REIMAGINING OUR MENTAL HEALTH SYSTEM TO ACHIEVE EQUITY AND HEALING FOR CHILDREN AND FAMILIES

Overview and Call-to-Action
January 2020
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
EVERYONE PAYS A HIGH PRICE
We have a fiscal and moral imperative to address the crisis

$11.6 BILLION

$11.6 billion was spent on hospital visits for mental health between 2006 and 2011

Mental health and substance use disorders are the leading causes of disease burden in the U.S.

37%

37% of students with mental illness age 14 and older, dropout of school—the highest dropout rate of any disability group

Untreated behavioral health needs can lead to lifelong challenges in social and emotional development, academic achievement, and physical health
THE “PRICE” IS HIGHER FOR BLACK AND BROWN CHILDREN
They receive the wrong services at the wrong time

81% of children on medicaid are black or brown.

The suicide rate for black children, aged 5-12 is 2x that of their white peers.

70% of youth in California's juvenile justice system have unmet behavioral health needs, and youth of color are over-represented in the system.

Addressing disproportionality in the mental health system is not just a matter of tweaking access or programs, it is a matter of rooting out racist infrastructure.
WE HAVE A ONCE-IN-A-GENERATION OPPORTUNITY
Public opinion and policymaker agendas are aligned

- **Political will**: New administration has stated focus on children’s well-being.

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

- **Economic rationale**:
  - Economic imperative is aligned with social justice imperative.
  - Funding for children’s mental health has increased at the federal, state and local levels since 2010.
  - Mental health revenues are growing, for example, an 80% increase in 2011 realignment subaccount.
WHAT WILL CALIFORNIA DO—
AS THE FIFTH LARGEST ECONOMY IN
THE WORLD—WHEN IT SEES THAT
TWICE AS MANY OF ITS CHILDREN
ARE TRYING TO KILL THEMSELVES?
Transforming the mental health system: We are a coalition-supported initiative to reimagine how California defines, finances, administers and delivers children’s mental health supports and services.

With a focus on equity + justice: We frame our approach to state and county finance reform with a clear and open acknowledgement of the ways existing child-serving systems have underserved, excluded, and in some cases harmed populations of children and families.
OUR VISION FOR CHANGE

Every child in California has a fair and intergenerational opportunity to attain their full health and developmental potential, free from discrimination.
FOUR KEY CHALLENGES TO REALIZE THIS VISION

1. **Root Causes**
   addressing societal inequities and structural racism

2. **The Access Gap**
   eligibility has increased, but access has declined

3. **A Broken Model**
   the current medical model does not address the crisis

4. **Fragmented Child-Serving Systems**
   children get their services from multiple systems that have little connection or accountability
Root Causes

THE IMPACT OF INDIVIDUAL AND STRUCTURAL ADVERSITY

ADVERSE CHILDHOOD EXPERIENCES
- Maternal Depression
- Emotional & Sexual Abuse
- Substance Abuse
- Domestic Violence
- Physical & Emotional Neglect
- Divorce
- Mental Illness
- Incarceration
- Homelessness

ADVERSE COMMUNITY ENVIRONMENTS
- Poverty
- Violence
- Discrimination
- Poor Housing Quality & Affordability
- Community Disruption
- Lack of Opportunity, Economic Mobility & Social Capital
Adverse Childhood Experiences (ACEs) impact every community

- 61.7% of adults have experienced one ACE
- And it’s higher in rural counties, e.g., Butte County, 76.5% of adults have experienced at least one ACE

Preventing ACEs could reduce a large number of health conditions, including up to 21M Cases of Depression.
Root Causes

STRUCTURAL ADVERSITY: POVERTY

2 in 10 Californians live in poverty

1 in 2 children live in or near poverty

California has one of the highest poverty rates under the supplemental poverty measure

70% of children born into poverty never get out

It now takes until age 26 for family sustaining employment—extending adolescence

Root Causes

STRUCTURAL ADVERSITY: DISCRIMINATION

In 99% of neighborhoods in the US, black boys earn less in adulthood than white boys who grow up in families with comparable income.
Regional centers that authorize lower amounts of services are mainly those with larger Hispanic and Black/African American client populations.
In recent years, the share of all income held by the top 1% has approached or surpassed historic highs.

2018 statistics show an alarming gap:

- **$1,693,094**
  - Average annual income at the top 1%

- **$55,152**
  - Average income of everyone else (the bottom 99%)

- **30.7x**
  - The top 1% make 30.7 times more than the bottom 99%

Root Causes

STRUCTURAL ADVERSITY: ISOLATION

Adverse environments build emotional and physical barriers to the connection people need to heal and thrive.

Geographic  Social  Cultural
Root Causes

SOCIAL MEDIA AND NEWS CYCLES COMPOUND THE PROBLEM

Adversity, poverty, inequality, racism and isolation are all compounded by the reality of modern digital communication; social media and the news cycle.

Adolescents who spend more than three hours a day on social media are more likely to report high levels of internalizing behaviors, e.g. fearfulness and social withdrawal, compared to adolescents who do not use social media at all.

The #1 pre-determine of human intelligence is safety. With technology, kids have easy and constant access to threatening and stressful information with no adult buffer.
Root Causes

THE DEFICIT CYCLE

The challenge crosses child-serving sectors and the consequences of failure are intergenerational.
WHAT DOES THIS MEAN?

- We live within systems, structures, and cultural norms that **corrode human relationships**, fracture and scatter communities, degrade human connections, and threaten the human spirit.

- This **isolates children and families** outside of the relationships they rely on to thrive and results in developmental delay, decreased educational attainment, social and emotional stress and impairment, anxiety, depression, shame, and self-harm.

- Existing efforts, remedies, and **solutions are misaligned** with addressing this problem and its multitude of symptoms.
ELIGIBILITY FOR MENTAL HEALTH SERVICES HAS INCREASED

6 million of California’s 10 million children are covered by Medi-Cal and EPSDT entitlement (a 33% increase over last five years)

96% of California children are covered by a health plan with a mental health benefit
The Access Gap

BUT ACCESS TO MENTAL HEALTH SERVICES HAS DECLINED

3%

The access rate (one time visit), has declined from 4.5% to 4.1%. For ongoing access (more than 5 visits), the rate is down to 3%

Those accessing care, are approaching the system in crisis

20%

There has been a 20% increase in crisis service utilization since 2011
THE MODEL FALLS SHORT OF NEEDS

~75% of mental illness manifests between the ages of 10 and 24. Adolescents are less likely to go to the doctor, so early warning signs are missed.

California has fewer than 1,150 child and adolescent psychiatrists to serve more than 9 million children in the state.

Only about 4-7% of children require medical intervention by diagnosis. 60-90% of kids should receive care without a diagnosis.
A Broken Model

AND IT IS NOT EQUIPPED TO HANDLE THE CRISIS

- We have no common framework for defining and understanding behavioral health among and between public systems and clinical care providers.

- Our public systems are deeply fragmented and under-resourced. Commercial payers have not effectively partnered with child-serving systems.

- A lack of clarity over whether youth mental health care is an essential benefit or a public utility prevents commercial payers from fully engaging.

- Our definition of medical necessity is outdated and inconsistent with emerging trends and evidence regarding the impact of trauma and adversity on social and emotional health.

- The field is young. Many clinical modalities with widespread application are less than 20 years old.
Fragmented Child-Serving Systems

Children and youth are expected to access mental health care through disconnected systems that are supported by disconnected service providers.
GOOD NEWS

If we look at it differently, this complex child-serving system is both the problem AND the solution.
THE CALIFORNIA CHILDREN’S TRUST HAS THREE STRATEGIC PRIORITIES TO ADDRESS THESE CHALLENGES

- **Expand Access and Participation**
- **Equity + Justice**
- **Maximize Funding**
- **Reinvent Systems**
Transformed behavioral health systems are not simply financed or administered differently, they are:

- anchored in new principles that acknowledge structural racism and poverty,
- informed by relationships to and with beneficiaries and
- designed as methods for accountability.
Maximize Funding

INCREASE STATE AND COUNTY SPENDING, AND FULLY CLAIM THE FEDERAL MATCH

How We Do It
- Reform state and local administrative practices
- Reform managed care

How We Center the Beneficiary Experience
Address California’s historical underinvestment in children of color
Maximize Funding

FOLLOW MEDICAID DOLLARS TO FIND MONEY LEFT ON THE TABLE

**Federal Government**
Distributed through Federal departments with funding authorized by Congress

**State of CA**
Acting as pass through, enhancer, or reconciler of funding

- Health Plans (MCO) CAPITATION
- County Mental Health Dept’s (MHP) CPE
- Dept. of Heath (LGA) CPE
- School Districts (LEAs/SELPAs) CPE
- Community Health Centers FQHC PPS
- Hospital UC/PH IGT
- Regional Center CPE
Expand Access and Participation

EXPAND WHO IS ELIGIBLE, WHO CAN PROVIDE CARE, WHAT IS PROVIDED, AND THE AGENCY OF THE BENEFICIARY

How We Do It
• Redefine medical necessity & provide services without diagnosis
• Expand peer-to-peer & social models
• Integrate CBOs in delivery

How We Center the Beneficiary Experience
• Ensure Access to care in CBO settings
• Ensure community beneficiaries take direct control
• Integrate non-traditional providers
• Remove diagnosis as a prerequisite
• Expand provider designations

Expand Access and Participation
Maximize Funding
Equity + Justice
Reinvent Systems
Reinvent Systems

INCREASE TRANSPARENCY AND ACCOUNTABILITY

How We Do It
• Integrate data systems
• Mandate common assessment tools
• Define a common set of outcomes
• Collaborative financing models
• Ensure geographic equity

How We Center the Beneficiary Experience
Directly tie patient experience to outcome measures and reimbursement tools

Expand Access and Participation
Maximize Funding
Reinvent Systems
Equity + Justice
THIS IS THE TRUST’S FRAMEWORK FOR SOLUTIONS

- **Expand Access and Participation**: Expand who is eligible, who can provide care, what is provided, and the agency of the beneficiary.
- **Maximize Funding**: Increase state and county spending, and fully claim the federal match.
- **Equity + Justice**: Increase transparency and accountability.
- **Reinvent Systems**: Reinvent systems.
OUR 2020 AGENDA

- Support Regional Initiatives/Pilots
- Advocate for State level policies
- Engage in debates on fiscal reforms
- Elevate Family/ Child/ and Community Voice
OUR CALL TO ACTION

Support statewide advocacy effort

Read and share our policy briefs

Join our Coalition

Become an ambassador for The Trust’s Framework for Solutions