MENTAL HEALTH

Mental health refers to an individual's ability to negotiate the daily challenges and social interactions of life without experiencing undue emotional or behavioral incapacity. Mental health and mental disorders can be affected by numerous factors including biologic, genetic, physical, and environmental conditions.[1]

Children and youth experiencing mental health problems can be withdrawn, anxious or depressed, show aggressive or delinquent behaviors or have attention or thought disorders. Children with unrecognized or untreated cognitive and emotional disorders cannot learn adequately at school or benefit readily from the healthy peer and family relationships that are essential to becoming a healthy and productive adult. They are at heightened risk for school failure and dropping out, alcohol and drug use, unsafe behaviors for HIV transmission, criminal involvement, and many other problems.[2] Major depression, if untreated, is a strong risk factor for attempted suicide in youth and adults.[3]

Nationally, an estimated two-thirds of all young people are not getting the mental health treatment they need.[4] Many children and youth do not have their mental health needs identified until they enter the juvenile probation or child welfare systems. Aggressive, acting out and delinquent behaviors are frequently the result of mental disturbance for children entering local juvenile probation programs. Nationally, it has been estimated that between 43 to 70% of abused and neglected children entering child welfare systems have mental health problems severe enough to warrant treatment.[5] In addition, an estimated 60% of teenagers in juvenile detention have behavioral, mental, or emotional disorders.[6]

Data Sources

Data on the prevalence of mental disorders among the San Francisco child and youth population is limited. In order to provide some indication of the mental health status among the City's children and youth, this section includes data from the following sources:

- Deaths due to suicide for San Francisco residents, children and youth, ages birth to 24 from 1990 to 1995;
- Preliminary results of the 1997 San Francisco Youth Risk Behavior Survey (YRBS) conducted by the San Francisco Unified School District (in conjunction with the federal Centers For Disease Control). The 1997 YRBS surveyed 1,783 public middle school (6^{th} through 8^{th} graders, ages 11 through 14 and older) and 1,914 public high school (9^{th} through 12^{th} graders, ages 15 to 18 and older).
- Demographic, utilization, and outcome data from the San Francisco Department of Public Health's Community Mental Health Services Division, Children, Youth, and Family Services Section,

[1] U.S. Department of Health and Human Services, Healthy People 2000 Review 1995-96

[2] Hyman, S., National Institute of Mental Health. Testimony on Children's Health. Appropriations Subcommittee on Labor, Health and Human Services and Education, Washington, D.C.: October 29, 1997.

[3] National Mental Health Association. Adolescent Suicide: Helping Depressed Teens. Virginia: National Mental Health Association, 1997.

[4] Estimation Methodology for Children with a Serious Emotional Disturbance. Federal Register, October 6, 1997.

[5] Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

[6] Leiter, V. Special Analysis of Data from the Office of Juvenile Justice and Delinquency Prevention Conditions of Confinement Study, D.C.: Office of Juvenile Justice and Delinquency Prevention, 1993.

which provides mental health services to severely emotionally disturbed San Francisco children and youth who receive Medi-Cal and/or are indigent.

Prevalence of Mental Illness – National Estimates

Various estimates suggest that up to 20% of children and adolescents throughout the U.S. suffer from serious diagnosable emotional or behavioral health disorders, which range from attention deficit disorder and depression to bipolar disorder and schizophrenia.[7] Data on the prevalence of mental illness for San Francisco children and youth are not available.[8]

Suicide and Depression

Suicides. In the absence of data on prevalence of mental illness in the population, data on suicide deaths are often used to provide an indication of the prevalence of the most severe mental health problems within the population. From 1990 to 1995, suicide was the second leading cause of death for San Francisco youth ages 15 to 24 (65 deaths) and the fifth leading cause of death for children and youth for all ages up to age 24 (80 deaths). Nationally, suicide is the third leading cause of death for youth ages 15 to 24.

Healthy People 2000 objectives regarding suicide in the youth population focus on adolescents ages 14 to 19 and female adolescents ages 14 to 17. Comparable data for San Francisco in these gender and age groups to compare with Healthy People 2000 goals were not available for this report.[9] (Also refer to the "Mortality" section of this report and the Appendix for more detailed data on suicide.)

Depression and Suicide-Related Thoughts and Behavior. The 1997 San Francisco Youth Risk Behavior Survey provides data on the prevalence of depression and suicide-related thoughts and behaviors among public school students at the middle and high school levels.

In 1997, three-fourths (77%) of San Francisco middle school students said that they "felt sad and depressed" at least one day over the past 30 days, with two-thirds (61%) feeling sad and depressed from one to nine days, and 4% feeling sad and depressed for all 30 days. Female middle school students (83%) were more likely than male students (71%) to have felt sad and depressed.[10]

A quarter (24%) of San Francisco middle school students said that they had seriously thought about killing themselves, compared to one-fifth (20%) of high school students who had seriously considered suicide. This compares to the national average of 24% for all students. San Francisco females were more likely to have seriously considered attempting suicide than were males, in both middle school (29% vs. 19%) and high school (25% vs. 15%) levels. These proportions are similar to national results (30% vs. 18%).

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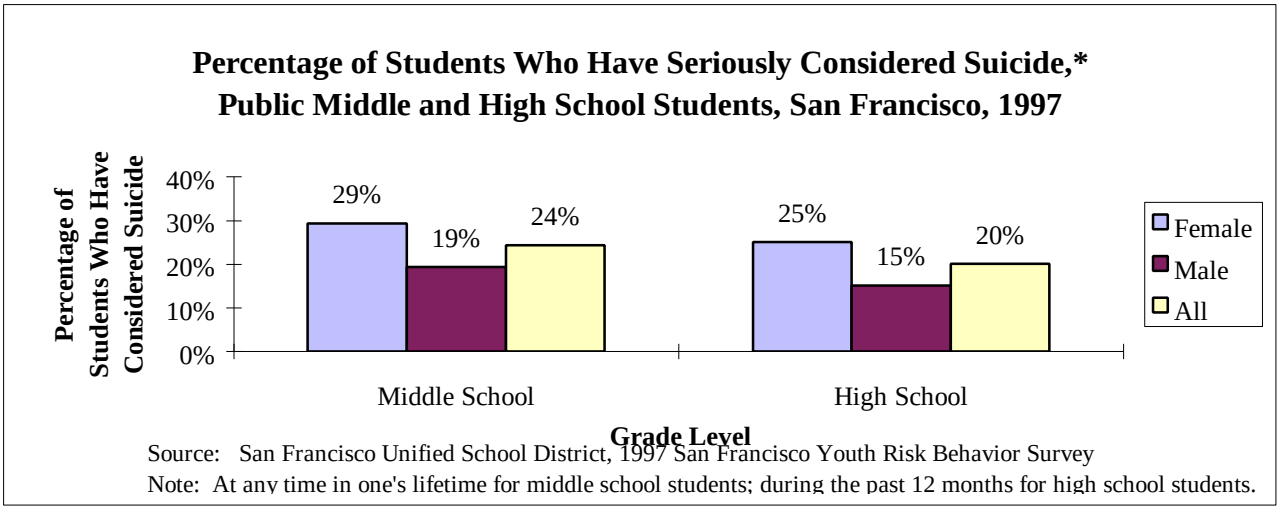
[7] Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

[8] Healthy People 2000 objective 6.3 seeks to reduce to less than 17% the prevalence of mental disorders among children and adolescents 18 years and under.

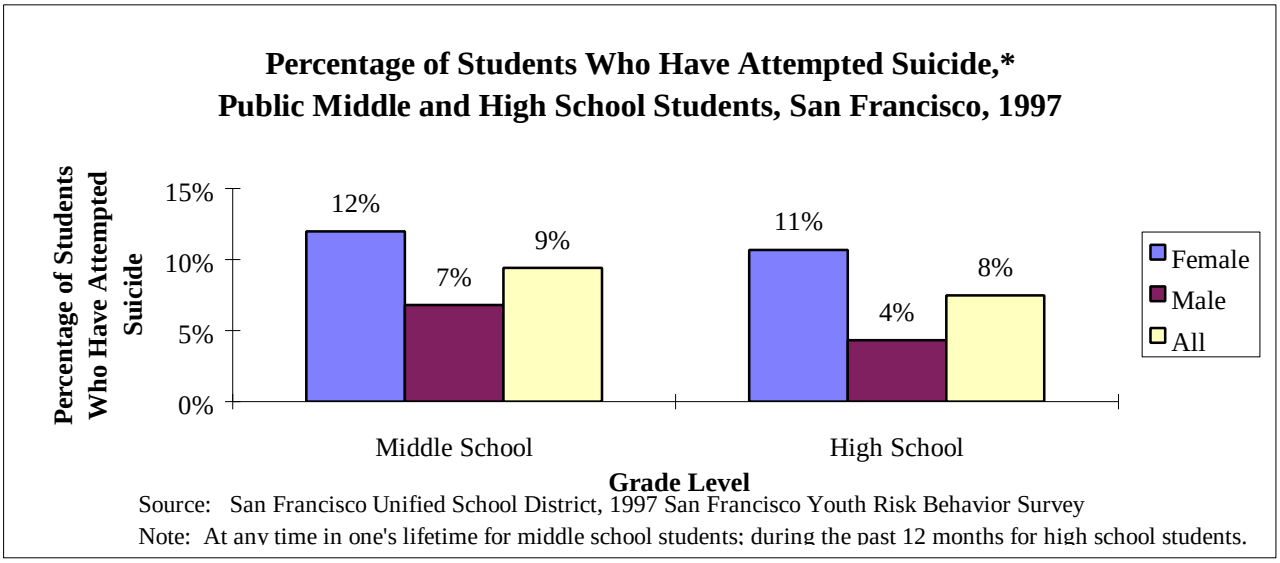
[9] Healthy People 2000 objectives related to suicide among youth include: To reduce suicides among adolescents ages 15 to 19 per 100,000 to 8.2 per 100,000 (objective 6.1a); to reduce suicide attempts among adolescents ages 14 to 17 to 1.8% (objective 6.2); and to reduce suicide attempts among female adolescents ages 14 to 17 to 2.0% (objective 6.2a).

[10] High school students were not asked this question; national data were not available.



In 1997, 13% of San Francisco middle school students had made suicide plan at least once, and 15% of San Francisco high school students had made a plan to kill themselves within the past 12 months. This compares to the overall national rate of 18%. Female students were more likely than male students to have made a plan to kill themselves, in both the middle (16% vs. 9%) and high school levels (18% vs. 12%), and also nationally (21% vs. 14%). In San Francisco, one of five (21%) 10th grade females had made a suicide plan.

In 1997, 9% of San Francisco middle school students said they had attempted suicide at least once in their lifetime, and 8% of high school students said that they had attempted suicide at least once within the past 12 months. Among high school students, 4% said they had attempted suicide at least twice, and 0.7% had attempted suicide 6 or more times (middle school students were not asked how many times they attempted suicide). Females were more likely than males to have tried to kill themselves, in both the middle school (12% vs. 7%) and high school (11% vs. 4%) levels. Nationally, females were also more likely than males (12% vs. 6%) to have attempted suicide.



Community Mental Health Services

Effective treatments for children's psychiatric disorders typically require not only direct interventions such as psychotherapy or medication but also a range of other actions, including interventions with parents and school personnel.[11] Researchers and clinicians agree that "systems of care" are needed to coordinate public and community-based mental health services for children and their facilities. These systems of care should include mental health assessment, early intervention, crisis intervention, outpatient and inpatient care, day treatment, in-home services, intensive and ongoing case management, and family support. While private insurance has historically covered some limited mental health services (especially inpatient services for severe cases), public agencies have played the primary role in serving children with serious mental health problems.[12]

In 1984, California began testing the Systems of Care model which is now operational in most counties. San Francisco's Mental Health System of Care for children, youth, and their families has been operational since 1991 and has responded to child abuse and neglect referrals, psychotic episodes, criminal law violations, learning disabilities, and other pressing mental health needs of San Francisco children and youth. Demand for mental health services has grown as a result of increased child abuse reporting and increased felony arrests of juveniles ages 12 to 17, including arrests for violent crimes. (Refer to the "Child Abuse and Neglect" and "Crime" sections of this report for more detailed data on child abuse and arrests.)

The following sections provide demographic, utilization, and outcome data on clients served by the San Francisco Mental Health System of Care for children and youth administered by the Children, Youth and Family Services Section of Community Mental Health Services (CMHS) within the San Francisco Department of Public Health. The mission of the Children, Youth, and Family Services (CYFSS) section is to manage mental health care for seriously disturbed children and youth residents of San Francisco up to age 19 who receive Medi-Cal benefits and/or have limited or no resources. The CYFSS provides mental health services through a comprehensive, culturally competent, community-based system of care that is consumer-driven, outcome-oriented and focused on treating the whole child and the family. CYFSS's two primary objectives are first, to provide treatment services to children and youth with serious emotional problems through a culturally competent system of care, and second, to provide assistance to families and communities in creating support networks for high-risk children and youth and their families.

To achieve its mission, CYFSS works in collaboration with many child-serving public and private agencies to provide a broad spectrum of mental health services for children and youth within the "System of Care". This continuum of services include and are not limited to: prevention and early intervention programs (Primary Intervention Programs (PIP), Healthy Start and Early and Periodic Screening, Diagnoses and Testing (EPSDT)); early mental health consultation (childcare centers; family resource centers/networks); primary care consultation liaison services; neighborhood-based outpatient services; day treatment programs; crisis intervention teams; school based mental health care; intensive case management; wrap-around (individualized) services; residential and substance treatment programs; and hospitalization and post-transitional services.); and foster care mental health services.

[11] Institute of Medicine. Research on Children and Adolescents with Mental, Behavioral, and Developmental Disorders: Mobilizing a National Initiative. D.C.: National Academy of Sciences Press, 1989

[12] Crowell, Areta, Emotional Health Services for Children, Youth: Coordinated Care, Insurance Coverage Needed, Sacramento: The California Center for Health Improvement, 1998.

(Refer to the Appendix for a detailed description of the San Francisco Mental Health System of Care for children and youth.)

Two recently implemented key initiatives involving CYFSS reflect CYFSS's direction for the future. As of April 1, 1998, CMHS Division of the San Francisco Department of Public Health (SFDPH), implemented Phase II of the State's Medi-Cal Mental Health Managed Care consolidation with the establishment of the San Francisco Mental Health Plan which includes CYFSS as part of the Plan. Under the Plan, the SFDPH assumes fiscal and management responsibility for all specialty mental health services for San Francisco Medi-Cal beneficiaries of all ages. Services are unchanged, except that a 24-hour, 7-day a week centralized intake unit with a toll-free number (1-888-246-3333) assists in providing more accessible, coordinated, and integrated services.

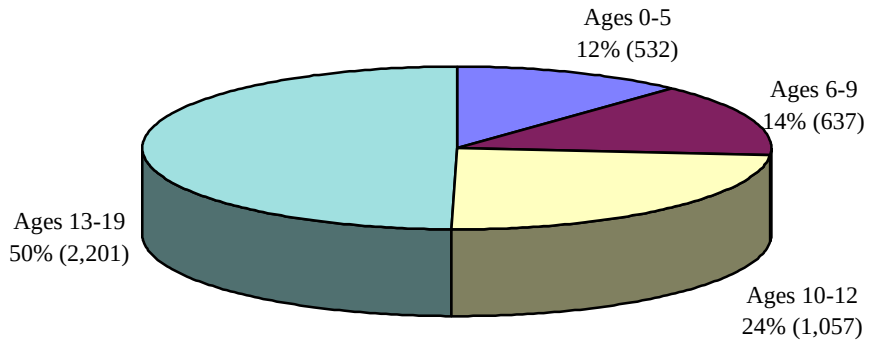
In 1997, CYFSS implemented a key initiative focusing on mental health services and juvenile justice-involved youth and their families. The initiative expanded San Francisco's Comprehensive Child Crisis Services to provide outreach and 24-hour accessibility to youth involved in or at risk for involvement in the juvenile justice system. The initiative provides a full range of mental health services from screening to assessment to medication case management of youth and their families. A comprehensive, multidisciplinary Youth Assessment Team at the Youth Guidance Center (Juvenile Hall) assess youth and develop a comprehensive mental health care plans for youth who are detained or being discharged from Juvenile Probation. The team, composed of representatives from Special Programs for Youth Health Services, Woodside Learning Center, Department of Human Services and Community Substance Abuse Services, collaborates in providing a coordinated care of plan.

Client Demographics and Baseline Data. The number of children and youth served by the Children, Youth, and Family Services Section has risen steadily since 1991, reaching 4,427 children and youth (unduplicated count) up to age 19 in FY 1996/97 (July 1 – June 30). The children and youth population comprised 22% of all CMHS clients (19,117). More male (59%; 2,603) than female (41%; 1,824) children and youth were served.[13]

[13] San Francisco Department of Public Health, Community Mental Health Services, Children, Youth, and Family Section, San Francisco County System of Care Implementation Proposal to the California Department of Mental Health, October, 1997.

By Age. In 1996/97, half (50%) of CMHS children and youth clients were ages 13 to 19.

Community Mental Health Services Clients, Ages 0-19, By Age Groups, FY 1996/97



Source: San Francisco Department of Public Health, Community Mental Health Services, 1998

By Race/Ethnicity. In FY 1996/97, African Americans comprised over one-third (38%) of children and youth clients followed by Latinos (18%), Whites (15%), Asians (12%), multi-racial/ethnic (4%), and others (16%).[14] African American children and youth comprise a disproportionate share of clients

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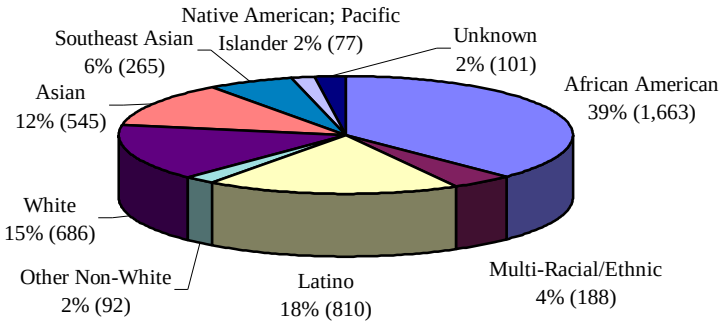
Community Mental Health Services Clients, Ages 0-19, By Race/Ethnicity, San Francisco, FY 1996/97



Source: San Francisco Department of Public Health, Community Mental Health Services, 1998

compared to their proportion of the San Francisco child and youth population. Since 1991, the numbers of Asian Americans have risen at a higher rate than for all the major racial/ethnic groups. In 1991, Asian Americans were served in number equal to Whites. (Refer to the Appendix for detailed data.)

By Zip Code of Residence. In FY 96/97, the largest number of CMHS child and youth clients were residents of the eastern and southeastern half of San Francisco including: North Beach, South Beach, Tenderloin, Japantown, Western Addition, Civic Center, South of Market, China Basin, Potrero Hill,

[14] These are the race/ethnicity categories designated by Community Mental Health Services.

Outer Mission, Bernal Heights, Bayview-Hunters Point, Visitation Valley, and Ocean-Merced Heights-Ingleside. (Refer to the Appendix for a map of clients ages 9 to 17 by zip code.)

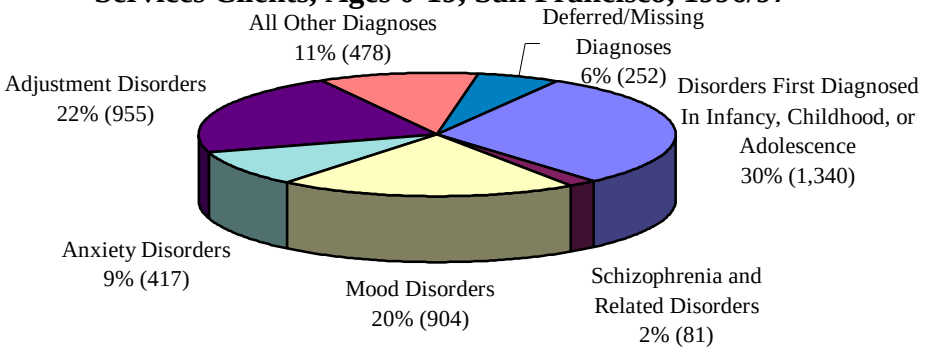
COMMUNITY MENTAL HEALTH SERVICES CLIENTS, AGES 0-19, BY ZIP CODE OF RESIDENCE, FY 1996/97

Zip Code	Neighborhood	#	%
94124	Bayview Hunters Point	496	11%
94110	Mission District	490	11%
94112	Excelsior	357	8%
94134	Visitacion Valley	273	6%
94102	Civic Center	159	4%
94115	Fillmore/Western Add'n	150	3%
94122	Inner Sunset	125	3%
94121	Outer Richmond	124	3%
94133	Telegraph Hill	108	2%
-	Other	2,145	49%
94109	TOTAL	4,427	100%

Source: San Francisco Department of Public Health, Community Mental Health Services

By Primary Diagnoses. In 1996/97, the most common primary diagnostic group for children and youth clients was disorders "first diagnosed in infancy, childhood, or adolescence," which applied to nearly

Primary Diagnostic Groups, Community Mental Health Services Clients, Ages 0-19, San Francisco, 1996/97



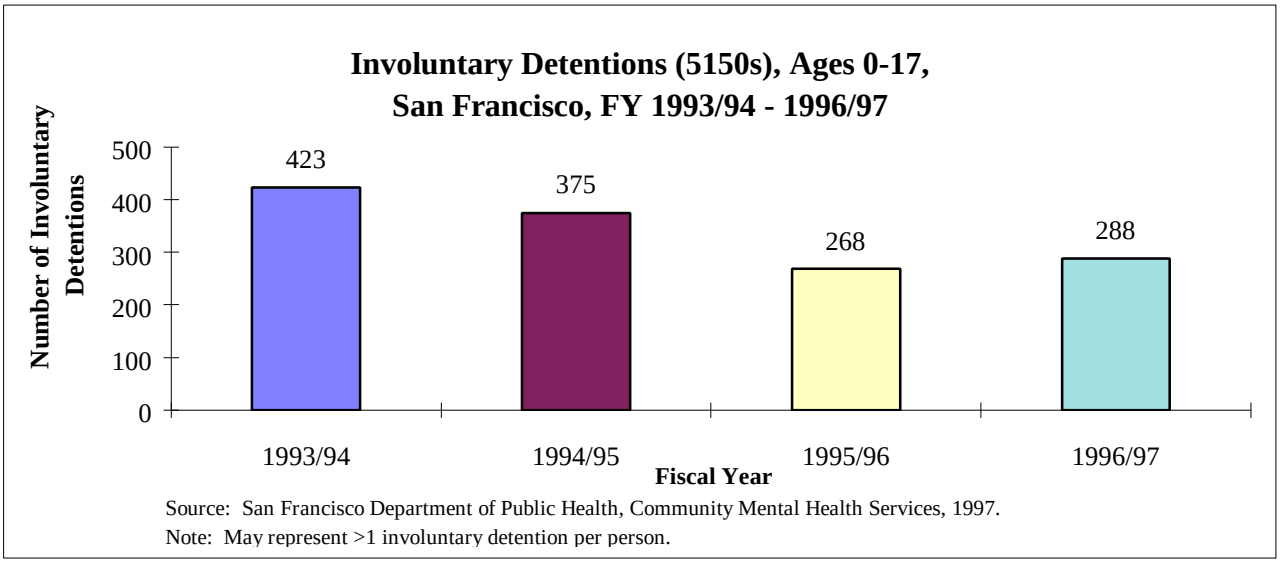
Source: San Francisco Department of Public Health, Community Mental Health Services

one-third (30%) of clients (1,340) at entry into services.[15] Within this diagnostic group, the most common diagnoses were oppositional defiant disorder (507), attention deficit hyperactivity disorder (258), and conduct disorder (258). The second and third most common primary diagnostic groups were adjustment disorders (22%; 955 clients) and mood disorders, including dysthymic disorders and major depression (20%; 904 clients). (Refer to the Appendix for detailed data.)

Highlights of System of Care Components. The following sections describe key service components of San Francisco's System of Care for children and youth including the demographic and the most recently available outcome data for these services.

Crisis Services; Involuntary Detentions (5150s). In San Francisco, the Comprehensive Child Crisis Service (CCCS) provides 24-hour comprehensive mental health assessment and crisis services for children and youth undergoing mental health crisis. CCCS functions as a gatekeeper into hospital services placing children and youth as necessary in psychiatric hospitals for a 72-hour evaluation period through the 5150 involuntary hospitalization process. Children or youth are admitted on a 5150 to a psychiatric hospital when they are found to be a danger to themselves or others.

In FY 1996/97, CCCS certified the need for 288 involuntary detentions (5150s) among San Francisco children and youth under age 18. This represents a 32% decline in the number of child and youth 5150s compared to FY 1993/94 (423), and contrasts with the 17% rise in 5150s among adults (18+ years of age) during the same time period (from 7,952 to 9,293). CMHS provides services to children and youth under 5150s if they receive Medi-Cal and/or have limited or no resources.



Source: San Francisco Department of Public Health, Community Mental Health Services, 1997.
Note: May represent >1 involuntary detention per person.

Psychiatric Inpatient Hospitalizations. As of early 1998, three facilities provided most psychiatric inpatient hospitalizations for children and youth residents of San Francisco including Ross Hospital (located in Kentfield in Marin County), McAuley Neuro-Psychiatric Institute at St. Mary's Medical Center in (San Francisco) and Walnut Creek Hospital (in Contra Costa County).

[15] Primary diagnoses are categorized within the primary diagnostic groups shown. Primary diagnoses are the first listed DSM IV Axis I diagnoses made at entry into services with the most continuous provider. The episode of care with the provider may have begun prior to the 1996/97 period..

From 1990 through mid-1996, a total of 1,102 child psychiatric hospitalizations occurred at McAuley Neuropsychiatric Institute and Langley Porter Neuropsychiatric Institute Inpatient Services at the University of California, San Francisco, with most hospitalizations (74%) at McAuley. An average of 137 children and youth were hospitalized each year at McAuley, and an average of 42 children and youth per year were hospitalized at Langley Porter.[16] Most (70%) of hospitalized children and youth were hospitalized only once, while others were admitted from two to fifteen times. The number of hospitalizations peaked in 1993 at 185 and declined to 166 in 1995. The average length of stay declined by almost half, from 22.5 days in 1990 to 11.5 days in 1995. As of April 1998, Langley Porter discontinued providing child psychiatric hospitalization.

State Psychiatric Inpatient Care. State hospitalization occurs only when providers find it impossible to contain a youth in a local treatment setting. Whenever possible, locales seek to decrease their reliance upon this most restrictive level of psychological service by providing effective and accessible care in the community.[17] Between 1985 and 1995, 38 children and youth from San Francisco were admitted to Napa State Hospital, which had been the state's single psychiatric hospital providing intensive, long-term 24-hour care to Northern California children and youth with severe mental disabilities. Children and youth hospitalized at Napa State suffered from severe episodes of violence, acute uncontrollable suicidality, and/or long standing organic and developmental problems, and represented a danger to themselves and others.

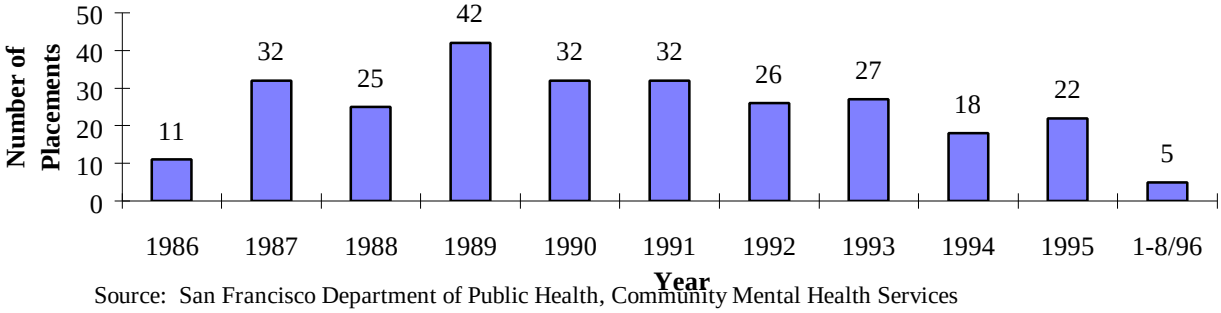
The majority (84%) of these 38 children hospitalized at Napa were admitted only once. The children ranged from ages 7 to 17, with an average age of 13. Two-thirds (26) were male and one-third (12) were female. Nearly half (47%; 16) were African American and 21% (7) were biracial. Others include Caucasian (18%; 6), Asian/Pacific Islander (9%; 3), and Hispanic (6%; 2).[18] On average, children and youth were hospitalized at Napa for 25 months, with a range of 3 weeks to over 7 years. Upon discharge from Napa, patients moved to other similar level of care facilities (16%), to sub-acute residential settings or group homes (26%), to their families (13%), or to other arrangements (35%). In 1998, Napa State Hospital closed its Children's Unit and all State hospitalizations now occur at Metropolitan Hospital in Los Angeles.

Residential Treatment. Residential treatment programs are private, non-profit facilities licensed by the State Department of Social Services to provide 24-hour care to children and youth in need of significant structure and comprehensive services in order to progress emotionally, developmentally and behaviorally. The facilities combine residential, educational, and clinical services in one setting. Most San Francisco children and youth are placed in residential treatment programs (out-of-home care) under the auspices of the Juvenile Court, through the San Francisco Department of Human Services or the San Francisco Juvenile Probation Department. Children and youth whose need for residential treatment is educationally based and who are identified through the Special Education Individual Educational Plan (IEP) process as Seriously Emotionally Disturbed are placed by CMHS and San

[16] San Francisco Department of Public Health, Community Mental Health Services, Mental Health Funded Child Psychiatric Inpatient Hospitalizations, 1990-Mid-1996, January 1997.
[17] San Francisco Department of Public Health, Division of Mental Health and Substance Abuse Services, System of Care for Children and Youth With Mental Health Needs and Their Families in the City and County of San Francisco, February 1997.
[18] These are the racial/ethnic categories designated by Napa State Hospital.

Francisco Unified School District under provisions of AB 3632.[19] The goal for children placed in residential teatment is to return to the home and/or community as quickly as appropriate.

From the inception of the program in 1986 through August 1996, 190 San Francisco children and youth have been placed in over 40 different mental health residential treatment facilities. The 190



Source: San Francisco Department of Public Health, Community Mental Health Services
Note: Data for 24 placements is missing, most were clients in the early years of the program.

children and youth represented 296 separate placements, an average of 1.6 placements per person. Most clients (122) were placed in care once, while others (68) were placed from two to six times. Over 70% of the placements were made in eleven facilities, four of which are located in San Francisco. The law requires that placements are to be made in the child's home county whenever possible and that other frequently-used facilities are located in adjacent and nearby counties. Over twice as many boys as girls were placed residentially, and the average age at the time of first admission was 13 years (range of ages 5 to 19). [20]

The number of placements has declined since 1989, most likely related to an increase in community support services including the inception of the Family Mosaic Project (in 1989) with its intensive case management and "wrap-around" service capacity.

Intensive Case Management - Family Mosaic Project. The Family Mosaic Project (FMP) is an intensive case management program that helps children and youth ages 3 to 18 with severe emotional problems and their families overcome fragmentation of treatment services that can result in expensive, traumatic, and frequent out-of-home placements. From 1990 to mid-1997, FMP served 696 children

[19] AB 3632 refers to a California State Assembly bill, the Special Education Individual Education Plan and Special Education Pupil (SEP) Program, a school-based program that identifies and treats children with mental health problems. Passed in 1985, the law establishes interagency responsibilities for providing services to handicapped children. Local mental health programs are responsible for providing mental health services to youth in SEPs who need treatment, including placement in residential treatment facilities, in order to benefit from their education. If placed out-of-home, the local mental health department is responsible for providing service coordination (case management). Children and youth must be at least school age and up to age 22 to qualify for AB 3632 services. Youth may continue to be eligible for special education, including AB 3632 services, until they receive their high school diploma or attain the age of 22, whichever comes first.

[20] San Francisco Department of Public Health, Community Mental Health Services, Mental Health Funded AB 3632 Residential Treatment, 1986-August 1996, December 1996.

and families with an average participation length of 14 months.[21] In partnership with other public and private child serving agencies, multi-disciplinary, multi-ethnic, and multi-lingual case managers and family advocates of FMP provides a diverse continuum of support services to the children, youth and their families in school, home and neighborhood settings. Services range from mental health treatment, case management, family advocacy, specialized tutoring, mentoring, respite care, and individualized services. The program has demonstrated positive outcomes including reduction in inpatient hospitalizations and out-of-home residential placements; reduction in criminal offenses and detentions; and associated cost-savings due to reduced institutional care and reduced criminal involvement.

From 1991 to 1995, FMP's recidivism rate was almost 20 points below the national average recidivism rate of 70% for juvenile offenders, with an average rate of pre- and post- felony offenses dropping by 46%.[22] In addition, children, youth and families served by FMP experienced:

- More stable and manageable behavior within a wider support network;
- Improved adaptive functioning and coping skills in home, school, and community settings;
- Return to autonomous development with opportunities to plan for a constructive future;
- Strengthened family connections, trust and responsibility;
- Improved peer relations and positive social activities;
- Reduced negative health and mental health outcomes and lifestyle patterns; and
- Reduced criminal victimization.

SED (Severely Emotionally Disturbed) School Mental Health Partnerships Programs. Since 1993/94, CMHS and the San Francisco Unified School District have collaborated to support teachers and other special education personnel in 33 Severely Emotionally Disturbed (SED) special day classrooms at the 1st through 12th grade levels in 20 different schools. In 1996/97, the program served 352 children and youth including 75% male and 25% female enrollees. More than half (54%) were African American, 14% Latino, 9% Asian/Pacific Islander, 4% Caucasian, 2% American Indian, 17% "other" or unknown. Most children and youth in SED classrooms had learning disabilities (50%) or serious emotional disturbances (44%) as their primary handicapping condition. The remaining children and youth had other conditions including mild to moderate cognitive delays, and speech, hearing, or language impairments.[23]

CASARC. In 1997, Child and Adolescent Sexual Abuse Resource Center (CASARC) treated 422 children and youth ages 0 to 18 who were victims of sexual abuse, incest, or assault.[24] CASARC operates under the auspices of Community Mental Health Services of the San Francisco Department of Public Health. CASARC provides 24-hour forensic crisis intervention and mental health treatment services to victims of sexual abuse and molestation. Mental health treatment services are critical and essential for children who are emotionally traumatized as a result of sexual abuse.

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[21] San Francisco Department of Public Health, Community Mental Health Services, Children, Youth and Family Services Section, Family Mosaic Project-Summary of Outcomes (1990-1997), November 1997.

[22] San Francisco Department of Public Health, Community Mental Health Services Section, Family Mosaic Project. Juvenile Probation Outcome Data: Rates of Offense as A Function of Program Involvement (1991-1995), Preliminary Data, July 1996.

[23] San Francisco Department of Public Health, Community Mental Health Services, School Mental Health Partnerships Teachers Reports on SED Children and Youth, 1996-97 School Year (Preliminary Data), September 1997

[24] Child and Adolescent Sexual Abuse Resource Center, Child and Adolescent Sexual Abuse Resource Center 1997 Statistics, 1998.

In 1997, two-thirds (68%; 286) of CASARC clients were female and nearly all (95%; 245 of 259) perpetrators were male. Clients were from all age groups: ages 0 to 3 (17%; 73 clients), ages 4 to 6 (26%; 109), ages 7 to 10 (22%; 91), ages 11 to 14 (19%; 80), ages 15 to 18 (14%; 58), and unknown ages (3%; 11). Forty-two percent (176) of clients were African American, followed by Latino (23%; 98), Caucasian (17%; 70), Asian/Pacific Islander (8%; 32) and "other" racial/ethnic groups (11%; 46).[25]

Foster Care Mental Health Program. The Foster Care Mental Health Program (FCMHP) was created as a collaborative effort between the Children, Youth, and Families Services section and the San Francisco Department of Human Services (DHS) to serve the mental health needs of children and youth from birth to age 18 who have been removed from the family home as a result of abuse, neglect or abandonment or those who are at-risk for out of home placement. This population served by the Children and Family Services of DHS currently consists of approximately 4,200 San Franciscan children and youth.

The FCMHP was developed in response to a need for centralized and systematic access, comprehensive assessments, coordination of mental health services, quality controls and interagency training and collaboration. The program strives to insure that all of these needs are met by overseeing access and authorization of mental health services for foster children. The program reviews mental health screenings completed by Child Welfare Workers, performs child and/or family assessments (or authorizes assessments by designated providers), provides case management that ensures that children connect to referred treatment providers, and authorizes treatment.

[25] These are the racial/ethnic categories designated by CASARC.