

Child and Adolescent Services Research Center



County of San Diego
Health & Human Services Agency

Children's Mental Health Services



Fifth Annual System of Care Report

Cumulative Data
1998-2003

Board of Supervisors

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

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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 Substance Abuse Mental Health Services Administration (SAMHSA)/CMHS 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. Despite budget reduction and the completion of the SAMHSA grant, San Diego Children's Mental Health Services and the System of Care Partners continue to sustain system of care values, principles and practice in the shaping of the delivery system. The major findings included in this report are summarized below.

Summary of Data

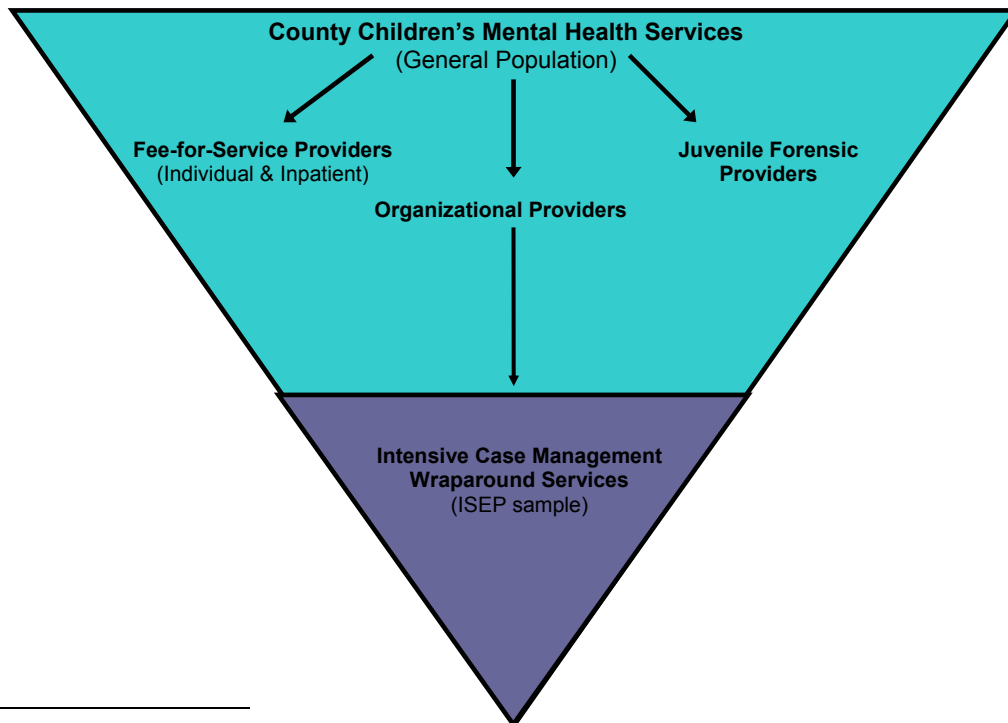
- * 17,992 youth (unduplicated client count) were provided mental health services in FY02-03, representing an 11% increase from the previous year and a 38% increase from FY98-99.
- * The majority of youth are males (63%) and are 13-17 years old (50%) in Children's Mental Health Services (CMHS). However, each year more youth 6-12 years old (39% in FY02-03) are receiving services.
- * The youth served are from diverse backgrounds, with Hispanics and then Whites as the largest race/ethnic groups (42% H & 33% W) in CMHS. Whites are the largest group in the Intensive Services Evaluation Project (ISEP) (40% W & 34% H).
- * Unduplicated counts of youth reveal that many youth are involved in more than one child service sector in a given year. Of youth receiving Mental Health services 36% are involved in Special Education (including all classifications), 24% in Child Welfare, 20% in Juvenile Justice and 6% in Alcohol/Drug.
- * The top four types of diagnoses of youth, assigned by clinicians, in CMHS are: 1) Adjustment, 2) Oppositional, 3) Depression and 4) ADHD.
- * Inpatient bed days decreased 14% from FY01-02 to FY02-03.
- * For ISEP long-term and short-term intensive programs, parents and youth reported significant symptom reduction from intake to 2 years. Only the long-term program produced significant reductions in functional impairment (e.g. less delinquency).
- * Parents of youth in both long-term and short-term programs report less global caregiver strain at 2 years.
- * Youth involved in the ISEP long-term and short-term intensive programs demonstrate reductions in delinquent behaviors and improvement in educational behaviors.
- * Parents generally report high satisfaction with services (ISEP sample), and there are no race/ethnic group differences.

Note: For the purpose of this report, youth refers to children and adolescents of all ages.

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 third largest county in California with a youth population estimated at approximately 742,584¹ in 2003 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 blue section of inverted triangle labeled "General Population").

San Diego County began implementing its coordinated system of care in 1997 under funding from the State of California (AB3015). In addition, in 1997 SD County was awarded additional resources to achieve two goals: 1) Impact broad system change by applying system of care values and principles to achieve improved coordinated and integrated services and 2) Develop wraparound-based services that would provide an alternative to restrictive settings of care for seriously emotionally disturbed (SED) youth. 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 purple 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 2000 Census Current Estimates, December 2003.

Report Contents

The enclosed report summarizes cumulative system data for children and adolescents served by county Children's Mental Health Services (CMHS), as well as clinical outcome data for youth involved in intensive case management programs. Following this introduction, the report is organized into eight sections that present the data from the two samples: CMHS 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 population from 1998 to 2003. The data answers the questions: "Who is the county serving?" and "What services did the youth receive?" (Chapter 3)
- 2) The second section, "Service Utilization by Client Characteristics," provides a description of amounts and types of services children and adolescents are using by multiple variables, including diagnosis, age, gender, race/ethnicity and funding source. This data is presented for the 2002-2003 fiscal year. (Chapter 4)
- 3) The third 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 case management services for youth in or at risk for restrictive placements: short-term intensive case management and long-term intensive case management. The data are presented for each sample by types of services received, demographics and clinical outcomes. (Chapter 5)
- 4) The fourth section, "Community Functioning Outcomes," reports on data associated with mental health improvements: substance use, juvenile justice recidivism and school achievement. These data are presented on youth in the ISEP population and/or youth receiving wraparound services who are involved in the juvenile justice system. (Chapter 6)
- 5) The fifth section, "System Outcomes," reports system level data on issues such as costs and service use patterns for each fiscal year. (Chapter 7)
- 6) The sixth section, "Consumer Perspectives," reports on data from youth and parent perspectives regarding mental health service issues. Family members provide both quantitative and qualitative information regarding their views about services. (Chapter 8)
- 7) The seventh section, "System of Care Outcome Goals," reports data on each of the SOC outcomes from the various populations of youth in CMHS. It includes information from research studies that were conducted in San Diego County. (Chapter 9)
- 8) The final section, "Future Directions" and "Future Directions in Research in San Diego," discusses new developments and proposed data analyses in the upcoming years for the county's Children's Mental Health Services. It also provides an overview of on-going research conducted in San Diego. (Chapter 10)

Participating Programs

Table 1 (pgs. 5-7) lists all of the mental health programs that have contracts with CMHS. These programs comprise the Organizational Providers service mechanism. The programs with asterisks are the mental health intensive case management programs that participated in the ISEP wraparound-based service. Table 2 (pg. 7) lists the Juvenile Forensic programs. As of June 2003, there were 147 Fee-for-Service (FFS) providers, including psychiatrists, psychologists, social workers and marriage and family therapists, contracted as child and adolescent only providers. Another 337 were contracted to treat adults, children and adolescents, yielding a total of 484 providers available to treat children and adolescents in San Diego County. Of these FFS providers, 54% were closed to new referrals and only providing services to existing clients.

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) and 6) North Inland (e.g. Escondido, Julian, San Marcos). The majority of organizational providers are located in the North Central region (40%). The other regions have similar percentages of organizational providers: 15% in Central, 13.5% in East, 13.5% in North Inland, 11% in South and 7% in North Coastal. The youth who received services from organizational providers live in all areas of the county. The distribution is fairly equal in size, with 21.5% of youth living in Central, 20% in North Central, 17% in South, 16.5% in East, 14% in North Inland and 11% in North Coastal. The majority of Fee-for-Service child and adolescent psychiatrists provide services in the North Central region, 24 treating children and 30 treating adolescents. The other regions have fewer psychiatrists: Central, 3 child and 10 adolescents; East, 7 child and 13 adolescents; South, 6 child and 6 adolescents; North Coastal, 2 child and 8 adolescents; and North Inland, 7 child and 11 adolescents. The regional breakdown for psychologists, social workers and marriage and family therapists shows similar patterns to the distribution of psychiatrists. However, these numbers are not specific to therapists treating child and adolescent populations. There are 186 therapists in North Central, 98 in Central, 91 in East, 39 in South, 70 in North Coastal and 71 in North Inland.

Cultural Competency

San Diego County is home to families from many diverse cultures and race/ethnicities. Many of the children, youth and families are in need of services in their primary language. Of the 84 contracted organizational providers, 70% offer services in Spanish. There are also a number of programs that offer services in additional languages: 23% offer services in European languages (i.e. German, French, Russian); 19% offer services in Asian/Pacific Islander languages (i.e. Tagalog, Vietnamese, Korean); 8% offer services in Middle Eastern languages (i.e. Farsi, Arabic) and 6% offer services in Sign Language. The Fee-for-Service providers also provide services in multiple languages. About 50% provide services in Spanish. The percentages offering services in other languages are the following: 18% European languages, 6% Asian/Pacific Islander languages, 14% Middle Eastern languages and less than 1% Sign Language.

Table 1: Organizational Providers: List of Participating Programs

Program Name	Type	Target Population
ALLY National City	Outpatient Clinic-EPSDT	Mental Health
ALLY South Bay – Sweetwater and South Bay Union	Outpatient School-based-EPSDT	Mental Health – School
ASPEN Community Services	Day Treatment Intensive/Outpatient	Mental Health
Building Effective Solutions Together (BEST) *	Intensive Case Management/Wraparound	MH, Probation, Child Welfare
BEST TBS	Therapeutic Behavioral Services	Mental Health
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 Center Collaborative	Day Treatment	Mental Health
Clark Center	Outpatient Clinic	Mental Health
CMHS 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
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
Lifeschool	Day Treatment Intensive	Mental Health – 2726
New Alternatives Children’s Day Treatment	Day Treatment Intensive	Mental Health – 2726

Program Name	Type	Target Population
New Alternatives Cabrillo	Day Treatment Intensive in a Residential Facility	Mental Health – Child Welfare
New Alternatives Cabrillo Assessment Center	Case Management	Mental Health – Child Welfare
New Alternatives # 16	Day Treatment Intensive in a Residential Facility	Mental Health – Child Welfare
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 Mental Health	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 – Crossroads	Outpatient Clinic	Mental Health
San Diego Center for Children	Day Treatment Intensive in a Residential Facility	Child Welfare
San Diego Center for Children – Foster Family Agency	Outpatient Clinic	Child Welfare-FFA
San Diego Center for Children – La Mesa/Spring Valley and Grossmont	Outpatient School-based	Mental Health – School
San Diego Center for Children-Discovery Hills	Day Treatment Intensive	Mental Health – 2726
San Diego Youth and Community Services	Outpatient Clinic	Probation
STEPS Day Treatment	Day Treatment Intensive Specialized	Mental Health
STEPS Outpatient	Outpatient Specialized	Mental Health
STEPS at Polinsky	Outpatient Specialized for Dependents	Mental Health
STEPS Vista	Day Treatment Intensive Specialized	Mental Health
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
San Ysidro Middle School	Outpatient School-based	Mental Health – School
Social Advocates for Youth (SAY) CATS I and II	Outpatient School-based	Probation
Social Advocates for Youth (SAY) Marshall	Outpatient School-based	School

Program Name	Type	Target Population
Southbay Community Services	Outpatient Clinic	Probation
Southbay Youth & Family Services-Nueva Vista Family Services	Outpatient Clinic	Mental Health
Southeast Mental Health Clinic	Outpatient Clinic	Mental Health
Therapeutic Services Inc. (TSI)	Outpatient Clinic	Mental Health
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-Foster Family Agency	Outpatient Clinic	Child Welfare-FFA
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-Foster Family Agency	Outpatient Clinic	Child Welfare-FFA
Youth Enhancement Services (YES) – San Ysidro and Sweetwater	Outpatient Clinic	Mental Health
YMCA TIDES	Outpatient Clinic	Mental Health

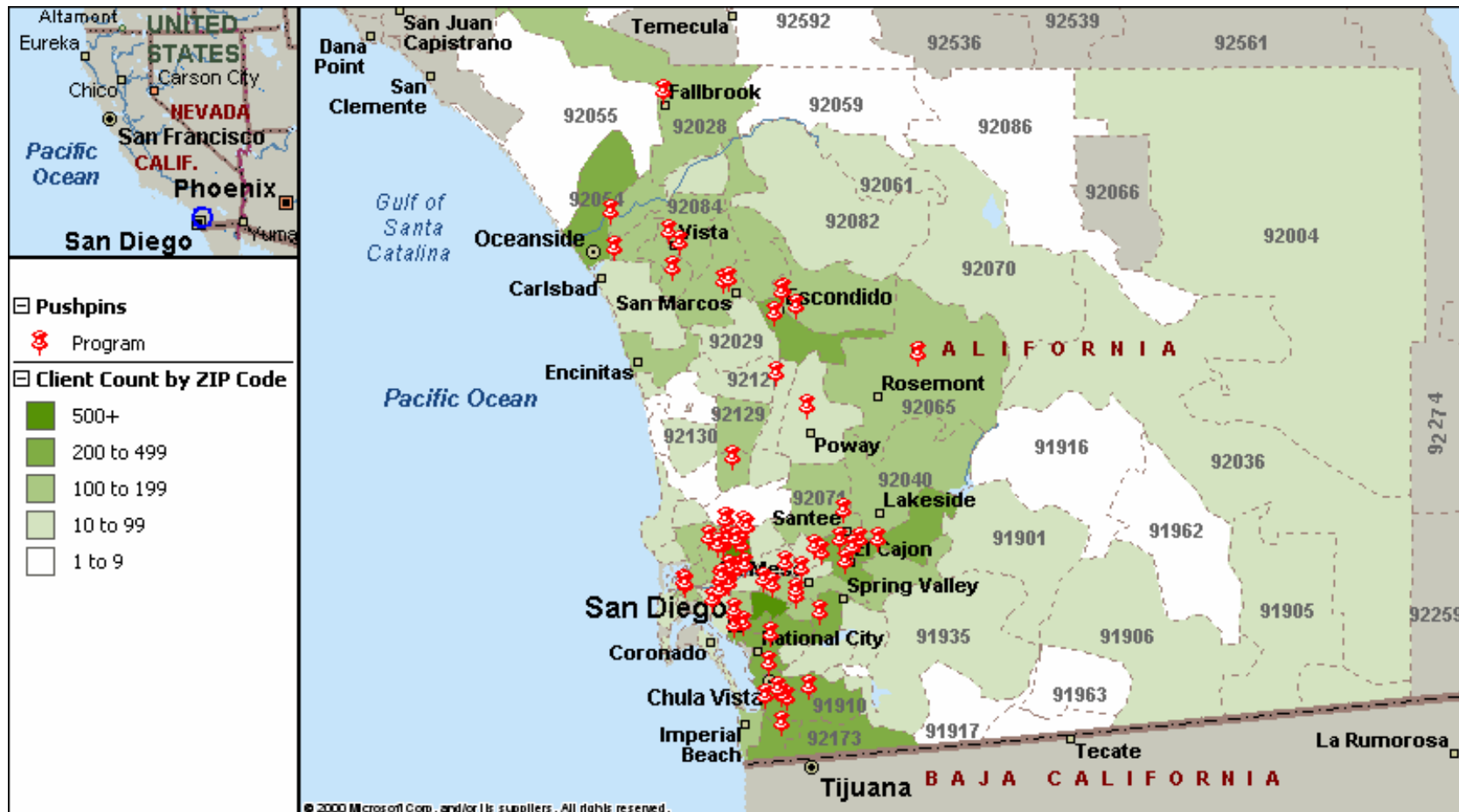
* ISEP programs

Table 2: Juvenile Forensic Programs

Program Name	Type	Target Population
Juvenile Hall Crisis Team	Juvenile Hall Detention Facility	Juvenile Forensic
Juvenile Ranch Facility	Juvenile Hall Detention Facility	Juvenile Forensic
Youth Correctional Center, Camp Barrett	Juvenile Hall Detention Camp	Juvenile Forensic
Spectrum	Juvenile Hall Detention Facility	Juvenile Forensic

Figure 1: Regional Locations of Youth and Programs Involved in Organizational Providers (County and Contracted)

The shaded areas represent the number of youth living in the zip code that participated in one or more organizational provider programs in 2003. The red pushpins represent the location of mental health organizational providers.



- The majority of programs, 40%, are located in the North Central region, with 15% in Central, 13.5% in East, 13.5% in North Inland, 11% in South and 7% in North Coastal.
- The percentages of youth living in each of the six SD County regions are as follows: 21.5% Central, 20% North Central, 17% South, 16.5% East, 14% North Inland and 11% North Coastal.

Description of the Children’s Mental Health Service System – General Population

San Diego County Children’s Mental Health Service System 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 they can provide services to a specialized population or a population in a specific setting (such as school-based). Youth served through these organizational providers are monitored by the county’s Quality Assurance (QA) department. The QA department conducts service utilization reviews and provides oversight amongst the multiple providers while monitoring the clinical services provided to youth. Juvenile Forensic Services provide services primarily in Probation institutions within the County. Juvenile Forensics oversees most mental health services provided to Probation.

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; the focus of rehabilitative is on skill building and behavioral adjustments. Case management services can be provided in conjunction with any of the other modes or they can be a stand alone service that “connects” children, youth and families to the services they need, monitors their care and oversees 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 throughout the entire county.

Youth may receive services from one or all of the delivery providers and modes in the course of a year. Figure 2 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: FY02-03 = 17,992, FY01-02 = 16,173, FY 00-01 = 15,025, FY99-00 = 13,181 and FY98-99 = 13,061 unduplicated clients. Figure 3 shows the breakdown of the number of unduplicated clients for each fiscal year by 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 ORG providers: 63% in FY02-03, 59% in FY01-02, 54% in FY00-01, 53% in FY99-00 and 59% in FY98-99. Also, note that a youth may receive services from more than one provider within the year but not necessarily simultaneously. Hence, the percent totals exceed 100%, and the client counts exceed the total sample size. Figures 4, 5 and 6 show the demographic make up of the entire CMHS 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 years. Race/ethnic distribution varies for Hispanics by fiscal year with continuous increases in the percent served within CMHS from 28% in FY98-99 to 43% (exceeding Whites at 33%) in FY02-03. 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 current population estimates of 2003 constructed from the 2000 census, the following race/ethnic groups served in CMHS are similar to the county population: Whites (33% CMHS vs. 40% census), Hispanics (43% CMHS vs. 39% census) and Native Americans (<1% CMHS vs. <1% census). However, there are almost 3 times as many African-American youth in services (17% CMHS vs. 6% census) than expected based on population census and half as many Asian/Pacific Islander youth in services (4% CMHS vs. 9% census).

Figure 7 displays the unduplicated client counts in Mental Health along with the unduplicated client counts in the other System of Care sectors. The Venn diagram proportionately shows the number of youth who are involved with another service sector in addition to Mental Health. Table 3a presents the percentages and numbers of youth overlapping with each of the sectors. For example, of youth in Alcohol and Drug, 37% are in Mental Health, 3% are in Child Welfare, 49% are in Juvenile Justice and 20% are in Special Education. Table 3b displays the single and multiple service sector use by each public agency (Special Education includes Emotionally Disturbed youth only). Youth in Child Welfare are the least likely to be involved in another service sector (68% not open to another sector). Figure 8 represents how and which clients use multiple services within the CMHS system. More specifically, this figure presents 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 table indicates that 80% of youth involved in residential mental health services also received Juvenile Forensic outpatient services. There are two notable changes 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 from FY01-02 (67%) to FY02-03 (50%). Second, the increased percentages of day rehabilitation services and organizational outpatient services from FY01-02 (47%) to FY02-03 (66%) are probably due to marked program growth at the Polinsky Children's Center. Refer to page 17 for descriptions of the service modalities presented in the table. Figure 9 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 organizational services. African-American youth are reported in higher percentages in rehabilitative day treatment and residential mental health services.

Figure 2: Children’s Mental Health System: Unduplicated Client Count Across All Providers and Modes by Fiscal Year

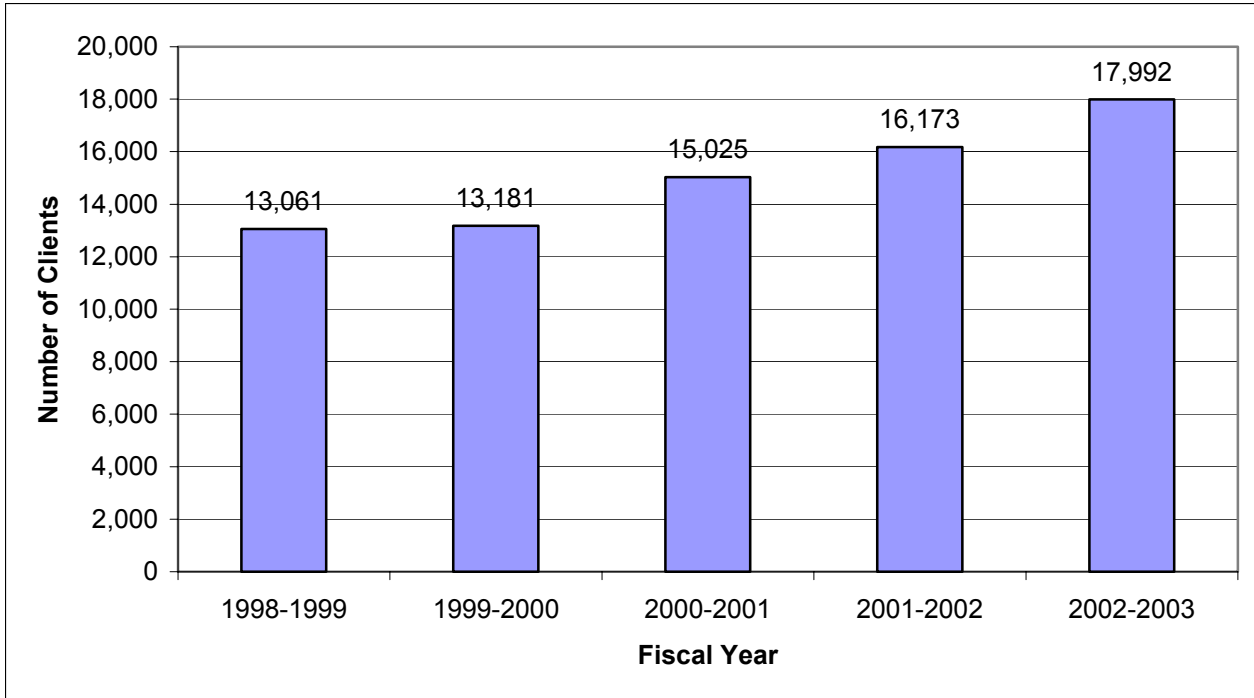


Figure 3: Children’s Mental Health System: Number of Total Client Counts by Fiscal Year and Provider

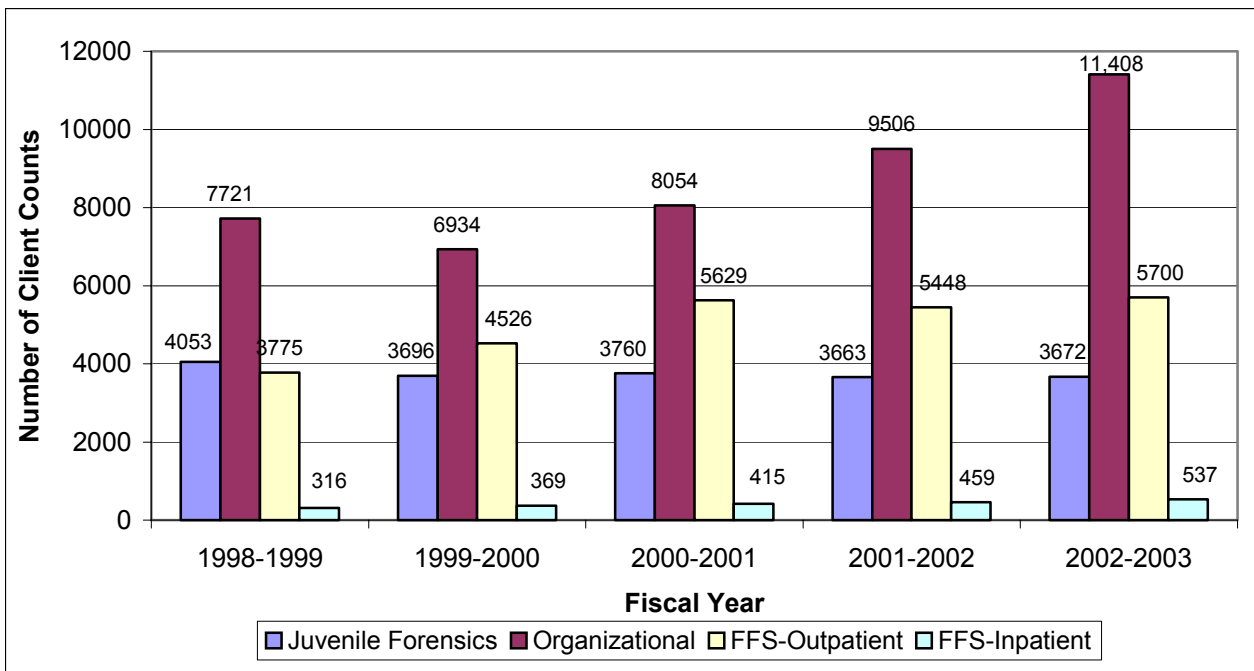


Figure 4: Children’s Mental Health System: Gender Distribution

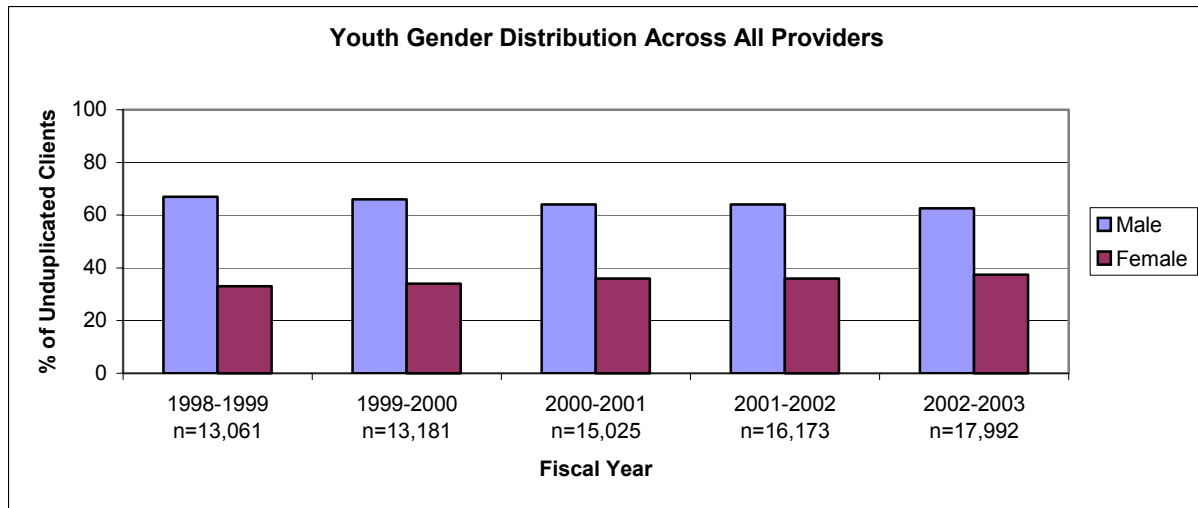


Figure 5: Children’s Mental Health System: Age Distribution

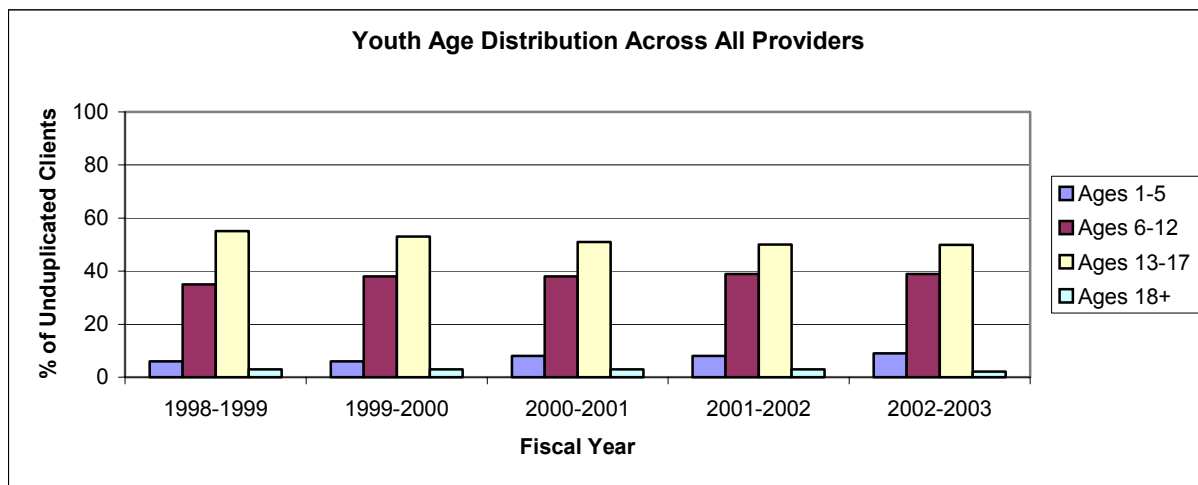
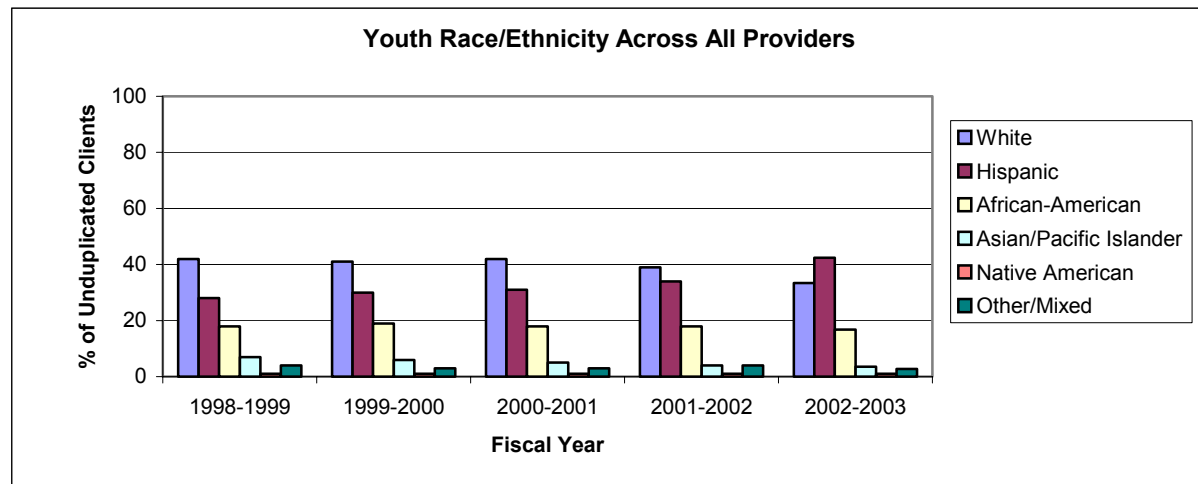
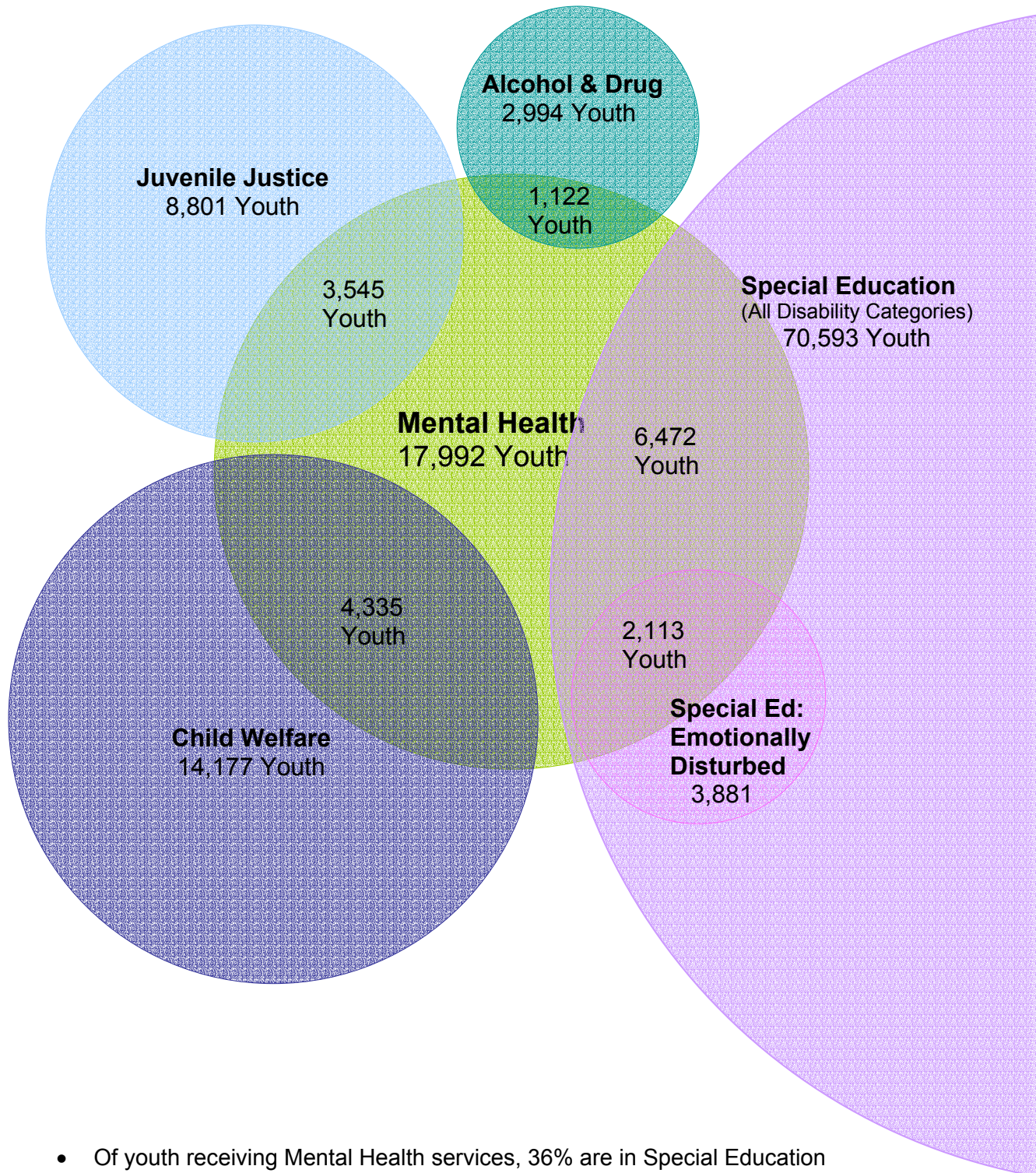


Figure 6: Children’s Mental Health System: Race/Ethnicity



**Figure 7: Unduplicated Counts of Youth Receiving Services from Mental Health
and the Overlap with Other Sectors
FY 2002-2003**



- Of youth receiving Mental Health services, 36% are in Special Education (12% Emotionally Disturbed), 24% in Child Welfare, 20% in Juvenile Justice and 6% in Alcohol & Drug.

Note: This figure displays sector overlap with Mental Health only. Overlaps across all sectors are presented in the cross tabulations in Table 3a page 14.

Table 3a: Unduplicated Client Counts Across System of Care Sectors for FY02-03^{1,2}

The data presented is the number of youth receiving services for each sector and the percent of youth overlap with other sectors. Percents are displayed by column.

	Alcohol & Drug	Child Welfare	Juvenile Justice	Mental Health	Special Education	Special Ed: ED Only
Alcohol & Drug	100% n=2994	<1% n=82	17% n=1463	6% n=1122	1% n=584	4% n=141
Child Welfare	3% n=82	100% n=14,177	3% n=257	24% n=4335	4% n=2814	13% n=519
Juvenile Justice	49% n=1463	2% n=257	100% n=8801	20% n=3545	3% n=1875	13% n=505
Mental Health	37% n=1122	31% n=4335	40% n=3545	100% n=17,992	9% n=6472	54% n=2113
Special Education	20% n=584	20% n=2814	21% n=1875	36% n=6472	100% n=70,593	100% n=3881
Special Ed: ED Only	5% n=141	4% n=519	6% n=505	12% n=2113	6% n=2113	100% n=3881

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

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

Table 3b: Single and Multiple Use by Service System Sectors, All Ages (Overall)

The data presented is the percent of youth open to only one sector (first row) and the percent of youth open to multiple service sectors (one, two, or three or more). Percents are displayed by column.

	Alcohol & Drug n=2994	Child Welfare n=14,177	Juvenile Justice n=8801	Mental Health n=17,992	Special Ed: ED Only n=3881
Not Open to Any Other Service Sector	44.7%	68.4%	52.1%	49.5%	40.9%
Open to One Other Service Sector	20.7%	27.0%	31.5%	40.0%	37.4%
Open to Two Other Service Sectors	30.8%	4.1%	14.7%	9.6%	18.2%
Open to Three or More Other Service Sectors	3.8%	0.5%	1.7%	0.9%	3.5%

- Almost 1/2 of youth in Alcohol and Drug are involved in Juvenile Justice.
- About 1/3 of youth in Child Welfare receive Mental Health Services.
- 40% of youth in Juvenile Justice are also in Mental Health.
- Of the total number of youth in Special Education, few are also involved in other child service sectors; however 1/2 of Emotionally Disturbed (ED) youth are in Mental Health.
- Youth in Child Welfare are less likely to be involved in another service sector.
- 1/5 of youth in Alcohol and Drug are involved in one other sector and about 1/3 are involved in two other sectors (typically JJ and MH).
- Very few youth are involved in three or more service sectors.

Figure 8: Children's Mental Health System: Single and Multiple Use by Service Mode^{1,2}

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 – Inst	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%

FY 2002-2003

	Inpatient N =771	Res-M.H. N =1198	Int. DT N =768	Day Rehab N =543	Case Mgmt. N =2346	OP-Org. N =8402	OP-FFS N =5700	OP-JF/Inst. N =5325	ESU N =1015
Inpatient	100.0%	11.5%	15.1%	13.1%	17.3%	5.7%	9.4%	3.5%	40.0%
Res-M.H.	17.9%	100.0%	38.8%	31.5%	10.1%	4.5%	9.2%	18.0%	15.1%
Int. DT	15.0%	24.9%	100.0%	34.8%	16.5%	3.7%	4.7%	4.9%	10.6%
Day Rehab	9.2%	14.3%	24.6%	100.0%	6.8%	4.2%	2.6%	5.8%	7.0%
Case Mgmt.	52.8%	19.8%	50.4%	29.3%	100.0%	14.5%	10.5%	10.0%	37.2%
OP – Org.	62.4%	31.7%	40.5%	65.7%	52.0%	100.0%	20.7%	17.2%	55.7%
OP – FFS	69.4%	43.9%	34.9%	27.8%	25.6%	14.0%	100.0%	16.2%	35.2%
OP – Inst	24.1%	80.0%	34.1%	56.7%	22.7%	10.9%	15.2%	100.0%	25.1%
ESU	52.7%	12.8%	14.1%	13.1%	16.1%	6.7%	6.3%	4.8%	100.0%

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

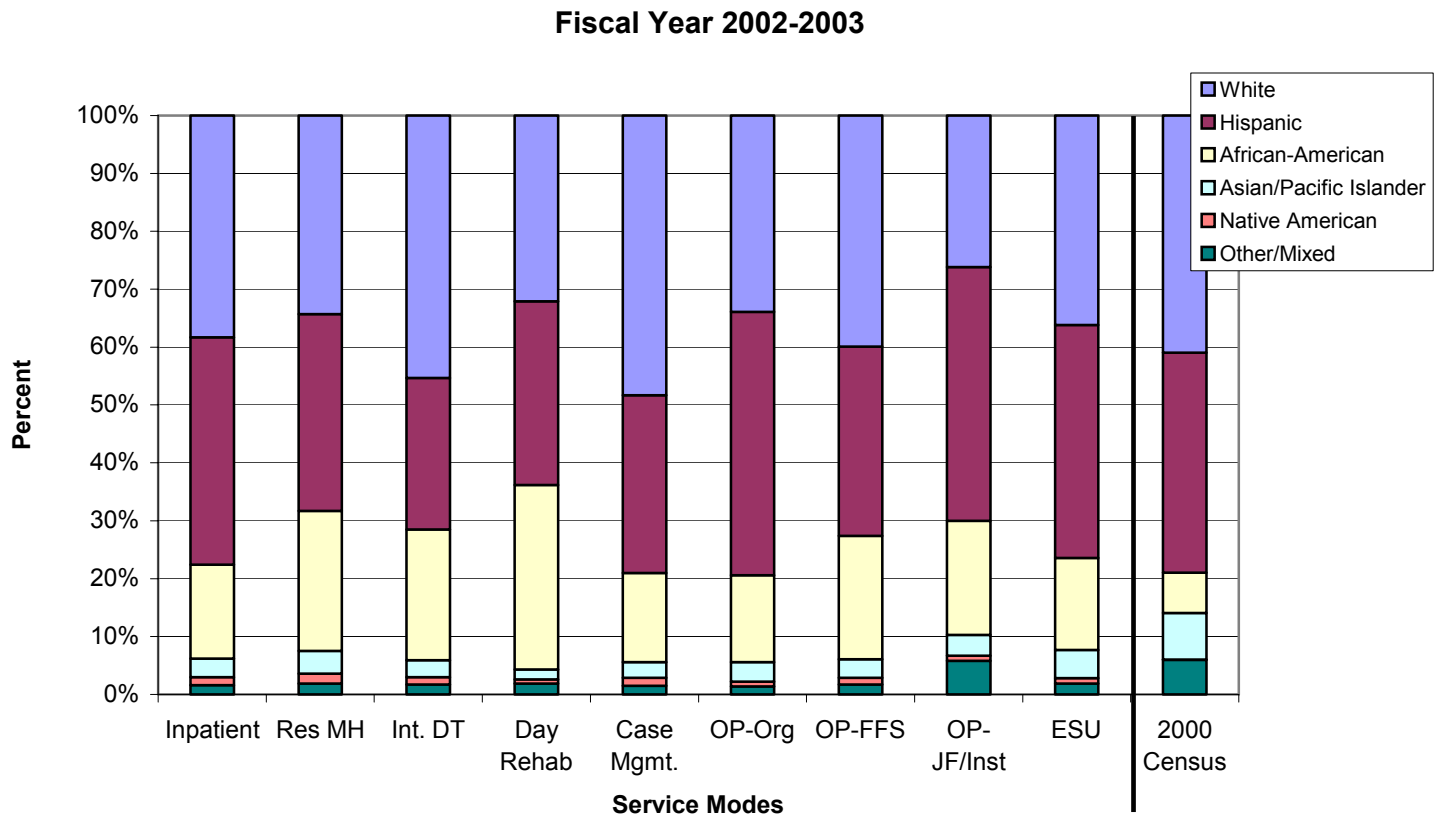
² Total exceeds 100% because youth can be open to more than two service modes within the year.

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

- Residential Mental Health serves children in group homes. The increase in Day Rehab for these youth reflects their participation in a new program at Polinsky Children's Center during change-of-placement intervals.

Figure 9: Distribution of Race/Ethnicity in Each Service Modality

Service Modality data is collected through administrative databases and 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.



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

- 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.
- Hispanic youth are receiving services as would be expected based on 2000 census with slight under-representation in Intensive Day Treatment.
- There are higher percentages of African-American youth involved in all levels of care, especially restrictive settings including Day Rehabilitation, Intensive Day Treatment, Residential Mental Health services and also Outpatient Fee-for-Service programs compared to 2000 census.
- Asian/Pacific Islander youth are under-represented in most services, with the Emergency Screening Unit serving the most Asian/Pacific Islander youth.

Service Utilization by Client Characteristics: CMHS (General Population)

San Diego County Children's Mental Health Services (CMHS) delivers services through three primary mechanisms: 1) Fee-for-Service providers (FFS), 2) Organizational providers (ORG) and 3) Juvenile Forensic services. Fee-for-Service and organizational providers both utilize United Behavioral Health for submitting claims data and receiving reimbursement for services, utilizing a standard MIS tracking system called INSYST. INSYST is a database that maintains client information and services provided for each provider by service modality. Juvenile Forensic providers utilize independent database systems (e.g. Juvenile Forensic and Spectrum) for capturing client characteristics and tracking services provided. Inpatient services also utilize an independent database system, called Telecare, for client and service information. By combining these four databases, information on the clinical profiles of youth and the amounts of services they obtained was analyzed for the entire CMHS. The data presented in this chapter cover all services provided to youth within CMHS for fiscal year 2002-2003.

The client characteristics were grouped into meaningful categories for age, gender, race/ethnicity and diagnosis. Diagnosis was determined by identifying the primary DSM-IV diagnosis at admission from the last episode of service prior to June 30, 2003. Earlier valid diagnoses were chosen when later episodes reported invalid diagnoses (e.g. 799.9-deferred). Diagnoses were then grouped into meaningful diagnostic categories according to Title 9 Medical Necessity Criteria of the California Code of Regulations list of included diagnoses. Diagnoses that are excluded according to Title 9 were categorized as "excluded" and remained in the analyses. "Invalid" diagnoses are ones in which there was no valid Title 9 or excluded code provided for any services for that particular client (most of the invalid diagnoses were 799.9-deferred diagnoses in the Fee-For-Service database). Only one primary diagnosis was indicated per client for these analyses. The funding source for services was also determined per client. Medi-Cal status was coded for FFS and ORG providers through service procedure codes. AB2726 status was coded if any visit record for a client contained a 2726 procedure code within the fiscal year.

Services were analyzed by meaningful service categories. Restrictive levels of services were reported in days and include inpatient, day treatment intensive, day treatment rehabilitation and crisis stabilization. Inpatient services include acute and administrative days. Day treatment intensive includes any program using a day treatment procedure code. Residential patch programs were grouped in this category along with intensive day treatment programs (AB2726), since they document services identically in INSYST. Day treatment rehabilitation includes services provided within day rehab procedure codes. Outpatient services were reported in minutes and included collateral, therapy, case management, assessment, medication, crisis services and therapeutic behavioral services (TBS). Collateral services include family therapy, case consultations, teacher or other professional consultations, attendance at IEP meetings or any other conversations related to the client and treatment plan. Therapy includes individual and group therapy. Case management includes case managing services and/or brokerage type services and rehabilitation services provided at an outpatient level by programs that have a specific contract with the county to provide such services. Assessment includes intake diagnostic assessments and psychological testing. Crisis services include crisis intervention services at either the provider site or at the Emergency Screening Unit. Medication services include medication evaluations and follow-up services. Therapeutic Behavioral Services (TBS) include services conducted by paraprofessionals to assist a youth in obtaining functional skills in the community, and are provided by programs with TBS contract. Children and youth may receive services from any or all of the various types of services in the course of a year. The data are presented in median and mode for each service type. The

median is the middle value in the distribution, and the mode is the value occurring most often (highest frequency).

Figure 10 shows the diagnosis categories by race/ethnicity. The percent displayed by each diagnosis portrays the total frequency of occurrence per diagnosis for the total sample. The most frequent diagnoses are 1) Adjustment disorders, 2) Oppositional Defiant disorders (including Conduct and Disruptive behaviors), 3) Depressive disorders (including Dysthymic) and 4) Attention Deficit Hyperactivity Disorders. For each disorder the race/ethnic breakdown is displayed. The race/ethnic breakdown for the total CMHS sample is displayed on the far right for comparison purposes. There are some interesting race/ethnic differences. For example, over 60% of youth diagnosed with Bipolar disorder are White. Hispanic youth are over-represented in the Adjustment disorders. African-American youth are over-represented in the Oppositional disorders and Asian/Pacific Islander youth are over-represented in Other diagnoses. The following are the three most frequent diagnoses per race/ethnic group: Whites-ADHD, Depressive, Oppositional; Hispanics-Adjustment, Depressive, Oppositional; African-Americans-Oppositional, Adjustment, ADHD; Asian/Pacific Islander-Depressive & Adjustment, Oppositional; and Native Americans-Oppositional, Adjustment, ADHD.

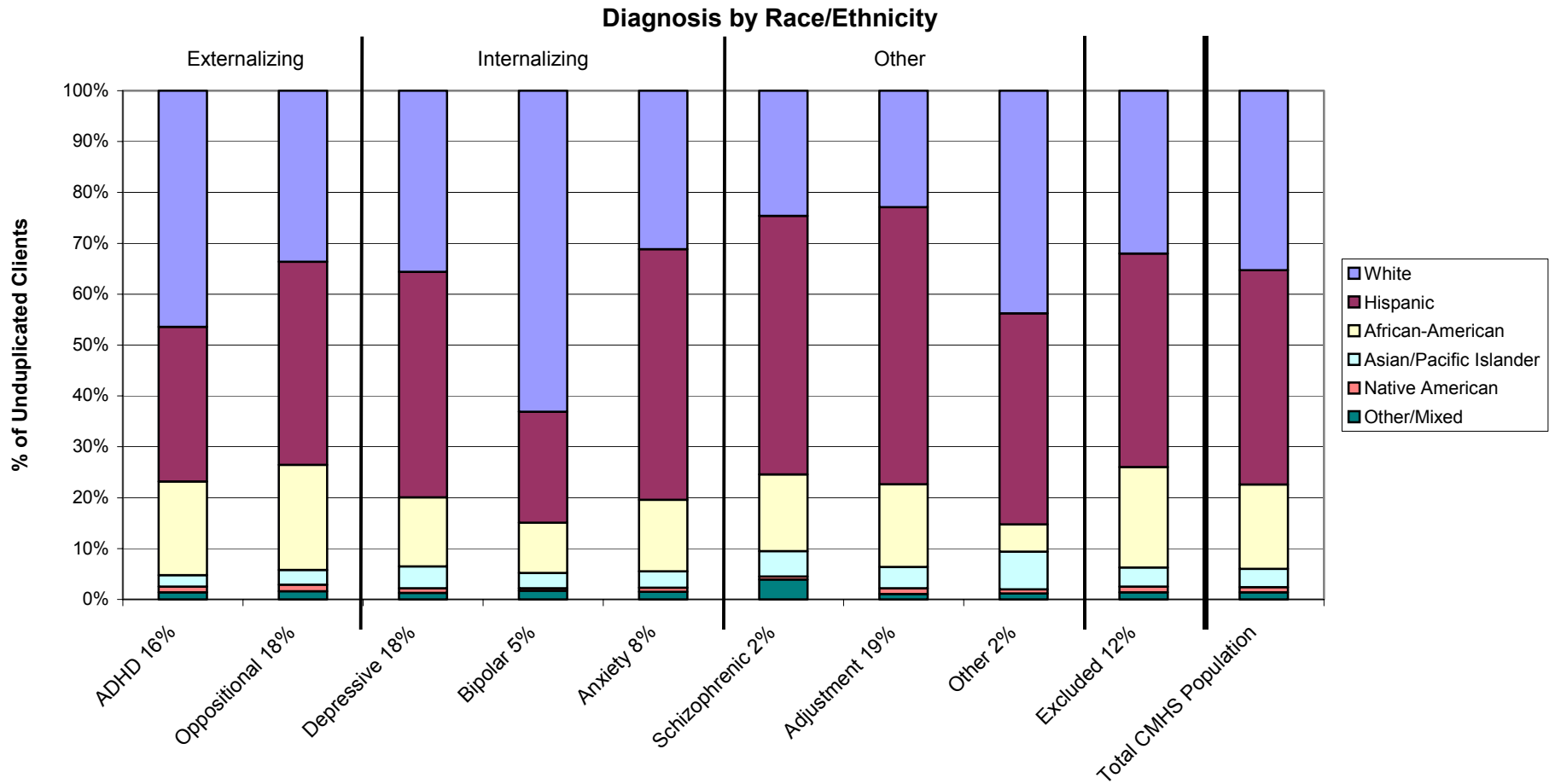
Figure 11 displays diagnosis categories by gender and then by age. Notable findings are that youth with Depressive, Bipolar, Anxiety and Adjustment disorders are equally distributed between males and females. All other disorders range between 60-80% males. Depressive, Bipolar and Schizophrenic disorders are occurring predominately in adolescents. Preschool children are being diagnosed with "excluded" diagnoses, primarily developmental disorders, via evaluations offered by Children's Hospital to infants and toddlers at Polinsky Children's Center and in the community. Latency age children are presenting most often with ADHD and Adjustment disorders. Youth with an Anxiety disorder are more often 5-11 years old.

Figure 12 presents diagnoses by funding source. The top figure shows the percent of youth receiving services through Medi-Cal for each diagnostic category. There are fewer youth with Bipolar and Other categories receiving services through Medi-Cal funds than other diagnostic groups. The bottom figure shows the percent of youth involved in AB2726 in each diagnostic category. Youth with Bipolar or ADHD disorder are more commonly in AB2726 compared to other disorders and the total sample.

Tables 4, 5, 6 and 7 present the median and mode number of service units per service modality for each race/ethnic group and each diagnostic category. The median is the number of units that falls in the middle of the distribution, with an equal number of units above and below it. The mode is the number of units that occur most frequently per group. Restrictive services, such as Inpatient, Day Treatment Intensive, Day Treatment Rehab and Crisis Stabilization are presented in days. Outpatient services, including Collateral, Therapy, Case Management, Assessment, Medication Support, Crisis Services and Therapeutic Behavioral Services (TBS), are presented in minutes. Each table displays the total number of minutes per service modality in the last row for comparisons. There are some race/ethnic differences and diagnosis differences. Youth with Adjustment disorders are receiving less inpatient, day treatment intensive and day treatment rehabilitative as well as less medication support. Youth with Bipolar and Schizophrenia receive more collateral services, case management services and medication support. Youth with ADHD and Anxiety receive the most individual or group therapy. Asian/Pacific Islander youth receive less restrictive levels of service compared to other race/ethnic youth. Hispanic youth receive less case management, medication support and TBS services. Native Americans also receive less medication support.

Figure 10: Diagnosis by Race/Ethnicity

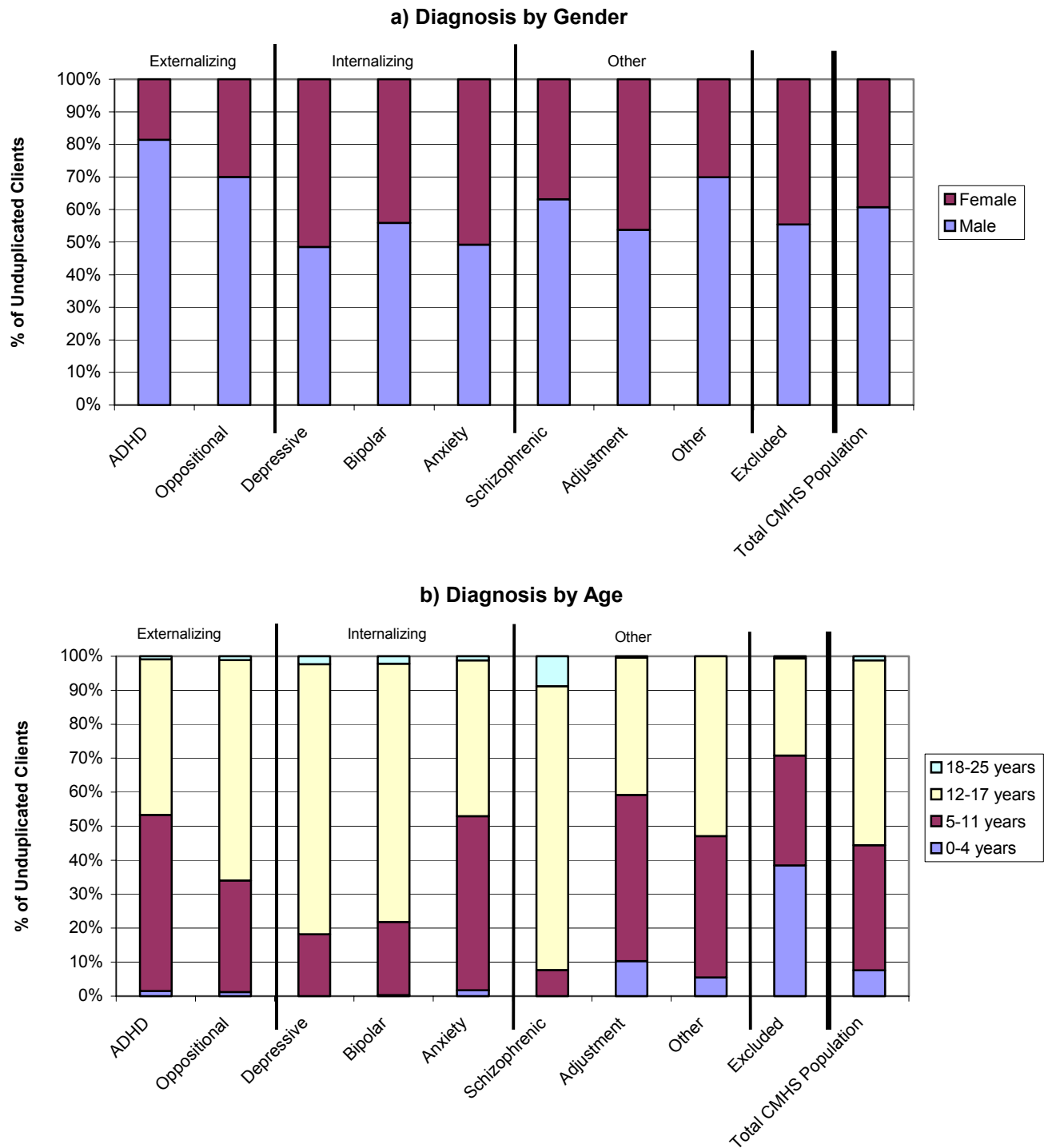
Diagnoses include youth’s primary DSM-IV diagnosis, reimbursable in MH according to Title 9. The “excluded” category includes Title 9 excluded diagnoses (i.e. autism, substance, LD). Percent of total sample for each diagnosis is presented on the x-axis (bottom).



- There are more White youth diagnosed as Bipolar and ADHD than other groups.
- Hispanic youth are more likely to have an Adjustment disorder diagnosis and less likely to be diagnosed with ADHD.
- Asian/Pacific Islander youth are diagnosed with Depression and Adjustment disorders the most.
- African-American youth are diagnosed with Oppositional disorder more often than other groups.

Figure 11: Diagnosis by Gender and Age

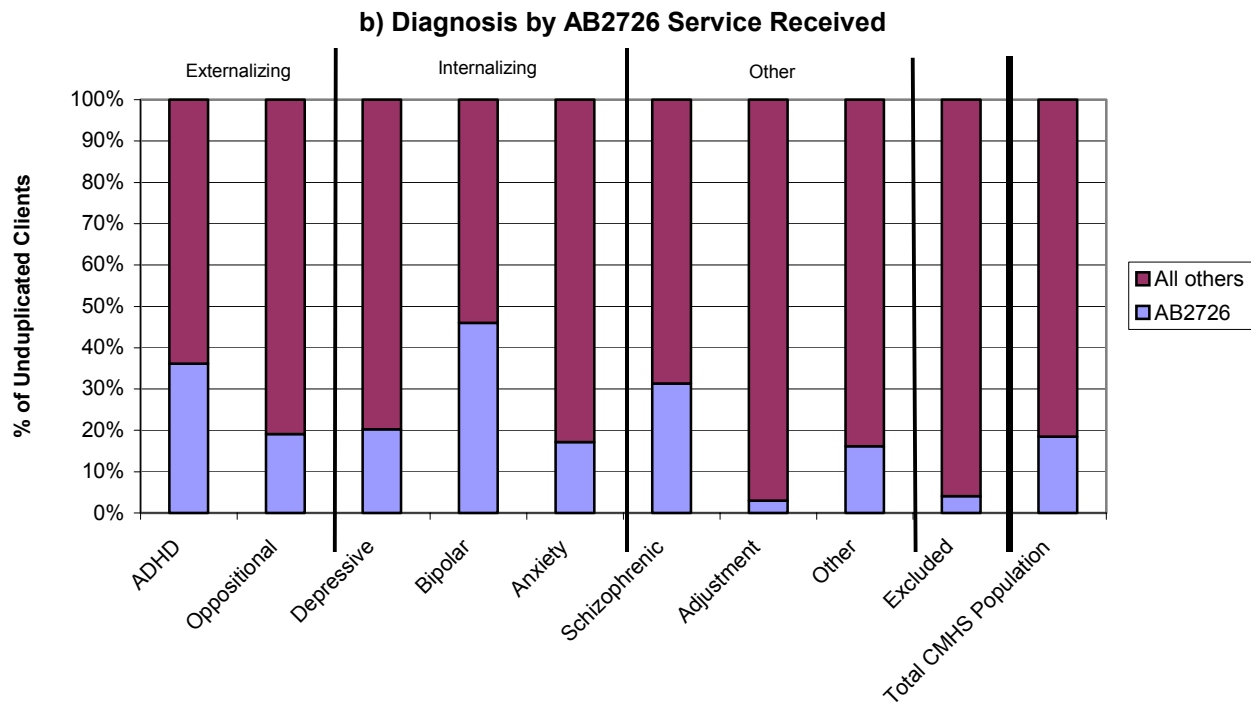
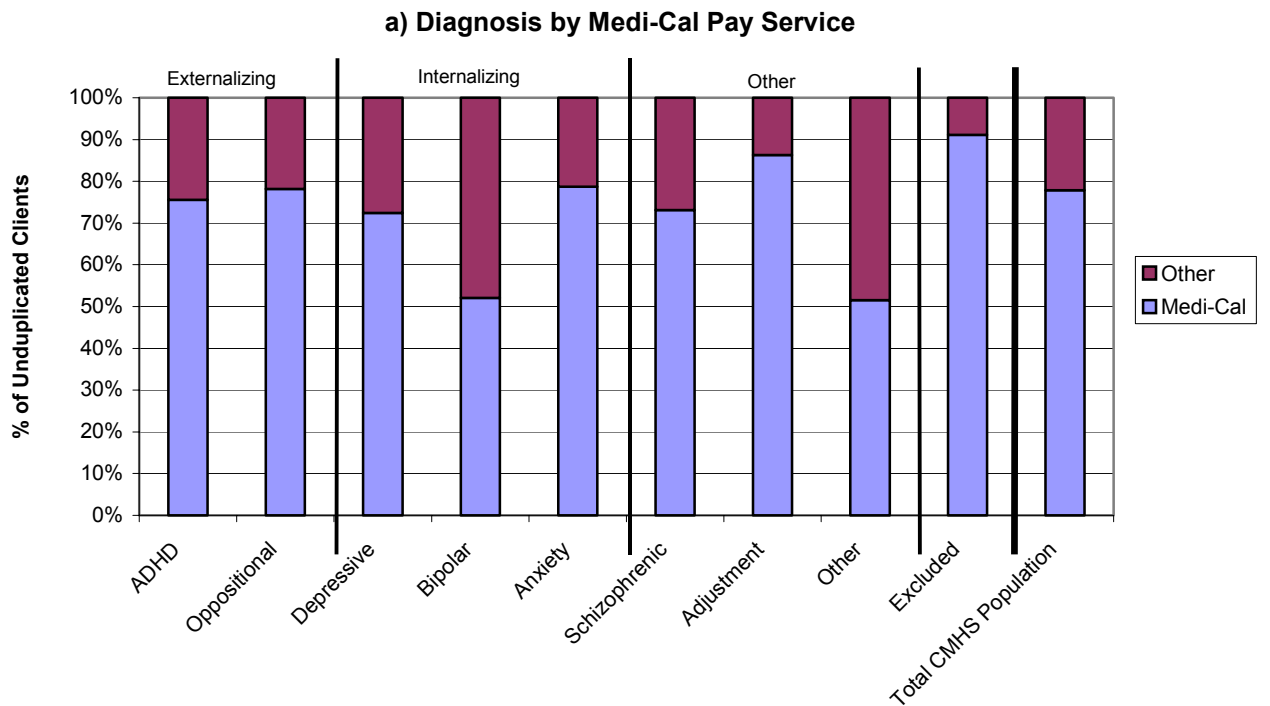
Diagnoses include youth’s primary DSM-IV diagnosis, reimbursable in MH according to Title 9. The “excluded” category includes Title 9 excluded diagnoses (i.e. autism, substance, LD).



- Depressive and Anxiety disorders are occurring equally in males and females.
- Adolescents are more likely to receive services for Depression, Bipolar and Schizophrenia.
- Preschoolers are primarily receiving developmental evaluations (the “excluded” category).

Figure 12: Diagnosis by Medi-Cal and AB2726

Diagnoses include youth’s primary DSM-IV diagnosis, reimbursable in MH according to Title 9. The “excluded” category includes Title 9 excluded diagnoses (i.e. autism, substance, LD).



- Youth with Bipolar and “Other” disorders are more likely to receive services through a funding source other than Medi-Cal.
- Youth in AB2726 services are primarily those with Bipolar and ADHD.

Table 4: Restrictive Levels of Service Utilization by Diagnosis and Race/Ethnicity

The median is the value in the middle of the distribution. It divides the distribution into the lower and upper 50% of the values. The mode is the value that occurs most frequently. The units presented are the number of days by diagnosis and race/ethnic group within each service modality.

Diagnosis	Inpatient			Day TX Int.			Day Rehab			Crisis Stabilization		
		Median Days	Mode Days		Median Days	Mode Days		Median Days	Mode Days		Median Days	Mode Days
ADHD	N=48	7	6	N=123	88	90	N=119	43	1	N=2	1	1
Oppositional/Conduct	N=148	10	4	N=178	56	13	N=351	37	3	N=12	1	1
Depressive	N=331	7	3	N=121	68	1	N=228	36.5	5,9,11 ^a	N=15	1	1
Bipolar	N=73	10	3	N=115	76	21,43 ^a	N=34	27	none	N=9	1	1
Anxiety	N=36	14	none	N=60	91	36	N=65	22	2	N=6	1	1
Adjustment	N=28	6	6	N=52	38	1	N=275	10	2	N=3	1	1
Schizophrenic	N=63	14	14	N=25	38	none	N=19	45	30	N=1	1	1
Other	N=2	102.5	none	N=18	120.5	1	N=8	35.5	none	N=1	1	1
Excluded	N=10	9	9	N=25	40	26,36 ^a	N=280	9	1	N=1	1	1
Invalid	N=3	8	none	N=3	62	none	N=50	2	1	N=0	**	**
Total Sample	N=801	8	3	N=720	65	1	N=1429	19	1	N=50	1	1

Ethnicity	Inpatient			Day TX Int.			Day Rehab			Crisis Stabilization		
		Median Days	Mode Days		Median Days	Mode Days		Median Days	Mode Days		Median Days	Mode Days
White	N=269	10.00	6	N=336	72.00	13	N=448	20.00	1	N=25	1.00	1
Hispanic	N=276	7.00	3	N=185	55	7	N=471	16	2	N=13	1.00	1
Black	N=116	9.00	3,6 ^a	N=148	67.5	3	N=376	25.5	2 ^a	N=7	1.00	1
Asian/Pacific Islander	N=22	8.5	none	N=20	7.00	1	N=47	9.00	2	N=2	1.00	1
Native American	N=9	7.00	none	N=9	23.00	14	N=22	23.5	14	N=0	**	**
Other/Mixed	N=11	5.00	none	N=14	87.5	none	N=31	40.00	none	N=1	1.00	1
Total Sample	N=801	8	3	N=720	65	1	N=1429	19	1	N=50	1	1

^a Multiple statistical modes exist. Multiple values are shown. ** No data given. "None" indicates no clear mode for that cell.

Table 5: Outpatient Service Utilization by Diagnosis

The median is the value in the middle of the distribution. It divides the distribution into the lower and upper 50% of the values. The mode is the value that occurs most frequently. The units presented are the number of minutes by diagnosis within each service modality. Numbers in parentheses are included to show number of 1 hour sessions (30 minutes for Med. Support).

Diagnosis	Collateral			Therapy			Case Management			Assessment		
		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins
ADHD	N=1524	533 (9)	30 (<1)	N=1608	812.5 (14)	60 (1)	N=922	267.5 (5)	60 (1)	N=432	100 (2)	50 (1)
Oppositional/ Conduct	N=1605	405 (7)	30 (<1)	N=924	710 (12)	50 (1)	N=1605	260 (4)	15 (<1)	N=444	100 (2)	50 (1)
Depressive	N=1533	375 (6)	60 (1)	N=1686	660 (11)	60 (1)	N=1081	240 (4)	60 (1)	N=448	100 (2)	50 (1)
Bipolar	N=439	607 (10)	30 (<1)	N=399	730 (12)	60 (1)	N=339	1240 (21)	30 (<1)	N=93	120 (2)	50 (1)
Anxiety	N=697	420 (7)	30,60 ^a (1)	N=771	765 (13)	60 (1)	N=463	260 (4)	60 (1)	N=189	100 (2)	50 (1)
Adjustment	N=1497	331 (6)	30 (<1)	N=1711	630 (11)	240 (4)	N=984	211.5 (4)	30,60 ^a (1)	N=573	150 (3)	50 (1)
Schizophrenic	N=129	549 (9)	30 (<1)	N=135	550 (9)	60 (1)	N=115	683 (11)	60 (1)	N=43	50 (1)	50 (1)
Other	N=175	420 (7)	45 (<1)	N=181	705 (12)	180 (3)	N=95	140 (2)	30 (1)	N=32	180 (3)	180,240 ^a (3,6)
Excluded	N=267	200 (3)	50 (1)	N=626	450 (8)	200 (3)	N=135	270 (6)	20,130 ^a (1,2)	N=909	50 (3)	180 (3)
Invalid	N=542	142.5 (2)	50 (1)	N=2463	300 (5)	50 (1)	N=232	375 (5)	120 (1)	N=1696	180 (1)	50 (1)
Total Sample	N=9478	305 (5)	30 (1)	N=13,648	465 (8)	50 (1)	N=5427	270 (5)	60 (1)	N=4859	70 (1)	50 (1)

^a Multiple statistical modes exist. Multiple values are shown. ** No data given. "None" indicates no clear mode for that cell.

Table 6: Outpatient Service Utilization by Diagnosis

The median is the value in the middle of the distribution. It divides the distribution into the lower and upper 50% of the values. The mode is the value that occurs most frequently. The units presented are the number of minutes by diagnosis within each service modality. Numbers in parentheses are included to show number of 1 hour sessions (30 minutes for Med. Support).

Diagnosis	Med. Support			Crisis Services			TBS		
		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins
ADHD	N=1192	191 (3)	90 (3)	N=239	105 (2)	90 (2)	N=42	5227 (87)	none
Oppositional/ Conduct	N=924	180 (3)	60 (2)	N=589	139 (2)	60 (1)	N=55	6705.89 (90)	5385 (90)
Depressive	N=1004	156.5 (3)	60 (2)	N=612	165 (3)	120 (1)	N=22	3337.5 (56)	8730 (146)
Bipolar	N=333	310 (5)	90 (3)	N=241	140 (2)	90 (2)	N=34	5372.5 (90)	2622 (44)
Anxiety	N=398	165 (3)	60,90 ^a (2)	N=137	135 (2)	60 (1)	N=25	3455 (58)	none
Adjustment	N=533	90 (2)	60 (2)	N=432	90 (2)	60 (1)	N=8	6855 (114)	none
Schizophrenic	N=119	255 (4)	60 (2)	N=91	200 (3)	60,90 ^a (1)	N=5	11505 (192)	none
Other	N=63	194 (3)	30 (<1)	N=66	90 (2)	60 (1)	N=1	5490 (92)	5490 (92)
Excluded	N=192	135 (2)	60 (2)	N=402	90 (2)	60 (1)	N=2	1082.5 (18)	none
Invalid	N=264	40.5 (1)	15 (<1)	N=72	60 (1)	60 (1)	N=0	** **	** **
Total Sample	N=5467	150 (5)	60 (2)	N=330 1	120 (2)	60 (1)	N=194	5280 (88)	330 ^a (6)

^a Multiple statistical modes exist. Multiple values are shown. ** No data given. "None" indicates no clear mode for that cell.

Table 7: Outpatient Service Utilization by Race/Ethnicity

The median is the value in the middle of the distribution. It divides the distribution into the lower and upper 50% of the values. The mode is the value that occurs most frequently. The units presented are the number of minutes received by race/ethnic group within each service modality. Numbers in parentheses are included to show number of 1 hour sessions (30 minutes for Med. Support).

Ethnicity	Collateral			Therapy			Case Management			Assessment		
		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins
White	N=3173	406 (7)	30 (<1)	N=4082	550 (9)	50 (1)	N=1864	328.5 (6)	60 (1)	N=1542	90 (2)	50 (1)
Hispanic	N=3921	279 (5)	60 (1)	N=5291	450 (8)	50 (1)	N=2294	211.5 (4)	60 (1)	N=1509	100 (2)	50 (1)
Black	N=1422	310 (5)	30 (<1)	N=2085	500 (8)	50 (1)	N=801	340 (6)	15 (1)	N=756	100 (2)	50 (1)
Asian/Pacific Islander	N=293	300 (5)	30 (<1)	N=400	445 (7)	150 (2)	N=196	330.5 (6)	120 (2)	N=118	100 (2)	50 (1)
Native American	N=87	470 (8)	30,60 ^a (<1)	N=116	435 (7)	200 (3)	N=63	420 (7)	none	N=46	75 (1)	50 (1)
Other/Mixed	N=178	124.5 (2)	15,60 ^a (<1)	N=345	250 (4)	50 (1)	N=83	210 (4)	none	N=54	50 (1)	50 (1)
Total Sample	N=9478	305 (5)	30 (1)	N=13,648	465 (8)	50 (1)	N=5427	270 (5)	60 (1)	N=4859	70 (1)	50 (1)

Ethnicity	Med. Support			Crisis Services			TBS		
		Median Mins	Mode Mins		Median Mins	Mode Mins		Median Mins	Mode Mins
White	N=2038	175 (6)	60 (2)	N=1089	120 (2)	50 (1)	N=89	5490 (92)	3168 (53)
Hispanic	N=1964	134.5 (4)	60 (2)	N=1264	110 (2)	60 (1)	N=43	3450 (58)	none
Black	N=951	160 (6)	60 (2)	N=584	120 (2)	60 (1)	N=47	5280 (88)	none
Asian/Pacific Islander	N=128	150 (6)	60,120 ^a (2)	N=143	106 (2)	60 (1)	N=1	6375 (106)	6375 (106)
Native American	N=54	90 (4)	90 (3)	N=33	120 (2)	none	N=1	6835 (114)	6835 (113)
Other/Mixed	N=85	165 (6)	60 (2)	N=78	117.5 (2)	60 (1)	N=3	6343 (106)	none
Total Sample	N=5467	150 (5)	60 (2)	N=3301	120 (2)	60 (1)	N=194	5280 (88)	330 ^a (6)

^a Multiple statistical modes exist. Multiple values are shown. ** No data given. "None" indicates no clear mode for that cell.

Intensive Services Evaluation Project

The federal Substance Abuse and Mental Health Services Administration (SAMHSA), in collaboration 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 and diffuse them 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 continued to serve and collect data on new clients until the summer of 2003. Follow-up data was collected by trained interviewers consecutively at 6-month intervals for the duration of the evaluation, which ended in August of 2003. This evaluation project provided the opportunity for up to 3 years of longitudinal data collected on youth who entered the system in 1999, whether or not they remained in services.

The goals for SD County and the broader national study were 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, costly, out-of-home care.

Children and adolescents were eligible to receive services from these more intensive wraparound-based system of care programs and could participate in the evaluation process if: a) they were less than 17.5 years old, b) they had 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 were at risk for a restrictive level of care.

The county implemented four intensive service programs for 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. 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, were 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 is presented separately for youth receiving short-term intensive case management services and for youth receiving long-term intensive case management services regardless of program. A short-term intensive case management service is defined as service received from one of the programs above for less than 6 months. A long-term intensive case management service is defined as service received from one of the programs for more than 6 months; often these youth received services for over 1 year. The data for the short-term and long-term samples are presented separately for each of the outcome measures. This allows direct comparisons to be made between relatively short (3-6 month) and more involved (typically about 1 year in length) wraparound based services. These comparisons allow for an initial examination of dosage effects, or otherwise stated, the required

amount of services needed for clinical improvement and positive life changes for youth and families.

Definitions

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 were collected by trained, independent interviewers at 6-month intervals for the duration of the evaluation (maximum of three years). The follow-up assessments were collected at each consecutive time point regardless of the type or amount of services the youth were receiving. Some youth may not have been 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 provides information on treatment results 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 assessment battery include measures assessing outcomes in multiple domains, including functional behaviors, symptomatology, social competence, caregiver stress, family resources, delinquent behaviors, educational behaviors and substance use. Refer to chapters 5 and 6 (pg. 32-33 and page 53) for a short description of each of the measures. There is also a sample of youth receiving services from BEST or CYFN who completed additional measures regarding educational performance and family involvement as a requirement of the AB3015 or SB163 evaluation protocols. This data is presented in the Community Functioning Outcomes and Consumer Perspectives chapters of this report.

Fiscal Year: The fiscal year for the Intensive Services Evaluation Project (ISEP) was October 1 through September 30 for each year except for the last fiscal year, which ended on August 31, 2003. The fiscal years represented in this report are 1998-1999, 1999-2000, 2000-2001, 2001-2002 and 2002-2003. Note, the ISEP assessments for the 1998-1999 year began in April 1999; therefore, this year represents 6 months of data.

Total Data Processed

Figure 13 presents 1) the number of completed baselines in the Intensive Services Evaluation Project for all the fiscal years by program and 2) the number of completed follow-ups since the project began recruiting youth in March 1999 and obtaining baselines in April 1999. The ISEP Enrollees by Cohort, bottom of page 34, shows the three cohorts of participants in ISEP. Each cohort represents youth and families who received services and who agreed to participate in the evaluation. For Cohort 1, the TOWER, BEST and CITY programs were active and the percentage of youths involved in services was much greater for the TOWER program, followed by CITY and then BEST. The percentages are different across programs because of program size, and when these programs were included as part of the CMHS funding. For Cohort 2, Lab/WRAP services were available, and for Cohort 3, CYFN began serving youth and families while Lab/Wrap youths were included in other programs or no longer received services.

Represented Samples

Is the ISEP sample representative of all the youth receiving intensive services? Overall the sample included in the evaluation is representative of youth receiving intensive case management services. Eighty-six percent of families of youth receiving intensive services participated in the evaluation project (n=303). 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 involving 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% who declined 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.

Wraparound Population History

Information was collected on all youth and families that enter into any of the wraparound-based programs mentioned above. This information was collected with the Descriptive Information Questionnaire as part of the intake to services assessment packet. The caregivers reported on youth history of particular risk factors, family history of particular risk factors, youth chronic health problems, insurance type and youth previous service utilization. Because the data was collected on all youth and families regardless of their participation in the ISEP evaluation the number of youth and families (n=811) reporting on these variables is significantly larger than the ISEP sample. Refer to Figures 14 & 15. Over 40% report youth history of psychiatric hospitalization and/or ran away from living environment. Approximately 40% of youth have also had substance abuse and/or a chronic health problem. 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 36% of the families include a biological parent that has received some form of treatment for substance abuse. Additionally, over 50% of the families report family violence, family mental illness and/or biological parent conviction of a crime. Twenty-three percent of the families report a biological parent having been in a psychiatric hospital in the past. Thirty-nine percent of the youth in these programs have a chronic health problem in addition to their mental health issues. Of these youth, 61% are taking medication for their health problem. Over half of the families report having Medi-Cal insurance (66%). 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 (71%) and/or psychotropic medication (69%). Other previous services include day treatment (34%), residential treatment (46%) and/or substance abuse treatment (24%).

Service

The youth involved in either long-term (primarily BEST, CITY and CYFN) or short-term (primarily 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 considered “restrictive,” such as hospitalization, residential placements, day treatments, group homes or juvenile camp environments. The “other” services category primarily consists of caregiver reports of probation or mentor services. Intensive case management programs strive 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 16 & 17). At 6 months, approximately 92% of the youth

who participate in long-term services continue to receive case management services, and 83% receive individual therapy. At 1 year, these percentages drop to 76% and 81% respectively, with percentages at 2 years down to 67% and 58% respectively. However, only 40% of the youth in the short-term services sample receive case management services at 6 months, 22% receive them at 1 year and only 12% receive them at 2 years. Yet, approximately 52-59% of the youth receive individual therapy at 6 months and 1-year follow-up assessment, with a drop to 32% at 2 years. This means that youth are continuing to receive traditional services post involvement with the short-term case management program, which typically lasts from 3-6 months. Two-thirds of the long-term youth receive psychotropic medications at 6 months, and about 1/2 receive medication at 1-year and 2-year follow-up. Between 35-45% of the youth in the short-term case management sample receive medication at all three time points, with the highest percentage receiving them at 1-year follow-up. Approximately 26% of the long-term youth and 18% of the short-term youth also receive services related to participation in recreational activities at 6 months. At 1-year follow-up, 35% of long-term youth and 18% of short-term youth receive recreational services. The percentage of youth receiving these services drops to 21% for long-term and 9% for short-term youth at 2 years. Another innovative service that is received in about 1/4 of both samples at 6 months is transportation services (typically to and from a traditional service program). This percent of youth receiving transportation services decreases to 20% of long-term and 6% of short-term youth at 2 years. The percentage of youth in the long-term sample involved in “restrictive” services decreased from 6 months to 2 years for all categories (hospitalization 15% to 7%, day treatment 25% to 11%, residential 23% to 14%, residential camp 3% to 1%), with the exception of therapeutic group home (14% to 17%) and therapeutic foster care (0% to 1%). The short-term sample shows some reduction in restrictive services for day treatment (7% to 0%), therapeutic group home (10% to 9%) and residential camp (7% to 3%). However, there are increases in hospitalizations (3% to 9%) and residential care (9% to 15%). It is the goal of the Intensive Services programs to reduce the number of youth who participate in restrictive services over time. Youth in long-term case management programs are more often involved in restrictive levels of services at entry into services. However, there are reductions in services at follow-ups, revealing some success in keeping children in home or home-like settings.

Sample Demographics

Three hundred and three youth/families have participated in the evaluation. Sixty-nine percent of these youth are males; 31% are females. The majority are adolescents 14 to 17 years old, with an average age of 14.44 years (range from 6-18 years old) at intake. The mean number of members living in the household is 4.5, with the mean number of children 2.74. Seventy-eight percent of youth are living with a biological parent(s). The median income is \$10,000-14,999, with the majority of families earning less than \$20,000 a year (Figure 18a). Few parents of youth report having a college degree (12%), and 30% of parents report having less than a high school diploma (Figure 18b). The youth and families are primarily from White or Hispanic race/ethnicity backgrounds with very few families from Asian/Pacific Islander or Native American groups (Figure 18c). The data was collected in Spanish for 16% of the interviews with parents and <1% for youth.

Family Resources

Information on the availability of adequate amounts of resources for families was collected from caregiver report, using 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 19 presents the top 4 resources rated as adequate and the bottom 4 resources rated as inadequate for both the long-term and short-term case management samples. About 85-90% of families report that resources related to basic needs are adequate at intake, 1 year and 2 years. There are a few slight increases in the number of families in the short-term sample at 2-year follow-up that report adequate levels of house, heat and indoor plumbing/water. Very few families in either sample report adequate levels of resources related to growth and support aspects of quality of life. There is a slight increase from intake to 2 years for the long-term sample on amount of money in savings and for the short-term sample on money to buy things for self (14% increase).

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 youth. Youth in the short-term intensive case management program show a greater change in points by 2-year follow-up, however this change is not significant due probably to the smaller sample size. The data for the short-term group does not show consistent reduction, but rather a more wavelike pattern of improvements with some increases in impairment prior to the more dramatic decreases (Figure 20). By examining the data by each CAFAS subscale, the long-term group reveals significant linear effect improvements for the role performance, moods/emotions and behavior towards others subscales. The short-term group reveals no significant linear effect improvements on any of the 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. They use information from the parent interviews to make the ratings.

Per parent interview report on the CBCL (administered by a trained interviewer), there are statistically significant linear effect improvements in the 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 21). 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 22). Both parent and youth report data show significant linear effect improvements for both samples in youth internalizing and externalizing subscales.

Comparing initial change scores for the long-term intensive case management group on the CBCL and YSR from intake to 1-year follow-up, parents and youth report similarly. They both report youth changing positively or staying the same more often than negative change. However, the youth report slightly more initial positive change; the parents report slightly more no change. Interviewer reports recorded on the CAFAS reveal higher percents of no change occurring. From 1 year to 2 years, youth report more positive change while parents report slightly more no change. Interviewer ratings report similar levels of positive, no and negative change from 1 year to 2 years. For the short-term intensive case management group, interviewer, parent and youth reports reveal similar patterns. From intake to 1 year all informants report more positive change than no or negative change. From 1 year to 2 years parents and interviewer ratings indicate more positive change, while youth report equal amounts of positive and no change. Refer to Figures 23, 24 & 25.

On the Caregiver Strain Questionnaire (CGSQ) there are statistically significant linear effect improvements for objective, subjective-internalized and global domains for families receiving long-term services. There are improvements on all domains (objective, subjective-externalized, subjective-internalized and global) for families receiving short-term services from baseline to 2 years (Figure 26). There are also specific statistically significant changes calculated by pairwise comparisons for objective, subjective-internalized and global caregiver

strain for the long-term and short-term groups with additional significant changes by pairwise comparisons for the short-term group for subjective-externalized. This suggests 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 statistically significant gains by pairwise comparisons on interpersonal and intrapersonal strength for the long-term case management group. The long-term group also shows linear effect improvements on all subscales (interpersonal, intrapersonal and affective strength, family involvement) with the exception of school functioning. For the short-term case management group, there are no significant linear effects or significant improvements on pairwise comparisons (Figure 27).

Table 8:

Brief Description of ISEP Clinical Measures

*Note: a trained interviewer administered all measures

Descriptive Information Questionnaire (DIQ)

- A survey to collect demographic and descriptive information on the family and child's previous history. It includes data on age, race, ethnicity and family background.
- All data collection instruments include a brief list of administrative items that should be completed by the interviewer to indicate how the questionnaire was administered (e.g., language, type of respondent, date of the questionnaire).
- Developed by Macromedia International, Inc.

Multi-Sector Service Contacts (MSSC)

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

Family Resource Scale (FRS)

- Assesses the caregiver's perception of the adequacy of the resources (e.g., food, shelter, money for bills) available to the family in the past 6 months. It asks about 30 common resources ranging from basic needs to resources related to quality of life.
- Developed by Macromedia International, Inc.

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 and disruption of functioning)
Thinking (rational thought processes)
- Developed by Kay Hughes, Ph.D.
- Separate version for ages 6 – 18 (CAFAS) and 4 – 5 (PECFAS).

Child Behavior Checklist (CBCL)

- Assesses social competence, behaviors and emotional problems according to the caregiver's report.
- Includes social competence section (Activities, Social Involvement and School) and Emotional/Behavior problems section (Internalizing, Externalizing and Total).
- Developed by Thomas Achenbach, Ph.D. (version 1991).

Youth Self-Report (YSR)

- Assesses an adolescent's perceptions of his or her social competence and behavioral and emotional problems.
- Includes social competence section (Activities, Social Involvement and School) and emotional/behavior problems section (Internalizing, Externalizing and Total).
- Developed by Thomas Achenbach, Ph.D. (version 1991).
- Measure is used for ages 11 – 18.

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.

Behavioral and Emotional Rating Scale (BERS)

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

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 caregiver's 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.

Figure 13: Intensive Services Evaluation Project (ISEP) Assessments Completed

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

1998-1999, 1999-2000, 2000-2001, 2001-2002 and 2002-2003 Fiscal Years

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

Number of Completed Follow-up Assessments by Timeframe from 4-9-1999 to 8-31-2003

Timeframe	# of Assessments	# of Eligible Assessments	Follow-up Completion Rate
Completed 6-month follow-ups	264	306	86%
Completed 1-year follow-ups	262	306	86%
Completed 18 month follow-ups	260	306	85%
Completed 2-year follow-ups	220	266	83%
Completed 30 month follow-ups	142	191	74%
Completed 3-year follow-ups	111	152	73%

Note: Follow-up assessments were completed as participants reached a given follow-up time point. Total number of assessments and completion rates include at least one informant's assessment (youth or family) per time point. There are some fluctuations of percents of completion rate by informant and by timeframe. Not all informants (parents and youth) completed each measure at each time point. For example, at 6-month follow-up 79% of parents and 75% of youth completed an assessment. The overall combined follow-up rate was 86%. At 2-year follow-up 68% of parents and 72% of youth completed an assessment. The overall combined follow-up rate was 83%.

ISEP Enrollees by Cohort

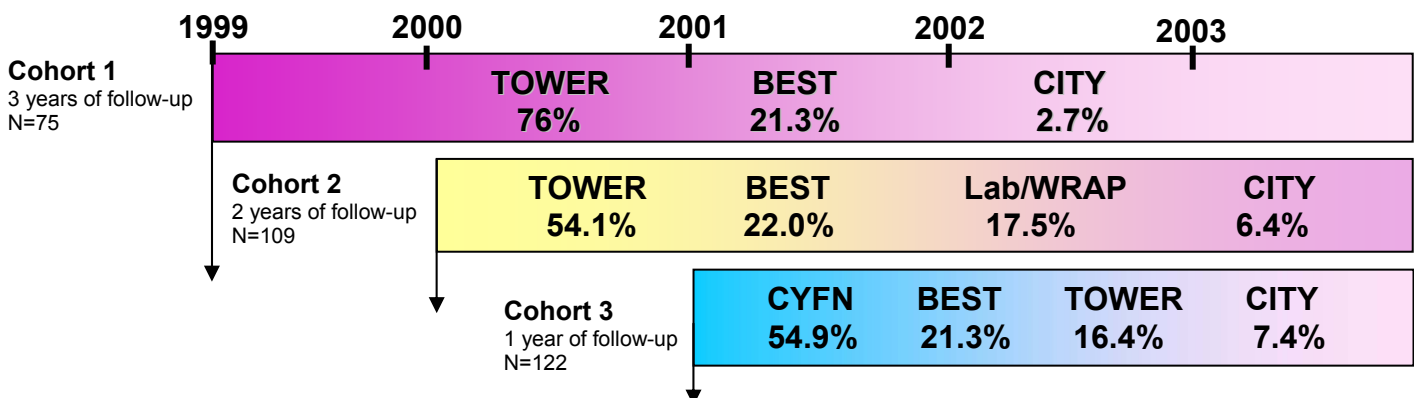
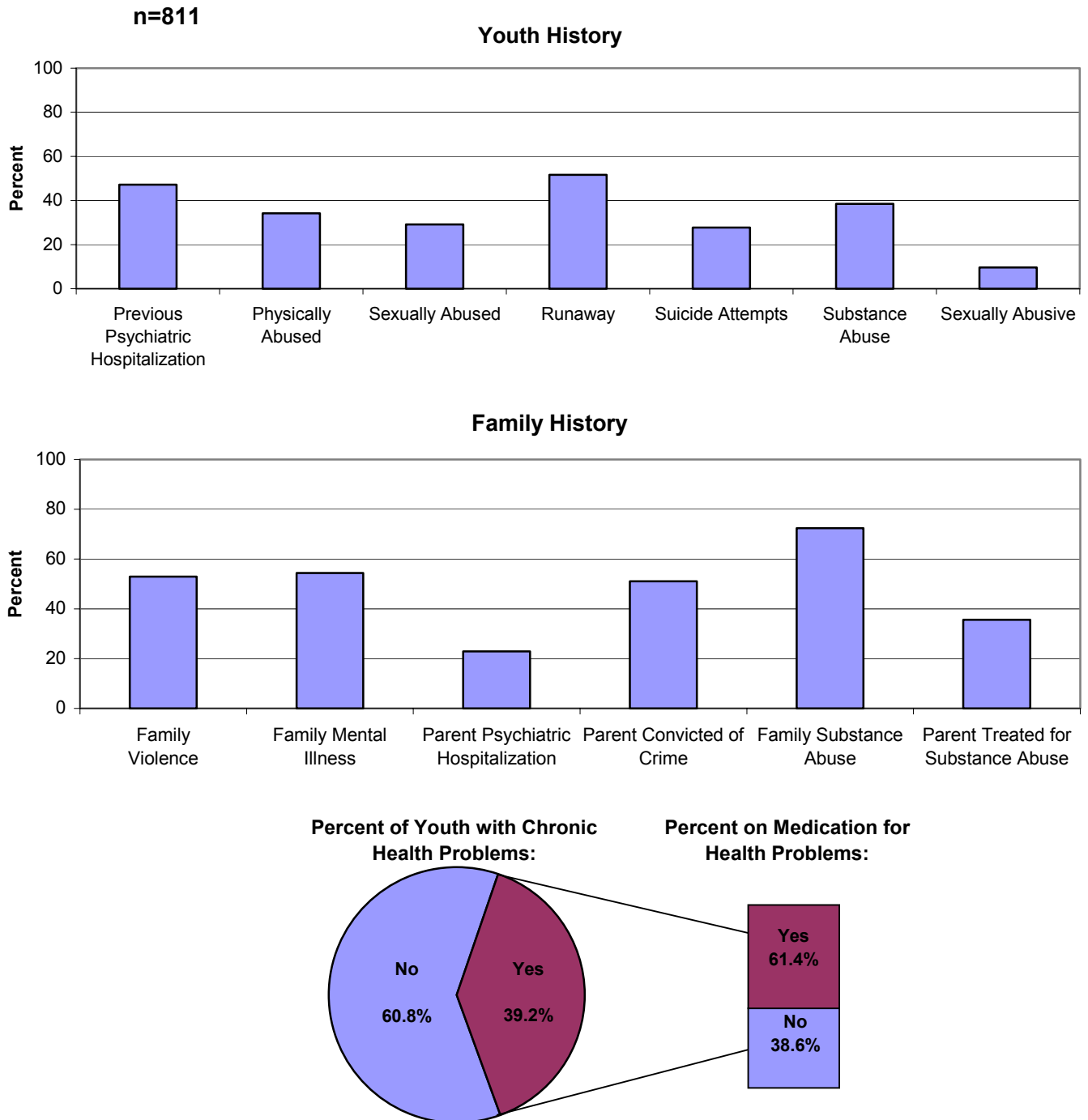


Figure 14: Wraparound Population History of Risk Factors

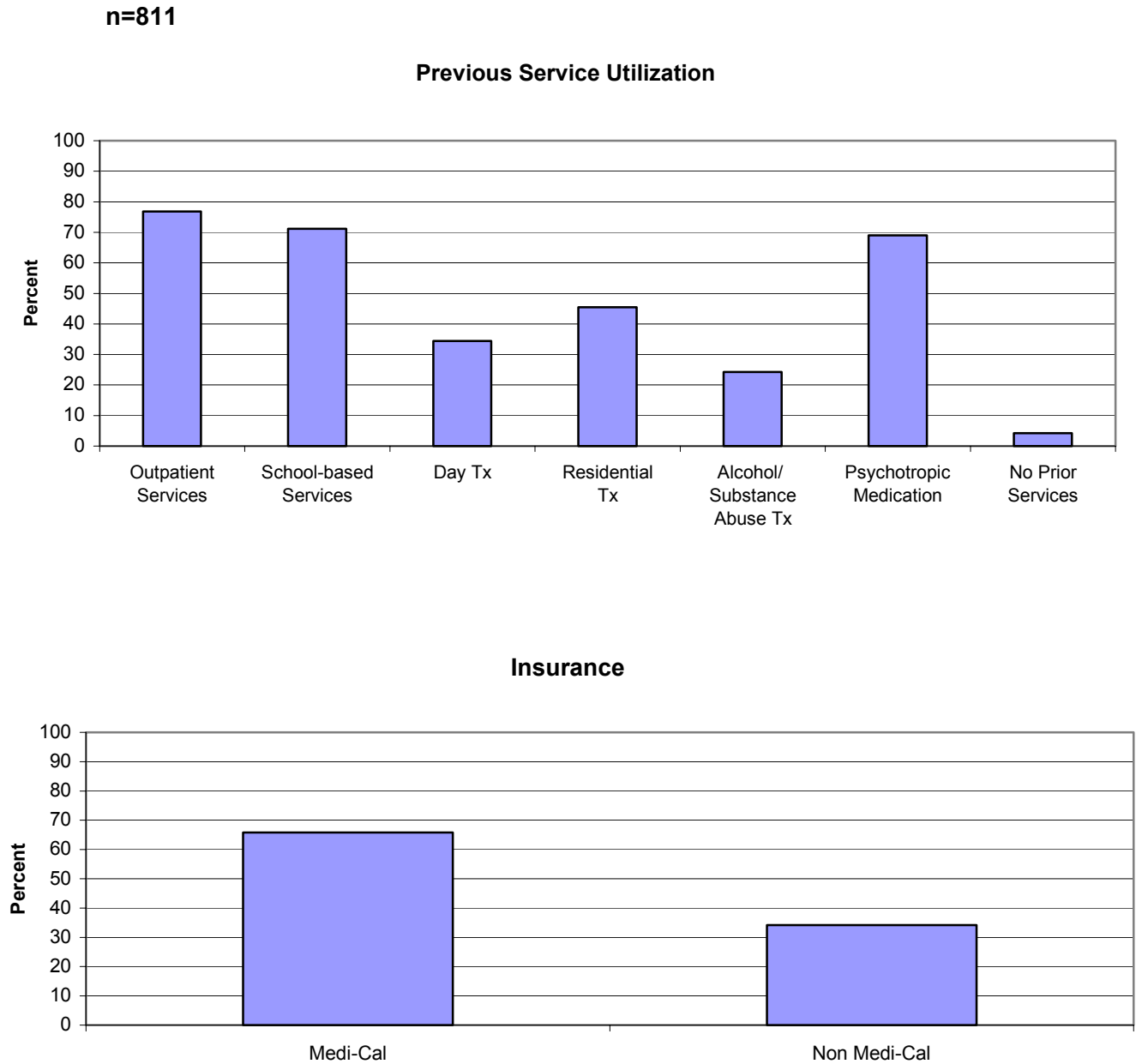
The information was collected from caregiver report on the Descriptive Information Questionnaire. It provides information about youth and family history, as well as service history. All families participating in wraparound programs responded to these questions, whether they participated in the ISEP evaluation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



- Over 40% of the youth have had previous psychiatric hospitalization and/or ran away from their living environment. Approximately 40% of youth also have had substance abuse and/or a chronic health problem.
- Over 50% of the families have a history of violence, mental illness and/or parental conviction of crime. 70% have a family history of substance abuse.

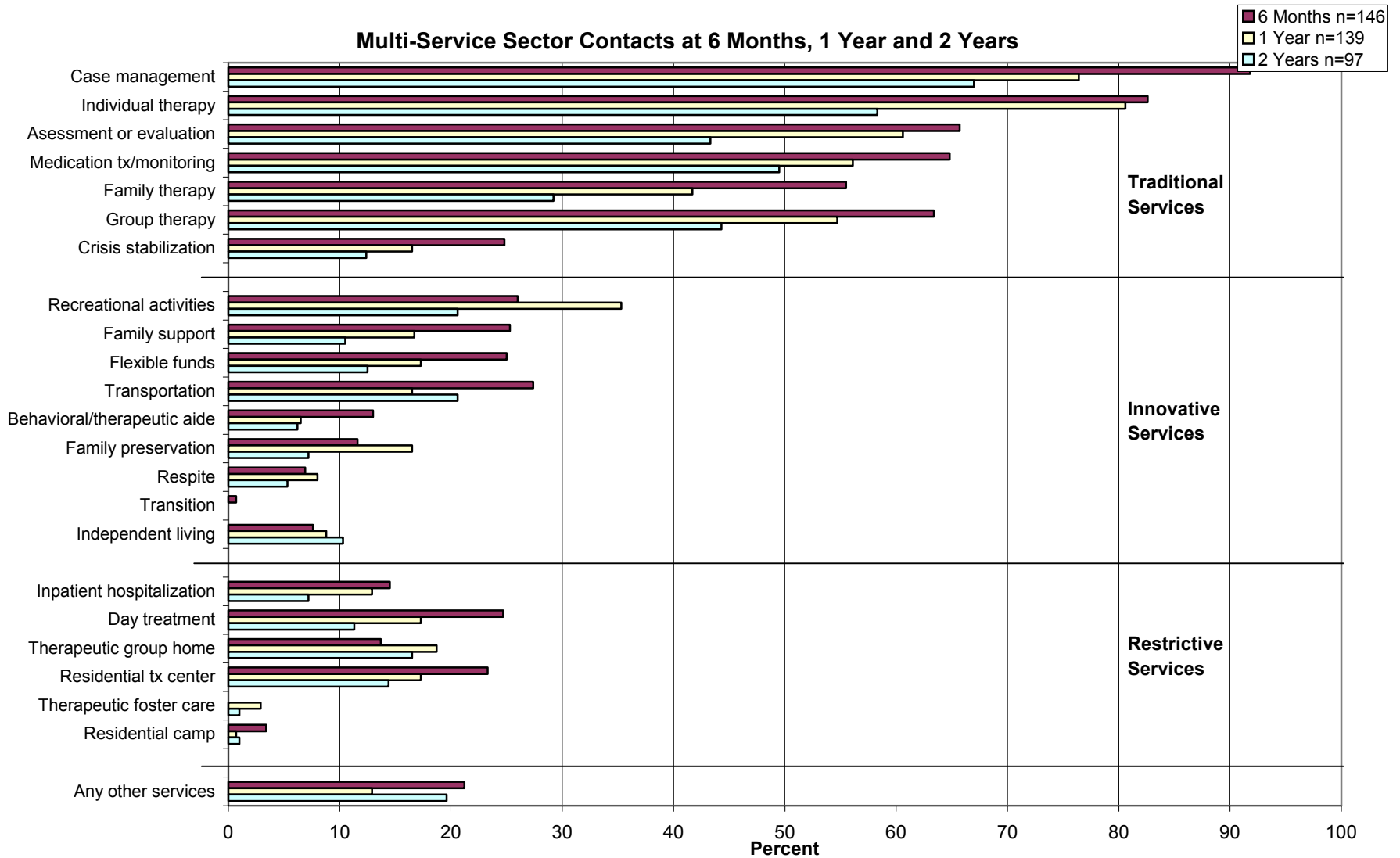
Figure 15: Wraparound Population History of Services

The information was 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.



- The majority of youth have received prior services in an outpatient and/or school-based program and 70% have received psychotropic medication.
- Most youth are Medi-Cal recipients.

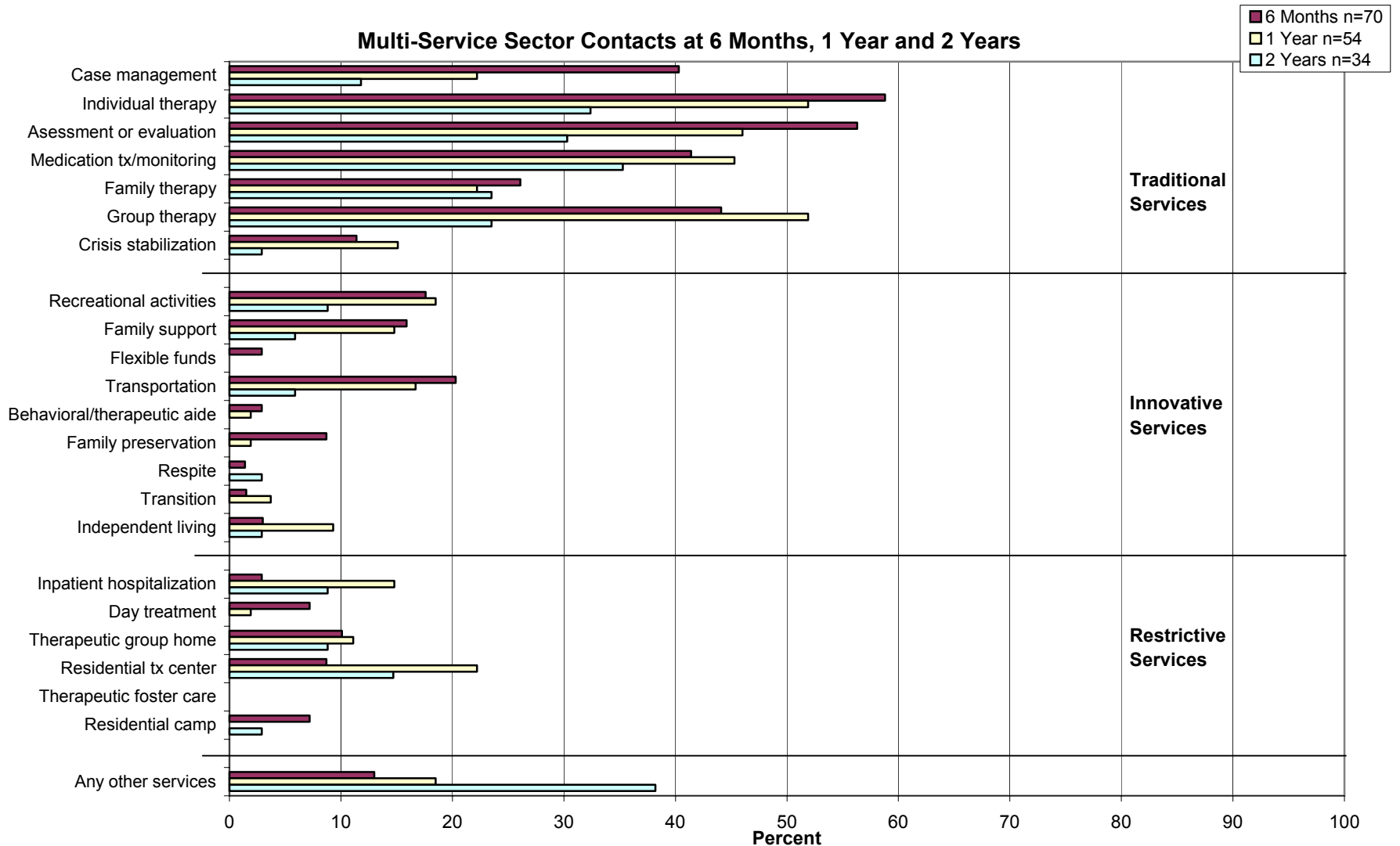
Figure 16: Parental Report of Types of Services Received at Least One Time During the Last 6 Months at Each Time Point: Long-term Intensive Service Case Management Program



Note: "Other" services consist primarily of probation and mentor services.

- Most youth continue to receive "traditional" types of services, but their use of traditional services reduces over time with the exception of crisis stabilization services (based on linear effect analyses, $p < .05$).

Figure 17: Parental Report of Types of Services Received at Least One Time During the Last 6 Months at Each Time Point: Short-term Intensive Service Case Management Program



Note: "Other" services consist primarily of probation and mentor services.

- About 1/3 of youth continue to receive "traditional" types of services, and their use of these services is not significantly reduced over time (based on linear effect analyses), as is demonstrated in the long-term intensive case management services sample.

Figure 18: ISEP Income Distribution, Caregiver Educational Level and Race/Ethnicity for Participants in both Long-term and Short-term Case Management Programs

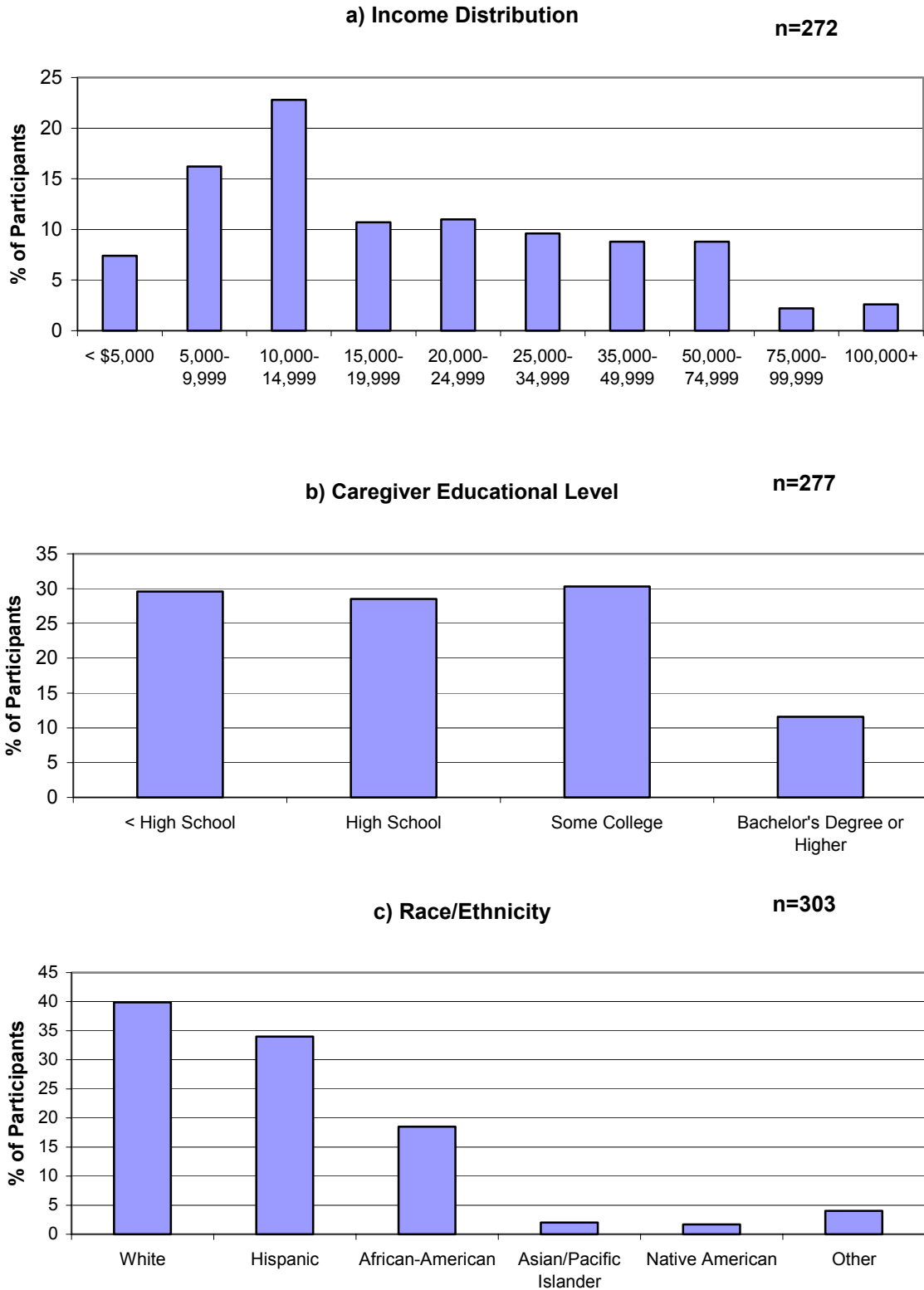
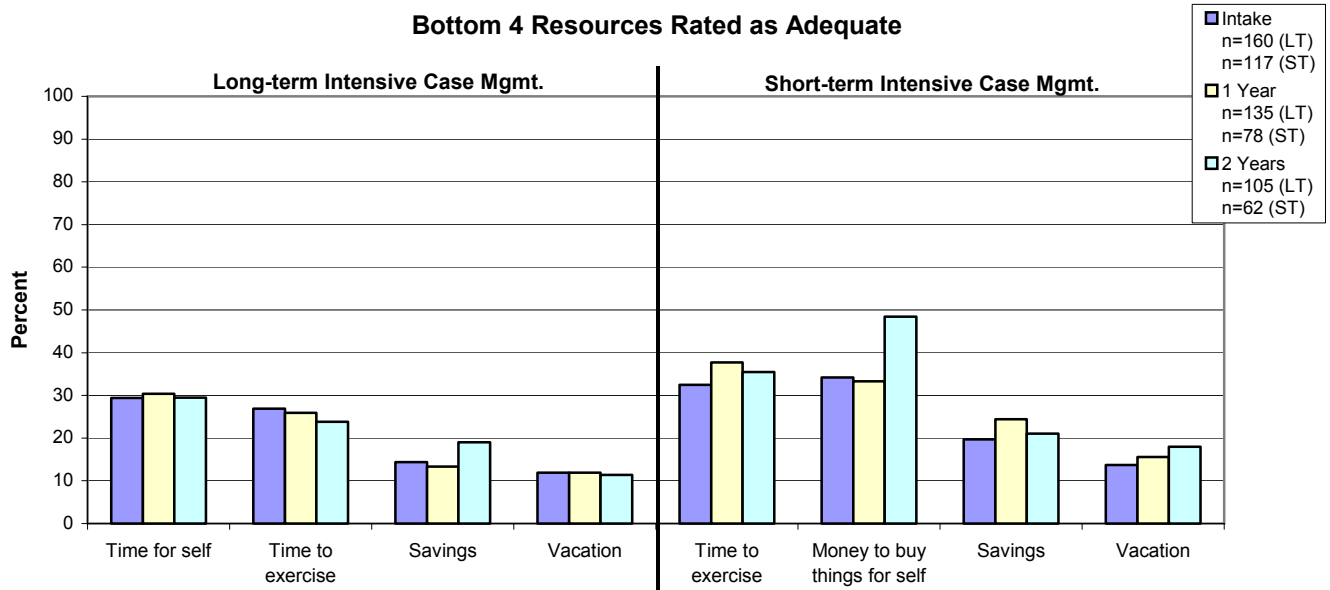
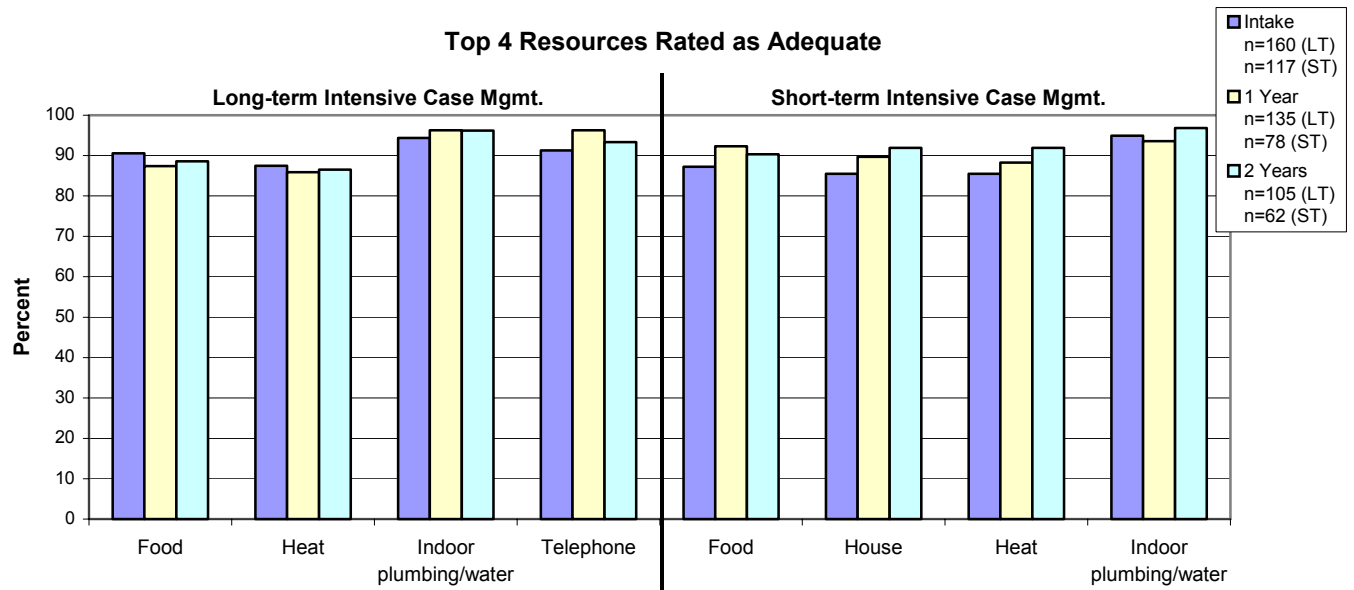


Figure 19: Family Resource Scale

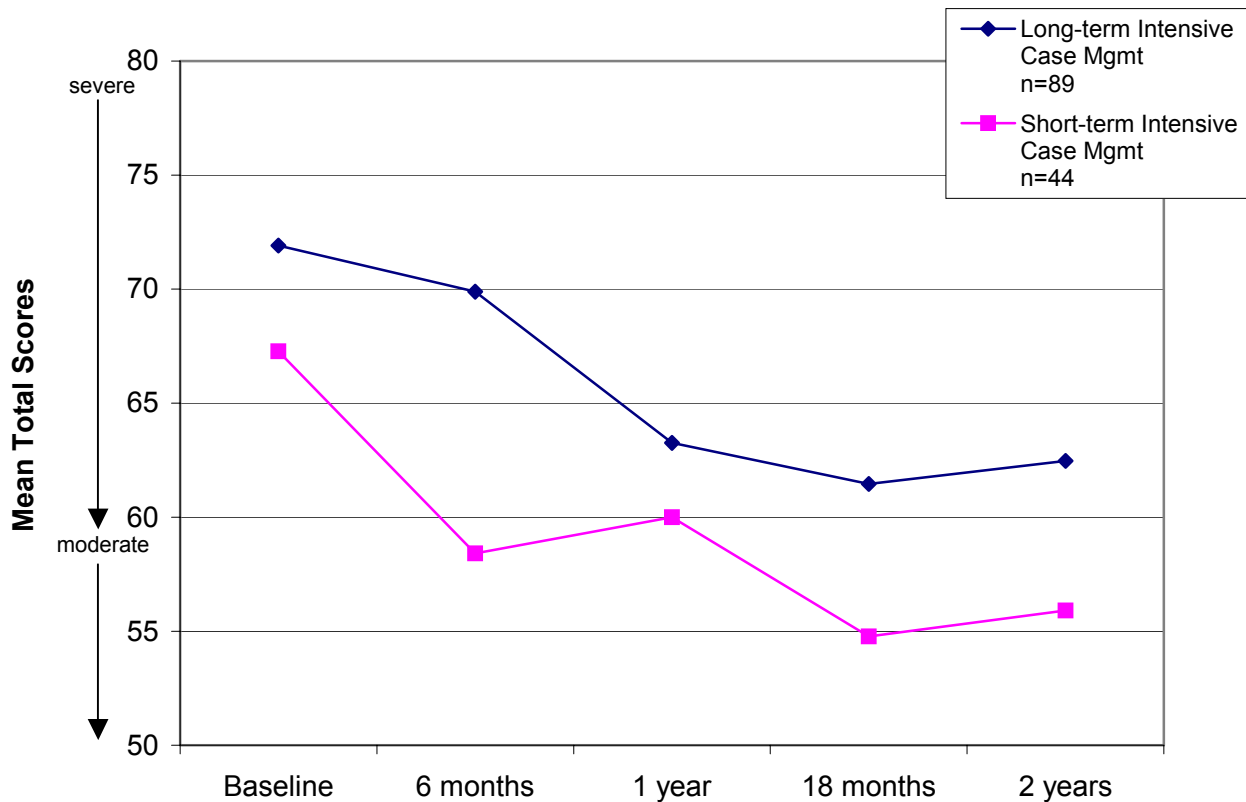
The Family Resource Scale is a caregiver report on the adequacy of resources to meet the family's needs. Caregivers report on a total of thirty resources. The top 4 resources (highest percentage of caregivers reporting as adequate) and the bottom 4 resources (lowest percentages of caregivers as reporting as adequate) are presented.



- About 85-90% of the families in both samples report adequate levels of resources related to meeting basic needs.
- Very few families in either sample report adequate levels of resources related to quality of life (i.e. growth and support).

Figure 20: 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 is meaningful change (less functional impairment) from baseline to 2 years for youth in long-term and short-term intensive case management programs. This change is statistically significant for youth in long-term programs (based on linear effect analysis, $p < .01$).
- Youth in the long-term intensive case management programs demonstrate greater improvements at 1 year compared to youth in short-term intensive case management programs.
- Youth in the long-term intensive case management programs were not significantly more impaired at intake than youth in the short-term intensive case management programs.

Figure 21: 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.

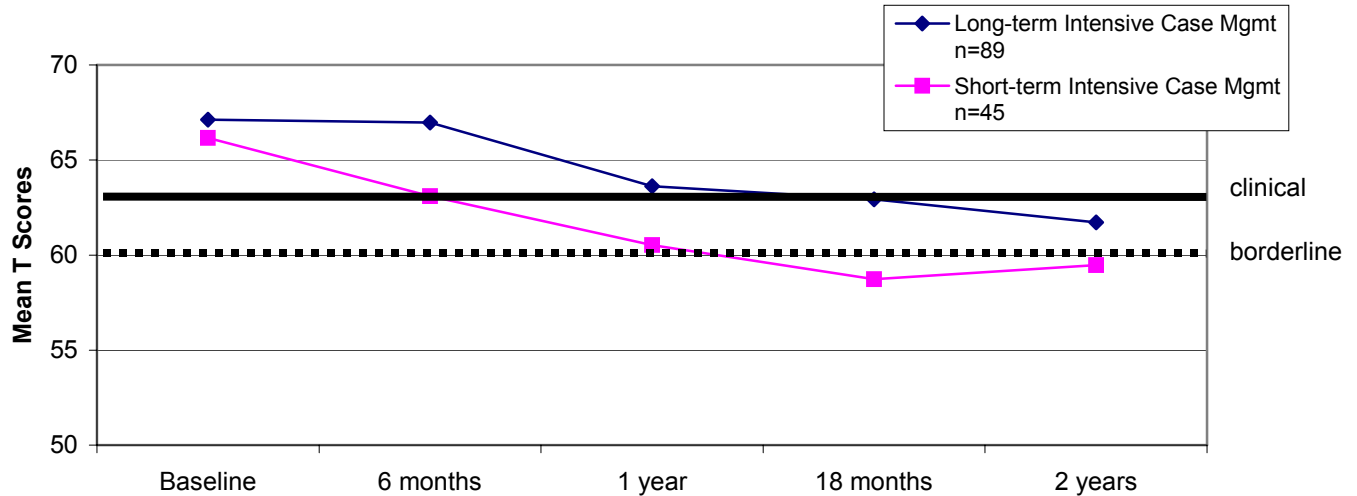
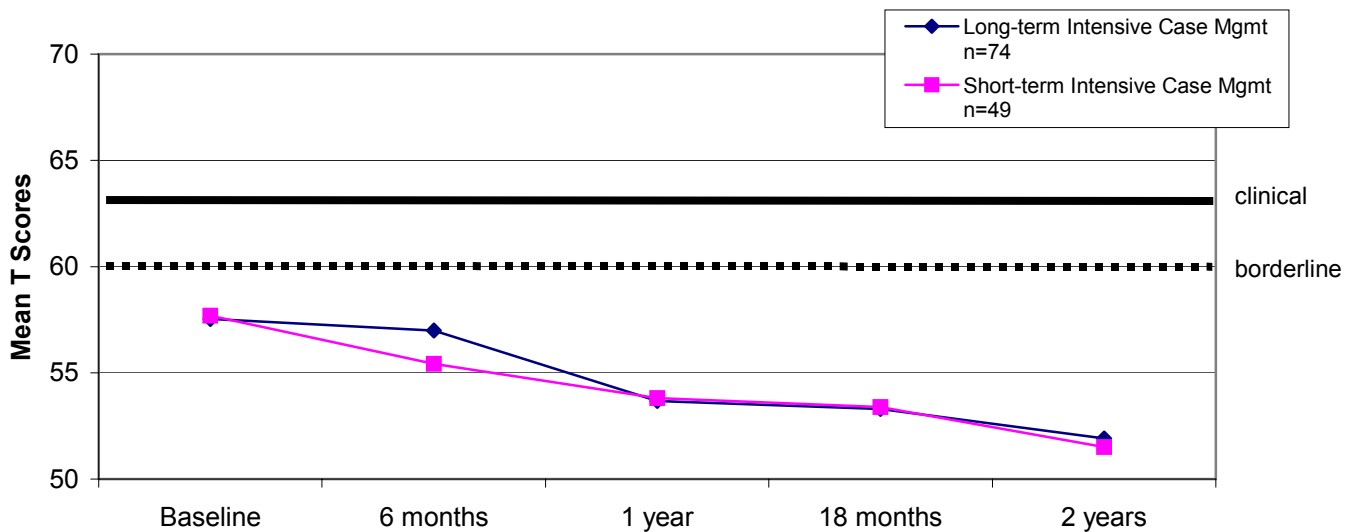


Figure 22: ISEP Youth Self-Report (YSR) Scores

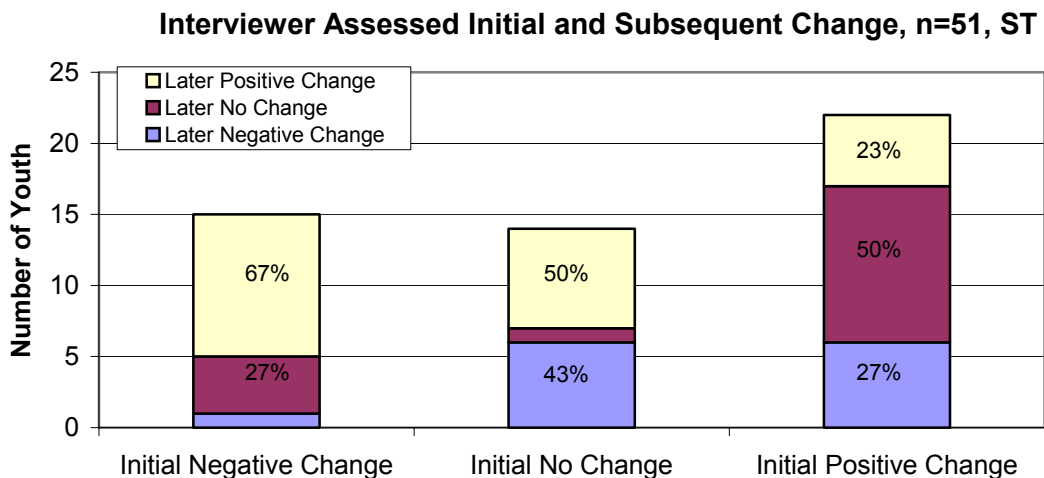
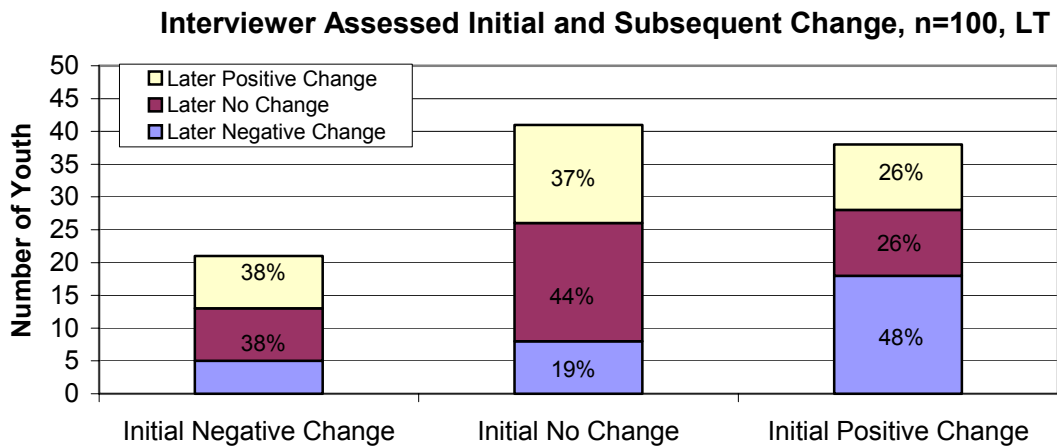
The YSR is an emotional/behavioral problems measure completed by interviewing the youth (11-18 yrs). “n” values reflect the number of youth who had YSR measures at all time points.



- Parents and youth are reporting improvements at 1 year for both long-term and short-term intensive case management samples.
- There are significant improvements from baseline to 2 years on parent and youth reports for both long-term and short-term intensive case management samples (based on linear effect analysis, $p < .01$).

Figure 23: ISEP Assessed Change from Intake to 1 Year, 1 Year to 2 Years by Interviewer Informant

In each graph the overall height of the bar indicates the number of cases with initial positive, no and negative change at 1 year on CAFAS. The stacked shaded areas within each bar represent the percent of youth who then report subsequent positive, no and negative change at 2-year follow-up. The top figure displays the long-term (LT) sample and the bottom figure displays the short-term (ST) sample.

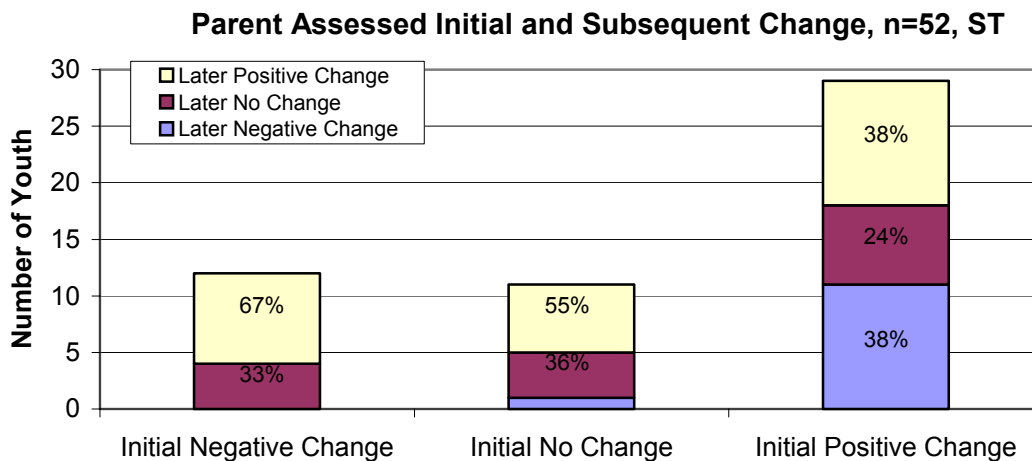
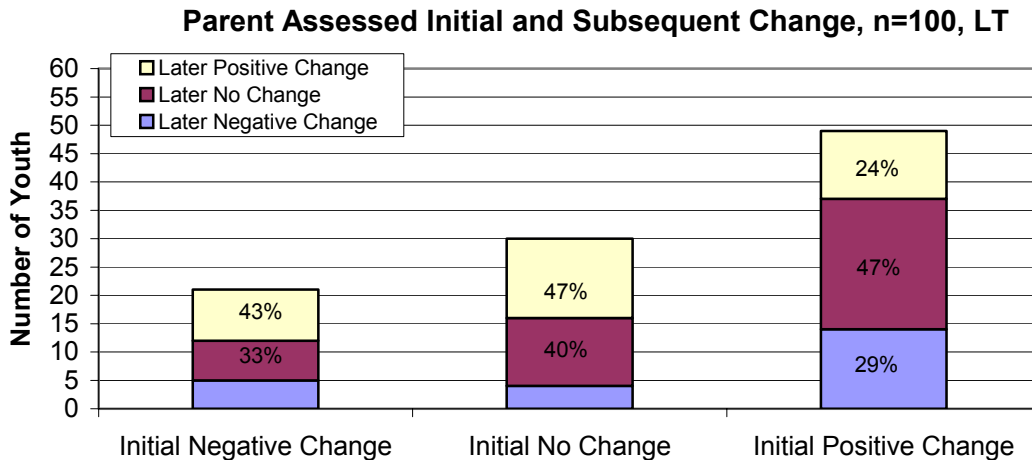


Note: The Y axis is proportionate to the total sample size for the long-term and short-term samples respectively.

- Approximately 40% of youth in both samples demonstrate positive changes within 1 year of services.
- Another 20-30% of youth show additional improvements between 1-2 year follow-ups (according to interviewer rating).

Figure 24: ISEP Assessed Change from Intake to 1 Year, 1 Year to 2 Years by Parent Informant

In each graph the overall height of the bar indicates the number of cases with initial positive, no and negative change at 1 year on CBCL. The stacked shaded areas within each bar represent the percent of youth who then report subsequent positive, no and negative change at 2-year follow-up. The top figure displays the long-term (LT) sample and the bottom figure displays the short-term (ST) sample.

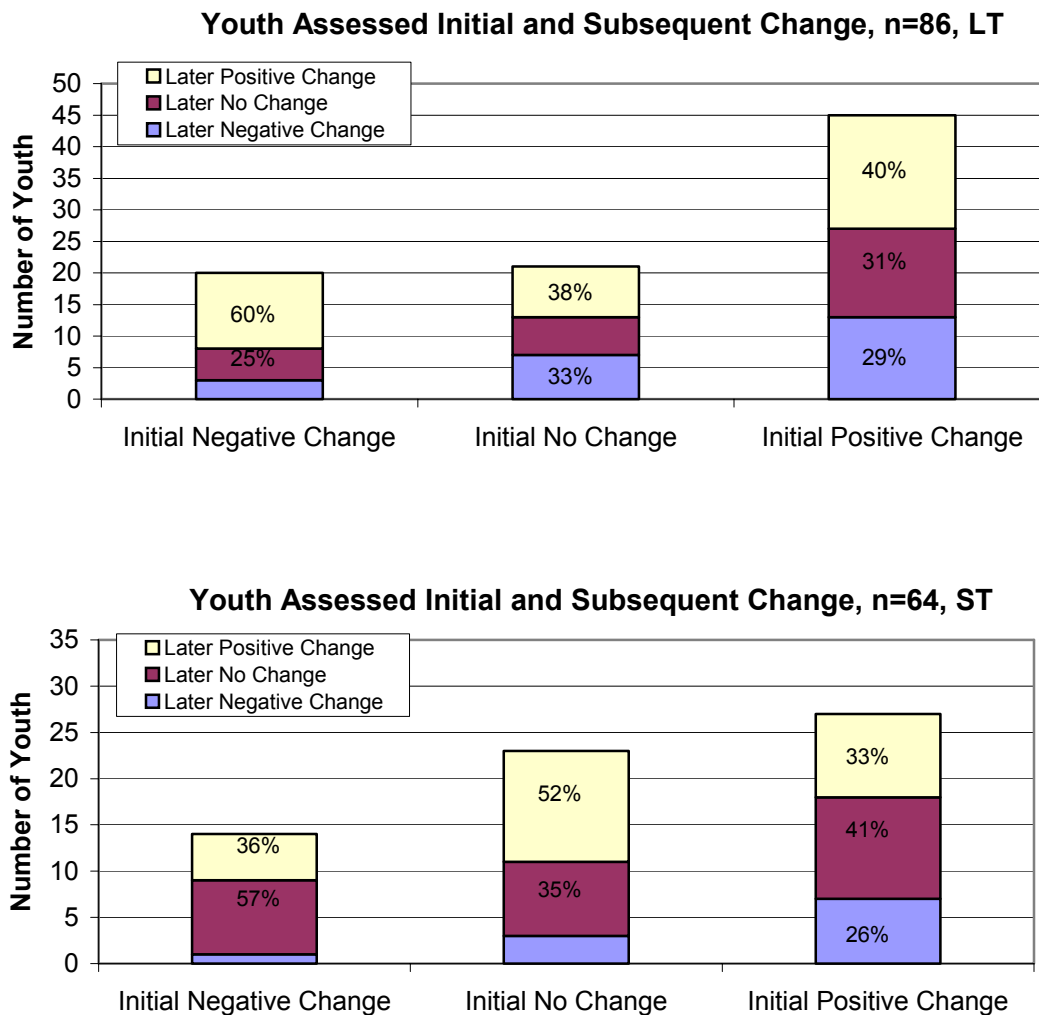


Note: The Y axis is proportionate to the total sample size for the long-term and short-term samples respectively.

- Approximately 50-55% of youth in both samples demonstrate positive changes within 1 year of services.
- Another 25% of youth show additional improvements between 1-2 year follow-ups (according to parent report).

Figure 25: ISEP Assessed Change from Intake to 1 Year, 1 Year to 2 Years by Youth Informant

In each graph the overall height of the bar indicates the number of cases with initial positive, no and negative change at 1 year on YSR. The stacked shaded areas within each bar represent the percent of youth who then report subsequent positive, no and negative change at 2-year follow-up. The top figure displays the long-term (LT) sample and the bottom figure displays the short-term (ST) sample.

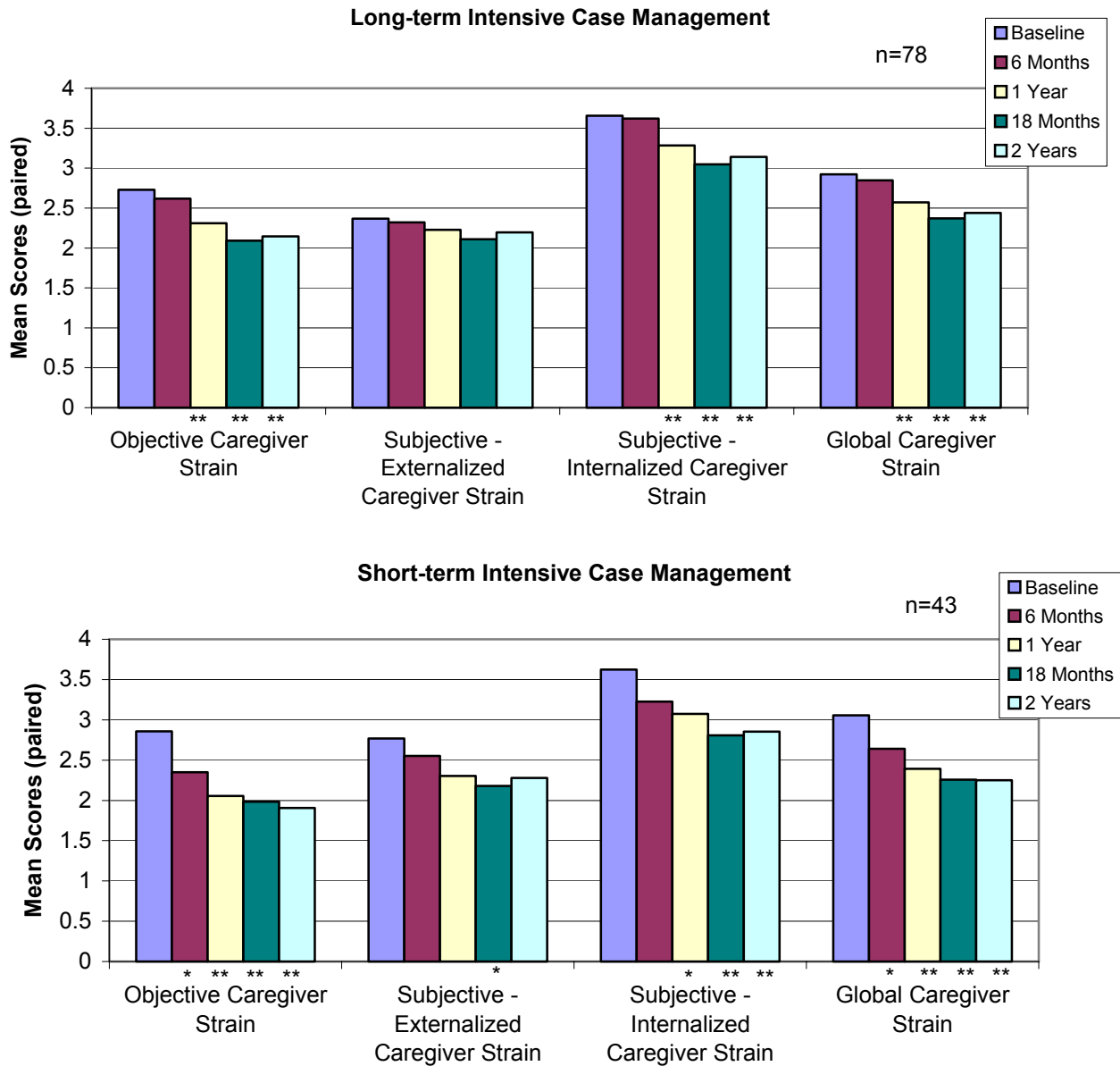


Note: The Y axis is proportionate to the total sample size for the long-term and short-term samples respectively.

- Approximately 40-50% of youth in both samples demonstrate positive changes within 1 year of services.
- Another 25% of youth show additional improvements between 1-2 year follow-ups (according to youth report).

Figure 26: ISEP Caregiver Strain Questionnaire (CGSQ)

The CGSQ, completed by interviewing the caregiver, assesses a family’s special demands associated with caring for a youth with SED. “n” reflects the number of caregivers who had CGSQ measures at all time points.

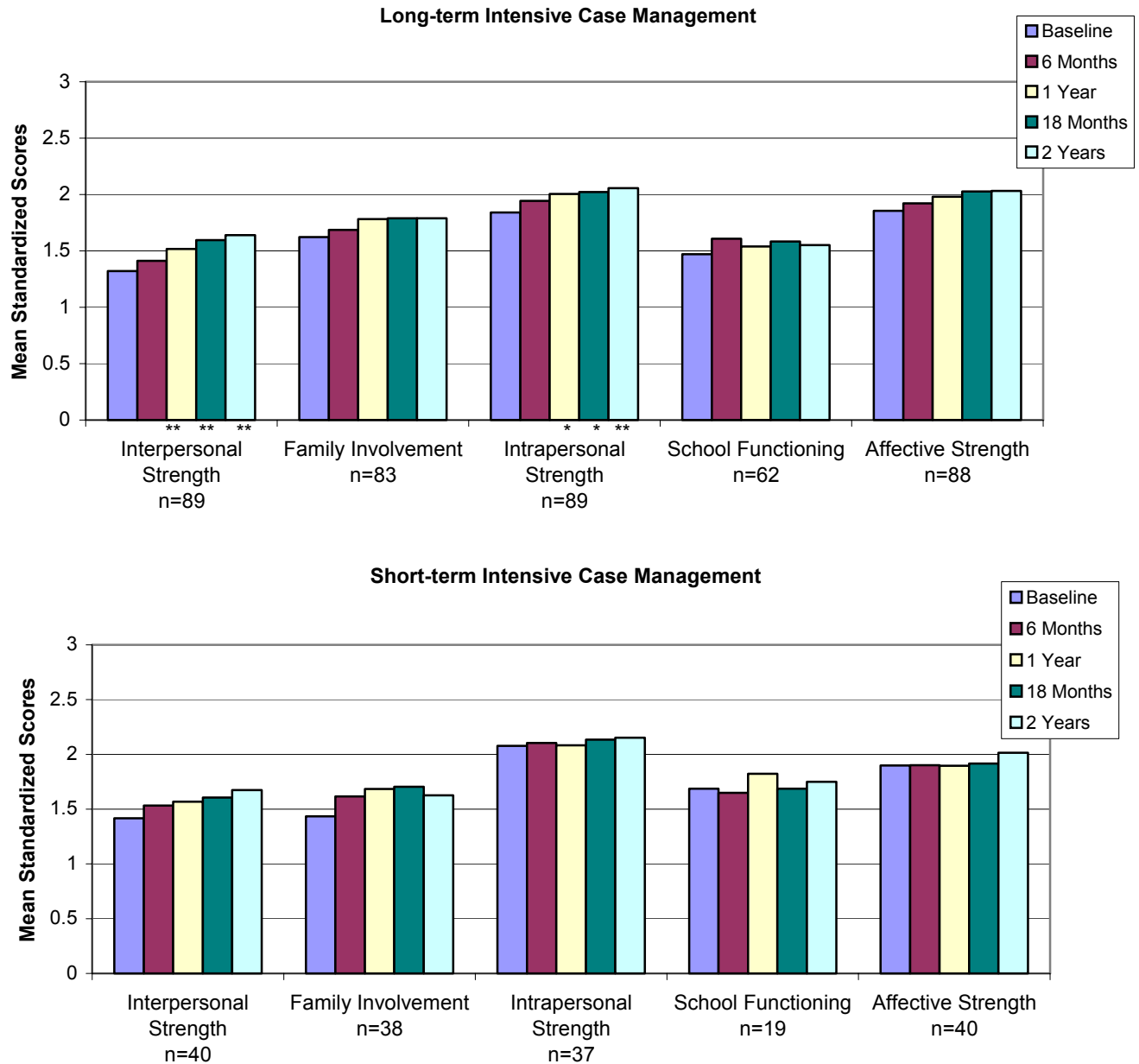


* represents statistical significance at p<.05 and ** represents p<.01 on pairwise comparisons from intake to each time point separately

- Parents of youth receiving long-term intensive case management services report less objective, subjective-internalized and global strain over time, linear effect p<.01.
- Parents of youth receiving short-term intensive case management services report less strain over time (objective, subjective-externalized, subjective-internalized and global), linear effect p<.01.

Figure 27: 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 short-term intensive case management services report minimal to no improvements over time, while parents of youth involved in long-term services report improvements over time with the exception of school functioning (based on linear effect analyses, p<.05).

Community Functioning Outcomes

Community Functioning Outcomes consist of youths behaviors in the community that often comes to the attention of agencies outside of mental health programs but within the larger System of Care framework. This section includes outcomes that assess the youth's functioning in areas related to the SOC partner sectors: Social Services, Probation, Alcohol and Drug and Education. These outcomes are considered to be important factors that impact a youth's overall ability to develop to their highest potential.

Substance Use

Substance use data was 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 was collected at baseline and each subsequent follow-up time point (typically every 6 months). Data was 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 29 & 30) 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 11.67 (SD 2.4), alcohol is 11.78 (SD 2.5), marijuana is 11.96 (SD 2.2) and other drugs combined is 13.08 (SD 2). There is also a much higher percent of youth who have used cigarettes (76%), alcohol (71%) 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 28 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 involvement. The average age in this sample is 16.0 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 alcohol, marijuana and cocaine is significantly higher (Figure 28). Regression analyses, which control for age, demonstrate that the probation youth have greater lifetime use of alcohol and marijuana compared to non-probation youth.

The majority of youth who report 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, 15-18 years old (Figures 29 & 30). In comparison to a youth's history of substance usage (lifetime usage), data for current usage shows dramatically lower percentages of youth. This means that there are fewer 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 (11-14 years old) show some increased usage over time for alcohol, cigarettes and marijuana, and older youth (15-18 years old) show some decreased usage of substances over time with the exception of alcohol. Older youth are also more likely to use gateway substances (alcohol and cigarettes) in higher dosages.

Delinquent Behavior

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 smaller 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

As of June 2002, the total number of youth served in mental health intensive case management programs that were involved in the juvenile justice system was 409. Of these, 302 had at least one arrest during the year prior to services. Charge data from the juvenile justice data system 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 at 1-year pre services is 1.79, and the mean charges at 1-year follow-up is .89. This represents an overall 50% decrease in the number of charges following participation in an intensive case management program. The majority of youth, 66%, show a decreased number of charges, 19% show no change and 15% show an increase in the number of charges at 1-year follow-up. One hundred and eighty-five youth have felony charges at 1 year prior to services. The mean number of felony charges is 1.36 prior to services and .32 post services. Of youth with felony charges prior to services, most (78%) show decreased felony charges, 20% show no change and 2% show an increase in felony charges at 1 year post entry.

TOWER served 202 youth who had prior involvement with the juvenile justice system from February 1999 to June 2002, which made them eligible for a 1-year follow-up. Of these youth, 168 have at least 1 charge in the year prior to services. The mean number of charges in the year prior to receipt of services is 1.92 charges. The mean number of charges 1-year post entry into the TOWER program is .83 charge. This represents a 57% decrease in the number of charges following participation in the program. Most youth show decreased charges at 1-year follow-up: 72% have fewer charges, 14% show no change and 14% have increased charges.

One hundred and nineteen youth involved in the TOWER program 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 is 1.39 charges. The mean number of felony charges after entry into the TOWER program is .31 charge. This represents a 78% decrease in the number of felony charges following participation in the program. Again, most of these youth show decreased felony charges at 1-year follow-up: 80% have fewer felony charges, 19% show no change and 1% have increased charges.

BEST served 141 youth who had prior involvement with the juvenile justice system from December of 1996 to June of 2002, which made them eligible for a 1-year follow-up. Of these youth, 85 have at least 1 charge in the year prior to services. The mean number of charges in the 1-year prior to receipt of services is 1.58 charges. The mean number of charges 1-year post entry into the BEST program is 1.12 charges. This represents a 29% decrease in the number of charges following participation in the program. At 1-year follow-up 55% show reduced charges, 24% show no change and 21% show increased 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 40 youth. For these 40 youth, the mean number of felony charges in the year prior to receipt of services is 1.27. The mean number of felony charges post entry into the BEST program is .45 charge. This represents a 65% decrease in the number of felony charges following participation in the program. Most of these youth show decreased felony charges at 1-year follow-up: 68% have fewer felony charges, 25% show no change and 7% have increased felony charges.

CYFN served 66 youth who had prior involvement with the juvenile justice system from February 1999 to June 2002, making them eligible for a 1-year follow-up. Of these youth, 49 have at least 1 charge in the year prior to services. The mean number of charges in the year prior to receipt of services is 1.73 charges. The mean number of charges 1-year post entry into the CYFN program is .71 charge. This represents a 59% decrease in the number of charges following participation in the program. Most youth show decreased charges at 1-year follow-up: 61% have fewer charges, 27% show no change and 12% show increased charges.

There were 26 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 is 1.31 charges. The mean number of felony charges post entry into the CYFN program is .15 charge. This represents a 89% decrease in the number of felony charges following participation in the program. Again, most of these youth show decreased felony charges at 1-year follow-up: 85% have fewer felony charges, 15% show no change and no youth have 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 are 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 31). By 2-year follow-up, youth significantly reduced their delinquent behaviors.

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 are lower percentages of youth involvement in each of the behaviors than at intake for both samples. At intake, 40% ST and 28% LT youth report involvement in a gang that participated in unlawful behaviors. At 2-year follow-up, there are 18% ST and 15% LT youth involved in these behaviors. Twenty-nine percent ST and 22% LT youth at baseline, and 13% ST and 13% LT youth at 2-year follow-up, report involvement in vandalizing property. About 43% ST and 34% LT youth at baseline and 29% ST and 22% LT youth at 2-year follow-up report carrying a weapon. In response to the question regarding theft and/or burglary, 18% ST and 10% LT report participation in these behaviors at baseline, and 12% ST and 8% LT report participation at 2-year follow-up. Thirty-five percent ST and 21% LT youth report participation in drug sales at baseline, and 18% ST and 22% LT report participation at 2-year follow-up. Lastly, 9% ST and 7% LT youth report having fired a gun/used a knife on someone or severely beaten someone at intake. Five percent ST and 10% LT report these behaviors at 2-year follow-up. The LT sample demonstrates a small increase at 2-year follow-up for weapon usage.

School Placement

For youth in BEST and CYFN intensive case management programs, data was collected on school placement using the Scale to Assess Restrictions of Educational Settings (SARES) per the AB3015/SB163 evaluation protocol. Case managers completed the scale per caregiver and youth report. Educational setting was collected as "current" setting and "predominant" setting in the past 1 year at baseline and subsequent follow-ups. School placement was presented for "current" setting from intake to 6 months and intake to 1 year (Figure 32). There are differences in the percentages of youth in the various school settings by time point, with most changes taking place from intake to 1-year follow-up. From intake to 1-year follow-up, the number of youth in special education placements increases from 17% to 32%. The number of youth in alternative school and day treatment settings decreases from approximately 7-9% from intake to 1 year. The number of youth in regular classrooms drops from 13% to 6% by 1-year follow-up.

As part of the ISEP assessment battery, school placement data was collected per caregiver report on the Educational Questionnaire. The Educational Questionnaire shows that about 40% of ISEP participants receive at least some remedial education services at baseline, 48% at 1 year and 46% at 2-year follow-up. Fifty-two percent of the youth have special education or an IEP plan at baseline, 59% at 1 year and 45% at 2-year follow-up. Also, 53% of youth are involved in self-contained special education classes (classroom of all special needs children) at intake, 55% at 1 year and 60% at 2-year follow-up. Only 11% of the youth who

needed special education services were involved in inclusive settings (typical classroom) at intake and 17% at 1-year and 2-year follow-ups.

School Conduct

For youth in intensive case management programs, data was collected from caregiver report on suspensions and expulsions using the Educational Questionnaire. At intake, 33% of the youth had been suspended (either in-school or out-of-school) in the past 6 months (Figure 33). This number decreased at 1-year follow-up to 24%, and decreased again at 2-year follow-up to 20%. The number of youth who were expelled in the past 6 months was 11% at intake and 5% at both 1-year and 2-year follow-up.

School Achievement

School achievement data was collected from those youth participating in intensive case management programs such as BEST, CYFN, CITY and TOWER. The majority of youth who completed school achievement measures participated in BEST or CYFN programs. From 1996 to 2003, 385 Wide Range Achievement Tests (WRAT3) were collected at baseline, 73 youth had an additional 6-month follow-up test averaging 5.01 months (SD=1.42) from baseline and 38 youth had a 1-year follow-up test averaging 10.42 (SD=1.33) from baseline. The WRAT3 tests achievement in reading, spelling and math. By comparing intake scores to 6-month follow-up on the absolute scores for each subscale, only 1 subscale, reading, reveals a significant improvement ($p<.05$). At 6-month follow-up, 60% of the youth demonstrate a positive change (a 2 point improvement on absolute score from intake to 6 months), 10% show no change and 30% show negative change in absolute reading scores. Fewer youth show improvements in absolute scores for spelling and math; 41% demonstrate a positive change for spelling and 44% demonstrate a positive change for math. Youth show 21% no change for spelling and 15% no change for math. Another 38% show negative change in spelling, and 41% show negative change in math. At 1-year follow-up, only the spelling subscale shows significant improvement ($p<.05$), with 50% reporting positive change, 21% reporting no change and 29% negative change in absolute scores. By 1-year follow-up, 42% of youth show a positive change in absolute math scores, 21% no change and 37% negative change. Absolute reading scores also improved, with 47% showing positive change, 14% no change and 39% negative change. Refer to Figure 34.

As part of the ISEP evaluation, caregivers were asked to report on their child's school achievement by indicating their grade average. At intake, 15% are failing, 11% have D average, 27% 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 and 2-year follow-ups. At 1 year, 12% are failing, 7% have D average, 29% have C average, 33% have B average, 14% have A average and 6% don't have a grade average (school does not provide). By 2-year follow-up, 10% are failing, 6% have D average, 28% have C average, 40% have B average, 11% have A average and 7% don't have a grade average (school does not provide). Refer to Figure 33.

School Attendance

School attendance data was collected for youth involved in intensive case management programs through both AB3015 and SB163 evaluation protocols and ISEP. Attendance data was collected for youth who participated in BEST and CYFN by either administrative records or parental report (when school records were not available) per requirement of funding mandate (AB3015 & SB163). Figure 35 displays school attendance for this sample. The data is presented

for youth who had less than 1 year of school attendance collected and youth who had 1 year or more of school attendance data collected. Overall, most youth attained or maintained perfect attendance. Youth with longer follow-up periods (9 months or more) did not show more improvements during this extended period compared to youth who had a follow-up between 4-8 months post service entry. This suggests that attendance improvements occurred quickly after services began.

Attendance was collected through parent report for youth participating in the ISEP evaluation. Caregivers completed 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 36). The improvement primarily occurs at the 2-year follow-up period, and this improvement is statistically significant for short-term youth. At intake, 68% of the youth in the long-term sample and 65% of the youth in the short-term sample have been absent from school in the previous 6 months. These percentages drop by 2-year follow-up: 49% of youth in long-term and 24% youth in short-term. The frequency of absences also reduces slightly over time for youth involved in long-term services. By 1 year, of those youth who were absent, 33% were absent infrequently (less than 1 day per month). A similar frequency of absences is seen at 2-year follow-up. Youth absent from school in the short-term group show 27% infrequent absences at 1 year and 2 years, but a slight increase in frequent absences (1 day or more per week) to 53% at 2 years. Note, youth may not be active in services at 2-year follow-up. Follow-up data was collected regardless of service involvement.

Table 9:

Brief Description of Community Functioning Measures

*Note: a trained interviewer administered all measures

Education Questionnaire (EQ)

- Assesses children's educational status and their experiences in school during the past 6 months according to the caregiver.
- Contains 21 questions, including items about school (first through twelfth grade) attendance; grade level; school achievement; type of school setting (e.g., special or alternative school; reasons for placements; special education; overall academic performance; and whether the child has been suspended, detained or expelled from school.
- Final items assess availability and effectiveness of help (from the school) to meet the educational, behavioral and/or emotional needs of the child.

Delinquency Survey (DS)

- Gathers information reported by youth about their delinquent behavior, such as contact with law enforcement and juvenile justice.
- Consists of 25 items that assess the youth's behavior toward others in the community, as well as contact with law enforcement, including criminal offenses, arrests and probation.
- Administered to youth aged 11 years and up.

Substance Use Survey, Parts A & B (SUS-AB)

- The SUS-AB has two parts:
 - SUS-A collects information about the frequency of a youth's substance use, including use of cigarettes, alcohol and other drugs.
 - SUS-B focuses on the consequences of substance use that youth have experienced ever and during the past 6 months.
 - The SUS-B is adapted from the Child & Adolescent Functional Assessment Scale (CAFAS) Parent Report with the permission of the author.

Scale To Assess Restrictions of Educational Settings (SARES)

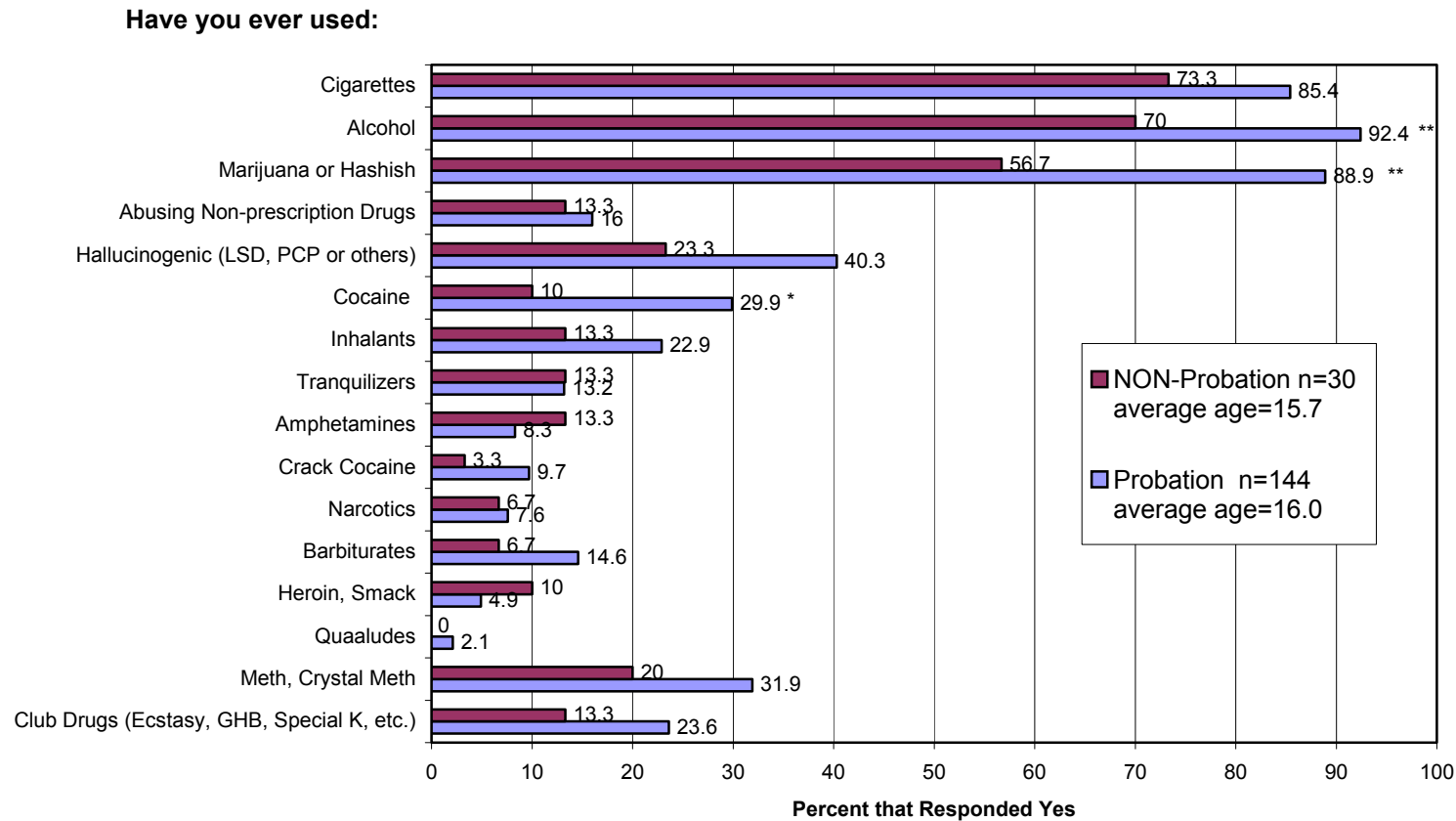
- Records the current and past educational setting of the youth.
- Clinician/Service Coordinator indicates the setting that best describes where the youth is educated.
- Developed by Dr. Michael Epstein in 1993.

Wide Range Achievement Test – 3rd Version (WRAT3)

- Assesses the youth's school achievement in three areas: Reading, Spelling and Arithmetic.
- Clinician/Services Coordinator administers each of the three subtests to the youth.
- For youth 5 – 18 years old.
- Developed by Dr. Joseph Jastak in the 1930's.
- Latest version is 3rd edition copyright 1993.

Figure 28: Lifetime Substance Use History by Probation Youth and Non-Probation Youth at Intake for 15-18 Year Olds

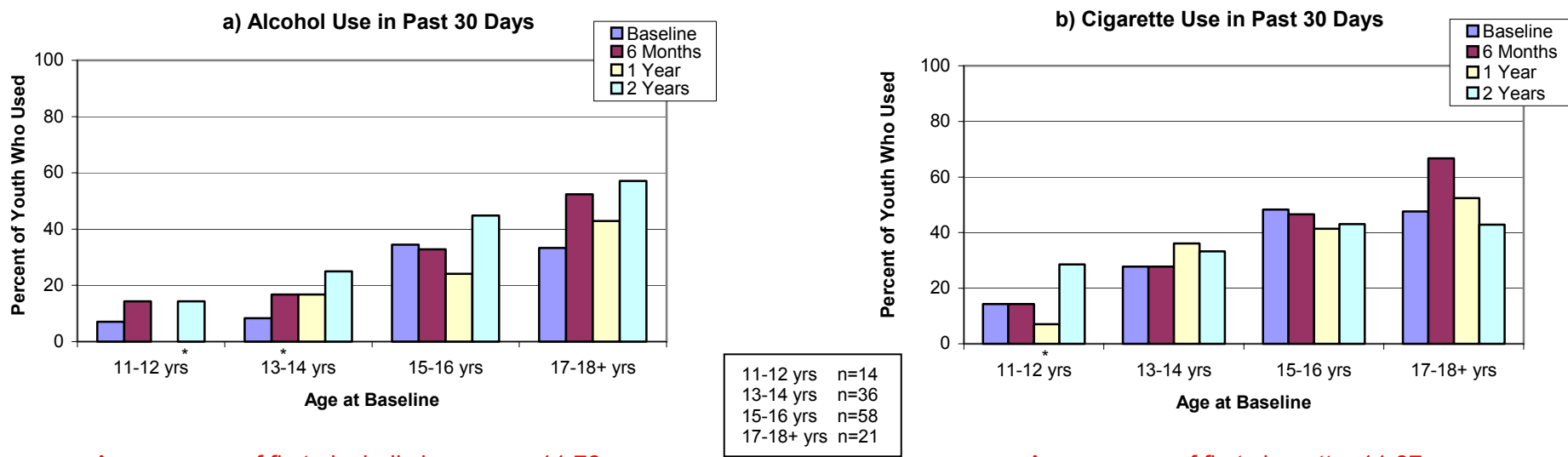
“Probation” youth have either current or prior involvement with the Juvenile Justice system at the time of baseline interview. “Non-probation” youth have never been involved in the Juvenile Justice system. Data was collected at baseline assessment.



* represents statistical significance at $p < .05$ and ** represents $p < .01$ on Chi-Square comparisons between Probation and Non-Probation youth

- Youth involved in the Juvenile Justice system are more likely to have used substances at baseline interview, prior to receiving Mental Health services.
- Probation youth use “gateway” substances significantly more than non-probation youth.

Figure 29: Current (Past 30 Days) Alcohol and Cigarette Usage at Baseline, 6-Month, 1-Year and 2-Year Follow-up by Age Group



Average age of first alcoholic beverage: 11.78 years

Average age of first cigarette: 11.67 years

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

Age	Baseline	6 Months	1 Year	2 Years
11-12 yrs	0.0% (0)	0.0% (0)	0.0% (0)	0.0% (0)
13-14 yrs	33.3% (1)	33.3% (2)	50.0% (3)	88.9% (8)
15-16 yrs	55.0% (11)	63.2% (12)	64.3% (9)	68.0% (17)
17-18+ yrs	71.4% (5)	90.9% (10)	66.7% (6)	66.7% (8)

Of youth who report smoking in past 30 days, percent (and number) who smoke daily:

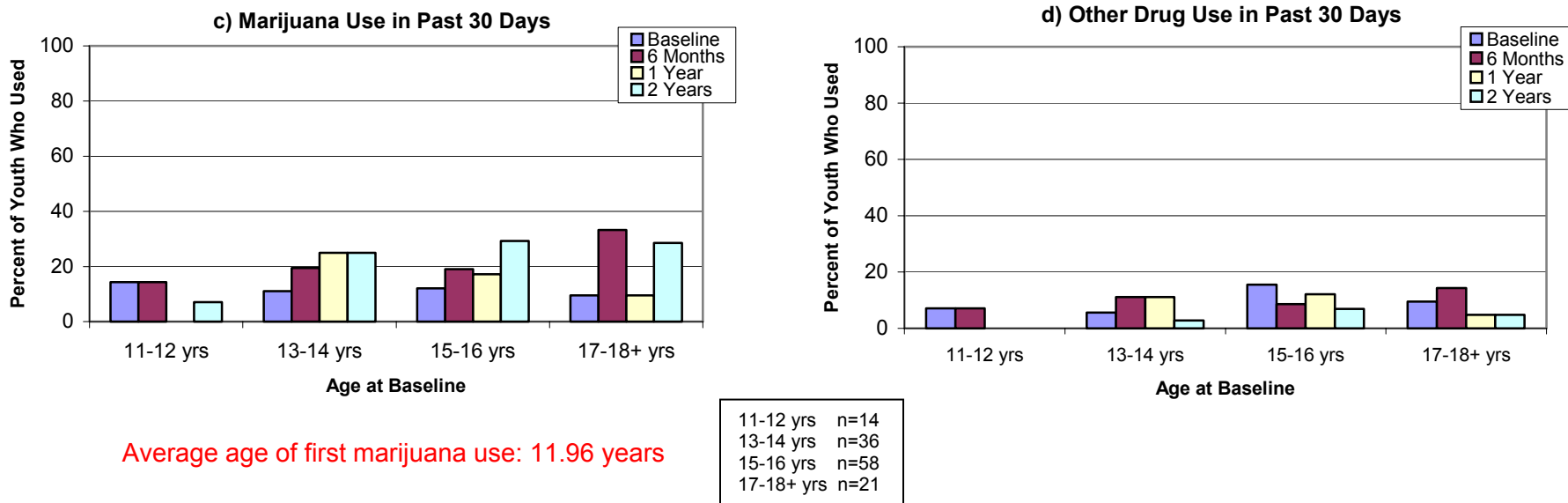
Age	Baseline	6 Months	1 Year	2 Years
11-12 yrs	50.0% (1)	0.0% (0)	0.0% (0)	25.0% (1)
13-14 yrs	40.0% (4)	60.0% (6)	46.2% (6)	75.0% (9)
15-16 yrs	46.4% (13)	66.7% (18)	54.2% (13)	60.0% (15)
17-18+ yrs	50.0% (5)	57.1% (8)	72.7% (8)	88.9% (8)

Note: Numbers in parentheses are the number of youth reporting binge drinking or daily smoking at each time point in each age group.

* represents statistical significance at p<.05 on Chi-Square comparisons from intake to each time point separately

- 11-12 year old youth show significant reduction in cigarette use at 1 year follow-up.
- 11-12 year olds at 2 years and 13-14 year olds at 6 months show significantly more alcohol use compared to usage at intake.
- Oftentimes increases over time are related to youth experimentation as they age.

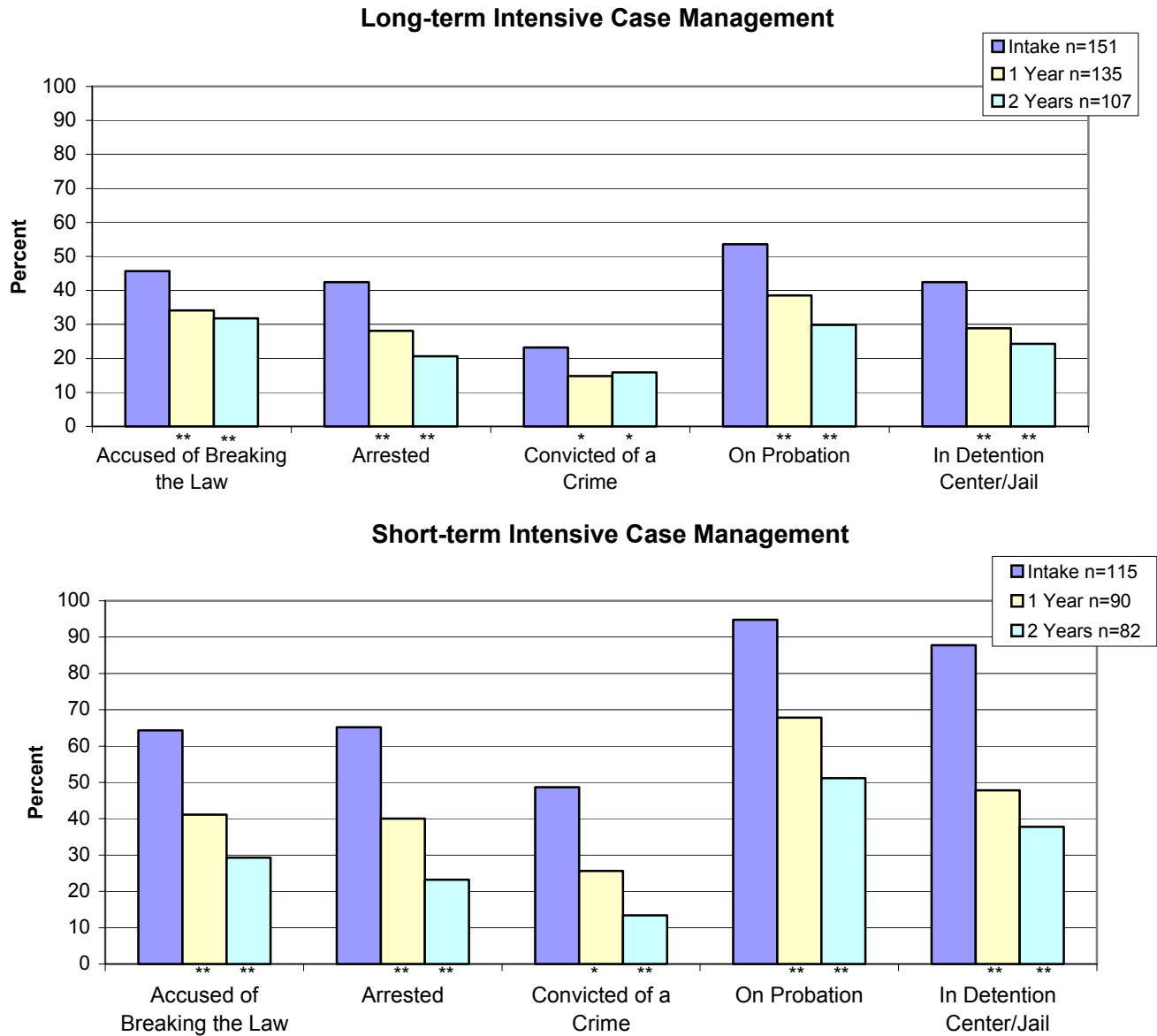
Figure 30: Current (Past 30 Days) Marijuana and Other Drug Usage at Baseline, 6-Month, 1-Year and 2-Year Follow-up by Age Group



- Adolescents demonstrate some trends towards reduction in other drug use at 1-year and 2-year follow-ups.
- 11-12 year old youth demonstrate some trends towards reduction in marijuana and other drug use.
- Oftentimes increases over time are related to youth experimentation as they age.

Figure 31: Youth Delinquent Behaviors

Youth delinquent behaviors were collected from youth report at baseline and follow-up interviews about each delinquent act and the consequences. The percentages represent youth who reported at least one occurrence of the given delinquent behaviors in the 6 months prior to assessment period.

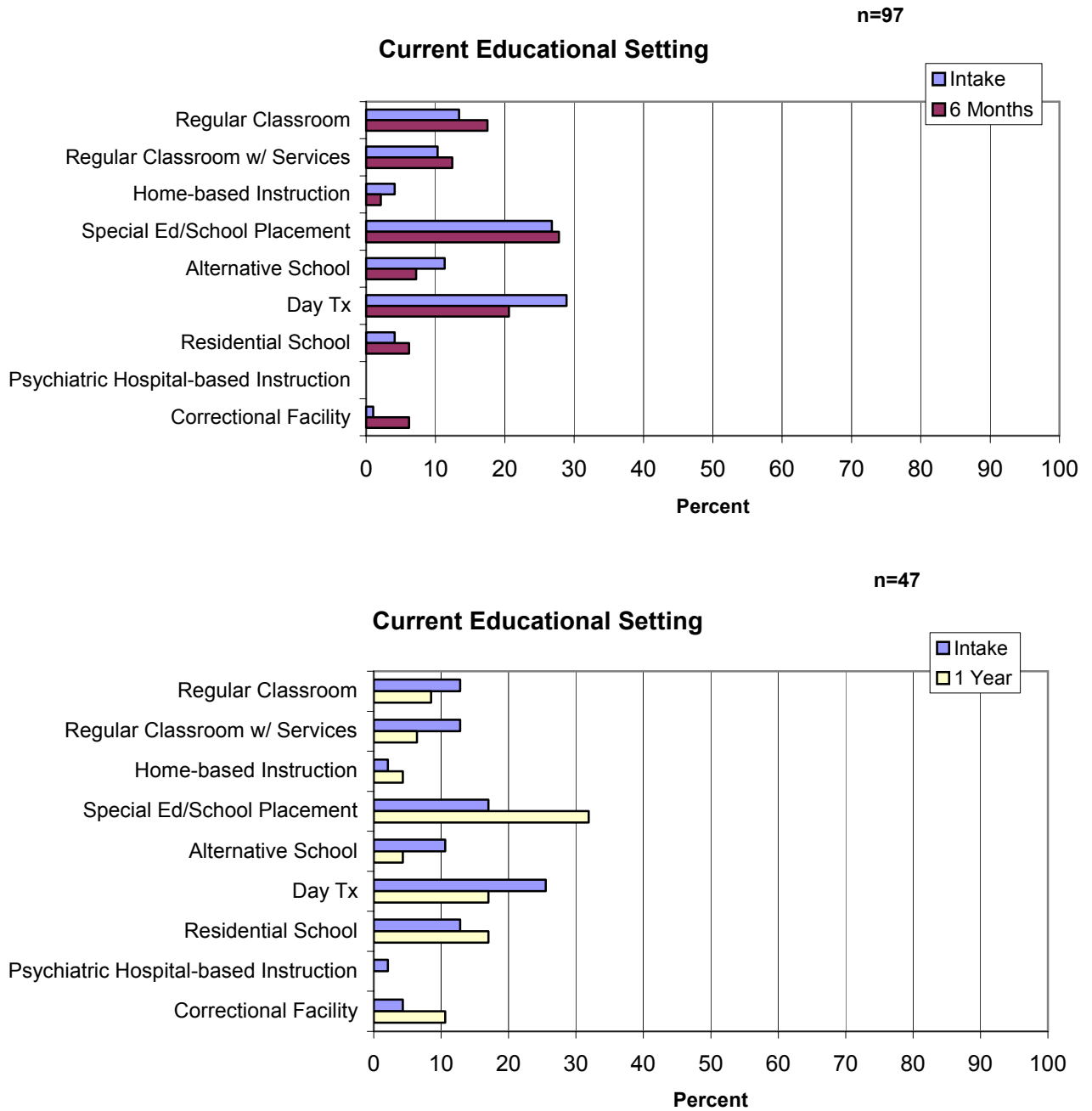


* represents statistical significance at $p < .05$ and ** represents $p < .01$ on Chi-Square comparisons from intake to each time point separately

- 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 significant decreases of self-reported delinquency over time for both samples.

Figure 32: Scale to Assess Restrictions of Educational Settings (SARES) – Current Educational Setting at Intake to 6 Months and Intake to 1 Year

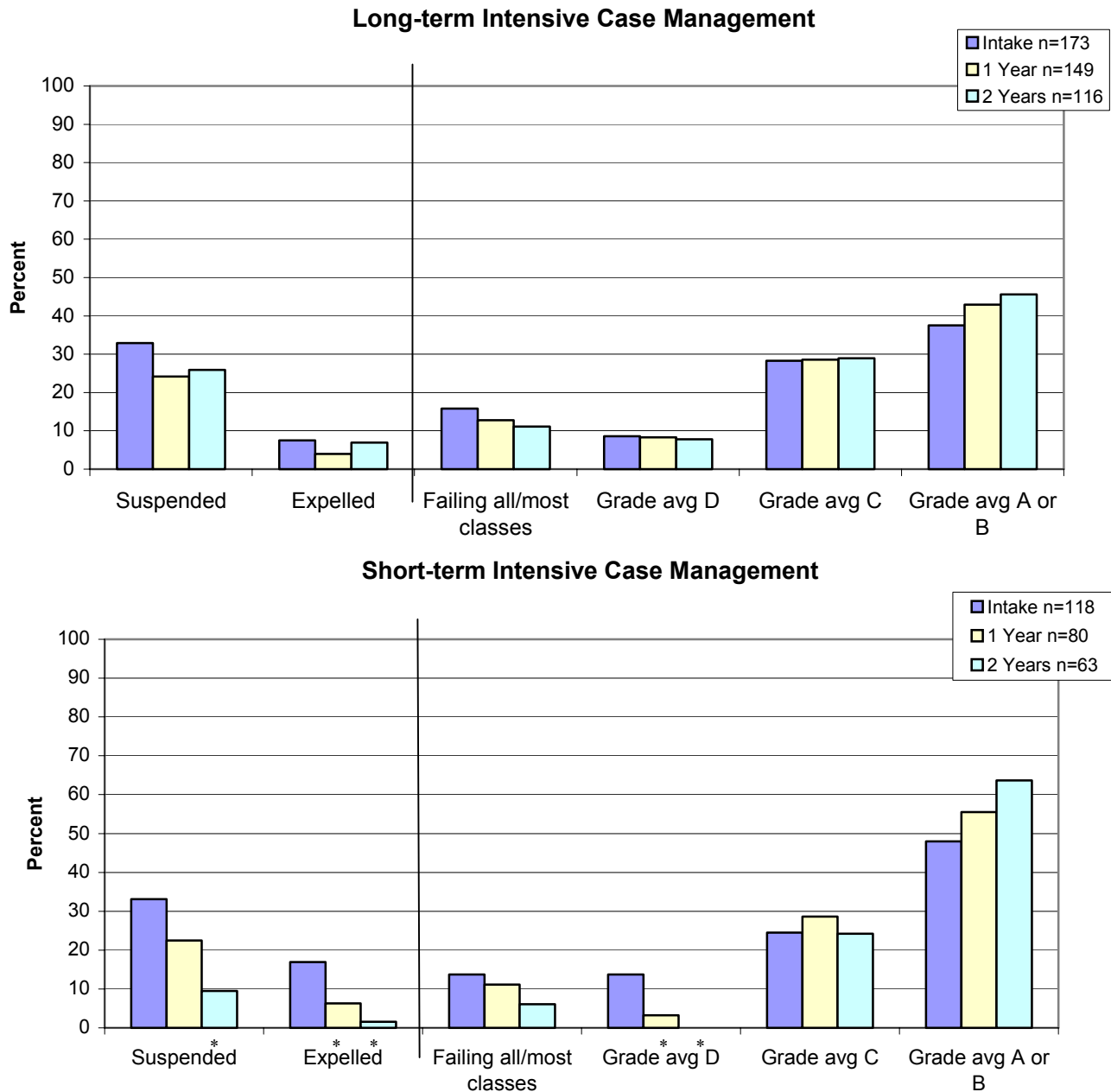
The educational setting was completed by the clinician/staff after interviewing the youth and family. The setting reported is "Current," which represents educational environments at time of assessment.



- There are higher percentages of youth in Special Education placements at 1 year compared to intake.
- There are fewer youth in day treatment and alternative school settings at 6 months and 1 year compared to intake.

Figure 33: Educational Behaviors

Youth educational behaviors were collected from caregiver report at baseline and follow-up interviews regarding school issues. The percentages represent youth who were reported as having at least one occurrence of the given educational situation in the 6 months prior to assessment period.

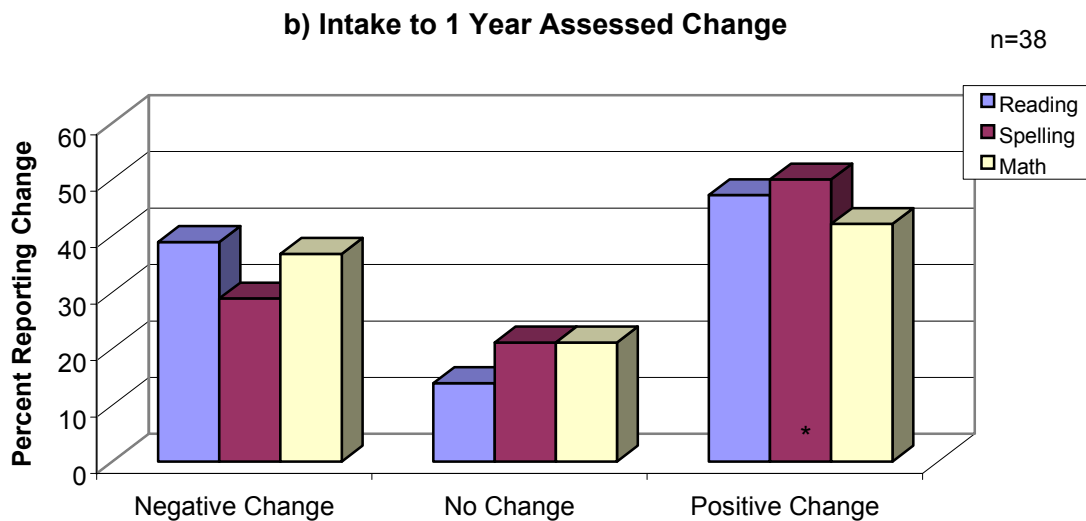
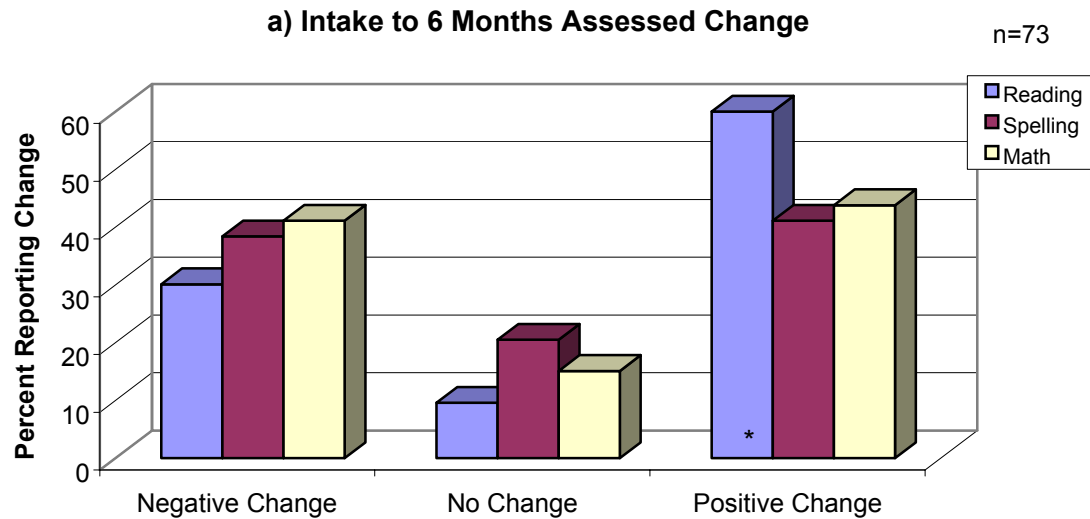


* represents statistical significance at $p < .05$ on Chi-Square comparisons from intake to each time point separately

- Youth in both samples demonstrate improved school conduct and school achievement.

Figure 34: WRAT3 School Achievement Test Scores

Wide Range Achievement Test (WRAT3) is a standardized school achievement measure. Mean Absolute Scores are presented for each domain: Reading, Spelling and Arithmetic. Higher scores indicate better performance and more knowledge and skills in domain.

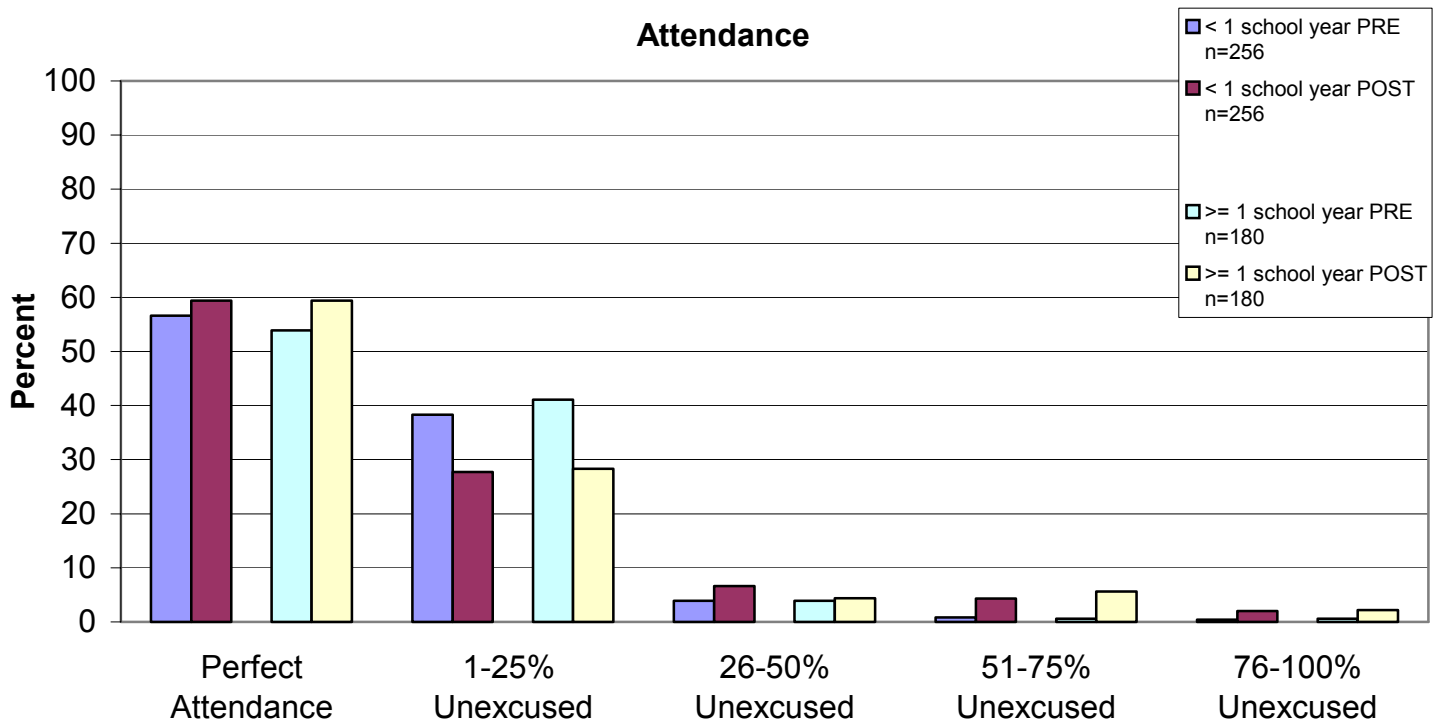


*represents statistical significance at $p < .05$ for paired t-tests from intake to follow-up

- 2/3 of youth demonstrate significant positive improvements in reading at 6 months.
- Nearly 1/2 of youth demonstrate significant positive improvements in spelling at 1 year.
- At a minimum, 40% improve in reading, spelling and math, however these changes are not all at a magnitude to reach statistical significance.

Figure 35: School Attendance

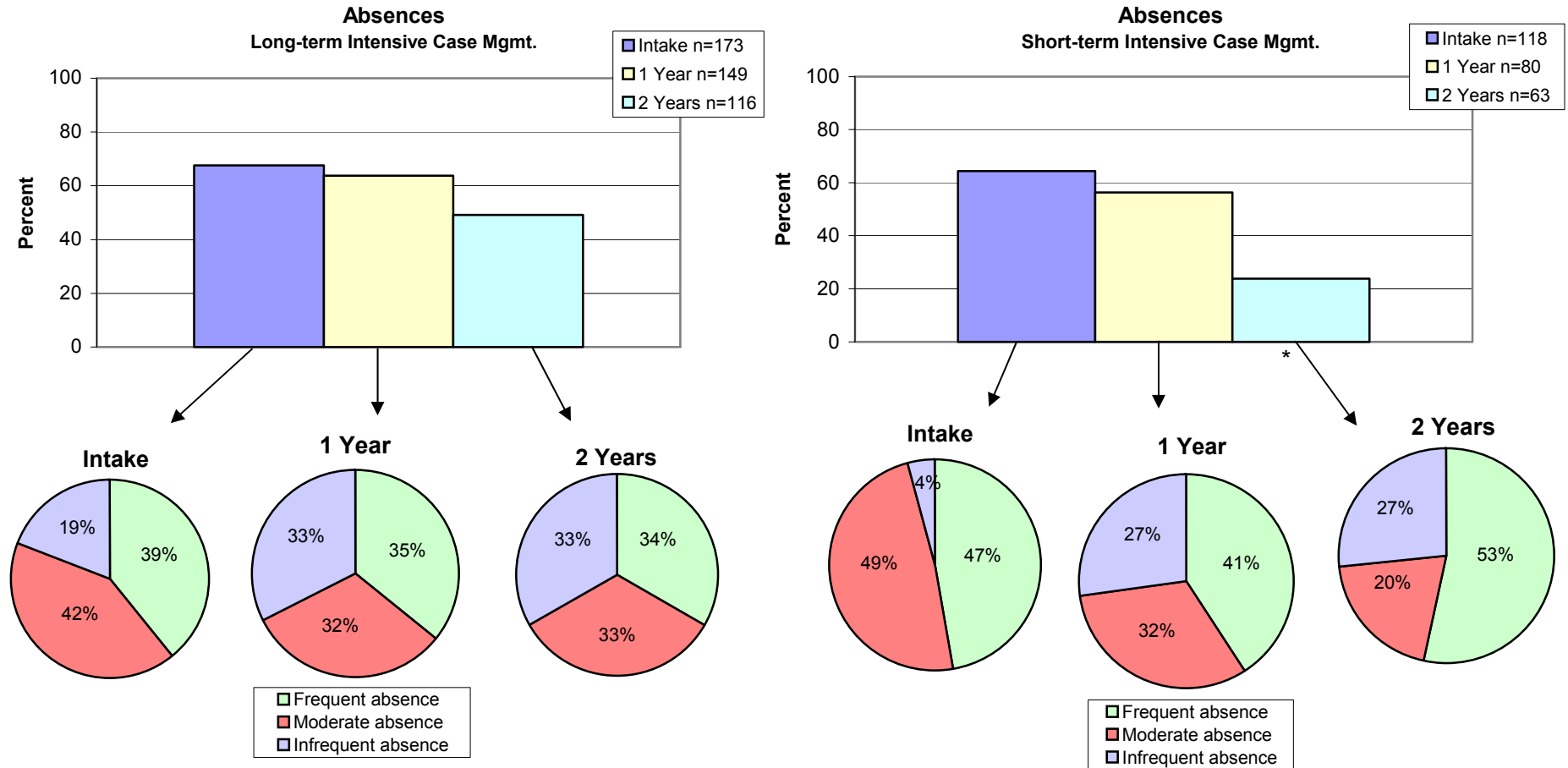
School attendance was calculated by averaging the first 3 months of attendance (at service entry) and comparing this to the average attendance of the last 3 months (at follow-up). Students with less than 1 year of attendance had follow-up occur between months 4-8. Students with more than 1 year had follow-up occur 9 months or more.



- About 60% of all youth attain or maintain perfect attendance at follow-up.

Figure 36: School Attendance for Youth in both Long-term and Short-term Intensive Case Management Programs

School attendance data was gathered by caregiver report from the Educational Questionnaire of youth in school. Absences include both excused and unexcused absences in the past 6 months. The bar graphs present the percent 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.



* represents statistical significance at p<.05 on Chi-Square comparisons from intake to each time point separately

- Youth school attendance is improving over time. Youth in the long-term sample are also reducing the frequency of their absences over time.

System Outcomes

One main goal 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.

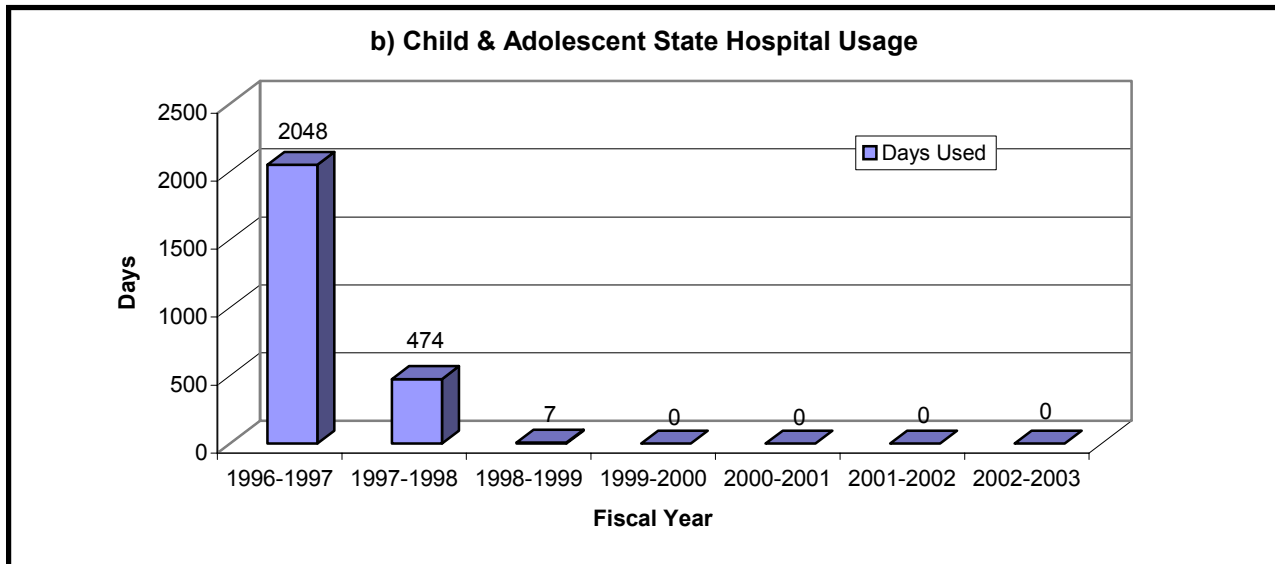
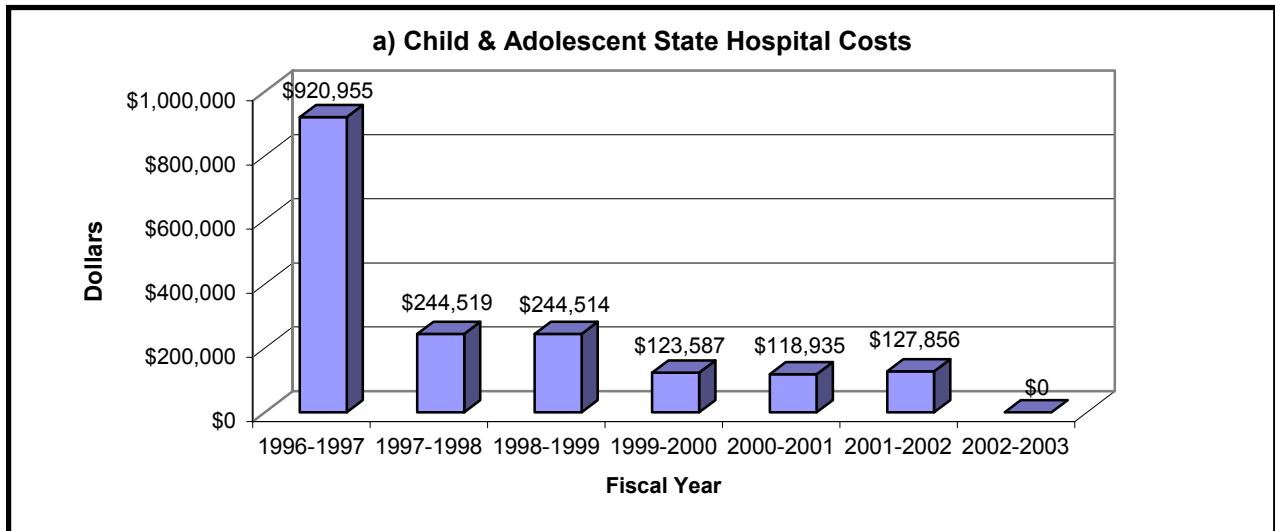
San Diego County Children's Mental Health has had the most impact in reducing state hospital utilization. This has been a primary target for improvement in CMHS with the implementation of the System of Care in San Diego. The establishment of the Community Intensive Treatment for Youth (CITY) program in July 1997 was aimed at reducing state hospital utilization. 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 37 reflects the dramatic decrease in state hospital costs and utilization, with a 100% reduction in costs and 100% reduction in utilization.

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 illustrates 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 through FY02-03. These increases are partly due to a rate increase for both programs. Overall, CAPS increased 16% and Medi-Cal FFS increased 5% from FY01-02 to FY02-03. The number of bed days used for CAPS and Medi-Cal FFS reduced in 02-03 by 14% even though the youth population increased in SD county (Figure 38).

Figure 39 shows that Group Home/Residential overall total costs have risen over the last fiscal year. Part of the total costs increase in the graph is caused by two factors: 1) the inclusion of the costs for placing probation youth through the CMHS Initiative and 2) the inclusion of group home alternatives to shelter care placements made by non-Residential Child Welfare staff within the Child Welfare sample. These costs were not included in past years. Comparing this recent fiscal year 02-03 to FY01-02, costs for Probation and Special Education remained stable, as did the number of placements. These data indicate a slowing of growth for these indicators. For Child Welfare placements made by Residential workers, which mirrors the data reported for prior years, there was also a slight decrease in both costs and the number of months in placement.

Figure 37: State Hospital Costs and Usage by Fiscal Year

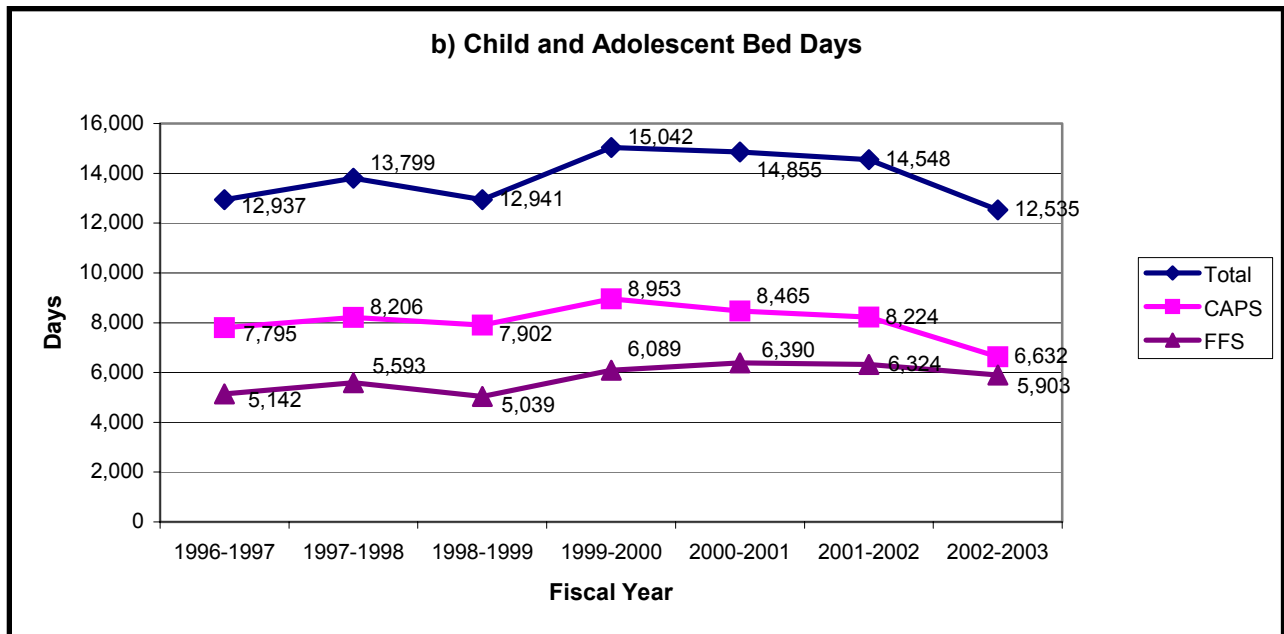
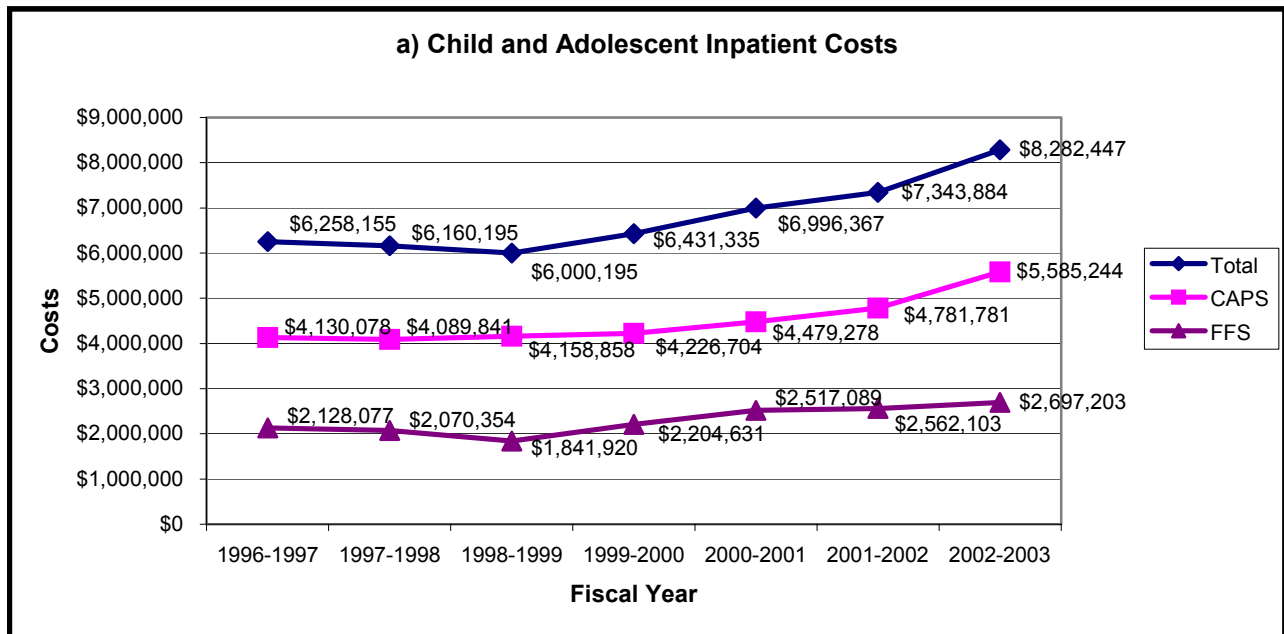
The state hospital cost is the amount contracted for usage. The days used are the actual number of bed days utilized by children and adolescents from San Diego County. A contract was signed at the beginning of the fiscal year to pay for beds regardless of usage in previous years. San Diego County purchased one bed for fiscal years 99-00, 00-01 and 01-02, but did not use them.



- This shows an overall 100% reduction in state hospital costs and state hospital bed days used between fiscal years 96-97 and 02-03.
- These reductions were accomplished primarily by the implementation of the CITY program, which transitions and/or diverts youth from state hospitals to local intensive case management programs in their home communities and provides “wraparound” services.

Figure 38: 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. Fee-for-Service Medi-Cal represents various psychiatric hospitals with a fixed daily rate.

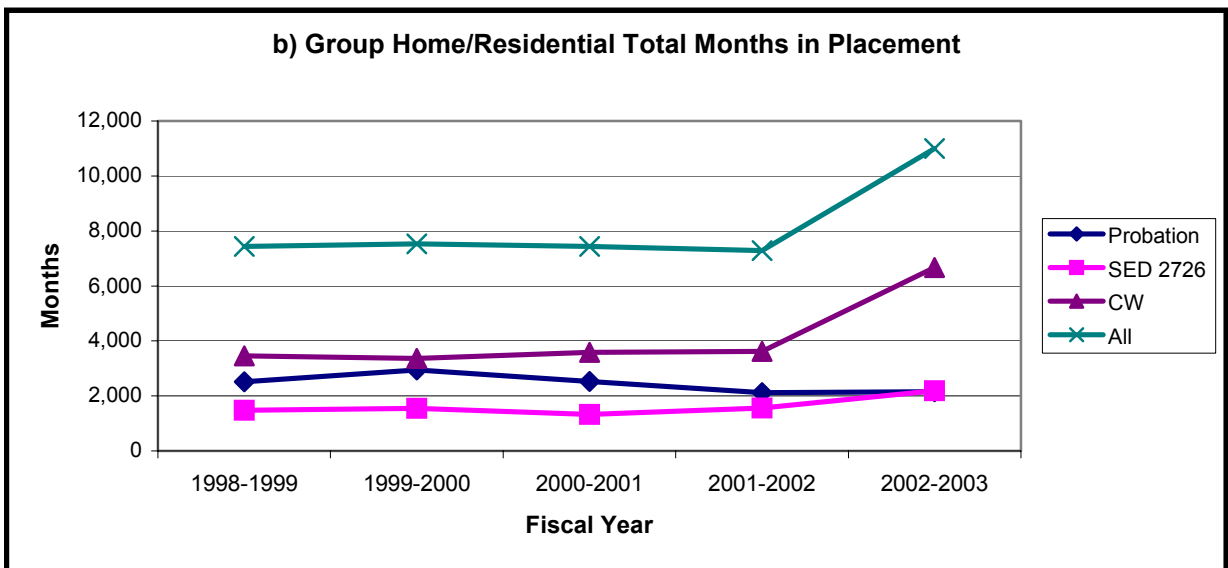
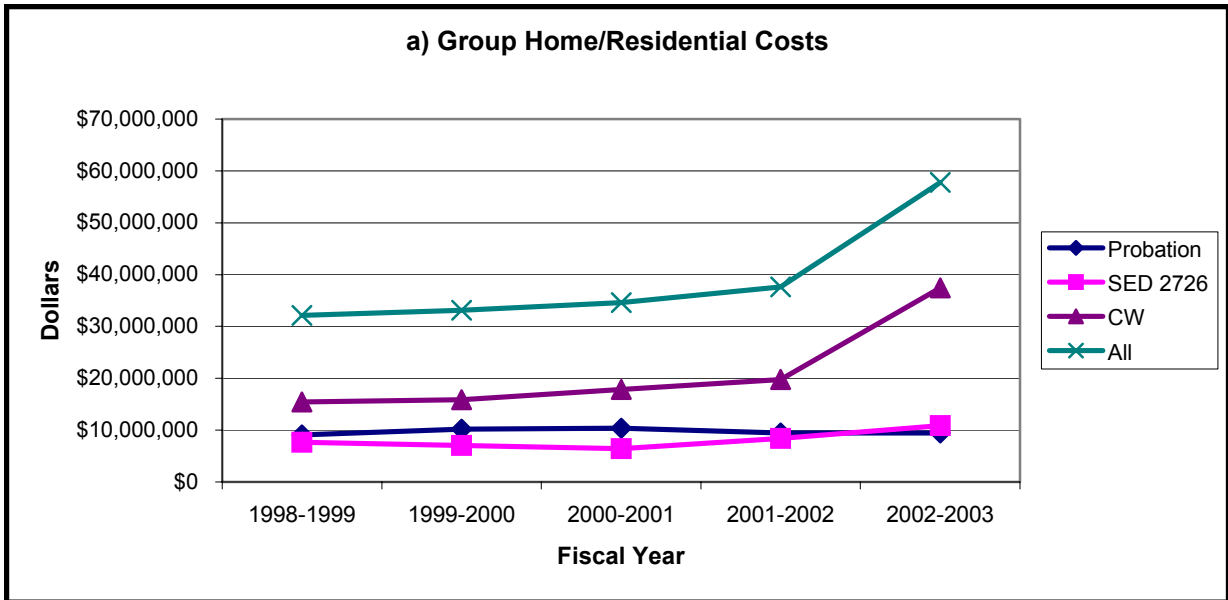


Note: For FY02-03, FFS bed days includes 687 admin days.

- For FY02-03, the CAPS costs include costs not paid by CMHS contract. The amount paid by the contract was \$4,931,781, a 3% increase from FY01-02 to 02-03.
- This shows a 5% increase in costs between FY01-02 and 02-03 for FFS Medi-Cal. These cost increases are partly due to rising costs for daily rates.
- The total amount of bed days from FY01-02 to 02-03 decreased by 14%.

Figure 39: 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.



Note: For FY02-03, cost and months in placement include Probation youth placed through the CMHS Initiative. CW data include group home alternatives to shelter care placements made by non-Residential social workers. Previous fiscal years did not include these data.

- Cost for Child Welfare placements made by Residential workers was \$18,688,596, a slight decrease from 01-02. Months in placement was 3,478, also a slight decrease from 01-02.

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, 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 and youth through ISEP. Standardized assessment tools and face-to-face interviews are used to collect the information.

This section presents the perspectives of families. Families' perspectives on satisfaction with services, quality of services and demonstration of program staff behavior according to the system of care principles are presented.

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 40). There are no statistically significant differences between parent and youth reports, with the exception of the long-term sample at 18 months. For both informants at each time point (with the exception of youth at 18 months), there is significantly less satisfaction for short-term services compared to long-term services. There are no significant differences between ethnic groups on level of family or youth satisfaction at 6 months, 1 year or 2 years (Figure 41).

Results from the Multidimensional Adolescent Satisfaction Scale (MASS) show very few race/ethnicity differences in either sample. For the long-term intensive case management sample, White youth report significantly higher levels of satisfaction in "meeting needs" than African-American youth at both 6-month and 1-year timeframes (Figure 42). For the short-term sample, White youth report significantly higher levels of "family involvement" than Hispanic youth at both 6-month and 1-year assessments (Figure 43). White youth also report significantly higher levels of satisfaction in "meeting needs" compared to Hispanic youth at 6 months. Additionally, African-American youth report significantly higher levels of "family involvement" compared to Hispanic youth at 6 months. 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 the intensive case management services were positive or negative for them. Responses from the 6-month follow-up were classified into categories by similarity. The frequencies of responses were then tallied for each category of response. Table 10 lists the categories by youth or caregiver, rank-ordered by frequency of responses from most frequent (1) to least frequent (8). Note that the numbers of comments were self-generated by both parents and caregivers and vary in frequency. There were a total of 174 caregivers who received services and were asked to comment. Nine caregivers provided no positive comment, and 133 caregivers provided no negative comment about services. There were a total of 159 youth who received services and were asked to comment. Fourteen youth provided no positive comment, and 136 youth provided no negative comment about services. Negative comments were made significantly less often than positive comments.

In tabulating the “Positive Comments” for both youth and caregivers, “types of services,” such as information, referrals, service coordination, advocacy, counseling, recreation, etc., were commented positively on most often and therefore ranked highest for both informants. The next highest ranking by both caregivers and youth was “program characteristics,” such as location of services, family focus, consistent services served, etc. Youth also ranked “outcomes” and “helpful” as the second highest categories. “Outcomes” includes comments related to the family and youth functioning, reuniting the family and keeping the youth on track. It was ranked seventh by caregivers. “Helpful” includes comments related to how helpful a program was overall or about the helpfulness towards addressing family issues. This category was ranked sixth by caregivers.

After examining “Negative Comments” for both youth 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 provider as their top concern. This category included dislike of service provider and dislike with provider traits such as unreliable, poor boundaries and ineffective.

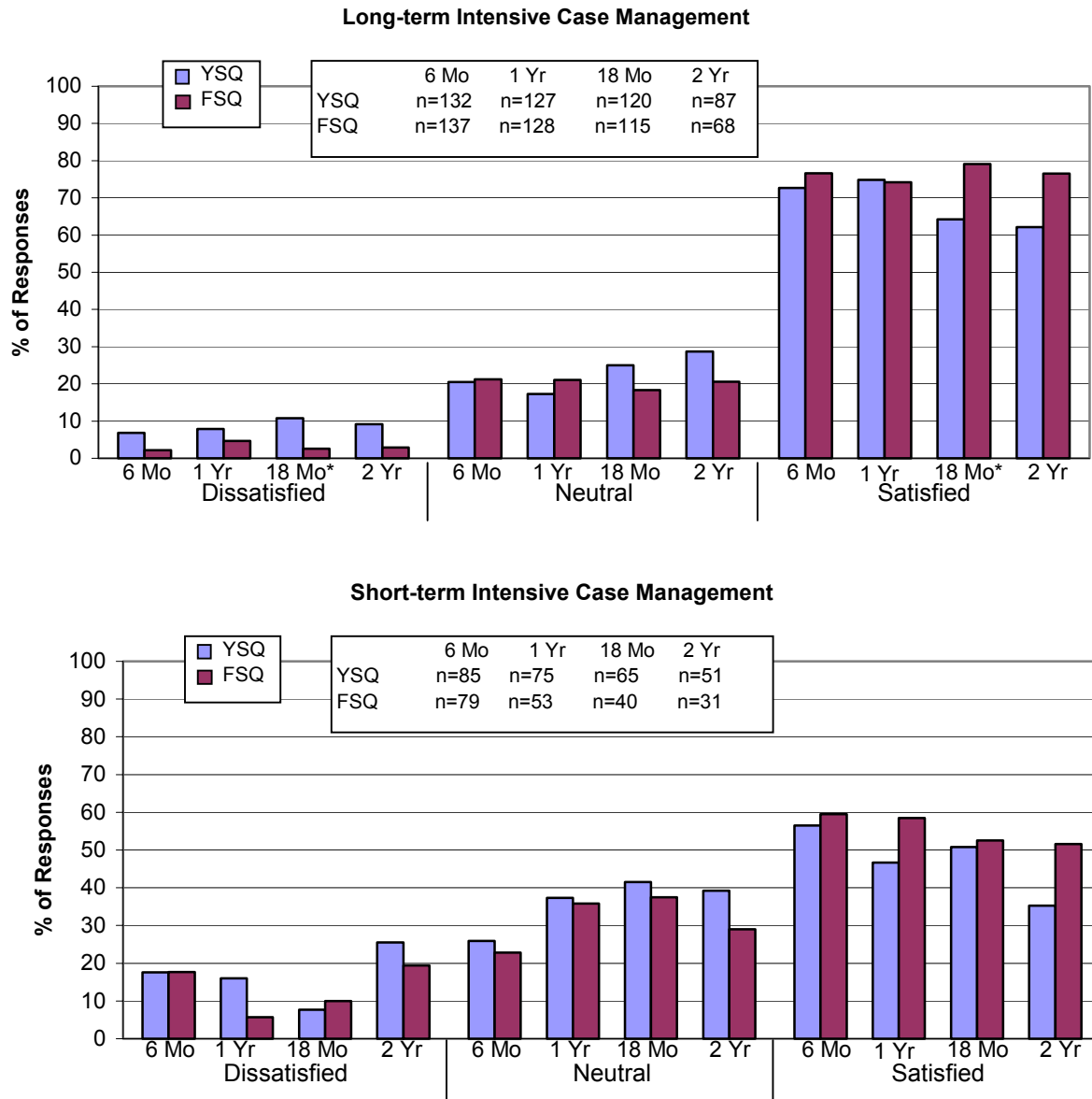
Adherence to Family-Centered Practice

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 44 presents the information on a selection of items from the FCBS at both 6-month and 1-year follow-up assessments. It also 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 respects their family’s

beliefs and customs at both time points. At 6-month assessment the following areas may be considered behaviors for staff improvement: (1) assisting families to receive help from friends and community (72%), (2) identifying child and family strengths (75%) and (3) assisting families in accessing resources (69%). Two of these areas are reported as improved at 1-year follow-up: (1) identifying child and family strengths (85%) and (2) assisting families in accessing resources (82%). Only 2% of families at 6 months and 4% of families at 1 year report that the staff makes decisions about their child's care without asking them. About 75% (6 months) and 85% (1 year) of the families report that the staff understands that they know their child better than anyone else does.

Figure 40: 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.

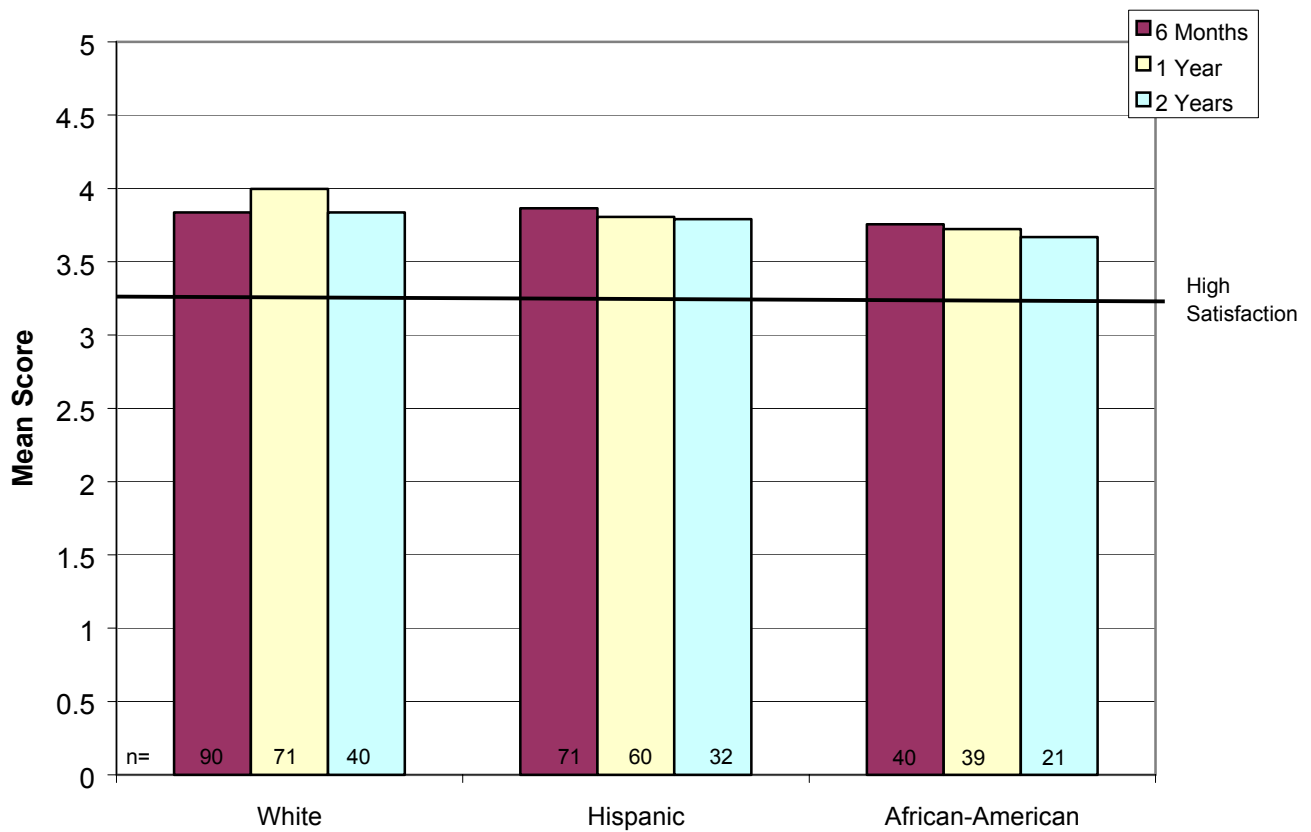


* represents statistical significance at $p < .05$ on Chi-Square comparisons of youth and family ratings

- Overall, for long-term intensive case management services, considerably more parents and youth report satisfaction with services compared to neutral and dissatisfied ratings.
- For both informants at each time point (with the exception of youth at 18 months), there is significantly less satisfaction for short-term services compared to long-term, based on Chi-Square comparisons ($p < .05$).

Figure 41: Family Satisfaction by Race/Ethnicity – Mean Scores at 6-Month, 1-Year and 2-Year Follow-ups

The Family Satisfaction Questionnaire (FSQ) is a measure of satisfaction with mental health services. The measure is a 5-point scale ranging from “very dissatisfied” to “very satisfied.” “n” refers to the number of respondents for each measure at each time point. The three main ethnic/racial groups are: White, Hispanic and African-American. Higher scores indicate greater satisfaction with services.

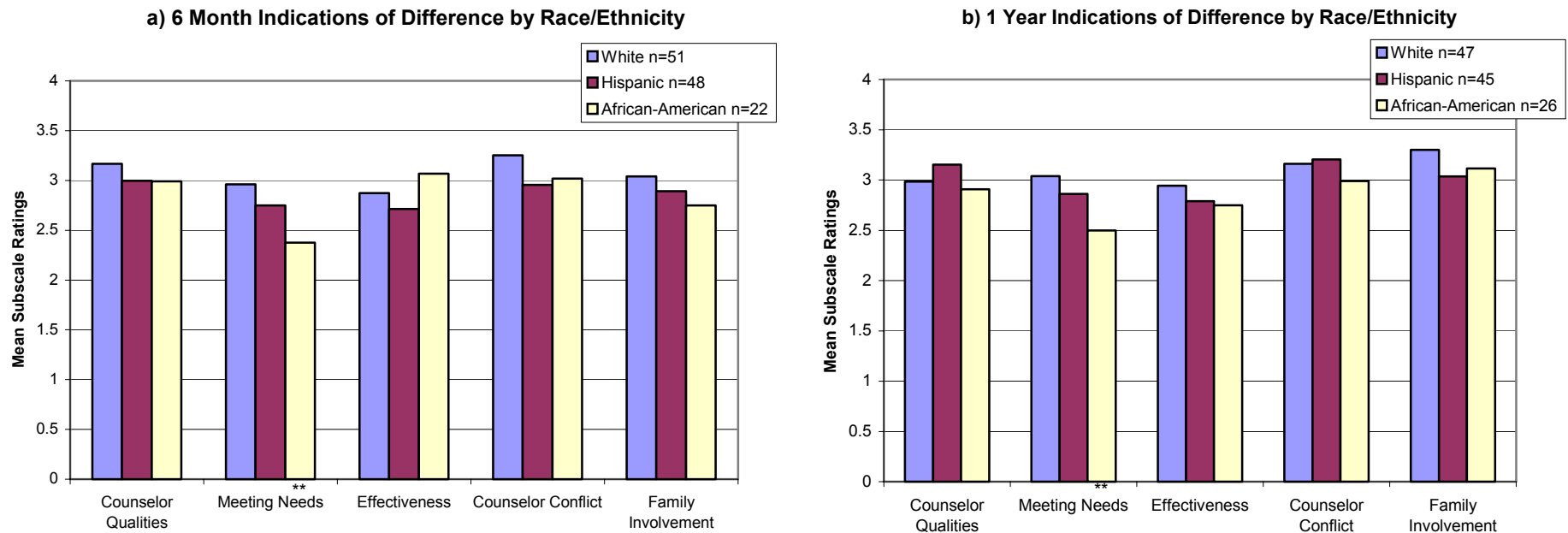


Note: The Asian/Pacific Islander and Other groups were not included in analyses due to their small sample size. However, their overall satisfaction levels appeared equivalent to other groups.

- Mean scores on the FSQ indicate high levels of satisfaction with mean score for all groups in the range of approximately 3.8 out of a total possible 5 points.
- There are no significant differences between ethnic groups on levels of family satisfaction at 6 months, 1 year or 2 years.
- Mean scores on the youth version of the satisfaction questionnaire (YSQ) show patterns of satisfaction similar to the FSQ.

Figure 42: 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 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.

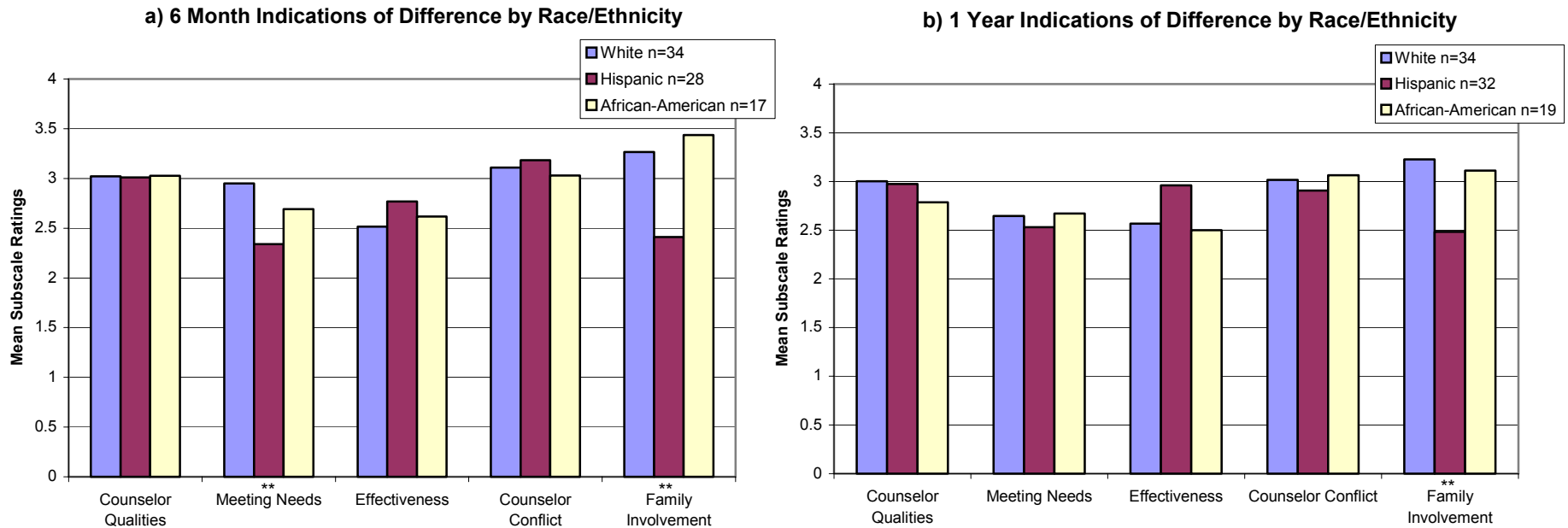


** represents statistical significance at $p < .01$ on Bonferroni multiple comparison test

- 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, at both 6 months and 1 year.

Figure 43: 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 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 $p \leq .01$ on Bonferroni multiple comparison test

- Youth, overall, are satisfied with counseling services.
- White youth report significantly more satisfaction with the level of intervention meeting their needs compared to Hispanic youth at 6 months. Additionally, African-American youth report significantly more satisfaction with level of family involvement compared to Hispanic youth at 6 months, $p < .01$.
- White youth report significantly more satisfaction with level of family involvement compared to Hispanic youth at 6 months and 1 year.

Table 10: ISEP Youth and Family Perceptions of Service Quality at 6-Month Follow-up

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

RANKING		CATEGORY	CAREGIVER		YOUTH	
C	Y		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>	93	27.7%	67	29.1%
2	2*	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>	82	24.4%	29	12.6%
3	3	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>	45	13.4%	26	11.3%
4	4	Basic Needs: <i>Use of flexible funds to provide food, transportation, clothing, help with housing.</i>	32	9.5%	24	10.4%
5	5	Communication: <i>Someone to talk to, offer advice, listen.</i>	30	8.9%	23	10.0%
6	2*	Helpful: <i>Helpful overall or with families' problems.</i>	29	8.6%	29	12.6%
7	2*	Outcomes: <i>Improved family and youth functioning, keep youth on track, help reunite the family.</i>	22	6.5%	29	12.6%
8	6	Like Program Overall: <i>General appreciation for the program.</i>	3	0.9%	3	1.3%
TOTALS			336	100	230	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. A total of 168 caregivers and 149 youth responded; 9 caregivers and 14 youth made no positive comments.

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

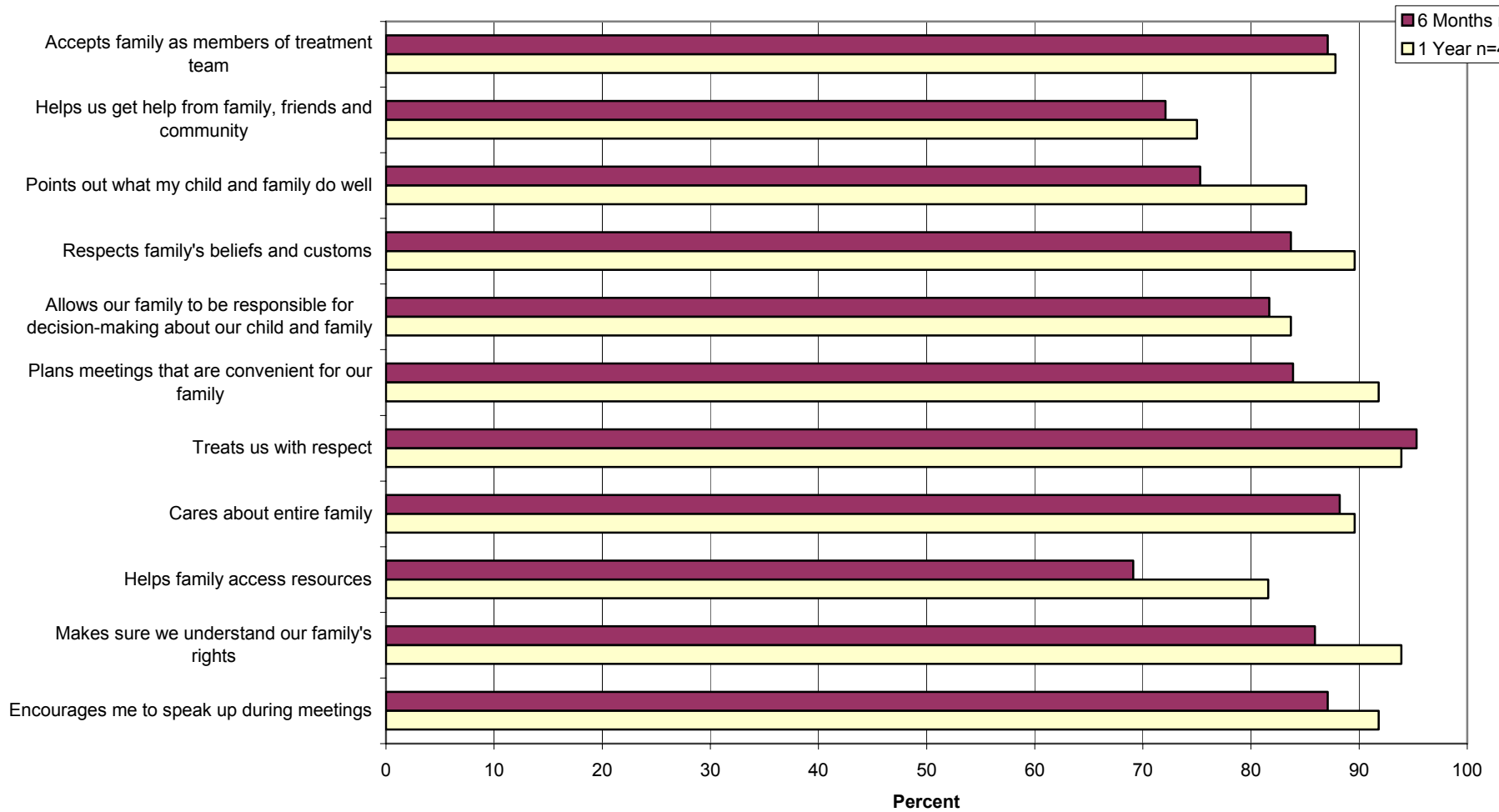
RANKING		CATEGORY	CAREGIVER		YOUTH	
C	Y		N	%	N	%
1	2	Dissatisfaction with Program: <i>Dissatisfied with aspect of the program such as lack of continuity, unreliable, poor communication, inability to engage family.</i>	34	61.8%	9	42.9%
2	1	Dissatisfaction w/ Provider: <i>Dislike of service provider, provider traits or provider performance such as unreliable, poor boundaries, ineffective.</i>	15	27.3%	11	52.4%
3	3	Dissatisfaction w/ Service: <i>Dissatisfaction with aspect of service such as amount of services provided, delayed service inception, poor follow through.</i>	6	10.9%	1	4.8%
TOTALS			55	100	21	100

Note: C = Caregiver; Y = Youth; N = number of responses for caregiver or youth in that category; % = percent of total caregiver or youth responses. A total of 168 caregivers and 149 youth responded; 133 caregivers and 136 youth made no negative comments.

1=most frequently mentioned
8=least frequently mentioned

Figure 44: Family-Centered Behavior Scale (FCBS)

Family’s perception of staff adherence to System of Care principles reported by the caregiver.



- 96.4% of families at 6 months and 98% of families at 1 year report 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.

System of Care Outcome Goals

San Diego County CMHS operates as a System of Care program (SOC). The System of Care is a comprehensive, integrated, community based, clinically sound and family centered structure for delivery of mental health and related supportive services to the children of San Diego County. The System of Care takes a broad approach, breaking down the separations that occur between and among traditionally structured and funded services and programs. The System of Care evolves over time through the trust and collaboration of its stakeholders. The System of Care is a collaboration of five public sector agencies (Children's Mental Health, Child Welfare, Juvenile Justice, Alcohol and Drug and San Diego Regional Center), the private sector, Education and families and youth. Beginning in 1997 San Diego implemented a system redesign at all levels, from top managers to service delivery staff, involving families and all relevant public and community-based agencies. The principles of System of Care have been embedded into the system and continue to inform the service delivery system. The guiding principles of SOC are as follows:

1. Services are collaborative, involving families, schools, child serving agencies and formal and informal community organizations, and demonstrate a full continuum of care that is flexible to the individual needs of the children/adolescents and their families.
2. Services are family centered and child-focused to promote family self-sufficiency, are culturally and linguistically competent and clinically sound, and are community-based. The services are meant to ensure that children and youth are best served within their life context.
3. The System of Care promotes easy and clear access to individualized services for all children and youth, with a smooth transition to adult services if needed.
4. The System of Care is accountable through clear outcomes, valid evaluation methods and proficient management information system. Assessments are strength-based; services are outcome driven. Client rights are protected.

The System of Care community has also defined a clear set of outcome goals to achieve within each sector across the system. The SOC Outcome Goals are as follows:

- 1. Children are living at home or in home-like settings**
- 2. Children are staying out of trouble**
- 3. Children are successful in school**
- 4. Children are safe**
- 5. Children are physically and emotionally healthy**
- 6. Clients are satisfied**

This chapter presents data according to the SOC Outcome Goals and Principles. Each section presents data collected for the general CMHS sample and the ISEP sample that relate to the SOC goals and principles. The sections also include research conducted in San Diego by investigators at the Child and Adolescent Services Research Center (CASRC) that corresponds to the SOC goals. This research provides additional information on San Diego's achievements and areas of further development towards meeting the System of Care vision that all of San Diego's children and youth will live at home or in home-like settings, be law abiding, successful in school, safe and healthy.

LIVE AT HOME OR IN HOME-LIKE SETTINGS

General Sample:

- 4% of youth in Mental Health Services had Inpatient Services (FY02-03) ↓ Reduction (5% in FY01-02)
- 7% of youth in Mental Health Services had Residential Services (FY02-03) ↑ Increase (6% in FY01-02)
- 30% of youth in MH Services had Juvenile Forensic Services (FY02-03) ↓ Reduction (34% in FY01-02)

ISEP Sample:

- 70% of youth live in “Home” or “Home-like” setting at entry to MH services
66% of youth live in Home/Home-like settings at 1 year ↓ Reduction
78% of youth live in Home/Home-like settings at 2 years ↑ Increase
- 27% of youth live in a “Restrictive” and 2% live in “Other” setting at entry to MH services
32% of youth live in a Restrictive setting at 1 year ↑ Increase
20% of youth live in a Restrictive setting a 2 years ↓ Reduction

Research in San Diego – Child Welfare:

James, S., Landsverk, J., & Slymen, D. J. Placement Movement in Out-of-Home Care: Patterns and Predictors (2004). Children and Youth Services Review, 16(2), 185-206.

- Despite significant placement movement, more than one-third of the children (35.6%) stabilized into a permanent setting within 45 days or as intended by the system, and another 28.6% found a stable placement within the first nine months.
- Children who stabilized early experienced fewer placement moves, fewer stays in residential care settings, fewer AWOL incidences, were more often placed with relatives and most importantly had the lowest level of behavior problems.
- Placement disruptions might not only be precipitated by behavioral problems but might also cause them, further propelling the foster child toward increasingly unstable patterns of placement movement.

Research in San Diego – Child Welfare:

James, S., Landsverk, J., Slymen, D. J., & Leslie, L. K. Predictors of Outpatient Mental Health Service Use - The Role of Foster Care Placement Change. (In Press). Mental Health Service Research

- Results of the current study indicate that a greater number of placement changes predict a greater number of outpatient mental health visits even after adjusting for other variables previously found to be predictive of outpatient mental health visits, including level of behavioral functioning.
- The study further found that children who experienced behavior-related placement changes had a 48% rate increase in outpatient mental health visits compared to their counterparts who changed placements due to other reasons.
- Findings also indicate that the child's level of behavior problems (as measured by the CBCL) most strongly predict outpatient mental health service use.

Clinical Implications: It takes time for children to move from restrictive living settings to home or home-like settings. Additionally, research shows that living in restrictive settings can directly impact a youth's behavior and functioning. Much energy should be focused on keeping youth out of restrictive settings and treating disruptive behaviors in foster care through special training of foster care providers and additional mental health interventions.

STAY OUT OF TROUBLE

General Sample:

- 6% of youth in Mental Health Services are also in Alcohol & Drug Services (n=1122)
↓ Reduction (7% in FY 01-02)
- 20% of youth in Mental Health Services are also in Juvenile Justice (n=3545)
↓ Reduction (23% in FY 01-02)

ISEP Sample:

- 73% of Non-Probation and 85% of Probation youth (15-18 years) report a history of smoking cigarettes
- 70% of Non-Probation and 92% of Probation youth report a history of drinking alcohol
- 57% of Non-Probation and 89% of Probation youth report a history of using Marijuana/Hashish
- 23% of Non-Probation and 40% of Probation youth report a history of using Hallucinogenic drugs
- 10% of Non-Probation and 30% of Probation youth report a history of using Cocaine drugs
- 20% of Non-Probation and 32% of Probation youth report a history of using Methamphetamine (Meth or crystal Meth) drugs
- 13% of Non-Probation and 24% of Probation youth report a history of using club drugs (i.e. Ecstasy, GHB, Special K)
- Average age of first cigarette=11.67
- Average age of first alcoholic beverage=11.78
- Average age of first marijuana use=11.96

Refer to Figures 28, 29 & 30 for more information on substance use.

- 52% of youth had a previous arrest 6 months prior to MH Services
28% of youth had an arrest in past 6 months at 1 year ↓ Reduction
15% of youth had an arrest in past 6 months at 2 years ↓ Reduction
- 71% of youth were on probation at entry to MH Services
42% of youth were on probation at 1-year follow-up ↓ Reduction
28% of youth were on probation at 2-year follow-up ↓ Reduction
- 71% of youth were in a Detention Center/Jail at entry to MH Services
42% of youth were in a Detention Center/Jail at 1 year ↓ Reduction
28% of youth were in a Detention Center/Jail at 2 years ↓ Reduction

Refer to Figure 31 for more information on delinquent behaviors.

Research in San Diego – Mental Health, Alcohol & Drug and Juvenile Justice:

Garland, A. F., Aarons, G. A., Brown, S. A., Wood, P. A., & Hough, R. L. (2003). *Diagnostic Profiles Associated With Use of Mental Health and Substance Abuse Services Among High-Risk Youths. Psychiatric Services, 54(4), 562-564.*

- Unmet need for services was greatest for the youths with a substance use disorder only, compared to youths with a mental health disorder or comorbid disorders.

Aarons, G. A., Brown, S. A., Hough, R. L., Garland, A. F., & Wood, P. A. (2001). *Prevalence of Adolescent Substance Use Disorders Across Five Sectors of Care. Journal of the American Academy of Child Adolescent Psychiatry, 40(4), 491-426.*

- Substance Use lifetime rates of 82.6% in AD, 62.1% in JJ, 40.8% in MH, 23.6% in SED and 19.2% in CW.
- Rates of SUDs were significantly higher among older youths and males.
- SUDs are highly prevalent among youths receiving care in the AD service sector as well as other sectors, particularly JJ and MH.
- Aggregated across all sectors, more than one-third of youths in the sample met criteria for a least one of the six SUDs in their lifetime, and one-quarter met criteria for a least one of the SUDs in the past year.

McCabe, K. M., Lansing, A. E., Garland, A., & Hough, R. L. (2002). *Gender Differences in Psychopathology, Functional Impairment, and Familial Risk Factors Among Adjudicated Delinquents. Journal of the American Academy of Child Adolescent Psychiatry, 41(7), 860-867.*

- Female delinquents had higher rates of parent-reported and self-reported psychological symptoms and higher rates of most DSM-IV disorders. In addition, female delinquents were more likely to have a history of almost all forms of parental abuse and neglect and were more likely to have a family history of mental illness than male delinquents.
- Both boys and girls involved in the juvenile justice system had higher rates of mental disorder and psychological distress than youths in the general population.

Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P. A. (In Press). *Mental Health Services Utilization by Youth in Public Sectors of Care. Mental Health Services Research.*

- Youth in Juvenile Justice had the lowest rates of use of most services, and involvement in JJ was associated with a decreased likelihood of mental health services.
- 52% of JJ youth had at least one psychiatric disorder, with most meeting criteria for ADHD or disruptive disorders.
- Youth involved with the Alcohol & Drug sector were similar to those in Juvenile Justice in that the services they received were predominantly correctional and residential based.
- 60% of youths from the Alcohol & Drug sector met criteria for a psychiatric disorder.

Clinical Implications: Clinicians and other public service sector professionals should be sensitive to the likelihood of Substance Use Disorders in youth in settings not specifically providing substance abuse treatment.

Clinical Implications: Probation officers and clinicians should be sensitive to the high rates of psychological problems (including disruptive behavior disorders) in youth in Juvenile Justice settings, especially adjudicated females, and make appropriate referrals to mental health services.

SUCCESSFUL IN SCHOOL

General Sample:

- 36% of youth in Mental Health Services are also in Special Education Services in their community school district (n=6472) in FY02-03 ↓ Reduction (37% in FY 01-02)

ISEP Sample:

- 24% youth in regular education, 27% in special ed, 29% in day treatment at entry to MH services
30% in regular ed ↑ Increase, 28% in special ed ↑ Increase, 21% in day treatment ↓ Decrease at 6 months (Refer to Figure 32)
- 68% of youth either improved or maintained perfect attendance from intake to 6 months in services (Refer to Figure 36)
- Youth show significant reductions in the number of excused and unexcused absences at 2 yrs after receiving Mental Health Services (Refer to Figure 36 for more information)
- 33% of youth had been suspended at least once in 6 months prior to MH Services
24% of youth had been suspended at least once in past 6 months at 1 year ↓ Reduction
20% of youth had been suspended at least once in past 6 months at 2 years ↓ Reduction
Refer to Figure 33 for more information on youth conduct.
- 11% of youth had been expelled in 6 months prior to MH Services
5% of youth had been expelled in past 6 months at 1 year ↓ Reduction
5% of youth had been expelled in past 6 months at 2 years → Maintained
Refer to Figure 33 for more information on youth conduct.
- 15% of youth are failing their classes within 6 months prior to MH Services
12% of youth are failing their classes within 6 months of 1 year assessment ↓ Reduction
10% of youth are failing their classes within 6 months of 2 year assessment ↓ Reduction
Refer to Figure 33 for more information on youth grades.
- 42% of youth are receiving an A or B grade average in 6 months prior to MH Services
47% of youth are receiving an A or B grade average at 1 year assessment ↑ Increase
51% of youth are receiving an A or B grade average at 2 year assessment ↑ Increase
Refer to Figure 33 for more information on youth grades.
- 60% of youth improved on reading domain of a standardized achievement test (WRAT3) from intake to 6 months after receiving Mental Health Services
- 41% of youth improved on spelling domain of a standardized achievement test (WRAT3) from intake to 6 months after receiving Mental Health Services
- 44% of youth improved on math domain of a standardized achievement test (WRAT3) from intake to 6 months after receiving Mental Health Services
Refer to Figure 34 for more information on the WRAT3.

Research in San Diego – Mental Health, Education:

Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P. A. (In Press). *Mental Health Services Utilization by Youth in Public Sectors of Care*. *Mental Health Services Research*.

- In the representative sample of youth who were involved in publicly funded sectors of care, overall, 87% had used at least one outpatient service and 71% had used a school-based service.
- Youth enumerated from the formal mental health sector and from special education SED programs had the highest rates of mental health service use.
- Youth in the special education sector also had extremely high utilization rates of specialty mental health services.
- Children in the child welfare system were less likely to use school-based services.

Clinical Implications: Mental health problems can impact school achievement, school attendance and overall school success. Mental Health providers should monitor a youth's school performance and should coordinate services with school settings.

CHILDREN ARE SAFE

General Sample:

- 4% of youth in Mental Health Services received an inpatient service (n=771) in FY02-03
↓ Reduction (5% in FY 01-02)
- 30% of youth in MH Services received a Juvenile Forensic service (n=5325) in FY02-03
↓ Reduction (34% in FY 01-02)
- 24% of youth in Mental Health Services are also in Child Welfare (n=4335) FY02-03
↓ Reduction (25% in FY 01-02)

ISEP Sample:

- 47% of youth have had a previous psychiatric hospitalization prior to receiving intensive case management services
- 28% of youth had a previous suicide attempt
- 34% of youth had been physically abused
- 29% of youth had been sexually abused
- 53% of youth have a history of family violence
- 52% of youth have a history of running away
- 39% of youth have a history of abusing substances

Refer to Figure 14 for more information on youth history.

Research in San Diego – MH, JJ, CW, AD and SED:

Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P. A. (In Press). Mental Health Services Utilization by Youth in Public Sectors of Care. Mental Health Services Research.

- In the representative sample of youths who were involved in publicly funded sectors of care, 45% had used at least one psychiatric inpatient service at some point during their lives.
- Youths in the special education sector also had extremely high rates of specialty mental health services; approximately 40% had a psychiatric hospitalization.

McCabe, K.M., Lucchini, S.E., Hough, R.L., Yeh, M., & Hazen, A. (In Review). The Relation Between Violence Exposure and Conduct Problems Among Adolescents: A Prospective Study.

- Exposure to community violence significantly predicted both conduct disorders and higher externalizing symptoms on the CBCL. These findings held even when controlling for demographic factors, conduct disorder diagnosis or externalizing problems and exposure to other forms of violence.
- Findings regarding family violence were less consistent. A history of child maltreatment was significantly related to conduct disorder, but was not predictive of externalizing symptoms (CBCL). Intimate partner violence was not predictive of either CD diagnosis or externalizing symptoms even when controlling for demographic factors, psychopathology and exposure to other forms of violence at intake.

Clinical Implications: A history of abuse and/or exposure to community violence often leads to serious emotional disturbance. These youth frequently require high levels of care such as hospitalization or intensive case management. Preventive programs in Child Welfare or Probation could impact the need for mental health services and improve child outcomes.

IMPROVED HEALTH: EMOTIONAL AND BEHAVIORAL FUNCTIONING

General Sample:

No information for this sample because the Performance Outcome Project (POP) data collection was cancelled by the state and discontinued locally in FY02-03.

ISEP Sample:

- 39% of youth have a chronic health problem along with a Mental Health condition
 - Of these youth, 61% are on medication for their Health condition (See Figure 14)
- 69% of youth received medication for emotional/behavioral symptoms related to MH condition (Refer to Figure 14)
- There is meaningful change (less functional impairment) from baseline to 2 years for youth in long-term and short-term intensive case management programs on repeat assessments (Refer to Figure 20)
- 45% of youth show a positive change from intake to 2 years CAFAS (24% negative change) (Refer to Figure 23)
- There are significant improvements from baseline to 2 years on parent and youth reports of emotional symptomatology for both long-term and short-term intensive case management programs on repeat assessments (Refer to Figures 21 & 22)
- 57% of youth show a positive change from intake to 2 years CBCL (18% negative change) (Refer to Figure 24)
- 57% of youth show a positive change from intake to 2 years YSR (21% negative change) (Refer to Figure 25)

Research in San Diego – Mental Health:

Baker, M. J. (2003) Youth clinical outcomes: Does race/ethnicity matter? Focal Point, 17, 6-9.

- Analyses of change from intake to six months reveal that Asian American/Pacific Islander youth and parents did not report improvements. However, per caregiver report, White youth demonstrate significantly larger improvements than other youth.
- Clinicians treating Asian/Pacific Islander youth did report improvements; in fact they reported the youth improved significantly more than youth of other cultural groups. Also, clinicians report Hispanic youth as less impaired at intake but improving similarly to other groups.

Clinical Implications: Youth that are severely impaired and at risk for restrictive levels of care are demonstrating improvements after 1 year and then maintaining gains to two years. Because youth receiving both short-term and long-term intensive case management services show improvements the amount of services required for improvements is not clear. Also, it is important to assess change from multiple informants as opinions may differ. Data on emotional and behavioral functioning are needed to guide both treatment and resource development.

CULTURAL AND LINGUISTIC COMPETENCE

General Sample:

- White (33% CMHS vs. 40% population), Hispanic (43% CMHS vs. 39% population) and Native American (<1% CMHS vs. <1% population) youth are represented as expected
- African-American youth (17% CMHS vs. 6% population) ↑ Higher than expected
- Asian/PI youth in services (4% CMHS vs. 9% population). ↓ Lower than expected
- ↑ White youth involved in Intensive Day Treatment and Case Management programs are more numerous compared to other services and 2000 census
- = Hispanic youth are receiving services as would be expected based on 2000 census with slight under-representation in Intensive Day Treatment
- ↑ African-American youth involved in all levels of care, especially restrictive settings including Day Rehabilitation, Intensive Day Treatment, Residential Mental Health services as well as Outpatient Fee-for-Services programs compared to 2000 census
- ↓ Asian/Pacific Islander youth are under-represented in most services with the Emergency Screening Unit serving the most youth

Refer to Figure 10 for more information on race/ethnicity and service modality.

- 70% of Organizational Providers offer services in Spanish, 19% in Asian/PI languages, 23% European languages, 8% Middle Eastern languages and 6% sign language
- 26% of all Fee-For-Service providers offer services in another language (n=200) of these: 50% Spanish, 6% Asian/PI languages, 18% European languages, 14% Middle Eastern languages and <1% sign language
- 60% of youth with Bipolar Disorder are White
- Hispanic youth are over-represented in Adjustment Disorders, and African-American youth are over-represented in Oppositional Defiant Disorders
- Asian/Pacific Islander youth receive relatively less restrictive levels of service
- Hispanic youth receive less case management, medication support and TBS services
- Native Americans receive less medication support

Refer to Figure 10 and Tables 4-7 for more information on race ethnicity and diagnoses/service utilization.

ISEP Sample:

- 40% White youth, ↑ more than CMHS as a whole
- 34% Hispanic youth, ↓ less than CMHS
- 19% African American youth, = about equal to CMHS
- 2% Asian youth, = about equal to CMHS
- 2% American Indian = about equal to CMHS
- 4% Other/mixed = about equal to CMHS

Refer to Figure 18c for more information on ISEP race/ethnicity.

- There are no significant differences between ethnic groups on levels of family satisfaction with services at 6 months, 1 year or 2 years (Refer to Figure 41)

Research in San Diego – MH, JJ, CW, AD & SED:

McCabe, K., Yeh, M., Hough, R. L., Landsverk, J., Hurlburt, M. S., Wells Culver, S., & Reynolds, B. (1999). *Racial/Ethnic Representation Across Five Public Sectors of Care for Youth*. *Journal of Emotional and Behavioral Disorders*, 7(2), 72-82.

- African Americans were over-represented in four of the five service sectors (Child Welfare, Mental Health, Juvenile Justice and SED).
- Asian/Pacific Islander Americans were under-represented in the CW, MH and SED sectors.
- Caucasian Americans were over-represented in the SED sector.
- Latinos were under-represented in CW and SED, over-represented in JJ.

(Striking differences in findings depended on the comparison group used, illustrating the importance of selecting appropriate comparisons that control for factors that may affect utilization, such as poverty status, insurance coverage and relative youth of the ethnic group.)

Hough, R. L., Hazen, A. L., Soriano, F. I., Wood, P., McCabe, K., & Yeh, M. (2002). *Mental Health Services for Latino Adolescents With Psychiatric Disorders*. *Psychiatric Services*, 53(12), 1556-1662.

- Rates of disruptive disorders were significantly lower among Latino adolescents than among White adolescents.
- Latinos with psychiatric disorders were significantly underserved compared to White youth.
- Latino adolescents with psychiatric disorders entered specialty mental health services at a later age and had attended fewer specialty mental health service visits in the previous years.

Leslie, L. K., Weckerly, J., Landsverk, J., Hough, R. L., Hurlburt, M. S., & Wood, P.A. (2003). *Racial/Ethnic Differences in the Use of Psychotropic Medication in High-Risk Children and Adolescents*. *Journal of the American Academy of Child Adolescent Psychiatry*, 42(12), 1433-1442.

- African-American and Latino youth had a reduced likelihood of using psychotropic medications compared to White children when controlling for age, gender, income, insurance status, involvement in the public mental health system, need and impairment.

Yeh, M., McCabe, K., Hurlburt, M., Hough, R., Hazen, A., Culver, S., Garland, A., & Landsverk, J. (2002). *Referral Sources, Diagnoses, & Service Types of Youth in Public Outpatient Mental Health Care: A Focus on Ethnic Minorities*. *The Journal of Behavioral Health Services & Research*, 29(1), 45-60.

- The results indicate that variations by race/ethnicity exist for referral sources, diagnoses received and services utilized by these youth, even when controlling for age, gender, functional impairment and prior service use.
- African American adolescents were more likely than Whites to be referred to mental health services from child welfare and juvenile justice, and both children and adolescents were less likely to be referred from the schools.
- Asian/PI youth entered services at a lower rate than that of other groups, and when they did enter, they were more likely to do so through involuntary means (from child welfare).
- Latino youth were more likely to have been referred to mental health services by family and were less likely to have entered services through a mental health agency than were Whites.

Baker, M. J. (2003) *Youth clinical outcomes: Does race/ethnicity matter?* *Focal Point*, 17, 6-9.

- Analyses of change from intake to six months reveal that Asian American/Pacific Islander youth and parents did not report improvements. However, per caregiver report, White youth demonstrated significantly larger improvements than other youth.
- Clinicians treating Asian/PI youth did report improvements. In fact, they reported the youth improved significantly more than youth of other cultural groups. Also, clinicians reported Hispanic youth as less impaired at intake but improving similarly to other groups.

Research in San Diego – MH, Edu, JJ & AD:

Yeh, M., McCabe, K., Hough, R. L., Dupuis, D., & Hazen, A. (2003). *Racial/Ethnic Differences in Parental Endorsement of Barriers to Mental Health Services for Youth*. *Mental Health Services Research*, 5(2), 65-77.

- Parents of ethnic minority youth actually reported fewer barriers to care than did parents of White ethnicity.
- Ethnic minority youth in this sample had higher levels of unmet need as compared to White youth.
- Contrary to prediction, African Americans, Asian/Pacific Islanders, and Latinos all endorsed a lower number of barriers than Whites.
- Barrier endorsement was unrelated to unmet need in this sample. However, upon further examination, the results suggest that future research on barriers to mental health care should consider cultural influences upon barrier endorsement.
- Acculturation to mainstream American culture was positively related to barrier endorsement, indicating that those families who identified more closely with American culture were actually reporting a greater number of barriers, even when controlling for symptom severity. These findings suggested that racial/ethnic and cultural variables did have an impact on barrier endorsement, albeit in the direction opposite to what was predicted.

Yeh, M., McCabe, K.M., Hough, R.L., Lau, A., Fakhry, F., & Garland, A. (In Press). *Why Bother with Beliefs?: Examining Relationships Between Race/Ethnicity, Parental Beliefs about Causes of Child Problems, and Mental Health Service Use*. *Journal of Consulting & Clinical Psychology*, 13-15.

- Parental beliefs reflecting Physical Causes, Relational Issues, Trauma, and Prejudice contributed in the relationship between race/ethnicity and mental health service use.
- Asian/PI and Latino youth were less likely than were Whites to use specialty mental health services, even when controlling for demographic variables and severity of symptomatology.
- Biopsychosocially-oriented beliefs were associated with a greater likelihood of mental health service use for two of the five belief categories examined.

Yeh, M., Hough, R.L., McCabe, K., Lau, A., & Garland, A. (2004). *Parental Beliefs about the Causes of Child Problems: Exploring Racial/Ethnic Patterns*. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43, 605-612.

- Ethnic minority parents are less likely to endorse biopsychosocial beliefs about the cause of their child's emotional/behavioral problems, with few racial/ethnic differences for sociological or spiritual/nature disharmony beliefs as causes.
- African-American, Latino and White parents all endorsed Personality most often, and Asian/PI parents reported this second most often, behind Friends. Spiritual Causes and Nature Disharmony were among the three least often endorsed causes for all four groups.

Aarons, G. A., Garland, A., Brown, S. A., & Hough, R. L. (In Press). *Race/Ethnic Disparity and Correlates of Substance Abuse Service Utilization and Juvenile Justice Involvement among Adolescents with Substance Use Disorders*. *Journal of Ethnicity in Substance Abuse*.

- Non-Caucasian youth may have limited access to services in the least restrictive (community-based) level of care.
- Non-Caucasian youth with Substance Use Disorders (SUD) were much more likely to be found in JJ settings where appropriate SUD services are less likely to be available.

Clinical Implications: Data reveal race/ethnic differentiations by referral source or entry into service programs in which minority youth are more likely to enter services through less voluntary mechanisms, such as probation or child welfare. Greater attention should be placed on outreach to minority groups providing services in less stigmatizing environments and reaching children at earlier stages. Services should focus on gaining parental support and adapting services to meet the needs of the family according to their culture and customs.

SATISFACTION OF CLIENTS

General Sample:

No information for this sample because no data were collected in FY02-03.

ISEP Sample:

- Mean scores on the Family Satisfaction Questionnaire (FSQ) indicate high levels of satisfaction with mean score for all groups in the range of approximately 3.8 out of a total possible 5 points (Refer to Figure 41)
- There are no significant differences between ethnic groups on levels of family satisfaction at 6 months, 1 year or 2 years (Refer to Figure 41)
- For both informants (parents and youth) at each time point (with the exception of youth at 18 months), there is significantly less satisfaction for short-term services compared to long-term (Refer to Figure 40)
- Youth, overall, are satisfied with counseling services on the Multidimensional Adolescent Satisfaction Scale (MASS). There is some race/ethnic variation by specific subscores (i.e. Meeting Needs) for short-term and long-term samples. (Refer to Figures 42 & 43)

Research in San Diego – Mental Health:

Garland, A. F., Aarons G. A., Hawley, K. M., & Hough, R. L. (2003). Relationship of Youth Satisfaction With Mental Health Services and Changes in Symptoms and Functioning. Psychiatric Services, 54(11), 1544-1546.

- Youths' global satisfaction was not significantly related to any parent- or observer-reported change in symptoms or functioning.
- Our findings suggest that consumer satisfaction should not be used as an indicator of effectiveness in reducing symptoms or improving functioning among youth.

Clinical Implications: Satisfaction with services are an important factor in the System of Care and may be an important factor predicting (and possibly reflecting) the extent of engagement in treatment. They may also be associated with the quality of the relationship with the clinician. However, satisfaction has not been found to be associated with symptom or functioning improvements which are strong indicators of treatment impacts.

QUALITY AND ACCOUNTABILITY

General Sample:

- In FY02-03, 80 medical record reviews were conducted with programs, averaging about 5 charts per program; approximately 400 charts total
- 100% score on Medi-Cal full system audit in FY02-03, excluding chart reviews

ISEP Sample:

- Families are experiencing fidelity of the System of Care principles in service at 6 months reported on the Family-Centered Behavior Scale:
 - Accepts family as members of team Always=87%
 - Helps us get the help we want from our support systems Always=72%
 - Points out what my child & family do well Always=75%
 - Respects our family's beliefs, customs and ways Always=84%
 - Plans meeting times and place that are good for us Always=84%
 - Treats us with respect Always=95%
 - Supports family in making decisions Always=82%
 - Helps my family get services from other agencies as needed Always=69%

Refer to Figure 44 for more information on the fidelity of these SOC principles.

- Caregivers report high quality of types of services offered and program characteristics
- Youth report high quality of types of services and quality of types of outcome goals
- Caregivers feel a need for improved quality related to continuity, communication and ability to engage with them as a family
- Youth feel a need for improved quality related to amount of service and follow through of services

Refer to Table 10 for more information on youth and caregiver satisfaction.

Research in San Diego – Mental Health:

Lewczyk, C. M., Garland, A. F., Hurlburt, M. S., Gearity, J., & Hough, R. L. (2003). Comparing DISC-IV and Clinician Diagnoses Among Youths Receiving Public Mental Health Services. Journal of American Academy of Child Adolescent Psychiatry, 42(3), 349-356.

- Diagnostic agreement between clinician and standardized assessment tool was poor overall
- Among youths who met DISC-IV criteria for ADHD, clinicians were six times less likely to diagnose ADHD for female youths.
- Among youths who met DISC-IV criteria for Disruptive Behavior disorder, clinicians were three times more likely to assign this diagnosis for youths involved in the SED sector.
- Contextual factors (child maltreatment, CW sector involvement) and demographic factors (minority status) were not significant predictors of diagnostic agreement.

Clinical Implications: The quality of diagnosis and treatment as reflected in medical records can impact client outcomes as well as funding.

FAMILY FOCUSED

General Sample:

No information for this sample because no data were collected.

ISEP Sample:

- 53% of youth have violence in family
- 54% of youth have a family member with a mental illness
- 47% of youth have parent who was in a psychiatric hospital
- 51% of youth have a parent who was convicted of a crime
- 72% of youth have a family member with a substance abuse disorder
- 36% of youth have a parent treated for substance abuse disorder

Refer to Figure 14 for more information on youth history.

- About 85-90% of families report adequate levels of resources related to meeting basic needs
- Very few families report adequate levels of resources related to quality of life (i.e. growth and support)

Refer to Figure 19 for more information on family resources.

- Parents of youth receiving long-term intensive case management services report less objective, subjective-internalized and global strain over time on Caregiver Strain Questionnaire
- Parents of youth receiving short-term intensive case management services report less strain over time (objective, subjective-externalized, subjective-internalized and global) on Caregiver Strain Questionnaire

Refer to Figure 26 for more information on caregiver strain.

- Families are experiencing the System of Care principles in service at 6 months:
 - Accepts family as members of team Always=87%
 - Helps us get the help we want from our support systems Always=72%
 - Points out what my child & family do well Always=75%
 - Respects our family's beliefs, customs and ways Always=84%
 - Plans meeting times and place that are good for us Always=84%
 - Treats us with respect Always=95%
 - Supports family in making decisions Always=82%
 - Helps my family get services from other agencies as needed Always=69%

Refer to Figure 44 for more information on the fidelity of these SOC principles.

Research in San Diego – Mental Health:

Baker, M.J & Hurlburt, M. (In Preparation). Parent and Family Factors in Children's Mental Health Services for Children with Disruptive Behavior Disorders.

- 30% of youth have a parent with a history of suicidality and 40% have a parent with current symptoms of depression at time of interview.
- 40-50% of parents report alcohol and drug problems (30-40% mothers with substance abuse).
- 55-60% of youth are living in single parent homes and 37% of families are living in poverty
- Parent and family characteristics have been found to impact treatment outcomes and treatment participation in efficacy studies.

Clinical Implications: The need to include the family in child treatment has been evident for decades and many therapies used with children include parents as either ancillary, supplementary or as primary in administering treatment. However, even though parents are expected to be the key agents in treatment implementation, issues that may impair their functioning (e.g. depression, substance abuse, family violence, low support, high stress) typically are not addressed explicitly in child treatment settings. Efforts should be made to address all needs of the family, including parental issues.

Future Directions

Outcome measurement is of increasing importance in our county and state. 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 outcome measures, appropriate sampling and relevant instruments. 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 03-04) 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. The new Children's Initiative wraparound program is anticipated to begin in the fall of 2004. In addition, the state (AB3015) 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 State of California's Performance Outcome System was significantly revised in accordance with fiscal cutbacks and shifts in outcome directives. System wide data collection under the new Performance Outcome Project consisted of administering the Youth Services Survey (YSS) and the Youth Services Survey-Family (YSS-F) in November 2003. The YSS and YSS-F surveys will be administered on a cross-sectional basis twice a year in the year 2004-2005. Additionally, upon recommendation from the Super Outcomes Committee, the Mental Health Board approved a new system-wide outcome data system consisting of the Child and Adolescent Measurement System (CAMS) measure and the Family Centered Behavior Scale (FCBS) measure. The CAMS assesses a child/youth's emotional and behavioral symptoms, functioning and strengths as well as other System of Care Outcome Goals such as staying safe, staying out of trouble, success in school etc. The FCBS assesses the extent to which System of Care Principles are being implemented in each type of CMHS service from the family's perspective. Cross-system outcome measurements involving school attendance, group home placements and arrests, will be collected on a smaller sample of youth (such as SB163 enrollees) 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 concluded in August 2003 as the SAMHSA System of Care grant ended.

As a result of these various changes, the System of Care Report in future years will be different in format and content. Reporting will 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 sustaining ongoing development in the system of care. Clinical data on youth outcomes will again be available for reporting in the future years.

Future Directions in Research in San Diego

There are a number of research studies that are being conducted in San Diego within the multiple service sectors included in San Diego's System of Care community. These studies are being conducted by research investigators of the Child Adolescent Services Research Center (CASRC) in collaboration with community programs. Five such studies are briefly summarized below.

The **Caretaker Enhancement and Enrichment Project (KEEP)**, “**KEEPing Kids in Placement Longer**,” is a five-year NIH-funded research project that is testing the “real world” effectiveness of an evidence-based intervention titled Parent Management Training (PI: Dr. Joe Price). The Parent Management Training intervention provides support and consultation to foster parents in a group format to address the behavioral problems of their foster children (ages 5 - 12) who are at high risk for psychological problems. It is being conducted in collaboration with the Child Welfare Services (CWS) and is currently in its fifth year of study. To date, KEEP has held 57 foster parent education and support groups in neighborhoods across the six regions of the county, reaching approximately 350 foster and kinship parents. The curriculum is covered in sixteen 1.5 hour sessions, with attendance rates averaging above 85 percent. Another 350 foster and kinship parents have participated in the control cohort. Identical interviews have been conducted with this group not enrolled in Project KEEP's training groups. Early outcomes indicate positive significance when comparing positive behavioral changes of the target children who were randomly assigned to the treatment group, particularly that group of children who were rated as having “moderate to high” number of problem behaviors at baseline. Based on the early positive results of KEEP, future plans are developing to 1) reach other age groups, 2) embed the principles of KEEP within the foster care system by teaching all foster and kinship parents the effective techniques used and 3) including KEEP training within the reunification process.

The **Practice and Research: Advancing Collaboration (PRAC)** project is a federally funded project sponsored by the National Institute of Mental Health (NIMH). Its goals are to learn more about how psychotherapy is practiced in community-based mental health clinics for children and families and to gain greater understanding about how to better integrate research and practice (PI: Dr. Ann Garland). The study began in September 2002 and is funded for five years. It will include approximately 40-50 clinicians and approximately 300 children ages 4-13 and their families entering treatment for disruptive behavior problems in six San Diego County outpatient mental health clinics. A unique component of this study is an active, constructive partnership between the researchers and clinicians to identify the most effective treatment practices for children and their families. A therapist advisory group (TAG), including at least one clinician from each of the six participating clinics, was formed to work closely with the research team at all stages of the project. The study will involve surveying approximately 85 clinicians, inquiring about common perspectives regarding essential treatment principles of effective care for children with disruptive behavior problems. Years 2-4 will examine how outpatient treatment for children with disruptive behavior disorders in community clinics is consistent with research-based principles (gathered from evidence-based practices) and consistent with practice-based principles (gathered from surveying clinicians). Years 2-4 will also examine how delivery of care consistent and inconsistent with these principles is associated with changes in selected child and family outcomes. To date, PRAC has enrolled 46 clinicians and 20 families.

The **Child & Adolescent Treatment Strategies (CATS)** project is a federally funded project sponsored by the National Institute of Mental Health (NIMH) to learn more about treatment strategies from therapists who work with children and families on a daily basis in publicly supported mental health care settings (PI: Dr. Michael Hurlburt). A specialized coding

system has been developed in the study to characterize the objectives that therapists pursue and the methods they use in their treatment sessions. The Child Therapy Process Rating System is linked both to strategies described in treatment approaches having a supporting basis of empirical evidence, as well as to strategies that therapists report are commonly used in the delivery of services. A group of 20 families participated in the initial design phase and assisted in refining the measurement system. Ultimately 100 families will participate, along with their therapists, in the CATS study. This study will provide rich information about the way therapists provide services to families, outcomes for children and families on several dimensions over time, as well as explore the relationships between different treatment approaches and client outcomes. This collaborative work with county agencies is designed to foster transfers of information between practice and research, and vice versa.

The **Study of Youth Treatment Environments (SYTE)** is funded by the National Institute of Mental Health (NIMH) (PI: Dr. Greg Aarons). The primary goal of SYTE is to better understand how organizational issues affect mental health providers, service quality and consumer satisfaction and outcomes. SYTE participants include over 380 mental health service providers and managers from 51 youth mental health programs in San Diego County. The data collected is shared with program managers and staff, providing them with feedback about leadership, organizational culture and organizational climate in their programs. Among issues discussed are strengths and areas for development and ways to improve organizational performance. SYTE has shown to date that better leadership results in a more positive organizational climate, and that a more positive climate is related to better clinician rated working alliances with youth and families receiving services. SYTE has also found that attitudes toward adoption of evidence-based practice are related to provider education level, professional experience, the type of organization in which providers work and organizational culture and climate. Additionally, in 2003 SYTE convened and began hosting a program manager leadership development group. Topics to be addressed are decided by the group and include professional development, management and human resource skills, ways to obtain funding, and understanding and addressing the full range of developmental needs of mental health professionals who manage and lead youth mental health programs.

The study of **Parent and Family Factors in Children's Mental Health** is funded by the National Institute of Mental Health (NIMH) (PI: Dr. Mary Baker). The study will examine the characteristics of parents and families of children receiving outpatient services for a disruptive behavior problems. Parents, youth and clinicians will be interviewed about which parent and family factors they feel may impact engaging in treatment and treatment outcomes. This information will be used to form an assessment battery for parents to complete that elucidates issues that they or their family are experiencing. This family-focused information will be linked to child services and child outcomes. Approximately 200 families will participate. Additionally, clinician's decision-making practices will be examined to further understand how parent and family issues are identified and addressed in child services. About 30 clinicians will be asked to participate. The study outcomes will provide information relevant to tailoring evidence-based practices to the needs of diverse, "real-world" families by providing clinicians with guidelines for making family-focused treatment decisions.