

Child and Adolescent Services Research Center



**County of San Diego
Health & Human Services Agency**

**Children's Mental Health Services
Sixth Annual System of Care Report**

Fiscal Year 2003-2004

Board of Supervisors

Pam Slater-Price, Chairwoman

Bill Horn, Vice-Chairman

Greg Cox

Dianne Jacob

Ron Roberts

Children's Mental Health Services

Sixth Annual System of Care Report

Fiscal Year 2003-2004

Child and Adolescent Services Research Center (CASRC)

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

Report Prepared By:

Jennifer Rolls Reutz, M.P.H.
Philip A. Hanger, Ph.D.
William Ganger, M.A.
Jay Gregory, M.A.
Shellane Calma, B.A.
Amelia Burns, B.A.

Acknowledgements

Our sincere appreciation to the youth, families, and staff who committed their time to complete the evaluations necessary to produce this report.

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

TABLE OF CONTENTS

Executive Summary		1
I Introduction		2
Report Contents.....		4
Participating Programs.....		6
<i>Table 1.1:</i> Organizational Providers.....		6
<i>Table 1.2:</i> Juvenile Forensic Programs.....		8
Regional Divisions.....		9
Cultural Competency.....		9
<i>Figure 1.1:</i> Regional Locations of Youth and Programs.....		10
II Description of the Children’s Mental Health Service System (CMHS)		11
<i>Figure 2.1:</i> Unduplicated Client Count Across All Providers and Modes by Fiscal Year.....		11
<i>Figure 2.2:</i> Number of Total Client Counts by Fiscal Year and Provider.....		12
<i>Figure 2.3:</i> Gender Distribution Across Mental Health Service System.....		12
<i>Figure 2.4:</i> Age Distribution Across Mental Health Service System.....		13
<i>Figure 2.5:</i> Race/Ethnicity Across Mental Health Service System.....		13
<i>Figure 2.6:</i> Unduplicated Counts of Youth Receiving Services from Mental Health and the Overlap with Other Sectors.....		15
<i>Table 2.1:</i> Unduplicated Client Counts Across System of Care Sectors.....		16
<i>Table 2.2:</i> Single and Multiple Use by Service System Sectors, All Ages (Overall).....		17
<i>Figure 2.7:</i> Single and Multiple Use by Service Mode.....		18
<i>Figure 2.8:</i> Distribution of Race/Ethnicity in Each Service Modality.....		19
Chapter Summary		20
III Service Utilization by Client Characteristics		21
<i>Figure 3.1</i> Primary diagnosis for CMHS clients in FY03-04.....		21
<i>Figure 3.2</i> Diagnosis by Race/Ethnicity.....		22
<i>Figure 3.3:</i> Diagnosis by Gender.....		23
<i>Figure 3.4</i> Diagnosis by Age		24
<i>Figure 3.5</i> Diagnosis by Medi-Cal.....		25
<i>Figure 3.6</i> Diagnosis by AB2726.....		26
<i>Table 3.1:</i> Restrictive Levels of Service Utilization by Diagnosis.....		27
<i>Table 3.2:</i> Outpatient Service Utilization by Diagnosis.....		29
<i>Table 3.3:</i> Restrictive Service Utilization by Race\Ethnicity.....		31
<i>Table 3.4:</i> Outpatient Service Utilization by Race/Ethnicity.....		33
Inpatient Service Use		34
<i>Figure 3.7</i> Inpatient Episode Count.....		34
<i>Figure 3.8</i> Inpatient Episodes by Age.....		35
<i>Figure 3.9</i> Inpatient Episodes by Gender.....		35

<i>Figure 3.10</i>	Inpatient Episodes by Race/Ethnicity.....	36
<i>Figure 3.11</i>	Inpatient Episodes by Primary Diagnosis.....	37
<i>Table 3.5</i>	Use of Restrictive Services by Children with Inpatient Episodes.....	38
<i>Table 3.6</i>	Use of Outpatient Services by Children with Inpatient Episodes.....	38
Service Use by Youth Receiving Wraparound/Intensive Case Management Services		39
<i>Figure 3.12</i>	Age Distribution for Youth Receiving Wraparound Intensive Case Management Services.....	39
<i>Figure 3.13</i>	Gender Distribution for Youth Receiving Wraparound Intensive Case Management Services	40
<i>Figure 3.14</i>	Race/Ethnicity of Youth Receiving Wraparound Intensive Case Management Services	40
<i>Figure 3.15</i>	Primary Diagnosis for Youth Receiving Wraparound Intensive Case Management Services	41
<i>Table 3.7</i>	Use of Restrictive Services by Youth in the Wraparound / Intensive Case Management sample.....	43
<i>Table 3.8</i>	Use of Outpatient Services by Youth in the Wraparound / Intensive Case Management sample.....	43
Service Use by Children with Open Child Welfare Cases		44
<i>Figure 3.16</i>	Age Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services.....	44
<i>Figure 3.17</i>	Gender Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services.....	45
<i>Figure 3.18</i>	Race/Ethnicity of Youth with Open Child Welfare Cases who are receiving CMHS Services.....	45
<i>Figure 3.19</i>	Primary Diagnosis for Youth with Open Child Welfare Cases who are receiving CMHS Services.....	46
<i>Table 3.9</i>	Use of Restrictive Services by Youth with Open Child Welfare Cases who are receiving CMHS Services.....	47
<i>Table 3.10</i>	Use of Outpatient Services by Youth with Open Child Welfare Cases who are receiving CMHS Services.....	47
Service Use by Youth Receiving Special Education Services		49
<i>Figure 3.20</i>	Age Distribution for Youth Receiving Special Education and Mental Health Services in FY03-04.....	49
<i>Figure 3.21</i>	Gender Distribution for Youth Receiving Special Education and Mental Health Services in FY03-04.....	50
<i>Figure 3.22</i>	Race/Ethnicity of Youth Receiving Special Education and Mental Health Services in FY03-04.....	50
<i>Figure 3.23</i>	Primary Diagnosis for Youth Receiving Special Education and Mental Health Services in FY03-04.....	51
<i>Table 3.11</i>	Use of Restrictive Services by Youth Receiving Special Education and Mental Health Services in FY03-04.....	52
<i>Table 3.12</i>	Use of Outpatient Services by Youth Receiving Special Education and Mental Health Services in FY03-04.....	52

IV Community Functioning Outcomes.....

Substance Use 54

Figure 4.1: Percent of youth who used substances in past month, by parent estimate or youth or self- report..... 54

Figure 4.2: Past Month Use of Substances by Length of Time receiving Services..... 55

Figure 4.3: Change over time on the CAFAS Substance Use subscale, Intake to 6 and 12 month follow-up points, for youth in the intensive case management / wraparound programs..... 56

Dual Diagnosis Youth 56

Figure 4.4: Age distribution for youth with a dual diagnosis..... 56

Figure 4.5: Racial/ethnic breakdown for youth with a dual diagnosis..... 57

Figure 4.6: Primary mental health diagnosis for youth with a dual diagnosis..... 57

Table 4.1: Restrictive service use by youth with a dual diagnosis..... 59

Table 4.2: Outpatient service use by youth with a dual diagnosis..... 59

Youth active to both CMHS and ADS sectors 60

Figure 4.7: Gender distribution for youth active to both CMHS and ADS..... 60

Figure 4.8: Age distribution for youth active to both CMHS and ADS 60

Figure 4.9: Race/ethnicity distribution for youth active to both CMHS and ADS 61

Figure 4.10: Primary diagnosis for youth active to both CMHS and ADS 61

Table 4.3: Restrictive service use by youth active to both CMHS and ADS 63

Table 4.4: Outpatient service use by youth active to both CMHS and ADS 63

Delinquent Behavior 64

Youth Services Survey (YSS) 64

Figure 4.11 Percent of youth who were arrested in past month, by parent or self-report..... 64

Figure 4.12 Past month arrests by length of time receiving services..... 65

Youth active to both CMHS and Probation sectors 65

Figure 4.13: Gender distribution for youth active to both CMHS and Probation 65

Figure 4.14: Age distribution for youth active to both CMHS and Probation..... 66

Figure 4.15: Race/ethnicity distribution for youth active to both CMHS and Probation..... 66

Figure 4.16: Primary diagnosis for youth active to both CMHS and Probation..... 67

Table 4.5: Restrictive service use by youth active to both CMHS and Probation..... 68

Table 4.6: Outpatient service use by youth active to both CMHS and Probation..... 68

School Achievement 69

Figure 4.17: WRAT3 School Achievement Test Scores – Intake to Six Months Assessed Change..... 69

Figure 4.18: WRAT3 School Achievement Test Scores – Intake to One Year Assessed Change..... 70

School Attendance 70

Figure 4.19: Percent of youth who were absent from school in past month, by parent or self-report..... 71

Figure 4.20: Percent of youth who were absent from school in past month, length of time receiving services..... 72

Figure 4.21: School attendance by youth receiving intensive case management / wraparound services..... 73

Chapter Summary 73

V	System Outcomes.....	74
	<i>Figure 5.1 :</i> State hospital costs by fiscal year.....	74
	<i>Figure 5.2 :</i> Inpatient costs by fiscal year.....	75
	<i>Figure 5.3 :</i> Inpatient bed days by fiscal year.....	75
	<i>Figure 5.4 :</i> Group home / Residential costs by fiscal year.....	76
	<i>Figure 5.5 :</i> Total months in Group home / Residential placement by fiscal year.....	76
	Chapter Summary	77
VI	Other Public Sector Data Sources.....	78
	Education Outcome Pilot Program	78
	<i>Table 6.1:</i> Providers participating in the Education Outcome Pilot Project, by SELPA.....	78
VII	Consumer Perspectives.....	81
	Youth Services Survey (YSS)	81
	<i>Figure 7.1:</i> November 2003 Youth Services Survey – All youth and parent responses.....	82
	<i>Figure 7.2:</i> November 2003 Youth Services Survey responses – youth and parent matched pairs.....	82
	<i>Figure 7.3:</i> November 2003 Youth Services Survey responses – Hispanic vs. non-Hispanic respondents.....	83
	<i>Figure 7.4 :</i> November 2003 Youth Services Survey by service modality.....	84
	Family-Centered Behavior Scale (FCBS)	84
	<i>Figure 7.5:</i> Family-Centered Behavior Scale (FCBS).....	85
VIII	Provider Perspectives.....	86
	Children’s System of Care Conference	86
	<i>Figure 8.1:</i> Attendees’ evaluation of the 2004 Children’s System of Care Conference.....	87
	<i>Figure 8.2:</i> Conference attendees’ attitudes toward Evidence-Based Practices.....	88
	Leadership Ratings	88
	<i>Table 8.1:</i> Leadership dimensions in the Multifactor Leadership Questionnaire.....	89
	<i>Figure 8.3:</i> Comparison of program manager and clinician leadership ratings countywide.....	90
	Chapter Summary	91
IX	System of Care Outcome Goals.....	92
	Living at Home or in Home-Like Settings.....	94
	Staying Out of Trouble.....	96
	Successful in School.....	97
	Children Are Safe.....	98
	Physically and Emotionally Healthy.....	99
	Clients are Satisfied	100
X	Future Directions.....	101

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

- * 17,716 youth (unduplicated client count) were provided mental health services in FY03-04, representing a 2% decrease from the previous year but an 18% increase from FY00-01.
- * The majority of youth served in CMHS are males (62%) and almost half are 13-17 years old (49%). However, each year more youth 0-5 years old (10%) and 6-12 years old (39%) are receiving services.
- * The youth served are from diverse backgrounds, with Hispanics and then Whites as the largest race/ethnic groups (45% H & 32% W) in CMHS. Whites are the largest group in the Intensive Case Management / Wraparound program (55% W & 25% 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, 17% in Juvenile Justice and 6% in Alcohol/Drug.
- * The top four types of diagnoses of youth, assigned by clinicians, in CMHS are, in descending order, 1) Adjustment disorders, 2) Depressive disorders, 3) Oppositional / Conduct disorders, and 4) ADHD.
- * Inpatient hospital costs decreased 12% from FY02-03 to FY03-04.
- * Parents generally report high satisfaction with services and there are no racial/ethnic group differences.

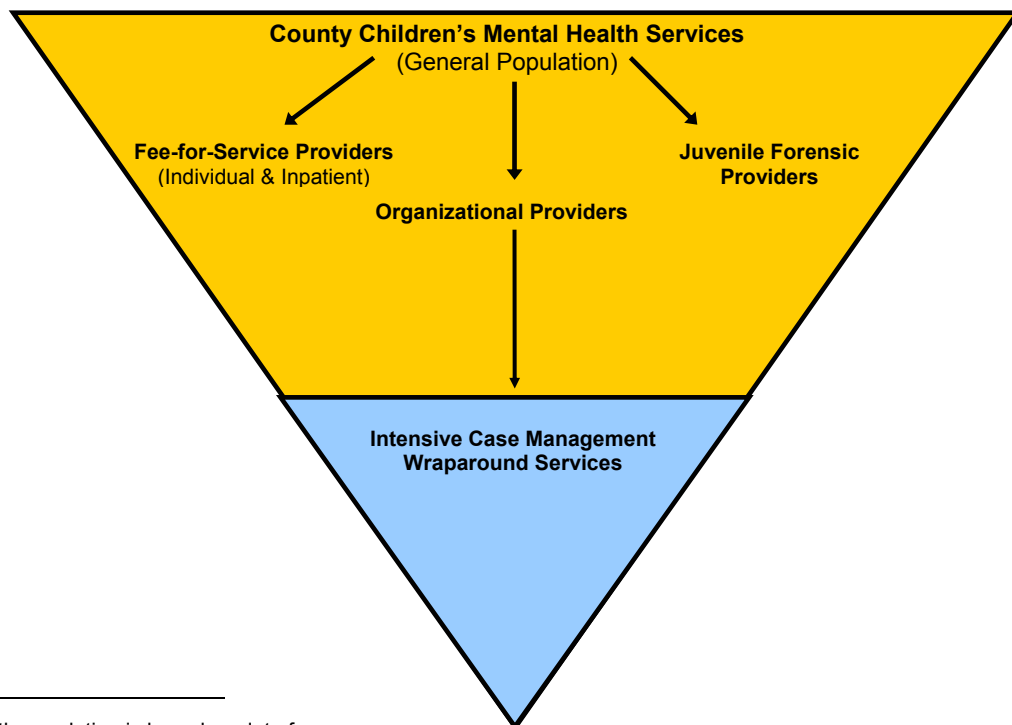
Note: For the purpose of this report, youth refers to children and adolescents of all ages.

Chapter 1: Introduction

This report provides information on San Diego County Children’s Mental Health Services (CMHS) clients and families served in Fiscal Year 2003-2004 (July 2003 – June 2004). CMHS primarily serves children and adolescents ranging in age from 1-18 years old, with some programs serving young adults, 18 to 25 years old, who are transitioning to adult services. San Diego is the third largest county in California with a youth population estimated at approximately 761,934¹ in 2003 and encompassing a vast diversity of race/ethnic groups, cultures and spoken languages. The CMHS program serves youth in the mental health population through three primary mechanisms: Fee-for-Service Providers, Organizational Providers and Juvenile Forensic Providers (see diagram below).

Fee-for-service providers are primarily 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 also three fee-for-service **inpatient hospitals** that provide services for child and adolescent Medi-Cal clients in San Diego County.

Organizational providers are community-based agencies and county-operated sites that are Medi-Cal certified and are either part of the Health & Human Services Agency (HHS) or have contracts with HHS to provide mental health treatment services to specified target populations (**Table 1.1**). These organizational providers are diverse and distributed across the county (**Figure 1.1**). They can be general treatment clinics, or they can provide services to a specialized population or a population in a specific setting (e.g. school, home, inpatient unit). 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.



¹ San Diego youth population is based on data from SANDAG, constructed from U.S. Census Bureau's 2000 Census SF1 and SF3; Current Estimates, July 2004

Juvenile Forensic Services provide services primarily in Probation institutions within the County (**Table 1.2**). Juvenile Forensic Services provides assessment, crisis intervention, consultation, and treatment services to children and adolescents who are involved with the Juvenile Court. Services are provided throughout the County at sites including Juvenile Hall and Girl's Rehabilitation Facility, Polinsky Children's Center, Juvenile Ranch Facilities, and Camp Barrett. Some of the services are provided by contract agencies for children who are wards and dependents of the court, such as intensive case management and outpatient services, transition services for wards leaving Juvenile Hall, and parent peer support counseling for families of children in Juvenile Hall.

San Diego County began implementing a **coordinated system of care** in 1997 under funding from the State of California (AB3015). San Diego County was also awarded additional funding in 1997 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. Several programs were developed and/or expanded to implement wraparound-based services:

- **Transition of Wards Embracing Recovery (TOWER)** - a short-term case management program for youth involved in the juvenile justice system (the program closed in May 2002).
- **Community Intensive Treatment for Youth (CITY)** - a long-term intensive case management state hospital alternative program for high-end youth needing intensive services.
- **Building Effective Solutions Together (BEST)** - a long-term case management service for youth who are court wards and dependents.

Additionally, the county began the **Children's Mental Health Services Initiative**, primarily funded from SB163, 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. The contractor for the CMHS Initiative during FY 03-04 was the **Child, Youth and Family Network (CYFN)**. A small number of youth have also received wraparound services through other contracted providers and entities, including TSI, Harmonium, and the San Diego County Wraparound Academy.

Outcomes Evaluation

San Diego County tracked outcomes for youth served by CMHS, both in the general mental health and wraparound services populations, through the **Performance Outcome Project (POP)**. This state-mandated project collected standardized measures on all youth receiving mental health services through CMHS at intake, 6-month follow-up time points, and discharge, to allow the county to assess change in functioning, community, and family status from interventions received. POP ended in August 2002 for the majority of programs delivering CMHS services; data collection continued for youth funded by the SB163 and 3015 programs (i.e. CYFN, BEST) until November 2003.

California replaced POP with the twice-yearly **Youth Services Survey (YSS)**. Studies showed that such a point-in-time collection schedule could be as effective at collecting satisfaction data as the periodic surveys done previously through POP. Under the YSS, all youth and families receiving services in a specific two-week time period complete the confidential satisfaction survey; aggregated results are reported back to the state, county, and individual programs. The first data collection wave took place in November 2003, while the subsequent collection wave, planned for May 2004, was cancelled. The YSS administration began the twice yearly schedule in FY04-05, with surveys completed in November 2004 and May 2005.

After the end of POP, the state also allowed individual counties to develop their own clinical outcome evaluation program. During FY03-04, a series of community stakeholder meetings were held to obtain input and feedback on the development of a countywide evaluation system for CMHS. Stakeholders, including clinicians, administrators, policy makers and families/consumers, were involved in the development process. After a thorough review of over fifty possible measures, the **Child and Adolescent Measurement System (CAMS) and the Family-Centered Behavior Scale (FCBS)** were chosen as the required measures because of 1) their ability to provide an assessment of San Diego County CMHS System of Care goals, and 2) the availability of information to be analyzed at multiple levels: the client level, the program level and the system level. Furthermore, service providers voted to enter and store their own data on-site into the Data Entry System (DES), providing regular downloads of their data to the SOCE team. Data collection with these instruments began in the fall of 2004 for youth receiving wraparound services; data collection expanded to all youth receiving CMHS services through organizational providers on January 1, 2005. Initial information from the CAMS and FCBS will be reported in the FY2004-2005 report.

Report Contents

Fiscal Year 2003-2004 fell in between the end of the POP data collection and the start of the CAMS / FCBS data collection. As a result, this report is limited in scope and capacity in its description of outcome data for children and adolescents served by Children's Mental Health Services (CMHS). The report presents the data from two samples (the CMHS population as a whole and the intensive case management / wraparound services population) and examines outcomes related to the System of Care Outcome goals:

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**

The chapters are broken out as follows:

Chapter 2: **Description of the Children's Mental Health Service System** provides information about the children and adolescents served by the CMHS from 2000 to 2004. The data addresses the questions: "Who is the County serving?" and "What services did youth receive?"

Chapter 3: **Service Utilization by Client Characteristics** provides a description of the amount and type of services used by children and adolescents, sorted by multiple variables, including diagnosis, age, gender, and race/ethnicity. Data is also presented for youth using inpatient or intensive case management services and those also receiving services from the Child Welfare or Special Education sectors. This data is presented for FY2003-2004.

Chapter 4: **Community Functioning Outcomes** reports on data associated with mental health improvements: substance use, juvenile justice involvement, and school absences and achievement.

- Chapter 5: **System Outcomes** reports system-level data on issues such as costs and service use patterns for each fiscal year.
- Chapter 6: **Public Sector Sources** reports on data from additional public services sectors involved in the system of care.
- Chapter 7: **Consumer Perspectives** reports on data from youth and parent perspectives regarding mental health service issues.
- Chapter 8: **Provider Perspectives** reports on data from providers regarding mental health service issues.
- Chapter 9: **System of Care Outcome Goals** reports data relevant to the SOC goals about youth served by CMHS. It also includes information from research studies that were conducted in San Diego County.
- Chapter 10: **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 ongoing research conducted in San Diego County.

Participating Programs

Table 1.1 lists the mental health programs that had contracts with CMHS during FY03-04. These programs comprise the Organizational Providers service mechanism. Table 1.2 lists the Juvenile Forensic programs.

Table 1.1: 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 – AB2726
Douglas Young Clinic	Outpatient Clinic	Mental Health
East County Child Day Treatment	Day Treatment Intensive	Mental Health – AB2726
Emergency Screening Unit	24-hour Emergency Services	Mental Health
EYE Ash/MHS Ash	Outpatient Clinic	Probation
Family Health Centers-Central	Outpatient Clinic-EPSDT	Mental Health
Family Health Centers-East	Outpatient Clinic-EPSDT	Mental Health

Program Name	Type	Target Population
Frontier Adolescent Day Treatment Center	Day Treatment Intensive	Mental Health – AB2726
Green Oak Ranch	Outpatient Clinic	Child Welfare
Hillcrest House	Outpatient Site-based	Child Welfare
Life School Adolescent Day Treatment	Day Treatment Intensive	Mental Health – AB2726
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
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-Discovery Hills	Day Treatment Intensive	Mental Health – AB2726
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 Viewridge	Day Treatment Intensive Specialized	Mental Health
Special Education Services Central & South Region	Case Management	Mental Health – AB2726
Special Education Services North Coastal & Poway Region	Case Management	Mental Health – AB2726
Special Education Services North & East Region	Case Management	Mental Health – AB2726
San Pasqual Academy	Day Rehab in Residential Facility	Child Welfare

Program Name	Type	Target Population
San Ysidro Middle School	Outpatient School-based	Mental Health – School
Social Advocates for Youth (SAY) CATS II	Outpatient School-based	Probation
Southbay Community Services	Outpatient Clinic	Probation
Southbay Youth & Family Services-Nueva Vista Family Services	Outpatient Clinic	Mental Health
Southeast Mental Health Clinic	Outpatient Clinic	Mental Health
Therapeutic Services Inc. (TSI)	Outpatient Clinic	Mental Health
Therapeutic Services Inc. Clark Stepdown	Outpatient Clinic	Mental Health
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 – AB2726
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

Table 1.2: 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

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)
- 6) North Inland (e.g. Escondido, Julian, San Marcos).

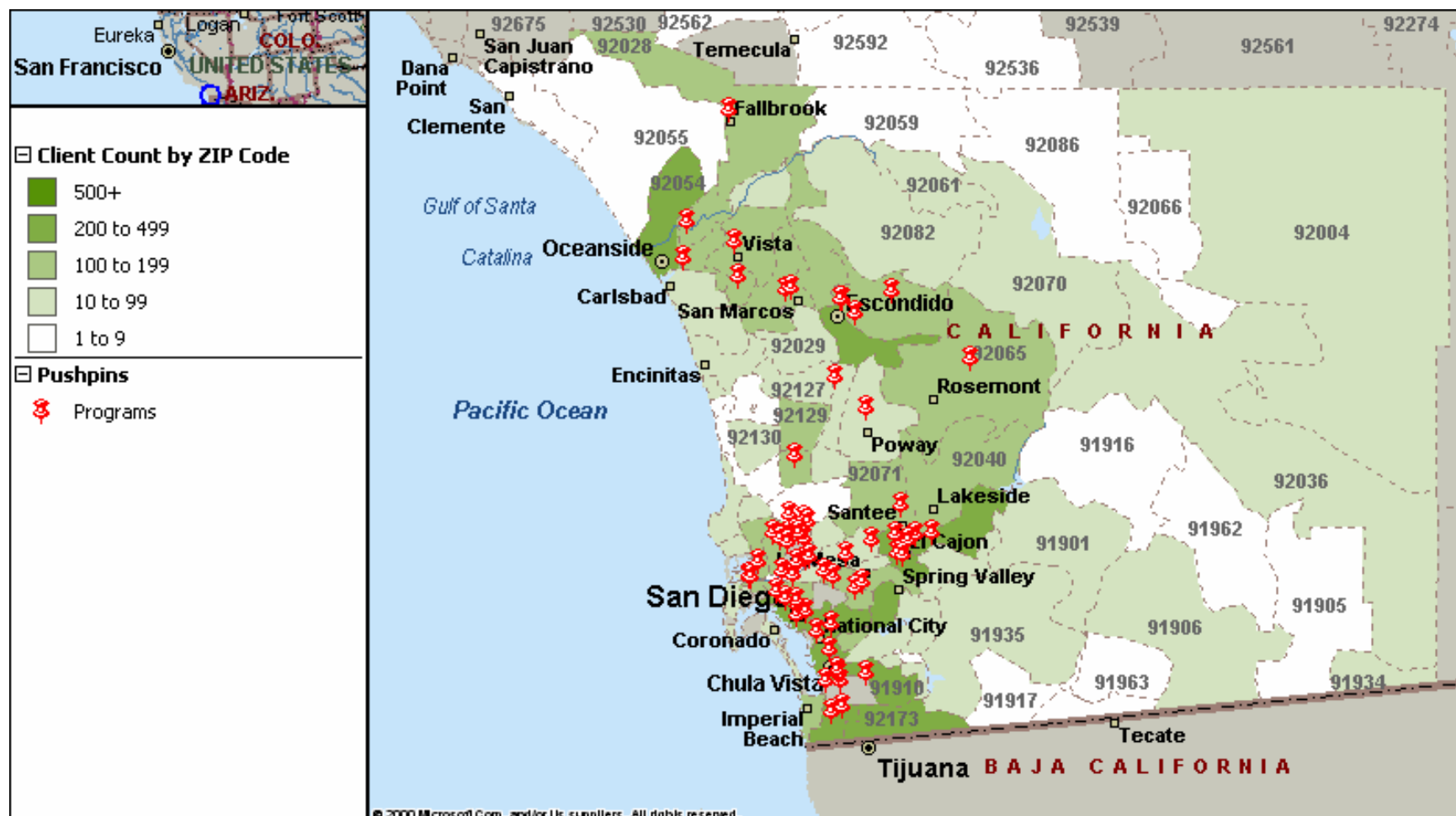
The majority of organizational providers are located in the North Central region (44%) (**Figure 1.1**). The other regions have similar percentages of organizational providers: 14% in Central, 10% in East, 14% in North Inland, 14% in South and 4% in North Coastal. The youth who received services from organizational providers live in all areas of the county. The distribution is fairly equal in size, with 27% of youth living in Central, 16% in North Central, 17% in South, 15% in East, 14% in North Inland and 11% in North Coastal.

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 70 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 American Sign Language.

Figure 1.1: 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 Fiscal Year 2003-2004. The red pushpins represent the location of mental health organizational providers.



Chapter 2: Description of the Children’s Mental Health Services Population

Youth served through Children Mental Health Services (CMHS) can receive services through three primary mechanisms, Fee-for-Service Providers, Organizational Providers, and Juvenile Forensic Services, which are described in more detail in Chapter 1. This chapter presents a description of the youth who receiving CMHS services in FY 03-04, compared to data from the past several years and the County’s youth population as a whole.

In Fiscal Year 2003-2004, CMHS served 17,716 unduplicated clients across all three provider mechanisms. In recent years, the unduplicated client count has been increasing (Figure 2.1).

Figure 2.1: Unduplicated Client Count Across All Providers and Modes by Fiscal Year

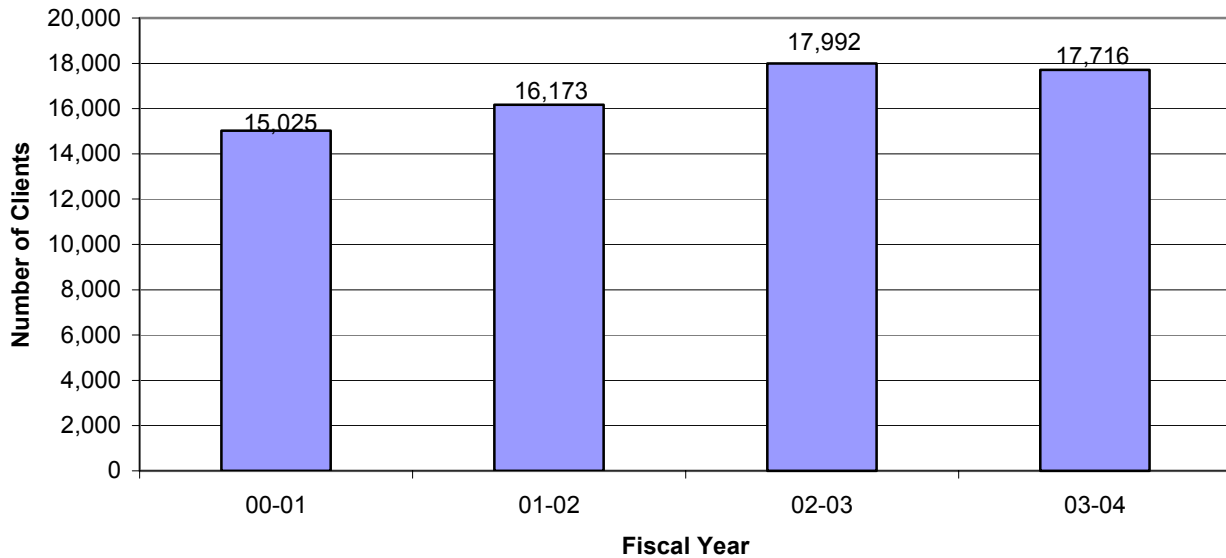
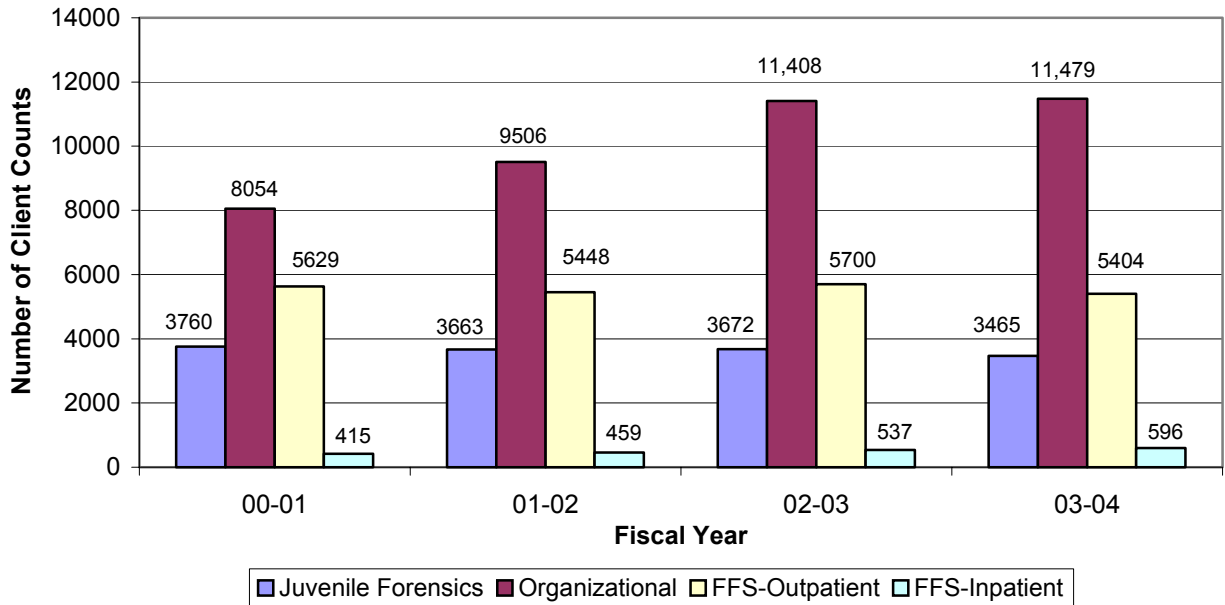


Figure 2.2 shows the breakdown of the number of unduplicated clients for each fiscal year by mechanism: FFS-Inpatient, FFS-Outpatient, Organizational Providers and Juvenile Forensic Services. Clients are increasingly being served through Organizational providers: 54% in FY00-01, 59% in FY01-02, 63% in FY02-03, and 65% in FY03-04. Note that a youth may receive services from more than one mechanism within the year and, therefore, the client counts exceed the total sample size.

Figure 2.2: Number of Total Client Counts by Fiscal Year and Provider



Gender distributions are stable across fiscal years, with a larger percent of males (approximately 65%) than females (approximately 35%) served through CMHS in FY03-04 (**Figure 2.3**). **Age** distributions are also fairly stable across fiscal years, with the majority of youth ranging in age from 13-17 years old (**Figure 2.4**). Both of these distributions vary widely from the 2000 Census data on youth in San Diego County (last set of columns on the right in figure), with males and adolescents being overrepresented in the CMHS client population and young children (ages 0-5) being underrepresented.

Figure 2.3: Youth Gender Distribution Across All Providers

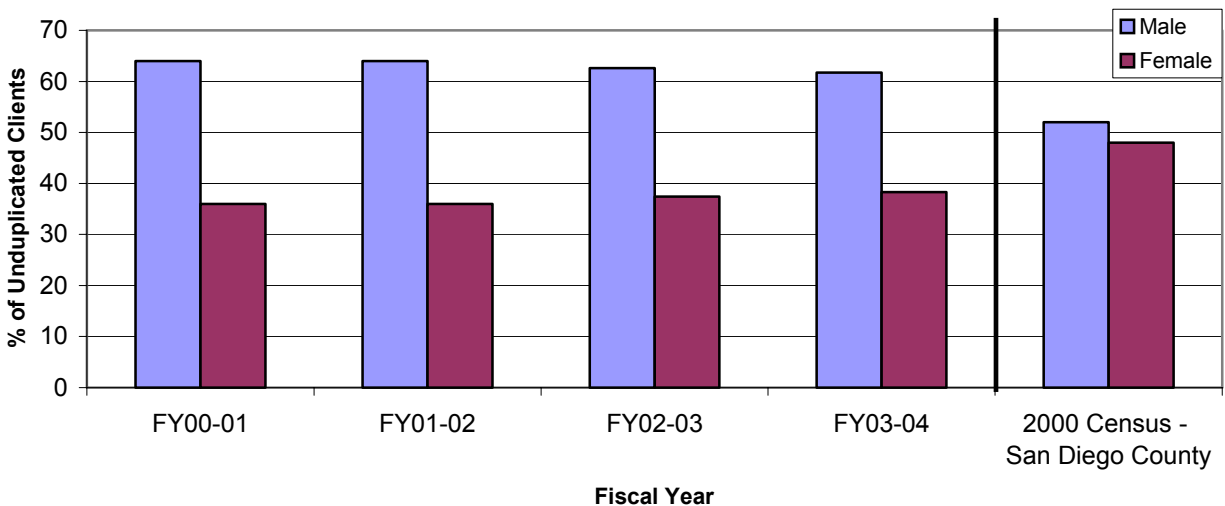
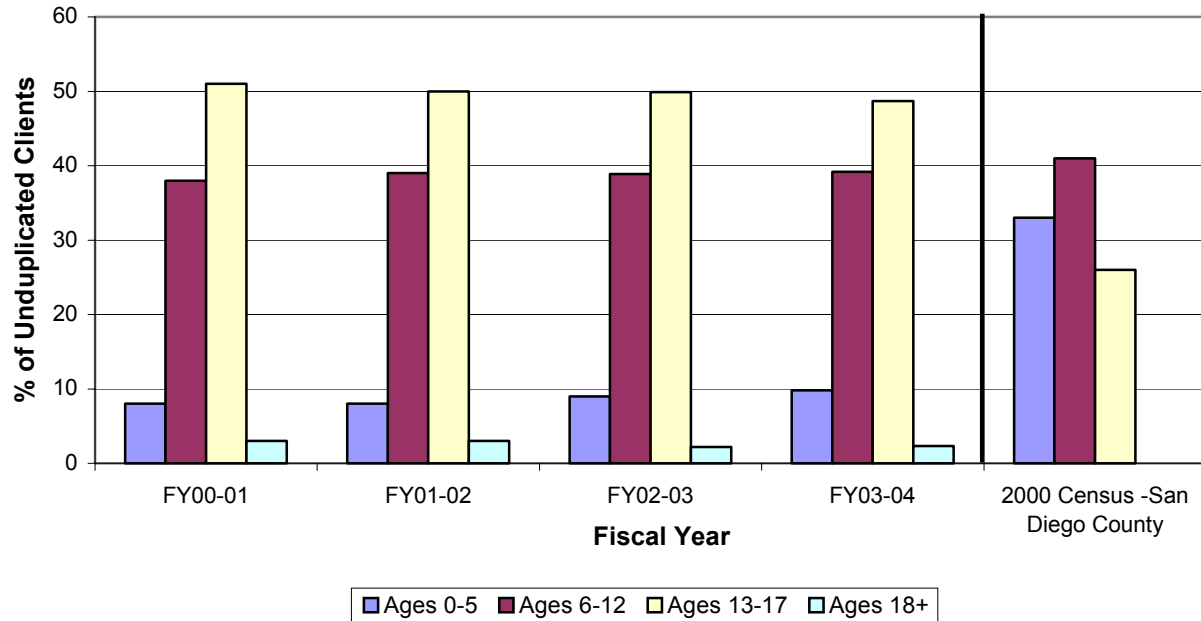
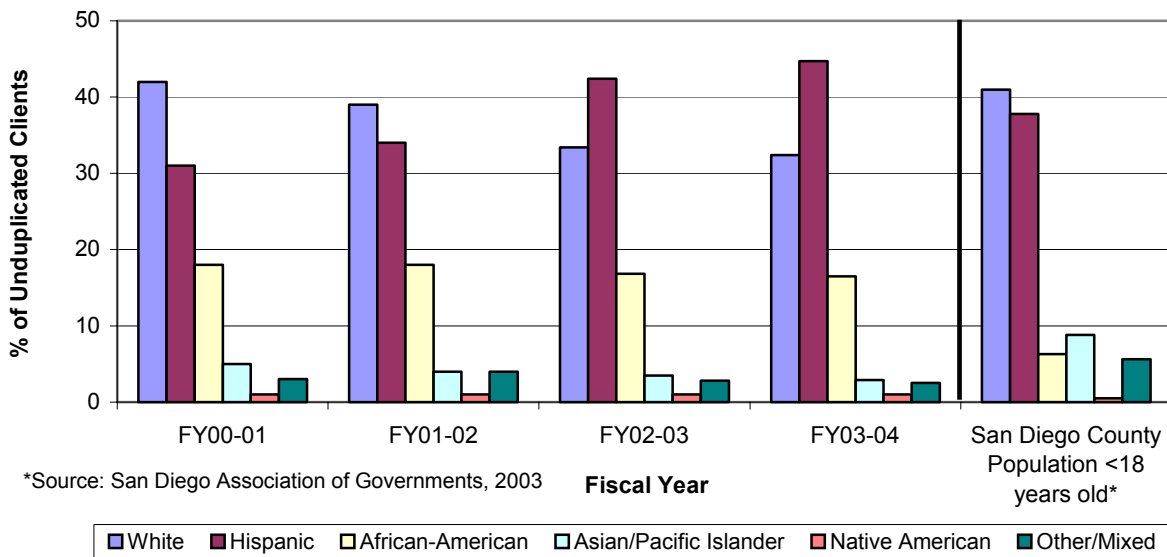


Figure 2.4: Youth Age Distribution Across All Providers



The **race/ethnicity** distribution of CMHS clients also varies from the countywide data (**Figure 2.5**). Hispanic youth continue to be the largest group served, composing 45% of the sample, continuing a pattern of increased prevalence in the percent served within CMHS. Hispanics are seen by CMHS at a prevalence rate that exceeded San Diego County census estimates (45% CMHS vs. 38% census), while Whites were underrepresented (32% CMHS vs. 41% census).

Figure 2.5: Youth Race/Ethnicity Across All Providers

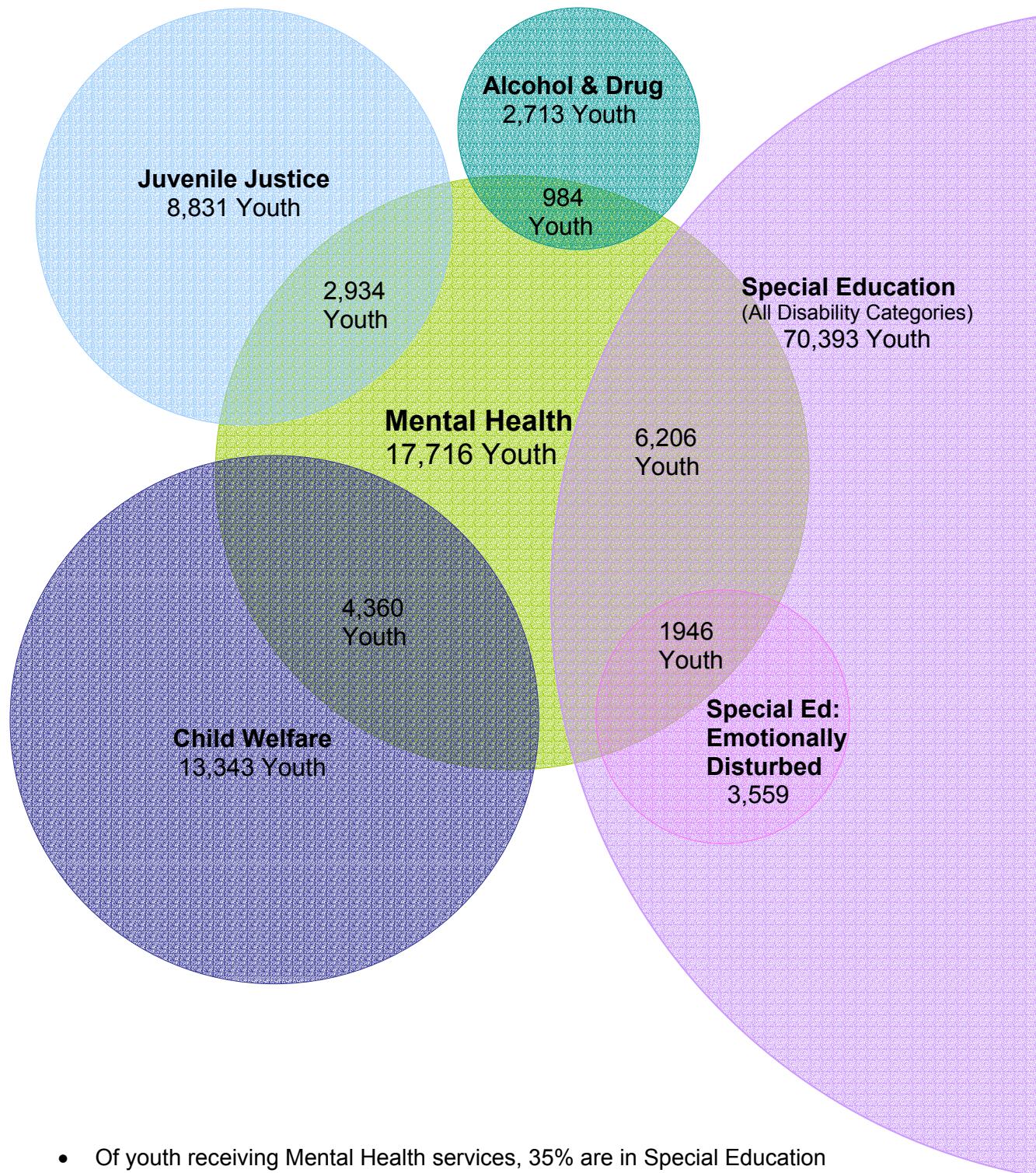


Almost three times as many African-American youth received services (17% CMHS vs. 6% census) than expected based on the population census. Only a third as many Asian/Pacific

Islander youth received services as expected based on the census (3% CMHS vs. 9% census). Native American youth were represented in the CMHS sample in proportion to their representation in the county population (<1% CMHS vs. <1% census), although this figure is difficult to interpret due to a possible floor effect from the small percentages involved. Finally, only half as many youth in the Other / Mixed racial/ethnic group, which includes youth who are of multiple racial/ethnic backgrounds or felt they were not adequately represented by the race/ethnicity options (White, Hispanic, African-American, Asian/Pacific Islander, or Native American), received services as expected based on their representation in the county youth population (3% CMHS vs. 6% census).

Figure 2.6 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.

Figure 2.6: Unduplicated Counts of Youth Receiving Services from Mental Health and the Overlap with Other Sectors - FY 2003-2004



- Of youth receiving Mental Health services, 35% are in Special Education (11% Emotionally Disturbed), 25% in Child Welfare, 17% 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 2.1.

Table 2.1 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 2.1: Unduplicated Client Counts Across System of Care Sectors for FY03-04^{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.

	Mental Health	Alcohol & Drug	Child Welfare	Juvenile Justice	Special Education	Special Ed: ED Only
Mental Health	100% n=17,716	32.4% n=984	32.7% n=4360	33.2% n=2934	8.8% n=6206	54.7% n=1946
Alcohol & Drug	5.6% n=984	100% n=3,036	0.9% n=123	9.8% n=865	0.8% n=529	3.6% n=127
Child Welfare	24.6% n=4360	4.1% n=123	100% n=13,343	4.8% n=424	3.7% n=2593	13.5% n=481
Juvenile Justice	16.6% n=2934	28.5% n=865	3.2% n=424	100% n=8,831	2.6% n=1858	12.2% n=434
Special Education	35% n=6206	17.4% n=529	19.4% n=2593	21.0% n=1858	100% n=70,393	100% n=3,559
Special Ed: ED Only	11% n=1946	4.2% n=127	3.6% n=481	4.9% n=434	5.1% n=3559	100% n=3,559

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.

- 35% of youth in Mental Health are involved in the Special Education sector.
- Nearly 33% of youth in Child Welfare receive Mental Health Services.
- Approximately 33% 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, over 50% of Emotionally Disturbed (ED) youth are in Mental Health.

Table 2.2 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).

Table 2.2: Single and Multiple Use by Service System Sectors, All Ages (Overall)

The data presented is the percent of youth open to only one sector and the percent of youth open to multiple service sectors. Percents are displayed by column.

	Mental Health n=17,716	Alcohol & Drug n=3,036	Child Welfare n=13,343	Juvenile Justice n=8,831	Special Ed: ED Only n=3,559
Not Open to Any Other Service Sector	61.4%	52.0%	65.5%	52.0%	40.8%
Open to One Other Service Sector	26.0%	22.3%	28.7%	39.3%	38.5%
Open to Two Other Service Sectors	10.9%	22.2%	4.9%	7.8%	16.8%
Open to Three or More Other Service Sectors	1.8%	3.5%	0.8%	0.9%	3.9%
Total	100%	100%	100%	100%	100%

- 38.6% of youth receiving Mental Health services were open to another sector in FY03-04
- Youth in Child Welfare are least likely to be involved in another service sector.
- Very few youth are involved in three or more service sectors within the fiscal year.

As described in Chapter 1, CMHS delivers services to youth through three primary mechanisms: 1) Fee-for-Service Providers, 2) Organizational Providers and 3) Juvenile Forensic Services. Within these three provider mechanisms, services may be delivered through different **service modes**. Service mode data is collected through administrative databases and coded using billed service code and reporting unit numbers.

The CMHS service modes include:

- **Inpatient services** - delivered in hospitals.
- **Residential services** - 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.
- **Intensive day treatment services** - 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. The focus is on psychotherapy interventions.
- **Rehabilitative day treatment services** - 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. The focus 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.

- **Outpatient services** - delivered in clinics, institutions, schools and homes. The largest services mode, outpatient services is often separated by delivery mechanism (FFS, Organizational, or JFS)
- **Emergency Screening Unit (ESU)** - provides crisis intervention, emergency screening services and crisis stabilization services (up to 24 hours) for children and adolescents throughout the entire county. Services are available 24 hours / 7 days a week.

Youth may receive services from one or several of the delivery mechanisms or modes in the course of a year. Figure 2.7 represents how and which clients use multiple services within the CMHS system. The column percents show 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 among youth receiving residential mental health services in FY03-04, 14% also received inpatient services and 63% received organizational outpatient services.

Figure 2.7: Single and Multiple Use by Service Mode¹
FY 2003-2004

Read Down ↓	Inpatient N =531	Res-M.H. N =646	Int. DT N =587	Day Rehab N =1354	Case Mgmt. N =2810	OP-Org. N =9366	OP-FFS N =5404	OP-JF/Inst. N =4548	ESU N =949
Inpatient	100.0%	14.4%	13.6%	7.2%	7.7%	3.5%	5.7%	2.6%	35.5%
Res-M.H.	17.5%	100.0%	39.7%	24.4%	8.2%	4.3%	6.6%	8.8%	10.1%
Int. DT	15.1%	36.1%	100.0%	11.8%	14.6%	4.0%	4.2%	3.3%	9.3%
Day Rehab	18.3%	51.2%	27.3%	100.0%	10.2%	11.6%	9.1%	15.3%	13.4%
Case Mgmt.	40.9%	35.8%	70.0%	21.1%	100.0%	19.1%	12.1%	11.8%	27.5%
OP – Org.	62.3%	63.0%	64.4%	80.4%	63.6%	100.0%	25.9%	22.4%	52.4%
OP – FFS	58.0%	54.8%	38.8%	36.5%	23.3%	14.9%	100.0%	15.6%	32.6%
OP – Inst	22.2%	61.6%	25.4%	51.4%	19.1%	10.9%	13.1%	100.0%	18.8%
ESU	63.5%	14.9%	15.0%	9.4%	9.3%	5.3%	5.7%	3.9%	100.0%
No Overlap	1.2%	1.2%	2.7%	5.6%	16.3%	59.8%	63.0%	63.3%	23.6%

FY 2002-2003

Read Down ↓	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%

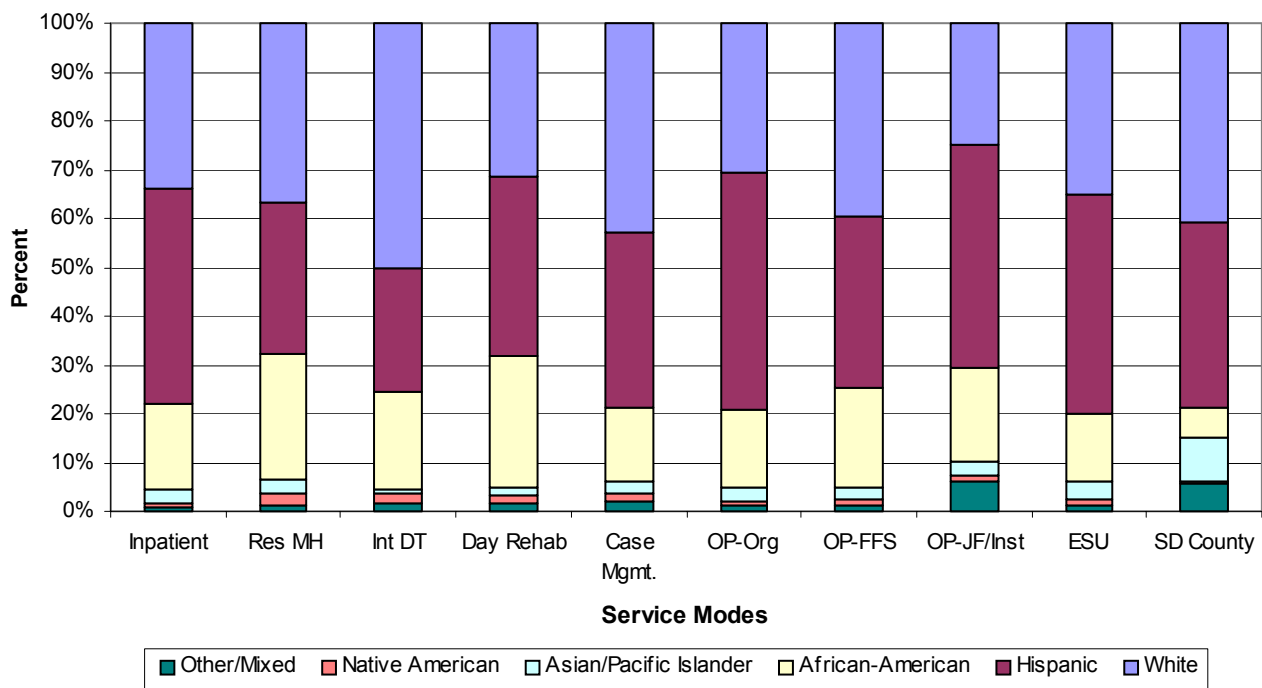
¹ Total exceeds 100% because youth can be open to multiple service modes within the year. Key-- Res-M.H.=Residential Mental Health Services, Int. DT=Intensive Day Treatment, Day Rehab=Rehabilitative Day Treatment, Case Mgmt.=Case Management, OP-Org.=Outpatient Organizational Programs, OP-FFS=Outpatient Fee-for-Services Programs, OPJF/Inst.= Outpatient Juvenile Forensic Institutions, ESU=Emergency Screening Unit.

There are several notable changes reflected in this table. First, youth receiving residential mental health services were more likely to also receive services from the other service modalities in FY03-04, as compared to FY02-03, with the exception of services from Outpatient Juvenile Forensics Institutions. Second, youth receiving Intensive Day Treatment, Day Rehab, and Case Management were more likely to also be receiving services from Outpatient Organizational Providers than in the previous year.

It should also be noted that there was a large decrease in the number of children receiving residential mental health services between FY02-03 and FY03-04, dropping from 1,198 to 646. Of possible significance, there was a corresponding increase in youth receiving Rehabilitative Day Treatment services from 543 in FY02-03 to 1,354 in FY 03-04. In addition, a large percentage of youth receiving outpatient services did not use any other service mode. For example, 59.8% of youth receiving Outpatient Organizational Program services did not receive services from any other mode. This can be contrasted with Inpatient services, in which only 1.2% of youth did not receive services from another modality during the year.

Figure 2.8 presents the **race/ethnicity** distribution in each of the service modalities. This figure demonstrates some variability between services. For example, there are relatively higher percentages of White youth utilizing intensive day treatment and Hispanic youth involved in outpatient organizational services, as compared to the San Diego County youth population (refer to the last column on right in the figure), while Hispanic youth are underrepresented in the Intensive Day Treatment modality. African-American youth are over-represented in all service modalities as compared to their distribution in the general youth population, while Asian-Pacific islander youth are underrepresented across the modalities. Youth can receive services from multiple modalities in a given year; therefore, it is not possible to determine whether these differences in racial/ethnic distribution are statistically significant.

Figure 2.8: Distribution of Race/Ethnicity in Each Service Modality



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.

Chapter Summary

- An increasing number of children are being served by the Children's Mental Health System
- The majority of children are served by County-contracted organizational providers
- Over 60% of the youth served are male, compared to 52% in the overall San Diego County youth population.
- About 45% of the youth receiving services are Hispanic, compared to 38% in the overall San Diego County youth population.
- Almost 40% of youth receiving CMHS services in FY03-04 were also open to another public sector of care, such as Alcohol and Drug Services, Child Welfare, Juvenile Justice, or Special Education, during the year.
- About 60% of youth receiving outpatient services did not receive services through any other service mode in FY03-04.
- The number of youth receiving rehabilitative day treatment services increased dramatically between FY02-03 and FY03-04, while the number of youth receiving residential mental health services was cut in half.
- Compared to the San Diego County youth population, African American youth are over-represented and Asian-Pacific Islander youth are under-represented in all service modes.

Chapter 3: Service Utilization by Client Characteristics

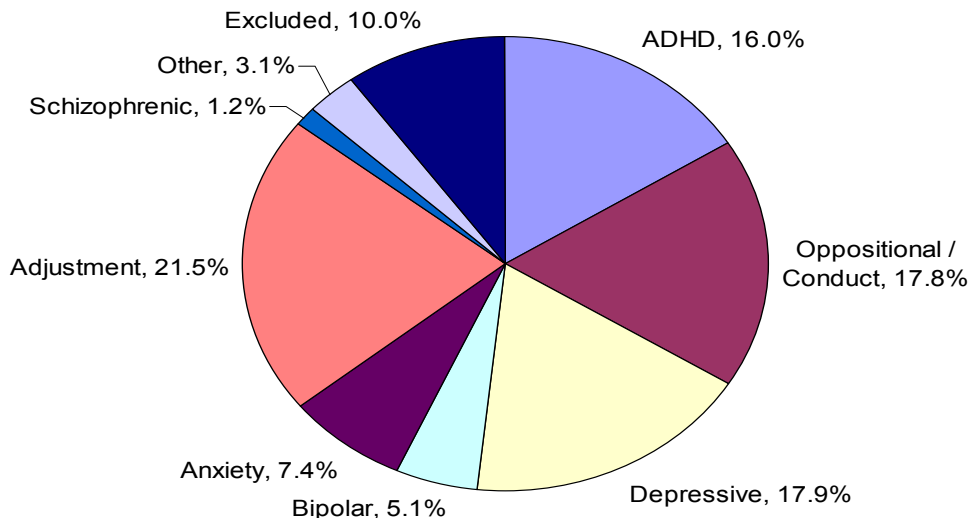
The data presented in this chapter describe the services provided to youth through CMHS for fiscal year 2003-2004, broken out by client demographics. In addition, analyses are presented for specific subpopulations of youth served by CMHS: those using inpatient or intensive case management services, and those receiving services from the Child Welfare or Special Education sectors.

As described in the previous chapters, CMHS delivers services through three primary mechanisms: 1) Fee-for-Service providers, 2) Organizational providers, and 3) Juvenile Forensic services. Data on the services delivered by these providers is collected in several different databases. Fee-for-Service and organizational providers both utilize United Behavioral Health for submitting claims data and receiving reimbursement for services, through a standard MIS database called **INSYST**. Juvenile Forensic providers utilize two independent database systems (**Juvenile Forensic Services** and **Spectrum**) for capturing client characteristics and tracking services provided. Inpatient providers also utilize an independent database system (**Telecare**) for client and service information. By combining these four databases, information on the youth served through CMHS and the amounts of services they obtained can be analyzed.

Client demographics were presented in Chapter 2. For the service use analyses, youth were grouped by age, gender, race/ethnicity and diagnosis, and compared to the CMHS population as a whole. Diagnosis was determined by identifying the **primary DSM-IV diagnosis** at intake from the last episode of service prior to June 30, 2004. Earlier valid diagnoses were chosen when later episodes reported “diagnosis deferred” (799.9) or **invalid diagnoses**, ones in which there was no valid Title 9 or excluded code provided for any services for that particular client. **Excluded diagnoses** are those categorized as “excluded” by Title 9 (i.e. autism, substance abuse, learning disabilities). Diagnoses were then grouped into meaningful diagnostic categories according to the Title 9 Medical Necessity Criteria of the California Code of Regulations list of included diagnoses. The **Other** category includes diagnoses such as Pervasive Developmental Disorder (PDD), Asperger’s Syndrome, Paraphilia, Reactive Attachment Disorder, elimination disorders, and eating disorders. Only one primary diagnosis was indicated per client for these analyses.

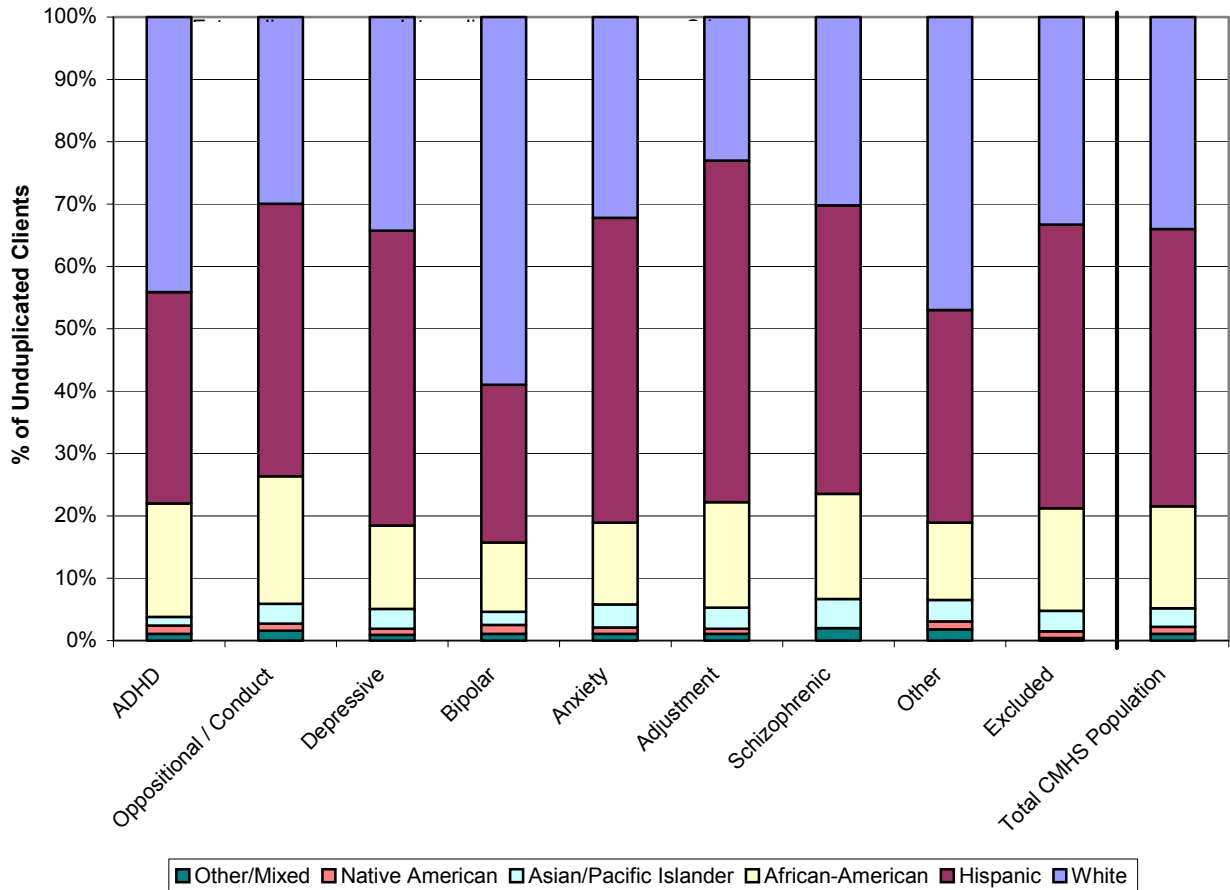
The most **common diagnoses** among youth served by the CMHS are 1) Adjustment disorders (21.4%), 2) Depressive disorders (including Dysthymic) (18.2%), 3) Oppositional Defiant disorders (including Conduct and Disruptive behaviors) (18.0%) and 4) Attention Deficit Hyperactivity Disorder (ADHD) (16.0%) (**Figure 3.1**).

Figure 3.1: Primary diagnosis for CMHS clients in FY03-04



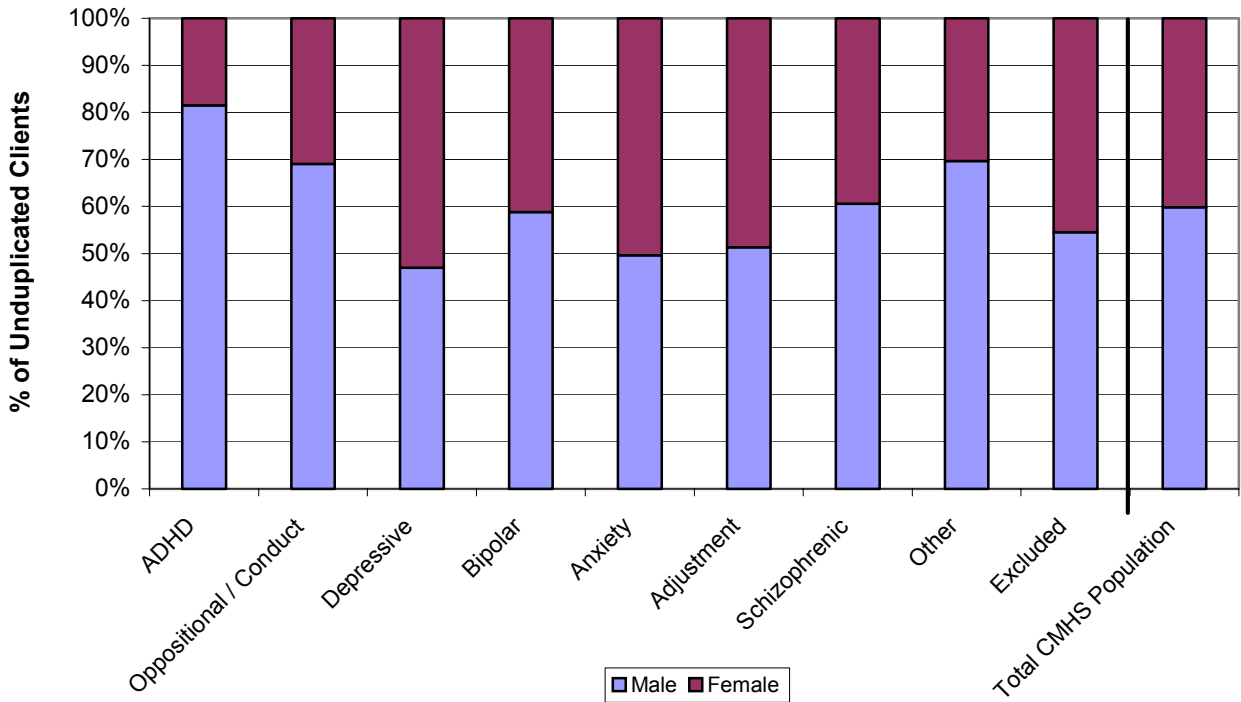
The diagnosis categories are examined by race/ethnicity in **Figure 3.2**. The racial/ethnic breakdown for the total CMHS sample is displayed on the far right for comparison purposes. Almost 60% of youth diagnosed with Bipolar disorder are White. Hispanic youth are relatively over-represented in the Adjustment disorders and African-American youth are over-represented in the Oppositional disorders and Asian/Pacific Islander youth are over-represented in the Schizophrenic disorders, compared to the racial distribution of the total CMHS population.

Figure 3.2: Diagnosis by Race/Ethnicity



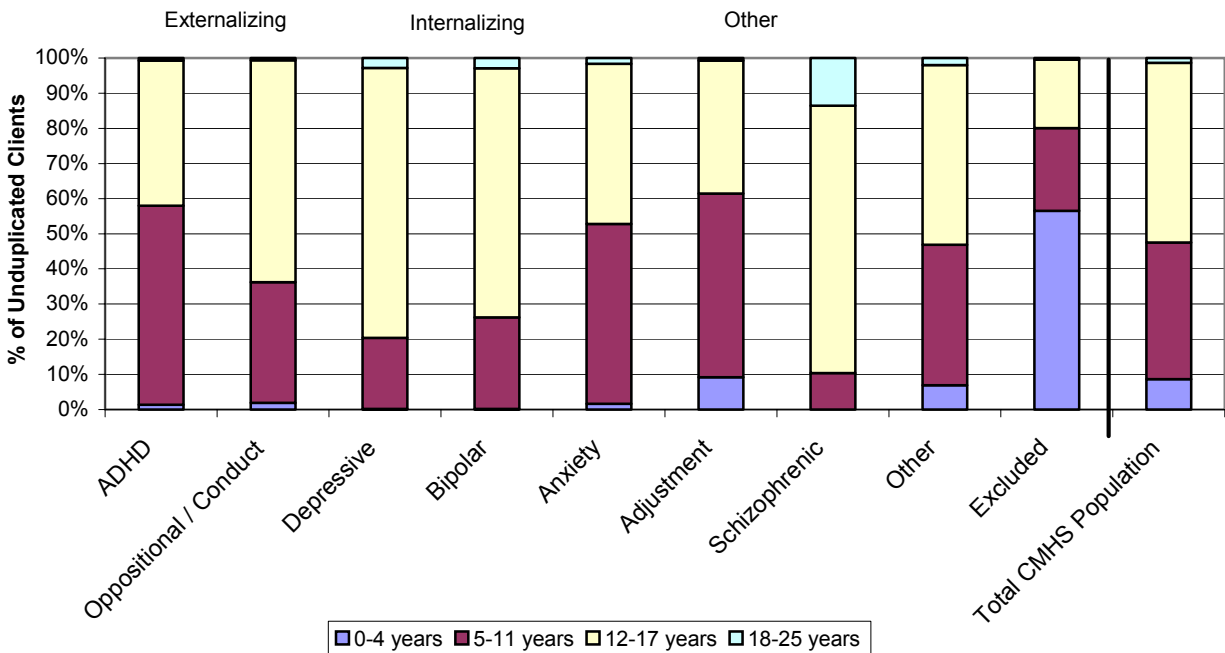
Males are more likely to be diagnosed with externalizing disorders, such as ADHD or Oppositional disorders, while females are more likely to be diagnosed with internalizing disorders, such as depressive or anxiety disorders, or adjustment disorders, as compared to their distribution in the total sample (Figure 3.3).

Figure 3.3: Primary Diagnosis by Gender



When diagnoses are examined by age, clear differences are present (**Figure 3.4**). Preschool children (age 0-4) are being diagnosed with Title 9 excluded diagnoses, primarily developmental disorders, a markedly higher rate compared to other age ranges. Elementary age children (age 5-11) are presenting most often with ADHD, anxiety, and adjustment disorders, while schizophrenic, depressive, and bipolar disorders are predominately diagnosed in adolescents. Finally, youth, ages 18-25, who continue to be served through CMHS are most likely to have a diagnosis of schizophrenia.

Figure 3.4: Primary Diagnosis by Age



Diagnoses were also examined by **funding source**, which was determined for each client. Medi-Cal status was coded for fee-for-service and organizational providers through service procedure codes. AB2726 status was coded if any visit record for the client contained an AB2726 procedure code within FY03-04 (Assembly Bill 2726 is a state-mandated program intended to serve children and youth 3 to 22 years of age receiving special education services who require mental health services in order to benefit from their educational program). **Figure 3.5** shows the percentage of youth who received services funded by Medi-Cal for each diagnostic category. There are fewer youth with Bipolar, Schizophrenia, and Other categories receiving services through Medi-Cal funds than other diagnostic groups, compared to the total CMHS population. **Figure 3.6** shows the percent of youth receiving services through AB2726 in each diagnostic category. Youth with Bipolar, Schizophrenia, or ADHD disorder are more commonly receiving AB2726-funded services.

Figure 3.5: Primary Diagnosis by Medi-Cal

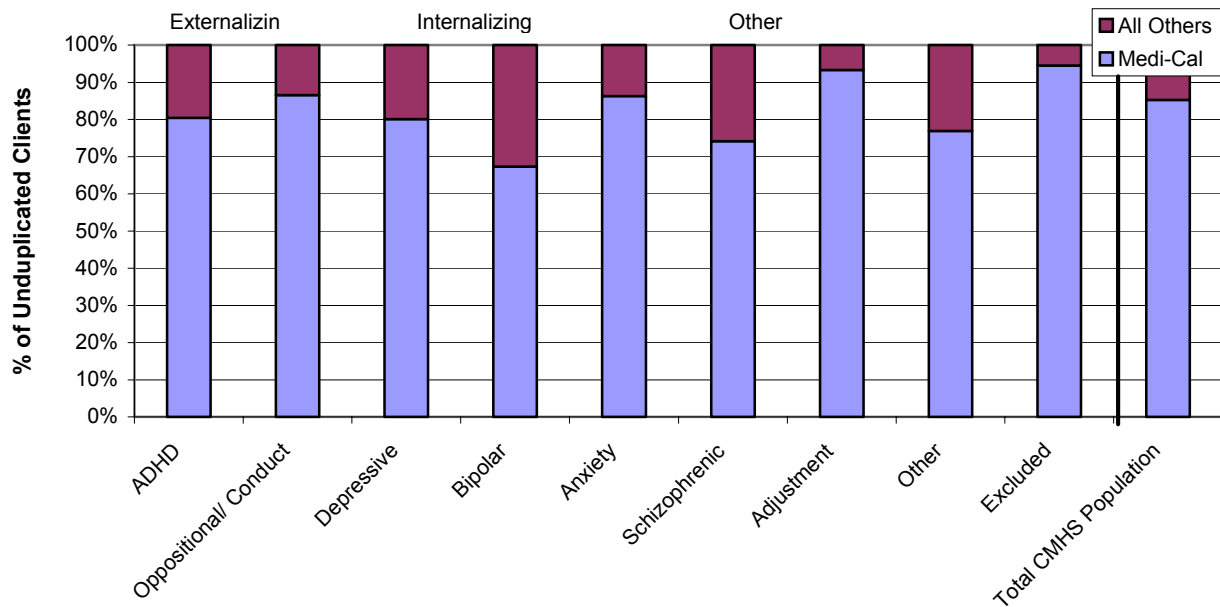
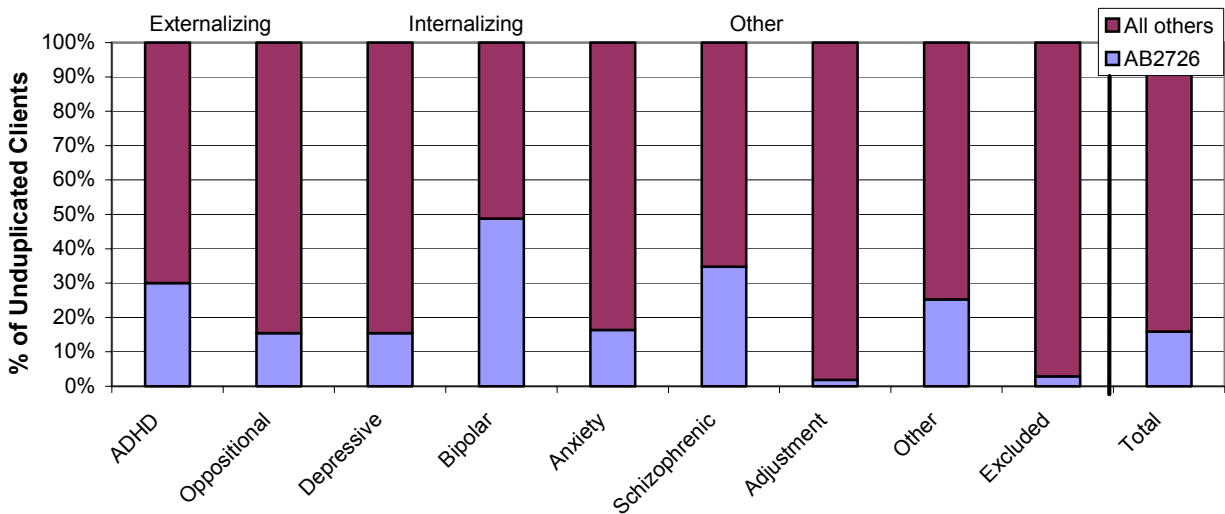


Figure 3.6: Primary Diagnosis by AB2726 Services Received



The remainder of this section examines the **type and amount of services received** during FY03-04. As described in Chapter 2, children and youth may receive services from any or all of the various modalities in the course of a year. Services were grouped into Restrictive and Outpatient categories for these analyses.

Restrictive services were reported in terms of the number of days of service received and included inpatient, day treatment intensive, day treatment rehabilitation and crisis stabilization.

- Inpatient services include both 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 under “day rehab” procedure codes in INSYST.

Table 3.1 presents the **mean and median number of days** per restrictive service modality for each diagnostic category, as well as the percentage of clients in the category who receive each service. The mean is the average number of days of service received across all clients receiving the service, while the median is the number of days that falls in the middle of the distribution, with an equal number of clients above and below it. Youth with invalid diagnoses were excluded from these analyses. Colors are used to indicate when results are 20% or more away from the CMHS system-wide results; blue/bold represents a results that is 20% or more above the CMHS result, while results that are 20% or more below the CMHS result are shown in red/*italics*.

These analyses show that **youth with a bipolar or schizophrenic diagnosis were more likely to use inpatient hospital days** (13.4% and 25.2% respectively as compared to 4.1% for the sample overall) and to use a greater number of days than youth with other diagnoses (mean of 18.8 and 26.5 days respectively, compared to 14.4 days overall). Youth with these diagnoses were also more likely to use intensive day treatment services. Youth with ADHD who used intensive day treatment or day rehabilitation services used more days on average than did youth with other diagnoses. Finally, as would be expected, youth with an excluded diagnosis used restrictive services at a very low rate.

Table 3.1: Restrictive Levels of Service Utilization by Diagnosis
Blue = 20+% higher than Total Sample **Red = 20+% lower than Total Sample**

Diagnosis	Inpatient			Day TX Intensive			Day Rehab			Crisis Stabilization		
	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days
Total Sample	3.1	14.4	8	5.9	86.7	72	11.2	44.2	17	2.1	1.2	1
ADHD	1.4	10.1	7	5.4	100.8	105	6.4	61.1	31	0.6	1.3	1
Oppositional/ Conduct	4.3	18.9	10	8.2	81.5	58	15.2	52.9	28	2.4	1.1	1
Depressive	9.3	10.0	6	5.6	76.6	66	11.6	55.6	28	4.9	1.2	1
Bipolar	13.4	18.8	14	26.2	95.2	77	7.4	49.8	25.5	5.7	1.4	1
Anxiety	2.7	12.6	10	6.1	86.0	75	9.0	41.0	16	1.7	1.1	1
Adjustment	0.9	7.0	4	1.2	66.4	53.5	15.9	30.3	8	0.8	1.1	1
Schizophrenic	25.2	26.5	14	17.4	90.9	70	6.5	49.7	40	7.1	1.2	1
Other	2.0	13.0	5	10.7	86.7	51	7.2	49.1	30	1.0	1.3	1
Excluded	0.5	12.2	4.5	0.2	11.0	11	6.2	19.3	9	0.2	1	1

Outpatient services were reported in terms of the minutes of service received and were broken out in several types of outpatient services:

- **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.
- **Medication services** include medication evaluations and follow-up services.
- **Crisis services** include crisis intervention services at either the provider site or at the Emergency Screening Unit.
- **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.

Table 3.2 presents the mean and median number of minutes per outpatient service modality for each diagnostic category. The mean is the average number of minutes across all clients receiving the service, while the median is the number of minutes that falls in the middle of the distribution, with an equal number of clients above and below it. Youth with invalid diagnoses were excluded from these analyses. Again, blue/bold and red/italics are used to indicate when results are 20% or more away from the CMHS system-wide results.

These analyses showed that, similar to the pattern for inpatient services, **youth with a bipolar or schizophrenic diagnosis used more outpatient services** than youth with other diagnoses. They were more likely to use services and to use more minutes of service, particularly in the case management and medication support categories. In addition, ADHD-diagnosed youth used medication support services at increased rates and utilized more minutes of TBS than other youth. Finally, youth with excluded diagnoses continued to use services at low rates in all service categories except assessment, as expected; 80% of these youth had received assessment services as compared to the overall mean of 51%.

Table 3.2: Outpatient Service Utilization by Diagnosis
Blue = 20+% higher than Total Sample **Red = 20+% lower than Total Sample**

Diagnosis	Collateral			Therapy			Case Management			Assessment		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	63.2	481.9	232	73.2	848.5	500	38.7	1101.7	163	50.6	184.1	130
ADHD	73.3	593.1	338	81.2	1088.8	780	46.3	1052.1	150	46.3	224.4	130
Oppositional / Conduct	70.7	569.8	300	78.9	1007.3	716	44.4	1257.6	160	46.1	208.6	150
Depressive	66.1	521.8	282.5	77.8	1049.1	706	40.6	1117.9	133	43.1	195	125
Bipolar	74.5	818.9	472	73.3	1106.3	780	59.4	2481.4	829	48.0	295.5	180
Anxiety	68.8	470.2	261.5	83.8	975	695.5	41.0	871.1	132	44.0	190.3	135
Adjustment	64.2	374.6	190	73.1	943.1	650	35.2	603.7	110.5	53.7	149.8	120
Schizophrenic	68.4	782.5	344	72.3	932.6	645	58.7	1882.2	510	47.7	268.4	170
Other	68.2	567.1	344	73.9	1614.9	947	38.2	933.5	122.5	44.9	239.5	180
Excluded	14.6	347.8	120	34.4	712.5	440	6.7	999.5	147	80.6	202.4	180

Diagnosis	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	46.2	254.4	160	13.1	237.9	135	1.3	5241.5	500
ADHD	65.5	269.1	198.5	6.8	187.4	92.5	1.7	6231.9	4977
Oppositional / Conduct	46.3	271.1	170	16.3	263	150	2.4	4600.7	4195
Depressive	51.4	236	155	20.8	285.2	195	1.1	5797.7	4676
Bipolar	68.7	485.9	310	22.5	466.7	225	4.5	6669.2	5156
Anxiety	52.7	273.4	194	11.0	198.8	137.5	1.4	2775.9	1890
Adjustment	29.0	199.4	140	10.3	148.9	95	0.3	3497.1	2357.5
Schizophrenic	75.5	394	280	29.7	349.1	309	2.6	1188.5	1383
Other	51.6	280.2	182.5	7.9	226.4	165	2.0	5901.5	5952
Excluded	21.2	230.2	200	6.1	148.5	105	0.0	NA	NA

NA = Not Applicable

Service Utilization by Race/Ethnicity

Further analyses were completed to examine the patterns of **service use across racial/ethnic categories (Table 3.3)**. Although they entered inpatient treatment at the same rates as children on average, Black children who utilized inpatient services remained hospitalized longer, on average, than those in other groups. Black children were also more likely to receive day rehabilitation services and to receive more days of day rehab treatment than other children. Asian / Pacific Islander youth received fewer days of inpatient, intensive day treatment, and day rehabilitation services than other children but were more likely to receive crisis stabilization services. Native American children were more likely than other children to utilize intensive day treatment, day rehabilitation, or crisis stabilization services during FY03-04. Children in the Other/Mixed category were less likely to use inpatient services, and those that did enter inpatient care received fewer days of service. They were also less likely to receive day rehabilitation services, but those that did received more days of service than average.

Table 3.3: Restrictive Service Utilization by Race/Ethnicity
Blue = 20+% higher than Total Sample **Red = 20+% lower than Total Sample**

Race/ Ethnicity	Inpatient			Day TX Int.			Day Rehab			Crisis Stabilization		
	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days	%	Mean Days	Median Days
Total Sample	3.2	14.4	8	4.7	86.7	72	8.9	44.2	17	1.7	1.2	1
White	3.3	13	8	6.9	90	74	8.2	45.9	18	1.8	1.2	1
Hispanic	3.2	14.1	7	2.8	81.5	69	7.6	36.6	14	1.7	1.1	1
Black	3.4	18.7	12	5.8	87.1	74	13.8	54.8	21.5	1.3	1.4	1
Asian/Pacific Islander	2.8	10.5	5	1.7	41.8	31	6.9	26.8	7.5	2.4	1.0	1
Native American	3.2	13.8	14	10.8	97.1	63	15.9	31.2	18	2.5	1.0	1
Other/Mixed	1.1	6.5	6	3.2	75.2	56	6.0	72.4	29	0.3	1.0	1

When **outpatient service use was examined by race/ethnicity**, three distinct patterns emerge. First, children in the Other/Mixed category were less likely to receive services in all categories except therapy and TBS (**Table 3.4**). In the therapy category, they were more likely to receive services, but received fewer minutes of therapy on average, as compared to other CMHS children. Second, the greatest variation in the number of minutes of services received was within case management, where White, Black, and Native American youth received over 1300 case management minutes on average and Hispanic, Asian/Pacific Islander, and Other/Mixed youth received fewer than 750 minutes on average. Finally, Native American youth were more likely to receive services in all categories except therapy, medication support, and TBS; they also received more collateral, therapy, and medication support minutes than average.

Overall CMHS Sample Summary

- Most common diagnoses are (in descending order) Adjustment disorders, Depressive disorders, Oppositional / Conduct disorders, and ADHD.
- Hispanic youth are overrepresented among youth with Adjustment disorders, while Whites are overrepresented among youth with Bipolar disorders.
- Males are more likely to have Externalizing disorders, while females are more common in the Internalizing categories.
- Over half of the youth with an Excluded diagnosis are under age 5.
- Over 80% of youth receiving CMHS services have Medi-Cal.
- Medi-Cal rates are lower for youth with a primary diagnosis of a bipolar or schizophrenic disorder. AB2726 rates are higher for these two diagnostic groups.
- There are wide variations in service use by the youth's race/ethnicity.
- Youth with a bipolar or schizophrenic primary diagnosis use more inpatient and outpatient services, both in terms of rate and amount of service use, than youth with other diagnoses.

Table 3.4: Outpatient Service Utilization by Race/Ethnicity
Blue = 20+% higher than Total Sample **Red = 20+% lower than Total Sample**

Race/ Ethnicity	Collateral			Therapy			Case Management			Assessment		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	55.5	481.9	232	77.1	848.5	500	31.6	1101.7	163	44.6	184.1	130
White	56.3	560.1	295	73.9	946.1	600	31.5	1532.1	237.5	46.7	208.9	130
Hispanic	57.0	439.8	209	78.4	809.8	500	32.5	732.3	114	43.7	172.5	137.5
Black	51.5	482	230	78.6	859.3	475	30.1	1372.8	242	45.4	179.1	120
Asian/Pacific Islander	53.9	387.5	185	77.4	986.1	550	35.3	682.6	160	39.2	174.7	135
Native American	63.1	629.9	326	75.2	1046.4	534.5	45.9	1397.1	360	51.0	190.2	115
Other/Mixed	40.1	349.5	150	86.0	534.0	250	15.8	711.8	120	26.9	204.9	120

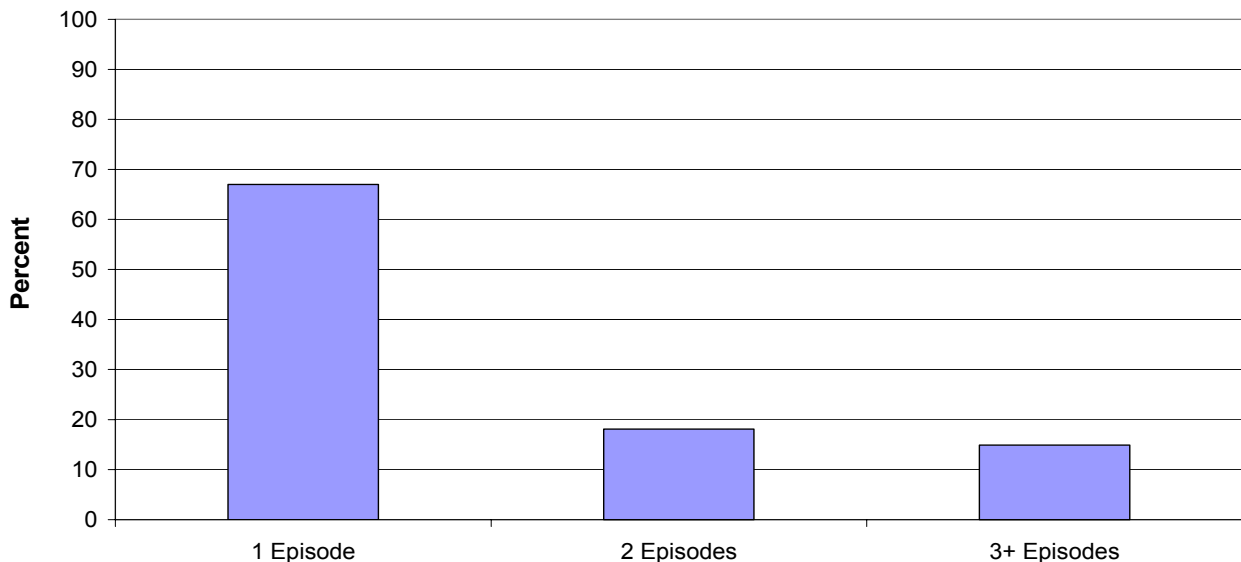
Race/ Ethnicity	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample	42.3	254.4	160	11.4	237.9	135	1.1	5241.5	4060
White	48.4	283.6	185	11.5	253.6	140	1.5	5598	4593.5
Hispanic	37.8	225	150	10.9	227.7	135	0.6	4838.4	2570
Black	46.0	271.5	180	12.9	253.7	120	1.5	4934.4	4579
Asian/Pacific Islander	34.9	194.9	142.5	12.3	195.1	125	0.4	5438	5438
Native American	38.9	373.3	225	15.9	242.1	180	0.6	10300	10300
Other/Mixed	27.2	242.4	130	6.0	165.7	135	0.3	2552	2552

Inpatient Service Use

One goal of the San Diego County System of Care is to **reduce the utilization of inpatient hospital services** and keep children in their homes or in the most home-like setting possible. In order to reduce the use of inpatient services, it is necessary to examine the characteristics of children who use the services, especially those with multiple inpatient admissions during the year. During FY03-04, 3.1% of children receiving CMHS services were admitted to an acute care hospital for mental health treatment.

While most children had only one inpatient stay, 33% of the inpatient sample had two or more episodes of care in the inpatient setting (**Figure 3.7**) in FY03-04. This is especially concerning given that **59% of children with two or more inpatient episodes were readmitted to the hospital within 30 days of the previous discharge.**

Figure 3.7: Inpatient Episode Count



The age and gender distributions of youth receiving inpatient services are vastly different from the distribution of youth receiving services overall. Adolescents, ages 12-17, make up 51% of the youth serviced by CMHS (refer to Figure 3.4), but 82% of youth with at least one inpatient episode (**Figure 3.8**). There was only one inpatient episode for youth under age 5 and, similarly, for ages 18 and over. In terms of gender, males are more likely to have received services in the CMHS as a whole (refer to Figure 3.3), but females are more likely to have accessed inpatient services (**Figure 3.9**).

Figure 3.8: Inpatient Episodes by Age

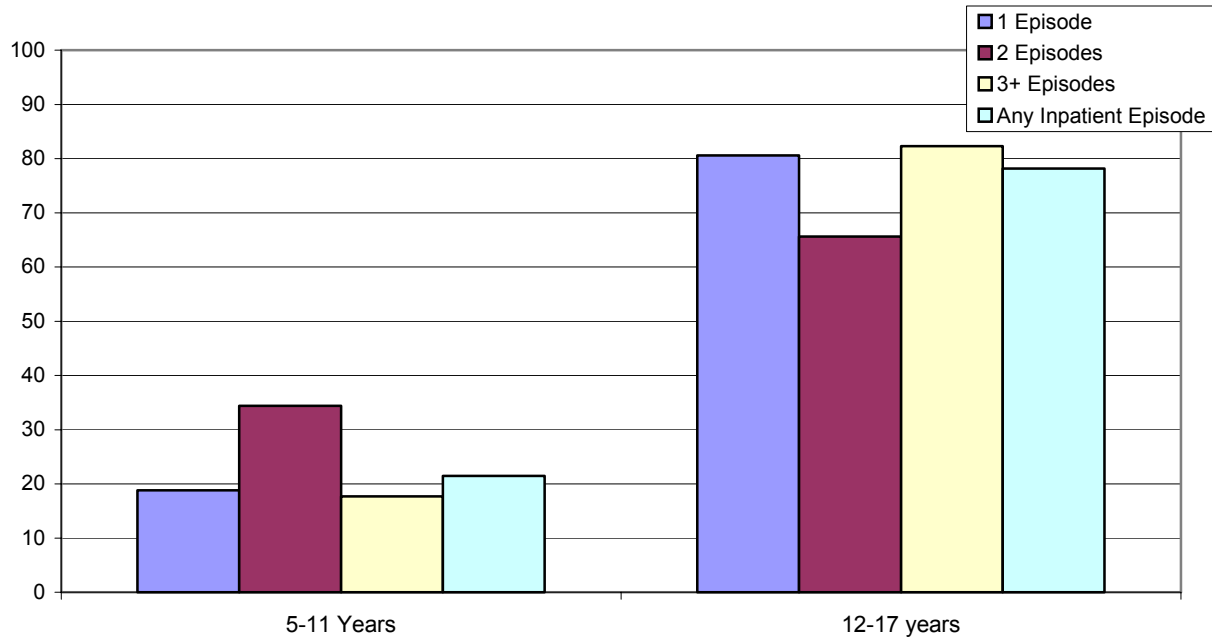
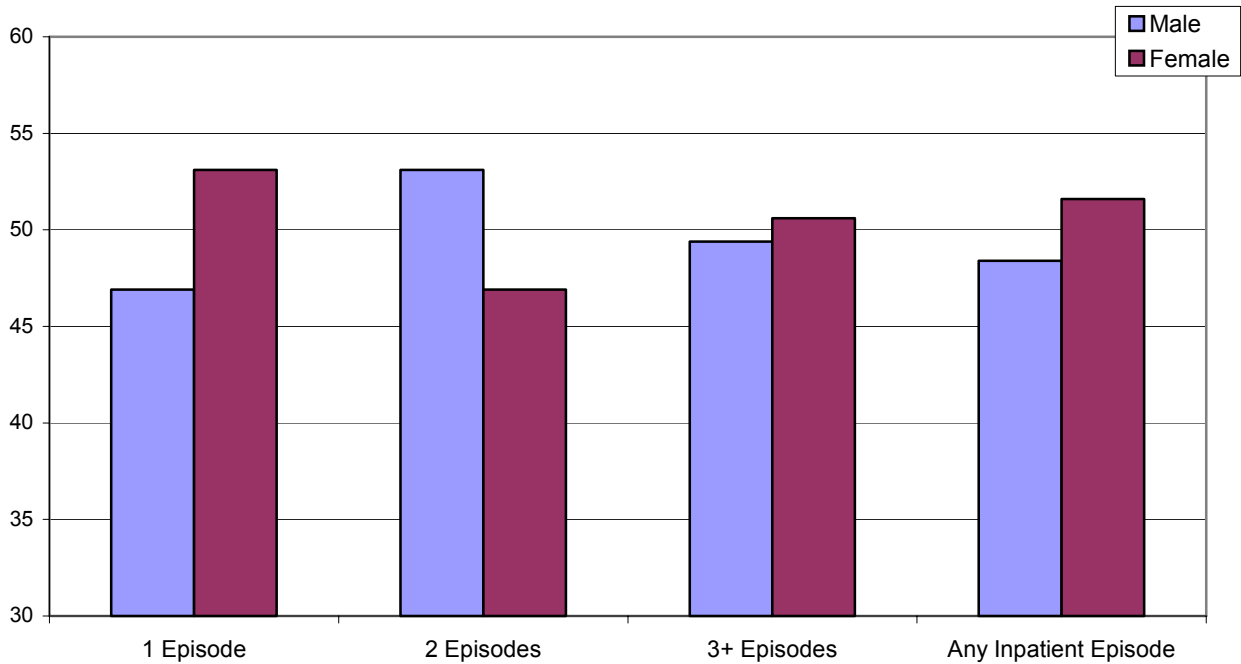


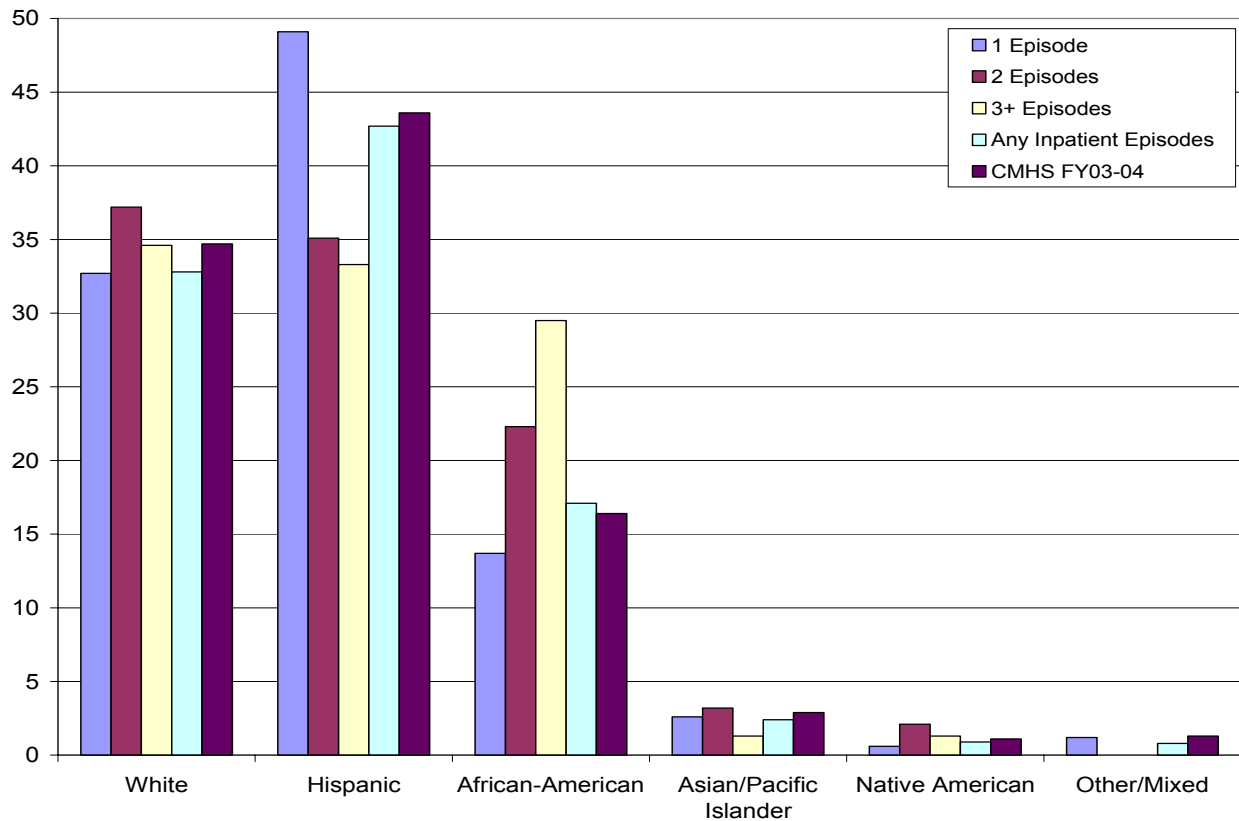
Figure 3.9: Inpatient Episodes by Gender



When child's race/ethnicity is examined in relation to use of inpatient services, there is little difference between **any use** of inpatient services and the racial/ethnic make-up of the total CMHS population (refer to the last two bars, "Any Inpatient Episodes" and "CMHS FY03-04", in **Figure 3.10**). Two significant patterns emerge, though, when the **number** of inpatient episodes

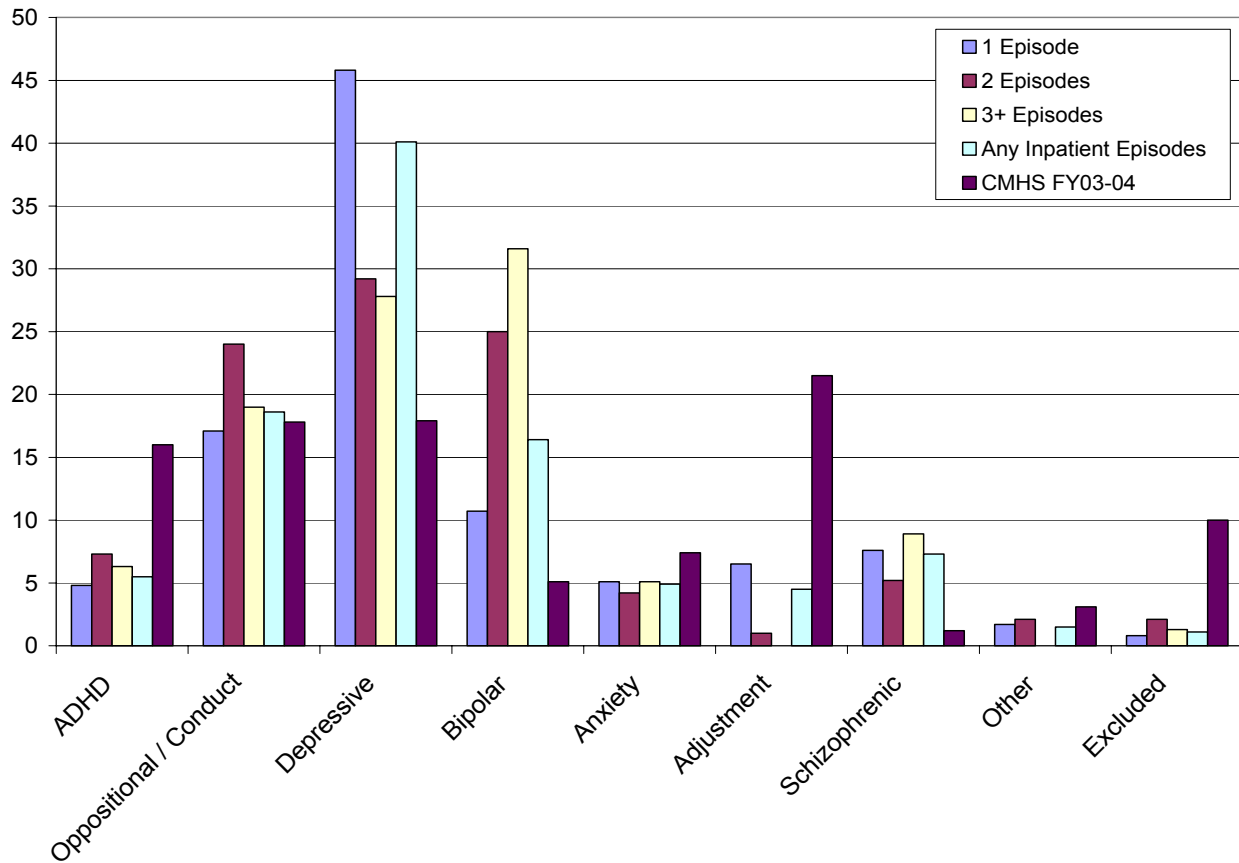
is examined (first three bars in **Figure 3.10**). First, Hispanic children are overrepresented among those with a single inpatient admission (49% as compared to 44% in the overall CMHS population) and underrepresented among those with multiple admissions. **African-American children are overrepresented among those with multiple inpatient admissions** (30% of those with 3 or more inpatient episodes as compared to 16% of the CMHS population), although their rates for single admissions are more consistent with their overall prevalence in the CMHS population.

Figure 3.10: Inpatient Episodes by Child’s Race/Ethnicity (p<0.05)



The use of inpatient services also varies widely by diagnosis, but largely according to expected patterns (**Figure 3.11**). First, **youth with a primary diagnosis of depressive, bipolar, or schizophrenic disorders are using inpatient services at rates much higher than their prevalence in the overall CMHS population**. For example, youth with a depressive diagnosis make up about 18% of the CMHS population, but compose 40% of youth with an inpatient admission. Similar overrepresentation is seen for bipolar (5% overall and 16% of inpatient) and schizophrenic (1% overall and 7% of inpatient) diagnoses. Several diagnoses are underrepresented, including adjustment disorders (22% overall and 5% of inpatient) and excluded diagnoses (10% overall and 1% of inpatient).

Figure 3.11: Inpatient Episodes by Primary Diagnosis



Finally, the use of less restrictive services by children with inpatient admissions during FY03-04 was examined. Ninety-four percent of children with an inpatient episode in FY03-04 had also used outpatient services during the year. Over 80% of youth with an inpatient admission had utilized Medi-Cal funding during the year, while about 20% had received AB2726 funded services. As shown in Tables 3.5 and 3.6, youth with inpatient episodes were more likely to have used services in each delivery mode than children in the general CMHS population and often received more days or minutes of service as well. The largest increases were, not surprisingly, in the crisis stabilization and crisis services modes.

Inpatient Service Use Summary

- About 3% of the CMHS population used inpatient services in FY03-04.
- 80% of youth using inpatient services are adolescents.
- Females are overrepresented in the inpatient sample, compared to the CMHS population.
- African-American youth are overrepresented among those with multiple admissions.
- 40% of the inpatient sample has a primary diagnosis of a depressive disorder.

Table 3.5. Use of Restrictive Services by Youth with Inpatient Episodes

Blue = 20+% higher than CMHS *Red = 20+% lower than CMHS*

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
Inpatient Use	100%	14.4	17.7	19.4%	88.2	62.6	15.1%	48.9	50.8	25.2%	1.3	0.7
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Table 3.6. Use of Outpatient Services by Youth with Inpatient Episodes

Blue = 20+% higher than CMHS *Red = 20+% lower than CMHS*

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Inpatient Use	64.2%	808.3	1051.9	51.8%	2923.2	4409.8	54.4%	266.0	273.4	69.1%	487.8	550.4
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Inpatient Use	65.9%	471.3	469.3	72.5%	1018.8	1051.5	9.8%	5472.6	4322.0
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

Service Use by Youth Receiving Wraparound/Intensive Case Management Services

In 1997, San Diego County began to implement a coordinated system of care for youth receiving mental health services. Wraparound-based services were developed to provide an alternative to restrictive settings of care for Emotional Disturbance (SED) youth. During FY03-04, wraparound intensive case management services were provided by several programs: Community Intensive Treatment for Youth (CITY), a state hospital alternative program for high-end youth needing intensive services; Building Effective Solutions Together (BEST), for youth who are court wards and dependents; and the Children's Mental Health Services Initiative, for SED youth at risk of placement in a restrictive, residential care facility from any of three service systems: mental health/education (AB2726), social services or probation. The contractor for the CMHS Initiative during FY 03-04 was the Child, Youth and Family Network (CYFN). In addition, staff from several other programs received training from San Diego County's Wraparound Academy and provided services to a small number of clients. The vast majority of youth receiving wraparound services were served by BEST or CYFN.

As expected, clients who receive wraparound services are different from the average CMHS client. Over 70% are between the ages of 12 and 17 (**Figure 3.12**) and over two-thirds are male (**Figure 3.13**).

Figure 3.12: Age Distribution for Youth Receiving Wraparound Intensive Case Management Services

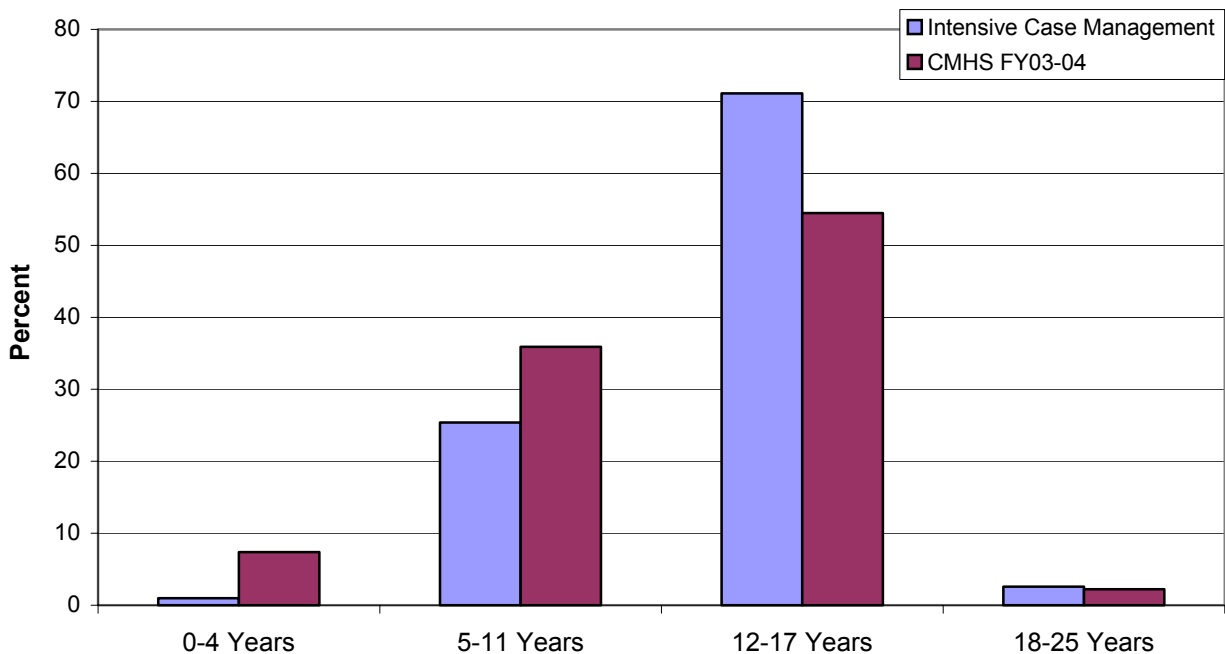
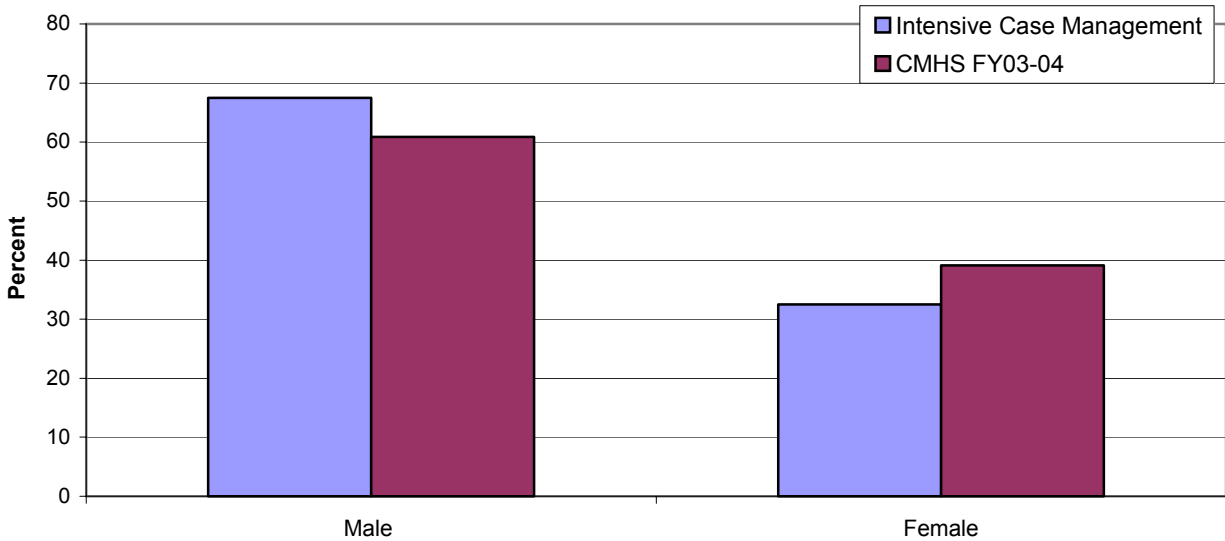
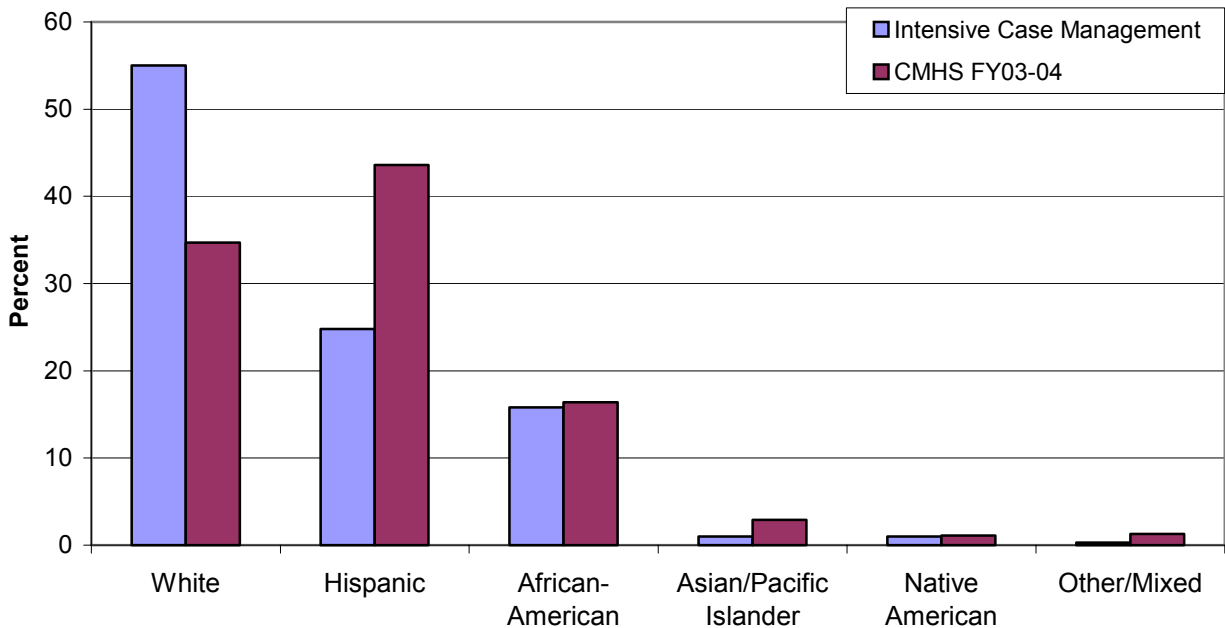


Figure 3.13: Gender Distribution for Youth Receiving Wraparound Intensive Case Management Services



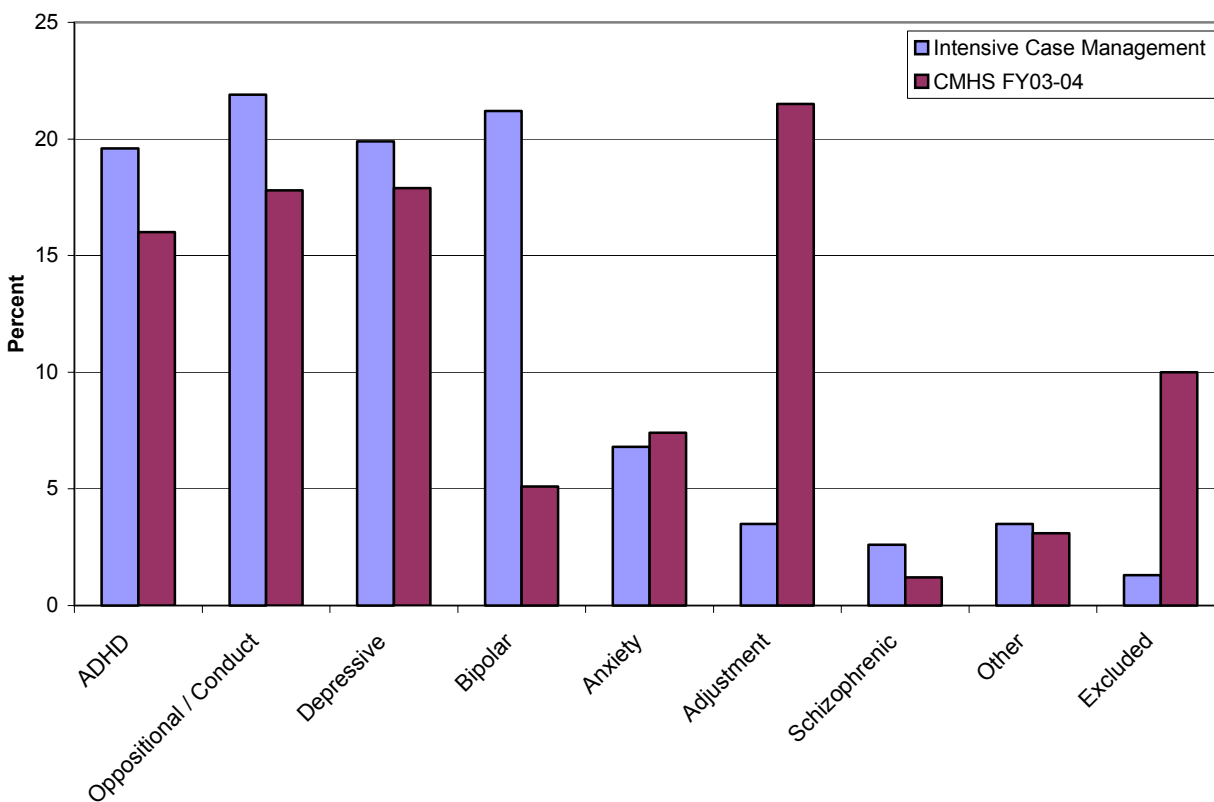
Racial/ethnic differences are present between these two populations as well, with White youth making up more than half of the population receiving wraparound services in FY03-04, as compared to 35% of the overall CMHS population (**Figure 3.14**). Hispanic youth are underrepresented, composing 25% of the wraparound sample as compared to 44% of the overall CMHS sample. Asian / Pacific Islander youth are also under-represented (1% of wraparound vs. 3% of overall CMHS).

Figure 3.14: Race/Ethnicity of Youth Receiving Wraparound Intensive Case Management Services



There is one major shift in diagnoses for youth receiving wraparound services: while adjustment disorders are the most common diagnosis in the overall CMHS population, less than 5% of youth in the wraparound sample have a primary diagnosis of an adjustment disorder (**Figure 3.15**). Instead, a much larger percentage of youth in the wraparound sample have a primary diagnosis of a bipolar disorder: 21% as compared to 5% in the overall CMHS population. Other common diagnoses in the wraparound sample are present at slightly higher rates than in the overall sample: Oppositional and Conduct disorders (22% vs. 18%), Depressive disorders (20% vs. 18%), and ADHD (20% vs. 16%). Finally, youth receiving wraparound services are twice as likely as those in the overall sample to have a primary diagnosis of schizophrenia.

Figure 3.15: Primary Diagnosis for Youth Receiving Wraparound Intensive Case Management Services



Service use by youth in the intensive case management sample also varies from that of the CMHS population as a whole. The largest differences are seen in the restrictive service settings, with **wraparound youth three times more likely to have received inpatient hospital services during FY03-04 than youth in the overall CMHS population (Table 3.7)**. Wraparound clients were also three times more likely to have used crisis stabilization services during the year. Finally, they were almost six times more likely to have received intensive day treatment services, although there was no difference in the use of day rehabilitation services.

There were also significant differences between the wraparound and overall MCHS populations for outpatient services (**Table 3.8**). Over 80% of youth in the wraparound sample utilized collateral services during the year, a 30% increase over the general CMHS population. In addition, they utilized almost twice as many minutes of collateral services on average. Wraparound youth were three times as likely as general population youth to have received case

management services and utilized almost five times as many case management service minutes as the general CMHS population. Wraparound youth were also more likely to have received crisis services, medication support, and TBS. Finally, although wraparound youth received therapy and assessments services at the same rate as general population youth, they received more minutes of each service on average.

Intensive Case Management Summary

- Over 70% of the intensive case management sample in FY03-04 are adolescents.
- Over two-thirds of the sample is male.
- Whites are overrepresented in the intensive case management sample, while Hispanics are correspondingly underrepresented, compared to the overall CMHS population.
- The most common primary diagnosis in the intensive case management sample (in descending order): Oppositional / conduct disorders, bipolar disorders, depressive disorders, and ADHD.
- Youth receiving intensive case management services are more likely than youth in the general CMHS population to have used inpatient or intensive day treatment services in FY03-04.

Table 3.7. Use of Restrictive Services by Youth in the Wraparound / Intensive Case Management sample
Blue = 20+% higher than CMHS **Red = 20+% lower than CMHS**

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
Intensive Case Management	9.6%	19.7	24.7	25.1%	97.0	73.7	8.0%	45.5	56.2	4.8%	1.3	0.6
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Table 3.8. Use of Outpatient Services by Youth in the Wraparound / Intensive Case Management sample
Blue = 20+% higher than CMHS **Red = 20+% lower than CMHS**

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Intensive Case Management	82.3%	928.6	1102.9	87.8%	5084.5	5108.1	47.6%	332.3	333.3	19.9%	328.4	366.3
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Intensive Case Management	67.8%	432.0	483.7	75.2%	1227.1	1202.1	5.5%	6700.5	4071.7
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

Service Use by Children with Open Child Welfare Cases

One area of interest to the San Diego County System of Care is the overlap between the mental health and child welfare sectors. It is well documented that children involved in the Child Welfare System (CWS) are an especially vulnerable population with studies estimating that over 40% of these children have significant emotional and behavioral health problems. These children have often experienced long-term abuse and/or neglect, which can have traumatic effects on children and require appropriate treatment.

To examine the Child Welfare – Mental Health overlap in San Diego County, a dataset containing a list of all children who had open Child Welfare cases during FY03-04 was obtained and compared to the CMHS dataset. In FY03-04, 24.6% of youth receiving mental health services also had an open Child Welfare case during the year. Looking at it from the Child Welfare perspective, 32.7% of youth with open Child Welfare cases in FY03-04 also received CMHS services during the year. This significant level of overlap fits with estimates of mental health need among children in the Child Welfare System.

Analyses showed that children receiving both child welfare and mental health services are younger than those receiving mental health services alone (**Figure 3.16**) and the ratio of male to female clients (**Figure 3.17**) is more even and closer to that of the San Diego County youth population as a whole (refer to Chapter 2, Figure 2.3).

Figure 3.16: Age Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services

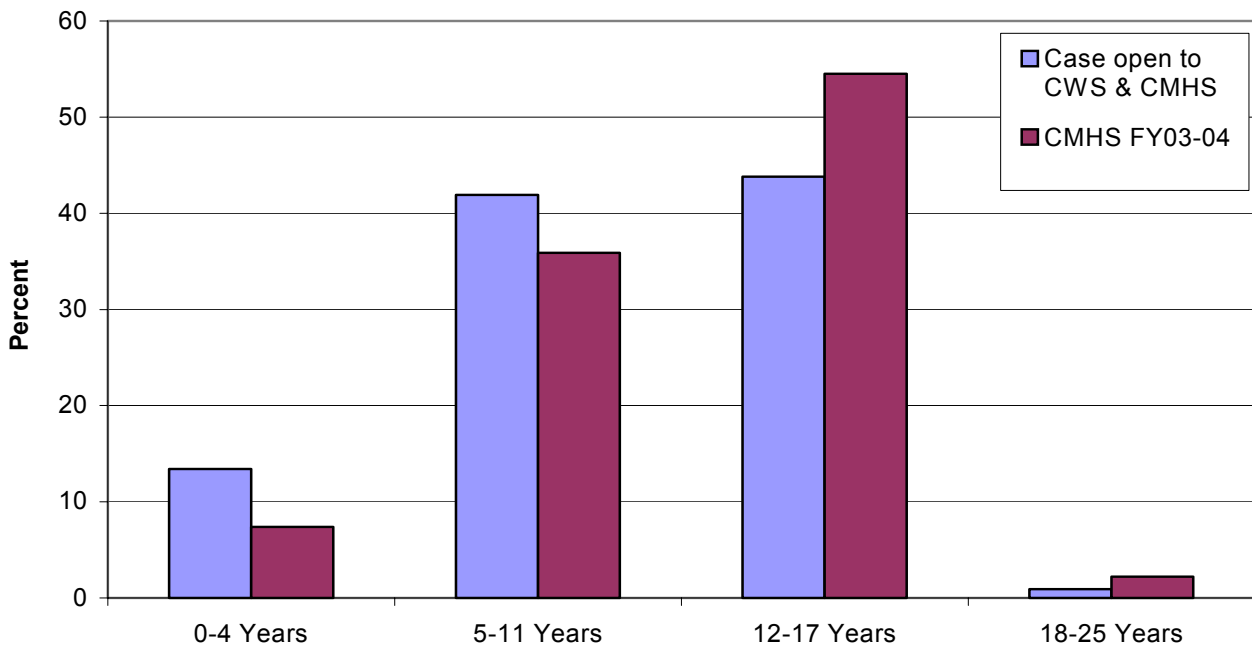
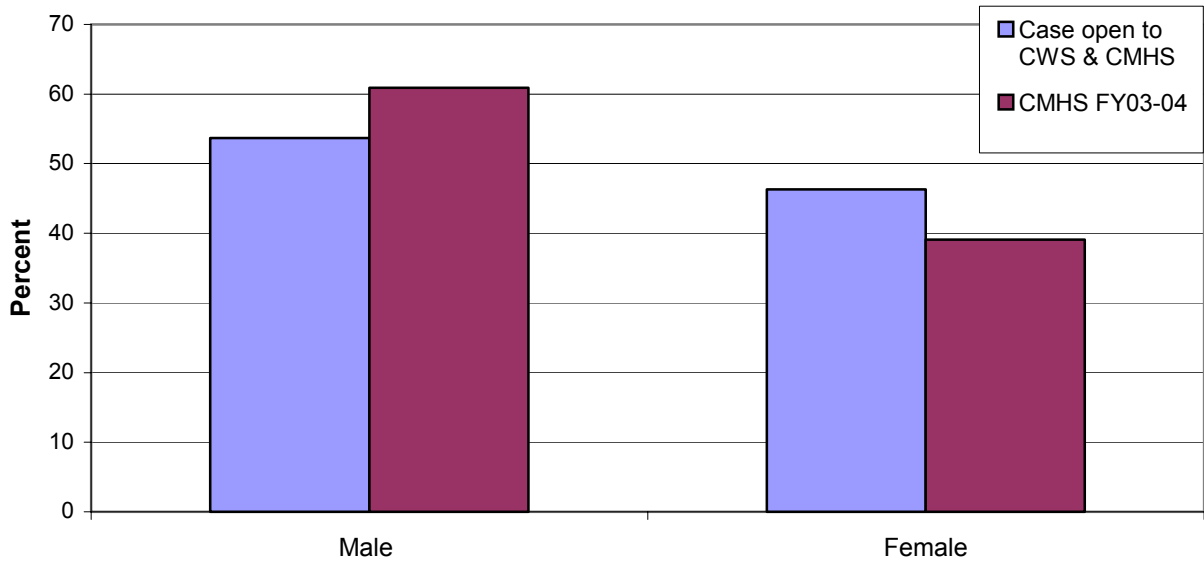
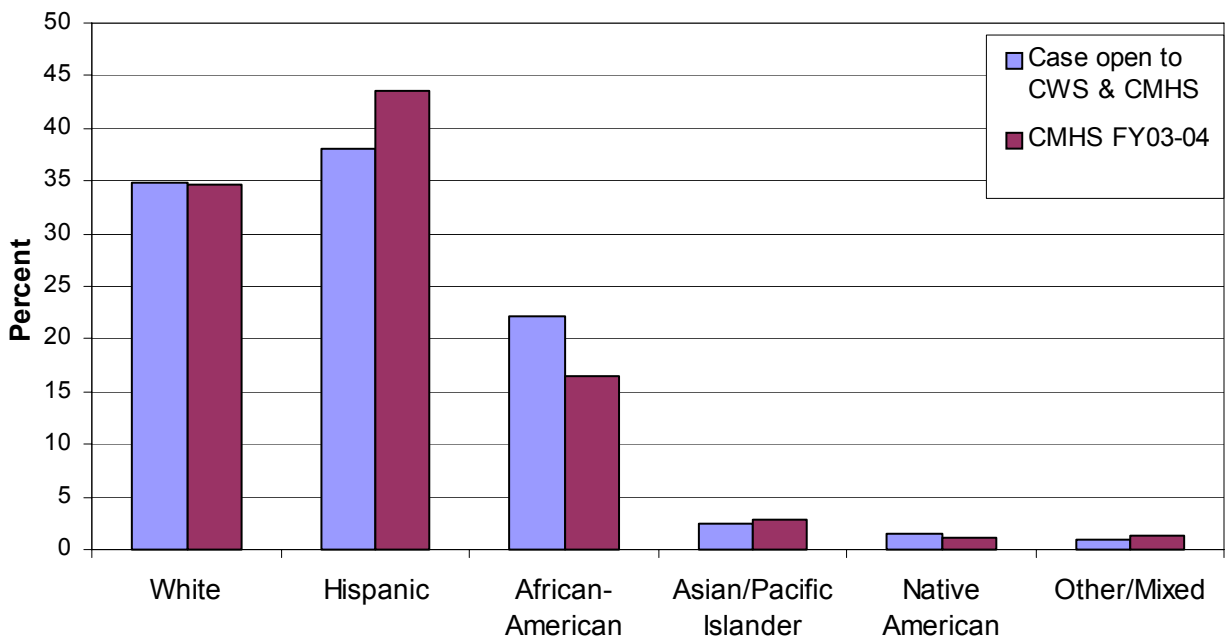


Figure 3.17: Gender Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services



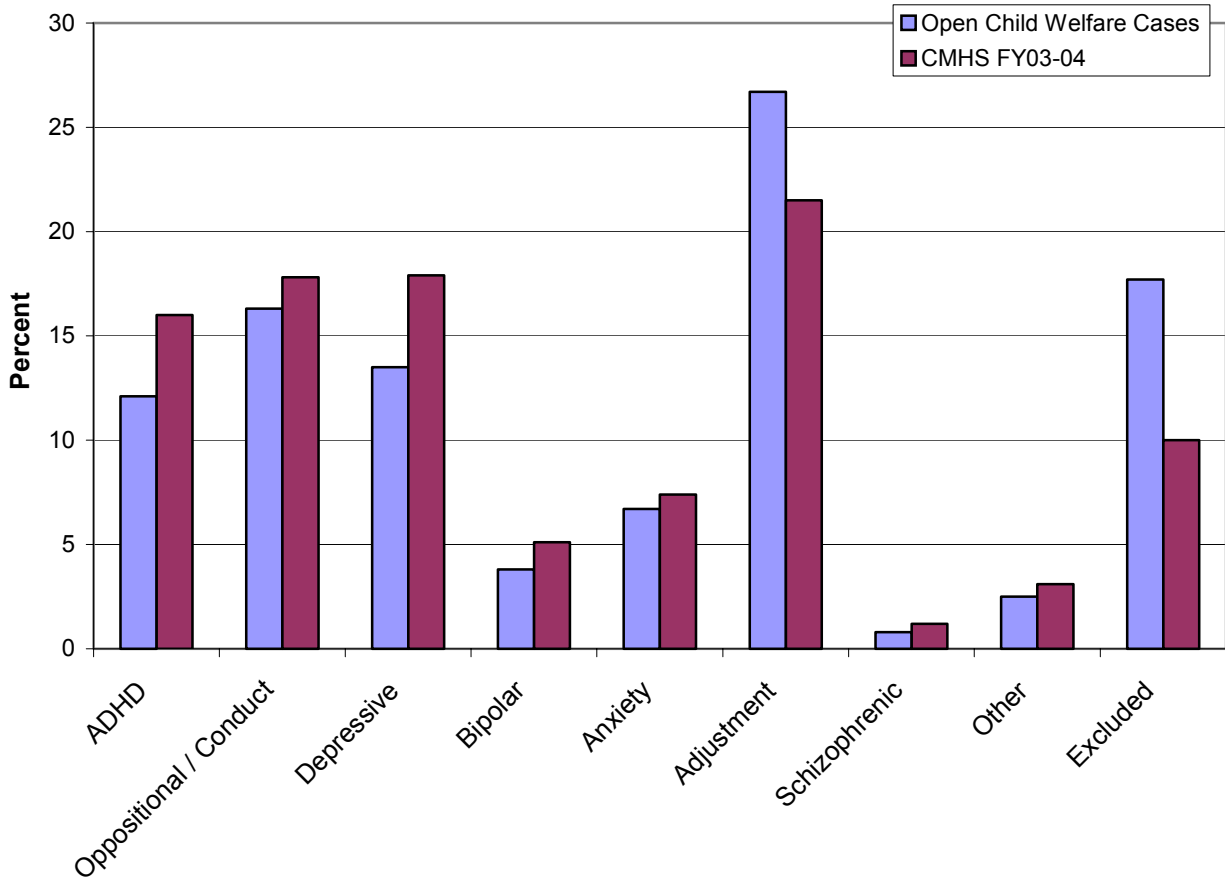
The racial/ethnic distribution for children receiving child welfare and mental health services (**Figure 3.18**) mirrors that of the overall CMHS population with two exceptions: there are proportionally fewer Hispanic youth and more African-American youth in the CWS-CMHS sample, compared to the overall CMHS population.

Figure 3.18: Racial/Ethnic Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services



The primary diagnosis for youth receiving both child welfare and mental health services also varies from the overall CMHS pattern in FY03-04 (**Figure 3.19**). Children open to the CWS in FY03-04 are more likely to have a primary diagnosis of an adjustment disorder or to have a diagnosis that is excluded under Title 9, such as autism or substance abuse. In addition, these youth are less likely to be diagnosed with ADHD or a depressive disorder.

Figure 3.19: Primary Diagnosis for Youth with Open Child Welfare Cases who are receiving CMHS Services



An analyses of the services used by youth receiving both CMHS and Child Welfare services (**Tables 3.9 and 3.10**) shows that they are about twice as likely to receive intensive day treatment (7.4% vs. 4.4%) or day rehabilitation services (18.6% vs. 8.4%) as youth active to the CMHS alone. In addition, while they received case management services at the same rate as youth active to the CMHS alone (about 30%), they received significantly more minutes of case management services on average (mean of 1825 minutes vs. mean of 1102 minutes).

Table 3.9. Use of Restrictive Services by Youth with Open Child Welfare Cases who are receiving CMHS Services
Blue = 20+% higher than CMHS

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
MH and CWS	3.4%	17.9	22.3	7.4%	82.2	66.3	18.6%	44.4	64.7	1.6%	1.3	0.8
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Table 3.10. Use of Outpatient Services by Youth with Open Child Welfare Cases who are receiving CMHS Services
Blue = 20+% higher than CMHS

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
MH and CWS	46.9%	496.1	733.0	30.0%	1825.0	3400.5	59.2%	185.6	164.3	12.7%	286.9	452.7
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
MH and CWS	48.2%	305.0	351.5	69.4%	980.0	1127.0	1.8%	5594.4	5378.9
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

Child Welfare Services Summary

- The sample is younger than the overall CMHS sample.
- The male to female ratio is more equal.
- African-Americans are seen at a proportionally higher rate and Hispanics at a proportionally lower rate, as compared to the overall CMHS population.
- Adjustment disorders and Excluded diagnoses are the most common primary diagnoses in the CWS-CMHS sample
- Youth in the CWS-CMHS sample are more likely to get day treatment services and receive more minutes of case management services on average than youth in the overall CMHS population.

Service Use by Youth Receiving Special Education Services

A goal of the San Diego County Children’s System of Care is to remove mental health barriers that affect success in school. Children with mental health problems may have problems in school, especially if their mental health condition impacts on their school attendance and performance. Many such children become involved in the Special Education system in their local school district, and a large percentage of these children are eligible for special education services under the Emotional Disturbance category.

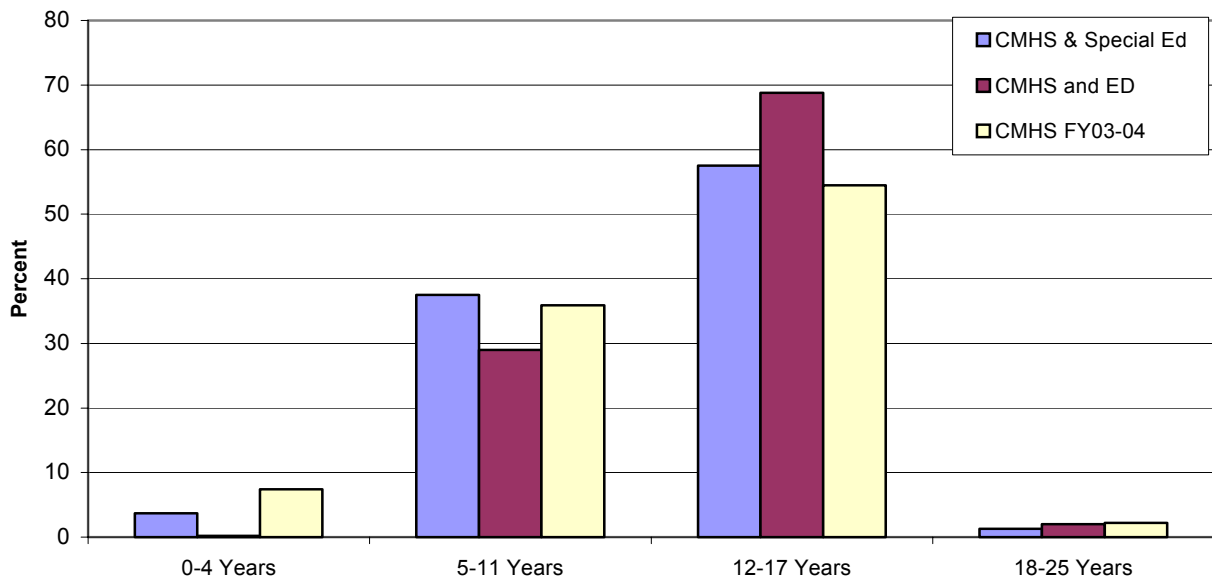
The **Education definition of Emotional Disturbance (ED)** is as follows: a condition exhibiting one or more of the following characteristics, over a long period of time and to a marked degree, that adversely affects educational performance:

1. An inability to learn which cannot be explained by intellectual, sensory, or health factors;
2. An inability to build or maintain satisfactory interpersonal relationships
3. with peers and teachers;
4. Inappropriate types of behavior or feeling under normal circumstances;
5. A general pervasive mood of unhappiness or depression; or
6. A tendency to develop physical symptoms or fears associated with personal or school problems.

A student needs to meet only **one** of the five criteria of the definition of ED to be classified as ED and eligible for special education services.

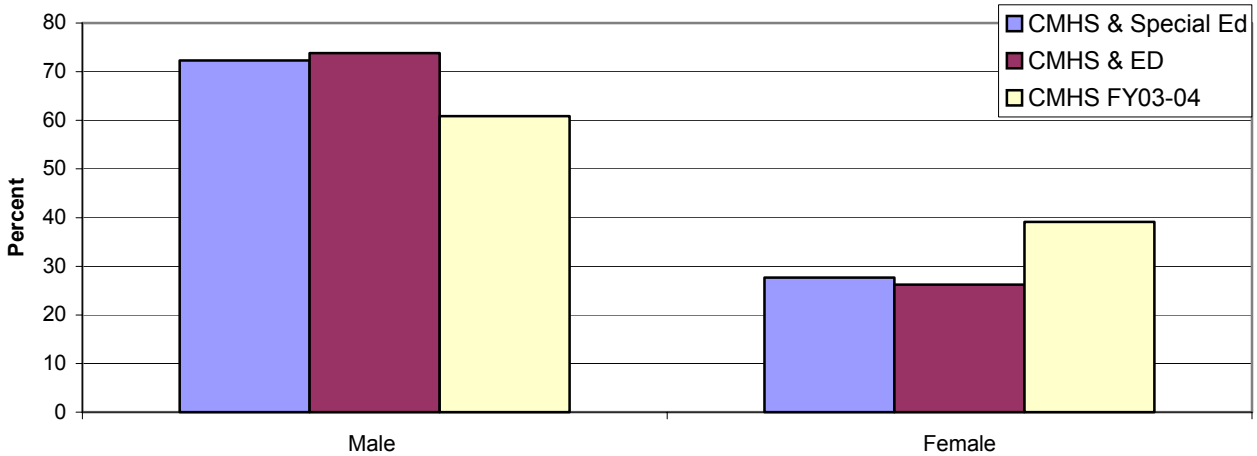
Using a dataset obtained through the six San Diego County Special Education Local Plan Areas (SELPA) of all children receiving special education services, and identifying a subset receiving services under the ED eligibility category, an examination was made of those children concurrently served by CMHS. The age distribution for youth receiving both special education and mental health services overall is similar to that of the CMHS population as a whole, while youth receiving mental health services that met the ED category requirements are more likely to be adolescents (**Figure 3.20**).

Figure 3.20: Age Distribution of Youth Receiving Special Education and Mental Health Services in FY03-04



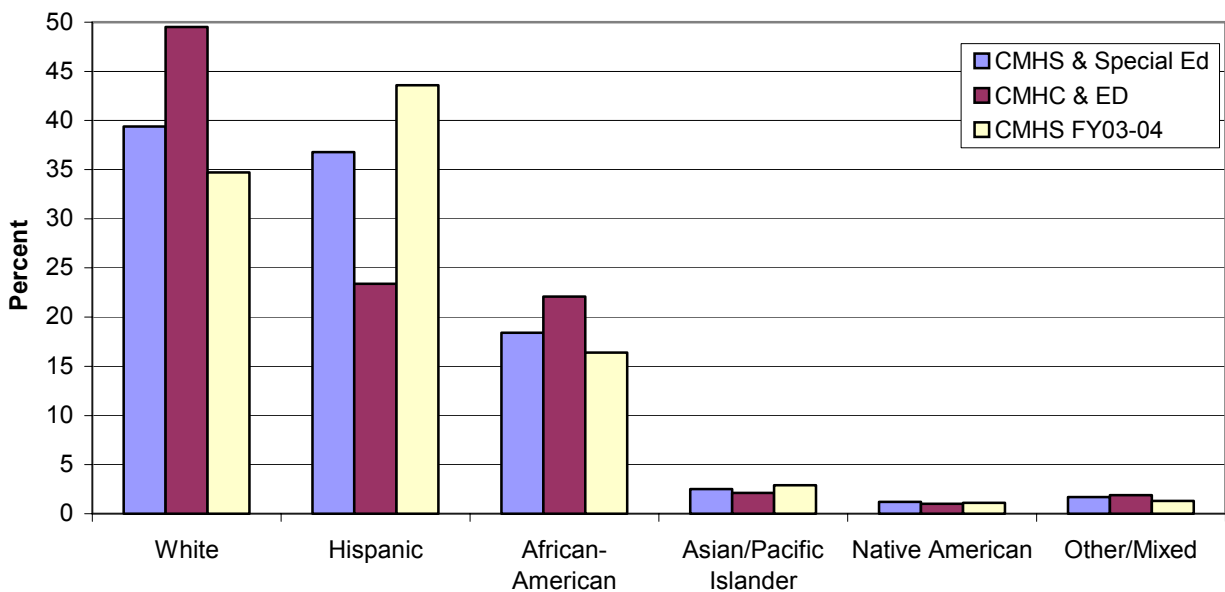
In both the overall special education and the ED category of special education services, male students are over-represented as compared to the CMHS population as a whole. In FY03-04, over 70% of the youth receiving special education services were male, as compared to slightly over 60% in the general CMHS population (Figure 3.21).

Figure 3.21: Gender Distribution of Youth Receiving Special Education and Mental Health Services in FY03-04



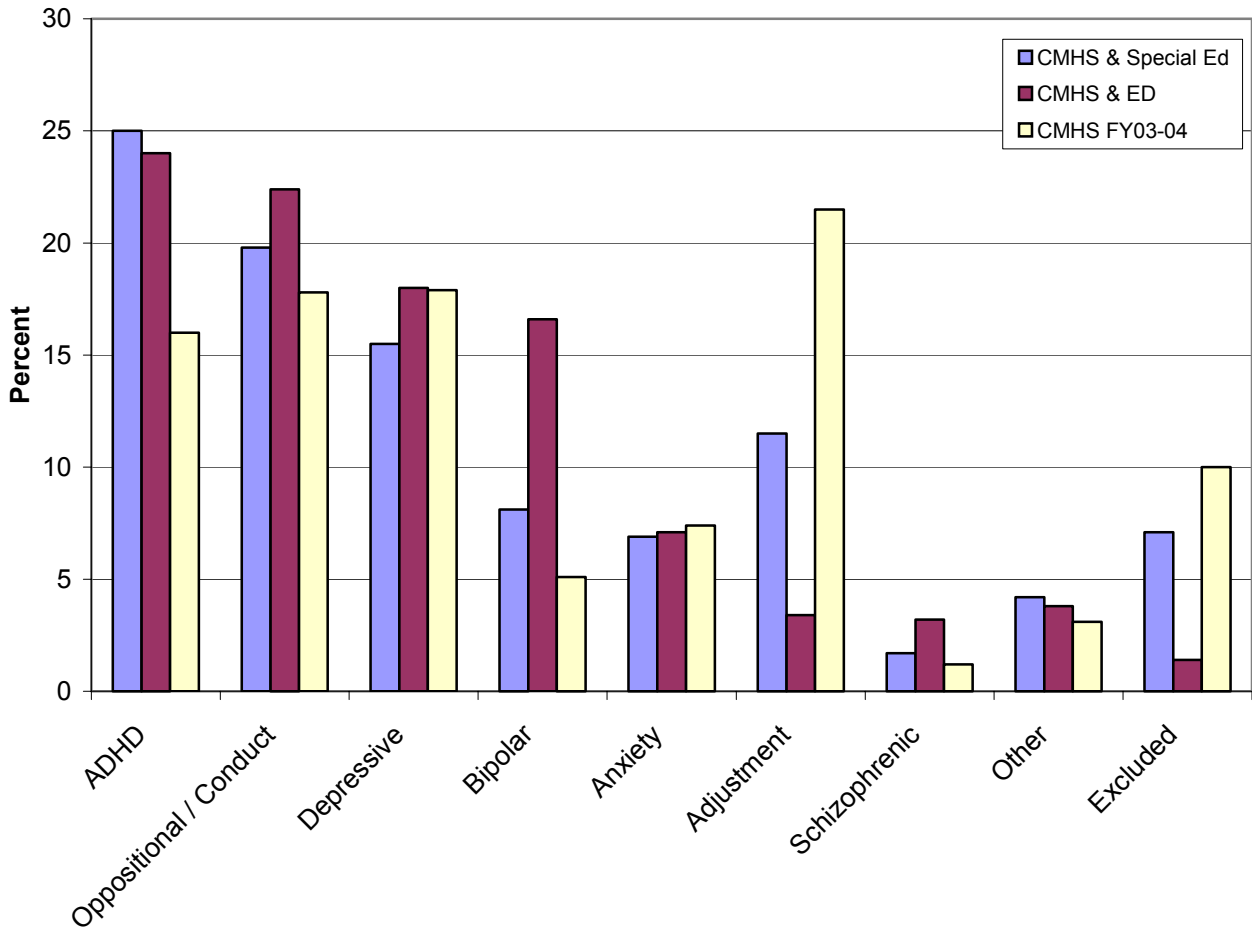
In terms of race/ethnicity, students in the overlapping special education-mental health services category are more likely to be White or African-American, and less likely to be Hispanic, as compared to the overall CMHS population (Figure 3.22). This is especially true for those youth receiving services through the ED category, where almost 50% of the students are White and less than 25% are Hispanic, as compared to 35% White and 44% Hispanic in the CMHS population.

Figure 3.22: Race/Ethnicity of Youth Receiving Special Education and Mental Health Services in FY03-04



The top three primary diagnoses for the special education and ED groups are the same: ADHD, Oppositional / Conduct disorders, and Depressive Disorders (**Figure 3.23**). ADHD is the most common primary diagnosis for youth receiving both Special Education and Mental Health services, accounting for 25% of youth in the overall Special Education group and 24% of those in the ED group. Finally, although Adjustment disorders account for 22% of primary diagnoses in the CMHS population, they account for 12% of the general special education group and 3% of the ED group.

Figure 3.23: Primary Diagnosis for Youth Receiving Special Education and Mental Health Services in FY03-04



Youth receiving Special Education and Mental Health Services are more likely to utilize services across the board, with higher rates of service use or more time in service for each restrictive and outpatient delivery mode (**Tables 3.11 and 3.12**). This is especially true for the ED sample, who were more likely to use each mode except Assessment and Therapy; in those two categories, they were as likely as youth in the overall CMHS population to be enrolled in the services, but utilized significantly more minutes of care.

Table 3.11. Use of Restrictive Services by Youth receiving Special Education Services
Blue = 20+% higher than CMHS

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
CMHS & Special Ed	3.9%	17.4	18.6	9.0%	92.2	68.5	9.0%	54.1	61.1	1.7%	1.3	0.8
CMHS & ED	6.7%	20.2	22.1	20.2%	93.2	68.2	12.3%	58.4	55.9	2.9%	1.3	0.6
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Table 3.12. Use of Outpatient Services by Youth receiving Special Education Services
Blue = 20+% higher than CMHS

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS & Special Ed	63.5%	628.9	831.6	40.5%	1492.6	3121.5	46.2%	235.0	253.9	11.9%	286.7	420.7
CMHS & ED	75.0%	817.8	1029.1	57.3%	2226.0	3836.9	45.6%	302.0	300.4	17.8%	331.9	435.4
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS & Special Ed	54.5%	306.9	365.5	77.9%	1030.4	1156.4	2.1%	5117.9	4487.4
CMHS & ED	67.8%	392.2	449.9	76.9%	1210.0	1236.4	4.1%	5565.2	5025.1
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

Special Education Services Summary

- Youth in the ED category are older than the overall CMHS population.
- 70% of the Special Education – CMHS population is male.
- White and African-American youth are overrepresented in the Special Education – CMHS sample, particularly among those in the ED category.
- ADHD and Oppositional/Conduct disorders are the most common primary diagnoses in this group.
- There are increased rates of service use and time in care for the Special Education – CMHS sample, compared to the overall CMHS sample.

Chapter 4: Community Functioning Outcomes

Community Functioning Outcomes consist of youth behaviors that often come to the attention of agencies other than mental health programs that are within the larger System of Care framework, such as Social Services, Probation, Education, and Alcohol and Drug Services. These outcomes are considered to be important factors that impact a youth's overall ability to develop to their highest potential and include substance use, delinquent behavior, school achievement, and attendance.

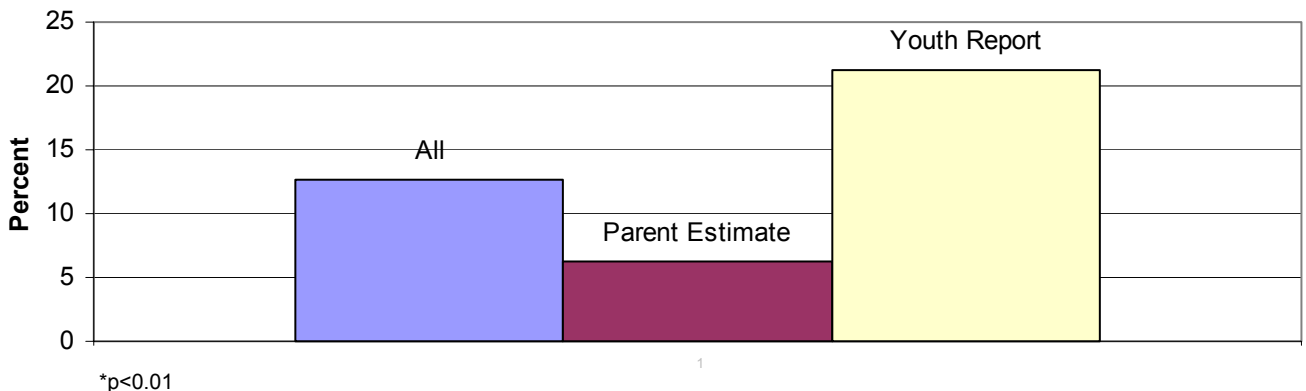
Substance Use

Information on substance use by youth active to the CMHS is available from four sources. First, all youth and caregivers who received services between November 1-15, 2003, completed the **Youth Services Survey (YSS)**, a state-mandated survey which contained a question about substance use in the month prior to the survey. Second, youth receiving services through the intensive case management programs completed the **Child & Adolescent Functional Assessment Scale (CAFAS)**, a rating scale which assesses a youth's degree of impairment in day-to-day functioning and includes a subscale on substance use.

To further examine youth with substance abuse issues in the CMHS population, we examined two additional sources of data. First, the INSYST database allows for providers to enter a **secondary substance abuse diagnosis** for each episode of care, which is also referred to as a **dual diagnosis**. This allowed us to examine the characteristics of those youth who have both a mental health and a substance use diagnosis. Second, using a database obtained from the **Alcohol and Drug Services (ADS) sector**, we were able to identify and characterize those youth who received services from both CMHS and ADS during FY03-04.

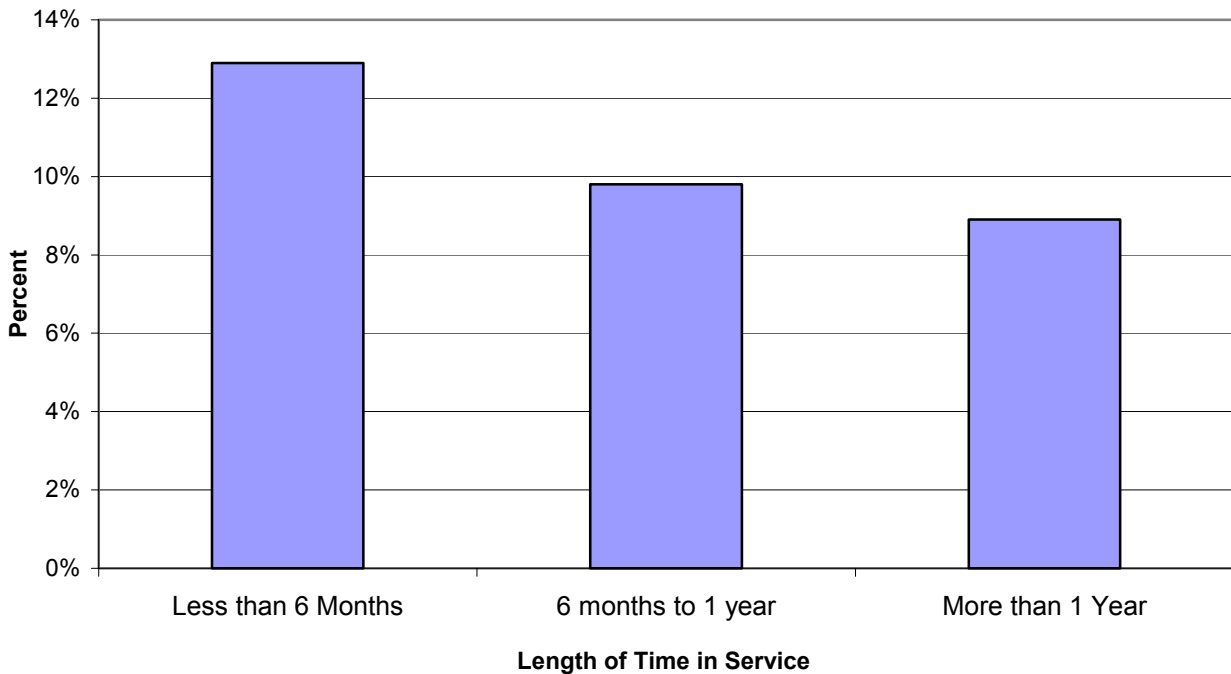
YSS respondents were asked whether the youth had used any of a list of substances (alcohol, cigarettes, ecstasy, cocaine, marijuana, crystal meth, inhalants, and hallucinogens) five or more times in the past month. In the overall sample of respondents (N=2364), 12.6% of youth and parents stated that the youth had used one of these substances 5 or more times in the past month (**Figure 4.1**). Youth were significantly more likely than parents to state that they have used substances recently ($p<.01$). The three most commonly used substances, in descending order, were cigarettes (8.8% used 5 or more times in past month), alcohol (5.3%), and marijuana (4.8%).

Figure 4.1: Percent of youth who used substances in past month, by parent estimate or youth or self-report



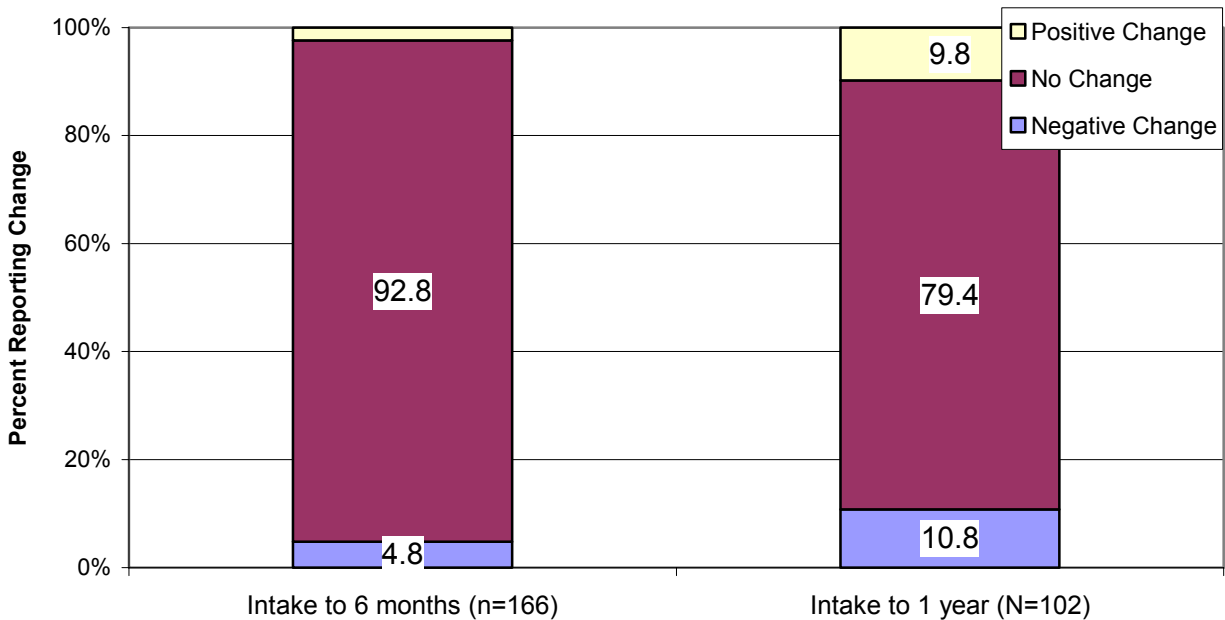
When reports of substance use on the YSS were examined by the length of time receiving CMHS services (**Figure 4.2**), the percentage reporting substance use decreases slightly as the time in service increases. The change in past month service use between youth receiving less than 6 months of service (12.9%) and youth in service more than 1 year (8.9%) is significant ($p < 0.05$), meaning that youth in service for more than one year are less likely to report having used any substance more than 5 times in the past month than those in services for less than six months.

Figure 4.2: Past Month Use of Substances by Length of Time receiving Services



Scores on the **substance use subscale of the CAFAS** were obtained on all youth receiving services through the intensive case management / wraparound programs at entry to services and at 6-month follow-up time points or discharge (**Figure 4.3**). The change in score was examined for all youth who remained in services for six months, and then again for all youth who remained in services for one year. “Change” was defined as a more than 10 point change in the CAFAS substance use subscale score and could be positive (greater than 10 point improvement in score) or negative (score worsens by more than 10 points). Any change of 10 points or less in either direction was classified as no change. Analyses showed that few substance use scores changed significantly while receiving wraparound services, and that the likelihood of positive change was no different from the likelihood of negative change at either 6 month or 12 month follow-up.

Figure 4.3: Change over time on the CAFAS Substance Use subscale, Intake to 6 and 12 month follow-up points, for youth in the intensive case management / wraparound programs.



Dual Diagnosis Youth

An examination of INSYST showed that 266 youth who received CMHS services in FY03-04 (1.6% of total CMHS population) had a secondary substance abuse diagnosis. Almost all of these youth were between the ages of 12 and 17 (**Figure 4.4**). The ratio of males to females mirrors that of the CMHS population as a whole, as does the racial/ethnic distribution of youth with a dual diagnosis (**Figure 4.5**).

Figure 4.4: Age distribution for youth with a dual diagnosis

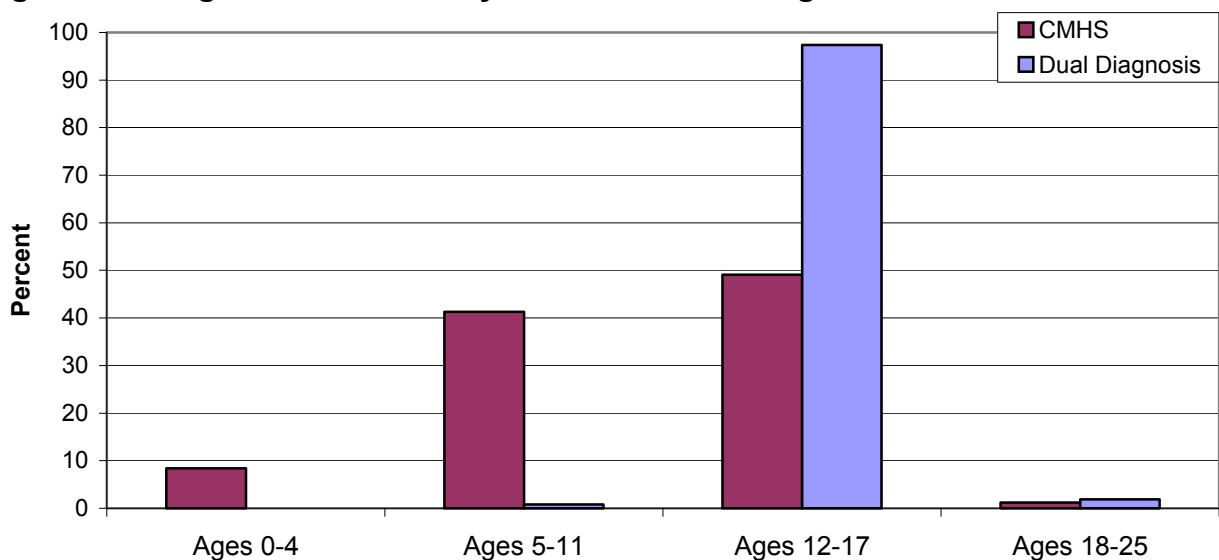
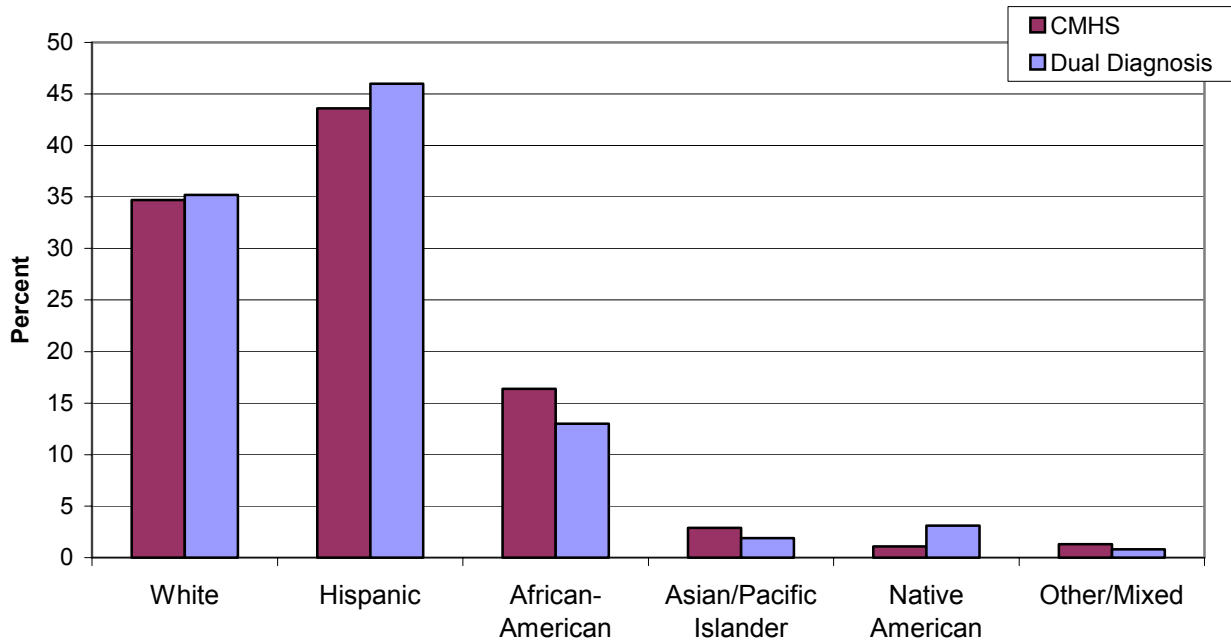
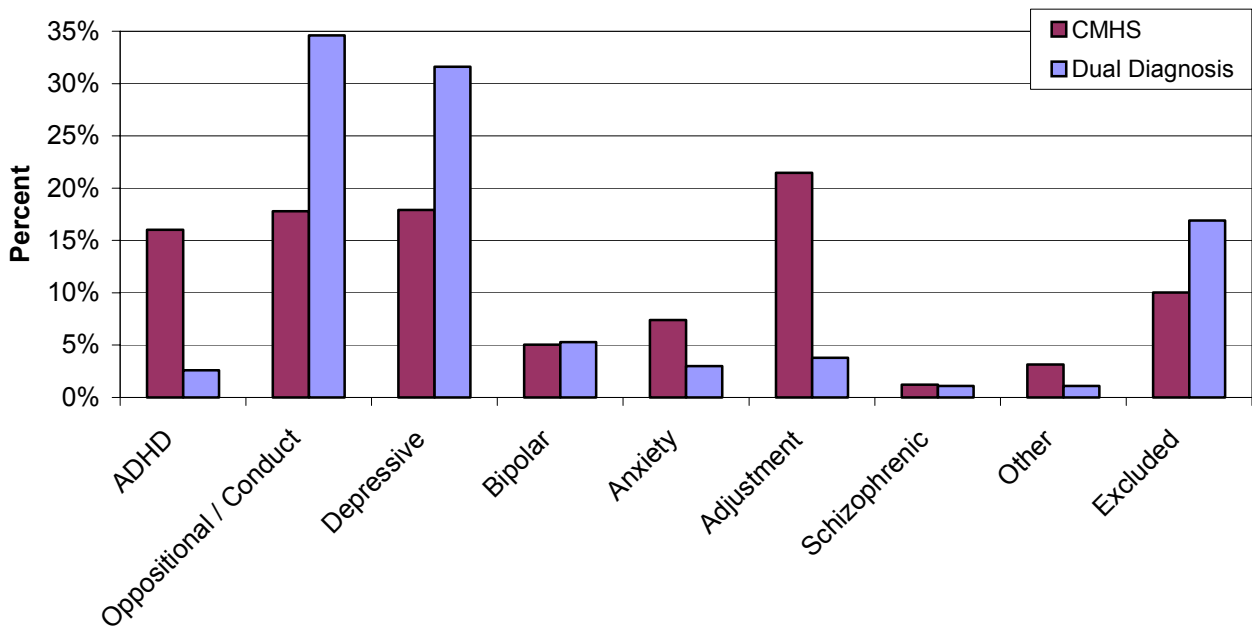


Figure 4.5: Racial/ethnic breakdown for youth receiving CMHS services with a dual diagnosis.



The majority of youth with a dual diagnosis come from one of three **primary diagnosis categories**: Oppositional and Conduct disorders (35%), Depressive disorders (32%), and Excluded diagnoses (17%) (Figure 4.6).

Figure 4.6: Primary Mental Health Diagnosis for youth with a Dual Diagnosis



An analysis of **service use patterns by youth with a dual diagnosis** showed that 33% had received services from ADS during FY03-04. These youth were more likely to have used inpatient or crisis stabilization services than the general population, but used fewer days of inpatient care on average (**Table 4.1**). Large differences were seen in the day treatment categories, with over 40% of dual diagnosis youth receiving day rehabilitation services and only 2% receiving intensive day treatment services. They received fewer days of day treatment services on average, however. In the outpatient area, youth with a dual diagnosis were more likely to receive collateral, case management, or crises services than youth in the overall CMHS population, and less likely to receive assessment services (**Table 4.2**).

Table 4.1: Restrictive Service Use by Youth with a Dual Diagnosis

Blue/Bold = 20+% higher than CMHS Red/Italics = 20+% lower than CMHS

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
Dual Diagnosis	3.8%	<i>7.0</i>	6.3	<i>2.3%</i>	<i>54.8</i>	48.7	41.0%	<i>32.8</i>	33.3	2.6%	1.0	0
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Table 4.2: Outpatient Service Use by youth with a Dual Diagnosis

Blue = 20+% higher than CMHS Red = 20+% lower than CMHS

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Dual Diagnosis	66.2%	409.3	629	39.8%	947.2	2137.3	<i>32.3%</i>	247.1	237.9	24.4%	221.7	239.5
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
Dual Diagnosis	37.2%	<i>156.6</i>	168.2	76.3%	939.2	1127.6	<i>0.0%</i>	---	---
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

Youth active to both CMHS and ADS sectors

The characteristics of youth who were active to both the CMHS and ADS sectors were examined using a dataset obtained from ADS that listed all clients served during FY03-04. Being active to both sectors is an indication that they have both mental health and substance use problems serious enough to warrant treatment. Results are shown in Figures 4.7-4.12. Overall, **5.2% of youth receiving CMHS services are also active to ADS**. These youth are more likely to be **male** and **adolescent**, with no youth under age 12 active to both the CMHS and ADS sectors (**Figures 4.7 and 4.8**). **Hispanic** youth are overrepresented as compared to their prevalence in the overall CMHS population.

Figure 4.7: Gender distribution for youth active to CMHS and ADS

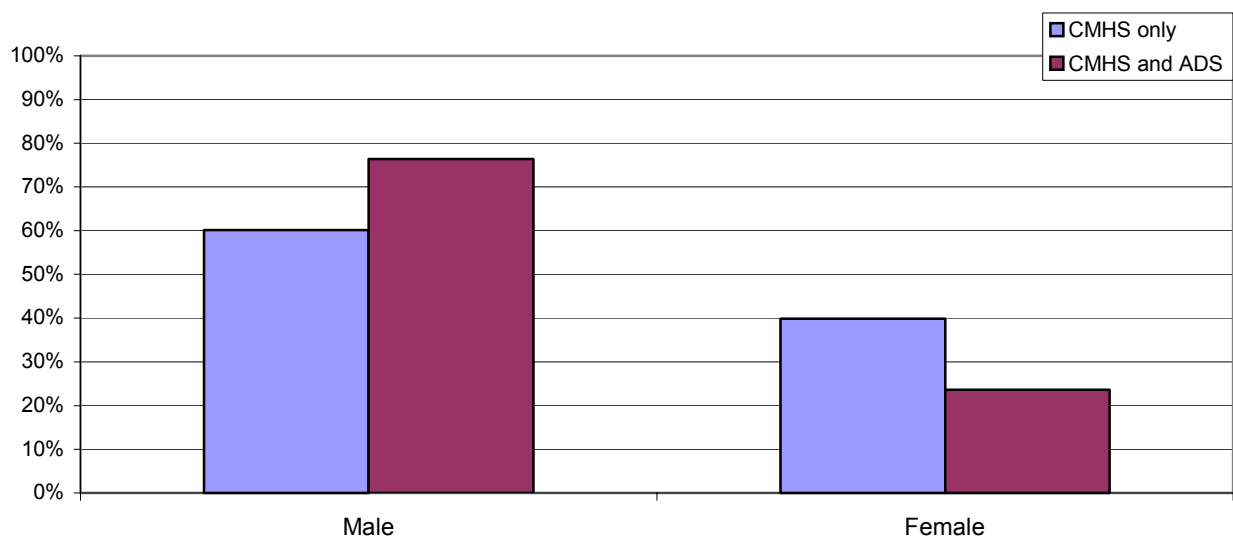


Figure 4.8: Age distribution for youth active to CMHS and ADS

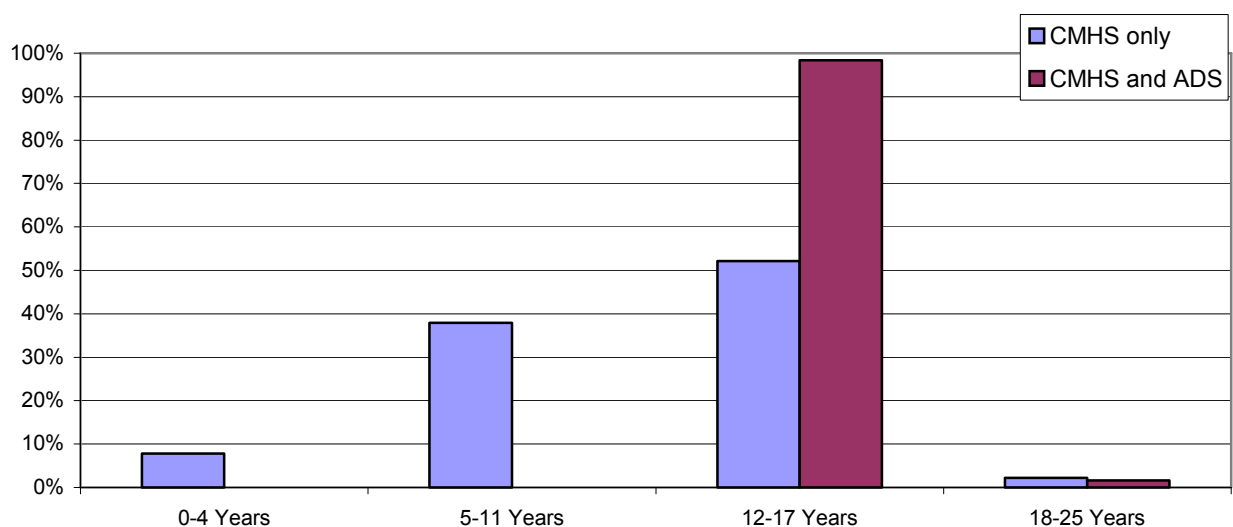
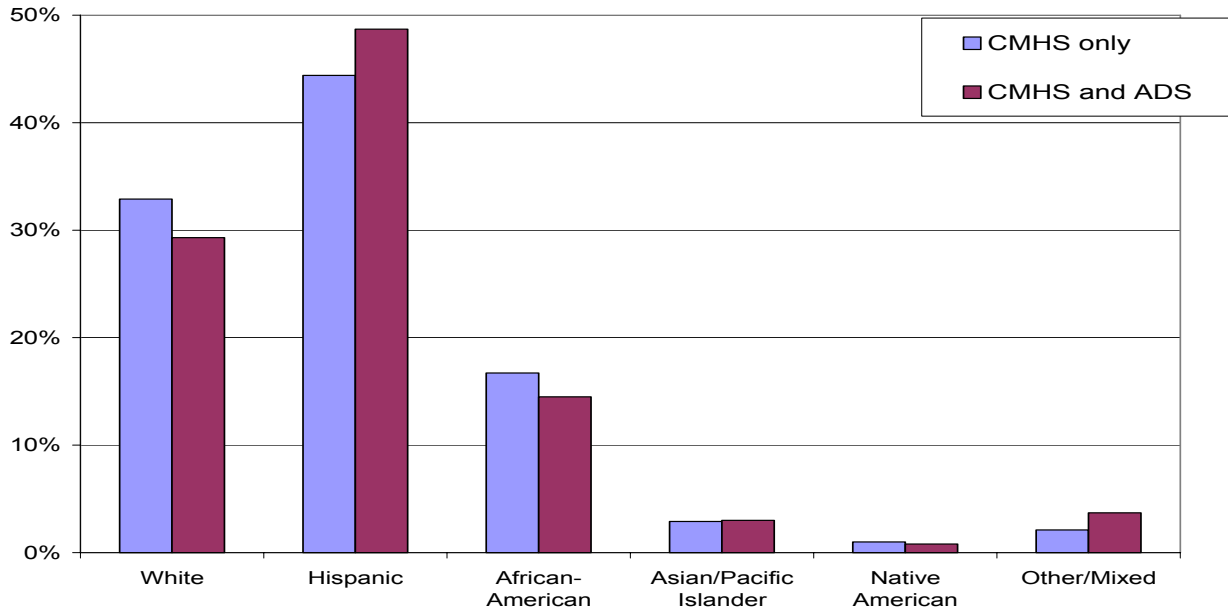
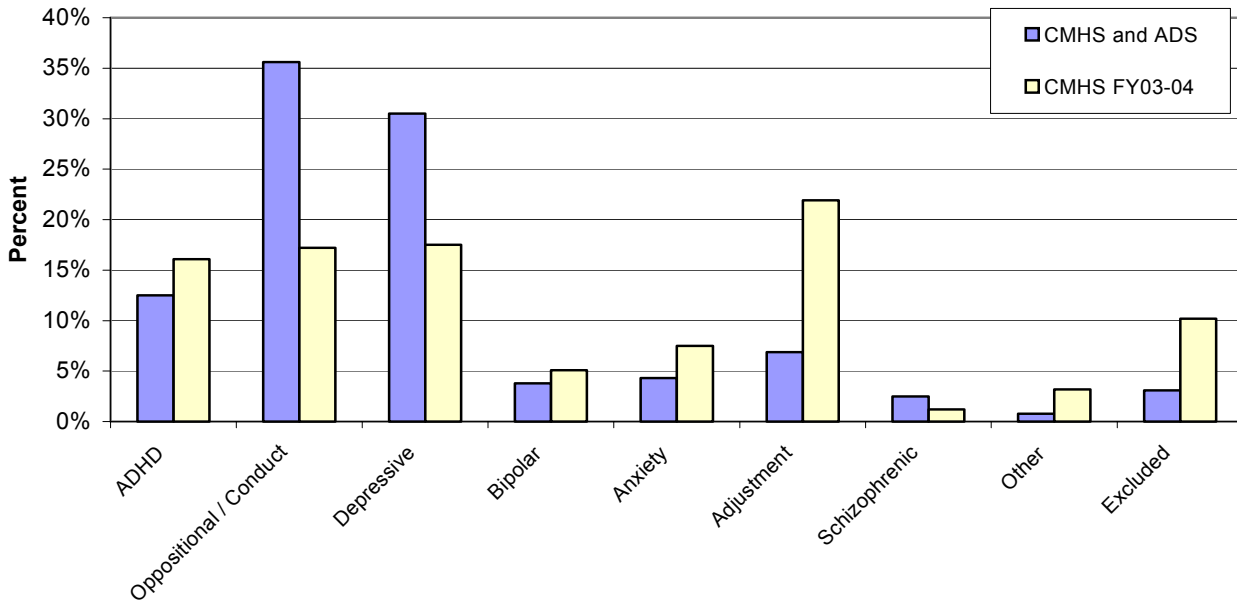


Figure 4.9: Race/Ethnicity distribution for youth active to CMHS and ADS



The most common **primary diagnoses** in this group are oppositional/conduct disorders (35.6%), depressive disorders (30.5%), and ADHD (12.5%). Interestingly, only 21.6% of youth active to both sectors had a dual diagnosis according to the mental health system (both mental health and substance use diagnoses entered into INSYST), which indicates that the mental health provider was either unaware of the co-occurring substance use issue or did not enter the secondary diagnosis into INSYST.

Figure 4.10: Primary diagnosis for youth active to CMHS and ADS



Service use by youth active to CMHS and ADS also varies from that of youth active to CMHS alone. First, youth active to both systems are more likely to use day rehabilitation services, and to use more days of service, than youth active to CMHS alone (**Table 4.3**). With regard to outpatient services (**Table 4.4**), youth active to both sectors are less likely to use case management, assessment, or TBS services, although those youth who do receive case management services use more total minutes on average than youth in CMHS alone. In addition, youth active to both sectors are more likely to receive crises services, but receive fewer minutes of services than youth in CMHS alone. Finally, youth active to CMHS and ADS receive fewer minutes of collateral, medication support, and therapy services than do youth active only to CMHS.

Summary

- Substance-using youth are more likely to be male and adolescent
- Hispanic youth are overrepresented among substance-using youth
- The primary diagnoses among these youth are Oppositional/conduct disorders and Depressive disorders.
- 22% of youth receiving CMHS services report having used substances at least five times in the past month

Figure 4.3: Restrictive Service Use by Youth active to CMHS and ADS
Blue/Bold = 20+% higher than CMHS *Red/Italics = 20+% lower than CMHS*

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
CMHS + ADS	2.7%	13.7	19.6	4.2%	<i>48.1</i>	42.6	13.8%	54.3	60.2	1.4%	1.1	0.3
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Figure 4.4: Outpatient Service Use by Youth active to CMHS and ADS
Blue = 20+% higher than CMHS *Red = 20+% lower than CMHS*

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS + ADS	50.5%	<i>370.9</i>	728.6	<i>17.8%</i>	1400.6	3050.7	<i>16.6%</i>	189.1	164.2	14.4%	<i>172.3</i>	220.8
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS + ADS	41.7%	<i>198.0</i>	175.7	91.3%	<i>581.9</i>	796.7	<i>0.3%</i>	<i>3481.7</i>	2087.9
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

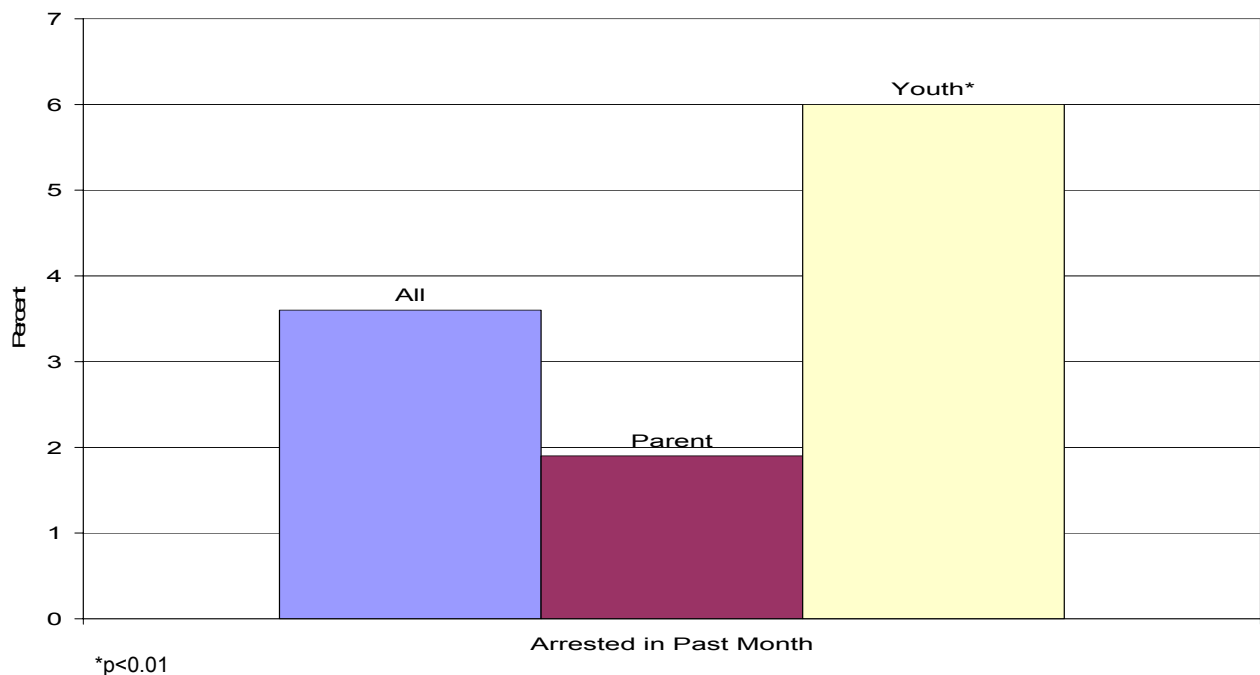
Delinquent Behavior

There are two sources of delinquency data for the FY 03-04 CMHS sample. First, the November 2003 **Youth Services Survey (YSS)** asked both the youth (ages 13+) and parent respondent to report on whether the youth had been arrested for any crimes in the past month, and if so, how many times had the youth been arrested. Second, using an administrative database obtained from the **San Diego County Probation department**, we were able to examine those youth who were active to both the CMHS and Probation departments in FY03-04.

Youth Services Survey (YSS)

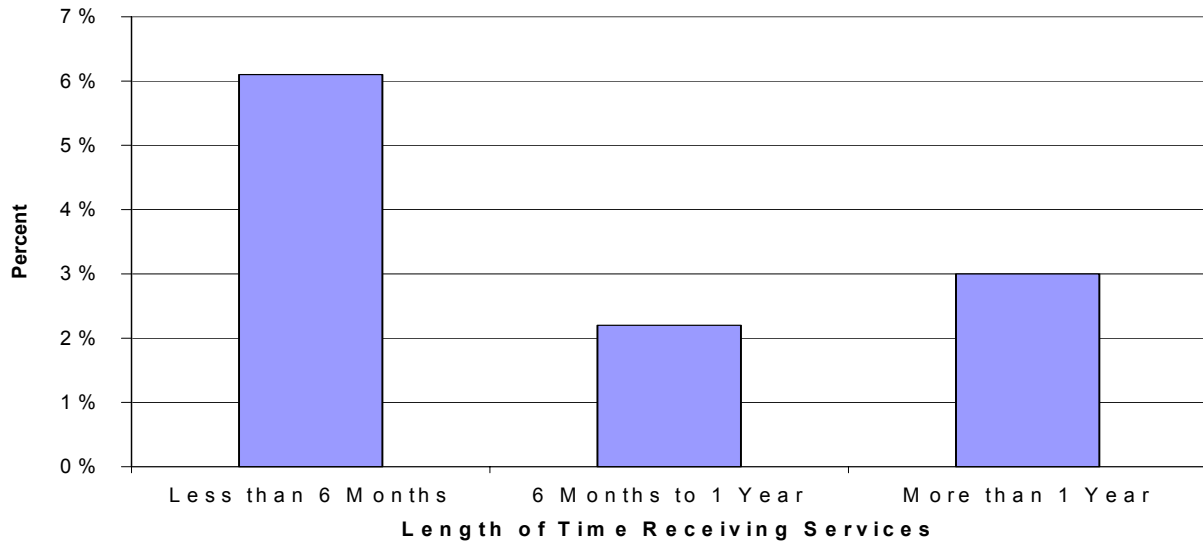
Data from the **November 2003 YSS** show that less than 4% of youth receiving services from CMHS had been arrested in the month prior to the survey (**Figure 4.11**). Youth were significantly more likely than parents to report having been arrested.

Figure 4.11: Percent of youth who were arrested in past month, by parent or self-report.



When this arrest data was examined in relation to the youth's length of time receiving mental health services, increased length of time in service was related to a decrease in reported arrests in the preceding month (**Figure 4.12**). Youth receiving services for either six months to one year, or more than one year, were significantly less likely than youth receiving services for less than six months to report having been arrested in the past month ($p<0.05$ for both). There was no significant difference in arrest reports between the 6-12 month and more than 1 year in service groups.

Figure 4.12. Past Month Arrests by Length of Time receiving Services



Youth active to both CMHS and Probation sectors

The characteristics of youth who were active to both the CMHS and Probation sectors were examined using a dataset obtained from the Probation department that listed all clients referred to Probation during FY03-04. Overall, **17% of youth receiving CMHS services are also active to Probation**. These youth are more likely to be **male** and **adolescent**, with no youth under age 5 active to both the CMHS and Probation sectors (Figures 4.13 and 4.14).

Figure 4.13: Gender distribution for youth active to CMHS and Probation

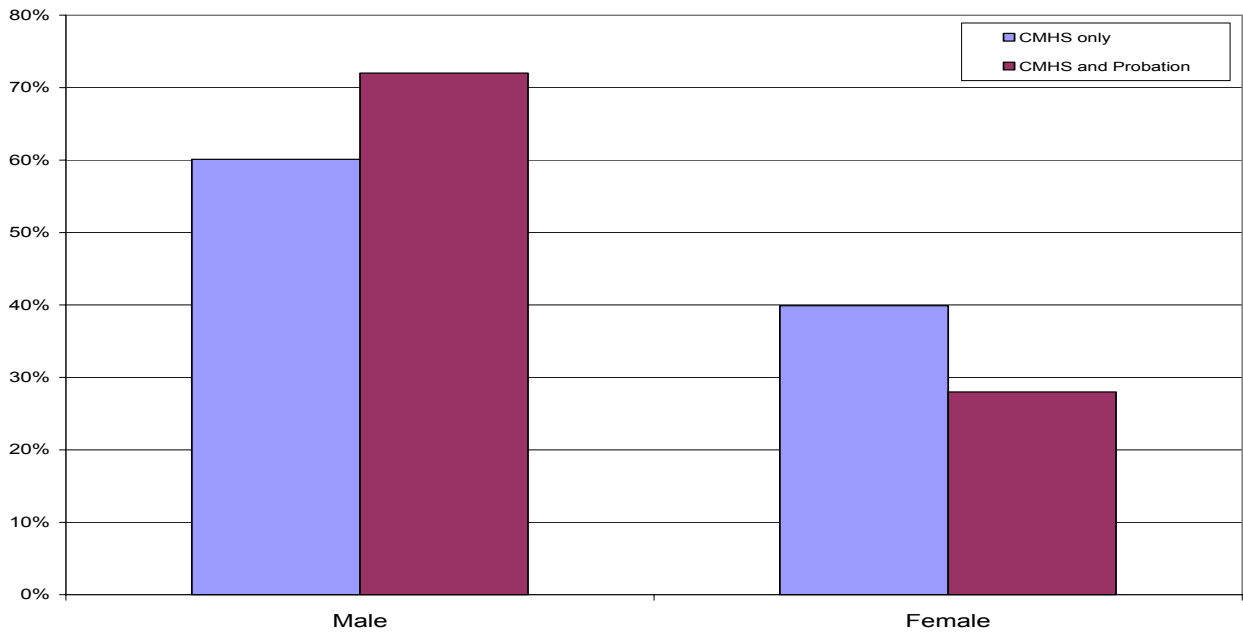
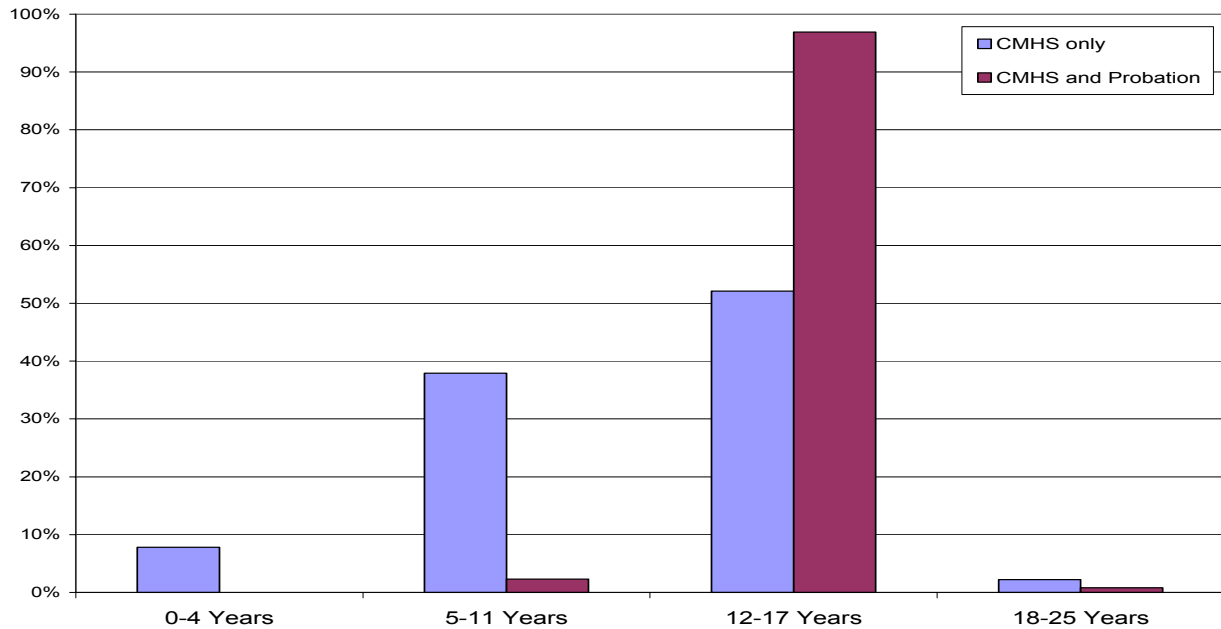
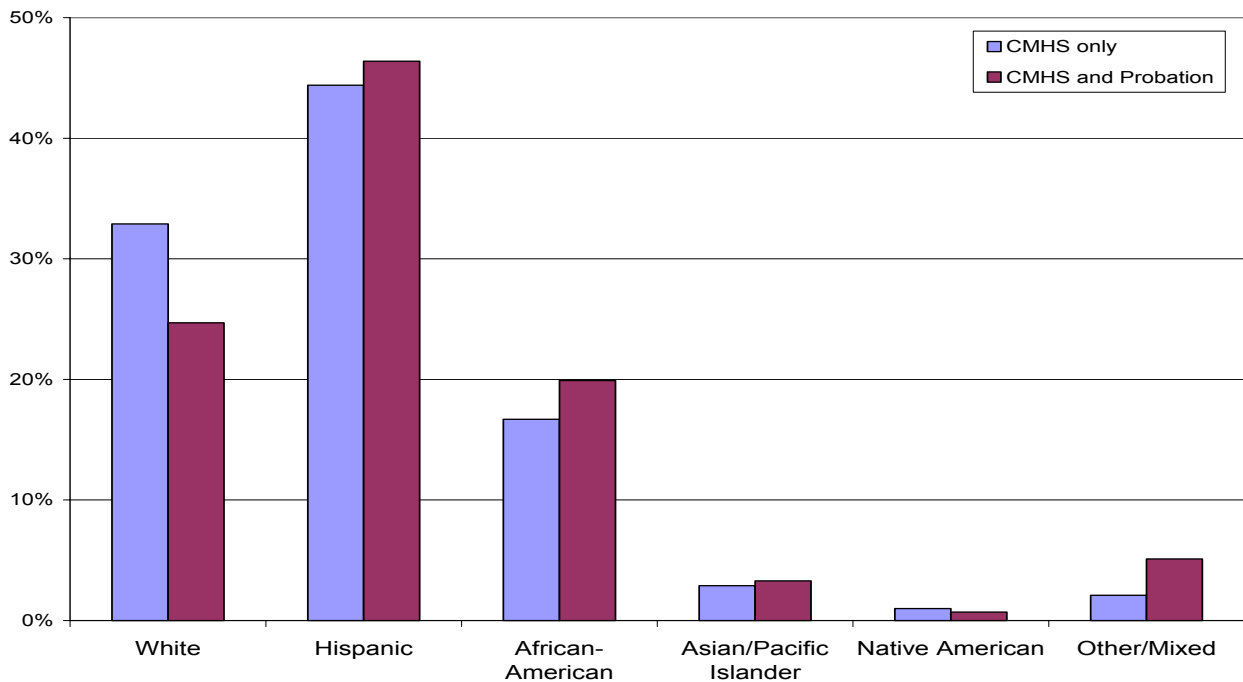


Figure 4.14: Age distribution for youth active to CMHS and Probation



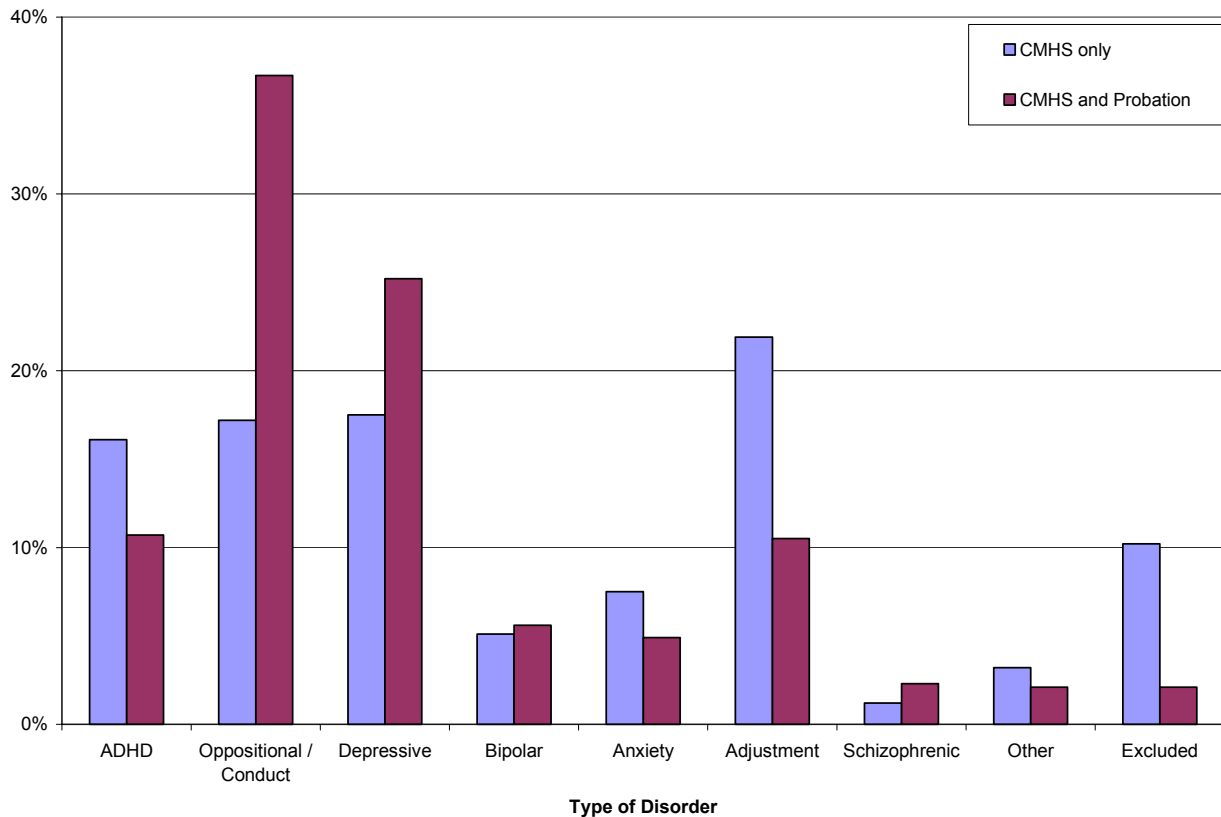
White youth are underrepresented in the population of youth active to both CMHS and Probation in FY03-04, as compared to their prevalence in the overall CMHS population (**Figure 4.15**).

Figure 4.15: Race/Ethnicity distribution for youth active to CMHS and Probation



The most common **primary diagnoses** in this group are oppositional/conduct disorders (36.7%), depressive disorders (25.5%), and ADHD (10.7%) (**Figure 4.16**). The oppositional and depressive disorders are more common in this population than in the CMHS sample as a whole, while the Adjustment and Excluded diagnoses are seen less often in this population.

Figure 4.16: Primary Diagnosis for youth active to CMHS and Probation



Service use by youth active to CMHS and Probation also varies from that of youth active to CMHS alone. First, youth active to both systems are more likely to use day rehabilitation services than youth active to CMHS alone (**Table 4.5**). With regard to outpatient services (**Table 4.6**), youth active to both sectors are less likely to use case management, assessment, or TBS services, although those youth who do receive case management services use more total minutes on average than youth in CMHS alone. Finally, youth active to both sectors are more likely to receive crises services than youth in CMHS alone.

Figure 4.5: Restrictive Service Use by Youth active to CMHS and Probation

Blue/Bold = 20+% higher than CMHS Red/Italics = 20+% lower than CMHS

	Inpatient			Intensive Day Treatment			Day Rehabilitation			Crisis Stabilization		
		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev		Mean Days	Std Dev
CMHS and Probation	3.5%	14.8	19.0	5.2%	71.0	60.0	10.4%	36.0	41.0	1.4%	1.2	0.8
CMHS FY03-04	3.1%	14.4	17.7	4.4%	86.7	67.0	8.4%	44.3	62.5	1.6%	1.2	0.6

Figure 4.6: Outpatient Service Use by youth active to CMHS and Probation

Blue = 20+% higher than CMHS Red = 20+% lower than CMHS

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS and Probation	49.1%	411.7	694.2	<i>20.9%</i>	1484.2	3364.0	<i>22.9%</i>	220.1	214.5	15.9%	255.7	427.7
CMHS FY03-04	53.5%	481.9	701.9	30.1%	1101.7	2575.6	44.5%	184.1	190.8	10.9%	237.9	339.6

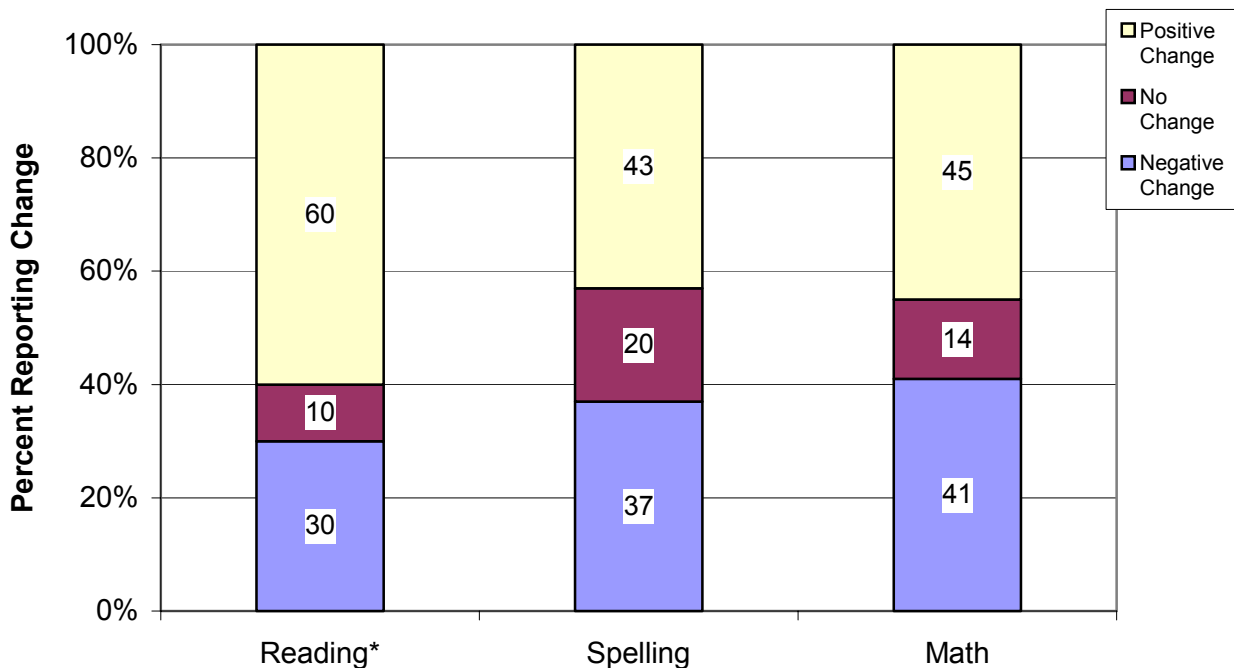
	Medication Support			Therapy			TBS		
		Mean Mins	Std Dev		Mean Mins	Std Dev		Mean Mins	Std Dev
CMHS and Probation	35.9%	243.0	292.3	90.4%	<i>610.8</i>	822.9	<i>0.7%</i>	<i>4182.5</i>	3343.8
CMHS FY03-04	42.3%	254.4	302.3	76.9%	848.5	1041.1	1.0%	5241.5	4858.6

School Achievement

School achievement data was collected from those youth participating in intensive case management/wraparound programs, such as BEST and CYFN, using the **Wide Range Achievement Tests (WRAT3)**. From 1996 to 2004, 416 WRAT3s were collected at baseline, 84 youth had a 6-month follow-up test, and 38 youth had a 1-year follow-up test. The WRAT3 measures attained academic skills in **reading, spelling and math** with higher scores indicating better performance.

Comparing intake scores to **6-month follow-up** on the absolute mean scores for each subscale, only 1 subscale, reading, reveals a significant improvement ($p < .05$) (**Figure 4.17**). At 6-month follow-up, **60% of the youth demonstrate a positive change on reading** (a 2 point improvement on absolute score from intake to 6 months), while 10% show no change and 30% show negative change in absolute reading scores. Fewer youth show improvements in absolute scores for spelling and math; **43% demonstrate a positive change for spelling** and **45% demonstrate a positive change for math**. Twenty percent of youth show no change for spelling and 14% no change for math. Another 37% show negative change in spelling, and 41% show negative change in math.

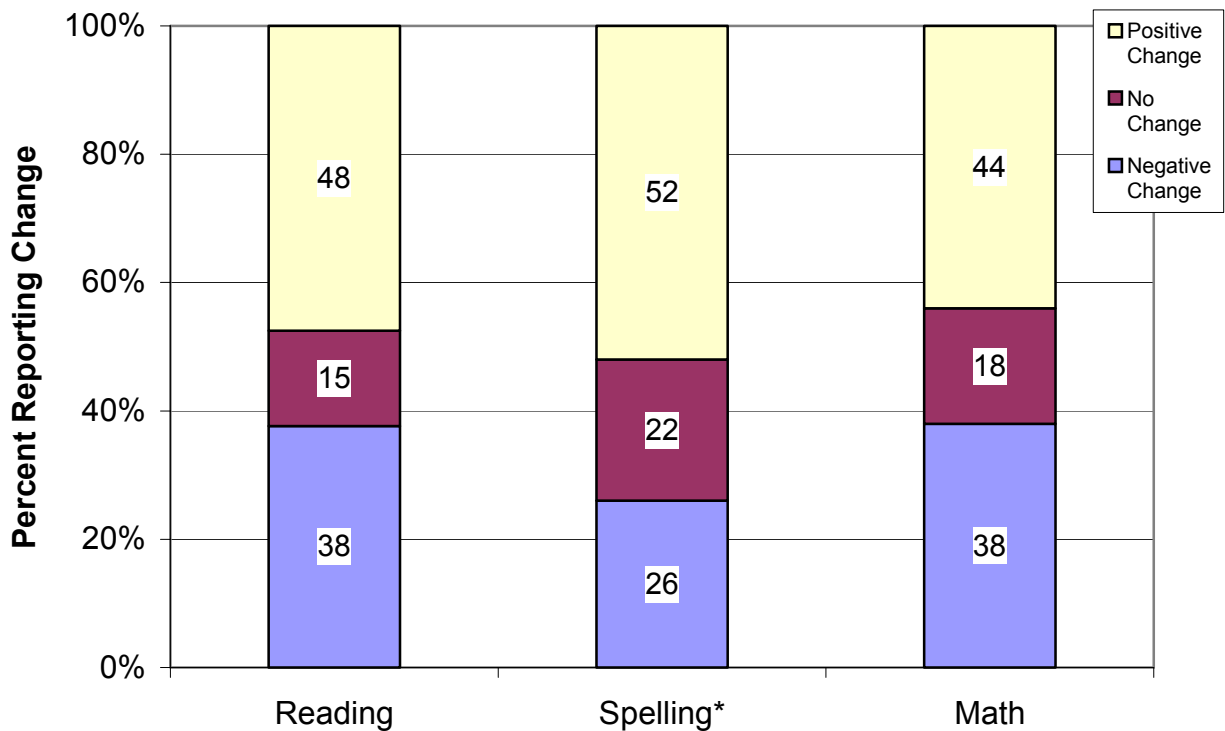
Figure 4.17: WRAT3 School Achievement Test Scores - Intake to 6 Months Assessed Change



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

At 1 year follow-up, only the spelling subscale shows significant improvement ($p < .05$), with **52% reporting positive change on spelling**, 22% reporting no change and 26% negative change in absolute scores (Figure 4.18). After one year, **44% of youth show a positive change in absolute math scores**, 18% no change and 38% negative change. Absolute reading scores also improved, with **48% showing positive change on reading**, 15% no change and 38% negative change.

Figure 4.18: WRAT3 School Achievement Test Scores - Intake to 1 Year Assessed Change



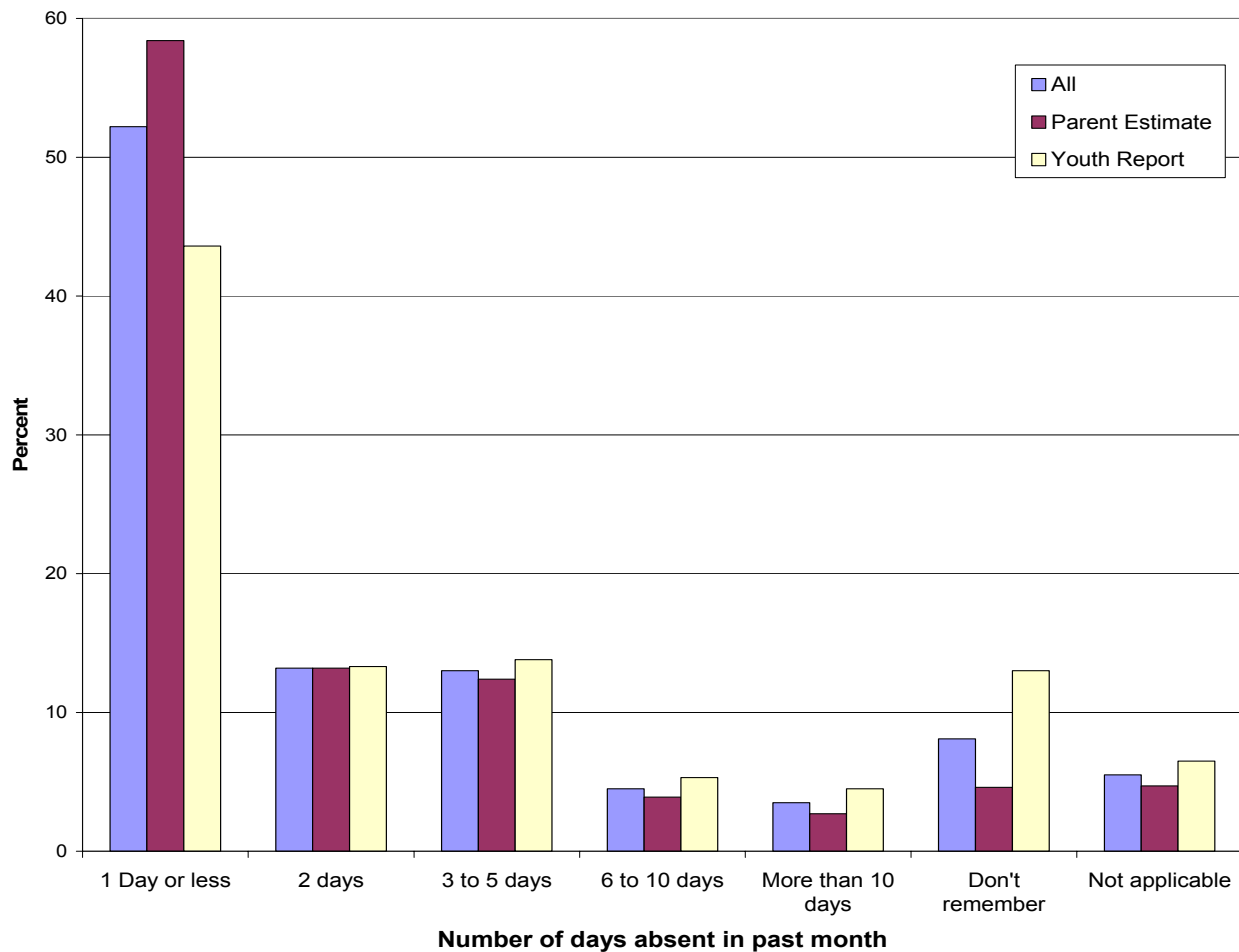
*represents statistical significance at $p < .05$ for paired t-tests from intake to follow-up

School Attendance

Absences from school were examined in FY03-04 through two measures: 1) a **Youth Services Survey (YSS)** question on past month absences and 2) **monthly attendance records** obtained for intensive case management/wraparound clients.

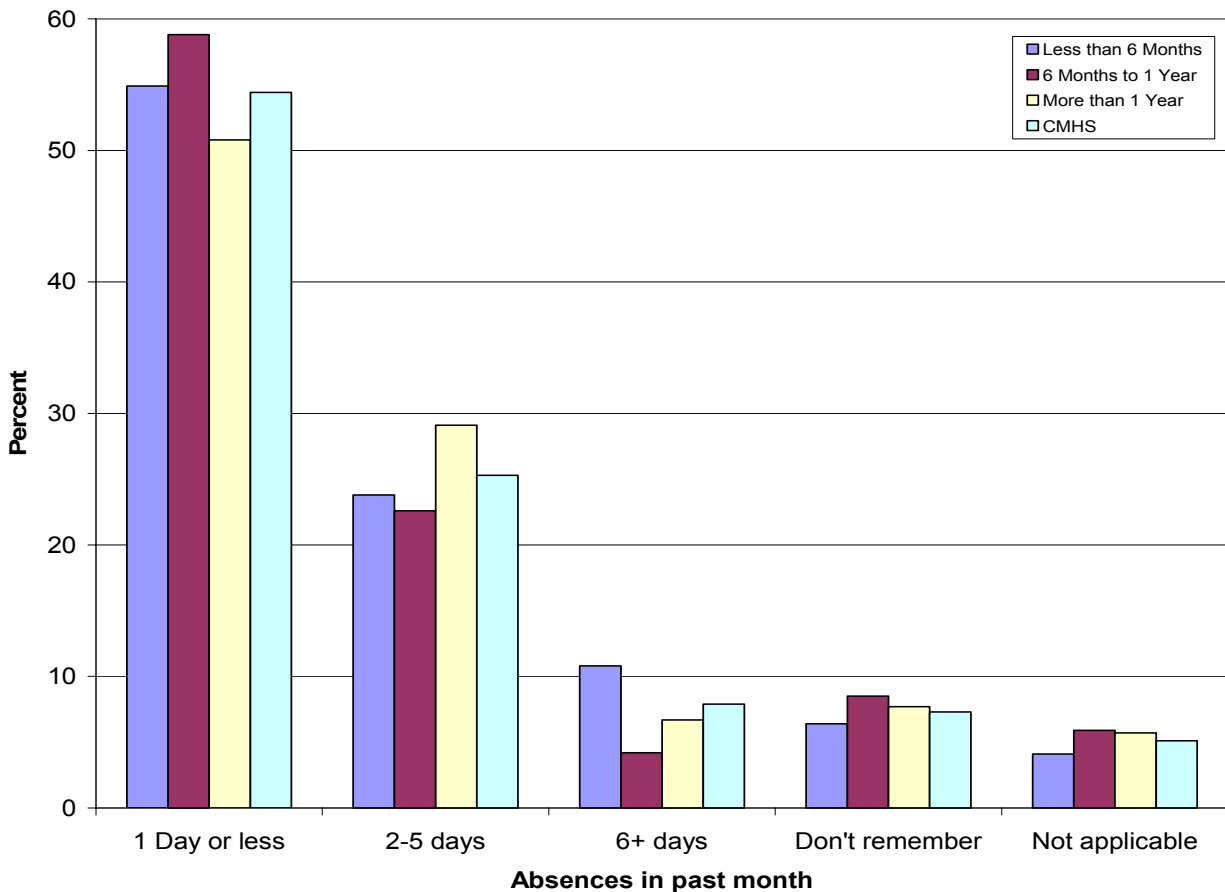
The **YSS** was administered to all children, ages 13 and older, who received CMHS services between November 1 and 15, 2003; parents of all children, regardless of age, were also asked to complete a survey. The focus of the survey was on satisfaction with services, but several additional questions asked about demographics and mental health risk factors and give a point-in-time estimate of attendance for all children receiving services during the survey period. **Overall, 52% of respondents said that the youth had been absent one day or less in the past month (Figure 4.19).** 13% of youth did not remember how many times they had been absent in the past month.

Figure 4.19. Percent of youth who were absent from school in past month, by parent or self-report on November 2003 Youth Services Survey.



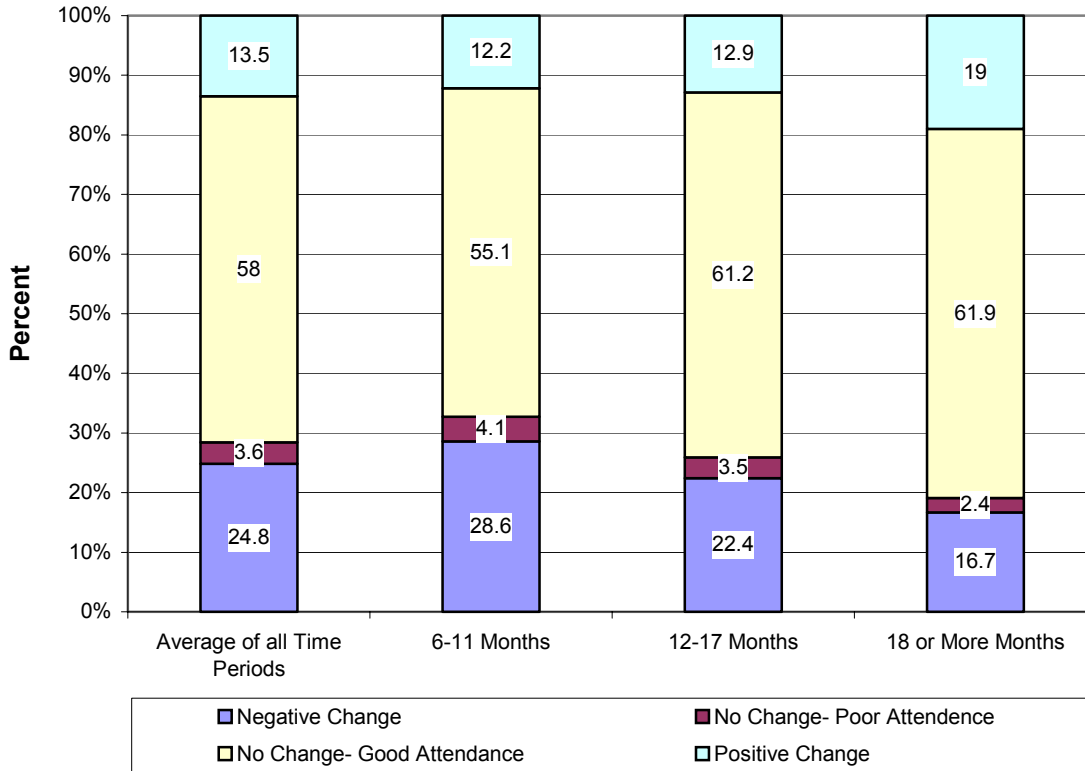
When the YSS data on attendance was grouped by the child’s length of time in CMHS services (**Figure 4.20**), youth who had received less than six months of service were more likely to have 6 or more reported absences in the past month than the overall CMHS population. Youth who had received over one year of service at the time of the YSS were more likely to report 2-5 absences in the past month. The pattern of past month absences in the “less than six months” group were significantly different from those in either the “6 months to 1 year” or “more than 1 year” groups. There was no significant difference in the absence pattern between the “6 months to 1 year” and “more than 1 year” groups.

Figure 4.20: Percent of youth who were absent from school in past month, by length of time receiving services



School attendance data was collected for youth receiving intensive case management / wraparound services by either administrative records or parental report (when school records were not available). **Figure 4.21** displays school attendance for this sample, with youth grouped by the period of attendance data obtained: 6-11 months, 12-17 months, and 18 months or more. School attendance was calculated by averaging the first 3 months of attendance (intake) and comparing this to the average attendance of the last 3 months available (follow-up). **Overall, over 70% of youth attained or maintained perfect attendance (no unexcused absences).** Youth with longer follow-up periods (12 months or more) showed more improvements during this extended period compared to youth who had a follow-up of less than 12 months post service entry. This suggests that about one year of service was necessary to impact attendance, and that more time in service results in a greater improvement in attendance. However, these differences are not statistically significant.

Figure 4.21: School Attendance by youth receiving intensive case management/ wraparound services



Chapter Summary:

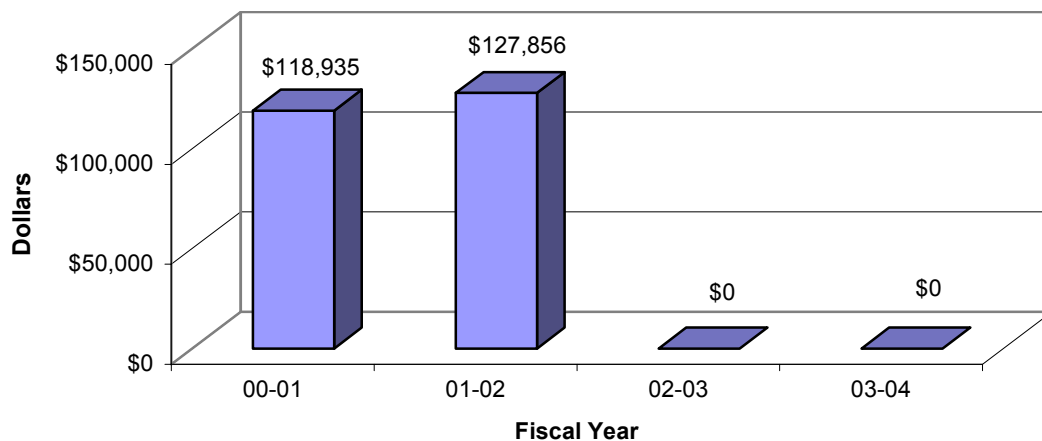
- 22% of youth in CMHS report having used substances at least 5 times in the past month
 - Reports of substance use decrease as the length on time in CMHS services increases
- 6% of youth, ages 13 and older, report having been arrested in the past month
 - Reports of arrests decrease as the length of time in CMHS services increases
- 48% of respondents said that the youth had 2 or more absences from school in the past month
 - Reports of absences decrease as the length of time in CMHS service increases

Chapter 5: System Outcomes

One goal of the San Diego County System of Care is to keep children and adolescents living at home or in home-like settings and thereby reduce state hospital, inpatient, and group home costs and utilization. Although some of these are located outside of the mental health sector, they are all involved in the overall system of care of child-serving sectors.

San Diego County CMHS has sustained its reduced **state hospital utilization**. The County contracts at the beginning of the fiscal year to pay for a set number of state hospital beds regardless of usage. San Diego County purchased one bed for fiscal years 00-01 and 01-02, but did not use them. As a result of this, no beds were purchased in FY02-03 or FY03-04. Figure 5.1 reflects the dramatic decrease in state hospital costs and utilization, with no state hospital beds contracted for or used in FY03-04. These reductions were accomplished primarily through the implementation of the local intensive case management programs, which divert youth from higher levels of placement including state hospitals utilizing “wraparound” services. Diverting youth from state hospital beds **saved the County at least \$127,856 in FY03-04** (based on FY01-02 costs).

Figure 5.1: State Hospital Costs by Fiscal Year



Acute inpatient hospitalization cost and utilization is another goal for careful monitoring and maintenance within the mental health system. 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.

Figures 5.2 and 5.3 illustrates the County costs and utilization for inpatient care for children and adolescents over the last four years. The costs are the dollar amount paid for acute inpatient days, and utilization is expressed as the number of beds used in acute inpatient units for children and adolescents. After having risen for the past three years, overall inpatient costs have dropped about 12% from FY 02-03 levels. CAPS costs decreased 9% and Medi-Cal FFS costs decreased 17% from FY02-03 to FY03-04. The number of bed days used for CAPS and Medi-Cal FFS continued to drop sharply, reducing 18% even though the Medi-Cal youth population in San Diego County continued to increase.

Figure 5.2: Inpatient Costs by Fiscal Year

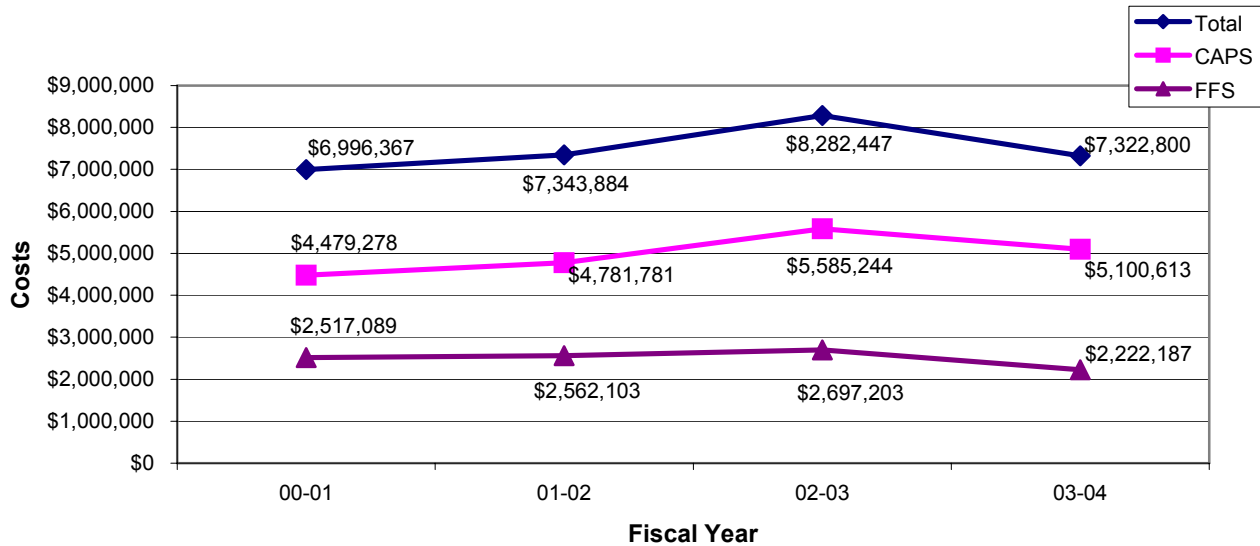
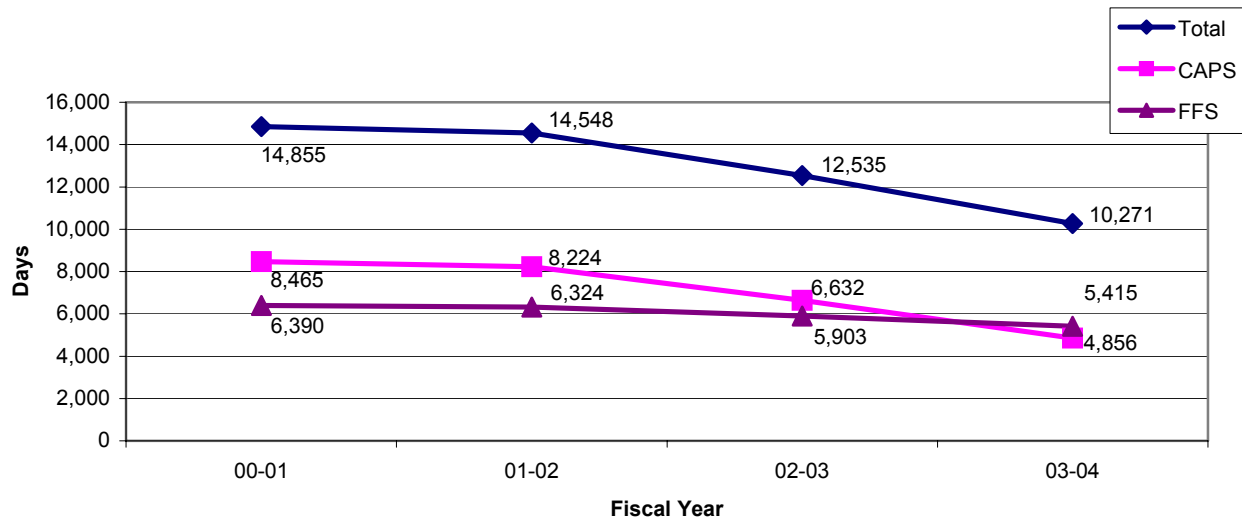


Figure 5.3: Inpatient Bed Days by Fiscal Year



Figures 5.4 and 5.5 show the costs and number of months in placement for each fiscal year, overall and by each placing county department (Probation, AB2726, Child Welfare). Total **Group Home/Residential** costs have risen slightly over the last fiscal year, but stayed largely in line with FY02-03 costs. The large increase in costs between FY01-02 and FY02-03 was caused primarily by the inclusion of group home alternatives to shelter care placements made by non-Residential Child Welfare staff within the Child Welfare sample. While Child Welfare costs and placements increased dramatically, costs and placements by Probation and AB2726 have remained stable over the past few years.

Figure 5.4: Group Home/Residential Costs by Fiscal Year

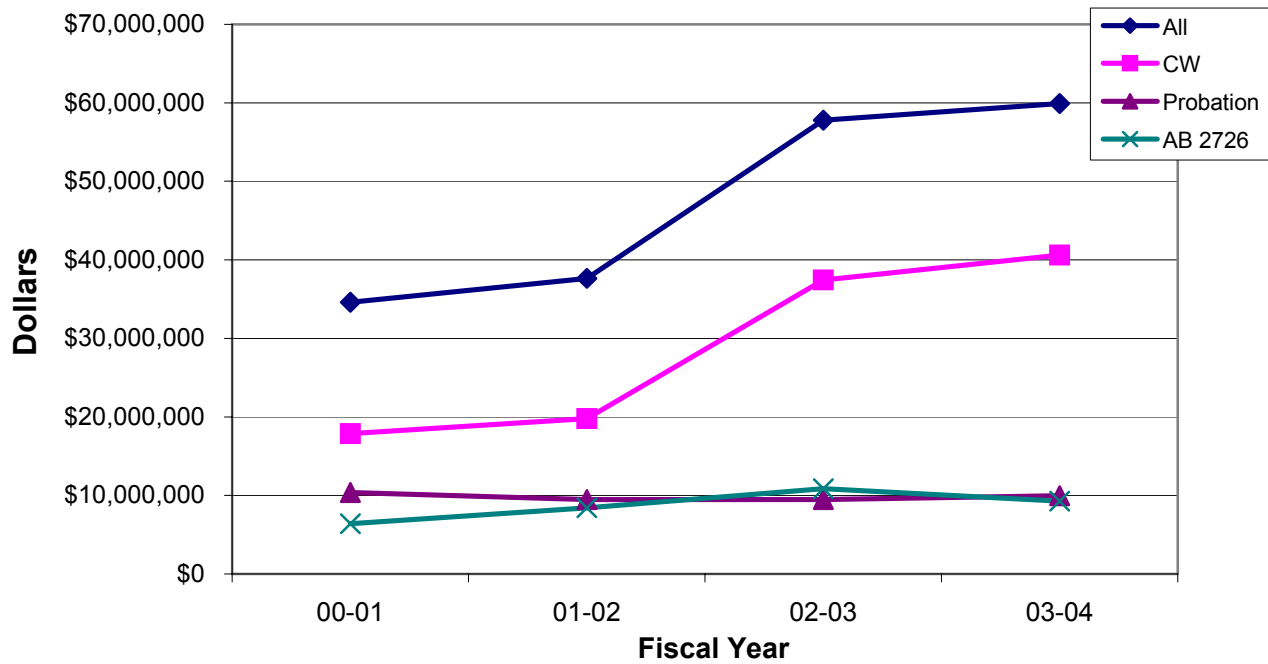
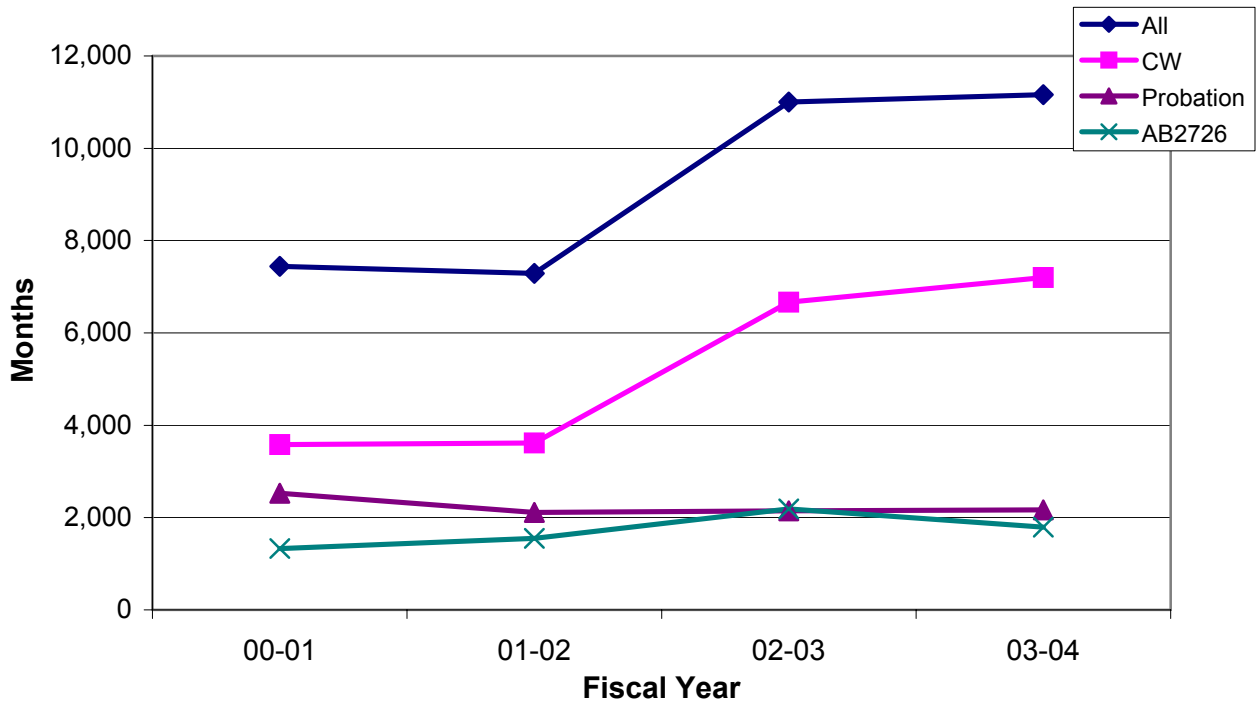


Figure 5.5: Total Months in Group Home/Residential Placement by Fiscal Year



Chapter Summary

Overall, San Diego County has been able to achieve a significant reduction in the use of state hospital beds in the past few years, with no children placed in the state hospital since FY99-00. The usage of local acute inpatient hospital beds has also been decreased dramatically in the past two fiscal years; however, due to increasing medical fees, the County's costs for these beds are not reduced as dramatically. Finally, the cost and amount of group home/ residential beds increased only slightly this year, after a large increase in FY02-03 which was driven largely by Child Welfare policies emphasizing the use of group home placements as an alternative to shelter care.

In Fiscal Year 2003-2004, San Diego County Children's Mental Health Services experienced:

- no use of state hospital beds
- a 12% decrease in acute inpatient hospital costs over FY02-03
- an 18% decrease in acute inpatient hospital days over FY02-03
- a slight increase in group home costs and usage over FY02-03

Chapter 6: Other Public Sector Data Sources

While Children’s Mental Health Services is a primary component of the San Diego County Children’s System of Care, other public service sectors, such as Education, Child Welfare and Probation, are also key components. All components of the System of Care are working towards the same general goals: keeping kids safe, out of trouble, in school, and healthy. Having a common purpose is essential, as many children receiving mental health services through CMHS are also receiving services through other public sectors.

To ensure collaboration and coordination of services across sectors, the San Diego County Children’s System of Care Steering Committee, begun in 1999 and now called the System of Care Council, brings together representatives of the various sector and stakeholder group on a monthly basis. In addition, several subcommittees have been formed to address specific work areas. The Outcomes subcommittee was formed and charged with developing a new countywide evaluation system to replace the state-mandated POP program, which ended in August 2002. The Educational Advisory Committee was developed to address issues specific to the Education and Mental Health sectors and began a pilot program to examine educational outcomes for youth receiving school-based mental health services; results are reported below.

Education Outcome Pilot Program

A primary goal of the System of Care is that children, including those with mental health problems, are successful in school. This goal is of great importance to the Education sector as well, which lead to the formation of the Educational Advisory Committee (EAC). In 2003, the EAC began the Education Outcome Pilot Project (EOP) to **track the educational progress of students receiving mental health services** in school based programs. The pilot’s objectives - 1) to measure educationally relevant outcomes for school-based, school-linked mental health services and 2) to assess whether mental health services effectively reduce or eliminate the emotional and behavioral barriers to student learning - is of critical importance, given that schools are often the “de facto” mental health services provider for many youth. In an effort to examine the relationship between receiving mental health services and educational outcomes, EOP is gathering data on **academic indicators** including: academic and citizenship grades, positive daily attendance, suspensions, and percentile scores from the California Achievement Test - Sixth Edition (CAT/6). Nine mental health providers representing six Special Education Local Planning Areas (SELPA) and 50 schools agreed to participate in the pilot project (**Table 6.1**).

Table 6.1 – Providers Participating in the Education Outcome Pilot Project by SELPA

Provider Organization	Special Education Local Planning Area (SELPA)
Children, Youth & Family Network	East County SELPA
San Diego Youth & Community Services	East County SELPA
Therapeutic Services, Inc.	East County SELPA
Vista Hill	North Inland SELPA
Mental Health Systems, Inc.	North Inland, Poway, North Coastal SELPAS
San Diego Center for Children	North Inland, Poway, North Coastal SELPAS
Children’s Hospital Outpatient Psychiatry	San Diego Unified SELPA
Mental Health Resource Center	San Diego Unified SELPA
Therapeutic Services, Inc.	South County SELPA

Data collection began in the fall of 2003 and was done by the pilot sites, which were provided with an ACCESS or EXCEL database for data entry. To date, data have been submitted by three MH providers representing a total of **63 students** (approximately 13% of the total projected participants). The mental health providers that submitted data are Vista Hill, Therapeutic Services Inc, and the San Diego Unified Mental Health Resource Center, which serve children within three SELPAs within San Diego County. The schools include 9 from the North Inland SELPA (Hansen Lane, Ramona, Mount Woodson, Barnett, James Dukes, Olive Pierce, Ramona High School, Montecito, and Ramona Community), 1 from the San Diego Unified SELPA (Sherman Elementary), and schools from the South County SELPA (Rice, El Toyon, San Ysidro, Mendoza, and Mar Vista).

Data was collected at three time points: baseline (the 90 days of regular school attendance prior to enrollment in the EOP), grading point 1 (the end of the first semester after enrollment in the EOP, defined as either the end of January or June, whichever applied. A student must have attended more than 50% of the given semester to be defined as Grading period 1 data), and grading point 2 (the end of the second semester after enrollment in the EOP, either the end of January or June, whichever applied). An examination of the data submitted shows that **many records are incomplete** and data are missing from key variables.

- CAT-6 Percentile Scores: 6 students have scores at baseline, 4 at grading period 1, and 9 at grading period 2.
- Academic grades: 57 students have grades at baseline, 37 at grading period 1, and 15 at grading period 2.
- Citizenship grades: 51 students have citizenship grades at baseline, 33 at grading period 1, and 14 at grading period 2.
- Positive Daily Attendance: 59 students have attendance information at baseline, 38 at time 1, and 18 at time 2.
- Suspensions: 49 students have information about the number of suspensions they received at baseline, 29 at grading period 1, and 11 at grading period 2.
- Days of Suspension: 52 students have information about the number of days of suspension they received at baseline, 29 at grading period 1, and 11 at grading period 2.

At this point, given the small number of students with data submitted (N=63) and the large amount of missing data, **it is not possible to analyze the impacts of receiving mental health services on educational outcomes**. However, a preliminary examination of the data on hand was conducted using those students who had information at both baseline and at the first grading period, with the exception of the CAT 6 percentile, as this data was missing for over 90% of the youth for whom data was submitted.

Pilot results to date

- **Academic grades:** On average, the students' academic grade percentage was 64% (within the D range) at baseline, and 62% (also within the D range) at grading period 1.

- **Citizenship grades:** At baseline, on average, their citizenship grade percentage was 68% (within the “needs improvement” range) and at grading period 1 was 63% (also within the “needs improvement” range).
- **Positive Daily Attendance:** Positive daily attendance on average was high at baseline (94%) and remained high at grading period 1 (94%).
- **Suspensions:** Their mean number of suspensions at baseline was 0.24, and had increased at grading period 1 to 0.55.
- **Days of Suspension:** The mean number of days spent in suspension at baseline was .45 and at grading period 1 was 1.0.

It is important to note that none of these differences were statistically significant. Also, due to the small sample size and the amount of missing data, the sample cannot be considered representative and the information cannot be used to make inferences about children in San Diego schools who are receiving mental health treatment.

Chapter 7: Consumer Perspectives

The San Diego County Children's Mental Health System of Care is built on the principle of a strong partnership between families/youth, public agencies, private organizations and education, working together and contributing to the overall quality of service for children. The practice of involving multiple stakeholders is 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 & Youth Roundtable of San Diego County. This family- and youth-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 families and youth into policy, programming and practice. Members of the Roundtable are currently participating in county committees and service programs, making tremendous contributions regarding the needs of families. 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.

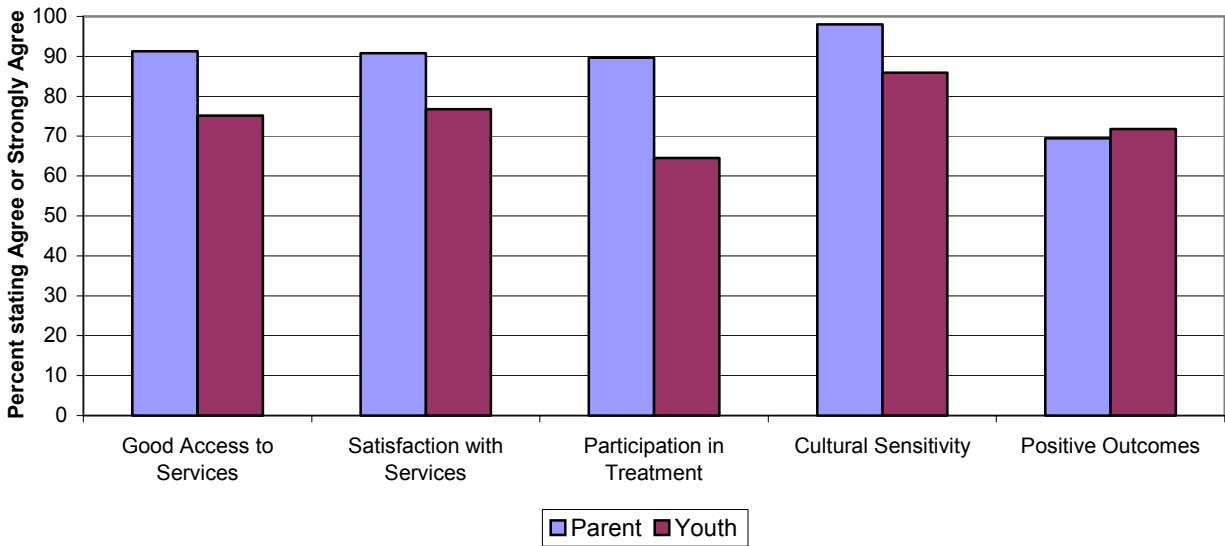
Another way to ensure that services are responsive to consumer needs is to collect information from youth and families about their satisfaction with services and their perspectives on the quality of services. During Fiscal Year 2003-2004, data on consumer satisfaction was collected in two ways. First, the state-mandated **Youth Services Survey (YSS)** was completed by all youth (ages 13+) and all available parents, regardless of the youth/client age, who utilized services between November 1 and 15, 2003. The majority of questions on the YSS focus on satisfaction with the provision of services and satisfaction with the results of services. The second manner in which satisfaction information was collected involved youth receiving intensive case management services, wherein the **Family-Centered Behavior Scale (FCBS)** was completed by the current caregiver during an in-person interview.

Youth Services Survey (YSS)

Data from the parent and youth respondents on the **YSS** is presented in **Figure 7.1**. Questions were grouped into five domains: Good Access to Services, Satisfaction with Services, Participation in Treatment, Cultural Sensitivity, and Positive Outcomes. A total of 2,434 surveys were completed during the November 2003 YSS collection period.

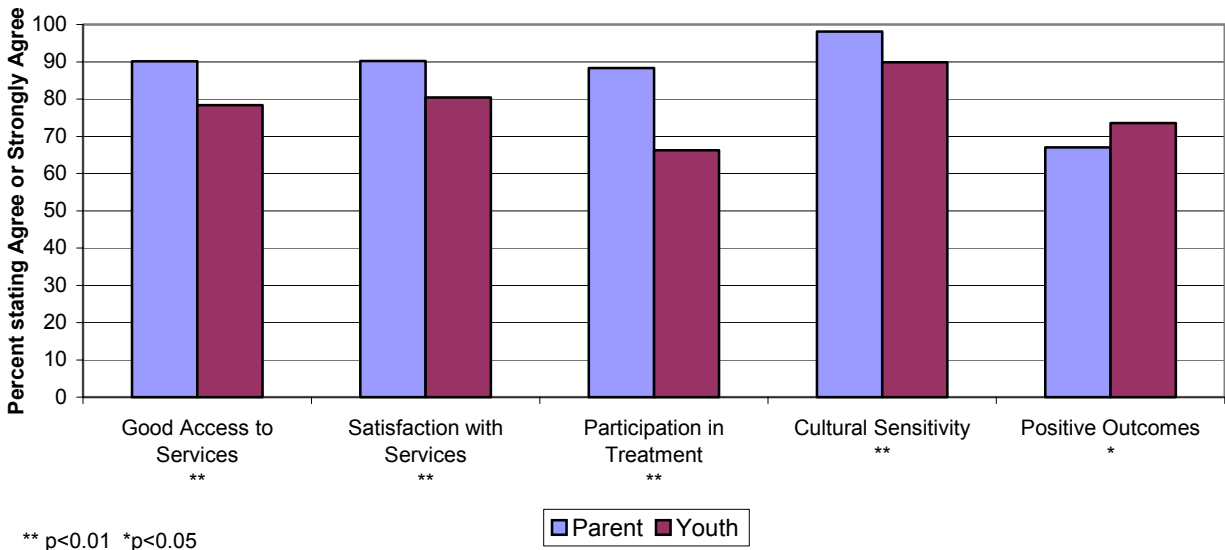
Overall, parent scores were higher than the youth respondents on all domains except Positive Outcomes. For example, 91% of parent respondents marked "Agree" or "Strongly Agree" on questions related to Good Access to Services (such as location and hours of services), as compared to 75% of youth. Differences were most striking on the Participation in Treatment domain: 90% of parents endorsed Agree or Strongly Agree, as compared to 65% of youth. Parent and youth scores were most similar on Positive Outcomes, which is also the only domain in which the youth scores were higher than the parent scores (72% vs. 70% respectively).

Figure 7.1: November 2003 Youth Services Survey – All Youth and Parent Responses



To examine the **amount of agreement** between parents and youth, we examined the responses for all clients in which both the youth and parent surveys were completed (**Figure 7.2**). This gives us information on the same services from the youth and parent point of view. The results here are similar to those seen in the overall sample: the youth and parent responses are different, with the parent scores being higher on all the domains except Positive Outcomes. Analysis showed that parents were significantly more likely than youth to have stated Agree or Strongly Agree on four of the domains examined (Good access to Services, Satisfaction with services, Participation in Treatment, and Cultural Sensitivity), while youth were more likely to have endorsed Agree or Strongly Agree for the Positive Outcomes domain.

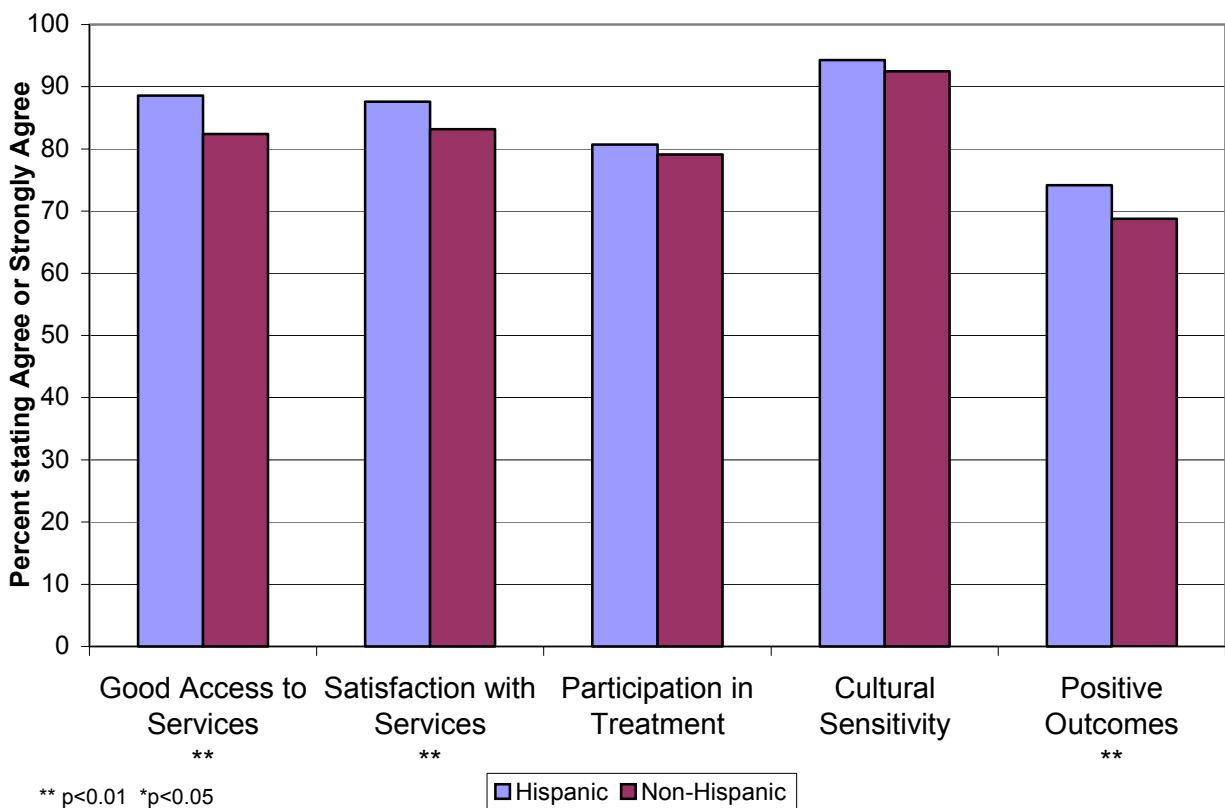
Figure 7.2: November 2003 Youth Services Survey Responses-Youth and Parent Matched Pairs



** p<0.01 *p<0.05

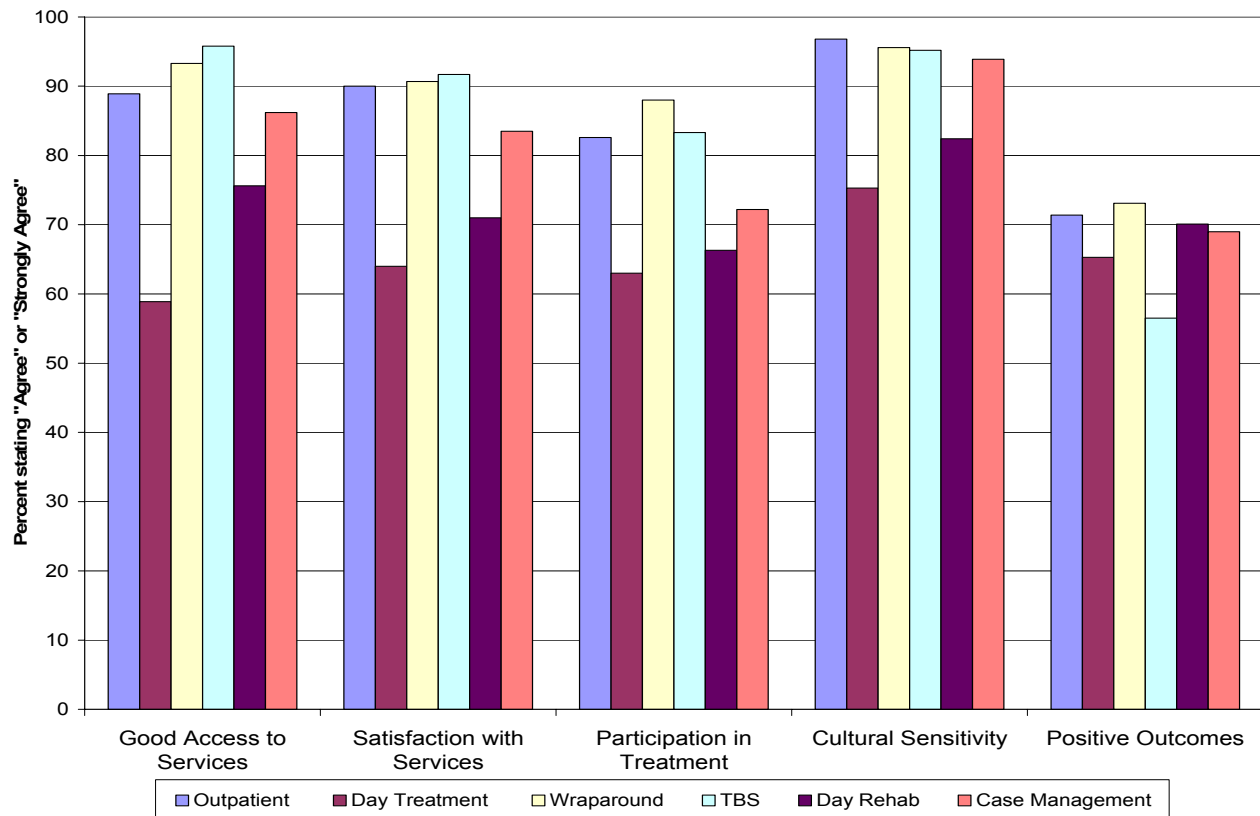
These satisfaction domains were also examined by the **child's ethnicity**. Responses from youth and parents were grouped based on the response to a question regarding whether either of the child's parents are of Mexican/Hispanic/Latino origin. In total, 900 surveys pertained to Hispanic youth and were compared to 1239 surveys for non-Hispanic youth (**Figure 7.3**). Analyses showed that respondents for Hispanic youth were more satisfied with Access to Services, Services in general, and Outcomes, as compared to respondents for non-Hispanic youth. There was no significant difference in satisfaction rates for Participation in Treatment or Cultural Sensitivity.

Figure 7.3: November 2003 Youth Services Survey Responses, Hispanic vs. Non-Hispanic Respondents



Results from the YSS show varying levels of satisfaction by the **service type** received by the youth (**Figure 7.4**). Parents and youth receiving intensive day treatment or day rehabilitation services reported significantly lower levels of satisfaction with access to services, general satisfaction with services, and cultural sensitivity, as compared to the other service groups. Youth and families receiving wraparound services report significantly higher satisfaction with participation in treatment than other modalities. Finally, families and youth receiving Therapeutic Behavioral Services (TBS) have the lowest scores on Positive Outcomes, although their ratings on the other domains are quite high.

Figure 7.4: November 2003 Youth Services Survey Responses by Service Modality

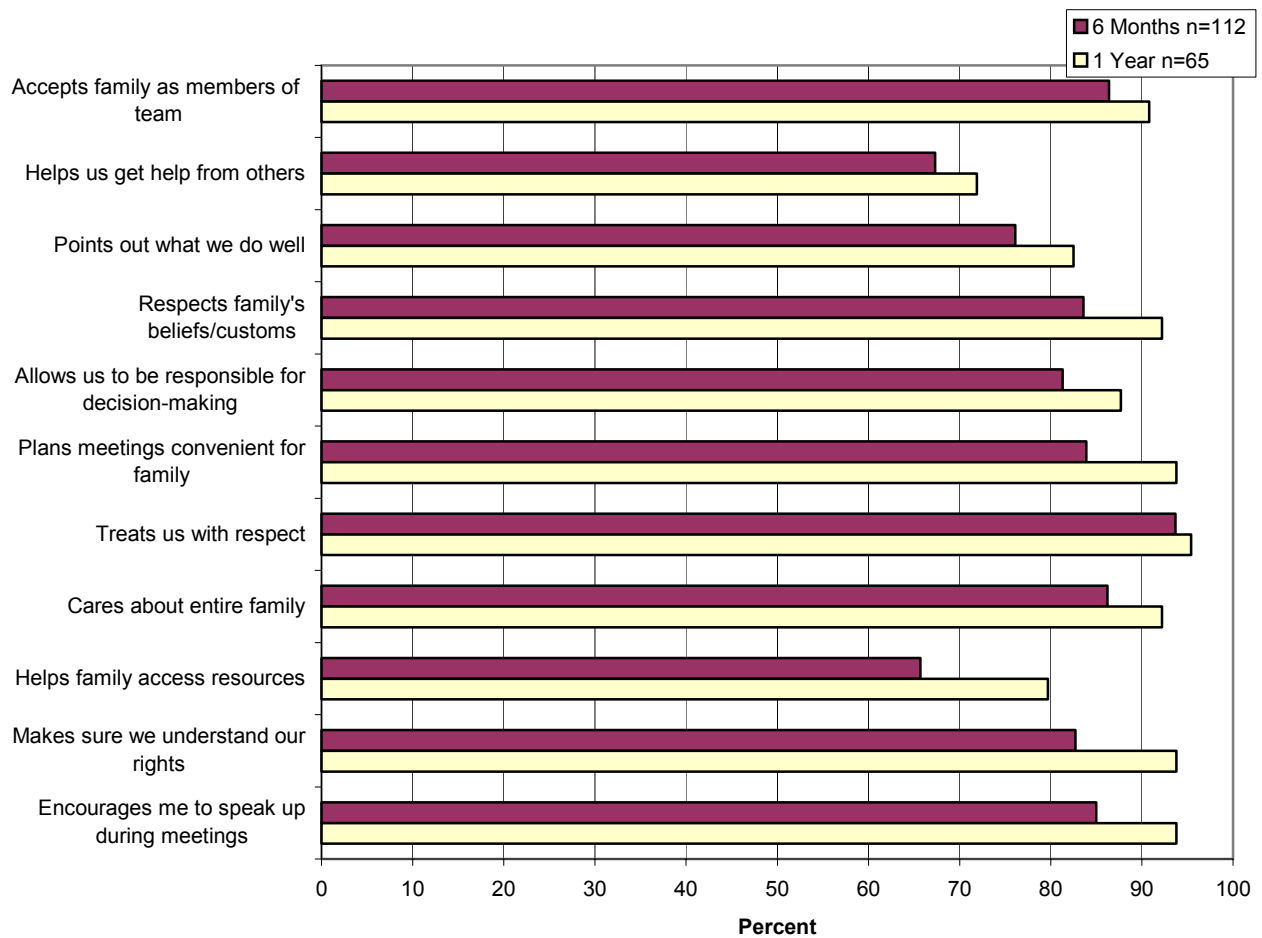


Family-Centered Behavior Scale (FCBS)

One principle of the San Diego County System of Care is that services be family centered, which is defined as the “service delivery, service planning, program, and policy development includ[ing] the full participation of families/care-givers and their children/youth.” To examine the integration of this principle into services, **families receiving intensive case management services completed the Family-Centered Behavior Scale (FCBS)**. In this measure, parents rate staff behavior on a Likert-type scale ranging from 1 (never performs the behavior) to 5 (always performs the behavior). The measure addresses three main elements of family-centered service delivery: 1) recognizing the key role of the family for children receiving mental health services, 2) maximizing the decision-making role of families and 3) using and building upon the strengths of families. Parents or current caregivers completed the FCBS at 6 months and 1 year after the start of services; results are shown in **Figure 7.5**, which displays the percentage of families that indicate that the staff “always” performs the identified behavior.

Overall, the results on the FCBS are very positive. Over 90% of families at both the 6 month and 1 year time points report that staff always treats them with respect. The lowest ratings at both time points are for (1) assisting families to receive help from friends and community and (2) assisting families in accessing resources. On average, the ratings at the 1 year point are higher than those at 6 months. This may indicate that families become more involved in and satisfied with services over time, or that those families with lower levels of satisfaction are no longer receiving services at 1 year.

Figure 7.5: Family-Centered Behavior Scale (FCBS)



Chapter Summary

- Self-report of satisfaction was very high, for both the overall CMHS sample and the Intensive case management / wraparound services sample
- Youth report lower satisfaction overall, but were more likely to report positive outcomes from treatment than were parents.
- Hispanic respondents reported satisfaction levels that were the same as or higher than those reported by non-Hispanic respondents.
- Intensive day treatment and day rehabilitation clients reported lower levels of satisfaction than other treatment modes.

Chapter 8: Provider Perspectives

The San Diego County Children's Mental Health System of Care relies on a strong partnership between families and youth, public agencies, private organizations, and education. As reported in Chapter 7, family and youth reported their perceptions of services provided by the system of care through the use of two different surveys. Service providers were asked to give feedback through two different routes. First, attendees of the San Diego County Children's System of Care (CSOC) Conference were asked to complete surveys describing themselves and what they learned from the conference. Second, through a federally funded research project, clinicians' perspectives on their organizations, the majority of which are county-contracted organizational providers, were obtained.

Children's System of Care Conference

On May 3, 2004, the third annual San Diego County Children's System of Care Conference was held. The conference was hosted by the CSOC Wraparound Training Academy and the Child & Adolescent Services Research Center (CASRC) and focused on evidence-based practices. To assess how well the conference met the needs of the participants, CASRC administered several questionnaires to those who attended, including a demographic information form, a conference evaluation form, and both a pre- and post-conference Evidence Based Practice Attitude Scale (EBPAS). Of the 200 participants who attended the conference, 63% completed the Demographics Information Form, 46% completed the Conference Evaluation Form, 58% completed the pre-conference EBPAS, 43% completed the post-conference EBPAS; 38% of attendees completed all four forms.

Of the participants that completed the Demographic Information Form, approximately three quarters were female. Their ages ranged from 21 to 72, with an average age of 42. Although the majority of participants were Caucasian (68%), participants from other racial/ethnic groups included Hispanic (16%), African American (8%), Asian or Pacific Islander (2%), Filipino (2%), Native American (.8%), participants of mixed ethnicity (2%), and participants of other races/ethnicities not captured in the previous categories (2%). The vast majority of participants had completed at least a Bachelor's Degree (97%), with 56% having obtained a Master's Degree and 11% having obtained a Doctorate Degree.

Conference participants came from many service sectors, although over half of the participants were from the Mental Health sector. Other represented sectors included Child Welfare (18%), Juvenile Justice (17%), Special Education (2%), Alcohol and Drug Services (2%), and other primary service sectors not captured in the previous categories (8%). Within these service sectors, participants also represented a wide variety of primary disciplines. The primary disciplines were Social Work (34%), Marriage and Family Therapy (23%), Probation (23%), and Psychology (14%).

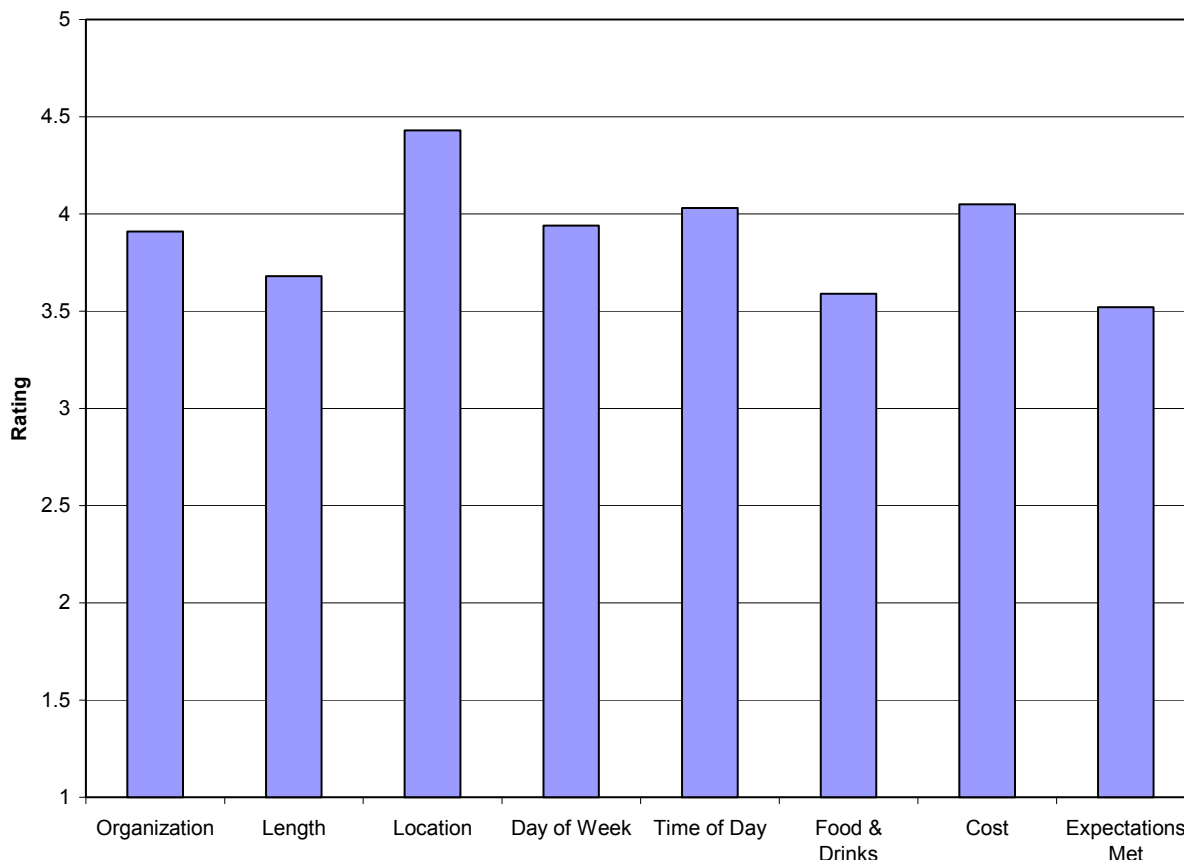
Attendees represented all levels of their organizations, including direct service providers (54%), management/supervision (38%) and administration (22%). Participants reported having spent an average of 14 years working with youths and families, and spending an average of 38 hours a week within the child service sector. Also, participants who completed the demographic information sheet reported an average monthly caseload of 16 clients and reported an average of 15 contacts with each client every month.

Conference Evaluation

To gauge whether or not the organizational characteristics of the conference met the expectations of the participants, all participants were given the Conference Evaluation Form. The form provided respondents the opportunity to rate aspects of the conference on a scale

from 1 (poor) to 5 (outstanding). **Figure 8.1** represents the average scores reported for each of the various conference characteristics. In general, participants indicated an average response of “good” (3.9). Specifically, participants reported on average that the cost, the time of day, and the location were each “good” (4.0, 4.0, and 4.4 respectively). Participants also on average rated the overall organization of the conference and the day of the week when the conference was held as approximately “good” (both given 3.9). When rating the length of the conference and whether or not the conference met participant expectations however, on average respondents rated each within the “somewhat” range (3.7 and 3.5 respectively).

Figure 8.1 Attendees’ Evaluation of the 2004 Children’s System of Care Conference



The conference was composed of 21 different session presentations relating to various aspects of Evidence-Based Practices. The Conference Evaluation Form also allowed participants to rate specific aspects of each session’s presentation. On average, participants rated the content of the session presentations, the handouts given at the presentations, and the presentation speakers as “good” (4.2, 4.0, and 4.4 respectively).

Attitudes toward Evidence-Based Practices

As the focus of the conference was educating attendees about evidence based practices, participants were given the Evidence-Based Practice Attitude Scale (EBPAS), a measure developed by Dr. Gregory Aarons, at the start and end of the conference to see whether or not their attitudes toward evidence-based practices (EBPs) had changed as a result of the conference. The EBPAS assesses four dimensions of attitudes toward adoption of EBPs

including 1) Likelihood of adopting EBP given **Requirements** to do so, 2) Willingness to adopt EBPs giving their Intuitive **Appeal**, 3) **Openness** to new practices, and 4) perceived **Divergence** of usual practice with research-based/academically developed interventions; scores range from 0 (not at all) to 4 (to a great extent).

Figure 8.2 Conference Attendees' Attitudes toward Evidence-Based Practices

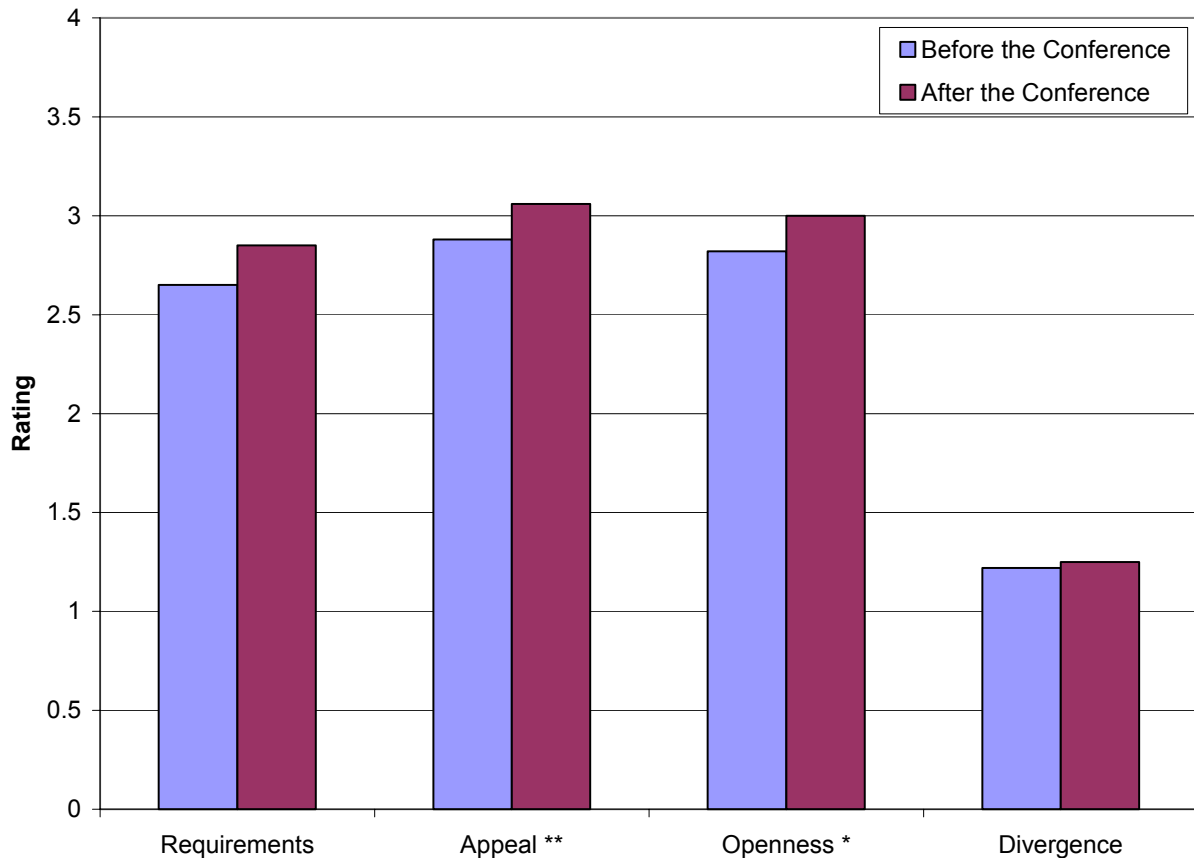


Figure 8.2 displays the average pre- and post-conference scores on the four dimensions of the EBPAAS. Two of the four dimensions showed significant changes between the pre and post scores. The Intuitive Appeal dimension rating was significantly higher ($p < .01$) after the conference, moving from an average of 2.9 to 3.1. This construct represents whether a participant is likely to adopt an Evidence-Based Practice if it makes sense, if it is intuitively appealing, if colleagues are happy with it, or if the participant has enough training. Participants also showed a statistically significant improvement ($p < .05$) on the Openness dimension, moving from 2.8 before the conference to 3.0 afterwards. This construct refers to the participant's likelihood of trying a new therapy, trying a therapeutic technique that is different than usual, using manual based treatment, or trying therapy developed by a researcher. For two remaining dimensions, Requirements and Divergence, there was no statistically significant difference between the average participant responses before and after the conference.

Leadership Ratings

Using funding from the National Institute of Mental Health, Dr. Gregory Aarons, a researcher with the Child and Adolescent Services Research Center, conducted a study of

children’s mental health providers in San Diego County. An on-site survey was conducted with public sector programs providing mental health services to children and adolescents and their families. Ninety-four percent of the organizations contacted about the study agreed to participate. Survey participants were 324 clinical and case management service providers and 52 program managers.

Eighty percent of respondents were full-time employees and primary disciplines included marriage and family therapy (33.9%), social work (32.3%), psychology (22.4%), psychiatry (1.6%), and “other” (9.9%; e.g., criminology, drug rehabilitation, education, public health). Interns made up less than one-quarter of the sample and represented disciplines of marriage and family therapy (46.8%), social work (24.7%), psychology (20.8%), psychiatry (1.3%), and “other” (6.5%). Participating programs were publicly funded child/adolescent mental health programs providing outpatient treatment (52.9%), day treatment (23.5%), case management (11.8%), wraparound services (7.8%), and inpatient treatment (3.9%). Most programs contracted with the County to provide children’s mental health services (83.7%), while others operate under the County administration structure (16.3%). There were large differences between the programs in terms of the number of unduplicated clients served per year (mean = 257.6; standard deviation = 452.8) and the number of clinical and/or case management service staff employed (mean = 6.6; range = 1–31).

During the survey, both front-line staff and program managers completed the Multifactor Leadership Questionnaire (MLQ) to assess the 12 dimensions of leadership listed in **Table 8.1**. Clinicians and case managers were asked to rate their program managers’ performance, while program manager were asked to rate themselves.

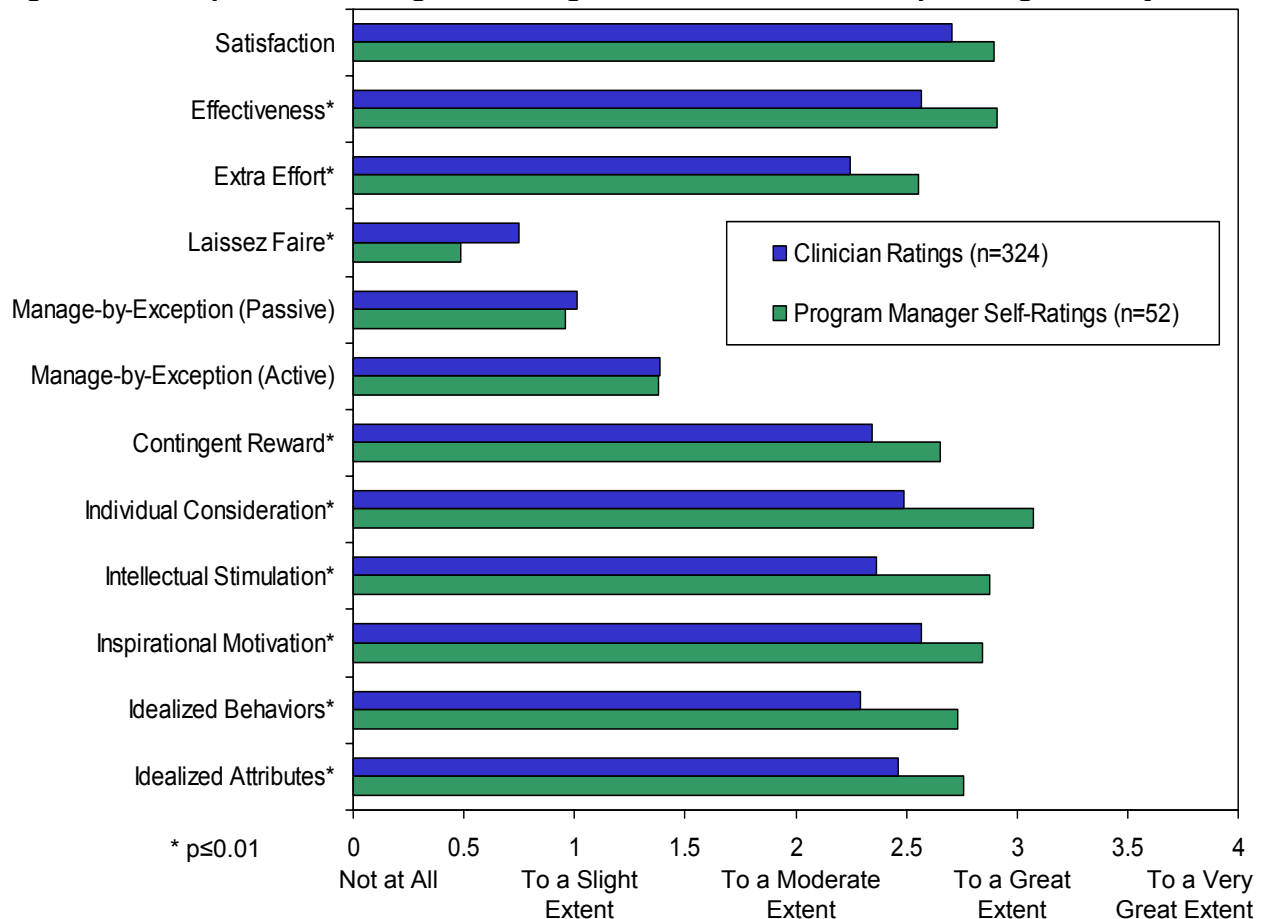
Table 8.1 – Leadership Dimensions in the Multifactor Leadership Questionnaire

- **Satisfaction** - The extent to which the respondent is satisfied with the program manager’s working style and leadership methods.
- **Effectiveness** - The extent to which the program manager operates in effective manner.
- **Extra Effort** - The extent to which the program manager inspires the staff to put forth extra effort
- **Laissez Faire Leadership** - The extent to which the program manager avoids decision-making and delays responding to urgent matters.
- **Management by Exception (Passive)** - The extent to which the program manager avoids action until problems become serious.
- **Management by Exception (Active)** - The extent to which the program manager focuses on and keeps track of mistakes.
- **Contingent Reward** - The extent to which the program manager acknowledges and rewards staff’s efforts.
- **Individual Consideration** - The extent to which the program manager appreciates each staff member’s individual contributions and needs.
- **Intellectual Stimulation** - The extent to which the program manager recognizes and accepts different perspectives.
- **Inspirational Motivation** - The extent to which the program manager exudes enthusiasm and positive attitudes.
- **Idealized Influence (Attributed)** - The extent to which the program manager acts confidently and in ways that instill pride and respect in the respondent.
- **Idealized Influence (Behavior)** - The extent to which the program manager considers values, beliefs, the importance of a strong sense of purpose and a collective sense of mission, and the moral and ethical consequences of decisions.

The responses of the clinician/case manager and program manager groups were compared and the results of the survey are shown in **Figure 8.3**. In each dimension, **program managers rated themselves more positively** than did the clinicians / case managers who worked for them; these differences were significant ($p \leq 0.01$) for 9 of the 12 dimensions at the countywide level. The largest discrepancies were found in the Individual Consideration (3.1 manager vs. 2.5 clinician) and the Intellectual Stimulation (2.9 manager vs. 2.4 clinician) dimensions.

Program-level reports were given to the individual programs as a feedback tool, as studies involving the MLQ have found that leadership ratings are related to organizational effectiveness. Specifically, there is a relationship between the differences in staff and program manager ratings and the level of performance problems experienced at the organization, including staff turnover and commitment to the organization. In other words, when managers and the staff they supervise have very different perceptions of the manager's leadership skills, the organization is more likely to experience increased performance problems and decreased staff retention.

Figure 8.3 Comparison of Program Manager & Clinician Leadership Ratings Countywide



Chapter Summary

- Attendees at the Children’s System of Care Conference come from a wide range of racial/ethnic groups, educational backgrounds, agencies, and service sectors.
- While overall ratings of the CSOC conference fell in the “good” range, the lowest rating (3.5 out of 5) was for the whether the conference met the participant’s expectations.
- After the conference, attendees were more open to trying new practices and more willing to try an evidence-based practice if it was intuitively appealing.
- Surveys of publicly funded children’s mental health provider organizations found that program managers were likely to rate their own leadership skills at a higher level than the clinicians and case managers working for them.

Chapter 9: 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. It evolves over time through the trust and collaboration of its stakeholders: public sector agencies (Children's Mental Health, Child Welfare, Juvenile Justice, Alcohol and Drug Services), private providers and agencies, Education, as well as families and youth served. 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. In 1999, the Children's System of Care Steering Committee was chartered by the County of San Diego Health and Human Services Agency to provide consumer and stakeholder input, direction, guidance and advisement as the County developed their Children's Mental Health System of Care. The multi-sector Steering Committee (renamed the Children's System of Care Council in 2005) meets on a monthly basis to advise the CMHS Director and provide community oversight for the System of Care.

The System of Care principles have been embedded into the system and continue to drive 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 strive towards within each sector across the system. **The SOC Outcome Goals are as follows:**

7. Children are **living at home** or in home-like settings
8. Children are **staying out of trouble**
9. Children are **successful in school**
10. Children are **safe**
11. Children are **physically and emotionally healthy**
12. Clients are **satisfied**

This chapter presents data according to the SOC Outcome Goals. Each section presents data collected for the overall CMHS population and the intensive case management

sample that relate to the SOC goals. 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 goals.

1. LIVING AT HOME OR IN HOME-LIKE SETTINGS

General Sample:

- 3% of youth in Mental Health Services used **Inpatient Services** ↓ **Decrease**
(4% in FY02-03)
- 4% of youth in Mental Health Services used **Residential Services** ↓ **Decrease**
(7% in FY02-03)
- 27% of youth in MH Services used Juvenile **Forensic Services** ↓ **Decrease**
(30% in FY02-03)

Intensive Case Management Sample:

Data collection for Intensive Case management youth changed between FY02-03 and FY03-04; comparable data points are not available.

- 10% of youth receiving Intensive Case Management services used **Inpatient Services**

Research in San Diego:

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.

- Examined sample of youth in the Child Welfare System in San Diego County
- 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.


James, S., Landsverk, J., Slymen, D. J., & Leslie, L. K. Predictors of Outpatient Mental Health Service Use - The Role of Foster Care Placement Change. (2004). Mental Health Services Research, 2004 Sep;6(3):127-41.

- Examined sample of youth in the Child Welfare System in San Diego County
- Results 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: Research shows that living in restrictive settings, especially when the placement is not stable, can directly impact a youth's behavior and functioning. San Diego County's efforts to keep youth out of restrictive settings should be continued. In addition, disruptive behaviors among youth in restrictive settings should be treated through special training of foster care providers and additional mental health interventions to reduce placement changes and movement to higher levels of care.

2. STAYING OUT OF TROUBLE

General Sample:

- 6% of youth, ages 13+, in Mental Health Services report that they were **arrested** in the past month
- 2% of parents report that their youth in Mental Health Services was **arrested** in the past month.
- 17% of youth in MH Services are also in **Juvenile Justice** (20% in FY 02-03)  **Decrease**

Intensive Case Management Sample:

No arrest data was collected during FY03-04

Research in San Diego:


Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P. A. (2004). Use of Mental Health Services by Youths in Public Sectors of Care. Mental Health Services Research, 6(4), 213-226.

- Examined sample of youth involved in public sectors of care in San Diego County
- 52% of JJ youth had at least one psychiatric disorder, with most meeting criteria for ADHD or disruptive disorders.
- Youth in Juvenile Justice had the lowest rates of use of most services, and involvement in JJ was associated with a decreased likelihood of using mental health services.
- 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: Youth who become involved in the Juvenile Justice system have high rates of psychological problems, including disruptive behavior disorders. Clinicians and Probation officers should be sensitive to the high rates of need among youth, both male and female, in Juvenile Justice settings and make appropriate referrals to mental health services.

3. SUCCESSFUL IN SCHOOL

General Sample:

- 35% of youth in Mental Health Services are also receiving **Special Education Services** in their community school district (36% in FY 02-03)  **Decrease**
- 52% of youth had been absent from school **one day or less** in the previous month, as reported on the YSS.

Intensive Case Management Sample:

- 37% had **perfect attendance** (no unexcused absences) while receiving services
- WRAT3** (standardized achievement test) results after receiving services for **6 months**:
- 60% of youth improved on the **reading** domain
 - 43% of youth improved on the **spelling** domain
 - 45% of youth improved on the **math** domain
- WRAT3** (standardized achievement test) results after receiving services for **1 year**:
- 48% of youth improved on the **reading** domain
 - 52% of youth improved on the **spelling** domain
 - 44% of youth improved on the **math** domain

Research in San Diego:

Hazen, A.L., Hough, R.L., Landsverk, J.A., & Wood, P. A. (2004). Use of Mental Health Services by Youths in Public Sectors of Care. Mental Health Services Research, 6(4), 213-226.

- In the representative sample of youth who were involved in publicly-funded sectors of care, overall, 71% had used a school-based mental health service.
- Youth enumerated from the formal mental health sector and from special education ED 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.

Clinical Implications: Mental health problems can impact school achievement, school attendance, and overall school success. Mental Health providers should be encouraged to monitor a youth's school performance and work with the youth's teachers and school to ensure that problems are addressed adequately. At a system level, Education and Mental Health should continue to explore possible methods of obtaining and sharing data across these two important domains.

4. SAFE

General Sample:

- 3% of youth in Mental Health Services received an **inpatient service** ↓ **Decrease**
(4% in FY02-03)
- 27% of youth in MH Services received a **Juvenile Forensic service** ↓ **Decrease**
(30% in FY02-03)
- 25% of youth in Mental Health Services are also in **Child Welfare** ↑ **Increase**
(24% in FY02-03)
- 2% of youth in Mental Health Services have a **dual diagnosis**
- 5% of youth in Mental Health Services are also **active to Alcohol and Drug Services**

Intensive Case Management Sample:

- 10% of youth in Intensive Case Management services used **Inpatient Services**
- 3% of youth in Intensive Case Management services have a **dual diagnosis**

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.

5. PHYSICALLY AND EMOTIONALLY HEALTHY

General Sample:

- 23.9% of youth, ages 13 and older, reported that they had an “ongoing medical condition or chronic illness”
- 38.7% of parents, regardless of child’s age, reported that their child had “ongoing medical condition or chronic illness”

Intensive Case Management Sample:

- 34.5% of youth, ages 13 and older, reported that they had an “ongoing medical condition or chronic illness”
- 47.9% of parents, regardless of child’s age, reported that their child had “ongoing medical condition or chronic illness”

Clinical Implications: Many youth in San Diego County have mental and physical health needs, regardless of the public sector that they are involved in. Additional efforts need to be made to screen, assess, and refer children for needed mental, physical, and developmental services across all public sectors.

6. SATISFIED

General Sample:

- **91% of parents** stated “agree” or “strongly agree” regarding overall satisfaction with services, as compared to **77% of youth**, on the November 2003 YSS

Intensive Case Management Sample:

- Scores on the **Family-Centered Behavior Scale (FCBS)** were very high:
 - An **average of over 80%** of parents responded “**Always**” to the FCBS questions
 - **94% of parents** stated that staff always treats them with **respect**.

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.
- These findings question the use of consumer satisfaction as an indicator of effectiveness in reducing symptoms or improving functioning among youth.

Clinical Implications: Satisfaction with services remain 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 may not be associated with symptom or functioning improvements.

Chapter 10: Future Directions

This report focuses on children who received services in Fiscal Year 2003-2004. Since that time, significant changes have occurred, and are planned to occur, in the Children's Mental Health Services system. These changes, described below, will impact CMHS service delivery in the coming years and affect the amount and type of data presented in this report.

1) The State of California's Performance Outcome System was significantly revised in accordance with fiscal cutbacks and shifts in outcome directives. Under the revised system, the state-mandated **Youth Services Survey (YSS)** will be administered on a cross-sectional basis twice a year to all youth and families receiving services during the two-week survey period. The YSS program began in November 2003.

2) The new Children's Initiative wraparound program began in the fall of 2004 with the consolidation of intensive case management services into one service provider, **Families Forward**. Outcome measurements being collected include school attendance and arrest records, in addition to measures of mental health outcomes and satisfaction.

3) 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 was initiated for organizational providers in January 2005. The CAMS assesses a child/youth's emotional and behavioral symptoms, functioning and strengths, while 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. Each provider organization is data entering and scoring these measures at their own site, to allow for immediate use of the results in clinical care. Data is collected from all providers quarterly so that system-wide reports can be generated.

4) With the passage by the voters of California of the **Mental Health Services Act**, the County of San Diego Children's Mental Health Services is poised to implement a significant system expansion. The Act established a 1% additional tax on the income of individuals that make a million dollars or more a year effective January 1, 2005. This will correspond to an additional 7 to 10 million dollars for the San Diego County Children's Mental Health system of care.

The local system of care has had a **significant expansion** in the past years. As an example, in FY 1997-1998, the total budget was \$24 million dollars and in FY 2005-2006 the budget is \$84 million dollars. This growth, which benefited primarily Medi-Cal eligible children and youth, allowed for the dramatic expansion of school based services, case management, wraparound and other community services. The proposed expansion through Mental Health Services Act dollars will **primarily benefit those poor children who do not qualify for Medi-Cal**. The expansion will occur, taking into consideration the input of stakeholders through numerous venues, as well as an in-depth gap analysis, and ultimately implement programs to meet the needs of San Diego's children.

In 2005-2006, other major initiatives are in process, including the implementation of **Behavioral Health services** which will align and coordinate mental health, alcohol and drug services funded by the County. Additionally, the County will be purchasing a new mental health **Management Information System** to replace its aging system.