

A____ TAB SECTION

DATE OF MEETING 2/24/16

MATERIAL
PREPARED BY: Tom Orrock

DATE MATERIAL
PREPARED 2/11/16

AGENDA ITEM:	Review and approve January 2016 meeting minutes
ENCLOSURES:	January 2016 Meeting Minutes

BACKGROUND/DESCRIPTION:

Continuous System Improvement Committee

Meeting Highlights

January 21, 2016

2270 Hotel Circle North, San Diego, CA 92108

Committee Members present:

Lorraine Flores, Chair	Walter Shwe, Chair-elect
Susan Morris Wilson	Noel O'Neill
Esmeralda Liberato	Raja Mitry
Celeste Hunter	Karen Hart
Monica Nepomuceno	Patricia Bennett

Staff present:

Tom Orrock, Linda Dickerson

Others present:

Beryl Nielsen, May Farr

Welcome and Introductions:

Lorraine Flores welcomed the committee members, staff, and guests present. It was announced that a quorum was established.

Review and Approve December meeting minutes:

Motion to approve December minutes by Susan, seconded by Karen. Minutes unanimously approved.

Data Notebook 2016: Planning and design of questions:

Susan and Linda will be heading up the effort for the 2016 Data Notebook (DNB).

Linda discussed the need to limit the number of questions in the next project. We will be focusing on children and youth so we have to ask for the most essential data to guide the project. Noel reminded the committee about the CBHDA let received last year and stated that the information will always be coming from the Quality Improvement section of the county Mental Health Boards. Noel made a recommendation to run the questions by Debbie Innes Gomberg who spearheads Measurements, Outcomes and Quality Assessment (MOQA). This data should be available because CMS is requiring data for the renewal waiver.

Patricia reminded the committee that we are completing the DNB in order to gather information for the advisory boards. Susan stated that we should be attempting to have Boards and Directors work together to complete the DNB. Noel stated that County Directors want questions that are able to be analyzed. Raja pointed out that we still have large disparities in some culture groups when it comes to access and availability of services.

The committee agreed that they should have a goal to receive feedback from all 58 counties.

EQRO provides data from EPSDT and foster care and data from DHCS should be available soon.

Monica stated that CDE will also have some data sets. Monica will connect Linda with Lisa Geller and of Foster Youth Services and Leane Z. of McKinney-Vento.

Susan stated that we will need to outline a timeline and work with the CALMHB. May Farr may have a plan to share that would assist in the process. CALMHB members could be invited to participate in planning meetings. CBHDA should be informed about how we'd like the process to look.

There will be a series of meetings held to complete the DNB. It was recommended that we meet every other Tuesday at 9:00am. All CSI members who can call in can do so as well as CALMHB members. Linda stated that there are two questions that she would like to ask. 1) What supports programs do you have for the caregivers of youth with severe mental health challenges? 2) What methods do you use to keep youth engaged in their mental health services? Linda requested that the CSI members send her one question within the next two weeks that might help guide our first discussion on the DNB questions.

2016 Work Plan Review:

The committee decided to remove the "Mental Health services in Juvenile Justice facilities" from the work plan and incorporate questions regarding youth in JJ facilities into the DNB project. The new focus of the committee will be on the mental health needs of LGBTQ youth. A new draft Work Plan will be developed by Tom and introduced to the committee for vote at the next meeting.

LGBTQ Youth Mental Health Services:

Panel presenters:

Max Disposti, Executive Director of North County LGBTQ Resource Center in Oceanside, CA.

Jasper McCarthy, Consumer and Volunteer at NC LGBTQ Resource Center.

Kathie Moehlig, Executive Director of TransFamily Support Services in San Diego, CA

Sam Moehlig, Consumer of services, son of Kathie M.

Max Disposti began his services in Oceanside 8 years ago. The centers were established because there were limited resources in the area for LGBTQ youth. The center offers a safe space for LGBTQ youth who are very high risk for abuse, depression, and suicide. He stated that disparities still exist for the community and that it is very difficult to find providers who understand the issue. Some providers have wrong perceptions of LGBTQ issues. Max provides education to hospitals, schools, therapist, and parents regarding the issues of LGBTQ youth in order to reduce the misunderstanding that many professionals have about the culture.

Jasper McCarthy is an 18 year old transgendered male who has received support at the NC Resource Center. Jasper is also working with Trans Youth Government. Jasper has been hospitalized four times for depression and spoke about his experiences in the psychiatric facilities. He attends Oceanside HS. He stated that school personnel is also not helpful at times. He has been sent to the Principal's office several times for going into the Men's bathroom. He stated that who the Principal is makes all the difference. He felt that middle school was a more dangerous place in regards to bullying, when compared to his high school experiences. Jasper highlighted the care he received while in psychiatric facilities and stated that he was often called out of his identified gender pronoun. One counselor said that she wouldn't refer to Jasper as a male because she was "just a pretty girl".

Kathy Moehlig is the Executive Director of TransFamily Services in San Diego. She is an advocate for families who are navigating the world of parenting LGBTQ youth in a sometimes hostile environment. Kathie runs support groups for trans families. She stated, "there is not a safe place for an LGBTQ youth to land when they have mental health issues in our county". As a result, they have formed a support group to provide wrap services to each other so that they can avoid hospital stays. The hospital stays cause greater problems for transgendered youth and can cause deeper depression and suicidality. Therapist, social workers, psychiatrists, and other psychiatric hospital personnel are uninformed about the sensitive issues of transgendered youth. Kathie also stated that many youth community activities are not available to trans youth because the people running the programs are not familiar with the culture.

Sam is a Freshman in high school and is currently home schooled. He transitioned to male in 2011. His symptoms of gender dysphoria started at age 8. When Sam learned that he could transition to a boy, he stated "Yep, sign me up." Sam had a therapist who did not understand his experiences. She decided to educate herself by paying to attend trainings so that she could continue to work with Sam. Sam stated that an educated therapist is key to good outcomes.

Committee comments, questions, follow up items, and other notes:

- Therapists are the gateway to transgender transitioning services. If therapists are not informed about the issue, transgendered youth have roadblocks to becoming who they perceive themselves to be.
- Psychiatric hospital staff who do not adhere to the wishes of transgendered youth in regards to how they are addressed may be causing psychological harm.
- The LGBTQ workforce needs to grow. The WET Pipeline program may be a good resource for this.
- Kathie M. stated that there is a training in May in LA regarding the topic of LGBTQ youth.
- Karen Hart stated that she would get Kathie connected to UACF.
- AB 1266 has been helpful to this population.
- School district middle and high school personnel need additional training on this subject. Monica Nepomuceno stated that she will look into adding information on LGBTQ to credentialing programs.

- Patricia Bennet asked how we can raise this issue to the state level so that we can start to measure issues of access, workforce, suicide rates, etc.
- What is Queer? Queer is a fluid term. If you are Queer you have no set type of person that you are attracted to. Queer is a rejection of prescribed labels on gender or attraction. Gender is a spectrum. Binary = 100% male or female identification.
- Monica N. asked, where do we go from here? What actions, policies, or legislation is needed to safeguard LGBTQ youth.
- Jasper on the Council??

Public comment:

No public comment

Meeting adjourned at 11:50 am

B_____ TAB SECTION

DATE OF MEETING 2/24/16

**MATERIAL
PREPARED BY: Tom Orrock**

**DATE MATERIAL
PREPARED 2/11/16**

AGENDA ITEM:	Review Data Notebook Questions and update on data request
ENCLOSURES:	2016 Data Driven Question Areas

BACKGROUND/DESCRIPTION:

The enclosures are a culmination of the feedback recently obtained from members of the CSI Committee regarding data driven questions for the DNB project.

Data-Driven Sample Question Areas for Committee to Consider:

Grounded in existing EPSDT- MH Data from DHCS or other Sources (MHSA, PEI, FSP for children/youth, etc).

System Performance Data: Access to Services

Wait time to first appointment for services for Children and Youth (same data supplied by MHPs to the EQRO); [how defined and calculated in each county?]

MH Program steps to improve timely access to care (e.g., increased recruitment and staffing, managing no-show rates, adding tele-psychiatry appointments, other strategies).

Integrated Care and Care Coordination

MH and Substance Use Treatment in Dual Diagnosis Clients

Linkage to Primary Care and wellness programs

Supports and services for caretakers who are responsible for children and youth with MH, SUD, or complex care needs (such as those with disabilities).

“Caretakers” includes parents, grandparents, foster care parents and others.

Fairness/Equity vs Disparities in Outreach and Access

Data for Children and Youth: DHCS data (not sure yet when these data will be available for individual counties?)

Focus Area: Foster children and youth (expecting new data from DHCS “soon”).

Focus Area: Role of language and culture in delivery of services. For example, a large group is those whose primary language at home is Spanish.

Data for Transition Aged Youth (16-25). Note: these are no longer published by the EQRO, but such data may be available to the county MHPs from the EQRO. This age group requires a separate data analysis not currently published by either DHCS or the current EQRO.

Timely Follow-up after Hospitalization for Children and Youth (e.g. step-down services):

Within 7 days: percentage of clients

Within 30 days: percentage of clients

Rates of Re-hospitalization within 30 days (percentages of total): our main goal is to reduce these events.

New Program Funding for Crisis services, Respite services, Peer Providers:

Within the last year, what new crisis and respite care resources became available in your county for children and youth?

What, if any, were the effects of these services; e.g., to reduce the numbers who were placed in a psychiatric hospital or similar facility?

Alternative Types/Locations of Service Delivery: e.g., Schools and school-based MH services (refer to prior report from CSI committee for question development).

Role of the MHSA Programs serving Children and Youth in Your County:

FSP service delivery

Prevention and Early Intervention Programs

Innovative (INN) Programs

CSS: community services and supports

Client Outcomes Data

DHCS has a current contract with UCLA to ascertain what data instruments (e.g. diagnostic questionnaires or checklists) are currently used by counties and their service providers. No outcomes data are available from DHCS at this time. However, many of the medium and larger population counties have their own data regarding client outcomes (optional question). If your county is one of those, they may have aggregate data suitable for sharing with their shareholders and public.

MHSOAC: An FSP classification project has been underway during 2015, to determine the best ways to categorize different programs.

MHSOAC: no new evaluations of client outcomes data (e.g. FSP clients or others) have been published/ posted during 2015, to my knowledge. It is possible that they have such data evaluations “in the works,” but no discussion of evaluation projects has occurred recently in the Evaluation Committee, because the last meeting occurred more than 6 months ago.

Research evaluating FSP services and outcomes in children and youth was conducted recently by Kate Cordell as part of her Ph.D. thesis project. Those data will be published in a professional journal (expected soon). During the study period, not all counties had FSP programs for children and/or youth <18, so only those counties with such programs were evaluated. The major focus was comparing outcomes of those in FSP programs to those children and youth who were receiving wrap-around services, intensive behavioral health services, (IBS, IHBS) and/or intensive care coordination.

Consumer Perception Survey Data: this will be available on a statewide basis for question items. Caveat#1: only a small percentage of MHP clients (youth or parents of children) actually fill out these surveys in each county, so the data may be skewed towards those who have favorable perceptions of services and their MH outcomes as a result of those services. Caveat #2: It is unlikely that detailed response data will be available for smaller population counties, due to the HIPAA/privacy issues encountered with small numbers of respondents.

Potential DN Items regarding Children and Youth based on 2016 CSI Committee Discussion and Submitted Questions

1. Does your county have a contract with the local Office of Education / SELPA to provide Special Educational behavioral Health services? Y_____ N_____

If yes, please list or describe briefly.

If no, what is the alternative in your county?

2. Does your county provide or contract EPSDT Alcohol and Other Drug Services to youth? Y_____ N_____

If yes, please list or briefly describe.

If no, then what is the alternative in your county?

3: “What services are available in your county to support families and caregivers* of children and youth with emotional or mental health challenges?”

*(*caregivers =parents, foster parents, grandparents or other relatives who have guardianship of a child/youth and provide care and family structure).*

4. Does your county use outcome measurement tools such as the CANS (Child and Adolescent Needs and Strengths), ANSA (Adult Needs and Strengths Assessment) or MORS (Milestones of Recovery Scale)? If so how does your county use them? (Note: some other major options may need to be included here— e.g. CALOCUS, etc.)

5. How are cultural competence/ethnic service managers and contracted providers involved in assuring services to children and youth, their parents and caregivers are culturally & linguistically appropriate, being responsive to the values and practices of the culture and the family's background? Do evaluations reflect and measure this? (Note, this question needs refining to focus on exactly what is it we want to measure with this question? i.e., something that can be counted or measured from existing data).

6. What LGBT--specific services are offered in each county. . Please list the types of services- i.e., outreach, family reunification/reconnection, counseling, etc. - with a brief description of the programs and services. (An important issue is that many agencies say they have LGBT services, but in reality the services are not really LGBT-specific).

7. Mental health needs and services for foster children and youth in your county: specific question to be developed after further discussion, possibly to include a more fully integrative perspective that includes substance use treatment and needs and perhaps something about a culture of trauma-informed care or coordinated efforts with local department of social services, aka child welfare department.

8. **Mental health and substance use treatment needs and outreach to youth in juvenile detention facilities or who are otherwise incarcerated:** *possible question area to be developed upon further discussion.*
9. **Efforts to develop resilience through trauma-informed perspectives or approaches in schools and MH treatment, or through PEI programs:** please list and briefly describe such programs in your community.
10. **Timely* linkage to follow-up MH services post-hospitalization and/or post-crisis services for children and youth: what are the main strategies and programs in your community?** (**Timely follow-up is measured at two time points: within 7 days and within 30 days post-release from hospital or crisis residential treatment services*). **Does your county have data regarding the percentage of children/youth who are re-hospitalized within 30 days after release from a psychiatric facility?** (*Please do not provide exact numbers of clients due to privacy concerns, especially in small counties*).
11. **What kind of supports exist in your county for children and youth with mental health challenges?**
12. **How are county programs collaborating or interfacing with school-based programs?** (Share the successes and challenges of collaborating).
13. **Do you feel school personnel are aware of the county programs? What can be done to better improve school personnel knowledge of county programs , efforts, and activities related to mental health?**
14. **How many youth suicides were reported in your county last year?**
15. **How many schools referred K-12 students to county programs last year?**
16. **How many K-12 students were served in your county last year?**

C____ TAB SECTION

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MATERIAL
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AGENDA ITEM:	Proposal to add AB 403 review to 2016 Work Plan
ENCLOSURES:	AB 403 Fact Sheet

BACKGROUND/DESCRIPTION:

AB 403 was chaptered in 2015 and will become law in January 2017. AB 403 is a comprehensive reform effort to ensure the well-being of foster youth in California. The reform calls for reduction of the use of congregate care (group homes) for foster youth and an expansion of the education and training of foster families or resource families. The fact sheet included with this packet provides a summary of the reform.

AB 403 (Stone): Foster Youth: Continuum of Care Reform

BILL SUMMARY

AB 403 is a comprehensive reform effort to make sure that youth in foster care have their day-to-day physical, mental, and emotional needs met; that they have the greatest chance to grow up in permanent and supportive homes; and that they have the opportunity to grow into self-sufficient, successful adults.

AB 403 addresses these issues by giving families who provide foster care, now known as resource families, with targeted training and support so that they are better prepared to care for youth living with them. The bill also advances California's long-standing goal to move away from the use of long-term group home care by increasing youth placement in family settings and by transforming existing group home care into places where youth who are not ready to live with families can receive short term, intensive treatment. The measure creates a timeline to implement this shift in placement options and related performance measures.

The measure builds upon many years of policy changes designed to improve outcomes for youth in foster care. It implements recommendations from CDSS's 2015 report, [California's Child Welfare Continuum of Care Reform](#), which were developed with feedback from foster youth, foster families, care providers, child welfare agency staff, policymakers, and other stakeholders.

PROBLEM BACKGROUND

For over a decade, California has implemented policies to reduce the number of children in out-of-home foster care placements, which has resulted in a decline from a high of over 100,000 youth in foster care in 1999 to about 60,000 in 2014. These policy changes have included preventative efforts to reduce the likelihood that a child is removed from his or her home, early intervention in child welfare cases, and assistance with finding children permanent homes with relatives and through adoption.

County child welfare agencies provide services to about 95 percent of youth in foster care, including

making arrangements for where the youth will reside and who will care for and take responsibility for the youth. Juvenile probation departments are responsible for the care of remaining 5 percent of foster youth.

"Continuum of care" refers to the spectrum of care settings for youth in foster care, from the least restrictive and least service-intensive (for instance, a placement with an individual foster family or an extended family member) to the most restrictive and most service-intensive (for instance, a group home with required participation in mental health treatment and limits on when the youth can leave the facility).

Most youth in foster care are placed in homes with resource families, but about 3,000 youth live in group home placements, also known as congregate care. Over two-thirds of the youth in congregate care have remained in such placements longer than two years, and about one-third have lived in such placements for more than five years.

Foster youth who live in congregate care settings are more likely than those who live with families to suffer a variety of negative short- and long-term outcomes. Such placements are associated with the creation of lifelong institutionalized behaviors, an increased likelihood of being involved with the juvenile justice system and the adult correctional system, and low educational attainment levels. Further, children who leave congregate care to return to live with their families are more likely than those who were in placed in family-based care to return to the foster system.

In spite of these well-known problems associated with this type of placement, too many children continue to be placed in, and remain living in, congregate care settings which do not always meet their needs or provide stable, supportive homes. AB 403 addresses this issue through a variety of policy changes.

COMPONENTS OF AB 403

To better meet the needs of youth in foster care and to promote positive outcomes for those youth as they

AB 403 (Stone): Foster Youth: Continuum of Care Reform

transition out of foster care, AB 403 implements the following policy changes:

- Updates the assessment process so that the first out-of-home placement is the right one.
- Establishes core services and supports for foster youth, their families, and resource families;
- Strengthens training and qualifications for resource families providing care to foster youth and congregate care facility staff;
- To the extent that the children are provided needed services and support, transitions children from congregate care into home-based family care with resource families;
- Transforms group homes into a new category of congregate care facility defined as Short-Term Residential Treatment Centers (STRTCs);
- Revises the foster care rate structure;
- Requires STRTCs and treatment foster family agencies to be certified by counties through their mental health plans;
- Evaluates provider performance.

AB 403 accomplishes the above in the following ways:

Home-Based Family Care: Reducing placements in congregate care settings will require specially trained resource families to be available to care for youth in home settings, either in resource families approved by a county or through a Foster Family Agency (FFA). AB 403 increases efforts to recruit and train families to meet the needs of foster youth as they step down from short-term residential placement settings with high service levels to less restrictive settings.

Residential Treatment: In order to reduce reliance on congregate care as a long-term placement setting, AB 403 narrowly redefines the purpose of group care. Group homes will be transitioned into a new facility type, STRTCs, which will provide short-term, specialized, and intensive treatment and will be used only for children whose needs cannot be safely met initially in a family setting. AB 403 establishes a timeline for this transition.

Providing Core Services: FFA programs, STRTCs, and social workers will provide core services and supports to foster youth and their placements. Depending on the type of placement and needs of a youth in foster care, core services may include: arranging access to specialized mental health treatment, providing transitional support from foster placement to permanent home placement, supporting connections with siblings and extended family members, providing transportation to school and other educational activities, and teaching independent living skills to older youth and non-minor dependents.

Cost: AB 403 establishes that both congregate care facilities and FFAs will offer the same level of core services to children at a rate that correlates with the level and type of services they provide. Social workers will provide additional core services and support to resource families. An initial state investment will lead to reduced placement costs, and to lower societal costs from improved outcomes.

Performance Measures and Outcomes: A multi-departmental review team will focus on the programs' administrative and service practices, and overall performance, to ensure providers are operating programs that use best practices, achieve desired outcomes for youth and families and meet local needs. To bolster this work, a satisfaction survey of youth and families will be used to determine their perception of the services they received, including whether the services were trauma-sensitive, and to provide feedback that can help programs serving youth and families make continuous quality improvements.

SUPPORT

- California Department of Social Services (sponsor)

OPPOSITION

- None received

FOR MORE INFORMATION

Contact: Arianna Smith
Office of Assemblymember Mark Stone
Phone: (916) 319-2029
arianna.smith@asm.ca.gov

D____ TAB SECTION

DATE OF MEETING 2/24/16

MATERIAL
PREPARED BY: Tom Orrock

DATE MATERIAL
PREPARED 2/11/16

AGENDA ITEM:	Dr. Caitlin Ryan presentation to the CSI Committee
ENCLOSURES:	Bio of Dr. Caitlin Ryan

BACKGROUND/DESCRIPTION:

The CSI committee should consider what information they would like to hear from Dr. Ryan as she presents to both the CSI Committee and the full Council in April 2016 Quarterly meeting. In order to keep from hearing a repeat of the information provided to the CSI Committee in the full Council meeting, the CSI Committee may want to consider asking Dr. Ryan for specific information that she will not necessarily discuss in the full Council setting.



Dr. Caitlin Ryan presents findings to the California Mental Health Planning Council on Protective Factors for LGBT Youth

Dr. Caitlin Ryan is the Director of the San Francisco based Family Acceptance Project. Her research on the protective factors for LGBT youth has been published in the Journal of Child and Adolescent Psychiatric Nursing as well as the Journal of Developmental Psychology. Her studies have found that parental and caregiving behaviors can protect LGBT youth from depression, suicidal thoughts, suicide attempts, and substance abuse. She found that LGBT youth who were rejected by their families were eight times as likely to attempt suicide, and three times as likely to use illegal drugs. It was also discovered that higher levels of acceptance led to higher levels of well-being. Something we have instinctually known to be true has been validated through her research.

The Family Acceptance Project has assisted socially and religiously conservative families to shift the discourse on homosexuality from morality to the health and well-being of their loved ones. The information and training that the Project provides goes beyond the typical focus on reducing harm and extends to the health and wellness of LGBT youth. Every three years, starting in 2003, they conduct a statewide telephone survey of all LGBT related support programs in order to assist parents and caregivers as they learn how to support their children.

Instead of disregarding parents who might initially show rejection behaviors, Dr. Ryan believes that with training, understanding, and support, they can become the major protective factor in their children's lives.

Thursday, April 21st

3:00pm

Holiday Inn - Golden Gateway

1500 Van Ness Avenue

San Francisco, CA 94109

For more information call (916) 324-0980