California Children's Trust

Reimagining Behavioral Health for California's Children

BREAKING BARRIERS, November 15th, 2018

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BEHAVIORAL HEALTH IS NOT SIMPLY A RESPONSE TO PATHOLOGY—IT IS A STRATEGY TO ACHIEVE EQUITY, HEALTHY DEVELOPMENT, AND SYSTEMS CHANGE.

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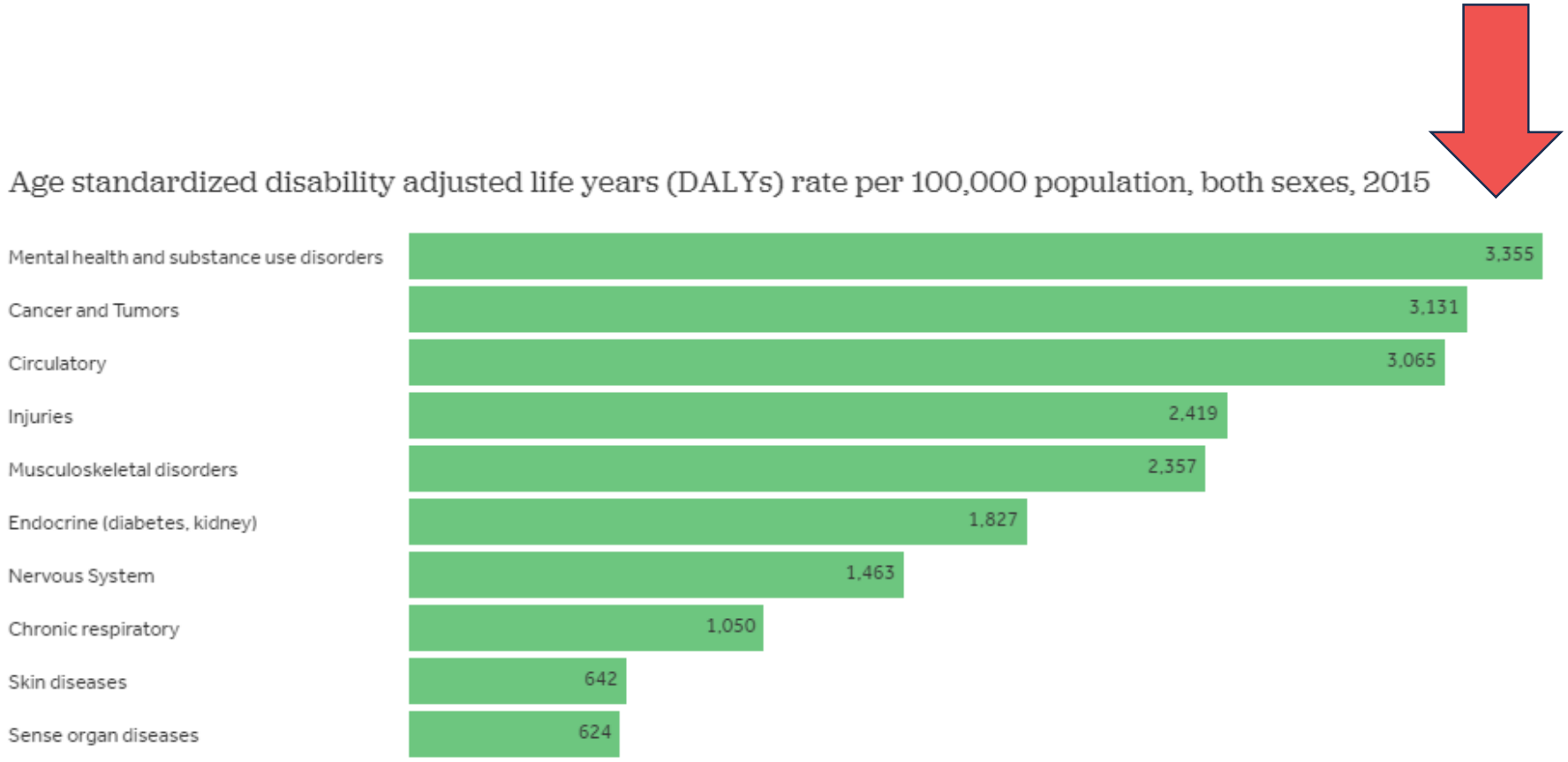
The Crisis is Real.
So Is the Opportunity.

Join us and help reinvent how we define, fund, administer, and measure the social and emotional health of California's Children

MENTAL HEALTH AND SUBSTANCE USE DISORDERS ARE THE LEADING CAUSES OF DISEASE BURDEN IN THE US



DALY, or the Disability-Adjusted Life-Year, is a metric that combines the burden of mortality and morbidity (non-fatal health problems) into a single number. One DALY can be thought of as one lost year of "healthy" life.

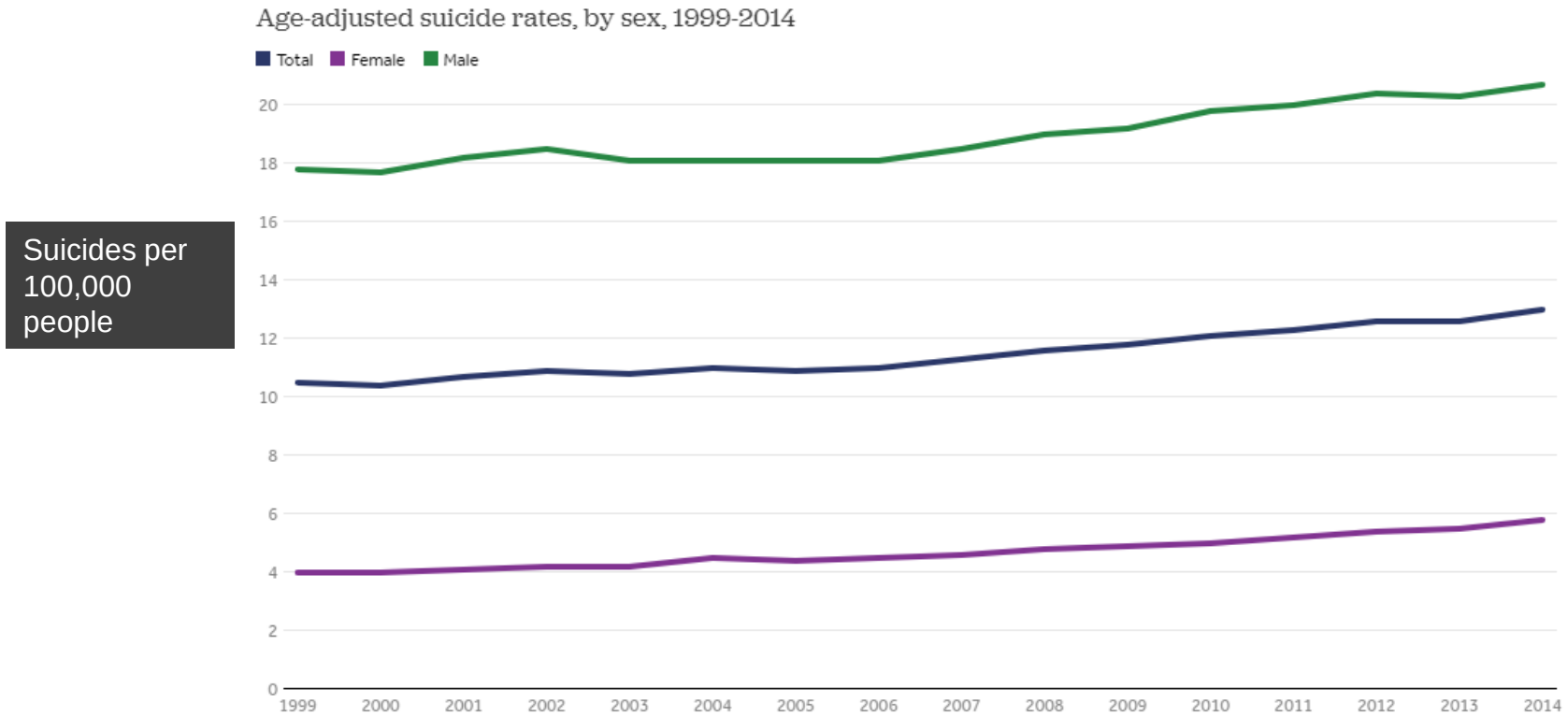
DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost (YLL) due to premature mortality in the population and the Years Lost due to Disability (YLD) for people living with the health condition or its consequences: **DALY = YLL + YLD**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

BEHAVIORAL HEALTH IS THE FUNDAMENTAL DRIVER OF MORBIDITY FOR 10- TO 24-YEAR-OLDS

Homicide, suicide, and unintentional injury (mostly car-related) are the three leading causes of death for youth ages 10-24.

In the last 10 years, suicide has leap-frogged cancer and unintentional injury and become the second leading cause of death for youth and young adults.



Suicide Data is Striking

After almost steadily declining between 1986 and 1999, the national suicide rate increased a startling 24% between 1999 and 2014, with a 2% increase per year beginning in 2006.

The suicide rate for young women ages 10-14 increased the most in that time, jumping 200% from 0.5 suicides per 100,000 to 1.5 suicides per 100,000.

And it's not just suicide rates…

There have been striking increases in both self-reported need (surveys) and demonstrated acuity (diagnosis and utilization of crisis and inpatient services) over the last 10 years of available data.

Overall All Cause children's hospitalizations are not increasing. **The primary drivers of increases in hospitalizations among youth and young adults are behavioral health conditions.**

https://www.healthsystemtracker.org/chart-collection/current-costs-outcomes-related-mental-health-substance-abuse-disorders/#item-prevalence-mental-illness-among-adults-relatively-stable

Children In California

10,192,863 children

5h largest economy in the world

20% of children live in poverty (8 of 10 will never move out)

More than 6 million of California's 10 Million Children Are Covered by MediCal and the EPSDT Entitlement (33% increase over last 5 years)

96% of children in California are covered by a health insurance plan with a mental health benefit.

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Low Income children and children from marginalized communities experience adversity at greater rates and bear a disproportionate burden of adverse outcomes.

African-American children are 7 times as likely as white children to be persistently poor.

Latino students in LAUSD drop out of school at a rate 7.5 times higher than that of their white counterparts.

over 70% of youth with mental health needs did not have access to services, even if they have health insurance. This increases to 80% among youth with non-English-speaking parents.

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Among children & adolescents enrolled in MediCal:

- 63.4% Hispanic
- 14.5% White
- 9% African American
- 7% Other
- 5.7% Asian/Pacific Islander
- 0.4% Alaskan Native/Native American

Sources: CA Department of Health Care Services, Research and Analytics Studies Division, "Medi-Cal Child Population Ages 0-11: Medi-Cal enrollment before the Affordable Care Act" May 2015, accessed at http://www.dhcs.ca.gov/dataandstats/statistics/Documents/CHIS_Children_0-11_Report_ADA.pdf
CA Department of Health Care Services, Research and Analytics Studies Division, "Medi-Cal Adolescent Population Ages 12-17: Medi-Cal enrollment before the Affordable Care Act" May 2015, accessed at http://www.dhcs.ca.gov/dataandstats/statistics/Documents/CHIS_Adolescent_Report_ADA.pdf

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California's children's mental health system is underperforming:

Most children get no support, and many get the wrong kind.

96% of children in California are covered by a health insurance plan with a mental health benefit.

But less than 1 in 4 receive any mental health treatment.

And now only 3% of low income children entitled to all the care they require get ongoing care (5 or more visits)

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THERE HAS BEEN STRIKING INCREASES IN MENTAL HEALTH NEEDS AND ACUITY AMONG YOUTH

Inpatient visits for suicide, suicidal ideation and self-injury **increased by 104% for children ages 1 to 17 years, and by 151% for children ages 10 to 14** between 2006 and 2011.

ED visits increased by 71% for impulse control disorders for children ages 1 to 17 years.

A total of **$11.6 billion was spent on hospital visits** for mental health between 2006 and 2011.

In California, **There has been a 50% increase in mental health hospital days** for children between 2006 and 2014

Things are getting worse.

For adolescents*:

- the rate of self-reported mental health needs has increased by 61% since 2005
- the rate of mental health-related hospitalizations has increased 50% since 2007

More children are eligible for services yet fewer are getting care. Since 2011 Realignment:

- Despite a 20% increase in the number of eligible children, there has been a concurrent 9% decrease in the rate of children receiving services.
- For those receiving services, there was a 20% increase in crisis services utilization.

***Data Source:** California Office of Statewide Health Planning and Development special tabulation; California Dept. of Finance, Population Estimates by Race/Ethnicity with Age and Gender Detail 2000-2009; Population Reference Bureau, Population Estimates 2010-2016 (Aug. 2017).

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THE MEDICAL MODEL ISN'T THE ANSWER

- Approximately 75% of mental illness manifests between the ages of 10 and 24. Since adolescents have the lowest rate of primary care utilization of any demographic group, it makes early warning signs difficult to detect.
- Provider shortages at the PCP and mental health practitioner level compound the challenge.
- Diagnosis-driven models are only appropriate for some children. Early identification and intervention is essential to any recovery framework.

How did we get here?

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.

These are hard truths and they require
a new approach...

AND

We have a generational opportunity to act. The crisis is real but so is the opportunity.

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The Children's Trust seeks to reinvent how we fund, purchase, deliver, and evaluate social, emotional, and developmental services and supports across systems.

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/

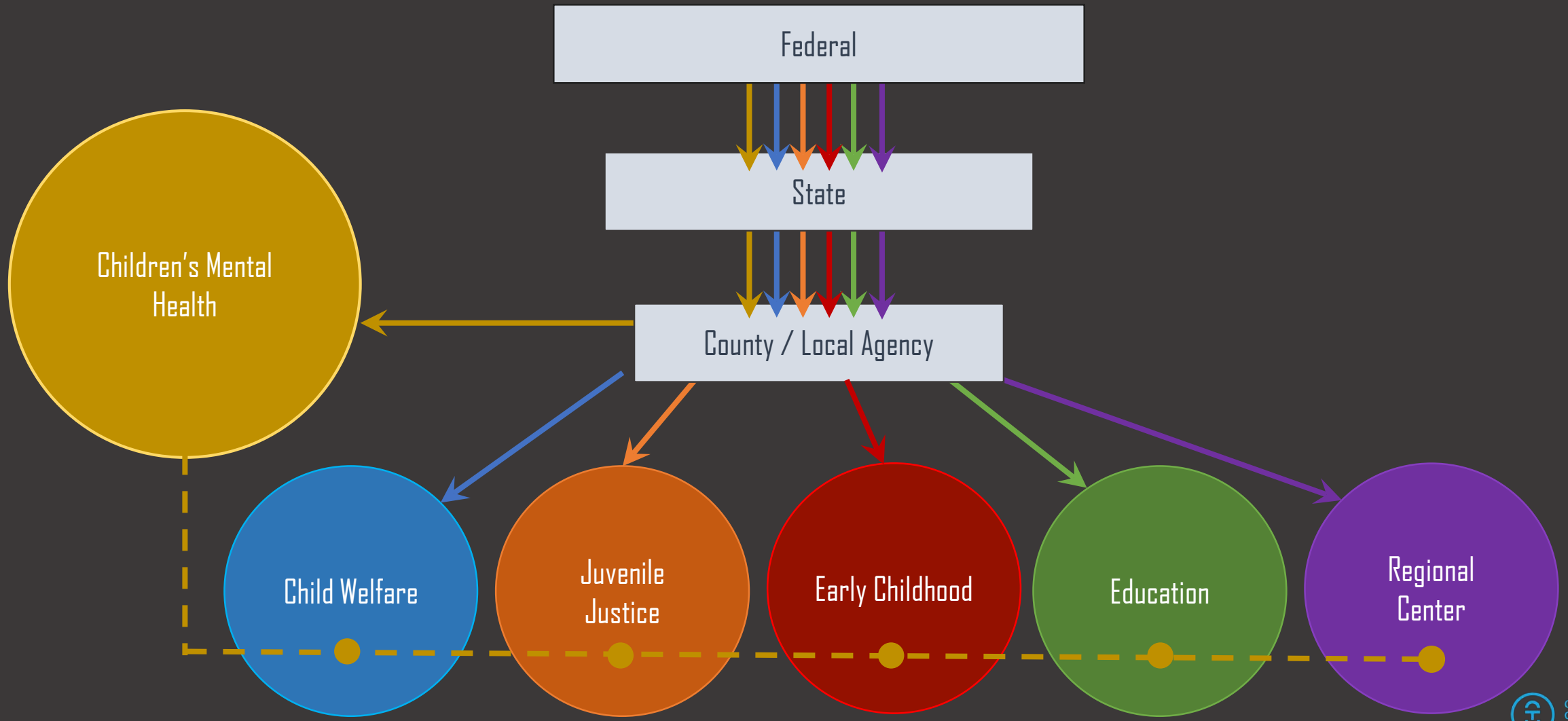
Lawrence, P.J., Rook, S., Creswell, C. 2017. "Review: Prevention of anxiety among at-risk children and adolescents-a systematic review and meta-analysis."Child and Adolescent Mental Health.; 22(3): 118–130

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

MEDICAID IS THE TIE THAT BINDS FRAGMENTED CHILDREN'S SYSTEMS



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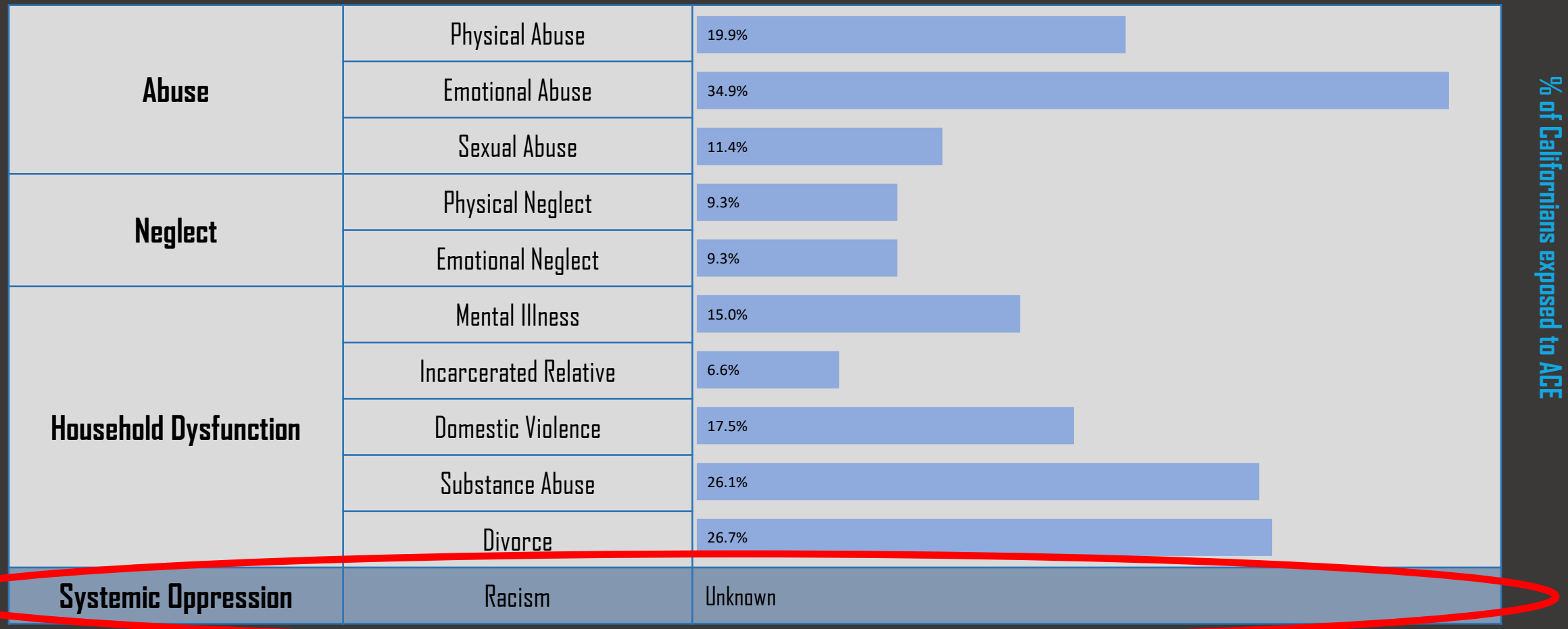
PREVALENCE OF ACEs



Source: Center For Youth Wellness - Data Report A Hidden Crisis (2014)

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We have new science and emerging practices that demonstrate the importance and promise of behavioral health

The Economic Imperative is aligned with the social justice imperative.

We face a generational opportunity to finance systems change at scale

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WHY NOW?

- Growing consensus that current design and outcomes are unacceptable
- Growing revenues (MHSA AND REALIGNMENT) in the context of the EPSDT Entitlement.
- Federal waiver opportunities
- National movement towards integration
- New science and learning that highlights the promise of behavioral health
- New state administration
- Need for Family Systems Models
- Workforce Scarcity as Opportunity
- Lessons Learned

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Mine that past for adaptive behavior…

ALAMEDA COUNTY

1.5 million residents

5 SELPAs

14 school districts

Thirteen 9-1-1 receiving centers

22 Hospitals

2,000 children in out-of-home care

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EPSDT EXPANSION TO SERVE MORE YOUTH

Source: Alameda County BHCS Children's System of Care

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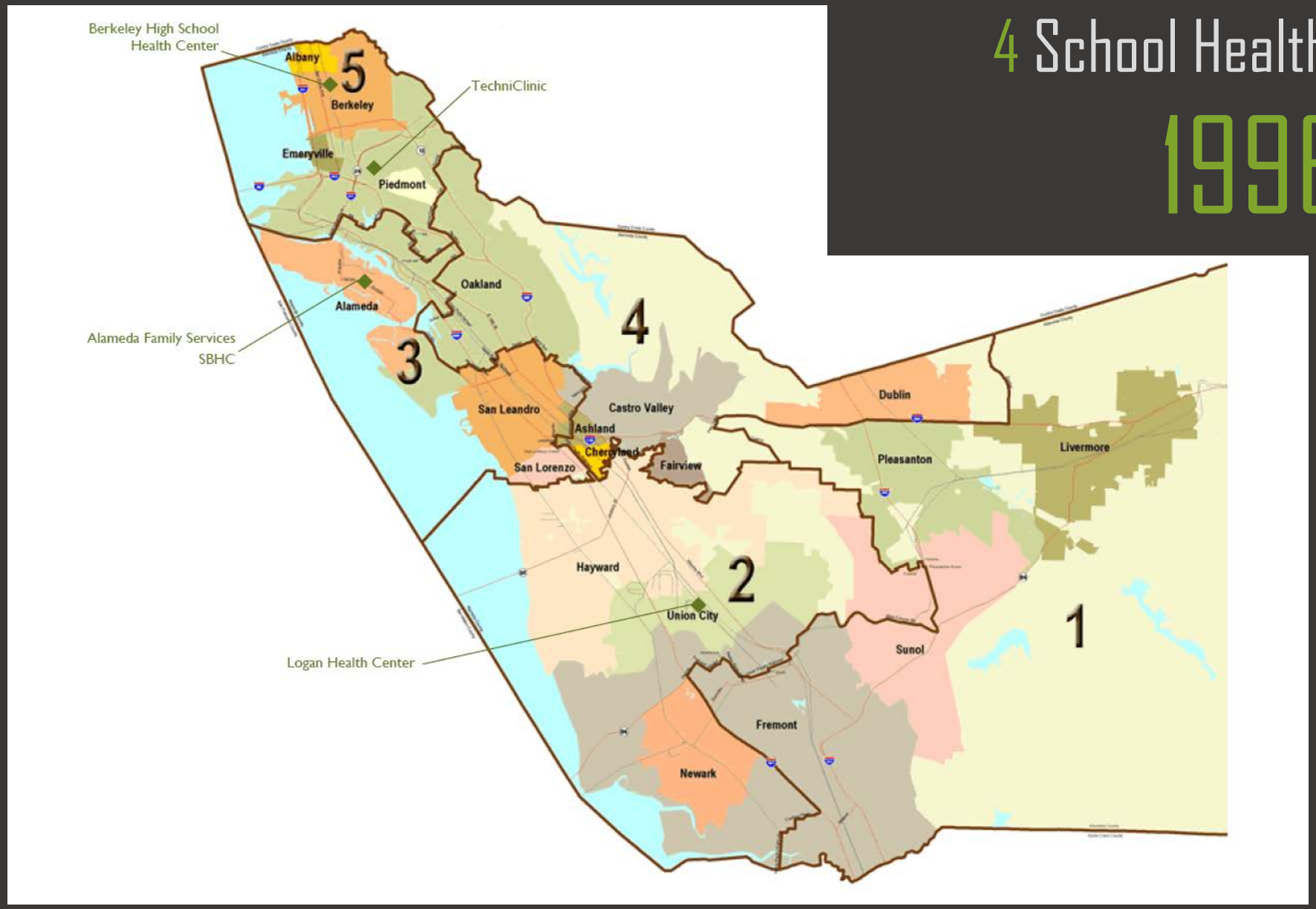
Alameda County
4 School Health Centers
1996



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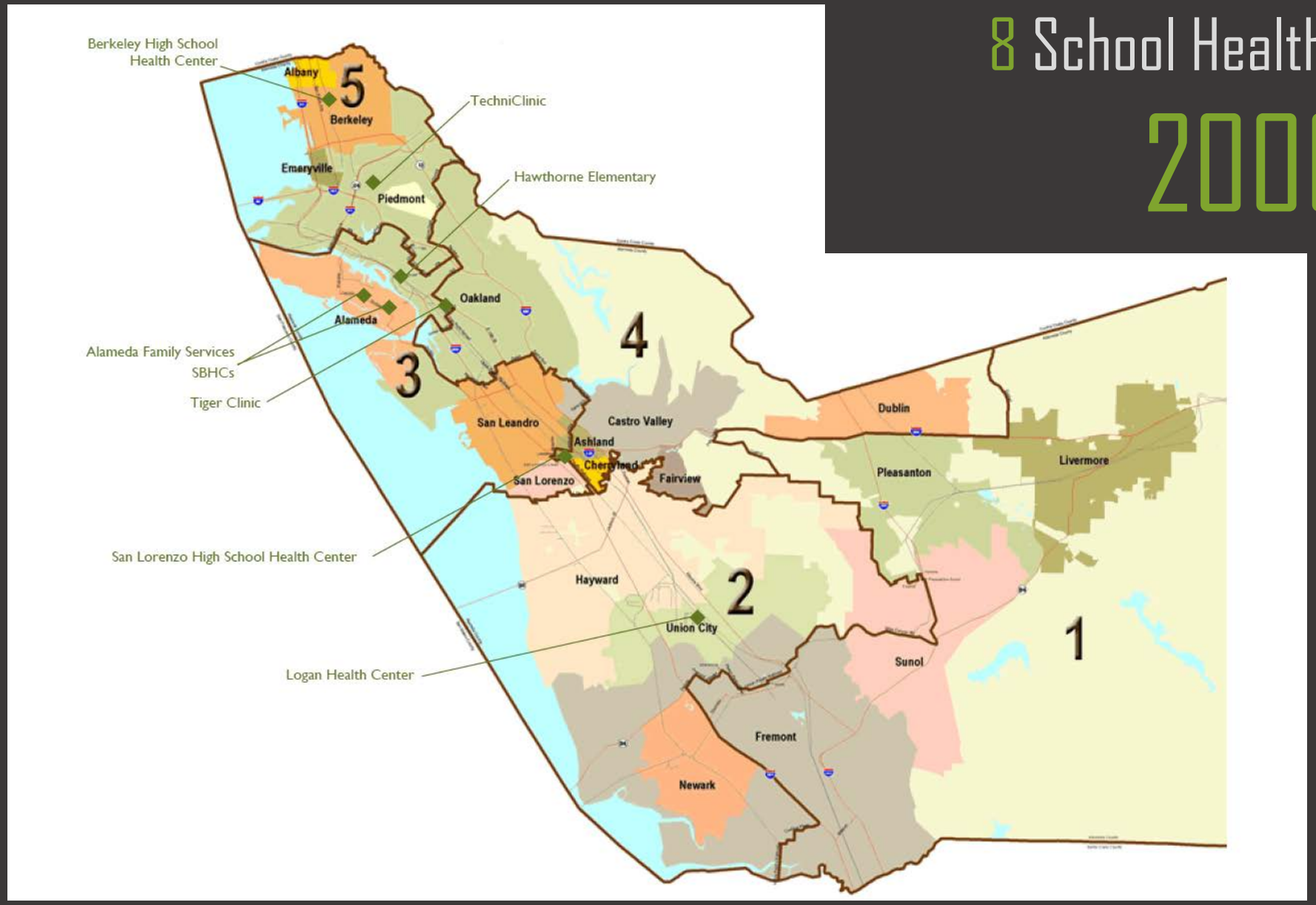
Alameda County
8 School Health Centers
2000



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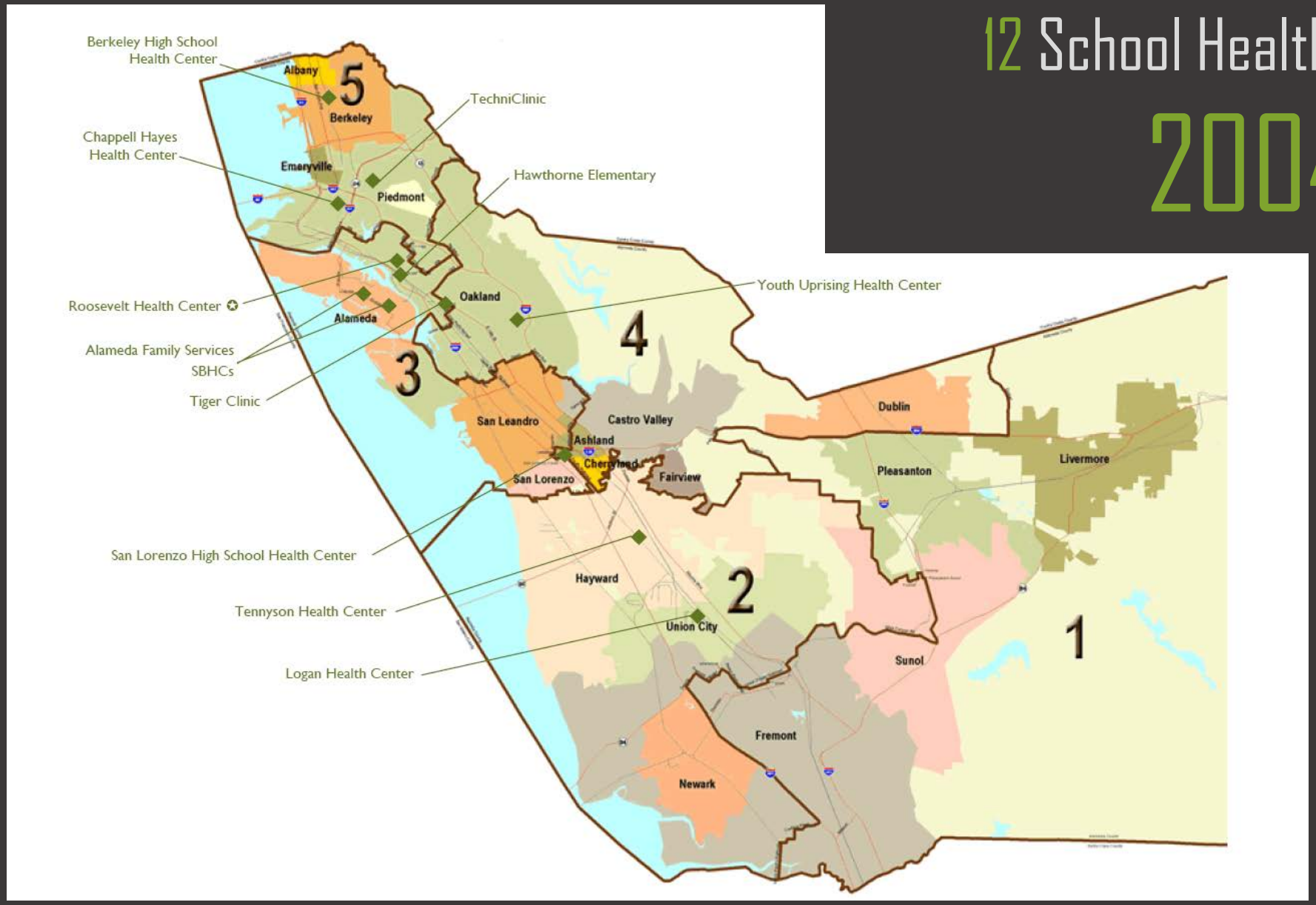
Alameda County
12 School Health Centers
2004



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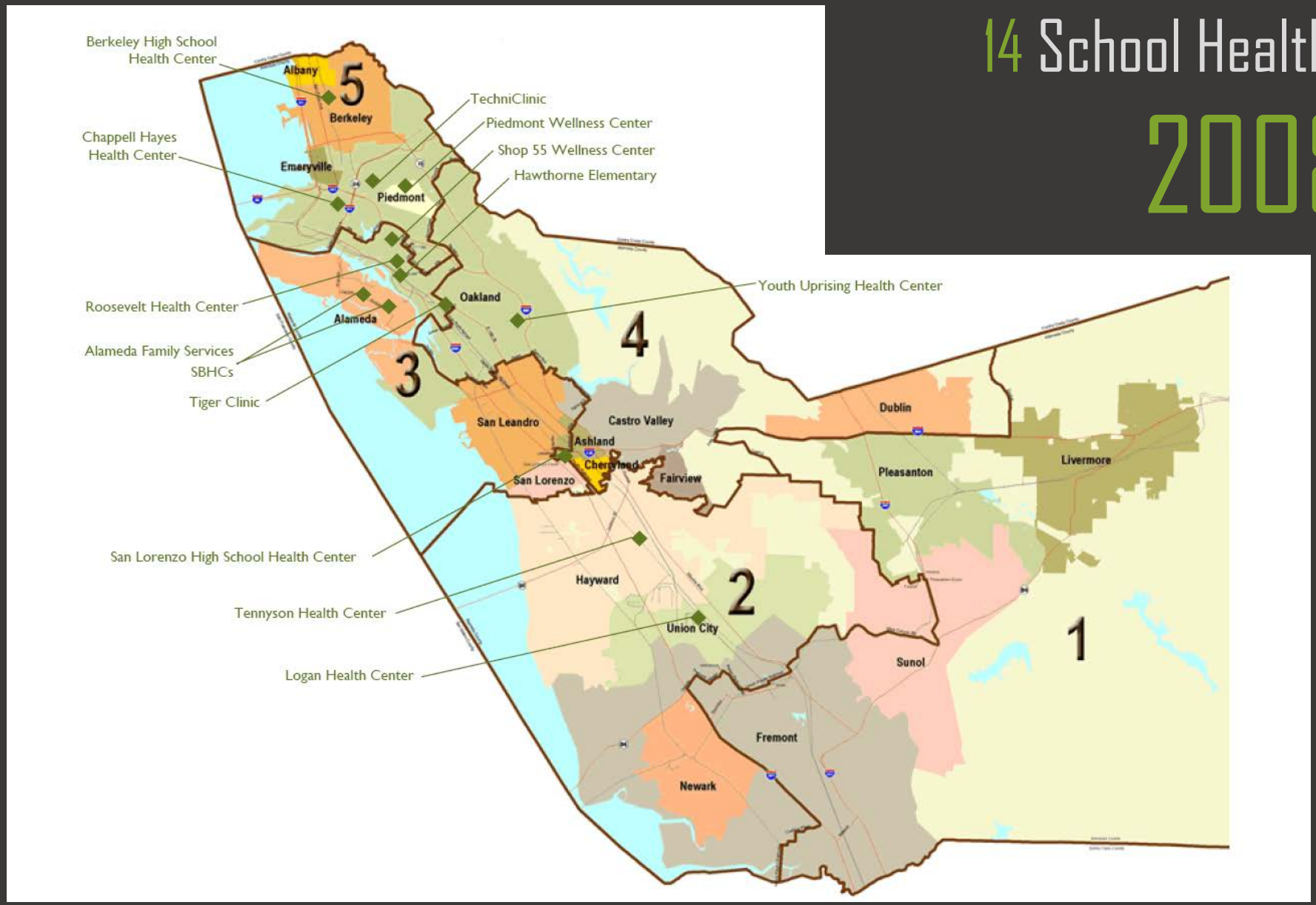
Alameda County
14 School Health Centers
2008



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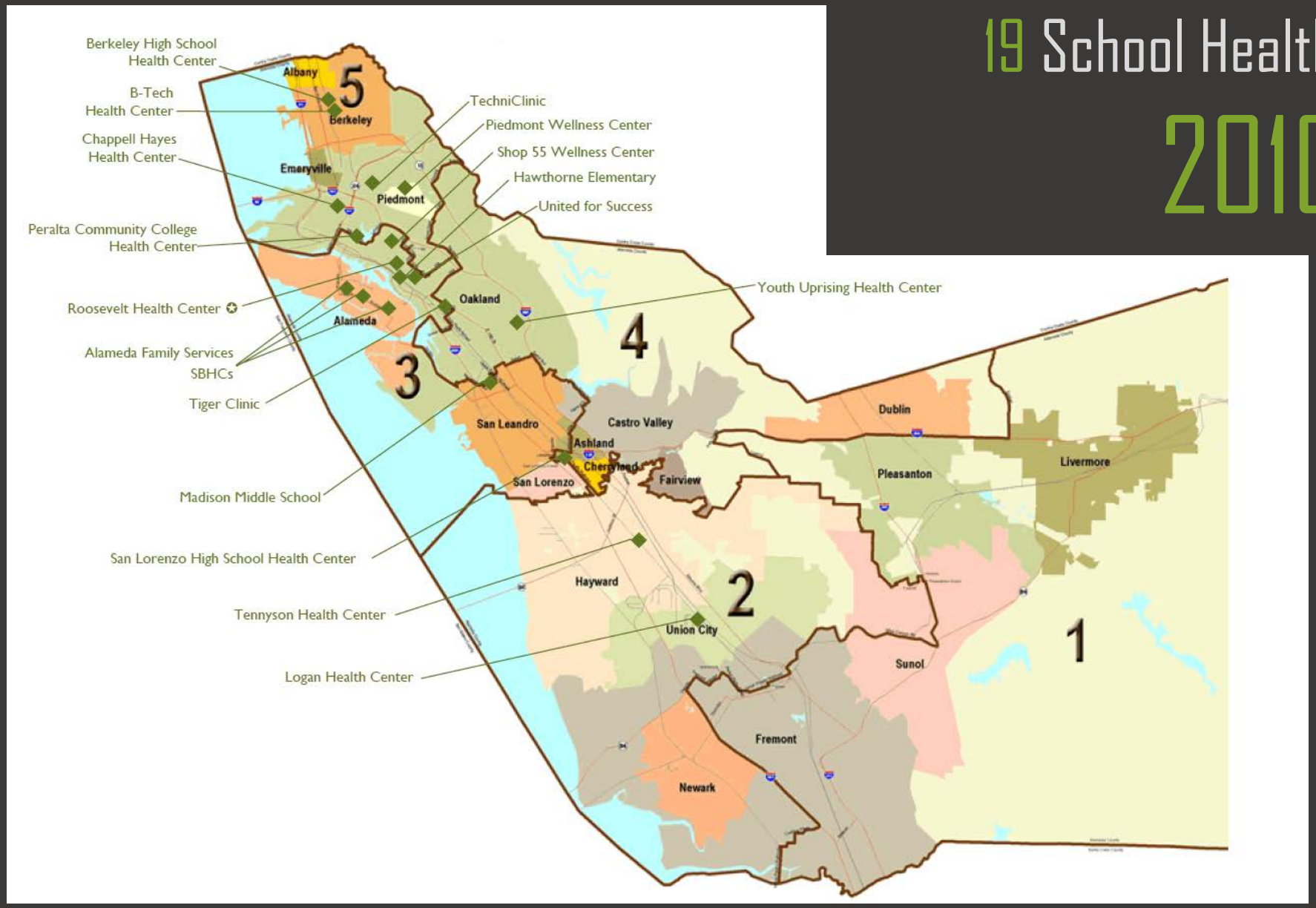
Alameda County
19 School Health Centers
2010



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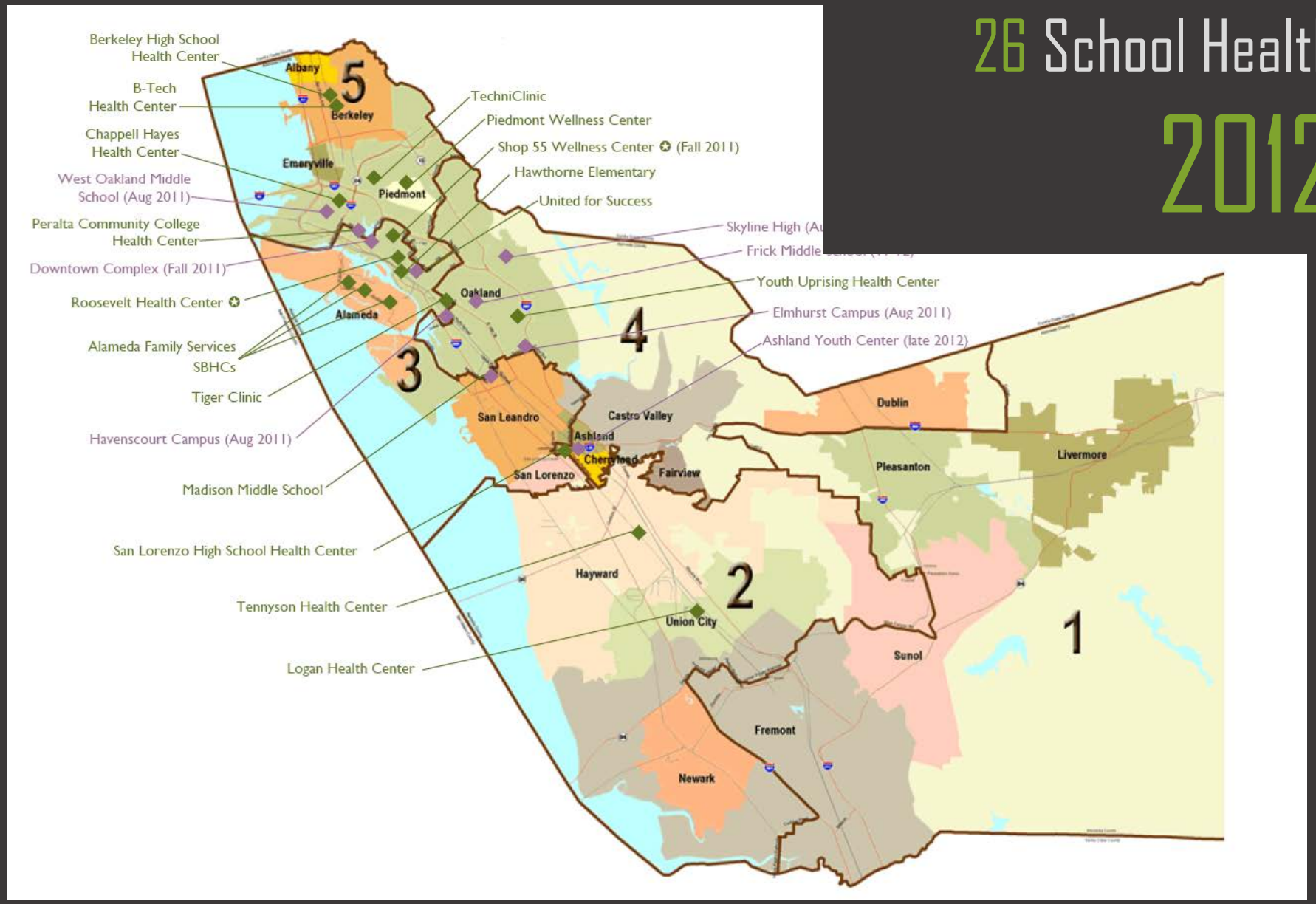
Alameda County
26 School Health Centers
2012



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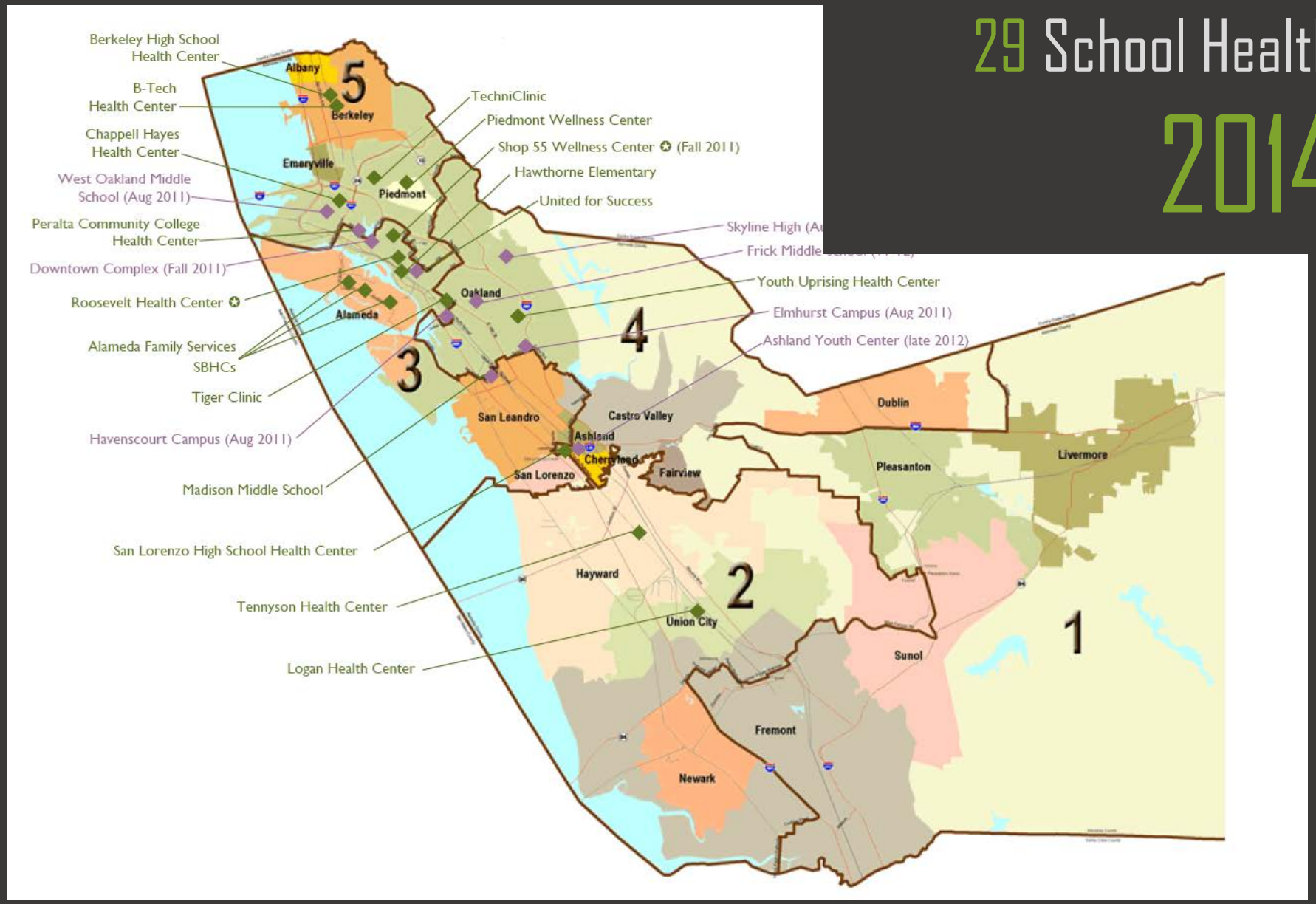
Alameda County
29 School Health Centers
2014



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Alameda County
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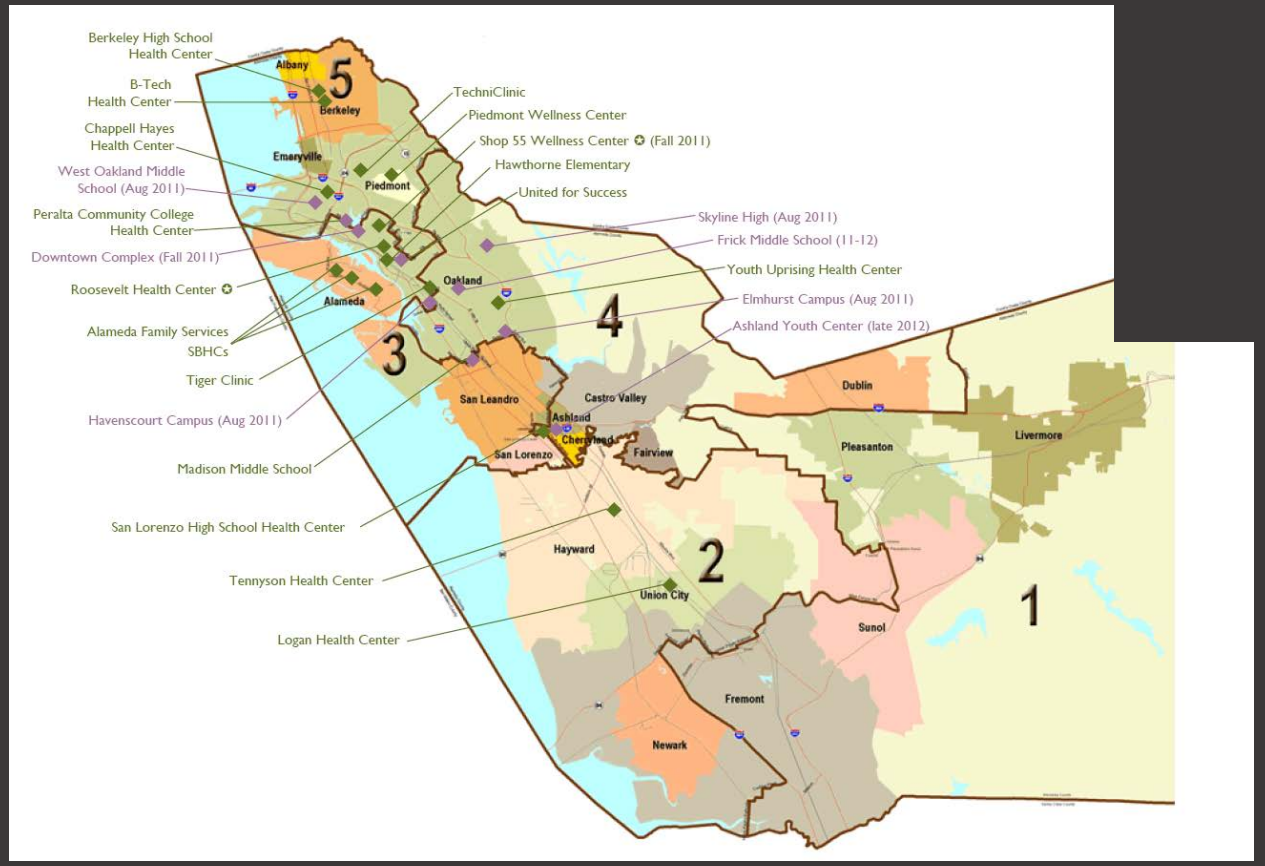

TODAY THERE ARE 200 SCHOOL BASED BEHAVIORAL HEALTH PROGRAMS IN ALAMEDA COUNTY

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We learned a lot.

We're very proud of what we did.

But we didn't fundamentally change children's outcomes.

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Reimagining Children's Behavioral Health

What if California children's behavioral health system was reimagined and re-engineered to support the healthy development of all children?

Health Equity	Healthy Development
Clinical Efficacy	Systems Change

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WHAT THIS MEANS

- NEW UNDERSTANDING OF THE NATURE AND SCOPE OF SERVICES
- MATCH DOLLARS AT THE STATE LEVEL VIA IGT AND DRAMATCIALLY EXPANDED INVESTMENT
- NEW COLLABORATIVE PURCHASING MODELS ACROSS CHILD SERVING SYSTEMS
- NEW MEASURES OF CHILD WELL BEING
- DRAMATIC EXPANSION OF TRADITIONAL AND NON TRADITIONAL SERVICES AND STRATEGIES

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HOW COULD WE PAY FOR IT?

- The Waiver Strategy
- The Growth Strategy
- State Plan Amendment
- Capitation or Enhanced FMAP
- County Mental Health Plan Capacity Building

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WHAT YOU CAN DO

- SIGN UP at www.cachildrenstrust.org and Join our Coalition.
- READ AND SHARE our Policy Briefs.
- REVIEW our Letter to the Governor Elect and SIGN if you can.
- PARTICIPATE on our design teams and co construction convenings
- Support us financially.

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