

Mental Health Services Act (MHSA)

EVALUATION BRIEF

Summary and Synthesis of Findings on MHSA Values

Submitted by:



UCLA Center for Healthier Children, Families & Communities



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Executive Summary

Summary and Synthesis of Findings on MHSA Values

Introduction

This report is one of two reports for the Mental Health Services Act (MHSA) statewide evaluation that summarizes and synthesizes existing evaluations and studies on the impact of MHSA.¹ The purpose of this current report is to provide a summary and synthesis of existing evaluations and studies on the impact of MHSA on nine MHSA values:²

1. Client and family involvement and engagement;
2. Disparities in access and outcomes;
3. Cultural competency;
4. Recovery/resiliency and wellness orientation;
5. Integrated mental health services;
6. Integration with substance abuse services and primary care;
7. Community partnerships and systems collaborations;
8. Stakeholder involvement throughout public mental health system; and
9. Co-occurring disorder services competency.

This executive summary provides a brief description of study methods, a summary of findings, and supporting recommendations.

Study Methods

Twenty-nine (29) of 58 counties are represented in this review of evaluations and studies of the impact of MHSA on MHSA values. From these 29 counties, a total of 202 documents were reviewed. In order to generate this summary and synthesis, researchers categorized information extracted from the documents as *high utility*, *low utility*, and *descriptive*. Utility was judged based on whether or not the document was a formal evaluation or study and whether or not it included a clear description of data source, samples, methods, analysis, and interpretation of findings. High utility documents comprised the basis for our summary analysis and the conclusions drawn about the impact of MHSA on MHSA values. (See the full report for details on study methods).

¹ Ward, K. J., & Yoo, J. (2011). *Evaluation brief: Summary and synthesis of findings on Community Services and Supports (CSS) consumer outcomes*. Los Angeles, CA: University of California Los Angeles Center for Healthier Children, Families & Communities.

² Refer to the full report for a definition of each MHSA value.

Summary of Findings

The review of hundreds of documents produced a summary of findings for all nine MHSA values; however, only two of the nine MHSA values had sufficient high utility information to assess the impact of MHSA on MHSA values. One of the syntheses was based on an earlier review of the impact of Community Services and Supports (CSS) on consumer outcomes.³ In summary, MHSA is impacting the MHSA value of recovery/resiliency and wellness orientation by reducing acute psychiatric hospitalizations, homelessness, and arrests. Yet these outcomes, which focus on the reduction of adverse effects, represent one of many possible domains of recovery for which no standard definition exists.

Based on this current summary of available evidence, MHSA is impacting the MHSA value of reducing disparities in access by improving penetration rates for certain racial/ethnic groups (e.g., Latinos, Pacific Islanders, Vietnamese) in some counties. The evidence also suggests that over-representation (e.g., among African Americans) and under-representation (e.g., among Asians) by race/ethnicity remain in the public mental health system. These documented disparities are consistent with the literature on mental health services access/usage by race and ethnicity,⁴ but the full scale of MHSA's impact on increasing or decreasing these disparities cannot be surmised at this time given the limited quantity and quality of information available.

Overall, sufficient information was not available to assess the degree of impact that MHSA has had on the remaining seven MHSA values. However, the information currently available was adequate to conclude that there is focused activity among counties related to implementing MHSA programs in line with the values of MHSA.

Recommendations

Based on the findings and review process for this summary and synthesis, recommendations are provided for next steps and needed resources regarding evaluation of the impact of MHSA on MHSA values:

- Focus future evaluations on program, system, and community level outcomes (e.g., staff competency, development of networks among service delivery systems, racial/ethnic disparities in outcomes) to understand the impact of MHSA on MHSA values. The MHSA

³ Ibid 1.

⁴ Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5), 792-797. Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by member of ethnic minority groups. *The American Psychologist, 45*(3), 347-55.

values mostly target outcomes at these levels. However, county evaluations are typically less focused on these types of outcomes. Instead, there has been greater focus on consumer level outcomes such as symptomology and functioning.

- Dedicate resources to providing counties with technical assistance on how best to design evaluation studies; collect and analyze data; and report, disseminate, and utilize findings. For the evaluation of MHSA values, focus technical assistance on program, system, and community level evaluation, with an emphasis on study design and measurement for this type of study. For example, use network analysis to measure collaboration and integration. Network analysis is a method for assessing the type and nature of relationships among individuals, groups, and organizations. The technical assistance should be tailored to the existing capacity of counties so that smaller counties, for example, receive technical assistance that is customized to their needs.
- Focus resources on future evaluations of MHSA values in the area(s) that currently have the greatest potential for meaningful cross-county analysis. Based on this summary and synthesis, the MHSA value with the greatest potential is the reduction of disparities in access. Information to help understand disparities reduction is being collected – for example, the number and characteristics of individuals being targeted and/or served by prevention and early intervention efforts. This information should be analyzed and reported in a way that compares the number targeted and/or served against, for instance, the county population in order to understand the degree to which disparities have or have not been reduced for particular groups. Counties may need technical assistance and/or specific reporting requirements to achieve this.
- Utilize the forthcoming PEI evaluations for a future summary and synthesis of the impact on MHSA values. These evaluation studies hold the most promise for addressing outcomes at the program, system, and community levels; however, they are still likely to be heavily focused on consumer level outcomes. To maximize resources, consider a future summary and synthesis of PEI evaluations that simultaneously reviews the span of consumer level outcomes alongside program, system, and community level outcomes that are mainly relevant to MHSA values. Refine and/or develop reporting structures for these PEI evaluations to get the most appropriate and consistent information about MHSA values across counties.

Evaluation Brief

Summary and Synthesis of Findings on MHSA Values

Introduction

This report is one of two reports for the Mental Health Services Act (MHSA) statewide evaluation that summarizes and synthesizes existing evaluations and studies on the impact of MHSA.ⁱ The purpose of this current report is to provide a summary and synthesis of existing evaluations and studies on the impact of MHSA on nine MHSA values:ⁱⁱ

1. **Client and family involvement and engagement** – This value promotes participation of consumers and family members in the development of treatment plans that take into consideration the individual’s strengths, goals, cultural background, and social beliefs.
2. **Disparities in access and outcomes** – This value promotes the strengthening and transformation of mental health services and systems to reduce disparities in access, utilization, and outcomes by age, race/ethnicity, gender, sexual orientation, language, disability, economic status, and other affiliations.
3. **Cultural competency** – This value promotes mental health services that reflect the values, customs, and beliefs of the population served by the mental health system.
4. **Recovery/resiliency and wellness orientation** – This value promotes services and systems that support consumers and family members in their efforts to overcome mental health illness and to live productive and fulfilling lives.
5. **Integrated mental health services** – This value promotes coordination among different service systems to provide a seamless experience for consumers and family members in accessing mental health services and supports.
6. **Integration with substance abuse services and primary care** – This value is based on the MHSA value of integrated mental health services, with a specific focus on integrating mental health services with substance abuse services and primary care.
7. **Community partnerships and systems collaborations** – This value promotes partnerships and collaborations among service delivery systems and community-based organizations to support an infrastructure for seamless and competent service delivery.
8. **Stakeholder involvement throughout public mental health system** – This value promotes participation of consumers and family members in planning, policy development, implementation of programs and services, and evaluation.
9. **Co-occurring disorder services competency** – This value addresses the competency of programs and systems to improve services and outcomes for consumers with co-occurring mental health and substance abuse disorders.

A description of the methods for collecting, reviewing, and analyzing county-level information on MHSA values precedes a more detailed reporting of findings on the impact of MHSA on each MHSA value. The evaluation brief ends with a discussion of the review process and findings, and offers supporting recommendations.

Methods

Data Collection Procedures

In March 2011, the evaluation team (via the California Mental Health Directors Association or CMHDA) sent an e-mail to the MHSA coordinator in every county with a request that they submit “existing evaluation/study reports and other documents” that describe the impact of the MHSA on the nine MHSA values.ⁱⁱⁱ The evaluation team also performed an exhaustive search of county websites for relevant information. A wide net was cast by searching each site to uncover reports and documents on mental health services that might reflect or encompass MHSA components. Finally, the evaluation team conducted a web-based search for evaluations and studies of the impact of MHSA on MHSA values.

In October 2011, the evaluation team (via CMHDA) sent out a second request for additional and/or updated evaluation reports or studies on the impact of the MHSA on MHSA values to help ensure that this summary would include the most current information available. The evaluation team also contacted a purposeful sample of 14 key informants from 11 counties who were identified as being knowledgeable about existing evaluation efforts in their counties and/or throughout the State.^{iv} These requests specifically defined “evaluation reports or studies” as written documents that detail the purpose of the evaluation/study, study questions, methods, findings, and interpretation. The requests further explained that documents absent this type of contextual detail – such as data tables, performance benchmarks, or PowerPoint presentations – were not being sought.^v

None of these requests for evaluation studies and reports asked counties to produce any new information for the purpose of this review, and counties were given approximately three weeks to respond to each request.

Response and Sample

Twenty-nine (29) of 58 counties are represented in this review of evaluations and studies of the impact of MHSA on MHSA values. Of the 20 counties that responded to our initial, follow-up, and key informant requests for evaluations and studies, 16 of them had documentation that was reviewed for this summary. Documents from 13 additional counties found on county websites were included in the review.

From the 29 counties represented in this report, a total of 202 documents were reviewed (see Appendix A for a table displaying documents reviewed for each county). This total includes 141 documents submitted directly to the evaluation team by counties, as well as 62 documents obtained through the search of county websites as well as other web-based sources.^{vi} It is important to note that few of the documents received from counties or retrieved from the web search were formal evaluation studies or reports. Documents that did not meet our criteria were nonetheless reviewed if they were submitted by counties; they were used as additional descriptive context for describing the impact of MHSA on MHSA values. If a study or other document was not specifically related to MHSA (e.g., a study on systems of care reflecting a period prior to MHSA implementation), it was not included in the review.

Data Extraction and Content Analysis

To develop a document review framework, three researchers independently reviewed and coded content from a sample of three counties to rate the utility of the information presented. The researchers then compared the extracted content and refined the coding scheme to establish consistency in the review across the researchers. For the purpose of this review, the *utility* of a report was judged based on whether or not the document was a formal evaluation or study and whether or not it included a clear description of data source, samples, methods, analysis, and interpretation of findings. The coding scheme used to define utility is below:

High Utility	The document was a formal evaluation study report with a clear description of data source, sample, methods, analysis, and interpretation.
Low Utility	The document was not necessarily a formal evaluation study report; however, it provided some information about data sources, sample, study methods, and/or analysis though not in adequate detail to confidently determine the validity or meaning of the information.
Descriptive	The document was not a formal evaluation study report and it provided no information about data sources, sample, study methods, and/or analysis.

All content was extracted, assigned a code, and categorized according to the MHSA value. Studies and other documents reviewed could have information that pertained to more than one value, both because there was some overlap in the definitions of values and reports often addressed more than one value. Researchers then examined the data available under each MHSA value category and synthesized the information to produce a summary for each value.

High utility documents from counties comprised the basis for our summary analysis and the conclusions drawn about the impact of MHSA on MHSA values. Low utility documents at times provided important specific findings about a value but must be interpreted cautiously. Ultimately, due to the lack of information about samples, data sources, methods, and analysis, both low utility and descriptive documents were only used descriptively to provide additional context to the body of information on the impact of MHSA on MHSA values. For a count of high utility, low utility, and descriptive documents per MHSA value, see Appendix B.

The summary for each MHSa value addresses the following:

- The amount of evidence available for each value overall;
- The number of high utility studies and a summary of high utility findings;
- The number of counties reporting low utility and descriptive documents and a summary of information reported; and
- A synthesis of what is known about the impact of MHSa on the MHSa value.

Findings

Client and Family Involvement and Engagement

There was a limited amount of evidence on the impact of MHSa on the MHSa value of client and family involvement and engagement. There were no high utility or low utility studies on this MHSa value. Descriptive documents from four counties that included information on this MHSa value provided general descriptions of using MHSa funds to hire staff for advocacy positions to engage families; involving the family in the consumer's treatment plan; and the role of family partners for advocacy and support to families with children in the mental health system. Altogether, sufficient information was not available to assess the degree of impact that MHSa has had on the MHSa value of client and family involvement and engagement.

Reducing Disparities in Access and Outcomes

There were two high utility studies on the MHSa value of reducing disparities in access (but not outcomes). One study reported that the number of Latino consumers served increased by 30% since MHSa was implemented. This finding reflects the county's reporting of outreach efforts to Latinos during MHSa implementation. Increases in penetration rates were also reported for Pacific Islander consumers and Vietnamese consumers – each by 9%. In comparison to the general county population, African American clients were over-represented at 9.2% versus 2.9% in the county, as were Latino clients at 19% versus 14.1% in the county. Conversely, Asian consumers were under-represented at 2.1% compared to 4.9% in the county. These findings were consistent with the second study on Full Service Partnership (FSP) that found that African American consumers were over-represented at 34% compared to 7% in the county and 26% in the Medi-Cal population. Conversely, Asian and Pacific Islander consumers were under-represented at 8% compared to 32% in the county and 21% in the Medi-Cal population. Moreover, Latino consumers were slightly over-represented at 18% compared to 14% in the county and 14% in the Medi-Cal population.

Low utility reports from three counties reported on disparities to access in several ways. One county reported that 40% of patients seen by Prevention and Early Intervention (PEI) therapists were from underserved cultural populations. Another county did not report actual figures but concluded that Latinos, Asians, and Pacific Islanders were “slightly under-represented” while African Americans, Native Americans, and people of multiple races were “slightly over-represented”. The next county reported that 92% of families in an FSP program for children received services in their primary language. Descriptive documents from 12 counties included information on this MHSA value. The most common information reported was the process undertaken by counties to outreach to underserved populations (including racial/ethnic groups; people who are Lesbian, Gay, Bisexual, Transgendered, or Questioning [LGBTQ]; people who are homeless; and different target populations by age). Altogether, findings from the high utility studies reflect trends of over-representation and under-representation in service access/use by race/ethnicity.^{vii} At the same time, the descriptive information indicates that MHSA is having an influence on this MHSA value by virtue of the fact that relatively many counties (over half the counties represented in this summary and synthesis) described their outreach and engagement activities.

Cultural Competency

There was a limited amount of evidence on the impact of MHSA on the MHSA value of cultural competency. There were no high utility studies on this MHSA value. Low utility studies from three counties reported on different constructs of cultural competency. One study reported that 92% of families in an FSP program for children received services in their primary language. The second study described how an MHSA program supported efforts by partner agencies to more effectively serve people from different cultural backgrounds. The third study reported on the cultural diversity of staff (measured by staff ethnicity and language proficiencies, for example) for the Workforce Education and Training component of MHSA. Descriptive documents on this MHSA value from 11 counties reported general information about staff trainings on various topics of cultural competency (e.g., LGBTQ issues), recruitment and hiring of bilingual and bicultural staff, and actions taken for greater outreach to certain racial/ethnic communities. Altogether, sufficient information was not available to assess the degree of impact that MHSA has had on the MHSA value of cultural competency.

Recovery/Resiliency and Wellness Orientation

The MHSA value of recovery/resiliency and wellness orientation potentially encompasses many concepts that could be evaluated or studied. The multiple domains reported by counties in evaluation studies and other documents reflect the varied aspects of recovery and the various ways in which this value is defined and ultimately measured. Four high utility studies for this MHSA value focused largely on “adverse effects” (i.e., one aspect of recovery) such as hospitalization and incarceration.^{viii} As summarized in a report of the impact of Community Services and Supports (CSS) on consumer outcomes, participation in CSS programs is strongly associated with reductions in homelessness, acute psychiatric hospitalizations, and arrests.^{ix}

Low utility reports from nine counties described similar outcomes, as well as outcomes on “quality of life” (i.e., another aspect of recovery) such as perceptions of wellbeing, satisfaction with life situations, and increasing protective factors. These reports, along with descriptive documents from 11 counties, also described recovery-oriented practices such as working with consumers to set life goals, providing diverse treatment options, offering choices, and providing individually-tailored services. Altogether, the evidence on the impact of MHSA on improving adverse effects is strong. However, sufficient information was not available to assess the degree of impact that MHSA has had on other aspects of recovery, resiliency, and wellness (e.g., meaningful and satisfying life changes as a result of recovery-oriented practices).

Integrated Mental Health Services

There was a limited amount of evidence on the impact of MHSA on the MHSA value of integrated mental health services. There was one high utility study that included information on this value; however, the reported findings were descriptive only, explaining that “nearly all” FSP programs evaluated connected consumers to primary care, substance abuse, dental, vision, and holistic therapy services, as well as housing and employment assistance and recovery-oriented programs such as peer-led groups. A low utility report from one county found that 20-61% of consumers in four FSP programs gained a primary care physician during program participation. Descriptive documents from four counties summarized their respective efforts to integrate mental health services into primary care; develop better referral systems for mental health; implement an evidenced based practice on depression into health clinics that serve primarily Latinos; and form collaborative agreements with health clinics and child development programs to integrate mental health and primary care services. Altogether, sufficient information was not available to assess the degree of impact that MHSA has had on the MHSA value of integrated mental health services.

Integration with Substance Abuse Services and Primary Care

There was a limited amount of evidence on the impact of MHSA on the MHSA value of integration with substance abuse services and primary care. There was one high utility study that included information on this value; however, the reported findings were descriptive only, explaining that “nearly all” FSP programs evaluated connected consumers to primary care and substance abuse. There were low utility documents from two counties. One county reported that average Level of Care Utilization System (LOCUS) scores for participants in the Co-occurring FSP program were reduced by almost 20%.^x Another reported that the percentage of consumers in four FSP provider sites who gained a primary care physician while in the program ranged from 20 to 61%. Descriptive documents from seven counties described county collaboration with public health departments and clinics, hiring mental health clinicians to assist primary care physicians, and integrating MHSA programming at sites that address substance abuse – particularly in a preventive manner (i.e., through PEI). Altogether, sufficient information was not available to assess the degree of impact that MHSA has had on the MHSA value of integrated mental health services with substance abuse and primary care services.

Community Partnerships and Systems Collaborations

There was a limited amount of evidence on the impact of MHSA on the MHSA value of community partnerships and systems collaborations. There were no high utility studies on this MHSA value. Low utility information was available from four counties that reported how PEI programming targets families in the child welfare system and the subsequent decline in re-referrals to the system; perceptions that collaboration has increased and collaborative partners have gained skills to improve collaboration and effect change; and level of consumer satisfaction with continuity of care. Descriptive documents from 11 counties offer general descriptions of the types of community partners that have been engaged (e.g., education, public health, juvenile justice, justice, housing, social services, media, faith-based organizations, and groups that represent unserved and underserved racial/ethnic populations), as well as the roles of those partners in collaboration efforts (e.g., co-locating staff in one another's agencies; serving as training partners; training staff in collaborative organizations). Altogether, sufficient evidence was not available to assess the degree of impact that MHSA has had on the MHSA value of community partnerships and systems collaborations.

Stakeholder Involvement throughout Public Mental Health System

There was one high utility study that addressed the MHSA value of stakeholder involvement throughout the public mental health system. Though the study overall was a high utility study, the information on stakeholder involvement was descriptive in nature. This study reported that all FSP programs within the county have "at least" two consumers employed at their respective sites and that "many" were hired with MHSA funds. Low utility reports from two additional counties contained information for this value. The first report described the success of a PEI program at doubling the number of residents both participating and assuming leadership positions in a community engagement project. The second report described how the county uses stakeholder input for data-driven program planning, implementation, and continuous quality improvement in partnership with the diverse communities it serves.

Descriptive documents from seven counties that included information on this MHSA value provided information about consumers being trained to lead peer support groups; being involved in steering committees and advisory boards; receiving media training to be spokespeople; attending conferences; assisting with advocacy and supports in homes and in the community; being employed at wellness centers; and no longer receiving disability benefits. Altogether, sufficient evidence was not available to assess the degree of impact that MHSA has had on the MHSA value of stakeholder involvement throughout the public mental health system.

Co-occurring Disorder Services Competency

There was a limited amount of evidence on the impact of MHSA on the MHSA value of co-occurring disorder services competency. There were no high utility studies on this MHSA value. Low utility reports from four counties presented disparate information such as baseline assessments of dual-diagnosis capability; the percentage (17-58%) of Full Service Partners who needed substance abuse treatment at intake who received it at follow-up; reduced LOCUS scores for Full Service Partners (on average by 20%); and key informant perceptions that MHSA programming has “increased agencies’ capacity to provide services to individuals with co-occurring disorders”. Descriptive documents from five counties reported the hiring of alcohol and drug counselors to programs based on the number of clients with co-occurring disorders and “lessons learned” about the importance of treating substance abuse alongside mental health issues. Altogether, sufficient evidence was not available to assess the degree of impact that MHSA has had on the MHSA value of co-occurring disorder services competency.

Discussion and Recommendations

Based on the findings and review process for this summary and synthesis, a discussion and supporting recommendations are provided for next steps and needed resources regarding evaluation of the impact of MHSA on MHSA values.

Discussion

Out of the large number of documents reviewed, there were few formal evaluations or studies that yielded high utility information for this summary and synthesis of the impact of MHSA on MHSA values. An earlier summary and synthesis of the impact of MHSA on CSS consumer outcomes also relied on relatively few formal evaluation studies or high utility information. It is therefore not surprising that we found a dearth of formal evaluation studies or high utility information specific to the impact of MHSA on MHSA values, because counties tend to focus their evaluation efforts on consumer-level outcomes rather than on a broader set of MHSA values covering multiple domains and levels (i.e., consumer, family, program, system, community). For instance, based on a recent PEI report, the local PEI evaluation plans are an example of counties’ tendency to focus on individual-level outcomes despite the fact that indicators of system and community change – critical cornerstones of prevention and early intervention – were required as part of the PEI evaluation.^{xi} In general, the focus on consumer-level outcomes means that evaluation resources are less so dedicated to studying program, system, and community level outcomes, which are largely consistent with how most MHSA values are defined.

The relatively large number of low utility and descriptive documents was insufficient in supporting a more substantive summary and synthesis because of several limitations in quality. In these documents, counties did not consistently report on the same indicators for each MHSA value. They did not always report the findings by age group or other important consumer demographics (e.g., race/ethnicity, gender). Counties did not always provide information on the data source (e.g., self-report, clinician rating). Oftentimes they did not provide specific timeframes for pre- and post-measurements. Sample sizes were not consistently provided for the analyses, and often there was no indication of whether the analyses included duplicated or unduplicated counts of consumers. Finally, the analytic methods used were not always clear in the presented results, and the reports typically were not accompanied by a narrative explaining and interpreting the findings.

Overall, both the limited quantity and quality of information hampered the ability to summarize and make definitive conclusions about the impact of MHSA on MHSA values across counties. The review of hundreds of documents produced a synthesis for only two of the nine MHSA values – one of which was based on an earlier review of the impact of CSS on consumer outcomes. In summary, MHSA is impacting the MHSA value of recovery/resiliency and wellness orientation by reducing acute psychiatric hospitalizations, homelessness, and arrests. Yet these outcomes, which focus on the reduction of adverse effects, represent one of many possible domains of recovery for which no standard definition exists. Therefore, a coherent synthesis on the full range of impact that MHSA is having on multiple domains of recovery is lacking.

Based on this current summary of available evidence, MHSA is impacting the MHSA value of reducing disparities in access by improving penetration rates for certain racial/ethnic groups (e.g., Latinos, Pacific Islanders, Vietnamese) in some counties. The evidence also suggests that over-representation (e.g., among African Americans) and under-representation (e.g., among Asians) by race/ethnicity remain in the public mental health system. These documented disparities are consistent with the literature on mental health services access/usage by race and ethnicity;^{xii} however, the full scale of MHSA's impact on increasing or decreasing these disparities cannot be surmised at this time given the limited quantity and quality of information available.

The abundant but disparate documentation of MHSA values indicates that there is indeed county activity related to all nine MHSA values. However, supporting evidence of this activity is less likely to exist in current evaluations or studies than in annual updates or other types of progress reports that typically describe program activities, successes, and challenges. In the future, as more PEI documentation from counties emerges, it may be a good source of information on the impact of MHSA on MHSA values such as reductions in disparities in access, integration of mental health services, community collaboration, cultural competence, and consumer and family engagement. Overall, the information currently available for this summary and synthesis was not sufficient to assess the extent to which MHSA is impacting all of the MHSA values, but it was adequate to conclude that there is focused activity among counties related to implementing MHSA programs in line with the values of MHSA.

Recommendations

- Focus future evaluations on program, system, and community level outcomes (e.g., staff competency, development of networks among service delivery systems, racial/ethnic disparities in outcomes) to understand the impact of MHSA on MHSA values. The MHSA values mostly target outcomes at these levels. However, county evaluations are typically less focused on these types of outcomes. Instead, there has been greater focus on consumer level outcomes such as symptomology and functioning.
- Dedicate resources to providing counties with technical assistance on how best to design evaluation studies; collect and analyze data; and report, disseminate, and utilize findings. For the evaluation of MHSA values, focus technical assistance on program, system, and community level evaluation, with an emphasis on study design and measurement for this type of study. For example, use network analysis to measure collaboration and integration. Network analysis is a method for assessing the type and nature of relationships among individuals, groups, and organizations. The technical assistance should be tailored to the existing capacity of counties so that smaller counties, for example, receive technical assistance that is customized to their needs.
- Focus resources on future evaluations of MHSA values in the area(s) that currently have the greatest potential for meaningful cross-county analysis. Based on this summary and synthesis, the MHSA value with the greatest potential is the reduction of disparities in access. Information to help understand disparities reduction is being collected – for example, the number and characteristics of individuals being targeted and/or served by prevention and early intervention efforts. This information should be analyzed and reported in a way that compares the number targeted and/or served against, for instance, the county population in order to understand the degree to which disparities have or have not been reduced for particular groups. Counties may need technical assistance and/or specific reporting requirements to achieve this.
- Utilize the forthcoming PEI evaluations for a future summary and synthesis of the impact on MHSA values. These evaluation studies hold the most promise for addressing outcomes at the program, system, and community levels; however, they are still likely to be heavily focused on consumer level outcomes. To maximize resources, consider a future summary and synthesis of PEI evaluations that simultaneously reviews the span of consumer level outcomes alongside program, system, and community level outcomes that are mainly relevant to MHSA values. Refine and/or develop reporting structures for these PEI evaluations to get the most appropriate and consistent information about MHSA values across counties.

End Notes

ⁱ Ward, K. J., & Yoo, J. (2011). *Evaluation brief: Summary and synthesis of findings on Community Services and Supports (CSS) consumer outcomes*. Los Angeles, CA: University of California Los Angeles Center for Healthier Children, Families & Communities.

ⁱⁱ These are nine values identified by the MHSOAC for the purpose of this summary and synthesis. The definitions of these values are based on the Mental Health Services Act.

ⁱⁱⁱ The full request was to submit information on the impact of MHSA programs on both consumer outcomes and MHSA values. Reports on the impact of CSS and PEI programs have been completed and submitted to the Mental Health Services Oversight and Accountability Commission (MHSOAC). This report summarizes and synthesizes the findings on the impact of MHSA on values.

^{iv} Key informants were identified in both large and small counties, including Butte, Los Angeles, Monterey, Napa, Placer, San Bernardino, San Francisco, San Luis Obispo, Santa Barbara, Stanislaus, and Sutter-Yuba.

^v In compliance with the contract language for this deliverable, existing evaluations and studies were sought and reviewed. Documents such as the counties' annual updates, which are not evaluation studies and are typically devoid of contextual information necessary to interpret the meaning or validity of outcomes presented, were not included in the summary and synthesis.

^{vi} Included in this count is an evaluation of FSPs throughout California: Scheffler, R., M., Felton, M., Brown, T. T., Chung, J., & Choi, S. (May 2010). *Evidence on the effectiveness of Full Service Partnership programs in California's public mental health system*. Berkeley, CA: Nicholas C. Petris Center on Health Care Markets and Consumer Welfare, School of Public Health, University of California, Berkeley. This report was referenced in the evaluation brief of CSS (see endnote i).

^{vii} Chow, J. C., Jaffee, K., & Snowden, L. (2003). Racial/ethnic disparities in the use of mental health services in poverty areas. *American Journal of Public Health, 93*(5), 792-797. Snowden, L. R., & Cheung, F. K. (1990). Use of inpatient mental health services by member of ethnic minority groups. *The American Psychologist, 45*(3), 347-55.

^{viii} This article describes several major domains of outcome measurement for mental health programs: McGlynn E.A. (1996): Setting the context for measuring patient outcomes. *New Directions in Mental Health Services, 71*:19-32. The domains referenced in this summary are based on this article.

^{ix} Ibid i.

^x The LOCUS provides an objective measure to help determine service needs and to measure progress toward treatment outcomes.

^{xi} Yoo, J., & Ward, K. J. (2011). *Evaluation report: Summary and synthesis of Prevention and Early Intervention (PEI) evaluations and data elements*. Los Angeles, CA: University of California Los Angeles Center for Healthier Children, Families & Communities.

^{xii} Ibid vi.

Appendix A

List of Documents Reviewed

County	Documents Submitted by County	Documents Downloaded from County Website
Alameda	<ul style="list-style-type: none"> • Bonita House, Inc. HOST Adult Full Service Partnership Program Outcomes June 2006 to December 2010 	<ul style="list-style-type: none"> • Utilization Data Series (June 26, 2005) on Prevalence Estimates • Original Prevalence Data Table • Enrollment and Demographic Information Form (EDIF)
Alpine		
Amador		
Berkeley City	<ul style="list-style-type: none"> • FY09-10 Annual Update Exhibit C • FY08-09 Implementation Progress Report Exhibit C1 of FY10-11 Annual Update • CSS Implementation Progress Report 2006 • MHSa Implementation Progress Report 2007 • CSS TAY Support Team FY08-09 and 09-10 Program Outcomes 	
Butte	<ul style="list-style-type: none"> • January 2011 Report on Intensive Service Users • February 2011 Report on Intensive Service Users • March 2011 Report on Intensive Service Users • Systems Performance Report September 2010 • Systems Performance Report October 2010 • Newsletter April 2010 (Volume 1, Issue 1) • Newsletter July 2010 (Volume 1, Issue 2) • Newsletter August 2010 (Volume 1, Issue 3) • Newsletter October 2010 (Volume 1, Issue 4) • Newsletter January 2011 (Volume 2, Issue 1) 	
Calaveras	<ul style="list-style-type: none"> • MHB Annual Report 2007 (draft) • MHB Annual Report MHSa Section FY08-09 • BHS Bulletin Spring 2011 • BHS Bulletin 2007 	
Colusa		
Contra Costa		<ul style="list-style-type: none"> • Contra Costa County Older Adult Mental Health Improving Mood: Providing Access to Collaborative Treatment (IMPACT) Program

Appendix A

List of Documents Reviewed

County	Documents Submitted by County	Documents Downloaded from County Website
(Contra Costa, cont'd)		<ul style="list-style-type: none"> • Summary and outcomes • MHSa CSS Report of Outcomes and Activities FY09-10
Del Norte		<ul style="list-style-type: none"> • Implementation Progress Report CSS Plan (July 2008)
El Dorado		<ul style="list-style-type: none"> • MHSa Update (PowerPoint presentation)
Fresno		<ul style="list-style-type: none"> • FY11-12 Annual Update Executive Summary • Fresno County Department of Behavioral Health Mental Health System Performance Review (2010) • Co-Occurring FSP Outcomes • Assertive Community Treatment (ACT) Outcomes: Children & TAY • Intensive Community Services and Support Team (ICSST): Adult & Older Adults • Integrated Mental Health: Adult FSP • Rural FSP: Adults & Older Adults • TAY Mental Health Services and Supports • Table listing days per outcome area for FSP programs
Glenn		
Humboldt		<ul style="list-style-type: none"> • TAY Collaboration First Year Evaluation • TAY Collaboration Second Year Evaluation
Imperial		
Inyo		<ul style="list-style-type: none"> • MHSa 2007 Implementation Progress Report
Kern		<ul style="list-style-type: none"> • Annual Report to the Board of Supervisors (2009)
Kings		
Lake		
Lassen		<ul style="list-style-type: none"> • Newsletter (2009, Volume 1, Issue 2): "Full Service Partnership Success Story"

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
Los Angeles	<ul style="list-style-type: none"> • Child FSP Client Satisfaction Survey (2009) • Child FSP Performance Evaluation Report (2010) • FSP Cost Avoidance Analysis • Annualized Living Arrangement Summary by Program for Adults • FCCS-TAY Residential Status 18-month Update (table) • FCCS-TAY Residential Status 24-month Update (table) • FCCS-TAY 6, 12, 18, 24-month updates (separate tables on outcomes other than residential status) • MHSA Successes in LA: Perspectives on Recovery and Resiliency (PowerPoint presentation) • MHALA MHSA Outcomes (tables) 	<ul style="list-style-type: none"> • MHSA Transformation Publication (2010)
Madera		<ul style="list-style-type: none"> • MHSA Early Implementation Study of CSS in Seven Counties
Marin	<ul style="list-style-type: none"> • FY10-11 Annual Update, including 9 enclosures 	<ul style="list-style-type: none"> • Family Partnership Needs Survey Analysis 2007
Mariposa		
Mendocino		
Merced		
Modoc		
Mono		
Monterey	<ul style="list-style-type: none"> • Nov 2008 Qualitative Data (PowerPoint presentation) • CSS FY08-09 Demographic Data • Monterey County System of Care Indicators and Evaluation Information (FY05-08) • May 2009 Behavioral Health presentation (PowerPoint presentation) • Monterey County Health Profile 2009: Behavioral Health • Mental Health Commission Presentation (Power Point presentation) 	<ul style="list-style-type: none"> • FY09-10 Annual Update • FY10-11 Annual Update • Outcomes for Children & Youth Receiving Mental Health Services (2008) • MHSA Fact Sheet (Winter 2007) • SOC Annual Evaluation Report (2008) • SOC Consumer Profile & Child and Family Outcome Studies (2009)
Napa		

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
Nevada	<ul style="list-style-type: none"> • EQM Families First Nevada (wraparound) 6-month Report (January 2010) • EQM Families First Nevada (wraparound) 6-month Report (January 2011) • EQM Families First Nevada (wraparound) 6-month Report (June 2011) • Nevada Report on FF Wraparound Services (February 2011) • July 2010 Report • September, October, and November 2010 Report • December 2010 Report • January 2011 Report • February 2011 Report • Final TPPC Report (April 2010) • New Directions Program Outcomes (July 2009 – May 2010) • FY09-10 Victor Community Support Services Outcome Summary • Turning Point Community Programs Report Card (April 2010) • SPI Talking Points (February 2010) • Outcomes Report_Revised_2011 	
Orange	<ul style="list-style-type: none"> • Orange County FSP Data Review (PowerPoint presentation) • Adult FSP Monthly Progress Report (table) • AMHS-MHSA Data and Outcome Measures (PowerPoint presentation) • Veterans Data (December 2009) • Measuring Consumer Attitudes Toward Education and Work at FSP (PowerPoint presentation) • Adult and Older Adult FSP Survey Instrument 2010 • UCLA Integrated Substance Abuse Program – Site Visit of Telecare/FSP Report and Graphs 	

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
(Orange, cont'd)	<ul style="list-style-type: none"> • UCLA Integrated Substance Abuse Program – Site Visit of Court & Choices Report and Graphs • Centralized Assessment Team (CAT) Reporting Map • CAT Diversions and Hospitalizations Report Table • CAT Evaluation (instrument) • CAT Follow-Up Linkage Form (instrument) • CAT Database (PowerPoint presentation) • Crisis Residential Data Table • Goodwill Data Table • Outreach & Engagement (O&R) Database by APOD (PowerPoint presentation) • O&R Contact Record (instrument) • CYS O&R Contact Record (instrument) • Outreach Reporting map • O&R Contacts and Linkages Report • Recovery Centers (RC) Contract Centers Data Definitions • RC Data Table • Adult & Older Adult Performance Measurement Department graphs (PowerPoint presentation) • Wellness Center Database (PowerPoint presentation) • Wellness Center Membership and Demographic Summary 	
Placer		
Plumas		
Riverside	<ul style="list-style-type: none"> • 4 Report Cards for FSP Programs (July 2006 – March 2010) • Report for Adult-MHSA Integrated Service Recovery Centers • Report for TAY MHSA Integrated Service Recovery Centers 	
Sacramento		<ul style="list-style-type: none"> • FY07-08 Mental Health Division 4th Quarter Dashboard • FY06-07 Intensive Service Teams Review

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
(Sacramento, cont'd)		<ul style="list-style-type: none"> • 2007 Cultural Competency Final Report • 2008 ACCESS Satisfaction Report • 2008 Network Provider Satisfaction Report • 2006 Cultural Competence Agency Self-Assessment • REPO Adult Outcomes (November 2008) • REPO Children Outcomes (November 2008) • REPO Older Adult Outcomes (November 2008) • FY07-08 REPO Annual Adult Outcomes • FY07-08 REPO Annual Child Outcomes • Pathways FSP Annual Report (December 2009) • Sierra FSP Annual Report (December 2009) • Transcultural Wellness Center Annual Report (December 2009) • Full Service Partnership Annual Report (December 2009)
San Benito		
San Bernardino	<ul style="list-style-type: none"> • San Bernardino County Foster Care Report Response • San Bernardino Dashboard on Mental Health and FSP Services • PEI Annual Program Analysis SAP FY10-11 • Reach Out Progress Report 2010-2011 • Rim Family Services Progress Report 2010-2011 • SBCSS Progress Report 2010-2011 • South Coast Progress Report 2010-2011 • Valley Star Progress Report 2010-2011 • Victor Progress Report 2010-2011 • Summary of Basic Outcome Indicators at First Year of FSP Partnership • Component Report – CCFSS • Component Report – CCRTCWIC • Component Report – Diversion 	

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
(San Bernardino, cont'd)	<ul style="list-style-type: none"> • Component Report – Forensic • Component Report – Homeless • Component Report – INFO • Component Report – Innovation • Component Report – PEI • Component Report – TAY • Component Report – Telecare MAPS • Component Report – WET • Component Report – Agewise 	
San Diego		<ul style="list-style-type: none"> • Effect of Full Service Partnerships on Homelessness (Gilmer, et al., 2010) • MHSA FSP Outcomes Assessment (2005) • San Diego County Update on Five Years of MHSA Transformation (Gilmer, et al.) • FY08-09 Children’s Mental Health Services Systems & Clinical Outcomes (CASRC Report) • FY08-09 Adult / Older Adult Mental Health Annual System of Care Report • MHSA Annual Housing Plan Update (July 2009)
San Francisco	<ul style="list-style-type: none"> • MHSA Five Year Report on Full Services Partnerships (Prentiss, et al.) • FSP Graduation Brief Process Report (2011) 	
San Joaquin		
San Luis Obispo		
San Mateo		
Santa Barbara		
Santa Clara		
Santa Cruz		
Shasta	<ul style="list-style-type: none"> • FSP Programs Report (December 2006 – January 2011) • Urgent Care Report • Wellness Center Quarterly Report (October – December 2010) 	

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
Sierra		
Siskiyou		
Solano		<ul style="list-style-type: none"> • FY08-09 County Health and Social Services Annual Report • FY09-10 MHSA CSS & PEI Data Report • MHSA Update to Local Mental Health Board (October 2010) • MHSA Update to Local Mental Health Board (November 2010)
Sonoma	<ul style="list-style-type: none"> • Community Intervention Program (CIP) Evaluation Brief (April 2009) • FSP Evaluation Brief (April 2009) • Sonoma Housing Needs Assessment Draft (May 2009) • Sonoma MHSA Evaluation Framework Draft (February 2011) 	<ul style="list-style-type: none"> • MHSA Status Report (December 2010)
Stanislaus	<ul style="list-style-type: none"> • 10 MHSA CSS Exhibits – Estimated/Actual Population Served (2006 – 2010) • 9 MHSA CSS Demographic Reports (2007 – 2010) • 5 FSP Outcome Reports • 5 Consumer Satisfaction Survey Reports • FY09-10 Annual Update • FY10-11 Annual Update • MHSA –CSS Implementation Progress Report (2007) • MHSA – CSS Implementation Progress Report (2006) • MHSA Annual Update FY10-11 PowerPoint presentation used at Representative Stakeholder Meeting (January 2010) • Representative Stakeholder Steering Committee Meeting Learning and Feedback Form (February 2011) 	<ul style="list-style-type: none"> • BHRS-funded AOD Data Charts (January 2011) • Summary of 09-10 Data for AOD Programs • AOD Data Packet 2010 • Stanislaus County Behavioral Health and Recover Services MHSA Representative Stakeholder Steering Committee Handout #1 (February 2011)
Sutter- Yuba		
Tehama		

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
Tri City		
Trinity		
Tulare		<ul style="list-style-type: none"> • MHSA Implementation Progress Report (2007)
Tuolumne		
Ventura	<ul style="list-style-type: none"> • Ventura Pacific Clinics Adult Wellness Recover Center (2009) • Family Access & Support Team (FAST) – Provider: United Parents • FAST Presentation to Community Leadership Team (January 2010) • FSP Quarterly Report (October 2010) • FSP Key Event Tracking • FSP Partnership Assessment without Residential Report • Children’s Outreach and Engagement Project Fillmore/Piru Community Leadership Presentation • MHSA Outreach and Engagement Program: Project Esperanza • Ventura County Behavioral Health Outreach Event Report (February 2011) • PAC Clinics TAY Life Domain Outcomes • Recovery Innovations of California Report of Services to Community Leadership Committee (September 2009) • Recovery Innovations California First Quarter Report (FY10-11) • Recovery Innovations California End of Year Report (FY09-10) • Outreach to African American Youth and Families – St. Paul Baptist Church • Ventura County Outcomes System Non-Standard Self Report for TAY • Ventura County Outcomes System Non-Standard Worker Report for TAY • TAY Contact Log (February 2011) 	

Appendix A

List of Documents Reviewed

County	CSS Documents Submitted by County	MHSA Documents Downloaded from County Website
(Ventura, cont'd)	<ul style="list-style-type: none">• TAY Outreach Log (February 2011)• Ventura County Outcomes System: Adult Self-Report• Ventura County Outcomes System: Preschool Parent• Ventura County Outcomes System: Worker Report	
Yolo		

Appendix B

Number of Counties Reporting Information for Each MHSA Value

Number of Counties Reporting Information for Each MHSA Value*			
MHSA Value	# of Counties Reporting High Utility Information	# of Counties Reporting Low Utility Information	# of Counties Reporting Descriptive Information
1. Client and family involvement and engagement	0	0	4
2. Disparities in access and outcomes	2	3	12
3. Cultural competency	0	3	11
4. Recovery/wellness/resiliency orientation	4	9	11
5. Integrated mental health services	1	1	4
6. Integration with substance abuse services and primary care	1	2	7
7. Community partnerships and systems collaborations	0	4	11
8. Stakeholder involvement throughout the public mental health system	1	2	7
9. Co-occurring disorder services competency	0	4	5

*Counts across high utility, low utility, and descriptive documents are not necessarily mutually exclusive. That is, a county who reported high utility data for a particular MHSA value may have also reported low utility and/or descriptive data for that same value.