

# California Children’s Full Service Partnership (FSP)

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February 17, 2015

# Acknowledgement

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- Contribution and oversight for these studies by:
  - **Lonnie Snowden, PhD**  
Professor of the Graduate School  
School of Public Health  
University of California, Berkeley
- Statistical review and analytical input:
  - **Tei Wei Hu, PhD, UC Berkeley**
  - **UC Berkeley D-Lab**
- Preparation, editing and review:
  - **Laura Hosier**
  - **Thomas Weitzel**
  - **Bethany Baynes**

# Purpose of Presentation

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1. Review evaluation efforts for Children’s FSP within contract 12MHSOAC025 (Unpaid Deliverable)
2. Identify two points to make in two research briefs

# Evaluation Topics

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- 1. Availability of Children’s FSP Programs**
  - What are the system, social, and economic level indicators which lead counties to commit more or less ‘slots’ for children’s FSP Programs ?
  
- 2. FSP Services Addressing Unserved and Underserved Children**
  - Do children’s FSP programs help reach underserved children in need?
  
- 3. Reduction in Mental Health Emergency Services (MHES)**
  - What are the effects on MHES for children served through FSPs?

# Presentation Overview

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- Background
  - Children’s Mental Disorders & Health
  - Usual Care in California
  - Full Service Partnerships for Children & Families
  - Wraparound Model
- Data Sources & Study Population
- Evaluation Topics
  - Availability of Children’s FSP Programs
  - Unserved and Underserved
  - Reduction in MHES

*“Whatever it takes”*

# Background

# Children’s Mental Disorders

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- ~9 million children in California
- >5% (450,000+) are affected by a mental health related condition
- Many (approximately 225,000) served through California’s county mental health systems each year
- Others are served through privately insured healthcare or remain unserved

# Children’s Mental Disorders

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- Only 1/3 to 1/2 receive any mental health services for their symptoms
- Early treatment can modify the progression over the course of a lifetime
- The children’s mental health system is fragmented and a footnote of a larger plan for adult mental health

# Trends in Children’s Mental Health

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- Shift away from institutionalization and removal from home
- Shift toward community-based mental health services and support to remain in home and in community
- However, for most severe, welfare needs extended beyond the capabilities of the community-based care and interfere with treatment

# Usual Care

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- Children with Medicaid meeting the medical necessity criteria served through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit
- EPSDT offers menu of mental health services:
  - individual therapy
  - group therapy
  - family therapy
  - crisis counseling
  - case management
  - special day programs
  - medication for mental health
- EPSDT designed “correct and ameliorate” mental illness

# Usual Care

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- Lawsuit in 1999 (*Emily Q. v. Belshe, CV-98-4181-WDK, C.D., Cal., May 5, 1999*)
  - Found children with severe mental health needs had been institutionalized too frequently
  - Required counties to provide additional alternative community based mental health “wraparound” services
- WIC 18250 (wraparound) allows funding up to the cost of group homes for family services in order to maintain youth in home

# Full Service Partnership Programs

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- Serve the highest-need clients in the public mental health system
  - History of homelessness, incarceration, and/or institutionalization
- Provides social welfare and mental health services
  - Comprehensive, recovery based services
  - Provide intensive case management on a 24/7 basis
  - Do “whatever it takes” to promote progress toward recovery

# FSPs for Children & Families

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- FSP pilots focused on adults
- Unclear how this is modeled for children and families
- Children and their families qualify for the program if
  - children were identified to have serious mental health issues
    - AND
  - had other characteristics related to risks for suicide, violence, residential instability, criminal justice involvement, or involuntary hospitalization.

# FSPs for Children & Families

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- Full Service Partnership toolkit (2011)
  - Guidance for counties
  - Emphasized the use of wraparound model for children
  - Emphasized philosophies:
    - “no fail” unconditional care
    - strength building
    - safe environments
    - natural and community support networks

# Wraparound Model

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- National program model created as an approach to reduce the need for higher level group homes
- Keep in or return youth to homes
- Team approach emphasizing 10 principles
  1. strengths & values based
  2. individualized
  3. team-based
  4. unconditional
  5. culturally competent
  6. community based
  7. family centered
  8. collaborative
  9. sustainable
  10. goal-driven

# FSPs for Children & Families

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- Address contextual factors of the children’s and families’ physical environment,
  - Enabling stable safe housing was emphasized
  - Services in order to improve their home environment, for example from FSP Toolkit:
    - Make referrals to shelters
    - Take into account neighborhood safety issues
    - Provide temporary financial assistance for rent, security deposits, etc.
    - Assist in navigating legal and social services
    - Connect to community resources that offer assistance with rent, utilities, food, etc.
    - Assist the family in establishing a household, and obtaining furniture, appliances and other household items through financial assistance or solicitation of donations
    - Create safe play spaces the child, youth and family can use;
    - Help the child, youth and family to develop and refine skills in cooking, cleaning, budgeting, decorating, basic home maintenance, and other functions for a safe and successful home
    - Help gain access to low-cost or no-cost housing alternatives and/or housing assistance
    - Fund skill-building classes or lessons to assist in maintaining a successful living environment

# FSPs for Children & Families

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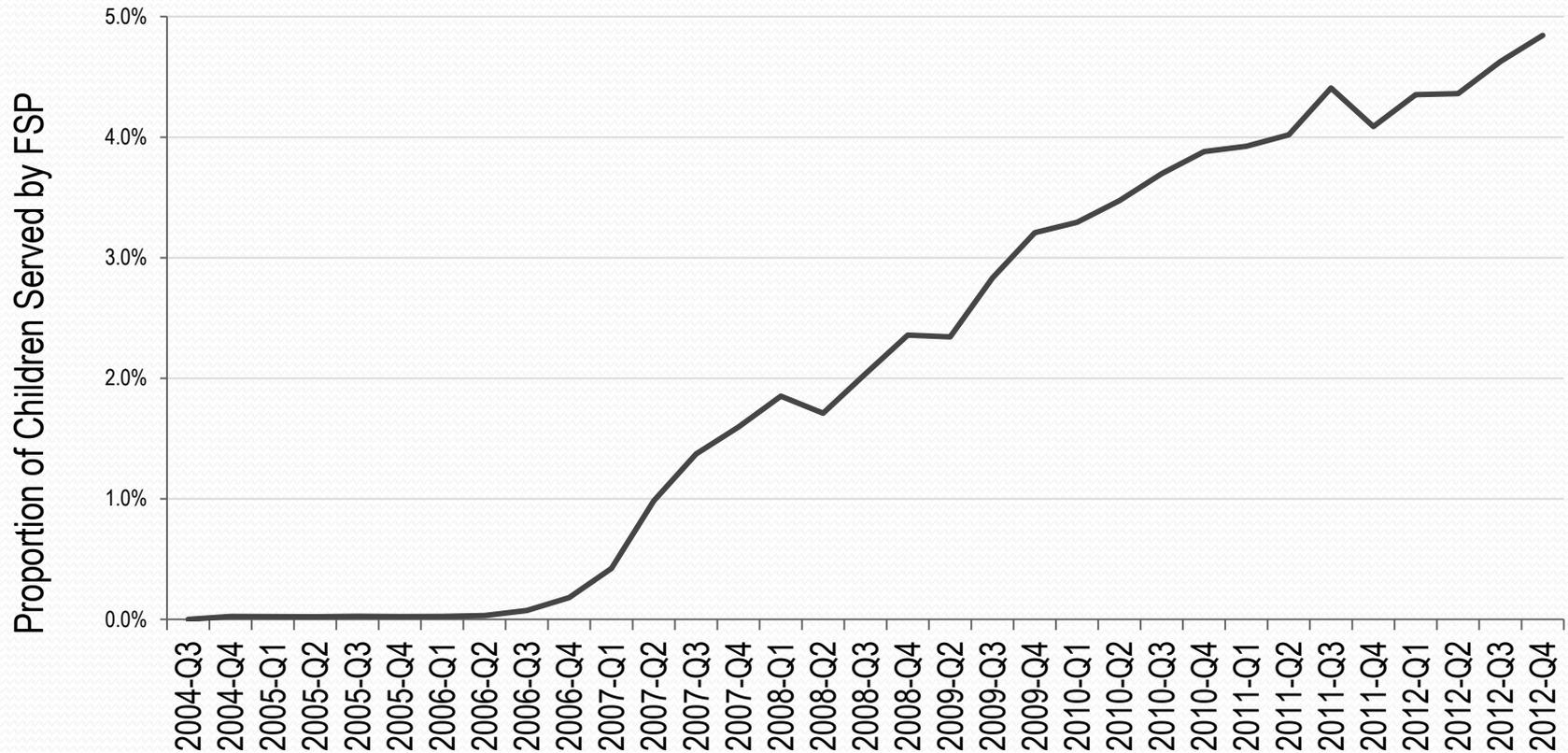
- Strength-based treatments
  - Help youth build and discover spiritual, personality, vocational and enrichment skills
- Encourage natural supports
  - Help youth and families to build natural supports through relationships with family, community groups, teachers, and resource providers
  - Invite natural supports into team meetings when therapeutically and culturally appropriate

# FSPs for Children Today

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- CA spends over \$100 million each year serving children and transition age youth (TAY, ages 16-25) in FSPs (UCLA, 2012)
- Over 24,000 children (0-18) served by FSPs since 2004
- FSPs continue to enroll over 4,000 children annually
- Approximately 4-5% of children in public mental health system are actively served via FSP in any given quarter (vs. 7-8% for adults)

# Proportion of Youth (Ages 6 to <18) Served by Counties Who Were Served by Full Service Partnerships, in Calendar Quarters after the Passage of MHPA in 2004



# Evaluation of Children’s FSPs

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- Little attention has been devoted to children’s outcomes in FSP programs
- Because of children’s mental health services through Medicaid (EPSDT), are FSPs for children needed?
- *Why do counties choose to serve children through FSPs?*

# FSPs Fill the Gap?

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- California’s data show that hospitalizations for youth under 21 have increased by 38% between 2007 and 2012
  - Suggests a continuing failure to treat youth within the community
  - Critics of the system suggest that there is a shortage of integrated care which is more intensive than a menu of weekly EPSDT’s services and less restrictive than hospitalization
  - Children’s FSPs are intended to fill that gap for the children and families it has the capacity to enroll

*Reference: Sacramento Bee Feb 2, 2014. Accessed on 10/23/2014 from <http://www.sacbee.com/news/local/health-and-medicine/article2590260.html>.*

# Relevant Questions about Children’s FSPs

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1. Who are FSPs serving and which children are continuing to be served only with EPSDT?
2. Are children served by FSPs receiving different care as compared to children served through EPSDT?
3. Are the FSPs resulting in significantly different outcomes for children as compared to similar children in usual care?

# **Data Sources & Study Population**

# Data for Evaluation

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- Client Services Information from Department of Health Care Services (DHCS)
- Linked with FSP Data Collection and Reporting System from DHCS
- July 1, 2004 – December 31, 2012
- Historical issues related to data reporting from counties to state
  - The dataset was reviewed for county-level consistency in reporting of counts of youth & services, and months/quarters with county-to-state data reporting issues were dropped from the dataset
  - 36 of the 58 available California counties were selected for research
  - represents ~70% of the total youth population served statewide
- Committee for the Protection of Human Subjects approval from both CA State and UC Berkeley

# Data for Evaluation

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- The dataset:
  - 623,031 total youth served within the CSS over 102 months
  - 15,904 were served by the FSP program
  - 7,127,833 months of service
  - Each child received average of 11.4 months of services within the county mental health system during the study period
  - FSP Data Collection Repository (DCR) data only used for identifying dates of FSP participation by individuals

**Evaluating:**

**1. Availability of Children’s FSP  
Programs**

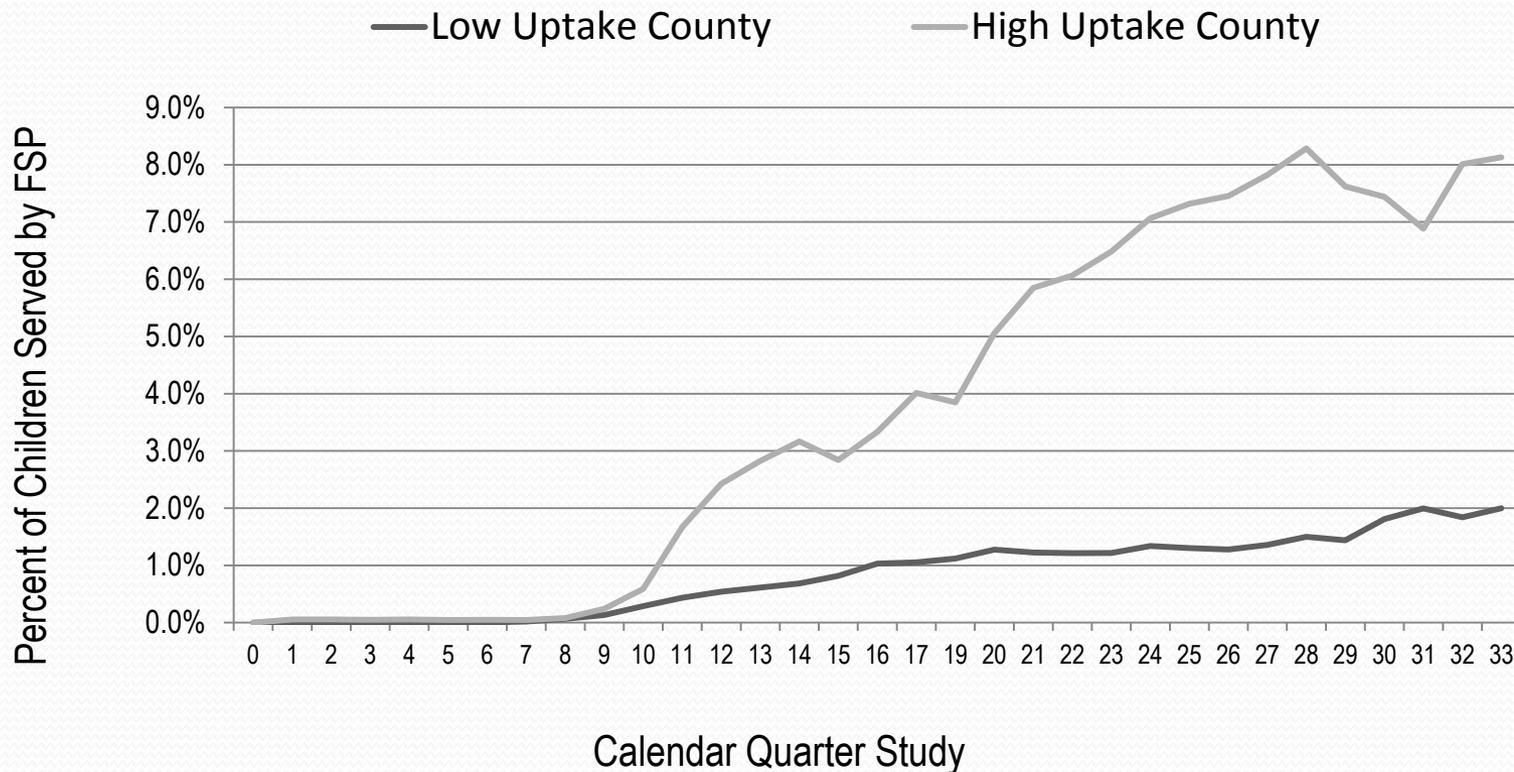
# Counties Differ in Availability of FSPs for Children

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- Some counties make more FSP program slots available to larger percentages of children
- Some counties do not serve children through FSPs
- The proportion of child caseloads served by FSP programs varies from 0% to >30% between counties
- Which counties offer FSPs to children?

# Counties Differ in Availability of FSPs for Children

- Differences between County Uptake of Children’s FSPs



# What Factors Influence Uptake?

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- Investigated county implementation of FSP programs for children by social, economic and caseload factors:
  - Time (Quarters 0-33)
  - Outcome (Dependent Variable)
    - % of Caseload Served by FSP Programs
  - County Characteristics
    - County Urbanity / Rurality
    - Annual Unemployment Rate
    - Annual Median Household Income
    - Annual Poverty Rate for children 5 to 17
    - Annual % of Children in Foster Care
  - Caseload Characteristics:
    - % Children Requiring Crisis Services
    - % Children by Age group (6 to 10, 11 to 14, 15 to 17)
    - % Children by Gender
    - % Children by Race
    - % Children with Diagnoses
      - PTSD, Substance Abuse, Bipolar, Depression, Anxiety, ADHD, Conduct Disorder, ODD/DBD, or Adjustment Disorder

# What Factors Influence Uptake?

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- Hierarchical Longitudinal Regression Model: random coefficient model for time–series cross-sectional analysis with robust standard errors
- 36 counties over 34 quarters
- Model estimated how much factors contributed to faster or greater uptake of children’s FSP programming over time

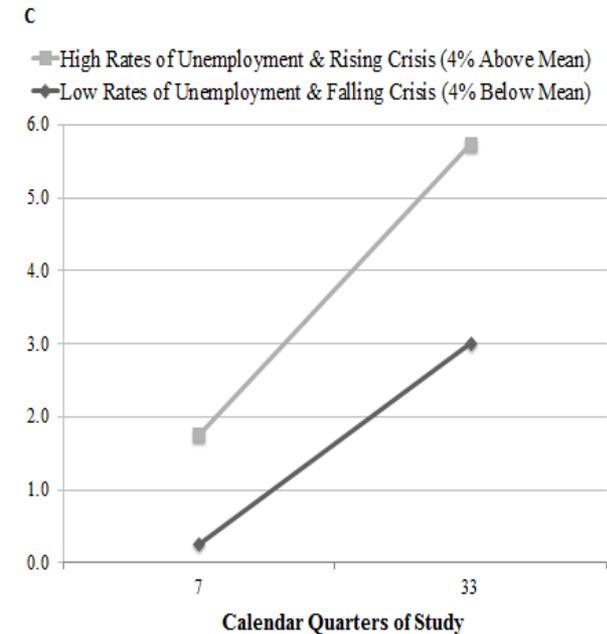
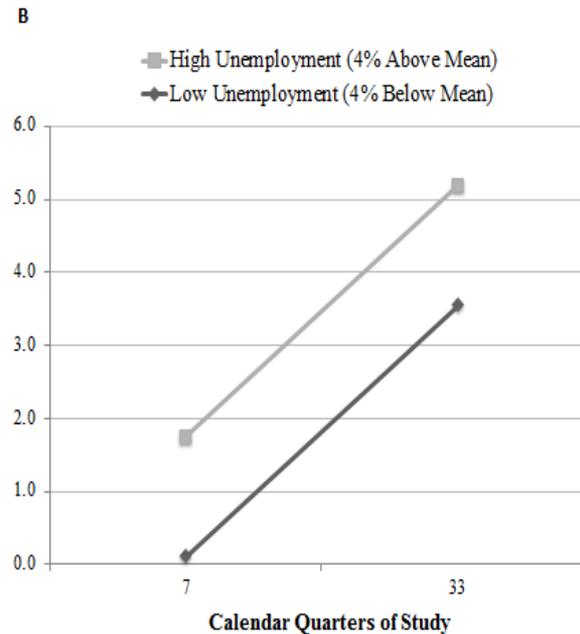
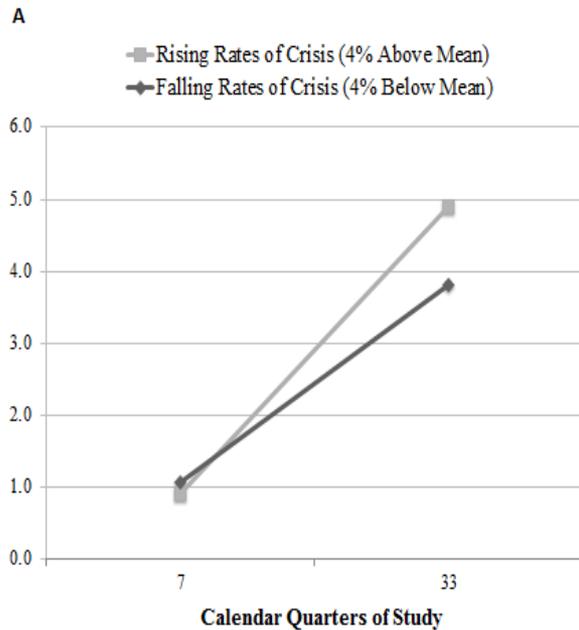
# Factors Influencing Uptake

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- Proportion of children served via FSPs was correlated with both county-level and caseload-level measures:
  - More uptake for counties was associated with rising rates of children’s crisis services use (assessed by interaction between crisis rate over time) ( $P < 0.05$ )
  - Counties with greater proportions of children in foster care offered FSPs to a greater proportions of children ( $P < 0.05$ )
  - The relative rate of unemployment was significant, indicating that the uptake increased, especially for counties experiencing higher unemployment rates ( $P < 0.01$ ).

# Factors Influencing Uptake

**Percent of Children in Caseload Served by an FSP Program in Counties with (A) Rising or Falling Rates of Crisis, (B) High or Low Rates of Unemployment, and (C) Both**



# County Uptake Conclusions

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- Rise in Emergency Crisis Services:
  - High uptake counties began with lower rates of emergency crisis services than low uptake counties, but high uptake counties experienced increasing rates, whereas low uptake counties began with higher emergency crisis services use rates, but they experienced declining rates
- Higher Unemployment:
  - High uptake counties experienced greater unemployment claims on average throughout the study as compared to low uptake counties
- County’s need for services can be viewed in both a dynamic context that considers increasing and decreasing levels of need, as well as a relative context of need comparative to surrounding counties or peers

**Evaluating:**  
**2. Whether FSPs Address  
Unserved and Underserved  
Children**

# Underserved

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- Underserved children with severe mental health issues are a difficult population to reach & engage
- FSPs seek to address this problem by utilizing
  - stakeholder informed outreach process,
  - unconventional connections to community based organizations
  - culturally sensitive, family-centered approach
- This would result in a service population different from those more often engaged in standard care
- Underserved children appear severe while having experienced less exposure to the mental health care system

# Hypothesis

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- Compared to Usual Care
  - FSP Children will show evidence of being underserved:
    - FSP enrolled children will be less likely to have received any prior mental health services
    - FSP enrolled children will have had less exposure to care in the county mental health system, on average

# Are FSPs Serving the Underserved?

- For the month in which a child enrolled into an FSP, how was he/she different from everyone else served by that county who were not selected for FSP?
- Logistic Regression with repeated sampling for odds of being selected for FSP during months in which county enrolled one or more children into FSP

# Are FSPs Serving the Underserved?

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- Limited the dataset to 2007 – 2012, because few youth enrolled before that period
- 14,887 enrolled into new FSPs during the study period
- Of 288,248 unique children available for enrollment
  
- Split file into age groups:
  - 6 to <11
  - 11 to <15
  - 15 to <18
  
- Regressed on the dichotomous variable of enrollment into FSP each month:
  - Service exposure (age first served and total months served)
  - Control for severity indicators (6-month history of substance abuse, trauma, diagnoses, and crisis services)

## Descriptive Statistics for Client-Months in Which County Enrolled Youth into Full Service Partnerships (2007 - 2012)

		Ages 6 to 10				Ages 11 to 14				Ages 15 to 17			
		Not Enrolled		Enrolled		Not Enrolled		Enrolled		Not Enrolled		Enrolled	
Client Months with FSP Enrollment in County	<i>N</i>	638,265		3,880		650,271		5,733		606,980		5,274	
Age													
Age at Potential Enrollment Month	<i>Mean SD</i>	8.7	1.4	8.6	1.4	13.1	1.2	13.3	1.1	16.5	0.8	16.4	0.9
Age First Served in County Mental Health	<i>Mean SD</i>	6.9	1.9	7.2	2.0	10.5	2.4	11.1	2.6	13.7	2.4	14.0	2.5
Exposure to Usual Care													
Prior Months Served in County System	<i>Mean SD</i>	17.5	14.2	12.6	13.3	24.0	20.1	17.3	18.8	23.2	20.5	17.1	19.1
Received Any Services in 6 Months Prior	<i>N %</i>	611,780	95.9%	3,009	77.6%	623,451	95.9%	4,525	78.9%	578,063	95.2%	4,286	81.3%
Race													
Latino / Hispanic	<i>N %</i>	300,328	47.1%	1,790	46.1%	271,419	41.7%	2,664	46.5%	258,116	42.5%	2,571	48.7%
African American / Black	<i>N %</i>	62,787	9.8%	330	8.5%	67,441	10.4%	472	8.2%	72,243	11.9%	371	7.0%
Other / Unknown	<i>N %</i>	228,342	35.8%	1,527	39.4%	246,127	37.8%	2,239	39.1%	209,824	34.6%	1,922	36.4%
White	<i>N %</i>	46,808	7.3%	233	6.0%	65,284	10.0%	358	6.2%	66,797	11.0%	410	7.8%
Gender													
Female	<i>N %</i>	224,368	35.2%	1,178	30.4%	257,305	39.6%	2,377	41.5%	269,190	44.3%	2,513	47.6%
Male	<i>N %</i>	413,897	64.8%	2,702	69.6%	392,966	60.4%	3,356	58.5%	337,790	55.7%	2,761	52.4%
Severity Indicator in Last 6 Months													
Trauma	<i>N %</i>	171,298	26.8%	1,328	34.2%	179,882	27.7%	1,867	32.6%	175,070	28.8%	2,328	44.1%
Substance Abuse	<i>N %</i>	2,991	0.5%	34	0.9%	25,533	3.9%	469	8.2%	131,581	21.7%	1,601	30.4%
Received Crisis Services	<i>N %</i>	41,944	6.6%	549	14.1%	88,865	13.7%	1,286	22.4%	124,850	20.6%	1,377	26.1%
Diagnosis in Last 6 Months													
Psychosis	<i>N %</i>	5,393	0.8%	92	2.4%	13,051	2.0%	209	3.6%	21,623	3.6%	339	6.4%
Bipolar	<i>N %</i>	49,800	7.8%	620	16.0%	106,408	16.4%	1,218	21.2%	135,569	22.3%	1,371	26.0%
Depression	<i>N %</i>	88,742	13.9%	673	17.3%	204,546	31.5%	2,288	39.9%	270,343	44.5%	2,538	48.1%
Anxiety Diagnosis	<i>N %</i>	76,934	12.1%	444	11.4%	69,659	10.7%	555	9.7%	62,057	10.2%	632	12.0%
Conduct Disorder	<i>N %</i>	6,097	1.0%	79	2.0%	19,465	3.0%	287	5.0%	53,550	8.8%	532	10.1%
ODD or DBD	<i>N %</i>	178,535	28.0%	1,383	35.6%	196,262	30.2%	2,236	39.0%	184,013	30.3%	1,573	29.8%
ADHD	<i>N %</i>	231,083	36.2%	1,466	37.8%	204,000	31.4%	1,411	24.6%	122,620	20.2%	894	17.0%
Adjustment Disorder	<i>N %</i>	149,654	23.4%	843	21.7%	105,494	16.2%	823	14.4%	79,301	13.1%	651	12.3%

Note: ADHD = Attention Deficit and Hyperactivity Disorder; ODD / DBD = Oppositional Defiant Disorder or Disruptive Behavior Disorder

# Results of Logistic Regression

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- As compared to the youth not enrolled, enrolled youth were more likely to have:
  - have been first served within the county mental health system at a younger age
    - (Ages 6-10 Odds Ratio (OR)=0.89,  $P<0.001$ ; Ages 11-14 OR=0.90,  $P<0.001$ ; Ages 15-17 OR=0.90,  $P<0.001$ )
  - Have received services in the prior six months
    - (Ages 6-10 OR=0.17,  $P<0.001$ ; Ages 11-14 OR=0.18,  $P<0.001$ ; Ages 15-17 OR=0.25,  $P<0.001$ )
  - Have reduced odds of enrollment with each additional month of prior exposure to standard care services
    - (Ages 6-10 OR=0.96,  $P<0.001$ ; Ages 11-14 OR=0.98,  $P<0.001$ ; Ages 15-17 OR=0.98,  $P<0.001$ )
  - While controlling for severity and demographic characteristics

# Results of Logistic Regression

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- When assessing severity indicators across all age groups, while controlling for all other variables in the model, all three models suggested that there was an increase odds of enrollment into a Full Service Partnership program for children noted to have:
  - Trauma (Ages 6-10 OR=1.48,  $P<0.001$ ; Ages 11-14 OR=1.29,  $P<0.001$ ; Ages 15-17 OR=1.93,  $P<0.001$ )
  - Substance abuse (Ages 6-10 OR=1.51,  $P<0.05$ ; Ages 11-14 OR=1.35,  $P<0.001$ ; Ages 15-17 OR=1.29,  $P<0.001$ )
  - Recent crisis services (Ages 6-10 OR=1.95,  $P<0.001$ ; Ages 11-14 OR=1.59,  $P<0.001$ ; Ages 15-17 OR=1.25,  $P<0.001$ )
  - Diagnosis of:
    - Psychosis (Ages 6-10 OR=1.92,  $P<0.001$ ; Ages 11-14 OR=1.54,  $P<0.001$ ; Ages 15-17 OR=1.71,  $P<0.001$ )
    - Bipolar (Ages 6-10 OR=2.26,  $P<0.001$ ; Ages 11-14 OR=1.49,  $P<0.001$ ; Ages 15-17 OR=1.31,  $P<0.001$ )
    - Depression (Ages 6-10 OR=1.41,  $P<0.001$ ; Ages 11-14 OR=1.39,  $P<0.001$ ; Ages 15-17 OR=1.11,  $P<0.001$ )
    - Conduct Disorder (Ages 6-10 OR=1.79,  $P<0.001$ ; Ages 11-14 OR=1.43,  $P<0.001$ ; Ages 15-17 OR=1.10,  $P<0.05$ )
    - ODD/DBD (Ages 6-10 OR=1.62,  $P<0.001$ ; Ages 11-14 OR=1.61,  $P<0.001$ ; Ages 15-17 OR=1.14,  $P<0.05$ )

# Underserved Conclusions

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- Children who are enrolled into the FSP appear to be significantly different in characteristic from other clients served in the same month within the county mental health system
- Even though enrolled youth were less likely to have received recent mental health services, they were more likely to have received recent crisis services, to have one of the diagnoses associated with functional impairment for their age group or to have concerns related to trauma or substance abuse

## **Evaluating:**

# **3. Whether FSPs Reduce the Need for Mental Health Emergency Services (MHES)**

# Do FSPs Fill the Gap?

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- Mental health emergency crises pose an immediate danger to the youth or to others
- MHES services often serve as a gateway to more restrictive levels of care, shifting youth out of the community setting and into more restrictive hospital or residential settings (Lyons et al., 1997)
- Crisis serves as an indicator of failed care
- Thus, a reduction of MHES is an indicator of program success of potentially “filling the gap”

# Mental Health Emergency Services

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- “Crisis intervention services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires more timely response than a regularly scheduled visit. Service activities include, but are not limited to, assessment, collateral and therapy. Crisis Intervention services may either be face-to-face or by telephone with the beneficiary or the beneficiary’s significant support person and may be provided anywhere in the community”.
- “Crisis stabilization services last less than 24 hours and are for, or on behalf of, a beneficiary for a condition that requires a more timely response than a regularly scheduled visit. Service activities include but are not limited to one or more of the following: assessment, collateral, and therapy. Collateral addresses the mental health needs of the beneficiary to ensure coordination with significant others and treatment providers”.

**= Mental Health Emergency Services (MHES)**

# Days of MHES

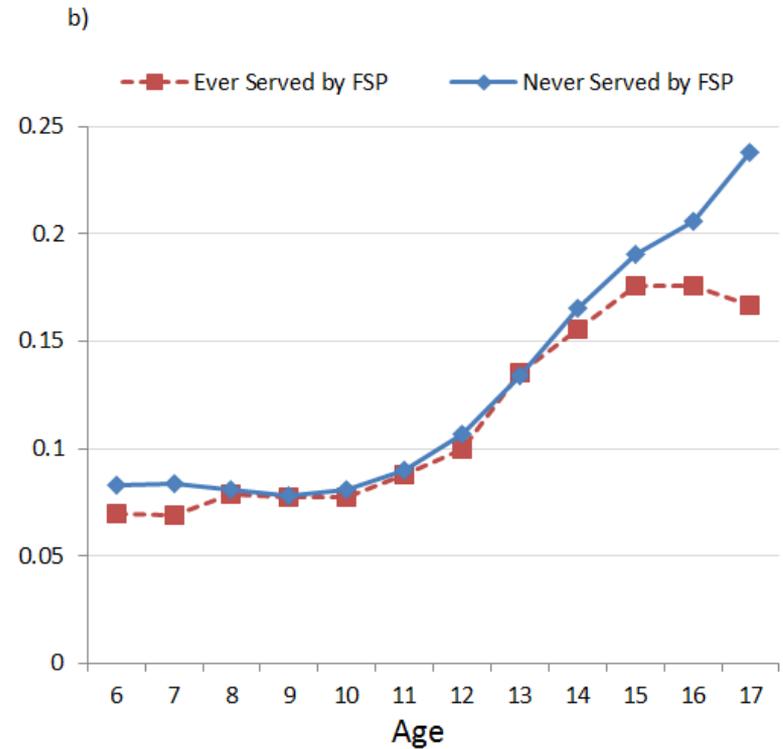
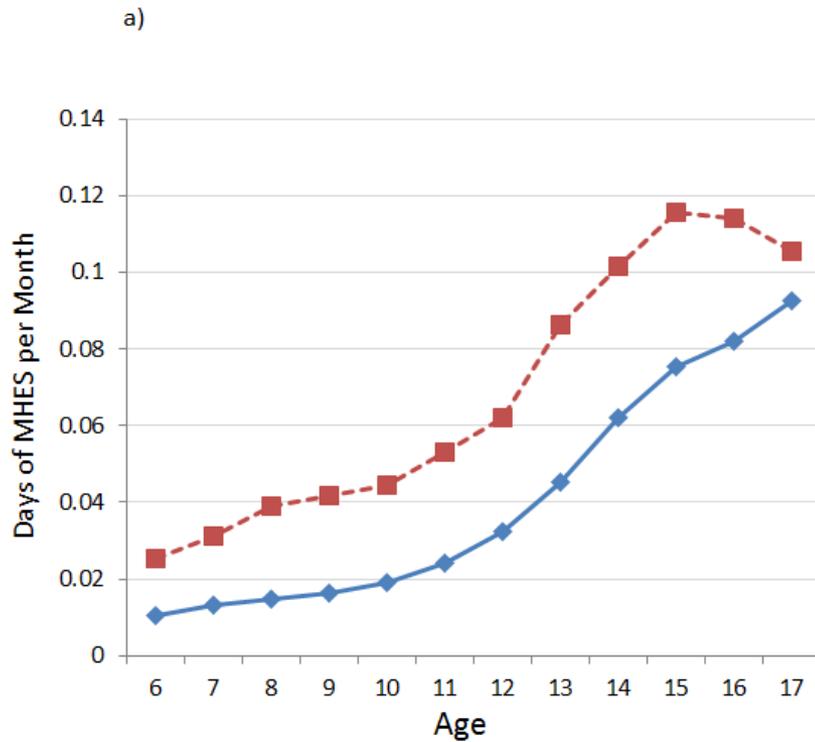
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- Approximately 10% of youth served by CSS each year experience the need for MHES, which are commonly referred to as crisis intervention and crisis stabilization services in California. These are categorized as “crisis intervention” care and “crisis stabilization” care.
- Days of MHES: The number of days on which the youth received MHES within each month the youth was served within the CSS systems was used as the outcome of interest
- The two forms of urgent care for crisis treatment (crisis intervention and crisis stabilization) were combined, and the total number of days within a month on which crisis services were received was tallied
- Days of MHES ranged from 0 to 31

# System Rates of MHES by Age

(a) All Youth Served

(b) Youth Served who had at Least 1 MHES



# Do FSPs Reduce MHES?

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- FSP had staggered implementation over the study’s 102 months (July 1, 2004 – Dec 31, 2012)
- Utilizing pooled, longitudinal, cross-sectional data cohorts we observed whether per-month MHES utilization decreased in response to FSP participation, comparing 3 groups:
  - Children before enrolling into FSP (Pre-FSP)
  - Children after enrolling into FSP (Post-FSP)\*
  - Children served exclusively through EPSDT (Usual Care)\*\*

\*All service months beginning with the first month of FSP enrollment were assigned as Post-FSP intervention group, whether or not the youth continued in FSP for the remainder of the study. This decision was made because FSP was assumed to have lasting effects (e.g. social services, housing, material supports and collateral service linkages) which once provided might not be withdrawn.

\*\*Usual care youth never participated in an FSP program during the 102 months of the study

# Split Age Models

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- The linked dataset was divided into age groups for analysis:
  - 6 to <11 year
  - 11 to <15 years
  - 15 to <18 year

# Split Datasets by Age Group

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- Within the 6 to <11 dataset
  - 219,763 Usual Care Youth
  - 6,089 Pre-FSP Youth
  - 4,771 Post-FSP Youth
  - Included a total of 2,354,021 months of services
  - Each youth served for an average of 10.6 months between these age
- Within the 11 to <15 dataset
  - 253,864 Usual Care Youth
  - 7,485 Pre-FSP Youth
  - 7,098 Post-FSP Youth
  - Included a total of 2,524,959 months of services
  - Each youth served for an average of 9.8 months of service between these ages
- Within the 15 to <18 dataset
  - 288,848 Usual Care Youth
  - 4,384 Pre-FSP Youth
  - 8,069 Post-FSP Youth
  - Included a total of 2,248,853 months of services
  - Each youth served for an average of 7.8 months between these ages.

# Analysis

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2-level random coefficient Poisson hierarchical linear model (HLM)

- Age during month of service (Age at Service Month) representing time
- Each Child-Month was identified as:
  - Usual Care
  - Pre-FSP
  - Post-FSP
- Interaction terms identified change in MHES across ages:
  - Pre-FSP x Age
  - Post-FSP x Age
  - Usual Care by Age acted as the control
- Controls for client severity included time varying clinical indicators of diagnosis, substance abuse, and traumatic experience

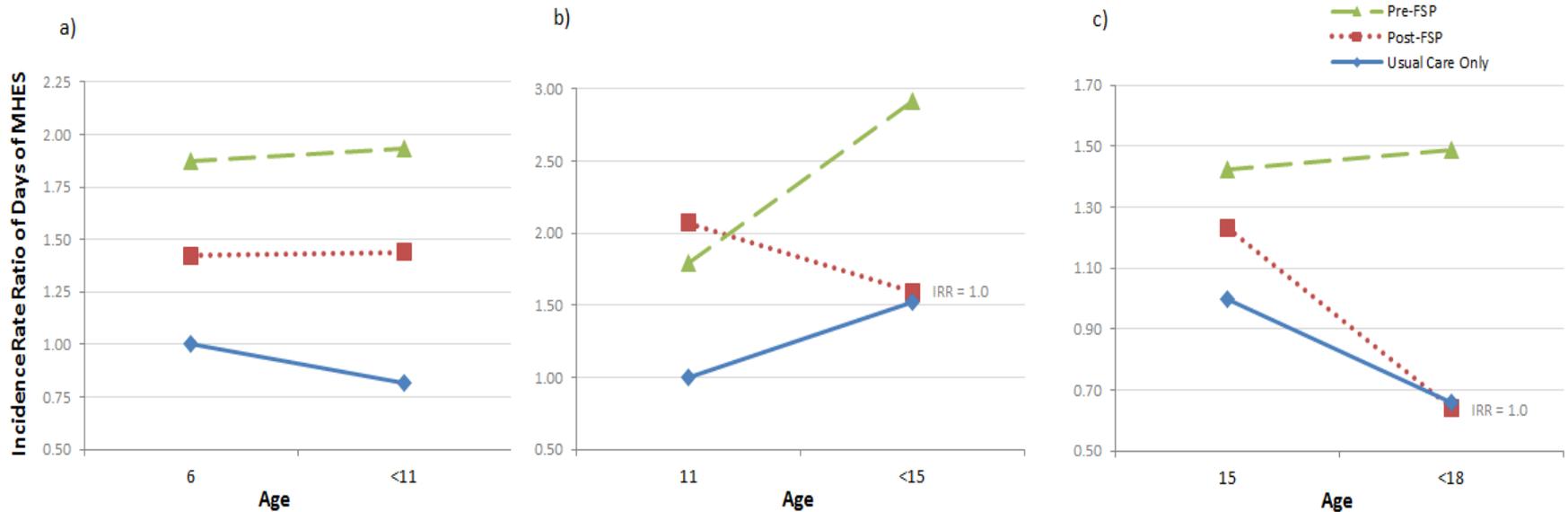
## RESULTS: Poisson 2-Level HLM of Monthly Days of MHES by Month of Service Age Nested within Client, Controlled by Fixed County Effects

	Ages 6 to <11		Ages 11 to <15		Ages 15 to <18	
	$\beta$	IRR	$\beta$	IRR	$\beta$	IRR
Intercept	-5.63 ***		-5.68 ***		-5.62 ***	
Pre-FSP	0.63 ***	1.88	0.58 ***	1.79	0.35 ***	1.42
Post-FSP	0.34 ***	1.41	0.73 ***	2.05	0.20 ***	1.22
Pre-FSP x Age	0.05 *	1.05	0.02	1.02	0.15 ***	1.16
Post-FSP x Age	0.04	1.04	-0.17 ***	0.84	-0.08 **	0.92
Age						
Age at Service Month	-0.03 ***	0.97	0.10 ***	1.11	-0.15 ***	0.86
Age First Served	0.25 ***	1.28	0.21 ***	1.23	0.18 ***	1.20
Cohort Age	-0.06 ***	0.94	-0.05 ***	0.95	-0.01 ***	0.99
Gender						
Female	-0.18 ***	0.84	0.31 ***	1.37	0.10 ***	1.11
Male (Reference)	0.00		0.00		0.00	
Race						
Latino	-0.50 ***	0.60	-0.24 ***	0.78	-0.08 ***	0.93
Black/ African Amer.	-0.10 **	0.90	-0.07 **	0.94	0.04 *	1.05
Other/ Unknown	-0.25 ***	0.78	0.08 ***	1.09	0.25 ***	1.30
White (Reference)	0.00		0.00		0.00	
Diagnosis						
Psychosis	1.10 ***	3.02	0.86 ***	2.37	0.79 ***	2.20
Bipolar Disorder	1.14 ***	3.14	0.88 ***	2.41	0.58 ***	1.79
Depression	0.54 ***	1.72	0.48 ***	1.62	0.26 ***	1.29
Adjustment Disorder	0.26 ***	1.29	0.20 ***	1.23	0.30 ***	1.35
Conduct Disorder	0.69 ***	2.00	0.33 ***	1.40	0.14 ***	1.15
Anxiety Disorder	-0.00	1.00	-0.32 ***	0.73	-0.34 ***	0.71
ODD / DBD	0.36 ***	1.43	0.03 **	1.03	-0.06 ***	0.94
ADHD	0.03	1.03	-0.32 ***	0.73	-0.43 ***	0.65
PTSD	0.34 ***	1.40	-0.02	0.98	-0.16 ***	0.85
Substance Abuse	0.71 ***	2.04	0.48 ***	1.61	0.22 ***	1.25

\*P ≤0.05; \*\*P ≤0.01; \*\*\*; P ≤0.0001

Note: ODD / DBD = Oppositional Defiant Disorder or Disruptive Behavior Disorder; ADHD = Attention Deficit and Hyperactivity Disorder; MHES = Mental Health Emergency Services; IRR = Incidence Rate Ratio; PTSD = Post Traumatic Stress Disorder

# Results: Change in Rates of MHES by Treatment and Age Groups



After beginning aggressive FSP treatment, children show significantly and rapidly reducing rates of MHES usage over time as compared to themselves before treatment and to all other children in usual care, providing strong evidence for the success of the FSP Program in reducing children’s crisis events and the associated need for MHES.

# Summary

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- FSP Programs interface social services with mental health
- Research suggests:
  - Counties with rising rates of children’s MHES and high unemployment implementing more FSPs to meet children’s needs
  - FSP programs reach underserved children with high need
  - FSP programs reduce the need for MHES in the population served
- More Research Needed:
  - Are the underserved children who are reached then engaged into the program for significant amounts of time/services?
  - How are services / supports in the FSP program different for EPSDT or standard wraparound?
  - Does the FSP program fill a gap for children who do not generally qualify for more intensive programs through EPSDT / wraparound?

# Feedback & Questions

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- Question to the committee:
  - From these studies, what are important points to make via two research briefs, which will communicate high level findings to broader audiences?

# References

# California Children’s Full Service Partnership (FSP)

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February 17, 2015