REPORT

EXECUTIVE SUMMARY

Unclaimed Children Revisited

California Case Study

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National Center for Children in Poverty
Mailman School of Public Health
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The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Using research to inform policy and practice, NCCP seeks to advance family-oriented solutions and the strategic use of public resources at the state and national levels to ensure positive outcomes for the next generation. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

Dedicated to Jane Knitzer.

UNCLAIMED CHILDREN REVISITED: California Case Study

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Setting the Context: UCR Background

Unclaimed Children Revisited (*UCR*) complements *Unclaimed Children: The Failure of Public Responsibility to Children in Need of Mental Health Services* (1982), a seminal report authored by Dr. Jane Knitzer. The initial report served to rally the child and adolescent mental health field to take action towards policy reform.

The current national study is a multi-pronged initiative that generates new knowledge about policies across the United States that promote or inhibit the delivery of high-quality mental health services and supports to children, youth, and families. *UCR* places a strong emphasis on identifying policies that support services that are culturally competent, developmentally appropriate, and research-informed. The initiative encompasses four main projects:

- a national survey of state-level children's mental health directors and advocates;
- a statewide case-study of California, with a focus on 11 counties;
- a case-study of outcomes-based management in children's mental health service delivery in Michigan; and
- a working paper series that explores the state of the field on family and youth engagement, financing, trauma, school-based mental health, and cross-systems support of effective practices.

The California Case Study

The *California Case Study (CCS)* represents a major component of *Unclaimed Children Revisited. CCS* is a multi-method, multi-level study that includes:

- analysis of the state policy context with special attention to specific reform-oriented policies, including the Mental Health Services Act;
- 11 in-depth county case studies that illustrate aspects of effective mental health service delivery and policy; and
- fiscal analysis designed to shed light on the current funding picture and the comparative efficacy of different financing approaches.

The 11 counties include: Alameda, Butte, Humboldt, Imperial, Los Angeles, Placer, San Diego, San Francisco, San Mateo, Santa Clara, and Santa Cruz.

The purpose of *CCS* is to identify, document, and analyze effective fiscal, infrastructural, and related policies that support research-informed practices for mental health services to children and adolescents in California. The study also generates "lessons learned" from individual initiatives. *CCS,* together with the other components of *UCR,* examines the current status of children's mental health policies in the United States, particularly those that support improved outcomes for children, adolescents, and their families.

The California Endowment Foundation and the Zellerbach Family Foundation funded the study.

Who Are California's Unclaimed Children Today?

Demographics Comparisons Between California and the 11 UCR Study Counties

The demographic profile of children and youth in the 11 UCR counties is remarkably similar to the general child population in California. The demographic profile of the study's population (young public mental health service users under 25) in the 11 UCR counties is also comparable to the same subgroup across the state; however, there are slightly larger Asian and smaller white populations in the UCR counties and slightly larger proportions of Spanish-speaking children and youth. Differences in gender and racial/ethnic composition, primary language utilization, and Medi-Cal (Medicaid) coverage arise when comparing young mental health service users and the general population of children and youth.

How representative of California are these study counties?

Children and youth in the study counties closely matched the rest of the state with slight differences in the proportion of children and youth that were of Asian-Pacific Island heritage (higher than state) and whites (lower than state).

Fifty percent of children and youth in the state lived in study counties. Of these children and youth, those with a primary language that was other than English represented a higher proportion of children than seen in the state as a whole.

How representative of California child and youth services users are those who reside in these study counties?

Fifty percent of all child and youth public mental health services users resided in these study counties. There were a higher proportion of African-American children and youth service users in these counties than in the state as a whole.

Across counties there was some variation in service use and between service users.

While research has shown that approximately six percent of California's school-age children have mental health problems, administrative data show that less than two percent are utilizing county mental health services. Child and youth mental health service users constituted two percent of the child and youth population in their counties. In the study counties the proportion of the child and youth population that were service users varied from four percent in San Francisco to one percent in Placer and Santa Clara counties respectively.

Although counties have experienced growing success in servicing this group, too many have needs that remain unmet. Unfortunately, young children and transition-age youth are even more vulnerable as providers and county system leaders struggle to serve them. Across counties public mental health services users who were children and youth differed by racial/ethnicity and primary language spoken.

Racial/Ethnic Background of Public Mental Health Service Users Under 25

Hispanics/Latinos make up the largest racial/ethnic group in California and in the 11 UCR counties. Even though they are also the largest group among county mental health service users, Hispanic/Latino children and youth are still under-represented. Asian-American children and youth are also under-represented; only three percent of service users are Asian-Americans while they make up 13 percent of the California population. African-American children and youth comprise a sizable proportion of public service users as well. Still, system leaders and providers repeatedly report struggles to serve children and youth of color, implying a shortage of adequate and culturally appropriate services for children of color. Similarly, children and youth whose primary language is not English are underrepresented among county mental health service users. Children lacking English language proficiency are also cited as a group that system leaders and providers report as struggling to serve, again supporting the argument for greater attention to increasing cultural and linguistic competencies in mental health service provision.

Demographic Comparisons Across Counties

- There is tremendous racial/ethnic diversity between counties.
- Hispanics/Latinos comprise nearly half (47 percent) of young county mental health service users in Santa Cruz County.
- Alameda County has the largest population of young Black/African-American county mental health service users (45 percent).
- Asian/Pacific-Islanders comprise 14 percent of young county mental health service users in San Francisco County.
- Humboldt County has the largest population of young American Indian/Alaskan Native and white county mental health service users (11 percent and 74 percent, respectively).
- Five counties – Placer, Imperial, Santa Clara, San Mateo, and Butte – do not consistently record the race/ethnicity of their young mental health service users.
- Blacks/African-Americans are over-represented in urban counties, such as Alameda, San Francisco, and Los Angeles. Whites are over-represented in the rural county of Humboldt.

Primary Language Background of Public Mental Health Service Users Under 25

On average 66 percent of young county mental health service users primarily speak English. Spanish is the second most common primary language among young county mental health service users across the 11 UCR study sites. Several counties do not consistently record the primary language of their young service users, particularly Los Angeles and Santa Clara.

Imperial has a higher proportion of Spanish-speaking service users (33 percent) than other counties, likely reflecting the large proportion of Hispanics/ Latinos living there. There is a large number of service users whose primary language remains unspecified, particularly in Los Angeles and Santa Clara counties. Counties without reliable records of this demographic indicator will continue to struggle in assessing efforts toward gaining stronger cultural competencies.

On average over half of child and youth service users in the study counties were covered by Medi-Cal. These service users overwhelmingly accessed community-based mental health services. These services range from individual and group therapy to case management services, intensive therapeutic services to crisis intervention and medication support. Other highlights of the service continuum include:

- Twenty-four-hour services represent only a tiny fraction of service delivery overall; however, within this grouping, many counties continue to rely heavily on residential placements.
- In general, family members and youth report brief waiting periods when seeking professional help, suggesting that when children and youth enter treatment access to services is timely.
- Children and youth with deep-end system involvement are most likely to be served well.

Policy Recommendations

The state of California and counties should:

- establish baseline data on who they serve and outcomes for children and youth;
- widely disseminate data on their child and youth users and their outcomes;
- create targeted strategies to enhance services to children and youth with co-occurring disorders;
- develop targeted interventions and engagement strategies for youth they find difficult to serve appropriately;
- evaluate access to services for youth with substance use disorders and develop a plan for sustaining funding and supports for services to this population; and
- develop strategies to assist counties with advanced mental health systems and supports in juvenile justice to showcase these strategies, and provide peer mentorships for other systems that struggle to serve these youth appropriately.

Research-informed Services (Evidence-based Practices)

County system leaders were less likely to reflect negatively about the use of evidence-based practices (EBPs), compared to providers or state system leaders. Overall, youths and family members that we interviewed had little knowledge about EBPs, indicating either that the youths and family members we interviewed did not receive EBPs or they are not well-informed about treatments that they are receiving. In particular, ethnic minorities were least likely to know about EBPs. Community leaders were more aware of EBPs, but many had mixed views. Among community stakeholders (family members, community leaders, and youth) who knew about EBPs, fully two-fifths expressed concerns and doubts about EBPs. Providers were more likely than either community stakeholders or system leaders to consider EBPs in a negative light. A common thread in the concerns about EBPs was the potential impact on individuals from diverse cultural and linguistic backgrounds.

About 60 percent of system leaders and providers who discussed EBPs are implementing them, suggesting that California system leaders and providers are indeed incorporating EBPs in their service-delivery systems. However, the scope often seems rather limited. The status of EBP implementation also varies by discipline and county.

The major strategy identified for EBP implementation was workforce development. This indicates that counties are still in the process of developing the workforce capacity to provide effective EBPs. A major obstacle to the promotion and adoption of EBPs is the state's inability to accurately track or incentivize their use.

Community leaders, providers, and system leaders all raised questions about the cultural competence of EBPs, suggesting that cultural competency is one of the major challenges to its adoption, given the diversity of California's population. Overall, juvenile justice has the highest percentage of leaders who discussed EBP implementation, followed by mental health and child welfare. Humboldt had the highest proportion of system leaders and providers who discussed the implementation of EBPs, followed by Imperial and San Diego leaders and providers.

THE CALIFORNIA CASE STUDY

STUDY DESIGN

Site Selection

Working with the California Strategic Advisory Work Group, NCCP identified 12 counties in California that are considered innovative in terms of children's mental health service delivery. The work group considered factors such as system of care involvement and cross-system collaborations as well as counties' support of initiatives focused on cultural competence, family/youth empowerment and support, and prevention and early intervention. Additional county diversity characteristics were taken into consideration, such as urban/rural designation, location within the state, and overall demographics. These counties included: Alameda, Butte, Contra Costa, Humboldt, Imperial, Los Angeles, Placer, San Diego, San Francisco, San Mateo, Santa Clara, and Santa Cruz. Of these 12 selected counties, all but Contra Costa County agreed to participate in the study. Of the remaining counties, four are rural and seven are non-rural (suburban or urban).

Data Sources

This study includes three major data sources: primary data collected through face-to-face and telephone interviews and focus groups; program-specific data provided by study participants; and secondary data from the California Department of Mental Health on Medi-Cal and Client and Service Information (CSI) System claims and enrollment data.

Participants

NCCP targeted three types of respondents for participation in the California Case Study:

- *State and County System Leaders* – Individuals who hold high-level county or state positions in child-serving agencies, former county directors, and experts on the following systems or disciplines: mental health; special education; public health; child welfare; juvenile justice; substance abuse and prevention; developmental disabilities; finance; and early childhood.
- *Providers* – Mental health providers: those who deliver any type of direct mental health services to children, youth, or families; and non-mental health providers: those who offer other direct services to children, youth, or families, including teachers and health professionals.
- *Community Stakeholders* – Community leaders: individuals whose prominence in the community stems from the perception that they represent some or all sectors of the community. Their standing may derive from their professional status, residency, group affiliation, historical roots, or moral, religious or ethical stance. Family members: parents, siblings, grandparents, other related primary caregivers, or guardians to a youth up to and including age 18 with the characteristics described above. Youth stakeholders: youths aged 14 to 25 who possessed one or more of the following characteristics: experience with one of the 11 targeted county mental health systems; expressed unmet need for mental health services; involvement with the special education (for SED only), juvenile justice, or social services systems; or identify as a homeless or runaway youth, former or current substance user, or gay, lesbian, bisexual or transgendered.

DATA COLLECTION METHODS

Primary Data

The California Case Study includes a comprehensive array of data collection instruments designed for each type of informant: system leader, provider, or community stakeholder.

Interviews and Focus Groups – Each interview discussion guide contains 15 to 35 questions, depending on area of expertise. Participants were interviewed individually or in small groups. Generally, interviews took place in person unless circumstances warranted a phone interview. Interviews lasted 30 to 90 minutes, with duration varying depending upon the format and response length. No respondent had access to the questions prior to the interview. System leaders were encouraged but not required to provide supplemental data to support their perspectives that would be included in secondary data analysis.

Sampling Methods

Interviews and Focus Group Participants – Invitation letters and informational documents about the California Case Study were sent to children's mental health directors in the 11 participating counties. Each was asked to provide NCCP with a contact to help coordinate the recruitment of system leaders and other stakeholders. A modified snowball technique was employed to identify additional system leaders, experts, and providers from various child-serving agencies in each county as potential respondents. Through these contacts, study fliers, community-based organizations, California-based consultants, and NCCP's local advisory board, we recruited youth consumers and their families from a range of cultural and linguistic backgrounds. The State Department of Mental Health also agreed to participate. A similar snowball technique was used with state-level key informants to recruit other leaders in state child-serving agencies.

Participant Demographics

Seven hundred seven individuals enrolled in CCS. Los Angeles County had the highest number of respondents; Humboldt County had the least. The final number of enrollees in the study for in-person and phone interviews was 676, which included 31 state-level system leaders; 179 county-level system leaders; 185 parents and caregivers; 191 youth; 61 service providers; 29 community leaders.

System Leaders

Two hundred ten state and county system leaders completed the study. Representation was strongest from the mental health sector and weakest from system leaders representing public health, substance abuse and treatment, and developmental disabilities. The average response rate among county system leaders varied widely, from 39 percent (public health) to 83 percent (mental health). Across counties, system leaders from San Diego had the highest response rate (79 percent), whereas Alameda and San Mateo Counties had the lowest (46 percent). Thirty-one state system leaders participated in the study, with the highest response from mental health leaders (93 percent).

Providers

The final sample contained 61 providers. Three-quarters of these were mental health providers; the remaining 15 identified as other health professionals or direct care providers.

Community Stakeholders

Overall, community stakeholder participation was strongest in Los Angeles County and weakest in Humboldt County. The community stakeholders who participated were comprised of community leaders (seven percent), family members (46 percent), and youths (47 percent). In addition to biological parents, family members interviewed also included grandparents, siblings, and foster parents.

An effort was made to engage a sample of community stakeholders that accurately reflects the cultural and linguistic diversity of each county. NCCP obtained the primary threshold languages of Medi-Cal beneficiaries for all of the target counties as a proxy measure for the linguistic backgrounds of the consumers. The number of threshold languages varied by county, with up to 12 in Los Angeles County. NCCP hired field staff representing 11 linguistic capacities, including Spanish, Tagalog, Vietnamese, Mandarin, Cantonese, Korean, Farsi (Dari), Khmer (Cambodian), Russian, Hmong, and West Armenian. All consent forms were made available in each of these languages, with the exception of Hmong and Tagalog. NCCP also partnered with a variety of organizations to target a number of culturally-specific groups, including the Asian American, African American, Russian, Middle Eastern, and Latino communities.

Secondary Data

To supplement and verify information obtained during primary data collection, NCCP researchers engaged in an extensive secondary data collection process. In addition to information provided by interviewees, NCCP analyzed the following sources:

- Medi-Cal Data Sets (2001-2006);
- County Secondary Data Sheets: Data sheets designed by NCCP were distributed to one key system leader by discipline in each county. The data sheets were intended to collect information on each county's service access and available funding streams;
- Client and Service Information System (CSI) Data; and
- California Outcomes Measurement System (CalOMS) Treatment Data.

Recommendations

The state of California and counties should:

- track and measure effectiveness and monitor or improve program implementation as an integral part of EBP implementation. This should include developing outcomes for children, youth and their families and indicators based on selected interventions;
- develop a mechanism for reaching consensus on fiscal ways to support implementation of EBPs;
- expand workforce competencies in EBPs in general and include a focus on culturally and linguistically appropriate EBPs and culturally-adapted strategies;
- increase technical assistance and supports on EBPs, the implementation of EBPs and county specific contexts for optimal adoption for providers;
- develop incentives to implement EBPs (include adequate reimbursement to cover costs associated with implementation and engagement strategies);
- reach out to community stakeholders and increase their awareness and knowledge regarding EBPs; and
- create general and targeted strategies to disseminated information of EBPs for all stakeholders.

Developmentally-appropriate Services and Supports

California system leaders and providers perceive the service capacity for young children as strong, which they attribute to strong collaboration across disciplines. School-based services are also seen as a strength and strong programming reflects AB 3632 (funding stream specifically for youth in special education with mental health problems in California that falls under the jurisdiction of the county mental health authority). On the other hand, services for transitional age youth were less frequently discussed compared with services for young children and school-age children and youth. Respondents who talked about services for transitional age youth (TAY) often discussed vocational and housing services.

Public financing was seen as a strength underlying services for school-age children. Yet across the developmental span, lack of funding was discussed as a major barrier for implementing services.

Overall, administrative data from the Client and Service Information (CSI) System shows strong services for school-age children in California. Leaders from more than half of UCR counties are also incorporating evidence-based services in school settings.

Recommendations

The state of California and counties should:

- support state and professional efforts to improve the competencies of all providers and teachers who work with children and youth with or at risk for mental health conditions so they are prepared to meet the needs of children;
- develop a comprehensive strategy and increase resources to support and expand the provision of prevention, early intervention and treatment services across the age-span;
- expand program service eligibility and flexibility for children and families covered by Medi-Cal, including opening up community-based services to transition-age youth to reduce inpatient service costs; and
- increase support and services for TAY transitioning to the adult system, including increasing Medi-Cal eligibility for TAY involved in the mental health system up to age 25.

Family- and Youth-driven Services

Researchers, advocates, and policy makers acknowledge family- and youth-driven services are a core component in promoting the transition from a child-centered perspective to a family-centered perspective in children's mental health policy and practice. Family and youth involvement and advocacy is a fundamental aspect to family- and youth-driven services.

Overall, system leaders and providers recognized the importance of family- and youth-driven services to support and promote positive change for

children and youth and their families. Most often, respondents reported on direct services that were offered at a local, county, and state level to treat the whole family. However, state or county strategies to promote the philosophy of family- and youth-driven services were not always consistent.

System leaders and providers discussed the array of services offered by their county or organization. They emphasized clinical treatments provided to children, youth, and families. Interestingly, in the analysis of the family and youth stakeholder interviews, we found that family member and youth stakeholders perceived clinical services and clinical workers to be the most helpful. In addition, family members and youth found community-based services to be the most helpful.

System leaders and providers described strategies and challenges to youth and family advocacy and involvement. These strategies reflect variation in involvement and advocacy by county and discipline. Analysis of the community leaders, family members and youth stakeholders reinforces this theme. Over one third of youth reported being actively involved in advocating for themselves or others with mental health care needs. There was significant involvement in advocacy by family members, youth and community leaders, but there is still progress to be made, specifically with non-English speaking stakeholders.

We provide insight into the perspectives of system leaders, providers, family members, and youth at a county and state level. The targeted counties appear to embrace the philosophy of family- and youth-driven care. Although, the philosophy is not fully embedded in practice across all counties and disciplines, there is progress being made towards family- and youth-driven services and care.

Progress varies by county and within county, and in order to create greater system-wide change, policies and funding streams need to facilitate family- and youth-driven services. Strategies need to go beyond providing direct services for select populations and reflect the overall philosophy of family- and youth-driven care where services are customized based on the individual needs of the child/youth and his or her family and at their direction. These changes in philosophy need to come from leadership at the state and county level to encourage the system to look at the family as a whole and perceive the family as a partner in reaching the desired goals of each child, youth, and family.

Policy Recommendations

The state of California and counties should:

- enact policies and funding streams needed to facilitate family and youth-driven services;
- ensure that strategies reflect overall philosophy of family and youth-driven care; and
- build capacity for more culturally and linguistically competent services to help promote advocacy in non-English speakers.

Culturally- and Linguistically-competent (CLC) Services

On the whole, system leaders and providers equally discussed strengths and challenges in providing culturally- and linguistically-competent services. The most frequently mentioned strengths by system leaders and providers were structural strengths such as providing specific CLC programs. The Mental Health Services Act (MHSA) is also perceived as a positive vehicle to promote CLC services. One notable strategy mentioned by system leaders and providers is providing incentives for hiring or developing bilingual and bicultural staff. The most frequently mentioned challenges relate to infrastructure issues, such as lack of culturally and linguistically competent staff and training. The second most frequently discussed challenge was the gap in services. System leaders and providers felt that Latino and Asian/Pacific Islander were the groups most lacking in terms of CLC services. Among community stakeholders, variations exist on the factors influencing access to children's mental health services. African-Americans perceived their race as a factor affecting their service access, while Latino and American Indian/Alaskan Natives felt neighborhood is the factor. An equal proportion of Latino groups suggested there was no effect of socioeconomic or demographic status on access. Asians/Pacific Islanders saw language and culture as major barriers to access.

Recommendations

The state of California and counties should:

- provide for and support counties leaders in the development of strategies to build an infrastructural response to improving the level of systems' cultural and linguistic competence and to reduce disparities based on race/ethnicity and language access;
- expand the workforce's capacity with providers from diverse racial, cultural, ethnic and linguistic communities;
- develop core competencies for providers in cultural and linguistic competence and provide necessary training to attain these competencies;
- address providers' concerns regarding insufficient cultural and linguistic competence and inadequate experience in specific community-based interventions for working with diverse populations;
- provide funding for intensive community engagement strategies;
- build on successful models implemented through the Mental Health Services Act and other funding;
- address the challenges posed by the non-supplantation clause, which undermines sustainability of effective cultural- and linguistically-appropriate programming;
- support capacity improvement for more culturally and linguistically competent services to help promote advocacy among non-English speakers;
- finance county to county peer learning on innovative strategies and effective interventions that improve cultural and linguistic competence in service delivery and reduce disparities;
- ensure that services provided to immigrants are effective and culturally and linguistically competent; and
- track data on race, ethnicity and English language proficiency of service users and their outcomes.

Prevention and Early Intervention (PEI) Within a Public Health Framework

California has enacted groundbreaking policies (MHSA, First 5, EPSDT expansion) designed to bring the children's mental health system in California toward a system of prevention and early intervention within a public health framework. System leaders and providers discussed strengths in PEI, which include a greater awareness of its value, and an increased emphasis on PEI efforts and initiatives. Respondents discussed a vast array of prevention programs and initiatives for early childhood and school-age youth, but offered few examples of prevention programs for transition-age youth.

Though California has made many strides in implementing prevention and early intervention, respondents also discussed challenges including low resources, service capacity, and lack of systemic priority in providing PEI services.

In these tough economic times, it is critically important to raise awareness of the long-term benefits and cost-effectiveness of PEI in reducing behavioral and emotional disorders in children.

Recommendations

The state of California and counties should:

- increase legislative and systemic funding, focus and support for prevention and early intervention practices and policies in mental health, as well as continued expansion of assessment and screening of at-risk children who may otherwise "fall through the cracks;"
- expand application and outcome tracking of evidence-based child and family prevention programs, supports, policies and strategies to help reduce risk factors in the child's environment (community, family, school, and individual) that can lead to future problem behaviors;
- integrate positive youth development models system-wide to increase bonding of children and engage families and communities in promoting and enhancing positive mental health in children; and
- strengthen collaboration within communities, and across county, state and federal disciplines through shared language and vision of children's

mental health; strategic planning; resources coordination; and the development of measurable outcomes tracked over time to ensure accountability over the long-term.

Financing Children's Mental Health Services

The study's review of financing in the counties included secondary data analysis using Medi-Cal data that confirmed information from key informant interviews of system leaders and providers who identified school-age children and youth as having the greatest access to mental health services. These analyses also support key informant themes that children and youth who are school-aged have access to a more vibrant and wider array of mental health services and supports than children in early childhood or youth transitioning to adulthood. The consequences of this according to our review of Medi-Cal data is one of displaced utilization by youth transitioning to adulthood. These youth and young adults with mental health problems are disproportionately represented in the most costly of the mental health treatment sector, inpatient care. They are driven to this level of care because of the poor funding options at the community level. This finding suggests that policy changes that open up community-based services to this group might be the most cost effective policy option.

The analyses also showed that among Medi-Cal enrollees, children with mental health conditions were more likely to be male than their counterparts without mental health conditions. Further, and consistent with other studies, per-claimant costs varied widely. However, the state's ability to understand the implications of this variation is somewhat limited by the inability to track costs and utilization data more precisely. Certain service categories are tracked in a manner that prevents service cost comparisons at a macro level or hinders greater understanding of the relative fiscal implications of different services within a service category. These challenges have serious implications for the delivery of effective services in the outpatient setting. In particular, despite an apparent policy push to advance evidence-based practices, these services are not easily tracked and not easily supported through financing.

Stakeholders provided perspectives on the strengths and challenges associated with adequately financing a range of children's mental health services in California that on balanced weighed heavily toward major barriers. While they identified major sources of funding, they also referenced the compelling need to support a comprehensive array of services and pinpointed the pivotal role Medi-Cal/EPSDT and MHSA plays in increasing access to services as clear system benefits. Emerging tensions and distrust often characterize stakeholder relationships particularly between different levels of government and between payers and providers. Increased fiscal tensions, particularly with Medi-Cal/EPSDT, has led some stakeholders perceive fiscal policy as one that undermines a comprehensive set of services, threatens innovation and flexibility and compromises greater adoption of funded empirically-supported or evidence-based practices.

A major concern is how to sustain existing programs as reflected in the views presented. In 2009 California faced one of its most severe budgetary crises. Significant paralysis in public budgetary decision-making ensued that put crucial mental health funding such as MHSA funding, a targeted fiscal stream, in jeopardy. MHSA's major components survived a ballot initiative aimed at redirecting some of those funds. The public financing of mental health services for children and youth in California remains fragile.

Policy Recommendations

The state of California and counties should:

- expand program service eligibility and flexibility for children and families covered by Medi-Cal. This should include policy changes that open up community-based services to transition-age-youth as a cost effective policy option;
- improve their abilities to track service utilization and costs, including tracking incentives for the implementation of evidence-based programs;
- develop specific fiscal incentives with relevant billing coded to encourage implementation of evidence-based practices;
- develop appropriate tools to measure change in child/participant, family and community level outcomes, both short term and long term;

- establish well-defined outcomes and indicators for tracking child and family outcomes at program and system levels;
- ensure that data sharing is a top priority by: (a) requiring the sharing of electronic records and data across counties and agencies; (b) making data sharing a condition of joint planning for children and family services; and (c) safeguarding privacy; and
- promote an effort to develop appropriate measuring tools and maintain consistency in evaluating service and system impacts on children and families.

Information Technology and Outcome Measurement

Information technology systems and outcomes management components provide accountability and transparency, which can contribute to more effective and sustainable services to children and families in need. The California DMH has encouraged the use of technology systems by providing funding, including MHSA funding, to counties to develop IT improvements and to implement electronic records. Respondents shared that data collection allows for quality assessment and improvement of services. Data sharing across systems can help facilitate joint-planning and better outcomes for families. There is some provider resistance to using IT systems. Information technology tracking systems are used for billing and finances and not outcomes. Some respondents noted confidentiality concerns and conflicts with HIPAA.

There have been some improvements in individual and program level outcomes, yet there is systematic inconsistency in measuring outcomes across all children in the system. At a system level, county reported performance measures are not appropriately measuring effectiveness of system-level impact on families and children. Respondents reported that outcome management is in its infancy. Numerous respondents suggested a lack of funding, data, and clear definitions as some of the challenges in measuring outcomes.

Recommendations

The state of California and counties should:

- establish well-defined outcomes and indicators for tracking child and family outcomes at program and system levels;
- increase in sharing of electronic records and data across counties and agencies to help facilitate joint-planning for children and family services;
- develop appropriate tools to measure change in child-participant, family and community level outcomes, both short term and long term; and
- promote an effort to develop appropriate measuring tools and maintain consistency in evaluating service and system impacts on children and families.

Lessons Learned

Consensus among key informants on areas that need reform in children's mental health is evident. Broadly, key informants agree that major changes need to occur in how services are delivered and funded. The nature of the suggested reforms in funding ranged from broad changes beyond the field such as universal insurance reform to targeted initiatives such as facilitating integration and funding flexibility. In particular, system leaders and providers expect to see the funding reform from the federal level.

This level of agreement across key stakeholders in the mental health system suggests room for a more cohesive and coherent agenda for children, youth, and their families. It also indicates that the state children's mental health field may be well-positioned to speak with one voice on funding and service delivery. All participants also agreed on the need for more family-based services, but in its implementation, it appears to mean different things depending on the key informant. While community stakeholders identified the need for strategies such as outreach and information to navigate the system, system leaders and providers did not mention these two important strategies. This gap suggests that state leaders need to create institutional policies that address these strategies in order to facilitate better access.