

Overview of the 2016 Project on Behavioral Health Services For Children and Youth in California



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For the California Behavioral Health Planning Council

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The California Behavioral Health Planning Council (Council) is under federal and state mandate to advocate on behalf of adults with severe mental illness and children with severe emotional disturbance and their families. The Council is also statutorily required to advise the Legislature on behavioral health issues, policies and priorities in California. The Council advocates for an accountable system of seamless, responsive services that are strength-based, consumer and family member driven, recovery oriented, culturally and linguistically responsive and cost effective. Council recommendations promote cross-system collaboration to address the issues of access and effective treatment for the recovery, resiliency and wellness of Californians living with severe mental illness.

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LIST OF ACRONYMS USED IN THIS REPORT

AA	Alcoholics Anonymous
AB	Assembly Bill
ACA	Affordable Care Act (2010)
ASIST	Applied Suicide Intervention Skills Training (includes related programs)
BH	Behavioral Health
BHCS	Behavioral Health Care Services (term used by some county departments)
BHU	Behavioral Health Unit
Cal OES	California Office of Emergency Services
CABHB/C	California Association of Behavioral Health Boards and Commissions
CBHDA	County Behavioral Health Directors Association
CBHPC	California Behavioral Health Planning Council (“Planning Council”)
CDSS	California Department of Social Services
CFR	Code of Federal Regulations
CFS	Child and Family Services (also see CFT: Child and Family Team).
CIT	Crisis Intervention Teams
CPS	Child Protective Service
CSEC	Commercially Sexually Exploited Youth
CSS	Community Services and Supports (category of MHSA programs),
CSU	Crisis Stabilization Unit
CWS	Child Welfare Services
CY	Calendar Year
DCR	Data system used by DHCS for FSP programs
DHCS	Department of Health Care Services
DN	Data Notebook
EBP	Evidence-based Program or Practice
ED or ER	Emergency Department or Emergency Room
EDAPT	Early Diagnosis and Preventative Treatment, a therapeutic model commonly funded as a PEI program by MHSA
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
EQRO	External Quality Review Organization
FEP	First Episode Psychosis program (SAMHSA-sponsored MHBG grant)
FSP	Full Service Partnership Program
FY	Fiscal Year
HIPAA	Health Insurance Portability and Accountability Act
GSA	Gay Straight Alliance (club or association)
ICC	Intensive Care Coordination
INN (or Inn)	Innovation Project funded by MHSA grant
IHBS	Intensive Home Based Services
Katie A	Refers to a lawsuit filed on behalf of foster care youth
LGBTQ	Lesbian, Gay, Bisexual, Transgender or Questioning
MCRT	Mobile Crisis Response Team (aka Mobile Crisis Support Team, MCST)
MD	Medical Doctor
MH	Mental Health
MHA	Mental Health America (Association)

MHBG	Mental Health Block Grant (from the federal government)
MHP	Mental Health Plan; county managed care plans for delivering BH services
MHSA	Mental Health Services Act (Proposition 63)
MHSOAC	Mental Health Services Oversight and Accountability Commission
MHWA	Mental Health Wellness Act (SB 82)
MIOCR	Mentally Ill Offender Crime Reduction Grant
MOU	Memorandum of Understanding, a type of legal agreement
MST	Mobile Support Team (also called MRT, Mobile Response Team)
ODS	Organized Delivery system (for SUD treatment services)
NA	Narcotics Anonymous
NAMI	National Association for Mental Illness
NorCal MHA	Northern California Mental Health Association
NSDUH	National Survey on Drug Use and Health (annual)
NTP	Narcotics Treatment Program
PATH	Projects for Assistance in Transition from Homelessness
PEI	Prevention and Early Intervention
PFLAG	Parents, Families, and Friends of Lesbians and Gays (organization)
PIER	P.I.E.R. Multi-Family Support Group
PREP	Prevention and Recovery in Early Psychosis (funded by Center for Medicaid Services Challenge grant)
Sac EDAPT	Sacramento (UC Davis) therapeutic model for Early Diagnosis and Preventative Treatment (commonly funded as a PEI program by MHSA)
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPT	Substance Abuse, Prevention and Treatment (grants from SAMHSA_
SB	Senate Bill
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SED	Seriously Emotionally Disturbed
SMHS	Specialty Mental Health Services
SMI	Seriously Mentally Ill
SOS	Signs of Suicide, a prevention program
SUD	Substance Use Disorders
TAY	Transition Age Youth
TESS	Transitional Engagement Supportive Services (e.g., for TAY foster youth)
WET	Workforce Education and Training (funded by MHSA and other sources)
WRAP	Wellness Recovery Action Plan
YFS	Youth and Family Services

INTRODUCTION: Project Objectives

The purpose of this report is to describe the observations and findings of the California Behavioral Health Planning Council (CBHPC) on the behavioral health (BH) needs and services for the children, youth, and transition age youth (TAY)¹ who are served by the public mental health (MH) system in California. This report includes responses by local county advisory board members to the 2016 Data Notebook issued by the CBHPC.

We chose to focus on children and youth because of the prevalence of mental disorders and the widespread experience of community and individual trauma as a complicating factor. It's estimated that 5%, or more, of California's 9 million children are affected by a MH-related condition. Of these, only one-third to one-half receive any MH services to treat their symptoms. Nationally, one of the top ten reasons² for hospitalization of children is for MH disorders. However, in California these disorders now comprise the number one reason for hospitalization of children ages 1-17.

Early intervention and treatment can change the trajectory of long-term chronic serious mental illness. That assumption underlies "Early and Periodic Screening, Diagnosis and Treatment" (EPSDT) programs that define certain MH services for children and youth up to age 21 under the Medicaid program, called Medi-Cal in California.

In California, Medi-Cal supports healthcare services for more than 6.3 million children (Fiscal Year, FY15-16). Of these, only slightly more than a quarter million (258,640) receive Specialty Mental Health Services (SMHS), which are targeted for those with serious emotional disorders (SED) or severe mental illness (SMI). This population, combined with those youth receiving treatment for a substance use disorder (SUD), is the main focus of the survey of the 2016 Data Notebook discussed in this report.

What is the Data Notebook?

The Data Notebook is a structured format for reviewing information and reporting on specific behavioral health services in each county. Each year the CBHPC researches and presents data from multiple sources with an interdisciplinary perspective shaped by a commitment to the values of "whole person care," in that behavioral and physical health services ideally should represent an integrated system of coordinated care. That perspective is particularly important for services to children, youth, and TAY. For the

¹ There are various definitions of the age ranges for these groups depending on data source as described in the table in Appendix I. In this report, the term "transition-age youth (TAY)" is taken to be ages 16-25, consistent with programs of the Mental Health Services Act.

² Excluding neonatal and adolescent pregnancy, affective disorders (primarily depression) represent 3.6% (or 74,000) of U.S. pediatric hospitalizations. <https://archive.ahrq.gov/data/hcup/factbk4.htm>. Also see the most recent California hospitalization data in www.kidsdata.org (accessed May 2018).

2016 project cycle, we received 44 Data Notebook reports from local boards representing data from 46 counties that comprised 87% of our state's population. Those responses represent one major source of information for this report.

Methods: Where Did We Find Resources for the Data?

We present a selective review of statewide data that is most relevant to the topic and its related discussion. Public resources for these data are listed in Appendix II. Any data reported for small population counties required special care to protect patient privacy; for example, by combining several counties' data together or by "masking" (redaction) of data cells containing small numbers. Data that we received from the California Department of Health Care Services (DHCS) or other agencies has been prepared with a level of redaction consistent with HIPAA³ and other privacy laws.

In this report we use that data to examine access and engagement in services by children, youth and families. Where available, we use that data to examine disparities in access by different cultural groups. In addition, we take a closer look at especially vulnerable populations of children and youth, for example those in foster care, or involved with the justice system, or who face other major challenges to their well-being and behavioral health. Wherever possible, research and data are shared to provide context for the issues and needs of these youth.

ACCESS: Outreach and Engagement with Services

Earlier in this report, it was indicated that at least 5% of California's 9 million children are affected by mental health issues and that less than one half receive any services. So reaching children and families with the needed services and supports is paramount. The CBHPC looked into what the data tells us about who is accessing services and how long they stay engaged with services.

One goal shared by the public mental health system and programs of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color⁴ and LGBTQ youth. If children, youth or their families are not

³ Health Insurance Portability and Accountability Act (1996), Section 1171, Part C, Subtitle F of Public Law 104-191.

⁴ The term, "communities of color," refers to Native Hawaiians and other Pacific Islanders; Latino/Hispanic Americans; Asian Americans; American Indians and Alaska Natives; and African Americans, inclusive of immigrants from Africa and the Caribbean. These groups have been given priority attention by the Office of Minority Health because of their well-documented health needs and disparate health status when compared to the total population. The CBHPC monitors and evaluates data about these groups as one way of assessing how effectively disparities and outcomes in health care are being addressed. LGBTQ refers to lesbian, gay, bisexual, transgender, or questioning persons.

accessing services, changes may need to be made to programs so that they better complement a family's culture or language needs. Therefore, we examine relevant indicators in the data compiled from county behavioral health plans for the treatment of serious emotional and MH disorders. The rich diversity of California presents challenges to providing culturally and linguistically appropriate services because our residents represent nearly every country of the world.

Demographics of Children/Youth Receiving Specialty MH Services

From data the counties report to the state, we can see how many children and youth in a county are eligible for Medi-Cal and how many made one or more visits for mental health services. There are several ways to measure service outreach and engagement that help evaluate how different groups are doing in accessing mental health care. The simplest way to examine the demographics of a service population is to look at "pie chart" figures which show the percentage of services provided to each group in our state. Figure 1 (top, next page) shows the percentages of children and youth from each major race/ethnicity group who made one or more visits for SMHS treatment during the fiscal year (FY). These overall proportions change by no more than about 1% in any given year for the state as a whole, even when total numbers change.

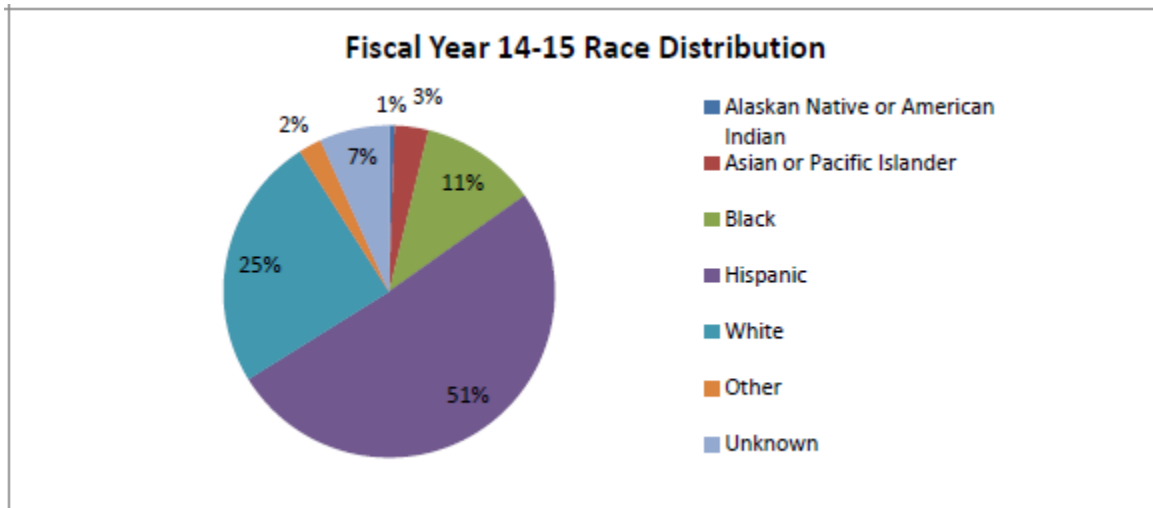
The lower half of the figure shows the percentage of each age group that received SMHS treatment. The gender distribution is not shown because it is fairly stable year over year across the state as a whole: about 45% of service recipients are female and about 55% are male.

Figure 1. Demographics, State of California (FY 2014-2015)

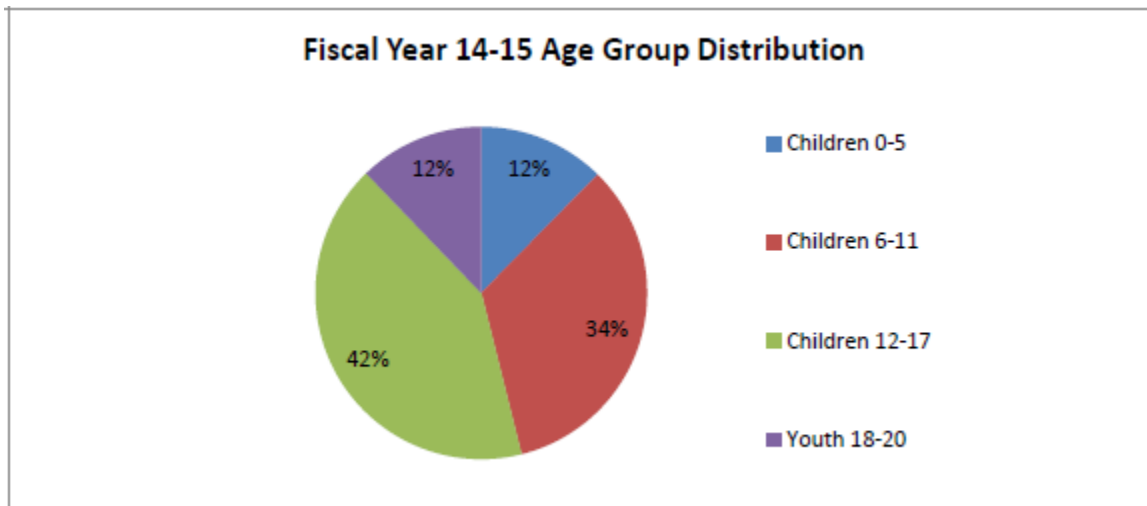
Unduplicated numbers of children and youth who were Medi-Cal eligible: **6,352,757**

Of those, the number of children and youth who received one or more SMHS: **266,915.**

Top: Major race/ethnicity groupings of children and youth who received one or more SMHS during the fiscal year.



Below: Age groups of children and youth who received one or more SMHS during the year.



Increased Numbers of Medi-Cal and SMHS Clients but Lower Rates of Access

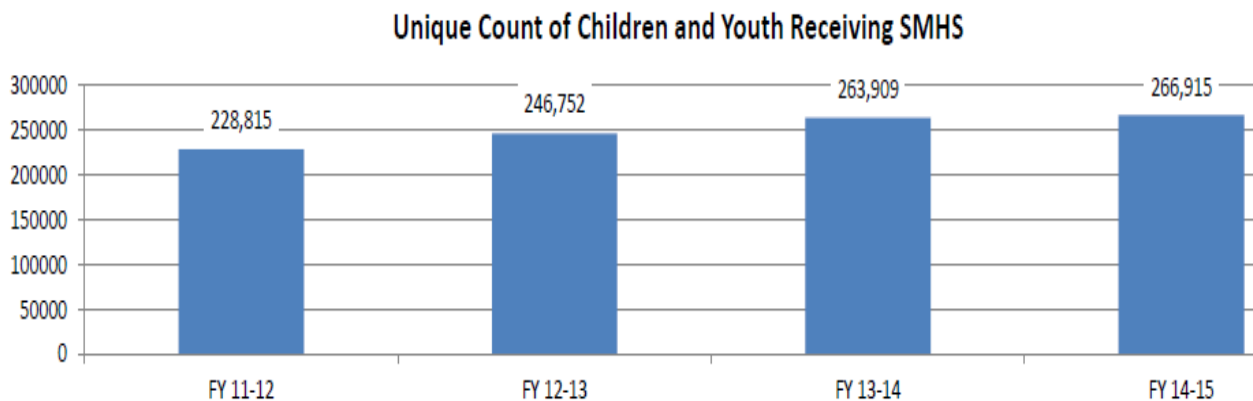
In contrast to the fairly stable proportions shown above, there have been marked increases in both the total numbers of people eligible for Medi-Cal and those who received SMHS since 2011. That year is when California began implementing the federal Affordable Care Act (ACA, 2010). The number of Medi-Cal eligible families and children increased significantly. Rapid expansion in the total Medi-Cal eligible population challenged resources at both state and county levels, as shown below.

Figure 2: Passage of the ACA (2010) Increased the Total Numbers of Children/Youth Eligible for SMHS Services funded by Medi-Cal.

Top: The rates of growth, year over year, are summarized to enable a simple, year-by-year comparison of the increase of those eligible for Medi-Cal with the increased numbers of children/youth that received SMHS during each FY.

SFY	Unique Count Receiving SMHS*	Year-Over-Year Percentage Change	Unique Count of Medi-Cal Eligibles	Year-Over-Year Percentage Change
FY 11-12	228,815		4,775,304	
FY 12-13	246,752	7.8%	5,476,043	14.7%
FY 13-14	263,909	7.0%	6,037,115	10.2%
FY 14-15	266,915	1.1%	6,352,757	5.2%
Compound Annual Growth Rate SFY**		5.3%		10.0%

Lower graph: shows the growth in numbers of children/youth receiving SMHS through FY 14 - 15.



*SMHS = Specialty Mental Health Services. See Measures Catalog for more detailed information.

**SFY = State Fiscal Year which is July 1 through June 30.

Measures of Access and Sustained Engagement with Services

Client access and engagement in services are complex issues and are somewhat difficult to measure. One way to assess client engagement is using “penetration rates.” Service penetration rates measure an individual’s initial access to SMHS provided by the local mental health plan (MHP). Figure 3 on the next page shows data that illustrate two common ways to measure penetration rates:

- One way is to count how many children and youth came in for at least one service during the year, as shown in the data in the top half of figure 3. These data may provide information about outreach and at least initial access to services for child/youth clients of different ages and race/ethnicity groups.
- Another way to measure the penetration rate is to consider how many clients had sustained access to services for at least five or more visits, as shown in the data in the lower half of figure 3. This is sometimes referred to as the “retention rate.”

Figure 3 (top, next page) shows how many children/youth received at least one SMHS. The second column shows the number who were certified as Medi-Cal eligible in each group. The final column at the right shows service penetration rates, which are calculated by dividing the number who received services by the total number who were Medi-Cal eligible.

The second table, in the lower part of Figure 3, shows data for those with longer engagement in services. The first column shows how many children/youth received five or more services during the fiscal year. The middle column, shows numbers who were Medi-Cal eligible. The column at the right shows the percentage in each group who received five or more services. This sustained engagement is another measure of access.

Figure 3. SMHS Visits and Service Penetration Rates, California (FY 2014 -15):

Top: Children and youth who received at least one SMHS visit during year.

	FY 14-15		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	266,915	6,352,757	4.2%
Children 0-5	33,050	1,899,764	1.7%
Children 6-11	90,003	1,838,788	4.9%
Children 12-17	111,313	1,622,677	6.9%
Youth 18-20	32,549	991,528	3.3%
Alaskan Native or American Indian	1,440	22,848	6.3%
Asian or Pacific Islander	8,795	560,523	1.6%
Black	30,374	463,333	6.6%
Hispanic	135,952	3,573,360	3.8%
White	66,224	1,001,776	6.6%
Other	6,015	237,756	2.5%
Unknown	18,115	493,161	3.7%
Female	119,396	3,133,356	3.8%
Male	147,519	3,219,401	4.6%

Below: Children and youth who received five or more SMHS visits during year.

	FY 14-15		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	203,992	6,352,757	3.2%
Children 0-5	22,063	1,899,764	1.2%
Children 6-11	71,497	1,838,788	3.9%
Children 12-17	88,340	1,622,677	5.4%
Youth 18-20	22,092	991,528	2.2%
Alaskan Native or American Indian	1,067	22,848	4.7%
Asian or Pacific Islander	6,758	560,523	1.2%
Black	23,354	463,333	5.0%
Hispanic	103,287	3,573,360	2.9%
White	50,912	1,001,776	5.1%
Other	4,570	237,756	1.9%
Unknown	14,044	493,161	2.8%
Female	90,189	3,133,356	2.9%
Male	113,803	3,219,401	3.5%

How Access and Engagement Changed Over Time for Different Groups

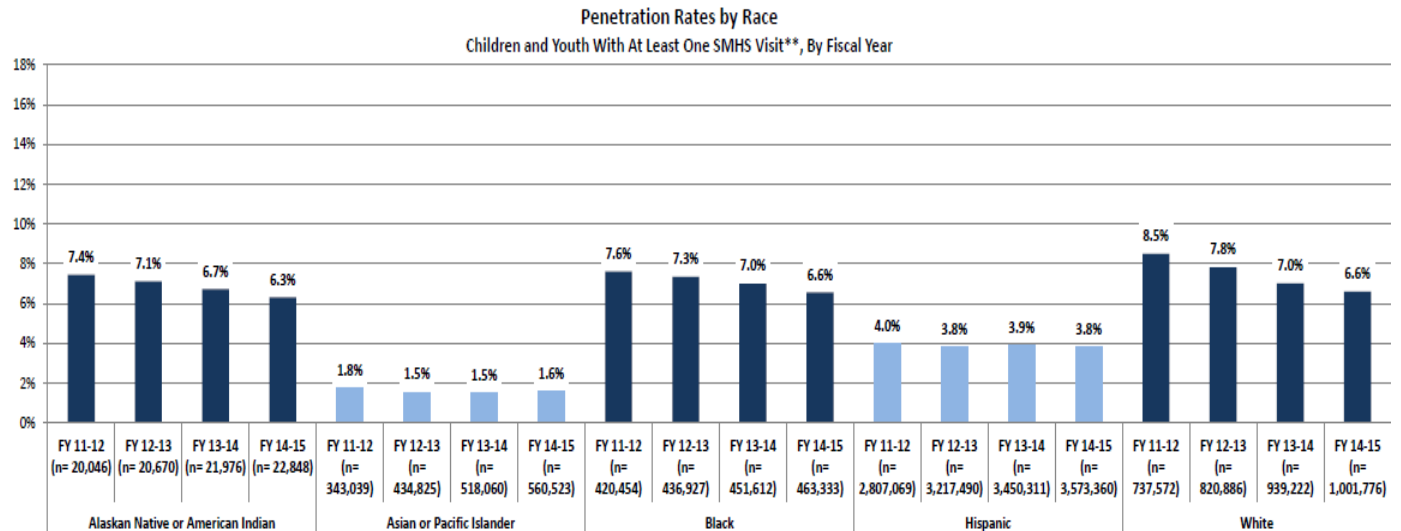
Next, we examine whether there were improved changes in access to services for children and youth. Figures 4-A and 4-B show changes over time in a set of bar graphs. The first graph (in 4-A) shows changes over four fiscal years in service penetration rates by race/ethnicity, for children and youth who had at least one visit for SMHS services. Each group of bars shows the changes over time for one major race/ethnicity group.

Similarly, Figure 4-B shows trends over time in continued service engagement for different race/ethnicity group members who received 5 or more services in the most recent four fiscal years.

Note that service penetration rates declined for some race-ethnicity groups even as the total numbers receiving SMHS increased for those groups, especially for African Americans, Native Americans, and Caucasians. However, that percent increase was less than the marked increase in numbers of those eligible for Medi-Cal. The data show that penetration rates for Asian Americans/Pacific Islanders and Hispanics declined very slightly or stayed nearly level in spite of greatly increased numbers of those eligible for Medi-Cal and who received SMHS.

These observed changes can be understood by taking into account the Medi-Cal expansion that occurred during the period 2011 to 2015 as the state began implementing the federal ACA (2010). Families with incomes up to 138% of the federal poverty level became eligible for Medi-Cal. Also, children and their families that were previously enrolled in the federal Children's Health Insurance Program (CHIP) transitioned to Medi-Cal as part of the expansion. The changes in total Medi-Cal eligible population resulted in a statewide increase of 14.7% in FY12-13 relative to the previous year, and a further increase of 10.2 % in FY 13-14.

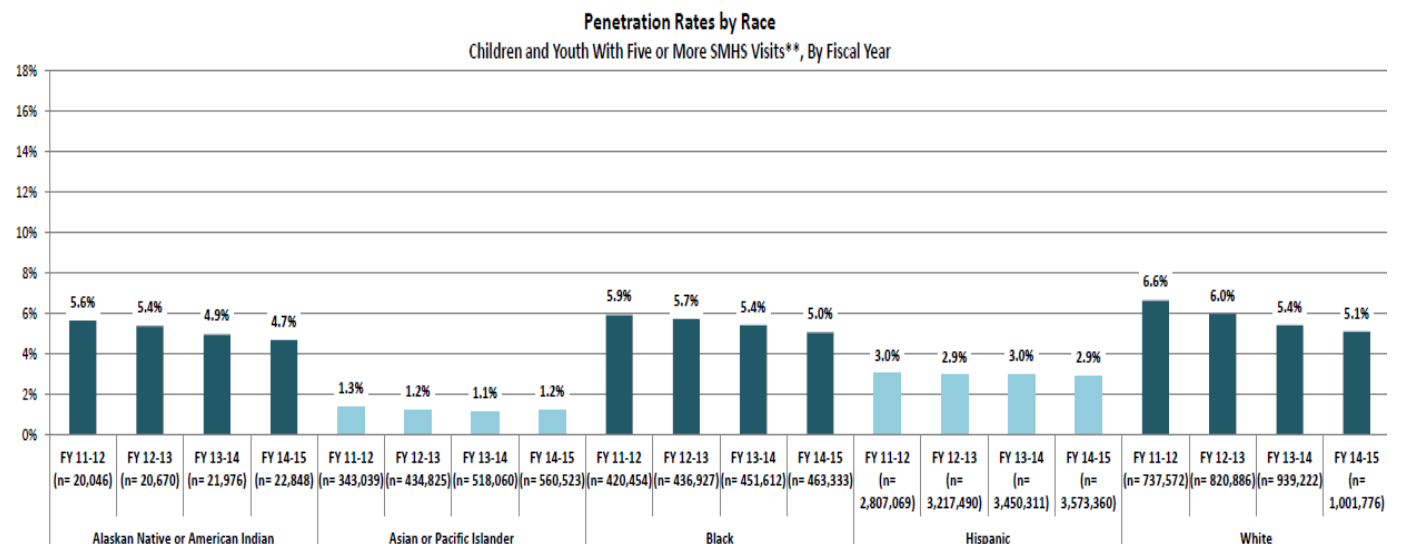
Figure 4-A. Access to SMHS: Changes Over a Four-Year Period in Service Penetration Rates by Race/Ethnicity, for Children/Youth with at Least One SMHS During a Fiscal Year. California, FY 11-12 through FY 14-15.



*Penetration Rate is defined as the percentage of SMHS eligible beneficiaries that have received a SMHS that was claimed via the Short-Dayle/Medi-Cal claiming system. This does not include non-specialty mental health services provided in Medi-Cal Managed Care system.

**Children and Youth that have received at least one SMHS that was claimed through the Short-Dayle/Medi-Cal claiming system on at least one (1) day in the Fiscal Year.

Figure 4-B. Retention and Engagement in SMHS: Changes over Time in Service Penetration Rates by Race-Ethnicity for Children/Youth with Five or more SMHS during a Fiscal Year. California, FY 11-12 through FY 14-15.



*Penetration Rate is defined as the percentage of SMHS eligible beneficiaries that have received a SMHS that was claimed via the Short-Dayle/Medi-Cal claiming system. This does not include non-specialty mental health services provided in the Medi-Cal Managed Care system.

**Children and Youth that have received at least five SMHS that were claimed through the Short-Dayle/Medi-Cal claiming system in the Fiscal Year.

The above information presents numbers for all of California. To get a local perspective, the Council provided county-specific data (or region-specific data where numbers were too small). Then, we asked the local boards whether they think their county is effective at providing access and engagement for children and youth in their communities.

Overwhelmingly, 41 of 44 counties indicated that their county is doing an effective job providing access and engagement for children and youth in all of their communities. The few counties which answered “no” cited barriers to access, including: outlying or rural areas, lack of transportation, lack of funding or funding restrictions, and lack of awareness by families about MH services available under full-scope Medi-Cal.

Some boards listed county programs that promote outreach and engagement activities which help to address specific behavioral health issues, such as:

- Follow-up care for children and youth after a mental health crisis or a psychiatric hospitalization.
- Mental health and other supportive services for foster care children and youth.
- Outreach, education, support, and engagement in MH services for LGBTQ youth and their loved ones.
- Substance use treatment services designed for specific age groups of children, youth, and TAY clients.
- Behavioral health services for justice-involved youth, both for those in custody and following release or on probation.
- Youth at risk for suicide or suicide attempts, and prevention, training and other outreach programs.
- Early identification, engagement, and intervention for first break (first episode psychosis) in adolescent and TAY clients.
- Role of Full Service Partnership (FSP) services and/or wrap-around services for children, youth, and TAY clients.

Timely Follow-up Services after Child/Youth Psychiatric Hospitalization

The goals of timely follow-up services after psychiatric hospitalization are to promote sustained recovery and to prevent a relapse that could lead to another hospitalization. Children and youth vary greatly in their path to recovery. Sometimes a subsequent hospitalization is needed in spite of the best efforts of the healthcare providers, parents/caregivers, and the clients themselves. Federal quality standards require that these data be collected and monitored to reduce rates of re-hospitalization.

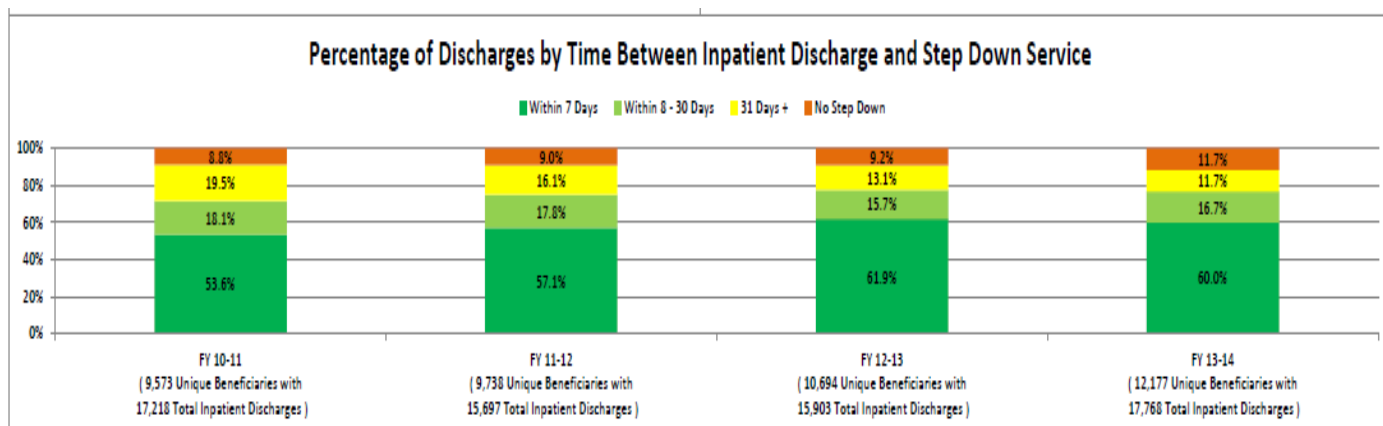
“Step-down” is a term used by some mental health care professionals to describe a patient’s treatment as “stepping down” from a higher intensity level of care to a lower level of care, such as outpatient care. Another example of step-down is when a hospital patient is transferred to crisis residential care or day treatment for further stabilization to promote a smoother transition to outpatient care.

Next, Figure 5 shows data for the overall population of children and youth under the age of 21 who were discharged from a psychiatric hospitalization. The upper half of the figure shows trends in the data from one fiscal year to the next. The columns in this table show the overall percentages of clients with follow-up services within 7 days and those who received such services within 30 days. These time frames reflect important federal healthcare quality measures that are used, not only for mental health, but for medical discharges after hospital stays for physical illnesses and injuries.

Figure 5. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization in California.

Time to Step Down Report: Children and Youth Stepping Down in SMHS Services Post Inpatient Discharge
Statewide as of July 28, 2015

Service FY	Count of Inpatient Discharges with Step Down within 7 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 7 Days of Discharge	Count of Inpatient Discharges with Step Down within 30 Days of Discharge	Percentage of Inpatient Discharges with Step Down within 30 Days of Discharge	Count of Inpatient Discharges with a Step Down > 30 Days from Discharge	Percentage of Inpatient Discharges with a Step Down > 30 Days from Discharge	Count of Inpatient Discharges with No Step Down*	Percentage of Inpatient Discharges with No Step Down*	Minimum Number of Days between Discharge and Step Down	Maximum Number of Days between Discharge and Step Down	Mean Time to Next Contact Post Inpatient Discharge (Days)	Median Time to Next Contact Post Inpatient Discharge (Days)
FY 10-11	9,229	53.6%	12,342	71.7%	3,359	19.5%	1,517	8.8%	0	1733	57.3	4
FY 11-12	8,962	57.1%	11,758	74.9%	2,530	16.1%	1,409	9.0%	0	1303	39.0	3
FY 12-13	9,850	61.9%	12,350	77.7%	2,090	13.1%	1,463	9.2%	0	987	27.8	2
FY 13-14	10,660	60.0%	13,619	76.6%	2,079	11.7%	2,070	11.7%	0	624	18.9	2



* No Step Down is defined as no Medi-Cal eligible service was claimed through Short-Doyle/Medi-Cal after a claimed inpatient service was billed with a discharge date. This category may include data currently unavailable to DHCS, such as beneficiaries that were moved to a community-based program or beneficiaries that were incarcerated.

When examining the post-hospitalization data, take special note of the percentages that received follow-up services within 7 days after discharge, within 30 days after discharge, or later. These time frames reflect federal healthcare quality standards.

In addition, many counties identified a need for programs or facilities to provide crisis-related services specifically to help children and youth⁵ avoid re-hospitalization.

Timeliness of Follow-up Services Post-Crisis or After Hospital Discharge:

The local boards were asked whether their data showed timeliness of follow-up services when a child/youth is discharged from a psychiatric hospitalization. Most counties, regardless of population size, answered in the affirmative. A few of the small and medium population counties answered in the negative with no further comment. Others

⁵ Statewide needs for youth crisis services were reviewed in a major report by CBHDA (County Behavioral Health Directors Association) in collaboration with the MHSOAC. Your local advisory board/commission may find this report highly informative (released in late spring, 2016).

provided information which showed the positive strategies being employed to achieve timely follow-up, even though they acknowledged room for improvement.

One county commented on their recently completed Performance Improvement Plan which had the goal of reducing the time to first follow-up service following discharge from the Crisis Stabilization Unit (CSU). They also plan, in similar fashion, for follow-up services when a child or youth is discharged from an out-of-county psychiatric hospital. They further stated that they seek to improve follow-up with non-Medi-Cal clients, which comprise about 10% of their CSU clients.

Another county provided the following comments which address some of the common challenges encountered by many small and medium-sized county MHPs:

- The MHP has a Youth and Family Services (YFS) hospital liaison who interfaces with the hospital treatment team/discharge planner and/or the youth/family during hospitalizations to ensure timely connection or reconnection with services.
- Timeliness metrics are somewhat misleading, since measurement is based on paid Medi-Cal claims. However, initial follow up services may be provided by the Mobile Crisis Response Team or Transitions Team that cannot bill Medi-Cal.
- Using paid claims to track timeliness, this MHP provides a first service post-hospitalization with an average of 13 days post discharge. While 67% of follow-up services meet the MHP standard of being within seven days post hospital release, there is clearly room for improvement [in this county].
- Some structural factors can impede timely post-hospital follow-up, such as staff turnover or if there is no psychiatric inpatient facility in [this] county so all hospitalizations for children/youth occur out-of-county.

Some of the local boards that answered “no” gave the following recommendations:

- Improve use of the hospital liaison and all available resources for connecting swiftly with youth, with attention to documenting and tracking services provided.
- Improve data quality to enable more accurate trending of this variable.

Services and Programs to Assist Parents of a Child after Crisis or Hospital Discharge:

Effective programming is necessary to meet the needs of both the child/youth and the parents in order to intervene early enough to avoid further crisis or hospitalization. Such events take a toll on families and they need supportive tools and resources to maintain

their child at home. Many counties offer specialized services and programs, such as parent training courses, peer parent mentors, and specific coordination with county staff to create a discharge and safety plan for the child. Examples of basic procedures and services include, but are not limited to, the following:

- Improved discharge planning and streamlined process, including contact with the family or guardian.
- Mobile Response Team (MRT or in some counties: Mobile Services Team, MST) can assist with discharge planning and schedule a follow-up appointment.
- Urgent appointments are offered to any client seen by the MRT.
- Expedite medication appointments or other clinical appointments as needed.
- Able to provide transportation when necessary.
- In rare cases when the parent is not available or where the child has been removed from a home pending foster placement, the child or youth may be placed in juvenile hall when no other option is available. In these cases, coordination of services and planning are essential.
- Other, more intensive, services and strategies include:
 - Child and Family Teaming
 - In-home behavioral supports
 - Therapeutic behavioral services
 - Intensive care coordination
 - Mental health rehabilitation
 - Case management
 - Emergency housing.

Services Not Funded by Medi-Cal that Support Families of Children/Youth Following Hospitalization or Other MH Crisis:

Although many services provided to children, youth and families are covered by Medi-Cal, other highly effective county services are not reimbursable. The post-hospital follow-up data previously shown are based on services billed to Medi-Cal. As a result, those data do not capture follow-up services supported by other funding sources. So the Council asked the local boards to identify or describe programs funded by other sources. They listed many different programs, some of which were MHSA-funded, some

receive funding from the SAMHSA Mental Health Block Grant (MHBG), county funds, or other resources. Below are examples of the most common services and programs:

- All services provided through peer and family advocates, e.g. Family Partners.
- Parenting classes, including “Strengthening Families” programs.
- In-home parenting services.
- National Association for Mental Illness (NAMI) provides Family-to-Family classes.
- Homeless youth drop-in center(s) provide TAY with basic needs (showers, laundry, food, etc.) while also working to gain trust to provide more intensive services (case management, counseling, crisis intervention, life skills groups).
- Full Service Partnership (FSP) programs for child/youth clients or their families.
- Culturally-based services, which may include therapeutic activity groups.
- Family Resource Centers help support families.
- Transitional Engagement Supportive Services (TESS), funded by MHS.
- California Office of Emergency Services (Cal OES) Child Abuse Treatment Program grants provide services to crime victims regardless of insurance status.
- Prevention and Early Intervention (PEI) programs—these are numerous and varied, ranging from programs such as “Strengthening Families at Risk” to those for early intervention and treatment of psychosis in adolescents and TAY.
- Youth eligible for educationally-related MH Services funded through schools.
- Some MH or SUD treatment services for probation youth that are funded by a Mentally Ill Offender Crime Reduction Grant (MIOCR).
- Family Advocacy program and their peer family advocates provide services supported by Mental Health America.

VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

Foster Children and Youth

Foster children and youth comprise an extremely vulnerable group that faces considerable life challenges. Serious mental health consequences may result from the traumatic experiences that led to placement in foster care. Foster children and youth are just 1.3 % of all Medi-Cal eligible children and youth (ages 0-20). However, they represent 13 % of the total children and youth who received SMHS in FY 2013 – 2014.

Recent studies^{6,7} of foster youth in California schools show that MH challenges affect outcomes in all aspects of their lives. These data demonstrate the following facts.

- **Time in Foster Care** – More than 43,000 (or about one of every 150 K-12) public-school students in California spent some period of time in child welfare supervised foster care.
- **Reason for Removal** – Of students in foster care, 78% were removed from birth families due to neglect, 11% physical abuse; 4% sexual abuse; and 7% other.
- **Grade Levels** – Of these students in foster care, 40% were in Elementary School; 23% were in Middle School; and 36% were in High School.
- **An At-risk Subgroup** – Nearly one in five students in foster care had a disability compared to 7% of all K-12 students and 8% low socioeconomic status (SES) students.
- **School Mobility** – Among students who had been in foster care for less than one year, 48% had changed schools during the academic year.
- **Achievement Gap** – Proficiency in English language arts for students in foster care was negatively correlated with grade level.
- **Drop-out and Graduation** – Students with three or more placements were more than twice as likely to drop out as students with one placement. However, this single-year dropout rate is still twice that for low SES students or K-12 students.
- **Conclusion:** these students constitute an at-risk subgroup distinct from low socioeconomic status students regardless of characteristics of their foster care.

⁶Summary from Child Welfare Council Report, 2014-2015; for more source material, see: <http://www.chhs.ca.gov/Child%20Welfare/CWC%202105%20Report-Approved090215.pdf>. Also see: The Invisible Achievement Gap, Part 1. Education Outcomes of Students in Foster Care in California’s Public Schools. <http://stuartfoundation.org/wp-content/uploads/2016/04/the-invisible-achievement-gap-report.pdf>.

⁷ The Invisible Achievement Gap, Part 2. How the Foster Care Experiences of California Public School Students Are Associated with Their Education Outcomes. <http://stuartfoundation.org/wp-content/uploads/2016/04/IAGpart2.pdf>

The problems and unmet service needs in the foster care population compelled child advocates to push for major changes. As a result, in 2012, Senate Bill 1013 was signed into law and directed the California Department of Social Services to work with counties and stakeholders to develop recommendations to address a myriad of issues in the child welfare system. These issues included rate-setting systems, identification and provision of needed support services, and performance standards and outcome measures for providers of out-of-home care placements.

In January 2015, the California Department of Social Services released California's Child Welfare Continuum of Care Reform to address the requirements of SB 1013. At present, the state, county welfare and mental health departments, schools and others are working actively to implement the 19 recommendations.

Overlapping those legislative and program developments, major changes were compelled by settlement of the "Katie A." lawsuit regarding the need of certain foster youth for specific types of more intensive mental health care. The services included under the 2011 court settlement order are intensive home-based services (IHBS), intensive care coordination (ICC), and therapeutic foster care (TFC). As a consequence, more foster youth are now receiving essential MH services.

The numbers of foster youth who received SMHS in recent years are shown below. These data do not include those with mild to moderate mental health needs who are served in the Medi-Cal Managed Care System or by school-based services.

HOW MANY CALIFORNIA FOSTER CHILDREN AND YOUTH RECEIVE SPECIALTY MENTAL HEALTH SERVICES (SMHS),* INCLUDING "KATIE A" SERVICES?

Statewide: (FY 2013-2014) Certified Medi-Cal eligible Foster Care Youth (age 0-20): 77,405.

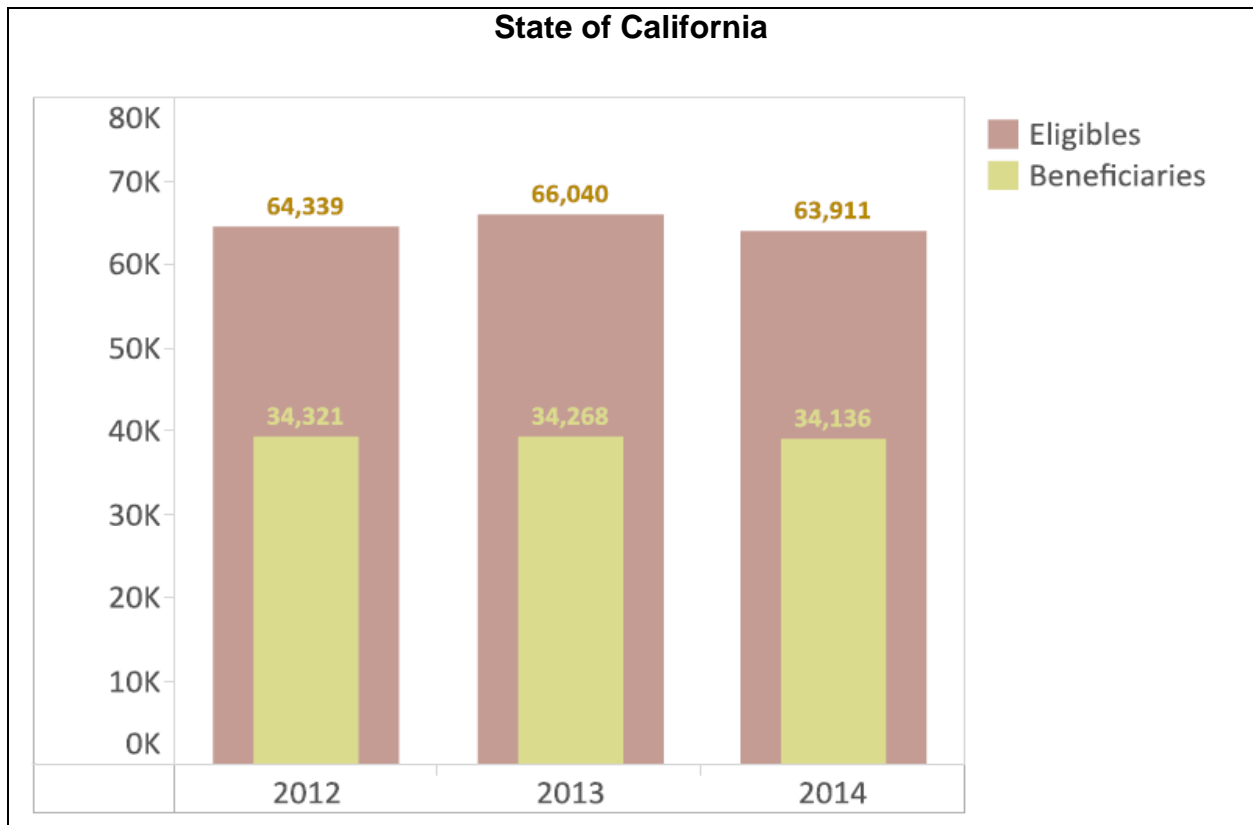
- Total number of Medi-Cal foster youth who received at least one SMHS: **34,353** (service penetration rate was 44.3 %).
- Total Medi-Cal eligible foster care youth who received five or more SMHS: **26,692.**

Statewide: (FY 2014-2015) Total Unique Katie A. Subclass Members: 14,927 received additional intensive mental health services, including in-home services if needed.

* Data reports are from: <http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx> for fiscal years 2014 or 2015 (depending on which data were available when this report was prepared).

The figure below shows changes over time in the percentage of Medi-Cal eligible foster children under 18 who received SMHS. Note the trends year-to-year in California.

Figure 6. Foster Youth Who Received Specialty MH Services, 2012-2014 ⁸



We asked local advisory boards how services are delivered and prioritized for foster youth in their county. Responses submitted by several boards, in partnership with their county departments of BH, were similar and described a standard of care, as follows.

Prioritizing mental health services for foster children/youth often involves several steps in the pathway to services and treatment, sometimes taken in sequence, or overlapping with other steps, or on a parallel time course, as follows:

1. When the child is taken into foster care, a Child Welfare Services social worker completes a screening to determine if the child may benefit from mental health services. If so, they will send a referral and the child is scheduled for an assessment to determine medical necessity. It is a priority to complete the mental health assessments and initial referrals quickly.

⁸ Medi-Cal Specialty Mental Health External Quality Review: FY 15-16 Statewide Report, Behavioral Health Concepts, Inc. California EQRO for Medi-Cal Specialty Mental Health Services. EQRO is the External Quality ReviOrganization. www.CALEQRO.com, see "Reports," and select either statewide or your county to view data.

2. Referral may be made to either the county Department of Behavioral Health for screening for SMHS, or to an outside provider for mild-to-moderate behavioral health needs, possibly through the Medi-Cal managed care health plans.
3. If screening indicates that the child or youth meets medical necessity criteria for specialty mental health, an additional assessment is made to determine whether the individual would benefit from intensive care coordination (ICC), (intensive home based behavioral health services (IHBS), or therapeutic behavioral health services (TBS). Some children or youth will meet criteria for the more intensive level of care defined under “Katie A” practice guidelines contained in Pathways to Wellness, (see DHCS website). Family wrap-around services may also be provided in coordination with those services, depending on demonstrated need.
4. The services and screenings listed above for foster care may also be provided to families at risk of having one or more children placed in foster care, as determined by Child Welfare Services.
5. For children and youth that receive SMHS, an initial Child Family Team (CFT) meeting likely will be scheduled. There is ongoing communication between Behavioral Health and Child Welfare through the referral process, shared tracking spreadsheet for referrals, multi-disciplinary meetings and collaboration between clinicians and social workers. Depending on the county and the ongoing needs of the foster child or youth, such multidisciplinary meetings may be held weekly to monthly, and may change with the situation.
6. Many county Departments of Behavioral Health are co-located with Child Welfare Services (CWS), or alternatively, have full-time clinicians stationed within the child welfare department. The goal is to promote ongoing care coordination and changes in behavioral health care as needed.
7. Some larger child welfare departments may have a full-time dedicated Behavioral Health Unit (BHU) that provides screening, assessment and services for most of their child/youth clients who need those services. There is continued monitoring and re-assessment as needed.
8. If the child or youth does not meet criteria for SMHS, they may be referred to other programs such as a Prevention and Early Intervention (PEI) Program or an Innovation program.

Some counties have additional programs to prioritize mental health care for foster children and youth, and designed to promote continued engagement in treatment by foster youth. Several counties reported extensive descriptions of specific evidence-based therapy and services for foster youth. The large variety of available services provides abundant evidence of the support system for foster youth, foster parents, and to parents whose children are at-risk of being placed in foster care.

Some counties expressed concern that there are still a significant number of foster children and youth who fail to get needed services or otherwise “fall through the cracks” of the system, especially when an out-of-county placement is made. Nonetheless, an overwhelming majority of local boards responded affirmatively when asked if their county did a good job of coordinating services to meet the mental health needs of children in foster care. The importance of co-location of services with child welfare was emphasized by many respondents.

One large county commented on judicial orders for treatment and the restrictions on confidentiality that can limit information sharing by mental health professionals with Child and Family Services (CFS) and even the foster parents. They stated:

“The biggest impact upon serving dependents has been the creation of a standing judicial order which authorizes CFS to consent to mental health treatments and authorizes behavioral health staff to release information. Prior to this standing order, extensive efforts were needed to get authorization from biological parents and/or individualized court orders to conduct an assessment. This one standing order has allowed CFS to refer a child for services and provide the behavioral health staff with all needed documentation to start services.”

More comments, strategies, and suggestions for foster youth MH services included:

- Need for more foster families within the county, and need for more training of foster parents, including an orientation to trauma-informed care.
- Sometimes foster parents become overwhelmed and decline more intensive services that have been recommended for the child, indicating a need for a more supportive role for staff to encourage the foster parent to understand the child’s needs and to assist them in accessing care.
- Difficulties persist in the ability to find and hire bilingual, bicultural licensed clinicians to work in the children’s system of care.
- Additional staff are needed to provide timely access to care for all children and youth, including those in foster care.

- More peer services are needed, including peer services for older youth and those TAY still receiving foster care or support during transition to independence.
- Parents of foster children also need peer/partner services.
- Transferring responsibility for out-of-county youth may have unintended adverse consequences, so both staff and clinicians need to be aware of such issues.
- BH treatment for Native American foster youth must include cultural and spiritual interventions. Models of Indigenous wellness are not strictly clinical but should include cultural components from providers able to provide linkage and service.
- There should be cultural coaches or experts able to provide direct service who have a variety of lived experiences, such as former foster youth, indigenous peoples, and LGBTQ communities.
- Behavioral health treatment should integrate the goal of recovery with a focus on the SAMHSA-defined “Eight Dimensions of Wellness,”⁹ which includes a recognition that the long-lasting effect of trauma is a complex and holistic issue.
- All treatment should be goal-based and youth-driven, and work toward assisting young people to develop life-long holistic coping mechanisms.
- Give foster youth a choice in receiving psychotropic medications:
 - Be transparent to foster youth regarding psychotropic medications.
 - Limit medication to the least intrusive, smallest amount possible.
 - Communicate information about drug side effects to foster parents.
 - Ensure that the response to any negative behavioral or affective changes caused by the medication is not further treatment with a higher dose or the addition of another medication.
 - Give psychoeducation for youth about medications and role in treatment.
- Engagement of foster youth and TAY with mental health services may be encouraged by social support and therapeutic activity groups (art, music, equine therapy, summer camps, and life skills training programs).

⁹ www.SAMHSA.gov The “Eight Dimensions of Wellness” include the following: emotional, physical, social, spiritual, intellectual, occupational, financial, and environmental realms of life. For a related recovery-focused perspective, SAMHSA has described four major “Dimensions of Recovery:” health, home, purpose, and community.

- Provide school-based services including coordinating with school psychologists and include after-school drop-in support programs for foster youth and peers.
- Children and youth who are in foster care as wards of the court system should be greeted immediately by a team of mental health professionals at the juvenile justice facility, to link youth with behavioral health services as soon as possible.

Lesbian, Gay, Bisexual, Transgender and Questioning Youth (LGBTQ)

LGBTQ youth are another group which may be underserved or inappropriately served. Most counties say that LGBTQ youth are welcome to engage in their standard programs and receive services, as are all other cultural groups. However, it is essential to understand how counties are serving the specific needs and difficulties faced by LGBTQ youth. The data show that members of the LGBTQ community access mental health services at a higher rate than heterosexuals, with some reports suggesting that 25-80% of gay men and women seek counseling. Many individuals report unsatisfactory experiences due to a therapist's prejudice, inadvertent bias, or simple inability to comprehend the experiences and needs of their LGBTQ clients.¹⁰ Research and experience demonstrate that LGBTQ youth have unique needs that are most effectively provided by therapists and program directors with specialized training in serving these specific populations. There is increased emphasis on trauma-informed therapies that are shown to improve outcomes when delivered within such programs.

Particular risks for LGBTQ youth and children include discrimination, bullying, violence, and even homelessness due to rejection by their families of origin or subsequent foster homes. Homelessness introduces great risk from all the hazards of "life on the street." In addition, research has shown that those LGBTQ youth who were rejected by their families were eight times as likely to attempt suicide, nearly six times more likely to have high levels of depression, and three times as likely to use illegal drugs.

However, evidence-based therapies do lead to better outcomes for LGBTQ youth. One example is the research by The Family Acceptance Project headed by Dr. Caitlin Ryan that demonstrated positive outcomes showing how important family acceptance is to the health and wellbeing of their LGBTQ family member.¹¹ This program facilitates reunification of youth with their families including those from traditional cultural backgrounds or those with conservative religious beliefs.

¹⁰ P. Walker et al., "Do No Harm: Mental Health Services: The Good, the Bad, and the Harmful."

¹¹ Dr. Caitlin Ryan, 2009. Helping Families Support Their Lesbian, Gay, Bisexual, and Transgender (LGBT) Children. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development. *Also see:* Ryan, C. (2014). Generating a Revolution in Prevention, Wellness & Care for LGBT Children & Youth, Temple Political & Civil Rights Law Review, 23(2): 331-344. Note that many research reports do not have the data option to identify under the "Q" part of LGBTQ, hence the use of just "LGBT" in many parts of our report

More information has come to our attention during the public review and discussion of this report. Recent studies provide more comprehensive information about the needs and experiences of LGBTQ youth and children in their communities.

National findings¹² on data from the juvenile justice system show that:

- Approximately 20% of all incarcerated youth are LGBT.
- Nearly 40% of incarcerated girls identify as LGBT.
- 85-90% of incarcerated LGBT youth are persons of color.⁴

Multiple reports document the vulnerability to substance use by LGBT youth:¹³

- Transgender students are nearly 4 times as likely to use cocaine/methamphetamines and 3 times as likely to use ‘ecstasy.’
- Lesbian, gay, and bisexual students are 2 times more likely to use cocaine or ‘ecstasy’ and almost 4 times as likely to use methamphetamines.

In Los Angeles County,¹⁴ approximately 1 in 5 (or about 1,400) foster youth identify as LGBTQ, and relative to non-LGBTQ foster youth are more likely to:

- Report being treated poorly by the foster care system (12.9% vs. 5.8%).
- Have been hospitalized for emotional reasons (13.5% vs 4.2%).
- Live in a group home (25.7% vs. 10.1%).
- Become homeless after leaving foster care (21.1% vs. 13.9%).

Recent surveys of the school experience of LGBTQ youth and children report that:¹⁵

- Fully 57.6% of students felt unsafe at school because of their sexual orientation.
- About 43.3% felt unsafe because of their gender expression or identity.
- About 46% had been disciplined at school.

All of these data underscore the importance of providing services that are well-informed and appropriate to address the needs of LGBTQ children and youth in our systems of education, foster care, juvenile justice, mental health and SUD treatment. Sound evidence-based practices are essential to assist and educate parents of LGBTQ youth.

¹² Unjust: LGBTQ Youth Incarcerated in the Juvenile Justice System (June, 2017), report authored by the Center for American Progress (Washington, D.C.), The Movement Advancement Project (Denver, Colorado), Youth First (Washington, D.C., www.youthfirstinitiative.org) and other partner organizations.

¹³ Youth Risk Behavior Survey (YRBS), Data for California (2015), Centers for Disease Control and Prevention, USA. Also see: California Healthy Kids Survey (CHKS) regarding transgender youth in the most recent data (Spring, 2018).

¹⁴ Sexual and Gender Minority Youth in Foster Care: Assessing Disproportionality and Disparities in Los Angeles (August, 2014). Report from L. A. Department of Children and Family Services, Los Angeles, CA.

¹⁵ Kosciw, J. G., *et al.* (2016). The 2015 National School Climate Survey: The Experiences of Lesbian, Gay, Bisexual, Transgender, and Queer Youth in Our Nation’s Schools. A Report from GLSEN, New York; www.GLSEN.org.

We asked local advisory boards whether their county has programs which are designed and directed specifically for LGBTQ youth? Two-thirds of counties responded “yes,” but one-third reported “no.” Those who answered “no” emphasized that all services and evidence-based practices are open to LGBTQ youth and that they are welcomed. The counties’ cultural competence committees provide LGBTQ-related training to staff and may include outside providers. In some of these counties, there are other LGBTQ services from groups such as Pride, Stonewall Alliance Center, NorCal MHA, or activity-based monthly support groups in the community (some of which are funded by MHSAs).

For example, one large county’s Children System of Care is working to increase culturally competent services to engage LGBTQ youth. They recognize that this population is at increased risk for suicide, homelessness, substance use and disengagement from family. They plan a more targeted approach by implementing a SAMHSA-funded program for “Helping Families to Support Their LGBTQ Children.”

County-based programs that are targeted for LGBTQ youth include:

- The Pride Center (and related programs, such as Pride House) and groups located at colleges and universities: offer free peer support services, outreach, advocacy, other resources, and linkage to other services.
- The Stonewall Alliance provides support, resources, education, advocacy, and celebration.
- Safe Zone Coalition operates a specialized Safe Zone Curriculum or may help participants make contact with therapy resources or self-help groups as needed.
- LGBTQ Collaborative: their projects provide education and legal services.
- “The Epicenter” provides continuous training for community-based organizations and BH service providers on LGBTQ cultural competence, to empower at-risk and system-involved youth ages 16-24,” and connect them to community resources. The Epicenter now partners with Turning Point of Central California.
- Transgender Advocacy Network: a peer-led group for transgender children, youth and their families.
- Parents, Families and Friends of Lesbians and Gays (PFLAG): provides support for families and friends of LGBTQ individuals through meetings and events.
- Gay/Straight Alliances clubs on school campuses facilitate social contacts, meet with potential allies, and function as one type of “Safe Zone.”

- The Trevor Project, a leading national organization providing crisis intervention and suicide prevention services to LGBTQ youth ages 12-24. This group provides crisis counseling, supportive counseling, and a sense of community. They also provide training on suicide prevention, risk detection and response. They have a toll-free suicide prevention hotline to connect youth to resources.
- NorCal MHA provides LGBTQ training in several counties through the LGBTQ California Reducing Disparities Project grant funded by The California Endowment as part of the Building Health Communities Initiative.

Because of the dramatic improvement in outcomes for LGBTQ youth who are able to receive acceptance from their family of origin, we asked local boards if their counties have programs or services designed to improve family acceptance of their LGBTQ youth, and/or with the goal to heal the relationship of the youth to his/her family? The large and medium size counties all responded “yes.” But the majority of small population counties responded “no,” citing a lack of resources and trained staff.

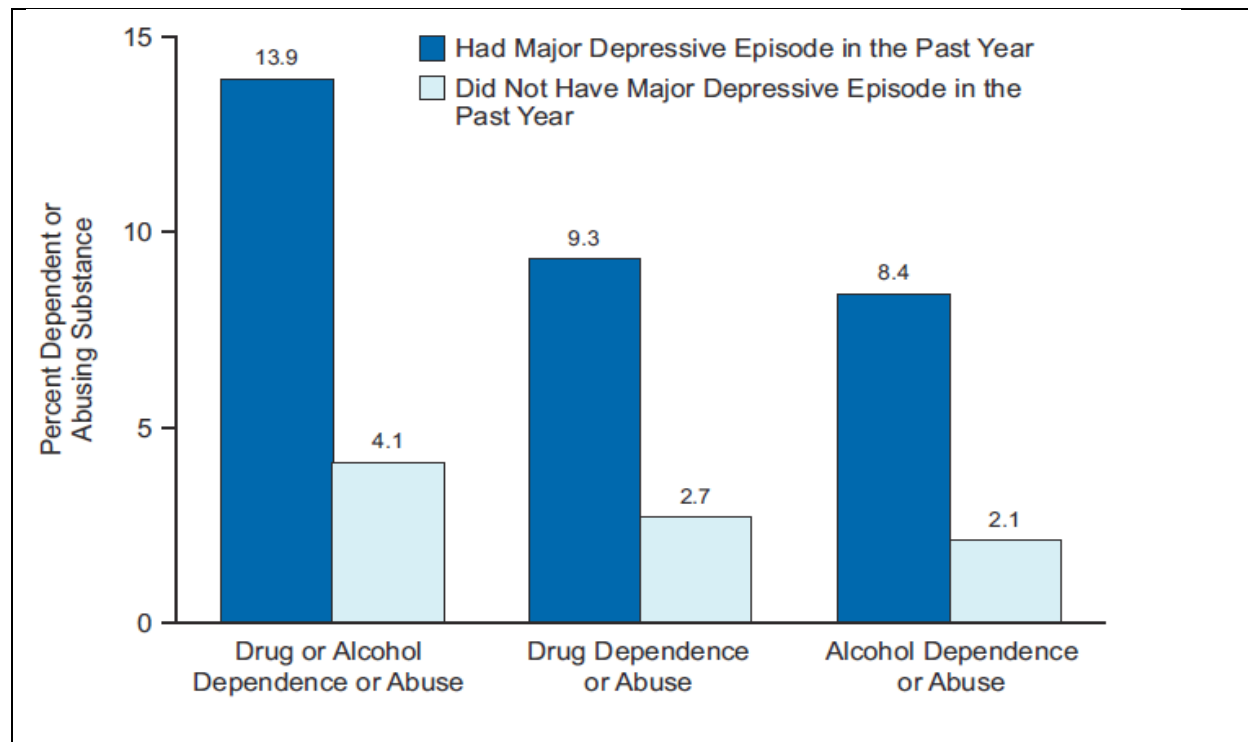
Children and Youth Affected by Substance Use Disorders

Counties generally have several levels of substance use disorder programs. These include prevention, treatment, and recovery supports. Prevention refers to services that target people before a diagnosable substance use disorder occurs, and may be based in schools or the community. Treatment refers to directly intervening in a substance use disorder using clinical means and evidence-based practices by trained clinical staff. Recovery support refers to supporting long term recovery and includes secondary prevention services as well. Resources for each of these main program areas are not equally available in all counties or areas of the state. Many small population counties have very limited types of substance use treatment programs.

Young people who engage in early substance abuse may do so because they are experiencing MH challenges. Children and youth experiencing a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to their same-age peer group without depression.¹⁶ (See figure below).

¹⁶ Results from the 2013 National Survey on Drug Use and Health: Mental Health Findings, at: <http://www.samhsa.gov/data/sites/default/files/NSDUHmhfr2013/NSDUHmhfr2013.pdf>

Figure 7. Past Year Substance Abuse and Depression in U.S. Youth, Age 12-17.



Previously, the Planning Council released a Data Notebook (2015) that included a section on substance use disorders in all groups, but emphasized adults and those with co-occurring mental health disorders. Community and school-based prevention efforts were also discussed. However, SUD services for children and youth were not addressed. Therefore, our focus here is SUD treatment for children and youth. Adverse outcomes may occur in adolescents placed in adult programs. Both experience and evidence show that children and youth are best served by treatment programs which are designed specifically for their emotional and social developmental stages. The recent legalization of marijuana in California may add to the numbers of youth needing substance use treatment.

In California, many of the 30 smaller population counties (<200,000), have limited treatment options, with an emphasis on outpatient treatment or abstinence programs.¹⁷ There are shortages of providers and of narcotic treatment programs (NTP), which are of concern given recent trends in narcotic drug abuse and overdoses in all age groups, including youth.

¹⁷California Substance Use Disorder Block Grant & Statewide Needs Assessment and Planning Report, 2015. Presented as a collaborative effort between numerous staff at DHCS, CDPH, and the UCLA Integrated Substance Abuse Program. <http://www.dhcs.ca.gov/provgovpart/Documents/2015-Statewide-Needs-Assessment-Report.pdf>

This table shows combined data for calendar years 2013-2015 regarding any alcohol or drug use in past month (“some”), as self-reported by California high school age youth.¹⁸

Table 1. Alcohol or Drug Use in Past Month by High School Age Youth

California	Percent	
	Some	None
Grade Level		
7th Grade	10.4%	89.6%
9th Grade	23.2%	76.8%
11th Grade	33.4%	66.6%
Non-Traditional	60.2%	39.8%

Numbers of Youth that Began Substance Use Disorder Treatment, FY 2013-2014:

California: Statewide Age < 18: 14,957 Age 18-25: 23,614

For comparison, the numbers who began SUD treatment, FY 2015-2016:

Ages 15-25: 31,010. (We do not have the breakdown for those under 18).

When the Council researched SUD treatment programs for youth, we found that essentially all counties offer substance abuse prevention services for youth either in the community or based at schools, sometimes in conjunction with mental health wellness and prevention programs. Nearly all counties offered outpatient drug-free individual counseling and/or group therapy to youth or children with a diagnosed substance use disorder, with treatment given by either the BH department or by an outside provider.

Some drug-free groups are held under the aegis of Alcoholics Anonymous or Narcotics Anonymous but are strictly limited to specific youth age groups. Such groups may take place on school sites after hours. Individual sessions with substance abuse counselors may occur at the county BH department, at a provider’s office, or local campus offices. TAY-specific therapy groups or individual counseling sessions are commonly offered.

More options for SUD treatment for all age groups are in the process of a staged roll-out in many counties. As of May 2018, at least 32 counties are implementing the Drug Medi-Cal Organized Delivery System (DMC-ODS), which requires that more types of SUD treatment be offered than just outpatient drug-free programs and that these services should be available to those eligible in their county. An additional eight small population northern counties are initiating a regional model in conjunction with

¹⁸ Data shown are from www.kidsdata.org.

‘Partnership Health Plan.’ Several counties emphasized that their ability to provide these expanded services depends critically on the ACA Medicaid expansion. More than half of clients needing SUD treatment require Medicaid (Medi-Cal) in order to access these services. Any rollback or repeal of this expansion would devastate our ability to pay for and provide these vital services in California.

Counties across the state have a large number of substance programs operating under a variety of different names, which may contribute to some confusion for people seeking services, especially those who are new to the system. Such confusion or lack of awareness of treatment programs can present a barrier to access.

Justice System-Involved Youth with Behavioral Health Needs

Children and youth with significant emotional or mental health issues may engage in behaviors which bring them into contact with the justice system. Other vulnerable groups include homeless youth and victims of sex trafficking. They face survival challenges “on the street” and increased risk of involvement with law enforcement.

This discussion will focus on juveniles with justice system involvement. Based on the limited data available, it is difficult to estimate how many are in need of mental health or substance use services. However, experience at the community level suggests that the behavioral health needs of this population are considerable and many are likely to be underserved, unserved, or undiagnosed. At a minimum, needs for substance use treatment are suggested by the finding that one-sixth of all juvenile arrests are for offenses involving drugs or alcohol. Many others committed offenses while impaired.

Several factors may contribute to the circumstances which lead to youth becoming involved with the justice system, and other consequences that follow. A recent report states that “the vast majority, between 75 and 93 percent of all youth entering the justice system are estimated to have experienced previous trauma.”¹⁹ Even more shocking, “girls in the justice system are 200 – 300 times more likely to have experienced sexual or physical abuse in the past than girls not in the justice system.”²⁰

The 2016 California Children’s Report Card²¹ defined one particularly vulnerable group as “crossover youth” (or multi-system users), because they have a history involving both the child welfare and juvenile justice systems. Often these children and youth have had multiple episodes of complex trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood.

¹⁹ Erica Adams, “Healing Invisible Wounds: Why Investing in Trauma-Informed Care for Children Makes Sense.” Justice Policy Institute, July 2010. http://www.justicepolicy.org/images/upload/10-07_REP_HealingInvisibleWounds_JJ-PS.pdf

²⁰ D. K. Smith, L. D. Levey and P. Chamberlain, “Adolescent Girls’ Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma.” *Child Maltreatment* 11.4 (2006):346-353. Print,

²¹ Website: www.ChildrenNow.org, see report: California Children’s Report Card, 2016.

Parental abuse or neglect may have resulted in the child's placement in foster care or a group home intended to provide for their safety and well-being. However, the experience of removal from one's home is highly traumatic and the foster home may not be able to fully meet the child's needs. Studies report that these "youth are more than two times as likely to be incarcerated for low-level offenses than their justice-involved peers who are not involved in the child welfare system."

The childhood experience of trauma may lead to poor emotional regulation, emotional outbursts, or disruptive behaviors in schools. Such events, in turn, can set the stage for suspension, expulsion, or other disciplinary actions in schools. Disruptive behaviors, left untreated, may progress to events which lead to justice system involvement. Trauma-informed strategies may better serve the needs of youth by diverting them to therapy instead of punishment or incarceration.

Historically, "students of color, LGBT students, and students with disabilities are disproportionately impacted by suspension and expulsion."²² Across all age groups, for similar low-level offenses, persons of color are more likely to be incarcerated and much less likely to be referred to therapy, diversion, or probation than are their white counterparts. Research shows that African American children and youth are more than twice as likely to be incarcerated for non-violent offenses compared to white youth. Thus, as a matter of equity (or fairness of access), we should consider strategies to engage youth of color in mental health and substance use treatment and diversion.

Many serious challenges are faced by incarcerated youth, who not only report despair and suicidal ideation but are at considerable risk for death by suicide.

- One national study²³ reported that approximately 10 percent of juvenile detainees had thought about suicide in the prior six months.
- About 11 percent of detained juveniles had previously attempted suicide.
- The rates of death by suicide for incarcerated juveniles are between two and four times higher than for the general population of the same age range.
- For comparison, the general population rate of death by suicide was 10.5 per 100,000 adolescents in 2010.

²²"Racial Disparities in Sentencing." American Civil Liberties Union, 27 Oct. 2014.

https://www.aclu.org/sites/default/files/assets/141027_iachr_racial_disparities_aclu_submission_0.pdf; and Soler, Mark, "Reducing Racial and Ethnic Disparities in the Juvenile Justice System." Center for Children's Law and Policy, 2013.

http://www.ncsc.org/~media/Microsites/Files/Future%20Trends%202014/Reducing%20Racial%20and%20Ethnic%20Disparities_Soler.ashx/

²³ K.M. Abram, J.Y. Choe, J.J. Washburn et al., "Suicidal Thoughts and Behaviors among Detained Youth," July 2014 Juvenile Justice Bulletin, pages 1-12.

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers²⁴ for misdemeanors, felonies and status offenses. “Status offenses” are those which would not be crimes for adults, e.g. truancy, runaway, breaking curfew, etc. Additionally, unknown numbers of youth are counseled and released to a parent or guardian without formal arrest.

Table 2. Numbers²⁵ and Types of Juvenile Arrests, California, 2014

Total population ²⁶ age 10-17	4,060,397	100 % of age 10-17
Total juvenile arrests	86,823	2.1 % of those aged 10-17
Status offenses	10,881	12.5 % of juvenile arrests
Misdemeanor arrests	48,291	55.6 % of juvenile arrests
Misdemeanor alcohol or drug:	9,676	20.0 % of misdemeanor arrests
Felony arrests	27,651	31.8 % of juvenile arrests
Felony drug arrests	3,058	11.1 % of felony arrests
All drug or alcohol arrests (misdemeanors & felonies)	12,734	14.7 % of all juvenile arrests

These data paint only a partial picture of the justice-involved juvenile population. Data are often lacking on who, how many, or what percentage may need behavioral health services. One goal of this discussion was to identify strategies which reach out to youth from all backgrounds. The desired outcomes are to engage individuals in treatment and diversionary programs, and to avoid detention, whenever possible.

Recent county-level arrest data were not available to us for all types of juvenile offenses. We presented the number of felony arrests for each county²⁷ in the Data Notebook, keeping in mind that these are only one-third of all juvenile arrests.

We asked local boards: does your county provide mental health or substance use treatment services to justice system-involved juveniles while they are still in custody?

All large and almost all medium population counties do provide mental health and substance use treatment services to juveniles while they are still in custody. And nearly two-thirds of small population counties provide behavioral health services to detained

²⁴Data are from: www.kidsdata.org, based on compilation of data from California Department of Justice records for 2014 juvenile arrest data. Total numbers of arrests declined in 2015 to 71,923, but overall percentages broken down by type of offense were similar to those for 2014.

²⁵ Percentages may not add to 100% due to rounding effects. Data reported by CA Department of Justice in 2015.

²⁶CA Department of Finance, Report P-3, December 2014

²⁷ County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children’s Health.

youth. However, at least 2 small counties do not have juvenile detention facilities. Most detained youth receive an initial evaluation for risk of suicide and possibly also an assessment for whether a mental health crisis or serious mental health condition is present. Some facilities do not provide any treatment after assessment.

When we asked about funding sources for behavioral health services for these youth, responses indicate that a large variety of sources are used, such as: general county funds, probation department funds, Juvenile Justice Crime Prevention Act, Youthful Offender Block Grant, SAMHSA-funded grants, City Law Enforcement Grants, Mentally Ill Offender Crime Reduction (MIOCR) Grant Program, Proposition 63 funds (MHSA), or Re-alignment I and II funds. Counties had different approaches to how funds from different sources were blended together to provide services.

In some counties, therapists from the County Department of Behavioral Health are provided access to the juvenile facilities to provide treatment or to plan for services after release. In other counties, mental health or substance use treatment services or therapy groups may be provided by other county personnel or contracted providers.

As mentioned previously for LGBTQ youth, those youth involved with the justice system also fare better when their families are engaged, accepting and supportive of them. Parents and other caring adults often report that they are at a loss to know how to keep their youth on a positive track.

Clearly, programs are needed to support and educate parents, so we asked local advisory boards if their county has programs that engage parents/guardians of juveniles involved with the justice system.

Responses indicate that nearly all counties actively try to engage the parent or guardian of the youth from the very beginning of the court process. Support groups and counseling inform and assist the parent/guardian, and help them understand the best way to support their loved one in recovery so that they succeed in meeting the requirements of the justice system and/or probation. However, there are barriers in that some parents/guardians do not want to be involved, or cannot because they work too many hours (including care for other children or family members). Or, parents may have other problems such as ongoing substance abuse or justice system issues of their own, either of which can impair their participation in the youth's treatment and recovery.

MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS HELP CHILDREN AND YOUTH RECOVER

California voters passed the Mental Health Services Act (MHSA) in November, 2004 to expand and improve public mental health services. MHSA-funded services and programs maintain a commitment to service, support and recovery. The MHSA is made up of five major components described below:²⁸

- **Community Services and Supports (CSS)** — provides funds for direct services to individuals with severe mental illness. Full Service Partnerships (FSP) are in this category; FSPs provide wrap-around services or “whatever it takes” services to consumers. Housing is also included in this category.
- **Capital Facilities and Technological Needs (CFTN)** — provides funds for building projects and to increase technological capacity for mental illness service delivery.
- **Workforce, Education and Training (WET)** — provides funding to improve and build the capacity of the mental health workforce.
- **Prevention and Early Intervention (PEI)** — invests of 20% of Proposition 63 funds to recognize early signs of mental illness and to improve early access to services and programs, including the reduction of stigma and discrimination.
- **Innovation (INN)** — funds and evaluates new approaches that increase access to the unserved and/or underserved communities; promotes interagency collaboration and increases the quality of services.

Prevention and Early Intervention (PEI) Programs and Services

Twenty percent of MHSA funds are dedicated to PEI programs as an essential strategy to “prevent mental illness from becoming severe and disabling” and to improve “timely access for under-served populations.” PEI programs work to reduce the negative outcomes related to untreated mental illness, including suicide, incarceration, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes.²⁹ Counties must use at least 51% of PEI funds to serve individuals 25 years of age and younger, according to the regulations (Section 3706). These programs provide for outreach, access and linkage to medically necessary care

²⁸ Mental Health Services Oversight and Accountability Commission, December 2012. “The Five Components of Proposition 63, The Mental Health Services Act (MHSA) Fact Sheet.”

http://mhsoc.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

²⁹ Mental Health Services Oversight and Accountability Commission, December 2012. “Prevention and Early Intervention Fact Sheet: What is Prevention and Early Intervention?”

http://www.mhsoc.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf

in an effort to provide early intervention and first break psychosis treatment to change the trajectory away from chronic serious mental illness.

Prevention of Suicide and Suicide Attempts

Public health data for California and the U.S. show that there are risks for suicide for multiple age groups and race/ethnicity populations. In particular, youth death by suicide and suicide attempts are serious public health concerns. Suicide is second to homicide as a leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.³⁰ Males are more likely to die by suicide, but females are more likely to report having attempted suicide. A recent national survey found that nearly 1 in 6 high school students (about 17%) reported seriously considering suicide in the previous year. Unfortunately, 1 in 13 (or 7- 8%) reported actually attempting it.³¹

The risks for youth death by suicide and suicide attempts are greatly increased for many vulnerable populations including: foster youth, youth with disabilities, those who face stressful life events, trauma or major school problems, incarcerated youth, LGBTQ youth, and individuals with mental illness or who experience substance misuse. Among racial and ethnic groups nationwide, American Indian/Alaska Native youth have the highest rates for death by suicide. Research confirms that LGBTQ youth are more likely to engage in suicidal behavior than their heterosexual peers.³²

Attempting to address the problem of youth death by suicide is both difficult and complex due to the diversity of needs and potential contributing factors, including family history or exposure to the suicidal behavior of others. Below, we show the number of youth deaths by suicide per year and by age group to gain perspective on the size of this problem in California.³³

³⁰ Child Trends Databank. (2015). Teen homicide, suicide, and firearm deaths. Retrieved from: <http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths>.

³¹ Centers for Disease Control and Prevention. (2015). Suicide prevention: Youth suicide. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html.

³² Marshal, M.P., et al. (2013) Trajectories of depressive symptoms and suicidality among heterosexual and sexual minority youth. *Journal of Youth and Adolescence*, 42(8), 1243-1256. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articales?PMC3744095/>

³³ <http://www.kidsdata.org>, topic: suicides by age group and year in California.

Table 3. California: Number of Youth Deaths by Suicide by Age Group, 2015.

California	Number
Ages 5-14	23
Ages 15-19	171
Ages 20-24	301
Total for Ages 5-24	495

By comparison, the number of youth suicide attempts is difficult to determine because those numbers are combined with hospital data for self-injury. In California, there were 3,575 hospitalizations for self-injury reported during 2014 for those age 24 years and younger. Estimates vary, but slightly less than half of self-injury events (e.g. about 1,660) may have been suicide attempts. As with the data for suicide deaths, these numbers should be viewed with a degree of critical skepticism. Actual intent may not be readily ascertainable due to insufficient evidence, privacy concerns, or reticence of loved ones. There also may be delays in reporting or under-reporting to the state.

Reports of suicidal ideation are much more common and show that much larger numbers of youth are at risk. As an example, we may consider data for the population of high school-age young people which was about 2.1 million in 2014 for California. That means there are between 500,000 and 530,000 individuals eligible for each of the four years of high school (based on ages). Not all members of these age groups are in school, but those not in school are also at risk.

Survey data (below) show that nearly one in five public high school students reported seriously considering attempting suicide in the prior 12 months in California.³⁴

³⁴ **Data Source:** California Department of Education, [California Healthy Kids Survey](#) and [California Student Survey](#) (WestEd). The 2011-2013 period reflects data from school years 2011-12 and 2012-13. District- and county-level figures are weighted proportions from the 2011-13 California Healthy Kids Survey, and state-level figures are weighted proportions from the 2011-13 California Student Survey.

Table 4. Public High School Students Reporting Thoughts of Suicide, 2013-2015

California	Percent			
	Female		Male	
Grade Level	Yes	No	Yes	No
9th Grade	26.5%	73.5%	11.0%	89.0%
11th Grade	22.4%	77.6%	13.3%	86.7%
Non-Traditional	32.5%	67.5%	23.2%	76.8%

Information from the KidsData.org website indicates that in 2015 in California, there were 23 children between the ages of 5 and 14 years that died by suicide. For the age group of 15 to 19 years old, 171 children died by suicide in California that same year.

Those numbers are shocking, especially for our youngest students. Therefore we asked local boards whether their county has programs that are specifically targeted at suicide prevention among children and youth under the age of 16?

More than 75% of responding counties have programs targeted at preventing suicides in those aged 16 and under. Several respondents commented that their programs were designed more for those aged 12-17, but that both office staff and clinical service providers were alert to the possibility that suicidal ideation, or plans, can arise in children as young as age 9-10. Many counties train their school teaching staff to be alert to this issue and what to do to get individuals promptly referred to professional help. Some schools have prevention and public health programs that address mental health issues, such as: how to deal with stress, prevention of bullying, and education about substance abuse, among other issues.

Many counties have specific programs; a few examples are listed below.

- Prevention and Early Intervention (PEI) programs for outreach and education provide training in the community, including in schools, to increase awareness of when a youth may be at risk and how to provide prompt linkages to services.
- Crisis Support Services Teens for Life Program, a classroom program designed for students to increase awareness of mental health issues. Other 'Teens for Life' curricula include School Gatekeeper Training adapted for these groups:
 - Teachers and other school staff.
 - School mental health counselors.
 - For parents.

- Crisis Support Services may provide community education programs.
- Text Line Program: Crisis Support Services, designed for middle and high school children and youth as a tool to provide crisis intervention.
- School-based counseling for students K-12, such as school counselors or therapists from the county Department of Behavioral Health Services.
- Mobile Crisis Support Teams that respond to mental health crises.
- Applied Suicide Intervention Skills Training (ASIST) for teachers, those in health and other 'helping professions,' and the general community. Related programs include safe TALK, suicide TALK, Mental Health First Aid, and Cognito.

Those few counties which did not have a youth suicide prevention program noted that they do provide website links for numbers to call in an emergency and/or to 24-hour regional hotlines. Mental health providers also provide referral to 24-hour crisis lines.

We received similar responses when we asked local boards about programs for Transition Age Youth (TAY) ages 16-25. However, for questions about this age group, we found that half to one-third of the medium-size counties indicated 'no'. For the small and large-population counties which responded 'yes', many had similar programs and crisis services for TAY as those listed above for youth age 16 and younger, but are tailored for the needs of TAY youth. In some counties, suicide prevention programs for adults included TAY-appropriate messaging but without specific targeting to youth.

In contrast, examples of specific youth-directed public information messaging campaigns include:

- Know the Signs, Each Mind Matters
- Youth for Change
- Signs of Suicide (SOS)
- Safe Talk
- Stigma Reduction campaigns
- The Trevor Project (a 24/7 crisis line for LGBT youth up to age 24).

Those and similar programs are also presented on community college and university campuses, in addition to standard campus-based counseling services.

The local boards also identified several priority areas which should be addressed:

- Increase collaboration between county BH and county offices of education.
- Need for suicide prevention programs tailored to LGBTQ youth and Tribal youth.

- Increased collaboration of county BH with emergency departments and law enforcement to build on previous interagency trainings on crisis intervention.
- Some respondents expressed need for technical assistance from experts in the field on evidence-based practices for children and youth aged 6-16 years.
- Increase collaboration between adjacent counties on some programs.

Early Identification of Risks for First Episode Psychosis

Sometimes, unfortunately, the first major indication parents may have about a “first break” or first episode of psychosis (FEP) in a child or youth may be changes in behavior, including an unusual drop in school grades, experimenting with substance use, running away, or behavior that gets the attention of the justice system. PEI programs for children and youth have a goal of identifying such persons early so that they receive appropriate services. In California, many MHPA-funded programs provide these services through PEI and/or CSS monies. Sometimes funds from more than one source are braided together by counties to support these programs.

Thus far, at the national level, the accumulating body of research provides very solid evidence for improved outcomes of specialized FEP programs. Therefore, additional federal funds from the Substance Abuse and Mental Health Services Administration (SAMHSA) have been set aside for programs that intervene early to target FEP and provide an effective level of coordinated care and treatment.

Recently (January 2014), SAMHSA awarded states additional Mental Health Block Grant (MHBG) funds to promote the development of an integrated Coordinated Specialty Care (CSC) program for TAY between 15-30 years of age who experience FEP. In California, forty-two counties are participating and have submitted an addendum to their MHBG application describing their FEP services. Clearly this is a major endorsement of the significance of the research and evidence supporting the efficacy of these early intervention programs for the TAY population.

We asked local boards: does your county have services or programs targeted for first break psychosis in children, youth and transition aged youth (TAY)? Counties described their early intervention programs, regardless of fund source. Thirty-seven (84%) of 44 county MHPs do have services targeted for FEP in children and/or youth and eleven counties indicated that they do not have this type of early intervention program.

All but one of the counties that answered “no” are small population, rural counties and do not have targeted programs for first break psychosis in children or youth. However, those youth who present with any psychotic symptoms are immediately assessed and enrolled in services. Sometimes the initial contact and diagnosis occurs in the emergency department or in limited crisis services that exist in some small counties.

Individualized treatment services are embedded within departments of behavioral health or may involve outside providers. For cases in which psychiatric hospitalization is necessary, the child or youth is admitted to an inpatient facility which often requires out-of-county travel.

One medium-sized county, which does not have a targeted program, utilizes FSP-type wraparound services as an alternative service for first episode psychosis in children and youth, with options for therapeutic behavioral services and cognitive behavioral therapy, when found to be medically necessary. Additional strategies include Assertive Community Treatment (ACT) with services available 24 hours/day, 365 days/year, for youth aged 16+ with SMI. This county also provides services to clients with high-acuity needs by contracting with Turning Point and may implement the UC Davis model of EDAPT (Early Diagnosis and Preventative Treatment).

The most commonly-cited programs were as follows:

- SAMHSA sponsored Mental Health Block Grant (MHBG) for First Episode Psychosis (FEP) set-aside funding; some counties provide services in Spanish.
- EDAPT, the UC-Davis therapeutic model for Early Diagnosis and Preventative Treatment, commonly funded as a PEI program by MHSa.
- Prevention and Recovery in Early Psychosis (PREP) funded by Center for Medicaid Services Challenge grant (some counties may also be working with the Felton Institute), as part of a Network Expansion Initiative.
- PIER Multi-Family Group, to engage families in support of the child/youth.
- Cognitive Behavioral Therapy (CBT) for psychosis.
- Coordinated Specialty Care (CSC), a model treatment program designed for adolescents and young adults. CSC is a team-based multi-component approach to diagnosing and treating first episode psychosis (SAMHSA MHBG grant).
- TAY participants in FSP programs/services (MHSa funded).
- In many counties, service teams meet the youth client (especially TAY) who may be experiencing first onset of mental illness wherever they are in the community. These teams provide crisis responses under various names: Mobile Support Teams (MST), Crisis Intervention Teams (CIT), Community Intervention Program(s) (CIP), and Crisis Assessment, Prevention and Education (CAPE).

Full Service Partnerships Improve Outcomes for Children and Youth

Full Service Partnership (FSP) programs provide a broad array of intensive, coordinated services to individuals with serious mental illness. These may also be referred to as “wrap-around” services. The FSP program philosophy is to “do whatever it takes” to help individuals achieve their goals for recovery. The services provided may include, but are not limited to, mental health treatment, housing, medical care, and job- or life-skills training.

Youth (and others) participating in these programs often use an evidence-based practice called the “Wellness Recovery Action Plan” (WRAP), which is “a self-designed prevention and wellness process that anyone can use to get well, stay well and make their life the way they want it to be.” This personalized wellness and recovery system is rooted in the principle of self-determination. The structured approach helps the client to monitor uncomfortable and distressing symptoms and can help one to reduce, modify or eliminate those symptoms by using planned responses. This includes plans for how the client would want others to respond when symptoms make it impossible for the client to make good decisions, take care of him or herself and be safe.

Clients in recovery also make use of a personal Wellness Toolbox, which is basically a workbook to fill out information in the daily maintenance plan to take better care of themselves. This Toolbox/workbook contains sections to identify personal resources such as friends or counselors, identify events or triggers that might make one feel worse, identify early warning signs, and describe what to do when things are breaking down into a crisis. Finally, it includes a section in which the client outlines a personalized post-crisis plan for recovery.

Research on TAY and adults has shown that FSP programs are effective in improving educational attainment while reducing homelessness, hospitalizations, and justice system involvement. These intensive services are costly, but the positive results largely outweigh the costs and ultimately produce cost savings to society.³⁵ Subsequent research³⁶ focused on outcomes in children and showed that when counties increased access and participation of children in FSP programs, the result was a significantly decreased use of psychiatric emergency services.

Overall, the data thus far indicate very good news. These positive outcomes are leading to a greater understanding of what works well for children, youth and their families. California seeks to increase resources to serve more children and youth in FSP programs due to urgent needs and the proven effectiveness of this service model.

³⁵ Prop 63 Mental Health Services Oversight and Accountability Commission (MHSOAC). Evaluation Fact Sheet: “Full Service Partnership (FSP) Program Statewide Costs and Cost Offsets”
http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_Eval5_FSPCostAndCostOffset_Nov2012.pdf

³⁶ Cordell, Kate. Ph.D. Thesis, California Children’s Full Service Partnership (FSP). UC Berkeley, 2015.

Examining FSP Outcomes Data for Children and Youth (TAY)

When a new client begins FSP services, data are collected to serve as a baseline for later comparisons including events that happened in the year prior to receiving services. Next, data are collected from each client after one year of services and then again at two years. The outcomes data are calculated as a change from the number of events for each client in the year prior to beginning FSP services, compared to one year later (and again at 2 years, for TAY).

Children's FSP data are shown for only one year of service, because children usually experience more rapid improvements than do TAY or adults. Here, improved academic performance is defined and measured as the percentage of children who had improved grades relative to baseline academic performance prior to beginning FSP services.

We asked local board members to examine the statewide data in these tables (following pages) taken from a report³⁷ by CBHDA released in early 2016. Specifically: first, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, note which outcomes show improvement and those which may need further attention to improve services for client recovery and well-being.

The goal was to consider how the statewide FSP outcomes data for children and youth might inform suggestions from board members for improving local services or programs. That discussion will follow the data presentation on the next two pages.

³⁷ Data reported from the new CBHDA-designed Measurements, Outcomes, and Quality Assessment (MOQA) data system for clients in FSP programs. <http://www.cbhda.org/wp-content/uploads/2014/12/Final-FSP-Eval.pdf>. Data from 41 counties were analyzed. We express great appreciation to CBHDA for sharing their data with the CMHPC.

Full Service Partnership Data: Children and Youth in CA, FY 2013-2014.

STATEWIDE DATA:

FSP Programs included in this analysis: 41 counties³⁸ plus Tri-Cities group reporting,

- Children (age 0-15): with at least one year of service.
- Transition Age Youth (/TAY, ages 16-25): with 2 years or more of services.

Table 5. Children, Ages 0-15 completed at least 1 year of FSP services (N=5,335).

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 year	Change in Client Outcomes at 2 years
Mental Health Emergencies	89% ↓	--
Psych. Hospitalizations	49% ↓	--
Out-of-Home Placements	12% ↓	--
Arrests	86% ↓	--
Incarcerations	40% ↓	--
Academic Performance	68% ↑	--

The data above shows that the majority of children who received FSP services experienced: decreases in total numbers of:

- mental health emergencies,
- hospitalizations,
- out-of-home placements,
- arrests, and
- incarcerations.

Academic performance increased, as measured by the percentage of children who had improved grades relative to baseline during the year prior to beginning FSP services.

³⁸ Alpine, Butte, Colusa, Contra Costa, El Dorado, Fresno, Humboldt, Kern, Kings, Marin, Los Angeles, Mariposa, Merced, Modoc, Monterey, Napa, Nevada, Orange, Placer, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, Sierra, Siskiyou, Sonoma, Stanislaus, Sutter-Yuba, Tehama, Trinity, Tulare, Tuolumne, Ventura, Yolo. Other counties do have FSP services but for technical reasons were not able to get the reports out of their data systems for this project.

Full Service Partnerships: Transition Age Youth in CA, FY 2013-2014.

Table 6. Transition Age Youth (TAY) ages 16-25.

N= 4,779 completed at least 2 years of FSP services.

Type of Events in the Preceding Year (measured as change from baseline)	Change in Client Outcomes at 1 Year	Change in Client Outcomes at 2 years
Mental health emergencies	84% ↓	86% ↓
Psych. hospitalizations	41% ↓	57% ↓
Emergency shelter use	20% ↓	53% ↓
Arrests	81% ↓	86% ↓
Incarcerations	45% ↓	49% ↓

The data in the table above show that: overall, transition-aged youth experienced decreases in total numbers of:

- mental health emergencies,
- hospitalizations,
- use of emergency shelters,
- arrests, and
- incarcerations.

Note: These beneficial outcomes occurred by the end of the first year of FSP services. Furthermore, these improvements continued and were sustained at the end of the clients' second year in FSP services.

Two types of outcomes, reduced psychiatric hospitalizations and use of emergency shelters, changed even more by the end of clients' second year in FSP services, compared to the end of the first year. These results point to the effectiveness of this model of services for this age group.

URGENT PROBLEMS AND UNMET NEEDS OF CHILDREN AND YOUTH

The most frequent types of adversity³⁹ experienced by children include severe poverty, loss of a parent due to death, incarceration, deportation or divorce, and living with a family member with SUD or mental illness. Severe poverty may involve lack of nutritious food, periods of homelessness or insecure housing, lack of resources for education or healthcare, and exposure to neighborhood violence. These traumatic events place children and youth at increased risk for their own SUD or MH disorders, for interacting with the justice system, for poor health, and for negative life outcomes.

The incidence of individual and community-level trauma⁴⁰ as a result of acts of violence in the past decade seems to have opened up a new level and range of adversity encountered by today's children, youth, and their families. In the U.S. today,⁴¹ the most frequent cause of death for all males ages 15--19 is from gun violence (homicide, suicide, and accidental) —a most sobering statistic. The occurrence of interpersonal or domestic violence, homicide, mass casualty events or natural disasters can be overwhelming to families, neighborhoods and first responders —and may create community-level trauma.

There is increasing recognition that trauma-informed care and perspectives and an understanding of the factors that promote individual and community resilience are very important to recovery. These constructive approaches assist both youth and adults to recover from trauma and to increase their ability to cope with life's challenges.

This section identifies some of the most urgent problems facing children and youth in California today. Some of these problems do fall under the formal definition for “adverse childhood experiences,” but we find that this urgent problem list addresses a far greater range of challenges, needs, and the lack of essential resources.

We asked the local advisory boards and commissions to provide input regarding their perceptions of the most urgent issues for children and youth in their communities.

Smaller population counties most commonly reported homelessness, systemic poverty, substance abuse and lack of transportation (as a barrier to access services, employment or training) as the most urgent problems for children and youth. Some counties identified use of emergency rooms for MH crises due to the lack of child or youth-focused crisis services or lack of psychiatric hospitalization options in or near the county. Another issue is the lack of foster families, including those trained for children

³⁹ Carle A, Smith A, Thomas A. (2018) Adverse Experiences. Child Trends (2013), <https://www.childtrends.org/indicators/adverse-experiences>

⁴⁰ Pinderhughes H, Davis R, Williams M. (2015). Adverse Community Experiences and Resilience: A Framework for Addressing and Preventing Community Trauma. Prevention Institute, Oakland, CA.

⁴¹ Pane, N.E. Data Point: Gun violence is the most common cause of death for young men. Feb. 22, 2018. <http://www.childtrends.org/gunv-violence-common-cause-death-young-men>.

with serious emotional disorders. Many counties have no outpatient detox or SUD residential treatment services for youth. Furthermore, individual small counties identified problems with one or more issues described by Alameda County below, illustrating that some “big city” problems now affect rural areas where they had been less frequent in the past.

The following summary (adapted from Alameda County’s response) provides a very comprehensive list of urgent problems for children and youth in California. Although many of these problems may seem to be most relevant to medium and large population counties, there is overlap with problems seen in some of the smaller population counties, with variability in which problems most affect a particular small county.

Homelessness was identified as the biggest problem for all age groups, including TAY, across the board. One provider also mentioned substandard housing, as families are unable to find landlords who will take Section 8 housing vouchers and end up living with relatives, in shelters or in their cars. Other families are living in substandard housing that is unsafe, not a legal dwelling, or not up to code such as a car garage. In other situations families are living in rat or mold infested housing within high crime neighborhoods. Homelessness has big impacts on school outcomes, mental health, physical safety, food security and access to basic medical care.

Immigration issues were identified as a major problem. Immigrant families fear that if they access public benefits they create a paper trail with the government that will place them at risk of deportation. The recent raids in California have been devastating for the immigrant community and have pushed them to take extreme measures to protect themselves and their children from deportation such as moving out of their homes and abandoning current employment to ensure their address is not on file anywhere.

For TAY, there is also a need for developmentally-appropriate services (TAY-young adult focus), substance use treatment for young adults, support for non-minor dependents in crisis, and more crisis residential beds are needed.

For adolescents, substance use in general is a major issue, but specifically use of marijuana (weed) as a coping mechanism. Many clinicians have clients who smoke a lot of weed to deal with the symptoms of trauma. Truancy seems to be an increasing problem at all age levels; there seems to be an increase in school avoidance related to anxiety but also school refusal for other reasons as well.

One clinic also reported a growth in suicide attempts among adolescent girls. Recently published research confirms an increase in both self-harm attempts and suicide attempts over the last five years in adolescent girls as a widespread problem.

Child sex trafficking is a major issue in many counties, even some small population counties along I-5 and other major freeways. For one example of how counties may address these problems, Alameda BHCS contracts with West Coast Children's Clinic C-Change Program to provide specialized mental health services to commercially sexually exploited youth (CSEC). Alameda County's Child Welfare Assessment Center, BHCS contracts with clinicians to provide mental health screening and assessment services to children and youth removed from their homes; this screening now includes a component on CSEC involvement or risk for involvement. In addition, the BHCS Children's System of Care has collaborated extensively with the county's Child Welfare Department, and other county departments and jurisdictions (Courts, District Attorney's Office, Probation, Police departments) to create a county-wide MOU that coordinates a cross-county response to identify, treat, and protect CSEC youth.

For early childhood: lack of quality childcare; occupational therapy services for young children to address sensory issues; early identification of social, emotional, or developmental issues that impact learning in pre-schools and primary schools; and a lack of services for children who do not have full scope Medi-Cal.

Other issues that county service managers mentioned include: exposure to violence, domestic violence in the home, community violence, witnessing/hearing about murders, having a relative or friend/acquaintance shot or killed, hearing gunshots on a regular basis, etc., and having an incarcerated family member; also poverty, income disparity, and lack of access to resources (jobs, job training, recreational opportunities). Many caregivers are not able to access the appropriate level of case management or mental health services they need, which has a direct impact on the work/services BHCS is providing to children and youth.

Finally, the experience of "**parentified**" youth, i.e. youth taking on parental and/or sibling caregiving responsibilities was also mentioned as a growing problem. Clearly, teen pregnancy and childbirth also result in similar problems of parental responsibility assumed by youth who are not well-prepared for these challenges.

In summary, this list is both comprehensive and daunting, but there is hope. Although it seems there are never sufficient resources to meet the need, California counties actively seek to stretch their resources, and collaborate with their county partners to co-deliver services to children and families who are often involved in multiple systems. Wrap-around services provided under the FSP programs demonstrate effectiveness and result in very positive improvements in function and life outcomes. Early intervention programs for psychosis produce better outcomes for the individual and his/her family and decrease the need for more intensive services in the long run.

CONCLUSIONS

California counties have been challenged in the last five years by substantial increases in total numbers of people eligible for Medi-Cal funded health care, including MH and substance use treatment. As of August 2017, fully 53.6% of California children's health care was funded through Medi-Cal, including those formerly covered by the federally-funded State Children's Health Insurance Program (S-CHIP). During this same period, new programs were initiated for foster care, crisis services, substance use treatment, and integrated services to coordinate behavioral and physical health care.

Thus, counties have been asked to provide more types of services and improved programs simultaneously with serving greater numbers of people. Both endeavors increased the total workload and counties have done everything possible to succeed.

The Council reviewed information that is available about basic indicators of system performance such as: total numbers served out of the eligible population, numbers of clients who received five or more services in a fiscal year, and service penetration rates. Penetration rates are one traditional quality measure tool used to assess the total percent of the eligible population that was served during a given year. The goal is to increase that percent year over year, especially for historically unserved and underserved groups. However, after the passage of the Affordable Care Act (2010), the total Medi-Cal eligible population increased so much and so rapidly that penetration rates have been rendered less informative than in the past as a measure of quality improvement. Our Planning Council members asked us to take a closer look at the data. The details of that analysis are summarized in the following discussion.

Our initial review of the data led us to predict that decreased service penetration rates for SMHS might occur as the result of rapidly expanding numbers of children and youth eligible for Medi-Cal services, even if total numbers receiving SMHS increased. By FY 2014-15, there had been an average annual compound rate of **10.2%** increase in numbers of children and youth who were Medi-Cal eligible compared to 'baseline' numbers in FY 2011-12.

At the same time, numbers of children and youth who received SMHS increased by an average annual compound rate of **5.3%** compared to 'baseline' numbers in FY 2011-12. Assuming that the prevailing incidence of mental illness remains the same,⁴² then the disparity between the rates of increase in SMHS clients (5.3%) and Medi-Cal eligible (10.2%) predicts that the greater numbers who need SMHS would strain resources in time, personnel, and funds for county staff and their providers.

⁴² It is possible that prevailing rates of mental illness could have increased during a given time period, but we have no data for that. A very large population sample is required to be collected over a number of years for the study analysis to be sensitive and reliable enough to demonstrate any trends in mental illness (increases or decreases).

Detailed review of the DHCS data does show that both statewide, and in many counties, that SMHS service penetration rates either decreased or stayed nearly the same during the four years studied. In some counties, there were marked decreases in service penetration rates for specific race/ethnicity groups (e.g. White, Black, American Indian) even though there were increased numbers of clients in those groups that received SMHS. In comparison, service penetration rates for Hispanics and Asian/Pacific Islanders usually stayed the same in spite of increased numbers of both Medi-Cal eligible clients and those who received SMHS in those groups. These data suggest that outreach efforts most likely were effective at engaging these clients

But there was very limited capacity to increase service engagement (more appointments) for the greater numbers of eligible children and youth. Year-over-year comparisons in most counties showed that the total numbers of children and youth receiving “five visits or more” of SMHS either increased or stayed about the same, regardless of any changes in penetration rates. Thus, according to these data, resource constraints might have resulted in not being able to meet all of the increased needs for continued treatment.

Returning to discussion of county efforts during the last three years, one especially noteworthy achievement is the substantial improvement in reducing the time to follow-up services after discharge of a child or youth from psychiatric hospitalization. The goal continues to be provision of the first follow-up service within 7 days after discharge, and no later than 30 days. Many counties seek to make initial follow-up services on the same day of discharge or within 24 hours, whenever possible. These sustained efforts by county staff account for improved performance outcomes statewide.

Despite resource challenges, all counties strive to address the MH service needs for their children and youth. Unfortunately, gaps remain in the quantity and types of substance use treatment services that are available for youth and TAY in small population counties. It is hoped that the programs under Drug Medi-Cal for SUD treatment will remedy these deficits. Many programs are already underway, and others are in a staged roll-out of service implementation. Some smaller population counties are collaborating to provide these services on a regional basis.

Responses from local boards noted that MHSA funds assisted counties in culturally-focused outreach, engagement, and education of the public about critical MH issues and services. These efforts addressed a number of problems, including: early psychosis/first break episodes, death by suicide and suicide prevention programs, and behavioral health issues in LGBT youth. MHSA funds also supported FSP and wrap-around services for children and youth, training and support for family members to assist their loved ones’ recovery, and programs to reduce homelessness for families with children.

However, there is a persistent statewide lack of sufficient workforce and behavioral health service providers (especially those who are bilingual and/or bicultural) in all parts of the public BH system across the state. Thus, stakeholders noted the need for more tele-health and tele-psychiatry services, especially in rural, small-population areas.

We received suggestions from local boards in their county Data Notebook reports and from public meetings. Some of their suggestions are incorporated into the policy recommendations by the Planning Council at the end of this report. Many comments came from families of youth, former foster youth, and adults who were past clients of the youth systems of care. The body of this report highlighted a number of stakeholder recommendations to improve care for children and youth; the most urgent ones follow.

- Increase training and implementation of trauma-informed care in schools and foster care and by all providers of therapy in every part of the system of care.
- Care providers and the foster care system should continue efforts to limit the use of psychopharmacology in foster youth to the lowest dosage and minimum number of drugs deemed medically necessary, for the shortest possible duration, and provide youth with information and choices.
- Support increased numbers of individuals with lived experiences who are trained to provide mental health and substance use treatment services; and where applicable, include participation of these individuals in state plans for Workforce, Education and Training (WET), as peer associates, for example.
- The stakeholder community has recognized the importance of timely data that includes all major race-ethnicity, cultural, and age groups, including outcomes for LGBT self-identified youth. They recommend that DHCS and the counties improve statewide data systems to increase our ability to analyze disparities in services and health outcomes in all these different groups of individuals.

Recommendations from the California Behavioral Health Planning Council

The following are recommendations from Planning Council members and links to data in this report that support our findings. These recommendations may overlap with some of those reported elsewhere by other stakeholder or advocacy groups.

- Experience and data regarding children in foster care⁴³ indicate there are substantial, ongoing mental health needs in this highly vulnerable population.

⁴³ See pages 22-28 in this report, Section titled "Foster Care."

Recommendation: The Council should continue monitoring implementation of the Continuum of Care Reform for foster care and evaluate the impact of this reform in reducing the numbers of children and/or time in out-of-home placement.

- Parental substance use disorders and overdoses are driving an accelerated increase in the number of children referred to foster care.⁴⁴

Recommendation: DHCS and other health care entities should monitor data from new programs for substance use treatment to ensure access by parents in order to build stronger and more effective families and to promote healthy communities.

- Substantial research demonstrates that severe poverty and/or homelessness can expose children to the cascading effects of lack of nutritious food, lack of health care, lack of a quality education, and lack of safety with the potential for exposure to domestic or community violence. These adverse childhood experiences increase life-long risks for poor mental and physical health outcomes.

Recommendation: County and non-profit provider agencies should collaborate with schools to identify families at risk and to connect them with services to address their critical needs for financial, housing, and social supports, including child care that may enable parents to work and help provide for their children.

- New parents may experience bewilderment, exhaustion, and distress when coping with the 24-hour needs and behaviors of young children. These stressors increase risks for child abuse from parents who love their children and want to provide the best care possible but who sometimes become overwhelmed.

Recommendation: Public health, social services, and mental health agencies should promote wider dissemination of information in multiple languages about parenting and normal child development for new parents. For example, First 5 California provides a helpful resource for families called “Help Me Grow”, a telephone line for advice and support for parents and young families.

⁴⁴ Williams, S.C. and K. DeVooght. (2017) Five Things to Know about the Opioid Epidemic and its Effect on Children. (re: top reasons for children to be in foster care). *Child Trends*, June 2, 2017. <https://www.childtrends.org/child-trends-5/5-things-know-opiod-epidemic-effect-children/>.

- An examination of state Medi-Cal data⁴⁵ for youth who received more than five or more SMHS services shows that the white population has the highest service penetration rates compared to other race/ethnicity groups. The obvious question is why? In terms of workforce cultural competency, are minority youth receiving services from providers that reflect their own race and culture? And do we see different demographic patterns of service access that vary across counties? ⁴⁶

Recommendation: County and non-profit agencies should seek out providers that reflect the demographic population served. Service access and engagement (as measured by penetration rates) can improve for minority groups when culturally relevant engagement occurs and culturally/linguistically appropriate services are accessible and available.

- More and more data demonstrate that LQBT⁴⁷ youth are quite vulnerable to symptoms of mental illness and that their rates of death by suicide are disproportionately high. The latest data for high school age youth show that 61% of those who identify as LGBT felt depressed in the previous year in contrast to 29% of their peers who identify as straight. These students felt so sad or hopeless for two weeks or more that they stopped their usual activities. Many counties indicated there are no specific programs for this population, rather they are welcomed into mainstream existing programs.

Recommendation: County and non-profit providers should do all they can to reach out to this community with culturally competent services that offer hope and stability. We advocate for a significant increase in providers who are trained and knowledgeable about the needs of LGBT youth and transition aged youth and who can be successful in engaging this vulnerable segment of our youth population.

- Research data strongly indicate that females⁴⁸ in foster care and juvenile justice systems are 200-300 times more likely, than the general population, to have experienced complex trauma such as repeated sexual or physical abuse. They have an especially critical need for trauma-informed care.

⁴⁵ See pages 11-15 of this report, section “Measures of Access and Sustained Engagement with Services.”

⁴⁶ BHC-CalEQRO Statewide Annual Report 2016-2017, see executive summary and report at: www.caleqro.com.

⁴⁷ KidsData.org, data released May 8, 2018. See also data in this report, pages 28-31, section “Lesbian, Gay, Bisexual, Transgender and Questioning Youth,” including data (2018) brought to our attention by Amanda Wallner, Director, California LGBT Health & Human Services Network.

⁴⁸ Smith, D.K., L. D. Levey and P. Chamberlain. Adolescent Girls’ Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma. *Child Maltreatment* 11.4 (2006):346-353

Recommendation: County and non-profit providers should recognize that once girls enter the justice system, a strong trauma-informed therapeutic intervention is needed and will be far more effective in bringing about positive change, compared to negative consequences (punishment) directed at curbing undesirable behaviors.

- Information collected from various sources by KidsData.org⁴⁹ show the alarming number of California high school students that experience periods of having suicidal ideation. Nearly one in five struggles with persistent thoughts of hopelessness. Statistics on youth death by suicide are shocking.

Recommendation: County and non-profit providers should have a direct link with the local high school so that school counselors have an immediate support team to assist a youth who has suicidal thoughts and difficulty contracting for safety.

- Outcomes data⁵⁰ for children and youth in Full Service Partnerships (FSP) demonstrate the success of this model of wrap-around services for this population and the reduction in long-term negative impacts and costs to society. Younger children (age ≤ 15 years) often meet their treatment goals in one year or less and maintain their improvement. The data further show the success of youth (aged 16-25) for whom mental health outcomes improve remarkably during one-to-two years of FSP services.

Recommendation: We believe that counties should place a higher priority on serving more children and youth in FSP programs. While all counties have FSP slots for adults, many counties tend to have fewer slots for youth or children.

The following recommendations build on strengthening and improving important existing programs, services, and policies at the state and local level.

Recommendation: DHCS, in partnership with counties, must work on local and statewide data systems to provide reliable and timely data that will track changes in client outcomes, evaluate effectiveness of programs and/or systems, and quantify disparities in both access to services and outcomes for historically underserved groups.

Recommendation: Legislators and other policy leaders must develop sustainable and consistent strategies to support a sufficient workforce to deliver MH and

⁴⁹ This report, pages 39-43, section "Prevention of Suicide and Suicide Attempts."

⁵⁰ This report, pages 45-48, section "Full Service Partnerships Improve Outcomes for Children and Youth."

substance use services, and ensure the inclusion of individuals with lived experience in all levels of the delivery system.

Recommendation: Leaders at the local level should improve collaboration between schools, law enforcement and other first responders to alert the school when a child has been exposed to a traumatic incident as this could lead to academic or behavioral problems. Such an alert can be the simple request to “focus on the child and handle them with care.”⁵¹

In conclusion, we offer this brief editorial comment. California has made enormous strides in expanding both quality of and access to behavioral healthcare over the last five to ten years. However, new federal policies and proposals, still under debate, may threaten funding for health care, behavioral health and all parts of the social safety net. If not vigorously and effectively opposed, cuts to critical supports for children and families could increase the likelihood that more children will live in severe poverty, have poorer mental and physical health resulting in a lack educational of achievement and fewer successful life outcomes.

⁵¹ Focusing on Children under Stress (FOCUS) model. See information at <https://www.focuscalifornia.org>.

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Data tables and figures:

- Behavioral Health Concepts, Inc. (External Quality Review Organization)—Data and figures for foster care, and Specialty Mental Health numbers for Adults and Children
- Office of Applied Research and Analytics, DHCS —SUDS treatment data
- Mental Health Analytics, DHCS—Data and figures for access, engagement, penetration rates, post-hospitalization follow-up
- County Behavioral Health Directors Association— Full service partnership (FSP) data
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Kings	San Benito	Trinity
Los Angeles	San Bernardino	Tulare
Madera	San Diego	Tuolumne
Marin	San Francisco	Ventura

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Appendix I: How Do the Data Sources Define Children and Youth?

Although it may be common to refer broadly to children and youth collectively as “youth,” discussions of data require precise definitions which may differ depending on the information source and its purpose. For example, “minor children,” also called juveniles, are defined by the legal system as those under the age of 18. Others may define subcategories by age to describe psychological or biological⁵² stages of development. Many data systems and their choice of measures (indicators) are based on requirements for state reports to the federal government.

Ideally, we might like to have all data broken down by the same age groups to simplify discussion. Unfortunately, that is not possible because we do not have access to the raw data sets for such a major analysis. Here, we used the age breakdowns provided by the various public data sources that are available to us.

Table: Categories used by Different Data Resources for Children and Youth

Category	EPSDT MH Services	CA EQRO	MHSA Programs	JUSTICE System	SMHSA, NSDUH, Federal datasets
Children (or Juveniles)	0-5	0-5	0-15	0-17	
“	6-11	6-17	--	--	6-11
“	12-17 (Youth or ‘Teens’)	--	--	--	12-17
Adults	18-20	>18	(varies)	>18	>18
Transition Age Youth (TAY)	N/A ⁵³	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

⁵² Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.

⁵³ N/A means not applicable, because this category is not available under this system or data source.

Appendix II. Where do We Get the Data and What Does It Contain?

CA DHCS: Child/Youth Mental Health Services Performance Outcomes System, ⁵⁴ http://www.dhcs.ca.gov	Mental health services provided to Medi-Cal covered children/youth through age 20, as part of the federally defined EPSDT ⁵⁵ benefits. Focuses on mental health services for those with serious emotional disorders or serious mental illness.
CA DHCS: Office of Applied Research and Analysis (OARA)	Substance Use Disorders Treatment and Prevention Services for youth and adults. Annual reports contain statewide data, some of which is derived from data entered into the “Cal-OMS” data system.
CA DOJ: Department of Justice yearly report on Juveniles. Data at: www.doj.ca.gov	Annual data for arrests of Juveniles (<18) for felonies, misdemeanors, and status offenses, with detailed analysis of data by age groups, gender, race/ethnicity, county of arrest, and disposition of cases.
External Quality Review Organization (EQRO), at www.CALEQRO.com	Annual evaluation of data for services offered by each county’s Mental Health Plan (MHP). The independent reviews discuss program strengths and challenges.
KidsData.Org, A Program of Lucile Packard Foundation for Children’s Health, see www.KidsData.org	Collects national, state, and county statistics. CA data are from DHCS, Depts. Of Public Health, Education, and Justice, Office of Statewide Health Planning and Development, “West-Ed,” and others.
Substance Abuse and Mental Health Services Administration (SAMHSA) www.samhsa.gov	Independent data reports and links to other federal agencies (NIMH, NIDA). Example: <u>National Survey on Drug Use and Health (NSDUH)</u> , which covers mental health, alcohol and drug use in adults and youth with analysis of needs and how many receive services.
County Behavioral Health Directors Association of California (CBHDA); see www.cbhda.org/	An electronic system (eBHR) to collect behavioral health data from CA counties for reporting in the “Measures Outcomes and Quality Assessment” (MOQA) database.

⁵⁴See recent reports at: www.dhcs.ca.gov/provgovpart/pos/Pages/Performance-Outcomes-System-Reports-and-Measures-Catalog.aspx, and http://www.dhcs.ca.gov/services/MH/Documents/POS_StatewideAggRep_Sept2016.pdf.

⁵⁵ EPSDT refers to Early, Periodic Screening, Diagnosis and Treatment. These federally-defined services are available to Medi-Cal covered children and youth from birth through age 20.