# PLACER & SIERRA COUNTIES: DATA NOTEBOOK 2016

## FOR CALIFORNIA

## BEHAVIORAL HEALTH BOARDS AND COMMISSIONS


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

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## FOR CALIFORNIA

## BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Populations (2016): Placer 373,796 Sierra County: 3,203

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

Placer County Children's System of Care and Sierra County Behavioral Health

Placer County: https://www.placer.ca.gov/departments/hhs/children

Sierra County: http://www.sierracounty.ca.gov/index.aspx?nid=181

Website for Local County MH Data and Reports:

http://www.placer.ca.gov/departments/hhs/children/leadership-vision-mission

http://www.sierracounty.ca.gov/DocumentCenter/View/2485

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

https://www.placer.ca.gov/departments/hhs/adult/mental-health-alcohol-drug-board

http://www.sierracounty.ca.gov/index.aspx?NID=332

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

Total number of persons receiving Medi-Cal in your counties (2013): 48,286

Average number Medi-Cal eligible persons per month (2014): 44,316

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 46.6 %

Adults, 18 and over: 53.4 %

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

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 2,035

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 39.1 %

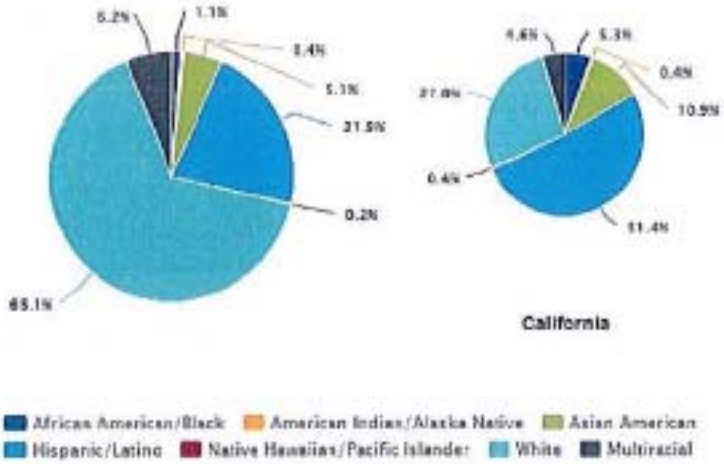
Adults, 18 and over: 60.9 %

County Data Page, supplemental:

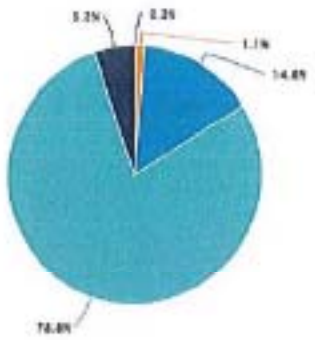
**Child Population, by Race/Ethnicity**

Year(s): 2015

**Placer County**




**Sierra County**

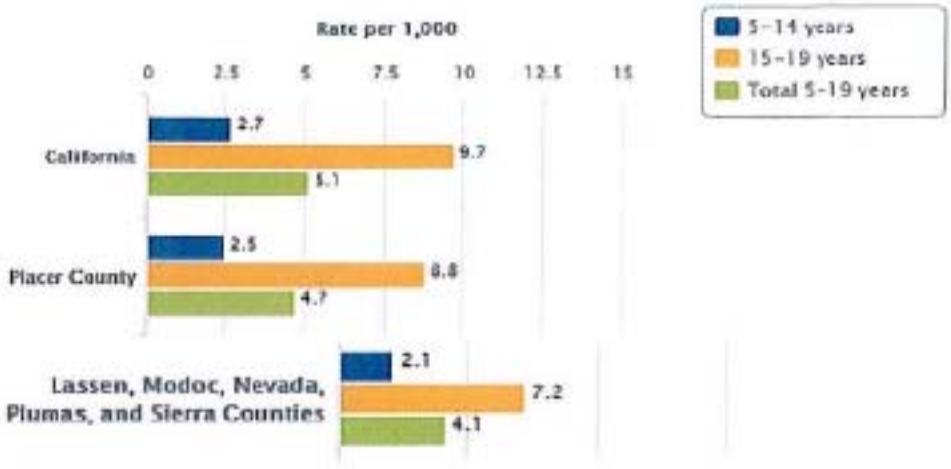



[2] Serious Mental Illness, term used for adults 18 and older.

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

## Hospitalizations for Mental Health Issues, by Age Group

Year(s): 2014



## INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

### What is the "Data Notebook?"

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

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

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

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

The Data Notebook is designed to meet these goals:

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

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

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

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

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

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

## Resources: Where do We Get the Data?

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

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

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

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

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

[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.

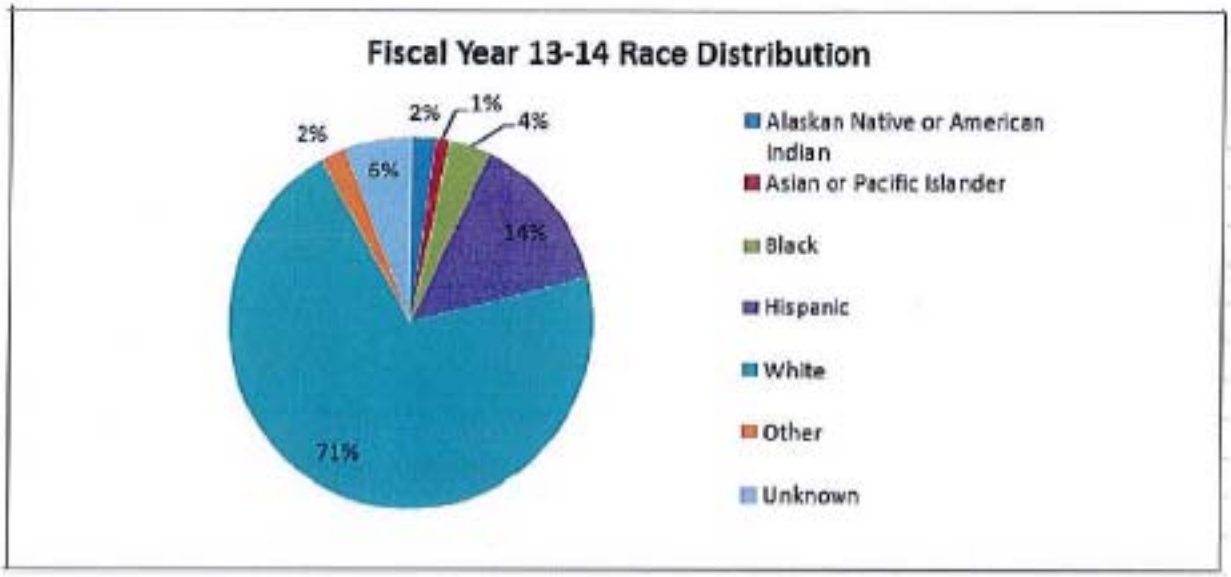
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

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

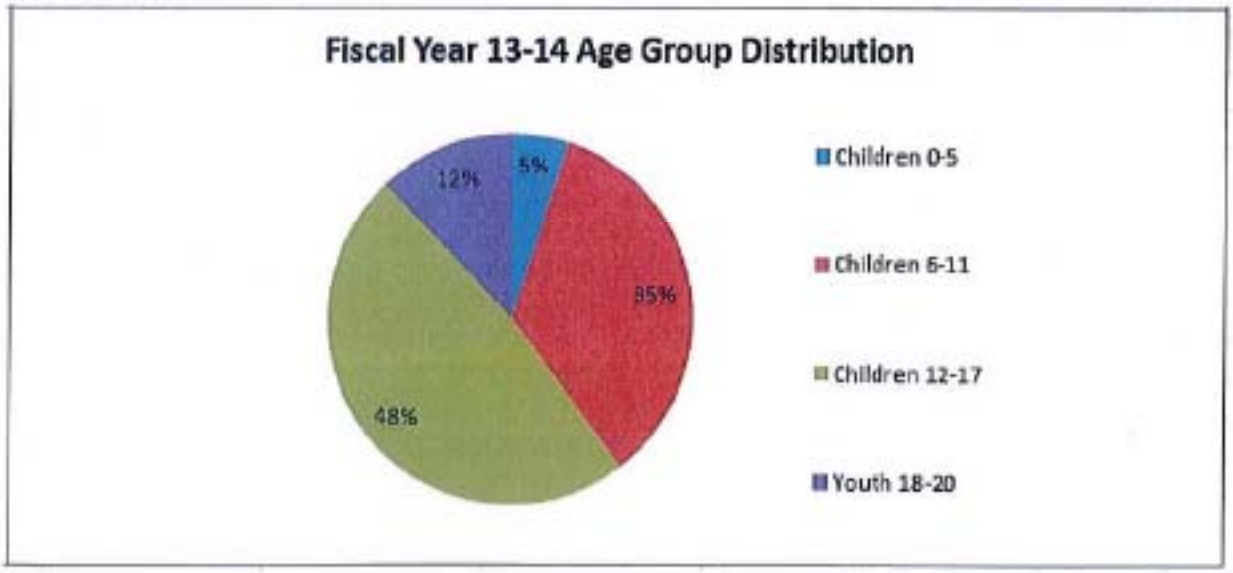
Unique numbers of children and youth who were Medi-Cal eligible: **28,107**

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **832**.

**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: Placer (FY 2013-2014):**

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

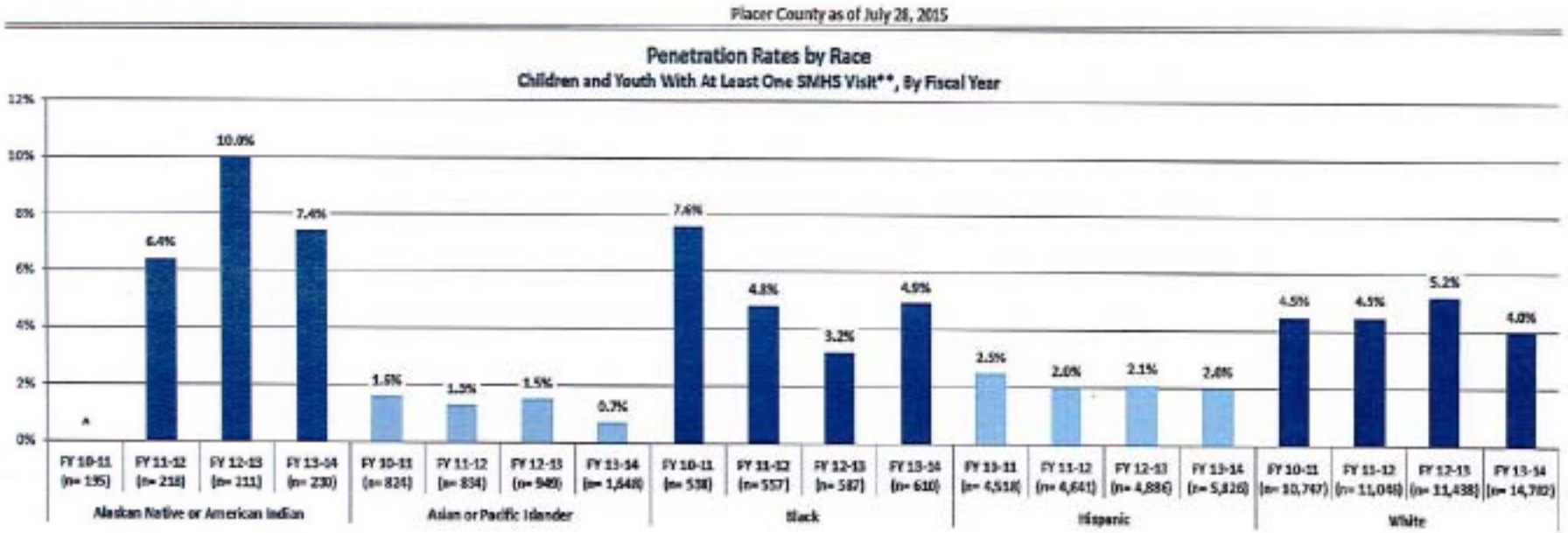
| | FY 13-14 | | |
|---|---|---|---|
| | Children and Youth with 1 or more SMHS Visits | Certified Eligible Children and Youth | Penetration Rate |
| **All** | **832** | **28,107** | **3.0%** |
| Children 0-5 | 42 | 8,643 | 0.5% |
| Children 6-11 | 288 | 8,548 | 3.4% |
| Children 12-17 | 401 | 7,327 | 5.5% |
| Youth 18-20 | 101 | 3,589 | 2.8% |
| Alaskan Native or American Indian | 17 | 230 | 7.4% |
| Asian or Pacific Islander | 11 | 1,648 | 0.7% |
| Black | 30 | 610 | 4.9% |
| Hispanic | 118 | 5,826 | 2.0% |
| White | 588 | 14,782 | 4.0% |
| Other | 18 | 3,342 | 0.5% |
| Unknown | 50 | 1,669 | 3.0% |
| Female | 386 | 13,695 | 2.8% |
| Male | 446 | 14,412 | 3.1% |

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** | **598** | **28,107** | **2.1%** |
| Children 0-5 | 28 | 8,643 | 0.3% |
| Children 6-11 | 219 | 8,548 | 2.6% |
| Children 12-17 | 281 | 7,327 | 3.8% |
| Youth 18-20 | 70 | 3,589 | 2.0% |
| Alaskan Native or American Indian | 13 | 230 | 5.7% |
| Asian or Pacific Islander | ^ | 1,648 | ^ |
| Black | 21 | 610 | 3.4% |
| Hispanic | 78 | 5,826 | 1.3% |
| White | 433 | 14,782 | 2.9% |
| Other | ^ | 3,342 | ^ |
| Unknown | 36 | 1,669 | 2.2% |
| Female | 288 | 13,695 | 2.1% |
| Male | 310 | 14,412 | 2.2% |

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

**Your County: Placer***




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

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

**No public data are available for Sierra County.**

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

**QUESTION 1A: PLACER COUNTY**

**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?**

Placer County Children's System of Care (CSOC) believes it is doing an effective job providing access and engagement for children and youth in all of its communities relative to Specialty Mental Health Services. In accordance with the Placer-Sierra MHP, Medi-Cal beneficiaries with mild to moderate impairments are referred to one of two Managed Care Plans (MCPs), and primary care providers are expected to provide mental health services for mild to moderate impairments. Medi-Cal beneficiaries that meet medical necessity criteria with moderate-severe impairment are referred to Placer County CSOC Mental Health for specialty mental health services.

Eligibility for Placer Children's Mental Health services includes full scope Medi-Cal beneficiaries, Healthy Families beneficiaries, and EPSDT and CMSP beneficiaries with low or no share of cost. Those who do not meet these eligibility criteria are assessed on an individual basis regarding their need for services.

Placer County CSOC has determined that a combination of federal and state services provided through the county, private provider, organizational providers, MHSA-funded FSP, PEI and innovation services provides a wide array of service options to serve children and youth in all our communities.

Therapeutic Behavioral Services (TBS) – Uplift provides Therapeutic Behavioral Services (TBS) are available for eligible children who need short-term behavioral support in addition to any other mental health services they are receiving. TBS's goal is to help children avoid being placed in a higher level of care such as a residential treatment facility or to help children make a successful move to a lower level of care such as returning home after residential treatment.

FSP Wraparound - Placer County CSOC works closely with partner agencies and communities to identify children (ages 0-17) who qualify for FSP Wraparound services. Working in concert with leadership development activities, staff utilizes the services of Family Advocates, Youth Coordinators, and Peer Mentors. Gateway Mountain Center provides adjunct therapeutic support to FSP youth for improved outcomes including: decreased incidents of mental health crisis; an increase in positive socialization; and increased engagement within one's community.

Fast Track Wrap – Uplift offers intensive, in-home, short-term wraparound services with the Fast Wrap program for children (ages 0-17) with a serious emotional disturbance and require family support services.

Sprouts Program – The Children's Receiving Home of Sacramento operates a Trauma Informed "Sprouts" Preschool. The Preschool provides site-based, daily therapeutic classroom services; team discussion and planning; adjunctive therapies; coordination and linkages with sustainable community services; and collateral services to the families of children ages 3 to 6 with a severe emotional disorder related to trauma.

High Acuity and Assisted Outpatient – Turning Point serves TAY (16+), adults, and older adults with severe mental illnesses (SMI) who require a higher intensity services. Priority is given to unserved or inappropriately served clients who are at risk of psychiatric hospitalization, homelessness, and those ready to exit psychiatric hospitals, facilities, IMDs or jails.

Bilingual/Bicultural Outreach – LLC and Placer County Office of Education (PCOE) provide bilingual, bi-cultural outreach and engagement services primarily to Latino children, TAY, adults, and families as a part of the FSP. Provide services to enrolled and non-enrolled consumers within each of the MHSA demographics.

Early Onset – Therapeutic Services – Sierra Native Alliance (SNA) provides early onset, short-term, culturally appropriate mental health therapy for community members with anxiety, depression, PTSD, and other disorders.

Teaching Pro-Social Skills (TPS) – Lighthouse Counseling provides TPS, also known as Aggression Replacement Training (ART) is a cognitive behavioral intervention program to help children and adolescents improve social skill competence and moral reasoning, better manager anger, and reduce aggressive behavior.

Youth Therapy – Uplift /Tahoe Safe Alliance provides individual, family and/or group therapy for children, youth and transition age youth in Spanish.

**QUESTION 1A: SIERRA COUNTY**

**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?**

Providing services to Sierra County's small population is challenging due to the intra-connectedness within communities, as well as, the inter-relationships and inter-connectedness which occur throughout the county as a whole. Dual relationships, along with a lack of anonymity, are a distinctive norm community members of Sierra County live and deal with on a day to day basis. Thus, providing specific programs

focusing on an under-represented, minority population inadvertently creates profiling of the population Sierra County Behavioral Health is seeking to serve. For example, a youth seeking services does not feel comfortable receiving services in a group setting because they can be identified, have a current or have had a previous relationship with the other youth receiving services or the facilitator of the service. More likely than not, there are familial ties to the youth and one or more of those individuals involved in receiving or providing the service. Once the service has a 'label' or a specific identified outcome, the youth attending have been profiled. Sierra County's community defined best practices, based on the challenges above, indicate building trust while participating in a universal or selective service strategy resulting in warm referrals is most successful.

**QUESTION 1B: PLACER COUNTY**

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

Placer County CSOC utilizes the following TAY outreach and engagement programs of the transitioned-ages youth funded largely through MHSA:

Tahoe Truckee Youth Suicide Prevention Coalition – Giving Voice - Tahoe Truckee Unified School District (TTUSD) collaborated with a number of Tahoe Truckee area community partners, including Placer and Nevada Counties to establish this coalition. They expanded the "Know the Signs Campaign" by engaging youth and community members in outreach events. Goals include educating the public about the signs of suicide, reducing stigma and discriminations, increasing awareness to strengthen social connections, and connecting young people with mental health resources. Plans to administer with partner InnerRhythms Dance Co., a new youth-driven suicide prevention arts program called "Giving Voice" is to be performed at least ten times in schools and the wider community, as well as coordinating a community movie night, facilitate Speaker's Bureau presentations and expanding existing outreach efforts.

School Wellness Centers – Tahoe Truckee Unified School District (TTUSD): Tahoe Wellness Centers provide a single point of entry for students to connect to supportive adults and access wellness services at the school. Students learn relevant skills for improving their well-being and understand how to navigate and access community resources. This project allows students to access services and supports that address physical, mental and emotional concerns and engage in activities that will increase their resiliency and overall well-being.

Adventure Risk Challenge (ARC) (English and Spanish) - Utilizing statewide campaigns Know the Signs, Each Mind Matters, Busco Apoyo, and My3 App, provide one-on-one and group outreach to youth in Tahoe (in Spanish and English) to educate about signs and symptoms of mental health and integrate efforts to reduce stigma and discrimination. In partnership with the Tahoe Truckee Unified School District, ARC will facilitate two weekend retreats each year for the peer mentors of the Wellness Centers.

The activities and curriculum of the weekend will serve to develop and train the peer mentors and to increase their awareness, preparedness, and knowledge about suicide prevention and stigma and discrimination reduction.

The YES Program provides peer support services for youth and TAY. Youth Coordinators, who have lived experience in the mental health, child welfare, and/or probation systems, work with TAY to help them accomplish their identified goals. This includes assistance on post-hospitalization transportation and support, system navigation, supporting youth and young adults in finding appropriate placement options and helping youth get their needs met in their placement. In addition, YES Coordinators use their experience and voice to transform system and community services. Youth Coordinators attend system-level meetings and provide youth voice to planning, management, and implementation activities within both CSOC and ASOC. Youth Coordinators support youth who are transitioning between CSOC and ASOC services.

Auburn Hip Hop Congress provides youth in Auburn with art, music, and leadership programs, community service opportunities, cultural awareness activities, performance opportunities, and a wide variety of quality events, including concerts, all age shows, workshops, and trainings.

The Latino Leadership Council (LLC) delivers the YEAGA and Peace 4 the Streets programs to provide mentoring to individual youth as well as offer leadership groups to promote positive cultural connections to assist Latino youth in developing resiliency in Spanish.

Bilingual/Bicultural Outreach – LLC and Placer County Office of Education (PCOE) provide bilingual, bi-cultural outreach and engagement services primarily to Latino children, TAY, adults, and families as a part of the FSP. Provide services to enrolled and non-enrolled consumers within each of the MHSA demographics.

Peer Leadership – Tahoe SAFE Alliance (TSA): Young Men's Work is a program for young men who are working together to solve problems without resorting to violence. This effective curriculum helps young men break the cycle of violence passed from generation to generation. Young women face many issues are they mature, such as eating disorders, depression, shame, low self-esteem, substance abuse, and abusive relationships. Young Women's Lives curriculum helps young women face problems, identify personal strengths and supportive resources, and develop new ways of thinking and addressing challenges-both internal and external. The peer leadership group will learn about teen issues such as bullying, anxiety, teen dating violence, sexual violence, tolerance, suicidal ideation, depression, non-suicidal self-injury and the influence of social media. The group creates plans to decrease stigma around mental health in their community/school.

Youth Services and Supports – Latino Leadership Council (LLC) (English and Spanish):

Male & female youth groups to address depression, cultural stressors, discrimination outside and internal to Latino communities, challenges related to biculturalism, education achievement gaps, and violence.

Stand Up Placer – Due to a recent grant award, Stand Up Placer has been able to expand mental health and substance use treatment services to transition age youth and adults in need of crisis intervention, therapy, counseling, advocacy, and support groups.

**QUESTION 1B: SIERRA COUNTY**

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

The same community defined best practice as listed above.

**QUESTION 1C: PLACER COUNTY**

**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.**

- Expand substance use services/options to include Al-Anon and AlaTeen and substance use education for the TAY population
- Improve outreach and services to Hispanic, Asian, and Black TAY through partnering with Auburn Hip Hop Congress, InnerRythym Dance Company (Tahoe-Truckee), YEAGA and Peace 4 the Streets.

**QUESTION 1C: SIERRA COUNTY**

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

**Yes ___ No__X__. If yes, please list briefly.**

**QUESTION 1D: PLACER COUNTY**

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

In addition to the strategies supplied for Question 1A, Placer County CSOC may utilize a combination of any of the following additional supportive strategies:

The Family Advocacy Program is designed to provide the necessary support, mentoring and advocacy to families participating in the CSOC through the employment of parents or caregivers who, themselves, have been service recipients of like services. Mental Health America (MHA) hires Family Advocates to work with parents and caregivers who receive services from the CSOC. Family Advocates offer support and services to parents and caregivers of children who have received outpatient and/or inpatient specialty mental health services and their families. They also offer WRAP trainings in the community, to ASOC clients, and family members. This program and its team members provide important feedback to the system on family perceptions, needs and concerns.

Promotor(a)s – (Latino Leadership Council (LLC)) Promotor(a)s are trained para-professionals to provide culturally appropriate services, education and support to monolingual Spanish speaking Latino families in the community. Promotor(a)s reach out into the community and assist individuals in navigating the service delivery system and accessing community resources. Cultural brokering is used as a key approach to increase access to, and to enhance the delivery of culturally competent care.

"Personas de Sabiduria"- LLC (Spanish): Conference for at least 90 Latino adults, in Spanish, that will allow persons to share their stories of recovery and resiliency from mental health and substance use disorders. In addition, provide bilingual, bi-cultural experts to lead workshops about various mental health/health issues. This conference builds resiliency and hope for recovery; along with an increased awareness of available supports and services.

Positive Indian Parenting – Sierra Native Alliance (SNA): Positive Indian Parenting provides culturally-relevant parenting education and support. This curriculum is provided in coordination with co-parenting, behavioral consultation, case management, and peer support to increase parenting skills and the resilience of families with children who have emotional and behavioral challenges.

Loving Solutions – North Tahoe Family Resource Center (NTFRC) (English and Spanish): Loving Solutions® is a parent-training program designed specifically for parents raising difficult younger children, ages 5-10 years. Also known as "Parent Project®, Jr.," this program utilizes the same principles found successful in Parent Project® Sr., adapted to the needs of younger children. Using a behavioral model, Loving Solutions is structured based on cooperative learning norms with group learning activities. Loving Solutions® also addresses the needs of children with Attention Deficit Disorder.

Active Parenting Now (APN) – KidsFirst (English and Spanish): APN empowers participants, teaching parenting skills to address sensitive issues such as drug abuse, sexual activity, self-harm, and violence. APN is a video-based, interactive learning experience featuring group discussion and practice activities

Parent Child Interaction Therapy (PCIT) – KidsFirst (English and Spanish): Parent-Child Interaction Therapy (PCIT) is provided through 14-20 weekly sessions, and is designed for parents with children (ages 2-7) who are exhibiting behavioral problems such as aggression, defiance, non-compliance, and temper tantrums. PCIT treatment is provided to the parent and child in two phases – Child-Directed Interaction (CDI) and Parent-Directed Interaction (PDI). During the CDI phase, parents engage their child in play situations, with the goal of restructuring and strengthening the parent-child relationship. During the PDI phase, which is similar to clinical behavior therapy, parents learn to use specific behavior management techniques while playing with their child.

Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – KidsFirst & Lighthouse (English and Spanish): Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapy approach for caregivers, children, and youth who are experiencing significant emotional and behavioral difficulties related to traumatic life events. TF-CBT provides short-term treatment (approximately 12 weekly sessions) targeted to overcoming specific trauma. To disrupt trauma-related mental illness, caregivers, children and youth are taught skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings and behaviors related to trauma; and improve coping skills of caregiver and child to create a better living environment for the family.

Perinatal Mood Disorder Treatment – KidsFirst (English and Spanish): This program aims to reduce depression, anxiety, and suicide through culturally- and age-appropriate services such as screening, assessment, evaluation, resources, home visitation, and short-term therapy for parents with children 0-5 years old.

Incredible Years (Dina School) – KidsFirst: The Dina Dinosaur School program for children ages 3-8 years focuses on social, emotional skills, and problem solving designed as a classroom prevention program. Dinosaur School compliments the Incredible Years parent curriculum and teaches children self-regulation and positive classroom behavior.

Attachment Based Family Therapy (ABFT) – KidsFirst (English and Spanish): ABFT is a treatment for adolescents, ages 12-18, designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. ABFT is short term, approximately 12-16 weekly sessions, and aims to strengthen or repair parent-adolescent attachment bonds and improve family communication. As the normative secure base is restored, parents become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.

Adult Support Groups – Latino Leadership Council (LLC): Peer-to-peer weekly groups "Rincon de las Comadres" are offered in Auburn, Roseville, and Lincoln to address issues of depression, anxiety, health, etc. These groups are open to men and women, and provided in Spanish.

Youth Therapy – Uplift and Tahoe SAFE Alliance (TSA) (English and Spanish): Uplift and Tahoe Safe Alliance offer individual, family, and group services to support individual, family and/or group therapy for children, youth and transitional aged youth.
Home to Stay Counseling and Supports for Birth and Kinship Families – Lilliput Children's Services: Intensive in-home support services and counseling to birth and kinship families whose youth are at risk of placement (or disruption) due to emotional, behavioral and mental health issues.

Incredible Years – KidsFirst (English and Spanish): The Incredible Years parent training intervention is a 12 week program focused on strengthening parenting competencies (monitoring, positive discipline, confidence, etc.) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competencies, and reduce conduct problems.

Non-Minor Dependent (NMD) – A small percentage of the non-minor dependents who have had a child receive community provided perinatal services through their NMD case.

## QUESTION 1D: SIERRA COUNTY

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

Individual referrals stemming from universal service strategies such as Student/Parent Navigator and Nurturing Parenting Programs along with collaboration with stakeholder agencies.

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

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

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

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

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

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

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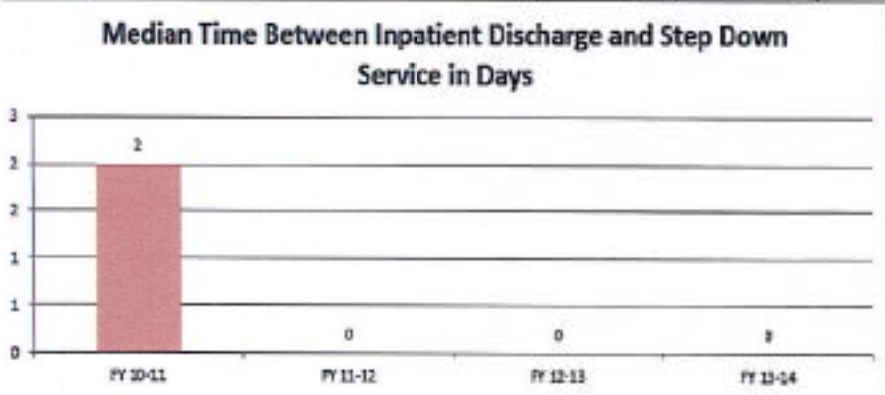
[14] Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late Spring, 2016).

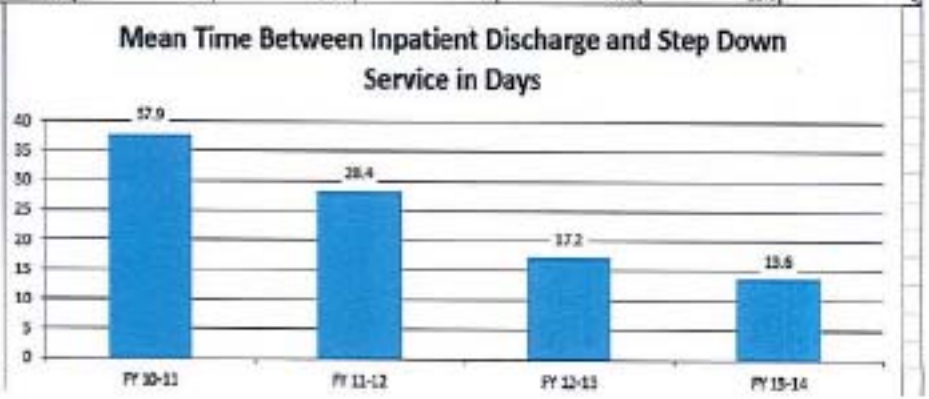
## Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization (2010-2014)

**Data for Placer* County are aggregated with all counties having medium-sized populations (200,000 – 750,000).**

**Medium Population Counties 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 | 382 | 61.9% | 466 | 75.5% | 83 | 13.8% | 66 | 10.7% | 0 | 1,402 | 37.9 | 2 |
| FY 11-12 | 584 | 71.0% | 687 | 83.5% | 85 | 10.3% | 51 | 6.2% | 0 | 970 | 28.4 | 0 |
| FY 12-13 | 597 | 78.4% | 649 | 85.3% | 50 | 6.6% | 62 | 8.1% | 0 | 676 | 17.2 | 0 |
| FY 13-14 | 635 | 73.5% | 715 | 82.8% | 67 | 7.8% | 82 | 9.5% | 0 | 473 | 13.6 | 0 |




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

*,^ = Data for this county (and Sierra County) are redacted due to small numbers and HIPAA/privacy regulations.

**QUESTION 2A: PLACER COUNTY**

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

**If no, please describe your concerns or recommendations briefly.**

**QUESTION 2A: SIERRA COUNTY**

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

**If no, please describe your concerns or recommendations briefly.**

**QUESTION 2B: PLACER COUNTY**

**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 following post hospitalization or MH crisis for TAY outpatient care follow-up process is currently in place for Placer County CSOC:

- Family and Children's Services (FACS) Intake Unit forwards copies of all assessments and Intake packets on a daily basis to the Mental Health Entry Program Supervisor for all youth under 18 years of age (PC MediCal and non PC MediCal youth) who received a psychological evaluation and/or discharge after a hospitalization.

- Within seven days of the assessment or hospitalization, the youth's parent/guardian is contacted via telephone by a Placer County CSOC MH clinician. The MH clinician ascertains whether the youth is connected or needs connection to after care services. Appropriate referrals for service are offered and/or completed on an as needed/requested basis to Anthem, private providers, community partners, etc.

## QUESTION 2B: SIERRA COUNTY

**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 hospital communicates with the Behavioral Health Director. Whether the TAY meets Sierra County Behavioral Health (SCBH) criteria or not, all are contacted through a case manager within a four day window. When SCBH is part of the discharge plan for the TAY youth communication is made to schedule needed services as soon as possible. If the client is not eligible for services through SCBH they are informed of services available to them. Spread sheets are maintained to track timeliness of follow up along with results.

## QUESTION 2C: PLACER COUNTY

**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.**

Placer County CSOC MH staff utilize the following strategies: verification of health insurance for proper referrals, referrals to county and community agencies for healthcare enrollment assistance, telephone call backs to all youth and/or parents/caregivers of youth, follow-up within seven days to ensure medication support continues without interruption and adequate after care services are in place or are being set in place through appropriate providers, and referrals to Mental Health Services Act Prevention Early Intervention (MHSA PEI) contracted providers for those who meet criteria. Any of the following community supports or services may be provided to the parent/caregiver if requested or needed:

The Family Advocacy Program is designed to provide the necessary support, mentoring and advocacy to families participating in the CSOC through the employment of parents or caregivers who, themselves, have been service recipients of like services. Mental Health America (MHA) hires Family Advocates to work with parents and caregivers who receive services from the CSOC. Family Advocates offer support and services to parents and caregivers of children who have received outpatient and/or inpatient specialty mental health services and their families. They also offer WRAP trainings in the community, to ASOC clients, and family members. This program and its team members provide important feedback to the system on family perceptions, needs and concerns.

Promotor(a)s – (Latino Leadership Council (LLC)) Promotor(a)s are trained para-professionals to provide culturally appropriate services, education and support to monolingual Spanish speaking Latino families in the community. Promotor(a)s reach out into the community and assist individuals in navigating the service delivery system and accessing community resources. Cultural brokering is used as a key approach to increase access to, and to enhance the delivery of culturally competent care.

"Personas de Sabiduria"- LLC (Spanish): Conference for at least 90 Latino adults, in Spanish, that will allow persons to share their stories of recovery and resiliency from mental health and substance use disorders. In addition, provide bilingual, bi-cultural experts to lead workshops about various mental health/health issues. This conference builds resiliency and hope for recovery; along with an increased awareness of available supports and services.

Positive Indian Parenting – Sierra Native Alliance (SNA): Positive Indian Parenting provides culturally-relevant parenting education and support. This curriculum is provided in coordination with co-parenting, behavioral consultation, case management, and peer support to increase parenting skills and the resilience of families with children who have emotional and behavioral challenges.

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Trauma Focused Cognitive Behavioral Therapy (TF-CBT) – KidsFirst & Lighthouse (English and Spanish): Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is a psychotherapy approach for caregivers, children, and youth who are experiencing

significant emotional and behavioral difficulties related to traumatic life events. TF-CBT provides short-term treatment (approximately 12 weekly sessions) targeted to overcoming specific trauma. To disrupt trauma-related mental illness, caregivers, children and youth are taught skills to help process thoughts and feelings related to traumatic life events; manage and resolve distressing thoughts, feelings and behaviors related to trauma; and improve coping skills of caregiver and child to create a better living environment for the family.

Perinatal Mood Disorder Treatment – KidsFirst (English and Spanish): This program aims to reduce depression, anxiety, and suicide through culturally- and age-appropriate services such as screening, assessment, evaluation, resources, home visitation, and short-term therapy for parents with children 0-5 years old.

Incredible Years (Dina School) – KidsFirst: The Dina Dinosaur School program for children ages 3-8 years focuses on social, emotional skills, and problem solving designed as a classroom prevention program. Dinosaur School compliments the Incredible Years parent curriculum and teaches children self-regulation and positive classroom behavior.

Attachment Based Family Therapy (ABFT) – KidsFirst (English and Spanish): ABFT is a treatment for adolescents, ages 12-18, designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and reduce dispositional anxiety. ABFT is short term, approximately 12-16 weekly sessions, and aims to strengthen or repair parent-adolescent attachment bonds and improve family communication. As the normative secure base is restored, parents become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.

Adult Support Groups – Latino Leadership Council (LLC): Peer-to-peer weekly groups "Rincon de las Comadres" are offered in Auburn, Roseville, and Lincoln to address issues of depression, anxiety, health, etc. These groups are open to men and women, and provided in Spanish.

Youth Therapy – Uplift and Tahoe SAFE Alliance (TSA) (English and Spanish): Uplift and Tahoe Safe Alliance offer individual, family, and group services to support individual, family and/or group therapy for children, youth and transitional aged youth.
Home to Stay Counseling and Supports for Birth and Kinship Families – Lilliput Children's Services: Intensive in-home support services and counseling to birth and kinship families whose youth are at risk of placement (or disruption) due to emotional, behavioral and mental health issues.

Incredible Years – KidsFirst (English and Spanish): The Incredible Years parent training intervention is a 12 week program focused on strengthening parenting competencies (monitoring, positive discipline, confidence, etc.) and fostering parents' involvement in children's school experiences in order to promote children's academic, social and emotional competencies, and reduce conduct problems.

safeTalk – PCOE: safeTALK is a three (3) to four (4) hour training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. As a safeTALK trained suicide alert helpers, individuals will be better able to (1) move beyond common tendencies to miss, dismiss, or avoid suicide; (2) identify people who have thoughts of suicide; and (3) apply the TALK steps (Tell, Ask, Listen, and KeepSafe) to connect a person with suicidal thoughts to suicide intervention caregivers.

**QUESTION 2C: SIERRA COUNTY**

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

The same applies here as above with specific contacts to parents. If Full Service Partnership services are applicable for the family and the youth wrap around like services are provided.

**QUESTION 2D: PLACER COUNTY**

**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.**

Placer County offers a broad spectrum of MHSA PEI funded services through the county, community, organizational, or private providers.

The YES Program provides peer support services for youth and TAY. Youth Coordinators, who have lived experience in the mental health, child welfare, and/or probation systems, work with TAY to help them accomplish their identified goals. This includes assistance on post-hospitalization transportation and support, system navigation, supporting youth and young adults in finding appropriate placement options and helping youth get their needs met in their placement. In addition, YES Coordinators use their experience and voice to transform system and community services. Youth Coordinators attend system-level meetings and provide youth voice to planning, management, and implementation activities within both CSOC and ASOC. Youth Coordinators support youth who are transitioning between CSOC and ASOC services.

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School Wellness Centers – Tahoe Truckee Unified School District (TTUSD): Tahoe Wellness Centers provide a single point of entry for students to connect to supportive adults and access wellness services at the school. Students learn relevant skills for improving their well-being and understand how to navigate and access community resources. This project allows students to access services and supports that address physical, mental and emotional concerns and engage in activities that will increase their resiliency and overall well-being.

Court Appointed Special Advocates (CASA) – Child Advocates of Placer County: CASA identifies adult volunteers to create a supportive, mentoring relationship with children

and youth who have been removed from their home due to neglect, abuse, or inability to manage the child's behavioral challenges. CASA volunteers meet with their identified child/youth at least twice a month and their mentoring relationship with the child typically lasts at least 1-2 years.

Tahoe Truckee Youth Suicide Prevention Coalition – Giving Voice - Tahoe Truckee Unified School District (TTUSD) collaborated with a number of Tahoe Truckee area community partners, including Placer and Nevada Counties to establish this coalition. They expanded the "Know the Signs Campaign" by engaging youth and community members in outreach events. Goals include educating the public about the signs of suicide, reducing stigma and discriminations, increasing awareness to strengthen social connections, and connecting young people with mental health resources. Plans to administer with partner InnerRhythms Dance Co., a new youth-driven suicide prevention arts program called "Giving Voice" is to be performed at least ten times in schools and the wider community, as well as coordinating a community movie night, facilitate Speaker's Bureau presentations and expanding existing outreach efforts.

Big Brothers Big Sisters of Tahoe (BBBS): By partnering with North Lake Tahoe county agencies, law enforcement, schools and community nonprofits, Big Brothers Big Sisters identifies children at risk of suffering from mental health challenges. These children's home, school and social situations are identified as high stress with the potential to create adverse effects. High risk children are paired with professionally supported one-to-one volunteer mentors (ages 16+) to supplement other mental health strategies with regular check-ins. Mentorships reduce risk behaviors and distress in children, and increase resilience, positive behaviors and functioning.

Boys and Girls Club (BGC) of North Tahoe: The Boys and Girls Club is co-located on the grounds of the North Tahoe elementary school. The BGC serves over 300 children and youth each school year. PEI funded prevention activities include four specific programs that offer group services to identified high risk children and youth. These groups include SMART Girls, which targets the development of life skills for 45 girls in grades 7-12; Stay SMART, which serves 30 children, ages 8-12 years, and develops skills in life decision skills and preventing the development of risky behaviors; SMART Kids, which serves 30 children, ages 6-8 years old, and also develops life decision skills and preventing risky behaviors; Triple Play serves 45 children, ages 6-14, developing healthy habits for mind, body, and soul (free time, socialization monitored by staff).

LLC delivers the YEAGA and Peace 4 the Streets to provide mentoring to individual youth as well as offer leadership groups to promote positive cultural connections to assist Latino youth in developing resiliency.

Youth Services and Supports – Latino Leadership Council (LLC) (English and Spanish): Male & female youth groups to address depression, cultural stressors, discrimination outside and internal to Latino communities, challenges related to biculturalism, education achievement gaps, and violence.

Youth Services and Supports – Sierra Native Alliance (SNA): Native peer support/mentoring groups to build youth resilience and positive cultural identity development.

Functional Family Therapy (FFT) – Placer County and Sierra Mental Wellness Group (English and Spanish): FFT is an empirically grounded, well-documented and highly successful family intervention for at- risk and juvenile justice involved youth and their families. The target population is youth ages 11-17 and their families, whose problems range from acting out, conduct disorder and alcohol/substance abuse.

Applied Intervention Skills Training (ASIST) – PCOE (English and Spanish): ASIST is a two-day (15 hours) intensive, interactive and practice-dominated workshop designed to help individuals recognize risk and learn how to intervene to prevent the immediate risk of suicide. The goal of ASIST is to enhance a caregiver's abilities to assist a person at risk to avoid suicide.

safeTalk – PCOE: safeTALK is a three (3) to four (4) hour training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. As a safeTALK trained suicide alert helpers, individuals will be better able to (1) move beyond common tendencies to miss, dismiss, or avoid suicide; (2) identify people who have thoughts of suicide; and (3) apply the TALK steps (Tell, Ask, Listen, and KeepSafe) to connect a person with suicidal thoughts to suicide intervention caregivers.

Therapeutic Mentoring – Gateway Mountain Center: Therapeutic mentoring program serves youth in North Tahoe who suffer from symptoms of mental illness, emotional disturbance and substance abuse. Counseling uses real life "treatments" including: deep personal connection, life-enriching experience, exercise, proper nutrition, nature-connection, learning new things, and personal reflection. The program is successful with decreasing risk behaviors and distress, increasing coping and resilience, improving functioning, reducing stigma, and increasing positive behaviors.

Stand Up Placer – Due to a recent grant award, Stand Up Placer has been able to expand mental health and substance use treatment services to transition age youth and adults in need of crisis intervention, therapy, counseling, advocacy, and support groups. One of their primary focus areas is the Commercial Sexually Exploited Children (CSEC) population who typically has a substance use disorder.

**QUESTION 2D: SIERRA COUNTY**

**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.**

- Post-hospitalization transportation back to Sierra County

- Contact with Peer Support
- If applicable, contact with the Student/Parent Navigator
- If applicable, linked to Nurturing Parenting programs
- Early Intervention Treatment through MHSA PEI
- Counselors are embedded in the schools through the school district

## VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

### Foster Children and Youth

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

The key findings for California foster youth included:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

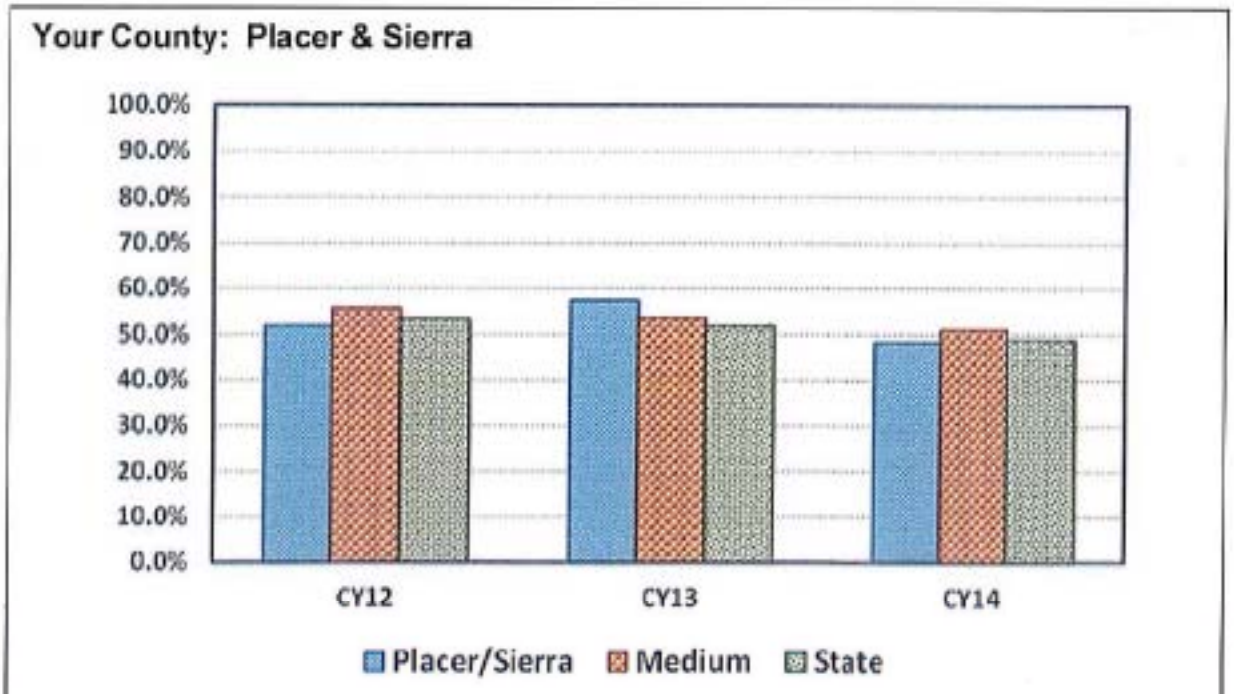



Figure 5. Shown above are the percentages of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the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

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

## QUESTION 3A: PLACER COUNTY

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

**Please list or describe briefly.**

Placer County CSOC initially required the child welfare case managers to request a child be screened upon the child's removal from their home. Unfortunately the case manager was not familiar enough with the child at that point in time to provide enough information as to what concerning behaviors the child was exhibiting, or if the child was still being impacted by the removal from their home. This resulted in inaccurate mental health screening results for a number of children. It was then decided the screening process should be delayed for 2-4 weeks until the child's normal behavior patterns could be determined. It was agreed between child welfare and mental health workers that a minimum of 30 days would provide a better snapshot of the child's behaviors.

A process to track open child welfare case dates was established. The Mental Health Entry Team Supervisor contacts each case worker between 30-45 days after a child has been removed to start the screening process. Each new case is assigned to a MH clinician who then either calls or meets with the case manager to discuss the child's concerning behavior, if any, and completes the Mental Health Screening Tool. Based on the outcome of that conversation, it is determined whether the case is referred on for a full assessment or no further assessment is needed.

Ongoing Mental Health clinicians complete the full biopsychosocial assessments and determine from the results of that assessment whether the child is referred on to a county, private provider or community partner for SMHS services.

## QUESTION 3A: SIERRA COUNTY

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

**Please list or describe briefly.**

Providing services to Sierra County's small population is challenging due to the intra-connectedness within communities, as well as, the inter-relationships and inter-connectedness which occur throughout the county as a whole. Dual relationships, along with a lack of anonymity, are a distinctive norm community members of Sierra County live and deal with on a day to day basis. Thus, providing specific programs focusing on an under-represented, minority population inadvertently creates profiling of the population Sierra County Behavioral Health is seeking to serve. For example, a youth seeking services does not feel comfortable receiving services in a group setting because they can be identified, have a current or have had a previous relationship with the other youth receiving services or the facilitator of the service. More likely than not,

there are familial ties to the youth and one or more of those individuals involved in receiving or providing the service. Once the service has a 'label' or a specific identified outcome, the youth attending have been profiled. Sierra County's community defined best practices, based on the challenges above, indicate building trust while participating in a universal or selective service strategy resulting in warm referrals is most successful.

Social Services makes referrals to Behavioral Health.

**QUESTION 3B: PLACER COUNTY**

**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 3B: SIERRA COUNTY**

**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: PLACER COUNTY**

**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.**

Overall, Placer County CSOC does a good job of coordinating between county child welfare services and mental health teams to meet the MH needs of foster care children and youth. During CY12, CY13 and CY14, the percentage of Placer County's foster care youth remained around 50% which was very close to other medium sized counties and the state average values.

Placer has noticed a decline for 2016 for both assessments and services. Management is in the process of reviewing assessment and referral data and has discovered three separate contributing factors. Management will continue to review data on a monthly

basis and will be meeting with MH and child welfare teams to brainstorm strategies to improve the processes. An initial goal is to provide more clinical support to the case managers so they have richer information on their children.

**QUESTION 3C: SIERRA COUNTY**

**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.**

Engagement strategies could be improved through communication and education with stakeholder entities. There are so few foster youth in Sierra County engagement strategies are often overlooked.

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

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

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

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

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

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

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

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

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

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

**QUESTION 4A: PLACER COUNTY**

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

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

**QUESTION 4A: SIERRA COUNTY**

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

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

**QUESTION 4B: PLACER COUNTY**

**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.**

Within the past year, the PFLAG Greater Placer County Chapter has been established and has monthly meetings for members. Their website has a very small listing of local resources and a larger number of regional and state-wide resources.

The Tahoe Truckee area has two school clubs, SAGA (Sexuality and Gender Acceptance) and Pride Club (Marginalized Orientations, Gender Identities and Intersex).

- Pride Club – a Truckee High Club that supports MOGII (Marginalized Orientations, Gender Identities and Intersex) youth and educates the school and the broader community about the broad spectrum of sexual orientations and gender identities.
- SAGA Club (Sexuality and Gender Acceptance) – a North Tahoe High club that supports LGBTQ students with different sexual orientations and gender identities and creates awareness about creating a safe and accepting school culture for all.

NorCal MHA provides LGBTQ training in Placer County through the LGBTQ California Reducing Disparities Project grant funded by The California Endowment as part of the Building Healthy Communities Initiative.

**QUESTION 4B: SIERRA COUNTY**

**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.**

**QUESTION 4C: PLACER COUNTY**

**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.**

Recommend meeting with PFLAG Greater Placer County Chapter, Pride Club and SAGA Club to brainstorm efforts on how to build a wider array of local resources for the LGBTQ population. Consider partnering with Placer County Office of Education to discuss the feasibility of re-starting the Gay Straight Alliance (GSA) Club or similar clubs at some of county high schools on the Western Slope.

**QUESTION 4C: SIERRA COUNTY**

**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.**

Providing services to Sierra County's small population is challenging due to the intra-connectedness within communities, as well as, the inter-relationships and inter-connectedness which occur throughout the county as a whole. Dual relationships, along with a lack of anonymity, are a distinctive norm community members of Sierra County live and deal with on a day to day basis. Thus, providing specific programs focusing on an under-represented, minority population inadvertently creates profiling of the population Sierra County Behavioral Health is seeking to serve. For example, a youth seeking services does not feel comfortable receiving services in a group setting because they can be identified, have a current or have had a previous relationship with the other youth receiving services or the facilitator of the service. More likely than not, there are familial ties to the youth and one or more of those individuals involved in receiving or providing the service. Once the service has a 'label' or a specific identified outcome, the youth attending have been profiled. Sierra County's community defined

best practices, based on the challenges above, indicate building trust while participating in a universal or selective service strategy resulting in warm referrals is most successful. Nurturing Parenting and Peer Support could be incorporated into services addressing the needs for LBGTQ youth and/or their families.

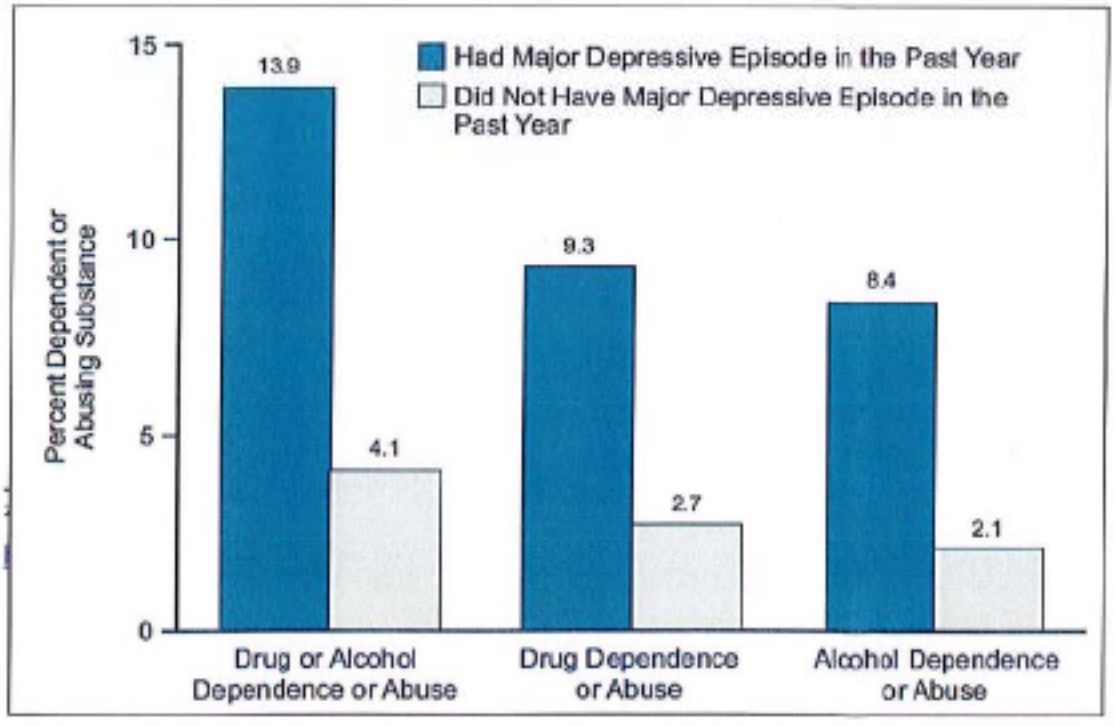
The Student/Parent Navigator can receive referrals from the schools and link youth or families to appropriate services.

## Children and Youth Affected by Substance Use Disorders

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

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

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



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

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

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

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

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

**Placer County:**

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

N/R = not reported; due to insufficient or no data reported to the agencies analyzing the survey data. Also: no data reported for Sierra County.

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

**California: Statewide**

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

**Your Counties:**

**Placer** **Sierra:**

**Age <18: 56** **Age 18-25: 268** **No data available.**

**QUESTION 5A: PLACER COUNTY**

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

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

In the past year, Placer County CSOC has instituted programmatic changes in their Drug Court model and switched to utilizing The Matrix Model, an evidence-based intensive outpatient treatment program. With this change it is anticipated CSOC will see an increased effectiveness and improved outcomes for the juvenile justice youth enrolled in the program. The new model utilizes individualized behavior contracts, wraparound, motivational interviewing, treatment groups, intensive case management, parent involvement and support group, community service, strength based, drug use education, fitness focused (all enrollees gym passes) and a skills building component. Youth are often grounded versus being returned back to the Juvenile Detention Facility to serve additional time in order to continue the services. All Drug Court youth have a

co-occurring disorder. The new model has increased collaboration with the Juvenile Probation Department and Juvenile Drug Court. Drug Court currently sponsors quarterly sober night events for the enrollees.

The Student and Family Support Program through Community Recovery Resources (CoRR) provides outpatient services for youth who have more significant issues and need more intensive, ongoing treatment. The program provides an assessment and individualized treatment plans for youth who are at risk of mental health disorders due to identified substance misuse or dependence, or have significant parent/family issues at home. These youth are not court ordered or enrolled in FSP.

Stand Up Placer – Due to recent grant award, Stand Up Placer has been able to expand mental health and substance use treatment services to transition age youth and adults in need of crisis intervention, therapy, counseling, advocacy, and support groups. One of their primary focus areas is the Commercial Sexually Exploited Children (CSEC) population who typically has a substance use disorder.

There may be future changes to the Drug Medi-Cal program, depending on whether ACA is repealed and replaced or not. The Drug Medi-Cal program funds specific treatment services delivered to Medi-Cal beneficiaries with substance use disorders (SUD). The volume of services provided under Drug Medi-Cal are expected to increase significantly in the coming years as Medi-Call eligible beneficiaries access the expanded SUD benefits and California counties implement the Drug Medi-Cal Organized Delivery System (DMC-ODS) waiver. It is estimated that approximately 12% (450,000 individuals) of the MCE eligible population have a substance use disorder.

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

**QUESTION 5A: SIERRA COUNTY**

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

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

- Outpatient treatment counseling
- Prevention Programs
- Referral to residential or detox if needed to outside care provider.

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

**QUESTION 5B: PLACER COUNTY**

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

**Please explain briefly.**

The youth substance treatment services through Drug Court have been available for a number of years. Due to funding, there are a limited number of available slots. CSOC added the community partner youth substance use treatment provider in 2015. However, there is still a need for additional youth substance use treatment options to meet the current demand for youth substance use services for those youth who do not have a co-occurring disorder but need some substance use education, support groups, etc. Currently no Ala-Teen or Al-Anon meetings are available for youth in Placer County.

**QUESTION 5B: SIERRA COUNTY**

**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.**

Sierra County Behavioral Health (SCBH) receives referrals from CPS, Probation, or the Community Outreach Coordinator per prevention programs. SCBH also provides educational materials.

## Justice System-Involved Youth with Behavioral Health Needs

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

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

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

A recent report states that "the vast majority, between 75 and 93 percent of all youth entering the justice system are estimated to have experienced previous trauma."[22] Even more shocking, "girls in the justice system are 200 – 300 times more likely to have experienced sexual or physical abuse in the past than girls not in the justice system." [23]

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

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

Historically, "students of color, LGBT students, and students with disabilities...are disproportionately impacted by suspension and expulsion."[25] Across all age groups, for similar low-level offenses, persons of color are more likely to be incarcerated and much less likely to be referred to therapy, diversion, or probation than are their white counterparts. Research shows that African American children and youth are more than

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

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

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

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

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

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

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

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

| | | |
|---|---|---|
| Total population[28] age 10-17 | 4,060,397 | 100 % of age 10-17 |

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

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

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

| | | |
|---|---|---|
| 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.

**Data shown below**:

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

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

**For your county: Placer** **241 juvenile felony arrests, 2014.**
**Sierra:** **0 juvenile felony arrests, 2014.**

## QUESTION 6A: PLACER COUNTY

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

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

**PROGRAM:** **FUNDING SOURCE: JJCPA funding**

Short-term mental health counseling is provided by an embedded mental health clinician to provide crisis-intervention and stabilization for incarcerated juvenile justice youth housed at the Placer County Juvenile Detention Facility. This position is paid for through Juvenile Justice Crime Prevention Act (JJCPA) funding.

There is not a full service substance use disorder treatment service or program for youth who are in custody. However, Drug Court can provide a modified program (without any family component) to incarcerated youth. Both Drug Court and Functional Family Therapy (FFT) are both available to juvenile justice youth who are not in custody. Drug Court is funded through SAMHSA Mental Health Block Grant (MHBG), Medi-Cal and MHSA. FFT is funded through Medi-Cal, SAMHSA MHBG, and MHSA

## QUESTION 6A: SIERRA COUNTY

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

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

**If yes, please list briefly. Please indicate (if available) the main funding[31] sources for these programs.**

**PROGRAM:** **FUNDING SOURCE:**

**QUESTION 6B: PLACER COUNTY**

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

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

**QUESTION 6B: SIERRA COUNTY**

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

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

**PROGRAM:** **FUNDING SOURCE:**

**QUESTION 6C: PLACER COUNTY**

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

**Yes_X__ No___. If yes, please list briefly.**

All of the following programs engage the parents/guardians of juveniles involved in the juvenile justice system:

- Juvenile Drug Court – The Matrix Model – strong family component (The Matrix Model enrollees also receive Wraparound services.)
- Functional Family Therapy – family therapy (youth and parent/guardian)

[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.

- Wraparound – intensive in-home support with a strong family component/family and youth services
- CoRR – outpatient – family therapy (youth and parent/guardian); outpatient – family counseling with a greater degree of family involvement

**QUESTION 6C: SIERRA COUNTY**

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

**Yes__X_ No___. If yes, please list briefly.**

## 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.

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[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.

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[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.

**Placer[4] County:**

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

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

*N/R: data not reported.

**Sierra County**: Also no data were reported.

**QUESTION 7A: PLACER COUNTY**

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

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

Placer County continues to support the statewide suicide prevention and Stigma Discrimination Campaigns that are managed by CalMHSA. The "Know the Signs" and "Each Mind Matters" campaigns, driven at the State level, has been very effective in the Placer community in educating about suicide prevention and reducing stigma and discrimination related to mental illness. Placer County widely uses materials and websites created from these initiatives.

The following county and community crisis intervention and prevention programs provide a plethora of services, supports, and education to children and youth and their families in our community:

Mental Health Crisis Intervention: Placer County Mental Health clinicians or community contractors have been certified to assess children for hospitalizations as a danger to self, danger to others, or gravely disabled due to a mental disorder (California Welfare and Institutions Code 5150). These staff then consult with designated psychiatrists who have the authority to admit children to certified or licensed psychiatric facilities.

Mental Health Entry Team provides follow up with youth and family within 7 days of them being released from a psychiatric hospital after being 5150's to ensure the youth has been or is getting connected with the appropriate mental health services.

The Mobile Crisis Team (16+) services are provided through an MOU in conjunction with all five Placer County law enforcement jurisdictions has significantly reduced the percentage of people hospitalized while in crisis. The MHP does not have a CSU.

Fast Track Wrap – Uplift offers intensive, in-home, short-term wraparound services with the Fast Wrap program for children (ages 0-17) with a serious emotional disturbance and require family support services.

The Crisis Resolution Center provides short-term out-client services as well as short-term residential care not to exceed 30 days for youth age 12 to 17. The facility is a six-bed (co-ed) group home facility with counseling facilities, fully licensed and professionally staffed to provide out-client family services and short-term residential care. Services include quality relationship counseling, conflict resolution, parent-child training and professional referral services.

Attachment Based Family Therapy (ABFT) is a treatment for adolescents, ages 12-18, designed to treat clinically diagnosed major depressive disorder, eliminate suicidal ideation, and to reduce dispositional anxiety. ABFT is short-term, approximately 12-16 weekly sessions, and aims to strengthen or repair parent-adolescent attachment bonds and improve family communication. As the normative secure base is restored, parents become a resource to help the adolescent cope with stress, experience competency, and explore autonomy.

Assertive Community Treatment (ACT) provides case management; initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other supports critical to a young adult's ability to live successfully in the community. ACT services are available 24/7 and are available to youth aged 16+ with SMI and a functional impairment where services beyond Wraparound would be required.

Adventure Risk Challenge - Utilizing statewide campaigns Know the Signs, Each Mind Matters, Busco Apoyo, and My3 App, provide one-on-one and group outreach in Spanish and English to high school age youth in the Tahoe area to educate about signs and symptoms of mental health and integrate efforts to reduce stigma and discrimination. In partnership with the Tahoe Truckee Unified School District, ARC will facilitate summer immersion programs, including two weekend retreats, each year for the peer mentors of the Wellness Centers. The education and activities serve to develop and train the peer mentors and to increase their awareness, preparedness, and knowledge about suicide prevention and stigma and discrimination reduction. Individualized tutoring and mentoring is provided as well.

School Wellness Centers – Tahoe Truckee Unified School District (TTUSD): Tahoe Wellness Centers provide a single point of entry for students to connect to supportive adults and access wellness services at the four high school wellness centers with linkages to the two middle schools. Students are trained to become Peer Mentors. Youth learn relevant skills for improving their well-being and understand how to navigate

and access community resources. This project allows students to access services and supports that address physical, mental and emotional concerns and engage in activities that will increase their resiliency and overall well-being.

Signs of Suicide (SOS) - The SOS Prevention program is an award winning, nationally recognized EBP program which teaches middle to high school age students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell). The SOS program teaches students that depression is a treatable illness. Students are taught that suicide is not a normal response to stress, but rather a preventable tragedy that often occurs as a result of untreated depression. Students are given specific action steps, encouraged to engage in a discussion about these issues with their parents, and utilize the peer-to-peer help-seeking model.

Tahoe Truckee Youth Suicide Prevention Coalition – Giving Voice - Tahoe Truckee Unified School District (TTUSD) collaborated with a number of Tahoe Truckee area community partners, including Placer and Nevada Counties to establish this coalition. They expanded the "Know the Signs Campaign" by engaging youth and community members in outreach events. Goals include educating the public about the signs of suicide, reducing stigma and discriminations, increasing awareness to strengthen social connections, and connecting young people with mental health resources. Plans to administer with partner InnerRhythms Dance Co., a new youth-driven suicide prevention arts program called "Giving Voice" is to be performed at least ten times in schools and the wider community, as well as coordinating a community movie night, facilitate Speaker's Bureau presentations and expanding existing outreach efforts.

Safe Talk is a three (3) to four (4) hour training that prepares anyone over the age of 15 to identify persons with thoughts of suicide and connect them to suicide first aid resources. As a safeTALK trained suicide alert helpers, individuals will be better able to (1) move beyond common tendencies to miss, dismiss, or avoid suicide; (2) identify people who have thoughts of suicide; and (3) apply the TALK steps (Tell, Ask, Listen, and KeepSafe) to connect a person with suicidal thoughts to suicide intervention caregivers.

Mental Health First Aid (MHFA) is a groundbreaking public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. MHFA is an interactive, 8-hour course that presents an overview of mental illness and substance use disorders in the U.S. and introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and provides an overview of common treatments. Participants learn a five-step action plan encompassing the skills, resources and knowledge to help an individual in crisis connect with appropriate professional, peer, social, and self-help care.

**QUESTION 7A: SIERRA COUNTY**

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

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

**QUESTION 7B: PLACER COUNTY**

**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 of the Placer County Crisis programs mentioned previously in Question 7A previously are also available to the TAY population. The following crisis programs (noted in detail for Question 7A above and programmatic statement not repeated due to redundancy) specifically targeting at preventing suicides in the TAY (16-25) population:

- Mobile Crisis Team (16+)
- Crisis Resolution Center (CRC) - age 12-17
- Attachment Based Family Therapy (ABFT) (12-18)
- Assertive Community Treatment (ACT) (16+)
- Adventure Risk Challenge (ARC) (14-18)
- Tahoe Truckee Youth Suicide Prevention Coalition – Giving Voice (12-18)
- School Wellness Centers (12-18)
- Signs of Suicide (SOS)
- Safe Talk (15+)
- Stand Up Placer (SUP)

The following Placer County programs specifically target at preventing suicides in transition aged youth (ages 16-25):

High Acuity and Assisted Outpatient - Serves TAY (16+), adults, and older adults with severe mental illnesses (SMI) who require a higher intensity service. Priority is given to unserved or inappropriately served clients who are at risk of psychiatric hospitalization, homelessness, and those ready to exit psychiatric health facilities, psychiatric hospitals, IMDs, or jail.

Homeless – ASOC serves TAY (18-25), Adults, and Older Adults with a severe and chronic mental illness who are homeless or at risk of homelessness. Homeless outreach is done in hospitals, jails, homeless camps, homeless shelters, and psychiatric hospitals to link adults with services such as mental health, alcohol/drug treatment, income, and

housing. It provides a "Whatever It Takes," 24/7 approach to assist people in their Recovery.

Co-Occurring - Provides outreach, engagement, and enrollment into Full Service Partnership (FSP) case management services for TAY, adults, and older adults with SMI who also have co-occurring substance use disorders in unserved populations or high utilizing populations of emergency and crisis services. Support is 24/7 with a "whatever it takes" philosophy to engage clients into ongoing and sustained treatment. Priority is given to clients who are at risk of psychiatric hospitalization, homelessness, and emergency room utilization.

**QUESTION 7B: SIERRA COUNTY**

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

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

**QUESTION 7C: PLACER COUNTY**

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

**Yes____ No__X___. If yes, please list briefly.**

**QUESTION 7C: SIERRA COUNTY**

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

**Yes__X__ No_____. If yes, please list briefly.**

Sierra County Behavioral Health provides Mental Health First Aide training to stakeholders and community members.

Individualized services are available.

## 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: PLACER COUNTY

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

**Yes____ No__X__**

From 2014 through 2016 Placer County SOC received FEP funding and began efforts to work with Turning Point Community Programs which was contracted to provide early intervention and treatment for those youth identified as being at high risk. The plan was hopefully model the program after the UC-Davis Early Diagnosis And Preventative Treatment (EDAPT) or SacEDAPT model programs that involve training to recognize signs and symptoms associated with major mental illnesses in young populations. Unfortunately Turning Point did not have sufficient staffing to allow for the necessary training required of supervisors and staff and Placer County declined the program funding.

Placer County utilizes FSP Wraparound (all Drug Court clients also receive Wraparound services) as an alternative service for first break psychosis in children and youth. The youth would also be offered additional services such as TBS and CBT. In addition, singularly or a combination of the following programs may be able to provide high intensity services and programs for the TAY FEP population:

Assertive Community Treatment (ACT) provides case management, initial and ongoing assessments; psychiatric services; employment and housing assistance; family support and education; substance abuse services; and other supports critical to a young adult's

ability to live successfully in the community. ACT services are available 24 hours per day, 365 days per year. These services are available to youth aged 16+ with SMI and a functional impairment where services beyond Wraparound would be required.

High Acuity and Assisted Outpatient – Turning Point serves TAY (16+), adults, and older adults with severe mental illnesses (SMI) who require a higher intensity services. Priority is given to unserved or inappropriately served clients who are at risk of psychiatric hospitalization, homelessness, and those ready to exit psychiatric hospitals, facilities, IMDs or jails.

The Student and Family Support Program through Community Recovery Resources (CoRR) provides outpatient services for youth who have more significant issues and need more intensive, ongoing treatment. The program provides an assessment and individualized treatment plans for youth who are at risk of mental health disorders due to identified substance misuse or dependence, or have significant parent/family issues at home. These youth are not court ordered or enrolled in FSP.

Placer County ASOC provides outreach, engagement and enrollment into FSP case management services for TAY (age 18-25), adults, and older adults with SMI who also have Co-Occurring substance use disorders in unserved populations or high utilizing populations of emergency and crisis services. Support is 24/7 with a "whatever it takes" philosophy to engage clients into ongoing and sustained treatment. Priority is given to clients at risk of psychiatric hospitalization, homelessness, and emergency room utilization.

Chapa De Indian Health Program provides out-client substance abuse program including behavioral health, co-occurring and supportive services, information and referrals. Services are free for Native Americans.

**QUESTION 8A: SIERRA COUNTY**

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

**Yes____ No__X__**

There are no targeted programs for first break psychosis in children and youth, and transition aged youth. However, individualized services are embedded within Sierra County Behavioral Health.

**QUESTION 8B: PLACER COUNTY**

**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.**

**QUESTION 8B: SIERRA COUNTY**

**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.**

Services are individualized based on need. MHSA and SAMHSA are the funding source.

**QUESTION 8C: PLACER COUNTY**

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

**Yes____ No__X__. If yes, please describe briefly.**

**QUESTION 8C: SIERRA COUNTY**

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

**Yes____ No__X__. If yes, please describe briefly.**

## Full Service Partnership (FSP) Programs for Children and Youth

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

Please examine the data in the following tables below taken from a report[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.

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[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 in 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: PLACER COUNTY**

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

In part, due to the State's Continuum of Care efforts, the most urgent child or youth problems for Placer County CSOC are out of county placements for children which lead to a lack of family continuity and therapeutic interventions, lack of providers and specialists, patients being impacted by the managed care plans' struggles with their network of care strategy, limited substance abuse services for youth and child welfare parents, and a rising homelessness population for the TAY population. More than likely, Placer will also see a rise in the number of placements for children in foster care due to the county emergency shelter closure in late November 2016.

**QUESTION 9A: SIERRA COUNTY**

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

- Truancy
- Substance abuse

**QUESTION 9B: PLACER COUNTY**

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

The statewide FSP data clearly shows improvements in all areas. Unfortunately Placer does not yet have access to the local FSP data for FY15-16 to compare against the FY14-15 data so we are not able to state what the most urgent problem for children or youth is in our community.

**QUESTION 9B: SIERRA COUNTY**

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

There is an identified need for a Behavior Intervention Specialist and more organized care targeting children or youth in our communities. These needs have been recognized and are currently being addressed by Sierra County Behavioral Health.

**Question 9C: PLACER COUNTY**

**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.**

**Question 9C: SIERRA COUNTY**

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

**Yes _X__ No___. If yes, please describe briefly.**

All services must be individualized as inter-relationships, lack of resources, geographic isolation, lack of transportation all play into wrap-around services being successful.

## 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

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

√ Data Notebook placed on Agenda and discussed at Board meeting

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

√ MH Board Children's Committee 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: County staff interviewed community partners for input as well.

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

Yes X No___

If yes, please provide their job classification Administrative Secretary

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

Name and County: Janna Jones, Placer County

Email: jljones@placer.ca.gov

Phone # 530.889.7254

Signature: Janna Jones

Other (optional): ___

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

Name and County: Sharon Stanners and Sharon Behrens, Placer County MHAOD Children's Committee

Email: stanners.sharon@gmail.com; starfish7373@gmail.com

Phone # 530.401.1292 or 916.580.5584

Signature: Sharon Stanners

## 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.

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_x__ Data Notebook placed on Agenda and discussed at Board meeting

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

_x__ MH Board partnered with county staff or director

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

___ Other; please describe: _____

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

Yes___ No_x__

If yes, please provide their job classification _____

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

Name and County: ___Laurie Marsh, Sierra County _____

Email_ lmarsh@sierracounty.ca.gov_____

Phone #___530-993-6745_____

Signature: _____

Other (optional): _____

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

Name and County: _____Laurie Marsh, Sierra County_____

Email: ___same as above_____

Phone #_____

Signature: _____

**REMINDER:**

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

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

**Please submit your Data Notebook report by email to:**

**DataNotebook@CMHPC.CA.GOV.**

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

**(916) 327-6560**

Or, you may contact us by postal mail to:

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