GLENN COUNTY: DATA NOTEBOOK 2016/17

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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GLENN COUNTY: DATA NOTEBOOK 2016/17

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2016):   28,668

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

   http://www.countyofglenn.net/govt/departments/mental_health/

Website for Local County MH Data and Reports: *see above.*

Website for local MH Board/Commission Information, Meetings, Reports: *see above.*

Specialty MH Data[1] from CY 2013-04: see MHP Reports at http://www.calegro.com/

Total number of persons receiving Medi-Cal in your county (2013):   10,913

   Average number Medi-Cal eligible persons per month (2014):   9,407

      Percent of Medi-Cal eligible persons who were:

         Children, ages 0-17:   51.4 %

         Adults, 18 and over: 48.6 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014):   664

      Percent of Specialty MH service recipients who were:

         Children, ages 0-17:   44.4 %

         Adults, 18 and over: 55.6 %

*Note: It was difficult to analyze the data provided in this Data Notebook because Glenn and Colusa County data was combined together. As a result, GCBH provided additional data and information specific to Glenn County to better understand services delivered in Glenn County.

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[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.

Glenn County Behavioral Health
Number and Percent of <u>Mental Health</u> Clients by <u>Funding</u>
FY 2015-16

	Medi-Cal	Non Medi-Cal	Total Mental Health
# of Clients	831	102	933
% of Clients	89.1%	10.9%	100.0%
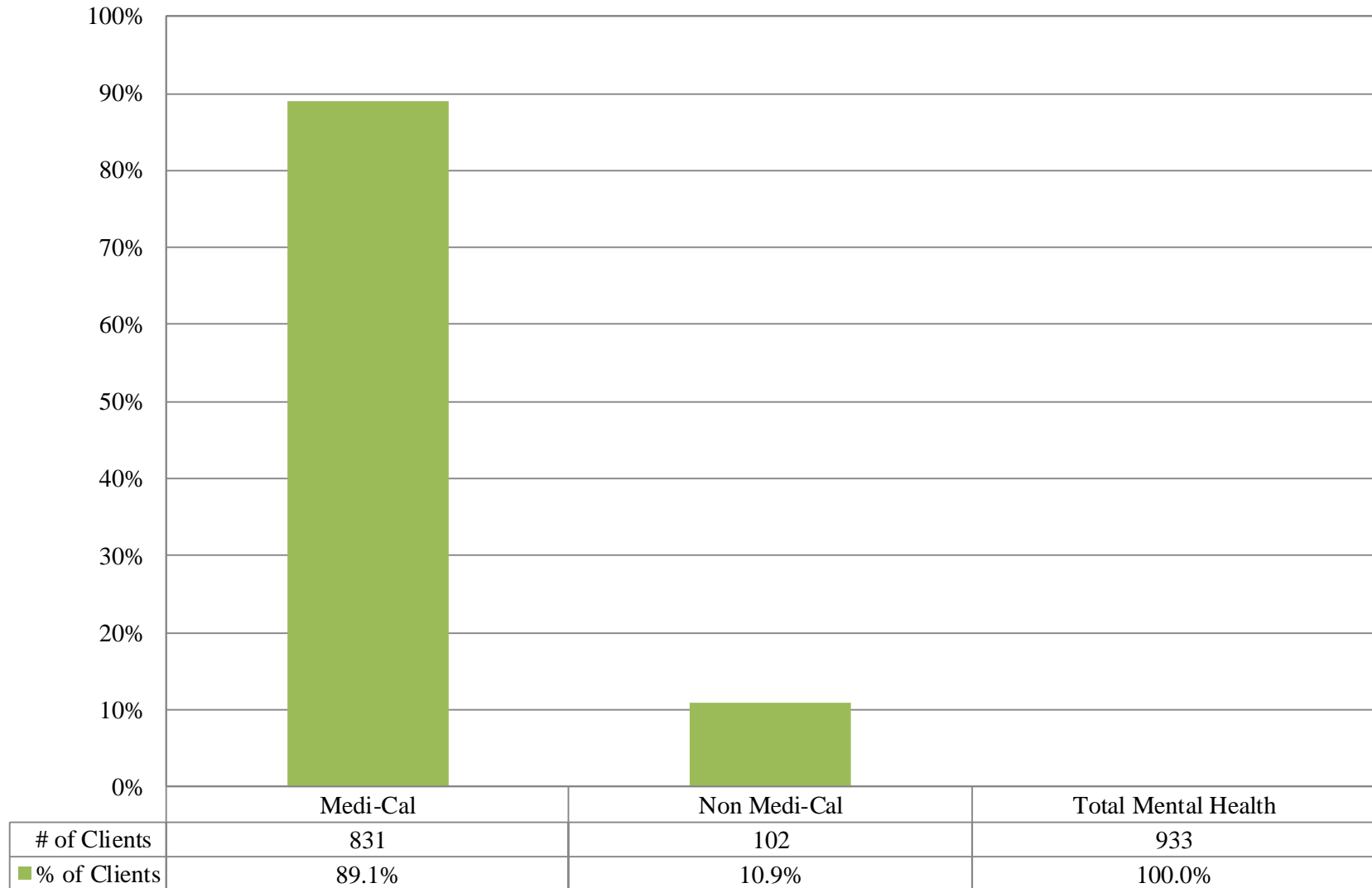
County Information Page, supplemental:

Child Population, by Race/Ethnicity

Year(s): 2015

Glenn County
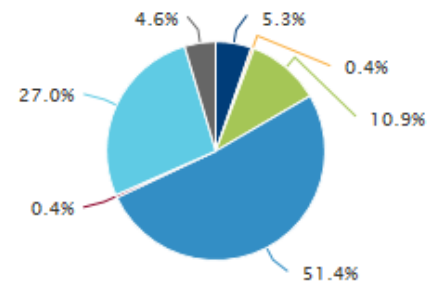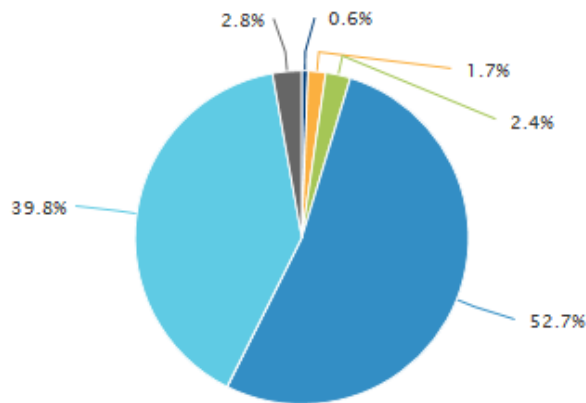
California

Legend:
- African American/Black
- American Indian/Alaska Native
- Asian American
- Hispanic/Latino
- Native Hawaiian/Pacific Islander
- White
- Multiracial

Glenn County values: 2.8%, 0.6%, 1.7%, 2.4%, 39.8%, 52.7%

California values: 4.6%, 5.3%, 0.4%, 10.9%, 27.0%, 0.4%, 51.4%

Hospitalizations for Mental Health Issues, by Age Group

Year(s): 2014

Rate per 1,000

Legend:
- 5–14 years
- 15–19 years
- Total 5–19 years

California:
- 2.7
- 9.7
- 5.1

Colusa, Glenn, and Lake Counties:
- 1.8
- 11.0
- 5.0

6
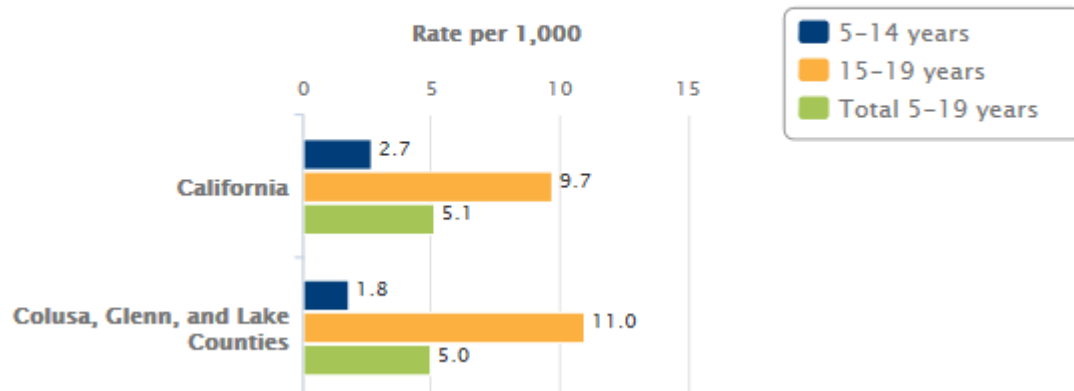
INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

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

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[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.

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.

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.

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[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.

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[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).

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[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.

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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.

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

Figure 1. Demographics for Your County: Glenn (FY 2013-14) and Service Utilization (FY 2015-16).

Your county Medi-Cal data are not yet available to the public. Instead, data for small-rural counties (population 1,000 – 50,000) are added together into summary data presented below and on the following pages. In addition, GCBH provided additional data on both Medi-Cal clients and non-Medi-Cal clients who received Specialty Mental Health Services.

For all ages, there were **831** people received one or more Medi-Cal Specialty Mental Health Services (SMHS). In addition, there were **102** others who were not Medi-Cal beneficiaries, but received Specialty Mental Health Services (SMHS). A total of **933** people received Specialty Mental Health Services in Glenn County in FY 2015-16.

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

Fiscal Year 13-14 Race Distribution

- Alaskan Native or American Indian
- Asian or Pacific Islander
- Black
- Hispanic
- White
- Other
- Unknown
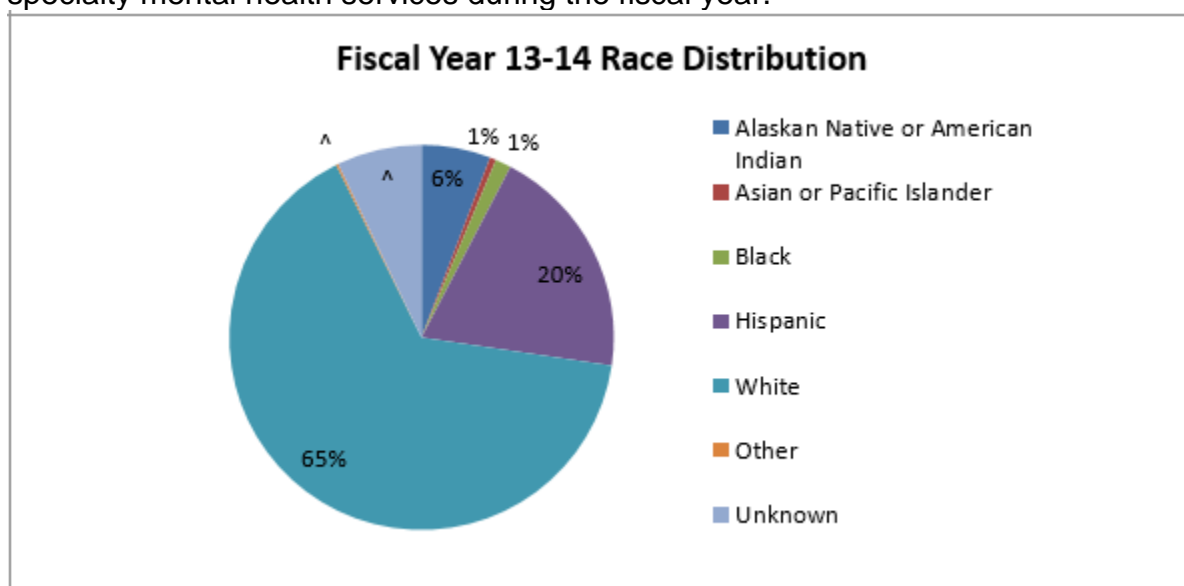
Below: Ages of children/youth who received at least one specialty MH service.

Fiscal Year 13-14 Age Group Distribution

- Children 0-5
- Children 6-11
- Children 12-17
- Youth 18-20

10% — 13% — 34% — 43%
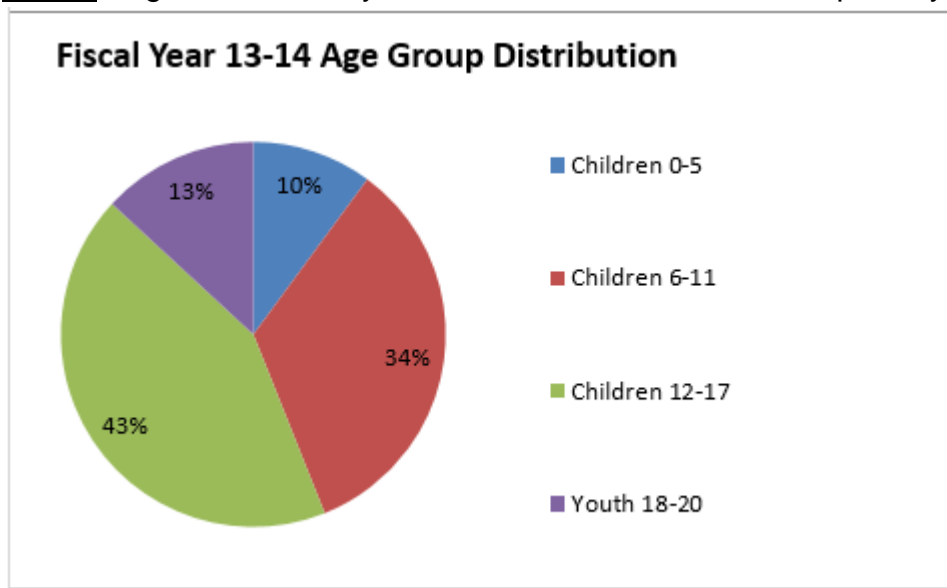
Glenn County Behavioral Health
Number and Percent of <u>Mental Health</u> Clients by <u>Age</u>
FY 2015-16

	0 - 15	16 - 25	26 - 59	60+	Total Mental Health
# of Clients	290	159	418	66	933
% of Clients	31.1%	17.0%	44.8%	7.1%	100.0%
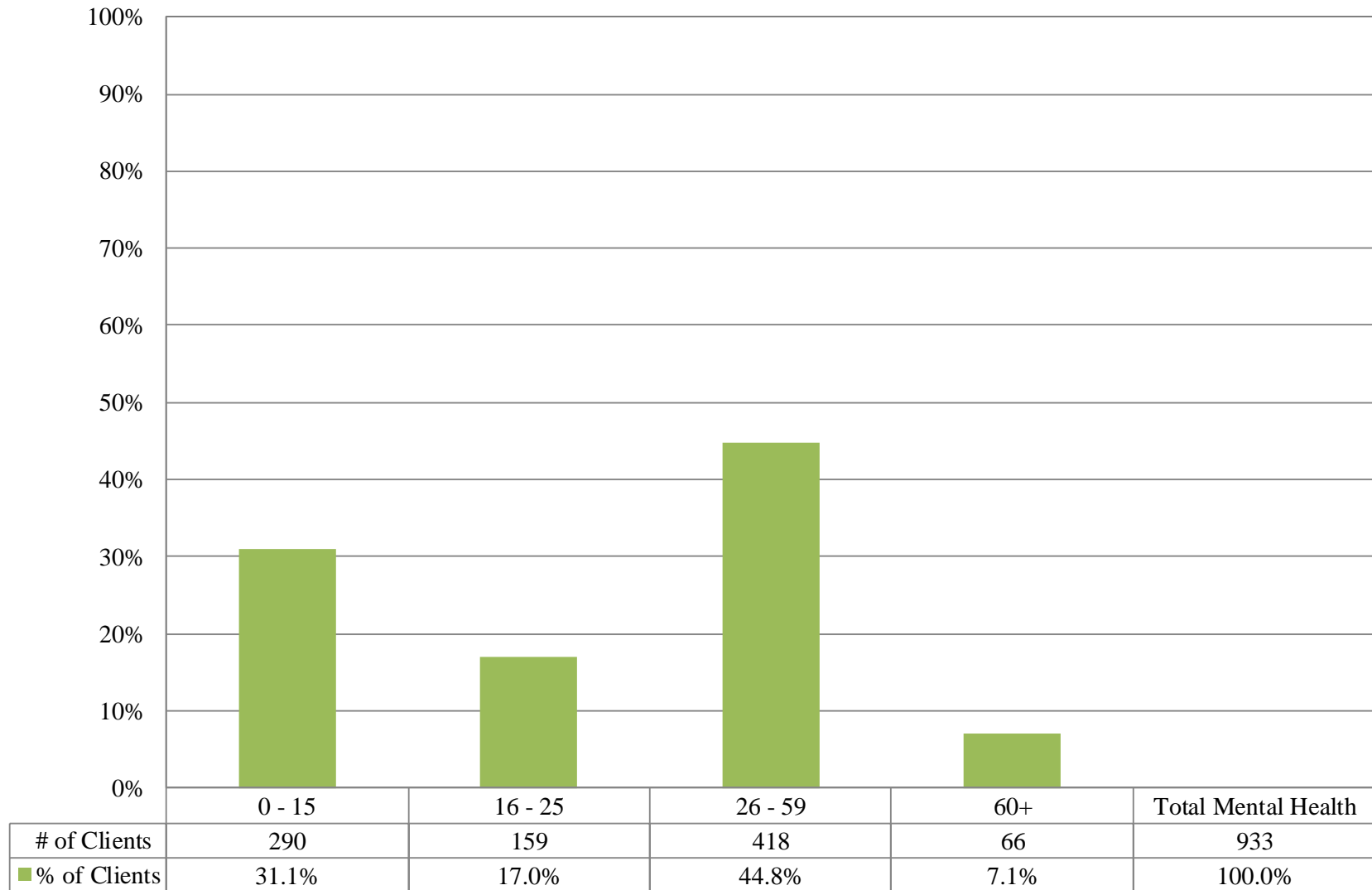
Glenn County Behavioral Health
Number and Percent of <u>Mental Health</u> Clients by <u>Gender</u>
FY 2015-16

	Male	Female	Total Mental Health
# of Clients	379	554	933
■ % of Clients	40.6%	59.4%	100.0%
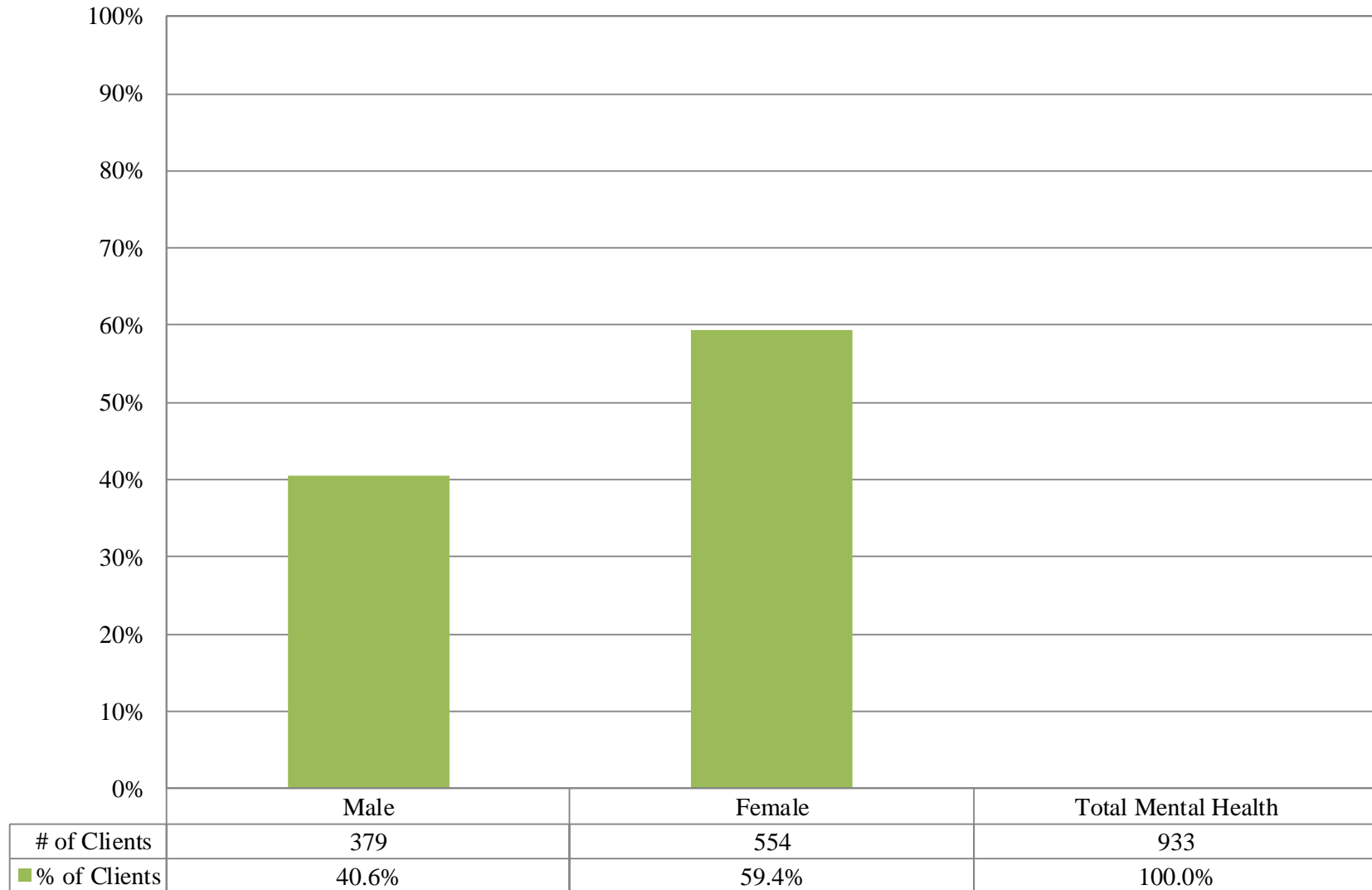
Glenn County Behavioral Health
Number and Percent of <u>Mental Health</u> Clients by <u>Race/Ethnicity</u>
FY 2015-16

	White/ Caucasian	Hispanic	Black/ African American	Asian/ Pacific Islander	American Indian/ Alaskan Native	Other/ Unknown	Total Mental Health
# of Clients	591	276	13	14	22	17	933
% of Clients	63.3%	29.6%	1.4%	1.5%	2.4%	1.8%	100.0%
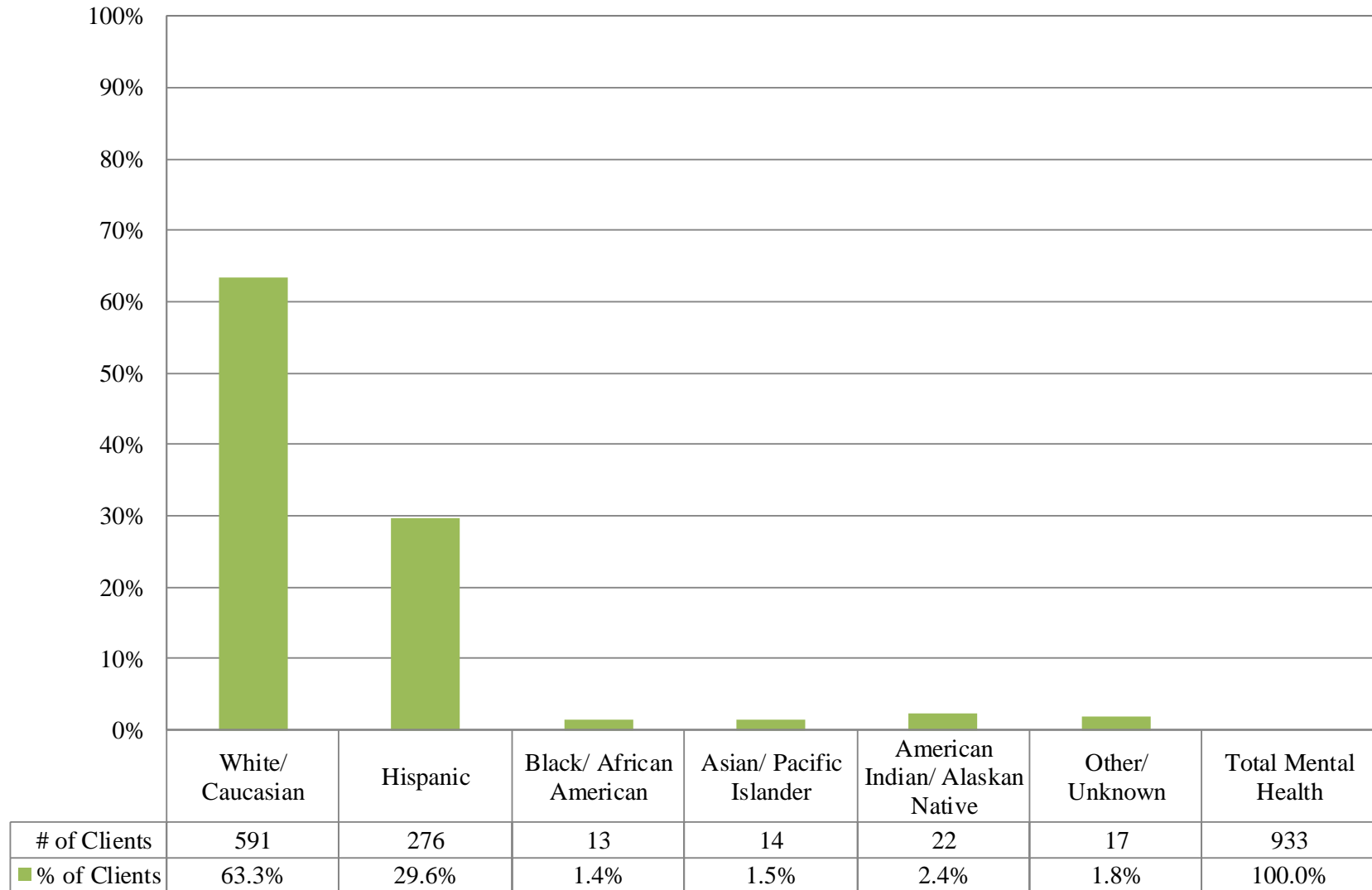
Glenn County Behavioral Health
Number and Percent of <u>Mental Health</u> Clients by <u>Preferred Language</u>
FY 2015-16

	English	Spanish	Hmong/Lao	Other/Unknown	Total Mental Health
# of Clients	778	150	4	1	933
■ % of Clients	83.4%	16.1%	0.4%	0.1%	100.0%
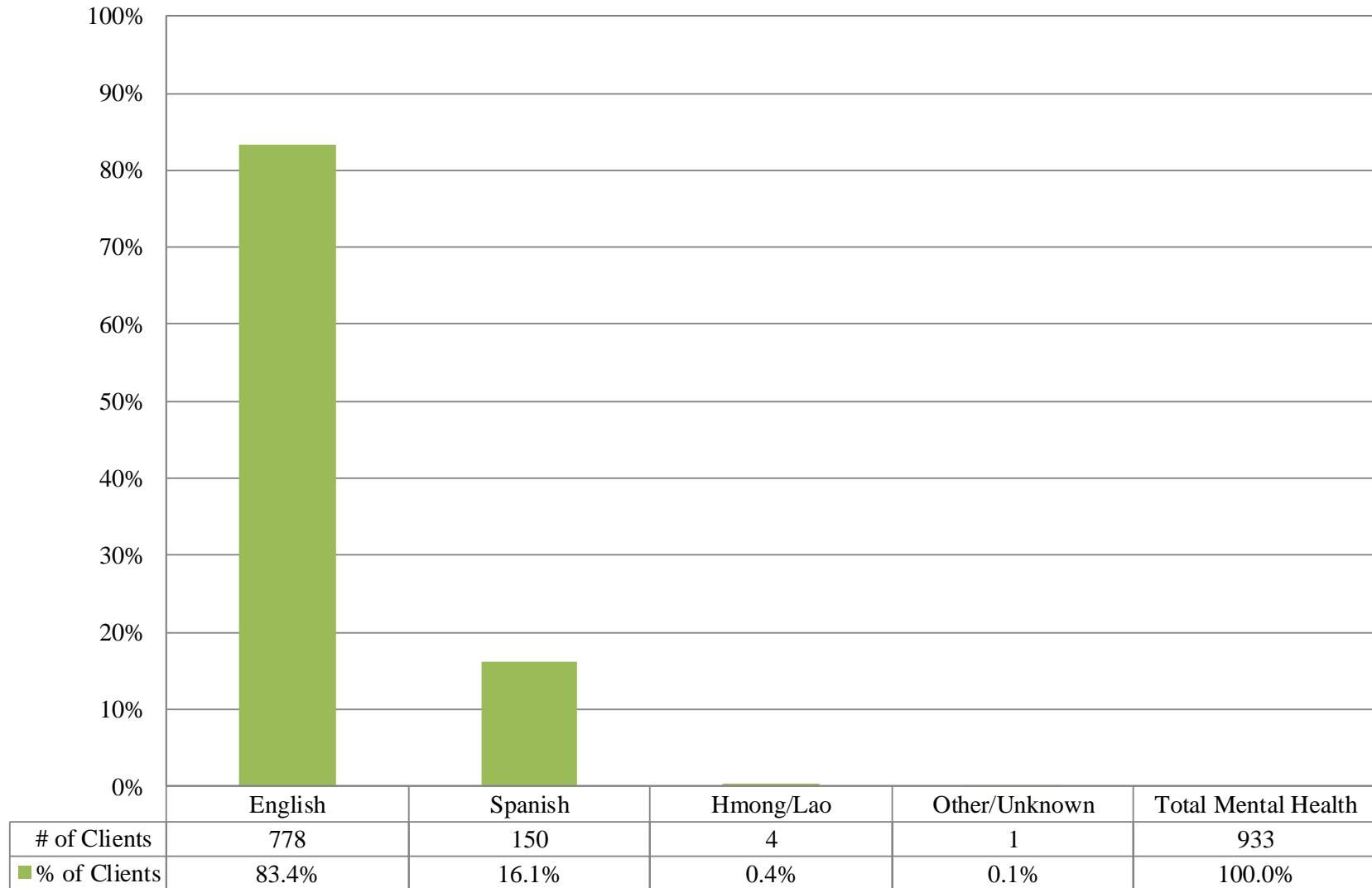
Glenn County Behavioral Health
Total Mental Health Hours, Clients, and Hours per Client per Year by Service Type
FY 2015-16

	Assessment	Katie A.	Plan Development	Individual Therapy	Rehab. Individual	Group	Case Management	Medication	Crisis Intervention	Total Mental Health
Total Hours	1,907.77	1,435.32	658.97	5,120.18	1,372.63	5,502.75	2,498.77	1,144.58	882.33	20,523.30
Und. Clts	618	33	383	563	210	167	570	290	207	933
Hrs/Clt	3.09	43.49	1.72	9.09	6.54	32.95	4.38	3.95	4.26	22.00
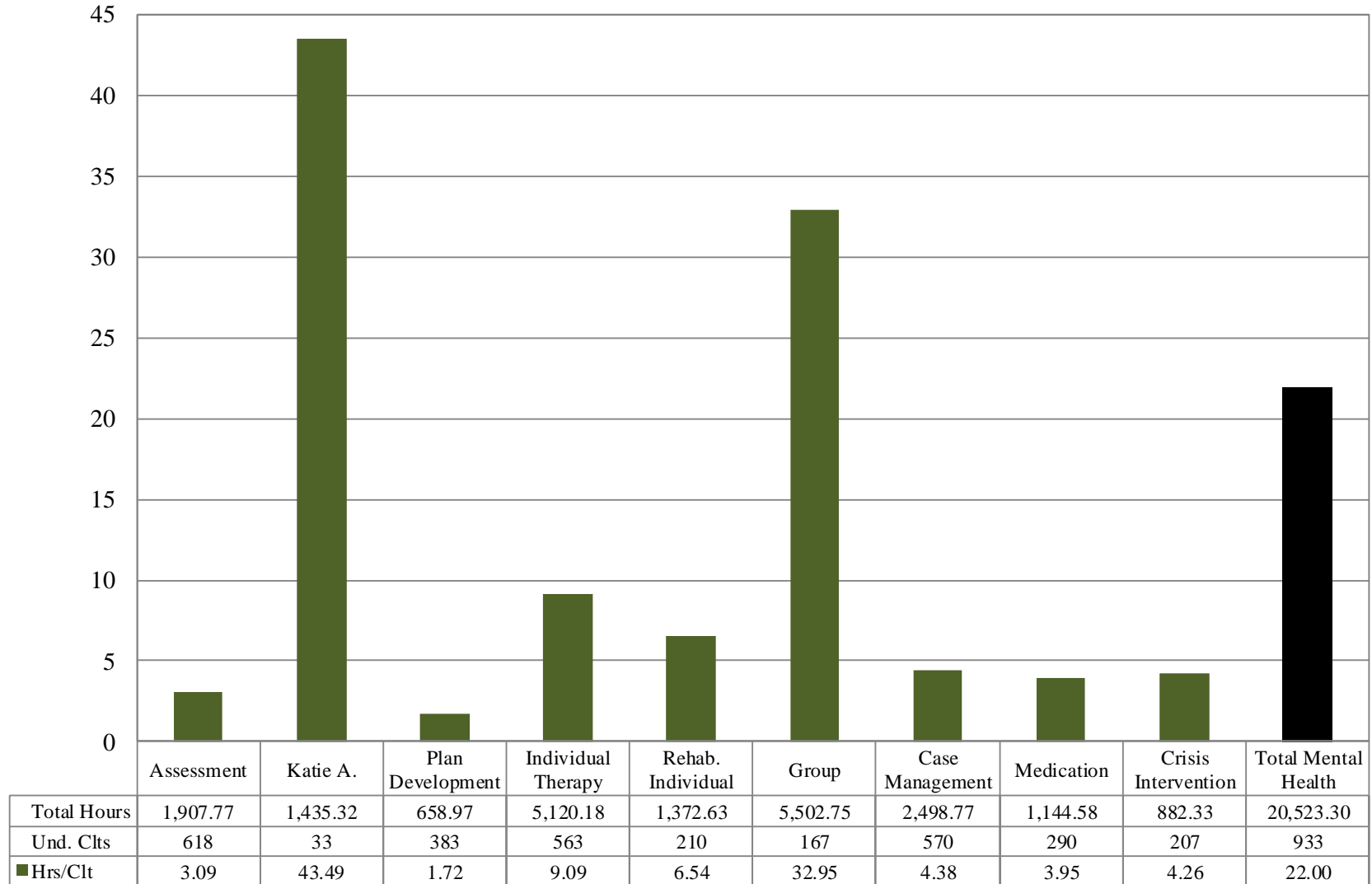
Client access and engagement in services is a complex issue and is somewhat difficult to measure. One way to measure client engagement is "penetration rates." Service penetration rates measure an individual's initial access and engagement in services provided by the local mental health plan. Figure 2 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 (2013-2014)
Your county data are combined with those of the group of small-rural counties.

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

	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
	FY 13-14		
All	2,703	47,051	5.7%
Children 0-5	273	14,972	1.8%
Children 6-11	915	13,706	6.7%
Children 12-17	1,160	11,880	9.8%
Youth 18-20	355	6,493	5.5%
Alaskan Native or American Indian	157	2,540	6.2%
Asian or Pacific Islander	14	1,099	1.3%
Black	36	454	7.9%
Hispanic	532	14,004	3.8%
White	1,766	24,513	7.2%
Other	^	360	^
Unknown	^	4,081	^
Female	1,266	23,175	5.5%
Male	1,437	23,876	6.0%

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

	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
	FY 13-14		
All	1,864	47,051	4.0%
Children 0-5	145	14,972	1.0%
Children 6-11	679	13,706	5.0%
Children 12-17	835	11,880	7.0%
Youth 18-20	205	6,493	3.2%
Alaskan Native or American Indian	105	2,540	4.1%
Asian or Pacific Islander	11	1,099	1.0%
Black	25	454	5.5%
Hispanic	380	14,004	2.7%
White	1,197	24,513	4.9%
Other	^	360	^
Unknown	^	4,081	^
Female	864	23,175	3.7%
Male	1,000	23,876	4.2%

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 Group: Small-rural Population Counties
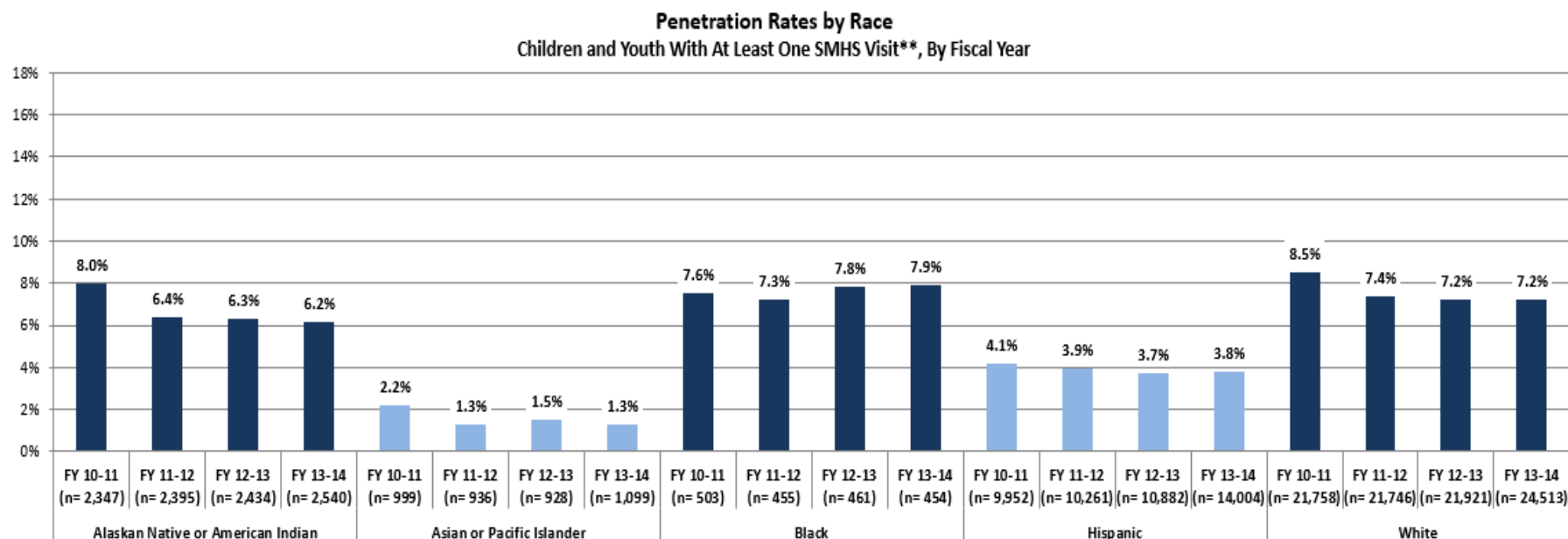
Understanding the changes observed above should take into account the expansion of the total Medi-Cal eligible population, which resulted in a statewide increase of nearly 12% in FY12-13 relative to the previous year. The expansion occurred in stages during 2011 to 2013 as the state began to implement 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.

 *,^ = Data redacted due to small numbers and HIPAA/privacy regulations.

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

QUESTION 1A:

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

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

The Behavioral Health Board discussed the range of services available for children and TAY in Glenn County. Specifically, they recognized the SMART Team and how a Sheriff's Deputy and Mental Health clinician respond to calls from the schools to address any threats or behavioral concerns. The TAY Center was also discussed as a valuable drop-in center that creates a warm and welcoming environment for youth.

QUESTION 1B:

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

The TAY Center's four paid Peer Mentors provide outreach and engagement in the schools, community, and at community events. The Peer Mentors identify different opportunities to welcome youth into the center. This includes offering 'soup night' once a month. Family members are also encouraged to attend these events, so parents become familiar with the TAY Center and 'feel comfortable' with having this center as a safe and positive environment.

QUESTION 1C:

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

Yes _X__   No_____.   If <u>yes</u>, please list briefly.

The BHB discussed the need to expand outreach efforts. There was a concern that this age group is difficult to engage, and sustain engagement, over time. There was discussion about also needing to expand outreach to the 20-25 year old population. These young adults are often invisible to the system, once they have dropped out of services. Unfortunately, many may end up in the legal system.

This is also a high risk time for substance use, with drugs and alcohol easily available to this vulnerable age group. In addition, many individuals with mental health symptoms try to self-

medicate with drugs and/or alcohol, which only masks what they are trying to cover up, and creates complex problems. There was discussion of needing a program to engage individuals as they are released from Juvenile Hall or Jail, and offer services to help support them to be successful at living in the community. There was also a suggestion to develop a brochure to give to people who are incarcerated, and let them know about the services that are available at Behavioral Health.

The BHB discussed Harmony House and how the Coaches are proactive at helping adults learn about services and welcoming new individuals into the program. The BHB members also discussed the need to provide outreach and engagement to caregivers, including parents of children, youth, adults with mental health challenges, as well as people who are caregivers for family members and/or elderly parents.

A new Prevention and Early Intervention Program, Strengthening Families, is already having success. This program welcomes families that include individuals who have mental health and/or substance use disorders. One of the Board Members has seen a dramatic change in families participating in the program.

There was also a discussion about older adults in the community who have a lot of mental health issues, as a result of taking care of a spouse, loss of a spouse, or other life events including reduced mobility or loss of a social support network.

QUESTION 1D:

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

The BHB members also discussed the need to provide outreach and engagement to caregivers, including parents of children, youth, adults with mental health challenges, as well as people who are caregivers for families and/or elderly parents.

BH also offers the Strengthening Families program, which is an evidence-based, family skills training program that helps improve parenting skills and family relationships. It also helps reduce problem behaviors, delinquency, and alcohol and drug abuse in children and youth, as well as helps improve social skills and school performance. Parents learn how to strengthen bonds with their children and learn more effective parenting skills.

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]

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[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).

Glenn County Mental Health Timeliness of Services

(*NOTE: HEDIS measure goal is 7-days post-discharge*)	All Services	Adult Services	Children's Services
Total number of hospital admissions	75	58	17
Total number of follow-up appointments	65	51	14
Average length of time for a follow-up appointment after hospital discharge.	3 days	3 days	6 days
MHP standard or goal	7 days	7 days	7 days
Percent of appointment that meet this standard	86.2%	88.2%	78.6%

Glenn County Mental Health Rehospitalizations

	All Services	Adult Services	Children's Services
Total number of hospital admissions	79	62	17
Total number with readmission within 30 days	21	19	2
Readmission rate (30 days)	26.6%	30.6%	11.8%
Goal readmission rate (30 days)	10%	10%	10%

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

Data are aggregated together for small population counties (50,000 – 199,999). No group data are available to the public yet for these measures for small-rural counties (1,000 -- 50,000).

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	99	48.5%	132	64.7%	61	29.9%	11	5.4%	0	748	150.1	6
FY 11-12	39	33.9%	96	83.5%	^	^	^	^	0	961	25.7	10
FY 12-13	120	58.0%	173	83.6%	23	11.1%	11	5.3%	0	392	20.4	6
FY 13-14	37	39.4%	59	62.8%	13	13.8%	22	23.4%	0	392	27.7	7

When examining the post-hospitalization data above, take note of the percentages who received follow-up services within 7 days after discharge or within 30 days after discharge. These time frames reflect federal healthcare quality measures that are also used for discharges after medical hospitalizations. On lower left 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).

Many small counties track "time to first appointment following discharge" within 7 days and for 30 days, combining the data of adults and children/youth. Those data may be found in your county "MHP report" at www.calegro.com.

*,^ = Data for this county (or group of counties) are redacted due to small numbers and HIPAA/privacy regulations.

QUESTION 2A:

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

If no, please describe your concerns or recommendations briefly.

QUESTION 2B:

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

The TAY staff and Peer Mentors offer services to youth who are hospitalized and/or in crisis. While this is a small number of youth, having the youth immediately engaged with the TAY Center and having a supportive community, is highly effective at helping youth remain living in the community. Also, upon release from the hospital, a crisis worker from BH meets with the youth and their family to discuss if the youth has an identified residence, if they need food, etc. Also, the hospital discharge plan is discussed and appointments made for seeing the BH psychiatrist and clinician, as needed. This helps make a smooth transition back into the community and helps support the youth and family to receive needed 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.

The Behavioral Health crisis and inpatient case management staff closely monitor each person who is in crisis and/or hospitalized. The Case Management Hospital Liaison is in daily contact with the hospital regarding each client, and in many cases provides transportation on the day of discharge, back to the community. This creates prompt follow-up to outpatient care, for all ages, including TAY.

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 <u>non</u>-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH 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 <u>one in five students in foster care</u> 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.

<u>Conclusion:</u> 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

[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 <u>intensive home-based services</u>, <u>intensive care coordination</u>, and <u>therapeutic foster care</u>. More recently, DHCS recognized that other children and youth also have a right to receive such services <u>if</u> 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 <u>not</u> include those with mild to moderate mental health needs who are served in the Medi-Cal Managed Care System. Also, these data do <u>not</u> 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) <u>Certified Medi-Cal eligible Foster Care Youth (age 0-20)</u>: **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) <u>Total Unique Katie A. Subclass Members</u>: **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**
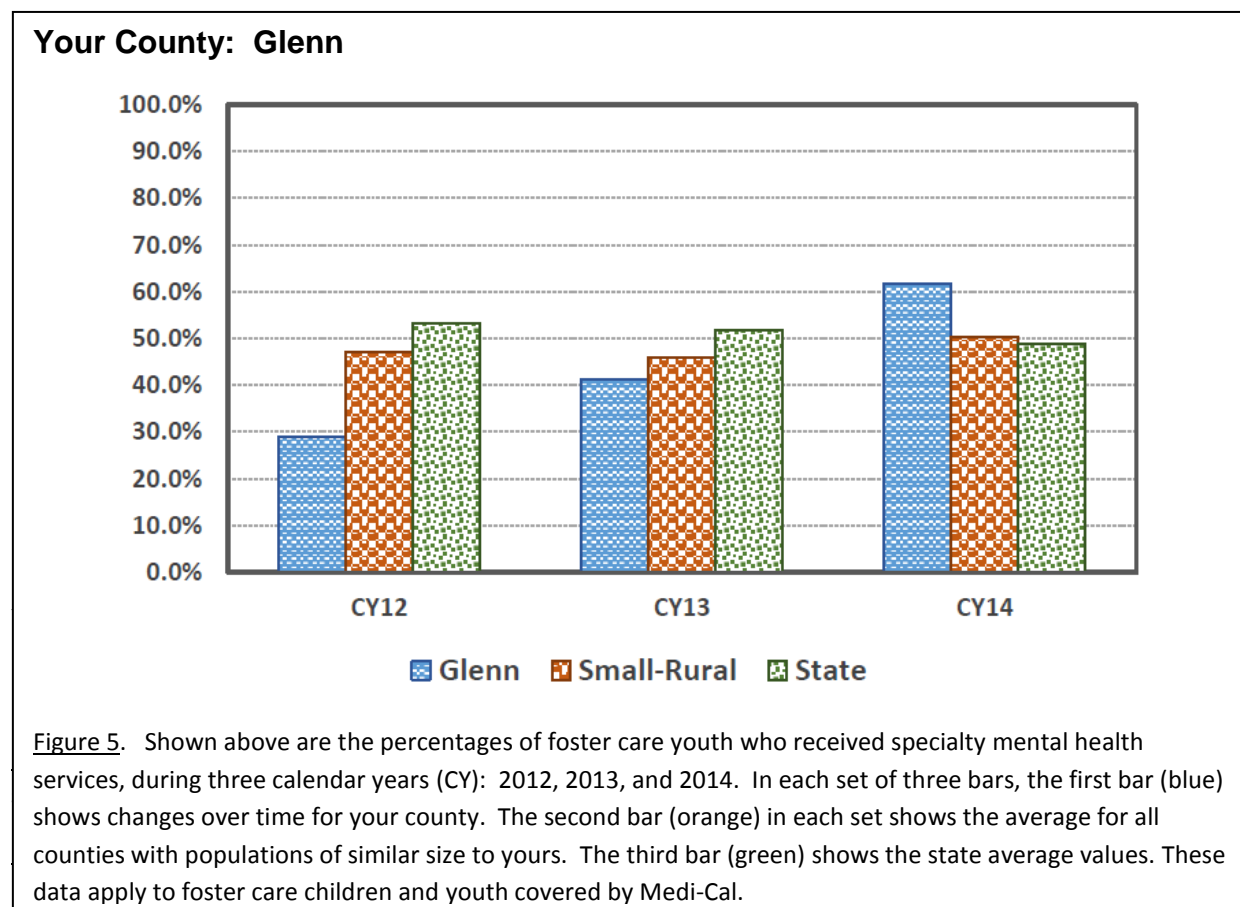- Therapeutic Foster Care: Data not yet available.

[*] 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

Your County: Glenn

Figure 5.   Shown above are the percentages 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. These data apply to foster care children and youth covered by Medi-Cal.

External Quality Review Organization. www.CALEQRO.com, see "Reports," and select your county to view.

shows changes over time for your county. The second bar (orange) in each set shows the average value for all counties with populations of similar size to yours. The third bar (green) in each set shows the state average values.

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.

GCBH works closely with Child Welfare Services (CWS) to coordinate services for foster children and youth. These two programs have worked together for the past several years, utilizing a Children's System of Care (CSOC) model of shared assessments and placement decisions. In recent years, the two agencies have also coordinated services for Katie A. children and are now working together to develop and implement the Continuum of Care Reform (CCR) services. A mental health clinician is co-loated at CWS to complete mental health assessments on all in-county foster care children, some who are placed regionally, and other children who are at risk for out-of-home placement. When a child is being placed into foster care, priority is given within the mental health system to provide a clinical assessment as quickly as possible. The managers of the two agencies coordiante services to provide timely access to needed services.

In addition, GCBH delivers mental health services through EPSDT in schools across the county. This provides speciality mental health services to meet the needs of children, youth, and families.

QUESTION 3B:

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

Yes__X__   No_____. If no, please explain briefly.

QUESTION 3C:

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

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

The BHB discussed the need for more foster families in and/or near Glenn County. There are additional requirements to become a foster parent, and there will be enhanced training available available to potential parents to develop skills to help manage difficult behavior. There was also recognition to the Strengthening Families program, and there was a suggestion that families that have children in placement could be encouraged to participate in the program, and potentially be reunited upon successful completion of the program.

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]

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[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.

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."

QUESTION 4A:

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

If yes, please list and describe briefly.

The TAY Center and Harmony House both create innovative programs and strategies to help engage LGBTQ youth and adults in activities. The Peer Mentors offer information about the TAY Center at each of the high schools. They have also had special activities, such as giving out wrist bands that express a welcoming message to the LGBTQ community. Coaches at Harmony House also have special activities to ensure the LGBTQ community feels welcomed at the Peer Run drop-in center. Services are also coordinated with the Stonewall Alliance Center, in Chico. This organization provides a safe, open, inclusive environemtn for all memebers of the gender and sexual minority and ally communtiy. This organization provides an excellent resource to our programs and provides training to help us strengthen our services to ensure we reduce barriers to services. Peer Mentors also conduct tabling at Stonewall events.

QUESTION 4B

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

If yes, please list or describe briefly.

The TAY Center and Harmony House also offers welcoming services to family members of LGBTQ. The BHB suggested expanding the Glenn County Behavioral Health website to offer resources in the county and region, with a description of services and contact information, to help welcome individuals and families from the LGBTQ community..

QUESTION 4C:

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

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

The BHB discussed a concern about bullying in the schools. The SMART Team and TAY Peer Mentors provide training in the schools to help reduce bullying and to provide ideas for teachers to address bullying behaivors.

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.

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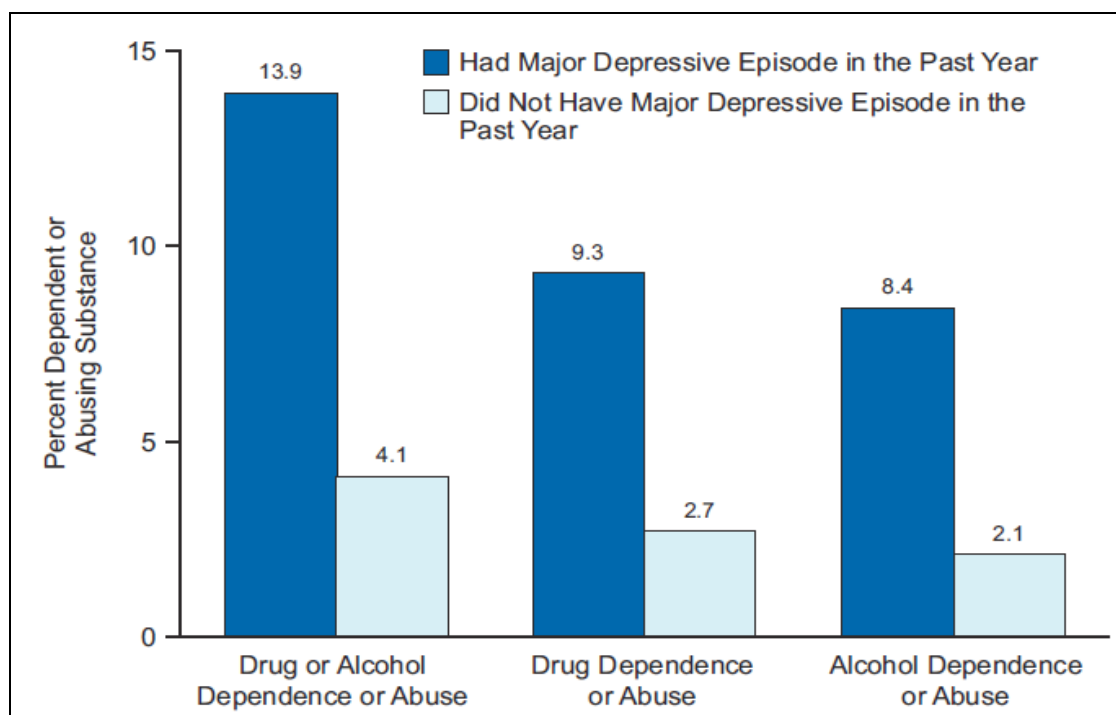
[20] Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at:
http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf

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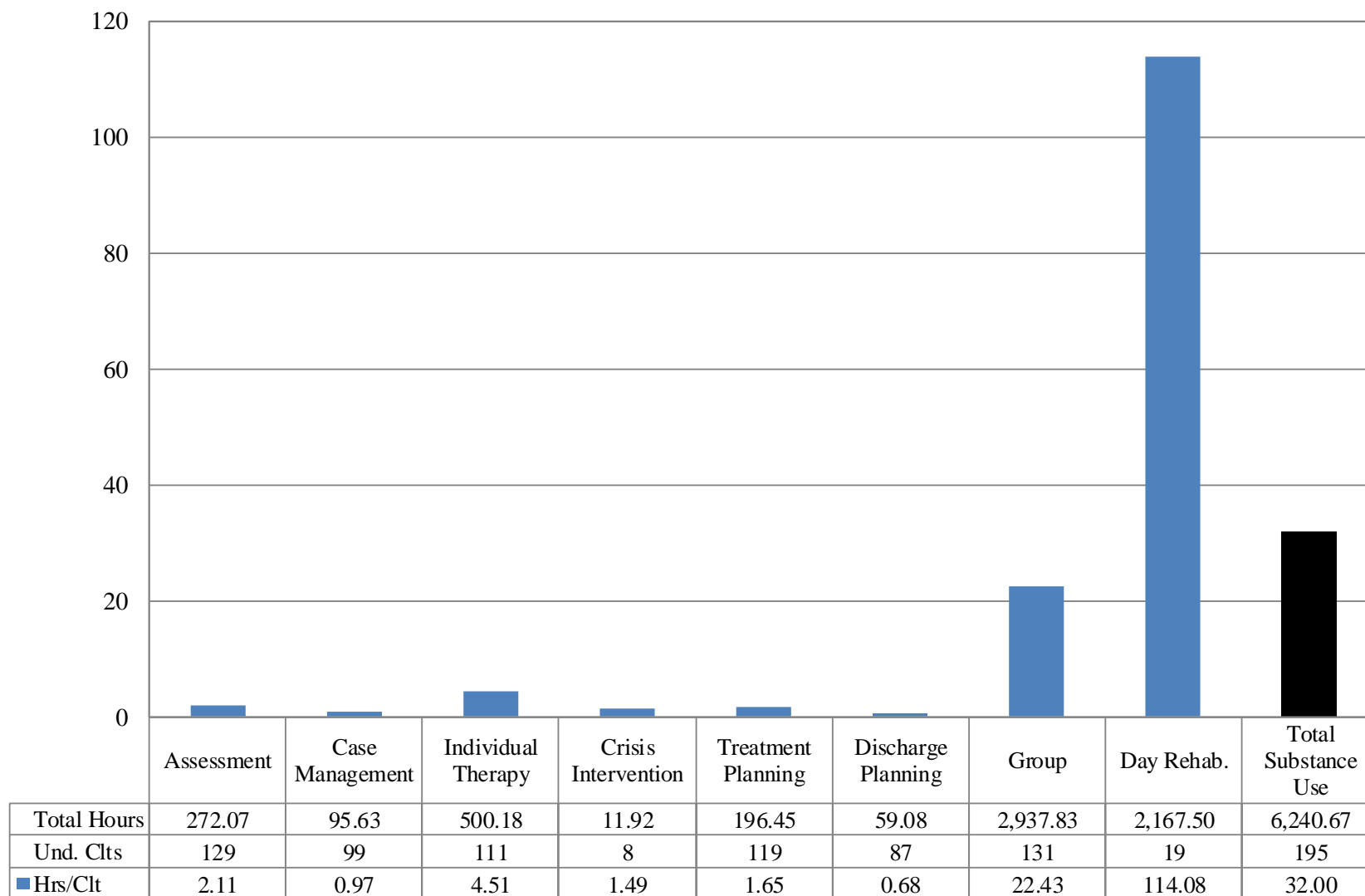
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[21]California Substance Use Disorder Block Grant & Statewide Needs Assessment and Planning Report, 2015. Presented as a collaborative effort between numerous staff at DHCS, CDPH, and the UCLA Integrated Substance Abuse Program. http://www.dhcs.ca.gov/provgovpart/Documents/2015-Statewide-Needs-Assessment-Repor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

Glenn County Behavioral Health: Substance Use Penetration Rate by Age, Race/Ethnicity, Language Preference, and Gender

	Glenn County Population 2010 Census		Substance Use Clients FY 2014/15		Glenn County Population Substance Use Penetration Rate FY 2014/15
Age Distribution					
0 - 15 years	6,520	23.2%	16	8.2%	16 / 6,520 = 0.2%
16 - 24 years	3,926	14.0%	54	27.7%	54 / 3,926 = 1.4%
25 - 59 years	12,505	44.5%	116	59.5%	116 / 12,505 = 0.9%
60+ years	5,171	18.4%	9	4.6%	9 / 5,171 = 0.2%
Total	**28,122**	**100.0%**	**195**	**100.0%**	**195 / 28,122 = 0.7%**
Race/Ethnicity Distribution					
White/ Caucasian	15,717	55.9%	105	53.8%	105 / 15,717 = 0.7%
Hispanic	10,539	37.5%	66	33.8%	66 / 10,539 = 0.6%
Black/ African American	192	0.7%	3	1.5%	3 / 192 = 1.6%
American Indian/ Alaskan Native	477	1.7%	9	4.6%	9 / 477 = 1.9%
Asian/ Pacific Islander	696	2.5%	8	4.1%	8 / 696 = 1.1%
Other/ Unknown	501	1.8%	4	2.1%	4 / 501 = 0.8%
Total	**28,122**	**100.0%**	**195**	**100.0%**	**195 / 28,122 = 0.7%**
Language Distribution					
English	-	-	182	93.3%	-
Spanish	-	-	10	5.1%	-
Other/ Unknown	-	-	3	1.5%	-
Total	**-**	**-**	**195**	**100.0%**	**-**
Gender Distribution					
Male	14,191	50.5%	119	61.0%	119 / 14,191 = 0.8%
Female	13,931	49.5%	76	39.0%	76 / 13,931 = 0.5%
Total	**28,122**	**100.00%**	**195**	**100.0%**	**195 / 28,122 = 0.7%**

Glenn County Behavioral Health: Substance Use Services
Total Hours, Clients, and Hours per Client _per Year by Service Type_
FY 2015-16

	Assessment	Case Management	Individual Therapy	Crisis Intervention	Treatment Planning	Discharge Planning	Group	Day Rehab.	Total Substance Use
Total Hours	272.07	95.63	500.18	11.92	196.45	59.08	2,937.83	2,167.50	6,240.67
Und. Clts	129	99	111	8	119	87	131	19	195
■ Hrs/Clt	2.11	0.97	4.51	1.49	1.65	0.68	22.43	114.08	32.00

Glenn County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	Any	None
7th Grade	N/R	N/R
9th Grade	N/R	N/R
11th Grade	N/R	N/R
Non-Traditional	N/R	N/R
All	N/R	N/R

N/R = not reported due to either insufficient or no data submitted to the survey agencies.

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

<u>**California: Statewide**</u>

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

<u>**Your County: Glenn – Total: 195**</u>

Age <16: 16   **Age 18-25:** 54   **Age 26-59:** 116   **Age 60+:** 9

QUESTION 5A:

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

If yes, please list or describe briefly.

If no, what is the alternative in your county?

The GCBH program offers Substance Use Disorder (SUD) services to persons of all ages. As noted above, there were 9 (8.2%) children and 54 TAY (27.7%) of the total persons served. In adition 55.9% of the SUD clients are Caucasian and 37.5% are Hispanic.

QUESTION 5B:

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

Please explain briefly.

The BHB noted that SUD services are being developed. There is more participation by youth. It was noted that it would be nice to have an Alcoholics Anonymous (AA), and Narcotics Anonymous (NA) group just focused on TAY, as many of the youth do not 'identify' with the adults and older adults who regularly attend the AA/NA meetings in the county. It was also suggested to introduce a program in Juvenile Hall and Jail, to engage individuals prior to release, and then work with them after release. Also, to identify a youth mentor to engage the youth, and support the indivdiual and family upon release. It was also suggested to get a pool of people who have clearance to enter the jail and offer AA/NA and other services. This would get people engaged in the program prior to release, and there could be better success in getting people involved in services, after being released.

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]

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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,

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."

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.

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[24] Website: **www.ChildrenNow.org**, see report: California Children's Report Card, 2016.
[25]"Racial Disparities in Sentencing." American Civil Liberties Union, 27 Oct. 2014.
https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf; and
Soler, Mark, "Reducing Racial and Ethnic Disparities in the Juvenile Justice System." Center for Children's Law and Policy, 2013.
http://www.ncsc.org/~/media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/

> *One major risk for incarcerated youth is suicide.*
>
> - One national study* reported that approximately 10 percent of juvenile detainees had thought about suicide in the prior six months.
>
> - About 11 percent of detained juveniles had previously attempted suicide.
>
> - The rates of completed suicides for incarcerated juveniles are between two and four times higher than for the general population.
>
> - The general population rate of completed suicides was reported in 2010 as 10.5 per 100,000 adolescents.
>
> *K.M. Abram, J.Y. Choe, J.J. Washburn et al., "Suicidal Thoughts and Behaviors among Detained Youth," July 2014 Juvenile Justice Bulletin, pages 1-12.

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

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

Total population[28] age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests

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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

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

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

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

Data shown below:

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

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

For your county: Glenn   16 juvenile felony arrests, 2014.

QUESTION 6A:

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

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

PROGRAM: FUNDING SOURCE:

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[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.

Some staff from BH are cleared to deliver services at JH and the jail. These programs are funded through realignment. These staff deliver some individual and/or groups services. There is a plan to expand services as the Mental Health Court and other services are expanded. The Board of Supervisors approved Glenn County to be a 'Stepping Up' county, which demonstrates the county's commitment to keeping persons with mental illness out of the jail and Juvenile Hall.

QUESTION 6B:

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

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

PROGRAM: **FUNDING SOURCE:**

Services in the Juvenile Hall and Jail are limited, as a result of limited funding, and a lockout for billing Medi-Cal for services delivered in these settings.

QUESTION 6C:

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

Yes_X__   No___.   If yes, please list briefly.

Glenn County has always had active Adult and Juvenile Drug Court programs. While there are fewer people involved this year, it is a high priority for BH and the community. It is also a high priority to involve families and parents in the Drug Court, whenever possible. Probation officers also work closely with family members and parents. Families are also referred to the Strengthening Families program. Some family members who finish the program have come back to be mentors for other families taking the Strengthening Families program for the first time. Also, families in the Child Welfare system who are in Family Maintenance, enroll in the Strengthening Families program in preparation for their child returning home.

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

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[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]

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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.

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.

Glenn County:

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

Suicidal Ideation (Student Reported), by Gender and Grade Level: 2011-2013				
Grade Level	Female		Male	
	Yes	No	Yes	No
9th Grade	N/R	N/R	N/R	N/R
11th Grade	N/R	N/R	N/R	N/R
Non-Traditional	N/R	N/R	N/R	N/R
All	N/R	N/R	N/R	N/R

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

As described in detail earlier in this report, the SMART Team responds to any high-risk behavior in the schools. The SMART Team also provides training for teachers and youth on topics that include suicide recognition and bullying. In addition, Peer Mentors from the TAY Center offer ongoing outreach and engagement regarding suicide, mental health issues, and substance use to

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[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.

the schools. Mental Health staff also periodically offer Mental Health First Aid training, SafeTALK, and ASIST training to community members.

QUESTION 7B:

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

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

See above Question 7A.

QUESTION 7C:

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

Yes_____   No__X___.   If yes, please list briefly.

Early Identification of Risks for First-break Psychosis

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

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

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

QUESTION 8A:

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

Yes__X__   No____

QUESTION 8B:

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

While we are a small, rural county, we have a very active TAY program that offers services to youth with mental health and/or substance use issues. Any youth experiencing a first break psychosis is offered services immediately. In addition, services are available to support the parent/caregiver and help them understand this complex illness. Services are funded by MHSA and Medi-Cal, as appropriate. The BHB members suggested having some additional information on the Glenn County website about first break psychosis and a link to the National Alliance for the Mentally Ill, NAMI. This would be valuable for parents/caregivers and family members who may not initially feel comfortable coming into the Behavioral Health office for information.

In preparation for release from a psychiatric hospitalization, the BH Hospital Liaison ensures that the individual gets an immediate appointment with the Telehealth psychiatrist, to check in on medications, and ensure the individual's symptoms are managed.

Family members are also working to start a NAMI chapter in Glenn County. BH staff strongly support these efforts, as this would be a valuable asset in this community.

QUESTION 8C:

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

Yes_____   No__X__. If yes, please describe briefly.

Full Service Partnership (FSP) Programs for Children and Youth

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

system involvement. Such intensive services can be costly, but their positive impact and results outweigh the costs and actually produce cost savings to society.[39]

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

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

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

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

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

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.

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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.

[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.

- 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.

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

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

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

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

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

All of these improved outcomes continued and were sustained at the end of the clients' second year in FSP services. Two types of outcomes, psychiatric hospitalizations and use of emergency shelters, had improved even more by the end of clients' second year of FSP services, compared to the end of the first year. The goal is to think about how the FSP outcomes data for children and youth may help inform your suggestions for improving local services or programs**.**

QUESTION 9A:

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

The Glenn County Children's System of Care has been a strong program for several years. One of the highest priorities is to continue to strengthen services for foster children, as the system begins to transform with new legislation. Identifying foster homes in Glenn County is also critical to help reunite families, so parents do not have to travel long distances in order to see their child in placement.

There is a growing issue for teens who are homeless and/or couch surfing. In addition, substance use with children and TAY continues to expand. Approximately 30% of all persons receiving Substance Use Treatment in Glenn County are under the age of 26.

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?

There is a plan to expand Rehabilitation and Case Management Services, to help provide more intensive services to high need individuals. no concerns for the FSP program. BH is also looking at develop levels of care, to help identify high need individuals and ensure that they are getting more intensive services.

Question 9C:

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

Yes ___ No__X_. If yes, please describe briefly.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

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

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

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

_X_ MH Board completed majority of the Data Notebook

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

_X_ Data Notebook placed on Agenda and discussed at Board meeting

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

___ MH Board partnered with county staff or director

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

___ Other; please describe: _____.

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

Yes_X__   No___

If yes, please provide their job classification _____

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

Name and County: __Amy Lindsey; _____

Email_____ alindsey@countyofglenn.net _____

Phone #__530-934-6582_____

Signature: _____

Other (optional): _____

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

Name and County: _Paul Adams_____

Email: ___ i_5recovery@yahoo.com_____

Phone #_____

Signature: _____

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

California Mental Health Planning Council