PROGRAM INFORMATION:

Program Title:	Community Services	**Provider:**	Central Star Behavioral Health, Inc.
Program Description:	Outpatient specialty mental health services for children and youth with serious emotional disturbances and parents with a serious mental illness, and court-specific services to children and families in Fresno County's Child Welfare Services system.	**MHP Work Plan:**	4-Behavioral health clinical care
Age Group Served 1:	CHILDREN	**Dates Of Operation:**	July 29, 2014 - present
Age Group Served 2:	ADULT	**Reporting Period:**	July 1, 2015 - June 30, 2016
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	EPSDT	**Other Funding:**	DSS

FISCAL INFORMATION:

Program Budget Amount:	$3,000,000	**Program Actual Amount:**	$2,426,668.26
Number of Unique Clients Served During Time Period:	979		
Number of Services Rendered During Time Period:	14,440		
Actual Cost Per Client:	$2,478.72		

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Outpatient
Contract Term:	07/29/2014 – 06/30/2019 (07/29/2014 – 06/30/2017 plus two optional one-year extensions)	**For Other:**	Click here to enter text.
		Renewal Date:	07/01/2019
Level of Care Information Age 18 & Over:	Traditional Outpatient Treatment (caseload 1:80)		
Level of Care Information Age 0- 17:	Outpatient Treatment		

TARGET POPULATION INFORMATION:

Target Population: All referred children, youth, parents, guardians, and foster parents involved with a child's CWS case. The target

population includes children and youth referred to in the *Katie A. Settlement Agreement* as members of the "class" and "subclass."

MHSA CORE CONCEPTS:

Please select MHSA core concepts embedded in services/ program: *(May select more than one)*	**Please describe how the selected concept (s) embedded** :
Recovery/Resiliency Orientation Cultural Competence Orientation Community Collaboration Client/Family Driven Program	Please note that SBHG's overall our Core Practice training curricula engages staff in discussion and mastery across all these MHSA core concept areas. Recovery and resiliency are fully infused via our selection of practice models for CS clinicians that include multiple hope, strength-based, skill building and wellness focused evidentiary practices. Cultural attunement is a strong, long held framework requiring active bi-annual planning with program specific projects and an explicit focus of staff recruitment and trainings (formal plan also provided to county). Learning and working with the communities we serve, our varied agency partners, especially child welfare and mental health, and facilitating connections to resources/services for our clients is mission critical to program success. CS is very much client/family driven! Regarding integrated care, we completed the COMPASS assessment this past year, and have identified key areas to move forward on regarding substance abuse screenings and assessments within the context of our current contract.

PROGRAM OUTCOME GOALS:

There are 10 goals articulated for the program: 1) Improved Child and Family Functioning; 2). Reduced Caregiver Challenges & Strain; 3) Reduced Child Maltreatment (Child Welfare Recidivism); 4) Continuation of Families in Multi-Family Support Groups; 5) Connections Made with Community Resources, Services and Supports; 6) Reduced Out-of-Home Placements and High-End Service Utilization; 7) Increased Endurance of Permanency Placements; 8) Improved Schooling Outcomes (Child/Youth & Young Adults); 9) Improved Vocational and Employment Outcomes (Older Youth & Young Adults); and, 10) Satisfied Youth/Young Adults, Caregivers and Agency.

PROGRAM OUTCOME DATA/INDICATORS:

The program applies the Stars Behavioral Health Group (SBHG) Client Outcome Report, the Child and Adolescent Needs and Strengths, the BASIS-24 (adult mental health), Active Parenting Survey, and satisfaction surveys. We hava an outstanding desire to also access child welfare datasets for pertinent analyses.

During FY 15-16, the team overcame the system of care and operational issues identified in last year's report regarding processing of referrals. This year, the team achieved an overall 77% rate of uptake of referrals into treatment. Those not enrolling refused or were not located, were NOA ineligible, or otherwise had their DSS cased closed prior to the authorization of a Plan of Care. There was a desirable steep reduction in

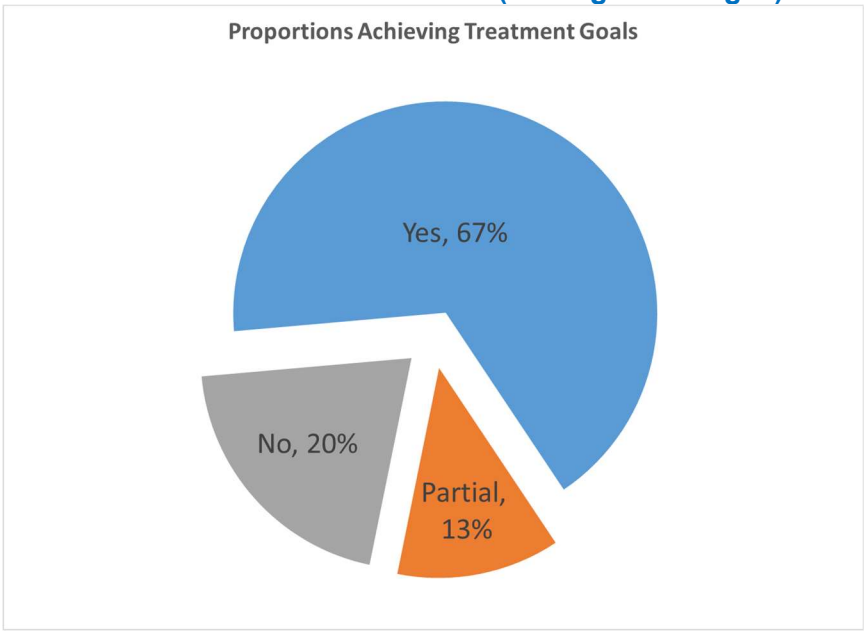
time to uptake, which now (since Jan 2016) averages 6 days, typically ranges up to 16 at most, and only very rarely (1%) extends beyond 30 days (compared to 40% during start-up year!). These positive changes are largely due to having fresh and qualified referrals, and a nicely evolving working relationship with child welfare.

To date, CS enrolled 1,175 clients (739 children/youth under age 18, and 436 adults) in 1,233 episodes of mental health care, with 99.8% of referrals coming from child welfare (3 individuals were referred from mental health programs). At the end of FY 15-16, there were 306 children and 127 adults on the active census. A large majority (95%) of program participants had only one enrollment (54 individuals had 2 enrollments, and 2 had 3 each). Of discharges, the average length of services was 134 days (range of 1-600). Half (median) discharged within 109 days. In addition to the above mental health treatment service enrollments, the team also provides comprehensive, consultative psychological evaluations for the child welfare department as part of this contract, and conducted 27 of these on distinct individuals during FY 15-16.

The children and youth were ages one month through 17 at admission, with an average age of 7 yrs., 48% female, and varied racial/ethnic backgrounds including 59% Hispanic/Latinos, 21% Caucasian, and 11% African American. Their caregivers, those enrolled as adult clients, were ages 18 through 66 at admission, average age of 34, and 63% female. Their ancestral backgrounds included 51% Hispanic/Latino, 34% Caucasian, and 10% African Americans. A little under 3% of all clients have Asian heritages, and just under 1% are North American Native Indians. Additional information about our clients' demographic and clinical profiles is available upon request, as are more details regarding central tendencies and patterns of mental health service utilization.

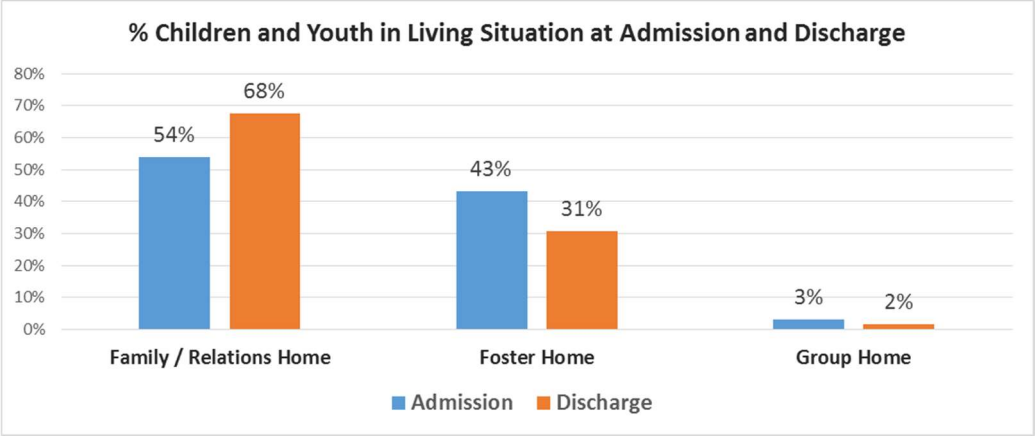
Following are a series of graphics on profile and outcome data from among the many measurements taken and currently available:

Treatment Goal Achievement (Among Discharges)

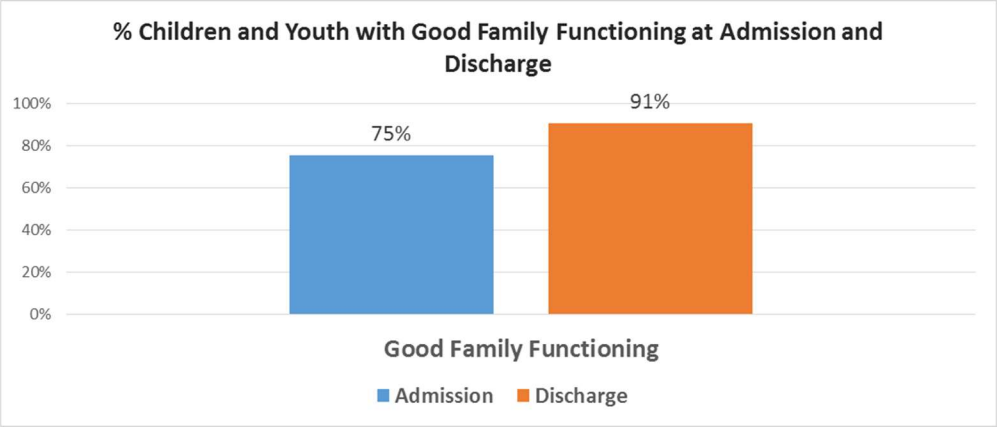


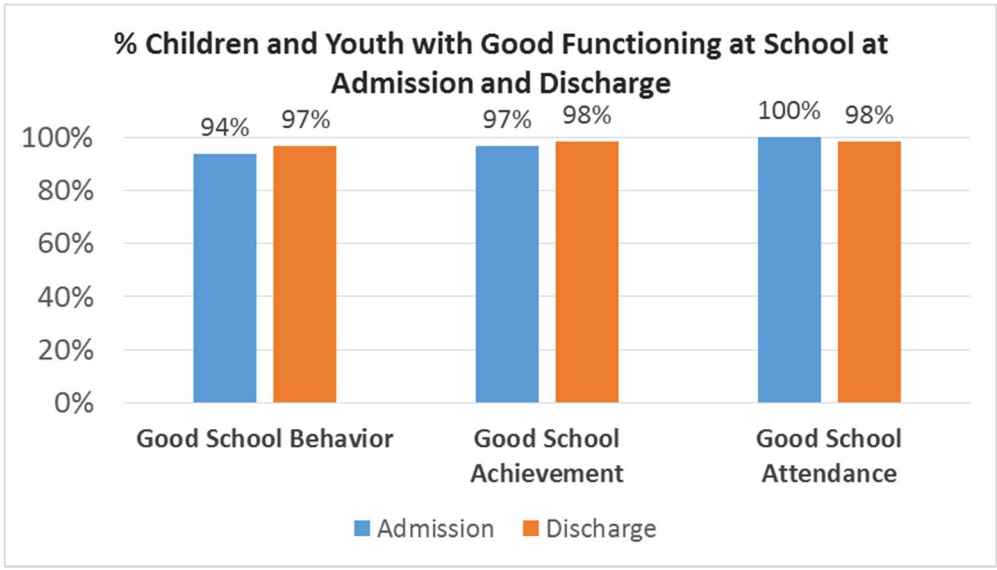
These results are solid and consistent with other SBHG programs serving child welfare and/or court referred youth and families. Mental health treatment goal obtainment refers to those specified on each clients' individualized plan of care, and primarily connects to program goal areas #1 Child and Youth Functioning and #2 Caregiver Challenges and Strain.

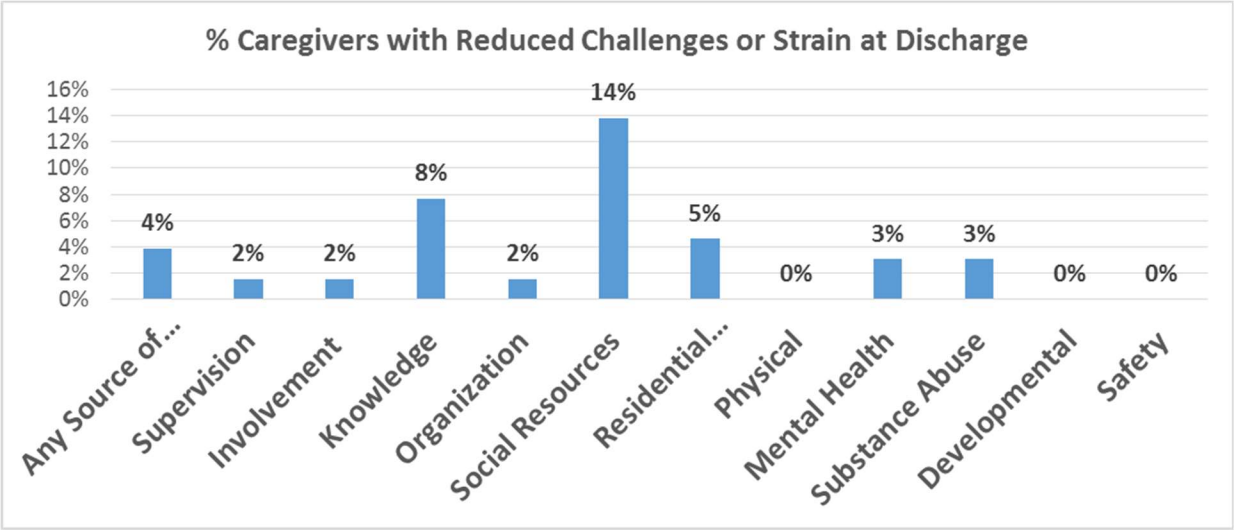
CANS Results



Above results reflect an upward net shift (+14%) of children living in family homes by discharge compared to when they enrolled in the program. No doubt the children's improved functioning with family and ability to persist with schooling (see below) helped.

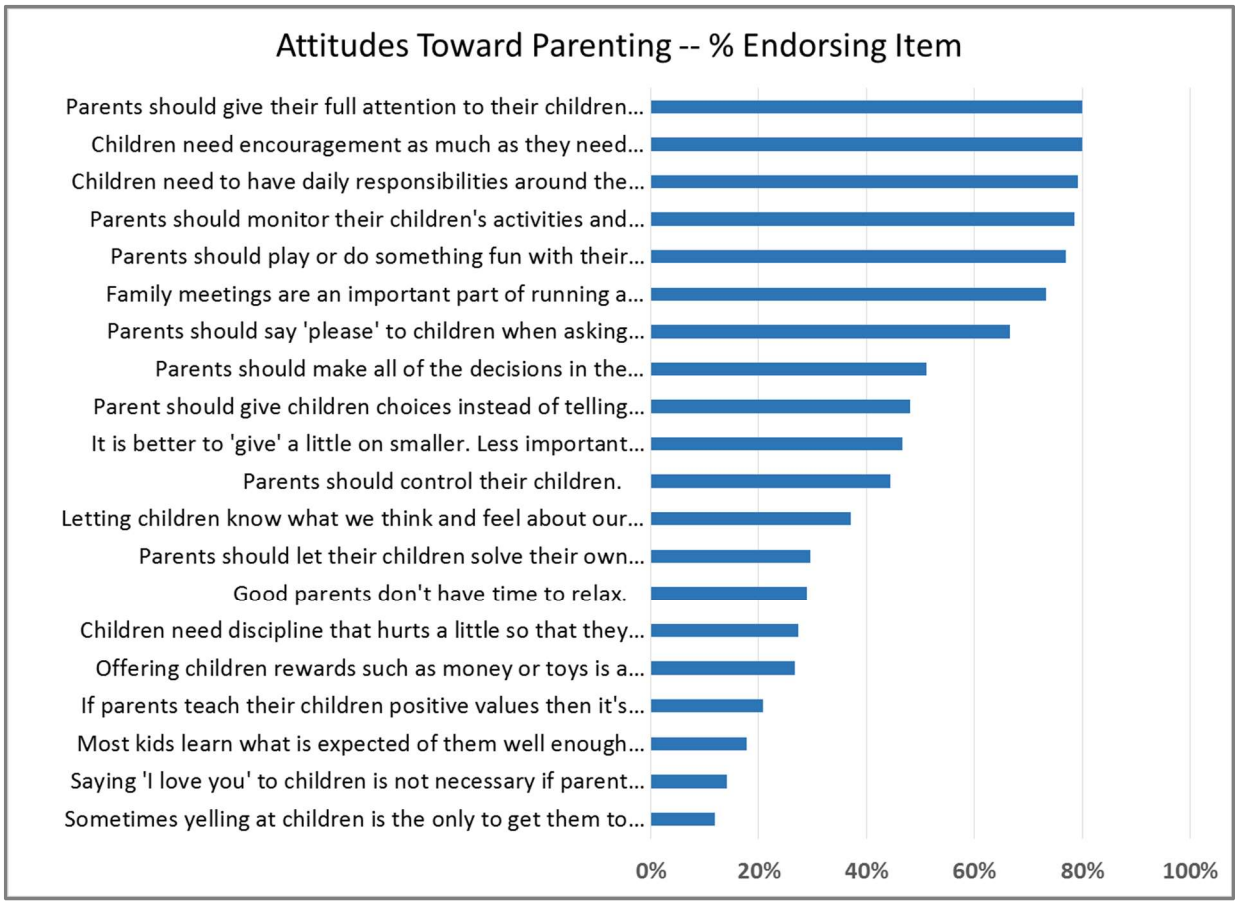






Also important is the caregivers' mental health and improved capacity to handle life's stressors. The graph above shows the net reductions (% percent at discharge minus % at admission) who had actionable levels of strain of challenges and strains of these types. More information from this, and other CANS scales will be provided in the child report.

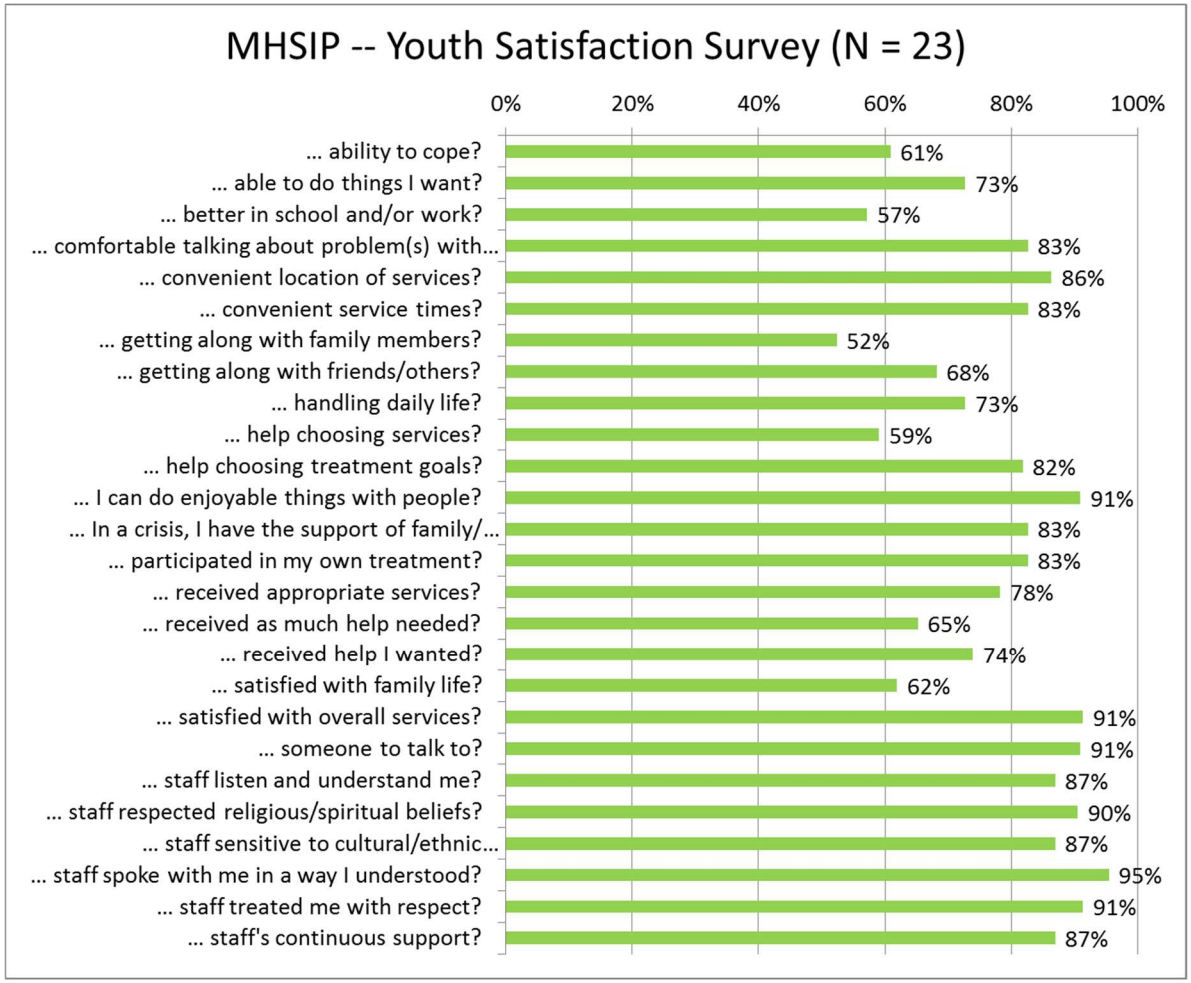
APS – Parenting Profile and Needs Assessment



The Active Parenting Survey (APS) is helpful for child welfare and parenting support and skill building programs in order to: raise awareness and collaboratively explore caregiver's views, and to track changes in attitudes and behaviors regarding parenting that impact child and family well-being. The survey includes items that have either positive (considered desirable by most child development experts) or negative (not desirable) valence. Our 135 caregiver respondents (54% foster parents, 24% mother or father, 22% extended family members) endorsements mirror these valences pretty well (e.g., among the 10 lowest endorsed items in the graph above are the non-desirable items). Exceptions -- considered not desirable yet endorsed by quite a few -- are: "Letting children know what we think and feel about our values has little influence on their behavior" (37% agreed); Parents should control their children (44%); and, "Parents should make all the decisions (51%). Also, the positive valence item "Parents should let their children solve their own problems" was only endorsed by 30%, and "It is better to 'give' a little on smaller, less important things than to always stand firm and provoke a fight" and "Parents should give children choices instead of telling them what to do" were endorsed

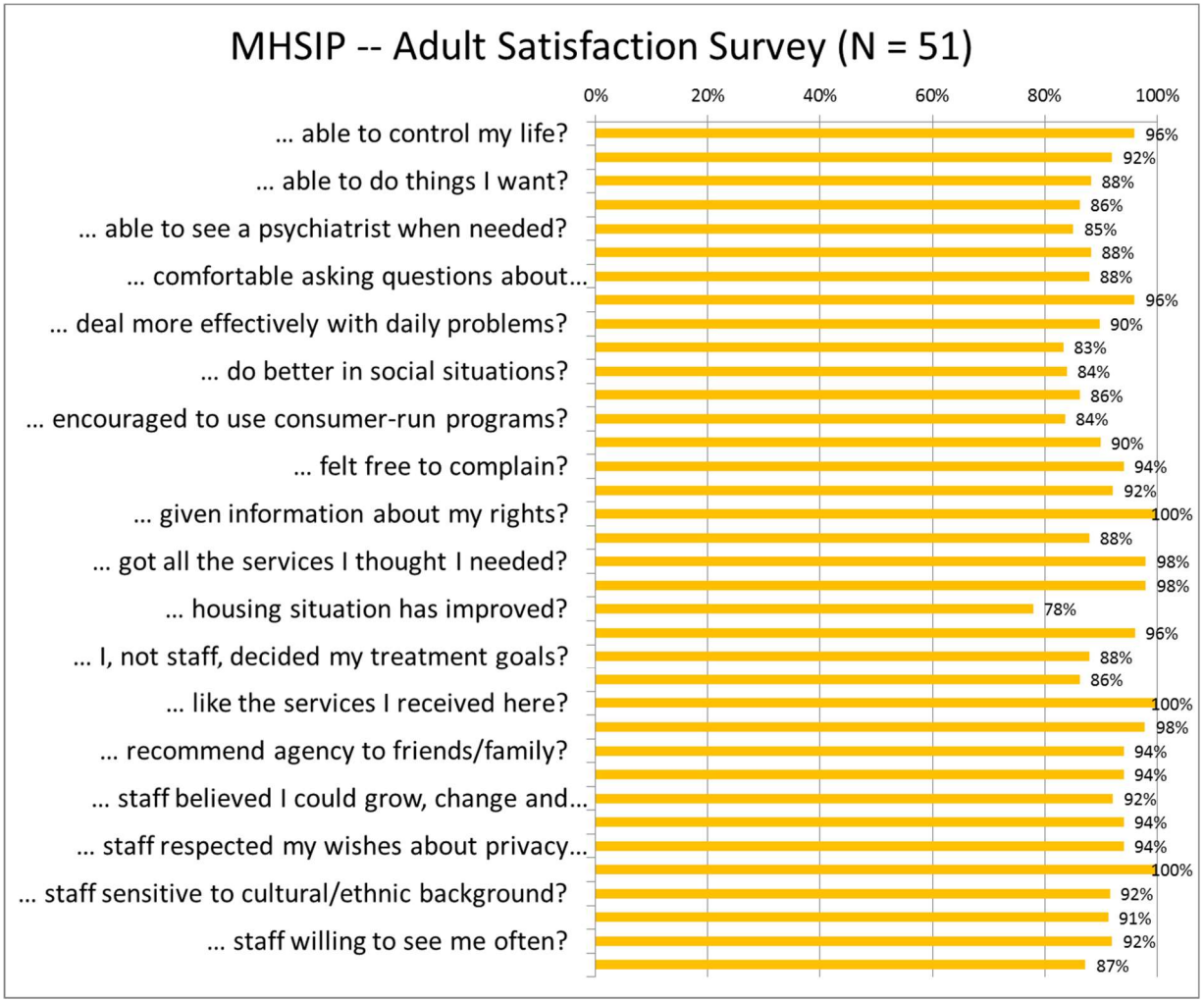
by less than half. We are providing additional information (e.g., perceptions about child, self-report on parenting behaviors and family life), along with guidance to the program from these surveys, and reporting more on this in the report to child welfare.

Client Satisfaction

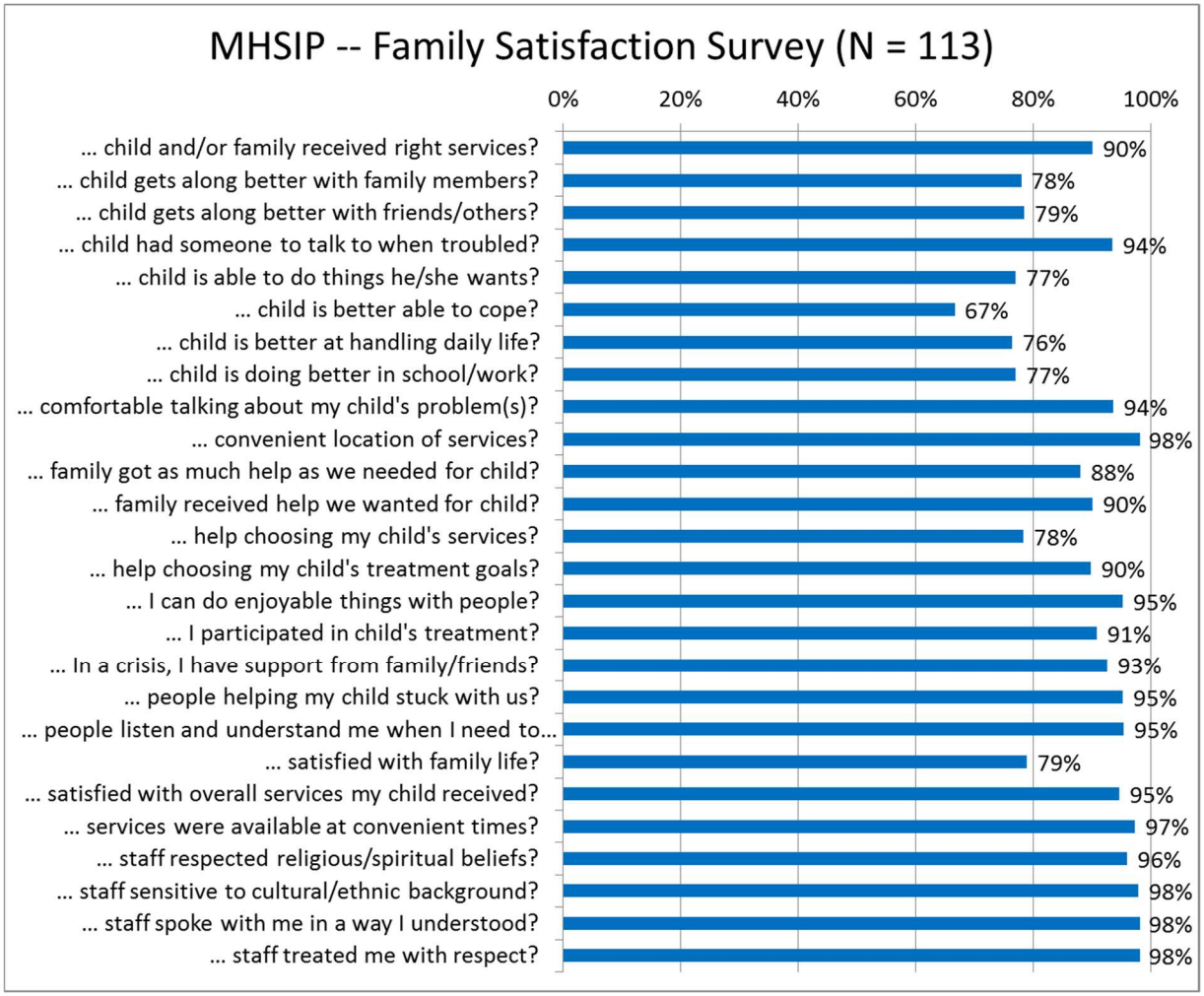


SBHG sets an 80% threshold for consumer surveys (strongly agree and agree responses combined), and expects the team to review and consider for QI any item or overall domain that falls below that benchmark. In this case, there are 11/26 (42%) items below expectation. The low performing items are primarily in one of four domains (per survey factor structure based on a Principle Component Analyses carried out on over ten years' worth of SBHG MHSIP surveying): Personal Effectiveness (e.g., getting along

with family members, better at school/work). The sample is (too) small, so the team will consider these data in light of other indicators before deciding whether to launch program QI at this time.



The adult survey sample is stronger, and the results are as well. There is 1/36 (3%) items below benchmark (note: not all the questions are visible due to font sizing and layout within context of report template – different graphing is available on request). The item pertains to the Community domain, which includes some issues (like housing) that mental health teams are typically limited to impact directly. We do expect staff to bring these issues forward to relevant agency partners and facilitate consumer connections to needed resources, so team reflection and discusion regarding housing may be warranted.



There are good numbers of caregiver surveys about their children's experience in the program and many items with strong (90% +) results! Kudo's to the team! There are 8/26 (31%) items below the 80% threshold (most are only a few points below) that warrant team review and consideration for QI. It may be meaningful that most of these items are about the same Personal Effectiveness domain (e.g., child better able to cope, getting along with family, etc.) that the youth also report as a struggle. Considered together, these two informants' input suggests that clinical review of staff's use of CBT, AF-CBT and behavioral support/coaching with the children/youth may be indicated. It is important to keep in mind, however, when interpreting these data that

the MHSIP survey process is cross-sectional: over half those surveyed (in this instance) had been in the program less than five months when answering these questions, and not yet experienced the benefits of a full course of care.

DEPARTMENT RECOMMENDATION(S):

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