Implementation of Age-Specific Services for Transition-Age Youths in California

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Objectives: This study examined the implementation of age-specific services for transition-age youths in California under the Mental Health Services Act (MHSA).

Methods: This study employed a sequential, exploratory mixed-methods design. Qualitative interviews with 39 mental health service area administrators in California were analyzed to develop an understanding of how the MHSA has facilitated the development of youth-specific programs or services. A quantitative survey of 180 youth-focused programs was also used to describe the range of services that were implemented, the use of evidence-based and promising practices, and the role of youths in the design, planning, delivery, and evaluation of services.

Results: Administrators described the MHSA as providing a programmatic focus and financial support for youth-specific services, outlining a stakeholder process to create buy-in and develop a vision for services, and emphasizing the role of youths in service delivery and planning. Youth-specific programs implemented a diverse array of services, including general medical care; employment and education support; housing placement and support; and family, mentoring, and social support. Programs described implementing evidence-based and promising practices and involving youths in service planning, implementation, or quality improvement activities.

Conclusions: The MHSA has had a substantial impact on the landscape of youth-specific services in California by expanding both the number of programs and the diversity in types of services and by promoting the engagement of youths in the planning and delivery of services. Additional efforts are necessary to determine the extent to which youth-specific services yield greater improvements in youths' outcomes compared with services designed for adults.

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Young adulthood is a critical developmental period, during which decisions made in areas such as education, employment, and parenting have lasting effects on lifetime trajectories (1). Economic restructuring, including increased costs of college and a decline in well-compensated entry-level employment, has increased the demands on youths and has changed and extended their pathways to independence (1). Successful transitions to adulthood are less likely among youths with serious mental illness, who, compared with their peers without mental illness, have lower rates of education and employment and higher rates of poverty, unplanned pregnancy, substance use disorders, homelessness, and criminal justice involvement (1–6). The challenges inherent in the transition to adulthood are often more difficult among foster care youths because of their emancipation, lack of natural mentors, justice system involvement, and needs for mental health services related to life transitions that are not adequately met by a mental health service system that is bifurcated for adults and children (1,7–9). Concerns about the mental health system's ability to engage and retain youths in treatment have prompted calls for services that are age specific and developmentally appropriate (1,10,11).

On November 2, 2004, California voters approved Proposition 63, which was signed into law as the Mental Health Services Act (MHSA). The MHSA applies a tax of 1% on incomes over $1 million to fund public mental health services (12). The MHSA provides new funding streams for specific types of services, such as full-service partnerships, and for priority populations identified as being underserved by the public mental health system (13). Transition-age youths are designated as a priority population under the MHSA, and public mental health agencies have used the opportunity to develop services tailored to this population (14,15).

Consistent with prior efforts focused on reforming the delivery of mental health care in California, the MHSA provides broad policy guidance but relied on local mental health agencies to design and implement new programs (16). As a result, we lack a clear understanding of how the MHSA has facilitated the development of youth-specific services, as well as the scale and scope of programs that have been

implemented for youths. Funding provided under the MHSA can be used only to expand mental health services and not to supplant existing state or county funds used to provide mental health services (17). This study aimed to identify specific policies and processes by which the MSHA has facilitated the development of youth-specific services and to describe the range of services that have been implemented for transition-age youth in California under the MHSA. This study also examined the use of evidence-based or promising practices and the role of youths in the design, planning, delivery, and evaluation of services (18).

METHODS

Study Design and Sample

This 2014 study employed a sequential, exploratory mixed-methods design (19). Qualitative, semistructured interviews with administrators in California's mental health service areas were used to assess how the MHSA has facilitated the development of youth-specific programs. Administrators were individuals who were involved in the development and oversight of programs for transition-age youths. A quantitative survey administered to youth service providers was used to describe the range of services that were implemented for transition-age youths (20). Providers were either program managers or agency or center directors. The qualitative and quantitative data were connected to provide complementarity, whereby the overarching policy processes of the MHSA as described by the interview respondents was compared with the actual services provided by youth-specific mental health programs in California.

California has 59 independent public mental health service areas: 57 areas are individual counties, two are separate city-based areas within counties, and one is a combination of two counties. Queries to mental health administrators and a review of MHSA service planning documents showed that 48 service areas had implemented youth-specific programs, including stand-alone youth-specific programs and youth-specific services embedded within larger non–youth-specific programs. Administrators were invited to participate in a semistructured phone interview and also asked for contact information for directors of programs providing youth-specific services who could respond to an online survey. Interviews were conducted with administrators in 39 service areas (81% response rate), and 180 out of 298 programs completed the program survey (60% response rate). [A table presenting detailed response rates by county is included in an online supplement to this article.]

Evaluation Advisory Group

This study was informed by an advisory group of three mental health administrators with expertise in implementing youth-specific programs, three youth-specific program directors, two program evaluators with context expertise, and two youths with both lived experience and expertise in program evaluation. Community involvement by key stakeholders was considered critical to ensure that the instruments developed for collecting data and the analyses conducted were responsive to the needs of administrators, program directors, and clients. The advisory group provided input on the research design, interview guide, survey questions, and interpretation of findings. The University of California, San Diego, Human Subjects Research Protections Program approved this study.

Data Collection and Analysis

Interviews were conducted with administrators representing 39 mental health service areas to discuss their perception of the role of the MHSA in the provision of services for transition-age youths. The interviews were conducted via telephone or in person in a setting of their choice (for example, in their office). Interviews were audio recorded and transcribed verbatim. Transcripts were read and organized using Dedoose qualitative analysis online software. Directed and conventional content analysis techniques were used to assign codes on the basis of a priori themes derived from the interview guide and on emergent themes raised by respondents (21). The qualitative analyses focused on responses related to the overarching a priori theme of MHSA's facilitation of the development of youth-specific services The transcripts were independently coded by two authors (SPH and SH) with expertise in medical anthropology and public health, under the supervision of the principal investigators (VDO and TPG). Disagreements in assignment or description of codes were resolved by team discussion. Segments of narrative were coded for descriptive content domains that emerged from the responses and then analyzed by using matrix analysis (22). The matrices were constructed for each descriptive content domain by creating a table to display the mental health service areas in the first column and the emergent themes in the column headings. Coded interview data were displayed by theme in individual vertical cells matching each of the service areas represented in the first column. This process allowed team members to view the body of data holistically, noting systematic similarities as well as trends or differences in the constructs of information across the interviews.

Youth-specific programs were requested to respond to an online self-administered survey. The survey collected quantitative data on program characteristics, the types of services provided for transition-age youths, the use of evidence-based practices, and the involvement of youths in service planning and governance. Lists of services were developed on the basis of a review of MHSA service planning documents, the authors' knowledge of general and youth-specific mental health services, and input from the evaluation advisory group. This list of evidence-based and promising practices for youths was also informed by a review of the literature and various data repositories of evidence-based treatments.

Answers to the survey were multiple choice and included a residual "other" category in which respondents could enter additional textual information. Categories were added when a sufficient number of programs had the same "other" response. Programs were asked to identify any important remaining gaps in services for youths. This question requested

TABLE 1. Themes and illustrative quotes from interviews in 2014 with administrators representing 39 mental health service areas about the role of the Mental Health Services Act (MHSA) in facilitating development of youth-specific services

Theme	Illustrative quotes
MHSA provided the programmatic focus and funding stream for youth-specific services	"I think the MHSA has provided us a very unique opportunity to be able to develop an array of services, from prevention to intervention, in areas where prior to the MHSA we did not have the funding or the really organized stakeholder process to move forward." "Virtually all of our services are funded under the MHSA. Our system of care we've developed from MHSA. And we did our best to create a continuum of care for transition-age youths struggling with a severe mental illness or being identified as having first symptoms of a serious mental illness. It's really allowed us to expand. We've moved from one program to now having 15, specifically for the transition-age youths." "Without MHSA our programs would not be in existence. The way that the MHSA laid out the priority populations by age and grouping them, I think, certainly helped facilitate that process."
Outlining a stakeholder process to create buy-in and develop a vision for youth-specific services	"[The process] has really initiated or "refired" the community to speak to the need of programming for our transition-age youths." "[We] utilized the stakeholder process to identify transition-age youths as an uninsured and underserved population. And we really developed a very, very rich vision for a continuum of age-specific programming." "I think [the process] has led people to recognize that transition-age youths are a population with unique needs and interests. . . . It's really revolutionized our whole way of conceptualizing the continuum of services, from childhood to adulthood."
Engaging youths in the delivery and development of services	"We use [peer] mentors for outreach and engagement on all levels of programming." "We hired the very first two peer and family advocates, and we started listening to them, and everyone was exposed to them throughout the system. It sort of opened people's ears up." "We involve transition-age youths in the planning, implementation, and evaluation of programs. It's sort of changed our culture to some degree on how we do things." "We have been trying to create credible images of what a transition-age youth is, and so it's really about how do we use youths in our system to make a difference? And so we use youths where we believe that youth voices are important, and we want to have a place for them to be able to use their voice. We invite them to our cultural competency committee. We have youths on our mental health advisory board. We also use them like we're doing for our bullying campaign—we're using them as facilitators. But the reason is because they thrive when they can use their voice and their voice is heard. We need to keep our services relevant and up to date and we use the youth voice to do that."

a text response, and answers were coded according to the service categories provided earlier in the survey. The survey was administered using Qualtrics online software. Weekly reminders were sent to program directors who had not initiated or completed their surveys. The survey data were reviewed and cleaned as responses were received, and clarifying queries were made to the respondents as necessary.

Descriptive analyses were used to characterize the scale and scope of youth-specific services and level of youth involvement in various activities. Regression analyses were used to compare services across counties by level of urbanization. Counties were placed into one of three categories on the basis of the size of their metropolitan statistical areas (MSAs) by using the 2013 National Center for Health Statistics urban-rural classification scheme (23): large central metro or large fringe metro (counties in MSAs of one million or more), medium or small metro (counties in MSAs of less than one million), or micropolitan or noncore (nonmetropolitan areas). A series of negative binomial regression models estimated the relationship between urbanization and the number of youth-specific services at the program level, controlling for funding type.

RESULTS

MHSA's Role in Facilitating Development of Age-Specific Services

Table 1 presents three emergent themes and illustrative quotes. The overarching a priori theme was the role of the MHSA in facilitating the development of youth-specific services. The first emergent theme was the MHSA's role in providing both a programmatic focus and a funding stream for youth-specific services. Most administrators described the MHSA as the sole reason for the existence of youth-specific services. Two administrators reported having small existing programs funded by federal grants. Many administrators described developing an array of programs or a youth-focused system of care. Common elements of the MHSA-funded system of care included permanent supportive housing and transitional housing, early intervention programs, youth-specific outpatient programs, drop-in counseling centers, employment support, life skills and vocational training, and community-embedded outreach services based in local high schools. Administrators credited the MHSA as spreading awareness of the need for age-specific services and promoting broader buy-in.

A second emergent theme considered the role of the stakeholder process outlined by the MHSA to support the identification and implementation of youth-specific services. The stakeholder process helped to create buy-in and to develop a vision for youth-specific services. A third emergent theme focused on the MHSA's role in emphasizing the role of youths in the delivery and development of youth-specific services. Youths were engaged as peer mentors, facilitators, and advisors to improve the effectiveness and relevance of services. Several county programs engaged youths in outreach

TABLE 2. Characteristics of 180 programs providing youth-specific services in California in 2014

Characteristic	N	%
Mental Health Services Act (MHSA) funding streams employed to support services	164	91
Full-service partnerships (FSPs): supportive housing programs that "do whatever it takes" to improve residential stability and engage clients in services	67	37
Community services and supports: non-FSP, community-based behavioral health services	44	24
Prevention and early intervention: services designed to provide early intervention or to engage clients before development of serious mental illness or emotional disturbance	89	49
Other MHSA funding	38	21
Non-MHSA funding	72	40
Early and Periodic Screening, Diagnosis, and Treatment: Medicaid-funded behavioral health services	60	33
Other	12	7
Annual caseload		
1–49	43	24
50–99	47	26
100–249	46	25
250–4,500	44	25
Age of clients (M±SD)		
Minimum	16±2	
Maximum	24±2	
Programs targeting specific priority populations		
Diagnosis		
Transition-age youths		
With serious mental illness	126	70
With co-occurring mental and substance use disorders	126	70
Residential setting of transition-age youths		
Homeless or at risk of becoming homeless	118	66
Aging out of the foster care system	106	59
Exiting the juvenile or criminal justice system	100	56
In institutional or residential care	61	34
Race-ethnicity of transition-age youths		
Latino	92	51
African American/black	79	44
Asian American	61	34
Native American/Alaska Native	57	32
Pacific Islander	50	28
Native Hawaiian	42	23
Other characteristic of transition-age youths		
Lesbian, gay, bisexual, transgender, or queer	88	49
Parenting or pregnant	77	43
Undocumented immigrant	68	38
Veteran	31	17
Other	14	8

to high schools in campaigns to address bullying, stigma, and suicide.

Implementation of Age-Specific Services Under the MHSA

Youth-specific services were implemented in 48 of California's 59 mental health service areas (81%). Only 11 (52%) of nonmetropolitan (that is, micropolitan or noncore) areas implemented youth-specific programs, compared with 19 (95%) of the medium and small metro areas and 18 (100%) of large central metro or large fringe metro areas.

Table 2 presents data on the funding streams employed and priority populations targeted by youth-specific programs in California. Notably, 164 programs (91%) received MHSA funding and thus represented new programs or services; 60 programs (33%) reported receiving funding from Medicaid through the Early and Periodic Screening, Diagnosis, and Treatment program, indicating that youth-specific programs leveraged multiple funding sources.

Programs identified their target or priority populations on the basis of diagnosis, residential setting, race-ethnicity, and other characteristics. Most programs targeted youths with serious mental illness or co-occurring mental and substance use disorders. Priority populations on the basis of residential setting included youths who are homeless or at risk of becoming homeless, those aging out of the foster care system, those exiting the juvenile or criminal justice system, or those in institutional or residential care. Other youth populations that were targeted by these programs include lesbian, gay, bisexual, transgender, or queer youths; parenting or pregnant youths; youths who are undocumented immigrants; and youths who are veterans.

As shown in Table 3, youth-specific programs offered a wide array of supportive services. The vast majority offered behavioral health services, and most programs offered general medical care. The most common behavioral health services were assessment, case management, crisis intervention, mental health rehabilitation, and medication management. About one-half of the programs offered coordination with general medical providers. Furthermore, one-quarter of the programs offered education programs to prevent sexually transmitted infections, and one in five programs offered HIV prevention education and screening for alcohol abuse.

Youth-specific programs also focused on services that help youths build their human capital and strengthen their financial skills, including services to support education and employment goals as well as financial and benefits management services. Approximately one-half of the programs provided coordination with secondary and postsecondary schools, and about one-third offered employment counseling or supported employment. Approximately one-half of the programs provided housing placement and support; most common was transitional or time-limited housing and independent housing.

Family counseling and psychoeducation were commonly offered, as were parenting skills for pregnant or parenting youths. Mentoring and peer support services included peer mentoring, supporting natural mentors, and peer-led

TABLE 3. Services offered in 2014 by 180 youth-specific programs in California

Service	N	%	Service	N	%
Behavioral health service	164	91	Housing and basic services		
Assessment	149	83	Housing placement and support	87	48
Case management	155	86	Congregate housing	23	13
Crisis intervention	146	81	Crisis residential	23	13
Intensive case management	103	57	Emergency shelter or respite	42	23
Medication management	142	79	Independent housing	44	24
Individual or group therapy	117	65	Transitional or time-limited housing	55	31
Mental health rehabilitation services	142	79	Vouchers or rental subsidies	26	14
Substance abuse treatment	80	44	Basic services	113	63
General medical services	113	63	Clothing	6	3
Coordination with general medical providers	91	51	Communication services	65	36
Family planning	22	12	Laundry services or tokens	47	26
Health education for prevention of HIV	40	22	Meals or vouchers	56	31
Health education for prevention of sexually transmitted infections	46	26	Showers	26	14
General medical care	14	8	Transportation or transportation vouchers	106	59
Physical wellness programs	32	18	Family, mentoring, and social services		
Screening and assessment	24	13	Family services	144	80
Screening for alcohol abuse	38	21	Family counseling	114	63
Testing for HIV infection	17	9	Family events	44	24
Testing for sexually transmitted infections	15	8	Family reunification services	20	11
Education, employment, benefits, and financial			Family psychoeducation	89	49
Education support	112	62	Multifamily group therapy	25	14
Coordination with secondary and postsecondary schools	99	55	Parenting skills for pregnant or parenting transition-age youth	81	45
Educational counseling	43	24	Mentoring support	108	60
Educational testing and assessment	21	12	Peer mentoring	80	44
Supported education	31	17	Professional mentoring	39	22
Employment support	98	54	Supporting natural mentors	59	33
Employment and vocational testing and assessment	34	19	Peer support	97	54
Employment counseling and placement	62	34	Peer-led counseling	34	19
Supported employment	69	38	Peer-led drop-in center or day program	27	15
Transitional employment	22	12	Peer-led education	41	23
Benefits management	102	57	Peer-led support groups	79	44
Benefits advocacy or enrollment	98	54	Peer-led warm line	7	4
Benefits coordination or management	57	32	Peer-run crisis intervention	12	7
Legal assistance	20	11	Peer-run crisis residential	6	3
Financial services	101	56	Social support services	151	84
Debt restructuring	26	14	Community integration and inclusion support	96	53
Financial literacy	101	56	Recreational activities	112	62
			Social skills training	140	78

support groups. Other social support services included community integration, recreational activities, and social skills training.

Regression analysis indicated that nonmetropolitan counties provided 1.9 fewer types of behavioral health services and 1.3 more types of peer services, compared with large central metro or large fringe metro counties ($p<.05$ each, data not shown). No significant differences were found by residential setting in other service types.

Table 4 presents data showing that most programs reported use of one or more evidence-based or promising practices. The most common evidence-based model was early intervention for psychosis. The most common process or approach was motivational interviewing, and the most common manualized therapy was trauma-informed cognitive-behavioral therapy.

As shown in Table 5, about two-thirds of programs involved youths in service planning, and nearly half involved youths as members of their advisory group, on planning or implementation committees, or in evaluation or quality improvement activities. Few programs included youths as members of their governing bodies.

Programs were queried about any remaining gaps in services for youths. The most frequently mentioned gaps included youth-specific housing and homelessness services, including needs for more independent and supportive housing, transitional housing, and youth-specific emergency overnight shelters (N=63, 35%). Gaps in youth-specific behavioral health services included outpatient and crisis residential services (N=42, 23%), and gaps in youth-specific employment support included supported employment, job placement, and job development (N=18, 10%).

TABLE 4. Use of evidence-based and promising practices in 2014 by 180 youth-specific programs in California

Practice	N	%
Use of any evidence-based or promising practice	160	89
Model	50	28
Assertive community treatment	17	9
Early intervention for psychosis	28	16
Individual Placement and Support	15	8
Permanent supportive housing	17	9
Process or approach	128	71
Managing and adapting practice	17	9
Motivational interviewing	107	59
Transition to Independence Process	50	28
Manualized therapy	136	76
Cognitive-behavioral therapy for psychosis	58	32
Dialectical behavior therapy	40	22
Integrated dual diagnosis treatment	38	21
Seeking Safety	27	15
Trauma-informed cognitive-behavioral therapy	91	51
Other manualized therapy	29	16

TABLE 5. Involvement of transition-age youths in program planning and governance in 180 youth-specific programs in California in 2014

Activity	N	%
Any involvement	144	80
Involved in service planning	118	66
Members of an advisory group or council	86	48
Involved in evaluation or quality improvement activities	76	42
Members of program's governing body	24	13

DISCUSSION

This study used mixed methods to identify specific policies and processes by which the MHSA facilitated the development of youth-specific services and to describe the range of services that have been implemented for transition-age youths in California under the MHSA. Administrators of mental health service areas described the MHSA as providing a programmatic focus and financial support for youth-specific services, outlining a stakeholder process to create buy-in and develop a vision for services and emphasizing the role of youths in service delivery and planning. Youth-specific programs implemented a diverse array of services, including general medical care; support of education and employment; housing placement and support; and family, mentoring, and social support. Programs largely described implementing evidence-based practices and involving youths in service planning, implementation, and quality improvement activities.

The youth-specific services described here are largely the result of an expansion in services under the MHSA. An overwhelming majority of programs reported receiving MSHA funding, and the MHSA has provisions against using the funds to supplant existing state or county funding for mental health services. Administrators described the MHSA as the primary catalyst for implementation of youth-specific services. A few administrators who described having preexisting, federally funded programs also credit the MHSA as supporting the continuation and expansion of these programs. The landscape of youth-specific services in California is substantially larger than what was offered nationally almost 15 years ago, when fewer than 20% of states reported offering any single type of youth-specific service and fewer than 10% reported offering these services statewide (24). In contrast, most services investigated previously are offered in the majority of programs included in this study.

A majority of youth-specific programs implemented evidence-based or promising practices. However, it is important to note that most evidence-based practices do not have evidence of efficacy specifically for youths. Notable exceptions include supportive age-specific evidence for Individual Placement and Support (both standard and as adapted for early intervention in psychosis), the Transition to Independence Process, and motivational interviewing (25–30). Given significant developmental differences between youths and mature adults, it should not be assumed that practices that have been shown to be effective for adults are similarly effective for youths. At least in some cases, evidence-based practices may need significant adaptation to adequately meet the needs of youths (1).

Youths were actively engaged in the design and delivery of services. The perceived benefits of greater youth involvement include programs' greater cultural competency with respect to youths, more effective outreach to youths in community settings, and a greater relevance of services to youths. Additional research should examine the degree to which youth involvement results in improvements in these areas.

This study had several limitations. Program data were obtained by using a self-administered survey. This is an expeditious approach to obtaining information on a critical array of practices across a wide range of programs, but it lacks some detail in measurement compared with what might be obtained from service utilization data; the depth of understanding or context that might be obtained from site visits is also lacking with this approach. Participation in the survey was voluntary, and not all California programs participated. Most missing responses originated from Los Angeles County. Although the MHSA has provisions against funds being used to supplant existing state or county funding for mental health services, we do not have concrete information on the extent to which this may have occurred. The data on use of evidence-based practices did not include information on fidelity to their respective models. Although this study did not investigate the impact of changing the nature of services for youths on their health or recovery outcomes, previous research demonstrated its impact on improved treatment attendance, and future research should investigate the impact on these important outcomes (14,15). The legislative approach pursued in California can serve as a policy model for other states that seek to improve services for this population.

CONCLUSIONS

The MHSA has had a substantial impact on the landscape of youth-specific services in California by providing a programmatic focus and financing and by outlining a stakeholder process that has created buy-in and a vision for a youth-oriented delivery system. The MHSA has also been also influential in promoting the engagement of youths in multiple areas of the service delivery system. Additional efforts are necessary to determine the extent to which the provision of youth-specific services yields greater improvements in outcomes compared with the provision of services that are designed for adults.

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