SAN DIEGO COUNTY: DATA NOTEBOOK 2016

FOR CALIFORNIA

BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

Prepared by California Mental Health Planning Council, in collaboration with:
California Association of Local Behavioral Health Boards/Commissions

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BEHAVIORAL HEALTH BOARDS AND COMMISSIONS

County Population (January, 2016): 3,288,612

Website for County Department of Mental Health (MH) or Behavioral Health:

- http://www.sdcounty.ca.gov/hhsa

Website for Local County MH Data and Reports:

- http://www.sdcounty.ca.gov/hhsa/programs/bhs/mental_health_services_act/tech nical_resource_library.html

Website for local MH Board/Commission Meeting Announcements and Reports:

- http://www.sandiego.networkofcare.org/mh/content.aspx?id

Specialty MH Data[1] from CY 2013: see Reports folder at http://www.calegro.com/

Total number of persons who received Medi-Cal in your county (2013): 652,845

Average number Medi-Cal eligible persons per month: (2014): 599,543

Percent of Medi-Cal eligible persons who were:

Children, ages 0-17: 52.6%

Adults, 18 and over: 47.4 %

Total persons with SMI[2] or SED[3] who received Specialty MH services (2014): 34,712

Percent of Specialty MH service recipients who were:

Children, ages 0-17: 46.1 %

Adults, 18 and over: 54.9 %

[1] Downloaded from www.CALEQRO.com. If you have more recent data available, please feel free to update this section within current HIPAA compliant guidelines. CY = calendar year.
[2] Serious Mental Illness, term used for adults 18 and older.
[3] Severe Emotional Disorder, term used for children 17 and under.

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INTRODUCTION: PURPOSE, GOALS, AND DATA RESOURCES

What is the "Data Notebook?"

The Data Notebook is a structured format for reviewing information and reporting on specific mental health services in each county. For example, the topic for our 2016 Data Notebook reviews behavioral health services for children, youth, and transition age youth (TAY)[4].

Each year, mental health boards and commissions are required to review performance data for mental health services in their county. The local boards are required to report their findings to the California Mental Health Planning Council (CMHPC) every year. Just like every other government agency that requires a report, the CMHPC creates a structured document for receiving information.

The Data Notebook is developed annually in a work group process with input from:

- the CA Mental Health Planning Council and staff members,
- CA Association of Local Behavioral Health Boards and Commissions (CALBHB),
- consultations with individual Mental Health Directors, and
- representatives of the County Behavioral Health Directors Association (CBHDA).

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates[5] to review performance data for their local county mental health services and report on performance every year,
- function as an educational resource on behavioral health data for local boards,
- enable the California Mental Health Planning Council (CMHPC) to fulfill its mandate[6] to review and report on the public mental health system in our state.

The Data Notebook is organized to provide data and solicit responses from the mental health board on specific topics so that the information can be readily analyzed by the CMHPC. These data are compiled by staff in a yearly report to inform policy makers, stakeholders and the general public. Recently, we analyzed all 50 Data Notebooks received in 2015 from the mental health boards and commissions. This information represented 52 counties[7] that comprised a geographic area containing 99% of this

[4] See various definitions of the age ranges for these groups depending on data source, Table 2, page 8.
[5] W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.
[6] W.I.C. 5772 (c), regarding annual reports from the California Mental Health Planning Council.
[7] Sutter and Yuba Counties are paired in one Mental Health Plan, as are Placer and Sierra Counties.

state's population. The analyses resulted in the Statewide Overview report that is on the CMHPC website at:

http://www.dhcs.ca.gov/services/MH/Pages/CMHPC-PlanningCouncilWelcome.aspx.

Our overall goal is to promote a culture of data-driven quality improvement in California's behavioral health services and to improve client outcomes and function. Data reporting provides evidence for advocacy and good public policy. In turn, policy drives funding for programs.

Resources: Where do We Get the Data?

The data and discussion for our review of behavioral health services for children, youth, and transition age youth (TAY) are organized in three main sections:

1) Access, engagement and post-hospitalization follow-up,
2) Vulnerable populations of youth with specialized mental health needs, and
3) Mental Health Services Act (MHSA) -funded[8] programs that help children and youth recover.

We customized each report by placing data for your county within the Data Notebook, followed by discussion questions related to each topic. Statewide reference data are provided for comparison for some items. A few critical issues are highlighted by information from research reports. County data are taken from public sources including state agencies. For small population counties, special care must be taken to protect patient privacy; for example, by combining several counties' data together. Another strategy is "masking" (redaction) of data cells containing small numbers, which may be marked by an asterisk "*", or a carat "^", or LNE for "low number event."

Many questions request input based on the experience and perspectives of local board members. Board members will need to address related questions about local programs and policies in their discussion. Basic information for that discussion may be obtained from local county departments of behavioral health or mental health.

This year we present information from California Department of Health Care Services (DHCS), information about some Mental Health Services Act (MHSA)-funded programs, and data from "KidsData.org," which aggregates data from many other agencies. These and other data resources are described in more detail in Table 1, below.

[8] Mental Health Services Act of 2004; also called Proposition 63.

Table 1. Who Produces the Data and What is Contained in these Resources?

CA DHCS: Child/Youth Mental Health Services Performance Outcomes System,[9] 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[10] benefits. Focuses on Specialty Mental Health Services for those with Serious Emotional Disorders (SED) or Serious Mental Illness (SMI).
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 the data for services offered by each county's Mental Health Plan (MHP). An independent review discusses program strengths and challenges; highly informative for local stakeholders.
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: National Survey on Drug Use and Health (NSDUH), 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.

[9] See 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.

[10] 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.

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 biological[11] stages of development. Many systems 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 (nor the resources) for such a major re-analysis. Here, we use the age breakdowns provided by the various public data sources that are available to us.

Table 2. 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[12]	16-25	16-25	N/A	16-25 (or one alternative used is 18-25 = young adults).

[11] Biological development loosely refers to pediatrics-defined stages of physical, cognitive and emotional growth.
[12] N/A means not applicable, because this category is not available under this system or data source.

How Can Local Advisory Boards Fulfill their Reporting Mandates?

What are the reporting roles mandated for the mental health/behavioral health boards and commissions? These requirements are defined in law by the state of California.

Welfare and Institutions Code, Section 5604.2 (a)

The local mental health board shall do all of the following:

(1) Review and evaluate the community's mental health needs, services, facilities, and special problems.

(2) Review any county agreements entered into pursuant to Section 5650.

(3) Advise the governing body and the local mental health director as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) ***Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.***

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

The structured format and questions in the Data Notebook are designed to assist local advisory boards to fulfill their state mandates, review their data, report on county mental health programs, identify unmet needs, and make recommendations. We encourage all local boards to review this Data Notebook and to participate in the development of responses. It is an opportunity for the local board and their supporting public mental health departments to work together on the issues presented in the Data Notebook.

This year we present information about important topics for children and youth. Each section is anchored in data for a current topic, followed by discussion questions. A final open-ended question asks about *"any additional comments or suggestions you may have."* Ideas could include a program's successes or strengths, changes or improvements in services, or a critical need for new program resources or facilities. Please address whatever is most important at this time to your local board and stakeholders and that also may help inform your county leadership.

We were very impressed with the level of participation in 2015, having received 50 Data Notebooks that represent data from 52 counties. Several examples of good and even exemplary strategies were evident in these reports. At least 22 local boards described a process that was largely collaborative in that board members worked with county staff to produce the Data Notebook. In several counties, the responses were developed by an *ad hoc* committee or special work group of the local board and staff and then presented to the local board for approval. In other counties, the responses in the Data Notebook were developed by staff and presented to the local boards for approval. In a few counties, responses were prepared by staff and submitted directly to the CMHPC.

In an August 25, 2015 letter, the County Behavioral Health Directors Association (CBHDA) endorsed the expectation that "the process of gathering this data should be collaborative between the Advisory Boards and the Mental Health Plans (MHPs)." They also stated that "then the process would be more natural to the actual dynamic that exists in the counties." The California Mental Health Planning Council fully supports these statements and finds them consistent with the spirit and intent of the statutes.

This year we encourage every local board to look at and participate in developing the responses to questions outlined in the Data Notebook. We hope this Data Notebook serves as a spring-board for your discussion about all areas of the mental health system, not just those topics highlighted by our questions.

The final page of this document contains a questionnaire asking about the strategies you employ to complete this year's Data Notebook. Please review these in advance, before beginning this work.

Thank you very much for participating in this project.

ACCESS TO SERVICES: Youth, Children, and their Families/Caregivers

Access: Outreach and Engagement with Services

One goal of the Mental Health Services Act (MHSA) is to promote outreach to engage all groups in services, including communities of color and LGBTQ[13] youth. If children, youth or their families are not accessing services, we may need to change our programs to meet their mental health needs in ways that better complement their culture or language needs. These values also guide the county mental health plans that provide specialty mental health services (SMHS). These services are intended for those with serious emotional disorders (SED) or serious mental illness (SMI).

As you examine data on the following pages, consider whether your county is serving all of the children and youth who need specialty mental health services. The standard data collected does not provide much detail about all the cultural groups that live in each county. The rich diversity of California can present challenges in providing services in a culturally and linguistically appropriate manner, as we have residents with family or ancestors from nearly every country.

From data the counties report to the state, we can see how many children and youth living in your county are eligible for Medi-Cal and how many of those individuals received one or more visits for mental health services. There are several ways to measure service outreach and engagement that help us evaluate how different groups are doing in their efforts to obtain 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 your county. Figure 1 on the top half of the next page shows the percentages of children and youth from each major race/ethnicity group who received one or more SMHS visits during the fiscal year (FY). The lower half of the figure shows the percentage of each age group that received specialty mental health services (SMHS, in the graphs and tables). 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% of recipients are male.

Following Figure 1, more detailed data are shown in Figures 2 and 3, describing the Medi-Cal eligible population of children and youth, the percentages of each group that received specialty mental health services, and changes in those numbers over time for the fiscal years 2010-2011 through 2013-2014.

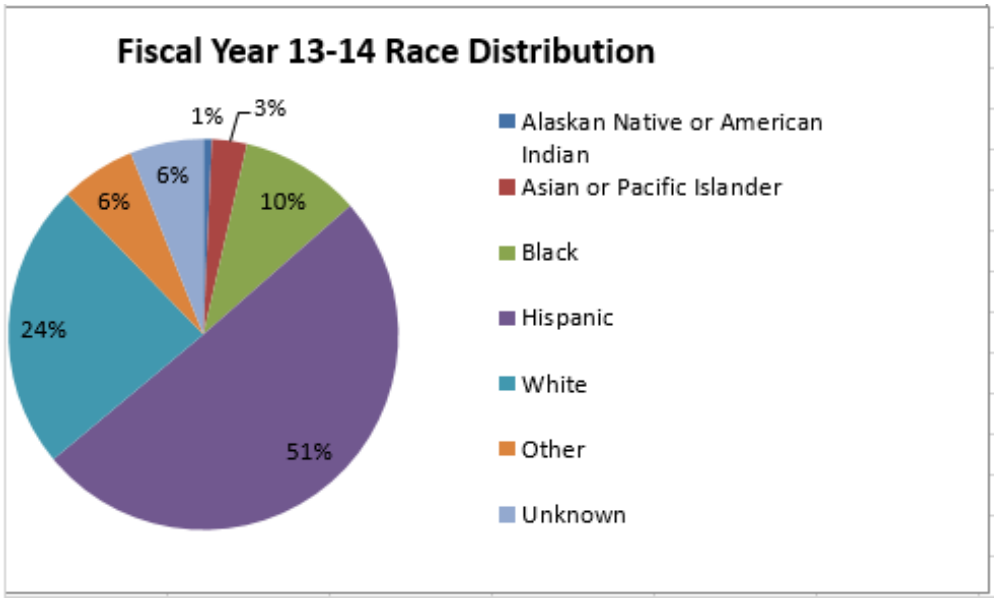
[13] Lesbian, Gay, Bisexual, Transgender, Questioning/Queer.

Figure 1. Demographics for Your County: San Diego (FY 2013-2014)

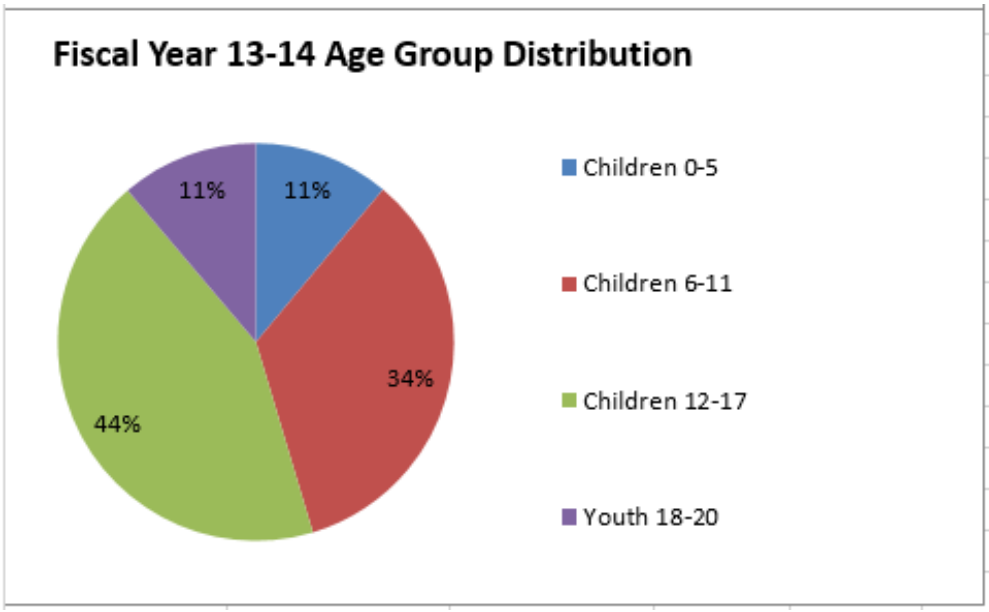
Unique numbers of children and youth who were Medi-Cal eligible: **407,026**

Of those, the numbers of children and youth who received one or more Specialty Mental Health Services (SMHS): **17,718**.

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



Below: Age groups of children and youth who received one or more specialty mental health services.



Client access and engagement in services is a complex issue and is somewhat difficult to measure. One way to measure client engagement is "penetration rates." Service penetration rates measure an individual's initial access and engagement in services provided by the local mental health plan. Figure 2 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 2. 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 had sustained access to services for at least five or more visits, as shown in the data in the lower half of figure 2. This is sometimes referred to as the "retention rate." This measure is often used as a proxy (or substitute) for client engagement. Here, we measure how many came in for five or more services during the year.

Figure 2: in the table at the top of the page, the first column of numbers show how many children/youth received at least one specialty mental health service. The second column shows the number who were certified 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 of Figure 2 shows data for those with more sustained engagement in accessing services. The first column of numbers show how many children/youth received five or more services during the fiscal year. The middle column, showing numbers who were Medi-Cal eligible, is identical to the middle column in table in the upper half of the page. The column at the far right shows the percentage in each group who received five or more services. Clearly, these numbers are much smaller than the corresponding rates in the data table shown above.

Figure 3 on the subsequent page shows a set of bar graphs: these graphs show changes over four fiscal years in service penetration rates by race/ethnicity, for children and youth who had at least one visit for services. Each group of bars shows the changes over time for one major race/ethnicity group. The final bar in each group illustrates the time point for FY 2013-2014 that was presented in more detail in figure 2. The "take home story" of figure 3 is the overall trend leading up to the most recent year's data. Please note that these data show the trends that occurred in the years following passage of the Affordable Care Act (2010).

Figure 2. Data Tables for SMHS Visits and Service Penetration Rates
Your County: San Diego (FY 2013-2014):

Top: Children and youth who received at least one specialty MH service during year.

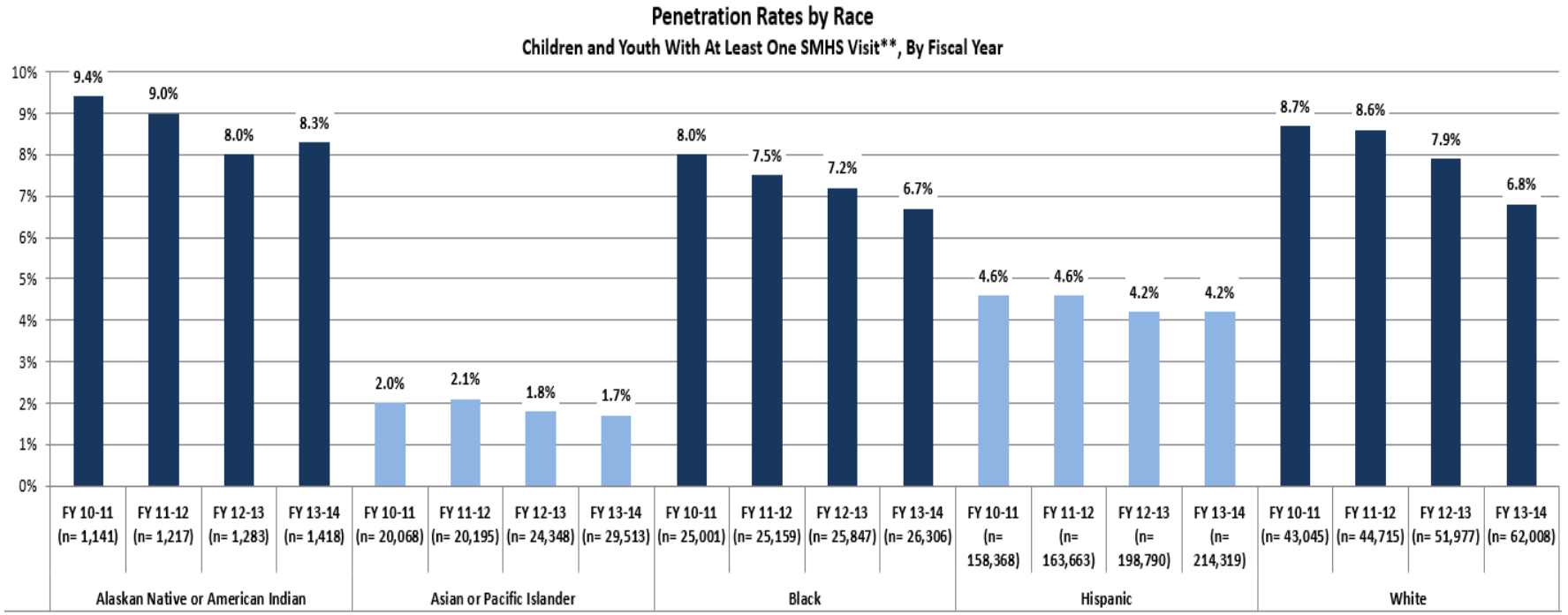
	FY 13-14		
	Children and Youth with 1 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**17,718**	**407,026**	**4.4%**
Children 0-5	1,969	131,533	1.5%
Children 6-11	6,069	117,931	5.1%
Children 12-17	7,701	104,032	7.4%
Youth 18-20	1,979	53,530	3.7%
Alaskan Native or American Indian	117	1,418	8.3%
Asian or Pacific Islander	512	29,513	1.7%
Black	1,765	26,306	6.7%
Hispanic	8,940	214,319	4.2%
White	4,214	62,008	6.8%
Other	1,096	43,127	2.5%
Unknown	1,074	30,335	3.5%
Female	7,836	200,688	3.9%
Male	9,882	206,338	4.8%

Below: Children and youth who received five or more specialty MH services during year.

	FY 13-14		
	Children and Youth with 5 or more SMHS Visits	Certified Eligible Children and Youth	Penetration Rate
All	**12,802**	**407,026**	**3.1%**
Children 0-5	940	131,533	0.7%
Children 6-11	4,670	117,931	4.0%
Children 12-17	5,883	104,032	5.7%
Youth 18-20	1,309	53,530	2.4%
Alaskan Native or American Indian	81	1,418	5.7%
Asian or Pacific Islander	324	29,513	1.1%
Black	1,274	26,306	4.8%
Hispanic	6,494	214,319	3.0%
White	3,086	62,008	5.0%
Other	767	43,127	1.8%
Unknown	776	30,335	2.6%
Female	5,605	200,688	2.8%
Male	7,197	206,338	3.5%

Figure 3. Changes Over Time in Service Penetration Rates by Race/Ethnicity, for Children/Youth with at Least One Specialty Mental Health Service During Fiscal Year. (FY 10-11 through FY 13-14).

Your County: San Diego



Understanding the changes observed above should take into account the expansion of the total Medi-Cal eligible population, which resulted in a statewide increase of nearly 12% in FY12-13 relative to the previous year. The expansion occurred in stages during 2011 to 2013 as the state began to implement the changes mandated in the federal Affordable Care Act (2010). Families with incomes up to 138% of the federal poverty level became eligible for Medi-Cal. Also, children and families previously enrolled in "CHIP," federal Children's Health Insurance Program transitioned to Medi-Cal.

Please consider the following discussion items after examining the data above regarding access and engagement in mental health services.

QUESTION 1A:

Do you think the county is doing an effective job providing access and engagement for children and youth in all of your communities?

Yes _X_ No____. If yes, what strategies seem to work well?

Overall, the County of San Diego is doing an effective job at engaging children and youth through in-school programs and community-based organizations that are contracted to provide services throughout the County. However, there are some individuals who may not be aware of County services, nor do they understand how to access them. In addition, the locations can be prohibitive for adequately serving youth (countywide) especially since youth often express issues with transportation.

Recommendations:

1. Future contracts could increase visibility and awareness of services throughout the county.

2. Consider augmenting contracts to engage youth in public health and prevention. Existing Friday Night Live partnerships (youth-driven programs to engage youth on middle and high school campuses) could incorporate more activities to support awareness of county programs.

3. Consider policy changes that increase positive activities for youth/transition age youth such as drug free parks and beaches, increasing opportunities for outdoor activities and engaging the community through *Live Well San Diego* partnerships in each region.

4. Incentivize public health, prevention providers and community-based organizations to expand youth partnerships and prevention outreach in each region either by contracts or recognition (i.e. *Live Well San Diego* partnerships).

QUESTION 1B:

What strategies are directed specifically towards outreach and engagement of transition-aged youth in your county? Please list or describe briefly.

Behavioral Health Services (BHS) has prioritized services to Transition Age Youth (TAY) since the early 90's. TAY are defined as individuals between the ages of 16 and 25. In San Diego, both the Adult/Older Adult and Children Youth and Families Systems of Care (CYFSOC) manage programs providing services to TAY. The CYFSOC has primary responsibility for TAY adolescents before they reach adulthood, ages 16-21.

<u>Current County of San Diego Strategies</u>

1. San Diego Youth Services and McAlister Addiction Treatment programs are both in schools and attending School Attendance Review Board (SARB) hearings, curfew sweeps and other meetings with parents in order to give a direct hand off to treatment. Currently, prevention programs engage middle-school aged youth, since age of first use, specifically for marijuana is 11 and 12.

2. Child Welfare Services (CWS) has implemented an infrastructure to support Extended Care Foster Youth, with programing that recognizes the unique life experiences, resiliency and challenges they face. A partnership with BHS strives to jointly promote permanency and wellness, which is informed

by the Core Practice Model initiated by the State under the Katie A. Settlement Agreement and extended under Continuum of Care Reform.

3. In 2001, a TAY Workgroup was established to further develop TAY specific programs, increase cross system collaboration and facilitate quality care coordination for TAY clients. The workgroup is a cross threading of partners from multiple sectors. An updated TAY Status Report and Recommendations was issued in January 2017 and is one vehicle utilized to guide the County and partners in ensuring needs for transitional aged youth are addressed.

4. TAY receive an array of services through BHS which focus on outreach, engagement and treatment. Services and programs which focus on TAY include:
   a) Transition evaluation: All youth engaged in services, age 16 and older, are evaluated on multiple domains to determine their readiness to transition into adulthood. An individualized plan is developed to support and prepare youth to gain mastery in necessary domains, considering the social, developmental, and clinical factors of each individual in this readiness assessment process.
   b) Full Service Partnership (FSP) transformation: Program enhancement and conversions began in Fiscal Year 2015-16 with a total of ten school based treatment programs transformed into FSPs utilizing a "whatever it takes" approach to offer integrated services with an emphasis on whole person wellness to promote access to medical, social, rehabilitative, or other needed community services and supports. The model broadens the program scope to offer ancillary supports, alcohol and drug counselors addressing co-occurring conditions, rehabilitation specialists, and/or family/peer partners.
   c) School Based Programing: BHS programing is co-located on over 400 school campuses County-wide. This represents over 50% of the schools in the county. Programing at high schools is a strategy to increase access points to transition age youth, using group therapy, peer input, guidance and support.
   d) Counseling Cove: County-wide program designed to specifically outreach and engage transition age youth who may be "couch surfing", runaway, or homeless. Clinicians team up with youth/peer and emphasize building trust to bring youth into treatment as a cornerstone of this program.
   e) Teen Recovery Centers (TRC): Outpatient alcohol and drug treatment programs that serve adolescents with alcohol and other drug related issues. Counselors provide assessments to determine level of treatment, frequency, and co-occurring issues. In 2015, the TRCs were redesigned to improve access by providing services at satellite locations with an emphasis on high schools as points of access.
   f) Catalyst: County-wide, intensive FSP program providing Assertive Community Treatment (ACT) and embedded supportive housing services for transitional-age youth who have a serious mental illness and have needs that cannot be adequately met through a lower level of care. Services are team-based, available around the clock, are primarily delivered on an outreach basis, and have a low participant-to-staff ratio (approximately 10:1).
   g) Oasis Clubhouse: This TAY exclusive, member-driven Clubhouse providing assistance throughout San Diego County for those experiencing mental health challenges (and who may have a co-occurring substance use disorder) to achieve goals in areas such as employment, education, social relationships, recreation, health, and housing, and supports access to medical, psychiatric, and other services.
   h) Kickstart: Implemented in 2009, Kickstart is a County-wide program providing Prevention and Early Intervention (PEI) services for persons age 10-25 who have emerging 'prodromal' symptoms of psychosis. This program has three service components including:
      - Prevention, through public education
      - Early Intervention, through screening potentially at risk youth; and
      - Intensive treatment, with treatment of youth who are identified as at risk and their families.
   i) Urban Beats: A Mental Health Services Act (MHSA) Innovations project providing a unique engagement model focused solely on expressive arts—including visual arts, spoken word, music, videos and performances and social media messaging created and developed by TAY clients of BHS that have experienced Severe Emotional Disturbance/Serious Mental Illness (SED/SMI) or

who are at-risk of mental health challenges. Urban Beats aims to improve TAY engagement, retention, and access to services while reducing stigma.

j) The Urban Street Angels-- an Emergency Shelter Bed contract specifically for TAY—outreaches to homeless TAY primarily in the Central Region (beach areas) to engage TAY where they live.

k) Substance Use Disorder (SUD) Perinatal Treatment Expansion: County-wide as of July 2017, this expansion of entry age for services of pregnant and parenting teen girls was adjusted to 15 years old and over in outpatient perinatal programs.

l) Ten outpatient clinics have TAY specialists (embedded in the program) who have specific qualifications to engage the TAY community and are active in the TAY Workgroup. They have the ability to outreach and engage TAY in the community as opposed to the youth coming in to the program.

QUESTION 1C:

Do you have any recommendations to improve outreach or services to specific ethnic or cultural groups of adolescents or transition-aged youth?

Yes _X_ No____. If yes, please list briefly.

1. Expand efforts to include children/youth/transition age youth (TAY) and their families from various ethic/cultural groups in the community forums.

2. Continue to increase BHS presence at community activities with information on all the programs that are available (i.e., farmers markets, town councils, resource fairs, etc.)

3. Increase public health and prevention messaging (an imperative since the passage of Prop 64) through enhancement and increasing of prevention and treatment funding for youth and TAY programs.

4. Messaging should be developed that is culturally competent including implementation of distributing messaging, social media and printed materials to diverse communities. Outreach to underserved / under represented communities and regions.

5. Existing public health and prevention services for children and youth could consider increased collaborations with public safety and education sectors, including specific and targeted messages to educators and classroom settings where the majority of San Diego's children, youth and TAY are a captive and more receptive audience.

QUESTION 1D:

What are your main strategies for assisting parents/caregivers of children with mental health needs? Please list or describe briefly.

Current County of San Diego Strategies

1. Case Management services – The majority of outpatient specialty mental health programs have case management staff dedicated to assisting parents/caregivers in supporting the youth and the overall family unit.

2. Assessments – Children served by Behavioral Health Services are provided an assessment within the first 30 days which includes evaluating the cultural factors and needs and strengths/resources of the family. Family and caregiver participation is a priority.

3. Full Service Partnerships – These programs support youth and families, using a “whatever it takes” approach, including 24/7 accessibility for families to establish stability and maintain engagement.

4. Parent Partners - Parent partners, who are persons with lived experience of having a child that has accessed services are mandated positons in specialized programs and are highlighted as a best practice for all programs to consider. These team members are uniquely positioned to support the caregiver with credibility as someone who has had similar experiences and challenges.

5. Family Therapy – Family therapy is a key value in the Behavioral Health Services’ system of care, recognizing that treating the child in the context of their family is generally most effective in making and sustaining healing and growth. Family therapy participation is generally reported as a challenge and therefore a Mental Health Services Act (MHSA) Innovation project was initiated in Fiscal Year 2015-16 to utilize Parent Partners trained in Motivational Interviewing to work with caregivers individually to educate about the value of family therapy, identify barriers and solutions to engagement.

6. Program Advisory Groups (PAG) – All Children, Youth and Families programs within Behavioral Health Services are required to have a program advisory group to advise the program on design, practice and policies. The PAG consist of at least 6 members, 50% of whom are youth or family members served by the program, and reflect the ages and cultures of the client population.

7. Caregiver Connections program – An MHSA Innovation program initiated in Fiscal Year 2015-16 and being considered for expansion, places care coordinators within a Behavioral Health Services program for the purpose of supporting the parent/caregiver in identifying and addressing their own behavioral health needs. Care coordinators offer caregivers:
    - Specialty groups to address caregiver symptomatology.
    - Counseling and education about caregiver stress and the impact of stigma.
    - Linkage of caregiver to existing services such as California Work Opportunity and Responsibility to Kids (CalWORKS) and Medi-Cal.

One recommendation made by the Workgroup completing this report is to expand the *It’s Up to Us* media campaign which is geared toward preventing suicide and eliminating the stigma of mental illness. This campaign is already effective in reaching out to adults and with an additional thread to reach out to parents it could prove helpful by improving their knowledge about where and how to access the resources available to assist them.

Access: 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.

"Step-down" is a term used by some mental health care professionals to describe a patient's treatment as "stepping down" from a higher level of care intensity 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.

Figure 4 on the next page shows data for the overall population of children and youth under the age of 21 who were discharged from a psychiatric hospitalization. In the upper half of the figure are data showing trends 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.

The lower half of Figure 4 shows graphs of the median and mean (average) times for outpatient follow-up (stepdown) services following discharge from child/youth psychiatric hospitalization. These are two important measures that can be used to evaluate whether timely follow-up services are provided. But, because some clients do not return for outpatient services for a very long time (or refused, or moved), their data affects the overall average (mean) times in a misleading way due to the large values for those "outliers." Instead, the use of median values is a more reliable measure of how well the county is doing to provide follow-up services after a hospitalization.

A related concern includes how we help children and youth handle a crisis so that hospitalization can be avoided. Although we do not have data for mental health crises, similar follow-up care and strategies are likely to be employed. Your local board may have reviewed the range of crisis services needed and/or provided in your community for children and youth. Many counties have identified their needs for such programs or facilities to provide crisis-related services.[14]

[14] 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).

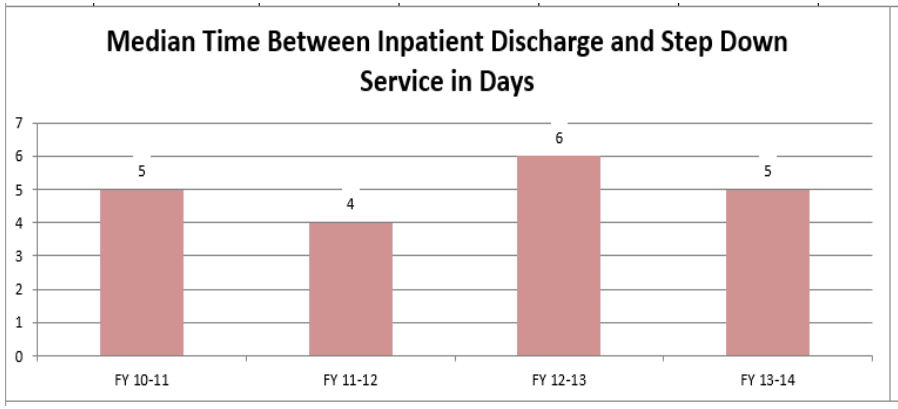
Figure 4. Time to Follow-up Services after Child/Youth Discharge from Psychiatric Hospitalization. (2010-2014).

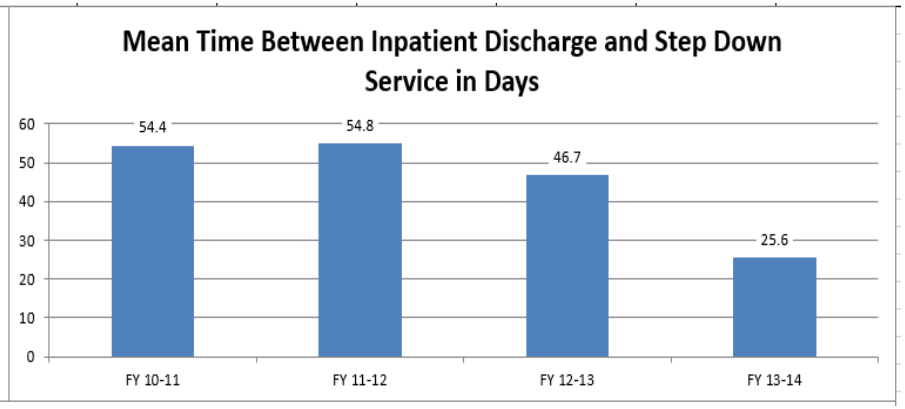
Your County: San Diego

Demographics Report: Unique Count of Children and Youth Receiving SMHS by Fiscal Year

San Diego County 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	674	50.2%	914	68.1%	275	20.5%	153	11.4%	0	1431	54.4	5
FY 11-12	618	53.1%	801	68.8%	230	19.8%	133	11.4%	0	1245	54.8	4
FY 12-13	479	46.7%	666	64.9%	211	20.6%	149	14.5%	0	873	46.7	6
FY 13-14	510	47.6%	729	68.0%	161	15.0%	182	17.0%	0	489	25.6	5





When examining the post-hospitalization data above, take special note of the percentages who received follow-up services within 7 days after discharge, within 30 days after discharge, or later than 30 days. These time frames reflect federal healthcare quality measures that are used for all types of discharges after hospital stays for mental or physical illnesses. Lower left side of graph shows median time for follow-up outpatient services after discharge, which may be the most reliable way of examining this issue. Also take note of mean time from discharge to step-down services (right side).

QUESTION 2A:

Do you think your county is doing an effective job providing timely follow-up services after a child or youth is discharged from a mental health hospitalization? Yes _X_ No____.

If no, please describe your concerns or recommendations briefly.

According to the data in Figure 4 (previous page), there appears to be an improvement in follow up services from Fiscal Year 2010-11 through Fiscal Year 2013-14. In addition, it is a current strategy by the County of San Diego to ensure at a minimum, each discharged patient is expected to have an identified appointment at a treatment program of their choice to occur within three days of the inpatient/emergency discharge.

QUESTION 2B:

After a hospitalization or MH crisis, what are the main strategies used to engage and ensure prompt follow-up for outpatient care in transition-aged youth? Please list briefly.

Current County of San Diego Strategies

Strategies to ensure Transition Age Youth (TAY) outpatient care engagement following a psychiatric crisis vary depending on whether the youth is actively engaged in the Behavioral Health Services system of care or not currently connected to services. In general, the following strategies are utilized:

1. Referrals and appointments – it is a community standard that discharge planning begins with service entry. With inpatient services, it is expected that a discharge session is held with the youth/family and when possible the treatment provider. As stated in Question 2A, each discharged patient is expected to have an identified appointment at a specific treatment program of their choice with an identified date and time for the appointment to occur within three days of inpatient/emergency discharge. Whether the appointment is made to the existing treatment provider, or a new provider, it is expected that the transition follows a warm handoff model with communication occurring for continuity of care.

2. Outpatient programs run a 'morning report' that informs them if any of their clients have been hospitalized. This allows the outpatient program to connect with the inpatient provider and the family in an expedited manner. Inpatient hospitals are also able to access data that highlights if the youth is currently or previously received services from the system of care.

3. Outpatient programs are mandated to prioritize all clients being discharged from an inpatient facility as well clients undergoing a mental health crisis.

4. Crisis Action Connection (CAC) – CAC is a Behavioral Health Services contracted program in which service delivery is designed with the primary purpose of supporting youth after a crisis, and ensuring that youth are effectively linked to on-going outpatient services while simultaneously receiving therapeutic, medication and case management support until that connection is established with an outpatient provider. The program prioritizes clients not already connected to an outpatient program.

5. A system report is generated monthly to determine which children/youth who received inpatient care have not been connected to outpatient services. The Emergency Services Unit (ESU) follows up with those families in effort to connect with them and engage the youth in treatment.

6. An Innovation project is being proposed to utilize tele-mental health as a therapeutic option post inpatient care to families who may be less interested or ready to utilize traditional outpatient treatment. A tele-session would be conducted prior to discharge, with a scheduled appointment for tele-mental health session upon return home. Case managers would also be available to support youth/family.

7. The Transition Team through Telecare (a County contracted provider) serves ages 18+ and ensure all clients are connected to appropriate level of care (which includes TAY services). Friends in the Lobby (another contracted program) also serves ages 18+ and engages families/caregivers of those who are psychiatrically hospitalized.

QUESTION 2C:

What are the main strategies used to help parents/caregivers of children access care promptly after a child's hospitalization or other mental health crisis? Please list briefly

Strategies to help parents/caregivers access services for children after a crisis are similar to the strategies utilized for Transition Age Youth (listed in Question 2B).

QUESTION 2D:

The follow-up data shown above are based on services billed to Medi-Cal. As a result, those data do not capture follow-up services supported by other funding sources. Examples may include post-hospitalization transportation back to the county, contact with a Peer/Family Advocate, or MHSA-based services.

Please list some <u>non</u>-Medi-Cal funded strategies your county may use to support families/caregivers following a child's hospitalization or other MH crisis.

<u>Current County of San Diego Strategies</u>
Funding streams such as Mental Health Services Act (MHSA) and realignment are incorporated with Medi-Cal funded programs to expand beyond the traditional Medi-Cal funded services. <u>Non</u>-Medi-Cal funded strategies beyond leveraging within a Medi-Cal funded program to support families/caregivers following crisis include:

1. The Access and Crisis Line (ACL) is a 24 hour/7 days a week hot line with a live chat option make clinicians available to all members of the community. Referral and resources can be obtained via the ACL as well as 2-1-1.

2. The County has an MHSA contract with National Alliance on Mental Illness (NAMI) San Diego which provides support to families managing a mental illness.

3. The Faith Based Initiative, an Innovation funded program, utilizes the community leaders in conjunction with faith based ministries to respond to community crisis as it relates to mental health. Education and crisis response components are utilized.

4. Solutions are explored and identified through an existing close collaboration between hospitals and the County. The Vice-President of the Hospital Association of San Diego and Imperial Counties and

the BHS Clinical Director co-chair the Hospital Partners workgroup, a high level group of hospital and County and community representatives who find solutions to inpatient related issues.

5. *It's Up to Us* stigma reduction media campaign creates public awareness about mental illness and encourages connections and supports and decreased isolation.

6. *Live Well San Diego* is the County's vision of individual and community members which infuses wellness education and provides a variety of supports throughout the County. For example, community events in parks and libraries as well as promotion of youth recreational activities all promote community engagement which leads to social supports.

Note: San Diego County does not make a distinction between consumers who are Medi-Cal versus non-Medi-Cal recipients with regard to delivery of services.

VULNERABLE GROUPS WITH SPECIALIZED MENTAL HEALTH NEEDS

Foster Children and Youth

Foster children and youth comprise a vulnerable group that faces considerable life challenges. Mental health consequences may result from the traumatic experiences which led to their 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 Specialty Mental Health Services (SMHS) in one year (FY 2013 - 2014). SMHS are services provided to children and youth with serious emotional disorders (SED) or to adults with serious mental illness (SMI). These mental health challenges affect outcomes in all aspects of their lives as has been described in recent studies[15,16] of foster youth in California schools:

The key findings for California foster youth included:

- **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 reasons.
- **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, although this single-year dropout rate is still twice as high as that for low SES students and for K-12 students.

Conclusion: Students in foster care constitute an at-risk subgroup that is distinct from low socioeconomic status students regardless of the characteristics of their foster care experience.

[15]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. Also see: Child Welfare Council Report, 2014-2015 for more source material, at: http://www.chhs.ca.gov/Child%20Welfare/CWC%202105%20Report-Approved090215.pdf.

[16] 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

As they reach adulthood, most foster youth will need continuity of care through Medi-Cal for services to promote mental health, independence, and connections within the community, including housing supports to avoid homelessness. Homelessness is a common outcome for foster youth who leave the system without either re-unification to their family of origin or an attachment to a permanent family.

One subgroup of foster youth has been referred to as "Katie A Subclass members," due to a lawsuit filed in federal court regarding their need for certain types of more intensive mental health services. The services included under the 2011 court settlement order are intensive home-based services, intensive care coordination, and therapeutic foster care. More recently, DHCS recognized that other children and youth also have a right to receive such services if there is a medical necessity.

The complex needs and large numbers statewide present challenges to the foster care and mental health systems. The numbers of foster youth who are receiving Specialty Mental Health Services 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. Also, these data do not reflect those with disabilities who are served through school-based mental health services as part of an "Individual Educational Plan."

HOW MANY FOSTER CHILDREN AND YOUTH RECEIVE SPECIALTY MENTAL HEALTH SERVICES,* 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 Specialty MH Service: **34,353** (service penetration rate is 44.3 %).
- Total Medi-Cal Eligible Foster Care Youth who received five or more Specialty MH Services: **26,692**.

Statewide: (FY 2014-2015) Total Unique Katie A. Subclass Members: **14,927**

- Members who received In-Home Behavioral Services: **7,466**
- Those who received Intensive Case Coordination: **9,667**
- Those who received Case Management/Brokerage: **9,077**
- Received Crisis Intervention Services: **523**
- Received Medication Support Services: **3,293**
- Received Mental Health Services: **12,435**
- Received Day Rehabilitation: **285**
- Received Day Treatment Intensive service: **63**
- Received Hospital Inpatient treatment: **19**
- Received Psychiatric Health Facility treatment: **41**
- Therapeutic Foster Care: Data not yet available.

* Data reports are from: http://www.dhcs.ca.gov/Pages/SMHS-Reports-2016.aspx. The data are for fiscal years 2014 or 2015 (depending on which data are the most recent available at the time of this report).

Next, the figure below shows the percentage of foster children under 18 who received specialty mental health services. Note the trends year-to-year for your county and the comparisons to counties with populations of similar size and to the state.

There may be several explanations possible for any observed differences. For example, some counties find it necessary to place a significant number of foster youth out-of-county in order to find specialized services or the most appropriate and safe living situation.

Another explanation is that the recent expansion of Medi-Cal markedly increased the total numbers eligible for coverage. More children and youth are now eligible to receive specialty mental health services. Even if there was an increase in total numbers who received these services, there may have been a decreased percentage of total eligible persons served. Also, in some counties there are shortages of mental health professionals trained to work with children and youth or who also have bilingual skills.

Figure 5. Percentages of Foster Youth Who Received Specialty MH Services

Your County: San Diego

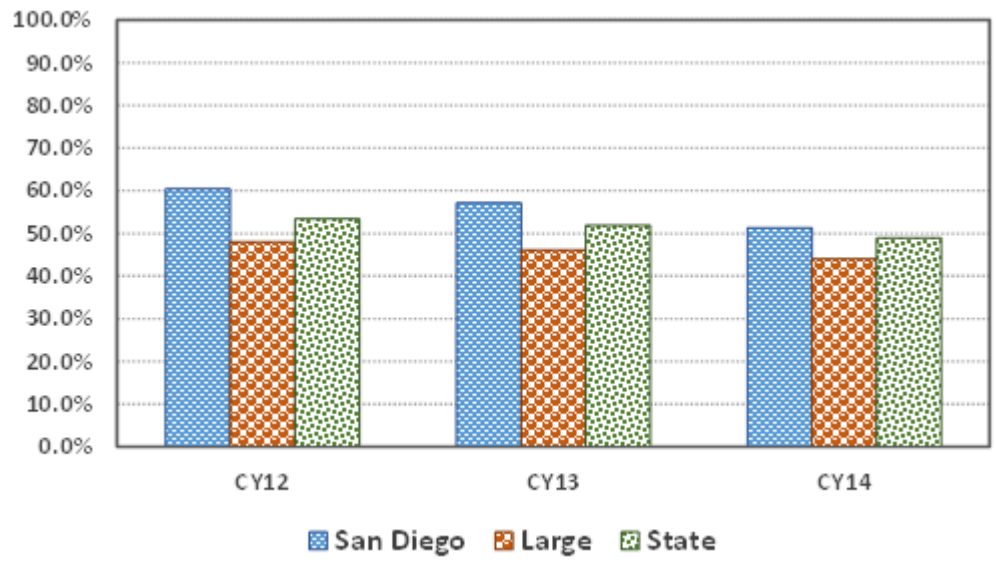


Figure 5. Shown above are data for the percentage of foster care youth who received specialty mental health services, during three calendar years (CY): 2012, 2013, and 2014. In each set of three bars, the first bar (blue) shows changes over time for your county. The second bar (orange) in each set shows the average for all counties with populations of similar size to yours. The third bar (green) shows the state average values.

[17] Behavioral Health Concepts, Inc. California EQRO for Medi-Cal Specialty Mental Health Services. EQRO is the External Quality Review Organization. www.CALEQRO.com, see "Reports," and select your county to view.

QUESTION 3A:

What major strategies are used in your county to provide mental health services as a priority for foster youth?

Please list or describe briefly.

Every foster youth receives various levels of mental health treatment when they are brought into the system (including dependency court and delinquency systems). Specific strategies are listed below.

County of San Diego Strategies

1. Coordination of services between the four sectors in Behavioral Health Services' Children, Youth and Families System of Care (CYFSOC): Family/Youth, Public agencies, Private organizations and Education, ensure accountability and delivery of service to the most vulnerable population, including foster youth.

2. The CYFSOC is guided by the mission statement of ensuring that all agencies serving San Diego county youth from age 0 through age 21 have coordinated services resulting in improved youth and family, and system outcomes consistent with System of Care values.

3. There is a strong commitment by all agency partners; Behavioral Health Services, Child Welfare Services (CWS) and Probation, to maintain a joint partnership to ensure oversight of Katie A. (rebranded in San Diego County as Pathways to Well-Being) processes for foster youth.

4. An executive-led workgroup, guided by a joint Memorandum of Understanding (MOU) brings together families, BHS, CWS, and Probation monthly to address the advancement of the Core Practice Model and prepare for Continuum of Care Reform (CCR).

5. System workforce trainings are done in a triad model, bringing together families, BHS staff, and CWS staff as experts in developing and jointly providing the trainings.

6. Mental health service delivery to foster youth has been enhanced since the implementation of Pathways to Well-Being with the inclusion of Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), as well as, a Child and Family Team (CFT).

7. BHS and CWS co-fund and co-monitor several programs that serve foster care children.

8. The screening and assessment process for foster youth has been augmented which includes a timely eligibility screening so that services are provided in a judicious and timely manner.

9. All services provided to foster youth ensure that there is a thoughtful transition plan and a warm-handoff to another provider when identified to be a need for the youth by the CFT.

10. Work with Public Health Nurses, Child Welfare, Probation and BHS is being done to ensure that foster youth prescribed psychotropic medication are provided with a timely JV220 and coordination of care.

In addition to the strategies listed above, the San Pasqual Academy is noteworthy as it was the first residential education campus for foster teens *in the nation* when doors opened in 2001. The 238-acre campus features individual family-style homes, an on-site, accredited high school, a cafeteria, a technology and career information center, an auditorium, recreation fields, a gymnasium, a Health and Wellness Center, a Day Rehabilitation Clinic through BHS, and a swimming pool. New Alternatives operates the residential program; the San Diego County Office of Education operates the high school program; San Diego Workforce Partnership offers a work readiness and self-sufficiency program; San Diego County Child Welfare Services provides social workers and a supervisor to handle case management. *Information excerpted from the San Pasqual Academy website: www.sanpasqualacademy.org.*

QUESTION 3B:

Do you think that your county does a good job of coordinating with your county department of social services or child welfare to meet the MH needs of foster care children and youth?

Yes_X__ No____. If no, please explain briefly.

There is a strong collaboration between CWS and BHS departments and staff.

QUESTION 3C:

Do you have any comments or suggestions about strategies used to engage foster youth and provide mental health services?

Yes___ No_X_. If yes, please list or describe briefly.

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. 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.[18]

Research and experience demonstrate that LGBTQ youth have unique needs that are most effectively provided by therapists and program directors with special training in addressing these unique populations. Outcomes are better when therapists and program leaders have received this specialized training.

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 contrast, family acceptance of youth is crucial to their health and wellbeing.[19]

The Family Acceptance Project:
A promising area of research and practice is represented by the Family Acceptance Project headed by Dr. Caitlin Ryan in San Francisco, CA. She and her team developed the first family-based model of wellness, prevention, and care to engage families to learn to support the LGBTQ children across systems of care. Her research on the protective factors for LGBTQ youth has been published in peer-reviewed journals. These studies found that parental and caregiver behaviors can help protect LGBTQ youth from depression, suicidal thoughts, suicide attempts, and substance abuse.

In contrast, she found that *the 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*.

The Family Acceptance Project has assisted socially and religiously conservative families to shift the discourse on homosexuality and gender identity from morality to the health and well-being of their loved ones, even when they believe that being gay or transgender is wrong. This effort included development of multicultural, multilingual, and faith-based family education materials designed to prevent family rejection and increase family support.

"We now know that kids have their first crush at about age 10. Many young people today are now coming out between ages 7-13. Parents sometimes begin to send rejecting messages as early as age 3…. These early family experiences … are crucial in shaping [their] identity and mental health."

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

[19] 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.

QUESTION 4A:

Does your county have programs which are designed and directed specifically to LGBTQ youth? _X_ Yes ___ No.

If yes, please list and describe briefly.

1. In 2016, Behavioral Health Services gave a report to the Behavioral Health Advisory Board on services to support LGBTQ (Lesbian, Gay, Bisexual, Transgender, Questioning) and Transition Age Youth (TAY) in the areas of suicide prevention, including:
   a) Amending the contract of Community Health Improvement Partners (CHIP) who has assisted in developing the San Diego County Suicide Prevention Action Plan. In 2016, the contract was amended to include LGBTQ and TAY as target populations for suicide prevention services.
   b) Reprocuring the school-based suicide prevention contract which provides services across San Diego County, with emphasis in areas that have the highest rate of occurrence. The contract provides prevention services to middle and high school students in all school districts and will offer targeted services for LGBTQ and TAY populations.
   c) In addition, the following services are also in place to support LGBTQ and TAY individuals at risk of suicide:
      - Access and Crisis Line
      - BHS contracts offer an array of services to address LGBTQ issues
      - PERT
      - GLSEN (Gay, Lesbian, Straight Education Network) trainings for adults working with LGBTQ youth
      - LGBTQ Alcohol and Other Drug (AOD) outpatient program for adults ages 18 and older
      - Probation Department training: All members of the Probation Department have been trained in best practices, preferred terminology, legal guidelines and community resources for serving LGBTQ adults and youth.

2. San Diego County BHS is currently in process of procuring a behavioral health treatment program that will provide a full range of mental health treatment services—including direct clinical services—specifically for the LGBTQ youth population called *Our Safe Place*. The program will have three drop-in centers in different parts of the County and offer supportive services (job training, life skills, and crisis support) to any youth who identifies as LGBTQ and could benefit from the services. The drop-in centers will have support groups for youth as well as family members and or caregivers with hours of operation seven days a week including evenings and weekends. An important component will be the inclusion of youth partners and a mentorship program. The anticipated start date is July 1, 2017.

3. The Juvenile Probation Department continues to focus on anti-bullying efforts in its juvenile institutions. There may be a need to develop a specific program directed toward transgender youth.

QUESTION 4B

Does your county or community have programs or services designed to improve family acceptance of their LGBTQ youth and/or with the goal of helping to heal the relationship of the youth to his/her family? Yes_X_ No____.

If yes, please list or describe briefly.

1. The *Our Safe Place* program (referenced in Question 4A) will offer individual, group and family therapy. Each one of these treatment approaches is intended to incorporate the youth family member and caregiver when appropriate. At the suggestion of Behavioral Health Advisory Board (BHAB), the Family Acceptance Project (FAP) was researched as a model to use to improve family acceptance of the LGBTQ youth, and it is envisioned that the program will incorporate FAP approaches and materials into the support groups at the drop-in centers. The goal is to have staff that have with firsthand experience as a recipient of LGBTQ services or that are active member of the LGBTQ community. Additionally, staff should be experienced and trained in the sensitivities of providing LGBTQ services and in meeting the needs of the population.

2. The County augmented the contract for its Suicide Prevention Council to provide additional GLSEN (Gay, Lesbian & Straight Education Network) training to school staff and parents directed specifically to heal relationships between LGBTQ youth and their families.

3. The *Breaking Down Barriers* program contract focuses on stigma and discrimination reduction and has a dedicated coordinator for outreach to the LGBTQ community.

QUESTION 4C:

Do you have any comments or suggestions about services or how to address unmet needs for LGBTQ youth in your community?

Yes_X_ No____. If yes, please list or describe briefly.

Recommendations

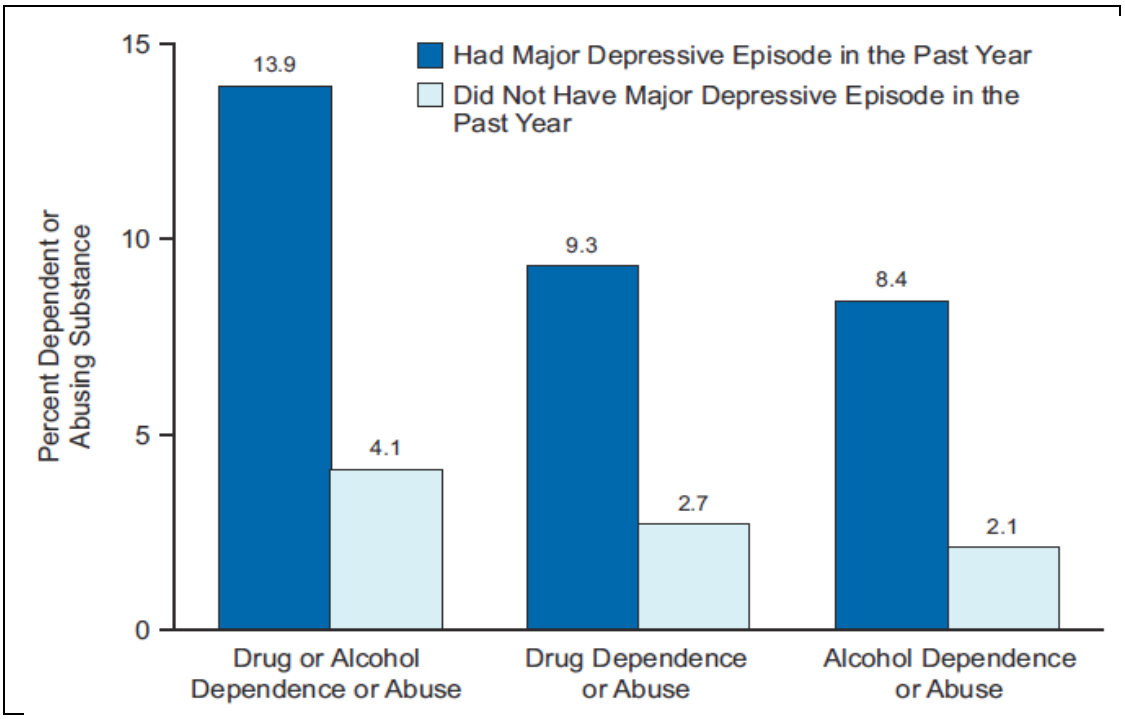
1. The County has extensive training programs in place but needs to work more in reducing the stigma of LGBTQ status (especially regarding the transgender population).
2. The County should continue holding community forums on LGBTQ youth and family member interactions.

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 mental health challenges. Children and youth who experience a major depressive episode are three times more likely to engage in alcohol or drug abuse (or both), compared to members of their same-age peer group who do not have depression.[20] (See next figure, 2013 data, NSDUH).

Figure 6. Past Year Substance Abuse and Depression in U.S. Youth, Age 12-17.



[20] 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

Last year's Data Notebook (2015) included a section on substance use disorders in all groups but emphasized adults and those with co-occurring mental health disorders. Both community and school-based prevention efforts were also discussed.

Substance abuse services for children and youth were not specifically addressed last year. Therefore, our focus for this discussion is limited to treatment needs and services for children and youth. Both experience and evidence show that children and youth under age 18 are best served by substance use treatment programs which are designed specifically for their emotional and social developmental stages.

In California, many of the 30 smaller population counties (<200,000), have limited treatment options, with an emphasis on outpatient treatment or abstinence programs.[21] There is a shortage of providers and of narcotic treatment programs (NTP), which is of concern given recent trends in narcotic drug abuse in all age groups, including youth. It is unknown how many counties have substance abuse treatment programs (and what type) that are designed specifically for youth under 18 or even for TAY (ages 16-25).

For your review, we are presenting data for total numbers of youth who initiated substance use treatment during FY 2013-2014 by participating in one of these three types of treatment: **outpatient, "detox", or residential treatment programs**. (NTP services and pregnant mother programs are not included). During that year, individuals may have started treatment one or more times in either the same or another program. However, these data count only the first episode of substance use treatment for an individual within that fiscal year. Both statewide and county data (where available) are shown.

[21]California 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

San Diego County:

Alcohol/Drug Use in Past Month (Student Reported), by Grade Level: 2011-2013		
Grade Level	Any	None
7th Grade	11.1%	88.9%
9th Grade	24.7%	75.3%
11th Grade	33.3%	66.7%
Non-Traditional	N/R	N/R
All	22.9%	77.1%

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

California: Statewide

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

Your County: San Diego

Age <18: 1,068 Age 18-25: 2,458

QUESTION 5A:

Does your county provide for substance use disorder treatment services to children or youth? Y_X_ N____

If yes, please list or describe briefly.

There are numerous County contractors that offer substance use disorder treatment to youth. McAlister Treatment, for example, offers: 30 day inpatient program, TRC (Teen Recovery Centers), outpatient programs and school-based programs.

SARB Hearings are available with prevention/treatment and multi sector support available to the youth / parent.

If no, what is the alternative in your county?

QUESTION 5B:

Do you think your county is effective in providing substance use disorder treatment to individuals under the age of 18? Yes_X_ No___.

Please explain briefly.

Yes, County substance use disorder (SUD) treatment services are effective for the most part but there is a need to reestablish a long-term residential drug treatment program in order to again have a placement for youth cases that exceed the 30-day inpatient program's capacity. Another recommendation is to assess any gaps in services and accessibility to services to avoid at-risk youth falling between the cracks. In mid-2016, the Phoenix House substance abuse residential programs in Descanso and Rancho del Campo were closed and no replacement programs have been established yet in San Diego County.

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 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 may be indicated by the data showing that one-sixth of all juvenile arrests are for offenses involving drugs or alcohol. Many others have committed offenses while impaired by alcohol or drugs of abuse.

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."[22] 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." [23]

The 2016 California Children's Report Card[24] defines 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 trauma or other severe adverse life experiences such as child abuse, profound neglect, or witnessing violence in their home or neighborhood. Parental abuse or neglect may have resulted in the child's placement in foster care or a group home, which is intended to provide for safety and well-being. In addition, the experience of removal from one's home is highly traumatic and the foster home may or may not be able to fully meet the child's needs. Studies show 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."

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[22] 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

[23] D. K. Smith, L. D. Leve and P. Chamberlain, "Adolescent Girls' Offending and Health-Risking Sexual Behavior: The Predictive Role of Trauma." *Child Maltreatment 11.4* (2006):346-353. Print,

[24] Website: **www.ChildrenNow.org**, see report: California Children's Report Card, 2016.

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."[25] 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 justice-involved youth. The most serious are those facing incarcerated youth; they report considerable despair and suicidal ideation.

One major risk for incarcerated youth is suicide.

- One national study* 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 completed suicides for incarcerated juveniles are between two and four times higher than for the general population.
- The general population rate of completed suicides was reported in 2010 as 10.5 per 100,000 adolescents.

*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.

[25]"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/

In California, how many persons under 18 have contact with the justice system each year? The following table shows 2014 juvenile arrest numbers[26] 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 3. Numbers[27] and Types of Juvenile Arrests, California, 2014

Total population[28] 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 can 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 is 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.

Addressing this topic may involve challenges in seeking information from other county agencies such as Juvenile Probation. Besides county departments of behavioral health, other limited funding sources for services may include: 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.

[26]Data 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.

[27] Percentages may not add to 100% due to rounding effects. Data are from California Department of Justice reported in 2015.

[28]CA Department of Finance, Report P-3, December 2014

Data shown below:

Recent county-level arrest data are not available to us for all types of juvenile offenses. However, we present the number of felony arrests for your county,[29] keeping in mind that these comprise only 31 % or about one-third of all juvenile arrests.

For state of California: **27,651 juvenile felony arrests, 2014.**

For your county: San Diego **2,061 juvenile felony arrests, 2014.**

QUESTION 6A:

Does your county provide mental health or substance use disorder treatment services or programs to justice system-involved juveniles while they are still in custody? Yes_X_ No___.

If yes, please list briefly. Please indicate (if available) the main funding[30] sources for these programs.

PROGRAM: **FUNDING SOURCE:**

Probation and BHS work collaboratively to address the needs of justice involved youth. Programming is offered through both entities who regularly conduct multidisciplinary teams that bring the various service providers together. The following are primarily BHS managed programs that support youth within the institutions:

1. Upon entering the juvenile justice detention, all youth are screened utilizing the Massachusetts Youth Screening Instrument (MAYSI-2). The screening is a first step in identifying youth who need a comprehensive behavioral health assessment. When elevated risk factors are identified, a mental health clinician meets with the youth to conduct a behavioral health assessment and connection to services is initiated as appropriate. At the recommendation of the Behavioral Health Advisory Board (BHAB), the Columbia Suicide Severity Rating Scale (C-SSRS) has been incorporated to screen youth entering the detention facility and when youth move between facilities.

2. County of San Diego's BHS Juvenile Forensic Services (JFS) STAT (Stabilization, Treatment, Assessment and Transition) Team provides mental health services and crisis response to youth within the County of San Diego Probation Department juvenile detention facilities and rehabilitation camps. Services include group, individual, psychotropic medication, and crisis management. Evidence-based practices are frequently employed in conjunction with traditional psychotherapy.
    - PROGRAM: STAT Team
    - FUNDING SOURCE: SAMHSA Mental Health Block Grant, Realignment, MHSA

3. Social Advocates for Youth (SAY) Dual Diagnosis program offers mental health and substance abuse services to Probation youth within County of San Diego Probation Department juvenile detention facilities and rehabilitation camps. Services include group counseling and psychosocial and

[29] County-level data are from www.KidsData.org, a program of Lucile Packard Foundation for Children's Health.

[30] This question is asking for only the main funding sources to highlight some of these programs and their successful implementation. We recognize that counties often weave together funding from different resources. If this information is not readily available, please enter N/A.

substance abuse education. The program uses a multi-disciplinary integrated approach, including the role of mental health paraprofessionals, for delivery of the required services.
    - PROGRAM: SAY Dual Diagnosis
    - FUNDING SOURCE: SAMHSA/Discretionary Funding

4. Vista Hill Juvenile Drug Court provides case management and liaison services to youth that are court ordered to participate. Services are primarily to out of custody youth but for those youth that are in the program and detained again there are 2 clinicians that provide mental health services, SUD (Substance Use Disorder) screening and case management to these probation youth at the detention facilities.
    - PROGRAM: Vista Hill Drug Court
    - FUNDING SOURCE: Juvenile Justice Crime Prevention Act (JJCPA), Substance Abuse Prevention and Treatment (SAPT), Federal Funding Participation (FFP)

5. San Diego Youth Services - Breaking Cycles Program provides substance abuse screening, groups and case management services to probation youth within County of San Diego Probation Department juvenile detention facilities and rehabilitation camps. The program utilizes several evidenced based practices in their treatment approaches. It was expanded in Fiscal Year 2015-16 to screen and work with Commercially Sexually Exploited Children (CSEC).
    - PROGRAM: Breaking Cycles
    - FUNDING SOURCE: JJCPA, Juvenile Forensic Assistance for Stabilization and Treatment (JFAST), MHSA

6. In March 2016, a new initiative began entitled the Trauma Reduction Unit program (TRU) in which abused boys in custody are given special attention (in mental health and education services). Although the program is limited to boys at Juvenile Hall, it should be expanded to girls and also to boys at East Mesa Juvenile Detention Center.

QUESTION 6B:

Are the mental health and substance use services provided to non-custodial youth involved with probation or diversion programs different from those services provided to youth in the general community? Yes_X_ No___

If yes, please list briefly. Please indicate (if available) the main funding source for these programs/services.

PROGRAM: FUNDING SOURCE:

Youth on probation are supervised by Probation Officers who coordinate group and individual counseling in a structured environment until the termination of probation, while the County's Juvenile Forensic Services STAT (Stabilization, Treatment, Assessment and Transition) Team provides mental health services and crisis response to non-custodial youth. The Juvenile Drug (or Mental Health) Court provides case management and liaison services to youth who may have qualified for a diversion program and who may be directed to a program such as the McAlister Institute. Unfortunately, the Phoenix House drug rehabilitation program in the County was closed in 2016.

Youth in the general community have access to after school programs or to teen recovery centers. Programs that are designed or have high utilization by non-custodial youth obtain appropriate training and establish consistent pathways to collaborate with probation.

Some of the non-custodial services within BHS that are routinely utilized and therefore geared to serve the needs of justice involved youth include:

1. Teen Recovery Centers
2. Juvenile Drug Court Case Management
3. JFAST – a mental health Court
4. Wraparound
5. Breaking Cycle
6. STEPS – works with sexually reactive youth
7. Multi-Systemic Therapy and Assertive Community Treatment (MST-ACT)

QUESTION 6C:

Do any of these programs engage the parents/guardians of juveniles involved with the justice system?

Yes_X_ No___. If yes, please list briefly.

Yes, parents/guardians of justice-system involved juveniles are encouraged to be part of the treatment as such family engagement and therapy is a core value of the system of care. Upon entering services, a comprehensive assessment is completed which calls upon the caregiver to engage and share their family experiences. Utilizing positions (such as family partners) has proven to be an effective approach to engage families. Recognizing that at times caregivers need their own support, referrals and connections to resources is another way to support the family unit.

MENTAL HEALTH SERVICES ACT (MHSA) PROGRAMS HELPING 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 services and programs maintain a commitment to service, support and assistance. The MHSA is made up of the five major components described below:[31]

- **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 funding for building projects and increasing technological capacity to improve 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)**—provides a historic investment of 20% of Proposition 63 funding 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, incarcerations, school failure or dropout, unemployment, prolonged suffering, homelessness, and the removal of children from their homes.[32] 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.

[31] Mental Health Services Oversight and Accountability Commission, December 2012. "The Five Components of Proposition 63, The Mental Health Services Act (MHSA) Fact Sheet." http://mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_FiveComponents_121912.pdf

[32] Mental Health Services Oversight and Accountability Commission, December 2012. "Prevention and Early Intervention Fact Sheet: What is Prevention and Early Intervention?" http://www.mhsoac.ca.gov/sites/default/files/documents/2016-02/FactSheet_PEI_121912.pdf

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 suicide and suicide attempts are serious public health concerns. Suicide is the second leading cause of death among young people ages 15-19 in the U.S., according to 2013 data.[33] Males are more likely to commit suicide, but females are more likely to report having attempted suicide. A recent national survey found that nearly 1 in 6 high school students (~17%) reported seriously considering suicide in the previous year, and 1 in 13 (or 7~8%) reported actually attempting it.[34]

The risks for youth suicide and suicide attempts are greatly increased for many vulnerable populations: foster youth, youth with disabilities, those who face stressful life events or significant problems in school, incarcerated youth, LGBTQ youth, and individuals with mental illness or who experience substance abuse. Among racial and ethnic groups nationwide, American Indian/Alaska Native youth have the highest suicide rates. Research confirms that LGBTQ youth are more likely to engage in suicidal behavior than their heterosexual peers.[35] Attempting to address the problem of youth suicide is both daunting and complex due to the diversity of needs and potential contributing factors for different individuals, including family history of suicide or exposure to the suicidal behavior of others. Below, we show the number of youth suicides per year by age group to gain perspective on the size of this problem in California.[36]

Table 4. California: Numbers of Youth Suicides by Age Group, 2011-2013.

California	Number		
Age	2011	2012	2013
5-14 Years	28	19	29
15-19 Years	163	129	150
20-24 Years	271	282	302
Total for Ages 5-24	462	430	481

[33] Child Trends Databank. (2015). Teen homicide, suicide, and firearm deaths. Retrieved from: http://www.childtrends.org/?indicators=teen-homicide-suicide-and-firearm-deaths.
[34] Centers for Disease Control and Prevention. (2015). Suicide prevention: Youth suicide. Retrieved from: http://www.cdc.gov/ViolencePrevention/pub/youth_suicide.html.
[35] 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/
[36] http://www.kidsdata.org , topic: suicides by age group and year in California.

By comparison, the number of youth suicide attempts is difficult to determine because they are combined with hospital data for self-injury. In California there were 3,322 hospitalizations for self-injury reported during 2013 for those age 24 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 the percentage of public high school students who reported seriously considering attempting suicide in the prior 12 months in California. [37]

Table 5. Public High School Students Reporting Thoughts of Suicide, 2011-2013

California	Percent	
Grade Level	Yes	No
9th Grade	19.3%	80.7%
11th Grade	17.5%	82.5%
Non-Traditional	19.4%	80.6%
All	18.5%	81.5%

Data from your county are shown on the next page (if available).[38] Some counties or school districts either did not administer the surveys or else did not report their results.

[37] **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.

[38] Source of data: http://www.kidsdata.org, topic: suicidal ideation by grade level, in California. Note on abbreviations: N/D = no data; N/R=not reported.

Table 6. Percent of High School Students Who Reported Thoughts of Suicide in San Diego County, 2011-2013

Suicidal Ideation (Student Reported), by Grade Level: 2011-2013		
Grade Level	Yes	No
9th Grade	20.6%	79.4%
11th Grade	19.1%	80.9%
Non-Traditional	N/R	N/R
All	19.8%	80.2%

QUESTION 7A:

Does your county have programs that are specifically targeted at preventing suicides in children and youth under 16 (ages 6-16) in your community?

Yes_X__ No_____ If yes, please list and describe very briefly.

Yes for ages 14-16; No for ages 6-13. Surveys of high school students are utilized to collect self-reported data on suicide attempts and suicide ideation. In 2015, San Diego County's Behavioral Health Advisory Board created a Suicide Prevention Workgroup and adopted 10 specific recommendations on December 3, 2015. Some of the recommendations target the prevention of suicides in children and youth such as utilizing the Columbia Suicide Severity Rating Scale (C-SSRS) in juvenile detention facilities.

In the juvenile justice system, each individual is screened using the C-SSRS and those who are at risk (probably less than 2 percent) are provided enhanced mental health services. Juvenile (and adult) detention facilities now have break-away sheets that can prevent hanging suicides. Drug education programs may prevent intentional overdoses. The County provides funding to the local Suicide Prevention Council which has a school collaborative sub-committee. County programs directed at ages 6-13 (educating parents, teachers, nurses) to recognize signs of suicide are almost non-existent.

Current County of San Diego Strategies

1. HERE NOW is an MHSA-Prevention and Early Intervention (PEI) suicide prevention program utilizing evidence-based practices and providing services in middle and high schools, and in community locations to educate and prevent suicides. It offers support services and necessary linkages.
2. *It's Up to Us* is a Countywide awareness campaign that focuses on stigma reduction. The campaign includes website as well as a Facebook page.
3. Suicide Prevention Council is a County-funded community-wide collaborative that provides oversight, guidance, and collective support to implement the recommendations of the Suicide Prevention Action Plan. The Council assists in the yearly Report Card which outlines the status of suicide and suicide prevention in San Diego County.

When a youth's risk factors are elevated, there are a number of programs and strategies that Behavioral Health Services utilize to prevent suicides in children and youth which include:

4. Access and Crisis Line which is availability 24/7, with "Live Chat" support during select hours.
5. Emergency Screening Unit (ESU) offers crisis stabilization for youth age 0-18 serves as the 24 hour emergency room for clients undergoing a psychiatric emergency.
6. Expanded Crisis Clinic availability for children and youth—now with two North County locations in addition to mobile assessment services.

7. Respite beds available for youth who do not meet criteria for hospitalization but would benefit from services in excess of what is allowed through crisis stabilization.
8. Dedicated inpatient psychiatric hospital beds at Rady Child and Adolescent Psychiatry Services (CAPS).
9. New programs developed targeting high-risk populations including new programming for LGBTQ youth, and Commercially Sexually Exploited Children (CSEC).
10. BHS Children, Youth and Families leadership sits on the Child Fatality Review committee reviewing all pediatric deaths investigated by the Medical Examiner (including suicide deaths), participates in the Clinical Care Review Workgroup, a group that reviews suicides in our system of care, and has worked with the Probation Department leadership to update suicide prevention efforts in the local detention facilities.

Trainings

11. Question, Persuade, and Refer (QPR) suicide prevention trainings.
12. Mental Health First Aid - provides skills to help someone who is experiencing a mental health crisis.
13. GLSEN (Gay, Lesbian and Straight Education Network) trainings for school personnel working with LGBTQI (Lesbian, Gay, Bisexual, Transgender, Questioning, Intersex) youth.
14. "Preventing Suicide: A Toolkit for High Schools" developed by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the US Department of Health and Human Services available to educational partners.

QUESTION 7B:

Does your county have programs that are specifically targeted at preventing suicides in transition aged youth (ages 16-25) in your community?

Yes__X__ No_____ If yes, please list and describe very briefly.

Yes for ages 16-18; No for ages 19-25. The programs and initiatives described above in the 7A response are available to transition age youth. Through the BHS Adult System of Care, young adults can access additional services. Although the County's *It's Up to US* initiative offers public service messaging and information in obtaining help, it is not specifically targeted at preventing suicide in transition aged youth. Data on how various suicide prevention programs operate in any specific age group is difficult to gather.

<u>Current County of San Diego Programs</u>

1. HERE NOW school based suicide prevention program provides prevention and early intervention services for middle and high school youth and was recently expanded to provide services countywide.
2. The *It's Up to US* countywide suicide prevention and stigma reduction media campaign was enhanced to include additional outreach to LBGTQI youth.
3. The Suicide Prevention Council contract was recently augmented to conduct targeted outreach to the TAY population, including CSEC (Commercial Sexual Exploitation of Children), homeless, former foster and pregnant and parenting TAY.
4. The County currently offers a 24/7/365 crisis phone line, and an online chat service (https://svcrplv.uhc.com/sdchat/) which youth may use between the hours of 4pm to 10pm Monday-Friday.

QUESTION 7C:

Do you have any further comments or suggestions regarding local suicide reduction/prevention programs?

Yes_X__ No_____. If yes, please list briefly.

Recommendations/Comments

1. Mental health programs should be combined with deterrence, self-help, and reduction of stigma.
2. In San Diego, some suicides occur by youth jumping from the Coronado Bay Bridge so efforts to put fencing on the bridge should be stepped up.
3. Drug overdose can be checked by reducing the easy availability of certain prescription drugs.
4. School administrators might consider the Massachusetts Youth Screening Instrument (MAYSI-2) in their school testing program. Those screened as at risk in the written MAYSI-2 can then be further tested face-to-face using the C-SSRS (more below).

There are two tools that provide significant value to those in crisis, and to those administering crisis and suicide prevention programs:

1. Columbia Suicide Severity Rating Scale (C-SSRS) which enables caregivers, school counselors, and parents the ability to quickly assess potential suicide risk by asking a series of questions. When used within an integrated information system, specifically to identify past harm-related behavior, the ability for caregivers to refer to appropriate interventions greatly reduces both the number of children referred to the most urgent services as well as the incidences of completed suicides.

   One program that includes the major components of the C-SSRS methodology is ZeroSuicide.org. Organizations that have adopted this program have seen dramatic, significant reductions in completed suicides.

2. A program at **CrisisTextLine.org** focuses on the pre-cursor thoughts, anxieties and actions of youth and adults in crisis, including suicidal ideation. This program provides the ability for County Behavioral Health Services, school districts, and other local agencies serving youth to deploy a crisis text-messaging service (SMS) that may be used by those in crisis to confidentially communicate with trained professionals and other volunteers who help answer questions or concerns and help the person decide on their next steps.

   The program could be adopted at minimal cost using the existing network or be adapted to fit the needs and concerns of the specific agency deploying the service. CrisisTextLine.org also publishes metrics of over 30 million-plus text communications including age of person in crisis, type of need, the day and time of week and much more at CrisisTrends.org. Researchers and academians may also apply to utilize datasets with deeper levels of information through the Enclave Data program at CrisisTextLine.org/open-data.

Early Identification of Risks for First-break Psychosis

Sometimes, unfortunately, the first major indication parents may have about first break psychosis in a child or youth may be changes in behavior, including an unusual drop in school grades, experimenting with substance abuse, 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 MHSA -funded programs provide these services. Thus far, the research and evidence for improved outcomes is solid enough to support these major efforts at both the state and national level. Therefore, now there are also federal funds from SAMHSA designed to intervene early to target first-break psychosis and provide a level of coordinated care and treatment that is effective. Some counties braid together funds from more than one source to support these programs and services.

Our questions address early intervention programs, regardless of funding source.

QUESTION 8A:

Does your county have services or programs targeted for first break psychosis in children and youth, and transition aged youth (TAY)?

Yes_X__ No____

QUESTION 8B:

If yes, please list by age range(s) targeted and describe the program or services briefly. Also, please include the major funding source, (i.e., MHSA, SAMHSA Block Grant, Realignment I/II, Medi-Cal, etc), if the information is readily available.

The BHS Adult and Older Adult system of care has a program (Pathways Community Services-Kickstart) that focuses exclusively on prodromal and first break psychosis in youth ages 10-25. This program provides medication management, individual therapy, family groups, occupational therapy, nursing, education and employment supportive services and peer support.

Additionally, this program also provides outreach and education to "gatekeepers" in our County to ensure that prodromal symptoms are identified, referred and treated in an attempt to prevent psychotic breaks. In Fiscal Year 2015-16, there were 138 youth served and of these 4% were ages 6-11, 61% were ages 12-17, 24% were ages 18-24, and 1% were over 25.

FUNDING SOURCE: MHSA-PEI (primarily, with a small portion of MHBG funding specifically for FEP youth ages 15-25).

QUESTION 8C:

Do you have any further comments or suggestions about local programs targeted for first break psychosis in children and youth?

Yes____ No__X__. If yes, please describe briefly.

Full Service Partnership (FSP) Programs for Children and Youth

Full Service Partnership programs (FSP) 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. Prior research has shown FSP programs to be effective in improving educational attainment, while reducing homelessness, hospitalizations, and justice system involvement. Such intensive services can be costly, but their positive impact and results outweigh the costs and actually produce cost savings to society.[39]

Overall, the data thus far indicates some very good news. These positive outcomes are leading to greater understanding of what works well for children and youth. We hope to increase resources to serve more children and youth in FSP programs.

Outcomes Data for Children and Youth (TAY) in FSP Programs

When a new client begins FSP services, data are collected to serve as a baseline for later comparisons. 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.

Please examine the data in the following tables below taken from a report[40] by CBHDA released in early 2016. First, examine the statewide data for children (age 0-15) and TAY (age 16-25). Next, for each of these age groups, take note of which outcomes show improvement and those which may need further attention to improve services for client recovery and wellbeing.

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[39] 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

[40] 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 for Children and Youth for Fiscal Year 2013-2014.

STATEWIDE DATA:
FSP Partners included in this analysis: 41 counties[41] plus Tri-Cities group reporting, Fiscal Year 2013-2014:

- 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 7. Children, ages 0-15.

N=5,335 completed at least 1 year 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	89% ⇩	--
Psych. Hospitalizations	49% ⇩	--
Out-of-Home Placements	12% ⇩	--
Arrests	86% ⇩	--
Incarcerations	40% ⇩	--
Academic Performance	68% ⇧	--

The data the table above show that: overall, children experienced decreases in total numbers of mental health emergencies, hospitalizations, out-of-home placements, arrests and incarcerations. There was an increase in academic performance, as measured by the percentage of children who had improved grades relative to baseline during the year prior to beginning FSP services.

[41] 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.

STATEWIDE DATA (Fiscal year 2013-2014): continued below.

<u>Table 8. Transition Age Youth</u> (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. These beneficial outcomes occurred by the end of the first year.

All of these improved outcomes continued and were sustained at the end of the clients' second year in FSP services. Two types of outcomes, psychiatric hospitalizations and use of emergency shelters, had improved even more by the end of clients' second year of FSP services, compared to the end of the first year.

The goal is to think about how the FSP outcomes data for children and youth may help inform your suggestions for improving local services or programs**.**

QUESTION 9A:

What are the most urgent child or youth problems in <u>your</u> county? (For example, homelessness, problems with school or work, arrests, incarcerations, use of emergency MH services or psychiatric hospitalizations, out-of-home placements for children, substance abuse, teen pregnancy/parenting, etc.).

Urgent child/youth problems in San Diego County include:

1. **Availability of psychiatric inpatient beds and strategies to address children/youth requiring psychiatric emergency services**
   Currently, there are 58 to 64 inpatient beds in psychiatric facilities for children and youth. During peak times, youth access emergency departments for extended periods of time due to lack of alternatives that can sustain their safety. In 2016, San Diego County received a grant from the California Health Facilities Financing Authority (CHFFA) which will triple the number of crisis stabilization beds from 4 to 12 by fall 2017. These beds which are used as alternatives to hospitalization have an over 70% hospitalization diversion rate. Additionally, the County intends to apply for funding and plans to develop crisis residence beds when these are promulgated by the State.

2. **Permanent and appropriate placement for foster youth**
   San Diego County prioritizes services to foster and dependent youth and is actively working in a strong partnership with Child Welfare Services and Probation to implement Continuum of Care Reform (CCR). CCR outcome goals include the reducing of congregate care placement settings, increasing the use of home base family care and decreasing the length of time to achieve permanency.

3. **Limited psychiatry resources**
   Programs struggle with finding sufficient psychiatry time to provide services to children and youth. Additionally, some children who no longer need therapy often are still in need of medication and their primary doctor does not have the expertise to provide this medication. Through the Innovations component of the Mental Health Services Act, Behavioral Health Services is proposing implementation of a medication clinic which will be able to manage complex medication for children and youth who have stabilized clinically but required ongoing medication management that the health plans and primary care physicians are not prepared to meet.

4. **Future impact of changes to the Affordable Care Act**
   Congressional action may reduce the number of lower-income individuals eligible for health insurance and Medi-Cal, thereby reducing access to care. This may push many of these individuals to clinics and emergency rooms and the County may not have the adequate resources to serve them due to possible reductions in funding.

5. **Substance Abuse**
   With the passage of Proposition 64 - the Adult Use of Marijuana Act (AUMA), permitting Californians to cultivate and use marijuana, thereby normalizing the use of marijuana in the State, it is anticipated there will be increased youth access to marijuana and various products containing marijuana. NOTE: On March 22, 2017, the Board of Supervisors, based on recently adopted State laws regarding local jurisdiction authority, voted to ban all medical and non-medical marijuana facilities, dispensaries and collectives, as well as all commercial farming, growing and cultivation operations in the

unincorporated areas of San Diego County. This ban does not restrict personal and private use of marijuana for medical and non-medical uses as allowed under California law.

QUESTION 9B:

Does the FSP data suggest how (or where) improvements to certain services or programs could affect outcomes, and thereby help address the most urgent problems for children or youth in your community?

The implementation of Proposition 47 (felonies became misdemeanors) interceded in this data period. This may have affected the validity of the improvements regarding arrests shown in data provided in this notebook. Statistics derived from ensuing data years should more accurately reflect client outcomes with respect to arrests.

Recommendation
There needs to be stronger prevention/early intervention (PEI) efforts to increase the deterrence of children and youth from substance use involvement, thus avoiding the need for later FSP/wraparound services for those individuals.

Question 9C:

Do you have any other comments or recommendations regarding your local FSP programs or other types of "wrap-around" services?

Yes _X_ No___. If yes, please describe briefly.

It is the opinion of this Workgroup that there would be significant value for all California Behavioral Health and other FSP programs to make available on a single publicly available website, their plans, reports and data – all in electronic machine-readable format to be delivered directly on this website or, links provided to allow access to such information and data.

To significant benefits include the opportunity for BHS and FSP programs to communicate their programs and outcomes but, to also identify and deploy evidence-based best practices used in peer-programs. Another significant benefit in making this information more easily accessible, is the ability for innovators (both within and outside existing organizations and programs) to make more informed contributions during the planning, development and feedback processes.

QUESTIONAIRE: How Did Your Board Complete the Data Notebook?

Completion of your Data Notebook helps fulfill the board's requirements for reporting to the California Mental Health Planning Council. Questions below ask about operations of mental health boards, behavioral health boards or commissions, regardless of current title. Signature lines indicate review and approval to submit your Data Notebook.

(a) What process was used to complete this Data Notebook? Please check all that apply.

___ MH Board reviewed W.I.C. 5604.2 regarding the reporting roles of mental health boards and commissions.

____MH Board completed majority of the Data Notebook

___ County staff and/or Director completed majority of the Data Notebook

___ Data Notebook placed on Agenda and discussed at Board meeting

_X_ MH Board work group or temporary ad hoc committee worked on it

_X_ MH Board partnered with county staff or director

___ MH Board submitted a copy of the Data Notebook to the County Board of Supervisors or other designated body as part of their reporting function.

___ Other; please describe: _____.

(b) Does your Board have designated staff to support your activities?

Yes_X_ No___

If yes, please provide their job classification: Administrative Analyst III

c) What is the best method for contacting this staff member or board liaison?
Name and County: _Traci Finch, County of San Diego____
Email: _Traci.Finch@sdcounty.ca.gov_____
Phone #: __(619) 584-3008_____

Signature: 

d) What is the best way to contact your Board presiding officer (Chair, etc.)?
Name and County: __Phillip Deming, County of San Diego_____
Email: __Deming@casadlc.com_____
Phone #: _(858) 592-1831_____

Signature: 

REMINDER:

Thank you for your participation in completing your Data Notebook report.

Please feel free to provide feedback or recommendations you may have to improve this project for next year. We welcome your input.

Please submit your Data Notebook report by email to:

DataNotebook@CMHPC.CA.GOV.

For information, you may contact the email address above, or telephone:

(916) 327-6560

Or, you may contact us by postal mail to:

- Data Notebook
- California Mental Health Planning Council
- 1501 Capitol Avenue, MS 2706
- P.O. Box 997413
- Sacramento, CA 95899-7413