

CHAPTER II

BACKGROUND: ISSUES FOR CALIFORNIA'S TRANSITION AGE YOUTH AND COUNTY SERVICES

“Listening, not imitation may be the sincerest form of flattery.”

—JOYCE BROTHERS

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BACKGROUND: ISSUES FOR CALIFORNIA'S TRANSITION AGE YOUTH AND COUNTY SERVICES

EXECUTIVE SUMMARY

Transition Age Youth (TAY) with serious mental illness are subject to profound disorientation on reaching age 18 and moving from the Children's into the Adult system of care. Loss of parental responsibility and leaving the Child Welfare, education and juvenile criminal systems, combined with changes in funding streams available for mental illness care, can take away needed supports even though the TAY may not be ready to enter the "adult" world. Because of this reduction in the available support systems, the percentage of young people receiving county mental health services in California drops sharply for those over 17.

Only about one-third of California counties have specific programs to help TAY make the transition from the Children's to the Adult system of care. There is an urgent need for every county mental health department to create a TAY policy with active participation from TAY representatives. This policy should address the needs of youth aged 14 to 24 and include assistance in employment preparation as well as access to the widest possible spectrum of community resources and services. The services provided to TAY should be client-driven, strength-based, recovery-oriented and culturally competent.

BACKGROUND: ISSUES FOR CALIFORNIA'S TRANSITION AGE YOUTH & COUNTY SERVICES

There are sharp differences between the Child and Adult public mental health service systems in California. One indicator of the difference is shown by the rate of service utilization. The following table shows rates of service use by three age groups: 14-17, 18-21, and 22-25. There is a decrease of close to 50% in the number of young people served by county mental health after age 18, compared to youth aged 14-17.

Age	Number Served by County Mental Health in 2001-02 ¹	% of all youth in California ²
14-17	75,403	3.85%
18-21	35,823	1.84%
22-25	25,284	1.78%

How do we explain the drop-off in the rate of service use? There are several explanations having to do with both institutional as well as developmental issues:

- legal status
- funding streams
- adolescent developmental needs
- attitudes of policy makers
- clinical diagnostic practices³

¹ Source of data: California Department of Mental Health, Client Services Information System, 2001-2002.

² Based on 2000 Census.

³ There are also similarities in the systems: both systems are vastly underfunded and serve only a fraction of those who need public mental health services; a large portion of incarcerated children and adults have significant mental

LEGAL STATUS

Because of the inherent vulnerability of children, many areas of law attempt to protect them, including parental responsibility, child welfare, juvenile justice, compulsory education and special education systems.

- Children and youth depend on parents/caregivers who have a legal responsibility to provide their food, shelter, clothing, and health and mental health care.⁴ In addition to legal requirements, the fact that most children have deep connections to parents and families means that effective treatment will acknowledge the importance of families and will usually include them. Parental responsibility includes giving permission for most medical treatment, including permission for most mental health services.
- The Child Welfare system is designed to protect the child from parental neglect or abuse.
- The Juvenile Justice system is designed to provide an age-appropriate response to juvenile offenders.
- Education: All children must be educated until they reach age 18 or receive a high school diploma or equivalent.⁵ Children with disabilities that interfere with their ability to benefit from their education have a right to receive those services through Special Education necessary to achieve educational benefits through age 21.
- Autonomy:
 - Most adults with psychiatric disabilities make their own health care decisions.⁶ Only adult conservatees have limitations comparable to those of minors in their ability to consent to treatment. Family members of adult clients are included in mental health services only with client permission, in contrast to treatment with minors, where professional standards require the inclusion of parents and other caregivers in direct treatment.
 - Transition Age Youth with mental health needs may not be aware of their need for mental health services, may not know how to access them, may be sensitive to the stigma of mental health services, and may reject identifying with adult mental health clients whom they perceive as being “disabled,” with the stigma associated with that status.

FUNDING

Funding for mental health and related supportive services is fragmented and often tied to rigid eligibility criteria.

- MediCal-eligible children with a mental health diagnosis that meets medical necessity criteria are federally entitled to receive mental health services through the Early Periodic Screening, Diagnosis and Treatment (EPSDT) Program. This includes those in the dependency and juvenile justice systems. A broad variety of types of services may be

health disorders; neither system has resources to provide early intervention or prevention services; and both systems rely on other public resources to assist individuals to achieve their goals.

⁴ Exceptions occur for children over the age of 12 who seek free confidential services connected to child abuse, substance abuse, and/or issues related to pregnancy or sexually transmitted disease.

⁵ For ages 16-18 Education Code sections 48200 permits a minimum of 4 hours per week in a continuation school and/or ROP program, or other educational program, and exempts those who are disqualified by physical or mental condition, or because personal services are required by a dependent.

⁶ With the exception of involuntary detention for assessment or treatment.

- provided when appropriate, and a large proportion of these costs are reimbursed to counties by federal and state funding.⁷
- Students in Special Education prior to high school graduation have federal entitlement to mental health services that assist the child to achieve educational benefit, although reimbursement technicalities and recent State funding shortages make this an underfunded and therefore underutilized resource.
 - MediCal-eligible adults may receive mental health services. However, the reimbursement is approximately half of that for EPSDT program services and the types of services eligible for reimbursement are more restricted than for children.
 - There are no adult entitlements comparable to EPSDT and Special Education entitlements. MediCal-eligible adults are entitled to medically necessary services through their managed care plan. Non-MediCal-eligible adults usually must meet a means test as well as stringent mental illness criteria to access public mental health services.

Funding sources reported by counties in the following table reflect these points. (Multiple funding sources may be used for a single individual.) The table shows a steady decline in use of Medi-Cal and IEP funding in the older age groups, with a concurrent increase in reliance on county funding.

NUMBER OF TAY SERVED BY CALIFORNIA COUNTIES 2001-02⁸

Funding Sources	Age 14-17	Age 18-21	Age 22-24	Total
All Funding Sources	75,403	35,823	25,284	136,510
MediCal Funding	47,533 (63%)	18,213 (51%)	11,529 (46%)	77,275
County Funding	32,389 (43%)	19,944 (56%)	15,391 (61%)	67,724
IEP Funding	12,430 (16%)	1,934 (5%)	34 (0%)	14,398
Healthy Families	34 (0%)	1 (0%)	0 (0%)	35

⁷ In spite of this it is estimated that about half of those eligible for services do not receive them. (California Mental Health Planning Council: California Mental Health Master Plan, Chapter 3, 2003, available at <http://www.dmh.cahwnet.gov/MHPC/reports.asp>.)

⁸ Source of data: California Department of Mental Health, Client Services Information System, 2001-2002.

DIAGNOSTIC PROFILE

The following table shows the distribution of diagnoses for various aged youth and young adults from 2001-2002 statewide data. Rates of diagnoses vary by age group.

MENTAL HEALTH DIAGNOSIS FOR YOUTH SERVED BY CALIFORNIA COUNTIES 2001-02⁹

Diagnosis/Age	Age 14-17	%	Age 18-21	%	Age 22-24	%
Schizophrenia	612	0.81%	2119	5.92%	2550	10.09%
Psychotic Disorders	1159	1.54%	2617	7.31%	2292	9.07%
Bipolar	3354	4.45%	3832	10.70%	3220	12.74%
Depressive Disorders	20161	26.74%	9281	25.91%	6474	25.61%
Post-traumatic Stress Disorder	2668	3.54%	856	2.39%	505	2.00%
Other Anxiety Disorders	1929	2.56%	1380	3.85%	1179	4.66%
Substance-related Disorders	1203	1.60%	1937	5.41%	1539	6.09%
Cognitive Disorders	18	0.02%	43	0.12%	33	0.13%
Personality Disorders	90	0.12%	232	0.65%	152	0.60%
Adjustment Disorders	10819	14.35%	4234	11.82%	2507	9.92%
ADHD/ADD	5545	7.35%	715	2.00%	134	0.53%
Disruptive Behavior Disorders	14350	19.03%	1302	3.63%	33	0.13%
Totals	61908	82.10%	28548	79.69%	20618	81.55%

As seen in the table, diagnostic issues change as youth age:

- The rate of schizophrenia diagnosis is 12 times greater for young adults aged 22-24 than for youth aged 14-17. Similarly, young adults are diagnosed with other psychotic disorders 6 times as frequently as youth, and bipolar disorder 3 times as frequently as youth.
- Rates of diagnosis for depressive disorders remain about the same, with about 25% of young people in services affected.
- ADHD/ADD and PTSD diagnoses are vastly reduced throughout the transition years.

While some of the changes are due to the typical age of onset of certain mental illnesses, the process of assigning a diagnosis is not necessarily objective, and may depend at least partly on contextual elements, including funding issues, social attitudes, age, class, and ethnic and racial discrimination.

COUNTY SURVEY OF SERVICES TO TAY

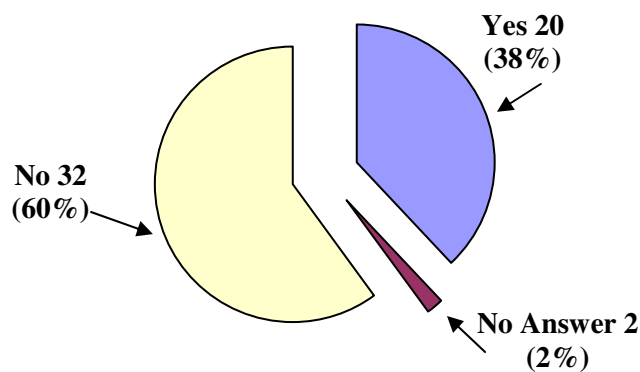
Additional descriptive data helps understand how counties have responded to the needs of TAY. Information about mental health services to TAY was gathered in a survey of county mental health agencies.¹⁰ Highlights of the results are summarized on the next page.

⁹ Source of data: California Department of Mental Health, Client Services Information System, 2001-2002.

¹⁰ Methodology: The TAY Committee developed 16 questions. Surveys were sent to 58 County Mental Health directors in December 2003. Fifty-three Directors or their designees responded. Several questions were found to be ambiguous, and were discarded. The Questionnaire is in Appendix A.

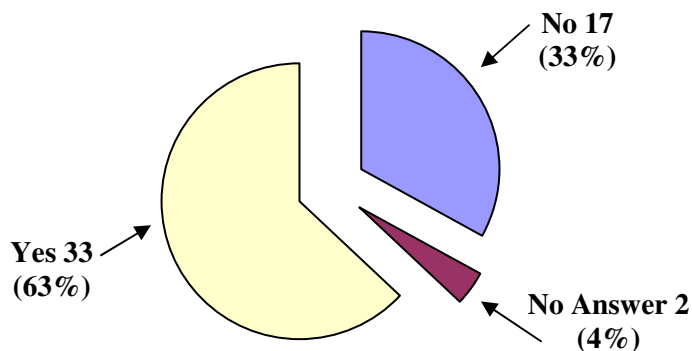
- 44 of 52 responding counties (85%) reported that their counties have services or programs available specifically to address the needs of TAY who are receiving public mental health services.
- 20 counties (38%) reported that their county mental health systems had outreach efforts that targeted transition age youth, as reflected in Chart #1, below.

CHART #1: DOES YOUR COUNTY MENTAL HEALTH SYSTEM CONDUCT OUTREACH EFFORTS TARGETING TRANSITION AGE YOUTH?



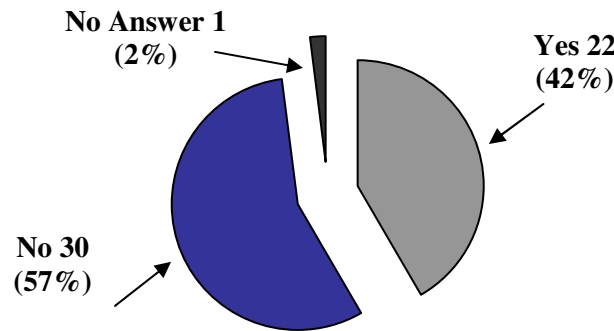
- 17 counties (33%) reported that specific policies and procedures that address services for TAY have been developed. See Chart #2.

CHART #2: HAVE SPECIFIC POLICIES AND PROCEDURES BEEN DEVELOPED IN YOUR COUNTY MENTAL HEALTH SYSTEM THAT ADDRESS SERVICES FOR TRANSITION AGE YOUTH?



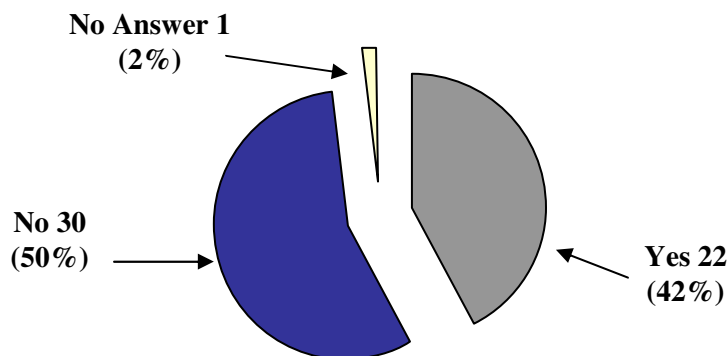
- 31 of 52 counties (60%) reported that they assign staff to work specifically with Transition Age Youth who have mental health conditions.
- 41 counties (77%) reported that the county formed collaborative partnerships with other agencies or entities in developing or delivering services to Transition Age Youth who are receiving mental health services.
- 22 of the 52 respondents (42%) reported that their mental health system tracks data specific to transition-age youth; 30 (56%) do not track TAY-specific data. See Chart #3 below.

CHART #3: DOES YOUR COUNTY MENTAL HEALTH SYSTEM TRACK DATA SPECIFIC TO TRANSITION AGE YOUTH?



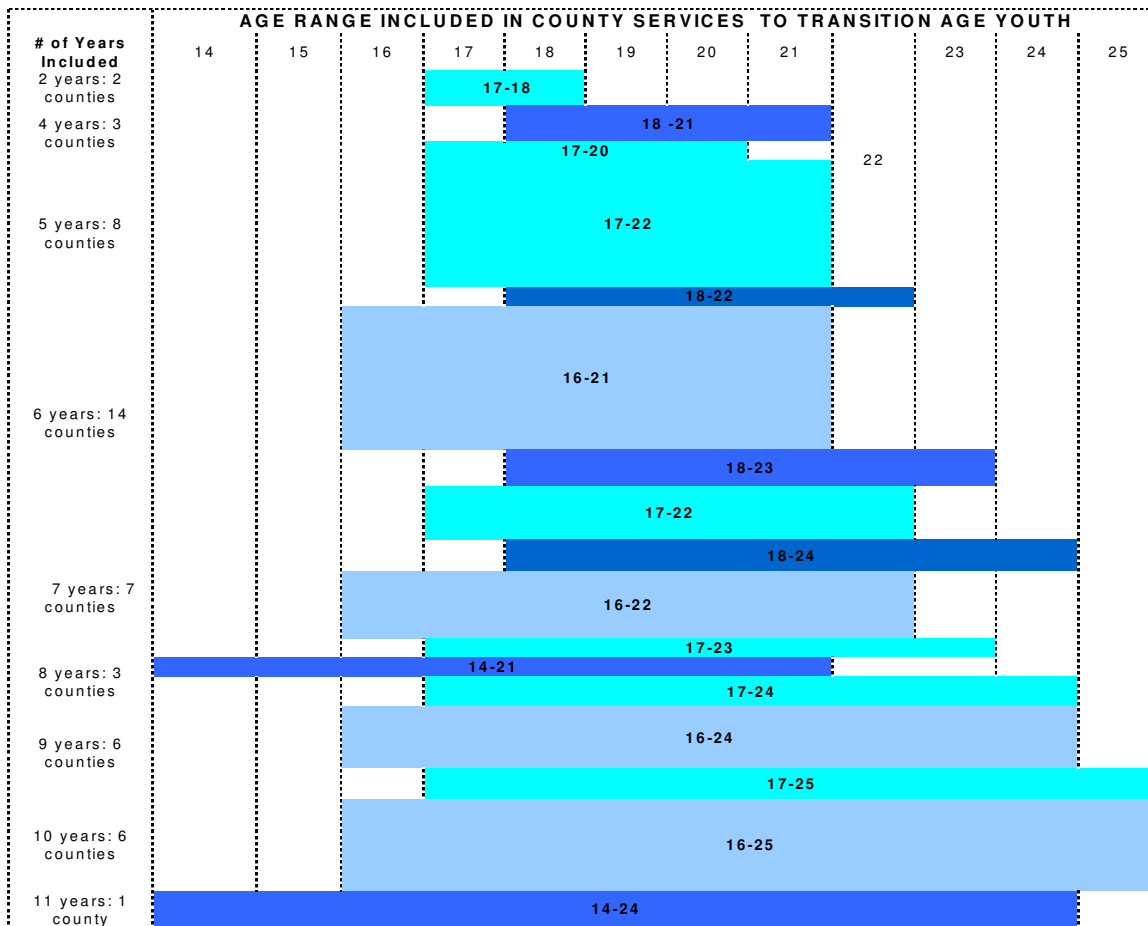
- 22 counties (42%) reported that the county mental health system conducts ongoing system planning or assessment activities specifically focused on the needs of Transition Age Youth with mental health conditions See chart #4 below.

CHART #4 (QUESTION 9): DOES YOUR COUNTY MENTAL HEALTH SYSTEM CONDUCT ONGOING SYSTEM PLANNING OR ASSESSMENT ACTIVITIES SPECIFICALLY FOCUSED ON THE NEEDS OF TRANSITION AGE YOUTH (TAY)?



- Just three counties (6%) reported youth voice in policy level decision making.
- A wide variation in the age ranges included in “transition age” was reported (see Chart #5): transition age started at 14 to 18 and ended at 19 to 25 years old. Total years included ranges from 2 to 11 years. Twenty-six (26) counties (52%) end transition age services at age 21, when Medi-Cal eligible youth are no longer included in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. The only age served by all reporting counties was age 18.

CHART #5



- Counties identified their strengths and weaknesses regarding TAY services (Number of counties reporting strength or weakness follows each statement in parentheses).

Strengths:

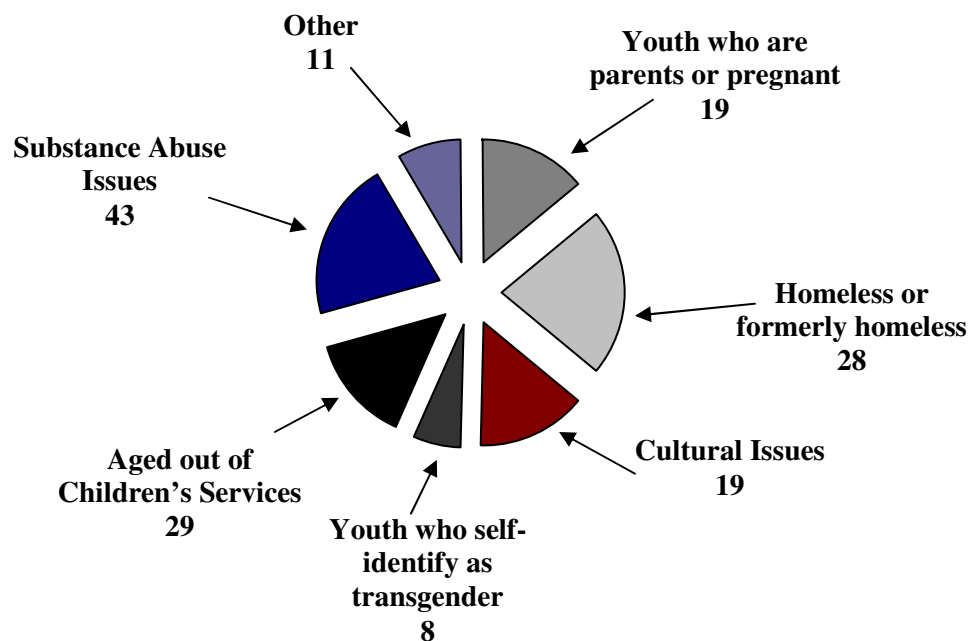
- Collaborative relationships with other agencies (19)
- Awareness of TAY needs (8)
- Small town/county and good relationships (5)

- Collaborative or seamless transition to adult services (4)
- Youth advocacy and including youth in planning (2)
- Housing resources for TAY (2)

Weaknesses:

- Lack of resources (funding and staff) (19)
- Lack of housing (6)
- No or limited specialized services (6)
- No formal TAY system, policies and/or services (6)
- Limited public transportation (3)
- Lack of youth involvement in policy development (3)
- Difficulty covering large geographical area (2)
- Counties identified the characteristics of their TAY population that are “prevalent enough to require special services” as seen in Chart #6.

CHART#6: WHAT ARE THE CHARACTERISTICS OF YOUR TAY POPULATION THAT ARE PREVALENT ENOUGH TO REQUIRE SPECIAL SERVICES?



CONCLUSIONS:

1. There are disparities of care for transition age youth that result from a combination of institutional and developmental factors. Efforts are needed to correct these disparities by increasing outreach and creating the kinds of services that are needed by this unique age group.
2. The fragmentation of funding and the rigid rules for categorical eligibility hamper efforts to integrate and individualize services. Efforts at local, county and state levels are needed to reduce fragmentation and increase flexibility for use of funding.
3. Counties report making progress in developing policies, infrastructure, and services for TAY, but more needs to be done. There is a need for more designated TAY resources

(funding and staff) as well as community supports such as housing, specialized services, and public transportation, among other services. There is also a need for agencies to collaborate and maximize resources.