PROGRAM INFORMATION:

Program Title: Community Services Program

Provider: Central Star Behavioral Health

MHP Work Plan: 4-Behavioral health clinical care

Program Description: Outpatient specialty mental health services and court-specific services for children and youth in Fresno County's child welfare services system, and their families.

Age Group Served 1: CHILDREN

Age Group Served 2: ADULT

Funding Source 1: Medical FFP

Funding Source 2: EPSDT

Dates Of Operation: July 29, 2014 - present

Reporting Period: July 1, 2018 - June 30, 2019

Funding Source 3: Other, please specify below

Other Funding: DSS

FISCAL INFORMATION:

Program Budget Amount: $4,000,000.00

Program Actual Amount: $2.987.446.99

Number of Unique Clients Served During Time Period: 1,028

Number of Services Rendered During Time Period: 20,143 services (1,091,969 units of service)

Actual Cost Per Client: $2,906.07

CONTRACT INFORMATION:

Program Type: Contract-Operated

Contract Term: 07/29/2014 – 06/30/2019 (07/29/2014 – 06/30/2017 plus two optional one-year extensions)

Type of Program: Outpatient

For Other:

Renewal Date: 07/01/2019

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 Services 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)

Integrated service experiences

Community collaboration

Cultural Competency

Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services

Access to underserved communities

Please describe how the selected concept (s) embedded :

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/or 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-Based Practices (EBPs), and community best practice standards selected specifically for their attunment to the needs of the service population; and, we employ a 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 specialty mental health services helps to meet the needs of KatieA child welfare/foster care clients whom have been historically unserved, underserved and/or poorly served and we abide by the CAPP and KatieA Core Practice models, as well as Stars Behavioral Health Group (SBHG) standards for collaboration and service integration.

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

NOTE: Reader will see three sections: **Measurement Protocols**; **Synopses** (highlights of outcomes); and **Details** (full details of outcomes).

Measurement Protocols:

Tools	Notes	Data Status
Referral, Intake & Service Utilization, incl. varied screening & assessment tools (e.g., ACES, CSSRS, PHN, SBIRT)*	Data points captured in 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 Business Analytics (BA) Dashboards, that are driven by the EHR 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 18-19 COR, N=212/493 (43%) 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 18-19 DC Status Form, N=216/493 (44%). DC form was newly implemented this 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= 117/493 (24%) CANS-50 and N=73/493 (15%) PSC-35. PSC was newly implemented this year.
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. No data to report so far.
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 18-19 BASIS, 171/290 (59%) matched pairs with both an initial and discharge report. Improved from 34% 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 2018 (N=128 caregivers, 57 adults, 25 youth respondents) and spring 2019 (89 caregivers, 56 adults, 23 youth) cycles. 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).
** Spring 2019 report is delayed while we implement new scanning (OCR) software to increase reporting efficiency in the future.

Synopses:

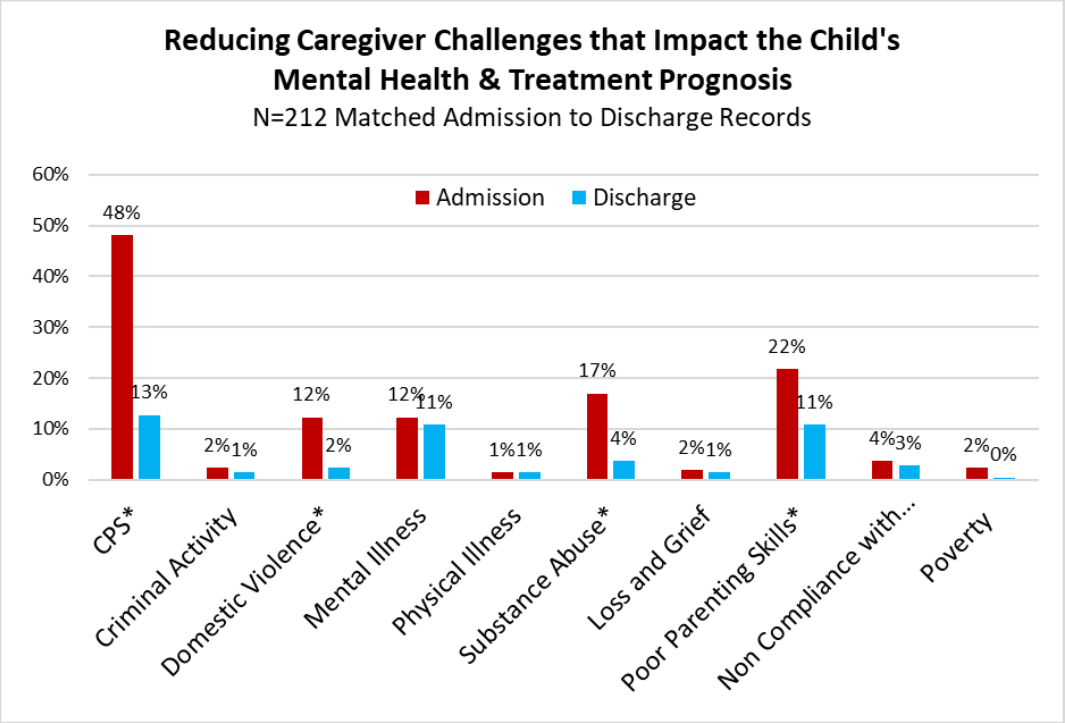
ACCESS

- Among 886 referrals of 718 unduplicated persons during the FY, N=141 (16%) did not enroll in the program – those who did not enrolle were nearly all were child welfare referrals; 78 children/youth and 63 adults. 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=710 (80%) of those referred enrolled in the program, and 35 recent referrals were in pending status at the end of the year. This rate of enrollements vis a vis referrals represents an uptick from 60% last year.
- During the year, the program served N=138 KatieA subclass eligible clients (20% of all children/youth served).
- For all enrolled clients, on average there was 33 days from referral to enrollment, median 25 days; range <1 day to 294 days. Staff 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

- While key schooling indicators – school attendance and achievement -- do not appear to improve per staff's information, they do based on caregiver ratings on relevant items on the Pediatric Symptom Checklist (PSC-35). The variations in results are most likely related to available samples as well as the informant type.
- About 16% of the youth have one or more types of school disciplinary problems at the time of enrollment, this drops to 11% by discharge.
- Overall, the majority of children/youth (88%) either maintained a stable living situation or experienced improvements. For example: close to 30% maintained in a family home and close to 26% maintained their foster placement; and, close to 30% were able to transition from a foster home to a family home.
- Regarding their child welfare planning tracts, 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. N=8 (3%) of youth were adopted after entering the program. 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. A good amount of detail regarding such child welfare results is provided on Form C.
- 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

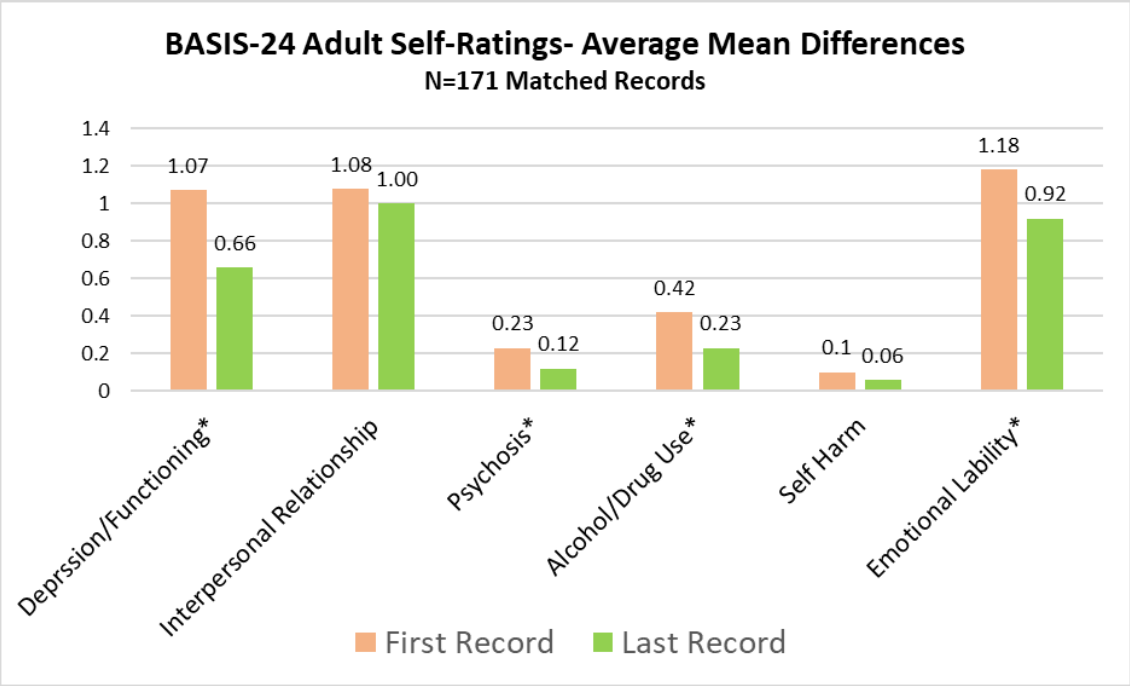
months prior to each report) are graphed below. Overall, the reductions across these challenges, especially the marked reductions regarding four areas, are very heartening: the proportions reduced from 48% to 13% for CPS, from 12% to 2% for Domestic Violence, from 17% to 4% for Substance Abuse, and from 22% to 11% for Poor Parenting Skills.



*Asterisks indicate statistically significant reductions in the proportions with challenge.

- Highlights from analyses of matched (enrollment to discharge) Child Adolescent Needs & Strength (CANS) records are that among Child Behavioral/Emotional Needs items, 4/8 (50%) showed significant treatment effects: Depression, Anxiety, Oppositional and Adjustment to Trauma. Among Life Functioning items, 3/9 (33%) showed a significant treatment effect: Family Functioning, Decision-Making, and Sleep. Among Risk Behaviors, the item (1/2 analyzed, or 50%), “Intentional Misbehavior” 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. We apply stringent criteria to defining and testing for treatment effects – details are graphed on Form C.

- On the Pediatric Symptom Checklist (PSC-35), many items, all 3 subscales (internalizing, externalizing and attention-deficity) and the total score showed desirable significant reductions from first to last records.
- The following graph presents results for N= 171 adult clients with matched first to last Behavior and Symptom Identifcation Scale (BASIS) records. A number of statistically significant results shine through. 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.



- Much information is provided on Form C in easy to read tables from the program’s first use, tool implemented this year, of a new Discharge Status Form in SBHG EHR. In the available sample of persons discharged , 63% of child/youth clients and 48% of adult clients met all, most or at least some of their mental health treatment goals this past year.
- The team offers referrals and linkages to varied types of aftercare resources, services and supports (listed on Form C – what “see below” references). The percents with varied statuses in this regard are shown below, for child/youth clients and their caregivers:

Post DC Services		
Behavioral Health:	Count	Percent
Client/Family Has No Need for Add'tl Services	107	49.5%
Client/Family Refused Any Post DC Services	24	11.1%
Client/Family Linkages Provided (see below)	85	39.4%
	216	100.0%
Community Resources:	Count	Percent
Client/Family Has No Need for Add'tl Services	84	38.9%
Client/Family Refused Any Post DC Services	30	13.9%
Client/Family Linkages Provided (see below)	102	47.2%
	216	100.0%

EFFICIENCY

- A good mix of varied services and supports are delivered to enrolled children, youth and their families, as well as to the adult clients enrolled in their own mental health treatment. Form C contains details utilization central tendencies (e.g., average UOS by service modality per client).
- Most (79%) of the total volume of community services, whether child/family or adult enrollments, involve direct contact with clients/caregivers (distinct from time involved with transportation, documentation, reporting, etc.). The rate is 65% for medication services; and, 48% for psychological testing.
- The average span of treatment (enrollment to discharge date) among N=493 closed child/youth cases was 293 days (median = 233). For N=290 discharged adult clients, the average was 210 days (median = 198). 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. Service locations for children and families have been at one of the program offices (28%), homes (26%), phone (23%) or other field settings (19%). Adults receiving mental health

treatment were seen at offices (52%), phone (24%), home (10%) or in the field (7%). Staff also see clients at group homes, shelters, treatment centers, hospitals and jails.

SATISFACTION

- During the fall 2018 survey cycle, a majority (91%) of caregiver respondents endorsed the program, as did many youth (84%) and adult clients about their own services (90%). Items falling below the company benchmark (85% or better results expected) pertain to perception of outcomes and are reviewed for quality improvement.
- A small sampling of comments:
- Caregiver of Anglo/Native American female adolescent – "Accurate assessments, helpful tools to use throughout the week and an ability to process behaviors together."
- Caregiver of Anglo/Latinx male young child -- "The most helpful was understanding my child's needs and wants and I feel like my child interacts better with others."
- Caregiver of male, ethnicity unknown, age 7 yrs. – "I have to comment I love what you guys have done to help me out thanks so much."
- Female youth, Latinx, age 16 yrs. -- "Talking about family issues that I didn't want to talk about with other people."
- Adult client, male Anglo/Latinx, age 30 yrs. -- "Central Star is a great program and I would recommend it to anyone.

Details:

Each section starts with a list of contract KPIs for the reporting area: Access, Effectiveness, Efficiency and Satisfaction. These key to a list on Form C, so persons can find the item within the reporting buckets, and thus they may not be in numeric order.

ACCESS

Access KPIs are defined by the program's child welfare stakeholders and there are also new state DHCS timeliness of care standards. CS is working in tandem with SBHG on revising BA dashboards for real time reporting on the new DHCS standards. Meanwhile, the program team tracks referrals to enrollments and other pertinent fields and date/time stamps in the referral module of the EHR – 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 886 referrals of 718 unduplicated persons during the FY, N=141 (16%) did not enroll in the program – nearly all child welfare referrals; 78

children/youth and 63 adults. 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=710* (80%) of those referred enrolled in the program, and 35 recent referrals were in pending status at the end of the year. This rate represents an uptick from 60% last year – leadership communicated about capacity early spring which slowed child welfare referrals during the last months of the year.

- During the year, the program served N=138 KatieA subclass eligible clients (20% of all children/youth served), with each receiving on average 884 units/minutes of Intensive Care Coordination (ICC), median 579 units, across from 1 to 143 discrete service dates. Each also participated on average in 1,205 units/minutes of Intensive In-Home Based Services (IIHBS), median 847 units, across from 1 to 116 service dates (22 service dates on average for each of these two service types).

- For all enrolled clients, on average there was 33 days from referral to enrollment, median 25 days; range <1 day to 294 days. N=86 (14%) enrolled within 10 days (0 thru 9 days) and N=38 (6%) took more than 90 days to enroll. 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.

- Services pick up quickly once a person is enrolled, with their first service contact after intake occurring on the same day, and/or very soon thereafter – average 1.3 days, range same day to 479 days. Overall, 90% participate in their first service within 10 days (0 thru 9 days) of enrollment; with first services focused on additional screenings and assessments or service plan development. The proportionately few outliers were 15 individuals awaiting psychiatric services. 7% of clients had a “No Contact” note documenting a missed/cancelled first appointment after their enrollment date.

  * Note: count is lower than total unduplicated served, as it pertains only to those referred and enrolled during the FY, whereas the total unduplicated served includes those continuing during FY 18-19 who enrolled prior to FY 18-19.

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.

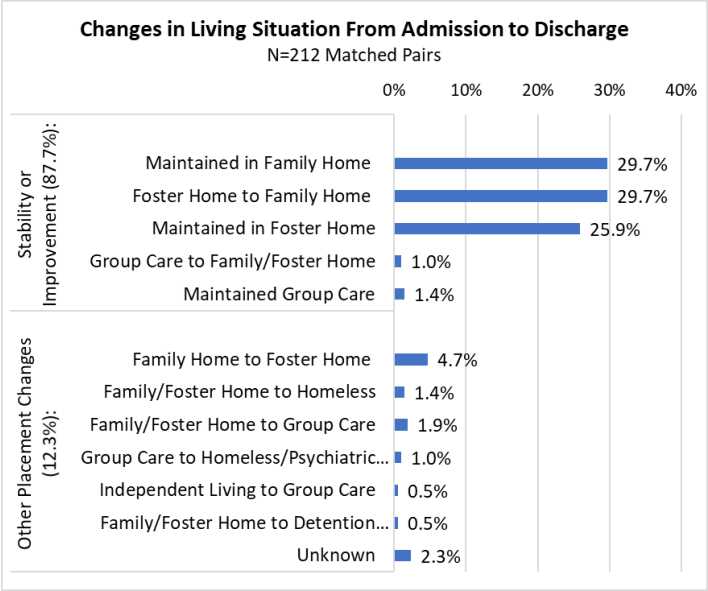
    - Most children and youth attended regular public schools (90%), and this proportion remained stable from enrollment to last record (212 COR Matched Pairs).
    - School attendance -- defined as enrolled in grades 1-12* and regularly attending 4 or more days per week – appears to decline from admission (80%) to discharge (72%). NOTE! Per caregiver's PSC-35 ratings (item #17), school attendance is improving significantly.
    - The proportion of children/youth achieving "C" grades or better also dropped a bit over time (60% → 57%). NOTE! Per caregiver's PSC-35 ratings (item #18), school grades are improving.
    - The average number of disciplinary problems (truancies, suspensions, expulsions, school behavior issues, etc.) declined from 0.19 at admission to 0.13 at discharge, a marginally significant reduction ($t= 1.6$; $p=.10$). About 16% of the youth have one or more problems of these types at the time of enrollment, this drops to 11% 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 in due course – if such are not already improving (per caregivers, they are improving -- see PSC-35 table to follow).

    *There were 184/212 (87%) 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=212 discharged children/youth served during FY 18-19 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 30% maintained in a family home and close to 26% 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, the tables below show the children/youth's status at admission (ADM) and discharge (DIS). 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.
  - N=8 (3%) of youth were adopted after entering the program.
  - 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.

Family Reunification:

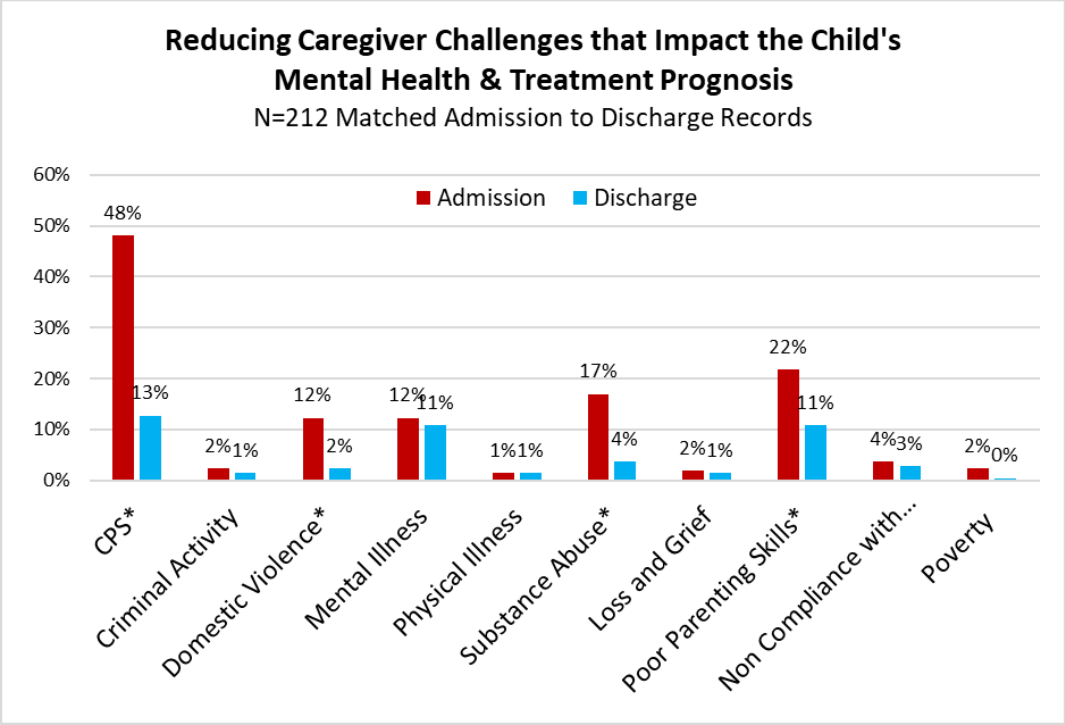
Reunification Achieved by Discharge:	**38.7%**
Achieved at ADM	6.6%
In Progress at ADM, Achieved by DIS	26.9%
Unknown at ADM, Achieved by DIS	5.2%
Reunification In Progress by Discharge:	**20.8%**
In Progress at ADM, In Progress by DIS	17.9%
Unknown at ADM, in Progress by DIS	2.8%
Reunification Failed by Discharge:	**27.4%**
In Progress at ADM, Failed by DIS	16.0%
Failed at ADM	7.5%
Unknown at ADM, Failed by DIS	3.8%
Reunification Unknown by Discharge:	**13.2%**
Unknown at ADM and DIS	7.1%
In Progress at ADM, Unknown by DIS	6.1%

Permanency Planning:

	Admission	Discharge
Prospective family identified/permanent foster care achieved/youth adopted	15.1%	26.9%
In progress	10.4%	7.1%

- 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 the next graph.
    - Overall, the reductions across these challenges, especially the marked reductions regarding four areas, are very heartening: the proportions reduced from 48% to 13% for CPS, from 12%

to 2% for Domestic Violence, from 17% to 4% for Substance Abuse, and from 22% to 11% for Poor Parenting Skills.



*Asterisks indicate statistically significant reductions in the proportions with challenge.

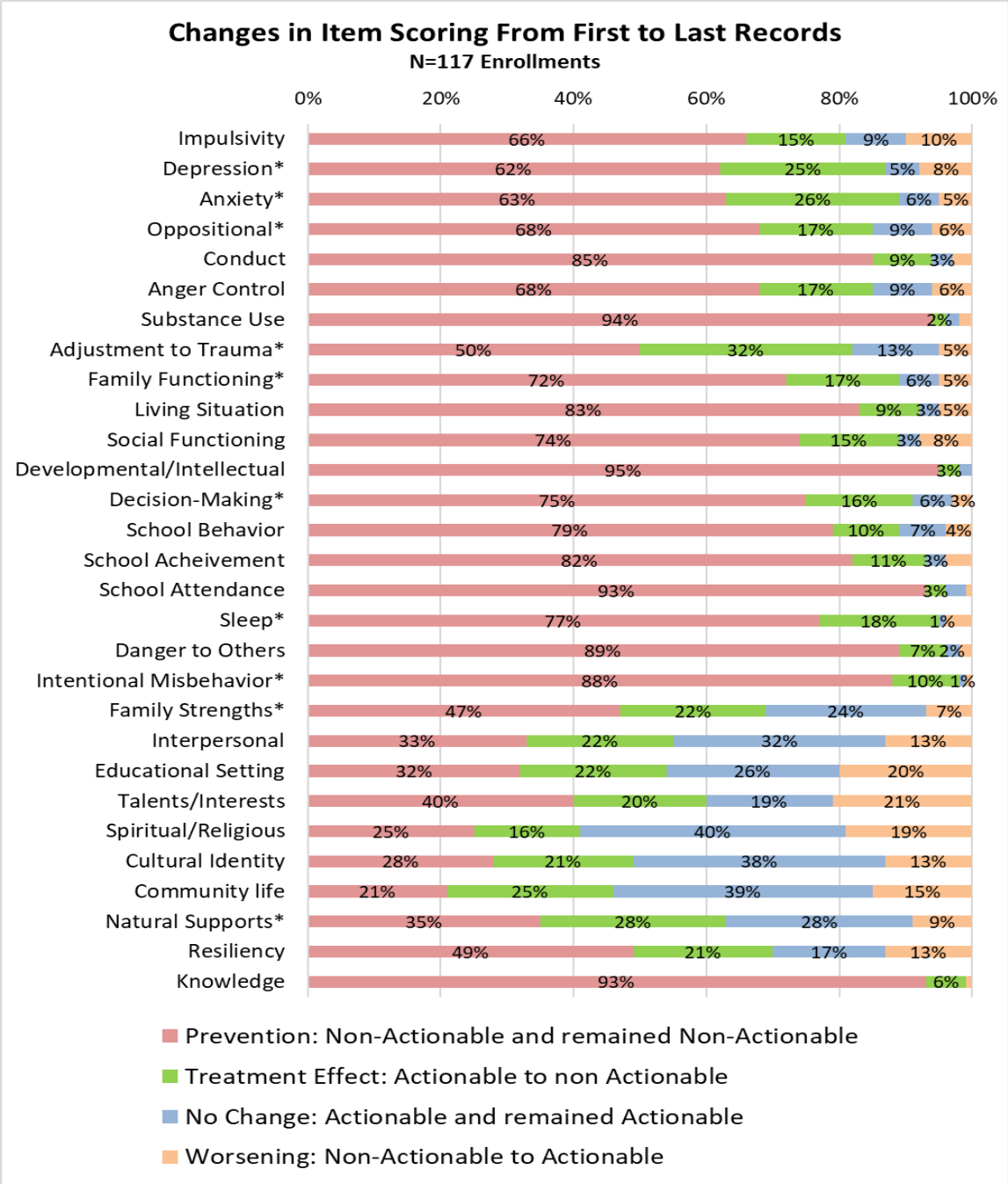
Child Adolescent Needs & Strengths (CANS-50) Analyses

- 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 with at least 2 records: an admit and a discharge (or far along in treatment) from Jan 2018 through Jun 2019.
    - 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.

- Tabled 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, 4/8 (50%) showed significant treatment effects: Depression, Anxiety, Oppositional and Adjustment to Trauma. Among Life Functioning items, 3/9 (33%) showed a significant treatment effect: Family Functioning, Decision-Making, and Sleep. Among Risk Behaviors, the item (1/2 analyzed, or 50%), "Intentional Misbehavior" 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.

CANS Results (N=117 Matched Pairs)


Changes in Item Scoring From First to Last Records
N=117 Enrollments
0%
20%
40%
60%
80%
100%
Impulsivity 66% 15% 9% 10%
Depression* 62% 25% 5% 8%
Anxiety* 63% 26% 6% 5%
Oppositional* 68% 17% 9% 6%
Conduct 85% 9% 3%
Anger Control 68% 17% 9% 6%
Substance Use 94% 2%
Adjustment to Trauma* 50% 32% 13% 5%
Family Functioning* 72% 17% 6% 5%
Living Situation 83% 9% 3% 5%
Social Functioning 74% 15% 3% 8%
Developmental/Intellectual 95% 3%
Decision-Making* 75% 16% 6% 3%
School Behavior 79% 10% 7% 4%
School Acheivement 82% 11% 3%
School Attendance 93% 3%
Sleep* 77% 18% 1%
Danger to Others 89% 7% 2%
Intentional Misbehavior* 88% 10% 1%
Family Strengths* 47% 22% 24% 7%
Interpersonal 33% 22% 32% 13%
Educational Setting 32% 22% 26% 20%
Talents/Interests 40% 20% 19% 21%
Spiritual/Religious 25% 16% 40% 19%
Cultural Identity 28% 21% 38% 13%
Community life 21% 25% 39% 15%
Natural Supports* 35% 28% 28% 9%
Resiliency 49% 21% 17% 13%
Knowledge 93% 6%
Prevention: Non-Actionable and remained Non-Actionable
Treatment Effect: Actionable to non Actionable
No Change: Actionable and remained Actionable
Worsening: Non-Actionable to Actionable

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 this year, and the initial study sample is of N=73 unduplicated clients aged 6-18 served during the FY with at least 2 records. The sample for children ages 4-5 yrs. was too small for 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. For clients aged 6-18, a total score greater than 28 indicates psychological impairment.
    - Additionally, scores for 3 distinct domains are computed: "Internalizing Problems" (sum of items 11,13,19, 22, and 27), "Attention Problems" (sum of items 4, 7-9, and 14), and "Externalizing Problems" (sum of items 16,29, and 31-35).
    - Notably, all 3 subscales as well as the total score showed desirable significant reductions from first to last records. In the table, p values highlighted in green indicate statistically significant reductions from first to last record (McNemar test).

PSC-35 Results (N=73 Matched Pairs)

Item/Subscale	Average (ADM or 1st Update)	Average (Later Update or Discharge)	P<.05	Avg Pre to Post Reduction
1. Complains of aches/pains	0.48	0.45	0.70	-6%
2. Spends more time alone	0.67	0.48	0.07	-28%
3. Tires easily, has little energy	0.44	0.29	0.11	-34%
4. Fidgety, unable to sit still	0.85	0.58	0.01	-32%
5. Has trouble with a teacher	0.59	0.40	0.04	-32%
6. Less interested in school	0.56	0.34	0.01	-39%
7. Acts as if driven by a motor	0.67	0.51	0.12	-24%
8. Daydreams too much	0.54	0.32	0.02	-41%
9. Distracted easily	1.07	0.78	0.01	-27%
10. Is afraid of new situations	0.76	0.47	0.01	-38%
11. Feels sad, unhappy	0.74	0.55	0.09	-26%
12. Is irritable, angry	0.93	0.66	0.01	-29%
13. Feels hopeless	0.46	0.27	0.04	-41%
14. Has trouble concentrating	0.93	0.64	0.02	-31%
15. Less interest in friends	0.34	0.20	0.13	-41%
16. Fights with others	0.66	0.37	0.00	-44%
17. Absent from school	0.36	0.14	0.01	-61%
18. School grades dropping	0.54	0.32	0.05	-41%
19. Is down on him or herself	0.50	0.34	0.12	-32%
20. Visits doctor, doctor finding nothing wrong	0.46	0.16	0.01	-65%
21. Has trouble sleeping	0.56	0.31	0.01	-45%
22. Worries a lot	0.75	0.51	0.06	-32%
23. Wants to be with you more than before	0.75	0.75	1.00	0%
24. Feels he or she is bad	0.37	0.25	0.15	-32%
25. Takes unnecessary risks	0.39	0.34	0.62	-13%
26. Gets hurt frequently	0.29	0.25	0.70	-14%
27. Seems to be having less fun	0.39	0.24	0.11	-38%
28. Acts younger than children his or her age	0.59	0.21	0.00	-64%
29. Does not listen to rules	0.91	0.60	0.01	-34%
30. Does not show feelings	0.88	0.44	0.00	-50%
31. Does not understand other people's feelings	0.75	0.44	0.00	-41%
32. Teases others	0.75	0.51	0.03	-32%
33. Blames others for his or her troubles	0.83	0.53	0.01	-36%
34. Takes things that do not belong to him or her	0.51	0.41	0.28	-20%
35. Refuses to share	0.29	0.34	0.50	17%

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. Results for the recent six month period are covered in detail in the companion report to the Child Welfare department.

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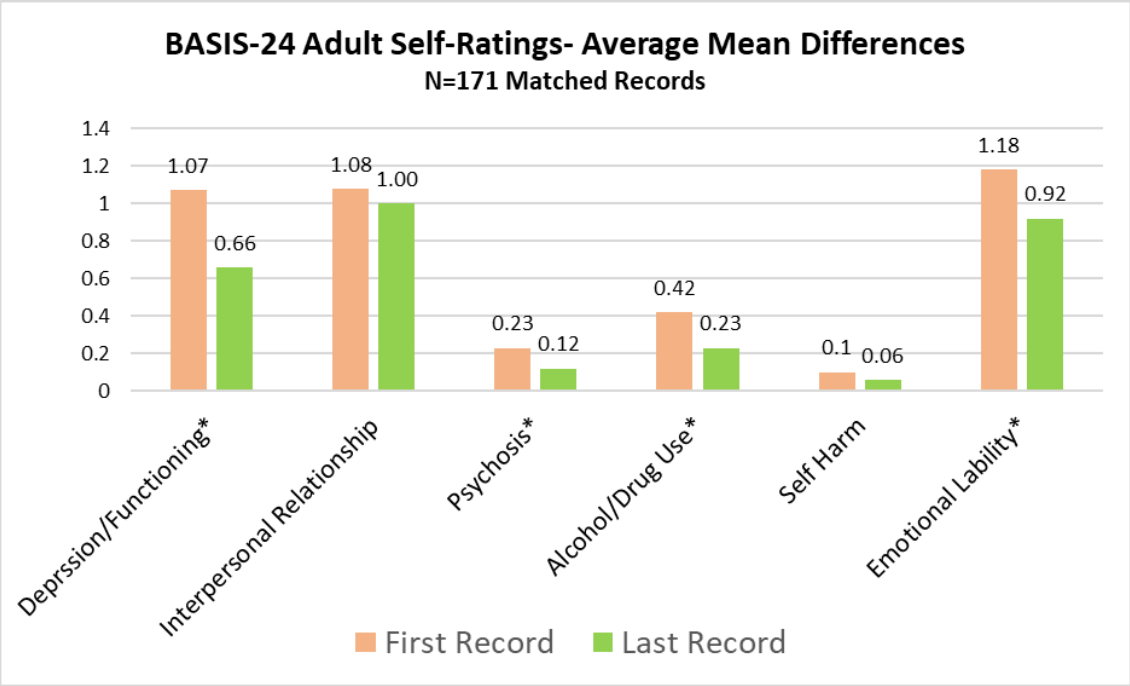
- The following graph presents results for N= 171 clients with matched first to last records, which represents 32% of the total unduplicated adult clients enrolled in their own mental health treatment services since the program began. A number of statistically significant results shine through. For example, 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.



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- Adult's self-reports also indicate they have, on average, 1.3 persons they rely on for support (excluding treatment providers) which slightly increases (1.5) by discharge. The most common persons listed as part of their support networks are spouses/partners, community/church, other family, and friends. There are positive (desirable) upticks in ratings on the item "feel close to another person" – from 58.4% at enrollment to 68.3% by discharge report "most" or "all" of the time on this item. There are also modest positive upticks on "someone to turn to for help" (73.4% to 75%) and on how they are "getting along with people outside the family" (80%, 81.6%).

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

DC Reason		Count	Percent
	Client/Caregiver Refused Services	17	7.9%
	Client/Family Completed Program	92	42.6%
	Move Out of Area	18	8.3%
	No Longer Meet Eligibility	6	2.8%
	Other	36	16.7%
	Services Discontinued	47	21.8%
	Total	216	100.0%

- If ineligible, moved out of area, and administratively discontinued services are removed from the denominator, the adjusted percent completing the program is 92/(216-71) = 63%

DC Context	Count	Percent
Against Medical Advice	33	15.3%
Need Higher Level of Care	6	2.8%
No Contact After Repeated Attempts	15	6.9%
Medical Hospitalization	0	0.0%
Psychiatric Hospitalization	0	0.0%
Incarceration	0	0.0%
Client Deceased	0	0.0%

DC Living Situation	Count	Percent
Congregate Care Settings	2	0.9%
Family Home	124	57.4%
Foster Family Home	66	30.6%
Independent Living	1	0.5%
Tx/Incarcerative Settings (Covered Elsewhere)	4	1.9%
Shelter, Homeless	5	2.3%
Unknown	14	6.5%
Total	216	100.0%

Treatment Progress	Count	Percent
Most/All Tx Goals Met (Substantial Progress)	117	54%
Some Tx Goals Met (Partial Progress)	34	16%
No or Very Few Tx Goals Met	56	26%
NA: Client Exited Before Assessment Completed	9	4%
Total	216	100.0%

Post DC Services		
Behavioral Health:	Count	Percent
Client/Family Has No Need for Add'tl Services	107	49.5%
Client/Family Refused Any Post DC Services	24	11.1%
Client/Family Linkages Provided (see below)	85	39.4%
	216	100.0%
Community Resources:	Count	Percent
Client/Family Has No Need for Add'tl Services	84	38.9%
Client/Family Refused Any Post DC Services	30	13.9%
Client/Family Linkages Provided (see below)	102	47.2%
	216	100.0%

Types of Post DC Bx Health Referrals & Linkages	Count	Percent
School-Based Counseling	10	5%
Outpatient Counseling	51	24%
Psychiatry Incl. Medication Services	14	6%
County Case Management	6	3%
Family Therapy or Rehab	6	3%
Group Therapy or Rehab	1	0%
Outpatient ATOD Counseling	1	0%
Intensive Outpatient Program	0	0%
Treatment Foster Care Program	2	1%
Day Treatment	0	0%
Adult Full Service Partnership	0	0%
Wraparound	1	0%
Other	32	15%

Types of Post DC Community Resource Referrals & Linkages	Count	Percent
AA Type Groups	0	0%
Domestic Violence Interventions	11	5%
Faith-Based Entitites	2	1%
Supported Housing	5	2%
Legal Resources	6	3%
Life Skills Classes	12	6%
Mentoring Programs	5	2%
NAMI Type Groups	1	0%
Parenting Skills Classes	12	6%
Peer to Peer Supports	3	1%
Advocacy Organizations	0	0%
Public Benefit Programs	0	0%
Recreational Programs	0	0%
Special Education Services	3	1%
Supported Education	1	0%
Volunteer Activities	0	0%
Other	97	45%

ADULT MENTAL HEALTH CLIENTS

DC Reason	Count	Percent
Client/Caregiver Refused Services	30	23%
Client/Family Completed Program	46	36%
Move Out of Area	1	1%
No Longer Meet Eligibility	8	6%
Other	23	18%
Services Discontinued	20	16%
Total	128	100%

- If ineligible, moved out of area, and administratively discontinued services are removed from the denominator, the adjusted percent completing the program is 46/(128-32) = 48%

DC Context	Count	Percent
Against Medical Advice	25	19.5%
Need Higher Level of Care	5	3.9%
No Contact After Repeated Attempts	24	18.8%
Medical Hospitalization	0	0.0%
Psychiatric Hospitalization	0	0.0%
Incarceration	2	1.6%
Client Deceased	0	0.0%

DC Living Situation	Count	Percent
Congregate Care Settings	3	2.3%
Family Home	62	48.4%
Foster Family Home	0	0.0%
Independent Living	25	19.5%
Tx/Incarcerative Settings (See Above)	7	5.5%
Shelter, Homeless	12	9.4%
Unknown	19	14.8%
Total	128	100.0%

Treatment Progress	Count	Percent
Most/All Tx Goals Met (Substantial Progress)	55	43%
Some Treatment Goals Met (Partial Progress)	19	15%
No or Very Few Tx Goals Met	49	38%
NA: Client Exited Before Assessment Completed	5	4%
Total	128	100.0%

Post DC Services		
Behavioral Health:	Count	Percent
Client/Family Has No Need for Add'tl Services	60	46.9%
Client/Family Refused Any Post DC Services	37	28.9%
Client/Family Linkages Provided (see below)	31	24.2%
	128	100.0%
Community Resources:	Count	Percent
Client/Family Has No Need for Add'tl Services	35	27.3%
Client/Family Refused Any Post DC Services	41	32.0%
Client/Family Linkages Provided (see below)	52	40.6%
	128	100.0%

Types of Post DC Bx Health Referrals & Linkages	Count	Percent
School-Based Counseling	3	2%
Outpatient Counseling	28	22%
Psychiatry Incl. Medication Services	5	4%
County Case Management	3	2%
Family Therapy or Rehab	5	4%
Group Therapy or Rehab	3	2%
Outpatient ATOD Counseling	7	5%
Intensive Outpatient Program	0	0%
Treatment Foster Care Program	0	0%
Day Treatment	0	0%
Adult Full Service Partnership	0	0%
Wraparound	0	0%
Other	10	8%

Types of Post DC Community Resource Referrals & Linkages	Count	Percent
AA Type Groups	7	5%
Domestic Violence Interventions	12	9%
Faith-Based Entitites	3	2%
Supported Housing	6	5%
Legal Resources	2	2%
Life Skills Classes	3	2%
Mentoring Programs	2	2%
NAMI Type Groups	1	1%
Parenting Skills Classes	11	9%
Peer to Peer Supports	3	2%
Advocacy Organizations	0	0%
Public Benefit Programs	0	0%
Recreational Programs	1	1%
Special Education Services	1	1%
Supported Education	0	0%
Volunteer Activities	0	0%
Other	43	34%

EFFICIENCY

- The tables 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). A few clients (N=30: 16 children/youth, 14 adults) had more than one discharge during the year – their units were combined across enrollments for the computation of central tendencies.

Utilization Central Tendencies for Discharged Child/Youth Clients FY 18-19

	Unduplicated Persons	Average Units (Mins)	Median	Range	Avg. Service Dates
Screenings & Assessments	338	161	132	0 to 546	7
Service Plans & Updates	349	50	38	0 to 239	3
Case Management	331	529	181	3 to 7,710	21
Collateral	202	400	211	8 to 2,473	8
Court Related Activities	385	45	36	0 to 314	2
Crisis Intervention	8	106	74	0 to 349	1
Family Rehab & Therapy	33	168	69	28 to 1,060	4
Individual Rehab & Therapy	259	960	748	0 to 5,051	19
Psychiatry & Medication Services	158	238	172	2 to 2,248	8

Utilization Central Tendencies for Discharged Adult Clients FY 18-19

	Unduplicated Persons	Average Units (Mins)	Median	Range	Avg. Service Dates
Screenings & Assessments	186	141	127	0 to 477	4
Service Plans & Updates	183	38	33	0 to 248	3
Case Management	143	154	65	0 to 7,574	8
Collateral	7	191	49	0 to 801	4
Court Related Activities	189	41	39	0 to 203	2
Crisis Intervention	4	87	99	0 to 150	1
Family Rehab & Therapy	7	143	75	34 to 471	4
Individual Rehab & Therapy	160	821	671	0 to 4,494	17
Psychiatry & Medication Services*	50	168	151	0 to 469	8

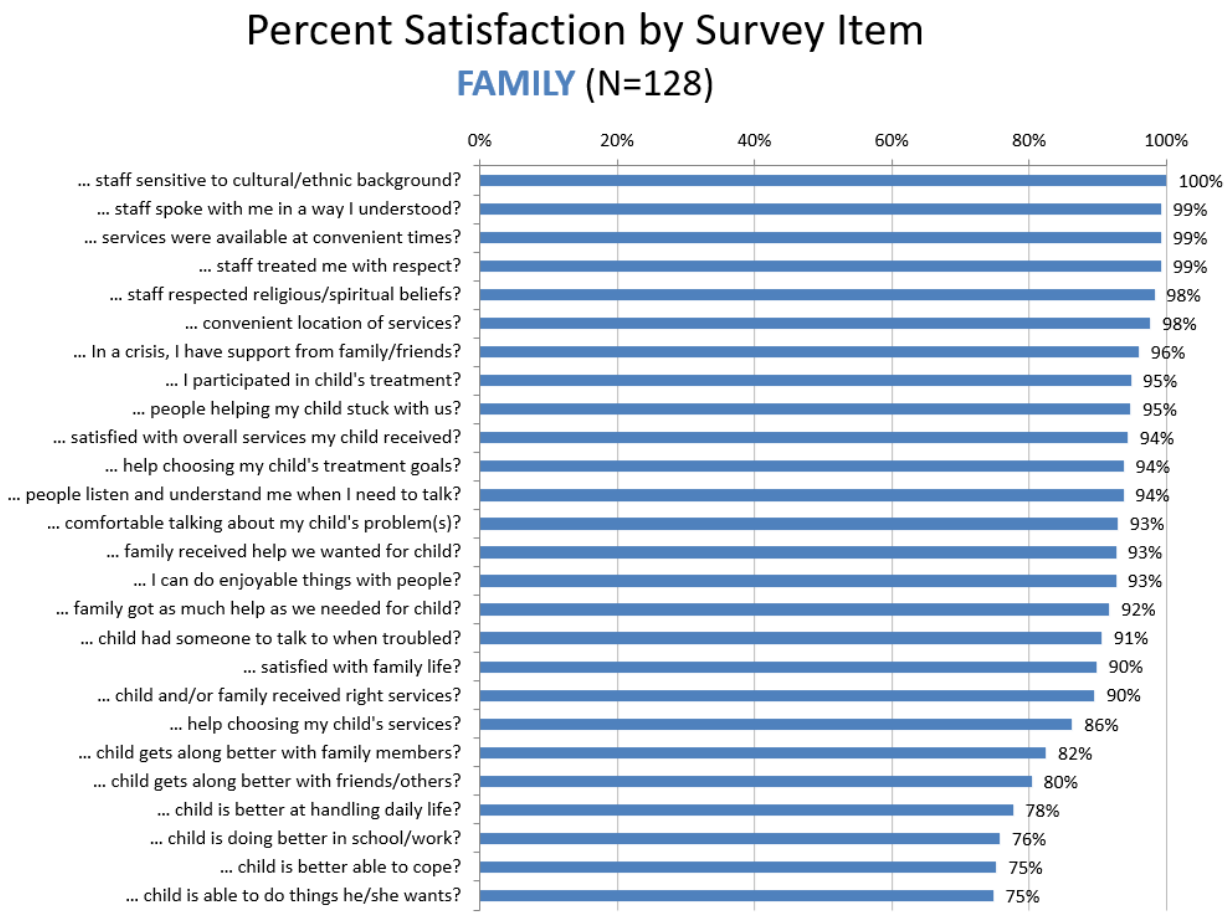
- Additionally, nearly every child/youth and adult client had at least one "No Contact" note, not included in the tables above, and on average they had 10 "No Contact" service date entries, meaning an appointment was cancelled, missed or rescheduled.
- Please note that Psychiatry and Medication Services in the table includes Psychiatric Referral (screening) and Psychiatric Evaluations (assessments), not just Medication Services. Subsets of N= 89 children and N=36 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. N=32 served, including N=20 discharges, during the year.
- Most (79%) of the total volume of community services, whether child/family or adult enrollments, involve direct contact with clients/caregivers (distinct from time involved with transportation, documentation, reporting, etc.). The rate is 65% for medication services; and, 48% for psychological testing (although with the latter, adults have higher percentage of direct touch (52% compared to 42%).

- The average span of treatment (enrollment to discharge date) among N=493 closed child/youth cases was 293 days (median = 233). For N=290 discharged adult clients, the average was 210 days (median = 198). 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 73% of services administered), and Shaw Ave (27%). Service contacts provided in the field and at these sites can help counter the social isolation that often impacts child welfare families. To date, service locations for children and families have been at one of these offices (28%), their homes (26%), on the phone (23%) or in the field (19%). Adults receiving mental health treatment were seen at offices (52%), phone (24%), home (10%) or in the field (7%). Staff also see clients at group homes, shelters, treatment centers, hospitals and jails.

SATISFACTION

- During the fall 2018 survey cycle, a majority (91%) of caregiver respondents endorsed the program, as did many youth (84%) and adult clients about their own services (90%). Caregiver responses to survey items are shown below.



- The items falling below company benchmark (85% or better results expected) pertain to perception of outcomes; they were reviewed for quality improvement at the time.
- A small sampling of comments:
  - Caregiver of Anglo/Native American female adolescent – "Accurate assessments, helpful tools to use throughout the week and an ability to process behaviors together."
  - Caregiver of Anglo/Latinx male young child -- "The most helpful was understanding my child's needs and wants and I feel like my child interacts better with others."

- Caregiver of male, ethnicity unknown, age 7 yrs. – "I have to comment I love what you guys have done to help me out thanks so much."
- Female youth, Latinx, age 16 yrs. -- "Talking about family issues that I didn't want to talk about with other people."
- Adult client, male Anglo/Latinx, age 30 yrs. -- "Central Star is a great program and I would recommend it to anyone."

What Barriers Prevent the Program from Achieving Better Outcomes? Leadership this past year addressed challenges related to staff turn-over: for example, some staffing changes were driven by staff being motivated to higher salaries in new counseling positions available through local school districts; other staffing changes came when some staff transferred internally to other, newly opening CS programs. Regarding the first challenge, salary reviews were conducted and some CS's positions were made more competitive to attract and retain qualified clinicians. Regarding the second challenge, the team worked collaboratively across CS's programs, new and old, to best match staff interests and talents to desired new positions, balanced to the need to time staff transitions so as to maximize continuity of care for clients/families (e.g., staff retaining some cases that were close to completion through completion even as they began to train in a new program). Staffing presents familiar, ongoing challenges in human service organizations and all of CS's leadership and staff were patient, cooperative, innovative during this entire overall process, maintaining a persistent focus on quality of care despite the turn-over. The team also continues its focus on timely referral and intake processing and is newly challenged in this regard due to the new state standards, about which they are building capacity to both monitor and improve performance as needed.

What Changes to the Program Would You Recommend to Improve the outcomes? A primary program challenge continues to be engaging more children, youth and caregivers in family therapy/rehabilitation and building supportive community around families. The uptick over the prior year in services being delivered to KatieA subclass is very positive and a continued focus. Attracting DBT trained personnel and/or placing some clinicians on a DBT certification path is another good focus, to help address the needs of adult clients; generally, the more attention to rebuilding and sustaining EBP use by clinicians (which was impacted by turn-over), the better.

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 this year, and the initial study

sample is of N=73 unduplicated clients aged 6-18 served during the FY with at least 2 records. The sample for children ages 4-5 yrs. was too small for 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. For clients aged 6-18, a total score greater than 28 indicates psychological impairment.
- Additionally, scores for 3 distinct domains are computed: "Internalizing Problems" (sum of items 11,13,19, 22, and 27), "Attention Problems" (sum of items 4, 7-9, and 14), and "Externalizing Problems" (sum of items 16,29, and 31-35).
- Notably, all 3 subscales as well as the total score showed desirable significant reductions from first to last records. In the table, p values highlighted in green indicate statistically significant reductions from first to last record (McNemar test).

PSC-35 Results (N=73 Matched Pairs)

Item/Subscale	Average (ADM or 1st Update)	Average (Later Update or Discharge)	P<.05	Avg Pre to Post Reduction
1. Complains of aches/pains	0.48	0.45	0.70	-6%
2. Spends more time alone	0.67	0.48	0.07	-28%
3. Tires easily, has little energy	0.44	0.29	0.11	-34%
4. Fidgety, unable to sit still	0.85	0.58	0.01	-32%
5. Has trouble with a teacher	0.59	0.40	0.04	-32%
6. Less interested in school	0.56	0.34	0.01	-39%
7. Acts as if driven by a motor	0.67	0.51	0.12	-24%
8. Daydreams too much	0.54	0.32	0.02	-41%
9. Distracted easily	1.07	0.78	0.01	-27%
10. Is afraid of new situations	0.76	0.47	0.01	-38%
11. Feels sad, unhappy	0.74	0.55	0.09	-26%
12. Is irritable, angry	0.93	0.66	0.01	-29%
13. Feels hopeless	0.46	0.27	0.04	-41%
14. Has trouble concentrating	0.93	0.64	0.02	-31%
15. Less interest in friends	0.34	0.20	0.13	-41%
16. Fights with others	0.66	0.37	0.00	-44%
17. Absent from school	0.36	0.14	0.01	-61%
18. School grades dropping	0.54	0.32	0.05	-41%
19. Is down on him or herself	0.50	0.34	0.12	-32%
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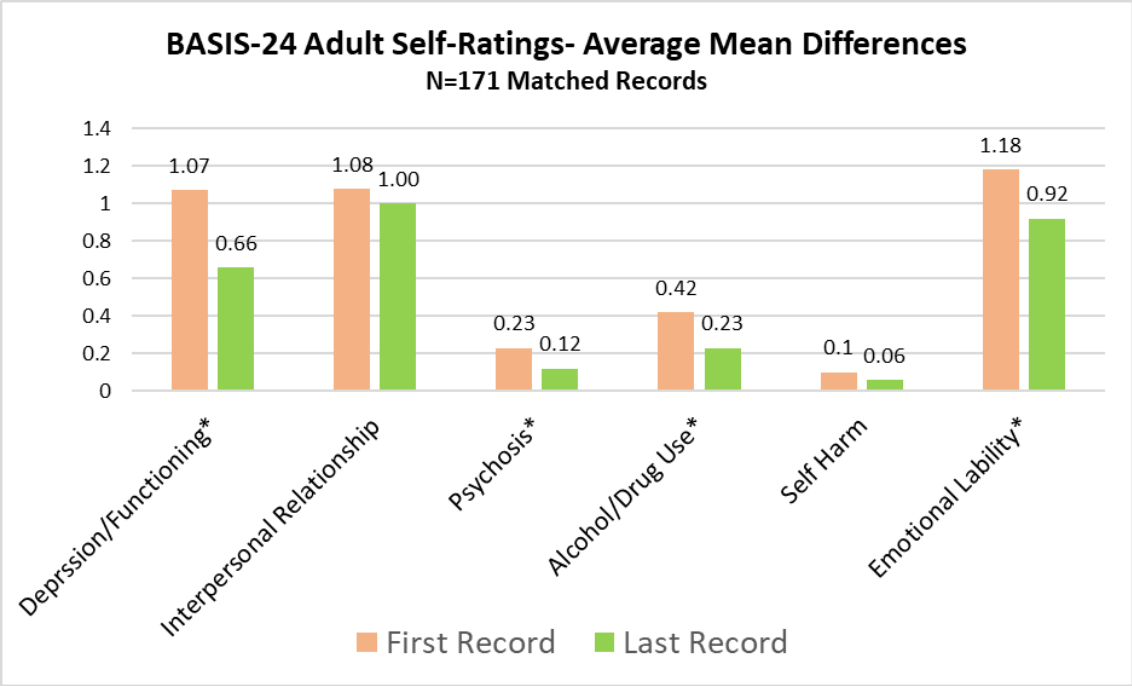

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	Move Out of Area	1	1%
	No Longer Meet Eligibility	8	6%
	Other	23	18%
	Services Discontinued	20	16%
	Total	128	100%

- If ineligible, moved out of area, and administratively discontinued services are removed from the denominator, the adjusted percent completing the program is 46/(128-32) = 48%

DC Context		Count	Percent
	Against Medical Advice	25	19.5%
	Need Higher Level of Care	5	3.9%
	No Contact After Repeated Attempts	24	18.8%
	Medical Hospitalization	0	0.0%
	Psychiatric Hospitalization	0	0.0%
	Incarceration	2	1.6%
	Client Deceased	0	0.0%

DC Living Situation	Count	Percent
Congregate Care Settings	3	2.3%
Family Home	62	48.4%
Foster Family Home	0	0.0%
Independent Living	25	19.5%
Tx/Incarcerative Settings (See Above)	7	5.5%
Shelter, Homeless	12	9.4%
Unknown	19	14.8%
Total	128	100.0%

Treatment Progress	Count	Percent
Most/All Tx Goals Met (Substantial Progress)	55	43%
Some Treatment Goals Met (Partial Progress)	19	15%
No or Very Few Tx Goals Met	49	38%
NA: Client Exited Before Assessment Completed	5	4%
Total	128	100.0%

Post DC Services		
Behavioral Health:	Count	Percent
Client/Family Has No Need for Add'tl Services	60	46.9%
Client/Family Refused Any Post DC Services	37	28.9%
Client/Family Linkages Provided (see below)	31	24.2%
	128	100.0%
Community Resources:	Count	Percent
Client/Family Has No Need for Add'tl Services	35	27.3%
Client/Family Refused Any Post DC Services	41	32.0%
Client/Family Linkages Provided (see below)	52	40.6%
	128	100.0%

Types of Post DC Bx Health Referrals & Linkages	Count	Percent
School-Based Counseling	3	2%
Outpatient Counseling	28	22%
Psychiatry Incl. Medication Services	5	4%
County Case Management	3	2%
Family Therapy or Rehab	5	4%
Group Therapy or Rehab	3	2%
Outpatient ATOD Counseling	7	5%
Intensive Outpatient Program	0	0%
Treatment Foster Care Program	0	0%
Day Treatment	0	0%
Adult Full Service Partnership	0	0%
Wraparound	0	0%
Other	10	8%

Types of Post DC Community Resource Referrals & Linkages	Count	Percent
AA Type Groups	7	5%
Domestic Violence Interventions	12	9%
Faith-Based Entitites	3	2%
Supported Housing	6	5%
Legal Resources	2	2%
Life Skills Classes	3	2%
Mentoring Programs	2	2%
NAMI Type Groups	1	1%
Parenting Skills Classes	11	9%
Peer to Peer Supports	3	2%
Advocacy Organizations	0	0%
Public Benefit Programs	0	0%
Recreational Programs	1	1%
Special Education Services	1	1%
Supported Education	0	0%
Volunteer Activities	0	0%
Other	43	34%

EFFICIENCY

- The tables 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). A few clients (N=30: 16 children/youth, 14 adults) had more than one discharge during the year – their units were combined across enrollments for the computation of central tendencies.

Utilization Central Tendencies for Discharged Child/Youth Clients FY 18-19

	Unduplicated Persons	Average Units (Mins)	Median	Range	Avg. Service Dates
Screenings & Assessments	338	161	132	0 to 546	7
Service Plans & Updates	349	50	38	0 to 239	3
Case Management	331	529	181	3 to 7,710	21
Collateral	202	400	211	8 to 2,473	8
Court Related Activities	385	45	36	0 to 314	2
Crisis Intervention	8	106	74	0 to 349	1
Family Rehab & Therapy	33	168	69	28 to 1,060	4
Individual Rehab & Therapy	259	960	748	0 to 5,051	19
Psychiatry & Medication Services	158	238	172	2 to 2,248	8

Utilization Central Tendencies for Discharged Adult Clients FY 18-19

	Unduplicated Persons	Average Units (Mins)	Median	Range	Avg. Service Dates
Screenings & Assessments	186	141	127	0 to 477	4
Service Plans & Updates	183	38	33	0 to 248	3
Case Management	143	154	65	0 to 7,574	8
Collateral	7	191	49	0 to 801	4
Court Related Activities	189	41	39	0 to 203	2
Crisis Intervention	4	87	99	0 to 150	1
Family Rehab & Therapy	7	143	75	34 to 471	4
Individual Rehab & Therapy	160	821	671	0 to 4,494	17
Psychiatry & Medication Services*	50	168	151	0 to 469	8

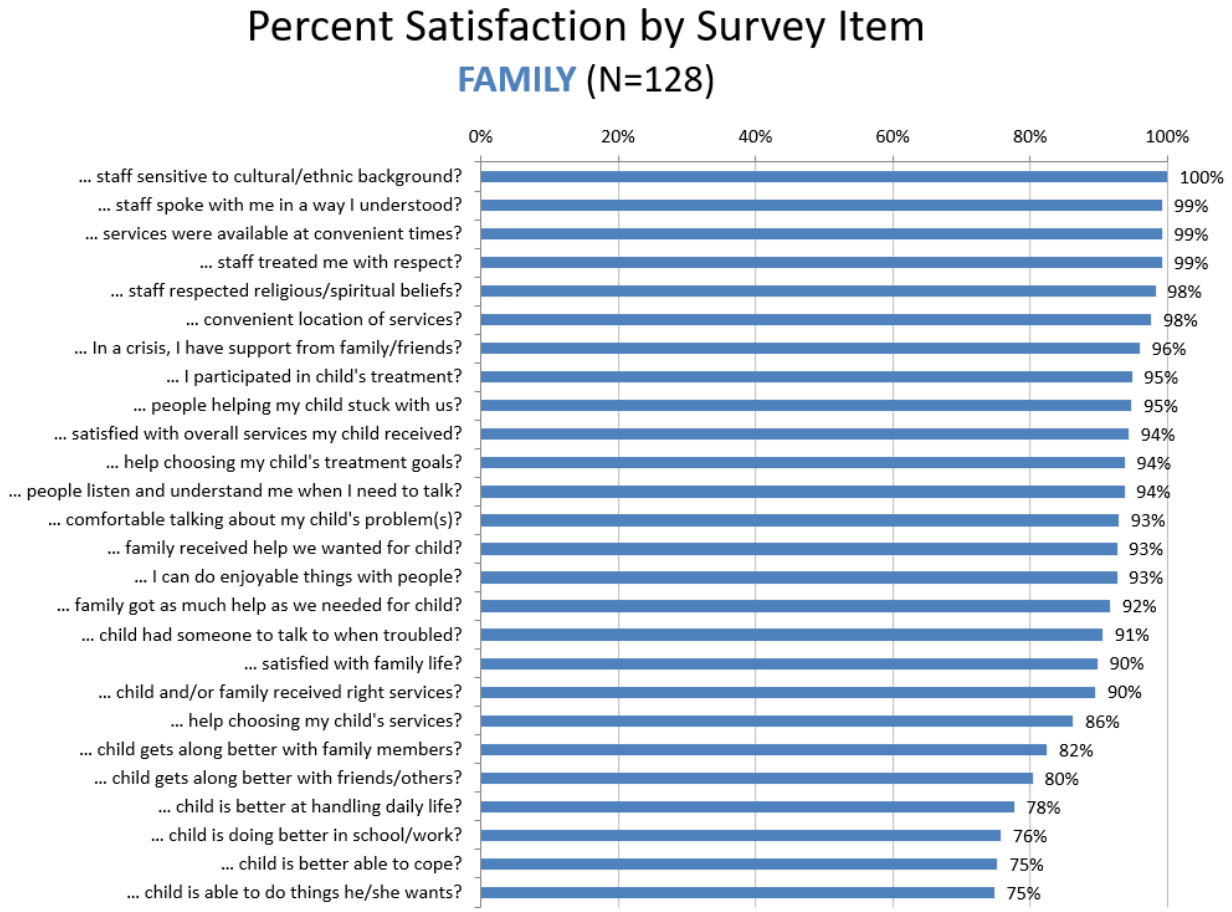
- Additionally, nearly every child/youth and adult client had at least one "No Contact" note, not included in the tables above, and on average they had 10 "No Contact" service date entries, meaning an appointment was cancelled, missed or rescheduled.
- Please note that Psychiatry and Medication Services in the table includes Psychiatric Referral (screening) and Psychiatric Evaluations (assessments), not just Medication Services. Subsets of N= 89 children and N=36 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. N=32 served, including N=20 discharges, during the year.
- Most (79%) of the total volume of community services, whether child/family or adult enrollments, involve direct contact with clients/caregivers (distinct from time involved with transportation, documentation, reporting, etc.). The rate is 65% for medication services; and, 48% for psychological testing (although with the latter, adults have higher percentage of direct touch (52% compared to 42%).

- The average span of treatment (enrollment to discharge date) among N=493 closed child/youth cases was 293 days (median = 233). For N=290 discharged adult clients, the average was 210 days (median = 198). 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 73% of services administered), and Shaw Ave (27%). Service contacts provided in the field and at these sites can help counter the social isolation that often impacts child welfare families. To date, service locations for children and families have been at one of these offices (28%), their homes (26%), on the phone (23%) or in the field (19%). Adults receiving mental health treatment were seen at offices (52%), phone (24%), home (10%) or in the field (7%). Staff also see clients at group homes, shelters, treatment centers, hospitals and jails.

SATISFACTION

- During the fall 2018 survey cycle, a majority (91%) of caregiver respondents endorsed the program, as did many youth (84%) and adult clients about their own services (90%). Caregiver responses to survey items are shown below.



- The items falling below company benchmark (85% or better results expected) pertain to perception of outcomes; they were reviewed for quality improvement at the time.

- A small sampling of comments:
  - Caregiver of an adolescent – "Accurate assessments, helpful tools to use throughout the week and an ability to process behaviors together."
  - Caregiver of young child -- "The most helpful was understanding my child's needs and wants and I feel like my child interacts better with others."
  - Caregiver of young child – "I have to comment I love what you guys have done to help me out thanks so much."
  - Female youth, age 16 yrs. -- "Talking about family issues that I didn't want to talk about with other people."
  - Adult client, age 30 yrs. -- "Central Star is a great program and I would recommend it to anyone."

DEPARTMENT RECOMMENDATION(S):

Click here to enter text.