PROGRAM INFORMATION:

Program Title:	Community Services	**Provider:**	Central Star Behavioral Health
Program Description:	Outpatient Mental Health Services and court-specific services for children and youth in Fresno County's child welfare systems, and their families	**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, 2019 – June 30, 2020
Funding Source 1:	Medical FFP	**Funding Source 3:**	Other, please specify below
Funding Source 2:	EPSDT	**Other Funding:**	DSS

FISCAL INFORMATION:

Program Budget Amount:	$4,750,000	**Program Actual Amount:**	$2,574,031.30
Number of Unique Clients Served During Time Period:	1,072		
Number of Services Rendered During Time Period:	19,723 services		
Actual Cost Per Client:	$2,401.15		

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Outpatient
Contract Term:	07/01/2019 – 06/30/2022 plus two optional one-year extensions	**For Other:**	
		Renewal Date:	07/01/2022

Level of Care Information Age 18 & Over: Medium Intensity Treatment (caseload 1:22)

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 child welfare case. The target population includes children and youth referred to in the Katie A Settlement Agreement as members of "class" and "subclass."

CORE CONCEPTS:

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program: *(May select more than one)*	**Please describe how the selected concept (s) embedded** :
Integrated Service Experience	
Community collaboration	All of these concepts are well expressed in there being funding for this kind of program and throughout service delivery. Central Star mental health staff collaborate with child welfare, courts, and behavioral healthcare staff for referrals, on Child and Family Teams (CFTs), in court, and for case management activities. Our staff master and apply Evidence-Informed Practices (EIPs), Evidence-Base Practices (EBPs), and community best practice standards selected specifically for their attunement to the needs of the service population; and, we employ multi-culturally diverse staff familiar to the Fresno communities being served. All of our services are anchored to principles of individualized care, and include explicit wellness/recovery and resiliency-promoting rehabilitative skills, therapeutic interventions and connections into community resources. Integrated psychological testing and psychiatry services are available as needed. By definition, the provision of speciality mental health services helps to meet the needs of Katie A child welfare/foster care clients whom have been historically unserved, underserved, and/or poorly served and we abide the CAPP and KatieA Core Practice models as well as Stars Behavioral Health Group standards for collaboration and service integration.
Cultural Competency	
Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services	
Access to underserved communities	

PROGRAM OUTCOME & GOALS
- Must include each of these areas/domains: (1) Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder
- Include the following components for documenting each goal: (1) Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

CLINICAL INFORMATION:

Program Utilizes the following:

- ***Evidence-Based Practices (EBPs)***. Among staff are individuals trained in Alternatives for Families Cognitive Behavioral Therapy (AF-CBT), Child Parent Psychotherapy (CPP), Dialectical Behavioral Therapy (DBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) or Mindfulness. Each practice addresses distinct clinical needs of children, caregivers and/or families.

- ***Evidence-Informed Practices (EIPs)***. All staff are exposed to select practices from a range of EBPs embedded in SBHG's Core Practices training program which covers Engagement & Retention; Wellness Education; Trauma Informed Care; Assessment, Treatment & Discharge by Clinical Pathway; Treatment Staff Supervision; and, Collaboration & Customer Services. For example, in the assessment, treatment and discharge unit for externalizing conditions, we integrate skills training from Aggression Replacement Training.

- ***Best Practices***. Services also include Intensive Care Coordination (ICC), Intensive Home-Based Services (IHBS), Case Management, and Crisis Intervention, as needed for KatieA status and/or individualized service plans. Professional psychiatric/psychological assessments are used. Team members apply wraparound and system of care concepts to case formulation and collaborative decision-making with children, families, allied service partners and other Central Star team members. Providers assertively advocate on behalf of youth/families to intervene as needed with schools, courts, placements and detention among other systems/settings; and, to build natural connections and community around each child/family.

OUTCOMES

Outcome Measures:

Tools	Notes	Data Status
Referral, Intake & Service Utilization, incl. varied screening & assessment tools (e.g., ACES, CSSRS, PHN, SBIRT)*	Data points captured in Stars Behavioral Health Group (SBHG) EHR, and/or Excel workbooks. Required by county, SBHG and/or SBHG for Joint Commission (JC) accreditation. Guides service planning for resolution of needs and risks.	Most completed in SBHG's EHR. SBHG is currently revising a Business Analytics (BA) Dashboards (driven by EHR data) on access to care to align indicators to new state DHCS timeliness of care standards.
TQM – Fidelity, Quality and Compliance Tracking	Varied protocols, Excel datasets or BA dashboards for IRs, complaints/grievances, Joint Commission (JC) Tracers, fidelity measures, QI efforts, etc.	Routinely completed, reported and authoritative data, mostly not included in this report, but will be presented at an upcoming CQI Quality Council.
SBHG EMR Client Outcome Report (COR) and Discharge Status Form	COR regarding child clients at enrollment, every six months & discharge. DC Status Form augments data collected at discharge. These tools primarily capture categorical statuses regarding life domains, system of care and aftercare referrals/linkages.	FY 19-20 COR, N=265/452 (59%) matched pairs with both initial and discharge report for analyses. Drop off in completion rate most likely related to staff turn-over and challenges of absorbing new tool requirements. FY 19-20 DC Status Form, N=399/413 (97%). DC form was newly implemented last year.

Performance Outcome System (POS) – Child Adolescent Needs Scale (CANS-50) and Pediatric Symptom Checklist (PSC-35).	State DHCS mandate for children's services, applied to Children ages 4 to 18 at time of program enrollment. Completed at intake, every six months through discharge. PSC meets SBHG's JC, requirement for use of a standardized tool, child clients.	Matched sets available on N= 163/339 (48%) CANS-50 and N=131/297 (44%) PSC-35 for FY 19-20.
Ages & Stages Questionnaire, completed at intake, every six months and discharge.	Tool for small children up to age 5 that assesses developmental milestones and pre-school functioning. ASQ meets JC requirement, young children.	Recently implemented in this FY 19-20 report.
Behavior & Symptom Identification Scale (BASIS-24)	Brief 24-item scale completed by adult clients at enrollment, every six months & discharge. BASIS-24 meets SBHG's JC requirement for use of standardized tool, adult clients.	FY 19-20 BASIS, 87/277 (31%) matched pairs with both an initial and reassessment or discharge report. A declined from 54% completion rate last year.
Client, Family & Agency Partner Surveys (state MHSIP surveys, SBHG Agency Partner Surveys)	Mandated state surveys collected twice a year from persons seen during a 1-week window. Agency Partner Surveys required by SBHG.	Team participated in state MHSIP data collection during fall 2019 (N=42 caregivers, 30 youth, and 17 adults, respondents). Spring report pending**. Agency Partner Surveys will be gathered this coming year.

* Adverse Childhood Experiences, Columbia Suicide Severity Rating Scale, Pain Health Nutrition, Screening Brief Intervention and Referral to Treatment (substance abuse risk screening questions).

During FY 2019-20, there were 1,130 community services treatment episodes involving N-777 unduplicated children'/youth and N=353 unduplicated adult clients, nearly all referred by DSS (97%) from within Fresno County. Additionally, 14 other persons received Psychological Testing services through the program.

The children/youth served were ages a few months through 17 yrs., with an average age of 8.9 yrs. (SD = 4.9). There were 49% female with heritages as follows: 51% Latino, 26% Anglo, 16% African, 4% Other/Mixed/Unknown/Native American and 3% Asian. Asian heritages were primarily Cambodian/Laotian/Filipino/Hmong. The children/youth were in treatment for primarily internalizing conditions (26%) such as anxiety, depression and adjustment reactions with attendant mood and/or anxiety features. Anxiety conditions co-occurred with post-traumatic stress for some youth clients.

The young adults and adults enrolled in their own mental health treatment were ages 18 to 71 with an average age of 35 yrs. They were 66% female with hertiages as follows: 49% Latino, 32% Anglo, 13% African, 3% Native/Other/Mixed/Unknown and 2% Asian. The adults were in treatment for primarily internalizing conditions (36%) such as anxiety, depression and adjustment reactions with attendant mood and/or anxiety features. Anxiety conditions co-occurred with post-traumatic stress for some clients.

In the sections that follow the key indicators with information and data are organized by the county's reporting categories: Access, Effectiveness, Efficiency and Satisfaction.

ACCESS

Access KPIs are defined by the program's child welfare stakeholders and state DHCS timeliness of care standards. The program team tracks referrals to enrollments and other pertinent fields and date/time stamps in the referral module of the EHR, along with additional service data entries for those who enroll in the program – data summarized:

- The team attempts outreach and engagement during multiple efforts to contact and resolve barriers during a 45-day outreach and engagement period. Among 1,009 referrals of 639 unduplicated persons during the FY, N=231 (23%) did not enroll in the program. As in prior reports, the most common reasons for no enrollment were caregiver refusals, services sought elsewhere, lack of medical necessity and CWS case closures.

- N=646 (64%) of those referred enrolled in the program. This rate represents a drop from 70% last year.

- During the year, the program served N=64 KatieA subclass eligible clients (13% of all children/youth served), with each receiving on average 38 units/minutes of Intensive Care Coordination (ICC), median 37 units, across from 3 to 198 units. Each

also participated on average in 58 units/minutes of Intensive Home Based Services (IHBS), median 58 units, and ranged from 1 to 184 units.

- For all enrolled clients, on average there were 25 days from referral to enrollment, median 19 days, and ranged 1 to 69 days. Long lapses are undesirable, and the team is challenged to achieve state timeliness of care standards. However, they document their efforts to quickly make contact, address child welfare and family concerns, and resolve logistical barriers (e.g., scheduling, transportation) to facilitate timely enrollments.

EFFECTIVENESS

1. *Improved Child and Family Functioning*
2. *Reduced Caregiver Challenges & Strain*
3. *Reduced Child Maltreatment (Child Welfare Recidivism)*
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)*

SBHG Child Client Outcome Report (COR) Analyses:

Statuses regarding schooling are tracked on the SBHG EHR Child COR at the youth's time of enrollment and discharge from the program. Progress with schooling is often negatively impacted by the kinds of family and/or child difficulties that prompt referrals for mental health services and such problems can be addressed in many circumstances through mental health interventions and supports.

- Most children and youth attended regular public schools (94%), and this proportion remained stable from enrollment to last record (265 COR Matched Pairs).
- School attendance -- defined as enrolled in grades 1-12* and regularly attending 4 or more days per week – appears to increase from admission (59%) to discharge (66%). The discharge proportion with regular school attendance is lower than last year's discharge percentage, 72%. Nonetheless, both based on the caregiver's PSC-35 ratings (item #17), which is consistent with the pre to post schooling information from the COR, school attendance improved statistically over time in treatment this past year (P>.001).

- The proportion of children/youth achieving "C" grades or better also increased during treatment this FY (36% → 43%), although the discharge proportion was higher last year 57%.
- The average number of disciplinary problems (truancies, suspensions, expulsions, school behavior issues, etc.) declined from 0.14 at admission to 0.09 at discharge. About 10% of the youth have one or more problems of these types at the time of enrollment, this drops to 6% by discharge. Reducing disciplinary issues is important to improving youth's engagement with and opportunities to benefit from their education, which ought to boost their attendance and grades over time (per caregivers, school performance is improving -- see PSC-35 table to follow).

*There were 251/265 (95%) in grades 1-12; others were in preschool, kindergarten, or another circumstance.

The proportions of children/youth in different living situations from admission to discharge are shown below for N=265 discharged children/youth served during FY 19-20 with both admission and discharge SBHG EHR Child Outcome Reports (CORs). Overall, the majority of children/youth (88%) either maintained a stable living situation or experienced improvements.

- Close to 39% maintained in a family home and close to 25% maintained their foster placement.
- Close to 30% were able to transition from a foster home to a family home.

Regarding their child welfare planning tracts, Figure 1 and Table 1 below show the children/youth's status at admission (ADM) and discharge (DIS). Overall, the proportion of children/youth making significant progress – prospective family identified, permanent foster care achieved, or youth adopted -- rose by almost 12% from admission to discharge. Some highlights are:

- 7% had achieved Family Reunification as of admission, and an additional 27% achieved it by discharge.
- 6% had achieved permanent foster care as of admission, which rose to 11% by discharge.
- Eight (3%) youth were adopted after entering the program.

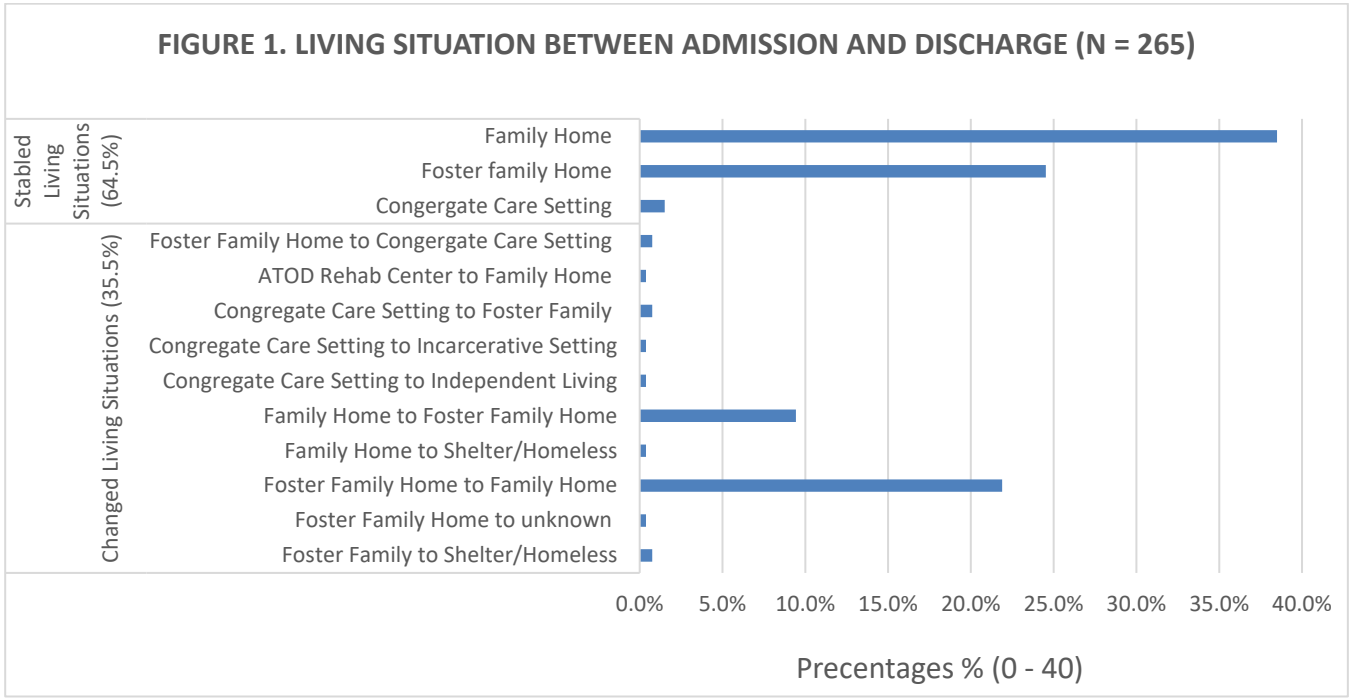


Table 1. Family Reunification from Admission to Discharge

Reunification Achieved by Discharge:	28.3%
Achieved at ADM	3.0%
In Progress at ADM, Achieved by DIS	18.1%
Unknown at ADM, Achieved by DIS	7.2%
Reunification in Progress by Discharge:	29.1%
In Progress at ADM, In Progress by DIS	21.5%
Unknown at ADM, In Progress by DIS	5.7%
Renunciation Achieved, In Progress by DIS	0.4%
Reunification Failed at ADM, In Progress by DIS	1.5%
Reunification Failed by Discharge:	22.3%
In Progress at ADM, Failed by DIS	11.3%
Failed at ADM	4.5%
Unknown by at ADM, Failed by DIS	6.0%

Reunification Achieved at ADM, Failed at DIS	0.4%
Reunification Unknown by Discharge:	20.0%
Unknown at ADM and DIS	9.1%
In Progress at ADM, Unknown by DIS	7.2%
Reunification Achieved at ADM, Unknown by DIS	1.5%
Reunification Failed at ADM, Unknown by DIS	2.3%

- Clinicians record their perspectives ("Yes" or "No") about whether each among ten different caregiver challenges "impact the child's well-being, mental health treatment and/or prognoses". The proportions with caregiver challenges (during six months prior to each report) are in Table 3 below.

- Overall, the reductions across these challenges, especially the marked reductions regarding four areas, are very heartening: the proportions reduced from 61% for CPS, 11% for Domestic Violence, 11% for Substance Abuse, and 8% Poor Parenting Skills.

Table 3. Caregiver Challenges

Challenges	Challenge Free "No" at ADM "No" at DIS	Improving "Yes" at ADM "No" at DIS	Continued Challenge "Yes" at ADM "Yes" at DIS	Worsening "NO" at ADM "YES" at DIS
CPS Reports	28.2%	60.6%	10.6%	1.9%
Criminal Activity	99.5%	0.5%	0.0%	1.1%
Domestic Violence	86.8%	10.5%	1.1%	3.2%
Mental Illness	93.7%	2.1%	1.6%	3.7%
Physical Illness	98.4%	0.5%	0.0%	2.1%
Substance Abuse	82.0%	11.0%	2.0%	6.0%
Loss and Grief	99.5%	0.0%	0.0%	0.5%
Poor Parenting Skills	79.5%	7.6%	5.2%	8.6%
Tx Non Compliance	93.7%	1.1%	0.5%	5.8%
Poverty	100.0%	0.0%	0.0%	0.0%

Note: On average there were 184 - 216 responses per challenge

Child Adolescent Needs & Strengths (CANS-50) Analyses

The CANS-50 child functioning assessment was implemented by the program January 2018. The following analyses are based on matched record sets of N=117 clients (15% sample) with at least 2 records who were served in the FY: an admit and a discharge (or far along in treatment) record as of the end of June 2020.

- CANS-50 ratings are numeric, i.e., 0 = No evidence; 1 = History, mild, suspicion; 2 = Moderate, action needed; 3 = Severe, disabling, dangerous, immediate action needed. Ratings of "2" or "3" are "Actionable" and indicate a need for clinical intervention. Ratings of "0" or "1" are "Non-Actionable", although new information or watchful waiting may be shift that. Generally, it is desirable to have lower ratings (less difficulties, less frequent symptoms, more strengths to build upon) and smaller proportions with 2+ ratings.

- Figure 2 below are the proportions of clients who transitioned from being "Actionable" to "Non-Actionable ("Treatment effect") or vice versa ("Worsening") or maintained stability by either staying "Actionable" ("No Change") or staying "Non-Actionable" ("Prevention") from first to last available record, for each analyzed item. Asterisks * indicate the treatment effect was significant (McNemar test). Data is only reported on CANS items with an average population score of 0.25 or more at intake (at least some prevalence apparent in the population).

- Highlights are that among Child Behavioral/Emotional Needs items, 5/6 (83%) showed significant treatment effects: Impulsivity, Depression, Anxiety, Anger and Trauma. Among Life Functioning items, 7/9 (78%) showed a significant treatment effect: Family Functioning, Living Situation, Social Functioning, Decision-Making, School Behavior, School Attendance, and Sleep. Among Risk Behaviors, the item (1/3 analyzed, or 33%), "Danger to Other" showed a significant treatment effect. And, 2/9 (22%) Caregiver Needs and Strengths items demonstrating a statistically significant treatment effect: Family Strengths, and Natural Supports.

- Please note: there is limited available data. Improved data collection/submission is needed to be fully confident in the pattern of results described.

CANS Results (N=141 Matched Pairs; on average 160 – 163 answers were given per item)

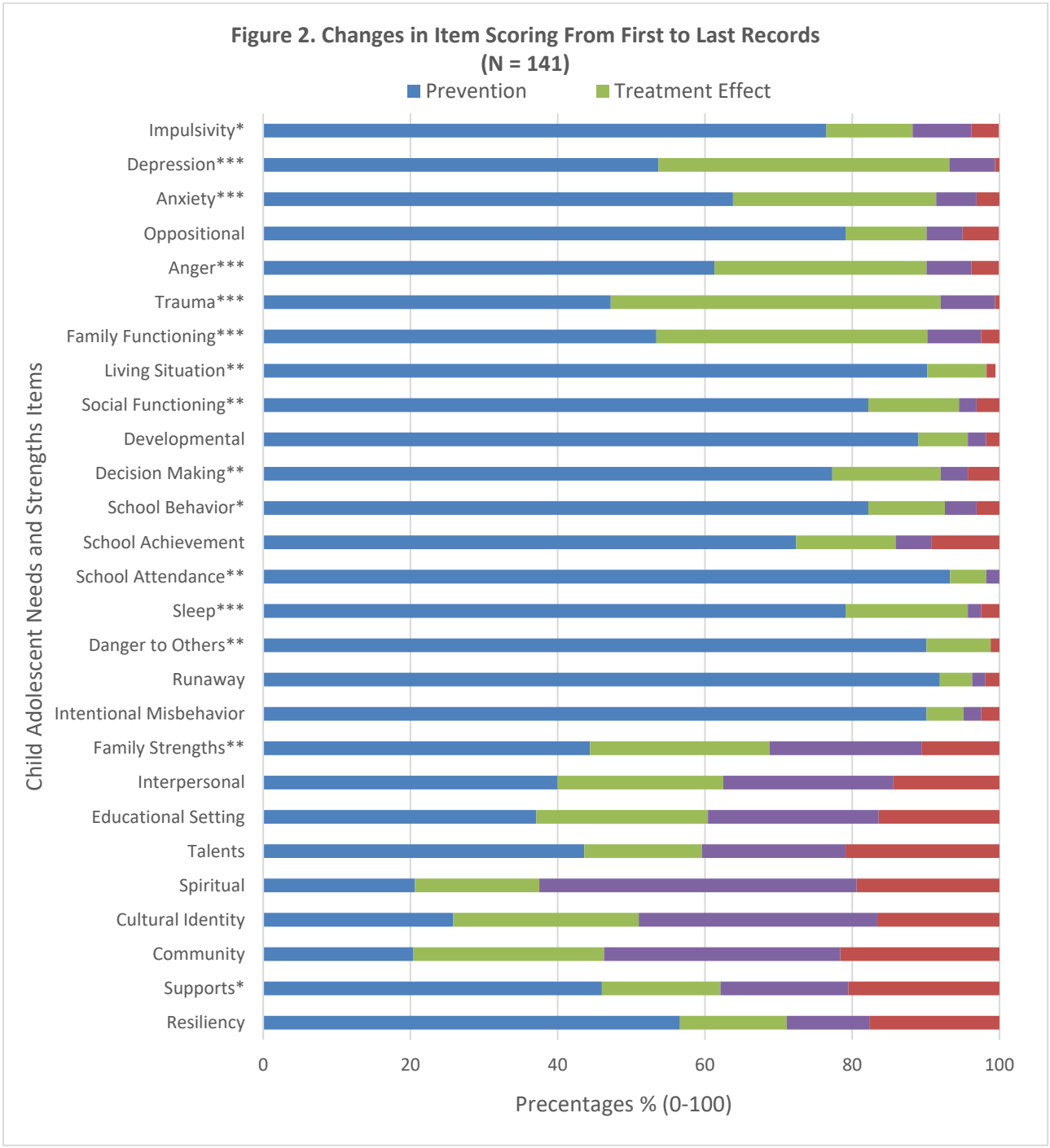


Figure 2. Changes in Item Scoring From First to Last Records
(N = 141)
Prevention
Treatment Effect
Child Adolescent Needs and Strengths Items
Impulsivity*
Depression***
Anxiety***
Oppositional
Anger***
Trauma***
Family Functioning***
Living Situation**
Social Functioning**
Developmental
Decision Making**
School Behavior*
School Achievement
School Attendance**
Sleep***
Danger to Others**
Runaway
Intentional Misbehavior
Family Strengths**
Interpersonal
Educational Setting
Talents
Spiritual
Cultural Identity
Community
Supports*
Resiliency
0
20
40
60
80
100
Precentages % (0-100)

Pediatric Symptom Checklist (PSC-35) Analyses

The PSC-35 consists of 35 items which are the caregiver's ratings about their child's behaviors, and it distinguishes between children aged 4–5 yrs. and 6–18 yrs., with the latter having higher cutoff scores to indicate psychological impairment. The PSC was newly implemented last year, and the initial study sample is of N=114 unduplicated clients (15% sample) aged 6-18 served during the FY 19–20 with at least 2 records. There was no data for children ages 4–5 yrs. for any analysis.

- PSC-35 ratings are numeric, i.e. 0 = Never; 1 = Sometimes, and 2 = Often, with lower ratings being desirable. For each client, a total score is computed by adding the scores of the 35 items. No more than 4 items can be missing per client. For clients aged 6 – 18, a total score greater than 28 indicates psychological impairment (see Table 4).

- Additionally, scores for 3 distinct domains are computed: "Internalizing Problems" (sum of items 11,13,19, 22, and 27; cutoff of 5 or above for impairment), "Attention Problems" (sum of items 4, 7-9, and 14; cutoff of 7 or above for impairment), and "Externalizing Problems" (sum of items 16,29, and 31-35; cutoff of 7 or above for impairment).

- Notably, 2 of the 3 subscales as well as the total score showed desirable significant reductions from first to last records. In Table 5, p values highlighted in yellow indicate statistically significant reductions from first to last record (Paired Means T-test).

- Please note: there is limited available data. Improved data collection/submission is needed to be fully confident in the pattern of results described.

PSC-35 Results (N=73 Matched Pairs)

Table 4. PSC - 35 Items Means Pair T-Test Pre and Post

	Pre		Post			
PSC - 35 Items	Mean	SD	Mean	SD	Change in Mean score	P-value
1. Complains of aches/pains	0.28	0.52	0.34	0.55	-0.05	0.380
2. Spends more time alone	0.71	0.72	0.53	0.68	0.17	0.027
3. Tires easily, has little energy	0.31	0.57	0.27	0.54	0.04	0.524
4. Fidgety, unable to sit still	0.90	0.82	0.68	0.76	0.22	0.006
5. Has trouble with a teacher	0.40	0.63	0.45	0.61	-0.05	0.401
6. Less interested in school	0.40	0.62	0.48	0.71	-0.08	0.271
7. Acts as if driven by a motor	0.57	0.74	0.53	0.74	0.04	0.581
8. Daydreams too much	0.48	0.68	0.45	0.64	0.04	0.610
9. Distracted easily	0.91	0.79	0.95	0.79	-0.05	0.501
10. Is afraid of new situations	0.62	0.66	0.48	0.66	0.14	0.052
11. Feels sad, unhappy	0.79	0.63	0.48	0.59	0.31	0.000
12. Is irritable, angry	0.84	0.76	0.73	0.70	0.11	0.140
13. Feels hopeless	0.38	0.61	0.22	0.47	0.16	0.012
14. Has trouble concentrating	0.72	0.72	0.76	0.74	-0.05	0.492
15. Less interest in friends	0.28	0.54	0.14	0.35	0.14	0.009
16. Fights with others	0.67	0.73	0.50	0.65	0.17	0.021
17. Absent from school	0.28	0.54	0.09	0.32	0.19	0.000
18. School grades dropping	0.47	0.66	0.38	0.67	0.11	0.132
19. Is down on him or herself	0.40	0.66	0.31	0.54	0.08	0.271
20. Visits doctor, finding nothing wrong	0.19	0.51	0.08	0.34	0.12	0.019
21. Has trouble sleeping	0.50	0.74	0.34	0.58	0.15	0.045
22. Worries a lot	0.54	0.68	0.48	0.60	0.06	0.354
23. Wants to be with you more than before	0.59	0.72	0.54	0.68	0.05	0.475
24. Feels he or she is bad	0.28	0.51	0.24	0.51	0.05	0.345
25. Takes unnecessary risks	0.36	0.60	0.33	0.60	0.03	0.629
26. Gets hurt frequently	0.28	0.59	0.25	0.56	0.03	0.639
27. Seems to be having less fun	0.30	0.54	0.14	0.43	0.15	0.014
28. Acts younger than children his or her age	0.49	0.71	0.45	0.67	0.04	0.617
29. Does not listen to rules	0.92	0.77	0.71	0.72	0.21	0.011
30. Does not show feelings	0.72	0.72	0.38	0.60	0.33	0.000
31. Does not understand other's feelings	0.60	0.69	0.42	0.60	0.18	0.012
32. Teases others	0.71	0.76	0.53	0.65	0.18	0.012
33. Blames others for his or her troubles	0.69	0.71	0.58	0.73	0.11	0.108

34. Takes things that do not belong self	0.47	0.69	0.38	0.64	0.08	0.167
35. Refuses to share	0.44	0.66	0.42	0.63	0.02	0.746

Note: 114 answered ALL items; on average there were 129-131 clients' answer each item; Standard Deviation (SD);
Yellow highlights indicate the difference from pre to post as statistically significant at the P > .05, .01, or .001

Table 5. Sub Scale Pre and Post Means Pair T-Test

	Pre		Post			
	Mean	SD	Mean	SD	Change in Mean score	P-value
Attention	3.55	2.69	3.34	2.85	0.21	0.448
Internalizing	2.40	2.36	1.63	1.89	0.78	0.002
Externalizing	4.50	3.84	3.64	3.23	0.85	0.004

Yellow highlights indicate the difference from pre to post as statistically significant at the P > .01

Behavioral & Symptom Identification Scale (BASIS-24) Analyses:

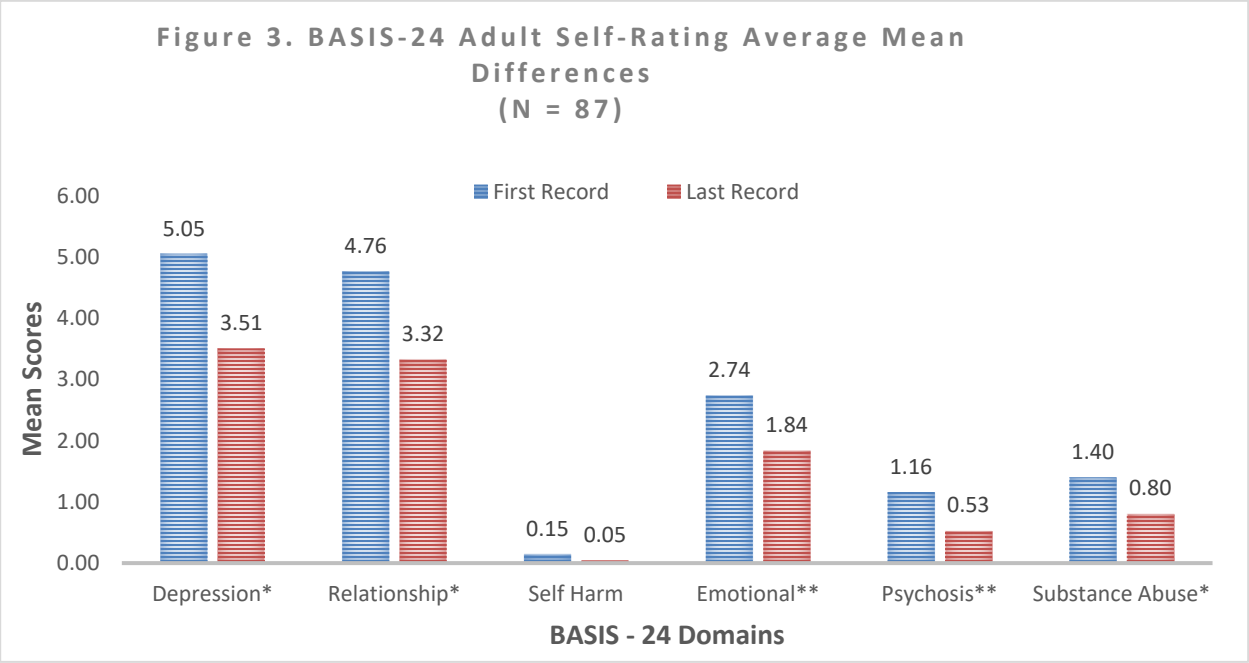
BASIS-24 data represent adult self-ratings among those adults enrolled in their own mental health treatment. For a comprehensive and in-depth look of BASIS-24 improvements, we present results for the time period of program inception to date, and some highlights of BASIS-24 results from the last 6 months or from admission to discharge. Clients with 1 or more missing were deleted. Results for the recent six-month period are covered in detail in the companion report to the Child Welfare department.

- BASIS-24 rating scales are numeric, i.e., 0 = "No difficulty" to 4 = "Extreme difficulty" and lower ratings are desirable. Additionally, scores for 6 distinct domains can be computed:" Depression/Functioning, "Interpersonal Relationships", "Psychosis", "Alcohol/Drug Use", "Self-Harm", and "Emotional Lability". Thus, reduction of score is the desirable outcome for the BASIS-24.

- The following Figure 3 presents results for N= 87 clients (25% sample) with matched first to last records. A number of the domains were statistically significant (see Figure 1 below). For example, reductions are seen in 4/6 of the domains: "Depression/Functioning", "Psychosis", "Alcohol/Drug Use", and "Emotional Lability". An asterisks in the graph below indicate a significant difference from first to last records (P<.05, .01).

- Please note: there is limited available data. Improved data collection/submission is needed to be fully confident in the pattern of results described.

BASIS -24 Adult Self-Rating Average Mean Differences between First and Last Record



- Results for the last six months (January 1, 2020 to June 31, 2020) are available for 28 unduplicated clients with matched first to last record sets. For this smaller sample there were not statistically significant findings.

SBHG EHR Discharge Status Form

The following snapshots are from recordings in the SBHG EHR documenting statuses at discharge of persons leaving services during the FY. The form was newly implemented this past year; thus, the counts do not reflect all discharges (however, they are solid samples). Statuses for children, youth and their families are presented first, followed by those for adults who enrolled in their own mental health treatment services.

CHILDREN & YOUTH

Table 6. Discharge Reason

	Counts	Percent
Client/Caregiver Refused Services	47	11.8%
No Longer Meet Eligibility	11	2.8%
Other (e.g., No Contact, Transfers)	85	21.3%
Client/Family Completed Program	187	46.9%
Moved Out of Area	19	4.8%
Services discontinue by Authorizing Entity	50	12.5%
Total	399	100.0%

- If ineligible, moved out of area, and administratively discontinued services are removed from the denominator (discharge reasons not under the program's control), the adjusted percent completing the program is 187/(399-80) = 59%.

Table 7. Discharge Circumstances

	Counts	Percent
Left Against Medical Advice	43	10.8%
Need Higher Level of Care	1	0.3%
DC Related to Family Unavailability	28	7.0%
Medical Hospitalization	2	0.5%
Psychiatric hospitalization	0	0.0%
Incarceration	1	0.3%
Client Deceased	0	0.0%
Varied Other Reasons	282	70.7%
Total	282	89.5%

*Note: does not sum to 100%

Table 8. Discharged Living Situation

	Counts	Percent
Independent Living	3	0.8%
Family Home	222	55.6%
Foster Family Home	133	33.3%
Shelter, Temporary Housing, Homeless	3	0.8%
Congregate Care Settings	4	1.0%
Tx/Incarcerative Settings	9	2.3%
Unknown	25	6.3%
Total	399	100%

Table 9. Children's Treatment Progress

	Counts	Percent
All or Most Treatment Goals Met	181	45.4%
Some Treatment Goals Met	65	16.3%
Few or No Treatment Goals Met	111	27.8%
pplicable (Client Exited before Assessment Completed)	42	10.5%
Total	399	100.0%

Table 10. Types of Post Discharge Bx Health Referrals & Linkages

	Count	Percent
1) General outpatient services	131	32.8%
2) Psychiatric services, incl. medication supports	6	1.5%
3) Intensive outpatient treatment programs	0	0.0%
4) Outpatient or residential substance abuse treatment	1	0.3%
5) Hospital, institutional or incarcerative settings	1	0.3%
6) Other behavioral healthcare services	30	7.5%
Total	169	42.4%

*Does not sum to 100%

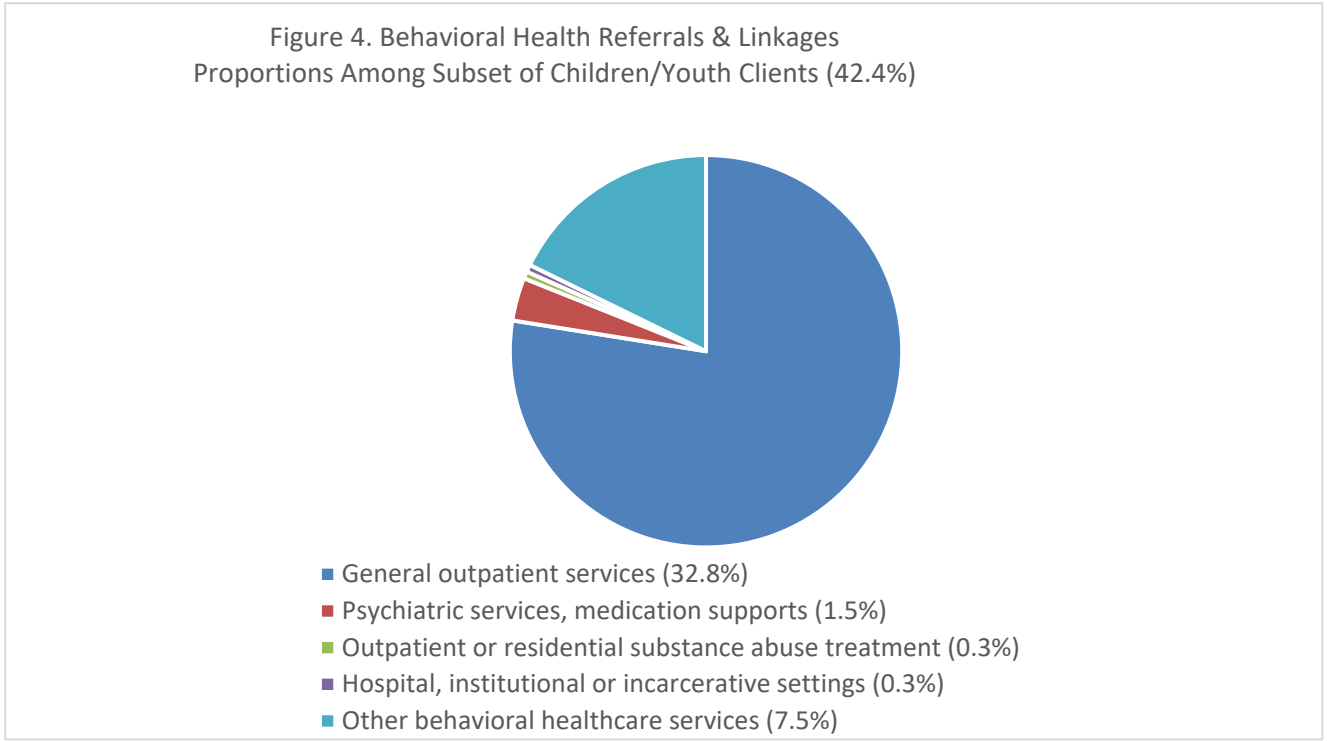
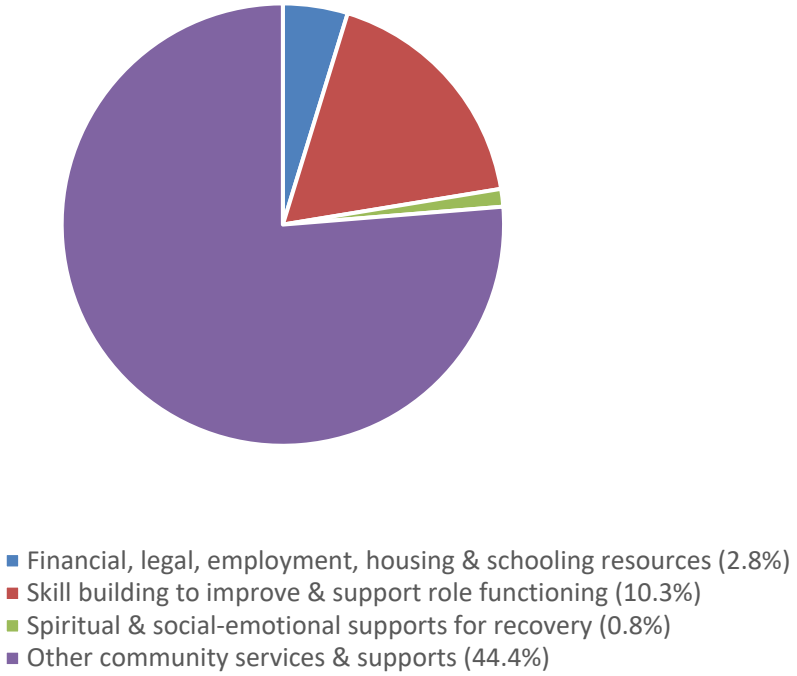


Figure 5. Referrals and linkages to Community Services & Support Proportions Among Subset of Children/Youth Clients (51%)



ADULT MENTAL HEALTH CLIENTS

Table 11. Discharge Reason

	Counts	Percent
Client/Caregiver Refused Services	28	15.3%
No Longer Meet Eligibility	5	2.7%
Other (e.g., No Contact, Transfers)	53	29.0%
Client/Family Completed Program	71	38.8%

Moved Out of Area	2	1.1%
Services Discontinued by Authorizing Entity	24	13.1%
Total	183	100.0%

- If ineligible, moved out of area, and administratively discontinued services are removed from the denominator (discharge reasons not under the program's control), the adjusted percent completing the program is 71/(183-31) = 47%.

Table 12. Discharge Circumstances

	Counts	Percent
Left Against Medical Advice	17	9.3%
Need Higher Level of Care	0	0.0%
DC Related to Family Unavailability	24	13.1%
Medical Hospitalization	1	0.5%
Psychiatric Hospitalization	0	0.0%
Incarceration	2	1.1%
Client Deceased	0	0.0%
Varied Other Reasons	122	66.7%
Total	166	90.7%

*Note: does not sum to 100%

Table 13. Discharged Living Situation

	Counts	Percent
Independent Living	46	25.1%
Family Home	90	49.2%
Foster Family Home	3	1.6%
Shelter, Temporary Housing, Homeless	7	3.8%
Congregate Care Settings	6	3.3%
Tx/Incarcerative Settings	8	4.4%
Unknown	23	12.6%
Total	183	100.0%

Table 14. Adult Treatment Progress

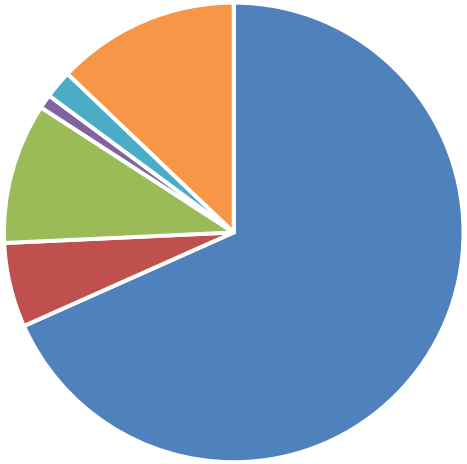
	Counts	Percent
All or Most Treatment Goals Met	72	39.3%
Some Treatment Goals Met	16	8.7%
Few or No Treatment Goals Met	58	31.7%
Not Applicable (Client Exited before Assessment Completed)	37	20.2%
Total	183	100.0%

Table 15. Types of Post Discharge Bx Health Referrals & Linkages

	Count	Percent
1) General outpatient services	39	21.3%
2) Psychiatric services, incl. medication supports	4	2.2%
3) Intensive outpatient treatment programs	0	0.0%
4) Outpatient or residential substance abuse treatment	1	0.5%
5) Hospital, institutional or incarcerative settings	0	0.0%
6) Other behavioral healthcare services	25	13.7%
Total	69	37.7%

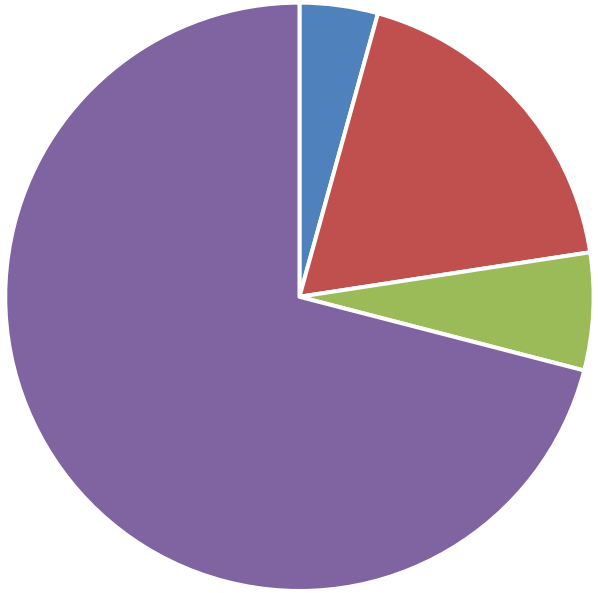
*Does not sum to 100%

Figure 6. Behavioral Health Referrals & Linkages
Proportions Among Subset of Adult Clients (37.7%)



- General outpatient services (51.1%)
- Psychiatric services, medication supports (4.4%)
- Intensive outpatient treatment programs (7.4%)
- Outpatient or residential substance abuse treatment (0.7%)
- Hospital, institutional or incarcerative settings (1.5%)
- Other behavioral healthcare services (9.6%)

Figure 7. Referrals and Linkages to Community Services & Supports Proportions Among Subset (94.8%)



- Financial, legal, employment, housing & schooling resources (2.2%)
- Skill building to improve & support role functioning (9.3%)
- Spiritual & social-emotional supports for recovery (3.3%)
- Other community services & supports (36.1%)

EFFICIENCY

Tables 16 and 17 below array utilization statistics, central tendencies per client by service population (child/youth and adults separately) among those with a completed episode of care during the FY, for their entire enrollment period (enrollment may have preceded the fiscal year and extended into it).

Table 16. Utilization Central Tendencies for Discharge Child/Youth Clients FY19-20

Service Type	Clients	Average Minutes	Median Minutes	SD	Range
Care Plans & Updates	389	43	31	48	0 - 466
Case Management	341	314	118	593	0 - 6010
Collateral	188	208	83	346	0 - 2516
Crisis Intervention	4	99	110	53	27 - 150
Family Therapy & Rehab	74	755	194	1199	0 - 6748
Group Therapy & Rehab	2	32	32	18	19 - 45
Individual Therapy & Rehab	284	504	763	763	0 - 6495
No Contact	432	1	0	8	0 - 117
Other, Varied	443	28	28	21	0 - 211
Psychiatric & Nursing Services	490	26	0	109	0 - 1330
Screenings, Assessments & Intake	509	80	0	115	0 - 1154

Notes: N = 510, Standard Deviation (SD)

Table 17. Utilization Central Tendencies for Discharged Adult Clients FY 19-20

Service Type	Clients	Average Minutes	Median Minutes	SD	Range
Care Plans & Updates	159	27	27	21	0 - 166
Case Management	120	104	55	156	0 - 1176
Collateral	2	120	120	74	67 - 172
Crisis Intervention	2	31	31	44	0 - 62
Family Therapy & Rehab	3	226	147	280	0 - 610
Group Therapy & Rehab	2	30	30	42	0 - 59
Individual Therapy & Rehab	127	394	200	519	0 - 3606
No Contact	204	2	0	6	0 - 50
Other, Varied	186	25	20	17	0 - 121
Psychiatric & Nursing Services	197	19	0	87	0 - 772
Screenings, Assessments & Intake	209	72	0	108	0 - 1260

Notes: N = 209, Standard Deviation (SD)

- Additionally, nearly every child/youth and adult client had at least one "No Contact" note, not included in the tables above, meaning an appointment was cancelled, missed or rescheduled.

- Please note that Psychiatry and Medication Services in the table includes Psychiatric Referral (screening) and Psychiatric Evaluations (assessments), not just Medication Services. Subsets of N=59 children and N=15 adults received Medication Services. The team's capacity to screen/refer and the doctor's capacity to conduct evaluations and to properly focus medication services on those in need is a constructive, efficient capacity of the overall program.

- The program also provides Psychological Testing services for referred persons, whom are not otherwise enrolled in the community services program during the year (N = 5 child/youth; N = 4 = adult).

- Most of the total volume of community services, whether child/family (71%) or adult (74%) enrollments, involve direct contact with clients/caregivers (distinct from time involved with transportation, documentation, reporting, etc.).

- The average span of treatment (enrollment to discharge date) among N=399 closed child/youth cases was 297 days (median = 245). For N=183 discharged adult clients, the average was 196 days (median = 179). These central tendencies are similar to the prior year.

- While primarily relevant to access, services are provided where the client is located or wants to be served, which also makes services efficient from the client/caregiver perspective. Staff try to balance field work with encouraging children, youth and families to come to one of two service sites available to the community for these services – on Fresno St. (oversees 64% of services administered), and Shaw Ave (36%). Service contacts provided in the field and at these sites can help counter the social isolation that often impacts child welfare families. This last year the teams took great measures to provide services continuously during the onset of the COVID-19 by offering on-line telehealth sessions and taking active steps to see clients/families at offices or in the field when safe to do so.

SATISFACTION

During the fall 2019 survey cycle, a majority (93%) of caregiver respondents endorsed the program. Caregiver responses to survey items are shown below on Figure 8.

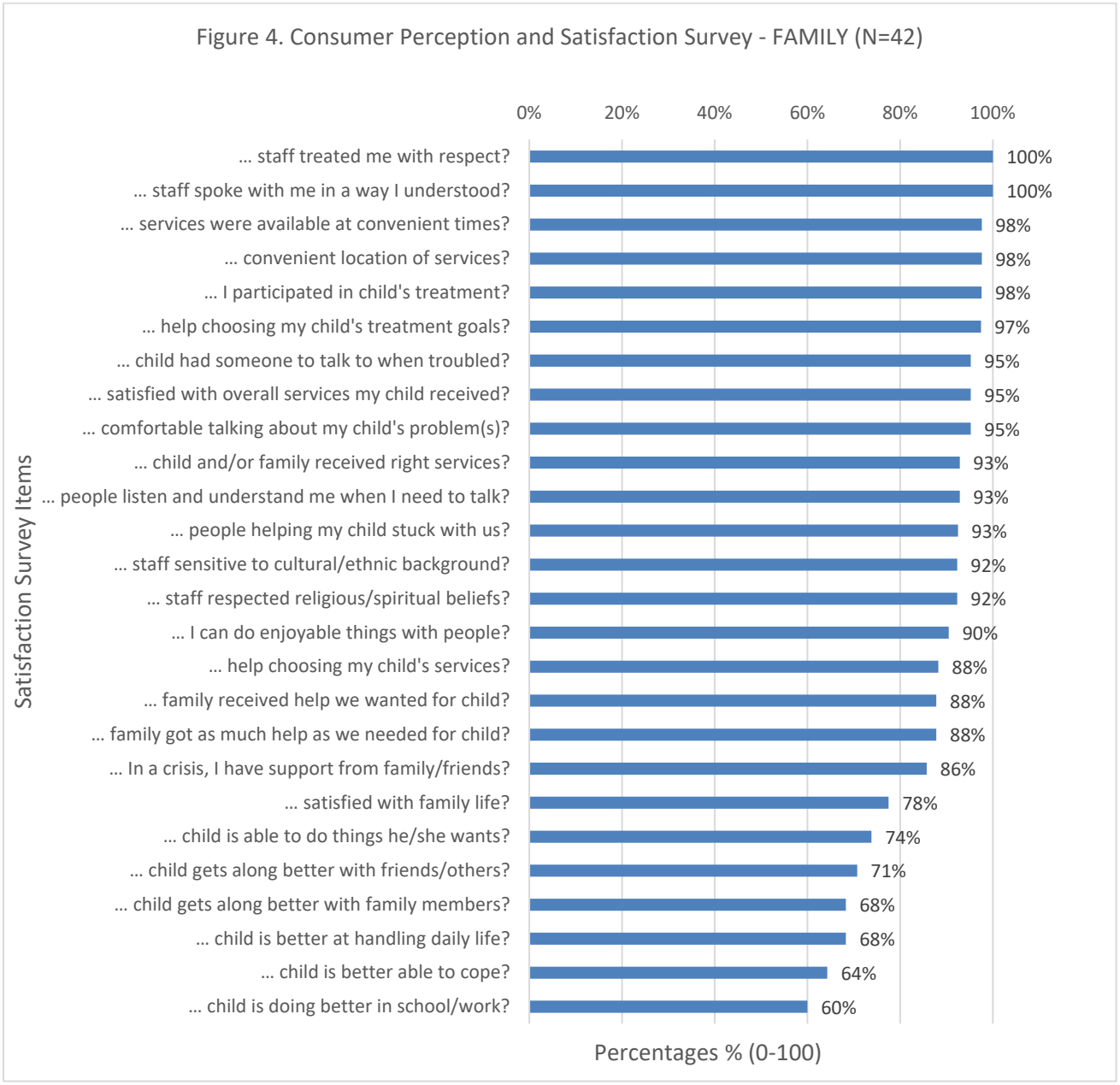


Figure 4. Consumer Perception and Satisfaction Survey - FAMILY (N=42)
0%
20%
40%
60%
80%
100%
Satisfaction Survey Items
... staff treated me with respect? 100%
... staff spoke with me in a way I understood? 100%
... services were available at convenient times? 98%
... convenient location of services? 98%
... I participated in child's treatment? 98%
... help choosing my child's treatment goals? 97%
... child had someone to talk to when troubled? 95%
... satisfied with overall services my child received? 95%
... comfortable talking about my child's problem(s)? 95%
... child and/or family received right services? 93%
... people listen and understand me when I need to talk? 93%
... people helping my child stuck with us? 93%
... staff sensitive to cultural/ethnic background? 92%
... staff respected religious/spiritual beliefs? 92%
... I can do enjoyable things with people? 90%
... help choosing my child's services? 88%
... family received help we wanted for child? 88%
... family got as much help as we needed for child? 88%
... In a crisis, I have support from family/friends? 86%
... satisfied with family life? 78%
... child is able to do things he/she wants? 74%
... child gets along better with friends/others? 71%
... child gets along better with family members? 68%
... child is better at handling daily life? 68%
... child is better able to cope? 64%
... child is doing better in school/work? 60%
Percentages % (0-100)

- The items falling below company benchmark (85% or better results expected) pertain to perception of family dynamics and outcomes; they were reviewed for quality improvement at the time. Note that MHSIPs are cross-sectional surveys and clients may be at any point, including early on, in treatment. Thus, these surveys are of limited utility for assessing treatment outcomes and are better attuned to gauging satisfaction and perceptions about current progress.
- A small sampling of comments:
    - Caregiver of Anglo/Native American female adolescent – "Someone to discuss concerns with. My child had someone they felt comfortable talking with (Karina Health providers)."
    - Caregiver of Other/Mixed male young child – "A lot of communication, they help in all areas, and wait until everything is ok."
    - Caregiver of female, Latinx child – "Being able to help my child achieve her milestones and better understands her needs."
    - Female youth, Other/Mixed – "The most helpful thing about the services I received is my coping skills."
    - Male youth, Other/Mixed — "have been able to communicate about problems and learned new information."
    - Adult client, female Anglo/Latinx – "I enjoyed my time here very much. The ladies at the front desk are polite and helped. I learned a lot during my time here and am grateful for having to come here in the first place."

DEPARTMENT RECOMMENDATION(S):