

Mental Health Services Act Evaluation:

Final Report

Phase III, Contract Deliverable 3

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Mental Health Services Act Evaluation: Phase III Final Report

Introduction

In November 2004, California voters passed Proposition 63, the Mental Health Services Act (MHSA), which called for the establishment of the Mental Health Services Oversight and Accountability Commission (MHSOAC). Section 10 of the MHSA (Welfare and Institutions Code Section 5845) established the MHSOAC and defined the creation and composition of the Commission. The role of the MHSOAC is to oversee the implementation of the Mental Health Services Act (MHSA). In this role, the MHSOAC has partnered with the UCLA Center for Healthier Children, Families, and Communities and our collaborators to evaluate the MHSA, through several research phases.

The MHSOAC charged the UCLA / Trylon / Clarus Evaluation Team with expanding upon the work progressing under Phase II, which focuses on activities and costs of local MHSA funds¹ and development of priority indicators for monitoring MHSA processes and impacts at statewide and county levels². The Phase III evaluation included focused investigations of Full Service Partnership (FSP) service costs and cost offsets, and a participatory evaluation of the impact of MHSA services on consumer outcomes. Following the completion of these distinct but important investigations, this Final Report serves to (1) summarize practically significant findings (e.g., supporting identification of implications for action) from each evaluation, (2) highlight conclusions that can be drawn from study findings, and (3) consider future directions for research, including recommended research approaches and data collection. As such, this report is intended to provide the MHSOAC and other MHSA stakeholders with lessons learned from the Phase III evaluation and discussion of implications for action.

The report is organized in a sequential fashion, with the Full Service Partnership Cost Offset Analysis discussed first, followed by considerations of the Participatory Investigation of the Impact of MHSA Services on Client Outcomes, and overarching conclusions and implications which can be drawn from MHSA Phase III Evaluation.

Full Service Partnership Cost Offset Analysis

Summary of Products & Practically Significant Findings

FSP services are intensive to meet the needs of FSP-targeted clients. This is driven primarily by the policy objective to meet the serious needs of the hardest-to-serve clients – those with severe mental illness. This policy objective includes meeting both the service and the quality-of-life needs of FSP

¹ This study has produced several reports, including “Full Service Partnerships: California’s Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Severe Mental Illness” (www.mhsoac.ca.gov/Evaluations/FullServicePartnershipAnalysis.aspx)

² This study has produced several reports, including “Mental Health Services Act Evaluation: Compiling Data to Produce All Priority Indicators” (www.mhsoac.ca.gov/Evaluations/docs/MHSA_Contract_Deliverable_2D.pdf)

clients and the social outcomes and services needs of California. To address this complex balance between policy objective and client needs, the Full Service Partnership Cost Offset study assessed a broad range of costs to citizens of California that are a consequence of service delivery to mental health clients most in need.

To highlight these findings, tables detailing cost per person are provided below (Tables 2.1 and 2.2), followed by cost offset tables (Tables 2.3 and 2.4).

Table 1. Full Service Partnership Services: Annualized Cost per-Client by Age Group (Fiscal Year 08-09)

	Number Served	Sum of Days	Number of Client Years	Annualized Cost per-FSP Client	Daily Cost per-FSP Client	FSP Costs Total	% of Total FSP Costs
CYF	4,296	983,187	2,693.7	\$ 21,931.29	\$ 60.09	\$ 59,076,305.79	19.0%
TAY	4,593	1,064,015	2,915.1	\$ 18,553.96	\$ 50.83	\$ 54,086,655.41	17.4%
Adults	9,640	2,404,022	6,586.4	\$ 26,737.23	\$ 73.25	\$ 176,102,066.30	56.7%
Older Adults	1,388	344,979	945.1	\$ 22,303.26	\$ 61.10	\$ 21,078,807.79	6.8%
Total	19,917	4,796,203	13,140.3			\$ 310,343,835.29	100.0%

- Annualized cost is the total cost for an FSP client over a year (12 months).
- The average annualized cost (across all age groups) for Fiscal Year 08-09 is \$23,617.71.
- The average daily cost (across all age groups) for Fiscal Year 08-09 is \$60.31.

Table 2. Full Service Partnership Services: Annualized Cost per-Client by Age Group (Fiscal Year 09-10)

	Number Served	Sum of Days	Number of Client Years	Annualized Cost per-FSP Client	Daily Cost per-FSP Client	FSP Costs Total	% of Total FSP Costs
CYF	6,348	1,444,331	3,957.1	\$ 17,481.79	\$ 47.90	\$ 69,177,192.53	18.3%
TAY	6,623	1,619,816	4,437.9	\$ 13,741.40	\$ 37.65	\$ 60,982,974.12	16.1%
Adults	12,733	3,456,407	9,469.6	\$ 23,626.13	\$ 64.73	\$ 223,729,986.45	59.1%
Older Adults	1,764	480,383	1,316.1	\$ 18,785.22	\$ 51.47	\$ 24,723,227.99	6.5%
Total	27,468	7,000,937	19,180.7			\$ 378,613,381.09	100.0%

- The average annualized cost (across all age groups) for Fiscal Year 09-10 is \$19,739.29.
- The average daily cost (across all age groups) for Fiscal Year 09-10 is \$50.55.

Full Service Partnership Cost Offsets by Age Group include: ³

Physical Health

- Acute Care Inpatient Hospitalization (number of days)
- Skilled Nursing (Non-Psychiatric) (number of days)
- Emergency Room Visits (number of times)

Psychiatric Care

- Inpatient Psychiatric Hospitalization (number of days)

³ Cost Offsets can be developed only for counties that submit data to the State Department of Mental Health’s Full Service Partnership (FSP) Data Collection and Reporting System (DCR). All of the variables used in the FSP Cost Offset analysis are contained in the DCR. EMT does not have access to non-DCR data from counties. The areas analyzed for savings are very similar to those analyzed in the evaluation of AB 2034 efforts, which included inpatient psychiatric hospitalization and incarceration. Emergency room use was also evaluated but was limited to psychiatric rather than physical health. California Department of Mental Health (2007). (unpublished) *Report to the Legislature on the effectiveness of integrated services for homeless adults with serious mental illness*. Sacramento, CA: Author.

- Long-Term Care (number of days) ⁴
- Skilled Nursing (Psychiatric) (number of days)

Criminal Justice Involvement

- Arrests (number of times)
- Division of Juvenile Justice (number of days)
- Juvenile Hall/Camp (number of days)
- Jail (number of days)
- Prison (number of days)

Table 3. Total Full Service Partnership Services – Costs & Cost Offsets (Fiscal Year 08-09 New Enrollees ONLY)

	Number of New Enrollees FY 08-09	Sum of Days	Total Cost for FY 08-09 New Enrollees	Total Cost Offset FY 08-09	Percent Offset FY 08-09
CYF	2,164	340,323	\$ 20,450,009.07	\$ 2,428,313.16	11.9%
TAY	2,327	371,250	\$ 18,870,637.50	\$ 22,437,417.44	118.9%
Adults	4,315	690,298	\$ 50,564,328.50	\$ 41,509,329.01	82.1%
Older Adults	582	91,220	\$ 5,573,542.00	\$ 5,421,665.55	97.3%
Total	9,388	1,493,091	\$ 95,458,517.07	\$ 71,796,725.16	75.2%

Table 4. Total Full Service Partnership Services – Costs & Cost Offsets (Fiscal Year 09-10 New Enrollees ONLY)

	Number of New Enrollees FY 09-10	Sum of Days	Total Cost for FY 09-10 New Enrollees	Total Cost Offset FY 09-10	Percent Offset FY 09-10
CYF	3,101	454,605	\$ 21,775,579.50	\$ 2,262,842.11	10.4%
TAY	2,977	496,190	\$ 18,681,553.50	\$ 27,501,007.94	147.2%
Adults	4,702	868,415	\$ 56,212,502.95	\$ 56,120,875.82	99.8%
Older Adults	645	103,459	\$ 5,325,034.73	\$ 3,857,684.17	72.4%
Total	11,425	1,922,669	\$ 101,994,670.68	\$ 89,742,410.04	88.0%

These findings support several important conclusions

- Cost savings over the two-year period are consistent in relative magnitude across age groups. In particular, TAY consumers experienced the greatest cost-related benefits of service. Transition-Age Youth are at high risk for criminal justice and crisis management services, and FSP participation apparently has a significant impact on consequences for this age group.
- Cost offsets are dramatically lower for the Children, Youth, and Family (CYF) age group. This may reflect the more preventive orientation of services for children, which is not as clearly reflected in the short time line of the measured offsets. Savings for children may appear over a much longer period of time, outside the currently funded study period. In addition, the “consequence” nature of the offset categories examined (e.g., criminal justice involvement) is more relevant to older age cohorts. ⁵ Effects of service are sensitive to life maturation, indicators of service success and the time horizon of measured effects.

⁴ Institution for Mental Diseases facilities/Mental Health Rehabilitation Centers. Key Event Tracking data do not distinguish between the two. Therefore, an average of the IMD and MHRC rates for the facilities contracted by each county was used as the basis for calculating the cost applied to the number of days in long-term care.

⁵ Although indicators such as education are logical choices for Children and Youth, challenges inherent in the statewide data collection system related to floor effects and missing data made this variable unsuitable for analysis. See Phase II Deliverable 2.E – Priority Indicators Report.

- Overall, across all age groups, 75 and 88 percent of FSP program costs for new enrollees in FY 08-09 and FY 09-10 (respectively) are offset by savings to the public mental health, health and justice systems. Although the argument of cost savings should never be advanced as the primary reason for providing public mental health services, results of this magnitude make a strong case for the wisdom of investing public resources in programs such as the Full Service Partnership.

Features of the report cited by legislators and other policy makers include cost per client and cost offsets by age group. These findings were deemed particularly relevant when informing the national dialogue about developing a sensible public mental health system in response to the Sandy Hook tragedy. The robust results attained by the California Mental Health Services Act, combined with the ability of California's model to pay for itself, in terms of savings elsewhere in the public system, was deemed highly desirable for replication elsewhere.

Future Cost Studies for Consideration

The following proposed investigations are theoretically possible through analysis of existing data. However, as any one study is developed, more detailed review of the data representing each process or outcome, highlighted below, may indicate that additional data collection is necessary due to incomplete, inconsistent, or otherwise insufficient existing information.

- *Participation in substance abuse treatment*: examine its potential role as a moderator (at the county level, potentially determining variation in cost offset), and also its potential for offsetting costs over a longer period of time (beyond the 12 month follow up period examined for the initial report). Substance abuse treatment has been shown to provide cost offsets over more extended periods of time (up to 24 months). In addition, an integrated service experience is a hallmark of FSP, suggesting that substance abuse treatment is an important service for individuals with co-occurring disorders. Of particular interest is the proportion of FSPs receiving treatment during FSP participation and its relationship to FSP impact.
- *Examination of the factors leading to some FSPs remaining in the program for more extended periods of time* (compared to those that discharge within 12 months), in order to more clearly determine the variables closely aligned with longer participation in treatment. Factors which may hold explanatory potential include:
 - Duration or frequency of hospitalization (i.e., psychiatric)
 - Duration or frequency of homelessness
 - Duration or frequency of incarceration

Such analyses would be beneficial in terms of providing greater understanding of the factors associated with variation in FSP outcomes over time. The priority indicator reports⁶ developed under MHSA Evaluation Phase II describe homelessness among FSPs within the past year, but this the indicator in isolation does not provide evidence for an association between participation in FSP and duration/frequency of homelessness prior to intake, or reduction in

⁶ Structured in accordance with required indicators as established by the Mental Health Planning Commission

homelessness after program initiation. These analysis approaches may provide clarification regarding consumer populations that tend to remain in the program longer, or that may tend to exhibit more immediate or long term outcome improvement.

- *CYF Cost Offsets*: The FSP Cost Offset Study found that only a small percentage of costs were offset for CYF, but the potential impact of FSP on CYF is likely more preventive in nature (which may be revealed as children mature over a longer period of time). In addition, the offset areas examined were more suited to TAY, Adults and Older Adults (for example, incarceration and psychiatric hospitalization). Therefore, we propose examining potential cost offsets over a longer period of time (up to two years) in the areas of education and school attendance using similar methodology to the FSP Cost Offset study.
 - The main difference between a study of CYF Cost Offsets in the areas of education and school attendance and the completed FSP Cost Offset study will be the methodology by which cost offsets are assigned to education and school attendance.⁷ Daily costs for incarceration, psychiatric hospitalization, etc. were readily available from archival data sources. A daily cost can also be applied for school attendance based upon the per-student rate paid to the district by the California Department of Education. However, calculating the value of educational level is more esoteric in nature and requires incorporation of longer-term trajectories (e.g., costs to the public system when education is derailed).
 - Following the methodology used for the FSP Cost Offset study, the Evaluation Advisory Group would be called upon to lend their guidance and input related to developing cost for education level (which would likely vary depending upon grade level).
- *Cost-Benefit Study*: UCLA proposes taking advantage of existing data collected by a subset of counties regarding individual's recovery process, including quality of life (e.g., roles and relationships via the Milestones of Recovery Scale - MORS) in order to extend the cost offset analyses into a cost-benefit study. The following steps are suggested in order to advance this study:
 - Survey counties administering the MORS to determine data collection strategies and respondent characteristics. Counties currently administering the MORS⁸ include:
 - Alameda
 - Butte
 - Contra Costa
 - Inyo
 - Kern
 - Los Angeles
 - Marin
 - Mono
 - Orange

⁷ We have already assigned expenditures to CYF participating in FSP – through use of the daily FSP CYF expenditure calculated for the completed study, the expenditure can be applied to a longer period of time.

⁸ All of these counties with the exception of Siskiyou have been trained in the use of MORS by Mental Health America of Los Angeles (MHALA), developer of the MORS.

- San Diego
- San Francisco
- Santa Clara
- Santa Cruz
- Siskiyou
- Ventura

In addition, within the coming quarter MORS training will be provided to Humboldt and Trinity counties, bringing the total number of counties to 17. Though this number does not represent the majority of counties across the state, the number of large counties implementing the MORS represents the majority of FSP participants across the state.

- Form an Evaluation Advisory Board to include representatives from MORS implementing counties and Mental Health America of Los Angeles to advise on the cost benefit study. For example, assigning value to quality of life (QUALYS) should be a shared decision. Dr. Brian Yates of American University, expert advisor for the FSP Cost Study, should be invited (and has agreed) to join the EAG for a cost benefit study, as QUALYS is a particular interest and expertise area.
- FSP expenditures have already been determined through the FSP Cost Offset Study. Therefore, this particular step need not be re-visited. However, MORS data will likely reflect more recent fiscal years (particularly if the two recently-trained counties are included in the study). FSP expenditure data reflects FY 08-09 and FY 09-10 and MORS may well reflect FY 10-11 and 11-12. Therefore, the EAG will want to explore options such as extending the per-person daily expenditure analysis into FY 10-11 and 11-12 (making adjustments as needed by county, depending upon stability between FY 08-09 and FY 09-10 and other considerations impacting stability). The major focus for the EAG is expected to be development of the dollar value for QUALYs and its application to MORS numeric scores. Following completion of this step, the methodological approach is similar to the FSP Cost Offset Study and need not be repeated here.

Consideration of Collection and Integration of Additional Service & Outcome Information for More Effective Evaluation of FSP Costs & Cost Offsets

Two key measurement areas are presently absent from the statewide Data Collection and Reporting system (DCR) that would greatly enhance the utility of evaluation efforts. They are:

1. **Quality of Life** measures, such as the Milestones of Recovery Scale (MORS) and
2. **Encounter-Level** data, documenting service exposure (date, length and type of service).

Quality of Life

As indicated previously, the MORS is already collected by a number of counties as part of their comprehensive evaluation of FSP. The following steps are recommended in order to expand this effort beyond that of a subset of counties:

1. Conduct a systematic poll among counties administering the MORS to assess data collection strategies and respondent characteristic.

2. Among counties that are not currently administering the MORS, assess barriers to implementation
3. Bring the findings back to an Evaluation Advisory Group in order to develop a roll out plan

The central issues for consideration in planning future evaluation of FSP cost offsets are burden and relevance to the individual counties charged with collecting necessary data. Lessons learned through this investigation and communication with stakeholders regarding study methods and findings suggest formation of an Evaluation Advisory Group comprised of representatives ultimately responsible for and charged with using this information to improve services. Such a group could examine feasibility (under the guidance of MHSOAC or a contractor hired by MHSOAC) and explore options for adopting the MORS statewide. Considerations of an advisory group might include a graduated roll-out for small counties and technical assistance to facilitate the process of MORS implementation and adoption. Such a process which considers and integrates county needs, resources, and capabilities for evaluation planning will be imperative for any future investigation of MHSA costs and cost offsets. Depending upon the recommendations of an Evaluation Advisory Group, the following steps may also be appropriate:

4. MHSOAC contracts with Mental Health America of Los Angeles (MHALA) to integrate their e-system (developed to house MORS data) into the DCR and the MORS data dictionary to be integrated into the DCR
5. MHSOAC contracts with MHALA for MORS training to be provided to counties not currently administering and for refresher training to other counties as needed (e.g., counties implementing that have not yet received training)
6. MHSOAC identifies a contractor to provide MORS data entry training and technical assistance regarding associated updates to the DCR, for all counties

Encounter-Level Data

As indicated above, the evaluation team feels strongly that feasibility at the county-level is a major consideration, particularly for data that is not currently integrated into any statewide MHSA system. Therefore, the following steps are recommended in order to explore the feasibility of collecting additional encounter-level data statewide for FSP clients:

1. Conduct a systematic poll of counties to determine:⁹
 - a. Is an encounter with an FSP identifiable in current billing systems? For example, is there a way to analyze existing MediCal and other billing data with regard to FSPs specifically? What can be done to analyze data regarding FSPs with no matching payer sources?
 - b. What billing/tracking system is used by the given county? Where is the county at in terms of the timeline for Electronic Health Record launch/implementation and what impact will it have upon the billing/tracking system currently in place?
 - c. Are these systems in place for all age groups? All contractors? What are the exceptions?

⁹ We strongly recommend that this survey of counties be informed and guided by input from the Evaluation Advisory Group before launch.

- d. What are the barriers at the county level to tracking FSP encounters? What FSP encounters are tracked? What is not currently captured in the system? Is only billable time documented?
2. Bring the findings back to the MHSOAC and/or MHSOAC contractor, which should include an IT expert in systems integration. An expert opinion will be provided after the findings are assessed as to the cost of integration across counties (attempting to integrate existing encounter-level data systems) compared with the cost of requiring counties to enter encounters into a new DCR module¹⁰, or another option. MHSOAC will need to determine if a feasible option exists from a cost perspective and if so, whether integration of existing systems, a new DCR module, or another option is desirable.

If additional FSP encounter level data collection is deemed necessary and feasible, the following steps are recommended.

3. Bring the findings back to the Evaluation Advisory Group for their input. Advisors could identify guidelines regarding how encounter-level data should be recorded and entered into a data system. Guidelines for entering encounter-level data are essential, because most DCR data is collected episodically – the system is not currently set up to enter daily data regarding FSPs. If additional data collection is necessary the level of burden on counties will be a substantial consideration.
4. MHSOAC contracts for either a new integrated system (IT contractor with HIPAA certification) or a new DCR module to house encounter-level data
5. MHSOAC contracts for a data dictionary to be developed, or the DCR data dictionary revised, for encounter-level data
6. MHSOAC contracts for encounter upload training to be provided to counties, or training in encounter data entry expectations and instructions
7. MHSOAC contracts for ongoing training/technical assistance for encounter upload, or encounter entry for all counties
8. MHSOAC sets decision rules for missing data/noncompliance

As the steps for developing these two key measurement areas suggest, while the integration of encounter-level data (e.g., either existing data or new data collection) with outcome data is desirable, such efforts must be weighed against practical considerations of cost and feasibility, at the county and statewide levels. While such data needs and considerations at county and statewide levels are not perfectly aligned, based upon our experiences the evaluation team believes that sufficient common ground exists to move forward with such data development opportunities in ways that are beneficial for all parties.

¹⁰ New data entry for encounter-level data is not recommended because encounter-level data not entered within 24 hours is often not entered at all or is entered incompletely or incorrectly. In such cases, inaccurate information can have more negative consequences than no information at all.

Participatory Investigation of the Impact of MHSA Services on Consumer Outcomes

Summary of Products & Practically Significant Findings

Initially, a participatory planning process involving stakeholders across the state was engaged to develop a proposal to evaluate services or strategies supported by General System Development (GSD) funds, which are intended to help counties improve programs, services and supports for individuals and families in need (e.g., peer support, education and advocacy, and crisis intervention). Based upon this proposal a survey was developed regarding seven indicators of the impact of GSD supported services on consumer outcomes. A statewide snowball/convenience sampling approach yielded 949 survey responses from consumers and stakeholders. The evaluation team produced a report describing three service areas studied (i.e., peer support services, employment support services, and crisis intervention services) and the impact of these service areas on client outcomes.

A summary of findings for each service area, and the indicators relevant to each, is presented below.

Peer Support Services:

- 10.0% of survey respondents who received peer support services reported difficulties accessing services.
- 76.8% of survey respondents agreed that peer support services they received fit their cultural and life experiences.
- 78.0% of survey respondents agreed that the physical spaces where peer support services were received were inviting and dignified.
- 76.7% of survey respondents agreed that the peer support services they received were what they wanted.
- Survey respondents who received peer support services reported a more positive perception of services as recovery oriented compared to those who did not receive peer support services despite wanting them. This difference was statistically significant.
- Survey respondents who received peer support services and those who did not despite wanting them did not report significantly different employment situations over a one-year period during which mental health services were received. In addition, 52.7% of survey respondents who received peer support services agreed that the services helped improve their employment situation.
- Survey respondents who received peer support services and those who did not despite wanting them did not report significantly different housing situations over a one-year period during which mental health services were received. In addition, 71.7% of survey respondents who received peer support services agreed that the services helped improve their living situation.
- Survey respondents who received peer support services reported a more positive perception of personal recovery/resilience compared to those who did not receive peer support services despite wanting them. This difference was statistically significant. In addition, 81.3% of survey respondents who received peer support services agreed that services helped them feel better, and 76.9% agreed that services helped with their recovery.

Employment Support Services:

- 21.1% of survey respondents who received employment support services reported difficulties accessing services.
- 56.7 % of survey respondents agreed that employment support services they received fit their cultural and life experiences.
- 72.2% of survey respondents agreed that the physical spaces where employment support services were received were inviting and dignified.
- 68.3% of survey respondents agreed that the employment support services they received were what they wanted.
- Survey respondents who received employment support services reported a more positive perception of services as recovery oriented compared to those who did not receive employment support services despite wanting them. This difference was statistically significant.
- Survey respondents who received employment support services and those who did not despite wanting them did not report significantly different employment situations over a one-year period during which mental health services were received. In addition, 67.2% of survey respondents who received employment support services agreed that the services helped improve their employment situation.
- Survey respondents who received employment support services and those who did not despite wanting them did not report significantly different housing situations over a one-year period during which mental health services were received. In addition, 64.3% of survey respondents who received employment support services agreed that the services helped improve their living situation.
- Survey respondents who received employment support services reported a more positive perception of personal recovery/resilience compared to those who did not receive employment support services despite wanting them. This difference was statistically significant.

Crisis Intervention Services:

- 21.1% of survey respondents who received crisis intervention services reported difficulties accessing services.
- Survey respondents who received crisis intervention services were more likely to have had routine mental health services before and after the crisis compared to those who did not receive crisis services despite wanting/needing them. This association was statistically significant.
- Survey respondents who received crisis intervention services reported a more positive perception of services as recovery oriented compared to those who did not receive crisis services despite wanting them. This difference was statistically significant.
- Survey respondents who received crisis intervention services and those who did not despite wanting them did not report significantly different employment situations over a one-year period during which mental health services were received.
- Survey respondents who received crisis intervention services and those who did not despite wanting them did not report significantly different housing situations over a one-year period during which mental health services were received.

- Survey respondents who received crisis intervention services reported a more positive perception of personal recovery/resilience compared to those who did not receive crisis services despite wanting them. This difference was statistically significant.
- Survey respondents who received crisis intervention services and those who did not despite wanting them did not report significantly different rates of psychiatric hospitalization over a one-year period during which mental health services were received.

Findings from a set of 40 qualitative interviews conducted with people with lived experience and their family members provided insights into the recovery/resilience orientation of MHSA services and how those services have promoted personal recovery/resilience and wellness in their lives.

Recovery/Resilience Orientation of Services

Interview respondents across the three service areas, highlighted above, characterized the mental health services they recently received as demonstrating recovery/resilience and wellness principles. Interview respondents reported that:

- Services were largely accessible;
- The system promoted engagement and continuous care;
- Services encouraged family involvement;
- Services supported the individual’s preferences and goals; and
- Services and staff were respectful of the individual’s cultural background.

Personal Recovery/Resilience and Wellness

Despite facing daily stressors and other risks to recovery, interview respondents had a positive outlook on the impact that MHSA services had on their daily lives. Key themes regarding the impact of MHSA services on consumers’ lives included:

- Learning and practicing successful strategies to proactively manage and/or cope with their mental health concerns;
- Pursuing meaningful activities, with a particular emphasis on “giving back” to their peers and communities;
- Connecting with individuals and with their communities for an increased sense of belonging;
- Enjoying a positive sense of self; and
- Experiencing hopefulness for the future.

Conclusions & Implications of Participatory Research

Participatory research findings suggest that services across the three service areas investigated are accessible. In particular, peer support services appear to be readily accessible to a broad base of individuals. However, there are access issues that remain to be addressed, especially for certain populations of individuals who have traditionally been underserved (e.g., individuals with physical disabilities and individuals who are homeless). In addition, study findings confirm that access to a

variety of supportive services is being achieved, and recipients perceive services as appropriately individualized, encouraging, and respectful of their wishes and goals.

Our analysis of peer support services appears especially important in the contexts of both promoting and sustaining MHSA services. Findings suggest peer support services, as integral to the larger continuum of care which includes professionals, appear to have great potential in impacting individuals with lived experience. In many respects, peer support services present a win-win situation for clients and funders, as they appear to be a solid investment for both. Peer support services involve clients, family members, and other natural supports; they do not rely primarily on and can supplement professional services; they are readily accessible; and they are less expensive. Often, peers can be powerful promoters of personal recovery in ways that professionals necessarily cannot, as they continually reinforce positive outcomes through improving self-perceptions (e.g., confidence, stability, and hope).

Finally, the participatory nature of this evaluation, including the personal dedication of several of the evaluation partners, was one of its greatest strengths. At all points throughout the study process, from survey development to report writing, input from the evaluation partners enriched the study. Participatory evaluations are generally thought to require a lengthier time period for development and implementation than conventional evaluations. This is due to the nature of the time it takes to facilitate *meaningful* engagement and *active* involvement of a group of Participatory Evaluation Partners (PEPs) who may or may not be familiar with evaluation research and therefore need some skill development and training to maximize their input. Such participatory research may also benefit from a more elongated study period to accommodate the limited time evaluation partners can devote to an evaluation project.

Consideration of Collection and Integration of Additional Service & Outcome Information for Future Evaluation of the Impact of General System Development (GSD) Services, and Consumer and Family Member Involvement

GSD services and strategies, as well as other services and strategies that involve clients, family members, and personal caregivers are very diverse across the state. Thus, the identification of additional service and outcome information, and appropriate integration for analysis of the impacts of GSD services and consumer involvement, depend largely on the cohesiveness (e.g., considering stability and implementation fidelity) of these services. This conclusion is based upon our experience in the participatory study, such that each service area examined required different types or modes of information (e.g., multiple sources of both qualitative and quantitative information) to capture the nature of the service in a comprehensive way. For example, some outcome indicators for employment support services are not applicable to crisis intervention services. That is, crisis services typically do not include assistance with employment; therefore, the impact of crisis services on client perceptions of employment readiness would not be applicable. As such, the evaluation team has concluded that future evaluations of such services will benefit greatly from very careful planning and assessment of the types of services that can and should be evaluated.

Appropriate consideration and planning might involve an evaluability assessment (i.e., examination of the readiness of a type of county program for statewide evaluation) to identify the qualities and

characteristics of services being implemented by counties, and data that exists or does not, regarding services and their impacts. This approach would allow for identification and clustering of programs by service area (e.g., peer support services, education and advocacy services, or crisis intervention services), length of implementation, data availability, and other characteristics that would have implications for statewide evaluation. An evaluability assessment could ensure a higher degree of cohesiveness in terms of the topic and sequence of studies conducted, the methods employed (e.g., for more regular and sustainable monitoring), and the types and quality of data collected. This type of assessment and planning will likely also reduce the amount of burden that might be placed on counties in terms of additional data collection, by focusing statewide evaluation resources on services and strategies that are ready to be evaluated at the state level, to produce results which can be used to identify implications for action. In other words, an evaluability assessment could provide a more detailed and complete picture of the services being offered and their readiness to be evaluated at the state level, including information gaps (e.g., unreliable, missing, or incomplete) that might require county technical assistance and training, or additional primary data collection. Additionally, counties with services and strategies not ready for state level evaluation will be identified, and subsequently evaluation capacity building could be conducted.

An evaluability assessment could take several forms, possibly including the type of evaluation advisory group discussed above. If implemented with proper expertise and the goals of both the MHSOAC and counties in mind, the evaluation team believes this planning approach will provide for more targeted, efficient (e.g., costs), and user focused (e.g., MHSOAC and other stakeholders) evaluation of services such as GSD and factors such as consumer and family member involvement.

Overarching Conclusions & Discussion

Despite the distinct nature of these two studies, key factors that warrant consideration in planning future statewide evaluations became evident through this work.

Evaluation Readiness of MHSO Services and Strategies is a significant factor in the generation of evidence that can support the identification of implications for action (e.g., policy changes to support service improvements). Evaluation is a resource-intensive activity that can provide the MHSOAC, county mental health program managers, and other stakeholders with vital information about service processes and impacts at multiple levels (e.g., state, county, provider, and individual). Unfortunately it is not uncommon for an evaluator to discover after an evaluation is underway that the program is not at a stage which will support the type of research that can drive decision making. Similar situations were found across both studies included in the Phase III evaluation, such that some counties, or service strategies they provide, were more or less ready to be evaluated.

There are several reasons why an MHSO service or strategy may not be ready for evaluation at a county or statewide level. For example, across a type of program or service strategy many counties may be experiencing significant changes or be impacted by contextual uncertainty (e.g., economic changes). Such flux and variation in services and strategies of community mental health systems have significant implications for the extent to which these services or strategies can or should be

evaluated at county or state levels. The uniqueness of county characteristics and associated needs often leads to a lack of stability or fidelity (uniformity) of implementation across counties and over time. As such it will be more useful to examine potential links between service strategies and outcomes in counties that have had relatively stable and comparable implementation of a strategy for a reasonable period of time, and less useful to attempt such analysis among counties lacking such stability and common services. Additionally, some counties which provide services and strategies which are appropriate for statewide evaluation may not be in the position to divert (or may not poses) the resources necessary to support a statewide evaluation.

Evaluability assessment could help the MHSOAC to determine the extent to which a representative group of counties (e.g., representative of the variation in service strategies across the state) is providing a service or strategy that is appropriate for statewide evaluation, and counties can and do support such an evaluation. If this is the case, the MHSOAC may determine that it is possible to conduct a statewide evaluation that is capable of producing results which support decision making regarding the given service strategy. This approach is preferable for several reasons (e.g., promote stakeholder buy-in), but likely among the most important reasons is that determining whether a service strategy is ready for an evaluation prior to beginning it can help ensure that precious evaluation resources are used at the most appropriate time. This point has been emphasized to the evaluation team often by counties and other stakeholders. These times of restricted or declining budgets require that evaluation resources be spent where that can be most productive and useful for all parties involved. Evaluability assessment is one way in which the MHSOAC can ensure that this is the case statewide.

The Unique Nature of Community Based Mental Health Systems should be well considered when conducting statewide evaluation of MHSOAC programs and services. Variation in community mental health care contexts (e.g., the county environment in which services and strategies occur) have long been observed, and have added significance for performance measurement approaches which value the influence of community based perspectives, as the MHSOAC does. The uniqueness of community based mental health systems has several implications for evaluation. Such variation is often a significant factor influencing a service or strategy's readiness for evaluation, as discussed above. However, in cases where a given service or strategy is ready for investigation, variation in community mental health systems has several other implications, such as the quality and quantity of available data, and the analyses that are possible to conduct. In the Phase III research, variation in the ways counties track (e.g., collect and report) cost information or outcomes associated with various costs, and track GSD services and associated outcomes, were significant factors in the types of research questions that were possible to answer, the analyses that were possible, and the generalizability of results. As such, the unique nature of community mental health systems should be a central consideration in evaluation approaches and the development of sustainable monitoring systems.

This is not to suggest that the uniqueness of community based mental health systems is something that requires standardization or even statistical control at the analysis stage (although this may be appropriate in some instances). On the contrary, it is the recommendation of the evaluation team that the MHSOAC and their evaluation partners understand the spectrum of county mental system

contexts and take advantage of these naturally occurring circumstances, rather than fighting them. This can be accomplished through adopting appropriate methodological approaches for the given investigation, which may include “natural variation”¹¹ or “most different systems design”¹². Development of statewide evaluation of MHSA services and strategies should account for the importance of community mental health care contexts for multiple aspects of the research process (e.g., county-based data collection and contribution to statewide data systems, and analysis and interpretation of county level variation).

These two overarching considerations are distinct issues to be confronted by ongoing and future evaluations, but are not unrelated. It is recommended that the MHSOAC, consumers, and other stakeholders of California’s community based mental health system consider the evaluation readiness of MHSA services or strategies and the uniqueness of community mental health systems when planning and implementing evaluations.

¹¹ Scheier, I. H. (1959). The method of natural variation in applied educational research. *Journal of Educational Research*, 52, 167–170.

¹² Ankar, Carsten. "On the Applicability of the Most Similar Systems Design and the Most Different Systems Design in Comparative Research." *International Journal of Social Research Methodology* 11.5 (2008): 389-401.