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NOTES OF COMMUNITY HEALTH CARE ROUNDTABLE

Thursday, April 21, 2005

FOCUS:

- 1) **Fresno Area Teen Screen Project** – **LeAnn Gouveia**, Executive Director, Survivors of Suicide; **Colleen Gregg**, Site Coordinator; **Cathy Phillips**, Mental Health Services Coordinator, Pages 1-6
- 2) **Central California Children’s Mental Health Update** – **Vera Kennedy**, CEO, Pages 7- 14
- 3) **Fresno County Department of Health Services, California Children’s Services** – **Eileen Rodriguez**, Division Manager and Administrator, Pages 14-15

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Fresno Area Teen Screen Project

LeAnn Gouveia, Executive Director, Fresno Survivors of Suicide Loss

Today I’m going to give you a short background on how Fresno Area Teen Screen Project got started and how we got to where we are today. We started a taskforce in suicide prevention a few years ago and tossed around some ideas. As a committee we started looking at the Columbia Teen Screen Project. Columbia Teen Screen is a mental health checkup program for high school students across America and probably in other countries now. It’s out of Columbia University in New York City. In the meantime, as we were looking at the program, there was a school psychologist at Hoover High who went to a conference workshop, and Cathy also went to a conference workshop on Columbia Teen Screen, and things just sort of coincided. Cathy was able to get the idea through the Fresno Unified School Board and it passed with flying colors. Then we started our planning of the project, which was a lot of planning, application to Columbia, and site coordinating. We started our first pilot in October of last year. It has been very successful, and we’re happy to talk to you about it.

Colleen Gregg, Health Educator, Health Department

Teen Screen really is about giving youth a mental health checkup. You’ve all been there before as teenagers. It’s a very, very difficult time for young folks, and often they don’t know who to talk to. Some are experiencing numbers of problems, and when they don’t know how to deal with their stress and their problems sometimes they’re turning to drugs and self-destructive behavior. We know that suicide is a huge issue among the youth. I want to talk about the

successful project that we've had in Fresno County. I'm very, very grateful that the health department has made this commitment to have myself, my supervisor, and a number of our staff involved in this Teen Screen Project in our community. We were only the second community in the State of California to offer Teen Screen to high school youth, so we're pretty proud that we moved forward with this effort.

Before Teen Screen Project in Fresno could be implemented, it was important to make sure that once kids were identified as being at risk there were resources available to provide the needed services

For several years we were meeting with a number of community members to talk about how we were going to deal with mental health issues and depression of youth and ultimately, unfortunately, youth suicide. Some of you know that is particularly of concern to us in our Hmong community. We had some association and some interest in Columbia Teen Screen. We contacted them. They told us we needed to submit a very, very lengthy and involved application to them, and we worked on that for about five months. It was important to us and critical to us that if we identified youth who had depression and other mental health issues that we were absolutely confident that we had places to send them in the community and if they were high-risk and needed to see somebody immediately that in fact those resources were there for us to plug them into. It was very important to Columbia University and very important to us that we identified our safety net, so we recruited community members and private practitioners and we trained and we made sure that we had services available, free, sliding scale, and Medi-Cal, services, that would accept their insurance and we had services that were culturally and language sensitive for the kids that we knew we were going to be seeing.

Hoover High School was very receptive to the program and got on board with the help of school psychologist, Sandra Pancratz, the principal, Doug Jones, and the Biology Department teachers

We're very, very fortunate that at Hoover High School the psychologist, **Sandra Pancratz**, had also at this time been back in Washington D.C. and attended a workshop and heard a little bit about Columbia Teen Screen. She talked to her administrator, Doug Jones, at Hoover High School, and I can't say enough about the work that they've done to be on board at Hoover High School with us. We went in to speak with the Biology Department and said, "We need to come into your classroom. We're going to do some education with the students. We're going to try to do some education for parents in our community. We need to pull the kids out of your class for this Teen Screen. We need you to help us facilitate this on campus," and they said, "What else can we do?" They started telling us about their experiences with kids that are high-functioning in the schools and are involved in sports, cheer, leadership, and doing very well in their classes who are coming to them secretly and saying, "I'm not handling things. I don't know what to do. I'm thinking of killing myself." There are also kids who come to our attention because they're not getting to school, but it's often the ones who fall between the cracks that we don't think of, kids that don't look like they need help, who in fact need help. Many of us in this room have known and have lost people to suicide. I lost a brother to suicide who struggled with this for many years. He was very bright. He was very, very well liked. He had personality plus. He was very sensitive. He was a great athlete, and he took his life, so I am particularly committed to

this issue, and I know others of you are as well. If you've worked with youth you know that they are a very interesting, very challenging, and really a very wonderful culture. I love working with this age group. They're often very straightforward and sort of in your face and very honest, and it really has been a great experience.

Fresno has a diverse group of organizations and practitioners working together to make the Teen Screen Project a reality

While working on our application to Columbia Teen Screen we had a consultant originally in New Mexico who was very, very supportive of us. He guided us along the way. He looked at the draft of our application, gave us some feedback before we sent in a final, and he said, "Wow! You folks in Fresno have got it going on. I look to you to be a model project." He was very impressed with the fact that we had Fresno Unified and the Community Health Department and Behavioral Health and Center for New Americans and the University and the high schools and Kaiser Permanente and California Psychological Institute and private practitioners on board. We had a very, very diverse group working together who were concerned and coming to the table saying, "We'll do whatever we can to work with these young people to help identify them and offer them services and get them the help they need." We've seen a number of private practitioners who have given their time to see these students in an interviewing role at the school site.

Students answer questions on the screening device and then they are scored as to whether they need a short debriefing afterwards or possibly referred on to case management

Columbia Teen Screen Program has been around for ten years, so we feel very, very good about the success of this project nationwide. The idea is that students are able to work either on paper or a computerized screen. We were fortunate enough to have laptops available for all the students at Hoover High School. They were able to take it in English or in Spanish. We offered it to the deaf and hard of hearing. We offered it to the special ed students there and to all other 10th graders and biology students. It's a diagnostic impression, so when the students take it we're then given a summary. We're given all of their answers, but we're also given a summary and the red flags come up in the areas which they've shared that they're having difficulty in. It then scores those students and it tells those of us who are helping with the screening if they need to talk to one of us just briefly afterwards to do about a two-minute debrief or if they need to talk to a clinician afterwards and go on possibly to case management services.

The screening is voluntary and completely confidential. Parents and their child both have to agree before students can take it the screening.

We first go into the biology classrooms and do a 20 to 30 minute very interactive educational piece. We also tell them where they can get help on campus or off campus free of charge. We talk to the students about stress and about emotional health and mental health. They're very verbal. They know exactly what the stressors are for teens. This particular project and this teen screen requires that we get the parents' permission before the teens can take the screen. It also requires that we get the students' permission or assent, so if the parents say yes but the student doesn't want to take it then they cannot take it. They have to agree. It is voluntary and

completely confidential. If we send home a letter to the parents offering this screening to their child and they agree that their child can take it and then the student doesn't want to take it we contact the parent, because that may in fact be a primary opportunity for parents to have a discussion with their kids and say, "You know, there was this opportunity at school for you to take this mental health screening and you didn't want to. Let's talk a little bit about that. What's going on?" I'm a parent, and if I believe that my child is having difficulty and that they're getting screened at school and then in fact they're not screened I'm out there thinking that things are okay, so I really appreciate the fact that somebody is going to contact me and say, "You know, you agreed to have Jonathan take the screen but he opted not to take it." That tells me as a parent that maybe I need to sit down and have a discussion with Jonathan just to make sure things are okay.

Parents may not want the screening done for their child because there is a stigma associated with mental health issues

Why would parents maybe not want their students to take the screen? They might have to confront the issues. They're going to have to deal with it. Why else? Maybe there is some cost involved. What else? Stigma. How long have we been working on taking the stigma out of mental health issues? I've been working on it personally for over 20 years since I've been involved with the Mental Health Association and doing suicide prevention. What about us getting too close to personal issues that are going on within the home? Many times there are things going on in the home and the parents would just rather have us not get into their business.

Students are given a chance to talk to someone after taking the screen even if they aren't determined to be a high-risk for suicide

So far we have offered 252 screens this year. We just finished one, so right now we have the data for 228. If they're not determined to be high-risk on this screen there is still an opportunity to be debriefed by one of us who simply says, "What did you think about taking this today? Did it bring up anything for you? Would you like to talk to somebody?" So even if they didn't come up positive on the screen, we give them an opportunity to speak with a clinician. The screen is completely confidential. We assign them a number that has nothing to do with their school student number. It's a completely random number that we use. We don't intermingle their Teen Screen summary with anything else from school. This stays separate from their school documents.

Out of the 228 students that have been screened 144 were debriefed and 71 were interviewed. Students who are interviewed are given the opportunity to receive services.

After the screening 144 students were debriefed and 71 were interviewed. We're finding about 40-something percent going on to be interviewed by a clinical person. After that there's an opportunity for them to either get some resolution, talk about whether they're already seeing somebody or they don't want to see somebody, or maybe they're seeing the student assistant counselor at school. Out of that 71, 35 have gone on to case management. What that means is we're following them. Cathy Phillips as the clinical coordinator is making sure that the person who spoke with them has spoken with their parent or their guardian, told them that their student

is having some difficulty, and offered them services. We know ultimately that's up to the parent or the guardian and the student, so we're hoping that they continue and they get some help.

Seventeen of the students screened had suicidal ideation and nine had attempted suicide. Many other students were positive for drug or alcohol abuse, phobias, or anxiety disorders.

The breakdown of the ethnicity according to how they self-identified is 48 Asian, 16 African American, 53 Caucasian, 54 Hispanic, 7 Native American, 36 mixed ethnicity, and 8 others. Then it goes on to ask about their living situation. We had 45 living just with mom, 9 living with dad, 5 living with grandparents, one living with an aunt or uncle, two with brother or sister, and 6 living with another adult. Out of the numbers that we've seen except for the 25 we last did that are not included in this yet, 17 had suicidal ideation. This is just 17 who shared it. There may be a number of others who haven't shared. Nine had a suicide attempt, so we know we're doing good work and we know it's critical work. Eight were positive for alcohol, nine were positive for marijuana, eight were positive for other drugs, 36 were positive for depression, 36 for social phobias, 48 for panic disorder, 38 for generalized anxiety, 19 for OCD, and 26 of those were seeing a mental health professional, which is really good news.

Kids can do the screen on a computer with headsets. They are often more comfortable working with a computer than sitting face to face with a professional.

We have found that kids really like working with computers. They're often more honest and more comfortable with the computer than sitting face to face with an adult or professional. We look at their ethnicity, their grade, their age, and who takes care of them. The questions are both on the screen for them and they also have headsets and the questions are spoken to them. It also asks about vision, hearing, and dental. We now have incorporated a referral to the nurse if they need it, which is a little bit new, something that Fresno does that other communities haven't. Although all 10th graders just had an opportunity to be screened for hearing and vision at school, we have incorporated a referral to the nurse. It asks about some general health questions and then they start getting into more of the emotional mental health and the behaviors.

After Columbia University approved the project, school partners and community partners were trained to do the screenings and provide interviews afterwards

We submitted our application to Columbia and we were reviewed, and fortunately pretty quickly we were approved. Then they said, "You need to select a site coordinator and send that person back to New York for a one-day training." That person was me. It was a really exciting opportunity. We got trained, came back, and we recruited people from the community and the school site. We are very, very grateful for the mentoring program at Hoover High School. They have a great relationship with their kids and they have been very involved in the project. Between our school partners and our community partners we trained screeners who helped the kids with the actual screening. LeAnn, my supervisor Thea Jones, and myself were the ones who went into the classroom, and then Cathy Phillips trained a number of clinicians to interview the students afterwards. Once we had all these trained folks in our community we were ready to set about the actual screenings at the school. We scheduled four screenings at the school a year ahead of time, which we thought was great foresight. However, when we got there we found that

there was difficulty with schedules and we had only gotten half of the school list, so we needed to schedule some additional screenings. We're going to meet our last deadline of May 3 for our final screening.

At the end of the screening kids can write down their own thoughts about it, and many kids have felt that it was very helpful

After the kids take the screen they're able to enter any narrative. "What did you think about this?" Many kids said in their own words and in their own language that they felt this was very helpful. This might have been their only opportunity to speak with somebody about this. So many kids said, "I'm so glad I did this. This is helping me understand what's going on with my life. I think it will be very, very helpful for other students."

Participant question: What did you do with the 17 students that you mentioned expressed suicidal ideations? Were you able to refer them or get some services for them or counseling?

Colleen Gregg: Once you identify the students and they see a clinician and you speak with the parents, you have little control after that. We try to follow these students and their parents for about a month checking in to see if they need additional assistance getting their students hooked up for services, but there is a little bit of frustration for us because we don't often know what happens after that. We will send a letter and we'll do follow-up phone calls, but sometimes we actually don't know if that student is in services. Ultimately our goal is to wait until that student has that first appointment and we know that they're connected. That doesn't always happen because sometimes the parents will say, "We're talking about it. We're thinking about it." I called and spoke with Columbia University because we weren't comfortable that we were leaving these students and these families after a month not knowing that they were connected, and Columbia is also concerned about this.

Cathy Phillips, Mental Health Services Coordinator, FUSD

I want to talk a little bit about the case management process. Please understand that this is not a clinical assessment that we're doing. That is done after the referral process has taken place. During the clinical interview usually the clinician will contact the parent with the student present so that they both know what's been shared because of confidentiality issues. Our case managers have been persons from the Comprehensive Youth Services or California State University, Fresno social work student interns, masters level, who make sure that the parents are connected up with the appropriate services. This is at the discretion of the families. We cannot dictate what they do, but we hope that they will feel the urgency of their loved one and make sure that they get services. We did have an experience where this one young man was having suicidal ideation on a daily basis and his caregiver did not know that until she was contacted by the case manager. She was so grateful that we had done this process and found out that her loved one was still in trouble, and she got him back into treatment right away, so it seems that it is making a difference.

Central California Children's Mental Health Update

Vera Kennedy, CEO, Central California Children's Mental Health

Today I'm going to talk about two different efforts that are happening in our community. The first is around the Mental Health Services Act. I think it's really important to update you. I'm going to do an overview just to basically let you understand what the local impact is going to be, what actual information has to be compiled and put together and submitted to the state in order for us to even access the resources that are available.

After the second year of the Mental Health Services Act Fresno County will receive approximately \$17 million a year for mental health services

First I'm going to go over just briefly what the projected allocations look like. The state is still working on making those determinations and it's all based on the 1% tax for people that make over a million dollars. The projections for year one look like about \$250 million and year two around \$683 million. It's expected to stay around \$600 million per year, which would be available to the 58 counties of California. Right now the projections for Fresno are \$6 million for year one, and we're looking at a sustainable revenue source for mental health services of about \$17 million per year once it gets going.

The advocacy groups that passed the Mental Health Services Act wanted a system that would begin working towards engaging consumers and their families in appropriate delivery of service and also in being part of the leadership and decision making

The Mental Health Services Act says that there are supposed to be provisions and some planning around developing services for older adults, adults, and children, and then there are two special program areas, innovative services and preventative and early intervention. In order to address those areas they're asking counties to do a planning process, and it's quite different than normal planning processes that we've seen before. The state has mandated these processes before and they're usually county hosted, there are one or two forums where people provide input, some things are put together, and then it's submitted to the state. Things have changed now. The act was passed by a bunch of advocacy groups including the Mental Health Association, NAMI, and United Advocates for Children of California along with others, so there are several leading organizations who helped put support behind passing this act. The reason they did it was not just for a revenue source for mental health services. They wanted to see true transformation. They wanted the system to begin working towards engaging consumers and their family members not only in appropriate delivery of service but also being part of the leadership and decision making. The act has several provisions about how to truly engage community, not just by holding a couple of public hearings or forums. It's really about everyone in the community being a stakeholder and being involved in the entire process. Some counties are going to do it better than others. Those counties that do it well will receive larger allocations, not just based on how well they're doing but also based on need, so you need to prove your need but also show that the community was involved in determining what that need was.

A request for future funding from the state needs to have five essential elements

There are five essential elements in your planning process that have to be part of your plan and your request for future funding. There was some initial planning that had to be conducted to submit to the state to get planning dollars. The official planning process will begin in May, and these are the areas that have to be in your program plan. You have to address how you're going to do community collaboration on an ongoing basis. You also have to show how you're going to address cultural competency issues. Cultural competency means that it's going to be culturally proficient and linguistically proficient and that people can get care within their traditions and cultures, so this is really different for a lot of us. Also, you have to show how your system is going to engage on an ongoing basis consumers and families in the entire process, so it's really involving consumers and families as part of their individual care management, which is new for us as well. There also needs to be a focus on wellness. In mental health, wellness means support around recovery. Once we overcome our obstacles we need to have those informal networks that help us with resiliency, so in the long run we're not relying on a system or particular physicians to help us through our problems but we actually learn to develop our own coping skills in order to function on a daily basis and do that throughout our lives. When we have informal networks we're not always having to rely on a system. We can rely on our families and our communities. The last thing is the integrated service experience. What this means is that we're going to have integrated services that are seamless.

The planning process that will be utilized is a seven-step process that was developed to prevent diabetes in an urban community near Chicago. It has been adapted to fit mental health.

I really hope that you participate in the planning process. Basically, this county for its planning process has developed a seven-step process. This is really to engage community stakeholders. We had to identify what it meant to include stakeholders and what process we were going to utilize in order to develop this. It is a true seven-step process that was developed as a medical model to prevent diabetes in an urban community in Chicago. We basically did some research because we were looking for a community process that would be not only participatory but it would also demonstrate the community and leadership roles in the major decision making. We've adapted this model and made some revisions so it fits mental health.

The first step in the planning process is the community dialogue

Step one is actually the community dialogue. The real effort will begin in May, and it will be a true effort to engage ethnically diverse communities as well as the community at large. There has been so far in the planning meetings a lack of consumer and family involvement, and it's during this community dialogue phase where the true outreach efforts must happen, not just through the media but through neighborhoods and local communities and on a one-on-one basis. The first couple of meetings will actually focus on developing a strategic communications plan in order to engage everyone in the process throughout the process, so it is open through the seven steps. Even as families are identified in step six they can still participate because this seven-step process is an ongoing effort that will continue every year. When you develop your three-year plan that has to be submitted to the state it's not over. The process continues annually. The state

is requesting information annually as far as how you are progressing on the transformation that you recommended by your community. Step one explains what the community dialogue is.

Step two is the stakeholder group formation. Four groups will be formed, which will address older adults, adults, children, and evaluation of the process.

Step two is the actual stakeholder group formation. There are going to be four different task groups, three of them addressing the specific populations that the state requires, so there is a task group on older adults, one on adults, and one on children. The fourth group is on evaluation. The evaluation will touch each of the three groups. Our next meeting will be on the Fresno State University campus and it will be the week of May 9. We're not sure what day, but I will make sure Laurie has that. For the first time, because several of the stakeholders have been pushing for this, it will be an evening meeting, from 6 to 8. Most of the meetings in the past have been during the work day, which for providers and professionals is great but we've been missing community members and consumers and families. There have been sign-ups already for people that want to participate in taskforce groups in those four different areas. At this first meeting they will actually select their chairs. There are going to be two chairs for every group. One will be a county staff mental health person based on the experience within that division. The second co-chair will be a community member that the task group members basically select. This first meeting, if you haven't come, would be a good time to learn because there will be an orientation to learn about the act, what your roles and responsibilities will be, and to see if you want to participate in a task group or have a leadership role as a co-chair. You can be in more than one task group. Right now the groups are really small. About 30 people have signed up for the taskforce groups, so we want to engage more people and we will continue to do the outreach efforts to get people involved. We're going to initiate step two at the same time the community dialogue is happening because we're behind schedule. The draft plan has to be completed by September 30. It's not due to the state until December 30, but there have to be 30 days of public comment, then it has to go to the mental health board for their review and they have to hold a public hearing, then all the recommendations and revisions that are required from the input of those two meetings have to be put into the plan, and the plan has to be revised and then go to the board of supervisors for final submission in December. That's why the draft plan has to be done in September and that's why we're engaging step one and step two at the same time knowing that we will need to have separate orientations for people that come late into the process.

Step three is stakeholder training. Community members will receive training along with everyone else so that they can participate and voice their opinions.

Step three is actually stakeholder training. There will be several trainings, not just on the act, because everybody has to understand the legal aspects of that, but trainings on what mental health looks like right now in these counties and what processes people are going through now to access services. We're doing this so that everyone has the same background and information as we begin looking into improvements and solutions for the system. There will also be training on different research methods, so if you're interested in evaluation but you're not sure how to do it, it doesn't matter. You can still be part of the evaluation taskforce group because we're all going to get training on how to do a focus group, how to interview individuals that we want information from, and those kinds of things. You don't have to feel like you're just a community

member and you don't know certain things about this. What you need to know is that your opinion counts and you're welcome in the process. We'll give you the tools you need so that you can help make decisions as a group.

In step four the community will decide what needs to be assessed, how to collect data, and what kind of system is needed to collect that data

Step four defines the assessment protocols. This is actually where the community will decide what needs to be assessed and what information they're missing. You will find out as you get an overview of what mental health looks like in this community that there isn't a baseline for juvenile offenders that are receiving mental health services. People are collecting numbers, but there is no true baseline on what the improvement rates are and what services are working. Community input is very important in this step. We will discuss how we're going to collect data and what kind of system should be put in place to collect that data.

Step five will consist of compiling information, making recommendations, gathering ideas, and disseminating those to the community through media and group meetings

Step five is based on the assessments that the community decides to do. They will then compile them, make some recommendations, gather some ideas, and disseminate those to the community at large through media and small group meetings. It will be the community participants that will be disseminating that information as a group rather than county staff just collecting the information and doing it themselves. It's true engagement in the process.

Step six is the development and implementation of the action plan, which will be a three-year plan

Step six is the development and implementation of the action plan. What happens, then, is all those assessment findings and the recommendations that the community taskforce groups make get put into a plan on how they're going to transform mental health in the future. It's a three-year plan, so you have to make these little time frames and these little outcomes that you want year by year. This is the step in which that is conducted.

Step seven entails evaluating how well the process worked as well as developing an evaluation plan on how to evaluate the three-year plan

Step seven is evaluation. Evaluation has two components to it. One is evaluating the process. How well did the community process work? Was there true engagement of community members? Did meeting times work? Secondly, the role of the evaluation taskforce is to develop an evaluation plan that goes with the three-year plan that's submitted to the state, so not only do you evaluate your process now, but you develop an evaluation process on how you're going to evaluate your three-year plan. This gives you an overview of the community participation process, and I hope that many of you will be engaged in that. This is a true opportunity for you to make a difference. It is not going to be county driven. It is truly community driven.

The Joint Powers Authority Planning Project is an effort of the six regional county mental health departments to examine and look at improving mental health services regionally

I wear several different hats in mental health, but primarily it's an advocacy hat. One of the other projects that I'm engaged in is I serve as the project director for the Joint Powers Authority Planning Project. That is an effort of the six regional county mental health departments to examine and look at improving mental health services regionally. One of the first priority efforts that they wanted to examine was how to get a child inpatient facility here. There is a particular population that regardless of what services look like are going to need intensive care, and rather than send those individuals out of the community, we want to keep them here locally so that families can truly be part of their care plans. It becomes a lot more difficult when we send children to Sacramento, Los Angeles, and San Francisco for services because a lot of these families don't have the resources to go up there every week to be part of the intervention. The planning partners are looking at how we can get a facility here locally, and we had a half-day planning session on what they want to see in an inpatient facility. Rather than just going out there and saying, "Who wants to provide services?" they said, "Let's put a design together of what we want and then take it out into the community and see who is willing to provide those services." This is their vision and desired model.

At least 12 children and as many as 29 children are referred to inpatient facilities outside our community every month, so we have the need for a facility here

The first thing they did was to examine the need for services and how many children really would use an inpatient facility if we had it here. The number of referrals that are made to inpatient facilities outside of our community at a minimum is 12 children a month. If we had an inpatient facility here, 12 children in the region could access it every month. On a maximum level we have 29 children. If you have individuals who have several illnesses or disorders, that number could increase if those kinds of interventions and treatments were offered in the inpatient facility.

Once kids have been stabilized in an inpatient facility and their stay is complete, they often are placed back into their own community without any transition services

Secondly, we looked at who these youth are, what they look like, and what their special needs are. Most of them are in crisis that requires some type of stabilization, but aside from that, a lot of these youth do not receive any transition services. Right now they're referred to inpatient facilities, and when their stay is complete they come back into the community without any type of seamless transition. They're basically thrown back into a community that they have been out of for a while, and then they're put into a facility like a group home, which is a different environment. They stop seeing the physician that they were seeing, so the connections that they've made with their physician and other staff are broken. That's a realization of what's happening now.

What is most important to the counties is that the facility takes all referrals and that the provider will follow the guidelines of the system of care for mental health

Often these youth are difficult to place. Sometimes after their inpatient stay there is nowhere else to send them. There's not a stepdown process. There's not a facility that helps them develop their functioning so that they can move into lower level homes with support. Also, they tend to be diagnosed with co-occurring disorders. Basically that means that they have some sort of mental illness either in two-fold or with substance abuse issues. Many times these youth are involved in the juvenile justice system, which has caused a problem in the past because not all inpatient facilities will allow access to their facility to juvenile offenders. In the past the facilities we had here would use that admittance policy not to allow offenders into their facility. Looking at the numbers and the youth profiles, the counties developed the service needs including what they want to see in this facility. What was most important to them is that the facility take all referrals, that the county decides who is appropriate to be in that facility, not the provider. As I said, some facilities have not accepted juvenile offenders in the past, and those youth tend to be the ones with the most intensive needs that require this type of treatment. Additionally, they want a provider that will follow the guidelines of the system of care principles. Mental health system of care includes many elements. Two of the primary ones are child and family involvement and cultural competency, which is in the Mental Health Services Act as well. The Mental Health Services Act was initially developed to fit the mental health system of care principles and guidelines.

The facility that provides inpatient services should also provide transition services

Additionally, the counties wanted to make sure that whoever provides the services does provide those transition services. A lot of times youth in an inpatient facility are told on their last day, "You're not going to be here tomorrow," so the shock and the emotions that go along with losing your support network have been difficult for youth. This addresses that issue as far as preparing youth that this is not a permanent stay, this is not a longterm stay, but letting them know that they're going to receive the same medical care throughout their service delivery and they're going to be in contact with the same physicians.

The counties are looking for new and innovative ideas rather than a traditional model

The partners also want to emphasize that these are new thoughts and ideas. They're not looking for a traditional model. They want to see structured care. Often people are in these facilities and no one is really monitored. There's nothing for them to do that's productive or that they can feel part of. They're usually just there sitting around all day until it's time for their treatment or their group or those kinds of activities. Also, we emphasize consumer family involvement and a single care plan. Often in county mental health when you refer somebody for services that agency develops their own care plan. They don't look at what the county has done already and they may not fit within each other, so counties want to make sure there is one care plan and everybody is working off the same plan towards the same goals that the consumer and family have been involved in.

The counties want to see a multidisciplinary team approach, an assessment team to ensure appropriate diagnosis, linkage with the county, and evaluation protocols

Additionally, they want to see multidisciplinary treatment teams within the inpatient facility. They don't want just one person engaged in the care of individuals. They want to see a team approach. They also want an assessment team because often the youth don't have the appropriate diagnosis and so they don't receive the appropriate treatment. They want to make sure that the individuals that are involved have a good background in this as well as coordinate with the care team. They also want a process where the county is linked and involved. Often when people are referred for external services they do not want the county engaged in the care management process. They basically want to accept the referral and handle the services to the youth on their own. In this aspect of inpatient care, the county wants to at least have one member that's part of the team, that sees the individual throughout. It has been a problem in the past when information has been kept from county care managers, so the county care manager will be an individual that is part of the multidisciplinary team and part of the assessment team so that individual has a link throughout their entire care, not just from the physician but also from someone who is helping them with their family and social supports. They also want some evaluation protocols and a way to define outcomes. We never get to see if services have really helped the individual. We know individuals go in and they come out, but we don't know the quality of service or what kind of outcomes can be expected for the youth that engage in the facility.

Also important to counties is that services are culturally and linguistically sensitive, that the facility is sustainable, and that there is a governance board with an oversight committee

Counties also want to see strength-based, family driven services that are not only culturally sensitive but linguistically sensitive. The county emphasizes that together they will contract with a provider as a region, they will access services as a region, and because they feel like they will be investing in a facility, they expect that facility to have a sustainability plan. They do not want to rely on a facility for services and then all of a sudden that facility no longer exists, which has been part of the problem in the past, so they want to demand that the provider have a sustainability plan. The JPA partners want to be part of a governance board that will have oversight over the inpatient facilities along with the provider, and they would have an oversight committee that would meet on a more regular basis to discuss day-to-day operations. Lastly, the JPA will hire and appoint staff members to serve the region. One county may host those staff members or they may do it regionally and hire an outside contractor.

The JPA has provided their recommendations to all providers in the region, and only Kaweah Delta has shown interested in it

The JPA has provided this presentation to providers in the region. They invited all the hospitals in the region to come and hear what the vision and model was. Only one provider showed up, and that provider does have interest in doing this, and that's Kaweah Delta. Right now the counties have each gone back to their legal councils and they're developing basically a joint powers agreement to work together and to contract with a provider for these services.

Fresno County Department of Health Services

Eileen Rodriguez, Division Manager and Administrator, California Children's Services

California Children's Services is a state mandated program that assists families, children, and young adults to receive services to treat their CCS-eligible diagnosis or condition. It is administered as a partnership between Fresno County Department of Community Health and the State Department of Health Services. The program has two main components, the CCS Administrative Unit and the Medical Therapy Program. The funding source for the CCS program is a combination of monies appropriated by the county, state general funds, and the federal government. Our CCS administrative unit works collaboratively with our healthcare providers in the community to facilitate, authorize, provide diagnosis and treatment, and provide medical case management for children and young adults under the age of 21 that have certain diseases, physical limitations, or chronic health conditions. In our unit we do not provide any hands-on direct patient care. Rather, we link our clients to services and providers outside in the community that can treat their CCS-eligible condition. Some of the medical problems that are eligible are congenital heart disease, cerebral palsy, cystic fibrosis, hemophilia, and we even treat some fractures such as femur fractures. We have state guidelines and regulations that we must apply when determining eligibility for the CCS program.

There are several eligibility criteria that must be met before a child can be covered by CCS

CCS eligibility criteria states that the age is to age 21 and the child must have or may have a medical program that CCS covers. They must be a resident of California and for Fresno County they must be a resident of Fresno County. The family adjusted gross income is under \$40,000 in the most recent tax year. However, children can still receive services if their family's income is over \$40,000 if one of the following are met: The child has full-scope Medi-Cal with no share of cost, the child has Healthy Families insurance, the out of pocket medical expenses for childcare are more than 20% of the family's income, it's been determined that the child only needs Medical Therapy Program services, the child is adopted with a known medical program that made him or her eligible for CCS, or the child needs to be seen by a doctor to see if he or she is eligible for CCS services. If they're eligible for the CCS program then we would open them up for full treatment services at that time.

Direct hands on care is provided through CCS by the Medical Therapy Program

The Medical Therapy Program provides physical therapy, occupational therapy, and medical therapy conference services, so this is the area of our program where direct hands-on care is given. Currently we have two medical therapy units. One is located at Ginsberg Elementary School and the other is at Storey Elementary School. We have a third one that is under construction out at Garfield in Clovis with a tentative opening date of July 5, 2005. We currently have a caseload of 946 clients receiving Medical Therapy Program services.

CCS works with young adults who will be turning 21 to help them learn how to take care of their own healthcare needs

Currently we have 7,926 clients. The majority of our caseload is the teenage years up to 20 years of age. We currently try to work with clients that are getting close to turning 21 by helping them transition into the community and into taking care of their own healthcare. We have a social worker on hand in our office that helps the young adult see what types of services they are going to need after the CCS case closes and link them to the correct providers.

CCS helps clients apply for Medi-Cal or Healthy Families

I want to go over some of the highlights of our program over the last few years where we've made some major strides in trying to link our clients with health insurance programs, CCS malocclusion program, and our outreach programs. The first one is regarding Medi-Cal applications. Prior to June 2003 our clients that did not have full-scope Medi-Cal or Healthy Families would have to come into our office and fill out our paperwork. They would have to show that they live here in Fresno County and then also bring in a current tax form to determine their financial eligibility. Based on family size and income, our staff would then refer them over to Medi-Cal or Healthy Families to apply to those programs. Prior to June 2003 that meant that the family had to then go out to the local office to apply for those insurance plans. As of June 2003 our staff assists clients that may be eligible for Medi-Cal or Healthy Families program in filling out their application. Since that time we have been able to assist 228 clients in applying for Medi-Cal and Healthy Families. When the client has an active case with us and for whatever reason loses their Medi-Cal or Healthy Families, we then try to contact the family and work with the providers in trying to reestablish Medi-Cal or Healthy Families coverage for that client.

In 2004 CCS held three very successful orthodontic screening clinics

In 2004 we held three very successful orthodontic screening clinics. We collaborated with Fresno County Education and Prevention Services to borrow their dental bus. We parked the bus across from the health department in a parking lot. AAMCO donated their parking lot at that time so that the families coming to receive the screening did not have to pay for parking, and we also were able to enlist three orthodontists, Dr. Asbury, Dr. Thompson, and Dr. Fremming, to help out with those screening clinics. It was very exciting to see that collaboration between our own department, the community, and even with AAMCO who allowed us to use their parking lot. Just yesterday we participated in a teacher's conference down at the Convention Center. We are very open to providing in-services to providers or being a part of any type of health fair or outreach services to the community. You can contact our department, and if you ever feel that it's appropriate for our program to be there we are more than willing to be there.

In closing, the CCS program provides the safety net for CCS-medically-necessary services for children of Fresno County, and our staff is dedicated to providing the services. We would like to thank you for your support of the program.