

**County Mental Health Tracking:
Stanislaus, Santa Clara and Orange Counties**

A Project of the
Center for Reducing Health Disparities
UC Davis School of Medicine

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Executive Summary

A county mental health tracking system should employ approaches that respond to the unique needs of each county, yet provide a method for understanding those needs in the larger context of the state.

Several approaches can facilitate this:

- Assess current mental health services provided by the counties,
- Improve the understanding in of population-level mental health care need (as describe in our report on the assessment of need using the California Health Interview Survey),
- And enhanced use of existing databases such as the Client and Services Information (CSI) database.

The goals of this project are to:

1. Demonstrate how existing data can be used to track mental health services access and utilization and examine possible disparities at the local level (census tracts within counties).
2. Show how modern spatial and statistical methodologies (using a geographic information system or GIS) can be used to illustrate meaningful patterns of mental health services access and utilization in an understandable way that will be useful to the counties.
3. Develop recommendations for tracking quality of care and cost-effectiveness of care for services delivered by the counties.

With these goals in mind, this report focuses on individuals with an Axis I diagnosis (see Appendix A) in the following way:

1. We discuss the prevalence of mental illness in California for context.
2. We analyze access to mental health care services and utilization of these services for individuals receiving county mental health services.
 - a. We report outcomes separately for different target populations (by age group, gender, and race/ethnicity) in order to increase knowledge about possible disparities in mental health services in the state.
 - b. We employ a geographic approach to facilitate targeted interventions that may effectively allocate limited resources.
 - c. We comment on information systems needs in order to track and improve mental health in the counties studied.

Introduction

“By expanding programs that have demonstrated their effectiveness, California can save lives and money. Early diagnosis and adequate treatment provided in an integrated service system is very effective; and by preventing disability, it also saves money. [...] California can do a better job saving lives and saving money by making a firm commitment to providing timely, adequate mental health services.”

– Mental Health Services Act: Findings and Declarations

“To 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.”

- Mental Health Services Act: Purpose and Intent

It is recommended that a high priority for a mental health tracking system in California be to develop measures for the evaluation of services given through the County mental health program. In California, each county has a uniquely diverse population and specific needs related to those populations and their local geographies. In this report, we highlight the innovative use of an existing data source, the California Department of Mental Health’s Client and Services Information (CSI) database, to better understand client access to mental health services, service utilization, and methods for assessing the effectiveness of services for different subgroups within the counties. It is critical to understand the challenges that each geography (herein county) faces in the delivery of mental health care services to its citizens. By doing so, policy makers can better respond to data illustrating inequities (or not) in the access and utilization of mental health care services and target resources appropriately.

To complete our analysis, we chose 3 California counties who both expressed an interest in participating in this research and also had a record of timely and comprehensive delivery of their CSI data to the Department of Mental Health (DMH). These counties are: Stanislaus, Santa Clara, and Orange County.

The CSI system collects data pertaining to mental health clients and the services they receive at the county level. This system reflects both the Medi-Cal and non-Medi-Cal clients and services provided in the county mental health program, providing the opportunity to gain a more complete picture of mental health services delivery. According to DMH, CSI:

“includes all providers whose legal entities are reported to the County Cost Report under the category Treatment Program and the individual and group practitioners, most of which were

formerly in the Fee-For-Service system. These practitioners are individual or group practice psychiatrists, psychologists, Licensed Clinical Social Workers (LCSW), Marriage, Family and Child Counselors (MFCC), and Registered Nurses (RN) as well as the Mixed Specialty group practices. In county-staffed providers, all clients and services must be reported. In contract providers, those clients and services provided under the contract with the county mental health program must be reported.”

In this report, we focus on the access and utilization of mental health care services at the county level, disaggregating the results by specific gender, racial, ethnic and age groups to better understand whether and where disparities in these measures may exist within the counties. However, we note that the CSI database provides a wealth of additional information that can be leveraged to further clarify the factors that predispose individuals from certain geographies or with certain social or demographic conditions to have better access to mental health care services within their county. Some examples of these data variables that are of particular interest include: nativity, primary and preferred language, comorbid conditions (Axis IV diagnoses), the global assessment of functioning (Axis V), and evidence based practice/service strategies. Please see additional discussion of future steps in the section entitled, “Conclusions and Recommendations.”

In the following sections of the report we will discuss the prevalence of mental illness in California to provide a context for understanding. We then discuss measuring access to mental health services and the utilization of those services. A comment about the spatial and statistical techniques used in mapping the data will be provided, while the comprehensive methodology is fully described in Deliverable #1. We will summarize our findings for each county, including differences and disparities among different subpopulations. And finally we will draw some conclusions and summarize our recommendations from this project. In addition, a full, in color atlas of maps for the Stanislaus and Santa Clara County are provided at the end.

Prevalence of Mental Illness in California

Mental health is an important public health issue. Estimates of past year prevalence of major depressive episodes among persons 18 years or older were nearly 7% in California[1]. The 12-month prevalence rates among youth aged 12 to 17 were even more pronounced (nearly 9%). That's a burden of

depression affecting more than 2.5 million individuals in the state. And that does not include other major mental illnesses like anxiety and/or substance abuse. According to a recently published health policy research brief, in 2005 nearly 4.9 million persons said they needed help for a mental or emotional health problem, but only one in three sought professional treatment[2].

Research has shown that significant disparities exist in the provision of mental health care services, particularly by racial and ethnic group. The disparities arise from multiple factors and include: limited English proficiency, geographic settings, fragmented services, cost and other social determinants of health. Tracking mental health delivery is critical to improving services equitably[3].

Measuring Access to Mental Health Care Services

To maintain a level of consistency in our county and statewide (see Deliverable #1) analyses assessment of mental health care services, we continue to define the access to mental health care services as a penetration rate. This measure is still a ratio, but with the county CSI data, the numerator and denominator are different than those used with state-level Medi-Cal data. In the numerator of this ratio, we included the number of individuals with a mental health diagnosis (as listed in Appendix A) who existed in the CSI database. The denominator was constructed to include the general population (or subpopulation of interest thereof). For example, when we examine female gender, we included all individuals in the CSI database with a diagnosis matching our list, divided by the population of women in a census tract. Of note, we have restricted our analysis to the year 2008, a year for which both CSI and census data were complete and available. We also limited the age range in our work to ages 12 to 64. Primarily, this restriction was enforced to maintain consistency between this analytic process and that used for Deliverable #1 at the state level.

It is worth noting that the conceptualization of 'access to care' is varied with many options available. It is our understanding that many counties preferentially use a measure of poverty in the denominator, rather than the general population. We did not pursue this for two reasons. First, poverty level, or measures of percentages below the poverty line are difficult to calculate. They require knowledge of family/household size and income at the individual level. Therefore, the rates cannot be calculated correctly using downloadable, aggregated census data. To our knowledge, these measures are not readily available at the census tract level, which is the scale of analysis for this work. Second, we would

argue that while income level is an important predictor of health and mental health status, it is not the only predictor. We suggest that for current and potential future work (see Conclusions and Recommendations section regarding geographic regression models), that income be used as a predictor, rather than as a construct of the outcome. Furthermore, as noted in Deliverable #3 concerning population-level need for mental health services, our use of general population data will provide a more comprehensive view of service delivery.

Please see the atlas for maps showing penetration rates by census tract as well as the clusters of high and low penetration.

Measuring Mental Health Care Services Utilization

The utilization of mental health care services was analyzed using a measure of the number of mental health visits per CSI client by census tract. For this work, we used the presumed outpatient population. The method for deriving the presumed outpatient population varied by county (please see details in the discussion of findings sections for each county) due to different methods for coding data fields. Providing an outpatient utilization rate allowed us to display utilization rates in a more meaningful way. For example, one might consider it reasonable for individuals with a mental health diagnosis to access outpatient mental health care services at a rate of once per quarter or even once per month. However it might be considered a failure of the system if those with mental illness saw a mental health provider fewer than two times per year. In other words, thresholds of appropriate utilization could be assessed. On the other hand, if inpatient visits were included, those patients who spend weeks to months to years in such a setting would skew the utilization rate to very high numbers that would not be amenable to a rational interpretation. Our selection of these service types was inclusive of at least 75% of the overall datasets for the counties.

Please see the atlas for maps showing utilization rates by census tract as well as the clusters of high and low utilization.

Spatial and statistical mapping techniques

Since the analysis was performed geographically at the census tract level, we required a fully geocoded dataset for both the numerator and the denominator. Geocoding was not consistently available from

the counties (see details in the county-level findings below), so geocoding was specifically done for this project. We obtained the patient’s full address as recorded in the CSI database and obtained a latitude and longitude for each address using a geocoder provided by the State of California. Then we ‘reverse geocoded’ those latitude and longitudes into the appropriate census tract for each client.

The overall spatial techniques used at the county level analysis mimic those use for the statewide analysis described in Deliverable #1. However, there is one important difference to note. Since hot spot analysis compares a local neighborhood of census tracts to the global dataset, that means that for each county the level of comparison for each census tract is the overall county mean. Therefore, the results show how a census tract or group of census tracts compares to the overall county-level delivery of service. When interpreting the county maps, one should consult the state-level map first to determine how the county performs relative to the state mean. If the county, for example, has a number of ‘cold spots’ or lower access and utilization of services, then one might interpret cold spots in the county-level analysis to reflect an even more dire level of service access and use.

Discussion of Findings in Stanislaus County

We found Stanislaus County to be very efficient in providing us with their CSI data for this research. They were able to provide these data in an easy to convert comma delimited format and send it with encryption via email. The dataset, however, was not able to be geocoded ‘in house,’ so we performed the geocoding ourselves. We found that several clients could not be geocoded and were thus excluded from analysis (Table 1 describes the anomalies). Although 94.3% of the population was included, it is important to note that two vulnerable populations were among those excluded – the homeless and those incarcerated without an address or institution name in the database.

Table 1. Stanislaus clients not included in the analysis.

| Number | Reason for Exclusion |
|--------|------------------------------|
| 250 | Homeless |
| 130 | Post Office Boxes |
| 53 | Street Address Blank |
| 2 | Incarcerated Without Address |
| 2 | Military or Out of State |

The population included in the analysis is described in Table 2 and is compared to available U.S. Census demographics from 2009. The number of individuals receiving county mental health care services is roughly 1.4% of the overall population. When comparing that percentage to the estimated prevalence of mental illness in California, this appears to indicate some level of service disparity.

Table 2. Stanislaus County CSI database clients (2008) compared to demographic data from the U.S. Census (2009).

| Total | CSI Clients N = 6,972 | U.S. Census Demographics N=510,385 |
|--------------------------|-----------------------------|--|
| Gender | | |
| Male | 46.7% | 49.6% |
| Female | 53.3% | 50.4% |
| Unknown | 0.04% | |
| Age | | |
| 12-17 | 32.4% | |
| 18-24 | 12.1% | |
| 25-44 | 32.3% | |
| 45-54 | 15.6% | |
| 55-64 | 7.6% | |
| Race* | | |
| White | 61.4% | 86.5% |
| African-American | 6.3% | 3.3% |
| Latino | 16.5% | |
| Asian/Pacific Islander | 5.5% | 5.7% |
| Am Indian/Alaskan Native | 1.3% | 1.6% |
| Other | 8.4% | 2.9% |
| Invalid/Decline to State | 0.7% | |
| Ethnicity | | |
| Hispanic | 35.4% | 40.3% |
| Non-Hispanic | 62.0% | 48.7% |
| Other | 2.5% | |

*The CSI database includes several sub-populations of Asian and Pacific Islander as well as Latino. To create the category of 'Asian/Pacific Islander' we combined the following groups: Filipino, Amerasian, Chinese, Cambodian, Japanese, Korean, Samoan, Asian Indian, Hawaiian Native, Guamanian, Laotian, Vietnamese, Other Asian or Pacific Islander, Assyrian-Iran, Assyrian-Iraq, Hmong, Mien, and Other Southeast Asian. To create the category of Latino, we combined: Latin American, Mexican American/Chicano, and Other Spanish.

In the Stanislaus County CSI database, we used the Service Delivery Mode variable to represent the presumed outpatient visits for the utilization rate. A summary of these data are shown in Table 3.

Table 3. Frequency of visits based on the Service Delivery Mode.

| Service Delivery Mode | Frequency | Percent |
|-----------------------|----------------|---------------|
| Office | 76,310 | 46.9% |
| Phone | 26,933 | 16.6% |
| Field | 21,004 | 12.9% |
| Home | 17,857 | 11.0% |
| School | 11,973 | 7.4% |
| Inpatient | 5,018 | 3.1% |
| Jail | 2,886 | 1.8% |
| Residential Treatment | 358 | 0.2% |
| Other Location* | 201 | 0.1% |
| Total | 162,540 | 100.0% |

*multiple smaller categories were collapsed to 'other location.'

We combined the categories of 'office' and 'school' to account for the outpatient visits (total of 54.3% of the visits).

When assessing the provision of services in Stanislaus County, it is helpful to begin at the state level (see Deliverable #1 and the statewide atlas) for context. The state-level trend is toward higher levels of utilization of services and low levels of access, particularly for men and white populations. One explanation for the high level of utilization, particularly when combined with lower levels of access may be that the patients in Stanislaus County have more serious conditions than elsewhere. As we look at the county level maps, the following trends emerge:

- The highest rates of access and utilization are in or near the cities of Ceres and Modesto, except for the Native American population which has a lower level of utilization in Modesto.
- Populations in or near the city of Salida often trend toward lower levels of access (especially for men and non-Hispanics) and higher levels of utilization, potentially indicating sicker patients who are in need of services but have difficulty getting access.
- Utilization of services near Oakdale is low for women and Latinos.
- Individuals aged 25-44 have the lowest utilization rates among the subgroups analyzed.

Discussion of Findings in Santa Clara County

Santa Clara County was very cooperative with regarding to providing us with data for this work. There were not able to support a compact file format that could be sent electronically. Instead, they provided two Microsoft Excel spreadsheets that needed to be merged on our end. Because of the size of these documents, they could not be emailed with encryption, so a DVD with the data was ‘handed off’ in person.

Santa Clara County was unable to geocode the data for us, so they provided client addresses that we geocoded ourselves. Approximately 5% of clients could not be geocoded and were thus excluded from the geographic analysis. This was due to difficulties with non-standardized addresses in the database. For example, streets in downtown San Jose did not initially geocode because of inaccurate North/South street designations. Streets were entered as “111 1ST N ST.” The correct/geocodable address is, “111 N 1ST ST.” While we were able to correct many of the input errors, 948 records remained ungeocodable. Specific recommendations regarding geocoding are made in the Conclusions and Recommendations section.

The population that was included in the geographic analysis is described in Table 4 and is compared to available U.S. Census demographics from 2009. Only 0.81% of the county’s population is receiving mental health care services through the county, clearly a shortfall when compared to the estimated prevalence of mental illness in California.

Table 4. Santa Clara County CSI database clients (2008) compared to demographic data from the U.S. Census (2009).

| Total | CSI Clients N= 14,460 | U.S. Census Demographics N=1,784,642 |
|---------------|--------------------------|--|
| Gender | | |
| Male | 49.6% | 51.1% |
| Female | 50.4% | 48.9% |
| Unknown | 0.01% | |
| Age | | |
| 12-19 | 23.4% | |
| 20-24 | 10.3% | |
| 25-44 | 38.2% | |
| 45-54 | 18.5% | |
| 55-64 | 9.7% | |

| Race* | | | |
|-----------|--------------------------|-------|-------|
| | White | 34.0% | 61.6% |
| | African-American | 6.9% | 2.9% |
| | Asian/Pacific Islander | 15.4% | 32.1% |
| | Am Indian/Alaskan Native | 1.1% | 0.8% |
| | Other | 31.9% | 2.7% |
| | Invalid/Decline to State | 10.7% | |
| Ethnicity | | | |
| | Hispanic | 31.7% | 26.3% |
| | Non-Hispanic | 54.9% | 37.2% |
| | Other | 13.4% | |

*The CSI database includes several sub-populations of Asian and Pacific Islander. To create the category of 'Asian/Pacific Islander' we combined the following groups: Filipino, Chinese, Cambodian, Guamanian, Japanese, Korean, Samoan, Asian Indian, Hawaiian, Laotian, Vietnamese, Hmong, Other Asian and Mien.

To represent the presumed outpatient visits for the utilization rate in Santa Clara County, we used the CSI variable, Service Delivery. Table 5 notes the types of delivery available in the Santa Clara CSI data.

Table 5. Frequency of visits based on the variable, Service Delivery.

| Service Delivery | Frequency | Percent |
|----------------------|----------------|---------------|
| Face-to-Face | 391,038 | 76.7% |
| Telephone Contact | 84,932 | 16.6% |
| Other Method | 24,584 | 4.8% |
| Consultation | 9,526 | 1.9% |
| Take Out - DADS Only | 16 | 0.0% |
| Courtesy - DADS Only | 13 | 0.0% |
| Total | 510,109 | 100.0% |

We combined the categories for 'Face-to-Face' and 'Consultation' to account for the outpatient visits (total of 78.5% of the visits).

Using data from the state-level, Santa Clara County appears to be universally providing fewer services than expected compared to the statewide mean. When we look closely at the county-level maps, the following patterns emerge:

- In or near the cities of Stanford and Palo Alto there is low access to service for women, Asians, and younger age groups (12 to 44). In the same areas and for the same groups there is a high level of utilization which may indicate sicker patients who have a hard time obtaining services.

- The lowest levels of access and utilization occur in and around the cities of: Saratoga, Los Gatos, Los Altos and Mountain View, indicating a need for more services.
- The areas with the highest levels of access are: San Jose, Alum Rock and Stanford.
- Asians have the lowest levels of access in the county.

Discussion of Orange County

Our intent was to include Orange County in this analysis. Unfortunately, despite our efforts, we were unable to obtain their CSI data.

Effectiveness and Cost-Effectiveness of Care

Before cost effectiveness can be adequately addressed, a robust set of measures for clinical effectiveness of treatment programs must first be developed. We recommend that a set of outcome measures for county mental health services be developed by a partnership consisting of DMH, MHSOAC, county mental health agencies, mental health clinicians, academic researchers, and other stakeholders, and included in the CSI database. Outcomes for an assessment of the effectiveness of mental health services should be:

1. measures considered appropriate by mental health clinicians;
2. measures that county agencies would find useful for their own internal evaluation of their program;
3. measures that academic researchers would consider suitable for analysis (e.g., free from potential sources of error and bias);
4. measures that stakeholders would consider fair indicators of effective treatment.

However, some basic measures of mental health services such as the pattern of receipt of services (e.g., retention and no-shows) and the type of services received (e.g., type of therapy, type of medication prescribed) could be put into place without undue effort or cost. This could be implemented relatively quickly and serve as a first step toward a more comprehensive assessment of effectiveness.

The following measures could be considered for use as outcomes for mental health services:

1. **Clinician's report on client's improvement or stabilization and functioning.** E.g., some aspects of the clinician's periodic progress notes are captured using a small number of standardized multiple choice questions.
2. **Client's self-report on satisfaction with care and assessment of how much it has helped.** E.g., the client completes a simple questionnaire about the quality of services received.
3. **Pattern of visits.** E.g., retention or drop-out, number of visits in a given time period, and amount of no-shows.
4. **Gap between initial contact with county agency and first visit (or no-show at first visit).**
5. **Type of mental health services received.** E.g., therapeutic approach (type of talk therapy received), individual or group therapy, type of clinicians seen (psychiatrist, psychologist, social worker, etc.).
6. **Medications.** Medications prescribed and medication adherence.
7. **Emergency mental health hospitalizations.**
8. **Non-mental health services received.** E.g., housing support, job training, and other health care services.
9. **Quality of life measures.** E.g., physical health status, stability of housing arrangement, safety of home environment, employment, and financial stability.

Measures (or data from which they could be constructed) for items 3 (except for no-show rate), 5 (partially), and 7 are already present in DMH's CSI database. For those clients covered under Medi-Cal, medication data (item 6) exists in the Department of Health Care Services Medi-Cal pharmacy database. Using these measures for evaluation purposes is not a difficult proposition: it merely requires an analysis of existing data to be conducted.

Note that many of these outcomes may be dependent on the severity of the client's condition. Hence, analyses of these data need to be done with an awareness of this, and with the use of an appropriate analytical approach, controlling for severity and possibly other factors as well. Such analyses are routine among academic researchers. One method, the Charlson comorbidity index, was developed to take advantage of billing data systems to better understand a patient's ten-year mortality risk. Database managers at the state-level (Medi-Cal) are already able to assign a Charlson score within their database. Such algorithms could be shared with counties to facilitate higher level analyses.

Conclusions and Recommendations

In order to better serve individual county populations, we recommend the following steps be taken;

1. **There should be a more thorough evaluation of the effectiveness of services delivered under the County mental health program.** This should be an immediate high priority for a mental health tracking system for California. In particular:
 - a. **Better outcome measures for county mental health services should be developed** by a partnership consisting of DMH, MHSOAC, county mental health agencies, mental health clinicians, academic researchers, and other stakeholders, and included in the DMH’s CSI database. Should access to care be included as an outcome measure, we recommend that it be revised to include a component of need (see Deliverable #3).
 - b. **Outcomes and assessment of county mental health services and MHSAs programs should include cost effectiveness and other economic-based measures.**
 - c. **There should be uniform statewide protocols for the collection of key measures** in the CSI database and for the same measures when collected as part of the evaluation of MHSAs programs. This especially includes measures of race and ethnicity (to match U.S. Census methods), and service delivery modes.
2. **Multidimensional analyses may improve the evaluation of disparities (or the lack of disparities) by race/ethnicity/nativity, gender, age, and other characteristics.** One-way tabulations of one or two outcome measures by a single demographic characteristic (e.g., race/ethnicity alone) may be insufficient to fully understand disparities. While we recommend multidimensional analyses over the geographic landscape of California, we also note that such analyses will require large and complete datasets (see also the explanation of Geographically Weighted Regression in Deliverable #1).
3. **The California Department of Mental Health’s Client and Services Information (CSI) database and the state’s Medi-Cal billing and pharmacy databases are “gold mines” for assessing disparities, and should be better utilized.** Ideally, these datasets should be merged to provide an opportunity to conduct the multidimensional analyses noted above.
4. **Perform routine geocoding of all CSI data and improve the standardization of address data.**
 - a. As mentioned in our statewide report, geocoding of all statewide datasets will soon be mandatory. We recommend that counties also pursue this process since it will strongly facilitate important geographic analyses. Furthermore, when done at the point of care,

issues such as post office boxes and homelessness can be addressed immediately, allowing inclusion of all individuals in the analysis (e.g., homeless people can provide a cross street where they spend time).

- b. If geocoding is done 'after the fact', i.e. processed in batches in the database, then address standardization (the formal recognizable format recommended by the U.S. Postal Service) is strongly recommended. To facilitate this we recommend that street directions, such as North, South, East and West be placed before the street name. The width of the address field needs to be increased to avoid truncation of street names. Apartment and suite numbers should be placed in a separate field from the primary street address.

Resources Cited

1. *State Estimates of Depression: 2004 and 2005*. The NSDUH Report 2007 [cited 06/24/2010]; Available from: <http://www.oas.samhsa.gov/2k7/states/depression.htm>.
2. Grant, D., et al., *Mental Health Status and Use of Mental Health Services by California Adults*. Policy Brief UCLA Center for Health Policy Research, 2010. **PB2010-6**: p. 1-8.
3. Primm, A.B., et al., *The Role of Public Health in Addressing Racial and Ethnic Disparities in Mental Health and Mental Illness*. Preventing Chronic Disease: Public Health Research, Practice, and Policy, 2010. **7**(1): p. 1-7.

Appendix A.

List of mental health diagnoses included in the county level analysis

| <i>Disorder</i> | <i>ICD 9 code</i> |
|--|-------------------|
| Psychotic disorder with delusions in conditions classified elsewhere (transient, organic, paranoid) | 293.81 |
| Psychotic disorder with delusions in conditions classified elsewhere (transient, organic, hallucinatory) | 293.82 |
| Schizophrenic disorders | 295.00 |
| Schizophrenia disorganized type | 295.10 |
| Latent schizophrenia | 295.50 |
| Other specified types of schizophrenia | 295.80 |
| Unspecified schizophrenia | 295.90 |
| Bipolar I disorder, single manic episode | 296.00 |
| Major depressive disorder, single episode | 296.20 |
| Major depressive disorder, recurrent episode | 296.30 |
| Bipolar I disorder, most recent episode (or current) manic | 296.40 |
| Major depressive disorder, circular type, if previous attack was of manic type | 296.50 |
| Bipolar I disorder, most recent episode (or current) depressed | 296.50 |
| Bipolar I disorder, most recent episode (or current) mixed | 296.60 |
| Bipolar I disorder, most recent episode (or current) unspecified | 296.70 |
| Bipolar disorder, unspecified | 296.80 |
| Major depressive disorder, psychotic | 298.00 |
| Autistic disorder | 299.00 |
| Anxiety state, unspecified | 300.00 |
| Panic disorder without agoraphobia | 300.01 |
| Generalized anxiety disorder | 300.02 |
| Phobia, unspecified | 300.20 |
| Agoraphobia with panic disorder | 300.21 |
| Agoraphobia without mention of panic attacks | 300.22 |
| Social phobia | 300.23 |
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| | |
|--|--------|
| Obsessive-compulsive disorders | 300.30 |
| Dysthymic disorder | 300.40 |
| Obsessive-compulsive personality disorder | 301.40 |
| Antisocial personality disorder | 301.70 |
| Borderline personality disorder | 301.83 |
| Alcohol dependence syndrome | 303.00 |
| Other specified drug dependence | 304.60 |
| Unspecified drug dependence | 304.90 |
| Alcohol abuse | 305.00 |
| Other, mixed, or unspecified drug abuse | 305.90 |
| Drug abuse (305.00-305.93)* | 305.93 |
| Acute reaction to stress | 308.00 |
| Adjustment disorder with disturbance of conduct | 309.30 |
| Posttraumatic stress disorder | 309.81 |
| Depressive disorder, not elsewhere classified | 311.00 |
| Disturbance of conduct, not elsewhere classified | 312.00 |
| Socialized conduct disorder | 312.20 |
| Intermittent explosive disorder | 312.34 |
| Conduct disorder, childhood onset type | 312.81 |
| Conduct disorder, adolescent onset type | 312.82 |
| Other conduct disorder | 312.89 |
| Overanxious disorder | 313.00 |
| Sensitivity, shyness, and social withdrawal disorder | 313.20 |
| Oppositional defiant disorder | 313.81 |
| Attention deficit disorder | 314.00 |
| Attention deficit disorder with hyperactivity | 314.01 |

*Note - this diagnostic category has a range of ICD-9 Codes
