LATINO(X) MENTAL HEALTH ADVOCACY CONCILIO

Senate Finance Committee
Behavioral Health Responses

Strengthening Workforce:

1. Policies that would encourage greater behavioral health care provider participation in federal programs:
    a. Increase payment reimbursement from all plans for mental health care providers. To encourage bilingual/ bicultural workforce, plans should pay additional for therapists who speak more than one language.
    b. Pay parity is important since many plans do not provide adequate reimbursement. Because of this, many therapists leave to start their own practice which charge a substantial amount of money per hour or session and do not tend to accept any type of insurance.
    c. Provide flexibility on treatment modalities such as the option to reimburse for both telehealth and in-person services.
    d. Regulate and provide oversight over mental health start-ups, especially those that provide tele-mental health services.
    e. Differential pay/reimbursement for bilingual behavioral health care providers so that financial compensation is reflective of their skillset

2. What barriers prevent patients from accessing needed behavioral health care services:
    a. Lack of bilingual/ bicultural providers who understand the communities they serve.
    b. Customer service that can clearly communicate with patients. Good frontline staff that has great customer service skills is imperative.
    c. High co-pays or deductibles from commercial plans for mental health services.
    d. Out-of-network providers have even higher co-pays that are passed on to customers.
    e. Not enough care navigators or case managers to help patients navigate the complicated health system, insurance coverage, and in-network vs out of network provider rules.
    f. Not streamlining systems for severe mental illness (SMI), mild to moderate cases, and substance use disorders (SUD). For example, in California, Medi-Cal does not allow organizations to get reimbursed for treating co-occurring disorders. If a patient has SUD and mental health issues, an organization is not reimbursed to treat both. Patients are treated for one or the other. This makes it difficult for patients to access proper care.
    g. Lack of psych beds at hospitals, especially for adolescent minors.

3. Policies to increase diversity in behavioral workforce:
    a. Improve payment reimbursement from all plans.
    b. Establish a mechanism to regulate and hold insurance plans accountable for not following the law in pay parity for mental health providers. Create high penalties that will show plans they must implement the law.
    c. Student loan forgiveness programs for students from underserved communities wanting to pursue careers in mental health. Create more grants through the Department of Education for students who are bilingual/ bicultural and want to pursue careers in mental health.

   d. Improve educational opportunities for people of color by working with universities and colleges on efforts to recruit more historically excluded communities.
   e. Add more counselors in high schools and universities that can better assist students of color with support services and understanding of the different career options available in the mental health field.

4. Federal policies that would best incentivize behavioral health care providers to train and practice in rural and other underserved areas:
   a. Student loan forgiveness that assures providers their loans will be forgiven once they complete time. Also, the process of loan forgiveness should be transparent and easy.
   b. Reimburse providers at a higher wage if they work in rural or underserved areas.
   c. Improve telehealth services and broadband access. Helping rural areas to improve their internet infrastructure will help patients receive needed services through telehealth and allow providers to better communicate with their patients and other health care professionals. This will help make providers' job easier and less frustrating.
   d. Provide funding for the appropriate hardware needed so that patients can access the internet in rural and underserved areas.

5. Payment or other system deficiencies that contribute to a lack of access to care coordination or communication between behavioral health professionals and other providers in the health care system:
   a. It is important to invest in EMR systems that can work for both behavioral health and health care. Federal policies should be created that provide consistency across the country so that all providers know what they can share with each other about their patients and so that they may provide more integrated care. The EMR system created should be able to be used by both health care and behavioral health providers. Currently, each hospital system and behavioral health organization use their own EMR. Because EMR systems are expensive, many organizations cannot afford a proper EMR system.
   b. Integrated care should be what all health plans strive for. The system is currently fragmented and there is no standardized way of evaluating patient progress or referral processes. Lack of care coordination between all providers is a problem.

6. Which characteristics of proven programs have most effectively encouraged individuals to pursue education and careers in behavioral health care?
   a. Establishing mentorship programs like "Mi Mentor" and "Health Career Connection." These programs provide mentorship and paid internships to historically underserved students.
   b. Develop a pipeline and invest in career counseling that begins in high school and continues through post-graduate programs so that counselors can speak and provide up-to-date resources to interested students about career options in behavioral health and social services.
   c. Schools should partner with Community-Based Organizations (CBOs) or other mental health providers to create a pipeline of future mental health providers.
   d. Provide funding to facilitate the aforementioned.

7. Should federal licensing and scope of practices requirements be modified to reduce barriers for behavioral health care workers seeking to participate in federal health care programs? If so, how?
    a. Lack of interstate licensing is an issue. Portability of license should be streamlined. For example, because social workers' licenses are issued at the state and provincial level, social workers need to apply to practice legally in a new jurisdiction. There needs to be a standardized way for licensing therapists. Creating a national behavioral health licensing board to help develop standards for all behavioral therapists would be a start. This board should include BIPOC perspectives.

8. What public policies would most effectively reduce burnout among behavioral health practitioners?
    a. Create a federal caseload limit for providers that will allow practitioners to have quality care vs. quantity care.
    b. Pay parity is important. There are some states that have pay parity laws in place, but they are not implemented properly or at all, so health plans are not penalized. Paying mental health providers wages commensurate to their education and experience is important. Unfortunately, many organizations do not pay therapists a decent wage, and many are forced to get second jobs. This leads to burnout.

Increasing Integration, Coordination, and Access to Care

1. What are the best practices for integrating behavioral health with primary care? What payment policies would best support care integration?

    a. **Improve mental health referrals** for Medi-Cal, Medicare, ACA marketplaces and exchanges, and commercial patients in ambulatory primary care. The referral process for mental health providers should be one where health care providers are aware and understand the different mental health services available in the community and within managed care plans. Educating staff on what each health plan offers for mental health services is important to understand what options patients have.
        - Convene with health plans to discuss how to improve the referral process between providers.
        - Research policies that improve or exacerbate the referral process and work with policymakers to make needed changes.
        - Provide thorough trainings for staff on new policies and procedures.
        - Train staff on mental health and help with stigma reduction.
        - Create a strategy to help guide the new process so that metrics can be checked and measured.
        - Take inventory of services available that are applicable to target populations.
        - Additional funding for adequate administrative support.

b. **Increase mental health care provider options** for patients: co-location, tele-mental health, self-help, and home visits. Currently, health plans have limited options on who their clients can see and where to go for mental health services.

   Tele-mental health can help reach more people than with the current system. Some patients and providers prefer that mental health services be available in their clinics to facilitate communication between providers. This is also convenient for the patients who will not need to travel to different places to receive both mental health and health care services. By improving options, patients are not limited and have a better chance of being happy with their mental health services and most likely continue with care. Focus on increasing bilingual/ bicultural providers and partnering with CBOs.

   Create a pipeline: working with behavioral health graduate school programs will help train a new mental health workforce. By providing stipends that are adjusted to the cost-of-living to students we are helping them financially, and we increase our chances of recruiting marginalized students, thus creating a workforce reflective of the communities served.

   Adding case managers to the team will help patients navigate the mental health and health care system in general.

c. **Technology plays a key role on the implementation of mental health services and innovation**. Behavioral health workforce + IT = increased access; we must take inventory of tele-behavioral health and self-help online tools (online collaborative care for cognitive behavioral therapy). We would need to educate patients on tele-mental health services, and it would require that patients have access to technology--not all do. Some patients may be reticent about having therapy over the phone or computer. This process would require understanding of HIPPA laws and learning what type of mental health therapy is best for the patient.

   A plethora of different platforms are available for tele-mental health. As many companies have caught on to the demand for this service, many have started to supply. With COVID-19 keeping people at home, technology plays a key role in service delivery.
   - Take inventory of services available.
   - Assess our patients' ability to access tele-mental health.
   - Assist patients in accessing technology to receive services.
   - Assess providers comfort with new technology.
   - Regular and ongoing trainings for staff on technology.

d. Payment models should promote holistic care. Payments per member per month (PMPM) by health plans to providers can help medical groups pay for needed mental and social services in their practices. The payments should be enough to cover staff and administration at an adequate rate with proper caseloads. These discussions should take place between health plans and providers. The government should incentivize plans to

pay IPAs and medical groups enough to support and evaluate an integrative care model. Additionally, it should include all private medical groups as well as FQHCs.

2. What programs, policies, data, or technology are needed to improve access to care across the continuum of behavioral health services?
    a. Each state must be responsible for auditing of mental health services that are available. States must work with counties to audit mental health services that are available in their respective regions. There must be a standardized way of collecting data, and that data should be presented to the public in an easy and efficient way.
    b. CMS and commercial plans need to collect data on mental health services they're providing per population and make it readily available to stakeholders and the public. Data should be granular enough to understand specific population barriers.
    c. Create a streamlined and easy-to-use system to navigate so that data about mental health services can be accessed in a timely manner by public and other stakeholders.

3. What programs, policies, data, or technology are needed to improve patient transitions between levels of care and providers?
    a. Investment in EMR systems so that there is better communication between behavioral health and health care providers.
    b. Invest in hiring case managers or patient advocates to help patients navigate the different systems of care.
    c. Collect data and evaluate programs for quality assurance.
    d. Create policies that incentivize plans and providers to collaborate and provide good quality care to patients.

4. What policies could improve and ensure equitable access to and quality of care for minority populations and geographically underserved communities?
    a. Create training standards that require therapists to be trained on BIPOC and LGBTQ+ issues so that they provide culturally responsive and adequate care.
    b. Require health plans to recruit more mental health providers of color, especially in areas that are historically underserved communities.
    c. Working with Behavioral Health Boards to streamline the process of acquiring supervision for clinicians seeking to become licensed.
    d. Health plans should be working with Behavioral health programs schools, to create pipelines of students to ensure that we are creating a diverse workforce.

5. How can crisis intervention models, like CAHOOTS, help connect people to a more coordinated and accessible system of care as well as wraparound services?
    a. Invest more in training frontline workers (EMTs, police officers, firefighters) on mental health issues.
    b. Invest in public education campaigns to destigmatize mental health issues.
    c. Federal peer certification program: Having people with lived experience participate in crisis intervention models to help others access services.
    d. Investing in the logistics and staffing for transporting patients to a medical facility during a mental health crisis.

6. How can providers and health plans help connect people to key non-clinical services that maintain or enhance behavioral health?
    a. Invest in more funding for case management services.
    b. Invest in transportation for people with disabilities or limited mobility, and seniors.
    c. Invest in technology.
    d. Invest in better care coordination between all providers.

Ensuring Parity

1. How can Congress improve oversight and enforcement of mental health parity laws that apply to private plans offering coverage under the federal health programs? How can we better understand and collect data on shortfalls in compliance with parity law?
    a. Congress needs to work with health plans to establish standards for adequacy of provider networks, provider directories, and access.
    b. Congress needs to consult with professional organizations (i.e., National Association of Social Workers, American Psychological Association), who have advocated on behalf of mental health professionals, to create an oversight committee while also including health plans in this conversation.
    c. Congress needs to provide funding to HHS to monitor pay parity in all 50 states and US territories.
    d. HHS needs to mandate health plans on data reporting and incentivize health plans to collect data. Additionally, states in general should be mandated through their own state health plan monitoring mechanisms to oversee parity laws and provide staffing for that specific purpose.
    e. Congress needs to allocate funding for staffing in order to monitor parity laws in each state.

2. How can Congress ensure that plans comply with the standard set by *Wit v United Behavioral Health?* Are there other payer practices that restrict access to care, and how can Congress address them?
    a. Congress needs to work with health plans to form an advisory board comprised of health plans, providers, community stakeholders and patients. This advisory board will serve to create guidelines on pay parity issues. Part of these standards should include that pay equity is ensured for women and BIPOC minority groups.

3. Are there structural barriers, such as the size of the provider network, travel time to a provider and time to an appointment, that impede access to the behavioral health care system?
    a. Yes, there are structural barriers such as issues with finding providers that accept commercial plans, Medicare, and Medicaid. The reason why is because many of these plans do not reimburse enough to mental health providers to stay in their networks.
    b. For rural areas, there are not enough providers and travel time is an issue for patients with limited transportation.
    c. Ensuring that patients can take paid time off if needed to go to an appointment with a mental health provider.
    d. Access to technology and broadband internet is severely lacking in rural areas and areas with underserved communities.

e. There are not enough bilingual/bi-cultural providers in areas with large populations of BIPOC communities.
f. Lack of childcare options in order to be able to attend an appointment with a mental health provider.

4. To what extent do payment rates or other payment practices (e.g., timeliness of claims payment to providers) contribute to challenges in mental health care parity in practice?
    a. Payment rates are inconsistent within health plans. For example, Medicare referrals for psychiatry pay more than Medicaid and some commercial plans. Payment rates are not standardized and not paid in a timely manner. Payment amount and schedule varies depending on health plan.

5. How could Congress improve mental health parity in Medicaid and Medicare? How would extending mental health parity principles to traditional Medicare and Medicaid fee-for-service programs impact access to care and patient health?
    a. Standardized payments will help with payment consistency within all health plans, and carveouts must be limited. SUD treatment must also be included in standardized payments.
    b. Payments need to be sufficient to incentivize mental health providers to stay in their networks.

Expanding Telehealth

1. How do the quality and cost-effectiveness of telehealth for behavioral health care services compare to in-person care, including with respect to care continuity?
    a. Higher level of care continuity with patients (both children and adults) increasing in percentage of attendance; quality of behavioral health care services has been mixed due to limited training, support, and guidance (uneven at best) for clinicians; cultural factors also impact the quality of behavioral health care services provided with lower income and non-English fluent patients receiving lower quality services and experiencing higher drop-out rates
    b. Conversely, patients with physical and cognitive disabilities who are unable to use the equipment properly and access tele-mental health platforms (many which are not ADA-compliant), have resulted in lower quality services and a disruption in care-continuity, making in-person services as the only feasible choice.

2. How can Congress craft policies to expand telehealth without exacerbating disparities in access to behavioral health care?
    a. This is as much an issue of Parity as it is of telehealth expansion. The expansion has resulted in an equality-based shift (not equity) in provision of care as therapists in organizations, including community mental health and schools, have been increasingly leaving for private practice tele-mental health. A majority of those therapists are primarily using an out-of-pocket-pay model
    b. Concerted efforts to increase affordable broadband access and service for lower income and rural residents; efforts should be well-publicized with broadband companies

collaborating in concerted efforts to help low-income residents receive information and sign-up for low fee/free broadband

c. Quality improvement (QI) efforts should measure disparities and improvements in them while ensuring that such efforts not create perverse incentives for providers to avoid serving low-income/minority patients; that they be applied to institutions where minority/low-income patients are most likely to receive care; and that the health organizations fully engage low-income/minority patients despite language or other barriers. Key to these efforts is a need to involve broad stakeholders in the development of disparities impact assessments to measure effect that the quality provisions will have on reducing disparities.
d. Clearer guidance on billing and reimbursement policies across payers is needed. Additionally lacking is payer consistency in "evaluation and management" (E/M) service reimbursement for telephonic encounters, which are fundamental to providing care to patients in the safety-net clinics/facilities
e. Fund technology access, equipment, and technical support for outpatient clinics and health care systems, prioritizing those serving medically underserved patients

3. How has the expanded scope of Medicare coverage of telehealth for behavioral health services during the COVID-19 pandemic impacted access to care?
    a. Expanding the scope of Medicare coverage of telehealth has provided significant increase in access to care for low-income beneficiaries. However, the overall loosening of telehealth (equality-based approach, not equity-based) requirements and restrictions has provided the opportunity for a significant number of mental health clinicians to shift to private practice (primarily tele-mental health) reducing the number of mental health clinicians providing services to lower-income patients, particularly Spanish-speaking Latino beneficiaries.

4. How should audio-only forms of telehealth for mental and behavioral health services be covered and paid for under Medicare, relative to audio-visual forms of telehealth for the same services?
    a. Lower rates for audio-only appointments have created financial hardships for practices and disproportionately affected therapist/mental health providers who care for Medicare beneficiaries and underserved patients. This highlights the importance of adequate reimbursement for telephone consultations in the short-term, and the need to address equitable access to internet and video-capable devices for underserved communities in the long-term.
    b. Although an overall high percentage of Latino adults have access to the internet, whether at home or through a smartphone, there are still disparities in technology use that must be considered when implementing tele-mental health services. In many Latino communities, many patients do not have video-capable devices and/or adequate internet or cellular coverage to conduct an encounter by any means other than on their landlines. Even when they do, Electronic Health Records Systems tend to be complicated to use and pose technical difficulties for both patient and provider during appointments.

5. Are there specific mental health and behavioral health services for which the visual component of a telehealth visit is particularly important, and for which an audio-only visit would not be appropriate?

a. The visual component is important when working with children and youth irrespective of diagnosis as non-verbal behavior is as important, if not, more important than verbal behavior. It is also important during parent/child sessions as well as for children with mental health disorders and developmental/intellectual disability
b. Working with trauma patients requires a lot of tracking of nonverbal and verbal behavior in order to pick up on subtle cues patient is experiencing trauma reminder
c. Required for Attention Deficit Disorder (ADD & ADHD) as well as Serious Mental Illness (SMI) such as Schizophrenia and Bipolar Disorder

For which specific mental and behavioral health services is there no clinically meaningful difference between audio-visual and audio-only formats of tele-health?

a. Insufficient research has been done but nonverbal cues/behavior are critically important in most mental health sessions

How does the level of severity of a mental illness impact the appropriateness of a telehealth visit?

a. Higher acuity mental health patients may require hospitalization or arrangement to go the nearest emergency room prior to the onset or during a crisis and tele-mental health is not likely to be appropriate for them. This is also true of patients with a history of hallucinations/delusions as technology is often a source of mistrust when talking about personal things (often part of their delusions)

6. How should Medicare pay for the practice expense portion of Medicare's telehealth payment for mental and behavioral health services?
    a. No comment

   Should the practice expense resources needed for telehealth forms of these services be independently measured, or should Medicare rely on the practice expense values used for in-person forms of Medicare payment for the services?
    a. No comment

7. Should Congress make permanent the COVID-19 flexibilities for providing telehealth services for behavioral health care (in addition to flexibilities already provided on a permanent basis in the SUPPORT for Patients and Communities Act and the Consolidated Appropriations Act, 2021)? If so, which services, specifically? What safeguards should be included for beneficiaries and taxpayers?
    a. Certain conditions should be met to ensure there is no over-reliance on telehealth services and that quality and quantity of service provided is equivalent to industry standards and best practices so services are not being used to bill beneficiaries/ taxpayers for services (such as filling out a survey) they otherwise would have not been charged for
    b. Issue of safety of patient, particularly those of higher acuity, should be a key consideration to ensure beneficiaries receive appropriate linkage to higher level of service when needed. This would require clinicians/therapist to have knowledge of crisis response options for a patient seen outside of the clinician's physical area of coverage

8. What legislative strategies could be used to ensure that care provided via telehealth is high-quality and cost-effective?
    a. Minimum standards implemented with equity front and center; funding for training on best practices of effective and efficient tele-mental health care practice

   b. The development of evaluation measures for telehealth programs is needed to assess telehealth services' ability to effectively provide quality clinical services, and to evaluate its safety, availability, and accommodation of care for limited-English proficient populations
   c. Ensuring the provision of quality care for linguistically and medically underserved populations may require standardized reporting across Medical Care Plans (MCPs) on access, utilization, and MCP measurement of outcomes for enrollees.

9. What barriers exist to accessing telehealth services, especially with respect to availability and use of technology required to provide or receive such services?
   a. There are approximately 21 million Americans still don't have access to broadband internet, this is particularly an issue for the Latino community which accounted for 51% of the U.S. population growth according the 2020 census.
   b. There needs to be a clear set of guidelines and well-considered plans for how therapists are expected to deal with crisis situations, which is currently lacking
   c. Payment structure should be standardized across states and payers. Insurers must not have the option to opt-out of coverage or reimbursement for telemedicine services.
   d. Payment parity: Payers should be expected to reimburse the same amount for telemedicine services as they would if the service were furnished in person.
   e. Minimize administrative barriers for payment and standardize billing procedures and codes for telehealth and Medicare reimbursement for mental health services in general. Both of these issues are contributing to reduce number of mental health clinicians providing both in-person and tele-mental health services to lower-income communities
   f. Medical interpreter use will need to be systematically incorporated into telehealth technology to ensure language-concordance is addressed to help alleviate the bilingual clinician shortage (stopgap measure)
   g. Digital inequity is greatest among Latinos who are monolingual Spanish-speaking with just 65% reporting having broadband connection while 25% have no connection/access and 10% must rely on their smartphones
   h. Continued limited available funding for community health organizations to improve and purchase EMRs and health information exchange platforms and often cannot afford upgrades and access technical assistance so ability to provide telehealth is limited.

Improving Access for Children and Young People

1. How should shortages of providers specializing in children's behavioral health care be addressed?
   a. HRSA funding specific for internship and fellowships (children's behavioral/mental health is a specialty) that have children's behavioral health tracks or would like to develop that specialty as part of their training program
   b. Accrediting bodies should provide comprehensive support for training programs/universities to expand graduate programs to include child/youth-specific tracks
   c. SAMHSA funding focused on developing evidence-based practices (EBPs) with BIPOC communities should be a priority. Eurocentric-EBPs have led to BIPOC communities

being left behind in terms of equity of care and contributed to shortage of child mental health care providers from BIPOC communities

d. Pilot programs with high schools and undergraduates to inform prospective students interested in psychology or mental health career tracks; specific focus should be on those interested in psychology and early childhood education
e. Open communication channels between high schools, 2-year colleges (including Community College), and graduate psychology programs/university to allow opportunities for diverse students to become acclimated to graduate life.
f. Find out what social media platforms are used by high schoolers and college students to target program/information delivery via those platforms
g. Many child psychologists do not accept insurance plans/Medi-Care because the reimbursements rates are low, and the paperwork is cumbersome – insurance reimbursement reform is key. Reimbursement rates that do not adequately reflect the more time consuming and complex work with children and their families act effectively as negative incentives, making the field less attractive, concurrently reducing available academic time (i.e., visibility and teaching involvement) of child psychology faculty
h. Trauma-informed and trauma-responsive training should be a critical part of training for clinical supervisors and child mental health providers because the lack of this training is resulting in secondary/vicarious trauma and burnout among child mental health providers given that a significant number of children they see have trauma histories

2. How can peer support specialists, community health workers, and non-clinical professionals and paraprofessionals play a role in improving children's behavioral health?
    a. Non-clinical professionals have the opportunity to provide psychoeducation, outreach and engagement in schools and other key systems/organizations children are involved with. This foot-in-the-door technique is key to reducing the stigma associated with parent's/caregivers willing to seek help for their child's mental health issues.
    b. They often have relationship with parents and the community that mental health professionals don't have the time/opportunity to cultivate which allows them the opportunity to broach the topic of mental health
    c. They may also be the first ones who notice potential mental health issues with a child/student allowing for timely identification and linkage to mental health services

3. Are there different considerations for care integration for children's health needs compared to adults' health needs?
    a. Billing becomes onerous when pediatrician and behavioral health professional see a child during the same medical health appointment, but this is the one of the best ways to reduce barriers to mental health access and stigma, especially for Latino and AAPI families.
    b. Linguistic and cultural considerations are key when looking at care integration for children's health because parents/caregivers may have different acculturation levels and/or linguistic ability compared to their children.
    c. Issues of mandated reporting to child protective services may arise during behavioral health care visit so clear policies, procedures, and buy-in is needed from all health professionals involved to ensure disruption of clinical services for other patients is minimized

d. Behavioral health professions (pediatricians and mental health providers) have to be well-informed of referral process and linkage to different non-clinical services
e. Child mental health providers are often assessing the entire family, including siblings, when meeting for a session/appointment with a child and may need to attend to family system factors during the appointment. This usually involves spending more time by the provider with the family. With adults, the focus during an appointment is exclusively on the health needs of the adult coming in for the health appointment. Potential impact on billing/reimbursement and scheduling/workload for child health providers.

4. How can federal programs support access to behavioral health care for vulnerable youth populations, such as individuals involved in the child welfare system and the juvenile justice system?
    a. Trauma-informed systems are needed to provide early identification of mental health needs for vulnerable youth populations and to prevent/reduce re-traumatization. Funding should be allocated to provide trauma-informed training to personnel working in these systems.
    b. Medicare funding should provide flexibility for system-involved youth, particularly those in the foster care system, to continue with current mental health therapist through telehealth regardless of change in placement. This allows mental health therapist to provide continuity of care no matter how many times the youth changes placements.
    c. Federal programs should ensure vulnerable youth have access to behavioral/mental health as a basic right as many system-involved are often unaware or not provided with mental health resources or services due to lack of funding and/or personnel.
    d. Suicide prevention should also be a key aspect of care provided to youth as many youth, particularly those in the foster care system, attempt or commit suicide with trauma more often underpinning the pain and desperation the youth experience.
    e. Federal funding/programs should also bolster access to long-term mental/behavioral health programs such as residential treatment facilities that provide alternative forms of mental health therapy (other than individual therapy sessions) for vulnerable youth needing intensive-inpatient mental health services.