

Project Summary

County: **Alameda County**
Date submitted: **4/13/2018**
Project Title: **Introducing Neuroplasticity to Mental Health Services for Children**
Total amount requested: **\$2,054,534**
Duration of project: **4 years**

General Requirement	Applies a promising community driven practice or approach that has been successful in a non-mental health context or setting to the mental health system
Primary Purpose	Increases the quality of mental health services, including measured outcomes

Problem

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. For example, childhood trauma and related stress may result in a delay in organized neurodevelopment due to prioritizing safety (fight/fright/freeze). This frequently results in functional issues such as hypersensitivity to touch, an inability to know where one is in space or a need to move constantly, as well as other behaviors that result in discipline, interrupted learning, and mental health services. Unfortunately, mental health practitioners are not trained to identify, nor treat, the neurodevelopmental disorders that may be contributing to the emotional and behavioral symptoms.

Data is not available to estimate the number of youth with emotional/behavioral issues who also have neurodevelopmental issues, but based on rates of emotional/behavioral symptoms and trauma among children, we can estimate that 67-90% (19,939 to 26,784) of students aged 5-12 in Alameda schools who exhibit emotional/behavioral symptoms have experienced trauma, a leading cause of neurodevelopmental issues.

In Alameda's recent Community Planning Process (CPP) for the MHSA Three Year Plan, 71% of respondents identified violence and trauma as a priority issue for youth. While MHSA Prevention, Education, and Innovation (PEI) provides some trauma related training and services in schools, the community requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – in schools.

Project

Brain research has helped us to understand the link between neurodevelopment and mental health. This has led to inter-disciplinary efforts and well developed assessments, but limited specific interventions. Most of these efforts are only available to clients in specialty centers and clinical settings. In addition, while the existing research supports the effectiveness of these efforts in regards to mental health outcomes, the research focusing on mental health is limited.

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Trained HANDLE® (Holistic Approach to Neuro-Development and Learning Efficiency) instructors provide training for clinical and non-clinical providers in unique assessment procedures and specific interventions. In addition, this project would evaluate the impact on mental health symptoms. This project proposes to:

- Train school and BHCS staff in the HANDLE model
- Have school staff refer students (K-5) exhibiting emotional/behavioral symptoms
- Conduct eligibility screening, gain parent permission
- Assess students, including a neurodevelopment assessment, in order to develop an intervention plan
- Provide 4-6 months of services each day in school by trained HANDLE practitioners

Evaluation

Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues. Alameda County aims to learn:

Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?

Learning Goals *(see Logic Model for more detail)*

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.
2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

The project could provide a model for improving underlying neurodevelopmental issues that lead to emotional and behavioral symptoms for a wide range of youth. The results will be shared statewide with mental health divisions, as well as regionally with schools, and further.

Budget

Salaries \$943,631	BH Clinical Supervisor (1.0 FTE) coordinate the program oversee Clinician II Clinician II (0.6-0.75 FTE) oversee HANDLE trained practitioners <i>Clinicians (0.2 FTE x 6 staff) attend training, conduct assessments (BHCS in-kind)</i>
Operating \$80,200	Substitute teacher time for teachers to attend training Materials, snacks, incentives
Consultants \$762,720	Parent Aids: parents or others who become trained HANDLE practitioners (2.0 FT) HANDLE Trainers; Evaluator
Indirect \$267,983	15% for BHCS to administer project

Introducing Neuroplasticity to Mental Health Services for Children

Logic Model

- Situation:**
- Alameda County Stakeholders requested Innovative approaches to addressing mental health issues in schools
 - Over 19% of Alameda County students (K-8) have been identified as having behavioral/emotional symptoms
 - 55-90% of these students have experienced trauma, a leading cause of neurodevelopmental issues
 - Mental health providers are not trained to identify or address neurodevelopmental issues

Inputs	Outputs		Outcomes -- Impact		
	Activities	Participation	Short	Medium	Long
Training in HANDLE® Personnel Time - BHCS program manager - BHCS clinicians - School staff - Student Aides (parents and others who are stipended) Substitutes to cover school staff as needed Materials Evaluator	Training - Concept, basic interventions - Screener training - Advanced training Students with emotional or behavioral problems and neuro-developmental weaknesses receive interventions every school day for 4 mos (6 mos advanced) (200 students) Pre/post evaluations	- All participating staff, other school staff, parents, etc. (150) - Clinicians, school staff (12) - Clinicians, school staff (6) Trained Practitioners assess students referred by school Student Aides provide interventions for students Parents/students, providers, school staff	Increase in knowledge and skills regarding neurodevelopment framework, assessment and interventions (75%) Students receiving interventions experience improved neuro-development (35%/50% advanced), emotional or behavioral symptoms (50%), and school performance (25%)	Increase neurodevelopment-informed response to students (50%) Students continue to show improvement (review of IEPs one year after intervention)	Increase understanding of student behavior (70%) Students experience long-term improved mental health and functional outcomes (not within scope of program evaluation)

Assumptions

Neurodevelopmental issues can cause/exacerbate behavioral/emotional symptoms. Strengthening neurodevelopment can reduce emotional/behavioral symptoms. HANDLE provides effective assessment and interventions that clinical and non-clinical people can be trained to conduct.

External Factors

- The number of schools that participate and level of follow-through. (So far 2 schools have committed to participation and training time).
- Parents approval of students' participation in services
- Participants exposure to further trauma

INNOVATIVE PROJECT PLAN DESCRIPTION

County: Alameda Date Submitted 4.13.18
Project Name: Introducing Neuroplasticity to Mental Health Services for Children

I. Project Overview

1) Primary Problem

a) *What primary problem or challenge are you trying to address?*

Many children with emotional and behavioral disorders have underlying neurodevelopmental differences that exacerbate the emotional and behavioral disorders. Finding a way to provide neurodevelopmental interventions, in addition to mental health interventions, should lead to better mental health and functional outcomes.

The causes of emotional disturbance, neurodevelopmental disorders, and other challenges among youth are complex and interactive – a mix of genetic, experiential and physical environment factors. Trauma is one of the more studied causes of neurodevelopmental disorders. Adverse childhood experiences (ACEs) can cause significant neurodevelopmental and brain dysfunction, which can result in physical, cognitive, emotional and behavioral issues (Perry et al, 1995; Felitti et al, 1998). A study of over 17,000 adults revealed a strong positive relationship between ACEs and the increased likelihood of behavioral health issues, suggesting disordered brain functioning in response to child trauma (Anda et al, 2006).

A common example is a child that develops a nervous system which functions in a high state of sympathetic response due to experiencing trauma. This state of flight/fight/freeze affects their emotions, behaviors, and ability to learn. Such a child is then diagnosed and treated based on their set of symptoms. If they are diagnosed with primarily a learning disorder, then they get one course of services. If they are diagnosed with primarily a mental health disorder they will be served within the mental health system. Unfortunately, **mental health practitioners are not trained to identify, nor treat, the neurodevelopmental disorders that may be contributing to the emotional and behavioral symptoms.** Mental health approaches focus on thoughts, emotions and behaviors to lower stress, and address symptoms of a child's diagnosis. It may help the child to manage the symptoms, but does not necessarily improve the underlying neurodevelopmental issues.

Due to lack of attention to the overlap of emotional or behavioral symptoms and neurodevelopmental weaknesses in children, it is hard to know how many children are experiencing this. But we have a few points of data that help us to estimate:

- In 2016, 4.2% (6,510) of Alameda County students ages 5-12 received special education services for emotional disturbance according to Lucile Packard's Foundation for Children's Health.

- In addition, approximately 15% (23,250) of general education students in Alameda County are referred to Mental Health Services Act (MHSA) Prevention and Early Intervention (PEI) funded services by school staff due to exhibiting behavioral/emotional issues.

While there is no way to know how many of these students have neurodevelopmental weaknesses, we do know:

- More than 2/3 of children report at least one traumatic event by age 16 (SAMHSA)
- Due to the link between trauma and mental health issues, 90% percent of clients in public behavioral health care setting have experienced trauma (integration.samhsa.gov/clinical-practice/trauma).

So we can estimate that 67-90% of children with behavioral health issues have experienced trauma. **This means between 19,939 and 26,784 students ages 5-12 in Alameda schools exhibit emotional/behavioral symptoms and have experienced trauma, a leading cause of neurodevelopmental issues.**

b) Describe what led to the development of the idea for your INN project

In Alameda's recent Community Planning Process (CPP) for the MHSA Three Year Plan, 71% of respondents identified violence and trauma as a priority issue for youth. MHSA Prevention and Early Intervention (PEI) programs currently provide some training to school staff to be better equipped to receive youth experiencing trauma. The Transition Age Youth (TAY) Full Service Partnership (FSP) also aims to provide trauma informed care. **In the CPP the community requested that Innovation try to find additional ways to address behavioral and emotional issues – whether related to trauma or not – in schools.** Currently, BHCS funds access and linkage programs at the school district level to implement Coordination of Services Teams (COST). These COST Teams are not assessing for neurodevelopmental weaknesses or strategies for strengthening neural pathways. However, many students have experienced different levels of community violence and trauma, which can lead to neurodevelopmental issues. Our current level of MHSA funded PEI services is missing this critical piece around neurodevelopmental issues and recovery from them.

Innovation offers a way to test an intervention before determining whether to formally integrate it into ongoing BHCS programs and practices. **This INN project tests whether addressing underlying neurodevelopmental weaknesses can reduce mental health symptoms. If successful it could be widely integrated into existing school-based services.**

2) What Has Been Done Elsewhere To Address Your Primary Problem?

BHCS staff has conducted research on the scientific framework of this project, as well as potential models through inter-net research and informational interviews. This research has focused on understanding the link between neurodevelopment and mental health for children, as well as models for addressing it.

- Christopher Gillberg, MD/PhD and professors of child and adolescent psychiatry, has developed the neurodevelopmental comorbidity framework for multi-disciplinary assessment and intervention.
- The MIND Institute in Davis focuses on non-mental health diagnoses and, like Gillberg, incorporates a multi-disciplinary approach to assessment and intervention.
- Bruce Perry, MD/PhD and expert in childhood trauma, has looked at the relationship between trauma and neurodevelopmental changes.
- Rick Gaskill, PhD/LCP and expert in childhood trauma, collaborates with Bruce Perry to educate about the neurodevelopmental impact of trauma, assessment protocols, and potential interventions.
- San Mateo Behavioral Health and Recovery Services began using the Neurosequential Model of Therapeutics (NMT) in their youth services in 2012. While there is limited evaluation data on the effect on emotional/behavioral outcomes, their experience supports its benefit. In 2016, San Mateo implemented an Innovation project to adapt these services for adults.

While the above work and Alameda's proposed project are based on the same brain research and intervention frameworks, the interventions are different. Gillberg and MIND's interdisciplinary approach requires a level of staffing not feasible in most settings. It is mainly used in specialty centers. NMT certification focuses on an approach, not specific interventions, and is open only to clinical providers. None of the models have substantial data showing the impact of the services on mental health outcomes for children.

This Innovation project aims to provide neurodevelopmental interventions for youth experiencing moderate and serious mental health issues in an accessible manner. Unlike the models above, Holistic Approach to Neuro-Development and Learning Efficiency (HANDLE®) provides training for clinical and non-clinical providers in assessment and specific interventions. In addition, this project would evaluate the impact on mental health symptoms.

3) The Proposed Project

- a) Provide a brief narrative overview description of the proposed project.*

This Innovation proposal integrates a neurodevelopmental approach into mental health services to achieve better outcomes. Holistic Approach to Neuro-Development and Learning Efficiency (HANDLE®) is a practice based on brain research on neuroplasticity and the effect of stress responses on learning, mood and behavior. It includes an initial assessment to determine inefficiencies in the communication between the body and the brain leading to functional difficulties. Based on that assessment a treatment plan is developed that specifies HANDLE interventions to address the neurodevelopmental weaknesses. HANDLE does not teach coping

mechanisms, it improves brain function, which ultimately reduces or eliminates the underlying neurodevelopmental problems contributing to emotional and behavioral symptoms.

Examples of interventions include:

- A child that skips the crawling stage of development may exhibit higher levels of clumsiness, an inability to focus, anxiety, frustration and ultimately hopelessness due to underdevelopment of the interconnections between the left and right hemispheres of the brain and interconnected neurodevelopmental systems. Activities, such as one that combines bouncing a ball in an intentionally rhythmic and repetitive manner, will recreate the neural connections that originally would have been developed during the child's crawling stage.
- A child diagnosed with PTSD due to physical abuse may be over- or under-sensitive to touch. This trauma expresses itself in learning difficulties and problematic behavior driven by the system's overreaction to physical contact. The child's brain has formed neural connections that interpret tactile sensation as a threat. A HANDLE treatment plan may include rolling a softball-sized ball along the child's arms in an organized rhythm to allow him to efficiently integrate sensory information from the tactile stimulation. By intentionally and repetitively creating appropriate stimuli in a safe environment, neural connections are formed, and the tactile sensation is reinterpreted by the brain as non-threatening. The trained adults around him (parents, teachers) will interpret his behavior and respond to it more appropriately. Rather than a punitive or 'fix him' approach, they will find ways to create an environment that is safe internally and externally in which he can heal, connect, develop positive self-esteem, and diminish symptomatic behavior.

The program will include the following steps:

- 1) Identify participating schools sites and staff to receive HANDLE training. (Initial engagement and commitments have already been developed.)
- 2) Provide an overview training about HANDLE to approximately 150 BHCS youth services staff, staff from participating schools, and parents of BHCS clients or students at the participating schools. School staff may include teachers, teacher's aides, behavioral specialist, psychologists, physical therapists, occupational therapists, and others. This training will be provided at the beginning of the project, and then periodically throughout the project as additional schools or personnel need training.
- 3) Provide training and certification for implementation partners:
 - a. Parent Aides (2.0 FTE, up to 6 part-time positions): Aides will include parents of BHCS clients and students at participating schools, among others. Aides will be screened appropriately and paid to provide the interventions for participating students. They will learn basic interventions during the overview training. Staff receiving HANDLE Practitioner training will teach them additional interventions as needed.

- b. Practitioners: Approximately 6 school staff and 6 BHCS staff will attend a 14-day training in conducting assessments and more specific interventions that takes place over two months. One school district has offered two schools sites and committed to the training requirements for participating staff (see letter of support). Six of the HANDLE Practitioners will later attend a 25-day training in more advanced assessments and interventions. This takes place over several months.
- 4) Implement assessment and intervention services.
- a. Identification: Students exhibiting emotional and behavioral problems will be identified by the school personnel. The parent(s) and teacher will be asked to complete a brief questionnaire and mark a checklist of concerns provided by HANDLE. Parent permission will be required to continue.
 - b. Assessment: Based on the results of the initial surveys, the children who meet criteria will be assessed by a trained HANDLE Practitioner.
 - c. Intervention: The HANDLE Practitioner will develop an intervention plan based on the neurological weaknesses identified. The Practitioner will meet with the student's caregiver and assigned Parent Aide to review the intervention plan. The Parent Aide will provide the intervention every school day for 4 months. In year 2 and 3 of the project, students who are assessed with more significant needs can be provided a more intensive 6-month intervention. For continuity of care for BHCS clients receiving these services, they will be screened by BHCS staff or the Practitioners will collaborate with BHCS staff.

As with other services provided through school settings, parent permission is required. With HANDLE, parent involvement is also welcome. Every effort will be made to present these services in a non-stigmatizing and sensitive way, especially given the potential involvement of parental abuse or neglect. HANDLE is an inherently nonjudgmental approach concerned with how to support the student's ability to navigate his/her inner and outer worlds efficiently. This is communicated to parents in writing and in informational meetings. Parental communication and a nonjudgmental approach is a significant part of the training process for HANDLE Practitioners.

- 5) Evaluate the effectiveness of the HANDLE interventions regarding emotional, behavioral and academic outcomes.
- b) *Identify which of the three approaches specified in CCR, Title 9, Sect. 3910(a) the project will implement.*

This proposal applies a promising practice that has been successful in non-mental health contexts. HANDLE's neurodevelopmental interventions, and neurodevelopmental approaches in general, are applied more often to cases of autism, learning disabilities, developmental delays, brain injury, and other situations not identified as primarily a mental health issue. They

have also been applied in cases where emotional/behavioral/mental health issues are present, but evaluation for mental health outcomes is extremely limited.

c) *Briefly explain how you have determined that your selected approach is appropriate.*

Neurosequential Model of Therapeutics (NMT) is based on the same brain research and frameworks as HANDLE. Some studies have found evidence of increased social-emotional development and improvements in problematic behavior in children receiving NMT (Barfield, Gaskill, Dobson, & Perry, 2012). In addition, San Mateo BHRS reports that among a sample of 10 youth receiving NMT assessments and NMT informed interventions, all showed improved self-regulation, and two-thirds showed improvements in sensory integration, relational, and cognitive domain measures. **This provides reason to believe that HANDLE, which is based on the same framework, would produce positive emotional and behavioral outcomes.**

HANDLE is a promising practice in childhood neurodevelopment with limited implementation and evaluation. HANDLE practitioners are scattered across several continents, with twelve certified Practitioners residing in California. While these HANDLE Practitioners' experience is that this approach significantly assists individuals experiencing a variety of developmental, behavioral and emotional issues, the evaluation of the practice is limited and not mental health specific. Studies to date suggest functional improvements in individuals who experienced traumatic brain injury and increased behavioral/emotional stability in children with ADHD diagnosis and those in out of home placement with childhood trauma.

HANDLE offers a feasible way to provide neurodevelopmental services for children experiencing emotional and behavioral issues, without requiring clinical level services.

4) Innovative Component

Neurodevelopmental research is still an emerging area. The research findings, but not the interventions, have recently become common curricula at university training programs for Masters in Social Work or Marriage and Family Therapy. Therapists currently working in the field are unlikely to have received any formal training in their master's degree programs in identifying and treating underlying neurodevelopmental issues that may be contributing to emotional and behavioral symptoms. While some mental health providers may have sought out training in this area, it is not a widely recognized approach. **Integrating neurodevelopmental assessments and interventions into mental health services is a significant change to existing practice that may lead to improved outcomes for youth experiencing a wide variety of mental health issues.**

5) Learning Goals / Project Aims

Alameda County aims to learn:

Can neurodevelopmental interventions provided in a non-clinical setting for youth with emotional and behavioral disorders reduce their symptoms and improve their functioning?

Learning Goals

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.
2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

Given that this project is implementing a model that has already been developed and implemented in non-mental health contexts, the core question is whether it improves mental health outcomes. In addition, a neurodevelopmental paradigm changes the understanding of emotional and behavioral challenges. This can affect many aspects of how the children are treated, such as whether or not they are referred for the services, how schools handle discipline, etc.

6) Evaluation or Learning Plan

Learning Goals

1. Determine if implementing a neurodevelopmental approach to mental health changes the way educators and mental health providers understand children with emotional and behavioral disorders.

Data to collect	Data collection method
Who participates <i>4 schools</i>	Project coordinator will track which schools participate
Who receives neurodevelopmental training <i>150 providers, school staff, parents 12 clinicians, school staff 6 clinicians, school staff (advanced)</i>	Project coordinator will track the number of people trained in each level of training, including their name and role (i.e., teacher, mental health provider, parent aide, etc.)
Attitudes, knowledge, skills, action regarding neurodevelopment framework, assessment, interventions <i>75% trained will show basic knowledge/skills 50% trained refer students to HANDLE or implement practices 70% trained express understanding of student behavior</i>	A survey will be conducted with participants at the end of each training. Referral patterns and implementation of practices will be tracked. Focus groups will be conducted at the conclusion of the project with participants.

2. Determine if neurodevelopmental interventions, using the HANDLE model, with youth with emotional and behavioral disorders reduces their emotional and behavioral symptoms and academic outcomes.

Data to collect	Data collection method
Who receives the services <i>200 receive intervention</i>	Project coordinator will keep records of students: <ul style="list-style-type: none"> - Referred for HANDLE assessment - Completing HANDLE assessment - Provided a HANDLE treatment plan - Provided HANDLE interventions, number/type of interventions In addition, if a youth referred for assessment did not receive services, the reason why will be recorded (i.e.; assessed as not appropriate for services, family declined service, etc.)
Improvement in areas student was weak in at time of assessment <i>35% of those receiving 4 month intervention</i> <i>50% of those receiving 6 month intervention</i>	Participating students receive an initial assessment to determine eligibility and interventions. A post-test at the conclusion of services will be used to determine changes in neurodevelopment.
Improvement in emotional or behavioral symptoms <i>50% of those receiving intervention</i>	Parent, school staff, teacher, and/or MH provider complete a measurement tool at the time of the assessment and at the conclusion of the services. A standardized, validated tool will be determined in consultation with the evaluators and include changes in mental health symptoms and emotional regulation. Examples: level of defiance, isolation, aggressiveness, fear/worry, flexibility, etc.
Improvement in school performance <i>25% of those receiving intervention</i>	Teachers will complete a tool at the time student is referred for assessment and again at completion of services regarding attendance, reading and math levels, discipline frequency, and other key indicators.

Data collection, evaluation and reporting for this project will be in alignment with the current Innovation Regulations. This includes collecting indicated demographic data, tracking changes made to the project in the course of implementation, and providing annual and final reports covering all required elements.

Longitudinal: Evaluators will review Individual Education Plans (IEP) for HANDLE participants that have an IEP. They will compare IEPs prior to services with those one year after the services to see if there are trends that can be discerned. These might include rate of growth in learning, presence of behavioral intervention plans, and other indicators.

Evaluation of this project will be contracted out. The evaluators will assist in developing appropriate tools, finalizing the evaluation plan, gathering and analyzing the data. They will provide a data entry method and review data on a regular basis to ensure appropriate quantity and quality, and provide technical assistance as needed. They will document factors that might affect the outcomes, such as normal developmental changes and changes in the home. While those factors cannot be controlled for, the evaluation design will attempt to increase the validity of the results.

7) Contracting

The implementation of this project will be led by BHCS staff.

- MOUs will be developed between BHCS and participating schools before school staff participate in certification process to clarify certification, implementation, and data collection expectations. These MOUs will be monitored on an ongoing basis by BHCS project lead to ensure compliance or need for amending the agreement.
- Written agreements will be developed with BHCS staff prior to certification process regarding certification, implementation and data collection. These expectations will be part of their BHCS position on monitored by their supervisor and the project lead
- Written agreements will be developed with Parent Aides prior to being hired regarding their scope of work. The project lead will meet regularly with Parent Aides to provide supervision.

II. Additional Information for Regulatory Requirements

1) Certifications

2) Community Program Planning

The community planning process for the MHSA Three Year Plan was conducted from June – October 2017. During that process Alameda County BHCS staff provided updates and information on current MHSA programs and community members provided input on mental health needs and services. There were three modes for providing input:

- Five large community forums (one in each Supervisorial District)
- Eighteen focus groups were conducted throughout Alameda County: Chinese speaking family members, African American family members, providers for refugees, providers for LGBTQ community, transitional age youth (2), Afghan immigrants, older adults, API and refugee providers and advocates, providers for individuals with developmental disabilities and mental illness, and Pool of Consumer Champions
- Community Input Surveys in all threshold languages: submitted by 550 unique individuals. Respondents were very diverse in age, race, and ethnicity. Fifty percent of respondents were from Oakland, while they make up only 30% of Alameda's population.

Survey respondents included: Mental health consumers (25%), family members (17%), community members (15%), education agency (2%), community mental health providers (14%), homeless/housing services (6%), county Behavioral Health staff (1%), faith-based organization (2%), substance abuse services provider (<1%), hospital/provider care (4%), law enforcement (1%), NAMI (1%), Veteran/Veteran services (1%), other community (Non-MH) service provider (5%), other/decline to state (9%).

Details of the process are provided in the MHSa Three Year Plan www.ACMHSA.org (click on Documents/MHSA Plans).

The BHCS systems of care and BHCS Housing Department were asked to submit proposals that addressed the needs identified in the community planning process. The proposed projects were vetted by MHSa staff based on whether they addressed community priorities, as well as other factors. For example, "Community Violence and Trauma" was identified as the second top priority for youth. (The first priority for youth was suicide prevention, which is being addressed by other BHCS projects.) For Innovation, there were multiple suggestions to address behavioral issues and trauma related issues in school settings.

This proposal was posted for public comment from April 13-May 13, 2018 and on May 14, 2018 a public hearing was held. Substantive comments received are included here.

MHSA Stakeholder Committee member: Collaborative services addressing the whole person has been a trend in the healthcare world, the theory behind which would ensure providers are adequately trained to see the whole picture. Therefore the idea of addressing neuroplasticity for children is an interesting one. Rebuilding brain connections to improve function would presumably be useful for all children who live in communities impacted by trauma and violence. In review of the proposal, it appears the population is defined as children experiencing behavioral and emotional issues but who do not have a learning disability or developmental or intellectual disability. Controlling for this is likely challenging, as assessing diagnostic criteria specifically enough to effectively rule out other overlapping conditions may be hard.

It is unclear how casual relationships will be determined between intervention and outcome given the children may be receiving mental health services in addition to the HANDLE services at the same time. The measures span a broad range of outcomes (emotional, behavioral, academics, etc.) The project has potential to focus very specifically, or address a wide range of things. E.g. either train specific providers to work with a specific identified population or train all individuals involved (parents, teachers, etc.) on the basics to provide service to all children in high need areas.

Response: Where the commenter wrote "it appears the population is defined as children experiencing behavioral and emotional issues but who do not have a learning disability or developmental or intellectual disability...." this is incorrect. The language in the proposal states students exhibiting emotional and behavioral problems **not explained by** intellectual or development disability will be identified by the school personnel. The reason for this is those

with a primary diagnosis of intellectual/developmental disability are eligible for more appropriate services through the Regional Center. We have amended the language in the proposal to clarify that.

This is a mental health grant thus the criteria for participation is based on mental health criteria. Although learning disabilities alone are not a criteria to qualify for the program, we expect children participating in the program may also have learning disabilities.

We agree with the comment that this type of intervention can help many people with trauma and we did need to focus criteria to evaluate the effectiveness of the interventions. This collaborative grant trains school personnel, enabling them to provide services in the future for students not served within this project.

While this project will not study the impact of HANDLE in isolation from other services, the project will have a professional evaluator to design methods to help determine the impact as best as possible. The evaluator will also work with multiple stakeholder groups (the HANDLE project staff, BHCS staff, families and the MHSA stakeholder committee staff) to fully develop the outcome measures, tools, and processes.

Family member of a client with serious mental illness: Is it clear that the Neuroplasticity Innovation Project under INN proposals is not expected to treat or reduce the incidence of schizophrenia, schizo-affective disorder, or bipolar disorder?

Response: Yes. This project offers a feasible way to provide neurodevelopmental services for children experiencing emotional and behavioral issues, without requiring clinical level services. This is a practice that's not directed at specific diagnoses. It addresses the neurodevelopment of each individual to increase his/her ability to process emotions, behaviors, symptoms and internal world more efficiently so that each can negotiate one's external world more effectively.

3) Primary Purpose

Increase the quality of mental health services, including measurable outcomes

4) MHSA Innovative Project Category

Introduces a new application to the mental health system of a promising community-driven practice or an approach that has been successful in a non-mental health context or setting.

5) Population (if applicable)

- a) *If your project includes direct services to mental health consumers, family members, or individuals at risk of serious mental illness/serious emotional disturbance, please*

estimate number of individuals expected to be served annually. How are you estimating this number?

This project expects to serve 70 students each year, leading to approximately 200 students receiving intervention services over three years. This is based on the rates of behavioral health issues among students and the likely participating schools. San Leandro Unified has committed to having one elementary school participate and potentially adding another if successful. Hayward Unified and Castro Valley Unified are also interested in participating. Assuming 4 schools participate with a total population of 2,000 students (5-12 years old), approximately 19% (380) have behavioral/emotional issues including those in Special Ed due to emotional disturbance and those referred to PEI services. Of those 380 students, at least 55% (209) have experienced trauma, a leading cause of neurodevelopmental issues. So, we expect that at least 200 students at participating schools would be eligible for services in any given year. Due to program capacity, a portion of those children would be identified each year.

b) Describe the population to be served, including relevant demographic information.

This project is intended to serve students from 5-12 years old. Those youth and families reflect the diversity of Alameda County and therefore any client materials produced would be translated into all threshold languages.

c) Does the project plan to serve a focal population, e.g., providing specialized services for a target group, or having eligibility criteria that must be met? If so, please explain.

Students exhibiting emotional and behavioral problems not explained by intellectual or development disability will be identified by the school personnel. Students with a primary diagnosis of intellectual or developmental disability are eligible for other services more appropriate for their needs. The parent(s) and teacher will be asked to complete a brief questionnaire and mark a checklist of concerns provided by HANDLE. Parent(s) would also complete a consent for participation. Based on the results of the initial surveys, the children who meet criteria will be assessed by a trained HANDLE Practitioner to determine eligibility.

6) MHS General Standards

- a) **Community Collaboration:** This project relies on schools and parents to participate in developing, implementing and evaluating this project. The project coordinator will work closely with the schools and Parent Aides to ensure that they are kept informed about program development and that their input guides the implementation.
- b) **Cultural Competency:** The implementation plan will be presented to the BHCS Cultural Competency Advisory Board for input. The partner schools will be selected in part based on the student population in terms of race, ethnicity, and free and reduced lunch statistics to ensure underserved populations have access to these services. In addition, ensuring

culturally and linguistically appropriate services will be a factor in selecting those to be trained in HANDLE.

- c) Client-Driven: This project is focused on youth ages 5-12, so there will be limited client input into the project development.
- d) Family-Driven: Family members will be among those recruited and paid to be trained in HANDLE and provide intervention services, as well as provide input on implementation and evaluation.
- e) Wellness, Recovery, and Resilience-Focused: This project aims to help clients re-wire neural pathways to reverse underlying neurodevelopmental problems leading to emotional and behavioral symptoms – contributing to recovery.
- f) Integrated Service Experience for Clients and Families: This project integrates traditional mental health services with a neurodevelopmental approach – which usually is only available to families that are in a position to seek out and pay for such services themselves. In addition, it provides the services within school settings, reducing the barriers to accessing the services.

7) *Continuity of Care for Individuals with Serious Mental Illness*

This project will serve some youth experiencing serious emotional disturbance. If for some reason the project is not sustained, trained BHCS providers can still provide assessments and train caregivers to provide the interventions, but there would not be Parent Aides to provide the services.

8) *INN Project Evaluation Cultural Competence and Meaningful Stakeholder Involvement.*

a) *Explain how you plan to ensure that the Project evaluation is **culturally competent**.*

This project would aim to be culturally competent by:

- Selecting culturally and linguistically diverse providers, parents, and school staff to provide services as well as provide input on the program implementation and evaluation
- Presenting the implementation plan and evaluation plan and tools to the BHCS Cultural Competency Advisory Board for input

b) *Explain how you plan to ensure **meaningful stakeholder participation** in the evaluation.*

The schools and providers will be engaged throughout the process to provide input on the evaluation plan and tools. They will also participate in selecting Parent Aides and be part of an ongoing committee to support integration of the program in a school setting.

9) Deciding Whether and How to Continue the Project Without INN Funds

BHCS will support the continuation of this project or components of this project based on a number of internal and external factors and processes including: 1) the evaluation results from the project, 2) support and buy-in from the Children's System of Care and 3) recommendations from the MHSA Stakeholder Committee & the CCAB, and 4) available funding. MHSA Prevention and Early Intervention (PEI) and Community Services and Supports (CSS) funds will be considered for ongoing funding of this project.

10) Communication and Dissemination Plan

- a) *How do you plan to disseminate information to stakeholders within your county and (if applicable) to other counties?*

The participating schools will be responsible for disseminating results within their schools and to other schools. The project coordinator will be responsible for reaching other stakeholders and counties. Updates on the project will be provided to stakeholders on an ongoing basis via email and presentations at existing meetings. The final evaluation report for this project will be shared widely by posting it on the BHCS website and announcing via email to stakeholders, including to mental health directors, and MHSA coordinators throughout California. In addition, presentations will be made to the MHSA Stakeholder Group, the Cultural Competency Advisory Board, consumer groups, NAMI, the Board of Supervisors, and school communities.

- b) *How will program participants or other stakeholders be involved in communication efforts?*

The participating schools will be responsible for sharing the results within their schools and with other schools, providing presentations to the organizations listed above, and forwarding email announcements to their stakeholders. The project coordinator will be responsible for website postings and email announcements.

- c) *KEYWORDS for search: Please list up to 5 keywords or phrases for this project that someone interested in your project might use to find it in a search.*

Mental health and neurodevelopmental disorders; Neurodevelopmental interventions for mental health disorders; HANDLE

11) Timeline

- a) *Specify the total timeframe (duration) of the INN Project:* **4 Years**
b) *Specify the expected start date and end date of your INN Project:*

Start: October 2018 End: September 2022

c) *Include a timeline that specifies key activities and milestones*

Timeline	Activities/Milestones
Oct-Dec 2018	Engage potential participating schools Develop training timeline Hire evaluator
Jan-Mar 2019	Introductory training for schools, BHCS staff, parents, potential Parent Aides Recruit potential Parent Aides
Apr-Jun 2019	Confirm participating schools Develop MOUs with schools
Jul-Aug 2019	On-board Parent Aides Finalize evaluation plan in collaboration with project staff and partners
Sept-Oct 2019	HANDLE Practitioner training conducted
Nov 2019	Begin process of referring students for assessments for Year 1 Begin screening students for Year 1
Dec 2019	Begin intervention services for students by Parent Aides for Year 1 Identify implementation issues with schools and make necessary changes
Jan-Mar 2020	Referral and screening concludes Intervention services continue
Apr 2020	Intervention services conclude
May 2020	Gather post tests for Year 1
Jun-Aug 2020	Identify implementation issues with schools and make necessary changes for Year 2 Determine additional trainings needs for school, Parent Aides, etc. Confirm Parent Aides for Year 2 Data analysis conducted by evaluators
Sept 2020	Implement additional trainings as needed Begin process of referring students for assessments for Year 2 Begin screening students Begin intervention services
Oct-Dec 2020	Continue screenings Continue intervention services Advanced training for 6 HANDLE Practitioners conducted
Jan 2021	Conclude screenings Continue intervention services Advanced training for HANDLE Practitioners concludes Identify children appropriate for advanced level of services
Feb-May 2021	Intervention services continue through April Begin advanced service assessments and services Gather post tests
Jun-Aug	Identify implementation issues with schools and make necessary changes for Year 3

2021	Confirm Parent Aides for Year 3 Data analysis conducted by evaluators
Sept 2021	Begin process of referring students for assessments for Year 3 Begin screening students Begin intervention services, including advanced services
Oct-Dec 2021	Continue screenings Continue intervention services
Jan 2022	Conclude screenings Continue intervention services
Feb-Apr 2022	Intervention services continue through April Gather posttests, including for advanced services
May-Jun 2022	Preliminary report on outcomes Share and discuss preliminary outcome report with stakeholders Determine whether or not to continue the program and funding
Jul-Sept 2022	Final INN program report Disseminate final report Finalize funding and plans to continue implementation if required

Interventions are provided every school day for 4 months (or 6 months for advanced interventions), therefore intake into services concludes 4 (or 6) months before the end of each school year.

This timeline includes evaluation throughout the project, including finalizing the evaluation plan and tools with input from project staff and partners; gathering data throughout the project; and analyzing the data with the project staff and partners. The last five months of the timeline allows time for data collection, analysis, dissemination, and the process to determine whether and how to continue the project. This work is feasible in this timeline because there will be efforts throughout the project to keep stakeholders informed and to consider sustainability plans.

12) INN Project Budget and Source of Expenditures

This INN Plan will use FY2010-11 funds that were deemed reverted back to the county of origin under **AB 114** to cover FY18-19 and FY19-20 expenses.

Participating schools will be contributing in-kind staff time and resources to this project. At this time that contribution is not calculated in the budget.

Project Budget by Year - Narrative

Salaries

FY18-19: 9 months (Oct. – June) Behavioral Health Clinical Supervisor at \$172,657 annual salary and benefits = **\$129,493**

FY19-20: Behavioral Health Clinical Supervisor (1 FTE) at \$172,657 FT annual salary & benefits = **\$172,657**

Clinician II (0.6 FTE) at \$141,032 FT annual salary & benefits = **\$84,619**

FY20-21: Behavioral Health Clinical Supervisor (1 FTE) at \$172,657 FT annual salary & benefits = **\$172,657**

Clinician II (0.75 FTE) at \$141,032 FT annual salary & benefits = **\$105,774**

FY21-22: Behavioral Health Clinical Supervisor (1 FTE) at \$172,657 FT annual salary & benefits = **\$172,657**

Clinician II (0.75 FTE) at \$141,032 FT annual salary & benefits = **\$105,774**

FY22-23: 3 months (Jul-Sep) incurs no additional costs for disseminating report and finalizing continuation of the project as appropriate

Total = \$943,631

Operating Costs

FY18-19 – FY21-22: Materials: Office supplies, HANDLE manuals, intervention tools (balls, etc). \$8000 total

Snacks and incentives: A safe environment is required for providing interventions, therefore food and other comforting items will be provided to participating students. \$5000 total

Mileage: BHCS staff travel to schools. \$6000 total

FY19-20 and FY20-21: Substitute teacher time to cover for teacher's attending training. \$170/day x 10 days x 6 teachers x 3 school districts x 2 yrs = \$61,200 total

Total = \$80,200

Consultant Costs/Contractors

FY18-19 - FY21-22 Evaluator: \$30,000 per year x 4 years = \$120,000 total

FY19-20 - FY21-22 Parent Aides: Mental Health Specialist II (2 FTE) at \$84,620 wages & benefits. The 2 FTE will be filled by up to 6 part time aides to ensure adequate staffing at times that students are available for services. 3 years = \$507,720

FY19-20 HANDLE Trainer: Introductory and HANDLE Practitioner trainings. \$45,000

FY20-21 HANDLE Trainer: Introductory and Advanced trainings. \$90,000

Total = \$762,720

Indirect

15% for county administration of the project. Applies to Personnel, Operating and Contract expenditures to provide Human Resources, Accounting, Budgeting, Information Technology, Business Services Office, and Legal management of staff and contract positions; rent, utilities, insurance; and other expenses necessary to administer the project.

Total = \$267,983

Expend by Fund Source – Narrative

Administration

- 50% of BH Clinical Supervisor time for program development & implementation = \$323,732
- Indirect expenses (as stated above) = \$267,983

Total = \$591,715

Evaluation

- 50% of BH Clinical Supervisor time for program development & implementation = \$323,732
- Evaluator: \$30,000 per year x 4 years = \$120,000

Total = \$443,732

BHCS In-Kind Funding

Behavioral Health Clinician II (0.2FTE x 6 positions) at \$134,316 FT = \$161,179/yr x 3 yrs
These clinicians will participate in trainings, assessments, and intervention plans

Total = \$483,537

B. New Innovative Project Budget By FISCAL YEAR (FY)*						
EXPENDITURES						
PERSONNEL COSTS (salaries, wages, benefits)	(salaries,	FY2018-19	FY2019-20	FY2020-21	FY2021-22	Total
		9 months				
1	Salaries	\$ 129,493	\$ 257,276	\$ 278,431	\$ 278,431	\$ 943,631
2	Direct Costs					\$ -
3	Indirect Costs	\$ 19,424	\$ 38,591	\$ 41,765	\$ 41,765	\$ 141,545
4	Total Personnel Costs	\$ 148,917	\$ 295,867	\$ 320,196	\$ 320,196	\$ 1,085,176
OPERATING COSTS						
		FY2018-19	FY2019-20	FY2020-21	FY2021-22	Total
		9 months				
5	Direct Costs		\$ 38,350	\$ 36,850	\$ 5,000	\$ 80,200
6	Indirect Costs	\$ -	\$ 5,753	\$ 5,528	\$ 750	\$ 12,030
7	Total Operating Costs	\$ -	\$ 44,103	\$ 42,378	\$ 5,750	\$ 92,230
NON RECURRING COSTS (equipment, technology)						
		FY2018-19	FY2019-20	FY2020-21	FY2021-22	Total
		9 months				
8						\$ -
9						\$ -
10	Total Non-recurring costs	\$ -	\$ -	\$ -	\$ -	\$ -
CONSULTANT COSTS/CONTRACTS (clinical, training, facilitator, evaluation)						
		FY2018-19	FY2019-20	FY2020-21	FY2021-22	Total
		9 months				
11	Direct Costs	\$ 30,000	\$ 244,240	\$ 289,240	\$ 199,240	\$ 762,720
12	Indirect Costs	\$ 4,500	\$ 36,636	\$ 43,386	\$ 29,886	\$ 114,408
13	Total Consultant Costs	\$ 34,500	\$ 280,876	\$ 332,626	\$ 229,126	\$ 877,128
OTHER EXPENDITURES (please explain in budget narrative)						
		FY2018-19	FY2019-20	FY2020-21	FY2021-22	Total
		9 months				
14						\$ -
15						\$ -
16	Total Other expenditures	\$ -	\$ -	\$ -	\$ -	\$ -
BUDGET TOTALS						
	Personnel (line 1)	\$ 129,493	\$ 257,276	\$ 278,431	\$ 278,431	\$ 943,631
	Direct Costs (lines 2, 5 and 11 from above)	(add \$ 30,000	\$ 282,590	\$ 326,090	\$ 204,240	\$ 842,920
	Indirect Costs (lines 3, 6 and 12 from above)	(add \$ 23,924	\$ 80,980	\$ 90,678	\$ 72,401	\$ 267,983
	Non-recurring costs (line 10)	\$ -	\$ -	\$ -	\$ -	\$ -
	Other Expenditures (line 16)	\$ -	\$ -	\$ -	\$ -	\$ -
	TOTAL INNOVATION BUDGET	\$ 183,417	\$ 620,846	\$ 695,199	\$ 555,072	\$ 2,054,534

C. Expenditures By Funding Source and FISCAL YEAR (FY)

Administration:

A.	Estimated total mental health expenditures for ADMINISTRATION for the entire duration of this INN Project by FY & the following funding sources:	FY2018-19 9 months	FY2019-20	FY2020-21	FY2021-22	Total
1	Innovative MHSA Funds	\$ 88,671	\$ 167,309	\$ 177,007	\$ 158,730	\$ 591,717
2	Federal Financial Participation					\$ -
3	1991 Realignment					\$ -
4	Behavioral Health Subaccount					\$ -
5	Other funding*					\$ -
6	Total Proposed Administration	\$ 88,671	\$ 167,309	\$ 177,007	\$ 158,730	\$ 591,717

Evaluation:

B.	Estimated total mental health expenditures for EVALUATION for the entire duration of this INN Project by FY & the following funding sources:	FY2018-19 9 months	FY2019-20	FY2020-21	FY2021-22	Total
1	Innovative MHSA Funds	\$ 94,747	\$ 116,329	\$ 116,329	\$ 116,329	\$ 443,734
2	Federal Financial Participation					\$ -
3	1991 Realignment					\$ -
4	Behavioral Health Subaccount					\$ -
5	Other funding*					\$ -
6	Total Proposed Evaluation	\$ 94,747	\$ 116,329	\$ 116,329	\$ 116,329	\$ 443,734

TOTAL:

C.	Estimated TOTAL mental health expenditures (this sum to total funding requested) for the entire duration of this INN Project by FY & the following funding sources:	FY2018-19 9 months	FY2019-20	FY2020-21	FY2021-22	Total
1	Innovative MHSA Funds	\$ 183,417	\$ 620,846	\$ 695,199	\$ 555,072	\$ 2,054,534
2	Federal Financial Participation					\$ -
3	1991 Realignment					\$ -
4	Behavioral Health Subaccount					\$ -
5	Other funding*		\$ 161,179	\$ 161,179	\$ 161,179	\$ 483,537
6	Total Proposed Expenditures	\$ 183,417	\$ 782,025	\$ 856,378	\$ 716,251	\$ 2,538,071

*If "Other funding" is included, please explain. BHCS in-kind for clinician time to attend training, conduct assessments, etc.

Example of a parent information sheet about HANDLE used by a practitioner

HANDLE

Often when a person experiences difficulties in behavior and functioning it is actually because they are doing the best they can within themselves to process the information they get through their senses from the world. When, for whatever reasons – no blame necessary – the information or the ability to process it is disorganized or irregular, the body/brain comes up with ‘workarounds’ that can look dysfunctional and can seem purposeful. When we are in high stress responses – whether these are motivated by internal or external stimuli, it is harder to connect, learn, and think clearly. We all protect ourselves in unconscious ways and when our bodies/brains do not communicate well together, we can often experience heightened sensitivity/reactiveness to others, anxiety, depression, difficulties in bowel/bladder control, relationship difficulties, speech and learning difficulties, etc. Calming strategies are temporary when the culprit for the stress is disorganized neurodevelopmental functioning. Interventions –social, emotional, and academic – are more effective when based on efficiently working foundational neurodevelopmental systems.

HANDLE is an acronym for Holistic Approach to NeuroDevelopment and Learning Efficiency. It is a paradigm that recognizes the body’s wisdom in communicating where inefficiencies in the body-brain connection reside. Once we recognize those inefficiencies, HANDLE provides a unique approach, through a home based movement based activity program {15 min a day usually} that helps to calm, organize and support the body/brain so behavior and functioning can improve. When people can do better, they generally do!

HANDLE activities are simple and individualized to the needs of each client. They are doable and many families find the time spent together doing them improves their relationships. They provide functional and developmental organization from the inside out, while reducing the stress response. The only requirements are a willingness to do the activities consistently, a willingness for things to be different, and a willingness to go slowly and gently so when the body/nervous system is stressed, activities are stopped. How to do all of this is taught and the willingness must be there.

May 10, 2018

To whom it may concern:

I very much support the incorporation of HANDLE into the school system. Before becoming a HANDLE Practitioner and Instructor, I got involved with this modality as a HANDLE Mom. My son was fourteen and "highly functioning on the autism spectrum" when we took on an individualized program for him. He was struggling with learning and attention; he was very uncoordinated; he was isolated socially and angry about it. His self-esteem was very low, as he believed that all his failures had to do with stupidity. Had you asked me at the time if I could imagine him taking college classes, driving, managing his social activities, dating, holding a job, traveling independently – I would have said no. Not maybe.

And yet he's done all of these. A young adult now, he is completing an AA degree this month and is three classes away from completing a second one. He was a juror on one occasion and worked on a farm overseas for several months, living with roommates. He made it to Ethiopia and back in one piece and made a few good decisions when facing bullies and others who tried to take advantage of him. He shops for himself and cooks for himself and balances his check book and manages his social life and work schedule. He drives. He is optimistic. This would not have happened without the gentle, respectful, effective support that he got from his HANDLE program and his HANDLE provider, Sindy Wilkinson.

I have since become a provider of HANDLE services, so I have seen many who benefited from this modality, including, but not limited to, people on the autism spectrum or those suffering from anxiety, depression and bipolar disorder.

I would love to see this support available to all the students who need it, and I welcome your questions.

Thank you for your consideration,

Dror Schneider
3254 Magowan Drive
Santa Rosa, CA 95405

May 9, 2018

I am happy to see that there is a possibility to offer HANDLE training to the teachers of young children in your schools

I am 76 years old and was fortunate to receive a HANDLE program from a friend 16 years ago. Although I was reasonably successful, I had struggled for most of my life with difficulties that I blamed on emotional or psychological issues. The things I learned about myself through this program convinced me that my nervous system had not fully developed when I was a child and that this was the cause of many of my difficulties. The HANDLE process taught me some simple movements and activities to educate the parts of my brain that had missed development all those years ago. It worked. Even today, with the challenges of an aging brain, I can manage better than when I was younger.

I do sometimes wonder how different my life might have been if I had been "HANDLED" when I was a child. I hope that you will give that opportunity to some of the children in your schools. It will help them to be calm and to learn and that will change the course of their lives.

Than you for receiving my opinions and experiences.

Marie McGarrity
m.mcgarrity@comcast.net

I lived in Alameda County for more than the 12 years my children were in public school; I'm aware of the range of student capabilities and issues. As a retired HANDLE Practitioner, I'm also aware of how HANDLE contributes to all learning, not limited to students with named "problems" that authoritative testing names as a "special" need. Additionally, my daughter has been an elementary school teacher for more than 20 years. Her experiences bolster my conviction that if teachers everywhere had HANDLE training to apply in their classrooms, and someone monitored performance change, district administrators would applaud themselves for having brought this approach into their schools.

When you validate that hypersensitivities, and distress over unusual behaviors, and a need to move, and distractibility... etc... impede use of what's taught, you will welcome HANDLE as a means to calm all such interference. I urge you to validate all that. Instead of thinking of single-child needs, acknowledge the reality that all of us can make our lives easier. The classroom setting would uniquely benefit because as teachers apply HANDLE principles and practices, the impact isn't perceived as "therapy" but as a kind of infrastructure for making best use of a curriculum.

Absent neurophysiological and emotional readiness, learning can be seriously blocked. HANDLE programs create that readiness. Please help your teachers help your students to do their best.

Marlene Bluestone Suliteanu

For information about the Holistic Approach to NeuroDevelopment and Learning Efficiency check out www.handle.org

From: Mike Wilson [<mailto:wilson.mtw17@gmail.com>]
Sent: Wednesday, May 02, 2018 8:56 PM
To: Mental Health Services Act <MHSA@acgov.org>
Subject: HANDLE evaluation

Hello,

It has come to my attention that Alameda County is evaluating HANDLE and I wanted to share a few things with you.

HANDLE treatment changed my family's future. It saved my son's life and opened up a world we never imagined.

Some would say that my son was on the spectrum and while it would be very easy to assume that he was on the very low side of the spectrum, it is true that he had many difficulties as a young boy. Through very careful attention from our HANDLE practitioner and diligent follow through by my wife and I, we were able to help our son become a different person.

Here is an essay he wrote describing his experience before and after HANDLE. I truly hope you will find a way to allow this process to be a part of your system.

Sincerely,

Mike Wilson

My Story... by Alex Wilson

If you asked me to think back to my earliest memories and describe myself I would have to say that I always felt that something was a little off. I never felt connected to the larger group of kids around me. I was alone and I couldn't figure out why. It's impossible in our culture to be different and left alone at the same time. The attention you get when you're different will eventually break you down.

School was torture. I wonder how I learned anything because I was so miserable. Every day I would come home, head to my room and cry. I was miserable. Never a day went by that I didn't spend time crying and feeling utterly hopeless.

Concentrating in class was nearly impossible. I was constantly in trouble with the teacher because I just couldn't pay attention no matter how simple the concepts were. Distractions came easy but it wasn't because I didn't care. I could read and retain information easily enough on my own, but in a larger learning environment there were just too many things going on in the classroom.

My son has been doing HANDLE therapy for almost a year now and I have seen the improvement in both school and home. I was able to learn more about how his body works in one HANDLE assessment than I have in all his psychological assessments combined. He likes doing the activities and he has seen the change in himself. He had gone into his appointment very hyper and unfocused. He couldn't sit still. As soon as we did the HANDLE activities he instantly had a calm body and mind. He was able to focus for 30 minutes. It was like seeing a completely different child. It happened like that at another appointment too. He came in really upset and agitated and instantly calmed and was happy after doing the activities. I am usually the skeptical parent but I truly believe in HANDLE Therapy. I have seen a drastic change within minutes of doing the activities. I don't know any other therapy that can do that. In addition, his teachers have said that he has more focus and has been able to remember more. He used to also have his aide write almost all his assignments. He is now writing everything himself. I am so glad he is doing HANDLE Therapy and I am so thankful for his therapist, Sindy. My son has been known to not connect with his therapist but he has with her. She is really great with him. I think that is really important.

Nicolette

Mom to 12 year old with Bipolar, ADHD, Anxiety, Auditory Processing Disorder, Speech and Language Disorder

Hello -

I am writing to urge support for the [Alameda County Behavioral Health Care Services 2019-2023 Innovation Plan](#), specifically for program number four, Introducing Neuroplasticity to Mental Health Services for Children.

As a parent of a child with neurodevelopmental issues that manifested as severe behavioral problems in elementary school, it is clear that schools are not equipped to understand or address the growing number of children who face the academic and social challenges caused by underdeveloped neural pathways. HANDLE, the intervention being proposed, has succeeded where every other approach could not, and over the course of a year helped my son to overcome the excruciating discomfort that had caused him to act out in destructive ways and to alleviate the massive shame that accompanied his behavior for years.

Our HANDLE practitioner, Sindy Wilkinson, is part of the BHCS team who would bring the approach to Alameda County schools. With her help, my husband and I have learned to do a HANDLE program with our son and the results have not only been personally astonishing but have greatly impacted his academic outcomes: able to manage his emotions and better navigate his physical surroundings, my son has gone from multiple incidents that caused him to miss several hours of classroom instruction to none. At the end of fifth grade, he completed roughly 50 percent of his work, and as he ends his sixth-grade year, that is now 100 percent. His early school years would have been so much easier not only for him but for his teachers, the school staff and administration and his classmates, if the underlying neurodevelopmental causes of his behavior and the fairly simple exercises to support his development were more widely known and understood.

Not every case of emotional disturbance or disruptive behavior may be due to neurodevelopmental issues, but children acting out in ways that are disrupting their school and home environments would be better served by considering this cause along with the more mainstream diagnoses whose treatment is harder to access and may only treat symptoms for a limited time. Imagine if this intervention could be applied to just a fraction of the children who currently qualify for special education and other health services - the long-term effects would change the trajectory of their academic and social success and reduce the need for ongoing services, lightening the burden on these already-limited resources.

I cannot urge support of this innovation plan strongly enough and hope to see HANDLE in many schools someday.

Thank you,

Sybil Wartenberg
Lafayette, CA



San Leandro Unified School District

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Deputy Superintendent
Educational Services

John Thompson, Ed.D.
Assistant Superintendent
Human Resources

Kevin Collins, Ed.D.
Assistant Superintendent
Business Services

May 23, 2018

To: Mental Health Services Oversight and Accountability Commission

San Leandro Unified School District (District) is excited to implement Alameda County Behavioral Health Care Services' "Introducing Neuroplasticity to Mental Health Services for Children" project. The District serves a socio-economically and ethnically diverse population of approximately 9000 students. The impact of trauma, behavioral, and emotional issues is a daily challenge for our students, families and staff. This project is an innovative approach to addressing the students' needs in an affordable and convenient way. Most often neuro-developmental interventions can only be accessed through out-of-pocket specialty programs, which many of our families cannot access.

The District has committed to implementing this program in one elementary school to begin with, including ensuring school staff participates in the necessary training and activities. The District believes this investment will result in better outcomes for students and more effective use of staff time. Once the project is up and running and the impact of the program is reviewed, we are interested in expanding the model to other schools in the district.

We are committed to this program's success, including reaching out to other school districts and helping to spread the word about our experience and learning.

Sincerely,

Dr. Michael McLaughlin
Superintendent
San Leandro Unified School District

