



Reshaping the
**Future of
Child
Wellness**



Tanya Mercado, LCSW
Dr. Frank Dussan, LCSW



www.achieve.lausd.net/smh

Table

of Contents

Introduction	1
Who We Are	2
Why this Matters	3
Public Funding for School Based Mental Health	4
School-Based Mental Health	5
Innovative Recommendations	6
❑ Strategic Priority 1: Prioritizing Mental Health: An Agenda for Transforming Prevention	
❑ Strategic Priority 2: First Things First: Investing in Child Mental Health	
❑ Strategic Priority 3: Systemic Collaboration: All in Today for our Children’s Tomorrow	
❑ Strategic Priority 4: Community Resilience: Empowering & Healing Communities	
❑ Strategic Priority 5: Demonstrating Impact: New Measures and New Voices	
Endnotes	23
Glossary	25



Primary Authors

Francisco Dussan, Ed.D, LCSW.; Organization Facilitator at LAUSD School Mental Health

Tanya Mercado, LCSW.; Organization Facilitator at LAUSD School Mental Health Consultant

Michael Butler, M.A.; Senior Associate at Health Management Associates

Advisory Committee

Pia Escudero, LCSW.; Executive Director of LAUSD Student Health and Human Services

Joel Cisneros, LCSW.; Director of LAUSD School Mental Health

Kim Griffin-Esperon, LCSW.; Administrative Coordinator of LAUSD School Mental Health

Patricia Lester, MD; Director of FOCUS (Families OverComing Under Stress) Program, Director of the UCLA Nathanson Family

Resilience Center, and the Medical Director of the Family Stress, Trauma and Resilience Clinic at UCLA.

Sheryl Kataoka, MD.; Training Director of the Child and Adolescent Psychiatry Fellowship at UCLA

Jeanne Ringel, Ph.D.; Director of the Access and Delivery Program at the RAND Corporation and Professor at the Pardee RAND Graduate School.

Maryjane Puffer, BSN, MPA.; Executive Director of the Los Angeles Trust for Children’s Health

Rebecca Hurtado, LCSW.; Mental Health Clinical Program Manager at the Department of Mental Health

Blanca Vega; Interim Division Chief, Community-Based Support Division Program Manager, Family Preservation/CAPIT/VOC.

Acknowledgements

We want to express special acknowledgements to the Anthony and Jeanne Pritzker Family Foundation for their generosity, transformational leadership, and commitment to child wellness. We thank you for investing and working alongside the Los Angeles Unified School District to improve the lives of our children.

We also want to recognize and thank the members of our Advisory Committee: Pia Escudero, Joel Cisneros, Kim Griffin-Esperon, Patricia Lester, Sheryl Kataoka, Jeanne Ringel, Maryjane Puffer, Rebecca Hurtado, and Blanca Vega for their selfless guidance and support. Their contributions were instrumental in shaping and completing this work. Special thanks is also given to Michael Butler whose guidance, experience, and wisdom elevated and brought this work to fruition.

We sincerely want to express our gratitude to everyone who contributed their expertise and knowledge to this report – in particular LAUSD Student Health & Human Services staff and local Community-Based Organizations whose collaborations are critical as we transform towards a child-centered and prevention focused model of care.



Introduction



For many years, public school staff have witnessed increases in student anxiety, depression, anger, and suicidal ideation. We know that students' ability to learn is significantly compromised by mental illness (individual and familial), as well as compounded by family and neighborhood violence and other trauma. COVID-19 has exacerbated these issues and made the long-standing mental health crisis in public schools even more evident, widespread, and deeply concerning.

The overriding mission of Los Angeles Unified School District's School Mental Health division is to address this ongoing need by expanding student and family access to School-Based Mental Health (SBMH) services, both prevention and intervention. Despite efforts to enhance linkages and referrals to agencies and community-based organizations (CBOs), placing mental health services on school campuses has been among the most successful for moving from referral to service delivery and overcoming the stigma associated with mental illness. To deepen and sustain these efforts, LAUSD School Mental Health requires access to more stable, augmented, coherent funding. Moving in these directions will require a focus on policy changes and advocacy, as well as higher levels of coordination across the mental health system of care, and a common framework for child mental health.

Indeed, the challenges and opportunities in SBMH require a county-wide, inter-agency focus. Therefore, we launched this project to bring together an advisory group of child centered stakeholders representative of different roles and perspectives relevant to SBMH within Los Angeles County. Our ideas and recommendations are intended to provide a catalyst for innovative thinking on SBMH, both in and outside of LAUSD.



Who We Are

Innovative Funding for Mental Health Access (IFMHA) is a multidisciplinary group of child advocates working together to transform the school-based mental health system. Our vision was born from the impending need to repurpose and redirect the current mental health system towards a child-centered and prevention-focused model of care.



Vision

We envision a future of child well-being in Los Angeles County, where children and their families are resilient, healthy, and safe.



Mission

Address child and youth mental health needs by developing innovative funding strategies to increase prevention and early intervention services throughout L.A County schools.



Why this Matters:

Mental health is often ignored and unrecognized as a crucial human condition that promotes individual and collective well-being. The consequences of its impact, however, are sounding off the alarms across national medical, political, and educational fields. National reports and data on school shootings and recurring suicidality among students reflect the wide-spread epidemic of mental health issues that have pervaded the educational system and are affecting the lives of 17.1 million children across the nation.¹

According to the results from the National Comorbidity Study-Adolescent Supplement (NCS-A), mental health illnesses are the most common health related issues that affect school-aged students across the United States.² Reports from the National Research Council and the Institute of Medicine report that an estimated 13-20% of children living in the United States experience a mental health disorder in any given year.³ This means that one in every five children experiences mental health issues that could potentially interfere with healthy emotional and cognitive development. More concerning as the Centers for Disease Control and Prevention (CDC) highlights the fact that suicide is the second leading cause of youth ages 10-14 while the average delay between onset of symptoms and treatment is ten years.⁴

Data from the Lucile Park Foundation for Children's Health reported that approximately 25% of seventh graders, 32% of ninth graders, and 33% of 11th graders in California suffer from depressive symptoms.⁵ To put these figures in perspective, the percentages of all three grade levels equates to approximately 430,000 students affected by depression in California alone. Unfortunately, only one out of four students with mental health disorders in the Golden State receive the treatment they need, and most of them will receive it at their schools.

Mental health challenges make it difficult—if not impossible—for children to engage, learn, perform, and become active participants in the educational process. However, the National Alliance on Mental Illness reports that 1 in 5 children ages 13-18 will, or will have, a serious mental health illness.⁶ Behavioral maladaptation, trauma symptoms and behaviors, performance, anger, depression, poor emotional regulation, poor academic performance, learning disabilities, and truancy are only some of the problems stemming from the mental health crisis in school systems both locally and nationally.

In sum, the above information practically begs for school system involvement in addressing the issues surrounding children's mental health. Children struggling with mental health and learning disorders are at risk for poor outcomes in school and in life, and lack of mental health interventions are only making matters worse.

There must be a national and local shift from traditional mental health services towards whole-child preventive approaches that integrate social and emotional health practices.

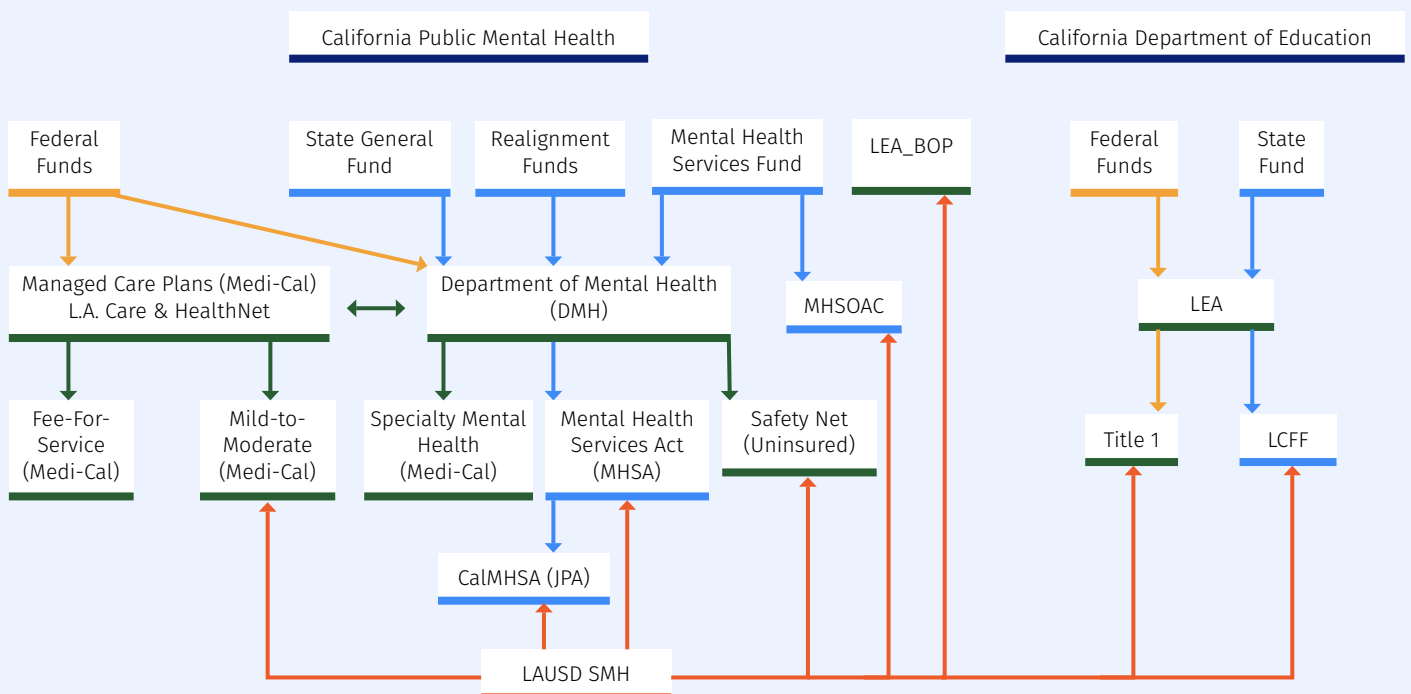


Prevention of mental health illnesses should be a public health priority if we truly want to address the mental health needs of our children. We must shift from a reactionary to a preventative multi-tiered system designed to reduce the onset of early life mental health illnesses through the use of universal and targeted interventions. A widely deployed, integrated system of evidence-supported, school-based mental health and preventive services is needed now if we want to help our children and our schools succeed.

Understanding Public Funding for School-Based Mental Health

California just passed a 4.4 billion-dollar historic investment in behavioral health services, including significant investments in SBMH. These are timely and needed resources, particularly now, as we recover from two crises affecting our communities: COVID-19 and mental health challenges. However, we and many other mental health advocates continue to raise the single most important barrier to care and services: the system funding model is fragmented. We believe that without a transformational financial reform very little will change irrespective of how much money is pumped into the system. California’s mental health system requires more than a generous and endless supply of cash; it needs an innovative, streamlined, and cohesive financial plan.

Below is a visual representation of the complexity of the mental health system both in LAUSD and the County of Los Angeles – particularly how funding is a major barrier to mental health access in schools.



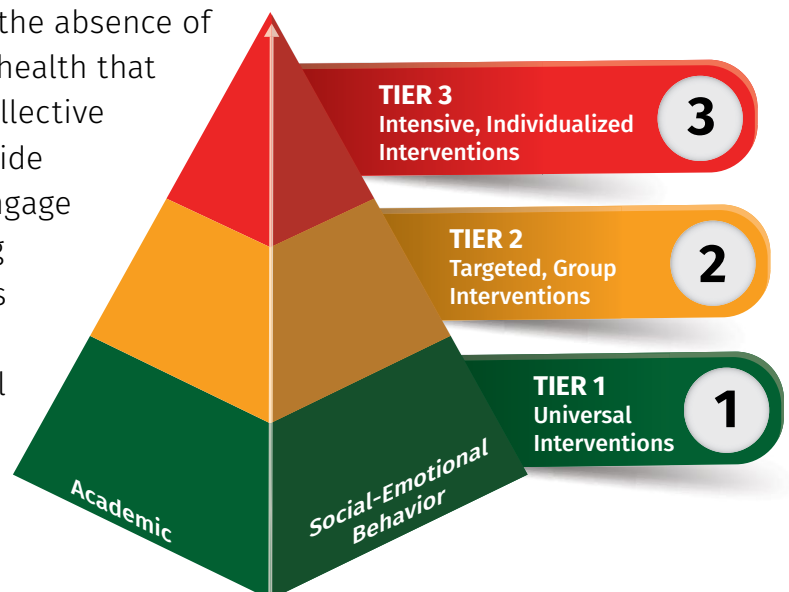
School-Based Mental Health: A Common Framework

Mental health is crucial for child development and their overall well-being. Students' cognitive and emotional development is interdependent and interrelated to their mental health condition. Research also demonstrates a strong association between positive mental health and student academic achievement, perceived positive school climate, lower rates of truancy and socially disruptive behavior.⁷ In contrast, untreated mental health illnesses contribute to behavioral difficulties, poor self-regulation, and social skills as well as substance use, learning and attention deficits, truancy, dropping out, and gang involvement among others.⁸

In a 2013-2014 screening of 572 LAUSD students, 88% reported experiencing three or more traumatic events in their lifetime, 55% of whom showed symptoms of PTSD, depression, or anxiety. It is evident that SBMH services have and continue to have the greatest impact on the future of our children. We strongly believe that the mission of every child-serving system should be preventing the onset of behavioral and emotional problems by serving them where they are: in schools.

Delivering mental health services in schools is a natural, convenient, and effective strategy to prevent and/or reduce mental health disorders. In fact, 70% of children in the United States receiving mental health treatment receive it at their schools.⁹ We believe that a key aspect of the effectiveness/success of SBMH is associated with the continuum of care model used to deliver tiered services to our students. This model is commonly known as a Multi-Tiered System of Supports (MTSS) which emphasizes prevention, wellness, universal screening and services, and targeted interventions for students with higher needs.

However, one of the greatest challenges for sustaining, expanding, and improving SBMH services is the absence of a common framework for children's mental health that integrates child-serving systems through collective goals and methods. We propose a system wide adoption and implementation of MTSS to engage in informed and systematic decision-making regarding students' needs and services. This model would provide a more clear and consistent approach to fund SBMH where all systems can focus on meeting the needs of children in the right setting, with the right services, with the right people, and at the right time.



- Tier I: Universal prevention services for **all** students to promote wellness and a healthy school climate.
- Tier II: Targeted (selective) services for **some** children at risk and/or showing signs and symptoms of developing mental health needs.
- Tier III: Intensive (indicative) services for **few** students with greater mental health needs.

The list of benefits associated with SBMH and the research that supports it shines a bright light on this issue. It is time we stop ignoring the facts and we start prioritizing school mental health as a commonsense approach to preventive care. To challenge the status quo, we must take a closer look at the obstacles that, for decades, have created a reactionary-fail-first-system that does not prioritize the prevention of mental health problems early in life.

Innovative Recommendations

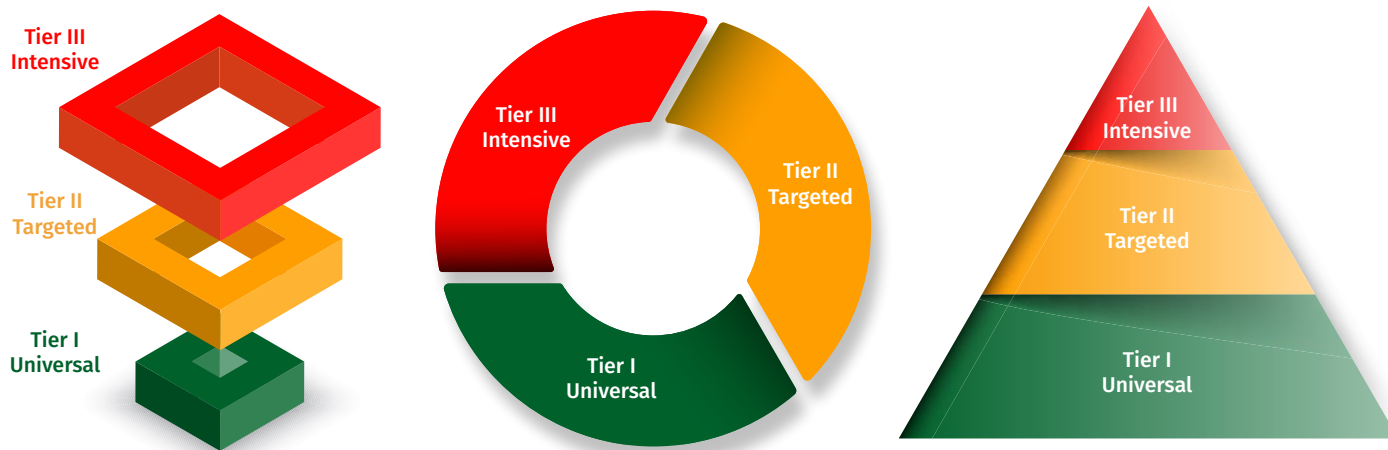
We are at a moment of possibility. There is an unprecedented and historical \$4.4 billion investment in behavioral health for children and youth. Although the existing mental health system continues to emphasize adult service and relies on a fragmented funding model to deploy its resources, we believe there is an opportunity to transform how California’s mental health system supports children and youth. The task ahead of us is to rethink and redeploy existing resources to address children’s mental health needs and maximize both access and impact across Los Angeles County. In this section, we provide a set of innovative funding strategies with policy, fiscal, and practical implications that could sustain and expand school-based mental health services.

Strategic Priority 1 – Prioritizing Mental Health: An Agenda for Transforming Prevention

The current system under-invests in preventative mental health (both Tier I and Tier II) services at scale. Instead, it prioritizes acute care (Tier III) tied to an individualized diagnosis. Our children and youth should not have to wait for an onset of symptoms or diagnosis or witness an impact on their ability to function in order to have their social emotional needs met. Similarly, much of what is termed prevention consists of social marketing campaigns to destigmatize mental health.

We aim to reimagine mental health prevention to be able to screen and provide services to underserved school-age populations at scale. We also intend to provide more direct preventative services that draw on Evidence Based Practices (EBPs). In this section, we provide a set of strategies intended to help invert the existing and reactive mental healthcare model.





Policy Challenge 1: Medical Necessity: New policy, Same Practice

The California Advancing and Innovating Medi-Cal (CalAIM) has reformed medical necessity provisions for specialty mental health that were inconsistent with federal and state mandates and programs such as the Early and Periodic Screening, Diagnostic, and Treatment and Mental Health Services Act-Prevention and Early Intervention (EPSDT). In fact, California is the first Medicaid program in the nation to qualify beneficiaries 21 and under for access to specialty mental health services based on exposure to trauma. However, additional steps/support may be needed to transition from policy into successful implementation - particularly in counties that continue to base eligibility on a psychiatric diagnosis. To reduce barriers to access for child mental health and restore the spirit of federal and state child behavioral programs, we recommend the following:

- Although specialty mental health medical necessity changes went into effect on Jan 1, 2022, children in L.A County continue to be diagnosed to access mental health services. Thus, we enlist the support of the DHCS in providing oversight and support to Los Angeles County Department of Mental Health when implementing CalAIM proposed improvements regarding medical necessity under the 1915(b) waiver. More specifically, we recommend LACDMH prioritize criteria 1 for Medi-Cal members under age 21.
 - *The beneficiary has a condition that puts the child or youth at high risk for a mental health disorder due to experiencing trauma, evidenced by any of the following: scoring in the high-risk range on a DHCS- approved trauma screening tool, or involvement in the child welfare system, or experience of homelessness*
- We encourage MCPs to uphold the promising changes to medical necessity and to increase access to the Family Therapy Benefit by expediting partnerships with schools. Major health plans such as L.A Care and HealthNet should invest in strategic outreach and engagement efforts to inform their consumers that families and their children can now access mental health services without the need for a psychiatric diagnosis. We believe little will change unless the mental health system implements awareness initiatives, which can in turn begin to root out years of stigma and mistrust that have discouraged our communities from accessing the services they need.



- Until contracts with mental health providers in L.A County reflect CalAIM medical necessity reforms, service agencies should not be required to diagnose children in order to be reimbursed for services provided through PEI. We believe that the current policy of blending MHSA-PEI dollars with Medi-Cal funds is a “fail first” reactionary and stigmatizing approach that does not need or benefit from applying reimbursement requirements similar to specialty mental health.

Policy Challenge 2: Child-Focused and Population-Based Approach

Improving the overall health and wellness of our communities demands that we collectively understand and respond to systemic inequalities responsible for health disparities within our communities. Now, more than ever, there is evidence that the development of mental health symptoms is correlated with the social drivers of health (poverty, racism/discrimination, food insecurity, homelessness, community violence, and lack of access to health care, etc.) that exist at the population level affects whole communities, not just individuals living in those communities.

To address these inequities, the CalAIM initiative proposes to “Identify and mitigate social determinants of health and reduce disparities or inequities” through a variety of components designed to reform the healthcare system.¹⁰ However, none of these services include school-based/child-focused programs known to promote and sustain child wellness. Although we support the state’s shift to a population-based healthcare model, community health requires an investment in prevention that addresses the mental health of our children. Below, we provide a set of policy recommendations to improve both health equity and child wellness.

- Include community support in DHCS preventive interventions in schools that address social drivers of mental health in children. Through CalAIM, Managed Care Plans and County Departments - particularly Public and Mental Health could implement school-based preemptive strategies known to improve the quality of life of the community. Examples of the kinds of programs and interventions that LEAs could conduct, sustain, and expand include:
 - o Prenatal and Early childhood (TRiEE)
 - o Parent Education (Resilient Families, Triple P)
 - o Community-based engagement, promotion, and prevention (resource fairs, workshops - action at the local level)
 - o Tier I - EBPs
 - o Green Spaces / Community Gardens
 - o Active spaces that encourage exercise
 - o Social Spaces that promote interaction



Under the new Enhance Care Management (ECM) program, children are only eligible for this benefit if they meet high-need criteria such as experiencing homelessness and/or transitioning from incarceration.¹¹ We believe, however, that preventive care starts with universally accessible care coordination services. In fact, MCPs have a legal obligation under the EPSDT mandate to provide care coordination for “all medically necessary services delivered both within and outside the MCP’s provider network” regardless of whether or not the beneficiary is considered “high-need.”¹²

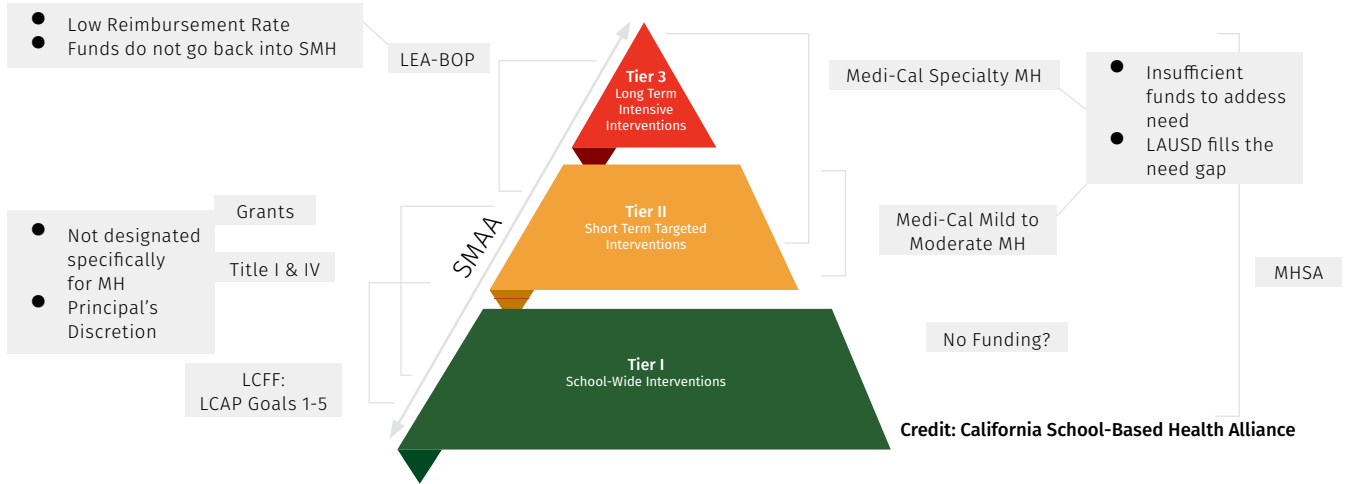


- We ask CalAIM and MCPs to expand and provide basic care management to ALL children so that they can access services that help reduce the risk of health and social-emotional difficulties from developing in the first place.
- Additionally, children will continue to have limited access to the full menu of services unless CalAIM includes schools as eligible providers of care coordination services. Children spend most of their day in schools and parents feel much more comfortable to ask trusted school staff for assistance and/or information about local resources. Schools have and continue to identify and link children to health services without support or fair compensation from MCPs. Managed Care Plans should see schools as foundational actors in health reform and as essential players in care coordination for children. We, therefore, ask CalAIM and MCPs to incorporate schools as part of their care coordination/case management model.
- Strengthen and revise LACDMH’s Health Neighborhoods Initiative (HNs) beyond “collaborative relationships” and coordination of services in our communities. Although we support this community change model, our children and families would benefit from school-based programs that promote protective factors and address social drivers of mental health.
 - o Same programs and interventions as listed above

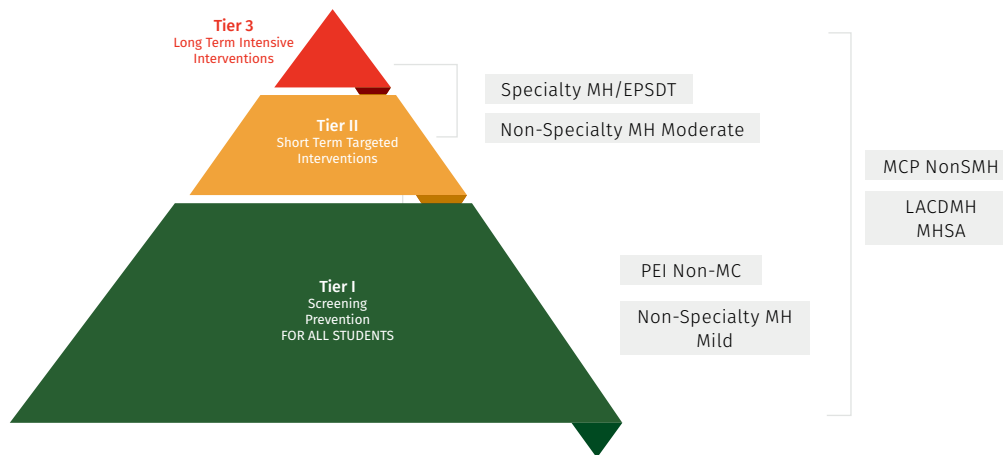
Fiscal Challenge: Multi-Tiered Systems of Support: Funding Prevention and Early Intervention

We previously recommended the adoption of MTSS as a common framework for child mental health, particularly in schools. However, we believe that MTSS also serves as a common-sense and child-centered funding structure that could help to deconstruct the current “fail first” approach. Below, we provide a visual that conceptualizes the complexity of the current funding model for SBMH followed by our fiscal recommendation.

Current Funding Structure



Proposed Funding Model



Managed Care Plans and County Departments could help schools deliver innovative Tier I screening and prevention programs for all students, irrespective of medical necessity, level of need, zip code, or school of attendance. Under CalAIM, MCPS could reimburse providers via capitated payments,¹³ which should incentivize grantors and grantees to provide these types of benefits.

- Develop systems of collaboration that lead to MCPs working with LEAs to provide capitation rates for Tier I interventions that address social drivers of both health and mental health.
- Develop a child-focused benefit by which non-medical settings such as school districts receive payment for delivering ECM services such as:
 - o Outreach and engagement
 - o Comprehensive assessment and care management plan
 - o Enhanced care coordination
 - o Health promotion
 - o Member and family supports
 - o Coordination of and referral to community and social support services

- Incentivize service agencies through LACDMH’s Healthy Neighborhood Initiative and MHSA-PEI to develop and implement projects/programs that address social drivers of health. Through PEI-Non-Medi-Cal payments, LEAs could also deliver Tier I EBPs across their schools and to all grade levels.

Practical Challenge: Child-Focused & Population-Based

In simple terms, population-based healthcare refers to strategies/approaches that focus on the wellness of a group of people rather than concentrating on the health outcomes of each individual. There is a consensus that this model is effective in terms of improving the well-being of the communities, while also providing a context for collaboration to occur across healthcare organizations, government agencies, and service providers.¹⁴ Below, we provide recommendations for how this model of care could be implemented to deliver effective and efficient SBMH services.



- Prepare heat maps to summarize and use data for decision-making on child mental health. Heat maps show the prevalence and geographical concentration of social drivers of health alongside other variables of interest. The resulting visual display of data helps to highlight where needs are greatest, as well as illustrating the mutually reinforcing factors impacting communities. As such, heat maps are effective tools that can help policy makers, community agencies, and school leaders identify and respond preemptively to biopsychosocial issues affecting specific populations. Key leaders in mental health (LACDMH, MHSOAC, MCPs, etc.) should collaborate with LEAs on mapping and using the resulting data for decisions tied to child mental health access and service delivery.
- Provide preventative mental health services that target the needs of each grade level and/or developmental stage:
 - o *Prenatal & Early Ed:* Early childhood mental health programs provide an opportunity to support the parents and caregivers of our youngest learners to ensure that they are equipped with the knowledge and skills needed to promote healthy social and emotional development. Prevention at this stage would consist of direct and sustainable funding to programs that deliver mental health consultation to school staff and parents; trauma informed professional development to school staff, and parent/caregiver workshops.
 - o *Elementary and Middle School:* Children during this developmental stage continue to lack cognitive and emotional structures necessary to negotiate family, community, and school stressors. Prevention at this stage would focus on mental health literacy, socio-emotional learning, substance use prevention, and strategies for resilience.



- o *High School*: Teenage years are without a doubt difficult and confusing times. Youth are also exposed to a variety of socio-emotional challenges that exacerbate existing mental health issues and often lead to risky/self-destructive behaviors. Prevention at this stage would involve greater emphasis on the most prevalent and critical mental health issues that show up in secondary schools including depression, anxiety, anger management, and suicide prevention.

Strategic Priority 2 - First Things First: Investing in Child Mental Health

The existing mental health system is geared towards funding and serving those (primarily adults) with severe mental health needs. However, several new investments are being made to reform the behavioral health system in California, including financial incentives to expand and sustain school-based services. But regardless of how much money is allocated, we must first need to shift from a reactionary to a preventative stance by prioritizing funding for child-centered mental health prevention and early intervention (PEI) in school-based settings. Below is a set of recommendations, we believe, puts children at the forefront of California's healthcare reform.

Policy Challenge 1: There are current policies that may be further evaluated to support a systemic transition from a reactionary to a preventative stance which would better meet the mental health needs for All children. In order to facilitate this we recommend the following policy recommendations:

- Amend the Mental Health Services Act (Proposition 63) to increase the minimum PEI investment from 20% to 30%. This would require action from the State legislature.
- Prioritize/redistribute MHSA funds for PEI school-based programs similar to L.A County's School Partnership Initiative.¹⁵ This would require action from the LA County Board of Supervisors.
- Invest in school-based PEI programs that prevent the onset of socio-emotional disturbances among students (Tier I supports), as well as Evidence-based Programs (EBPs) that address early mental health interventions (Tier II). This change would involve the MHSOAC.

Policy Challenge 2: The existing LA County system for engaging stakeholders around mental health priorities and funding does not adequately represent children and school-based mental health, nor are these advisory bodies required to base decisions on data. We believe the following policy recommendations could help the Service Area Leadership Teams (SALTs) become a more community-based, equitable, and effective forums for stakeholder input and decision-making:

- Ensure SALTs include representation from child-serving systems that can elevate all children’s voices and advocate for their well-being—particularly public schools and school-based mental health representatives. Such a change falls under the authority of the LACDMH.
- Require SALTs to use regional data indexes and data sources such as the Student Equity Need Index (SENI) and the Los Angeles County COVID-19 Medical Vulnerability Indicators to ensure data-driven and science-based decisions. This would likely require action on the part of the L.A County Board of Supervisors.
- Review the extent to which LACDMH’s spending of MHSA funds and the MHSA Three-Year Program and Expenditure Plan reflects local priorities articulated by SALT stakeholders. This proposed change would involve MHSOAC.

Funding Challenge 1: California’s public mental health funding is fragmented, categorical, and restrictive. Additionally, this system does not incentivize universally accessible preventive care for our children. However, the following fiscal recommendations could help deliver targeted, timely, and effective mental health services to children and youth.



- Shift funding toward block grants that allow Local Education Agencies discretion in providing SBMH. There is both precedent for this and alignment with the MHSOAC recommendations regarding flexible funding to enable schools to provide mental health services that address the needs of their local communities.¹⁶ Current funding allocations are administered by LA County DMH, CALMHSA, and MHSOAC.
- Review contractual requirements of grants to determine the chief factors that make it difficult for LEAs and community agencies to intervene and address community needs. These proposed changes would involve LA County DMH and MHSOAC.

Funding Challenge 2: In California, Managed Care Plans are responsible for ensuring children enrolled in Medi-Cal receive mental health screenings and “mild-to-moderate” services. All children are entitled to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coverage for preventative evidence-based interventions and early identification and intervention services. However, most MCPs do not fund/reimburse mental health providers for Tier I preventative interventions. California has recently taken significant steps to address this issue by incentivizing MCPs to build partnerships with LEAs and develop a more comprehensive child-focused system. Given this historic opportunity, we are optimistic that the following recommendations could accelerate partnerships between LEAs and MCPs:

- Operationalize the EPSDT benefit for public school students enrolled in Medi-Cal through direct LEA-MCP partnerships and ongoing collaboration to fund and align “mild-to-moderate” services with a prevention-focused and tiered framework for service delivery such as MTSS.

- Fund and focus LEA-MCP partnerships on the development of systems for collecting and reporting annual pediatric metrics as required by the Centers for Medicare & Medicaid Services. Beginning in 2024, MCPS must collect, report, and improve both physical and behavioral health child quality outcomes. With funding and formal partnership agreements, LEA and MCP partners can begin to build the capacity and infrastructure necessary to share data and implement school-based mental health programs.
- Increase fee rates for individual psychotherapy sessions. The average reimbursement rate per session ranges between \$50-\$75 dollars per session, which is not enough to sustain the actual cost of delivering services.

Practical Challenge: MHSA funds are administered by three separate entities: LA County DMH, MHSOAC, and CALMHSA. Navigating these entities poses barriers for schools and LEAs seeking funding for SBMH services and support. Moreover, each entity has unique program objectives and contractual requirements. We offer the following recommendations for streamlining the current funding system to better equip providers meet the mental health needs of children and families enrolled in public schools:



Restructure the funding allocation process to allow for a single entity to award SBMH funds. This would reduce the administrative and upfront financial burden of both LEAs and other service providers when applying for MHSA funds. Proposed changes would require involvement of LA County DMH, MHSOAC, and CALMHSA.



Increase preventive programs using the Community Schools Initiative model. This initiative uses a community-based framework that allows subsidiaries to invest in programs relevant to the needs of the communities they serve. Its funding structure promotes innovation, efficiency, and sustainability—elements urgently needed in our mental health system. A shift toward prevention would likely involve LA County DMH as well as the LA County Board of Supervisors.



Expand Peer-to-Peer (P2P) programs focused on prevention and advocacy at the local level. Experts describe this “P2P” approach as a multi-benefit solution for youth as it focuses on prevention, enables culturally responsive support, mitigates the provider shortage, and offers workforce development opportunities for youth. A current program led by The Los Angeles Trust for Children’s Health is implemented in five high schools in LAUSD. Students involved in the Community Ambassador Network or CAN participate in mental health awareness activities, collaborate with Student Advisory Board (SAB) engagement efforts, and conduct outreach through their school communities.¹⁷ A shift toward P2P would likely involve LA County DMH as well as the LA County Board of Supervisors.





Prioritize funding for local, decentralized mental health stigma reduction efforts. LEAs understand the needs of regional and localized school communities. Moreover, they are better equipped to enlist local stakeholders in the design and implementation of social marketing aimed at reducing the stigma associated with mental health. The proposed change would impact CALMHSAs who currently administer mental health stigma reduction efforts.

Strategic Priority 3 – Systemic Collaboration: All in Today for our Children’s Tomorrow

The current child and youth mental health system is characterized by service gaps, with few incentives or forums for interagency cooperation and joint action across funding streams. In fact, the Surgeon General’s Advisory on Protecting Youth Mental Health recently singled out the need for greater cross-sectoral collaboration to meet the mental health needs of young people and their families.¹⁸ The current and ongoing mental health crisis offers an opportunity to counter the classic siloed approach with expanded collaboration and partnership that provides a coordinated response to an issue which is, by definition, cross-sectoral and complex. In this section, we provide a set of strategies for a model of professional collaboration that leverages and organizes the expertise of multiple sectors and stakeholders.

Policy Challenge: Establish a countywide Center for Healthy Schools & Communities

To better meet the mental health needs of LA County’s children and families, we must transform the current child-serving ecosystem. We must enlist multiple public agencies to act in coordination with one another and cooperate across different funding streams. Changes in governance aimed at integrating and coordinating collaboration between county, health, and education systems are a vehicle for such a new approach. Fortunately, Alameda County’s Center for Healthy Schools and Communities offers a replicable model for interagency cooperation.¹⁹ To move in this direction, we recommend the following policy recommendations:

- In alignment with the Office of Child Protection Strategic Plan,²⁰ and contributing partners, develop an LA County Center for Healthy Schools and Communities (LACHSC) that draws on the Alameda County framework.
- Align the new LACHSC with the motion passed by the Los Angeles County Board of Supervisors (September 15, 2021) to establish the Los Angeles County Office of Prevention Services, as a governance structure designed to “...coordinate and effectuate a comprehensive community-based prevention services delivery system... [with the] necessary budgeting, staffing, contracting, and data sharing authorities across relevant departments to effectuate Countywide community-based prevention service delivery.

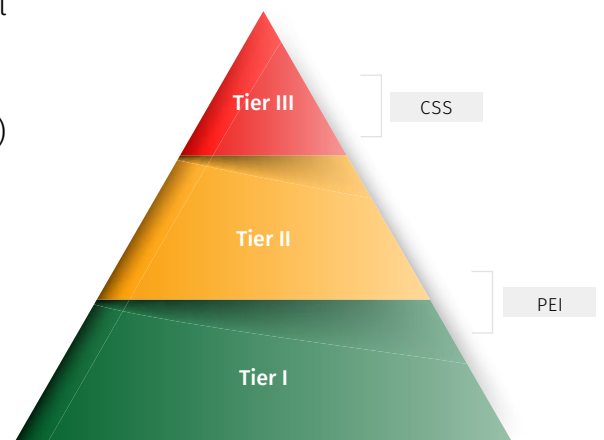


We envision LACHSC to encompass a holistic systemic approach for the overall well-being of ALL of L.A. County children, youth, families, and communities independent of involvement in the child welfare system involvement. LACHSC would incorporate all child serving stakeholders with health and education experts leading the way, utilizing the term “school health” to reflect the common vision for such initiative, recognizing the critical link between student well-being and academic success. In sum, the above-mentioned paves the way for multisystem accountability, more increased and equitable practices for the screening of ALL children.

Fiscal Challenge 1: Leveraging Existing MHSA Resources

Annually, the MHSA provides L.A. County approximately \$600 million distributed to five components, each supporting different elements of the mental health system. We believe this is a solid and robust financial foundation that, if reallocated, could help L.A County support the overarching goal of MHSA: “design, expand, and *transform* California’s county mental health system.” Below, we provide a set of fiscal recommendations to finance an interagency governance system/structure designed to implement a school-based mental health delivery system which emphasizes prevention.

- Adopt the MTSS framework as the financial model for the proposed LACHSC governance system/structure. As mentioned before, this model will allow child-serving systems to deliver tiered services in alignment with MHSA components - particularly Community Services and Support (CSS) and Prevention and Early Intervention (PEI).
- Consider how best to incorporate an equity lens for resource allocations through the proposed LACHSC. For example, LAUSD has developed a Student Equity Needs Index (SENI) that could be adapted and expanded to measure regional/ community needs (see Strategic Priority 4 below).
- L.A County Board of Supervisors along with LACDMH should redistribute PEI funds to provide sustainable funding to LACHSC for Tier I and Tier II SBMH.
- LAC Board of Sups and LACDMH should consider reallocating a portion of funds supporting Statewide PEI programs towards school-based programs and services managed by the new LACHSC.
- Designate funding specifically for Tier III SBMH using CSS programs such as Outpatient Services, Linkage, and Planning, Outreach and Engagement.



- Allow the new LACHSC to administer MHSAs Innovation component (INN), an annual amount of \$5 million designed to fund time-limited pilot projects with promising contributions to the mental health system.²¹
- Have MHSOAC allocate a portion of the MHSAs funds to the new LACHSC to fulfill the Commission’s recommendation for transforming schools into “centers of wellness and healing, with prevention and intervention efforts designed to reach children even as infants.”²²

Fiscal Challenge 2: Maximizing Federal Resources

California counties are missing the opportunity to draw federal resources upwards of \$100 million for mental health funding.²³ The Federal Medical Assistance Program (FMAP) guarantees a 50% match of Certified Public Expenditures (CPEs). This generally means that for every dollar California spends on Medi-Cal services, the federal government matches it with a dollar. With children comprising 40% of all Medi-Cal recipients, there are a lot of matching funds potentially at stake. We recommend the following as steps and sources of funding to support and finance the LACHSC governance structure:



- Identify local funding sources for SBMH programs that serve as an eligible match to leverage the EPSDT federal benefit.
- County-Based Administrative Activities (CMAA) program which funds efforts to identify and enroll potential eligible individuals into Medi-Cal.
- Families First Prevention Services Act (FFPSA) which aims to prevent children from entering foster care by allowing federal reimbursement for mental health services, substance use treatment, and in-home parenting skill training.
- California also passed AB 153 which authorizes funding for federally approved prevention services that have been shown to reduce foster care system involvement, including mental health services.

Practical Challenge - A Model that Works: Alameda County Center for Healthy Schools & Communities

Uniting under LACHSC would help establish a countywide framework/model further strengthening current programs/initiatives that make up our child-serving systems. LACHSC would function as the vehicle for systemic collaboration necessary to meet the ever-growing needs of All children, youth, families, and communities. However, there are a few practical challenges that we must first consider:

- Assign/select central leadership (Chair, co-chairs)
- Develop common mission, vision, goals, and definitions
- Require/direct participation from all relevant County Departments
- Engage regional stakeholders including CBOs and school-based divisions
- Develop common policy/advocacy goals

Strategic Priority 4 - Community Resilience: Empowering & Healing Communities

Los Angeles County is a mosaic of diverse, dynamic communities. The complexity of this landscape reveals both the importance and the need for greater community-level adaptability and resilience. Indeed, the concept of Community Resilience may provide an appropriate framework for thinking about how to rebuild mental health and community well-being. In the context of SBMH, this first requires shifting from an individual school to a regional or multi-school unit of analysis. With a larger community or neighborhood perspective, we can begin to mobilize collective action to reduce disparities and promote wellness and well-being. Below, we provide a set of recommendations to advance Community Resilience within SBMH that include policy, fiscal, and practical implications.

Policy Challenge: Focusing on Regional Communities

One key lesson of the pandemic is that crises have disproportionate impacts in each neighborhood and community. It highlighted geographic disparities in terms of morbidity and mortality which, in turn, correlated with other social determinants of health. In fact, data demonstrates that where people live (i.e., zip code) is a better predictor of health outcomes than their genetics. Applied to mental health, these facts suggest a need for a more decentralized response to localized needs. At the same time, we need to expand the focus of the SBMH delivery system from an individual school to the larger region in which multiple schools serve a community of children, youth, and families over grade levels and across time. Put another way, the intended beneficiaries of SBMH live, work, and play within a larger context than a school, but a much smaller universe than a county Service Planning Area or SPA. We believe that building community resilience at the regional level is an effective, practical approach that could help county leaders increase mental health access, expand, as well as deploy existing resources in a more culturally responsive and equity manner. The following are policy recommendations that would elevate and integrate a regional approach to community resilience.

- Define and designate regional boundaries for coordination and delivery of SBMH. These could use the Community of (in) Schools or similar models which tend to locate services within a feeder pattern of early education, elementary, middle, and high schools that serve a given community. In large part, these preK-12 feeder patterns better correspond with zip code and other markers of community or neighborhood. This would require action from the LA County Board of Supervisors.



- Allocate resources and assign service providers regionally. Shifting to a regional or community-based approach suggests a corresponding change in how leaders consider population needs, necessary resources, and mix of services and supports. Scaling these to the regional level helps ensure that access to SBMH is less dependent on the awareness and volition of individual school leaders. Providers operating across multiple schools gain economies of scale regarding public engagement and stigma reduction. Lastly, the regional approach facilitates the review of community level data tied to both output and outcomes. This would require action from the LA County Board of Supervisors, county departments, school districts, and community-based organizations.

Fiscal Challenge: Strategic and Community-Based Funding

Funding for public services should be in alignment with the needs and strengths of each region/community. This will require L.A County officials to develop a north star with high-level outcomes and then empower localized strategies and responses to achieve these system goals. Fiscal decentralization is a crucial element for community resilience because it gives communities a stake in decisions that affect them. With the involvement of community members and leaders committed to the overall well-being of their neighborhoods, solutions can be tailored to meet localized needs and specific equity gaps. The following are fiscal recommendations, we believe, could help elevate, empower, and invigorate our communities.

- Share and allocate fiscal resources at regional level: As mentioned previously, fiscal decentralization is an important factor for communities to be able to identify gaps, manage resources, and build resilience. Regional aggregations also provide potential economies of scale for the allocation of fiscal and human resources involved in SBMH delivery and coordination.
- Ensure that fiscal allocations are data-driven and needs-based: Extant regional data (i.e., by zip code, census tract, school data) provide the basis for tailoring SBMH services and supports to meet local needs. Because these data highlight regional differences and disparities, their widespread use will likely contribute to equitable distribution of funds for community-based programs and services.

Practical Challenge: Building Community Resilience

We have discussed the importance of community distinctiveness when developing policy and fiscal strategies. It is also important to consider socio-economic and demographical differences during both development and implementation of practices. Each community should be supported and empowered to develop practices that build resilience based on their own identity and resources. In this case, each region/community should establish protocols for SBMH service delivery that increase access, quality, equity, and integration of additional supports. Although we will refrain from providing delineated guidance, we believe a solid first step rests on local leader's understanding of their communities and value of schools as resource hubs.



Strategic Priority 5 – Demonstrating Impact: New Measures and New Voices

With increased attention and public interest in mental health, we have an opportunity to tell a compelling story about the critical importance and holistic impact of SBMH services. At present, the story of mental health relies upon outputs and service utilization. The status quo is limiting as it is difficult to make informed decisions based on agreed upon outcomes. Moreover, it largely excludes youth and community voices in describing the impact of SBMH services and supports. Now is the time to blend quantitative data with qualitative stories of transformation that elevate and amplify the voices of youth, families, and school communities. In this section, we provide a set of strategies to advance a holistic model of accountability that can, in turn, aid outreach and dissemination of SBMH services.

Policy Challenge: Data Exchange for Mental/Behavioral Health

To understand and respond appropriately to mental health disparities and inequities in Los Angeles County, we need to develop and implement a well-coordinated data exchange. The public mental health system must have the capacity to share secured data seamlessly across service agencies/entities, while overcoming barriers caused by complexity and lack of communication across systems of care. As California prepares to implement CalAIM, we are at an inflection point. Now more than ever, mental health needs a dashboard that serves as a platform for information, decision-making, collaboration, and accountability. We also believe that data should reflect the lived experiences of our children and families. Below, we provide a set of recommendations based on current gaps:

- Establish central leadership/oversight of the data exchange: As we have mentioned before, the mental health system is fractured and lacks a strong central authority responsible for developing and ensuring compliance of common goals and outcomes. Therefore, LA County should create an oversight structure/authority in charge of setting parameters regarding data collection and reporting, use by service providers, sharing across agencies, etc. Accountability might, for example, rest with the newly developed LACHSC outlined in Strategic Priority 3 above. Alternatively, another governance or oversight body could be charged with monitoring accountability through the data exchange.



- Supplement outputs with outcomes: Currently, the mental health system is primarily interested in measuring outputs or counts of participation in programs, training, or services delivered by a given provider. Grants often incentivize service agencies to focus all their resources into delivering more instead of better. The current system focuses on measures of efficiency (doing things right or improving what is already being done) rather than their effectiveness (doing the right thing or focusing on what matters). In LA County, the non-profit sector is severely impacted by restrictive output measures that limit their ability to evaluate and report the value of their services. To clarify, we believe both output and outcome measures are important and necessary, but we are challenging the system to include measures that better communicate impact/effects/results. Moving in this direction would likely involve several key steps including:
 - * Define/Identify Outcomes
 - * Operationalize Outcomes into Data indicators and metrics
 - * Align Outcomes with Outputs
 - * Develop an Inclusive Data Collection Plan
 - * Clarify Reporting requirements
- Revised Methods and Approaches to Evaluating the Impact of SBMH: With mental health, we want to tell stories about the children and families we serve. We want to know who is accessing SBMH, what services, programs, and support have been most effective, and where they want SBMH to become more responsive and/or focused on the future. By elevating the voices of those who day in and day out contend with socio-emotional challenges, we hope to contextualize and better communicate data on the impact and transformational potential of SBMH. Such efforts also serve to demonstrate a willingness to address historical inequities, providing a humanistic and whole-person approach when collecting, analyzing, and reporting data. We recommend a utilization-focused evaluation approach (i.e., involving and prioritizing the needs of those who are the intended beneficiaries of programs, services, and other initiatives) that explores and analyzes multiple ways of understanding SBMH's role in communities throughout LA County.

Fiscal Challenge: Cost-Benefit Analysis

Most educators do not have to be persuaded that investing in child mental health has a direct impact on both individual and societal outcomes. Put simply, children cannot learn effectively if they are struggling with mental illness, trauma, etc. There is also emerging consensus regarding the importance of mental health prevention as a strategy to increase community wellness, particularly in underserved, low-income communities. Unfortunately, we lack the ability to quantify exactly how much return on investment or ROI accrues from prioritizing early interventions in mental health and community well-being. To get there, we need to fund a true cost-benefit longitudinal study. Parallel efforts regarding early childhood education revealed a ROI of \$8 for every \$1 of social investment. A financial/economic evaluation will allow us to identify costs and benefits associated with school-based universal prevention programs. Thus, we recommend the following:

- Provide resources for a Cost-Benefit Analysis on School-based Preventative Mental Health in L.A County: Develop a Request for Proposal to conduct a longitudinal study on the economic costs and benefits of SBMH within LA County. Such a study would examine the ROI associated with mental health investments, programs, and services. Such a study could provide the quantitative basis for longer-term resource allocations within and across the mental health system.



Practical Challenge: Elevating Youth, Family and Community Voice

It is more imperative than ever to highlight the importance of youth and community voice in the development of prevention efforts, co-design of instruments and tools and other data evaluation practices. By engaging intended users as partners, leaders, and decision makers we can help optimize the personal factor and increase the likeliness of user involvement and sense of ownership of the program in its entirety. Furthermore, it assures that prevention and community development efforts are better aligned with community needs. This is especially critical within communities of color that have historically and systematically been marginalized.



By lifting the voice of youth and families in the planning, development, and implementation of services, programs, and resources, we have the capacity to make a positive impact in the present lives of youth and family, and in turn initiate an investment in the sustainability of their communities. Providing a platform and an opportunity for the integration of youth (and families) to share and utilize their lived experience as expertise is valuable. We recommend that CALMHSA further harness the power of youth, family, and community voice:

- Expand programs such as the Youth Voice-Community Ambassador Network (CAN). The L.A. Trust for Children’s Health has sponsored Student Advisory Boards at schools to promote health advocacy and leadership skills.²⁴ Topics vary and include focus on mental health education and promotion with the goal of building students’ capacity to serve as mental health advocates in their school communities. Similar, parallel efforts and networks might be used to incorporate family engagement.



Endnotes

1. Costello E., Mustillo S., Erkanli A., Keeler G., & Angold A. (2003). Prevalence and development of psychiatric disorders in childhood and adolescence. *Archives of General Psychiatry*. 60(8):837-844.
2. Merikangas, K.R., He, J., Burstein, M., Swanson, S.A., Avenevoli, S., Cui, L., Benjet, C., Georgiades, K., Swendsen, J., (2010). Lifetime prevalence of mental disorders in US adolescents: Results from the national comorbidity study-adolescent supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry*. 49(10): 980-989.
3. Griffith, A. (2010). Committee on the prevention of mental disorders and substance abuse among children, youth, and young adults, National Research Council and the Institute of Medicine: preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities. *Journal of Child and Family Studies*, 19(5), 675-676.
4. Center for Disease Control, "[Facts About Suicide](#)." Accessed March 21, 2022
5. Lucile Park Foundation for Children's Health. "[Number of youth suicides, by age](#)." Accessed February 12, 2021
6. National Alliance of Mental Illnesses (NAMI). (2015). [Mental Health by the Numbers](#). November, 2020
7. Lester, L., & Cross, D. (2015). The Relationship Between School Climate and Mental and Emotional Wellbeing Over the Transition from Primary to Secondary School. *Psychology of well-being*, 5(1), 9. <https://doi.org/10.1186/s13612-015-0037-8>
8. [How Mental Health Disorders Affect Youth](#). Youth.gov
9. Hurwitz, L., & Weston, K. (2010). Using coordinated school health to promote mental health for all students. *National Assembly on School-Based Health Care*
10. California Department of Health Care Services (DHCS). <https://www.dhcs.ca.gov/provgovpart/Documents/CalAIM/CalAIM-Executive-Summary.pdf>
11. California Department of Health Care Services, "[Enhanced Care Management Policy Guide](#)," May, 2022
12. California Department of Health Care Services, "[All-Plan Letter #19-010: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21](#)," August 14, 2019.
13. California Department of Health Care Services, "[Community Supports or In Lieu of Services \(ILOS\) Policy Guide](#)," April, 2022



14. Giles-Corti, B., Vernez-Moudon, A., Reis, R., Turrell, G., Dannenberg, A. L., Badland, H., ... & Owen, N. (2016). City planning and population health: a global challenge. *The lancet*, 388(10062), 2912-2924.
15. Los Angeles County, Community of Schools Initiative http://file.lacounty.gov/SDSInter/dmh/1051008_PreventionServices_SchoolPartnershipInitiative_CommunitySchools_012919.pdf
16. Los Angeles Department of Mental Health. <http://file.lacounty.gov/SDSInter/bos/supdocs/134496.pdf>
17. The Los Angeles Trust for Children’s Health. <https://www.thelatrust.org/student-engagement>
18. Office of the Surgeon General. (2021). Protecting Youth Mental Health: The US Surgeon General’s Advisory <https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf>
19. Alameda County School-Based Behavioral Health. https://achealthyschools.org/wp-content/uploads/2020/03/116_Alameda_County_School-Based_Behavioral_Health_Model.pdf
20. Los Angeles County Office of Child Protection. Countywide Child Protection Strategic Plan. <https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/8643614b-6aa5-4224-9a7d-d6943cb353f1/OCP%20Strategic%20Plan%202016-2026.pdf>
21. Welfare & Institutions Code 5830 allows INN to subsidize programs that: a) Make change to an existing mental health practice or approach, including, but not limited to, adaptation for a new setting or community; b) Introduce a new application to the mental health system of a promising community-driven practice or an approach that has been successful in non-mental health contexts or settings.
22. Mental Health Services Oversight & Accountability Commission. Every Young Heart & Mind: Schools as Centers of Wellness https://mhsoac.ca.gov/wp-content/uploads/schools_as_centers_of_wellness_final-2.pdf
23. Cal Health Report. <https://www.calhealthreport.org/2019/10/03/millions-gone-unclaimed-behind-californias-troubled-mental-health-care-funding-system/>
24. The Los Angeles Trust for Children’s Health. Student Advisory Boards <https://www.thelatrust.org/student-engagement>



Glossary

CalAIM	California Advancing and Innovating Medi-Cal is a far-reaching, multi-year plan to transform California’s Medi-Cal program and to make it integrate more seamlessly with other social services. Led by California’s Department of Health Care Services, the goal of CalAIM is to improve outcomes for the millions of Californians covered by Medi-Cal, especially those with the most complex needs.
CALMHSA	The California Mental Health Services Authority is a coalition of county governments working to improve mental health outcomes for the state’s individuals, families, and communities.
CAN	The Community Ambassador Network program is designed to hire, train, and certify community members who will be able to function as “lay” mental health workers in their own neighborhoods (where they actually live). The Community Ambassadors, as such, can become local access agents, problem-solvers, and system navigators to help those in need find relevant resources.
CMAA	Local Governmental Agencies participating in the County-Based Medi-Cal Administrative Activities program are eligible to receive federal reimbursement for the cost of performing administrative activities that directly support efforts to identify and enroll potential eligible individuals into Medi-Cal.
CPE	Public entities may certify that they spent funds on Medicaid items or services that are eligible for Federal matching funds. These funds are referred to as Certified Public Expenditures and may be claimed as the State’s share of Medicaid expenditures as long as they comply with Federal regulations and are being used for the required purposes (42 CFR § 433.51 and 45 CFR § 95.13.)
CSS	The Community Services and Support component is used to provide direct services to adults and older adults with serious mental illness and children and youth with serious emotional disturbance who meet the criteria set forth in Welfare and Institutions Code (W&I Code) section 5600.3.
DHCS	The California Department of Health Care Services is a department within the California Health and Human Services Agency that finances and administers a number of individual health care service delivery programs, including Medi-Cal, which provides health care services to low-income people.
EBP	Evidence-Based Practice is the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences.



ECM	Enhanced Care Management is a new statewide Medi-Cal benefit available to select “Populations of Focus” that will address clinical and non-clinical needs of the highest-need enrollees through intensive coordination of health and health-related services. It will meet beneficiaries wherever they are – on the street, in a shelter, in their doctor’s office, or at home.
EPSDT	The Early and Periodic Screening, Diagnostic and Treatment benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. EPSDT is key to ensuring that children and adolescents receive appropriate preventive, dental, mental health, and developmental, and specialty services.
FFPSA	The Family First Prevention Services Act will enhance support services for families to help children remain at home and reduce the use of unnecessary congregate care placements by increasing options for prevention services, increased oversight, and requirements for placements, and enhancing the requirements for congregate care placement settings.
FMAP	Medicaid is a federal program that covers many long-term care services for eligible people. States manage Medicaid programs and share the costs of these programs with the federal government. Centers for Medicare Services reimburses each state for a percentage of its total Medicaid expenditures. This percentage, which varies by state, is called the Federal Medical Assistance Percentage .
ILOS	In Lieu of Services are services or settings that are offered in place of services or settings covered under the California Medicaid State Plan and are medically appropriate, cost-effective alternatives to services or settings under the State Plan.
INN	The Innovation component funds projects designed to test time-limited new or changing mental health practices that have not yet been demonstrated as effective. The purpose of the INN component is to infuse new, effective mental health approaches into the mental health system, both for the originating county and throughout California.
LACDMH	Los Angeles County Department of Mental Health is responsible for providing or arranging for the provision of Specialty Mental Health Services to Medi-Cal beneficiaries in the county.
LEA	A Local Education Agency is a public authority that is designed to oversee the implementation of education policies as set forth by the government.
MCP	Medi-Cal Managed Care Plans are a type of health insurance (e.g., L.A Care, HealthNet). They have contracts with health care providers and medical facilities to provide care for members at reduced costs.
MHSA	The Mental Health Services Act addresses a broad continuum of prevention, early intervention, and service needs and the necessary infrastructure, technology, and training elements that effectively support the public behavioral health system.



MHSOAC	<u>The Mental Health Services Oversight and Accountability Commission</u> primary function is to oversee the implementation of the Mental Health Services Act. The Commission distributes grants, collects, and shares spending and efficacy data on local programs, spreads best practices, conducts research into critical subject areas like criminal justice involvement of people with mental health needs, and engages experts to develop policy proposals and other pathbreaking solutions.
MTSS	<u>A Multi-Tiered System of Support</u> is an integrated, comprehensive framework for local educational agencies that aligns academic, behavioral, and social-emotional learning in a fully integrated system of support for the benefit of all students.
PEI	<u>The Prevention and Early Intervention</u> component funds programs designed to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for the underserved.
SALT	The primary goal of each <u>Service Area Leadership Team</u> is for representatives of the community to convene and develop stakeholder priorities that will advise LACDMH on its planning to develop and improve its services and partnerships.
SBMH	<u>School-Based Mental Health</u> refers to the provision of mental health services in schools. School-based mental health services are delivered by trained mental health professionals who are employed by schools, such as school psychologists, school counselors, school social workers, and school nurses. By removing barriers such as transportation, scheduling conflicts and stigma, school-based mental health services can help students access needed services during the school-day.
SENI	<u>The Student Equity Need Index</u> is a student-based equity need index used to inform the allocation of funds so that LAUSD can efficiently address the achievement gap. Includes indicators that measure percentages of targeted student populations, academic and community indicators that determine Highest, High, Moderate, Low, and Lowest need schools throughout all school levels in LAUSD.
SPA	<u>A Service Planning Area</u> is a specific geographic region within Los Angeles County. The regions allow L.A County to provide services targeted to the specific needs of the residents in these areas.
ROI	<u>Return on Investment</u> is a metric used to understand the profitability of an investment. It compares how much you paid for an investment to how much you earned to evaluate its efficiency
TRiEE	<u>The Trauma and Resilience informed Early Education</u> Program utilizes a prevention model to increase protective factors and reduce risk factors for children and families in Early Education Centers





Reshaping the
**Future of
Child Wellness**

www.achieve.lausd.net/smh

Tanya Mercado, LCSW
Dr. Frank Dussan, LCSW

