Children's Mental Health Strategy Session

On March 29, 2017, Zellerbach Family Foundation convened advocates, service providers and funders with a commitment to children's mental health for a strategy session on how to move California forward in meeting the mental health care needs of our state's most vulnerable youth.

The objective for the meeting was to take initial steps to establish a coordinated effort to align opportunities and initiatives and work collaboratively and strategically to best meet the mental health needs of children in California.

Longer term, the goal is to develop a prioritized, coordinated, and actionable agenda for working collectively toward a seamless, accountable public system of care where mental health and wellness is part of an overall vision of child well-being.

The agenda for the meeting began with a brief overview of the indicators of the gap between this vision and the current reality, followed by a summary of public financing, our delivery system of mental health care, some of the challenges and opportunities. The breakout sessions were organized around three discussion areas: Full and Equitable Access, Coordination of Resources and Services, and Quality and Accountability.

This summary memo includes:

1. Synthesis of breakout group recommendations
2. Summary chart and comments from existing landscape of efforts exercise
3. Full report out notes from breakout groups (which are summarized in section 1)

1. Breakout group discussions: Themes and recommendations

Recommendations from the breakout groups centered on several themes, including: addressing the need for new research and data to inform policy and practice; addressing the challenges of siloed efforts and supporting coordination efforts; leveraging existing opportunities; and identifying and engaging stakeholders, champions, and influencers. Recommendations that are actionable and achievable in the short or medium term are indicated with one asterisk (*), those that are longer term objectives with two asterisks (**).

Cross-Cutting Priorities and Vision for Child Well-Being**

- The overarching goal should be well-being and wellness of the whole child: system to support stability, youth/family wellness.
- Reorient system so that care is provided even when outside of diagnosis/incident (IEP, diagnosis, crime) and provide treatment for both system-and non system-involved.
- Change the reality that you have to "fail into care."
- Truly and meaningfully engage children and youth, and TAY, to achieve youth-centered reform.
- Address racial and economic biases as basis for reform in policy and practice.

- Address urban/rural differences, as well as language and cultural factors.
- Acknowledge and address workforce issues (e.g., shortage in many counties of mental health professionals) through recruitment, training, retention and address the need for an overall trauma-informed workforce.

Overall Approach to Achieving an Accountable System of Care

- Build a stakeholder coalition to support unified efforts by building upon and incorporating existing efforts.*
- Evaluate/assess successful models of coalitions such as IHSS, Step Up for Kin, CSS, or Autism advocates to guide the development of this coalition.*
- Develop a brand (promise) for this effort in order to articulate a common goal with common language that makes it clear what's at stake, why this is important, and why it matters, for all of us.*

Full and Equitable Access

- Conduct a landscape assessment of what has worked, what is effective, both in California and nationwide (don't reinvent, learn from other model programs and effort).*
- Build out a matrix of best practice models for care, by specific population (addressing diverse needs, not one size fits all): define them clearly, do the research and homework on landscape of what exists.*
- Build a comprehensive crisis response system.**
- Engage the schools, where children and youth spend their days, and provide opportunity for mental health, trauma informed practices.**
- Use Congregate Care Reform (CCR) as a lever to address access issues (even if it's imperfect).**
- Educate law enforcement/probation/judiciary, and all systems that interact with children, youth and families on best practices.**

Coordinated Resources and Services

- Better understand how MHSA dollars are currently used.
- Advocate for MHSA dollars to be allocated as intended, highlight their use and hold systems accountable.**
- CA is currently in the process of implementing managed care standards and ensuring consistency with the final CMS rule. This is an opportunity to align standards across multiple systems.**
- Map out existing funding sources and look for efficiencies/inefficiencies, assuming that 90% of what is needed is fundable; identify the gaps.*
- Lift up what works, identify the jurisdiction, e.g, counties and communities with strong leadership that are the bright spots.**
- Pressure/engage DHCS regarding EPSDT requirements.**
- IDEA: demonstrate with CBO as lead and controlling use of funds; enhanced coordination model for families - to model for families the specific skills that they need to help raise healthy kids.**

- No wrong door. Continue with screening and access points to care are as a young person is entering the welfare or justice system, but allow for access earlier in their development: not an opt-in, but a mandatory screen to support healthy development, ensure wellness.**

Quality and Accountability

- Define what is meant by quality services, what the CSOC is trying to achieve: give it language.*
- Develop and/or promote common assessment tools.**
- Data wishlist for better indicators: Map out data requirements to fill in the gaps to reach goals of access, coordination and quality, and determine both when reported and where there is overlap, with integration of county and state level data reporting.**
- Develop a "results based accountability" framework, and add well-being indicators for mental health.**
- Consider working with a university to become the "data house" for children's mental health, similar to UCB and child welfare for CCWIP.**
- Follow up to implementation of SB 1291, work to get more data elements to report out on in order to hold public agencies accountable.**
- Establish leadership pathways and maybe launch a Leadership training program (see examples, UCSF health care leadership programs).**

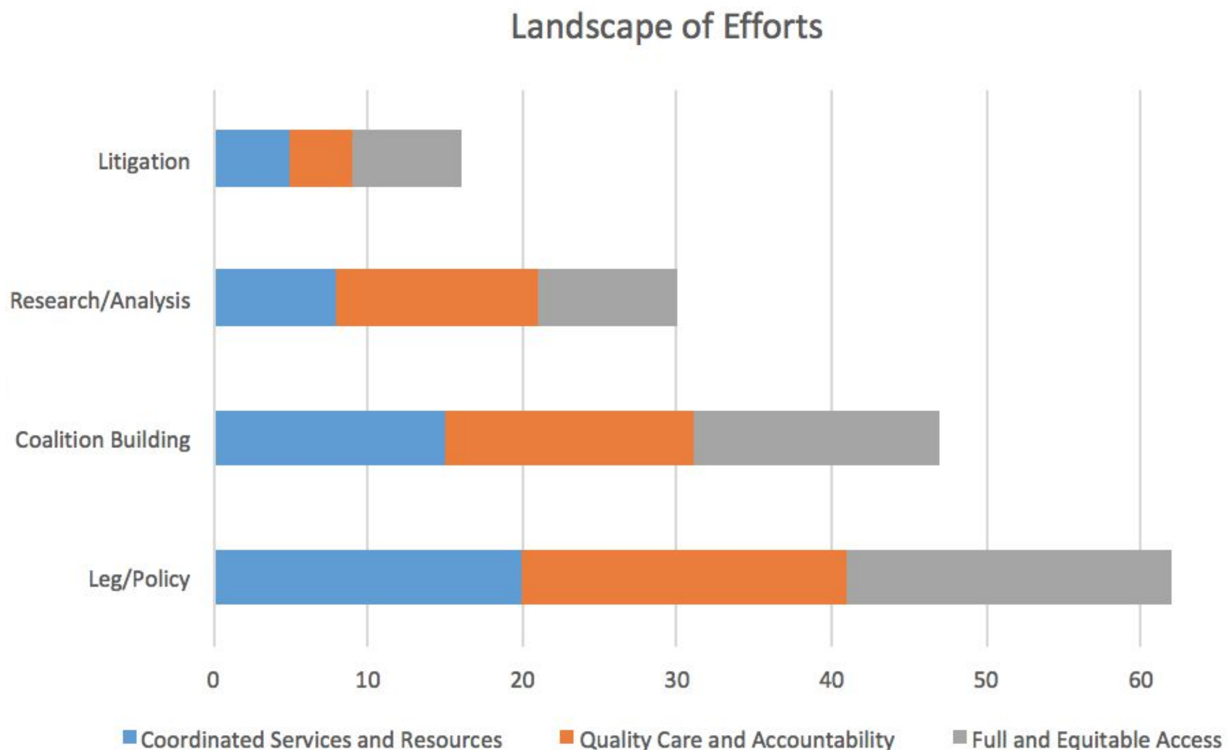
Attendees' comments on next steps[1]

- NCYL: We plan to focus on the data and would help lead that effort.
- WSJ: Sai: Messaging not clear enough. Compelling message people cannot walk away from. I cannot do without children's mental health
- LPFCH: Ed Schor: More information about, as we think about integrating physical and mental health, issues and opportunities.
- YLC: Jennifer: We will continue to focus on policy. Trauma informed work. Quality parenting work with state and counties.Supporting parents as primary intervention, message it in a mental health context. Quality care and accountability, what we know works vs. what is happening on the ground.
- CYC: Haydee: reaching out to Peers, convening book re mental health for TAY and sharing that. Create a plan with them to share that perspective.
- YMA: Annabelle: Institutionalize youth engagement in decision making.
- CACFS: Lynn: Longer term looking at how we work and change things.
- CHILDREN NOW: Jessica: group to further define and come to a consensus on a vision for what would be an ideal CSOC. Immediate, work already underway around CCR, leveraging. Coordinating advocacy and shorter term fixes. Do not create new barriers. MTSS (Multi-Tiered System of Support) bill.
- EBCLO: Rob: track and support legislation.

[1] A handful of attendees had to leave before our closing session so their next steps are not reflected here.

- BLUE SHIELD: Rachel: Committed to putting resources into the kinds of ideas discussed.
- RYSE: Kanwarpal: How we heal to reveal the opportunities for liberation. Key to support and shift systems. Embrace pain and vulnerability.
- CDF: Janis: We are going back to this work, which we started last summer looking at CBOs, other models, look at the landscape, lifting up the models that have successes.
- STEINBERG: Anna: using language more critically and intentionally. Use language to be transformative. Sponsoring 5 bills, another 15 engaged on, this can inform that policy work. Internship program.
- LINCOLN: Chris: Learn more and see if we can adopt or adapt some of the New Jersey model.
- YMA: Patrick: Work to turn promises into practice. Hope today is that we can recognize need for and actually move forward on building a more sustainable collaborative. Children, youth, parents, families, providers, advocates working off a common goal. System backsliding, move it forward.
- Haydee and Kanwarpal: Start some of this work with a open-space session, have the community/coalition do the work to define, prioritize.

2. Participant Input on Landscape of Efforts



Full and Equitable Access

21 Leg/Policy
16 Coalition Building
9 Research/Analysis
7 Litigation
+: Partnerships/capacity building for public agencies; leadership development; direct services; integrating funding streams to improve access; advocacy education; adult healing; creating community grounded systems
Comments: Youth at the center; radically infuse love at every step; white supremacy and fragility of systems decision makers

Coordinated Services and Resources
20 Leg/Policy
15 Coalition Building
8 Research/Analysis
5 Litigation
+: Provide wraparound services; leadership retreat; partnerships/capacity building with public agencies; direct services; advocacy education
Comments: Collaboration has to be value-based

Quality Care and Accountability
21 Leg/Policy
16 Coalition Building
13 Research/Analysis
4 Litigation
- + Youth-centered decision making and advocacy; direct service; practice-based research (radical inquiry); workforce training; partnership capacity building with public agencies

Comments: If it's not racially just it's not trauma informed. Name harms of conventional social science research.

3. Full report-out notes from breakout sessions

Group 1

Overall: use CCR as a lever, even if an imperfect one. Address historic barriers.
Engage youth/youth-centered reform
Articulate a common goal with common language that makes it clear what's at stake, why this is important, and why it matters, for all of us.

Full and Equitable Access
- Establish wellness actions for young people going through trauma outside the system--pre-diagnosis. (giving foster kids a diagnosis for care when what they have is a broken heart)
- Foundation should be stability with the goal of wellness.

- Close the gaps in coverage to ensure service delivery, starting point for access.
- Role of primary care
- Better use of screening tools
- Pressure DHCS re EPSDT requirements
- Address racial AND ECONOMIC bias in diagnosis and treatment
- Focus school-based health in areas of greatest need
- Address stigma to getting access to services and within the system. Opportunity to change the language around social/emotional health and well being.
- Support young people outside the school system (TAY), 2 systems, ensure continuity
- Address urban/rural disparities (esp with presumptive transfer)
- Language access barrier
- Change restraint/incarcerate first approach. OPP: no restraint model

Coordinated Services and Resources

- Serve the WHOLE CHILD
- Build continuity of care with school as the epicenter
- Support children in families/permanency (equip families with tools)
- Embed social emotional learning into the school system OPP: Bundle/link health care and emotional health services at school.
- Address administrative burden. OPP: waiver? Other states do this
- Find counties with champions for CSOC work. Lift them up and support their efforts, then look to shine light, have them mentor other counties. Develop county-level model, with a toolkit of strategies that work (for like demographics, geography, conditions, etc.)
- Address lack of crisis services with a comprehensive crisis response system
- TAY approach to ensure continuity of care. OPP: care coordination guide

Quality Care and Accountability

- Every kids welfare is our welfare
- Define quality services: what is the children's system of care trying to achieve
- Address a system that does not allow youth to stay with a provider when they are "better," too well (mild-moderate transition)
- Address workforce: training for public mental health workforce, also recruiting and retention strategies (address attrition). Also, specifically school-based counselors
- Alternative crisis response system
- Measure, assess, and report with mental health services and across integrated relevant systems across different age groups

Opportunities:

- Build a stakeholder coalition
- Work with a university to become the data house for children's mental health, similar to UCB and child welfare
- Define quality services/what the CSOC is trying to achieve
- Research what different populations need. 90% of what is needed is fundable, identify the gaps.

- Build out a matrix of best practice models for care: define them clearly, do the research and homework on landscape of what exists
- Educate family/law enforcement/probation on best practices
- Add well-being indicators/wellness
- Establish support system for communities to address kids' needs
- Trainings
- Offer a 1-800 on campus support
- Map out data requirements--when data reported/overlap, state level unite for tracking youth mental health

Group 2

VISION (that we ALL must agree on)

- well articulated VALUES and vision - reflects their actions
- state the historical implications of how the systems were set up
- Keep children out of the system
    - IEP
    - Diagnosis
    - Crime
- System is informed
- shared values
- building a beloved community - including treating the family, seeing the family as an intervention itself
- understand racism and racial oppression

COMPONENT 1: full and equitable access

- force system to have partnerships with community resources
- eliminating the need for diagnosis - becoming involved in a system is enough
- engaging families where they are
- Mental Health Services Act
    - policy shift - requirement to have youth deciding how the money is spent
    - show up to meetings and share voice
    - it was supposed to happen this way - how hold accountable

COMPONENT 2: coordinated services and resources

- culture change - work is approached in a different way
- include those affected in the solutions
- may not be the evidence base but be willing to listen to other ideas that may meet families where they are
- quality parenting initiative - have a joint conversation to set the vision; not process but placement/conversations between players (birth parents, foster parents, child)
- IDEA: demo with CBO as lead and controlling use of funds
- IDEA: enhanced coordination model for families - to model for families the specific skills that they need to help raise healthy kids

COMPONENT 3: quality care and accountability

- trauma informed workforce through:
- uncomfortable conversations - recognize that the system is set up to work as it is; elevate what we hear from communities so that the "system" knows it
    - ex. Adult educators - how are you experiencing trauma
- collective thinking around data elements to report out on to determine how close we are to the vision
    - funding
    - outcomes
        - ex. SB1291 - data elements to report out on to hold public agencies accountable
- gather feedback
    - MHSA allocation

SHORT TERM

- Example of good approach with CCR - Angie Schwartz - relative caregivers focus

MEDIUM TERM

- referrals by pediatricians for community resources - strengthening partnerships

LONG TERM

- conflicting policies
    - supporting policies that are interested
- continuum of care
    - those involved with system vs prevention of involvement with system
- culture shift
    - ex. St Paul - vision for children's health and make every funding decision based on it
    - informed by young people - getting proximate
    - evidence base = relationship
    - ex. San Diego school - work can be done without systems imposing it on them
- Tools
    - step out of the existing paradigm - what are other tools we have?
- Evidence - what do we mean by this and change the definition?
- Funding
    - know that expertise is not always what we think
    - funds belong to YOUNG PEOPLE
    - Demonstration site - CBO is the lead
    - structured around adults
    - kids fighting for scraps
- FY - treat youth but also parents - example: Kinship Program - activities for FAMILIES - hugely successful
- not just about children but also the relationship with the parent
- CCR
    - de-incentivizes kinship system - not enough money

- Example: New Jersey Model
    - all children (child welfare, juvenile justice) - come through care coordination team - in charge of case planning, getting services, and coordinating care; contract services
        - not left to individual silos to be responsible for child but to the system of care that is responsible for coordination
        - no kids are sent out of state
        - someone is responsible for coordination
    - common assessment - CANS
        - high needs workgroup - demystified why children were being sent out of state - assessment to re identify needs - often times didn't need to be at higher levels of care

Group 3

Equitable Access

- Issues is where we started with, as the need is to cover all children and youth and ensure this results in screening and care for those that need it, as soon as they need it. Further, because 96% of children in the public health system are eligible for mental health services though entitlements under EPSDT, IDEA, MHSA, etc. the state and counties have a legal obligation to ensure access is a promise that is kept. Currently, however this is clearly not the case.
- It was also discussed that too often the screening and access points to care are as a young person is entering the welfare or justice system and not earlier in their development (in schools, community/family settings, "no wrong door") when care could be preventative and stabilizing. As screening tools are used, they are often opt-in requiring those assessing to indicated a young person should receive care. However as we know young people have been subjected to trauma or other challenges prior to entering the welfare or justice system they should have a presumptive opt-in screening and the onus be on providers and care teams to provide evidence for an exception for mental health care.
- Statistics regarding children in youth accessing mental health services (not accounting for quality or cultural or linguistic responsiveness):
    - There are approximately 5.5 million children in Medi-Cal.
    - According to prevalence rates for serious mental illness or serious emotional disturbance, there are likely at least 500,000 that need mental health services.
    - According to billing data 150,000 children have been screened and are accessing some level of mental health care.
    - This results in approximately 350,000 children that have not even been screened and identified to the public system but who have a very serious need for care.
- With these stark facts in mind, it became clear that we really cannot uncouple improving access from measuring the **quality of care and accountability**. The only way to hold systems accountable for screening and access, we must be collecting and reporting out sound and timely data. This will act in many ways as a driver of change and established

a shared vision for how understand the current landscape, identify what specifically needs to improve and change via policy and system redesign to get us to equitable access.

- Also noted was that existing data collection and the development of evidence based practices has been almost solely normed to white cultures and is not responsive to ethnic, cultural, or linguistic diversity. This gap in how we provide support and care to underserved communities must be addressed and made a clear priority.
- While there has been a notable lack of leadership on data and accountability on mental health by the state, especially since the merger of the Department of Mental Health into
- DHCS and realignment of service responsibility to the counties, there are some opportunities emerging that we can collectively leverage. They include:
    - Private payers are transitioning to **performance based payments** to guide the behavior and outcomes of providers. As the move towards integrated care continues as well, there will be more evidence for value based payments as well as the system design that supports them.
    - CMS issued its final rule on managed care to states and CA is currently in the process of implementing the standards and ensuring consistency with the rule. This is an opportunity to **align standards across multiple systems**.
    - **Legislative leaders, their staff, and other decision makers** are starting to “speak our language” around ACEs, Toxic Stress, Trauma and the need for prevention and early intervention. We can **use this interest and turn it into policy action** and increased engagement with the state, counties, and providers on system redesign and improvements.
- A clear takeaway was the need to **establish a unified coalition with a broad spectrum of support**. The opportunity to continue this conversation and work was strongly expressed and a short term next step is to **look at successful models of coalitions** such as IHSS, Step Up for Kin, CSS, or Autism advocates to guide the development of this coalition. With a strong coalition, clear roles and responsibilities, and agreed on definitions of terms and goals across the spectrum of participants the collective impact has dramatic potential.

Closing comments:
Jesse: focus on data, help lead that effort.

Sai: Messaging not clear enough. Compelling message people cannot walk away from. I cannot do without children’s mental health

Ed Schor: More information about, as we think about integrating physical and mental health, issues and opportunities.

Jennifer: focus on policy. Trauma informed work. Quality parenting work with state and counties.Supporting parents as primary intervention, message it in a mental health context. Quality care and accountability, what we know works vs. what is happening on the ground.

Haydee: reaching out to Peers, convening book re mental health for TAY and sharing that. Create a plan with them to share that perspective.

Annabelle: Institutionalize youth engagement in decision making.

Celia: part of the data/learning is programs that work.

Lynn: Longer term looking at how we work and change things.

Jessica: group to further define and come to a consensus on a vision for what would be an ideal CSOC. Immediate, work already underway around CCR, leveraging. Coordinating advocacy and shorter term fixes. Do not create new barriers. MTSS bill.

Rob: East Bay Children's Law, support legislation.

Rachel: Committed to putting resources into the kinds of ideas discussed.

Kanwarpal: How we heal to reveal the opportunities for liberation. Key to support and shift systems. Embrace pain and vulnerability.

Janis: Back to work started last summer looking at CBOs, other models, look at the landscape, lifting up the models that have successes.

Anna: using language more critically and intentionally. Use language to be transformative. Sponsoring 5 bills, another 15 engaged on, this can inform that policy work. Internship program.

Chris: New Jersey model.
Wellness first, prevention. Then what? Crisis services and intervention.