THERE IS A CRISIS IN CHILDREN’S MENTAL HEALTH

Consider the facts

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 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% 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
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?
CALIFORNIA CHILDREN’S TRUST IS DRIVING THE REFORM

- **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
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
- Discrimination
- Community Disruption
- Violence
- Poor Housing Quality & Affordability
- Lack of Opportunity, Economic Mobility & Social Capital
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: ISOLATION

Adverse environments build emotional and physical barriers to the connection people need to heal and thrive.
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-determinate of human intelligence is safety. With technology, kids have easy and constant access to threatening and stressful information with no adult buffer.
Root Causes

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

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.

There has been a 20% increase in crisis service utilization since 2011.
~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.
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.
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
- Maximize Funding
- Reinvent Systems
- Equity + Justice
THE STRATEGIES ARE CENTERED ON EQUITY + JUSTICE

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 Health (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

Equity + Justice
Maximize Funding
Expand Access and Participation
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
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
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