

# IMPERIAL COUNTY: DATA NOTEBOOK 2016

## FOR CALIFORNIA

### BEHAVIORAL HEALTH BOARDS AND COMMISSIONS



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

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## FOR CALIFORNIA

### BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2016): 185,831

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

<http://www.imperial.networkofcare.org>

Website for Local County MH Data and Reports:

Same as above

Website for local MH Board/Commission Information, Meetings, and Reports:

Same as above

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

Total number of persons receiving Medi-Cal in your county (2013): 78,323

Average number Medi-Cal eligible persons per month (2014): 69,754

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 45.2%

Adults, 18 and over: 54.8 %

Total persons with SMI<sup>2</sup> or SED<sup>3</sup> who received Specialty MH services (2014): 4,865

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 52.0 %

Adults, 18 and over: 48.0 %

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<sup>1</sup> Downloaded from the website, [www.calegro.com](http://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.

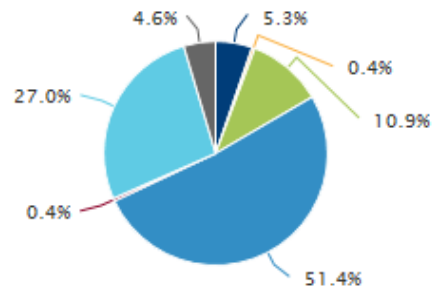
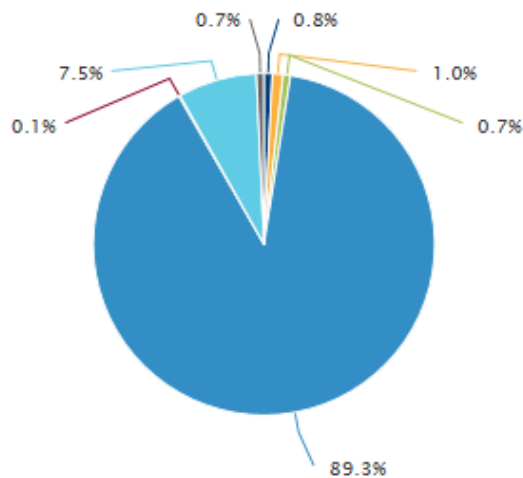
<sup>2</sup> Serious Mental Illness, term used for adults 18 and older.

<sup>3</sup> Severe Emotional Disorder, term used for children 17 and under.

## Child Population, by Race/Ethnicity

Year(s): 2015

### Imperial County

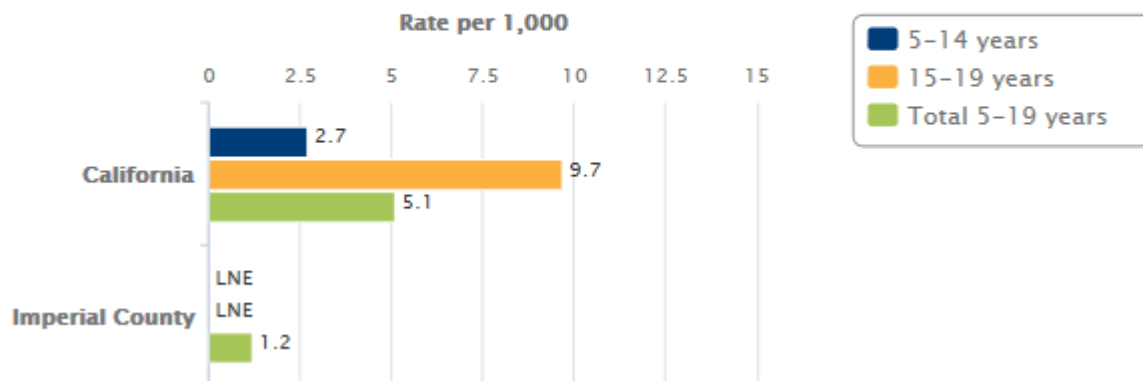


### California

■ African American/Black ■ American Indian/Alaska Native ■ Asian American  
■ Hispanic/Latino ■ Native Hawaiian/Pacific Islander ■ White ■ Multiracial

## Hospitalizations for Mental Health Issues, by Age Group

Year(s): 2014



## 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)<sup>4</sup>.

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<sup>5</sup> 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<sup>6</sup> 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<sup>7</sup> that comprised a geographic area containing 99% of this

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<sup>4</sup> See various definitions of the age ranges for these groups depending on data source, Table 2, page 8.

<sup>5</sup> W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

<sup>6</sup> W.I.C. 5772 (c), regarding annual reports from the California Mental Health Planning Council.

<sup>7</sup> 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<sup>8</sup> 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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<sup>8</sup> 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, <sup>9</sup> <a href="http://www.dhcs.ca.gov">http://www.dhcs.ca.gov</a>	Mental health services provided to Medi-Cal covered children/youth through age 20, as part of the federally defined EPSDT <sup>10</sup> 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: <a href="http://www.doj.ca.gov">www.doj.ca.gov</a>	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 <a href="http://www.CALEQRO.com">www.CALEQRO.com</a>	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 <a href="http://www.KidsData.org">www.KidsData.org</a>	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) <a href="http://www.samhsa.gov">www.samhsa.gov</a>	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: <u>National Survey on Drug Use and Health (NSDUH)</u> , 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 <a href="http://www.cbhda.org/">www.cbhda.org/</a>	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the “Measures Outcomes and Quality Assessment” (MOQA) database.

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

<sup>10</sup> 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<sup>11</sup> 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**

<b>Category</b>	<b>EPSDT MH Services</b>	<b>CA EQRO</b>	<b>MHSA Programs</b>	<b>JUSTICE System</b>	<b>SMHSA, NSDUH, Federal datasets</b>
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 <sup>12</sup>	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

<sup>11</sup> Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.

<sup>12</sup> 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 TO SERVICES: Youth, Children, and their Families/Caregivers

### Access: Outreach and Engagement with Services

One goal of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color and LGBTQ<sup>13</sup> 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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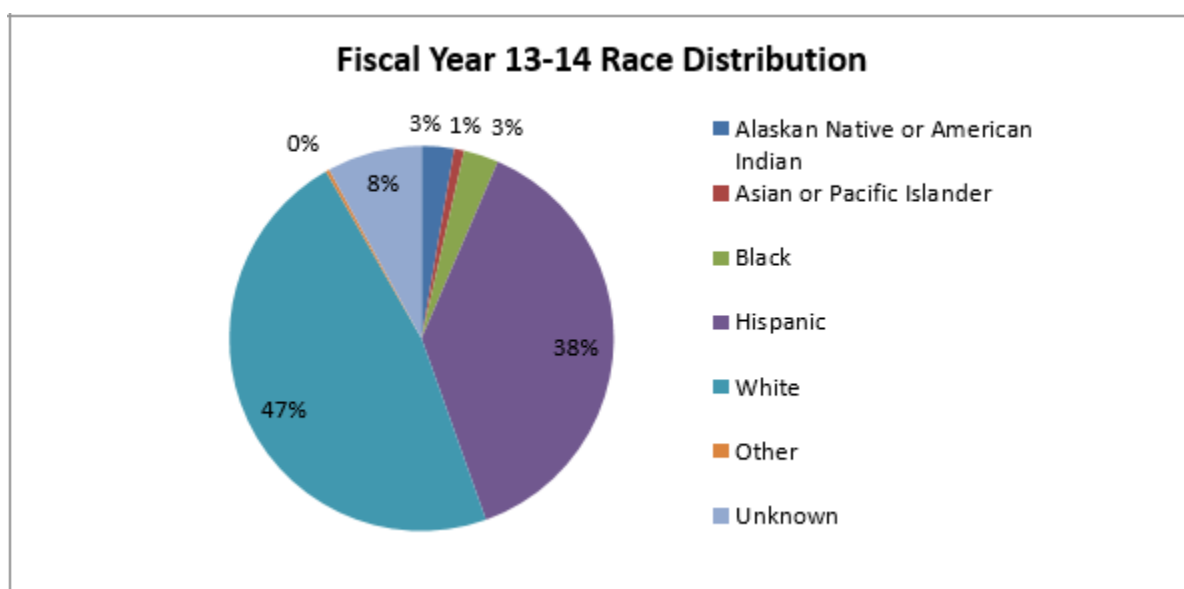
<sup>13</sup> Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

### **Figure 1. Demographics for Your County: Imperial (FY 2013-2014)**

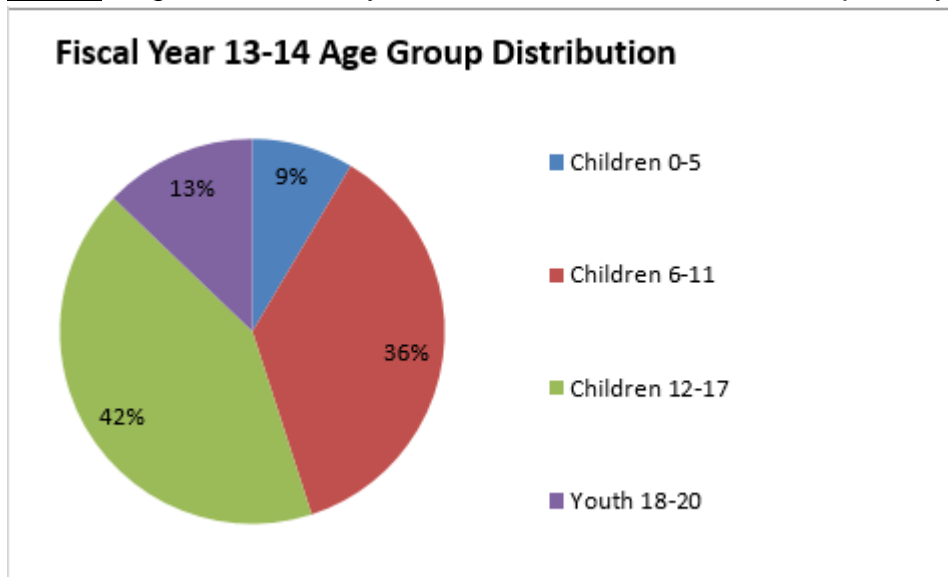
Your county Medi-Cal data are not available to the public. Instead, data for small counties (population 50,000 – 199,999) are added together into summary data presented below and on the following pages.

Unique numbers of children and youth who were Medi-Cal eligible: **290,031**  
Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **14,090**.

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



**Below:** Ages of children/youth who received at least one specialty MH service.



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 counties.

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

	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
<b>All</b>	<b>14,090</b>	<b>290,031</b>	<b>4.9%</b>
Children 0-5	1,204	94,029	1.3%
Children 6-11	5,137	84,937	6.0%
Children 12-17	5,942	72,362	8.2%
Youth 18-20	1,807	38,703	4.7%
Alaskan Native or American Indian	383	5,992	6.4%
Asian or Pacific Islander	119	9,450	1.3%
Black	413	5,444	7.6%
Hispanic	5,363	140,056	3.8%
White	6,644	98,979	6.7%
Other	43	1,918	2.2%
Unknown	1,125	28,192	4.0%
Female	6,027	143,049	4.2%
Male	8,063	146,982	5.5%

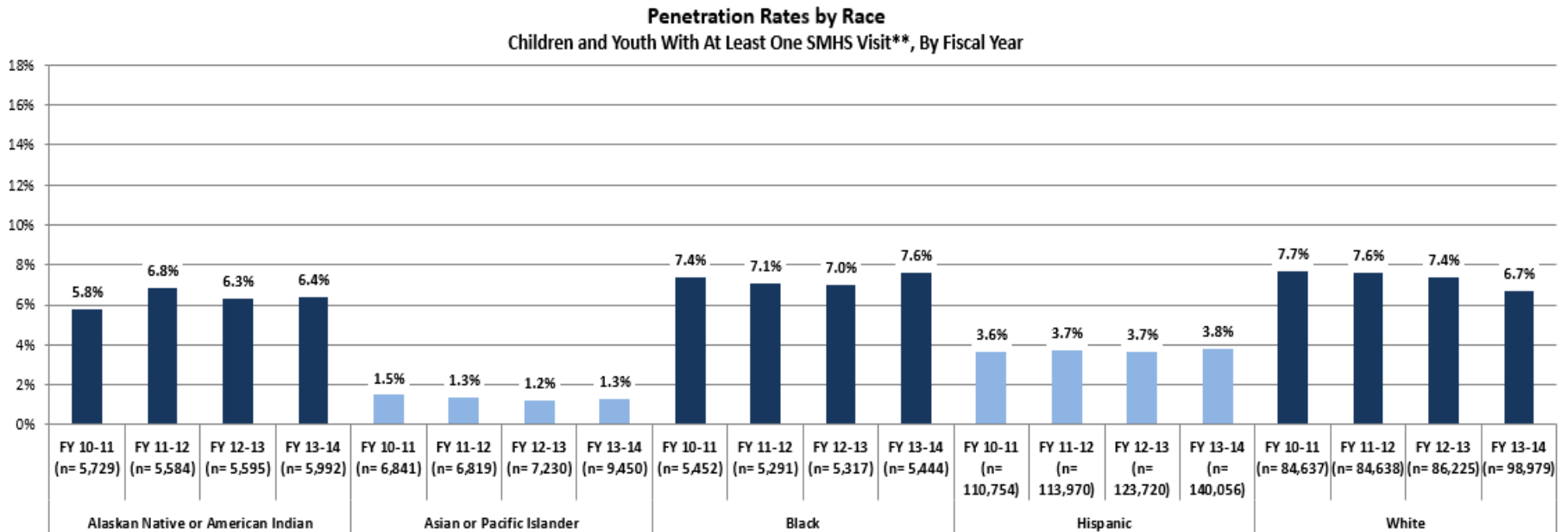
Below: Children and youth who received five or more specialty MH services during year.

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
<b>All</b>	<b>10,234</b>	<b>290,031</b>	<b>3.5%</b>
Children 0-5	718	94,029	0.8%
Children 6-11	3,969	84,937	4.7%
Children 12-17	4,409	72,362	6.1%
Youth 18-20	1,138	38,703	2.9%
Alaskan Native or American Indian	272	5,992	4.5%
Asian or Pacific Islander	80	9,450	0.8%
Black	322	5,444	5.9%
Hispanic	3,788	140,056	2.7%
White	4,890	98,979	4.9%
Other	34	1,918	1.8%
Unknown	848	28,192	3.0%
Female	4,287	143,049	3.0%
Male	5,947	146,982	4.0%



**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 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?**

ICBHS has regionalized outpatient clinics that provide services to children and youth which has significantly increased access and engagement to children, youth and their families. Outpatient clinics are located in the three major cities of Imperial County and in one of the remote communities. Three of our clinics are part of Family Resource Centers located at school sites. Under MHSA programs, PEI and Innovation, all services are provided in non-traditional settings such as client homes, schools, and community locations selected by parents/legal guardians.

The Children and Adolescents Unit has implemented Parents Reach Achieve and eXcel through Engagement Strategies (PRAXES) which is a model intended to provide psychoeducation to parents on the child's mental health disorder to reduce parental stress and improve engagement in the child's treatment to improve child's outcomes.

As part of the training plan for all clinical staff, ICBHS requires that staff attend the Skilled Helper and Motivational Interviewing training to provide the necessary skills to successfully engage children, youth and their families in treatment.

**QUESTION 1B:**

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

ICBHS has an Outreach and Engagement program that conducts activities throughout the community that target the different populations served by our department, including transition-age youth. Some of the activities include participation in health fairs and presentation to schools and community agencies. Some of the outreach activities focus specifically in the LGBT and Muslim populations.

The department also participates in collaborative meetings with agencies that serve transition-age youth such as schools, Department of Social Services, Probation Department, SELPA and San Diego Regional Center.

**QUESTION 1C:**

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

Yes   X   No \_\_\_\_\_. If yes, please list briefly.

ICBHS has identified a drop from services and less admissions for transition-age youth. There seems to be a need to place more emphasis on providing education to youth and their parents/legal guardians on the importance of continuing treatment for chronic disorders as there tends to be a perception that youth outgrow some of these disorders. Even though many of our patients are discharged from services, many youth terminate services when not recommended and parents become more disengaged as youth start voicing their desire to stop treatment.

**QUESTION 1D:**

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

ICBHS has a number of services which are provided to children with mental health needs. Services are provided based on the child's individual needs and may include one or more of the following: Medication Support Services, Therapeutic Behavioral Health Services, Intensive Care Coordination, Intensive Home-based services, Mental Health Services, Targeted Case Management, Crisis Interventions and Referral to Inpatient Care. Some of the treatment models specifically implemented for the treatment of children include the following:

- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) - for children who have been exposed to a traumatic event. This model is being offered as treatment and early intervention.
- Coping Cat – for the treatment of anxiety in children and youth
- Interpersonal Psychotherapy (IPT) – for the treatment of depression in youth.
- Aggression Replacement Training (ART)– for children with challenging behaviors.
- First Step to Success (FFS) – for kindergarten-age children exhibiting behavioral problems in Kindergarten.
- Functional Family Therapy (FFT) – for youth with behavioral, educational and conduct problems.

- Incredible Years (IY) – Preschool and School Age programs – to assist parents in promoting children’s development in a positive environment.
- Parents Reach Achieve and eXcel through Engagement Strategies (PRAXES) - to provide psychoeducation to parents on the child’s mental health disorder to reduce parental stress and improve engagement in the child’s treatment to improve child’s outcomes.
- Cognitive Behavioral Therapy (CBT) – for youth with anxiety and depression disorders.
- Vista Sands Socialization Program – school-based program for elementary school age children funded by SHAMSA for children with behavioral and emotional problems affecting home, school or community functioning.
- Adolescent Habilitative Learning Program – school-based program for junior high or high school students with behavioral and emotional problems affecting home, school and community functioning.

## 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.

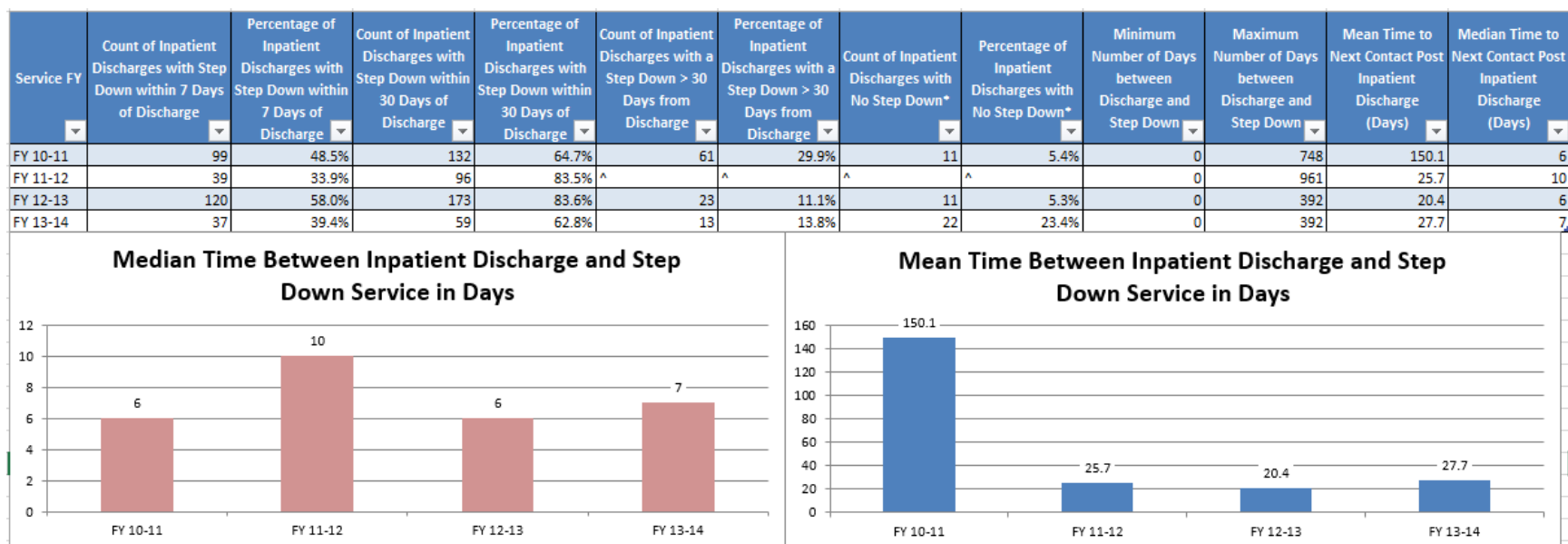
A related concern includes how we help children and youth handle a crisis so that hospitalization can be avoided. Although we do not have data for mental health crises, similar follow-up care and strategies are likely to be employed. Your local board may have reviewed the range of crisis services needed 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.<sup>14</sup>

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

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

Data for your county\* are aggregated together with small population counties (50,000 – 199,999).



When examining the post-hospitalization data above, take special note of the percentages who received follow-up services within 7 days after discharge, within 30 days after discharge, or later than 30 days. These time frames reflect federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries. On lower left side graph, the median time for follow-up is the most useful measure of this outcome. Zero days would indicate that clients were seen as outpatients on the same day as the hospital discharge. Also take note of mean time (average) from discharge to step-down services (right side graph).

\*,^ = Data 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.**

ICBHS has established policies and procedures that outline the steps to follow after a client has been hospitalized or had a mental health crisis and was seen at the Crisis and Referral Desk. In both cases, a mental health rehabilitation technician is assigned to ensure close follow-up and coordination is done during and after a client's discharge from an inpatient hospital or our Crisis and Referral Desk.

For clients who are active in services, the assigned case coordinator is in contact with parents/legal guardian/significant support person, to provide guidance on the process, maintain open communication and assist with discharge planning. The service coordinator keeps the treatment team informed of client's status and coordinates follow-up appointments to ensure client is seen by the assigned psychiatrist within the established timeframe of 7 days from discharge.

For new or re-admit clients ages 13 to adults, who reside in Imperial County, a mental health rehabilitation technician (MHRT) from the Transitional Engagement Supportive Services (TESS) program is assigned to provide the client and parent/legal guardian/significant support, guidance on the process, maintain open communication and assist with discharge planning. The assigned MHRT informs of available services and guides them through the process of obtaining an intake assessment and psychiatric assessment. This MHRT remains on the case until the client is seen by the psychiatrist and provides information on the case to ensure a smooth transition into outpatient 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.**

Parents/caregivers are provided with one-on-one assistance and support by a MHRT. The MHRT engages with family by providing psychoeducation on mental health disorders; providing supportive counseling and guidance on how to navigate through the hospital/crisis and outpatient service; coordinating and engaging in discharge planning; and developing skills to support the child after a hospitalization of crisis.

For new or re-admit clients, parents are assisted in initiating services with ICHBS by coordinating an initial intake assessment and a initial psychiatric appointment.

For individuals that do not want to access services, linkage to private providers or community agencies is facilitated.

## **QUESTION 2D:**

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

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

During discharge planning, the MHRT evaluates family needs and communicates with family, significant supports persons and community service agencies to ensure access to necessary services. The MHRT assists with transportation arrangements by engaging the family, public transportation or with the assistance of ICBHS Transportation Unit, if needed.

MHSA – Transitional Engagement Supportive Services (TESS) is funded by MHSA. This program is intended to assist new or re-admit clients in accessing services. A MHRT from the TESS program is assigned to provide the client and parent/legal guardian/significant support, guidance on the process to access outpatient mental health services including an intake and psychiatric assessment. The MHRT also facilitates communication between hospital staff, client/parent/legal guardian/significant support person to coordinate discharge planning. The MHRT provides information on



available outpatient mental health services and guides them through the process of accessing these services. This MHRT remains on the case until the client is seen by the psychiatrist and provides information on the case to ensure a smooth transition into outpatient services.

ICBHS provides the same engagement activities, free of charge, to all individuals regardless of insurance coverage or if the individual is self-pay. For individuals that do not want to access ICBHS services, linkage to private providers or community agencies is facilitated.

## 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<sup>15,16</sup> of foster youth in California schools:

The key findings for California foster youth included:

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

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

<sup>15</sup>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>.

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

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

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

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

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

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

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

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

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

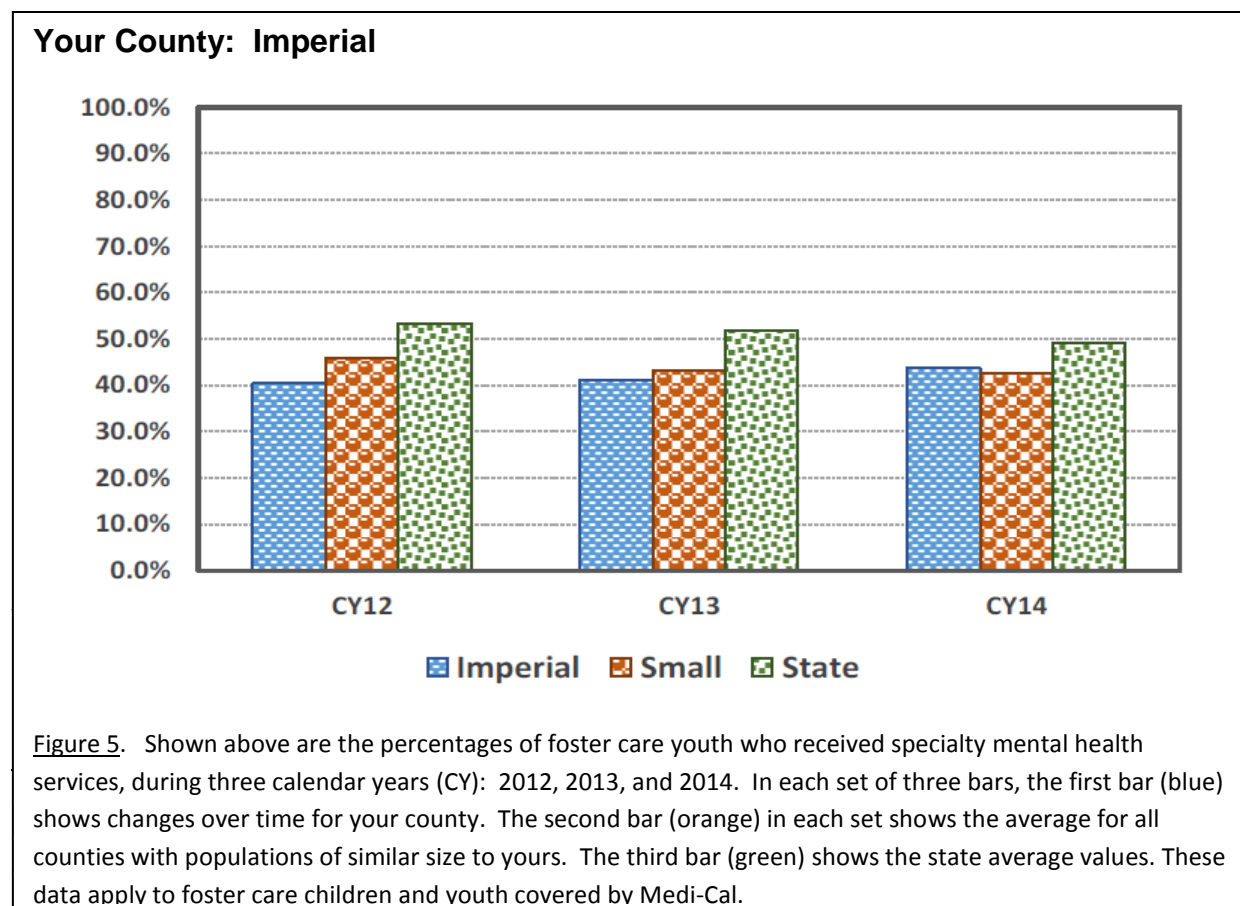
\* Data reports are from: <http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx>. The data are for fiscal years 2014 or 2015 (depending on which data are the most recent available at the time of this report).

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

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

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

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



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

**QUESTION 3A:**

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

**Please list or describe briefly.**

ICBHS has been working closely with Department of Social Services (DSS) to develop a process to ensure foster youth in need of services are identified and evaluated. An MOU was developed between the two agencies that outlines our agencies' responsibilities and exchange of information. The process includes the screening of all dependent children and voluntary cases to determine the need for a mental health assessment. A referral to ICBHS is generated on all cases where the screening tool identifies the need for a mental health evaluation. ICBHS then proceeds to evaluate and determine if the child meets medical necessity criteria for services and makes treatment recommendations. If clients do not meet criteria for Specialty Mental Health Services, they are referred to other programs such as the Prevention and Early Intervention or Innovation program.

ICBHS does continuous assessment on all foster youth to evaluate treatment needs.

**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.**

ICBHS and DSS have regular meetings to discuss services for foster care children and youth. Both agencies have assigned liaison staff to coordinate the appropriate processing of all referrals and to communicate the status and treatment recommendations. During these meetings concerns are discussed and efforts are made to remove barriers or provide clarification to staff.

ICBHS has also been providing training on common mental health disorders in children and youth and on supportive interventions to foster parents.

**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.**

ICBHS has identified that children are able to engage in treatment, however, in many cases foster parents become overwhelmed and decline more intensive services, which are recommended by the treatment team. This has been discussed with DSS who have been providing support and education to foster parents on the importance of ensuring that children receive the recommended treatment.

Youth are increasingly being included in the decision making process for their own health care. This is an important developmental step to encourage as the youth needs take ownership of the decisions made during treatment. Psychoeducation about medications and their diagnosis are important elements to empower youth to engage in treatment and become an active participant rather than a passive recipient. Once the youth turns 18, many new issues and challenges will arise in addition to managing a mental illness. Developing and maintaining a healthy support system is a key element in the preparation to face this new phase of development. Parents/guardians can be a valuable source of support and must be encouraged to participate whenever appropriate. ICBHS staff can commit additional time and focus to this important transitional time and work towards helping the youth build a collaborative relationship with their parents/guardians.

## 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.<sup>18</sup>

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.<sup>19</sup>

### 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."

<sup>18</sup> P. Walker et al., "Do No Harm: Mental Health Services: The Good, the Bad, and the Harmful."

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

**QUESTION 4A:**

**Does your county have programs which are designed and directed specifically to LGBTQ youth? Yes\_\_\_ No X.**

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

Enhanced training and education is provided to staff regarding cultural awareness which also includes a focus on LGBTQ youth and families. This is emphasized to ensure that staff are informed and sensitive to the particular needs and mental health challenges facing this population. This training serves a valuable part in creating a receptive and therapeutic environment. Additionally, staff has established an LGBTQ Youth committee to engage consumers in order to obtain input on creating a welcoming and nurturing environment within our clinics. Finally, each clinic location has been designated an LGBTQ Safe Zone and is identified with a "Safe Zone" poster. This has been done in order to clearly communicate that clinics are welcoming and receptive locations for the LGBTQ community.

**QUESTION 4B**

**Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes\_\_\_ No X.**

**If yes, please list or describe briefly.**

Enhanced training and education is provided to staff regarding cultural awareness which also includes a focus on LGBTQ youth and families. This is emphasized to ensure that staff are informed and sensitive to the particular needs and mental health challenges facing this population. This training serves as a valuable part in creating a receptive and therapeutic environment and is utilized by treatment staff to assist LGBTQ youth in improving and strengthening family relationships. Finally, each clinic location has been designated an LGBTQ Safe Zone and is identified with a "Safe Zone" poster. This has been done in order to clearly communicate that clinics are welcoming and receptive locations for 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.**

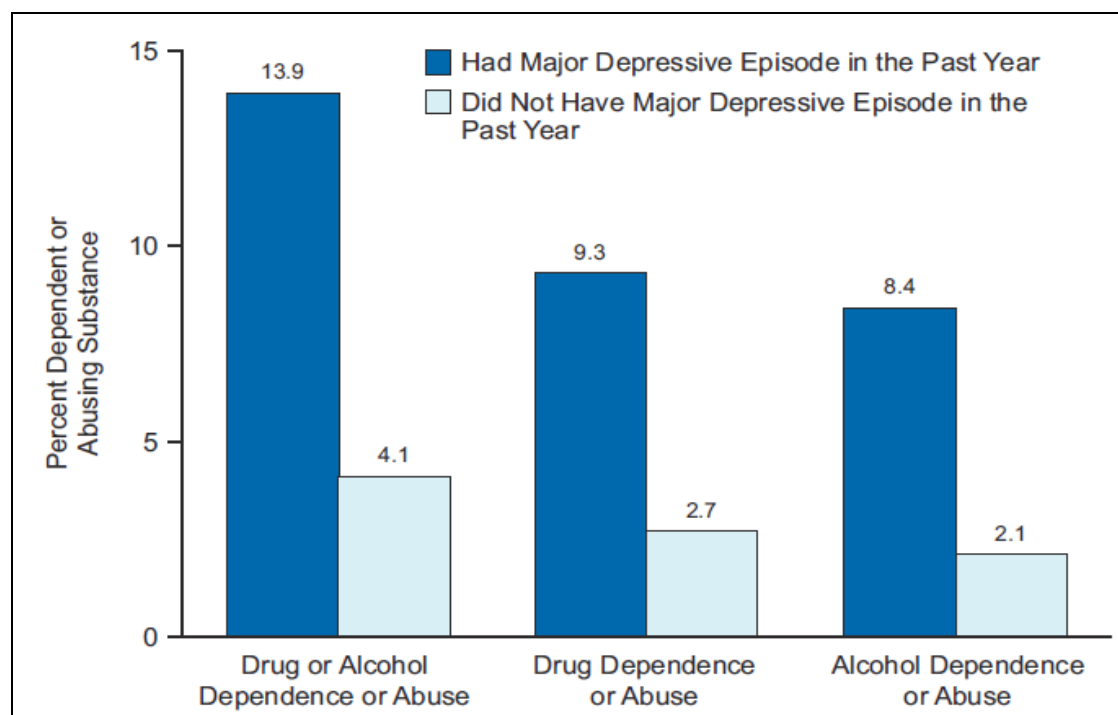
Efforts should be made to collect data to define the community of LGBTQ youth and their families. This information would help ICBHS to identify the type and extent of unmet needs. This information would assist in developing programs, providing targeted services or directing resources to address the unmet needs.

## 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.<sup>20</sup> (See next figure, 2013 data, NSDUH).

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



<sup>20</sup> 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.<sup>21</sup> 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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<sup>21</sup>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>

## Imperial County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	Any	None
7th Grade	16.8%	83.2%
9th Grade	31.6%	68.4%
11th Grade	41.8%	58.2%
Non-Traditional	N/R	N/R
All	29.6%	70.4%

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

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

### California: Statewide

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

### Your County: Imperial

Age <18:      216      Age 18-25:      64

## QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Yes   X   No       

If yes, please list or describe briefly.

Outpatient Drug Free group therapy is provided to youth who have a diagnosed substance use disorder.

Substance Use Disorder treatment services are provided regionally at the following schools:

- Calexico Aurora High School
- Calexico High School
- Calexico Academy School
- Central Union High School-El Centro
- Brawley Del Rio Academy
- Brawley Union High School
- Brawley Desert Valley High School

## El Centro Valley Academy School

Services are provided to the youth involved in the Justice system by providing services at the Juvenile Hall facility. Outpatient services are also offered at an outpatient clinic setting in El Centro. There are no residential services available in Imperial County however, residential 14 day detoxification is provided through a contract provider (McAllister Institute) in San Diego. Outreach and Drug prevention services are provided to schools and the community.

**If no, what is the alternative in your county?**

### **QUESTION 5B:**

**Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes   X   No**

**Please explain briefly.**

Substance Use Disorder treatment services are provided regionally at the following schools:

- Calexico Aurora High School
- Calexico High School
- Calexico Academy School
- Central Union High School-El Centro
- Brawley Del Rio Academy
- Brawley Union High School
- Brawley Desert Valley High School
- El Centro Valley Academy School

Services are provided to the youth who are in custody and identified as having substance use problems by providing services at the Juvenile Hall facility. Outpatient services are also offered at an outpatient clinic setting in El Centro. There are no residential services available in Imperial County however, detoxification is provided through an out of county contract provider.

Services that are provided regionally ensure that children and youth have access to needed services close to the cities where they reside. Additionally, providing services at school sites allows children and youth to access services where they are during the day without depending on family members to transport them to scheduled appointments.

## 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.”<sup>22</sup> 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.”<sup>23</sup>

The 2016 California Children’s Report Card<sup>24</sup> defines one particularly vulnerable group as “crossover youth” (or multi-system users), because they have a history involving both the child welfare and juvenile justice systems. Often these children and youth have had multiple episodes of trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood. Parental abuse or neglect may have resulted in the child’s placement in foster care or a group home, which is intended to provide for safety and well-being. In addition, the experience of removal from one’s home is highly traumatic and the foster home may or may not be able to fully meet the child’s needs. Studies show that these “youth are more than two times as likely to be incarcerated for low-level offenses than their justice-involved peers who are not involved in the child welfare system.”

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<sup>22</sup> 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](http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf)

<sup>23</sup> 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,

<sup>24</sup> Website: [www.ChildrenNow.org](http://www.ChildrenNow.org), see report: California Children’s Report Card, 2016.

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

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

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

**One major risk for incarcerated youth is suicide.**

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

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

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<sup>25</sup>“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](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/](http://www.ncsc.org/~media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/)

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers<sup>26</sup> 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<sup>27</sup> and Types of Juvenile Arrests, California, 2014**

Total population <sup>28</sup> age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

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

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

<sup>26</sup>Data are from: [www.kidsdata.org](http://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.

<sup>27</sup> Percentages may not add to 100% due to rounding effects. Data are from California Department of Justice reported in 2015.

<sup>28</sup>CA Department of Finance, Report P-3, December 2014



**Data shown below:**

Recent county-level arrest data are not available to us for all types of juvenile offenses. However, we present the number of felony arrests for your county,<sup>29</sup> 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: Imperial 95 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<sup>30</sup> sources for these programs.**

Services are provided for juveniles who are in custody who have been referred to Behavioral Health for services when they display significant symptoms of severe depression, suicidal ideation, and irrational, violent or self-destructive behaviors.

**PROGRAM:**

Juvenile Hall Mental Health Services  
Medication Support

Mental Health Services-Assessment  
Mental health Services-Therapy  
Mental Health Services-Targeted Case Management  
Mental Health Services-Rehabilitation  
Suicide Assessment/ Safety Plan Development  
Substance Use Disorder Groups

**FUNDING SOURCE:**

Realignment  
Probation-MOU &  
Realignment  
Realignment  
Realignment  
Realignment  
Realignment  
Probation-MOU

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<sup>29</sup> County-level data are from [www.KidsData.org](http://www.KidsData.org), a program of Lucile Packard Foundation for Children's Health.

<sup>30</sup> 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.

**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   X   No**

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

**PROGRAM:**

Moral Reconciliation Therapy  
Substance Use Disorder Groups-Community Schools  
Substance Use Disorder Groups-Outpatient Clinic  
MHSA-Full Service Partnership

**FUNDING SOURCE:**

Short Doyle Medi-cal  
Drug Medi-cal  
Drug Medi-cal  
MHSA

**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.**

Parents/guardians of juveniles are welcomed and encouraged to participate in treatment services whenever possible. Collateral contacts between treatment staff and the parents/guardians are conducted when appropriate. MHSA Full Service Partnership participants receive case management services which include contacts with parents/guardians and home visits.

## 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:<sup>31</sup>

- **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.<sup>32</sup> 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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<sup>31</sup> 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](http://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf)

<sup>32</sup> 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](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.<sup>33</sup> 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.<sup>34</sup>

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.<sup>35</sup> 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.<sup>36</sup>

**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

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

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

<sup>35</sup> 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/articles/PMC3744095/>

<sup>36</sup> <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.<sup>37</sup>

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

California	Percent	
	Yes	No
Grade Level		
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).<sup>38</sup> Some counties or school districts either did not administer the surveys or else did not report their results.

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<sup>37</sup> **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.

<sup>38</sup> **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.

**Imperial County:**

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

<b>Suicidal Ideation (Student Reported), by Grade Level: 2011-2013</b>		
<b>Grade Level</b>	<b>Yes</b>	<b>No</b>
9th Grade	21.6%	78.4%
11th Grade	18.0%	82.0%
Non-Traditional	N/R	N/R
All	20.0%	80.0%

**QUESTION 7A:**

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

**Yes \_\_\_\_ No X If yes, please list and describe very briefly.**

The two target population under the Prevention and Early Intervention (PEI) are ***trauma-exposed individuals*** and ***children and youth in stress families***. Due to the low incidence of suicide in children and youth ages 6 to 16 in Imperial County, ICBHS decided not to focus on this target population. However, the outreach and prevention activities conducted under our PEI program include education on suicide prevention. These activities are conducted county wide and many of them take place in schools where children and youth are the target audience.

**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.**

ICBHS training plan requires that all clinical staff attend specific trainings that focus on suicide prevention. These trainings include:

- Mental Health First Aid
- Applied Suicide Intervention Skills Training (ASIST)
- Suicide & Self Harm

ICBHS has certified trainers for the Mental Health First Aid and ASIST. These trainings are provided on a regular basis and invitations are extended to community partners like law enforcement, education, and probation staff.

**QUESTION 7C:**

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

**Yes   X   No        If yes, please list briefly.**

ICBHS increased its collaboration with emergency departments and law enforcement departments. This was successful via the implementation of evidence based practices / trainings such as the Crisis Intervention Team (CIT). The CIT took effect in April and May 2016. Since then ICBHS has held monthly meetings with local hospitals and law enforcement agencies for the development and establishment of new protocols to provide appropriate interventions for individuals at risk. These efforts need to continue to ensure adequate collaborate efforts.

The department periodically evaluates data on suicides in our community. This data is and will be used to identify community needs and for program planning. The department will also continue to include partner agencies in suicide prevention trainings to ensure that those who come in contact with individuals at risk of suicide are able to intervene appropriately.





## Early Identification of Risks for First-break Psychosis

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

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

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

### QUESTION 8A:

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

Yes   X   No       

### QUESTION 8B:

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

Age Range: 12-25

Description: The PIER model is an early treatment for adolescents and young adults which focuses on the pre-psychotic phase of a developing psychotic illness. The expected outcome is to avoid the potentially devastating consequences of mental illness, allowing individuals to achieve their full potential.

The key components to the PIER Model are:

1. Community Outreach/ Education
2. Assessment
3. Treatment
  - a. Family psycho-education
  - b. Supported education and employment
  - c. Low dose medication as indicated

Funding Source:   Mental Health Block Grant  
                          Mental Health Services Act

**QUESTION 8C:**

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

Yes ☐    No ☒    If yes, please describe briefly.

## 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.<sup>39</sup>

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<sup>40</sup> by CBHDA released in early 2016. First, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, take note of which outcomes show improvement and those which may need further attention to improve services for client recovery and wellbeing.

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<sup>39</sup> 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](http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_Eval5_FSPCostAndCostOffset_Nov2012.pdf)

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

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

**STATEWIDE DATA:**

FSP Partners included in this analysis: 41 counties<sup>41</sup> plus Tri-Cities group reporting, Fiscal Year 2013-2014:

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

**Table 7. Children, ages 0-15.**

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

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

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

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

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

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

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

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

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

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

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

#### **QUESTION 9A:**

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

1. Problems with school performance
2. Use of emergency MH services
3. Substance Abuse

Services provided through Katie A including Intensive Care Coordination and Intensive Home Based Services and Case Management services through MHSA Full Service Partnerships have had some impact on those problem areas listed above.

#### **QUESTION 9B:**

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

The FSP data for children 0-15 with a completion of 1 year of FSP Services show only a 12% decrease in Out of Home Placements. This suggests improvements can be made in an attempt to decrease Out of Home Placements.

Mental Health Plans (MHPs) are obligated to provide Intensive Care Coordination (ICC) and intensive Home Based Services (IHBS) through EPSDT benefit to all children and youth under age 21 who are eligible for the full scope of Medi-Cal services and meet the medical necessity criteria for Specialty Mental health services. These services along with the use of Child and Family Teams (multi-agency, multi-partner participants) can be utilized in a more extensive manner to achieve the goal of reducing out of home placements.

**Question 9C:**

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

**Yes   X   No        If yes, please describe briefly.**

Wrap-around services through the use of Child and Family Teams are being implemented in order to provide Intensive Care Coordination and Intensive Home Based Services. This method will result in an intensive level of service delivery including significant individuals involved in the child’s life who provide parenting, daily care, education, health care, mental health care, and significant others.

## QUESTIONNAIRE: How Did Your Board Complete the Data Notebook?

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

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

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

☐ MH Board completed majority of the Data Notebook

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

☒ Data Notebook placed on Agenda and discussed at Board meeting

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

☒ MH Board partnered with county staff or director

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

☐ Other; please describe: \_\_\_\_\_.

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

Yes ☒ No ☐

If yes, please provide their job classification: Administrative Services Supervisor

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

Name and County: Marcy Sesma Lopez, Imperial County

Email: [marcysesma@co.imperial.ca.us](mailto:marcysesma@co.imperial.ca.us)

Phone #: (442)265-1605

Signature: \_\_\_\_\_

Other (optional): \_\_\_\_\_

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

Name and County: Benny Benavidez, Imperial County

Email: [ben.benavidez@hotmail.com](mailto:ben.benavidez@hotmail.com)

Phone #: (760)353-8919

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](mailto: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

