSENTIAL MEDICAL PAYORS AND THE NEED TO KNOW THEM ALL

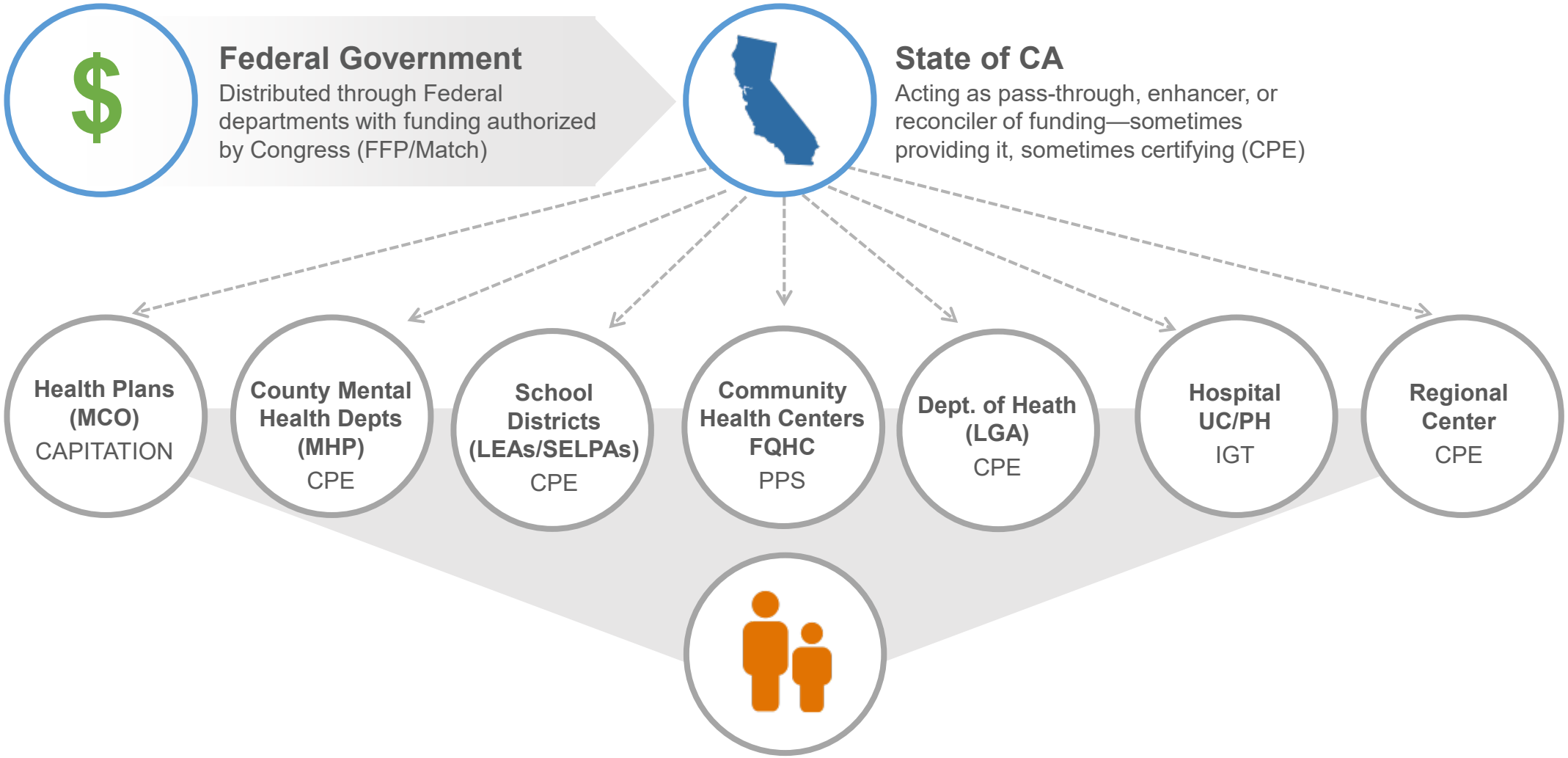
THE FEDERAL MATCH IS GUARANTEED:



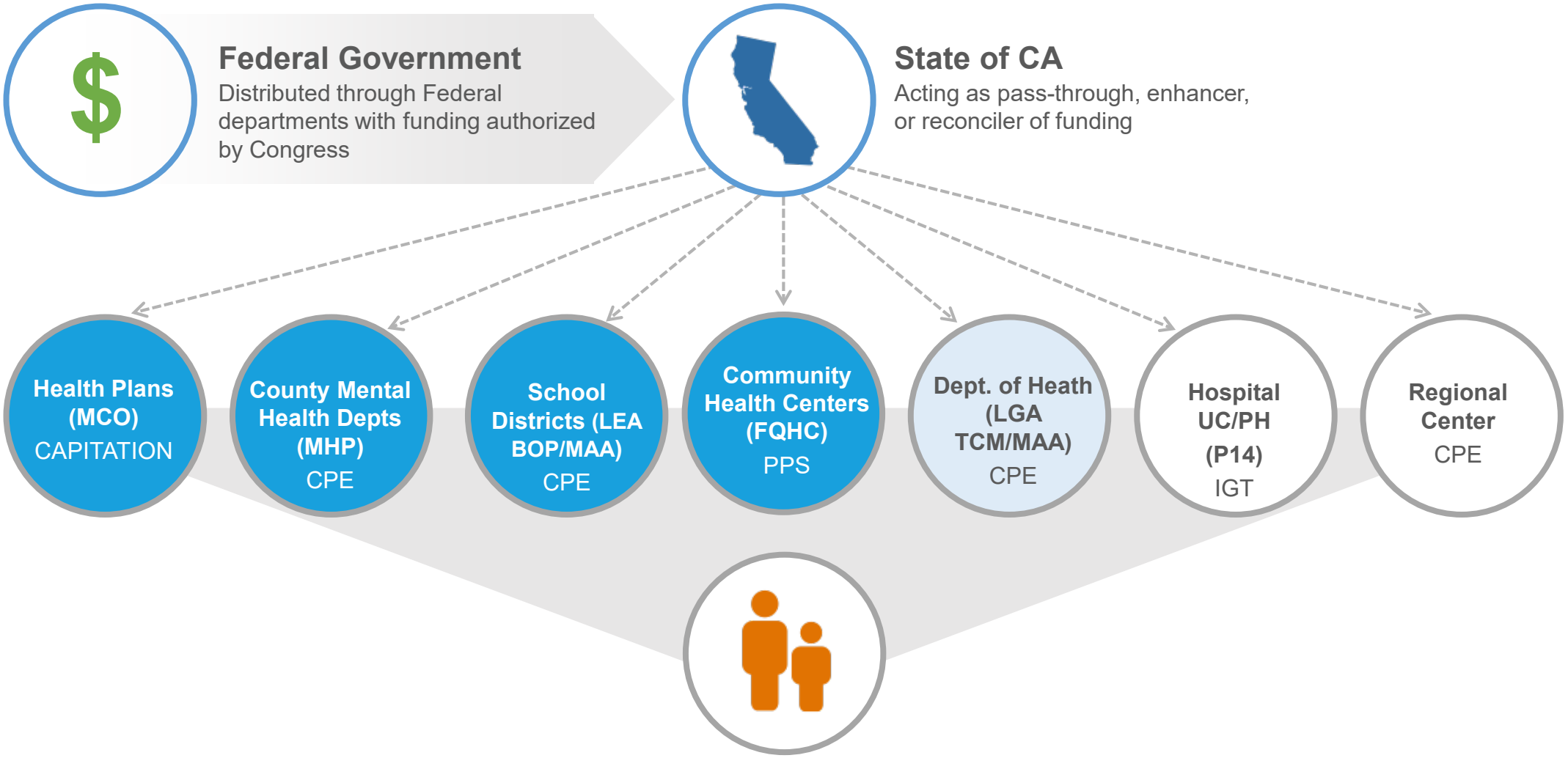
Certified Public Expenditure (CPE) = A governmental entity, including a governmental provider (e.g., county hospital, local education agency) incurs an expenditure eligible for FFP under the state's approved Medicaid state plan (DHCS definition).

Federal Financial Participation (FFP) = The federal share of Medicaid dollars when all state and federal requirements are met.

THE MEDICAID MAP: WHO PAYS FOR FEDERALLY ENTITLED SERVICES TO CHILDREN AND FAMILIES



WHO ARE THE MOST IMPORTANT PAYORS FOR SCHOOLS?



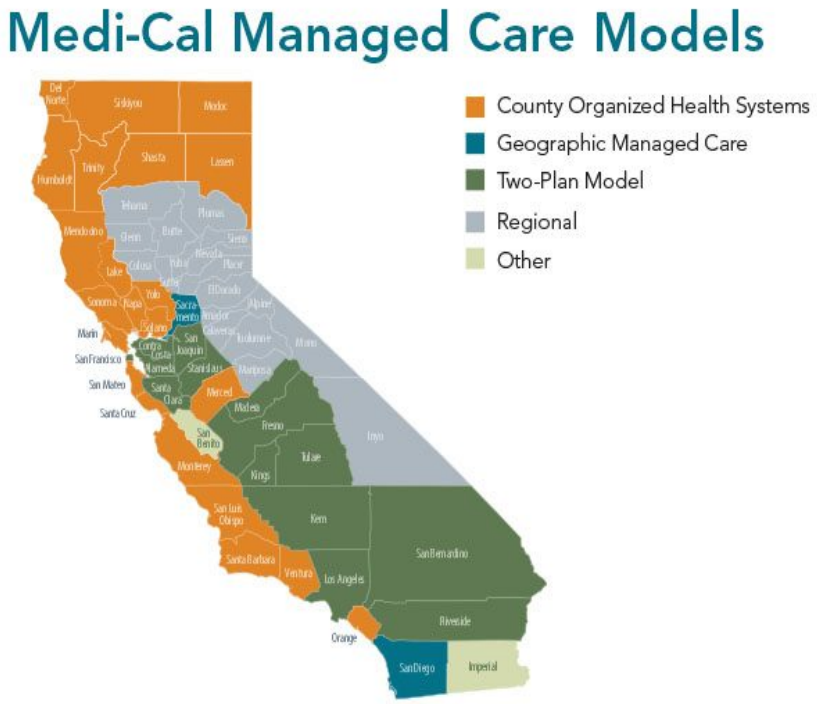
A DEEPER DIVE INTO THE BIG THREE:

1) Mental Health Plans (County MHPs)
2) MediCal Managed Care Organizations in Santa Clara (MCO's)
3) Understanding the LEA Program: Direct Billing and Administrative Claiming (LEA BOP/SMAA)

MOST MEDI-CAL BENEFICIARIES ENROLLED IN MANAGED CARE

- California was first state to implement Medicaid managed care starting in 1970s
- Medi-Cal managed care expanded slowly until mid-1990s
- Approximately 80% (10+ million) of Medi-Cal beneficiaries enrolled in health plans
- Managed care available statewide in all 58 counties

MEDI-CAL MANAGED CARE MODELS BY COUNTY



Source: California Department of Health Care Services.

- **COHS:** 6 plans, 22 counties
- **Two-Plan:** 9 Local Initiatives and 3 commercial plans, 14 counties
- **GMC:** 8 commercial plans, 2 counties
- Regional: 2 commercial plans, 18 counties
- **Imperial:** 2 commercial plans, 1 county
- **San Benito:** 1 commercial plan, 1 county

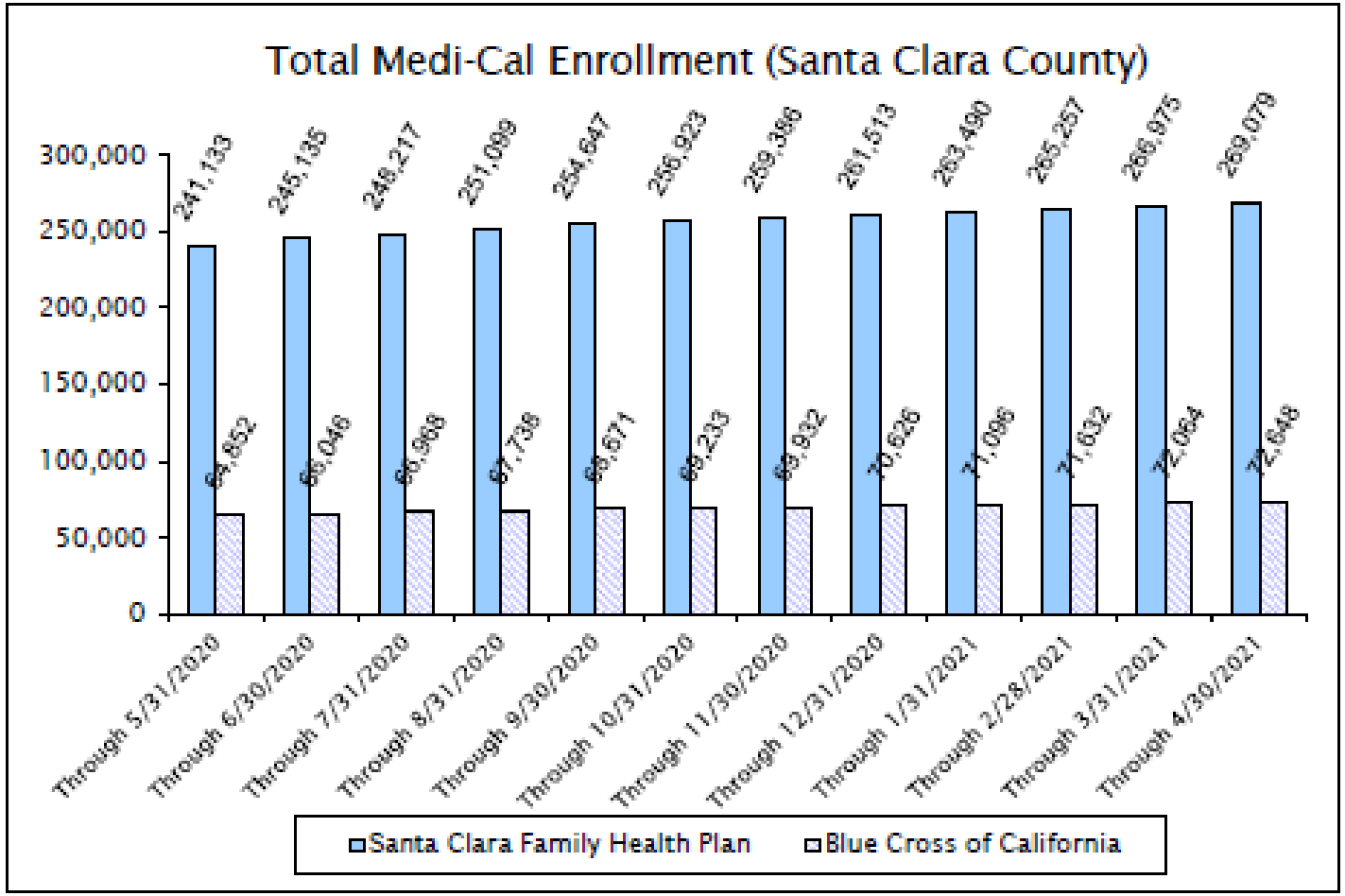
MEDI-CAL RELIES HEAVILY ON PUBLIC HEALTH PLANS

- Unlike most states which contract with a limited number of commercial health plans, Medi-Cal contracts with 24 different health plans
- Medi-Cal health plans include 15 local, county-based (“public”) health plans
- 9 Local Initiatives
- 6 COHS
- Local health plans operate in 36 counties
- Local health plans provide coverage for more than 2/3 of Medi-Cal managed care population

SANTA CLARA IS A TWO PLAN COUNTY

Local Initiative (public) Health Plan: Santa Clara Family Health Plan (SCFHP)

Commercial Plan: Anthem Blue Cross (Anthem)



SANTA CLARA IS A TWO PLAN COUNTY

Local Initiative (public) Health Plan: Santa Clara Family Health Plan (SCFHP)

Commercial Plan: Anthem Blue Cross (Anthem)

But four health plans actually cover some medical beneficiaries because of sub capitation agreements:

Total SCFHP Medi-Cal 274,030
SCFHP VHP Medi-Cal 136,328
SCFHP Kaiser Medi-Cal 32,568
Total Anthem: 73,648

KEY COMPONENTS OF MEDI-CAL MANAGED CARE

- Medi-Cal beneficiaries can choose their health plan or be “auto-assigned” to available health plan (non-COHS counties)
- Medi-Cal health plan members choose their PCP or are “auto-assigned” by health plan
- Health plans paid monthly on a prospective, capitated basis (“per member, per month”)
- Health plans provide physical and some mental health benefits (lower-acuity MH services)

SOME SERVICES “CARVED-OUT” FROM HEALTH PLANS

- Most health plans are not required to cover:
  - Specialty mental health and SUD services
  - Long-term care services and supports
  - Organ transplants

- Health plans have been responsible for most prescription drug coverage but will be “carved out” effective later in 2021

MEDI-CAL MANAGED CARE & BEHAVIORAL HEALTH

- Delivery of Medi-Cal BH services bi-furcated between counties and Medi-Cal health plans
  - Counties responsible for specialty mental health and SUD services
  - Health plans responsible for lower-acuity mental health services (i.e., “mild-to-moderate” services)

- Fragmented delivery system leads to frustration for patients, providers, health plans & counties

MEDI-CAL MANAGED CARE & MENTAL HEALTH CARE

- Health plans required to provide the same **mild-to-moderate benefits** as FFS Medi-Cal program beginning in 2015:
  - Individual and group mental health evaluation and treatment (psychotherapy)
  - Psychological testing
  - Outpatient services to monitor drug therapy
  - Outpatient lab, drugs, supplies and supplements
  - Psychiatric consultation
- Health plans contract with providers to deliver services to enrollees and must meet network adequacy requirements defined by DHCS
- Some Medi-Cal health plans manage mental health benefit directly; others contract with managed behavioral health organization (BHO)

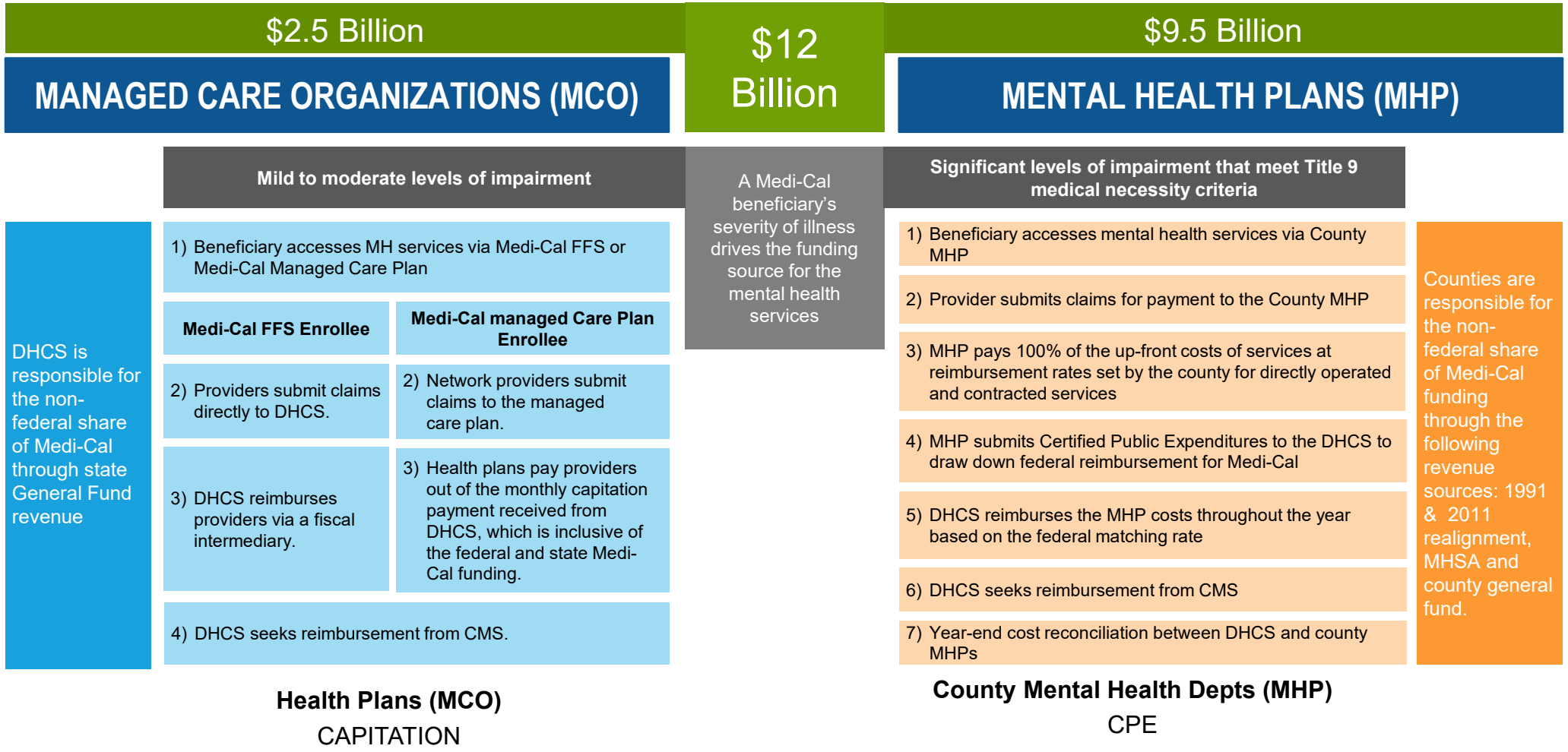
Individual/Group vs Organizational/Facility Credentialing

- The Provider Contract/Credentialing type has significant implications for credentialing & ongoing operations.
- Facilities accredited by JCAHO, COA or CARF do not require a Beacon site visit.
- Registered Interns are an allowable provider type in CA Medi-Cal managed care.

INDIVIDUAL PRACTITIONER CREDENTIALING	ORGANIZATIONAL CREDENTIALING
Beacon individually credentials and recredentials the following categories of clinicians in private solo or group practice settings: ▪ Psychiatrists ▪ Physicians certified in Addiction Medicine ▪ Psychologists ▪ Licensed Clinical Social Workers ▪ Master's-level ANCC board certified Behavioral or Mental Health Clinical Nurse Specialists/Psychiatric Nurses ▪ Licensed behavioral health counselors ▪ Licensed Marriage and Family Therapists ▪ Licensed chemical dependency professionals ▪ Advanced chemical dependency professionals ▪ Certified alcohol counselors ▪ Certified alcohol and substance/drug abuse counselors ▪ Other behavioral healthcare specialists who are master's level or above and who are licensed, certified, or registered by the state in which they practice	Beacon credentials and recredentials facilities and licensed outpatient agencies as organizations. Facilities that must be credentialed by Beacon as organizations include: ▪ Licensed outpatient clinics and agencies, including hospital-based clinics ▪ Federally Qualified Healthcare Centers (FQHCs), accredited and non-accredited ▪ Freestanding inpatient behavioral health facilities – freestanding and within general hospital ▪ Inpatient behavioral health units of general hospitals ▪ Inpatient detoxification facilities ▪ Other diversionary behavioral health services including: 1. Partial hospitalization 2. Day treatment 3. Intensive outpatient 4. Residential 5. Substance use rehabilitation

beacon

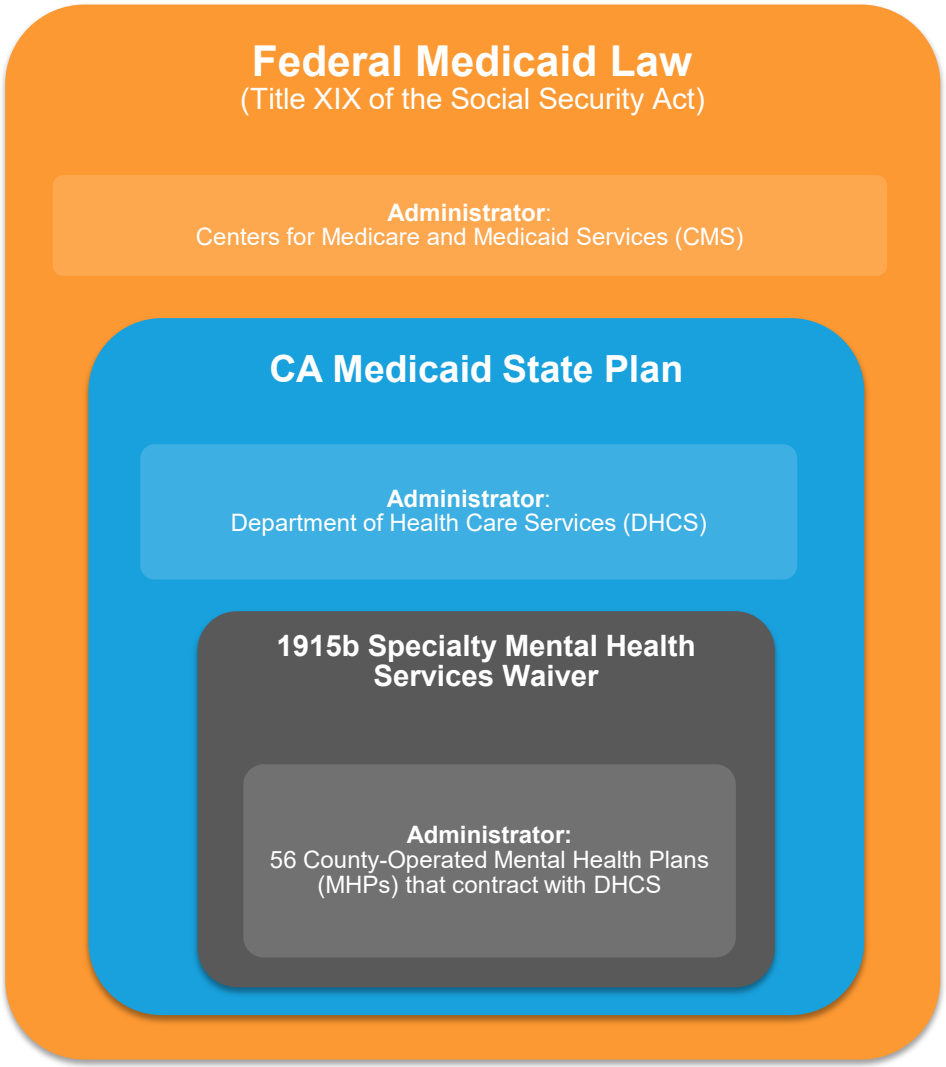
OVERVIEW OF FUNDING MEDI-CAL MENTAL HEALTH SERVICES



FUNDING MEDI-CAL SPECIALTY MENTAL HEALTH SERVICES

Here's what you need to know:

1. The federal Centers for Medicare and Medicaid Services (CMS) administers the federal Medicaid programs for people with low incomes and/or disabilities.
2. California operates the largest Medicaid program in the nation, called Medi-Cal
3. The state Department of Health Care Services (DHCS) administers the Medi-Cal program.
4. Local Mental Health Plans (MHPs) are county-organized and operated entities that contract with DHCS to provide Medi-Cal specialty mental health services.
5. Counties manage **non-risk contracts**, meaning there is no ceiling on the amount of federal reimbursement they may draw down so long as counties can provide the non-federal share using the various dedicated mental health funding sources.
6. Counties are both administrators and providers of mental health services. Counties vary in the portion of services they provide directly and contract out, but as much as 80% of services are provided via contractors in some counties.



REVENUE COLLECTION AND THE "BIG THREE"

Most state revenue for mental health services flows directly to county-managed accounts. State law dictates how counties must spend these funds, but counties have significant flexibility and local control.

1. **State Collects The "Big Three" Dedicated Revenue Sources**

- MHSA tax on personal income more than $1 million
- 2011 realignment funds: state sales tax
- 1991 realignment funds: State sales tax and vehicle license fees

2. **State controller distributes revenue to county accounts according to methodologies outlined in state law**

3. **Money deposited into County Subaccounts**

- 2011 Realignment Subaccount
- Mental Health Services Act Account
- 1991 Realignment Subaccount
- Local taxes or fee collections

Counties must match 1991 realignment mental health funds with a "maintenance of effort" amount of local tax money.

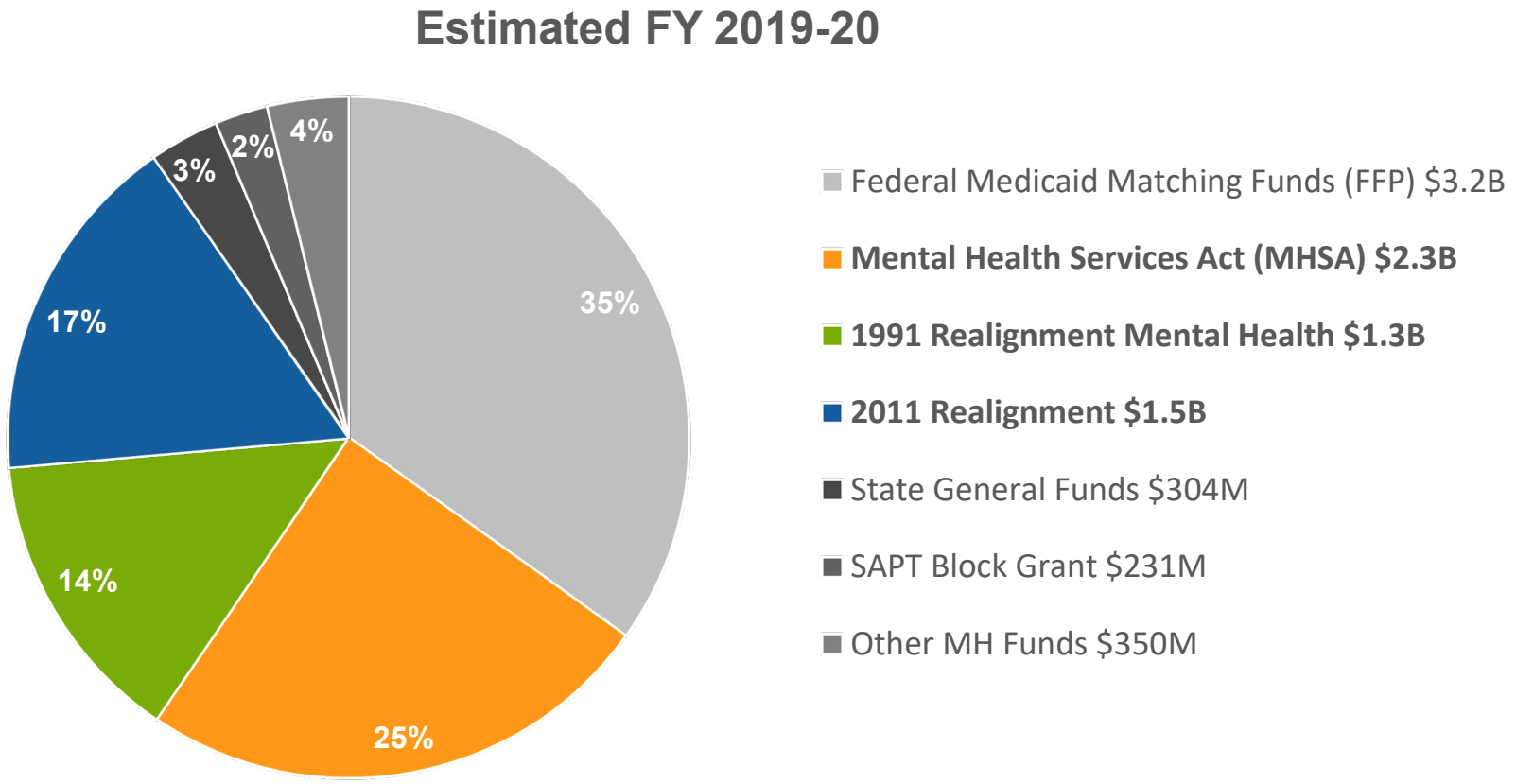
California pays for public mental health services primarily through dedicated revenue sources that are not directly subject to the annual state appropriations process.

Through a unique policy approach known as "realignment," revenue flows directly from the state to counties through a distribution methodology set in state law.

Counties must use these funds for certain programs and populations. Generally, Medi-Cal beneficiaries have first priority for the funds, as the law only requires that services for uninsured residents be provided "to the extent resources are available."

If demand and costs exceed the revenue a county receives from the state, the county must use local dollars to cover the difference or some clients' needs may go unmet. Some counties contribute more local dollars to mental health services than others.

THE "BIG THREE": 3 PRIMARY SOURCES OF NON-FEDERAL FUNDS (CPE) ARE ESSENTIAL TO MENTAL HEALTH PLAN OPERATIONS.



Sources: CA Governor's 2020-21 Budget (January 2020); CA State Controller's Office; and DHCS Medi-Cal Estimates

TIMELINESS AND ACCESS TO CARE IN MENTAL HEALTH PLANS (MHPS):

Santa Clara's Mental Health Plan must provide care within 15 miles or 30 minutes from the beneficiary's residence assuming the beneficiary (under 21 years of age) meet's the MHP's definition of MediCal Necessity:

- You must meet one of 18 covered diagnosis and he intervention (the mental health service that you need) must be focused on addressing the impairment.[15]

- And the intervention must meet specialty mental health service criteria. This means that your condition would be responsive to mental health treatment, but would not be responsive to physical health care based treatment.[1]

THE FOLLOWING SERVICES ARE COVERED BY MENTAL HEALTH PLANS (MHPS):

1. Rehabilitative Mental Health Services, including:
    - Mental health services
    - Medication support services
    - Day treatment intensive
    - Day rehabilitation
    - Crisis intervention
    - Crisis stabilization
    - Adult residential treatment services
    - Crisis residential treatment services
    - Psychiatric health facility services
2. Psychiatric inpatient hospital services
3. Targeted case management
4. Psychiatrist Services
5. Psychologist services
6. EPSDT supplemental specialty mental health services (for individuals under age 21); and
7. Psychiatric Nursing Facility Services

UNDERSTANDING THE DIFFERENCE BETWEEN HOW MHP'S AND MCO'S GET PAID:

MCO's (health plans) are paid in capitation—a set per member per month payment are already blended state and federal dollars.

MHP's (county mental health plans) operate under what is called a "Certified Public Expenditure" methodology. The used multiple sources of non-federal funds, fully fund the cost of the servies and then retroactively claim federal matching funds. Per minute, per beneficiary, per service mode or code.

LEA BILLING: THE BILLING OPTION PROGRAM AND ADMINISTRATIVE ACTIVITIES

The LEA Program in California is among the most troubled and underperforming in the nation—generating about 10% as much federal funds per Medicaid eligible student as the highest preforming states. Disallowance rates have routinely exceeded 30%.

A history of contradictory guidance and under resourced technical assistance has led to less than half of all LEA's statewide participating in LEA BOP

MediCal enrollment growth, LEA's growing interest in providing health services, and recent changes at the state and federal level have created new opportunities to explore LEA Reimbursement—particularly for schools with high concentrations of low-income students.

OVERVIEW OF THE LEA MEDICAL PROGRAM:

The LEA Program is authorized under California's W&I Code section 14132.06, and reimbursement is based upon a "fee-for-service" model.

The LEA Program provides reimbursement to LEAs (school districts, county offices of education, charter schools, community colleges, and university campuses) for health related services provided by qualified health service practitioners to Medi-Cal eligible students under the age of 22.

LEA Program allows local school districts to receive reimbursement for medically-necessary Medicaid health-related services

DHCS is able to reimburse districts **for half of the cost** to provide eligible Medicaid services by drawing down federal matching funds

LEA BILLING: THE BILLING OPTION PROGRAM AND ADMINISTRATIVE ACTIVITIES

The Billing Option Program **(BOP)** pays fee for service for a defined set of services delivered by qualified providers hired or contracted by the LEA with nonfederal dollars

The School Administrative Activities **(SMAA)** pays for time spent by staff paid for with nonfederal dollars or contractors administering, planning, conducting outreach, brokering, or determining eligibility:

BOP = SPECIFIC SERVICES TO STUDENTS IN MEDICAL
SMAA = TIME ON TASK DOING ALLOWABLE ACTIVITIES

Both programs operated under a Certified Public Expenditure (CPE) model—meaning LEA's must fully fund staff or contracts and **get a percentage of their expenditures** matched.

SCHOOL BASED ADMINISTRATIVE ACTIVITIES (SMAA):

The SMAA program authorizes governmental entities to submit claims and receive reimbursement for activities that constitute administration of the federal Medicaid program.

he program allows school claiming units to be reimbursed for some of their administrative costs associated with school-based health and outreach activities that are not claimable under the LEA BOP or under other Medi-Cal programs.

SCHOOL BASED ADMINISTRATIVE ACTIVITIES (SMAA):

In general, the cost of school-based health and outreach activities reimbursed under SMAA consist of:

- Referring students/families for Medi-Cal eligibility determinations
- Providing health care information
- Referring, coordinating and monitoring health services
- Coordinating services between agencies

SCHOOL BASED ADMINISTRATIVE ACTIVITIES (SMAA):

LEAs Participating in SMAA To participate in SMAA, all LEAs must:

1. Contract through either their regional Local Educational Consortium (LEC) or county Local Governmental Agency (LGA)
2. Submit a Time Survey Participant Universe list to their LEC/LGA for preapproval;
3. Submit school calendars and work schedules for their participants to their LEC/LGA;
4. Ensure participants are not 100% federally funded;
5. Complete a Roster Report;
6. Participate in a Random Moment Time Survey (RMTS);
7. Review LEA Coding Report and validate participant's time and cost;
8. Submit an invoice for reimbursement;
9. Maintain an operational/audit file; and
10. Review and validate participant's time and costs

THE LEA BILLING OPTION PROGRAM (BOP) COVERED SERVICES:

BOP is for Direct Services to MediCal Beneficiaries.

Eligible services include:

- Health and Mental Health Evaluation and Education Assessments
- Nursing Services
- Nutrition Services
- Occupational Therapy
- Optometry Services
- Orientation and Mobility
- Physical Therapy
- Physician Services
- Psychology and Counseling
- Respiratory Care
- School Health Aide Services
- Specialized Medical Transportation
- Speech Therapy
- Targeted Case Management

How Does the LEA Medi-Cal Billing Option Program Work?

The LEA hires practitioners based on the school budget for that fiscal year.

The LEA Program is a reimbursement program. LEAs must have the finds budgeted for the practitoners providing services prior to seeking reimbursement from the LEA Program.

LEAs pay for the services upfront and are reimbursed the FFP 50% rate relatvie to the cost of each individual service from federal funds based upon a "fee-for-service" model.

The LEA bills Medi-Cal for direct medical services provided by qualified practitioners, identified in the LEA Medi-Cal Billing Option Program Provider Manual, to Medi-Cal eligible students with an IEP/IFSP.

When a practitioner provides service to a Medi-Cal eligible student, the LEA may submit a claim for reimbursement for services covered under the LEA Program.

Claims are filed using the traditional Medi-Cal fee-for-service system through Xerox, the fiscal intermediary for DHCS.

Funds are disbursed in accordance to the information provided by the LEA on the Payment Receiver Agreement (DHCS 6246).

Xerox mails the LEA a check and remittance advice detail (RAD), which outlines the LEAs transaction information for that checkwrite.

To be reimbursed for delivering Medi-Cal services (at 50%)

- School districts submit Medi-Cal claims to the fiscal intermediary
- Maintain documentation of service delivery
- Complete annual cost reporting (CRCS)
- Take part in final settlement process, including a cost reconciliation process
- Participate in the Random Moment Time Survey (RMTS)
- Comply with Program timelines and submit required document

LEA BOP STATE PLAN AMENDMENT CHANGES:

In June of 2020, SPA 15-021 was approved.

It creates major changes four Program changes:

1. Expands covered services
2. Expands allowable practitioner types
3. Expands the covered population to include Medicaid beneficiaries outside of special education lifts caps on most services
4. Incorporates RMTS for LEA BOP services (initial survey period pending CMS approval)

LEA PROGRAM KEY RESOURCES:

Additional website resources –
LEA Onboarding Handbook
LEA Toolbox
FAQs
Transportation Billing Guide
Glossary of Terms

LEA Program Mailbox
(LEA@DHCS.CA.GOV)

HOW TO MAKE IT WORK:

BUBBLE GUM, SHOESTRING, FEDERAL MATCHING FUNDS, AND A CULTURE OF COLLABORATION

THE RIGHT INTERVENTIONS CAN CHANGE THE TRAJECTORY

We have new science and emerging practices that demonstrate the power of behavioral health services.

If we have the courage, will, and skill to apply this work to improve the lives of children and families…

- Interventions that increase resilience can have a moderating effect on depressive symptoms for children exposed to trauma.
- Targeted individual and group interventions to reduce risk factors and increase protective factors can prevent the onset of childhood depression and anxiety.
- Individual, group, and family treatment interventions can relieve symptoms of traumatic stress; improve cognitive, behavioral, social and emotional health; and improve children's performance in school.

Wingo, A., Wrenn, G., Pelletier, T., Gutman, A., Bradley, B. and Ressler, K. 2010. "Moderating effects of resilience on depression in individuals with a history of childhood abuse or trauma exposure." J Affect Disord. 126(3): 411-414. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3606050/

Lawrence, P.J., Rook, S., Creswell, C. 2017. "Review: Prevention of anxiety among at-risk children and adolescents-a systematic review and meta-analysis."Child and Adolescent Mental Health.; 22(3): 118–130

Saxena, S., Jane-Llopis, E., Hosman, C. 2006. "Prevention of mental and behavioural disorders: implications for policy and practice." World Psychiatry. Feb; 5(1): 5-14.

Substance Abuse and Mental Health Administration. 2018. Helping Children and Youth Who Have Traumatic Experiences. Retrieved from: https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf

The National Child Traumatic Stress Network. "Treatments that Work." Retrieved on May 13, 2018, from: https://www.nctsn.org/treatments-and-practices/treatments-that-work/interventions

THE EVOLUTION OF PSYCHOTHERAPY: HOW ARE BEST PRACTICES APPLIED?

Current practices consolidate cognitive and behavioral therapies and apply them to emerging delivery models.

WAVE 1
Psychoanalysis
(e.g. Freud, Jung)

1899-
Freud's *The Interpretation of Dreams*

1913
Jung establishes Analytical Psychology

1921
Jung publishes *Personality Types*

WAVE 2
Behavior Modification
(e.g. Skinner, Watson)

1913
Watson's *Psychology as the Behaviorist Views It*

1938
Skinner publishes *Behavior of Organisms*

1953
Behavior Research Laboratory

1968
Applied Behavior Analysis

WAVE 3
Humanistic/Experiential Psychotherapy
(e.g. Erikson, Frankl)

1928-1930
Frankl began counseling students for free in Vienna

1933
Erikson becomes first U.S. child psychoanalyst

1959
Frankl's book became *Man's Search for Meaning*

1969
Erikson publishes *Gandhi's Truth*, showcasing ego psychology

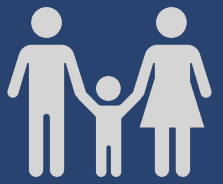
WAVE 4
Cognitive Psychotherapy

1960s: CBT
(Cognitive Behavioral Therapy)

1970s: Narrative Therapy

1980s: DBT
(Dialectical Behavior Therapy)

1996: MST
(Multisystemic Therapy)



WE ARE HERE
Consolidation and Application in Emerging Delivery Models

Medication Assisted Therapy

Wraparound

Crisis Response

Congregate care

Family Resource Models

School Based

Telepsychiatry

Co-location

COGNITIVE BEHAVIORAL THERAPY (CBT) IS A TYPE OF TALK THERAPY IN WHICH THE PRACTITIONER HELPS THE PATIENT BECOME AWARE OF NEGATIVE THINKING

COGNITIVE BEHAVIORAL THERAPY (CBT and TF-CBT)

CBT is a short-term, goal-oriented practice based on the idea that the way a person thinks and acts fundamentally affects the way that person feels.

CBT helps the patient become aware of inaccurate or negative thinking so they can view challenging situations more clearly and respond to them in a more appropriative way.

Trauma-Focused CBT (TF-CBT) is similar to CBT, but focuses specifically on children and youth impacted by trauma.

TF-CBT is a components-based treatment model that incorporates trauma-sensitive interventions with cognitive behavioral therapy.

Patients work with a mental health counselor during a limited number of sessions in a structured way. Standard techniques include:

- **Exposure therapy**, in which a person with anxiety is gradually exposed to the things that trigger their anxiety. Through the process, their anxiety lessens as they see they are actually able to face fears with no major adverse effects.
- **Altering negative or inaccurate thought patterns** or behavior by replacing them with positive thoughts and behaviors. This helps the patient view challenging situations more clearly and respond to them in a more effective way, thus mitigating anxiety and depression.

Studies show that CBT is as effective, or more effective, than antidepressant medications, and appears to more effectively reduce risk of relapse.

- The American Psychological Association (APA) describes CBT as:

  "A form of psychological treatment that has been demonstrated to be effective for a range of problems including depression, anxiety disorders, alcohol and drug use problems, marital problems, eating disorders and severe mental illness."

  APA emphasizes that advances in CBT have been made on the basis of both research and clinical practice. In this manner, CBT differs from many other forms of psychological treatment.
- The Mayo Clinic credits CBT as an effective tool in treating a *"range of mental health disorders including depression, post-traumatic stress disorder (PTSD) or an eating disorder."*

TF-CBT is widely recognized as an evidence-based treatment for children and adolescents (and their caregivers) impacted by trauma.

- According to the NCTSN, TF-CBT has the strongest research evidence of any treatment model for traumatized children. The NCTSN states that "multiple randomized controlled trials and replication studies including international studies have been conducted documenting the effectiveness of TF-CBT for improving a range of problems among these children."

Read more on TF-CBT:

Sources: *Mayo Clinic, American Psychological Association, National Child Traumatic Stress Network*

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2748674/

https://www.mayoclinic.org/testsprocedures/cognitive-behavioral-therapy/about/pac-20384610

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2748674/

https://www.nctsn.org/interventions/trauma-focused-cognitive-behavioral-therapy

DIALECTICAL BEHAVIOR THERAPY (DBT) COMBINES TWO OPPOSITES IN THERAPY – ACCEPTANCE AND CHANGES – TO HELP SUICIDAL AND SEVERELY DEPRESSED YOUTH

DIALECTICAL BEHAVIOR THERAPY (DBT)

Dialectical Behavior Therapy is a modified form of CBT. It uses traditional CBT techniques while promoting additional psychosocial skills such as mindfulness, acceptance and tolerating distress.

Psychology Today summarizes DBT as follows:

"DBT provides clients with new skills to manage painful emotions and decrease conflict in relationships. DBT specifically focuses on providing therapeutic skills in four key areas.

1. First, mindfulness focuses on improving an individual's ability to accept and be present in the current moment.
2. Second, distress tolerance is geared toward increasing a person's tolerance of negative emotion, rather than trying to escape from it.
3. Third, emotion regulation covers strategies to manage and change intense emotions that are causing problems in a person's life.
4. Fourth, interpersonal effectiveness consists of techniques that allow a person to communicate with others in a way that is assertive, maintains self-respect, and strengthens relationships."

https://www.psychologytoday.com/us/therapy-types/dialectical-behavior-therapy

DBT was originally developed to treat chronically suicidal individuals diagnosed with borderline personality disorder (BPD). It is now recognized as the 'gold standard' psychological treatment for this population.

Research has also shown that it is effective in treating a wide range of other disorders such as substance dependence, depression, post-traumatic stress disorder (PTSD), and eating disorders.
https://behavioraltech.org/resources/faqs/dialectical-behavior-therapy-dbt/

Read More: "Dialectical Behavior Therapy Current Indications and Unique Elements":
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2963469/

IN SOME CASES, A COMBINATION OF CBT AND MEDICATION CAN BE MORE EFFECTIVE THAN EITHER TREATMENT ALONE

COMBINATION CBT AND ANTI-DEPRESSANT MEDICATION THERAPY

Powerful one-two punch.
Some studies have shown that, in adolescents with depression or anxiety, a combination of CBT and medication (selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors) can often be more effective than either approach used independently.

"Studies suggest that adolescents who are depressed may benefit most from a combination of cognitive behavioral therapy and an antidepressant medication such as Prozac (an SSRI or selective serotonin reuptake inhibitor). This combination approach is effective in reducing depressive symptoms as well as decreasing suicidal ideation (thoughts) and suicide attempts."

"A Combination of Cognitive Behavioral Therapy & Antidepressant Medication Works Best for Depressed Adolescents." https://www.mentalhelp.net/blogs/a-combination-of-cognitive-behavioral-therapy-antidepressant-medication-works-best-for-depressed-adolescents/

The U.S. Department of Health and Human Services advocates for more research to better understand the risks and benefits of the combined approach:

"The combination of medications and cognitive behavioral therapy is more effective than either treatment alone, but the benefits and risks of each need to be considered…future research should address treatment of children who have other psychiatric conditions in addition to anxiety, evaluate the effectiveness of the components of cognitive behavioral therapy, compare drugs head to head, and study the long-term adverse effects of medications"

"Anxiety in Children." https://effectivehealthcare.ahrq.gov/topics/anxiety-children/research-2017

Read more: "Cognitive-Behavioral Therapy vs. Medication for Childhood Anxiety": https://www.jwatch.org/na45007/2017/09/12/cognitive-behavioral-therapy-vs-medication-childhood

MULTISYSTEMIC THERAPY (MST) OFFERS FAMILY AND COMMUNITY-BASED INTERVENTION FOR AT-RISK YOUTH

MULTISYSTEMIC THERAPY (MST)

MST is aimed primarily at high-risk youth involved in the juvenile justice system and/or with substance abuse issues. This treatment focuses on decreasing youth violence, antisocial behavior and out-of-home placements.

According to the Encyclopedia of Mental Disorders:

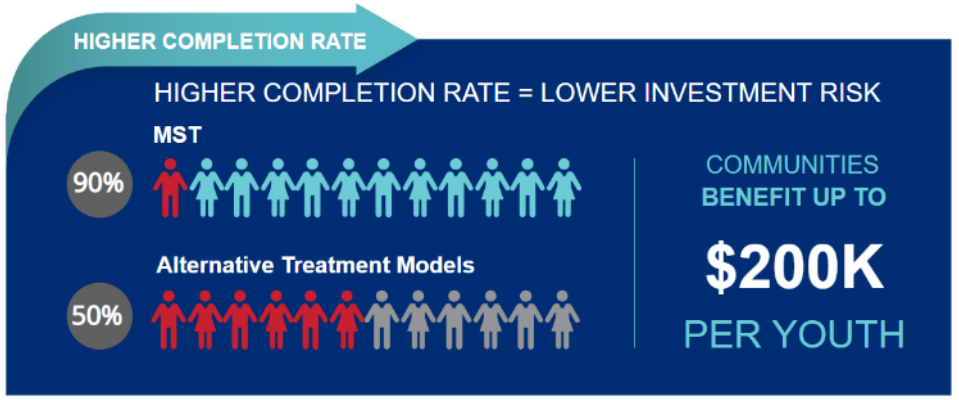
"Multisystemic therapy (MST) is an intensive family- and community-based treatment program designed to make positive changes in the various social systems (home, school, community, peer relations) that contribute to the serious antisocial behaviors of children and adolescents who are at risk for out-of-home placement. These out-of-home placements might include foster care, group homes, residential care, correctional facilities, or hospitalization." *http://www.minddisorders.com/Kau-Nu/Multisystemictherapy.html#ixzz5SokgeA00*

The California Evidence-Based Clearing House identifies 3 critical features of MST:

1. "Integration of empirically based treatment approaches to address a comprehensive range of risk factors across family, peer, school, and community contexts
2. Promotion of behavior change in the youth's natural environment, with the overriding goal of empowering caregivers
3. Rigorous quality assurance mechanisms that focus on achieving outcomes through maintaining treatment fidelity and developing strategies to overcome barriers to behavior change."

http://www.cebc4cw.org/program/multisystemic-therapy/detailed

According to MST Services, a mental health specialist group that partners with provider organizations and service systems, "MST delivers superior clinical and financial results relative to incarceration and alternative treatments."



http://www.mstservices.com

PARENT MANAGEMENT TRAINING (PMT) AIMS TO CHANGE PARENTING BEHAVIOR IN ORDER TO CHANGE NEGATIVE CHILD BEHAVIOR

PARENT MANAGEMENT TRAINING (PMT)





PMT refers to a treatment approach which focuses on changing negative parent behaviors – through teaching positive reinforcement and techniques for setting appropriate boundaries – in order to change negative behavior in children.

Recognizing that negative parental behavior and negative child behavior are frequently linked, PMT seeks to change a child's disruptive behaviors with interventions that change parent behaviors.

PMT has been found particularly effective in treating child disruptive behavior, particularly oppositional defiant disorder (ODD) and conduct disorder (CD).

Read More: http://www.minddisorders.com/Ob-Ps/Parent-management-training.html

Read More: "Effects of Culturally Adapted Parent Management Training on Latino Youth Behavioral Health Outcomes." http://cssr.berkeley.edu/cwscmsreports/LatinoPracticeAdvisory/Culturally%20Adapted%20Parent%20Mgmt%20Training.pdf

Read More: "Parent Management Therapy/Cognitive Behavioral Therapy (PMT/CBT) for Behavior Problems." https://depts.washington.edu/hcsats/PDF/factsheets/Behavior-Tx.pdf

Read More: http://www.minddisorders.com/Ob-Ps/Parent-management-training.html

WRAPAROUND IS A COMPREHENSIVE, HOLISTIC, FAMILY-DRIVEN APPROACH TO YOUTH MENTAL HEALTH THAT INCLUDES THE CHILD'S NATURAL SUPPORT SYSTEM

WRAPAROUND

TEAM APPROACH

Wraparound refers to a system of care management that includes a child's natural support system (family members, extended family, other caregivers, teachers and physicians) as well as agency professionals and mental health care providers.

This type of coordinated, team approach has been shown to be effective in treating a child's mental health and is also more likely to keep that child in the home or in a "home-like" setting.

"The wraparound team process has established itself as a standard of care for children and youth with complex needs and their families who require coordination of care and for whom a single intervention is unlikely to suffice. The wraparound practice model operationalizes critical system of care principles such as family driven and youth guided, community based, and collaborative; it is extremely popular with families; and the process is locally adaptive in that it can be flexibly applied in a range of public service systems […] Research results indicate that wraparound's strongest evidence for positive effects are in the residential, family, and cost domains."

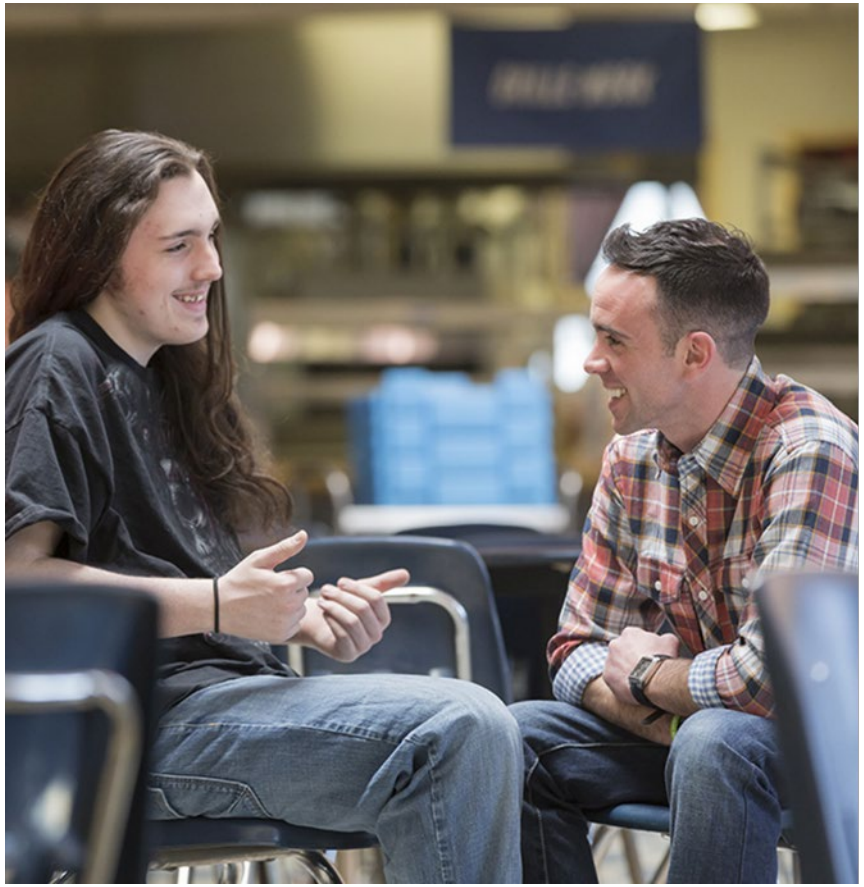
"Family Driven, Individualized, and Outcomes Based: Improving Wraparound Teamwork and Outcomes Using the Managing and Adapting Practice (MAP) System," Bruce Chorpita, Eric Bruns and Janet Walker. *https://nwi.pdx.edu/NWI-book/Chapters/Bruns-5g-wrap-MAP.pdf*

"The benefit of wraparound is that it coordinates multiple evidence-based services or other services that a child or youth is receiving. It brings in these natural supports that are in the child's life and community all to the table and all the folks that are supposed to be working with that youth and family – and helps everybody be on the same page. In some ways that care coordination piece is super critical. It is a different type of way of interacting with the youth and family than specific clinical interventions – and they are definitely complimentary."
- Abram B. Rosenblatt, Ph.D. Westat

Read More – Report on Wraparound efficacy and cost: https://depts.washington.edu/wrapeval/sites/default/files/presentations/Wrap-MAP%20Calif%20WA%20institute%206-13-12.pdf

"I'VE BEEN THERE": COMBINING PERSONAL EXPERIENCE AND FORMAL TRAINING TO HELP YOUTH WITH MENTAL HEALTH NEEDS

YOUTH PEER SUPPORT/FAMILY SUPPORT – PEER-TO-PEER



There is a movement to include youth peer support and family support in systems of care. Peers who have had experiences with mental health conditions and families that have had experiences with raising a child with mental health issues can offer support those in similar situations.

According to Westat, the peer support model is a *"burgeoning area"* in Youth Mental Health.

Read More: "The future of mental health care: peer-to-peer support and social media": https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4830464/

Read More – on a youth and multicultural Peer to Peer outreach program in Sacramento, CA: http://www.namisacramento.org/training/peertopeer.html

Read More – National Alliance on Mental Illness for example of Peer to Peer training program: https://www.nami.org/Find-Support/NAMI-Programs/NAMI-Peer-to-Peer

Read More – Mental Health America: http://www.mentalhealthamerica.net/peer-services

TELEHEALTH INCREASES ACCESS TO MENTAL HEALTH SUPPORT

TELEPSYCHIATRY OR TELEHEALTH

Telehealth is a collection of means or methods for enhancing health care and health education delivery through digital and telecommunications technologies.

Multiple factors have driven the adoption of telehealth in the field of adult mental health in recent years:

- **Increased access:** shortages of mental health specialists in certain regions can be alleviated with virtual access
- **Less stigma** comes with meeting with a mental health practitioner online, from home, relative to an in-person visit
- **New, virtual providers and platforms** crowding the space offering video consultations and texting services

Read More – telehealth specific to mental health care, see: "Health Systems Target Telehealth to Fill a Mental Healthcare Gap":https://mhealthintelligence.com/news/health-systems-target-telehealth-to-fill-a-mental-healthcare-gap

Read More: "Telehealth use in behavioral health cases shows promise in cost control, with utilization on the rise" https://www.healthcarefinancenews.com/news/telehealth-use-behavioral-health-cases-shows-promise-cost-control-utilization-rise

Read More: "A new emphasis on telehealth: How can psychologists stay ahead of the curve — and keep patients safe?": https://www.apa.org/monitor/2011/06/telehealth.aspx

Read More: Center for Connected Health Policy: The National Telehealth Resource Center: http://www.cchpca.org/what-is-telehealth

Read More: National Consortium of Telehealth Resource Centers: https://www.telehealthresourcecenter.org

Read More: http://www.cchpca.org/sites/default/files/uploader/Telehealth%20Definintion%20Framework%20for%20TRCs_0.pdf

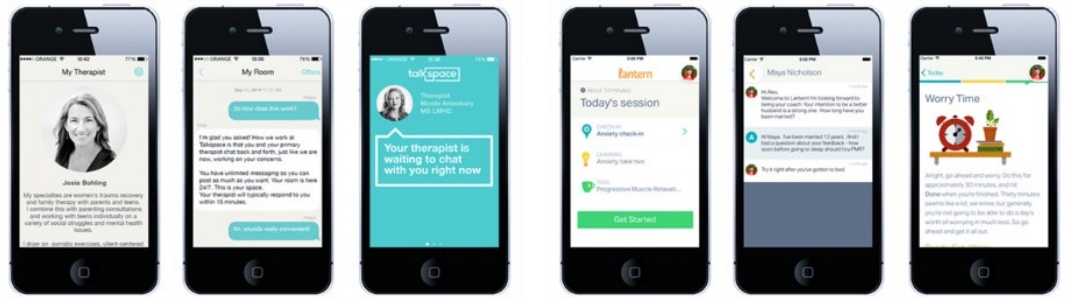
MENTAL HEALTH APPS SHOW PROMISE, ESPECIALLY FOR TEENS

MENTAL HEALTH APPS

- The idea is *not* that apps would replace traditional face-to-face therapy; instead, apps can **provide individualized support and increase access** to resources and interventions.
- The **immediate availability of support** is another advantage.
- Apps may also help to **overcome geographical and financial barriers to treatment** and engage traditionally hard-to-reach groups.
- They may also **reduce barriers for youth seeking mental health support**, such as the stigma or discomfort attached to discussing one's mental health through more traditional, face-to-face channels.

"A growing technology sector is creating coaching, counseling and monitoring services for teens and young adults fighting eating disorders, depression, anxiety and other mental health issues. The programs promise to open new avenues for those who… want or need more mental health care but — because of high service costs, logistical hassles, struggles with stigma or other obstacles — would not otherwise get it."

NPR piece: "New Apps Give Teens Easier, Persistent Access To Mental Help":
https://www.npr.org/2015/01/13/377038618/new-apps-give-teens-easier-persistent-access-to-mental-help



Read More: "Mental Health Mobile Apps for Preadolescents and Adolescents: A Systematic Review":
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5465380/

Read More: "Top 25 Best Mental Health Apps: An Effective Alternative for When You Can't Afford Therapy?":
https://www.psycom.net/25-best-mental-health-apps

THE PROBLEM IS THE PROBLEM; THE PERSON IS NOT THE PROBLEM

NARRATIVE THERAPY

Narrative therapy is a social-justice oriented, collaborative and non-pathologizing approach in which the therapist encourages the patient to narrate their story, then helps them to see how the events and problems that occur in that story are actually separate from them, rather than part of who they are.

In Narrative Therapy, clients learn the ways in which the negative events in their stories have come to shape their identities. In collaboration with the therapist, they learn to 're-write their stories.'
ttps://www.psychologytoday.com/us/therapy-types/narrative-therapy

An adolescent who has had numerous run-ins with the law may come to identify as an "offender," or a "criminal." Through Narrative Therapy, that adolescent would learn instead that the things that have happened to him or to her and the decisions and mistakes they have made are not actually who they are and do not define them.

This separation of the problem from the person empowers the individual "to make changes in their thought patterns and behavior and 'rewrite' their life story for a future that reflects who they are, what they are capable of, and what their purpose is, separate from their problems."
https://www.psychologytoday.com/us/therapy-types/narrative-therapy

Narrative therapy "is a way of working that considers the broader context of people's lives particularly in the various dimensions of diversity including class, race, gender, sexual orientation and ability."
http://www.narrativetherapycentre.com/narrative.html

Read more: **https://positivepsychologyprogram.com/narrative-therapy/**

Read more: **https://www.bostoneveningtherapy.com/2015/03/5-things-to-know-about-narrative-therapy/**

IT CAN BE DONE:

We have new science and emerging practices that demonstrate the promise of behavioral health and the critical role schools can and must play

AND
There is striking evidence of a crisis

AND
Sgnifiganct Resources Are Flowing to Schools

AND
There is a way to finance broad reform if we use all of the tools at our disposal

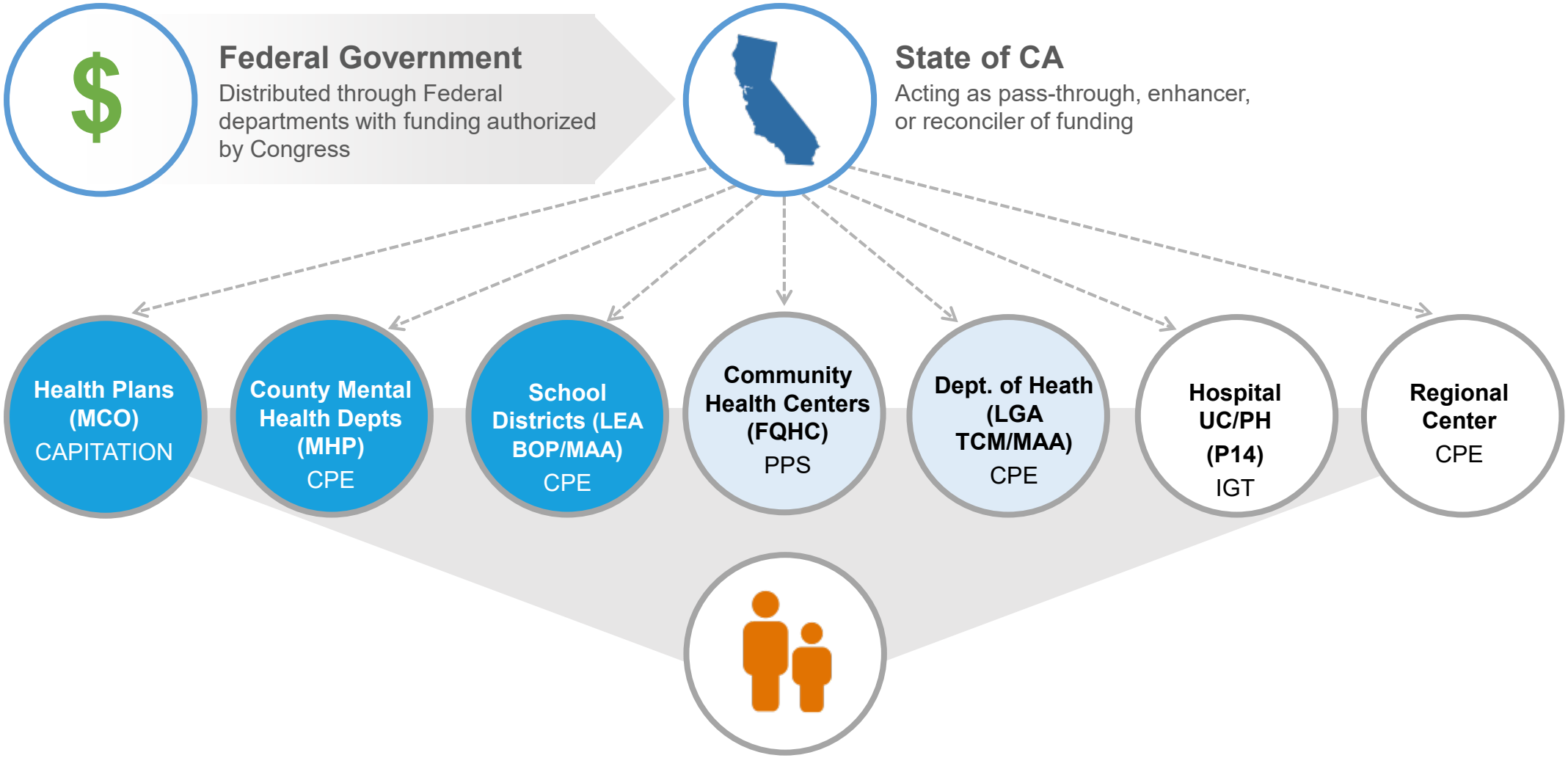
THERE IS HOPE

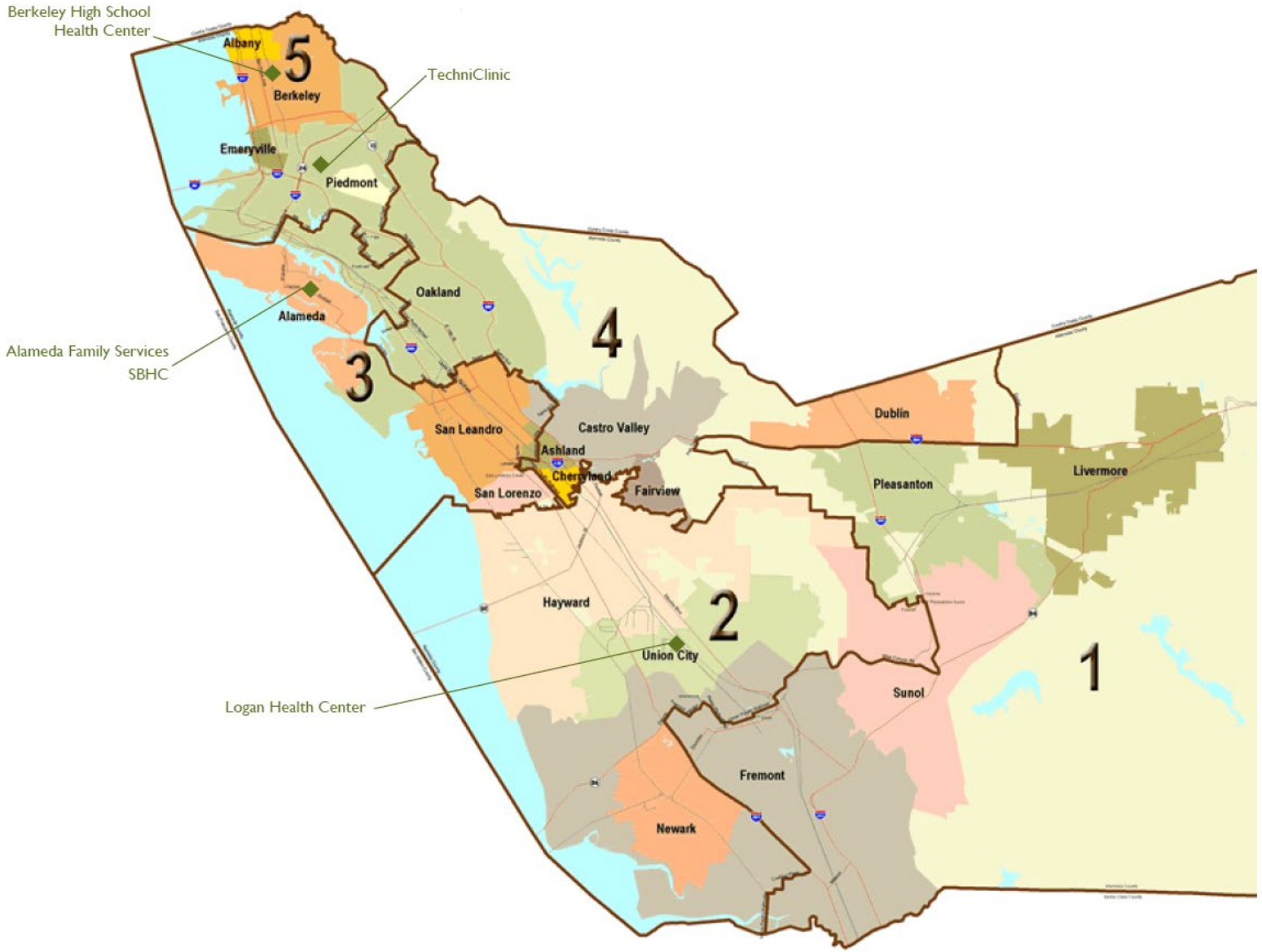
There are new and emerging practices.

Integration is possible - within health systems and among child serving systems.

It is past time.

WHO ARE THE MOST IMPORTANT PAYORS FOR SCHOOLS?



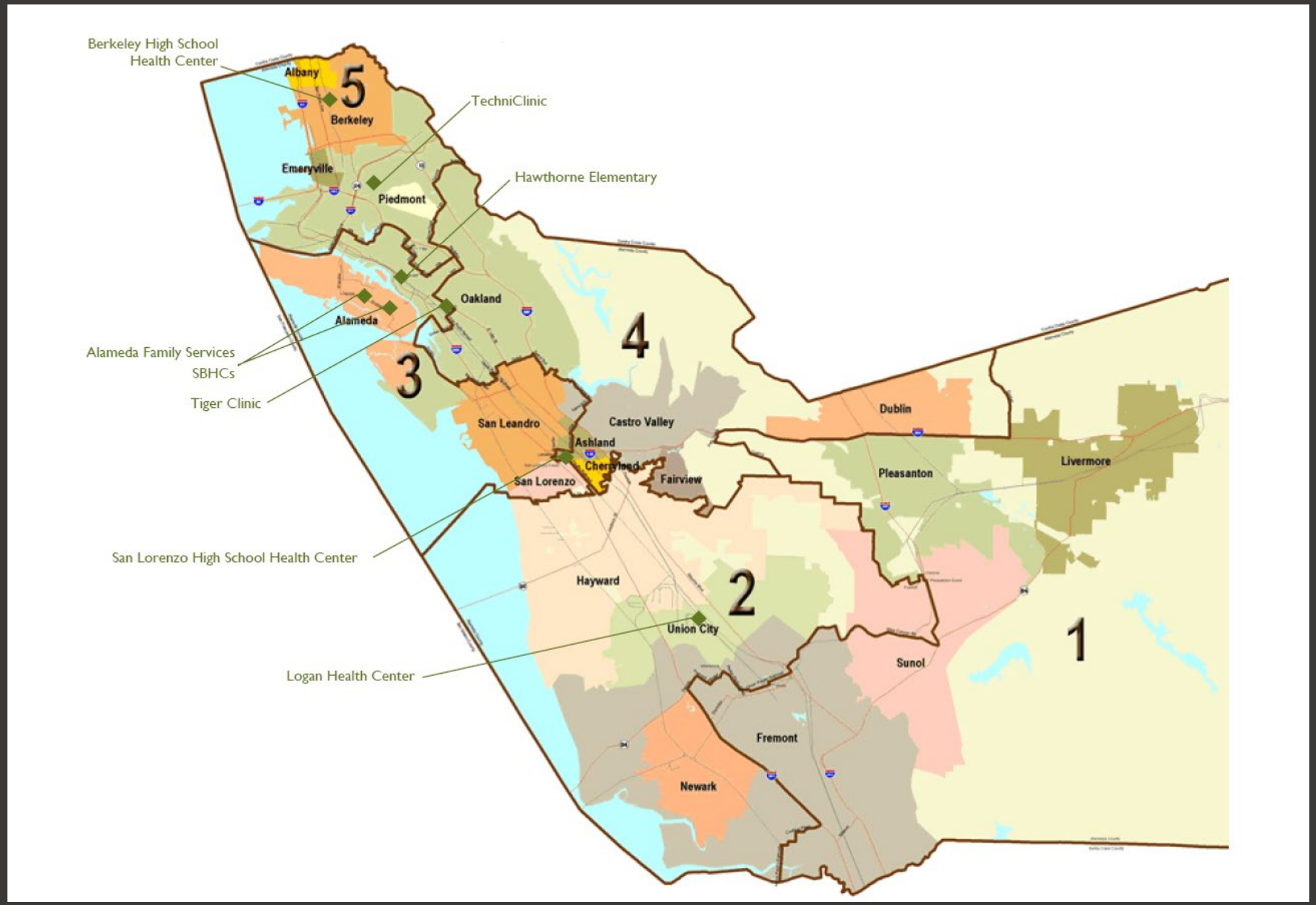


Alameda County

4

School Health Centers

1996

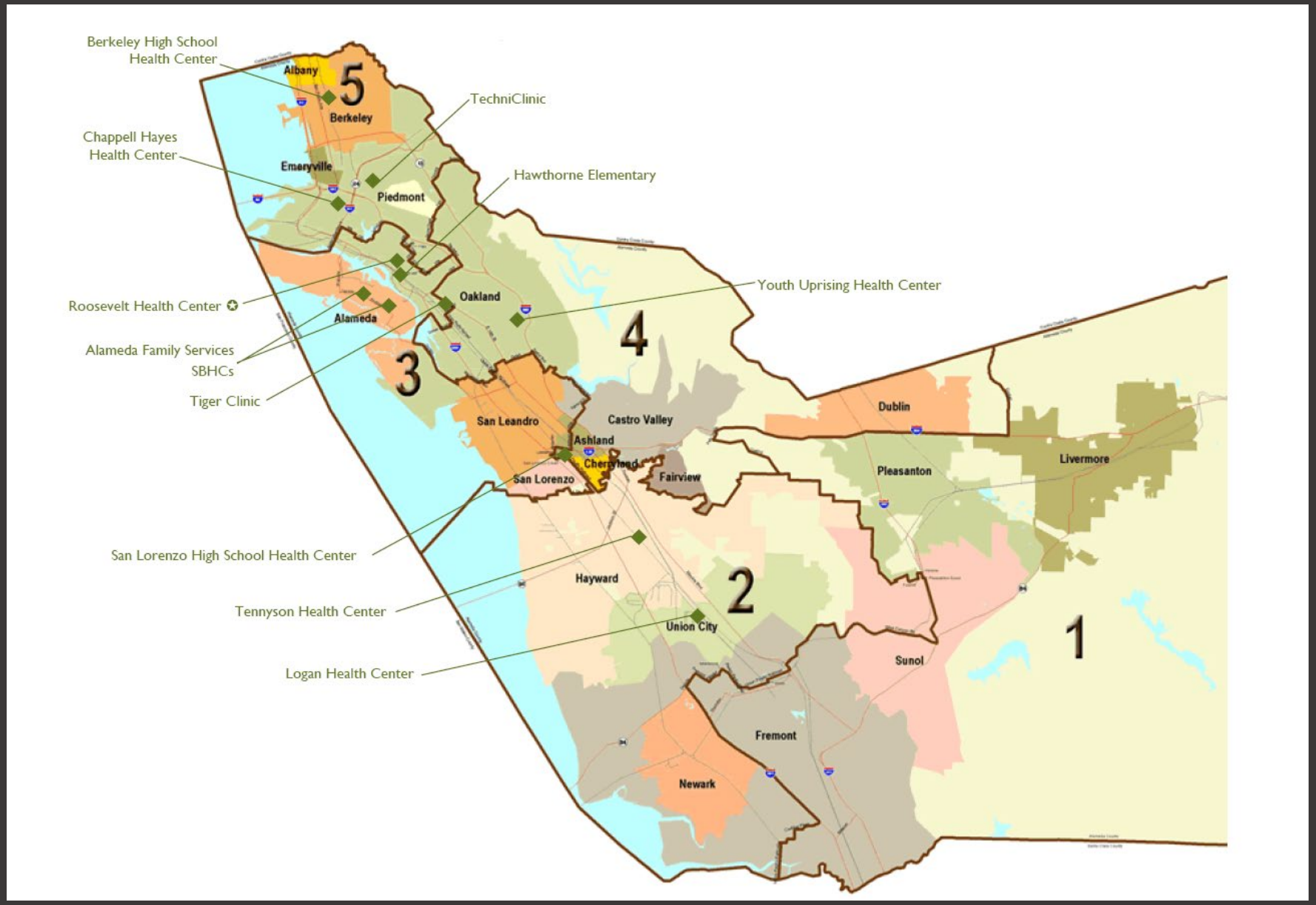


Alameda County

8

School Health Centers

2000

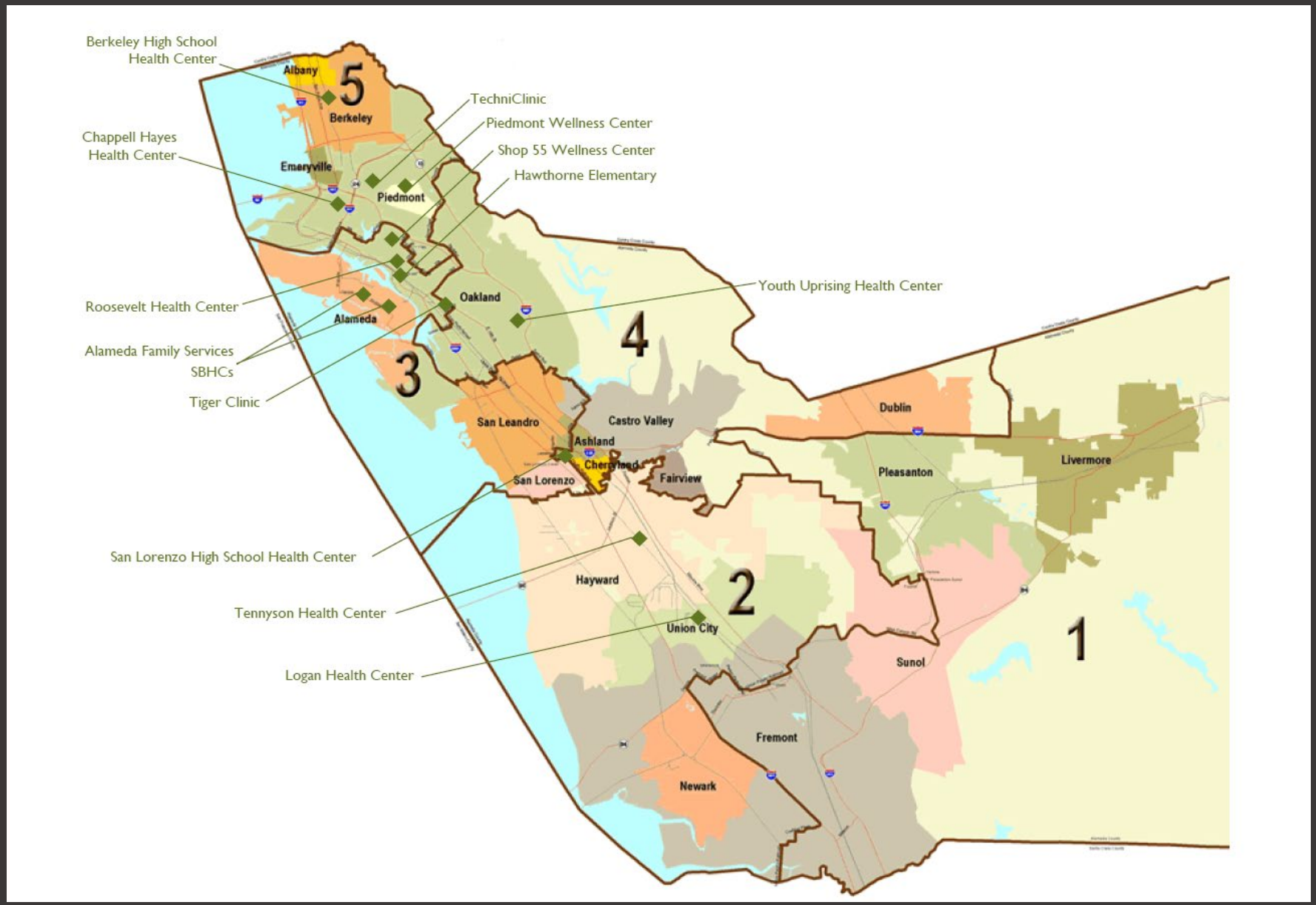


Alameda County

12

School Health Centers

2004



Alameda County

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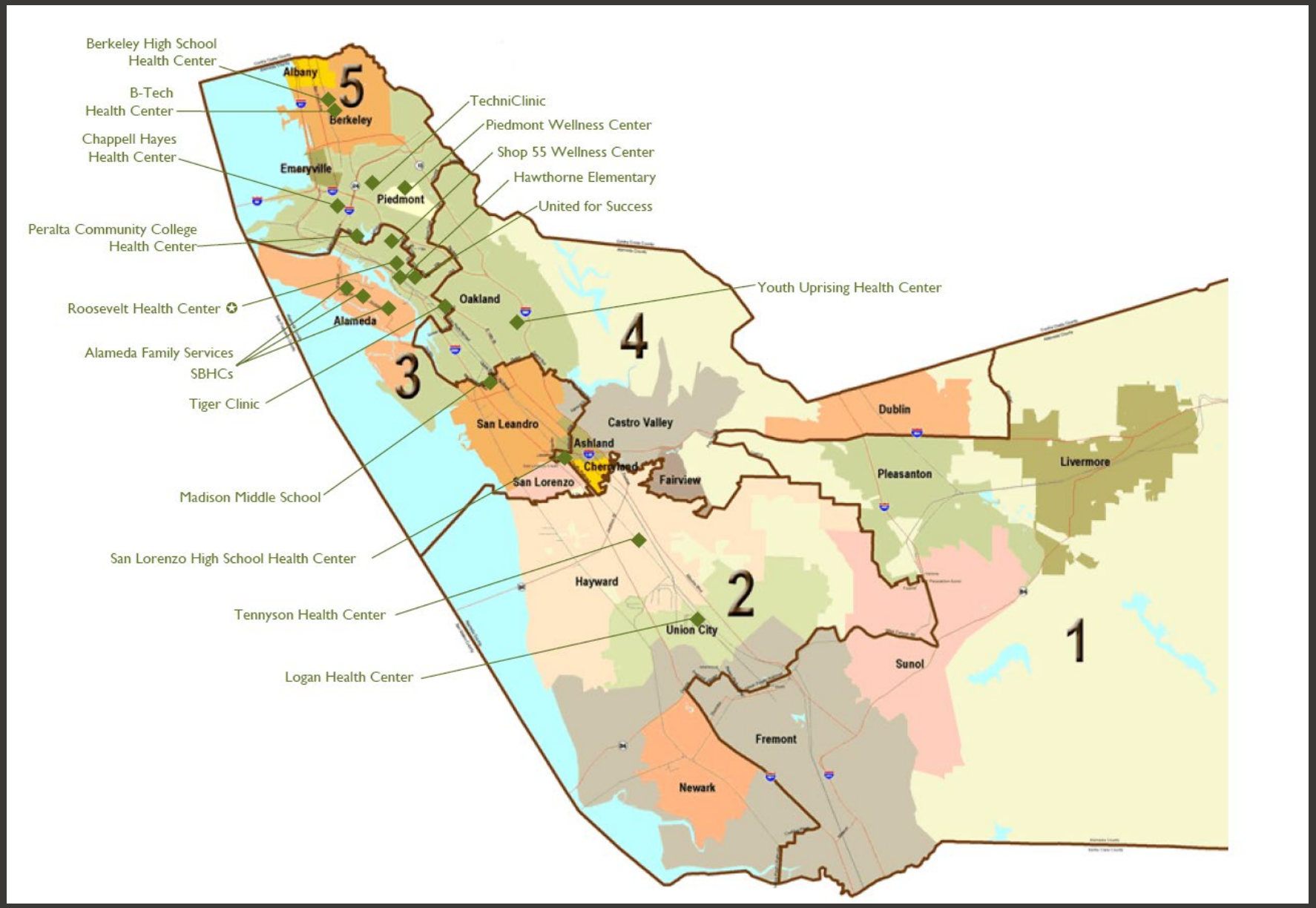
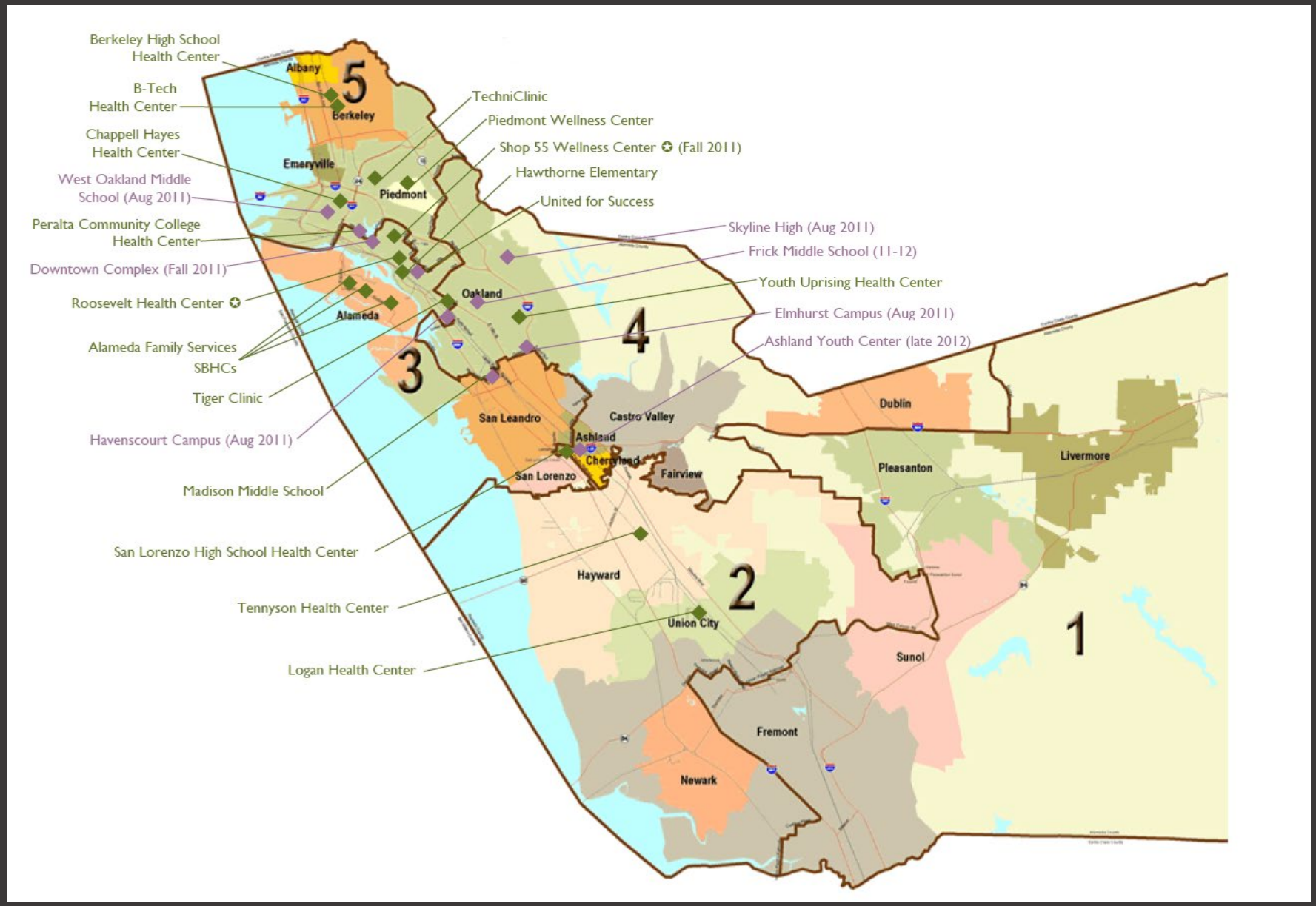
School Health Centers

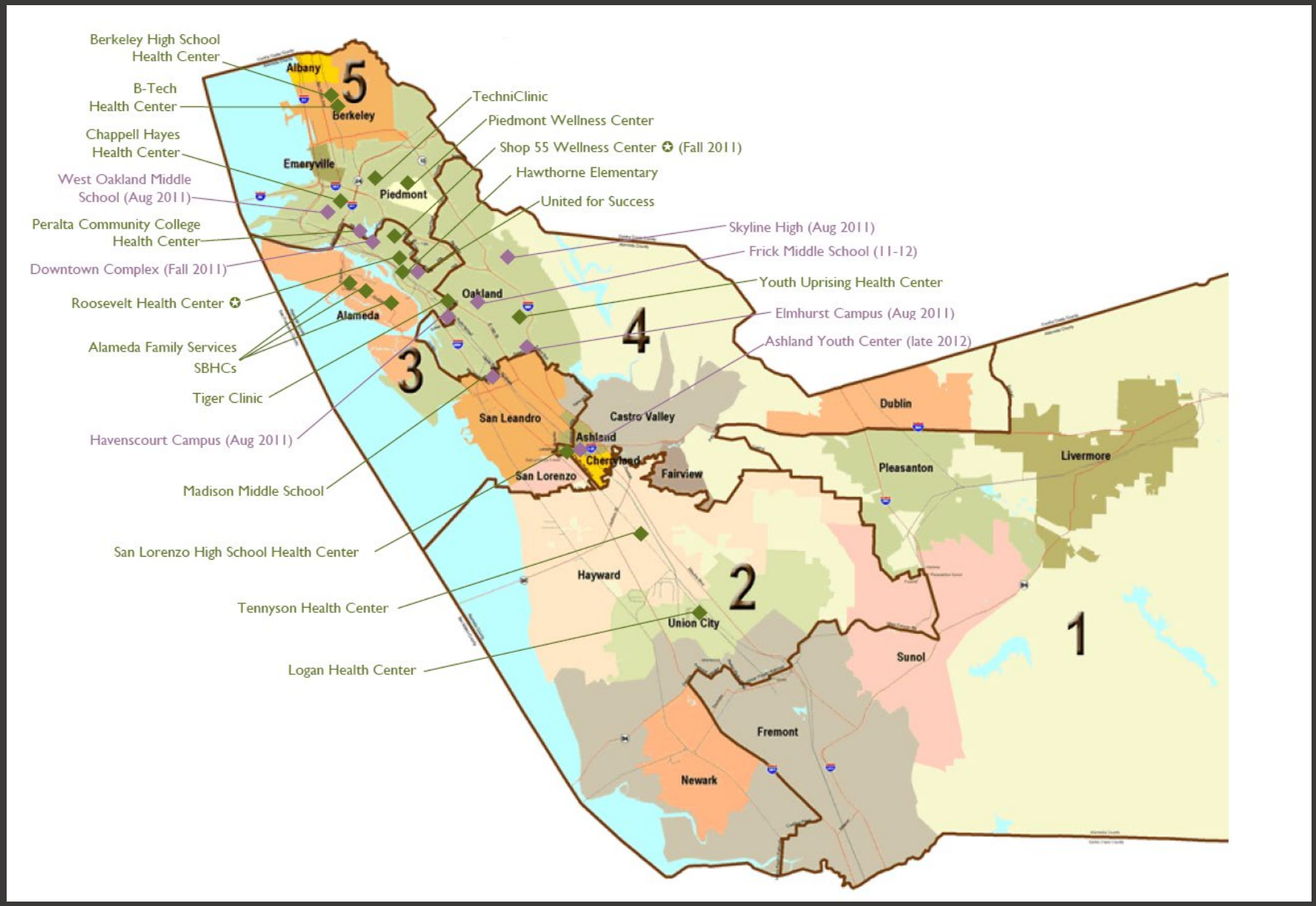
2008



Alameda County 19 School Health Centers 2010



Alameda County 26 School Health Centers 2012



Alameda County 29 School Health Centers 2014

TODAY THERE ARE 200 SCHOOL BASED BEHAVIORAL HEALTH PROGRAMS IN ALAMEDA COUNTY

FOLLOWING MEDICAID DOLLARS CAN WORK

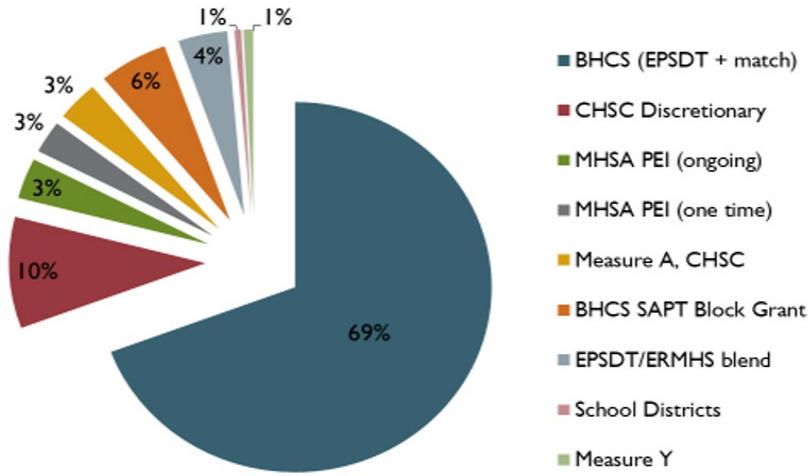
Persistence. Questioning the culture of entrenched systems. Mutual accountability.

1996
Alameda County
4 School Health Centers

2019
Alameda County
200 School Health Centers

Today
10,000 Children Added Care – Most Through Schools

Nine funding sources bundled to match this funding



The California Children's Trust and The Santa Clara County Office of Education

A Deep Dive into Financing and Sustaining School Heath Programs

@CAChildrenTrust
www.cachildrenstrust.org

Practical Guide for Financing Social, Emotional, and Mental Health in Schools: https://cachildrenstrust.org/wp-content/uploads/2020/08/practicalguide.pdf