

Mental Health Service Utilization for Transition Age Youth in the Child Welfare System:
Tracking the Early Implementation of the Mental Health Services Act in Santa Clara
County

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Executive Summary

Introduction

For transition age youth in the child welfare system who are also being served by the public mental health system, the transition out of state care and into adulthood occurs during a critical developmental period. Research suggests that this developmental stage, often characterized as “emerging adulthood,” constitutes an important time period for learning adaptive behaviors and promoting resilience (Arnett, 2000; Hines, Merdinger & Wyatt, 2005; Obradovic, Burt & Masten, 2006). For transition age youth involved in the child welfare and mental health systems, experiences of trauma, lack of family support, and often long histories in out-of-home care may contribute to and worsen mental health problems, placing these youth at risk for a number of challenges during the transition to adulthood. When transition age youth are discharged from both the child welfare and mental health systems, typically at age 18, they face new eligibility requirements in order to access public services. This leaves many vulnerable youth with few resources, guidance or support during a time of increased vulnerability.

With the passage of Proposition 63 in November 2004, California voters approved approximately \$700 million in new state funding for mental health services in California; approximately 20 percent of these funds are being devoted to children

and youth with mental health problems (California Department of Mental Health [CDMH], 2007). As California counties implement Proposition 63, now commonly referred to as the Mental Health Services Act (MHSA), mental health systems have a unique opportunity to fill the critical gap in mental health services for transition age youth involved in both the child welfare and mental health systems. The potential for improving services to promote resilience and positive outcomes for this population hinges on the extent to which the child welfare and mental health systems are able to collaborate effectively.

In order to help inform the process of service development and implementation associated with the MHSA, there is a need for a better understanding of this population of youth, as well as factors that impact interagency collaboration between the child welfare and mental health systems. This study builds on a previous CalSWEC-funded study on mental health service utilization and outcomes for child welfare clients (Hines, Lee, & Osterling, 2006) and ongoing partnerships with the mental health and child welfare systems in Santa Clara County, a large and extremely diverse California county.

Research Questions

Five sets of research questions guided the study. The first four sets of questions were studied with quantitative methods and a sample of transition age youth (ages 15 to 19) who were concurrently receiving services through the child welfare and mental health systems in Santa Clara County, and included the following:

1. Demographics: What are the demographic and child welfare system-related characteristics of transition age youth in the child welfare system who are involved in the mental health system? How does this group compare to transition-age child welfare clients who are not involved in the mental health system?
2. Need: What is the clinical need (youth functional status and diagnosis) for mental health services of transition-age youth in the child welfare system? Are there differences by demographic and system-related characteristics regarding the clinical need for mental health services?
3. Utilization: During early implementation of the MHSA in Santa Clara County: What are utilization patterns for transition-age child welfare clients involved in the mental health system? What types of services are utilized? What is the intensity (i.e., frequency and duration) of services? What demographic and system-related characteristics are associated with treatment type and intensity? What is the relationship between clinical need (youth functional status and diagnosis) and treatment type and intensity?
4. Outcomes: During early implementation of the MHSA in Santa Clara County: What is the association between mental health service utilization and child welfare system placement status, including relative and non-relative foster care; group home or residential treatment center; transitional housing; and family placement? What is the association between mental health service utilization and youth functional status and diagnosis? What demographic and system-related characteristics are associated with mental health service utilization and placement and functional status?

The fifth set of questions utilized qualitative methods and a sample of professionals involved in the child welfare and mental health systems in Santa Clara

County and focused on:

5. System Collaboration: Prior to and during early implementation of the MHSA in Santa Clara County, what factors impede or facilitate collaborative practice between the child welfare and mental health systems, with a particular focus on transition age youth? What are the specific provisions in Santa Clara County's implementation of the MHSA for interagency collaboration with regard to transition-age youth?

Methods

In order to address questions 1 through 4, analysis was conducted on a merged database with child welfare and mental health system data. The study included a total sample of (N=3,347) total case closures over an 18-month period between November 1, 2005 and April 30, 2007. The sample size of all transition-aged youth in the child welfare system (CWS) was 638 clients of the 3,347 cases extracted during the study period. Within this 638 TAY sample, 147 transition-aged youth were involved in the mental health system (MHS) and 481 were not referred to the MHS, serving as the comparison group.

Analysis consisted of a series of univariate, bivariate, and multivariate tests. Univariate and bivariate statistics were utilized to answer the questions regarding demographics and differences according to major characteristics, including the initial comparison of those children referred to the MHS versus those who were not referred. Bivariate analyses were also used to answer the questions regarding MHS utilization according to major characteristics. Finally, multivariate logistic and linear multiple regression models were utilized to answer the questions regarding significant predictors related to mental health service utilization and to child welfare system outcomes.

In order to examine question 5 - interagency collaboration with regard to transition age youth prior to and during early implementation of the MHSA, a case study qualitative research design was utilized. A case study qualitative research design involves the study of an issue or problem that is examined by exploring "cases" within a "bounded system" (Creswell, 2007). This study is exploring interagency collaboration as it relates to transition age youth, from the perspectives of two "cases." The two cases include the Child Welfare System (CWS), specifically the Department of Family and Children Services (DFCS), within Santa Clara County, and the Mental Health System (MHS), specifically, the Mental Health Department (MHD), in Santa Clara County. The "bounded system" is the setting or context in which these cases are located—in this study, the bounded system is Santa Clara County. Santa Clara County is a large and ethnically diverse County located in the Bay Area of Northern California.

Interviews with program managers and supervisors in both the CWS and MHS in Santa Clara County, as well as within community-based organizations funded by the MHSA to provide services to transition age youth were conducted in order to understand perspectives from both systems. To measure interagency collaboration before the MHSA, qualitative data collected during our previous CalSWEC-funded study (Hines, Lee, & Lemon, 2006) during February-March 2006 (Time 1) was used and compared to responses from participants during interviews this year (February-May, 2007).

Interview data were analyzed using Atlas Ti, a qualitative analysis software package. Qualitative analysis procedures included a process of reviewing transcribed notes of interviews to identify preliminary topics related to each question or set of

questions; preliminary themes were then coded (i.e. the occurrence of each theme in the interview was identified and tabulated). Coded topics were then condensed through a process of combining codes into broader categories. The final coded topics were then arranged into Figures (i.e. Figures, 1, 2 and 3 in Results Section) in order to illustrate the responses that related to the interview questions.

Key Findings

In answer to our first set of questions, regarding demographics, CWS characteristics of TAY involved in the both the CWS and the MHS, compared to those CWS youth not involved in the MHS the following key findings emerged:

- The average age at time of CWS entry of the TAY referred to the MHS was significantly older than those not referred to the MHS.
- Those TAY referred to the MHS entered the MHS an average of 3 years after their entry into the CWS.
- There were no significant differences between those TAY referred to the MHS and not referred regarding the demographic characteristics of gender and ethnicity.
- A greater percentage of those TAY who were physically abused or sexually abused were more likely to be referred to the MHS compared to those transition-age youth suffering other types of abuse.
- TAY referred to the MHS were more likely to have their cases closed with a classification in family reunification compared to those not in MHS.
- Transition-age youth referred to the MHS had shorter stays in the CWS.
- Those referred to MHS were more likely to have the family stabilized than those not referred to the MHS.

Regarding our second set of questions regarding the clinical need of TAY in the CWS referred to the MHS the following key findings emerged:

- Regarding clinical need, as reflected by primary diagnoses of TAY, the majority were designated with an adult-type disorder,
- In regards to the age at entry into the CWS, those with adjustment disorders entered the CWS at the oldest age and those with childhood disorders at the youngest.
- Diagnosis varied significantly by gender; girls were classified more often than boys with adult disorders and boys classified more often than girls with childhood disorders.
- Diagnosis did not vary by ethnicity.
- A greater proportion of females within the Latino and Asian/PI groups were more likely to be diagnosed with an adjustment disorders compared to Whites and African Americans.
- TAY diagnosed with childhood disorders had a significantly longer average stay in the CWS compared to those with adjustment disorders and adult disorders.
- In testing time in the CWS by ethnicity and primary diagnosis, there was not a significant interaction effect. There was an indication of a main effect by ethnicity; among the 4 major groups, Asian/PIs were in the CWS significantly less time than Latinos, African Americans, and Whites.

Our third set of questions focused on MHS utilization by TAY in the CSW. The following are the major findings related to this area:

- Regarding out-patient services, the average dosage was 1.56 hours of service.
- The overwhelming majority of TAY received out-patient services as the primary mode of treatment.
- There was no significant relationship regarding age at entry into the CWS, gender, ethnicity, type of abuse, service component at time of case closure, or time in the CWS with mode of mental health service.
- No statistical relationship was found with CWS characteristics (age at CWS entry and time in CWS) and dosage of out-patient services.
- There was no significant relationship regarding gender, ethnicity, type of abuse, or service component at time of case closure with dosage of outpatient services.
- In predicting the utilization of out-patient services (dosage in hours), the overall model with age at CWS entry, time in the CWS, sex, ethnicity, type of abuse leading to removal, service component at time of case closure, and mental health diagnosis was not significant. Within the model, none of the individual predictors was significant.
- In predicting mental health treatment completion (vs. treatment non-completion, other or unknown outcomes) of those receiving out-patient services, the overall model with out-patient dosage (services in hours), age at CWS entry, time in the CWS, sex, ethnicity, service component at time of case closure, type of abuse leading to removal, and mental health diagnosis was significant. Within the model, dosage of out-patient services was significant with those receiving more treatment more likely to have completed treatment. Also, those diagnosed with an adjustment disorder were less likely to have completed treatment compared to those with a childhood disorder.

Regarding MHS Utilization and CSW Outcomes for TAY the following findings emerged:

- Within the sample of CWS transition-age youth referred to the MHS, there was no statistical relationship between whether youth were stabilized with their families and mode of mental health services.
- In examining family stabilization by major CWS demographic characteristics (age, gender, and ethnicity) specifically among those who received out-patient services, a significant relationship was found with age at entry into the CWS. Among those who received out-patient services, those who entered the CWS at an older age were also more likely to have their family stabilized compared to those who entered at a younger age.
- Among those who received out-patient services, no relationship was found between gender and stabilization; and, no relationship was found between ethnicity and stabilization.
- In predicting family stabilization, age at CWS entry was significant with

those entering at an older age more likely to be stabilized and similarly time in the CWS was significant, with those in the system less time more likely to be stabilized. Service component at time of case closure was also significant with those in FM more likely to be stabilized than those not in FM. Since FM means that families would be receiving the very services that promote family stability, cases with that closing service component would be expected to be more likely to be stabilized. Diagnosis was also significant with those with an adjustment disorder or adult disorder) more likely to be stabilized with their families than those diagnosed with a childhood disorder.

Our fifth set of questions utilized qualitative methods and focused on system collaboration and barriers to service utilization for TAY. The following summarizes results in three areas:

1. Service Needs of Transition Age Youth and Existing Collaborative Practices (implemented before the MHSA) focused on serving Transition Age Youth during Emerging Adulthood:

- ◆ Respondents identified developmental and contextual service needs focused on the unreasonable expectation of independence at age 18 for transition age youth who have grown up within the context of the child welfare and mental health systems.
- ◆ Respondents also discussed the need for more formal services for transition age youth including substance abuse and housing services, and the need for more informal support services, such as mentors and greater attention among workers to listening to the youth themselves.
- ◆ The Independent Living Program and emancipation conference were mentioned as existing interventions that serve as a potential point of collaboration between the child welfare and mental health systems, although no formal collaboration between ILP and mental health is currently taking place.
- ◆ Similarly, California Connected by 25 (CC25), a new initiative aimed toward transition age youth in the child welfare system, was identified as a potential point of collaboration between the systems, although no formal collaboration between CC25 and mental health is currently taking place.
- ◆ Last, wraparound and system of care services (focused on collaborative and intensive services) were described by respondents as beneficial and effective for transition age youth involved in both systems.

2. Specific Provisions in Santa Clara County's Implementation of the Mental Health Services Act (MHSA) for Interagency Collaboration with Regard to Transition Age Youth: The Full Service Partnership Program:

- ◆ Interview respondents indicated that the only program currently being funded by the MHSA that is targeted toward transition age youth in child welfare and mental health systems is the Full Service Partnership program.
- ◆ Key informants from community based organization implementing the Full Service Partnership program described the program as holistic and strength-based, yet also indicated that (at the time of the interview) little training had been conducted on how to implement the program and receive referrals and there was

an overall limited number of available slots for youth (a total of 30 youth slots among the three service providers).

- ◆ In addition, respondents also commented that the Full Service Partnership programs for transition age youth are focusing their referrals on youth coming from the juvenile justice system, rather than the child welfare system.
- ◆ A focus on the juvenile justice system, rather than the child welfare system was described as a strategic decision related to funding and the belief that youth in the juvenile justice system have access to fewer resources than those in the child welfare system (who have access to Medi-cal).
- ◆ As a result of this focus on the juvenile justice system, respondents did not describe collaborative practices between the child welfare and mental health systems in the implementation of the Full Service Partnerships.

3. Factors that Impede or Facilitate Collaboration between the CWS and MHS Prior to and during Early Implementation of the MHSA:

- ◆ In general, respondents continued to emphasize topics related to system divisions and a need for collaboration and integration of services and systems.
- ◆ Factors that impede collaboration included: 1) system divisions (i.e. differing professional orientations, differing goals and mandates and eligibility restrictions), 2) budget stressors—discussed only at Time 2 (i.e. separate funding, unstable funding, and mental health budget cuts), and 3) workload stressors—discussed only at Time 2, which indicted burnout and turnover of employees.
- ◆ Factors that facilitate collaboration included: 1) increasing communication (i.e. meetings, public awareness, and use of internet and newsletters, and 2) service integration (i.e. cross-training, developing a common vision and organizational support, joint funding and co-location of services).
- ◆ During the Time 2 interview, there was a new and strong emphasis on budget problems as a critical barrier to interagency collaboration, as well as the role of heavy workloads in preventing collaboration from occurring.
- ◆ In addition, during the Time 2 interview, respondents also discussed the potentially beneficial role of increasing public awareness and using joint funding to meet the needs of transition age youth in the CWS and MHS.

Implications for Practice, Policy, and Further Research

Taken together, these findings suggest several implications for practice, policy, and research. With respect to practice, perhaps the most striking finding is the overall lack of mental health services provided to transition age foster youth. Transition age youth in the child welfare system are at a high risk for a variety of mental health problems, yet the average dosage of outpatient mental health services provided to the sample in this study was just over 1 ½ hours of outpatient services. While outpatient therapy/counseling was the most common mode of treatment provided, the short amount of time that transition age foster youth spent in services may indicate that outpatient mental health services may not be the best treatment modality for this population. Developmentally, transition age youth are within an “emerging adulthood” stage of development in which they are exerting independence as they transition from adolescence into young adulthood. As such, transition age youth may not be easily engaged into traditional outpatient mental

health services and may simply not comply with treatment. More research is needed on the types of interventions that would be most effective in engaging transition age foster youth into services and promoting more resilient outcomes among this population.

In addition, qualitative results suggest that continuing problems with collaborative practice between the CWS and MHS may also be a contributing factor to problems in mental health service delivery to transition age foster youth. Although in the previous study conducted in 2005-2006, respondents in the qualitative portion of the study expressed hope and excitement regarding the potential of the MHSA to increase collaborative practice between the CWS and MHS, findings from this study suggest that new system stressors are negatively affecting collaboration between the two systems. Budget cuts in the MHS, combined with workload stressors, such as burnout and turnover, were emphasized by interview respondents during the follow-up interviews as barriers to collaborative practice. Practice implications of these findings suggest that both the CWS and MHS need to renew efforts to promote collaborative practice by focusing on increasing communication and promoting system integration.

With respect to policy, the current study has implications for the continuing implementation of the MHSA in Santa Clara County, and around the state of California. At the time this study was conducted, implementation of the MHSA in Santa Clara County was just beginning and the Full Service Partnership (FSP) was the only program being implemented that was directed specifically toward transition age youth. Although strategic plans related to the MHSA indicated that transition age youth in the child welfare system were supposed to be included within the target population for the FSP, qualitative results indicated that, in practice, foster youth were not receiving FSP services, nor were they being targeted for services. Instead, transition age youth from the juvenile justice system were being targeted for FSP services. Targeting FSP services to youth in the juvenile justice system was described as a strategic decision related to funding streams; specifically youth in the juvenile justice system cannot qualify for Medi-Cal, while those in the child welfare system can (and therefore presumably qualify for public mental health services). Because the FSP is being funded through the MHSA, it was considered a program that could be directed toward juvenile justice youth—without the restriction of Medi-Cal eligibility. However, quantitative results from this study suggest that even though transition age youth qualify for Medi-Cal, they appear to be receiving only a very small dose of outpatient services through the Medi-Cal based public mental health system. Thus, the belief that transition age youth should not be targeted for FSP services because they are being served through Medi-Cal appears to be erroneous.

Results from the current study indicate that, even though transition age foster youth may qualify for Medi-Cal, they should not continue to be left out of the MHSA implementation. In the MHSA plan for Santa Clara County other services for transition age youth that are planned (but not yet implemented) include a crisis drop in center, partnerships with education, and a redesign of the outpatient behavioral system. Findings from this study clearly suggest the need for an increased focus on the mental health service needs of transition age youth in the child welfare system within the implementation of the MHSA. The new funding associated with the MHSA, combined with the planned programs that have yet to be implanted, provide an important opportunity for meeting the needs of transition age youth in the child welfare system.

This study, conducted during early implementation of the MHSA, points to the critical need for more mental health services, and perhaps, different treatment modalities, to meet the needs of transition age youth in the child welfare system.

In addition, this study also had implications for future research. As was noted above, more research is needed on the specific types of mental health interventions that are most effective with transition age youth in the child welfare system. Experiences of trauma, poverty, and out-of-home placement create unique service needs among this population, and more research is needed to understand the types of interventions that are most effective in promoting resilient outcomes. There is also a need to continue to evaluate the impact of the MHSA on transition age youth in the child welfare system, as well as the impact of the MHSA on collaborative practice between the CWS and MHS. Future studies may assess the degree to which transition age foster youth are being served by MHSA programs, the types of outcomes associated with participation, as well as any improvements or decline in the level of collaboration between the CWS and MHS.

Overall, the current study has shed light on the population of transition age youth who are involved in both the child welfare and mental health systems. This group of young people must transition out of state care and into adulthood during a critical developmental period. This developmental period of “emerging adulthood” is a time for learning new behaviors and skills. Mental health services provided during this developmental stage may be of critical importance in promoting resilient outcomes among transition age foster youth. The MHSA provides a unique opportunity to provide more services to transition age youth in the child welfare system, as well as services that are more developmentally appropriate for this population. This study has identified a number of important findings that can inform the continuing implementation of the MHSA. Ultimately, utilization of these findings within the MHSA implementation has the potential to improve services and outcomes for transition age youth in the child welfare system.

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