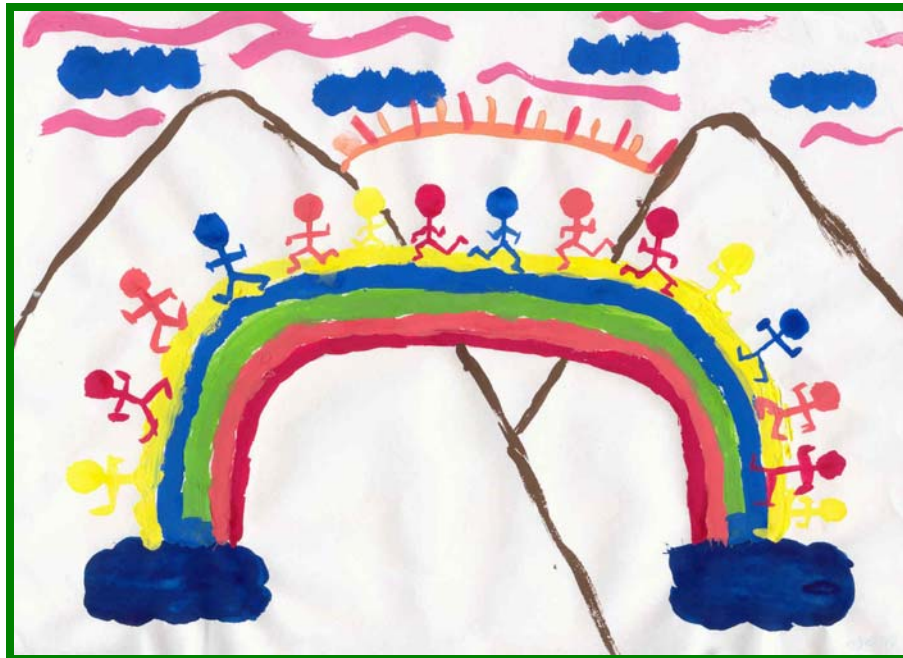


Child and Adolescent Services Research Center



County of San Diego
Health & Human Services Agency

Children's Mental Health Services



Fourth Annual System of Care Report

Cumulative Data
1996-2002

Board of Supervisors

Supervisor Greg Cox, Chairman
Supervisor Dianne Jacob, Vice Chairwoman
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Supervisor Ron Roberts
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Children's Mental Health Services

Fourth Annual System of Care Report

Cumulative Data 1996-2002

Child and Adolescent Services Research Center

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 – Ariel Remington, age 12, 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 was to develop and implement a children's mental health "system of care" 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 youth at risk for placement in restrictive settings. These programs emphasize 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

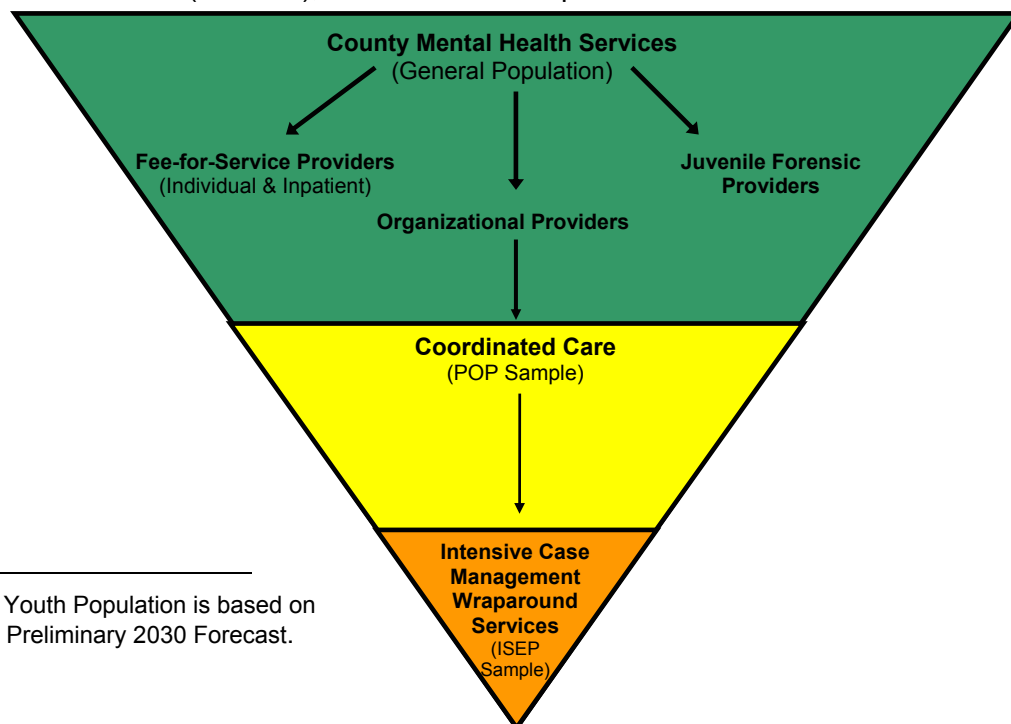
- * 16,173 youth (unduplicated client count) were provided mental health services in 2001-2002. An 8% increase from the previous year and a 44% increase from 1996-1997.
- * The majority of youth are males (64%) and are 13-17 yrs old (50%) in the youth general mental health system (GMHS). However, each year more youth 6-12 yrs old (39% in FY01-02) are receiving services.
- * The youth served are from diverse backgrounds with Whites and Hispanics being the largest race/ethnic groups (39% W & 34% H) in GMHS. Hispanics surpass Whites in POP sample (41% H & 33% W) in FY01-02. Whites are the largest group in ISEP (40% W & 34% H).
- * There is significant overall improvement in youth functioning and symptoms during treatment according to the parent, youth and clinician at each time point; intake-6 months, intake-1 year, intake-2 years, intake-3 years (clinician do not report significant improvement at 3 yr).
- * Repeated measures show continuous statistically significant improvement over time for youth who completed intake, 6-month, 1-year and 2-year assessments, according to all informants: clinicians, parents and youth.
- * For ISEP long-term & short-term intensive programs, parents and youth reported significant symptom reduction from intake to 2-yrs. However, only the long-term program produced significant reductions in functional impairment based on clinician report.
- * Parents generally report high satisfaction with services (POP, School-based, Clinic-based and ISEP samples) and there are no race/ethnic group differences.
- * State Hospital costs reduced 86% and bed days used reduced 100% from FY96-97 to 01-02.
- * For both ISEP long-term and short-term intensive programs, approximately 90% of the families report adequate levels of resources related to meeting basic needs, while very few families report adequate levels of resources related to quality of life.
- * At 2-year assessment, school absences decreased by 50% for youth in both ISEP long-term and short-term intensive case management samples per caregiver report.

Introduction

The San Diego County Children's 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 estimated at approximately 742,281¹ in 2002 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 (top green section of inverted triangle labeled "General Population"). The Organizational Providers make up the county's Coordinated Care population (middle yellow section of diagram labeled "POP sample"; refer to page 14 for complete definitions).

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 a state mandated Performance Outcome Project (POP) data collection process. According to this state mandate, standardized clinical data were collected on all children and adolescents as they entered coordinated mental health care and as they progressed 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, 2002.

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 (bottom orange section of triangle labeled "ISEP sample"). One program, Transition of Wards Embracing Recovery (TOWER), was a short-term case management program. Two programs: Community Intensive Treatment for Youth (CITY) and Building Effective Solutions Together (BEST) are long-term case management programs. Additionally, the county 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 a restrictive, residential care facility level 12 or above from any of three service systems: mental health/education (AB2726), social services or probation.



¹ San Diego Youth Population is based on SANDAG's Preliminary 2030 Forecast.

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 nine sections that present the data from the three samples: general, POP and ISEP.

- 1) The first section, "Description of the Children's Mental Health Service System," provides descriptive information about children and adolescents in the general mental health service system from 1996 to 2002. 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, 2000-2001 and 2001-2002. 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's and adolescents' behavioral and emotional symptomatology and overall functioning throughout their course in treatment. The samples include youth with intakes and follow-ups within the 1997-2002 fiscal years, reporting follow-ups that range from 6 months to 3 years.
- 4) The fourth section, "School-Based Outpatient Services," includes summaries and outcome information for the county's School-based service programs. This data is presented in comparison with the POP Clinic-based outpatient services 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 two types of intensive service programs for youth in or at risk for restrictive placements: short-term intensive case management (TOWER) and long-term intensive case management (CITY, BEST and CYFN). The data are presented for each sample by types of services received, demographics and clinical outcomes.
- 6) The sixth section, "Supplementary Outcomes," reports on data associated with mental health improvements: substance use, juvenile justice 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, "Consumer Perspectives," reports on data from family perspectives and clinician perspectives regarding mental health service issues. Family members provide qualitative information regarding their views about services. Clinicians report on their use of and attitudes about the Performance Outcome Project, which is the utilization of a standardized

battery of assessments to evaluate youth outcomes in public mental health services.

- 8) The eighth section, "System Outcomes," reports system level data on issues such as costs and service use patterns for each fiscal year.
- 9) 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, 2002. 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 by the youth’s clinician 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 CYFN). Follow-up assessments are collected by trained, independent interviewers 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 (CLEP), Child Behavior Checklist (CBCL), Youth Self Report (YSR), Child & Adolescent Functional Assessment Scale (CAFAS) and the Client Satisfaction Questionnaire (CSQ). Refer to section four (pg. 22) for descriptions of the measures. The intensive wraparound programs have additional parent and family measures. Refer to section seven (pg. 53) for a short description of each additional measure. There is also a subset of youth who completed additional measures reported in the supplementary outcomes and consumer perspectives sections of this report. Refer to each of those sections for a short description of the assessment measures.

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, 2000-2001 and 2001-2002. 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, 2000-2001 and 2001-2002. Note, the ISEP assessments for the 1998-1999 year began in April 1999; therefore, this year represents 6 months of data.

Participating Programs

Table 1 (pgs. 8-10) 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 (e.g. La Jolla, Linda Vista, Mira Mesa, Miramar, Tierrasanta), 2) Central (e.g. Downtown, Encanto, College Grove, Paradise Hills), 3) South (e.g. Chula Vista, San Ysidro, Coronado, Imperial Beach), 4) East (e.g. El Cajon, Alpine, Campo, Spring Valley, La Mesa, Jamul), 5) North Coastal (e.g. Carlsbad, Oceanside, Rancho Santa Fe, Oceanside) and 6) North Inland (e.g. Escondido, Julian, San Marcos). The majority of programs are located in the North Central region (37%). The other regions have similar percentages of POP programs: 15% in South, 14% in Central, 14% in East, 14% in North Inland and 6% 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 23% of youth living in Central, 19% in South, 16% in East, 16% in North Central, 15% in North Inland and 11% in North Coastal.

Data Processed to Date

Figure 2 (pg. 12) 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 each subsequent year and has increased substantially during the most recent year 2001-2002. The number of both intakes and follow-ups increased 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 that year 1,603 youth entered CC and 58.5% 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 1,959 youth entered CC and 66.5% completed POP assessments. In the 2000-2001 fiscal year 2,863 youth entered CC and 71% completed POP assessments and in the 2001-2002 fiscal year 3,429 youth entered CC and 68.7% completed POP assessments.

Performance Outcome Project

Is the POP sample representative of the larger coordinated care group? After examining the most recent fiscal year, 2001-2002, overall there are no significant differences in the POP sample versus the larger coordinated care (CC) group. However, there are slight differences in percentages for specific demographics. Males are slightly over-represented (63.4% POP vs. 59.2% CC), making females slightly under-represented (36.6% POP vs. 40.8% CC). Youth 16-20 years old are slightly under-represented (14.0% POP vs. 17.3% CC) while the other age ranges are represented as expected. There is some variation by race/ethnicity as well. Whites are slightly under-represented (42.6% POP vs. 45.5% CC) as are African-Americans (15.3% POP vs. 17.9% CC), while Hispanics are slightly over-represented (33.5% POP vs. 26.9% CC). Asian/Pacific Islanders and Native Americans are represented as expected.

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=306). Fifty-one youth and families (14%), who were eligible for participation in the evaluation (based on specific eligibility criteria put forth by SAMHSA), declined to participate in the study. There were no statistically significant differences between the two groups as far as age (14.88 years (SD=2.1) for the group who declined vs. 14.24 years (SD=2.5) for the interviewed group), gender or ethnicity. Thirty-six of the youth who declined were male (70.6% vs. 68.6% in interviewed sample) and 15 were female. Twenty-four were White (47.1% vs. 40.2% in interviewed sample) and 27 were Non-White. Compared to the interviewed sample, 25.5% were Hispanic vs. 33.7% in interviewed sample; 13.7% were African-American vs. 18.6% in interviewed group; 3.9% Asian/Pacific Islander vs. 2.0% in interviewed sample; and 9.8% were classified as Other vs. 5.6% in the interviewed group.

Table 1: POP Participating Programs

Program Name	Type	Target Population
ALLY National City	Outpatient Clinic-EPSDT	Mental Health
ALLY South Bay	Outpatient School-based-EPSDT	School
ASPEN Community Services	Day Treatment Intensive/Outpatient	Mental Health
Building Effective Solutions Together (BEST) *	Intensive Case Management/Wraparound	MH, Probation, Child Welfare
Cabrillo Assessment Center	Day Rehab-EPSDT	Child Welfare
Cabrillo Day Treatment	Day Treatment Intensive in a Residential Facility	Child Welfare
Cajon Valley School Project	Day Rehab	Mental Health – School
Casa De Amparo	Outpatient Clinic	Child Welfare
Children's Outpatient Psychiatry	Outpatient Clinic	Mental Health
Child, Youth and Family Network (CYFN)*	Intensive Case Management/Wraparound	Mental Health/Child Welfare/Probation/Education
Clark Collaborative	Day Treatment	Mental Health
Critical Care TBS	Therapeutic Behavioral Services	Mental Health
Comprehensive Adolescent Treatment Center (CATC)	Day Treatment Intensive in a Residential Facility	Mental Health – Child Welfare
Community Intensive Treatment for Youth (CITY)*	Intensive Case Management/Wraparound	Probation/Child Welfare/Mental Health
Discovery Valley/Phase II	Day Treatment Intensive	Mental Health – 2726
Douglas Young Clinic	Outpatient Clinic	Mental Health
East County Child Day Treatment	Day Treatment Intensive	Mental Health – 2726
East County Mental Health	Outpatient Clinic	Mental Health
Emergency Screening Unit	24-hour Emergency Services	Mental Health
EYE Ash/MHS Ash	Outpatient Clinic	Probation
EYE San Marcos	Outpatient School-based	Mental Health – School
Family Health Centers-Central	Outpatient Clinic-EPSDT	Mental Health
Family Health Centers-East	Outpatient Clinic-EPSDT	Mental Health
Foster Family Agency	Outpatient Clinic	Foster Family Agency
Frontier Adolescent Day Treatment Center	Day Treatment Intensive	Mental Health – 2726
Green Oak Ranch	Outpatient Clinic	Child Welfare
Hillcrest House	Outpatient Site-based	Child Welfare

Program Name	Type	Target Population
Lifeschool	Day Treatment Intensive	Mental Health – 2726
New Alternatives Children's Day Treatment	Day Treatment Intensive	Mental Health – 2726
New Alternatives # 16	Day Treatment Intensive in a Residential Facility	Mental Health – CPS
New Alternatives TBS	Therapeutic Behavioral Services	Mental Health
New Alternatives-Transitional Residential Services	Case Management	Child Welfare
North County Lifeline	Outpatient Clinic	Probation
Palomar Family Counseling	Outpatient Clinic	Mental Health
Palomar Family Counseling-Fallbrook	Outpatient School-based	Mental Health
Para Las Familias	Outpatient Clinic	Young Children
Pioneer Family Counseling	Outpatient Clinic	Mental Health
Polinsky Center	Outpatient Site-based	Child Welfare
Polinsky Day Rehab	Day Rehab	Child Welfare
Rainbow Center	Outpatient School-based	Mental Health/School SED
Reflections Central Program	Day Rehab	Probation
Rural Family Counseling Services	Outpatient Clinic	Mental Health
San Diego Center for Children	Day Treatment Intensive in a Residential Facility	Child Welfare
San Diego Center for Children-Discovery Hills	Day Treatment Intensive	Mental Health – 2726
San Diego Youth and Community Services	Outpatient Clinic	Probation
Sexual Treatment Education Program & Services (STEPS) Day Treatment	Day Treatment Intensive 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 Intensive Specialized	Mental Health
Sexual Treatment Education Program & Services (STEPS) Viewridge	Day Treatment Intensive 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 Pasqual Academy	Day Rehab in Residential Facility	Child Welfare

Program Name	Type	Target Population
San Ysidro Middle School	Outpatient School-based	Mental Health
Social Advocates for Youth (SAY) CATS II	Outpatient School-based	Probation
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
Therapeutic Services Inc. Clark Stepdown	Outpatient Clinic	Mental Health
Transition of Wards Embracing Recovery (TOWER)* (closed 5/02)	Intensive Case Management for Probation (Short-term)	Probation
Transition Team	Case Management for Inpatient (Short-term)	Mental Health
Trinity Foster Care	Outpatient Clinic	Foster Family Agency
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 Intensive	Mental Health – 2726
Vista Hill-Central, North & South Regions	Outpatient School-based	Probation
Vista Hill-Escondido	Outpatient School-based	Mental Health – School
Vista Hill-Ramona	Outpatient School-based	SED
Walden Family Services	Outpatient Clinic	Foster Family Agency
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 the zip code that participated in one or more coordinated care programs in 2002. The red pushpins represent the location of mental health coordinated care programs.



- The majority of programs, 37% are located in the North Central region with 15% of the programs in South San Diego, 14% in Central, 14% in East, 14% in North Inland and 6% in North Coastal.
- The percent of youth living in each of the six SD County Regions is the following: 23% Central, 19% South, 16% East, 16% North Central, 15% North Inland and 11% North Coastal.

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

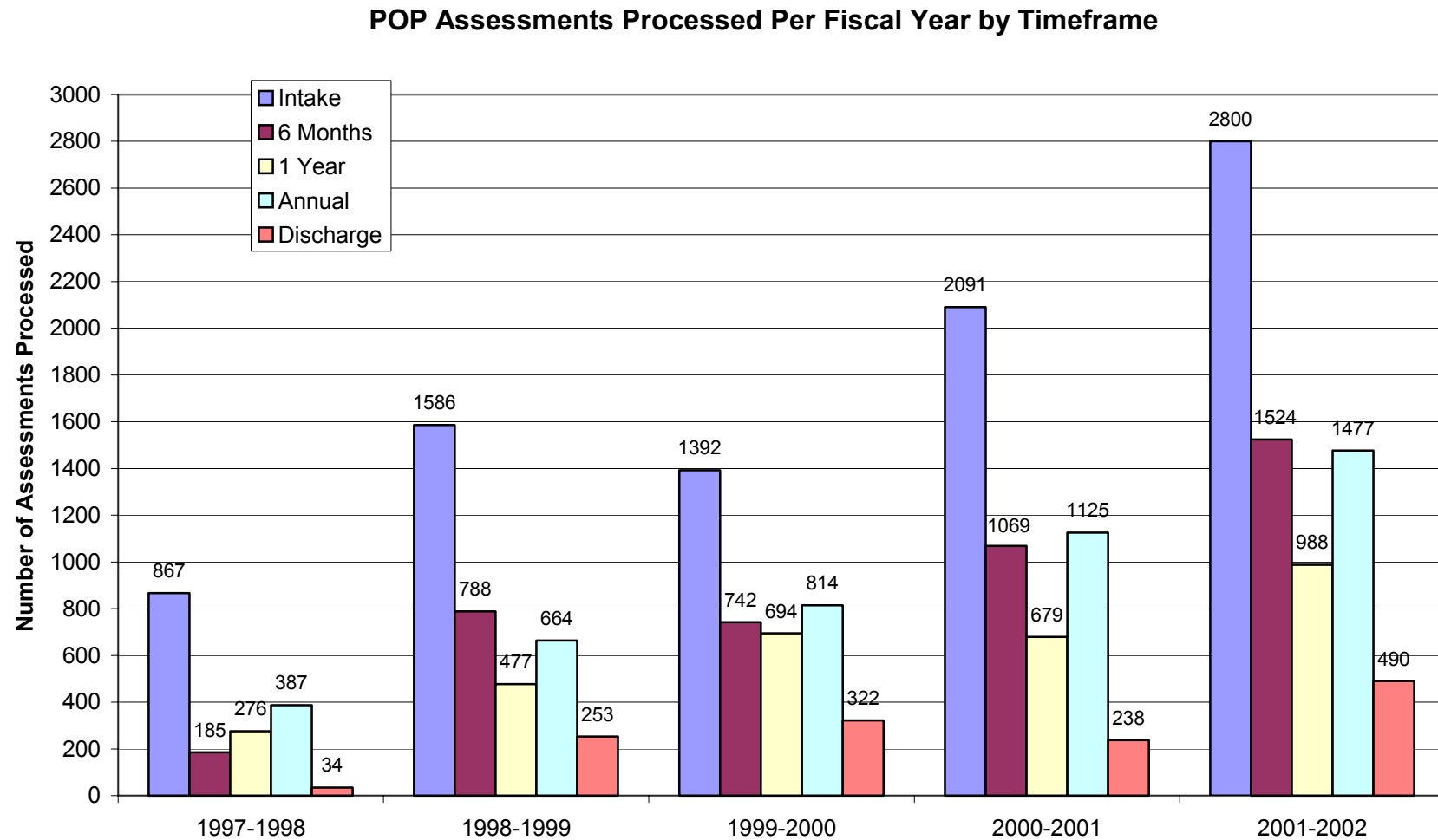


Figure 3: Intensive Services Evaluation Project (ISEP) Assessments Completed to Date

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

1998-1999, 1999-2000, 2000-2001 and 2001-2002 Fiscal Years

Agency					
TOWER	BEST	CITY	Lab/WRAP	CYFN	TOTAL
136	66	18	19	67	306

Number of Completed Follow-up Assessments by Timeframe as of 9-30-2002

Timeframe	# of Assessments
Completed 6-month follow-ups	264
Completed 1-year follow-ups	218
Completed 18 month follow-ups	151
Completed 2-year follow-ups	110
Completed 30 month follow-ups	57
Completed 3-year follow-ups	12

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 (HHSA) or have contracts with HHSA to provide mental health treatment services to specified target populations. These organizational providers are variable and distributed across the county. They can be general treatment clinics, or provide services to a specialized population or in a specific setting (such as school-based). Youth served through these organizational providers encompass the Coordinated Care system. Coordinated Care is the utilization management system that provides oversight amongst the multiple providers and monitors the clinical services provided to youth. Juvenile Forensic Services provide services primarily in Probation or Child Welfare (CWS) institutions within the County. Juvenile Forensic oversees all mental health services to Probation and CWS populations.

Within these three provider mechanisms, services may be delivered in different modes. The primary modes are outpatient, inpatient, residential, day treatment, case management, therapeutic behavioral services 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. These services may be short-term or long-term in nature. 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. Therapeutic behavioral services are specialized short-term one-to-one behavioral coaching for youth and families in home, community or placement settings. These services are available to prevent hospitalizations, placements in higher levels of care and/or assist transition to lower levels of care. Crisis intervention services are provided by the Emergency Screening Unit (ESU) which is a 24 hour/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: FY01-02 = 16,173, 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: 59% in FY01-02, 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 did organizational providers (41%). This data is reflective of the more inclusive target population definition within the FFS-Outpatient database 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. Figures 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. Notice there are slight increases in the percent of latency age children in the more recent fiscal years. The highest percent of children ranging in age 6-12 years old is evident in the most recent year FY01-02. Race/ethnic distribution varies for Hispanics by fiscal year with continuous increases in the percent served within CMHS from 25% in FY96-97 to 34% (just below Whites at 39%) in FY01-02. The race/ethnic distribution for Children's Mental Health is similar to the San Diego County distribution with the exception of African-American and Asian/Pacific Islander youth. According to 2000 census, the following race/ethnic groups served in CMHS are similar to the county population: Whites (39% CMHS vs. 41% census), Hispanics (34% CMHS vs. 38% census) and Native Americans (1% CMHS vs. .05% census). However, there are twice as many African-American youth in services (18% CMHS vs. 7% census) than expected based on population census and half as many Asian/PI youth in services (4% CMHS vs. 8% census).

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 a high percent of youth involved in residential mental health services or day rehabilitation services as also receiving Juvenile Forensic outpatient services. There are also two notable changes that are reflected in this table. First, intensive day treatment services has started to embed case management services into their program; thus there was a reduction in the percent of youth receiving day treatment and case management services in FY01-02 (67%) from FY00-01 (82%). Second, the increased percentages of day rehabilitation services and organizational outpatient services from FY00-01 (10.9%) to FY01-02 (46.8%) are probably due to marked program growth at the Polinsky Children's Center. Refer to page 14 for descriptions of the service modalities presented in the table. 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 involved in outpatient juvenile forensic services, outpatient organizational services and emergency screening unit services. African-American youth are reported in higher percentages in rehabilitative day treatment and residential mental health services.

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

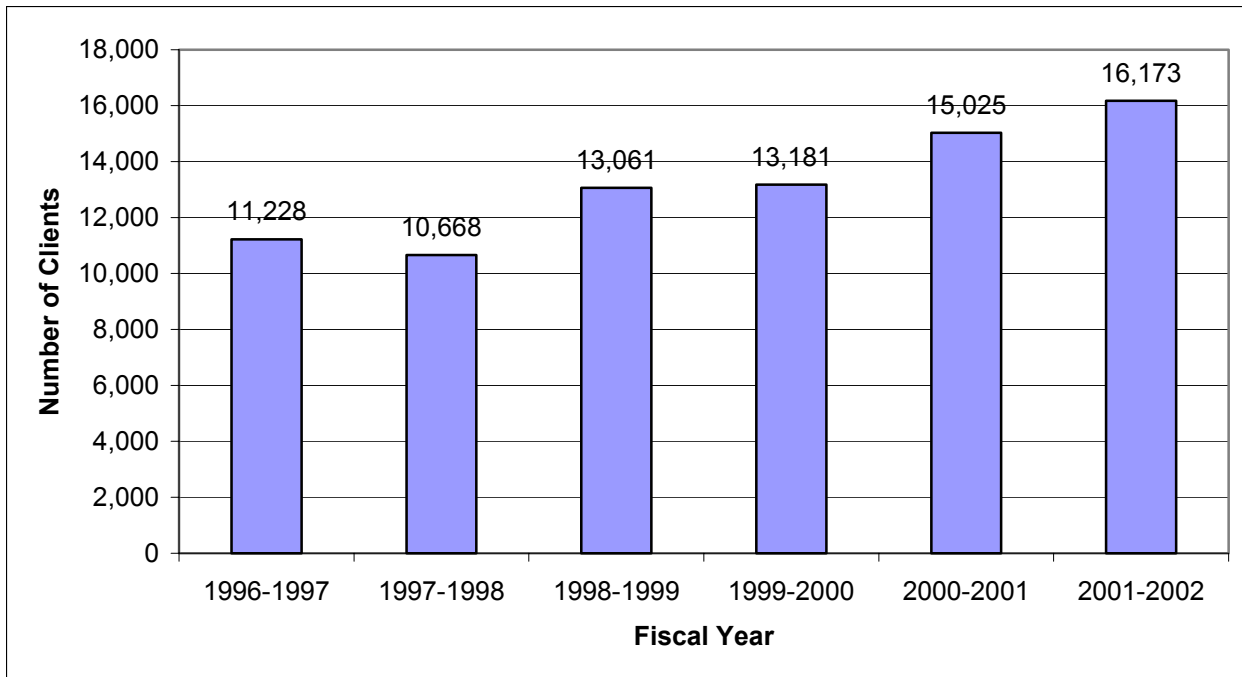
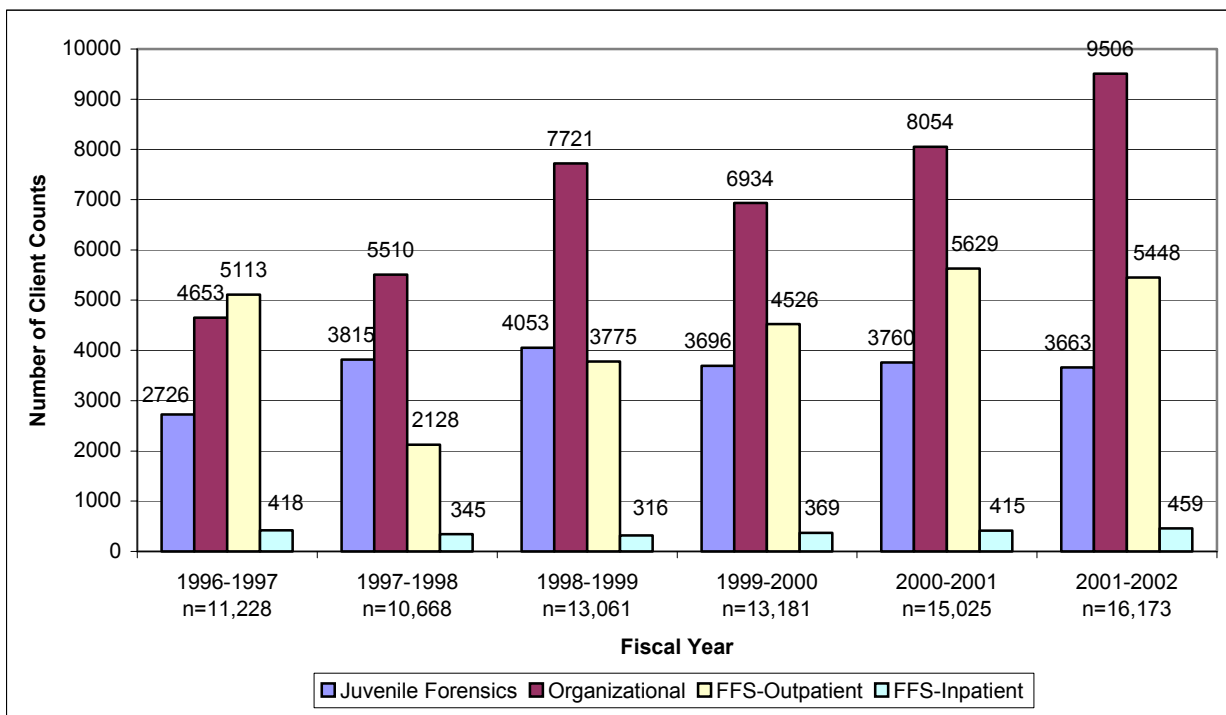


Figure 5: Children's Mental Health System: Number of Total Unduplicated Client Counts by Fiscal Year and Provider



Note: FY 1996-1997 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

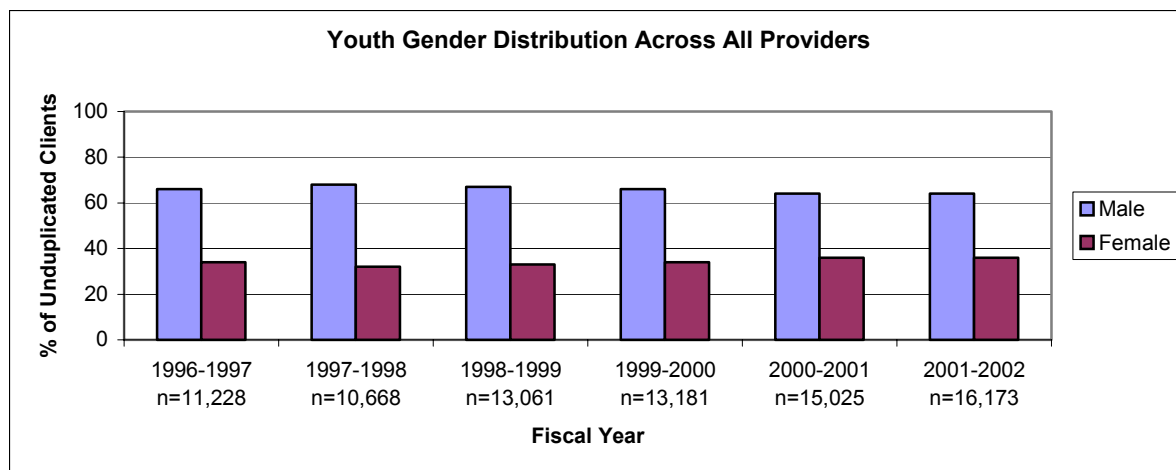


Figure 7: Children's Mental Health System: Age Distribution

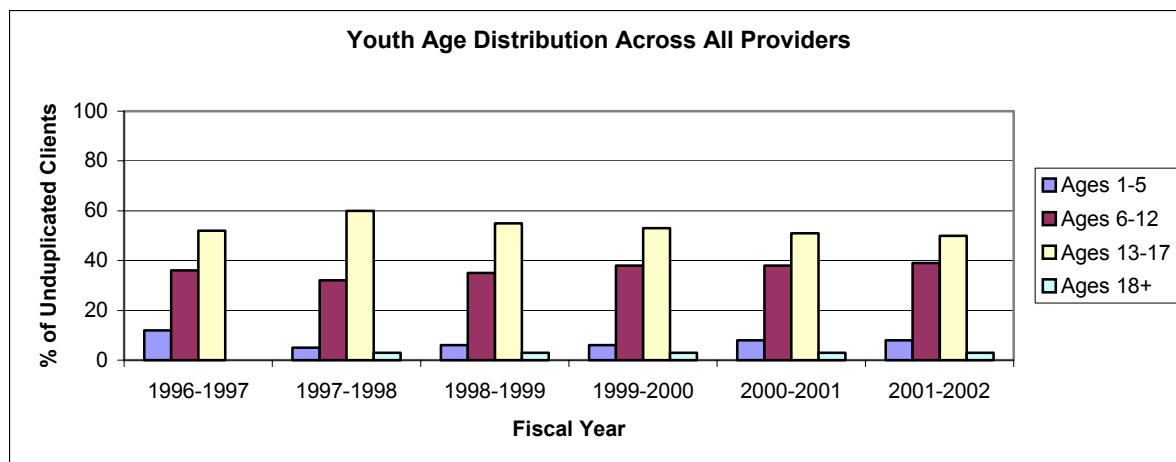
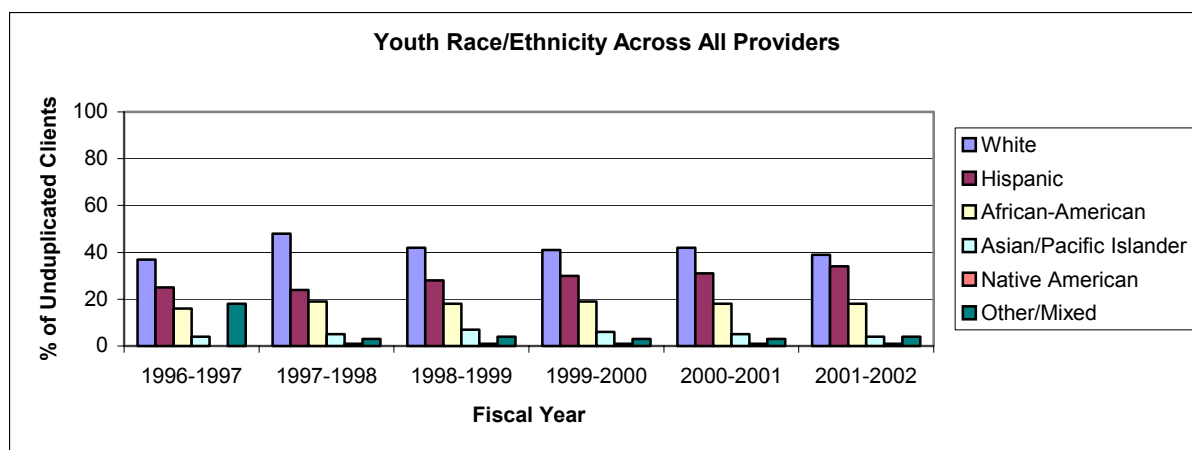


Figure 8: Children's Mental Health System: Race/Ethnicity



Note: FY 1996-1997 other/mixed data is elevated due to its inclusion of "unknown" race/ethnicity during that fiscal year.

Figure 9: Children's Mental Health System: Single and Multiple Use by Service Mode^{1,2}

FY 2000-2001

	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 – JFS	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%

FY 2001-2002

	Inpatient N =824	Res-M.H. N =901	Int. DT N =422	Day Rehab N =393	Case Mgmt. N =2055	OP-Org. N =6253	OP-FFS N =5448	OP-JF/Inst. N =5428	ESU N =1108
Inpatient	100.0%	16.2%	10.4%	10.4%	15.3%	6.7%	8.5%	3.9%	42.5%
Res-M.H.	17.7%	100.0%	14.0%	18.3%	11.2%	4.3%	7.5%	12.5%	16.9%
Int. DT	5.3%	6.5%	100.0%	20.1%	13.8%	3.2%	2.1%	1.8%	4.6%
Day Rehab	5.0%	8.0%	18.7%	100.0%	6.0%	2.9%	1.9%	5.2%	3.6%
Case Mgmt.	38.2%	25.6%	67.1%	31.3%	100.0%	15.7%	9.3%	9.0%	28.0%
OP – Org.	50.8%	29.5%	47.9%	46.8%	47.6%	100.0%	17.0%	11.9%	45.8%
OP – FFS	56.4%	45.6%	26.8%	26.5%	24.8%	14.8%	100.0%	14.9%	36.1%
OP – JFS	25.4%	75.2%	22.5%	72.0%	23.9%	10.4%	14.9%	100.0%	25.0%
ESU	57.2%	20.8%	12.1%	10.2%	15.1%	8.1%	7.3%	5.1%	100.0%

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

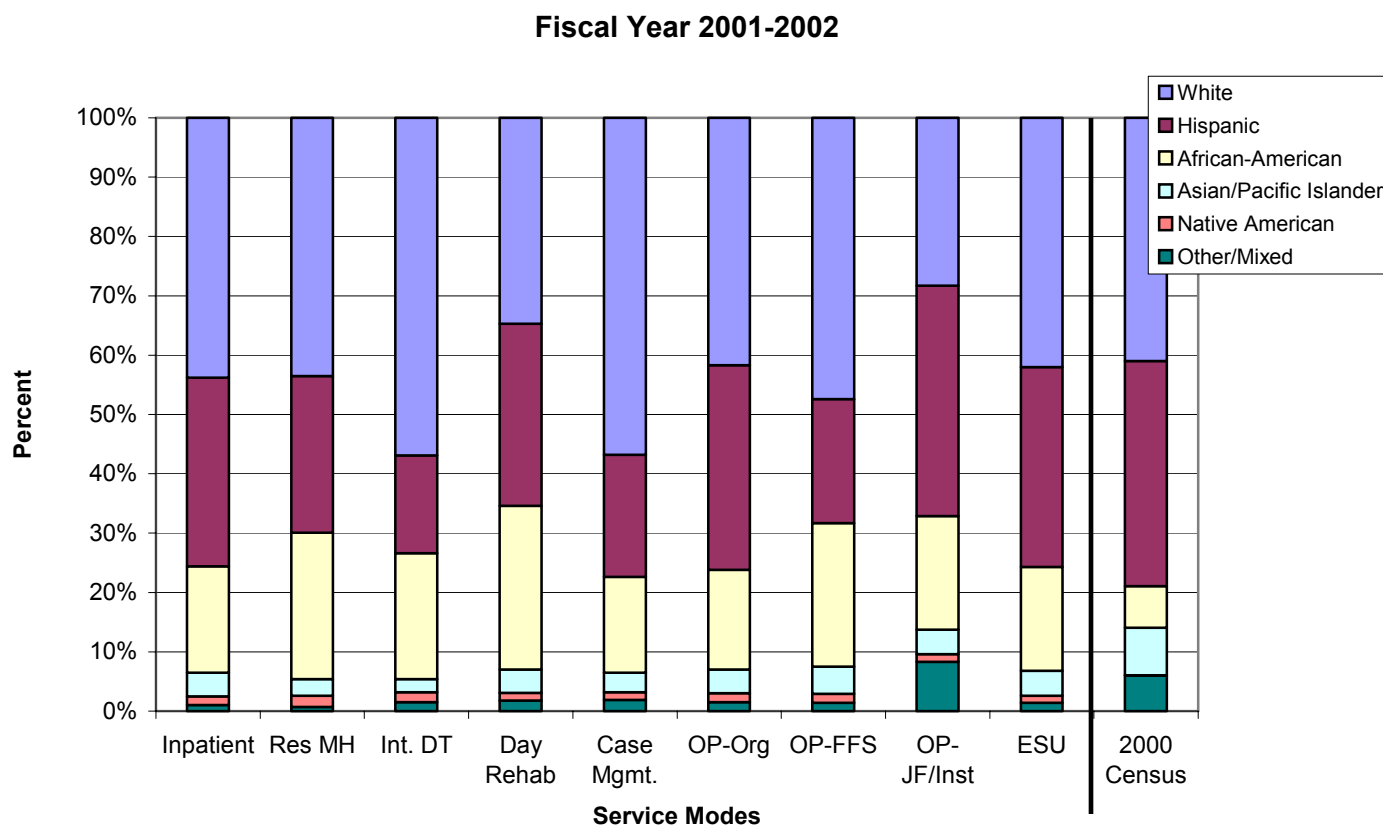
²Total exceeds 100% because youth can be open to more than two service modes within the year.

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

- A high percentage of youth involved in residential and day rehabilitation services are also involved in Juvenile Forensic outpatient services.

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 compared to other services and 2000 census.
- There are higher percentages of Hispanic youth involved in Outpatient Juvenile Forensic services, Outpatient Organizational programs and Emergency Screening Unit programs compared to other services but not 2000 census.
- There are higher percentages of African-American youth involved in Day Rehabilitation, Residential Mental Health services and Outpatient Fee-for-Services programs compared to other services and 2000 census.

(Key) – Res-M.H.=Residential Mental Health Services, Int. DT=Intensive Day Treatment, Day Rehab=Rehabilitative Day Treatment, Case Mgmt.=Case Management, OP-Org.=Outpatient Organizational Programs, OP-FFS=Outpatient Fee-for-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 California State System of Care outcomes. The Performance Outcome Project (POP) collects, analyzes and reports back the information that is gathered in the 1997-2002 evaluation process.

This report is a cumulative analysis of the data that the POP team has collected from July 1, 1997 to June 30, 2002. The data has been collected for five 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 program's 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 936 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 1,425 intake assessments. In the 1999-2000 year, 1,365 intake assessments were collected, in 2000-2001 year 2,015 intake assessments were collected and in 2001-2002 year 2,503 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% in 98-99, 65% in 99-00, 60% in 00-01 and 61% in 01-02. FY01-02 and FY00-01 have 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 and 2001-2002 years with more youth between the ages of 13-18 compared to the other years, which had more children in the 6-12 year old group (Figure 11b). There also is a continuous increase in youth of the Hispanic ethnicity group over the last 4 years (Figure 12a). This is the largest ethnic group surpassing the White group starting in 99-00 and remaining as the largest group in 01-02. There are significantly more MFCC/MFT/MA staff completing POP intake assessments for FY01-02 than other fiscal years (Figure 13). Consequently, there is a lower percentage of trainees (psychology, social work and counseling) completing intake assessments during the past 2 fiscal years (00-01 & 01-02). Degreed staff, both licensed and post-grad awaiting licensure, account for the largest percent of staff completing POP assessments in 2001-2002.

Cohort Clinical Profiles

There are also both stable and variable findings in clinical profiles of children and adolescents by fiscal year. Overall, latency age youth and adolescents present with similar functional impairment levels across fiscal years. However, young children demonstrate score variations over time. Young children (under the age of 6) were entering the system at gradually higher levels of impairment on the Preschool and Early Childhood Functional Assessment Scale (PECFAS) from 97-00. Then in the more recent fiscal years 00-01 and 01-02 there was a drop in entry impairment level (Figure 14b). This is probably due to the introduction of 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). There appears to be a slight trend in 01-02 for clinician report showing less functional impairment. This finding is probably related to the increase in programs in San Diego established utilizing EPSDT funds and serving youth within broader eligibility criteria. Additionally, both the parents (CBCL) and youth (YSR) are reporting less behavior and emotional problems on average in the 00-01 and 01-02 years (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 and youth report similar levels of social competency across the fiscal years. The total scores all reveal a lack of competencies, with scores at the clinical level, according to the caregivers (Figures 16a,b).

When the data are 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 and 01-02 fiscal years compared to earlier years. (Figure 17b).

Per clinician report on the CAFAS, the data show for FY01-02 that Whites are significantly more impaired at intake than African-American youth (Figure 18a). Overall, White youth are being reported as having higher levels of functional impairment compared to other race/ethnic groups. Parents report decreases in entry CBCL total scores for each race/ethnic group in more recent years of 00-01 and 01-02 (Figure 18b). In FY01-02 parents of White youth reported significantly more problems compared to Hispanics, African-Americans/Blacks and Asian/Pacific Islanders. 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 was not possible to report on their data in earlier years and they are not included in one-way analysis of variance for any of the fiscal years.

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. (version 1991)
- Main version for ages 4-18; separate version for ages 1 ½-4

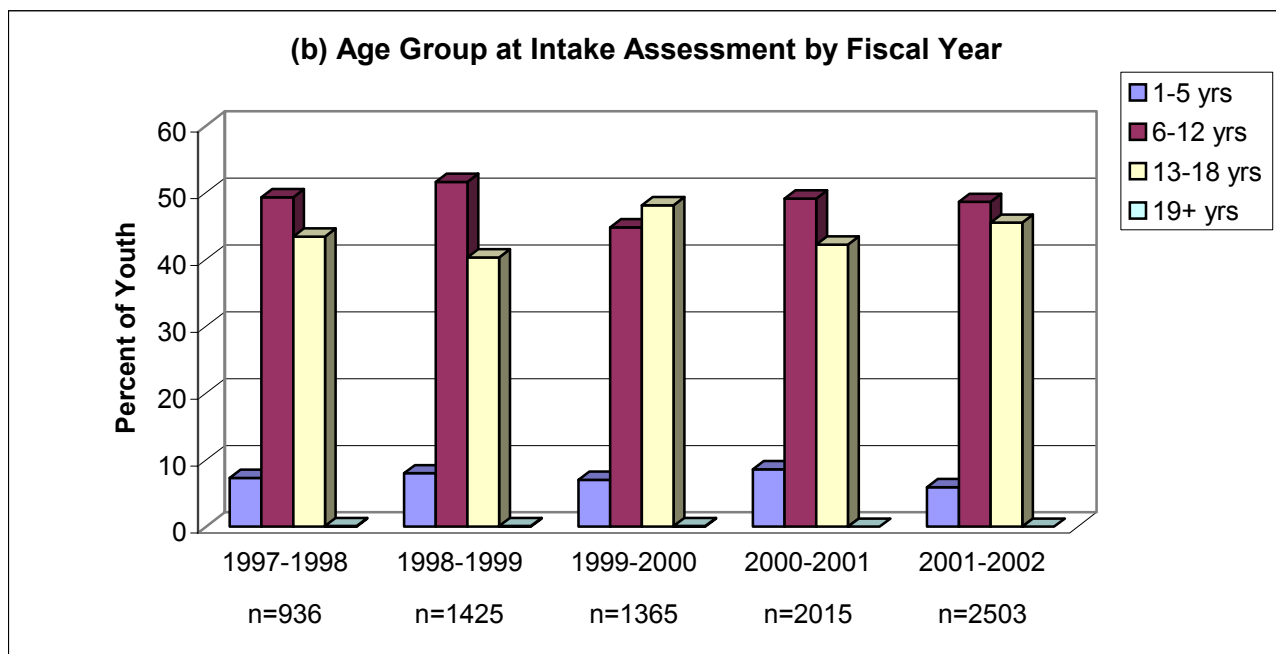
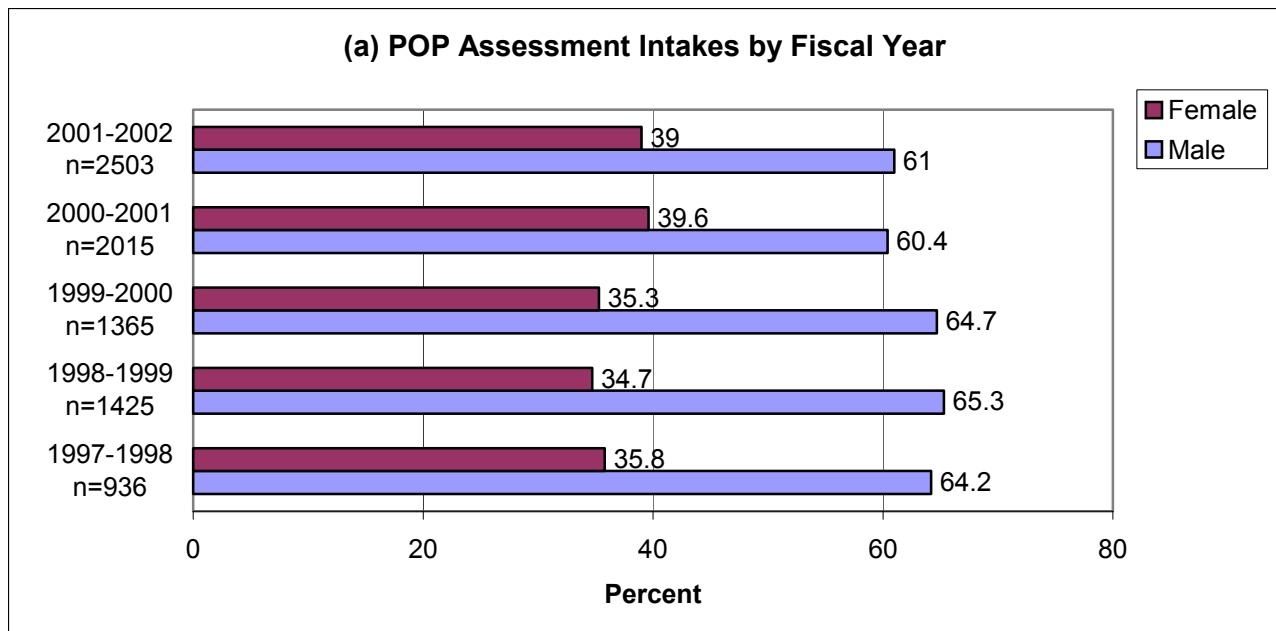
Youth Self Report (YSR)

- Assesses a youth's competencies and behavior problems according to the youth
- Developed by Thomas M. Achenbach, Ph.D. (version 1991)
- 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)
- Measure is used for ages 11-18

Client Satisfaction Questionnaire (CSQ-8)

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

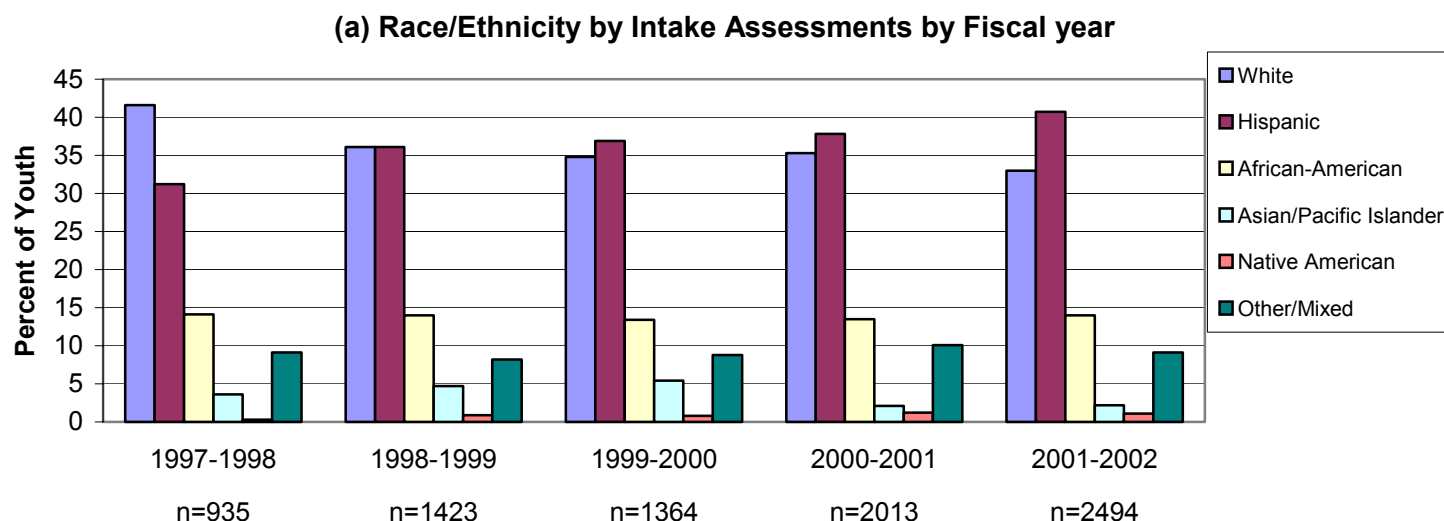
Figure 11: POP Intake Cohorts by Sex and Age



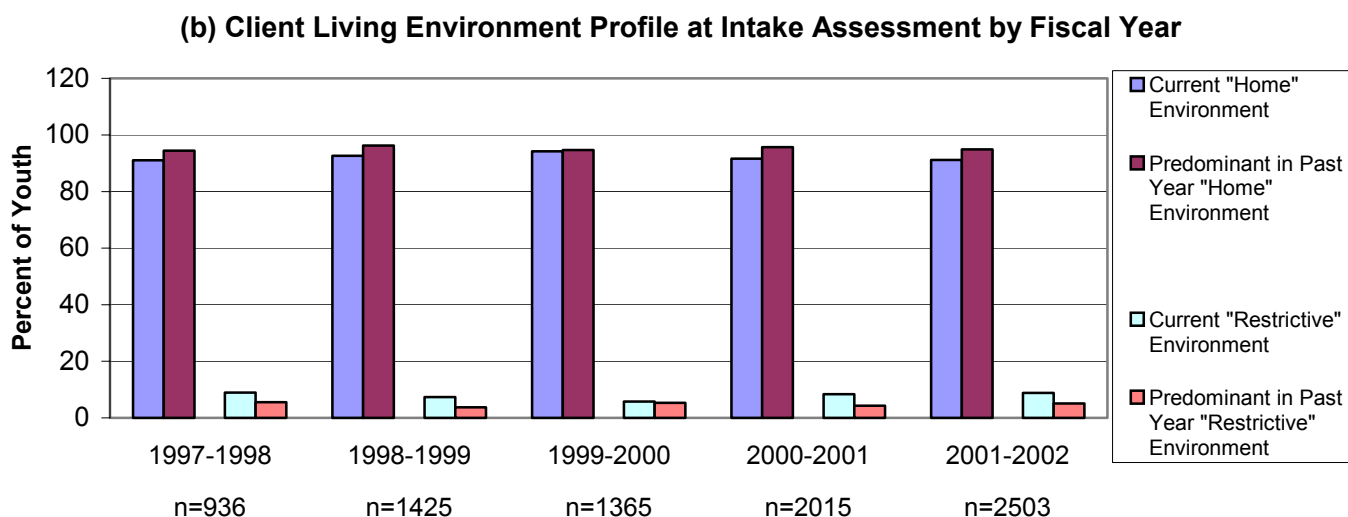
- More males than females receive mental health services and complete POP intake assessments for each fiscal year; however, 2000-2001 and 2001-2002 had significantly less males than other fiscal years.
- There were significantly more POP intake assessments for the older age group (13-18 yrs) in 1999-2000 and 2001-2002 years than compared to older youth in 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.



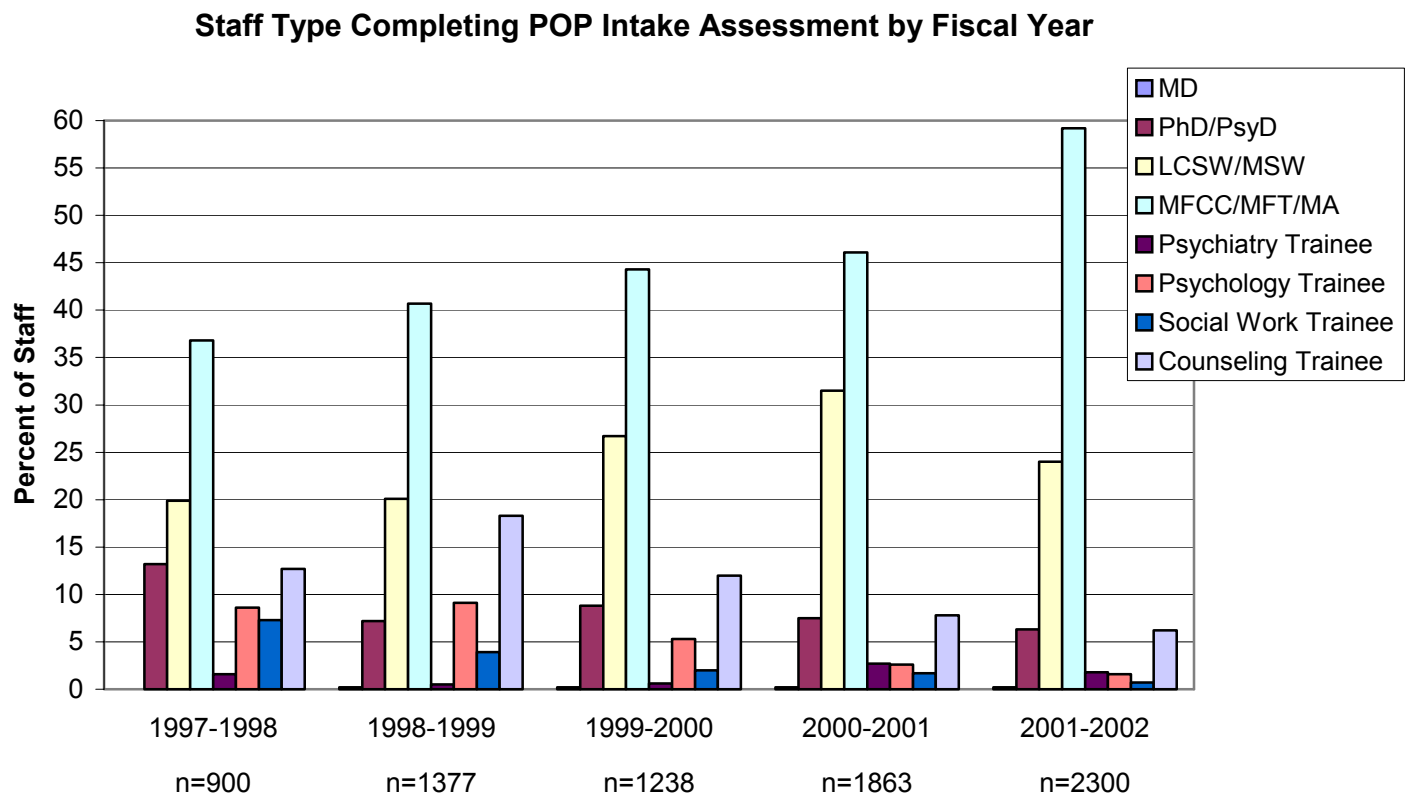
The Client Living Environment Profile is completed by the clinician after interviewing the youth and family. "Home" environment includes bio/adopted homes, foster home and living independently. "Restrictive" environment includes incarceration, psych hospital, group home and homeless settings. "Current"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



- In 1999-2000, Hispanics surpassed Whites in percent of youth completing POP intake assessments. Hispanics continued to remain higher than Whites in 2000-2001 and 2001-2002.
- Youth are primarily living in Home settings at POP intake assessment for each fiscal year.

Figure 13: POP Intake Cohorts by Staff Type

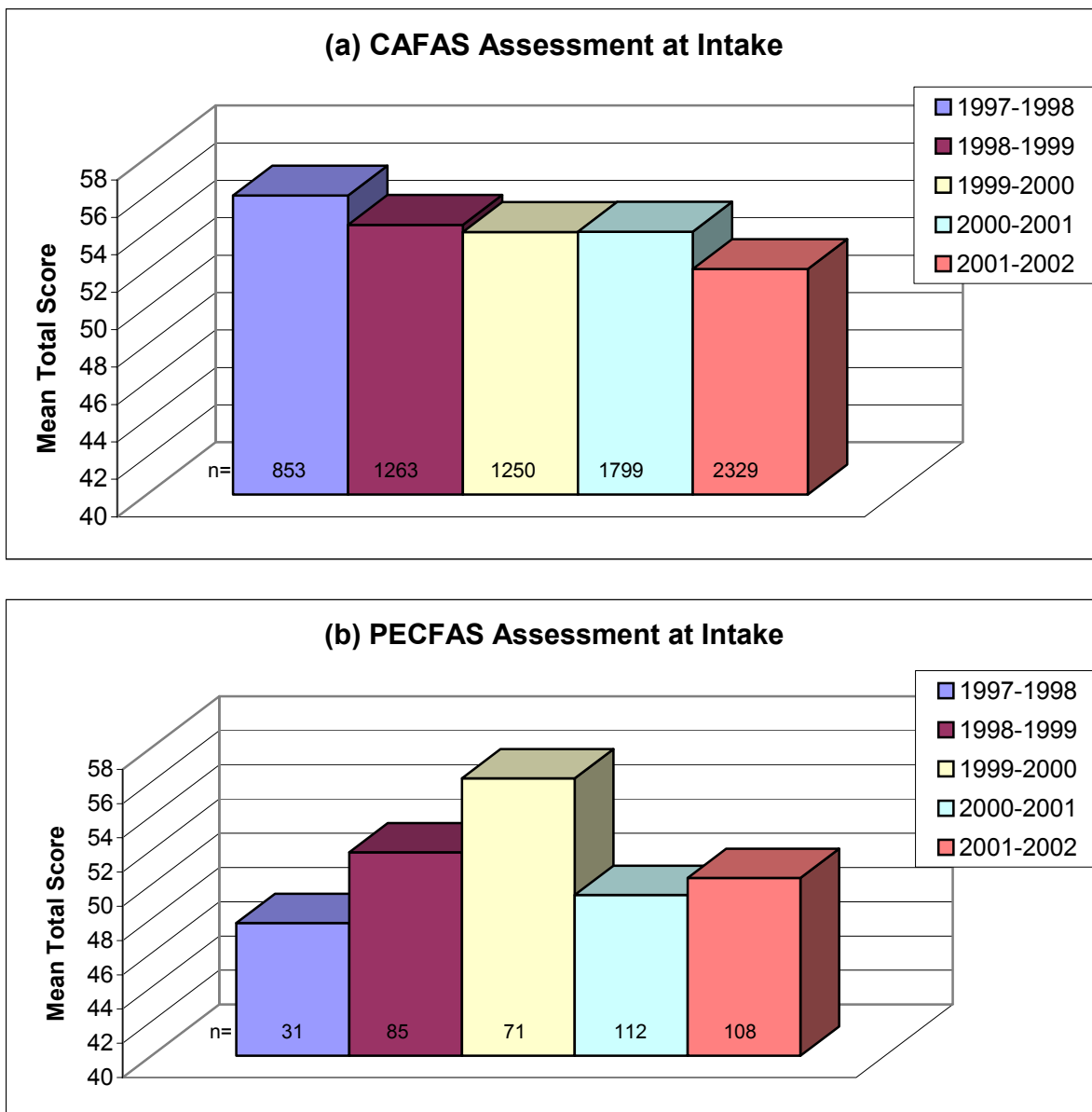
Percent of youth receiving services from each type of staff at Intake assessment. These staff members completed the assessments.



- There were significantly more MFCC/MFT/MA staff completing POP intake assessments for 2001-2002 than other fiscal years.
- Degreed staff, both licensed and post-grad with no license, continued to account for the largest percent of staff that complete POP intake assessments.
- Trainee staff completing POP intake assessments have continued to decrease each fiscal year.

Figure 14: POP Intake Cohorts by Fiscal Year – CAFAS and PECFAS Total Scores

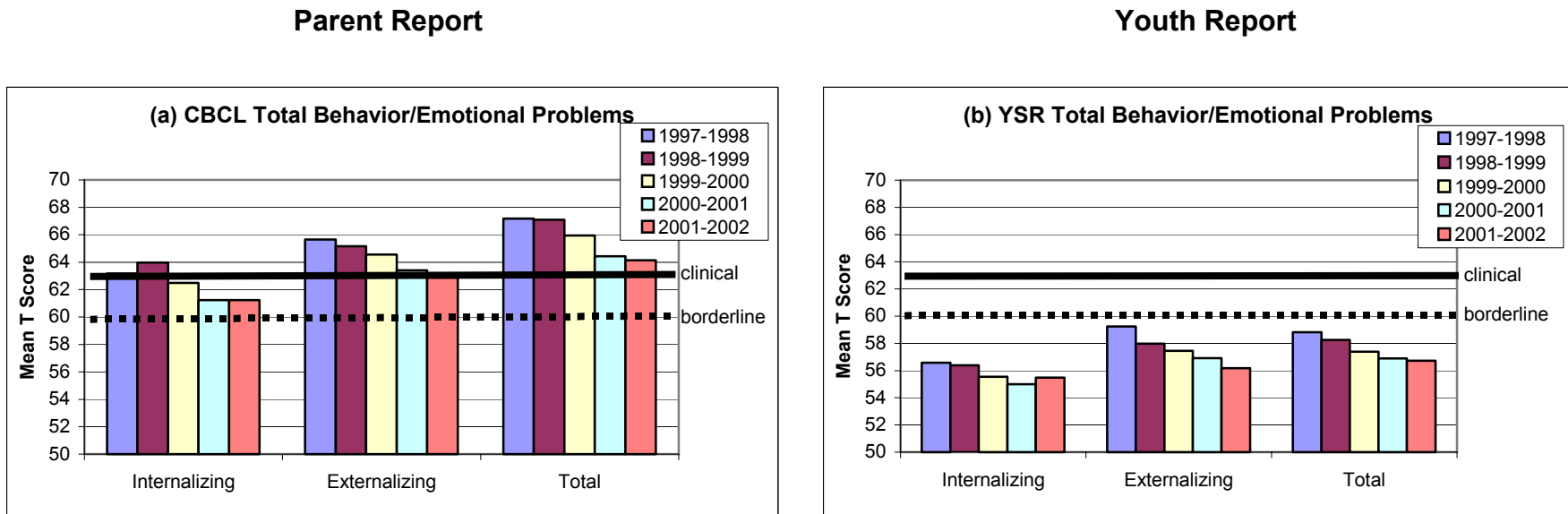
CAFAS is the functional assessment measure for youth 6-18 years old. PECFAS is the comparable functional assessment measure for children 4-5 years old. Both measures are completed by the clinician at intake assessment. High scores indicate more impairment.



- Overall, youth are entering the system with moderate levels (40-60) of impairment reported by clinicians on the CAFAS.
- 2001-2002 had the overall lowest CAFAS score for youth at intake than any other fiscal year.
- Mean CAFAS scores in 2001-2002 were significantly lower than in 1997-1998.
- Young children vary within moderate levels (40-60) of impairment by fiscal year.

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.

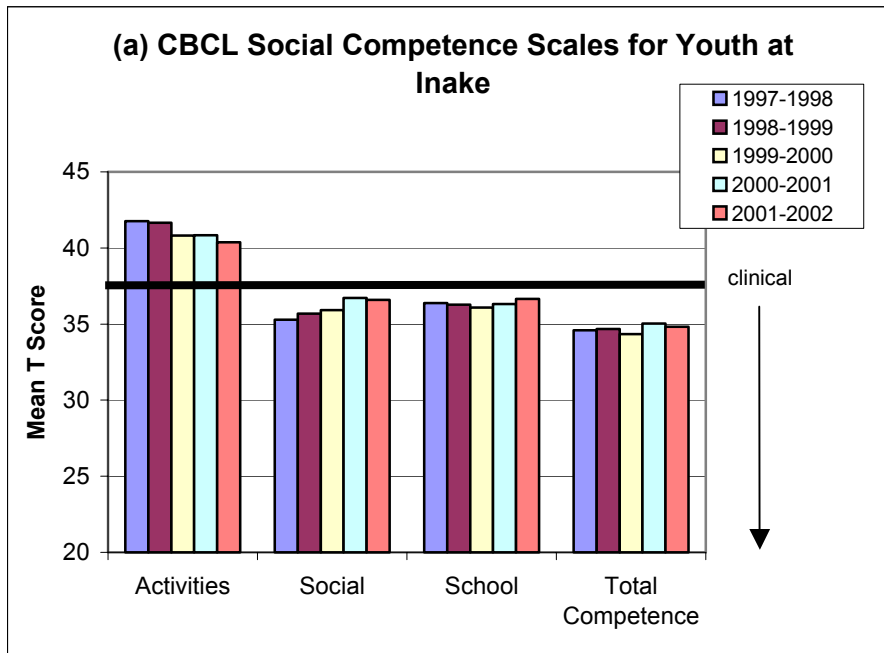


- Parents reported a decrease in total problems at POP intake assessment by each fiscal year.
- Youth reported significantly fewer problems at intake assessment compared to parents for each fiscal year.
- Both parents and youth reported more externalizing problems than internalizing problems at intake for each fiscal year.
- In 2000-2001 and 2001-2002, parents reported significantly less total problems at POP intake assessment for youth entering services compared to 1997-1998, 1998-1999 and 1999-2000.

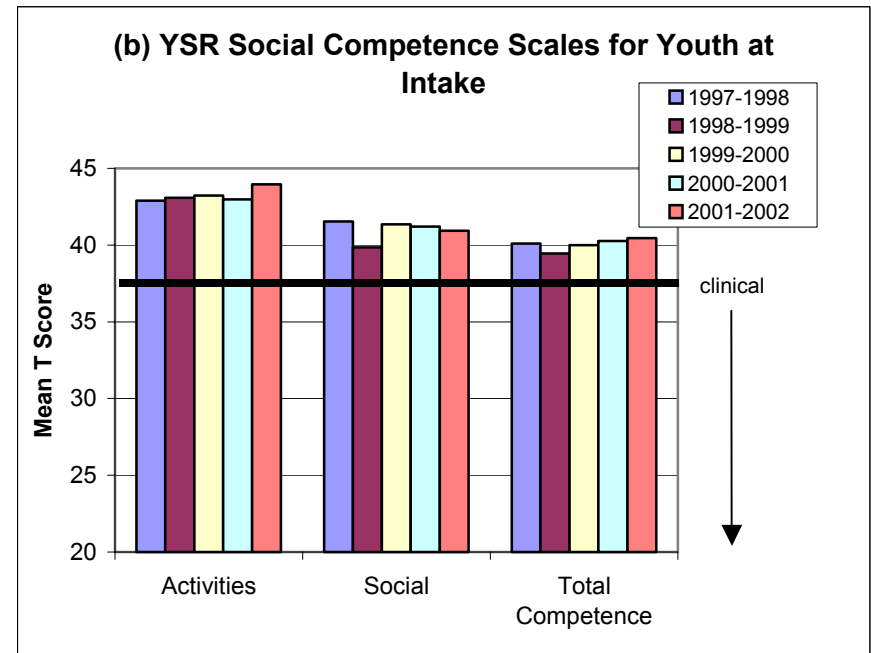
Figure 16: POP Intake Cohorts by Fiscal Year – Youth Competency Scales by Parent and Youth Report

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

Parent Report



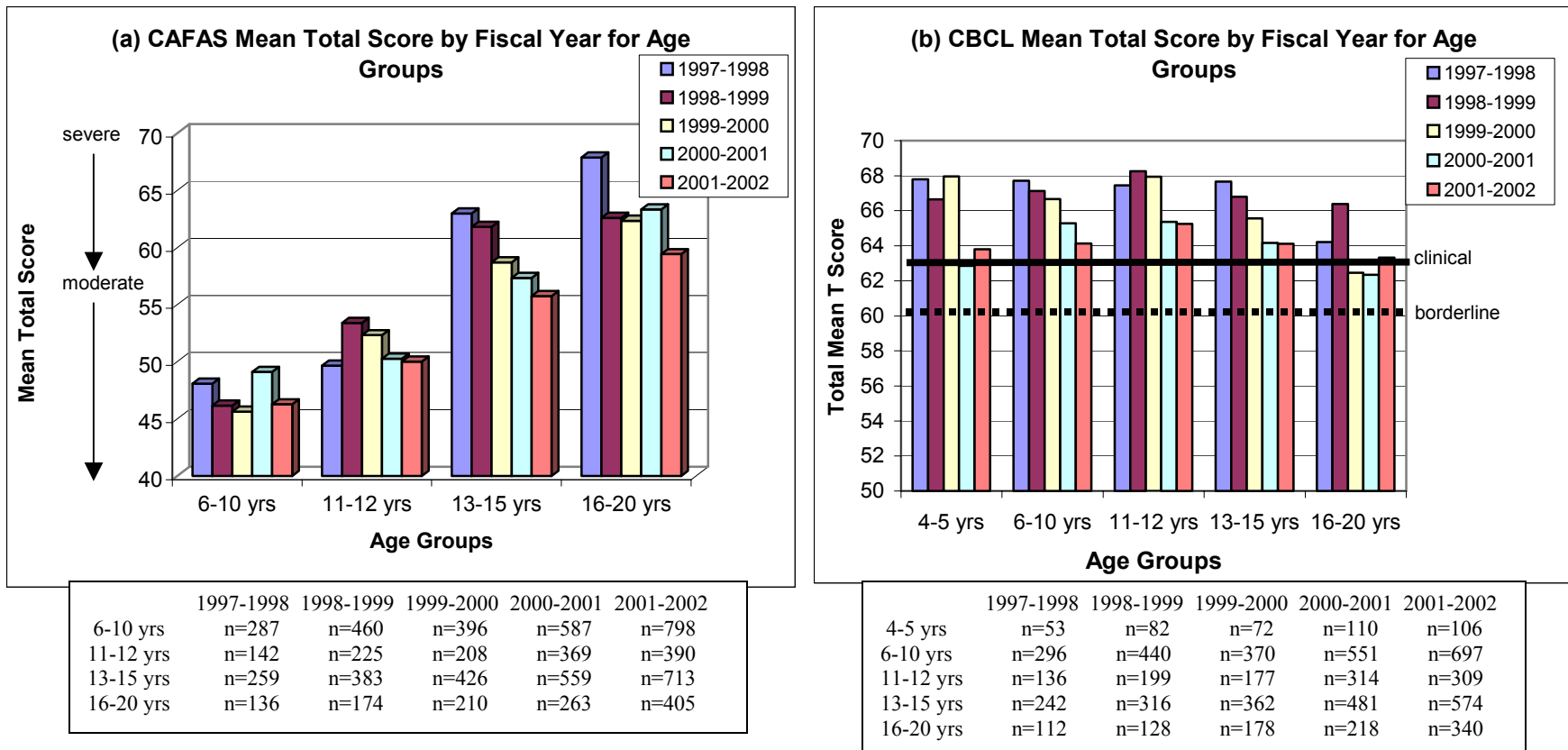
Youth Report



- Parents reported clinical levels of social, school and total competence for each fiscal year, meaning youth have poor competence skills.
- Overall, youth reported significantly more social competencies than parents for each fiscal year.
- There are no significant differences between fiscal years.

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.

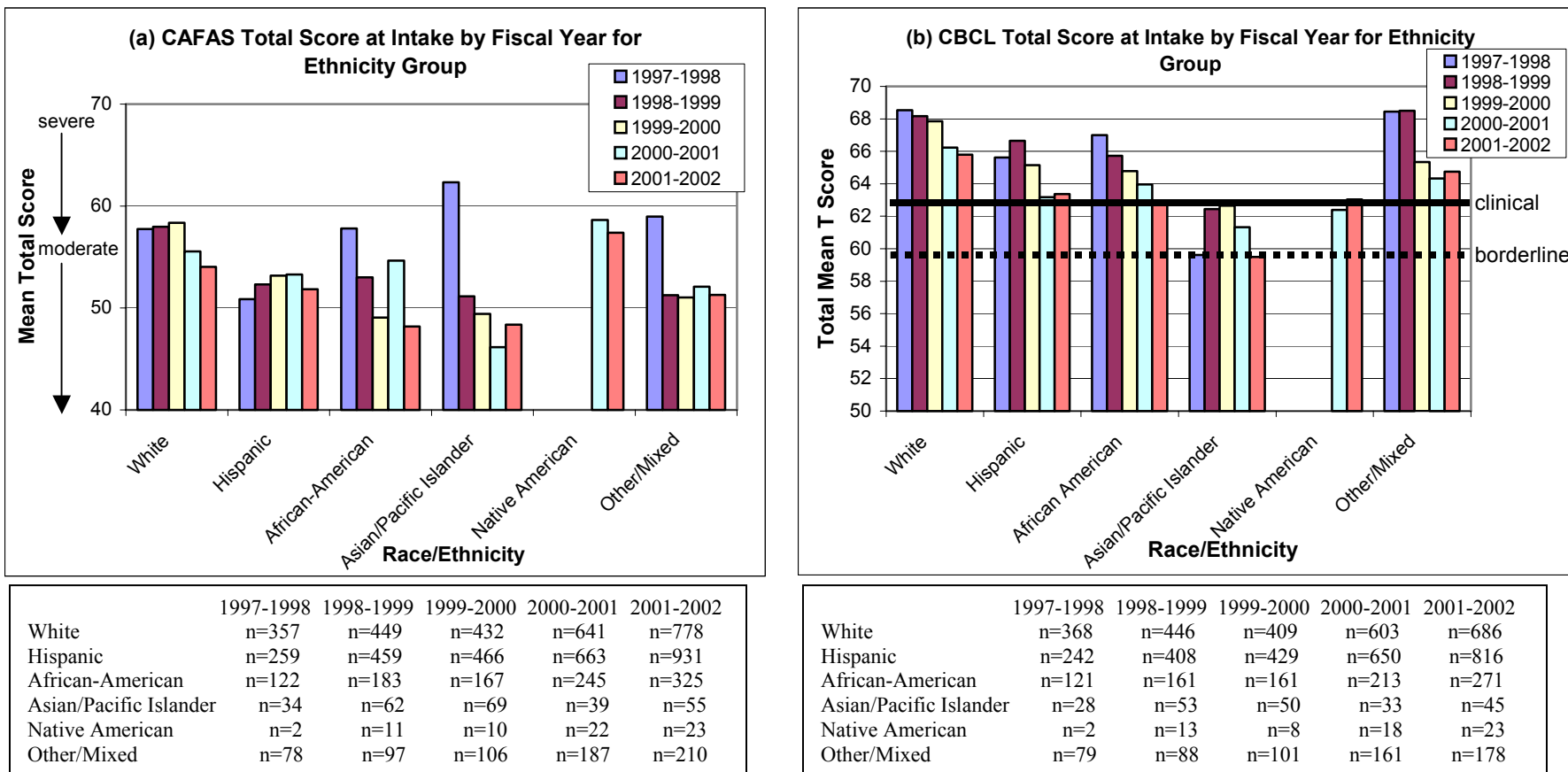


- Per clinician report (CAFAS), older youth (>16 yrs) are significantly more impaired at intake at each fiscal year compared to latency age youth (6-12 yrs).
- There is a trend towards parents reporting less problems in more recent fiscal years (2000-2001 and 2001-2002) than previous years.

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.



- Clinicians reported less impairment of youth across all groups at intake in 2001-2002 compared to 2000-2001 except for Asian/Pacific Islanders.
- In each fiscal year, Asian/Pacific Islanders reported fewer problems per parent report (CBCL) compared to all other groups.
- In 2001-2002, parents of White youth reported significantly more problems compared to Hispanics, African-Americans and Asian/Pacific Islanders.

Note: The Native American group was not included in the analyses for 1997-1998, 1998-1999 and 1999-2000 due to their small sample size.

Clinical Outcomes

The Performance Outcome Project has collected data for five fiscal years, 1997-2002, for youth who have received 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=3059), 2) youth with an intake and 1-year follow-up (n=1883), 3) youth with an intake and 2-year follow-up (n=734) and 4) youth with an intake and 3-year follow-up (n=307). There is also a cohort that has assessments at each of the following timeframes: intake, 6 months, 1 year and 2 years for which repeated measure analyses were completed (n=342).

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 19a,b,c). Clinicians, parents and youth agree that improvements are significant for each cohort with the exception of the intake to 3-year cohort, which is not statistically significant according to clinicians ($p=0.107$, $n=307$). When the data is examined by change scores for each measure, the information varies somewhat by informant (see Figure 20). For each timeframe cohort, clinicians report no change occurring more often than positive or negative change and more often than parents and youth. Parents and youth report similar patterns of positive and negative change for intake to 6 months and intake to 1-year cohorts. This pattern shifts over time, and by intake to 2-year follow-up, youth report positive change occurring more often than do parents and clinicians. 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 (48%), parents (61%) and especially youths (64%). Clinicians report primarily no further improvements for youth (62%) 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. These variations may be related to the construct assessed (functional impairment versus symptomatology) or informant (clinician perspective versus caregiver and youth). Analyses conducted by race/ethnicity, age and sex show no additional significant differences than those reported above.

After investigating the youth who have intake and 6-month follow-up assessments by fiscal years, results show consistent improvements for each fiscal year (see Figure 22). 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 clinician reported 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). Clinicians report higher levels of functional impairment, on both the CAFAS (youth) and PECFAS (preschool), for children in long-term services (>2 years). 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.

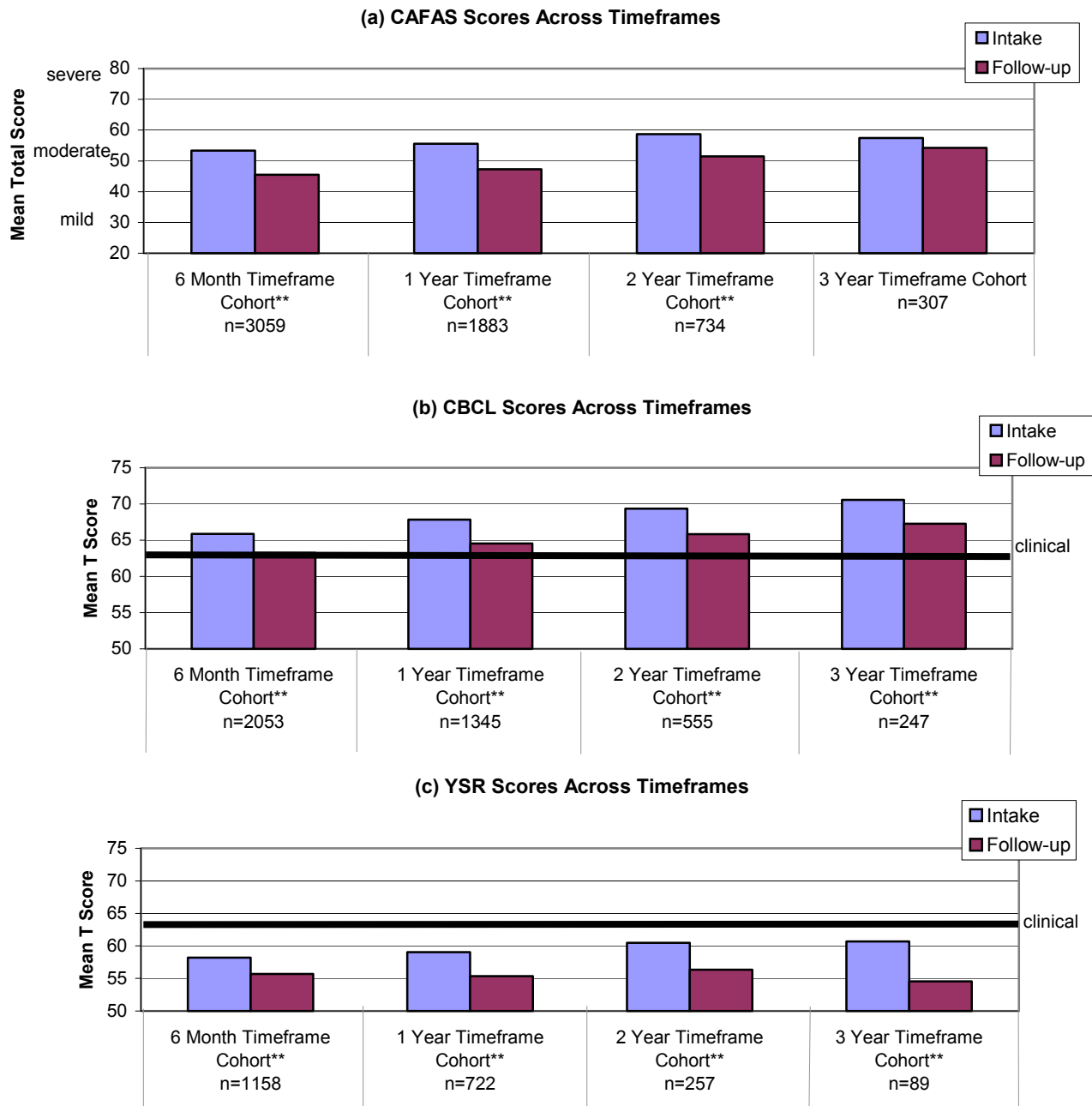
Repeated measures analyses for youth who completed intake, 6-month, 1-year and 2-year assessments show continuous statistically significant improvement over time on the CAFAS per clinician report. Parents and youth also reported incremental statistically significant improvements over time on behavior 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. Statistical significance is evident for only White and Hispanic youth on the CAFAS demonstrating further improvement from 6 months to 1 year according to clinicians. By examining the overall means, African-American youth show a deterioration trend from 6 months to 1 year (Figure 26). However, paired t-test show similar mean scores at 6 months and 1 year for African-American youth. Regression analyses controlling for gender and age indicate that from intake to 6 months and intake to 1 year, Asian/Pacific Islander and Hispanic youth show significantly more improvement than Whites according to clinician report (CAFAS).

Per parent report (CBCL), there are statistically significant changes from intake to 6 months and intake to 1 year on paired sample t-tests for all race/ethnic groups with the exception of Asian/Pacific Islanders. Only Hispanic youth continue to improve from 6 months to 1 year on paired samples according to parent report. Overall group means show increased levels of symptomatology from 6 months to 1 year for all groups except Asian/Pacific Islander which show an opposite pattern. Whites and African-Americans show initial improvements (statistically significant from intake to 6 months) and then decline from 6 months to 1 year, while 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, paired t-test analyses show that White and Hispanic youth (YSR) report continuous improvement from intake to 6 months to 1 year (statistically significant). However, African-American youth report improvement from intake to 6 months and intake to 1 year but report increased problems at 1-year assessment compared to 6 months (Figure 28). Regression analyses indicate no significant effects of race/ethnicity on follow-up scores.

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 and more symptoms.

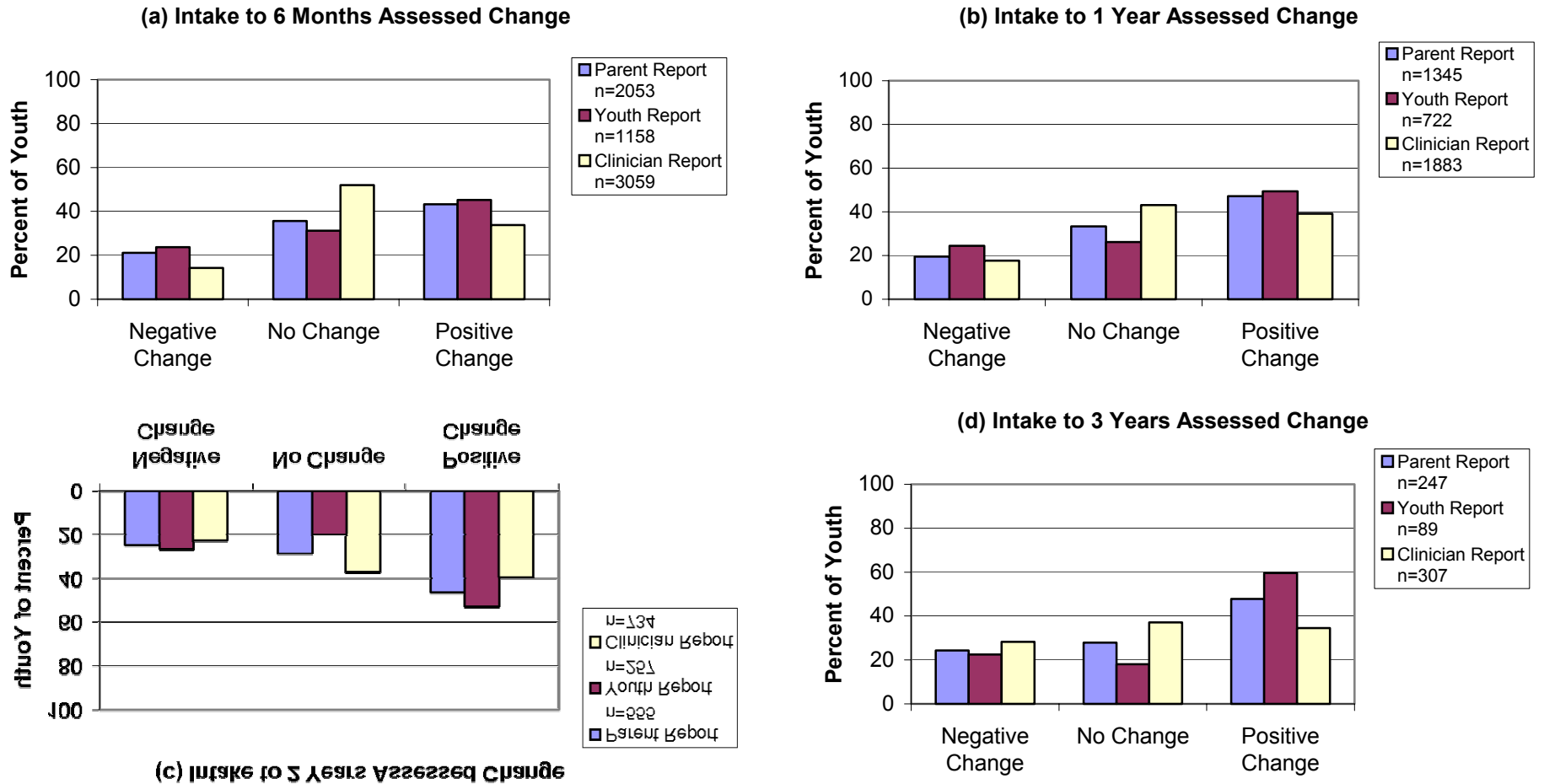


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- Parents and youth reported statistically significant levels of improvement for each cohort while clinicians do not for the 3-year timeframe cohort.

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

“Negative change” indicates youth whose condition deteriorated, “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 and YSR and a 10-point change on CAFAS.

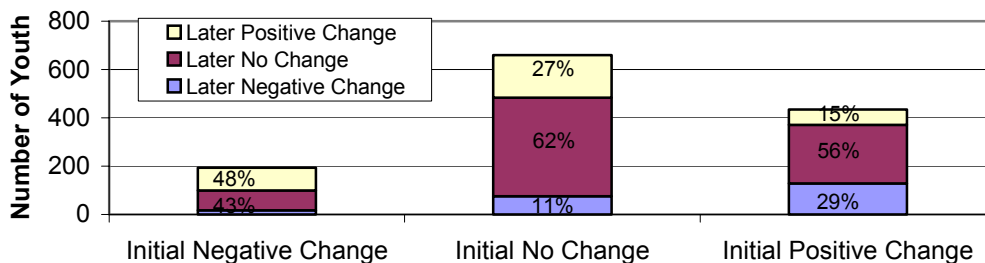


- Similar percentages are being reported as positive change over the various timeframe cohorts.
- Clinicians tend to report “no change” more often than do parents and youth.
- Relative to clinicians and parents, youth are reporting more negative change at each timeframe except the 3-year timeframe cohort. However, youth also reported the most positive change at each timeframe compared to clinicians and parents.

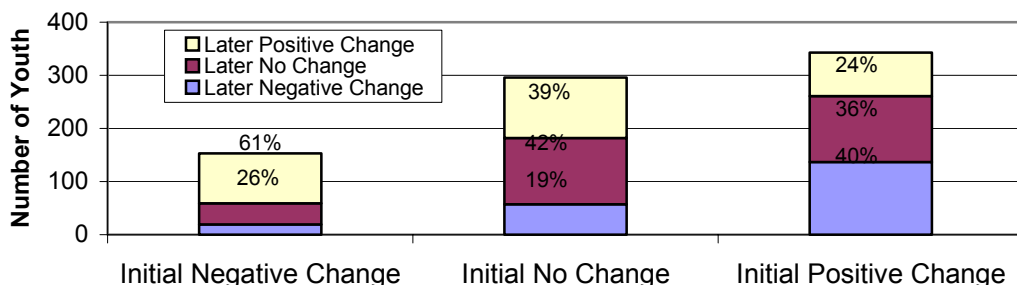
Figure 21: Assessed Change from Intake to 6 Months, 6 Months to 1 Year by Informant

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

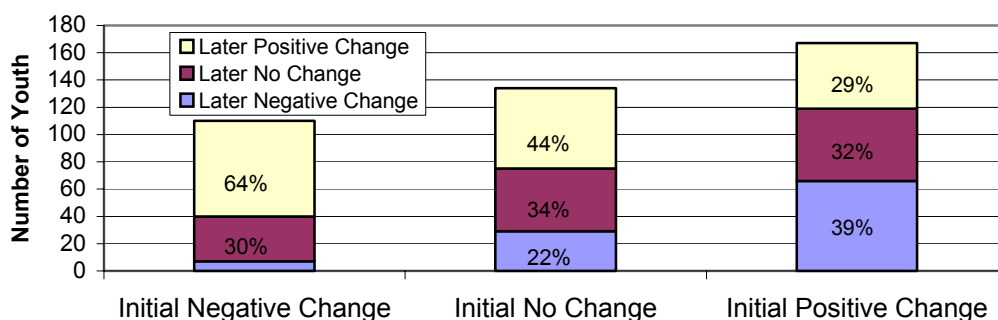
a) Clinician Assessed Initial and Subsequent Change, n=1288



b) Parent Assessed Initial and Subsequent Change, n=792



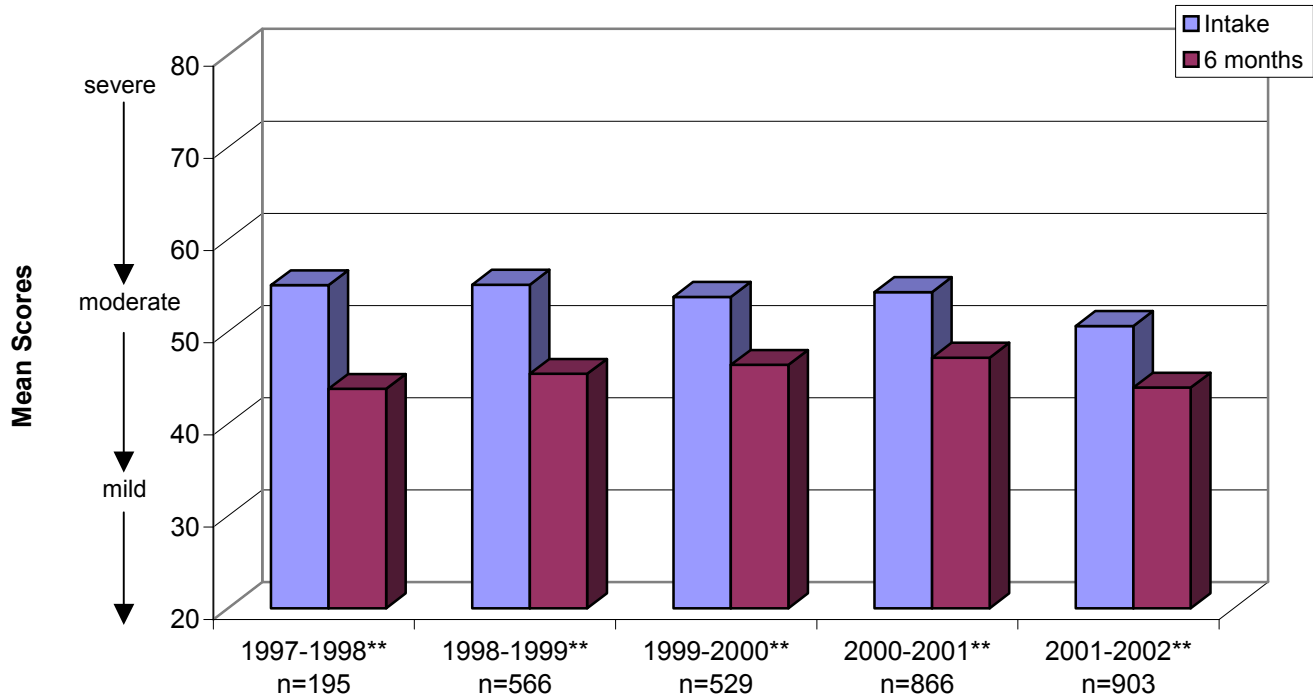
c) Youth Assessed Initial and Subsequent Change, n=411



- 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 youth.
- For youth who improved in the first 6 months, a third of them continued to improve in the subsequent 6 months according to parents and youth.
- Clinicians are more likely to report no change during the first 6 months and also during the subsequent 6 months compared to parents and youth.

Figure 22: Intake to 6 Months 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 five fiscal years. Higher scores indicate more dysfunction.

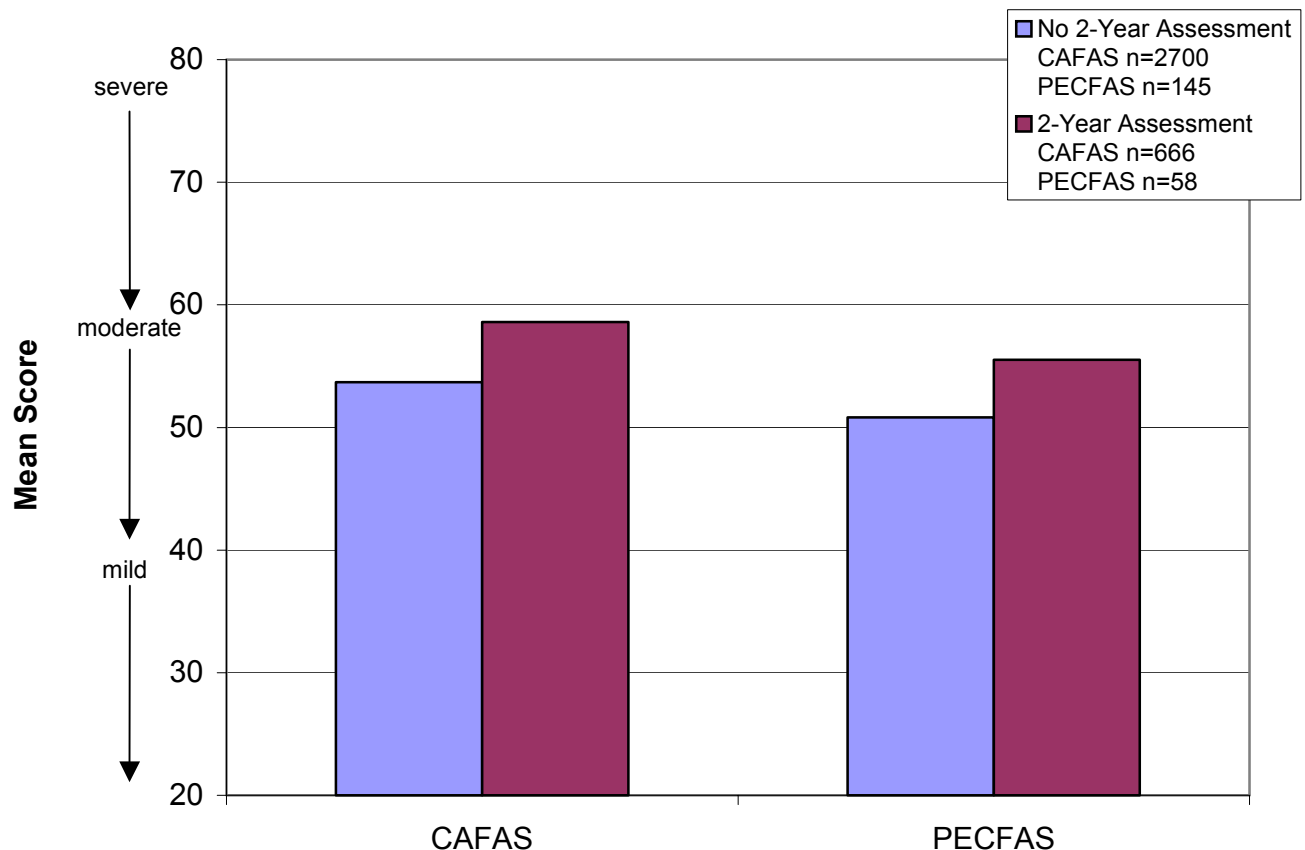


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- Clinician reports of youth functioning show significantly improved functioning at the 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 five years of study.

Figure 23: Intake Profiles (FY 97-98, 98-99, 99-00) – CAFAS Scores for Youth With and Without 2-Year Assessments

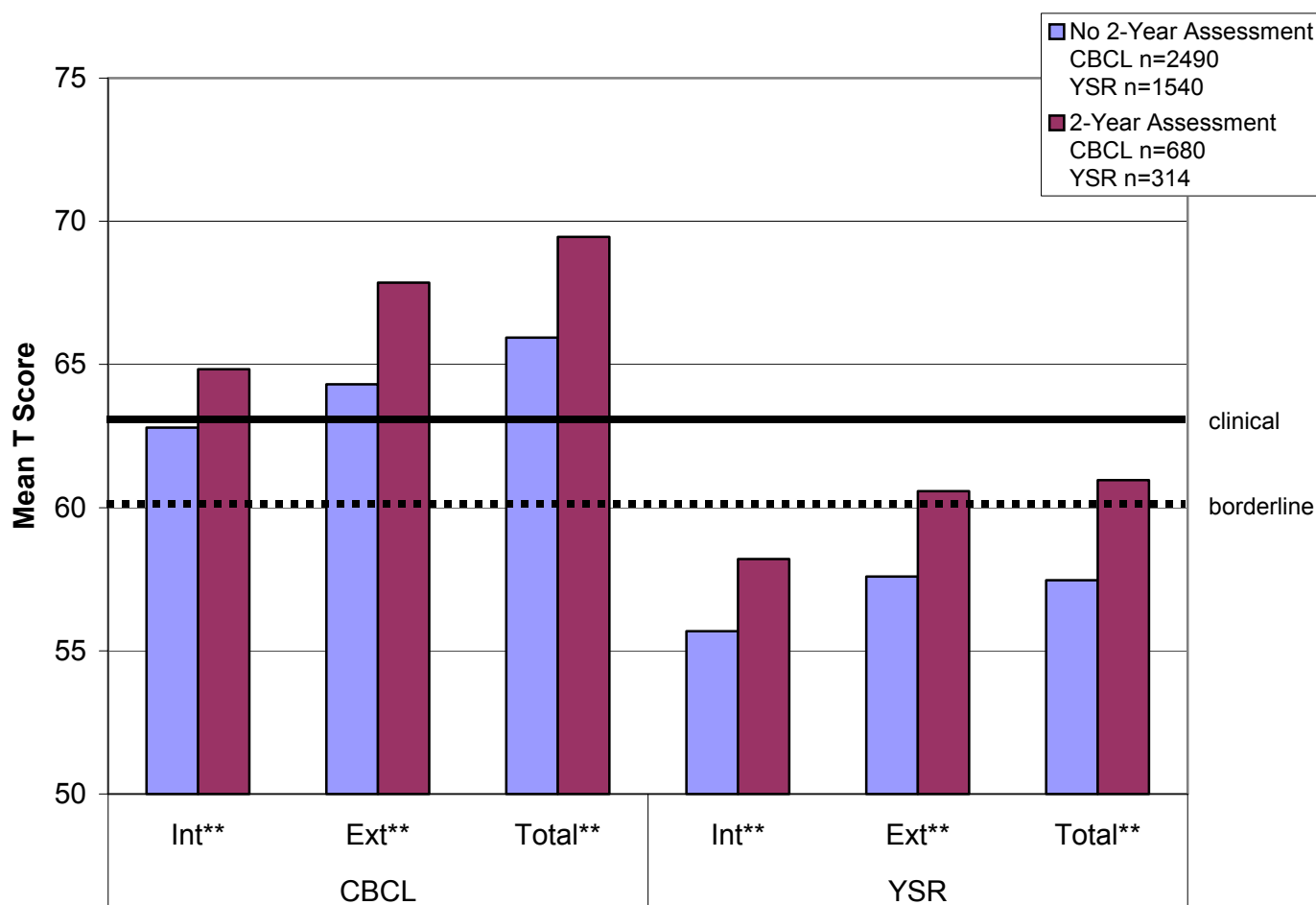
The CAFAS is a functional impairment measure completed by the clinician. The PECFAS is the equivalent measure for children 4-5 years old. The bars indicate mean intake functioning levels for youth who were eligible (intake assessment conducted more than 2 years ago) but did not have a POP assessment at the 2-year follow-up and those that did have a 2-year follow-up assessment (meaning still in services). 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 more functional impairment (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 the small sample size at the 2-year assessment).
- This finding suggests that youth who stay in services for long periods of time are more severely impaired when they enter the system.

Figure 24: Intake Profiles (FY 97-98, 98-99, 99-00) – CBCL and YSR Scores for Youth With and Without 2-Year Assessments

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.

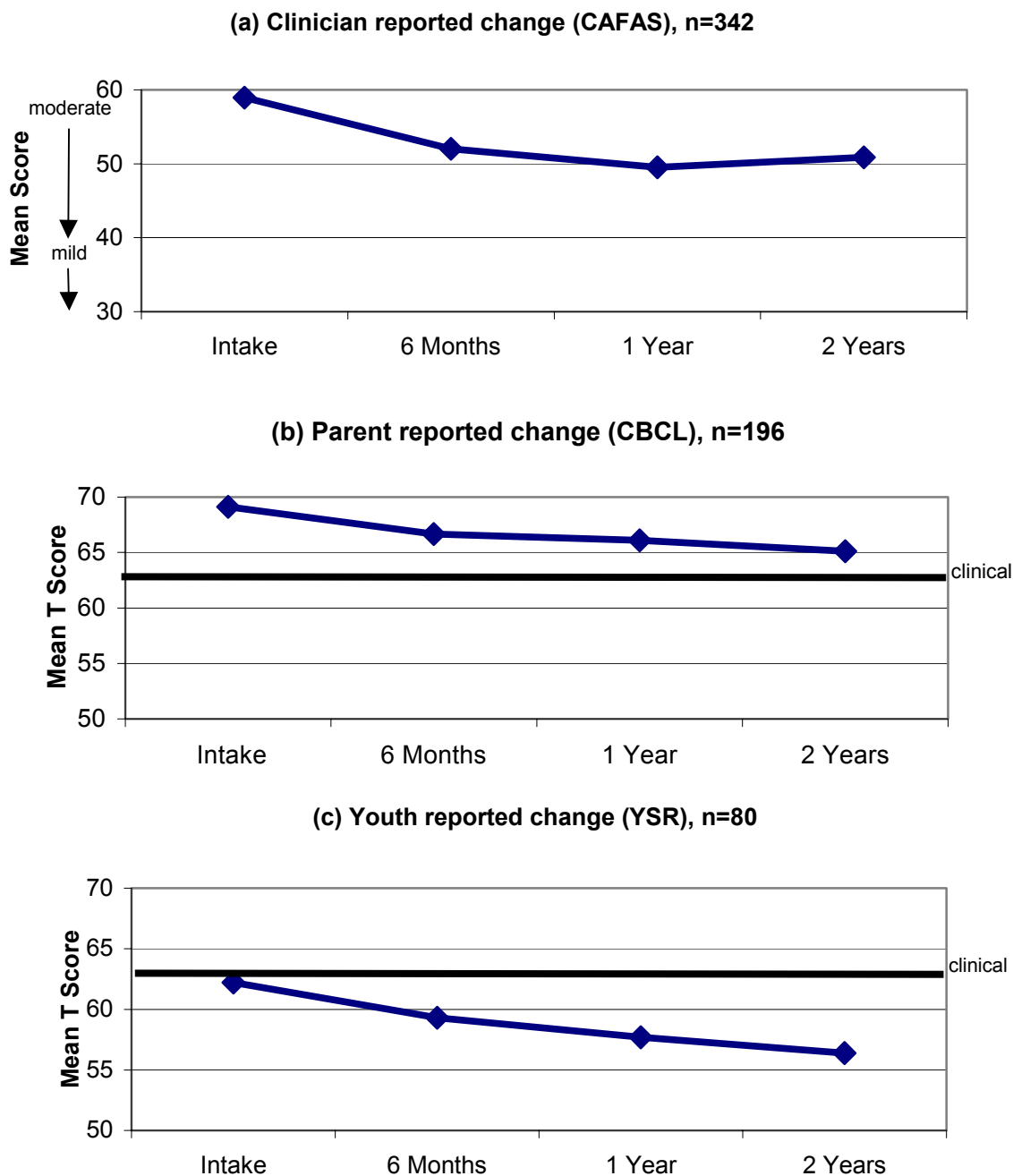


* represents statistical significance at $p < .05$ and ** represents $p < .01$

- 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 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 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 Months, 1 Year and 2 Years

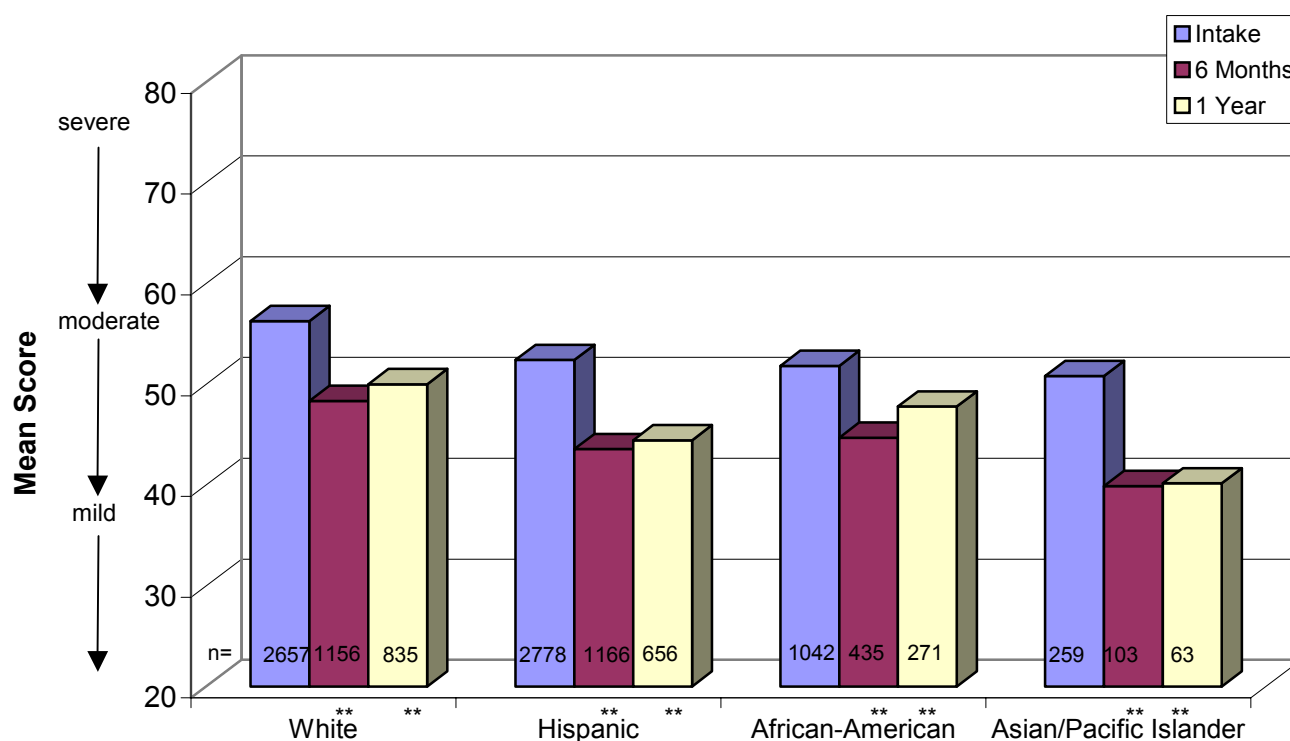
The CAFAS is completed by the clinician, CBCL is completed by the parent, and YSR by the youth (11-18 yrs). The data points display mean scores, with higher scores indicating greater severity. These figures present repeated assessment data (i.e. same youth at each time point).



- All three informants report statistically significant improvements over time from intake to 2 years on repeated measures of functioning and behavior problems.

Figure 26: Clinician Assessed Change by Race/Ethnicity – Mean CAFAS Scores at Intake, 6 Months and 1 Year

The CAFAS is a functional impairment measure completed by the clinician. The four main ethnic/racial groups are: White, Hispanic, African-American, and Asian/Pacific Islander. Higher scores indicate lower psychological functioning.



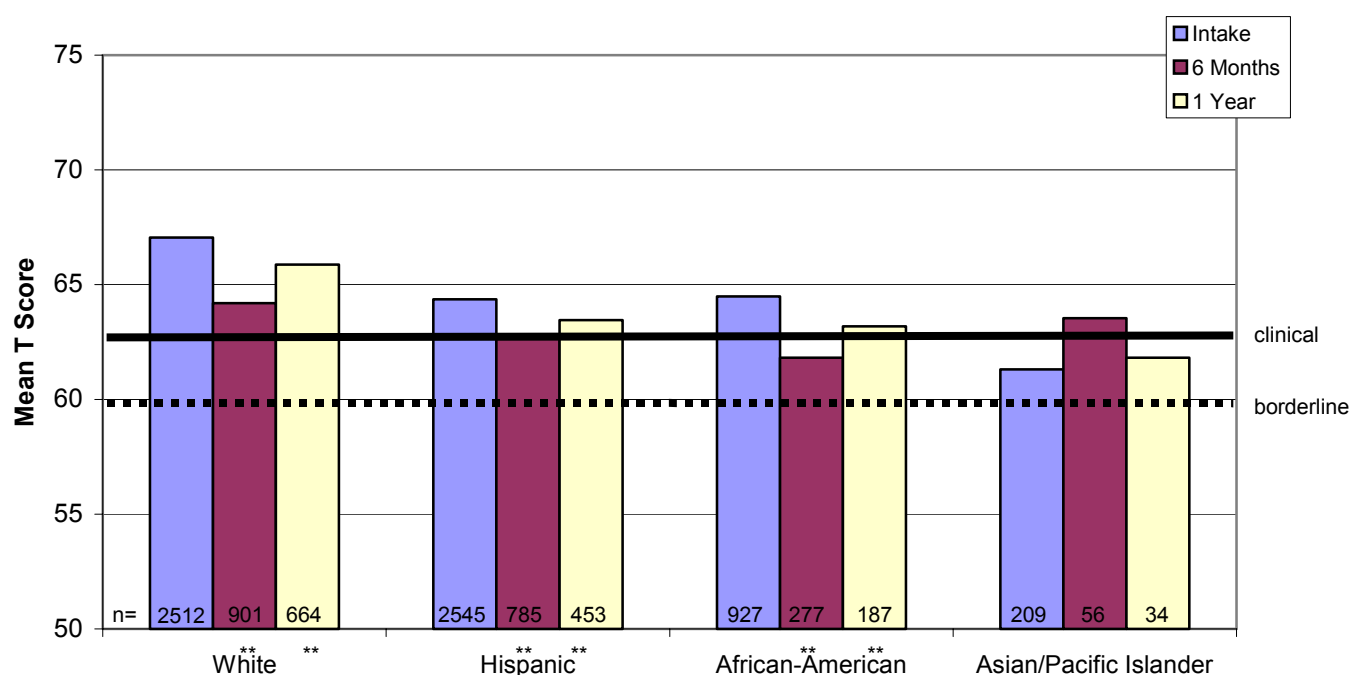
* represents statistical significance at $p < .05$ and ** represents $p < .01$ for paired t-tests

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.

- Each of the ethnic groups show statistically significant improvement in functioning from intake to 6 months and 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 and intake to 1 year, Asian/Pacific Islander and Hispanic youth show statistically more improvement than White youth.

Figure 27: Parent Assessed Change by Race/Ethnicity – Mean CBCL Scores at Intake, 6 Months and 1 Year

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



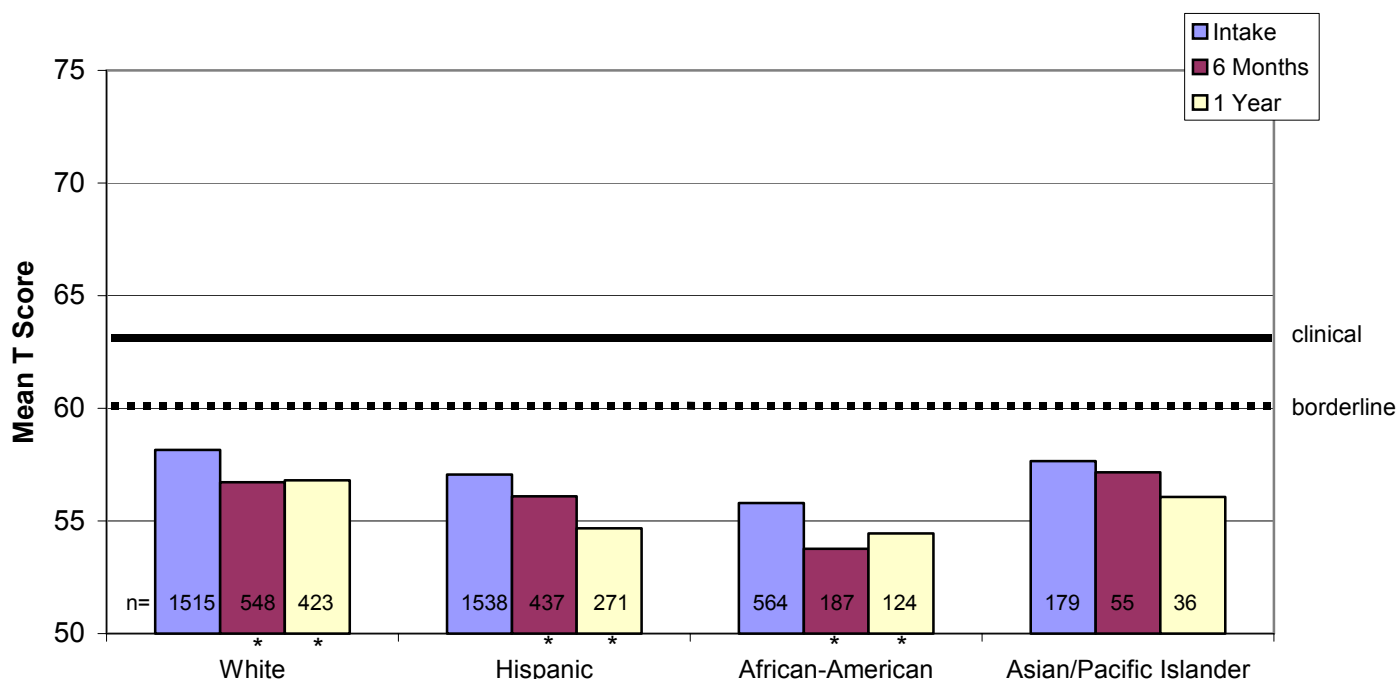
* represents statistical significance at $p < .05$ and ** represents $p < .01$ for paired t-tests

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.

- 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/Pacific Islander youth, parents reported increased emotional/behavioral problems at 6 months.
- At 1-year assessment, all groups except Asian/Pacific Islander youth report increased emotional/behavioral problems compared to 6-month assessments.
- Regression analyses indicate no significant differences by ethnicity on follow-up scores.

Figure 28: Youth Assessed Change by Race/Ethnicity – Mean YSR Scores at Intake, 6 Months and 1 Year

The YSR is an emotional/behavioral problem measure completed by the youth (11-18 yrs). The four main ethnic/racial groups are: White, Hispanic, African-American 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

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.

- According to most youth there is a decrease in reported emotional/behavioral problems from intake to 6 months, with the exception of Asian/Pacific Islander youth.
- For Hispanic and Asian/Pacific Islander 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 6 months. White youth report roughly the same amount of emotional/behavioral problems at 1 year compared to 6 months.
- Regression analyses indicate no significant differences by ethnicity on follow-up scores.

School-Based Outpatient Services

School-Based Services were established by utilizing funds from the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program, which 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 later. In sum, the EPSDT program focuses on 1) broadening eligibility criteria and 2) providing a broader array of services to eligible youth. This allowed the opportunity for the development of innovative ways to reach and treat more youth. Thus, the county began developing a system in which youth could receive mental health services at their school sites.

This service expansion occurred primarily in the fiscal years 2000-2001 and 2001-2002 with an emphasis on expanding services to schools, under the intention of serving youth from underserved populations and communities, and multi-service system youth. Approximately 32 million dollars was allocated to provide service expansion in several phases throughout the county. There were about ten new organizational providers added to the CMHS cadre of providers and more than 20 new programs/program sites. This included 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 (TBS), which is a rehabilitation service conducted by paraprofessionals to improve a youth's functional impairment. TBS services are often provided in a child's home and/or community. The paraprofessionals support the child and family in performing everyday activities such as attending school, participating in extracurricular activities and positively interacting with family members.

Youth who have obtained services at a school site or in any 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 "school-based" outpatient programs compared to those youth involved in "clinic-based" outpatient services. The two cohorts are labeled School-based and Clinic-based. The total sample size for the School-based youth for this report is 1,283 youth and the total sample for Clinic-based is 4,536. For those youth who have remained in services for at least 6 months a follow-up assessment was collected. The sample sizes for the 6-month follow-up are the following: School-based sample is 379 and the Clinic-based sample is 1,117.

Sample Demographics

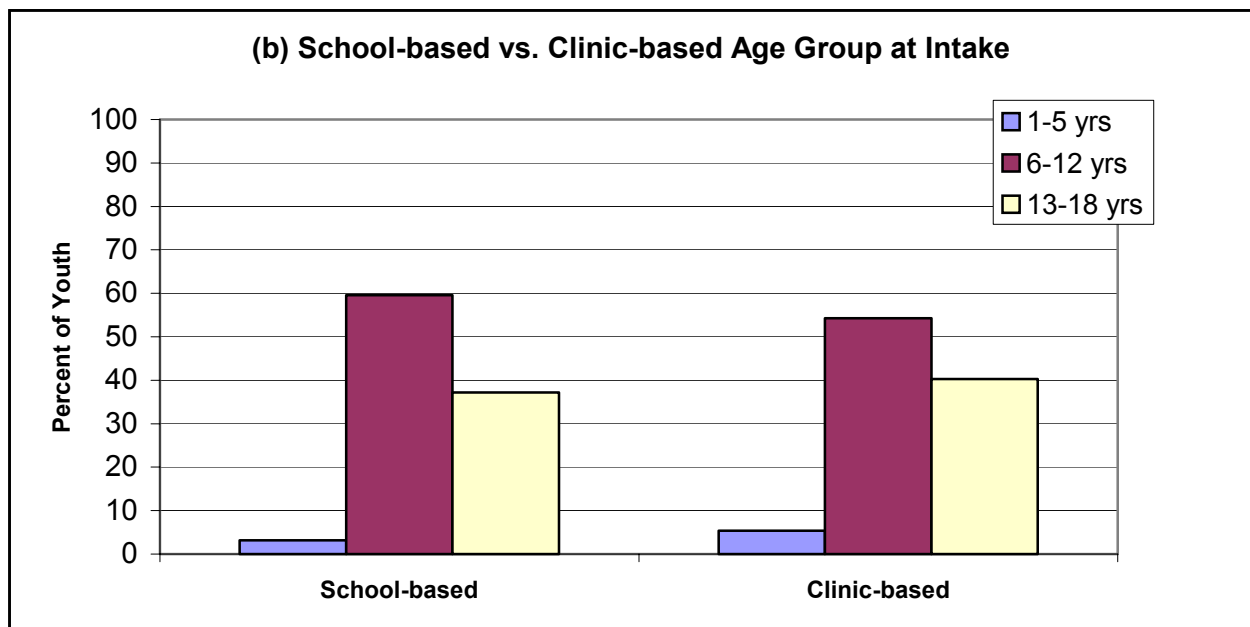
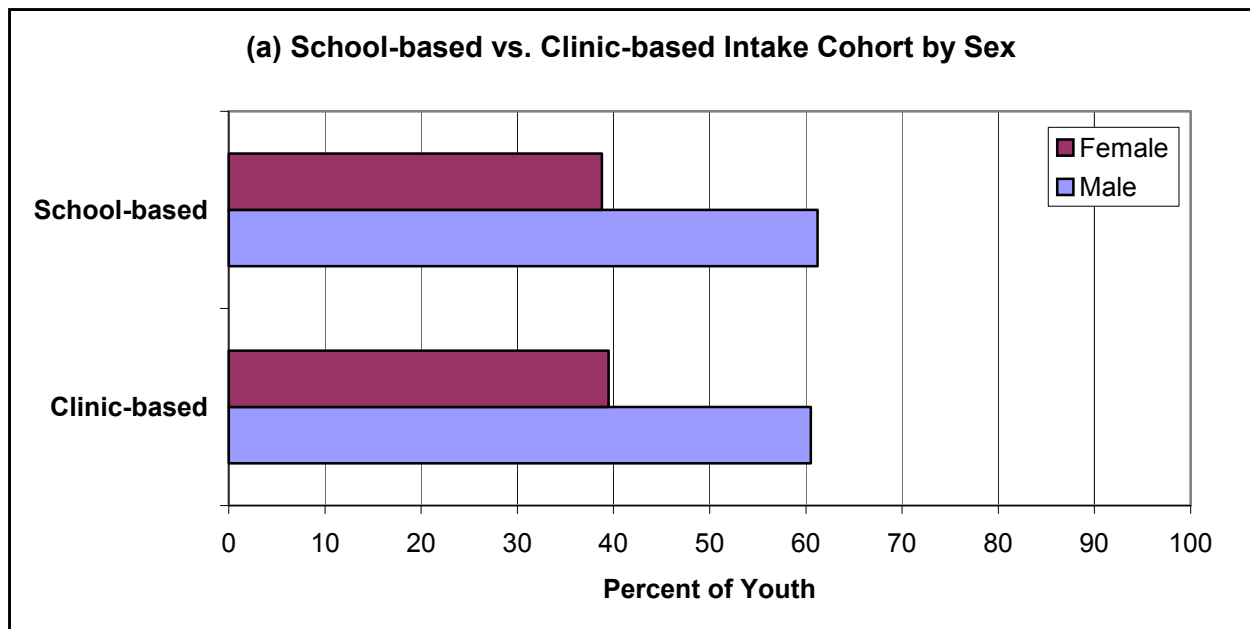
In comparing the School-based sample to the Clinic-based sample there are some interesting differences in demographic characteristics. The percentage of males and females is similar in both samples (61% males) (Figure 29a). The age distribution of the youth entering the School-based programs is different than the Clinic-based sample. By comparing means and modes the youth are younger in the School-based sample with more latency age youth receiving services compared to the Clinic-based sample that has more adolescents (Figure 29b). There are also more youth in the Hispanic race/ethnicity group involved in School-based programs (51.5%) compared to Clinic-based (41.5%) (Figure 30).

Clinical Outcomes

In comparing the clinical profiles of children and adolescents in School-based programs to those in Clinic-based outpatient programs, School-based youth display significantly less impairment at intake according to clinician, parent and youth reports. The mean CAFAS (clinician report) score at intake for School-based is 50.02 (n=1228) versus 52.59 for Clinic-based (n=4177). The CBCL total T-score (parent report) at intake for School-based is 63.23 (n=1035) versus 65.34 for Clinic-based (n=3893). The YSR total T-score (youth report) at intake for School-based is 56.75 (n=628) versus 57.82 for Clinic-based (n=2239).

From intake to 6 months for each sample (School-based and Clinic-based), clinician, parent and youth reports reflect statistically significant overall improvement (Figure 31a,b,c). There are no statistical differences between the amount of improvement between the two groups. When the data are examined by change scores for each measure, the information varies by informant for both School-based and Clinic-based samples. At the 6-month follow-up clinicians are more likely to report no change occurring for both School-based and Clinic-based youth (Figure 32a,b,c).

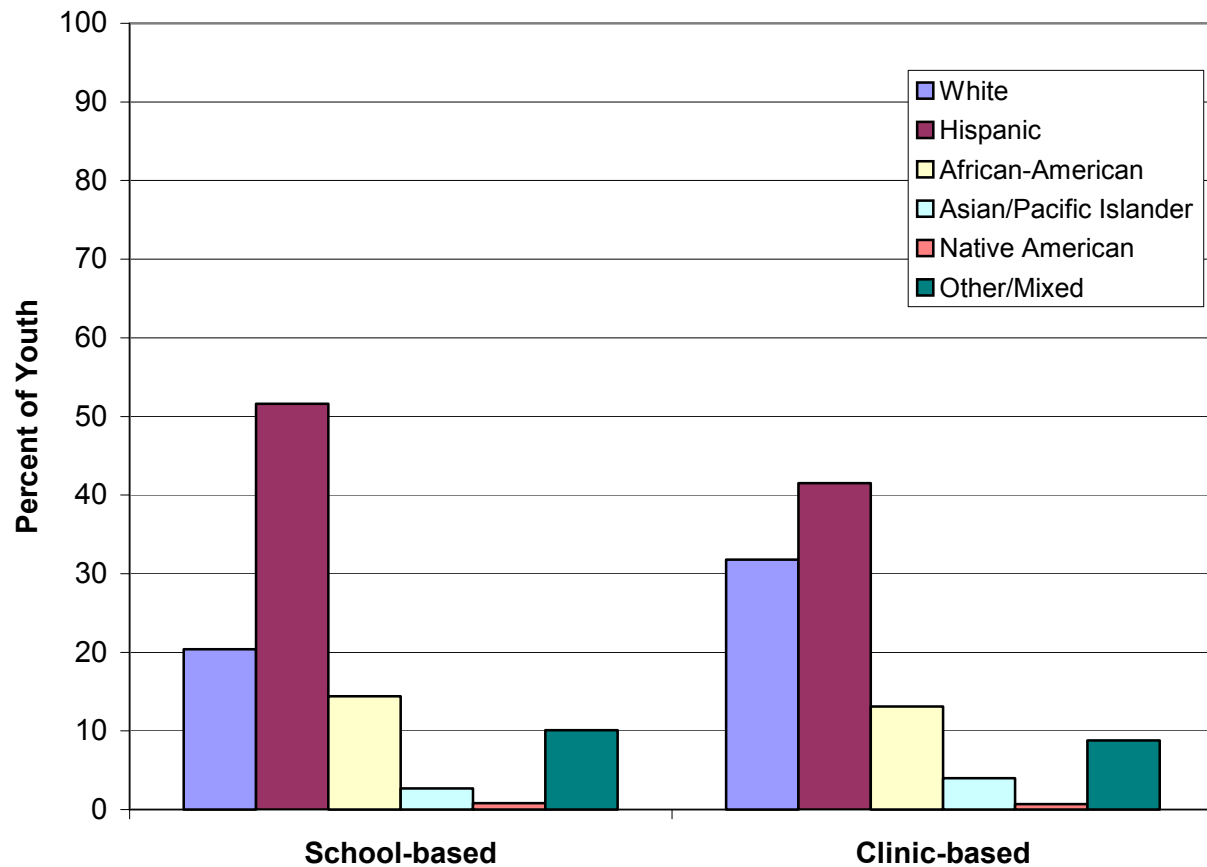
Figure 29: School-based vs. Clinic-based Intake Cohorts by Sex and Age



- Gender distribution is approximately the same in school-based services and clinic-based services, with more males entering into both services.
- There is a slightly higher percentage of 6-12 year olds entering school-based services than clinic-based services.

Figure 30: School-based vs. Clinic-based Intake Cohorts by Race/Ethnicity

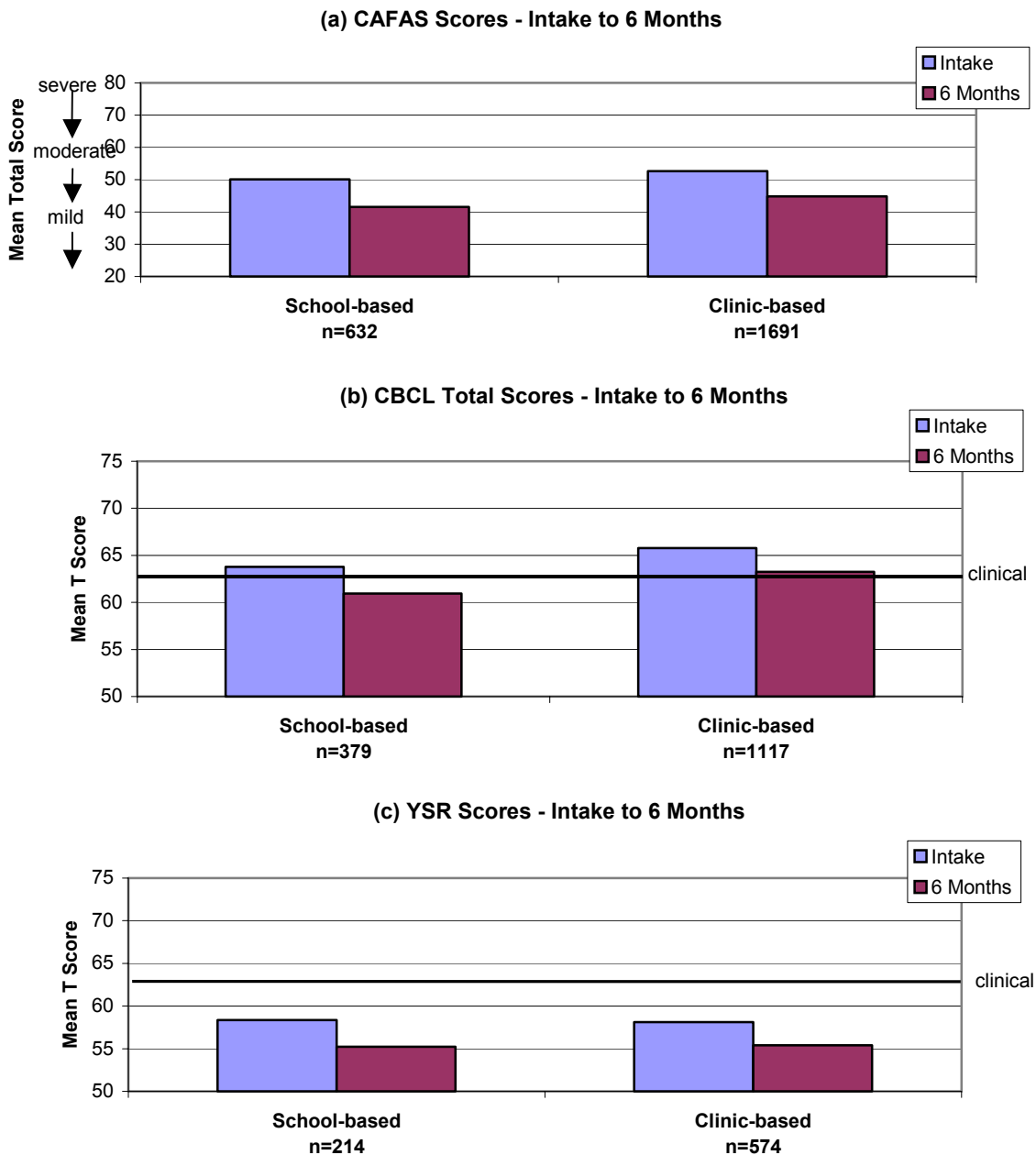
Race/Ethnicity is reported by the clinician after interviewing the youth and family.



- Fewer Whites entered school-based services than clinic-based services.
- More Hispanics entered school-based services than clinic-based services.

Figure 31: School-based vs. Clinic-based Clinician, Parent and Youth Reports at Intake and 6 Months – Change in CAFAS, CBCL and YSR Scores

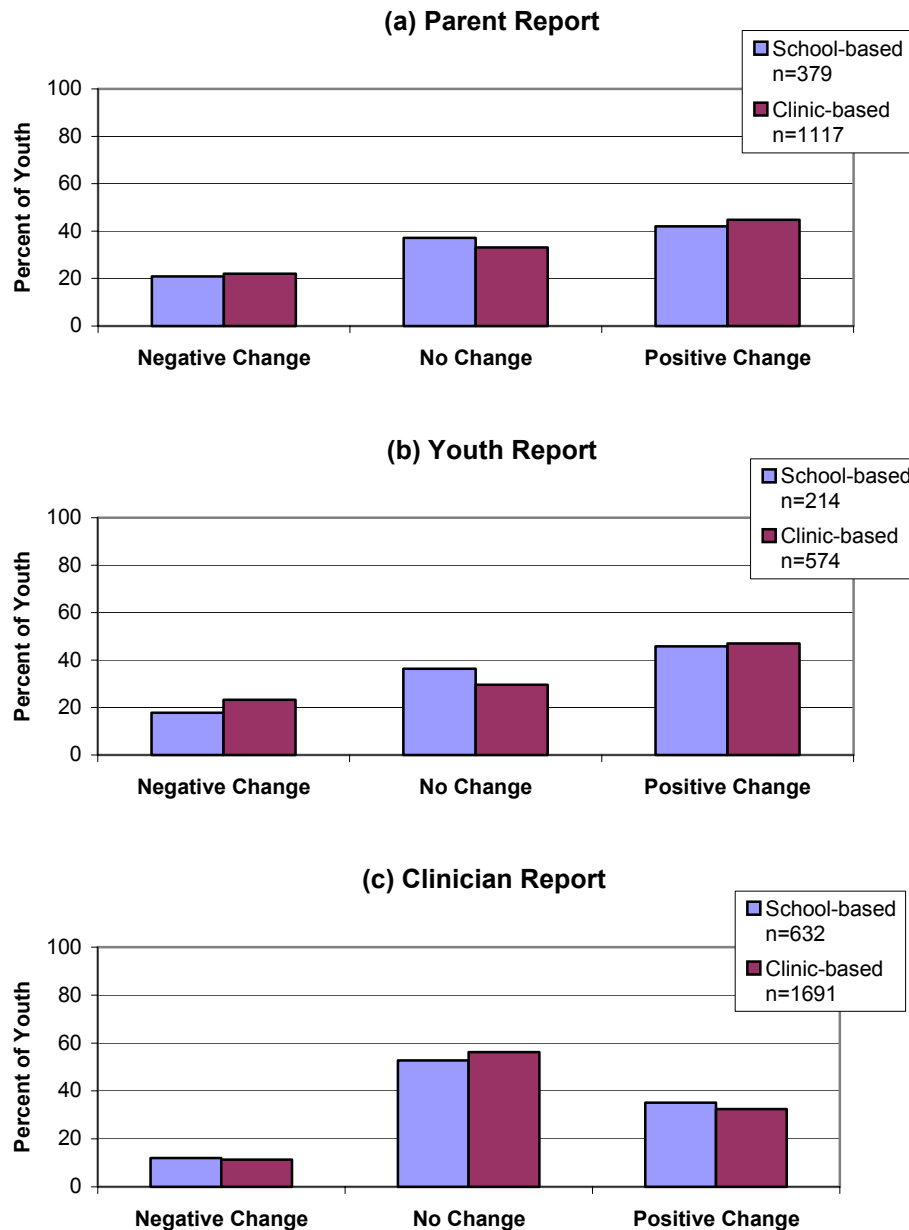
The CAFAS is a functional impairment measure completed by the clinician. The CBCL and YSR are comparable emotional/behavioral measures completed by the parent and youth (11-18 yrs). The bars indicate mean levels of functioning at intake and 6-month follow-up.



- There are significant differences between school-based and clinic-based samples at intake for CAFAS, CBCL and YSR scores based on independent sample comparisons. Overall, school-based youth are less impaired at intake into services.
- Clinicians, parents and youth report significant improvement from intake to 6 months for youth in both school-based and clinic-based services.

Figure 32: School-based vs. Clinic-based Assessed Change in Treatment from Intake to 6 Months – 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.



- Parents, youth and clinicians are reporting similar percentages of positive change, no change and negative change for youth in both school-based and clinic-based services.
- Clinicians tend to report more no change than parents or youth for both samples.

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 United States. 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 will continue to serve and collect data on new clients. Follow-up data is collected by trained interviewers (not the treating clinicians as done in POP) consecutively at 6-month intervals for the length of the evaluation, ending in August of 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, whether or not they remained in services.

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 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) they 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 was a short-term intensive service program for youth involved in the juvenile justice system (this program closed in May 2002). 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 (44%) followed by BEST (22%), CYFN (22%), Wraparound Laboratory/SB163 (6%) and CITY (6%). The data will be presented separately for short-term intensive case management services (i.e. TOWER) and long-term intensive case management services (i.e. BEST, CYFN and CITY).

Wraparound Population History

Information is collected on all youth and families that enter into any of the wraparound-based programs mentioned above. This information is collected with the Descriptive Information Questionnaire as part of the intake to services assessment packet. The caregivers report on

child history of particular risk factors, family history of particular risk factors, youth chronic health problems, and insurance type and youth previous service utilization. Because the data is collected on all youth and families regardless of their participation in the ISEP evaluation the number of youth and families (n=689) reporting on these variables is significantly larger than the ISEP sample. Refer to Figure 33. Over 40% reported youth history of psychiatric hospitalization, runaway acts and substance abuse issues. About 28% of the youth had a past suicide attempt. There was also a large percentage of families reporting family substance abuse problems (72%). About 34% of the families include a biological parent that has received some form of treatment for substance abuse. Additionally, 50% of the families report family violence, family mental illness and/or biological parent conviction of a crime. Twenty percent of the families report a biological parent having been in a psychiatric hospital in the past. There are 39% of the youth in these programs that have a chronic health problem in addition to their mental health issues. Of these youth, 48% are taking medication for their health problem. Over half of the families report having Medi-Cal insurance (65%). Most of the families report some type of previous service with only 4% of the sample reporting no prior service involvement. The majority of youth have received outpatient services (77%), school-based services (69%) and/or psychotropic medication (68%). Other previous services include day treatment (33%), residential treatment (44%) and/or substance abuse treatment (26%).

Service

The youth involved in either long-term (BEST, CITY and CYFN) or short-term (TOWER) intensive service programs may receive a variety of services that are “wrapped” around them according to youth and family individual 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 also be ones that are considered “restrictive” such as hospitalization, residential placements, day treatments, group homes or juvenile camp environments. The “other” services category primarily consisted of caregiver reports of probation or mentor services. The goal of intensive case management programs are to wrap alternative services available in the community in order to reduce the time youth spend in restrictive services. The data shows that for both samples, youth are involved in Traditional Services more than other types (Figures 35 & 36). At 6 months, approximately 90% of the youth who participate in long-term services continue to receive case management services and 85% received individual therapy. These percentages remain in the 80% range at 1 year. However, only 49% of the youth in the short-term services sample receive case management services at 6 months and only 22% receive them at 1 year. Yet, approximately 55-59% of the youth receive individual therapy at 6 months and 1-year follow-up assessment. This means that youth are continuing to receive traditional services post involvement with the short-term case management program, which typically lasted from 3-6 months. Two-thirds of the long-term youth received psychotropic medications at 6 months and 1/2 received medication at 1 year. About 1/2 of the youth in the short-term case management sample received medication at both time points. Approximately 1/3 of the long-term youth and 15% of the short-term youth also receive services related to participation in recreational activities. Another innovative service that is received in about 1/4 of both samples is transportation services (typically to and from a traditional service program). The percentage of youth in the long-term sample that are involved in “restrictive” types of services decreased from 6 months to 1 year for all categories (hospitalization 16% to 14%, day treatment 24% to 14%, residential 24% to 19%), with the exception of therapeutic foster care (12% to 17%). The short-term sample does not show a

pattern of reduction for restrictive services but rather increases in hospitalizations (1% to 12%) and residential care (9% to 16%) with similar percents at both time periods for therapeutic group home (13% to 13%). Day treatment did reduce from 10% at 6 months to 5% at 1 year. 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 number of youth who participate in restrictive services over time. Thus, longer-term programs were more effective in meeting this goal.

Sample Demographics

To date, three hundred and six youth/families 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) at intake. The mean number of members living in the household is 4.49 with a mean number of children being 2.73 and 78% of youth are living with a biological parent(s). The median income is \$15,000-19,999 with the majority of families earning less than \$20,000 a year (Figure 37a). Few parents of youth report having a college degree (11%) and 30% of parents report having less than a high school diploma (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 17% of the interviews with parents and 0% for youth.

Family Resources

Information about the availability of adequate amounts of resources for families is collected from caregiver report on the Family Resource Scale. This measure reports on 30 different types of resources needed by households with children. The types of resources range from those available for growth and support (i.e. money for luxuries, time for personal growth) to basic needs (i.e. housing, food, utilities) to intra-family and outside supports (i.e. time to be with family, childcare). Figure 38 presents the top 5 resources rated as adequate and the bottom 5 resources rated as adequate for both the long-term and short-term case management samples. About 90% of families report that resources related to basic needs are adequate at both intake and 1 year. There are a few slight increases in the number of families that report adequate levels of telephone service for long-term sample at 1-year follow-up and increases in number of families that report adequate levels of food, housing and heat for the short-term sample at 1-year follow-up. Very few families in either sample are reporting adequate levels of resources related to growth and support aspects of quality of life. There are slight increases from intake to 1 year for the short-term sample on time to exercise, amount of money in savings and ability to take vacations.

Clinical Outcomes

The outcome data show linear effect improvements (less functional impairment) on the CAFAS from baseline to 2-year follow-up for the long-term intensive case management. Continual improvements over time are not evident for the short-term intensive case management group. The data for this group shows an increase in functional impairment at 2-year assessment (Figure 39). By examining the data by each CAFAS subscale, the long-term group reveals linear effect improvements for the Home, Community and Moods subscales. The short-term group reveals linear effect improvements on Community and Self-Harm subscales.

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 total problem T-score over time for each sample (long-term and short-term). There are continuous gains reported from baseline to 2 years (Figure 40). 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 total emotional/behavioral problems on the YSR from intake to 2 years for both groups (Figure 41). In comparing change scores for the long-term intensive case management group 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. However the interviewer reports recorded on the CAFAS reveal higher percents of no change occurring (Figure 42a). From intake to 1 year, youth report more positive change than parents or interviewer ratings and interviewers report no change occurring more often compared to parent and youth report (Figure 42b). Intake to 6-month data reveals reports of positive, negative and no change for parents and youth but higher percentages of negative change and lower percentages of positive change for interviewer reports on the CAFAS. From intake to 1 year, parents report the highest percent of positive change compared to youth and interviewer reports.

On the Caregiver Strain Questionnaire (CGSQ) there are statistically significant linear effect improvements for internalized domain for families receiving long-term services and all domains (objective, subjective and global) for families receiving short-term services from baseline to 2 years (Figure 44). There are also specific statistically significant changes calculated by pairwise comparisons for objective, subjective-internalized and global caregiver strain for the short-term services group but no significant effects for the long-term group. 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 for the long-term case management group. For the short-term case management group, there were significant linear effects but no significant improvements on pairwise comparisons. There was no change in regard to School Functioning (Figure 45).

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 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 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)

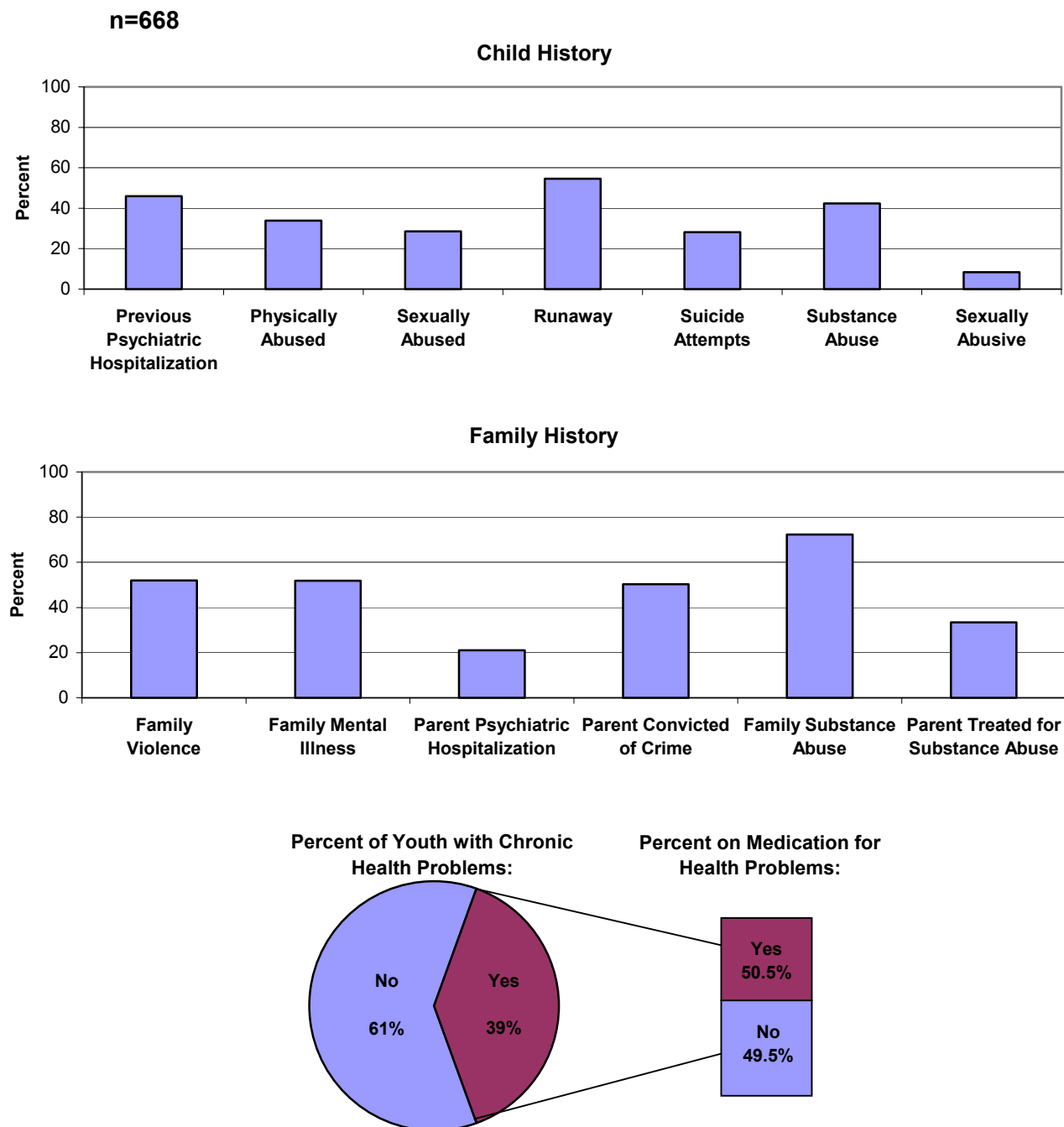
- Assesses the youth's satisfaction with counseling services/psychotherapy
- Scales: counselor qualities, meeting needs, effectiveness, counselor conflict, and family involvement
- 23 items total

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 33: Wraparound Population History of Risk Factors

The information is collected from caregiver report on the Descriptive Information Questionnaire. It provides information about youth and family history, as well as service history. All families participating in wraparound programs responded to these questions, whether they participated in the ISEP evaluation or not.



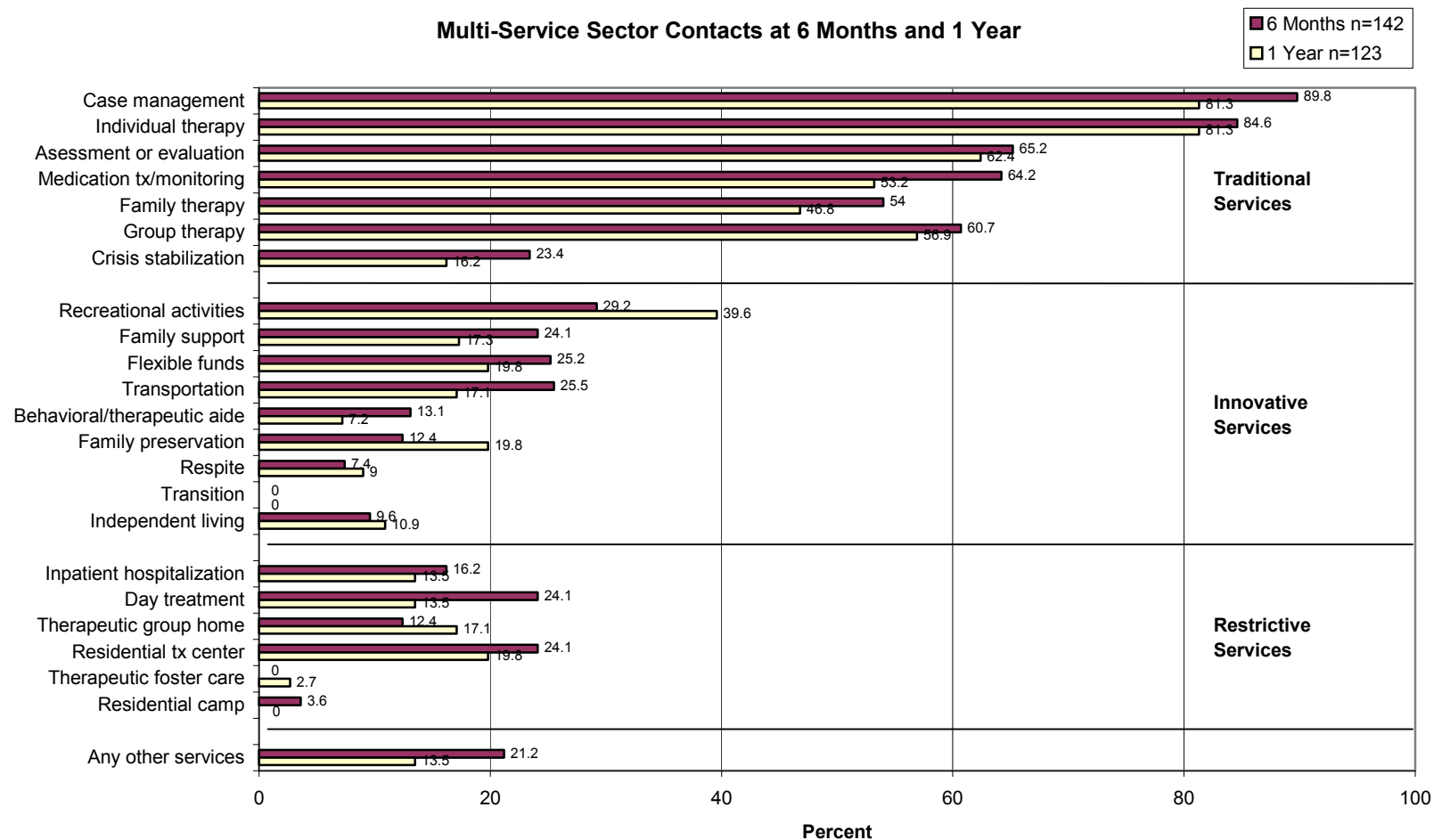
- Over 40% of the youth have had previous psychiatric hospitalization, substance abuse and/or ran away from living environment. Approximately 40% of youth also have a chronic health problem.
- Over 50% of the families have history of violence, mental illness, substance abuse and parental conviction of crime.

Figure 34: Wraparound Population History of Services

The information is collected from caregiver report on the Descriptive Information Questionnaire. It provides information of youth and family history, as well as service history. All families participating in wraparound programs responded to these questions, whether they participated in the ISEP evaluation or not.



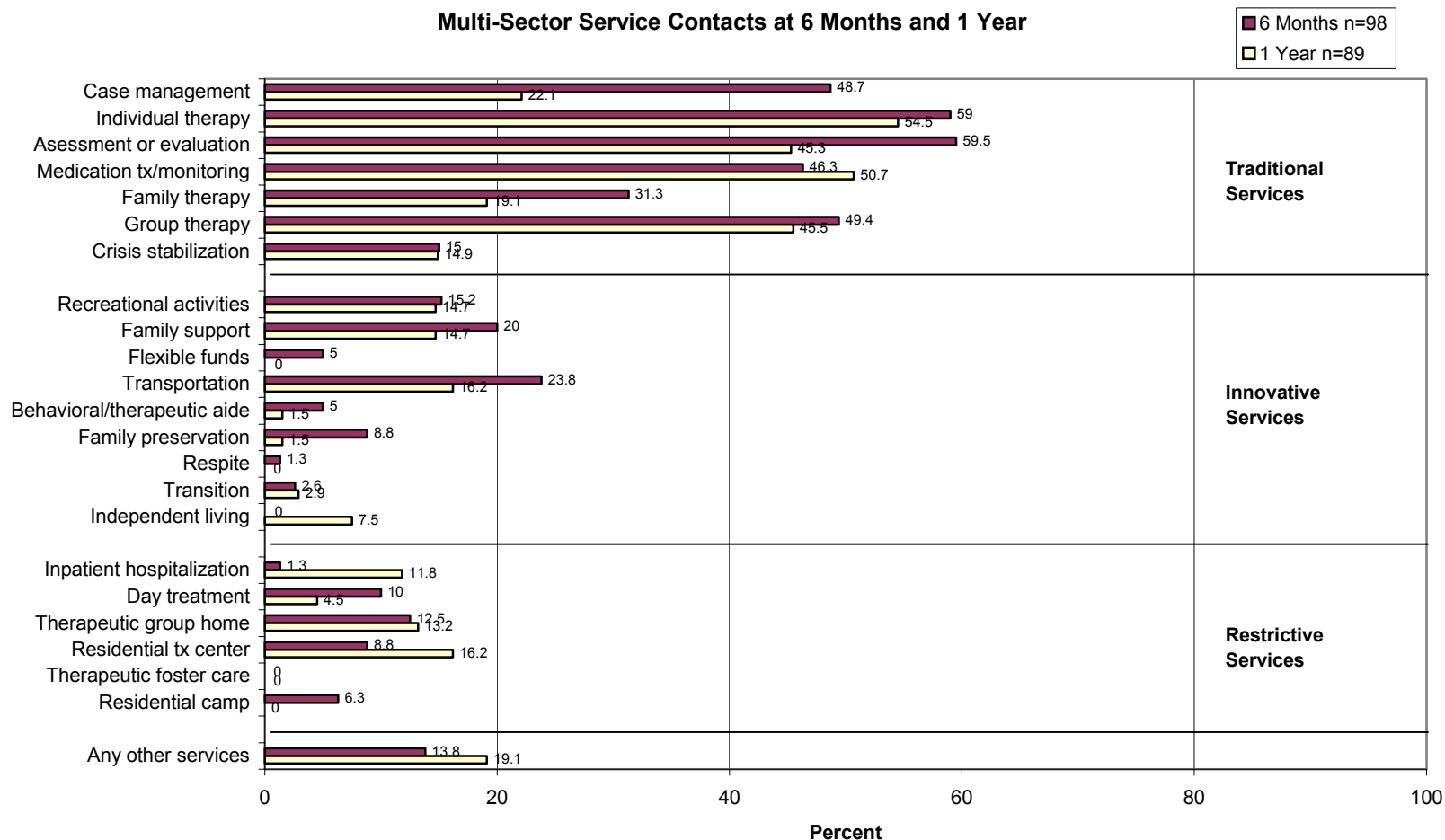
Figure 35: Parental Report of Types of Services Received During and After Participation in a Long-term Intensive Service Case Management Program



- The majority of youth received “Traditional” types of services.
- The percent of children involved in “Restrictive” services decreased from 6 months to 1 year.
- Two-thirds of youth received medication services at 6 months and 1/2 received psychotropic medication services at 1 year.

Note: “Other” services consist primarily of probation and mentor services.

Figure 36: Parental Report of Types of Services Received During and After Participation in a Short-term Intensive Service Case Management Program – For Youth Who Were Referred to Services from Probation



- The majority of youth received “Traditional” types of services.
- Youth remain in individual and group therapy post involvement with the case management program.
- About 1/2 of the youth received psychotropic medication services.
- Restrictive services were more likely at 1-year than 6-months after entering the program

Note: “Other” services consist primarily of probation and mentor services.

Figure 37: ISEP Income Distribution, Caregiver Educational Level, and Race/Ethnicity for Participants in both Long-term and Short-term Case Management Programs

n=306

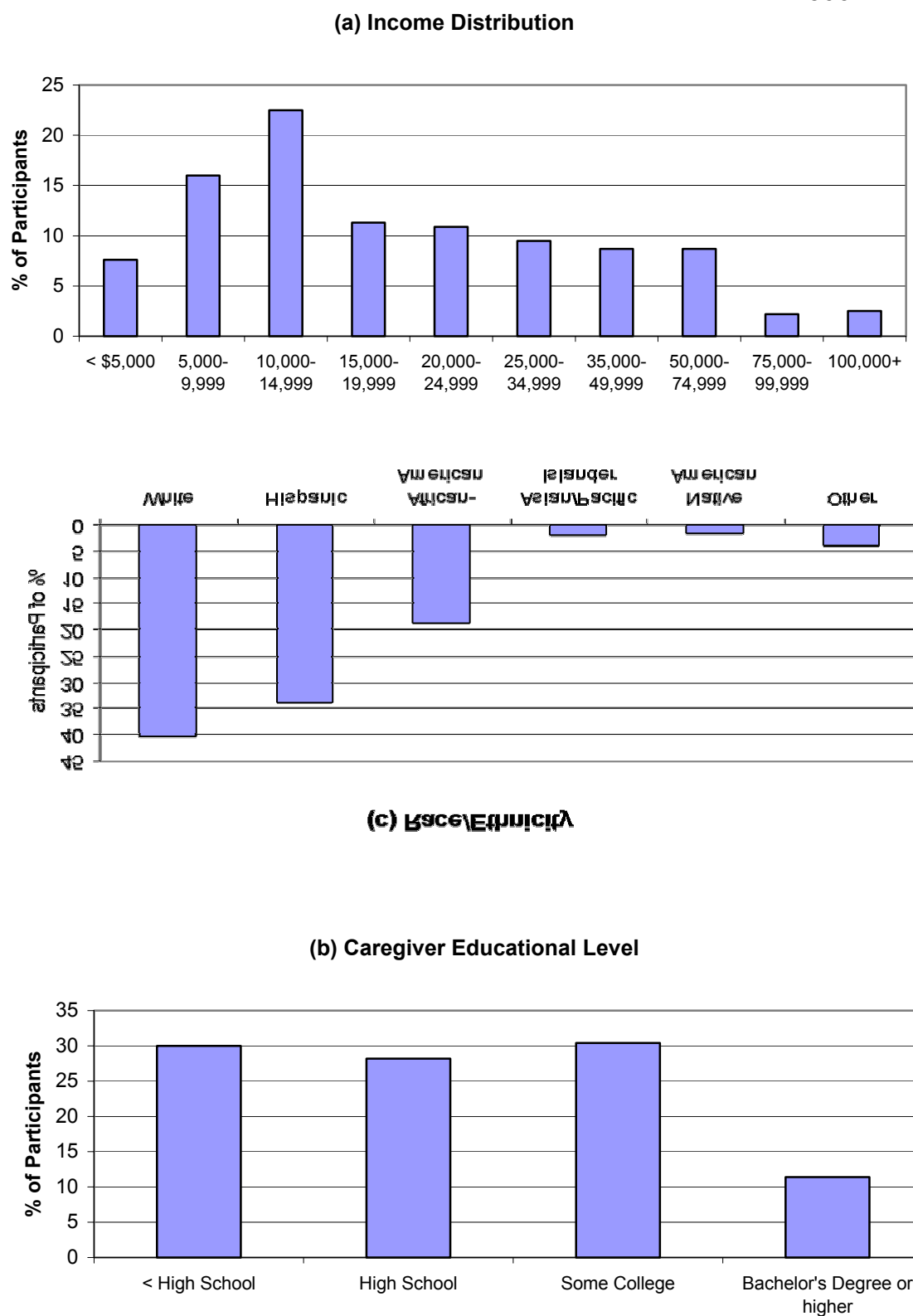
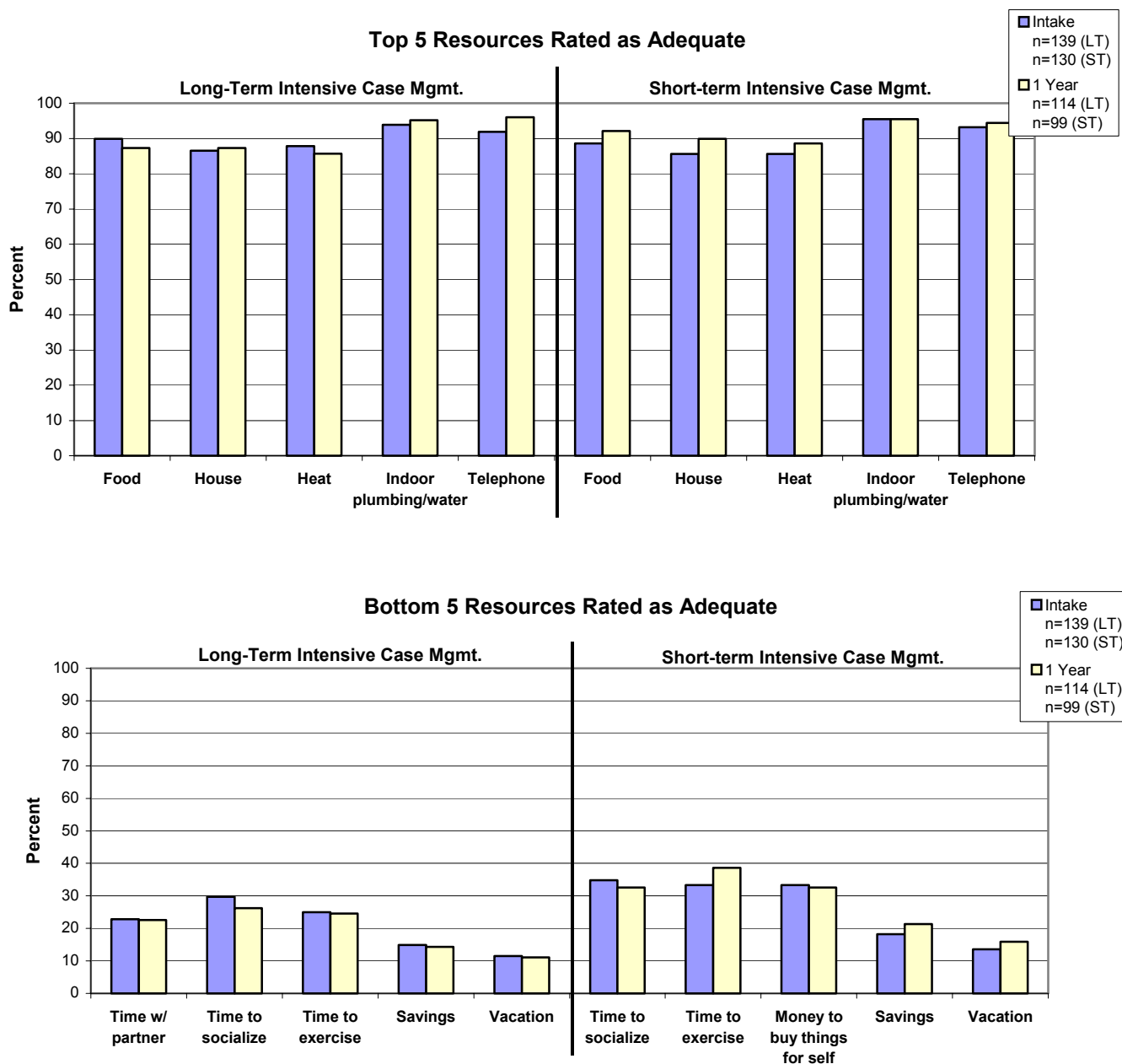


Figure 38: Family Resource Scale

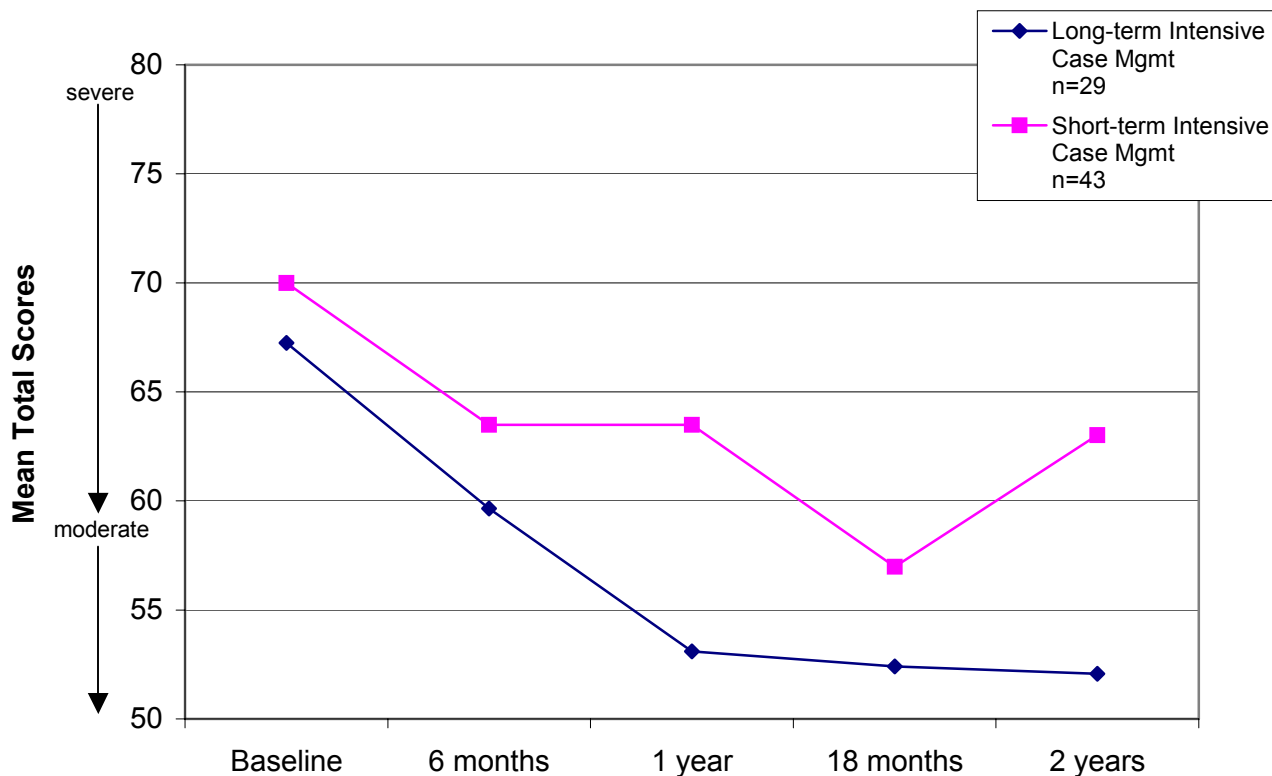
The Family Resource Scale is a caregiver report of the adequacy of resources to meet the family's needs. Caregivers report on a total of thirty resources. The top 5 resources (highest percentage of caregivers reporting as adequate) and the bottom 5 resources (lowest percentages of caregivers as reporting as adequate) are presented.



- About 90% of the families report adequate levels of resources related to meeting basic needs for both samples.
- Very few families report adequate levels of resources related to quality of life (i.e. growth and support) for both samples.

Figure 39: ISEP CAFAS – Total Functional Impairment from Baseline to 2 Years

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.



- There are significant improvements (less functional impairment) from baseline to 2 years for youth in long-term intensive case management programs.
- Youth in the long-term intensive case management programs demonstrate greater improvements at 1 year and 2 years compared to youth in short-term intensive case management programs.
- Although the youth were not significantly different at intake, by 2-year assessment the youth in Long-term Case Management services are functioning significantly better.

Figure 40: ISEP Child Behavior Checklist (CBCL) Scores

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.

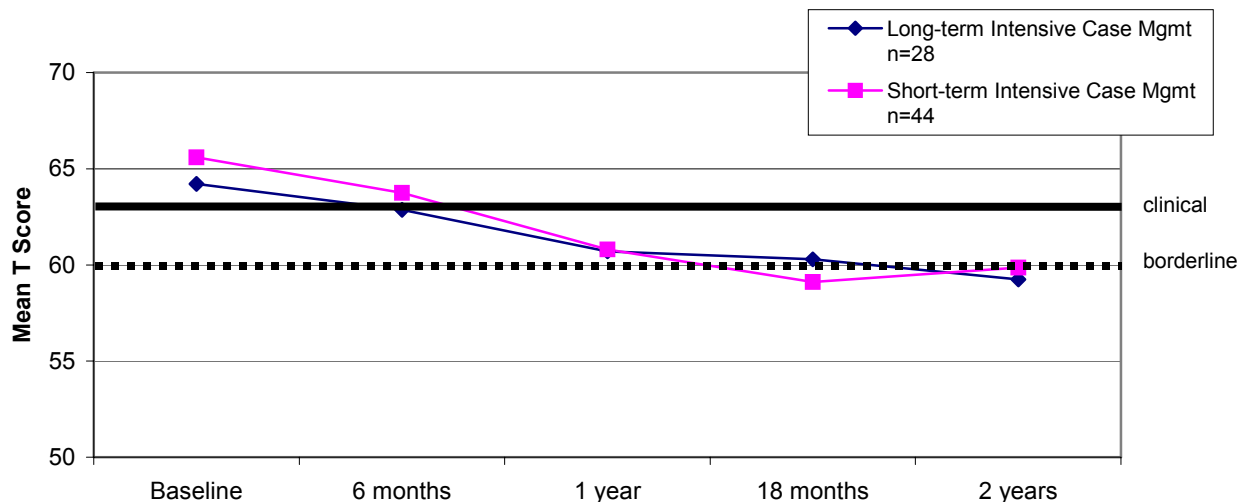
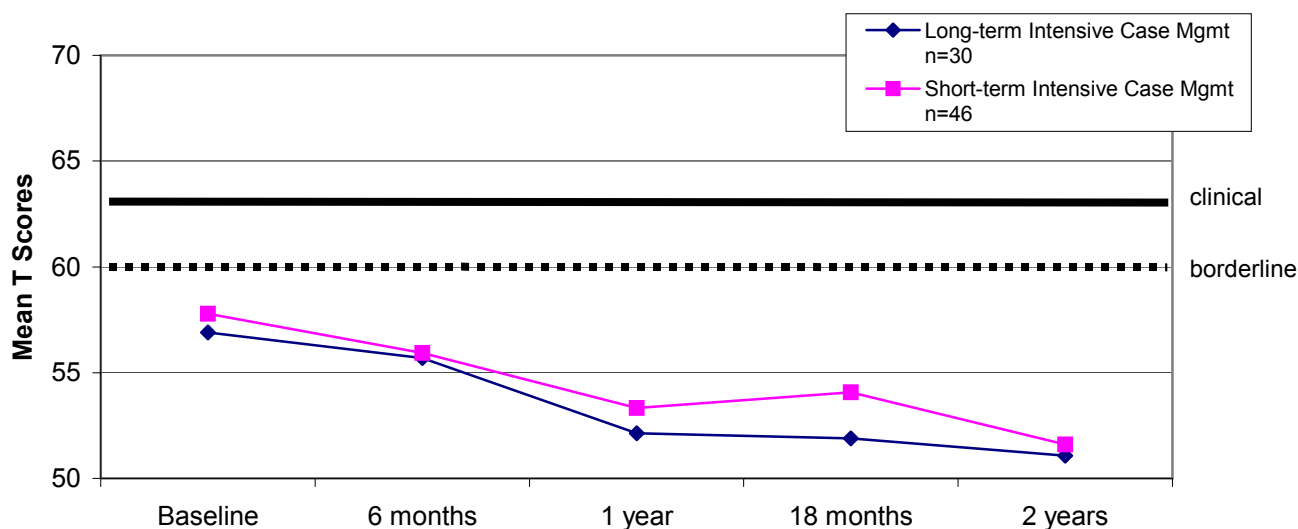


Figure 41: ISEP Youth Self-Report (YSR) Scores

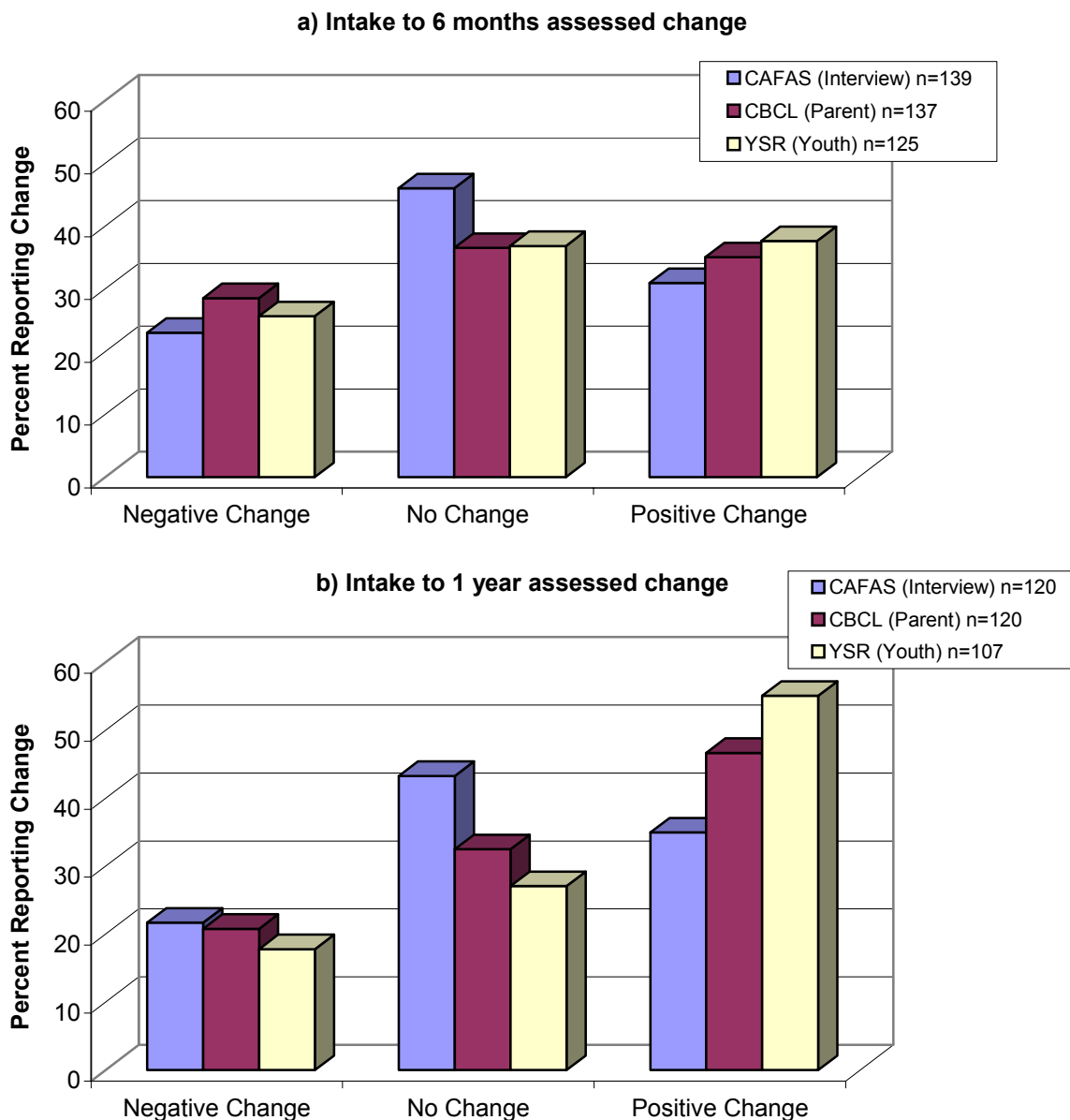
The YSR is an emotional/behavioral problems measure completed by interviewing the youth (11-18 yrs) from baseline to 2 years at 6-month intervals. “n” values reflect the number of youth who had YSR measures at all time points.



- Parents and youth are reporting improvements at 6 months and 1 year for both long-term and short-term intensive case management programs.
- There are significant improvements from baseline to 2 years on parent and youth reports for both long-term and short-term intensive case management programs.

Figure 42: ISEP Assessment of Change – Intake to 6 Months and Intake to 1 Year – Total Problems for Youth in Long-term Intensive Case Management Programs

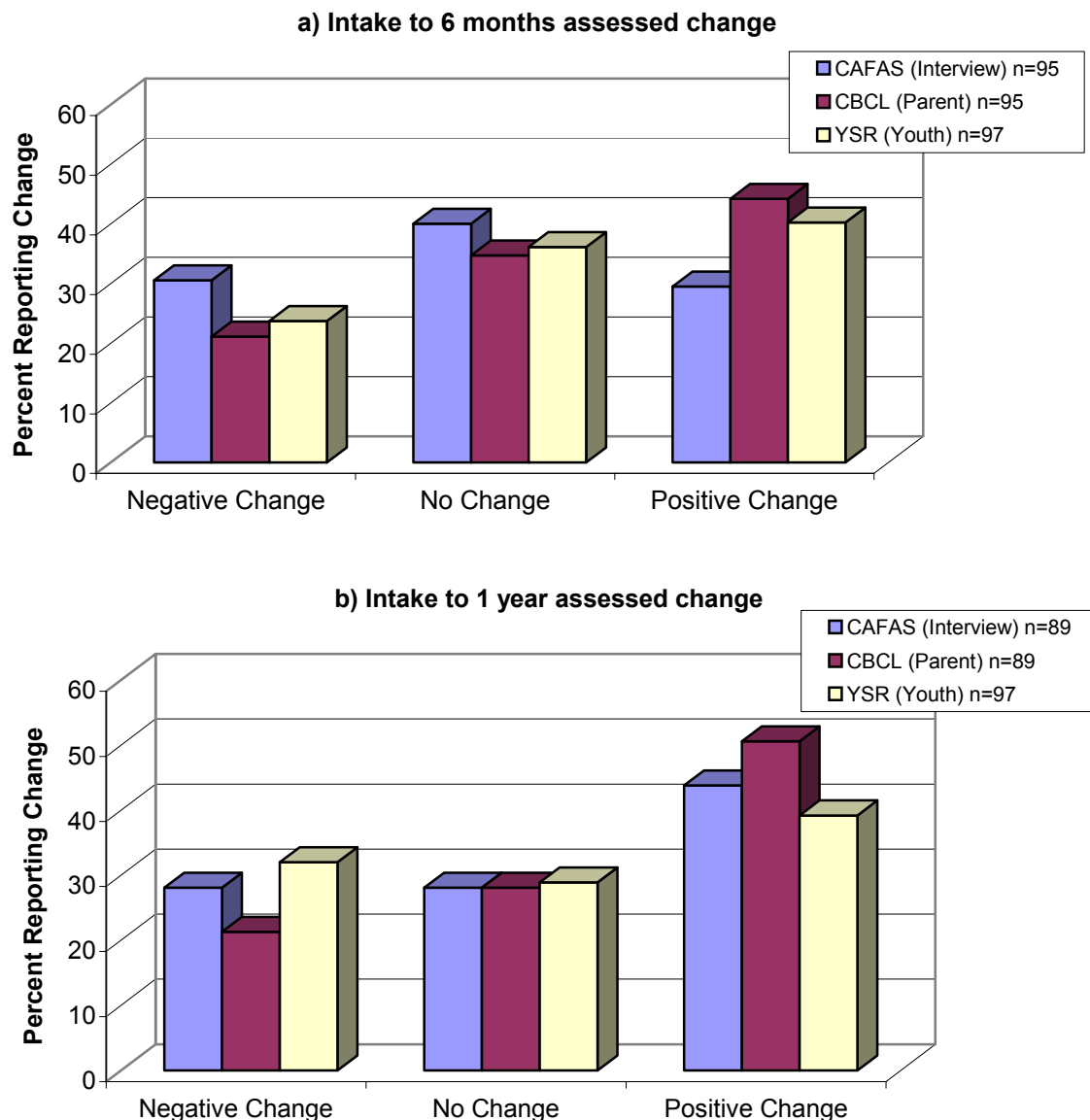
“Negative change” indicates youth who got worse, “no change” indicates youth who stayed the same and “positive change” indicates youth who got better, according to parents, youth and interviewer rating (combines information from parent and youth report). Positive change is defined as greater than a 10-point change on CAFAS (interview assessment of functioning) and a 3-point change on CBCL (parent report symptoms) and YSR (youth report symptoms).



- More youth report “positive change” than parents or interviews at 1 year.
- Interviews report more “no change” compared to parents or youth at both 6 months and 1 year, indicating no change in functional impairment.

Figure 43: ISEP Assessment of Change – Intake to 6 Months and Intake to 1 Year – Total Problems for Youth in Short-term Intensive Case Management Programs

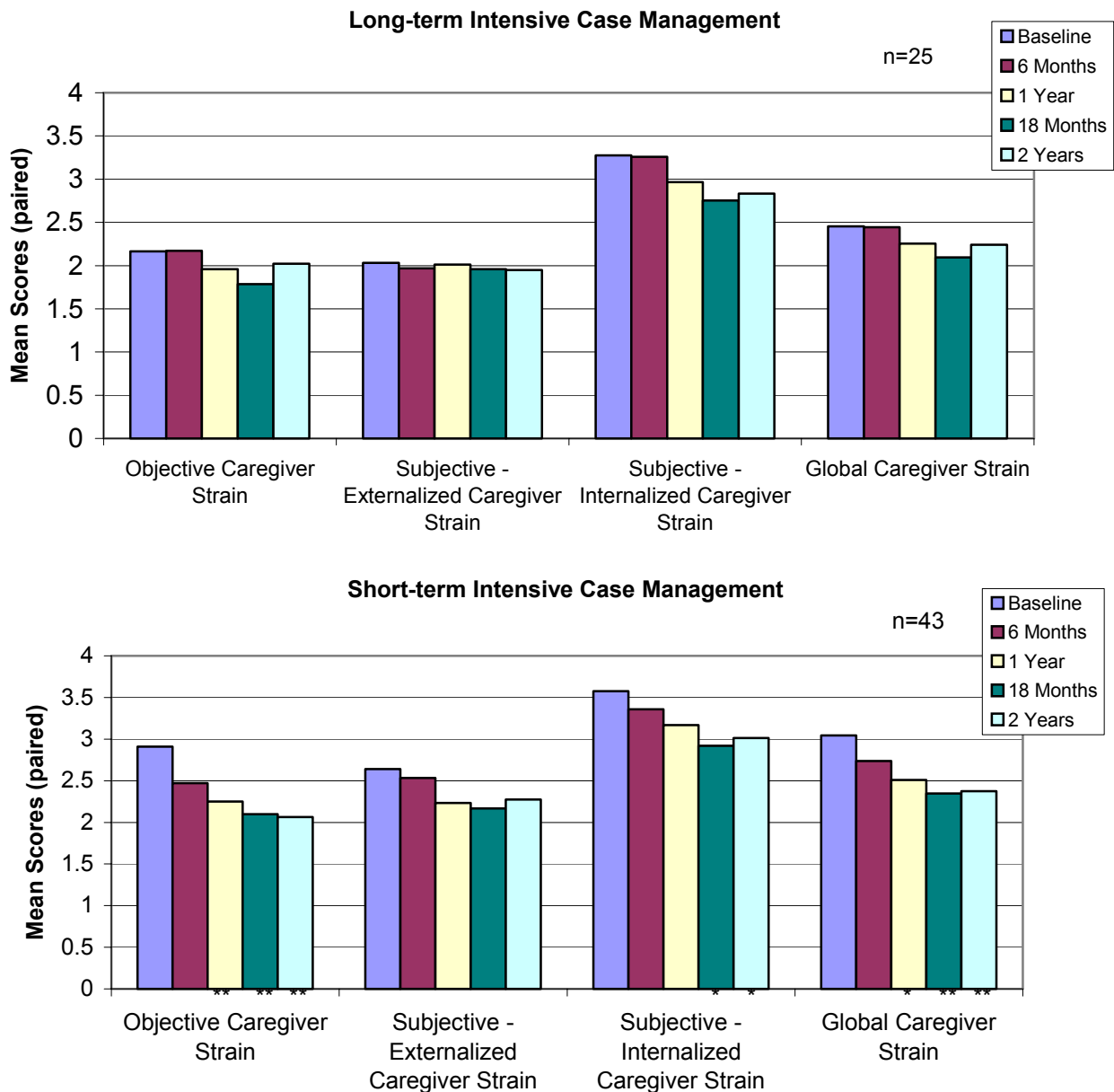
“Negative change” indicates youth who got worse, “no change” indicates youth who stayed the same and “positive change” indicates youth who got better, according to parents, youth and interviewer rating (combines information from parent and youth report). Positive change is defined as greater than a 10-point change on CAFAS (interview assessment of functioning) and a 3-point change on CBCL (parent report symptoms) and YSR (youth report symptoms).



- All informants report more “positive change” at 1-year assessment.
- More youth report “negative change” at 1 year compared to parents.

Figure 44: 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.

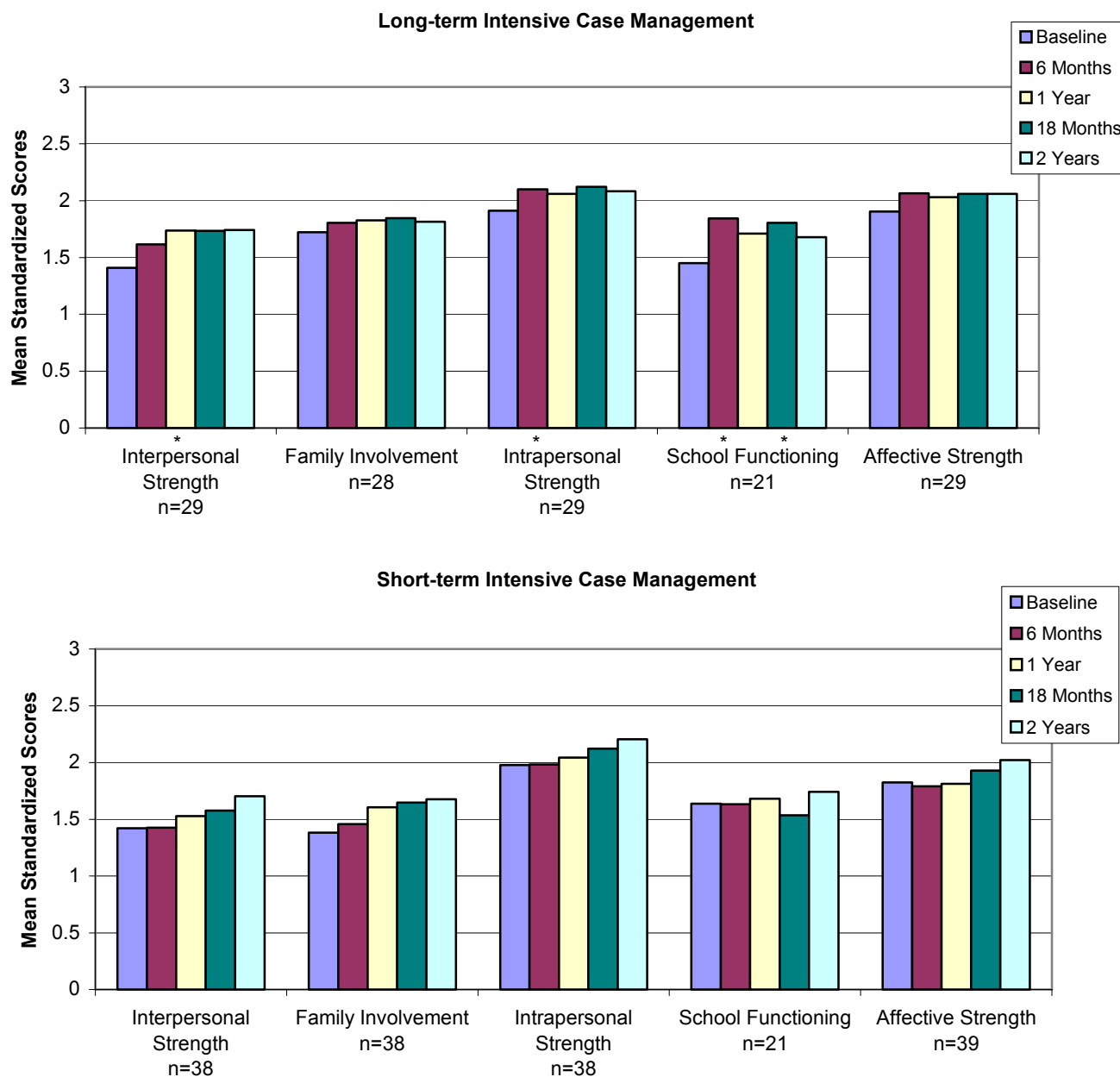


* represents statistical significance at $p < .05$ and ** represents $p < .01$ on pairwise comparisons from intake to each time point separately

- Parents of youth receiving long-term intensive case management services report less internalized strain over time (e.g. feelings of guilt, worry and fatigue), linear effect $p < .05$
- Parents of youth receiving short-term intensive case management services report less strain over time (objective, subjective-externalized, subjective-internalized and global), linear effects $p < .01$

Figure 45: 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 comparisons from intake to each time point separately

- Parents of youth involved in long-term intensive case management services report minimal to no improvements over time while parents of probation youth involved in short-term services report improvements over time with the exception of school functioning (based on linear effect analyses), based on linear effect analyses.

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, frequency of usage 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 11.47 (SD 2.6), alcohol is 11.48 (SD 2.7), marijuana is 11.89 (SD 2.1) and other drugs combined is 13.73 (SD 1.6). There is also a much higher percent of youth who have used cigarettes (77%), alcohol (73%) and marijuana (69%) in their lifetime compared to all other drugs (47%).

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, ages 15-18 years old, who have been or currently are on probation compared to youth with no probation status. The average age in this sample is 16.1 for probation youth and 15.7 for non-probation youth. The probation youth report higher lifetime substance use for most substance categories. Their use of cigarettes, alcohol, and marijuana, LSD/PCP, Cocaine and Methamphetamine are significantly higher (Figure 46). Regression analyses, which control for age, demonstrate that the probation youth have greater lifetime use of alcohol, marijuana, LSD/PCP, cocaine in powder form and crystal meth compared to non-probation youth.

The majority of youth who reported use of "gateway" (alcohol, marijuana) substances in their lifetime range in age from 13-18 years old. However, youth who have used other illicit 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 users than who have used or possibly experimented in the past. The data reveal different patterns of current usage (past 30 days) by age and by substance use. Younger youth show some increased usage over time and older youth show some decreased usage. Older youth are also more likely to use gateway substances (alcohol and cigarettes) in higher dosages.

Recidivism

San Diego County has developed collaborative juvenile justice/mental health programs designed to reduce out-of-home placement and decrease recidivism among youth participating in these programs. The programs are TOWER, BEST and to a small extent CYFN. All of the programs are intensive case management services that apply System of Care and wraparound philosophies. TOWER was a short-term program (3-6 months) while BEST and CYFN serve youth for longer periods of time (6-12 months or more).

Administrative Records

The total number of youth served in mental health intensive case management programs that were involved in the juvenile justice system is 301, of which 235 youth had at least one arrest during the year prior to services. The mean number of charges at 1-year pre services is 1.81 and the mean charges after 1 year of services is 1.00. The majority of youth, 62%, decreased the number of charges, 20% showed no change and 18% increased the number of

charges after 1 year of services. There were 147 youth who had felony charges at 1 year prior to services. The mean number of felony charges is 1.37 prior to services and .35 post services. Most youth with felony charges prior to services, 76% reduced the number of felony charges, 20% showed no change and 4% had an increase of felony charges at 1 year post services.

TOWER served 161 youth who had prior involvement with the juvenile justice system from February of 1999 to June of 2001 which made them eligible for a 1-year follow-up. Of these youth, 140 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 1.96 charges. The mean number of charges 1-year post entry into the TOWER program was .94 charge. This represents a 55% decrease in the number of charges following participation in the program. Most youth decreased their number of charges at 1-year follow-up; 67% had a reduced number of charges, 17% showed no change and 16% had an increased number of charges.

There were 99 youth involved in the 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 1.41 charges. The mean number of felony charges after entry into the TOWER program was .32 charges. This represents a 78% 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, 19% showed no change and 2% had an increased number of felony charges.

BEST served 118 youth who had prior involvement with the juvenile justice system from December of 1996 to June of 2001 which made them eligible for a 1-year follow-up. Of these youth, 78 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 1.62 charges. The mean number of charges 1-year post entry into the BEST program was 1.21 charges. This represents a 26% decrease in the number of charges following participation in the program. At 1-year follow-up 53% had a reduced number of charges, 24% showed no change and 23% 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 41 youth. For these 41 youth, the mean number of felony charges in the year prior to receipt of services was 1.27. The mean number of felony charges post entry into the BEST program was .44 charge. This represents a 65% 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: 69% had a reduced number of felony charges, 24% showed no change and 7% had an increased number of felony charges.

CYFN served 22 youth who had prior involvement with the juvenile justice system from February of 1999 to June of 2001 which made them eligible for a 1-year follow-up. Of these youth, 17 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 1.53 charges. The mean number of charges 1-year post entry into the CYFN program was .59 charge. This represents a 43% decrease in the number of charges following participation in the program. Most youth decreased their number of charges at 1-year follow-up; 67% had a reduced number of charges, 17% showed no change and 16% had an increased number of charges.

There were 7 youth involved in CYFN 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 1.43 charges. The mean number of felony charges post entry into the CYFN program was .14 charge. This represents a 90% 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: 86% had a reduced number of felony charges, 14% showed no change and no youth had an increased number of felony charges.

Delinquency Survey

The delinquency survey is used to interview youth involved in ISEP about their engagement in a number of delinquent acts and/or behaviors. The data is presented for youth involved in long-term intensive case management programs (LT) and youth involved in short-term case management programs (ST). Per youth report, there are decreases in accusations of breaking the law, arrests, convictions of crimes, probation status and detention/jail time for both long-term and short-term case management youth over time (Figure 49). By 2-year follow-up, these differences were significantly less than the percentages of youth involved in juvenile delinquent situations at intake.

The survey also asks youth to report on the occurrence or involvement in a host of delinquent behaviors in the past 6 months. In general, by 2-year follow-up there were lower percentages of youth involvement in each of the behaviors than at intake for both samples. At intake, 39% ST and 27% LT youth reported involvement in a gang that participated in unlawful behaviors and there were 19% ST and 9% LT youth involved in these behaviors at 2-year follow-up. There were 26% ST and 24% LT youth at baseline and 19% ST and 4% LT youth at 2-year follow-up that reported involvement in vandalizing property. About 44% ST and 37% LT youth at baseline and 31% ST and 20% LT youth at 2-year follow-up reported carrying a weapon. In response to the question asking about theft and/or burglary, 16% ST and 12% LT reported participation in these behaviors at baseline and 14% ST and 2% LT reported participation at 2-year follow-up. There were 33% ST and 21% LT youth who reported participation in drug sales at baseline and 25% ST and 13% LT reported participation at 2-year follow-up. Lastly, 7% ST and 9% LT youth reported having fired a gun or used a knife on someone or severely beaten someone and 10% ST and 5% LT reported these behaviors at 2-year follow-up.

School Placement

Data is collected on youth school placement for those youth in intensive case management programs. Educational setting is collected as "current" setting and "predominant" setting in the past 1 year at baseline and subsequent follow-ups. School placement is presented for three time points: intake, 6 months and 1 year (Figure 50). There are differences in the percentages of youth in the various school settings by time point. At baseline, 20% of youth are in regular classrooms and 20% in special education placements. About 10% of youth are in more intensive settings such as day treatment, residential or alternative schools. At 6 months, 25% of the youth are in special education placements and 25% are in day treatment with about 15% in regular classrooms. At 1 year, over 30% of the youth are in special education.

For those involved in the ISEP evaluation, about 40% receive at least some remedial education services at baseline and 48% receive some remedial education services at 1 year. Fifty-two percent of the youth have special education or an IEP plan at baseline and 59% at 1-year follow-up. There were also 54% of the youth who were involved in special education classes that were self-contained classes (all special needs children) at intake and 55% at 1-year follow-up. There were only 10% of the youth who needed special education services involved in inclusive settings at intake and 17% at 1-year follow-up.

School Attendance

School attendance data is collected per parent report for those youth participating in the ISEP evaluation. Caregivers complete an Educational Questionnaire via interview at baseline and subsequent follow-ups every 6 months. Caregivers report on the frequency of absences

including excused and unexcused reasons for absence. The data show decreases in overall absence rates over time for both long-term intensive case management and short-term intensive case management samples (Figure 51). The improvement primarily occurs at the 2-year follow-up period. At intake, 69% of the youth in the long-term sample and 60% of the youth in the short-term sample have been absent from school in the previous 6 months. These percentages drop dramatically by 2-year follow-up: 34% of youth in long-term and 28% youth in short-term. The frequency of absences also reduces over time for youth involved in long-term services. By 2 years, of those youth who were absent, 55% were absent infrequently, meaning less than 1 day per month. Youth who were absent from school in the short-term sample did not reveal the same patterns of frequency of absence over time. The frequency of absences remain about the same for these youth at the subsequent follow-up periods with approximately one-half demonstrating frequent levels of absence; 1 day or more per week. Note, youth may not be active in services at 2-year follow-up. Follow-up data is collected regardless of service receipt.

Data was also collected on suspensions and expulsions. At intake, 34% of the youth had been suspended (either in-school or out-of-school) in the past 6 months. This number reduced at 1-year follow-up with 26% of the youth reported a prior suspension in the past 6 months. The number of youth who reported being expelled in the past 6 months was 12% at intake and 5% at 1-year follow-up.

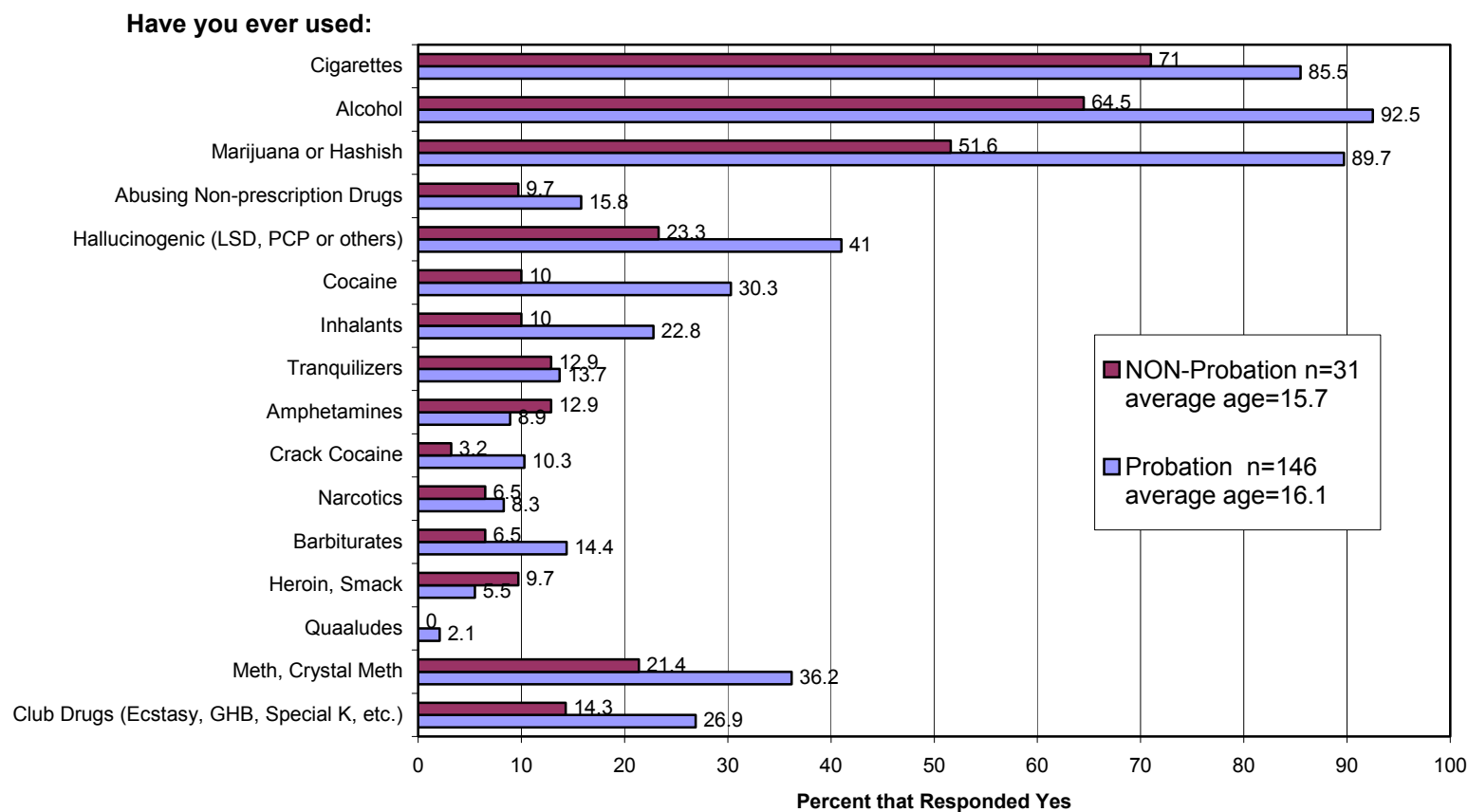
School Achievement

School achievement data was collected from those youth participating in intensive case management programs such as BEST, CYFN, CITY, TOWER and VISTA HILL (AB3015 programs). The majority of youth who completed school achievement measures participate in BEST or CYFN programs. From 1996 to 2002, 265 Wide Range Achievement Tests (WRAT3) were collected at baseline and 58 youth had an additional 6-month follow-up test averaging 4.8 months (SD=1.42) from baseline and 22 youth had a 1-year follow-up test averaging 10.55 (SD=1.50) from baseline. The WRAT3 tests achievement in reading, spelling and math. By comparing intake scores to 1-year follow-up on the absolute scores for each subscale, only 1 subscale, Reading, revealed a significant improvement ($p<.05$). At 6-month follow-up, 17% of the youth demonstrated a positive change (a 5 point improvement on raw score from intake to 6 months), 67% with no change and 16% with negative change in raw scores in reading. There were fewer youth with improvements in raw scores for spelling with 10% demonstrating a positive change, 83% no change and 7% negative change. For math raw scores, 16% of youth showed positive change, 69% showed no change and 16% showed negative change. The numbers of youth demonstrating positive change on school achievement increased at 1-year follow-up. At 1-year follow-up, 27% of the youth demonstrated a positive change (a 5 point improvement on raw score from intake to 1 year), 73% with no change and 0% with negative change in raw scores in reading. There were more youth with improvements in raw scores for spelling at 1 year with 18% demonstrating a positive change, 77% no change and 5% negative change. For math raw scores, 23% of youth showed positive change, 68% showed no change and 9% showed negative change.

As part of the ISEP evaluation, youth are requested to report on their school achievement by indicating their grade average. At intake, 15% are failing, 11% have D average, 28% have C average, 30% have B average, 11% have A average and 6% don't have a grade average (school does not provide). There are some improvements of grade average by 1-year follow-up. At 1 year, 12% are failing, 7% have D average, 28% have C average, 33% have B average, 14% have A average and 6% don't have a grade average (school does not provide).

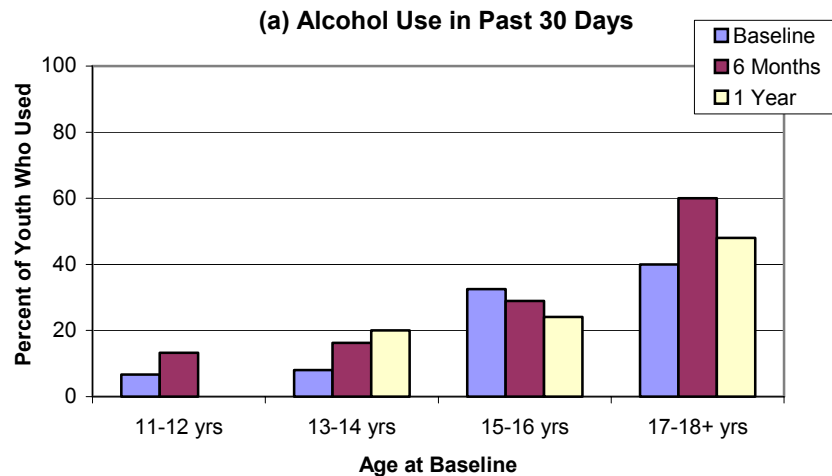
Figure 46: Lifetime Substance Use History by Probation Youth and Non-Probation Youth at Intake for 15-18 Year Olds

“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 services receipt.

Figure 47: Current (Past 30 Days) Alcohol and Cigarette Usage at Baseline, 6-Month and 1-Year Follow-up by Age Group

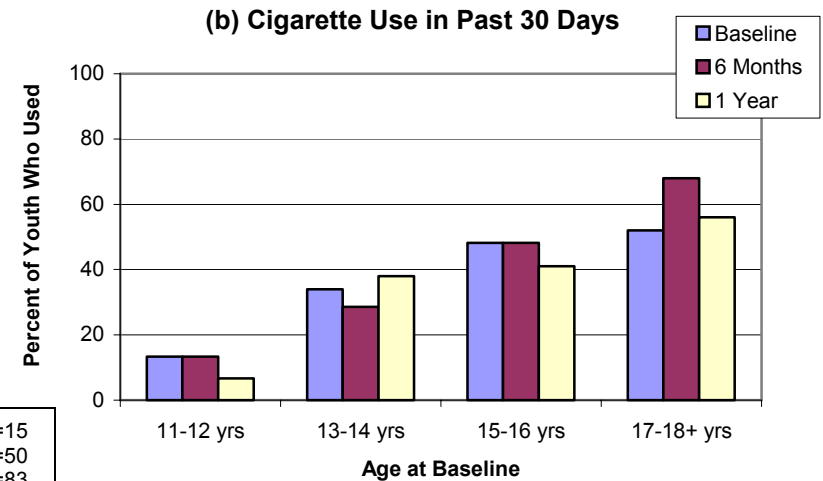


11-12 yrs n=15
13-14 yrs n=50
15-16 yrs n=83
17-18+ yrs n=25

Average age of first alcoholic beverage: 11.48

Of youth who reported drinking in past 30 days, percent who reported binge drinking (5+ alcoholic beverages at one time):

Age	Baseline	6 Months	1 Year
11-12 yrs	0.0% (0)	0.0% (0)	0.0% (0)
13-14 yrs	50.0% (2)	37.5% (3)	60.0% (6)
15-16 yrs	51.9% (14)	72.0% (18)	65.0% (13)
17-18+ yrs	80.0% (8)	80.0% (12)	66.7% (8)



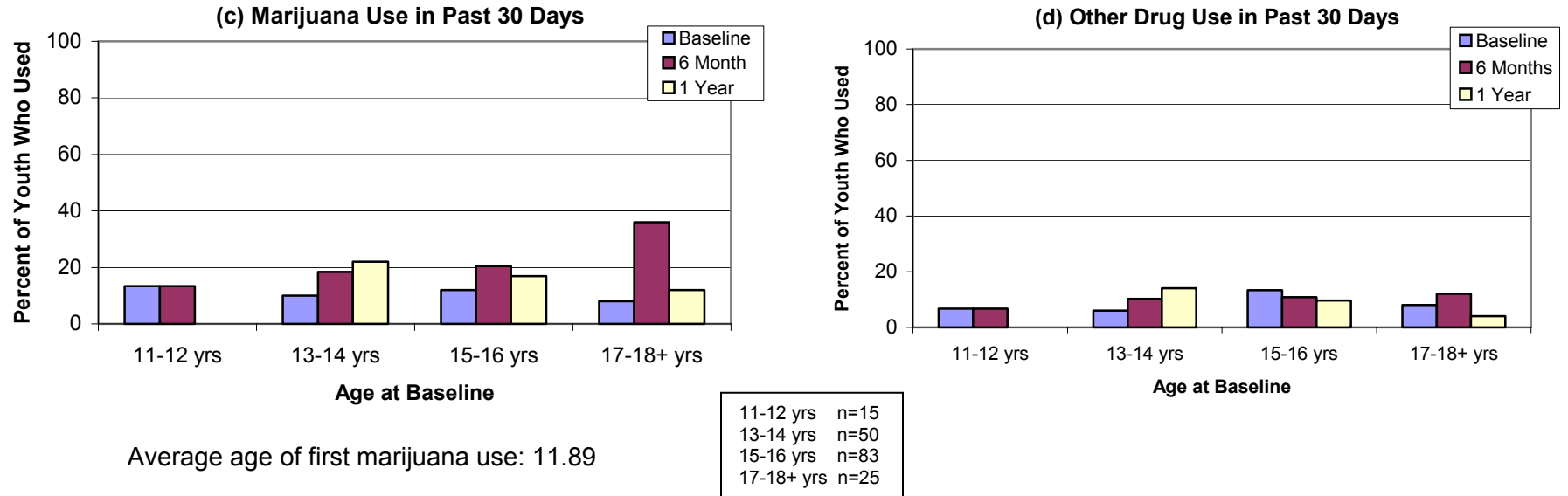
Average age of first cigarette: 11.47

Of youth who reported smoking in past 30 days, percent who smoke daily:

Age	Baseline	6 Months	1 Year
11-12 yrs	50.0% (1)	0.0% (0)	0.0% (0)
13-14 yrs	47.0% (8)	50.0% (7)	52.6% (10)
15-16 yrs	55.0% (22)	67.5% (27)	52.9% (18)
17-18+ yrs	53.8% (7)	58.7% (10)	64.3% (9)

- 15-16 year old youth demonstrate some trends towards reduction in cigarette use.
- Oftentimes increases over time are related to youth experimentation as they age.

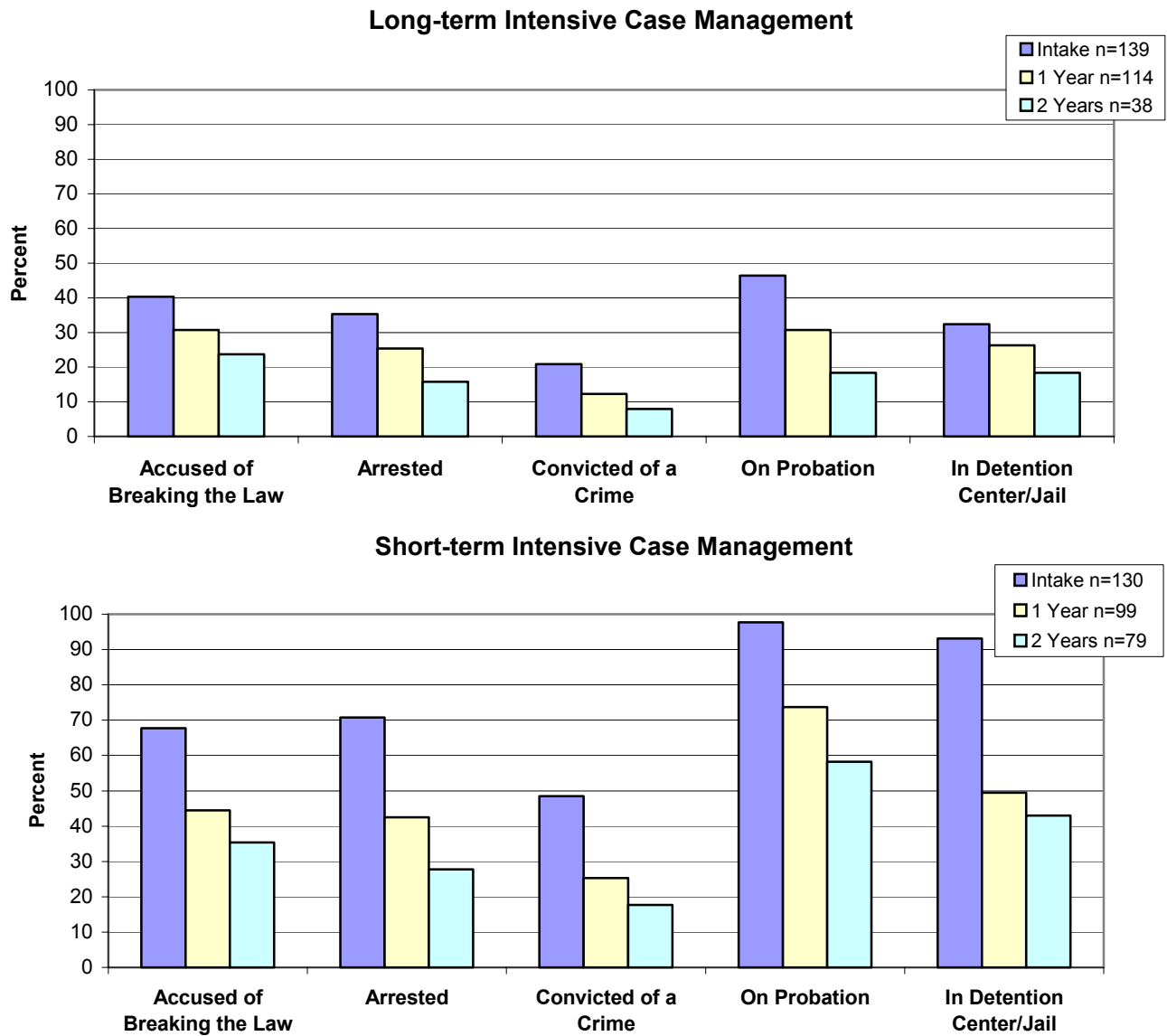
Figure 48: Current (Past 30 Days) Marijuana and Other Drug Usage at Baseline, 6-Month and 1-Year Follow-up by Age Group



- 15-16 year old youth demonstrate some trends towards reduction in substance use.
- Oftentimes increases over time are related to youth experimentation as they age.

Figure 49: Youth Delinquent Behaviors

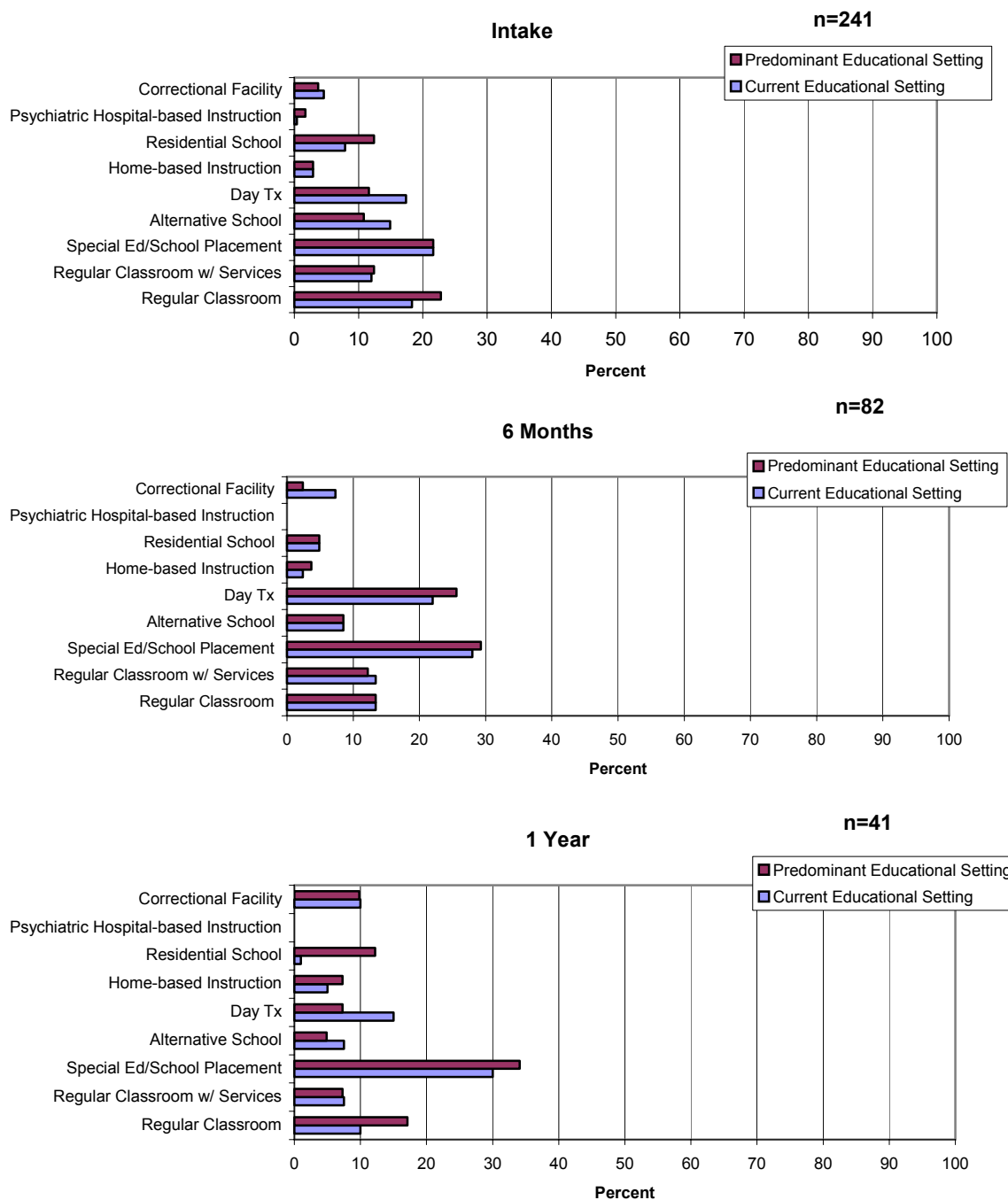
The youth delinquent behaviors are collected from the youth through interviews at baseline and subsequent follow-ups regarding behaviors they engaged in the past 6 months. The percentages present the number of youth who responded they had at least one occurrence of the following situations in the past 6 months.



- The short-term sample has higher percentages of youth involved with the juvenile justice system. Most of these youth entered into the TOWER program from a juvenile justice referral.
- There are dramatic decreases of self-reported delinquency over time for both samples.

Figure 50: Scale to Assess Restrictions of Educational Settings (SARES) – Educational Setting at Intake, 6 Months and 1 Year – Current and Predominant

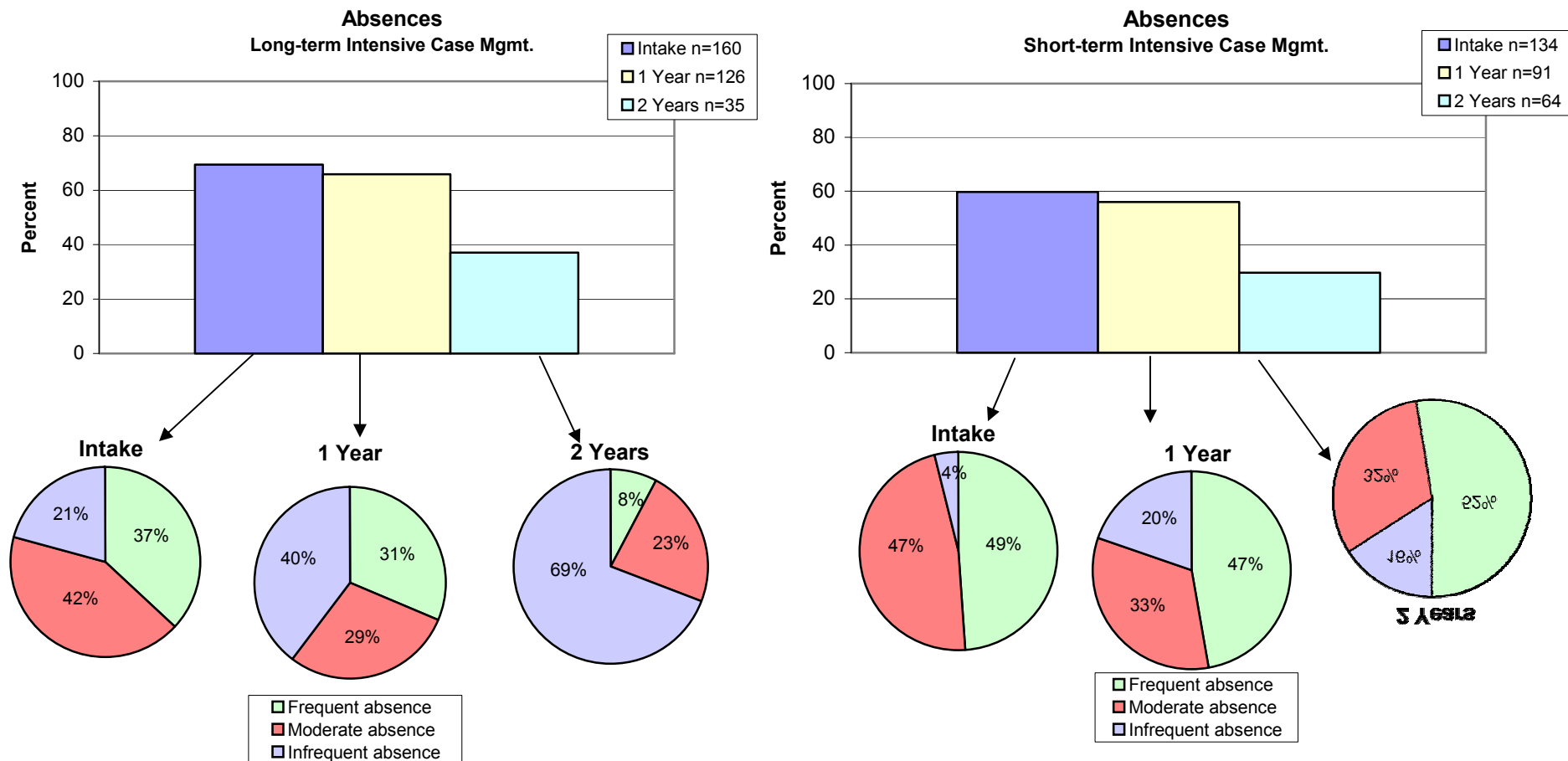
The educational setting is completed by the clinician/staff after interviewing the youth and family. "Current" represents educational environments at time of assessment and "Predominant" represents educational environments over the past 12 months.



- There are higher percentages of youth in special education placements at 6-month and 1-year follow-up compared to intake.
- There are fewer youth in day treatment settings at 1 year compared to intake and 6 months.

Figure 51: School Attendance for Youth in both Long-term and Short-term Intensive Case Management Programs

The data on school attendance is gathered by caregiver report from the Educational Questionnaire. Absences include both excused and unexcused absences in the past 6 months. The percentages present the number of youth who were absent. The pie charts present the frequency of absences for those youth who were absent in past 6 months. "Infrequent" absence is less than 1 day per month, "moderate" is between 1-2 days per month and "frequent" is 1 or more days per week.



- Youth school attendance is improving over time. At 2-year assessment, there is half as much reported absence for youth in both samples. Youth in the Long-term sample are also reducing the frequency of their absences over time.

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, and foster agency and foster home costs and utilization.

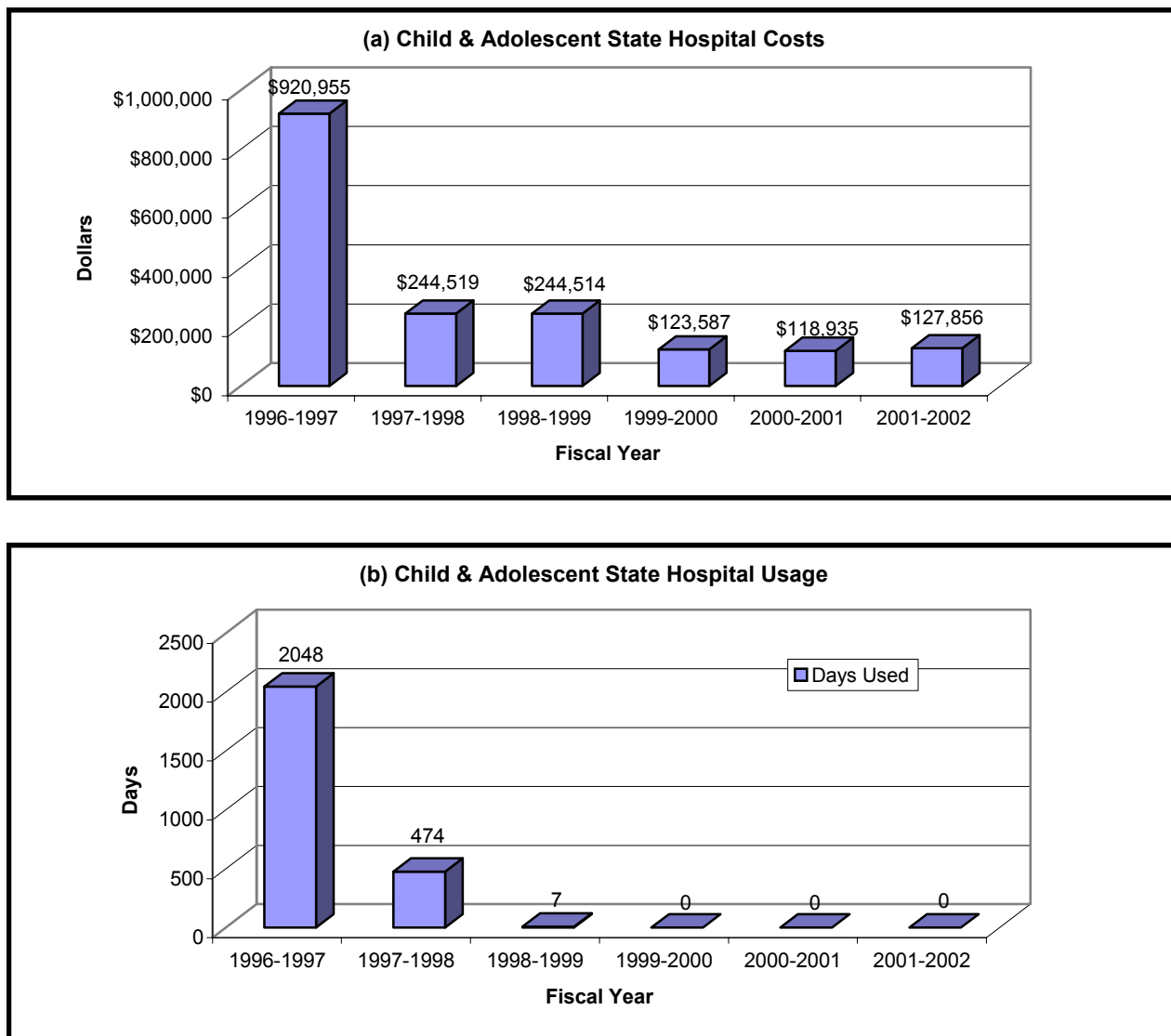
The area on which San Diego County Children's Mental Health has had the most impact has been in the reduction of State Hospital utilization. This has been a primary target for improvement in CMHS with the implementation of the System of Care in San Diego. The establishment of the Community Intensive 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 52 reflects the dramatic decrease in State Hospital costs and utilization, with an 86% reduction in costs and 100% reduction in utilization. Note that a contract is signed at the beginning of the fiscal year to purchase 1 bed regardless of usage.

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 in two different ways: 1) CAPS, a contracted program with UCSD Child and Adolescent Psychiatric Services (CAPS) for a fixed number of beds using both Medi-Cal and non-Medi-Cal funding, and 2) Medi-Cal fee-for-service (FFS) using various psychiatric hospitals with a fixed daily rate. Figure 53 demonstrates both the County costs and utilization for inpatient care for children and adolescents over the last six 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 FFS facilities. These costs continued to rise in FY01-02. These increases are partly due to a rate increase for both programs. Overall, CAPS increased 7% and Medi-Cal FFS increased 2% from FY01-02. The number of bed days used for CAPS and Medi-Cal FFS remained stable in the past two years even though the youth population increased in SD county.

Figure 54 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 01-02 to FY00-01, overall costs have risen 9%, while overall placements have risen only 2%. The differential in costs is primarily related to the increased cost in FY01-02 by the Child Welfare department (CWS). These data indicates a slowing of growth for these indicators. Months in placement remain stable with slight differences by placing agency. From FY00-01 to FY01-02 SED 2726 has increased placements while CWS remain the same and Probation decreased placements. Only CWS has increased costs, respective to the increases in placements. These increases by CWS are probably reflecting the local efforts to reduce the amount of time children spend at Polinsky (a CWS 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 number of placements and expenditures for CPS (the highest placing agency of the three).

Figure 52: State Hospital Costs and Usage by Fiscal Year

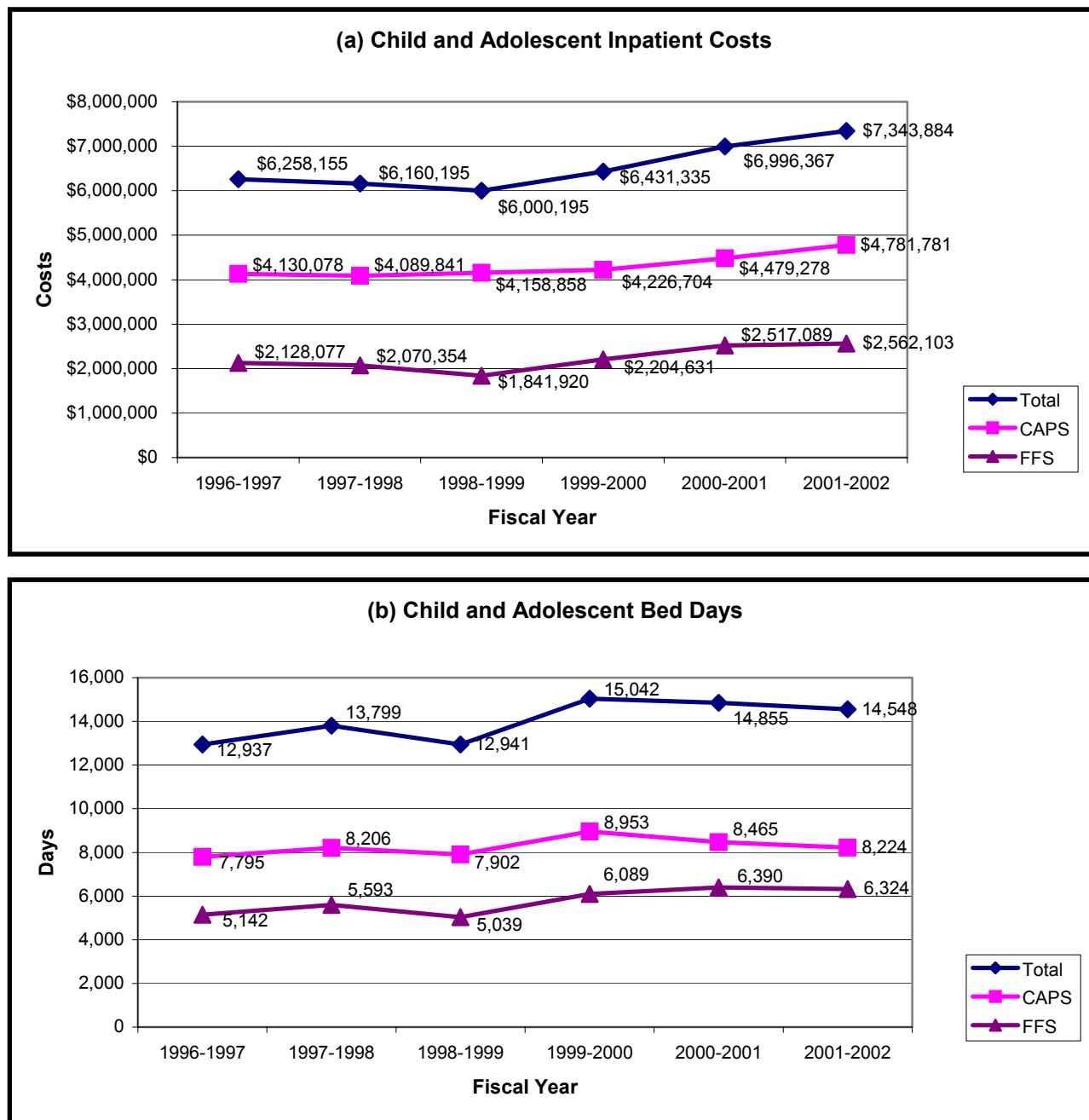
The state hospital cost is the amount contracted for usage. The days used is the actual number of bed days utilized by children and adolescents from San Diego County. A contract is signed at the beginning of the fiscal year to pay for beds regardless of usage. San Diego County purchased one bed for fiscal year 2001-2002.



- This shows an overall 86% reduction in State Hospital costs and 100% reduction in State Hospital bed days used between fiscal years 1996-1997 and 2001-2002. There was an 8% rate increase in State Hospital costs between fiscal years 2000-2001 and 2001-2002.
- These reductions were accomplished primarily by the implementation of the CITY program which transitions and/or diverts youth from State Hospitals to a local intensive case management program in their home communities and provides “wraparound” services.

Figure 53: Inpatient Costs and Bed Days by Fiscal Year

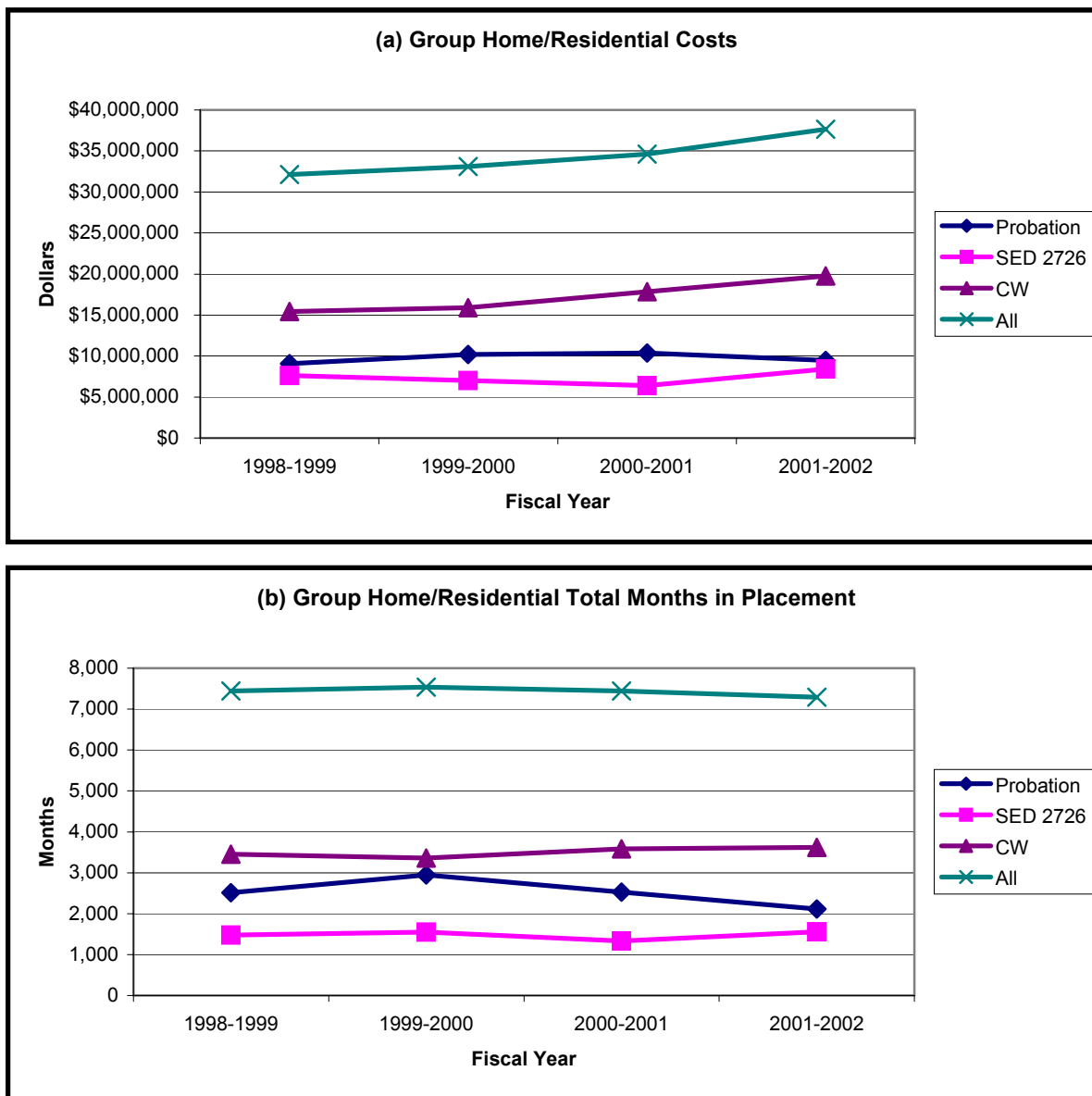
The costs are the amount for acute inpatient days and the number of days is the beds used in acute inpatient units for children and adolescents. There are two different mechanisms: CAPS is the contracted program for a fixed number of beds utilizing both Medi-Cal and non-MC funding and Fee-for-Service Medi-Cal represents various psychiatric hospitals with a fixed daily rate.



- This shows a 7% increase in costs between fiscal year 2000-2001 and 2001-2002 for CAPS and a 2% increase for FFS Medi-Cal. These cost increases are partly due to rising costs for daily rates.
- The total amount of bed days from fiscal year 2000-2001 to 2001-2002 remained stable.

Figure 54: Group Home/Residential Costs and Total 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 Welfare (CW) and All departments together.



- Comparing fiscal year 2001-2002 to fiscal year 2000-2001, costs rose by 9% while placements decreased by 2% despite the larger client population in the system.
- Increased costs are primarily due to the increased costs of Child Welfare and SED 2726.

Consumer Perspectives

San Diego's Children's Mental Health System of Care is built on the principle that all stakeholders: policy makers, administrators, clinicians and families work together and contribute to the overall quality of service for children. The practices of involving multiple stakeholders' opinions are evident in various ways. These may be operated as both formal and informal mechanisms established within children's system of care. One such formal mechanism is the Family RoundTable of San Diego County. This family-focused action group was formed to collaborate with and advise community agencies such as CMHS to support efforts towards providing positive change for children and their families and incorporating the "voice" of parents into policy, programming and practice. Members of the Family Partnership and RoundTable are currently participating in county committees and service programs and making tremendous contributions regarding the needs of families. There are eight programs funded by CMHS that have family partners. The goals of such family partnership involvement are threefold: 1) increase the understanding of the family perspective and needs, 2) build bridges and provide for open communication between families and professionals and 3) provide valuable feedback about consumer satisfaction with services.

Another way to create services that are responsive to consumer needs is to collect information from families about their satisfaction with services and their perspectives on the quality of services. Collecting data on consumer satisfaction has been built into the system wide evaluation program. Data is collected on satisfaction of services from parents through POP and from caregivers and youth through ISEP. Standardized assessment tools and face-to-face interviews were used to collect the information.

Additionally, information regarding the clinicians' perspective about the POP evaluation process and the use of standardized assessment in practice was collected from a volunteer-based survey of program staff participating in POP.

This section presents the perspectives of these two critical stakeholders described above: families and clinicians. Families' perspectives on satisfaction with services, quality of services and demonstration of program staff behavior according to the system of care principles are presented. Secondly, clinicians' perspectives on the use of standardized assessment measures and the value of such tools are offered.

Satisfaction-POP

All families from various 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 and 2-year reports (Figure 55). Additionally, parents are reporting high levels of satisfaction for each fiscal year during each assessment time period. There are no differences between follow up time points (Figure 56).

Satisfaction-School-based vs. Clinic-based

Satisfaction data reveals that both groups report high satisfaction with services. There are no statistical differences between School-based and Clinic-based parent ratings of satisfaction with services (Figure 57).

Satisfaction-ISEP

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 from both samples (long-term and short-term) reported satisfaction with services most often (Figure 58). Both respondents in each sample report “satisfied” or “neutral” evaluations of services at 6 months and 1 year significantly more often than the percent reporting “dissatisfied.” There are no statistically significant differences between parent and youth reports with the exception of the long-term sample at 18 and 24 months. For the long-term sample, youth are also reporting neutral satisfaction significantly more than parents. Results from the Multidimensional Adolescent Satisfaction Scale (MASS) show very few race/ethnicity differences for both samples. For the long-term intensive case management sample, White youth report significantly higher levels of satisfaction in “meeting needs” than African-Americans at both 6-month and 1-year timeframes (Figure 59). For the short-term sample, White youth report higher levels of “family involvement” than Hispanic youth at both 6 months and 1-year assessments (Figure 60). Note, the data was analyzed by White, Hispanic and African-American race/ethnicity groups only because the other groups were too small to be included in statistical analyses.

Quality Improvement-ISEP

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 lists the categories by youth or caregiver rank ordered by frequency of responses from most frequent (1) to least frequent (8). 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 often than positive comments.

In tabulating the “Positive Comments” for both youths and caregivers, the theme of “types of services” related to specific services received, such as information, referrals, service coordination, advocacy, counseling, recreation, etc., was generated the most often and therefore ranked highest for both informants. The next highest ranking differed for caregivers and youth. Caregivers ranked “program characteristics” such as location of services, family focus, consistent services, etc. This category was rated third for youth. Youth ranked “outcomes” as the second highest category. “Outcomes” includes comments related to the family and youth functioning, reuniting the family and keeping the youth on track and was ranked as seventh by caregivers.

After examining “Negative Comments” for both youths and caregivers, three categories of dissatisfaction were coded: program, provider and service. The top ranked category for caregivers was dissatisfaction with program. This category involved comments related to lack of continuity, poor communication and poor engagement. The youth ranked dissatisfaction with services as their top concern. This category included dissatisfaction with the amount of services provided, delays in service inception and poor follow through.

Adherence to Family-Centered Practice

The intensive case management programs all operate as system of care programs adhering to the defined SOC principles. These principles involve providing services that are

community-based, coordinated, family-centered, culturally competent, strength-based and that include the family in all decision-making in regards to treatment planning and service delivery. An assessment tool, The Family-Centered Behavior Scale (FCBS) was used to assess the degree to which family-centeredness is demonstrated by the intensive case management programs per parent/caregiver report. The parents rate staff behavior on a Likert-type scale ranging from 1, never performs the behavior, to 5, always performs the behavior. The measure attends to three main elements of family-centered service delivery: 1) recognizing the centrality of families to children receiving mental health services, 2) maximizing the decision-making role of families and 3) using and building upon the strengths of families. Figure 61 presents the information on a selection of items from the FCBS at both 6-month and 1-year follow-up assessments and displays the percentages of families that indicate that the staff “always” performs the identified behavior. Over 90% of the families report that the staff always treats them with respect and over 80% of the families report that the staff respect their family's beliefs and customs. At 6-month assessment the following areas may be considered behaviors for staff improvement: (1) assisting families to receive help from friends and community (75%), (2) identifying child and family strengths (74%) and (3) assisting families in accessing resources (72%). Two of these areas were reported as improved at 1-year follow-up: (1) identifying child and family strengths (86%) and (2) assisting families in accessing resources (89%). Only 3% of families at 6 months and 8% of families at 1-year report that the staff makes decisions about their child's care without asking them. About 77% (6 months) and 90% (1 year) of the families reported that the staff understands that they know their child better than anyone.

Clinician Perspectives of Standardized Assessment

A survey was developed and disseminated in the Fall of 2002 inquiring about staff perspectives on the use and value of the standardized assessment protocol used in the POP program. The survey was completed on a volunteer basis from program staff (providers, administrators and managers) representing the cadre of CMHS organizations/programs. The staff responded to questions related to the “helpfulness” of the data collected through POP, the frequency of use of the data, the ways in which they use the data, the specific components of the POP program that were useful or valuable and the specific components that were not useful or of value. Lastly, the staff provided suggestions for future outcomes or indicators of clinical improvement. Refer to Table 5 and Figures 62 & 63.

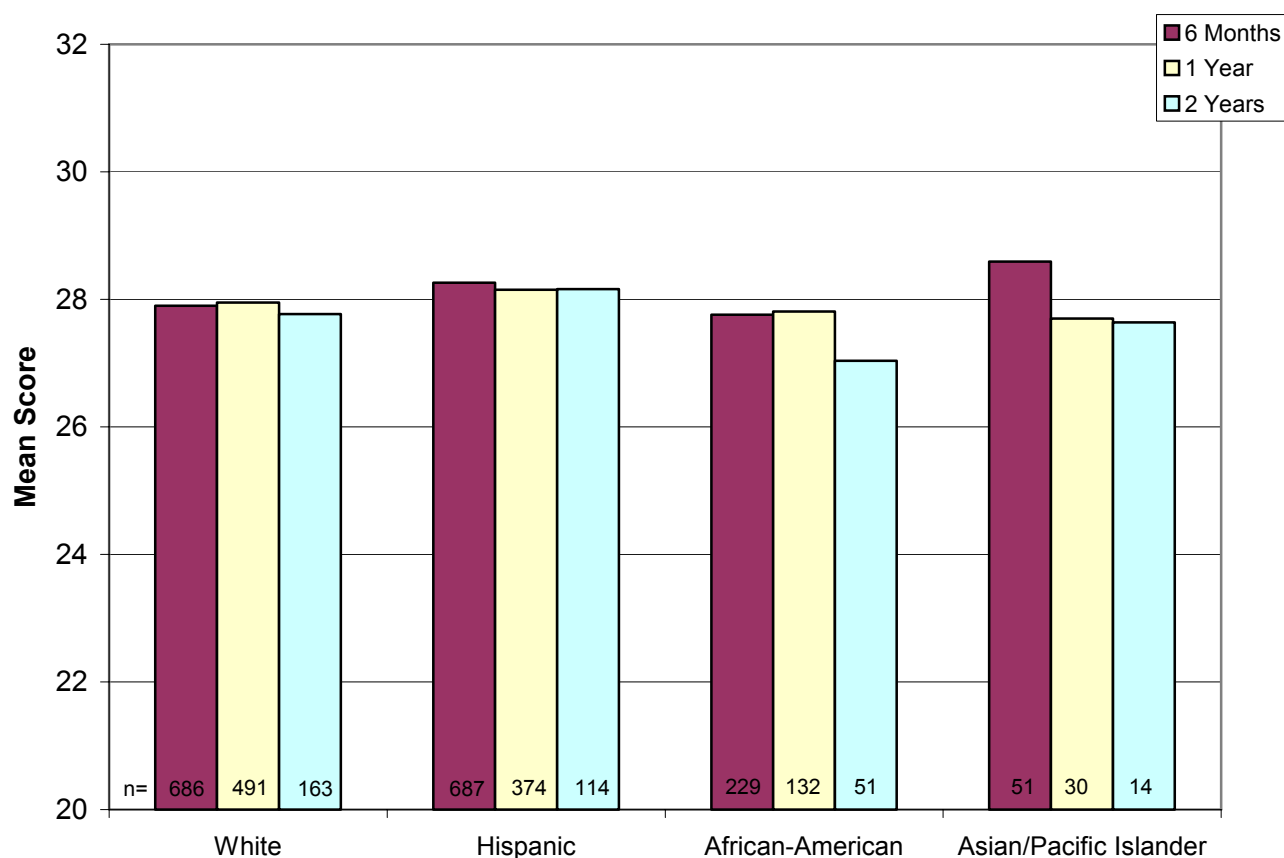
There were a total of 219 completed surveys. The majority of staff respondents were direct service providers (73%). There were also staff with administrative positions (12%), management positions (6%) and those that hold more than one position (i.e. service provider and management) (9%) (Table 5). About 40% of the staff reported the POP data to be helpful, 37% reported the data to be a little helpful and 23% not at all helpful. Forty-two percent of staff reported using the data on an occasional basis, 21% reported using the data quite infrequently and 37% reported using it infrequently or not at all. The “uses” of the data reported by staff were treatment planning (33%), complying to contract (29%), initial diagnosis (24%), monitoring treatment (24%), nothing (24%), other uses (12%), service revisions (10%), program reporting/evaluation (10%) and outreach (4%). These uses varied by staff position. Service providers' top three uses of the data were: treatment planning (35%), initial diagnosis (26%) and monitoring treatment (26%). Administrative staff's top three uses were: complying to contract (35%), program reporting (31%) and nothing (31%). Management staff's top uses were: complying to contract 38% and nothing (38%). Multiple position staff's uses were: complying to contract (60%), treatment planning (55%) and initial diagnosis (30%). The majority of the staff reported feeling positive about the change in policy ending the POP mandate and suspending the completion of the POP protocol (Figure 62). The reasons typically given were related to the

length of the protocol and the burden of paperwork. Many of the staff also believed that it was burdensome for parents to complete the measures. Additionally there were some differences by program modality with the outpatient programs (both clinic and school-based) and case management programs reporting more positive uses and more frequent use of the POP protocol compared to day treatment, residential, inpatient and other programs.

Qualitative data revealed that the top category concerning the value of the POP measurement system was related to the measures used (45%) (Figure 62). Staff especially liked having information available from the parent and youth perspectives of problems. Qualitative responses about staff opinions of what was not useful or valuable were categorized as participant related challenges (29%) and data issues (24%) (Figure 63). Staff felt that parents and youth had difficulty completing the measures and also felt that the measures did not capture the data in which they were interested in or felt that the measures were too long. The last question on the survey inquired about future indicators to be collected as outcomes for clinical improvement. The majority of staff indicated an interest in information from the client's perspective (Figure 63). They also wanted information related to a client's functioning (institutional-societal 48%) and a client's psychological-behavioral impairment (52%).

Figure 55: Client Satisfaction by Race/Ethnicity – Mean Scores at 6-Month, 1-Year and 2-Year Follow-ups

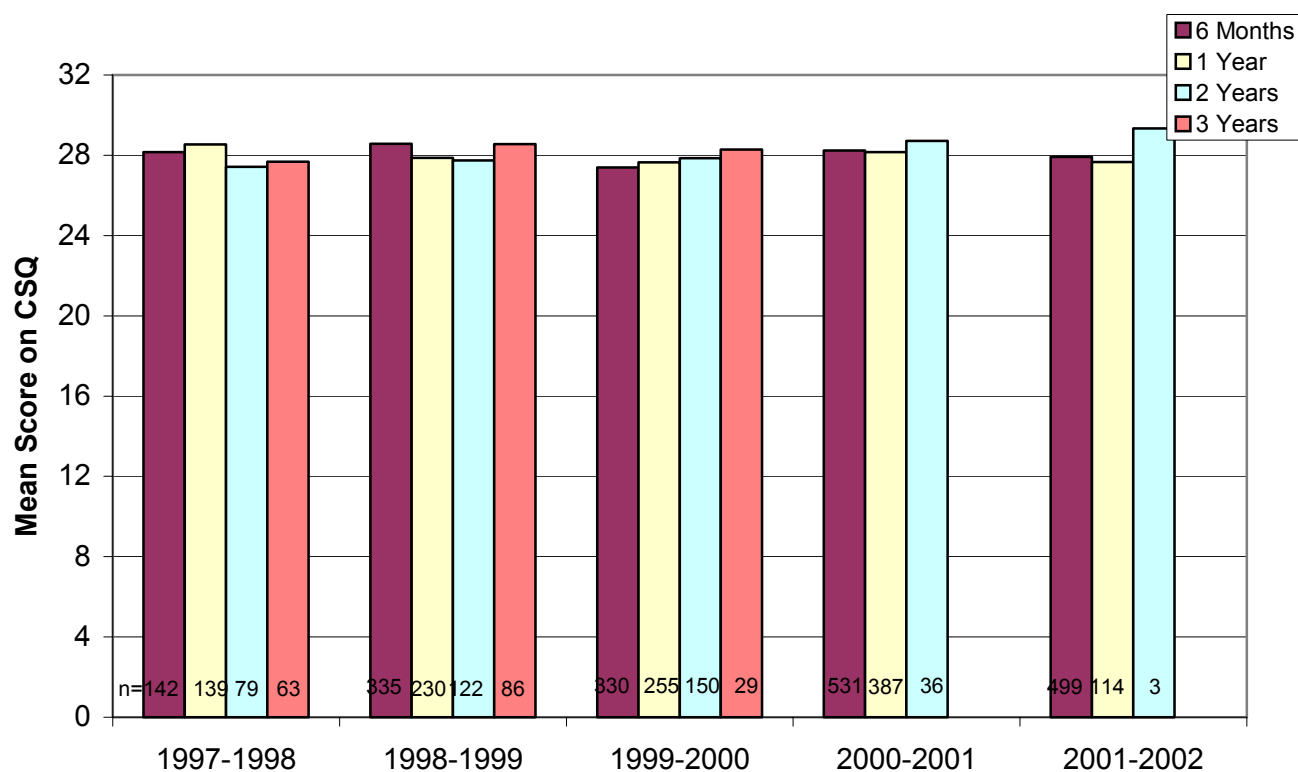
The Client Satisfaction Questionnaire (CSQ) is an 8-question form that is completed at follow-ups by the parent or caregiver. The four main ethnic/racial groups are: White, Hispanic, African-American and Asian/Pacific Islander. Higher scores indicate greater satisfaction with services.



- 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, 1 year or 2 years.

Figure 56: POP Intake Cohorts by Fiscal Year – Parent Satisfaction of Mental Health Services for Their Youth

The Client Satisfaction Questionnaire (CSQ) 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 and 2001-2002 fiscal years because many cases have not reached a follow-up time point. High satisfaction equals mean scores from 27-32.

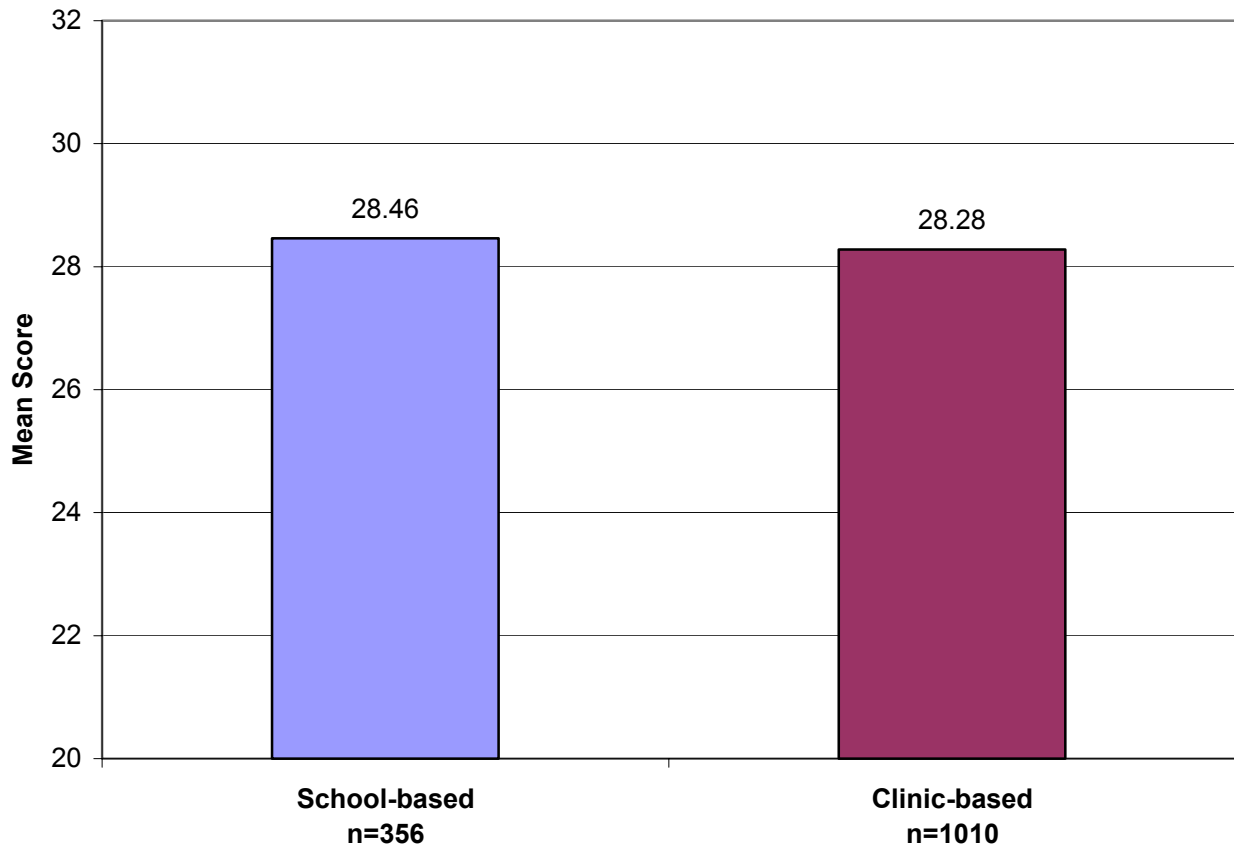


- Parents report high levels of satisfaction across each fiscal year. There is no difference between follow-up time points (6 months, 1 year, 2 years or 3 years).

Note: No 3-year data is available for 2000-2001 or 2001-2002 at this point in time.

Figure 57: School-based vs. Clinic-based Client Satisfaction at 6 Months

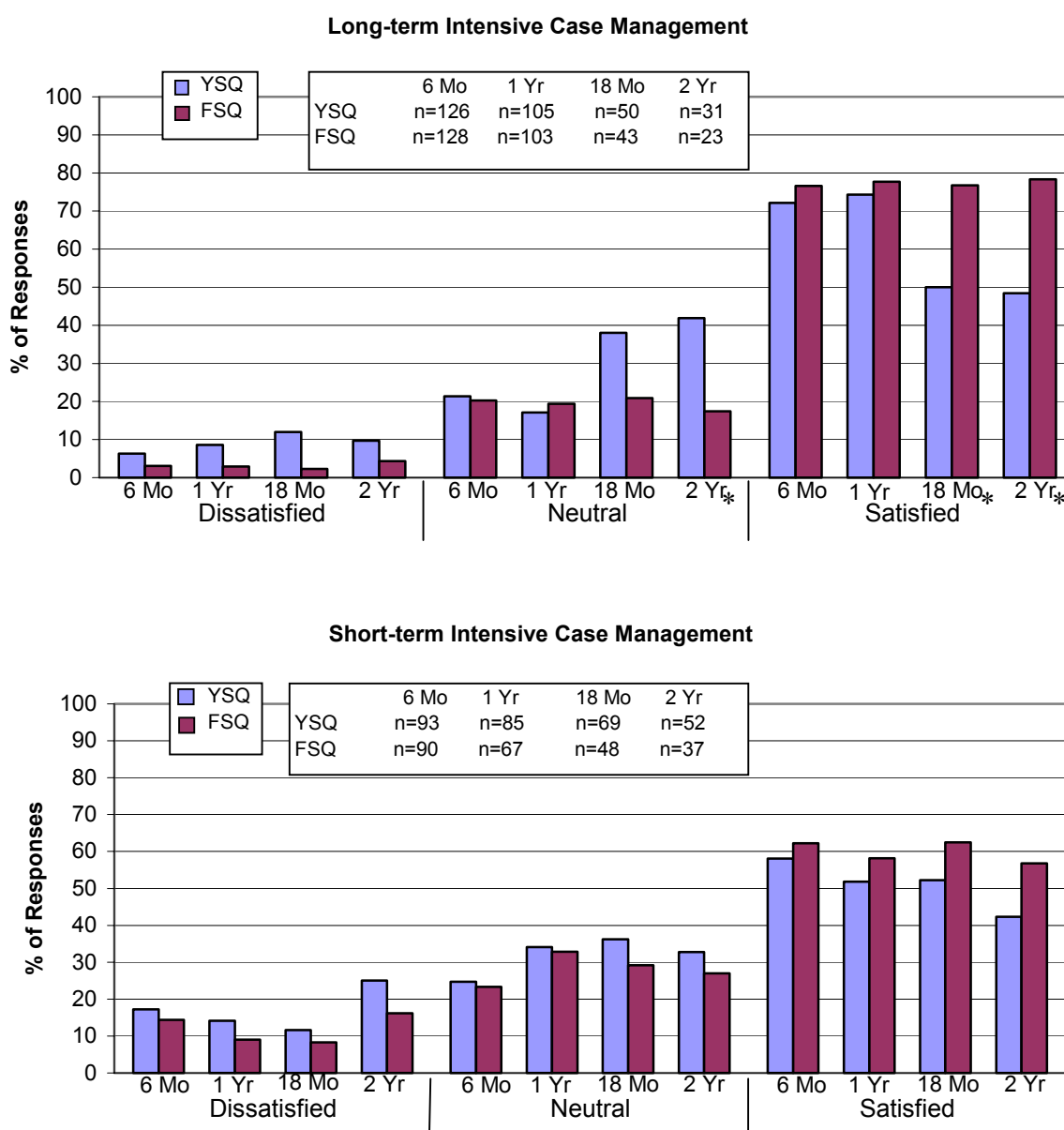
The Client Satisfaction Questionnaire (CSQ) is an 8-question form that is completed at follow-ups by the parent or caregiver. Higher scores indicate greater satisfaction with services.



- Parents of youth in both school-based and clinic-based services report high levels of satisfaction.

Figure 58: ISEP Youth and Family Satisfaction – 6 Months, 1 Year, 18 Months and 2 Years

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.

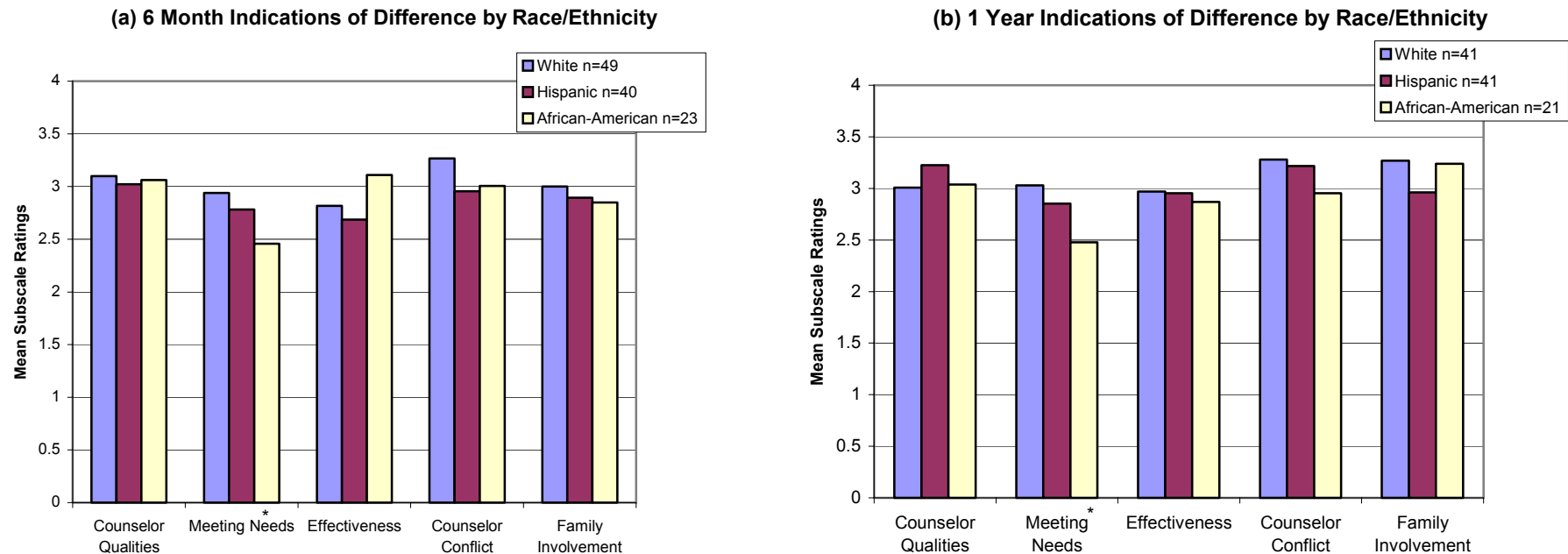


* represents statistical significance at $p < .05$ on Chi-Square comparisons of youth and family ratings.

- Overall, for both populations (short-term and long-term) there are significantly more parents and youth reporting satisfaction with services compared to neutral and dissatisfied ratings.

Figure 59: ISEP Multidimensional Adolescent Satisfaction Scale (MASS) – 6-Month and 1-Year Indications of Difference by Race/Ethnicity – Long-term Intensive Case Management Programs

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.

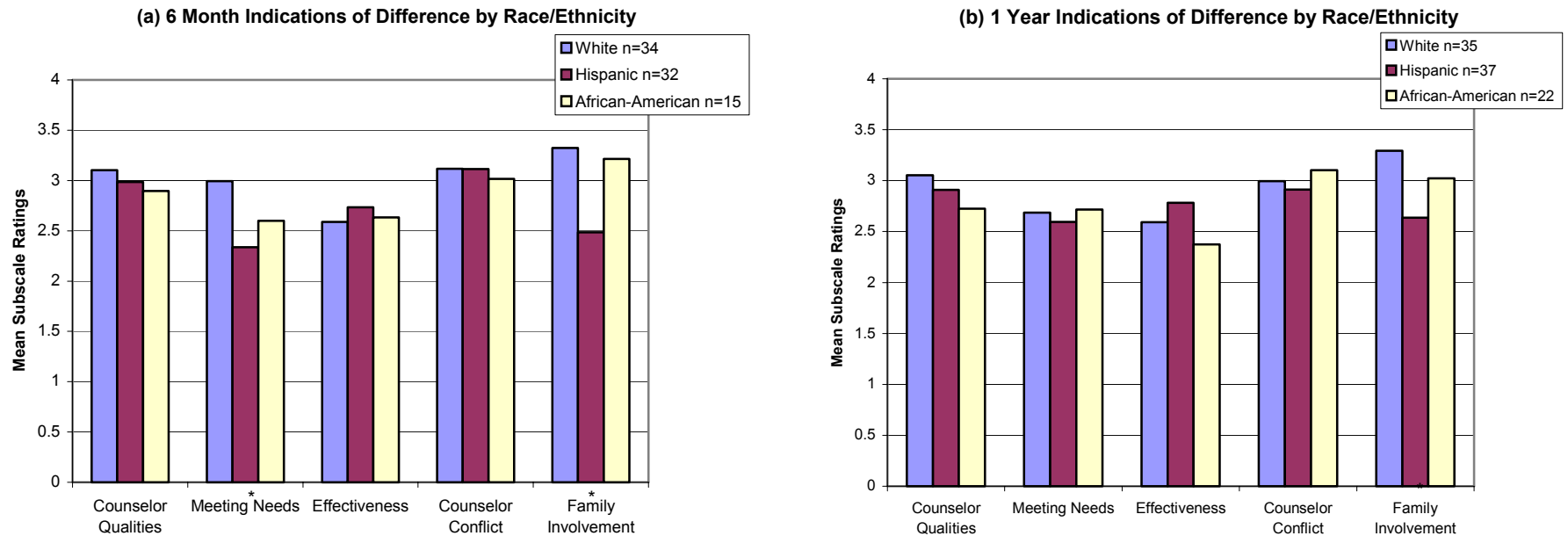


* represents statistical significance at $p < .05$

- Youth, overall, are satisfied with counseling services.
- White youth report significantly more satisfaction with the level of intervention meeting their needs compared to African-American youth.

Figure 60: ISEP Multidimensional Adolescent Satisfaction Scale (MASS) – 6-Month and 1-Year Indications of Difference by Race/Ethnicity – Short-term Intensive Case Management Programs

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.



represents statistical significance at $p < .05$

- Youth, overall, are satisfied with counseling services.
- White youth report significantly more satisfaction with level of family involvement compared to Hispanic youth.

Table 4: ISEP Youth and Family Perceptions of Service Quality

Rankings of Caregiver and Youth Positive Perception of Service Quality Listed in Order of Frequency of Caregivers' Comments

RANKING			CAREGIVER		YOUTH	
C	Y	CATEGORY	N	%	N	%
1	1	Types of Services: <i>Mentioned specific service received such as information or referrals, coordination of services, mentorship, advocacy, counseling, recreation, help with school, setting goals, etc.</i>	132	27.6	108	35.5
2	3	Program Characteristics: <i>Specific characteristics of the program mentioned such as services delivered at client location, family focus, available, consistent, good rapport, communicate well about program, etc.</i>	121	25.2	38	12.5
3	5	Provider Characteristics: <i>Specific provider characteristic mentioned such as are caring, consistent, positive, nice, supportive, understanding, conscientious, provider goes out of way, etc.; liked provider.</i>	99	20.7	28	9.2
4	4	Basic Needs: <i>Use of flexible funds to provide food, transportation, clothing, help with housing.</i>	41	8.6	29	9.5
5	6	Helpful: <i>Helpful overall or with families' problems.</i>	31	6.5	25	8.2
6	7	Communication: <i>Someone to talk to, offer advice, listen.</i>	25	5.2	23	7.6
7	2	Outcomes: <i>Improved family and youth functioning, keep youth on track, help reunite the family.</i>	19	4.0	50	16.4
8	8	Like Program Overall: <i>General appreciation for the program.</i>	11	2.3	3	0.1
		TOTALS	479	100	304	100

Note: C = Caregiver; Y = Youth; N = number of responses for caregiver or youth in that category; % = percent of total caregiver or youth responses. An additional 16 caregivers and 35 youth made no comments.

Rankings of Caregiver and Youth Negative Perception of Service Quality Listed in Order of Frequency of Caregivers' Comments

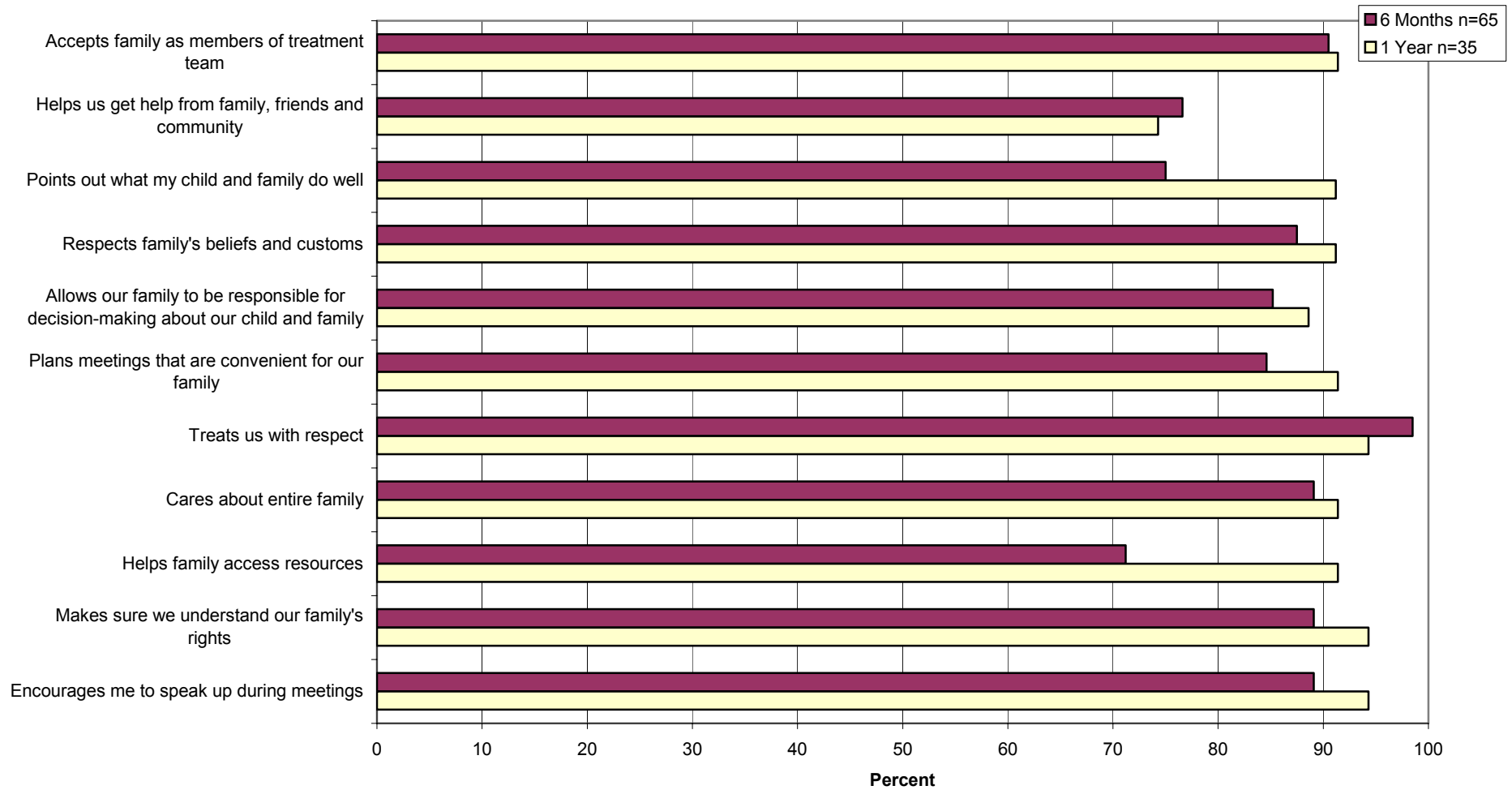
RANKING			CAREGIVER		YOUTH	
C	Y	CATEGORY	N	%	N	%
1	2*	Dissatisfaction with Program: <i>Dissatisfied with aspect of the program such as lack of continuity, unreliable, poor communication, inability to engage family.</i>	42	51.2	9	32.1
2	2*	Dissatisfaction w/ Provider: <i>Dislike of service provider, provider traits or provider performance such as unreliable, poor boundaries, ineffective.</i>	28	34.1	9	32.1
3	1	Dissatisfaction w/ Service: <i>Dissatisfaction with aspect of service such as amount of services provided, delayed service inception, poor follow through.</i>	12	14.6	10	35.7
		TOTALS	82	100	28	100

Note: C = Caregiver; Y = Youth; N = number of responses for caregiver or youth in that category; % = percent of total caregiver or youth responses; *denotes tied ranking. An additional 185 caregivers and 182 youth made no comments.

1=most frequently mentioned

8=least frequently mentioned

Figure 61: Family-Centered Behavior Scale (FCBS)



- 96.8% of families at 6 months and 97.1% of families at 1 year reported that the staff member never makes negative judgments about them because of the ways that they are different from the staff member (e.g. race, income level, job, religion)
- In general, these ratings indicate good adherence to the System of Care principles, including family involvement.

Table 5: POP Survey Data – Clinicians’ Perspectives on the Performance Outcome Project (POP)

This survey was completed on a volunteer basis by program staff (service providers, administrative personnel and/or managers). The staff completed the surveys anonymously.

Number of Surveys Received

Staff Position	Quantity	Percent of Sample
Service Provider	160	73%
Administrative	26	12%
Management	13	6%
Multiple Roles	20	9%
Totals	219	100%

Data collected through the POP program was: (Respondents rated answers on a scale from 1-5, with 1=Extremely Helpful and 5=Not at all Helpful)

Staff Position	Mean
Service Provider	3.7 (n=160)
Administrative	3.6 (n=26)
Management	4.3 (n=13)
Multiple Roles	3.4 (n=20)
All	3.7 (n=219)

I used the data collected from the POP assessments: (Respondents rated answers on a scale from 1-5, with 1=Frequently and 5=Infrequently)

Staff Position	Mean
Service Provider	3.7 (n=160)
Administrative	3.9 (n=26)
Management	4.4 (n=13)
Multiple Roles	3.5 (n=20)
All	3.8 (n=219)

	Service Providers n=160	Administrative n=26	Management n=13	Multiple Roles n=20	Overall n=219
Initial diagnosis	26% (42)	12% (3)	8% (1)	30% (6)	24% (52)
Outreach efforts	4% (7)	4% (1)	0% (0)	0% (0)	4% (8)
Monitoring treatment	26% (42)	12% (3)	15% (2)	25% (5)	24% (52)
Complying to contract	23% (37)	35% (9)	38% (5)	60% (12)	29% (63)
Service revision	11% (17)	4% (1)	8% (1)	10% (2)	10% (21)
Treatment plan	35% (56)	15% (4)	15% (2)	55% (11)	33% (73)
Program reporting	7% (11)	31% (8)	0% (0)	10% (2)	10% (21)
Other	12% (19)	15% (4)	8% (1)	15% (3)	12% (27)
Nothing	24% (38)	31% (8)	38% (5)	5% (1)	24% (52)

Figure 62: POP Survey Data – Clinicians’ Perspectives on the Performance Outcome Project (POP)

Use of POP Program Data

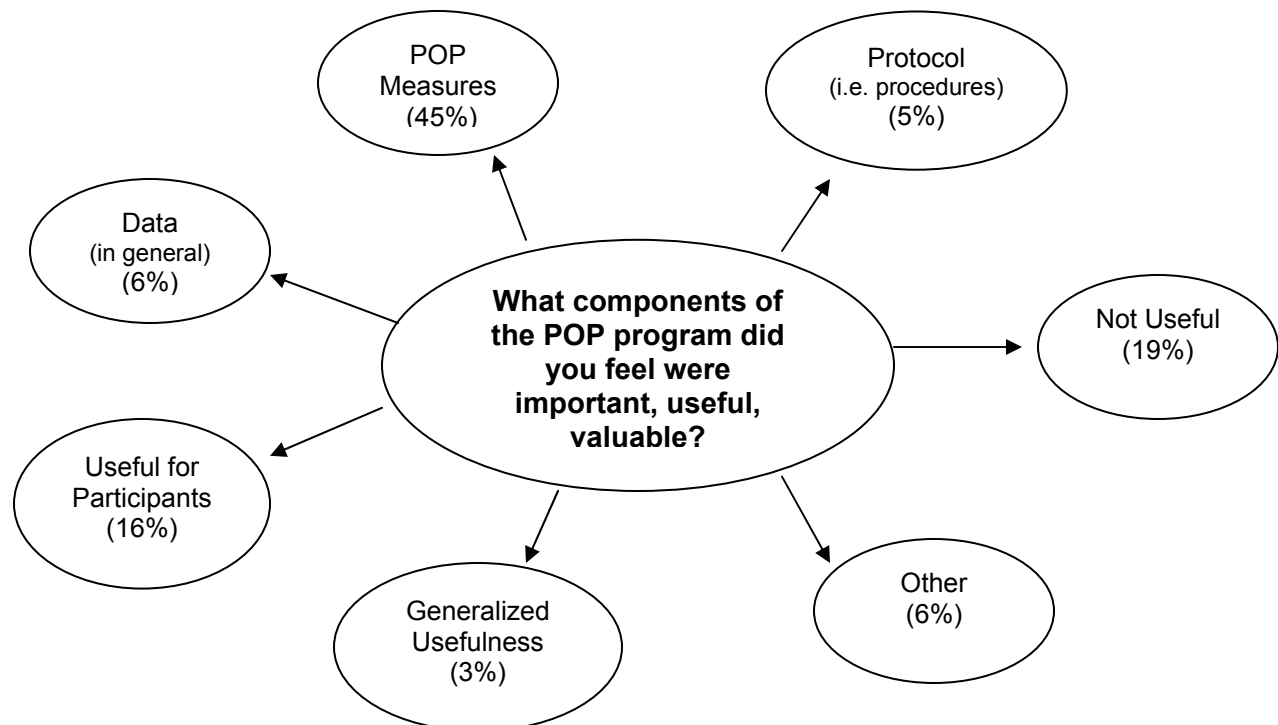
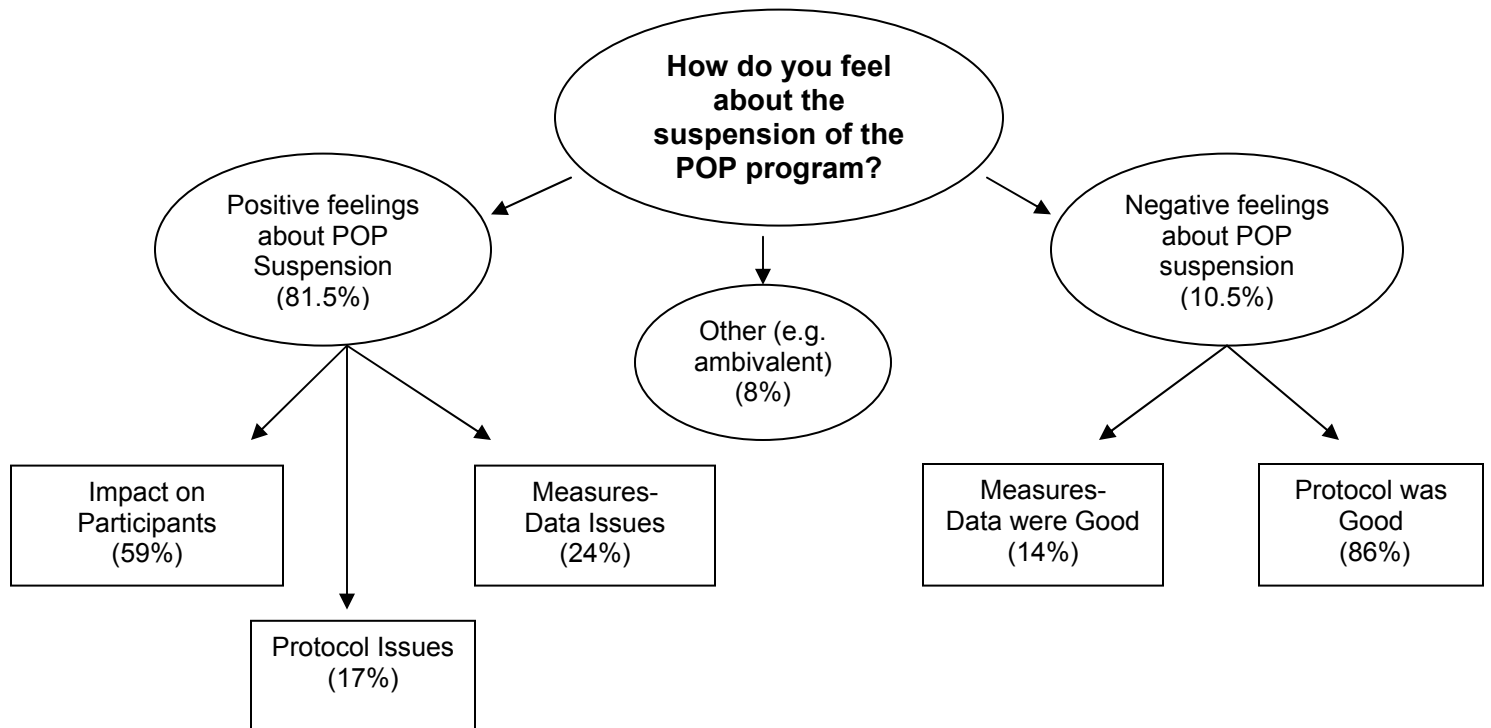
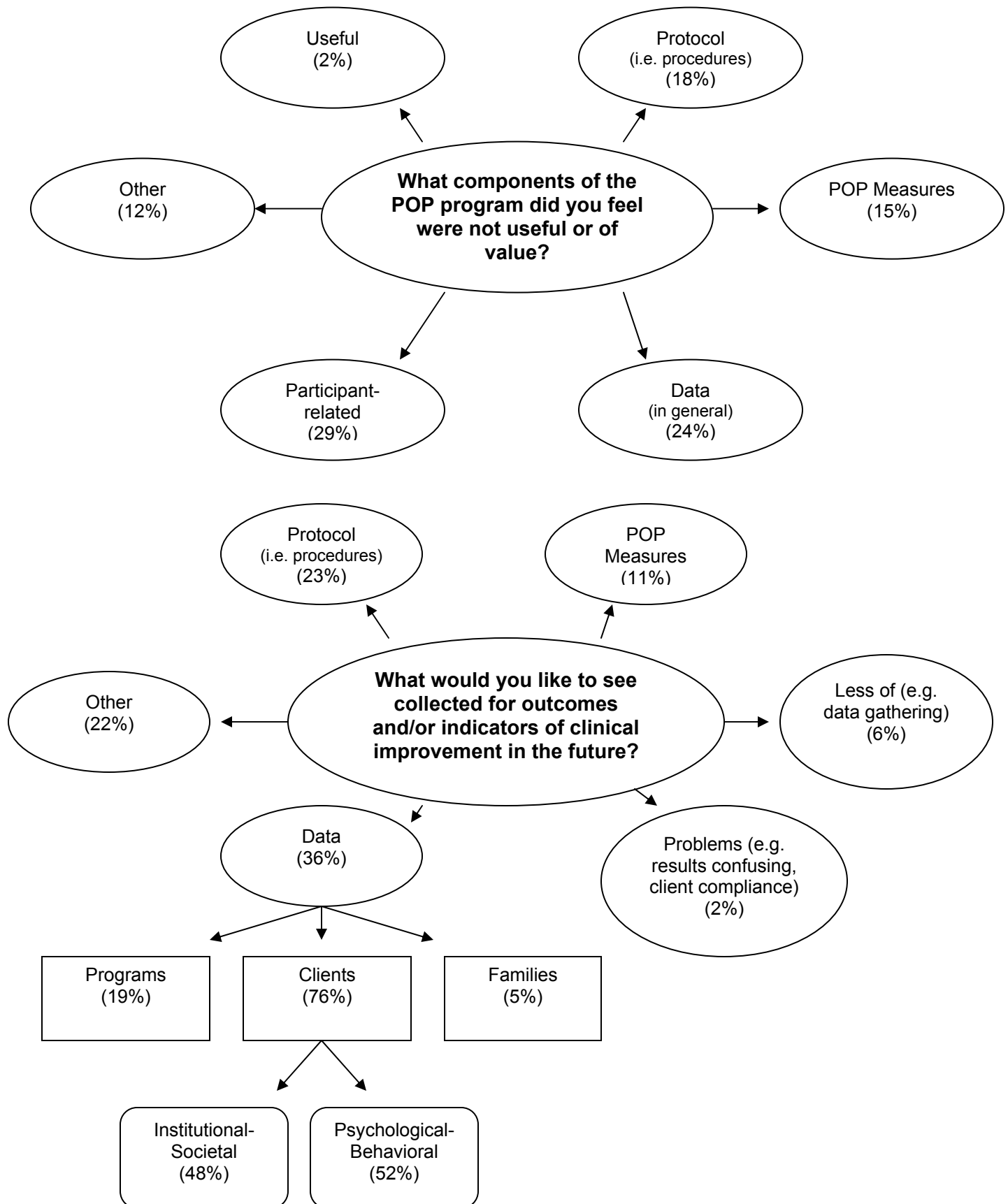


Figure 63: POP Survey Data – Clinicians’ Perspectives on the Performance Outcome Project (POP)



Future Directions

Outcome measurement is of increasing importance in our state and county. Grant proposals, Board letters, contracts, and funding streams all emphasize measurable goals and outcomes as ways to determine if programs are effective in serving families and if funding should be made available for new projects. The Children's System of Care Steering Committee has formed a subcommittee, the Super Outcomes Committee, to create a coordinated structure for choosing and collecting these various outcomes. There is also new emphasis on consumer involvement in program evaluation and planning, and many agencies have begun to employ clients and family members as direct service providers.

This year (Fiscal Year 02-03) has seen some significant funding cutbacks, with consequent loss of program capacity. It is likely that this trend will continue through Fiscal Year 04-05. The funding shortfall may delay the implementation of some new programs and result in the scaling back of some existing efforts. Outcome measurement has been important in making decisions about effective use of resources, such as the planned combination of three major wraparound programs into a single entity. In addition, the state has begun to focus on child outcome measurements that reach well beyond traditional therapy goals, with measures of school attendance, law enforcement contact, and out of home placements as key indicators.

The Performance Outcome Project is being significantly revised in accordance with this new focus. Many of the former POP measures—clinician, youth, and parent ratings of the child's clinical status—were discontinued by the State of California Department of Mental Health, effective September 2002. Systemwide data collection under the Performance Outcome Project is expected to resume in November 2003 with a much reduced but more cost-effective set of tools. The Youth Satisfaction with Services survey and the Youth Satisfaction with Services—Family version will be administered on a cross-sectional basis twice a year. Cross-system outcome measurements involving school attendance, group home placements, etc., will be collected on a smaller sample of youth as needed for reporting requirements and special projects. These outcomes, which are similar to some of those collected for the ISEP project, relate more directly to the client's functioning in the community outside the mental health "office." Data collection for the ISEP project will be concluded in August 2003 as the SAMHSA System of Care grant ends.

As a result of these various changes, the System of Care Report in future years will be different in format and content. A final presentation will be made on the ISEP sample in next year's report. Longitudinal measurements of changes in clinical status and family satisfaction will no longer be available for the POP sample, but will be replaced by client and family satisfaction ratings of the entire system at a point in time. Reporting will also focus on measurements that reach beyond the clinical mental health system and reflect clients' progress and status in the larger systems of schools, juvenile justice, and child welfare. Outcomes in this broader context will assist the County of San Diego and its provider agencies in planning for an efficient and collaborative system of care.