SONOMA COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with: California Association of Local Behavioral Health Boards/Commissions

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BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2016): 501,959

Website for County Department of Mental Health (MH) or Behavioral Health:

http://www.sonoma-county.org/health/about/behavioralhealth.asp

Website for Local County MH Data and Reports:

http://www.sonoma-county.org/health/publications/index.asp

Website for local MH Board/Commission Meeting Announcements and Reports:

http://www.sonoma-county.org/health/meetings/mhboard.asp

Specialty MH Data[1] from CY 2013: see MHP Reports folder at http://www.calegro.com/

Total number of persons receiving Medi-Cal in your county (2013): 395,598

Average number Medi-Cal eligible persons per month (2014): 89,608

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 50.5 %

Adults, 18 and over: 49.5 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 3,088

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 45.1 %

Adults, 18 and over: 54.9 %

[1] Downloaded from the website, www.calegro.com. If you have more recent data available, please feel free to update this section within current HIPAA compliant guidelines. CY = calendar year.

[2] Serious Mental Illness, term used for adults 18 and older.

[3] Severe Emotional Disorder, term used for children 17 and under.

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INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. For example, the topic for our 2016 Data Notebook reviews behavioral health services for children, youth, and transition age youth (TAY)[4].

Each year, mental health boards and commissions are required to review performance data for mental health services in their county. The local boards are required to report their findings to the California Mental Health Planning Council (CMHPC) every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information.

The Data Notebook is developed annually in a work group process with input from:

- the CA Mental Health Planning Council and staff members,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB),
- consultations with individual Mental Health Directors, and
- representatives of the County Behavioral Health Directors Association (CBHDA).

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates[5] to review performance data for their local county mental health services and report on performance every year,
- function as an educational resource on behavioral health data for local boards,
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

The Data Notebook is organized to provide data and solicit responses from the mental health board on specific topics so that the information can be readily analyzed by the CMHPC. These data are compiled by staff in a yearly report to inform policy makers, stakeholders and the general public. Recently, we analyzed all 50 Data Notebooks received in 2015 from the mental health boards and commissions. This information represented 52 counties[7] that comprised a geographic area containing 99% of this state's population. The analyses resulted in the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

[4] See various definitions of the age ranges for these groups depending on data source, Table 2, page 8.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W.I.C. 5772 (c), regarding annual reports from the California Mental Health Planning Council.
[7] Sutter and Yuba Counties are paired in one Mental Health Plan, as are Placer and Sierra Counties.

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function. Data reporting provides evidence for advocacy and good public policy. In turn, policy drives funding for programs.

Resources: Where do We Get the Data?

The data and discussion for our review of behavioral health services for children, youth, and transition age youth (TAY) are organized in three main sections:

1) Access, engagement and post-hospitalization follow-up,
2) Vulnerable populations of youth with specialized mental health needs, and
3) Mental Health Services Act (MHSA) –funded[8] programs that help children and youth recover.

We customized each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide reference data are provided for comparison for some items. A few critical issues are highlighted by information from research reports. County data are taken from public sources including state agencies. For small population counties, special care must be taken to protect patient privacy; for example, by combining several counties' data together. Another strategy is "masking" (redaction) of data cells containing small numbers, which may be marked by an asterisk "*", or a carat "^", or LNE for "low number event."

Many questions request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. Basic information for that discussion may be obtained from local county departments of behavioral health or mental health.

This year we present information from California Department of Health Care Services (DHCS), information about some Mental Health Services Act (MHSA)-funded programs, and data from "KidsData.org," which aggregates data from many other agencies. These and other data resources are described in more detail in Table 1, below.

[8] Mental Health Services Act of 2004; also called Proposition 63.

Table 1. Who Produces the Data and What is Contained in these Resources?

CA DHCS: Child/Youth Mental Health Services Performance Outcomes System,[9] http://www.dhcs.ca.gov	Mental health services provided to Medi-Cal covered children/youth through age 20, as part of the federally defined EPSDT[10] benefits. Focuses on Specialty Mental Health Services for those with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI).
CA DHCS: Office of Applied Research and Analysis (OARA)	Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the "Cal-OMS" data system.
CA DOJ: Department of Justice yearly report on Juveniles. Data at: www.doj.ca.gov	Annual data for arrests of Juveniles (<18) for felonies, misdemeanors, and status offenses, with detailed analysis of data by age groups, gender, race/ethnicity, county of arrest, and disposition of cases.
External Quality Review Organization (EQRO), at www.CALEQRO.com	Annual evaluation of the data for services offered by each county's Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.
KidsData.Org, A Program of Lucile Packard Foundation for Children's Health, see www.KidsData.org	Collects national, state, and county statistics. CA data are from DHCS, Depts. Of Public Health, Education, and Justice, Office of Statewide Health Planning and Development, "West-Ed," and others.
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: National Survey on Drug Use and Health (NSDUH), which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.
County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the "Measures Outcomes and Quality Assessment" (MOQA) database.

[9] See recent reports at: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

[10] EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.

How Do the Data Sources Define Children and Youth?

Although it may be common to refer broadly to children and youth collectively as "youth," discussions of data require precise definitions which may differ depending on the information source and its purpose. For example, "minor children," also called juveniles, are defined by the legal system as those under the age of 18. Others may define subcategories by age to describe psychological or biological[11] stages of development. Many systems are based on requirements for state reports to the federal government. Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the various public data sources that are available to us.

Table 2. Categories used by Different Data Resources for Children and Youth

Category	EPSDT MH Services	CA EQRO	MHSA Programs	JUSTICE System	SMHSA, NSDUH, Federal datasets
Children (or Juveniles)	0-5	0-5	0-15	0-17	
	6-11	6-17	--	--	6-11
	12-17 (Youth or 'Teens')	--	--	--	12-17
Adults	18-20	>18	(varies)	>18	>18
Transition Age Youth (TAY)	N/A[12]	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

[11] Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.

[12] N/A means not applicable, because this category is not available under this system or data source.

How Can Local Advisory Boards Fulfill their Reporting Mandates?

What are the reporting roles mandated for the mental health/behavioral health boards and commissions? These requirements are defined in law by the state of California.

Welfare and Institutions Code, Section 5604.2 (a)

The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) ***Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.***

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

The structured format and questions in the Data Notebook are designed to assist local advisory boards to fulfill their state mandates, review their data, report on county mental health programs, identify unmet needs, and make recommendations. We encourage all local boards to review this Data Notebook and to participate in the development of responses. It is an opportunity for the local board and their supporting public mental health departments to work together on the issues presented in the Data Notebook.

This year we present information about important topics for children and youth. Each section is anchored in data for a current topic, followed by discussion questions. A final open-ended question asks about *"any additional comments or suggestions you may have."* Ideas could include a program's successes or strengths, changes or improvements in services, or a critical need for new program resources or facilities. Please address whatever is most important at this time to your local board and stakeholders and that also may help inform your county leadership.

We were very impressed with the level of participation in 2015, having received 50 Data Notebooks that represent data from 52 counties. Several examples of good and even exemplary strategies were evident in these reports. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff to produce the Data Notebook. In several counties, the responses were developed by an *ad hoc* committee or special work group of the local board and staff and then presented to the local board for approval. In other counties, the responses in the Data

Notebook were developed by staff and presented to the local boards for approval. In a few counties, responses were prepared by staff and submitted directly to the CMHPC.

In an August 25, 2015 letter, the County Behavioral Health Directors Association (CBHDA) endorsed the expectation that "the process of gathering this data should be collaborative between the Advisory Boards and the Mental Health Plans (MHPs)." They also stated that "then the process would be more natural to the actual dynamic that exists in the counties." The California Mental Health Planning Council fully supports these statements and finds them consistent with the spirit and intent of the statutes.

This year we encourage every local board to look at and participate in developing the responses to questions outlined in the Data Notebook. We hope this Data Notebook serves as a spring-board for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

The final page of this document contains a questionnaire asking about the strategies you employ to complete this year's Data Notebook. Please review these in advance, before beginning this work.

Thank you very much for participating in this project.

ACCESS TO SERVICES: Youth, Children, and their Families/Caregivers

Access: Outreach and Engagement with Services

One goal of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color and LGBTQ[13] youth. If children, youth or their families are not accessing services, we may need to change our programs to meet their mental health needs in ways that better complement their culture or language needs. These values also guide the county mental health plans that provide specialty mental health services (SMHS). These services are intended for those with serious emotional disorders (SED) or serious mental illness (SMI).

As you examine data on the following pages, consider whether your county is serving all of the children and youth who need specialty mental health services. The standard data collected does not provide much detail about all the cultural groups that live in each county. The rich diversity of California can present challenges in providing services in a culturally and linguistically appropriate manner, as we have residents with family or ancestors from nearly every country.

From data the counties report to the state, we can see how many children and youth living in your county are eligible for Medi-Cal and how many of those individuals received one or more visits for mental health services. There are several ways to measure service outreach and engagement that help us evaluate how different groups are doing in their efforts to obtain mental health care.

The simplest way to examine the demographics of a service population is to look at "pie chart" figures which show the percentage of services provided to each group in your county. Figure 1 on the top half of the next page shows the percentages of children and youth from each major race/ethnicity group who received one or more SMHS visits during the fiscal year (FY). The lower half of the figure shows the percentage of each age group that received specialty mental health services (SMHS, in the graphs and tables). The gender distribution is not shown because it is fairly stable year over year across the state as a whole: about 45% of service recipients are female and about 55% of recipients are male.

Following Figure 1, more detailed data are shown in Figures 2 and 3, describing the Medi-Cal eligible population of children and youth, the percentages of each group that received specialty mental health services, and changes in those numbers over time for the fiscal years 2010-2011 through 2013-2014.

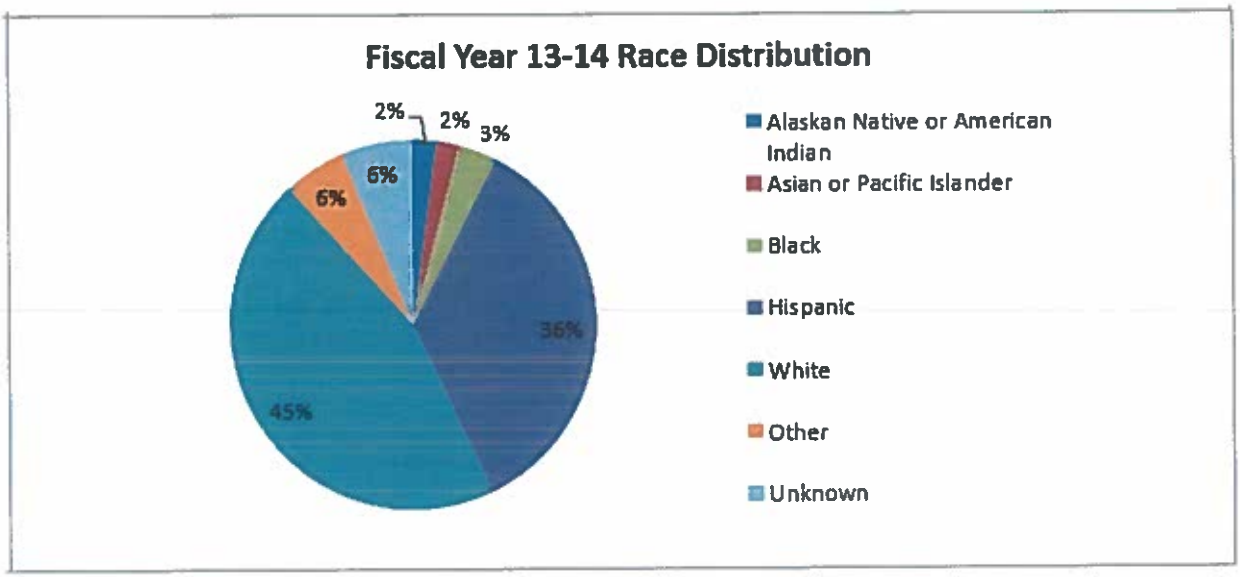
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

Figure 1. Demographics for Your County: Sonoma (FY 2013-2014)

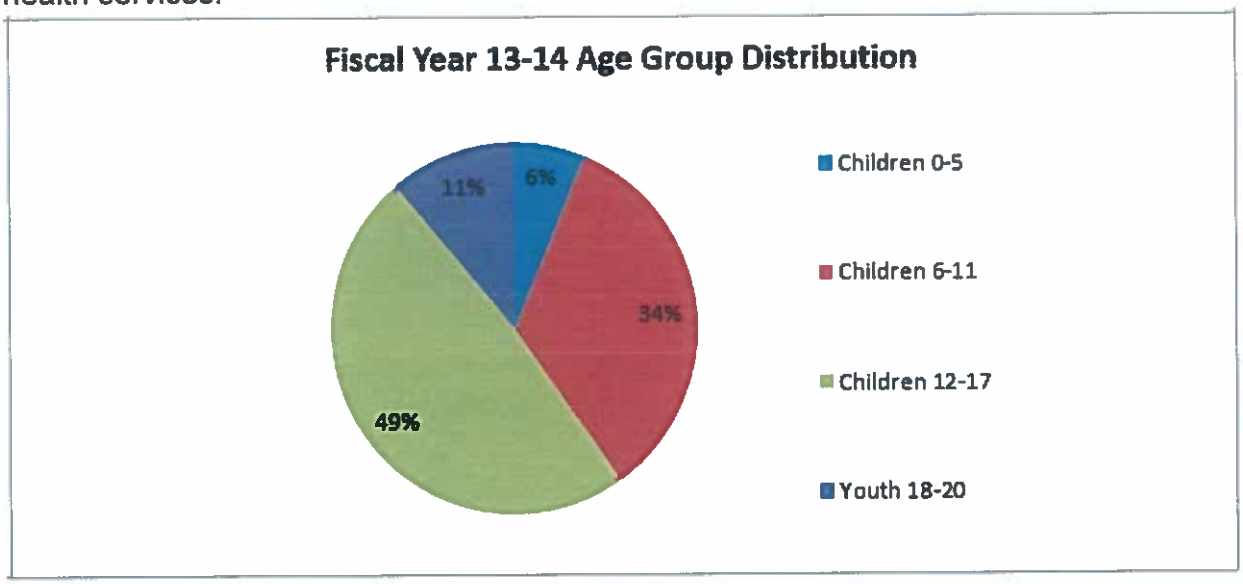
Unique numbers of children and youth who were Medi-Cal eligible: **57,704**

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **1,612**.

Top: Major race/ethnicity groupings of children and youth who received one or more specialty mental health services during the fiscal year.



Below: Age groups of children and youth who received one or more specialty mental health services.



Client access and engagement in services is a complex issue and is somewhat difficult to measure. One way to measure client engagement is "penetration rates." Service penetration rates measure an individual's initial access and engagement in services provided by the local mental health plan. Figure 2 on the next page shows data that illustrate two common ways to measure penetration rates:

- One way is to count how many children and youth came in for at least one service during the year, as shown in the data in the top half of figure 2. These data may provide information about outreach and at least initial access to services for child/youth clients of different ages and race/ethnicity groups.

- Another way to measure the penetration rate is to consider how many had sustained access to services for at least five or more visits, as shown in the data in the lower half of figure 2. This is sometimes referred to as the "retention rate." This measure is often used as a proxy (or substitute) for client engagement. Here, we measure how many came in for five or more services during the year.

Figure 2: in the table at the top of the page, the first column of numbers show how many children/youth received at least one specialty mental health service. The second column shows the number who were certified Medi-Cal eligible in each group. The final column at the right shows service penetration rates, which are calculated by dividing the number who received services by the total number who were Medi-Cal eligible.

The second table of Figure 2 shows data for those with more sustained engagement in accessing services. The first column of numbers show how many children/youth received five or more services during the fiscal year. The middle column, showing numbers who were Medi-Cal eligible, is identical to the middle column in table in the upper half of the page. The column at the far right shows the percentage in each group who received five or more services. Clearly, these numbers are much smaller than the corresponding rates in the data table shown above.

Figure 3 on the subsequent page shows a set of bar graphs: these graphs show changes over four fiscal years in service penetration rates by race/ethnicity, for children and youth who had at least one visit for services. Each group of bars shows the changes over time for one major race/ethnicity group. The final bar in each group illustrates the time point for FY 2013-2014 that was presented in more detail in figure 2. The "take home story" of figure 3 is the overall trend leading up to the most recent year's data. Please note that these data show the trends that occurred in the years following passage of the Affordable Care Act (2010).

Figure 2. Data Tables for SMHS Visits and Service Penetration Rates
Your County: Sonoma (FY 2013-2014):

Top: Children and youth who received at least one specialty MH service during year.

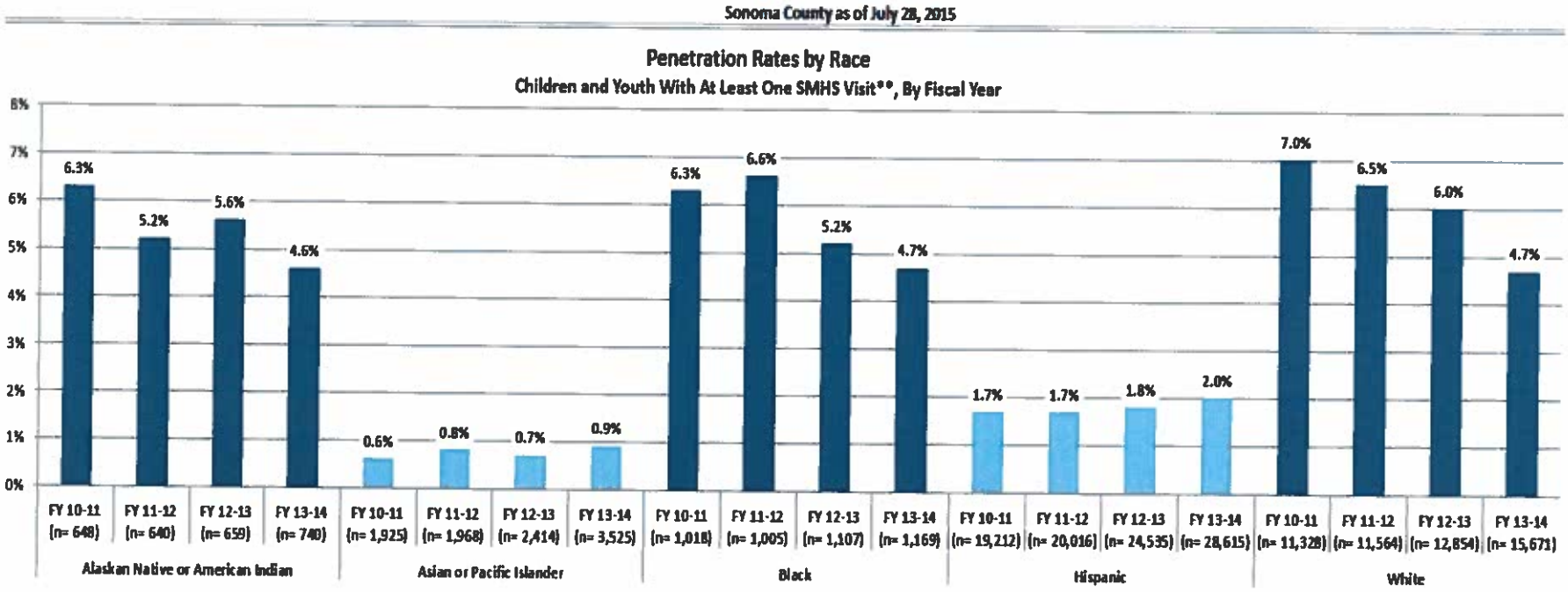
	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	1,612	57,074	2.8%
Children 0-5	101	18,466	0.5%
Children 6-11	547	17,562	3.1%
Children 12-17	785	14,291	5.5%
Youth 18-20	179	6,755	2.6%
Alaskan Native or American Indian	34	740	4.6%
Asian or Pacific Islander	32	3,525	0.9%
Black	55	1,169	4.7%
Hispanic	572	28,615	2.0%
White	729	15,671	4.7%
Other	88	4,200	2.1%
Unknown	102	3,154	3.2%
Female	745	28,105	2.7%
Male	867	28,969	3.0%

Below: Children and youth who received five or more specialty MH services during year.

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	1,298	57,074	2.3%
Children 0-5	71	18,466	0.4%
Children 6-11	470	17,562	2.7%
Children 12-17	633	14,291	4.4%
Youth 18-20	124	6,755	1.8%
Alaskan Native or American Indian	27	740	3.6%
Asian or Pacific Islander	27	3,525	0.8%
Black	44	1,169	3.8%
Hispanic	464	28,615	1.6%
White	582	15,671	3.7%
Other	71	4,200	1.7%
Unknown	83	3,154	2.6%
Female	587	28,105	2.1%
Male	711	28,969	2.5%

Figure 3. Changes Over Time in Service Penetration Rates by Race/Ethnicity, for Children/Youth with at Least One Specialty Mental Health Service During Fiscal Year. (FY 10-11 through FY 13-14).

Your County: Sonoma



Understanding the changes observed above should take into account the expansion of the total Medi-Cal eligible population, which resulted in a statewide increase of nearly 12% in FY12-13 relative to the previous year. The expansion occurred in stages during 2011 to 2013 as the state began to implement the changes mandated in the federal Affordable Care Act (2010). Families with incomes up to 138% of the federal poverty level became eligible for Medi-Cal. Also, children and families previously enrolled in "CHIP," federal Children's Health Insurance Program transitioned to Medi-Cal.

Please consider the following discussion items after examining the data abo 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 √ No____. If yes, what strategies seem to work well?

As stated above access and engagement in services is a complex issue and is somewhat difficult measure. The data provided above is data that can be gathered only once an individual has rece service that can be claimed (billed) to Medi-Cal. The above data only tells a small part of the sto does not reflect the actual work of engagement and access in Sonoma County. As the data belo children, youth, and transition age youth are accessing services at other sites that do not claim specialty mental health services.

Sonoma County Behavioral Health, through Mental Health Services Act has invested millions of into access and engagement. Furthermore, Sonoma County Behavioral Health has been able to data showing how many children, youth, and transition age youth are being reached through th strategies. Some of these strategies are The data below indicates where individuals may be gett mental health screenings, treatment and also, when data is available, services effectiveness.

Sonoma County Behavioral Health provides engagement services to children and youth through Mental Health Services Act (MHSA) Prevention funded services and programs. The purpose of and engagement is two-fold:

1. Reducing stigma and discrimination about mental health to increase access, and
2. To increase access through reaching, identifying and engaging individuals who may requ health treatment.

During FY 15/16 MHSA provided the following engagement services in order to increase access:

Community Based Organizations engagement programs to increase access:

- Early Childhood Services (0-5) Collaborative is a collaborative of 4 agencies (Child/Paren Jewish Family and Children Services, Early Learning Institute, and Petaluma People Servi Center) along with First 5 Sonoma County funded by MHSA to provide prevention servic children from birth to age 5 and their families throughout Sonoma County. In the past fi the 0-5 Collaborative served 3,300 individuals. These services include mental health scre Triple P Positive Parenting Program and other parent supports, case management for w diagnosed with Perinatal Mood Disorder, service navigation, and mental health consulta Program Effectiveness (2010-2014):
  Community and the Program outcomes:
  - The rate of substantiated reports for child abuse and neglect in Sonoma County

decreasing: The rate of these reports, per 1,000 children under age six, has gone down from 10.5 in 2010 to 6.9 in 2014. The Collaborative evaluator LFA and First 5 believe this positive development is, in part, a product of the combined efforts of MHSA-PEI 0-5 grantees.

- Nearly 3,000 at risk children 0-5 and their families received services. Agencies met the majority of their targets and supported parents to become confident nurturers who promote their children's healthy social-emotional development.
- More than 500 children were screened and referred for further assessment: MHSA PEI 0-5 programs used the evidenced based **Ages and Stages Questionnaire 3** and
- **Ages and Stages Questionnaire – Social Emotional** to screen children for developmental or social-emotional delays and referred those deemed at risk for further assessment.

Service Outcomes:

- 53% of children exhibited a decrease in the intensity of difficult behaviors. Children showed reliable, positive change of the evidence based ECBI (Eyberg Child Behavior Inventory) Intensity sub-scale
- 63% of children exhibited a decrease of difficult behaviors. Children showed reliable, positive change of the ECBI Problem sub-scale
- 95% of children showed a decrease in negative parent/child interaction. Parents showed a reliable, positive change of the Parenting Scale
- 88% of the families who received Triple P or Parent Education and Support program services reported a decrease in score on the Parental Stress Index

- Action Network administers the Across Ages and Cultures (AAC) project. Action Network provides services to individuals who reside in along Sonoma and Mendocino County's isolated Redwood Coast. The AAC provided 102 children, youth from birth to age 15 and their families a variety of services including: Triple P Positive Parenting, **screening using the Ages and Stages Questionnaire – Social Emotional**, and QPR (Question, Persuade, Refer) Suicide Prevention Training.
- Early Learning Institute (ELI) is a community based nonprofit created to provide and promote developmental services education and support to youth children, their families and the community at large. ELI provides a comprehensive **screening** to at-risk children who are referred from anywhere in the community. Children are screened for developments, medical, and social/emotional issues and are referred to the appropriate provider. Three Hundred and two (302) children were given a periodic developmental and social emotional screening, using the evidence based **Ages and Stages Questionnaire** 3 and **Ages and Stages Questionnaire – Social Emotional**, for the first time; 566 children were rescreened.
- North Bay Suicide Prevention (NBSP) Hotline of Sonoma County, formerly a program of Family Service Agency of Marin (FSA) and now Buckelew Programs, provides 24/7 suicide prevention and crisis telephone counseling. NBSP Hotline highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. During the fiscal year. 8% (359) callers to the Hotline were between the ages of 0 to 25 years old (1% were 15 or younger).
- West County Community Services provided crisis support services to 93 individuals designated to stabilize individuals and families in their homes, shorten the amount of time that individuals and families stay in shelters, and assist individuals and families with securing affordable housing.

Thirty-five percent (35%) were to individuals between the ages 0 to 25.

Community Organizations engaging historically underserved populations to increase access:

- Positive Images is the only agency in Sonoma County serving the unique needs of Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex, Asexual, Agender youth ages 12 to 25. Mental health services target the LGBTQ+ with a special emphasis of youth of color ages 12-25 and their parents and caregivers through education, training, and information. Positive Images served 811 individuals.
- Community Baptist Church Collaborative is located at Community Baptist Church in Santa Rosa and was the denomination's first African American church. Currently, CBC has an ethnically and culturally diverse congregation. CBC provides programming and services to children, youth, and their families including special services to seniors that are supported by volunteers and donations. Eight hundred and eighty-eight (880) children and youth from birth to age 15 and transition age youth 16 to 25 received mental health information and education through 3 programs targeting these ages groups: The Village Project (children 8-12), Saturday Academy (adults bring a youth relative or friend), and Rites of Passage (youth 14-18). The Saturday Academy conducted 2 QPR trainings. Outcomes following the QPR 71% of all who attended stated they were more likely to ask someone if they were thinking about suicide. 77% stated their level of understanding about suicide and suicide prevention were rated high compared to 39% before.
- Latino Service Providers serves and strengthens Hispanic families and children by building healthy communities and reducing disparities in Sonoma County. LSP's vision is a community where Latinos are fully integrated by having equal opportunities, support, and access to services in the pursuit of a higher quality of life. Mental health engagement services were provided 1,341 individuals up to the age of 25 with resources that increase access by reducing stigma about mental health.

School Based Services to engage individuals to increase access:

- Santa Rosa Junior College PEERS (People Empowering Each Other to Realize Success) Coalition mobilizes the student voice to increase the ability to effectively raise awareness of mental health and increase utilization of services. The PEERS Coalition reached 890 students. SRJC also provides students with and on-line health magazine that was visited by 3,032 students.
- Project SUCCESS Plus (PS+) Collaborative provides substance use prevention and early intervention with high school students in 16 mainstream and alternative high schools High Schools throughout Sonoma County 1,982
- La Luz Center at El Verano Elementary School Family Resource Center provides a Behavior Specialist and Behavior Interventionist to work with students (pre-K to 5th grade) who need short term behavioral support.

Community Health Centers engagement programs to increase access:

- Sonoma County Indian Health Project: Aunties and Uncles Mentorship Program for children and

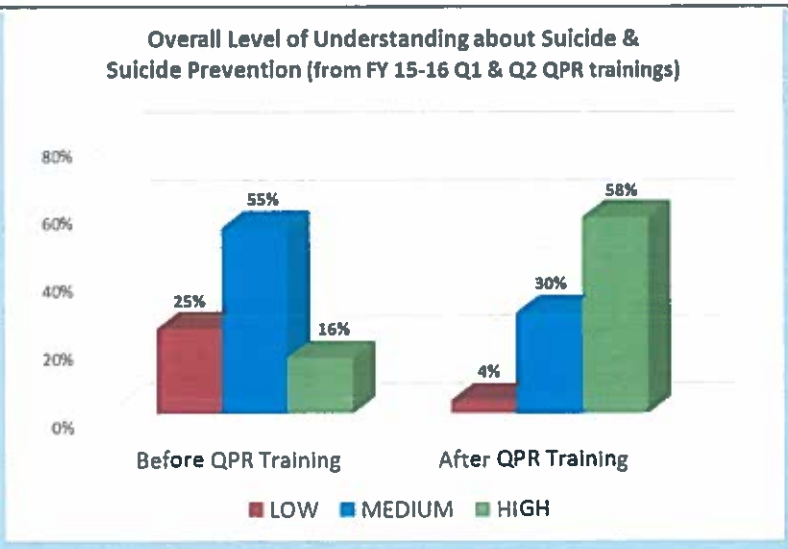
youth from birth to age 25 and **depression screening** for 1,818 youth ages 15 to 24 in the medical clinic and provided **psychiatric consultation**, including medication supports and case management to 150 individuals ages of 16 to 25.

- Alexander Valley Health Center: 1,698 children between the ages of 5 to 11 and 1,770 youth ages 12 to 19 years received behavioral health **screenings** using the **Pediatric Screening Checklist**. As a result, a total of 136 children and youth received behavioral health services at the health center from a licensed clinical social worker, psychologist or psychiatrist.
- Alliance Health Center: 4% of children and youth ages 16-25 received a face-to-face **psychiatric consultation**
- Santa Rosa Community Health Centers 27% (218) of children and youth from birth to age 25 received face-to-face **psychiatric consultation** including medication supports and case management. Seven hundred and sixty-four (764) children, youth, and parent/caregiver received patient support groups, and/or **mental health treatment**: brief therapy and/or Parent Child Interaction Therapy (PCIT).
- West County Community Services provided warm hand off from primary care provider; rapid psychosocial assessment; mobilization of psychosocial supports; stabilization counseling (case management), Follow-up services through the crisis, linkage with needed services including referral to Russian River Health Center or other therapy services or for assessment for specialty mental services to 5%.

Sonoma County Behavioral Health engagement programs to increase access:

- Community Intervention Program provides outreach and engagement services to Sonoma County's most vulnerable individual. These populations include: people who are homeless, people who abuse substances, Veterans, the LGBTQQI community, individuals who are geographically isolated, ethnic and cultural communities, and the like. CIP provided services to 116 individuals age 0 to age 25. Outreach and Engagement Services include: Triple P – Positive Parenting Program that target locations where Latino families congregate; specifically at churches. CIP uses the and adapted the evidence based **Adult Needs and Strengths Assessment (ANSA)** and **Child Assessment of Needs and Strengths (CANS)** to **screen** for mental health needs.
- Crisis Assessment, Prevention, and Education (CAPE) Team focuses on the high school and college aged population. In the fiscal year, the CAPE Team provided crisis intervention services to 442 unduplicated youth. CAPE uses the evidence based **Crisis Assessment Tool (CAT)** to **screen** for mental health crisis for individuals under 18 and the **ACAT (Adult Crisis Assessment Tool)** for individuals who are 18 to 25.

CAPE also provided QPR (Question, Persuade, Refer) suicide prevention training to 3,709 high school students. Below is a sample of training outcomes:



- Mobile Support Team provided crisis intervention services to 611 individuals; 14% were 15 or under and 26% were 16 to 25 years old. MST uses the evidence based Crisis Assessment Tool (CAT) to screen for mental health crisis for individuals under 18 and the ACAT (Adult Crisis Assessment Tool) for individuals who are 18 to 25.

QUESTION 1B:

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

Unless otherwise specified, services outlined above are provided to transition age youth. The above organizations use the following strategies:

- Integrate services into pre-existing activities/services/programs
- Hire individuals that identify/share similar experience of the populations targeted
- Provide services were populations the organizations targets naturally congregate
- Provide services in the language of the populations the organizations target
- Increase awareness about mental health issues and the impacts on targeted communities
- Provide incentives for participation
- Work with trusted community members to become a trusted provider
- Provide services in non-traditional settings (churches, businesses, etc.)
- Utilize existing structures for engagement (community gatherings, meetings, etc.)
- Use alternative methods for engagement (storytelling, art projects, etc.)
- Use alternative forms of communication (email, websites, texts)

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 √ No____. If yes, please list briefly.

The MHB understands that there has been an influx of new beneficiaries and that the County struggles to keep up with the increased demand. In spite of this increased demand, the County is doing well to serve API and Latinos. However, the MHB also recognizes the need to increase penetration rates, specifically with Latinos, and understands that there is a Performance Improvement Plan in place to address this issue.

The MHB also recognizes the unmet need for supports for parents of children, adolescents, and transition age youth.

The MHB also recognizes that there are data limitations for the data provided by the Council about the services of the County MHP.

QUESTION 1D:

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

Sonoma County Behavioral Health contracts with organizations whose express purpose is to assist parents/family members/caregivers of children, youth, and transition age youth (TAY) to engage in services in order to access services for children with mental health needs. These engagement and access services include:

Buckelew Family Service Coordination (FSC) Program empower family members of adults with mental illness by helping them gain competencies in system navigation, providing education about mental illness, helping them develop knowledge of, access to, and contact with community resources and supports. The FSC program maintains a flexible, collaborative, and recovery-oriented approach. Five percent of FSC services targeted transition age youth ages 16 to 25. FSC uses the Zarit Burden Interview tool to survey participants to assess effectiveness of services. A sample of the findings are as follows:

- Systems Navigation: 100% of families reported accessing 2 or more resources for their loved one (consumer).
- Education and Support: 100% of families reported that they strongly agree or agree that they have a better understanding of mental illness and how mental illness can affect the entire family system.
- Empowerment and Self-Efficacy: 100% of families reported strongly agree or agree that they have a sense of increased hope and empowerment for their family member's well-being.

NAMI – Sonoma County provides services to the families and loved ones of mental health consumers. Some of these services target the general community, others are targeting specific groups.

- Services targeting the general community include: warmline; advocacy and outreach focusing on underserved communities, referrals to NAMI Signature programs, educational groups, support

groups, resource information and referrals. Nine percent of NAMI's services targeted children, youth, and transition age youth.

- Services targeting family/caregivers/loved ones whose family member has experienced a crisis: NAMI – Sonoma County also has a contract with Sonoma County Behavioral Health to provide follow up to family members referred by the Mobile Support Team (MST) and the Crisis Assessment, Education, and Prevention (CAPE Team).
- Services targeting school age youth: NAMI Sonoma County also has a project funded through Project SUCCESS Plus (PS+) that focuses on schools. Under PS+, NAMI provides services that are tailored to the needs of each school. For example: Cotati-Rohnert Park hosted a presentation by NAMI and sponsored by PS+ and Rancho Cotati PTA: "Parents and Teachers as Allies, Windsor gave 4 presentations for parents during the fall on suicide prevention, anxiety and a presentation in Spanish on mental health education.

La Luz Center at El Verano Elementary School Family Resource Center in Sonoma Valley provides Parent Coaching, intensive services to meet the immediate needs of families whose children attend El Verano Elementary School.

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]

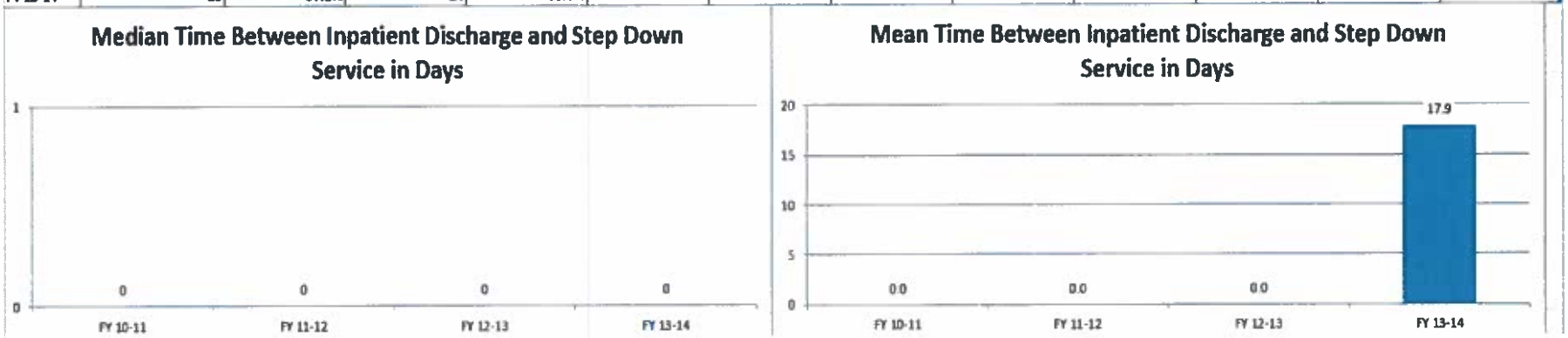
[14] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

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

Your County: Sonoma

Sonoma 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	^	^	^	^	^	^	^	^	0	0	0.0	0
FY 11-12	^	^	^	^	^	^	^	^	0	0	0.0	0
FY 12-13	^	^	^	^	^	^	^	^	0	0	0.0	0
FY 13-14	20	57.1%	24	68.6%	^	^	^	^	0	136	17.9	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. On lower left side graph, the median time for follow-up is the most useful measure of this outcome. Zero days would indicate that clients were seen as outpatients on the same day as the hospital discharge. Also take note of mean time (average) from discharge to step-down services (right side graph).

^ = Data redacted due to small numbers and HIPAA/privacy regulations. Nonetheless, we can see that there is some useful data for FY 13-14 in the last row of the Table at the top of the figure, indicating some success in providing follow-up services after discharge.

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 √ No____.

If no, please describe your concerns or recommendations briefly.

Beginning in fiscal year 2008/09 Sonoma County Behavioral Health (SCBH) – Mental Health Plan (MHP) joined medium sized counties in a statewide Performance Improvement Project (PIP) with the purpose of engaging Medi-Cal beneficiaries and unfunded individuals into specialty mental health services if necessary as well as preventing psychiatric re-hospitalization.

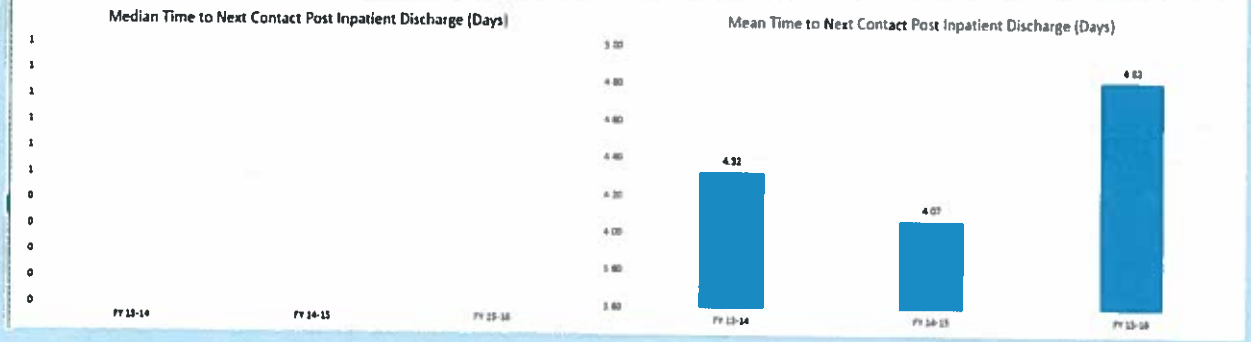
SCBH undertakes post psychiatric hospitalization services to the following populations:

a. Sonoma County Medi-Cal beneficiaries who ARE currently receiving specialty mental health services from SCBH MHP,
b. Sonoma County Medi-Cal beneficiaries who ARE NOT currently receiving specialty mental health services from SCBH MHP, and
c. Medically indigent adults – individuals over the age of 18.

The data presented below represents children, youth, and transition age youth who experienced a psychiatric hospitalization and were eligible to receive post psychiatric hospitalization services.

Figure 4a: Sonoma County MHP Data: Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization

Services FY	Number of Psychiatric Hospitalizations	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 StepDown within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 days of 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 13-14	139	94	67.63%	114	82.01%	3	22	15.83%	0	39	4.32	0
FY 14-15	209	141	67.46%	170	81.34%	5	34	16.27%	0	45	4.07	0
FY 15-16	188	127	67.55%	150	79.79%	7	31	16.49%	0	48	4.82	0



The differences in the data provided by the DHCS to the CA Behavioral Health Planning Council in Figure 4 and the data provided by SCBH – MHP Figure 4a may be attributed to the methodology used to collect the data.

Figure 4 counts data only through claims. Specialty Mental Health Medi-Cal claims only occur when Sonoma County Medi-Cal beneficiaries ARE currently receiving specialty mental health services from SCBH MHP.

Figure 4a provided by Sonoma County MHP counts data through:

- Specialty Mental Health Medi-Cal claims for post psychiatric hospitalization services provided to Sonoma County Medi-Cal beneficiaries who ARE currently receiving specialty mental health services from SCBH MHP, AND
- Information collected during post psychiatric hospitalization services provided to Sonoma County Medi-Cal beneficiaries who ARE NOT currently receiving specialty mental health services from SCBH MHP, AND
- Information collected during post psychiatric hospitalization services provided to Medically Indigent Adults (MIA) – individuals over the age of 18 – this category would include transition age youth up to age 26.

The sample in Figure 4a demonstrates a significantly larger number of individuals receiving post psychiatric hospitalization services.

Figure 4a demonstrates Sonoma County MHP mean time to next contact following a psychiatric hospitalization discharge is just over 4 business days. This is 3 days faster than the Division standard of 7 business days and well below the standards put out by the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a tool used by more than 90% of America's health plans to measure performance on important dimensions of care and service.

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.

Post psychiatric hospitalization services:
The strategy Sonoma County MHP has undertaken regarding post psychiatric hospitalization services is to provide home visits. Home visits take place within 7 business days of discharge from a psychiatric hospital. SCBH MHP's hospital discharge planners arranges the visits with SCBH staff. Psychiatric inpatient hospital discharge staff inform the individual of the home visit and SCBH follows up with a phone call to the individual or his/her parent/caregiver.

SCBH staff person is required to make the post psychiatric home visit within 7 business days of psychiatric hospital discharge. Assignments are made to the following staff:

a. For Sonoma County Medi-Cal beneficiaries who ARE currently receiving specialty mental health services from SCBH MHP, SCBH Youth & Family, including the Transition Age Youth Full Service Partnership staff (Y&F including TAY) PSC is responsible for clients on their caseload;
b. Sonoma County Medi-Cal beneficiaries who ARE NOT currently receiving specialty mental health services from SCBH MHP, the Crisis Assessment, Prevention, and Education (CAPE) Team for children and youth under the age of 18 and the Community Intervention Program (CIP) generally for individuals over the age of 18.
c. Medically indigent adults – individuals over the age of 18, generally CIP provides this

services for individuals over the age of 18.

Post Psychiatric Home visits focus on 4 specific areas for the individual and his/her parent/caregiver:

1. Assessment of how the client is doing post hospitalization. During the post psychiatric home visit, staff who visit individuals on their caseload will assess the need to increase the level of care needed to prevent re-hospitalization and promote recovery and resilience. For individuals who are visited by CAPE and CIP, the staff complete an evidence based outreach screening tool Child Assessment of Needs and Strengths (CANS) for individuals under 18 or the Adult Needs and Strengths Assessment (ANSA) for individuals over the age of 18 checklist to determine the need for specialty mental health services.
2. Medication Adherence to ensure that the individuals who wish to take medications is able to fill any prescriptions, understands the medication regimen, etc. and for those who do not, that the individuals has other strategies for coping with issues that may arise related to the initial psychiatric hospitalization.
3. Environment Check to ensure the living arrangement is safe and conducive to recovery vis a vis, other inhabitants, food availability, etc.
4. Follow-up appointment(s) with MD, personal service coordinator, Access Team, or outside provider including assisting the individual to make the follow up appointment, potentially providing reminders, assisting with transportation services, reminder calls, etc. Parents/Caregivers are also provided with support resources.

There are occasions when a post psychiatric hospitalization home visit is not possible. This most often occurs when an individual is placed outside of the county in a group home or in a locked psychiatric facility. In these cases, Y&F, including TAY provides will call the facility to ensure the individual is getting their needs met, to coordinate follow up treatment and assess future need.

The MHB encourages transparency to ensure care givers for those placed out of county follow the same protocols for Sonoma County beneficiaries in residence.

The MHB recommends that the staff ensure the same rigor of follow up by providers to individuals who cannot receive a post hospital home visit.

For mental health crisis NOT involving psychiatric hospitalization:
Most mental health crisis do not require psychiatric hospitalization. SCBH MHP has numerous avenues to assist. These include:

- The Crisis Assessment, Prevention, and Education (CAPE) Team: The Crisis Assessment, Prevention, and Education (CAPE) Team is a prevention and early intervention strategy specifically designed to intervene with transition age youth, ages 16 to 25, who are at risk of or are experiencing first onset of serious psychiatric illness and its multiple issues and risk factors: substance use, trauma, depression, anxiety, self-harm, and suicide risk. The CAPE Team aims to prevent the occurrence and severity of mental health problems for transition

age youth.

- The purpose of the Community Intervention Program (CIP) is to provide outreach to disparate populations (those who have been historically underserved by mental health services) in an effort to engage people from these populations into mental health services. CIP focuses its activities on reaching, identifying, and engaging unserved individuals and communities in the mental health system, and reducing disparities identified by Sonoma County.
- Sonoma County Department of Health Services Behavioral Health Division has partnered with law enforcement to implement the Sonoma County Behavioral Health (SC-BHD) Mobile Support Team. The Mobile Support Team (MST) is staffed by behavioral health professional who provide field-based support to law enforcement officers responding to a behavioral health crisis.
- Crisis Stabilization Unit (CSU) provides 24 hour-a-day, 7 day-a-week crisis intervention, assessment, medication, and up to 23 hours of supportive care for individuals in an acute mental health crisis. Services are available at CSU for children, youth, adults, and their families. Referrals are made to Crisis Residential Services or inpatient mental health facilities for those needing a higher level of psychiatric inpatient care.
- 24 Hour Hotline is available to any Sonoma County resident who needs help. The hotline is a vital resource to any family member, loved one, friend or ally who may be worried about someone who may be suicidal. The hotline is administered by the *North Bay Suicide Prevention Program*.

For Sonoma County Medi-Cal beneficiaries who ARE currently receiving specialty mental health services from SCBH MHP, SCBH Youth & Family, including the Transition Age Youth Full Service Partnership staff (Y&F including TAY) the PSC will assess the individual for the need for more intensive services. Intensive services could include a transition from an outreach team to an intensive outreach team such as a Full Services Partnership (FASST or TAY).

- Family Advocacy, Stabilization and Support Team (FASST) is an FSP that provides family-centered wraparound specialty mental health services for children who are at risk for out of home placement.
- Transition Age Youth FSP is multidisciplinary teams that provides intensive field based specialty mental health services targeted at Transition Age Youth (TAY) ages 18-25. FSP has a "whatever it takes" philosophy for working with individuals.

Sonoma County Medi-Cal beneficiaries who ARE currently receiving specialty mental health services from SCBH MHP, SCBH Youth & Family, can also be referred to contactors to receive more intensive interventions such as Therapeutic Behavioral Services (TBS) or WRAPAROUND.

- Therapeutic Behavioral Services (TBS) is an intensive, individualized, one-to-one behavioral coaching program available to children/youth up to age 21 who are experiencing a current emotional or behavioral challenge or experiencing a stressful life transition.
- WRAPAROUND services provides services to surround multi-problem youngsters and families with customized services that are not Medi-Cal claimable. These services are holistic, strengths based, and individualized for the family. WRAPAROUND is approach is more a

process than a service. Children who qualify for Medi-Cal qualify for WRAPAROUND services. (*WRAPAROUND is process that provides child and non-minor dependents with family-based service alternatives to group home care. It is NOT a mental health service. WRAPAROUND is funded through State and county share of foster care placement dollars that would have otherwise been paid to a group home. The State and county share of foster care funds can be used in a flexible manner to provide Wraparound Services.)*

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.

As stated in the above questions, SCBH provides supports to parents and caregivers as well as the child, youth, transition age youth following a psychiatric hospitalization or a mental health crisis. Families are referred provided with the following referrals for supports:

- Buckelew Programs Family Services Coordination provides support, navigation, education and advocacy for family members/caregives of individuals with mental illness to help access both public and private mental health services.
- National Alliance on Mental Illness (NAMI) Sonoma County provides education, support, and advocacy through groups, Warmline, lending library, workshops, training, and advocacy to family members and loved ones with mental health issues.
- 24 Hour Hotline is available to any Sonoma County resident who needs help. The hotline is a vital resource to any family member, loved one, friend or ally who may be worried about someone who may be suicidal. The hotline is administered by the *North Bay Suicide Prevention Program.*
- Crisis Intervention Training for Law Enforcementis a community partnership of law enforcement, mental health and addiction professionals, individuals who live with mental illness and/or addiction disorders, their families and other advocates. It is an innovative first-responder model of police-based crisis intervention training to help persons with mental disorders and/or addictions access medical treatment rather than place them in the criminal justice system due to illness related behaviors. It also promotes officer safety and the safety of the individual in crisis.

Question 2B outlines other services available to support family members/caregivers of individuals receiving services for specialty mental health (WRAPAROUND, TBS)

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.

Question 2A - **Post psychiatric hospitalization services** section outlines services that are made available to individuals outlined in Question 2A.

Question 2B - **For mental health crisis NOT involving psychiatric hospitalization** section outlines services available to all Sonoma County residents who may be in crisis who are not currently receiving specialty mental health services.

Sonoma County also has other strategies for mental health crisis.

- The Crisis Intervention Training for Law Enforcement that provides 32 hours of mental health training for officers who are in the field.
- The Community Intervention Program will expand to outreach to individuals, specifically transition age youth who may be in a mental health crisis.
- The Mobile Support Team responds in partnership with law enforcement in the field to any Sonoma County resident who may be experiencing a mental health crisis
- The Crisis Assessment, Prevention, and Education Team responds to high school age youth who may be experiencing a mental health crisis.

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

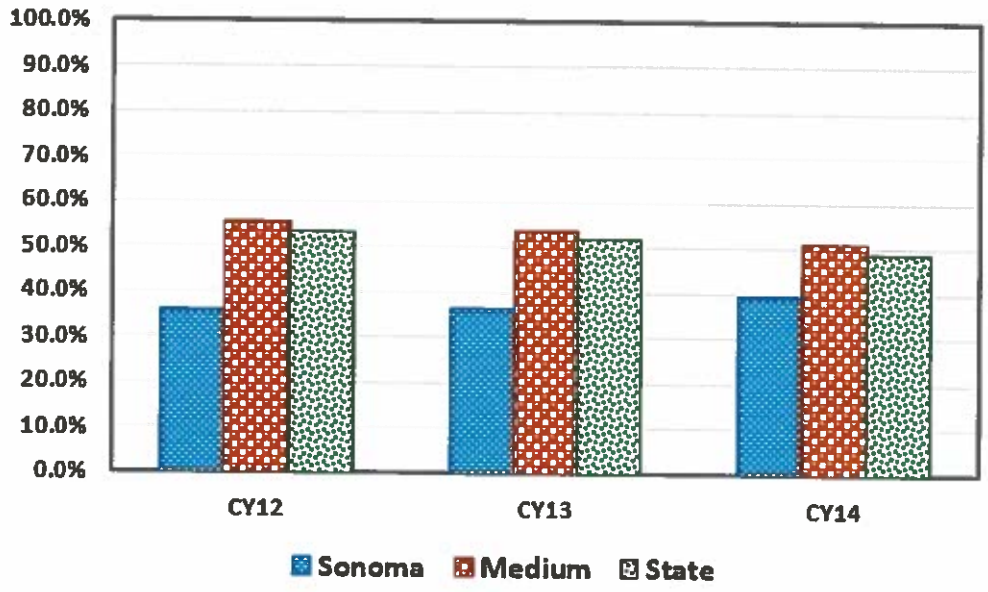


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows 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.

Sonoma County's Mental Health Plan (MHP) and Child Welfare Services (CWS) employs a number of strategies to ensure that the provision of mental health services is a priority for foster youth. These strategies include:

SCBH MHP has a dedicated screener that is co-located at the CWS Family, Youth, and Children's Services (FY&C) office and the emergency shelter Valley of the Moon (VOM). This clinician screens every child entering the FY&C system and tracks the screening, referral, assessments completed and the outcomes on an excel spreadsheet.

Joint data base:

- SCBH MHP screener has access to CWS FY&C and updates basic information about dates of SCBH screenings and referrals for assessments.
- SCBH screener updates tracking spreadsheet and has a system in place to receive regular updates about incoming children and the outcomes of assessments.

Electronic Health Record (EHR) accessible to both CWS and MHP

- SCBH screener accesses the MHP EHR and assessment database (DCAR) and also has access to CWS database

Screening/Referral/Assessment Coordinator

- This dedicated screener directly communicates with SCBH program managers about new referrals for assessments. SCBH facilitates a weekly assessment meeting with the MHP assessors and tracks outcomes on an Assessment excel spreadsheet.

All children who screen positive for mental health needs are offered a full assessment. SCBH clinician screens youth by utilizing an Outreach Child Assessment of Needs and Strengths (CANS) to screen for need. An algorithm is used to determine level of care. Those youth who are screened to have mental health need are referred to the MHP Youth and Family Services (YFS) for a full assessment. YFS utilizes an assessment tracking excel spreadsheet to track all referrals and outcomes of assessments. YFS facilitates a weekly assessment meeting to review all completed assessments to assign to treatment services based on an algorithm that determines level of care. All of these activities are tracked and monitored by the program managers of SCBH.

FY&C implemented an evidence based "access-linkage" model identified to be effective in the delivery of services to families who present with multiple co-occurring problems: *Together to Engage, Act and Motivate - (TEAM).* TEAM staff employs effective strategies including facilitating

multi-disciplinary, family-involved, team meetings, outreach to families, advocacy, and service coordination with all youth coming into the foster care system. SCBH MHP staff regularly participate on the TEAMs which serves as the Child Family Team (CFT) consistent with the Core Practice Model guidelines for Pathways to Wellness.

- Family and children are involved in every point of the decision-making and engaged in the design of every aspect of the service plan.
- Members of the CFT have included clergy, family elders, ILP coordinators, friends and anyone else of the child or family's choosing.

SCBH Clinicians are the Intensive Care Coordinator's (ICC). SCBH provides ICC and Intensive Home Based Services (IHBS) that embody the principles of the Core Practice Model and are family centered, individualized, culturally relevant and strength based, designed to ameliorate mental health conditions that interfere with a child's successful functioning in the home and community. Services are administered by a team in a community based setting, and rely on natural community supports to develop a child and family services plan.

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__√__ No____. If no, please explain briefly.

Sonoma County has a shared Mental Health Plan and Child Welfare Services management structure, as evidenced by joint meetings, joint trainings, co-location of services, and implementation of joint policies and procedures that guide the work. This shared management structure ensures coordination at the departmental level.

Outlined in the previous question are the co-location of services and how joint policies and procedures have been implemented to ensure foster youth receive the appropriate mental health services.

Sonoma County also seeks stakeholder input process that includes providers, family members, and foster youth. This is done through stakeholder meetings, surveys, focus groups, discussion forms, and the like. Examples of stakeholder input includes:

- Foster Care Coalition – Leadership from community agencies that serve foster youth, along with leadership from the following: School District, Probation, Behavioral Health, and FY&C. Formed in 2015 and meets quarterly.
- The Children's Collaborative Meeting – includes community members and providers;
- As part of participation in the statewide evaluation of the IV-E Waiver, FY&C surveys parents and CWS social workers, foster parents, and foster youth.

SCBH and Human Services FY&C participate in a shared management process whereby both organizations meet regularly to discuss systems issues, client issues, and other areas of coordination and concern. In order to do so, SCBH and SC- HSD FY&C have regularly scheduled meetings. These regular meetings include:

Leadership Team
Purpose: Discuss systematic issues that affect service provision: budget, staffing, changes in mandates, data and evaluation review of outcomes, quality improvement plans. Members: Behavioral Health Division (BHD): Director, Section Manager for Youth & Family Services, Quality Improvement Manager, Foster Youth Team (FYT) Program Manager. Family, Youth, and Children's Services Division (FY&C): Director, 2 FY&C Section Managers. Meeting Schedule: Quarterly

Managers Team
Purpose: Discuss operations issues related to implementation of services, workflow, and co-location issues, etc. Members: BHD FYT Program Manager; FY&C Section Manager; Meeting Schedule: Monthly

TEAM/TDM (Team Decision Making) Expansion Meeting
Purpose: To improve the number and efficiency of Child Family Team meetings; Members: FY&C Supervisor, Section Manager, FY&C staff; BHD FYT Program Manager; Meeting Schedule: Monthly

Placement, Assessment and Resource Committee, (PARC)
Purpose: To address the appropriate level of care needs for placement when considering ITFC, Wrap Around, or Residential Treatment with the goal of keeping children in the least restrictive setting possible. Members: 2-3 FY&C Section Managers, FY&C social worker for cases presented ; Sonoma County Office of Education (SCOE) Representative; BHD FYT Program Manager, FYT clinician for cases presented; Meeting Schedule: Bi-Weekly

Case Management Council (CMC)
Purpose: Discuss referrals and level of care needs for outpatient specialty mental health services and WRAPAROUND. Members: Department of Probation representative; FY&C Section Manager; Sonoma County Office of Education representative; BHD FYT Program Manager, SCOE representative; SENECA Family of Agencies representative; Meeting Schedule: Bi-Weekly

The MHB suggests that the MHP should train and coordinate with school psychologists.

QUESTION 3C:

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

Yes_√__ No____. 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? __√__ Yes ___ No.

If yes, please list and describe briefly.

Positive Images is a community-based non-profit and is the only agency in Sonoma County serving the unique needs of Gay, Lesbian, Bisexual, Transgender, Queer, Gender-Queer, Questioning, and Intersex (GLBTQQI) youth ages 12 to 25. Positive Images provides seminars teaching youth, staff, volunteers, and the community about the indicators of mental distress specific to the GLBTQQI population; enhancing relationships with ethnic communities through targeted recruitment for youth and adults of color for peer and mentoring programs; sharing information with all partners, especially faith-based groups, law enforcement, and juvenile justice organizations; and training youth outreach workers to engage more GLBTQQI youth and allies in programs and services. This program receives funding from Mental Health Services Act – Sonoma County Prevention and Early Intervention (PEI) component.

LGBTQ Connection Napa • Sonoma is an initiative fueled by youth and other emerging leaders, fosters a healthier, more vibrantly diverse and inclusive community. Each year, LGBTQ Connection engages 3,500 LGBTQ people, their families and community, and trains 500 providers from local organizations across Northern CA to increase the safety, visibility, and well - being of LGBTQ residents. In Napa and Sonoma Counties the program operated local LGBTQ community centers, supporting underserved LGBTQ youth and elders. The Napa and Sonoma office of the LGBTQ Connection each provide a safe and trusted space to cultivate hubs of vibrant activities and caring community. This programs received funding from Mental Health Services Act- statewide dollars from State of CA: Public Health Department: Office of Health Equity.

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__√__ No____.

If yes, please list or describe briefly.

- Positive Images
- NAMI – Sonoma County

QUESTION 4C:

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

Yes__√__ No____. If yes, please list or describe briefly.

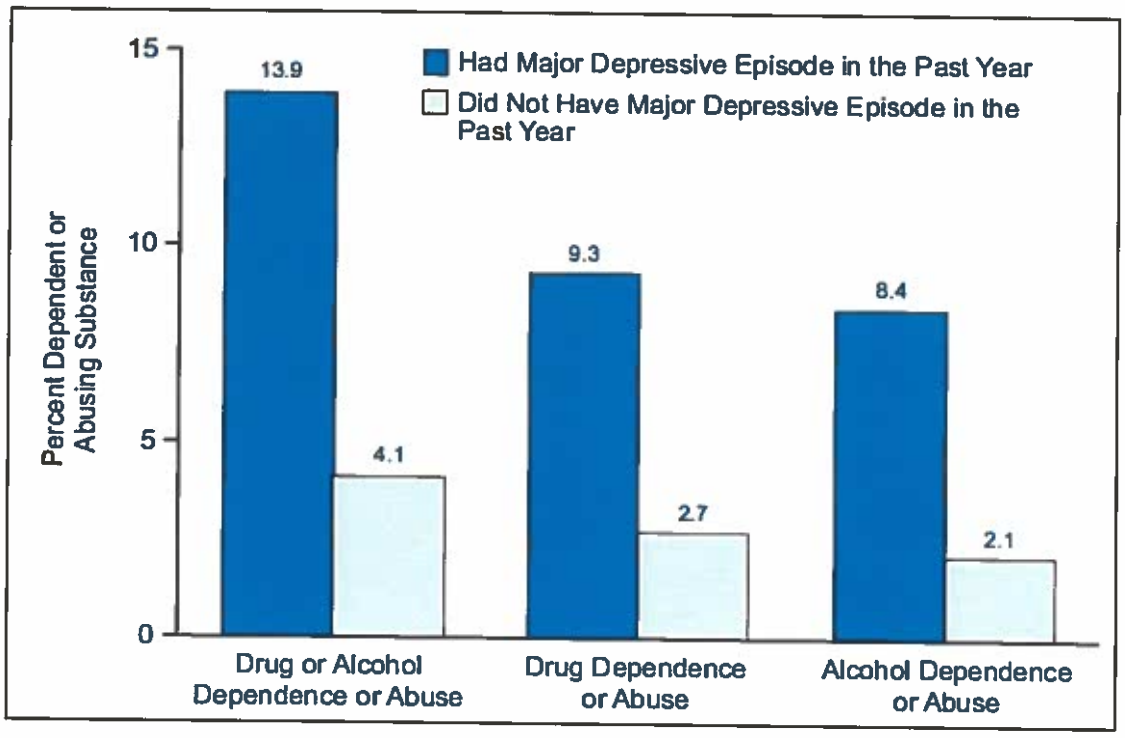
Sonoma County has a large, but invisible LGBTQQI community that supports, accepts, and helps the LGBTQQI community.

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

Sonoma County:

Alcohol/Drug Use In Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	Any	None
7th Grade	9.7%	90.3%
9th Grade	29.7%	70.3%
11th Grade	45.6%	54.4%
Non-Traditional	67.9%	32.1%
All	34.7%	65.3%

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: Sonoma

Age <18: 306 **Age 18-25: 571**

QUESTION 5A:

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

If yes, please list or describe briefly.

Currently, SCBH contracts with community organizations to provide substance use disorders treatment. These providers implement services for youth and for children, services are provided to mothers. These services include:

For Women and Children, including Perinatal Treatment:

Drug Abuse Alternative Center (DAAC) Perinatal Intensive Day Treatment Program:
The Perinatal Program offers intensive outpatient services for pregnant and parenting women who have alcohol or other drug problems. A safe and nurturing environment supports a woman's recovery with individual and group counseling sessions. Transportation is provided to and from treatment with co-op childcare, a nutritious snack and sessions covering topics centered around pregnancy and parenting and also include denial management, relapse

prevention, coping skills, nutritional education, life skills, and developmental screening for participating children. Clients attend sessions daily Monday – Friday for an average length of 9-12 months.

Women's Recovery Services (WRS): WRS provides residential treatment services WRS Treatment Programs provide a highly structured daily program, including comprehensive substance dependence education, evidence based groups on self-esteem, trauma, parenting education, non-violent communication, relationships, and a weekly process group. WRS provides a daily Children's Program, guided by a Child Care Provider and Parenting Educator, while women are in treatment groups each day and evening. Each women is assigned an individual case manager who will guide her throughout her treatment stay and will address issues related to her successful completion of the treatment program.

California Human Development (CHD) for Women and Children: CHD provides residential treatment services at Stonehouse. This 40-bed comprehensive residential treatment program is based on respect, compassion, and the knowledge that successful recovery encompasses the whole person—the mind, the body, and the spirit. Because it takes commitment and time to overcome addiction, our program offers residential treatment from 30 days to 12 months with 26 weeks of free aftercare. We recommend a minimum of 90 days for greatest success. Treatment services include: Individual and group counseling, Exercise, nutrition, and life-skills programs, Parenting education and family reunification. Job readiness preparation, Housing and employment assistance, Relapse prevention, anger management, and self-esteem training, Extensive 12-Step involvement

Services for Youth

DAAC
Outpatient Treatment for Youth At the main Santa Rosa facility and a satellite site located at Ridgway High School, Outpatient Treatment provides assessment, evaluation, education and counseling for youth (ages 12-18); parental consent is not required, although parental involvement is encouraged. Designed to support youth and their families in achieving a life free from substances, Outpatient Treatment provides individual, family, and group counseling, as well as case management, life skills training, and peer support. The length of treatment is based on the youth's needs and completion of individualized treatment goals. Groups focus on alcohol and other drug education, relapse prevention, development of a sober and healthy support network, and integration of recovery tools into the young person's daily life. Family members are encouraged to participate in treatment whenever possible, participating in collateral/family sessions and the free weekly Family and Friends Support Group. Most youth qualify for Minor Consent Medi-Cal; therefore, there is no cost to the youth or his/her parents. Hours: Monday - Thursday 9:00am - 9:00pm, Friday 9:00am - 5:00pm

Adolescent Treatment Program (ATP/ATEP): The Adolescent Treatment Program provides weekly youth outpatient treatment at various sites in the outlying areas of Sonoma County including the mainstream and alternative/community schools of the following districts: Cloverdale, Windsor,

Healdsburg, Sonoma Valley, West County (Forestville), Cotati-Rohnert Park, Petaluma and at YouthBuild Santa Rosa (in partnership with John Muir Charter School and Community Action Partnership Sonoma County. *Services at Santa Rosa Junior College for young adults ages 16-25 years due to begin as of January 18, 2011.* ATP also includes a parent component whereby parents can engage in a weekly support group, participate in individual or family counseling sessions, or receive consultation by phone with regard to their child and his/her substance use issues. Services are offered at no cost to the teen or his/her family members.

Alternatives to Detention (A2D) : Supported by Sonoma County Juvenile Probation, Alternatives to Detention serves youth ages 14-17 years of age who are currently in, or at risk of being referred from, County Juvenile Probation. Youth are engaged in both group and individual counseling services, which are client-specific. The 30-day program provides for 2-hour interactive group sessions (Monday through Friday at CHOPS Teen Club/Santa Rosa or Monday through Thursday at San Antonio High School/Petaluma) focused on issues of basic knowledge about drugs, abuse and addiction; criminal conduct and the influence of alcohol and other drugs; learning communication skills; relapse prevention, including identification of triggers and high-risk situations and managing cravings and urgings; coping and avoidance skills; assertive skills development; strategies to enhance self-control, recognize triggers and learn coping skills to avoid high-risk situations and the desire to use; understanding values and moral development; understanding and practicing empathy; selecting a support system and/or peer group and conflict management. Services are offered at no cost to the teen or his/her family members. Youth at the CHOPS Teen Club location in Santa Rosa are also given a one-year pass to CHOPS, with access to the facilities and programs of the club.

CHC
Outpatient Treatment for Youth throughout Sonoma County. Services include: evaluation, assessment and individual treatment plans; individual and group counseling sessions with groups for teens; referrals to community services such as housing, employment, health coverage, and food and legal assistance; and transition planning to prevent relapse. Services are offered in English and Spanish and are bicultural in approach. Our clients gain a clinical understanding of their addiction and build new life skills to support long-term sobriety.

The MHB looks forward to Sonoma County's 2017 implementation of the Drug Medi-Cal-Organized Delivery System (DMC-ODS) Pilot Program. DMC-ODS will provide services to youth that will include; screening, assessment, intake, case management, outpatient and intensive outpatient, therapy (individual, group, and family), recovery services.

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___.

Please explain briefly.

The MHB is looking forward to see what develops with the new DMC-ODS services and how the services develop especially for Transition Age Youth ages 18-25

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 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."

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[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.

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.

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.

[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/

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
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.

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[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

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: Sonoma **326 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 √ No ___.

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

PROGRAM:	FUNDING SOURCE:
Specialty mental health services including assessment, crisis intervention and stabilization, and medication monitoring are provided to adolescents receiving services through other Sonoma County Department of Human Services programs: Los Guilicos Juvenile Hall; Valley of the Moon Children's Home; Child Protective Services	Juvenile Probation
Substance Use Disorder Services for Children and their Families include: Dependency Drug Court provides court-supervised case management and referral to treatment programs for parents and guardians whose children have been, or are in danger of being, removed from the home due to substance use issues. Drug Free Babies case management program is for pregnant and delivering women to reduce the negative impact of prenatal tobacco, alcohol, and other drug exposure.	Juvenile Probation

QUESTION 6B:

[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.

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___

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

PROGRAM:	FUNDING SOURCE:
Sunny Hills ACT: Juvenile Offenders 12 years or older with Full Scope Medi-Cal can be referred to this program by a Sonoma County Juvenile Court Judge or Probation Department who meet Medical Necessity criteria for specialty mental health services in conjunction with a significant substance use disorder.	Medi-Cal reimbursement
Sunny Hills PRIDE: Juvenile Offenders 12 years or older who are on probation with gang conditions with Full Scope Medi-Cal can be referred to this program by a Sonoma County Juvenile Court Judge or Probation Department who meet Medical Necessity criteria for specialty mental health services in conjunction with a significant substance use disorder.	Medi-Cal reimbursement
SCBH Full Service Partnership Forensic Assertive Community Treatment (FACT) Team: Full Services Partnerships (FSPs) are multidisciplinary teams that provide intensive field based specialty mental health services targeted at specific populations with a service commitment of doing "whatever it takes". These focal populations include the FACT Team. FACT is an FSP that works with a probation officer to provide community-based specialty mental health services to people referred through Mental Health Court.	Medi-Cal reimbursement

QUESTION 6C:

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

Yes__√__ No___. If yes, please list briefly.

Services provided at the while youth are in custody generally do not involve parents. However, once non-custodial youth become involved with probation or diversion programs the programs outlined in Question 6B include working with family members.

The MHB suggests working with concerned families to provide supports rather than only those who are justice involved.

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.

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[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.

Sonoma County:

Table 6. Percent of High School Students Reporting Thoughts of Suicide, 2011-13

Suicidal Ideation (Student Reported), by Grade Level: 2011-2013		
Grade Level	**Yes**	**No**
9th Grade	18.7%	81.3%
11th Grade	18.3%	81.7%
Non-Traditional	22.5%	77.5%
All	19.4%	80.6%

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**_____ **If yes, please list and describe very briefly.**

Prevention Campaigns:

EACH MIND MATTERS – CA's Mental Health Movement has numerous programs to reduce stigma and discrimination, to address student mental health, and to prevent suicide. *Know the Signs* is a 5 pronged project aimed at prevention of suicide in young people. This campaign is funded with California County dollars including Sonoma County. These MHSA funds this project through CalMHSA. These resources are made available to all Sonoma County Behavioral Health contractors and other interested stakeholders. The *Know the Signs* campaign components include:

Suicide Is Preventable: This statewide media campaign's goal is to prepare Californians to prevent suicide by knowing the warning signs for suicide, finding the words to offer support, and reaching out to local resources. An array of multicultural poster, handbill, business cards, and literature are provided to contractors and other stakeholders who are interested in displaying these materials (health centers, libraries schools, social service agencies, business owners, etc.) www.SuicideisPreventable.org.

My3: My3 is a safety plan mobile app that connects users who are at-risk for suicide directly to their support network and a crisis hotline for 24-hour support. Sonoma County staff have youth download this app onto their phones following a suicide prevention training = QPR. www.my3app.org.

Your Voice Counts: This resource component provides campaign materials that can be viewed and downloaded and customized. These resources include: medial outreach toolkits, recommendations for reporting suicide, How to use social media for suicide prevention guide, and research reports. Sonoma County has distributed the AP Style Guide to all newspapers and publications throughout

Sonoma County. www.yourvoicecounts.org.

Directing Change: This statewide contest encourages high school students and college students to create a 60-second video about suicide prevention or ending the silence of mental illness. Sonoma County schools have won regional and state level awards for 3 years. www.directingchange.org.

Technical Assistance: *Know the Signs* provides Sonoma County with enhanced technical assistance and one-on-one support with suicide prevention projects in the county. Most recently, they provided technical assistance to SCBH staff to develop 'safety signs' that are posted at all SMART train stations in Sonoma and Marin counties.

Walk In Our Shoes is also part of the EACH MIND MATTERS campaign funded with Sonoma County MHSA dollars to reduce stigma associated with mental illness by de-bunking myths and education 9-13 year olds about mental wellness. The Walk In Our Shoes campaign utilized real stories from teens and youth adult to teach youth about mental health challenges and wellness.

Trainings for Youth and Gatekeepers:

QPR is an evidence based training. QPR stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. QPR can be learned in our Gatekeeper course in as little as one hour.

Each year, SCBH CAPE Team trains incoming freshman at the high schools in QPR. Last year CAPE trained over 6000 students.

Intervention specifically to address suicide

Assessing and Managing Suicide Risk: SCBH clinicians have been trained in Assessing and Managing Suicide Risk (AMSR). AMSR is a suicide prevention training for all licensed staff that presents providers with the most common dilemmas they face and the best practices for addressing these dilemmas. Clinicians use AMSR for youth who are at high risk for suicide.

Crisis Intervention

24 Hour Hotline: SCBH provides access to a 24 Hour hotline to any Sonoma County resident who may be experiencing a mental health crisis. The North Bay Suicide Prevention (NBSP) Hotline of Sonoma County, a program of Family Service Agency of Marin (FSA), provides 24/7 suicide prevention and crisis telephone counseling. FSA's highly trained and supervised phone counselors provide crisis prevention and intervention to people in distress and/or their family and friends. Counselors help to enhance the callers' coping and problem-solving skills, giving people in crisis alternatives to violence to themselves or others and relief from the profound isolation of crisis, loss and/or chronic mental illness. Accredited by the American Association of Suicidology, FSA's Hotline has been part of the National Suicide Prevention Lifeline (a toll free national number that connects callers to their closest certified crisis line) since its inception in 2005.

Mobile Support Team (MST): Sonoma County Department of Health Services Behavioral Health Division has partners with Police Departments of Santa Rosa, Petaluma, Cotati, Rohnert Park, and Petaluma as well as the Sheriff's Office to implement the Mobile Support Team. The Mobile Support Team is staffed by behavioral health professional who provides field based support to law enforcement officers responding to a behavioral health crisis, including children, youth, and transition age youth.

Crisis Assessment, Prevention, and Education (CAPE): The CAPE Team aims to prevent the occurrence and severity of mental health problems for transition age youth. The CAPE Team is staffed by licensed mental health clinicians. Services are located in most Sonoma County public high schools, Santa Rosa Junior College and Sonoma State University. CAPE provides mobile response on campus to youth who may be experiencing a mental health crisis. The CAPE Team also serves as a member of the Santa Rosa Junior College Crisis Intervention Resource Team (CIRT). CIRT deals with disruptive situations and includes representatives from District Police, Student Services, Student Health Services, Student Psychological Services, Disability Resources Department, Counseling, and Sonoma County Behavioral Health. The goal of CIRT is to prevent crises before they occur through the provision of training, consultation, and intervention on request.

Crisis Stabilization Unit (CSU): Provides 24 hour-a-day, 7 day-a-week crisis intervention, assessment, medication, and up to 23 hours of supportive care for individuals in an acute mental health crisis. Services are available at CSU for children, youth, adults, and their families. Referrals are made to Crisis Residential Services or inpatient mental health facilities for those needing a higher level of psychiatric inpatient care.

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 √ **No**_____ **If yes, please list and describe very briefly.**

CAPE Team: The Crisis Assessment, Prevention, and Education Team (CAPE Team) is a prevention and early intervention strategy specifically designed to intervene with transition age youth ages, 16 to 25, who are at risk of or are experiencing first onset of serious psychiatric illness and its multiple issues and risk factors: substance use, trauma, depression, anxiety, self-harm, and suicide risk.

The CAPE Team aims to prevent the occurrence and severity of mental health problems for transition age youth. The CAPE Team is staffed by Sonoma County Behavioral Health licensed mental health clinicians. Services are located in most Sonoma County public high schools, Santa Rosa Junior College and Sonoma State University. The CAPE Team has 5 essential components:

- Mobile Response in schools by licensed mental health clinicians with youth who may be experiencing a mental health crisis.

- Consultation, Screening, and Assessment of at-risk youth in high schools and colleges.
- Training and Education for students, selected teachers, faculty, parents, counselors and law enforcement personnel to increase awareness and ability to recognize the warning signs of suicide and psychiatric illness.
- Peer-based and Family Services including increasing awareness, education and training, counseling, and support groups for at-risk youth and their families.
- Integration and Partnership with existing school and community resources including school resource officers, district crisis intervention teams, student and other youth organizations, health centers, counseling programs, and family supports including *National Alliance on Mental Illness* and Sonoma County Behavioral Health Division (SC-BHD).

Santa Rosa Junior College PEERS Coalition: The PEERS Coalition is a program within Student Health Services that utilizes the authentic and creative voices of students to increase the conversation about mental health at SRJC. By raising awareness and reducing stigma around mental health, we foster an accepting environment that promotes student wellness and success. The PEERS student team plans events, educates students about mental wellness, and collaborates with other student groups on campus.

QUESTION 7C:

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

Yes__√__ No_____. If yes, please list briefly.

Provide prevention services to younger children, including QPR.

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 √ **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.

Funded through Medi-Cal with MHSA matching dollars, the Transition Age Youth (TAY) – Full Service Partnership targets youth who are experiencing first break psychosis. The TAY Team is a multidisciplinary team that provides intensive field based specialty mental health services targeted at youth between the ages of 18 and 25 with a service commitment of doing "whatever it takes". Specialty mental health services include medication support, targeted case management, therapy, and referral and linkage to housing, employment, and other resources. TAY Care Coordinator works closely with VOICES to provide peer supports, and Social Advocates for Youth, and Buckelew Programs to provide support for independent living.

In order to ensure appropriate interventions, SCBH received funding from SAMHSA to support training in the following evidence based interventions:

Prevention and Recovery for Early Psychosis (PREP) training for Transition Age Youth Full Service Partnership staff to assist in the integration of a number of evidence based practices that have demonstrated effectiveness in addressing the needs of individuals experiencing early psychosis. Training was provided by the Felton Institute. This training included Cognitive Behavioral Therapy for Psychosis (CBTp) and Structure Clinical Interview for DSM 5 (SCID);

- Structured Clinical Interview for DSM (SCID) training for Access, Crisis Assessment, Prevention and Education, Youth and Family Services, and Transition Age Youth Full Service Partnership mental health staff. SCID is a semi-structured interview guide for making DSM-5 diagnoses. It is administered by a clinician or trained mental health professional that is familiar with the DSM-5 classification and diagnostic criteria;

- Cognitive Behavioral Therapy for Psychosis (CBTp) training for Youth and Family Services, Crisis Assessment, Prevention and Education Team and Transition Age Youth Full Service Partnership mental health staff. CBTp is an evidence-based intervention, shown to be effective in reducing distress and functional deficits associated with psychotic symptoms. CBTp targets symptoms across the spectrum of psychosis, from individuals identified as being 'at-risk' of developing psychosis (prodromal) to early onset (including first episode/first break) and for those with chronic psychosis symptoms.

Other programs include:

- Crisis Assessment, Prevention, and Education (CAPE) Team provides crisis response to transition age youth (ages 16-25) who may be experiencing first onset of mental illness. Services are located in fifteen Sonoma County high schools, Santa Rosa Junior College, Family Justice Center Sonoma County, Positive Images, and VOICES. CAPE also provides training and education to students, family members, teachers, and other school personnel.

- Mobile Support Team (MST) responds in the community by law enforcement request to support people who may be experiencing a mental health or substance use disorder crisis. MST provides support, referral, and follow up post-crisis to the individual experiencing the crisis, as well as to family members and loved ones, in an effort to prevent the need for future crisis response.

- Community Intervention Program (CIP) provides services countywide to Sonoma County's most vulnerable populations, in their homes and at places where they congregate, on the street, or where they seek services. Populations include: people who are homeless, people with substance use disorders, ethnic and cultural communities, veterans, and people who are Medi-Cal beneficiaries or indigent, who have recently experienced a psychiatric hospitalization. CIP is available to law enforcement for pre-arranged community response.

QUESTION 8C:

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

Yes √ **No**____. **If yes, please describe briefly.**

The MHB suggests the following:

- More mental health education for children
- Parent support for children and youth who have lost contact with the schools or who are home schooled
- Engaging children and youth in projects like *Directing Change, Mental Health First Aid,* and *Bring Change to Mind.*

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 <u>your</u> 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.).

Homelessness, drug use, disconnectedness, family awareness about mental illness, dropping out of school, need for vocational education.

QUESTION 9B:

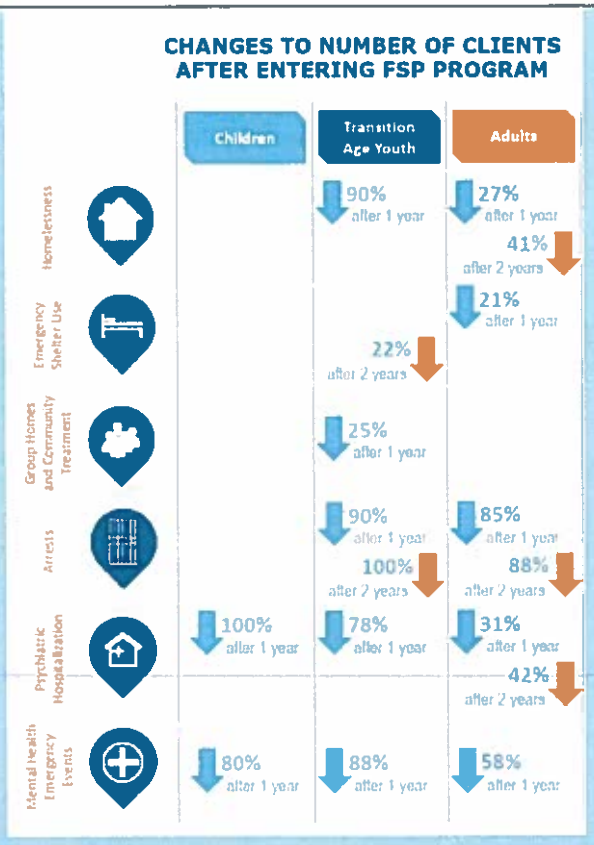
Do the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community?

The Sonoma County Behavioral Health Division (SC-BHD) provides data to the public showing how MHSA-funded services improve the lives of Sonoma County residents with serious mental illness while lowering the burdens on criminal justice, health care, and other social services. Data is publicly available on the SC-BHD website in the MHSA Annual Update at: http://www.sonoma-county.org/health/about/behavioralhealth_mhsa.asp

Sonoma County collects and reports data to the state that show that FSP services have reduced homelessness, incarcerations, and emergency room visits among Sonoma County's children and youth living with serious emotional disturbances and adults living with serious mental illness. Sonoma County Reports the number of people served, the type of service(s) provided, and the results of that service use to the Department of Health Care Services annually including data about FSPs.

The following chart illustrates some positive outcomes for Sonoma County FSP clients that were active during FY 15-16 (at least one year in the FSP program for children and two years for other clients).

Compared to the year before entering the FSP program, clients show significant reductions in areas such as homelessness, arrests, and psychiatric hospitalizations.



FSP data for Adults has been included in this report as 3% of the clients receiving services from the Integrated Recovery Team (IRT) and 19% of the Forensic Assertive Community Treatment (FACT) Team are between the ages of 18 and 25.

IRT provides intensive services and supports to adults with serious and persistent mental illness and substance use disorders, in partnership with Buckelew Programs, Inc.

FACT provides intensive mental health services to mentally ill offenders through a mental health court, in partnership with Buckelew Programs, Inc.

Question 9C:

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

Yes ___ No_√_. 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.

_x_ 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

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

_x_ 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.

_x_ Other; please describe: The MHB will submit the Data Notebook to their representative Supervisor of the Board.

The MHB wishes to thank the Behavioral Health staff for their work on this document.

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

Yes_x_ No___

If yes, please provide their job classification _Section Manager and Administrative Aide

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

Name and County: Susan Castillo

Email Susan.Castillo@sonoma-county.org

Phone # (707) 565-5005

Signature: Susan Cas

Other (optional): _____

OR

Name and County: Rhonda Darrow

Email Rhonda.Darrow@sonoma-county.org

Phone # (707) 565-4854

Signature: Glenda Dawson

Other (optional): _____

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

Name and County: Asghar Ehsan County of Sonoma

Email: Asghar.wafa@Gmail

Phone # 707-339-1793

Signature: Asg

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413