

**Mental Health Services Act Evaluation:
Initial Statewide Priority Indicator Report
Contract Deliverable 2E, Phase II**



UCLA Center for Healthier Children, Youth and Families



EMT Associates, Inc.

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The following report was funded by the
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INVITATION: Stakeholder Feedback

As with all deliverables related to this contract, comments from stakeholders, including the mental health service community at large are invited in response to this draft report to ensure that the report reflects a balanced representation of the system and its consumers. The UCLA-EMT Evaluation Team welcomes general comments and responses to this report the accompanying guidance document located at the following link:

https://acsurvey.qualtrics.com/SE/?SID=SV_3ZXXq73kNvERClE

Given the large number of readers who will review this report, we ask for concise feedback that will help the evaluation team revise. The team would greatly appreciate comments about the following topics:

- What indicators do you find more instructive, and why?
- What indicators do you find least instructive, and why?
- Analysis and Reporting Questions
 - Do you have suggestions for alternate ways of computing specific indicators presented in this report? Please provide explanation.
 - Do you have suggestions for alternate ways of presenting specific indicators presented in this report? Please provide explanation.
- Implications
 - Do the indicators presented in this report provide an accurate representation of consumer outcomes? If no, please explain.
 - Do the indicators presented in this report provide an accurate representation of mental health system performance? If no, please explain.
- General Comments

The feedback period will close on Tuesday, August 28. Following the close of the feedback period, the evaluation team will incorporate, where possible, or note feedback in a revised, final report – a statewide evaluation of the priority indicators for the Mental Health Service Act (MHSA). This statewide evaluation report, updated with stakeholder input, will serve as an initial effort to move toward ongoing monitoring of system performance focused on improving quality of the mental health system.

The Evaluation Team thanks you in advance for your insights.

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OVERVIEW

In 2004, California voters approved Proposition 63 – referred to as the Mental Health Services Act (MHSA) – which was set forth to meet the following five broad goals using prevention and early intervention programs:

- (a) *Define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care.*
- (b) *Reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness.*
- (c) *Expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations. These programs have already demonstrated their effectiveness in providing outreach and integrated services, including medically necessary psychiatric services, and other services, to individuals most severely affected by or at risk of serious mental illness.*
- (d) *Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure. State funds shall be available to provide services that are not already covered by federally sponsored programs or by individuals' or families' insurance programs.*
- (e) *Ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices subject to local and state oversight to ensure accountability to taxpayers and to the public.¹*

Thus, the MHSA is a multi-faceted approach to consumer wellness and improved mental health system functioning that fosters innovative programs, mental health awareness, and effective treatment. The approach is sustained by state funding, and monitored and improved through ongoing evaluation.

The current report contributes to ongoing MHSA evaluation through improving measurement of outcomes at the consumer and system levels. The Mental Health Services Act Oversight and Accountability Commission (MHSOAC) charged the UCLA-EMT Evaluation Team with exploring impacts of the MHSA on California's mental health service system and its consumers. Part of this effort is achieved by assembling several years of consumer intake, service, and consumer satisfaction responses to document and assess mental health consumer outcomes and system performance during the past several years. The goal of the current report is to document the MHSA's impact on the system and its consumers using existing data, which has been arranged into target outcomes (referred to as *priority indicators*) that are of particular interest to the MHSOAC and mental health service stakeholders.² Per contract language, the evaluation team is to:

¹ Text retrieved on December 20, 2011 from The California Department of Mental Health web site, located at http://www.dmh.ca.gov/Prop_63/mhsa/docs/Mental_Health_Services_Act_Full_Text.pdf.

² *Stakeholder* is broadly defined in the evaluation. Stakeholders include consumers (clients), consumers' family members, persons with "lived experience," data analysts, service providers, mental health service organization staff and leadership, and any person with a vested interest in mental health systems.

Design and complete statistical analyses and reports that measure impact of MHSA at individual and system levels on indicators specified in the Matrix of California's Public Mental Health System Prioritized Performance Indicators at the state and county levels. Draft templates, documentation of analysis, and initial statewide reports will be circulated to key stakeholders and made available to the public for input by posting on the web and making a hard copy available upon request.

Individual client outcomes for full service partnerships (FSPs) by age group must be addressed for each domain (education/employment, homelessness/housing and justice involvement) as specified. Note: this impact analysis at the individual level is limited to available data (i.e., a small segment of public mental health clients, full services partners, is reflected in this data.) Mental Health system performance must address family/client/youth perception of well-being, demographics of FSP population, FSP access to primary care, penetration rate and changes in admissions for the entire public community mental health population, involuntary care, and annual numbers served through CSS. (Workforce indicators will not be addressed through this RFP.)

The priority indicators (referred in the above, italicized contract language as *prioritized performance indicators*) are the key to the current evaluation; they were designed to assess how the MHSA has impacted mental health consumers and the mental health system in target areas that should be most changed through implementation of MHSA.

The process by which priority indicators were developed can be reviewed in earlier reports available (http://healthychild.ucla.edu/MHSA_evaluation.asp). Advice from stakeholders was adapted and this report examines if these adapted indicators provide meaningful information. This report provides additional information on other potential indicators to determine if they add useful and critical information. Decisions have not been made to change the previously approved priority indicators. As such, this report represents a fundamental step in an ongoing process to refine and potentially develop priority indicators that are not only measurable but useful to the variety of stakeholders invested in this work.

Priority indicator development was a joint effort between the California Mental Health Planning Council, MHSOAC, stakeholders, and the evaluation team. The evaluation team facilitated discussions between interested stakeholders to create the strongest, most comprehensive representations of priority indicators that both aligned with early conceptualizations and feedback using the data that was already collected across the state with some regularity. Where gaps existed, the evaluation team proposed new data collection that will improve future evaluation, but is beyond the evaluation team's current scope of work. Details of the priority indicator development process are provided in the Background and Methods sections, below.

Background

The evaluation team completed fundamental groundwork before arriving at this report. To date, the team has documented evaluation planning in four reports:

- *Defining Priority Indicators* – Identifies and defines priority indicators, through exploration of the indicators proposed by the California Mental Health Planning Council¹ to assess target outcomes of mental health consumers and the performance of the mental health system.
- *Defining Priority Indicators (revised)* – The initial report was revised to include information regarding the comprehensiveness and appropriateness of indicators, gather through a two-phase stakeholder feedback process. First, the initial report was posted to UCLA and MHSOAC web sites for public review. The team welcomed general comments through an open call for

feedback. A guidance document that included specific questions regarding the initial report's content and accessibility was also included with the report to aid review. In the revised report, the evaluation team illustrated how stakeholder feedback was integral to indicator development. Further, the team requested that readers alert their peers and clients to the report to broaden the diversity of feedback. Second, the evaluation team hosted online orientations to the report (webinars) with two stakeholder groups further explaining the report's purpose and the type of feedback sought. The call for feedback was open for just over four weeks.

- *Compiling Data to Produce all Priority Indicators* – Proposes measurement methods for priority indicators and how they can be computed/calculated primarily utilizing existing data. The report also details potential data sources and specific variables or data fields, which can be utilized to build comprehensive indicators of mental health consumer outcomes and system performance.
- *Compiling Data to Produce all Priority Indicators (revised)* – The initial report was revised to include information regarding measurement methods and the adequacy of existing data sources, gathered through a similar stakeholder feedback process to that which followed the *Defining Priority Indicators* report (i.e., public dissemination, accompanying report feedback guidance document, presentations, webinars).

The current report takes another step to document statewide priority indicator development through the initial analysis of existing data for fiscal years 2008-09 and 2009-10. Through the analysis process, some proposed data sources or methods of indicator calculation, put forward in previous reports by stakeholders and the evaluation team, were found to not be feasible or meaningfully analyzable, due to limitations of data formatting or availability. Priority indicator learning and development leading up to the current report are detailed in Appendix E.

The following table outlines priority performance indicators modified by the stakeholder review process. Given the current status of data, not all indicators were possible for this report. These challenges are explained throughout the document.

Table 1. Priority Indicators

CONSUMER-LEVEL INDICATORS	CONSUMERS EVALUATED				
	SERVICE POPULATION	CHILDREN	TAY	ADULTS	OLDER ADULTS
Domain 1: Education/ Employment					
<i>Indicator 1.1. Average school attendance per year</i>	All Consumers	x	x		
<i>Indicator 1.2. Proportion Participating in Paid and Unpaid Employment</i>	FSP Consumers		x	x	x
Domain 2: Homelessness/Housing					
<i>Indicator 2.1. Homelessness and Housing Rates</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 2.2. Proportion housed/ not homeless annually</i>	All/FSP Consumers	x	x	x	x
Domain 3. Justice Involvement					
<i>Indicator 3.1. Arrest Rate</i>	FSP Consumers	x	x	x	x
<i>Indicator 3.2. Proportion Incarcerated</i>	All/FSP Consumers	x	x	x	x
Domain 4. Emergency Care					
<i>Indicator 4.1. Emergency Intervention for Mental Health Episodes</i>	All Consumers	x	x	x	x

<i>Indicator 4.2. Emergency Intervention for Co-occurring Physical Injury</i>	n/a				
Domain 5. Social Connection					
<i>Indicator 5.1. Proportion Who Identify Family Support</i>	n/a				
<i>Indicator 5.2. Proportion who Identify Community Support</i>	n/a				

SYSTEM-LEVEL INDICATORS	CONSUMERS EVALUATED				
	SERVICE POPULATION	CHILDREN	TAY	ADULTS	OLDER ADULTS
Domain 6. Access					
<i>Indicator 6.1. Demographic Profile of Consumers Served</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 6.2. Demographic Profile of New Consumers</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 6.3. Penetration of Mental Health Services</i>	All Consumers	x	x	x	x
<i>Indicator 6.4. Access to a Primary Care Physician</i>	FSP Consumers	x	x	x	x
<i>Indicator 6.5. Consumer / Family Perceptions of Access to Services</i>	All Consumers	x	x	x	x
Domain 7. Performance					
<i>Indicator 7.1. FSP Consumers Served Relative to Planned Service Targets</i>	FSP Consumers	x	x	x	x
<i>Indicator 7.2. Involuntary Status</i>	All Consumers	x	x	x	x
<i>Indicator 7.3. 24-Hour Care</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 7.4. Consumer and Family Centered Care</i>	All Consumers	x	x	x	x
<i>Indicator 7.5. Integrated Service Delivery</i>	FSP Consumers	x	x	x	x
<i>Indicator 7.6. Consumer Wellbeing</i>	All Consumers	x	x	x	x
<i>Indicator 7.7. Satisfaction</i>	All Consumers	x	x	x	x
Domain 7. Structure					
<i>Indicator 7.1. Evidence Based or Promising Practices and Programs</i>	FSP Consumers	x	x	x	x
<i>Indicator 7.2. Cultural Appropriateness of Services</i>	FSP Consumers	x	x	x	x
<i>Indicator 7.3. Recovery, wellness, and Resilience Orientation</i>	FSP Consumers	x	x	x	x

The report is organized by the following topics:

1. A description of methods used, including data sources, limitations, and data preparation procedures
2. Priority indicator analyses and findings
3. Discussion and implications of priority indicator findings
4. Next steps for the evaluation

METHODS

Priority indicators presented in the current report – built upon the California Mental Health Planning Council’s indicator proposal and approved by the MHSOAC² – were further developed through consideration of MHSOAC needs and goals, assessment of existing state and county data sources, and their measurement quality. Revised priority indicators were disseminated for

stakeholder feedback.³ As directed by the MHS AOC, priority indicators were created using existing data sources that are systematically collected and reported by California counties, the California Department of Mental Health (DMH), and other state institutions or offices.

Data Sources

Client & Service Information (CSI)

The CSI system is a repository of county, client (e.g., age, gender, preferred language, education, employment status, living arrangement, etc.), and service information (number and length of service contact). The data is collected from all consumers who receive mental health services, including consumers involved in the Full Service Partnership.

Data Collection and Reporting (DCR) System

The DCR system houses data for consumers who are served through Full Service Partnership programs. Data from assessments – the Partnership Assessment Form (PAF), Key Event Tracking (KET), and Quarterly Assessment (3M) – are collected for consumers in specific age categories. The PAF reflects consumer history and baseline information, including consumer education and/or employment, housing situation, legal issues, health status, and substance use. The KET reflects any important changes in the consumer’s life such as housing, education and/or employment, and legal issues during full service partnership. The 3M is used to collect information quarterly on key areas such as education, health status, substance use, and legal issues.

Performance Outcomes and Quality Improvement (POQI) – Consumer Perception Surveys (CPS)

These consumer surveys are customized for consumer groups (e.g., youth, adults, and older adults) with access to mental health services. Instruments are composed of widely validated measures such as the Child Behavior Checklist, Youth Self Report, and Restrictiveness of Living Environment Scale for youth assessment; the Global Assessment of Functioning, Behavior and Symptom Identification Scale, and the California Quality of Life for adults; and the Brief Symptom Inventory, Senior Outcomes Checklist 10, and Index of Independent Activities of Daily Living for older adults. The data, designed to inform treatment planning and service management, are collected from individuals with “serious, persistent” mental illness who have received services for 60 days or more and are not categorized as “medication only.” For FY 2008-09 and prior years, a convenience sampling approach was used wherein county level mental health service providers administered surveys twice a year for a two-week period, in early May and November. Investigation of the convenience sampling methodology revealed the resulting information was not representative of the larger mental health service population.⁴ Beginning with FY 2009-10, representatives at the Institute for Social Research at California State University at Sacramento designed a random sampling methodology intended to produce data that is more representative of the perceptions of the mental health service population. The random sampling method is currently under evaluation. As such comparisons of CPS data between fiscal years cannot be made.

County MHS A Plans & Annual Updates

- **Three Year Plans & Annual Updates**

Counties are mandated to report Three-Year Program and Expenditure Plans and Annual Updates to plans. Three-Year Program and Expenditure Plans and Annual Updates for FYs 2008-09 and 2009-10 were systemically reviewed for information regarding county planned or

administered services, relevant to specific priority indicators, including:

- Consumer Served through CSS
- Client and Family Centered Care
- Integrated Service Delivery
- Evidence Based Practices and Programs
- Recovery Wellness, and Resilience Orientation

The evaluation team coded planning or service activity information for relevance to each domain. This coding process provided for descriptive analysis of differences in planned or implemented service strategies statewide.

- **Workforce, Education and Training (WET Plans)**

Approved Workforce Education and Training (WET) Components of the Mental Health Services Act Three-Year Program and Expenditure Plans were available for fifty-three counties. WET plans were reviewed and coded for information regarding the following Priority Indicators:

- Cultural Appropriateness of Services
- Recovery Wellness, and Resilience Orientation

This coding process provided for descriptive analysis of county efforts to address the shortage of qualified individuals to provide behavioral health care services.

Other Sources

- **Estimates of Need for Mental Health Services**

To achieve a standardized rate for penetration of services across all counties, the evaluation team contracted with Dr. Charles Holzer for statewide and county mental health service need estimates. Dr. Holzer previously developed penetration rate estimates for the California Department of Mental Health. Specifically, he applied predicted probabilities from demographic models to cross-tabulations of Census population estimates. Holzer estimated the probability of persons with serious mental illness using data from the National Comorbidity Survey Replication and generated prevalence data estimates for several Census years and used the most up-to-date National Comorbidity Survey data. (For additional information regarding prevalence estimate methodology see Dr. Holzer's website at http://66.140.7.155/estimation/3_Synthetic/synthetic.htm).

- **Involuntary Status**

- *Involuntary Status* information (FY 2008-09) was provided by DMH for the following service categories: 72 hour Evaluation and Treatment (Adults, Children); 14 and 30-day Intensive Treatment; 180-day Post Certification Treatment; and Temporary and Permanent Conservatorships. Involuntary status data for FY 2009-10 was not available from DMH as of the preparation of this report.

Data Review & Verification Processes

Initial Review

To assess the quality and completeness of existing data sources, descriptive analysis was conducted to explore the distribution of quantitative data fields and variation in qualitative (e.g., narrative) information, between fiscal years, within counties, and across the state. This allowed the evaluation team to work collaboratively with DMH representatives and county staff to explain unusual data patterns (e.g., variation in completeness of information year to year, or differences in reporting formats). The team maintained contact with key DMH staff and several county representatives (e.g.,

Evaluation Advisory Group Members) throughout the analysis process, troubleshooting data irregularities and limitations as necessary.

The review process also included merging consumer level data files from various sources to determine the completeness of cases—whether a consumer’s information could be considered complete across data sources and the target fiscal years (i.e., FY 2008-09 and 2009-10).

Data Quality Assurance Reports

Substantial variation (values and reporting patterns) was found between counties, within CSI and DCR data fields identified for constructing priority indicators, during the data review period. These findings, in addition to stakeholder feedback to our previous report about identifying data sources for the statewide MHSA evaluation (see *Mental Health Services Act Evaluation: Compiling Data to Produce All Priority Indicators*, November 2, 2011), demonstrated a need for the evaluation team to provide county representatives an opportunity indicate the quality of key data and contextual information needed for analysis, interpretation, and decisions based on this data.

The evaluation team provided MHSA coordinators and mental health service directors, within each county and municipality with CSI or DCR data in state databases, with a Data Quality Assurance Report on April 9, 2012. Reports displayed basic descriptive information for each CSI and DCR data field the evaluation team previously identified as useful for constructing priority indicators. County representatives had the option of indicating and explaining data quality online or by annotating the report directly and returning it to the evaluation team.

Twenty-eight counties and municipalities provided responses within six weeks of receiving their Data Quality Assurance Report (see Appendix A for counties represented in the report). Responding counties represented a broad cross-section of the state (see Figures 1-3, below). Responding counties represent a majority of the state population, account for substantial proportions of most MHSA regions, and represent the racial and ethnic diversity of the state (see Figures 1-3). For additional descriptive analysis of counties responding to Data Quality Assurance Reports, see Appendix B.

Figure 1. Population of Counties Responding/Not Responding to Data Quality Assurance Reports

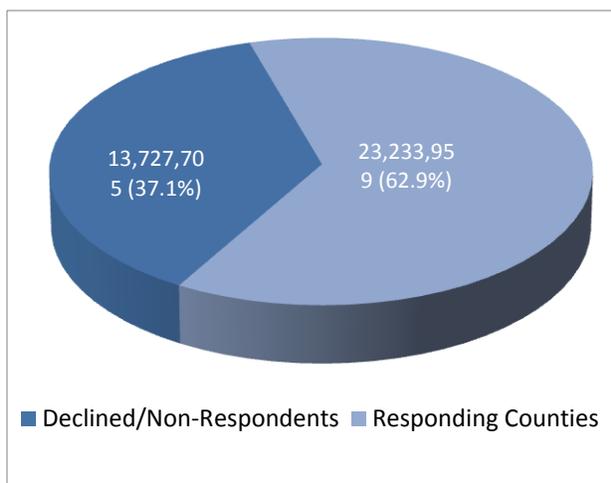


Figure 2. Counties Responding/Not Responding to Data Quality Assurance Reports, by Region

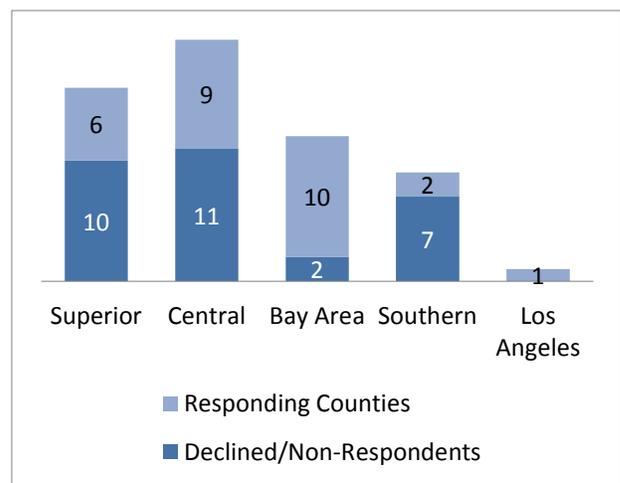
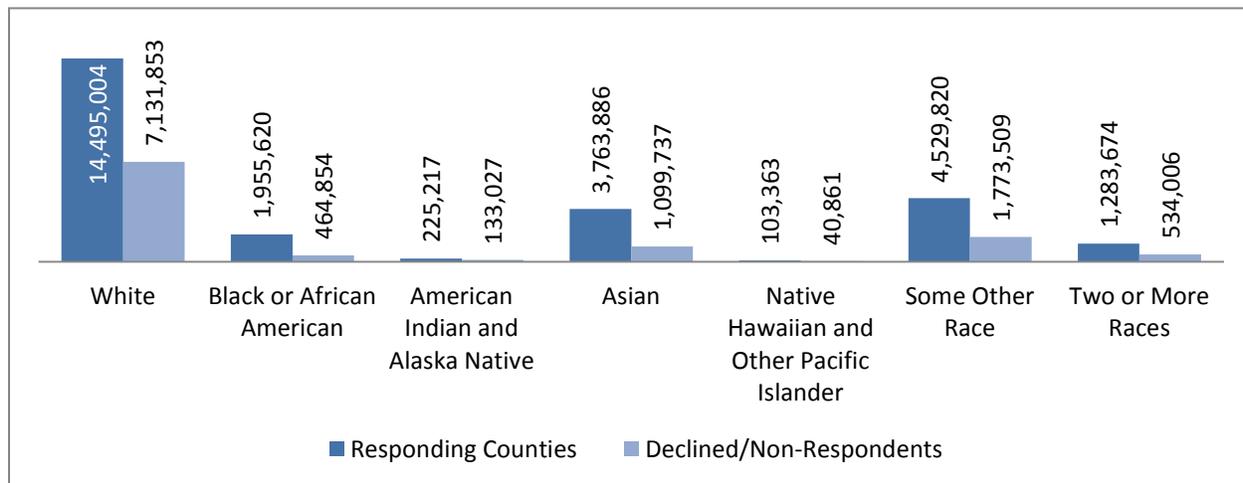


Figure 3. Race Dispersion of Counties Responding/Not Responding to Data Quality Assurance Reports



Stakeholder feedback to previous reports identifying data sources for the statewide MHSA evaluation and to the county-specific Data Quality Assurance Reports was generally consistent. Responses across responding counties indicated that the majority of fields were accurate, however few fields, such as Race and Ethnicity, received much more inconsistent evaluations of accuracy. Data quality evaluations received from a cross-section of the state greatly influenced the data sources and data fields utilized, as well as the analysis and reporting decisions of the evaluation team. The data review and verification process impacts this report most notably, as priority indicators utilizing CSI or DCR data are presented separately in the findings summary for counties who “verified” the accuracy of data underlying each priority indicator, and are reported in Appendix C for those who did not. To note, although county representatives may verify its county’s data, only some of the data may be deemed useful for inclusion in calculations for a given priority indicator.

Data Considerations & Limitations

Overall, comparisons presented between and across fiscal years must be interpreted with caution due to the completeness, reliability, and quality issues summarized above, and detailed in the remainder of this section.

Missing / Unknown Data

All quantitative data sources and specific data fields utilized to compile priority indicators contained some level of missing (e.g., no data reported) or unknown (e.g., data provided does not conform to data system dictionaries) information. For indicators computed with underlying data containing a substantial proportion of missing or unknown information (i.e., substantial enough to potentially influence practical interpretation of indicators), the proportion of such information is reported in narrative, tables, or figures.

Client & Service Information (CSI) and Data Collection and Reporting (DCR) Systems

Stakeholder feedback suggested inconsistency and potential inaccuracy among Race and Ethnicity data fields may be due in part to changes in the format of these fields in the CSI and DCR data

systems. In 2006, DMH implemented changes to Ethnicity and Race fields due to Uniform Data System/Data Infrastructure Grant (DIG) requirements from the Federal government (see *DMH Information Notice: 06-02*; April 18, 2006). Although DMH provided training about changes to these data fields, Race and Ethnicity information seems to be reported with greater inconsistency across counties, relative to other fields. Because demographic information in the CSI system is transferred to corresponding fields in the DCR system, Race and Ethnicity information in both systems was analyzed but interpreted with caution. To overcome potential shortcomings of this change, the evaluation team used consumers' pre-DIG Race and Ethnicity information to replace blank fields in their post-DIG Race and Ethnicity fields, for all analyses involving demographic information.

Consumer Perception Surveys

For FY 2008-09 and prior years, county level providers used convenience sampling, administering Consumer Perception Surveys twice a year for a two-week period in early May and November. Investigation of the convenience sampling methodology revealed the resulting information was not representative of the larger mental health service population.⁵ Beginning with FY 2009-10, a random sampling methodology was developed at the Institute for Social Research at California State University at Sacramento, through which surveys are administered annually. This change in sampling methodology was intended to produce data that is more representative of the perceptions of the mental health service population. The random sampling method utilized is currently under evaluation. Given the change in methodologies, comparisons of CPS data between fiscal years cannot be made.

Data not Available in State Databases

Representatives from seven counties or municipalities that currently do not have data contained in the DCR database for FY 2008-09 or 2009-10 were given the opportunity to provide data to the evaluation team for key DCR fields noted in the data report. Of the counties not captured in the DCR database, four representatives provided data within eight weeks of receiving the data quality assurance report. This information was considered in analyses and preparation of this report. Other county representatives who provided or may provide DCR data directly to the evaluation team subsequent to June 8, 2012 will be considered for future reports.

Implications for Analysis and Reporting

The data review and verification process, stakeholder feedback, and the data considerations and limitations (detailed in preceding sections) greatly influenced analysis and reporting decisions of the evaluation team. This is most evident in the reporting format of priority indicators in this report. Specifically for priority indicators involving CSI or DCR data reviewed by counties, results are presented in the main body of this report for counties whose representatives "verified" the accuracy of data underlying each priority indicator. This reporting format allows for presentation and interpretation of indicators among counties whose representatives indicated confidence in the underlying data. This format presents the most complete and informative picture of consumer outcomes and system performance possible with current data. Results for other counties for which data was not verified to build specific indicators are presented alongside counties for which data was verified in Appendix C. Appendix C illustrates response results for all counties, including those for counties whose representatives indicated a lack of confidence or did not respond to their provided Data Quality Assurance Report.

Overall, priority indicator differences are relatively small between counties whose representatives who provided verification of underlying data and those who did not. However, for indicators taking into account fields such as Race or Ethnicity, priority indicator differences are frequently more

pronounced due to the smaller number of county representatives indicating confidence in the accuracy or completeness of these fields. Readers should be aware that these fields are considered less reliable, complete, representative, or generally accurate by many counties, and as such information presented from these fields may be less representative of the overall service population, relative to other service information.

Findings Summary

This section provides detailed findings about each priority indicator by domain (refer back to Table 1). CSI and DCR data presented for each priority indicator represent only counties whose representatives verified the accuracy of *all* variables used to create each priority indicator. If a county representative replied that one variable was inaccurate, then that county was not included in analysis. To illustrate, counties with shaded rows, below, are included in the priority indicator 3.1 calculation. Thus, Butte, Calaveras, Contra Costa, Fresno, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, Santa Clara, Sierra, Siskiyou, Solano, Trinity, Tulare, and Tuolumne are included in the calculation. Counties indicating any variable necessary to calculate indicator 3.1 as inaccurate, per review by county representatives, are not included in the priority indicator 3.1 calculation. Refer to Appendix B for a full account.

Illustration: 3.1 Justice Involvement

County	DCR		
	ArrestPast12 (PAF-Non-Res)	ArrestPrior12 (PAF-Non-Res)	
Alameda (1)	nr	nr	
Butte (4)	✓	✓	Included in calculation
Calaveras (5)	✓	✓	
Contra Costa (7)	✓	✓	
Fresno (10)	✓	✓	
Glenn (11)	x	x	
Kings (16)	nr	nr	
Lake (17)	✓	✓	
Los Angeles (19)	✓	✓	
Madera (20)	✓	✓	
Marin (21)	nr	nr	
Mariposa (22)	✓	✓	Not included in calculation
Napa (28)	✓	✓	
Placer (31)	✓	✓	
San Benito (35)	nr	nr	
San Bernardino (36)	✓	✓	
San Francisco (38)	✓	✓	
San Joaquin (39)	nr	nr	
San Mateo (41)	nr	nr	
Santa Barbara (42)	nr	nr	
Santa Clara (43)	✓	✓	
Santa Cruz (44)	nr	nr	
Sierra (46)	✓	✓	
Siskiyou (47)	✓	✓	
Solano (48)	✓	✓	
Stanislaus (50)	nr	nr	
Trinity (53)	✓	✓	
Tulare (54)	✓	✓	
Tuolumne (55)	✓	✓	

KEY	
✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

The following summary captures findings from initial analysis existing data to produce priority performance indicators. These findings are preliminary given the early stage of indicator development. Readers will note that the evaluation team does not often make comparisons across years given changes in data collection methodologies or the number of counties reporting relevant data. In some cases, details are provided about priority indicators that could not be compiled due to a lack of accurate, reliable, or complete existing data.

Using an iterative process, the MHSOAC will review these priority indicators and their outcomes to work toward a complete and instructive set of priority performance indicators that best capture MHSA impact on mental health service consumers and system performance. The following summary provides guidance about the use of priority indicators—if they will be sustainable and meaningful moving forward in regular evaluations.

Consumer-Level Indicators:

Domain: Education and Employment

Priority Indicator: 1.1 – Average School Attendance per Year

Data Source: Consumer Perception Survey (Youth)

Counties/Municipalities Included: All

Priority indicator 1.1 was designed to be an account of how many days, on average, youth and TAY consumers attended school during a school year. The evaluation team proposed calculating this count using Consumer Perception Surveys (CPS) and Data Collection and Reporting (DCR) data. CPS data provided an opportunity for the evaluation team to calculate counts of absentee days, which more closely aligned with the intent of the indicator compared to DCR data. CPS data collected from youth consumers and family members/caregivers was used to calculate the proportion of children and TAY expelled or suspended from school. Youth and TAY responses collected during FY 2008-09 and Family member/caregiver responses collected during FY 2009-10 were used to calculate proportions.

Figure 1.1 – 1. Proportion of Child and TAY Consumers Reporting Expulsion or Suspension (FY 2008-09)

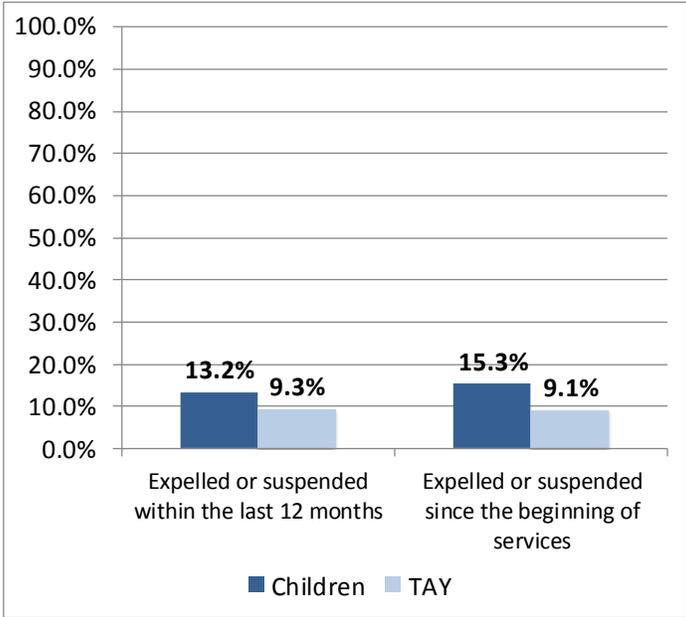
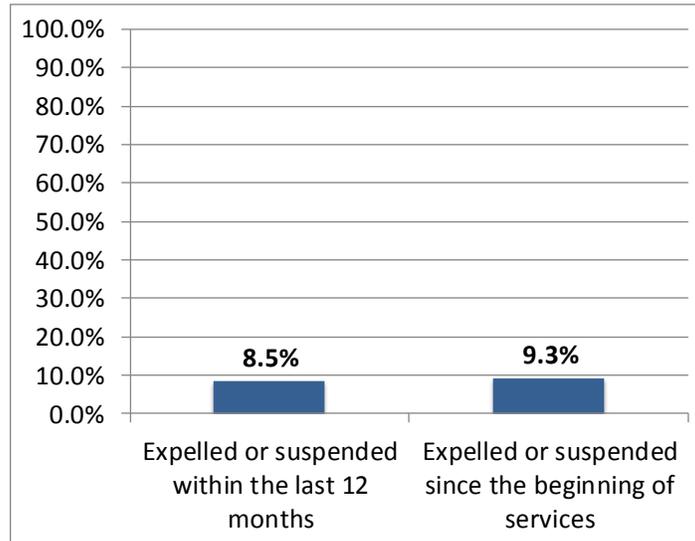
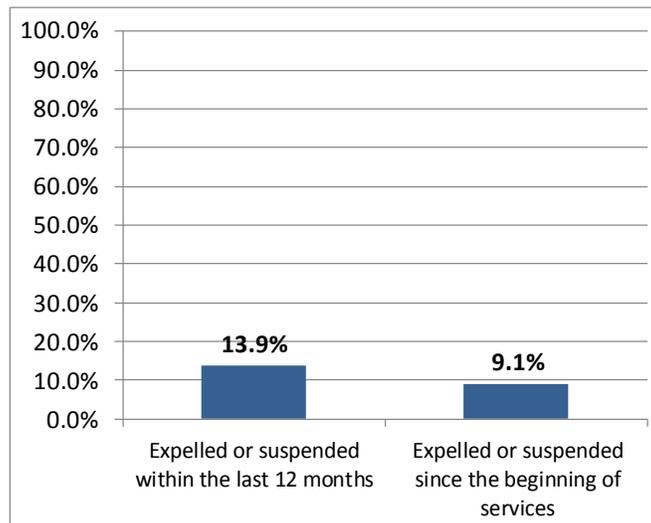


Figure 1.1 - 2. Proportion of Family Members/Caregivers Reporting Child or TAY Expulsion or Suspension (FY 2008-09)



Approximately 13% of child mental health consumers and 9% of TAY mental health consumers reported expulsion or suspension within 12 months prior to completing a survey during FY 2008-09. During the same period, approximately 16% of children and 9% of TAY consumers reported being expelled or suspended since initiating services. Family members/caregivers indicated that approximately 9% of their youth (children and TAY) had been expelled during both target periods (within 12 months and during the beginning of services).

Figure 1.1 - 3. Proportion of Family Members/Caregivers Reporting Child or TAY Expulsion or Suspension (FY 2009-10)



Family members/caregivers surveyed during FY 2009-10 reported that 14% of youth (children and TAY combined) were expelled or suspended during the last 12 months, and 9% of youth were expelled or suspended since beginning services. Youth consumers did not complete a distinct survey from family members/caregivers in FY 2009-10. Consumer-reported suspension or expulsion provides some insight into the school attendance patterns of mental health consumers. However, service information that directly tracks school attendance will provide a clearer picture of the educational involvement of mental health consumers.

Data Source: *Data Collection and Reporting (DCR)*

Counties/Municipalities Included: *Butte, Calaveras, Contra Costa, Fresno, Lake, Napa, Placer, San Bernardino, Santa Clara, Siskiyou, Trinity, Tuolumne*

(12 counties; 43% of counties responding to Data Quality Assurance Reports; 20% of all counties)

The evaluation team’s data review revealed that calculations involving DCR data was less meaningful than what CPS data yielded when interpreted. DCR data did not provide any count of attendance or absentee days, rather it provided a general estimate (e.g., *Always attends school (never truant); Attends school most of the time; Sometimes attends school; Infrequently attends school; and Never attends school*). Without absolute values, it is not possible for the evaluation team to determine the distinction between a youth who attends school “sometimes” or “infrequently,” for example. The absence of counts in DCR data challenged the team’s ability to calculate an average; calculating the recommended ratio (number of school attendance days during a consumer’s school year divided by the number of days during a consumer’s school year) was not possible. Using DCR data, the evaluation team calculated an alternative ratio – proportion of children and TAY who attend school at least “most of the time.” That is, this ratio combined those who attended school always and attended school most of the time.

Figure 1.1 – 4. Estimate of Youth Reporting “Always attends school” and “Attends school most of the time” (FY 2008-09)

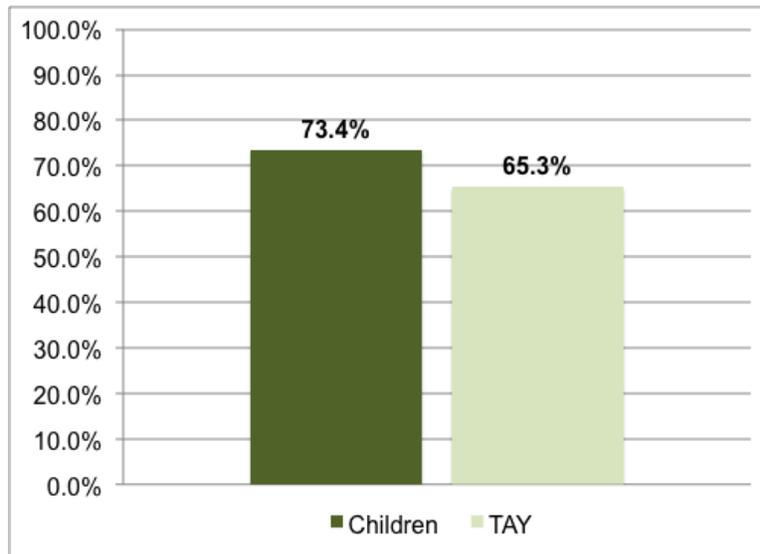
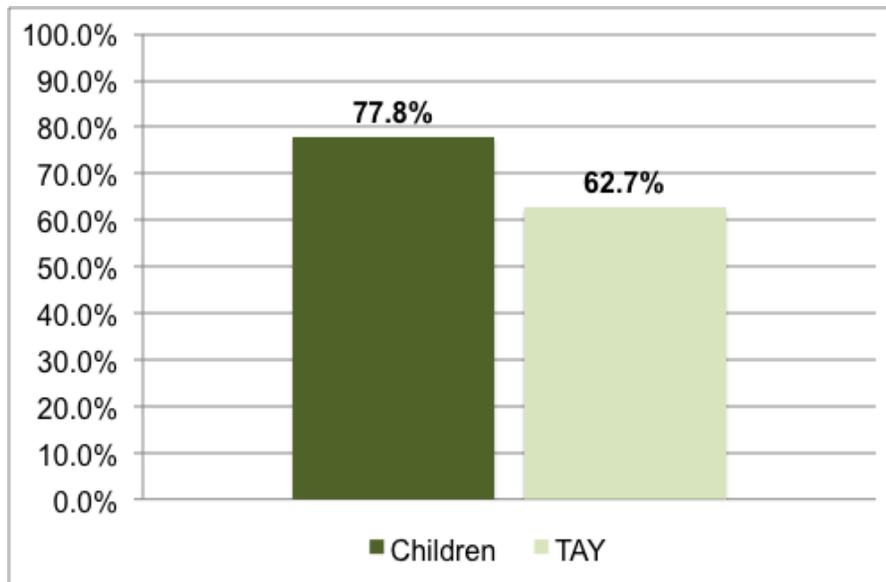


Figure 1.1 – 5. Estimate of Youth Reporting “Always attends school” and “Attends school most of the time” (FY 2009-10)



According to DCR data from the 12 valid counties, 73% of children attended school at least “most of the time” during FY 2008-09 and FY 2009-10. This proportion was lower for TAY among which 65% attended school at least most of the time. A similar pattern is seen for FY 2009-10 data wherein more children report attending school at least “most of the time” compared to TAY. One possible reason for the discrepancy in the proportions between children and TAY is that there is much more missing data (blank data cells) for TAY. For example, for FY 2008-09, there is approximately 78% missing data compared to 16% missing for children. Given that TAY encompasses the ages of 16-25, it is possible that the large proportion of missing data can be explain by consumers over 18 years old who are no longer enrolled in secondary education (wherein attendance is tracked). The ratios provide only a rough estimate of school attendance, as it is not known what exactly the differences are between the five attendance categories.

Priority Indicator: 1.2 Proportion Participating in Paid and Unpaid Employment

Data Source: Client & Service Information (CSI)

Counties/Municipalities Included (14): Butte, Fresno, Lake, Mariposa, Napa, Placer, San Bernardino, Santa Clara, Santa Cruz, Siskiyou, Solano, Trinity, Tulare, Tuolumne

(14 counties; 50% of counties responding to Data Quality Assurance Reports; 24% of all counties)

The proportion of employed TAY, adult, and older adult mental health consumers throughout the state was calculated to identify how many consumers were employed throughout the state. These ratios indicate the proportions of TAY, adults, older adults who were employed for pay at any given point in time during each fiscal year.

Among the 12 counties that verified employment information, the proportions of employed TAY, adults, and older adults for FYs 2008-09 and 2009-10 were low, with no more than 8% of consumer employment for either year and for any age group (TAY, adults, older adults). During FY 2008-09, 526 (97.7%) of employed TAY consumers, 1,760 (97.8%) of employed adult consumers, and 86 (90.7%) of employed older adult consumers held paid employment. During FY 2009-10, 585 (98.3%) of TAY consumers, 1,602 (97.8%) of adult consumers, and 92 (90.2%) of older adult consumers held paid employment.

Figure 1.2- 1. Proportion of Employed Mental Health Consumers by Employment Type (FY 2008-09)

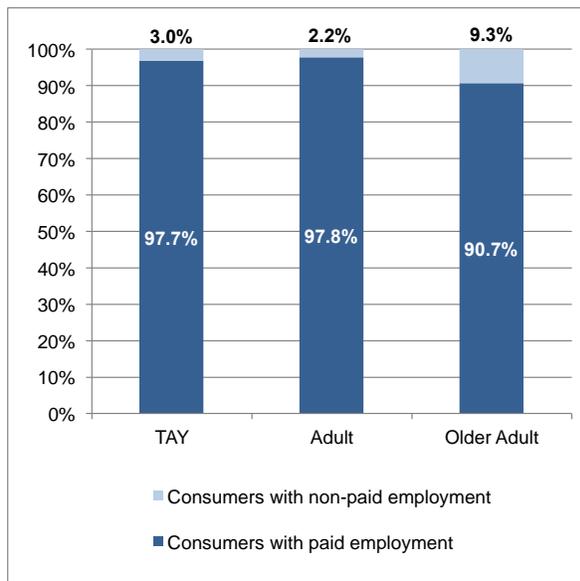
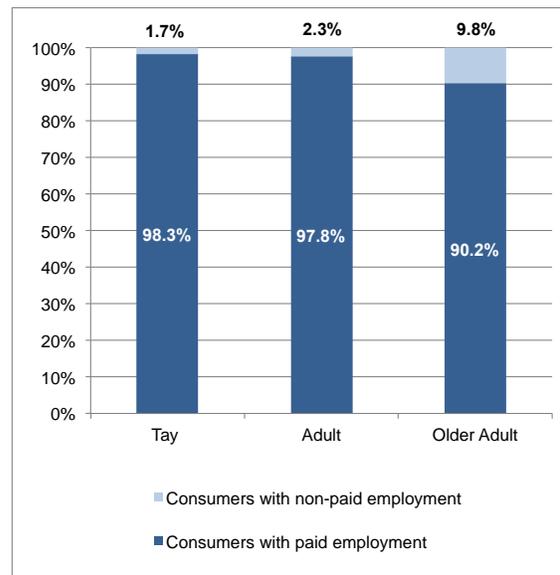


Figure 1.2- 2. Proportion of Employed Mental Health Consumers by Employment Type (FY 2009-10)



Data Source: Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Lake, Napa, Placer, Santa Clara, Siskiyou, Trinity, Tulare, Tuolumne

(12 counties; 43% of counties responding to Data Quality Assurance Reports; 20% of all counties)

The proportion of employed TAY, adult, and older adult Full Service Partnership consumers served during FY 2008-09 or 2009-10 was calculated. These ratios indicate 1) the proportion of TAY, adults, older adults who were employed, and 2) whether their employment was paid or non-paid at any given point in time during each fiscal year.

According to verified DCR data from 12 counties, 41 (6.5%) TAY consumers, 71 (5.5%) adult consumers, and two (1.3%) older adult consumers were employed during FY 2008-09. More than 85% of all employed consumers, across all age groups, held paid employment. As indicated by an asterisk (*) in Figure 1.2-1, a small proportion of employed TAY were more likely to hold paid and non-paid jobs simultaneously, which accounts for a total 105% employment rate. Employed adults and employed older adults held either a paid job or a non-paid job but not both. Fewer employed consumers held paid employment during FY 2009-10, compared to the previous year. Specifically, the proportion of TAY and adult consumers with paid employment decreased by less than 4%. Older adults, who had scant representation in the county verified data, maintained a 100% paid employment rate.

Figure 1.2 - 3. Proportion of Employed FSP Consumers by Employment Type (FY 2008-09)

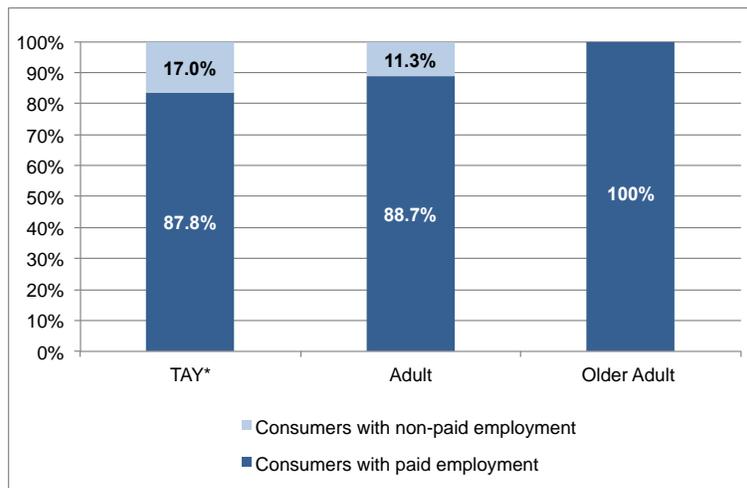
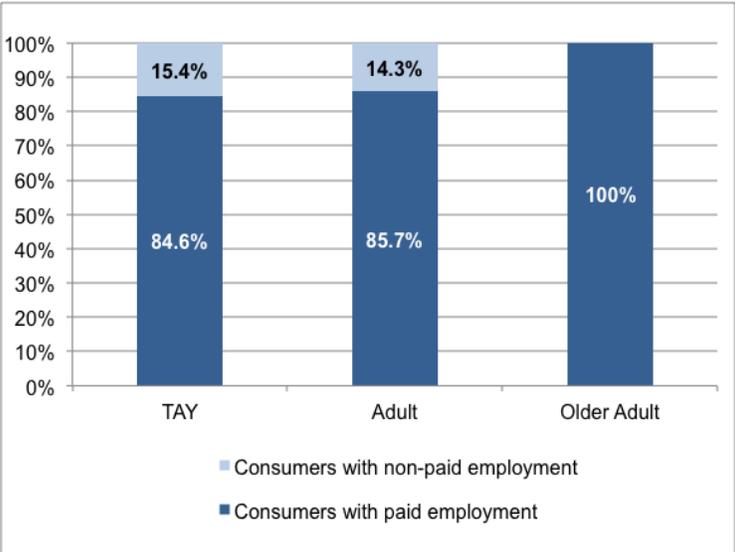


Figure 1.2 - 4. Proportion of Employed FSP Consumers by Employment Type (FY 2009-10)



Domain: Homelessness and Housing

Priority Indicator: 2.1 Homelessness and Housing Rates

Data Source: Client & Service Information (CSI)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Sierra, Siskiyou, Solano, Trinity, Tulare, Tuolumne

(20 counties; 71% of counties responding to Data Quality Assurance Reports; 34% of all counties)

Rates of homelessness and housing were examined among all mental health consumers, and more specifically among FSP consumers. Presented below are the rates of consumers identified as having one of four housing statuses: unknown, independent,⁶ homeless, and foster. Most CSI consumers accounted for in verified data had independent housing statuses, meaning that they resided in a house or apartment with varying levels of support. Among all consumer age groups, housing remained effectively unchanged. Rates of homeless child, TAY and older adult FSP consumers were relatively low and highest among adult CSI consumers (see Figure 2.1 – 1 and 2.1 – 2). Among FSP consumers, homelessness was more prevalent, particularly among adults and older adults. This trend held true among FSP consumers across the target fiscal years (2008-09 and 2009-10).

As with all graphs in this report, “missing data,” or cells that were blank in datasets, are not captured in illustrations. Thus, each age group shown does not sum to 100%.

Figure 2.1 - 1. Proportion of CSI Consumers’ Housing Statuses (FY 2008-09)

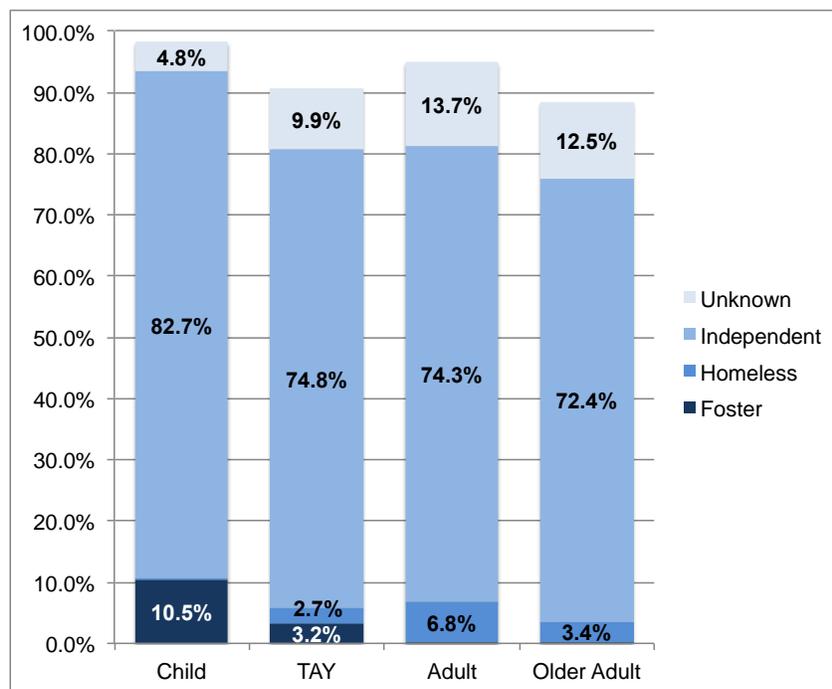
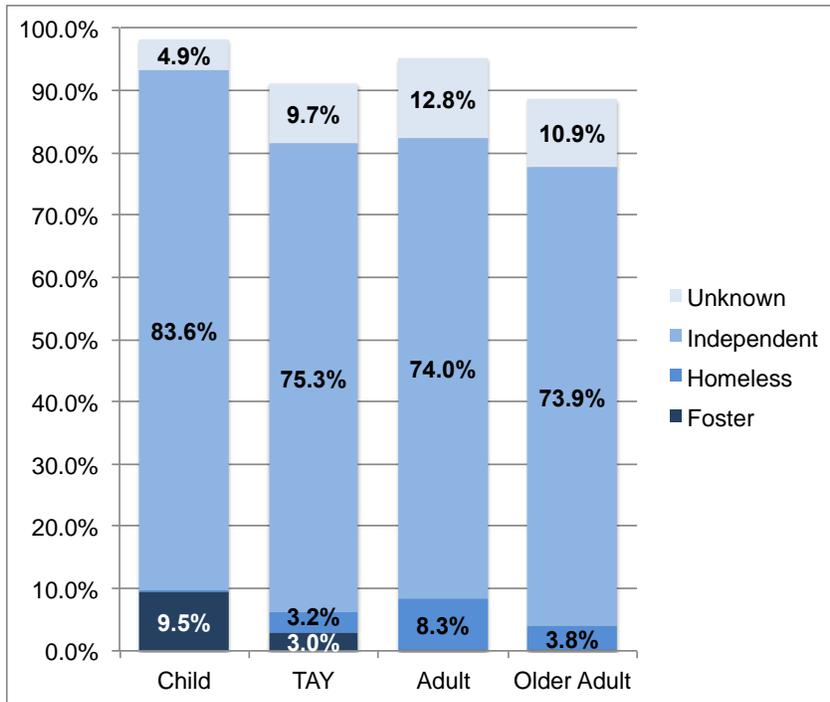


Figure 2.1 - 3. Proportion of CSI Consumers' Housing Statuses (FY 2009-10)



Data Source: Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Sierra, Siskiyou, Solano, Trinity, Tulare, Tuolumne

Figure 2.1 - 2. Proportions of FSP Consumers Homeless and Housed (FY 2008-09)

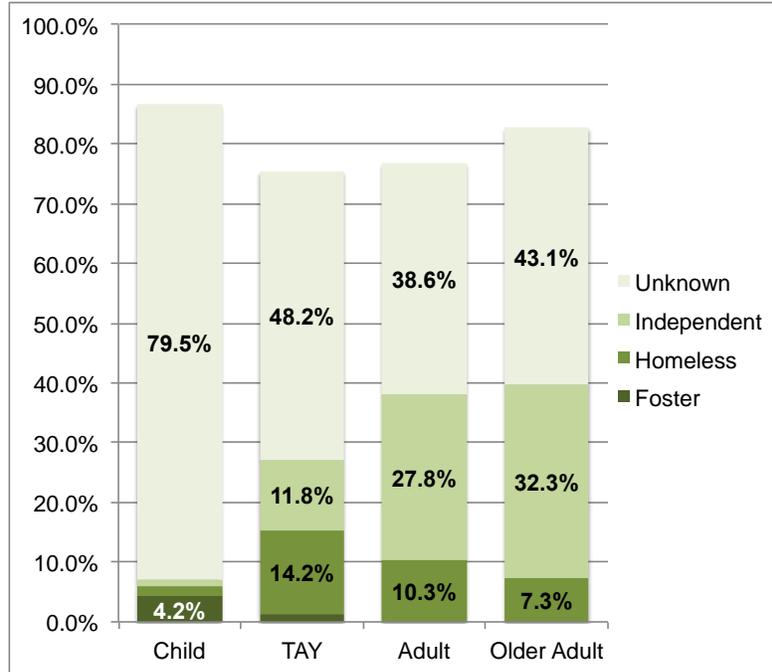
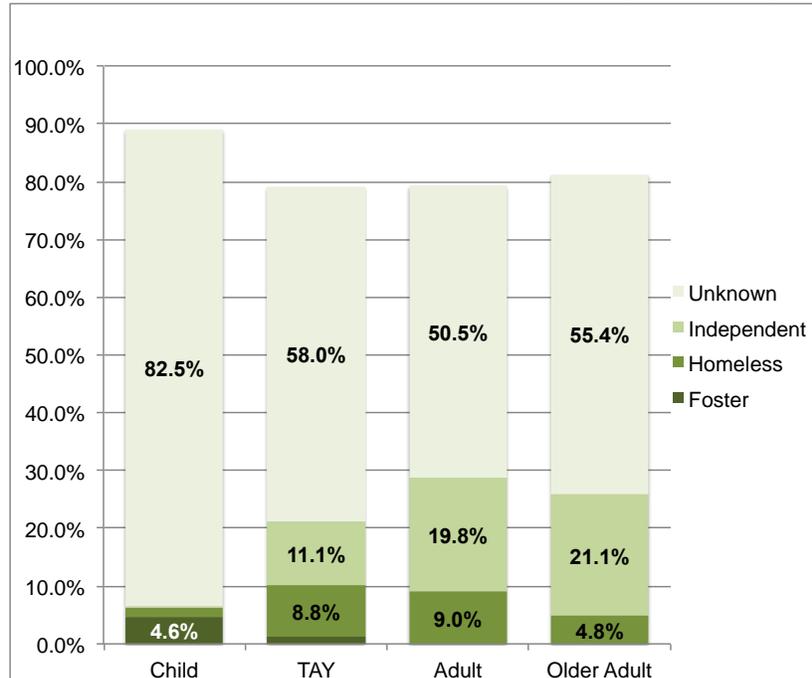


Figure 2.1 - 4. Proportions of FSP Consumers Homeless and Housed (FY 2009-10)



Domain: Justice Involvement

Priority Indicator: 3.1 Arrest Ratio

Data Source: Consumer Perception Surveys (Youth, Youths' Families, Adults, and Older Adults)

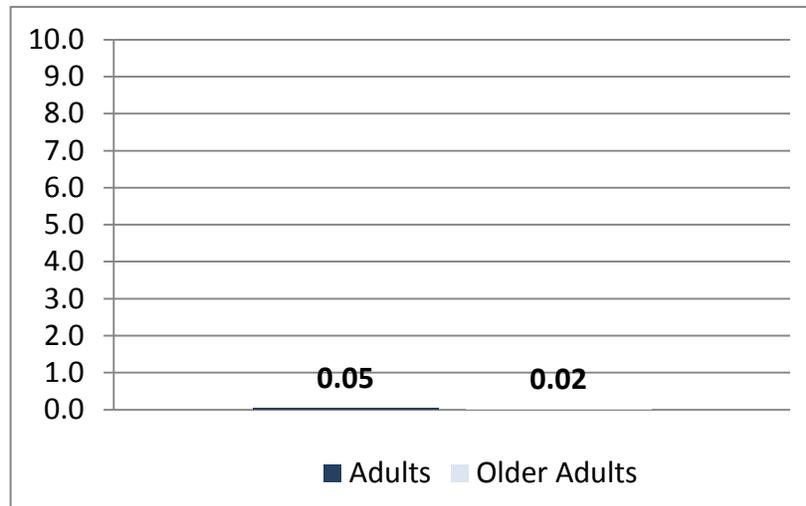
Counties/Municipalities Included: All

Priority indicator 3.1 was designed to capture consumers who were arrested at any point during the previous 12 months. The ratio is the number of total arrests during the fiscal year within an age group by the total number of unique clients in that age group.

Arrest information contained in the Client & Service Information (CSI) system was indicated to be inaccurate by most counties responding to the Data Quality Assurance Reports. Thus, CPS data was used as an initial source to estimate arrest rates. The evaluation team examined available arrest information from adult and older adult surveys to understand how often consumers were detained within 12 months prior to completing the survey. The following outcomes are estimates from these consumer reports. Outcomes indicate that each adult and older adult CSI consumer had <1 arrest on average.

Only data from FY 2008-09 is presented because the dataset provided a count of individual clients. This was not possible with FY 2009-10 data. Estimates are accurate to the extent that respondents are willing to disclose their arrests.

Table 3.1 - 1. Arrest Rate Per CPS Survey Respondent/Consumer (FY 2008-09)



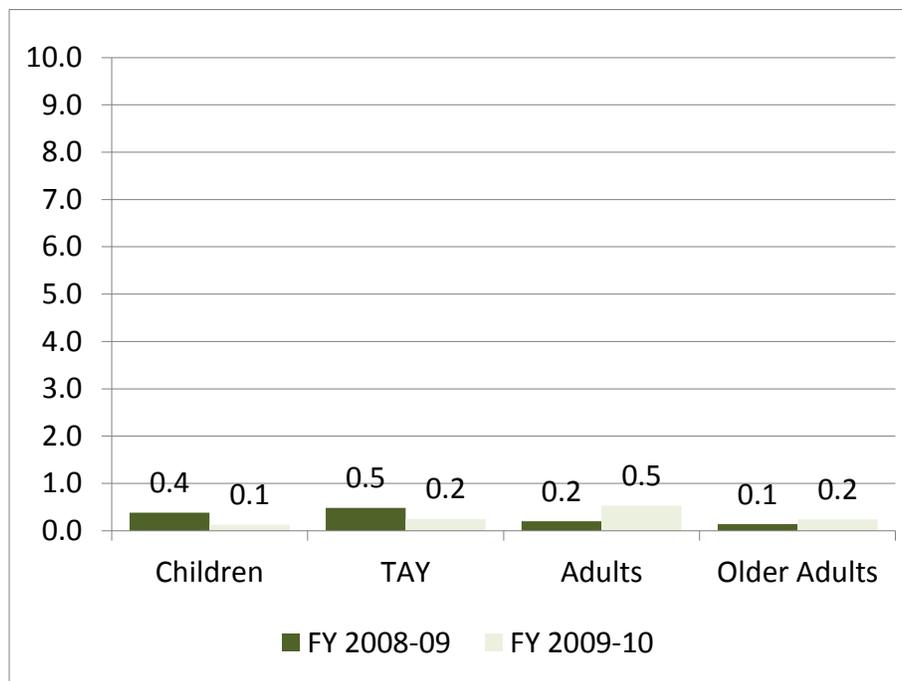
Data Source: Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, Santa Clara, Sierra, Siskiyou, Solano, Trinity, Tulare, Tuolumne

(19 counties; 68% of counties responding to Data Quality Assurance Reports; 32% of all counties)

Arrests occurring within 12 months of assessment were examined among FSP consumers served during FY 2008-09 and 2009-10. Across both years, each consumer had <1 arrest. During this time, TAY and Adults were more likely to experience arrest than children and older adults. Adults were more likely to experience arrest than consumers in all other age (Figure 3.1 – 2).

Figure 3.1 - 2. Arrest Rate Per FSP Consumer



Priority Indicator: 3.2 Proportion Incarcerated

Data Source: Client & Service Information (CSI)

Counties/Municipalities Included: Calaveras, Placer, Santa Clara, Santa Cruz, Siskiyou, Solano, Trinity

(7 counties; 25% of counties responding to Data Quality Assurance Reports; 12% of all counties)

Stakeholders proposed incarceration as a priority indicator, to further assess the rates of detention among mental health consumers throughout the state. Currently there is scant incarceration data about all mental health consumers exists, relative to data collected regarding arrests. Alternative measures of incarceration in the CSI dataset include using conservatorship data for TAY consumers (e.g., ward of the juvenile court) or legal class data, for example. However, feedback from stakeholders, and review of existing data revealed limited reliability of currently collecting information relevant to incarceration. Per stakeholders' suggestions, the evaluation team seeks new data collection to identify the number of consumers receiving services while incarcerated during the fiscal year and the number of those who were incarcerated at any point during that same year.

Domain: Emergency Care

Priority Indicator: 4.1 Emergency Intervention for Mental Health Episodes

Data Source: Client & Service Information (CSI)

Counties/Municipalities Included: Butte, Calaveras, Lake, Mariposa, Napa, Placer, Santa Clara, Santa Cruz, Trinity, Tulare, Tuolumne

(11 counties; 39% of counties responding to Data Quality Assurance Reports; 19% of all counties)

Limited intervention-like services are tracked within the Client & Service Information (CSI) system. Service types include *crisis stabilization-emergency room, crisis stabilization-urgent care, adult crisis residential, professional inpatient visit crisis intervention* and the like—each that can be grouped as “visits to a hospital” or “visits to a non-hospital facility.” A list of facilities within each category is located in Appendix F.) Mental health consumer visits to either a hospital or a non-hospital facility for mental health intervention was evaluated.

The evaluation team presents the average number of mental health consumers’ visit to a hospital for mental health episodes in FY 2008-09 or 2009-10. Findings showed that all age groups use emergency interventions at a similar rate. Further, trends show that consumers tend to use non-hospital facilities more often than hospitals.

Figure 4.1 - 1. Hospital Visits and Non-hospital Visits per CSI Consumer (FY 2008-09)

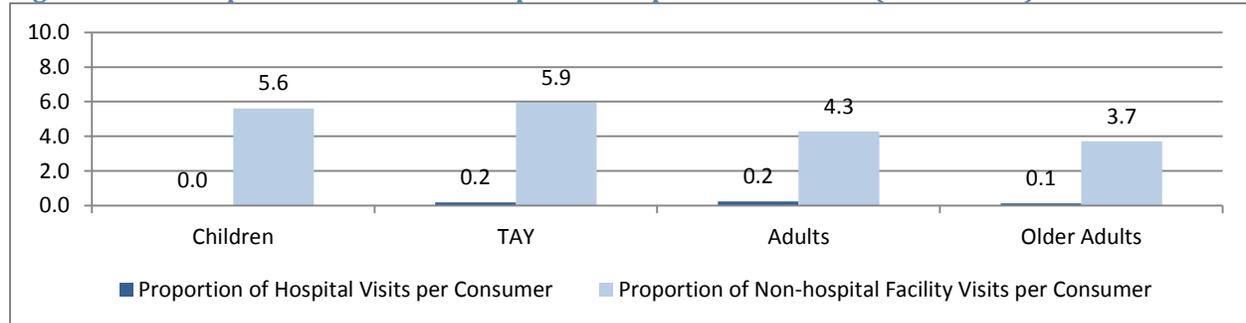
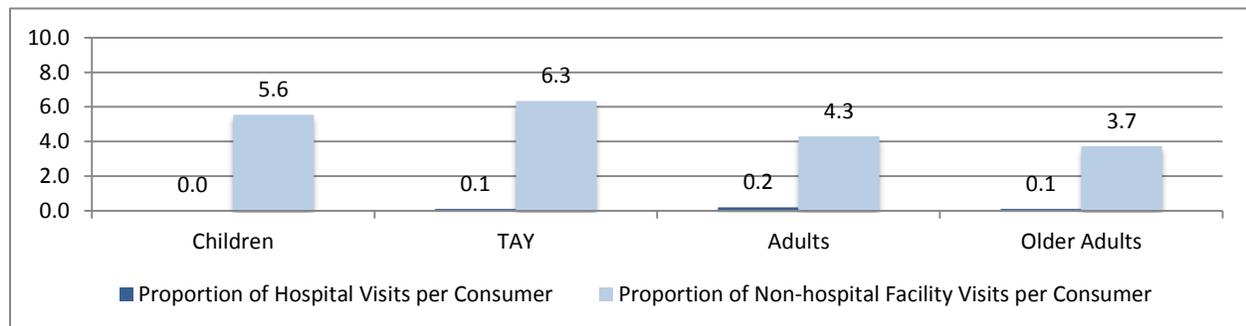


Figure 4.1 - 2. Hospital Visits and Non-hospital Visits per CSI Consumer (FY 2009-10)



Information with which to assess FSP consumers’ use of emergency intervention services for mental health episodes was not available at the time of this report.

Priority indicator: 4.2 Emergency Intervention for Co-occurring Physical Injury

The priority indicator “Emergency Intervention for Co-occurring Physical Injury” was proposed by stakeholders as a second and equally-important way to assess how often mental health consumers use emergency intervention (e.g., hospitals) for mental health needs. The reasoning was that some physical injuries are related to – if not caused by – a change in mental health stability.

This priority indicator is key to comprehensively understanding consumers’ use of emergency interventions (compared to a more substantial reliance on services that help consumers maintain mental health on a regular basis). However, an account of hospital visits that specifically identify physical injuries to mental health is currently unavailable to the evaluation team. The evaluation team recommends additional examination of current CSI and DCR files that include hospital visit variables to determine where it could be useful to note where hospital visits for physical injuries are related to mental health.

Domain: Social Connections

Priority Indicator: 5.1 Proportion Who Identify Family Support

The priority indicator *Social Connections* was proposed by stakeholders as an addition to the original proposed indicator set. As suggested in the report leading to this work, new data – the number of family members that a consumer identifies as supportive – is required to calculate this indicator.

Priority Indicator: 5.2 Proportion who Identify Community Support

Direct measures of consumer perceived support from non-family members are not currently available. As suggested in the report leading to this work, new data – specifically, the number of non-family members that a consumer identifies as supportive and the number of organizations that a consumer visits voluntarily and regularly to receive appropriate and high quality services – are required to calculate this indicator.

System-Level Indicators:

Domain: Access

Priority Indicator: 6.1 - Demographic Profile of Consumers Served

Data Source: Client & Service Information (CSI); Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

(22 counties; 78% of counties responding to Data Quality Assurance Reports; 37% of all counties)

This indicator profiles mental health consumers overall and full service partners (FSPs) served during FY 2008-09 and 2009-10. Service populations are presented by race/ethnicity, age, and gender; these figures provide basic demographic descriptions of those receiving mental health services across the state.

Figure 6.1 - 1. Race/Ethnicity of Mental Health Consumer

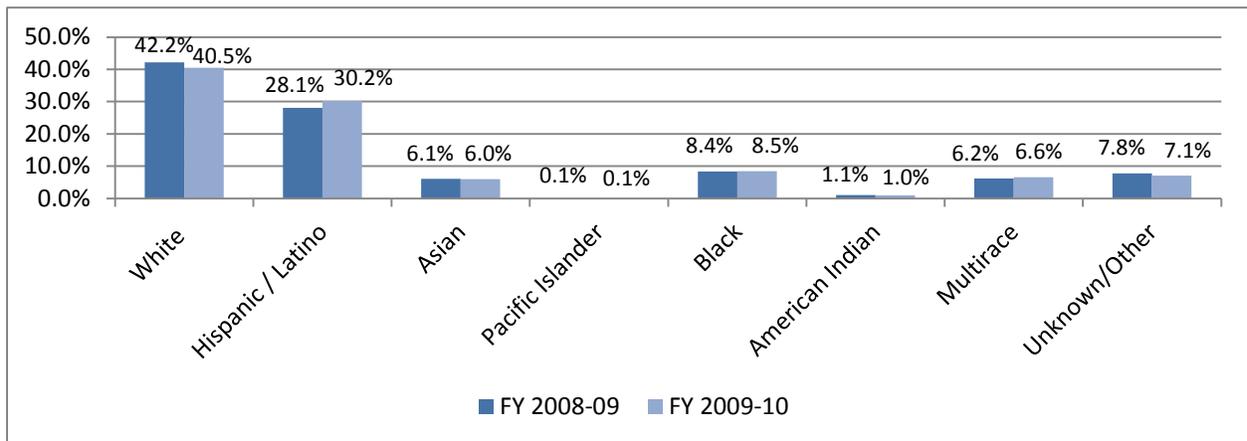
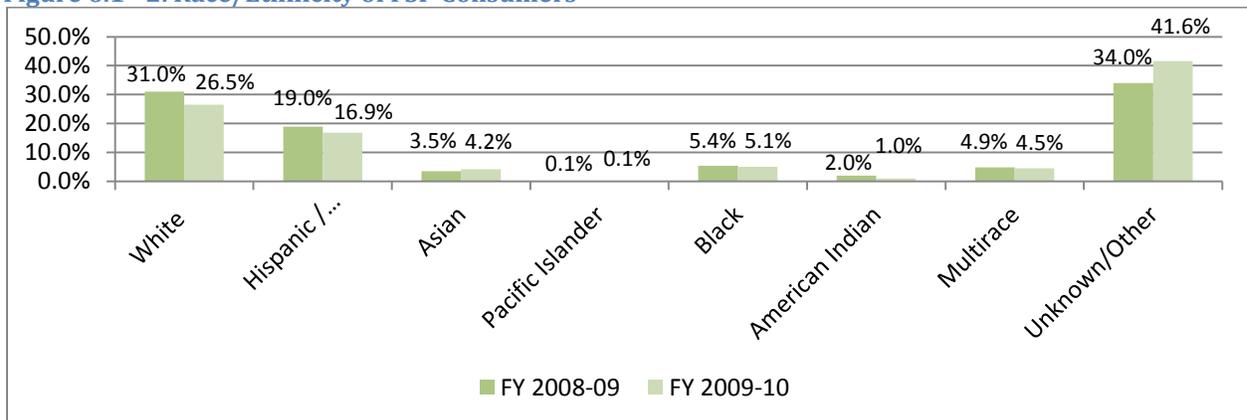


Figure 6.1 - 2. Race/Ethnicity of FSP Consumers



Among counties whose representatives verified race and ethnicity fields in CSI and DCR databases, mental health consumers identified as Hispanic/Latino, Black, and Multiracial increased proportionally, year-to-year (see Figure 6.1 - 1). Asian FSP consumers increased proportionally, year-to-year (see Figure 6.1 - 2). These trends suggest minority groups are becoming a larger part of the FSP and overall mental health service populations. However, a majority of counties providing responses to Data Quality Assurance Reports did not verify the accuracy and completeness of their race and ethnicity data. Additionally, a large proportion of FSP consumers were missing Race/Ethnicity information in the DCR database. As such, the racial and ethnic breakdown of mental health consumers during FY 2008-09 and 2009-10 must be interpreted with caution.

Counties with verified consumer age information in CSI and DCR databases show proportional service increases among child, TAY and older adult mental health consumers (see Figure 6.2 - 3) and proportional service increases among child and TAY FSP consumers (see Figure 6.2 - 4). Service trends suggest these groups are becoming a larger part of their respective mental health service populations.

Figure 6.1 - 3. Mental Health Consumers by Age Group

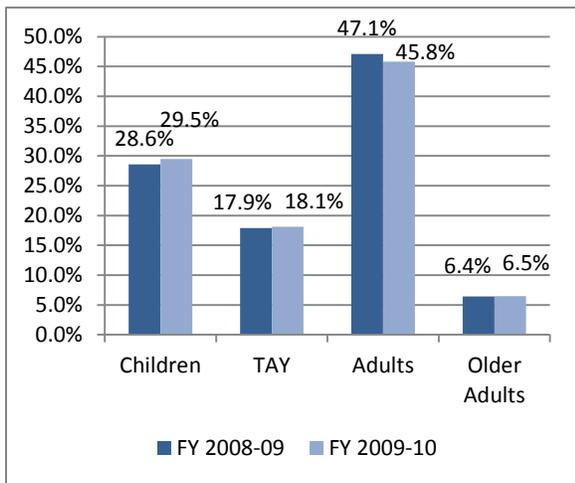
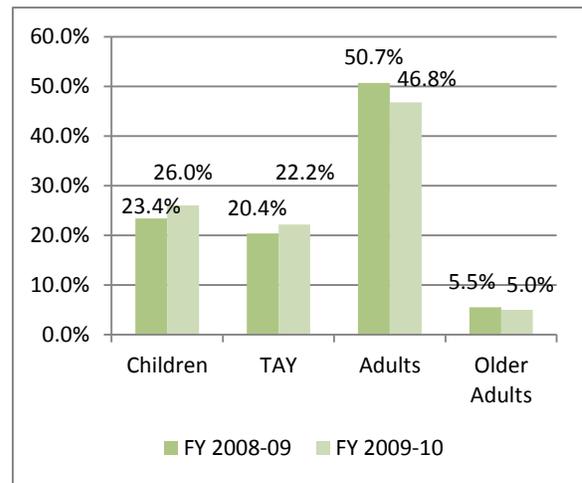


Figure 6.1 - 4. FSP Consumers by Age Group



Counties with verified gender data revealed the proportion of female and male mental health consumers and FSP consumers remained steady, year-to-year.

Figure 6.1 - 5. Mental Health Consumers by Gender

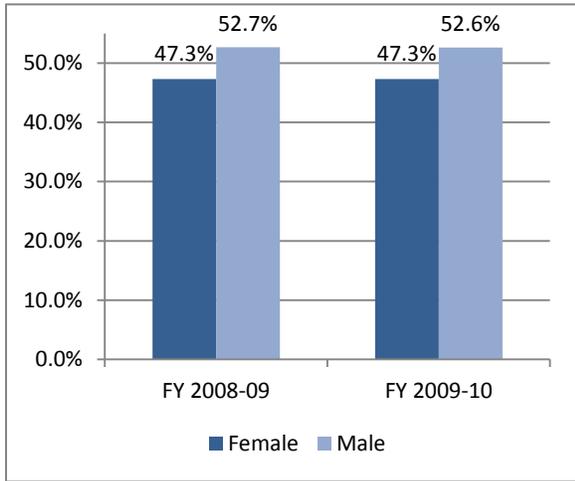
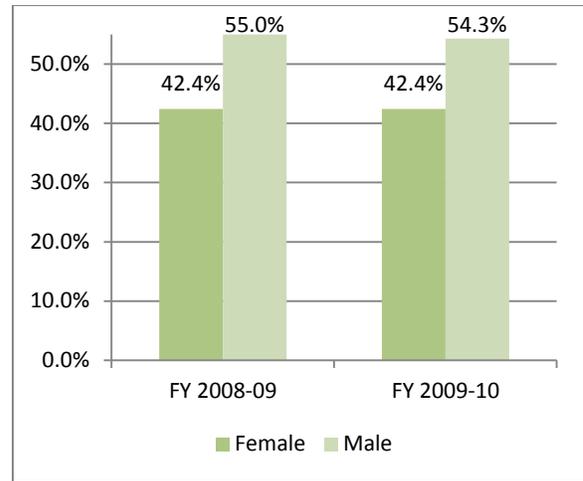


Figure 6.1 - 6. FSP Consumers by Gender



Priority Indicator: 6.2 - Demographic Profile of New Consumers

Data Source: Client & Service Information (CSI); Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

(23 counties; 82% of counties responding to Data Quality Assurance Reports; 39% of all counties)

The frequency and characteristics of new mental health consumers (i.e., those initiating services within the FY) can provide insight into the changing makeup of the overall service population and indicate the extent to which mental health disparities amongst un-served and underserved populations are reduced. Among counties that verified service date information in the CSI and DCR systems, the proportion of new mental health consumers increased and the proportion of new FSP consumers decreased year-to-year (see Figures 6.2 - 1 & 6.2 - 2).

Figure 6.2 - 1. New and Continuing Mental Health Consumers Served

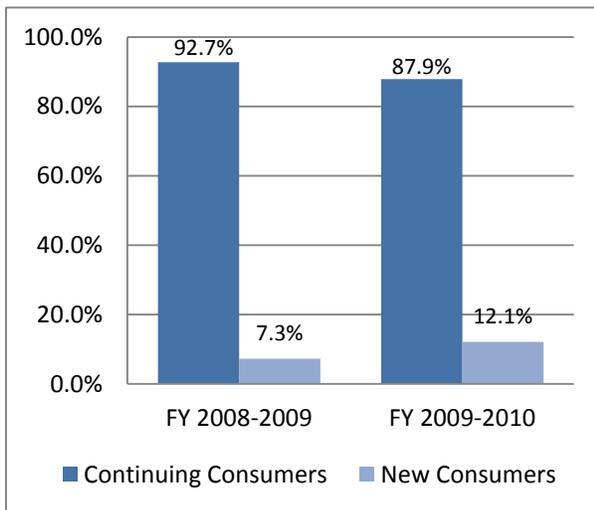
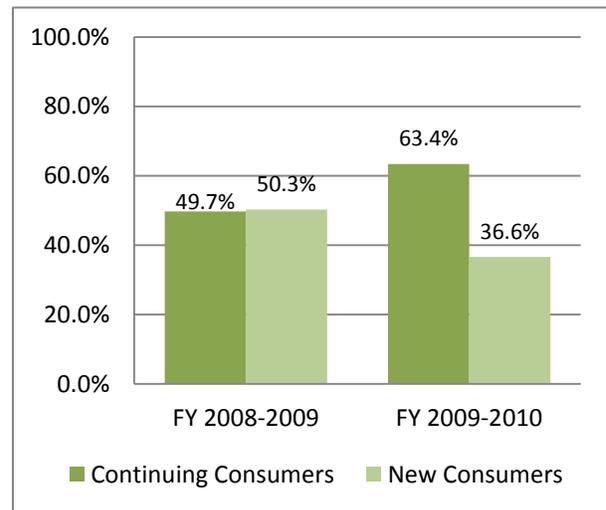


Figure 6.2 - 2. New and Continuing FSP Consumers Served



Between FY 2008-09 and 2009-10, the proportion of new Hispanic/Latino, Asian, Black, and Multirace mental health consumers increased (see Figure 6.2 - 3). Among FSP consumers, the proportion of new Asian and Black consumers increased while all other racial/ethnic groups decreased as a proportion of the new FSP service population, year-to-year.

Figure 6.2 - 3. Race/Ethnicity of New Mental Health Consumers

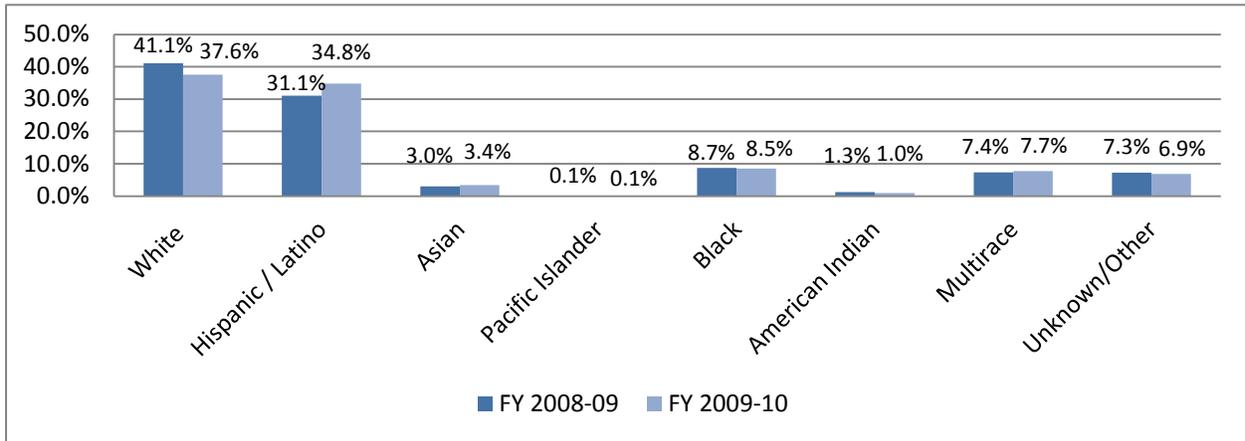
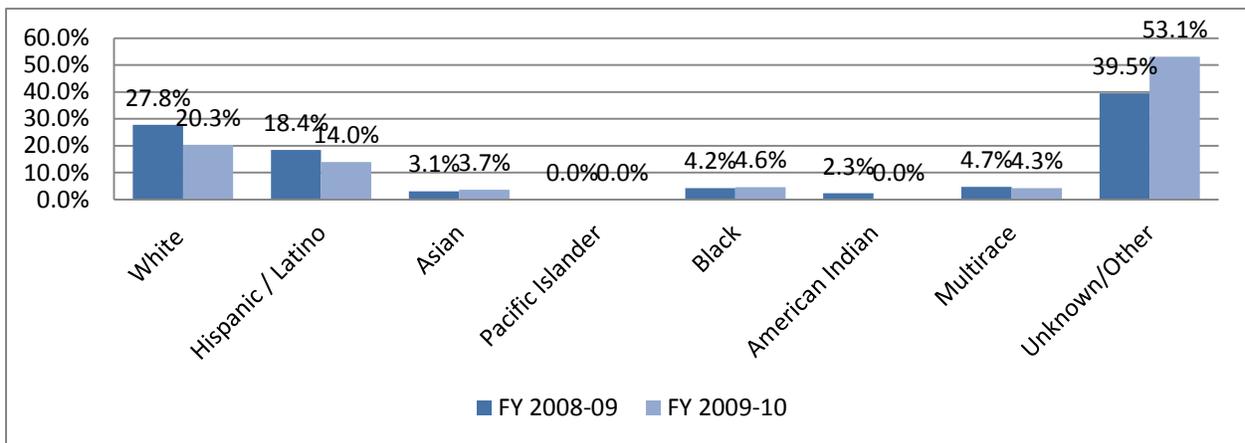


Figure 6.2 - 4. Race/Ethnicity of New FSP Consumers



Older adult, adult, and TAY consumers increased as a proportion of all new mental health consumers, while TAY and children increased as a proportion of FSP consumers served between FY 2008-09 and 2009-10 (see Figures 6.2 - 5 & 6.2 - 6).

Figure 6.2 - 5. New Mental Health Consumers by Age Group

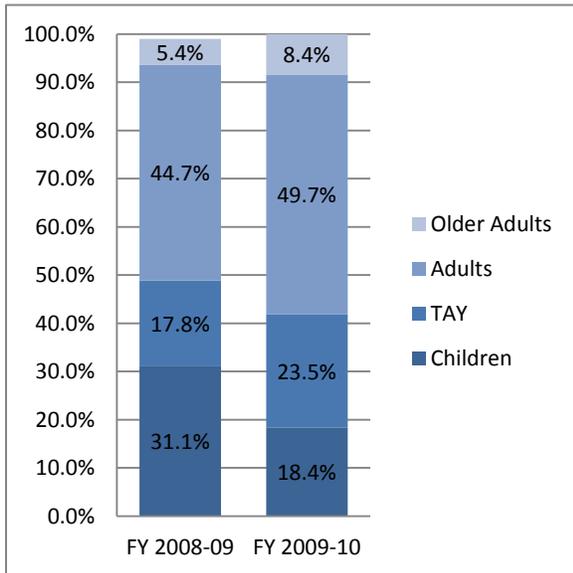
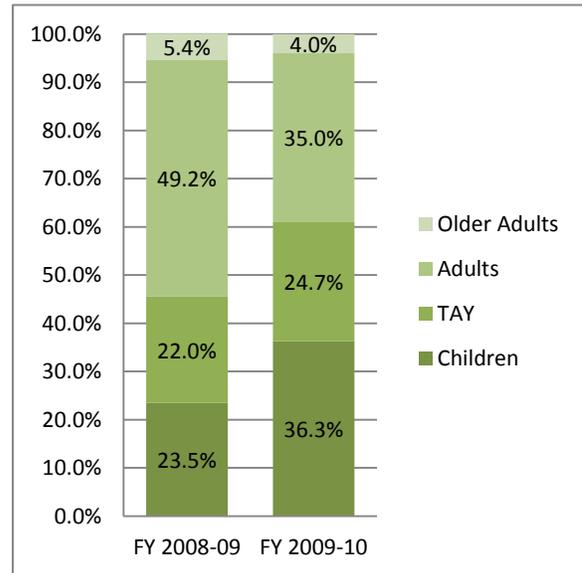


Figure 6.2 - 6. New FSP Consumers by Age Group



The gender figures for new mental health consumers and new FSP consumers held relatively steady, year-to-year (see Figures 6.2 - 7 & 6.2 - 8).

Figure 6.2 - 7. Gender of New Mental Health Consumers

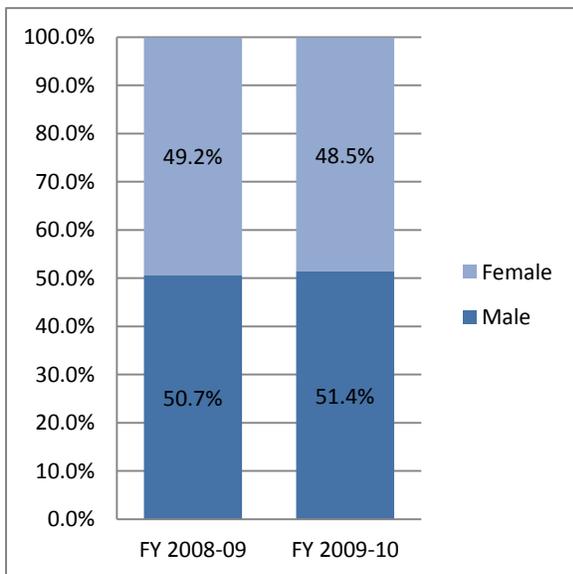
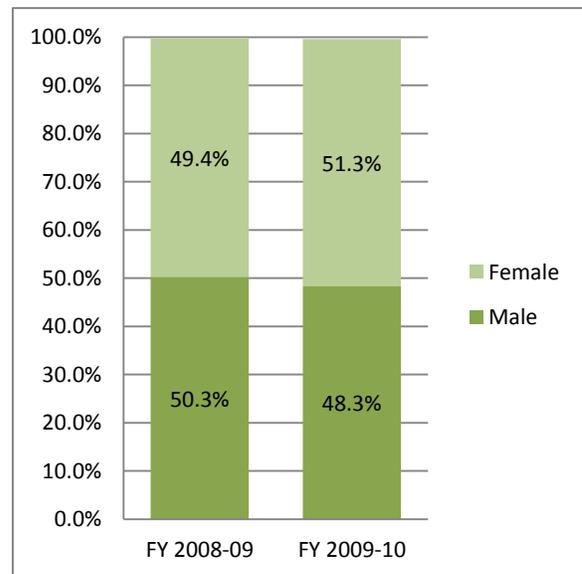


Figure 6.2 - 8. Gender of New FSP Consumers



Mental health services or FY 2009-10 served fewer new mental health consumers and new FSP consumers than in the previous year; however, service to new minority mental health consumers (e.g., Hispanic/Latino and Multirace) and new minority FSP consumers (e.g., Asian) increased, year-to-year. Additionally, more new child and TAY consumers were served in FY 2009-10 than in the previous year.

Priority Indicator: 6.3 – Penetration of Mental Health Services

Data Source: Client & Service Information (CSI); Data Collection and Reporting (DCR)

Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

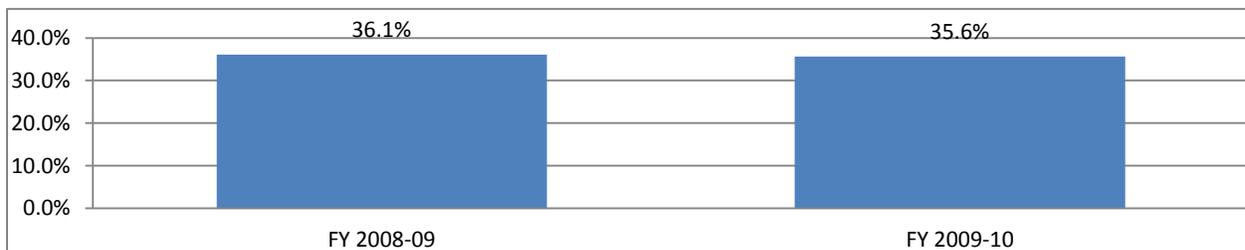
(22 counties; 79% of counties responding to Data Quality Assurance Reports; 37% of all counties)

Priority indicator 6.3 details the extent to which mental health services are reaching California residents estimated to be in need of services.⁷ This metric provides indications of how well the mental health system is meeting the level of need among various populations.⁸

Rate of penetration of service can be defined in a myriad of ways. As a result, the mental health field lacks a standard penetration rate calculation and reporting format. For example, the National Association of State Mental Health Program Directors' (NASMHPD) penetration rate calculation includes several outcome indicators such as: denial of care, consumer perception of access, and utilization rates.⁹ Given this variation, penetration rate calculations using the same formula but different data sources may produce very distinct results. To arrive at a rate of penetration of services standardized across California counties, the evaluation team adopted Dr. Charles Holzer's methods for estimating need for mental health services.¹⁰ These methods are in line with those previously employed by CADMH.

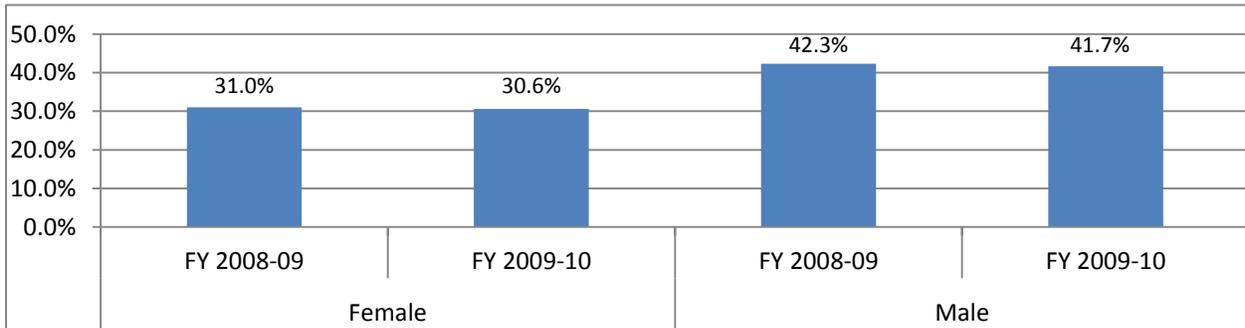
Specifically, predicted probabilities from demographic models were applied to cross-tabulations of Census population estimates.¹¹ Estimations of persons with serious mental illness (SMI) were derived utilizing data available from the National Comorbidity Survey Replication.¹² Rates of service among all mental health consumer, and specifically among race/ethnicity, gender, and age groups were set against estimates of need for mental health services statewide, to arrive at rates of penetration of services.

Figure 6.3 - 1. Penetration Services among those Estimated to be in Need



Among counties that verified service data, more than one third of those estimated to be in need of service (i.e., serious mental illness) were served in FY 2008-09 and 2009-10 (Figure 6.3 - 1).

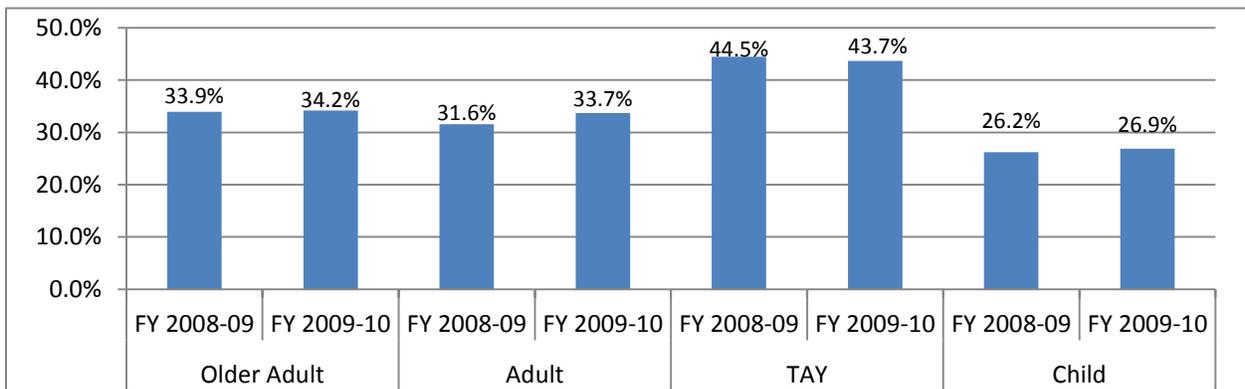
Figure 6.3 - 2. Penetration Services among those Estimated to be in Need, by Gender



More males than females estimated to experience serious mental health illness were served in FY 2008-09 and 2009-10 (see Figure 6.3 - 2). Within gender groups, rates of penetration of services remained steady, year-to-year.

Among age groups, TAY mental health consumers overall and FSP consumers had the greatest penetration of services during FY 2008-09 and 2009-10. Child mental health consumers and FSP consumers had the lowest rate of service penetration. Within age groups, penetration rates remained relatively stable, year-to-year (see Figure 6.3 - 3).

Figure 6.3 - 3. Penetration Services among those Estimated to be in Need, by Age Group



Rates of service penetration were greatest among Black and American Indian mental health consumer groups for FY 2008-09 and 2009-10. Penetration rates among White and Hispanic racial/ethnic groups were also above fifty percent (see Figures 6.3 - 4 & 6.3 - 5).

Figure 6.3 - 4. Penetration Services among those Estimated to be in Need, by Race/Ethnicity (FY 2008-09)

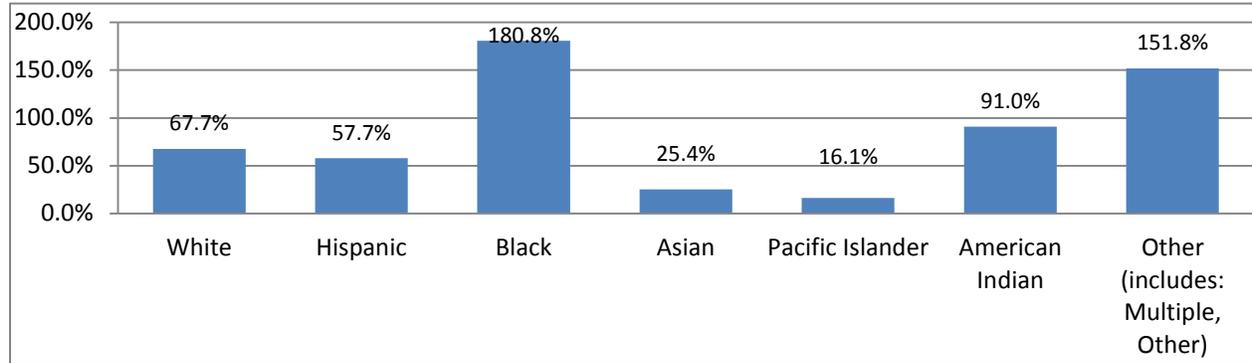
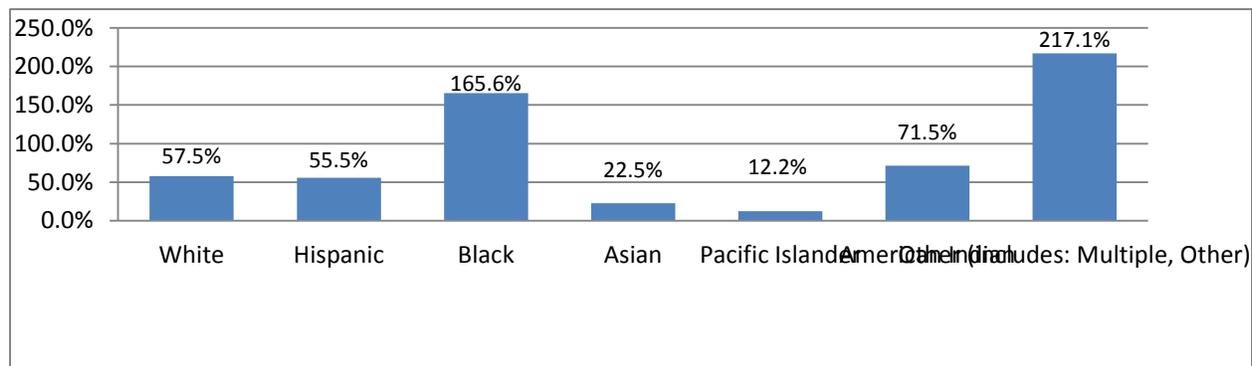


Figure 6.3 - 5. Penetration Services among those Estimated to be in Need, by Race/Ethnicity (FY 2009-10)



Priority Indicator: 6.4 – Access to a Primary Care Physician

Data Source: Data Collection and Reporting (DCR)

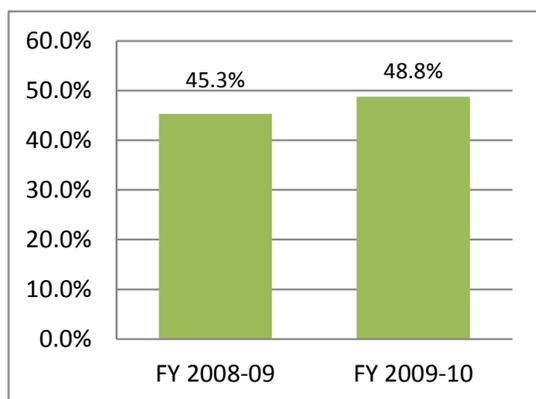
Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

(22 counties; 79% of counties responding to Data Quality Assurance Reports; 37% of all counties)

Many mental health consumers view primary care as a cornerstone to their healthcare and look towards general practitioners to assist with their mental health service provision.¹³ Primary care providers, however, may be reluctant to offer such services due to lack of training and experience related to mental illness. Proper training for general practitioners can mitigate this reluctance and allow for mental health services to occur in primary care settings, thus positively impacting the lives of several mental health patients.¹⁴

Including primary care with mental health care helps patients address their multiple needs in a more systemic and holistic fashion. For instance, patients with mental illness (particularly schizophrenia) often have poorer physical health relative to the general population.¹⁵ Primary care facilities can offer a space for patients to address their multiple needs. This ensures that patients receive all levels of needed services. Primary care physicians can provide wellness checks for mental health care consumers, much in the same way that they do for diabetes patients.¹⁶ Moreover, coordination between the psychiatrist and primary care doctor is important to ensure that there are no negative drug interactions.¹⁷ Therefore, access to primary care may help improve recovery for mental health consumers.¹⁸ Further, consumers often will not accept referrals to mental health providers, and in such cases primary care providers by default become the sole practitioner treating a mental health consumer.¹⁹ Mental health consumers' access to primary care not only enhances recovery but often becomes the only treatment option for several patients. With this context, indicator 6.5 provides indication of the level of primary care FSP consumers received.²⁰

Figure 6.4 - 1. FSP Access to a Primary Care Physician



Overall FSP access to a primary care physician increased year-to-year (see Figure 6.4 - 1).

FSP access to a primary care physician increased proportionally among TAY consumers but decreased moderately among all other age groups (see Figure 6.4 - 2).

Figure 6.4 - 2. FSP Access to a Primary Care Physician, by Age Group

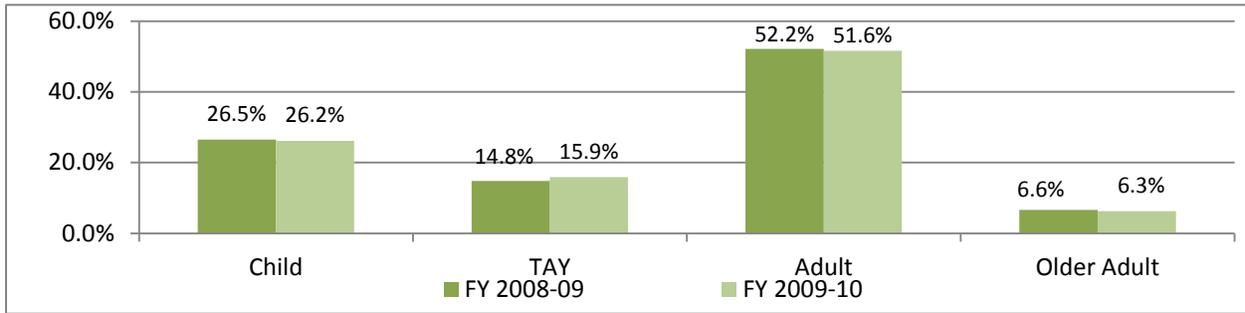
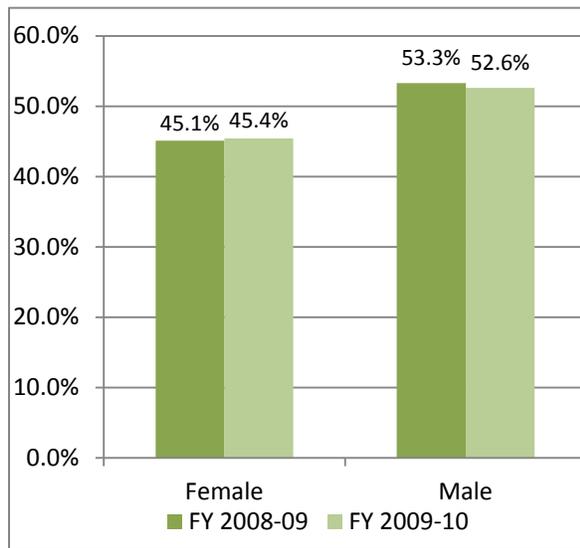


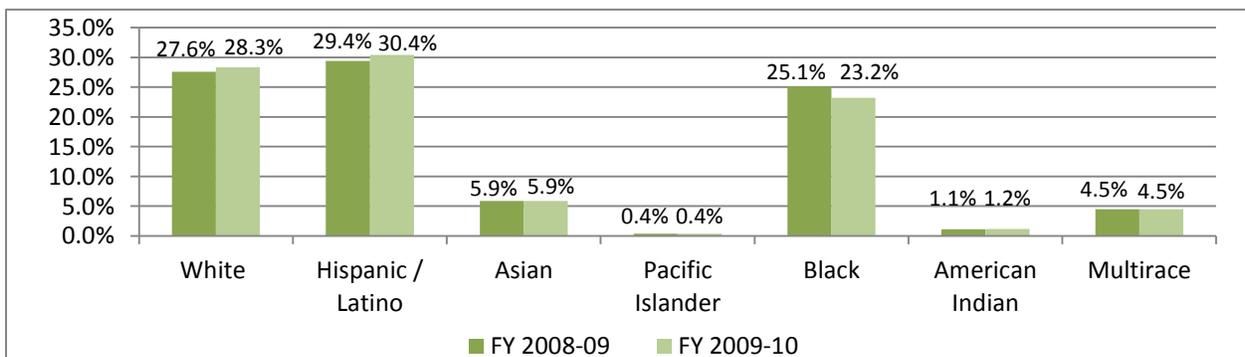
Figure 6.4 - 3. FSP Access to a Primary Care Physician, by Gender



FSP access to a primary care physician increased proportionally year-to-year among female consumers but decreased among male consumers (see Figure 6.5 - 3).

Conversely, access to a primary care physician increased among White, Hispanic/Latino, and American Indian FSP consumers, but decreased among Black FSP consumers, year-to-year (see Figure 6.5 - 4).

Figure 6.4 - 4. FSP Access to a Primary Care Physician, by Race/Ethnicity



Priority Indicator: 6.5 – Consumer / Family Perceptions of Access to Services

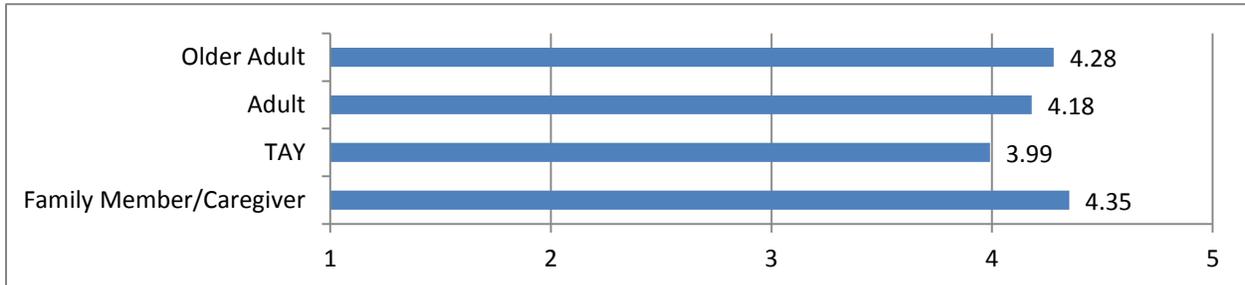
Data Source: Consumer Perception Surveys

Sample Analyzed: Consumer Perception Survey Respondents: All

Organizational, economic, and demographic factors have been found to influence consumer access to mental health services. Specifically, changes in the treatment system that weaken or eliminate public programs, overburden staff, or de-emphasize quality standards can negatively affect patients' access to services.²¹ Rising health care costs are also shown to influence rates of mental health service access along racial/ethnic or income based lines.²² Given this context of access to appropriate mental health care services, consumer and family perceptions of access to care were investigated. This provides a glimpse into the consumer understanding of the mental health care system.

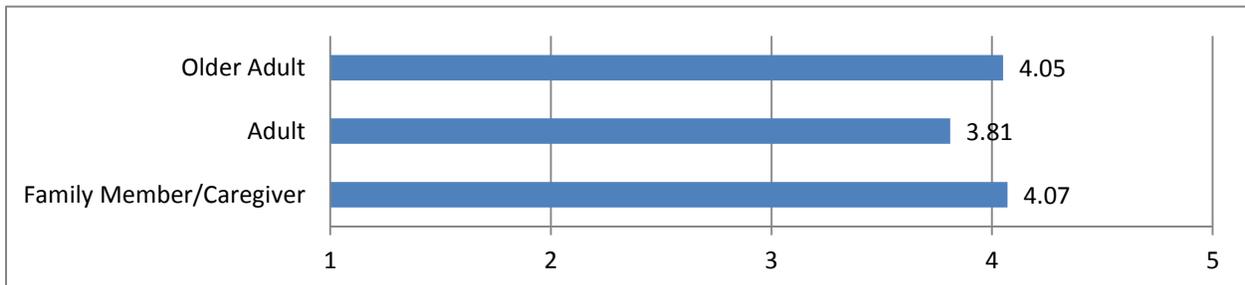
Data resulting from the FY 2008-09 and 2009-10 Consumer Perception Surveys were analyzed to create aggregate mean ratings of perception of access to mental health services. Among family members/caregivers and TAY respondents, ratings summarize perceptions of convenient service location and available service times. Among adult and older adult respondents, ratings summarize perceptions of the convenience of the location of services, the times services were available, staff willingness to provide service, prompt staff response to calls, ability to receive all necessary services, and ability to see a physician as needed. Five-point response scales (i.e., 1 – Strongly Disagree to 5 – Strongly Agree) were provided to respondents; thus, ratings of 3.5 or greater generally indicate positive perceptions of access to services.

Figure 6.5 – 1. Consumer Perceptions of Access to Mental Health Services, FY 2008-09



(See Appendix C, Table 6.5 -1 for response rates)

Figure 6.5 – 2. Consumer Perceptions of Access to Mental Health Services, FY 2009-10



(See Appendix C, Table 6.5 -1 for response rates)

Aggregate ratings indicate that all consumer respondent groups (i.e., family/caregiver, TAY, adult, and older adult) held positive impressions of their access to mental health services during both fiscal years analyzed (see Figure 6.5 - 1 & 2). However, such trends must be interpreted with caution, as the convenience sampling method employed to gather FY 2008-09 data has been found to not be representative of the entire mental health service population.²³ Additionally, the random sampling method employed during FY 2009-10 is currently under evaluation.

Within racial/ethnic groups, ratings of access to services were highest among adult and older adult Hispanic/Latino respondents in FY 2008-09 and 2009-10. Perceptions were relatively consistent across respondent groups (see Table 6.5 - 1).

Table 6.5 - 1. Consumer Perceptions of Access to Mental Health Services by Race/Ethnicity

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ²⁴	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
White	4.36 (n=13,035)	4.07 (n=564)	4.06 (n=7,782)		4.18 (n=20,190)	3.69 (n=842)	4.29 (n=2,381)	4.01 (n=1,345)
Hispanic / Latino	4.38 (n=17,783)	4.12 (n=490)	4.04 (n=4,700)		4.27 (n=11,400)	3.95 (n=227)	4.44 (n=893)	4.20 (n=414)
Asian	4.33 (n=1,211)	3.98 (n=57)	3.93 (n=1,004)		4.20 (n=3,133)	4.05 (n=181)	4.33 (n=332)	4.08 (n=465)
Pacific Islander	4.34 (n=476)	3.70 (n=23)	4.01 (n=487)		4.24 (n=1,752)	3.76 (n=26)	4.08 (n=41)	3.69 (n=8)
Black	4.34 (n=6,121)	4.06 (n=160)	3.97 (n=4,463)		4.22 (n=6,627)	3.80 (n=201)	4.28 (n=472)	4.01 (n=159)
American Indian	4.32 (n=1,742)	4.06 (n=69)	4.01 (n=1,748)		4.14 (n=2,634)	3.62 (n=108)	4.26 (n=185)	3.87 (n=114)

Ratings of access to mental health services were higher among female TAY and adult consumers, but higher among male family members/caregivers (see Table 6.6 - 2).

Table 6.5 - 2. Consumer Perceptions of Access to Mental Health Services by Gender

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ²⁵	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
Female	4.35 (n=13,052)	4.06 (n=399)	4.09 (n=10,176)		4.24 (n=22,915)	3.82 (n=934)	4.33 (n=2,531)	4.09 (n=1,586)
Male	4.37 (n=21,115)	4.08 (n=653)	3.95 (n=12,116)		4.19 (n=18,486)	3.80 (n=631)	4.31 (n=1,574)	3.97 (n=771)
Other	4.23 (n=26)	4.00 (n=1)	3.44 (n=101)		3.95 (n=291)	3.01 (n=4)	4.21 (n=20)	4.05 (n=7)

Overall, ratings suggest that on average, consumers held generally positive perceptions of their access to services.

Domain: Performance

Priority Indicator: 7.1 – FSP Consumers Served Relative to Planned Service Targets

Data Source: Data Collection and Reporting (DCR); County Plans / Annual Updates

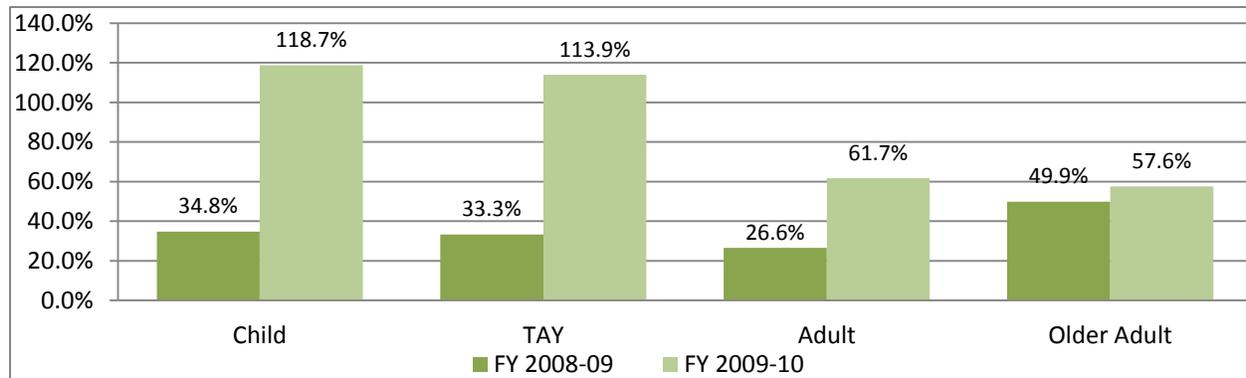
Counties/Municipalities Included (22): Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

(22 counties; 79% of counties responding to Data Quality Assurance Reports; 37% of all counties)

The number of FSP consumers served annually through Community Services and Support (CSS) programs relative to those who were targeted for service was examined to provide insight into the extent to which service levels have met expectations. FSP service targets were systematically collected from county three year plans and annual updates.

Among counties whose representatives verified their FSP service information, 29.5% (14,332/48,642) of the statewide FSPs service target was met in FY 2008-09 and 79.4% (18,357/23,112) in FY 2009-10. This improvement in the ratio of FSP consumers served to targeted is reflective of increased service rates, as well as increasingly accurate county service targets, as county's CSS programs become more established.

Figure 7.1 - 1. FSP Consumers Served to Planned Service Target, by Age Group



Because CSS programs are often tailored to serve specific age groups, ratios of FSP consumers served to those targeted for service were explored within age groups. Service ratios improved among all age groups year-to-year. However, child and TAY service rates exceeded service targets during FY 2009-10. Again, this is attributable to increased service rates and more accurate service targets.

Priority Indicator: 7.2 – Involuntary Status

Data Source: California DMH Reports – Involuntary Services, Seclusion, and Restraint

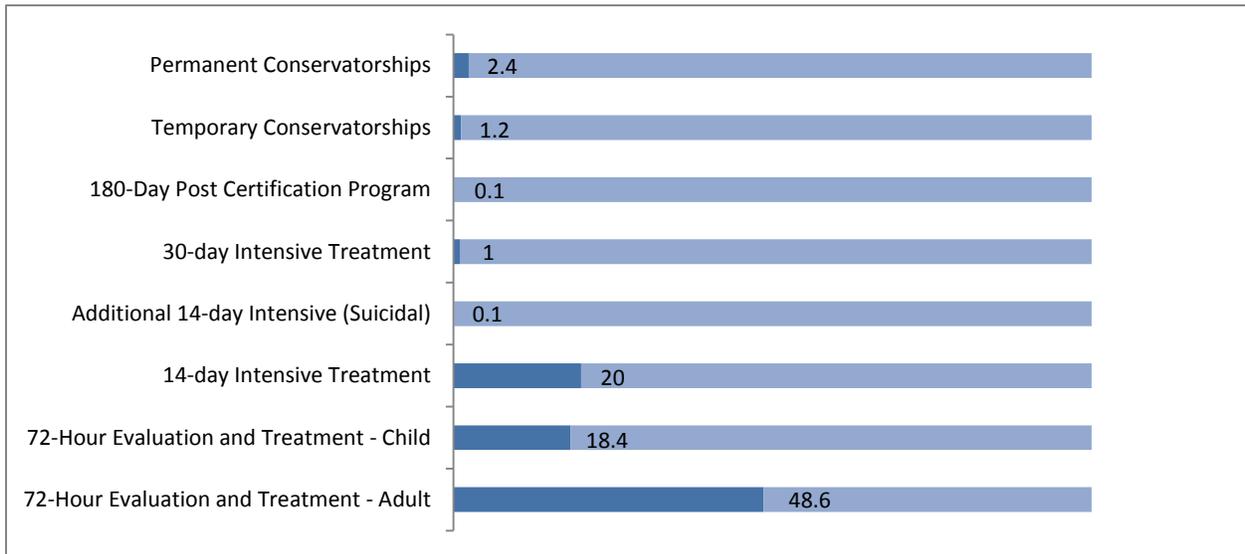
Counties/Municipalities Included: All

On July 1, 1969, the Lanterman-Petris-Short Act (LPS) became part of California’s Community Mental Health Services Law.²⁶ LPS resulted from statewide concerns regarding civil commitment of the mentally ill. California conducted a two-year review to redesign and improve involuntary care procedures. In sum, persons deemed “gravely disabled” or dangerous to themselves or others may enter the LPS involuntary care system.²⁷

Involuntary status refers to a legal intervention designed for persons with severe mental illness who are at risk for relapse and need ongoing care.²⁸ Involuntary care proponents assert that such services improve treatment adherence and may catalyze mental health services to mobilize and improve rigor.²⁹

Indicator 7.2 provides indication of the rate of involuntary status among all mental health consumers, during FY 2008-09.³⁰ Seventy-two hour evaluation and treatment services are the starting point for persons entering the involuntary care services system, thus 72-Hour services to children and adults were among the highest reported. Moreover, 14-day intensive treatments immediately follow 72-hour evaluations; therefore, these rates are also relatively high. Generally, the service rate patterns displayed in Figure 7.2 - 1 are reflective of the path mental health consumers take through the involuntary services system.

Figure 7.2 - 1. Involuntary Status Per 10,000, FY 2008-09



Priority Indicator: 7.3 – 24-Hour Care

Data Source: Client & Service Information (CSI); Data Collection and Reporting (DCR)

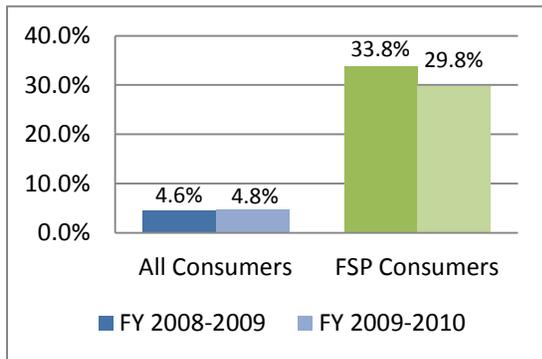
Counties/Municipalities Included: Butte, Calaveras, Contra Costa, Fresno, Kings, Lake, Los Angeles, Madera, Mariposa, Napa, Placer, San Bernardino, San Francisco, San Joaquin, Santa Clara, Santa Cruz, Sierra, Siskiyou, Solano, Stanislaus, Trinity, Tulare, Tuolumne

(23 counties; 82% of counties responding to Data Quality Assurance Reports; 39% of all counties)

Individuals with prolonged mental health related disability (examples include schizophrenia, schizoaffective disorder, and bipolar disorder) utilize substantial mental health resources due to the need for 24-hour care.³¹ Twenty-four-hour care services vary by age group. Specifically, Skilled Nursing Facilities and State Hospitals generally serve adults, older adults, and transition age youth (TAY). Community Treatment Facilities (CTFs) and Rate Care Level 14 (RCL 14) serve children and TAY. Mental Health Rehabilitation Centers (MHRCs) serve all populations yet separate children from adults and older adults.

Rates of 24-hour care can provide an indication of how well the mental health system is confronting the challenges of providing such intensive services. The mental health consumers and FSP consumers who received 24-hour care during FY 2008-09 and 2009-10 are detailed below.

Figure 7.3 - 1. 24-Hour Care Rates



Among counties that verified service data, proportionally more mental health consumers but fewer FSP consumers received 24-hours services during FY 2009-10 than in the previous year (see Figure 7.3 - 1).

The proportion of mental health consumers receiving 24-hour services decreased among all age groups, year-to-year. In contrast, the proportion of child and adult FSP consumers receiving 24-hour care increased during this period (see Figures 7.3 – 2 & 3).

Figure 7.3 - 2. Mental Health Consumers Receiving 24-Hour Care, by Age Group

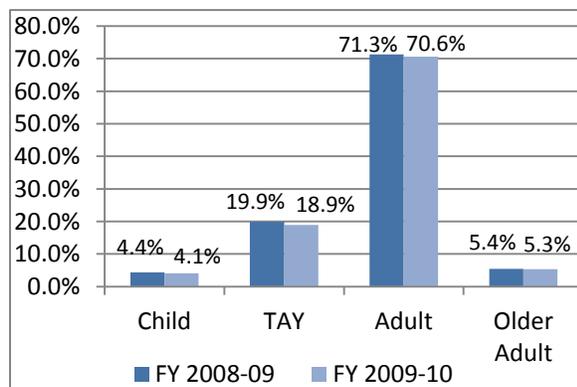
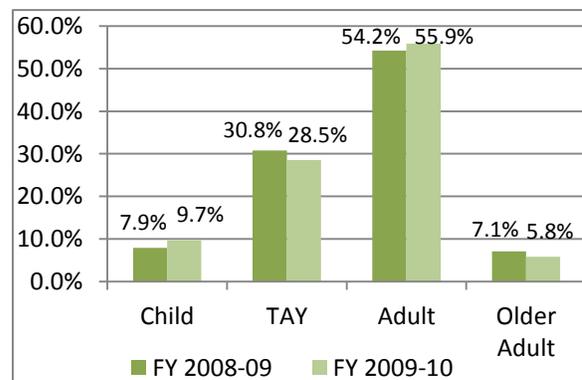


Figure 7.3 - 3. FSP Consumers Receiving 24-Hour Care, by Age Group

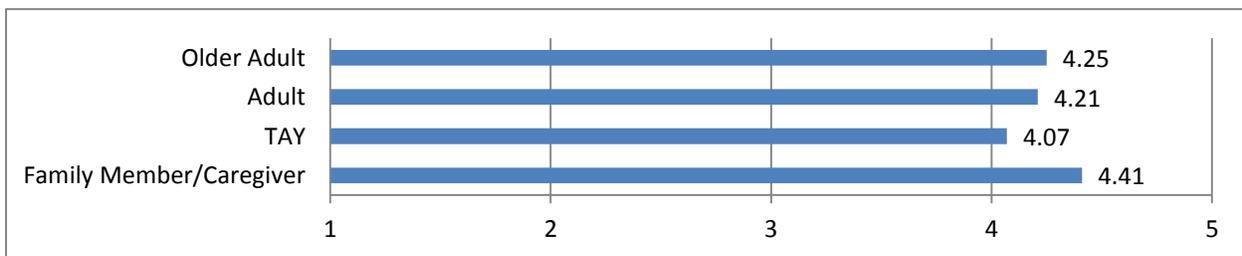


Priority Indicator: 7.4 – Consumer and Family Centered Care

Data Source: Consumer Perception Surveys

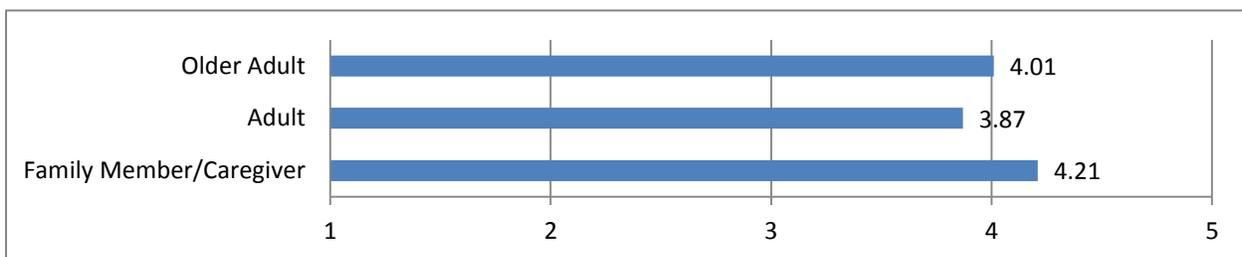
Sample Analyzed: Consumer Perception Survey Respondents To provide insight into consumer and family perceptions of their received care, the receive data resulting from the FY 2008-09 and 2009-10 Consumer Perception Surveys were analyzed to create aggregate ratings of consumer and family centered care. Among family members/caregivers and TAY respondents, ratings summarize perceptions of: respectful treatment by staff, staff respect for religious/spiritual beliefs, good communication with staff, staff sensitivity to cultural or ethnic background, and contribution to choosing child’s services and treatment goals. Among adult and older adult respondents, ratings summarize perceptions of: staff encouragement of recovery, freedom to raise complaints, receiving information about rights, encouragement to take responsibility for lifestyle, information about potential side effects of treatments, staff respect for confidentiality, staff sensitivity to cultural background, provision of sufficient information to assume personal management of illness, and encouragement to use consumer run programs. Five point response scales (i.e., 1 – Strongly Disagree to 5 – Strongly Agree) were provided to respondents, thus ratings of 3.5 or greater generally indicate positive perceptions of consumer/family centered care.

Figure 7.4 – 1. Perceptions of Consumer/Family Centered Care, FY 2008-09



(See Appendix C, Table 7.4 - 1 for response rates)

Figure 7.4 – 2. Perceptions of Consumer/Family Centered Care, FY 2009-10



(See Appendix C, Table 7.4 - 1 for response rates)

When compared to the subsequent year, ratings of consumer/family centered care were higher among FY 2008-09 respondents. However, differences between these fiscal years must be interpreted with caution, as the convenience sampling method employed to gather FY 2008-09 data has been found to not be representative of the entire mental health service population.³² Additionally, the random sampling method employed during FY 2009-10 is currently under evaluation.

Within each fiscal year analyzed, family member/caregiver ratings were the most positive among age groups (see Figure 7.4 - 1).

Table 7.4 - 1. Perceptions of Consumer/Family Centered Care, by Race/Ethnicity

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY ³³ 2009- 2010	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
White	4.46 (n=13,093)	4.23 (n=568)	4.13 (n=7,858)		4.23 (n=20,149)	3.80 (n=841)	4.27 (n=2,374)	3.99 (n=1,343)
Hispanic / Latino	4.42 (n=17,887)	4.22 (n=492)	4.11 (n=10,822)		4.29 (n=11,376)	4.02 (n=397)	4.40 (n=894)	4.13 (n=416)
Asian	4.41 (n=1,216)	4.12 (n=57)	4.06 (n=1,016)		4.19 (n=3,126)	4.01 (n=181)	4.27 (n=332)	3.99 (n=464)
Pacific Islander	4.45 (n=479)	4.02 (n=23)	4.05 (n=494)		4.23 (n=1,748)	3.87 (n=26)	4.20 (n=40)	3.58 (n=8)
Black	4.40 (n=6,141)	4.17 (n=162)	4.03 (n=4,525)		4.25 (n=6,612)	3.87 (n=201)	4.26 (n=473)	4.00 (n=159)
American Indian	4.41 (n=1,753)	4.32 (n=70)	4.09 (n=1,775)		4.22 (n=2,626)	3.83 (n=108)	4.23 (n=185)	3.90 (n=114)

Table 7.4 - 2. Perceptions of Consumer/Family Centered Care, by Gender

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY ³⁴ 2009- 2010	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
Female	4.40 (n=13,123)	4.18 (n=402)	4.15 (n=10,290)		4.29 (n=22,881)	3.91 (n=932)	4.32 (n=2,526)	4.05 (n=1,587)
Male	4.43 (n=21,224)	4.23 (n=656)	4.04 (n=12,282)		4.18 (n=18,450)	3.84 (n=630)	4.25 (n=1,575)	3.93 (n=769)

Consumer/family-centered care ratings were highest among Hispanic/Latino adults and older adults during FY 2008-09 and 2009-10 (see Table 7.4 - 1). Female respondents indicated higher average ratings of consumer/family-centered care than male consumers among TAY, adult, and older adult respondents.

Priority Indicator: 7.5 – Integrated Service Delivery

Data Source: County Plans / Annual Updates

Counties/Municipalities Included: All

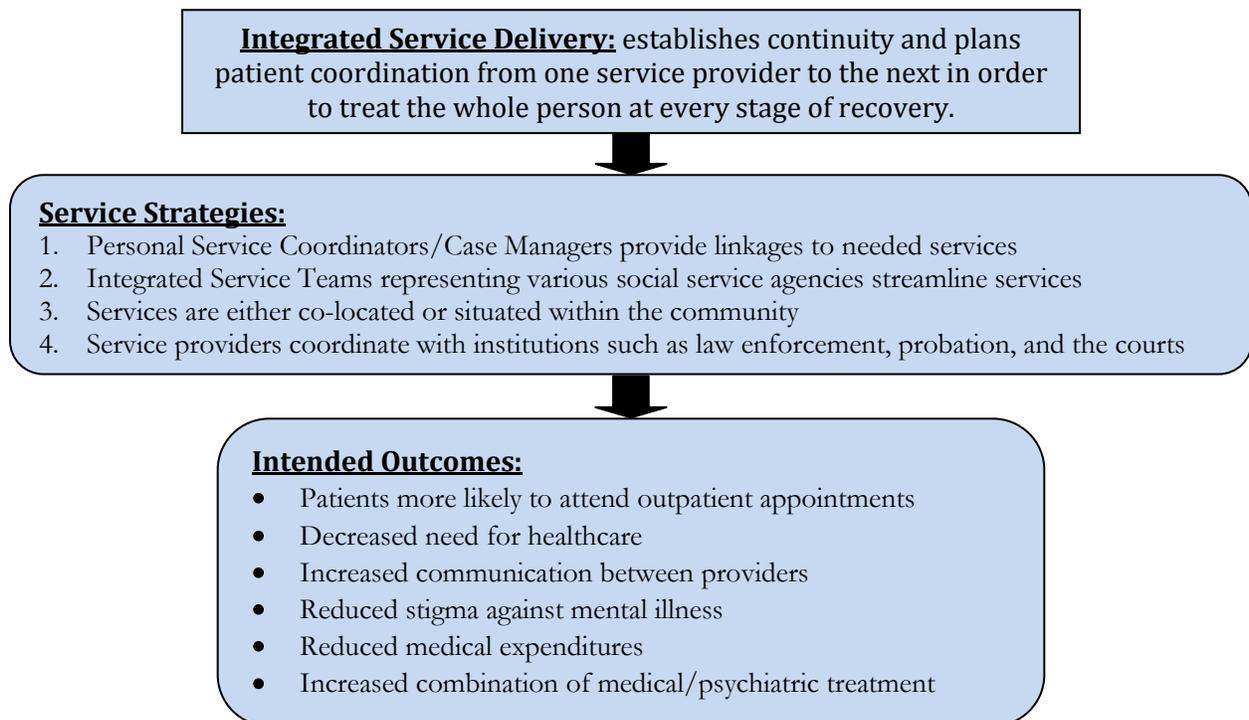
The Mental Health Services Act (MHSA) guidelines recognize that unaligned mental health services provide barriers to access for mental health consumers. MHSA therefore promotes integrated care that addresses all consumer needs at every stage of recovery. In order to establish integration, service providers coordinate treatment from one service provider to the next.³⁵ Integrated service delivery implies that county mental health programs ensure that consumers transition smoothly from intensive levels of care to outpatient care.

Integrated service processes are not tracked reliably statewide, thus county plans and annual updates were systematically reviewed and coded to identify planned strategies and services. Most counties (92%; 54) were found to detail plans for integrated service delivery. The following details common integrated service delivery strategies revealed through this analysis.

Common Integrated Service Delivery Strategies

Counties detailed plans for a myriad of initiatives to foster integrated service delivery. These actions include: referral to community contacts after referral or discharge, client movement in response to need, stability of the client caregiver relationship, communication among providers, and efforts to retrieve clients lost in the system.³⁶ Figure 7.5 - 1, highlights four key strategies for achieving integrated service delivery and their intended outcomes.

Figure 7.5 - 1. Consumer and Family Centered Care definition, service strategies, and intended outcomes³⁷



Nearly all (53) county CSS plans included brief statements regarding plans to provide “integrated services”, although 71% (42) of county CSS plans provided more detailed descriptions of these service strategies. Four key integrated service strategies found across counties (see Table 7.5-1)

Table 7.5 - 1. Common Integrated Service Delivery Strategies

Service Strategy	Counties/Municipalities Planning to Implement Strategy
Personal Service Coordinators/Case Managers provide linkages to needed services	13 (22%)
Integrated Service Teams representing social service agencies streamline services	35 (59%)
Services are either co-located or situated within the community	16 (27%)
Service providers coordinate with institutions such as law enforcement, probation, and the courts	21 (36%)

Detailed descriptions of each service strategy are provided below:

1) Personal Service Coordinators/Case Managers provide linkages to needed services. 22%

(13) of county plans indicated that a specific mental health employee will coordinate consumer transition from one service to the next. Plans indicate that these staff members work one-on-one with the consumer and their individualized wellness plans; consumers therefore receive the services and supports most relevant to them. Furthermore, because the individual staff member oversees the case from the beginning, he or she is able to make sure the consumer does not become “lost in the system.”

Personal Service Coordinator/Case Manager Statement from County CSS Plan: “As Personal Service Coordinators/Case Managers, they will participate in delivering services and coordinating care from the time a client enters the program, throughout the service delivery program, and until discharge. These individuals will provide family support, supportive services, linkage to services, rehabilitation services, and transportation.”

2) Integrated Service Teams representing social service agencies streamline services. 59% (35)

of county plans indicated that counties intend to coordinate service teams to streamline transitions from one level of care to the next. For example, social services, mental health services, inpatient facilities, and recovery centers collaborate to form one line of care. Plans state that this will allow clients to experience a “seamless transition” from one service to the next. Often, the variety and complexity of services prevents successful transition from one level of care to the next; plans state that this streamlined system will provide direct service paths to ensure that clients continue receiving a high quality of care.

3) Services are either co-located or situated within the community. 27% of county plans (16)

indicate that they intend to locate different services within the same facility or imbed services in existing community locations. Therefore, as consumers transition to less intensive levels of care, they would not need to seek out a new service provider or location. County plans indicate that co-locating services or placing them in the community minimizes the logistical issues consumers often face when trying to navigate the mental health system; consumers can easily move from one service to the next without having to rearrange existing service patterns.

Co-located Services Statement from County CSS Plan: “Integrated physical and mental health services, which includes co-location and/or collaboration with primary care clinics or other health care sites and providers to provide individualized, inter-disciplinary, coordinated services. Linkage will be provided for children and families served in these settings to the full range of mental health services when needed.”

Furthermore, when such services are situated in the community, CSS plans explain that consumers will feel more comfortable accessing needed services, resulting in improved coordination.

- 4) **Service providers coordinate with institutions such as law enforcement, probation, and the courts.** 36% of county plans (21) indicate intentions to coordinate transition services with public institutions. Often, mental health consumers begin receiving care in these institutions; when such consumers transition out of their institutional placement, they need assistance with coordinating service provision. As CSS Plans indicate, communicating with jails and other institutions where the patient once resided allows service providers to transfer case histories; new providers can therefore target service needs. Several county plans indicate that mental health staff members would visit these public institutions before the consumer is released in order to formulate a service plan. Such planning helps ensure that mental health consumers successfully transition from one level of care to the next.

Analysis of county plans suggests that substantial variation in integrated service strategies exists across counties. Such strategies set the stage for integrated service delivery models which are often very detailed, as consumers' paths through a streamlined system of care require coordination of several agencies and services. Investigation of these strategies and service models may provide insight into their effectiveness to support smooth consumer transitions to less intensive forms of care.

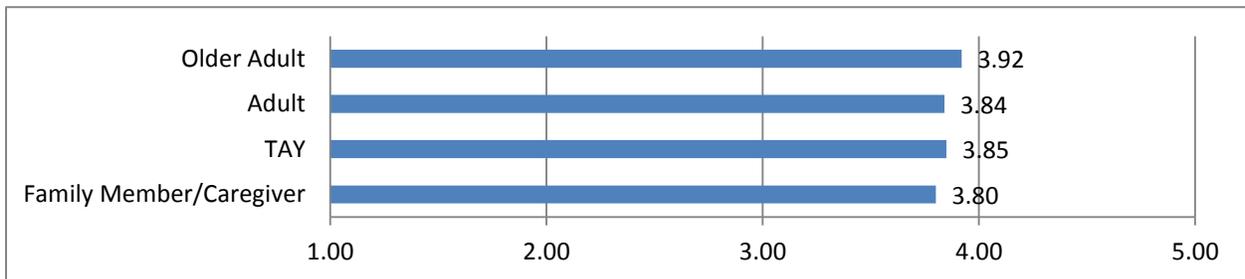
Priority Indicator: 7.6 – Consumer Wellbeing

Data Source: Consumer Perception Surveys

Sample Analyzed: Consumer Perception Survey Respondents The concept of quality of life encompasses many mental health and non-mental health related consumer outcomes relevant to the care of persons with serious mental illness. Quality of life has been defined as a broad concept, representing a person’s sense of well-being that stems from satisfaction or dissatisfaction with areas of life that are important to her/him.³⁸ Consumers see quality of life as the ability to achieve what many others take for granted; this includes housing, social support, meaningful activities, and an adequate standard of living.³⁹

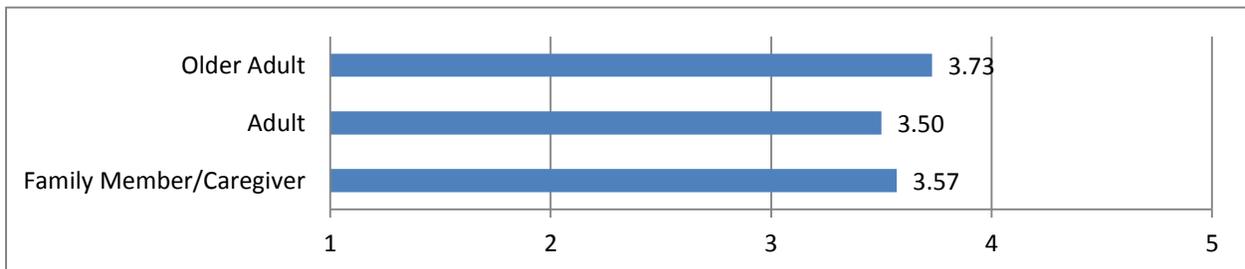
To provide insight into consumer and family perceptions, data regarding wellbeing as a result services received, from the FY 2008-09 and 2009-10 Consumer Perception Surveys were analyzed to create aggregate mean ratings. Among family members/caregivers and TAY respondents, ratings of wellbeing as a result of services summarize perceptions of: the ability to handle daily life, good relations with family members and friends, school or work performance, coping with setbacks, and satisfaction with family. Among adult and older adult respondents, ratings of wellbeing as a result of services summarize perceptions of: handling daily problems, control of one’s own life, ability to deal with crisis, good relations with family members, ability to handle social situations, school or work performance, meaningful activities, ability to take care of needs, coping with setbacks, ability to do things one want to, contentment with friendships, having people to share activities with, sense of community belonging, and support of family and friends. Five point response scales (i.e., 1 – Strongly Disagree to 5 – Strongly Agree) were provided to respondents, thus ratings of 3.5 or greater generally indicate positive perceptions of wellbeing.

Figure 7.6 – 1. Perceptions of Wellbeing, FY 2008-09



(See Appendix C, Table 7.6 - 1 for response rates)

Figure 7.6 – 2. Perceptions of Wellbeing, FY 2009-10



(See Appendix C, Table 7.6 - 1 for response rates)

Overall, ratings indicate that on average, consumers and family members during FY 2008-09 and 2009-10 held positive perceptions of their wellbeing as a result of the services they received. However, differences between these fiscal years must be interpreted with caution, as the

convenience sampling method employed to gather FY 2008-09 data has been found to not be representative of the entire mental health service population.⁴⁰ Additionally, the random sampling method employed during FY 2009-10 is currently under evaluation.

Within each fiscal year analyzed, older adult ratings were more positive than any other age group (see Figure 7.6 - 1). Ratings of wellbeing were highest among Hispanic/Latino consumers, with the exception of adults in FY 2009-10 (see Table 7.6 - 1). Males generally indicated higher average ratings of wellbeing than female consumers during both fiscal years examined (see Table 7.6 - 2).

Table 7.6 - 1. Perceptions of Wellbeing, by Race/Ethnicity

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ⁴¹	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
White	3.73 (n=12,860)	3.52 (n=562)	3.85 (n=7,774)		3.84 (n=20,021)	3.41 (n=842)	3.91 (n=2,330)	3.70 (n=1,340)
Hispanic / Latino	3.89 (n=17,476)	3.64 (n=494)	3.89 (n=10,732)		3.95 (n=11,362)	3.68 (n=371)	4.09 (n=871)	3.88 (n=407)
Asian	3.86 (n=1,192)	3.50 (n=57)	3.81 (n=1,007)		3.90 (n=3,138)	3.69 (n=182)	3.99 (n=322)	3.74 (n=464)
Pacific Islander	3.80 (n=473)	3.42 (n=23)	3.81 (n=487)		3.90 (n=1,757)	3.78 (n=26)	3.76 (n=41)	3.63 (n=10)
Black	3.69 (n=6,043)	3.56 (n=161)	3.85 (n=4,476)		3.86 (n=6,609)	3.51 (n=202)	3.96 (n=463)	3.73 (n=158)
American Indian	3.74 (n=1,705)	3.50 (n=70)	3.84 (n=1,754)		3.82 (n=2,645)	3.50 (n=108)	3.83 (n=181)	3.59 (n=113)

Table 7.6 - 2. Perceptions of Wellbeing, by Gender

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ⁴²	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
Female	3.80 (n=12,865)	3.54 (n=401)	3.82 (n=10,173)		3.85 (n=22,786)	3.50 (n=936)	3.95 (n=2,478)	3.74 (n=1,575)
Male	3.81 (n=20,804)	3.57 (n=652)	3.90 (n=12,154)		3.90 (n=18,426)	3.50 (n=631)	3.96 (n=1,534)	3.69 (n=769)

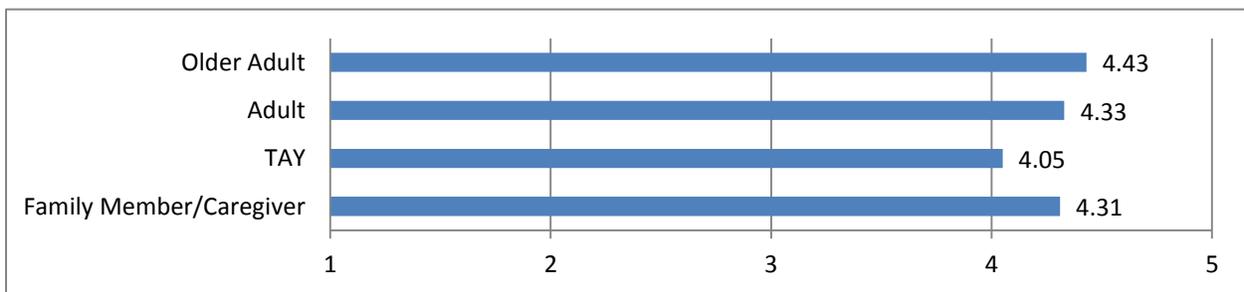
Priority Indicator: 7.7 – Satisfaction

Data Source: Consumer Perception Surveys

Sample Analyzed: Consumer Perception Survey Respondents The perceptions of mental health consumers and families are an important source of information regarding users’ experiences with services, service providers, and service coordination. Positive relationships between satisfaction ratings and treatment outcomes have been documented.⁴³ Satisfaction is an indication of the extent to which services and supports meet the needs of clients and families and is considered a key dimension of service quality.

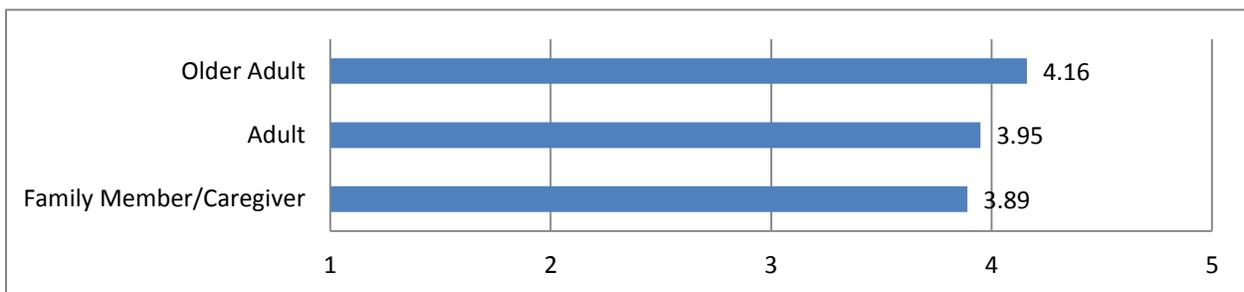
To provide insight into consumer and family satisfaction with services, data resulting from the FY 2008-09 and 2009-10 Consumer Perception Surveys were analyzed to create an aggregate of this dimension. Among family members/caregivers and TAY respondents, ratings of satisfaction summarize perceptions of: overall satisfaction with services, commitment of staff, the availability of someone to speak with when troubled, appropriateness of services, receipt of help wanted, and receipt of sufficient help. Among adult and older adult respondents, ratings of satisfaction summarize perceptions of: positive appraisal of services, preference for service agency when other options exist, and willingness to recommend services to others. Five-point response scales (i.e., Strongly Disagree – Strongly Agree) were provided to respondents, thus ratings of 3.5 or greater generally indicate positive perceptions of consumer/family-centered care.

Figure 7.7 – 1. Satisfaction with Services, FY 2008-09



(See Appendix C, Table 7.7 – 1 for response rates)

Figure 7.7 – 2. Satisfaction with Services, FY 2009-10



(See Appendix C, Table 7.7 – 1 for response rates)

Average ratings of satisfaction remained in the positive range in both fiscal years, indicating general satisfaction with services. Differences between these fiscal years must be interpreted with caution, as the convenience sampling method employed to gather FY 2008-09 data has been found to not be representative of the entire mental health service population.⁴⁴ Additionally, the random sampling method employed during FY 2009-10 is currently under evaluation.

Within each fiscal year analyzed, older adult ratings were more positive than any other age group (see Figure 7.7 - 1).

Table 7.7 - 1. Satisfaction with Services, by Race/Ethnicity

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ⁴⁵	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
White	4.31 (n=13,069)	3.87 (n=568)	4.10 (n=7,858)		4.35 (n=20,155)	3.84 (n=838)	4.47 (n=2,375)	4.13 (n=1,347)
Hispanic / Latino	4.35 (n=17,821)	3.93 (n=495)	4.09 (n=10,812)		4.42 (n=11,388)	4.07 (n=368)	4.57 (n=892)	4.33 (n=415)
Asian	4.31 (n=1,214)	3.86 (n=57)	4.02 (n=1,015)		4.32 (n=3,131)	4.12 (n=180)	4.42 (n=332)	4.15 (n=459)
Pacific Islander	4.33 (n=478)	3.68 (n=23)	4.04 (n=495)		4.38 (n=1,753)	3.82 (n=26)	4.15 (n=41)	3.60 (n=8)
Black	4.28 (n=6,124)	3.87 (n=162)	4.02 (n=4,521)		4.35 (n=6,618)	4.03 (n=203)	4.37 (n=472)	4.15 (n=159)
American Indian	4.27 (n=1,746)	4.00 (n=70)	4.06 (n=1,772)		4.30 (n=2,626)	3.80 (n=109)	4.44 (n=184)	4.10 (n=114)
Unknown	-- (n=5,109)	-- (n=102)	-- (n=5,012)		-- (n=11,262)	-- (n=230)	-- (n=1,240)	-- (n=420)

Satisfaction ratings varied substantially across racial/ethnic groups (see Table 7.7 - 1). As compared to males, female consumers indicated greater satisfaction with services across most age groups and both fiscal years examined (see Table 7.7 - 2).

Table 7.7 - 2. Satisfaction with Services, by Gender

	Family Member/ Caregiver		TAY		Adult		Older Adult	
	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010 ⁴⁶	FY 2008- 2009	FY 2009- 2010	FY 2008- 2009	FY 2009- 2010
Female	4.31 (n=13,082)	3.87 (n=404)	4.13 (n=10,279)		4.41 (n=22,891)	4.01 (n=931)	4.49 (n=2,527)	4.22 (n=1,583)
Male	4.32 (n=21,176)	3.90 (n=655)	4.02 (n=12,281)		4.32 (n=18,457)	3.85 (n=628)	4.42 (n=1,571)	4.04 (n=768)

Overall ratings indicate that on average, consumers and family members during FY 2008-09 and 2009-10 were generally satisfied with the services they received; this provides a positive indication of service quality.

Domain: Structure

Priority Indicator: 8.1 – Evidence Based or Promising Practices and Programs

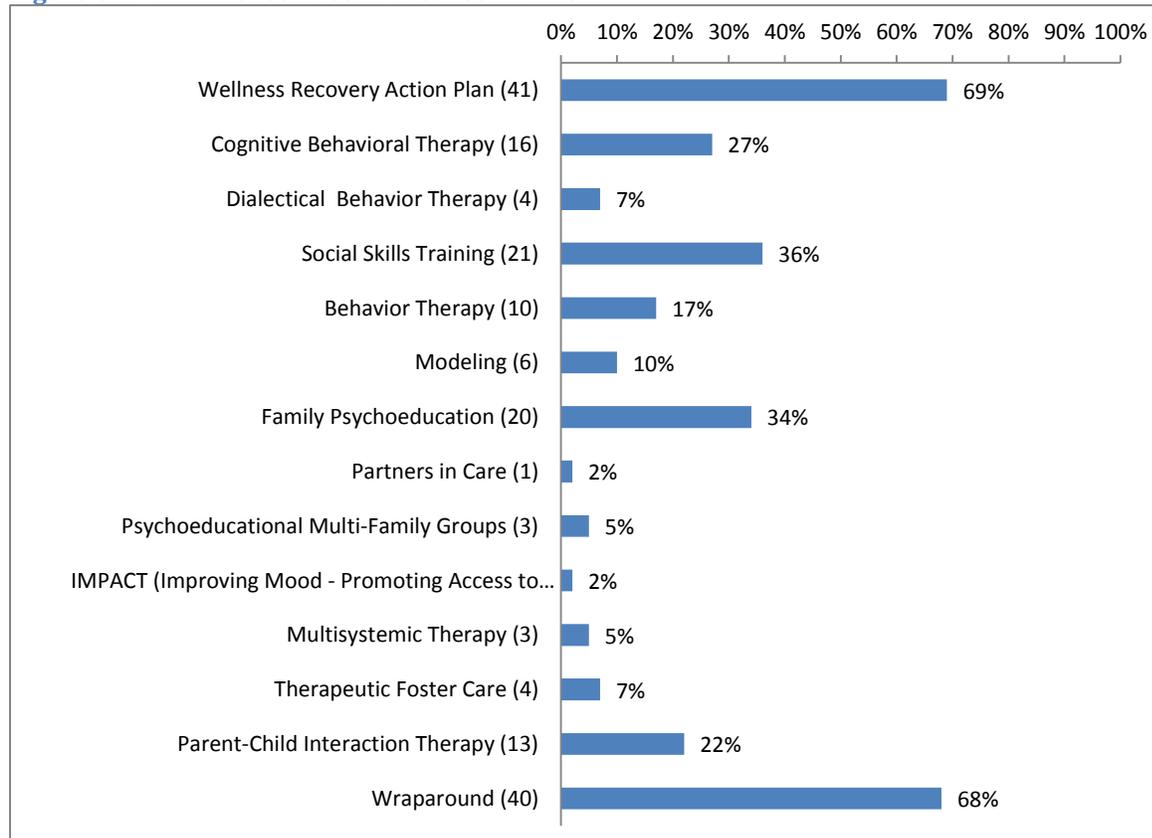
Data Source: County Plans / Annual Updates

Counties/Municipalities Included: All

Evidence Based Practice (EBP) refers to a body of scientific knowledge about service practice; specifically, the term indicates the quality, robustness, or validity of scientific evidence as it is examined in the clinical setting.⁴⁷ In other words, EBPs are interventions that have been found to consistently improve client outcomes.⁴⁸ The use of such established practices is considered an indicator of appropriate and competent care.

Historically, California has not rated highly on evidence based practice implementation across the mental health system, in reports to SAMHSA. MHPA-supported implementation of evidence based or promising practices is not tracked reliably statewide. To provide indication of the prevalence of EBPs or promising practices planned, county plans and annual updates were initially reviewed and coded to assess the variety of services. Services found were identified as evidence based by a panel of experts, county representatives, and other stakeholders. Then county plans were coded to assess the frequency of plans to implement evidence based practices. Figure 8.1 - 1 highlights EBPs and the prevalence with which they were planned to be implemented statewide.

Figure 8.1 - 1. Evidence Based Practices Planned



The most common EBPs planned across the state include “Wraparound” services and “Wellness Recovery Action Plans.” These approaches have the common thread of tailored or individualized treatment to achieve wellness goals. The prevalence with which these EBPs were planned across the state reflects the emphasis on client centered care throughout the mental health care system.

To familiarize the reader with the EBPs planned across the state, the proceeding section details each approach.

Evidence Based Practices – Detail

Wellness Recovery Action Plan (WRAP): Allows mental health consumers to recognize their personal assets in order to create an individualized action plan tailored towards the consumers’ goals; the WRAP model facilitates mental health consumers in directing their own path to wellness.⁴⁹

Cognitive Behavioral Therapy: Focuses on treating a consumer’s negative thought patterns and attempts to uncover the beliefs that promote such thinking; this reflective process aids in reversing maladaptive thinking patterns.⁵⁰

Dialectical Behavior Therapy: Modification of Cognitive Behavioral Therapy designed to specifically treat individuals with self-harm behaviors; clients receive individual therapy, skills group, and phone coaching.⁵¹

Social Skills Training: Teaches mental health consumers about the verbal and nonverbal behaviors in social interactions in order to help consumers relate to other individuals.⁵²

Behavior Therapy: Increases the mental health consumer’s engagement in positive activities in order to help the individual comprehend how changing their behavior can change how they are feeling.⁵³

Modeling: Mental health consumers observe individuals coping in situations that typically cause them anxiety; the underlying principle is that people can change through watching others successfully managing problems typically faced by the client.⁵⁴

Family Psychoeducation: Consumers and their families engage in psychoeducation therapy for at least six months; therapy focuses on education about the illness, problem solving, creating social supports, and developing coping skills.⁵⁵

Partners in Care: Attempts to improve the quality of mental health care through collaboration between specialist and generalist, active case management, and patient empowerment.⁵⁶

Psychoeducational Multifamily Groups: Similar to Family Psychoeducation, however this approach involves consumers and their families meeting with five to six additional families in one setting.⁵⁷

IMPACT (Improving Mood--Promoting Access to Collaborative Treatment): Depression treatment for older adults using a collaborative and stepped care approach in primary care.⁵⁸

Multisystemic Therapy: Improves outcomes for chronic and violent juvenile offenders through implementing an intensive community and family based treatment program in which clinicians are available “24/7”.⁵⁹

Therapeutic Foster Care: Places foster care children with families who have been specially trained to care for youth with specific medical or behavioral needs.⁶⁰

Parent-Child Interaction Therapy: Assists youth with emotional and behavioral disorders through focusing on changing the behavior of both the parent and the child by restructuring interaction patterns.⁶¹

Wraparound: A community based empowerment approach designed for families of children and adolescents with emotional and behavioral disorders; treatment provides an individualized strengths and resiliency counseling for one to two years.⁶²

Priority Indicator: 8.2 – Cultural Appropriateness of Services

Data Source: Workforce Education and Training (WET) Plans; County Plans / Annual Updates

Counties/Municipalities Included: All

Disparities exist amongst racial and ethnic minorities regarding access and utilization of mental health services.⁶³ To mitigate this issue, researchers suggest that practitioners adapt their services to meet the cultural and linguistic needs of their client demographic. Often, this type of provision is referred to as “cultural competency.” Cultural competence refers to a set of skills or processes that allow mental health practitioners to provide services in the most appropriate way for the diverse populations they serve.⁶⁴ This approach includes attention to language differences and how culture affects attitudes, expressions of distress, and help seeking practices. Culturally competent services and professionals demonstrate respect for consumers’ cultural context and are willing to learn about other cultures.⁶⁵ Implementing culturally competent practices can help break down barriers that underserved or un-served individuals often face when seeking treatment.

Culturally competent services are not tracked reliably statewide, thus county plans and annual updates were systematically reviewed and coded to identify culturally appropriate strategies and services. All California Counties detailed plans to implement culturally competent services, most in line with the recommendations of the *California Mental Health Master Plan*. Further investigation into each culturally competent service strategy planned, and their prevalence across the state, was conducted. The proceeding narrative highlights the specific *California Mental Health Master Plan* recommendations and the percent of counties planning to utilize such strategies.

Prevalence of Culturally Competent Service Strategies

Service Strategy	Counties/Municipalities Planning to Implement Strategy
“Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization, a diverse staff and leadership that are representatives of the demographic characteristics of the service area”	40 (68%)
“Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services”	52 (88%)
“Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area”	24 (41%)
“Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement”	44 (75%)
“California should improve access to treatment by providing high quality, culturally responsive, and language-appropriate mental health services in locations accessible to racial, ethnic, and cultural populations”	52 (88%)

Culturally competent service strategies are detailed below:

“Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization, a diverse staff and leadership that are representatives of the

demographic characteristics of the service area.” 68% (40) of counties plan to provide culturally competent services through recruiting, retaining, and promoting staff that are representative of the population served. This strategy helps ensure that consumers receive care from individuals who are knowledgeable and aware of their specific ethnic, cultural, and linguistic background.

“Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services.” 88% (52) of counties plan to provide linguistically appropriate services through bilingual staff and/or interpreter services. Counties have recognized where language gaps exist and indicate plans to target those specific threshold languages in order to provide culturally appropriate services.

Culturally Appropriate Materials Example from County CSS Plan:
“[County] will employ culturally competent community visibility by making use of “home-grown” media, such as radio stations and publications that promote wellness and resiliency at the local level”

“Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area.” 41% (24) of counties plan to create and disseminate patient-related materials reflective of the culture and language in a particular service area. Several counties stated that this would be done through upgrading signage at facilities and providing culturally specific décor. Other plans described culturally and linguistically relevant materials used for outreach and education.

Culturally Appropriate Materials Example from County CSS Plan: *“[County] made a major commitment to adapting facilities to the diverse cultural backgrounds of county residents to assure their comfort as they access mental health services. Over the course of two years nearly ten thousand dollars was spent on the acquisition of multicultural art to be placed in all consumer lobbies.”*

“Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement.” 75% (44) of county CSS plans indicate that they plan to partner with communities to incorporate the natural supports and culture of a particular service population. For example, several communities planned to partner with tribal organizations and ethnicity specific organizations to assist in the wellness and recovery of consumers.

Community Partnership Example from County CSS Plan: *“Community cultural practices – traditional practitioners, natural healing practices and ceremonies recognized by communities in place of or in addition to mainstream services.”*

“California should improve access to treatment by providing high quality, culturally responsive, and language-appropriate mental health services in locations accessible to racial, ethnic, and cultural populations.” 88% (52) of counties plan to implement mental health care services in the community, and 81% (48) specified where services will occur. The following locations include those targeted for community based service provision:

- Consumer homes
- Schools (Preschool, Elementary, Middle and High Schools)
- Neighborhood Community Organizations
- Adult Residential Facilities
- Congregate Housing Centers
- Faith-Based Providers
- Homeless Shelters
- Foster Homes
- Jails and Juvenile Halls
- Primary Care Clinics
- Migrant Labor Camps
- Assisted Living Centers

Providing services in these community settings is intended to allow consumers to feel comfortable; services provided in a culturally or socially familiar context is more meaningful to the consumer.

Priority Indicator: 8.3 – Recovery, Wellness, and Resilience Orientation

Data Source: Workforce Education and Training (WET) Plans; County Plans / Annual Updates

Counties/Municipalities Included: All

MHSA guidelines recognize and support the emerging statewide “recovery, wellness, and resiliency orientation” approach.⁶⁶ The recovery, wellness, and resilience perspective acknowledges that all individuals can recover from mental illness; this includes individuals experiencing extreme difficulties over a long period of time. Mental health consumers and practitioners with a recovery, wellness, and resiliency orientation do not believe that individuals with mental illness will continue to deteriorate. Rather, they encourage mental health improvement in non-sequential, dynamic stages. These stages embrace the concepts of hope, empowerment, self-responsibility, and a meaningful role or “niche” in life.⁶⁷

The CA Wellness Recovery Task Force outlines the following as cornerstones of a recovery-oriented system:

- A widespread understanding of, and belief in, recovery among staff, consumers and family members
- Quality of life program elements that lead to the creation of integrated services
- Quality of life outcome data incorporated into program design monitoring
- Consumers and family members widely employed throughout mental health administration and programs in a variety of roles.
- Leadership promotion of recovery-oriented principles and practices
- Staff training focused on recovery-oriented values, principles and practices
- Partner with community resources to maximize access
- Reduction in the use of hospitals and institutional settings (if not the elimination)
- People who are homeless, institutionalized, and those in transition from the children's system of care to adulthood are effectively engaged and supported
- Consumers and families involved in all aspects of system planning and management⁶⁸

To provide a greater understanding of how counties intend to promote a wellness, recovery and resilience orientation, county plans and annual updates were systematically reviewed and coded to identify relevant strategies and services. The prevalence of strategies and services intended to promote a wellness, recovery and resilience orientation are detailed in the following sections.

Collaboration with Community Services

According to the California Wellness Recovery Task Force a recovery-oriented mental health system “partners with community resources to maximize access.” A review of county CSS Plans illustrates that 96% (57) of counties plan to collaborate with community resources. Most counties (86%; 51) provided detailed collaboration descriptions. These plans align with recommendations outlined in the *California Mental Health Master Plan: A Vision for California*. These recommendations outline two forms of community collaboration. The quotation below illustrates the specific recommendation.

“Partnership development will focus on two separate groups—service providers and other community groups that have access to children and families. Relationships with these groups will help to expand referral and training opportunities.”

Interagency collaboration represents the first recommendation, such that: “The county mental health departments should actively facilitate the interagency collaboration among social services, health, and mental health agencies to serve racial, ethnic, and cultural populations more effectively.” 83% (49) of counties plan to coordinate mental health services with related agencies in the community. For example, several plans illustrate intentions to collaborate with county departments and social service agencies.

The second recommendation pertains to “ecologically valid services.” According to the Master Plan: “Ecologically valid services enhance access by being provided in churches, housing projects, and other community facilities used by racial, ethnic, and cultural communities.” Another recommendation states that “The DMH should encourage county mental health departments and the agencies with which they contract to structure services so clients can use natural support systems in their own racial, ethnic, and cultural communities.”. 68% of counties plan to implement ecologically valid services. For many counties, this service provision entails partnering with organizations that consumers already utilize as support systems.

Example of Ecologically Valid Services from County CSS Plan: “[Services] will not only help the individuals/families identify these strengths but will also try to identify and collaborate with any spiritual or religious leaders, natural support systems, community organizations and self-help groups that could be beneficial to the recovery process for an individual/family”

Substance Abuse Treatment

The second California Wellness Recovery Task Force cornerstone states that recovery oriented care includes: “Quality of life program elements that lead to the creation of integrated services.” Therefore, staffing substance abuse specialists helps promote recovery, resilience, and wellness. The following figures display the percentage of counties planning to include substance abuse specialists on staff. A review of all county CSS Plans reveals that 78% (46) of counties plan to include substance abuse specialist as part of the mental health staff.

Discharge Planning

The California Wellness Recovery Task Force states that a recovery-oriented system includes: “People who are homeless, institutionalized, and those in transition from the children's system of care to adulthood are effectively engaged and supported.” The *California Mental Health Master Plan: A Vision for California* further details what this transition implies. One aspect requires mental health providers to “specify discharge readiness criteria, i.e., when services will no longer be necessary.” Once practitioners determine consumer readiness, the practitioner must create a plan for the consumer’s discharge. The specific recommendation states “All counties should establish an Interagency Policy Council...the duties of this council would be to coordinate discharge planning, provide consistent treatment of clients in jails, and implement and expand diversion programs.” In addition to incarcerated consumers, discharge planning should include individuals in inpatient and acute facilities.

County CSS plans indicate that 30% (18) of counties plan on implementing discharge planning and/or creating discharge criteria. Fifteen percent (9) of counties detailed the services they intended to provide.

Developing specific discharge criteria represents the first dimension of discharge planning. The *California Mental Health Master Plan: A Vision for California* indicates that these criteria are part of each consumer's individualized plan; these criteria are therefore specific to the individual's needs and abilities to transition out of service provision. Plans also state that this plan is frequently used to help children and adolescents transition to out of state services such as foster care and group homes.

Creating a discharge plan for persons incarcerated, residing in inpatient facilities, or acute care is the second aspect to discharge planning. CSS Plans detail that this planning requires coordination with various agencies in order to ensure a proper

Example of Discharge Planning from County CSS Plans: *"One full time staff will be located at the Main Jail and will focus on discharge planning to ensure a seamless transition into a community facility."*

transition that prevents consumers from becoming "lost in the system." Plans also explain that Personal Service Coordinators or Multidisciplinary Teams will be responsible for this discharge planning; these individuals will attend discharge meetings and craft individualized plans based on the consumers' needs.

Workforce Education and Training for a Recovery, Wellness and Resilience Orientation

County Workforce Education and Training (WET) Plans indicate which programs promote recovery, resiliency, and wellness. According to totals compiled from each county WET Plan Action Matrix, 98% (406) of all actions planned across all counties promote recovery, resiliency, and wellness.

Discussion: Consumer-Level Priority Indicators

Consumer-level priority indicators were designed to assess consumers' dispositions over time, including those sponsored by the MHSA. The indicator set should measure both mental health and cues of mental health service impact on consumers. The utility of each indicator is briefly discussed by priority indicator.

Domain: Education and Employment

Education – FY 2009-10 data was not analyzable for comparison; it remains to be seen if an anticipated decrease across the proportion of children decreased from year to year. Data proposed for this indicator – how often children and TAY attend school – is not currently collected, thus an estimate of attendance was calculated using suspensions and expulsions. This misses the mark on measuring daily absences and should be addressed through data collection or indicator refinement for future reports.

Employment – DCR data provided robust information with which to calculate paid and non-paid employment rates across FY 2008-09 and 2009-10. Data revealed that of the small percentages of FSP consumers who were employed, most received pay for their work. Nearly all CSI employed consumers received pay. The variables used provide information regarding the proportion of employed consumers at any given point in the fiscal years; however do not provide a sense of how long consumers held a particular employment status. A close examination of the data indicated that consumers, who are surveyed multiple times during each fiscal year, maintained their employment statuses for much of the year.

Domain: Homelessness and Housing

There are some outstanding questions regarding the accuracy and reliability of the data in reflecting the status of housing for consumers. The data used in determining housing status were collected sporadically. For FSP consumers, these data were collected through Key Event Tracking (KET); for CSI consumers, through periodic updates. However, feedback from counties suggests that a uniform standard does not exist for such updates. This reduces confidence that these data faithfully and completely capture a description of a status so transitory as homelessness. In particular, it would be reasonable to expect that those consumers at highest risk would also be least likely to be represented in such periodic updates. There are, then, two issues that need further study before making substantive claims based on these data: (1) the standard practices for meriting and recording such periodic updates; and (2) the efficacy of these practices in faithfully and completely representing the consumer population.

Domain: Justice Involvement

Arrests – The evaluation team attempted to calculate both arrests and incarcerations to examine consumers' involvement with the justice system during FY 2008-09 and 2009-10. Consumer perception surveys provided scant information (and none about youth arrests). However, DCR data revealed more robust findings – the arrest rate was <1 per FSP consumer. Other variables are available in the data to more closely examine post-arrest activities such as detention, incarceration, probation camp and the like. Subsequent reports would be improved with the addition of this information once it has been reviewed by counties.

Incarcerations - Stakeholders proposed incarceration counts to gain more insight about the state of consumers' justice involvement. While there are variables that are similar to incarceration, none directly measure this in both CSI and DCR datasets in ways that can be easily extracted for analysis,

which creates a challenge for the evaluation. A review of the legal class categories might yield a new field such that incarcerations can be accounted for in subsequent evaluations.

Domain: Emergency Care

Emergency Intervention for Mental Health Episodes – Calculations using CSI data showed that on average consumers visited hospitals for mental health episodes less than once annually. Such visits were rare across the target fiscal years. In contrast, consumers often visited non-hospital facilities for emergency care. Consumers visited such facilities between four and six times annually, suggesting that urgent care is addressed largely by these facilities. Findings are limited by the lack of comparable DCR data to reveal where FSP consumers receive their emergency care. The evaluation team seeks such information in the services of understanding how FSP consumers are similar or dissimilar in the ways that they address their emergency care needs.

Emergency Intervention for Co-occurring Physical Injury – No data is currently available to create an appropriate measure of co-occurring physical injury. Medical notes that could clearly identify such injuries for extraction and quantification have not yet been identified. A systematic way of collecting such information through CSI or DCR is recommended for the purpose of capturing how many visits consumers make to any urgent care facility for injuries that are related to or caused by mental health instability.

Domain: Social Connections

Social Connection – Stakeholders suggested social connections as an additional indicator domain to measure well being. The indicator is a strong addition to consumer-level measurement, however data is not readily available to count how many family members, non-family members, and organizations consumers deem “supportive” during a crisis and everyday life.

Discussion: Mental Health System Performance Indicators

This report represents an important step toward refining priority performance indicators of the mental health system. System level priority indicators were designed to provide a multidimensional understanding of how the mental health system overall, and MHSA supported programs specifically, are serving consumers and their families, providers, and other stakeholders. Conclusions and implications regarding the reliability, diagnostic utility and sustainability of system level priority indicators, which can be drawn from the analyses of existing data presented in this report, are discussed below.

Domain: Access

Demographic Profile of Consumers Served – Services to minority consumers increased year-to-year as a proportion of the overall service population. Results provide better understanding of the extent to which county mental health systems are serving minority and other traditionally underserved or unserved populations. However, the snapshot of mental health service populations provided by this indicator must be viewed with an understanding of the brief time span investigated (FY 2008-09 and 2009-10), as well as inconsistencies of mental health service information (e.g., year-to-year and between counties) expressed by several counties and stakeholders, and supported data quality analysis. This indicator can provide important understanding of mental health service populations and their changing composition. Further analysis of service information from additional years will provide greater insight concerning changes in minority participation in the mental health system and what drives it.

New Consumers – The proportion of all new mental health consumers increased and the proportion of new FSP consumers decreased year-to-year. Older adult, adult, and TAY consumers increased as a proportion of all new mental health consumers, while TAY and children increased as a proportion of FSP consumers served between FY 2008-09 and 2009-10. Understanding who new mental health consumers are can provide indication of changes in the composition of service populations. This indicator will provide greater understanding as analysis of information from additional service years is conducted.

Penetration of Mental Health Services – A moderate proportional decrease in penetration rates year-to-year was found, however this trend should be considered in the context of increasing service need and decreasing county resources, since the 2008 economic downturn. Indications of the extent to which mental health services are reaching those in need are a crucial component of a multidimensional assessment of the mental health system. As the accuracy of estimations of the need for mental health services improves, the rate of penetration of mental health services will become more reliable and instructive.

Access to a Primary Care Physician – Many mental health consumers view primary care as a cornerstone to their healthcare and therefore look towards general practitioners to assist with their mental health service provision.⁶⁹ Trends suggest that FSP consumers' access to a primary care physician is increasing. This indicator provides insight into the extent to which consumers are connected with a key point of access to mental health service. More complete and regular tracking of this factor among FSP consumers, and initiating tracking of this factor among all mental health consumer, would increase the diagnostic value of this indicator.

Perceptions of Access – Ratings suggest that on average consumers held positive perceptions of their access to mental health services. As noted earlier, concerns regarding the sampling methods utilized to collect consumer perception information reduce confidence in the representative nature of this data, and do not allow for reliable comparisons across time. Implementation of a sampling methodology, which can produce information that is representative of consumer perceptions statewide and in each county, will improve the accuracy and utility of this indicator.

Domain: Performance

FSP Consumers Served – The ratios of FSP consumers served to planned service targets improved year-to-year. This trend is attributable to increased service rates and more accurate service targets established by counties as programs become more established. This indicator provides insight into the extent to which service levels are in line with service projections of counties. As county service projections become more precise and additional years of data are available, the accuracy of this indicator and utility for monitoring service patterns will improve.

Involuntary Status – Involuntary status rate patterns largely reflected the path mental health consumers take through the involuntary services system. Investigations of involuntary status patterns over time are necessary to provide a fuller picture of their use. This indicator has the potential to provide monitoring of intense services, which require substantial resources.

24-Hour Care – Overall, FSP consumers received 24-hours services at greater rates, compared to all mental health consumers, during FY 2008-09 and 2009-10. This is likely attributable to FSP eligibility criteria and the resources of CSS programs to provide such intensive services. However, a larger proportion of adult mental health consumers overall received 24-hour care, relative to adult FSP consumers, which may be indicative of FSP emphasis on consumer progress toward less intensive forms of care. This indicator can provide monitoring of the success of the mental health system in transitioning consumers to less intensive forms of care.

Consumer and Family Centered Care – Average ratings indicate consumers held positive perceptions of consumer and family centered care. A variety of consumer/family centered care strategies were planned across counties, with common emphasis on placing the needs and empowerment of consumers at the center of the service process. Considering these assessments together, this indicator can provide insight into the service approaches which support a consumer and family oriented care.

Integrated Service Delivery – Mental Health Services Act (MHSA) guidelines recognize that unaligned mental health services create barriers to care for mental health consumers. Analysis of county plans suggests substantial variation in integrated service strategies across counties. Such strategies set the stage for integrated service delivery models, which are often very detailed, as consumers' paths through a streamlined system of care require coordination of several agencies and services. Further investigation of these strategies and routine tracking of the processes involved are necessary to create a more comprehensive indicator of successful integration of service delivery, which can support smooth consumer transitions to less intensive forms of care.

Consumer Wellbeing – Ratings indicate on average consumers and family members during FY 2008-09 and 2009-10 held positive perceptions of their wellbeing as a result of the services they received. These perceptions provide another indication of the quality and appropriateness of care consumers receive.

Satisfaction – Ratings suggest that on average consumers and family members during FY 2008-09 and 2009-10 were generally satisfied with the services they received. This indicator provides another consumer driven assessment of service quality.

Domain: Structure

Evidence Based Practices – The most common EBPs found among county plans include “Wraparound” services and “Wellness Recovery Action Plans.” These approaches have the common thread of tailored or individualized treatment to achieve wellness goals. The prevalence with which these EBPs were planned across the state reflects the emphasis on client centered care among MHSA supported programs. While this indicator does provide insight into the diversity and prevalence of planned evidence-based services, routine tracking of such services will be necessary to create an indicator which can reliably monitor patterns of EBP use over time.

Cultural Appropriateness of Services – Studies indicate that mental health interventions targeted at a specific cultural group are more effective than interventions aimed to serve a diverse cultural group. Furthermore, interventions conducted in the client’s native language are twice as effective as interventions conducted in English. As such the most commonly planned strategies to provide culturally appropriate services across the state are intended to address service disparities among MHSA programs. However, routine tracking of processes intended to promote culturally appropriate service will be necessary to create an indicator, which can reliably monitor the use and effectiveness of these efforts.

Recovery, Wellness, and Resiliency Orientation – MHSA values support the emerging statewide “recovery, wellness, and resiliency orientation” approach. The variety and comprehensiveness of planned strategies intended to promote this approach (e.g., Collaboration with Community Services, Substance Abuse Treatment, and Discharge Planning, and Workforce Education and Training) demonstrate a strong base has been provided to support the expansion of this orientation. However, routine tracking of processes intended to promote a recovery, wellness, and resiliency orientation will be necessary to create an indicator, which can reliably monitor the use and effectiveness of these efforts.

System Indicator Summary

The system level priority indicators presented in this report provide a multidimensional assessment of access, performance qualities, and the structure and orientation of the MHSA programs and the mental health service system more broadly. Analyses presented provide greater understanding of the reliability, diagnostic utility and sustainability of system level priority indicators, in light of existing data system and sources. Many system-level indicators were found hold explanatory potential regarding the progress the community mental health system. Other indicators were found to require additional development or supporting information. As such, this report represents an important intermediate step, necessary to arrive at a more focused, reliable, and instructive mental health performance monitoring system.

Next Steps for the Evaluation

The following figure outlines next steps for the evaluation (additional detail is provided below):

Initial State Level Priority Indicator Report - for Stakeholder Input

- The present report highlighted initial analysis of priority indicators, developed by the California Mental Health Planning Council, stakeholders, experts, and the evaluation team. and approved by the MHSOAC .

Stakeholder Feedback Process (through August 28, 2012)

- The current report and a feedback guidance document will be widely disseminated , and posted at <http://www.mhsoac.ca.gov/Announcements/announcements.aspx>
- Webinars will be held, which summarize this report and detail the stakeholder feedback process

Final State Level Priority Indicator Report - Including Stakeholder Feedback

- The current report will be revised to incorporate feedback from stakeholders
- A revised report will present analysis of indicator data from all counties, regardless of response to Data Quality Assurance Reports
- A revised report is due to the MHSOAC on September 30th 2012

Initial County Level Priority Indicator Reports

- Reports will be developed for each California county and municipality administering MHSA programs, which include analysis of a refined set of priority indicators for county level performance monitoring
- These reports will be designed to provide each county and municipality with an in depth look at priority indicators of consumer outcomes and community mental health system performance
- Initial County reports are due to the MHSOAC on September 30th 2012

State & County Level Priority Indicator Reports (2nd edition)

- Reports will be produced at the state and county levels, which present analysis of the most recent data available, and revised priority indicators based upon stakeholder feedback and lessons learned from initial priority indicator analysis
- The 2nd editions of state and county level reports are due to the MHSOAC on March 31st, 2013

Additional detail follows, regarding the stakeholder feedback process, which will guide revision and development of this report, as well as upcoming reports:

Stakeholder Engagement and Feedback

Stakeholder feedback throughout the evaluation process has been integral to shaping this and other documents about priority indicator development. The evaluation team incorporates stakeholder feedback – a continual process – in generating all statewide and county-specific reports.

In the evaluation's earliest stages, input was collected from stakeholders through email correspondence and webinar discussions.³ Through a series of conference calls, data stakeholders (senior analysts from the California Department of Mental Health) provided information about and access to the project's target databases (e.g., CSI and DCR). Other critical participants in the feedback process included county representatives who were responsible for their local data. They verified data accuracy through quality assurance reports. Their responses were requisite in creating a more meaningful array of indicators from which the MHSOAC will select a final set to measure MHSA impact.

In continuing this valuable process, the evaluation team invites readers' responses to the current document. The UCLA-EMT evaluation team welcomes general comments and responses to the accompanying guidance document found at:

<http://www.mhsoac.ca.gov/Announcements/announcements.aspx>.⁷⁰

The feedback period will close on Tuesday, August 28, 2012. Following the close of the feedback period, the evaluation team will incorporate, where possible, or note feedback in a revised, final report. In addition, subsequent to the release of this report, webinars will be held for all interested stakeholders. Webinars will include introduction to this report and details regarding the stakeholder feedback process. A schedule of upcoming webinars will be publically disseminated and posted at:

<http://www.mhsoac.ca.gov/Announcements/announcements.aspx>.⁷¹

This dissemination and feedback process will provide an opportunity for a spectrum of stakeholders, as well as experts in the field, to contribute to the refinement of priority indicators and initial examination of MHSA impact on specific populations (e.g., age groups, race/ethnicity, and economic/living situation).

Upcoming Reports

Mental Health Services Act Evaluation: Initial Statewide Priority Indicator Report (including stakeholder input)

Following the close of the feedback period (ending Tuesday, August 28), the evaluation team will incorporate, where possible, or note feedback in a revised version of the present report. The revised report, to be delivered on September 30, 2012, will present analysis of indicator data from all counties, regardless of response to Data Quality Assurance Reports. The report will also

³ Members of the California Mental Health Directors Association (CMHDA) Indicators, Data, Evaluation and Accountability (IDEA) Ad-Hoc Committee and MHSA stakeholders provided input as a part of webinar discussions. In addition, the evaluation team extended an electronic call for feedback through approximately 30 mental health organizations and agencies of various clientele, size, focus, and reach throughout the state (refer to Appendix A of *Mental Health Services Act Evaluation: Compiling Data to Produce All Priority Indicators*; November 2, 2011).

emphasize the vital role of stakeholders in the development and revision process, so as to ensure the most appropriate and accurate refinement of the priority indicators of the community mental health system.

Mental Health Services Act Evaluation: Initial County Priority Indicator Reports

The UCLA-EMT MHSA evaluation team will prepare additional quarterly reports that detail indicators of mental health consumer outcomes and mental health system performance at the county level. Reports will be developed for each California county and municipality administering MHSA programs, which include a refined set of priority indicators appropriate for county level performance monitoring. These reports – available to county representatives, clients, families, stakeholders, policy makers, providers, and the like – will be designed to provide an in-depth look at indicators of the outcomes of their consumers and the performance of their community mental health system.

Appendix A – California Counties that Participated in the Data Quality Assurance Report Exercise

County	County Identification Number
1) Alameda	1
2) Butte	4
3) Calaveras	5
4) Contra Costa	7
5) Fresno	10
6) Glenn	11
7) Kings	16
8) Lake	17
9) Los Angeles	19
10) Marin	21
11) Mariposa	22
12) Napa	28
13) Placer	31
14) San Benito	35
15) San Bernardino	36
16) San Francisco	38
17) San Joaquin	39
18) San Mateo	41
19) Santa Barbara	42
20) Santa Clara	43
21) Santa Cruz	44
22) Sierra	46
23) Siskiyou	47
24) Solano	48
25) Stanislaus	50
26) Trinity	53
27) Tulare	54
28) Tuolumne	55

Appendix B – Account of Counties Included in Priority Indicator Calculations Requiring CSI or DCR Data

1.2 Education and Employment: Employment Status

County	CSI	DCR					
	P-03.0 Employment Status	Curr_Transitional	Curr_In-House	Curr_Non-paid	Curr_OtherEmployment	Curr_Competitive	Curr_Supported
Alameda (1)	nr	nr	nr	nr	nr		
Butte (4)	✓	✓	✓	✓	✓		
Calaveras (5)	x	✓	✓	✓	✓		
Contra Costa (7)	x	✓	✓	✓	✓		
Fresno (10)	✓	✓	✓	✓	✓		
Glenn (11)	x	x	x	x	x		
Kings (16)	nr	nr	nr	nr	nr		
Lake (17)	✓	✓	✓	✓	✓		
Los Angeles (19)	x	x	x	x	x		
Madera (20)	x	x	x	x	x		
Marin (21)	nr	nr	nr	nr	nr		
Mariposa (22)	✓	x	x	nr	x		
Napa (28)	✓	✓	✓	✓	✓		
Placer (31)	✓	✓	✓	✓	✓		
San Benito (35)	x	nr	nr	nr	nr		
San Bernardino (36)	✓	✓	x	✓	✓		
San Francisco (38)	x	x	x	x	x		
San Joaquin (39)	x	nr	nr	nr	nr		
San Mateo (41)		nr	nr	nr	nr		
Santa Barbara (42)	nr	nr	nr	nr	nr		
Santa Clara (43)	✓	✓	✓	✓	✓		
Santa Cruz (44)	✓	nr	nr	nr	nr		
Sierra (46)	✓	x	x	x	x		
Siskiyou (47)	✓	✓	✓	✓	✓		
Solano (48)	✓	✓	nr	✓	✓		
Stanislaus (50)	✓	nr	nr	nr	nr		
Trinity (53)	x	✓	✓	✓	✓		
Tulare (54)	✓	✓	✓	✓	✓		
Tuolumne (55)	✓	✓	✓	✓	✓		

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

2.1 Homelessness and Housing

County	DCR		
	Current	Living Situation	Date Completed
Alameda (1)	nr		
Butte (4)	✓		
Calaveras (5)	✓		
Contra Costa (7)	✓		
Fresno (10)	✓		
Glenn (11)	x		
Kings (16)	✓		
Lake (17)	✓		
Los Angeles (19)	x		
Madera (20)	✓		
Marin (21)	nr		
Mariposa (22)	✓		
Napa (28)	✓		
Placer (31)	✓		
San Benito (35)	nr		
San Bernardino (36)	✓		
San Francisco (38)	✓		
San Joaquin (39)	✓		
San Mateo (41)	nr		
Santa Barbara (42)	nr		
Santa Clara (43)	✓		
Santa Cruz (44)	nr		
Sierra (46)	✓		
Siskiyou (47)	✓		
Solano (48)	✓		
Stanislaus (50)	nr		
Trinity (53)	✓		
Tulare (54)	✓		
Tuolumne (55)	✓		

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

3.1 Justice Involvement

County	DCR	
	ArrestPast12 (PAF-Non-Res)	ArrestPrior12 (PAF Non-Res)
Alameda (1)	nr	nr
Butte (4)	✓	✓
Calaveras (5)	✓	✓
Contra Costa (7)	✓	✓
Fresno (10)	✓	✓
Glenn (11)	x	x
Kings (16)	nr	nr
Lake (17)	✓	✓
Los Angeles (19)	✓	✓
Madera (20)	✓	✓
Marin (21)	nr	nr
Mariposa (22)	✓	✓
Napa (28)	✓	✓
Placer (31)	✓	✓
San Benito (35)	nr	nr
San Bernardino (36)	✓	✓
San Francisco (38)	✓	✓
San Joaquin (39)	nr	nr
San Mateo (41)	nr	nr
Santa Barbara (42)	nr	nr
Santa Clara (43)	✓	✓
Santa Cruz (44)	nr	nr
Sierra (46)	✓	✓
Siskiyou (47)	✓	✓
Solano (48)	✓	✓
Stanislaus (50)	nr	nr
Trinity (53)	✓	✓
Tulare (54)	✓	✓
Tuolumne (55)	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

4.1 Emergency Care: Emergency Intervention for Mental Health Episodes

County	CSI			
	S-06.0 Service Function	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender
Alameda (1)	nr	nr	nr	nr
Butte (4)	✓	✓	✓	✓
Calaveras (5)	✓	✓	✓	✓
Contra Costa (7)	✓	x	✓	✓
Fresno (10)	✓	✓	x	x
Glenn (11)	x	nr	x	x
Kings (16)	nr	nr	nr	nr
Lake (17)	✓	✓	✓	✓
Los Angeles (19)	✓	x	✓	✓
Madera (20)	x	x	x	x
Marin (21)	nr	nr	nr	nr
Mariposa (22)	✓	✓	✓	✓
Napa (28)	✓	✓	✓	✓
Placer (31)	✓	✓	✓	✓
San Benito (35)	x	x	x	x
San Bernardino (36)	✓	x	✓	✓
San Francisco (38)	✓	nr	✓	✓
San Joaquin (39)	✓	x	✓	✓
San Mateo (41)	nr		x	
Santa Barbara (42)	nr	nr	nr	nr
Santa Clara (43)	✓	✓	✓	✓
Santa Cruz (44)	✓	✓	✓	✓
Sierra (46)	✓	x	✓	✓
Siskiyou (47)	✓	✓	nr	nr
Solano (48)	✓	✓	✓	✓
Stanislaus (50)	✓	nr	✓	✓
Trinity (53)	✓	✓	✓	✓
Tulare (54)	✓	✓	✓	✓
Tuolumne (55)	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

6.1 Access: Demographic Profile of Consumers Served

County	CSI				DCR				
	Ethnicity	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender	Gender	Ethnicity_A	Ethnicity_B	Race	Age_Group
Alameda (1)	nr	nr	nr	nr					
Butte (4)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Calaveras (5)	✓	✓	✓	✓	✓	x	x	x	✓
Contra Costa (7)	x	x	✓	✓	✓	x	x	x	✓
Fresno (10)	x	✓	x	x	✓	x	x	x	✓
Glenn (11)	x	nr	x	x	x	x	x	x	x
Kings (16)	nr	nr	nr	nr	x	x	x	nr	nr
Lake (17)	✓	✓	✓	✓	x	x	x	x	✓
Los Angeles (19)	x	x	✓	✓	✓	x	x	x	✓
Madera (20)	x	x	x	x	✓	✓	✓	✓	✓
Marin (21)	nr	nr	nr	nr					
Mariposa (22)	x	✓	✓	✓	✓	nr	x	✓	✓
Napa (28)	✓	✓	✓	✓	✓	✓	x	x	✓
Placer (31)	✓	✓	✓	✓	✓	x	x	✓	✓
San Benito (35)	x	x	x	x					
San Bernardino (36)	x	x	✓	✓	x	x	x	x	✓
San Francisco (38)	✓	nr	✓	✓	✓	x	x	x	✓
San Joaquin (39)	nr	x	✓	✓	✓	x	x	nr	nr
San Mateo (41)			x						
Santa Barbara (42)	nr	nr	nr	nr					
Santa Clara (43)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Santa Cruz (44)	✓	✓	✓	✓					
Sierra (46)	x	x	✓	✓	✓	x	x	✓	✓
Siskiyou (47)	✓	✓	nr	nr	x	x	x	x	✓
Solano (48)	x	✓	✓	✓	✓	x	x	nr	✓
Stanislaus (50)	nr	nr	✓	✓	✓	x	x	nr	nr
Trinity (53)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tulare (54)	✓	✓	✓	✓	✓	x	x	✓	✓
Tuolumne (55)	✓	✓	✓	✓	✓	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

6.2 Access: New Consumers by Demographic Profile

County	CSI					DCR			
	S-16.0 From/Entry Date	Ethnicity	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender	PartnershipDate	Gender	Race and Ethnicity	Age_Group
Alameda (1)	nr	nr	nr	nr	nr	nr	nr	nr	nr
Butte (4)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Calaveras (5)	✓	✓	✓	✓	✓	✓	✓	x	✓
Contra Costa (7)	✓	x	x	✓	✓	✓	✓	x	✓
Fresno (10)	✓	x	✓	x	x	✓	✓	x	✓
Glenn (11)	x	x	nr	x	x	x	x	x	x
Kings (16)	nr	nr	nr	nr	nr	✓	x	x	nr
Lake (17)	✓	✓	✓	✓	✓	✓	x	x	✓
Los Angeles (19)	✓	x	x	✓	✓	✓	✓	x	✓
Madera (20)	nr	x	x	x	x	✓	✓	✓	✓
Marin (21)	nr	nr	nr	nr	nr				
Mariposa (22)	✓	x	✓	✓	✓	✓	✓	nr	✓
Napa (28)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Placer (31)	✓	✓	✓	✓	✓	✓	✓	x	✓
San Benito (35)	nr	x	x	x	x				
San Bernardino (36)	✓	x	x	✓	✓	✓	x	x	✓
San Francisco (38)	✓	✓	nr	✓	✓	✓	✓	x	✓
San Joaquin (39)	✓	nr	x	✓	✓	✓	✓	x	nr
San Mateo (41)				x					
Santa Barbara (42)	nr	nr	nr	nr	nr				
Santa Clara (43)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Santa Cruz (44)	✓	✓	✓	✓	✓	nr	nr	nr	nr
Sierra (46)	✓	x	x	✓	✓	✓	✓	x	✓
Siskiyou (47)	✓	✓	✓	nr	nr	✓	x	x	✓
Solano (48)	✓	x	✓	✓	✓	✓	✓	x	✓
Stanislaus (50)	✓	nr	nr	✓	✓	✓	✓	x	nr
Trinity (53)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tulare (54)	✓	✓	✓	✓	✓	✓	✓	x	✓
Tuolumne (55)	✓	✓	✓	✓	✓	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

6.3 Access: Penetration Rate

County	CSI				DCR		
	Ethnicity	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender	Gender	Race and Ethnicity	Age_Group
Alameda (1)	nr	nr	nr	nr	nr	nr	nr
Butte (4)	✓	✓	✓	✓	✓	✓	✓
Calaveras (5)	✓	✓	✓	✓	✓	x	✓
Contra Costa (7)	x	x	✓	✓	✓	x	✓
Fresno (10)	x	✓	x	x	✓	x	✓
Glenn (11)	x	nr	x	x	x	x	x
Kings (16)	nr	nr	nr	nr	x	x	nr
Lake (17)	✓	✓	✓	✓	x	x	✓
Los Angeles (19)	x	x	✓	✓	✓	x	✓
Madera (20)	x	x	x	x	✓	✓	✓
Marin (21)	nr	nr	nr	nr			
Mariposa (22)	x	✓	✓	✓	✓	nr	✓
Napa (28)	✓	✓	✓	✓	✓	✓	✓
Placer (31)	✓	✓	✓	✓	✓	x	✓
San Benito (35)	x	x	x	x			
San Bernardino (36)	x	x	✓	✓	x	x	✓
San Francisco (38)	✓	nr	✓	✓	✓	x	✓
San Joaquin (39)	nr	x	✓	✓	✓	x	nr
San Mateo (41)			x				
Santa Barbara (42)	nr	nr	nr	nr			
Santa Clara (43)	✓	✓	✓	✓	✓	✓	✓
Santa Cruz (44)	✓	✓	✓	✓	nr	nr	nr
Sierra (46)	x	x	✓	✓	✓	x	✓
Siskiyou (47)	✓	✓	nr	nr	x	x	✓
Solano (48)	x	✓	✓	✓	✓	x	✓
Stanislaus (50)	nr	nr	✓	✓	✓	x	nr
Trinity (53)	✓	✓	✓	✓	✓	✓	✓
Tulare (54)	✓	✓	✓	✓	✓	x	✓
Tuolumne (55)	✓	✓	✓	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

6.4 Access: New High Need Consumers

County	CSI						DCR						
	P-03.0 Employment Status	P-09.0 Living Arrangement	S-06.0 Service Function	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender	Current	Current_Unemployed	Gender	Ethnicity_A	Ethnicity_B	Race	Age_Group
Alameda (1)	nr	nr	nr	nr	nr	nr	nr	nr	nr	nr	nr	nr	nr
Butte (4)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Calaveras (5)	x	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x	✓
Contra Costa (7)	x	✓	✓	x	✓	✓	✓	✓	✓	x	x	x	✓
Fresno (10)	✓	✓	✓	✓	x	x	✓	✓	✓	x	x	x	✓
Glenn (11)	x	x	x	nr	x	x	x	x	x	x	x	x	x
Kings (16)	nr	nr	nr	nr	nr	nr	✓	✓	x	x	x	nr	nr
Lake (17)	✓	✓	✓	✓	✓	✓	✓	✓	x	x	x	x	✓
Los Angeles (19)	x	x	✓	x	✓	✓	x	x	✓	x	x	x	✓
Madera (20)	x	x	x	x	x	x	✓	✓	✓	✓	✓	✓	✓
Marin (21)	nr	✓	nr	nr	nr	nr							
Mariposa (22)	✓	✓	✓	✓	✓	✓	✓	✓	✓	nr	x	✓	✓
Napa (28)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	✓
Placer (31)	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	✓	✓
San Benito (35)	x	x	x	x	x	x							
San Bernardino (36)	✓	✓	✓	x	✓	✓	✓	✓	x	x	x	x	✓
San Francisco (38)	x	x	✓	nr	✓	✓	✓	✓	✓	x	x	x	✓
San Joaquin (39)	x	x	✓	x	✓	✓	✓	x	✓	x	x	nr	nr
San Mateo (41)					x								
Santa Barbara (42)	nr	nr	nr	nr	nr	nr							
Santa Clara (43)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Santa Cruz (44)	✓	✓	✓	✓	✓	✓			nr	nr	nr	nr	nr
Sierra (46)	✓	✓	✓	x	✓	✓	✓	✓	✓	x	x	✓	✓
Siskiyou (47)	✓	✓	✓	✓	nr	nr	✓	✓	x	x	x	x	✓
Solano (48)	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	nr	✓
Stanislaus (50)	✓	✓	✓	nr	✓	✓	nr	x	✓	x	x	nr	nr
Trinity (53)	x	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Tulare (54)	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	x	✓	✓
Tuolumne (55)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

6.5 Access: Access to Primary Care Physician

County	DCR			
	PhysicianCurr	Gender	Race and Ethnicity	Age_Group
Alameda (1)	nr	nr	nr	nr
Butte (4)	✓	✓	✓	✓
Calaveras (5)	✓	✓	x	✓
Contra Costa (7)	✓	✓	x	✓
Fresno (10)	✓	✓	x	✓
Glenn (11)	x	x	x	x
Kings (16)	✓	x	x	nr
Lake (17)	✓	x	x	✓
Los Angeles (19)	✓	✓	x	✓
Madera (20)	✓	✓	✓	✓
Marin (21)				
Mariposa (22)	✓	✓	nr	✓
Napa (28)	✓	✓	✓	✓
Placer (31)	✓	✓	x	✓
San Benito (35)				
San Bernardino (36)	✓	x	x	✓
San Francisco (38)	✓	✓	x	✓
San Joaquin (39)	✓	✓	x	nr
San Mateo (41)				
Santa Barbara (42)				
Santa Clara (43)	✓	✓	✓	✓
Santa Cruz (44)		nr	nr	nr
Sierra (46)	✓	✓	x	✓
Siskiyou (47)	✓	x	x	✓
Solano (48)	✓	✓	x	✓
Stanislaus (50)	✓	✓	x	nr
Trinity (53)	✓	✓	✓	✓
Tulare (54)	✓	✓	x	✓
Tuolumne (55)	✓	✓	✓	✓

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

7.1 Performance: Consumers Served Annually through CSS

County	DCR					County 3-Year Plans	Annual Updates
	PartnershipDate	GlobalID	Gender	Race and Ethnicity	Age_Group		
Alameda (1)	nr	nr	nr	nr	nr		
Butte (4)	✓	✓	✓	✓	✓		
Calaveras (5)	✓	✓	✓	x	✓		
Contra Costa (7)	✓	✓	✓	x	✓		
Fresno (10)	✓	✓	✓	x	✓		
Glenn (11)	x	x	x	x	x		
Kings (16)	✓		x	x	nr		
Lake (17)	✓	✓	x	x	✓		
Los Angeles (19)	✓	✓	✓	x	✓		
Madera (20)	✓	✓	✓	✓	✓		
Marin (21)	nr	nr					
Mariposa (22)	✓		✓	nr	✓		
Napa (28)	✓	✓	✓	✓	✓		
Placer (31)	✓	✓	✓	x	✓		
San Benito (35)	nr	nr					
San Bernardino (36)	✓	✓	x	x	✓		
San Francisco (38)	✓	✓	✓	x	✓		
San Joaquin (39)	✓	nr	✓	x	nr		
San Mateo (41)	nr	nr					
Santa Barbara (42)	nr	nr					
Santa Clara (43)	✓	✓	✓	✓	✓		
Santa Cruz (44)	nr	nr	nr	nr	nr		
Sierra (46)	✓	✓	✓	x	✓		
Siskiyou (47)	✓	✓	x	x	✓		
Solano (48)	✓	✓	✓	x	✓		
Stanislaus (50)	✓	nr	✓	x	nr		
Trinity (53)	✓	✓	✓	✓	✓		
Tulare (54)	✓	✓	✓	x	✓		
Tuolumne (55)	✓	✓	✓	✓	✓		

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

7.3 Performance: 24-Hour Care

County	CSI						DCR			
	Mode of Service	C-10.0 Race	C-03.0 Date of Birth	C-05.0 Gender	Current	GlobalID	Gender	Race and Ethnicity	Age_Group	
Alameda (1)	nr	nr	nr	nr	nr	nr	nr	nr	nr	
Butte (4)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Calaveras (5)	✓	✓	✓	✓	✓	✓	✓	x	✓	
Contra Costa (7)	✓	x	✓	✓	✓	✓	✓	x	✓	
Fresno (10)	✓	✓	x	x	✓	✓	✓	x	✓	
Glenn (11)	x	nr	x	x	x	x	x	x	x	
Kings (16)	nr	nr	nr	nr	✓		x	x	nr	
Lake (17)	✓	✓	✓	✓	✓	✓	x	x	✓	
Los Angeles (19)	✓	x	✓	✓	x	✓	✓	x	✓	
Madera (20)	x	x	x	x	✓	✓	✓	✓	✓	
Marin (21)	nr	nr	nr	nr	nr	nr				
Mariposa (22)	✓	✓	✓	✓	✓		✓	nr	✓	
Napa (28)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Placer (31)	✓	✓	✓	✓	✓	✓	✓	x	✓	
San Benito (35)	x	x	x	x	nr	nr				
San Bernardino (36)	✓	x	✓	✓	✓	✓	x	x	✓	
San Francisco (38)	✓	nr	✓	✓	✓	✓	✓	x	✓	
San Joaquin (39)	nr	x	✓	✓	✓	nr	✓	x	nr	
San Mateo (41)	nr		x		nr	nr				
Santa Barbara (42)	nr	nr	nr	nr	nr	nr				
Santa Clara (43)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Santa Cruz (44)	✓	✓	✓	✓	nr	nr	nr	nr	nr	
Sierra (46)	✓	x	✓	✓	✓	✓	✓	x	✓	
Siskiyou (47)	✓	✓	nr	nr	✓	✓	x	x	✓	
Solano (48)	✓	✓	✓	✓	✓	✓	✓	x	✓	
Stanislaus (50)	nr	nr	✓	✓	nr	nr	✓	x	nr	
Trinity (53)	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Tulare (54)	✓	✓	✓	✓	✓	✓	✓	x	✓	
Tuolumne (55)	✓	✓	✓	✓	✓	✓	✓	✓	✓	

KEY

✓	Accurate
x	Inaccurate
nr	No response
	Available variables not reviewed by counties

Appendix C – Results from Verified and Unverified County Data

Priority Indicator: 1.2 – Education/Employment: Proportion Participating in Paid and Unpaid Employment (TAY, Adult, Older Adult)

Table 1.2 - 1. Proportion of Consumers Employed (Paid and Unpaid) (TAY, Adult, Older Adult)

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	526 (5.08%)	585 (4.85%)	39 (6.46%)	35 (4.31%)
Adult	1760 (7.83%)	1602 (6.67%)	69 (5.49%)	69 (4.47%)
Older Adult	86 (3.33%)	92 (2.87%)	2 (1.64%)	1 (.58%)
Total	2373	2279	110	105
Unverified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	1959 (4.11)	2558 (4.12%)	340 (7.87%)	491 (7.91%)
Adult	6747 (6.36%)	8321 (6.61%)	431 (4.72%)	662 (4.93%)
Older Adult	413 (3.0%)	510 (2.94%)	35 (2.39%)	49 (2.61%)
Total	9119	11389	806	1202

Table 1.2 - 2. Proportion Participating in Paid and Unpaid Employment (TAY, Adult, Older Adult)

Verified								
Age Group	All Consumers (CSI)				FSPs (DCR)			
	FY 2008-2009		FY 2009-2010		FY 2008-2009		FY 2009-2010	
	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid
TAY	514 (97.72%)	16 (3.4%)	575 (98.92%)	10 (1.71%)	34 (87.18%)	7 (17.95%)	29 (82.85%)	6 (17.15%)
Adult	1722 (97.84%)	38 (2.16%)	1567 (97.82%)	37 (2.31%)	62 (89.86%)	7 (10.14%)	60 (86.96%)	11 (13.04%)
Older Adult	78 (90.70%)	8 (9.30%)	83 (90.21%)	9 (9.78)	2 (100%)	0 (0%)	1 (100%)	0 (0%)
Total	2314	62	2225	56	98	14	90	17
Unverified								
Age Group	All Consumers (CSI)				FSPs (DCR)			
	FY 2008-2009		FY 2009-2010		FY 2008-2009		FY 2009-2010	
	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid	Paid	Unpaid
TAY	1935 (98.77%)	26 (1.33%)	2519 (98.48%)	41 (1.60%)	319 (6.47%)	22 (6.47%)	462 (94.09%)	34 (6.92%)
Adult	6576 (97.47%)	182 (2.70%)	8108 (97.44%)	227 (2.73%)	346 (80.28%)	85 (19.72%)	513 (82.48%)	114 (18.32%)
Older Adult	371 (89.83%)	43 (10.41%)	468 (91.76%)	46 (9.02%)	26 (74.29%)	9 (25.71%)	35 (71.43%)	14 (28.57%)
Total	8882	251	11095	314	691	116	1010	162

Table 1.2 - 3. Proportion Participating in Paid Employment (TAY, Adult, Older Adult)

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	514 (97.72%)	575 (98.92%)	34 (87.18%)	29 (82.85%)
Adult	1722 (97.84%)	1567 (97.82%)	62 (89.86%)	60 (86.96%)
Older Adult	78 (90.70%)	83 (90.21%)	2 (100%)	1(100%)
Total	2314	2225	98	90
Unverified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	1935 (98.77%)	2519 (98.48%)	319 (6.47%)	462 (94.09%)
Adult	6576 (97.47%)	8108 (97.44%)	346 (80.28%)	513 (82.48%)
Older Adult	371 (89.83%)	468 (91.76%)	26 (74.29%)	35 (71.43%)
Total	8882	11095	691	1010

Table 1.2 - 4. Proportion Participating in Unpaid Employment (TAY, Adult, Older Adult)

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	16(3.4%)	10(1.71%)	7 (17.95%)	6 (17.15%)
Adult	38(2.16%)	37(2.31%)	7 (10.14%)	11 (13.04%)
Older Adult	8(9.30%)	9(9.78)	0(0%)	0(0%)
Total	62	56	14	17
Unverified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
TAY	26(1.33%)	41(1.60%)	22 (6.47%)	34 (6.92%)
Adult	182 (2.70%)	227 (2.73%)	85 (19.72%)	114 (18.32%)
Older Adult	43 (10.41%)	46(9.02%)	9 (25.71%)	14 (28.57%)
Total	251	314	116	162

Priority Indicator: 2.1 – Homelessness/Housing: Housing Situation

Table 6. Number of Consumers Experiencing Homelessness During Year

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	62 (0.2%)	69 (0.2%)	11 (1.8%)	13 (1.6%)
TAY	490 (2.7%)	658 (3.2%)	154 (14.2%)	128 (8.8%)
Adult	2688 (6.8%)	3585 (8.3%)	167 (10.3%)	220 (9%)
Older Adult	154 (3.4%)	205 (3.8%)	18 (7.3%)	16 (4.8%)
Total	3394 (3.8%)	4517 (4.7%)	350 (9.8%)	377 (7.5%)

Not Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	305 (0.6%)	395 (0.6%)	29 (2%)	35 (1.5%)
TAY	1299 (2.9%)	1464 (2.7%)	227 (12.4%)	259 (9.4%)
Adult	6714 (6.8%)	7942 (7.3%)	893 (18.8%)	774 (13.6%)
Older Adult	511 (3.7%)	584 (3.7%)	59 (7.4%)	44 (4.3%)
Total	8829 (4.2%)	10385 (4.3%)	1208 (13.7%)	1112 (9.4%)

Table 7. Number of Consumers in Independent Housing Situations During Year

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	21912 (82.7%)	23206 (83.6%)	7 (1.1%)	3 (0.4%)
TAY	13613 (74.8%)	15543 (75.3%)	128 (11.8%)	162 (11.1%)
Adult	29150 (74.3%)	31848 (74%)	449 (27.8%)	483 (19.8%)
Older Adult	3264 (72.4%)	4009 (73.9%)	80 (32.3%)	71 (21.1%)
Total	67939 (76.8%)	74606 (77%)	664 (18.6%)	719 (14.2%)
Not Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	35789 (64.8%)	40896 (65.1%)	6 (0.4%)	5 (0.2%)
TAY	28058 (63.5%)	33459 (62.7%)	268 (14.6%)	342 (12.5%)
Adult	67139 (68%)	74004 (67.8%)	1519 (32.1%)	1606 (28.1%)
Older Adult	8154 (59.1%)	9519 (60%)	218 (27.5%)	206 (20.2%)
Total	139140 (65.7%)	157878 (65.5%)	2011 (22.8%)	2159 (18.3%)

Table 8. Number of Consumers in Foster Housing Situations During Year

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	2774 (10.5%)	2637 (9.5%)	26 (4.2%)	38 (4.6%)
TAY	577 (3.2%)	620 (3%)	13 (1.2%)	19 (1.3%)
Adult	37 (0.1%)	35 (0.1%)	0 (0%)	0 (0%)
Older Adult	8 (0.2%)	6 (0.1%)	0 (0%)	0 (0%)
Total	3396 (3.8%)	3298 (3.4%)	39 (1.1%)	57 (1.1%)
Not Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	4462 (8.1%)	5055 (8.1%)	54 (3.7%)	125 (5.4%)
TAY	893 (2%)	1093 (2%)	14 (0.8%)	32 (1.2%)
Adult	55 (0.1%)	44 (0%)	0 (0%)	0 (0%)
Older Adult	15 (0.1%)	13 (0.1%)	0 (0%)	0 (0%)
Total	5425 (2.6%)	6205 (2.6%)	68 (0.8%)	157 (1.3%)

Table 9. Number of Consumers Housed During Year

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	25653 (96.8%)	26772 (96.4%)	133 (21.4%)	151 (18.4%)
TAY	16143 (88.7%)	18261 (88.4%)	497 (45.8%)	580 (39.7%)
Adult	31637 (80.6%)	34662 (80.5%)	970 (60%)	1164 (47.8%)
Older Adult	3804 (84.4%)	4659 (85.8%)	138 (55.6%)	147 (43.8%)
Total	77237 (87.3%)	84354 (87.1%)	1738 (48.7%)	2042 (40.4%)
Not Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	44391 (80.4%)	50075 (79.8%)	471 (32.4%)	709 (30.7%)
TAY	36191 (81.9%)	43930 (82.3%)	1033 (56.3%)	1421 (51.8%)
Adult	76527 (77.5%)	84614 (77.5%)	3261 (68.8%)	3713 (65.1%)
Older Adult	9848 (71.4%)	11398 (71.9%)	428 (54%)	504 (49.5%)
Total	166957 (78.8%)	190017 (78.8%)	5193 (58.9%)	6347 (53.9%)

Table 9. Number of Consumers With Missing or Unknown Housing Status During Entire Year

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	1285 (4.8%)	1373 (4.9%)	494 (79.5%)	678 (82.5%)
TAY	1794 (9.9%)	2001 (9.7%)	523 (48.2%)	847 (58%)
Adult	5385 (13.7%)	5495 (12.8%)	624 (38.6%)	1230 (50.5%)
Older Adult	565 (12.5%)	590 (10.9%)	107 (43.1%)	186 (55.4%)
Total	9029 (10.2%)	9459 (9.8%)	1748 (48.9%)	2941 (58.2%)
Not Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	11552 (20.9%)	13475 (21.5%)	1003 (68.9%)	1623 (70.3%)
TAY	7269 (16.4%)	8485 (15.9%)	777 (42.3%)	1279 (46.6%)
Adult	16873 (17.1%)	17738 (16.3%)	1312 (27.7%)	1855 (32.5%)
Older Adult	3492 (25.3%)	3911 (24.7%)	341 (43.1%)	501 (49.2%)
Total	39186 (18.5%)	43609 (18.1%)	3433 (38.9%)	5258 (44.7%)

Priority Indicator: 3.1–Justice Involvement

Table 3.1 - 1. Arrest Rate Per FSP Consumer

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child			1,239 (38.2%)	12 (12.9%)
TAY			607 (48.0%)	563 (24.7%)
Adult			352 (19.7%)	689 (53.0%)
Older Adult			12 (13.6%)	20 (24.1%)

Total			2,210	1,284
Unverified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child			36 (5.1%)	86 (2.7%)
TAY			483 (20.1%)	614 (20.1%)
Adult			477 (30.0%)	1,432 (26.1%)
Older Adult			49 (12.5%)	100 (13.2%)
Total			1,045	2,232

Priority Indicator: 4.1 – Emergency Care: Emergency Intervention for Mental Health Episodes

Table 4.1 - 1. Average Number of Annual Hospital Interventions Per Consumer

Verified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	0.0	0.0		
TAY	0.2	0.1		
Adult	0.2	0.2		
Older Adult	0.1	0.1		
Total	<i>n/a</i>	<i>n/a</i>		
Unverified				
Age Group	All Consumers (CSI)		FSPs (DCR)	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	0.0	0.1		
TAY	0.3	0.3		
Adult	0.4	0.4		
Older Adult	0.2	0.2		
Total	<i>n/a</i>	<i>n/a</i>		

Priority Indicator: 6.1 - Demographic Profile of Consumers Served

Table 6.1 - 1. Race/Ethnicity of Mental Health Consumers

Verified				
Race/Ethnicity	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
White	23,844 (42.2%)	20,737 (40.5%)	229 (31.0%)	232 (26.5%)
Hispanic / Latino	15,911 (28.1%)	15,454 (30.2%)	140 (19.0%)	148 (16.9%)
Asian	3,446 (6.1%)	3,086 (6.0%)	26 (3.5%)	37 (4.2%)
Pacific Islander	67 (0.1%)	56 (0.1%)	1 (0.1%)	1 (0.1%)
Black	4,759 (8.4%)	4,336 (8.5%)	40 (5.4%)	45 (5.1%)
American Indian	625 (1.1%)	501 (1.0%)	15 (2.0%)	9(1.0%)
Multirace	3,500 (6.2%)	3,370 (6.6%)	36 (4.9%)	39 (4.5%)
Unknown/Other	4371 (7.8%)	4,183 (7.1%)	251 (34.0%)	364 (41.6%)

Total	56,523	51,175	738	875
Unverified				
Race/Ethnicity	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
White	212,096 (34.3%)	214,849 (33.2%)	7,449 (35.7%)	10,531 (36.1%)
Hispanic / Latino	170,963 (27.7%)	179,254 (27.7%)	5,297 (25.4%)	7,666 (26.3%)
Asian	39,109 (6.3%)	30,323 (4.7%)	1,068 (5.1%)	1,399 (4.8%)
Pacific Islander	2,078 (0.3%)	2,205 (0.3%)	58 (0.3%)	86 (0.3%)
Black	104,502 (16.9%)	108,757 (16.8%)	4,138 (19.8%)	5,301 (18.2%)
American Indian	4,097 (0.7%)	4,072 (0.6%)	200 (1.0%)	271 (.9%)
Multirace	42,864 (6.9%)	44,365 (6.9%)	1,442 (6.9%)	2,193 (7.5%)
Unknown/Other	41,842 (6.8%)	63,784 (9.9%)	1,209 (5.8%)	1,695 (5.8%)
Total	617,551	647,609	20,861	29,142

Table 6.1 - 2. Age of Mental Health Consumers

Verified				
Age Group	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Children	94,589 (28.6%)	96,499 (29.5%)	3,353 (23.4%)	4,773 (26.0%)
TAY	59,259 (17.9%)	59,268 (18.1%)	2,926 (20.4%)	4,075 (22.2%)
Adults	156,156 (47.1%)	149,638 (45.8%)	7,268 (50.7%)	8,596 (46.8%)
Older Adults	21,235 (6.4%)	21,400 (6.5%)	785 (5.5%)	913 (5.0%)
Unknown	2 (0.0%)	7 (0.0%)	--	--
Total	331,241	326,812	14,332	18,357
Unverified				
Age Group	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Children	86,240 (25.2%)	78,725 (21.2%)	1,336 (18.4%)	2,039 (17.5%)
TAY	64,219 (18.7%)	58,997 (15.9%)	1,999 (27.5%)	2,942 (25.2%)
Adults	170,122 (49.6%)	148,030 (39.8%)	3,128 (43.0%)	5,545 (47.6%)
Older Adults	22,121 (6.5%)	20,250 (5.4%)	804 (11.1%)	1,134 (9.7%)
Unknown	131 (0.0%)	65,961 (17.7%)	--	--
Total	342,833	371,963	7,267	11,660

Table 6.1 - 3. Gender of Mental Health Consumers

Verified				
Gender	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Female	156,516 (47.3%)	154,604 (47.3%)	5,182 (42.4%)	6,489 (42.4%)
Male	174,521 (52.7%)	172,010 (52.6%)	6,717 (55.0%)	8,308 (54.3%)
Unknown/Other	204 (0.1%)	198 (0.1%)	310 (2.5%)	498 (3.3%)
Total	331,241	326,812	12,249	15,295
Unverified				
Gender	All Consumers		FSPs	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Female	167,295 (48.8%)	179,930 (48.4%)	4,087 (43.5%)	6,351 (43.1%)
Male	174,187 (50.8%)	191,151 (51.4%)	4,953 (52.7%)	7,890 (53.5%)
Unknown/Other	1,351 (0.4%)	882 (0.3%)	350 (3.7%)	498(3.4%)
Total	342,833	371,963	9,390	14,739

Priority Indicator: 6.2 - Demographic Profile of New Consumers

Table 6.2 - 1. New and Continuing Mental Health Consumers

Verified				
	FY 2008-2009		FY 2009-2010	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
All Consumers	24,151 (7.3%)	307,090(92.7%)	39,420(12.1%)	287,392(87.9%)
FSP Consumers	7,206(50.3%)	7,126(49.7%)	6,714(36.6%)	11,643(63.4%)
Unverified				
	FY 2008-2009		FY 200-2010	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
All Consumers	121,585(35.5%)	221,248(64.5%)	91,925(24.7%)	280,038(75.3%)
FSP Consumers	3,071(42.3%)	4,196(57.7%)	6,063(52.0%)	5,597(48.0%)

Table 6.2 - 2. Race/Ethnicity of New and Continuing Mental Health Consumers

Verified				
	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
White	5,565(41.0%)	57,819(38.4%)	4,373(37.6%)	43,414(36.3%)
Hispanic / Latino	4,224(31.1%)	35,861(23.8%)	4,046(34.8%)	30,654(25.6%)
Asian	412(3.0%)	6,388(4.2%)	394(3.4%)	4,962(4.1%)
Pacific Islander	15(.1%)	278(.2%)	10(.1%)	246(.2%)
Black	1,183(8.7%)	17,745(11.8%)	992(8.5%)	12,944(10.8%)
American Indian	179(1.3%)	1,015(.7%)	121(1.0%)	788(.7%)
Multirace	1,011(7.4%)	14,556(9.7%)	896(7.7%)	12,222(10.2%)
Unknown/Other	996(7.3%)	16,903(11.2%)	806(6.9%)	14,477(12.1%)
Unverified				
	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
White	17,587(41.0%)	104,960(22.5%)	15,752(39.8%)	124,905(23.7%)
Hispanic / Latino	10,601(24.7%)	57,015(12.2%)	10,569(26.7%)	66,388(12.6%)
Asian	3,081(7.2%)	13,107(2.8%)	2,724(6.9%)	16,779(3.2%)
Pacific Islander	46(.1%)	437(.1%)	41(.1%)	557(.1%)
Black	3,547(8.3%)	38,324(8.2%)	3,327(8.4%)	47,544(9.0%)
American Indian	466(1.1%)	1,944(.4%)	402(1.0%)	2,172(.4%)
Multirace	2,503(5.8%)	27,724(5.9%)	2,451(6.2%)	31,976(6.1%)
Unknown/Other	5,107(11.9%)	223,475(47.9%)	4,271(10.8%)	237,572(45.0%)

Table 6.2 - 3. Race/Ethnicity of New and Continuing FSP Consumers

Verified				
	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
White	107(27.8%)	122(34.6%)	71(20.3%)	161(30.7%)
Hispanic / Latino	71(18.4%)	69(19.5%)	49(14.0%)	99(18.9%)
Asian	12(3.1%)	16(4.5%)	13(3.7%)	25(4.8%)
Pacific Islander	0(0.0%)	1(.3%)	0(0%)	1(.2%)
Black	16(4.2%)	24(6.8%)	16(4.6%)	29(5.5%)
American Indian	9(2.3%)	4(1.1%)	0(0%)	8(1.5%)
Multirace	18(4.7%)	18(5.1%)	15(4.3%)	24(4.6%)
Unknown/Other	152(39.5%)	99(28.0%)	186(53.1%)	178(33.9%)
Unverified				
	FY 2008-09		FY 2009-10	

	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
White	3,398(34.4%)	4,051(36.9%)	4,630(37.3%)	5,901(35.3%)
Hispanic / Latino	2,630(26.6%)	2,667(21.1%)	3,343(26.9%)	4,323(25.9%)
Asian	540(5.5%)	609(5.6%)	556(4.5%)	965(5.8%)
Pacific Islander	32(.3%)	30(.3%)	40(.3%)	46(.3%)
Black	1,821(18.4%)	2,317(21.1%)	1,887(15.2%)	3,414(20.4%)
American Indian	63(.6%)	52(.5%)	60(.5%)	89(.5%)
Multirace	805(8.1%)	637(5.8%)	1,062(8.5%)	1,131(6.8%)
Unknown/Other	603(6.1%)	606(5.5%)	849(6.8%)	846(5.1%)

Table 6.2 - 4. New and Continuing Consumers by Age Group

Verified				
Age Group	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Children	13,253(31.1%)	81,336(28.2%)	2,171(32.3%)	2,602(22.3%)
TAY	51,305(17.8%)	51,305(17.8%)	1,729(25.8%)	2,346(20.1%)
Adults	19,026(44.7%)	137,130(47.5%)	2,548(38.0%)	6,048(51.9%)
Older Adults	2,331(5.5%)	18,904(6.5%)	266(4.0%)	647(5.6%)
Unknown/Other	1(0.0%)	1(0.0%)	0(0%)	0(0%)
Unverified				
Age Group	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Children	36,442(30.0%)	49,798(22.5%)	1,115(18.4%)	924(16.5%)
TAY	24,330(20.0%)	39,889(18.0%)	1,422(23.5%)	1,520(27.2%)
Adults	54,160(44.5%)	115,962(52.4%)	3,015(49.7%)	2,530(45.2%)
Older Adults	6,548(5.4%)	15,573(7.0%)	511(8.4%)	623(11.1%)
Unknown/Other	105(.1%)	26(0.0%)	0(0%)	0 (0%)

Table 6.2 - 5. New and continuing FSP Consumers by Age Group

Verified				
Age Group	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Children	1,691(23.5%)	1,662(23.3%)	1,193(36.3%)	3,580(23.7%)
TAY	1,583(22.0%)	1,343(18.8%)	812(24.7%)	3,263(21.6%)
Adults	3,545(49.2%)	3,723(52.2%)	1,148(35.0%)	7,448(49.4%)
Older Adults	387(5.4%)	398(5.6%)	130(4.0%)	783(5.2%)
Unverified				
Age Group	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Children	709(23.1%)	627(14.9%)	727(26.9%)	1,312(14.6%)
TAY	919(29.9%)	1,080(25.7%)	623(23.1%)	2,319(25.9%)
Adults	1,145(37.3%)	1,983(12.1%)	1,154(42.7%)	4,391(49.0%)
Older Adults	298(9.7%)	506(12.1%)	197(7.3%)	937(10.5%)

Table 6.2 - 6. Gender of New and Continuing Mental Health Consumers

Verified				
Gender	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Female	20,926(49.2%)	135,590(47.0%)	19,123(48.5%)	135,481(47.1%)

Male	21,582(50.7%)	152,939(53.0%)	20,252(51.4%)	151,758(52.8%)
Unknown/Other	57(0.1%)	147(0.0%)	45(0.1%)	153(0.0%)
Unverified				
Gender	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Female	60,071(49.4%)	107,224(48.5%)	44,426(48.3%)	135,504(48.4%)
Male	61,176(50.3%)	113,011(51.1%)	47,200(51.3%)	143,951(51.4%)
Unknown/Other	338(0.3%)	1013(0.5%)	299(0.3%)	683(0.2%)

Table 6.2 - 7. Gender of New and Continuing FSP Consumers

Verified				
Gender	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Female	2,400(42.6%)	2,782(42.3%)	2,125(40.8%)	4,364(43.3%)
Male	3,053(54.2%)	3,664(55.7%)	2,796(53.7%)	5,512(54.7%)
Unknown/Other	178(3.1%)	132(2.0%)	282(5.4%)	199(1.9%)
Unverified				
Gender	FY 2008-09		FY 2009-10	
	New Consumers	Continuing Consumers	New Consumers	Continuing Consumers
Female	2,013(43.3%)	2,074(43.7%)	3,174(41.9%)	3,177(44.3%)
Male	2,432(52.3%)	2,521(53.1%)	4,089(54.0%)	3,801(53.0%)
Unknown/Other	201(4.3%)	149(3.1%)	311(4.1%)	186(2.6%)

Priority Indicator: 6.3 – Penetration of Mental Health Services

Table 6.3 - 1. Penetration of Services by Gender

Verified				
	Female		Male	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Holzer Target	502,793	504,781	412,699	412,699
All Consumers	156,516(31.1%)	154,604(30.6%)	174,521(42.3%)	172,010(41.7%)
FSP Consumers	5,182(1.0%)	6,489(1.3%)	6,717(1.6%)	8,308(2.0%)
Unverified				
	Female		Male	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Holzer Target	578,502	584,025	492,543	486,335
All Consumers	167,295(28.9%)	179,930(30.8%)	174,187(35.4%)	191,151(39.3%)
FSP Consumers	4,087(0.7%)	4,953(0.8%)	6,351(1.3%)	7,890(1.6%)

Table 6.3 - 2. Penetration of Services to by Age Group

Verified						
	Holzer Target		All Consumers		FSP Consumers	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
Children	361,012	359,213	94,589 (26.2%)	96,499 (26.9%)	3,353(0.9%)	4,773(1.3%)
TAY	133,211	135,679	59,259 (44.5%)	59,268 (43.7%)	2,926(2.2%)	4,075(3.0%)
Adults	494,918	444,154	156,156 (31.6%)	149,638 (33.7%)	7,268(1.5%)	8,596(1.9%)
Older Adults	62,621	64,721	21,235 (33.9%)	21,400 (33.1%)	785(1.3%)	913(1.4%)

Unverified						
	Holzer Target		All Consumers		FSP Consumers	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
Children	303,731	305,199	86,240(28.4%)	78,725(25.8%)	1,336(0.0%)	2,309(0.8%)
TAY	123,148	124,460	64,219 (52.1%)	58,997 (47.4%)	1,999(0.1%)	2,942(2.4%)
Adults	441,460	496,571	170,122(38.5%)	148,030(29.8%)	3,128(0.0%)	5,545(1.1%)
Older Adults	55,841	57,843	22,121(39.6%)	20,250(35.0%)	804(0.0%)	1,134(2.0%)

Table 6.3 - 3. Penetration Rate by Race / Ethnicity

Verified														
	White		Hispanic		Black		Asian		Pacific Islander		American Indian		Other (includes: Multiple, Other)	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
Holzer Target	35,233	36,047	27,557	27,824	2,632	2,619	13,576	13,714	416	458	687	701	3,183	3,354
All Consumers	23,844 (67.7%)	20,737 (57.5%)	15,911 (57.7%)	15,454 (55.5%)	4,759 (180.8%)	4,336 (165.6%)	3,446 (25.4%)	3,086 (22.5%)	67 (16.1%)	56 (12.2%)	625 (91.0%)	501 (71.5%)	4,831 (151.8%)	7,283 (217.1%)
FSP Consumers	229 (0.6%)	232 (0.6%)	140 (0.5%)	148 (0.5%)	40 (1.5%)	45 (1.7%)	26 (0.2%)	37 (0.3%)	1 (0.2%)	1 (0.2%)	15 (2.2%)	45 (6.4%)	48 (1.5%)	52 (1.6%)
Unverified														
	White		Hispanic		Black		Asian		Pacific Islander		American Indian		Other (includes: Multiple, Other)	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
Holzer Target	734,901	729,743	820,207	833,957	143,732	143,378	116,789	118,511	4,187	4,893	15,927	16,185	56,285	56,456
All Consumers	212,096 (28.9%)	214,849 (29.4%)	170,963 (20.8%)	179,254 (21.5%)	104,502 (72.7%)	108,757 (75.9%)	39,109 (33.5%)	30,323 (25.6%)	2,078 (49.6%)	2,205 (45.1%)	4,097 (25.7%)	4,072 (25.2%)	58,860 (104.6%)	59,433 (105.3%)
FSP Consumers	7,449 (1.0%)	10,531 (1.4%)	5,297 (0.6%)	7,666 (0.9%)	4,138 (2.9%)	5,301 (3.7%)	1,068 (0.9%)	1,399 (1.2%)	58 (1.4%)	86 (1.8%)	200 (1.3%)	271 (1.7%)	1,713 (3.0%)	1,580 (2.8%)

Priority Indicator: 6.4 – Access to a Primary Care Physician

Table 6.4 - 1. Access to a Primary Care Physician (County Verified Data)

Verified		
	Current Primary Care Physician	
	FY 2008-2009	FY 2009-2010
All FSP Consumers	6,433 (45.3%)	8,857 (48.8%)
Age Group		
	FY 2008-2009	FY 2009-2010
Child	1,704 (26.5%)	2,317 (26.2%)
TAY	951 (14.8%)	1,411 (15.9%)
Adult	3,355 (52.2%)	4,571 (51.6%)
Older Adult	423 (6.6%)	558 (6.3%)
Race / Ethnicity		
	FY 2008-2009	FY 2009-2010
White	1,772 (27.5%)	2,507 (28.3%)
Hispanic / Latino	1,890 (29.4%)	2,694 (30.4%)
Asian	377 (5.9%)	522 (5.9%)
Pacific Islander	24 (.4%)	34 (.4%)
Black	1,617 (25.1%)	2,053 (23.2%)
American Indian	68 (1.1%)	107 (1.2%)
Multirace	291 (4.5%)	400 (4.5%)
Unknown/Other	394 (6.1%)	540 (6.1%)
Gender		
	FY 2008-2009	FY 2009-2010
Female	2,899 (45.1%)	4,019 (45.4%)
Male	3,431 (53.3%)	4,656 (52.6%)
Unknown/Other	103 (1.5%)	182 (2.0%)

Table 6.4 - 2. Access to a Primary Care Physician (County Unverified Data)

Unverified		
	Current Primary Care Physician	
	FY 2008-2009	FY 2009-2010
All FSP Consumers	4,271 (57.7%)	7,233 (61.0%)
Age Group		
	FY 2008-2009	FY 2009-2010
Child	763 (17.9%)	1,182 (16.3%)
TAY	870 (20.4%)	1,421 (19.6%)
Adult	2,053 (48.1%)	3,788 (52.4%)
Older Adult	585 (13.7%)	842 (11.6%)
Race / Ethnicity		
	FY 2008-2009	FY 2009-2010
White	2,193 (51.3%)	3,554 (49.1%)

Hispanic / Latino	659 (15.4%)	1,358 (18.8%)
Asian	272 (6.4%)	369 (5.1%)
Pacific Islander	9 (.2%)	14 (.2%)
Black	401 (9.4%)	705 (9.7%)
American Indian	46 (1.1%)	61 (.8%)
Multirace	447 (10.5%)	746 (10.3%)
Unknown/Other	244 (5.7%)	426 (5.8%)
Gender		
	FY 2008-2009	FY 2009-2010
Female	1,968 (46.1%)	3,195 (44.2%)
Male	2,187 (51.2%)	3,849 (53.2%)
Unknown/Other	116(2.7%)	189(2.6%)

Priority Indicator: 6.5 – Access to a Primary Care Physician

Table 6.5 - 1. Consumer Perceptions of Access to Mental Health Services

	Family Member/ Caregiver		TAY	Adult		Older Adult	
	FY 2008-2009	FY 2009-2010	FY 2008- 2009	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Respondents	4.35 (n=36,292)	4.07 (n=1,094)	3.99 (n=24,225)	4.18 (n=47,878)	3.81 (n=1,612)	4.28 (n=4,773)	4.05 (n=2,489)

Priority Indicator: 7.1 – Consumer Served through CSS

Table 7.1 - 1. FSP Consumers Served Compared to those Targeted for Service

Verified		
	FSPs Statewide	
	FY 2008-2009	FY 2009-2010
FSP Consumers	14,332	18,357
FSP Targets	48,642	23,112
Percent of Target	29.5%	79.4%
Unverified		
	FSPs Statewide	
	FY 2008-2009	FY 2008-2009
All FSP Consumers	7,267	11,660
Total FSP Targets	15,271	26,732
Percent of Target	47.6%	43.6%

Table 7.1 - 2. FSP Consumers Served Compared to those Targeted for Service, by Age Group

Verified								
	Children		TAY		Adults		Older Adults	
	FY 2008-2009	FY 2009-2010						
FSP Consumers	3,353	4,773	2,926	4,075	7,628	8,596	785	913
Total FSP Targets	9,633	4,020	8,785	3,579	28,650	13,928	1,574	1,584
Percent of Target	34.8%	118.7%	33.3%	113.9%	26.6%	61.7%	49.9%	57.6%
Unverified								
	Children		TAY		Adults		Older Adults	
	FY 2008-2009	FY 2009-2010						
FSP Consumers	1,336	2,039	1,999	2,942	3,128	5,545	804	1,134
Total FSP Targets	3,029	5,444	3,111	6,034	5,638	11,728	3,493	3,526
Percent of Target	44.1%	37.5%	64.3%	48.8%	55.5%	47.3%	23.0%	32.1%

Priority Indicator: 7.3 - 24-Hour Care

Table 7.3 - 1. 24-Hour Care (County Verified Data)

Verified				
	All Consumers		FSP Consumers	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Total	15,127	15,646	5,820	2,196
Age Group				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	659 (4.4%)	649 (4.1%)	143 (7.9%)	214 (9.7%)
TAY	2,865 (18.9%)	3,121 (19.9%)	554 (30.8%)	626 (28.5%)
Adult	10,793 (71.3%)	11,041 (70.6%)	975 (54.2%)	1,228 (55.9%)
Older Adult	810 (5.4%)	834 (5.3%)	127 (7.1%)	128 (5.8%)
Race / Ethnicity				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
White	5,952 (39.3%)	4,435 (28.3%)	1,313 (32.7%)	1,918 (32.5%)
Hispanic / Latino	3,077 (20.3%)	1,635 (10.4%)	856 (21.3%)	1,237 (21.0%)
Asian	821 (5.4%)	498 (3.2%)	177 (4.4%)	281 (4.8%)
Pacific Islander	67 (.4%)	13 (.1%)	6 (.1%)	20 (.3%)
Black	3,046 (20.1%)	1,528 (9.8%)	671 (16.7%)	984 (16.7%)
American Indian	85 (.6%)	82 (.5%)	46 (1.1%)	68 (1.2%)
Multirace	891 (5.9%)	976 (6.2%)	485 (12.1%)	722 (12.2%)
Unknown/Other	1,188 (7.9%)	6,479 (41.4%)	467(11.6%)	674(11.4%)
Gender				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Female	6,043 (39.9%)	6,246 (39.9%)	714 (39.7%)	901 (41.0%)
Male	9,055 (59.9%)	9,378 (59.9%)	1,000 (55.6%)	1,159 (52.8%)

Unknown/Other	29(0.2%)	22 (0.1%)	85(4.8%)	136(6.1%)
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Table 7.3 - 2. 24-Hour Care (County Unverified Data)

Unverified				
	All Consumers		FSP Consumers	
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Total	24,233	21,673	15,779	6,578
Age Group				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Child	1,061 (4.4%)	940 (4.3%)	552 (10.0%)	840 (12.4%)
TAY	4,808 (19.8%)	4,355 (20.1%)	1,108 (20.1%)	1,541 (22.8%)
Adult	16,825 (69.4%)	14,977 (69.1%)	3,440 (62.5%)	3,928 (58.1%)
Older Adult	1,524 (6.3%)	1,383 (6.4%)	404 (7.3%)	449 (6.6%)
Race / Ethnicity				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
White	13,219 (54.5%)	11,168 (51.5%)	3,285 (32.0%)	5,271 (34.8%)
Hispanic / Latino	3,734 (15.4%)	3,413 (15.7%)	3,181 (31.0%)	4,698 (31.0%)
Asian	1,184 (4.9%)	966 (4.5%)	583 (5.7%)	773 (5.1%)
Pacific Islander	22 (.1%)	29 (.1%)	32 (.3%)	42 (.3%)
Black	3,169 (13.1%)	2,667 (12.3%)	2,099 (20.4%)	2,728 (18.0%)
American Indian	178 (.7%)	138 (.6%)	90 (.9%)	111 (.7%)
Multirace	1,617 (6.7%)	1,551 (7.2%)	477 (4.6%)	799 (5.3%)
Unknown/Other	1,110(4.6%)	1,741 (8.1%)	528(5.1%)	737(4.8%)
Gender				
	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Female	10,743 (44.3%)	9,519 (43.9%)	2,399 (43.6%)	2,912 (43.1%)
Male	13,468 (55.6%)	12,130 (56.0%)	3,011 (54.7%)	3,674 (54.4%)
Unknown/Other	22 (0.1%)	24 (0.1%)	94(1.7%)	172(2.5%)

Priority Indicator: 7.4 – Consumer and Family Centered Care

Table 7.4 - 1. Perceptions of Consumer/Family Centered Care

	Family Member/ Caregiver		TAY	Adult		Older Adult	
	FY 2008-2009	FY 2009-2010	FY 2008- 2009	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Respondents	4.41 (n=36,588)	4.21 (n=1,102)	4.07 (n=24,669)	4.21 (n=47,614)	3.87 (n=1,608)	4.25 (n=4,757)	4.01 (n=2,489)

Priority Indicator: 7.6 – Consumer Well Being

Table 7.6 - 1. Perceptions of Wellbeing

	Family Member/ Caregiver		TAY	Adult		Older Adult	
	FY 2008-2009	FY 2009-2010	FY 2008- 2009	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Respondents	3.80 (n=35,746)	3.57 (n=1,095)	3.85 (n=24,270)	3.84 (n=47,012)	3.50 (n=1,611)	3.92 (n=4,523)	3.73 (n=2,450)

Priority Indicator: 7.7 – Satisfaction

Table 7.7 - 1. Satisfaction with Services, by Race/Ethnicity

	Family Member/ Caregiver		TAY	Adult		Older Adult	
	FY 2008-2009	FY 2009-2010	FY 2008- 2009	FY 2008-2009	FY 2009-2010	FY 2008-2009	FY 2009-2010
Respondents	4.31 (n=35,540)	3.89 (n=1,103)	4.05 (n=24,694)	4.33 (n=47,900)	3.95 (n=1,607)	4.43 (n=47,900)	4.16 (n=2,485)

Appendix D – Comparisons between Counties Responding to Data Quality Assurance Reports and Declined/ Non-respondents

Figure E - 1. Population of Counties Responding/Not Responding to Data Quality Assurance Reports

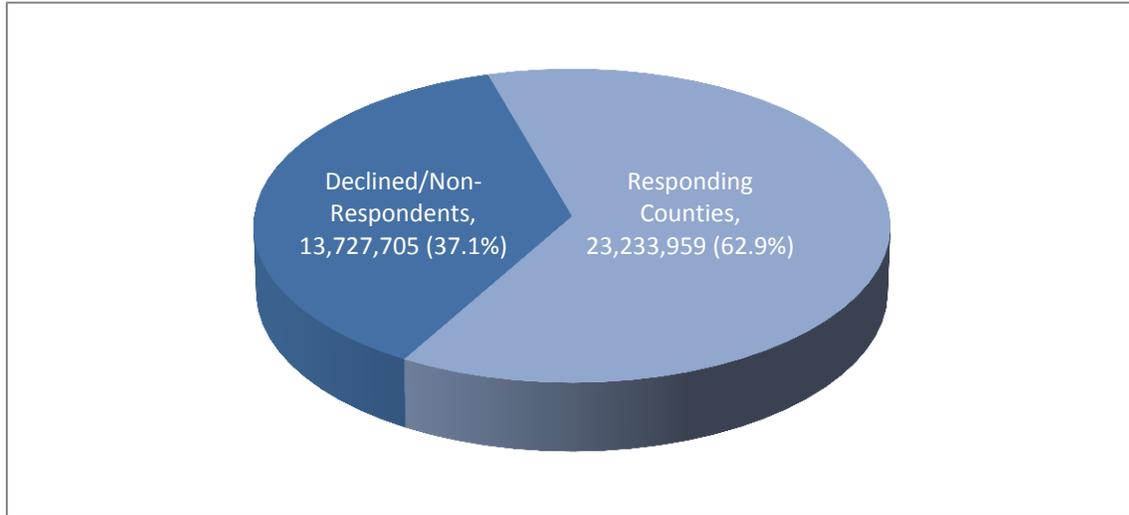


Figure E - 2. Counties Responding/Not Responding to Data Quality Assurance Reports, by Size Category

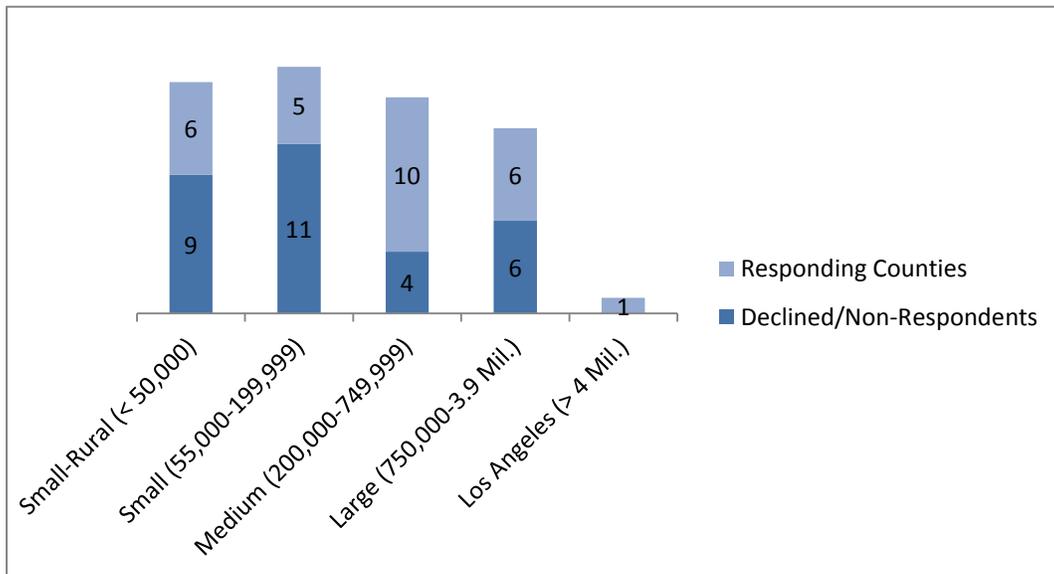


Figure E - 3. Counties Responding/Not Responding to Data Quality Assurance Reports, by Region

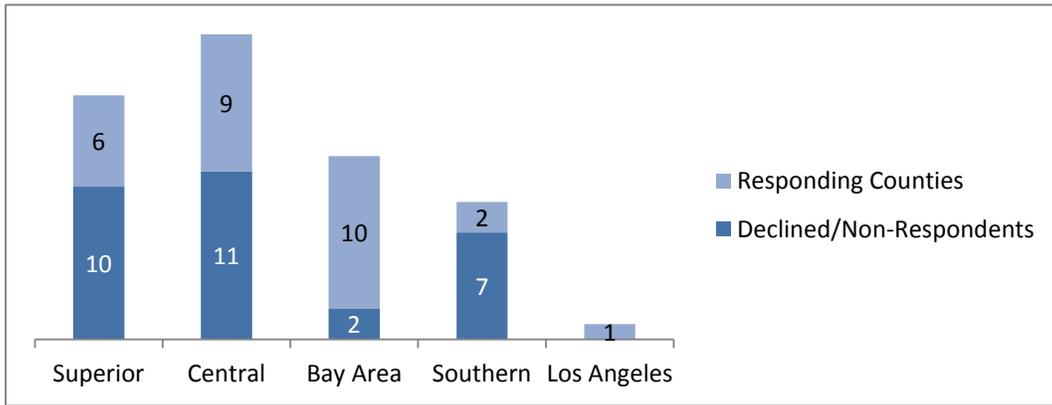


Figure E - 4. Race Dispersion of Counties Responding/Not Responding to Data Quality Assurance Reports

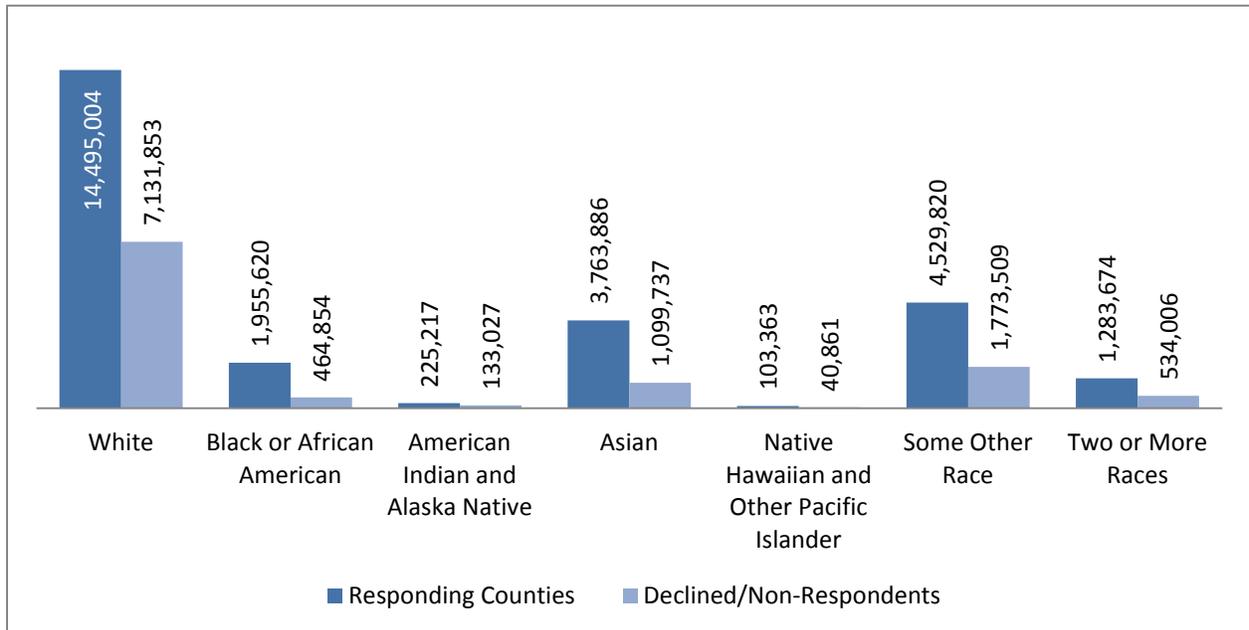


Figure E - 5. Latino Ethnicity Dispersion of Counties Responding/Not Responding to Data Quality Assurance Reports

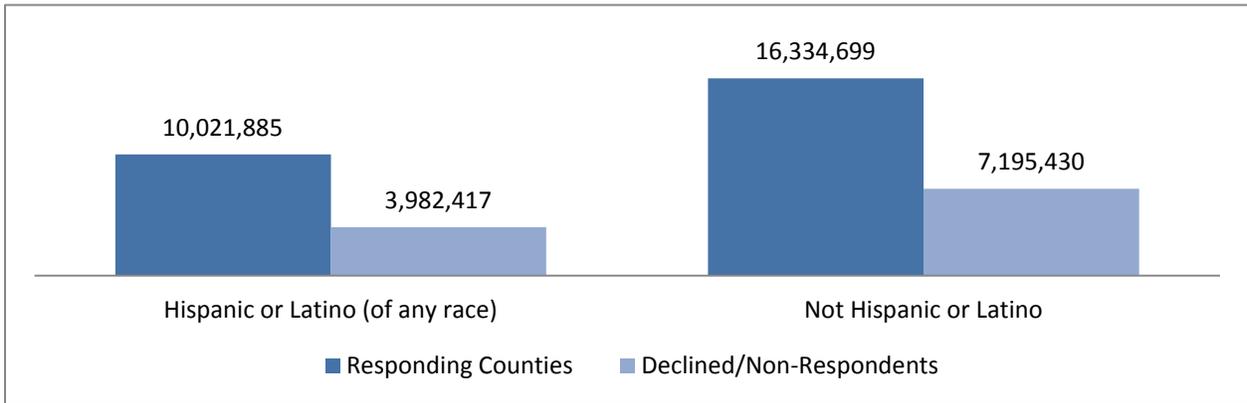
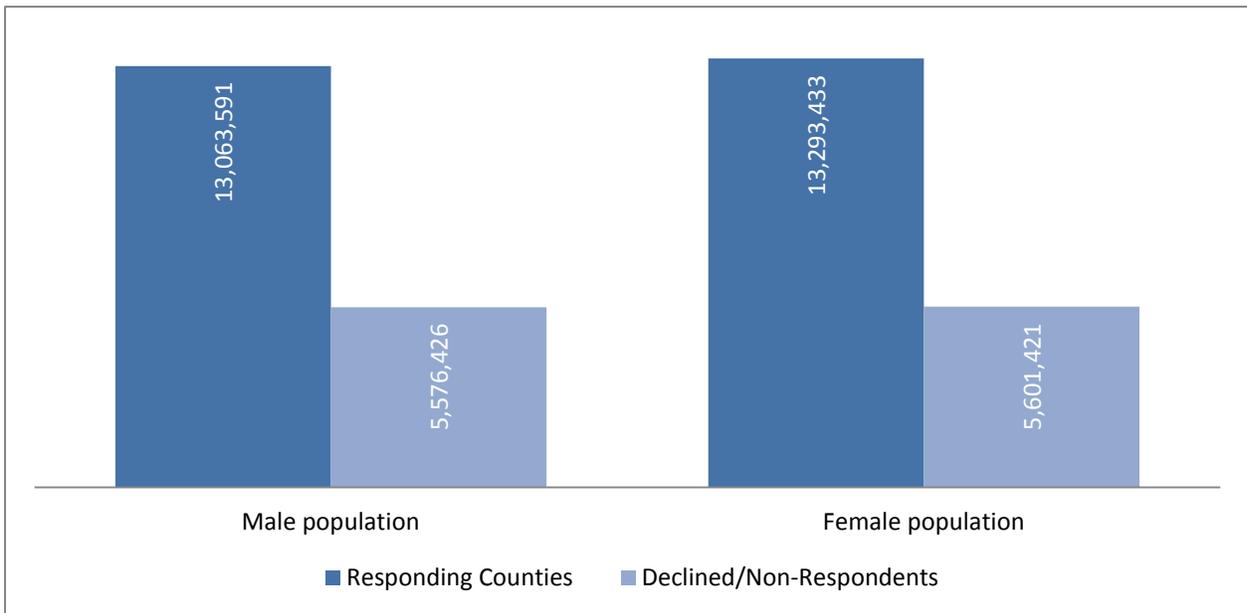


Figure E - 6. Gender Dispersion of Counties Responding/Not Responding to Data Quality Assurance Reports



Appendix E – Priority Indicator Development Subsequent to Deliverable 2D

CONSUMER-LEVEL INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	FROM 2D REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS
Domain 1: Education/ Employment			
<i>Indicator 1.1. Average school attendance per year</i>	CPS	Total # of expulsions/suspensions per total # of unique student consumers	No count of school days attended/absent is available. Instead the team calculated the average number of expulsion/suspension days per student consumer.
<i>Indicator 1.2. Proportion participating in paid and unpaid employment</i>	DCR	Total # of employed-paid consumers by total # of by total number of work-eligible FSP consumers Total # of employed-unpaid consumers by total # of work-eligible FSP consumers	No Change
Domain 2: Homelessness/Housing			
<i>Indicator 2.1. Proportion homeless annually</i>	CSI; DCR	Total # of children, TAY, adults, or older adults (all consumers and FSP consumers) homeless during the FY by total # of consumers	This is a <i>version of</i> Recommended Ratio 5 in 2D. Days homeless were inconsistently tracked in data.
<i>Indicator 2.2. Proportion housed/ not homeless annually</i>	CSI; DCR	Total # of children, TAY, adults, or older adults (all consumers and FSP consumers) housed during the FY by total # of consumers	No change. This is Recommended Ratio 5 in 2D.
Domain 3. Justice Involvement			
<i>Indicator 3.1. Proportion arrested</i>	DCR	Total # of arrests per total # of unique consumers Total # of arrest events (jail, juvenile hall, probation camp, etc.) per total # of unique FSP consumers	No change. This is Recommended Ratio 2 in 2D. This is a <i>version of</i> Recommended Ratio 2 in 2D.
<i>Indicator 3.2. Proportion incarcerated</i>	CSI; DCR		New data collection was proposed, thus this has been removed from the report.
Domain 4. Emergency Care			
<i>Indicator 4.1. Emergency intervention for mental health episodes</i>	CSI	Total # of hospitalizations per total # of unique mental health consumers	This is a <i>version of</i> Recommended Ratio 1. Total number of hospital visits is unavailable in datasets. The denominator was changed.

CONSUMER-LEVEL INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	FROM 2D REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS
<i>Indicator 4.2. Emergency intervention for co-occurring physical injury</i>			New data collection was proposed, thus this indicator is not included in the report.
Domain 5. Social Connectedness			
<i>Indicator 5.1. Proportion who identify family support</i>			New data collection was proposed, thus this has been removed from the report.
<i>Indicator 5.2. Proportion who identify community support</i>			New data collection was proposed, thus this has been removed from the report.

SYSTEM-LEVEL INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	EXPLANATION OF CHANGE FROM 2D REPORT
Domain 6. Access			
<i>Indicator 6.1. Demographic profile of consumers served</i>	CSI; DCR	% of Overall and FSP service populations represented by Racial/Ethnic, Age, and Gender Groups	No Change
<i>Indicator 6.2. Demographic Profile of New Consumers</i>	CSI; DCR	% of Overall and FSP service populations represented by new consumers (served less than 6 months), by Racial/Ethnic, Age, and Gender Groups	No Change

SYSTEM-LEVEL INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	EXPLANATION OF CHANGE FROM 2D REPORT
<i>(Previously Indicator 7.6) Indicator 6.3. Penetration of Mental Health Services</i>	CSI; Estimates (Holzer) of Serious Mental Illness (SMI) in CA	Ratio of all mental health consumers served to estimates of need for service (SMI)	Indicator reordered due to more appropriate conceptual fit with Access measurement domain, noted by experts and stakeholders.
<i>(Previously Indicator 6.3) Indicator 6.4. High need consumers served</i>			Indicator removed due to redundancy with Consumer Indicators.
<i>Indicator 6.5. Access to Primary Care Physician</i>	DCR	% of FSP consumers indicating access to a primary care physician	No Change
<i>Indicator 6.6. Consumer/Family Perceptions of Access to Services</i>	CPS	Mean aggregate ratings of consumer perception of access to services	No Change
Domain 7. Performance			
<i>Indicator 7.1. FSP Consumers Served</i>	DCR; County Plans / Annual Updates	Ratio of FSP consumers served to planned service levels	<ul style="list-style-type: none"> • Formerly titled “Consumers Served Annually through CSS”. Title changed for accuracy/specificity of data available. • CSS Exhibit 6 data was reported to be unreliable by many experts and stakeholders. So, service levels planned by counties were utilized as the denominator for this indicator calculation.
<i>Indicator 7.2. Involuntary Status</i>	California DMH Reports of Involuntary Status	Rate of involuntary services per 10,000 served.	<ul style="list-style-type: none"> • Indicator name changed (formerly “Involuntary Care”) for accuracy (per MHSAOC request) • Involuntary Status information only available from CA-DMH through FY 2008-09, thus 2009-10 is not available for reporting • Seclusion/Restraint information only available from 7 state facilities. Because the community mental health system is the focus of this report, seclusion/restraint will not be reported.
<i>Indicator 7.3. 24-hour care</i>	CSI; DCR	% of Overall and FSP consumers who received 24-hr services	No Change
<i>Indicator 7.4. Consumer and Family Centered Care</i>	CPS	Mean aggregate ratings of consumer/family centered care	Formerly titled “Appropriateness of Care”. Title changed for accuracy/specificity of data available.

SYSTEM-LEVEL INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	EXPLANATION OF CHANGE FROM 2D REPORT
<i>Indicator 7.5. Integrated Service Delivery</i>	County Plans / Annual Updates	Prevalence of planned county strategies for achieving integrated service delivery.	<ul style="list-style-type: none"> Formerly titled “Continuity of Care”. Title changed in response to expert/stakeholder feedback and for accuracy/specificity of data available. CSI and DCR data fields proposed for analysis in deliverable 2D were found incomplete and unreliable. As Integrated Service Delivery is an MHSA service goal, county plans were systematically coded to assess the prevalence of county strategies for achieving integrated service delivery.
<i>Indicator 7.6. Consumer wellbeing</i>	CPS	Mean aggregate consumer/family rating of wellbeing	No Change
<i>Indicator 7.7. Satisfaction</i>	CPS	Mean aggregate consumer/family rating of satisfaction with services	No Change
Domain 8. Structure			
<i>Indicator 8.1. Workforce composition</i>			Indicator removed due to redundancy with the work of other contractors (per MHSAOC request).
<i>Indicator 8.2. Evidence-based Practice Programs</i>	County Plans / Annual Updates	Prevalence of evidence based practices planned	Proposed DCR data fields were reported to be unreliable by experts and stakeholders, and were found to be incomplete through our analysis. Evidence based practices were identified by an expert contractor and our advisory panel. Then county plans were coded to assess the prevalence of plans to implement evidence based practices.
<i>Indicator 8.3. Cultural Appropriateness of Services</i>	WET Plans; County Plans / Annual Updates	Prevalence of planned county strategies for providing culturally appropriate services	Only 1 currently collected CPS item assesses cultural appropriateness of services. Such a narrow measure would not be instructive. Thus, county plans were systematically coded to assess the prevalence of culturally appropriate service strategies planned.
<i>Indicator 8.4. Recovery, wellness, and resilience orientation</i>	WET Plans; County Plans / Annual Updates	Prevalence of planned county strategies for promoting a recovery, wellness, resilience orientation	Resources were not available to conduct the additional a data collection, proposed in Deliverable 2D. Thus, county plans were systematically coded to assess the prevalence planned strategies to promote a recovery, wellness, resilience orientation

Appendix F – CSI Service Function Variables for Hospitalization and Non-Hospitalization Designation

The following pages are from the CSI Data Dictionary. They describe services in which consumers are enrolled, including emergency interventions. The enclosed definitions guide our designation of “hospitalization” – use of a hospital for intervention services – and “non-hospitalization” – use of a non-hospital facility for such services.

S-06.0 SERVICE FUNCTION

PURPOSE:

Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service.

FIELD DESCRIPTION:

Type:	Character
Byte(s):	2
Format:	XX
Required On:	All Service Records
Source:	Local Mental Health

VALID CODES:

24 Hour Services/Mode 05

10-18	= Hospital Inpatient
19	= Hospital Administrative Day
20-29	= Psychiatric Health Facility (PHF)
30-34	= SNF Intensive
35	= IMD Basic (no Patch)
36-39	= IMD With Patch
40-49	= Adult Crisis Residential
50-59	= Jail Inpatient
60-64	= Residential, Other
65-79	= Adult Residential
80-84	= Semi-Supervised Living
85-89	= Independent Living
90-94	= Mental Health Rehab Center

Outpatient Services/Mode 15

01-09	= Linkage/Brokerage
10-18	= Collateral
19	= Professional Inpatient Visit - Collateral
30-38	= Mental Health Services (MHS)
39	= Professional Inpatient Visit - MHS
40-48	= Mental Health Services (MHS)
49	= Professional Inpatient Visit - MHS
50-57	= Mental Health Services (MHS)
58	= Therapeutic Behavioral Services (TBS)
59	= Professional Inpatient Visit - MHS
60-68	= Medication Support (MS)
69	= Professional Inpatient Visit - MS
70-78	= Crisis Intervention (CI)
79	= Professional Inpatient Visit - CI

Day Services/Mode 10

20-24	= Crisis Stabilization - Emergency Room
25-29	= Crisis Stabilization - Urgent Care

- 30-39 = Vocational Services
- 40-49 = Socialization
- 60-69 = SNF Augmentation
- 81-84 = Day Treatment Intensive - Half Day
- 85-89 = Day Treatment Intensive - Full Day
- 91-94 = Day Rehabilitation - Half Day
- 95-99 = Day Rehabilitation - Full Day

The coding scheme follows the County Cost Report definitions.

COMMENTS:

For information about reporting clients, services, and providers, see Technical Supplement TS-F: REPORTING TIPS, Tip One.

For examples of reporting this data element, see Technical Supplement TS-F: REPORTING TIPS, Tip Two.

DEFINITIONS:

24 Hour Services/Mode 05

Hospital Inpatient (10-18)	Services provided in an acute psychiatric hospital or a distinct acute psychiatric part of a general hospital that is approved by the Department of Health Services to provide psychiatric services.
Hospital Administrative Day (19)	Local Hospital Administrative Days are those days that a patient's stay in the hospital is beyond the need for acute care and there is a lack of nursing facility beds.
Psychiatric Health Facility (PHF) (20-29)	Psychiatric Health Facility Services are therapeutic and/or rehabilitation services provided in a non-hospital 24-hour inpatient setting, on either a voluntary or involuntary basis. Must be licensed as a Psychiatric Health Facility by the Department of Mental Health.
SNF Intensive (30-34)	A licensed skilled nursing facility which is funded and staffed to provide intensive psychiatric care.
IMD (Institute for Mental Disease)	For this service function an IMD is a SNF where more than 50% of the patients are diagnosed with a mental disorder. The federal government has designated these facilities as IMDs. No Patch.
Basic (35)	Organized therapeutic activities which augment and are integrated into an existing skilled nursing facility.
With Patch (36-39)	
Adult Crisis Residential	Therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured

(40-49)	program as an alternative to hospitalization for persons experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care.
Jail Inpatient (50-59)	A distinct unit within an adult or juvenile detention facility which is staffed to provide intensive psychiatric treatment of inmates.
Residential, Other (60-64)	This service function includes children's residential programs, former SB 155 programs, former Community Care Facility (CCF) augmentation, and other residential programs that are not Medi-Cal certified or defined elsewhere.
Adult Residential (65-79)	Rehabilitative services, provided in a non-institutional, residential setting, which provide a therapeutic community including a range of activities and services for persons who would be at risk of hospitalization or other institutional placement if they were not in the residential treatment program.

24 Hour Services/Mode 05 (continued)

Semi-Supervised Living (80-84)	A program of structured living arrangements for persons who do not need intensive support but who, without some support and structure, may return to a condition requiring hospitalization. This program may be a transition to independent living.
Independent Living (85-89)	This program is for persons who need minimum support in order to live in the community.
Mental Health Rehab Center (90-94)	This is a 24 hour program which provides intensive support and rehabilitation services designed to assist persons 18 years or older, with mental disorders who would have been placed in a state hospital or another mental health facility to develop the skills to become self-sufficient and capable of increasing levels of independent functioning.

Day Services/Mode 10

Crisis Stabilization - Emergency Room (20-24)	This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of a client exhibiting acute psychiatric symptoms, provided in a 24-hour health facility or hospital based outpatient program. Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.
Crisis Stabilization - Urgent Care (25-29)	This is an immediate face-to-face response lasting less than 24 hours, to or on behalf of a client exhibiting acute psychiatric symptoms, provided at a certified Mental Health Rehabilitation provider site. Service activities are provided as a package and include but are not limited to Crisis Intervention, Assessment, Evaluation, Collateral, Medication Support Services, and Therapy.

Vocational Services (30-39)		Services designed to encourage and facilitate individual motivation and focus upon realistic and attainable vocational goals. To the extent possible, the intent is to maximize individual client involvement in skill seeking and skill enhancement, with an ultimate goal of self-support.
Socialization (40-49)		Services designed to provide activities for persons who require structured support and the opportunity to develop the skills necessary to move toward more independent functioning.
SNF Augmentation (60-69)		Organized therapeutic activities which augment and are integrated into an existing skilled nursing facility.
Day Treatment Intensive Half Day (81-84) Full Day(85-89)		Day Treatment Intensive service provides an organized and structured multi-disciplinary treatment program as an alternative to hospitalization, to avoid placement in a more restrictive setting, or to maintain the client in a community setting.
Day Rehabilitation Half Day (91-94) Full Day (95-99)		Day Rehabilitation service provides evaluation and therapy to maintain or restore personal independence and functioning consistent with requirements for learning and development.
<u>Outpatient Services/Mode 15</u>		
Linkage/Brokerage (01-09)		Linkage/Brokerage services are activities that assist a client to access medical, educational, social, prevocational, vocational, rehabilitative, or other needed community services.
Collateral (10-18)		Collateral and Mental Health Services are interventions designed to provide the maximum reduction of mental disability and restoration or maintenance of functioning consistent with the requirements for learning, development, independent living, and enhanced self-sufficiency.
Mental Health Services (MHS) (30-38, 40-48, 50-57)		
Therapeutic Services (TBS) (58)	Behavioral	These services are the same as collateral and Mental Health Services, except they consist of one-to-one therapeutic contacts with a mental health provider and a beneficiary for a specified short-term period of time (shadowing), which are designed to maintain the child/youth's residential placement at the lowest appropriate level by resolving target behaviors and achieving short-term treatment goals. The mental health provider is on-site and is immediately available to intervene for a specified period of time, up to 24 hours a day, depending on the need of the child/youth.
Professional Inpatient Visit - Collateral or MHS (19, 39, 49, 59)		These services are the same as Mental Health Services except the services are provided in a non-SD/MC inpatient setting by professional staff.
Medication Support		Medication support services include prescribing, administering,

- (60-68) dispensing, and monitoring of psychiatric medication or biologicals necessary to alleviate the symptoms of mental illness.
- Professional Inpatient Visit - Medication Support (69) - These services are the same as Medication Support except the services are provided in a non-SD/MC inpatient setting by professional staff.
- Crisis Intervention (70-78) - Crisis Intervention is a service, lasting less than 24 hours, to on behalf of a client for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy.
- Professional Inpatient Visit - Crisis Intervention (79) - These services are the same as Crisis Intervention except the services are provided in a non-SD/MC inpatient setting by professional staff.

For more details on these definitions, see the California Code of Regulations, Title 9, Chapter 11 and the County Cost Report documentation.

USER/USAGE INFORMATION:

This data element is needed for detailed identification of the types of services being given as well as for linking to cost reports.

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- ¹ California Mental Health Planning Council (January, 2010). *Performance Indicators for Evaluating the Mental Health System*.
- ² Op. cit.
- ³ *Mental Health Services Act Evaluation: Compiling Data to Produce All Priority Indicators*; November 2, 2011
- ⁴ Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.
- ⁵ Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.
- ⁶ Independent for the CSI is defined as: A = House or apartment (includes trailers, hotels, dorms, barracks, etc.); B = House or apartment and requiring some support with daily living activities (applies to adults only); C = House or apartment and requiring daily support and supervision (applies to adults only); and D = Supported housing (applies to adults only).
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- ¹⁷ California Association of Social Rehabilitation Agencies. (2007). *Developing Systems and Services that Support People in Wellness and Recovery*. Sacramento: California Institute for Mental Health.
- ¹⁸ Friedmann, P. J. (1999). Organizational Correlates of Access to Primary Care and Mental Health Services in Drug Abuse Treatment Units. *Journal of Substance Abuse Treatment* , 71-80.
- ¹⁹ Blount, A. (2003). Integrated Primary Care: Organizing the Evidence. *Families, Systems and Health* , 121-134.
- ²⁰ Primary care physician access is not reliably track among all mental health consumers, as it is among FSP consumers. Thus, only FSP consumers were analyzed under this indicator.
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- ²² Mojtabai, R. (2005). Trends in Contacts with Mental Health and Cost Barriers to Mental Health Care Among Adults with Significant Psychological Distress in the United States: 1997-2002. *American Journal of Public Health* , 2009-2014.
- ²³ Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.
- ²⁴ Consumer Perception Surveys were not completed by youth during FY 2009-10
- ²⁵ Consumer Perception Surveys were not completed by youth during FY 2009-10
- ²⁶ Hart, Mark Alan. (1974) "Civil Commitment of the Mentally Ill in California: The Lanterman-Petris-Short Act." *Loyola of Los Angeles Law Review* , 93-136.
- ²⁷ Op cit
- ²⁸ Swanson, J. W. (2000). Involuntary Outpatient Commitment and reduction of Violent Behavior in Persons with Severe Mental Illnesses. *The British Journal of Psychiatry* , 324-331
- ²⁹ Op cit
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