Please consider the following discussion items after examining the data above regarding access and engagement in mental health services.

QUESTION 1A:

Do you think the county is doing an effective job providing access and engagement for children and youth in all of your communities?

Yes _X__ No____. If yes, what strategies seem to work well?

Peer support and navigators as well as outreach to teams to work well. Provide access education and referrals via information booth, community outreach at schools, medical service providers and college campuses. School consultation models for families via PEI, contract provider as well as 0-5 program outreach.

QUESTION 1B:

What strategies are directed specifically towards outreach and engagement of transition-aged youth in your county? Please list or describe briefly.

- **TAYA (Josie's Place) service team and drop in center (26-25)**
- **The Spot youth leadership project (12-24)**
- **Youth leadership PEI MHSA all ages**
- **Boys and Girls Club of Stanislaus County**
- **Center for Human Services Friday Night Live**
- **Juvenile Justice Peer Navigator program**
- **King Kennedy Center Youth programing**

QUESTION 1C:

Do you have any recommendations to improve outreach or services to specific ethnic or cultural groups of adolescents or transition-aged youth?

Yes _X__ No____. If yes, please list briefly.

- **Need to continue expansion of services for LGBTQT for TAY and children**
- **Additional services for Assyrian community for children and youth.**

QUESTION 1D:

What are your main strategies for assisting <u>parents/caregivers</u> of children with mental health needs? Please list or describe briefly.

- **Identify needs through the assessment process. Utilize the CANS (Child and Adolescent needs and Strengths) to further identify appropriate levels of treatment.**
- **Engaging families through the use of peer navigators and parent partners.**
- **Psychoeducation and supports via referrals for NAMI, El Concilio, promatoras, PEI fathers project, local FRCs in Stanislaus County.**

Access: Timely Follow-up Services after Child/Youth Psychiatric Hospitalization

The goals of timely follow-up services after psychiatric hospitalization are to promote sustained recovery and to prevent a relapse that could lead to another hospitalization. Children and youth vary greatly in their path to recovery. Sometimes a subsequent hospitalization is needed in spite of the best efforts of the healthcare providers, parents/caregivers, and the clients themselves.

"Step-down" is a term used by some mental health care professionals to describe a patient's treatment as "stepping down" from a higher level of care intensity to a lower level of care, such as outpatient care. Another example of step-down is when a hospital patient is transferred to crisis residential care or day treatment for further stabilization to promote a smoother transition to outpatient care.

Figure 4 on the next page shows data for the overall population of children and youth under the age of 21 who were discharged from a psychiatric hospitalization. In the upper half of the figure are data showing trends from one fiscal year to the next. The columns in this table show the overall percentages of clients with follow-up services within 7 days and those who received such services within 30 days. These time frames reflect important federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries.

The lower half of Figure 4 shows graphs of the median and mean (average) times for outpatient follow-up (stepdown) services following discharge from child/youth psychiatric hospitalization. These are two important measures that can be used to evaluate whether timely follow-up services are provided. But, because some clients do not return for outpatient services for a very long time (or refused, or moved), their data affects the overall average (mean) times in a misleading way due to the large values for those "outliers." Instead, the use of median values is a more reliable measure of how well the county is doing to provide follow-up services after a hospitalization.

A related concern includes how we help children and youth handle a crisis so that hospitalization can be avoided. Although we do not have data for mental health crises, similar follow-up care and strategies are likely to be employed. Your local board may have reviewed the range of crisis services needed and/or provided in your community for children and youth. Many counties have identified their needs for such programs or facilities to provide crisis-related services.[14]

[14] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

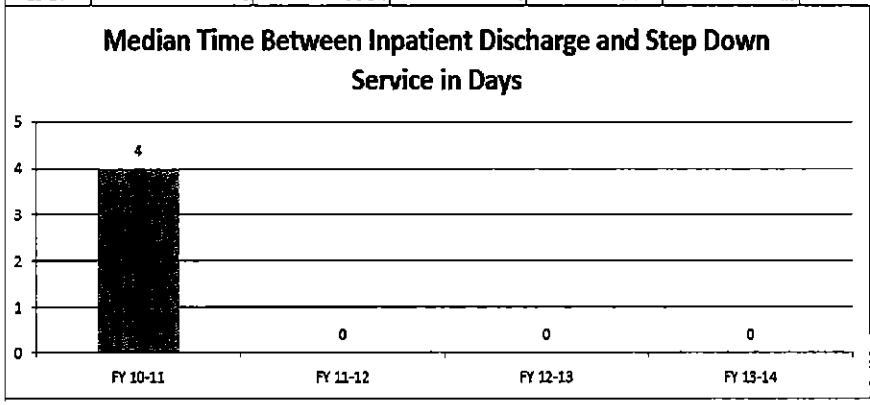
Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization. (2010-2014).

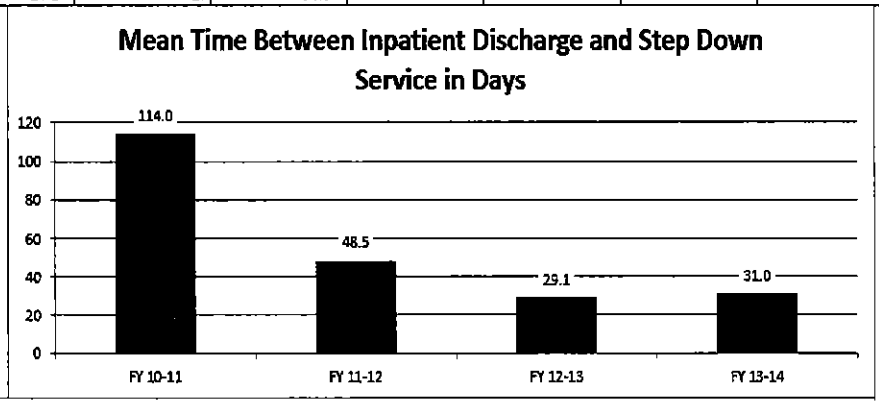
Your County: Stanislaus

Demographics Report: Unique Count of Children and Youth Receiving SMHS by Fiscal Year

Stanislaus County as of July 28, 2015

Service FY	Count of Inpatient Discharges with Step Down within 7 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 7 Days of Discharge	Count of Inpatient Discharges with Step Down within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 Days of Discharge	Count of Inpatient Discharges with a Step Down > 30 Days from Discharge	Percentage of Inpatient Discharges with a Step Down > 30 Days from Discharge	Count of Inpatient Discharges with No Step Down**	Percentage of Inpatient Discharges with No Step Down	Minimum Number of Days between Discharge and Step Down	Maximum Number of Days between Discharge and Step Down	Mean Time to Next Contact Post Inpatient Discharge (Days)	Median Time to Next Contact Post Inpatient Discharge (Days)
FY 10-11	34	38.6%	43	48.9%	17	19.3%	28	31.8%	0	1354	114.0	4
FY 11-12	85	61.2%	94	67.6%	26	18.7%	19	13.7%	0	594	48.5	0
FY 12-13	114	74.5%	121	79.1%	15	9.8%	17	11.1%	0	671	29.1	0
FY 13-14	48	52.2%	62	67.4%	13	14.1%	17	18.5%	0	401	31.0	0





When examining the post-hospitalization data above, take special note of the percentages who received follow-up services within 7 days after discharge, within 30 days after discharge, or later than 30 days. These time frames reflect federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries. The median time (left side) is a more reliable method for this measure. "Zero" days indicates that the client was seen as an outpatient on the same day as the discharge. Also take note of mean time from discharge to step-down services (right side).

QUESTION 2A:

Do you think your county is doing an effective job providing timely follow-up services after a child or youth is discharged from a mental health hospitalization? Yes _X__ No____.

If no, please describe your concerns or recommendations briefly.

QUESTION 2B:

After a hospitalization or MH crisis, what are the main strategies used to engage and ensure prompt follow-up for outpatient care in transition-aged youth? Please list briefly.

For 16-18 year olds hospital liaison refers any uninsured/Medi-cal to Aspiranet Stabilization Program during hospitalization to they can begin to engage before discharge. Providers already open to families are notified so ensure additional services or more intensive services can be secured.

18-25 year old have Transition Trac to support during as well as after hospitalization

QUESTION 2C:

What are the main strategies used to help parents/caregivers of children access care promptly after a child's hospitalization or other mental health crisis? Please list briefly.

- **Crisis intervention program for children, 24/7 four chair program providing family support, crisis de-escalation and avert hospitalization for children.**
- **Aspiranet Stabilization Program step down from hospital for engagement and assessment for ongoing mental health services. Warm hand off to on-going service providers.**

QUESTION 2D:

The follow-up data shown above are based on services billed to Medi-Cal. As a result, those data do not capture follow-up services supported by other funding sources. Examples may include post-hospitalization transportation back to the county, contact with a Peer/Family Advocate, or MHSA-based services.

Please list some non-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH crisis.

- **Children's Crisis Intervention Program**
- **Peer Navigators**
- **CART Contract to provide transportation at time of discharge from hospitalization for families without transportation**
- **Parent Partners referrals**
- **Family Advocate for Early Psychosis.**

VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

Foster Children and Youth

Foster children and youth comprise a vulnerable group that faces considerable life challenges. Mental health consequences may result from the traumatic experiences which led to their placement in foster care. Foster children and youth are just 1.3 % of all Medi-Cal eligible children and youth (ages 0-20). However, they represent 13 % of the total children and youth who received Specialty Mental Health Services (SMHS) in one year (FY 2013 - 2014). SMHS are services provided to children and youth with serious emotional disorders (SED) or to adults with serious mental illness (SMI). These mental health challenges affect outcomes in all aspects of their lives as has been described in recent studies[15,16] of foster youth in California schools:

The key findings for California foster youth included:

- **Time in Foster Care** – More than 43,000 (or about one of every 150 K-12) public-school students in California spent some period of time in child welfare supervised foster care.
- **Reason for Removal** – Of students in foster care, 78% were removed from birth families due to neglect, 11% physical abuse; 4% sexual abuse; and 7% other reasons.
- **Grade Levels** – Of these students in foster care, 40% were in Elementary School; 23% were in Middle School; and 36% were in High School.
- **An At-risk Subgroup** – Nearly one in five students in foster care had a disability compared to 7% of all K-12 students and 8% low socioeconomic status (SES) students.
- **School Mobility** – Among students who had been in foster care for less than one year, 48% had changed schools during the academic year.
- **Achievement Gap** – Proficiency in English language arts for students in foster care was negatively correlated with grade level.
- **Drop-out and Graduation** – Students with three or more placements were more than twice as likely to drop out as students with one placement, although this single-year dropout rate is still twice as high as that for low SES students and for K-12 students.

Conclusion: Students in foster care constitute an at-risk subgroup that is distinct from low socioeconomic status students regardless of the characteristics of their foster care experience.

[15]The Invisible Achievement Gap, Part 1. Education Outcomes of Students in Foster Care in California's Public Schools. http://stuartfoundation.org/wp-content/uploads/2016/04/the-invisible-achievement-gap-report.pdf. Also see: Child Welfare Council Report, 2014-2015 for more source material, at: http://www.chhs.ca.gov/Child%20Welfare/CWC%202105%20Report-Approved090215.pdf.

[16] The Invisible Achievement Gap, Part 2. How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. http://stuartfoundation.org/wp-content/uploads/2016/04/IAGpart2.pdf

As they reach adulthood, most foster youth will need continuity of care through Medi-Cal for services to promote mental health, independence, and connections within the community, including housing supports to avoid homelessness. Homelessness is a common outcome for foster youth who leave the system without either re-unification to their family of origin or an attachment to a permanent family.

One subgroup of foster youth has been referred to as "Katie A Subclass members," due to a lawsuit filed in federal court regarding their need for certain types of more intensive mental health services. The services included under the 2011 court settlement order are intensive home-based services, intensive care coordination, and therapeutic foster care. More recently, DHCS recognized that other children and youth also have a right to receive such services if there is a medical necessity.

The complex needs and large numbers statewide present challenges to the foster care and mental health systems. The numbers of foster youth who are receiving Specialty Mental Health Services are shown below. These data do not include those with mild to moderate mental health needs who are served in the Medi-Cal Managed Care System. Also, these data do not reflect those with disabilities who are served through school-based mental health services as part of an "Individual Educational Plan."

HOW MANY FOSTER CHILDREN AND YOUTH RECEIVE SPECIALTY MENTAL HEALTH SERVICES,* INCLUDING "KATIE A" SERVICES?

Statewide: (FY 2013-2014) Certified Medi-Cal eligible Foster Care Youth (age 0-20): **77,405.**

- Total Number of Medi-Cal Foster Youth who received at least one Specialty MH Service: **34,353** (service penetration rate is 44.3 %).
- Total Medi-Cal Eligible Foster Care Youth who received five or more Specialty MH Services: **26,692**.

Statewide: (FY 2014-2015) Total Unique Katie A. Subclass Members: **14,927**

- Members who received In-Home Behavioral Services: **7,466**
- Those who received Intensive Case Coordination: **9,667**
- Those who received Case Management/Brokerage: **9,077**
- Received Crisis Intervention Services: **523**
- Received Medication Support Services: **3,293**
- Received Mental Health Services: **12,435**
- Received Day Rehabilitation: **285**
- Received Day Treatment Intensive service: **63**
- Received Hospital Inpatient treatment: **19**
- Received Psychiatric Health Facility treatment: **41**
- Therapeutic Foster Care: Data not yet available.

* Data reports are from: http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx. The data are for fiscal years 2014 or 2015 (depending on which data are the most recent available at the time of this report).

Next, the figure below shows the percentage of foster children under 18 who received specialty mental health services. Note the trends year-to-year for your county and the comparisons to counties with populations of similar size and to the state.

There may be several explanations possible for any observed differences. For example, some counties find it necessary to place a significant number of foster youth out-of-county in order to find specialized services or the most appropriate and safe living situation.

Another explanation is that the recent expansion of Medi-Cal markedly increased the total numbers eligible for coverage. More children and youth are now eligible to receive specialty mental health services. Even if there was an increase in total numbers who received these services, there may have been a decreased percentage of total eligible persons served. Also, in some counties there are shortages of mental health professionals trained to work with children and youth or who also have bilingual skills.

Figure 5. Percentages of Foster Youth Who Received Specialty MH Services

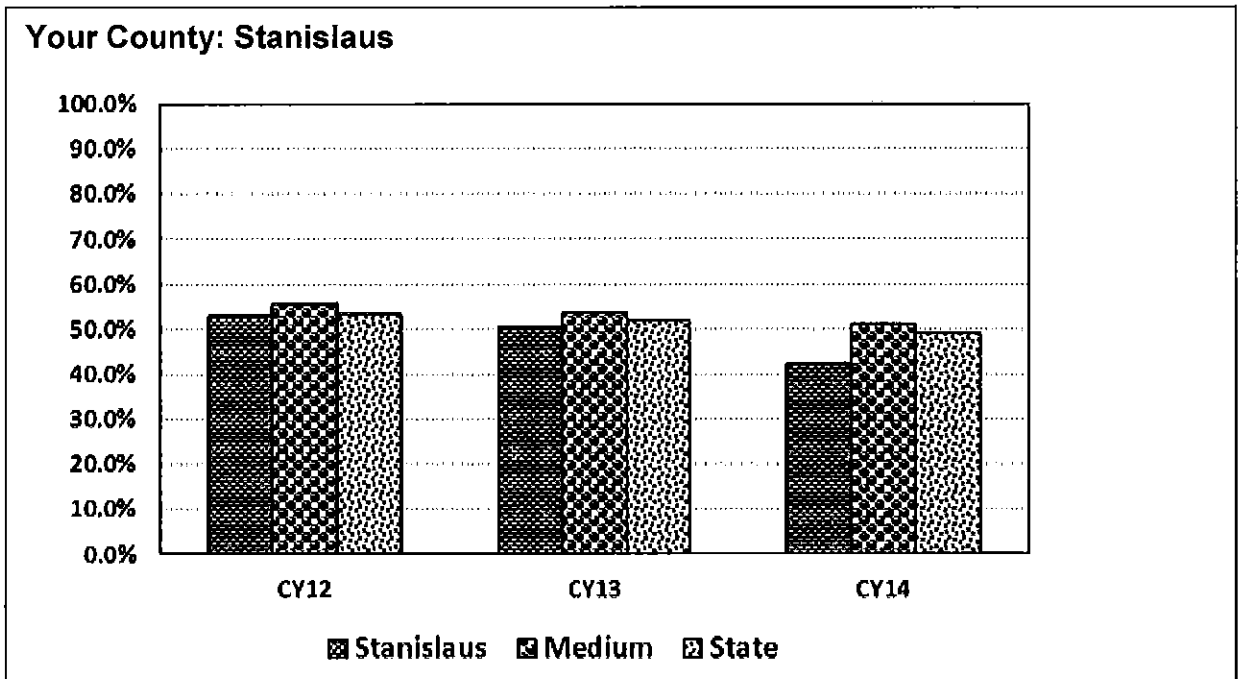


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

[17] Behavioral Health Concepts, Inc. California EQRO for Medi-Cal Specialty Mental Health Services. EQRO is the External Quality Review Organization. www.CALEQRO.com, see "Reports," and select your county to view.

QUESTION 3A:

What major strategies are used in your county to provide mental health services as a priority for foster youth?

Please list or describe briefly.

- **Katie A (Pathways to Wellbeing) screening for mental health needs**
- **19 years of collocated services, collaborative systems as well as referral processes, collocated Katie A services and strong oversight committee.**

QUESTION 3B:

Do you think that your county does a good job of coordinating with your county department of social services or child welfare to meet the MH needs of foster care children and youth?

Yes__X__ No____. If no, please explain briefly.

QUESTION 3C:

Do you have any comments or suggestions about strategies used to engage foster youth and provide mental health services?

Yes___ No__X__. If yes, please list or describe briefly.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQ)

LGBTQ youth are another group which may be underserved or inappropriately served. Most counties say that LGBTQ youth are welcome to engage in their standard programs and receive services, as are all other cultural groups. However, it is essential to understand how counties are serving the specific needs and difficulties faced by LGBTQ youth. Members of the LGBTQ community access mental health services at a higher rate than heterosexuals, with some reports suggesting that 25-80 % of gay men and women seek counseling. Many individuals report unsatisfactory experiences due to a therapist's prejudice, inadvertent bias, or simple inability to comprehend the experiences and needs of their LGBTQ clients.[18]

Research and experience demonstrate that LGBTQ youth have unique needs that are most effectively provided by therapists and program directors with special training in addressing these unique populations. Outcomes are better when therapists and program leaders have received this specialized training.

Particular risks for LGBTQ youth and children include discrimination, bullying, violence, and even homelessness due to rejection by their families of origin or subsequent foster homes. Homelessness introduces great risk from all the hazards of "life on the street." In contrast, family acceptance of youth is crucial to their health and wellbeing.[19]

The Family Acceptance Project:
A promising area of research and practice is represented by the Family Acceptance Project headed by Dr. Caitlin Ryan in San Francisco, CA. She and her team developed the first family-based model of wellness, prevention, and care to engage families to learn to support the LGBTQ children across systems of care. Her research on the protective factors for LGBTQ youth has been published in peer-reviewed journals. These studies found that parental and caregiver behaviors can help protect LGBTQ youth from depression, suicidal thoughts, suicide attempts, and substance abuse.

In contrast, she found that *the LGBTQ youth who were rejected by their families were eight times as likely to attempt suicide, nearly six times more likely to have high levels of depression, and three times as likely to use illegal drugs.*

The Family Acceptance Project has assisted socially and religiously conservative families to shift the discourse on homosexuality and gender identity from morality to the health and well-being of their loved ones, even when they believe that being gay or transgender is wrong. This effort included development of multicultural, multilingual, and faith-based family education materials designed to prevent family rejection and increase family support.

"We now know that kids have their first crush at about age 10. Many young people today are now coming out between ages 7-13. Parents sometimes begin to send rejecting messages as early as age 3.... These early family experiences ... are crucial in shaping [their] identity and mental health."

[18] P. Walker et al., "Do No Harm: Mental Health Services: The Good, the Bad, and the Harmful."

[19] Dr. Caitlin Ryan, 2009. Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. *Also see*: Ryan, C. (2014). Generating a Revolution in Prevention, Wellness & Care for LGBT Children & Youth, Temple Political & Civil Rights Law Review, 23(2): 331-344.

QUESTION 4A:

Does your county have programs which are designed and directed specifically to LGBTQ youth? _X__ Yes ___ No.

If yes, please list and describe briefly.

- The Place
- Central Valley Pride Center
- GSA in most area high schools

QUESTION 4B

Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes_X__ No____.

If yes, please list or describe briefly.

- **Josie's Place Service Team and Drop in Center (16-25)**
- **Silver Services (55+) weekly groups**
- **Community Transgendered Support (all ages)**

QUESTION 4C:

Do you have any comments or suggestions about services or how to address unmet needs for LGBTQ youth in your community?

Yes_X__ No____. If yes, please list or describe briefly.

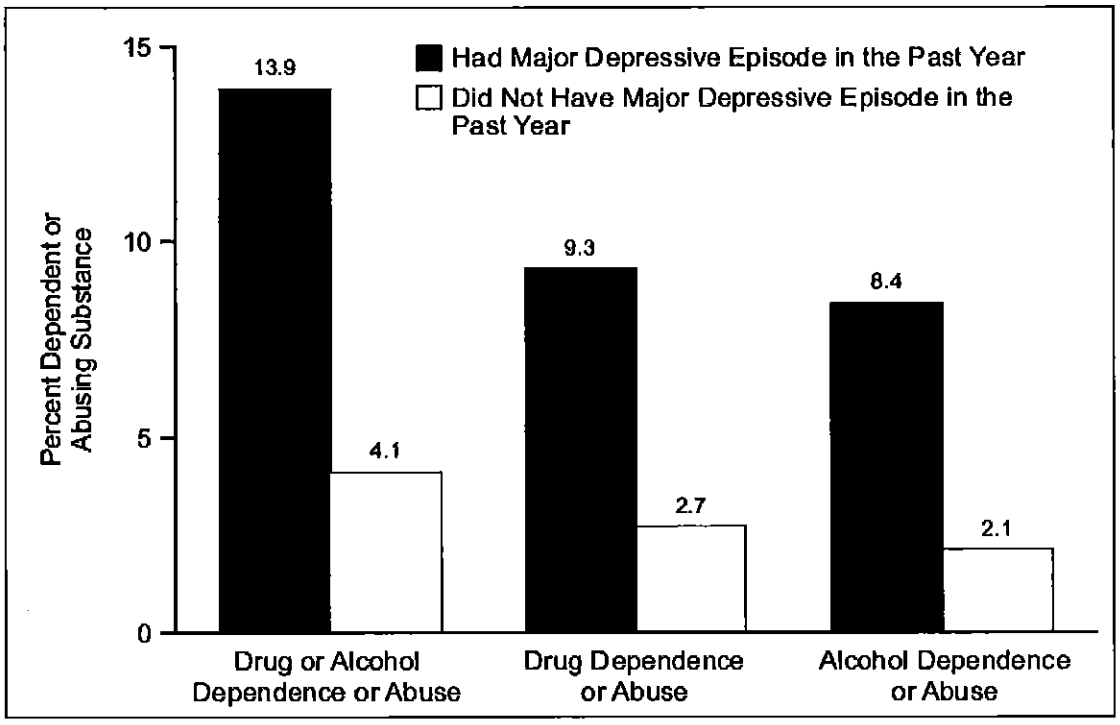
Additional training and expansion of LGBTQ services.

Children and Youth Affected by Substance Use Disorders

Counties generally have several levels of substance use disorder programs. These include prevention, treatment, and recovery supports. Prevention refers to services that target people before a diagnosable substance use disorder occurs, and may be based in schools or the community. Treatment refers to directly intervening in a substance use disorder using clinical means and evidence-based practices by trained clinical staff. Recovery support refers to supporting long term recovery and includes secondary prevention services as well. Resources for each of these main program areas are not equally available in all counties or areas of the state. Many small-population counties have very limited types of substance use treatment programs.

Young people who engage in early substance abuse may do so because they are experiencing mental health challenges. Children and youth who experience a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who do not have depression.[20] (See next figure, 2013 data, NSDUH).

Figure 6. Past Year Substance Abuse and Depression in U.S. Youth, Age 12-17.



[20] Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf

Last year's Data Notebook (2015) included a section on substance use disorders in all groups but emphasized adults and those with co-occurring mental health disorders. Both community and school-based prevention efforts were also discussed.

Substance abuse services for children and youth were not specifically addressed last year. Therefore, our focus for this discussion is limited to treatment needs and services for children and youth. Both experience and evidence show that children and youth under age 18 are best served by substance use treatment programs which are designed specifically for their emotional and social developmental stages.

In California, many of the 30 smaller population counties (<200,000), have limited treatment options, with an emphasis on outpatient treatment or abstinence programs.[21] There is a shortage of providers and of narcotic treatment programs (NTP), which is of concern given recent trends in narcotic drug abuse in all age groups, including youth. It is unknown how many counties have substance abuse treatment programs (and what type) that are designed specifically for youth under 18 or even for TAY (ages 16-25).

For your review, we are presenting data for total numbers of youth who initiated substance use treatment during FY 2013-2014 by participating in one of these three types of treatment: **outpatient, "detox", or residential treatment programs**. (NTP services and pregnant mother programs are not included). During that year, individuals may have started treatment one or more times in either the same or another program. However, these data count only the first episode of substance use treatment for an individual within that fiscal year. Both statewide data and county data (where available) are shown.

[21]California Substance Use Disorder Block Grant & Statewide Needs Assessment and Planning Report, 2015. Presented as a collaborative effort between numerous staff at DHCS, CDPH, and the UCLA Integrated Substance Abuse Program. http://www.dhcs.ca.gov/provgovpart/Documents/2015-Statewide-Needs-Assessment-Report.pdf

Stanislaus County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013

Grade Level	Any	None
7th Grade	15.3%	84.7%
9th Grade	29.1%	70.9%
11th Grade	39.6%	60.4%
Non-Traditional	64.7%	35.3%
All	32.4%	67.6%

Numbers of Youth that Began Substance Use Disorder Treatment, FY 2013-2014:

California: Statewide

Age < 18: 14,957 Age 18-25: 23,614

Your County: Stanislaus

Age <18: 36 Age 18-25: 352

QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Y_X___ N____

If yes, please list or describe briefly.

- **The Last Resort**
- **Center for Human Services outpatient treatment**
- **Juvenile Drug Court**
- **Steps to Freedom Juvenile Justice**
- **Stanislaus Recovery Center (18-25)**
- **Aegis, Nirvana and Genesis (18+)**
- **1st Step (moms with children)**

- **Prodigal Sons and Daughters**

If no, what is the alternative in your county?

QUESTION 5B:

Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes___ No_X__.

Please explain briefly.

Difficulty engaging substances use population

Justice System-Involved Youth with Behavioral Health Needs

Children and youth with significant emotional or mental health issues may engage in behaviors which bring them into contact with the justice system. Other vulnerable groups include homeless youth and victims of sex trafficking. They face survival challenges "on the street" and increased risk of involvement with law enforcement.

This discussion will focus on juveniles with justice system involvement. Based on the data available, it is difficult to estimate how many are in need of mental health or substance use services. However, experience at the community level suggests that the behavioral health needs of this population are considerable and many are likely to be underserved, unserved, or undiagnosed. At a minimum, needs for substance use treatment may be indicated by the data showing that one-sixth of all juvenile arrests are for offenses involving drugs or alcohol. Many others have committed offenses while impaired by alcohol or drugs of abuse.

Several factors may contribute to the circumstances which lead to youth becoming involved with the justice system, and other consequences that follow.

A recent report states that "the vast majority, between 75 and 93 percent of all youth entering the justice system are estimated to have experienced previous trauma."[22] Even more shocking, "girls in the justice system are 200 – 300 times more likely to have experienced sexual or physical abuse in the past than girls not in the justice system." [23] The 2016 California Children's Report Card[24] defines one particularly vulnerable group

[22] Erica Adams, "Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense." Justice Policy Institute, July 2010. http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

[23] D. K. Smith, L. D. Leve and P. Chamberlain, "Adolescent Girls' Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma." *Child Maltreatment 11.4* (2006):346-353. Print,

[24] Website: **www.ChildrenNow.org**, see report: California Children's Report Card, 2016.

as "crossover youth" (or multi-system users), because they have a history involving both the child welfare and juvenile justice systems. Often these children and youth have had multiple episodes of trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood. Parental abuse or neglect may have resulted in the child's placement in foster care or a group home, which is intended to provide for safety and well-being. In addition, the experience of removal from one's home is highly traumatic and the foster home may or may not be able to fully meet the child's needs. Studies show that these "youth are more than two times as likely to be incarcerated for low-level offenses than their justice-involved peers who are not involved in the child welfare system."

The childhood experience of trauma may lead to poor emotional regulation, emotional outbursts, or disruptive behaviors in schools. Such events, in turn, can set the stage for suspension, expulsion, or other disciplinary actions in schools. Disruptive behaviors left untreated may progress to events which lead to justice system involvement. Trauma-informed strategies may better serve the needs of youth by diverting them to therapy instead of punishment or incarceration.

Historically, "students of color, LGBT students, and students with disabilities...are disproportionately impacted by suspension and expulsion."[25] Across all age groups, for similar low-level offenses, persons of color are more likely to be incarcerated and much less likely to be referred to therapy, diversion, or probation than are their white counterparts. Research shows that African American children and youth are more than twice as likely to be incarcerated for non-violent offenses compared to white youth. Thus, as a matter of equity (or fairness of access), we should consider strategies to engage youth of color in mental health and substance use treatment and diversion.

Many serious challenges are faced by justice-involved youth. The most serious are those facing incarcerated youth; they report considerable despair and suicidal ideation

[25]"Racial Disparities in Sentencing." American Civil Liberties Union, 27 Oct. 2014. https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf; and Soler, Mark, "Reducing Racial and Ethnic Disparities in the Juvenile Justice System." Center for Children's Law and Policy, 2013. http://www.ncsc.org/~/media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/

One major risk for incarcerated youth is suicide.

- One national study* reported that approximately 10 percent of juvenile detainees had thought about suicide in the prior six months.
- About 11 percent of detained juveniles had previously attempted suicide.
- The rates of completed suicides for incarcerated juveniles are between two and four times higher than for the general population.
- The general population rate of completed suicides was reported in 2010 as 10.5 per 100,000 adolescents.

*K.M. Abram, J.Y. Choe, J.J. Washburn et al., "Suicidal Thoughts and Behaviors among Detained Youth," July 2014 Juvenile Justice Bulletin, pages 1-12.

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers[26] for misdemeanors, felonies and status offenses. "Status offenses" are those which would not be crimes for adults, e.g. truancy, runaway, breaking curfew, etc. Additionally, unknown numbers of youth are counseled and released to a parent or guardian without formal arrest.

Table 3. Numbers[27] and Types of Juvenile Arrests, California, 2014

Total population[28] age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests

[26]Data are from: www.kidsdata.org, based on compilation of data from California Department of Justice records for 2014 juvenile arrest data. Total numbers of arrests declined in 2015 to 71,923, but overall percentages broken down by type of offense were similar to those for 2014.

[27] Percentages may not add to 100% due to rounding effects. Data are from California Department of Justice reported in 2015.

[28]CA Department of Finance, Report P-3, December 2014

Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

These data can paint only a partial picture of the justice-involved juvenile population. Data are often lacking on who, how many, or what percentage may need behavioral health services. One goal of this discussion is to identify strategies which reach out to youth from all backgrounds. The desired outcomes are to engage individuals in treatment and diversionary programs, and to avoid detention, whenever possible.

Addressing this topic may involve challenges in seeking information from other county agencies such as Juvenile Probation. Besides county departments of behavioral health, other limited funding sources for services may include: Juvenile Justice Crime Prevention Act, Youthful Offender Block Grant, SAMHSA-funded grants, City Law Enforcement Grants, Mentally Ill Offender Crime Reduction (MIOCR) Grant Program, Proposition 63 funds (MHSA), or Re-alignment I and II funds.

Data shown below:

Recent county-level arrest data are not available to us for all types of juvenile offenses. However, we present the number of felony arrests for your county,[29] keeping in mind that these comprise only 31 % or about one-third of all juvenile arrests.

For state of California: **27,651 juvenile felony arrests, 2014.**

For your county: Stanislaus **545 juvenile felony arrests, 2014.**

QUESTION 6A:

Does your county provide mental health or substance use disorder treatment services or programs to justice system-involved juveniles while they are still in custody? Yes_X__ No___.

If yes, please list briefly. Please indicate (if available) the main funding[30] sources for these programs.

PROGRAM: **FUNDING SOURCE:**

QUESTION 6B:

Are the mental health and substance use services provided to non-custodial youth involved with probation or diversion programs different from those services provided to youth in the general community? Yes___ No_X__

If yes, please list briefly. Please indicate (if available) the main funding source for these programs/services.

PROGRAM: **FUNDING SOURCE:**

QUESTION 6C:

Do any of these programs engage the parents/guardians of juveniles involved with the justice system?

Yes___ No__X_. If yes, please list briefly.

[29] County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children's Health.
[30] This question is asking for only the main funding sources to highlight some of these programs and their successful implementation. We recognize that counties often weave together funding from different resources. If this information is not readily available, please enter N/A.

MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS HELPING CHILDREN AND YOUTH RECOVER

California voters passed the Mental Health Services Act (MHSA) in November, 2004 to expand and improve public mental health services. MHSA services and programs maintain a commitment to service, support and assistance. The MHSA is made up of the five major components described below:[31]

- **Community Services and Supports (CSS)**—provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or "whatever it takes" services to consumers. Housing is also included in this category.
- **Capital Facilities and Technological Needs (CFTN)**—provides funding for building projects and increasing technological capacity to improve mental illness service delivery.
- **Workforce, Education and Training (WET)**—provides funding to improve and build the capacity of the mental health workforce.
- **Prevention and Early Intervention (PEI)**—provides a historic investment of 20% of Proposition 63 funding to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN)**—funds and evaluates new approaches that increase access to the unserved and/or underserved communities; promotes interagency collaboration and increases the quality of services.

Prevention and Early Intervention (PEI) Programs and Services

Twenty percent of MHSA funds are dedicated to PEI programs as an essential strategy to "prevent mental illness from becoming severe and disabling" and to improve "timely access for under-served populations." PEI programs work to reduce the negative outcomes related to untreated mental illness, including suicide, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes.[32] Counties must use at least 51% of PEI funds to serve individuals 25 years of age and younger, according to the regulations (Section 3706). These programs provide for outreach, access and linkage to medically necessary care.

[31] Mental Health Services Oversight and Accountability Commission, December 2012. "The Five Components of Proposition 63, The Mental Health Services Act (MHSA) Fact Sheet." http://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

[32] Mental Health Services Oversight and Accountability Commission, December 2012. "Prevention and Early Intervention Fact Sheet: What is Prevention and Early Intervention?" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf

Prevention of Suicide and Suicide Attempts

Public health data for California and the U.S. show that there are risks for suicide for multiple age groups and race/ethnicity populations. In particular, youth suicide and suicide attempts are serious public health concerns. Suicide is the second leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.[33] Males are more likely to commit suicide, but females are more likely to report having attempted suicide. A recent national survey found that nearly 1 in 6 high school students (~17%) reported seriously considering suicide in the previous year, and 1 in 13 (or 7~8%) reported actually attempting it.[34]

The risks for youth suicide and suicide attempts are greatly increased for many vulnerable populations: foster youth, youth with disabilities, those who face stressful life events or significant problems in school, incarcerated youth, LGBTQ youth, and individuals with mental illness or who experience substance abuse. Among racial and ethnic groups nationwide, American Indian/Alaska Native youth have the highest suicide rates. Research confirms that LGBTQ youth are more likely to engage in suicidal behavior than their heterosexual peers.[35] Attempting to address the problem of youth suicide is both daunting and complex due to the diversity of needs and potential contributing factors for different individuals, including family history of suicide or exposure to the suicidal behavior of others. Below, we show the number of youth suicides per year by age group to gain perspective on the size of this problem in California.[36]

Table 4. California: Numbers of Youth Suicides by Age Group, 2011-2013.

California	**Number**		
Age	**2011**	**2012**	**2013**
5-14 Years	28	19	29
15-19 Years	163	129	150
20-24 Years	271	282	302
Total for Ages 5-24	462	430	481

[33] Child Trends Databank. (2015). Teen homicide, suicide, and firearm deaths. Retrieved from: http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths.

[34] Centers for Disease Control and Prevention. (2015). Suicide prevention: Youth suicide. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html.

[35] Marshal, M.P., et al. (2013) Trajectories of depressive symptoms and suicidality among heterosexual and sexual minority youth. Journal of Youth and Adolescence, 42(8), 1243-1256. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articales?PMC3744095/

[36] http://www.kidsdata.org , topic: suicides by age group and year in California.

By comparison, the number of youth suicide attempts is difficult to determine because they are combined with hospital data for self-injury. In California there were 3,322 hospitalizations for self-injury reported during 2013 for those age 24 and younger. Estimates vary, but slightly less than half of self-injury events (e.g. about 1,660) may have been suicide attempts. As with the data for suicide deaths, these numbers should be viewed with a degree of critical skepticism. Actual intent may not be readily ascertainable due to insufficient evidence, privacy concerns, or reticence of loved ones. There also may be delays in reporting or under-reporting to the state.

Reports of suicidal ideation are much more common and show that much larger numbers of youth are at risk. As an example, we may consider data for the population of high school-age young people which was about 2.1 million in 2014 for California. That means there are between 500,000 and 530,000 individuals eligible for each of the four years of high school (based on ages). Not all members of these age groups are in school, but those not in school are also at risk.

Survey data (below) show the percentage of public high school students who reported seriously considering attempting suicide in the prior 12 months in California. [37]

Table 5. Public High School Students Reporting Thoughts of Suicide, 2011-2013

California	**Percent**	
Grade Level	**Yes**	**No**
9th Grade	19.3%	80.7%
11th Grade	17.5%	82.5%
Non-Traditional	19.4%	80.6%
All	18.5%	81.5%

Data from your county are shown on the next page (if available).[38] Some counties or school districts either did not administer the surveys or else did not report their results.

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[37] **Data Source:** California Department of Education, California Healthy Kids Survey and California Student Survey (WestEd). The 2011-2013 period reflects data from school years 2011-12 and 2012-13. District- and county-level figures are weighted proportions from the 2011-13 California Healthy Kids Survey, and state-level figures are weighted proportions from the 2011-13 California Student Survey.

[38] Source of data: http://www.kidsdata.org, topic: suicidal ideation by grade level, in California. Note on abbreviations: N/D = no data; N/R=not reported.

Table 6. Percent of High School Students Who Reported Thoughts of Suicide, 2011-2013

Stanislaus County:

Suicidal Ideation (Student Reported), by Grade Level: 2011-2013

Grade Level	Yes	No
9th Grade	21.8%	78.2%
11th Grade	18.0%	82.0%
Non-Traditional	23.0%	77.0%
All	20.5%	79.5%

QUESTION 7A:

Does your county have programs that are specifically targeted at preventing suicides in children and youth under 16 (ages 6-16) in your community?

Yes____ No__X___ If yes, please list and describe very briefly.

QUESTION 7B:

Does your county have programs that are specifically targeted at preventing suicides in transition aged youth (ages 16-25) in your community?

Yes_X___ No_____ If yes, please list and describe very briefly.

- **Transition Trac does outreach, referrals and intervention (18+)**
- **Josie's Place (16-25)**
- **PHF**
- **Outreach and Engagement through MHSA**

QUESTION 7C:

Do you have any further comments or suggestions regarding local suicide reduction/prevention programs?

Yes____ No_____. If yes, please list briefly.

Early Identification of Risks for First-break Psychosis

Sometimes, unfortunately, the first major indication parents may have about first break psychosis in a child or youth may be changes in behavior, including an unusual drop in school grades, experimenting with substance abuse, running away, or behavior that gets the attention of the justice system. PEI programs for children and youth have a goal of identifying such persons early so that they receive appropriate services.

In California, many MHSA -funded programs provide these services. Thus far, the research and evidence for improved outcomes is solid enough to support these major efforts at both the state and national level. Therefore, now there are also federal funds from SAMHSA designed to intervene early to target first-break psychosis and provide a level of coordinated care and treatment that is effective. Some counties braid together funds from more than one source to support these programs and services.

Our questions address early intervention programs, regardless of funding source.

QUESTION 8A:

Does your county have services or programs targeted for first break psychosis in children and youth, and transition aged youth (TAY)?

Yes__X__ No____

QUESTION 8B:

If yes, please list by age range(s) targeted and describe the program or services briefly. Also, please include the major funding source, (i.e., MHSA, SAMHSA Block Grant, Realignment I/II, Medi-Cal, etc), if the information is readily available.

14-25 years old, outreach to the community to provide psychoeducation about first break psychosis and prodromal symptoms, intensive treatment for consumers, families and caregivers.

QUESTION 8C:

Do you have any further comments or suggestions about local programs targeted for first break psychosis in children and youth?

Yes____ No__X__. If yes, please describe briefly.

Full Service Partnership (FSP) Programs for Children and Youth

Full Service Partnership programs (FSP) provide a broad array of intensive, coordinated services to individuals with serious mental illness. These may also be referred to as "wrap-around" services. The FSP program philosophy is to "do whatever it takes" to help individuals achieve their goals for recovery. The services provided may include, but are not limited to, mental health treatment, housing, medical care, and job- or life-skills training. Prior research has shown FSP programs to be effective in improving educational attainment, while reducing homelessness, hospitalizations, and justice system involvement. Such intensive services can be costly, but their positive impact and results outweigh the costs and actually produce cost savings to society.[39]

Overall, the data thus far indicates some very good news. These positive outcomes are leading to greater understanding of what works well for children and youth. We hope to increase resources to serve more children and youth in FSP programs.

Outcomes Data for Children and Youth (TAY) in FSP Programs

When a new client begins FSP services, data are collected to serve as a baseline for later comparisons. Next, data are collected from each client after one year of services and then again at two years. The outcomes data are calculated as a change from the number of events for each client in the year prior to beginning FSP services, compared to one year later (and again at 2 years, for TAY).

Children's FSP data are shown for only one year of service, because children usually experience more rapid improvements than do TAY or adults. Here, improved academic performance is defined and measured as the percentage of children who had improved grades relative to baseline academic performance prior to beginning FSP services.

Please examine the data in the following tables below taken from a report[40] by CBHDA released in early 2016. First, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, take note of which outcomes show improvement and those which may need further attention to improve services for client recovery and wellbeing.

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[39] Prop 63 Mental Health Services Oversight and Accountability Commission (MHSOAC). Evaluation Fact Sheet: "Full Service Partnership (FSP) Program Statewide Costs and Cost Offsets" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_Eval5_FSPCostAndCostOffset_Nov2012.pdf

[40] Data reported from the new CBHDA-designed Measurements, Outcomes, and Quality Assessment (MOQA) data system for clients in FSP programs. http://www.cbhda.org/wp-content/uploads/2014/12/Final-FSP-Eval.pdf. Data from 41 counties were analyzed. We express great appreciation to CBHDA for sharing their data with the CMHPC.

Full Service Partnership Data for Children and Youth for Fiscal Year 2013-2014.

STATEWIDE DATA:

FSP Partners included in this analysis: 41 counties[41] plus Tri-Cities group reporting, Fiscal Year 2013-2014:

- Children (age 0-15): with at least one year of service.
- Transition Age Youth (/TAY, ages 16-25): with 2 years or more of services.

Table 7. Children, ages 0-15.

N=5,335 completed at least 1 year of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 year	Change in Client Outcomes at 2 years
Mental Health Emergencies	89% ⇩	--
Psych. Hospitalizations	49% ⇩	--
Out-of-Home Placements	12% ⇩	--
Arrests	86% ⇩	--
Incarcerations	40% ⇩	--
Academic Performance	68% ⇧	--

The data the table above show that: overall, children experienced decreases in total numbers of mental health emergencies, hospitalizations, out-of-home placements, arrests and incarcerations. There was an increase in academic performance, as measured by the percentage of children who had improved grades relative to baseline during the year prior to beginning FSP services.

[41] Alpine, Butte, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Kings, Marin, Los Angeles, Mariposa, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter-Yuba, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo. Other counties do have FSP services but for technical reasons were not able to get the reports out of their data systems for this project.

STATEWIDE DATA (Fiscal year 2013-2014): continued below.

Table 8. Transition Age Youth (TAY) ages 16-25.

N= 4,779 completed at least 2 years of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 Year	Change in Client Outcomes at 2 years
Mental health emergencies	84% ⇩	86% ⇩
Psych. hospitalizations	41% ⇩	57% ⇩
Emergency shelter use	20% ⇩	53% ⇩
Arrests	81% ⇩	86% ⇩
Incarcerations	45% ⇩	49% ⇩

The data in the table above show that: overall, transition-aged youth experienced decreases in total numbers of mental health emergencies, hospitalizations, use of emergency shelters, arrests and incarcerations. These beneficial outcomes occurred by the end of the first year.

All of these improved outcomes continued and were sustained at the end of the clients' second year in FSP services. Two types of outcomes, psychiatric hospitalizations and use of emergency shelters, had improved even more by the end of clients' second year of FSP services, compared to the end of the first year.

The goal is to think about how the FSP outcomes data for children and youth may help inform your suggestions for improving local services or programs.

QUESTION 9A:

What are the most urgent child or youth problems in your county? (For example, homelessness, problems with school or work, arrests, incarcerations, use of emergency MH services or psychiatric hospitalizations, out-of-home placements for children, substance abuse, teen pregnancy/parenting, etc.).

- **Incarcerations**
- **Substance abuse**
- **Homelessness, hospitalization**
- **Lack of child related hospital facilities**
- **School problems and employment**

QUESTION 9B:

Do the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community Yes

Question 9C:

Do you have any other comments or recommendations regarding your local FSP programs or other types of "wrap-around" services?

Yes ___ No_X_. If yes, please describe briefly.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

___ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

___MH Board completed majority of the Data Notebook

_X_ County staff and/or Director completed majority of the Data Notebook

___ Data Notebook placed on Agenda and discussed at Board meeting

___ MH Board work group or temporary ad hoc committee worked on it

___ MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

___ Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes___ No_X__

If yes, please provide their job classification _____

(c) What is the best method for contacting this staff member or board liaison?

Name and County: __Veronica Ortiz-Valle/Stanislaus County_

Email____vortiz@stanbhrs.org_____

Phone #____209- 525-6206_____

Signature: _____

Other (optional): _____

(d) What is the best way to contact your Board presiding officer (Chair, etc.)?

Name and County: __Jack Waldorf/Stanislaus County_____

Email: Sharkie@softcom.net

Phone #_____209-204-9997

Signature: _____