Child and Adolescent Services Research Center

County of San Diego
Health & Human Services Agency

Children's Mental Health Services

Seventh Annual System of Care Report

Fiscal Year 2004-2005

Children's Mental Health Services

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Child and Adolescent Services Research Center (CASRC)

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

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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.

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Executive Summary

The County of San Diego received funding under the State System of Care program (AB3015) in 1996. The purpose of this funding was to develop and implement a children's mental health "system of care" that emphasizes establishing goals, building interagency coalitions and designing services that focus on quality, continuity and client-centeredness for a defined target population. The county also received additional funding for more intensive services from a federal Substance Abuse Mental Health Services Administration (SAMHSA)/CMHS grant and from the state SB163 program for youth at risk for placement in restrictive settings. These programs emphasize establishing goals representative of both system of care and wraparound initiatives, including principles of involving parents in all aspects of service delivery and providing culturally competent and community based integrated care. In addition, requirements are set forth to monitor the system for client benefit and public cost savings. Despite budget changes 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

* 17,286 youth (unduplicated client count) used mental health services in FY04-05, representing a 2% decrease from the previous year but an 16% increase from FY00-01. (Chapter 2)

* The majority of youth served in CMHS are males (60%) and over half are 13-17 years old (54%). (Chapter 2)

* The youth served are from diverse backgrounds, with Hispanics and then Whites as the largest race/ethnic groups (46% H & 31% W) in CMHS. (Chapter 2)

* 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, 33% are involved in Special Education (including all classifications), 25% in Child Welfare, 14% in Juvenile Justice and 3% in Alcohol/Drug. (Chapter 2)

* 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. (Chapter 3)

* Preliminary outcomes data shows that clients are making significant improvements in the first 6 months of services, by both parent and youth report. (Chapter 4)

* Parents generally report high satisfaction with services. (Chapter 10)

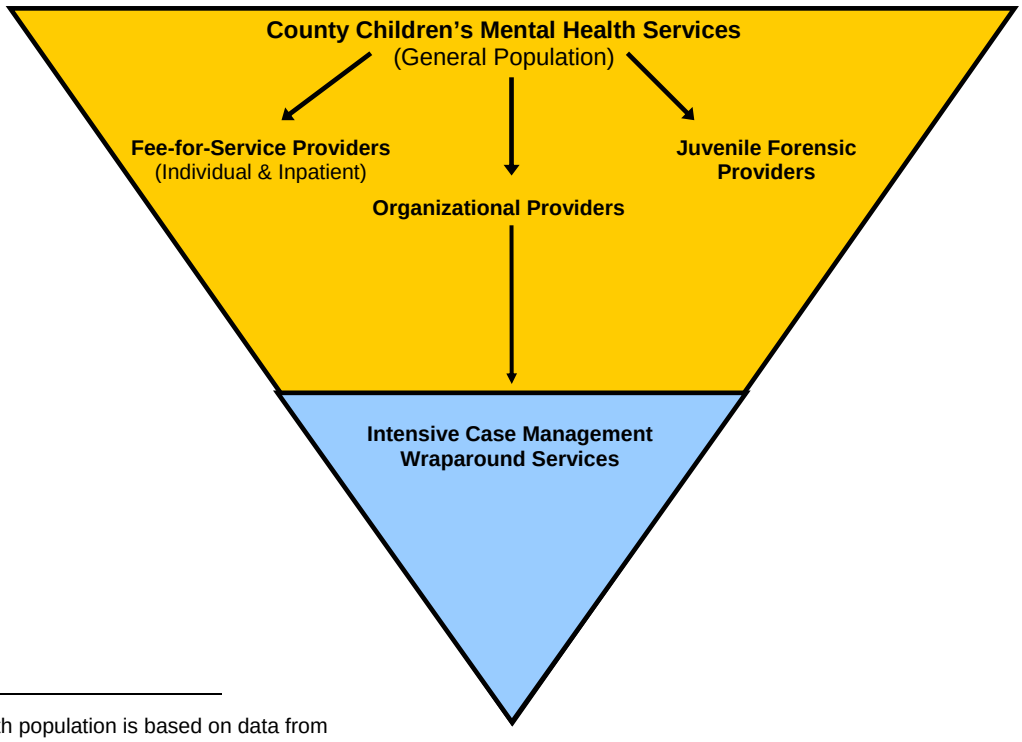
Note: For the purpose of this report, youth refers to children and adolescents of all ages.

Chapter 1: Introduction

This report provides information on San Diego County Children's Mental Health Services (CMHS) clients and families served in Fiscal Year 2004-2005 (July 2004 – June 2005). CMHS primarily serves children and adolescents ranging in age from 0-17 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 768,537[1] in 2005 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 provider systems: 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 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 clients in San Diego County.

Organizational providers are community-based agencies and county-operated sites that are either part of the Health & Human Services Agency (HHSA) or have contracts with HHSA to provide mental health treatment services to specified target populations (**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). Youth served through these organizational providers are monitored by the county's Quality Improvement (QI) unit. The QI unit monitors the multiple providers and clinical services provided to youth.



[1] San Diego youth population is based on data from SANDAG, Current Estimates, Fall 2005

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.

In FY04-05, changes were made to wraparound services in San Diego County and the TOWER, BEST, and CITY programs ended. In addition, the CYFN program closed and the County's wraparound services moved to a new contractor, **Families Forward**.

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 the POP satisfaction measures 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 period took place in November 2003,

while a subsequent collection period, 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 are detailed in this report.

Report Contents

Fiscal Year 2004-2005 includes the first 6 months of the CAMS / FCBS data collection, and, 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) – few children have 2 datapoints to examine. The report presents the available data 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 Services Population** provides information about the children and adolescents served by the CMHS from 2001 to 2005. The data addresses basic questions, such as "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 services. This data is presented for FY2004-2005.

Chapter 4: **Client Outcomes on the Child & Adolescent Measurement System (CAMS)** reports on outcomes results.

Chapter 5: **Wraparound / Intensive Case Management Services** provides a description of the amount and type of services used by children and adolescents receiving wraparound services during FY04-05.

Chapter 6: **Service Utilization by Children with Open Child Welfare Cases** provides a description of the amount and type of services used by children and adolescents who were open to Child Welfare Services during FY04-05.

Chapter 7: **Service Use by Youth Receiving Special Education Services** provides a description of the amount and type of services used by children and adolescents who were open to Special Education Services during FY04-05.

Chapter 8: **Service Use by Youth Receiving Probation Services** provides a description of the amount and type of services used by children and adolescents who were open to Probation Services during FY04-05. Arrest data is also reported.

Chapter 9: **Services for Youth with Substance Use Problems** provides a description of the amount and type of services used by children and adolescents who were open to Alcohol and Drug Services during FY04-05, or had a dual diagnosis during the year. In addition, data on past-month substance use is reported.

Chapter 10: **Child, Youth, and Family Satisfaction** reports the results of the Youth Services Survey and the Family-Centered Behavior Scale.

Chapter 11: **System of Care Outcome Goals** reports data relevant to the SOC goals about youth served by CMHS.

Chapter 12: **Directions** discusses new developments for the county's Children's Mental Health Services.

Participating Providers

Contracted Providers

Table 1.1 lists the mental health programs that had contracts with CMHS during FY04-05. These programs comprise the Organizational Providers service mechanism.

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. Over 85% of the contracted organizational providers offer services in Spanish. There are also a number of contractors that offer services in additional languages: 31% offer services in Asian/Pacific Islander languages (i.e. Tagalog, Vietnamese, Korean); 30% offer services in European languages (i.e. German, French, Russian); 10% offer services in American Sign Language; and 6% offer services in Middle Eastern languages (i.e. Farsi, Arabic).

Fee-For-Service Providers

There were an average of 179 Fee-for-Service (FFS) providers, including psychiatrists, psychologists, social workers and marriage and family therapists, contracted as child and adolescent only providers. Another 409 were contracted to treat adults, children and adolescents, yielding a total of 588 providers available to treat children and adolescents in San Diego County. Of these FFS providers, on average, 56% were closed to new referrals and only providing services to existing clients.

Almost half (49%) of the Fee-for-Service child and adolescent psychiatrists provide services in the North Central region, 24 treating children and 32 treating adolescents. The other regions have fewer psychiatrists: Central (7%), 1 child and 7 adolescents; East (17%), 6 child and 14 adolescents; South (10%), 5 child and 6 adolescents; North Coastal (5%), 1 child and 5 adolescents; and North Inland (12%), 6 child and 8 adolescents. The regional breakdown for psychologists, social workers and marriage and family therapists shows similar patterns to the distribution of psychiatrists, with the largest number concentrated in the North Central region. Overall figures are as follows: 32% in North Central, 19% in Central, 17% in East, 7% in South, 13% in North Coastal and 13% in North Inland. However, these numbers are not specific to therapists treating child and adolescent populations, but include data on therapists who treat adults and older adults as well.

The Fee-for-Service providers also provide services in multiple languages. About 57% provide services in Spanish. The percentages offering services in other languages are the following: 6% Asian/Pacific Islander languages, 13% Middle Eastern languages and 3% Sign Language.

Regional Divisions

San Diego County is divided into six regions, which are shown on the maps throughout this report.

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).

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
BEST	Intensive Case Management / Wraparound	Mental Health, Child Welfare, Probation
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
CAT - Hickory - MHS	Outpatient Clinic	Probation
Children Youth and Families Network (CYFN)	Intensive Case Management / Wraparound	Mental Health, Child Welfare, Probation
Children's Outpatient Psychiatry	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
Discovery Valley/Phase II	Day Treatment Intensive	Mental Health – 2726
Douglas Young Clinic	Outpatient Clinic	Mental Health
East County Child Day Treatment	Day Treatment Intensive	Mental Health – 2726
Emergency Screening Unit	24-hour Emergency Services	Mental Health
Families Forward	Intensive Case Management / Wraparound	Mental Health, Child Welfare, Probation
Family Health Centers-Central	Outpatient Clinic-EPSDT	Mental Health
Family Health Centers-East	Outpatient Clinic-EPSDT	Mental Health
Fred Finch Youth Center-San Diego	Day Treatment	Mental Health
Frontier Adolescent Day Treatment Center	Day Treatment Intensive	Mental Health – 2726
Green Oak Ranch	Outpatient Clinic	Child Welfare
Hillcrest House	Outpatient Site-based	Child Welfare
Life School Adolescent Day Treatment	Day Treatment Intensive	Mental Health – 2726
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 – 2726
San Diego Youth and Community Services	Outpatient Clinic	Probation
STEPS Day Treatment	Day Treatment Intensive Specialized	Mental Health
STEPS Outpatient	Outpatient Specialized	Mental Health
STEPS at Polinsky	Outpatient Specialized for Dependents	Mental Health
STEPS Viewridge	Day Treatment Intensive Specialized	Mental Health
Special Education Services Central & South Region	Case Management	Mental Health – 2726
Special Education Services North Coastal & Poway Region	Case Management	Mental Health – 2726
Special Education Services North & East Region	Case Management	Mental Health – 2726
San Pasqual Academy	Day Rehab in Residential Facility	Child Welfare
San Ysidro Middle School	Outpatient School-based	Mental Health – School
Social Advocates for Youth (SAY) CATS 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 – 2726
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

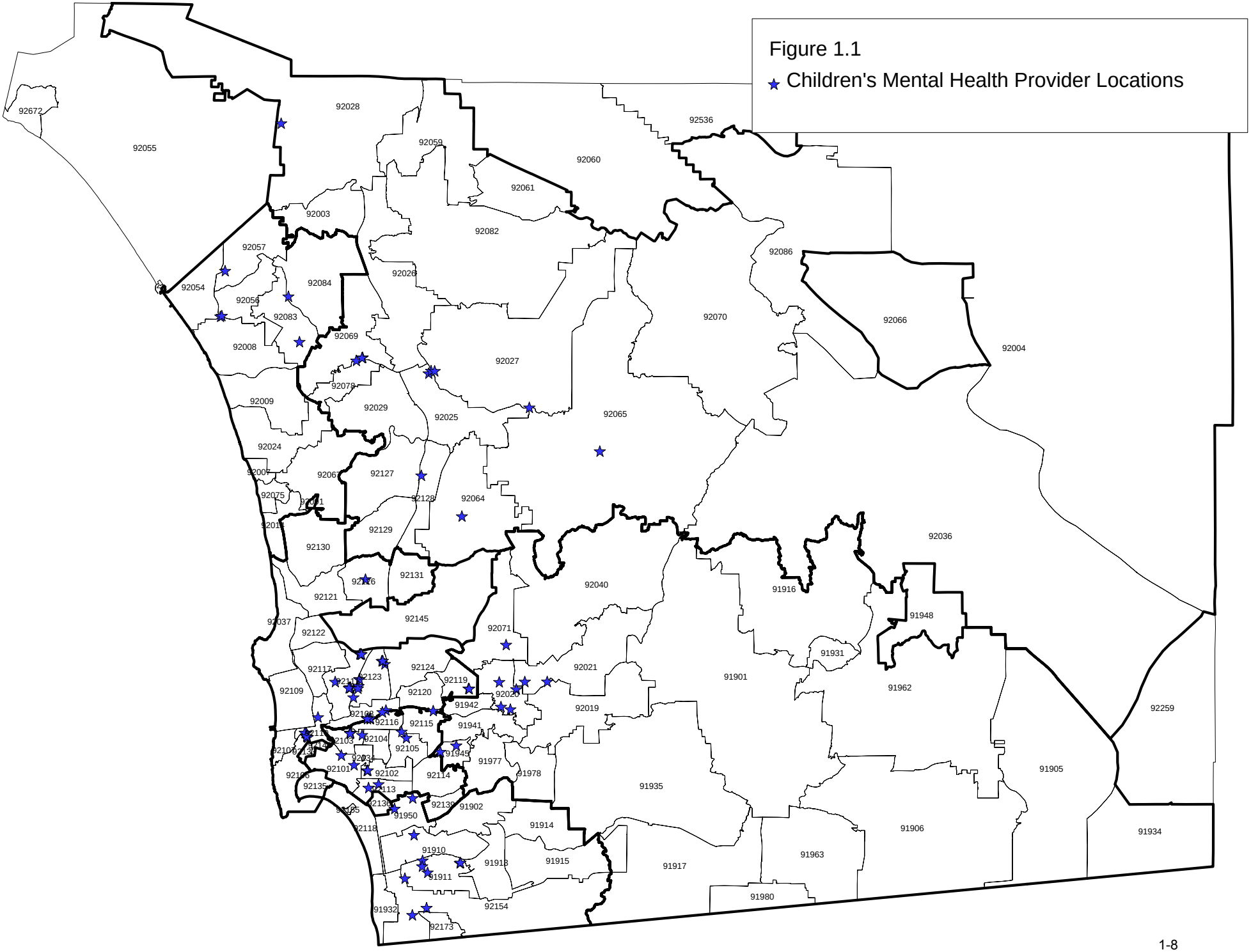


Figure 1.1
Children's Mental Health Provider Locations
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Chapter 2: Description of the Children's Mental Health Services Population

Youth served through Children's Mental Health Services (CMHS) can receive services through three primary mechanisms, Fee-for-Service (FFS) Providers, Organizational Providers, and Juvenile Forensic Services, which were described in more detail in Chapter 1. This chapter presents a description of the youth receiving CMHS services in FY 04-05, compared to data from the past several years and the County's youth population as a whole.

In Fiscal Year 2004-2005, CMHS served 17,286 unduplicated clients across all three provider mechanisms. In recent years, the unduplicated client count has remained between 16 to 18 thousand youth served each year (**Figure 2.1**).

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

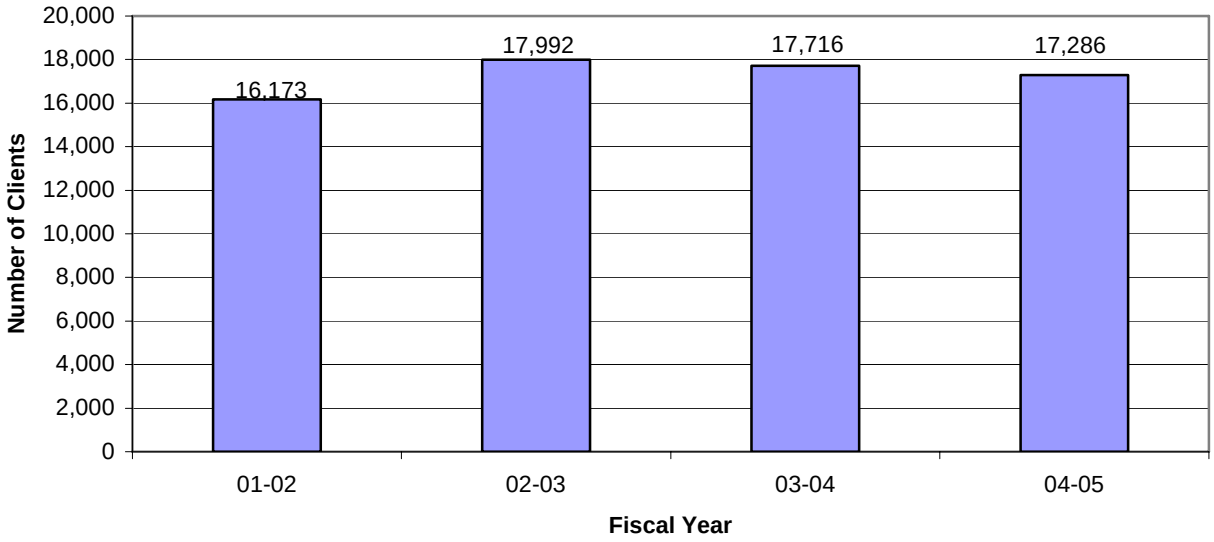
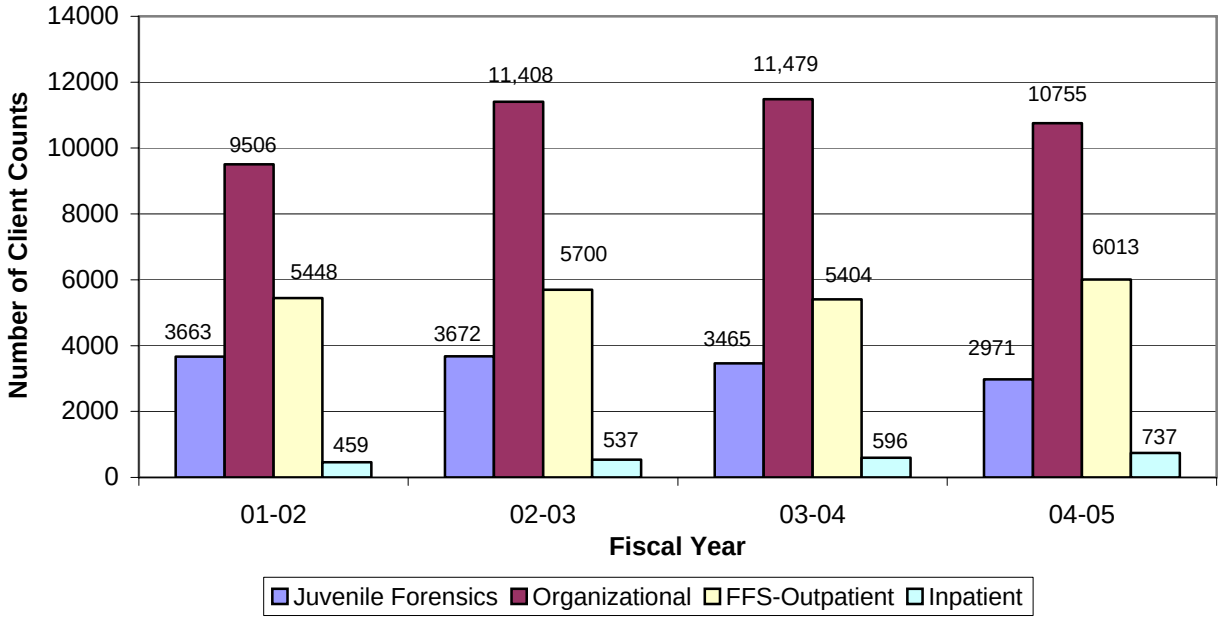


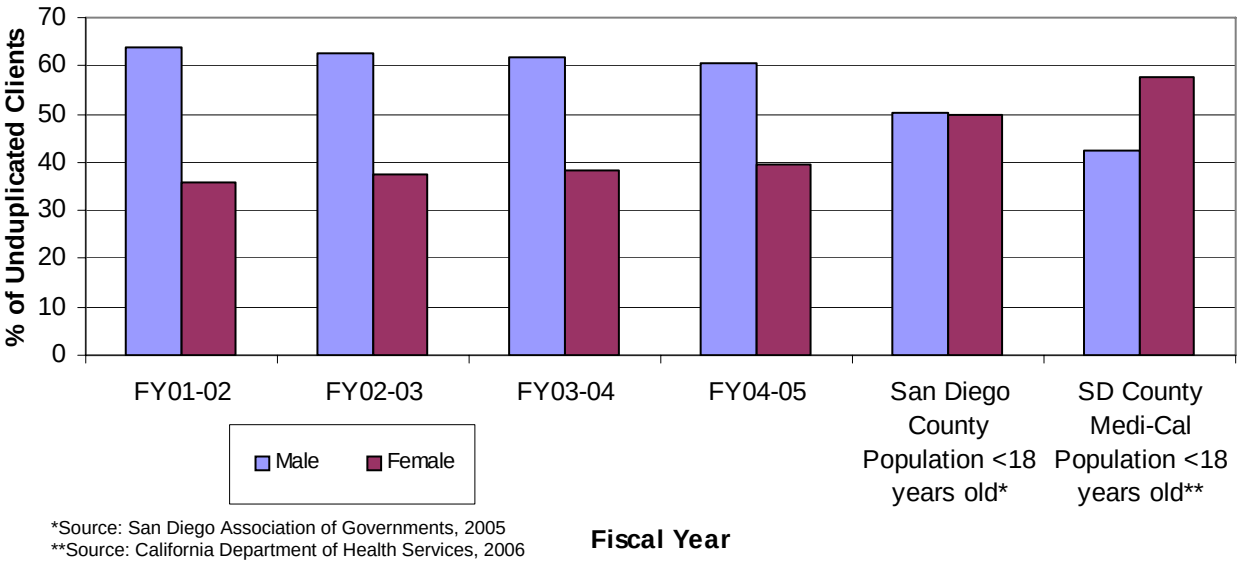
Figure 2.2 shows the breakdown of the **number of unduplicated clients for each fiscal year by mechanism**: Inpatient, FFS-Outpatient, Organizational Providers and Juvenile Forensic Services. Note that a youth may receive services from more than one mechanism within the year and, therefore, the client counts exceed the total sample size.

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



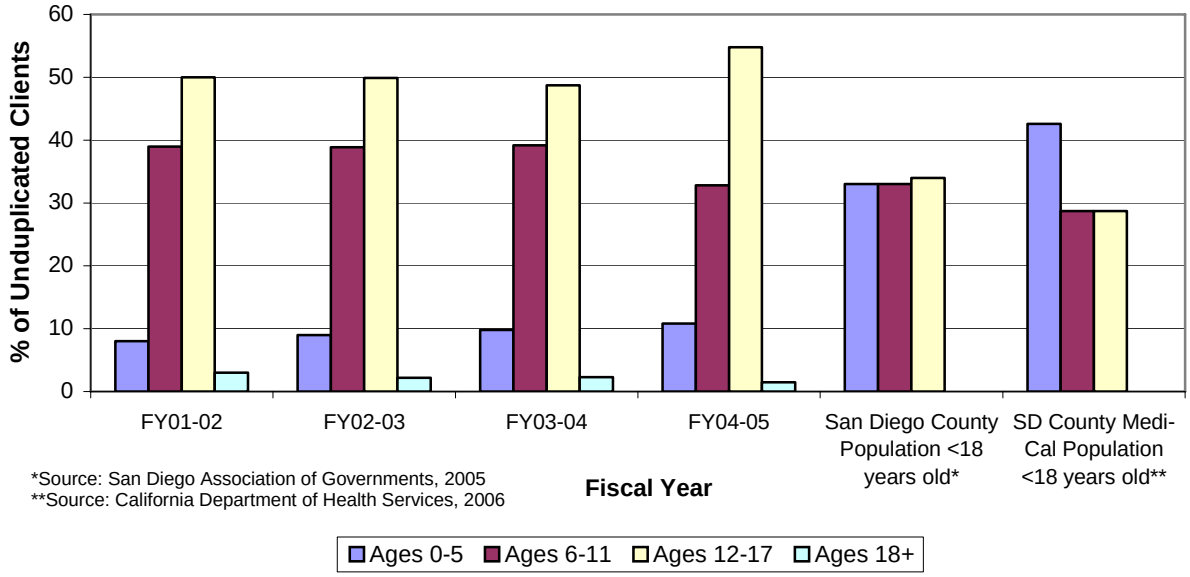
Gender distributions are relatively stable across fiscal years, with a larger percent of males than females served through CMHS in FY04-05 (**Figure 2.3**); a trend is present with the percentage of female clients increasing slowly over time. **Age** distributions are also fairly stable across fiscal years, with the majority of youth between 12-17 years old (**Figure 2.4**). The age and gender distributions vary widely from the 2005 SANDAG estimates for all youth in San Diego County, as well as the San Diego County Medi-Cal population under age 18 (last pair of columns on the right in figures), 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



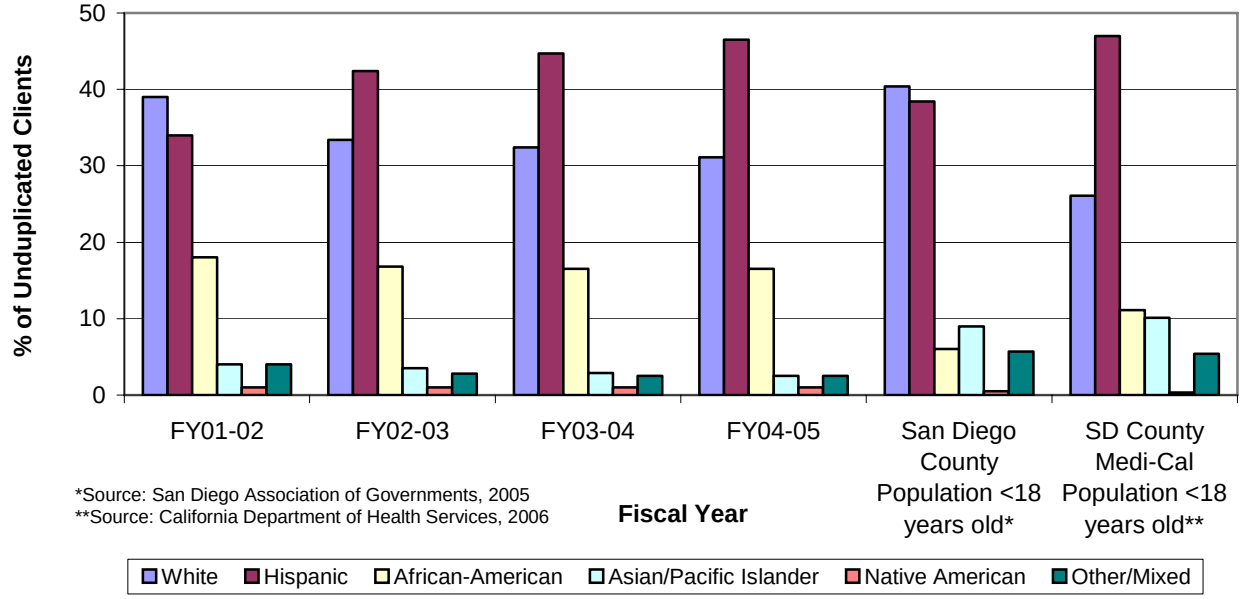
*Source: San Diego Association of Governments, 2005
**Source: California Department of Health Services, 2006

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 46% of the sample, continuing a pattern of increased prevalence of Hispanics served within CMHS. Hispanics are seen by CMHS at a rate that exceeded San Diego County youth census estimates (46% CMHS vs. 38% census), while Whites were underrepresented (31% CMHS vs. 41% census). However, the racial/ethnic distribution is more similar to that of the youth Medicaid population in San Diego County as a whole (refer to last column in figure)

Figure 2.5: Youth Race/Ethnicity Across All Providers



More African-American youth received services than expected based on the population census or the County Medi-Cal population, while only a third as many Asian/Pacific Islander youth received services as expected based on the same estimates. Native American youth were represented in the CMHS sample roughly in proportion to their representation in the county population, 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 and Medi-Cal populations.

Further analyses of the gender, age, and racial/ethnic groups served by CMHS was completed to identify where in the County these unserved and underserved groups were located. Using zip code level data obtained from the United States Census, as well as additional data from the San Diego Association of Governments (SANDAG) and specific departments from the County of San Diego, maps were generated to visually display the locations of the targeted populations.

Figure 2.6 provides basic information about the location of youth most likely to be served by the public mental health sector, as it shows the location of the San Diego County population, ages 0-17, who are **below 200% of the Federal Poverty Level**. The zip codes labeled in red are the zip codes that have the highest percentages in the county. For example, the 92105 zip code (City Heights) has 7.9% of the low income youth in the county. Other zip codes with high percentages of children living in poverty include 92113 (Logan Heights) – 6.0%, 91950 (National City) – 4.9%, 92102 (Golden Hill) – 5.2%, and 92054 (Oceanside) – 4.6%.

Figures 2.7 and 2.8 show the location of two targeted low income (less than 200%FPL) populations: **young children** (ages 0-4) and **transition age youth** (ages 18-24). Young children living in poverty are concentrated in several areas, with over 9% of the county's low income young child population in a single zip code: 92105 (City Heights). Other areas that have over 5% of the county's young children living in poverty include 92113 (Logan Heights) - 5.5%, 92102 (Golden Hill) - 5.5%, and 92054 (Oceanside) - 5.3%.

Transition age youth living in poverty are concentrated in several areas, with the largest concentration living in the 92115 area code, which is located around San Diego State University (6.1%). Five percent of these low income youth are living in City Heights (92105), while other areas with large concentrations include 92109 (Mission and Pacific Beaches) - 3.9%, 92113 (Logan Heights) - 3.6%, and 92054 (Oceanside) - 3.4%.

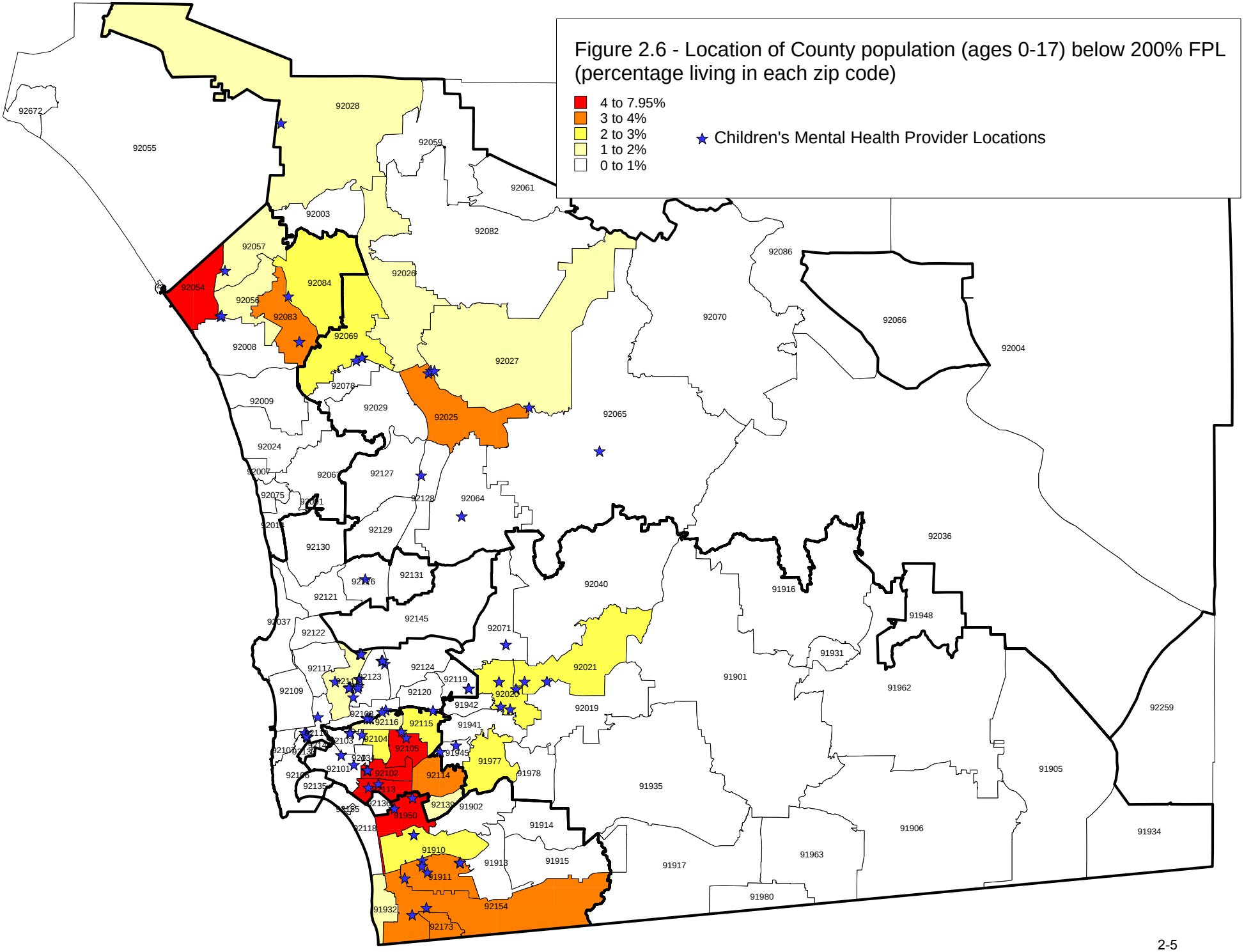


Figure 2.6 - Location of County population (ages 0-17) below 200% FPL (percentage living in each zip code)
4 to 7.95%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Children's Mental Health Provider Locations
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91918
91915
91917
91911
91980
91932
92154
92173

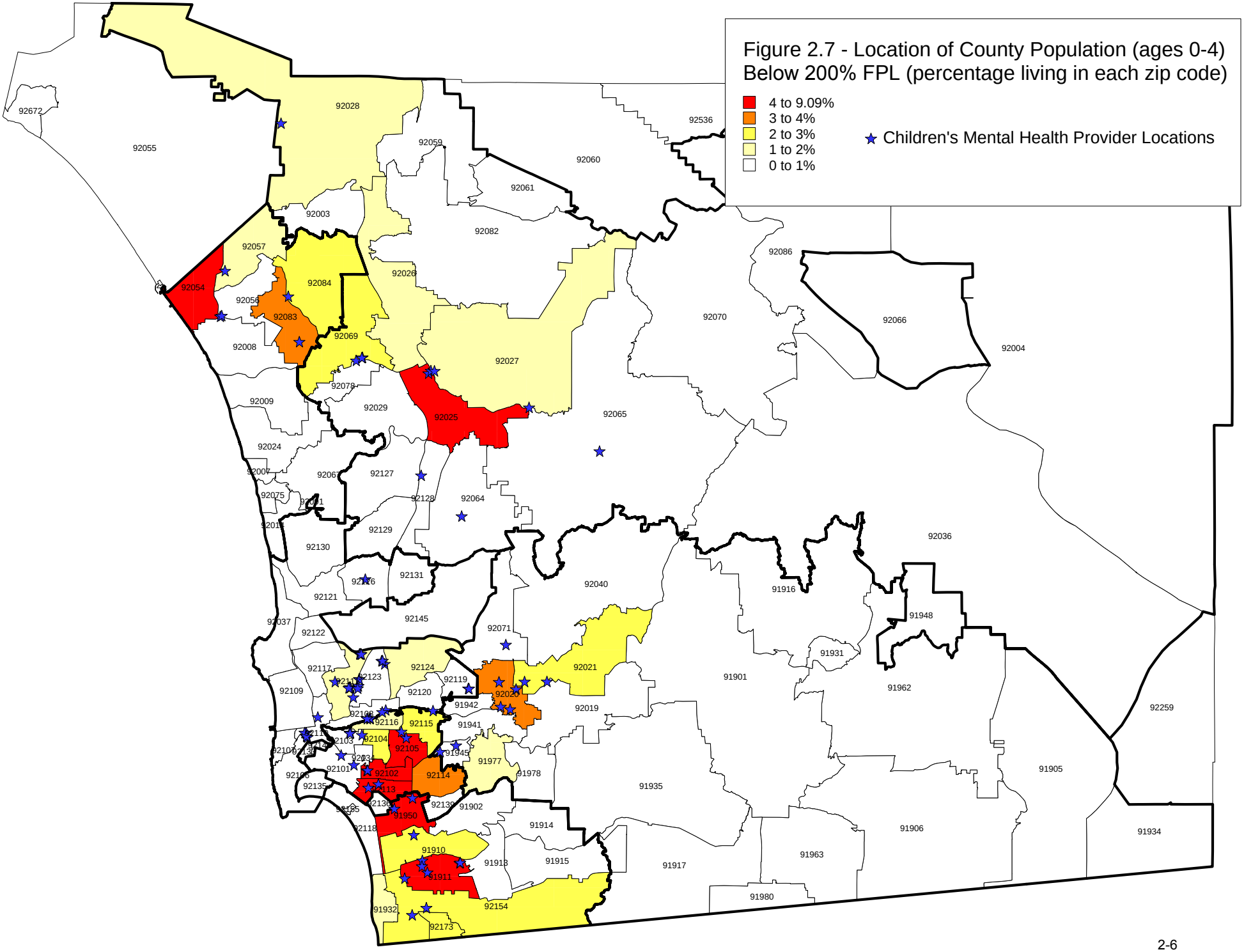
Figure 2.7 - Location of County Population (ages 0-4) Below 200% FPL (percentage living in each zip code)
4 to 9.09%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Children's Mental Health Provider Locations
92672
92055
92028
92059
92536
92060
92061
92003
92082
92057
92086
92054
92084
92026
92056
92083
92070
92066
92069
92008
92004
92027
92078
92009
92029
92025
92065
92024
92007
92127
92075
92128
92064
92129
92036
92130
92131
92040
91916
92121
92145
91948
92037
92122
92071
91931
92117
92124
92021
91901
92109
92120
92020
91962
91942
92019
92259
92116
92115
91941
92104
92105
91945
91977
91905
92102
92114
91978
92135
92113
91935
92130
91902
91950
91914
91906
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91963
91917
91911
91980
91932
92154
92173

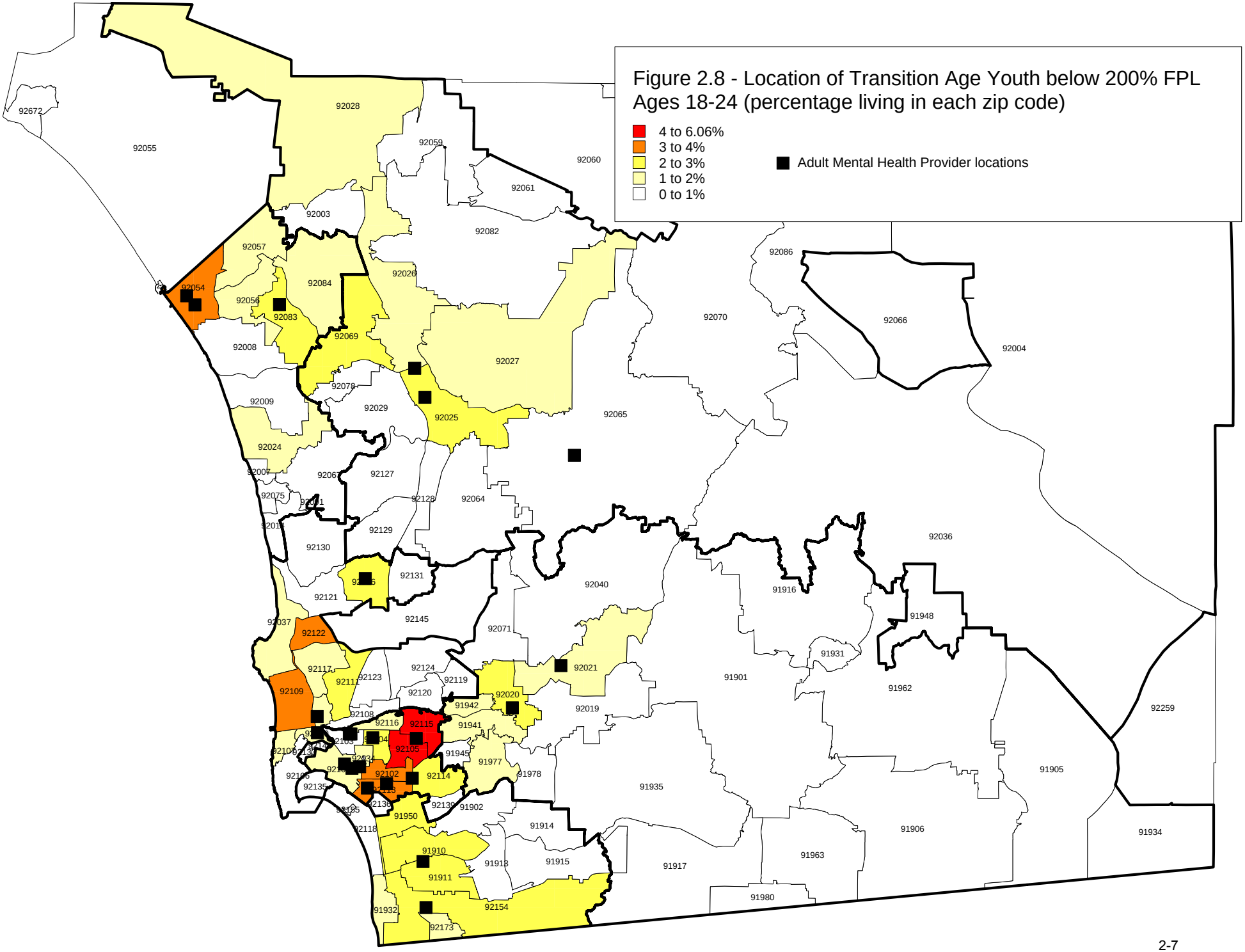
Figure 2.8 - Location of Transition Age Youth below 200% FPL
Ages 18-24 (percentage living in each zip code)
4 to 6.06%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Adult Mental Health Provider locations
92672
92055
92028
92059
92060
92061
92003
92082
92057
92086
92054
92084
92026
92056
92083
92069
92070
92066
92008
92027
92004
92078
92009
92029
92025
92065
92024
92007
92127
92075
92128
92064
92201
92129
92036
92130
92131
92040
91916
92121
92145
91948
92037
92122
92071
92117
92124
92021
91931
92111
92123
92119
91901
92109
92120
92020
91962
91942
92108
92019
92259
92116
92115
91941
92105
91945
91977
91905
92102
92114
91978
92135
91935
92136
92130
91902
91950
91914
92118
91906
91934
91910
91918
91915
91963
91911
91917
91980
91932
92154
92173

In addition, analyses were done to examine the geographic location of two specific racial/ethnic groups that were identified as unserved. **Figures 2.9 and 2.10** show the location of **Asian/Pacific Islander** and **Hispanic** youth, ages 0-17, who are living below 200% of the Federal Poverty Limit, and are thus likely to be served by CMHS. Almost twenty percent of low income Asian/Pacific Islander (API) youth are located in a single zip code: 92105 (City Heights), while other areas with large percentages of low income API youth include 92111 (Linda Vista) – 7.9%, 92115 (College Area) – 7.7%, 92126 (Mira Mesa) – 6.2%, and 92114 (Encanto) – 4.9%. Low income Hispanic youth are more spread out, with the largest concentration (8.0%) located in City Heights (92105). Other areas with large concentrations include 92113 (Logan Heights) – 7.7%, 92102 (Golden Hill) – 6.2%, 91950 (National City) – 5.5%, and 92054 (Oceanside) – 5.2%

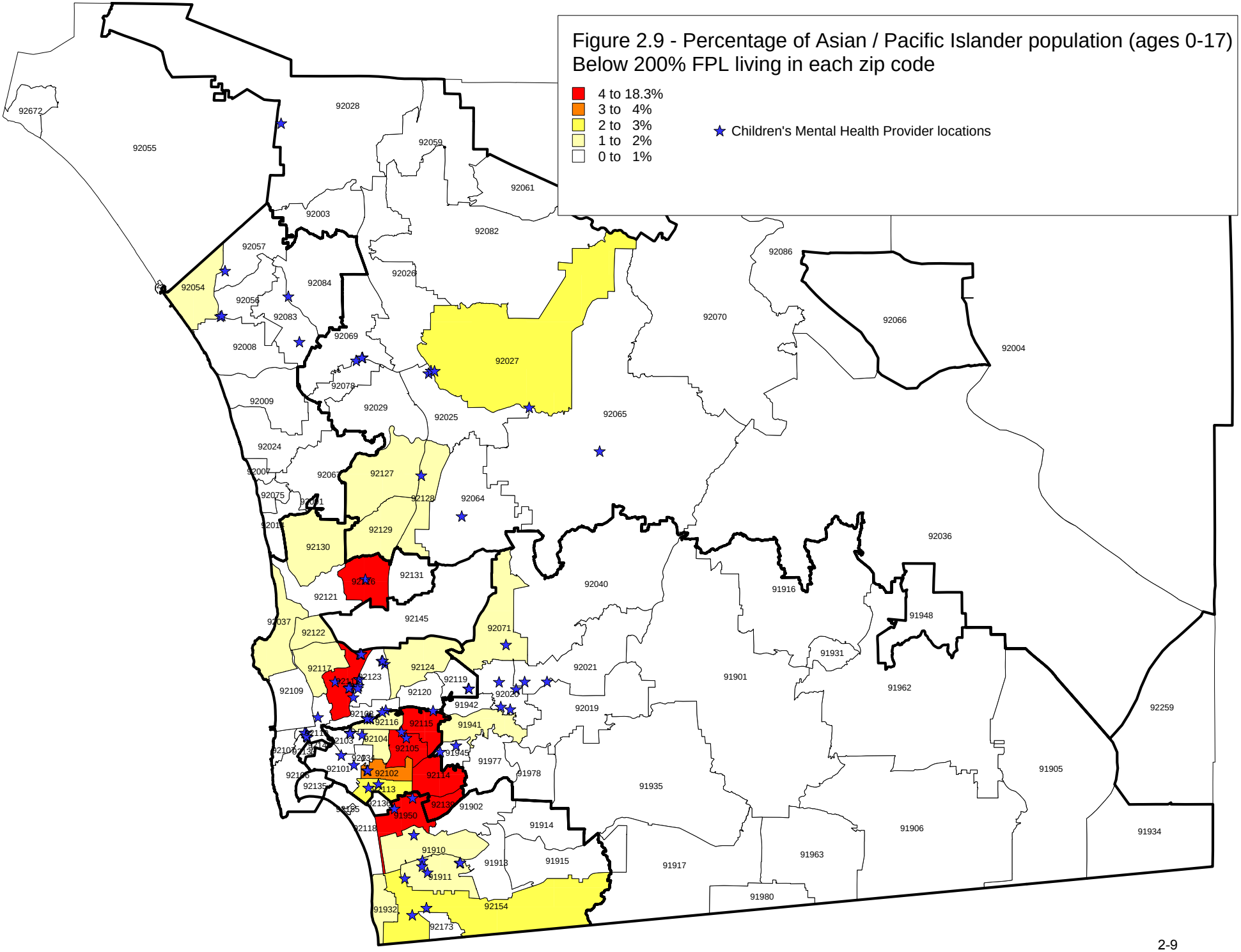
Figure 2.9 - Percentage of Asian / Pacific Islander population (ages 0-17) Below 200% FPL living in each zip code
4 to 18.3%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Children's Mental Health Provider locations
92672
92055
92028
92059
92061
92003
92082
92057
92086
92054
92084
92026
92056
92083
92070
92066
92008
92069
92004
92027
92078
92009
92029
92025
92065
92024
92007
92127
92075
92128
92064
92201
92129
92036
92130
92131
92040
92121
91916
92037
92145
91948
92122
92071
91931
92117
92124
92021
92123
92119
91901
92109
92120
92020
91962
91942
92019
92259
92116
92115
91941
92104
92105
91945
92101
92102
91977
91978
91905
92114
92135
92113
91935
92130
91902
91950
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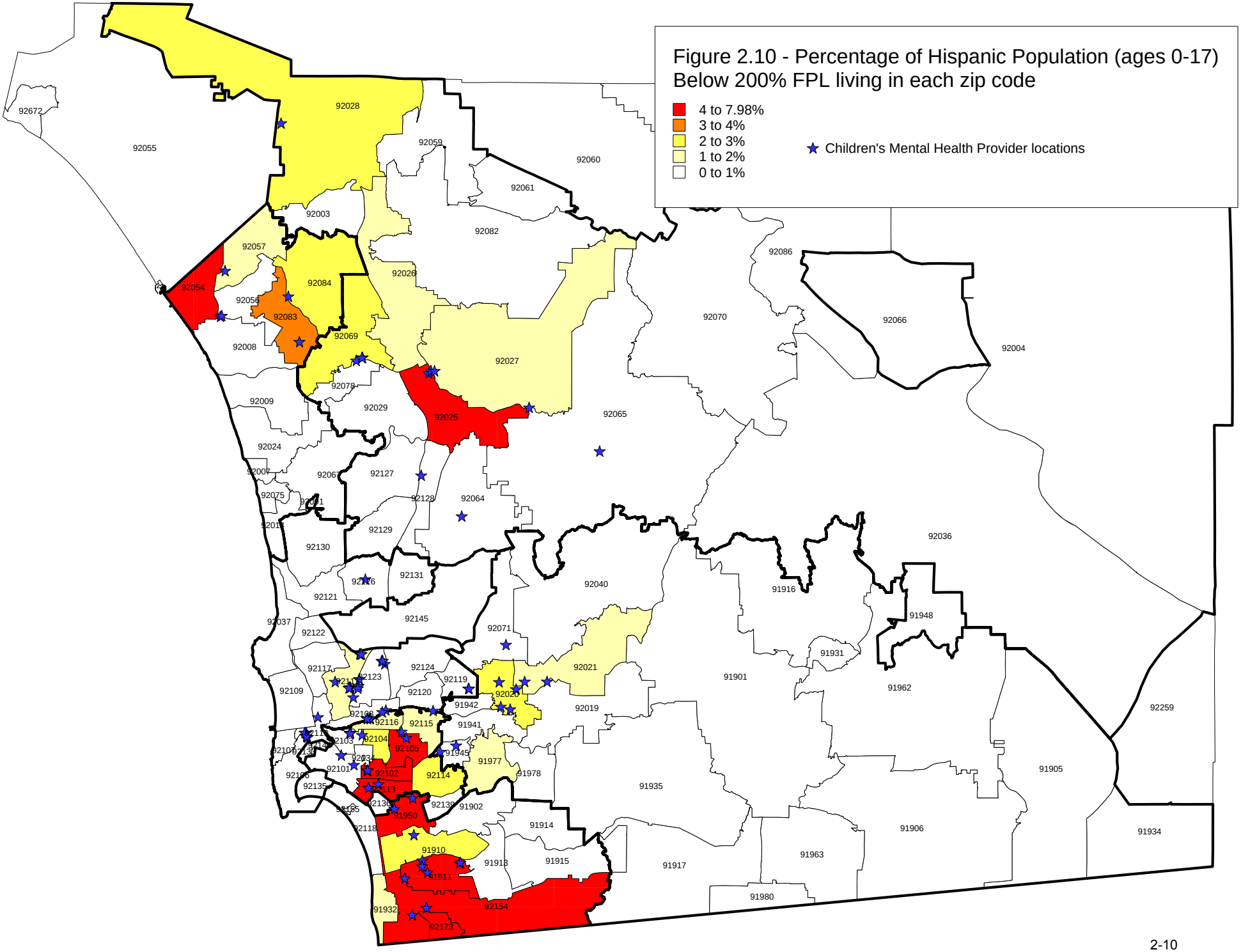
Figure 2.10 - Percentage of Hispanic Population (ages 0-17) Below 200% FPL living in each zip code
4 to 7.98%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Children's Mental Health Provider locations
92672
92055
92028
92059
92060
92061
92003
92082
92057
92086
92054
92084
92026
92056
92083
92070
92066
92069
92008
92004
92027
92078
92009
92029
92025
92065
92024
92007
92006
92127
92075
92128
92064
92129
92036
92130
92131
92040
91916
92121
92145
91948
92037
92122
92071
91931
92117
92124
92021
91901
92109
92120
92020
91962
91942
92019
92259
92116
92115
91941
92104
92105
91945
91977
92101
92102
92114
91978
91905
92135
92113
91935
92130
91902
91950
91914
91906
92118
91934
91910
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92154
91980
92173

Figure 2.11 displays the **unduplicated client counts** in Mental Health along with the unduplicated client counts in the other System of Care sectors. The Venn diagram shows the number of youth who are involved with another service sector in addition to Mental Health. Of youth receiving Mental Health services in FY04-05, 32.9% also received Special Education services (10.1% Emotionally Disturbed), 24.6% Child Welfare, 14.3% Juvenile Justice, and 2.7% Alcohol & Drug during the fiscal year.

Table 2.1 presents the percentages and numbers of youth overlapping with each of the sectors. For example, of youth involved with the Alcohol and Drug sector, 32% also received Mental Health services during the year, 5% were involved with Child Welfare, 25% with Juvenile Justice and 15% with Special Education.

Table 2.1: Unduplicated Client Counts Across System of Care Sectors for FY04-05[1,2]

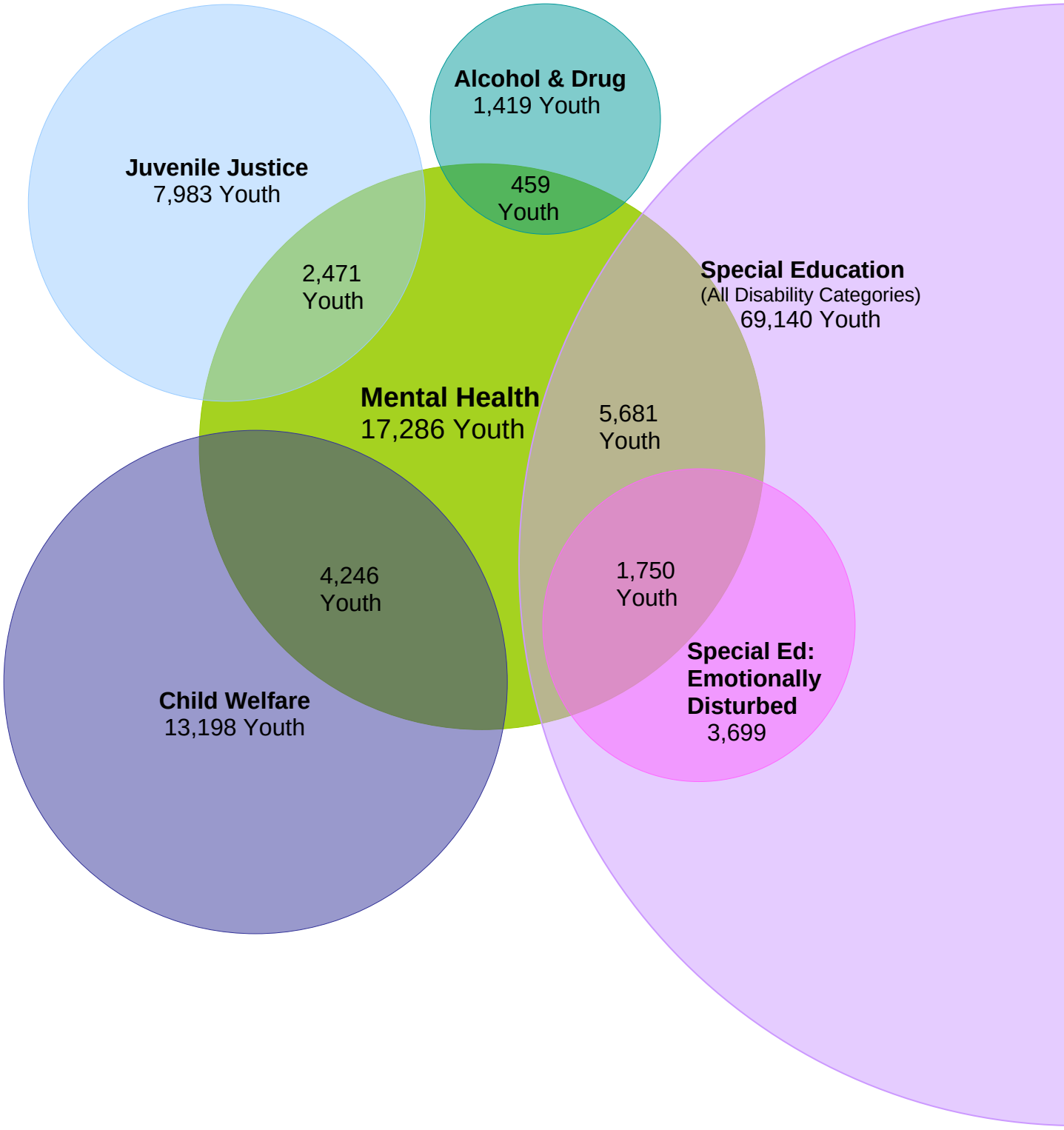
The data presented is the number of youth receiving services for each sector and the percent of youth overlap with other sectors. Percents are displayed for each column.

	Mental Health	Alcohol & Drug	Child Welfare	Juvenile Justice	Special Education	Special Ed: ED Only
Mental Health	**100% N=17286**	**32%** n=459	**32%** n=4246	**31%** n=2471	**8%** n=5681	**47%** n=1750
Alcohol & Drug	**3%** n=459	**100% N=1419**	**<1%** n=66	**5%** n=360	**<1%** n=217	**1%** n=50
Child Welfare	**25%** n=4246	**5%** n=66	**100% N=13198**	**4%** n=348	**3%** n=2403	**13%** n=466
Juvenile Justice	**14%** n=2471	**25%** n=360	**3%** n=348	**100% N=7983**	**2%** n=1621	**10%** n=372
Special Education	**33%** n=5681	**15%** n=217	**18%** n=2403	**20%** n=1621	**100% N=69140**	**100% N=3699**
Special Ed: ED Only	**10%** n=1750	**4%** n=50	**4%** n=466	**5%** n=372	**5%** n=3699	**100% N=3699**

[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.

- 33% of youth in Mental Health were involved in the Special Education sector in the fiscal year.
- 32% of youth in Child Welfare also received Mental Health Services during FY04-05.
- 31% of youth in Juvenile Justice were also involved with Mental Health in FY04-05.
- Among youth receiving Special Education services, very few were also involved in other child service sectors during the fiscal year; however, almost 50% of youth classified as Emotionally Disturbed (ED) also received services from Mental Health during FY04-05.

Figure 2.11: Unduplicated Counts of Youth Receiving Services from Mental Health and the Overlap with Other Sectors - FY 2004-2005



Note: This figure displays sector overlap with Mental Health only. Overlaps across all sectors are presented in Table 2.1.

Table 2.2 displays the single and multiple service sector use by each public agency (Special Education includes youth classified as Emotionally Disturbed only).

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 for each column.

	Mental Health n=17,286	**Alcohol & Drug** n=1,419	**Child Welfare** n=13,198	**Juvenile Justice** n=7,983	**Special Ed: ED Only** n=3,699
Not Open to Any Other Service Sector	55.0%	57.1%	66.5%	65.2%	42.4%
Open to One Other Service Sector	38.9%	22.4%	28.7%	26.3%	37.0%
Open to Two Other Service Sectors	5.5%	18.0%	4.2%	7.4%	17.6%
Open to Three or More Other Service Sectors	0.6%	2.5%	0.6%	1.1%	2.9%
Total	100%	100%	100%	100%	100%

- 45% of youth receiving Mental Health services were also open to another sector in FY04-05, an increase from 38.6% in FY03-04
- Very few youth were involved in three or more service sectors within the fiscal year.
- Two-thirds of youth involved in Child Welfare or Juvenile Justice did not receive services from any other sector during the year.

Service Modes

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:

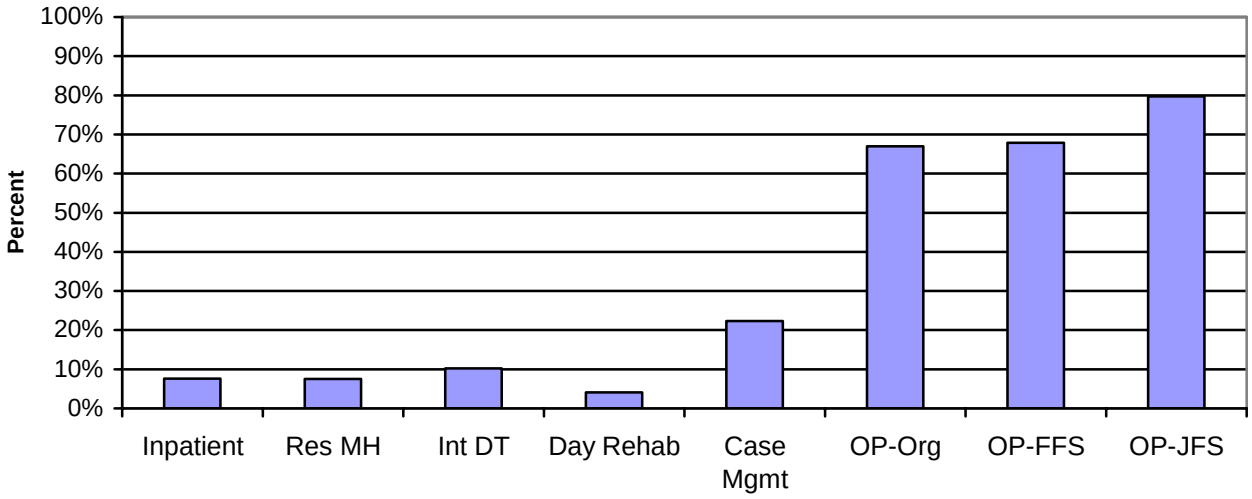
- **Inpatient services** - delivered in hospitals.
- **Residential services** - divided in the way they are funded, with Child Welfare providing the funding for "room and board" and Mental Health providing the funding for treatment services through either an outpatient mode or a day treatment mode "patched" 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.
- **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 service modes in the course of a year. Figure 2.12 shows which clients used services from a single mode within the CMHS system during the fiscal year. For example, only 7.5% of youth receiving residential mental health services used no other type of mental health services during the year, while almost 80% of youth getting Outpatient Juvenile Forensic services received no other mental health services during the year.

Figure 2.12: Percentage of Clients Using Services from a Single Service Mode



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-JFS= Outpatient Juvenile Forensic Services.

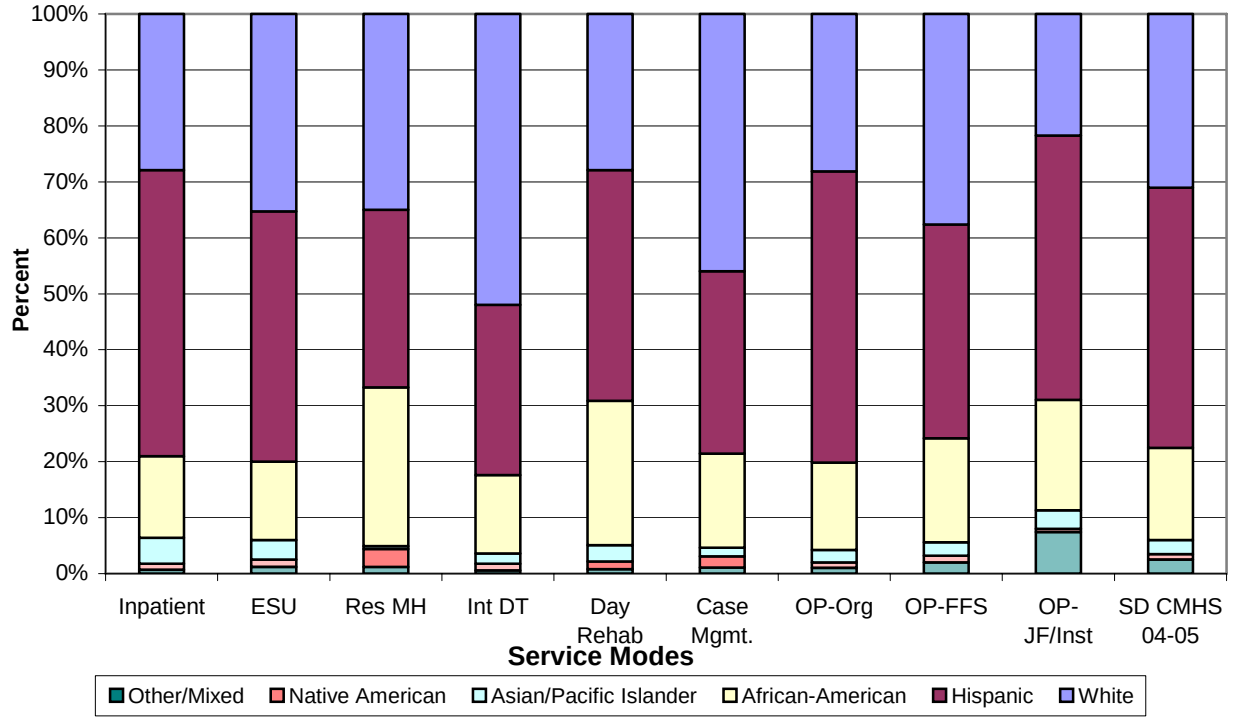
It should be noted that the number of children receiving residential mental health services continues to decrease, dropping from 1,198 in FY02-03 to 416 in FY04-05. In addition, a large percentage of youth receiving outpatient services did not use any other service mode. For example, 67% of youth receiving Outpatient Organizational Program services did not receive services from any other mode. This can be contrasted with Inpatient services, in which only 7.6% of youth did not receive services from another mode during the year.

Figure 2.13 presents the **race/ethnicity** distribution in each of the service modes. This figure demonstrates some variability between services. For example, there are relatively higher percentages of White youth utilizing intensive day treatment and case management services, as compared to their frequency in the San Diego County Mental Health Services youth population as a whole (refer to the last column on right in the figure). African-American youth are over-

represented in the residential mental health and day rehabilitation service modes as compared to their distribution in the general youth population. It should be noted that data on OP-JFS services comes from a separate database from the other services, which collects data on race/ethnicity in a slightly different format; this may be causing the variation in race/ethnicity present. Also, youth can receive services from multiple modes in a given year; therefore, it is not possible to determine whether these differences in racial/ethnic distribution are statistically significant.

Figure 2.14 shows the **gender** distribution in each service modality. Females are overrepresented in the inpatient and emergency screening modalities, as compared to their overall population, while males are overrepresented in intensive day treatment and juvenile forensics services.

Figure 2.13: Distribution of Race/Ethnicity in Each Service Modality



Key – ESU=Emergency Screening Unit, 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.

Figure 2.15 shows the age distribution of youth served in the mental health system in FY0405. The message in this figure is that the higher-end services, including inpatient, residential, and day treatment services, are more likely to be delivered to adolescents. Children, ages 11 and under, are more commonly receiving organizational and fee-for-service outpatient services. The largest mode serving clients ages 18 and older is Juvenile Forensics, although again it should be noted that this data comes from a different database than the other modes, which may contribute to differences in which data is collected.

Figure 2.14: Gender Distribution in Each Service Modality

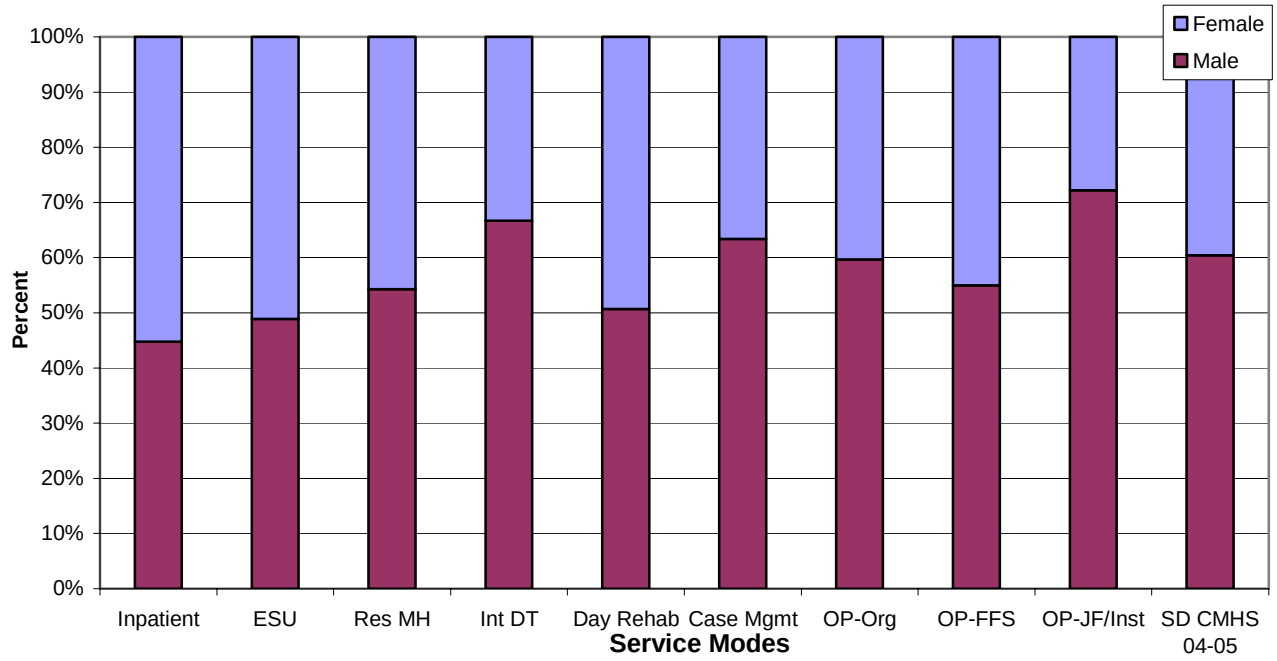
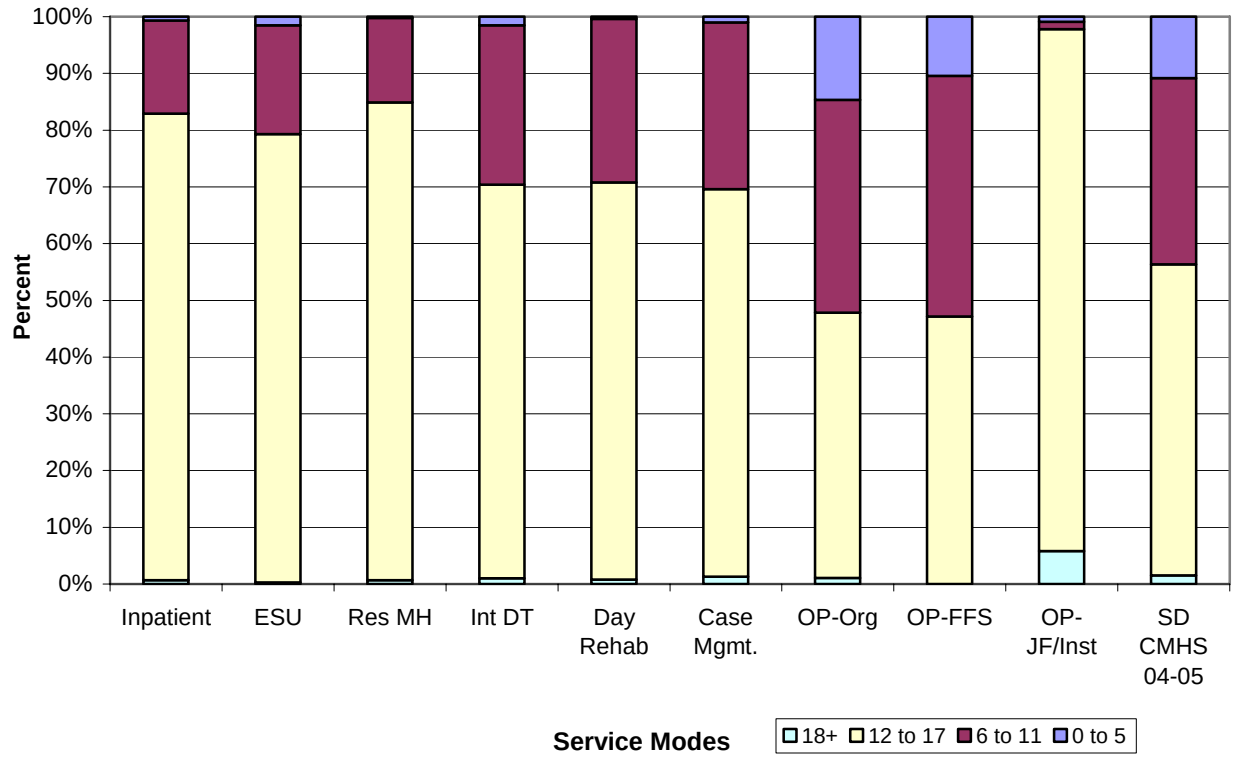


Figure 2.15: Age Distribution in Each Service Modality



Chapter Summary

- Over 17,000 children and adolescents were served by the Children's Mental Health System in FY0405.
- Over 60% of children are served by County-run or contracted organizational providers.
- Over 60% of the youth served are male, compared to 50% in the overall San Diego County youth population.
- About 46% of the youth receiving services are Hispanic, compared to 47% in the County's youth Medi-Cal population.
- Almost 40% of youth receiving CMHS services in FY04-05 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.
- Over 67% of youth receiving outpatient services did not receive services through any other service mode in FY04-05.

Chapter 3: Service Utilization by Client Characteristics

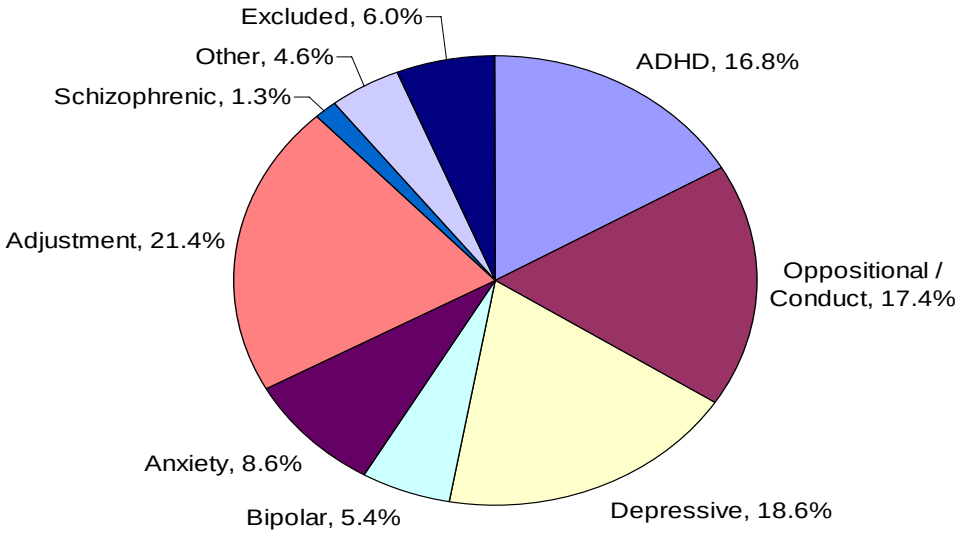
The data presented in this chapter describe the services provided to youth through CMHS for fiscal year 2004-2005, broken out by client demographics. In addition, analyses are presented for youth served by CMHS who used inpatient services during the year.

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. By combining these three 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, 2005. 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, 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.

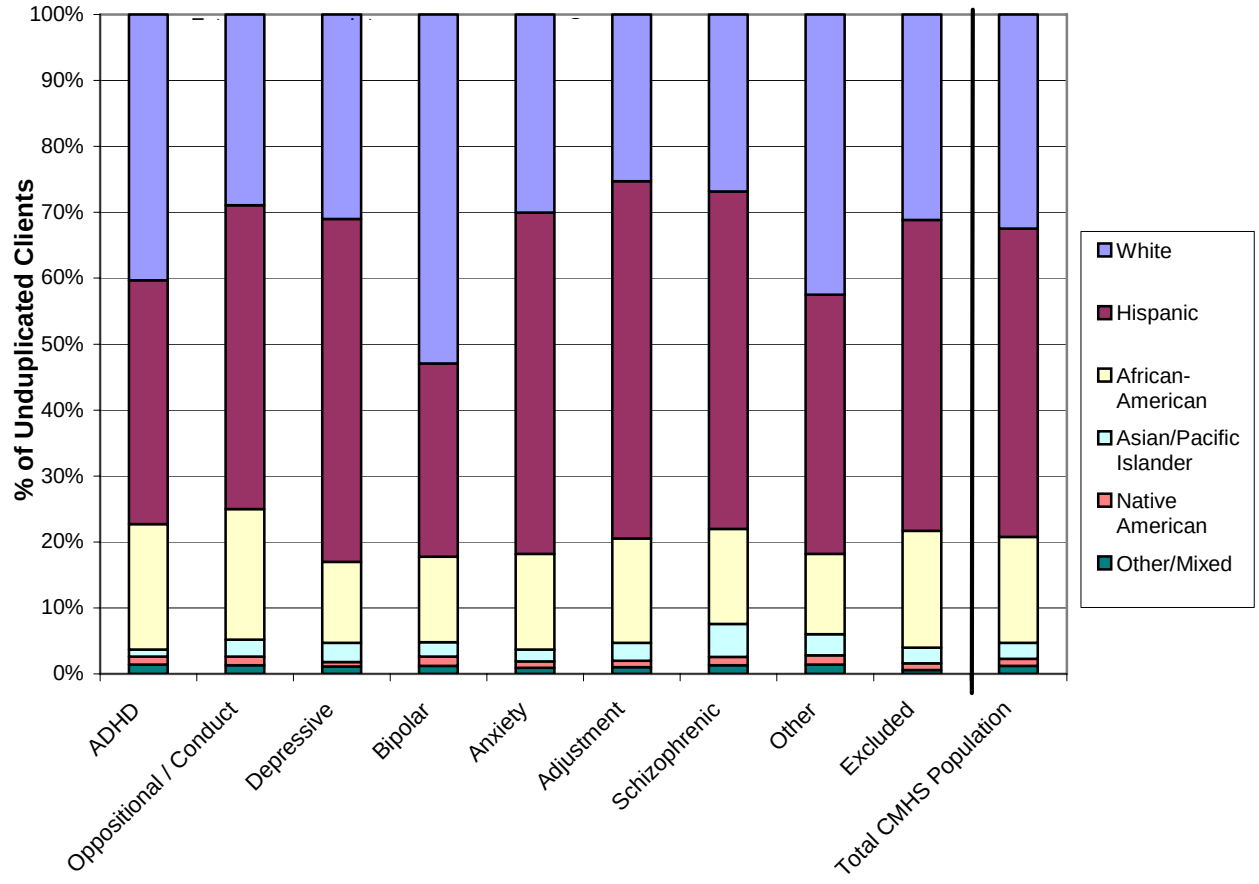
The most **common diagnoses** among youth served by the CMHS are 1) Adjustment disorders (21.4%), 2) Depressive disorders (including Dysthymic) (18.6%), 3) Oppositional Defiant disorders (including Conduct and Disruptive behaviors) (17.4%) and 4) Attention Deficit Hyperactivity Disorder (ADHD) (16.8%) (**Figure 3.1**). These results are similar to the FY0304 pattern of diagnoses, indicating that the distribution is consistent over time.

Figure 3.1: Primary diagnosis for CMHS clients in FY04-05



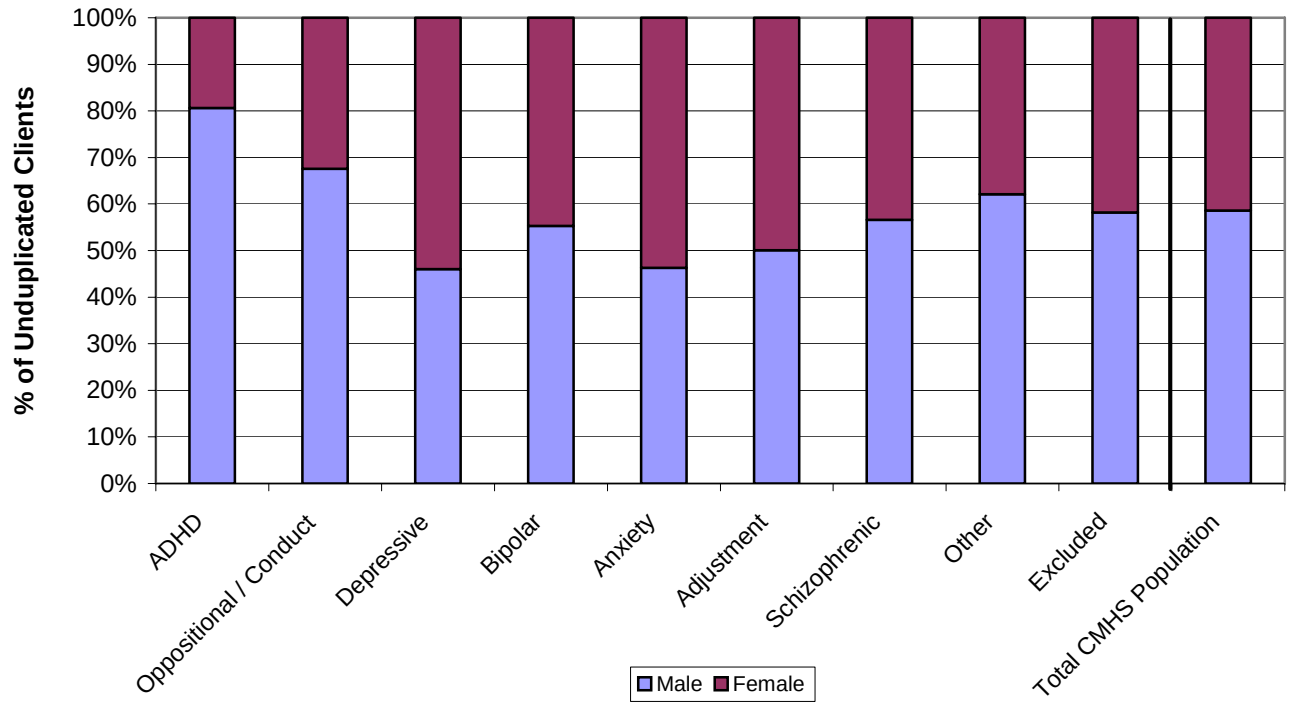
The diagnosis categories are examined by race/ethnicity in **Figure 3.2**. The racial/ethnic breakdown for the total CMHS sample is displayed on the far right for comparison purposes. Over 50% of youth diagnosed with Bipolar disorder are White. Hispanic youth are over-represented in the Adjustment disorders, African-American youth are overrepresented in the Oppositional disorders, and Asian/Pacific Islander youth are overrepresented in the Schizophrenic disorders, compared to the racial/ethnic distribution of the overall CMHS sample. These results are similar to the FY03-04 patterns, indicating that the distribution is consistent over time.

Figure 3.2: Diagnosis by Race/Ethnicity



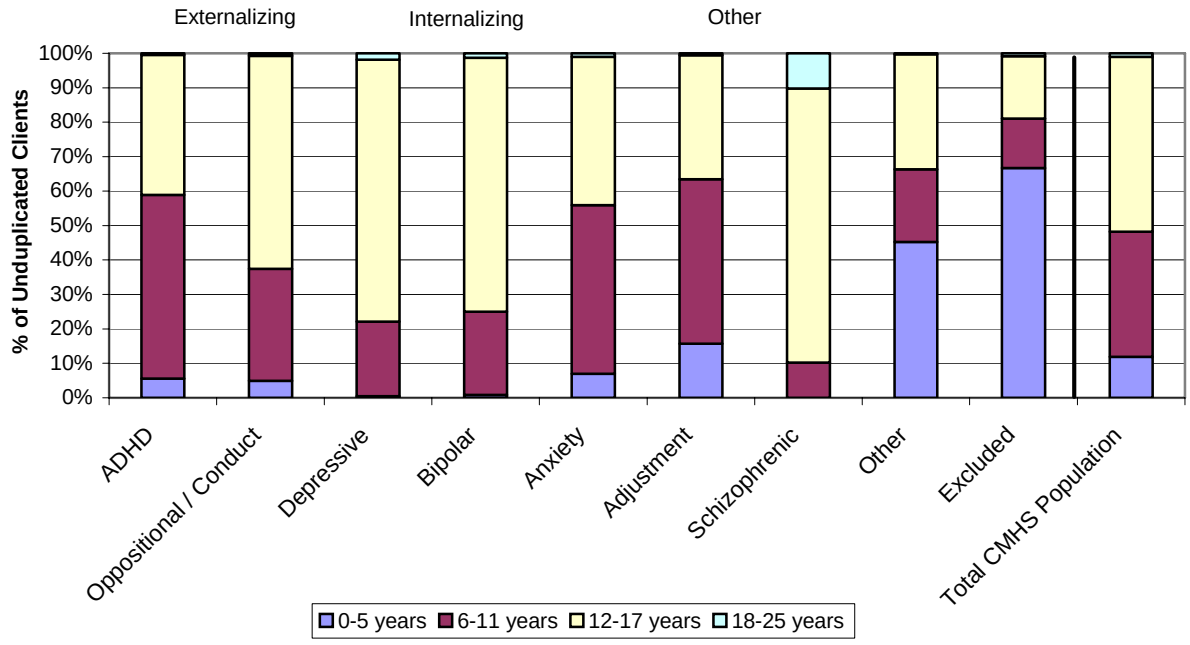
Males are more likely to be diagnosed with externalizing disorders, such as ADHD or Oppositional disorders, while females are more likely to be diagnosed with internalizing disorders, such as depressive or anxiety disorders, as compared to their distribution in the total sample (**Figure 3.3**). Again, these results are similar to the FY03-04 patterns, indicating that the distribution is consistent over time.

Figure 3.3: Primary Diagnosis by Gender



When diagnoses are examined by age, clear differences are present (**Figure 3.4**). Young children (age 0-5) are being diagnosed with Title 9 excluded diagnoses, primarily developmental disorders, at a markedly higher rate compared to other age ranges. Elementary age children (age 6-11) 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. These patterns are also consistent with those found in FY03-04.

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 FY04-05 (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). **Overall, 88% of youth received Medi-Cal funding during the year, while 3.2% received AB2726 funding. Figure 3.5** shows the percentage of youth who received services funded by Medi-Cal for each diagnostic category. There are fewer youth in the Bipolar or Schizophrenic 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 in the Bipolar, Schizophrenic, or ADHD categories are more commonly receiving AB2726-funded services.

Figure 3.5: Primary Diagnosis by Medi-Cal

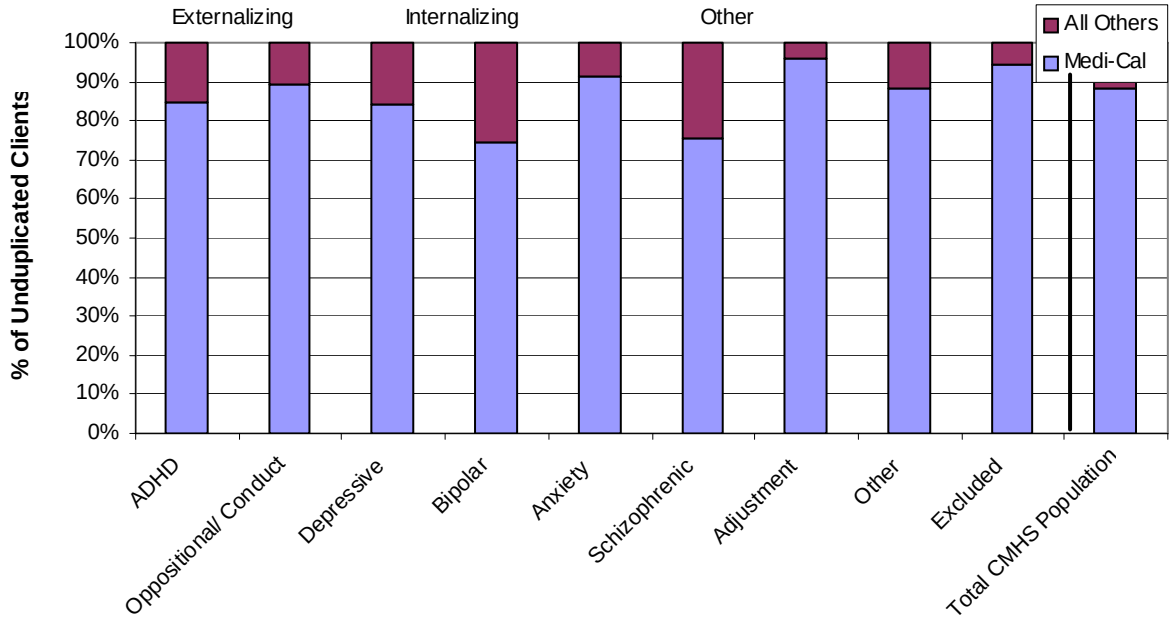
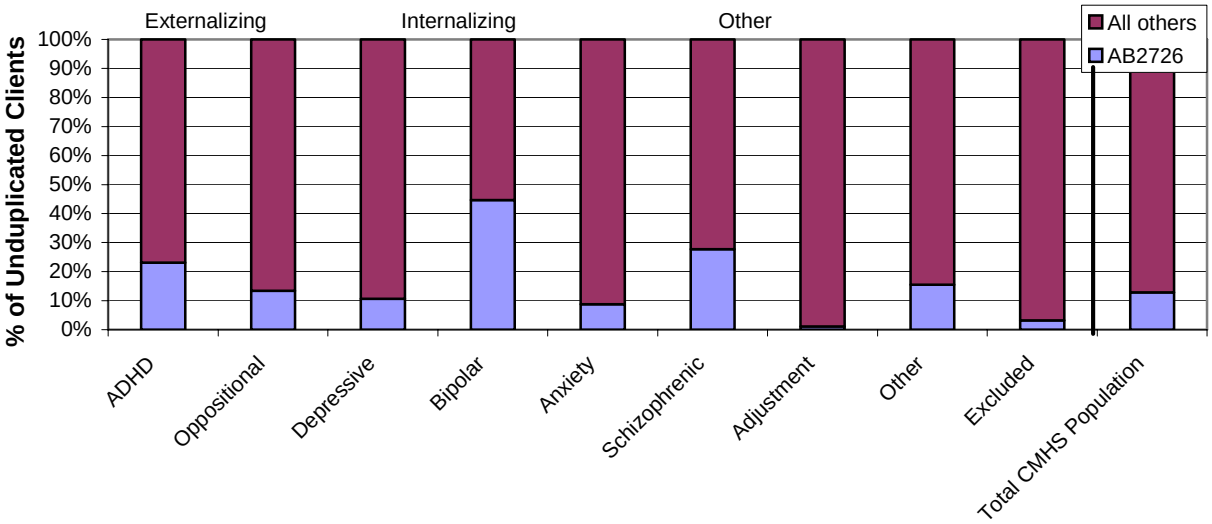


Figure 3.6: Primary Diagnosis by AB2726 Services Received



In summary, the distribution of diagnoses in the FY04-05 CMHS sample, as well as the relationship of diagnoses with race/ethnicity, gender, age, and funding source, is very similar to those found in FY03-04. This would indicate that the patterns accurately reflect what is occurring in the system and that no major changes in diagnostic patterns occurred over the two year period.

The remainder of this section examines the **type and amount of services received** during FY04-05. As described in Chapter 2, children and youth may receive services from any or all of the various modes 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 mode 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** (20.5% and 38.6% respectively as compared to 4.3% for the sample overall) in FY04-05. Youth with these diagnoses were also more likely to use intensive day treatment services. Youth with ADHD or Depression who used day rehabilitation services used more days on average then 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[1]	4.3	13.5	8	5.6	90.5	76	9.0	47.4	17	1.8	1.2	1
ADHD	*1.9*	15.6	8	4.8	87.3	75	*4.6*	**70.3**	42	0.4	1.2	1
Oppositional/ Conduct	5.5	15.7	8.5	**8.3**	84.8	68.5	**12.1**	54.0	31	2.1	1.1	1
Depressive	**11.6**	*9.7*	7	4.6	87.0	67	8.8	**75.2**	38	**4.4**	1.1	1
Bipolar	**20.5**	**17.4**	10	**23.7**	105.6	88	*7.0*	53.4	20.5	**4.3**	1.4	1
Anxiety	*2.5*	12	9	5.4	83.4	71.5	*7.0*	53.6	16	*0.8*	1.2	1
Adjustment	*1.1*	*8.2*	6	*1.1*	*68.1*	27	**14.5**	*22.5*	9	*0.6*	1.1	1
Schizophrenic	**38.6**	**18.6**	13	**11.4**	100.5	106	*6.0*	*32.4*	31	**7.2**	1.2	1
Other	*1.5*	**17.8**	11	**6.8**	100.2	86	*2.6*	*31.7*	12.5	*0.5*	1.3	1
Excluded	*0.6*	*7.4*	5	*0.5*	*40.3*	34.5	*3.2*	*30.9*	13	*0.6*	1.0	1

[1] Youth with an invalid or missing diagnosis are excluded from these analyses.

Outpatient services were reported in terms of the minutes of service received and were broken out into 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 youth in obtaining functional skills in the community, and are provided by programs with a 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** on average than youth with other diagnoses. They were more likely to use services and to use more minutes of service, particularly in the case management, assessment, and medication support categories. In addition, ADHD-diagnosed youth used medication support services at increased rates, compared to other youth. Finally, as expected, youth with excluded diagnoses used services at low rates in all service categories except assessment: 86% of these youth had received assessment services as compared to the overall mean of 63%.

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[1]	60.2	534.5	250	73.9	1004.8	705	33.5	821.9	145	63.3	227.0	180
ADHD	65.6	616.0	320	82.2	1089.1	800	37.9	916.2	135	55.7	254.1	170
Oppositional / Conduct	67.9	604.8	275	77.3	996.8	709	38.7	948.9	145	62.4	255.0	180
Depressive	63.4	510.8	253.5	80.5	1062.3	745	36.8	*625.8*	110	59.3	226.4	180
Bipolar	**72.9**	**916.7**	390.5	71.5	1150.3	810	**56.5**	**1411.0**	295	62.7	**342.1**	215
Anxiety	57.8	464.7	245	84.3	978.6	750	28.8	*621.6*	96	54.9	197.2	150
Adjustment	61.0	*322.6*	150	74.4	859.9	610	27.6	*520.6*	158	68.0	*168.8*	140
Schizophrenic	63.3	**871.6**	307	63.8	869.8	560	**48.8**	**1391.8**	175	62.7	**285.7**	195
Other	*43.0*	583.1	265	*50.4*	**1377.4**	980	*23.3*	**989.7**	206	**76.5**	237.6	180
Excluded	*14.6*	*301.4*	140	*26.4*	*639.7*	300	*0.76*	*470.5*	170	**85.6**	219.1	195

Diagnosis	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample[1]	35.2	265.5	150	8.6	280.1	180	1.6	5024.4	4344.5
ADHD	**55.5**	248.3	175	*4.0*	*200.0*	120	1.9	5548.5	5670
Oppositional / Conduct	37.7	297.2	160	**12.5**	298.5	192.5	**2.7**	4348.3	3465
Depressive	40.9	230.8	135	**14.9**	286.1	200	*1.0*	*3404.9*	2074.5
Bipolar	**64.4**	**455.5**	285	**16.0**	**346.7**	190	**4.9**	**6044.3**	5800
Anxiety	31.4	231.0	124.5	*5.2*	313.3	160	*1.5*	5232.2	4675
Adjustment	*13.7*	*131.5*	83.5	*4.7*	*213.1*	140	*0.5*	4621.8	4320
Schizophrenic	**65.7**	**369.2**	230	**31.3**	269.1	207.5	**3.0**	4601.4	5323
Other	*26.6*	273.6	180	*2.5*	226.3	80	*1.5*	**8280.9**	8659
Excluded	*8.8*	*164.8*	90	*2.3*	292.7	180	*0.1*	*3806.0*	3806

[1] Youth with an invalid or missing diagnosis are excluded from these analyses.

Service Utilization by Race/Ethnicity

Further analyses were completed to examine the patterns of **service use across racial/ethnic categories** (**Table 3.3**). Asian / Pacific Islander youth were more likely to receive inpatient and crisis stabilization services than other youth. Black children were more likely to receive day treatment and day rehabilitation services and to receive more days of day rehab treatment than other children. Native American children were more likely than other children to utilize inpatient, intensive day treatment, day rehabilitation, or crisis stabilization services during FY04-05. Children in the Other/Mixed category were less like to use any of the restrictive levels of service.

When **outpatient service use was examined by race/ethnicity**, two distinct patterns emerge. First, children in the Other/Mixed category were less likely to receive services in all categories except therapy (**Table 3.4**). In the therapy category, they received fewer minutes of service on average, as compared to other CMHS children. Second, Native American youth were more likely than other youth to receive services in case management, crisis services, and TBS; they also received more collateral and therapy minutes than average.

Overall CMHS Sample Summary

- Most common diagnoses are (in descending order) Adjustment disorders, Depressive disorders, Oppositional / Conduct disorders, and ADHD.
- There was variation in primary diagnosis by racial/ethnic group, following a pattern seen in previous years.
- Males are more likely to be diagnosed with an Externalizing disorder, while females are more likely to be diagnosed with an Internalizing disorder.
- Two-thirds of the youth with an Excluded diagnosis are young children, ages 0-5.
- Overall, 88% of youth received Medi-Cal funding during the year, while 3.2% received AB2726 funding.
- Use of Medi-Cal funding was less common among youth with a primary diagnosis of a bipolar or schizophrenic disorder, while use of AB2726 funds were higher for these two diagnostic groups.
- 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.
- There are wide variations in service use by the youth's race/ethnicity.

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[1]	4.3	13.5	8	4.5	89.8	76	7.3	46.7	17	1.5	1.2	1
White	4.9	14.4	8	**6.5**	93.8	82	6.5	54.6	19.5	1.2	1.1	1
Hispanic	3.9	13.0	7	*2.9*	94.5	80	6.4	*35.7*	13.5	1.6	1.2	1
Black	4.6	14.3	9	**5.7**	73.6	55	**11.3**	**56.7**	21	1.3	1.3	1
Asian/Pacific Islander	**5.4**	13.7	7.5	*1.7*	**141.7**	194	8.4	*35.8*	10.5	**3.9**	1.0	1
Native American	**8.1**	13.0	12	**9.9**	86.3	80	**10.6**	54.5	24	**6.4**	1.0	1
Other/Mixed	*2.7*	*5.4*	4.5	*1.9*	72.3	49	*2.4*	40.1	10	*0.8*	1.0	1

[1] Youth with a missing race/ethnicity code are excluded from these analyses.

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[1]	56.0	474.7	250	77.0	848.8	705	27.8	809.1	145	56.6	212.5	180
White	55.0	**574.5**	240	74.4	935.4	575	29.5	940.7	210	58.1	230.6	150
Hispanic	58.6	423.4	194	78.1	814.0	505	27.2	649.6	110	57.3	201.2	170
Black	53.5	456.7	160	77.7	821.6	492.5	28.1	**1011.6**	214	56.5	211.6	150
Asian/Pacific Islander	50.6	*352.4*	166.5	76.4	835.3	450	25.8	581.8	240	47.7	202.6	150
Native American	59.6	**699.9**	270	77.6	**1109.3**	635	**36.0**	789.9	276	59.0	238.8	160
Other/Mixed	*39.3*	*322.6*	130	87.2	*564.0*	250	*11.8*	870.6	110	*32.1*	180.7	100

Race/ Ethnicity	Medication Support			Crisis Services			TBS		
	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins	%	Mean Mins	Median Mins
Total Sample[1]	31.4	249.4	150	7.4	264.8	180	1.3	4983.1	4344.5
White	34.4	281.7	150	7.1	231.1	152	1.6	5653.1	5323
Hispanic	29.4	222.5	130	7.7	272.4	170	*0.9*	4121.2	3380
Black	33.9	255.6	145	7.2	299.9	180	**2.0**	4905.3	4270
Asian/Pacific Islander	*22.6*	259.2	135	**11.3**	301.6	290	*0.2*	**7153**	7153
Native American	36.6	296.7	217	**9.3**	233.3	190	**2.5**	4339.3	2725
Other/Mixed	*22.2*	*175.1*	100	*2.9*	238.2	220	*0.3*	**11357**	11357

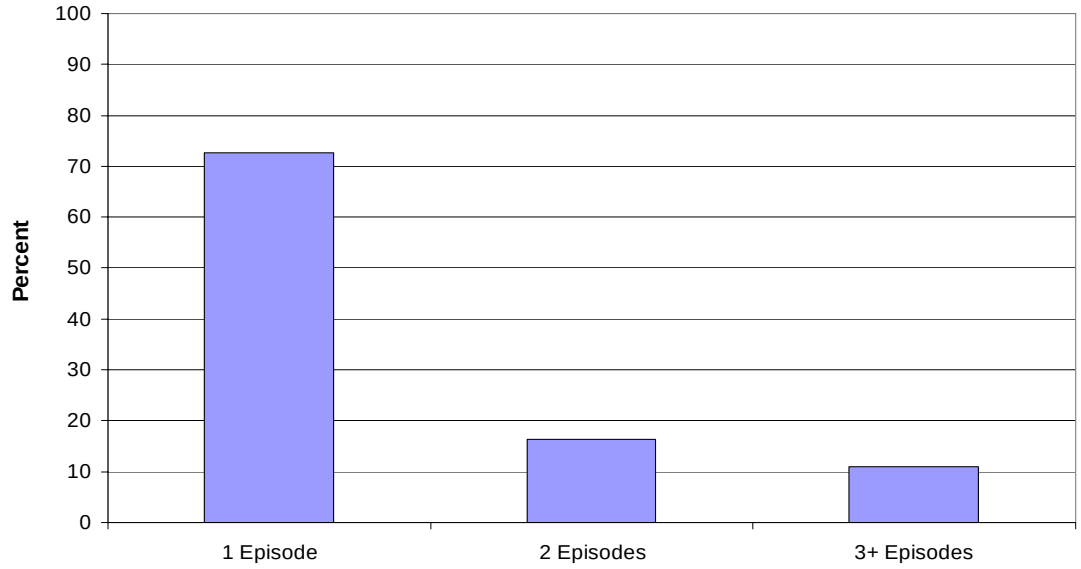
[1] Youth with a missing race/ethnicity code are excluded from these analyses.

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 FY04-05, **4.3%** of children receiving CMHS services were admitted to an acute care hospital for mental health treatment.

While most children had only one inpatient stay, 27% of the inpatient sample had two or more episodes of care in the inpatient setting (**Figure 3.7**) in FY04-05. This is especially concerning given that **57% 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 geographic distribution of children utilizing publicly funded inpatient services (**Figure 3.8**) was examined. The zip codes labeled in red are the areas that have the highest percentages of youth receiving inpatient services. One zip code, 92123 (Kearny and Serra Mesa), has 10.7% of the inpatient-utilizing youth in the county, while the next highest zip code, 91911 (Chula Vista), has 5.3%. Other areas contributing large percentages of the youth inpatient population include 91950 (National City) – 4.1% and 92114 (Encanto) – 4.0%. It should be noted that these percentages may be skewed, as the main Juvenile Detention facility in San Diego County and the Polinsky Center (the county's receiving center for abused and/or neglected youth) are both located in zip code 92123 and are likely to serve as a pathway into inpatient mental health services. In addition, the county's Emergency Mental Health Screening Unit for youth is located in zip code 91911 – this is the primary route for youth entering inpatient services

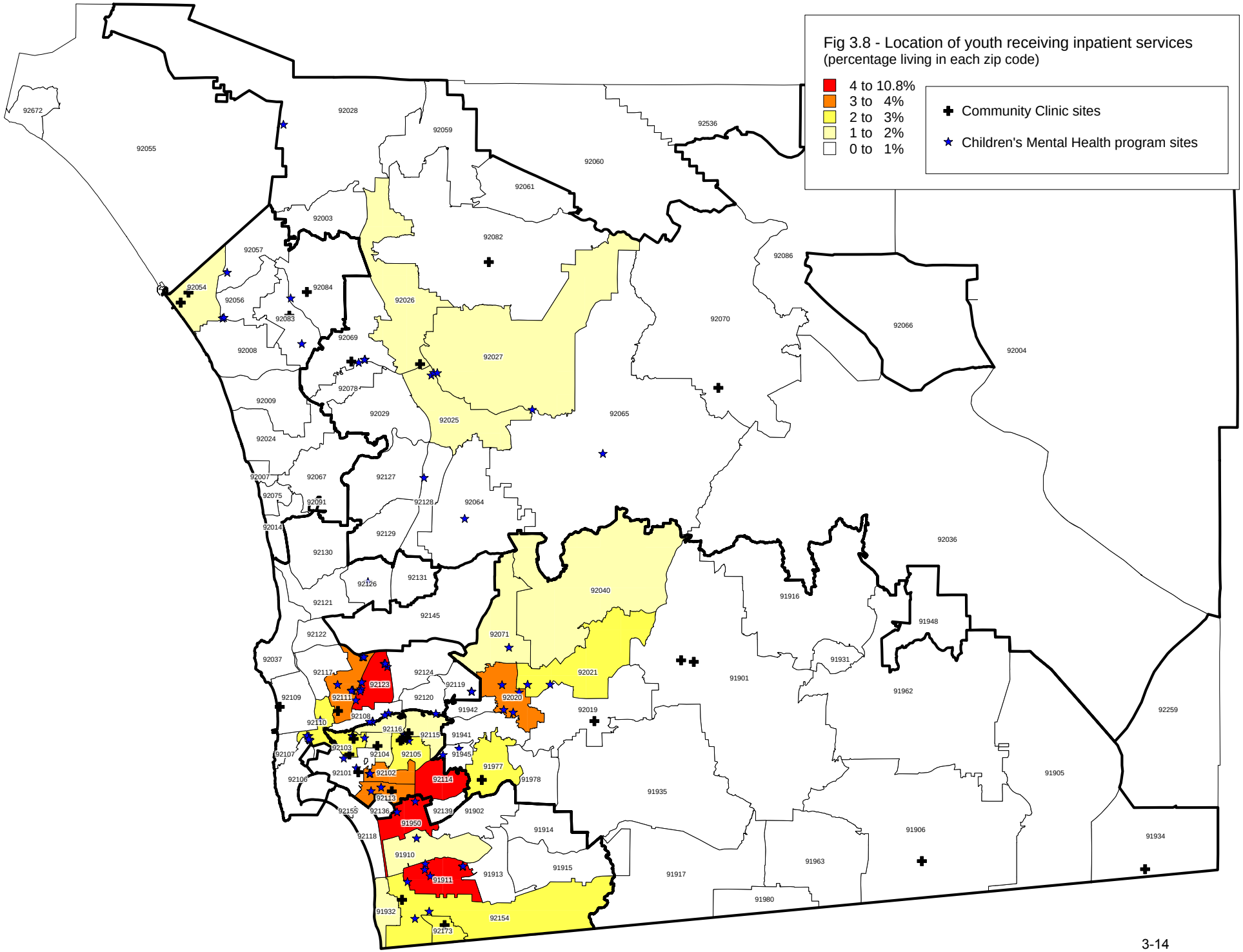


Fig 3.8 - Location of youth receiving inpatient services
(percentage living in each zip code)
4 to 10.8%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Community Clinic sites
Children's Mental Health program sites
92672
92028
92059
92536
92055
92060
92061
92003
92082
92057
92086
92054
92056
92084
92026
92083
92070
92066
92008
92069
92004
92027
92078
92009
92029
92025
92065
92024
92007
92067
92127
92075
92091
92128
92064
92014
92129
92036
92130
92131
92126
92040
91916
92121
92145
91948
92122
92071
92037
92117
92124
92021
91931
92123
92119
91901
92109
92111
92120
92020
91962
92108
92019
92259
92110
92116
92115
91941
92103
92104
92105
91945
92107
91977
91905
92101
92102
92114
91978
92106
92113
91935
92155
92136
92139
91902
91950
91914
91906
91934
92118
91910
91915
91963
91911
91913
91917
91932
91980
92154
92173

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 55% of the youth serviced by CMHS (refer to Figure 2.4), but 79% of youth with at least one inpatient episode (**Figure 3.9**). There were only six inpatient episodes for youth under age 6 and three episodes 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 2.3), but females are more likely to have accessed inpatient services (**Figure 3.10**).

Figure 3.9: Inpatient Episodes by Age

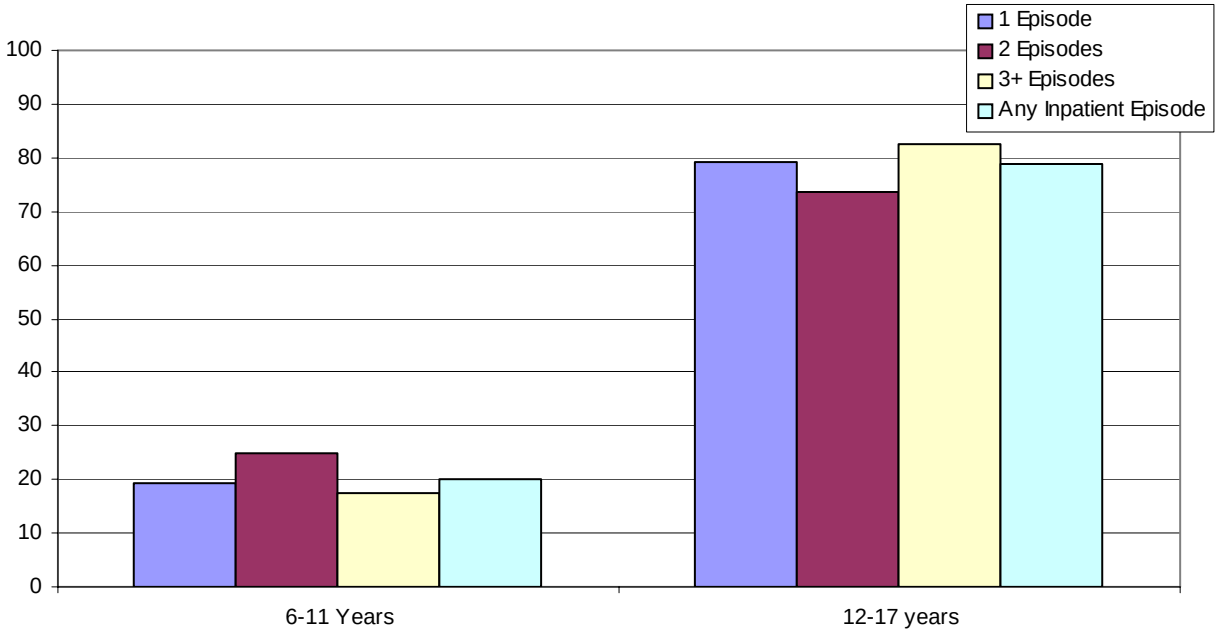
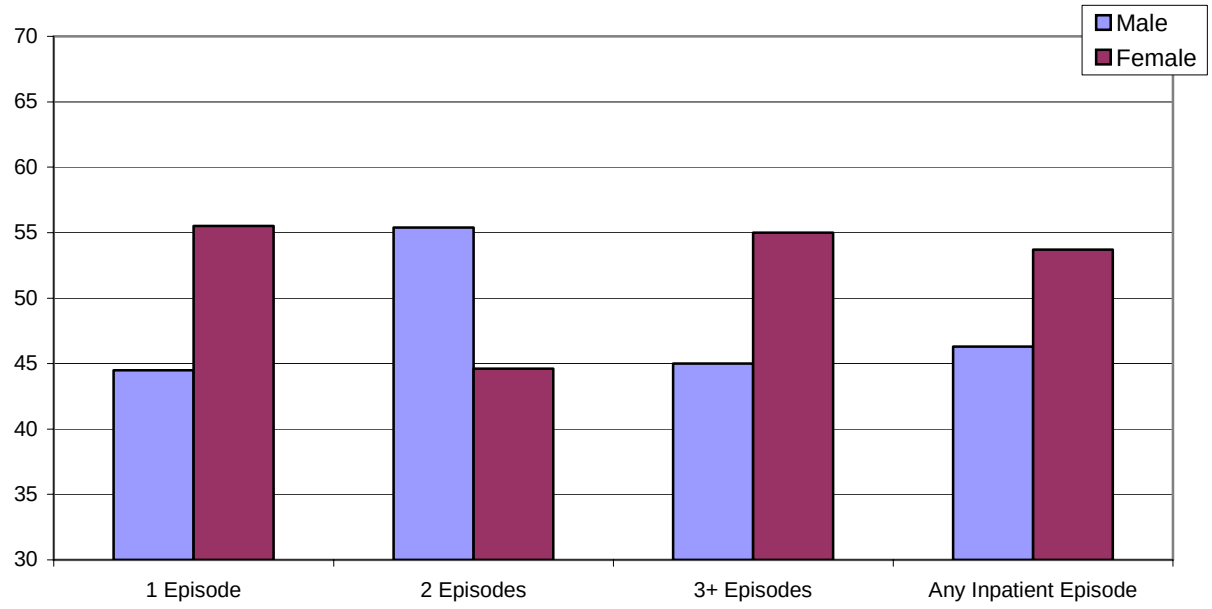
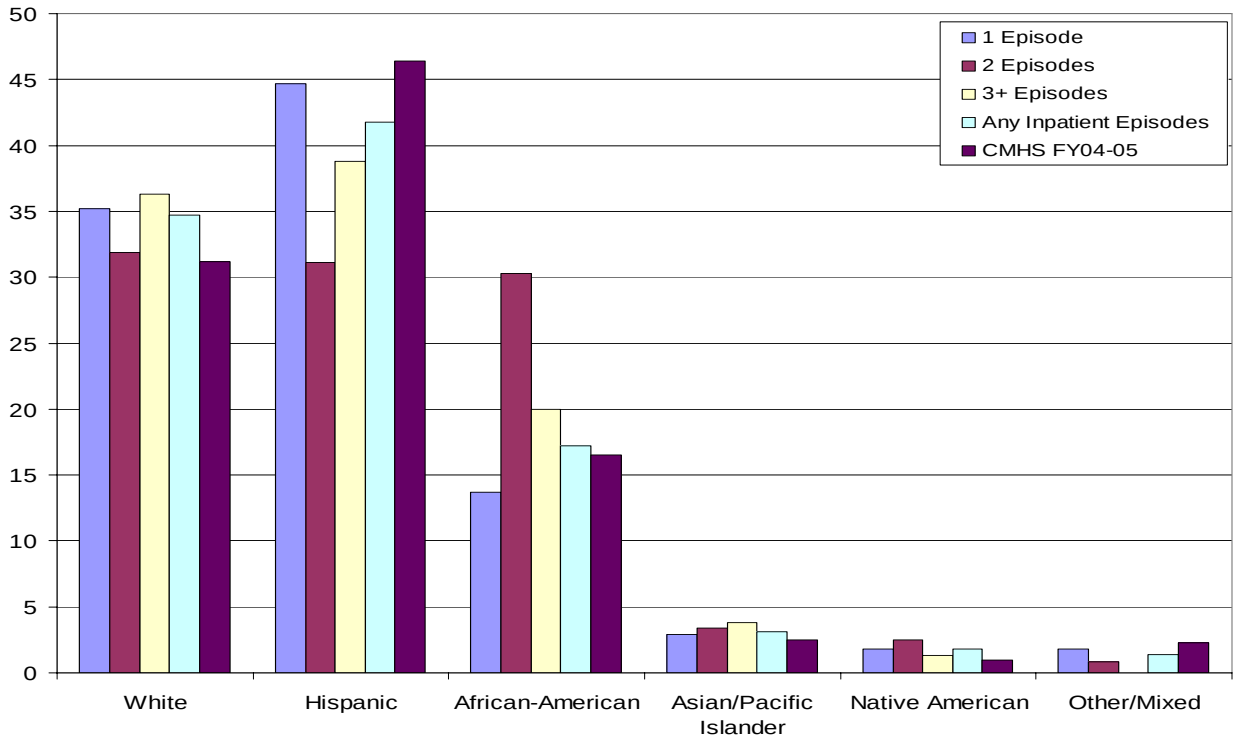


Figure 3.10: Inpatient Episodes by Gender



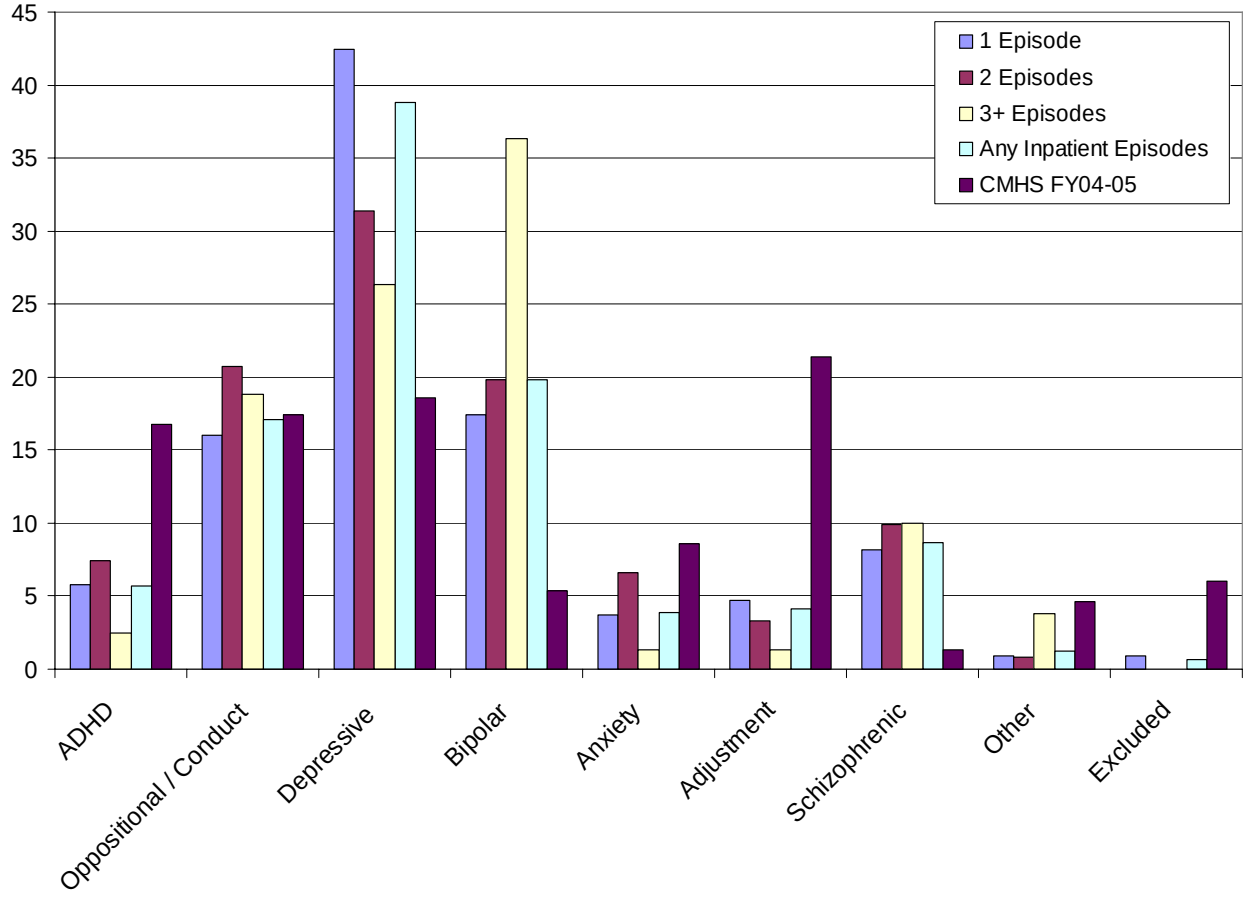
When child's race/ethnicity is examined in relation to use of inpatient services, there is little difference between **any use** of inpatient services and the racial/ethnic make-up of the total CMHS population (refer to the last two bars, "Any Inpatient Episodes" and "CMHS FY04-05", in **Figure 3.11**). One significant patterns emerges, though, when the **number** of inpatient episodes is examined (first three bars in Figure 3.11): **African-American children are overrepresented among those with two inpatient admissions** (30% of those with 2 inpatient episodes as compared to 17% of the CMHS population), and Hispanic youth are similarly underrepresented.

Figure 3.11: Inpatient Episodes by Child's Race/Ethnicity



The use of inpatient services also varies widely by diagnosis, but according to expected patterns (**Figure 3.12**). First, **youth with a primary diagnosis of depressive, bipolar, or schizophrenic disorders are using inpatient services are rates much higher than their prevalence in the overall CMHS population**. For example, youth with a depressive diagnosis make up about 19% of the CMHS population, but compose 39% of youth with an inpatient admission. Similar overrepresentation is seen for bipolar (5% overall and 20% of inpatient) and schizophrenic (1% overall and 9% of inpatient) diagnoses. Several diagnoses are underrepresented, including adjustment disorders (21% overall and 4% of inpatient) and excluded diagnoses (6% overall and 1% of inpatient).

Figure 3.12: Inpatient Episodes by Primary Diagnosis



Finally, the use of less restrictive services by children with inpatient admissions during FY04-05 was examined. Ninety-two percent of children with an inpatient episode in FY04-05 had also used outpatient services during the year. Over 88% of youth with an inpatient admission had utilized Medi-Cal funding during the year, while 18% 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 and/or received more days or minutes of service in each delivery mode, compared to children in the general CMHS population. The largest differences were, not surprisingly, in the crisis stabilization and crisis services modes.

Inpatient Service Use Summary

- About 4% of the CMHS population used inpatient services in FY04-05.
- Over 75% 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.
- 39% 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	Median Days		Mean Days	Median Days		Mean Days	Median Days		Mean Days	Median Days
Inpatient Use	**100%**	13.5	8	**18.6%**	91.7	80	**11.7%**	*32.9*	15.5	**18.4%**	1.2	1
CMHS FY04-05	4.3%	13.5	8	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

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	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins
Inpatient Use	60.4%	**1091.7**	480	**54.5%**	**1684.7**	511	66.2%	**342.8**	230	**52.0%**	**419.1**	280
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.8	180

	Medication Support			Therapy			TBS		
		Mean Mins	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins
Inpatient Use	**59.0%**	**481.5**	300	69.6%	**1054.8**	705	**9.4%**	4995.6	4379
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

Chapter 4: Client Outcomes on the Child and Adolescent Measurement System (CAMS)

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 October 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 is reported below; results of the FCBS are reported in Chapter 10. Copies of the CAMS measures are included at the end of this chapter.

In order to examine client outcomes, two data points are necessary. The CAMS (developed by Ann Doucette, Ph.D. and Leonard Bickman, Ph.D., of Vanderbilt University) is administered to youth, ages 11 and older, and all caregivers at Intake (start of services) and then repeated periodically to assess progress. Finally, it is repeated again at discharge from services. The CAMS assesses a child's competencies, behavior, and emotional problems, according to the youth and caregiver report, and examines the following domains:

- Symptomatology-Behavioral Functioning: Symptom severity for attention deficit hyperactivity disorder, conduct disorder, oppositional behavior disorder, anxiety, and depression, as well as youth functioning at home, in school, with peers, and in social activities. This domain can be divided into Internalizing and Externalizing behaviors.
- Social Competence: Areas of strength for youth.
- Acuity: The need for urgent care based on harmful behavior toward self or others.
- Functional Impairment: The frequency with which a client's behavior causes problems for them in different settings and how long a client has had problems.
- Hopefulness: Sense of hope for the future (since it has been found to be an important aspect of resilience). Note: This scale is only on the Youth version of the CAMS.

Given that most programs did not begin using the CAMS until January 2005, and the fiscal year ended on June 30, 2005, there are a limited number of clients who had two CAMS data points collected in FY04-05, as the entire time period is only 6 months. However, we can look at preliminary results from the relatively small number of client with 2 data points. The majority of these were receiving wraparound services, which began using the CAMS in October 2004, allowing for more youth with 2 datapoints.

Figure 4.1 shows the change in CAMS scores as reported by the caregiver for those youth with both an Intake and 6 Month CAMS in FY04-05 (N=107). Caregivers reported significant improvements in CAMS scores on all domains ($p<0.05$). Note: a decrease in Internalizing and Externalizing behaviors is considered an improvement, while an increase in Social Competence is considered an improvement.

Figure 4.1. Caregiver Report of CAMS scores – Change between Intake and 6 Months

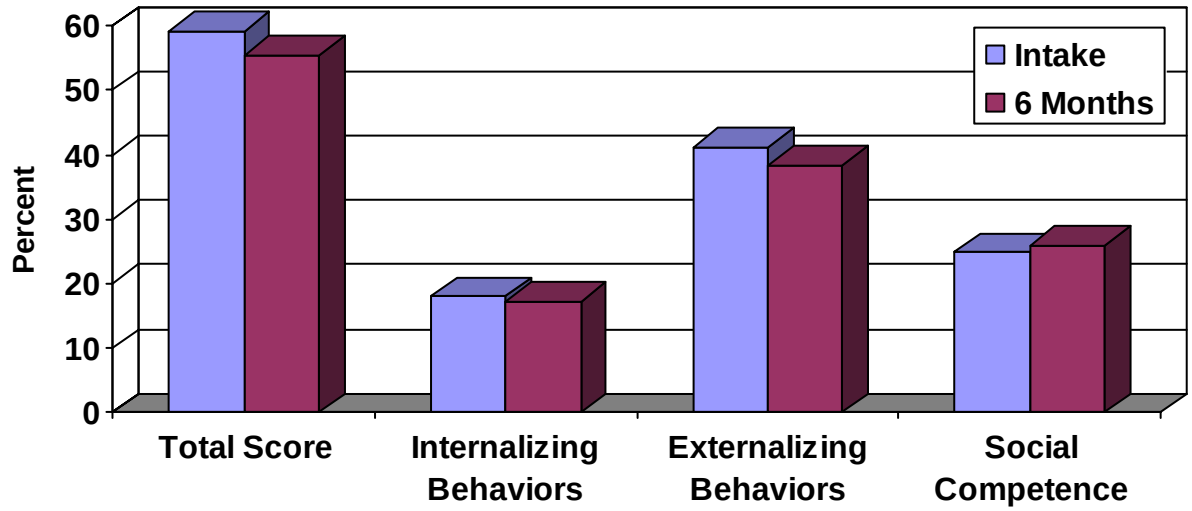
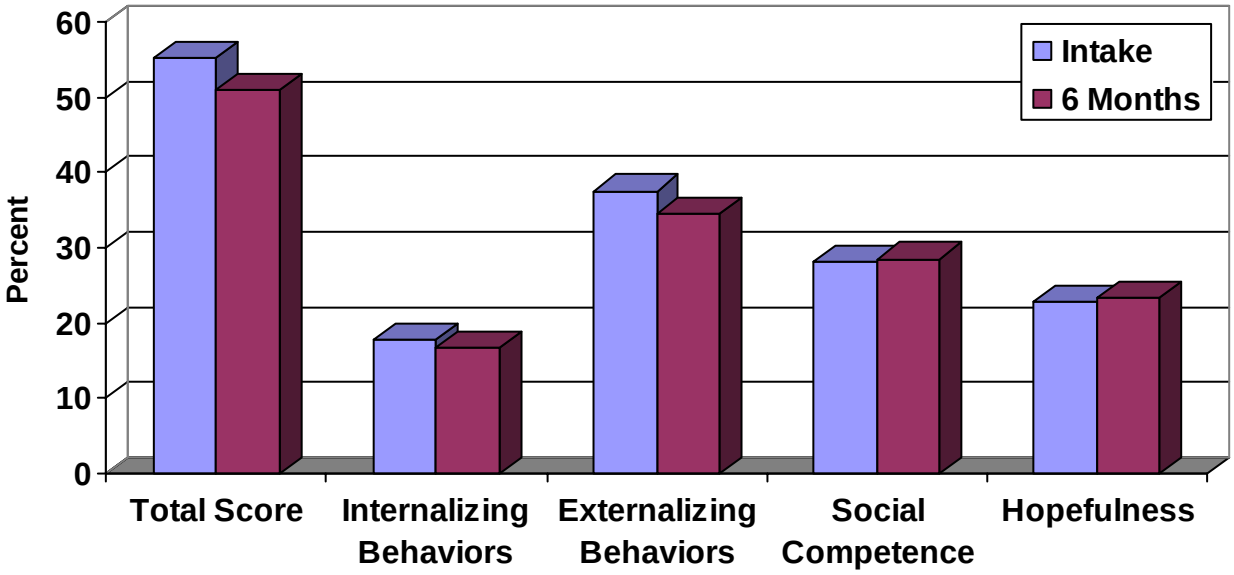


Figure 4.2 shows the change in CAMS scores as reported by youth with both an Intake and 6 Month CAMS in FY04-05 (N=59). Youth reported significant improvements on the Symptom Behavior domain ($p<0.05$). Improvement was seen on the Social Competence and Hopefulness scales as well, although it was not significant. Note: a decrease in Internalizing and Externalizing behaviors is considered an improvement, while an increase in Social Competence and Hopefulness is considered an improvement.

Figure 4.2 Youth Report of CAMS Scores – Change between Intake and 6 Months



In summary, this preliminary information shows that youth receiving mental health services are improving over time, although the number of youth with two data timepoints is very limited. In FY0506, a much larger sample will be available, and we will be able to examine changes over time in more detail.

Chapter 5: 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 FY04-05, the programs providing wraparound intensive case management services underwent a transition, with several programs ending in the fall of 2004 [Community Intensive Treatment for Youth (CITY), Building Effective Solutions Together (BEST), and the Child, Youth and Family Network (CYFN)]. A new program, Families Forward, was contracted in September 2004 to deliver services as part of 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. 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 in FY04-05 were served by Families Forward.

In all, **275 youth received wraparound services during FY04-05**. As expected, clients who receive wraparound services are different from the average CMHS client. Approximately 65% of wraparound clients are between the ages of 12 and 17 (**Figure 5.1**) and over two-thirds are male (**Figure 5.2**).

Figure 5.1: Age Distribution for Youth Receiving Wraparound Intensive Case Management Services

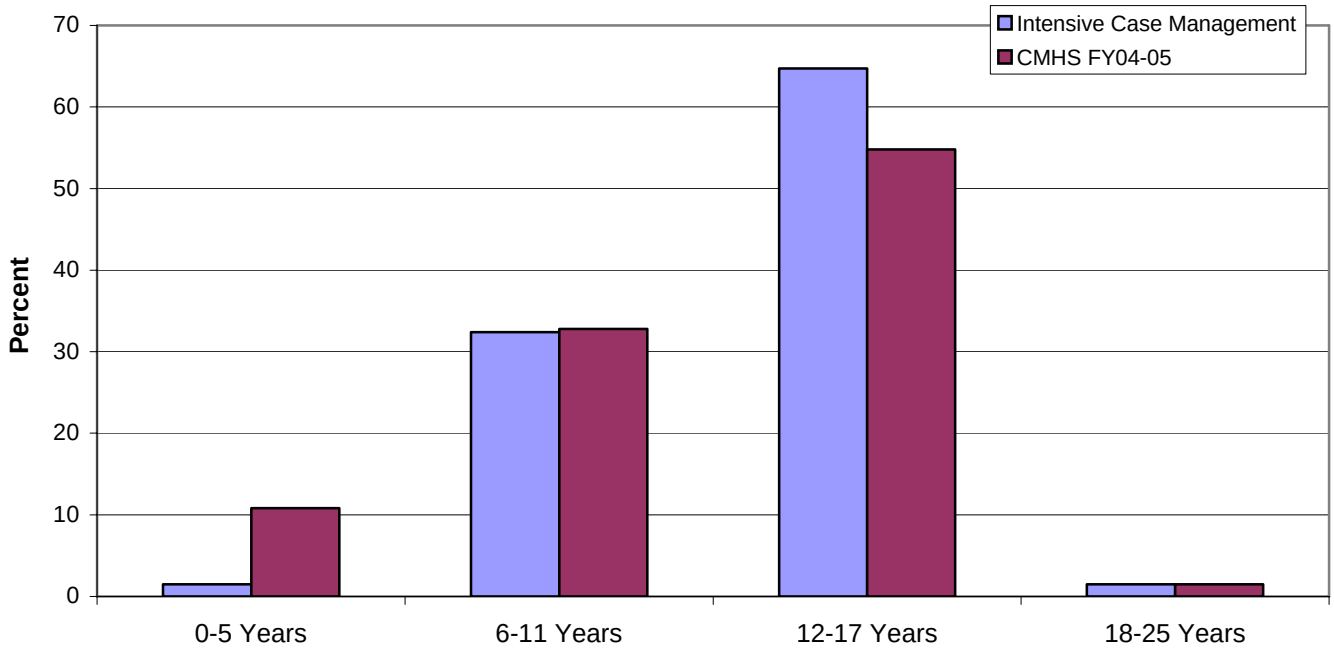
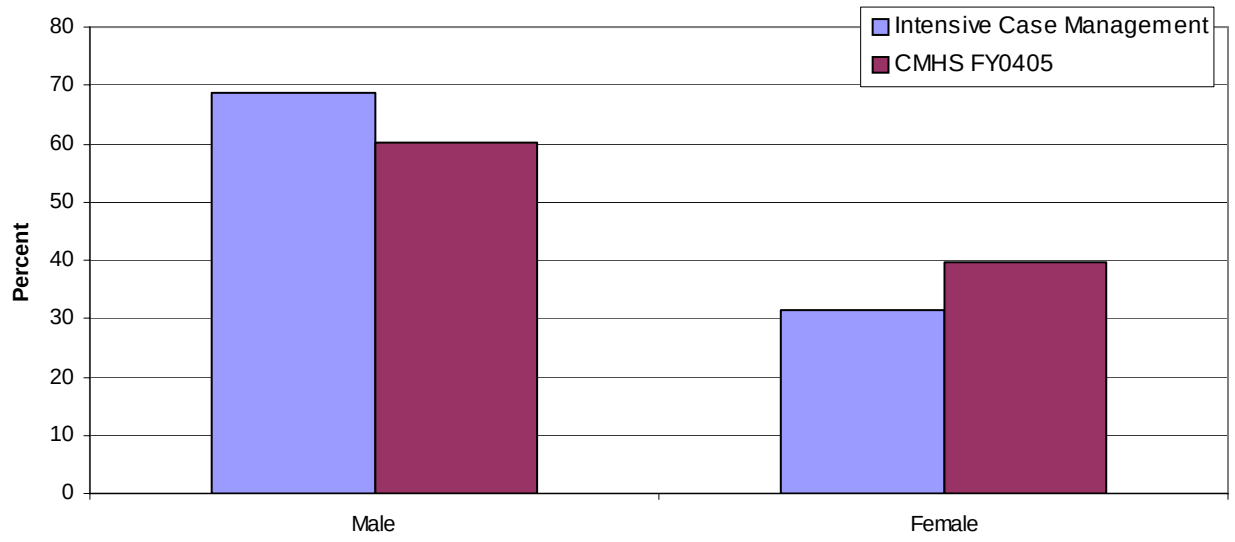
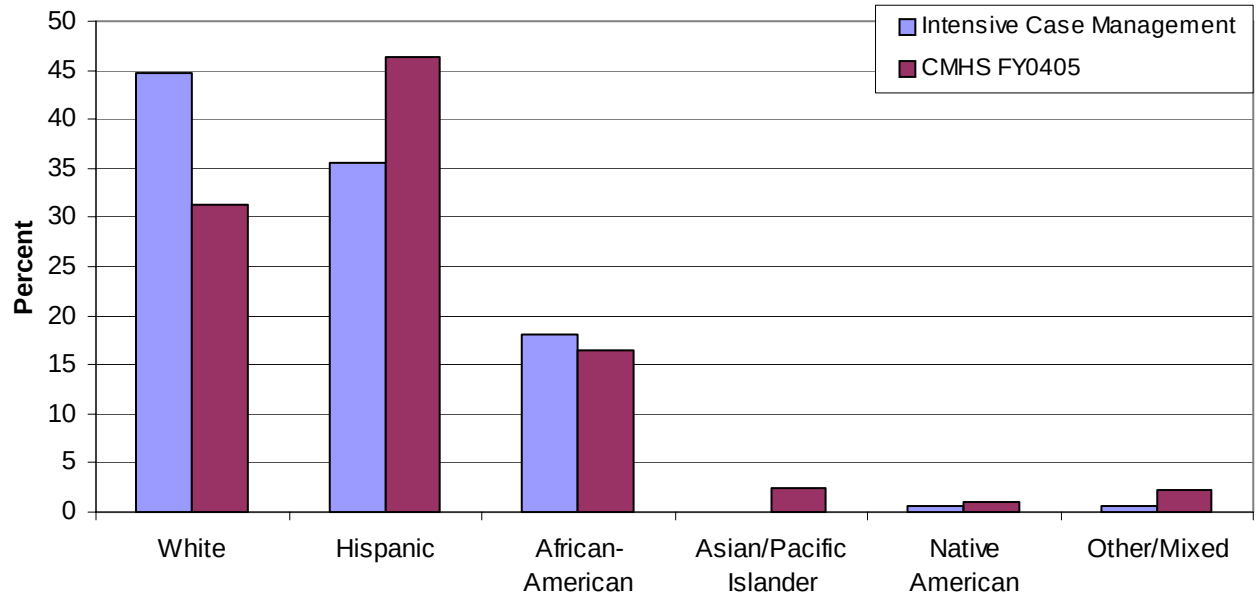


Figure 5.2: Gender Distribution for Youth Receiving Wraparound Intensive Case Management Services



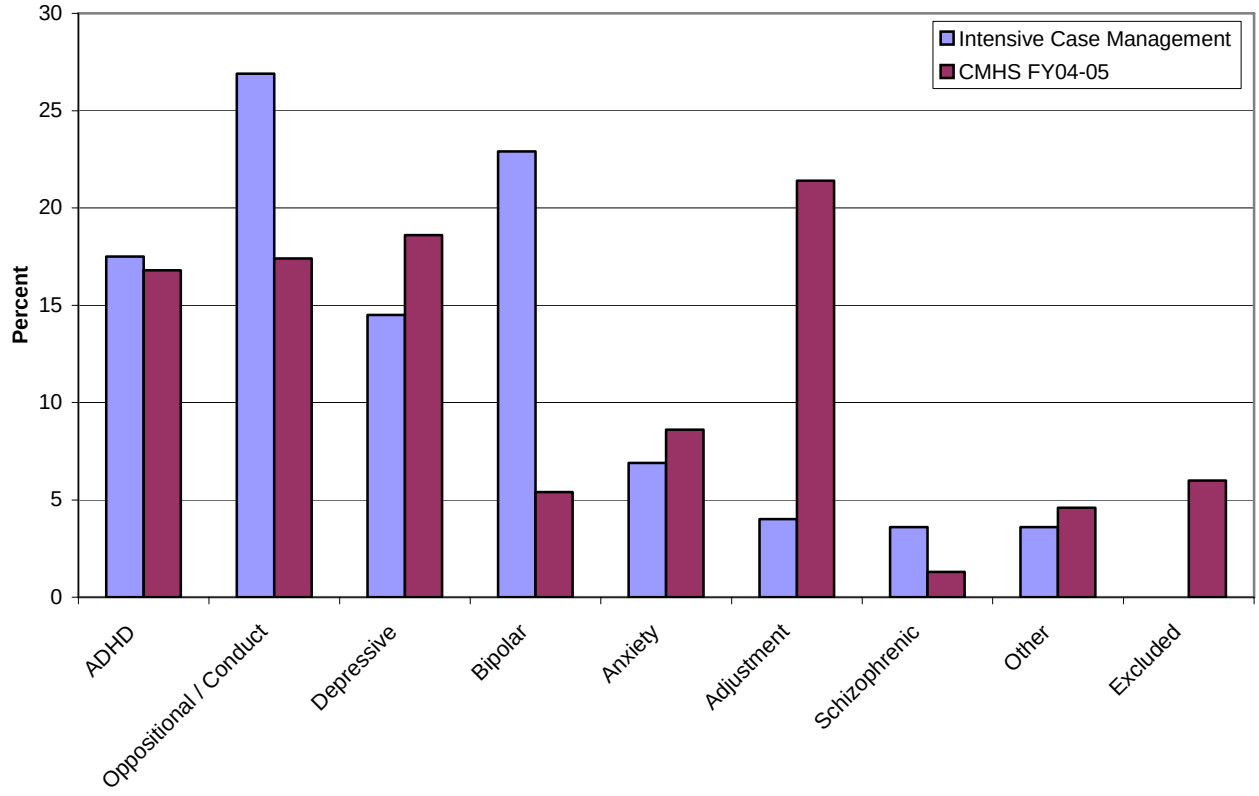
Racial/ethnic differences are present between these two populations as well, with White youth making up 45% of the population receiving wraparound services in FY04-05, as compared to 31% of the overall CMHS population (**Figure 5.3**). Hispanic youth are underrepresented, composing 36% of the wraparound sample as compared to 46% of the overall CMHS sample. No Asian / Pacific Islander youth received wraparound services during FY04-05.

Figure 5.3: Race/Ethnicity of Youth Receiving Wraparound Intensive Case Management Services



There are several differences in primary diagnosis between youth receiving wraparound services and the general CMHS population (**Figure 5.4**). Over one quarter of youth receiving wraparound services have a primary diagnosis of an Oppositional or Conduct disorder, a much higher rate than that in the general CMHS population (27% vs. 17%). In addition, while adjustment disorders are the most common (21%) diagnosis in the overall CMHS population, only 4% of youth in the wraparound sample have a primary diagnosis of an adjustment disorder. A much larger percentage of youth in the wraparound sample have a primary diagnosis of a bipolar disorder: 23% as compared to 5% in the overall CMHS population. Finally, youth receiving wraparound services are over twice as likely as those in the overall sample to have a primary diagnosis of schizophrenia.

Figure 5.4: 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 five times more likely to have received inpatient hospital services during FY04-05 than youth in the overall CMHS population** (**Table 5.1**). Wraparound clients were also four times more likely to have used crisis stabilization services during the year. Finally, they were six times more likely to have received intensive day treatment services, although there was no difference in the use of day rehabilitation services. It should be noted that these are services the youth received during the fiscal year, and not necessarily while the youth was receiving wraparound services. For example, a youth may have been in an inpatient setting and then transitioned to wraparound services when they returned home.

There were also significant differences between the wraparound and overall CMHS populations for outpatient services in FY04-05 (**Table 5.2**). These differences were expected, given that wraparound services are meant to be an alternative to out of home or restrictive setting placement. **Over 95% of youth in the wraparound sample utilized collateral services during the year, a 35% increase over the general CMHS population**. In addition, they utilized almost seven times as many minutes of collateral services on average. As expected, Wraparound youth were three times as likely as general population youth to have received case management services and utilized almost six 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, assessments, and TBS. Finally, although wraparound youth received therapy services at a rate similar to that of general population youth, they received more minutes of therapy service on average.

Intensive Case Management Summary

- Two thirds of the intensive case management sample in FY04-05 are adolescents.
- Over two-thirds of the sample are 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, ADHD, and depressive disorders.
- As expected, youth receiving intensive case management services during FY04-05 were more likely than youth in the general CMHS population to have used most forms of restrictive and outpatient services during the year.

Table 5.1. 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	Median Days		Mean Days	Median Days		Mean Days	Median Days		Mean Days	Median Days
Intensive Case Management	**8.7%**	12.7	11	**35.6%**	**115.8**	115.5	10.9%	42.8	21	**7.3%**	1.2	1
CMHS FY04-05	1.7%	13.0	7	5.6%	90.5	76	9.0%	47.4	17	1.8%	1.2	1

Table 5.2. 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	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins
Intensive Case Management	**95.6%**	**3723.8**	2915	**99.3%**	**4870.5**	4050	**88.4%**	**494.9**	400	**24.7%**	**442.2**	260
CMHS FY04-05	60.2%	534.5	250	33.5%	821.9	145	63.3%	227.0	180	8.6%	280.1	180

	Medication Support			Therapy			TBS		
		Mean Mins	Median Mins		Mean Mins	Median Mins		Mean Mins	Median Mins
Intensive Case Management	**77.8%**	**533.1**	361.5	79.6%	**1270.7**	1034	**15.6%**	5718.4	5005.0
CMHS FY04-05	35.2%	265.5	150	73.9%	1004.8	705	1.6%	5024.4	4344.5

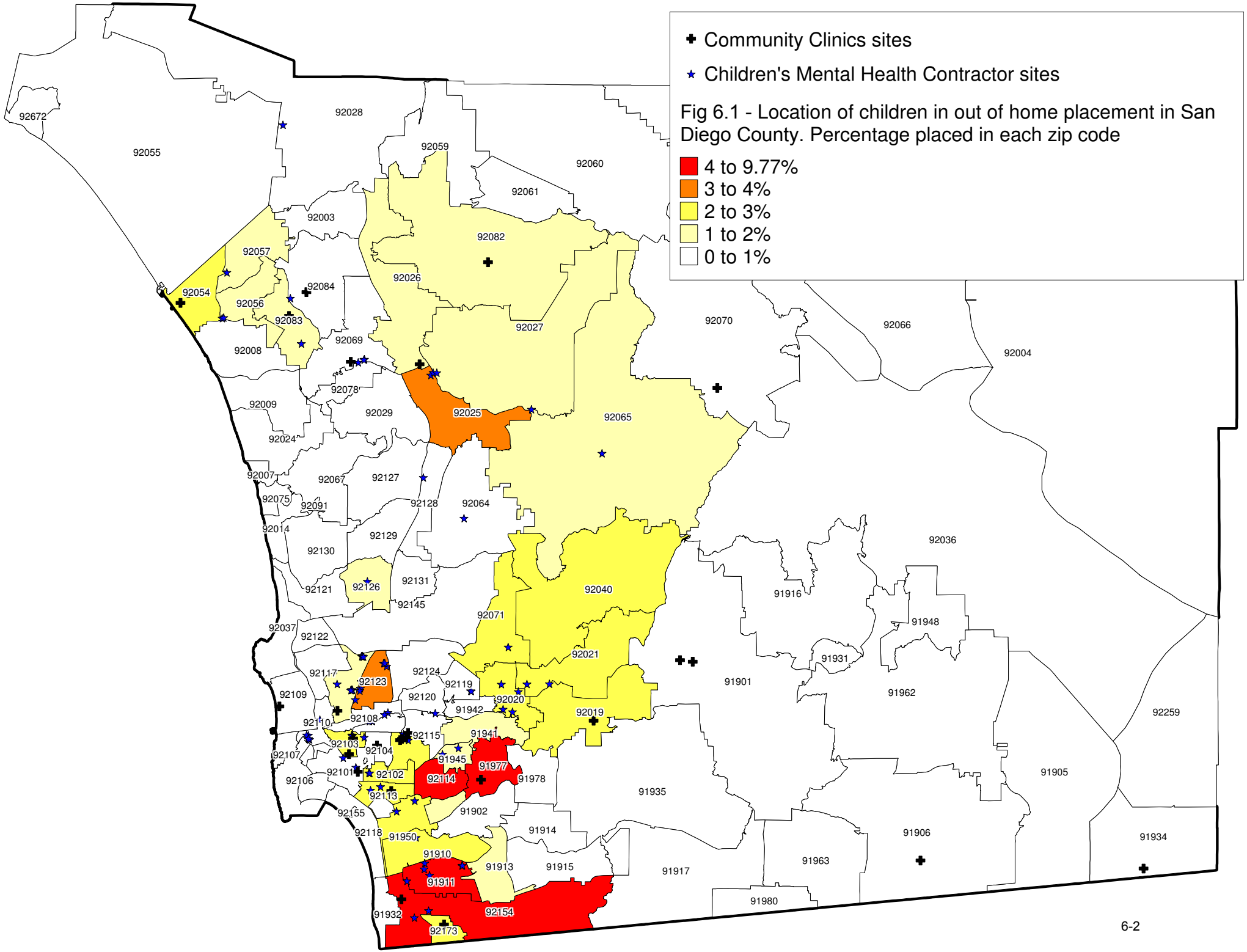
Chapter 6:
Service Utilization by Children with Open Child Welfare Cases

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.

Youth who are removed from their homes and placed in out of home care through the CWS are often considered to have the most significant mental health needs. An analysis of where these children are located in the county was completed as part of the MHSA gap analyses. **Figure 6.1** shows the zip codes with the largest percentages of **youth in out of home care in 2005**. 9.8% of children in foster care are placed in the 92114 zip code (Encanto). Other areas with high percentages of youth in placement through the CWS include 91911 (Chula Vista) - 5.6%, 92154 (Nestor) - 5.4%, and 91977 (Spring Valley) - 4.9%.

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 FY04-05 was obtained and compared to the CMHS dataset. In FY04-05, 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, 32.2% of youth with open Child Welfare cases in FY04-05 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 6.2**) and the ratio of male to female clients (**Figure 6.3**) is more even and similar to that of the San Diego County youth population as a whole (refer to Chapter 2, Figure 2.4), as well as the overall Child Welfare population.


Community Clinics sites
Children's Mental Health Contractor sites
Fig 6.1 - Location of children in out of home placement in San Diego County. Percentage placed in each zip code
4 to 9.77%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
92672
92028
92055
92059
92060
92061
92003
92082
92057
92026
92084
92054
92056
92083
92027
92070
92066
92004
92008
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92067
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92064
92014
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91948
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92173
6-2

Figure 6.2: Age Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services

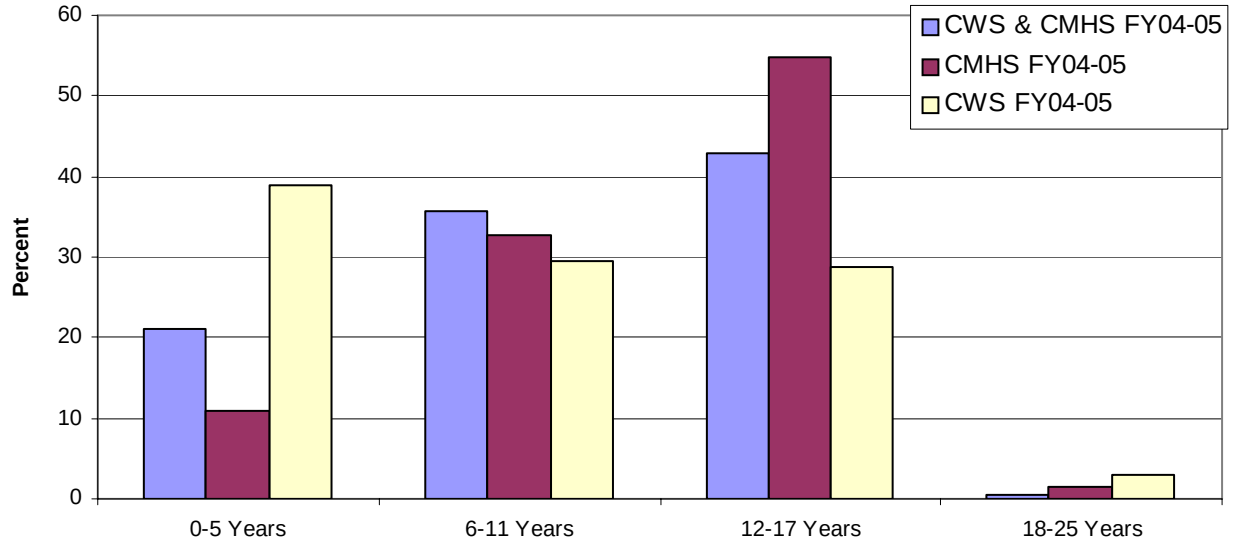
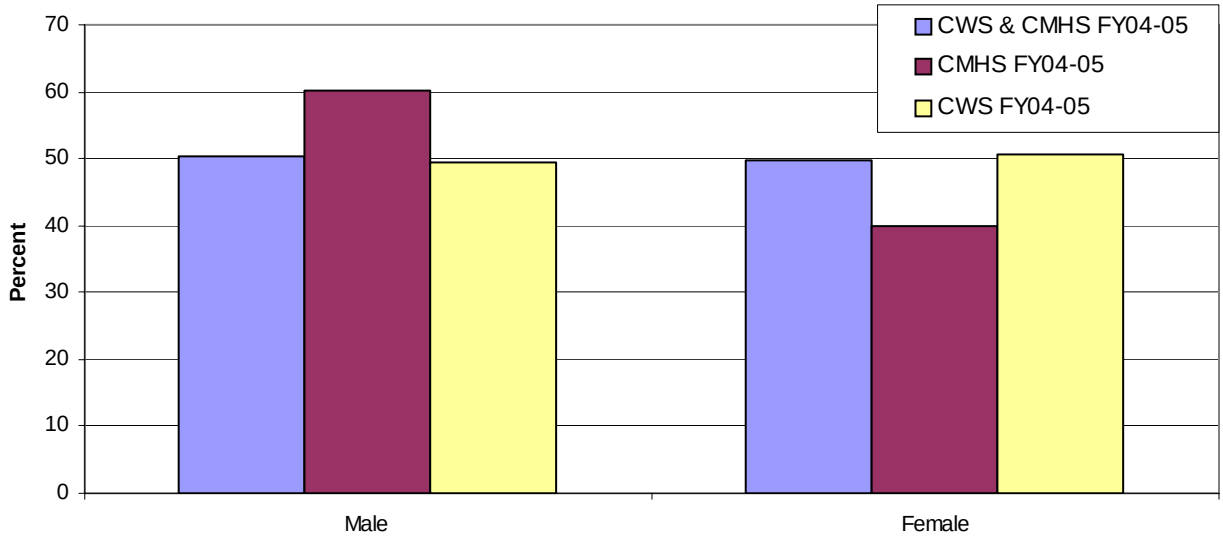
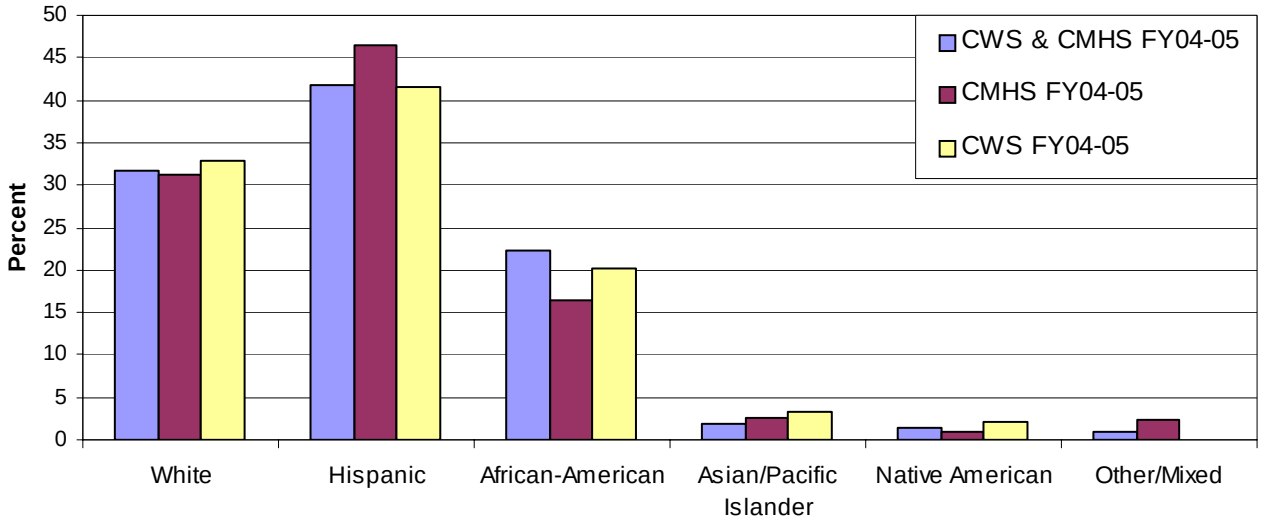


Figure 6.3: Gender Distribution for Youth with Open Child Welfare Cases who are receiving CMHS Services



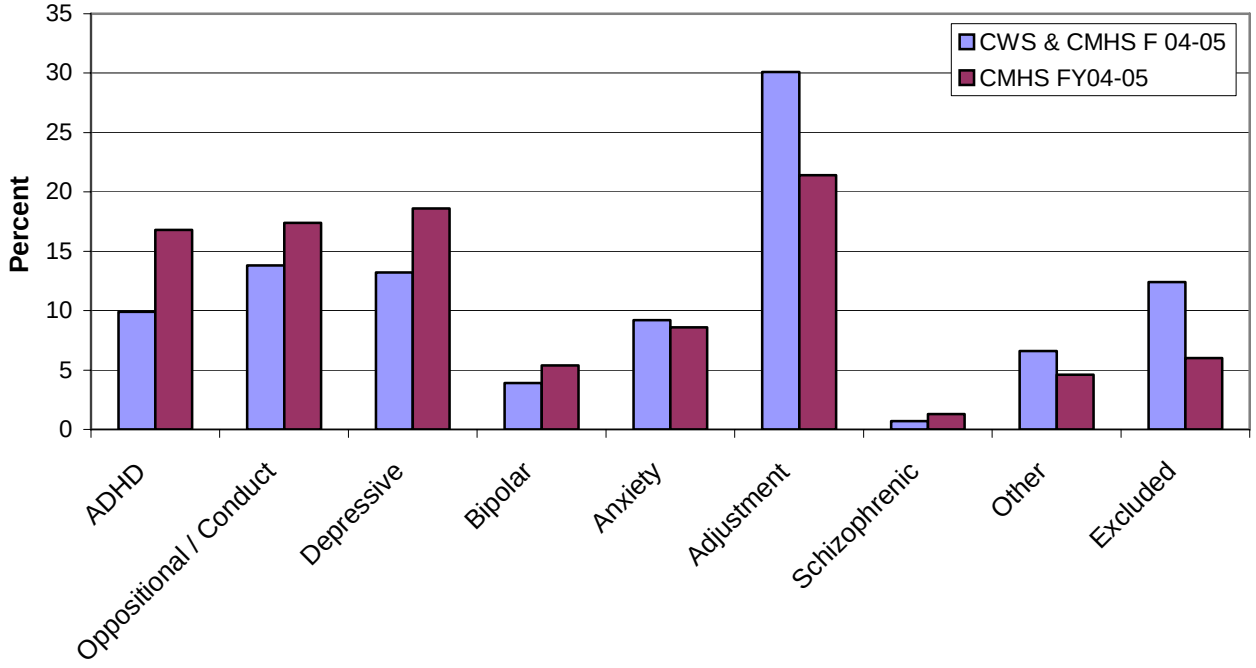
The racial/ethnic distribution for children receiving child welfare and mental health services (**Figure 6.4**) mirrors that of the overall CMHS population with two exceptions: there are proportionally fewer Hispanic youth and more African-American youth in the CWS-CMHS sample, compared to the overall CMHS population. As with gender, the racial/ethnic distribution is similar to that of the overall CWS population.

Figure 6.4: 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 FY04-05 (**Figure 6.5**). Children open to the CWS in FY04-05 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 6.5: 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 6.1 and 6.2**) shows that they are over twice as likely to receive intensive day treatment (9.5% vs. 4.5%) or day rehabilitation services (19.7% vs. 7.3%) 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 1866 minutes vs. mean of 809 minutes). In addition, they were more likely to have received Assessment or TBS services than youth active to the CMHS alone.

Child Welfare Services Summary

- The sample is younger than the overall CMHS sample.
- The male to female ratio is close to 50:50 and is more balanced than the ratio in the overall CMHS sample.
- 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, day rehab, assessment and TBS than youth in the overall CMHS population.

Table 6.1. 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	Med Days		Mean Days	Med Days		Mean Days	Med Days		Mean Days	Med Days
CWS & CMHS	1.6%	13.5	8	**9.5%**	88.5	70	**19.7%**	45.2	13	1.2%	1.4	1
CMHS FY04-05	1.7%	13.0	7	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

Table 6.2. 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	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CWS & CMHS	44.5%	499.3	150	30.3%	**1266.6**	398.5	**73.1%**	216.0	180	7.7%	**329.2**	165
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.8	180

	Medication Support			Therapy			TBS		
		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CWS & CMHS	28.4%	**377.2**	195	62.9%	991.6	690	**2.4%**	5422.1	4471.5
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

Chapter 7:
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 difficulties 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.

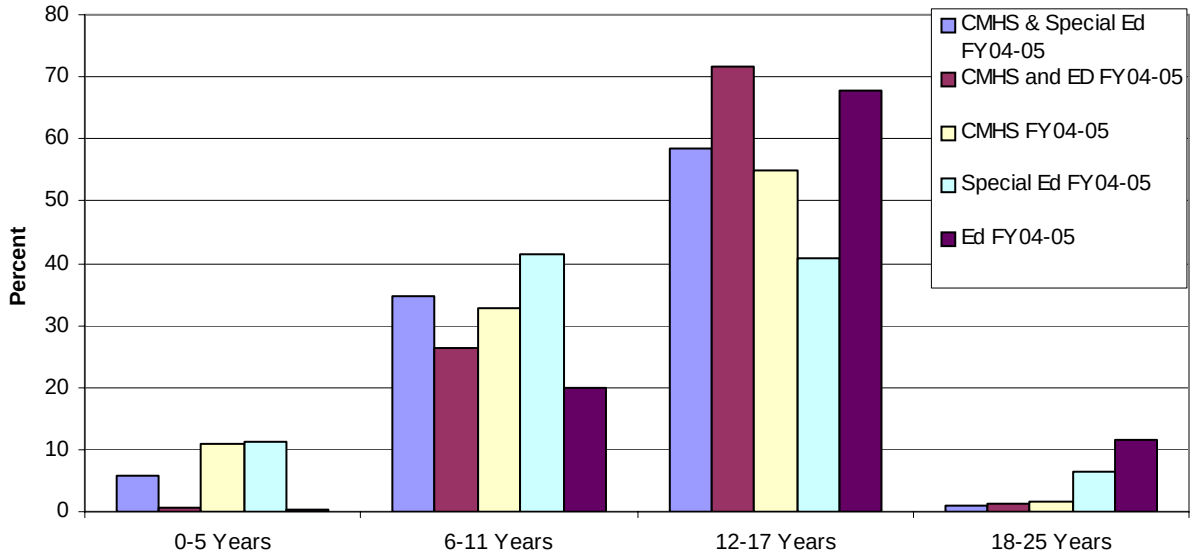
The **Education definition of Emotional Disturbance (ED)** is as follows: a condition exhibiting one or more of the following characteristics, over a long period of time and to a marked degree, that adversely affects educational performance:

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 with peers and teachers;
3. Inappropriate types of behavior or feeling under normal circumstances;
4. A general pervasive mood of unhappiness or depression; or
5. 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.

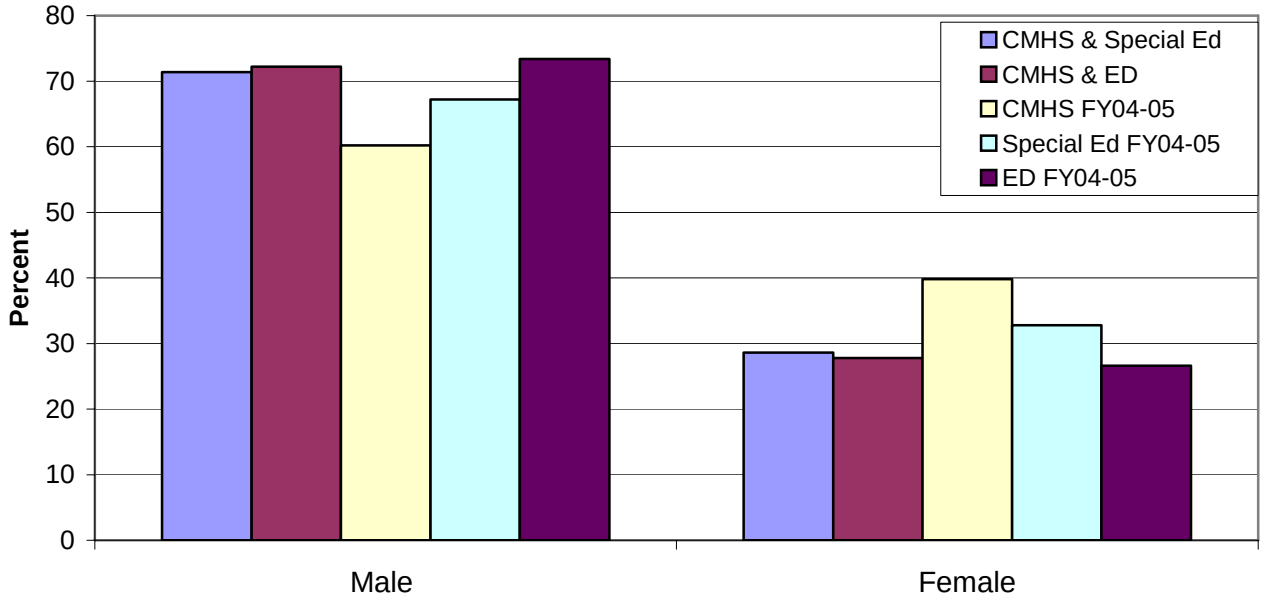
Using a dataset obtained through the six San Diego County Special Education Local Plan Areas (SELPAs) of all children receiving special education services, and identifying a subset receiving services under the ED eligibility category, an examination was made of those children concurrently served by CMHS. The **age** distribution for youth receiving both special education and mental health services overall (blue bar in figure below) is similar to that of the CMHS population as a whole (yellow bar), while youth receiving mental services that met the ED category requirements are more likely to be adolescents (**Figure 7.1**).

Figure 7.1: Age Distribution of Youth Receiving Special Education and Mental Health Services in FY04-05



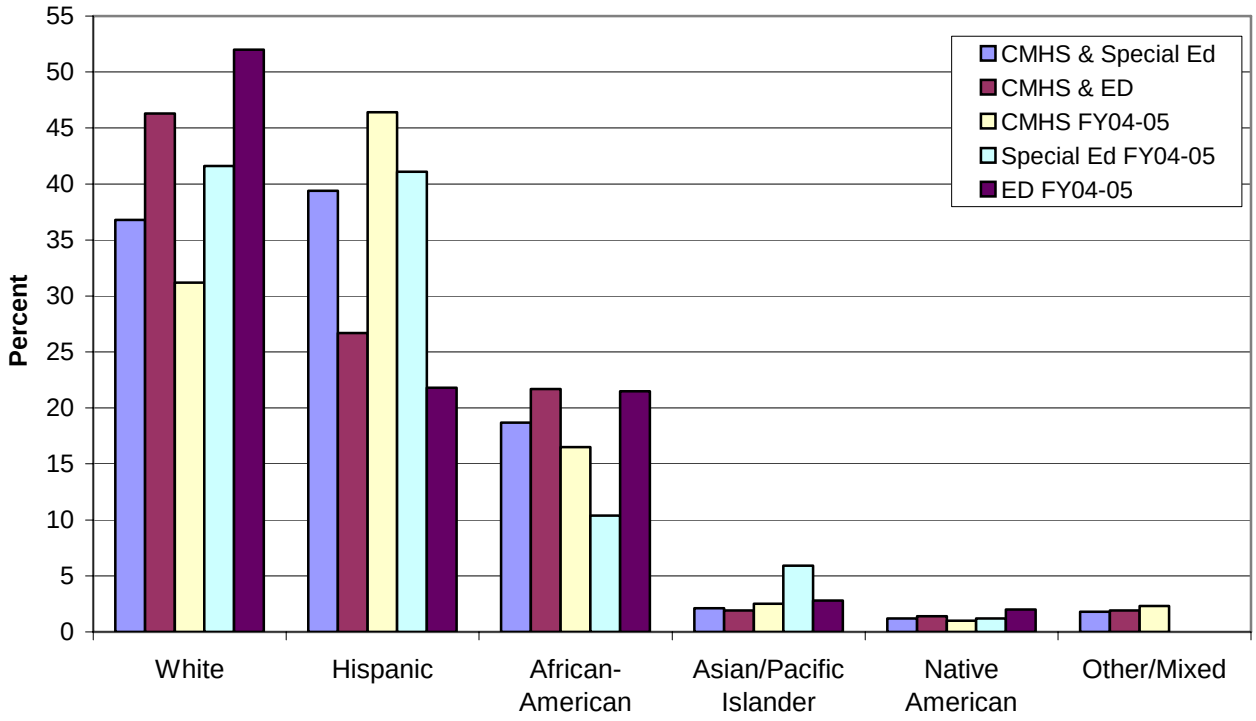
Among youth receiving mental health services in the ED category and overall special education services, male students are over-represented as compared to the CMHS population as a whole. In FY04-05, over 70% of the youth receiving special education and mental health services were male, as compared to slightly over 60% in the general CMHS population (**Figure 7.2**). These rates are comparable to those of Special Education and ED overall.

Figure 7.2: Gender Distribution of Youth Receiving Special Education and Mental Health Services in FY04-05



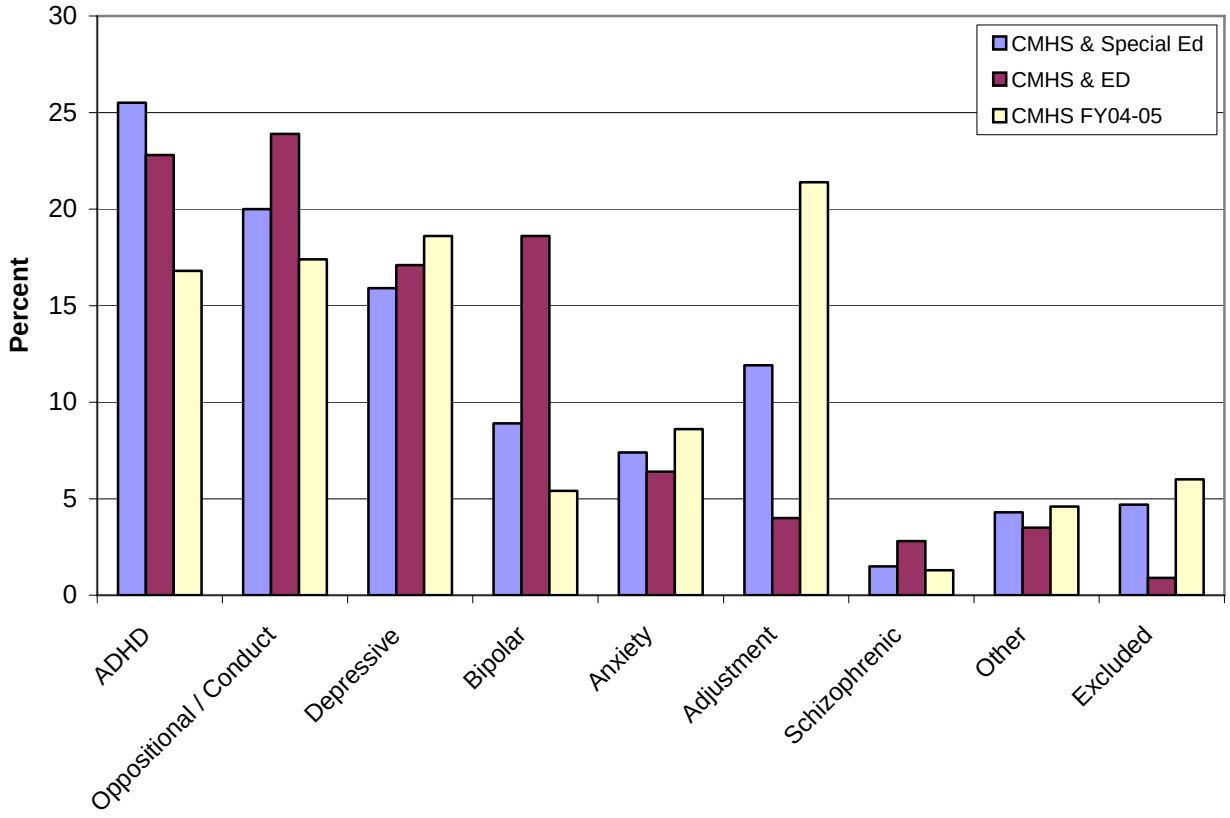
In terms of **race/ethnicity**, students in the overlapping special education-mental health services category are more likely to be White or African-American, and less likely to be Hispanic, as compared to the overall CMHS population (**Figure 7.3**). This is especially true for those youth receiving services through the ED category, where 46% of the students are White and 27% are Hispanic, as compared to 31% White and 46% Hispanic in the overall CMHS population. The racial /ethnic distributions of the Special Education and ED categories differs widely from that of the CMHS population was a whole, as can be seen in Figure 7.3. Youth receiving Special Education and/or ED services are more likely to be White, and less likely to be Hispanic, than youth receiving mental health services overall.

Figure 7.3: Race/Ethnicity of Youth Receiving Special Education and Mental Health Services in FY04-05



As shown in **Figure 7.4**, the top three **primary diagnoses** for special education are ADHD (25%), Oppositional / Conduct disorders, and Depressive Disorders, while for the ED group, the most common diagnoses are Oppositional / Conduct disorders (26%), ADHD, and Excluded diagnoses. Finally, although Adjustment disorders account for 21% of primary diagnoses in the CMHS population, they account for 12% of the general special education group and 1% of the ED group.

Figure 7.4: Primary Diagnosis for Youth Receiving Special Education and Mental Health Services in FY04-05



Youth receiving Special Education and Mental Health Services are more likely to **utilize services** across the board, with higher rates of service use and/or more time in service for each restrictive and outpatient delivery mode (**Tables 7.1 and 7.2**). 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. These patterns are consistent with the special education – mental health overlap data from FY03-04.

Special Education Services Summary

- Youth in the ED category are older than the overall CMHS population.
- Over 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.

Table 7.1. 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	Med Days		Mean Days	Med Days		Mean Days	Med Days		Mean Days	Med Days
CMHS & Special Ed	2.1%	15.7	9.0	**8.3%**	95.9	82.0	7.7%	50.8	23.0	1.6%	1.3	1.0
CMHS & ED	**3.8%**	**16.7**	9.5	**18.1%**	96.2	82	**11.2%**	**59.7**	34	**3.2%**	1.4	1
CMHS FY04-05	1.7%	13.0	7	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

Table 7.2. Use of Outpatient Services by Youth receiving Special Education Services
Blue = 20+% higher than CMHS

	Collateral			Case Mgmt / Rehab			Assessment			Crisis Services		
		Mean Mins	Med Min		Mean Mins	Med Min		Mean Mins	Med Min		Mean Mins	Med Min
CMHS & Special Ed	62.3%	**655.0**	290	**36.9%**	**1074.8**	219.5	57.7%	**279.2**	180	8.9%	316.8	180
CMHS & ED	**72.0%**	**874.5**	390	**54.1%**	**1358.9**	365	56.8%	**389.0**	280	**15.0%**	**358.9**	215
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.8	180

	Medication Support			Therapy			TBS		
		Mean Mins	Med Min		Mean Mins	Med Min		Mean Mins	Med Min
CMHS & Special Ed	**44.3%**	**308.8**	180	77.3%	1003.5	660	**2.3%**	5002.1	3890
CMHS & ED	**59.6%**	**396.8**	265	75.4%	**1177.9**	886	**4.1%**	5245.4	3879
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

Chapter 8:
Service Use by Youth Receiving Probation Services

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 active to Probation during FY04-05. Overall, **14.3% of youth who received CMHS services in FY 04-05 were also active to Probation during the year.** 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 8.1 and 8.2**).

Figure 8.1: Gender distribution for youth active to CMHS and Probation

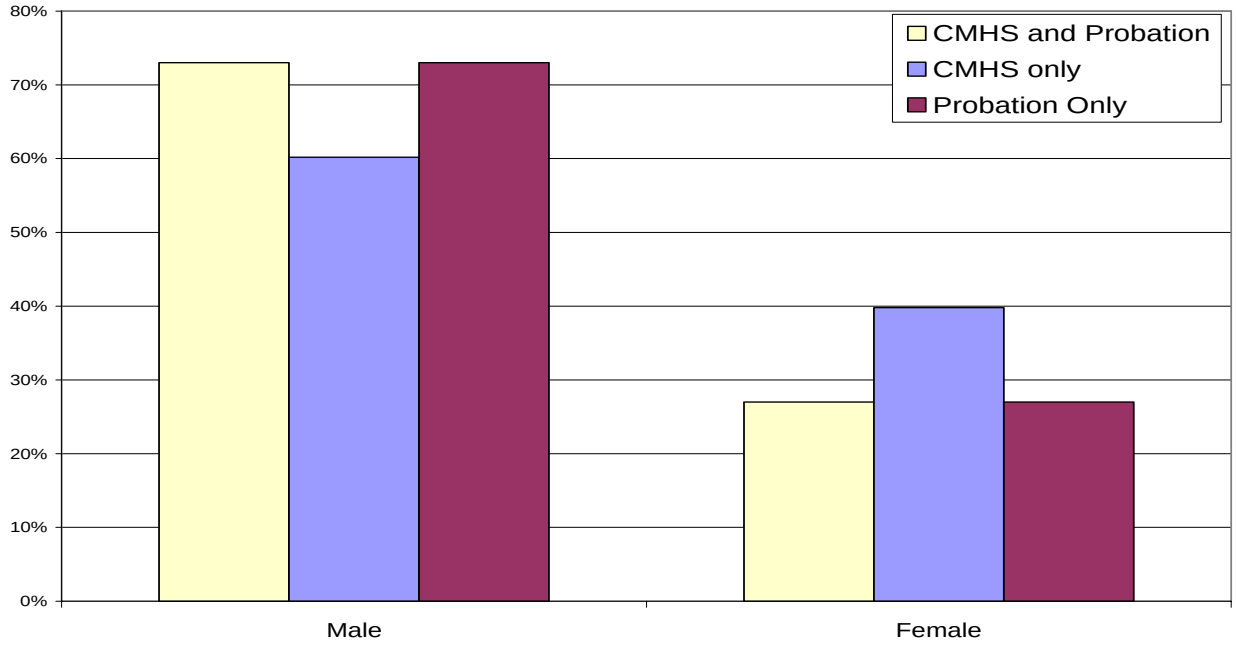
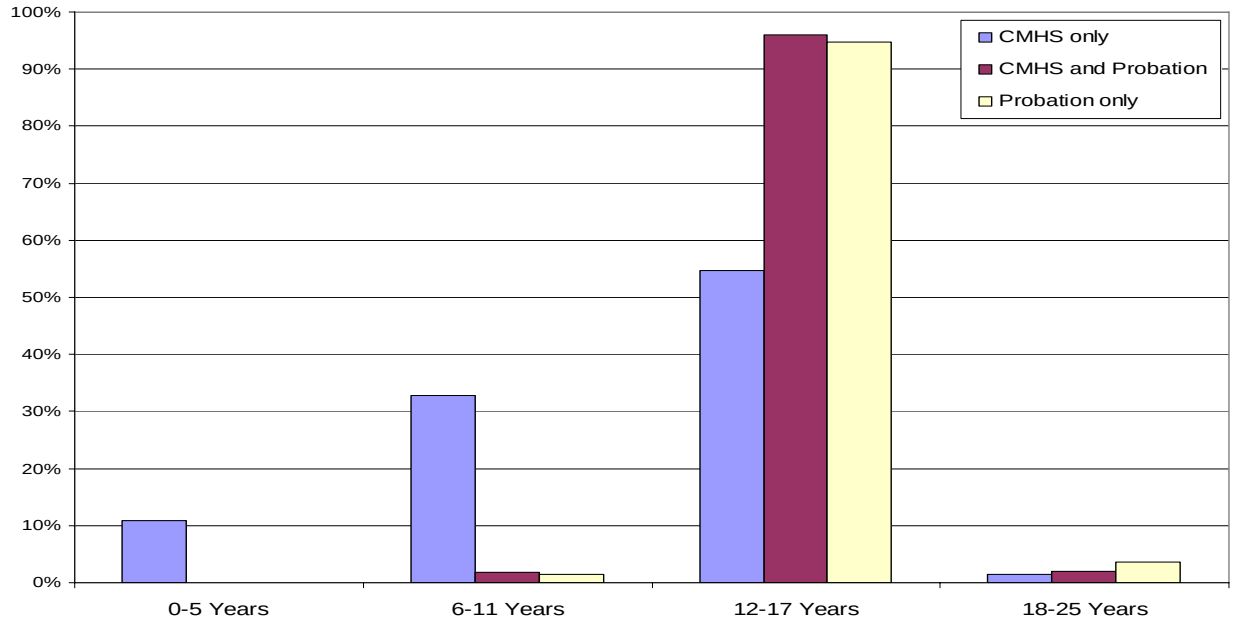
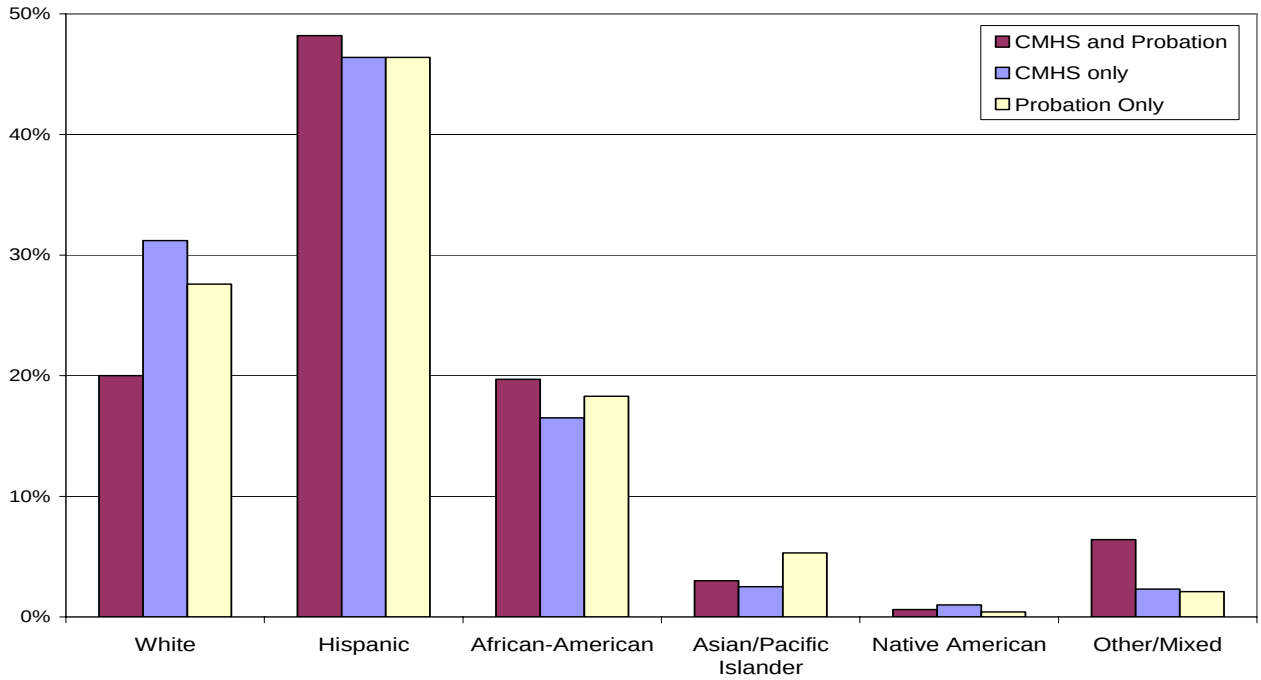


Figure 8.2: Age distribution for youth active to CMHS and Probation



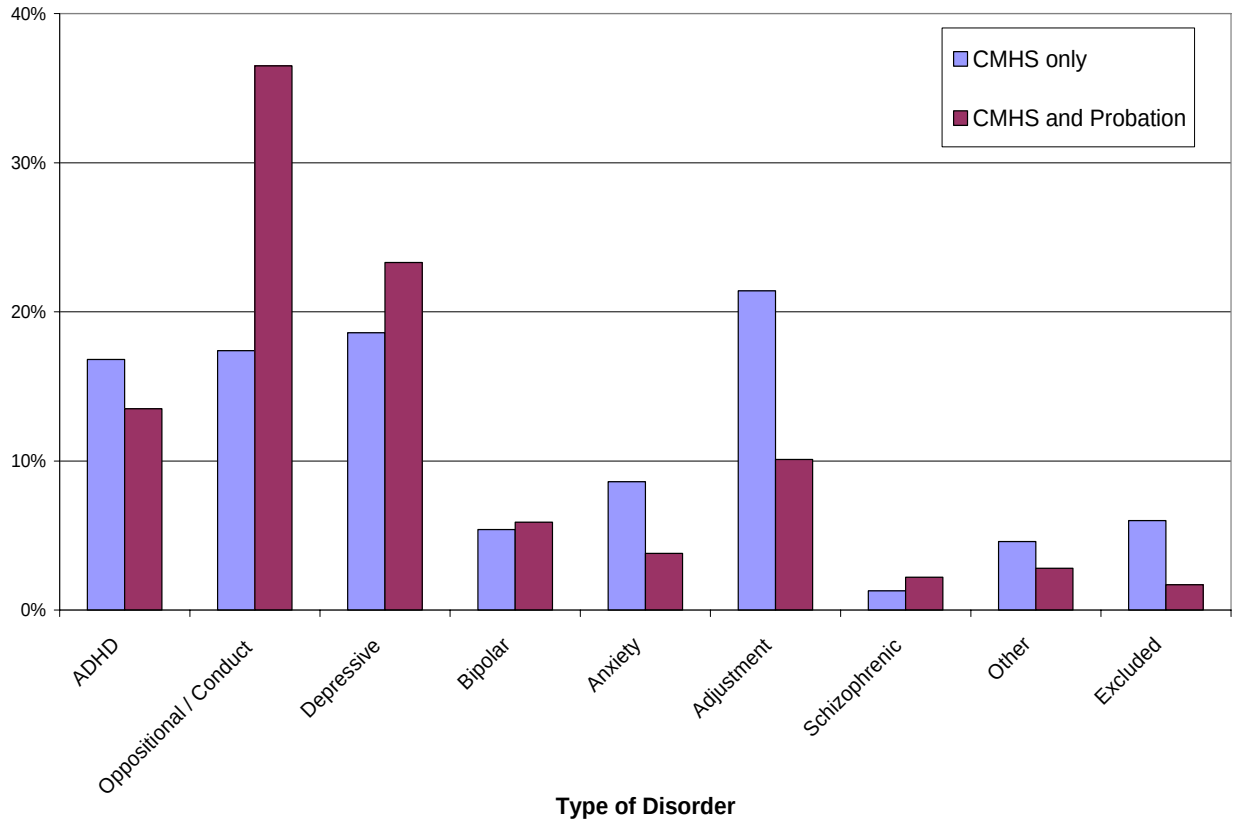
White youth are underrepresented in the population of youth active to both CMHS and Probation in FY04-05, as compared to their prevalence in the overall CMHS population (**Figure 8.3**).

Figure 8.3: Race/Ethnicity distribution for youth active to CMHS and Probation



The most common **primary diagnoses** in this group are oppositional/conduct disorders (36.5%), depressive disorders (23.3 %), and ADHD (13.5%) (**Figure 8.4**). The oppositional and depressive disorders are more common in this population than in the CMHS sample as a whole, while the Adjustment, Anxiety, and Excluded diagnoses are seen less often in this population.

Figure 8.4: Primary Diagnosis for youth active to CMHS and Probation



The geographic location of youth involved with Probation was also examined. **Figure 8.5** shows the zip codes that have the highest percentages in the county. Five percent of youth involved with Probation were from zip code 92105 - City Heights, while similar numbers were from 92114 (Encanto – 4.6%) and 92113 (Logan Heights – 4.0%). Note: 3.5% of the Probation youth did not have zip codes listed in the Probation datafile, while 2.4% had California zip codes outside of San Diego County and 2.4% had zip codes outside of California.

Service use by youth active to CMHS and Probation varies from that of youth active to CMHS alone (**Tables 8.2 and 8.2**). Youth active to both sectors are less likely to use case management or assessment services, and to receive fewer minutes of collateral and therapy services 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.

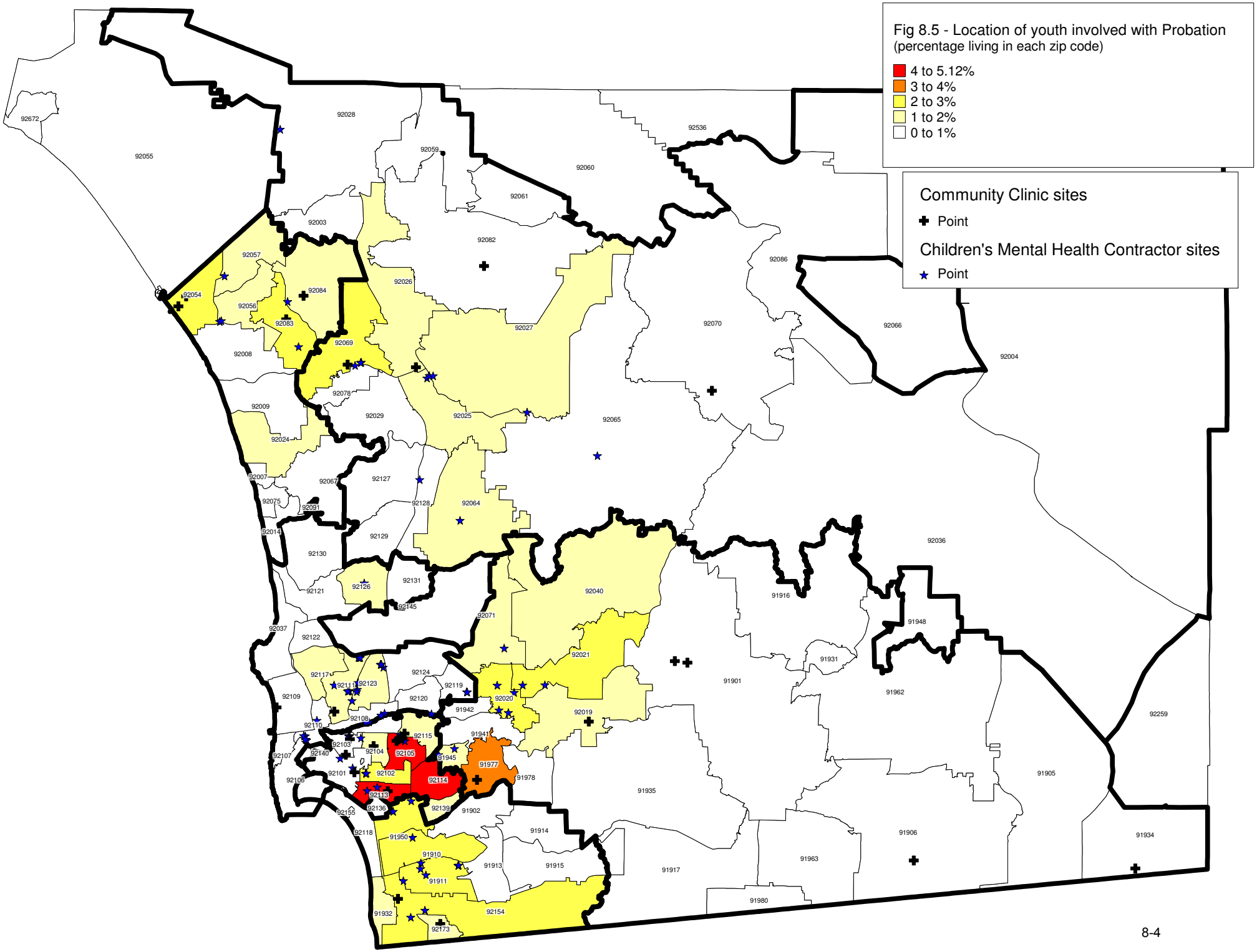


Fig 8.5 - Location of youth involved with Probation
(percentage living in each zip code)
4 to 5.12%
3 to 4%
2 to 3%
1 to 2%
0 to 1%
Community Clinic sites
Point
Children's Mental Health Contractor sites
Point
92672
92055
92028
92059
92536
92060
92061
92003
92082
92057
92086
92054
92084
92056
92083
92026
92027
92070
92066
92008
92069
92004
92078
92009
92029
92025
92065
92024
92007
92067
92127
92075
92091
92128
92064
92014
92129
92036
92130
92121
92126
92131
92040
91916
92145
92071
91948
92037
92122
92021
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92020
91901
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92105
91945
91977
92107
92140
92102
91978
91905
92101
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92113
91935
92136
92139
91902
92155
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92118
91950
91906
91934
91910
91913
91915
91963
91911
91917
91980
91932
92154
92173
8-4

Table 8.1: 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	Med Days		Mean Days	Med Days		Mean Days	Med Days		Mean Days	Med Days
CMHS and Probation	1.4%	*9.9*	9	4.2%	82.6	71.5	8.4%	38.6	27	1.3%	1.2	1
CMHS FY04-05	1.7%	13.0	7	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

Table 8.2: 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	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CMHS and Probation	55.6%	*335.0*	93.5	*15.6%*	885.0	195	*22.5%*	264.0	180	**9.3%**	246.6	120
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.5	180

	Medication Support			Therapy			TBS		
		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CMHS and Probation	32.0%	230.2	120	88.1%	*571.0*	270	1.1%	4643.6	3730.5
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

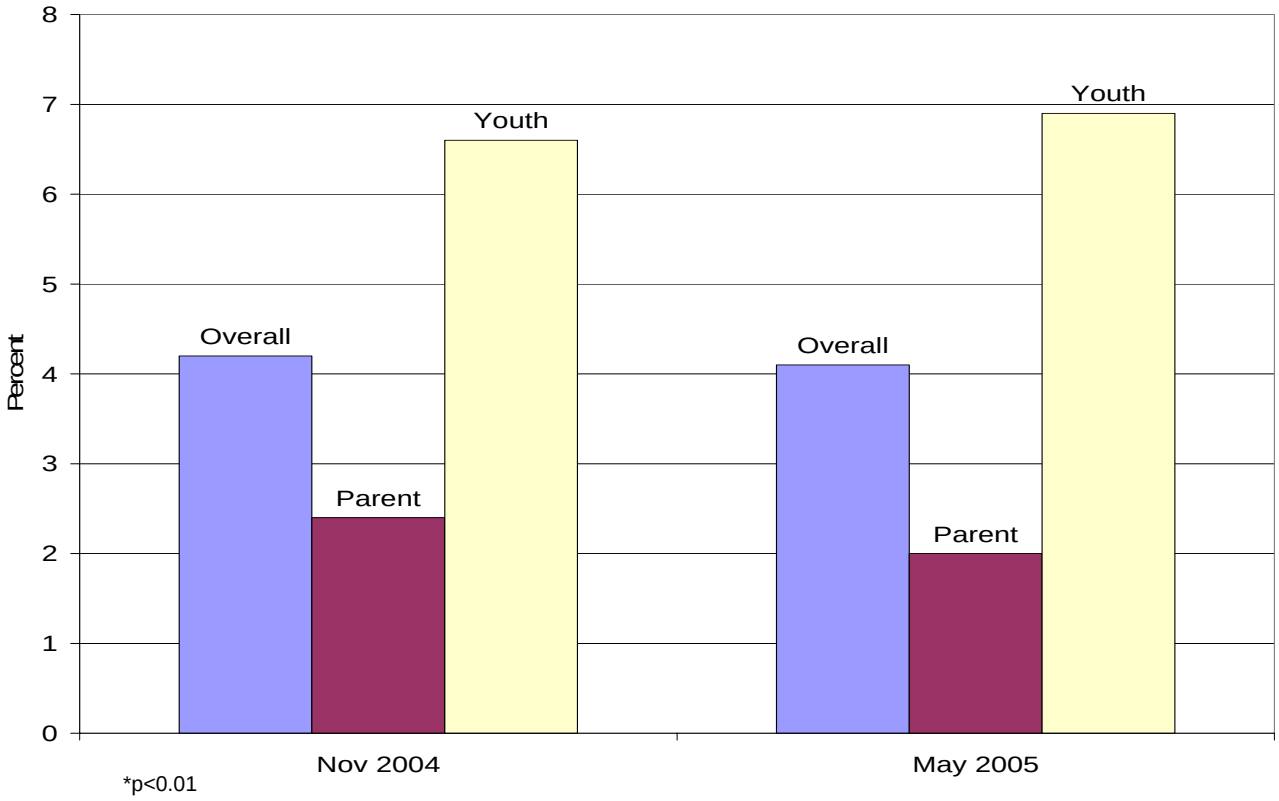
Delinquent Behavior

Additional information about delinquent behavior is available for youth receiving CMHS services in FY04-05. The **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 the youth had been arrested. The YSS was administered to all clients during 2 two-week periods in November 2004 and May 2005.

Youth Services Survey (YSS)

Data from the **November 2004 and May 2005 YSS** show that about 4% of youth receiving services from CMHS had been arrested in the month prior to the survey (**Figure 8.5**). Youth were significantly more likely to self-report having been arrested, as compared to parent report of youth arrests.

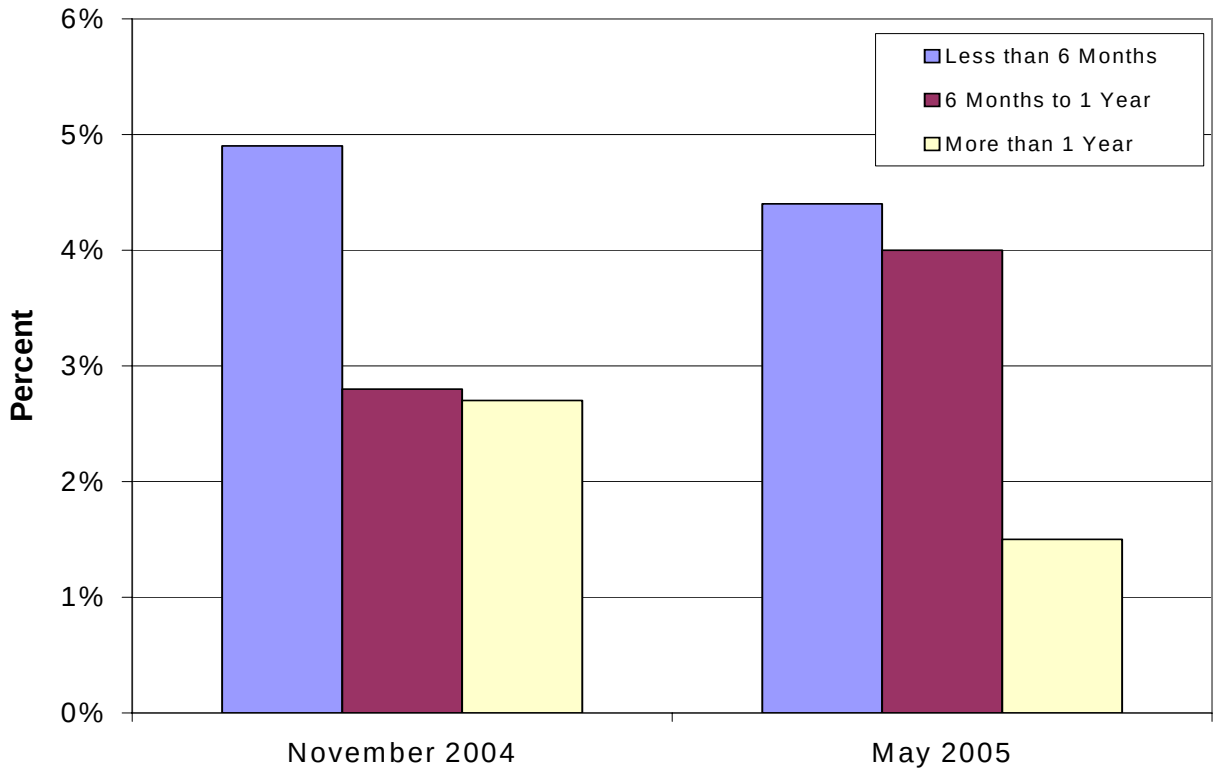
Figure 8.5: Percent of youth who were arrested in past month, by parent or self-report.



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 8.6**). 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 then 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 months and more than 1 year in service groups.

Figure 8.6. Past Month Arrests by Length of Time receiving Services



Chapter 9:
Services for Youth with Substance Use problems

Information on substance use by youth active to the CMHS is available from several sources. First, 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 FY04-05. In addition, 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. Finally, all youth and caregivers who received services during the FY04-05 **Youth Services Survey (YSS)** periods (November 1-15, 2004 and May 2-13, 2005) answered a question about youth substance use in the month prior to the survey.

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 FY04-05. 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 9.1-9.4. Overall, **2.7% of youth receiving CMHS services were also active to ADS** during the fiscal year. 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 9.1 and 9.2**). **African American** youth are slightly under-represented as compared to their prevalence in the overall CMHS population.

Figure 9.1: Gender distribution for youth active to CMHS and ADS

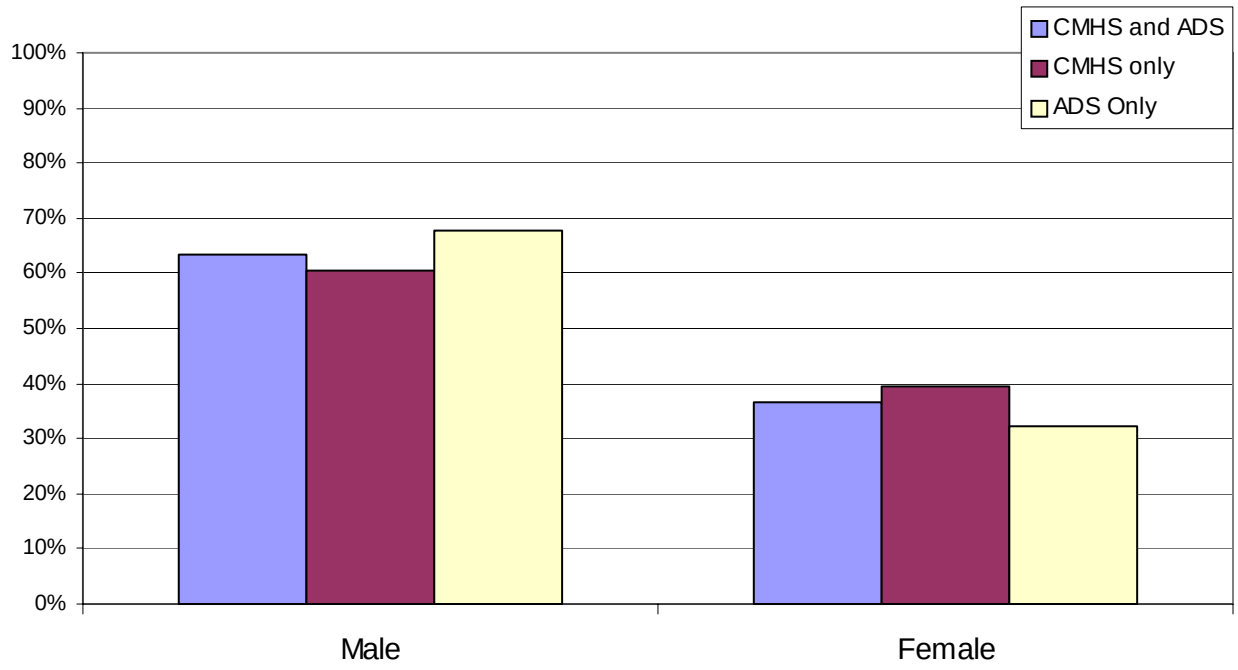


Figure 9.2: Age distribution for youth active to CMHS and ADS

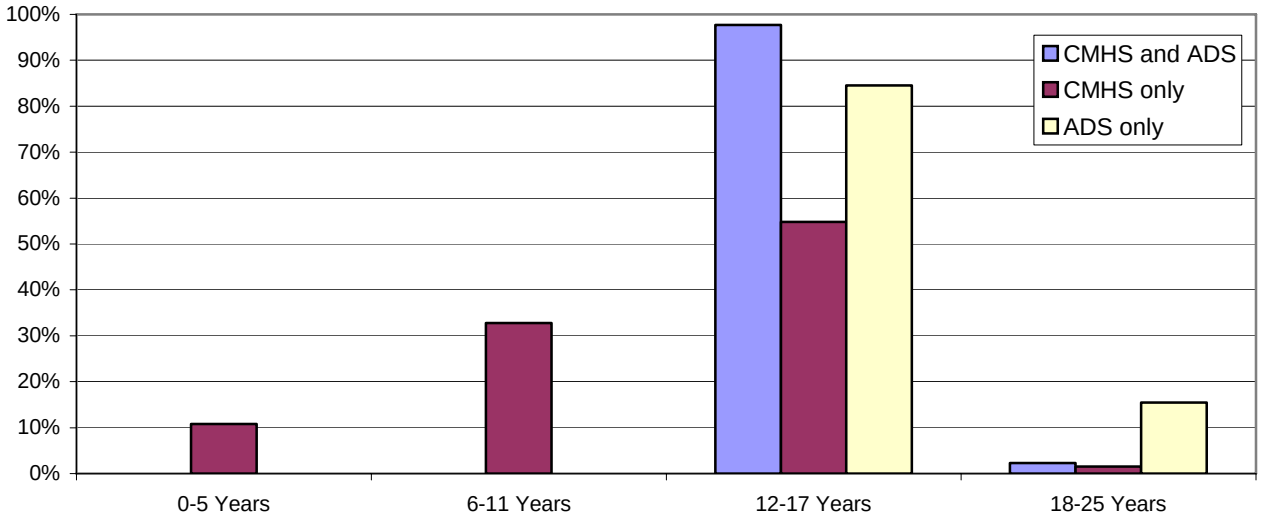
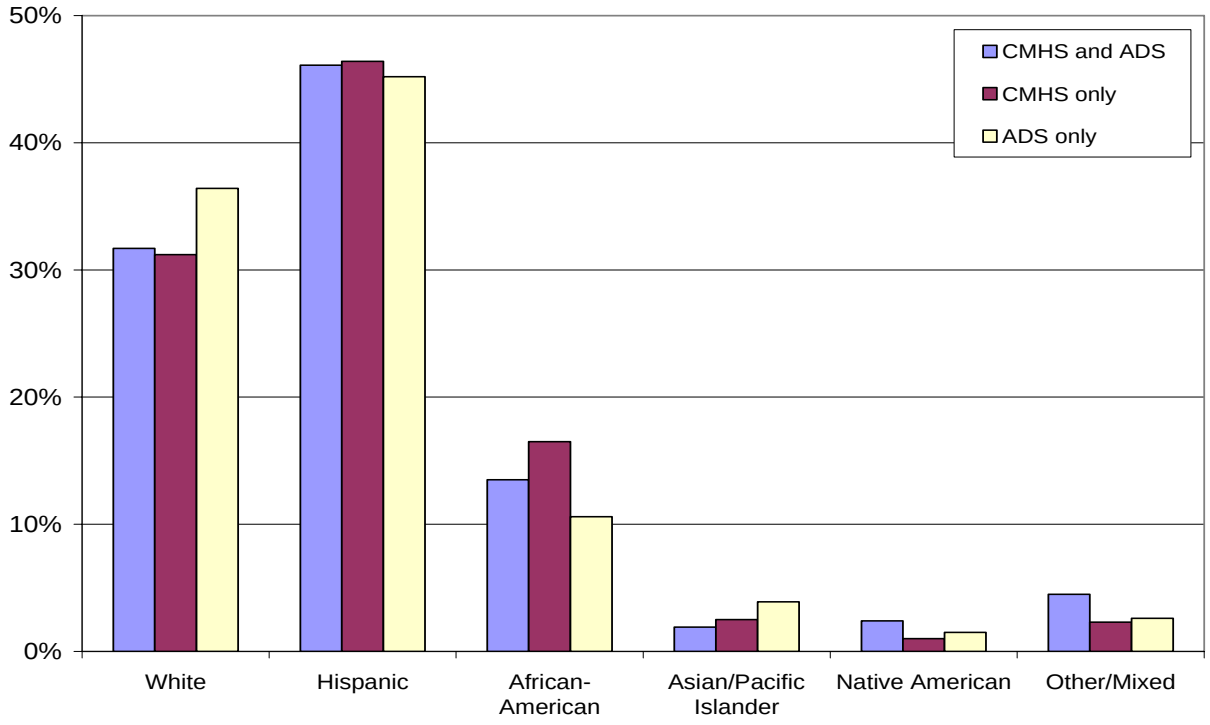


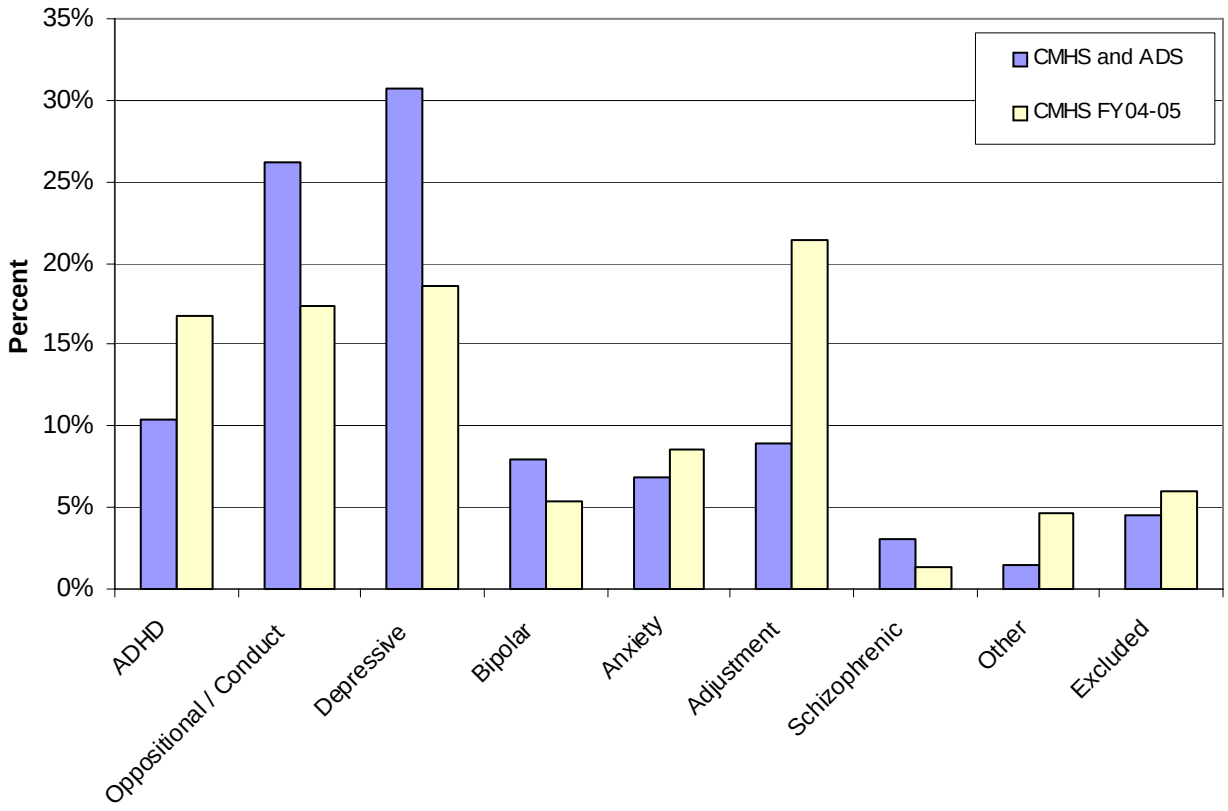
Figure 9.3: Race/Ethnicity distribution for youth active to CMHS and ADS



The most common **primary diagnoses** in this group are depressive disorders (30.7%), oppositional/conduct disorders (26.2%), and ADHD (10.4%). Interestingly, **only 24.9% 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. This increased slightly from FY03-04, when 21.6% of clients active to both sectors had a dual diagnosis.

Figure 9.4: 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 9.1**) and are also less likely to use intensive day treatment services. With regard to outpatient services (**Table 9.2**), youth active to both sectors are less likely to use case management or assessment services, although those youth who do receive assessment services use more total minutes on average than youth in CMHS alone. Finally, youth active to CMHS and ADS receive fewer minutes of medication support and therapy services than do youth active only to CMHS.

Table 9.1: 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	Med Days		Mean Days	Med Days		Mean Days	Med Days		Mean Days	Med Days
CMHS + ADS	1.5%	**17.6**	17	*3.1%*	*63.2*	48	**10.7%**	**57.5**	41	1.7%	1.1	1
CMHS FY04-05	1.7%	13.0	7	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

Table 9.2: 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	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CMHS + ADS	56.6%	381.0	105	*19.0%*	865.7	180	*26.4%*	**258.6**	157	7.6%	186.5	115
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.8	180

	Medication Support			Therapy			TBS		
		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
CMHS + ADS	35.9%	*190.2*	125	84.7%	*665.4*	315	1.0%	4662.2	4947
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

Dual Diagnosis Youth

An examination of INSYST showed that 306 youth who received CMHS services in FY04-05 (**1.8%** of total CMHS population) had a secondary substance abuse diagnosis. Almost all of these youth were between the ages of 12 and 17 (**Figure 9.5**). The ratio of males to females mirrors that of the CMHS population as a whole, while White and Hispanic youth are overrepresented, and African-American youth underrepresented, in the racial/ethnic distribution of youth with a dual diagnosis (**Figure 9.6**).

Figure 9.5: Age distribution for youth with a dual diagnosis

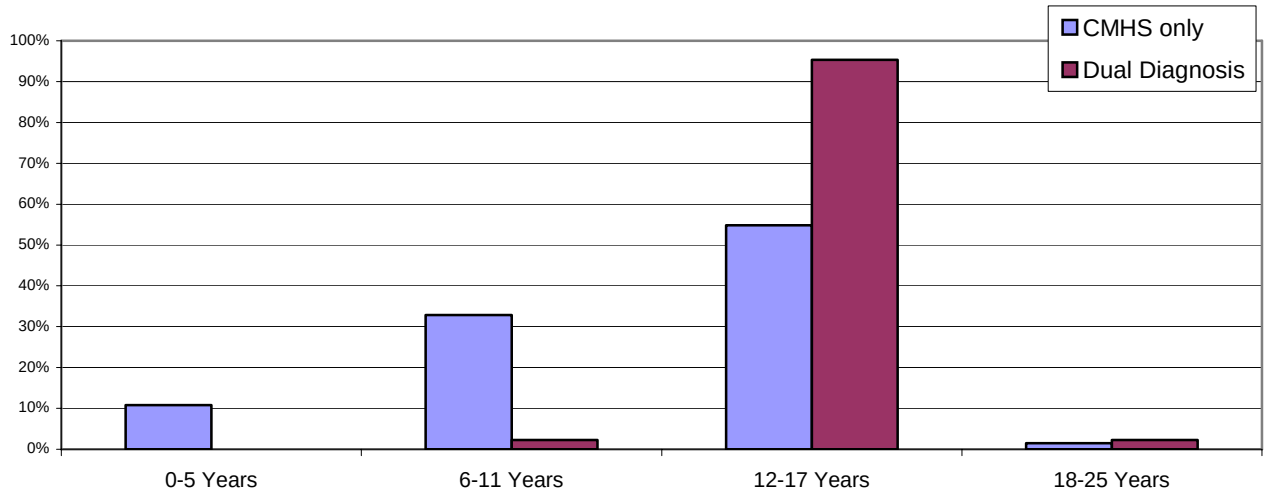
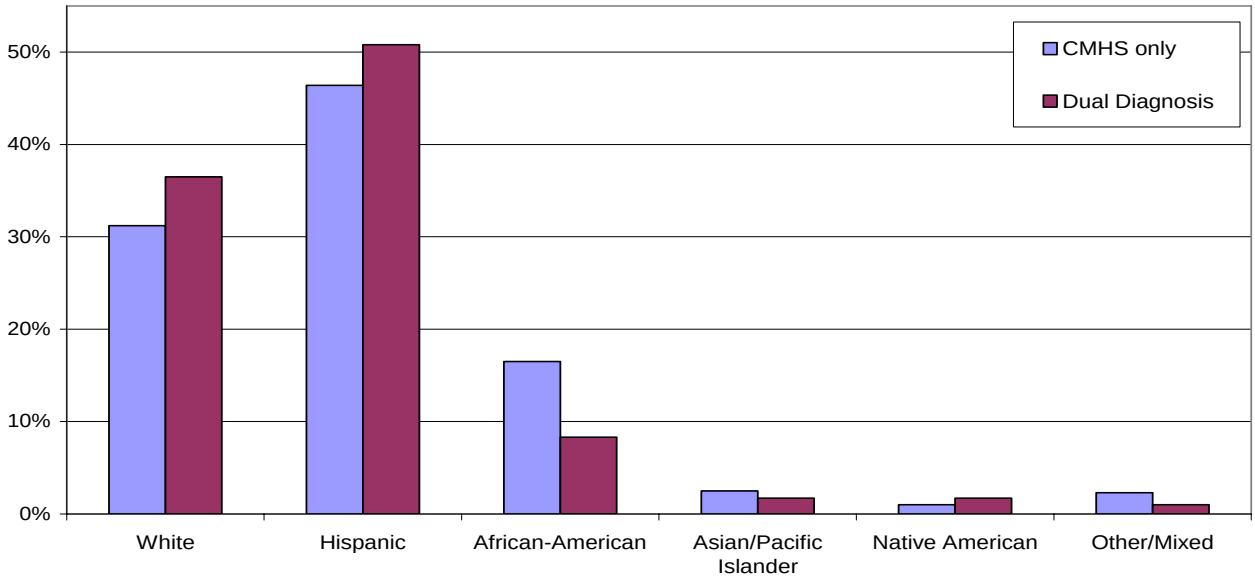
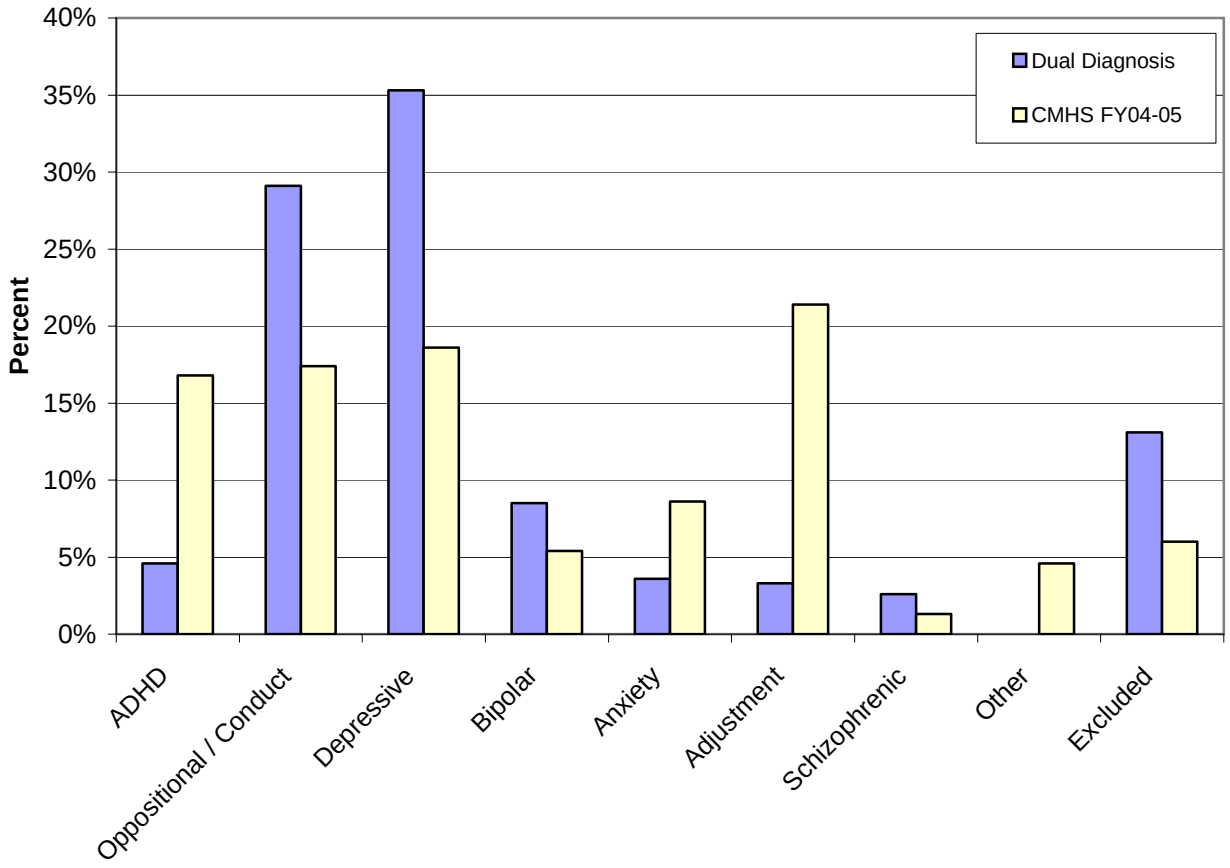


Figure 9.6: Racial/ethnic breakdown for youth receiving CMHS services with a dual diagnosis.



The majority of youth with a dual diagnosis come from one of three **primary diagnosis categories**: Depressive disorders (35%), Oppositional and Conduct disorders (29%), and Excluded diagnoses (13%) (**Figure 9.7**).

Figure 9.7: Primary Mental Health Diagnosis for youth with a Dual Diagnosis



An analysis of service use patterns showed that **17.3% of youth with a dual diagnosis had received services from ADS during FY04-05, a decrease from 33% in FY03-04.** Youth with a dual diagnosis were more likely to have used inpatient, day rehab, or crisis stabilization services than the general population, but used fewer days of inpatient care on average (**Table 9.3**). Large differences were seen in the day treatment categories, with 30% of dual diagnosis youth receiving day rehabilitation services and only 4% receiving intensive day treatment services, with fewer days of intensive day treatment services received on average. In the outpatient area, youth with a dual diagnosis were more likely to receive collateral, case management, crises, or medication support services than youth in the overall CMHS population, although they received fewer minutes of case management and medication support services on average. In addition, on average, they received more minutes of assessment services (**Table 9.4**).

Table 9.3: 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	Med Days		Mean Days	Med Days		Mean Days	Med Days		Mean Days	Med Days
Dual Diagnosis	**4.6%**	*9.6*	7	3.6%	*44.6*	35	**30.4%**	46.0	36	**5.9%**	1.1	1
CMHS FY04-05	1.7%	13.0	7	4.5%	89.8	76	7.3%	46.7	17	1.5%	1.2	1

Table 9.4: 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	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
Dual Diagnosis	**67.6%**	459.5	284	**41.5%**	*577.6*	60	53.3%	**316.2**	235	**16.7%**	314.7	255
CMHS FY04-05	56.0%	474.1	250	27.8%	809.1	145	56.6%	212.5	180	7.4%	264.8	180

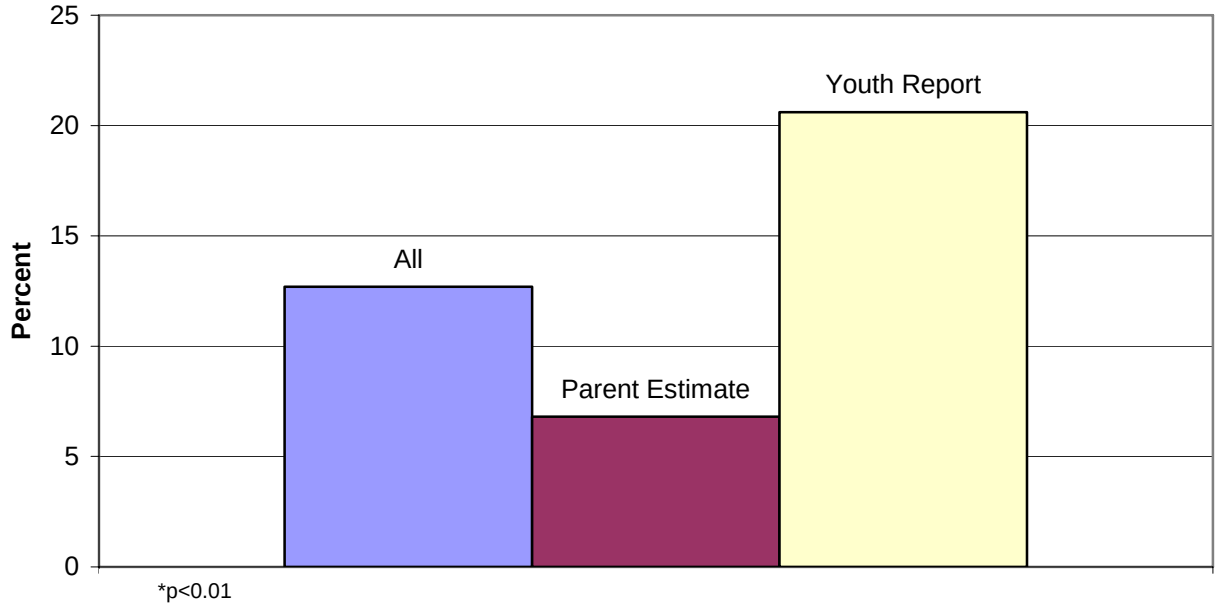
	Medication Support			Therapy			TBS		
		Mean Mins	Med Mins		Mean Mins	Med Mins		Mean Mins	Med Mins
Dual Diagnosis	**41.8%**	*188.7*	144	73.5%	874.4	690	0.7%	2039.5	---
CMHS FY04-05	31.4%	249.4	150	77.0%	848.8	705	1.3%	4983.1	4344.5

Youth Services Survey

The **Youth Services Survey (YSS)** provided an additional source of data regarding substance use by youth serviced through the public mental health system. All youth, ages 13 and older, who received services during the FY04-05 YSS periods (November 1-15, 2004 and May 2-13, 2005) answered a question about substance use in the month prior to the survey. In addition, caregivers of all youth (ages 0-17) answered a question about youth substance use in the part month.

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) three or more times in the past month. In the overall sample of respondents from the November and May survey periods (N=4744), 13.0% of youth and parents stated that the youth had used one of these substances 3 or more times in the past month (**Figure 9.8**). Youth were significantly more likely than parents to state that they have used substances recently – 21.0% vs. 6.9% respectively (p<.01). The three most commonly used substances, in descending order, were cigarettes (8.7% used 3 or more times in past month), alcohol (6.8%), and marijuana (6.7%).

Figure 9.8: Percent of youth who used substances in past month, by parent estimate or youth or self-report



The sample of youth who self-reported substance use, or whose caregivers reported they had used substances, in the past month was then examined. The gender distribution (**Figure 9.9**) was more balanced than that of the overall CMHS sample or the sample of youth receiving services from ADS. The age distribution of youth using substances was heavily skewed towards adolescents, while the racial/ethnic distribution was similar to that of the CMHS population overall, with the exception that more substance-using youth identified themselves as being of other or mixed race/ethnicity on the YSS than in the CMHS population (**Figures 9.10-11**).

Figure 9.9: Gender distribution for youth with YSS reported substance use

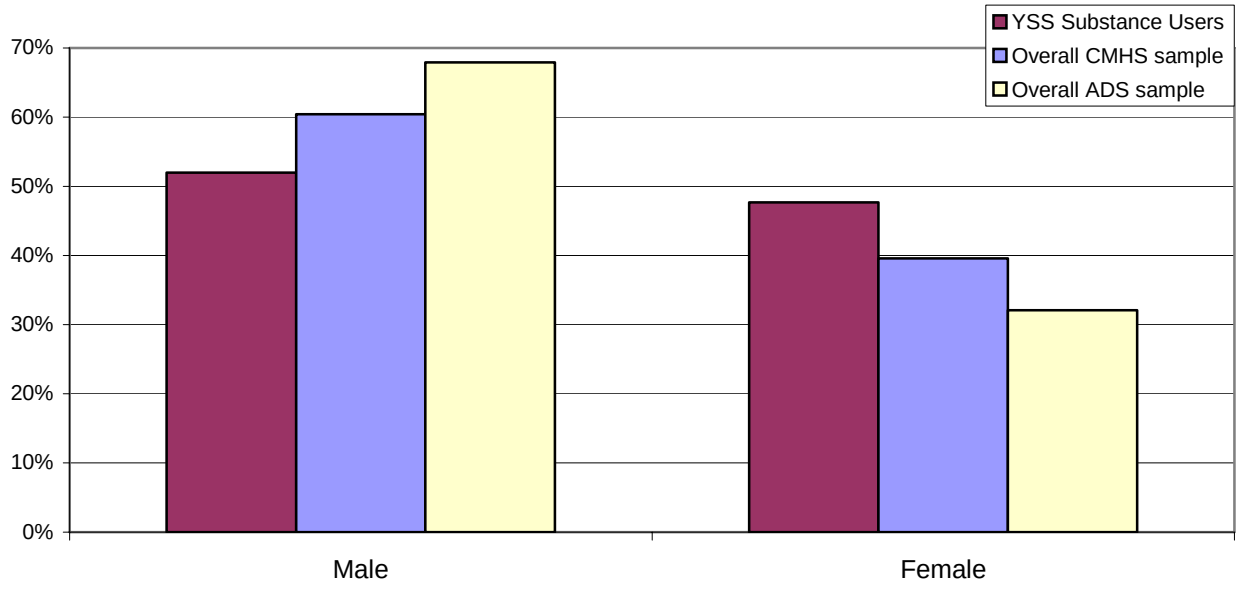
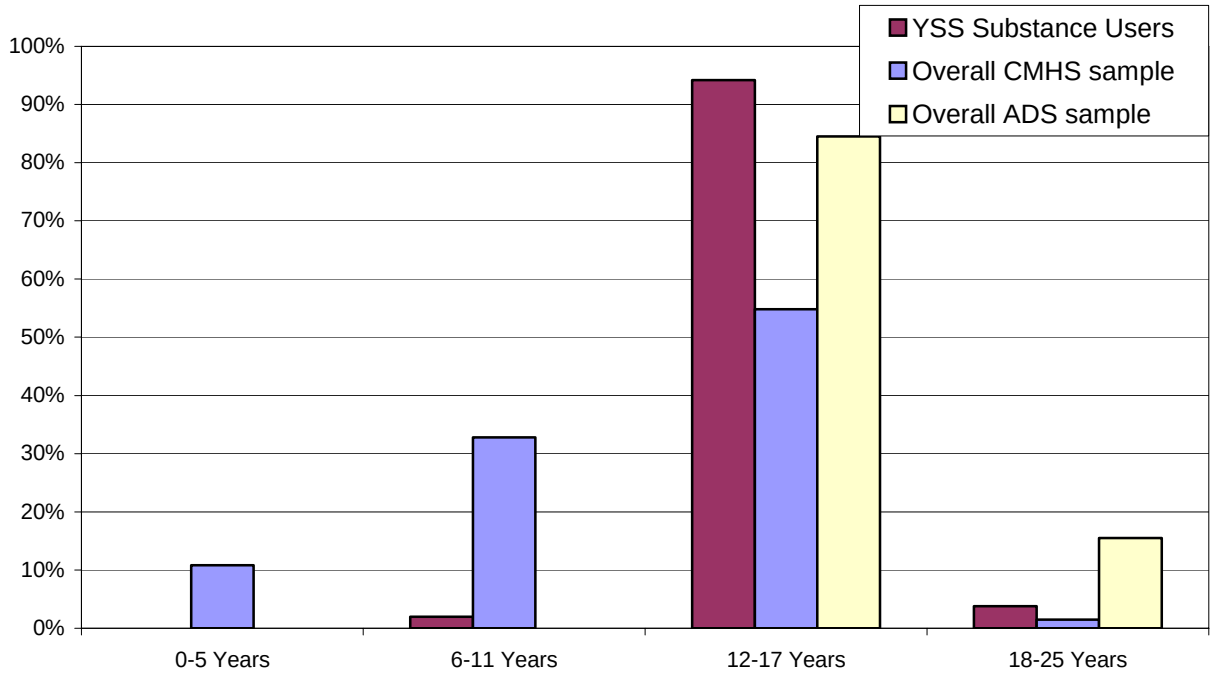


Figure 9.10: Age distribution for youth with YSS reported substance use



When reports of substance use on the YSS were examined by the length of time receiving CMHS services (**Figure 9.12**), 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 and youth in service more than 1 year is significant ($p<0.01$), meaning that youth in service for more than one year are less likely to report having

used any substance 3 or more times in the past month, compared to those in services for less than six months.

Figure 9.11: Race/ethnicity distribution for youth with YSS reported substance use

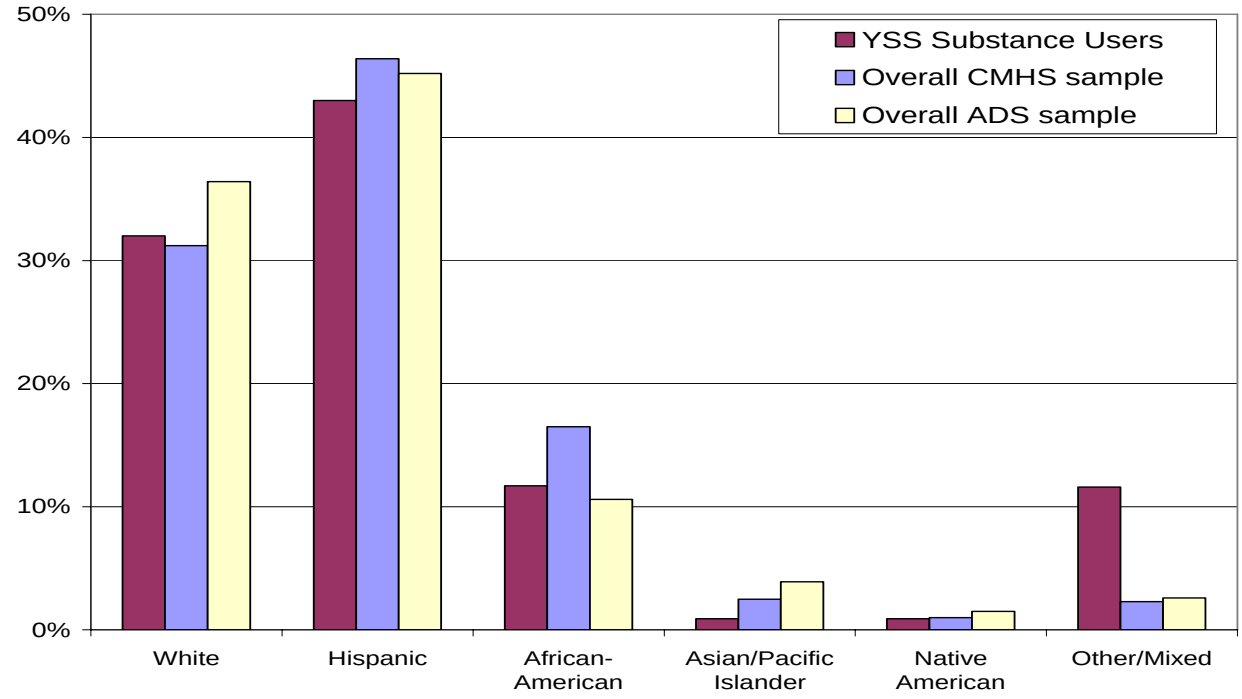
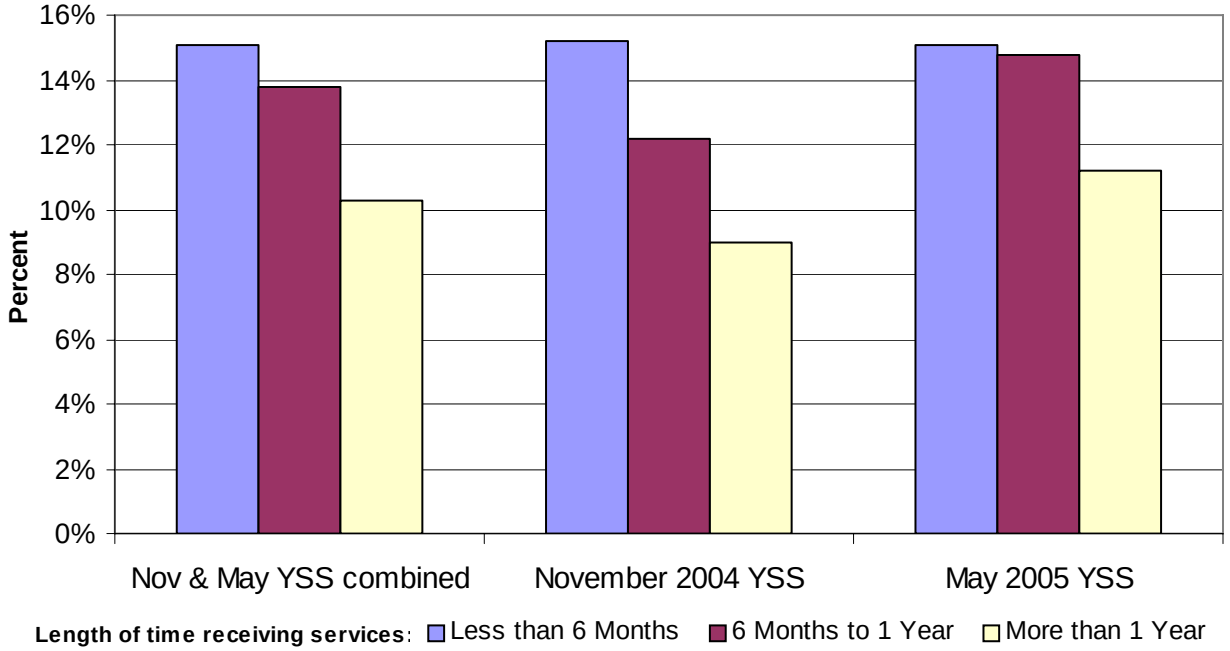


Figure 9.12: Past Month Use of Substances by Length of Time receiving Services



Chapter Summary

- Substance-using youth are more likely to be male and adolescent
- The primary diagnoses among these youth are Oppositional/conduct disorders and Depressive disorders.
- 21% of youth receiving CMHS services report having used substances at least three times in the past month
- Youth who have been receiving mental health services for one year or more are less likely to report substance use on the Youth Services Survey (YSS) than those receiving services for less than 6 months.

Chapter 10: Child, Youth, and Family Satisfaction

The San Diego County Children's 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 2004-2005, 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/caregivers, regardless of the youth/client age, who utilized services between November 1 and 12, 2004 and/or May 2 and 13, 2005. The majority of questions on the YSS focus on satisfaction with the provision and results of services. The second manner in which satisfaction information was collected is the **Family-Centered Behavior Scale (FCBS)**, which is completed by the parent/ caregiver every six months from the start of services through discharge. In previous fiscal years, the FCBS was used only with clients receiving intensive case management / wraparound services; on January 1, 2005, clients in all programs began to complete the FCBS.

Youth Services Survey (YSS)

Data from the family and youth respondents on the **YSS** is presented in **Figures 10.1-10.4**. Questions were grouped into five domains: Good Access to Services, Satisfaction with Services, Participation in Treatment, Cultural Sensitivity, and Positive Outcomes. A total of 4,744 surveys were completed during the November 2004 and May 2005 collection periods. Copies of the survey, as well in the item-level responses, are included at the end of this chapter.

Overall, parent/caregiver ratings were higher than the youth ratings on the 5 domains across the 2 survey periods. For example, 93.6% of parent respondents marked "Agree" or "Strongly Agree" on questions related to Good Access to Services (e.g. location and hours of services), compared to 79% of youth. Differences were most striking on the Participation in Treatment domain: 90.4% of parents endorsed Agree or Strongly Agree, compared to 62.0% of youth. Parent and youth scores were most similar on Positive Outcomes, which is also the only domain in which youth scores were higher than parent scores (70.6% vs. 71.2% respectively).

San Diego County YSS results are also compared to statewide and Southern California results on the YSS (**Figures 10.1 – 10.4**). Results on the Family survey show that parents/ caregivers in San Diego County are consistently more satisfied with services than are families in the state as whole, or in the Southern California region. The Youth results are more variable, with greater satisfaction on 2 of the 5 domains in the November 2004 YSS and on 4 of the 5 domains in the May 2005 YSS. In contrast, youth in San Diego County consistently rated their satisfaction with Participation in Treatment lower than youth in the state or Southern California.

Figure 10.1: November 2004 Youth Services Survey Results – Youth Survey

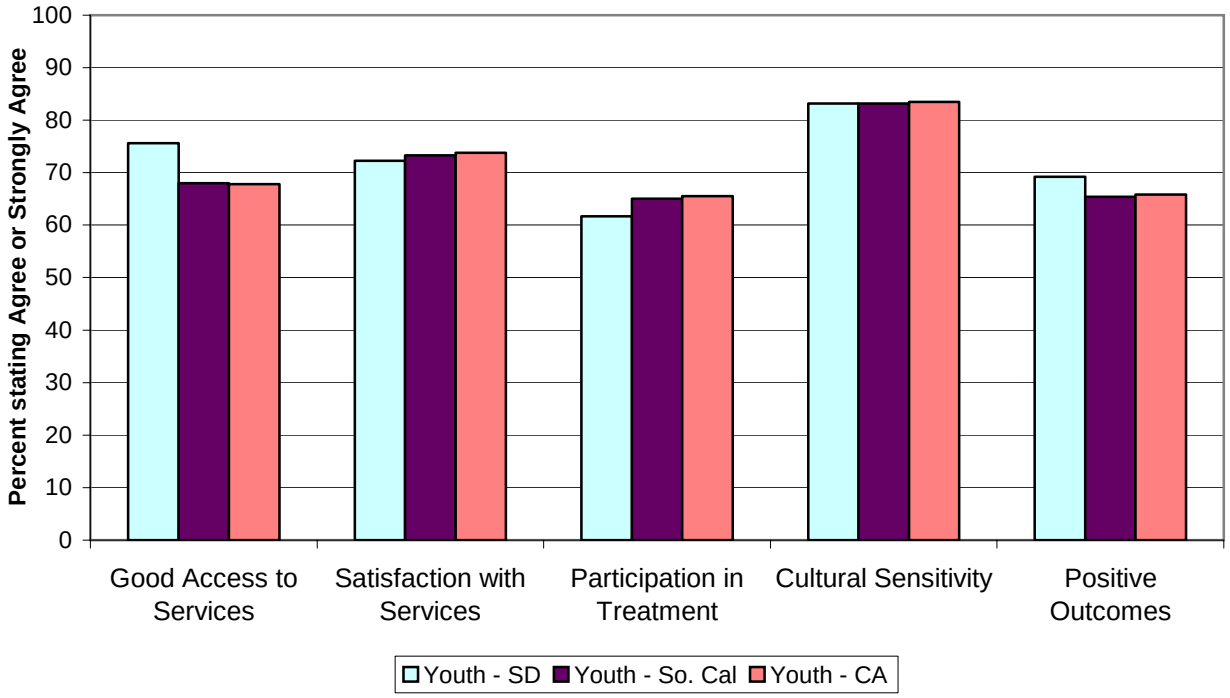


Figure 10.1: November 2004 Youth Services Survey Results – Family Survey

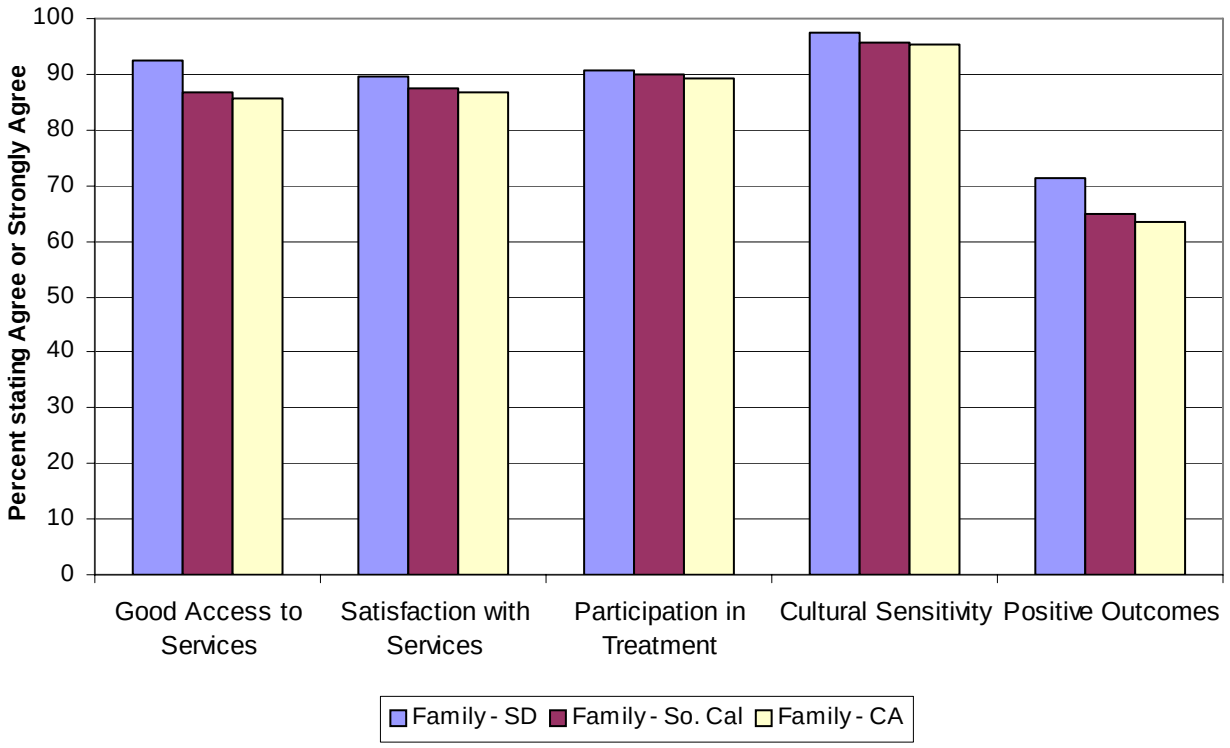


Figure 12.3: May 2005 Youth Services Survey Results – Youth Survey

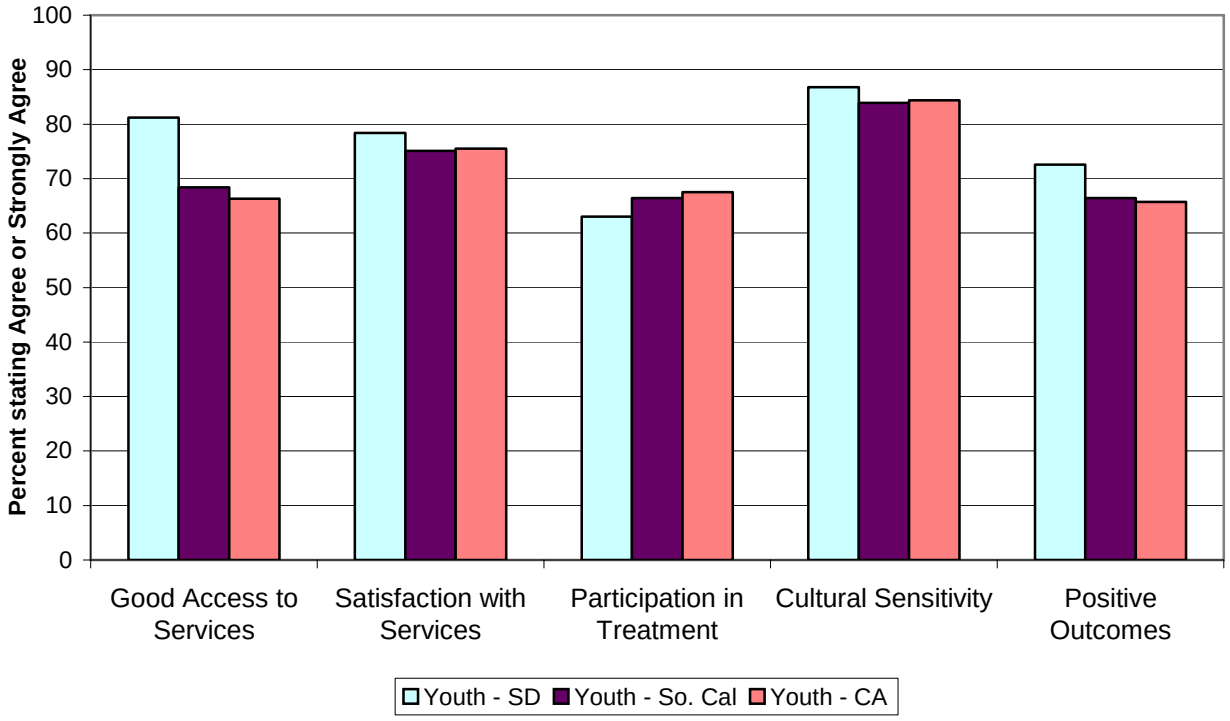
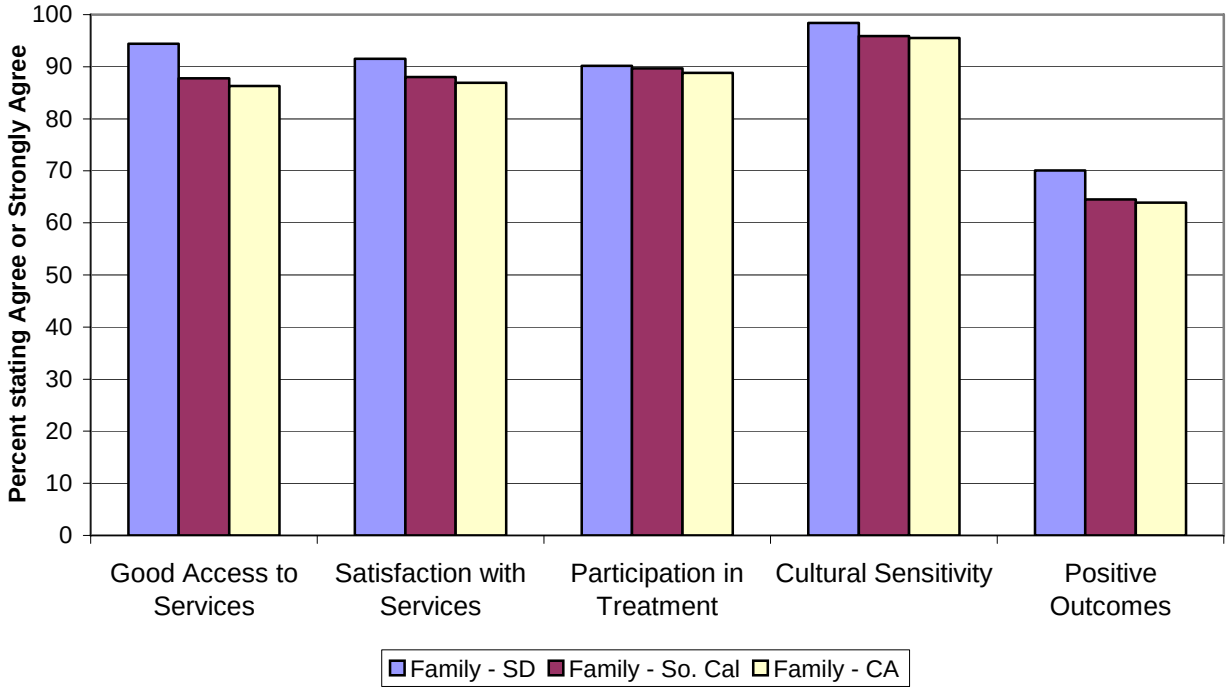


Figure 10.4: May 2005 Youth Services Survey Results – Family Survey



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 10.5-6**). 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. In both the November 2004 and the May 2005 YSS periods, analysis showed that parents were 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 10.5: November 2004 Youth Services Survey Responses - Youth and Parent Matched Pairs

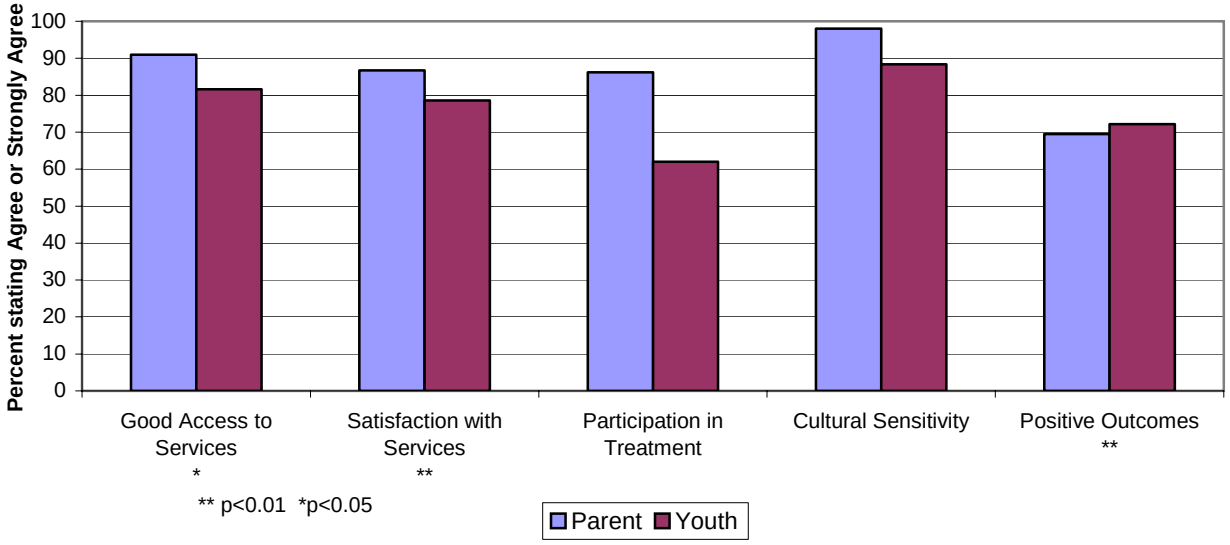
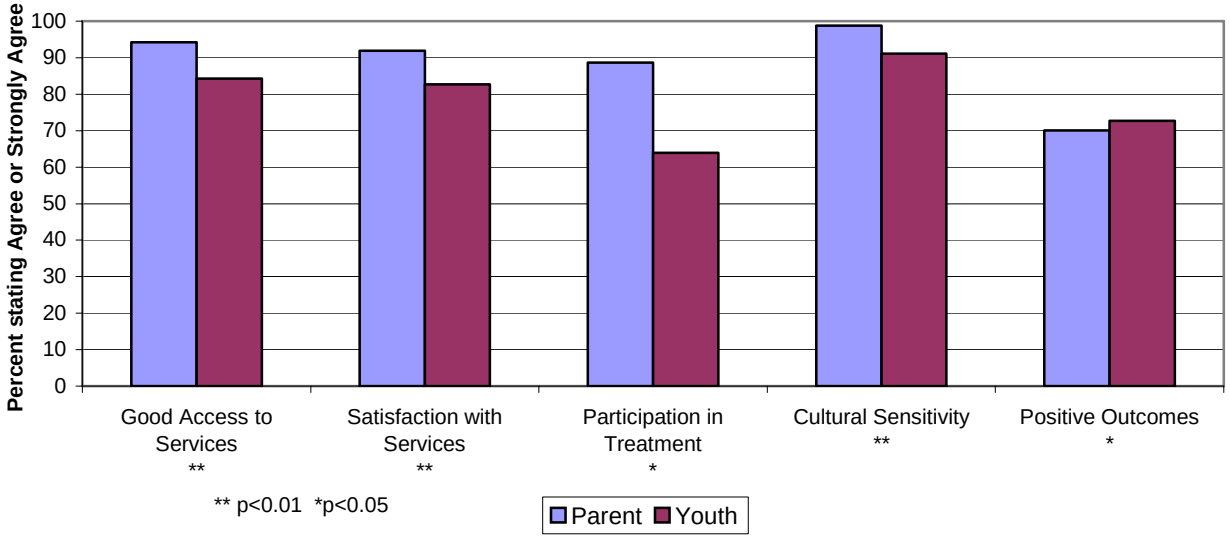


Figure 10.6: May 2005 Youth Services Survey Responses - Youth and Parent Matched Pairs



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. Analyses showed that respondents for Hispanic youth were more satisfied on all 5 domains examined by the YSS, as compared to respondents for non-Hispanic youth (**Figures 10.7 and 10.8)**. There were statistically significant differences in satisfaction rates during both data collection periods for the domains of Good Access to Services, General Satisfaction with Services, and Participation in Treatment.

Figure 10.7: November 2004 Youth Services Survey Responses, Hispanic vs. Non-Hispanic Respondents

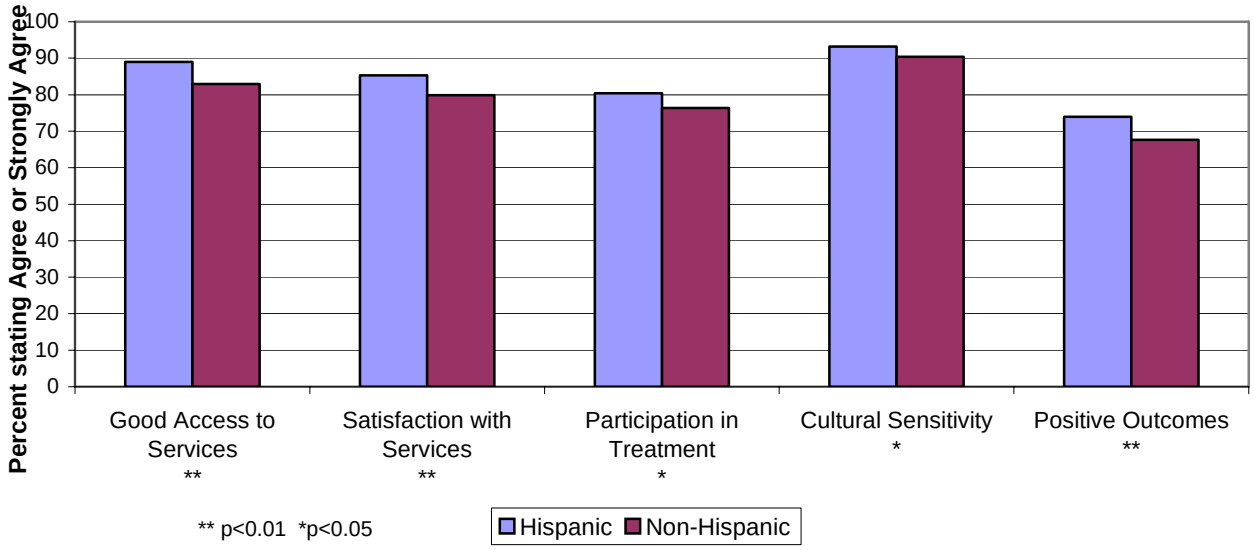
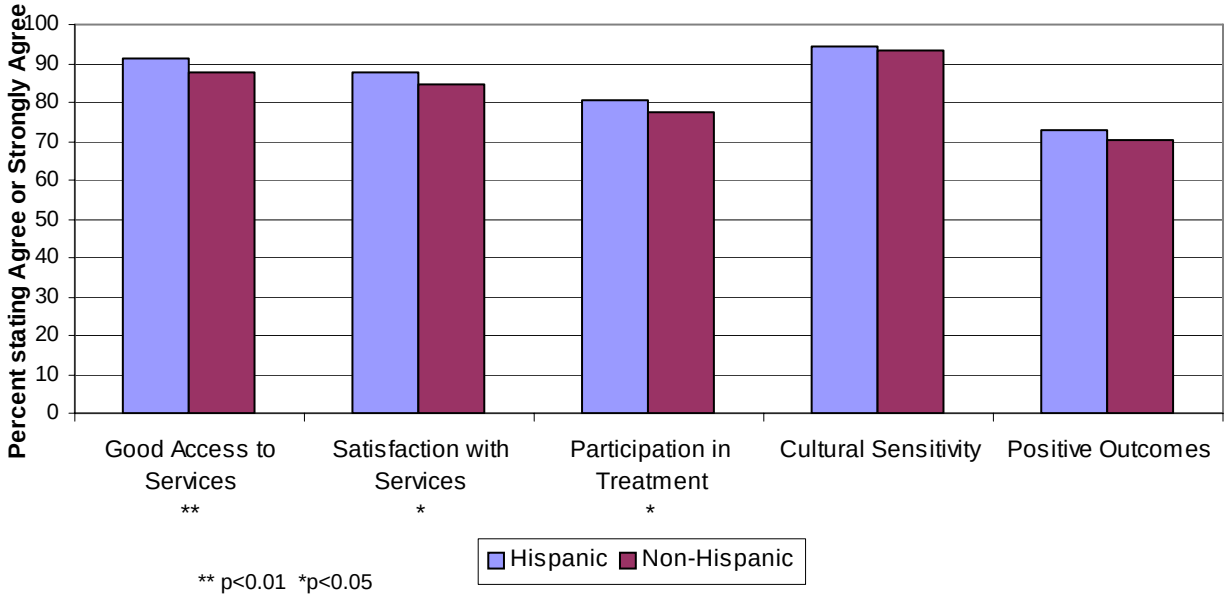


Figure 10.8: May 2005 Youth Services Survey Responses, Hispanic vs. Non-Hispanic Respondents



Results from the YSS show varying levels of satisfaction by the **service type** received by the youth (**Figure 10.9 – 10.12**). Parents and youth receiving intensive day treatment or day rehabilitation services reported lower levels of satisfaction with access to services, general satisfaction with services, and cultural sensitivity on average, as compared to the other service groups; this difference was more marked in the youth responses. Cultural Sensitivity has the highest scores across the modalities, while Positive Outcomes is the lowest scored area on average. Parent scores are higher on average than the youth scores. It should be noted that, although the absolute scores vary between the November and May survey periods, the response patterns are similar across the two periods.

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, beginning January 1st, 2005, families receiving services completed the **Family-Centered Behavior Scale (FCBS)** every six months, as well as at discharge. 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. A copy of the FCBS is included at the end of this chapter.

As data collection began in January 2005, we have limited data for FY04-05, but overall, the results on the FCBS are very positive. At six months of service, the average score was 4.66, or 93.2%. After one year in service, families were giving the staff a rating of 4.70, or 94%, while at discharge, the rating was 4.68, or 93.6%. The average rating across the three timepoints was **4.68, or 93.6%**. These scores fall in between "most of the time" and "always" on the frequency of performing family-centered behaviors, indicating that families feel services are typically family-centered.

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.

Figure 10.9: November 2004 Youth Services Survey Responses by Service Modality – Youth Survey

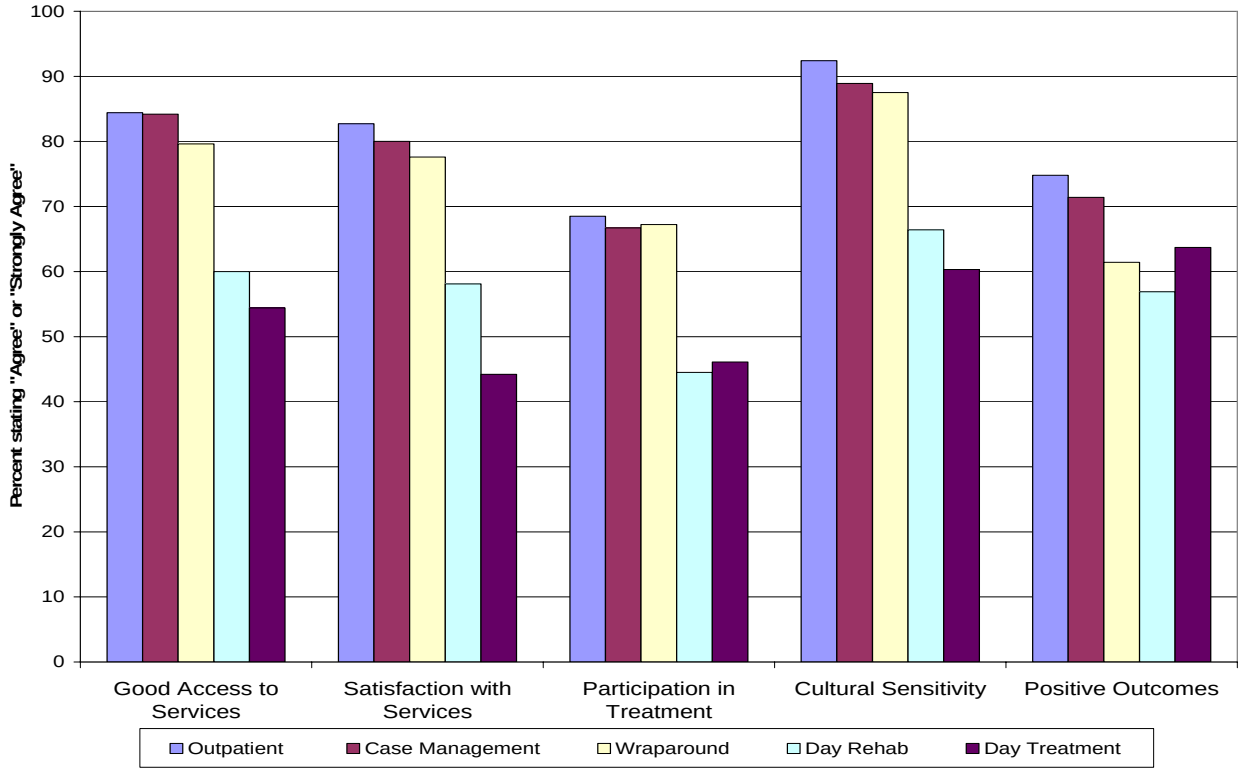


Figure 10.10: November 2004 Youth Services Survey Responses by Service Modality – Family Survey

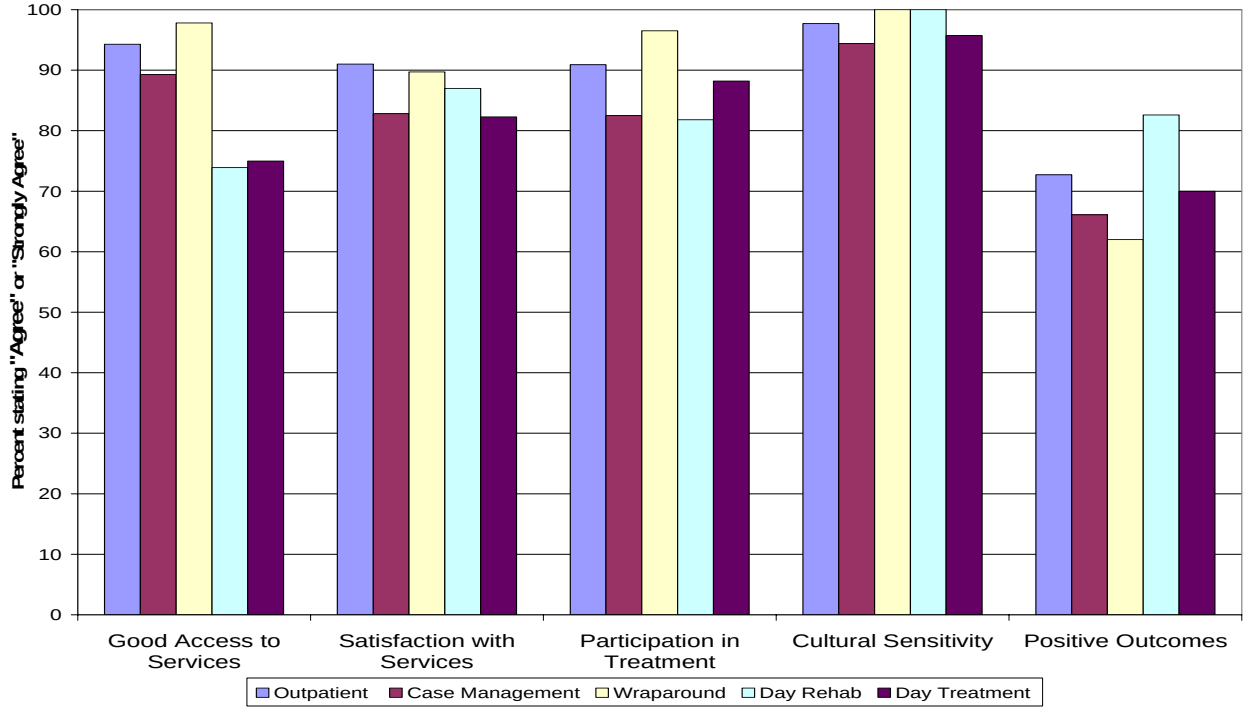


Figure 10.11: May 2005 Youth Services Survey Responses by Service Modality – Youth Survey

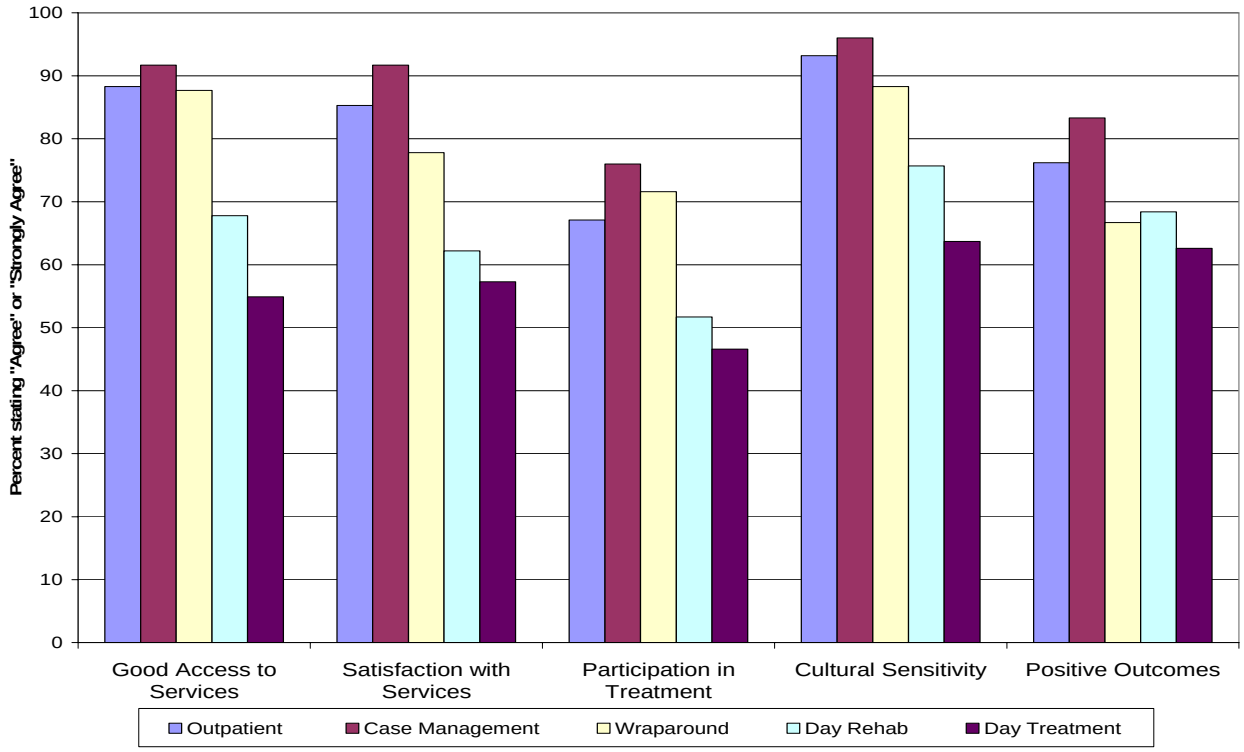
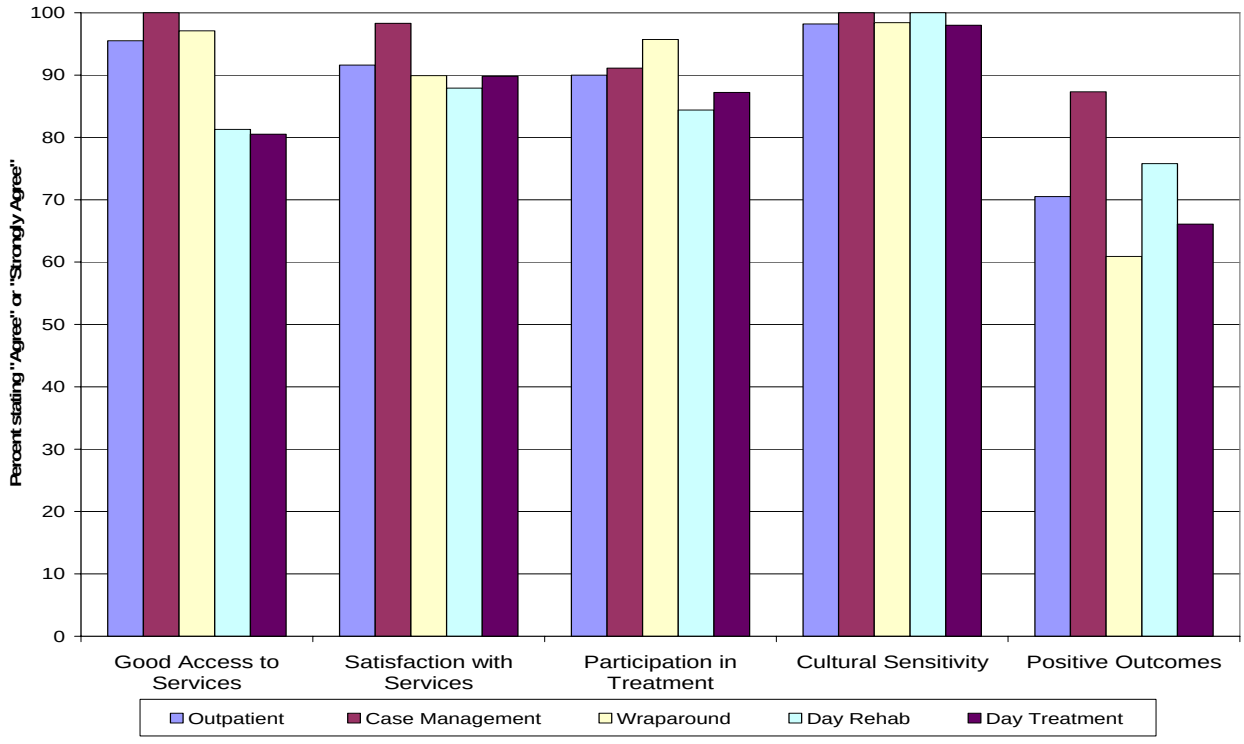


Figure 10.12: May 2005 Youth Services Survey Responses by Service Modality – Family Survey



CALIFORNIA DEPARTMENT OF Mental Health

ENGLISH Family Survey

YOUTH SERVICES SURVEY FOR FAMILIES* (YSS-F)

Please help our agency make services better by answering some questions. Your answers are confidential and will not influence current or future services you or your child will receive. **For each survey item below, please fill in the circle that corresponds to your choice. Please fill in the circle completely.** ***EXAMPLE:*** Correct ● Incorrect ✗ ✓

Approximately, how long has your child received services here? (CHOOSE ONE)

- ○ This is my child's first visit here.
- ○ My child has had more than 1 visit but has received services for less than 1 month.
- ○ Received services for 1 - 2 months.
- ○ Received services for 3 - 5 months.
- ○ Received services for 6 months to 1 year.
- ○ Received services for more than 1 year.

Please answer the following questions based on the **last 6 months** OR if services have not been received for 6 months, just give answers based on the services that have been received so far. Indicate if you **Strongly Disagree, Disagree,** are **Undecided, Agree,** or **Strongly Agree** with each of the statements below. If the question is about something you or your child have not experienced, fill in the circle for **Not Applicable** to indicate that this item does not apply.

	Strongly Disagree	Disagree	Undecided	Agree	Strongly Agree	Not Applicable
1. Overall, I am satisfied with the services my child received.	○	○	○	○	○	○
2. I helped to choose my child's services.	○	○	○	○	○	○
3. I helped to choose my child's treatment goals.	○	○	○	○	○	○
4. The people helping my child stuck with us no matter what.	○	○	○	○	○	○
5. I felt my child had someone to talk to when he / she was troubled.	○	○	○	○	○	○
6. I participated in my child's treatment.	○	○	○	○	○	○
7. The services my child and / or family received were right for us.	○	○	○	○	○	○
8. The location of services was convenient for us.	○	○	○	○	○	○
9. Services were available at times that were convenient for us.	○	○	○	○	○	○
10. My family got the help we wanted for my child.	○	○	○	○	○	○
11. My family got as much help as we needed for my child.	○	○	○	○	○	○
12. Staff treated me with respect.	○	○	○	○	○	○
13. Staff respected my family's religious / spiritual beliefs.	○	○	○	○	○	○
14. Staff spoke with me in a way that I understood.	○	○	○	○	○	○
15. Staff were sensitive to my cultural / ethnic background.	○	○	○	○	○	○
As a result of the services my child and / or family received:						
16. My child is better at handling daily life.	○	○	○	○	○	○
17. My child gets along better with family members.	○	○	○	○	○	○
18. My child gets along better with friends and other people.	○	○	○	○	○	○
19. My child is doing better in school and / or work.	○	○	○	○	○	○
20. My child is better able to cope when things go wrong.	○	○	○	○	○	○
21. I am satisfied with our family life right now.	○	○	○	○	○	○

*Molly Brunk, Ph.D., 1999. This instrument was developed as part of the State Indicator Project funded by the Center for Mental Health Services (CMHS) . It was adapted from the Family Satisfaction Questionnaire used with the CMHS Comprehensive Community Mental Services for Children and their Families Program and the MHSIP Consumer Survey.

Continued on the Next Page...

CSI County Client Number

Must be entered on BOTH PAGES 1 AND 2

Version 10/04

57717

Please answer the following questions to let us know a little about your child.

ENGLISH Family Survey

1. What is your child's gender? ○ Female ○ Male ○ Other

2. Are either of the child's parents of Mexican / Hispanic / Latino origin? ○ Yes ○ No ○ Unknown

3. What is your child's race? **(Mark all that apply.)**
- ○ White / Caucasian
- ○ Black / African American
- ○ Asian
- ○ American Indian / Alaskan Native
- ○ Native Hawaiian / Other Pacific Islander
- ○ Mexican/Hispanic
- ○ Unknown
- ○ Other_____

4. **Child's** Age ☐☐

5. What is your **child's** date of birth? (Write it in the boxes AND fill in the circles that correspond. See Example.)

Date of Birth (mm-dd-yyyy)

☐☐ - ☐☐ - ☐☐☐☐

0	○	○	○	○	○	○	○	○	○	○
1	○	○	○	○	○	○	○	○	○	○
2	○	○	○	○	○	○	○	○	○	○
3	○	○	○	○	○	○	○	○	○	○
4	○	○	○	○	○	○	○	○	○	○
5	○	○	○	○	○	○	○	○	○	○
6	○	○	○	○	○	○	○	○	○	○
7	○	○	○	○	○	○	○	○	○	○
8	○	○	○	○	○	○	○	○	○	○
9	○	○	○	○	○	○	○	○	○	○

EXAMPLE: Date of birth on April 30, 1987:

1. Write in your **child's** date of birth → 04 - 30 - 1987
2. Fill in the corresponding circles

Date of Birth (mm-dd-yyyy)

0	○	●	○	●	○	○	○	○	○	○
1	○	○	○	○	●	○	○	○	○	○
2	○	○	○	○	○	○	○	○	○	○
3	○	○	●	○	○	○	○	○	○	○
4	○	●	○	○	○	○	○	○	○	○
5	○	○	○	○	○	○	○	○	○	○
6	○	○	○	○	○	○	○	○	○	○
7	○	○	○	○	○	○	○	○	○	●
8	○	○	○	○	○	○	○	○	●	○
9	○	○	○	○	○	○	○	●	○	○

6 Does your child have an ongoing medical condition or chronic illness? ○ Yes ○ No List:_____

7. In the **past MONTH**, how many times was your child arrested for any crimes?
○ No arrests ○ 1 arrest ○ 2 arrests ○ 3 arrests ○ 4 or more arrests

8. How often was your child absent from school during the **last MONTH?**
○ 1 day or less ○ 2 days ○ 3 to 5 days ○ 6 to 10 days ○ More than 10 days ○ Not applicable / Not in school ○ Do not remember

9. Please mark the substances your child has used at least 3 times in the **last MONTH (Mark all that apply):**
○ none ○ ecstasy ○ marijuana ○ inhalants, huffing ○ alcohol, beer, wine ○ opiates, heroin
○ cigarettes ○ cocaine, crack ○ crystal meth, speed ○ hallucinogens (LSD, PCP etc.) ○ injected any substance

10. Were the services your child received provided in the language he / she preferred? ○ Yes ○ No

11. Was written information (e.g., brochures describing available services, your rights as a consumer, and mental health education materials) available to you in the language you prefer? ○ Yes ○ No

12. Please identify who helped you complete any part of this survey **(Mark all that apply):**
- ○ I did not need any help.
- ○ A mental health advocate / volunteer helped me.
- ○ Another mental health consumer helped me.
- ○ A member of my family helped me.
- ○ A professional interviewer helped me.
- ○ My child's clinician / case manager helped me.
- ○ A staff member other than my child's clinician or case manager helped me.
- ○ Someone else helped me. Who?: _____

Thank you for taking the time to answer these questions!

FOR OFFICE USE ONLY

REQUIRED Information:

Date of Survey Administration

11 – ☐☐ – 2004

Reporting Unit

☐☐☐☐☐

Make sure the same CSI County Client Number is written on BOTH PAGES 1 AND 2 OF THIS SURVEY.

☐☐☐☐☐☐☐☐☐☐

CSI County Client Number

Must be entered on BOTH PAGES 1 AND 2

Reason for Non-Completion (if applicable):
- ○ Refused
- ○ Impaired
- ○ Language
- ○ No Show
- ○ Caregiver Unavailable
- ○ Other_____

57717

Version 10/04

Youth Services Survey Results - Nov 2004

Countywide San Diego

Youth Form

Submitted: 1072 Completed: 811 Not Completed: 261

Reason Not Completed: 101 Refused, 12 Impaired, 2 Language, 72 No Show, 6 Caregiver Unavailable, 68 Other

How long were services received?	Count	Percent		Count	Percent
One Visit	49	7.6	3 - 5 Months	130	20.2
> One Visit < One Month	58	9.0	6 Months to 1 Year	132	20.5
1 - 2 Months	94	14.6	More Than 1 Year	182	28.2
			Total Responses	645	

Questions based on services received in last 6 months	Strongly Disagree %	Disagree %	Undecided %	Agree %	Strongly Agree %	N/A %	Total
1. Overall, satisfied with services received	4.8	5.0	14.9	42.5	30.6	2.2	837
2. Helped to choose services	9.0	16.6	19.9	34.0	15.0	5.5	820
3. Helped to choose treatment goals	5.2	8.0	14.4	48.1	21.6	2.7	825
4. The people helping stuck with us no matter what	3.9	6.3	17.4	38.1	31.9	2.4	824
5. Felt had someone to talk to when troubled	4.7	7.2	12.9	40.4	32.7	2.1	829
6. Participated in treatment	3.4	5.6	15.5	50.5	22.5	2.4	821
7. The right services were received	4.5	7.2	18.1	43.9	24.3	2.1	823
8. Location of services was convenient	4.3	6.3	16.0	45.0	25.6	2.7	811
9. Services available at convenient times	5.0	6.6	16.7	45.3	23.9	2.5	816
10. Got the help wanted	4.7	8.1	16.5	41.4	27.0	2.3	826
11. Got as much help as needed	4.2	9.1	20.2	39.6	24.6	2.3	816
12. Staff treated me with respect	5.0	4.5	9.5	39.9	39.1	2.0	819
13. Staff respected religious/spiritual beliefs	3.6	3.2	11.3	39.0	33.7	9.2	823
14. Staff spoke in understandable way	3.3	3.6	10.4	45.2	34.4	3.0	825
15. Staff sensitive to cultural/ethnic background	3.9	3.3	13.8	40.1	30.6	8.2	816
As a result of the services received:							
16. Better at handling daily life	4.0	5.0	21.2	44.7	22.1	3.0	824
17. Get along better with family members	3.9	7.4	20.0	43.1	22.3	3.4	822
18. Get along better with friends, other people	2.4	4.9	17.9	45.3	24.9	4.5	819
19. Doing better in school and/or work	3.3	7.2	19.9	41.9	24.2	3.5	823
20. Better able to cope when things go wrong	4.0	7.7	23.5	41.1	20.9	2.8	820
21. Satisfied with family's life right now	6.4	10.9	22.7	35.0	21.6	3.4	818

Youth Services Survey Results - Nov 2004

Countywide San Diego

Family Form (Completed by Parent/Caregiver)

Submitted: 1667 Completed: 1101 Not Completed: 566

Reason Not Completed: 98 Refused, 4 Impaired, 6 Language, 141 No Show, 245 Caregiver Unavailable, 72 Other

How long were services received?	Count	Percent		Count	Percent
One Visit	53	5.5	3 - 5 Months	167	17.5
> One Visit < One Month	75	7.8	6 Months to 1 Year	205	21.4
1 - 2 Months	179	18.7	More Than 1 Year	278	29.0
			Total Responses	957	

Questions based on services received in last 6 months	Strongly Disagree %	Disagree %	Undecided %	Agree %	Strongly Agree %	N/A %	Total
1. Overall, satisfied with services received	1.2	1.9	5.0	36.9	53.7	1.3	1090
2. Helped to choose services	2.9	4.1	3.8	48.1	33.1	7.9	1072
3. Helped to choose treatment goals	1.4	3.3	4.6	47.1	38.7	4.9	1076
4. The people helping stuck with us no matter what	1.5	2.8	6.4	37.8	48.0	3.6	1078
5. Felt had someone to talk to when troubled	1.3	2.1	5.4	40.7	47.6	3.0	1082
6. Participated in treatment	0.9	1.7	2.1	46.4	45.5	3.3	1077
7. The right services were received	1.4	2.1	7.9	39.7	46.3	2.5	1082
8. Location of services was convenient	1.2	4.4	2.9	40.2	49.5	1.7	1087
9. Services available at convenient times	1.2	2.9	3.5	40.6	50.1	1.7	1085
10. Got the help wanted	1.6	2.7	9.5	39.1	43.9	3.2	1084
11. Got as much help as needed	1.6	4.3	13.2	36.5	40.8	3.7	1078
12. Staff treated me with respect	1.1	0.6	1.3	33.6	62.7	0.6	1084
13. Staff respected religious/spiritual beliefs	0.8	0.5	3.0	33.9	50.6	11.3	1084
14. Staff spoke in understandable way	1.1	0.5	1.2	37.4	58.8	1.1	1084
15. Staff sensitive to cultural/ethnic background	1.0	0.7	3.8	34.8	48.1	11.6	1073
As a result of the services received:							
16. Better at handling daily life	1.8	5.6	19.5	40.0	27.7	5.3	1082
17. Get along better with family members	1.9	7.9	17.6	43.4	24.5	4.8	1079
18. Get along better with friends, other people	1.9	5.8	16.7	46.8	23.6	5.2	1074
19. Doing better in school and/or work	4.5	7.4	16.8	38.2	28.1	5.0	1083
20. Better able to cope when things go wrong	3.3	8.9	22.4	40.1	20.9	4.5	1078
21. Satisfied with family's life right now	5.3	12.5	18.5	37.6	22.2	3.9	1075

Youth Services Survey Results - May 2005
Countywide San Diego
Youth Form

Submitted: 1686 Completed: 1232 Percent Completed: 73%

Not Completed: 454
Reason Not Completed: 220 Refused, 20 Impaired, 5 Language, 122 No Show, 11 Caregiver Unavailable, 76 Other

How long were services received?	Count	Percent		Count	Percent
One Visit	64	6.8	3 - 5 Months	195	20.6
> One Visit < One Month	76	8.0	6 Months to 1 Year	227	23.9
1 - 2 Months	127	13.4	More Than 1 Year	259	27.3
			Total Responses	948	

Questions based on services received in last 6 months	Strongly Disagree %	Disagree %	Undecided %	Agree %	Strongly Agree %	N/A %	Total
1. Overall, satisfied with services received	4.4	4.9	11.3	43.5	34.3	1.6	1252
2. Helped to choose services	11.3	14.5	20.8	33.3	14.2	5.9	1247
3. Helped to choose treatment goals	5.7	7.6	14.6	46.5	22.6	3.0	1242
4. The people helping stuck with us no matter what	4.4	5.6	14.0	40.6	32.9	2.5	1246
5. Felt had someone to talk to when troubled	4.2	6.5	12.5	44.9	30.1	1.9	1252
6. Participated in treatment	3.0	3.8	13.3	52.6	24.8	2.5	1248
7. The right services were received	3.8	4.8	15.7	46.4	27.2	2.0	1241
8. Location of services was convenient	4.5	4.5	13.1	44.8	30.7	2.3	1242
9. Services available at convenient times	3.9	5.5	14.7	46.2	27.0	2.6	1248
10. Got the help wanted	3.7	5.9	15.4	45.7	27.5	1.9	1242
11. Got as much help as needed	4.2	6.9	17.9	41.2	27.5	2.2	1248
12. Staff treated me with respect	3.7	3.7	7.2	42.8	40.3	2.3	1237
13. Staff respected religious/spiritual beliefs	2.6	2.2	10.8	39.2	35.4	9.6	1246
14. Staff spoke in understandable way	2.7	1.9	8.6	47.1	37.7	2.0	1239
15. Staff sensitive to cultural/ethnic background	3.5	2.3	11.3	43.1	30.6	9.3	1241
As a result of the services received:							
16. Better at handling daily life	4.2	4.7	18.7	46.8	22.4	3.2	1238
17. Get along better with family members	4.0	7.2	20.2	41.3	23.3	4.0	1239
18. Get along better with friends, other people	3.9	5.1	15.5	44.7	27.3	3.6	1238
19. Doing better in school and/or work	4.1	6.4	17.8	42.0	25.1	4.6	1241
20. Better able to cope when things go wrong	4.7	5.0	20.6	45.4	20.3	4.0	1240
21. Satisfied with family's life right now	8.1	8.1	20.8	36.4	22.9	3.8	1253

Youth Services Survey Results - May 2005
Countywide San Diego

Family Form (Completed by Parent/Caregiver)

Submitted: 2633 Completed: 1608 Percent Completed: 61%

Not Completed: 1025

Reason Not Completed: 299 Refused, 17 Impaired, 37 Language, 167 No Show, 426 Caregiver Unavailable, 79 Other

How long were services received?	Count	Percent		Count	Percent
One Visit	89	6.5	3 - 5 Months	292	21.2
> One Visit < One Month	115	8.3	6 Months to 1 Year	326	23.7
1 - 2 Months	196	14.2	More Than 1 Year	360	26.1
			Total Responses	1378	

Questions based on services received in last 6 months	Strongly Disagree %	Disagree %	Undecided %	Agree %	Strongly Agree %	N/A %	Total
1. Overall, satisfied with services received	1.1	1.8	4.6	38.8	51.9	1.9	1598
2. Helped to choose services	1.3	5.0	4.5	50.1	33.4	5.7	1580
3. Helped to choose treatment goals	1.0	3.2	5.3	47.8	38.2	4.5	1572
4. The people helping stuck with us no matter what	1.8	2.1	5.4	37.5	47.6	5.6	1581
5. Felt had someone to talk to when troubled	1.2	1.8	5.7	39.3	48.4	3.7	1584
6. Participated in treatment	1.1	1.4	3.1	48.0	43.7	2.7	1587
7. The right services were received	1.1	1.5	8.5	42.9	43.5	2.7	1583
8. Location of services was convenient	1.7	2.8	3.1	41.2	50.1	1.1	1589
9. Services available at convenient times	1.1	2.0	2.6	43.0	49.8	1.5	1588
10. Got the help wanted	1.0	2.1	8.9	41.7	43.3	3.0	1585
11. Got as much help as needed	1.3	3.2	12.7	40.2	38.6	4.0	1570
12. Staff treated me with respect	0.9	0.1	1.0	32.2	64.5	1.2	1589
13. Staff respected religious/spiritual beliefs	0.9	0.0	2.7	32.3	49.9	14.3	1577
14. Staff spoke in understandable way	0.9	0.1	1.0	37.0	59.7	1.2	1594
15. Staff sensitive to cultural/ethnic background	0.9	0.4	2.8	34.4	47.5	14.0	1577
As a result of the services received:							
16. Better at handling daily life	2.7	5.3	20.8	43.0	23.3	5.0	1580
17. Get along better with family members	2.4	6.5	19.2	45.1	21.4	5.4	1576
18. Get along better with friends, other people	2.1	5.8	19.9	45.7	21.6	5.0	1572
19. Doing better in school and/or work	3.1	8.0	18.9	40.9	24.0	5.1	1581
20. Better able to cope when things go wrong	3.5	8.6	24.1	40.6	18.6	4.6	1584
21. Satisfied with family's life right now	4.8	13.2	20.6	38.8	19.2	3.5	1589

SYSTEM OF CARE EVALUATIONS
Family-Centered Behavior Scale

Client ID Number | | | | | | | | | |

Client Date of Birth | | | / | | | / | | |

Assessment Date | | / | | | / | | |

Reporting Unit | | | | | |

Staff ID | | | | | | |

Time Frame

	12 = 12 Months/1 Year	24 = 24 Months/2 Years	
06 = 6 Months	18 = 18 Months	77 = Discharge	Other = Enter the number of months

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Instructions: Read each item thinking about the person you have been asked to rate. Bubble in the circle beside each item that most closely fits your opinion of how often the staff member does the things described in each item. Rate the behavior on a scale from "Never" to "Always." Bubble in "I don't know" if you have not had the chance to observe how the staff member acts.

THE STAFF MEMBER...	Never 1	Rarely 2	Sometimes 3	Most of the time 4	Always 5	I don't know 6
1. accepts our family as important members of the team that helps our child.	○	○	○	○	○	○
2. helps us get all the information we want and/or need.	○	○	○	○	○	○
3. helps us get the help we want from our family, friends, and community.	○	○	○	○	○	○
4. blames me for my child's problems.	○	○	○	○	○	○
5. points out what my child and family do well.	○	○	○	○	○	○
6. listens to us.	○	○	○	○	○	○
7. respects our family's beliefs, customs, and ways that we do things in our family.	○	○	○	○	○	○
8. helps us do the same kinds of things that other children and families do.	○	○	○	○	○	○
9. makes it clear that we as a family, not the professional, are responsible for deciding what is done for our child and family.	○	○	○	○	○	○
10. plans meetings at times and places that are good for our family.	○	○	○	○	○	○
11. criticizes what we do with our child.	○	○	○	○	○	○
12. treats us with respect.	○	○	○	○	○	○

SYSTEM OF CARE EVALUATIONS
Family-Centered Behavior Scale

Client ID Number

THE STAFF MEMBER...	Never 1	Rarely 2	Sometimes 3	Most of the time 4	Always 5	I don't know 6
13. makes negative judgments about us because of ways that we are different from the staff member (such as race, income level, job, or religion).	○	○	○	○	○	○
14. cares about our entire family, not just the child with special needs.	○	○	○	○	○	○
15. makes decisions about my child's care without asking me what I want.	○	○	○	○	○	○
16. helps my family meet our needs as we see them.	○	○	○	○	○	○
17. suggests things that we can do for our child that fit into our family's daily life.	○	○	○	○	○	○
18. understands that I know my child better than anyone else does.	○	○	○	○	○	○
19. helps my family get services from other agencies or programs as easily as possible.	○	○	○	○	○	○
20. talks in everyday language that we can understand.	○	○	○	○	○	○
21. helps our family expect good things in the future for ourselves and our children.	○	○	○	○	○	○
22. makes sure we understand our family's rights.	○	○	○	○	○	○
23. accepts our feelings and reactions as normal for our situation.	○	○	○	○	○	○
24. wants to hear what we think about this program.	○	○	○	○	○	○
25. supports my making as many decisions as I choose to about what is done for my child and family.	○	○	○	○	○	○
26. encourages me to speak up during meetings with professionals when there is something I want to say.	○	○	○	○	○	○

Chapter 11: 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:**

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

This chapter presents data on the SOC Outcome Goals for the CMHS population.

1. LIVING AT HOME OR IN HOME-LIKE SETTINGS

General Sample:

- 4% of youth in Mental Health Services used **Inpatient Services**
  (3% in FY03-04, 4% in FY02-03)

- 2% of youth in Mental Health Services used **Residential Services**
  (4% in FY03-04, 7% in FY02-03)

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:

- 7% of youth, ages 13+, in Mental Health Services report that they were **arrested** in the past month (6% in FY03-04)
- 2% of parents report that their youth in Mental Health Services was **arrested** in the past month. (2% in FY03-04)
- 14% of youth in MH Services are also in **Juvenile Justice**
  (17% in FY03-04; 20% in FY 02-03)

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:

- 33% of youth in Mental Health Services are also receiving **Special Education Services** in their community school district
  (35% in FY03-04, 36% in FY 02-03)

- 54% of youth had been absent from school **one day or less** in the previous month, as reported on the YSS.
  (52% in FY03-04)

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:

- 4% of youth in Mental Health Services received an **inpatient service** in FY04-05 (3% in FY03-04, 4% in FY02-03)
- 25% of youth in Mental Health Services were also involved in **Child Welfare** in FY04-05 (25% in FY03-04, 24% in FY02-03)

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:

- 22% of youth, ages 13 and older, reported that they had an "ongoing medical condition or chronic illness
  (24% in FY03-04)
- 32% of parents reported that their child had "ongoing medical condition or chronic illness"
  (39% in FY03-04)
- 2% of youth in Mental Health Services have a **dual diagnosis**
  (2% in FY03-04)
- 3% of youth in Mental Health Services are also **active to Alcohol and Drug Services**
  (5% in FY03-04)

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, asses, and refer children for needed mental, physical, and developmental services across all public sectors.

6. SATISFIED

General Sample:

- **90% of parents** stated "agree" or "strongly agree" regarding overall satisfaction with services, as compared to **72% of youth**, on the November 2004 YSS
- **92% of parents** stated "agree" or "strongly agree" regarding overall satisfaction with services, as compared to **78% of youth**, on the May 2005 YSS
  - **91% of parents** stated "agree" or "strongly agree" regarding overall satisfaction with services, as compared to **77% of youth**, on the November 2003 YSS.
- The average score on the Family-Centered Behavior Scale in FY04-05 was **93.6%**

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.