Stars Behavioral Health Group

Star View Adolescent Center

FY 08-09 Report and Historical Trends

OVERVIEW

- This report summarizes information about *Star View Adolescent Center*[1] program fiscal year (FY) 2008-2009, as well as trends over recent years (FY 05-06 forward).
- Since opening in 1996, Star View has provided a secure, enriched and integrated treatment program for adolescents ages 11 thru 17 who have profoundly disabling emotional and behavioral problems that reflect developmental trauma and create very serious safety issues for themselves and/or others. Program goals are to stabilize the young person, decrease their mental health disabilities and promote recovery from trauma, facilitate their educational and vocational attainment, reconnect them to family whenever possible, and return them to safe, supported community living.
- The clinical program model is built upon principles of trauma-informed care, newly framed over the past few years.[2] These principles shape all aspects of program culture, staff training and development, and Star View's array of programmatic offerings including the selection and implementation of evidence-based practices guided by *Stars Behavioral Health Group* (SBHG).
- The program goals are reflected in the bundled and integrated structure of the program which includes a *Psychiatric Health Facility* (PHF) medical and nursing intensive inpatient service; *Community Treatment Facility* (CTF) residence with care management; *Intensive Day Treatment* (DTI) therapy and rehabilitation in individual, group, family and community contexts; and, *Non-Public School* (NPS) accredited middle and high school called *South Bay High School.* Additional specialty services such as medication supports, behavioral coaching, and crisis intervention are part of each youth's individualized treatment plan, with behavioral coaching (i.e., *Therapeutic Behavioral Services*) being the predominant type (68%) provided among the specialty mental health services.
- The program's goals are also reflected in the outcomes tracked for each and every client served which are reported herein, along with profile and utilization data, and continuously reviewed as part of the agency's Total Quality Management program: a) Are Star View's youth safe while in the setting and able to return to lower levels of care and live in the community?; b) Are the youth attending and progressing in school and/or vocationally? c) Are they improving in their health and mental health, including reducing substance abuse? d) Are they out of trouble with the law?

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For more information contact: Karyn L. Dresser, Ph.D. Dept. of Research & Program Practices, SBHG. Phone: 510-635-9705; Email: kdresser@starsinc.com or Peter Zucker, Ph.D., Vice President of Clinical Services, SBHG. Phone 310-221-6336; Email: pzucker@starsinc.com.

HISTORICAL MILESTONES

March-November, 1996: Licensure, *Plan of Operations*, first services.

December, 2000: RCL 14 group home is relicensed as a Community Treatment Facility (CTF).

March, 2003: Closure of Los Angeles (LA) County's MacLaren Children's Shelter, with redirection of youth to Star View and increased partnerships with the Department of Children and Family Services (DCFS) around permanency planning.

September, 2003: Implementation of *Workability* program to support youth's vocational training.

January, 2004: Practices aligned to California's Senate Bill (SB) 130 regarding use of restrictive interventions. The Community Treatment Facility voluntary eliminates use of mechanical restraints.

October, 2004: Began *Aggression Replacement Training* (ART) with EQUIP groups that address anger management, social skills, thinking errors, and moral reasoning.[3]

May, 2005: Training and certification of clinical staff in *Dialectical Behavior Therapy* (DBT).[4]

July, 2005: First admission from a county other than LA (agency currently contracts with 13 counties).

March, 2006: Piloted "residential-wraparound" providing wraparound with 20 youth and families from the time of admission. The pilot was successful; however, an ongoing funding mechanism for the enhanced community team process was not available.

January, 2007: Updated *Plan of Operations* with underlying focus on trauma-informed care, increased attention to family finding, and promoting success with community outings and transition support.

May, 2007: South Bay School achieves accreditation (six year term) from the *Western Association of Schools and Colleges* (WASC).

September, 2007: Began *Structured Psychotherapy for Adolescents Responding to Chronic Stress* (SPARCS).[5]

January, 2008: Very last child/youth patients are discharged from Metropolitan State Hospital. Redirection of highest acuity and most long served (chronic) youth to Star View.

Ongoing & Recurring: Aesthetic, dietary and security enhancements.

TREATMENT JOURNEYS

Becoming well from serious mental illnesses as a child, and/or after physical, emotional and/or sexual trauma -- where life, health and/or well-being are seriously threatened -- is not typically simple or straight-forward, but rather involves high levels of supportive individualized interventions, the grace of time, and much patience and persistence from all involved. Two recent stories (names changed to protect privacy) illustrate the kinds of treatment journeys of the youth served by Star View.

Gabriella *A few years ago, when she was not quite a teen, Gabriella was raped by four men. Unfortunately, this event occurred near where she lived which was rife with gang activity, and against a backdrop of pre-existing depression, and problems in her family (i.e., domestic violence, parental substance abuse, and inadequate supervision of children). Gabriella's coping mechanisms were overwhelmed and she adopted two strategies after this severe trauma which further complicated her path toward recovery: she joined a gang for protection and became aggressive with others (an effort to regain a sense of safety in the world); and, she began using a variety of street drugs (an effort to numb herself to psychological pain). In not much time, her troubled behaviors worsened: she experienced mental confusion and psychotic symptoms, and had suicidal thoughts. She escalated in the types and frequency of self-harm behaviors, attempting to overdose and using everyday objects to cut into her arms.*

As her unsafe behaviors emerged, Gabriella began her journey through the service system which included at least six psychiatric hospitalizations, removal from home due to neglect, and time spent in shelters and emergency housing. A little over six months after the rape and at least five hospitalizations, Gabriella arrived at Star View, where all aspects of treatment need, schooling, and permanency planning could be brought into focus through the multi-disciplinary team process with her strengths identified and brought into service planning. Gabriella experienced modest stability over a nine month period. She struggled with school attendance yet achieved passing grades, and showed interest and talent in art. Then, as the specialized trauma programming (i.e., DBT and SPARCS) began getting deeper into addressing her trauma experience and family issues, she entered a period of cycling acuity, using the one-on-one attention available on the PHF to safely stabilize vis a vis cutting and embedding behaviors and sexual acting out with other girls. She was able to transfer back to the CTF three times over two years, with each CTF placement lasting a little longer than the previous one, signaling increasing tolerance for milieu living and program participation. Her treatment was able to focus in on helping her develop distress tolerance and self-soothing skills -- including when she was flooded by trauma memories -- to replace her prior reliance on aggression, substance abuse, and cutting/embedding. Staff provided specific comforting and reality-oriented interventions that helped Gabriella get through the worst of her trauma distress. As Gabriella mastered positive coping -- and remained substance free in placement -- she became optimistic about her potential for success in life and confident and proud about becoming a positive role model and leader amongst her peers. She benefitted greatly by reclaiming support from her family which was made possible through her therapist's skill and persistence at creating an alliance with the family whom shifted from hostility to support toward treatment. Staff conveyed that the whole family was traumatized by what had happened and would benefit from working together in recovery. The family began participating in family therapy and developed the mutually shared aim of eventual family reunification. Gabriella is now ready for an interim, stable community placement in a lower level group home.

Tuyen *Tuyen was born to a Asian American mother, sired by an African American father, into a maternal family system that could not abide her mixed ethnicity and no paternal family contact as the father left as soon as she was born. She was raised by her mother and step-father since age three. Her step-father's family also compared her unfavorably to her siblings and saw Tuyen as having little possibility for a good life because of her mixed heritage. Tuyen's problems began very early. There were reports from toddlerhood extending throughout childhood of hyperactivity and dangerous impulsivity. She received a diagnosis of bipolar disorder at age eight; later, other diagnoses would include mood disorder, intermittent explosive disorder and oppositional defiant disorder. Over time she became more aggressive toward peers and family alike, flailing and failing at school, and her mother among others became frightened by her. By the time she arrived at Star View at age 14, she had experienced over 13 psychiatric hospitalizations, a dozen CPS investigations of the family (for physical abuse, none substantiated), and multiple high-end residential treatment placements. When Tuyen began treatment at Star View she had a rash of medical issues (e.g., asthma, myopia, scoliosis, esophageal reflux disease), much regressed behavior (like a five year old), academic delay, and was suffering terribly from paranoid perceptions and command hallucinations (e.g., voices telling her to hurt herself or others). Also problematic for future community living, she was impulsively aggressive toward others.*

Tuyen has not had an easy time and she required much individualized attention including one unusually long stay on the highly structured PHF unit. Significant talents were applied to sorting out her medical and diagnostic issues and identifying the best medicine at just the right dose to stabilize her severe psychiatric symptoms while allowing sufficient alertness to gain from therapy and schooling. In time, she has had an excellent treatment response, with dramatically reduced incidents of assaults. Contributing to this were skillful efforts by staff to identify the triggers of her aggression, orient her to reality, reassure safety, and praise appropriate behaviors and personal successes (however small), all with a soft, calm voice. She is now well positioned to take advantage of the CTF milieu program, including continued learning from Aggression Replacement Training (especially Skills-Streaming Groups, which focus on pro-social interactional skills), and attending school more regularly. She is able to focus on her favorite subjects (e.g., biology) and on gaining the course credits she needs to meet 10th grade requirements. Discharge planning is underway.

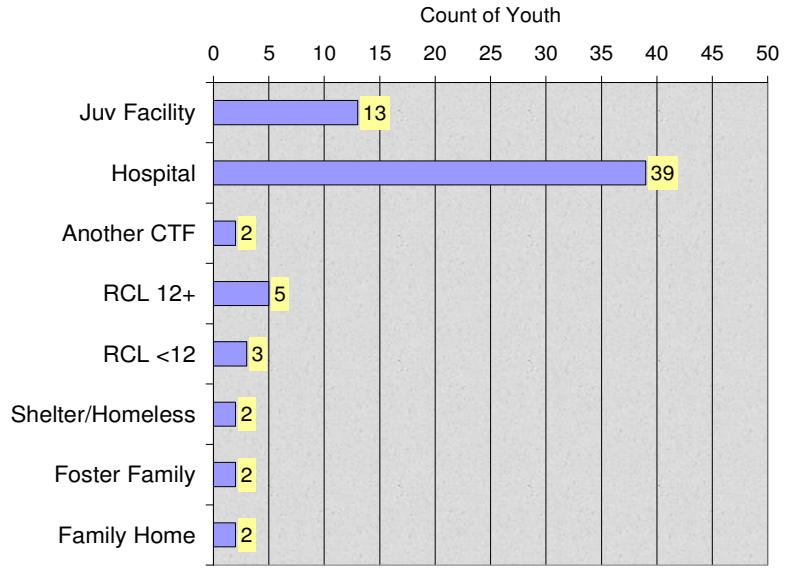
YOUTH & FAMILY PROFILE

Youths' Demography

	Ages 11 Thru 14 *(N=33)*		Ages 15 Thru 17 *(N=69)*		
	Females	Males	Females	Males	*Ethnic:*
Afr. American	8	6	17	7	*38*
Anglo American	7	0	13	3	*23*
Asian American	0	0	0	0	*0*
Hispanic/Latino	7	5	17	11	*40*
Native American	0	0	0	0	*0*
Mixed Ethnicity	0	0	1	0	*1*
Age by Gender:	*22*	*11*	*48*	*21*	*102*

During FY 08-09 Star View served 102 (unduplicated) youth, who were 15.4 years of age on average and majority (69%) female. The youth came from varied ethnic backgrounds with 40% Hispanic/Latino heritage, 37% African American, and 23% Anglo American. The recent FY continues a historical shift toward higher proportions of females and Latino clients.

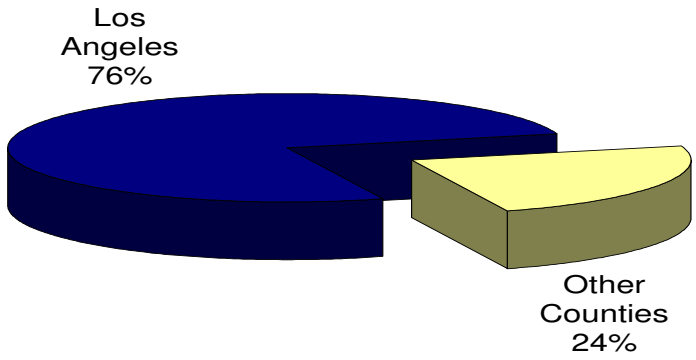
Immediately Prior Living or Placement Situation



During FY 08-09, youth arrived at Star View's PHF from the external settings shown.[6] The majority are transferred from hospitals within their communities, typically having arrived there from group homes. Another good number are youth with serious emotional disturbances arriving from juvenile detention facilities.

These data represent a departure from prior years, with more arriving through juvenile facilities this year compared to earlier (20% this year, 10% prior years), offset by fewer arriving from group homes (16% to 27%).

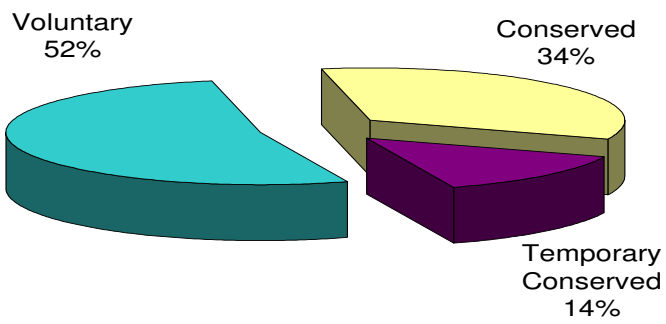
Home (Jurisdictional) County



Along with Los Angeles, over the last four years there were also enrollments from Alameda, Contra Costa, El Dorado, Mendocino, Modoc, Riverside, San Bernardino, San Diego, San Mateo, Santa Clara, Tehama and Tulare counties. Since 2006, there has been an average increment of 2 new counties using the facility each year. Star View is the primary referral resource for highest acuity youth in California.

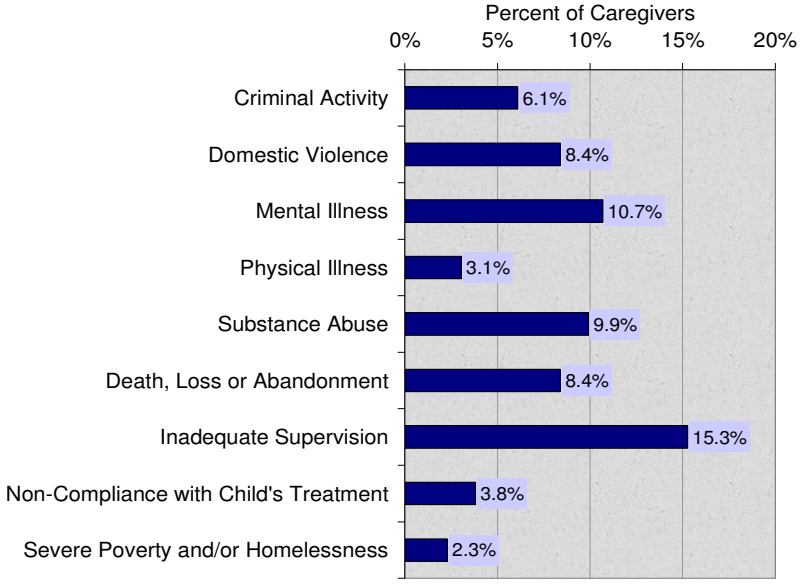
The great majorities (95%) of youth were court dependents referred by social services; others were referred by mental health.

Legal Status of Admission



A little over half the youth were voluntary admissions (per their parent or legal guardian) through the juvenile court's 6552 statutes with a few Special Education/Mental Health Services' AB 3662 (Chapter 26.5). The others were conserved by the court or on temporary conservatorship. These proportions are quite consistent over the years.[7]

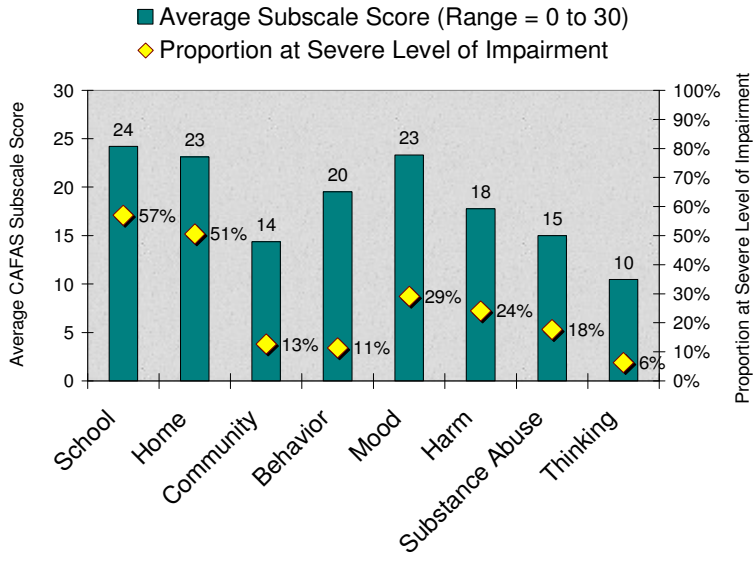
Caregiver Challenges



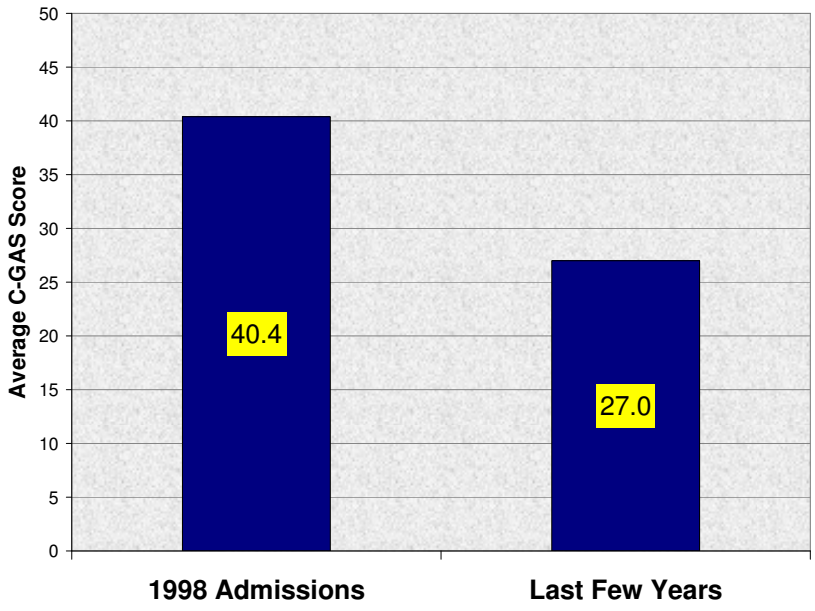
For Star View's youth, the primary support group (i.e., family) is by far the predominant psychosocial stressor (95%) recorded on diagnostic Axis IV.

During intake, clinicians assess the kinds of challenges of the care-giving environment that impact the youth's mental health and future prognoses. Although the information is often incomplete initially, this is done so the treatment team can begin to address care giving and permanency as soon as possible to help prepare the youth for future transition to community placements or family homes.

Community Functioning



Clinicians use the *Child and Adolescent Functional Assessment Scale* (CAFAS)[8], and the baseline assessments are shown, both average scale scores (range 0 to 30, with 30 being severe dysfunction) and percentages with severe levels of impairment. According to CAFAS interpretative guidelines, 92% of Star View's youth require *more than* outpatient services and *at least* 75% require intensive treatment.



The CAFAS severity levels are corroborated by the Axis V *Children's Global Assessment of Functioning Scores* (C-GAS).[9] In this population, admission C-GAS scores average 27 with a median (50%tile) of 25 on a scale from 0 to 100 where 100 is optimal functioning. This is true of the past few years.

When the program opened in 1998 the average C-GAS was 40. In the long view, there has been increasing severity of problems among referred youth as hospitals and residential settings have closed and systems of care have aimed to maintain youth as long as possible in community settings. When those efforts fail, and safety becomes critically salient, these most difficult of all youth are referred to the CTF.

System of Care –
Risk Levels and Placement Types

2007 Study of 207 Los Angeles Youth	Group Homes	GH RCL-14	**CTFs**	State Hospital
Psychosis	9%	40%	**50%**	67%
Attention/Impulse	49%	81%	**89%**	75%
Depression/Anxiety	46%	71%	**74%**	83%
Anger Control	60%	89%	**86%**	58%
Antisocial	43%	50%	**68%**	33%
Trauma Adjustment	46%	48%	**59%**	67%
Abuse History	60%	45%	**66%**	58%
Family Mental Illness	61%	68%	**78%**	58%
Danger to Self	18%	48%	**65%**	50%
Fire Setting	2%	4%	**7%**	0%
Runaway	22%	48%	**65%**	50%

Star View participated in an independent study[10] that demonstrates the seriousness and complexity of problems among those enrolling at the CTF level of care compared to other types of placements.

There were 11 areas -- all related to mental health and risk behaviors -- that met a clinically actionable level of treatment need, distinct from non-clinical populations. There are very high percentages of high risk behaviors among those entering CTFs. Per the author's conclusions the distinctions match the rationales (eligibility criteria) for a tiered system of care.

Axis I Clinical Diagnoses

	% of Clients	% of Diagnoses
Internalizing Disorders:		
Bipolar Disorder	35.3%	18.4%
Post Traumatic Stress Disorder	28.4%	14.8%
Major Depression	26.5%	13.8%
Mood Disorders NOS	21.6%	11.2%
Externalizing Disorders:		
Attention Deficit Hyperactivity	9.8%	5.1%
Intermittent Explosive Disorder	7.8%	4.1%
Oppositional Defiant Disorder	5.9%	3.1%
Major Mental Illness:		
Schizoaffective Disorder	6.9%	3.6%
Psychotic Disorder NOS	4.9%	2.6%
Other:		
Reactive Attachment	3.9%	2.0%
Developmental Disorder	3.0%	1.5%

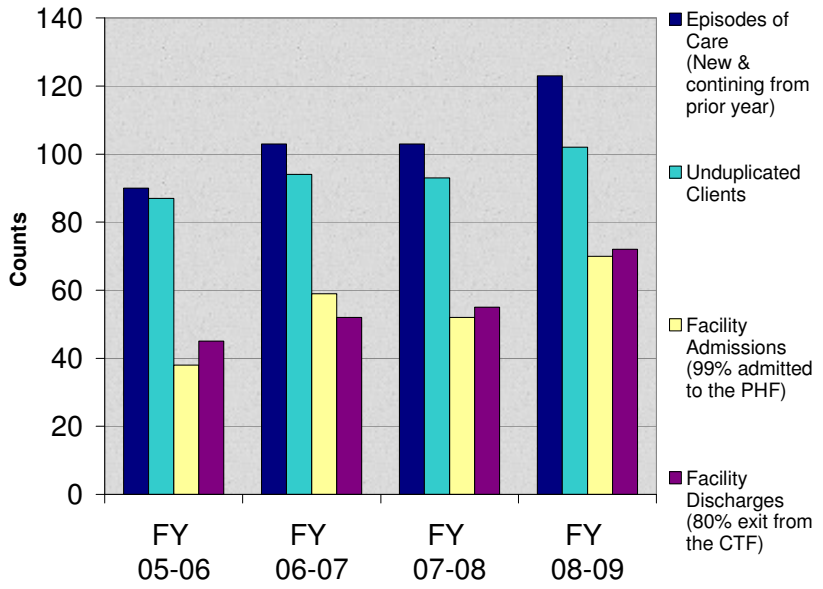
The broad clinical pathways of Star View's youth and the most prevalent diagnoses within each pathway are shown for youth served during FY 08-09.[11] On average, the youth have 1.9 Axis I diagnoses each.

The program serves many youth with complex developmental trauma, including those with diagnoses across clinical pathways and/or diagnoses with complicating features (e.g., Bipolar with Psychotic Features) and recurring and/or severe notations. A few (3%) are diagnosed on Axis II with Borderline Personality and others show these tendencies.

Roughly 33% of youth have co-occurring substance abuse and/or dependency (primarily polysubstances); and, 50% have one or more physical health conditions.[12]

STAR VIEW UTILIZATION

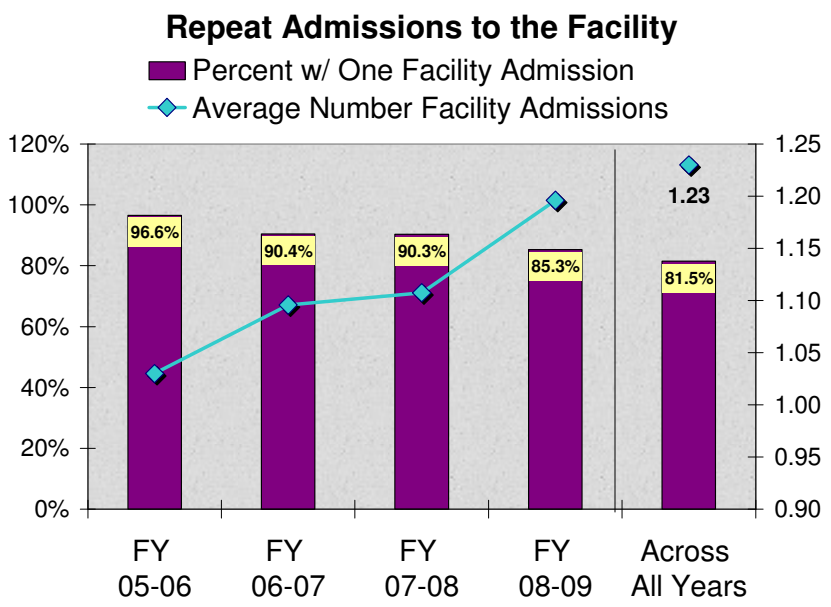
Utilization of the Adolescent Center



On average each year over the last four years, Star View provided 105 episodes of care to 94 unduplicated youth.

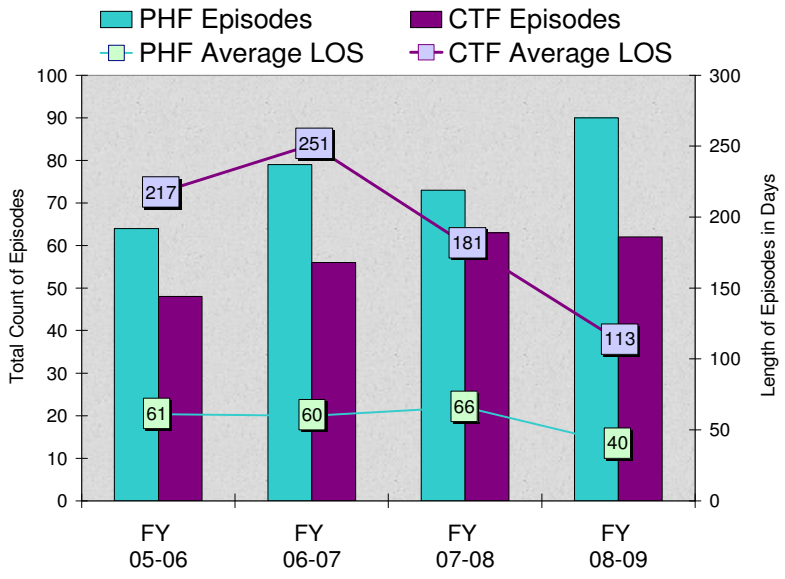
On average each year during this same period, there were 55 external admissions (arriving from outside the agency versus transfer from CTF to PHF) to Star View, and 56 discharges out the facility.

FY 08-09 figures are elevated over prior years: during this past year, there were 123 episodes of care, 102 unduplicated youth, 70 external admissions, and 72 discharges.



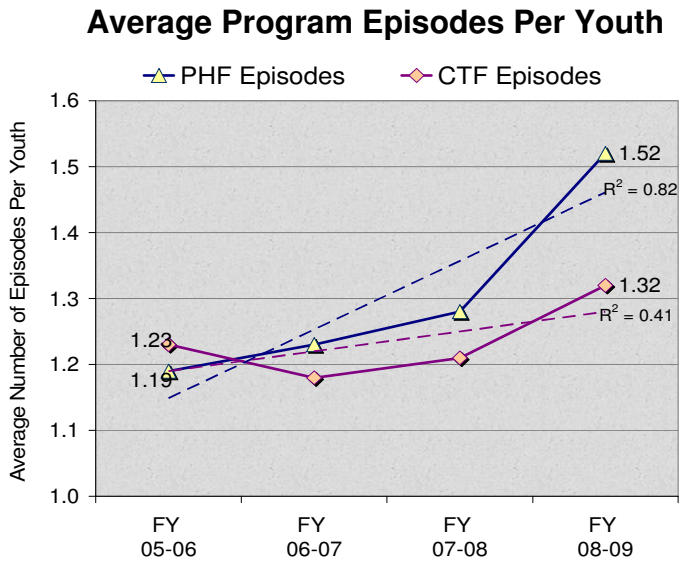
When assessed over multiple years, repeat admissions to the facility of the same youth from external locations occur among roughly 20% of the population.[13] For "Across All Years", *all* episodes of the youth were tallied, even those occurring prior to the years included in the graph. However, most of the repeat activity occurs within a year's time.

There has been a historical increase in external re-admissions within the year. This also speaks to the rising acuity and complexity of problems among the youth population at this level of care.[14]



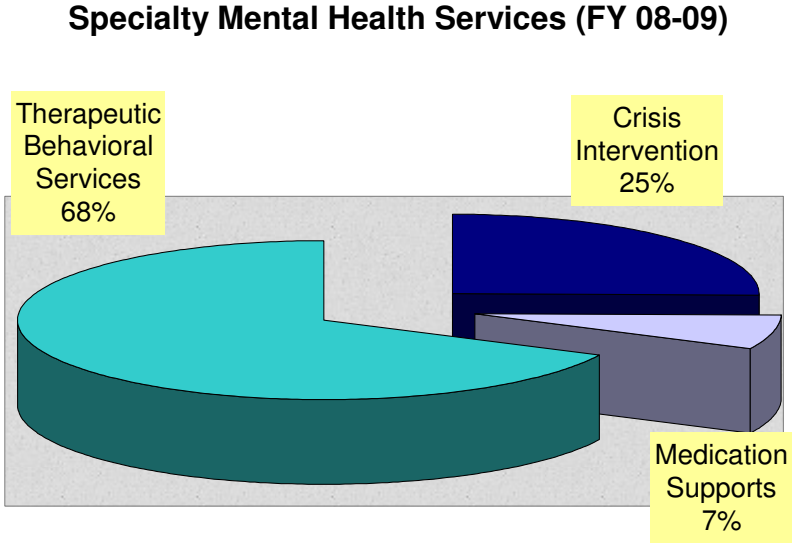
The overall volume of PHF episodes increased during FY 08-09 and there were corresponding declines in the average length of service episodes on the PHF and CTF. In the graph the bars are total episode counts and the numbers shown are the episode lengths in days: 113 days on average in the CTF and 40 days on average in PHF per youth per episode during FY 08-09.

Not graphed are the average daily censuses, which were 13 on PHF and 38 on the CTF this past year. This is near full capacity; the agency reserves one bed on each unit for urgent admissions.



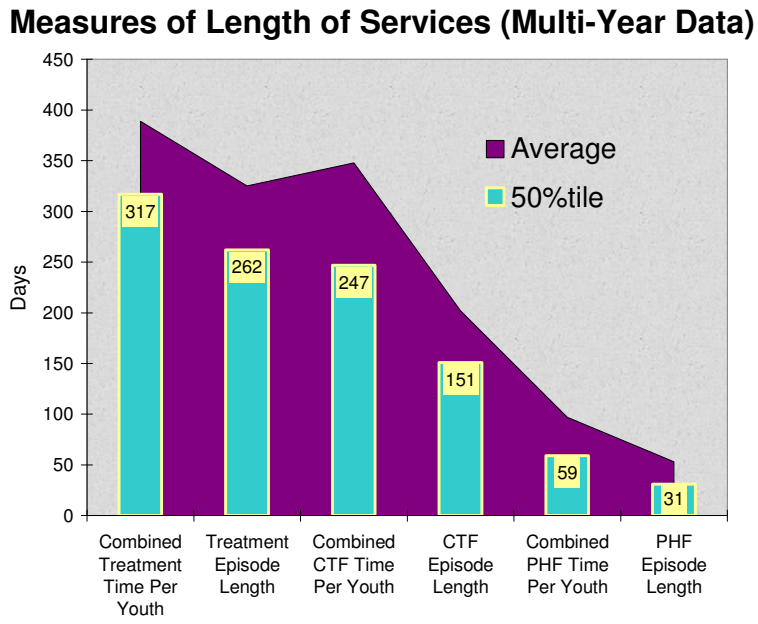
Across years, the average number of PHF episodes is 1.9 per youth and roughly 40% of youth have more than one PHF episode, including both external admissions (discussed prior) and internal transfers from the CTF.

The graph shows that the average number of PHF and CTF episodes per youth within a year's time has increased over the last four years. This again signifies a more disturbed clientele who have greater challenges achieving basic security, attachment, and progress in their trauma treatment.[15]



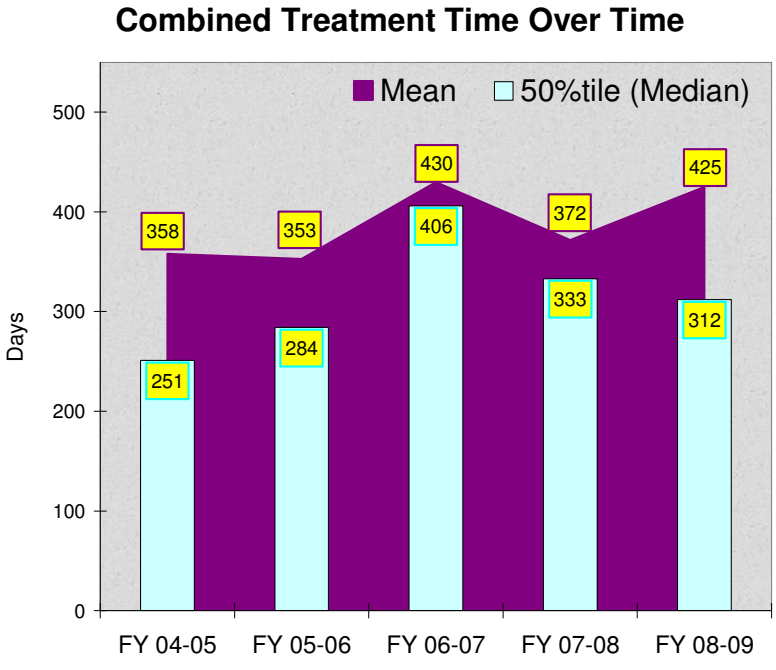
On average, while on the PHF, each youth participates in 28 hours of programming per week which includes comprehensive assessments, medical/nursing care, on-unit schooling, support around daily living habits, and rehabilitative therapies focused on life skills, creative arts and recreation. On the CTF, they participate in an average of 30 hours of day treatment per week which includes comprehensive care management, individual, family and group therapy, individual and group rehabilitative interventions, and support for milieu/daily living, along with NPS attendance. In addition, each youth might also require additional specialty mental health services of the types shown, which average 2.5 hours per youth per week.

There is considerable variation in the use of specialty services, which are planned for by the treatment team including the doctor, youth and family. The program promotes interdisciplinary approaches and makes much use of therapeutic behavioral coaching.



In a program that sometimes must coordinate internal transfers or external discharges to hospitals to safely manage acuity while sustaining therapeutic focus for the majority, there are different ways to address length of services.

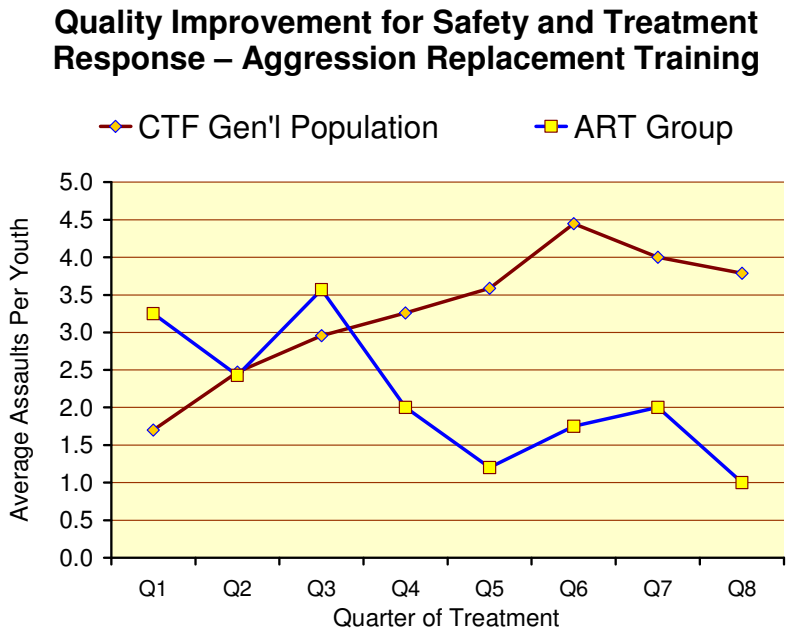
For example, the combined treatment time spans multiple facility admissions of a youth, and treatment episode length is the time at Star View across PHF and CTF episode(s). The fact that averages exceed the days by which 50% (median) are discharged reflects the impacts on service lengths of subsets of youth.[16]



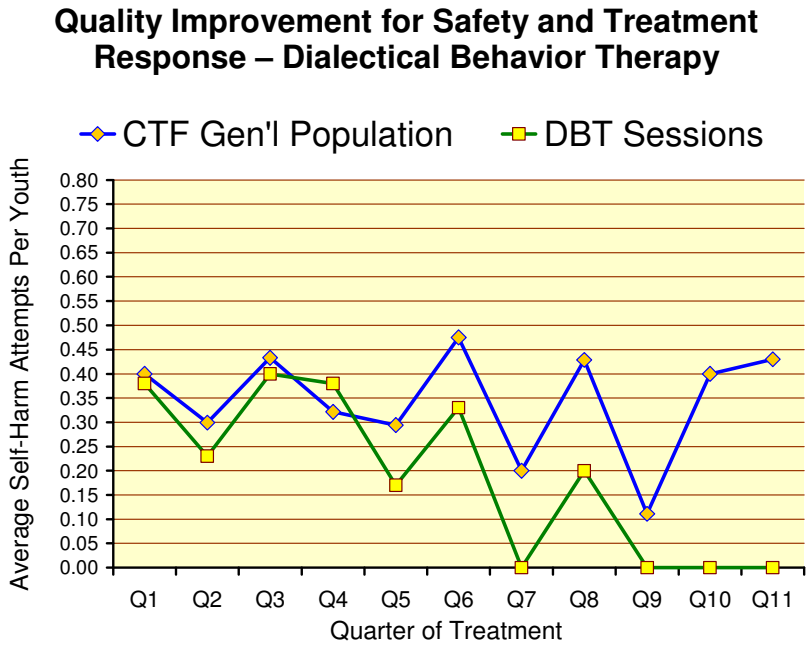
There has been some variation year to year in the combined treatment time as shown. When averages greatly exceed the median, it means there is a subset of youth with exceptionally complex diagnoses and difficult challenges moving through treatment, which has consistently been the case across years (except among discharges in FY 06-07 when most youth required longer overall treatment contact).[17]

It is also the case that there is a strong linear increase in variability (standard deviation) in combined treatment time (not shown), which would be consistent with increased individualization of case handling in the overall system of care and more individualized treatment within the Star View program.[18]

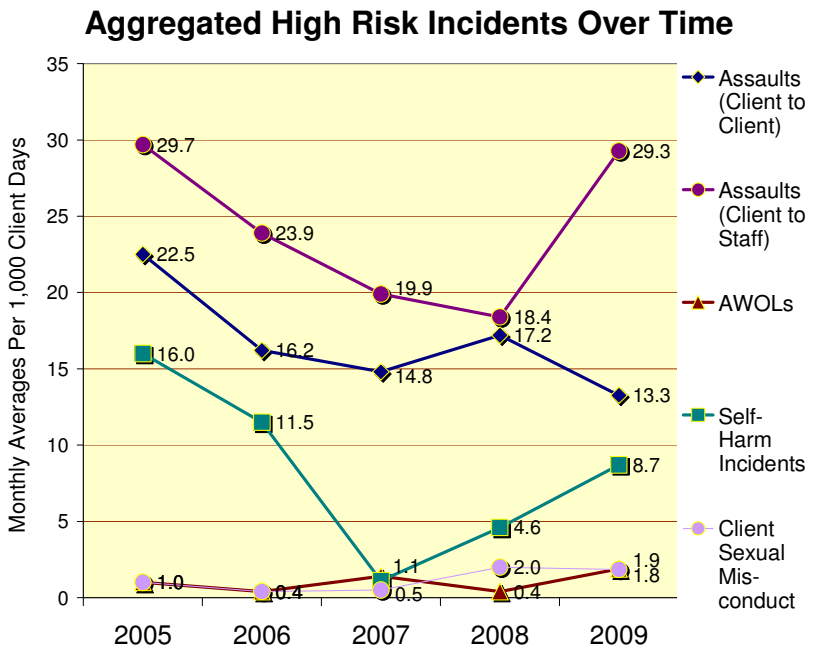
YOUTH & FAMILY OUTCOMES



Over the past four years, there have been major initiatives to implement evidentiary practices, such as *Aggression Replacement Training* (ART) for youth with angry and aggressive behavior. Studies were done on an early cohort of 7 youth participating in an ART group, compared to all Star View youth during the same time period, regarding assaults over time in treatment. The study group's assaults tapered off dramatically: there were *no* more assaults after the eighth quarter.[19] In contrast, aggression tended to increase and persist in the general population. ART is now a standard Star View curriculum for all youth.

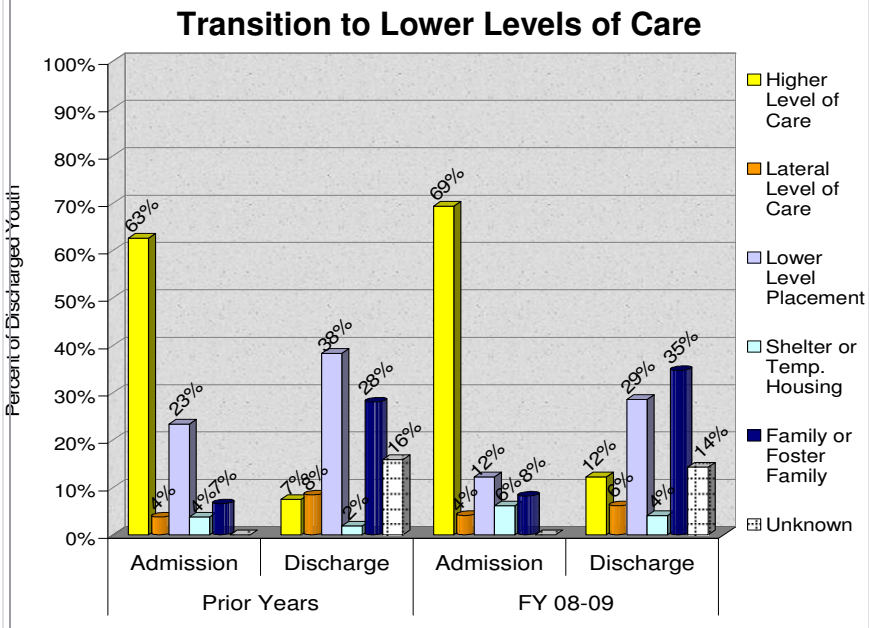


Similarly, positive results were generated from the implementation of *Dialectical Behavior Therapy* (DBT) for youth with emotion regulation issues that can result in self-harm. A study on 18 girls who were early participants revealed both the telltale erratic cycles of persons with this kind of treatment need and, importantly, the tapering down to zero self-harm attempts, in marked contrast to the overall population. A group version of DBT, called *Structured Psychotherapy for Adolescents Responding to Chronic Stress* (SPARCS) is now in the process of being implemented as a standard curriculum for all youth.



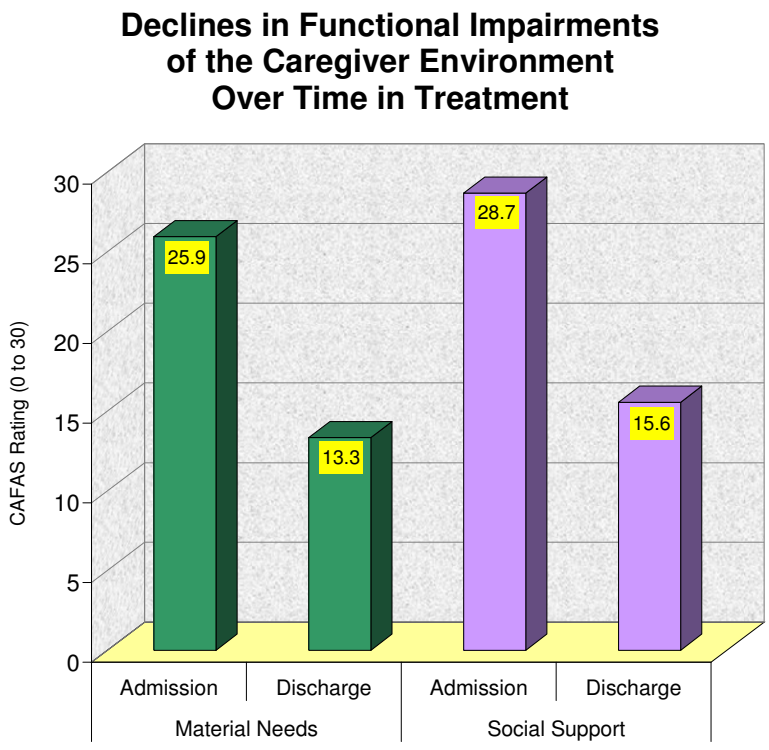
Over a multi-year period, and with the implementation of evidence-based practices and improved incident management, the CTF made strides at reducing aggregate levels of risk behaviors. As with most complex programs, there are fluctuations in performance with periods of lost positive momentum on some indicators.[20] For example, often, the youth that come to Star View harbor strong negative perceptions toward adults -- and also toward restrictive placement -- that get channeled onto staff. This makes the process of therapeutic alignment an ongoing challenge that requires continuously fresh attention to staff support and training.

Fortunately, the youth are not aggressing nearly as much toward each other, and the assaults toward staff are often of a mild or symbolic nature. Worker's compensation injuries are way down.



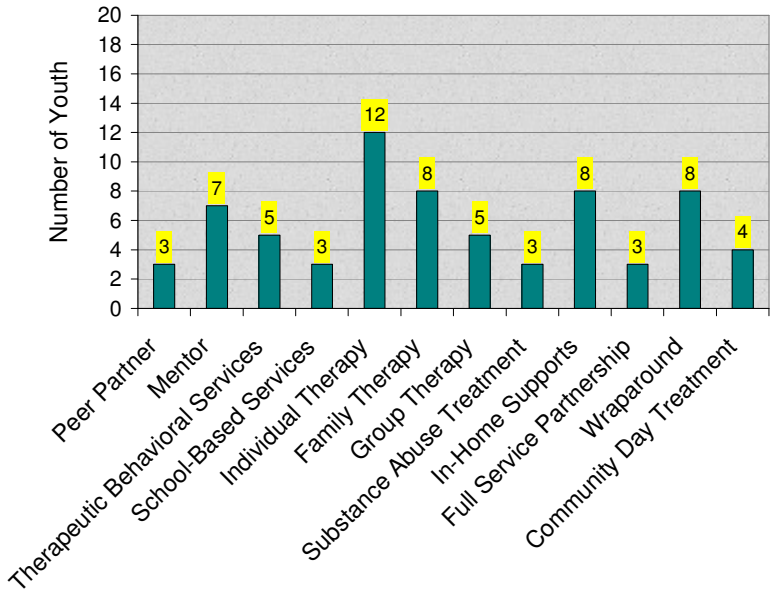
The discharge placements of youth exiting Star View from the CTF consistently involve strong shifts toward community-based care. During FY 08-09, a majority (63%) of those discharged went to lower level group homes, foster homes or family homes whereas 74% of admissions had arrived from higher or lateral settings. Each youth's permanency situation is uniquely worked out and this pattern of effecting lower level placements is a long standing marker of Star View's success.

In FY 08-09, there were 7 "unknown" CTF discharge destinations which included 3 AWOL and 4 *Against Medical Advice* (AMA) where the youth left with their child welfare case worker. Altogether this past year, there were 10 AMA discharges (others left to community placements or family).



Being able to return to a family home implies improvements in the family's -- or in the new compared to prior family's -- capacity to provide for the youth. Important improvements at being able to meet both the material and social support needs of Star View's youth are evident among those discharged to family or foster family homes (based on 18/20 such youth with available records). Advances in social support often occur through the family therapy that Star View's clinicians provide when there is family available to work with.

The graph shows average reductions in impairments, on the CAFAS family scales where 0=no impairment, 10=minimal, 20=moderate, and 30=severe. In aggregate, the destination family settings are between the moderate and minimal impairment range.



Initial available data[21] indicate youth leaving the CTF for community placements and family homes had 3.6 (range = 1 to 6) new community services and supports worked out through their Star View treatment team that include the types shown. Staffs connect youth and their families to many different community programs, including but not limited to Star View's outpatient services continuum.

Improved School Attendance and Grades

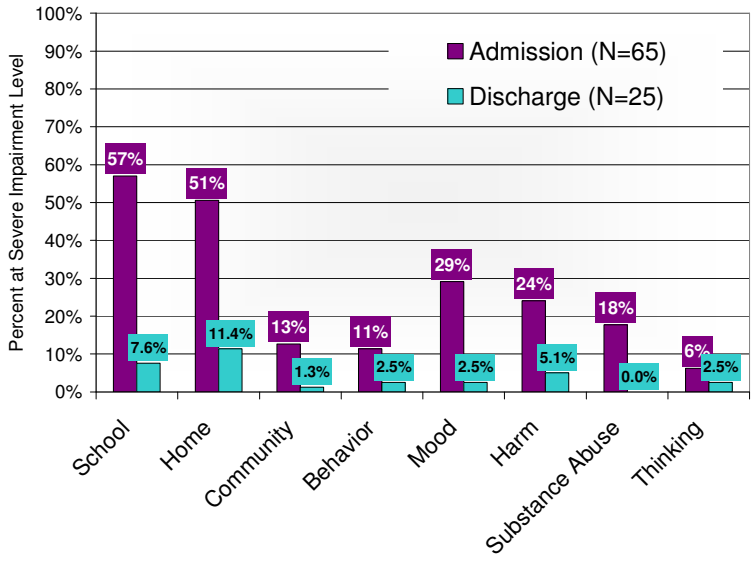
	Admission	Discharge
Average Attendance (days/week)	3.4	3.7
Percent w/ Regular Attendance (4-5 days/week)	57%	67%
Average GPA	2.4	2.6
Percent w/ 3.0 ("B Average") or Better GPA	26%	48%

Schooling gains show up in attendance and grades. Importantly, the modest change in aggregate grade point average (GPA) masks a marked increase from 26% to 48% of students achieving 3.0 ("B") or better grades by discharge[22] – kudos to these youth and to three students who achieved all requirements for high school graduation in 2009!

SBHG and Star View are very proud that the South Bay High School achieved *Western Association of Schools and Colleges* (WASC) accreditation making the full complement of quality schooling standards and a regular high school curriculum available to adolescents with serious mental illnesses.

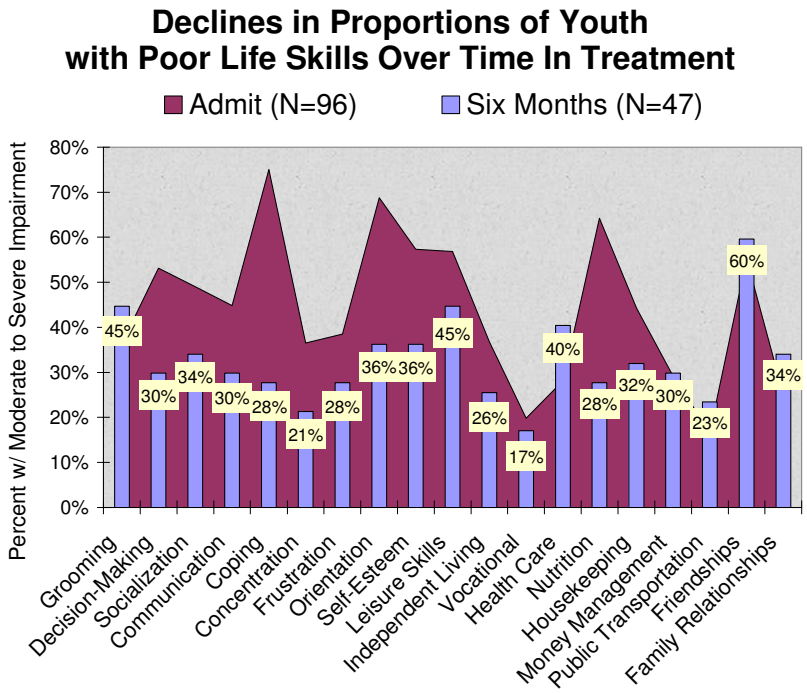
Star View also recently opened an adjacent community day school for local community youth with behavioral problems who need a non-public school placement.

Declines in Proportion of Youth with Severe Levels of Impairment Over Time in Treatment



As measured by the CAFAS, in aggregate, there are marked gains in functioning in multiple domains with greatly reduced proportions of youth at the "severe" (rating = 30) levels of impairment by discharge. Per CAFAS guidelines, roughly 20% of youth will continue to need intensive treatment after leaving Star View, whereas upon admission at least 75% met this CAFAS criterion.[23]

Further analyses of matched pairs (youth with both admission and discharge ratings) indicate statistically significant reductions in impairments occurred regarding school, community, moods, and self-harm, with all other areas trending in the desired direction.



Rehabilitation staff apply the *Independent Living Skills Scale* (ILSS)[24] which addresses life skills in 19 areas (scale from 0=severe dysfunction to 4=age appropriate). These data are tracked over the first year of treatment, and most gains (reduced dysfunction) are seen in the first six months -- except regarding health care, friendships and family which require more time and work. "Health care" involves youth's capacity to seek out assistance regarding health matters and the youth need much coaching to do so in a timely manner.

Strong gains are in the skill sets that are more under youths' control and a focus of rehabilitation groups and therapy – e.g., decision-making, coping, self-esteem, and communication. In a residential milieu, youth also learn about nutrition, housekeeping, and healthy leisure activities.

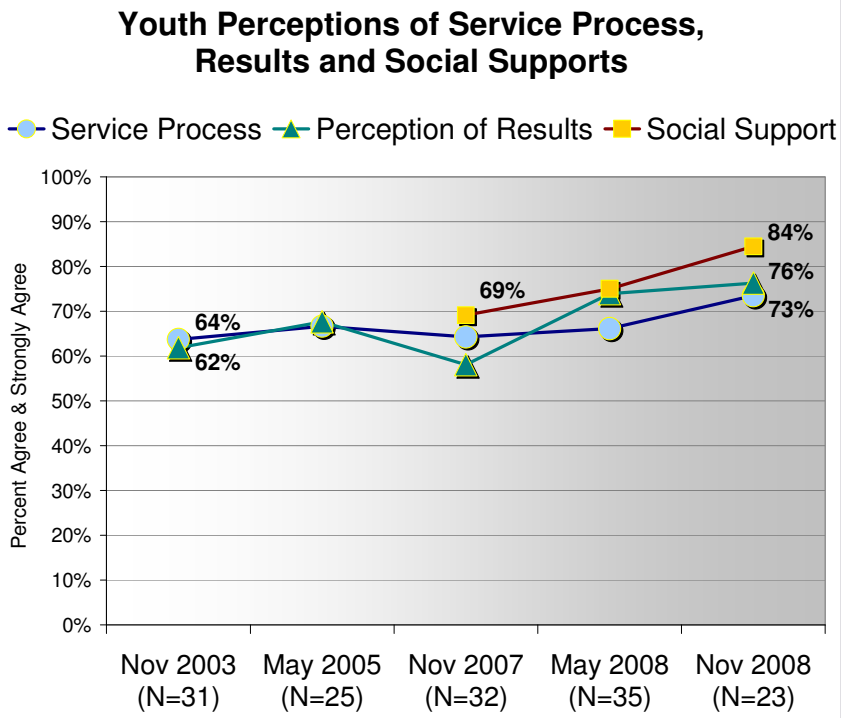
Features of the Workability Program*:*

- On-site workability workshops
- Educational field trips
- Industry tours
- Classes on vocational planning

Workshops Address:

- Letter writing
- Completing applications
- Mock interviews
- Understanding employers' expectations
- Learning how to budget, use a bank, and save

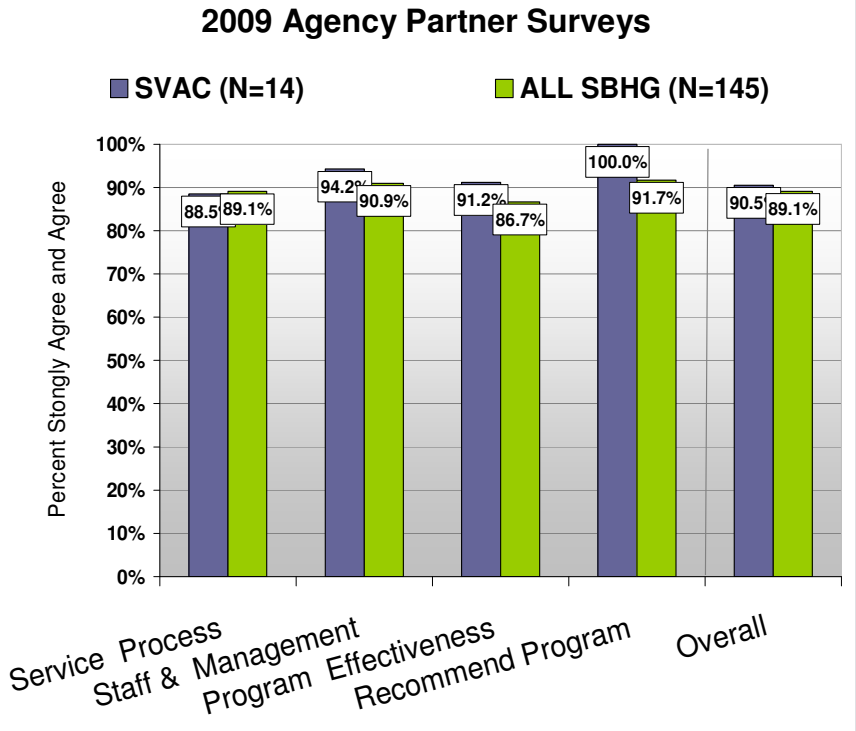
All clients are involved in workability in one or more of the ways shown. Thirty six students were placed in paid employment this past year and roughly 25% had workability activities within the facility at the time of discharge. For these and other youth, arranging vocational engagements is an additional discharge support that staff provides.



Star View voluntarily participates in state-wide surveying of client satisfaction[25] and continuously applies the findings to quality improvements. The program has worked to enhance services with trauma-informed care, evidentiary practices, schooling and community supports. As a result, youth perceptions regarding these features of the program have improved over time.[26]

Examples of youth comments reveal what they find most helpful:

- *"Treatment! Getting therapy I need."*
- *"Help so I don't fight so much; staff talk with me when I am mad and I know I can always talk with them."*
- *"The rehab, outings, and school programs! Teachers help me a lot."*



Agency partners surveyed about Star View included 14 administrators, direct service personnel and teachers from county departments or other provider agencies and community organizations. Star View received much positive feedback and some suggestions, and did very well relative to other SBHG organizations. Each area includes multiple specific questions. Topics related to the attractiveness of the (older) facility (item in service process) and staff communications with agency partners (item in staff and management) were highlighted for quality improvement.

Importantly, there were 15% more agency partners responding positively about the program since the last round of surveys (conducted late 2007) with gains made in all topical areas.

CONCLUSIONS

There is a finite set of options for safely holding onto and transforming the lives of youth with extremely disordered thinking, moods, and behaviors. Wraparound and other intensive community-based intervention programs can and do work for many youth and these are best used whenever possible. However, unfortunately, there are periods of time in some youths' lives when their difficulties are unusually complex, their life experiences include profound trauma that is overwhelming, their behaviors are extreme and dangerous, and their individual options are very limited. During these periods a safe and secure treatment setting is vitally important to preserve and protect life, heal trauma, and provide a platform for psychiatric symptom reduction, behavioral coaching, and life skills development.

Historically, hospitals, state hospitals, and secure residential treatment attempted to fill this specific niche; juvenile detention has also been used as an unfortunate last resort for youthful offenders with mental illnesses. But, the problem with hospitals is that they are ill equipped to provide needed longer term treatment; the problem with state hospitals was that they were highly institutional settings not focused on transitioning youth back to their home and community; and, the problem with detention is that it is inappropriate for effective treatment of youth with mental and emotional problems. The remaining option is secure residential treatment, of which the CTF is a well-reasoned model that combines security, therapy, education, rehabilitation, family and community reconnection, and thoughtful discharge planning. Star View's PHF brings the added benefit of offering nursing and psychiatric management on site during the most acute periods of youth's symptoms.

Our partnership with the counties we serve is optimally focused on the shared mission of helping California's youth with the highest levels of mental health treatment need to succeed. Star View has always participated in important and transformational changes in the broader systems of care that help youth succeed -- such as the application of evidence-based practices -- and will continue to do so. The agency currently faces a number of challenges in pursuit of its mission and seeks strong partnerships and collaboration on behalf of youth and families. These challenges include: embracing more acutely disturbed youth arriving from more counties; fine-tuning the optimal mix of practices and supports that help youth overcome complex developmental trauma; enhancing the difficult milieu work of staff while minimizing staffs' secondary (vicarious) trauma; bringing greater clinical oversight to the maintenance of fidelity practices; and, coping with the ever increasing volume of regulatory reviews. Star View is well positioned to address these challenges through capable administrative and clinical leadership focused on continuous quality improvements that derive from open, creative and supportive solution-building. We greatly value the commitment, collaboration and feedback of the broader human services community in this ongoing process of review and renewal.

Technical Notes

[1] To make this report easier to read, the name "Star View" will be used throughout. However, there are actually three separate legal entities: 1) *Star View Adolescent Center* refers to mental health treatment services provided in the form of a Psychiatric Health Facility, Intensive Day Treatment, Therapeutic Behavioral Services, and other Medi-cal funded EPSDT services; 2) *Star View Community Treatment Facility* refers to the licensed residential program (room and board) funded through foster care; and, 3) *South Bay High School* is a non-public school certified by the State Department of Education, with educational as well as mental health (AB 3632) funding of some clients. *Star View Community Services* (not covered in this report) is a separate outpatient continuum of services that is also an SBHG affiliated organization and operates in parts of the greater Los Angeles area. Sometimes, youth from the adolescent center receive follow-up care through *Star View Community Services*, including in the TEAMMATES wraparound program, System of Care, or Full Service Partnership programs. Other times, youth discharged from the facility are connected to other providers in their area.

[2] For more information about the program model please see the agency Program Statement and related documents titled "Program for Safe Management and Healing of Complex Psychological Trauma" and "Star View Adolescent Center Trauma-Informed Program Model".

[3] Youth with externalizing problems benefit from *Aggression Replacement Training* (ART) with EQUIP groups which focus on building a strong positive peer culture and teaches youth a wide range of specific skills in the areas described. ART/EQUIP continues as a regular offering of the DTI program. Implementation requires staff training and certification, ongoing supervision to model fidelity, and tracking outcomes of the groups using standardized tools. For more information please see: Goldstein, AP, Glick, B., and Gibbs, C, (1998) *Aggression Replacement Training—Revised Edition: A Comprehensive Intervention for Aggressive Youth*; and, Gibbs, J.C., Granville Bud Potter, G.B., and Arnold Goldstein, A. (1995). *The EQUIP Program: Teaching Youth to Think and Act Responsibly through a Peer-Helping Approach*, both at www.researchpress.com.

[4] *Dialectical Behavioral Therapy*[4] (DBT) involves once weekly individual psychotherapy along with other interventions appropriate for clients who have long-standing problems with intense emotions (e.g., anger, shame, guilt, anxiety, sadness) that they have trouble modulating (their emotional arousal is rapid, peaks at a high level, and takes more time to return to baseline than for most people). DBT has been shown to be effective with clients who engage in self-harmful and life-threatening behaviors, reducing such behavior, associated crisis and psychiatric hospitalization, and premature drop-out from treatment. The focus of DBT is to actively teach skills within the context of the therapeutic relationship that will help the client manage otherwise disorganizing emotions. Linehan, M (1993) *Cognitive Behavioral Treatment of Borderline Personality Disorder* and *Skills Training Manual for Treating Borderline Personality Disorder.* New York: Guilford Press. Also: http://faculty.washington.edu/linehan; and, Allmon, D., Armstrong H.L. Heard, M.M., Linehan, and A. Suarez (1991). *Cognitive-Behavioral Treatment of Chronically Parasuicidal Borderline Patients.* Archives of General Psychiatry, volume 48, pages 1060-1064.

[5] *Structured Psychotherapy for Adolescents Responding to Chronic Stress* (SPARCS) is a group therapy practice based on DBT principles that offers positive skill-building for traumatized youth whom need assistance regarding: 1) regulating emotions and impulsive behavior; 2) successfully negotiating and developing trusting relationships; 3) seeing a purpose and future in life; 4) reintegration of dissociated cognitive, emotional, and physical experiences; 5) chronic physical complaints; and, 6) negative self-perception. DeRosa, R. & Pelcovitz, D. (2005) Treating traumatized adolescent mothers: A structured approach. In N. Boyd-Webb (Ed.), *Working with traumatized youth in child welfare*. NY: Guilford Press, pp. 219-245; Cook, A. et al. (2005) Complex trauma in children and adolescents. *Psychiatric Annals, 35(5),* 390-398; and, DeRosa, R. & Labruna, V. (2009) *Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)* California Evidence-Based Clearinghouse for Child Welfare (CEBC): http://www.cachildwelfareclearinghouse.org.

[6] These data are admissions during the FY using the last admission of those with repeat episodes within the FY and not including internal transfers from the CTF. There was missing data (not shown) on two admissions. This is a different snapshot than what is shown in the outcomes section, which tracks the admission to discharge settings of *discharged* youth during the year, from the time of their facility arrival even if such occurred prior to FY 08-90.

[7] This statistic reflects on the high level of disorder in the youth and the medical-legal complexities staff manage to ensure compliance with LPS regulations.

[8] Hodges, K & Wong, M.M. (1996). *Psychometric characteristics of a multidimensional measure to assess impairment: The Child and Adolescent Functional Assessment Scale.* Journal of Child and Family Studies, *5*, 445-467.

[9] Shaffer, D., Gould, M.S., Brasic, J. Ambrosini, P., Fisher, P., Bird, H. & S Aluwahlia (1983). *A children's global assessment scale (CGAS).* Archives of General Psychiatry, *40*, No.11, 1228-1231.

[10] Lyons, J.S. (June, 2006). *Analyses of Children and Adolescents Placed in Group Home, RCL-14, CTF and Metropolitan State Hospital through Los Angeles County Mental Health, Child Welfare, and Juvenile Justice.* Northwestern University Measurements were based on *Child and Adolescent Needs & Strengths* (CANS), mental health version.

[11] Compared to prior years, the FY 08-09 cohort presented very similarly with a few exceptions. There were declines in the proportion of youth with externalizing disorders (30% prior to 24%), especially in combination with internalizing conditions; in those with substance abuse (38% to 33%); and, in the proportion of youth with more than one Axis I diagnoses excluding substance abuse (49% to 43%).

[12] The most common health problems are asthma, overweight/obesity, hypothyroidism, and enuresis/encopresis. About 5% have borderline intellectual functioning.

[13] Among many factors tested, some associate to repeat admissions. These include high acuity resulting in transfer to another hospital and complex diagnoses (e.g., spanning two or more clinical pathways). Males and those leaving to family homes tend to be less likely to return.

Factors Related to Re-Admission	Average # Admits	Statistical Significance
OVERALL AVERAGE	1.23	--
Initial Discharge to RCL 12+ Group Homes	1.30	p<.000
Complex Diagnostic Combinations	1.60	p<.008
Three or More Axis I Diagnoses	1.67	p<.000
Initial Discharge to Area Hospitals	2.36	p<.000

[14] Across years, the majority (85%) of PHF discharges are to the CTF. Of the 15% externally discharged from the PHF, most go to local area hospitals. Some leave to unknown destinations, most often per court order with their child welfare case worker on *Against Medical Advice* (AMA) status; some of these end up requiring re-admission to the facility, particularly if any of the re-admission factors describe above are characteristics of the case. AWOL from the PHF occurs very rarely (once in the four years addressed in this report).

[15] This pattern, along with the rise in repeat external admissions, might also reflect system of care pressures to reduce lengths of stay (note such lengths are declining), thereby discouraging the full duration of services some youth require, resulting in re-admissions.

[16] The 50%tile (median) lengths on the PHF are similar to those reported prior (e.g., agency report of 2005), but have increased on the CTF even as the average lengths of discrete CTF episodes have declined. There is a subset of kids whom leave the CTF for the PHF or external hospitalizations and return to the agency, driving down discrete CTF episode lengths and driving up total treatment time.

[17] Some factors associate to more combined days of treatment at Star View. These include discharges to group homes of any level (meaning permanency is harder to achieve and/or discharge arrangements take longer) or to hospitals, as well as complex diagnoses (e.g., spanning two or more clinical pathways). Males and those leaving to juvenile detention or on AWOL/AMA status tend to have fewer total days, generally.

Factors Related to Length of Stay	Average Combined Days	Statistical Significance
OVERALL AVERAGE	389	--
Two or More Axis I Diagnoses	458	p<.006
Ultimate Discharge to Group Homes	469	p<.053
Discharges to Area Hospitals	478	p<.053
Complex Diagnostic Combinations	481	p<.004

[18] The standard deviations related to combined days of treatment increased from 157 in FY 04-05 to 395 as of FY 08-09, linear trend $R^2 = 0.82$.

[19] This study and the DBT study to follow were presented at the *American Association of Children's Residential Centers* (AACRC) conference (San Diego, October 29 to November 1, 2008). Zucker, P.Z., McCauley, M.A., Munde, M. & Dresser, K.D. *Creating Clinical Focus and Implementing Evidence-Based Practices in Residentially-Based Services for Youth.* For more information contact Stars Behavioral Health Group: 510-635-9705 ext. 207.

[20] Star View tracks many indicators of operational and quality performance that are available for review and discussion by the entire team and agency partners during quarterly CQI Councils. For other examples, since 2005 uses of physical restraints to manage risk behaviors that threaten client and/or staff safety are down on the CTF and PHF; and the length of time youth spend in involuntary seclusion has been reduced by almost half in both programs. The agency has increased its overall clinical capacity and made solid inroads to shifting the milieu culture from pre-SB 130 "hands-on" to managing high risk behaviors

through positive behavioral support and trauma treatment. There are many current challenges commanding leadership attention and the lost ground regarding client to staff assaults and self-harm are highest among all priorities.

[21] The data element was newly introduced this year, and there are data collected so far on 21/58 (36%) CTF discharges.

[22] Schooling outcomes tend to be bifurcated with a small subset that are very behind and remain at very low performance levels and drive down average change scores – also note that schooling progress can be greatly inhibited by the very nature of psychiatric disorder and medication needs. On the other hand, a larger proportion of youth are making good progress. Many of Star View's youth are quite bright and re-engage well with schooling once they are psychiatrically stable.

[23] The CAFAS findings are quite consistent with clinician's experience-based ratings of whether specific individualized treatment goals of each youth were met by discharge. Clinicians indicate roughly 80% made solid treatment gains (some or most goals achieved).

[24] The ILSS was designed by Dr. Zucker and has been in use in SBHG agencies for ten years.

[25] The surveys are not required by the state Department of Mental Health for hospital and residential programs. Star View participates nonetheless because the Administrator greatly values hearing from the youth and DCFS endorses use of the surveys.

[26] The domain "social support" includes questions newly introduced by the state in November 2007. There was an insufficient sample available from Star View in May 2009 so those data points are not shown. The November 2009 surveying was cancelled statewide by the State Department of Mental Health.