Child and Adolescent Services Research Center

County of San Diego
Health & Human Services Agency

Children's Mental Health Services

Second Annual System of Care Report

Cumulative Data
1996-2000

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In conjunction with County of San Diego
Health & Human Services Agency

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A special thanks to the clerical and support staff who patiently transmitted the data for their programs.

TABLE OF CONTENTS

I Executive Summary 1

II Introduction 2

Report Contents 3
Definitions 4
Participating Programs 5
Data Processed to Date 5
Represented Samples 5
Table 1: POP Participating Programs 6
Figure 1: POP Assessments Processed Per Month by Fiscal Year 8
Figure 2: Intensive Services Evaluation Project Referrals & Assessments 9

III Description of the County Mental Health Service System 10

Figure 3: Unduplicated Client Count by Fiscal Year 12
Figure 4: Percent of Total Unduplicated Client Count by FY and Database 12
Figure 5: Gender Distribution Across Mental Health Service System 13
Figure 6: Age Distribution Across Mental Health Service System 13
Figure 7: Ethnicity Across Mental Health Service System 13
Figure 8: Single and Multiple Use by Service Mode 14

IV Description of Performance Outcome Project (POP) Intake Cohorts 15

Cohort Sample Size 15
Cohort Demographics 15
Cohort Clinical Profiles 15
Table 2: Brief Description of POP Clinical Measures 17
Figure 9: POP Intake Cohorts by Sex and Age 18
Figure 10: POP Intake Cohorts by Race/Ethnicity and Youth Living Environment 19
Figure 11: POP Intake Cohorts by Program Type and Staff Type 20
Figure 12: POP Intake Cohorts by Fiscal Year: CAFAS and PECFAS Total Scores 21
Figure 13: POP Intake Cohorts by Fiscal Year: CBCL and YSR Total Behavior/Emotional Scores 22
Figure 14: POP Intake Cohorts by Fiscal Year: Youth Competency Scales by Parent and Youth Report 23
Figure 15: POP Intake Cohorts by Fiscal Year: CAFAS and CBCL Mean Total Scores by Age Group 24
Figure 16: POP Intake Cohorts by Fiscal Year: CAFAS and CBCL Mean Total Scores by Race/Ethnicity 25

TABLE OF CONTENTS

V Total POP Intake Sample 26

Figure 17: Total POP Intake Sample: CAFAS Mean Total Scores by Program Type 27
Figure 18: Total POP Intake Sample: CBCL and YSR Mean Total T Scores by Program Type 28
Figure 19: POP Intake Cohorts by Fiscal Year: Parent Satisfaction of Mental Health Services for their Youth 29

VI Clinical Outcomes 30

Figure 20: Clinician, Parent and Youth Reports at Intake and Follow-up – Change in CAFAS, CBCL, YSR Scores Across Timeframes 32
Figure 21: Assessed Change in Treatment Across Timeframes – Parent, Youth and Clinician Reports 33
Figure 22: Assessed Change from Intake-6mo, 6mo-1year by Informant 34
Figure 23: Intake to 6 Month Change in CAFAS Scores by Fiscal Year of Intake 35
Figure 24: Intake Profiles (FY 97-98) – CAFAS Scores for Youth with and Without 2 Year Assessments 36
Figure 25: Intake Profiles (FY 97-98) – CBCL and YSR scores for Youth with and Without 2 Year Assessment 37
Figure 26: Change Across Time – CAFAS, CBCL and YSR at Intake, 6 Month and 1 Year 38
Figure 27: Clinician Assessed Change by Race/Ethnicity – Mean CAFAS Scores at Intake, 6 Month and 1 Year 39
Figure 28: Parent Assessed Change by Race/Ethnicity – Mean CBCL Scores at Intake, 6 Month and 1 Year 40
Figure 29: Youth Assessed Change by Race/Ethnicity – Mean YSR Scores at Intake, 6 Month and 1 Year 41
Figure 30: Client Satisfaction by Ethnicity – Mean Scores at 6 Months and 1-Year Follow-ups 42

VII Intensive Services Evaluation Project (ISEP) 43

Recidivism 44
School Achievement 45
Table 3: ISEP: Brief Description of ISEP Clinical Measures 46
Figure 31: ISEP: Income Distribution, Caregiver Educational Level, and Race/Ethnicity 47
Figure 32: ISEP CAFAS: Total Functional Impairment at Baseline and 6 Months 48
Figure 33: ISEP: Child Behavior Checklist (CBCL) 49
Figure 34: ISEP: Youth Self-Report (YSR) Scores 50
Figure 35: ISEP: Assessments of Change, Baseline to 6-month: Total Problems 51

TABLE OF CONTENTS

VII Intensive Services Evaluation Project (ISEP) – continued

Figure 36: ISEP: Caregiver Strain Questionnaire 52
Figure 37: ISEP: Behavioral and Emotional Rating Scale (BERS) Subscales 52
Figure 38: ISEP: Youth & Family Satisfaction, 6 months 53
Figure 39: Multidimensional Adolescent Satisfaction Scale (MASS), 6-month Indications of Difference by Race/Ethnicity 54

VIII System Outcomes 55

Figure 40: State Hospital Costs and Usage by Fiscal Year 56
Figure 41: Inpatient Costs and Bed Days by Fiscal Year 57
Figure 42: Group Home/Residential Costs and Months in Placement by Fiscal Year 58
Figure 43: Group Home Expenditures and Placement by Fiscal Year – State of California and San Diego County 59

IX Future Directions 60

Executive Summary

The County of San Diego received funding under the State System of Care program (AB3015) in 1996. The purpose of this funding is to develop a children's mental health "system of care" that implements a system that emphasizes establishing goals, building interagency coalitions and designing services that focus on quality, continuity, and client-centeredness for a defined target population. The county also received additional funding for more intensive services from a federal CMHS/SAMHSA grant and from the state SB163 program for high-end youth at risk for placement in restrictive settings. The Intensive Services Evaluation Project (ISEP) evaluates the process and outcomes of this innovative program that emphasizes establishing goals representative of both system of care and wraparound initiatives including principles of involving parents in all aspects of service delivery, and providing culturally competent and community based integrated care. In addition, requirements are set forth to monitor the system for client benefit and public cost savings. The major findings included in this report are summarized below.

Summary of Data

* 12,957 youth (unduplicated client count) were provided mental health services in 1999-2000. A 3% increase from the previous year and a 9% increase from 1996-1997.

* The majority of youth are males (66%) and are 13-17 yrs old (51%) in the youth General Mental Health System. However, each year more youth 6-12 yrs old (38% in FY99-00) are receiving services.

* The youth served are of a diverse background with Whites and Hispanics being the largest race/ethnic groups (34% & 31%) in GMHS. Hispanics surpass Whites in percentage of youth completing POP assessments (38% & 34%) in FY99-00. Hispanics are also the largest group in the ISEP sample (41% to 32% Whites).

* There is significant overall improvement in youth functioning during treatment according to the clinician at each time point; intake-6 months, intake-1 year, intake-2 year and overall improvement in youth symptoms for each time point according to the parent. Youth report improvements for intake-6 month and intake-1 year (no intake-2 year).

* Repeated measures show continuous improvement for youth from intake to 6 months to 1 year according to all informants: clinicians, parents and youth. However, the average level of impairment at 1 year is still within the clinical impairment range.

* Parents of youth in the ISEP sample report significantly less objective, subjective-internalized and global caregiver strain. Suggesting improvements for the family too.

* All parents are satisfied with services (both POP and ISEP samples) and there are no race/ethnic group differences.

* State Hospital costs reduced 87% and bed days used reduced 100% from FY96-97 to 99-00.

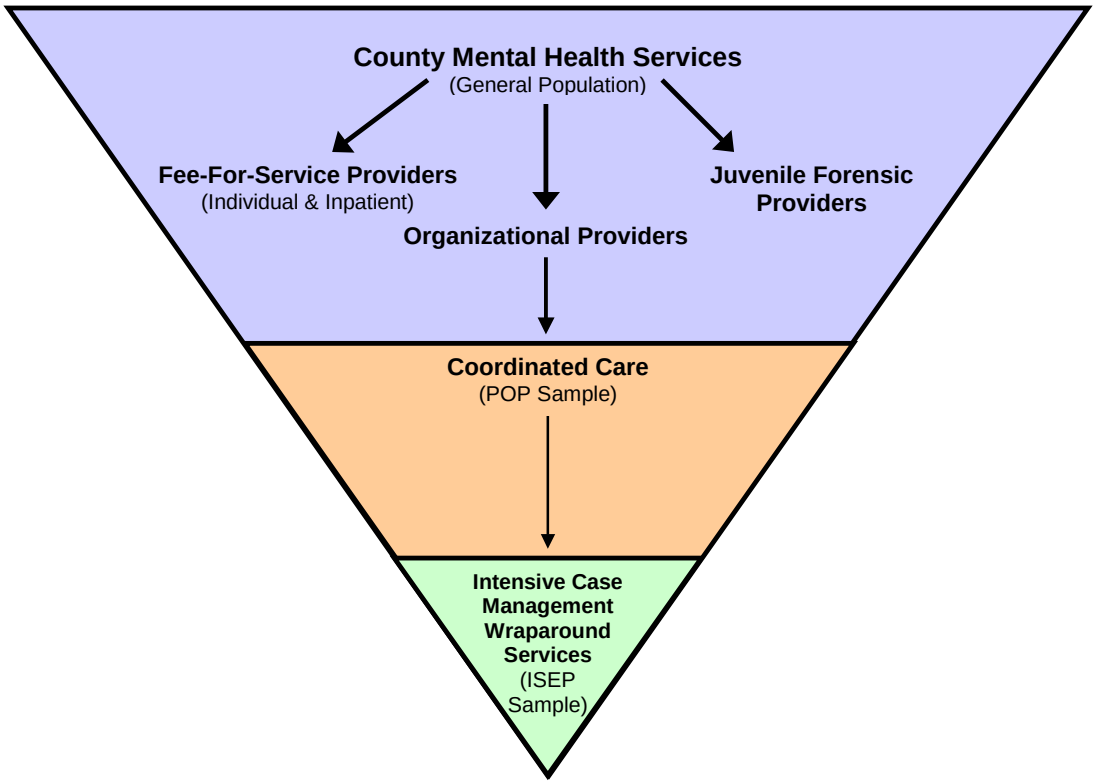
* Group Home costs are 11% below statewide average and 16% below statewide average number of placements at end of FY99-00.

Introduction

The San Diego County Mental Health Services (CMHS) primarily serves children and adolescents ranging in age from 2-18 years old with some programs serving youth, 18 to 21 years old, transitioning to adult services. It is the second largest county in California with a youth population of 764,235 in 2000 encompassing a vast diversity of race/ethnic groups, cultures and spoken languages. The CMHS serves youth in the general mental health population through three primary mechanisms: Fee-for-Service Providers, Organizational Providers and Juvenile Forensic Providers. The Organizational Providers make up the county's Coordinated Care population.

San Diego County began implementing its coordinated system of care in 1997 under funding from the State of California (AB3015). In addition to the gradual transition into coordinated services across agencies, the county also implemented the state mandated Performance Outcome Project (POP) data collection process. According to this state mandate, standardized clinical data must be collected on all children and adolescents as they enter coordinated mental health care and as they progress through the county's mental health system. This report presents a cumulative comprehensive summary of data collected under the performance outcome requirements from July 1, 1997 to June 30, 2000.

In 1997 SD County was awarded additional resources to provide wraparound-based services for seriously emotionally disturbed (SED) youth needing more intensive involvement with services as an alternative to restrictive settings of care. The Intensive Services Evaluation Project (ISEP) began collecting information on the implementation of wraparound-based services through the development and/or expansion of three programs: Transition of Wards Embracing Recovery (TOWER), Community Intensive Treatment for Youth (CITY) and Building Effective Solutions Together (BEST). More recently the county also began the Mental Health Initiative (formerly Wraparound Laboratory/SB163) primarily funded from SB163 to provide integrated wraparound services for SED youth at risk of placement in restrictive care at a level 12 or above residential facility from any of four service systems: mental health, social services, education or probation.



Report Contents

The enclosed report summarizes cumulative system and clinical outcomes for children and adolescents served by county mental health services. Following this introduction, the report is organized into six sections that present the data from the three samples: general, POP and ISEP.

1) The first section, "Description of the Children Mental Health Service System," provides descriptive information about children and adolescents in the general mental health service system from 1996 to 2000. The data answers the questions: "Who is the county serving?" and "What services did the youth receive?"

2) The second section, "Performance Outcome Project Intake Cohorts," provides descriptive information about the children and adolescents who entered into the coordinated care mental health system and completed POP measures during each fiscal year of data collection, 1997-1998, 1998-1999 and 1999-2000. The data presents demographics, race/ethnicity, living environments, program and staff information and clinical profiles of the youth by fiscal year.

3) The third section, "Total POP Intake Sample," provides descriptive information about a cumulative sample of youth who receive services from four different program types (Inpatient, Outpatient, Day treatment & Case Management). This section also reports the level of satisfaction with services reported by families.

4) The fourth section, "Clinical Outcomes," contains longitudinal outcome data regarding changes in children and adolescent's behavioral and emotional symptomatology and overall functioning throughout their course in treatment. The samples include youth with intakes and follow ups within the 1997-2000 fiscal years, reporting follow-ups that range from 6 months to 2 years.

5) The fifth section, "Intensive Services Evaluation Project" (ISEP), includes summaries and outcome information for the county's wraparound-based service programs. The county implemented three intensive service programs for youth in or at risk for restrictive placements: TOWER, CITY, and BEST. NOTE: youth participating in the Wraparound Lab and SB163 services are also included in this sample for this report.

6) The sixth section "System Outcomes" reports system level data on issues such as costs and service use patterns for each fiscal year.

Definitions

Intake Cohorts: The sample of children and adolescents included in this report are those for whom intake assessments were completed as the youth entered into the coordinated care mental health system. The cohorts are defined by fiscal years.

Follow-up Sample: The sample of children and adolescents included in this report are those for whom an intake assessment and at least one follow up assessment are available. The intake assessment was completed no earlier than July 1 1997 and the follow up assessment was completed no later than June 30 2000. We have labeled these youth the "follow-up" sample because they are the youth with clear longitudinal follow-up data. Single time point data and varied timeframe data are available for many additional youths, but we chose to present only those with defined intake and follow up time points so that we could examine longitudinal change over time in treatment.

For Performance Outcome Project (POP) Only

Intake and Follow-up Assessments: Intake assessments refer to the first performance outcome assessment time point when a youth enters into coordinated care mental health services. However, for youth who were in the coordinated mental health care system prior to July 1, 1997, there is no intake assessment and only follow up assessments are available. Therefore, these youths are not included in the longitudinal outcome sample. Follow-up assessments include the same battery of assessments completed at intake with the addition of a service satisfaction measure. Follow-ups are collected at 6-months during the first year of services and annually at the coordinated care date for each following year. The longest timeframe of follow up measures available for the reported sample is 2 years.

For Intensive Services Evaluation Project (ISEP) Only

Baseline and Follow-up Assessments: Baseline assessments refer to the first assessment time point after a youth enters into the specific wraparound program (TOWER, CITY, BEST or Wraparound Laboratory/SB163). Follow up assessments are collected at 6-month intervals for the length of the evaluation (maximum of three years). The follow up assessments are collected at each consecutive time point regardless of the type or amount of services the youth are receiving. Some youth may not be receiving any services at the time of follow up assessment. This data collection design provides detailed longitudinal information about the youth pre and post wraparound service involvement and makes available information about changes and maintenance of outcomes.

Assessments: The assessment batteries include the same measures at each timeframe: intake, 6-month, annual and discharge (with satisfaction measures collected at follow ups only). The assessments for the Performance Outcome Project (POP) include the Client Living Environment Profile, Child Behavior Checklist, Youth Self Report, Child & Adolescent Functional Assessment Scale and the Client Satisfaction Questionnaire. Refer to section two (pg. 17) for descriptions of the measures. The intensive wraparound programs have additional parent and family measures. Refer to section five (pg. 46) for a short description of each additional measure.

Fiscal Year: The fiscal year for the Performance Outcome Project (POP) begins on July 1 and ends on June 30. The fiscal years represented in this report are 1997-1998, 1998-1999 and 1999-2000. The fiscal year for the Intensive Services Evaluation Project (ISEP) begins on October 1 and ends on September 30 due to funding year timeframes. The fiscal years represented in this report are 1998-1999 and 1999-2000. Note, the assessments for the 1998-1999 year began in April 1999; therefore, this year represents 6 months of data.

Participating Programs

Table 1, below, lists all of the mental health programs participating in the performance outcome project and contributing data to this report. The programs with asterisks are the mental health intensive case management programs participating in the ISEP wraparound-based service project and contributing additional data to this report.

Data Processed to Date

Figure 1, below, presents the number of performance outcome assessments processed each month since the requirement started in July 1997. Note that the number of assessments processed per month increased dramatically in the first two years.

Figure 2, below, presents the number of referrals to the Intensive Services Evaluation Project that were received each year by program and the number of completed baselines and follow ups since the project began recruiting youth in March 1999 and obtaining baselines in April 1999.

Represented Samples

One of the goals for the County Mental Health Services is to collect outcome measures on all youth receiving services in the Coordinated Care (CC) system. This performance outcome project began in the 1997-1998 fiscal year. During this year 1,578 youth entered CC and 57.4% completed POP assessments. In the 1998-1999 fiscal year a new system for monitoring coordinated care youth was established in which the United Behavioral Health began managing the system and providing youth with coordinated care admit dates. Due to this system change and the need for creating an algorithm to determine dates for youth in the system of coordinated care, an exact number of new admits to the system is unavailable. In the 1999-2000 fiscal year 1,786 youth entered CC and 62.6% completed assessments.

Performance Outcome Project

In order to determine the extent to which the POP samples represent all youth in the coordinated care system, the demographic characteristics were compared. After examining the most recent fiscal year, 1999-2000, the POP sample is representative for males and females as expected. Children 1-3 and 4-5 years old are also represented as expected. Children 6-10 and 11-15 years old are over-represented (29.8% & 49.1% POP vs. 25.2% & 43.1% no assessment) and adolescents 16-20 are under-represented (14.9% POP vs. 23.5% no assessment). This large discrepancy is partially due to the fact that youth older than 18 years old typically do not participate in POP. There is some variation by race/ethnicity as well. Whites, Asian American/Pacific Islanders and Native Americans are represented as expected yet Spanish/Hispanics are over-represented (33.6% POP vs. 29% no assessment) and African American are slightly under-represented (15.4% POP vs. 16.9% no assessment).

Intensive Services Evaluation Project

In order to determine the extent to which the evaluation samples represent all youth served through an intensive service program, the demographic characteristics were compared. Eighty-nine percent of youth receiving intensive services participated in the evaluation project (n=173). Twenty-two youth and families (11%) refused to participate in the evaluation. Participant gender was similar to non-participants (74.6% male and 77.3% male, respectively). More White families refused participation compared to other race/ethnicity groups (n=9, 40.9% in refusal sample vs. 30.9% in interviewed sample). Only four Hispanic families refused participation (18.2% in refusal sample vs. 44.2% in interviewed sample).

Table 1 : **POP Participating Programs**

Program Name	Type	Target Population
Alvin Dunn School	Outpatient School-based	School SED
Building Effective Solutions Together (BEST) *	Intensive Case Management /Wraparound	Mental Health
Breaking Cycles	Intensive Case Management /Wraparound	Probation
Comprehensive Adolescent Treatment Ctr. (CATC)	Residential Intensive	Mental Health
Community Intensive Treatment for Youth (CITY)*	Intensive Case Management /Wraparound	Probation/Child Protective Services/Mental Health
Cabrillo Day Treatment	Residential Intensive	Child Protective Services
Cabrillo Assessment Center	Outpatient-EPST	Child Protective Services
Children's Outpatient Psychiatry- Central	Outpatient Clinic	Mental Health
Children's Outpatient Psychiatry- North Coastal	Outpatient Clinic	Mental Health
Children's Outpatient Psychiatry- North Inland	Outpatient Clinic	Mental Health
Douglas Young Clinic	Outpatient Clinic	Mental Health
East County Child Day Treatment	Day Treatment	Mental Health
East County Mental Health	Outpatient Clinic	Mental Health
Emergency Screening Unit	24-hour Emergency Services	Mental Health
Escondido Youth Encounter	Outpatient Clinic	Probation
Escondido Youth Encounter- San Marcos	Outpatient Clinic	Probation
Frontier Adolescent Day Treatment Center	Day Treatment	Mental Health – 2726
Frontier Outpatient Services	Outpatient Clinic	Mental Health
Hillcrest House	Outpatient Site-based	Child Protective Services
Lifeschool	Day Treatment	Mental Health – 2726
New Alternatives Children's Day Treatment	Day Treatment	Mental Health – 2726
New Alternatives # 16	Residential Intensive	Mental Health
New Alternatives- Transitional Residential Services	Case Management	Child Protective Services
North County Lifeline	Outpatient Clinic	Probation
Phase II	Day Treatment	Mental Health – 2726
Polinsky Center	Outpatient Site-based	Child Protective Services
Poway School	Outpatient School-based	School SED
Rainbow Center	Outpatient School-based	Mental Health

Program Name	Type	Target Population
Reflections Central Program	Day Rehab	Probation
Riley School	Outpatient School-based	School SED
Rural Family Counseling Services	Outpatient Clinic	Mental Health
San Diego Youth and Community Services	Outpatient Clinic	Probation
Sexual Treatment Education Program & Services (STEPS) Day Treatment	Day Treatment Specialized	Mental Health
Sexual Treatment Education Program & Services (STEPS) Outpatient	Outpatient Specialized	Mental Health
Sexual Treatment Education Program & Services (STEPS) at Polinsky	Outpatient Specialized for Dependents	Mental Health
Sexual Treatment Education Program & Services (STEPS) Vista	Day Treatment Specialized	Mental Health
Sexual Treatment Education Program & Services (STEPS) Viewridge	Day Treatment Specialized	Mental Health
Special Education Services Central & South Region	Case Management	Mental Health – 2726
Special Education Services North Coastal & Poway Region	Case Management	Mental Health – 2726
Special Education Services North & East Region	Case Management	Mental Health – 2726
San Ysidro Middle School	Outpatient School-based	Mental Health
Social Advocates for Youth (SAY)	Outpatient Clinic	Probation
Southbay Community Services	Outpatient Clinic	Probation
Southbay Youth & Family Services	Outpatient Clinic	Probation
Southeast Mental Health Clinic	Outpatient Clinic	Mental Health
Transition of Wards Embracing Recovery (TOWER)*	Intensive Case Management for probation (Short-term)	Probation
Transition Team	Case Management for Inpatient (Short-term)	Mental Health
UCSD Child & Adolescent Psychiatric Services (CAPS)	Inpatient	Mental Health
Union of Pan Asian Communities (UPAC)	Outpatient Clinic	Mental Health
Venture Adolescent Day Treatment	Day Treatment	Mental Health – 2726
Youth Enhancement Services (YES)	Outpatient Clinic	Mental Health

*** ISEP** Participating Program

Figure 1:

	July	Aug.	Sept.	Oct.	Nov.	Dec.	Jan.	Feb.	March	April	May	June
1997-1998	34	108	88	154	130	80	88	253	154	163	252	266
1998-1999	226	273	179	211	292	211	323	388	460	309	375	571
1999-2000	304	365	324	270	323	278	295	432	365	345	360	349

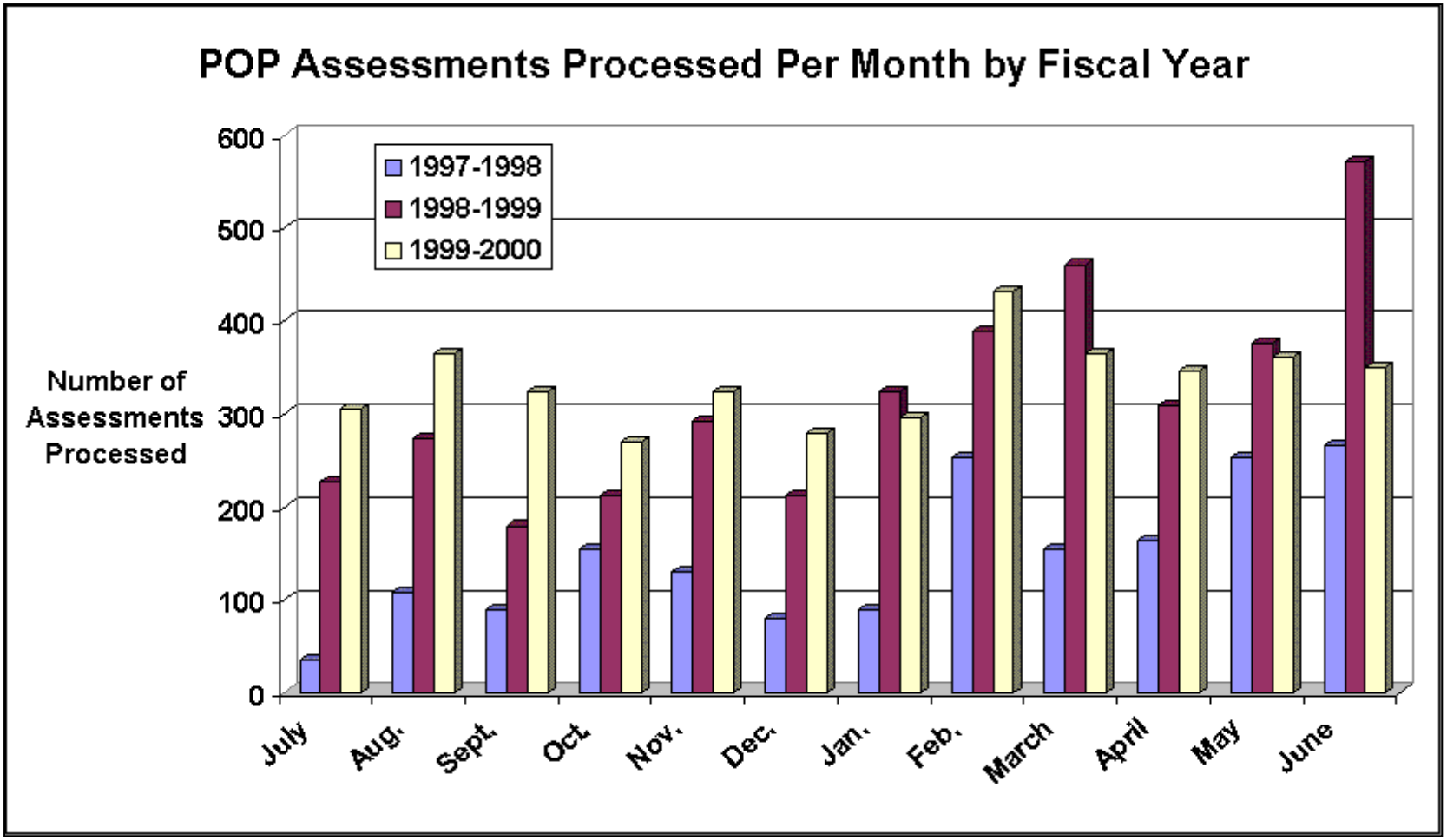


Figure 2: **Intensive Services Evaluation Project Referrals & Assessments**

# of referrals made from each program for 98-99 and 99-00 fiscal years

	3/1/99 to 9/30/99	10/1/99 to 9/30/00
TOWER	63	74
BEST	19	22
CITY	2	7
Wraparound Laboratory/SB163*		20
Total	84	123

* Program began in the Fall of 1999.

# of completed assessments for combined 98-99 and 99-00 fiscal years

Timeframe	# Assessments
Completed baselines	171
Completed 6 month follow ups	93
Completed 12 month follow ups	41
Completed 18 month follow ups	2

Description of the San Diego County Children's Mental Health Service System - General Population

San Diego County Children's Mental Health Services delivers services to the general child and adolescent mental health population through three primary mechanisms: 1) individual and inpatient fee-for-service providers, 2) organizational providers and 3) Juvenile Forensic Services. Individual providers are licensed clinicians in private practice who provide services to Medi-Cal clients on a fee-for-service basis. These providers are spread out over the county and represent a diversity of disciplines, cultural-linguistic groups and genders in order to provide choice for eligible clients. There are three in-county fee-for-service hospitals that provide inpatient services for child and adolescent Medi-Cal clients. Organizational providers are community-based agencies and county-operated sites that are Medi-Cal certified and are either part of the Health & Human Services Agency (HHSA) or have contracts with HHSA to provide mental health treatment services to specified target populations. These organizational providers are variable and distributed across the county. They can be general treatment clinics, or provide services to a specialized population or in a specific setting (such as school-based). Youth served through these organizational providers encompass the Coordinated Care system. Coordinated Care is the utilization management system that provides oversight amongst the multiple providers and monitors the clinical services provided to youth. Juvenile Forensic Services provide services primarily in Probation or Child Protective Services (CPS) institutions within the County. Juvenile Forensic oversee all mental health services to Probation and CPS populations.

Within these three provider mechanisms, services may be delivered in different modes. The primary modes are outpatient, inpatient, residential, day treatment, case management and crisis intervention. Outpatient services are delivered in clinics, institutions, schools and homes. Inpatient services for children and adolescents are delivered in hospitals. Residential services are divided in the way they are funded, with Child Welfare providing the funding for "room and board" and Mental Health providing the funding for treatment services through either an outpatient mode or a day treatment mode "patched" on to the "room and board" funding. Day treatment services are most often provided in an integrated setting with the child's education as part of the day. These services are planned and delivered in close coordination with a local education agency (LEA). Day treatment services are also divided into "intensive" and "rehabilitative" services. The focus of intensive is on psychotherapy interventions and the focus of rehabilitative is on skill building and behavioral adjustments. Case management services may be provided in conjunction with any of the other modes or can be a stand alone service to "connect" children, youth and families to the services they need, monitor their care and oversee the components of care provided to the child and family. "Intensive" case management services are a combination of several modes with services being focused on the home and family in a "wraparound" model. The goal of these services is to keep children and adolescents in a home setting with services "wrapped" around the home, rather than sending children into residential treatment settings. Crisis intervention services are provided by the Emergency Screening Unit (ESU) which is a 24hour/7 days a week program. ESU provides crisis intervention, emergency screening services and crisis stabilization services (up to 24 hours) for children and adolescents in the entire county.

Children and youth may receive services from one or all of the delivery providers and modes in the course of a year. Figure 3 displays the unduplicated client count across all the service delivery providers and modes. It shows that in each of the identified fiscal years the county served: FY99-00 = 12,957; FY98-99 = 12,530; FY97-98 = not available; and FY96-97 = 11,877 unduplicated clients (there is no data for FY97-98 due to a change in data systems). Figure 4 shows the breakdown of the percent of unduplicated client counts for each fiscal year by each provider type: FFS-Inpatient, FFS-Outpatient, Organizational Providers (Short-Doyle) and Juvenile Forensic Services. The majority of clients in the recent years were served through

organizational providers: 53% in FY99-00 and 52% in FY98-99. However, in FY96-97 FFS-Outpatient served the majority of clients totaling 48%. Note that a youth may receive services from more than one provider within the year but not necessarily simultaneously so the percent totals exceed 100%. Also note that there is no FFS-Inpatient data for FY96-97. This database system began in 1998. Figure 5, 6, and 7 show the demographic make up of our entire served population of unduplicated clients. Gender distributions are stable across each fiscal year with a larger percent of males, approximately 66%, than females, approximately 34%, served through CMHS. Age distributions are also fairly stable across fiscal years with the majority of youth ranging in age from 13-17 years old. There were slightly more children ranging in age 6-12 years old in the more recent year FY99-00. Race/ethnic distribution varies for Hispanics by fiscal year with continuous increases in the percent served within CMHS from 24% in FY96-97 to 31% (just below Whites at 34%) in FY99-00. There was also an increase of Native American youth served through CMHS in FY 99-00.

Figure 8 represents how and which clients use multiple services within the CMHS system. More specifically, these tables present the cross tabulations of service modes for youth in the general mental health population. The percents signify how many youth participate in more than one service mode and which service modes are typically utilized by the same youth. For example, the tables display an increase by fiscal year in the number of youth who have an inpatient stay and participate in case management services from 14.6% in FY96-97 to 36.3% in FY99-00. Refer to page 10 for descriptions of the service modalities presented in the table.

Figure 3: **Children's Mental Health System: Unduplicated Client Count Across All Providers and Modes by Fiscal Year**

(There is no data for FY 97-98)

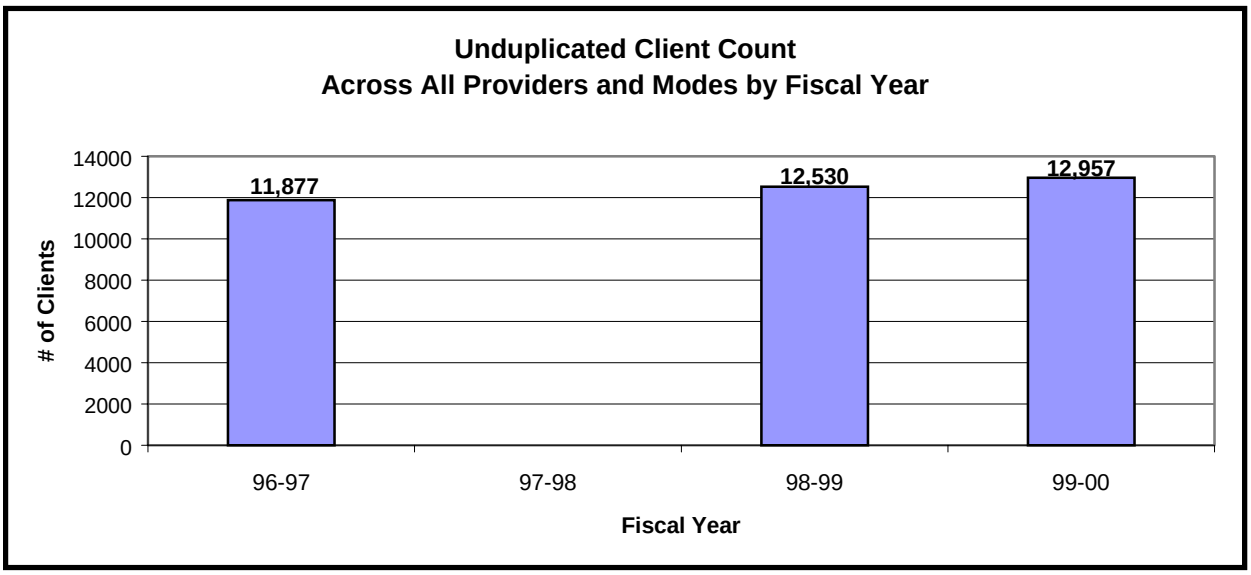


Figure 4: **Children's Mental Health System: Percent of Total Unduplicated Client Count by Fiscal Year and Provider**

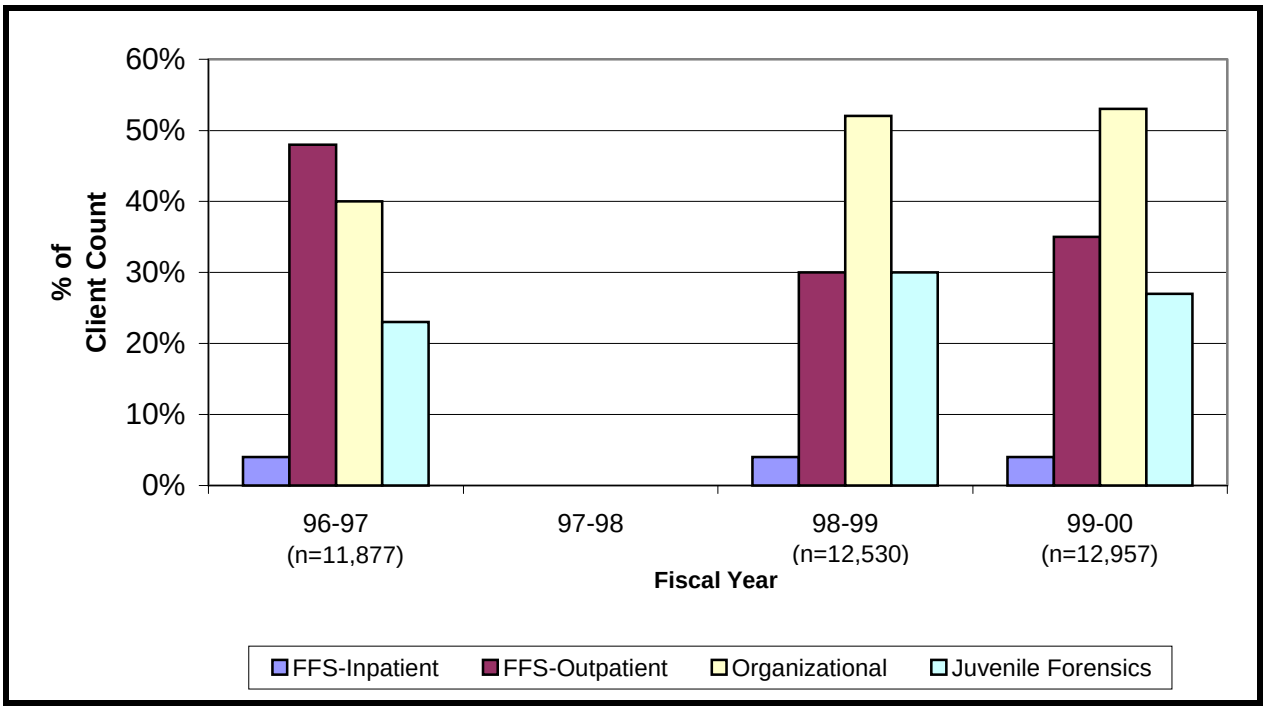


Figure 5: **Children's Mental Health System: Gender Distribution**

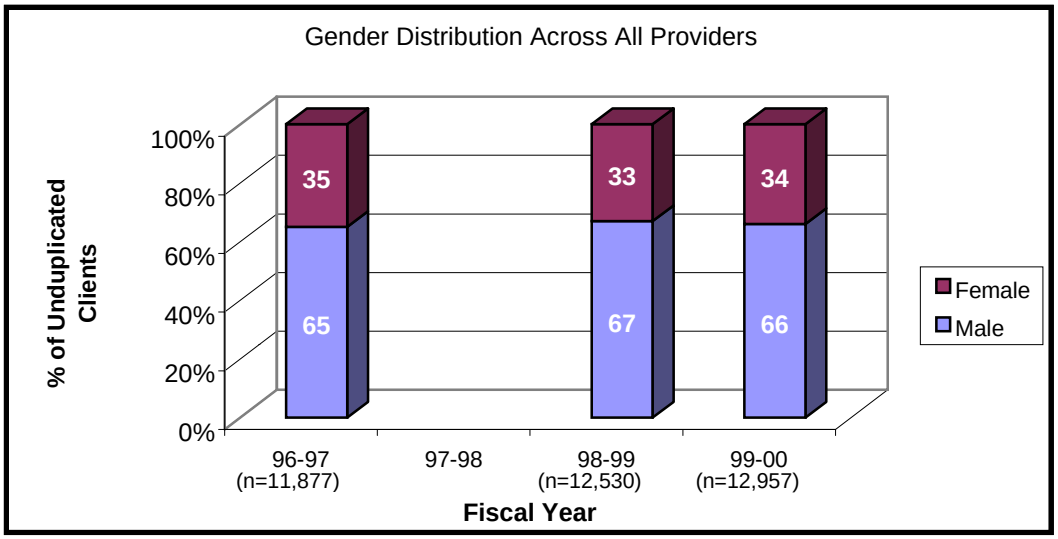


Figure 6: **Children's Mental Health System: Age Distribution**

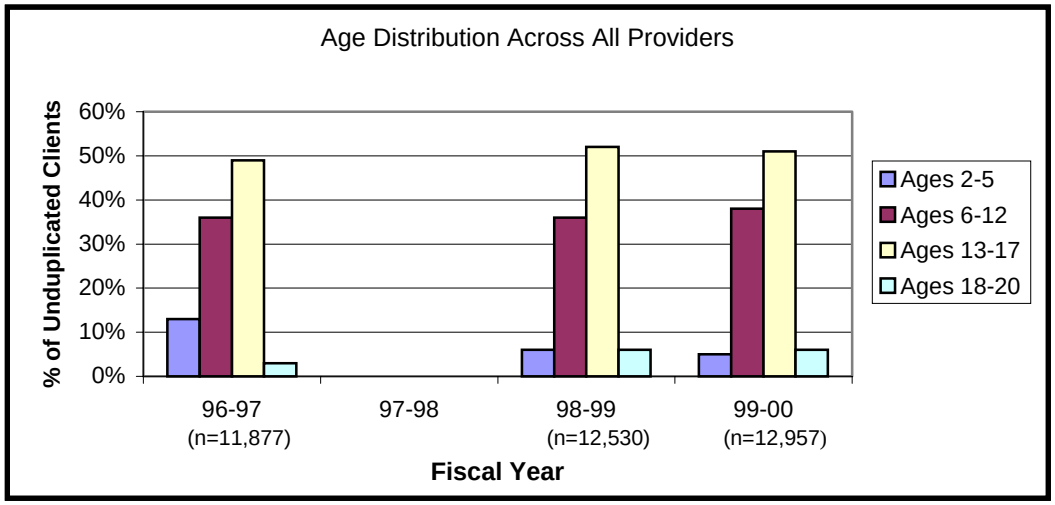


Figure 7: **Children's Mental Health System: Race/Ethnicity**

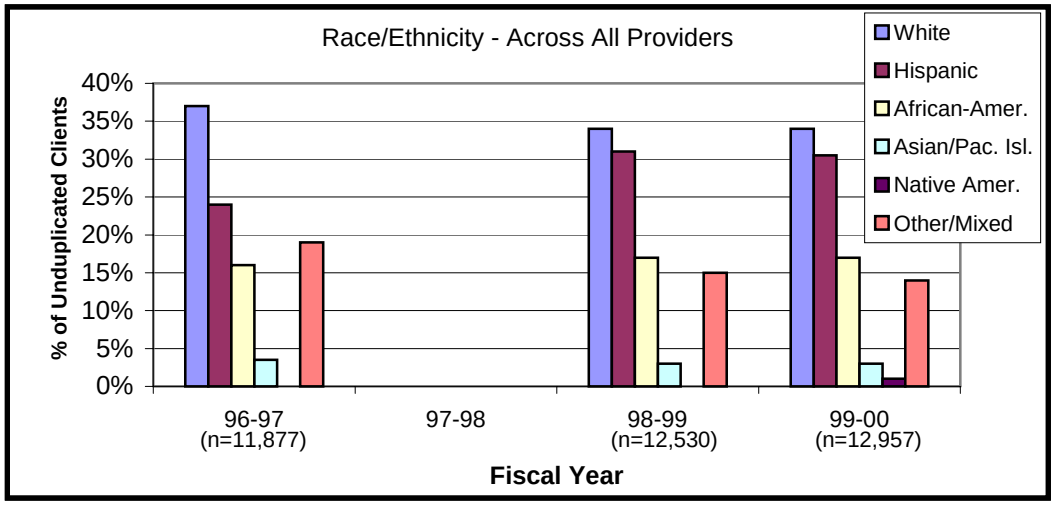


Figure 8: Children's Mental Health System: Single and Multiple Use by Service Mode[1]

FY 96-97

	Inpatient N =623	Res-M.H. N =130	Int. DT N =211	Day Rehab N =0	Case Mgmt. N =916	OP-Org. N =2501	OP-FFS N =5686	OP-JF/Inst. N =3963	ESU N =1158
Inpatient	100.0%	33.8%	11.8%	N/A	10.3%	7.2%	6.3%	3.4%	43.3%
Res-M.H.	7.1%	100.0%	9.5%	↓	10.7%	0.7%	1.3%	0.9%	10.2%
Int. DT	3.9%	15.4%	100.0%		22.8%	3.4%	0.8%	0.6%	4.5%
Day Rehab	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
Case Mgmt.	14.6%	75.4%	99.1%		100.0%	15.0%	3.6%	2.9%	18.4%
OP – Org.	28.3%	13.1%	40.3%		41.0%	100.0%	7.8%	3.8%	27.4%
OP – FFS	57.6%	55.4%	22.7%		23.3%	18.0%	100.0%	12.7%	42.9%
OP – Insti	21.5%	26.9%	10.4%		12.4%	6.1%	8.7%	100.0%	22.4%
ESU	79.1%	90.8%	24.6%		23.3%	12.7%	8.6%	6.5%	100.0%

FY 97-98
(There is no data for FY 97-98)

FY 98-99

	Inpatient N =703	Res-M.H. N =237	Int. DT N =262	Day Rehab N =0	Case Mgmt. N =1223	OP-Org. N =3643	OP-FFS N =3742	OP-JF/Inst. N =5462	ESU N =1155
Inpatient	100.0%	29.5%	11.1%	N/A	26.3%	6.2%	11.3%	3.4%	38.5%
Res-M.H.	9.7%	100.0%	5.7%	↓	6.9%	1.0%	2.6%	2.2%	12.4%
Int. DT	4.0%	6.3%	100.0%		18.9%	3.2%	1.0%	0.6%	4.2%
Day Rehab	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
Case Mgmt.	44.2%	35.4%	88.2%		100.0%	12.4%	8.6%	4.0%	26.7%
OP – Org.	31.0%	14.8%	44.7%		37.0%	100.0%	9.5%	4.9%	30.8%
OP – FFS	60.2%	40.5%	14.9%		27.1%	9.8%	100.0%	11.6%	32.2%
OP – Inst	25.5%	50.2%	11.8%		17.7%	7.4%	16.8%	100.0%	25.5%
ESU	61.3%	60.3%	18.7%		25.2%	9.8%	9.8%	5.4%	100.0%

FY 99-00

	Inpatient N =727	Res-M.H. N =596	Int. DT N =323	Day Rehab N =164	Case Mgmt. N =1671	OP-Org. N =3743	OP-FFS N =4566	OP-JF/Inst. N =5125	ESU N =1124
Inpatient	100.0%	14.3%	14.2%	1.2%	16.0%	7.4%	10.3%	3.4%	39.7%
Res-M.H.	11.6%	100.0%	5.9%	0.0%	9.9%	2.0%	4.8%	8.8%	9.4%
Int. DT	6.2%	3.2%	100.0%	0.0%	16.9%	4.3%	1.6%	1.0%	4.0%
Day Rehab	0.3%	0.0%	0.0%	100.0%	1.9%	0.2%	0.4%	3.1%	0.8%
Case Mgmt.	36.3%	27.9%	87.6%	18.9%	100.0%	17.5%	9.0%	9.3%	23.8%
OP – Org.	37.8%	12.4%	49.8%	5.5%	39.3%	100.0%	10.7%	5.8%	31.6%
OP - FFS	64.6%	37.2%	22.9%	10.4%	24.7%	13.1%	100.0%	13.9%	36.5%
OP – Inst	23.5%	75.3%	15.8%	98.2%	28.4%	7.9%	15.5%	100.0%	26.6%
ESU	60.2%	17.8%	13.9%	5.5%	16.0%	9.5%	8.9%	5.8%	100.0%

[1] Youth may be open to more than two service modes within the year but not necessarily simultaneously.

[2] Total exceeds 100% because youth can be open to more than two service modes within the year.

(Key) – Res-M.H.=Residential Mental Health Services, Int. DT=Intensive Day Treatment, Day Rehab=Rehabilitative Day Treatment, Case Mgmt.=Case Management, OP-Org.=Outpatient Organizational Programs, OP-FFS=Outpatient Fee-for-Service Programs, OP-JF/Inst.=Outpatient Juvenile Forensic Institutions, ESU=Emergency Screening Unit.

Performance Outcome Project Intake Cohorts

The San Diego County Mental Health Department has an ongoing evaluation system in place that fulfills the state mandate for monitoring services and that measures the progress toward expected System of Care outcomes. The Performance Outcome Project (POP) collects, analyzes and reports back the information that is gathered in the evaluation process.

This report is a cumulative analysis of the data that the POP team has collected from July 1, 1997 to June 30, 2000. The data has been collected for three years, which provides an opportunity to investigate population changes over time. The information presented in this section describes Intake cases into Coordinated Care only. This allows for comparisons between fiscal years to examine any population differences that may be occurring in SD County. Note: Only those youth who are served through an organizational provider are in Coordinated Care and evaluated by POP.

Cohort Sample Size

The data collection process began in the 1997-1998 fiscal year. That year was the programs start up year of complying with the state mandate and collecting assessment measures. There was also a change in the data-monitoring program to the MIS system during that year, which caused the data to be unavailable for a specific time period. Due to this data transition process the number of recorded youth in Coordinated Care was reduced and because programs were just starting with the data collection process the number of assessments was low. The POP program collected intake assessments on 981 children and adolescents. During the 1998-1999 fiscal year, the Coordinated Care program was more widely spread, the data collection process was in full operation, and POP collected 1,458 intake assessments. In the 1999-2000 year, 1,346 intake assessments were collected.

Cohort Demographics

In comparing the POP samples by fiscal year there are some stable and varied demographic and programmatic characteristics by cohorts. The percentage of males to females appears to remain about the same over time. The percent of males are 63.8% in 97-98, 65.1% in 98-99 and 64.6% in 99-00 (Figure 9a). The age distribution of the youth entering the system varies by fiscal year. By comparing means and modes, the youth are older in the more recent 1999-2000 year with more youth between the ages of 13-15 compared to the other years, which had more children in the 6-12 year old group (Figure 9c). There also appears to be an increase in youth of the Spanish/Hispanic ethnicity group in the 1999-2000 year (Figure 10a). This is the largest ethnic group surpassing the White group in 99-00. Youth in 1999-2000 are living in slightly more “home” environments at the time of assessment then youth in the previous years (Figure 10b). There are also more youth participating in case management programs in the recent year then the past (Figure 11a). There is more Master level counselors (both marriage and family and social work) completing Intake assessments in 99-00 then the other years (Figure 11b). However, there is a lower percentage of trainees (psychology, social work and counseling) completing intake assessments during this year.

Cohort Clinical Profiles

There is also some variation in clinical profiles of children & adolescents by fiscal year. Across all ages children are differing in their overall functioning levels at intake per report of clinicians by fiscal year. Young children (under the age of 6) are entering the system at higher levels of impairment on the Preschool and Early Childhood Functional Assessment Scale (PECFAS) in 99-00 (Figure 12b). However, the opposite was found for older youth (6-18).

They are entering the system with less impairment represented by lower scores on the Child and Adolescent Functional Assessment Scale (CAFAS) in 99-00 (Figure 12a). Both the parents (CBCL) and youth (YSR) are reporting less behavior and emotional problems in the 99-00 year (Figure 13a,b). However, per parent's report (CBCL) the youth are still exhibiting total scores at intake in the clinical range indicating a need for mental health services (Figure 13a). Parents and youth do not report any differences by fiscal year on social competency scales (Figure 14a,b).

When the data is examined by age group and ethnicity some other patterns appear. Older youth are clearly more functionally impaired at intake then younger children with adolescents demonstrating the highest level of functional impairment according to clinicians completing the CAFAS (Figure 15a). These findings vary slightly by fiscal year with the exception occurring in 97-98 with older adolescents entering the system at very high levels of impairment. However, older adolescents have less behavior and emotional problems reported by parents completing the CBCL, especially in 99-00 (Figure 15b).

Per clinician report, the data shows the Spanish/Hispanic group entering services with more functional impairment over time while the African American group is entering services with less impairment by fiscal year (Figure 16a) on the CAFAS. White youth appear to remain at moderate levels of impairment for each year on this measure. Parents report similar results by ethnic group on the CBCL (Figure 16b). Parents of African-American youth are reporting fewer problems over time while Whites are reporting stable levels in the high clinical range. Asian/Pacific Islander parents are reporting fewer problems then other ethnic groups each year. Note: the Native American group is a very small number of youth so it is not possible to report on their data.

Table 2:

Brief Description of POP Clinical Measures

Child and Adolescent Functional Assessment Scale (CAFAS)

- Clinician assesses degree of impairment in children and adolescents
- Clinician rates the child's lowest level of functioning in the following five domains:
  Role Performance: School/Work, Home, Community (functioning in societal roles)
  Behavior Toward Others (daily behavior)
  Moods/Self-Harm: Moods/Emotions, Self-Harmful Behavior (modulation of emotions)
  Substance Use (extent of use & disruption)
  Thinking (rational thought processes)
- Developed by Kay Hodges, Ph.D.
- Separate version for ages 6-18 (CAFAS) and 4-5 (PECFAS)

Child Behavior Checklist (CBCL)

- Assesses a child's competencies and behavior problems according to the parent/caregiver
- Includes Social Competence section (activities, social involvement and school) and Emotional/ Behavior Problems section (total, internalizing syndromes, externalizing syndromes)
- Developed by Thomas M. Achenbach, Ph.D. (latest version 1991)
- Main version for ages 4-18; separate version for ages 2-3

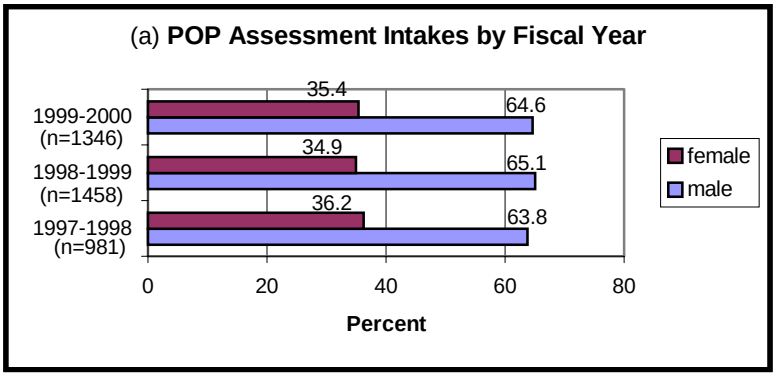
Youth Self Report (YSR)

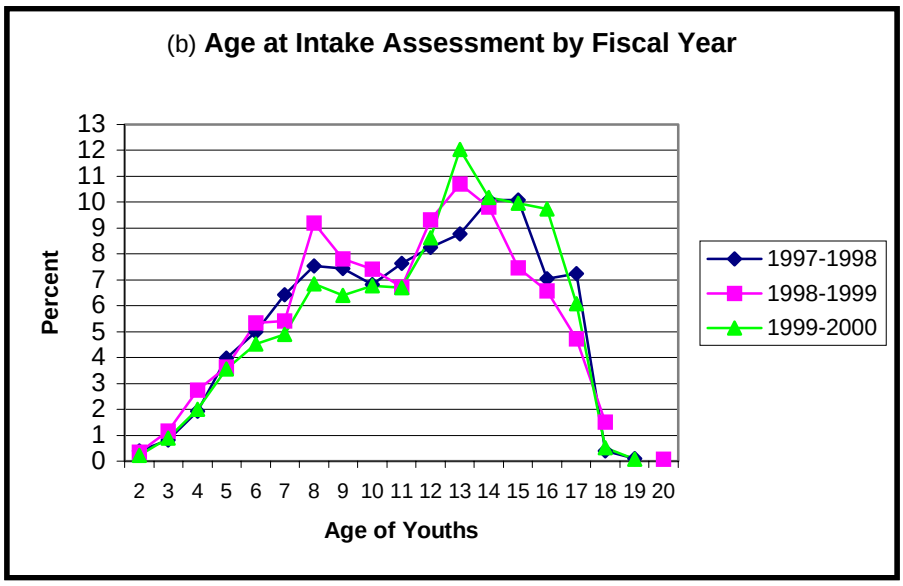
- Assesses a youth's competencies and behavior problems according to the youth
- Developed by Thomas M. Achenbach, Ph.D. (latest version 1991)
- Measure is used for ages 11-18
- Largely contains the same items as the CBCL and provides equivalent scores: Social Competence (activities and social involvement) and Emotional/Behavior Problems (total, internalizing syndromes, externalizing syndromes)

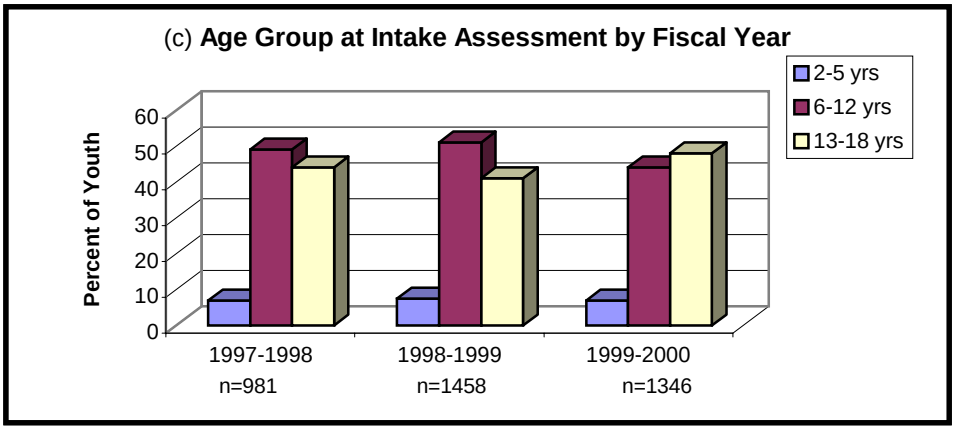
Client Satisfaction Questionnaire (CSQ-8)

- Assesses the parent/caregiver's satisfaction with mental health services
- Developed by Drs. Atkisson, Larsen, Hargreaves, LeVois, Nguyen, Roberts and Stegner (latest version 1990)
- Parent/caregiver rates general satisfaction with services for his/her child

Figure 9: **POP Intake Cohorts by Sex and Age**



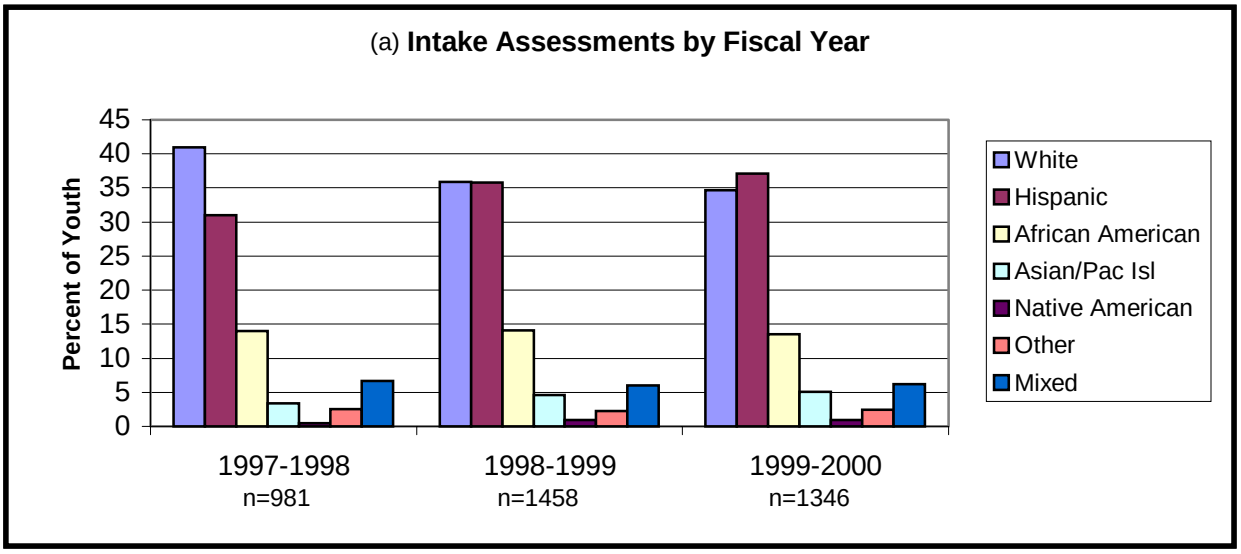




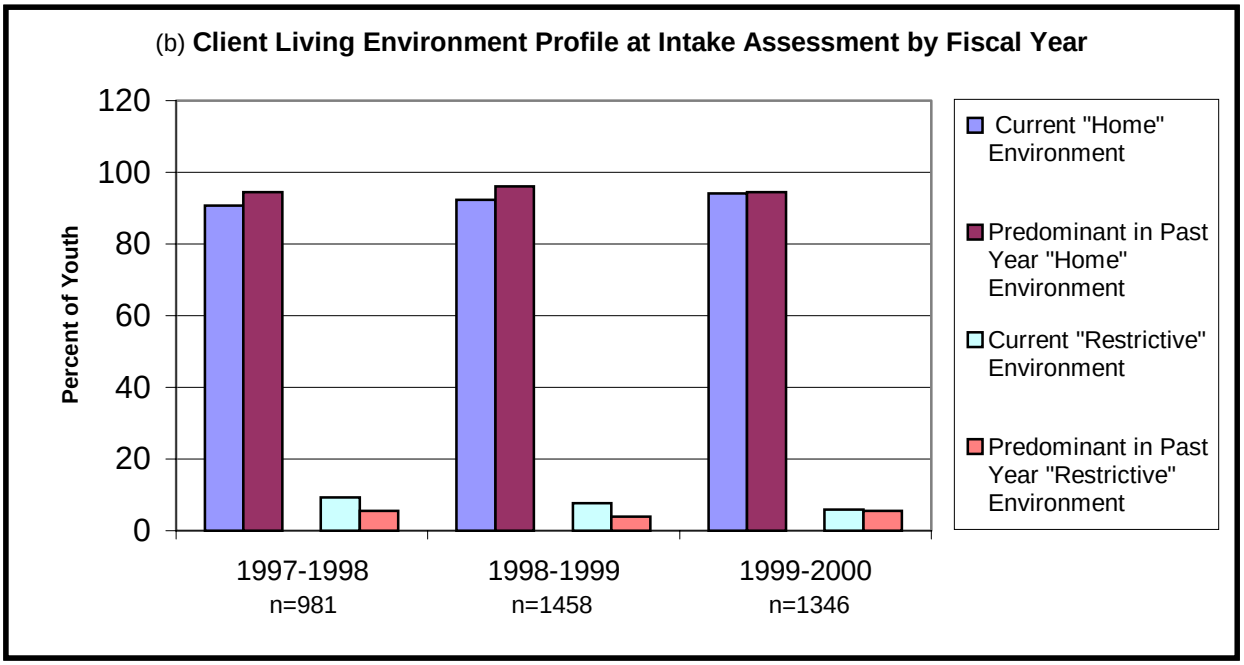
- More males than females receive mental health services & complete POPs, but no significant difference by fiscal year.
- Youth 12-14 years old are the most prevalent ages completing POP assessments for each fiscal year.
- There are significantly more POP intake assessments for the older age group in 99-00.

Figure 10: **POP Intake Cohorts by Race/Ethnicity and Youth Living Environment**

Race/Ethnicity is reported by the clinician after interviewing the youth and family.



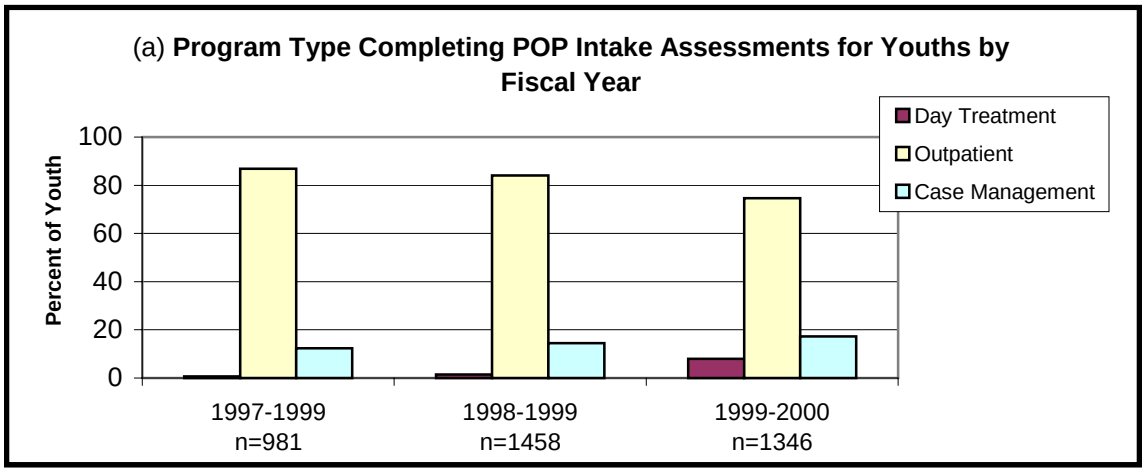
The Client Living Environment is completed by the clinician after interviewing the youth and family. "Home" environment includes bio/adopted homes, foster care and living independently. "Restrictive" environment includes incarcerated, psych hospital, group home and homeless. "Current" represents living environment at time of assessment, and "Predominant" represents living environment over past 12 months.



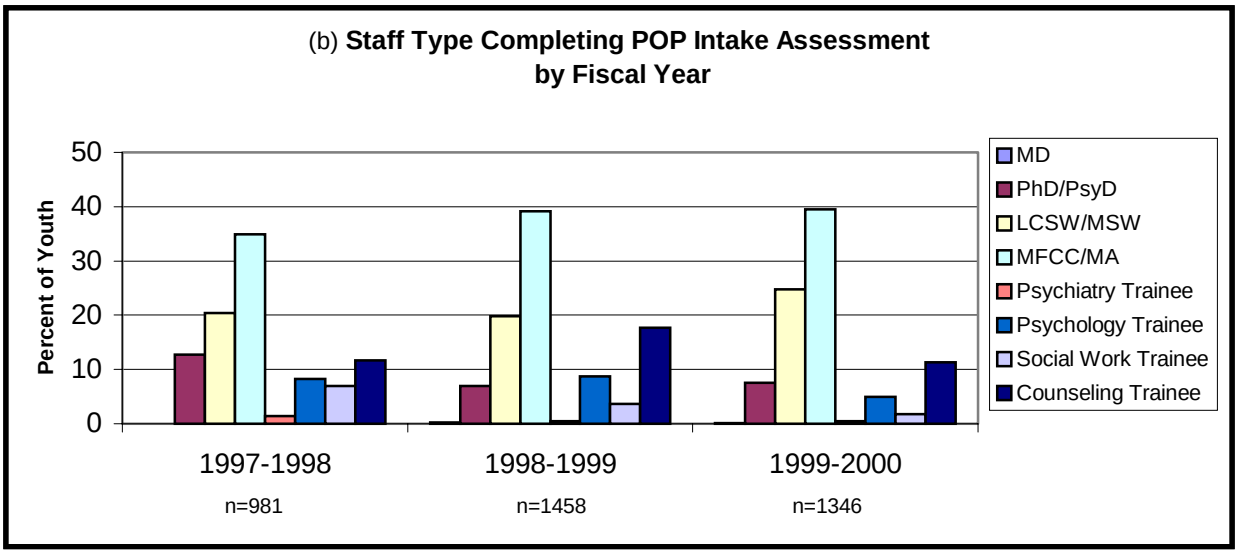
- In 1999-2000 Spanish/Hispanics surpass Whites in percent of youth completing POPs at Coordinated Care Intake.
- Youth are primarily living in Home settings at POP assessment Intake for each fiscal year.

Figure 11: **POP Intake Cohorts by Program Type and Staff Type**

Percent of youth receiving services from each type of program at the time of Intake assessment.



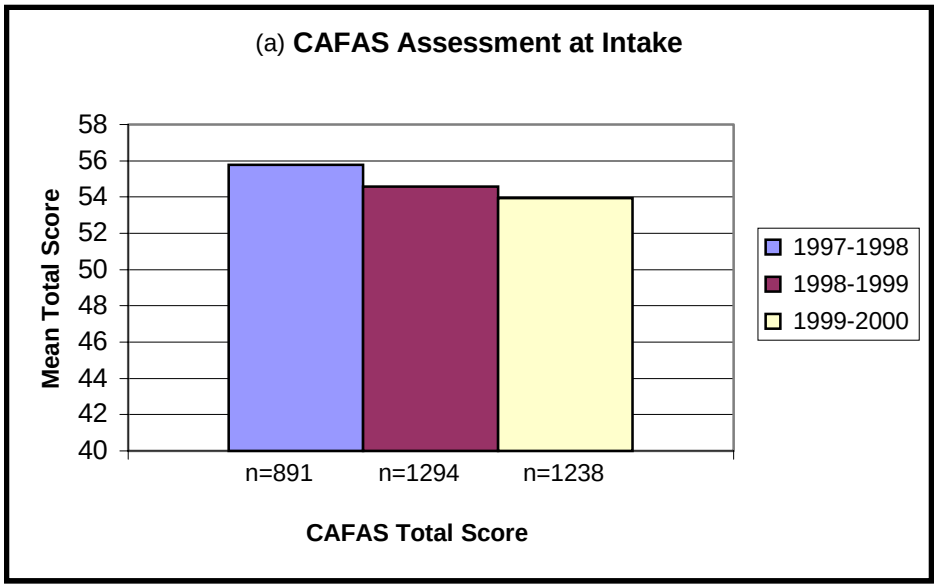
Percent of youth receiving services from each type of staff at Intake assessment. These staff members completed the assessments.

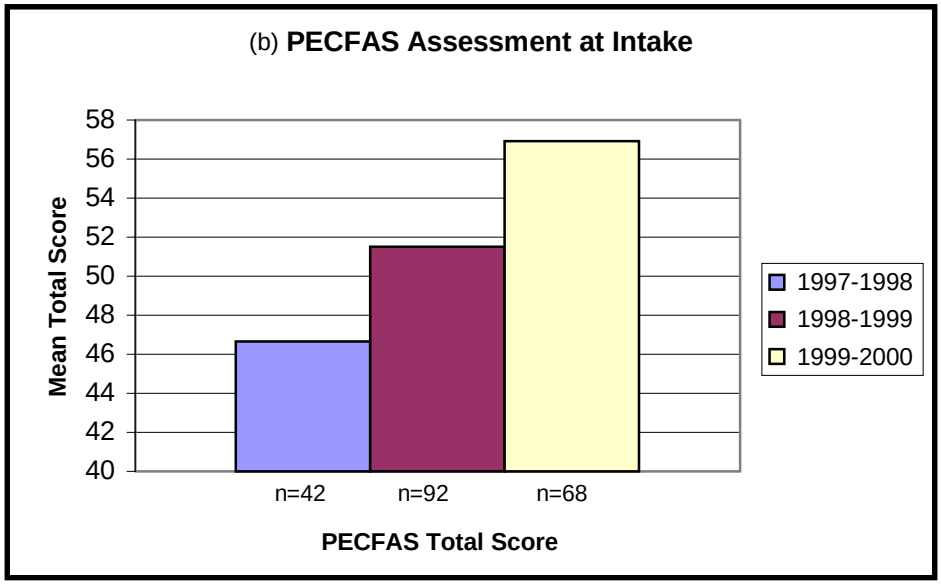


- In 1999-2000 more youth completed POP intake assessments through case management and day treatment services compared to previous years.
- In 1999-2000 more youth completed POP intake assessments with licensed staff and less from trainees then the other fiscal years.

Figure 12: **POP Intake Cohorts by Fiscal Year: CAFAS and PECFAS Total Scores**

CAFAS is the functional assessment measure for youth 6-18 years old. PECFAS is the comparable functional assessment measure for children 4-5 years old. Both measures are completed by the clinician at intake assessment. High scores indicate more impairment.

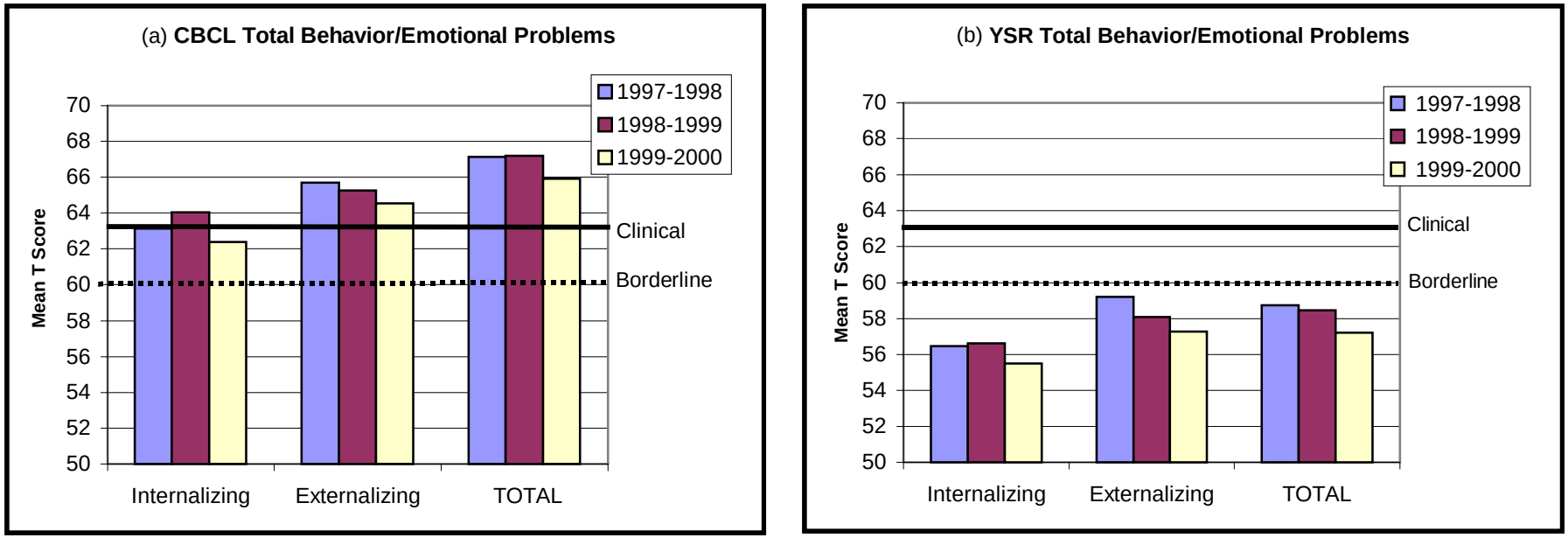




- There is an opposite pattern for young children versus older children by fiscal year.
- Young children are significantly more impaired over time at POP Intake into Coordinated Care.

Figure 13: **POP Intake Cohorts by Fiscal Year: CBCL and YSR Total Behavior/Emotional Scores**

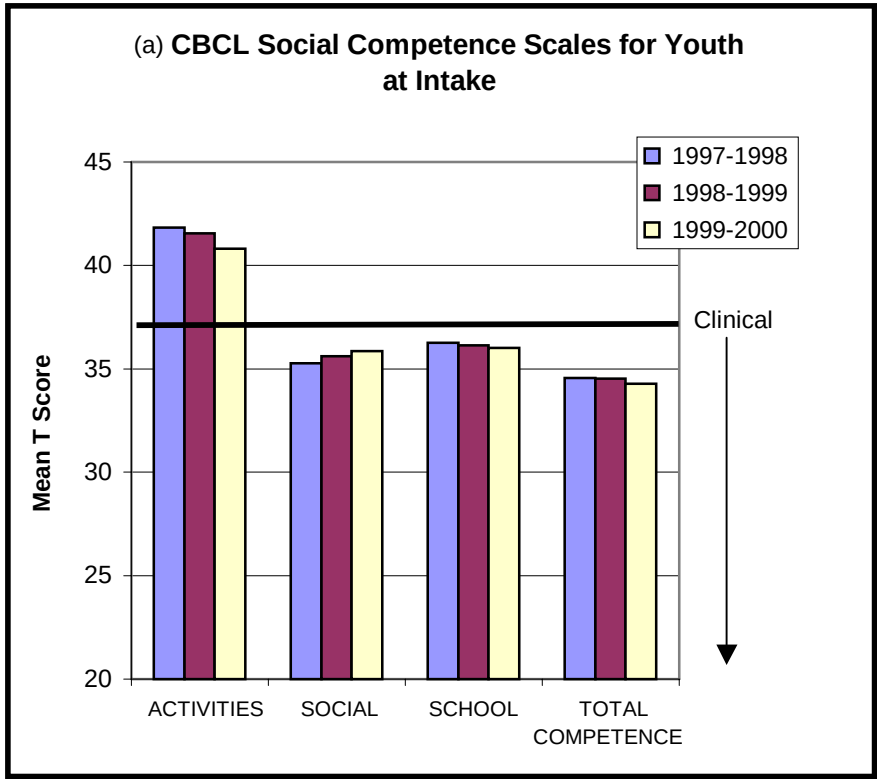
CBCL is reported by the parent and the YSR is reported by the youth (11-18 yrs). Both measures are comparable reports of behavior and emotional problems. Internalizing includes withdrawn, somatic complaints and anxious/depressed symptoms. Externalizing includes delinquent and aggressive behavior. Total includes all problem areas. The lines indicate borderline clinical and clinical range levels. High scores represent more problems.

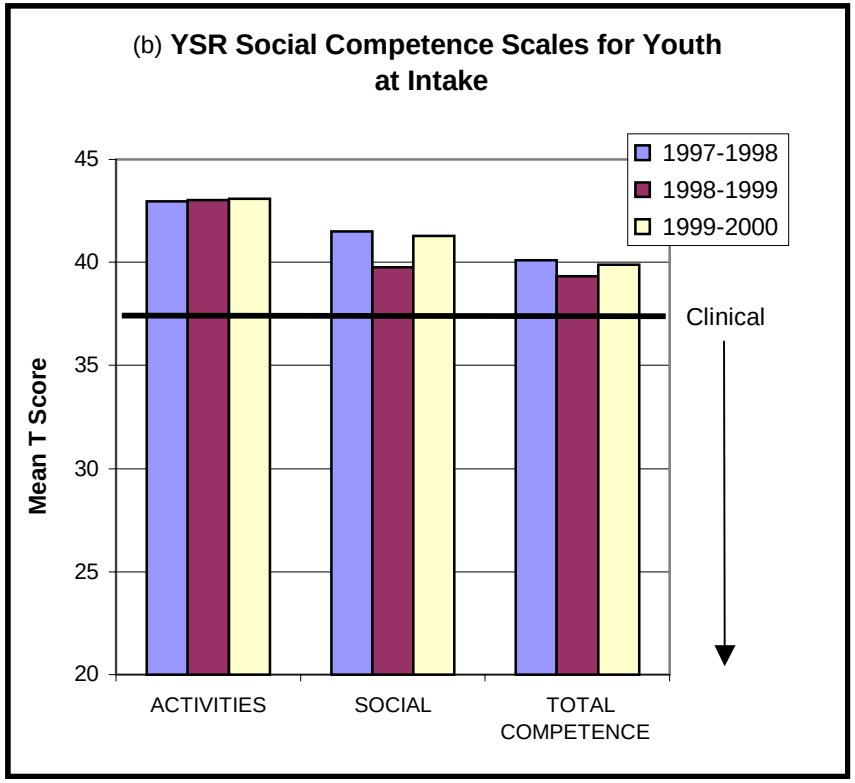


- In 1999-2000 parents and youth report significantly less total problems at POP assessment for youth entering services compared to other years, yet still clinically symptomatic according to parents.
- Youth report significantly fewer problems at Intake for each fiscal year compared to parents.

Figure 14: **POP Intake Cohorts by Fiscal Year: Youth Competency Scales by Parent and Youth Report**

The CBCL is a parent report of youth Social Competency and the YSR is a youth (11-18 yrs) report of youth Social Competency. The youth version does not report the school subscale. Higher scores represent better functioning and more social competence.

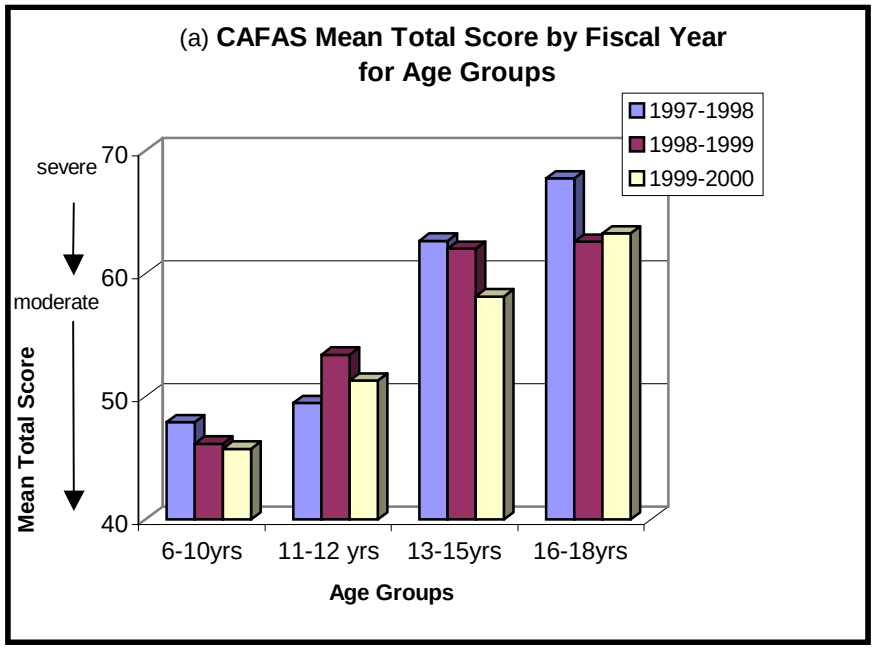




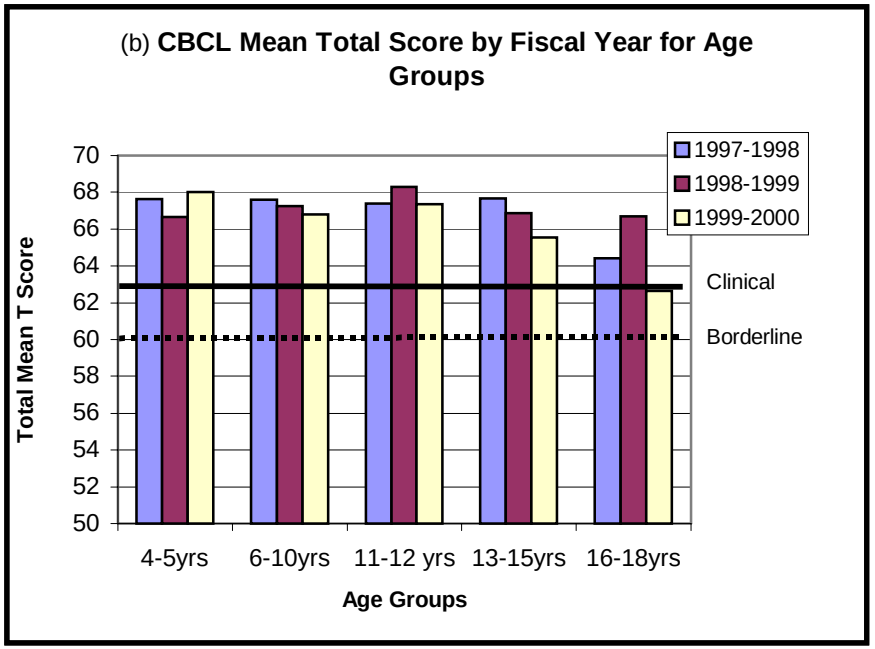
- Parents report clinical levels of social, school and total competence for each fiscal year, meaning youth have poor competence skills.
- Overall, youth report more social competencies than parents. There is no significant variation by fiscal year.

Figure 15: **POP Intake Cohorts by Fiscal Year: CAFAS and CBCL Mean Total Scores by Age Group**

CAFAS is a measure of functional impairment reported by the clinician. CBCL is a measure of behavior and emotional problems reported by the parent. Higher scores on both measures indicate more problems and dysfunction.



	1997-1998	1998-1999	1999-2000
6-10 yrs	n=298	n=467	n=389
11-12 yrs	n=149	n=228	n=205
13-15 yrs	n=273	n=395	n=422
16-18 yrs	n=141	n=182	n=212



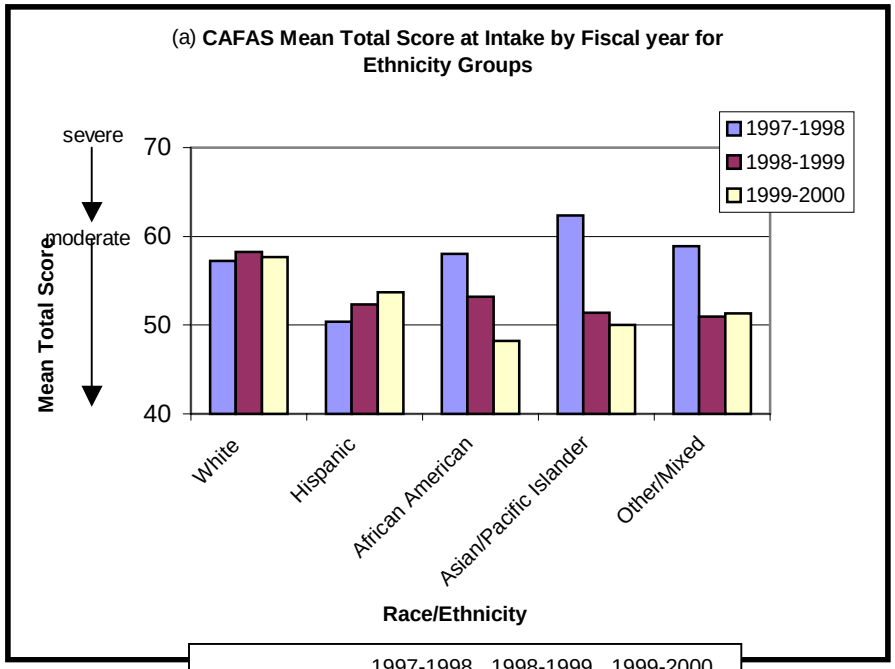
	1997-1998	1998-1999	1999-2000
4-5 yrs	n=55	n=82	n=68
6-10 yrs	n=306	n=448	n=367
11-12 yrs	n=140	n=202	n=172
13-15 yrs	n=256	n=326	n=358
16-18 yrs	n=117	n=135	n=181

- Per clinician report, older youth are significantly more impaired at intake at each fiscal year compared to other ages.
- Per parent report, older youth (16-18 yrs) have significantly less problems in the 1999-2000 fiscal year compared to other years and age groups.

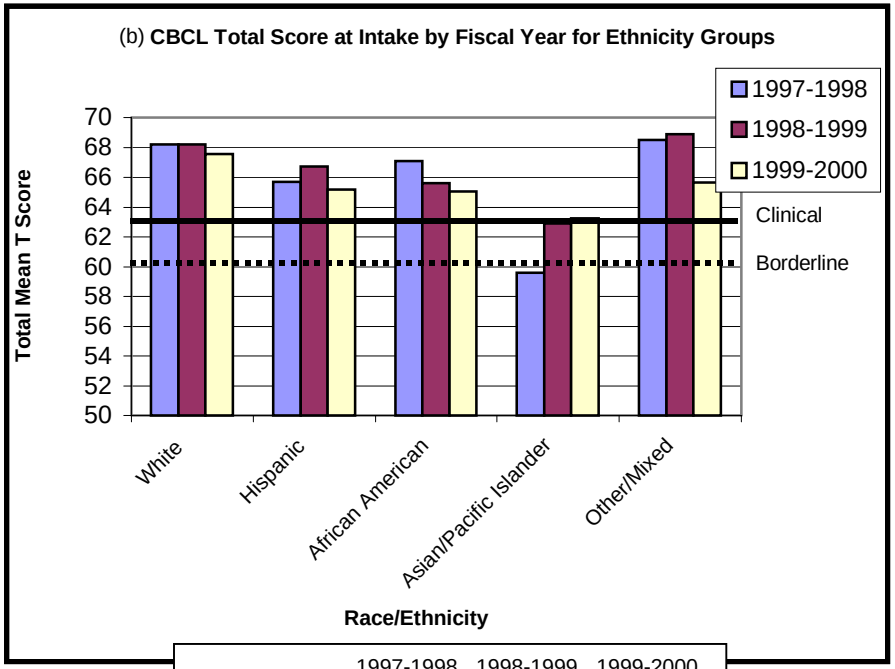
Note: Clinicians complete the PECFAS for children 4-5 years old. PECFAS data is not presented here due to measurement differences.

Figure 16: **POP Intake Cohorts by Fiscal Year: CAFAS and CBCL Mean Total Scores by Race/Ethnicity**

CAFAS is a measure of functional impairment reported by the clinician. CBCL is a measure of behavior and emotional problems reported by the parent. Higher scores on both measures indicate more problems and dysfunction.



	1997-1998	1998-1999	1999-2000
White	n=366	n=458	n=424
Hispanic	n=268	n=466	n=463
African American	n=126	n=189	n=165
Asian/Pac. Islander	n=34	n=64	n=65
Native American*	n=4	n=11	n=11
Other/Mixed	n=81	n=102	n=101



	1997-1998	1998-1999	1999-2000
White	n=377	n=454	n=401
Hispanic	n=249	n=414	n=425
African American	n=124	n=165	n=158
Asian/Pac. Islander	n=28	n=54	n=47
Native American*	n=4	n=13	n=9
Other/Mixed	n=82	n=94	n=98

- Per clinician and parent report, assessed African American youth entered services less impaired over time per fiscal year while Whites entered highly impaired for each year.
- In 97/98, Hispanics were significantly less impaired at Intake per clinician report than other groups and in 99/00, African Americans were significantly less impaired than other race/ethnic groups.
- In each fiscal year, Asians/Pacific Islanders had significantly less problems per parent report compared to all ethnicity groups.

***Note:** The Native American group was not included in the analyses due to their small sample size.

Total POP Intake Sample

This section of the report is a cumulative analysis of the data that the POP team has collected from July 1, 1997 to June 30, 2000. The information presented in this section describes new cases into coordinated care only. The data is combined across years to allow for more detailed analysis by client characteristics and program types.

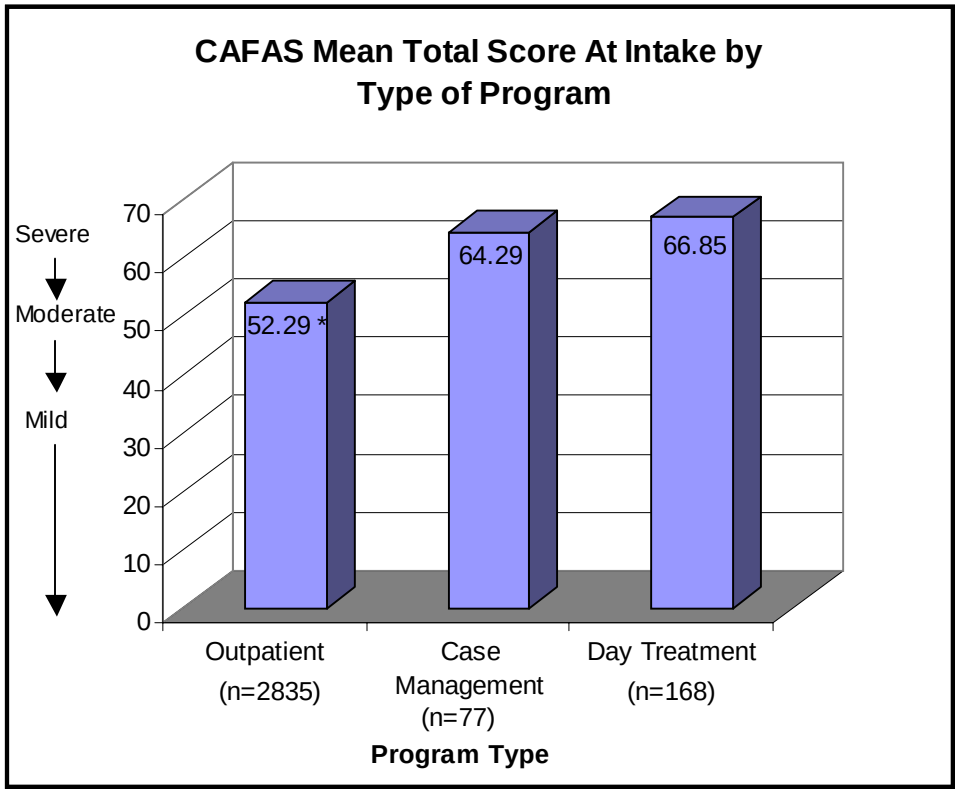
There are some clear differences on the CAFAS total scores at intake by type of program. The program type reflects the type of service the youth received during the time of initial intake assessment. Note that many youth (n=551) enter the coordinated care system through a case management service. For 147 of these youth, this case management service completed the intake assessment only and then referred the youth to an appropriate program. The data for these youth was recoded to represent the intake program type as the program type they received services from at the 6-month assessment time point: 36 were day treatment, 98 were outpatient, and 13 were case management. For a number of these youth (n=351), information about post-intake service type is not available; therefore the data was not included in the analyses.

Youth receiving case management and day treatment services are significantly more functionally impaired then youth in outpatient services (Figure 17). Case management youth also have more behavior and emotional problems according to their parents than outpatient and day treatment youth. Parents of youth receiving case management services report significantly more externalizing and total problems than both outpatient and day treatment. Per youth reports, adolescents receiving case management services have more externalizing and total problems than other youth but not internalizing problems (Figure 18b). However, none of the mean scores from youth groups reach clinical significance. (Note, the inpatient group was not included in the analyses due to their small sample size.)

Client satisfaction scores are high for each fiscal year and program type at last assessment for those youth who entered CC during the 1997-2000 fiscal years (Figure 19a & b). Analyses were performed for race/ethnicity and age groups as well. The satisfaction scores are high for each race/ethnicity group, with no significant difference between groups. There is also limited variation between satisfaction scores of children of different age groups. All parents rate services highly. Note that the completion rate of the CSQ is significantly lower than the other measures collected at follow up. In 1997/98 45% of POP follow-ups had a CSQ measure and there was 42% in 1998/99 and 45% in 1999/00.

Figure 17: **Total POP Intake Sample: CAFAS Mean Total Scores by Program Type**

CAFAS is a measure of functional impairment reported by the clinician. Higher scores represent more impairment and dysfunction.

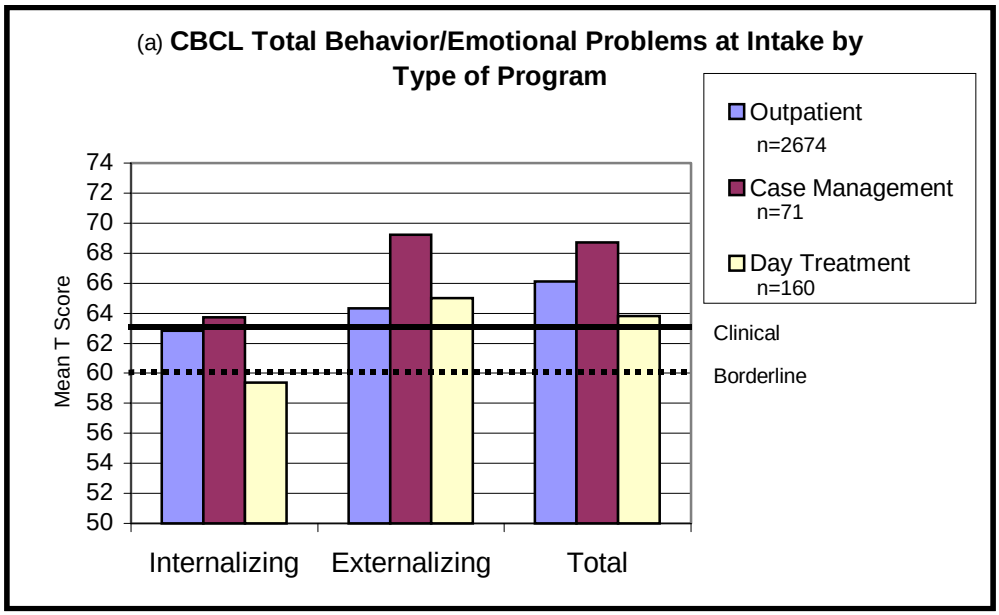


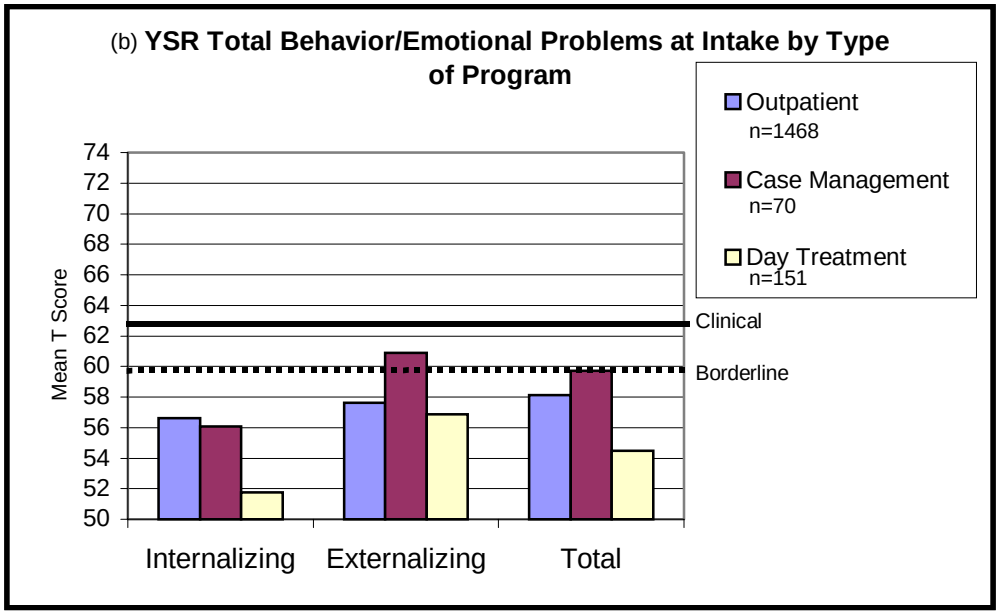
- Youth entering the Coordinated Care system through an outpatient clinic are significantly less impaired than youth entering and receiving services in case management and day treatment programs.

Note: The inpatient group was not included in the analyses due to their small sample size.

Figure 18: **Total POP Intake Sample: CBCL and YSR Mean Total T Scores by Program Type**

CBCL is a measure of behavioral and emotional problems per parent report. The YSR is the comparable measure of problems per youth report. Higher scores represent more problems and symptomatology. The lines indicate borderline and clinical range levels. Internalizing includes withdrawn, somatic complaints and anxious/depressed symptoms. Externalizing includes delinquent and aggressive behaviors. Total includes all problem areas.



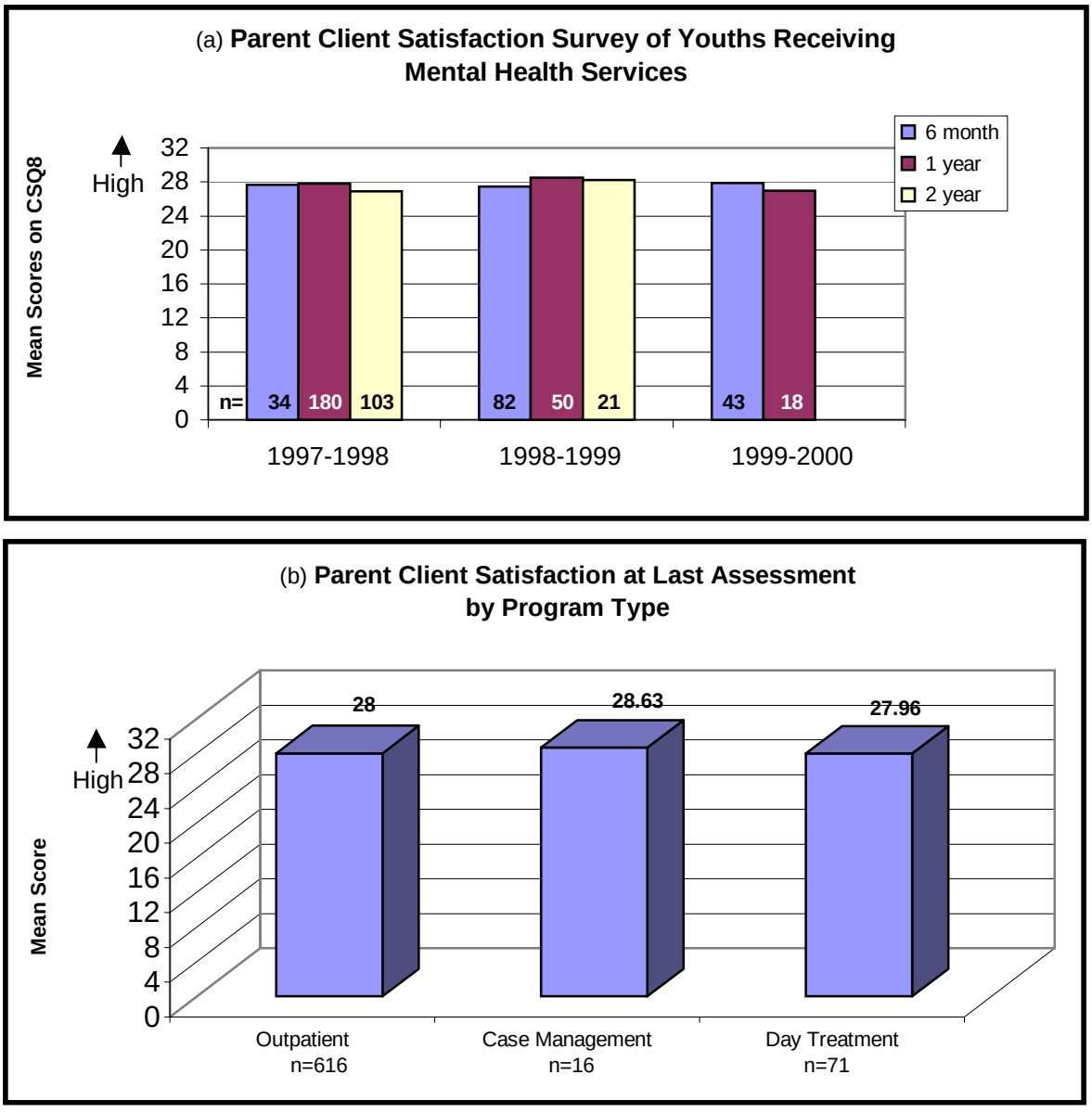


- Parents report significantly more problems than youth in general. Parents of youth in case management programs report significantly more problems than outpatient or day treatment for externalizing and total problems.

- Youth in day treatment programs report significantly less internalizing and total problems than youth in the other programs.

Figure 19: **POP Intake Cohorts by Fiscal Year: Parent Satisfaction of Mental Health Services for their Youth**

The Client Satisfaction Survey is an 8-question form that is completed at follow-ups by the parent/caregiver. They are asked to rate the quality of services and their level of satisfaction with services received. A limited amount of data is reported for the 1999-2000 fiscal year because many cases have not yet reached a follow up time point. High satisfaction equals mean scores from 27-32.



- Parents report high levels of satisfaction across each fiscal year. There is no difference between follow-up time points: 6 mo, 1 yr, or 2 yr (no 2 yr data available for the 99/00 cohort).
- Parents also report high levels of satisfaction across each program type.

Note: The data was also analyzed by age group and ethnicity group and no group differences were found.

Clinical Outcomes

The Performance Outcome Project has collected data for three fiscal years, 1997-2000, for youth who have obtained services in the coordinated care mental health system through organizational providers. Some youth remain in the system receiving services over a period of time and have outcome data systematically collected at follow up points ranging from 6 months to 2 years. By analyzing the data cumulatively, there is an opportunity to examine the data longitudinally for youth who have intake and follow up assessments. This section reports on three follow-up cohorts: 1) youth with an intake and 6 month follow up (n=1240), 2) youth with an intake and 1 year follow up (n=729), and 3) youth with an intake and 2 year follow up (n=174). There is also a cohort that has assessments at intake, 6 months and 1 year for which repeated measure analyses were completed (n=402).

Across each timeframe cohort (intake to 6 months, intake to 1 year and intake to 2 years) parent and clinician reports reflect overall improvement (Figure 20a,b). Youth, however, report improvement for 2 timeframes (intake to 6 month and intake to 1 year) but not for longer term services, intake to 2 years (Figure 20c). When the data is examined by change scores for each measure, the information varies by informant (Figure 21). From intake to 6 months, clinicians report no change occurring more often then positive or negative change and compared to parents and youth. This pattern shifts over time, and by intake to 2-year follow-up, clinicians report positive change occurring more often than no change or negative change. Relative to clinicians and parents, youth are reporting more negative change, and this difference is most pronounced at the 2-year follow-up. Further analysis of the data indicates that change from Intake to 1 Year is more complex than a continual pattern of improvement across time. Instead, it appears that individual patterns of change are variable. Figure 22 shows the percentage of youth who got worse, stayed the same or improved in the initial 6 months of treatment and in the subsequent 6 months of treatment. For youth who improve in the first 6 months, almost equivalent proportions of them further improve, stay the same or deteriorate in the next 6 months according to both parents and youth. Clinicians report larger proportions of youth as staying the same (later no change) in the subsequent 6 months.

After investigating the youth who have intake and 6 month follow up assessments by fiscal years, results show consistent improvements for each fiscal year. There is no difference by fiscal year. These consistent findings are true for all informants (clinicians, parents and youth) across both functional impairment and symptomatology (Figure 23 shows clinician report).

Youth who continue receiving services over long periods of time (minimum 2 years) appear to be more severely impaired when they enter the system by all informants' reports. Figure 24 compares the intake scores of youth who received services for a minimum of 2 years and were assessed at 2-year follow-up with those youth who were eligible for a 2-year follow-up but were not assessed (primarily due to discharge/termination of services). Both parents and youth also report more symptoms for youth who receive a 2-year follow up assessment (Figure 25). These findings suggest that youth who stay in services for long periods of time are more severely impaired when they enter the system, indicating a need for long-term care.

Repeated measures analyses for youth who completed intake, 6 month and 1 year assessments show continuous statistically significant improvement over time on the CAFAS per clinician report. Parents and youth also reported incremental statistically significant improvements over time on behavior and emotional problems (CBCL & YSR) (Figure 26).

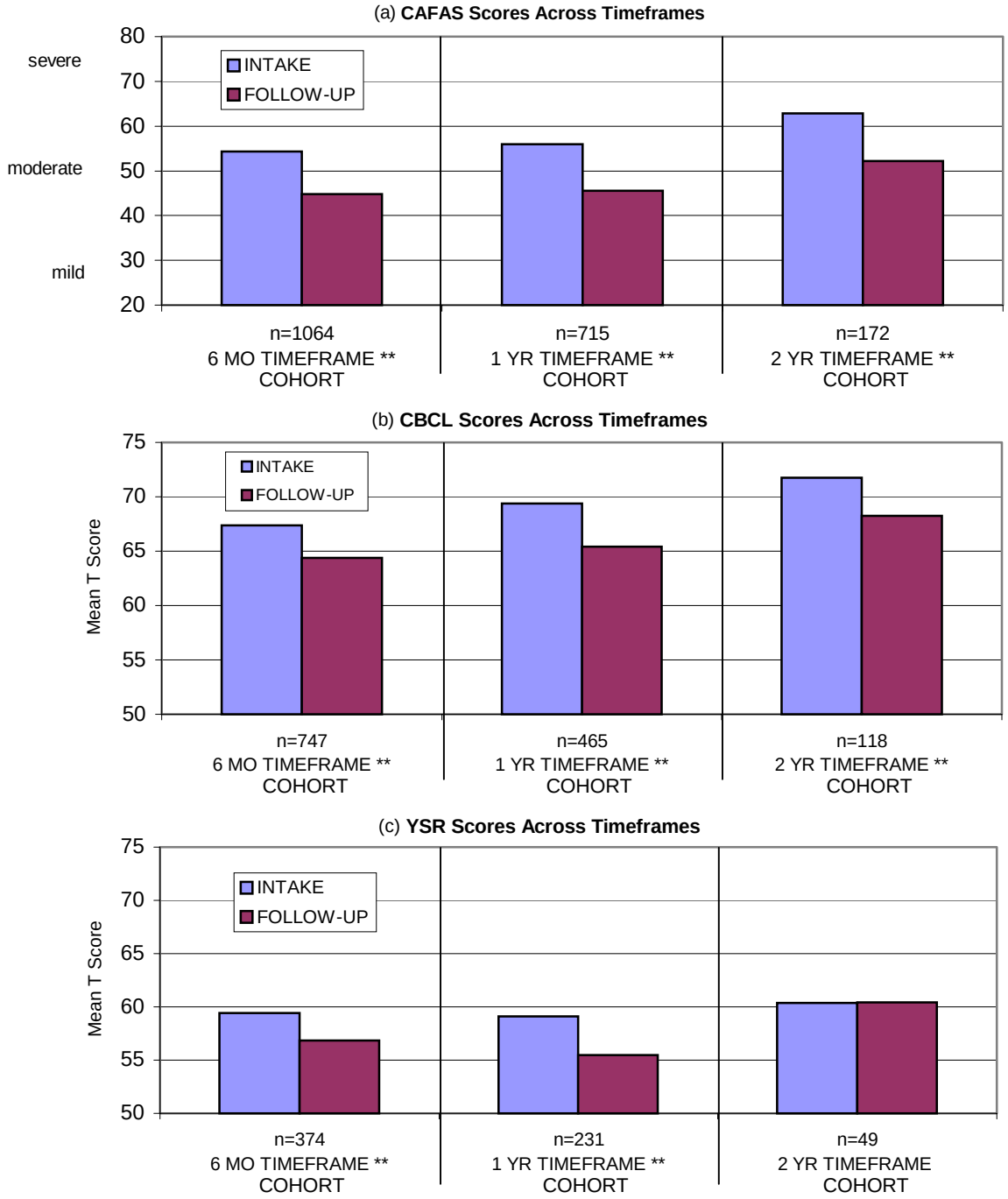
Statistically significant improvements occur from intake to 6 months for all race/ethnicity groups per clinician report. Regression analyses indicate that from intake to 6 months, Asian/Pacific Islander youth show significantly more improvement than others. However, continuous improvement from 6 months to 1 year varies by ethnic group. Hispanics and African Americans show slight improvement over time on the CAFAS while Whites stay the same and Asian/Pacific Islander youth show a deterioration trend from 6 months to 1 year (Figure 27). Further analyses indicate that White youth show significantly less improvement from intake to 1 year than other groups. These effects of ethnicity hold when gender and age are controlled. Per

parent report (CBCL), Hispanics and African Americans improve slightly from intake to 6 months and then remain the same from 6 months to 1 year (no statistically significant change). Whites show some initial statistically significant improvements and then decline from 6 months to 1 year and Asian/Pacific Islanders show on going deterioration over time (Figure 28). Regression analyses indicate that from intake to 6 months parent reports of Asian/Pacific Islander youth show significantly less improvement than other groups. Further analyses indicate that from Intake to 1 year Whites show significantly more improvement than others. These effects of ethnicity hold when gender and age are controlled. Taken together with results of regression analyses of CAFAS scores, these results indicate that parents and clinicians have greatly different perspectives on which groups improve. Furthermore, Hispanic and African American youth (YSR) report continuous improvement from intake to 6 months to 1 year. However, White youth report improvement from intake to 6 months only and Asian/Pacific Islander youth report increase problems over time (Figure 29). Regression analyses indicate no significant effects of race/ethnicity on follow-up scores. Note: results reported by the Asian American/Pacific Islander group should be interpreted with caution due to the small overall sample size.

All race/ethnicity groups reported high levels of satisfaction with services. There were no significant differences between ethnic groups and no significant differences between satisfaction over time, 6 months versus 1 year reports (Figure 30).

Figure 20: **Clinician, Parent and Youth reports at Intake and Follow-up Change in CAFAS, CBCL and YSR Scores Across Timeframes**

The CAFAS is a functional impairment measure completed by the clinician. The CBCL and YSR are comparable emotional/behavioral measures completed by the parent and youth (11-18 yrs). The bars indicate mean levels of functioning at intake and follow-up across three time frames: Intake to 6 months, Intake to 1 year, and Intake to 2 years. Higher scores indicate lower levels of functioning.



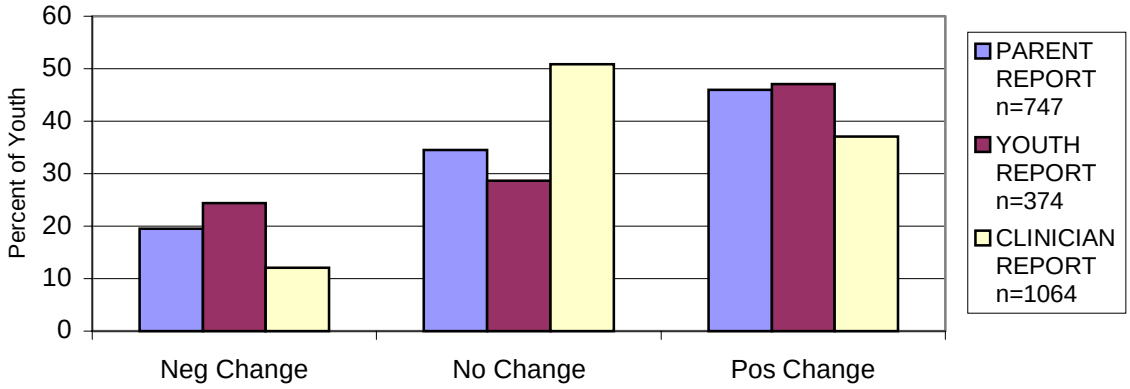
- Across each timeframe cohort, there is statistically significant improvement according to clinician reports on the CAFAS, and parent reports on the CBCL.
- Youth reports on the YSR indicate statistically significant change in behavior problems only for the intake to 6 month and Intake to 1-year timeframe cohorts.

Note: ** indicates statistically significant change.

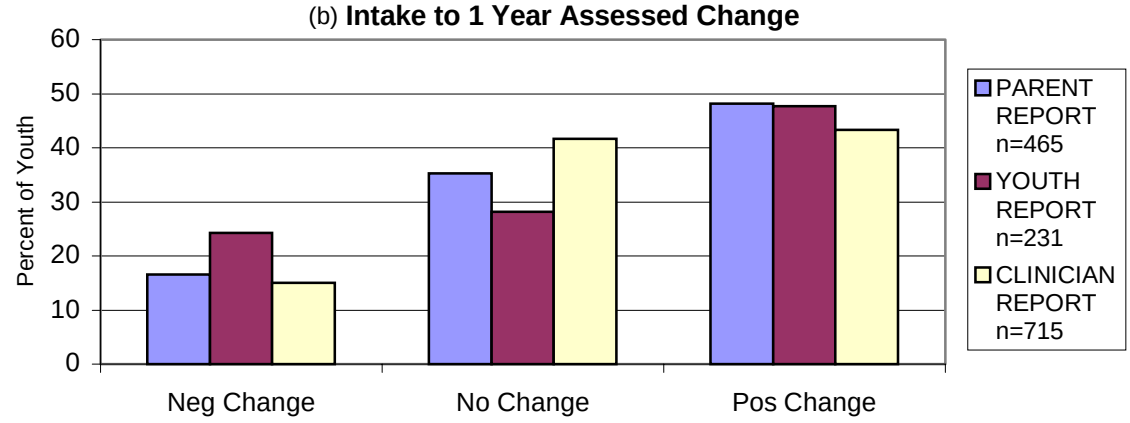
Figure 21: **Assessed Change in Treatment Across Timeframes – Parent, Youth and Clinician Reports**

"Negative change" includes youth who got worse, "no change" includes youth who stayed the same, and "positive change" includes youth who got better according to each informant. Significant change is defined as greater than a 3-point change on the CBCL or YSR and a 10-point change on the CAFAS.

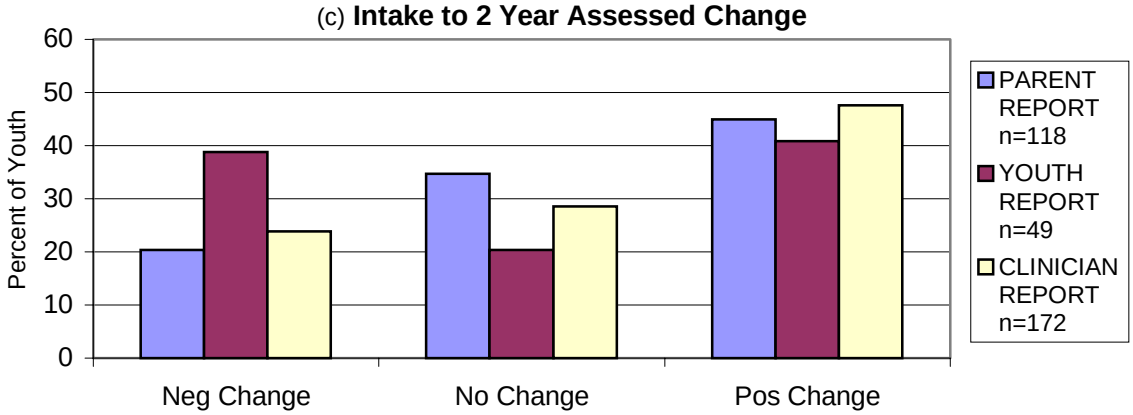
(a) **Intake to 6 Months Assessed Change**



(b) **Intake to 1 Year Assessed Change**



(c) **Intake to 2 Year Assessed Change**



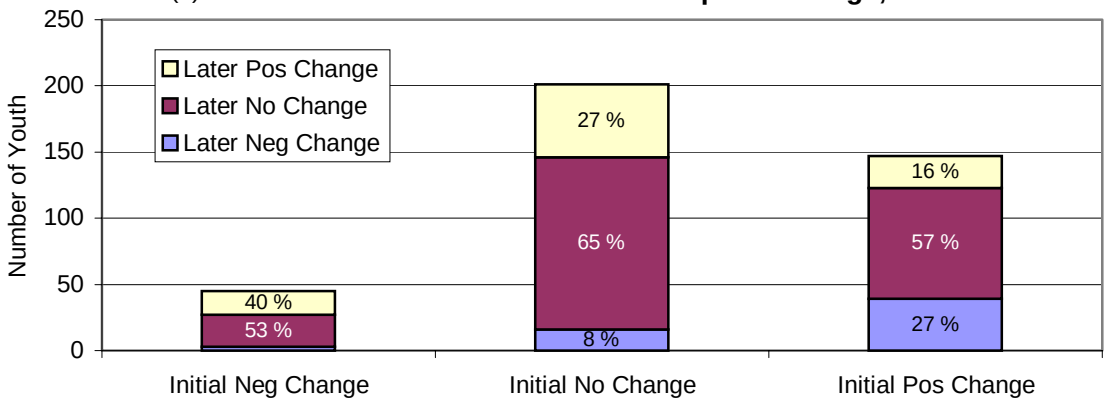
- Similar percentages are being reported as positive change over the various timeframes. Clinicians tend to report more no change than parents and youth at 6 months, but their reported change patterns come to resemble those of parents more at the 2-year follow-up.

- Relative to clinicians and parents, youth are reporting more negative change and this difference is most pronounced at the 2 year follow-up.

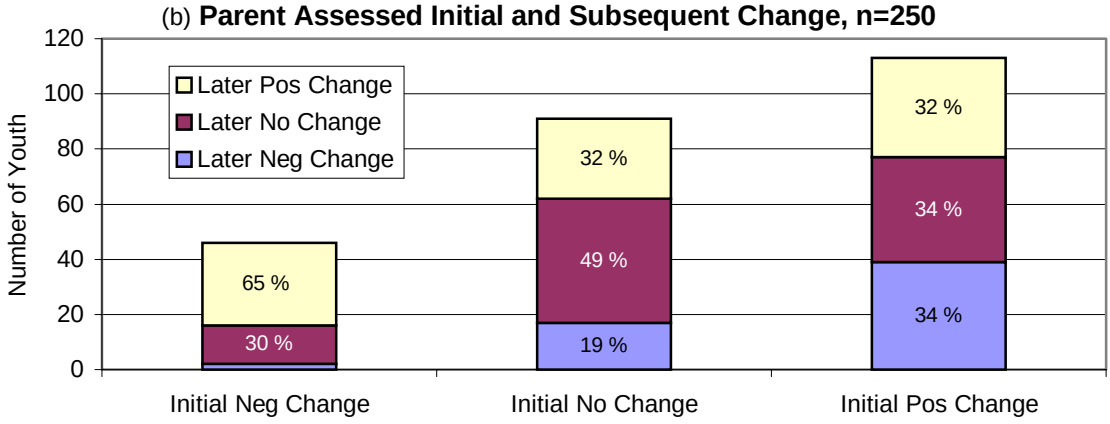
Figure 22: **Assessed Change from Intake-6mo, 6mo-1year by Informant**

In each graph the overall height of the bar indicates the number of cases with initial positive, no, and negative change at 6 months. The stacked shaded areas within each bar represent the percent of youth who then report subsequent positive, no and negative change at 1-year follow-up. One graph is displayed for each informant.

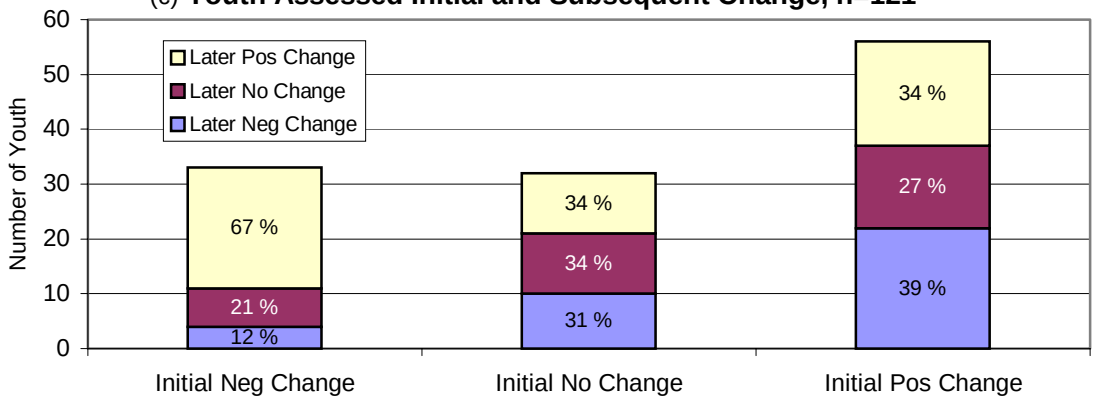
(a) **Clinician Assessed Initial and Subsequent Change, n=393**



(b) **Parent Assessed Initial and Subsequent Change, n=250**



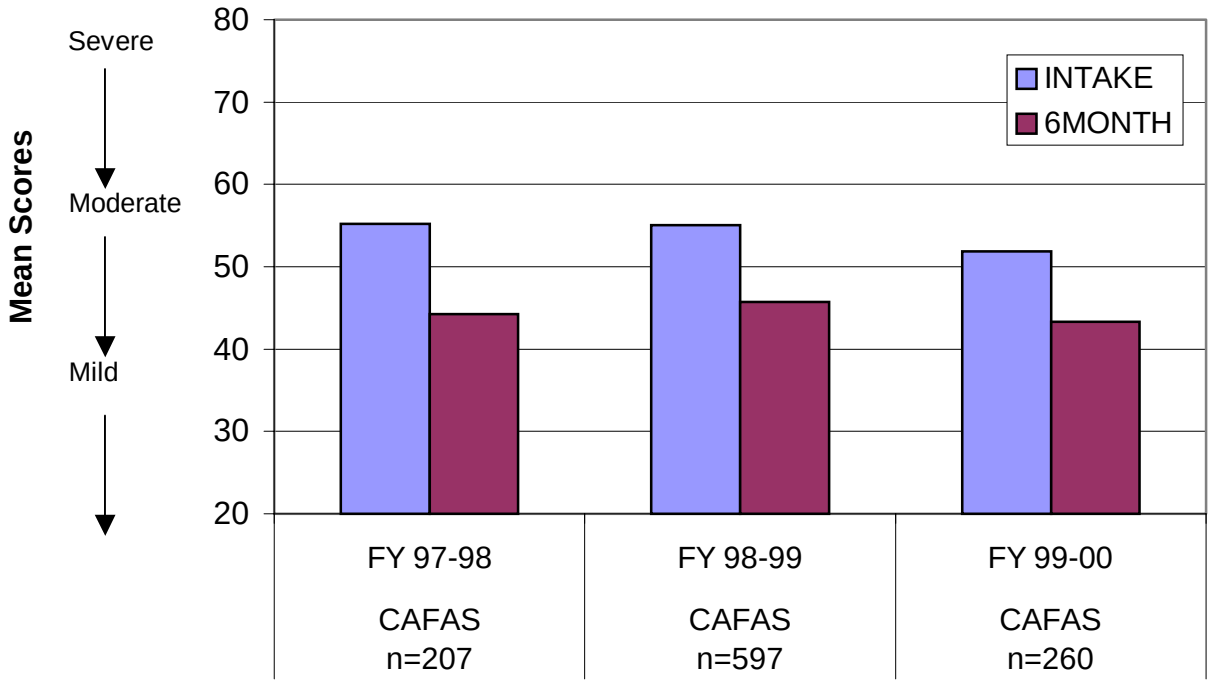
(c) **Youth Assessed Initial and Subsequent Change, n=121**



- For youth who improve in the first 6 months, almost equivalent proportions later further improve, stay the same or deteriorate in the next 6 months according to both parents and youth.

Figure 23: **Intake to 6 Month Change in CAFAS Scores by Fiscal Year of Intake**

The CAFAS is a measure of functional impairment completed by the clinician. The bars indicate mean functioning level at intake and at 6-month follow-up for youth across the three fiscal years. Higher scores indicate more dysfunction.



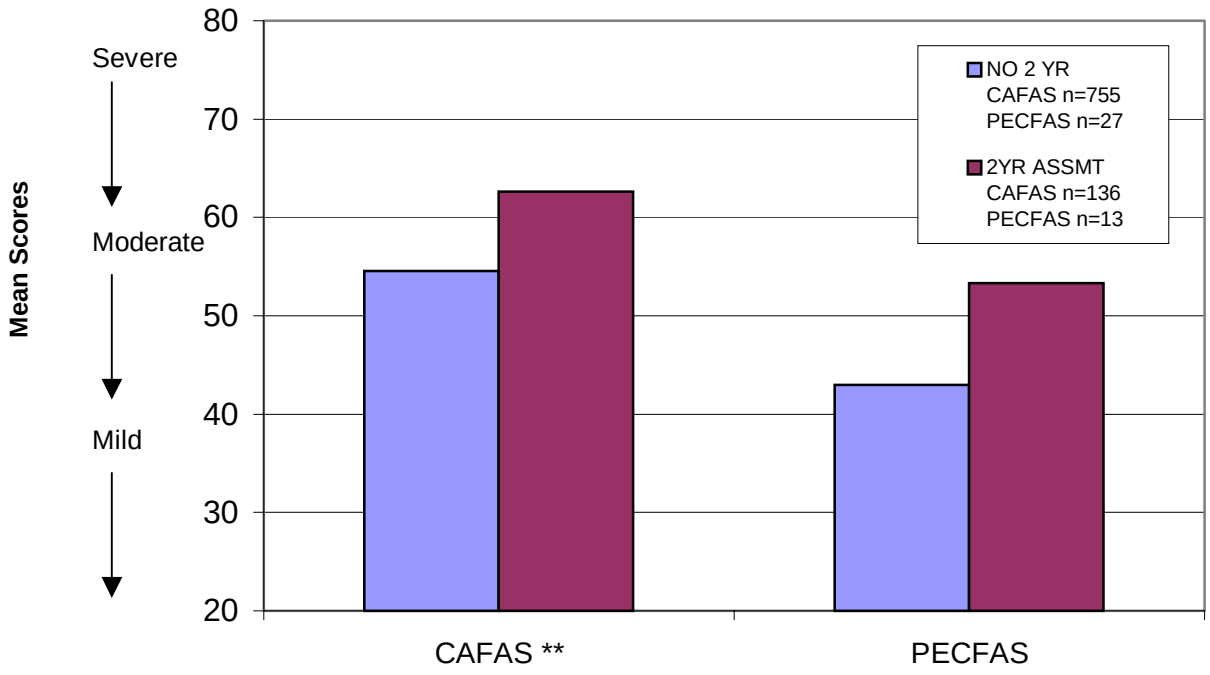
- Clinician reports of youth functioning show significantly improved functioning at 6-month follow-up compared to intake across each fiscal year.

- This finding suggests that patterns of improvement in psychosocial functioning according to provider reports have remained consistent across the three years of study.

(Note: Similar improvements were found on both parent and youth measures, with no difference by fiscal year.)

Figure 24: **Intake Profiles (FY 97-98) – CAFAS Scores for Youth With and Without 2-Year Assessments**

The CAFAS is a functional impairment measure completed by the clinician. The PECFAS is the equivalent measure for children 4-5 years old. The bars indicate mean intake functioning levels for youth who did not have a POP assessment at the 2-year follow-up and those that did have a 2-year follow-up assessment. Higher scores indicate lower functioning.

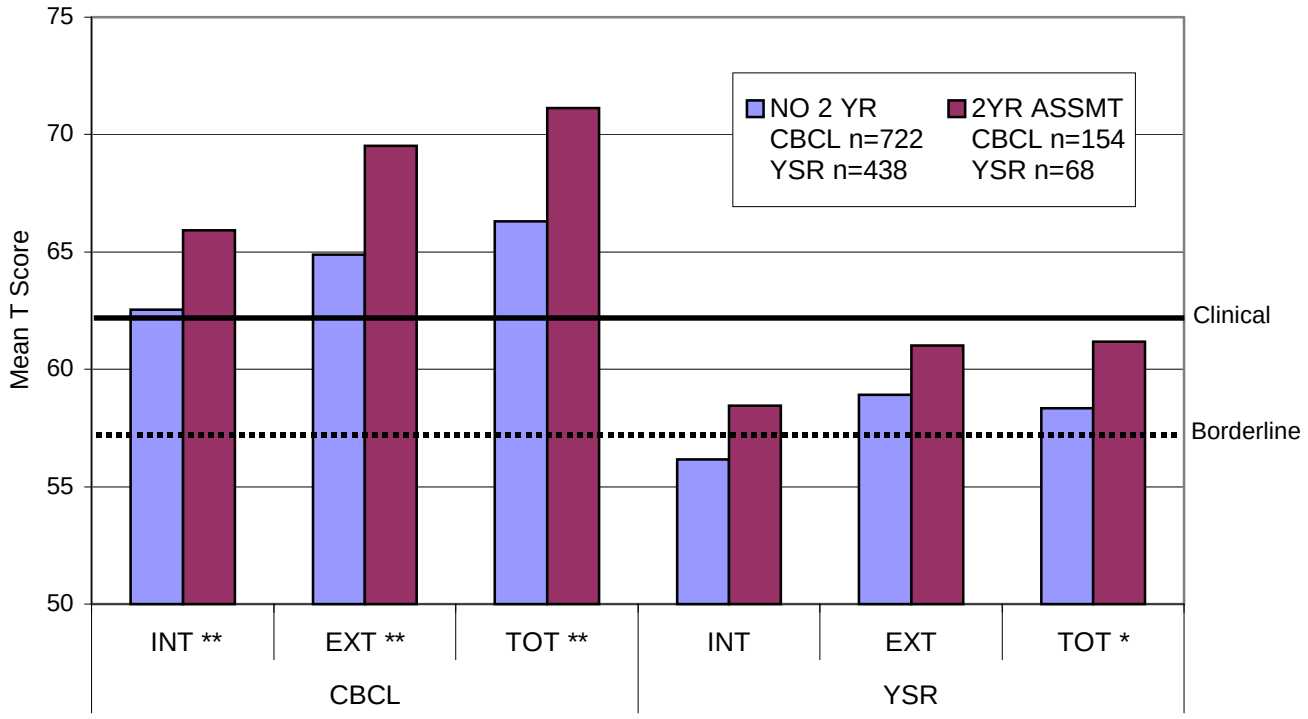


- Clinician reports of functioning on the CAFAS indicate that youth who later receive a 2 year follow-up assessment have significantly lower functioning (higher scores) at intake than those youth who do not have a 2-year follow-up assessment.

- This finding suggests that youth who stay in services for long periods of time are more severely impaired when they enter the system.

Figure 25: **Intake Profiles (FY 97-98) CBCL and YSR Scores for Youth With and Without 2 Year Assessment**

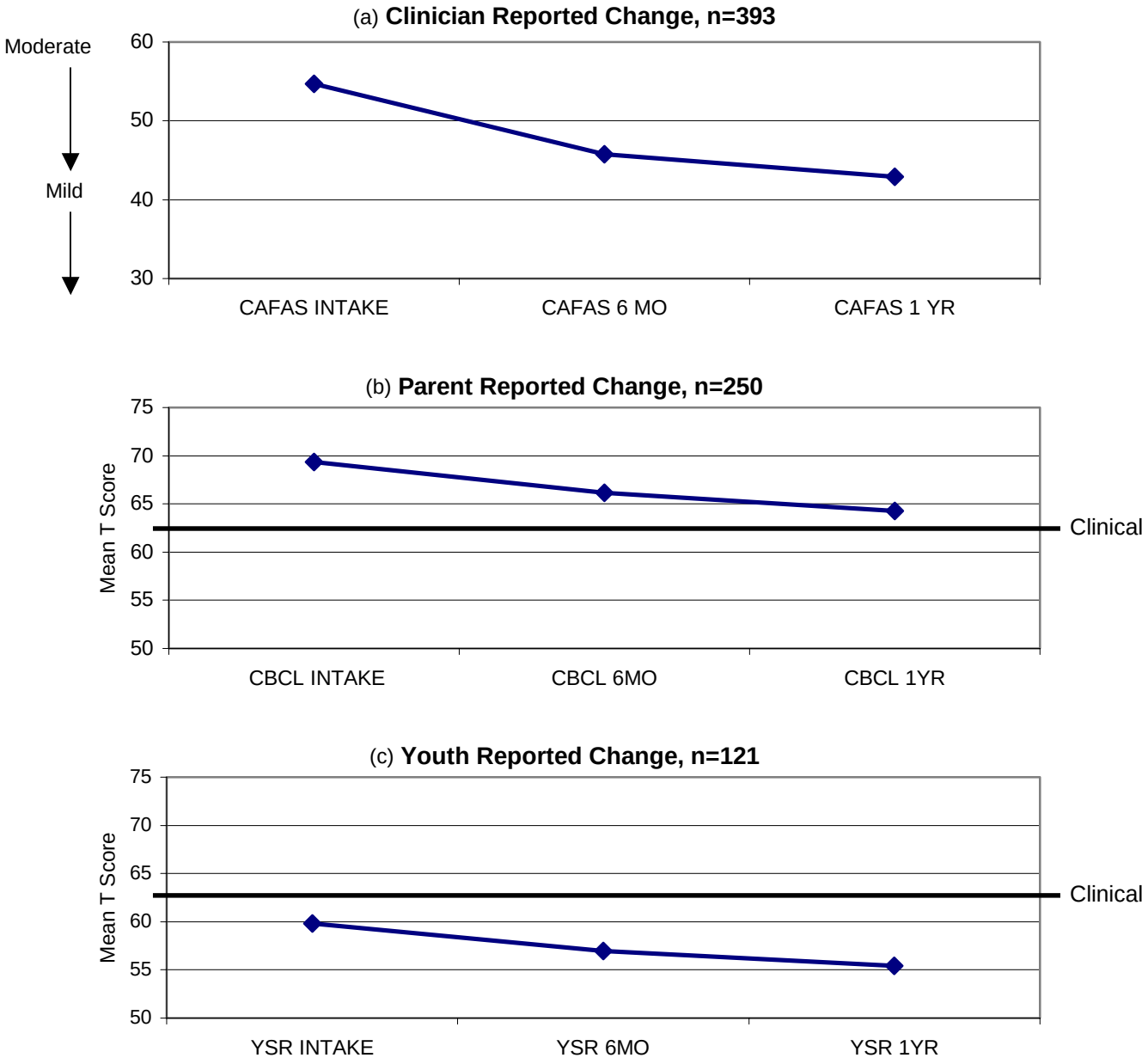
The CBCL is completed by the parent and the YSR is completed by the youth (11-18 yrs). Both measures assess functional/behavioral problems. The bars indicate mean intake levels for youth who did not have a POP assessment at the 2-year follow-up and those that did have a 2-year follow-up assessment. Higher scores indicate more severe problems. Externalizing problems include aggressive and delinquent behavior. Internalizing problems include depression/anxiety, somatic complaints and withdrawn behavior.



- Parent reports (CBCL) of internalizing, externalizing, and total problems show significantly higher severity at intake for youth who receive a 2-year follow-up assessment than for youth who do not.
- Youth reports (YSR) of total problems show significantly higher severity at intake for youth who receive a 2-year follow-up assessment than for youth who do not.
- This finding suggests that youth who stay in services for long periods of time are more severely impaired when they enter the system.

Figure 26: **Change Across Time – CAFAS, CBCL and YSR at Intake, 6 Month and 1 Year**

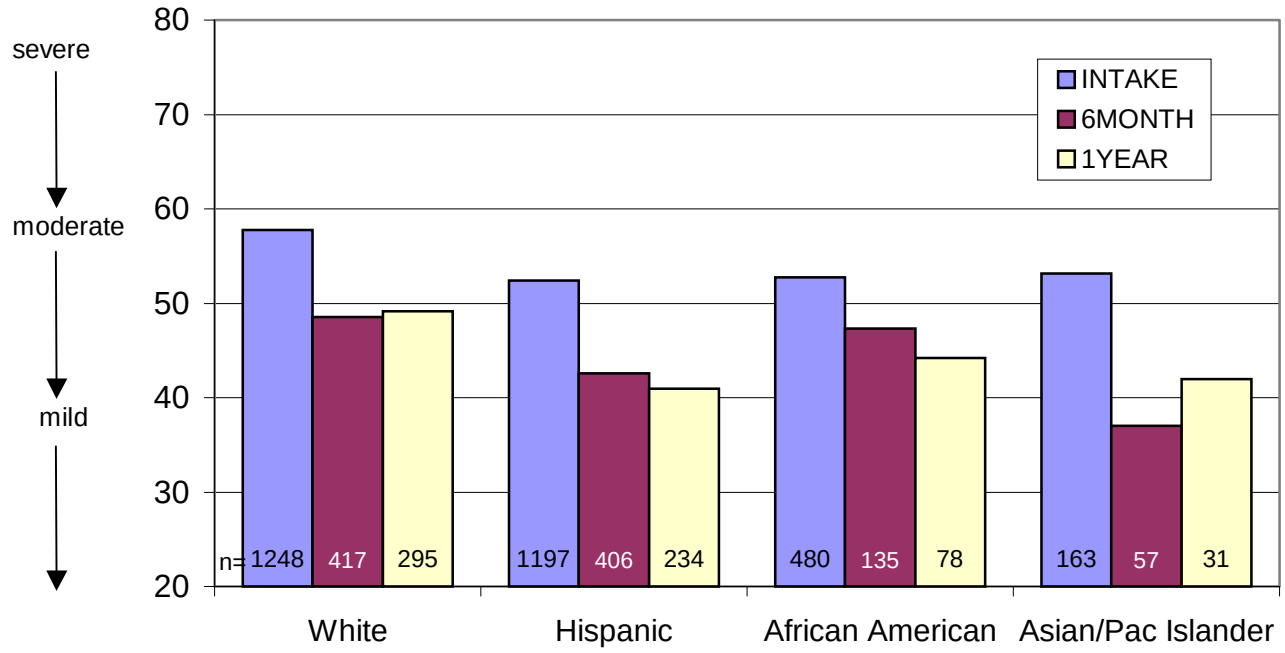
The CAFAS is completed by the clinician. The CBCL is completed by parent and YSR by youth (11-18 yrs). The data points display mean scores, with higher scores indicating greater severity.



- Across all reporters and measures, there is statistically significant change from Intake to 1 year on measures of functioning and behavior problems over time.

Figure 27: **Clinician Assessed Change by Race/Ethnicity – Mean CAFAS Scores at Intake, 6 Month and 1 Year**

The CAFAS is a functional impairment measure completed by the clinician. The four main ethnic/racial groups are: Whites, Hispanics, African Americans, and Asian/Pacific Islanders. Higher scores indicate lower psychosocial functioning.



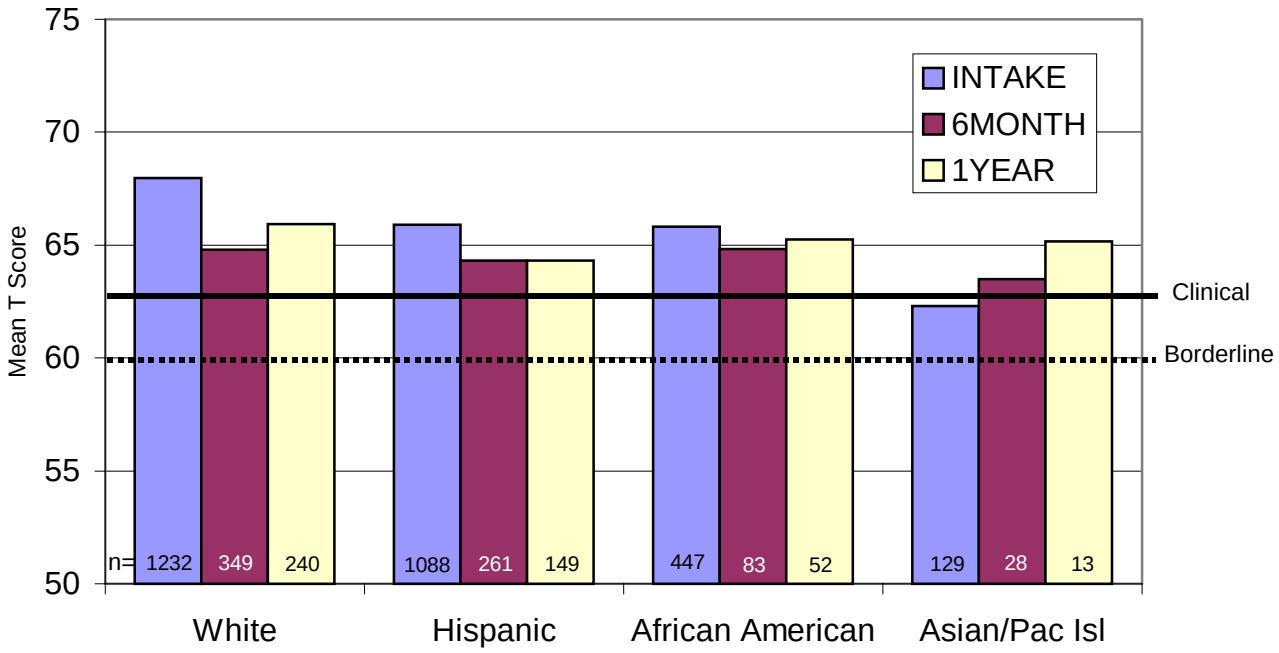
- Each of the groups shows statistically significant improvement in functioning from Intake to 6 months, and from Intake to 1 year, according to clinician reports.

- Regression analyses of clinician reported functioning indicate that from intake to 6 months, Asian/Pacific Islander youth show significantly more improvement than others. Analyses also indicate that from Intake to 1 year, White youth show significantly less improvement than others. Note: These effects of ethnicity hold when gender and age are controlled.

(Note: Bars present aggregated data for all youth with intake and follow-up measures per timeframe. Not all youth are the same in each bar.)

Figure 28: **Parent Assessed Change by Race/Ethnicity – Mean CBCL Scores at Intake, 6 Month and 1 Year**

The CBCL is an emotional and behavioral problems measure completed by the parent. The four main ethnic/racial groups are: White, African American, Hispanic, and Asian/Pacific Islander. Higher scores indicate greater severity of emotional/behavioral problems.



- For all groups except Asian/Pacific Islander youth, there is a decrease in parent reported behavioral problems on average from Intake to 6 months. However, for Asian/Pacific Islander youth there is an increase in parent reported behavior problems.

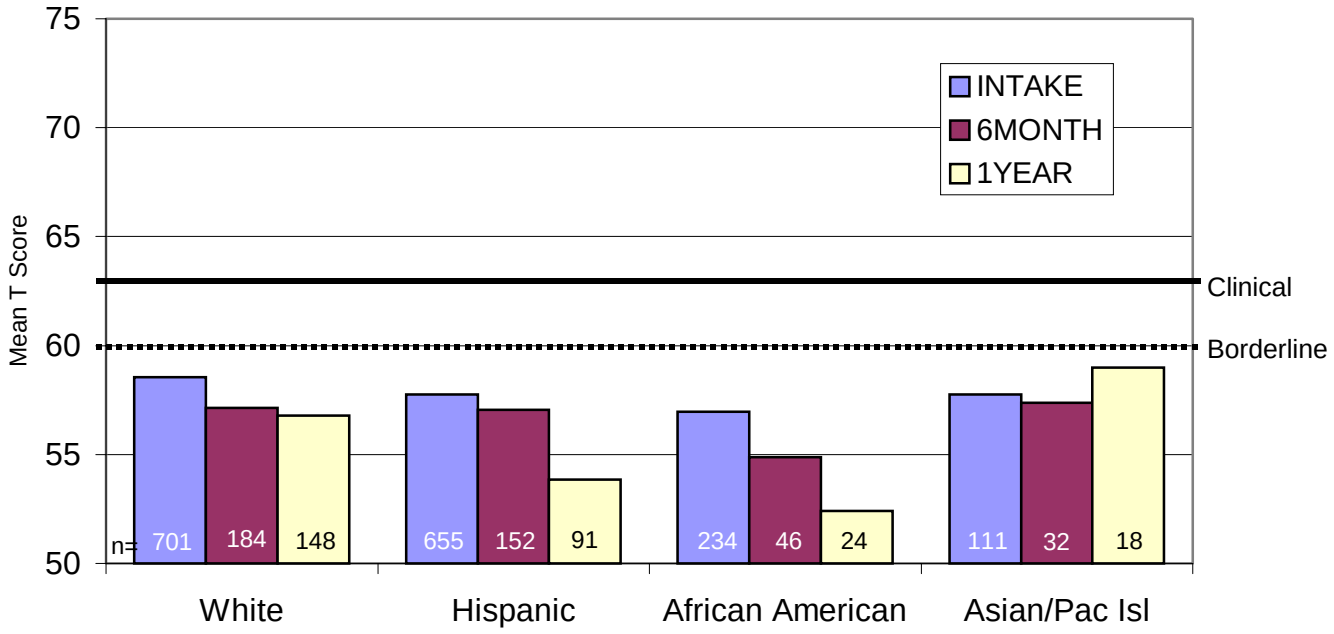
- Regression analyses of parent reported behavior problems indicate that from intake to 6 months, Asian youth show significantly less improvement than others. Analyses also indicate that from Intake to 1 year, White youth show significantly more improvement than others.

  Note: These effects of ethnicity hold when gender and age are controlled.

(Note: Bars present aggregated data for all youth with intake and follow-up measures per timeframe. Not all youth are the same in each bar.)

Figure 29: **Youth Assessed Change by Race/Ethnicity – Mean YSR Scores at Intake, 6 Month and 1 Year**

The YSR is an emotional/behavioral problems measure completed by the youth (11-18 yrs). The four main ethnic/racial groups are: White, African American, Hispanic, and Asian/Pacific Islander. Higher scores indicate greater severity of behavioral problems.



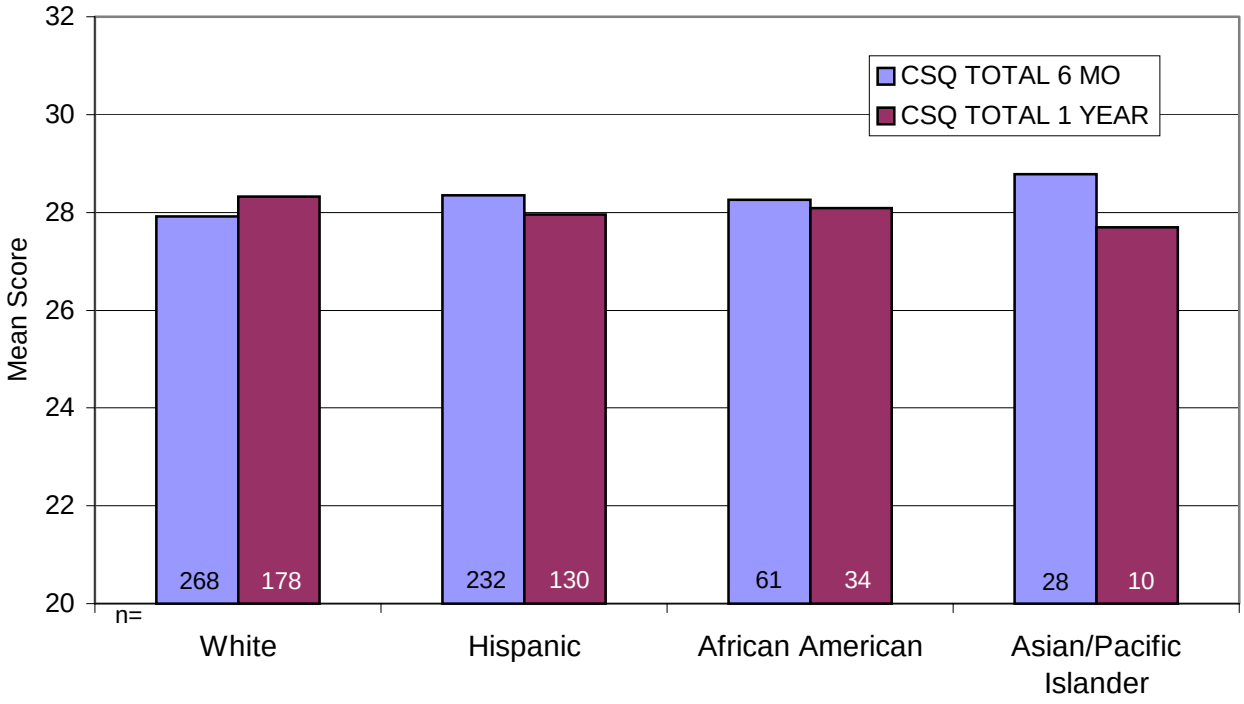
- For all groups except Asian youth, there is a decrease in youth reported behavioral problems on average from Intake to 6 months. However, for Asian youth there is, on average, an increase in youth reported behavior problems from Intake to 1 year. In this respect, the analyses of YSR scores over time parallel the patterns of CBCL scores.

- Regression analyses of youth reported behavior problems indicate no significant effects of race/ethnicity on follow-up scores.

(Note: Bars present aggregated data for all youth with intake and follow-up measures per timeframe. Not all youth are the same in each bar.)

Figure 30: Client Satisfaction by Ethnicity – Mean Scores at 6 Months and 1-Year Follow-Ups

The Client Satisfaction Survey is an 8-question form that is completed at follow-ups by the parent or caregiver. The four main ethnic/racial groups are: White, African American, Hispanic, and Asian/Pacific Islander. Higher scores indicate greater satisfaction with services.



- Mean scores on the CSQ indicate high levels of satisfaction, with mean scores for all groups in the range of approximately 28 out of a total possible 32 points.

- There were no significant differences between ethnic groups on levels of client satisfaction at 6 months or at 1 year.

Intensive Services Evaluation Project
(formerly Heartbeat Evaluation Project)

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) with the Center for Mental Health Services (CMHS) established a national project to promote and develop the varied innovations represented by the system of care concept that have been diffused throughout the country. Phase II of this nation wide project began funding 9 sites in 1997 including SD County. The SD County program collected its first intake assessments in April of 1999. The program will continue to serve and collect data on new clients through fall of 2001. Follow-up data is collected consecutively at 6-month intervals for the length of the evaluation, ending in 2002. This provides the opportunity for up to 3 years of longitudinal data to be collected for youth who entered the system in 1999.

The goals for SD County and the broad national study are to develop, implement, and evaluate the system of care wraparound program serving seriously emotionally disturbed (SED) youth. The SOC theory asserts that to serve SED youth, service delivery systems need to offer a wide array of accessible, community-based service options that center on the children's individual needs, include the family in treatment planning and delivery and that are provided in a culturally competent manner. An emphasis is placed on serving children in the least restrictive setting that is clinically appropriate, culturally competent, and that provides service coordination and interagency collaboration. The program objectives include targeting the most severely troubled youth in an effort to strengthen community-based alternatives to restrictive and costly out-of-home care.

Children and adolescents are eligible to receive services from these more intensive wraparound-based system of care programs and participate in the evaluation process if: a) they are less than 17.5 years old, b) they have at least one DSM-IV diagnosis which prevents them from functioning in their home, school or community and which requires multi-agency services, and c) are at risk for a restrictive level of care.

The county implemented three intensive service programs for coordinated care youth in or at risk for restrictive placements: TOWER, CITY, and BEST. The TOWER program is a short-term intensive service program for youth involved in the juvenile justice system. CITY is a state hospital alternative program for high-end youth needing intensive services, and BEST is an intensive service for youth who are also wards and dependents. In addition, youth participating in the Wraparound Laboratory/SB163 intensive services wraparound program are included in this sample for this report. The data from each of the programs: TOWER, BEST, CITY, Wraparound Laboratory/SB163 was collapsed into one follow up sample. The TOWER program contributes the largest amount of data to the sample (71.5%) followed by BEST (19%), CITY (3.5%) and Wraparound Laboratory/SB163 (6%).

To date, one hundred and seventy-one youth have participated in the evaluation. Seventy-four percent of these youth are males and 26% are females. The majority are adolescents 14 to 17 years old with an average age of 15.6 years (range from 7-18 years old). The majority of families have 3-4 members living in the household with 87.1% of youth living with a biological parent(s). The median income is $15,000-19,999 with the highest percentage of families earning less than $15,000 a year (Figure 31a). Very few parents of youth report having a college degree and 28.9% of parents reported having less than a high school degree (Figure 31b). The youth and families are primarily from a Spanish/Hispanic or White race/ethnicity backgrounds with very few families from Asian/Pacific Islander and Native American groups (Figure 31c). The data was collected in Spanish for 16.4% of the interviews with parents and 0% for youth.

The outcome data shows a general trend of improvement (less functional impairment) on the CAFAS from baseline to 6 month follow up for each of the subscales except substance use and role performance in the home setting (Figure 32). The improvement on the moods/emotions subscale is statistically significant. Note in this sample, a trained interviewer rather than the treating clinician completes the CAFAS. Interviewers are trained to criterion and assessed for accuracy each year. Per parent interview report (CBCL [administered by a trained interviewer]), the youth appear to be improving in their behavior and emotional problems over time. There are continuous

gains reported from baseline to 6 months to 1 year (Figure 33). Similar results are reported by interviewing youth on the YSR (administered by a trained interviewer). Even though overall scores reported by the youth are lower than parental reports, reductions over time are still evident (Figure 34). Note that the sample of youth with 12 month assessment data was not significantly different from other youth at baseline. In comparing change scores on the CBCL and YSR from baseline to 6 months parents report slightly more positive change than youth and significantly more negative change. Youth reported positive change and no change equally with negative change occurring less frequently (Figure 35). On the Caregiver Strain Questionnaire (CGSQ) there is improvement in each domain (objective, subjective and global) from baseline to 6 months (Figure 36). Statistically significant decreases were observed for Objective, Subjective-Internalized and Global measures of caregiver strain between baseline and 6 months. The decrease in Subjective-Externalized caregiver strain approached statistical significance. This means that parents felt less burdened over the course of the follow-up period. The Behavioral and Emotional Rating Scale (BERS), a strength-based measure, shows a non-statistically significant trend towards gains on Interpersonal and Intrapersonal Strength, Family Involvement and School Functioning. There was no change in regard to Affective Strength (Figure 37).

The satisfaction information for ISEP shows that, in general, youth and families are satisfied with services. The parent and youth satisfaction measures use comparable 5-point scales ranging from “very dissatisfied” to “neutral” to “very satisfied”. Parents and youth report higher satisfaction with services most often (Figure 38). Both respondents report “satisfied” or “neutral” evaluations of services at 6 months significantly greater than the percent reporting “dissatisfied.” There are no statistically significant differences between parent and youth reports. Results from the Multidimensional Adolescent Satisfaction Scale (MASS) showed that adolescents were especially satisfied with the level of family involvement and the absence of conflict with their counselors. The data was analyzed by White and Hispanic race/ethnicity groups. Note other race/ethnicity groups were too small to be included in statistical analyses but demonstrated similar patterns as the White group. With the exception of "effectiveness" of services the satisfaction levels of Hispanics were generally lower than Whites, suggesting less satisfaction with counseling. Hispanics’ lower ratings for “meeting needs” and “family involvement” closely approach statistical significance as did the higher Hispanic rating for “effectiveness” (Figure 39). (Note that current sample sizes may be too small to detect statistical significance for these ethnic differences.)

Recidivism

San Diego County has developed two collaborative juvenile justice/mental health programs designed to reduce out-of-home placement and decrease recidivism among youth participating in these programs. The two programs are TOWER and BEST. Both are intensive case management services that apply SOC and wraparound philosophies. TOWER is a short-term program (3-6 months) while BEST serves youth for longer periods of time (6-12 months).

TOWER served 126 youth who had prior involvement with the juvenile justice system from February of 1999 to June of 2000. Of these youth, 17 had intakes prior to June of 1999, which made them eligible for a 1 year follow-up and all of these 17 youth had data points collected at pre and post receipt of services. The number of charges was calculated for 1 year prior to program entry and 1-year post program entry.

The mean number of charges in the year prior to receipt of services was 1.82 charges. The mean number of charges 1-year post entry into the TOWER program was 1 charge. This represents a 45% decrease in the number of charges following participation in the program. Most youth decreased their number of charges at 1-year follow up; 65% had a reduced number of charges, 18% showed no change and 18% had an increased number of charges.

BEST served 90 youth who had prior involvement with the juvenile justice system from December of 1996 to June of 2000. Of these youth, 75 had intakes prior to June of 1999, which made them eligible for a 1 year follow up and all of these 75 youth had data points collected at pre

and post receipt of services. As above, the number of charges was calculated for 1 year prior to program entry and 1-year post program entry.

The mean number of charges in the 1 year prior to receipt of services was 1.17 charges. Note, 24 youth had no charges in the 1 year prior to receiving services from BEST. This is probably due to the youth residing in Juvenile Hall or at a camp facility. The mean number of charges 1-year post entry into the BEST program was 1.31 charges. This shows an increase of the number of charges when all youth are included in the analyses. There is an approximately equal balance of youth reducing, remaining the same and increasing their number of charges at 1 year follow up; 33% had a reduced number of charges, 31% showed no change and 36% had an increased number of charges.

When the youth who had no charges at baseline are removed from the analyses the mean number of charges at baseline is 1.73. The mean number of charges at 1-year follow up for those youth who had at least one charge at baseline is 1.33 charges. Thus, there was a 23% decrease in the number of charges following participation in the program for those youth who had at least one charge in the year prior to program entry. Again, if the youth who had no charges at baseline are removed from the analyses: 49% had a reduced number of charges, 27% showed no change and 24% had an increased number of charges.

School Achievement

School achievement data is collected from those youth participating in the BEST intensive case management program. From 1996 to 2000, 74 Wide Range Achievement Tests (WRAT3) were collected at baseline and 25 youth had an additional follow up test averaging 15.4 months (SD=8.1) from baseline. The WRAT3 tests achievement in reading, spelling and math. The only subscale with a significant difference was the Spelling Grade Equivalent scores. The mean at baseline was 6.2 (SD=3.6) and the mean at follow up was 7.0 (SD=3.5) for the Spelling Grade Equivalent score. The Reading Grade Equivalent mean score at baseline was 9.3 (SD=3.8) and 9.1 (SD=3.7) at follow up and the Math Grade Equivalent mean score at baseline was 6.9 (SD=3.2) and 6.7 (SD=3.1) at follow up.

Table 3 :

Brief Description of ISEP Clinical Measures

The following measures are used in addition to the POP measures*:

*Note: a trained interviewer administers all measures

Behavioral and Emotional Rating Scale (BERS)

- Identifies emotional and behavioral strengths of children aged 5 to 18.
- Five dimensions of childhood strengths correspond to the subscales in the measure: Interpersonal Strength, Family Involvement, Intrapersonal Strength, School Functioning, and Affective Strength.
- Completed by interviewing the caregiver

Caregiver Strain Questionnaire (CGSQ)

- Assesses how families are affected by the special demands associated with caring for a child with a serious emotional disturbance.
- Comprised of three related dimensions of caregiver strain (objective strain, internalized subjective strain, and externalized subjective strain) and a global strain total score.
- Formerly known as the Burden of Care Questionnaire
- Completed by interviewing the caregiver

Family Satisfaction Questionnaire (FSQ-A)

- Assesses the parent/caregiver's satisfaction with services as a whole, child's progress, cultural competence, and family focus, as well as whether the services children and families received have improved caregivers' ability to work outside of the home.
- Respondents report to their satisfaction on a five-point scale ranging from "very dissatisfied" to "very satisfied" by interview.
- Questions that refer to the individual, who works outside of the home, may or may not be the respondent.
- Abbreviated version has not yet been tested (internal consistency for items on full version)

Youth Satisfaction Questionnaire (YSQ-A)

- Assesses the youth's satisfaction with services as a whole, youth's progress, cultural competence and family focus
- Completed by interviewing the youth aged 11-18
- Respondents report to their satisfaction on a five-point scale ranging from "very dissatisfied" to "very satisfied".
- Abbreviated version has not yet been tested (internal consistency for items on full version)

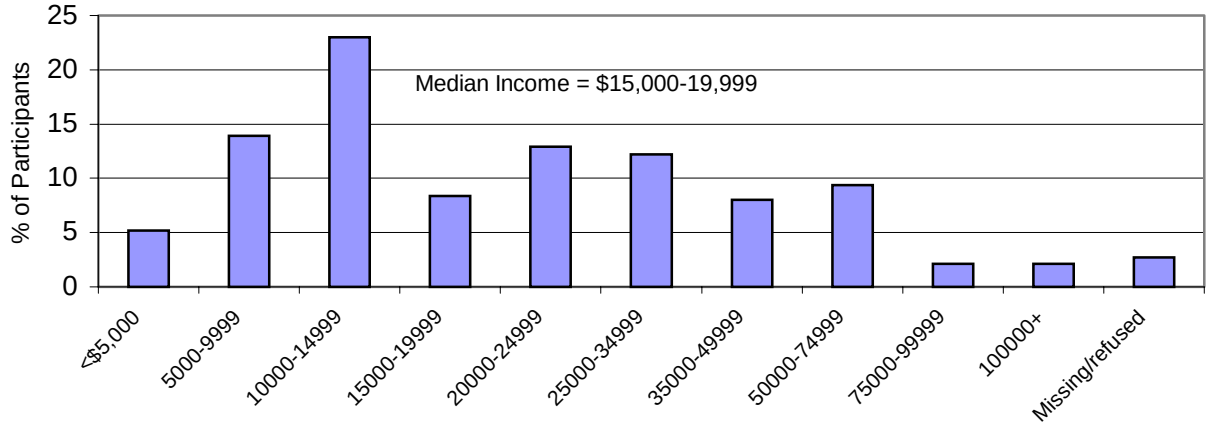
Multidimensional Adolescent Satisfaction Scale (MASS- 23)

- Assesses the youth's satisfaction with counseling services/psychotherapy
- Scales: counselor qualities, meeting needs, effectiveness, counselor conflict, and family involvement
- 23 items total

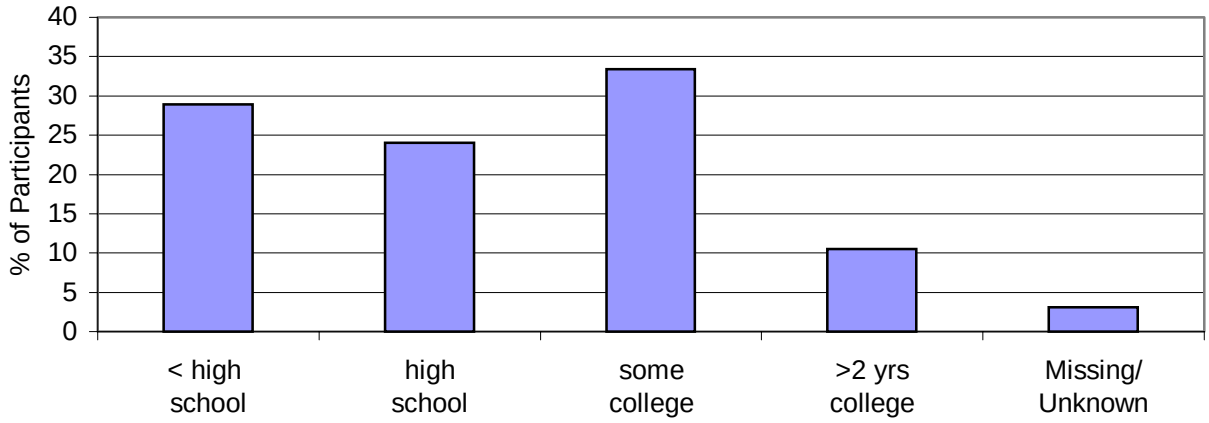
Figure 31: **ISEP: Income Distribution, Caregiver Educational Level, and Race/Ethnicity**

(n = 171)

(a) Income Distribution



(b) Caregiver Educational Level



(c) Race/Ethnicity

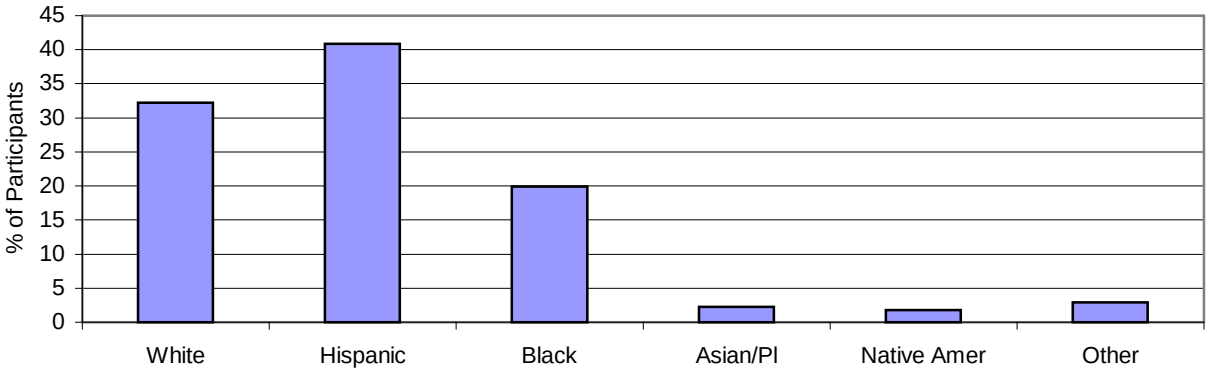
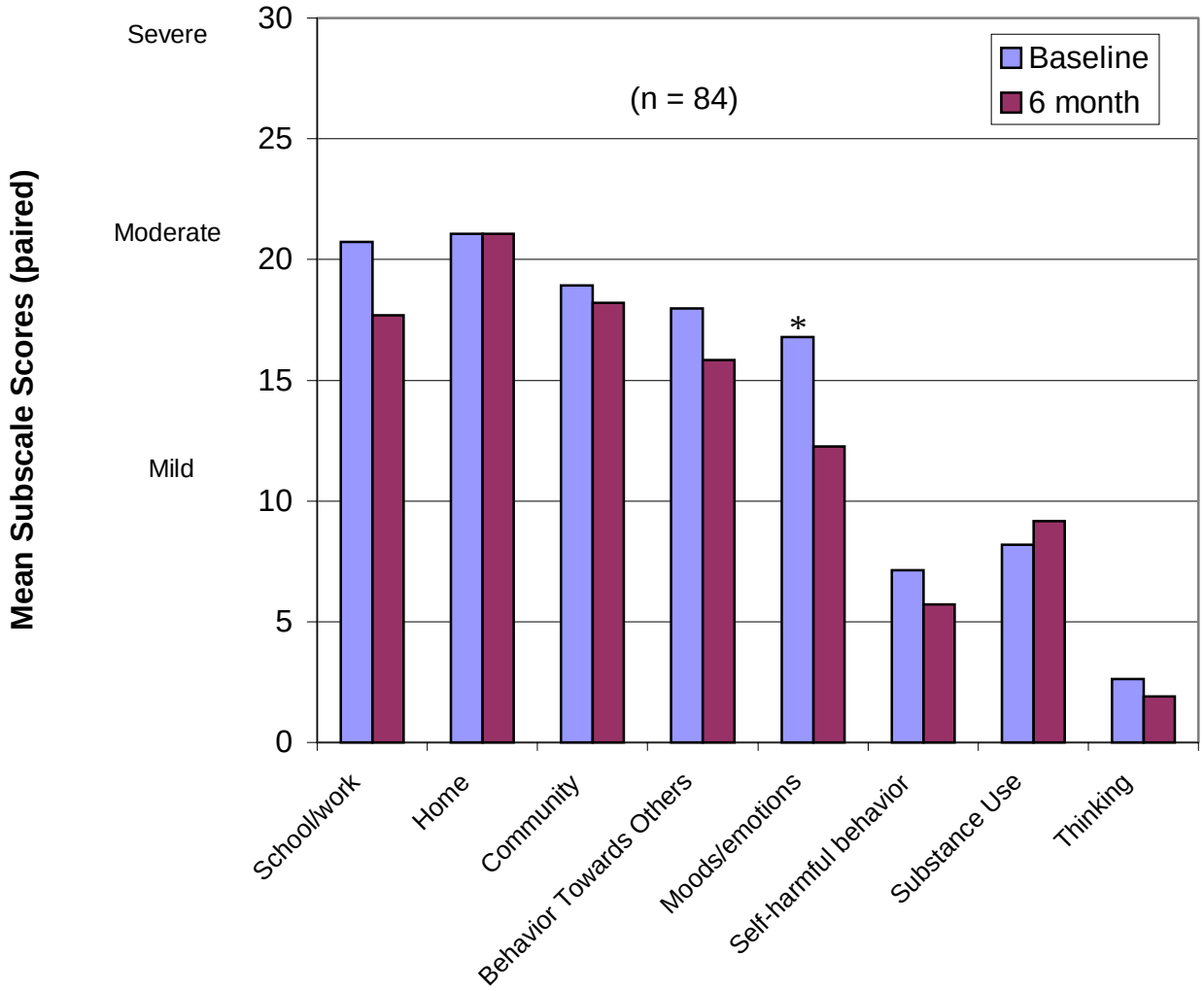


Figure 32: **ISEP CAFAS: Total Functional Impairment at Baseline and 6 Months**

The CAFAS is a functional impairment measure completed by a trained interviewer. Higher scores represent more problems in child functioning. "n" equals the number of children and youth who had measures at two time points. Subscales range from 0 – 30.

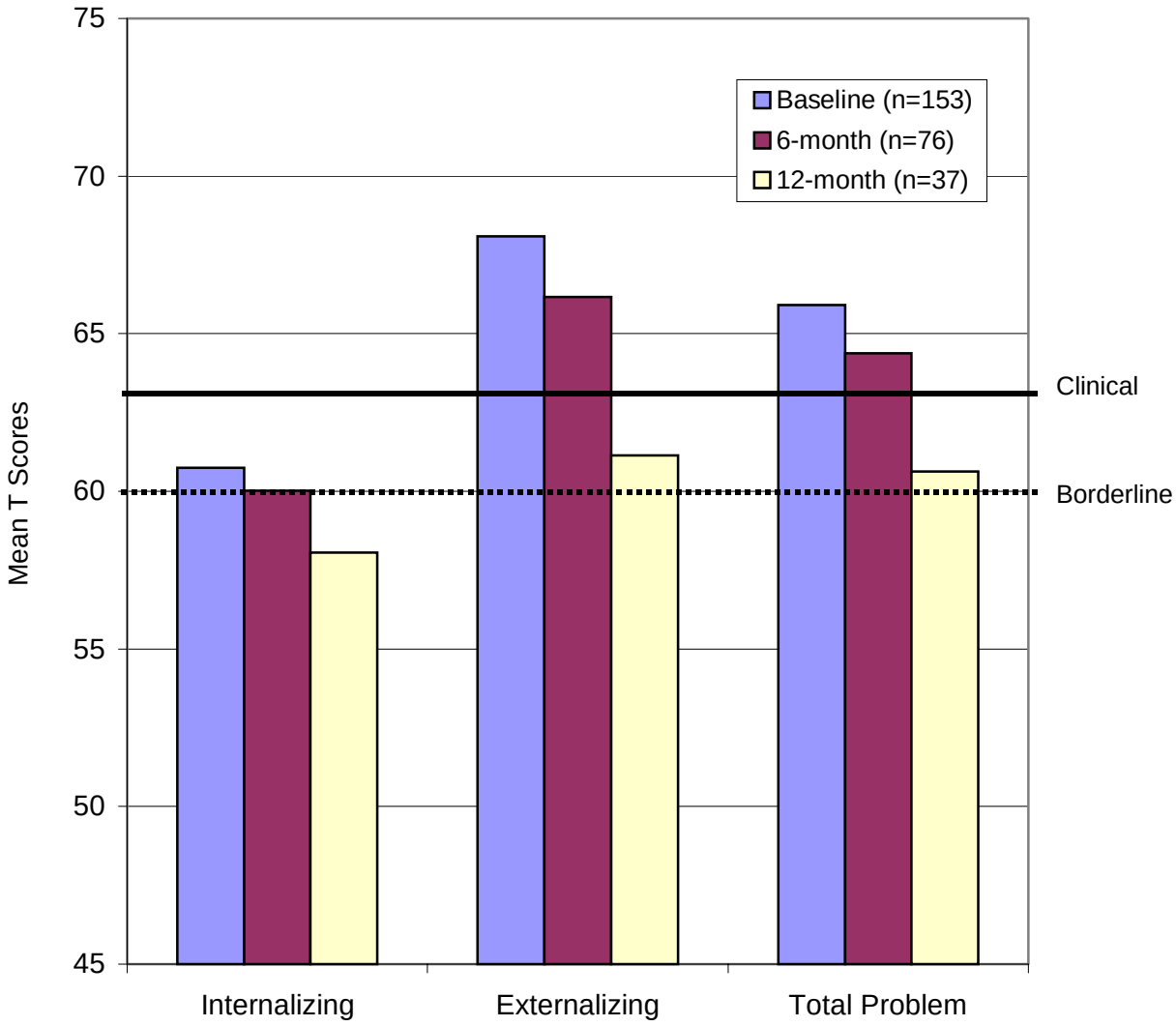


- There is a general trend of improved (lower) scores on all subscales, with the exceptions of home role performance and substance use.
- The improvement on the moods/emotions subscale is statistically significant.

* Indicates statistical significance.

Figure 33: **ISEP: Child Behavior Checklist (CBCL)**

The CBCL is an emotional/behavioral problems measure completed by interviewing the parent or caregiver. "n" values refer to the number of caregivers for which there was data at each time point.

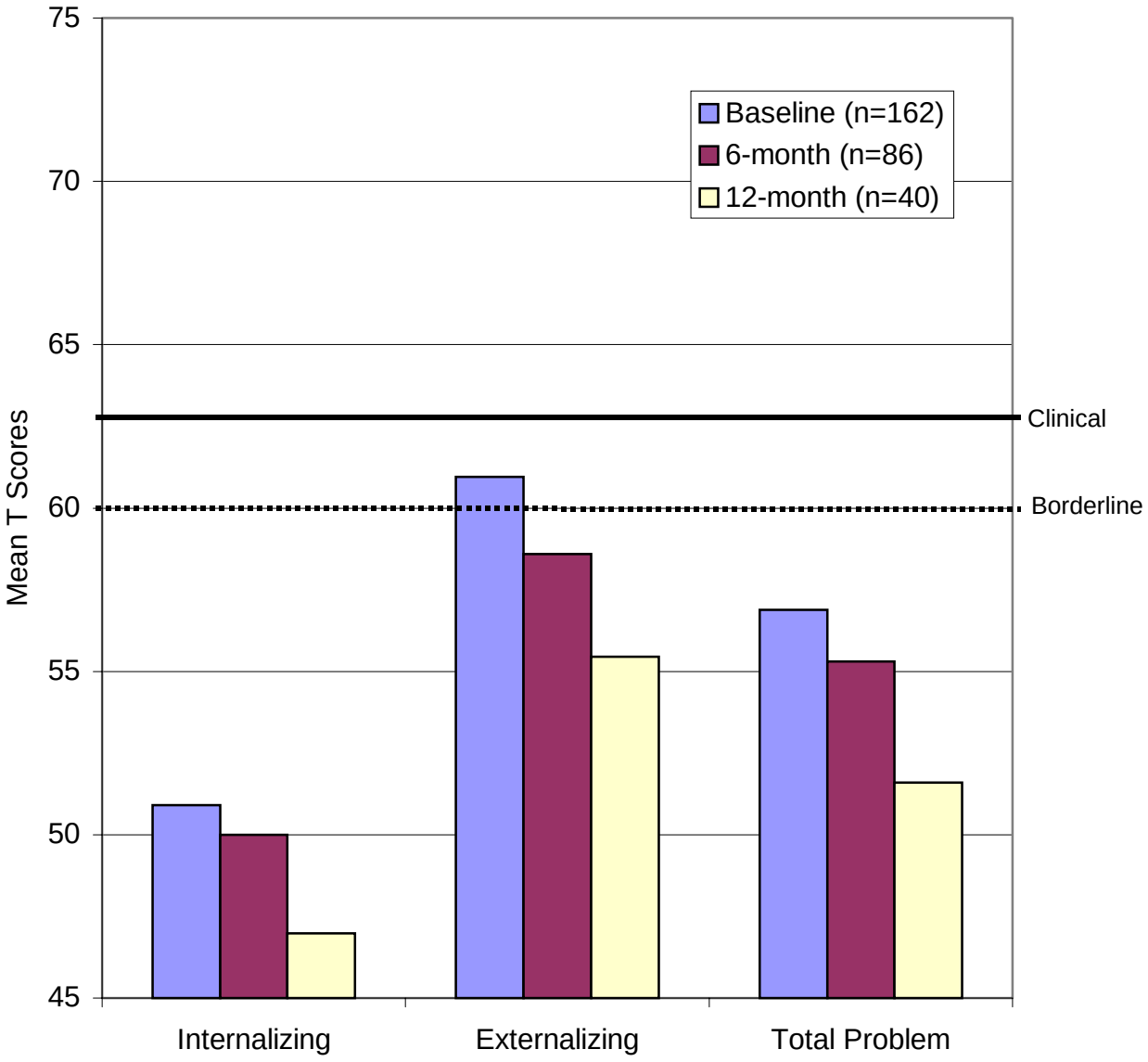


- There are similar trends of reduction in caregiver-reported internalizing behavior, externalizing behavior, and total problems over the three time points.
- These trends are similar to those reported by youth (see Youth Self Report graph), although caregivers generally assign somewhat higher scores to youth than the youth assign to themselves.

*Note: Mean baseline T scores of participants who had measures at 12 months were not significantly different from those of other participants.

Figure 34: **ISEP: Youth Self-Report (YSR) Scores**

The YSR is an emotional/behavioral problems measure completed by interviewing the youth (11-18 yrs) at baseline, 6 months and 12 month time points*. "n" values reflect the number of youth who had YSR measures at each time point.

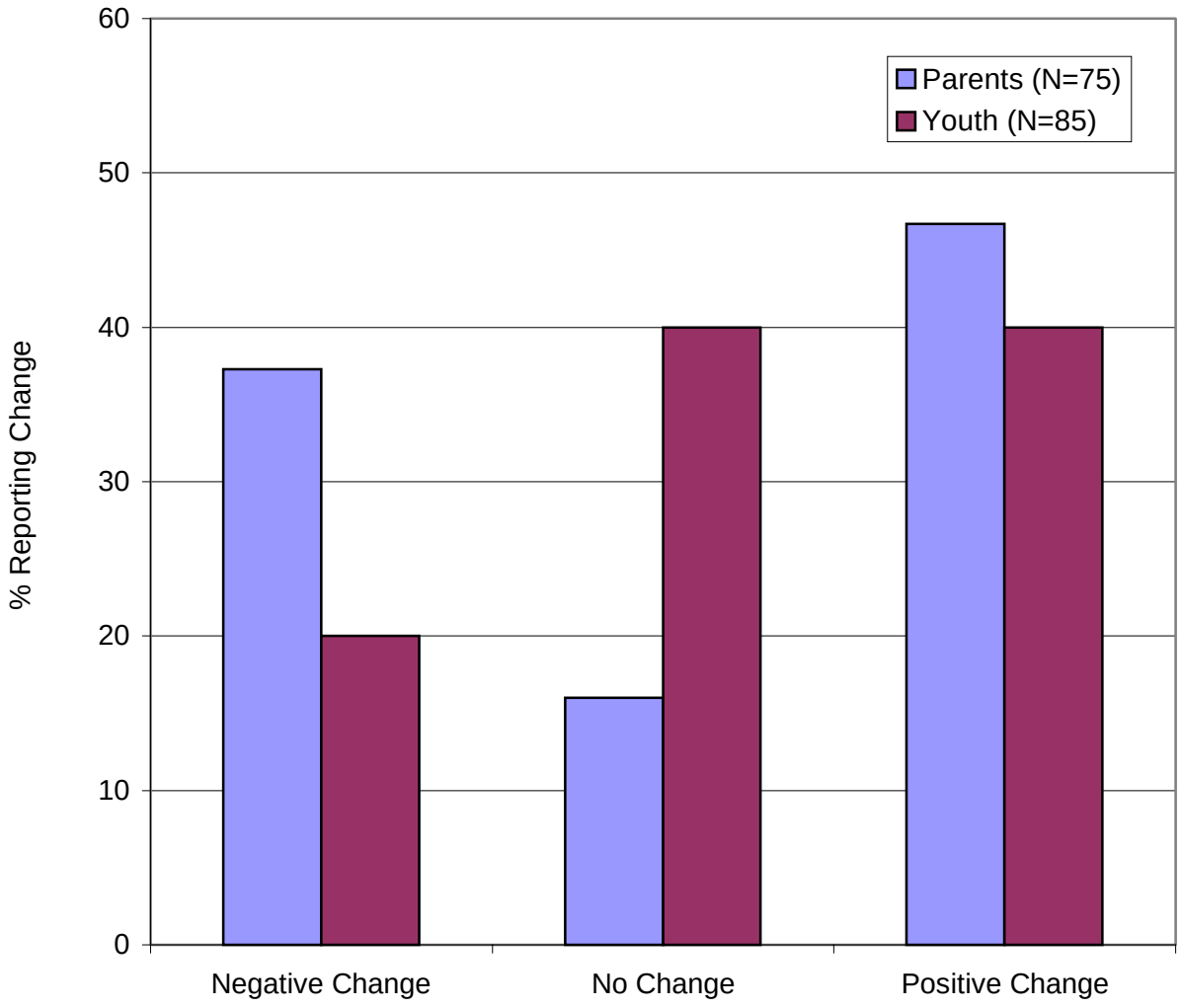


- There are similar trends of reduction in self-reported internalizing behavior, externalizing behavior, and total problems over the three time points.
- There is a statistically significant improvement from baseline to 1 year for internalizing, externalizing, and total problems.

*Note: Mean baseline T scores of participants who had measures at 12 months were not significantly different from those of other participants.

Figure 35: **ISEP: Assessments of Change, Baseline to 6-month – Total Problems**

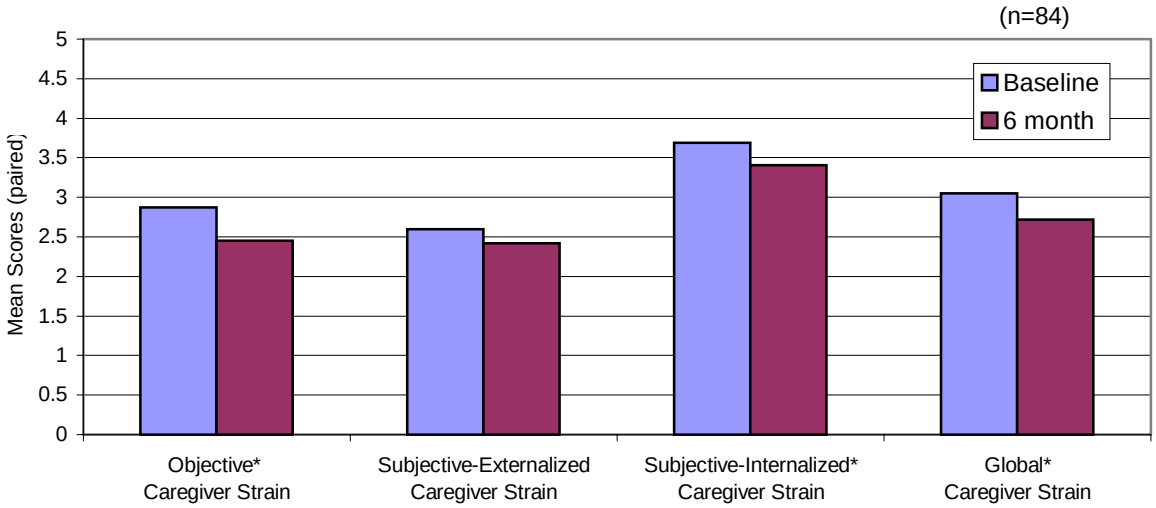
Emotional/Behavioral Problems were represented by interviewing **parents** (measured by Child Behavior Checklist) and by interviewing **youth** (measured by Youth Self Report) at baseline and 6 months. Change scores are defined as greater than a 3-point change on CBCL and YSR.



- Parents reported slightly more "positive change," significantly less "no change," and significantly more "negative change" than youth reported.

Figure 36: ISEP: Caregiver Strain Questionnaire (CGSQ)

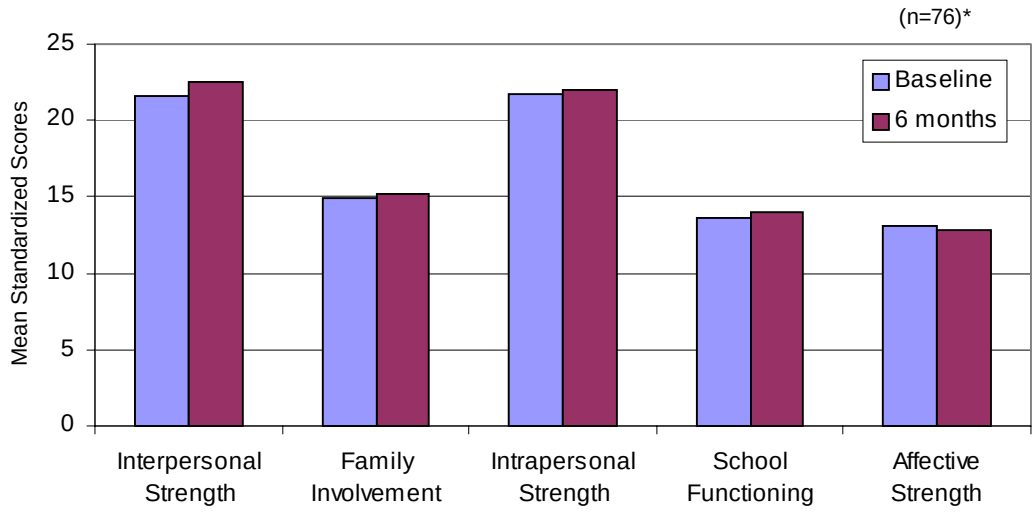
The CGSQ assesses a family's special demands associated with caring for a youth with SED completed by interviewing the caregiver. "n" reflects the number of caregivers who had CGSQ measures at both time points.



- Statistically significant decreases were observed for objective, subjective-internalized and global measures of caregiver strain between baseline and 6 months. The decrease in subjective-externalized caregiver strain approached statistical significance.

Figure 37: ISEP: Behavioral and Emotional Rating Scale (BERS) Subscales

BERS is a strength-based measure of youth behavior completed at baseline and 6 months by interviewing the caregiver. Higher values indicate more positive/constructive behaviors. "n" reflects the number of youth who had measures at both time points.

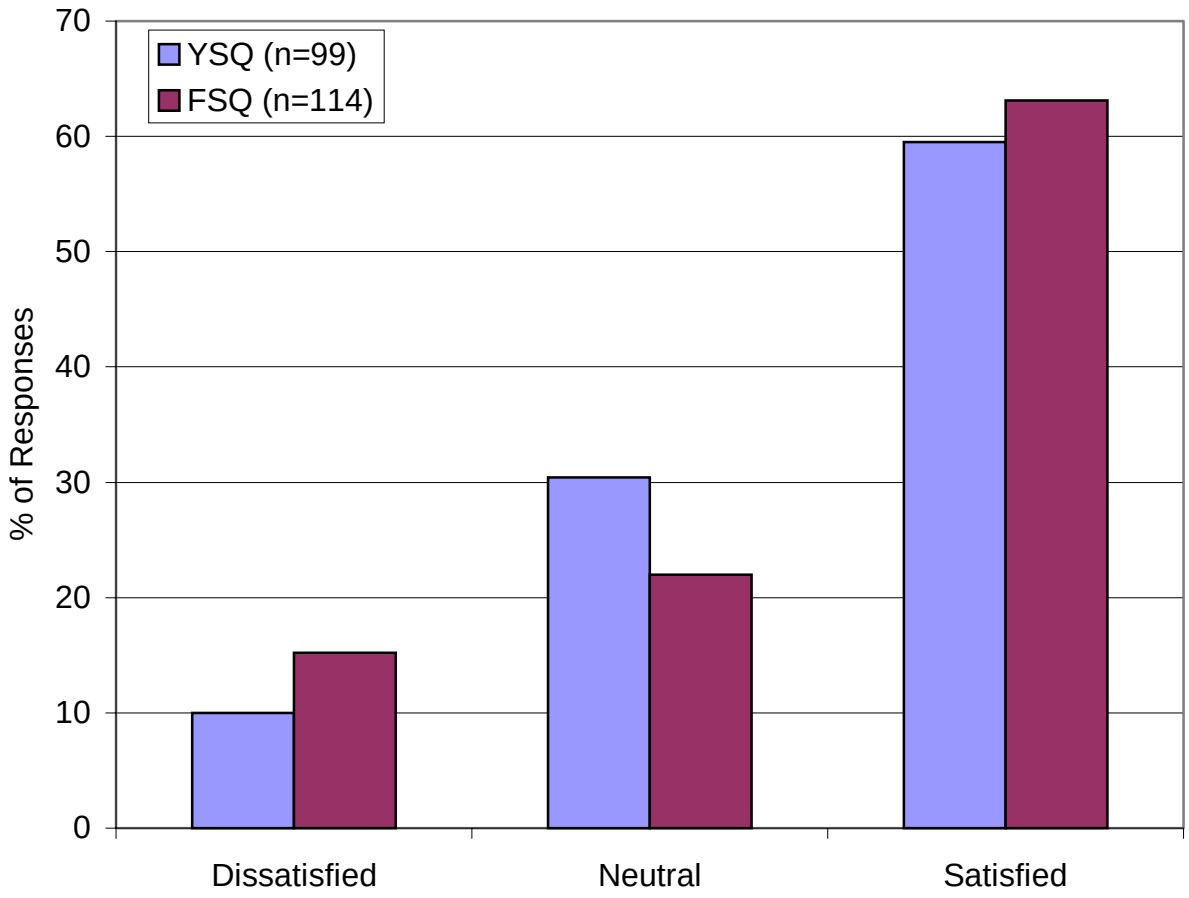


- Although none of the observed changes on the BERS subscales were statistically significant, there is a general trend towards slight improvement on each subscale between baseline and 6 months, with the exception of Affective Strength.

*Note: n=59 for school functioning subscale.

Figure 38: **ISEP: Youth & Family Satisfaction, 6 months**

The Youth Satisfaction Questionnaire (YSQ) and Family Satisfaction Questionnaire (FSQ) are comparable measures of satisfaction with mental health services. The measure is a 5-point scale ranging from “very dissatisfied” to “very satisfied”. "n" refers to the number of respondents for each measure.

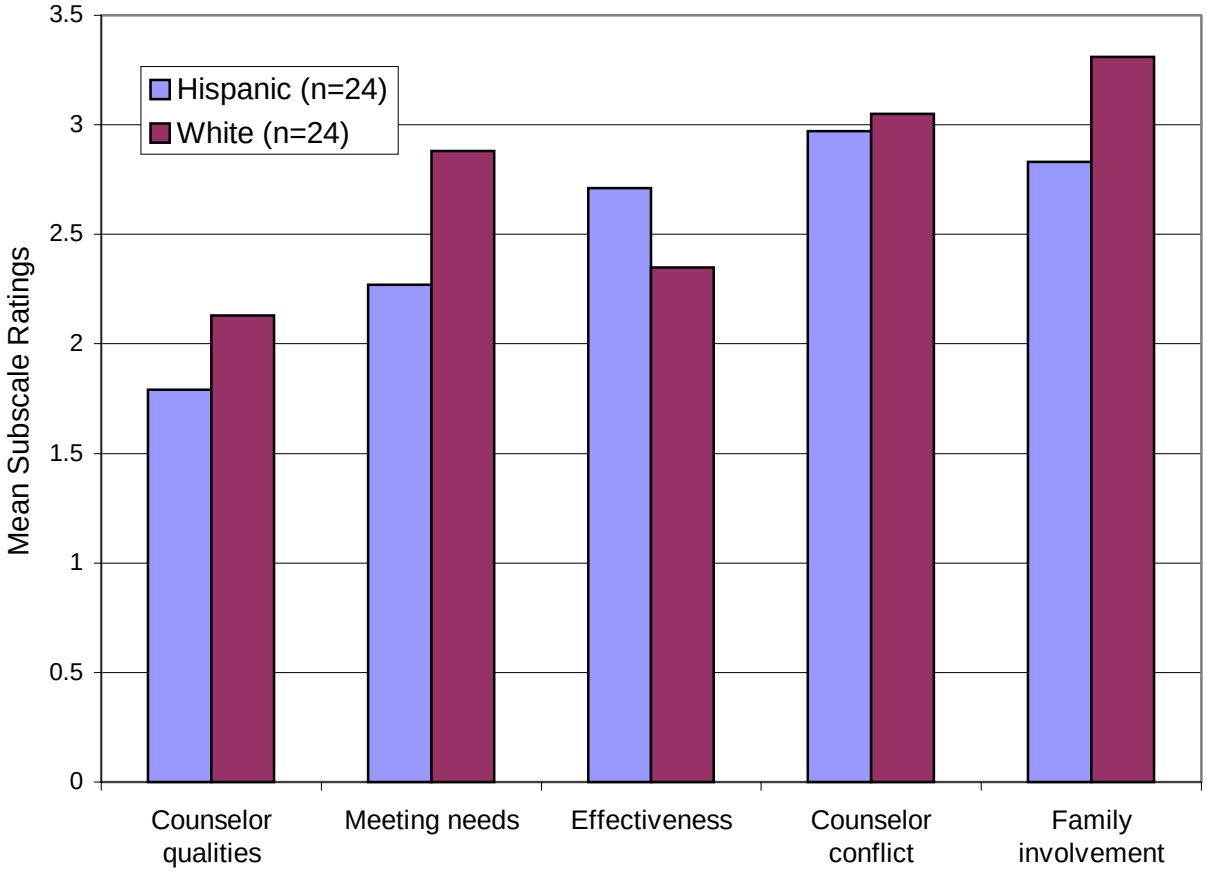


- For youth and caregivers, the percentage of respondents reporting "satisfied" or "neutral" evaluations of services at 6 months is significantly greater than the percentage reporting that they were "dissatisfied" with services.

- Although the differences were not statistically significant, youth reported a higher percentage of "neutral" evaluations of services than caregivers. In turn, compared to youth, caregivers reported both more "satisfied" as well as more "dissatisfied" evaluations of services.

Figure 39: **Multidimensional Adolescent Satisfaction Scale (MASS), 6-Month Indications of Difference by Race/Ethnicity**

The MASS scale measures youth satisfaction with counseling services. The two largest ethnic/racial groups: Hispanics and Whites are presented. "n" refers to the number of participants in each group.



- Hispanic participants had distinct pattern of responses on the MASS when compared to the White racial/ethnic subgroup.
- With the exception of “effectiveness," the responses of Hispanics are generally lower relative to the responses of Whites, suggesting less satisfaction with counseling.
- Lower Hispanic ratings for "meeting needs" and "family involvement" closely approach statistical significance, as does the higher Hispanic rating for "effectiveness".

System Outcomes

One of the important goals of the State funded System of Care Program (AB3015) is to measure whether different types of interventions with children and families can have impacts on other parts of the child-serving system. The potential areas for capturing system data are: state hospital, inpatient, and group home costs and utilization.

The area San Diego County Children's Mental Health has had the most impact has been in the reduction of State Hospital utilization. This has been a primary target for improvement in CMHS with the implementation of the System of Care in San Diego. The establishment of the Community Intensive Treatment for Youth (CITY) program in July 1997 was aimed at reducing utilization of the State Hospital. The primary concern was that the State Hospital was not located in the county. Therefore, there was little opportunity to transition children and youth into more normalized environments and there was difficulty in maintaining family and community ties. Figure 40 reflects the dramatic decrease in State Hospital costs and utilization, with an 87% reduction in costs and 100% reduction in utilization. (Costs can never completely be eliminated due to the need to have access to the State Hospital by purchasing a minimum of one bed at the beginning of the fiscal year, by contract.)

Acute inpatient hospitalization cost and utilization is another goal for careful monitoring and maintenance within the mental health system. This is a very expensive and restrictive service with a significant budgetary impact. Beginning in January 1996, the county managed acute inpatient facilities under two different funding sources: 1) CAPS, a contracted program with UCSD Child and Adolescent Psychiatric Services (CAPS) for a fixed number of beds, and 2) Medi-Cal, a fee-for-service program with various psychiatric hospitals with a fixed daily rate. Figure 41 demonstrates both the County costs and utilization for inpatient care for children and adolescents over the last four years. In general, costs and utilization have remained fairly stable until this last year. In FY99-00 a concerted effort to maximize utilization of the "fixed" bed contract with UCSD has resulted in a 13% increase in utilization, with only a 2% increase in cost. Medi-Cal utilization of inpatient has increased 21% over the course of the last year. This was probably due to a number of factors. Population growth for minors in San Diego County increased to approximately 1,500. Subsequently, uninsured populations for health care for the working poor also increased which can have an effect on Medi-Cal eligibility, therefore utilization. The 2% increase in the utilization of administrative bed days reflect an increase in the number of youth awaiting group home/residential treatment placements while in the hospital. This suggests that there were an insufficient number of group homes available to San Diego County youth. This effect is further substantiated by the number of dependent youth awaiting placement at Polinsky.

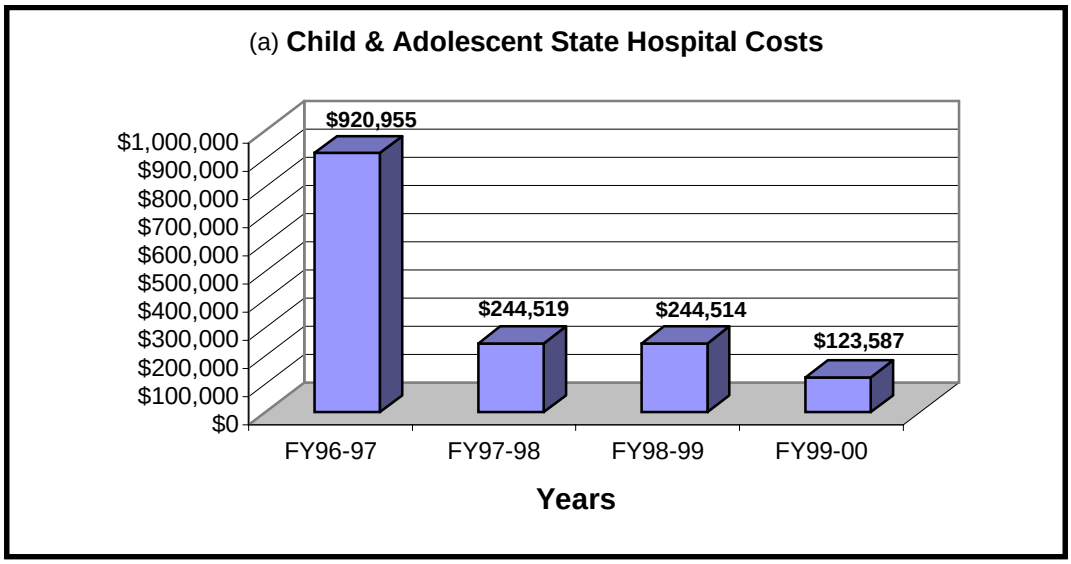
Figure 42 shows that Group Home/Residential placements and costs have risen over the last 3 years but appear to have stabilized in the last year. Over the three-year period, placements have risen 9%, while costs have risen 21%. The differential is primarily related to rate increases in FY98-99 for group home providers related to the cost of caring for youth in these 24-hour settings. In the past year, the change in costs and utilization has been only 3.1% and 1.2% respectively. This indicates a slowing of growth for these indicators. It is noted from the inpatient utilization data that the lack of growth in the availability of group home beds may be backing up the inpatient and shelter care (Polinsky) systems. Different from the FY98-99, in FY99-00 CPS has decreased placements and Probation has increased placements. Both CPS and Probation have increased costs. This is due to the increase in fees both programs experienced in FY99-00 related to serving all youth within the state (prior usage of out-of-state placements were less expensive).

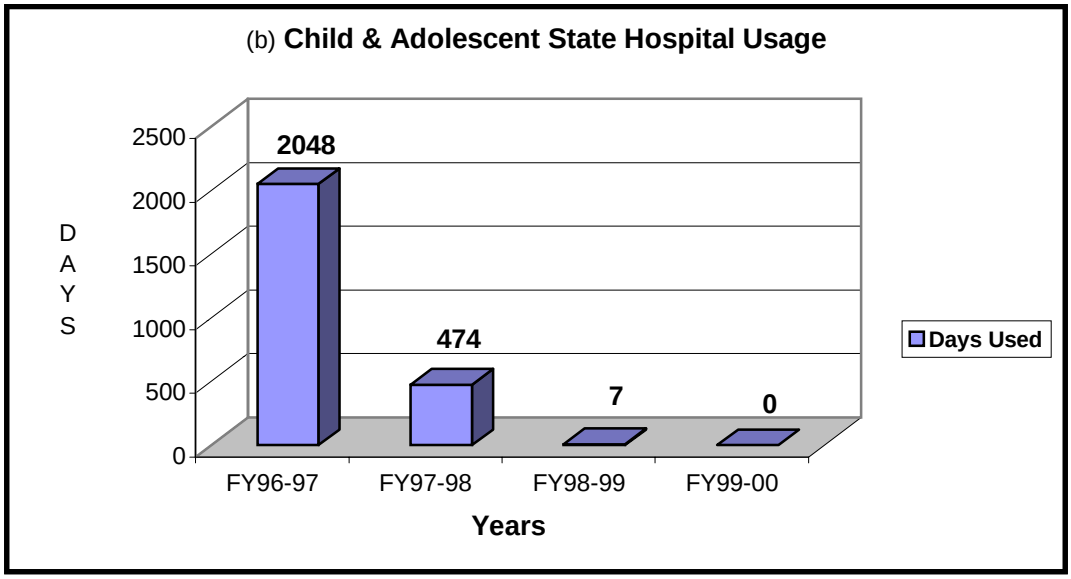
AB2726 data show a different pattern. AB2726 has decreased cost and increased placements in 99-00. The decreased costs may be the result of out-of-state placements in which the costs are not recorded in this database, therefore, showing a reduction in the amount spent for placements.

In comparing SD county expenditures and placements to the State (Figure 43), SD County was 11% below the statewide average expenditures and 16% below the statewide average number of placements at the end of FY99-00. Note: SD County does not report FFA as Group Home data.

Figure 40: **State Hospital Costs and Usage by Fiscal Year**

The state cost is the amount contracted for usage. The days used is the actual number of bed-days utilized by children and adolescents from San Diego County. A contract is required and signed at the beginning of the fiscal year to pay for beds regardless of usage. San Diego County purchased one bed (the minimum) for fiscal year 99-00.



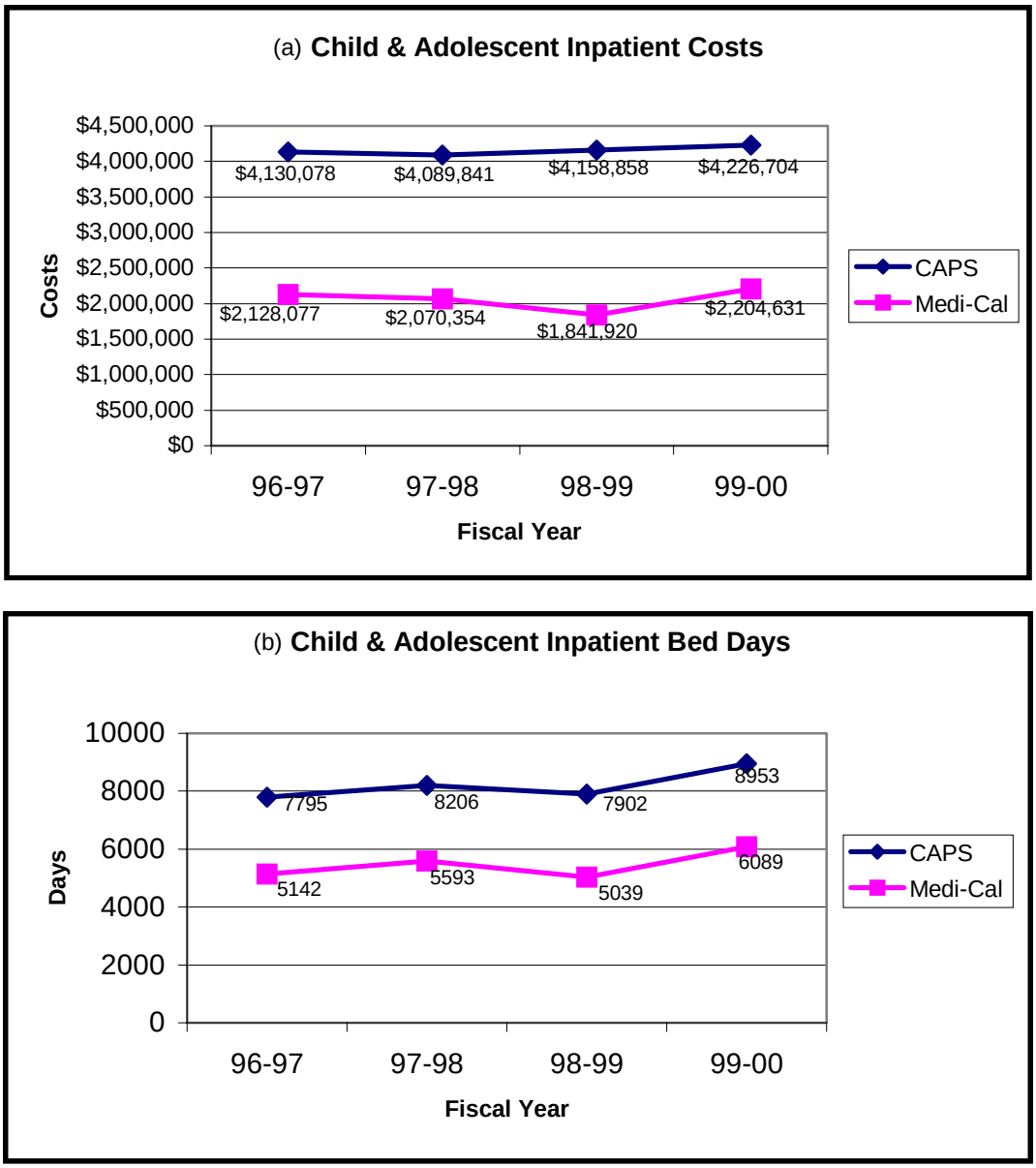


- This shows an overall 87% reduction in State Hospital costs, and 100% reduction in State Hospital bed days used, between FY96-97 and FY99-00.

- This was accomplished with the implementation of the C.I.T.Y. program, which transitioned youth from the State Hospital to a local intensive case management program with "wraparound services."

Figure 41: **Inpatient Costs and Bed Days by Fiscal Year**

The costs are the amount for acute inpatient days and the number of days is the beds used in acute inpatient units for children and adolescents. There are two different funding sources: CAPS is the contracted program for a fixed number of beds, and Medi-Cal is a fee-for-service program with various psychiatric hospitals with a fixed daily rate.



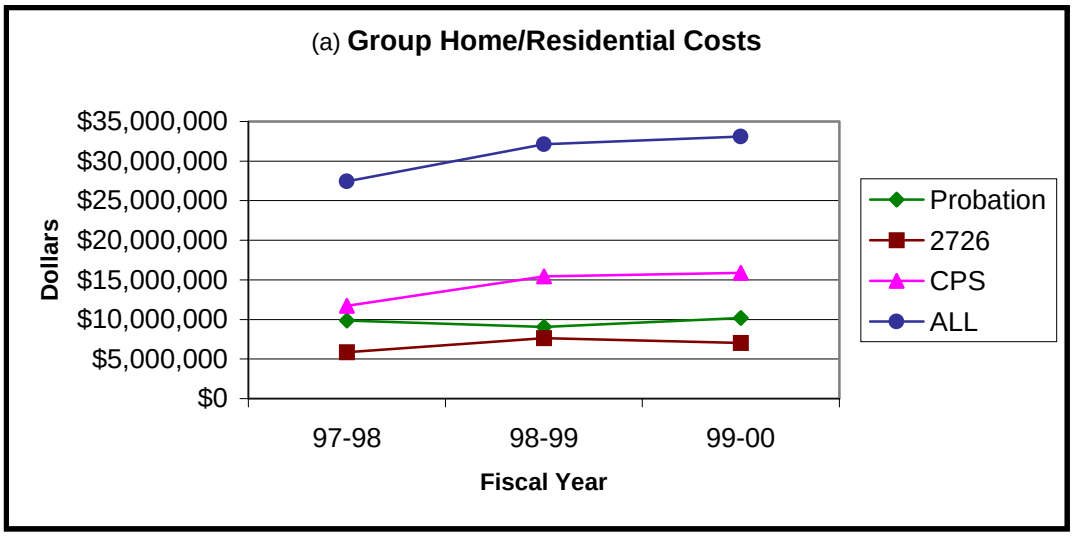
- This shows a 13% increase in the number of acute inpatient bed days utilized by the CAPS program, with a 2% increase in cost, between FY98-99 and FY99-00.

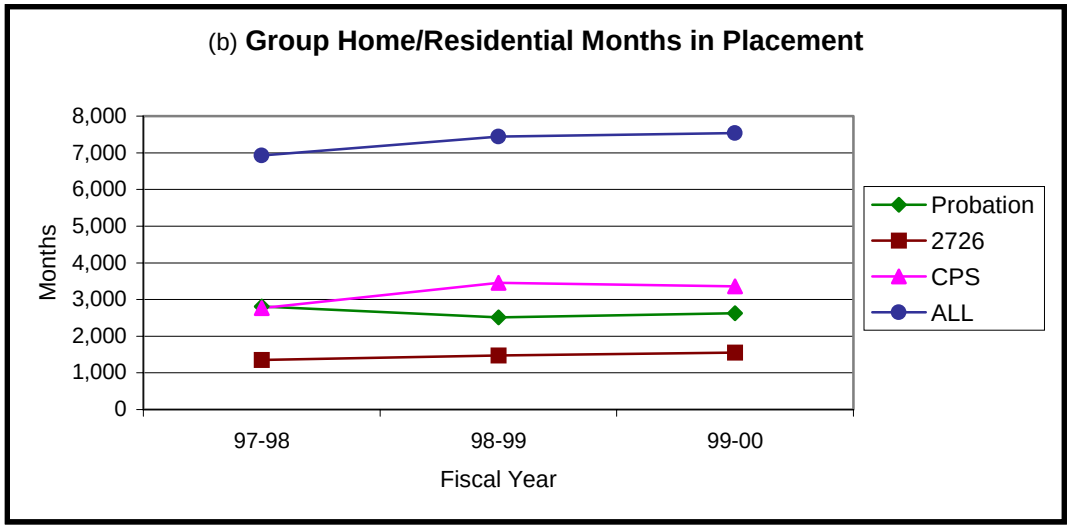
- This shows a 21% increase in the number of acute inpatient bed days utilized by the Medi-Cal program, with a 20% increase in cost, between FY98-99 and FY99-00.

- 2% of the increase in cost between FY98-99 and FY99-00 for the Medi-Cal program was due to increases in the administrative bed day rate.

Figure 42: **Group Home/Residential Costs and Months in Placement by Fiscal Year**

The costs are the amount paid for group home/residential care and the months are number of months in placement for San Diego County children and adolescents. The lines indicate the placing county department: Probation, 2726, Child Protective Services (CPS), and All departments together.





- This shows a 21% overall increase in the costs for group home/residential care and a corresponding 9% overall increase in the number of months in placement utilized by San Diego County children and adolescents between FY 97-98 and 99-00.

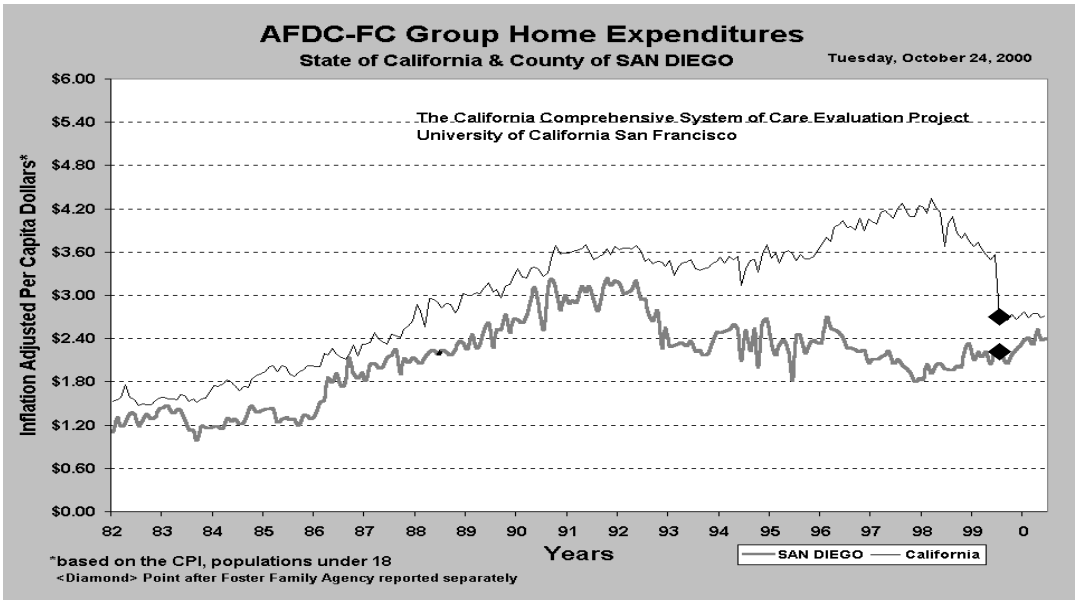
- Over the three-year period, the overall changes in costs and placements per department were as follows:

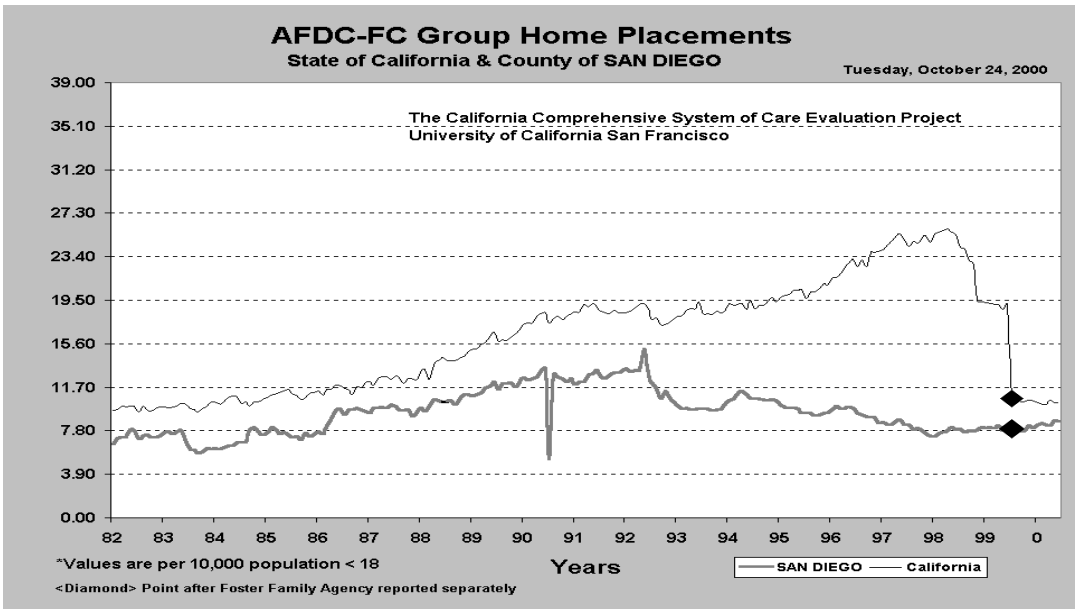
  - Probation costs increased 3.6% while placements decreased 6.5%
  - 2726 costs increased 20% and placements increased 15%
  - CPS costs increased 36% and placements increased 21%

- This shows that the cost increase (since months in placement also increase) is not due to cost of service increases alone.

Figure 43: **Group Home Expenditures and Placements by Fiscal Year**

The group home expenditures are per population, and the numbers of placements are per 10,000 population, for San Diego County and for the California statewide average. The years represented are from 1982 through 2000.





- The sharp drop on these graphs in July 2000 for California is due to the state removing Foster Family Agency (FFA) payments from the Group Home data. Counties were reporting this information differently, some as Group Home and some as Foster Care. All counties now report it separately. San Diego County never reported it as Group Home data.

- The removal of the FFA cost shows that the earlier large difference between San Diego County and the statewide average was significantly due to this anomaly.

- San Diego County was 11% below the statewide average expenditure and 16% below the statewide average number of placements at the end of June 2000.

Future Directions

The "System of Care" (SOC) for children and adolescents in the County of San Diego continues to grow as new funding is received and innovative services are built and expanded. It is expected that these new programs will allow the County to provide services to more youth and to provide more intensive and appropriate services to children and adolescents in the least restrictive environment.

Most recently the implementation of the Children's Mental Health Initiative has occurred in Winter 2001. This program (primarily funded under SB163) allows for youth to be served in their local communities with an intensive array of "wraparound" services. The goal is to provide sufficient services to be able to maintain youth in their own homes and communities, rather than place them in more restrictive out-of-home treatment settings. While this program has been partially implemented in the 2000 year through the Wraparound Laboratory described in the report, the program is now being fully implemented with the goal to serve more than 200 children and adolescents.

Additionally, the County is in the process of expanding its SOC through increased funding from the State AB3015. This expansion will be targeted to school sites that serve seriously emotionally disturbed children and adolescents through the provision of school-based outpatient services. This expansion will provide services to 35 school districts serving approximately 370 additional children and adolescents.

Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funds have allowed for expansion of services for many more at-risk children and adolescents in order to help prevent more serious problems from developing down the road. This service expansion has occurred primarily in the 2000-2001 fiscal year with an emphasis on expanding services to schools, underserved populations and communities, Probation Wards and CPS Dependents. Approximately 28 million dollars has been contracted in several phases to allow for this expansion. Approximately ten new organizational providers have been added to the CMHS cadre of providers, more than 20 new programs/program sites have been added and school-based services are now available in a multitude of school sites, approximately 182 schools, through the expansion of both existing and new providers. This particular expansion should have a dramatic effect on the number of youth served through CMHS over the next two years.

Also, the Wraparound Training Academy was established to train a cross-section of professional and paraprofessional staff in new and creative intervention strategies in order to successfully reach more families and youth in the community. The focus of their service is to integrate the family into services and build upon their strengths and empower them to overcome difficult issues. This "partnership" focus with families is aimed at strengthening the delivery of mental health services by using the "best" of families, children and adolescents, community supports and professionals to accomplish the treatment goals and plans of each individual child or adolescent. This model focuses on creating a "team" that coordinates and plans for services youth need to ensure that all participants are headed in the same direction.

As more youth are served by the system of care and data are collected, there will be increased opportunities to examine group differences in patterns of improvement and to evaluate how these new strategies and interventions make a difference. There will be opportunities for linking service utilization with outcome data to further examine how length of stay and dosage affects outcomes. Data will be available to compare various programs and types of services. Efforts to examine the affects of client characteristics with service usage and outcomes will be more successful as numbers increase. Such analyses require a larger number of youth with data at multiple time points for meaningful comparisons. Lastly, there will be more opportunities for meaningful comparisons of youth over time and across cohorts as the sample sizes increase.