KERN 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

This page intentionally left blank.

TABLE OF CONTENTS

Table of Contents

This page intentionally left blank.

KERN COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (2016): 886,507

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

http://www.co.kern.ca.us/artman2/kcmh/publish/

Website for Local County MH Data and Reports:

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

http://www.co.kern.ca.us/kcmh/bhb

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

Total number of persons receiving Medi-Cal in your county (2013): 329,016

Average number Medi-Cal eligible persons per month (2014): 296,472

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 54.3 %

Adults, 18 and over: 45.7 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 13,134

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 54.0 %

Adults, 18 and over: 46.0 %

---

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

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

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

This Page Intentionally Left Blank

INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

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

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

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

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

The Data Notebook is designed to meet these goals:

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

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

---

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

state's population. The analyses resulted in the Statewide Overview report that is on the CMHPC website at:

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

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

Resources: Where do We Get the Data?

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

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

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

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

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

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

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

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

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

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

How Do the Data Sources Define Children and Youth?

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

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

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

[11] Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.
[12] N/A means not applicable, because this category is not available under this system or data source.

How Can Local Advisory Boards Fulfill their Reporting Mandates?

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

Welfare and Institutions Code, Section 5604.2 (a)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Thank you very much for participating in this project.

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

Access: Outreach and Engagement with Services

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

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

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

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

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

---

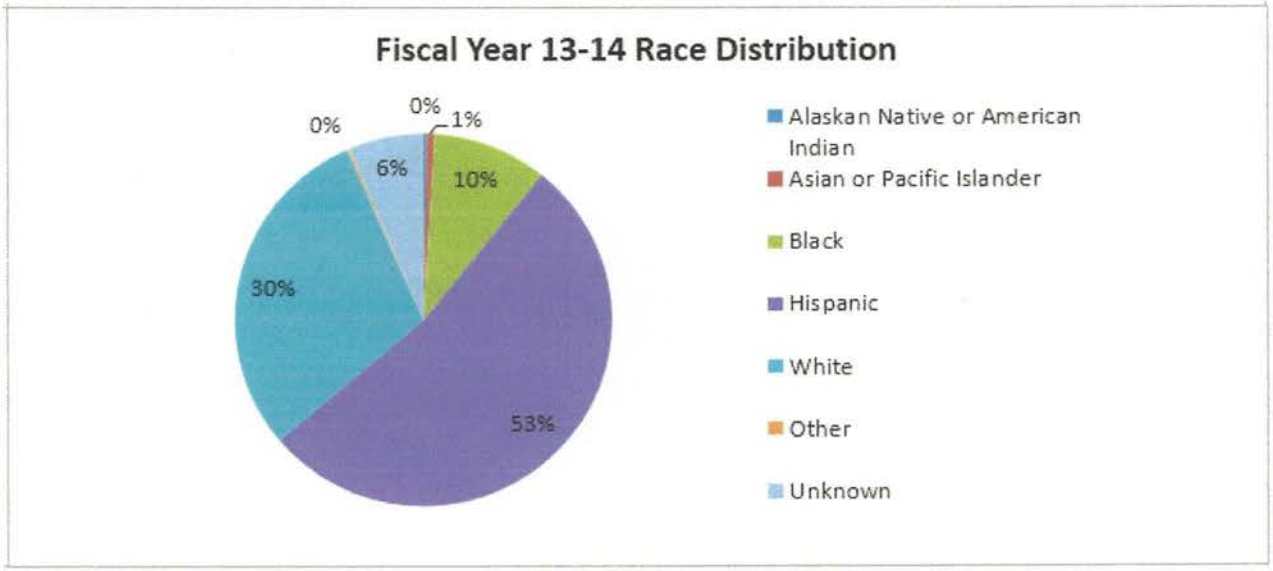
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

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

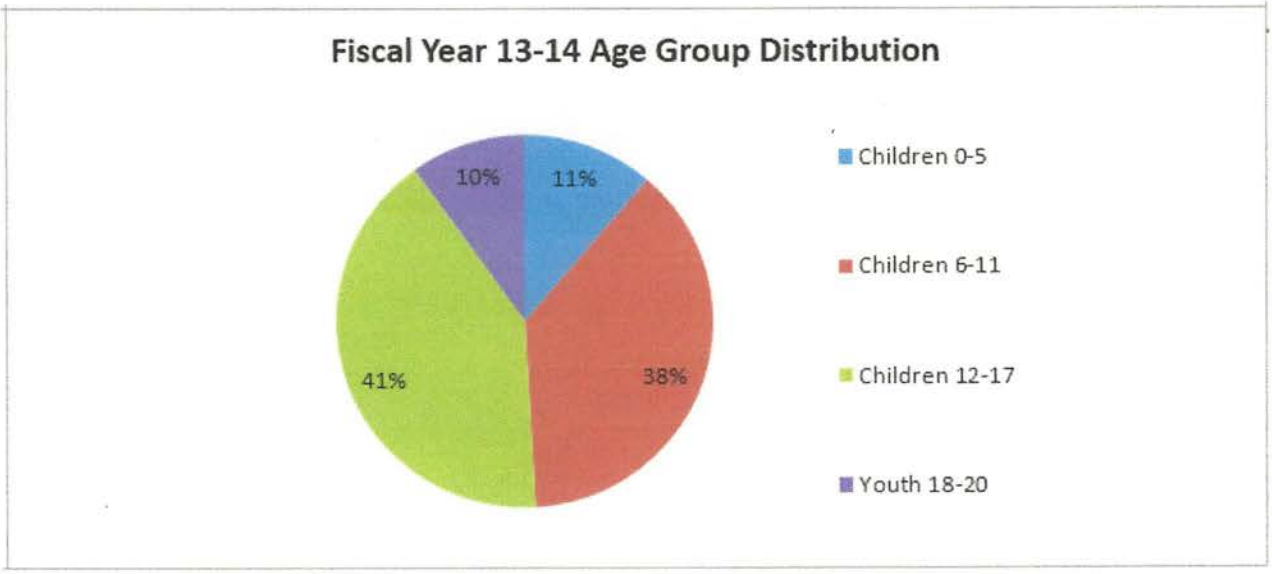
Unique numbers of children and youth who were Medi-Cal eligible: ***200,060***

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **8,028**.

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



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



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

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

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

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

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

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

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

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

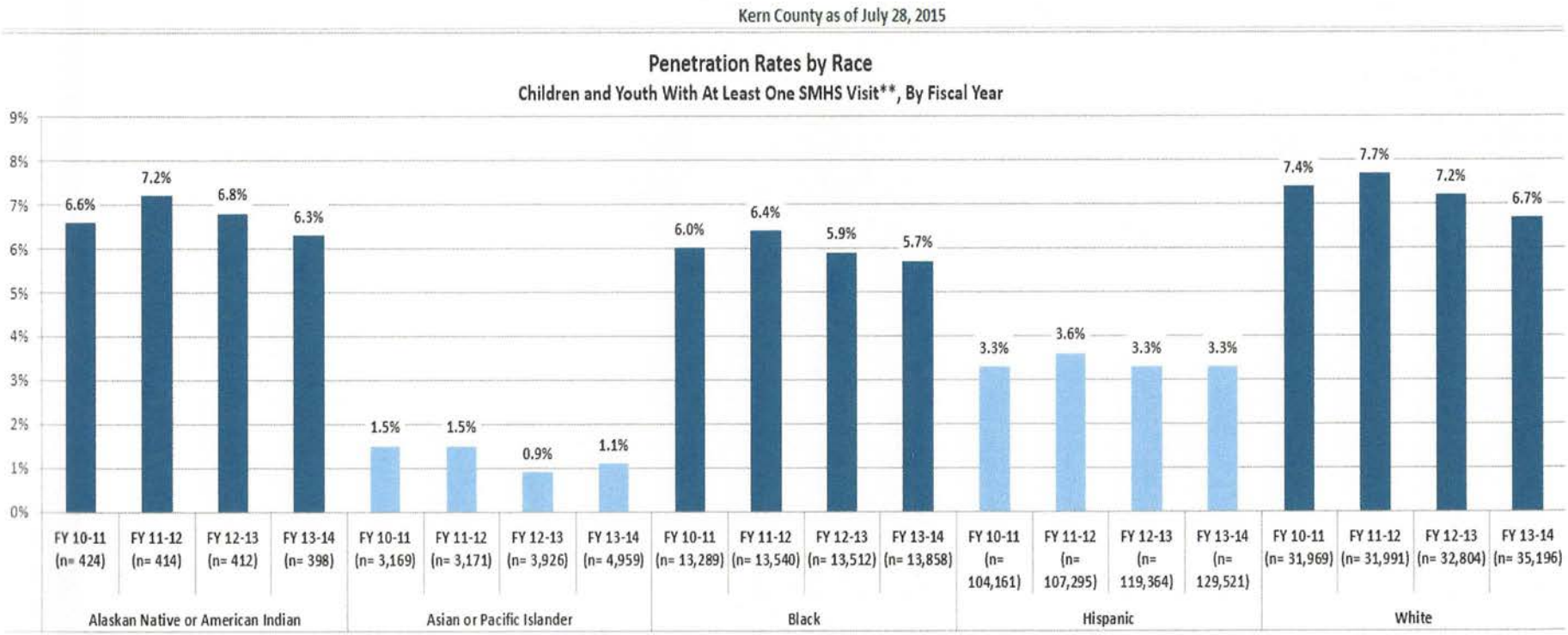
	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**8,028**	**200,060**	**4.0%**
Children 0-5	907	66,567	1.4%
Children 6-11	3,035	58,817	5.2%
Children 12-17	3,291	48,892	6.7%
Youth 18-20	795	25,784	3.1%
Alaskan Native or American Indian	25	398	6.3%
Asian or Pacific Islander	54	4,959	1.1%
Black	790	13,858	5.7%
Hispanic	4,253	129,521	3.3%
White	2,371	35,196	6.7%
Other	18	573	3.1%
Unknown	517	15,555	3.3%
Female	3,446	99,960	3.4%
Male	4,582	100,100	4.6%

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

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**5,032**	**200,060**	**2.5%**
Children 0-5	381	66,567	0.6%
Children 6-11	1,989	58,817	3.4%
Children 12-17	2,223	48,892	4.5%
Youth 18-20	439	25,784	1.7%
Alaskan Native or American Indian	18	398	4.5%
Asian or Pacific Islander	29	4,959	0.6%
Black	450	13,858	3.2%
Hispanic	2,638	129,521	2.0%
White	1,529	35,196	4.3%
Other	^	573	^
Unknown	^	15,555	^
Female	2,104	99,960	2.1%
Male	2,928	100,100	2.9%

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: Kern



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

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

QUESTION 1A:

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

Yes_X_ No____ If yes, what strategies seem to work well?

The Children's System of Care (CSOC) through MHSA PEI has implemented several programs to increase access: Youth Brief Treatment, Youth Juvenile Justice Engagement, Foster Care Engagement and Transitional Age Youth Career Development. In addition, Full Service Partnerships, Youth Multi-Agency Integrated Service Team (MIST), Youth Wraparound, and Transitional Age Youth (TAY) teams that have 24/7 access are available throughout the county. These programs seek to ensure that engagement, assessment and linkage occurs for specialized populations. The teams that provide these programs are strategically located in areas to target underserved population including:

- Child Guidance - GSA[14] 1 Delano; GSA 4 West Bakersfield
- Clinica Sierra Vista - GSA 9 Arvin; GSA 10 Central and Southeast Bakersfield
- College Community Services - GSA 2 Wasco
- Kern County Mental Health (KCMH) - GSA 11 East Bakersfield
- KCMH Specialty Services, Youth Wraparound, and MIST
- Transitional Age Youth (TAY) Team (Stationed at America's Job Center of California, Dream Center and Residences at West Columbus)
- Foster Care, Co-located at Kern County Department of Human Services

Targeted Specialized Populations include:

- Hispanic population residing in outlying areas with lower penetration rates
- Youth involved in the juvenile justice system
- Foster youth
- Homeless Families
- Transitional Age Youth
- Commercially Sexually Exploited Youth
- LGBTQ

[14] **GSA—Geographic Service Area*

Collaborative relationships and community outreach are essential to implementing strategies throughout the community to increase access to care.

Community Partners Include:

- Schools: Partnering with our educational system is essential in providing services to our children and families. For over 20 years, all Kern County schools have had a mental health provider assigned to serve our target population on each school campus.
- Department of Human Services (DHS): KCMH works collaboratively to assist foster youth with linkage to needed services. Integration of agencies is essential to providing quality care for foster youth. KCMH has formed several inter-agencies teams, which integrate DHS staff into the mental health teams. These teams include Foster Care, Youth Wraparound, and the Multi-Agency Integrated Service Team (MIST). Additionally, KCMH provides mental health staff co-located on DHS sites.
- Kern County Network for Children: A community collaborative that serves to improve child safety in our community. KCMH attends their monthly meetings in order to educate the community on the services we offer.
- Probation: KCMH has designed programming to ensure Juvenile Justice Youth are engaged in services. KCMH utilizes probation staff that are co-located and part of the MIST and Wraparound team. We work closely with them to assist with needed services and reduce recidivism to keep youth from returning to the Juvenile Justice system. KCMH also has a Juvenile Probation Psychiatric Services (JPPS) team that is located at Juvenile Hall in order to assist youth that have psychiatric needs while incarcerated. In addition, KCMH partners with Kern County Superintendent of Schools (KCSOS) and Kern County Probation, with staff placed at Blanton Academy, which primarily serves Juvenile Justice Youth.

Out Reach and Education

- In an effort to ensure that the community is aware of available services the CSOC care provided outreach and education to approximately 15,259 people in 2016.

QUESTION 1B:

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

The CSOC understands that this special population is at high risk, especially those who are emancipating from the Juvenile Justice and Child Welfare Systems. The TAY team

specializes in engaging this population into services and overall support as they transition into adulthood. Some strategies include the following:

- Career Days at Bakersfield College/ California State University of Bakersfield (CSUB), where TAY staff are available to speak with youth and provide immediate referrals/services.
- Yearly participation at "Independent City" an outreach and engagement effort to Transitional Age Youth.
- Health Fair with Kern County Public Health Department
- Dream Center: Kern County Mental Health has strategically placed TAY staff at this location (due to this being a hub for transitional age youth) to increase outreach and engagement efforts.
- KCMH and Providers works with the Independent Living Program and DHS workers to promote mental health well-being and reduce the stigma often associated with receiving mental health services among TAY youth.
- KCMH outreach to youth at the 2016 California Children's Services Transition Conference in order to provide education about the TAY program, as well as reduce stigma.
- MHSA PEI Career Development program and Full Service Partnership to provide preventative care and more intensified services as they are needed.
- Geographic service area providers engage Youth in Community by being available in events and places that Transitional Age Youth Frequent.

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.

We would like to see more evidenced based training within the mental health services for specific ethnic or cultural populations.

Additional recommendations are to increase the specialized service provision for TAY youth beyond the existing service parameters for current KCMH TAY program (currently focused on foster youth) to offer the specialized service to all TAY youth, regardless of

foster care history, and to support and train a specialized ASOC team to provide age appropriate services to the TAY population.

QUESTION 1D:

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

Main strategies for assisting parents/caregivers of youths with mental health needs:

- Ensure that all services when possible are family focused.
- Integration of parents and families in all mental health services that strive to provide support and psycho-education to the entire family.
- Child and Family Teams – As part of the Continuum of Care Reform all foster youth will begin to have Child and Family Team (CFT) meetings that emphasize the importance of the families' voice. As a part of this plan, mental health providers are ensuring that part of the team discussion includes working with the social worker to identify family, or other long-term relationships/placement, that can be engaged in family therapy at the onset of treatment.
- Intensive Care Coordination, previously a service for Katie A subclass youth, is now expanded to all Medi-cal beneficiaries who meet criteria, which will allow for an increase of Child and Family Teams.
- Support for parents via parent support groups or other more formalized Evidence-based approaches such as Systematic Training for Effective Parenting (STEPS), Therapeutic Foster Care, or Functional Family Therapy.
- Drop in parent support groups are offered through some providers regardless of if they are currently engaged in services through an existing service team.
- Provide information and referrals to parents for other community resources.
- Continue to engage with youth and families to identify barriers and decrease stigma, so that they may increase participation in mental health treatment.
- Continue to identify family's basic needs in order to maintain stable housing and a safe environment for our youth and families, so that they are able to focus on their mental health treatment
- Advocate for parents with other community agencies, such as schools, DHS, and Probation.
- Assist parents in linking to their own mental health services when indicated.

- Ongoing assessment of self-care for staff, in order to continue being objective and provide support and hope for the families

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 (step-down) 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.[15]

---

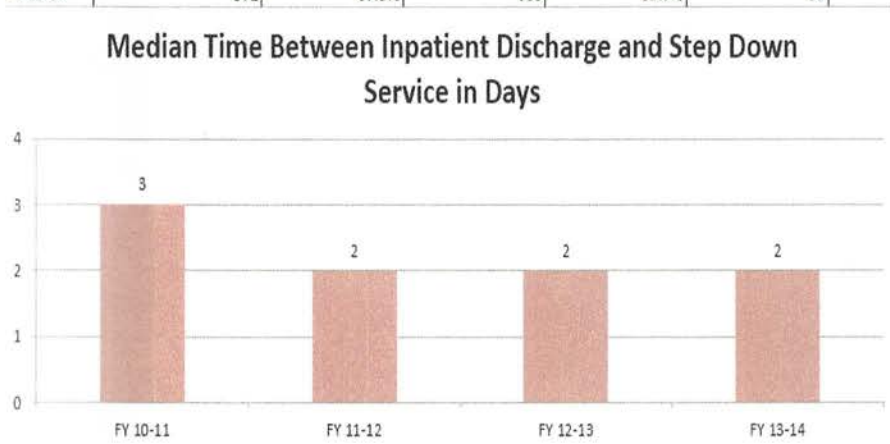
[15] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

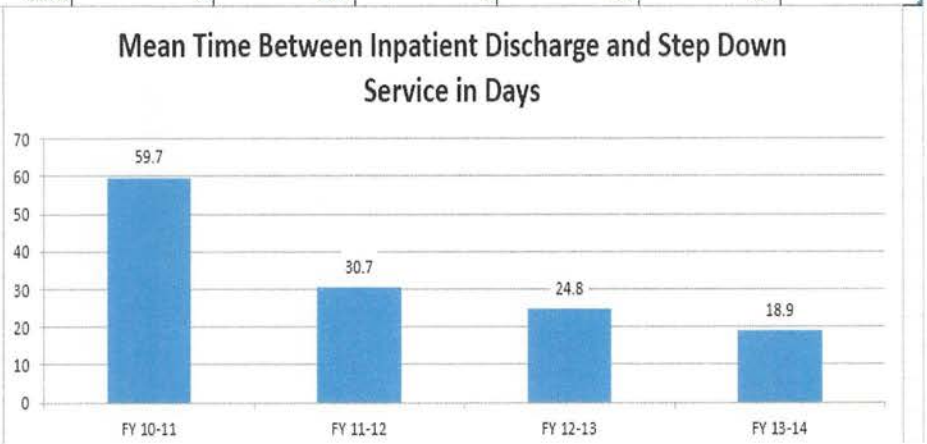
Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization. (2010-2014).

Your County: Kern

Kern County as of July 28, 2015

Service FY	Count of Inpatient Discharges with Step Down within 7 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 7 Days of Discharge	Count of Inpatient Discharges with Step Down within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 Days of Discharge	Count of Inpatient Discharges with a Step Down > 30 Days from Discharge	Percentage of Inpatient Discharges with a Step Down > 30 Days from Discharge	Count of Inpatient Discharges with No Step Down**	Percentage of Inpatient Discharges with No Step Down	Minimum Number of Days between Discharge and Step Down	Maximum Number of Days between Discharge and Step Down	Mean Time to Next Contact Post Inpatient Discharge (Days)	Median Time to Next Contact Post Inpatient Discharge (Days)
FY 10-11	191	59.9%	237	74.3%	51	16.0%	31	9.7%	0	1698	59.7	3
FY 11-12	251	69.0%	295	81.0%	39	10.7%	30	8.2%	0	1035	30.7	2
FY 12-13	452	67.9%	541	81.2%	78	11.7%	47	7.1%	0	779	24.8	2
FY 13-14	572	67.9%	680	80.7%	93	11.0%	70	8.3%	0	624	18.9	2





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).

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.

Current considerations are that a seven day parameter to follow up from an inpatient discharge is most likely too long of a timeframe; recognizing children and family should be seen sooner than seven days following an inpatient discharge.

QUESTION 2B:

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

- The automatic referral to Youth Wraparound for all crisis utilization helps to ensure timely follow up after hospitalization. Referrals occur upon one of the following:
  - ✓ After engagement by our Mobile Evaluation Team;
  - ✓ Through admission to the Psychiatric Evaluation Center (PEC); or
  - ✓ Through subsequent admission to inpatient hospitalization

- The KCMH Youth Wraparound team works with the youth and family to determine the most appropriate service provider, which could be the Geographic Service Area (GSA) outpatient provider, the TAY team, or an Adult System of Care (ASOC) team. These youth are at a fragile age between the Children's and Adult System of Care. If determined that the youth would be better served by the ASOC, the CSOC continues to serve youth until a successful warm handoff has occurred. Furthermore, if needed the CSOC may continue to serve youth and collaborate with the ASOC to facilitate a slower transfer while the youth adjusts to the adult service team.

- More often than not, transitional-aged youth continue to receive services through the CSOC, either through the appropriate GSA provider or the TAY Team. The Transition to Independence Process (TIP) model is utilized to engage youth in services and the process below is followed to ensure that transition-aged youth

and families are engaged, and receive prompt follow-up after hospitalization or other mental health crisis.

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.

- Youth Wraparound is notified when Youth utilizes crisis services (PEC or hospitalization) and rapid efforts to provide access to treatment occur. The Youth Wraparound Team focuses on the following:

  - ✓ Triage
  - ✓ Assessment
  - ✓ Plan Development
  - ✓ Advocacy and Linkage to services
  - ✓ Intensification of existing or adjunct services

- During hospitalization of youth, the Wraparound team follows up with the inpatient hospital through a Daily Treatment Focus (DTF) meeting to ensure services are properly coordinated, and that as the youth discharges the family's needs and preferences are prioritized.

- The CSOC has service providers located throughout the county that, upon discharge, quickly engage with the family to provide safety planning and offer mental health services including, but not limited to: psychiatric services, family therapy, Intensive Home Based Service (IHBS), and Therapeutic Behavioral Services (TBS).

- For Fiscal Year 15/16 the standard of providing a minimum of one (1) clinical service within seven (7) calendar days of hospital release was met at 98% for the Children's System of Care.

- Several evidence based approaches such as Dialectical Behavior Therapy (DBT), Aggression Replacement Training (ART) and Family Functional Therapy are available to youth and families.

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.

- The Youth Wraparound team is an MHSA FSP team available to ensure that children and families are provided appropriate care after hospitalization.
- Youth Wraparound engages each referral to encourage, support, and link youth and families to ensure linkage to appropriate outpatient mental health services.
- Youth Wraparound, as permitted by the family, will engage other community and natural supports to ensure families' needs are met.
- Family Advocate is available to assist families when needed.

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[16,17] 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.

---

[16] 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.

[17] 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

Your County: Kern

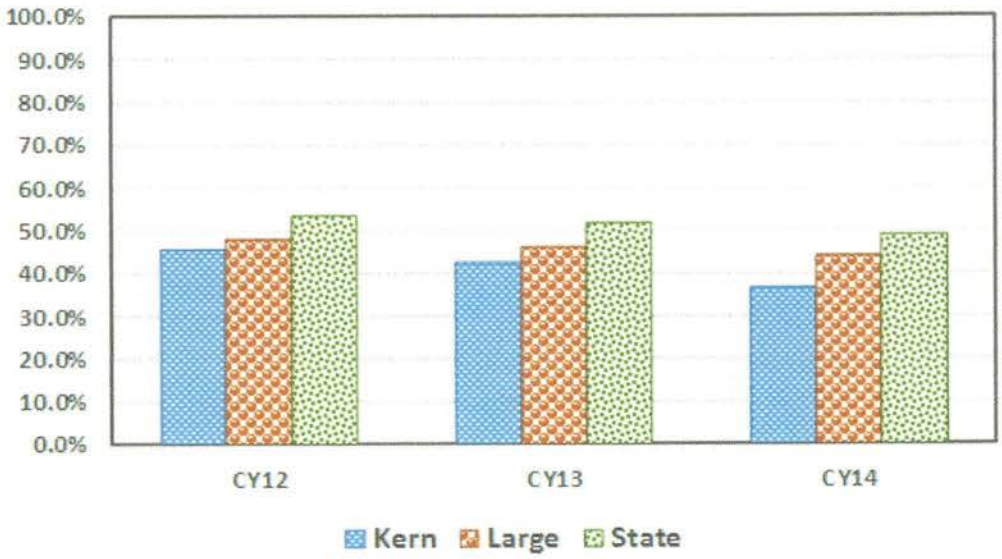


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows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

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

Figure 5a. Updated Percentages of Foster Youth Who Received Specialty MH Services (FY 13-15)

Kern County:

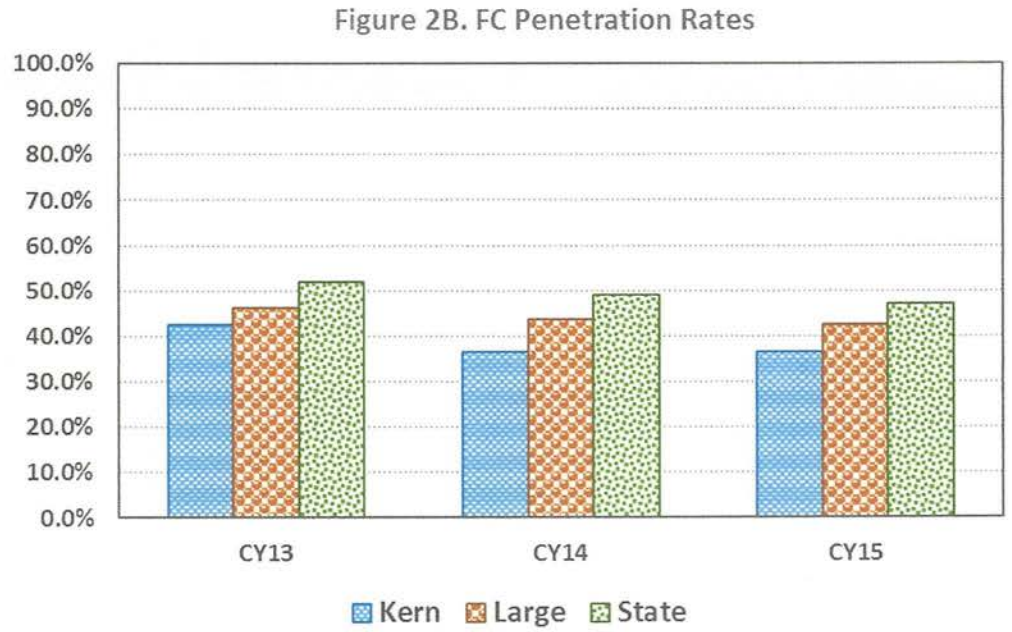


Figure 5a. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2013, 2014, and 2015. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

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.

- Pathways to Well Being (Katie A Subclass) - In order to prevent youth from experiencing high levels of distress that may move them into the need for Subclass services, KCMH places an emphasis on early intervention that will promote stability in our children's lives.
- KCMH Foster Care Team is co-located at Jamison Children's Center and provides screening and assessment to all foster youth (3-18) that come into the Child Welfare System.

- Screenings include the identification of Subclass youth, as well as, youth that may not meet Subclass criteria, but may benefit nonetheless from receiving ICC and IHBS.
- KCMH Foster care team provides assessments to youth that are referred annually or otherwise identified by the Department of Human Services (DHS).
- KCMH works with our contract providers to ensure that as youth are placed in the community, that they receive timely access to ongoing treatment.
- KCMH and contract providers work collaboratively with the child's social worker, foster parents, biological parents and other community resources to develop a care plan, with the ultimate goal of obtaining a safe and permanent home, and maintaining the child's overall well-being.
- KCMH Foster Care Team staff is co-located at DHS OC Sills in order to provide DHS social workers with psycho-education about the impact trauma has on foster youth, and to assist with navigating the Mental Health System.
- KCMH and contract providers offer a wide range of culturally and linguistically appropriate specialty mental health services, including: individual therapy, individual rehabilitation, group therapy, group rehabilitation, and crisis, ICC, IHBS and TBS.
- KCMH provides evidence-based treatment that are available to foster youth including, Dialectical Behavior Therapy (DBT), Cognitive Behavioral Therapy (CBT), Solution-Focused Therapy (SFT), Motivational Interviewing, Kern County Treatment Foster Care Oregon (KC-TFCO), Transition to Independence Process (TIP) model, and Functional Family Therapy (FFT).
- Special Multi-Disciplinary Agency and Referral Team (SMART) is a committee that includes KCMH, contract providers (Child Guidance Clinic, Clinica Sierra Vista, and College Community Services), DHS, Probation Department, and the Department of Public Health. The committee convenes weekly for case reviews to identify high-risk foster youth including Katie A Subclass youth (Pathways to Well Being), and ensure that coordinated services are rendered in a timely manner.

Continuum of Care Reform

In addition to the above existing strategies a multitude of efforts are occurring to assist our system in making all transitions needed to achieve the goals of the newly implemented Continuum of Care Reform. Some of these strategies include the following:

- Ongoing coordination with DHS and Probation, including participation in several state and local workgroups. Local workgroups include Resource Family

Approval Process, Child and Family Team Steering Committee, and Continuum of Care Reform implementation workgroup

- Amending of process in the SMART Committee to accommodate mandates of AB409
- Support, training and development of group homes as they transition to Short Term Residential Treatment Programs
- Support, training and development of Foster Family Agencies in the implementation of Treatment Foster Care
- Redesign of service delivery to incorporate expansion to the continuum of care, which includes an emphasis working with social workers to incorporate family and natural supports into treatment.

QUESTION 3B:

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

Yes_X___ No____. **If no, please explain briefly.**

QUESTION 3C:

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

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

Working with DHS to provide training and set up process to ensure that all children in foster care are referred to mental health for an annual mental health assessment. Annual mental health assessments would allow for early identification of mental health needs and ensuring foster children are connected to mental health services when needed.

Increased training and engagement by mental health staff with foster parents to support them in recognizing mental health needs that may present that are not connected to behavioral issues. Training could focus on increasing knowledge and awareness of mental health symptoms and how to support youth getting engaged in mental health services. An organized approach to ensure consistent, comprehensive information regarding mental health symptoms or signs and how to access services would be beneficial for adults with foster children.

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.[19]

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.[20]

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."

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

[20] 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 _X__ No.

If yes, please list and describe briefly.

- KCMH Children's System of Care is working to increase culturally competent services to further serve and engage LGBTQ youth recognizing that this population is at an increased risk for suicide, homelessness, substance use and disengagement from their family and supports. We currently provide services to these youth, however, are seeking a more targeted approach and exploring the implementation of a "Helping Families to Support Their LGBTQ Children" (SAMHSA).

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.

Kern County does not have specific program or services designed to provide this service. The general areas of service offered for LGBTQ youth offered through KCMH include:

- LGBTQ youth who are experiencing mental health issues may be stigmatized due to a mental health diagnosis, as well as, due to issues surrounding sexual orientation. These will often lead to high risk factors that providing treatment that supports, prevents isolation and ensures that these youth maintain relationships with family and other supports is essential.
- LGBTQ youth are provided with specialty mental health services and may receive services from any of the GSA providers.
- TAY LGBTQ Group—in development

Community Resources

- Gay and Lesbian Center
  902 18th Street, Bakersfield, Ca 93301
  (661) 843-7995

http://www.glcenterbak.org/events.html

- ✓ Support group for parents of transgender youth every other Saturday 1:30-3PM at the Gay and Lesbian Center. The Center's Calendar:
- ✓ Gender Rebels support group for ages 14 and over, Thursday from 6:30-8PM

- Consumer Family Learning Center
  - ✓ LGBTQ support group that meets every Thursday at 3-4PM.
- AA group for LGBTQ individuals Mondays at 7:30PM
  1001 34th St.
  (661) 324-0371
- Open and Affirming Churches for LGBTQ individuals:
  - Center for Spiritual Living
  - First Congregational Church
  - St. Paul's Episcopal Church
  - Unity Center
  - Unitarian Universalist Fellowship of Kern
- Bakersfield LGBTQ an online meet-up group in which they coordinate online then meet in various local places for events, such as bowling nights: https://www.meetup.com/Bakersfield-LGBTQ/

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.

Building specific service programs that integrate collaboration between medical and mental health services for transgendered youth to ensure comprehensive, collaborative care is needed.

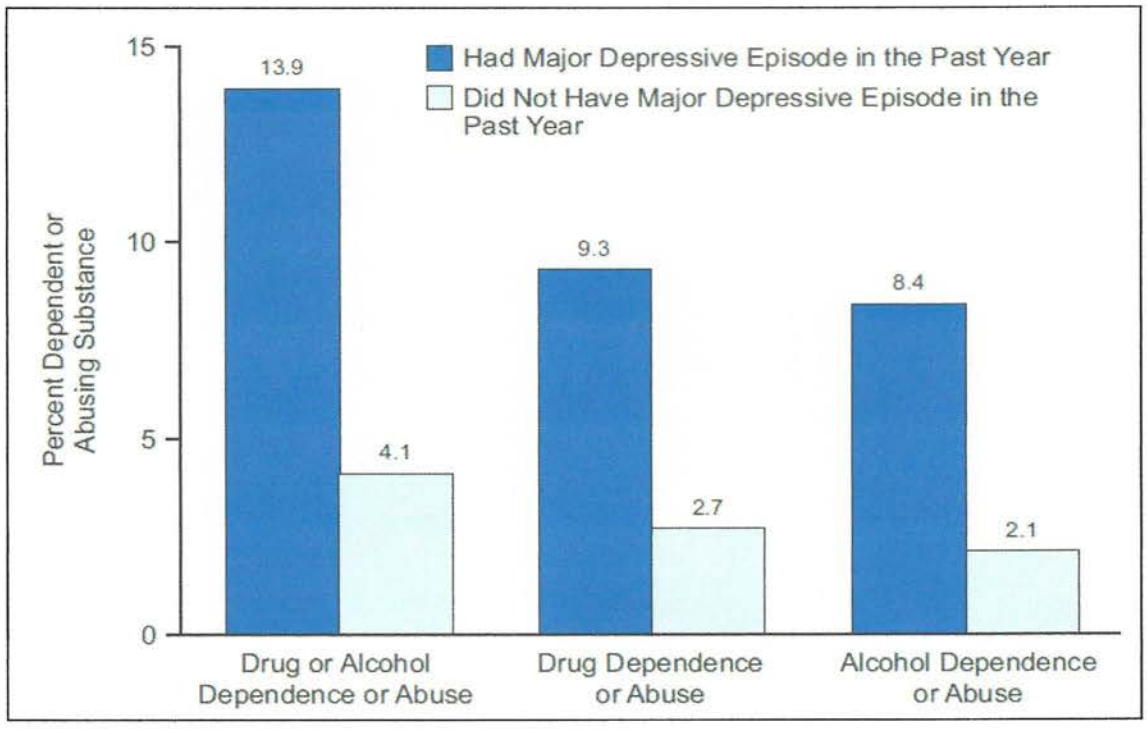
Additionally, increased outreach and education for suicide prevention for targeted and specific to LGBTQ youth is needed in the community.

Children and Youth Affected by Substance Use Disorders

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

Young people who engage in early substance abuse may do so because they are experiencing mental health challenges. Children and youth who experience a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who do not have depression.[21] (See next figure, 2013 data, NSDUH).

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



[21] 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.[22] 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.

[22]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

Kern County:

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

Grade Level	Any	None
7th Grade	14.2%	85.8%
9th Grade	N/R	N/R
11th Grade	N/R	N/R
Non-Traditional	N/R	N/R
All	14.2%	85.8%

N/R = not reported, due either to insufficient or no data reported to the agency analyzing the surveys.

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: Kern

Age <18: 129 Age 18-25: 482

QUESTION 5A:

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

If yes, please list or describe briefly.

- KCMH provides ongoing Co-occurring Disorder (COD) trainings to their staff (new staff training Recovery Academy, Drug Trends, Prevention, TIP, DBT, Change Agents, etc.) KCMH also provides these trainings to their partner agencies to provide continuity of care.
- For youth ages 12 to 17, KCMH provides Substance Use Disorder (SUD) treatment services in West Kern and through greater Bakersfield clinic sites (Clinica Sierra Vista Ebony Program). Youth can access and consent to treatment services which may include assessment, treatment planning, group and individual counseling. Treatment is facilitated utilizing the Matrix Curriculum, an evidenced based program.
- Additional SUD treatment services are provided for adolescents enrolled in several community schools and several high schools within Kern County. SUD

treatment services at community schools assist students in addressing substance related violations in the education code that led to expulsion from the student's home school district. The Matrix Model is also utilized in these schools.

- KCMH utilizes the screening tool UNCOPE-HF for co-occurring disorders and provides the most effective care for every assessment and re-assessment provided. The screening tool allows for early identification of substance use disorders, which may lead to specialized treatment or referral for services.
- The CSOC provides Co-occurring services in all services areas and it is expected that all providers are competent to provide integrated services.
- The TAY team utilizes two substance abuse specialists on their team, providing TIP model interventions to assist youth in addressing their substance use/abuse. TAY also maintains a GATE Keeper on staff, ensuring efficient referral to additional substance use services through the KCMH GATE team.
- KCMH also provides COD treatment for youth while incarcerated, utilizing the corrections system to provide rehabilitation services. TAY team also supports the linkage of youth served through the Juvenile Probation Psychiatric Service to engage into substance use treatment upon discharge from Juvenile Hall.

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.

There is a need for more substance use providers specific for youth and especially TAY (16-25) aged youth throughout the county.

A suggestion for specific sober living residential programs for TAY aged youth was made, recognizing that 18-25 year olds often do not do well in sober living environments with older adults who have different needs regarding their substance use disorders.

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."[23] 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." [24]

The 2016 California Children's Report Card[25] 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."

---

[23] 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

[24] 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,

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

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

Historically, "students of color, LGBT students, and students with disabilities...are disproportionately impacted by suspension and expulsion."[26] 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.

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

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers[27] 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[28] and Types of Juvenile Arrests, California, 2014

Total population[29] 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.

---

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

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

[29] 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,[30] 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: Kern **821 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[31] sources for these programs.

Kern County Mental Health programs served a total of 1,723 clients while in custody for FY 15-16.

- The Kern County Probation Department screens every youth placed into custody in any of the four juvenile detention facilities to identify potential mental health needs. The screening instrument, Massachusetts Youth Screening Instrument-2, uses seven scales to assess the youth: alcohol and drug use, anger-irritability issues, depression and anxiety, somatic complaints, suicide ideation, thoughts disturbance, and traumatic experiences.

- These screenings lead to subsequent referrals to the mental health treatment providers located at each facility for further evaluation and treatment. Incarcerated youth have access to psychiatric services, individual, family, and group therapy, substance use disorder treatment and case management services. Treatment for youth is based on evidenced-based and best practice models (i.e. Aggression Replacement Training, Trauma-Informed treatment, Seeking Safety, DBT, Matrix, Forward Thinking, and Moral Recognition Therapy)

- At the James G. Bowels Juvenile Hall and the Pathways female commitment program the on-site mental health treatment provider is Juvenile Probation

[30] County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children's Health.
[31] 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.

Psychiatric Services. At the Camp Erwin Owen boy's commitment program, the treatment provider is College Community Services. At Kern Crossroads Facility boys program, the treatment provider is Phoenix House.

PROGRAM: Pathways commitment, Juvenile Hall, Furlough

FUNDING SOURCE: Juvenile Justice and Delinquency Prevention (JJDP), STOP, Realignment funding.

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.

- Juvenile Justice Youth may access Specialty Mental Health Services as any other Medi-cal beneficiary. However, it is recognized that this population often needs much engagement in order to successfully link to treatment. As a result, there is an emphasis on discharge planning for youth that are exiting Juvenile Hall.

- The Youth Multi-Agency Integrated Service Team (MIST) provides specialty mental health care for children and families and included on this team is a probation officer to assist with coordination of care between agencies.

- A mental health staff that is dedicated to working with families, probation, geographic service area mental health providers and Department of Human Services eligibility worker to help ensure that appropriate aftercare occurs.

- In addition, the PEI Juvenile Justice Engagement Program is available to provide evidence based treatment, Family Functional Therapy, and linkage to non-custodial Juvenile Justice Youth.

- The Probation Department has a prevention team for youth that come in contact with the juvenile justice system, but are not adjudicated. KCMH works with probation to ensure linkage to the appropriate community providers/resources.

PROGRAM: Prevention and Early Intervention Juvenile Justice Engagement, Specialty Mental Health Services available throughout county.

FUNDING SOURCE: MHSA Prevention and Early Intervention and Full Service Partnership, full scope Medi-cal, Supportive Therapeutic Options Program (STOP).

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.

- Each of our juvenile detention facilities' mental health treatment providers engage parents in the youths' treatment through family therapy sessions, as well as outreach activities such as Saturday Parent/Youth Relationship Workshops.
- Family therapy may continue as youth exit the institution and are linked to the geographic service area provider.
- Prevention and Early Intervention Juvenile Justice Engagement program utilizes evidenced based approach of Family Functional Therapy to engage families into treatment.
- Parenting support groups offered by geographic service area providers.
- In order to ensure easy access home based services are available to family.
- Family therapy and sessions are specific component of Juvenile Sexual Offender Program
- Parents and mental health staff collaborate in pre-release meetings for commitment programs (Pathways, Camp Owens and Kern Crossroads)

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:[32]

- **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.[33] 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.

---

[32] 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

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

Prevention of Suicide and Suicide Attempts

Public health data for California and the U.S. show that there are risks for suicide for multiple age groups and race/ethnicity populations. In particular, youth suicide and suicide attempts are serious public health concerns. Suicide is the second leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.[34] 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.[35]

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.[36] 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.[37]

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

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

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

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

[37] 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. [38]

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

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

Data from your county are shown on the next page (if available).[39] Some counties or school districts either did not administer the surveys or else did not report their results.

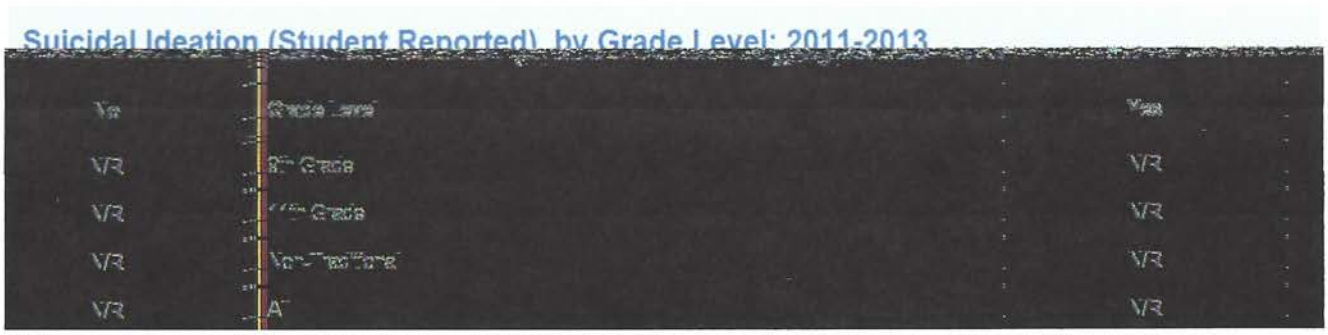
---

[38] **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.

[39] 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.

Kern County:

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



N/R = not reported, due either to insufficient or no data reported to the agency analyzing the surveys.

Youth Who Reported Needing Help for Emotional or Mental Health Problems

2005	2007	2009	2011-2012	2013-2014
19.1%	15.1%	9.7%	LNE	LNE

LNE = Low number event, meaning too few responses were recorded for statistical validity and/or not meeting criteria for public data release per HIPAA and privacy regulations.

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.

- KCMH Full Service wraparound teams, stationed throughout the county with Area Providers, focus on providing services to youth who are in need of intensive intervention in order to decrease self-harming and other high risk behaviors.
- KCMH provides a 24-hour crisis hotline as well as a Psychiatric Evaluation Center (PEC), which collaboratively work to assist client and families in resolving crisis episodes and assist in linkage to outpatient treatment. Upon request from the PEC unit, same day assessments are available from the GSA or other Specialty Mental Health Team.
- Through collaboration with law enforcement the Mobile Evaluation Team can intervene and assist in linkage to crisis based services, either through the PEC or through a direct referral to Youth Wraparound.
- All mental health providers have a 24-hour crisis line.

- All youth referred for outpatient mental health services receive a suicide screening at assessment.
- As clinically needed, psychiatric appointments are expedited.
- The Prevention & Early Intervention (PEI) Program and Outreach and Education Program completes trainings in the community, including schools, to increase awareness of when a youth may be at risk, including identification of red flags and mental health symptoms that youth may be exhibiting.
- PEI program staff provide same day walk-in screenings and assessments for early detection and linkage to appropriate mental health services.

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.

All KCMH employees are trained in Applied Suicide Intervention Skills Training (ASIST), which is an evidence-based program, developed for ages sixteen and above. The ASIST workshops are divided into five sections that follow in a logical progression to gradually build comfort and understanding around suicide and suicide intervention.

- Preparing: Sets the tone, norms, and expectations of the learning experience.
- Connecting: Sensitizes participants to their own attitudes towards suicide. Creates an understanding of the impact that attitudes can have on the intervention process.
- Understanding: Overviews the intervention needs of a person at risk. It focuses on providing participants with the knowledge and skills to recognize risk and develop safety plans to reduce the risk of suicide.
- Assisting: Presents a model for effective suicide intervention. Participants develop their skills through observation and supervised simulation experiences in large and small groups.
- Networking: Generates information about resources in the local community. Promotes a commitment by participants to transform local resources into helping networks.

Additionally, KCMH provides the following services to prevent suicides in transition aged youth:

- Hotline Outreach workers engage in outreach events at Kern County high schools, some junior high schools and several church youth groups to discuss teen depression and suicide.

- Youth Mental Health First Aid is often provided within the community, including schools, to increase awareness of when a youth may be at risk, including identification of red flags and mental health symptoms that a youth may be exhibiting.

- KCMH provides a 24-hour crisis hotline. The Hotline collaborates with the Psychiatric Evaluation Center (PEC) to work to assist clients and families in crisis episodes to either provide immediate crisis treatment or linkage to outpatient treatment.

- Mobile Evaluation Team (MET) collaborates with law enforcement to provide community evaluations and services for crisis de-escalation and to maintain safety.

- Specialized DBT services, an evidenced-based therapy that is highly effective in addressing suicidal, para-suicidal and self-harming behaviors and substance use is available through the outpatient teams.

- Identification of suicide needs and risk are generally presented in the mental health assessment and treatment is generally directed to address specific needs of the individuals served, with prioritization for urgent services when needed.

- We have full service partnerships (WRAP teams) located around the county which provide intensive services to higher risk youth.

QUESTION 7C:

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

Yes _X_ No_____. If yes, please list briefly.

- Identified needs to address this need for the 6-16 age range are:
    - Establishing an evidenced based program model for suicide assessment and intervention specialized for children age 6-16.

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.

For youth age 0-21:

- Youth Wraparound Full Service Partnership provides intervention to youth experiencing first breaks

    - ✓ All youth in Kern County that access crisis services or are hospitalized are automatically referred to Youth Wraparound. The Youth Wraparound Full Service Partnership is available throughout the county with GSA providers and allows for early identification and intervention for youth that may be experiencing first break psychosis. .

- ✓ Youth Wraparound works to rapidly to ensure timely access to outpatient mental health services.

- ✓ Ongoing services include but are not limited to:

    - Assessment, treatment planning and development, psychiatric evaluation, targeted case management services, psychotherapy, family therapy, rehabilitation services, co-occurring services, crisis services, TBS, sub-class referral and Katie-A/ICC, IHBS, and referral to mental health groups such as Dialectical Behavior Therapy (DBT).

For children age 16-25:

- Transitional Aged Youth (TAY) Team has the following programs:

    - ✓ Dream Center is a drop in center, which is considered the hub for foster youth. The TAY team has an office, along with Probation, DHS, Kern County Network for Children, and Kern County High School District. Approximately a quarter of the youth referred to the TAY team come from this center. Many of the youth have not had mental health services before and by being present at the site, TAY staff are able to identify emotional and behavioral problems and provide early intervention to youth that may be experiencing a first break.

    - ✓ The TAY Career Development Program, which targets Foster/Probation youth. The goal of the TAY Career Development Program is to provide transition aged youth between the ages of 16-25, with the unique opportunity to work in conjunction with the professionals from America's Job Center of California, Kern High School District, and Kern County Mental Health's TAY team to develop the necessary skills to enter the workforce while simultaneously learning to self-manage their mental health symptoms. The program addresses psychosocial, situational, and adjustment stressors that impair them from seeking, finding, and maintaining employment. This program is funded through the MHSA Prevention and Early Intervention (PEI) funds made available through Prop 63. All referrals come from DHS (AB12), Aspiranet, Group Homes, Schools, and self-referrals. An initial assessment is completed and if youth meets criteria he/she will remain with this PEI Program. If deemed too severe for the PEI program, then youth are transitioned into the Full Service Partnership program. In both programs the following services are provided:

- Assessment, treatment planning, case management, collateral, psychiatric care, medication support/management, individual and group rehabilitative service, crisis service, individual and family therapy and intensified services such as ICC, IHBS, and TBS

QUESTION 8C:

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

Yes_X__ No____. If yes, please describe briefly

A recommendation was made for a program that addresses specific cultural and ethnic needs for youth experience a first break psychosis, specifically to target Hispanic populations served throughout Kern County.

Additional needs are increased community outreach and education for first break psychosis.

It is anticipated that with the increased assessments provided to foster youth (annual assessment process), early intervention and identification for first break psychosis within this population will allow increased, faster access to mental health services.

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.[40]

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 does 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[41] 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.

---

[40] 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

[41] 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[42] 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.

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

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

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

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

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

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

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

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

QUESTION 9A:

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

- Homelessness and substance abuse are the most urgent problems in our county. According to the Kern County 2016 Census, homelessness for youth ages 18-24 has increased 71% since 2015. Many of our TAY youth are forced out of their placements after turning 18, with nowhere to go. Homelessness increases the likelihood of drug use and abuse (Tompsett, Domoff, and Toro, 2013), which exacerbates mental health symptoms. These youth tend to get stuck in the cycle of homelessness and drug abuse, with no opportunities for stabilization.

  Tompsett, C.c., Domoff, S., & Toro, P. (2013). *Peer Substance Use and Homelessness Predicting Substance Abuse from Adolescence Through Early Adulthood. American Journal of Community Psychology, 51(3/4), 520-529.*

- Development for Short Term Crisis services that will include substance use treatment.

- Additional services that focus on unique needs of LGBTQ youth are needed. This population is at increased risk for suicide, homelessness, and drug abuse (Keuroghlian, Shtasel, and Bassuk, 2014). Currently, there is no way to track this high risk factor in our youth. Developing systems to track data could help in informing our decisions for improving outreach, as well as providing specific training for intervening with LGBTQ youth.

  Keuroghlian, A.S., Shtasel, D., & Bassuk, E.L. (2014). Out on the street: A public health and policy agenda for lesbian, gay, bisexual, and transgender youth who are homeless. American Journal Of Orthopsychiatry, 84(1), 66-72, doi:10.1037h0098852

- Early identification and referral of foster youth who may be in need of mental health services. Plan is to continue to provide training to DHS to ensure early identification and referral.

- Continue to work with DHS to recruit and train quality resource families that can be used to increase permanency for foster youth and meet goals of Continuum of Care Reform.

- Ongoing Training and support to successfully implement mandates of CCR, specifically a high degree of support to Short Term Residential Therapeutic Programs, as they commence providing mental health services.
- Continue to develop strategies to ensure access to services across a large geographic area.
- Commercially sexually exploited children (human trafficking): Increased education through community providers, foster care, partner programs (DHS, Probation, Public Health) to increase awareness and address the needs of these children.
- Increased treatment and more prevention services for substance use in youth.

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?

- Children in stable permanent homes with adequate supervision with caregivers who are trained in mental health issues and behavioral interventions have a much higher success rate in area such as engaging in high risk behaviors, being at risk for sexual exploitation, decrease in substance use, increase in school attendance, and a decrease in incarcerations/hospitalizations.
- The FSP data (emergency interventions, incarcerations, hospitalizations, residential and employment status) helps inform interventions by providing the team with useful feedback about effectiveness of the mental health interventions and allows for adjustment to approve future outcomes.
- Some deficits that have been noted in the FSP database are that there is no Key Event Tracking (KET) for changes in household size, due to the youth having children. This is a huge change for our youth that often leads to an increase in severity, intensity, and frequency of mental health symptoms, and negatively impacts the youths' global functioning. Also, there is no functional way to track education for TAY youth. Although education status is represented in KETs, the outcomes reports do not provide data for this population.

Question 9C:

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

Yes ___ No _X__. If yes, please describe briefly.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

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

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

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

___MH Board completed majority of the Data Notebook

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

_X_ Data Notebook placed on Agenda and discussed at Board meeting

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

___ MH Board partnered with county staff or director

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

___ Other; please describe: _____.

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

Yes_X__ No___

If yes, please provide their job classification _QID Administrator

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

Name and County: _Ross Kremsdorf, Kern County Mental Health_

Email__rkremsorf@co.kern.ca.us_____

Phone #___(661) 868-780_____

Signature: _____

Other (optional): _____

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

Name and County: _Kate Tandy, PhD., Kern County_____

Email: _____kqtandy@yahoo_____

Phone #___(661) 332-3084_____

Signature: _____

REMINDER:

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

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

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

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

(916) 327-6560

Or, you may contact us by postal mail to:

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