

Child and Adolescent Services Research Center



County of San Diego
Health & Human Services Agency

Children's Mental Health Services



Third Annual System of Care Report

Cumulative Data
1996-2001

Board of Supervisors

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

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An appreciation to all the staff, youth and families who committed their time to complete all of the evaluations that were necessary to accomplish this report.

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

We would like to give recognition and thanks to our artist- Julia Chang, age 10, for specially creating the art for our cover.

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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

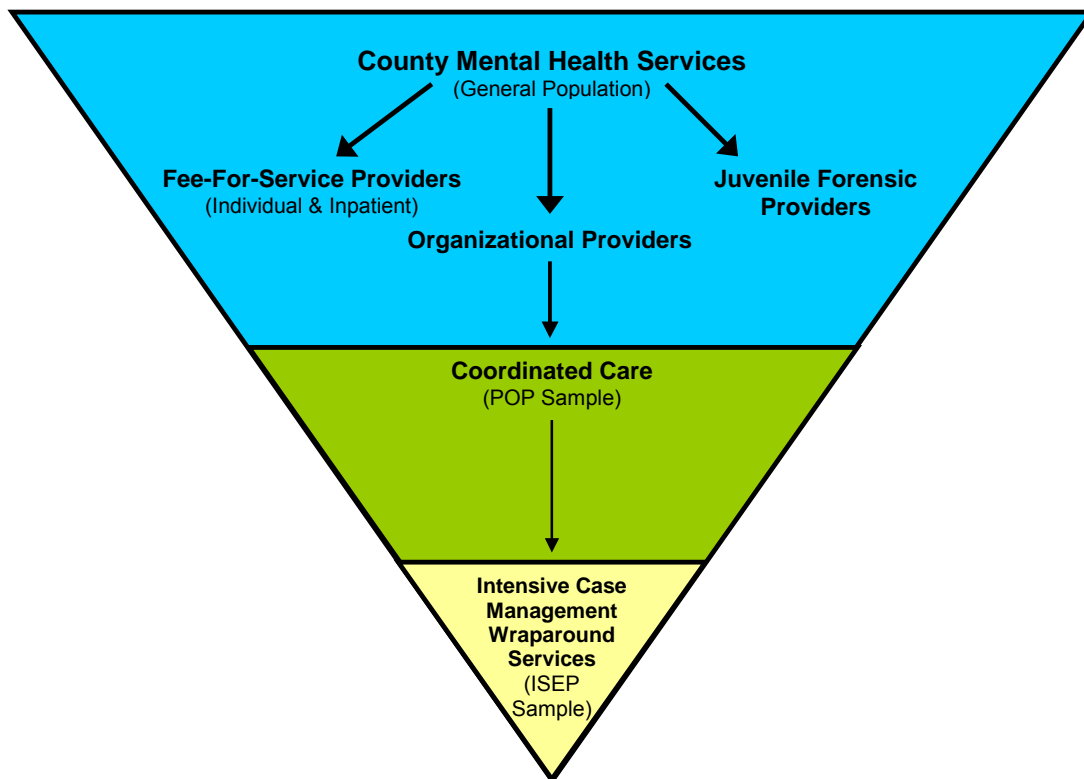
- * 15,025 youth (unduplicated client count) were provided mental health services in 2000-2001. A 14% increase from the previous year and a 34% increase from 1996-1997.
- * The majority of youth are males (64%) and are 13-17 yrs old (51%) in the youth general mental health system (GMHS). However, each year more youth 6-12 yrs old (38% in FY00-01) are receiving services.
- * The youth served are from diverse backgrounds with Whites and Hispanics being the largest race/ethnic groups (42% W & 31% H) in GMHS. Hispanics surpass Whites in percentage of youth completing POP assessments (38% H & 36% W) in FY00-01. Whites are the largest group in the ISEP sample (39% W to 34% H).
- * There is significant overall improvement in youth functioning and symptoms during treatment according to the parent at each time point; intake-6 months, intake-1 year, intake-2 year, intake-3 year. There is overall improvement in youth functioning and symptoms for 3 out of the 4 time points according to the clinician and youth.
- * Repeated measures show continuous improvement for youth from intake to 6 months to 1 year according to all informants: clinicians, parents and youth. However, according to parents, the average severity of behavior problems at 1 year is still within the clinical impairment range.
- * Parents of youth in the ISEP sample report significantly less objective, subjective-internalized, subjective-externalized and global caregiver strain at 1 year follow up.
- * Parents generally report high satisfaction 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 00-01.
- * Group Home costs are approximately 24% below statewide average and the number of placements are approximately 5% below statewide average at the end of the year 2001.

Introduction

The San Diego County Mental Health Services (CMHS) primarily serves children and adolescents ranging in age from 1-18 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 approximately 779,177 in 2001 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, 2001.

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 Children's Mental Health Initiative project primarily funded from SB163 and conducted by the Child, Youth and Family Network (CYFN) 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 three service systems: mental health/education (AB2726), social services 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 eight 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 2001. 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, 1999-2000 and 2000-2001. 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, "Clinical Outcomes," contains longitudinal outcome data for the POP sample 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 1997-2001 fiscal years, reporting follow-ups that range from 6 months to 3 years. Service satisfaction data for the mental health services is also reported.
- 4) The fourth section, "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT), includes summaries and outcome information for the county's EPSDT service programs. This data is presented in comparison with the POP sample.
- 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 four intensive service programs for youth in or at risk for restrictive placements: TOWER, CITY, BEST and CYFN. The data presents types of services received, demographics, clinical outcomes and quality improvement indicators such as quality of services and satisfaction data.
- 6) The sixth section "Supplementary Outcomes" reports on data associated with mental health improvements: substance use, recidivism and school achievement. This data is presented on youth in the ISEP population and/or youth involved in the juvenile justice system.
- 7) The seventh section "System Outcomes" reports system level data on issues such as costs and service use patterns for each fiscal year.
- 8) The final section "Future Directions" discusses new developments and proposed data analyses in the upcoming years for the county's Children's Mental Health Services.

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 2001. 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 3 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 INITIATIVE). 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 four (pg. 19) for descriptions of the measures. The intensive wraparound programs have additional parent and family measures. Refer to section seven (pg. 51) 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, 1999-2000 and 2000-2001. 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, 1999-2000 and 2000-2001. Note, the assessments for the 1998-1999 year began in April 1999; therefore, this year represents 6 months of data.

Participating Programs

Table 1 (pg. 7) 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.

Regional Divisions

San Diego County is divided into six regions: 1) North Central (i.e. La Jolla, Linda Vista, Mira Mesa, Miramar, Tierrasanta), 2) Central (i.e. Downtown, Encanto, College Grove, Paradise Hills), 3) South (i.e. Chula Vista, San Ysidro, Coronado, Imperial Beach), 4) East (i.e. El Cajon, Alpine, Campo, Spring Valley, La Mesa, Jamul), 5) North Coastal (i.e. Carlsbad, Oceanside, Rancho Santa Fe, Oceanside) and 6) North Inland (i.e. Escondido, Julian, San Marcos). The majority of programs are located in the North Central region (36%). The other regions have similar percentages of POP programs: 17% in South, 13% in Central, 13% in East, 13% in North Inland and 8% in North Coastal. The youth who participated in the POP program live in all areas of the county. The distribution is fairly equal in size with 21% of youth living in Central region, 19% in North Central and South, 17% in East, 14% in North Inland areas and 10% in North Coastal region.

Data Processed to Date

Figure 2 (pg. 11) presents the number of performance outcome assessments processed for each fiscal year since the requirement started in July, 1997. Note that the number of assessments processed per year increased dramatically in the first two years and has increased substantially during the most recent year 00-01. The number of intakes and follow ups continue to increase each year.

Figure 3, presents the number of completed baselines in the Intensive Services Evaluation Project that were completed for all the fiscal years by program and the number of completed 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 1,610 youth entered CC and 57.5% completed POP assessments. In the 1998-1999 fiscal year a new system, Management Information System (MIS) was established in which the United Behavioral Health began organizing 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. There was, however, an increase in the number of new youth to the system during this year. In the 1999-2000 fiscal year 1,919 youth entered CC and 65.8% completed assessments and in the 2000-2001 fiscal year 2,720 youth entered CC and 64% completed POP assessments.

Performance Outcome Project

Is the POP sample representative of the larger coordinated care group? After examining the most recent fiscal year, 2000-2001, the POP sample is representative for males and females as expected. Children 4-5 years old are slightly over-represented (6.7% POP vs. 3.5% county) while the other age ranges are represented as expected. There is some variation by race/ethnicity as well. African Americans, Asian American/Pacific Islanders and Native Americans are represented as expected yet Spanish/Hispanics are over-represented (35% POP vs. 29% county) and White youth are under-represented (39.7% POP vs. 44.4% county).

Intensive Services Evaluation Project

Is the ISEP sample representative of all the youth receiving intensive services? Eighty-six percent of families of youth receiving intensive services participated in the evaluation project (n=298). Forty-eight youth and families (16%) declined to participate in the evaluation. These youth were similar in age to the interviewed sample primarily 14-17 years old. There were slightly more younger youth in the interviewed sample. Thirty-three of the youth were male (68.8% vs. 68.5% in interviewed sample) and 15 were female. More White youth declined compared to other race/ethnicity groups (n=24, 50% vs. 40% in interviewed sample). Fewer Hispanic and African-American families declined compared to the interviewed sample (27.1% vs. 33.8% for the Hispanic group and 12.5% vs. 18.7% for the African-American group).

Table 1: POP Participating Programs

Program Name	Type	Target Population
Alvin Dunn School	Outpatient School-based	School SED
ALLY National City	Outpatient Clinic-EPSDT	Mental Health
ALLY South Bay	Outpatient School-based-EPSDT	School
ASPEN Community Services	Day Treatment	Mental Health
Building Effective Solutions Together (BEST) *	Intensive Case Management /Wraparound	Mental Health, Probation, CPS
Breaking Cycles	Intensive Case Management /Wraparound	Probation
Cabrillo Day Treatment	Residential Intensive	Child Protective Services
Cabrillo Assessment Center	Outpatient-EPSDT	Child Protective Services
Casa De Amparo	Outpatient-Institution based	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
Child, Youth and Family Network (CYFN)*	Intensive Case Management/Wraparound	Mental Health/Social Services/Probation/Education
Critical Care TBS	Therapeutic Behavioral Services	Mental Health
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
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
Family Health Centers-Central	Outpatient Clinic-EPSDT	Mental Health
Family Health Centers-East	Outpatient Clinic-EPSDT	Mental Health
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

Program Name	Type	Target Population
Lifeschool	Day Treatment	Mental Health – 2726
New Alternatives Cajon Valley	Outpatient School-based	Mental Health/SED
New Alternatives Children's Day Treatment	Day Treatment	Mental Health – 2726
New Alternatives # 16	Residential Intensive	Mental Health
New Alternatives TBS	Therapeutic Behavioral Services	Mental Health
New Alternatives- Transitional Residential Services	Case Management	Child Protective Services
North County Lifeline	Outpatient Clinic	Probation
Palomar Family Counseling	Outpatient Clinic	Mental Health
Para Las Familias	Outpatient Clinic	Young Children
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/School SED
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

Program Name	Type	Target Population
Southbay Community Services	Outpatient Clinic	Probation
Southbay Youth & Family Services -Nueva Vista Family Services	Outpatient Clinic	Mental Health
Southeast Mental Health Clinic	Outpatient Clinic	Mental Health
Therapeutic Services Inc. (TSI)	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
Vista Hill-Central & North Coastal	Outpatient School-based	Probation
Vista Hill-Ramona	Outpatient School-based	SED
Youth Enhancement Services (YES)	Outpatient Clinic	Mental Health

* ISEP Participating Program

Figure 1: Regional Locations of Youth and Programs involved in Coordinated Care POP Program

The shaded areas represent the number of youth living in that zip code that participate in coordinated care and have completed POP assessments. The red push pins represent the location of mental health coordinated care programs.



- The majority of programs, 36%, are located in the North Central region with 17% of the programs in South San Diego, 13% in Central, 13% in East, 13% in North Inland and 8% in North Coastal.
- The percent of youth living in each of the six SD County Regions is the following: 19% N. Central, 21% Central, 19% South SD, 17% East, 14% North Inland, 10% North Coastal.

Figure 2: Performance Outcome Project (POP) Data Processed to Date

POP Assessments Processed Per Fiscal Year by Timeframe

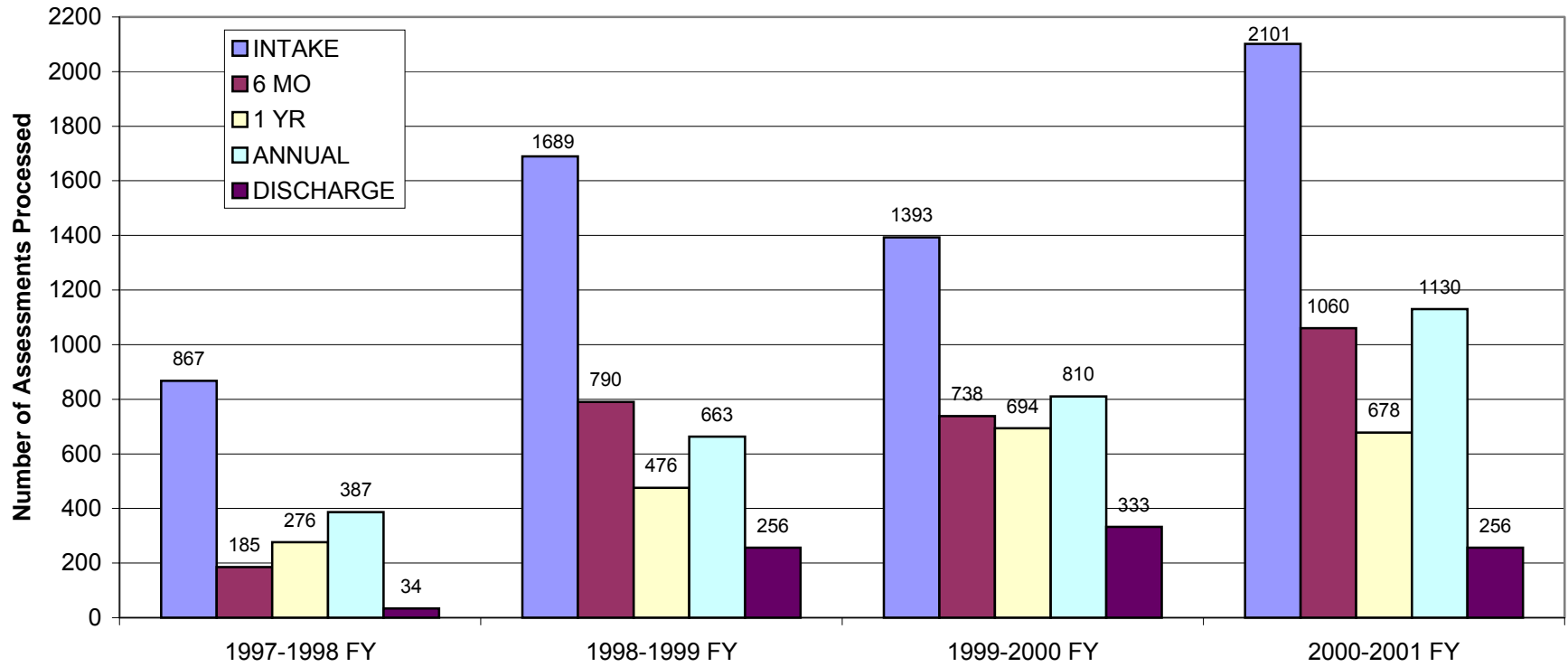


Figure 3: Intensive Services Evaluation Project (ISEP) Assessments Completed to Date

Cumulative Total Number of Completed Baseline Assessments by Agency for Combined Years

98-99, 99-00, and 00-01 Fiscal Years

Agency					
TOWER	BEST	CITY	Lab/WRAP	CYFN	TOTAL
135	66	18	19	60	298

Number of Completed Follow up Assessments as of 9-30-2001

<u>Timeframe</u>	# of Assessments
Completed 6 month Follow ups	162
Completed 12 month Follow ups	144
Completed 18 month Follow ups	90
Completed 24 month Follow ups	40

Note: Follow up assessments are completed as participants reach a given follow up time point.

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 (HHS) or have contracts with HHS 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 4 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: FY 00-01= 15,025; FY99-00 = 13,181; FY98-99 = 13,061; FY97-98 =10,668; and

FY96-97 = 11,228 unduplicated clients. Note that in the 96-97 fiscal year the client counts are elevated due to a more inclusive target population definition. This year included youth from both the state and county mental health populations. Figure 5 shows the breakdown of the number 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: 54% in FY00-01; 53% in FY99-00 and 59% in FY98-99. However, in FY96-97 FFS- Outpatient served slightly more clients (46%) than through organizational providers (41%). This data is reflective of the more inclusive target population definition within the FFS-Outpatient data base during this fiscal year only. Also, 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% and the client counts exceed the total sample size. Figure 6, 7, and 8 show the demographic make up of the entire served population of unduplicated clients. Gender distributions are stable across each fiscal year with a larger percent of males, approximately 65%, than females, approximately 35%, 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 FY00-01. 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% (below Whites at 42%) in FY00-01.

Figure 9 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 a residential mental health services and participate in an outpatient juvenile forensic institution service from 49.8% in FY86-99 to 80.2% in FY00-01. Refer to page 13 for descriptions of the service modalities presented in the table. Furthermore, Figure 10 presents the race/ethnicity distribution in each of the service modalities. This figure demonstrates some variability between services. For example, there are higher percentages of White youth utilizing intensive day treatment and case management services and higher percentages of Hispanic youth using day rehabilitation and outpatient juvenile forensic services. Black and Native American youth are reported in higher percentages in residential mental health services.

Figure 4: Children’s Mental Health System: Unduplicated Client Count Across All Providers and Modes by Fiscal Year

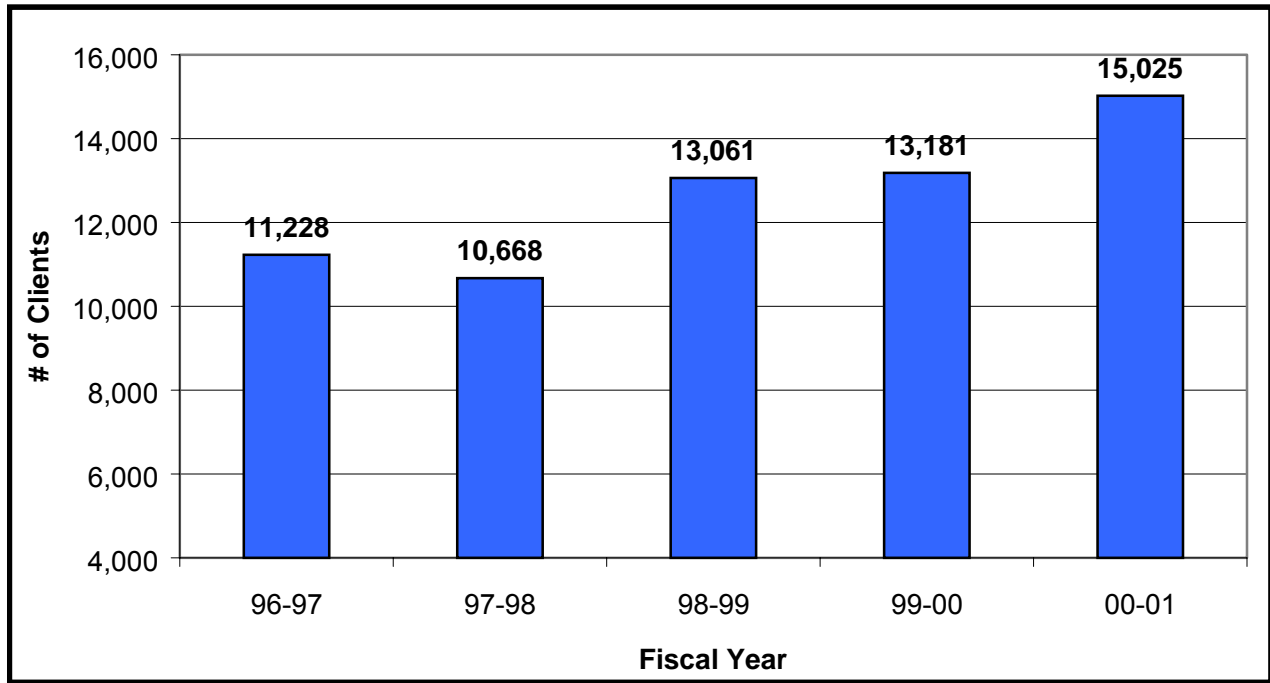
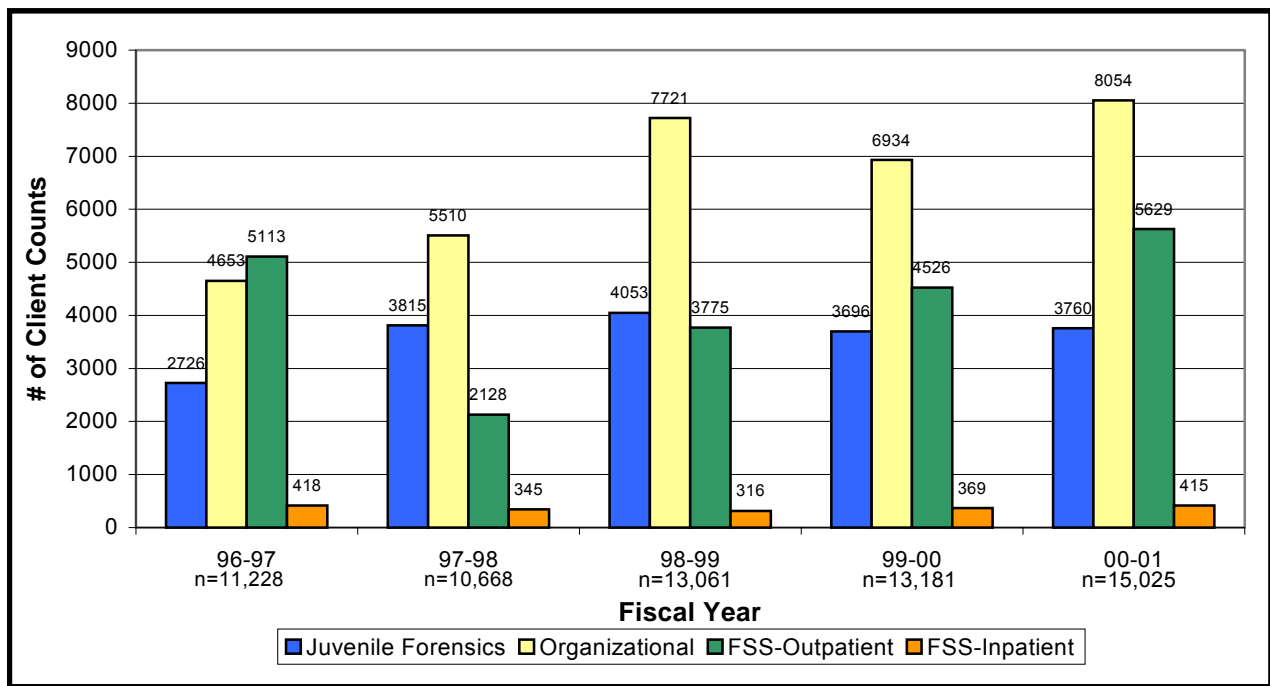


Figure 5: Children’s Mental Health System: Number of Total Unduplicated Client Counts by Fiscal Year and Provider



Note: FY96-97 FFS-Outpatient data is elevated due to a more inclusive target population definition during that fiscal year.

Figure 6: Children's Mental Health System: Gender Distribution

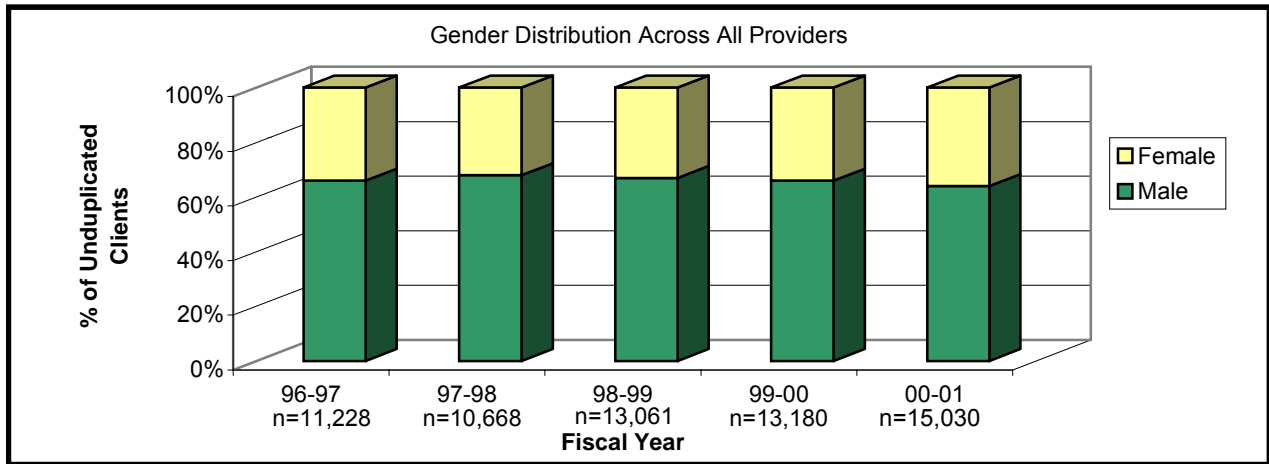


Figure 7: Children's Mental Health System: Age Distribution

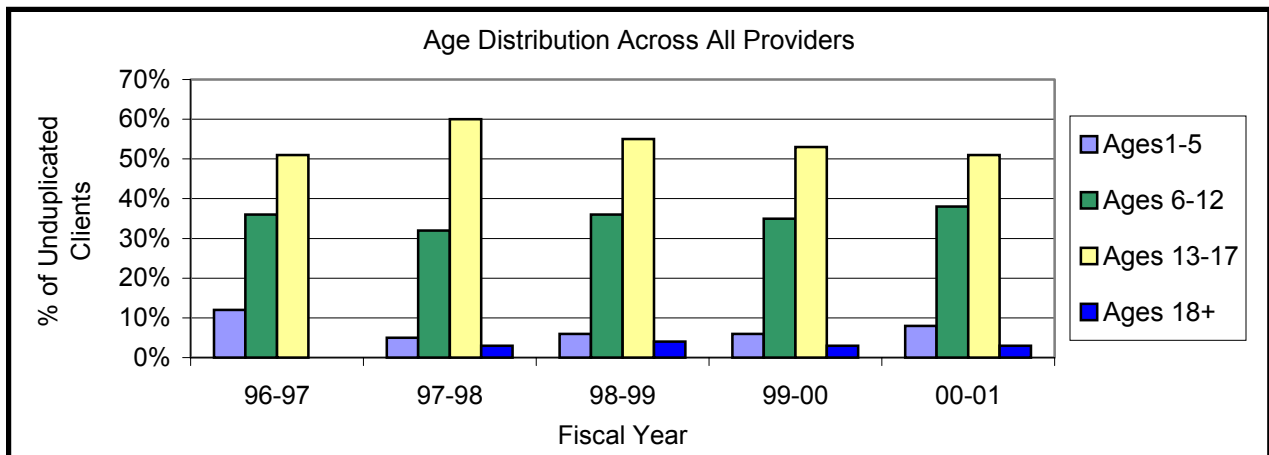


Figure 8: Children's Mental Health System: Race/Ethnicity

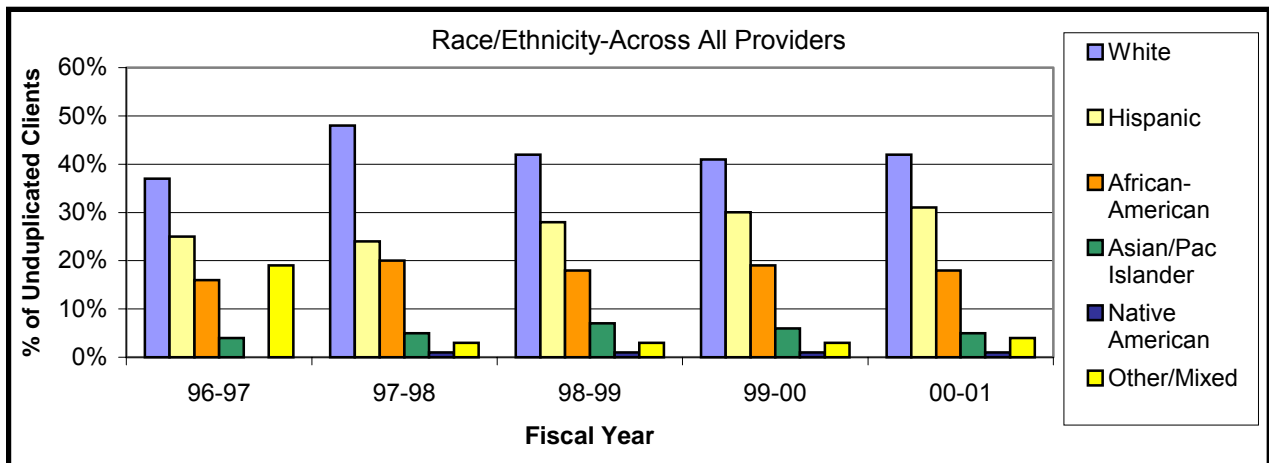


Figure 9: Children’s Mental Health System: Single and Multiple Use by Service Mode¹

FY 98-99

	Inpatient N =853	Res-M.H. N =236	Int. DT N =265	Day Rehab N =0	Case Mgmt. N =1236	OP-Org. N =3692	OP-FFS N =3775	OP-JF/Inst. N =5710	ESU N =1181
Inpatient	100.0%	31.8%	12.1%	N/A	26.4%	6.7%	11.8%	3.2%	41.3%
Res-M.H.	8.8%	100.0%	5.7%	↓	6.9%	1.1%	2.6%	2.0%	12.2%
Int. DT	3.8%	6.4%	100.0%		19.0%	3.2%	1.1%	0.6%	4.1%
Day Rehab	0.0%	0.0%	0.0%		0.0%	0.0%	0.0%	0.0%	0.0%
Case Mgmt.	38.2%	36.0%	88.7%		100.0%	12.6%	8.7%	3.7%	26.4%
OP – Org.	28.8%	16.5%	44.2%		37.8%	100.0%	9.7%	4.8%	30.4%
OP – FFS	52.3%	41.1%	15.5%		26.7%	10.0%	100.0%	11.0%	32.0%
OP – Insti	21.7%	49.8%	12.1%		17.2%	7.5%	16.6%	100.0%	24.5%
ESU	57.2%	61.0%	18.5%		25.2%	9.7%	10.0%	5.1%	100.0%

FY 99-00

	Inpatient N =691	Res-M.H. N =599	Int. DT N =311	Day Rehab N =164	Case Mgmt. N =1665	OP-Org. N =3759	OP-FFS N =4526	OP-JF/Inst. N =5298	ESU N =1121
Inpatient	100.0%	11.4%	11.4	1.2%	13.6%	6.4%	8.7%	2.8%	36.6%
Res-M.H.	9.8%	100.0%	5.1	0	99%	2.0%	5.9%	8.5%	9.5%
Int. DT	5.5%	2.7%	100.0%	0	16.3%	4.2%	1.4%	0.9%	4.0%
Day Rehab	0.3%	0.0%	0.0%	100.0%	1.9%	0.2%	0.4%	2.9%	0.8%
Case Mgmt.	32.9%	27.5%	87.1%	18.9%	100.0%	17.4%	9.0%	8.7%	23.9%
OP – Org.	34.9%	12.4%	50.8	5.5%	39.2%	100.0%	10.8%	5.5%	31.7%
OP – FFS	56.7%	36.7%	20%	10.4%	24.6%	13.0%	100.0%	13.1%	36.4%
OP – Inst	21.3%	75.1%	15.1%	93.9%	27.6%	7.7%	15.3%	100.0%	26.5%
ESU	59.3%	17.7%	14.7%	5.5%	16.1%	9.4%	9.0%	5.6%	100.0%

FY 00-01

	Inpatient N =723	Res-M.H. N =863	Int. DT N =356	Day Rehab N =238	Case Mgmt. N =1821	OP-Org. N =4815	OP-FFS N =5629	OP-JF/Inst. N =5472	ESU N =1150
Inpatient	100.0%	12.4%	11.0%	2.5%	16.0%	6.3%	7.9%	3.4%	35.9%
Res-M.H.	14.8%	100.0%	7.9%	3.0%	9.9%	3.5%	7.4%	12.6%	13.0%
Int. DT	5.4%	3.2%	100.0%	3.7%	16.0%	3.8%	1.5%	1.2%	4.1%
Day Rehab	0.8%	0.8%	2.2%	100.0%	3.9%	0.5%	0.6%	4.0%	1.2%
Case Mgmt.	40.4%	21.0%	82.0%	29.3%	100.0%	17.0%	8.7%	8.6%	29.6%
OP – Org.	42.0%	19.7%	52.0%	10.9%	45.1%	100.0%	13.7%	7.9%	39.7%
OP – FFS	61.5%	48.0%	24.2%	14.7%	26.8%	16.1%	100.0%	16.1%	37.4%
OP – Inst	25.9%	80.2%	18.5%	93.3%	25.7%	9.0%	15.7%	100.0%	25.7%
ESU	57.1%	17.4%	13.2%	5.9%	18.7%	9.5%	7.6%	5.4%	100.0%

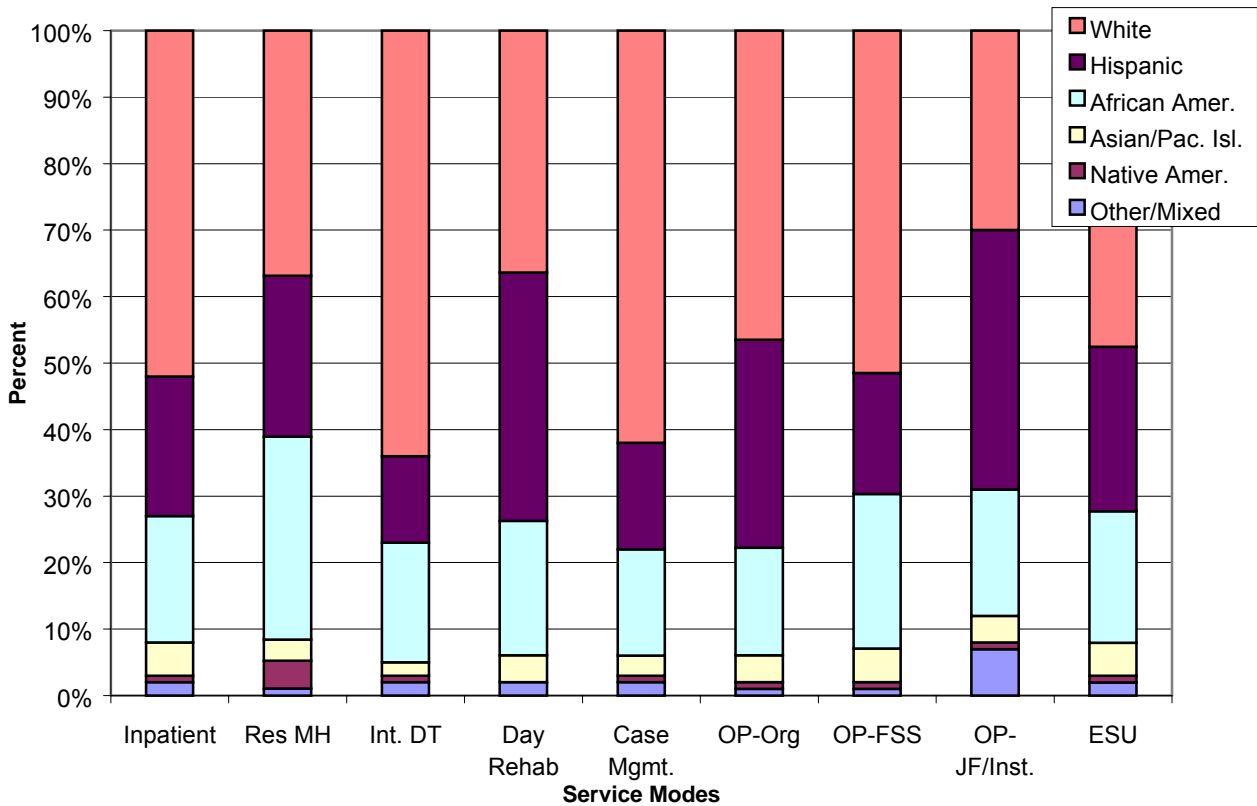
¹ Youth may be open to more than two service modes within the year but not necessarily simultaneously.

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-FSS=Outpatient Fee-for-Service Programs, Op-JF/Inst.=Outpatient Juvenile Forensic Institutions, ESU=Emergency Screening Unit.

Figure 10: Distribution of Race/Ethnicity in Each Service Modality

Service Modality data is collected through the administrative databases and is coded based on billed service code and reporting unit numbers. The race/ethnicity information is also collected from the information inputted into the administrative databases.



- The data demonstrate variability by race/ethnicity in the various service modalities.
- There are higher percentages of White youth involved in Intensive Day Treatment and Case Management programs.
- There are higher percentages of Hispanic youth involved in Day Rehabilitation and Outpatient Juvenile Forensic services.
- There are higher percentages of African-American and Native American youth participating in Residential Mental Health programs compared to other services.

(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-FSS=Outpatient Fee-for-Services 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, 2001. The data has been collected for four 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 948 children and adolescents. During the 1998-1999 fiscal year, the Coordinated Care program was more wide spread, the data collection process was in full operation, and POP collected 1,434 intake assessments. In the 1999-2000 year, 1,375 intake assessments were collected and in 2000-2001 year 1,959 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 for most of the fiscal years. The percent of males are 64% in 97-98, 65.1% in 98-99, 64.6% in 99-00 and 59.9% in 00-01. FY00-01 reveals significantly less males and more females than the other fiscal years (Figure 11a). The age distribution of the youth entering the system varies by fiscal year. By comparing means and modes, the youth are older in the 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. The recent 00-01 year shows an increase in young children receiving POP assessments (Figure 11b). There also appears to be a continuous increase in youth of the Hispanic ethnicity group in the last 2 years (Figure 12a). This is the largest ethnic group surpassing the White group starting in 99-00 and remaining as the largest group in 00-01. Youth in each fiscal year are living in home environments during the current time of assessment and predominately in the past year prior to assessment. There are no differences between fiscal years (Figure 12b). There are more Master level counselors (both marriage and family and social work) completing Intake assessments in 99-00 and 00-01 than the other years (Figure 13). However, there is a lower percentage of trainees (psychology, social work and counseling) completing intake assessments during these past 2 years.

Cohort Clinical Profiles

There is also some variation in clinical profiles of children & adolescents by fiscal year. Across all ages children are differing by fiscal year in their overall functioning levels at intake per clinicians. Young children (under the age of 6) were entering the system at higher levels of impairment on the Preschool and Early Childhood Functional Assessment Scale (PECFAS) from 97-00. Then in the more recent fiscal year 00-01 there was a drop in entry impairment level (Figure 14b). This is probably due to the Para Las Familias EPSDT program, which serves the majority of young children (<6yrs). This program reaches out into the community and serves youth at younger ages and less impairment to prevent further problems from developing. For older youth, there is very little change by fiscal year entry level scores. They are entering the system with similar impairment levels represented by scores on the Child and Adolescent Functional Assessment Scale (CAFAS)(Figure 14a). Both the parents (CBCL) and youth (YSR) are reporting less behavior and emotional problems in the 00-01 year (Figure 15a,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 15a). Parents (but not youth) report slightly high level of social competency in the 00-01 fiscal year. Yet the total scores still remain at a clinical level according to the caregivers (Figures 16a,b).

When the data is examined by age group and ethnicity some other patterns appear. Older youth are clearly more functionally impaired at intake than younger children with adolescents demonstrating the highest level of functional impairment according to clinicians completing the CAFAS (Figure 17a). 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 and 00-01. Parents of all age groups report less impairment during the recent 00-01 fiscal year. (Figure 17b).

Per clinician report, the data shows the Spanish/Hispanic group entering services with more functional impairment over time while the Asian-Pacific Islander group is entering services with less impairment by fiscal year on the CAFAS (Figure 18a). White youth appear to remain at moderate levels of impairment for each year on this measure with a slight decrease in the most recent 00-01 fiscal year. Parents report decreases in entry CBCL total scores for each race/ethnic group in the 00-01 fiscal year (Figure 18b). Asian/Pacific Islander parents are reporting fewer problems than 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

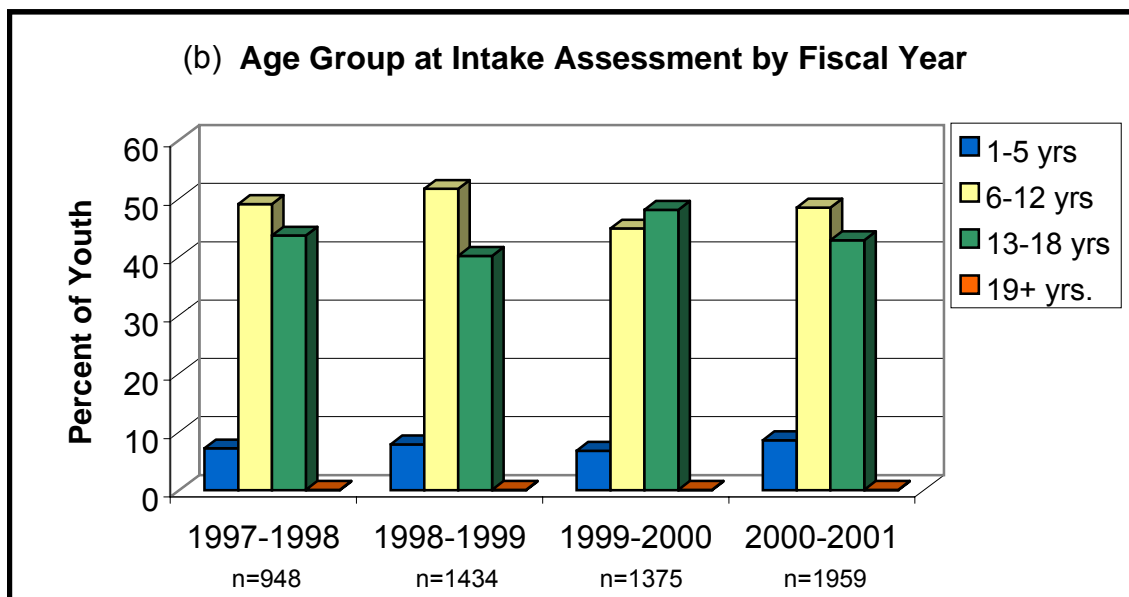
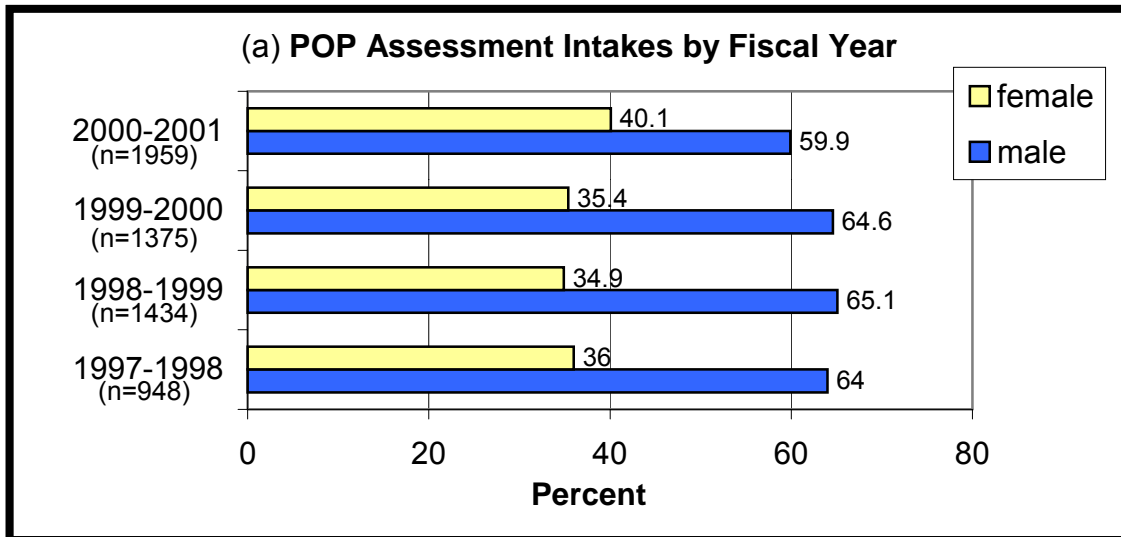
Youth Self Report (YSR)

- 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

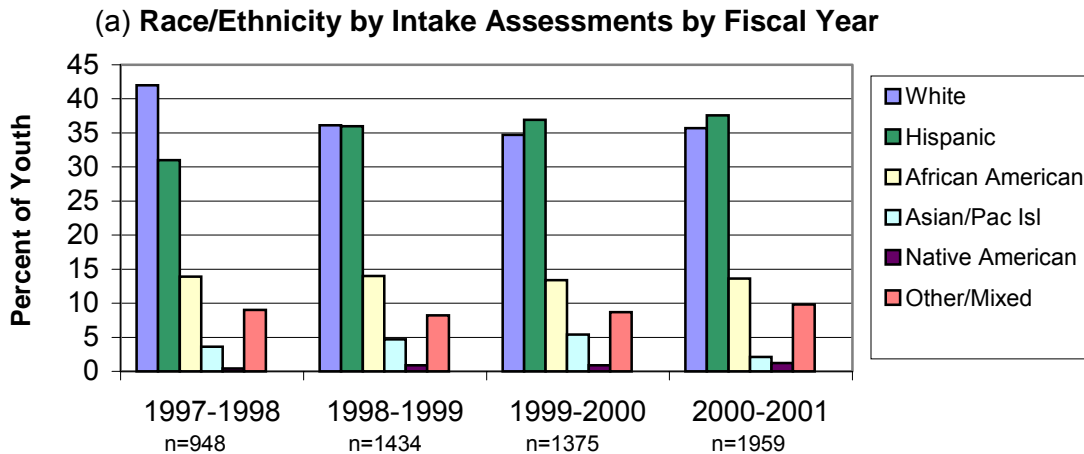
Figure 11: POP Intake Cohorts by Sex and Age



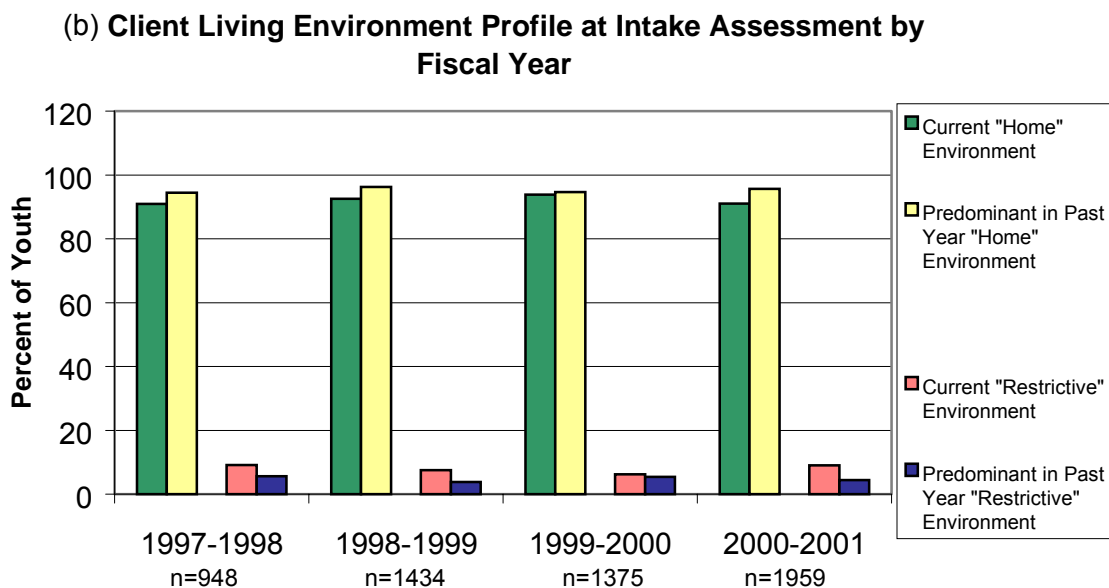
- More males than females receive mental health services & complete POP's for each fiscal year; however, 2000-2001 had significantly less males than the other fiscal years.
- There were significantly more POP intake assessments for the older age group in 99-00 than the other fiscal years.

Figure 12: POP Intake Cohorts by Race/Ethnicity and Youth Living Environment

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



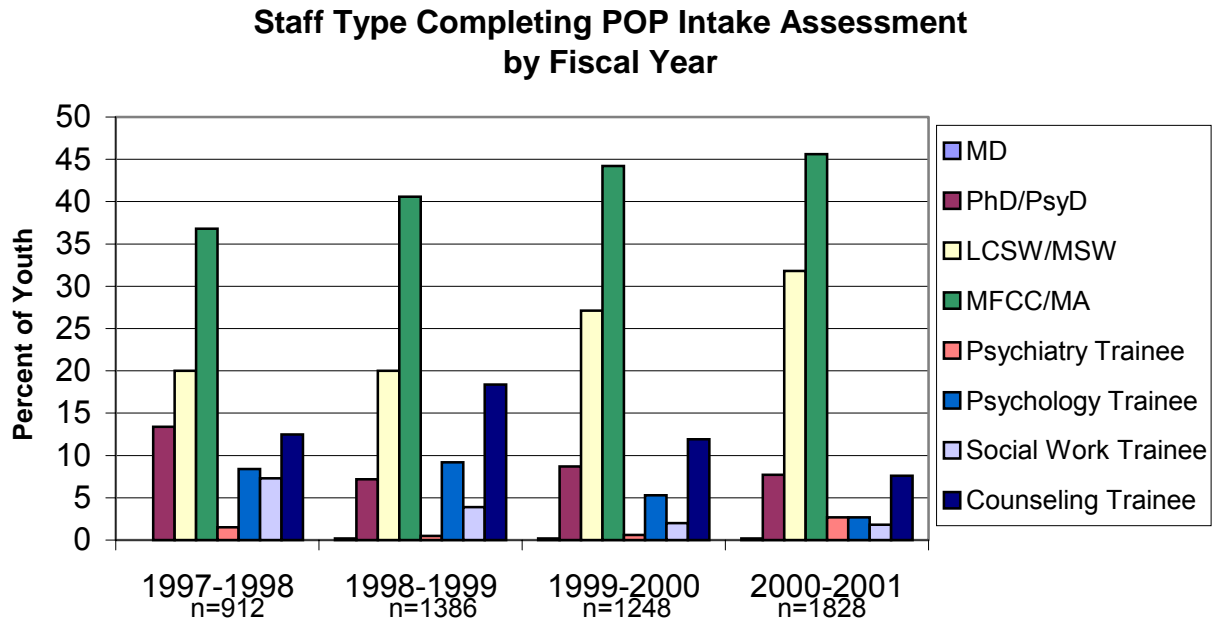
The Client Living Environment is completed by the clinician after interviewing the youth and family. “Home” environment includes bio/adopted homes, foster care and living independently. “Restrictive” environment includes incarceration, psych hospital, group home and homeless settings. “Current” represents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



- In 99-00 Hispanics surpassed whites in percent of youth completing POPs at CC Intake and remained high during 00-01.
- Youth are primarily living in Home settings at POP assessment Intake for each fiscal year.

Figure 13: POP Intake Cohorts by Staff Type

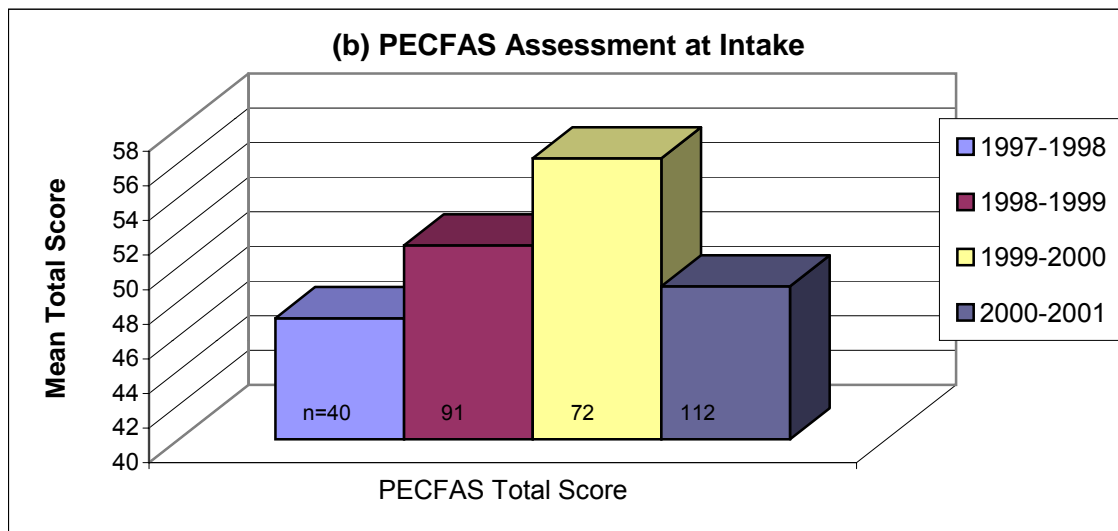
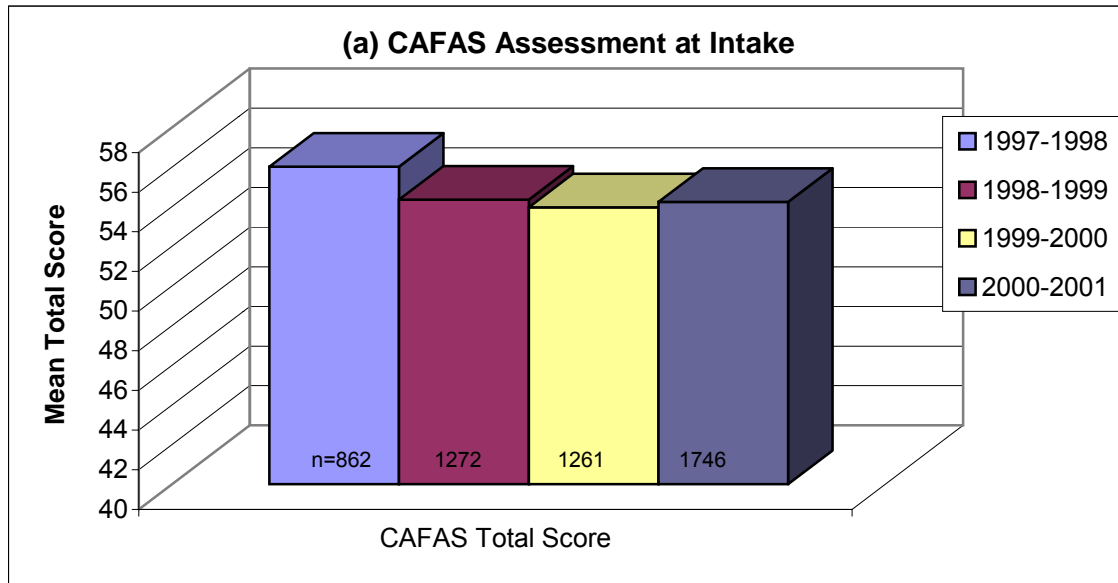
Percent of youth receiving services from each type of staff at Intake assessment. These staff members completed the assessments.



- There is a continuous increase in the percent of licensed staff, both LCSW/MSW and MFCC/MFT, that complete POP intake assessments.
- There is a decrease by each fiscal year in the percent of all trainees in completed POP intake assessments.

Figure 14: 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.



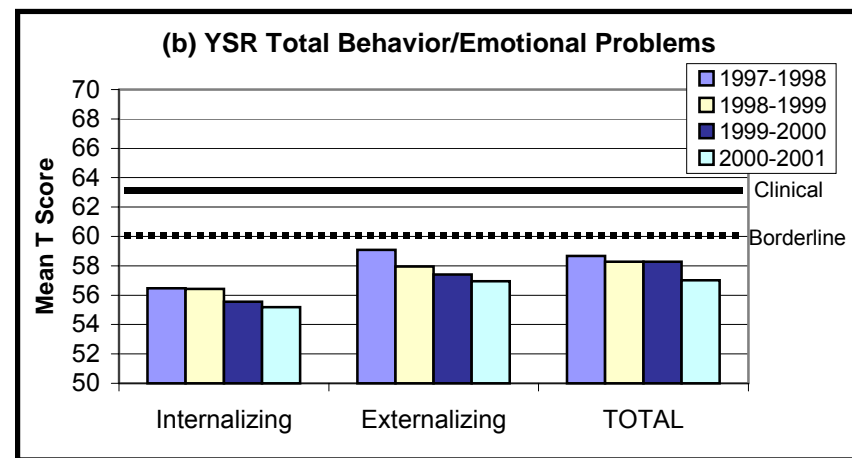
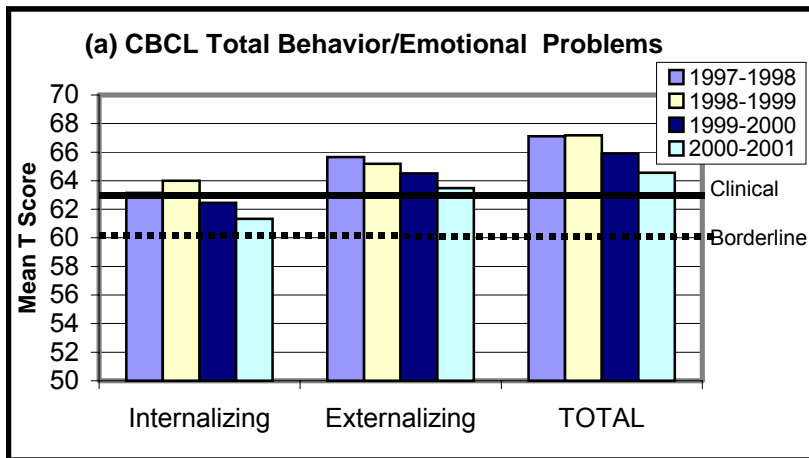
- Overall, youth are entering the system with moderate levels (40-60) of impairment reported by clinicians on the CAFAS. There are no significant differences by fiscal year.
- Young children vary within the moderate level of impairment (40-60) by fiscal year, yet the variation is not statistically significant.

Figure 15: 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.

Parent Report

Youth Report



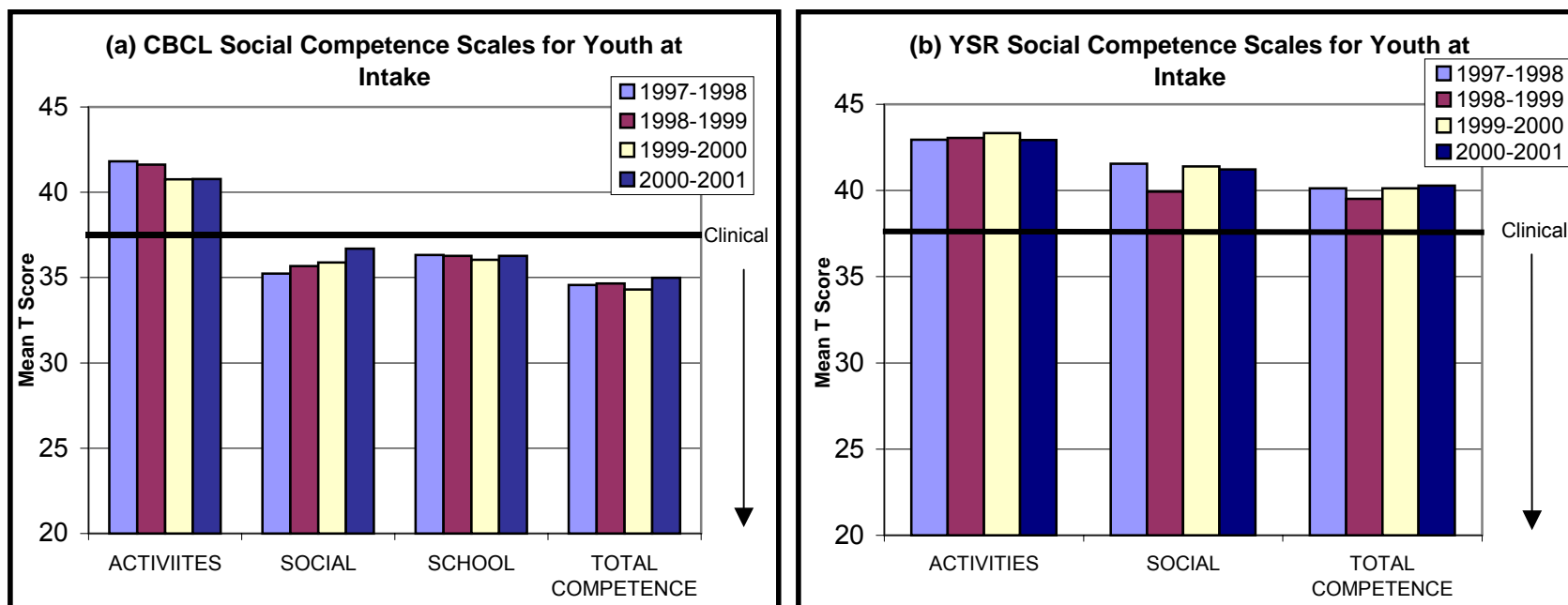
- In 00-01, parent (not youth) report significantly less total problems at POP intake assessment compared to other fiscal years.
- Youth report significantly fewer problems at intake assessment for each fiscal year compared to parents.

Figure 16: 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.

Parent Report

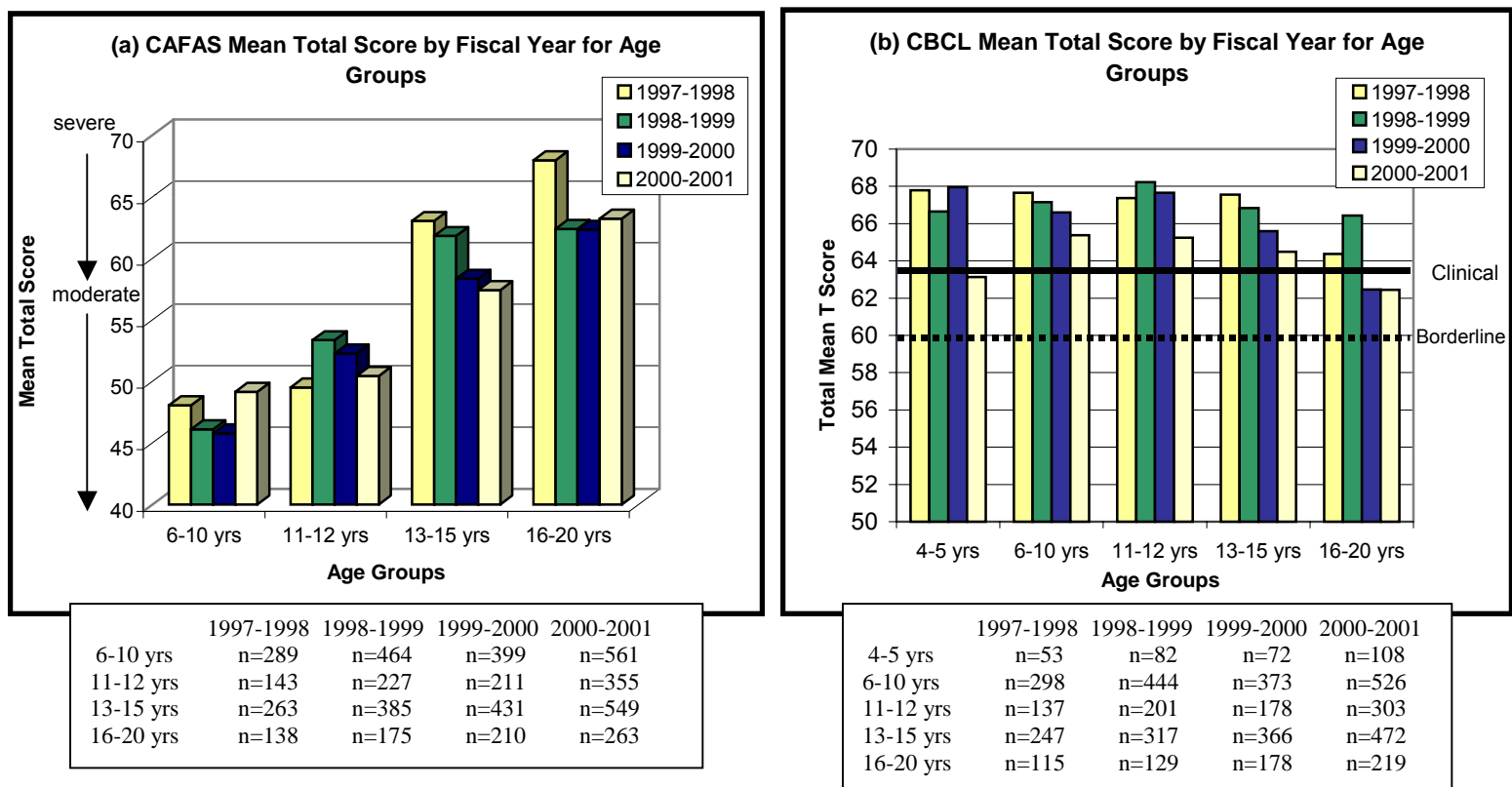
Youth Report



- Parents report clinical levels of social, school and total competence for each fiscal year, meaning youth have poor competence skills.
- Overall, youth report significantly more social competencies than parents.

Figure 17: 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.

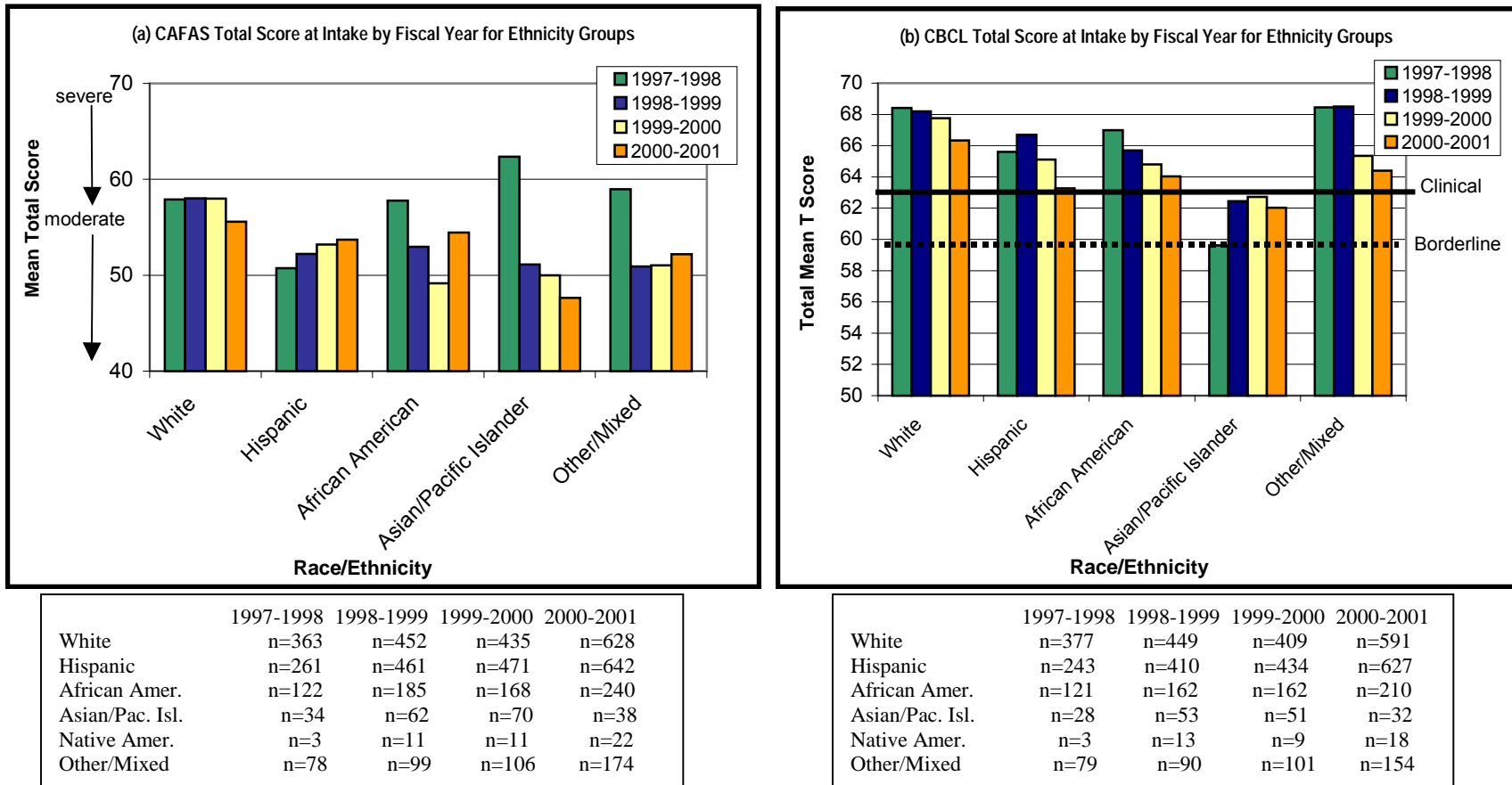


- Per clinician report (CAFAS), older youth (>16yrs) are significantly more impaired at intake at each fiscal year compared to other ages.
- Per parent report (CBCL), older youth (>16) have significantly less problems at intake for each FY compared to others.

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

Figure 18: 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.



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

- In each FY, Asian/PI parents reported less problems compared to all other ethnicity groups.
- In 00-01 parents of White youth reported significantly more problems compared to Hispanics and Asian/Pis.

Clinical Outcomes

The Performance Outcome Project has collected data for four fiscal years, 1997-2001, 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 3 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 four follow-up cohorts: 1) youth with an intake and 6 month follow up (n=1661), 2) youth with an intake and 1 year follow up (n=1045), 3) youth with an intake and 2 year follow up (n=365) and 4) youth with an intake and 3 year follow up (n=101). There is also a cohort that has assessments at intake, 6 months and 1 year for which repeated measure analyses were completed (n=435).

Across each timeframe cohort (intake to 6 months, intake to 1 year, intake to 2 years and intake to 3 years) parent, clinician and youth reports reflect overall improvement (Figure 19 a,b,c). Per clinician and youth report the improvements are significant for each cohort with the exception of the intake to 3 year cohort which is approaching statistical significance according to clinicians ($p=.07$, $n=101$) and no significance according to youth ($p=.152$, $n=30$). According to the parents, all cohorts improved significantly. When the data is examined by change scores for each measure, the information varies somewhat by informant (see figure 20). From intake to 6 months, clinicians report no change occurring more often than 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 occurs at each timeframe. 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 21 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 did not improve in the first 6 months, the majority of them later improved in the subsequent 6 months according to clinicians, parents and especially youths. Clinicians report primarily no further improvements for youth who showed no change in the first 6 months while parents and youth report more equivalent proportions of subsequent improvement, no change and negative change.

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; statistically significant improvements occur across each FY. These consistent findings are true for all informants (clinicians, parents and youth) across both functional impairment and symptomatology.

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 23 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) per clinician report. Both parents and youth also report more symptoms for youth who receive a 2-year follow up assessment (Figure 24). 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.

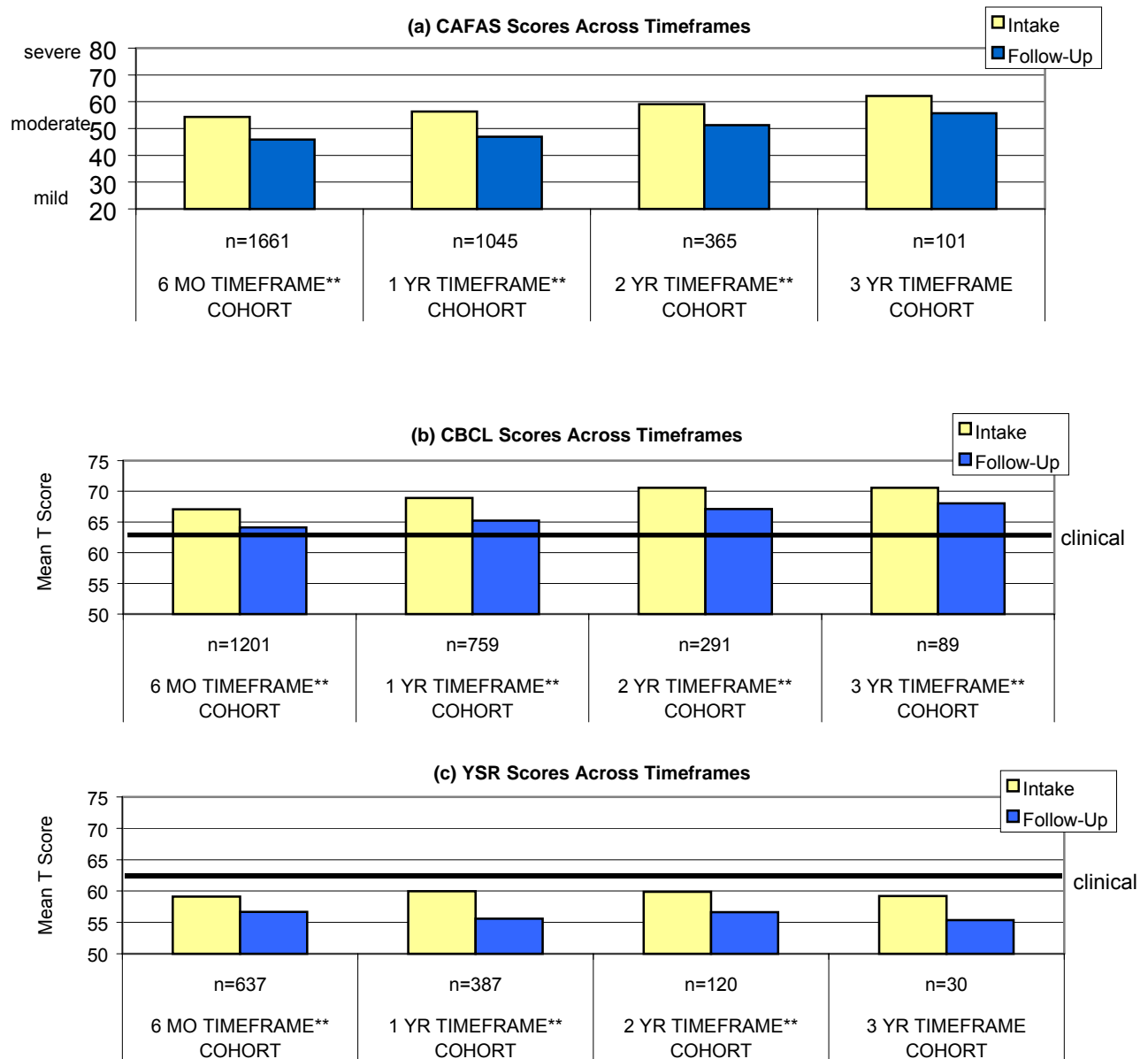
Repeated measures analyses for youth who completed intake, 6 month and 1 year assessments show continuous statistically significant improvement over time on the CAFAS per clinician report. Parents and youth also reported incremental statistically significant improvements over time on behavior and emotional problems (CBCL & YSR) (Figure 25).

Statistically significant improvements on paired sample t-tests occur from intake to 6-months and from intake to 1-year for all race/ethnicity groups per clinician report. However, continuous improvement from 6-months to 1-year varies by ethnic group. White and Hispanic youth also show statistically significant improvements from 6-months to 1-year. While, African-American and Asian/Pacific Islander youth show a deterioration trend from 6-months to 1-year (Figure 26). Regression analyses indicate that from intake to 6-months, Asian/Pacific Islander youth show significantly more improvement than others and that White youth show significantly higher scores at 6-month assessment indicating less improvement compared to other ethnic groups. These effects of ethnicity hold when gender and age are controlled. Per parent report (CBCL), Hispanics improve from intake to 6-months and then remain the same from 6-months to 1-year. There are statistically significant changes from intake to 6-month, intake to 1-year and 6-months to 1-year on paired sample t-test. Whites and African-Americans show some initial improvements (statistically significant from intake to 6-months) and then decline from 6-months to 1-year and Asian/Pacific Islanders show deterioration at both time points in relation to intake (Figure 27). Regression analyses indicate no statistically significant differences by ethnicity. 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, White, Hispanic and Asian American/Pacific Islander youth (YSR) report continuous improvement from intake to 6-months to 1-year (statistically significant for Hispanics). However, African-American youth report improvement from intake to 6-months only and report increased problems at 1-year assessment (Figure 28). 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 sample size at follow ups.

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 29).

Figure 19: 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 four time frames: Intake to 6 months, Intake to 1 year, Intake to 2 years and Intake to 3 years. Higher scores indicate lower levels of functioning.

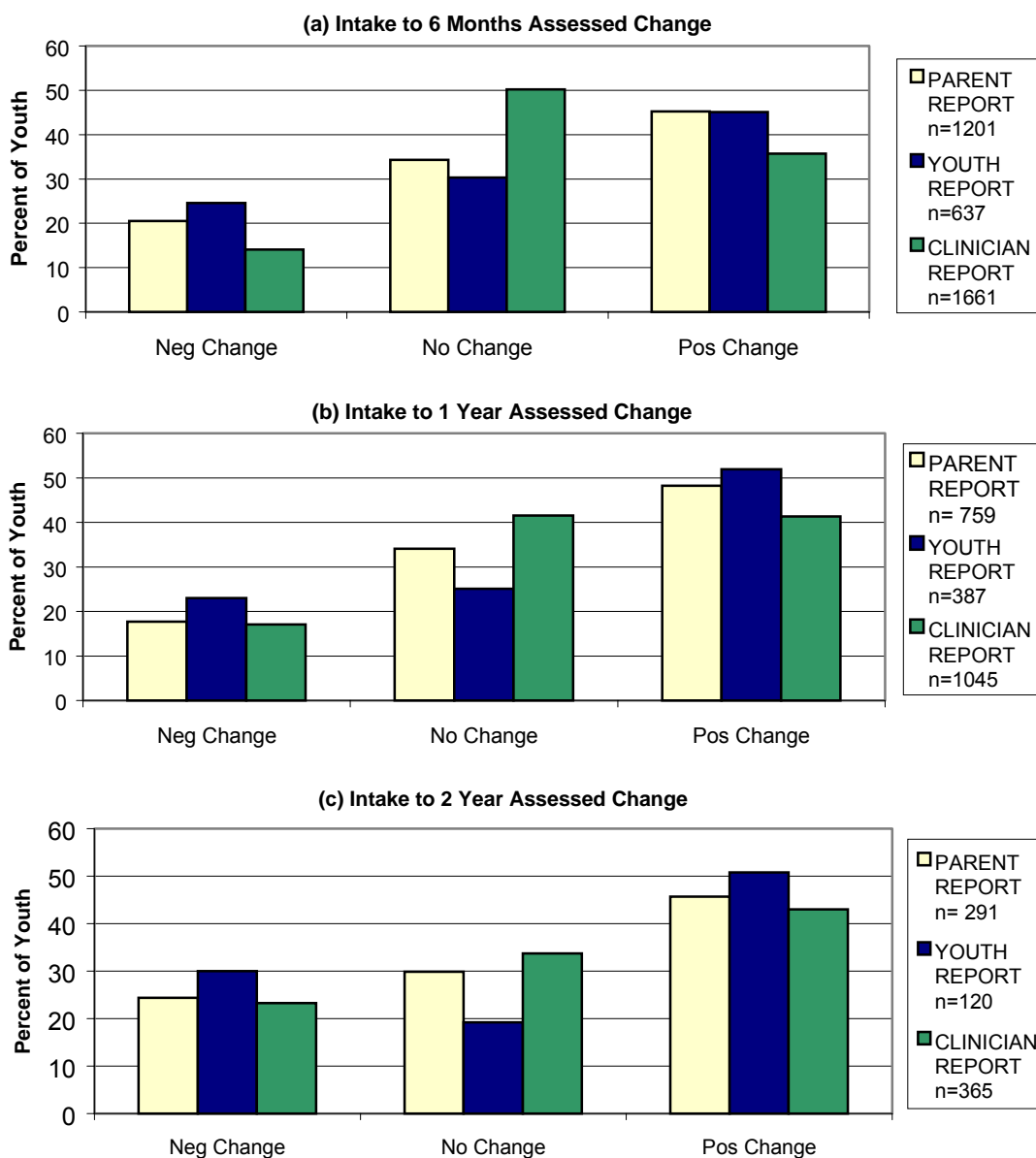


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- Parents report statistical significant levels of improvement for each cohort while clinicians and youth do not for 3 yr timeframe cohort.

Figure 20: Assessed Change in Treatment Across Timeframes- Parent, Youth and Clinician Reports

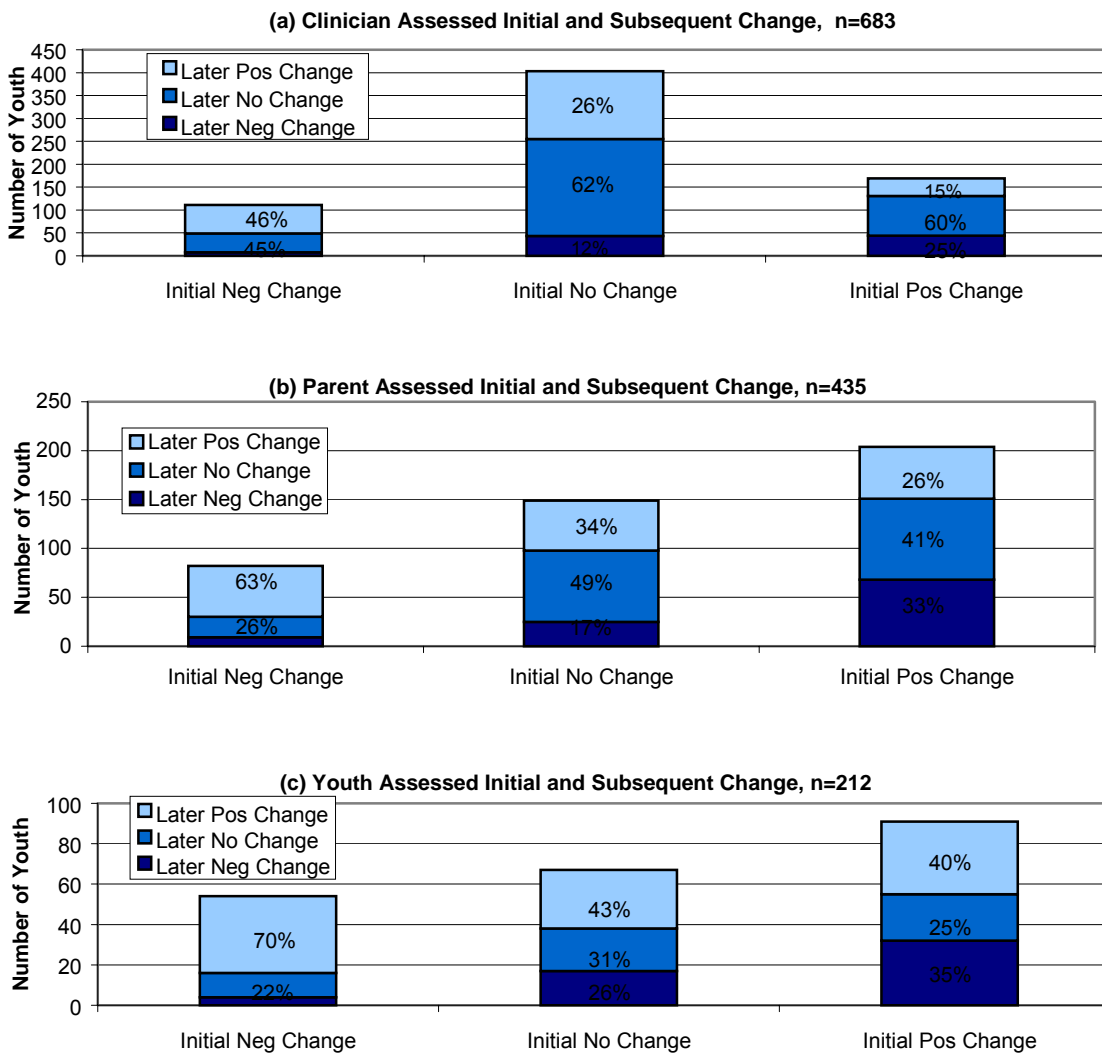
“Negative change” indicates youth who got worse, “no change” indicates youth who have stayed the same, and “positive change” indicates youth who got better according to each informant. Significant change is defined as greater than a 3-point change on CBCL or YSR and a 10-point change on CAFAS.



- Similar percentages are being reported as positive change over the various timeframe cohorts. Clinicians tend to report more no change than parents and youth.
- Relative to clinicians and parents, youth are reporting more negative change at each of the timeframes.

Figure 21: Assessed Change from Intake-6mo, 6mo-1year by Informant

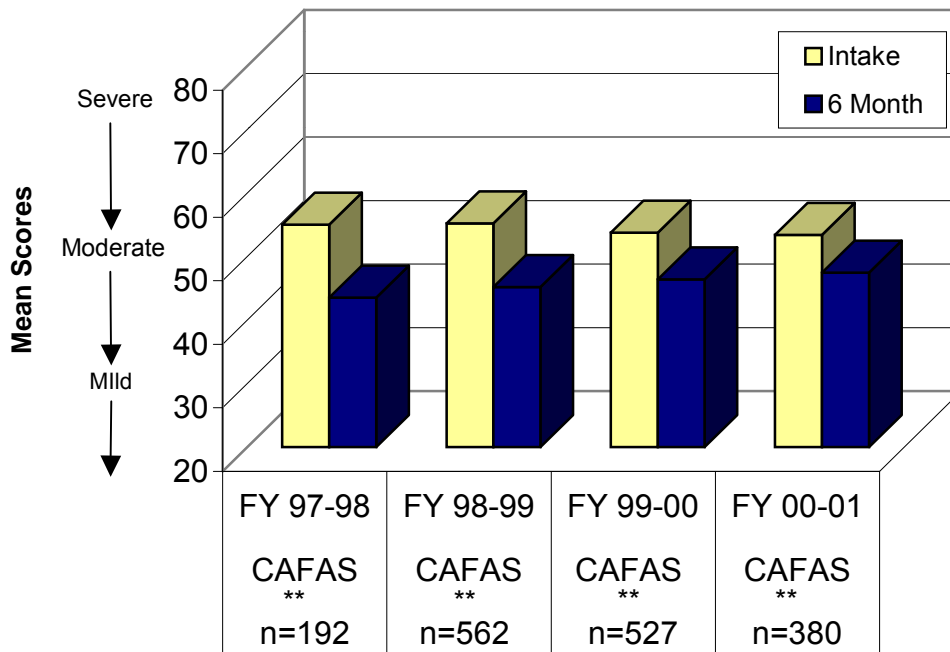
In each graph the overall height of the bar indicates the number of cases with initial positive, no, and negative change at 6 months. The stacked shaded areas within each bar represent the percent of youth who then report subsequent positive, no and negative change at 1-year follow-up. One graph is displayed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



- For youth who did not improve in the first 6 months, the majority of them later improved in the subsequent 6 months according to clinicians, parents and especially youths.
- Clinicians report primarily no further improvements for youth who showed no change in the first 6 months while parents and youth report more equivalent proportions of subsequent improvement, no change and negative change.

Figure 22: Intake to 6 Month Change in CAFAS Scores by Fiscal Year at 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 four fiscal years. Higher scores indicate more dysfunction.



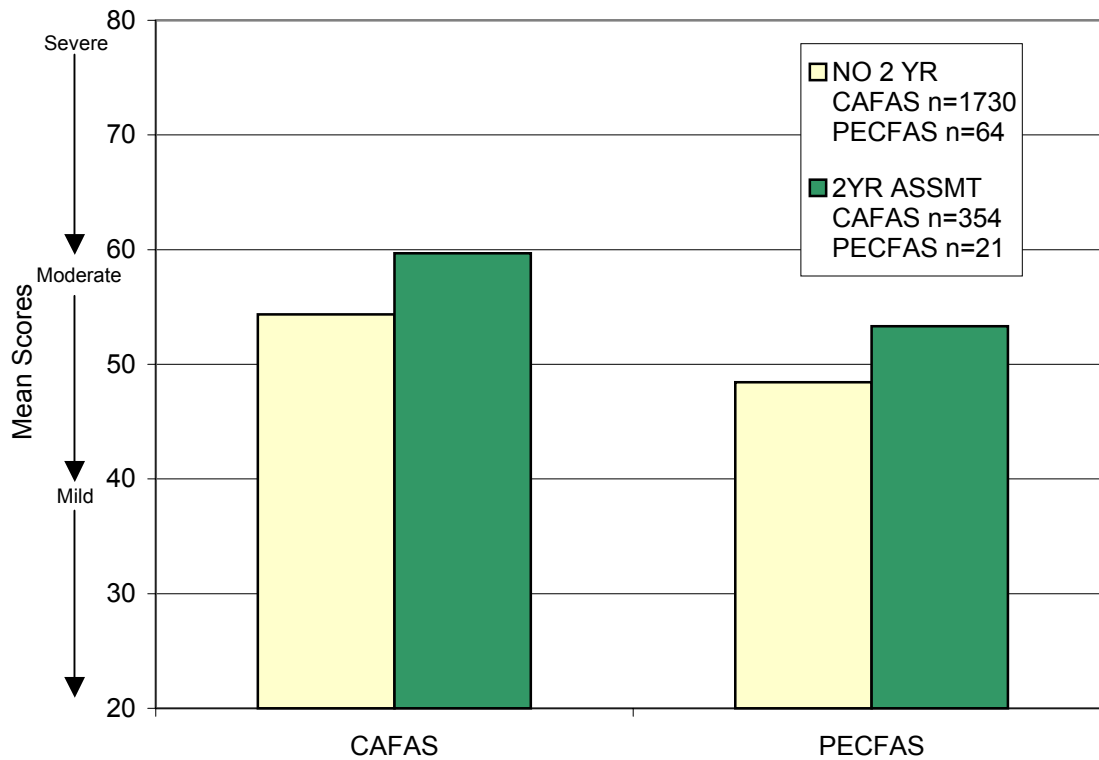
* represents statistical significance at $p < .05$ and ** represents $p < .01$

- 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 four years of study.

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

Figure 23: Intake Profiles (FY 97-98, 98-99)- CAFAS Scores for Youth With and Without 2-Year Assessments

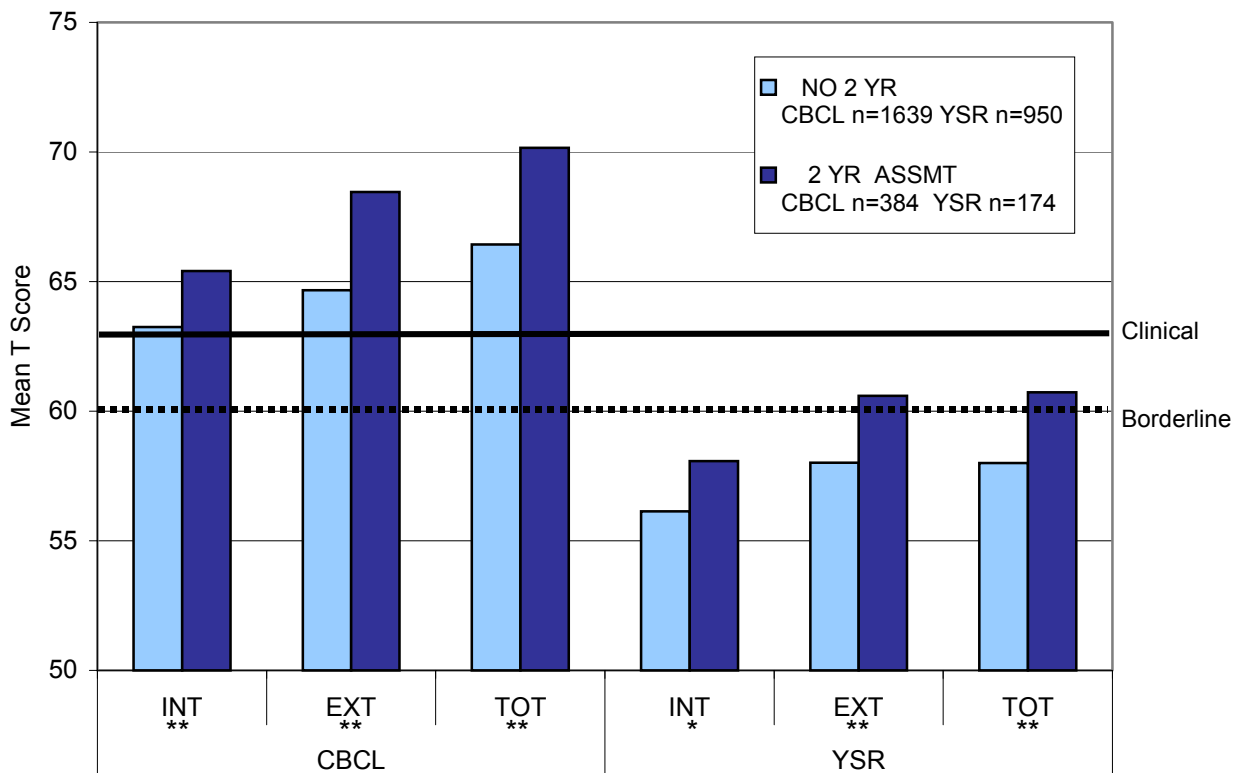
The CAFAS is a functional impairment measure completed by the clinician. The PECFAS is the equivalent measure for children 4-5 years old. The bars indicate mean intake functioning levels for youth who were eligible but did not have a POP assessment at the 2-year follow-up and those that did have a 2-year 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. There is a similar trend on the PECFAS, however, the differences are not statistically significant (possibly due to small sample size at 2 yr assessment).
- This finding suggest that youth who stay in services for long periods of time are more severely impaired when they enter the system.

Figure 24: Intake Profiles (FY 97-98, 98-99) 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.

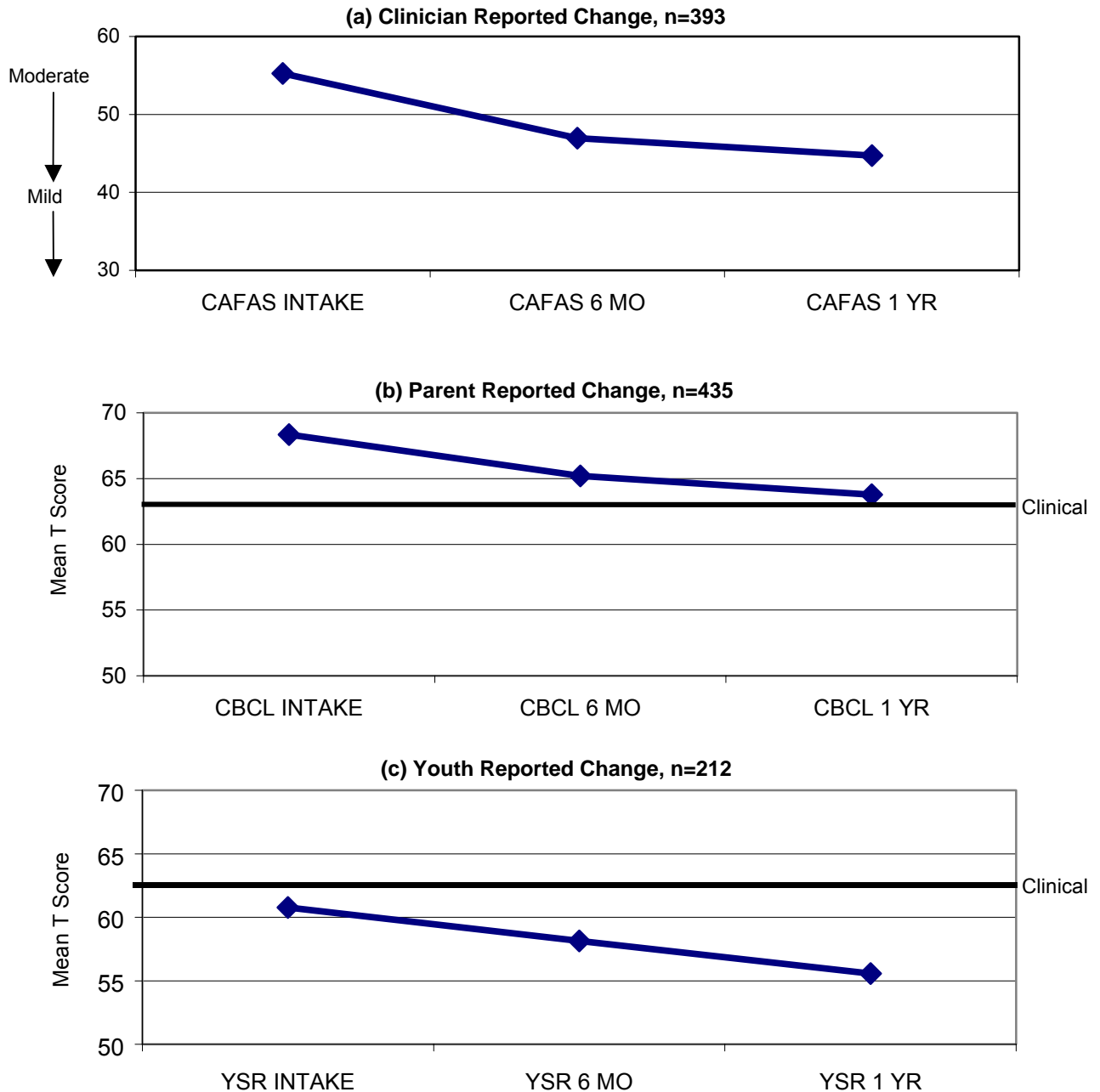


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- Parent reports (CBCL) of internalizing, externalizing and total problems are significantly higher at intake for youth who receive a 2-year follow-up assessment than for youth who do not.
- Youth reports (YSR) of internalizing, externalizing and total problems are significantly higher at intake for youth who receive a 2-year follow-up assessment than for youth who do not.
- These findings suggest that youth who stay in services for longer periods of time are more severely impaired when they enter services.

Figure 25: Change Across Time- CAFAS, CBCL and YSR at Intake, 6 Month and 1 Year

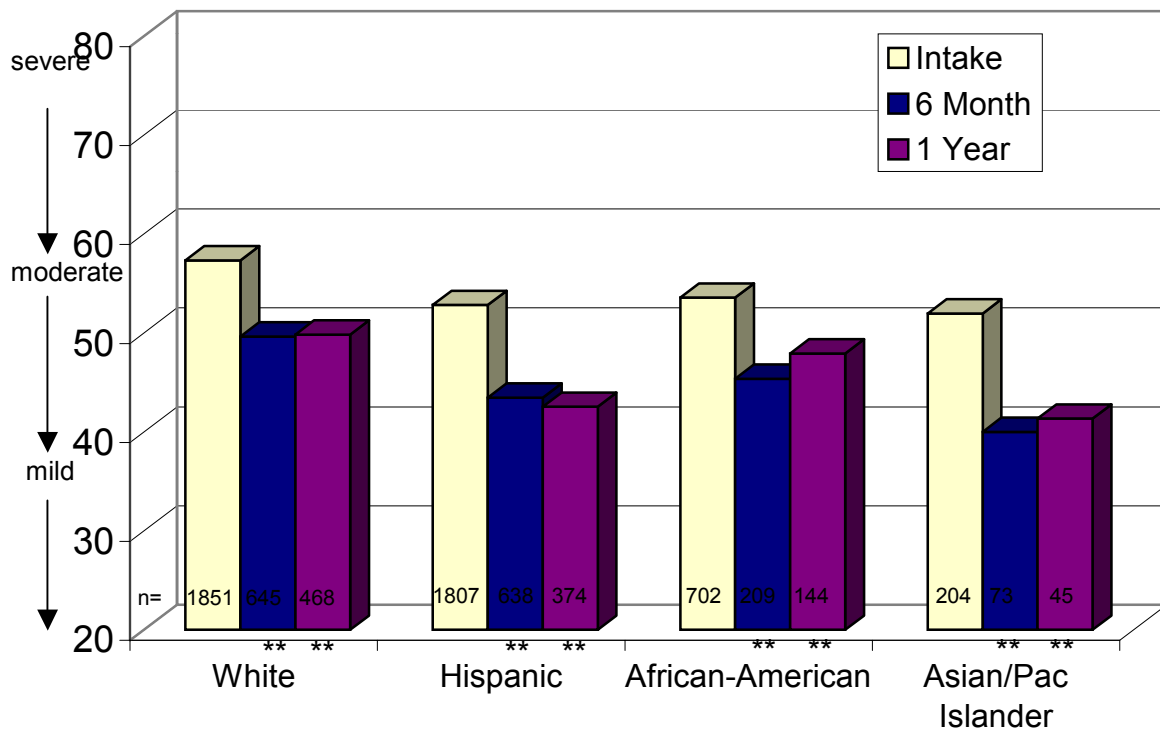
The CAFAS is completed by the clinician, CBCL is completed by the parent, and YSR by the youth (11-18 yrs). The data points display mean scores, with higher scores indicating greater severity.



- All three informants report statistically significant improvements over time from intake to 1 year on repeated measures of functioning and behavior problems.

Figure 26: 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: White, Hispanics, African-Americans, and Asian/Pacific Islanders. Higher scores indicate lower psychological functioning.



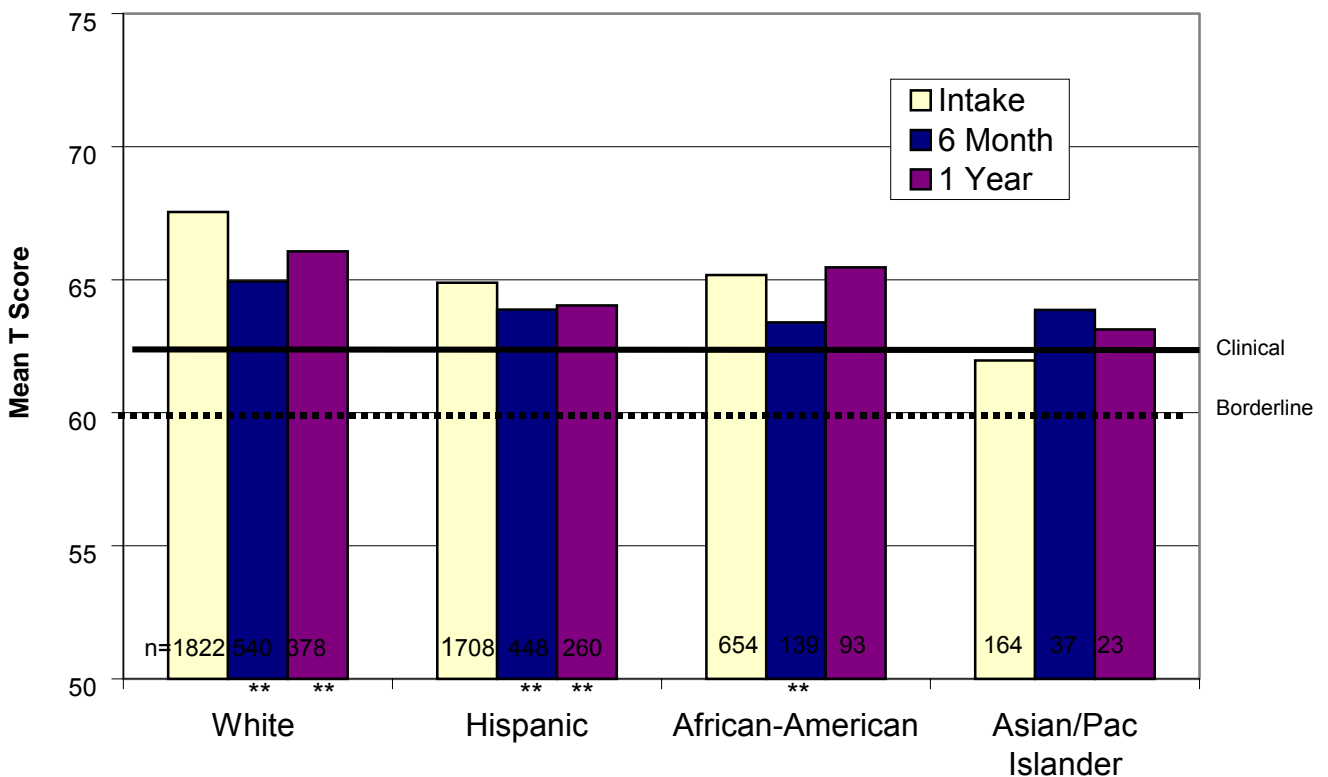
* represents statistical significance at $p < .05$ and ** represents $p < .01$ for paired t-tests

- Each of the groups show statistically significant improvement in functioning from intake to 6 months and from intake to 1 year on paired t-tests, according to clinician reports.
- Regression analyses of clinician reports of functioning indicate that from intake to 6-months, Asian/Pacific Islander youth show significantly more improvement than others.

Note: Bars represent aggregated data for all youth with intake and follow-up measures per timeframe. Not all youth are the same in each bar. Regression analyses effects of ethnicity controlled for gender and age.

Figure 27: 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, Hispanics, and Asian/Pacific Islander. Higher scores indicate greater severity of emotional/behavioral problems.



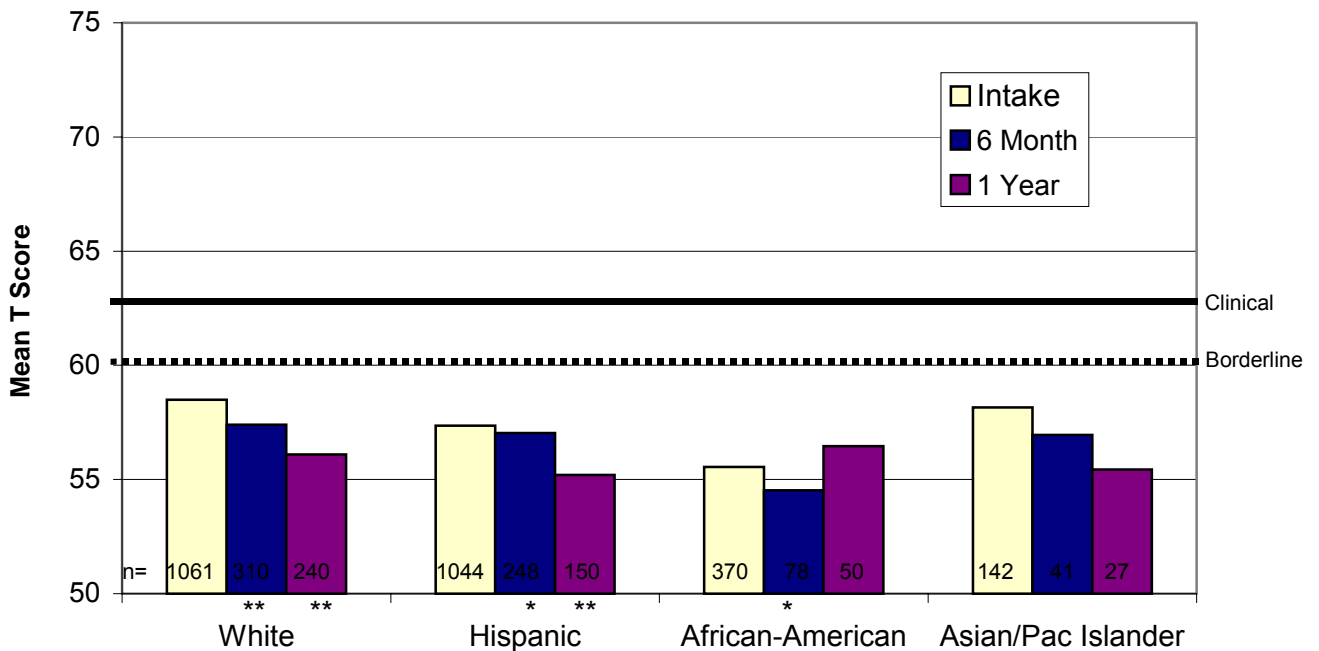
* represents statistical significance at $p < .05$ and ** represents $p < .01$ for paired t-tests

- For all groups except Asian/Pacific Islander youth, there is a decrease in parent reported emotional/behavioral problems from intake to 6 months. For Asian/PI youth, parents reported increased emotional/behavioral problems at 6 month.
- At 1 year assessment, parents of White and African-American youth report increased emotional/behavioral problems compared to 6-month assessment. Parents of Asian/Pacific Islander youth continue to report higher levels at 1 year follow up compared to intake.
- Regression analyses of parent reported emotional/behavior problems indicate no significant differences by ethnicity on follow up scores.

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



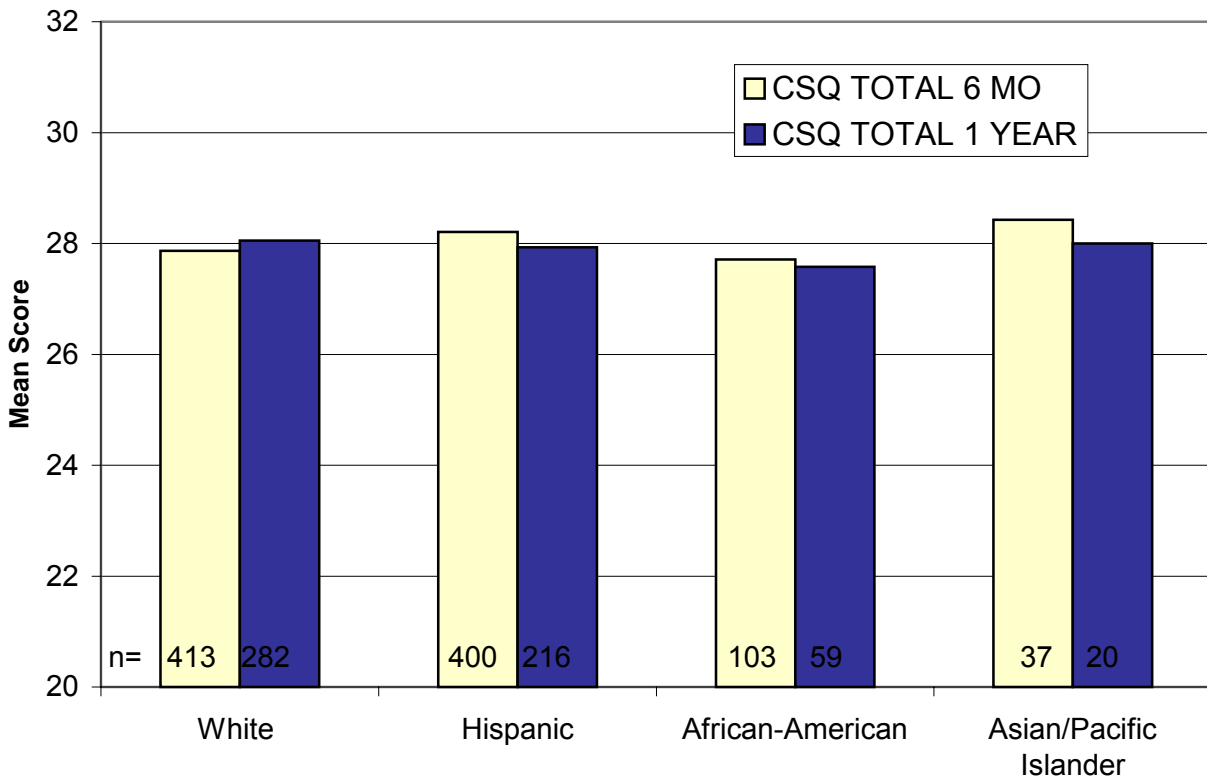
* represents statistical significance at $p < .05$ and ** represents $p < .01$ for paired t-tests

- According to most youth there is a decrease in reported emotional/behavioral problems from Intake to 6-months.
- For all youth, except African-American youth, there continues to be reported improvements at the 1-year follow-up assessment. African-American youth report increased emotional/behavioral problems at 1-year compared to Intake and 6-month assessment.
- Regression analyses of youth reported emotional/behavioral problems indicate no significant effect 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. Regression analyses effects of ethnicity controlled for gender and age.

Figure 29: Client Satisfaction by Race/Ethnicity- Mean Scores at 6 Months and 1-Year Follow-Ups

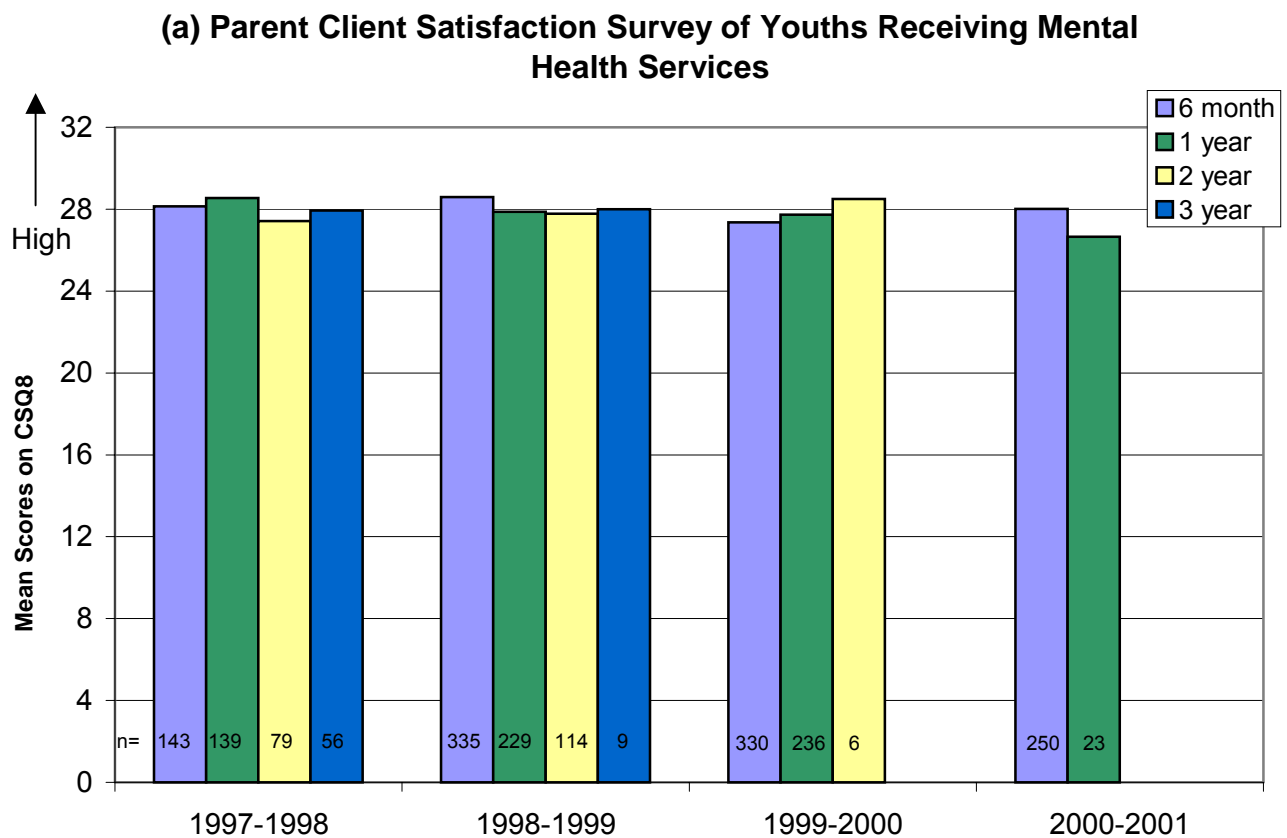
The Client Satisfaction Survey is an 8-question form that is completed at follow-ups by the parent or caregiver. The four main ethnic/racial groups are: White, African-American, Hispanic, and Asian/Pacific Islander. Higher scores indicate greater satisfaction with services.



- Mean scores on the CSQ indicate high levels of satisfaction with mean score for all groups in the range of approximately 28 out of a total possible 32 points.
- There are no significant differences between ethnic groups on levels of client satisfaction at 6 months or at 1 year.

Figure 30: 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 2000-2001 fiscal year because many cases have not 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 month, 1 yr, 2yr or 3yr.

Note: There are no 3 yr data available for 99-00 and 2 yr & 3 yr data available for the 00-01 fiscal years at this point in time.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is a specialized program funded by the state's Medi-Cal system. The program allows for an expansion of mental health services to include diagnosed but less impaired children and adolescents. It allows for youth to receive services earlier (in terms of both younger ages and/or less severity of issues) in order to help prevent more serious problems from developing down the road. In sum, the EPSDT program focuses on 1) broadening eligibility criteria and 2) providing a broader array of services to eligible youth.

This service expansion has occurred primarily in the fiscal year 2000-2001 with an emphasis on expanding services to schools, underserved populations and communities, and multi-service system youth involved in sectors such as Probation Wards and CPS Dependents. Approximately 32 million dollars has been allocated to provide service expansion in several phases throughout the county. There have been about ten new organizational providers added to the CMHS cadre of providers and more than 20 new programs/program sites. This includes many new school-based services, which are continuing to be developed in a multitude of school sites with the goal to provide services to over 200 schools throughout the county. There have also been specific program expansions to include specialized services such as Therapeutic Behavioral Services, which is a rehabilitation service conducted by paraprofessionals to improve a youth's functional impairment.

Youth who have obtained services in an EPSDT program are also part of the larger coordinated care mental health system and, therefore, complete POP assessments. 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 youth involved in EPSDT programs compared to those youth involved in "other" types of coordinated care services. The two cohorts are labeled EPSDT and POP. The POP cohort represents the youth in the POP sample other than EPSDT programs. The total sample size for the EPSDT youth for this report is 874 youth and the total sample for POP (minus EPSDT) is 4,842. For those youth who have remained in services for at least 6 months a follow-up assessment was collected and then annually. The sample sizes for the 6-month follow-up EPSDT cohort is 177 and for the POP cohort is 1,484. The sample sizes for the 1-year follow-up EPSDT cohort is 45 and for the POP cohort is 1,000.

Cohort Demographics

In comparing the EPSDT sample to the POP sample there are some interesting differences in demographic characteristics. The percentage of males in the EPSDT programs is less than the POP sample. The percent of males are 58.4% for EPSDT and 63.8% for POP (Figure 31a). The age distribution of the youth entering the EPSDT programs is also different than the POP sample. By comparing means and modes the youth are younger in the EPSDT sample with more latency aged youth receiving services compared to the POP sample that has more adolescents (Figure 31b). There is also more youth of Hispanic race/ethnicity group involved in EPSDT programs (43.1%) compared to POP (34.6%) (Figure 32a). While, predominantly all youth in both EPSDT and POP samples are living in "home" environments at the time of assessment (Figure 32b).

Clinical Outcomes

In comparing the clinical profiles of children and adolescent in EPSDT programs versus those in other POP programs, EPSDT youth are statistically significantly, less impaired at intake

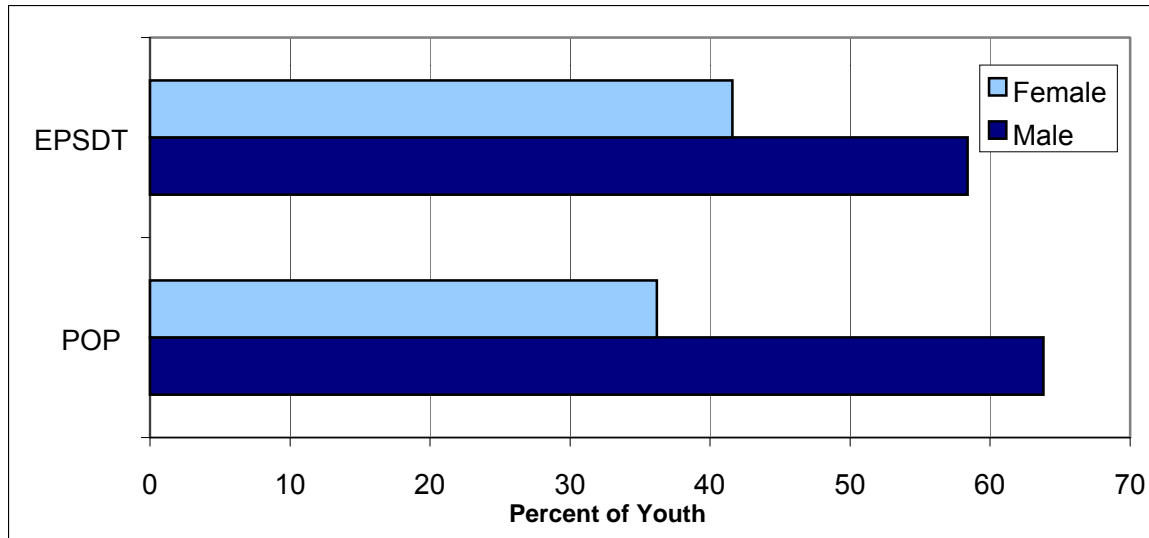
according to clinician and parent reports. The mean CAFAS score at intake for EPSDT is 50.17 (n=761) versus 55.36 for POP (n=4302). The CBCL total T-score at intake for EPSDT is 62.59 (n=713) versus 66.55 for POP (n=4105). There was no statistical difference between the groups at intake according to the youth assessment on the YSR.

Across each timeframe cohort (intake to 6 mths and intake to 1 yr) and for each sample (EPSDT and POP) clinician, parent and youth reports reflect overall improvement. However, EPSDT youth show statistically significant improvements from intake to 6-month follow-up according to clinicians and parents, not youth. While POP youth show statistically significant improvements for both timeframe cohorts, intake to 6-month and intake to 1-year, according to all three informants: clinicians, parents and youths (Figure 33 a,b,c). When the data is examined by change scores for each measure, the information varies by informant for both EPSDT and POP samples. At the 6-month follow-up clinicians report more no change occurring for both EPSDT and POP youth (Figure 34 a, b). At the 1-year follow up all informants are reporting more positive change for both EPSDT and POP youth (Figure 34 c, d). The percent of youth reporting positive change is very high in the EPSDT sample, however the overall sample size is quite small (n=17)(Figure 34d).

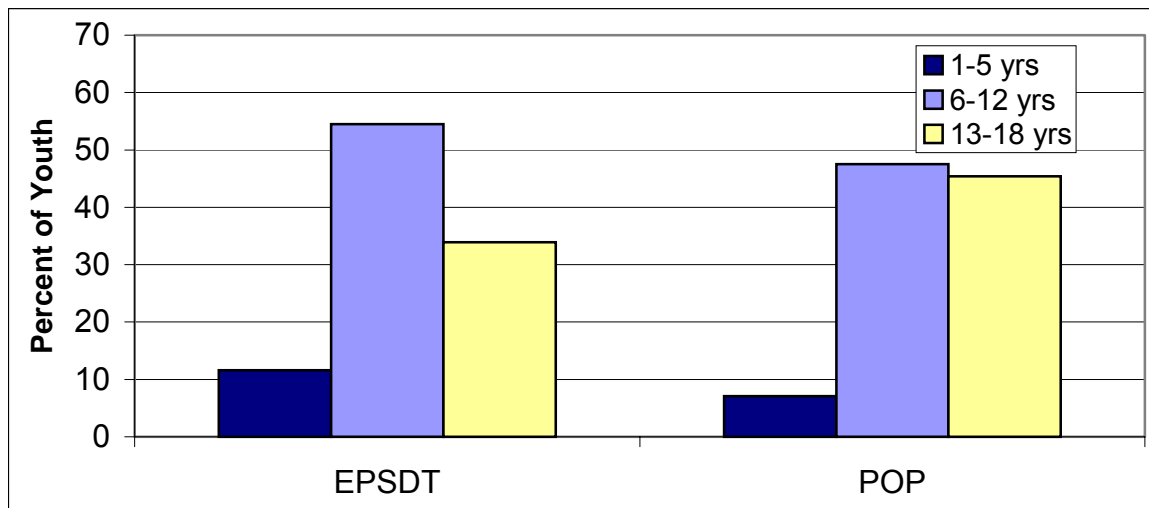
Repeated measures analyses for youth who completed intake, 6-month and 1-year assessments show continuous statistically significant improvement over time on the CAFAS, CBCL and YSR for the POP sample. However, for the EPSDT sample, clinicians (CAFAS) do not report continuous statistically significant improvement over time (Figure 35a). There are statistically significant linear effects per parent report (CBCL) and per youth report (YSR) for the EPSDT sample (Figure 35 b, c).

Figure 31: POP vs. EPSDT Intake Cohorts by Sex and Age

(a) POP vs. EPSDT Intake Cohort by Sex



(b) POP vs. EPSDT Age Group at Intake

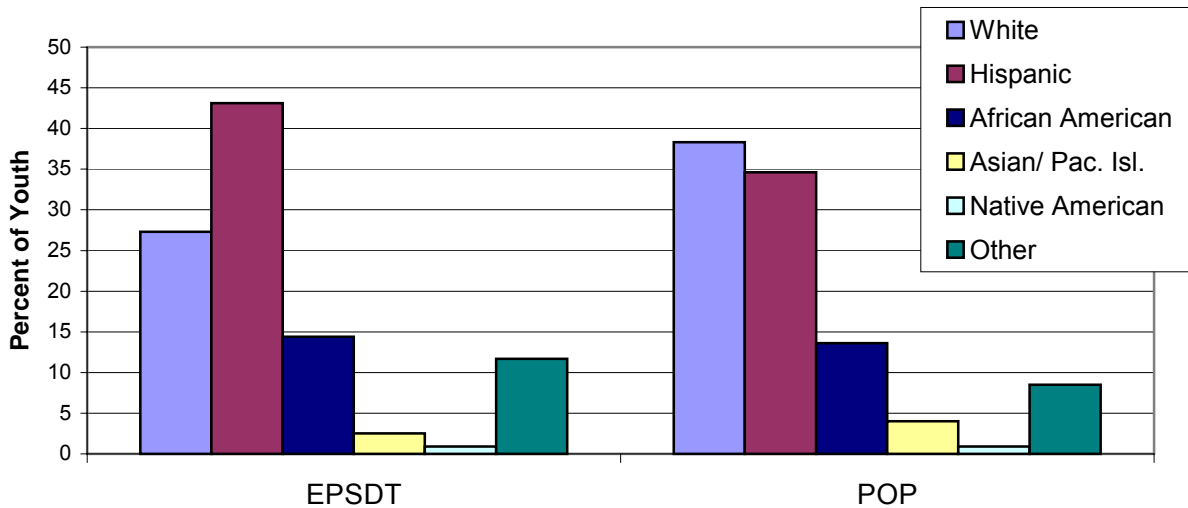


- More females enter EPSDT service programs than other POP programs.
- There is a higher percentage of latency age children in EPSDT programs than other POP programs.

Figure 32: POP vs. EPSDT Intake Cohorts by Race/Ethnicity and Living Environment

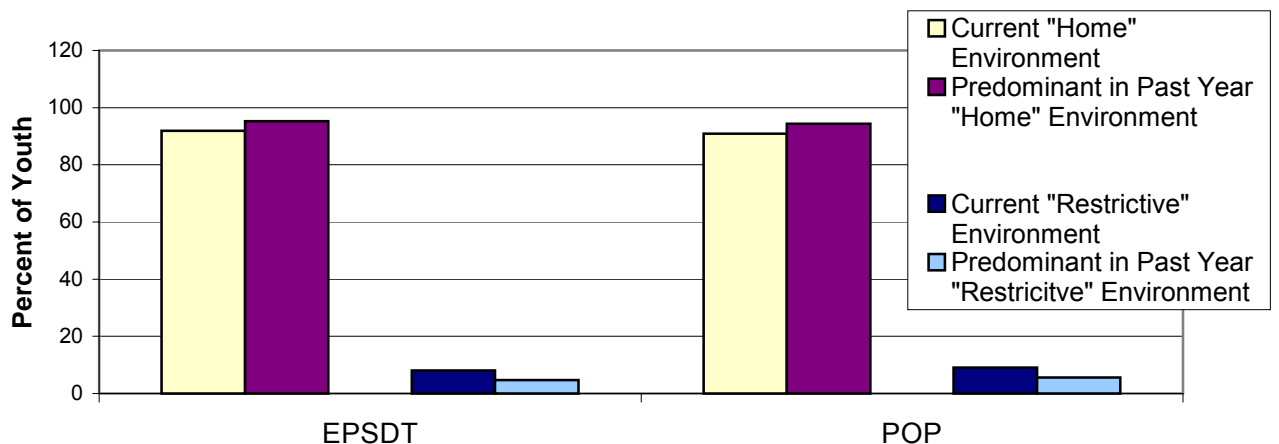
(a) POP vs. EPSDT Intake Cohorts by Race/Ethnicity

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



(b) POP vs. EPSDT Client Living Environment Profile at Intake Assessment

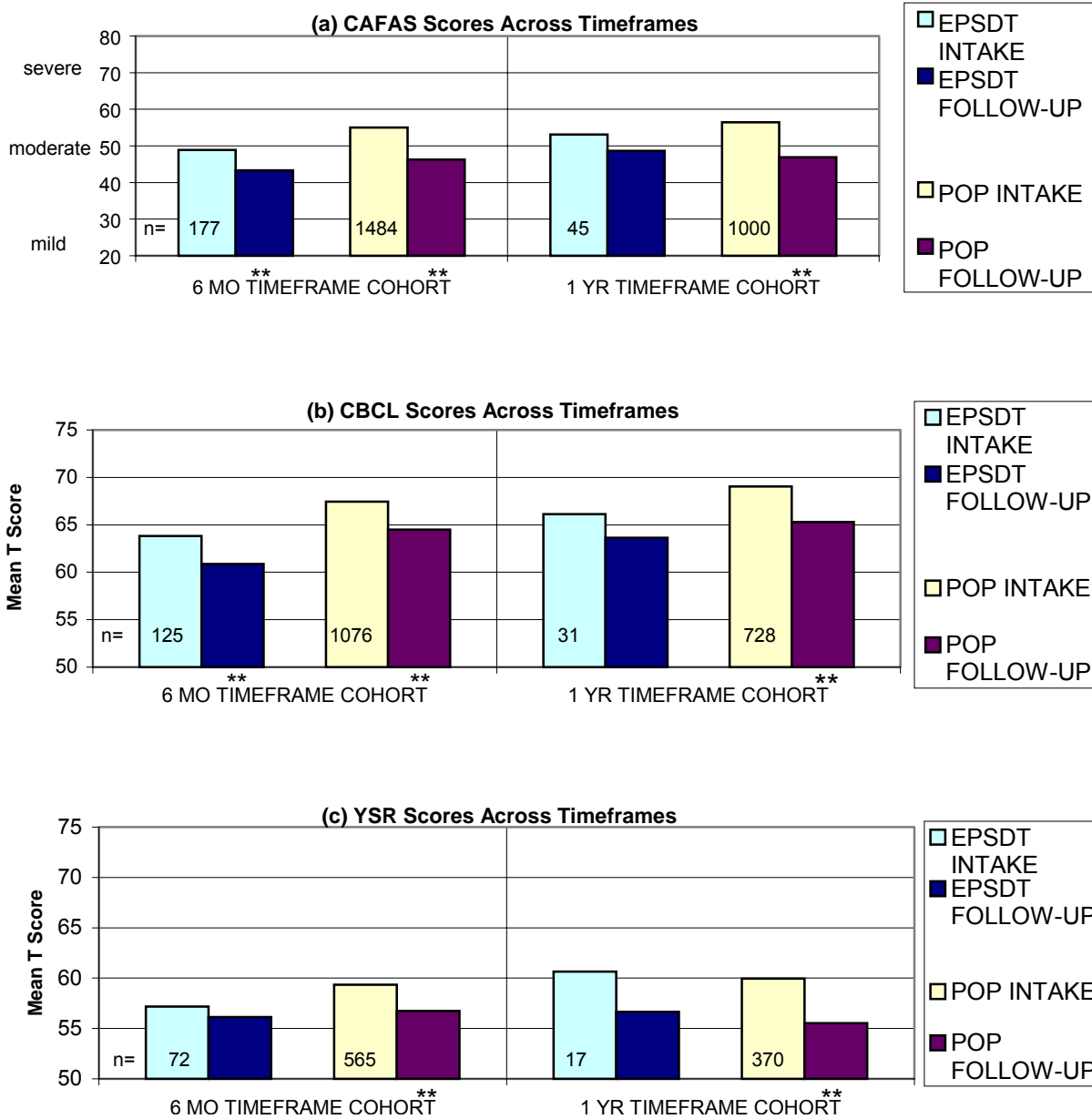
The Client Living Environment is completed by the clinician after interviewing the youth and family. “Home” environment includes bio/adopted homes, foster care and living independently. “Restrictive” environment includes incarcerated, psych hospital, group home and homeless. “Current” represents living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



- There are more Hispanic youth in EPSDT Programs compared to other POP programs.
- All youth predominantly live in “Home” settings at time of intake.

Figure 33: POP vs. EPSDT 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 (11-18yrs). The bars indicate mean levels of functioning at intake and follow-up across two timeframes: Intake to 6-months and Intake to 1-year.

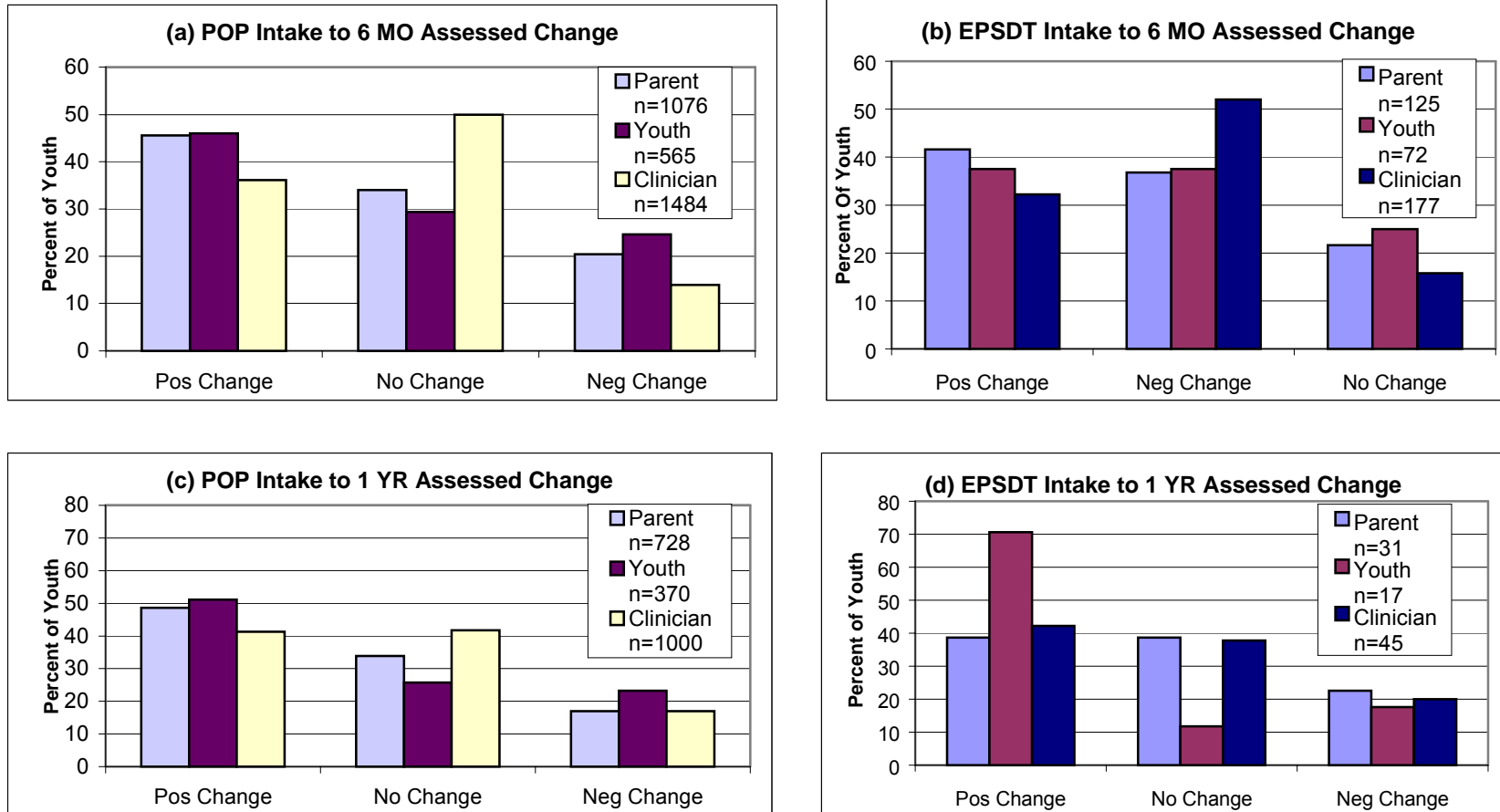


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- Clinicians and parents report statistical significant levels of improvement for EPSDT youth from intake to 6-month only.
- Clinicians, parents and youth report statistical significant levels of improvement for both cohorts (intake-6month & intake-1year) for POP sample.
- EPSDT youth are significantly less impaired at intake compared to POP according to clinicians and parents.

Figure 34: EPSDT vs. POP Assessed Change in Treatment Across Timeframes- Parent, Youth and Clinician

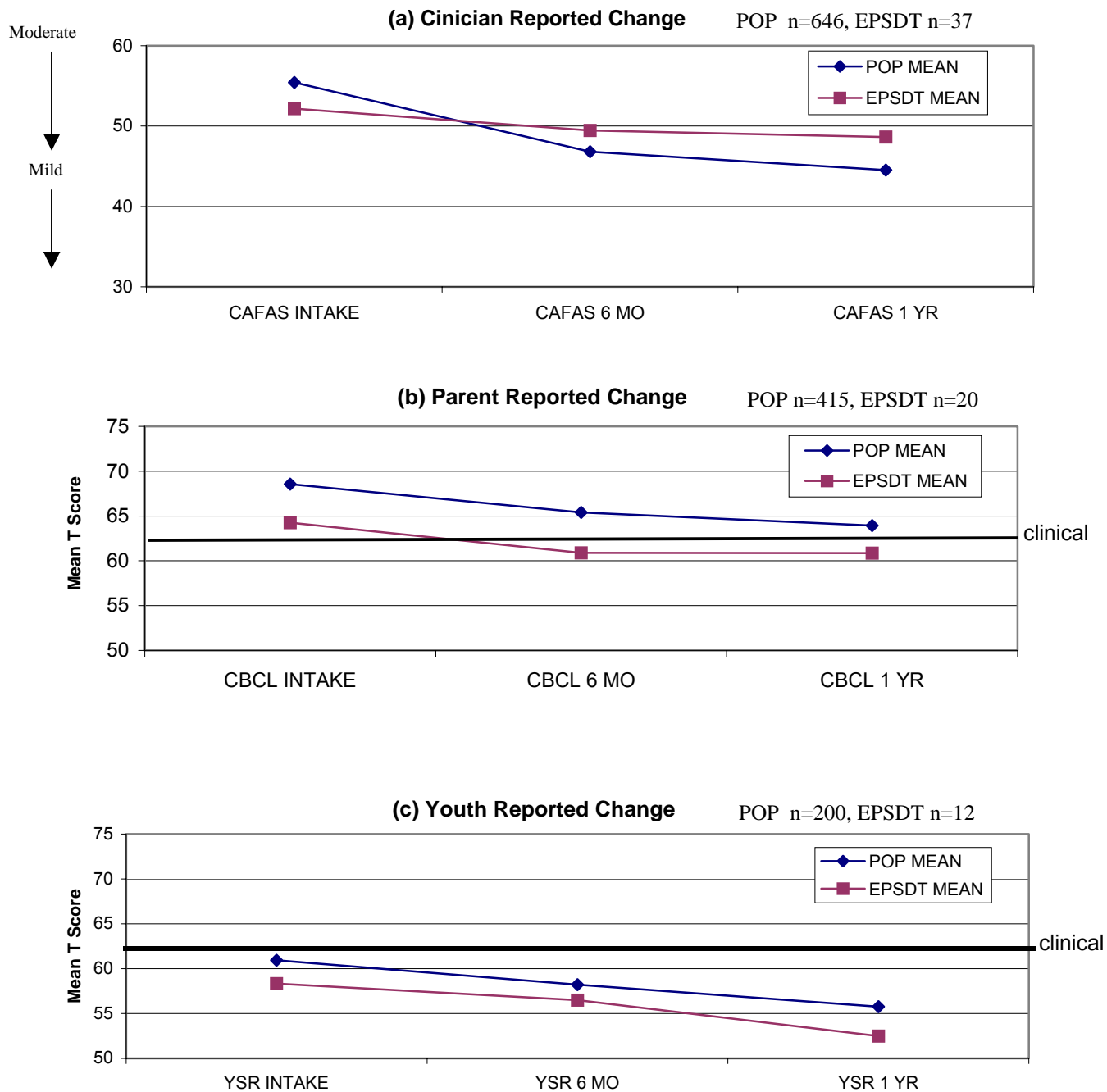
“Negative change” indicates youth who got worse, “no change” indicates youth who stayed the same and “positive change” indicates youth who got better according to each informant. Significant change is defined as greater than a 3-point change on CBCL or YSR and a 10-point change on CAFAS.



- At 6 months, the multiple informants are reporting similar types of change for youth in EPSDT & POP
- At 1 year, youth in EPSDT programs are reporting more positive change compared to others and compared to POP

Figure 35: EPSDT vs. POP Change Across Time- CAFAS, CBCL and YSR at Intake, 6 Months and 1 Year

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



- EPSDT sample, according to parents and youth, demonstrate statistically significant linear effects from intake to 1 year. Clinicians do not report significant improvements for EPSDT youth.

Intensive Services 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 innovations represented by the children's system of care concept that have been diffused throughout the country. Phase II of this nationwide 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 continues to serve and collect data on new clients. Follow-up data is collected consecutively at 6-month intervals for the length of the evaluation, ending in 2003. This evaluation project 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 programs 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 youths 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 four intensive service programs for coordinated care youth in or at risk for restrictive placements: TOWER, CITY, BEST and CYFN. The Transition of Wards Embracing Recovery (TOWER) program is a short-term intensive service program for youth involved in the juvenile justice system. The Community Intensive Treatment for Youth (CITY) is a long-term intensive case management state hospital alternative program for high-end youth needing intensive services. Building Effective Solutions Together (BEST) is a long-term intensive case management service for youth who are also wards and dependents and Child, Youth and Family Network (CYFN) is a long-term intensive case management program for youth from any one of four sectors: mental health, juvenile justice, social services and education. In addition, a few youth participating in the Wraparound Laboratory/SB163 intensive services wraparound program were included in the sample for this report. The data from each of the programs: TOWER, BEST, CITY, CYFN and Wraparound Laboratory/SB163 was collapsed into one follow up sample. The TOWER program contributed the largest amount of data to the sample (45.3%) followed by BEST (22.1%), CYFN (20.1%), Wraparound Laboratory/SB163 (6%) and CITY (3.5%).

Services

The youth involved in the long term intensive service programs (BEST, CITY & CYFN) receive a variety of services that are “wrapped” around them according to the youth’s and family’s individualized needs. These services can be “traditional” types of services such as case management, individual, group or family therapy, medication, crisis stabilization or evaluation. The services may also include “innovative” types of assistance that were made available as part of the new system of care program. These services may include recreation, respite, transportation, flexible funds, family support and preservation, behavioral aide or independent living assistance. Lastly, the services may be ones that are considered “restrictive” such as hospitalization, residential placements, day treatments, group homes or camp environments. The goals of intensive case management programs is to wrap alternative services available in the community in order to reduce the time youth spend in restrictive services. The data shows that youth are involved in Traditional Services more than other types. Approximately 1/3 of the youth also receive transportation services (typically to and from a traditional service program) and participate in recreational activities. There are also ¼ of the youth who have resided in a residential facility at 6-month follow up. As more youth are assessed at longer follow up time-points the data can be compared by services by follow up time-points. It is the goal of the Intensive Services programs to reduce the percentages of youth who participate in restrictive services over time.

Sample Demographics

To date, two hundred and ninety eight youth have participated in the evaluation. Sixty-nine percent of these youth are males and 31% are females. The majority are adolescents 14 to 17 years old with an average age of 14.45 years (range from 6-18 years old). The mean number of members living in the household is 4.38 with a mean number of children being 2.63 and 56% of youth are 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 37a). Very few parents of youth report having a college degree and 30% of parents reported having less than a high school degree (Figure 37b). The youth and families are primarily from White or Hispanic race/ethnicity backgrounds with very few families from Asian/Pacific Islander and Native American groups (Figure 37c). The data was collected in Spanish for 16% of the interviews with parents and 0% for youth.

Clinical Outcomes

The outcome data show linear effect improvements (less functional impairment) on the CAFAS from baseline to 18-month follow up for each of the subscales except substance use and school/work. However, there is a trend towards significance for the school/work subscale ($p=.07$) (Figure 38). 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]), there are statistically significant linear effect improvements in youth behavior and emotional problems over time. There are continuous gains reported from baseline to 18-months (Figure 39). 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. Youth report data show statistically significant linear effects of improvement for externalizing and total emotional/behavioral problems on the YSR from intake to 18-months (Figure 40).

In comparing change scores on the CBCL and YSR from baseline to 6 months parents and youth report very similarly. They both report youth changing positively or staying the same

equally and either of these more often than negative change (Figure 41a). From intake to 1-year, parents report slightly more youth with positive change and youth report negative change occurring more often compared to parent report (Figure 41b). On the Caregiver Strain Questionnaire (CGSQ) there is statistically significant linear effect improvements for each domain (objective, subjective and global) from baseline to 18-months (Figure 42). Statistically significant decreases were observed for Objective and Global measures of caregiver strain between baseline and 6-months. Then all subscales: objective, externalized subjective, internalized subjective and global were all statistically significant from baseline to 1-year (Figure 42). 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, and Family Involvement. These subscales showed linear effects but no significant improvements on pairwise comparisons. There was no change in regard to School Functioning nor Affective Strength (Figure 43).

Quality Improvement

Consumer perspectives are important in understanding how mental health services are perceived and evaluated by youths and families. At the close of each interview youths and caregivers were given the opportunity to talk about what aspects of services were positive or negative for them. Responses were classified into categories by similarity. The frequencies of responses were then tallied for each category of response. Table 4 list the categories by youth or caregiver ranked ordered by frequency of responses from most frequent (1) to least frequent (14). Note that the number of comments were self-generated by both parents and caregivers and vary in frequency. Sixteen caregivers and thirty-five youth had no comment or said “none” to the question inquiring about positive aspects of services and one hundred and eighty-five caregivers and one hundred and eighty-two youth had no comment or said “none” to the questions inquiring about negative aspects of services. The negative comments were generated significantly less than positive comments.

In tabulating the “Positive Comments” for both youths and caregivers, the theme of “provider characteristics” such as a service provider demonstrating attention and caring was generated the most often and therefore ranked highest for both informants. However, comments about “recreational activity” had the next highest frequency and subsequently ranked 2nd for youths. These comments were generated less often by parents and consequently ranked 8th for caregivers. This suggests that recreation was a more important positive aspect of services for youths relative to caregivers. Another example is that of “service coordination”, which was the 6th most frequently endorsed issue for caregivers and was mentioned by only one youth ranking it as least important.

After examining “Negative Comments” for both youths and caregivers, the category of “poor engagement” was the most frequently mentioned concern for both informants. Comments were related to poor follow-through after initial contacts for services. For youths, dissatisfaction with provider or “provider characteristics” was the 2nd most frequently mentioned concern, while this was the 3rd for caregivers.

Satisfaction

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 reported satisfaction with services most often (Figure 44). Both respondents report “satisfied” or “neutral” evaluations of services at 6-months and 1-year 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 counselor's qualities, the level of family involvement and the absence of conflict with their counselors at both 6-month and 1-year follow-ups. The data was analyzed by White, Hispanic and African-American race/ethnicity groups. Note other race/ethnicity groups were too small to be included in statistical analyses. At 6-month follow up, White youth rated "meeting needs" significantly higher than the youth from the other 2 ethnic groups. This was not the case at the 1-year follow up assessment. There were no statistically significant differences between groups at 1-year (Figure 45). (Note that current sample sizes may be too small to detect statistical significance for some ethnic differences.)

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)

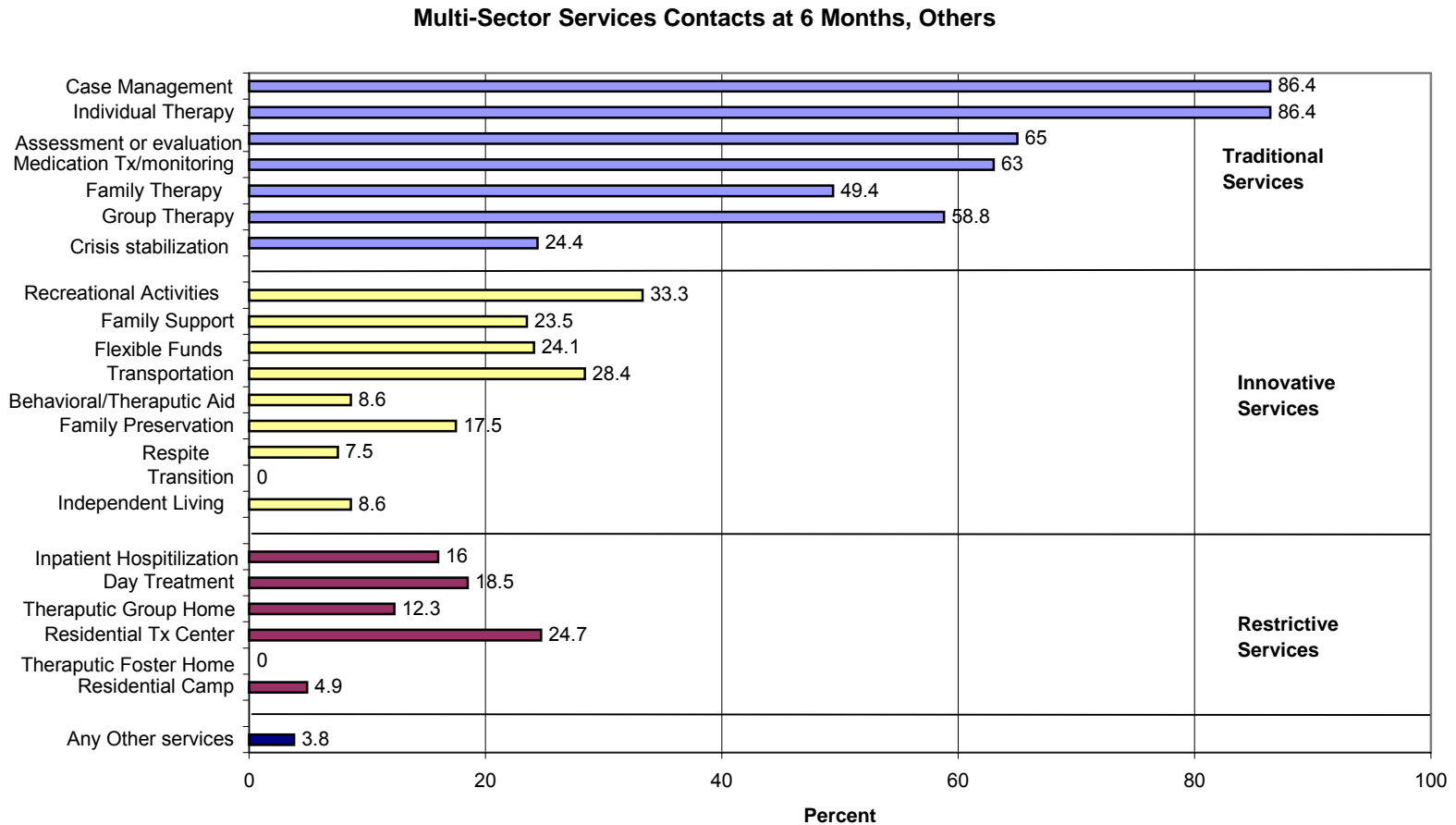
Multidimensional Adolescent Satisfaction Scale (MASS- 23)

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

Multi-Sector Services Contacts (MSSC)

- Records caregivers' reports of services used in multiple child-serving sectors and whether services met the child and family's needs.
- Records where, how much of each service type and when the service was received and captures more extensive information than is tracked in the MIS.

Figure 36: Parental Report of Types of Services Received During Participation in a Long-term Intensive Service Case-Management Program



- The majority of youth have received “Traditional” types of services. Approximately 1/3 of youth also receive transportation and participate in recreational activities.

Figure 37: ISEP: Income Distribution, Caregiver Educational Level, and Race/Ethnicity

(n=295)

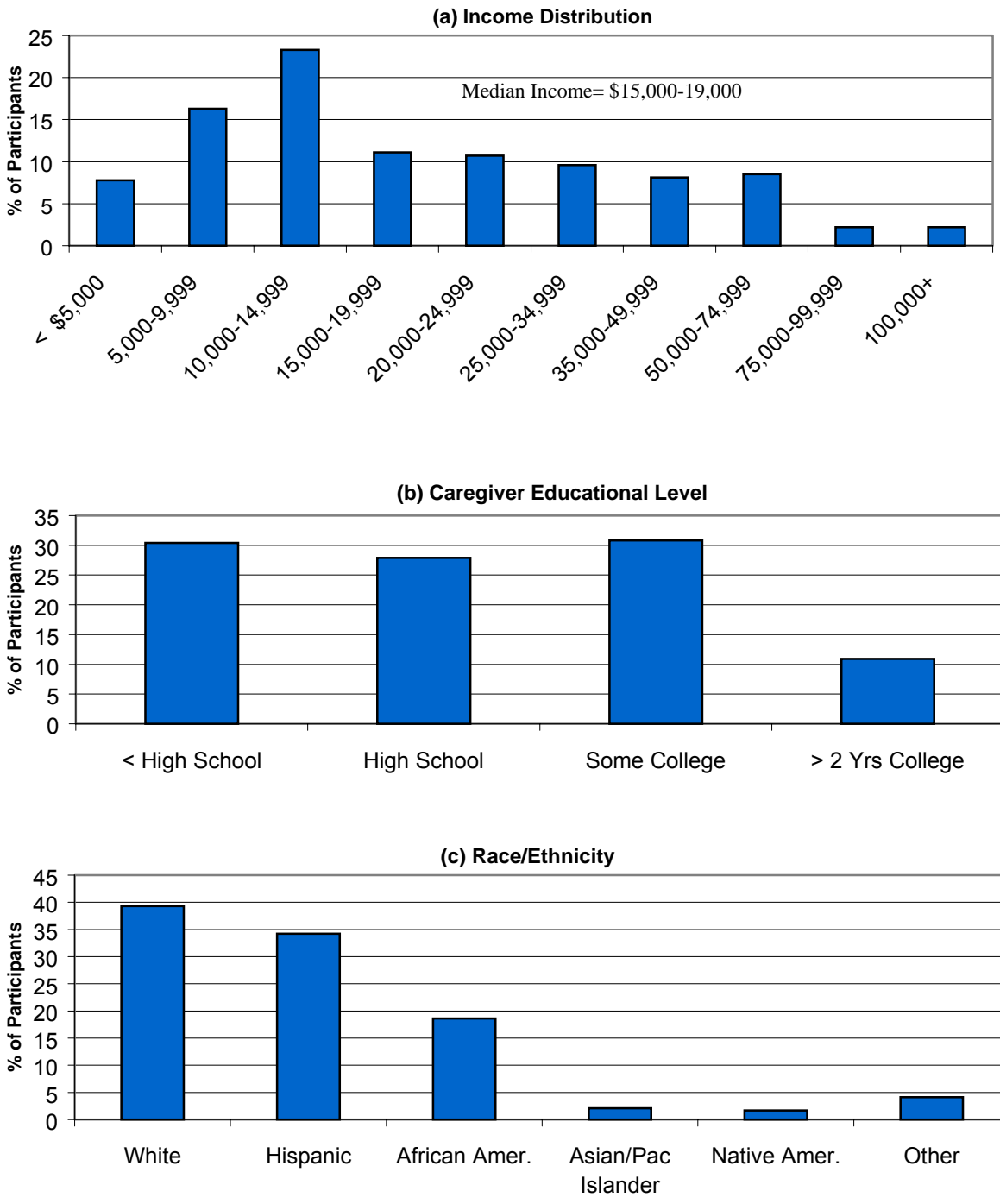
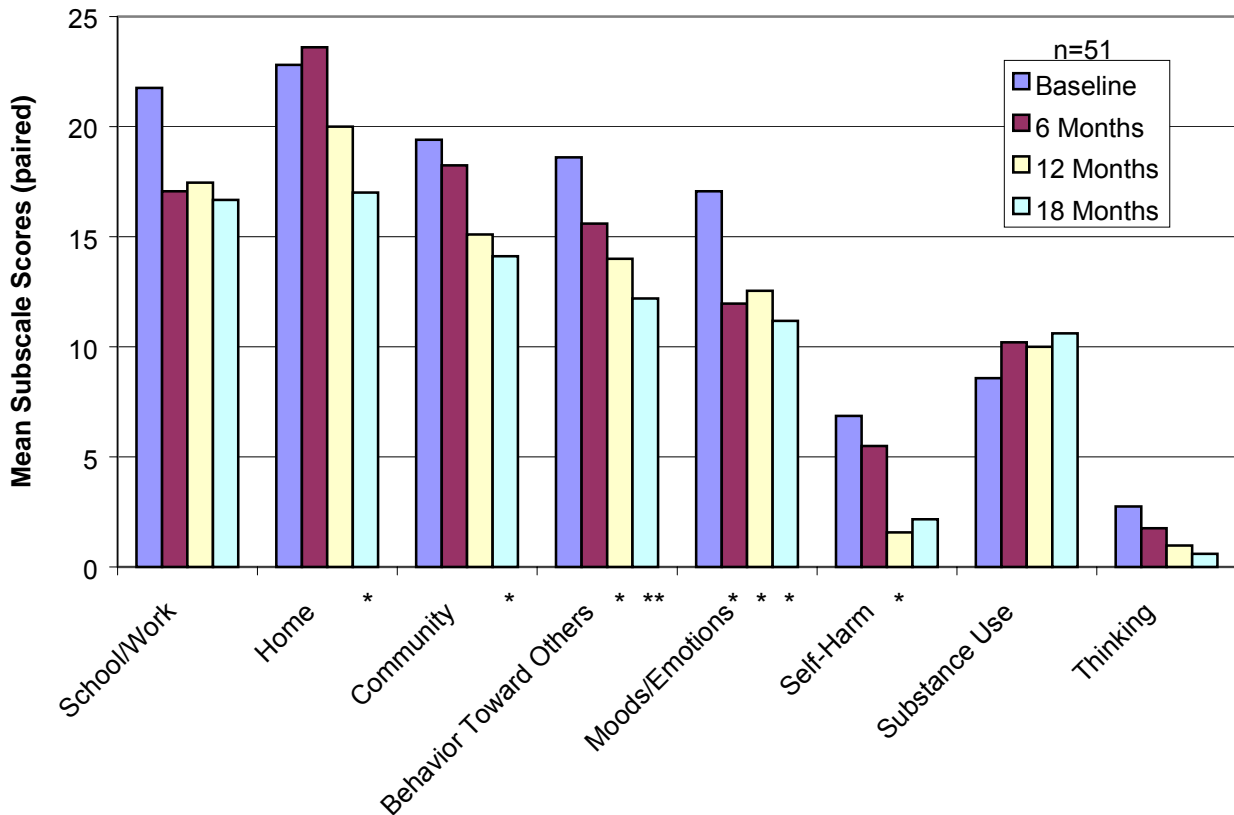


Figure 38: ISEP CAFAS: Total Functional Impairment from Baseline to 18 Months

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 all time points. Subscales range from 0-30.



* represents statistical significance at $p < .05$ and ** represents $p < .01$ based on pairwise comparisons of intake and each follow-up timepoints separately

- There are linear effect improvements (less functional impairment) from baseline to 18-month follow up for each of the subscales except substance use and school/work.
- There are statistically significant improvement on pairwise comparisons for home, community, behavior towards others, moods/emotions and self-harm subscales.

Figure 39: 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 all time points.

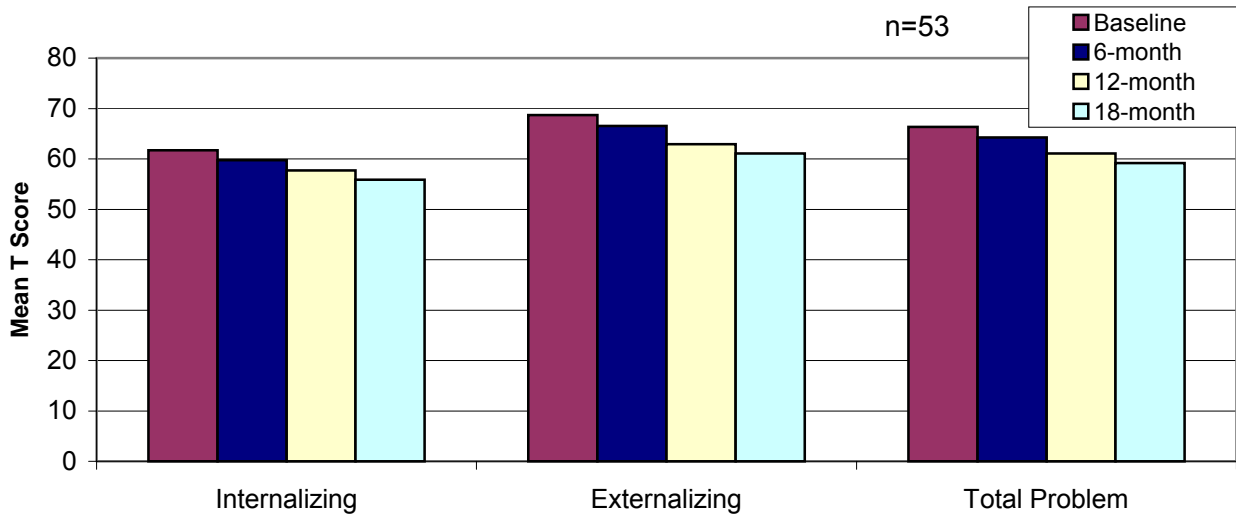
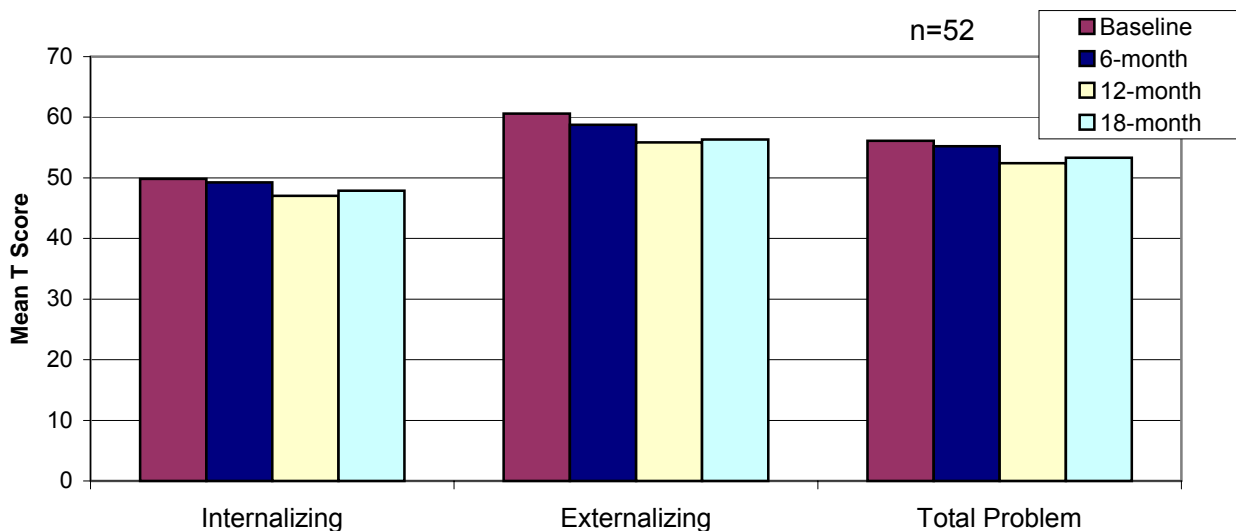


Figure 40: ISEP: Youth Self-Report (YSR) Scores

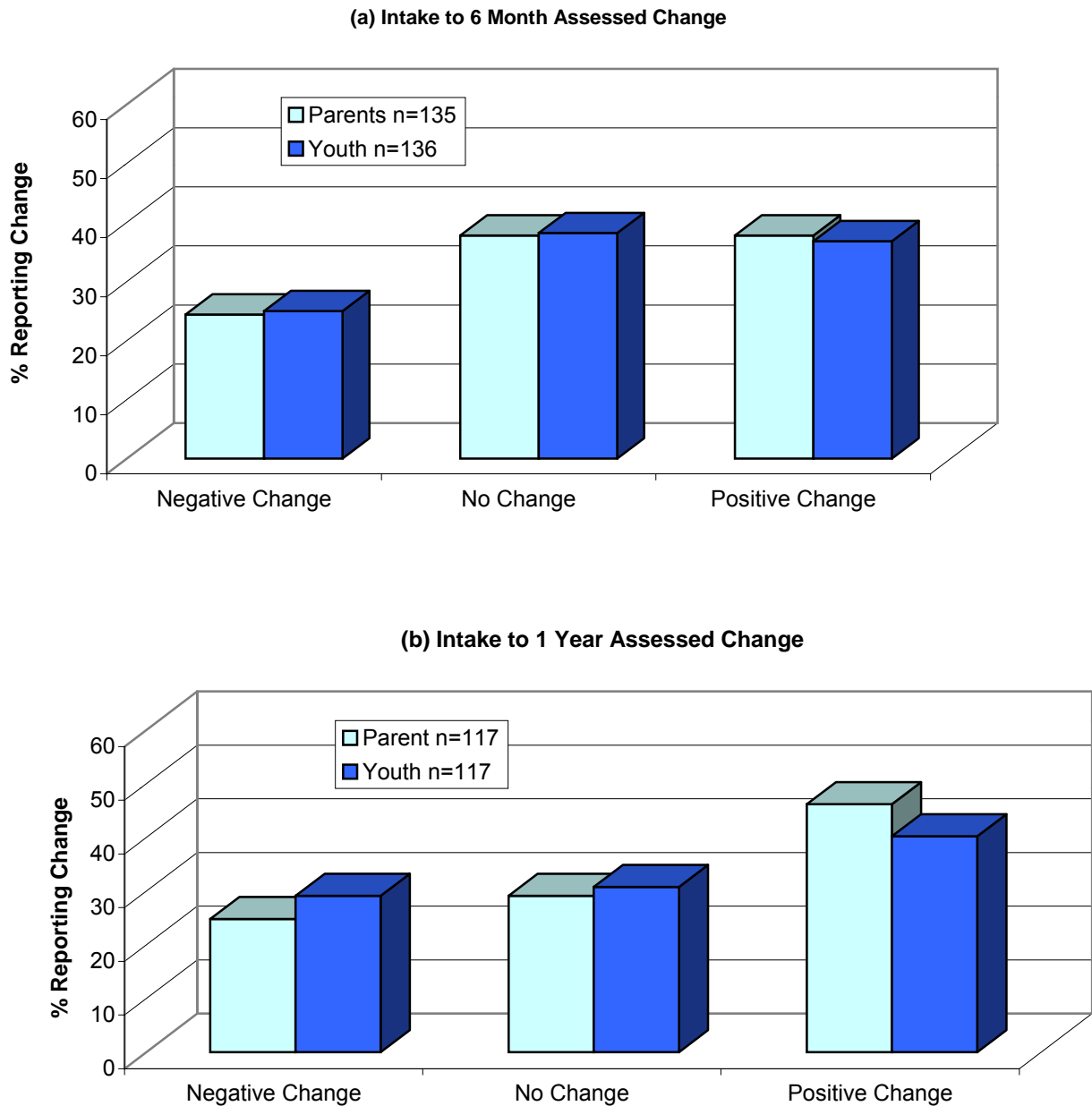
The YSR is an emotional/behavioral problems measure completed by interviewing the youth (11-18 yrs) from baseline to 18 months at 6-month intervals. “n” values reflect the number of youth who had YSR measures at all time points.



- Parents and youth are reporting slight improvements over time.
- There are no statistically significant reported decreases by either informant.

Figure 41: ISEP: Assessment of Change, Intake 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, 6-months and 1-year. Change scores are defined as greater than a 3-point change on CBCL and YSR.



- Parents and youth report very similar patterns of change at the 6-month and 1-year follow ups, with more positive change occurring at 1-year.

Figure 42: 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 all time points.

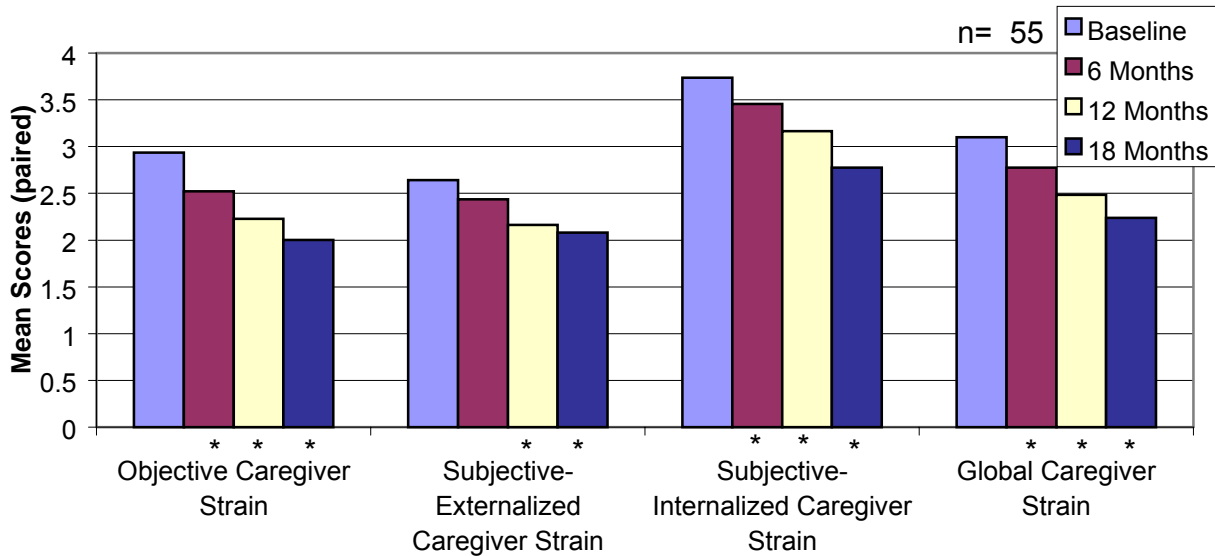
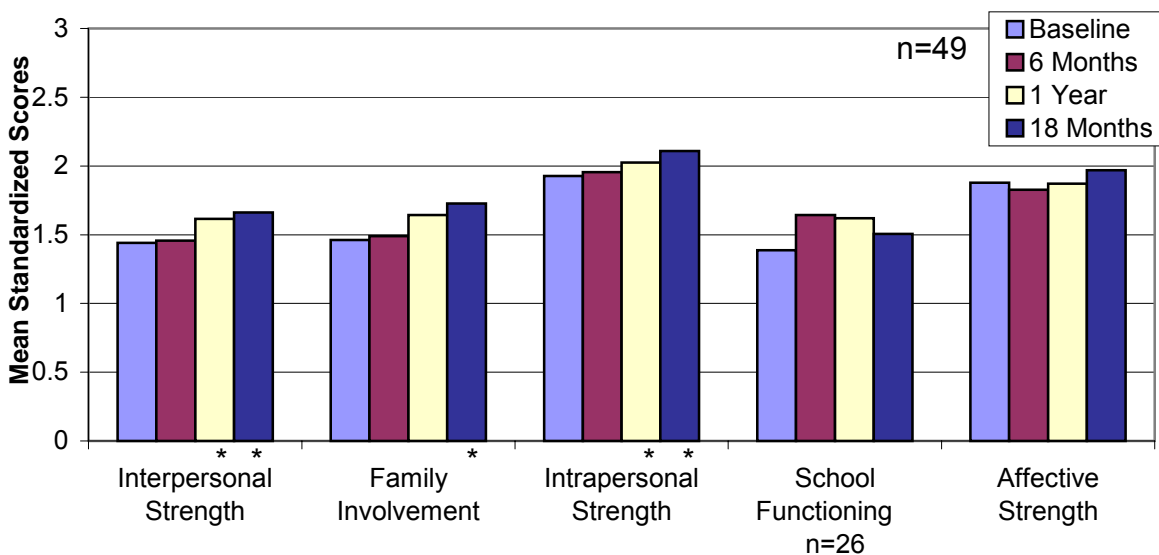


Figure 43: ISEP : Behavioral and Emotional Rating Scale (BERS) Subscales

BERS is a strength-based measure of youth behavior completed at baseline and follow ups by interviewing the caregiver. Higher values indicate more positive/constructive behaviors. “n” reflects the number of youth who had measures at all time points.

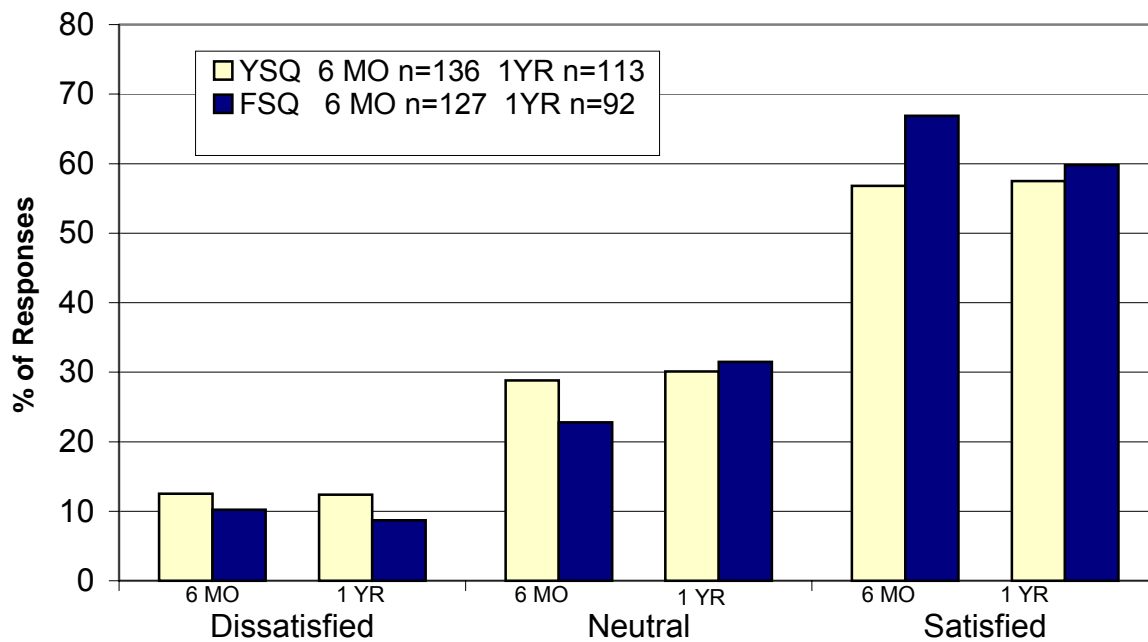


* represents statistical significance at p<.05 and ** represents p<.01 on pairwise t-tests from intake to each timepoint separately

- Parents are reporting less stress over time on the CGSQ and reporting more youth strengths on the BERS from intake to 18-months.

Figure 44: ISEP: Youth & Family Satisfaction, 6 Months and 1 Year

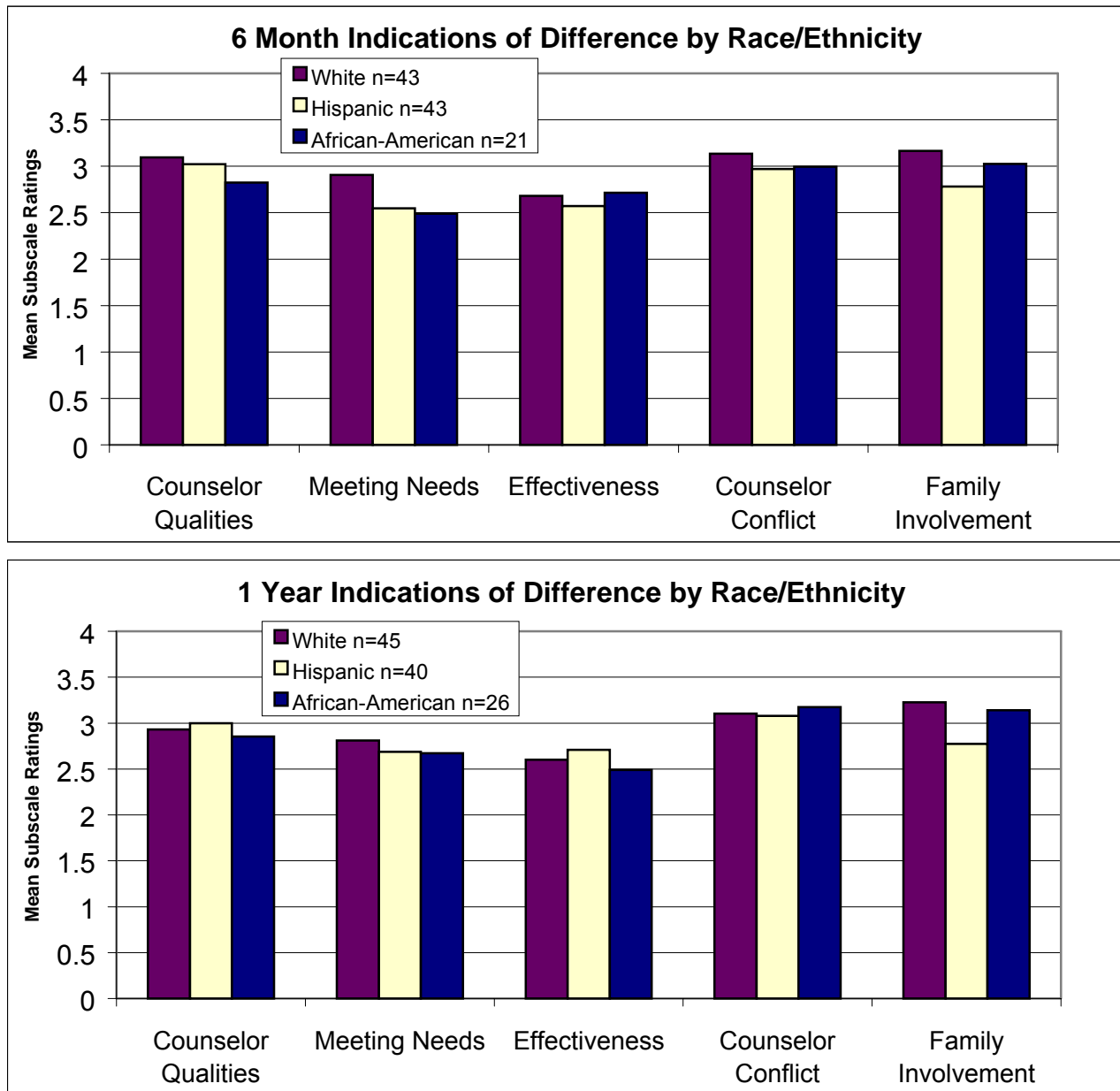
The Youth Satisfaction Questionnaire (YSQ) and Family Satisfaction Questionnaire (FSQ) are comparable measures of satisfaction with mental health services. Both measures are 5-point scales ranging from “very dissatisfied” to “very satisfied”. “n” refers to the number of respondents for each measure at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



- 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.
- Both youth and parent satisfaction reports remain positive at 1-year follow up.

Figure 45: ISEP Multidimensional Adolescent Satisfaction Scale (MASS), 6-Month and 1-Year Indications of Difference by Race/Ethnicity

The MASS scale measures youth satisfaction with counseling services. The three largest ethnic/racial groups: Whites, Hispanics and African-Americans are presented. “n” refers to the number of participants in each group.



- Youth, overall, are satisfied with counseling services. Youth rate the counselor qualities,” level of family involvement” and the absence of “conflict with their counselors”, with the highest amount of satisfaction at both follow-ups.
- There are no race/ethnicity differences.

Table 4: Youth and Caregiver Perceptions of Services Quality

Listed in Order of Caregiver's Frequency Comments

What have you found to be most helpful in working with [agency]?

Ranking by Frequency		Positive Youth and Caregiver-Generated Comments By Predominant Categories	Frequency and Percent of Comments	
Caregiver	Youth		Caregiver	Youth
1	1	Provider Characteristics: Responding to clients' needs, liking, trust, emotional support, and helpfulness.	126 (33.1%)	77 (30.2%)
2	5	Basic needs: Using flexible funds to provide food, transportation, clothing, and help with housing.	42 (11.1%)	20 (7.8%)
3	9	Information & referrals: Providing a wide range of information and ideas, as well as referring families to appropriate services.	33 (8.7%)	9 (3.5%)
4	3	Family focus: Focusing on the family as a whole, reuniting families, and teaching families the skills necessary to stay together.	31 (8.2%)	26 (10.2%)
5	10	Availability: Easily accessible for help.	29 (7.6%)	8 (3.1%)
6	14	Service Coordination: Linking the family to needed services.	20 (5.3%)	1 (0.0%)
7	13	Continuity: Consistency in service; reliable.	18 (4.7%)	5 (2.0%)
8	2	Recreation: Facilitating recreational activities; coordinating and/or providing funds for recreational activities.	16 (4.2%)	36 (14.1%)
9	11	Advocacy: Supporting families at important events such as IEP meetings and court hearings.	14 (3.7%)	7 (2.7%)
9	7	Counseling: Formal and informal individual and family therapy.	14 (3.7%)	13 (5.1%)
11	8	Mentoring: Program staff acting as mentors to support, teach, and encourage family members.	13 (3.4%)	10 (3.9%)
12	6	Help with school: Helping with homework, helping to establish IEPs, and getting youth back into school or into more appropriate schools.	9 (2.4%)	16 (6.3%)
13	4	Life skills: Helping to find a job by assisting in filling out applications or preparing for interviews; providing resources for developing life skills such as independent living programs.	8 (2.1%)	21 (8.2%)
14	12	Setting clear goals: Assisting the family in setting clear goals for treatment.	7 (1.8%)	6 (2.4%)
Total Comments:			380	255

NOTES: Duplicate ranking numbers indicate equal numbers of responses for two categories. An additional 16 caregivers and 35 youth had no comment or said "none" to this question. Percentages may not equal 100% due to rounding.

What are some of the problems you've experienced [with agency], if any?

Ranking by Frequency		Negative Youth and Caregiver-Generated Comments By Predominant Categories	Frequency and Percent of Comments	
Caregiver	Youth		Caregiver	Youth
1	1	Engagement: Slow startup of services, inadequate explanation of program and program goals.	38 (36.9%)	34 (60.7%)
2	3	Follow through: Program staff not keeping in contact with families, being unreliable or not doing what was promised.	16 (15.5%)	5 (8.9%)
3	2	Provider Characteristics: Clients' dislike of provider traits or the rules/decisions of the provider.	13 (12.6%)	14 (25.0%)
4	4	Availability: Families not being able to contact program staff when needed or lack of timely response.	12 (11.7%)	1 (1.8%)
5	-	Effectiveness: Haven't helped family.	8 (7.8%)	0
5	-	Communication: Not adequately communicating services available; not communicating about youth's progress.	8 (7.8%)	0
7	4	Continuity: Not having a consistent caseworker.	5 (4.9%)	1 (1.8%)
8	4	Cultural competence: Not being culturally sensitive; not providing a caseworker who speaks family's primary language.	2 (1.9%)	1 (1.8%)
9	-	Basic needs: Not providing a basic need.	1 (1.0%)	0
Total Comments:			103	56

NOTES: Duplicate ranking numbers indicate equal numbers of responses for two or more categories. An additional 185 caregivers and 182 youth had no comment or said "none" to this question. Percentages may not equal 100% due to rounding.

Supplementary Outcomes

Substance Use

Substance use data is collected as part of the Intensive Services Evaluation Project (ISEP). Youth receiving intensive case management services may be referred to specialty alcohol/drug services or may receive substance abuse services within the case-management program. The data is collected at baseline and each subsequent follow up time point (typically every 6 months). Data is gathered regarding youths' lifetime usage, age of first usage, usage in past 30 days and usage in past 6 months for each substance category: cigarettes, alcohol, marijuana and 13 drug categories on the Substance Use Survey. (See Figures 47 & 48). The data show that youth use "gateway" substances such as cigarettes, alcohol and marijuana at younger ages when compared to other drugs. The average age of first usage for cigarettes is 11.25 (SD 2.8), alcohol is 11.52 (SD 2.6), marijuana is 11.81 (SD 2.3) and other drugs combined is 13.73 (SD 1.6). There is also a much higher percent of youth who have used cigarettes (79%), alcohol (78%), and marijuana (73%) in their lifetime compared to all other drugs which range from Quaaludes (1%) to LSD/ PCP or ACID (30%) with the average age of youth at 15.52 (SD 1.6).

However, there is a difference in usage by those youth involved in the Juvenile Justice sector and those youth who do not have a history with Juvenile Justice. Figure 46 shows lifetime usage (youth responds "yes" to question, "Have you ever tried...?") at baseline for youth who have been or currently are on probation compared to youth with no probation status. The average age for probation youth is 16.04 (SD 1.2) and non-probation youth is 14.42 (SD 1.9). The probation youth report higher lifetime substance use for most drug categories. Their usage of cigarettes, alcohol, marijuana, LSD/PCP, Cocaine and Meth are significantly higher (Figure 46). Note that the higher mean age for probation youth contribute to the higher lifetime percentages. Nevertheless, Regression analyses, which control for age, demonstrate that the probation youth have used in their lifetime alcohol, marijuana, LSD/PCP, cocaine in powder form and crystal meth more often than non-probation youth.

The majority of youth who have used "gateway" substances in their lifetime are in the age range from 13-18 years old. However, the youth who have used drugs in their lifetime are typically older, 17-18 years old (Figures 47 & 48). In comparison to a youth's history of substance usage (lifetime usage) data for current usage shows significantly lower percentages of youth. This means that there are fewer numbers youth who are active uses than who have used or possibly experimented in the past. There is also not as much variation by age for youth who report current usage. The age range is 13-18 years old (compared to 11-18 for lifetime use). The data show increased substance use at 6-months compared to baseline for cigarettes and slight increased use for alcohol. Youth who used marijuana and/or drugs at baseline tend to continue to use at 6-month follow up as well.

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 or more).

TOWER served 129 youth who had prior involvement with the juvenile justice system from February of 1999 to June of 2000 which made them eligible for a 1 year follow-up and 115 of these youth had at least 1 charge in the year prior to services so the data was analyzed comparing charges 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 2.01 charges. The mean number of charges 1-year post entry into the TOWER program was .93 charge. This represents a 54% decrease in the number of charges following participation in the program. Most youth decreased their number of charges at 1-year follow up; 60% had a reduced number of charges, 23% showed no change and 17% had an increased number of charges.

There were 81 youth involved in TOWER program that had a felony charge during the 1 year prior to service receipt. The mean number of felony charges in the year prior to receipt of services was 1.46 charges. The mean number of felony charges post entry into the TOWER program was .33 charge. This represents a 77% decrease in the number of felony charges following participation in the program. Again most of these youth decreased their number of felony charges at 1-year follow up: 79% had a reduced number of felony charges, 18.5% showed no change and 2.5% had an increased number of felony charges.

BEST served 93 youth who had prior involvement with the juvenile justice system from December of 1996 to June of 2000 which made them eligible for a 1-year follow up and 64 of these youth had at least 1 charge in the year prior to services so the data was analyzed comparing charges 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 1.69 charges. The mean number of charges 1-year post entry into the BEST program was 1.38 charges. This represents a 18% decrease in the number of charges following participation in the program. There is an approximately equal balance of youth reducing, remaining the same and increasing their number of charges at 1 year follow up; 31.3% had a reduced number of charges, 29.2% showed no change and 39.7% had an increased number of charges.

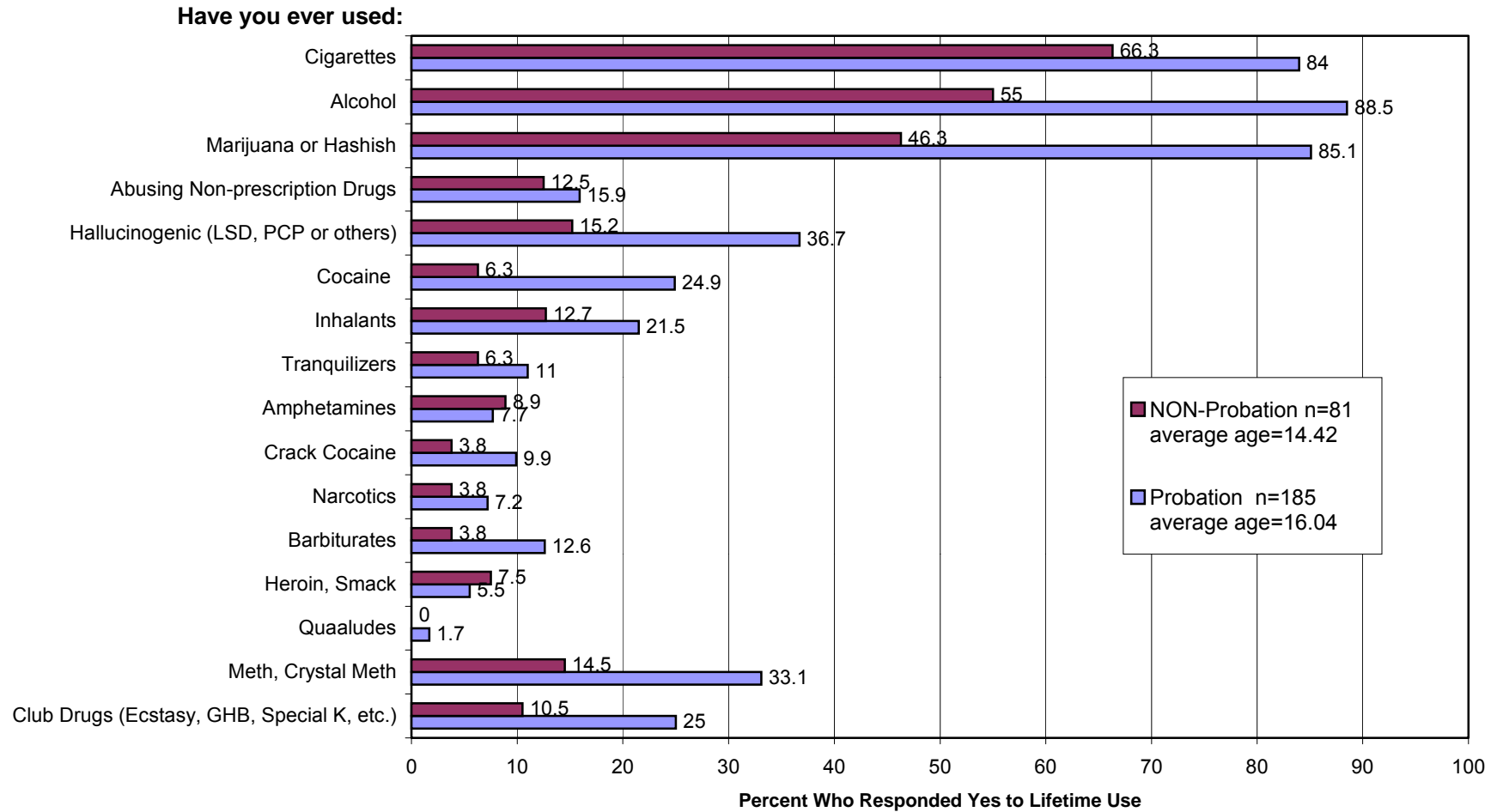
When the youth involved in BEST who had felony charges at 1-year prior to service receipt are analyzed separately, the sample decreases to 33 youth. For these 33 youth, the mean number of felony charges in the year prior to receipt of services was 1.30. The mean number of felony charges post entry into the BEST program was .48 charge. This represents a 63% decrease in the number of felony charges following participation in the program. Most of these youth decreased their number of felony charges at 1-year follow up: 66% had a reduced number of felony charges, 24% showed no change and 9% had an increased number of felony charges.

School Achievement

School achievement data is collected from those youth participating in the BEST and CYFN intensive case management programs. From 1996 to 2001, 163 Wide Range Achievement Tests (WRAT3) were collected at baseline and 37 youth had an additional follow up test averaging 15.81 months (SD=9.6) 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=3.3) and the mean at follow up was 7.0 (SD=3.3) for the Spelling Grade Equivalent score. The Reading Grade Equivalent mean score at baseline was 8.8 (SD=3.6) and 8.7 (SD=3.5) at follow up and the Math Grade Equivalent mean score at baseline was 6.4 (SD=3.2) and 6.4 (SD=3.1) at follow up. There were approximately 1/3 of youth who had a positive change, 1/3 with no change and 1/3 with negative change in raw scores in reading. There were more youth with improvements in raw scores for spelling with 39% positive change, 44% no change and 17% negative change. For math raw scores, 33% of youth showed positive change, 44% showed no change and 22% showed negative change.

Figure 46: Lifetime Substance Use History by Probation and Non-Probation Youth

“Probation” youth are those youth who have either current or prior involvement with the juvenile justice system at the time of baseline interview. “Non-probation” youth are those youth who have never been involved in the juvenile justice system. Data was collected at baseline assessment.



- Youth involved in the Juvenile Justice system are more likely to have used substances at baseline interview prior to Mental Health service receipt.

Figure 47: Lifetime and Current (past 30 days) of Alcohol and Cigarette Usage at Baseline and 6-Month Follow-up by Age Group

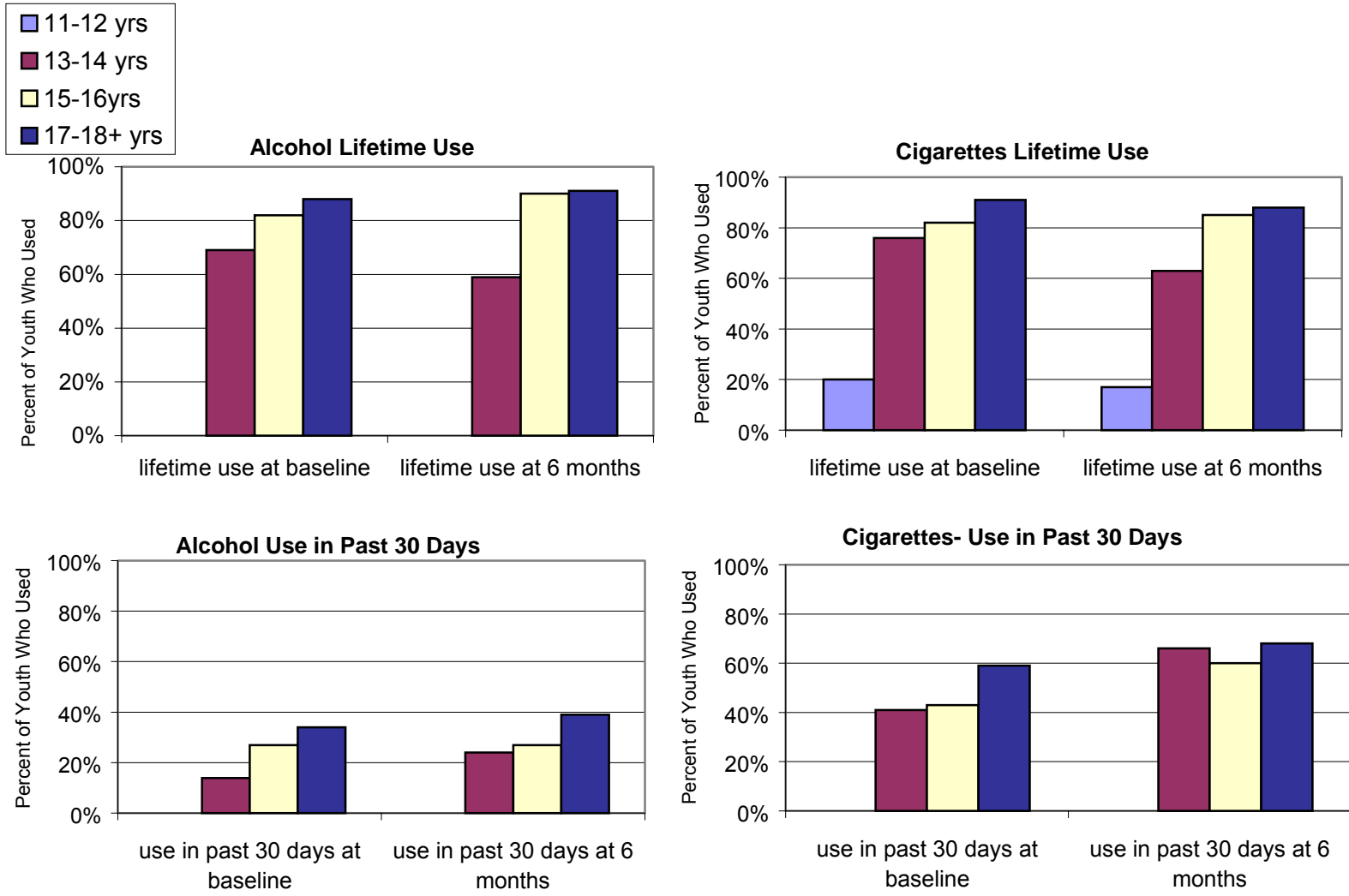
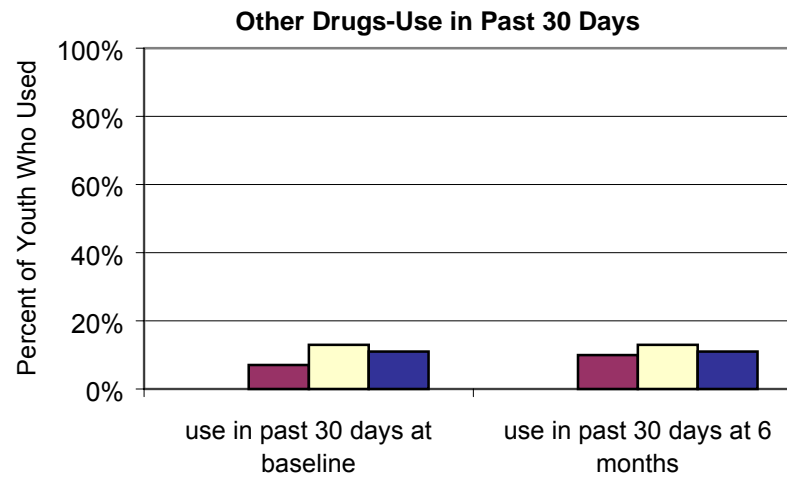
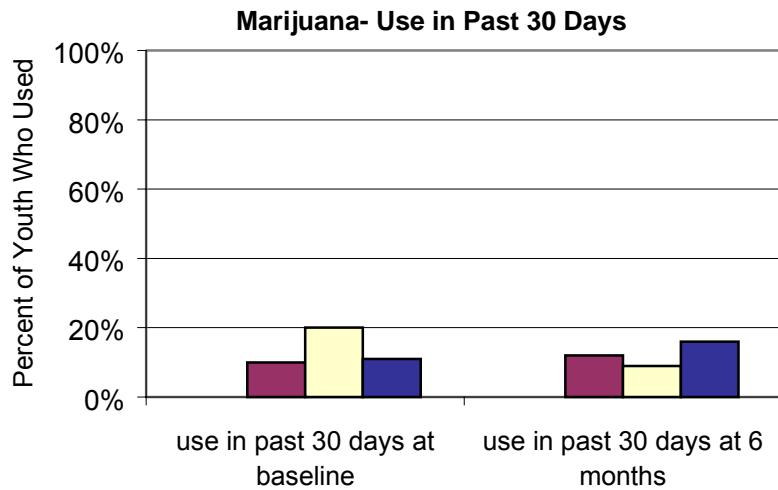
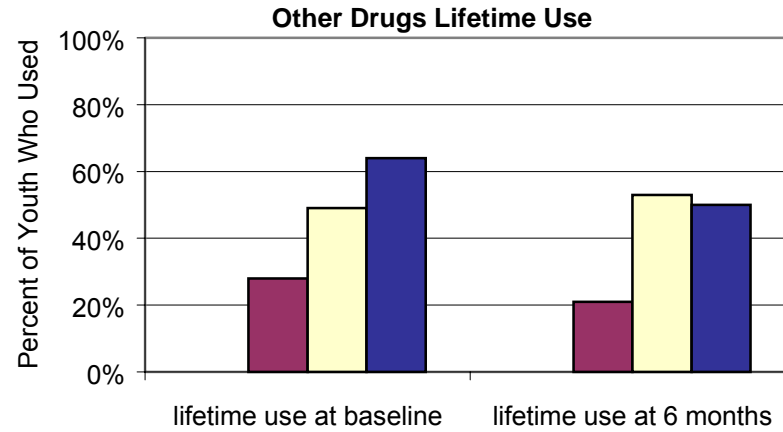
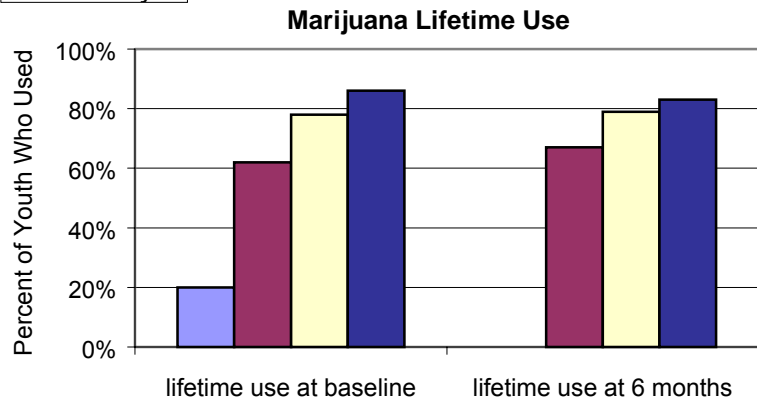
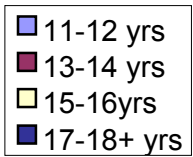


Figure 48: Lifetime and Current (past 30 days) of Marijuana and Other Drugs Usage at Baseline and 6-Month Follow-up by Age Group



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 have impacts on other parts of the child-serving system. The potential areas for capturing system data are: state hospital, inpatient, group home, foster agency, and foster home costs and utilization.

The area on which 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 49 reflects the dramatic decrease in State Hospital costs and utilization, with an 87% reduction in costs and 100% reduction in utilization. Note that 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 50 demonstrates both the County costs and utilization for inpatient care for children and adolescents over the last five years. In general, costs and utilization have remained fairly stable until the fiscal year 99-00. In FY00-01 the costs increased for both CAPS and Medi-Cal facilities. This was partly due to a rate increase for both programs. Overall, CAPS increased 6% and Medi-Cal increased 14% from FY99-00. The Medi-Cal increases were probably due partially to population growth. Population growth for minors in San Diego County increased by approximately 10,610 youth (under the age of 19) from 2000 to 2001. Subsequently, uninsured health care populations also increased which can have an effect on Medi-Cal eligibility, therefore resulting in increased Medi-Cal costs. The number of bed days used for CAPS decreased by 5% and increased by 5% for Medi-Cal. The 5% increase in the utilization of bed days may reflect an increase in the number of youth awaiting group home/residential treatment placements while in the hospital. This could suggest 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

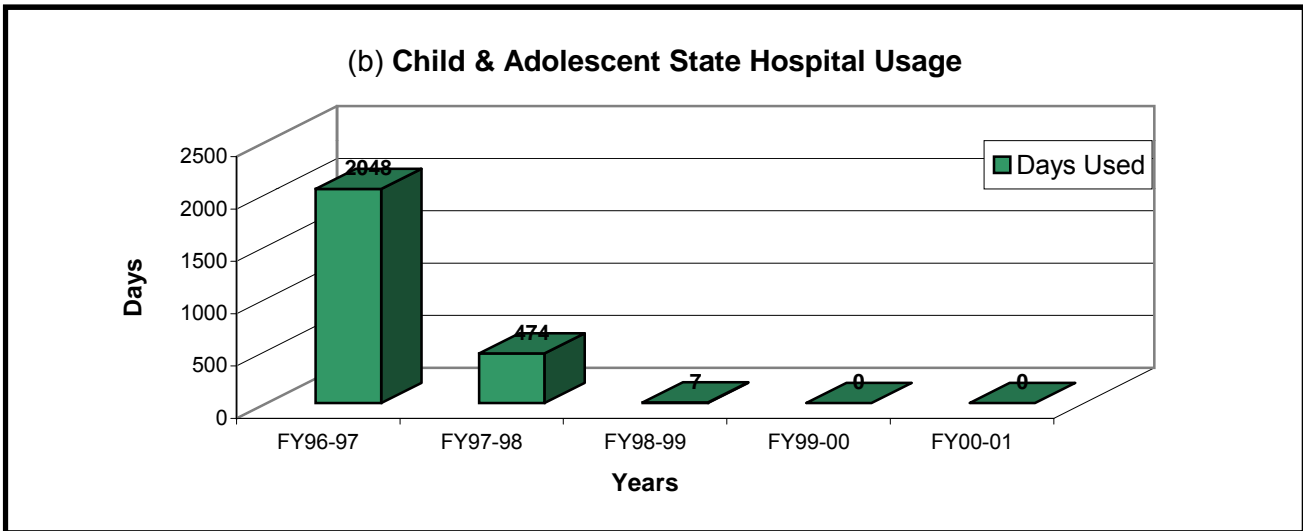
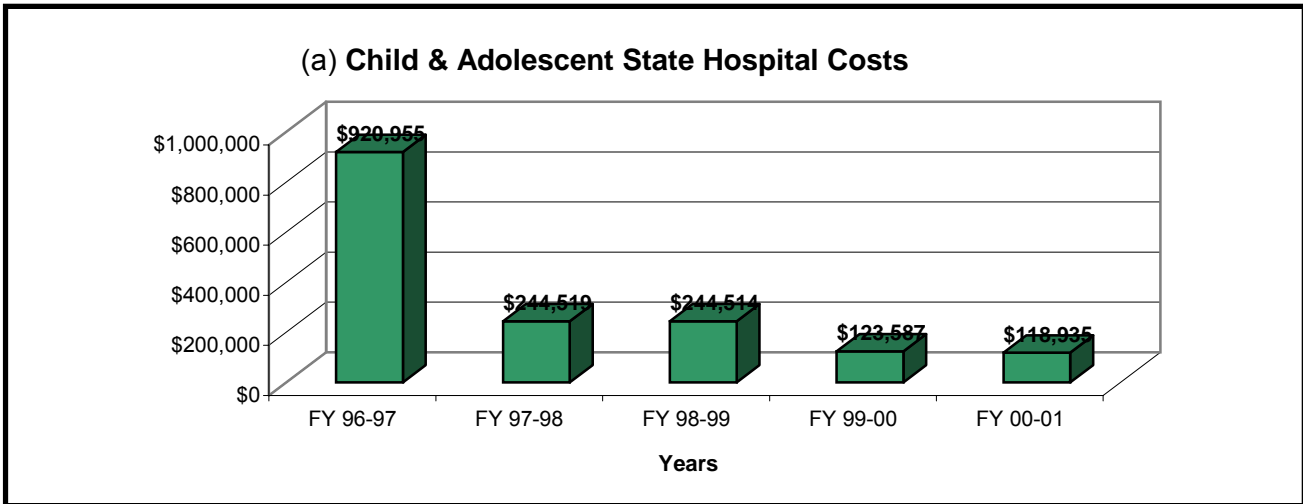
Figure 51 shows that Group Home/Residential overall total costs have slightly risen over the last 3 years while months in placement has remained stable. In comparing this recent fiscal year 00-01 to FY99-00, overall costs have risen 4%, while overall placements have declined by 1%. The differential in costs is primarily related to the increases in FY00-01 by the Child Protection Service department. In the past year, the change in costs and utilization has been only 9% and 6% respectively. This data indicates a slowing of growth for these indicators. Different from the FY99-00, in FY00-01 CPS has increased placements and Probation and Education/Mental Health (AB2726) have decreased placements. Only CPS has increased costs, respective to the increases in placements. These increases by CPS are probably reflecting the local efforts to reduce the amount of time children spend at Polinsky (a CPS shelter care setting) and place children in the most appropriate settings based on each child's individual needs. In the past, children remained at Polinsky for periods longer than anticipated due to a lack of needed group home placements. This "system back up" has begun to be eliminated which results in the reported increases in placements and expenditures for CPS.

In comparing SD county total out-of-home expenditures and total foster family agency placements to the State (Figure 52), SD County was 15% below the statewide average expenditures and is well below the statewide average number of FFA placements (SD approximately 50,000 vs State

approximately 180,000). San Diego has been able to keep FFA placements down by utilizing kinship care and other wraparound services that assist in keeping the child in the community. San Diego is also slightly below the statewide average in AFDC-FC Foster Home expenditures but slightly above the statewide average in AFDC-FC Foster Home placements. Again, this reflects the efforts in placing youth in the appropriate settings and eliminating the “back up” at the shelter care facility (Polinsky). However, when you compare San Diego to the state in regards to more restrictive levels of care for foster care children San Diego is greatly below for Foster Family Agency placements and below for Group Home placements for foster care youth in the year 2000.

Figure 49: State Hospital Costs and Usage by Fiscal Year

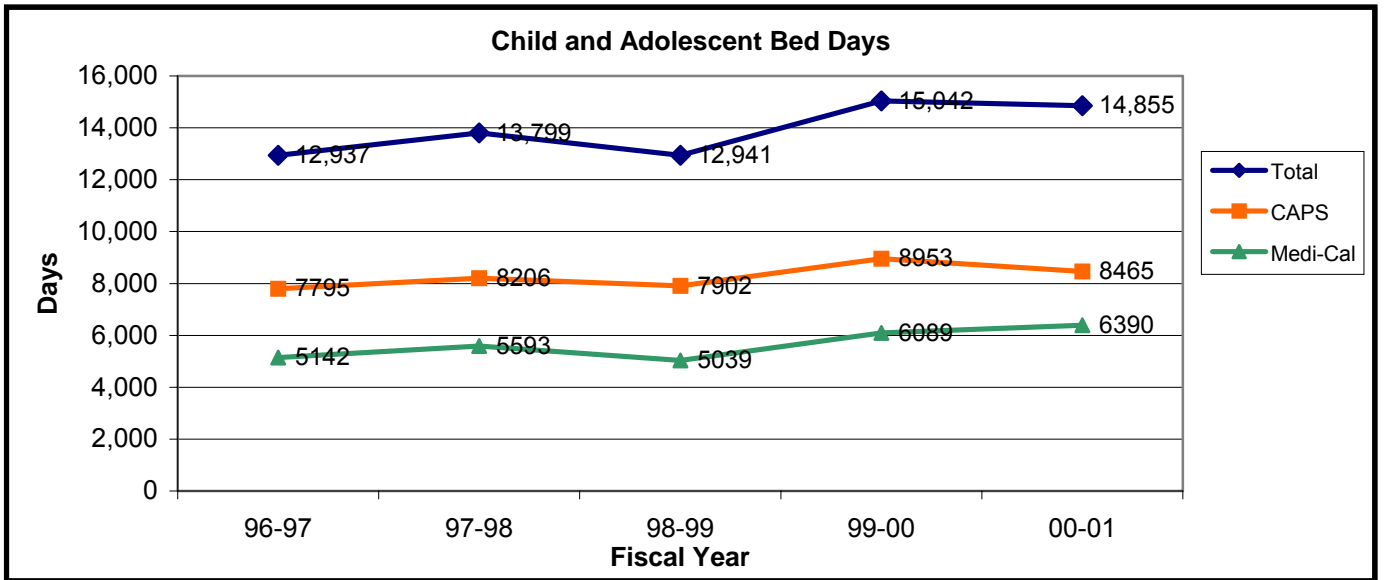
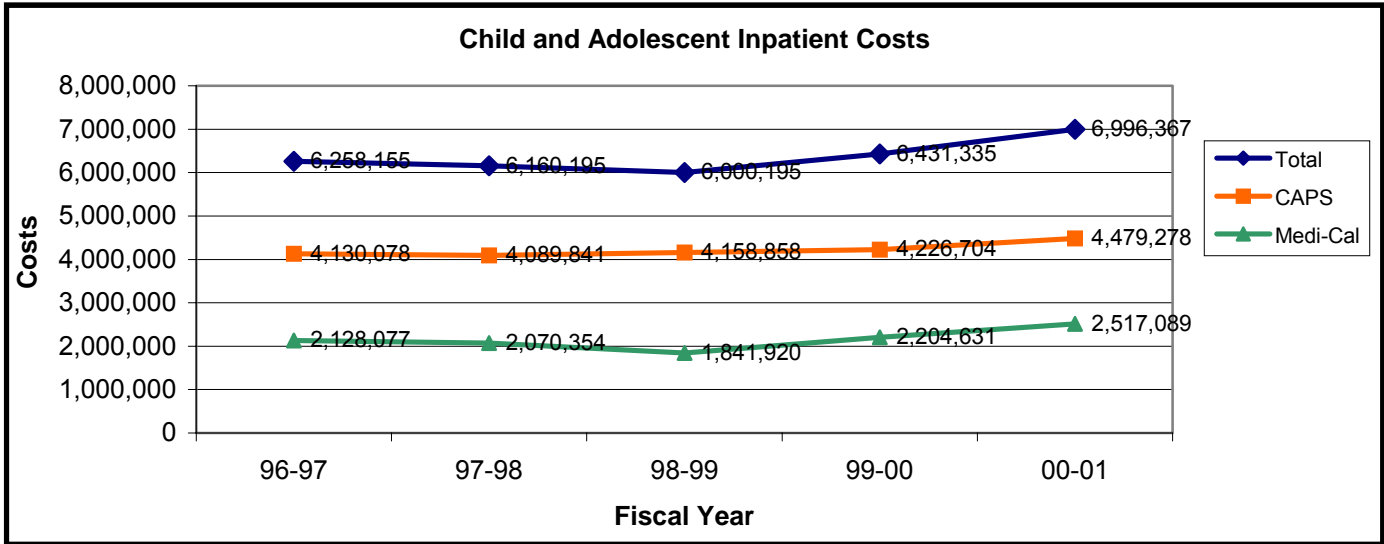
The state cost is the amount contracted for usage. The days used is the actual number of bed-days utilized by children and adolescents from San Diego County. A contract is required and signed at the beginning of the fiscal year to pay for beds regardless of usage. San Diego County purchased one bed (the minimum) for fiscal year 00-01.



- This shows an overall 87% reduction in State Hospital costs and 100% reduction in State Hospital bed days used between fiscal years 96-97 and 00-01.
- These reductions were accomplished primarily by the implementation of the CITY program which transitions youth from State Hospitals to a local intensive case management program in their home communities and provide “wraparound” services.

Figure 50: Inpatient Costs and Bed Days by Fiscal Year

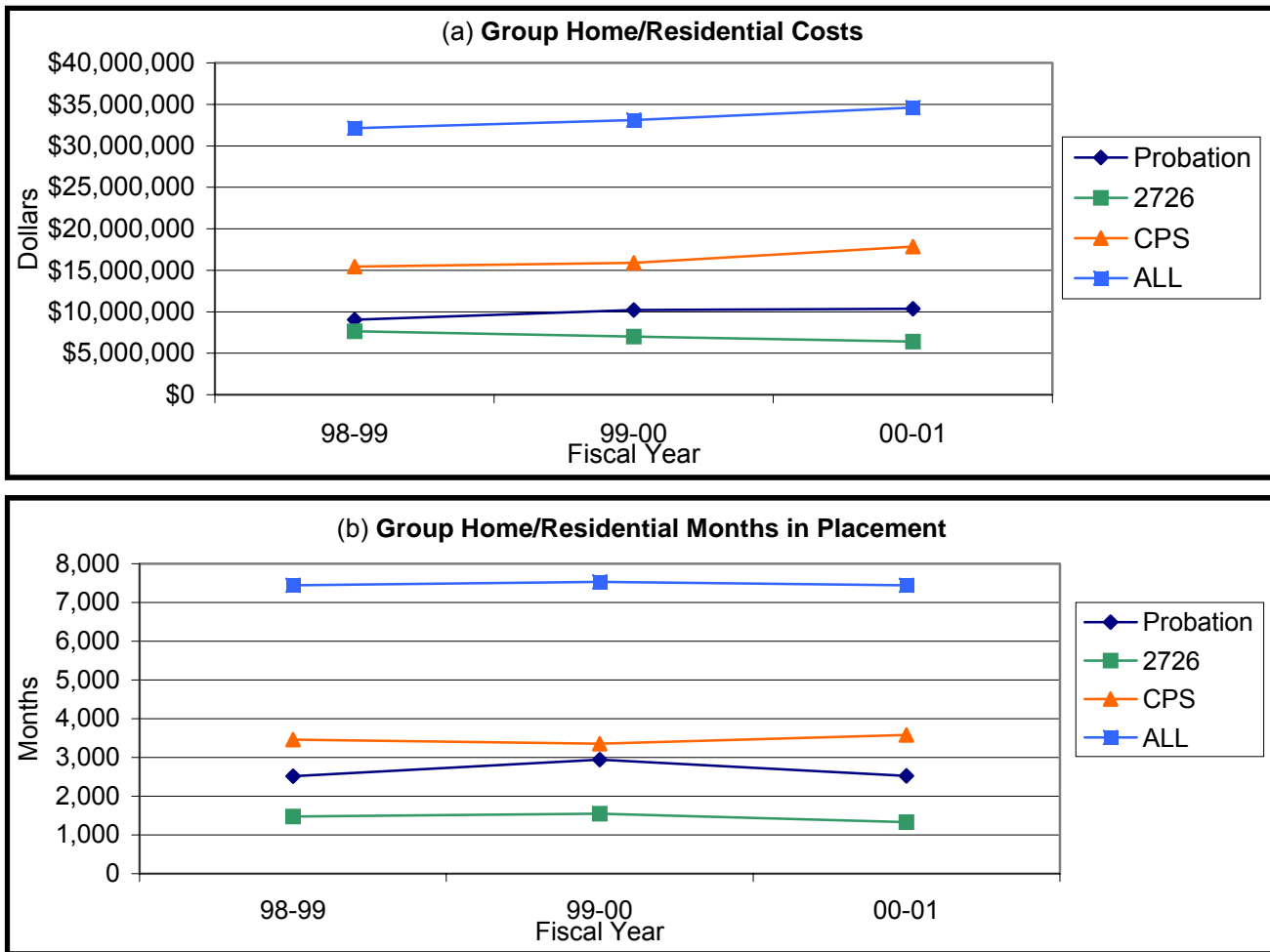
The costs are the amount for acute inpatient days and the number of days is the beds used in acute inpatient units for children and adolescents. There are two different funding sources: CAPS is the contracted program for a fixed number of beds, and Medi-Cal is a fee-for-service program with various psychiatric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



- This shows a 6 % increase in costs between FY99-00 and FY00-01 for CAPS and a 14 % increase for Medi-Cal. These costs increases are partly due to rising costs for daily rates.
- The total amount of bed days used from FY99-00 to FY00-01 remained stable.

Figure 51: 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.



- Comparing FY00-01 to FY99-00, costs rose by 4% while placements decreased by 1%.
- Increased costs are primarily due to the increased costs of Child Protective Services (CPS)
- The data indicates a slowing of growth on these indicators over time.

Figure 52: Total Out-of-Home and Foster Family Placement by Fiscal Year

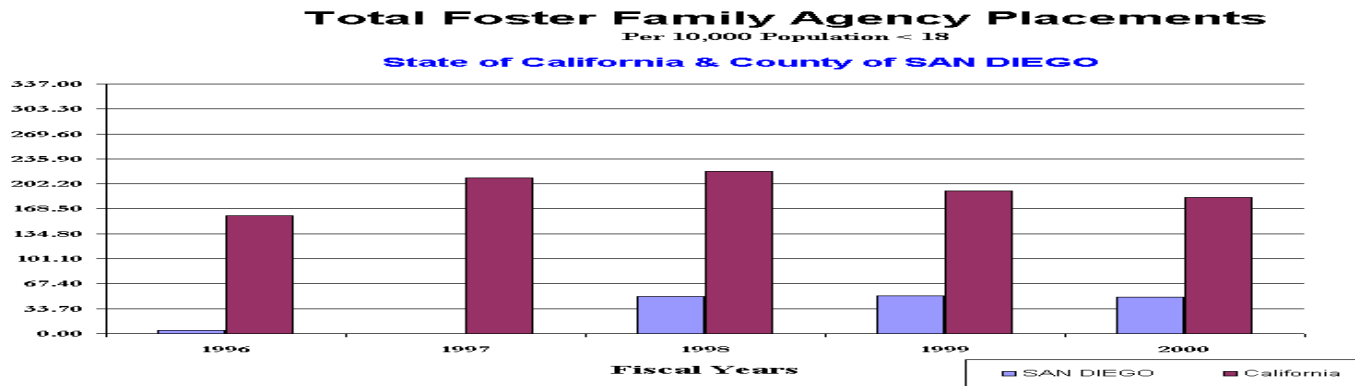
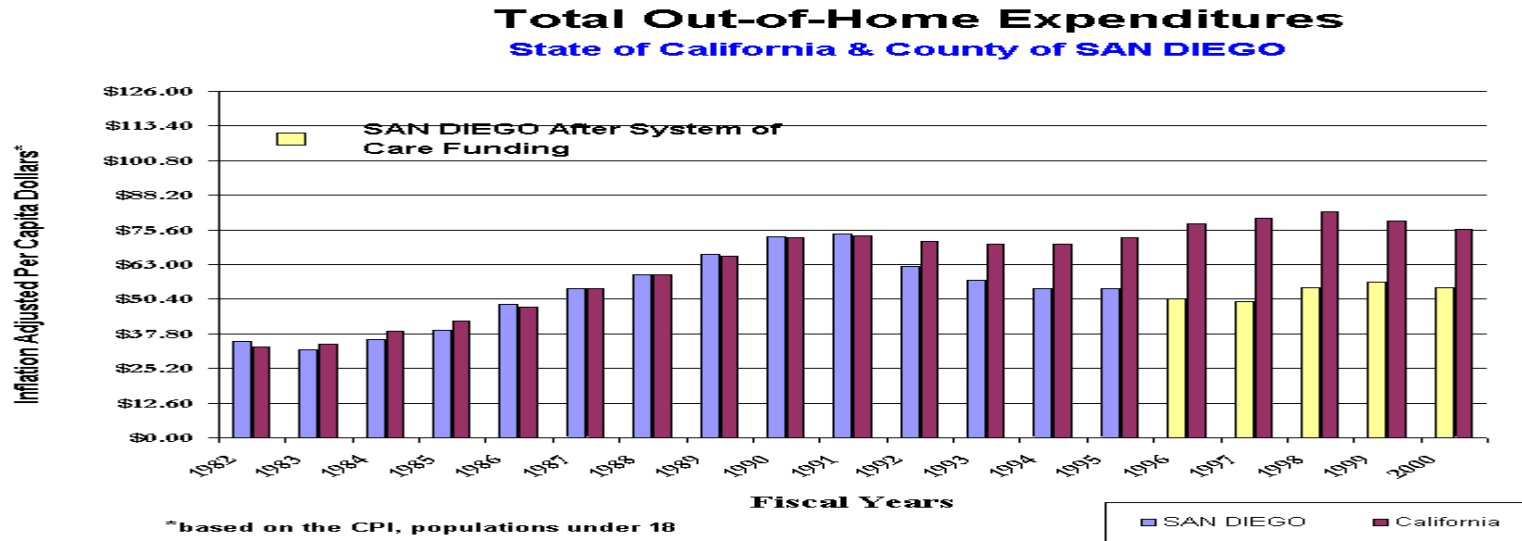


Figure 53: Foster Home Expenditures and Placement by Fiscal Year

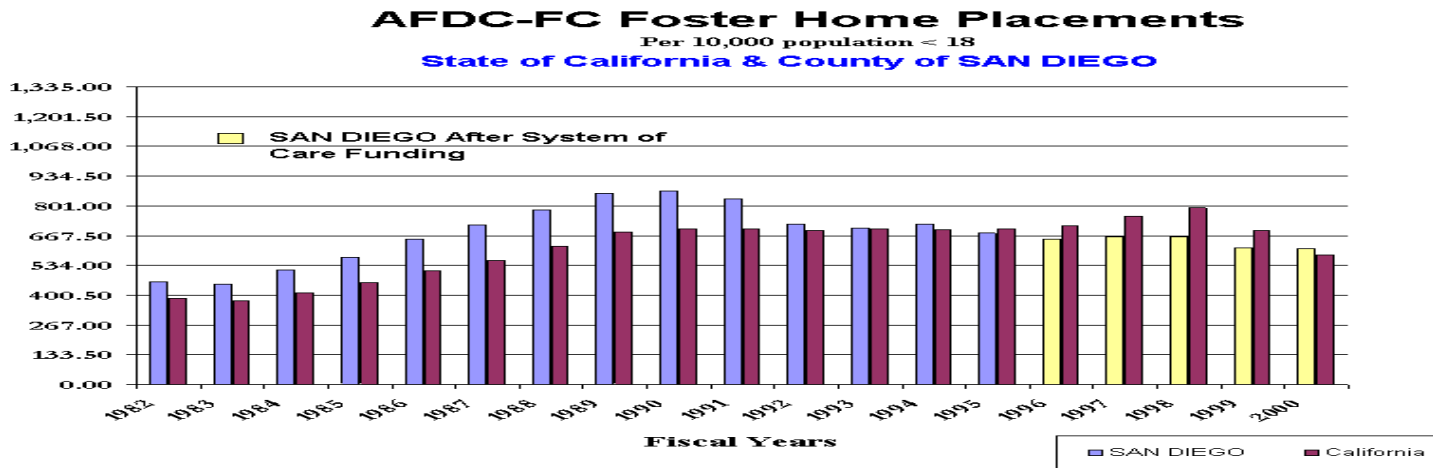
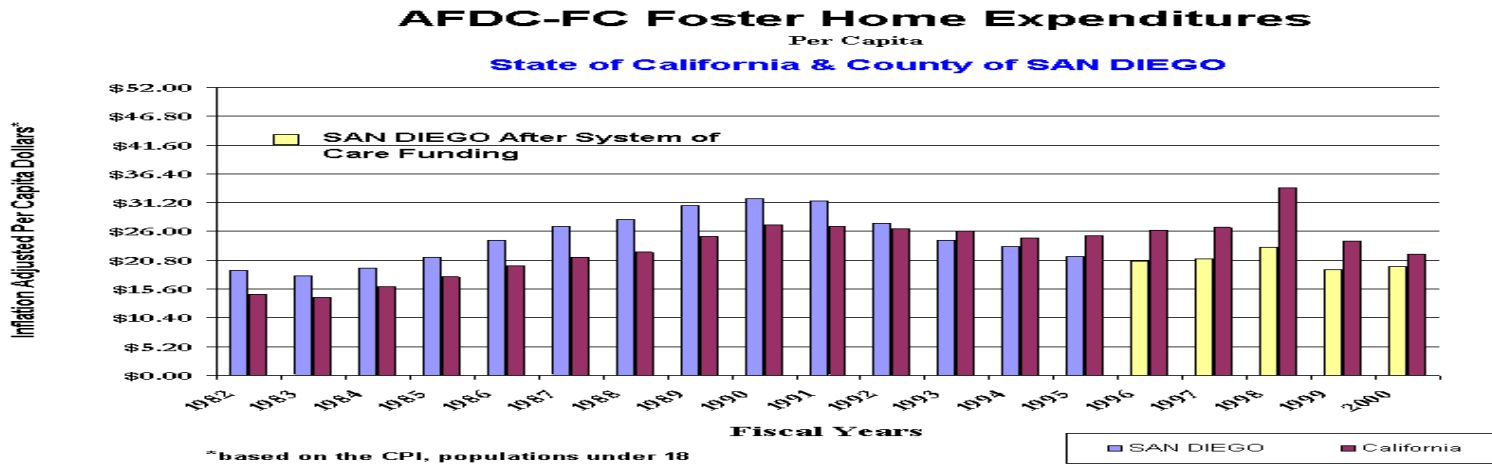
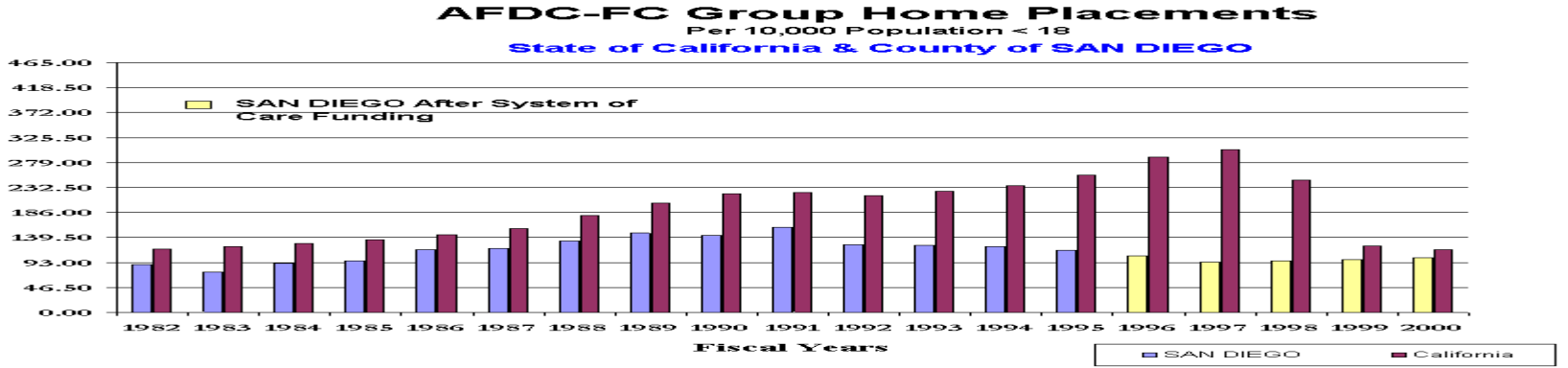
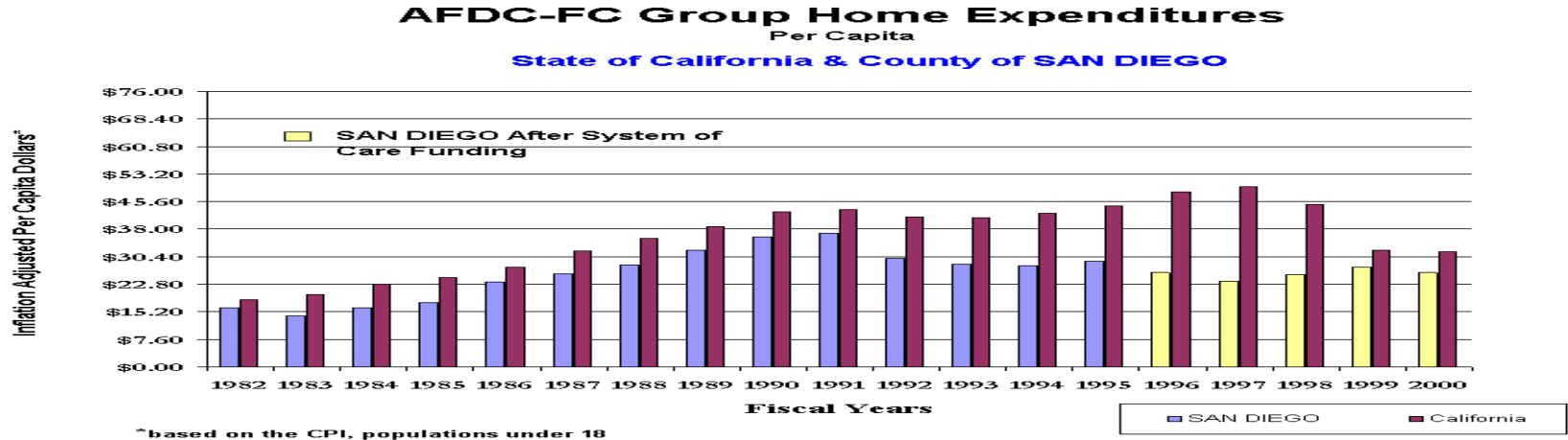


Figure 54: Group Home Expenditures and Placements by Fiscal Year



Future Directions

The "System of Care" (SOC) for children and adolescents in the County of San Diego continues to grow, improving the quality of services and identifying issues to be addressed through system change. This is accomplished by reviewing the data put forth in this report, and as new funding is received, building and expanding innovative services. For example, this report suggests the need to conduct quality improvement analysis and to plan specific programming to address two specific findings: 1) "high risk" youth are using substances at increased rates and 2) specific race/ethnic groups are reporting less improvements. Potential system improvement should include continual tracking and planning of new programs to address these needs described above, for example, developing specialized treatments for dual diagnosis conditions (mental health and substance abuse issues) and focusing more on culturally competent services in order to address the individual needs of various ethnic groups so that outcomes demonstrate improvements for all youth and families. It is expected that these new programs will continue the efforts that 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.

San Diego County recently developed and began executing various new innovative services. First, the implementation of the Children's Mental Health Initiative 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 contributed partial data to this report the program is now being fully implemented with the goal to serve more than 200 children and adolescents each year and is participating in full evaluation so that the data can be presented in upcoming reports. The evaluation of the program is a collaborative effort between Child, Youth and Family Network (CYFN), Community Care Systems (CCS) and the Child and Adolescent Services Research Center (CASRC) and involves collecting information in the form of both standardized measures and indicators that allows for a strong foundation of data to substantiate the value added of "wraparound" processes and efforts of the Initiative specifically.

Additionally, the County is in the process of expanding its SOC through increased funding from the State AB3015. This expansion will continue to 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 32 school districts serving approximately 300 additional children and adolescents by the end of FY03. Data is collected on these youth as well as program specific outcome measures in order to further understand the program's effectiveness; more specifically what contribution the program is making and how the program is performing. Future reports will be able to present this data in comparison to those youth served by community outpatient clinics.

Medi-Cal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) funds continue to allow 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 and 2001-2002 fiscal years with an emphasis on expanding services to schools, underserved populations and communities, probation wards and CPS Dependents. Approximately 32 million dollars has been contracted in several phases (1-3) to allow for this expansion. This growth will continue through 2002 resulting in a cumulative total of about 38 million dollars for program 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 229 schools, through the expansion of both existing and new providers. These expansions should have a dramatic effect on the number of youth served through CMHS over the next two years.

Within this expansion from EPSDT some specialized services and youth populations have been developed. One such service is the Therapeutic Behavioral Services (TBS). This is a program that trains paraprofessionals to provide intensive short-term one to one services to high need youth and families. TBS is delivered through two contracted providers and targets children and youth to age 21 who are at risk of placement in a level 12 group home, re-hospitalization and/or who are transitioning to a lower level of care. The goal of TBS is to stabilize these children and youth who are at risk of losing their living environment due to emotional or behavioral issues.

The county has also begun expanding its services to foster care youth. Mental health services are now available in at least four Family Foster Agencies to provide services to youth in an integrated package. Foster youth are also receiving mental health services at the San Pasqual Academy. This program provides day rehabilitative services within the academy and after school. Services focus on skill-building, social skills and other rehabilitative services including transition services.

Additionally, the Clark Collaborative program recently began. It is an innovative program that “patches” intensive day treatment services, within a Level 14 adolescent group home, with the goal of reducing the length of stay in high end placement. The group home provider partners with another mental health contractor who provides case management and flexible services that are “wrapped around” the youth and family. The case manager and family identify a “wrap team” at the time of admission to the group home and focus on the discharge needs and supports for the family and youth.

Furthermore, the Wraparound Training Academy continues to flourish as a cross-sectional program encompassing 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 effects of client characteristics on 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.