County of San Diego
Behavioral Health Services

Transition Age Youth Status Report and Recommendations

FY 2010 – 2011

Health & Human Services Agency
Behavioral Health Services
Mental Health Division

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TRANSITION AGE YOUTH SERVICES
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Mental Health Transition Age Youth Services Plan

I. System Status Update

In July, 2000, San Diego County Mental Health Services introduced a five (5) year Youth Transition Services Plan in response to a recognition that that there were significant service gaps for youth as they transition from the Children's System of Care to the Adult System of Care. This transition plan presented a blueprint for improved service delivery within the Mental Health Systems.

During the initial 5 year period, and the subsequent 5 years, many efforts have been made to increase effective interagency collaboration and to improve service delivery in the System of Care for children and Transition Age Youth (TAY). Several initiatives were successfully introduced including the Children's Mental Health System development of a wraparound approach for the clients and families served, and the Adult Mental Health System implementation of an integrated bio-psychosocial rehabilitation model of service delivery. In addition, Mental Health Services and Alcohol and Drug Services participated in the Comprehensive Continuous Integrated System of care (CCISC) best practice model. This is an integrated treatment intervention that culminated in administratively integrating Mental Health Services and Alcohol and Drug Services under a Behavioral Health Services unit in 2005. This integrated initiative was very successful in creating a "no wrong door" approach for clients of all ages with both mental illness and substance use.

A specific example of collaborative efforts in the Children's System of Care is the Family & Youth Roundtable (FYRT) that began in 2005. This is an independent family and youth led organization that works to build an interconnection between the families and youth receiving services and the public child-family serving agencies that serve the communities, such as: Children's Mental Health, Juvenile Justice, Education and Child Welfare.

Also in 2005, the County submitted their initial Mental Health Services Act (MHSA) Community Services and Supports (CSS) Plan to the State requesting available funding. The MHSA provides funding to transform mental health service delivery and requires systemwide goals which include: a) Increasing service capacity b) Minimizing Barriers and Decreasing Stigmatization, c) Improving Outcomes, d) Implementing Full Service Partnerships, e) Supporting Greater Client and Family Participation, f) Integrating Primary Care in the Continuum of Care, g) Increasing the Use of Proven, Innovative, Value-Driven and Evidence-Based Programs, and h) Enhanced Planning and Use of Data.

With broad stakeholder input and the approval of the MHSA CSS Plan by the Department of Mental Health (DMH), the County was able to develop and implement services and programs that targeted the specialized needs of TAY. These included: an intensive Assertive Community Treatment (ACT) Full Service Partnership (FSP) program with integrated services and supported

housing for persons 16-25 years of age; a member-run, age appropriate Clubhouse providing peer education and support, skill development, employment and educational support services; a comprehensive dual diagnosis residential treatment program; and a creation of specific age and developmentally appropriate enhanced outpatient mental health services for persons 18-25 in ten (10) outpatient mental health clinics throughout the County. In addition, MHSA Prevention and Early Intervention (PEI) specialized programs were initiated to focus on prevention and early intervention efforts. The Kickstart program educates community members to help identify TAY (in this program, individuals who are 12-25 years of age) who are experiencing at-risk or high risk behaviors or features of a first psychotic episode. Other programs include supports for families to assist in maintaining a safe home for children and reducing the effects of trauma exposure and to prevent re-traumatization related to exposure to domestic and/or community violence, and the assessment of and short term interventions in rural community clinics for children, youth and TAY in an integrated Behavioral Health and Primary Care Services program. (Please see Attachments A & B for a full listing of MHSA CSS and PEI programs).

These system of care models, initiatives and programs support the desired comprehensive transition services for TAY individuals that are in need of continued age appropriate mental health services. Over time and with the benefit of additional resources through the MHSA, the County has been working steadily to ensure services are developmentally and culturally appropriate, individualized, accessible, coordinated, community based and integrated with other public and private initiatives.

II. Overview and Purpose of Transition Age Youth (TAY) 5 Year Plan

The County's Health and Human Services Agency (HHSA) provides services to TAY in a number of different departments, including Child Welfare Services (CWS), County Mental Health Services (CMH), Alcohol and Drug Services (ADS), San Diego County Office of Education (SDCOE) and San Diego County Probation Department. It is crucial that these agencies, and providers outside of HHSA, work collaboratively and in an integrated fashion to assist TAY in achieving educational, employment, and housing goals while increasing access to comprehensive health care and establishing support systems to facilitate community integration.

a. Mission

Children's Mental Health System and the Adult Mental Health System, in partnership with youth and their families, will develop and implement age, developmental, and culturally competent individualized mental health services for youth faced with transition issues, in order to facilitate their transition from adolescence to an independent, self-sufficient adult. In alignment with the County's Health Strategy Agenda, this plan will be a roadmap to building a better system, supporting healthy choices, and pursuing policy changes for a healthy environment.

b. Objective

The objective of this plan is to continue to advance the development and implementation of specific TAY strategies in the areas of access to care, service delivery, funding, and training of staff to provide youth and young adults with the necessary, comprehensive, services to become self-sufficient and successful in their integration into community living. In order to achieve this, a strength-based and consumer/family centered practice shall be provided within a wraparound and bio-psychosocial rehabilitation approach.

c. Goals

The following priority goals have been identified:

1. Implement a seamless referral and transition process for TAY requiring continued clinical services in the Adult System of Care, as early as possible, to increase access to services and retention rates.
2. Ensure a successful transition into Adulthood and independence.
3. Facilitate sharing of TAY information between agencies.
4. Encourage youth, including foster youth, and families to participate in prevention and early intervention and outpatient TAY programs to provide earlier intervention and decrease inpatient/emergency services and jail services.
5. Increase engagement rate of TAY in the Adult System of Care where appropriate.
6. Promote Wellness, Recovery and Resiliency.
7. Increase Peer Support.
8. Increase skill building services to promote independence and self sufficiency.
9. Understand the TAY culture and provide appropriate and relevant staff development & training.
10. Increase Evidence Based Practice interventions, such as Trauma Informed Treatment, Supported Education and Supported Employment.
11. Develop and implement suicide, stigma and discrimination prevention campaigns specific to TAY.
12. Reduce health care disparities.

d. Target Population

The specific criteria for the population served will include:

- Title IX Chapter 11, Medi-Cal Specialty Mental Health Services
- AB 3632 Students
- Wards and Dependents meeting the above criteria
- Youth Served in the Children's System of Care that meet the Target Population in the Adult System of Care.

The current Adult County Mental Health target population definition includes individuals with a serious psychiatric illness that threatens personal or community safety, or that places the individual at significant risk of grave disability due to functional impairment. People with a serious, persistent psychiatric illness who, in order to sustain illness stabilization, require complex psychosocial services, case management and / or who require unusually complex medication regimens. Children System of Care target population is focused on seriously emotionally disturbed (SED) clients (per California Welfare & Institutions Code Section 5600.3). In addition, the target population identified for MHSA services are Children/Youth who are Seriously Emotionally Disturbed (SED) and TAY with Severe Mental Illness (SMI), ages 16-25. Priority is given to individuals who are homeless, or at risk of being homeless, are unserved or underserved, who may have been in juvenile institutions or justice system, and who may have a co-occurring mental illness and substance abuse.

e. TAY Workgroup

The TAY Workgroup was formed in an effort to increase integration and provide quality care coordination for clients served. The workgroup is a cross threading of partners from multiple sectors, including Child/Youth Mental Health providers, Adult Mental Health providers, County Administration, Child Welfare Services, School District representatives, TAY Service Providers, Juvenile Forensics, Alcohol and Drug Services, Advocacy Agencies and other Community

Based Organizations. Membership is open and this workgroup meets on a monthly basis to discuss TAY issues and concerns, to help address gaps in resources and to create an informative network and partnership. The TAY workgroup will be a guiding force in implementing this Transition Age Youth Services plan.

III. WHO ARE THE TRANSITION AGE YOUTH

The MHSA definition of TAY includes individuals age 16-25. These clients receive an array of services in the Children's System of Care and/or in the Adult System of Care, including outreach, outpatient clinic services, case management, TAY specific services, jail services, inpatient services, emergency services and individual Fee for Service type services. In an effort to review demographics of the mental health services TAY population, the following data for Fiscal Year 07-08, Fiscal Year 08-09 and Fiscal Year 09-10 was provided:

TAY Clients receiving services in Adult Outpatient programs

	FY 07-08	FY 08-09	FY 09-10
Unique Clients	1,308	1,411	1,210
AGE			
Age 16-17	1%	1%	1%
Age 18-24	76%	79%	79%
Age 25	23%	21%	20%
GENDER			
Female	52%	53%	51%
Male	48%	47%	49%
RACE			
White	45%	47%	48%
Hispanic	34%	33%	31%
African American	8%	8%	8%
Asian	6%	5%	5%
Native American	1%	1%	1%
Other/Unknown	6%	6%	7%
LANGUAGE			
English	86%	85%	86%
Spanish	9%	8%	8%
Other or Unknown	6%	6%	6%
DIAGNOSIS			
Schizophrenia & Schizoaffective	21%	19%	22%
Bipolar Disorders	16%	17%	21%
Major Depression Disorders	28%	28%	22%
Other Psychotic Disorders	7%	5%	8%
Other Depression/Adjustment	14%	17%	17%
Anxiety Disorder	12%	12%	9%
SUBSTANCE USE			
Any substance use disorder	22%	34%	47%
INSURANCE			
Uninsured	59%	58%	50%
Medi-Cal	40%	41%	45%
LIVING SITUATION			

Board & Care	4%	5%	7%
Homeless	5%	5%	4%
Lives Independently	75%	78%	78%

In FY 07-08, there were 1,308 unique clients, in FY 08-09 there were 1,411 unique clients and the number of unique clients in FY 09-10 was 1,210. Of these clients 76%-79% were between the ages of 18-24, while 1% were 16-17 years old, and 20%- 23% were 25 years of age. Of the total, 51% to 53% were female and 47% to 49% were male across the Fiscal Years (FY). The data indicates that 45% of clients were White, 34% were Hispanic, 8% were African American, 6% were Asian, 1% were Native American and 6% were Other/Unknown in FY 07-08, while FY 08-09 and FY 09-10 figures were very similar. English was the preferred language for 85%- 86% of the clients each FY, with 8% to 9% indicating Spanish as a preferred language. In FY 07-08 and FY 09-10, 65% of the TAY clients were diagnosed with Schizophrenia/Schizoaffective, Bipolar Disorder or Major Depression Disorder, and the percentage was comparable at 64% in FY 08-09. Other psychotic disorders made up 5%-8% of diagnoses, while Other depression/Adjustment and Anxiety was indicated for 26% of clients in FY 07-08 and FY 09-10 and for 29% of clients in FY 08-09. Data shows that 22% of clients were diagnosed with any Substance Use Disorder in FY 07-08, and this increased to 34% in FY 08-09 and to 47% in FY 09-10. In the first two FYs, 58%-59% of the clients seen were uninsured while in FY 09-10 this figure decreased to 50%. Also noted was that 75%-78% of clients reported living independently, while 4%-5% were homeless across all FYs.

Within the Children's System of Care, the following demographic data was available for FY 09-10. Data for FY 07-08 and FY 08-09 was unavailable.

TAY Clients receiving services in Children Outpatient programs

	FY 09-10
Unique Clients	3,543
AGE	
Age 16-17	81%
Age 18-24	19%
Age 25	0%
GENDER	
Female	34%
Male	66%
RACE	
White	22%
Hispanic	53%
African American	14%
Asian	3%
Native American	1%
Other/Unknown	7%
LANGUAGE	
English	83%
Spanish	15%
Other or Unknown	1%
DIAGNOSIS	
ADHD	7%

Oppositional/Conduct Disorders	24%
Depressive Disorders	29%
Bipolar Disorders	11%
Anxiety Disorders	10%
Adjustment Disorders	11%
Schizophrenic Disorders	2%
Other/Excluded	5%
SUBSTANCE USE	
Any substance use disorder	17%
INSURANCE	
Uninsured/Unknown	22%
Medi-Cal	66%
LIVING SITUATION	
House or Apartment	48%
Correctional Facility	40%
Foster Home	2%
Group Home	4%
Residential Treatment Facility	1%
Children's Shelter	2%
Homeless	1%
Other/ Unknown	3%

TAY Clients receiving services in TAY specific programs in the Adult System of Care

	FY 07-08	FY 08-09	FY 09-10
Unique Clients	835	918	905
AGE			
Age 16-17	3%	2%	2%
Age 18-24	94%	93%	91%
Age 25	4%	5%	6%
GENDER			
Female	45%	43%	43%
Male	54%	56%	57%
RACE			
White	41%	43%	36%
Hispanic	34%	34%	38%
African American	15%	12%	13%
Asian	7%	7%	7%
Native American	1%	1%	1%
Other/Unknown	3%	3%	4%
LANGUAGE			
English	91%	92%	91%
Spanish	7%	5%	7%
Other or Unknown	2%	3%	1%
DIAGNOSIS			
Schizophrenia & Schizoaffective	20%	24%	27%
Bipolar Disorders	18%	19%	23%
Major Depression Disorders	27%	24%	23%

Other Psychotic Disorders	7%	6%	6%
Other Depression/Adjustment	19%	17%	15%
Anxiety Disorder	10%	9%	6%
SUBSTANCE USE			
Any substance use disorder	29%	47%	50%
INSURANCE			
Uninsured	49%	45%	36%
Medi-Cal	50%	54%	59%
LIVING SITUATION			
Board & Care	5%	6%	4%
Homeless	8%	6%	7%
Lives Independently	71%	79%	84%

Unique clients served in FY 07-08 equaled 835, increased to 918 in FY 08-09 and stayed comparable with 905 in FY 09-10. Male clients accounted for 54%-57% of the population in each FY, with females comprising 43%-45% of the clients. In FY 07-08 & FY 08-09 41%-43% of clients were White while that percentage reduced to 36% in FY 09-10. In FY 09-10, the percentage of Hispanic clients increased from 34% in FY 07-08 & FY 08-09 to 38%, and African American clients represented 12%-15% each year (which is 4-7% higher than those in non-TAY specific outpatient programs). Across all FYs, 7% of clients were Asian, 1% Native American and 3%-4% were listed as Other/Unknown. Over 90% of clients indicated English as their preferred language each year.

Diagnoses of Schizophrenia/Schizoaffective disorders accounted for 20% and 27% over the three FYs, while Bipolar disorders were at 18% in FY 07-08, 19% in FY 08-09 and 23% in FY 09-10. Major Depression Disorder was indicated for 27% in FY 07-08, 24% in FY 08-09 and 23% in FY 09-10. Other psychotic disorders made up 6% to 7% of diagnoses each FY and Other depression/Adjustment disorders were diagnosed in 19% of the population in FY 07-08, 17% in FY 08-09 and decreased to 15% in FY 09-10. Anxiety disorder was indicated in 6% to 10% of clients across all FYs, with FY 09-10 recording the lowest percentage. In regards to Substance Use Disorder, 29% were indicated in FY 07-08 while 47% recorded any substance use disorder in FY 08-09 and this continued to increase to 50% in FY 09-10. Uninsured clients made up 45%-49% of the clients served in FY 07-08 and FY 08-09 while in FY 09-10 this figure was 36%. The majority of clients reported living independently, specifically 71% in FY 07-08, 79% in FY 08-09 and up to 84% in FY 09-10, while 8% were homeless in FY 07-08, 6% were homeless in FY 08-09 and 7% were homeless in FY 09-10.

TAY Clients receiving Fee For Service (FFS) treatment in the Adult System of Care

	FY 07-08	FY 08-09	FY 09-10
Unique Clients	1,277	1,163	1,307
AGE			
Age 16-17	1%	1%	0%

Age 18-24	85%	87%	89%
Age 25	14%	12%	11%
GENDER			
Female	57%	57%	57%
Male	40%	42%	43%
RACE			
White	40%	35%	35%
Hispanic	31%	28%	31%
African American	14%	14%	15%
Asian	4%	4%	3%
Native American	0%	1%	1%
Other/Unknown	11%	19%	16%
LANGUAGE			
English	83%	79%	79%
Spanish	6%	5%	7%
Other or Unknown	10%	15%	13%
DIAGNOSIS			
Schizophrenia & Schizoaffective	23%	16%	15%
Bipolar Disorders	12%	14%	12%
Major Depression Disorders	23%	26%	26%
Other Psychotic Disorders	7%	4%	5%
Other Depression/Adjustment	24%	26%	27%
Anxiety Disorder	9%	12%	13%
SUBSTANCE USE			
Any substance use disorder	5%	7%	10%
INSURANCE			
Uninsured	1%	2%	0%
Medi-Cal	99%	98%	100%
LIVING SITUATION			
Board & Care	3%	4%	6%
Homeless	1%	1%	2%
Lives Independently	23%	48%	61%
Other/Unknown	70%	44%	30%

Mental Health Services contracts with providers to serve Medi-Cal clients in a Fee for Service network. The clients served in this sector appear similar to clients described in the outpatient programs detailed above. In FY 07-08 there were 1,277 unique clients served, in FY 08-09 there were 1,163 unique clients and in FY 09-10 this number increased to 1,307. Approximately 87% of clients were ages 18-24 and 1% were ages 16-17 across FYs, while 14% were age 25 in FY 07-08, 12% were age 25 in FY 08-09 and 11% were age 25 in FY 09-10. In each FY, 57% of clients were female. Race was also consistent each FY and 35%-40% of clients were White, 28%-31% were Hispanic,14% -15% were African American, 3%-4% were Asian, up to 1% were Native American and 11%-19% were listed as Other/Unknown.

English was the primary language of choice for 83% of clients in FY 07-08 and 79% of clients in both FY 08-09 & FY 09-10. Spanish was listed as the preferred language for 5%-7% of the clients each FY and Other/Unknown accounted for the remaining percentage. Approximately 58% of the TAY clients were diagnosed with Schizophrenia/Schizoaffective, Bipolar Disorder or Major Depression Disorder in FY 07-08, 56% in FY 08-09 and 53% in FY 09-10. Other

psychotic disorders made up 7% of diagnoses in FY 07-08, 4%-5% in FY 08-09 & FY 09-10 respectively, while Other depression/Adjustment and Anxiety was indicated for 33% of clients in FY 07-08, for 38% of clients in FY 08-09 and for 40% of clients in FY 09-10. A Substance Use diagnosis was listed for 5% of clients in FY 07-08 ,7% in FY 08-09 and 10% in FY 09-10, which may be the result of under-reporting. It was reported that 99%-100% of clients served had Medi-Cal across all three years. In FY 07-08, 23% were noted to live independently, 70% listed the living situation as Other/Unknown and 1% were homeless, while in FY 08-09, the Other/Unknown category was reduced to 44%, and 48% of the clients were reported as living independently with 1% identified as homeless and in FY 09-10 data showed that the Other/Unknown category reduced to 30%, clients living independently increased to 61% and 2% were reported as homeless.

Within the Children's System of Care, the following demographic data was available for FY 09-10. Data for FY 07-08 and FY 08-09 was unavailable.

TAY Clients receiving FFS Treatment in the Children's System of Care

	FY 09-10
Unique Clients	472
AGE	
Age 16-17	100%
Age 18-24	0%
Age 25	0%
GENDER	
Female	52%
Male	48%
RACE	
White	29%
Hispanic	39%
African American	19%
Asian	3%
Native American	1%
Other/Unknown	10%
LANGUAGE	
English	84%
Spanish	8%
Other or Unknown	8%
DIAGNOSIS	
ADHD	13%
Oppositional/Conduct Disorders	17%
Depressive Disorders	31%
Bipolar Disorders	16%
Anxiety Disorders	10%
Adjustment Disorders	10%
Schizophrenic Disorders	1%
SUBSTANCE USE	
Any substance use disorder	7%
INSURANCE	
Uninsured	0%
Medi-Cal	91%

LIVING SITUATION	
House or Apartment	53%
Correctional Facility	7%
Foster Home	4%
Group Home	14%
Residential Treatment Facility	2%
Children's Shelter	3%
Homeless	0%
Other/ Unknown	17%

TAY Clients in inpatient and jail services in the Adult System of Care

	FY 07-08	FY 08-09	FY 09-10
Unique Clients	3,016	3,423	3,576
AGE			
Age 16-17	5%	6%	7%
Age 18-24	83%	82%	80%
Age 25	12%	12%	13%
GENDER			
Female	30%	30%	30%
Male	70%	70%	69%
RACE			
White	49%	47%	47%
Hispanic	26%	25%	26%
African American	14%	16%	15%
Asian	4%	4%	4%
Native American	1%	0%	1%
Other/Unknown	6%	7%	7%
LANGUAGE			
English	91%	86%	85%
Spanish	5%	5%	5%
Other or Unknown	4%	8%	10%
DIAGNOSIS			
Schizophrenia & Schizoaffective	5%	5%	4%
Bipolar Disorders	9%	8%	8%
Major Depression Disorders	7%	8%	9%
Other Psychotic Disorders	10%	10%	10%
Other Depression/Adjustment	41%	39%	37%
Anxiety Disorder	9%	10%	10%
SUBSTANCE USE			
Any substance use disorder	21%	34%	41%
INSURANCE			
Uninsured	84%	80%	70%
Medi-Cal	13%	17%	25%
LIVING SITUATION			
Board & Care	1%	2%	3%
Homeless	4%	5%	6%

Lives Independently	36%	36%	34%
Justice Related	55%	50%	44%

The clients in this category have only received inpatient/emergency/jail services in our system. In FY 07-08, this included 3,016 unique clients, in FY 08-09 there were 3,423 unique clients and the number increased to 3,576 in FY 09-10. As with other services, approximately 80%-83% of these clients were age 18-24, 5% were age 16-17 and 12% -13% were age 25 across all FYs. The majority of clients were male comprising 69%-70% each FY. Race was similar across all FYs with 47% to 49% of the clients identifying as White, 25%-26% Hispanic, 14% -16% African American, 4% Asian, 1% Native American and 6%-7% Other/Unknown. It is notable that the percentage of Hispanic clients in this category was lower than in the outpatient treatment category, while the percentage of African American clients was comparable to clients being seen in TAY specific programs and by FFS providers. In FY 07-08, the preferred language for 91% of clients was English, 5% preferred Spanish and 1% listed preferred language as Other Asian, and 3% were Other/Unknown. English was also the preferred language for 86% of clients in FY 08-09, with Spanish reported as the preferred language for 5% and 8% were listed as Other/Unknown. In FY 09-10, the figures were similar with English being the preferred language for 85% of clients, Spanish for 5% of clients and 10% of clients recorded as Other/Unknown.

Diagnoses were somewhat consistent across the three FYs, with Schizophrenia/Schizoaffective, Bipolar Disorder or Major Depression Disorder accounting for 21%, Other Psychotic Disorders for 10%, Other Depression/Adjustment and Anxiety for 47%- 50%. However, Substance Use Disorder is indicated for 21% in FY 07-08, increased to 34% in FY 08-09 and demonstrated a further increase to 41% in FY 09-10. The insurance status ranged from 84% uninsured, 13% Medi-Cal and 3% Other Private in FY 07-08, to 80% uninsured, 17% Medi-Cal and 3% Other Private in FY 08-09 and 70% uninsured, 25% Medi-Cal and 5% Other Private in FY 09-10. Of these clients, 55% had a justice related living situation, 36% lived independently and 4% were homeless in FY 07-08. In FY 08-09, 5% were homeless, 36% lived independently and 50% had a living situation that was justice related. In FY 09-10, 34% lived independently, 6% were homeless and 44% had a justice related living situation. It is recommended that TAY jail data be analyzed to determine the number of TAY that are not connected with the outpatient mental health system to better design programs that meet the needs of these TAY.

Within the Children's System of Care, the following demographic data was available for FY 09-10. Data for FY 07-08 and FY 08-09 was unavailable.

TAY Clients not receiving outpatient services in the Children's System of Care

*Clients received some type of service other than outpatient

	FY 09-10
Unique Clients	563
AGE	
Age 16-17	72%
Age 18-24	23%
Age 25	0%
GENDER	

Female	43%
Male	57%
RACE	
White	38%
Hispanic	38%
African American	13%
Asian	5%
Native American	1%
Other/Unknown	5%
LANGUAGE	
English	89%
Spanish	7%
Other or Unknown	4%
DIAGNOSIS	
ADHD	11%
Oppositional/Conduct Disorders	15%
Depressive Disorders	34%
Bipolar Disorders	18%
Anxiety Disorders	7%
Adjustment Disorders	4%
Schizophrenic Disorders	7%
SUBSTANCE USE	
Any substance use disorder	19%
INSURANCE	
Uninsured	16%
Medi-Cal	59%
LIVING SITUATION	
House or Apartment	71%
Correctional Facility	2%
Foster Home	2%
Group Home	15%
Residential Treatment Facility	5%
Children's Shelter	0%
Homeless	1%
Other/ Unknown	3%

Obvious differences in the data for TAY clients in the Children's System of Care in comparison to the Adult System of Care include diagnostic profiles and range of living situations. The variation in client diagnoses, and program targeted diagnoses, is one example of how the transition from one System to the other has been difficult for clients and providers. There are also some variances in penetration rates for often underserved populations in the Adult System of Care, including Hispanic and African American clients. One theory for the higher percentages of Hispanic and African American clients being served in the Children's System of Care is the availability of clinicians on school sites, increasing the youth's access to care.

Below is a chart that depicts the total number of unique TAY clients and corresponding demographic data for all TAY who received Adult outpatient services, TAY specific services, FFS, inpatient and jail services, and Child outpatient services (in FY 09-10 only).

	FY 07-08	FY 08-09	FY 09-10
Unique Clients	6436	6915	11576
AGE			
Age 16-17	3%	4%	35%
Age 18-24	83%	83%	57%
Age 25	14%	13%	8%
GENDER			
Female	42%	41%	39%
Male	57%	59%	61%
RACE			
White	45%	45%	36%
Hispanic	30%	28%	37%
African American	13%	13%	14%
Asian	5%	5%	4%
Native American	1%	1%	1%
Other/Unknown	7%	8%	8%
LANGUAGE			
English	88%	85%	84%
Spanish	6%	6%	9%
Other or Unknown	5%	9%	7%
DIAGNOSIS			
Schizophrenia & Schizoaffective	10%	9%	7%
Bipolar Disorders	9%	9%	10%
Major Depression Disorders	13%	13%	7%
Other Psychotic Disorders	6%	6%	4%
Other Depression/Adjustment (*Adjustment Only in Children's System data)	20%	21%	15%
Anxiety Disorders	7%	8%	7%
ADHD	Data Unavailable	Data Unavailable	3%
Oppositional/Conduct Disorders	Data Unavailable	Data Unavailable	7%
Depressive Disorders (*Children's System data only)			9%
Other/Excluded	Data Unavailable	Data Unavailable	2%
SUBSTANCE USE			
Any substance use disorder	19%	31%	29%
INSURANCE			
Uninsured	58%	58%	37%
Medi-Cal	40%	40%	55%
LIVING SITUATION			
Board & Care	2%	3%	2%
Homeless	4%	4%	3%
Lives Independently	45%	53%	32%
Justice Related	29%	26%	14%
House or Apartment	Data Unavailable	Data Unavailable	20%
Correctional Facility	Data Unavailable	Data Unavailable	13%
Foster Home	Data Unavailable	Data Unavailable	1%

Group Home	Data Unavailable	Data Unavailable	2%
Residential Treatment Facility	Data Unavailable	Data Unavailable	1%
Children's Shelter	Data Unavailable	Data Unavailable	1%
Other	Data Unavailable	Data Unavailable	1%

In addition to the data outlined above, an important aspect to consider when discussing the TAY population is Child Welfare Services. To examine the Child Welfare – Mental Health overlap in San Diego County, a dataset containing a list of all children who had open Child Welfare cases during FY08-09 was obtained and compared to the CMHS dataset. In FY08-09, 3,634 clients, or 20.4% of youth receiving mental health services, were also open to the Child Welfare System. Looking at it from the Child Welfare perspective, 29.8% of youth with open Child Welfare cases in FY08-09 also received CMHS services during the years. Special efforts need to be made to increase seamless mental health service referrals for foster youth as early as possible.

First Service Use

In reviewing how TAY clients first access mental health services, Fiscal Year 07-08 and Fiscal Year 08-09 data shows that when clients are receiving non-TAY specific services in outpatient programs, 74-78% of them first use services in the Adult outpatient system. When looking at clients receiving services in TAY specific programs, it reflects that 61-72% first receive services in the Adult outpatient system, while 16-22% of clients have an Emergency Psychiatric Unit (EPU) or Emergency Screening Unit (ESU) initial contact. Data indicates that TAY clients using FFS treatment begin receiving services in that system 81-86% of the time. As for clients not receiving outpatient services in the system, 46-51% receive their first mental health services in jail, while 31-34% have initial contact with the EPU/ESU and 13%-15% are first served by PERT.

In addition to presenting a picture of the TAY clients we serve, the data outlined regarding demographics of clients and first use of services demonstrates some key findings that assisted with development of the goals outlined in this plan.

1. There are almost as many, if not more, TAY clients receiving inpatient/emergency/jail services as there are receiving outpatient and TAY specific services.
2. The vast majority of TAY clients are not accessing services through Children's Mental Health and transitioning into Adult Mental Health Services.
3. Ethnic and cultural disparities are present. County mental health services serves a smaller percentages of some specific cultures, as compared to their prevalence in the San Diego County Medi-Cal population.
    a. In 2006-2007, the percentage of Medi-Cal eligible Adult Latino clients was 59% and eligible Child/Youth Latino clients was 70%. The data shows that actual TAY Latino clients ranged from 26%-34% across services received in FY 07-08 and FY 08-09.
    b. The percentage of Medi-Cal eligible Adult Asian clients was 9% and the percentage of eligible Child/Youth Asian clients was 6% in FY 06-07. Actual TAY Asian clients ranged from 4%-7% across services received in FY 07-08 and FY 08-09.
    c. The percentage of Medi-Cal eligible Adult and Child/Youth Native American clients in FY 06-07 was 2%. Data demonstrates that the percentage of TAY Native Americans served was 1% across both FY 07-08 and FY 08-09.
    d. The percentage of Medi-Cal eligible Adult African American clients was 8% and for Child/Youth clients it was 9% in 2006-2007, while actual TAY

African American clients served varied from 8% to 16% across services received in FY 07-08 and FY 08-09.

IV. Strengths and Gaps in the System of Care for TAY

a. Referral Process

At this time, transition of youth into the Adult mental health system of care typically occurs when the youth is about 17.5 years of age. A referral is made from a Children's Mental Health Services provider to an Adult System of Care provider for a client's transition into a new program with a new provider, as clinically indicated. If a routine referral has been unsuccessful, the County of San Diego Mental Health Services has a Policy and Procedure citing an established process for the transition of TAY clients (Policy No. 01-02-212, "Transition Age Youth Referral", Attachment C). The current County policy specifies that a client's transition to adult services is to be based on the continuing mental health needs of the individual and the age of the individual (those who are reaching 18 years of age). However, the transition from the Children's to the Adult System of Care has been a challenge for clients, family members, clinicians and the systems of care. There are multiple Federal, State and local policies and regulations that need to be considered and aligned to ensure a smooth transition at the appropriate age.

In the interim, it is recommended that MHS broaden its clinical attention to address transition issues prior to age 17.5, in an effort to increase effective interagency collaboration and address barriers that exist. This should entail developing a standardized process for identifying and addressing transition issues for youth across multiple systems. Most notably, it is well documented that children involved in the Child Welfare System (CWS) are an especially vulnerable population with studies estimating that over 40% of these children have significant emotional and behavioral health needs.

b. Collaborations and Partnerships

Although there have been gains in system collaboration and partnership, there are currently opportunities to expand inter-agency collaboration, cooperation and communication. This would include, but not be limited to, engaging providers from Adult Mental Health, Children's Mental Health, Middle Schools, High Schools, Colleges, Child Welfare Services, Juvenile and Criminal Justice Systems, Vocational Rehab, Mental Illness Advocacy Groups, Physical Healthcare representatives and Housing representatives. There are multiple venues that partners participate in where TAY issues can be addressed, however, it is the intent to invite participants from these agencies to the established TAY workgroup initially. Next steps for the workgroup would then be to review all current TAY plans, documents, committees and workgroups to determine ways to collaborate and optimize existing efforts. For instance, the County of San Diego's Commission on Children, Youth and Families is an existing committee established to identify and address the needs of children, youth and families and to achieve better outcomes for children of all ages and at all stages of development. In working towards improved collaboration, the overarching goal is to strengthen and formalize these partnerships and to develop practices that will bridge and facilitate program development and address transition issues, concerns and services for TAY in an effective manner. Furthermore, in alignment with our physical health integration efforts, collaborations and partnerships emphasizing health and wellness of TAY need to be a top priority.

c. Outreach and Engagement

With the advent of MHSA requirements for County's to develop TAY specific services, the County's Mental Health system has responded by developing and creating services specifically targeting the TAY population. Outreach and engagement has been part and parcel of additional services for this population as TAY do not traditionally access mental health services due to the stigma associated with seeking services. These efforts need to continue in order to minimize the effects of untreated mental health conditions. Research has demonstrated that TAY have not been effectively engaged, and that providers need to be provided with training and education to be skilled about the TAY culture, to have working knowledge of brain development and developmental stages, in an effort to work with this specific population. It is important to establish expectations on the individual's developmental capabilities, not only their age, which can sometimes be difficult for service providers to do. There are unique challenges, as youth are often distrustful of mental health and social services systems and providers must be resourceful, flexible and respectfully persistent as they work to gain trust and build the connection towards health. At a recent TAY Un-Convention, the use of peer mentors was strongly recommended to bridge the gap. Presenters discussed the unique aspects of peer mentors in facilitation engagement as an effective intervention to increase access to needed care.

d. Access to Services

Although it is noted that the County has made many efforts to provide age and developmentally appropriate services, there are still limited resources for TAY specific services. However, in FY 09-10 data shows that wait times for TAY programs have decreased. In July, 2009, the average wait time for Mental Health services in TAY programs was 9.3 days, while in April, 2010, it was 3.1 days. For Psychiatric services, the average wait time in TAY programs in July, 2009 was 11.1 days and it was 7.0 days in April, 2010. This decreasing trend could be the result of multiple factors. During the past year, the County has worked steadily to ensure that the people receiving specialty mental health services are the ones who need this level of service and has moved to shorter term treatment model. It is unknown at this time if utilization management practices led to decreased wait times, if shorter term services have been more effective or if fewer TAY were accessing services. It is recommended that TAY specific services and relevant data be evaluation by programs to assess penetration, retention and planned discharges versus dropping out of treatment. In addition, longitudinal follow up of TAY with planned discharges and TAY dropping out of treatment will inform the system as to outcomes.

e. Types of Services

Current services available for TAY in the Children/Youth mental health system include:

- Psychosocial Assessment
- Medication Management
- Individual/Group Therapy
- Family Therapy
- Substance Abuse Assessment/Treatment
- Case Management
- Wraparound
- Day Treatment Intensive
- Day Rehabilitation
- Residential (through AB 3632)
- Emergency Screening
- Crisis Stabilization

- Acute inpatient hospitalization
- Therapeutic Behavioral Services (TBS) accessible only to full-scope Medi-Cal beneficiaries under 21 years, with serious emotional problems
- Referral and Support Lines
- Rehabilitative Services
    - Basic Life Skills/Social Skills
    - Independent Living Skills

Current services available for TAY in the Adult mental health system include:

- Psychosocial Assessment
- Medication Management
- Individual/group therapy/family therapy
- Substance Abuse Assessment/Treatment
- Clubhouse Socialization
- Case Management
- Therapeutic Behavioral Services (TBS) accessible only to full scope Medi-Cal beneficiaries under 21 years with serious emotional problems
- Acute inpatient hospitalization
- Long term care
- Crisis Residential Services
- Supported Education
- Supported Employment
- Supported Housing
- Peer Warmline/Support Line
- Psycho-education
    - Mental health/mental disorders
    - Support groups
    - Self-help
    - Peer Mentors

Although TAY services are available, it is notable that there is a need to develop and increase TAY capacity in all levels of care and to tailor service delivery in alignment with the goals outlined in this plan. Specific emphasis should be placed on the health and wellness of TAY, with continued efforts to integrate Mental Health and Primary Care and Alcohol and Drug services. This will require a continued shift in perspective while working with the TAY population and entails system, program and staff development activities.

V. Outcomes

The use of data is essential in guiding a process. Outcomes should be specific, measurable and meaningful and are derived from goals. They are important indicators for systems, programs and clients. A continuous quality improvement process promotes the need for objective data to analyze and improve processes and should be applied to meet the needs of those we serve and to improve the services we offer. As we discuss outcomes, it is important to note that the County has embarked on identifying ways to determine and measure system, program and provider cultural competency outcomes. This is an integral piece of effective service delivery, and is one way the County hopes to improve overall outcomes for San Diego.

a. **System Outcomes**

In the County, there are multiple identified Systemwide outcomes delineated in the MHSA CSS Plan. These include: reducing the number of hospitalizations and readmissions, reducing the number of incarcerations, reducing the number of homeless, reducing the number of those using only emergency services, reducing the number of those using only jail MH services, and increasing the number of clients employed. The data for these outcomes will need to be collected and analyzed for TAY to evaluate the success, and/or the areas needed for improvement.

Other system outcomes involve County initiatives to increase integrated care, in which each involved provider organization is expected to maintain relationships as part of a network responsible for delivering services and supports, and to increase coordinated care, which works to have all aspects of a client's care be carried out by one provider. In the past year, these efforts have primarily been targeted with physical health in mind. Many clients with severe and persistent mental illness lack a regular medical provider, despite the recognition that many clients have, or are at risk for, serious physical health problems. The County is working to ensure mental health providers are actively linking clients to medical providers, and working with medical providers to coordinate medical and mental health care. For those clients who are currently functionally stable and require continued psychotropic medication, but not specialty mental health services, the County is working towards coordinated care, where a primary care physician would continue to monitor the clients physical health and mental health needs, with consultation from a mental health provider as needed. In addition, the County will be utilizing the Recovery Oriented System Indicators (ROSI) tool to monitor the recovery orientation of the Mental Health System. These efforts will be monitored, and data will be analyzed, to determine the true impact on system and, ultimately, client outcomes.

b. Program Outcomes

At the program level the County's goal is to utilize best and promising practices. There are multiple practices, including evidence-based practices (EBP), being utilized in programs throughout the County including, but not limited to:

- Medication management
- Illness self-management
- Integrated dual disorder treatment
- Supported employment
- Family psycho-education
- Assertive Community Treatment
- Rehabilitation Skill Teaching
- Social Skills Training
- Trauma focused Cognitive Behavioral Therapy (CBT)

Programs are expected to monitor effectiveness of services, perform utilization management, and collect and report on client outcomes in an effort to demonstrate efficacy. For programs utilizing EBP, programs are responsible to provide training to staff and to utilize evaluation tools to ensure fidelity to the model of service.

For TAY, there is an evidence-supported practice that has been shown to be effective in improving the outcomes of youth and young adults with Emotional or Behavioral Difficulties (EBD). This is the Transition to Independence Process (TIP) Model. It is a recommendation that the County evaluate the implementation of this model and if determined, ensure the appropriate training and staff development resources are provided.

Another recommended intervention for TAY is the development of trauma-informed care. It is necessary for programs to be available to provide trauma-specific services, including evidence-based and emerging best practice treatment models**.** Individuals with histories of violence, abuse, and neglect from childhood onward make up the majority of clients served by public mental health and substance abuse service systems.

Regardless of services implemented, the developmental stages of TAY and the service barriers unique to TAY will require specialized training and targeted staff development. This will ensure some consistent standards across TAY service providers. In addition to workforce education, there will need to be an evaluation and outcomes component to monitor program success. As one example, the County has determined that the Recovery Self Assessment (RSA) tool will be used to monitor the recovery orientation of programs.

c. Client Outcomes

Client outcomes are vital in demonstrating client symptoms, functioning, quality of life and personal growth. Mental Health Services had identified multiple outcomes measures for Adults and for Children/Youth, but there are no TAY specific measures to date. In the Adult system, the Recovery Markers Questionnaire (RMQ), the Illness Management and Recovery scales (IMR) and the Substance Abuse Treatment Scale-Revised (SATS-R) tools will be used to track client outcomes. As these are newer measures, the County will be working to examine initial data to determine baseline information and can provide outcome updates in the future. In the Children's system, the Child and Adolescent Measurement System (CAMS), the Children's Functional Assessment Rating Scale (CFARS), and the CRAFFT, which measures substance abuse involvement will be utilized for measuring client outcomes. The County will be providing outcome updates based on these tools. As this data is presented and reviewed, it is recommended that data is available specifically for the TAY population so measurements over time can be reviewed and analyzed to ensure that the clients receiving services are showing improved outcomes in this age group.

Overall, the goals presented in this plan are aimed to assist in improving system, program and client outcomes. Implementing a seamless referral process; supporting communication between agencies; encouraging youth participation and engagement in services; working towards a successful transition into Adulthood, not just Adult Services; utilizing skill building; promoting wellness and recovery; increasing peer supports and peer voice; expanding the use of EBP interventions; ensuring staff are trained appropriately on TAY culture, ethnic cultures, and on TAY development will increase access to care, promote independence and self sufficiency, positively affect all aspects of an individual's life and have an impact on the youth served as well as the programs and system that serves them.

VI. RECOMMENDATIONS:

1. It is recommended that the County broaden its clinical attention to address transition issues prior to age 17.5, in an effort to increase effective interagency collaboration and to address barriers that exist. This should entail developing a standardized process for identifying and addressing transition issues for youth across the Children's SOC, Child Welfare Services, Probation, Alcohol and Drug Services and Adult SOC.

2. It is recommended that the TAY Workgroup be expanded to include representatives from SELPA's (for Middle Schools and High Schools), Colleges, Vocational Rehab, additional Mental Illness Advocacy Groups and Housing representatives to formalize input,

collaborations and partnerships to address issues and strategies and to recommend practices that will bridge the existing gaps in the system of care.

3. It is recommended that the TAY Workgroup be transformed to a TAY Council that would function similar to the other Council's established by the Mental Health Director.

4. It is recommended that TAY capacity be increased where there are gaps in treatment and services and that service delivery is tailored in alignment with the goals outlined in this plan. For instance, transportation is a barrier with this population that services need to address and flexibility of programs is a key for this population. There are cultural considerations that need to be focused on, as well as the need for an integrated physical health component as part of a rounded wellness approach.

5. It is recommended that MHS and CWS and County Probation have a series of roundtables to discuss strengths, barriers, challenges and opportunities that impact successful transition services for TAY in these systems of care. Further integration with probation and CWS as part of the standard infrastructure is hoped to be accomplished so that common goals and objectives are established and collectively achieved.

6. It is recommended that TAY Peer Mentor capacity be developed in the system of care and the Transition to Independence Process (TIP) Model of service be considered for incorporation in TAY programs. It also recommended that the County evaluate the implementation of this model and if determined, ensure the appropriate training and staff development resources are provided.

7. It is recommended that programs that provide services for TAY be trained in trauma-informed care. In addition, training regarding overall needs of this specific population (developmental, psychological, economic, etc) is recommended, and these trainings should include effective interventions, system connections, legal issues, financial options, and knowledge of other resources required to effectively serve this population.

8. It is recommended that TAY specific programs, services and relevant data be evaluated by program to assess penetration, retention and planned discharges versus dropping out of treatment. In addition, longitudinal follow up of TAY with planned discharges and of TAY dropping out of treatment will inform the system as to outcomes. Data collection and analysis should include the evaluation of program strengths, successes and gaps.

9. It is recommended that the Recovery Markers Questionnaire (RMQ), the Illness Management and Recovery scales (IMR), the Substance Abuse Treatment Scale-Revised (SATS-R), the Child and Adolescent Measurement System (CAMS) and the Child Functional Assessment Rating Scales (CFARS) be analyzed for TAY to determine recovery gains and client outcomes that are age specific and to determine if other measures are more appropriate for this cohort. It is also recommended that system measures be identified and implemented.

10. It is recommended that all future TAY plans be broadened to reflect the county's Behavioral Health System by including initiatives, data, outcomes and recommendations related to youth served within both the County's Mental Health System and the Alcohol and Drug System.

VII. TIMELINES

It is suggested that timelines for the above ten recommendations be agreed upon in concert with the Behavioral Health Services Administration to prioritize next steps. The Adult and Older Adult Assistant Deputy Director will convene the Behavioral Health Services Administration within 30 days of the release of this report update to define priorities and next steps.

VIII. DISSEMINATION OF TRANSITION AGE YOUTH SERVICES STATUS REPORT

The Transition Age Youth Services Status Report for FY 2010-2011 will be distributed to the TAY Workgroup, Children's Council and Adult Council. The Mental Health Board, (MHB) will also receive a copy and be provided a presentation at an upcoming MHB meeting. In addition, the Mental Health Contractor's Association and the Mental Health Coalition will receive copies.

IX. REFERENCES

County of San Diego MHSA Community Services and Supports (CSS) Plan, 2005

County of San Diego MHSA CSS Plan Addendums, 2006-2010

County of San Diego, *Children's Mental Health Services System and Clinical Outcomes Fiscal Year 2008-2009,* July, 2010

County of San Diego/Health Services Research Center (HSRC) Insyst/Anasazi data reports: InSyst 2/2009 download (FY 0708), Anasazi 10/2009 download and Insyst 10/2008 download (FY0809).

Clark, Hewitt B., Unruh, Deanne K, *Transition of Youth & Young Adults with Emotional or Behavioral Difficulties.* Maryland: Paul H. Brookes Publishing Co., 2009

Health Services Research Center (HSRC) and Child and Adolescent Services Research Center (CASRC), *Progress Towards Reducing Disparities: A Report for San Diego County Mental Health, Five Year Comparison, FY 2001-2002 to FY 2006-2007*, 4/28/09

Human Rights Watch, *My So-Called Emancipation From Foster Care to Homelessness for California Youth*, 2010.

Jennings, Ann, *Models for Developing Trauma-Informed Behavioral Health Systems and Trauma-Specific Services*, 2004

X.ATTACHMENTS

A. MHSA Community Services and Supports(CSS) Program Summary
B. MHSA Prevention and Early Intervention (PEI) Program Summary
C. Mental Health Services Policy No. 01-02-212, “Transition Age Youth Referral”