

**Mental Health Services Act Evaluation:  
Compiling Community Services and Supports (CSS) Data  
to Produce All Priority Indicators  
Contract Deliverable 2F, Phase II**



**UCLA Center for Healthier Children, Youth and Families**



**EMT Associates, Inc.**

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The following report was revised in partnership with stakeholders who provided important historical context, data consultation, and revisions to ensure this report is accurate and accessible to the broadest audience possible. Feedback, collected prior to, during, and following report development, was crucial to developing this report. The UCLA-EMT Evaluation Team would like to express sincere appreciation to the research analysts, advocates, consumers and family members, agency representatives, service providers, and MHSOAC representatives who contributed invaluable insights to this document and previous versions.

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## Purpose

The Mental Health Services Act Oversight and Accountability Commission (MHSOAC) charged the UCLA-EMT Evaluation Team with tracking the Mental Health Services Act's (MHSA) impact on mental health service consumers and the community mental health service system. The current report details the initial effort toward this goal.

Here, we provide a snapshot of consumer outcomes and community mental health system performance—a first step toward developing a set of indicators that can help stakeholders with ongoing quality improvement. This report is the first in a series designed to update stakeholders about mental health consumer outcomes and service system progress. Tracking performance on particular outcomes over time, across programs, and/or in comparison to other counties can provide useful information to those planning, operating and monitoring services. Indicators are intended to be used for planning, quality improvement, and other applications that stakeholders deem important. In this way, among many others, stakeholders can play a vital role in a continuous quality improvement process.

## Background

### *What are Priority Indicators and what are they intended to do?*

Two concerns of public mental health system stakeholders are accountability and the ability to conduct continuous quality improvement activities. One strategy is to use a set of indicators to measure performance. The California Mental Health Planning Council proposed and defined a set of performance indicators, referred to as priority indicators, 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 MHSA implementation. Indicators will help track progress among consumers and across community mental health systems. At the consumer level, outcomes such as education and employment will be followed, while outcomes including mental health service penetration and consumer demographics are examined at the broader system level. This report examines the core set of priority indicators vetted by the MHSOAC.

### *Previous work of the UCLA-EMT Evaluation Team leading to this report*

The evaluation team began its work using the California Mental Health Planning Council's definitions –its collective vision of how indicators might best be measured. (These fundamental definitions are located in Appendix A and are discussed in preceding reports available at [http://healthychild.ucla.edu/MHSA\\_evaluation.asp](http://healthychild.ucla.edu/MHSA_evaluation.asp).) Priority indicator development was a joint effort among the MHSOAC, stakeholders, and the evaluation team. The evaluation team facilitated discussions among interested stakeholders to create the strongest, most comprehensive representations of priority indicators that aligned with both early conceptualizations and feedback using the data that were 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 team's current scope of work.

The evaluation team adapted advice from stakeholders, and this report examines whether these adapted indicators provide meaningful information. Although stakeholders proposed additional indicators, these measures have not yet been vetted by the MHSOAC to determine whether they add useful and crucial information that aligns with the need. The MHSOAC has yet to decide whether to change the previously approved priority indicators. Thus, the evaluation team explored the first proposed priority indicators in this report, which serves as a fundamental step in the ongoing

process to refine and expand priority indicators that are not only measurable but also useful to the range of stakeholders invested in this work.

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

**Report title: *Defining Priority Indicators***

**Report version: Draft for stakeholder review**

Here, the evaluation team began to refine the core set of priority indicators proposed by the California Mental Health Planning Council to assess target outcomes of mental health consumers and the performance of the mental health system. The evaluation team and the MHSOAC made this report version available to the public through mass e-mail announcements and online at UCLA and MHSOAC websites. A guidance document that included specific questions regarding the initial report's content and accessibility was also included with the report to aid review. The evaluation team requested that readers alert their peers and clients to the report to broaden the diversity of feedback. The team also hosted two webinars, or online orientations to the report, with stakeholder groups that provided an overview of the report's purpose and the type of feedback sought. The call for feedback was open for one month.

**Report title: *Defining Priority Indicators***

**Report version: Final, revised with stakeholder input**

In the revised report, the evaluation team illustrated how stakeholder feedback was integral to indicator development. This report incorporated changes driven by stakeholders' comments about the comprehensiveness and appropriateness of the indicators.

**Report title: *Compiling Data to Produce All Priority Indicators***

**Report version: Draft for stakeholder review**

In this report, the evaluation team proposed how priority indicators could be calculated using existing statewide data. The report also detailed all possible data sources and specific variables or data fields that might be used to build comprehensive priority indicators. The evaluation team made this draft widely available for feedback using a strategy similar to that of the Defining Priority Indicators-Draft report; the report's availability and a call for feedback were announced online. Readers could download the report and an accompanying guidance document from the UCLA or MHSOAC websites and respond with comments within the month-long feedback period.

**Report title: *Compiling Data to Produce All Priority Indicators***

**Report version: Final, revised with stakeholder input**

The initial report was revised to include information regarding measurement methods and the adequacy of existing data sources, gathered through a stakeholder feedback process similar to that used for the final Defining Priority Indicators report.

This report is the next step in documenting priority indicator development. The evaluation team reviewed data from 2005 through 2011 in search of one fiscal year in which data cells were largely filled where expected. Two such fiscal years were identified – FYs 2008-09 and 2009-10. Through analysis, some proposed data sources or methods of indicator calculation, suggested in previous reports by stakeholders and the evaluation team, were found to not be possible or to not produce meaningful outcomes due to data limitations. Decisions made about previously proposed indicators, based on data limitations, are summarized in Appendix B.

## Stakeholder (Consumer/Client) Feedback

It should be noted that the following report was shaped by the input of stakeholders who have engaged the mental health services system. The evaluation team facilitated a webinar on September 17, 2012, during which several report segments (e.g., executive summary, priority indicators definition, priority indicator summary page, and illustrations) were reviewed and discussed at length. The goal of this review was to ensure that language was widely accessible to all readers and that concepts, including those statistical in nature, were clear. A few suggestions included the following:

1. Simplify language such as changing “utilize” to “use.”
2. Define statistical terms (e.g., “n” refers to the number of consumer/clients within a particular population).
3. Explain the importance of data deemed “missing” from calculations.
4. Refer to consumers as “consumers/clients.”

To the extent possible and where revisions enhance understanding, these suggestions are incorporated throughout the following report. To note, the team refers to “consumers” throughout the document for brevity and to match terms used by those who designed this project. However, we do recognize the ongoing conversation about stakeholders’ engagement in mental health services as consumers and clients. Stakeholder comments about concepts beyond the scope of this report are noted (see Appendix C) but not addressed in this document.

## Review of Existing Data

As directed by the MHSOAC, priority indicators were built upon existing data sources that are systematically collected by California counties and reported to the California Department of Health Care Services (DHCS).<sup>1</sup> To accomplish this, existing data systems were reviewed to assess their suitability for supporting outcome and performance monitoring through priority indicators. Several criteria were used to evaluate the suitability of existing data sources, including:

- *Available* – Data accessible in an analyzable format
- *Complete* – Levels of missing information within key data fields did not prevent meaningful analysis and interpretation
- *Sustained* – Data sources is likely to continue to exist in the foreseeable future
- *Relevant* – Data relevant to populations of interest (e.g., all mental health consumers and Full Service Partnerships)
- *Longitudinal* – Data available for multiple service years
- *Multilevel* – Data can be analyzed at multiple levels (e.g., state, county, and individual)

The application of these criteria to each key data source and important considerations and limitations regarding each data source overall are summarized in the *Data Sources* table below. These criteria were also applied to the specific data fields used to build each priority indicator. Review of indicator-specific data fields is summarized within the tables that introduce the analysis and findings of each priority indicator (see *Priority Indicator Analysis and Findings* section below).

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<sup>1</sup> Previously the Department of Mental Health (DMH); The DHCS abbreviation will be used to refer to work completed by DMH.

## Data Sources

### *Client & Service Information (CSI)*

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

**Review Findings:**

Available ✓    Complete ✓    Sustained ✓    Relevant ✓    Longitudinal ✓    Multilevel ✓

**Considerations and Limitations:** Stakeholder feedback to previous evaluation team reports suggested that 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 data system (see *DMH Information Notice: 06-02*). For details regarding the *Race and Ethnicity* data field changes and procedures employed by the evaluation team to improve data quality, see Appendix D.

Additionally, the completeness of data fields used to calculate indicators varies greatly across fiscal years and among counties (e.g., greater than 50% in some cases). Thus the representativeness and interpretability of such data fields is in doubt. Proportions of missing or unknown information are noted within each indicator section throughout the report.

### *Data Collection and Reporting (DCR) System*

**Summary:** 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 FSP. The 3M is used to collect information on a quarterly basis, regarding key areas such as education, health status, substance use, and legal issues.

**Review Findings:**

Available ✓    Complete ✓    Sustained ✓    Relevant ✓    Longitudinal ✓    Multilevel ✓

**Considerations and Limitations:** Race and ethnicity information in the DCR system is imported from the CSI system by DHCS. As such, the limitations of this information noted for the CSI system also apply here. Specifically, stakeholder feedback to previous evaluation team reports suggested that 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 DCR data system (see *DMH Information Notice: 06-02*). For details regarding race and ethnicity data field changes and procedures employed by the evaluation team to improve data quality, see Appendix D.

Additionally, representatives from seven counties or municipalities that currently do not have data contained in the DCR database for FYs 2008-09 or 2009-10 were given the opportunity to provide data to the evaluation team for DCR fields used to calculate indicators. Of the counties not captured in the DCR database for various reasons (e.g., county data incompatibly formatted DHCS 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. The DCR data that other county representatives provided or may provide directly to the evaluation team after June 8, 2012, will be considered for future reports.

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

**Summary:** These consumer surveys are customized for consumer groups (e.g., family members/caregivers, youth, adults, and older adults) receiving mental health services. Instruments are composed of widely validated measures

of several domains, including satisfaction, access, quality / appropriateness of services, outcomes, functioning, and social connectedness. The data, designed to inform treatment planning and service management, are collected from a sample of individuals with “serious, persistent” mental illness who have received services for 60 days or more and are not categorized as “medication only.”

*Review Findings:*

Available ✓      Complete ✓      Sustained ✓      Relevant ✓      Longitudinal ✓

*Considerations and Limitations:* For FY 2008-09 and prior years, a convenience sampling approach was used in which 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.<sup>2</sup> Beginning with FY 2009-10, a random sampling methodology was employed to produce data that are more representative of the perceptions of the mental health service population. As such, comparisons involving CPS data collected in FY 2008-09 and FY 2009-10 cannot be made.

*Note* – The smaller sample generated by the random sampling method employed in FY 2009-10 does not allow for consumer perception analyses at the county levels for this fiscal year.

*Note* – The sampling methods that have been employed to date do not capture specific mental health service populations, such as those in institutions for mental disease or prison.

## *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 DHCS. He estimated the proportion of persons with serious mental illness among those whose income falls within 200% of the federal poverty level, using data from the most up-to-date National Comorbidity Survey Replication and generated prevalence estimates for several Census years. (For additional information regarding prevalence estimate methodology, see Dr. Holzer’s website at [http://66.140.7.155/estimation/3\\_Synthetic/synthetic.htm](http://66.140.7.155/estimation/3_Synthetic/synthetic.htm)).

*Review Findings:*

Available ✓      Complete ✓      Relevant ✓      Longitudinal ✓

### **Involuntary Status**

Involuntary status information (FY 2008-09) was provided by DHCS 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 were not available from DHCS as this report was being prepared.

*Review Findings:*

Available ✓      Complete ✓      Sustained ✓      Relevant ✓      Longitudinal ✓

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<sup>2</sup> Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.

### *Procedures for handling missing / unknown data*

The quantity of missing or unknown data (e.g., values) was found to vary considerably across data sources, data fields, and fiscal years. For data fields determined to be necessary for the construction of priority performance indicators (detailed in priority indicator summary tables, see *Priority Indicator Analysis and Findings* section below), if the amount of missing or unknown data was substantial (i.e., greater than 10% of cases), the evaluation team communicated with DHCS analysts and requested input from counties via a data verification process (detailed below) regarding context and interpretation of such data fields. Where adequate information was received to interpret missing or unknown values (i.e., see Appendix D), the evaluation team was able to analyze and interpret such data fields according to current protocols specified in the data dictionaries relevant to each data system. The proportion of missing and unknown information relevant to each priority indicator is noted throughout the report, in footnotes immediately below the relevant table or figure. Accordingly, the frequencies and percentages included in all data displays do not include missing cases.

### *Summary of data “verification” process*

In a first attempt to calculate priority indicators, the evaluation team asked county representatives to weigh in on the quality of select data. The evaluation team narrowed a pool of possible calculations to one practical calculation for each priority indicator. The selection was based on predetermined criteria (see *Compiling Data to Produce All Priority Indicators*, November 2, 2011), an extensive review of the available data, and discussions within the evaluation team about whether proposed calculations could be meaningfully extrapolated to mental health consumer populations. This process revealed the need for a more thorough data quality review. Closer examination of the data needed for each calculation revealed that substantial variation (values and reporting patterns) existed among counties/municipalities, within CSI and DCR data fields identified for constructing priority indicators, during FYs 2008-09 and 2009-10. The variation, in addition to stakeholder feedback to our previous report, demonstrated a need for county representatives to indicate the quality of key data and contextual information needed for analysis, interpretation, and decisions based on this data.

At the direction of the MHSOAC ad-hoc committee, the evaluation team provided representatives from all counties/municipalities the opportunity to review and comment on their data quality. The team sought feedback from county MHSA coordinators and mental health service directors who were most familiar with local mental health data about the accuracy of particular data (i.e., if the demographic distribution pulled from the state datasets for their particular county seemed correct).

The evaluation team developed an outcomes report for targeted data that was distributed to representatives in each county. The committee revised the document for brevity such that representatives would note only whether data were “accurate” or “inaccurate.” A text field was included for any explanation of why data was deemed “inaccurate.” County representatives were asked to respond to non-missing data; “unknown,” “missing,” and blank fields were grouped into one category.<sup>3</sup>

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<sup>3</sup> Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.

### *Recruitment*

County representatives received an e-mail alert about the incoming report and the evaluation team's goals. Subsequently, the team distributed county-specific reports via e-mail with an invitation to complete the review by May 4, 2012. The evaluation team distributed .pdf versions of the reports for representatives to review with their data teams but asked representatives to enter their final responses online at a link provided in the report. Counties that were not enrolled in statewide reporting were asked to provide a download of specific data for the years specified. Although the importance of county-level feedback was stressed, neither the MHSOAC ad-hoc committee nor the evaluation team mandated participation. Instead, the consequences of spotty participation from county representatives were noted in the invitation. The text included in the report introduction is as follows:

*We hope to get responses from all counties. At the very least we hope to get responses from a sufficient number and variety of counties so that the data in the statewide report is representative. To determine that a sufficient representation is achieved, participating counties must commit to participation by April 16, 2012. If we do not get a representative sample of counties, we have been asked to move forward with the statewide report using all the data available from both CSI and DCR (confirmed and unconfirmed). We will also be producing county level reports and will use available confirmed and unconfirmed DCR and CSI data. Again we are hoping every county participates and returns this profile indicating the quality of the data they submitted to the state system.*

### *Data Quality Assurance Report Outcomes*

Twenty-nine of 59 total counties and municipalities provided responses within six weeks of receiving their Data Quality Assurance Report. Responding counties represented a broad cross-section of the state population, accounted for substantial proportions of most MHSA regions, and represented the state's racial and ethnic diversity. (For descriptive analysis of counties/municipalities represented in the quality assurance exercise, see Appendix E.) Stakeholder feedback to previous reports identifying data sources for the statewide MHSA evaluation and feedback to the county-specific Data Quality Assurance Reports were generally consistent. Responses across counties indicated that the majority of fields were accurate. However, a few fields, such as race and ethnicity, received much more inconsistent evaluations of accuracy. Feedback about data quality was a factor in final decisions about what to use from state databases.

### *Strategy Assessment*

The data quality assurance exercise was an effort by the ad-hoc committee and the evaluation team to identify data that could provide accurate insight about priority indicators. The process was important as the group attempted the first round of calculations; data deemed "accurate" by county representatives, and ultimately used in the draft priority indicators report, was vital to refining calculations. Although the method was well-intentioned, it could not be fully realized because of limited participation from counties; counties that did not participate could not be authentically represented.

As a result, the MHSOAC ad-hoc committee redirected the evaluation team to incorporate all data in state databases needed to calculate priority indicators based on the participation rate of counties during the data quality assurance exercise. Without means to ensure that all counties participate, this particular exercise will not be involved in future report development.

### Priority Indicators Evaluated<sup>4</sup>

The set of priority performance indicators evaluated in this report were arrived at through the following processes:

- The careful consideration of the California Mental Health Planning Council and approval of the MHSOAC;<sup>5</sup>
- Consideration of the MHSOAC goal of developing a comprehensive outcome and performance monitoring system built upon existing data systems;
- Consideration of consumer feedback to previous evaluation team reports regarding proposed priority indicators (e.g., “Defining Priority Indicators”);
- Review of existing data sources to assess their suitability for supporting outcome and performance monitoring through priority indicators (see *Review of Existing Data*, above); and
- County feedback regarding the quality and completeness of key data fields necessary to calculate priority performance indicators (see *Summary of data “verification” process*, above).

Through these evaluation processes and careful deliberation of the MHSOAC in collaboration with the evaluation team, a set of 12 priority performance indicators was developed. These indicators can be categorized as those intended to provide insight into the outcomes of mental health consumers (“Consumer Indicators”) and those intended for monitoring the performance of the community mental health system more broadly (“System Indicators”). Consumer and system indicators, and the consumer groups they assess, are summarized in the table below.

### Priority Indicators

	CONSUMERS EVALUATED				
	SERVICE POPULATION	CHILDREN	TAY	ADULTS	OLDER ADULTS
<b>CONSUMER INDICATORS</b>					
<i>Indicator 1 – Average School Attendance Per Year</i>	All/FSP Consumers	x	x		
<i>Indicator 2 – Employed Consumers</i>	All/FSP Consumers		x	x	x
<i>Indicator 3 – Homelessness and Housing Rates</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 4 – Arrest Rate</i>	All/FSP Consumers	x	x	x	x
<b>SYSTEM INDICATORS</b>					
<i>Indicator 5 – Demographic Profile of Consumers Served</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 6 – Demographic Profile of New Consumers</i>	All/FSP Consumers	x	x	x	x
<i>Indicator 7 – Penetration of Mental Health Services</i>	All Consumers	x	x	x	x
<i>Indicator 8 – Access to a Primary Care Physician</i>	FSP Consumers	x	x	x	x
<i>Indicator 9 – Perceptions of Access to Services</i>	All Consumers	x	x	x	x
<i>Indicator 10 – Involuntary Status</i>	All Consumers	x	x	x	x
<i>Indicator 11 – Consumer Well-Being</i>	All Consumers	x	x	x	x
<i>Indicator 12 – Satisfaction</i>	All Consumers	x	x	x	x

<sup>4</sup> Although we received strong indicator suggestions from stakeholders, this report helps vet the appropriateness of the original set proposed by the California Mental Health Planning Council. If the MHSOAC chooses, it may vet additional indicators, particularly those proposed by stakeholders, when revising the pool.

<sup>5</sup> California Mental Health Planning Council (January, 2010). *Performance Indicators for Evaluating the Mental Health System*.

### *Criteria used to evaluate priority indicators*

Specific criteria, developed in collaboration with the MHSOAC, were established to evaluate priority performance indicators. These criteria, outlined for consumer and system indicators below, reflect the goals of the MHSOAC for monitoring consumer outcomes and community mental health system performance at multiple levels (i.e., state and county) for the purposes of planning and quality improvement. These criteria may include:

#### **Consumer Indicator Evaluation Criteria:**

- Indicator can describe changes in consumer outcomes (e.g., change since initiation of services) or describe the current status of consumers.<sup>6</sup>
- Indicator can provide meaningful and relevant insight into the outcomes of service populations of interest (e.g., all mental health consumers, FSP consumers, and demographic groups).
- Indicator can provide meaningful and relevant insight into the outcomes of consumers statewide and at the county level.
- Indicator provides “actionable” insight, which stakeholders can use to identify areas for service improvement.

#### **System Indicator Evaluation Criteria:**

- Indicator can describe meaningful changes in system performance over time.
- Indicator can provide meaningful and relevant insight regarding the extent and quality of services provided to populations of interest (e.g., all mental health consumers, FSP consumers, and demographic groups).
- Indicator can provide meaningful and relevant insight into the performance of the community mental health system at the statewide and county levels.
- Indicator provides “actionable” insight, which stakeholders can use to identify areas for improving the performance of the mental health system.

The application of consumer and system indicator evaluation criteria to each priority indicator is detailed in the *Priority Indicator Analysis and Findings* section below.

### **Report Organization**

The remainder of the report summarizes each indicator and its outcomes, calculated using select statewide data from FYs 2008-09 and 2009-10. First, the evaluation team presents individual-level priority indicators (those specific to consumers), followed by a discussion and summary of these indicators. The team then does the same for system-level priority indicators (pertaining to community mental health systems throughout the state). A summary table precedes each indicator and its outcomes to orient the reader to what the indicator measures, how it was calculated, and its usefulness. Following a review of all indicators, the evaluation team describes stakeholder feedback and considerations. The report ends with an outline of the team’s next steps in the evaluation.

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<sup>6</sup> Calculations for employment, education, and arrests in this report were created using intake data. Calculations in subsequent reports will incorporate post-enrollment data.

### *Indicator summary tables*

Each priority indicator is introduced and summarized in a concise and organized table in the *Priority Indicator Analysis and Findings* section below. Indicator summary tables are organized into the following sections:

- *Indicator Summary* – Provides a brief definition of the indicator
- *Indicator Calculation* – Details the computation used to produce the indicator
- *Data Sources* – Specifies the data sources and relevant data fields (variables) used to compute the indicator
- *Review of Existing Data* – Review of data quality criteria (specified in the *Review of Existing Data* section above) as applied to indicator-specific data fields
- *Analytic Potential of Indicator* – Review of indicator evaluation criteria (specified in the section on *Criteria used to evaluate priority indicators* above)

### *Note regarding indicator data displays*

Each indicator is presented through one or more graphical displays of information. These displays include figures (e.g., bar graphs) and tables of frequencies and percentages. The symbol “n” within the displays stands for the number of consumers included in the analysis. For ease of viewing and interpreting data displays specific to a service population, figures that display indicator information relevant to all mental health consumers are presented in blue, and those relevant to FSP consumers are presented in green.

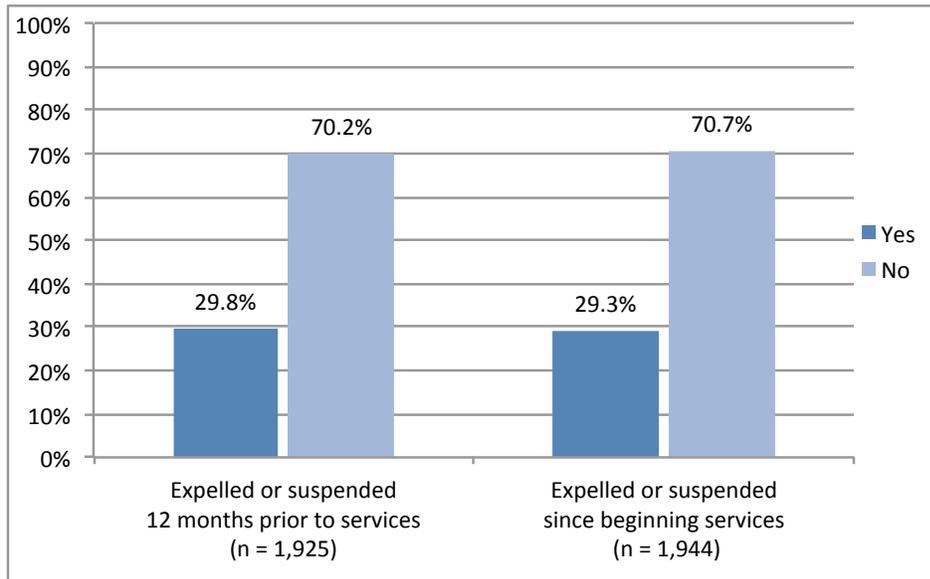
# Priority Indicators Analysis and Findings: Consumer Indicators

## Priority Indicator 1: School Attendance

### 1.1 Expulsions and Suspensions Per Year (CPS)

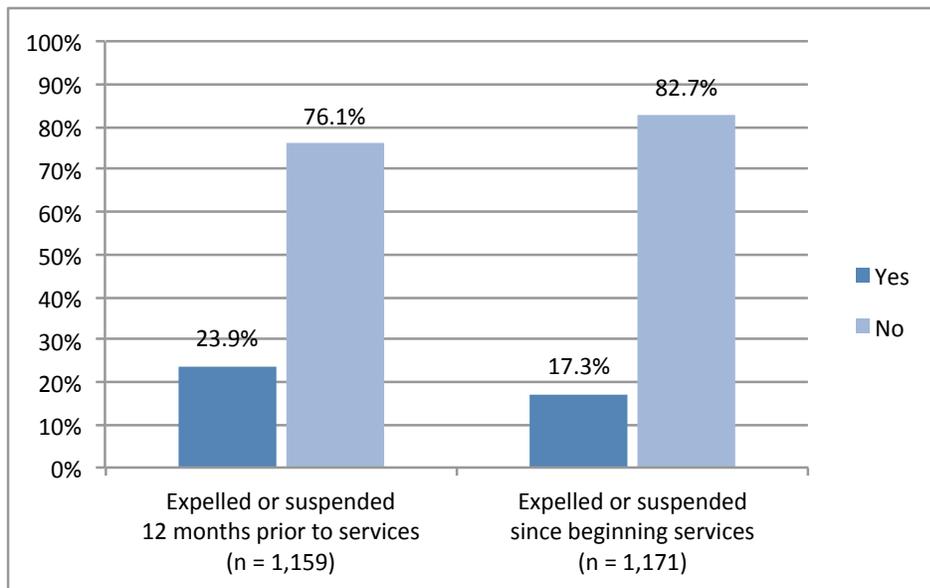
<i>Indicator Summary</i>
<p>This indicator provides the proportion of children and TAY who reported being suspended/expelled 12 months prior to receiving services and the proportion of children and TAY who reported being suspended/expelled since beginning services. This indicator includes only children and TAY who reported receiving services for 6 to 12 months and responded to a consumer perception survey. This indicator provides information regarding whether the proportion of suspended/expelled clients has increased or decreased after 6 to 12 months of service. This indicator does not measure school attendance, but it provides just one measure of why children or TAY would not attend school.</p>
<i>Indicator Calculation</i>
<ul style="list-style-type: none"><li>• The number of reported suspensions/expulsions 12 months prior to services divided by the total number of children and TAY for who we have data</li><li>• The number of reported suspensions/expulsions since beginning services divided by the total number of children and TAY for who we have data</li></ul> <p>Note: Clients were surveyed multiple times during the 2008 – 2009 fiscal year. However, only the first survey administration was used to get the proportion of children and TAY who reported being suspended/expelled 12 months prior to beginning services and since beginning services as it had the most complete data.</p> <p>Additionally, the TAY age group was revised to include only the ages of 16 – 18 (rather than 16 – 25) because attendance variables are less clear or less relevant to clients older than 18.</p>
<i>Data Sources</i>
<p>Consumer Perception Survey (CPS) for Youth Data Fields: HowLong, LES12EXPSUS, LES12PSTEXPSUS</p>
<i>Review of Existing Data</i>
<ul style="list-style-type: none"><li>• Data sources likely to be sustained</li><li>• Data relevant to populations of interest (youth and TAY)</li><li>• Approximately 17.5% missing or unknown values</li></ul>
<i>Analytic Potential of Existing Data</i>
<ul style="list-style-type: none"><li>• Analysis across time possible</li><li>• Analysis among specific service populations not possible</li><li>• State and county level analysis possible</li></ul>

**Figure 1.1-1- Proportion of Children Expelled/Suspended 12 Months Prior to Services and Since Beginning Services, FY 2008-09**



Unknown/missing for Expelled/Suspended 12 month prior to services = 18.7% (n = 444); Unknown/missing for Expelled/Suspended since beginning services = 18.0% (n = 435)

**Figure 1.1-2 - Proportion of TAY Expelled/Suspended 12 Months Prior to Services and Since Beginning Services, FY 2008-09**



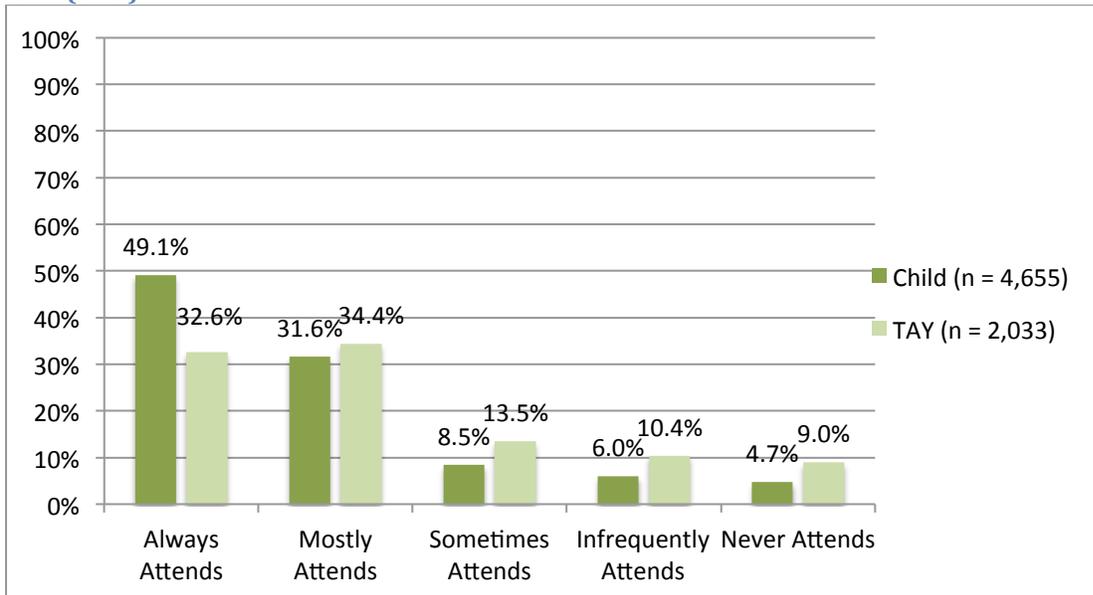
Unknown/missing for Expelled/Suspended 12 month prior to services = 17.4% (n = 245); Unknown/missing for Expelled/Suspended since beginning services = 16.8% (n = 230)

During FY 2008-09, expulsion/suspension rates were higher for children than those for TAY. Thirty percent of children reported being expelled or suspended 12 months prior to services compared to 24% of TAY. Twenty-nine percent of children were expelled or suspended since beginning services compared to 17% of TAY.

## 1.2 Average School Attendance Per Year (FSP)

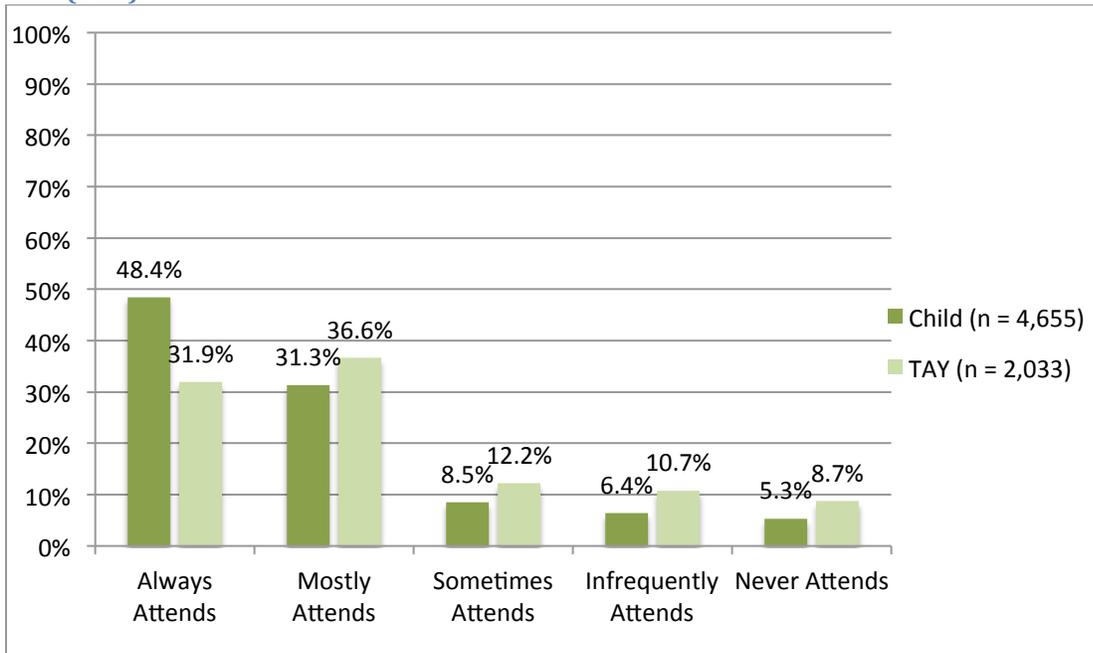
<b><i>Indicator Summary</i></b>
This indicator provides descriptive information regarding the frequency for which Full Service Partnership consumers (children and TAY) attended school during the 2008-09 and 2009-10 fiscal years. Outcomes are a summary of admission data.
<b><i>Indicator Calculation</i></b>
<ul style="list-style-type: none"><li>• The number of children who attended school always, mostly, sometimes, infrequently, and never divided by the number of children for which there were data</li><li>• The number of TAY who attended school always, mostly, sometimes, infrequently, and never divided by the number of TAY for which there were data</li></ul> <p>Note: Age groupings were revised such that: Child ages = 1-15 (same as previously) TAY ages = 16-18 (16-25 previously)</p> <p>The TAY age group was revised because education variables would be less clear for clients older than 18.</p>
<b><i>Data Sources</i></b>
DCR (PAF - NONRES) Data Field: AttendanceCurr
<b><i>Review of Existing Data</i></b>
<ul style="list-style-type: none"><li>• Data sources likely to be sustained</li><li>• Data relevant to populations of interest (FSPs)</li><li>• Amount of missing data for child age group is approximately 6%</li><li>• Amount of missing data for TAY age group is approximately 46%</li></ul>
<b><i>Analytic Potential of Indicator</i></b>
<ul style="list-style-type: none"><li>• Analysis across time possible</li><li>• Analysis among specific service populations possible</li><li>• State- and county-level analysis possible</li></ul>

**Figure 1.2-1 –The frequency with which children and TAY attended school, FY 2008-09 admission data (DCR)**



Child % missing data = 6.4% (n = 299), TAY % missing data = 47.5% (n = 966)

**Figure 1.2-2 –The frequency with which children and TAY attended school, FY 2009-10 admission data (DCR)**



Child % missing data = 5.8% (n = 390), TAY % missing data = 44.4% (n = 1,327)

Trends are similar across FY 2008-09 and 2009-10. Most children and TAY consumers are categorized as “always” or “mostly” attending school. Smaller proportions report attending “sometimes,” “infrequently,” and “never.” Children are more likely than TAY to “always attend” school, according to data.

## Priority Indicator 2: Employment

### Indicator Summary

This indicator provides the proportion of TAY, adults and older adults who are employed (paid and non-paid, including voluntary contributions) and not employed as recorded during the most recent update (second date of service). This indicator provides descriptive information regarding clients' employment status during their second date of service.

### Indicator Calculation

#### Client & Service Information (CSI)

- The number of paid employed clients divided by the total number of TAY, adults, and older adults for whom there were employment data.
- The number of nonpaid employed clients divided by the total number of TAY, adults, and older adults for whom there were employment data.
- The number of non-employed clients divided by the total number of TAY, adults, and older adults for whom there were employment data.

Note: There were multiple periodic updates for clients within each fiscal year. These ratios provide information for those who had a second periodic update (referred to in datasets as "ServiceDate.2," or the second date of service) within a given fiscal year. Additionally, the age groupings were revised to capture those truly eligible for employment. Those who indicated they were retired or incarcerated were excluded from calculations.

#### Data Collection and Reporting (DCR)

- The number of TAY, adults, and older adults who reported paid employment at admission divided by the total number of TAY, adults, and older adults.
- The number of TAY, adults, and older adults who reported nonpaid employment at admission divided by the total number of TAY, adults, and older adults.
- The number of TAY, adults, and older adults who did not report any employment at admission divided by the total number of TAY, adults, and older adults.

Note for CSI and FSP data:

Age groupings were revised such that  
TAY ages = 18-25 (previously 16-25)  
Older adults = 60-65 (60 and up previously)

### Data Sources

CSI Periodic Post-dig, Data Field: Employment Status

DCR (PAF - NONRES) Data Fields: Current\_CompetitiveAvgHrWeek, Current\_SupportedAvgHrWeek, Current\_TransitionalAvgHrWeek, Current\_In-HouseAvgHrWeek, Current\_OtherEmploymentAvgHrWeek, Current\_Non-paidAvgHrWeek

### Review of Existing Data

#### Client & Service Information (CSI)

- Data sources likely to be sustained
- Data relevant to populations of interest (all consumers)
- Data available across multiple service years
- Approximately 23% missing/unknown values

*Data Collection and Reporting (DCR)*

- Data sources likely to be sustained
- Data relevant to populations of interest (FSPs)

The amount of missing data for these ratios is unknown given how the employment data are collected. There is no data code option for “missing;” as a consequence, blank responses are either missing or not applicable.

***Analytic Potential of Indicator***

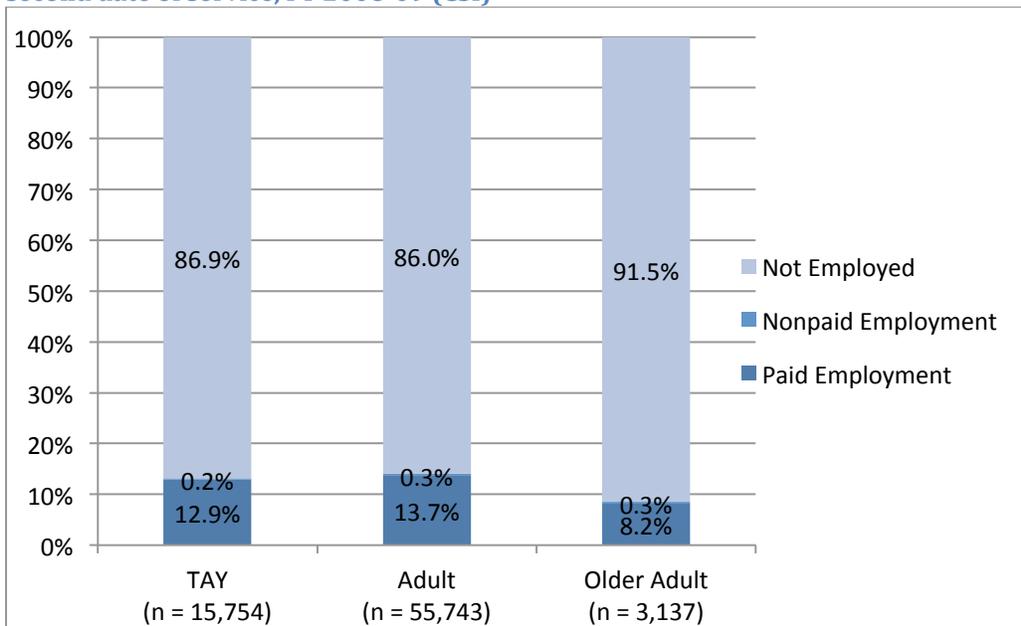
*Client & Service Information (CSI)*

- Analysis across time possible but very difficult
- Analysis among specific service populations not possible
- State- and county-level analysis possible

*Data Collection and Reporting (DCR)*

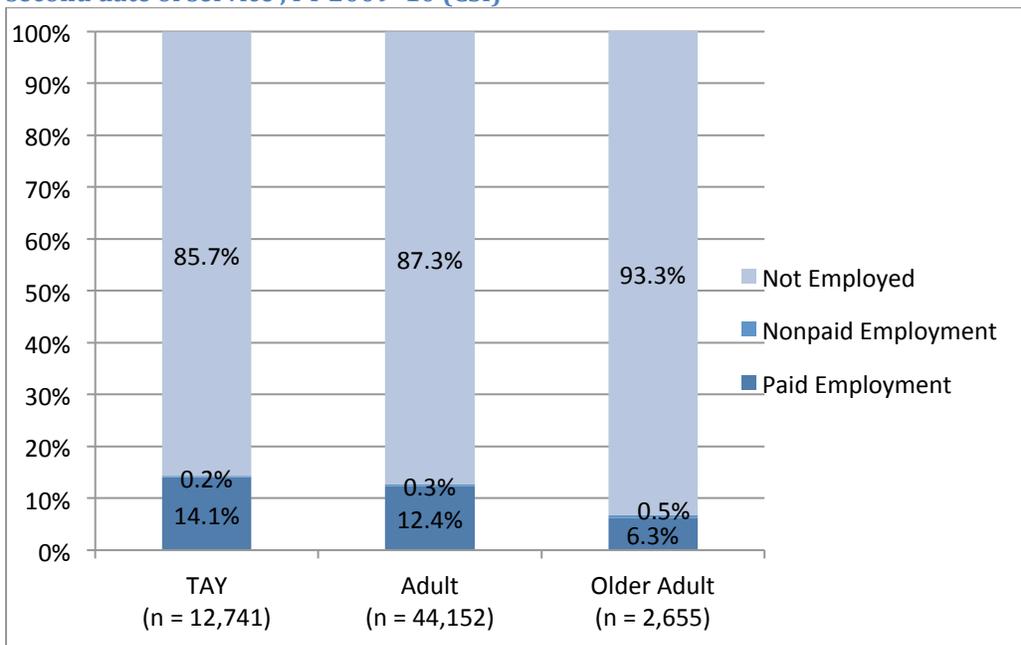
- Analysis across time possible
- Analysis among specific service populations possible
- State- and county-level analysis possible

**Figure 2.1 - Proportion of clients who were employed and not employed as reported during their second date of service, FY 2008-09 (CSI)**



Unknown/Missing for FY 2008-09 = 23.8% (n = 41,621)

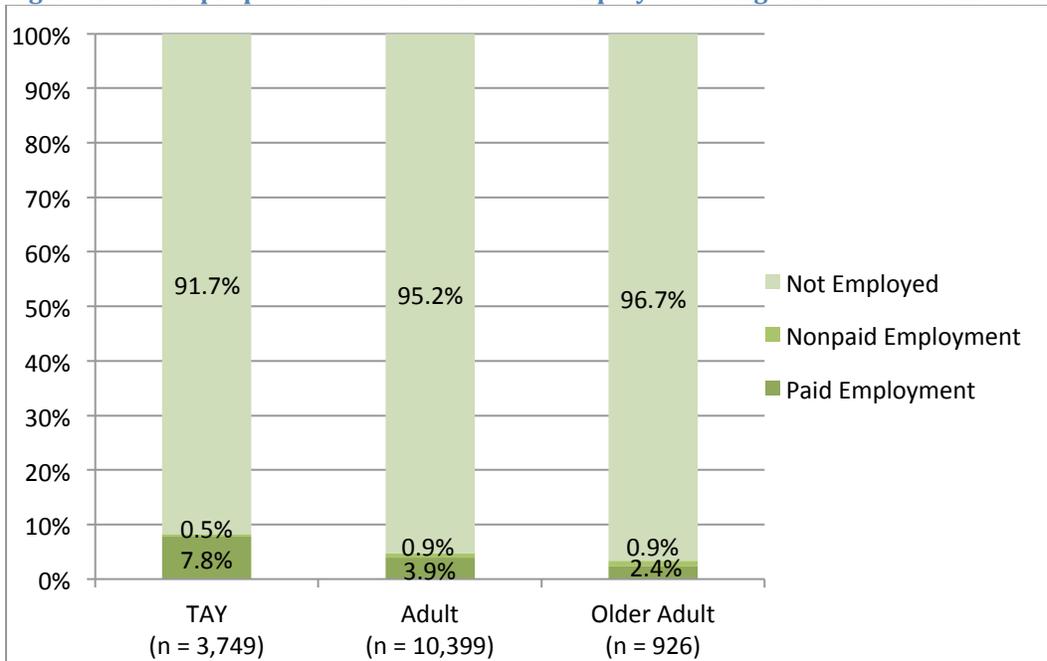
**Figure 2.2 - Proportion of clients who were employed and not employed as reported during their second date of service, FY 2009-10 (CSI)**



Unknown/Missing for FY 2009-10 = 21.9% (n = 46,014)

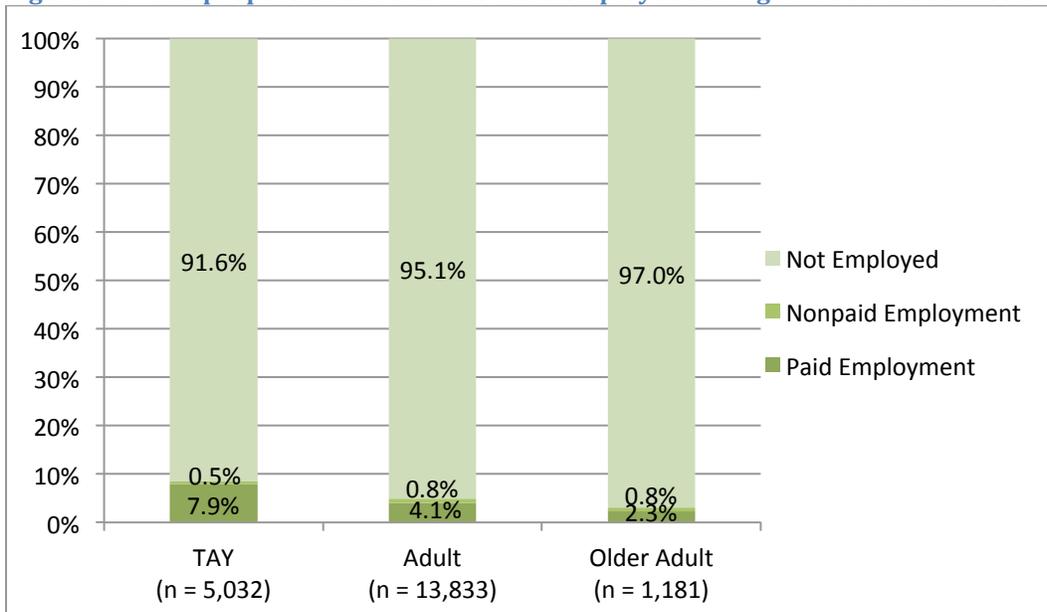
Among all age groups, at least 86% of consumers were not employed during FY 2008-09 and 2009-10. Older adults were least likely to be employed. Of those consumers who were employed, most were involved in paid employment, including volunteer work.

**Figure 2.3 -The proportion of FSPs who were employed during FY 2008–09 admission (DCR)**



Amount of missing data unknown for FY 2008–09. There is no data code for missing data. Blank data cells can be interpreted as either “not applicable” or “missing.”

**Figure 2-4 -The proportion of FSPs who were employed during FY 2009–10 admission (DCR)**



Amount of missing data unknown for FY 2009–10. There is no data code for missing data. Blank data cells can be interpreted as either “not applicable” or “missing.”

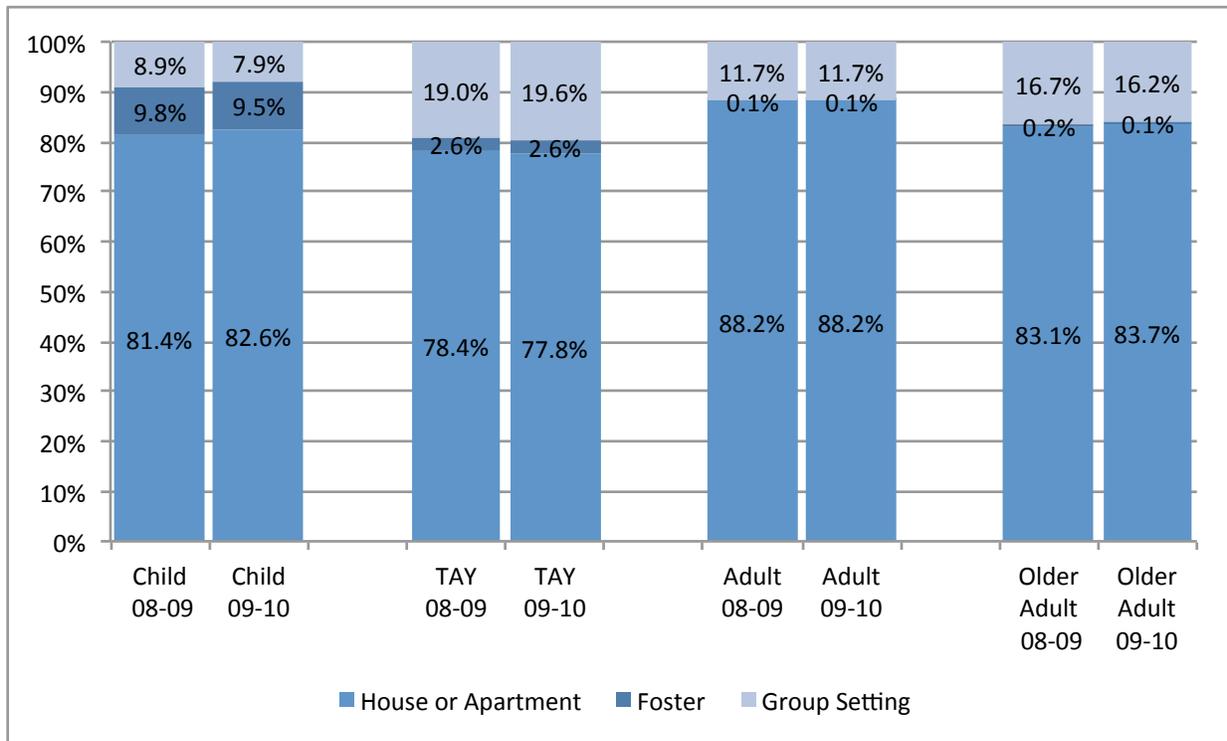
Trends among Full Service Partnership (FSP) participants were similar to what was seen among consumers in the CSI. Admission data showed that most consumers (at least 92%) in each age group were not employed during intake. Older adults were least likely to be employed. Of those who were employed, most were paid.

## Priority Indicator 3: Homelessness and Housing Rates

<b><i>Indicator Summary</i></b>
<p>This indicator summarizes the housing status of all mental health consumers and FSPs served during FYs 2008-09 and 2009-10. There are two parts: (a) a breakdown by most recently available housing status and (b) the percentage of consumers experiencing homelessness at any point during the year.</p>
<b><i>Indicator Calculation</i></b>
<p>Frequencies of the most recent housing statuses were computed for mental health and FSP consumers served in FYs 2008-09 and 2009-10. This calculation excludes consumers with no housing data within the given FYs or consumers whose most recent status was homeless. The percentages of mental health and FSP consumers who experienced homelessness at any point during the given FY were also computed.</p> <p>Note that a consumer who was most recently homeless would not be included in the first indicator for most recent housing status, whereas a consumer who was previously homeless and more recently reported as not homeless would be included.</p>
<b><i>Data Sources</i></b>
<p><i>Client &amp; Service Information (CSI):</i> H-01.0 County / City / Mental Health Plan Submitting Record; H-02.0 County Client Number; C-03.0 Date of Birth; P-01.0 Date Completed; P-09.0 Living Arrangement</p> <p><i>Data Collection and Reporting (DCR) Key Event Tracking (KET):</i> 1.01 Global ID; 1.02 Assessment ID; 1.07 Age Group; 3.01 CountyID; 3.06 Assessment Date; 5.01 DateResidentialChange; 5.02 Current</p>
<b><i>Review of Existing Data</i></b>
<p>These data were taken from the Key Event Tracking (KET) updates for FSP consumers and the periodic updates for all mental health consumers, limited to the given fiscal year. Any consumer who did not have an update available during the year was not included. Data sources are likely to be sustained in the foreseeable future, providing a consistent source for tracking system performance moving forward. Taking a conservative approach, we considered cases without valid data “missing.” (These particular consumers have an update, but the updates do not include housing information.) It should be noted that the data reporting and collection practices currently in place do not allow for a distinction between missing data from unreported changes in housing status and blank values from standard data entry practices. This is especially notable in the KET updates for FSP consumers, leading to large percentages of “missing” data. These results should be interpreted cautiously. In particular, there is the risk of systematic bias in underreporting certain housing statuses.</p>
<b><i>Analytic Potential of Indicator</i></b>
<p>Data across service years support analysis of the distribution and change of housing statuses, including homelessness, among consumers.</p>
<b><i>Indicator Displays</i></b>
<p>The first set of charts displays the most recently reported non-homeless housing statuses of consumers, by percentage, during each fiscal year. The second set displays the percentages of consumers who were reported as experiencing homelessness at any time during the fiscal year.</p>

A comparison of the two fiscal years indicates relatively steady housing rates across the entire population of consumers. Of the housing options, most children, TAY, adults, and older adults reside in a house or apartment. This category includes consumers who live fully autonomously or receive some level of structured support. Group settings were the next most frequent option. The least common category for children and TAY was housing through foster care (children more than TAY). In rare instances, adults and older adults were identified as being housed through foster care also.

**Figure 3.1 – Most recent housing status excluding homelessness, all consumers (CSI)**



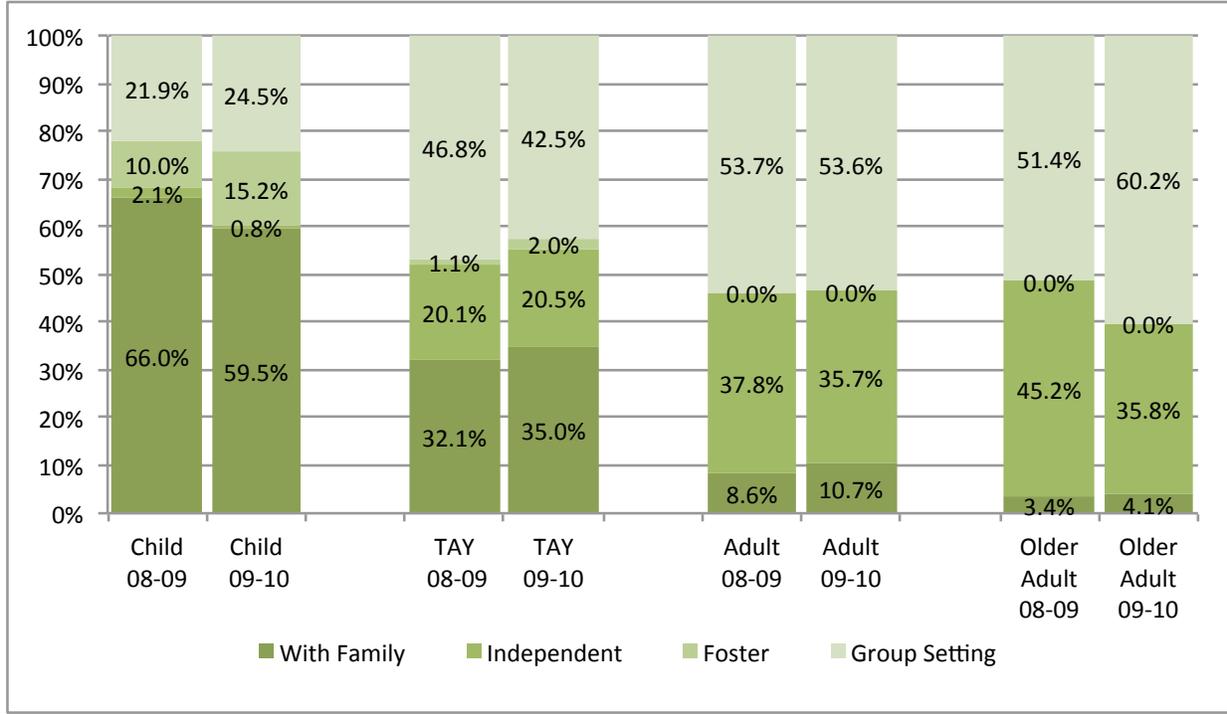
Unknown/Missing for FY 2008-09 = 15.7% (*n* = 12,837) for children; 14.5% (*n* = 9,063) for TAY; 16.1% (*n* = 22,258) for adults; and 22.2% (*n* = 4,057) for older adults  
 Unknown/Missing for FY 2009-10 = 16.4% (*n* = 14,848) for children; 14.2% (*n* = 10,485) for TAY; 15.3% (*n* = 23,233) for adults; and 21.2% (*n* = 4,501) for older adults

The subset of consumers enrolled in FSPs showed much more variation in housing status between the two fiscal years compared. Although children were more likely to live with family, TAY housing oscillated between family and group settings. Among adults and older adults, the group setting was more prevalent, followed by independent living. However, caution should be used in attempting to directly compare these results for FSP consumers with the previous results for all consumers. The FSP data contained more refined information, which led to more finely grained categories. Additionally, the amount of missing or unknown data for FSP consumers increased dramatically

\* We cannot distinguish between KETs “for a change in housing” and those “not for a change in housing” because multiple status changes (for housing, employment, etc.) can and were inputted in each KET. Both unknown and missing are included here to be thorough.

from the 2008-09 fiscal year to the 2009-10 fiscal year. Any changes in the percentages from year to year should be interpreted cautiously.

**Figure 3.2 – Most recent housing status excluding homelessness, FSP consumers only (DCR)**

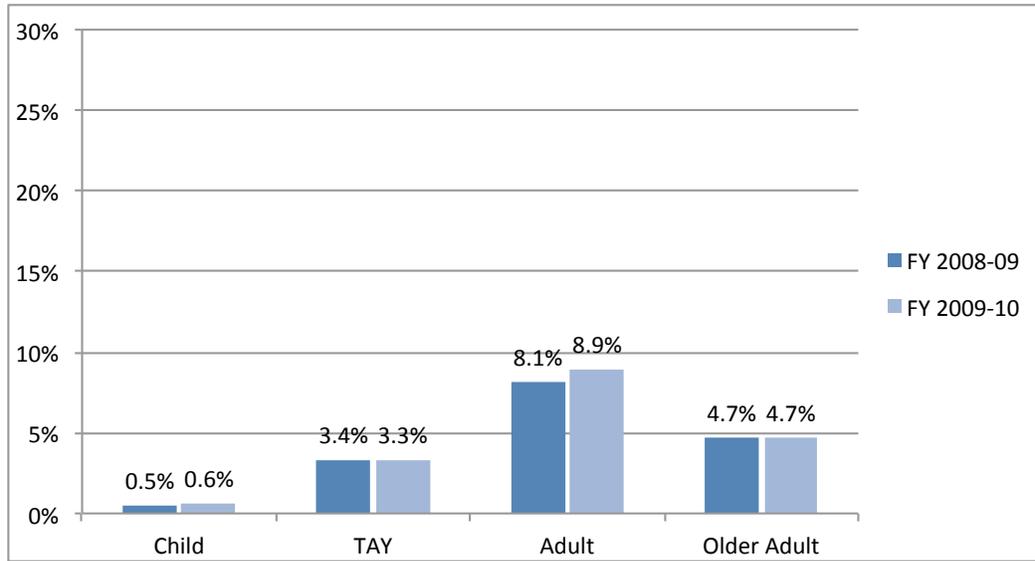


Unknown/Missing for FY 2008-09 = 71.6% (*n* = 1,497) for children; 44.6% (*n* = 1,300) for TAY; 30.5% (*n* = 1,936) for adults, and 43.2% (*n* = 448) for older adults

Unknown/Missing for FY 2009-10 = 73.2% (*n* = 2,301) for children; 50.6% (*n* = 2,126) for TAY, 37.9% (*n* = 3,085) for adults; and 50.9% (*n* = 687) for older adults

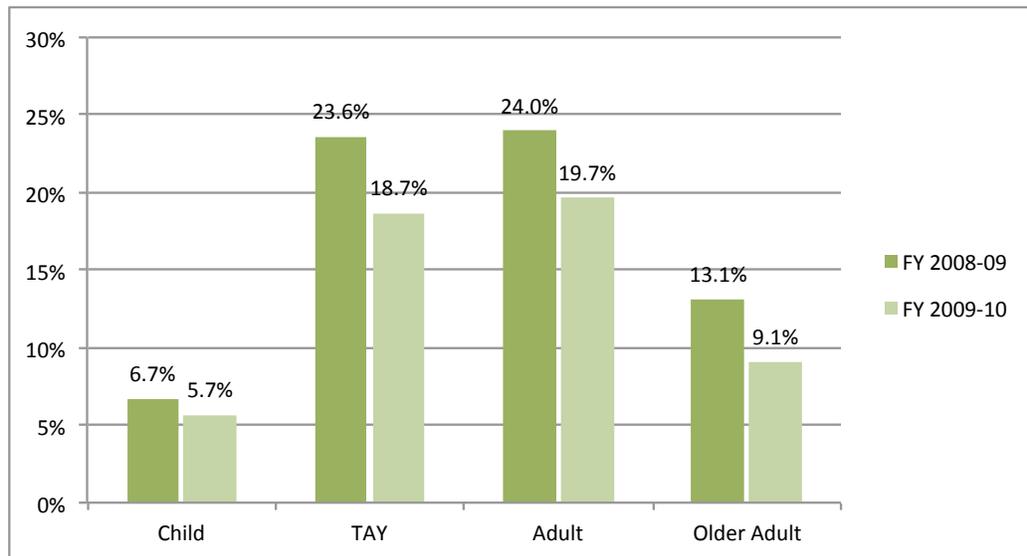
In the population of all consumers, the percentages of each age category who experienced homelessness remained fairly stable across the two fiscal years examined. For FSP consumers only, the percentages of those who experienced homelessness show a decline in every age category. However, as previously noted, there is also an increase of unknown or missing data from one year to the next. Considering that the increase in such data is larger than the suggested decrease in homelessness, there may not be enough evidence to support a conclusion of decrease in homelessness among FSP consumers between the two years.

**Figure 3.3 – Experienced homelessness at any point during the year, all consumers (CSI)**



Unknown/Missing for FY 2008-09 = 15.7% (*n* = 12,837) for children; 14.5% (*n* = 9,063) for TAY; 16.1% (*n* = 22,258) for adults; and 22.2% (*n* = 4,057) for older adults  
 Unknown/Missing for FY 2009-10 = 16.4% (*n* = 14,848) for children; 14.2% (*n* = 10,485) for TAY; 15.3% (*n* = 23,233) for adults; and 21.2% (*n* = 4,501) for older adults

**Figure 3.4 – Experienced homelessness at any point during the year, FSP consumers only (DCR)**



Unknown/Missing for FY 2008-09 = 71.6% (*n* = 1,497) for children; 44.6% (*n* = 1,300) for TAY; 30.5% (*n* = 1,936) for adults, and 43.2% (*n* = 448) for older adults  
 Unknown/Missing for FY 2009-10 = 73.2% (*n* = 2,301) for children; 50.6% (*n* = 2,126) for TAY; 37.9% (*n* = 3,085) for adults; and 50.9% (*n* = 687) for older adults

## Priority Indicator 4: Arrest Rates

### Indicator Summary

This indicator provides the proportion of youth, adults, and older adults who reported being arrested 12 months prior to receiving services and the proportion of youth, adults, and older adults who reported being arrested since beginning services.

For calculations involving consumer perception surveys, this indicator includes only youth, adults, and older adults who reported receiving services for 6 to 12 months. This indicator provides information regarding whether the proportion of arrested clients has increased or decreased after 6 to 12 months of service.

For calculations involving Full Service Partnership consumers, this indicator tracks arrests prior to enrollment using intake data. This indicator accounts for consumers enrolled during the target fiscal years for which PAF surveys are available.

### Indicator Calculation

#### Consumer Perception Surveys (CPS)

- The number of reported arrest 12 months prior to services divided by the total number of youth, adults, and older adults for who there was data
- The number of reported arrest since beginning services divided by the total number of youth, adults, and older adults for who there was data

Note: Clients were surveyed multiple times during the 2008 – 2009 fiscal year. However, only one survey administration was used to get both the proportion of clients who reported being arrested 12 months prior to beginning services and since receiving services.

Age groupings are as follows:

- Youth, 1 – 25 years
- Adult, 26 – 59 years
- Older adult, 60 and above

#### Data Collection and Reporting (DCR)

- The number of youth (children and TAY), adults, and older adults reporting arrests 12 months prior to enrollment divided by the total number of unique clients for who there was data
- The number of youth (children and TAY), adults, and older adults reporting arrests 12 months prior to the past 12 months divided by the total number of unique clients for who there was data

Note: In rare cases where two surveys were entered for one client, only the earliest entry was used in calculations.

### Data Sources

Consumer Perception Survey (CPS) for Youth, Adults, and Older Adults Data Fields: HowLong, LES12AREST, LES12PSTAREST

Data Collection and Reporting (DCR PAF NONRES): Age\_Group, ArrestPast12, ArrestPrior12

### Review of Existing Data

#### Consumer Perception Surveys (CPS)

- Data sources likely to be sustained
- Data relevant to populations of interest
- Approximately 16% missing or unknown values for youth

- Approximately 14.5% missing or unknown values for adult
- Approximately 18.5% missing or unknown values for older adult

*Data Collection and Reporting (DCR)*

- Data sources likely to be sustained
- Data relevant to populations of interest
- On average, 5% missing or unknown values for youth
- On average, 2% missing or unknown values for adults
- On average, 5.5% missing or unknown values for older adults

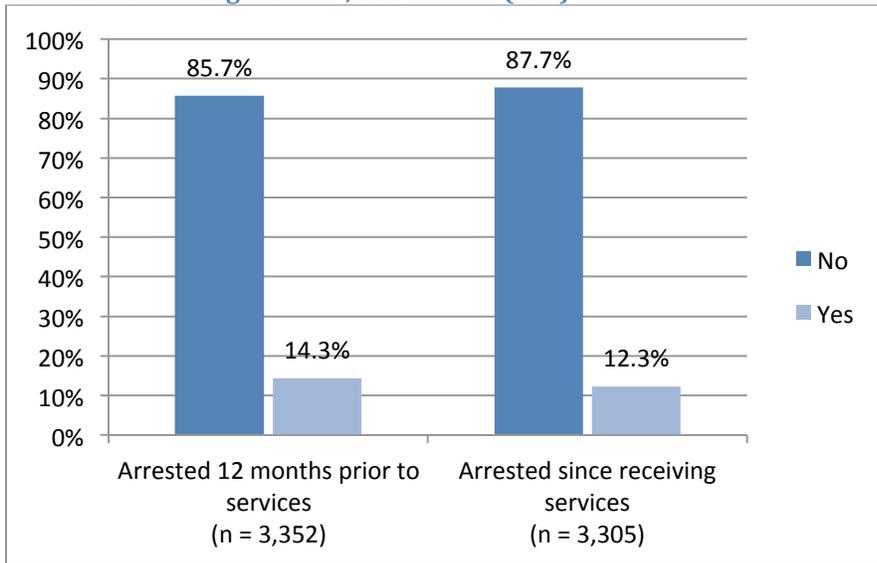
***Analytic Potential of Existing Data***

*For both data sources*

- Analysis across time possible
- Analysis among specific service populations not possible
- State and county individual level analysis possible

*Note: As of the submission of this report, a new calculation has been proposed to examine arrest rates. The proposed calculation would use FSP-DCR data during consumers' enrollment (not intake as it is presented here). An updated indicator will be available shortly.*

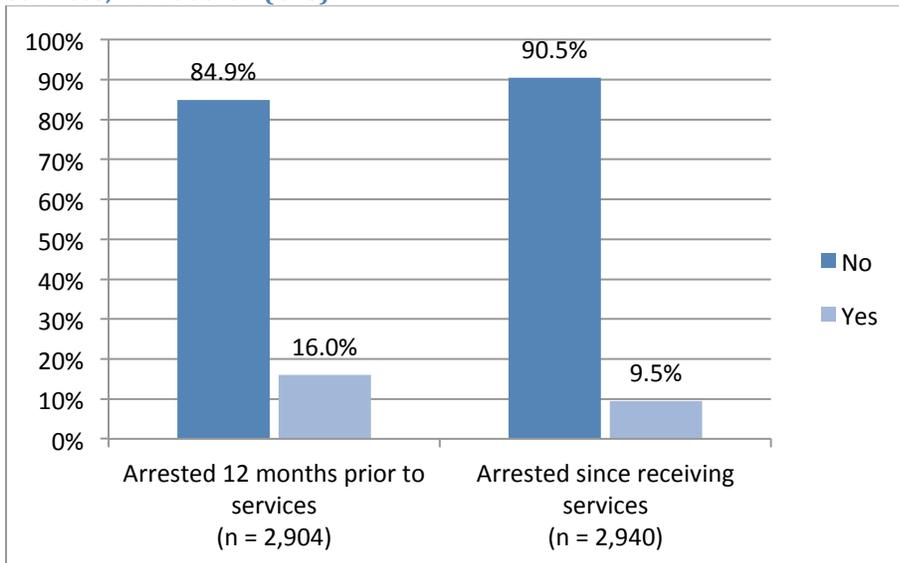
**Figure 4.1 – Proportion of youth (children and TAY) who were arrested prior to beginning services and since receiving services, FY 2008-09 (CPS)**



Missing/unknown for *Arrested 12 months prior to services* = 16.5% (n = 651)

Missing/unknown for *Arrested since receiving services* = 15.4% (n = 604)

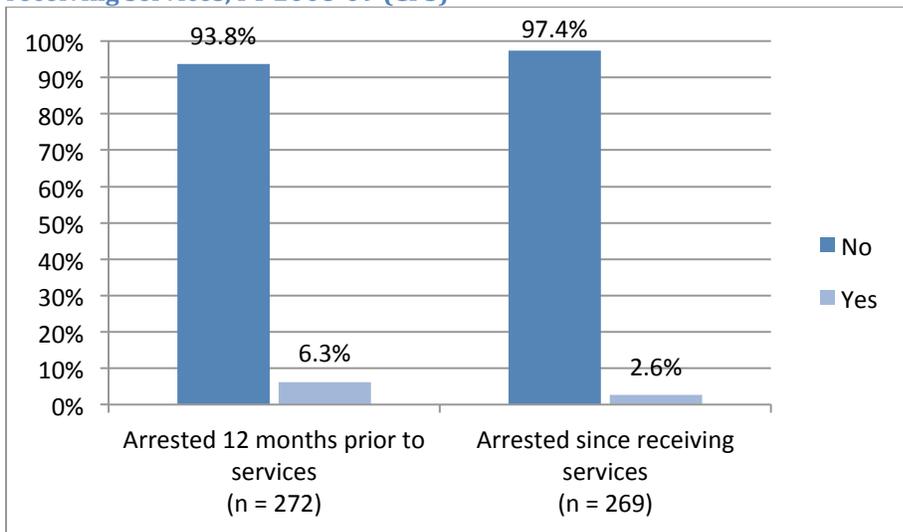
**Figure 4.2 – Proportion of adults who were arrested prior to beginning services and since receiving services, FY 2008-09 (CPS)**



Missing/unknown for *Arrested 12 months prior to services* = 15% (n = 514)

Missing/unknown for *Arrested since receiving services* = 14% (n = 478)

**Figure 4.3 - Proportion of older adults who were arrested prior to beginning services and since receiving services, FY 2008-09 (CPS)**



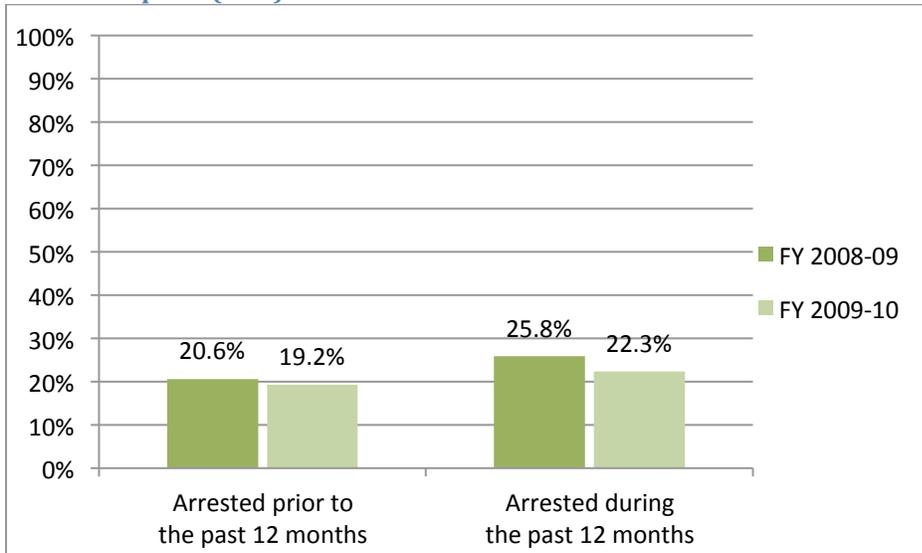
Missing/unknown for *Arrested 12 months prior to services* = 18.1% (n = 60)

Missing/unknown for *Arrested since receiving services* = 19% (n = 63)

Across the three age groups, most survey respondents (at least 85%) reported that they had not been arrested within 12 months prior to services. More respondents (at least 88% in each age group) reported that they had not been arrested since receiving services. Of the three age groups, older adults had the lowest arrest rates.

Available DCR data shows that there were fewer arrests among adults and older adults from “prior to the past 12 months” to “the past 12 months.”

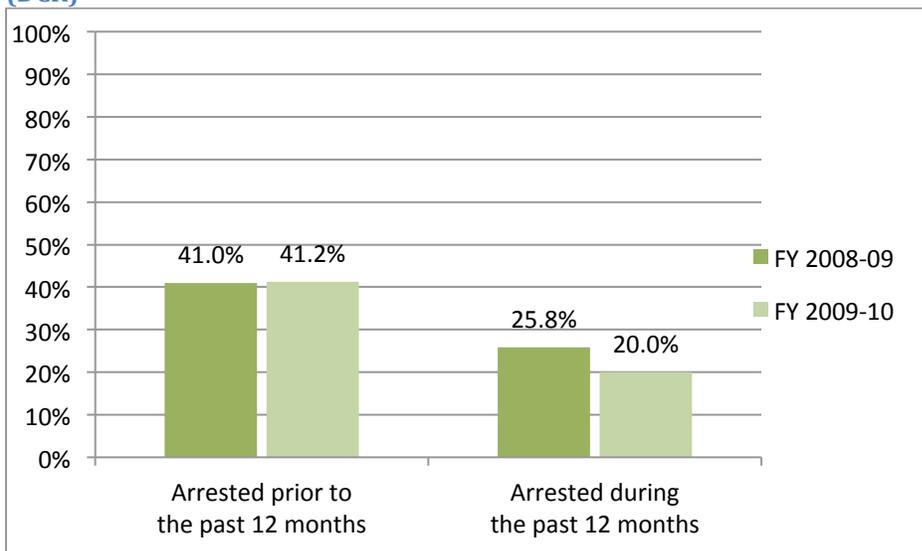
**Figure 4.4 - Proportion of youth (Children and TAY) who were arrested within the past 12 months and 12 months prior (DCR)**



Missing/Unknown for FY 2008-09: Arrested during the past 12 months = 7.8% (n = 384); Arrested prior to the past 12 months = 2.5% (n = 121)

Missing/Unknown for FY 2009-10: Arrested during the past 12 months = 2.0% (n = 131); Arrested prior to the past 12 months = 2.8% (n = 182)

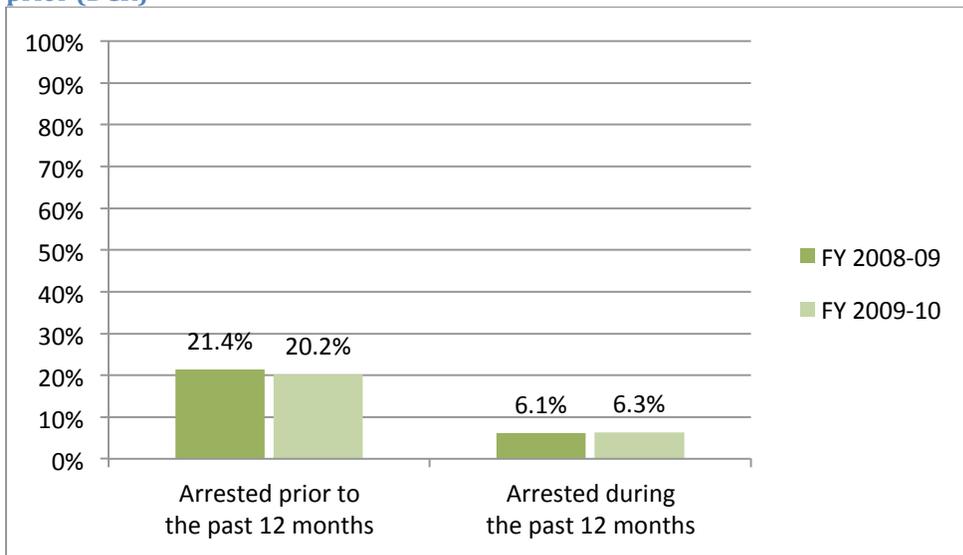
**Figure 4.5 - Proportion of adults who were arrested within the past 12 months and 12 months prior (DCR)**



Missing/Unknown for FY 2008-09: Arrested during the past 12 months = 2.6% (n = 125); Arrested prior to the past 12 months = 1.4% (n = 69)

Missing/Unknown for FY 2009-10: Arrested during the past 12 months = 1.7% (n = 98); Arrested prior to the past 12 months = 1.3% (n = 75)

**Figure 4.6 Proportion of older adults who were arrested within the past 12 months and 12 months prior (DCR)**



Missing/Unknown for FY 2008-09: *Arrested during the past 12 months* = 5.1% ( $n = 36$ ); *Arrested prior to the past 12 months* = 6.1% ( $n = 43$ )

Missing/Unknown for FY 2009-10: *Arrested during the past 12 months* = 3.6% ( $n = 29$ ); *Arrested prior to the past 12 months* = 6.8% ( $n = 55$ )

## Discussion: Consumer Indicators

### Domain: Education and Employment

**Education** – In the absence of data that tell how many days a youth attended or was absent from school, the evaluation team used suspension/expulsion counts collected through consumer perception surveys. Thus, findings only capture youths who completed surveys. Attendance among FSP consumers was captured by estimates of how often youth, including TAY 18 years old and younger, attended school. No numerical values were available; rather consumers responded “always,” “mostly,” or “sometimes” attends. These findings have limited reach. (The information that is sought – attendance – is not currently collected. Available data measure something other than attendance.) The type of data needed for this calculation begins with survey revisions. Or the indicator definition might be revised to accommodate existing data and expectations of what the data can provide.

**Employment** – DCR data provided robust information with which to calculate paid and nonpaid employment rates across FYs 2008-09 and 2009-10. Of the small percentage of all consumers and FSP consumers who were employed, nearly all received pay for their work. The variables used provide information regarding the proportion of employed consumers at any given point in the fiscal years. However, variables do not provide a sense of how long they 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 consumers’ housing status. The data used in the calculation 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 for such updates does not exist. This reduces confidence that KET and DCR 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 require further study before substantive claims based on these data can be made: (1) the standard practices for meriting and recording such periodic updates; and (2) the effectiveness of these practices in faithfully and completely representing the consumer population.

### Domain: Arrest Rates

Consumer perception surveys only provided arrest information about persons who completed surveys. Although arrest rates suggest that consumers do not often interact with law enforcement in this way, it is a less accurate estimate than what the team would find using a more comprehensive dataset such as the CSI. The evaluation team has identified possible additional CSI data from which to glean arrest rates. However, the data were not as complete during the fiscal years identified. Subsequent reports would benefit from diligent tracking of arrests within the CSI and an expansion of the definition to include incidents that lead to “jail,” “juvenile detention,” “incarceration,” “Department of Juvenile Justice” intervention and the like. DCR data provided additional insights into arrests, but information was limited. Arrest data are available in intake forms, which do not necessarily capture activities that take place during services.

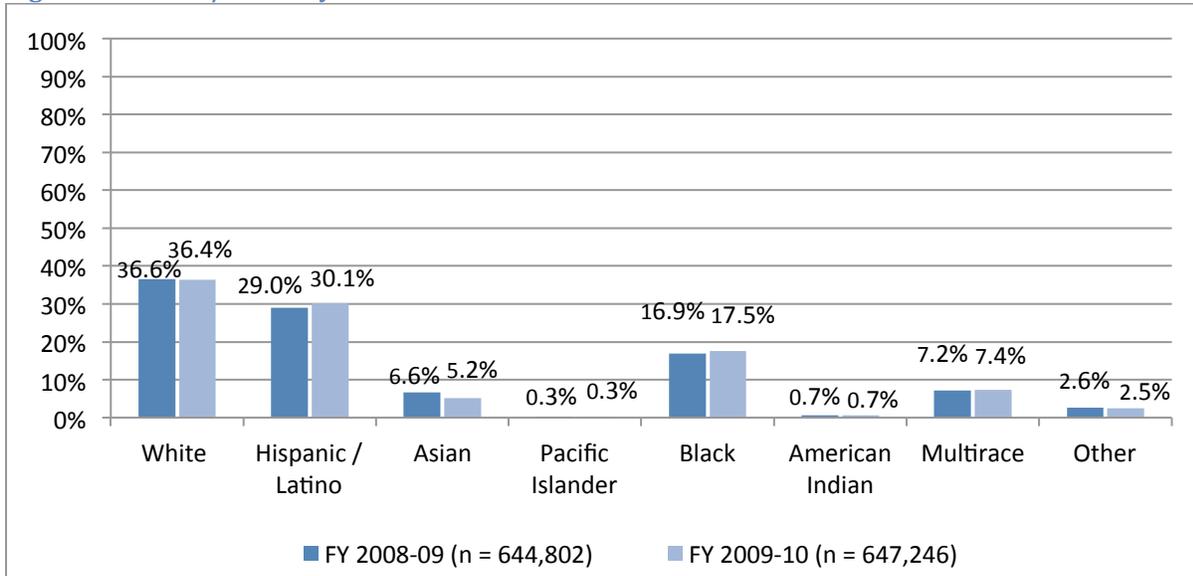
# Priority Indicators Analysis and Findings: Community Mental Health System Indicators

## Priority Indicator 5: Demographic Profile of Consumers Served

<p><i>Indicator Summary</i></p>
<p>This indicator profiles the demographics (race/ethnicity, age, and gender) of all mental health consumers and Full Service Partnership consumers served during FYs 2008-09 and 2009-10. It summarizes levels of service to California’s diverse population supported by the community mental health system.</p>
<p><i>Indicator Calculation</i></p>
<ul style="list-style-type: none"> <li>• The frequencies of all mental health consumers and FSP consumers served in FYs 2008-09 and 2009-10 were calculated overall.</li> <li>• Additionally, the proportion of consumers represented by race/ethnicity, age, and gender categories was calculated by dividing the number of consumers within each demographic category by all consumers served. Proportions were calculated for both service populations (all consumers and FSPs) and both fiscal years examined (see Figures 5.1-5.6 below).</li> </ul>
<p><i>Data Sources</i></p>
<p><i>Client &amp; Service Information (CSI) Data Fields:</i> H-01.0 County / City / Mental Health Plan Submitting Record; H-02.0 County Client Number; C-05.0 Gender; C-09.0 Ethnicity; C-10.0 Race; S-05.0 Mode of Service; S-16.0 From / Entry Date; S-17.0 Through / Exit Date; S-23.0 Date of Service.</p> <p><i>Data Collection and Reporting (DCR) Data Fields:</i> 1.01 Global ID; 1.02 Assessment ID; 1.04 Date Partnership Status Change; 1.05 Partnership Status; 1.07 Age Group; 1.08 Assessment Type; 2.01 CSI Date of Birth; 2.02 Gender; 2.03 CSIRace1; 2.04 CSIRace2; 2.05 CSIRace3; 2.06 CSIRace4; 2.07 CSIRace5; 2.10 CSI Hispanic; 3.01 County ID; 3.05 Partnership Date; 3.06 Assessment Date.</p>
<p><i>Review of Existing Data</i></p>
<ul style="list-style-type: none"> <li>• Data sources likely to be sustained</li> <li>• Data relevant to populations of interest (all consumers and FSPs)</li> <li>• Data available across multiple service years</li> <li>• Less than 10% missing or unknown values (see Appendix D for details of recoding race/ ethnicity data fields)</li> </ul>
<p><i>Analytic Potential of Indicator</i></p>
<ul style="list-style-type: none"> <li>• Analysis across time possible</li> <li>• Analysis among specific service populations possible (e.g., all consumers, FSPs, demographic groups)</li> <li>• State- and county-level analysis possible</li> </ul>

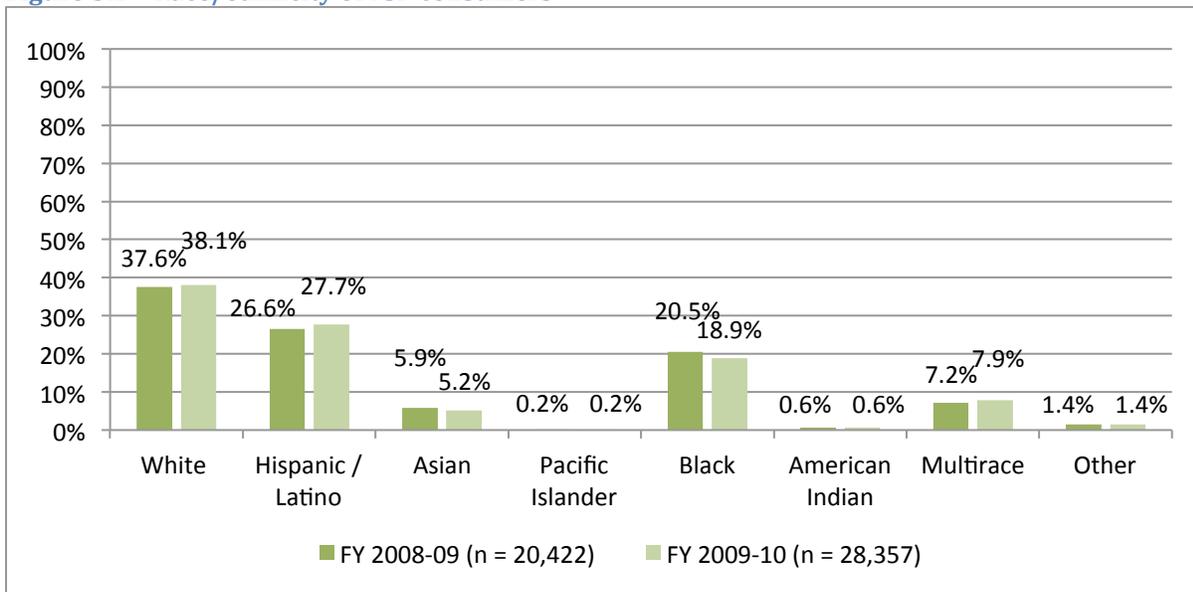
Figures 5.1 and 5.2 display the race and ethnicity of mental health and FSP consumers served in FYs 2008-09 and 2009-10. More white and Hispanic/Latino consumers were served compared to other racial or ethnic categories within each fiscal year analyzed.

**Figure 5.1 – Race/ethnicity of mental health consumers**



FY 2008-09 Unknown/Missing = 7.3% (n = 49,303); FY 2009-10 Unknown/Missing = 8.7% (n = 60,490)

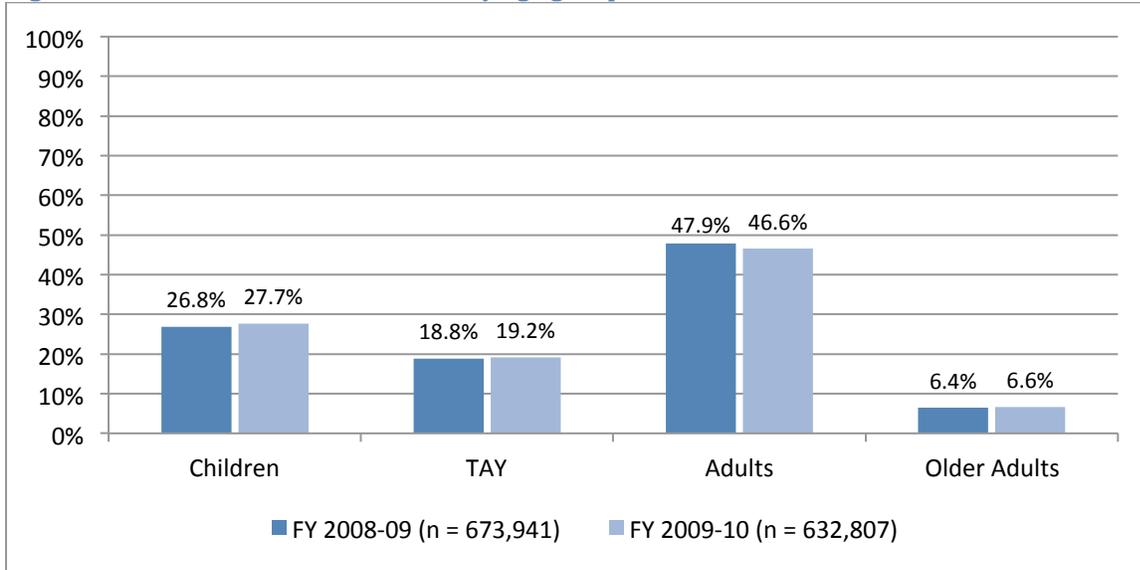
**Figure 5.2 – Race/ethnicity of FSP consumers**



FY 2008-09 Unknown/Missing = 5.4% (n = 1,177); FY 2009-10 Unknown/Missing = 5.5% (n = 1,660)

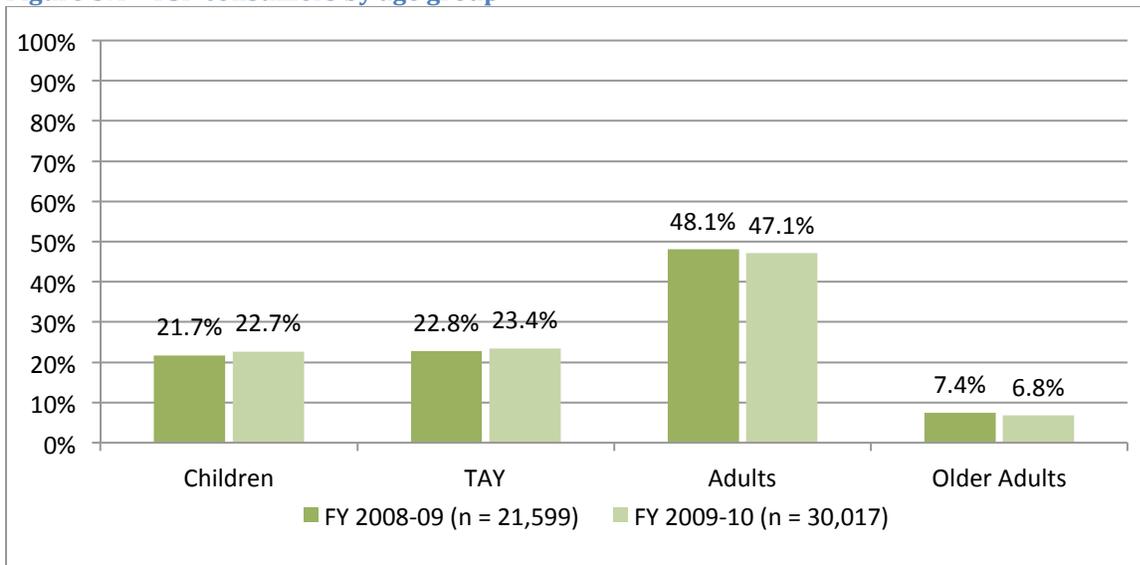
Figures 5.3 and 5.4 display all mental health and FSP consumers served within age group during FYs 2008-09 and 2009-10. More adults were served compared to other age groups within each fiscal year analyzed.

**Figure 5.3 – Mental health consumers by age group**



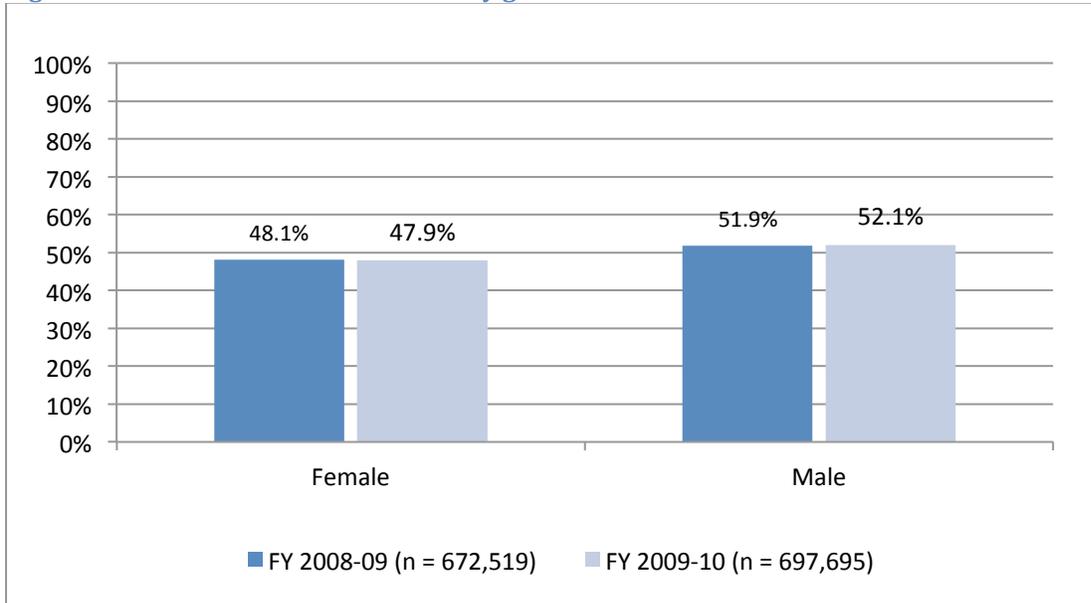
FY 2008-09 Unknown/Missing = 0.0% (n = 133); FY 2009-10 Unknown/Missing = 9.4% (n = 65,968)

**Figure 5.4 – FSP consumers by age group**



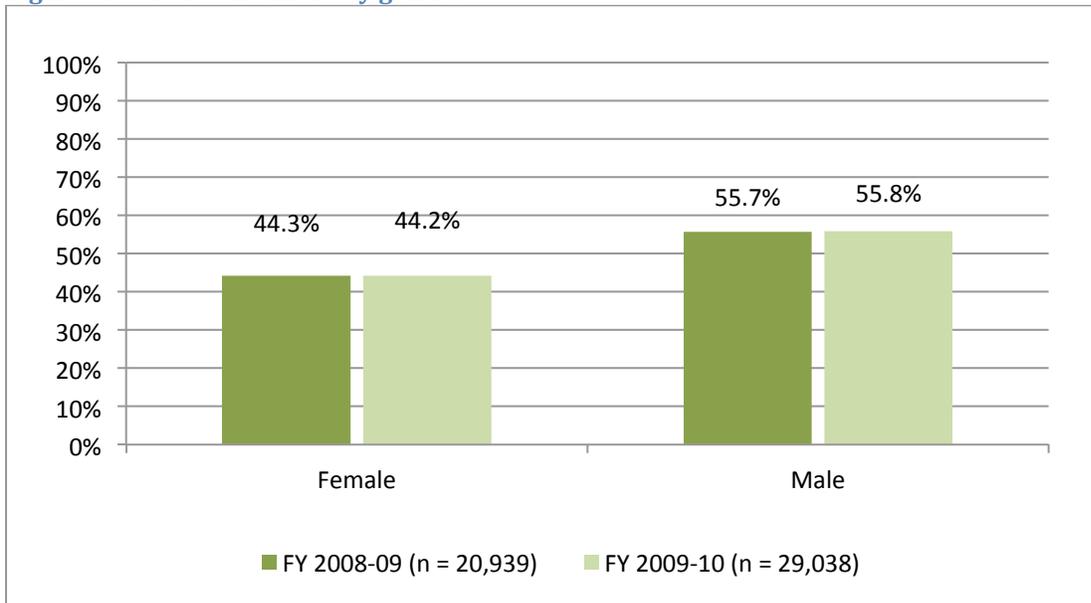
Figures 5.5 and 5.6 display gender of mental health and FSP consumers served in FYs 2008-09 and 2009-10. More male consumers were served compared to female consumers within each fiscal year analyzed.

**Figure 5.5 - Mental health consumers by gender<sup>7</sup>**



FY 2008-09 Other/Unknown/Missing = 0.2% (n = 1,555); FY 2009-10 Other/Unknown/Missing = 0.2% (n = 1,080)

**Figure 5.6 - FSP consumers by gender**



FY 2008-09 Other/Unknown/Missing = 3.1% (n = 660); FY 2009-10 Other/Unknown/Missing = 3.3% (n = 979)

<sup>7</sup> Consumer stakeholders felt it important to note that “transgender” is not currently a category that is available in the datasets. Male and female categories might incorporate this population, but it cannot be distinguished as a third group from existing data.

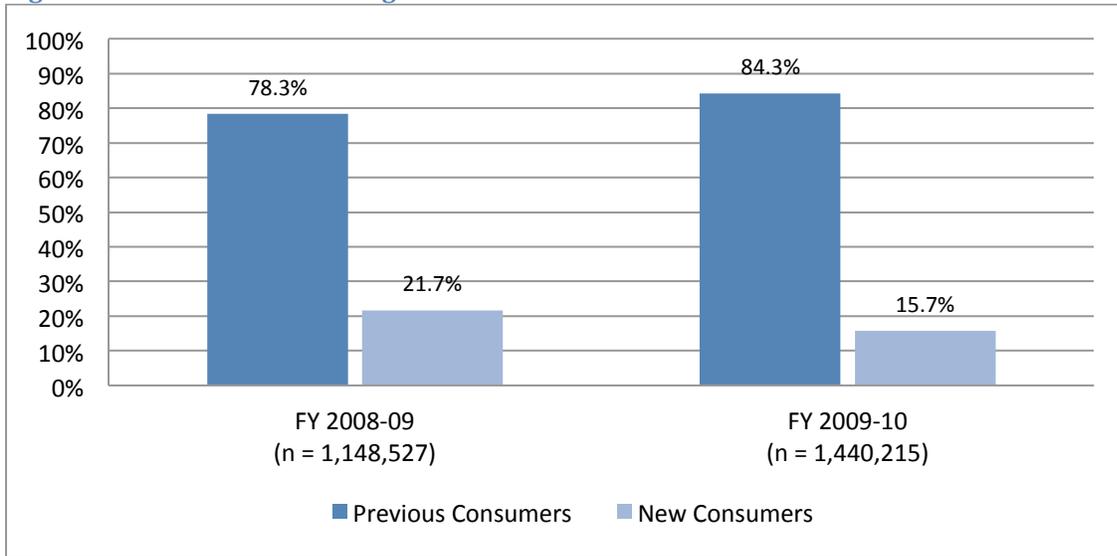
## Priority Indicator 6: Demographic Profile of New Consumers

<i>Indicator Summary</i>
<p>This indicator profiles new mental health consumers (i.e., served during FY, without service for prior six months) overall and full service partners (FSPs) served during FYs 2008-09 and 2009-10.</p>
<i>Indicator Calculation</i>
<ul style="list-style-type: none"><li>• For all mental health consumers, CSI data support calculation of new (i.e., did not receive services for 6 months prior to given FY) versus past consumers (i.e., initial services received prior to the given FY) overall and within race/ethnicity, age, and gender categories. The frequency of new consumers served was divided by all previous consumers served, in each fiscal year, to calculate the proportion of new consumers served. This same calculation was conducted within each demographic category (race/ethnicity, age, and gender), in each FY (see Figures 6.1 – 6.4 below).</li><li>• For FSPs, DCR data support calculation of new (i.e., did not receive services for 6 months prior to given FY) versus existing (i.e., current Full Service Partners) overall and within race/ethnicity, age, and gender categories. The frequency of new consumers served was divided by all existing consumers, in each fiscal year, to calculate the proportion of new consumers served. This same calculation was conducted within each demographic category (race/ethnicity, age, and gender), in each FY (see Figures 6.5 – 6.8, below).</li></ul>
<i>Data Sources</i>
<p><i>Client &amp; Service Information (CSI) Data Fields:</i> H-01.0 County / City / Mental Health Plan Submitting Record; H-02.0 County Client Number; C-05.0 Gender; C-09.0 Ethnicity; C-10.0 Race; S-05.0 Mode of Service; S-16.0 From / Entry Date; S-17.0 Through / Exit Date; S-23.0 Date of Service.</p> <p><i>Data Collection and Reporting (DCR) Data Fields:</i> 1.01 Global ID; 1.02 Assessment ID; 1.04 Date Partnership Status Change; 1.05 Partnership Status; 1.07 Age Group; 1.08 Assessment Type; 2.01 CSI Date of Birth; 2.02 Gender; 2.03 CSIRace1; 2.04 CSIRace2; 2.05 CSIRace3; 2.06 CSIRace4; 2.07 CSIRace5; 2.10 CSI Hispanic; 3.01 County ID; 3.05 Partnership Date; 3.06 Assessment Date.</p>
<i>Review of Existing Data</i>
<ul style="list-style-type: none"><li>• Data sources likely to be sustained</li><li>• Data relevant to populations of interest (all consumers and FSPs)</li><li>• Data available across multiple service years</li><li>• Less than 10% missing or unknown values (see Appendix D for details of recoding race/ ethnicity data fields)</li></ul>
<i>Analytic Potential of Indicator</i>
<ul style="list-style-type: none"><li>• Analysis across time possible</li><li>• Analysis among specific service populations possible (e.g., all consumers, FSPs, demographic groups)</li><li>• State- and county-level analysis possible</li></ul>

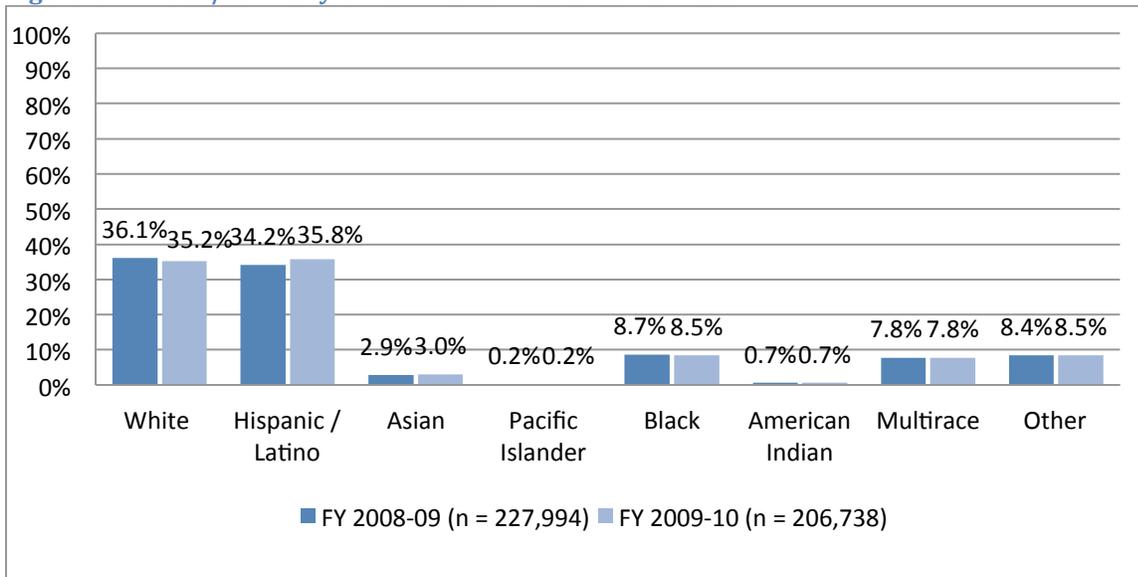
**All Consumers - Data Source: Client & Service Information (CSI)**

Figures 6.1 – 6.4 present new mental health consumers served during FY 2008-09 and 2009-10 overall and by demographic categories. New consumers (i.e., did not receive services for six months prior to given FY) represented a smaller proportion of all consumers served compared to previous consumers (i.e., initiated services prior to given FY), in each FY examined. New white and Hispanic/Latino consumers represented greater proportions of all new consumers served than other racial or ethnic groups in both fiscal years (see Figure 5.1). More new adult consumers were served in each FY compared to other age groups. More new male consumers were served in each FY compared to female consumers.

**Figure 6.1 – New and continuing mental health consumers served**

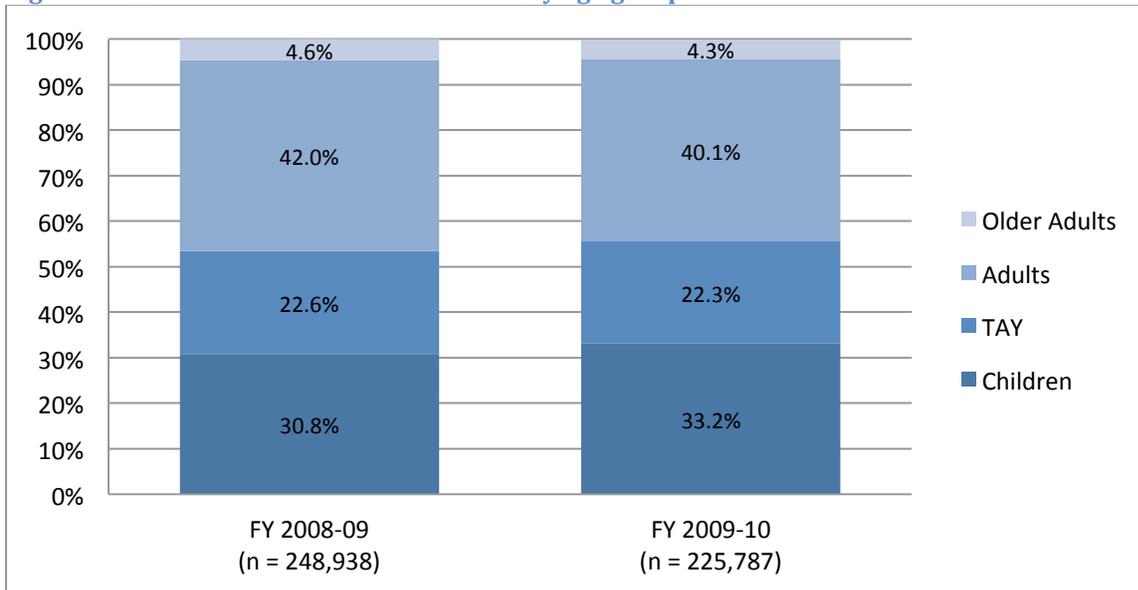


**Figure 6.2 – Race/ethnicity of new mental health consumers**



FY 2008-09 Unknown/Missing: 8.4% (n = 21,034); FY 2009-10 Unknown/Missing: 8.3% (n = 19,159)

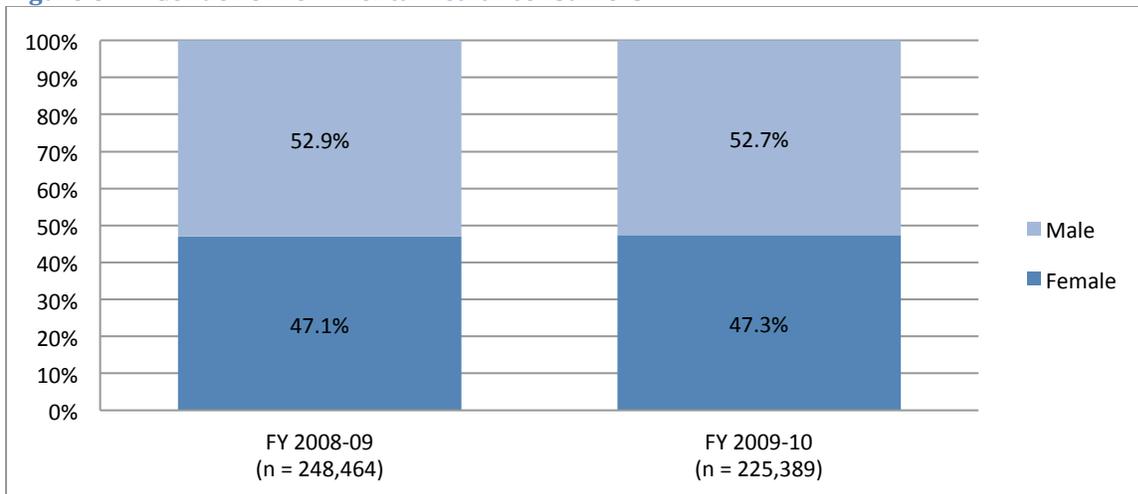
**Figure 6.3 – New mental health consumers by age group**



FY 2008-09 Unknown/Missing 0.0% (n = 90); FY 2009-10 Unknown/Missing 0.0% (n = 110)

Child and TAY consumers represent larger proportions of all new consumers (Figure 6.3) compared to the proportions these age groups represent among all consumers served in each FY analyzed (see Figure 5.3).

**Figure 6.4 – Gender of new mental health consumers**



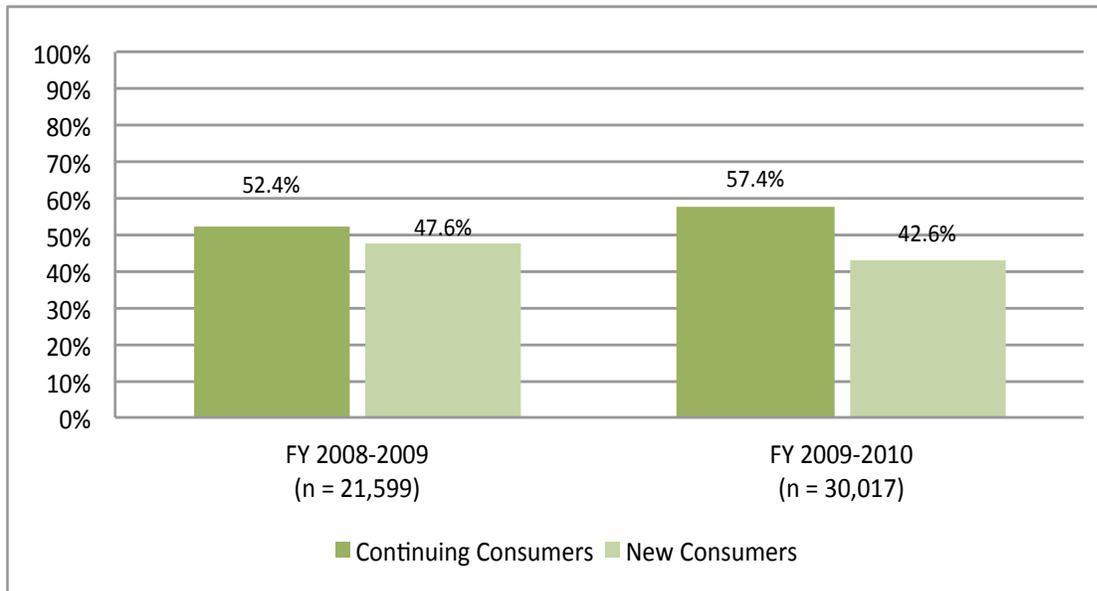
FY 2008-09 Other/Unknown/Missing = 0.2% (n = 564); FY 2009-10 Other/Unknown/Missing = 0.2% (n = 508)

Male consumers represent a larger proportion of all new consumers (Figure 6.4) compared to the proportion males represent among all consumers served in each FY analyzed (see Figure 5.5).

**FSP Consumers – Data Source: Data Collection and Reporting (DCR)**

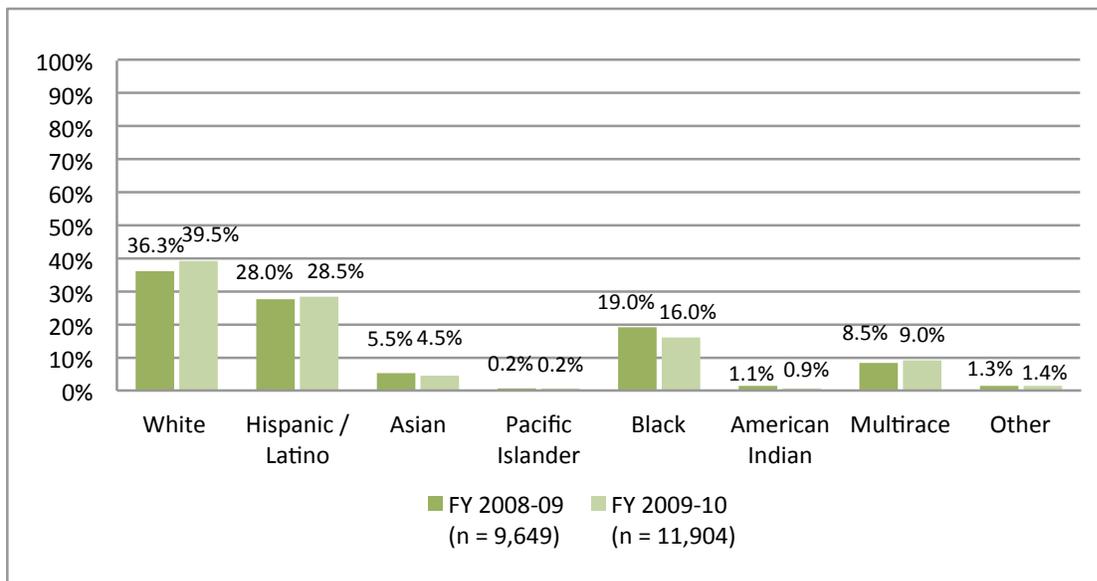
Figures 6.5 – 6.8 present new FSP consumers (i.e., did not receive services for six months prior to given FY) served during FYs 2008-09 and 2009-10 overall and by race/ethnicity, age, and gender categories. New FSPs represented a smaller proportion of all consumers served compared to continuing consumers (i.e., current Full Service Partners), in each FY examined. New white and Hispanic/ Latino consumers represented greater proportions of all new consumers served than any other racial or ethnic groups in both fiscal years examined. More new adult consumers were served in each FY compared to other age groups. More new male consumers were served in each FY compared to female consumers.

**Figure 6.5 – New and continuing FSP consumers served**



FY 2008-09 Unknown/Missing = 5.7% (n = 2,673); FY 2009-10 Unknown/Missing = 14.9% (n = 7,032)

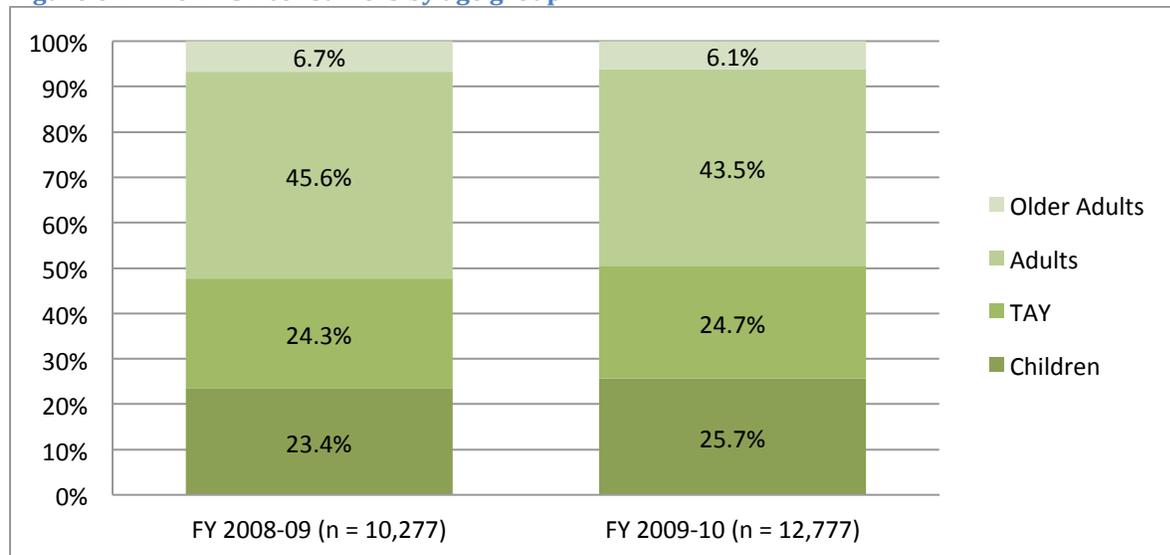
**Figure 6.6 – Race/ethnicity of new FSP consumers**



FY 2008-09 Unknown/Missing = 6.1% (n = 628) FY 2009-10 Unknown/Missing = 6.8% (n = 873)

Hispanic / Latino, American Indian, and multiracial consumers represent a larger proportion of all new consumers (Figure 6.6) compared to the proportions these racial/ethnic groups represent among all consumers served in each FY analyzed (see Figure 5.2).

**Figure 6.7 – New FSP consumers by age group**



Child and TAY consumers together represent larger proportions of all new consumers (Figure 6.7) compared to the proportions these age groups represent among all consumers served in each FY analyzed (see Figure 5.4).

**Figure 6.8 – Gender of new FSP consumers**



FY 2008-09 Other/Unknown/Missing = 3.7% (n = 379); FY 2009-10 Other/Unknown/Missing = 4.6% (n = 593)

In FY 2008-09, female consumers represented a larger proportion of all new consumers (Figure 6.8) compared to the proportion they represented among all consumers served (see Figure 5.6). In

FY 2009-10, male consumers represented a larger proportion of all new consumers (Figure 6.8) compared to the proportion they represented among all consumers served (see Figure 5.6).

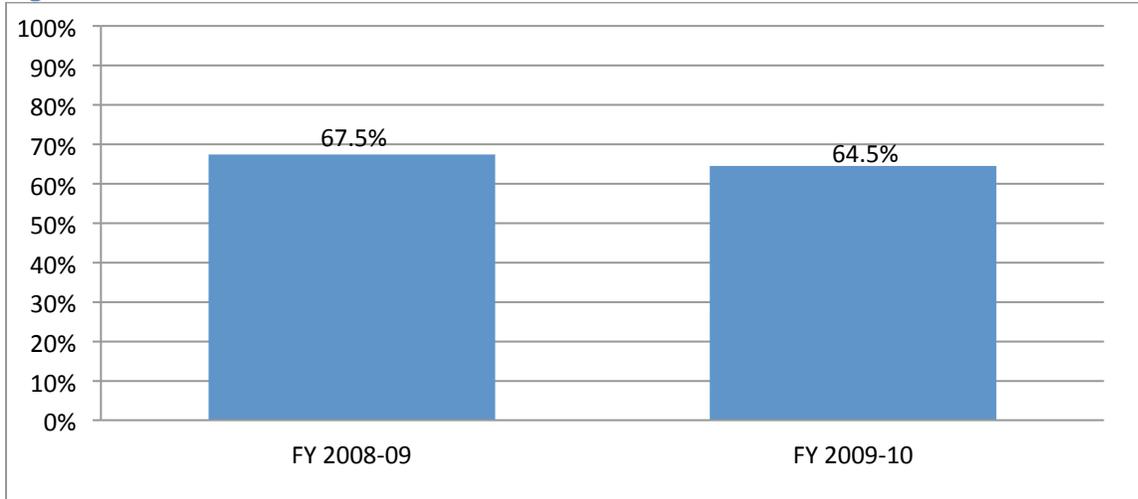
Service levels and demographic characteristics of new mental health consumers served can indicate the changing makeup of the service population and potentially provide insight regarding the extent to which unserved and underserved populations are entering the community mental health system.

## Priority Indicator 7: Penetration of Mental Health Services

<p><b><i>Indicator Summary</i></b></p>
<p>This indicator details rates of service access relative to estimates of need for service among Californians earning less than 200% of the federal poverty income level. This metric is intended to show the extent to which service access is in line with the level of need for services.</p>
<p><b><i>Indicator Calculation</i></b></p>
<p>The number of all mental health consumers served (i.e., at least one service received during FY) was divided by estimates of need for service (Holzer Targets) among Californians earning less than 200% of the federal poverty income level and among demographic category (i.e., race/ethnicity, age, and gender). (See Figures 7.1-7.5 below).</p>
<p><b><i>Data Sources</i></b></p>
<ul style="list-style-type: none"> <li>• <i>Client &amp; Service Information (CSI) Data Fields:</i> H-01.0 County/City/Mental Health Plan Submitting Record; H-02.0 County Client Number; C-05.0 Gender; C-09.0 Ethnicity; C-10.0 Race; S-05.0 Mode of Service; S-16.0 From / Entry Date; S-17.0 Through / Exit Date; S-23.0 Date of Service.</li> <li>• Estimates of need for mental health services (Holzer Targets) among Californians earning less than 200% of the federal poverty income level.</li> </ul>
<p><b><i>Review of Existing Data</i></b></p>
<ul style="list-style-type: none"> <li>• Data sources likely to be sustained</li> <li>• Data appropriate for analysis of all mental health consumers. The estimates of need for service (Holzer Targets) used are not appropriate points of comparison for FSP service levels.</li> <li>• Data available across multiple service years</li> <li>• Less than 10% missing or unknown values (see Appendix D for details of recoding race/ ethnicity data fields)</li> </ul>
<p><b><i>Analytic Potential of Indicator</i></b></p>
<ul style="list-style-type: none"> <li>• Analysis across time possible</li> <li>• Analysis among specific service populations possible (e.g., all consumers, FSPs, demographic groups)</li> <li>• State- and county-level analysis possible</li> </ul>

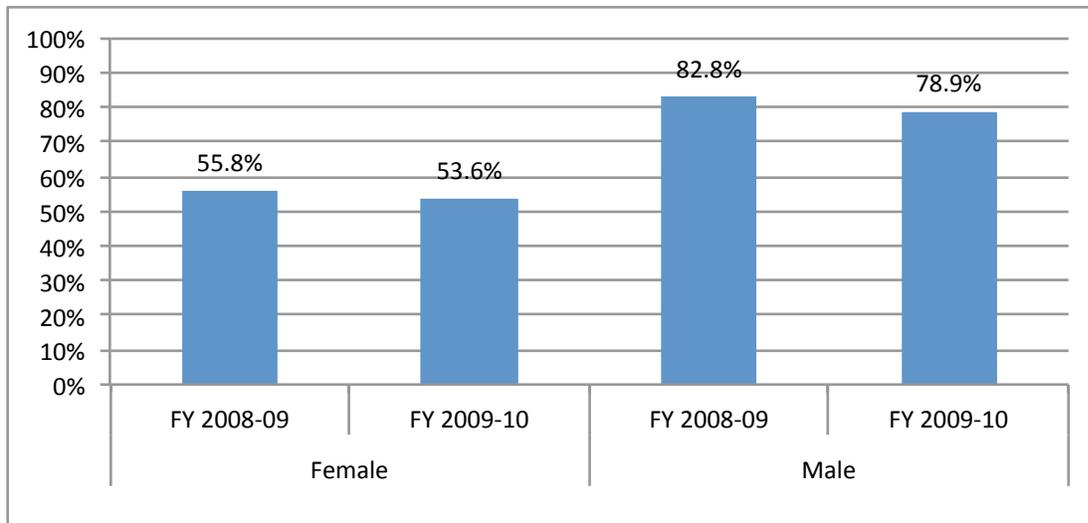
The ratio of consumers served (i.e., at least one service received during FY) to those estimated to be in need of service was lower in FY 2009-10 than in the previous fiscal year (see Figure 7.1). A similar pattern is reflected among female and male consumers (see Figure 7.2).

**Figure 7.1 – Penetration of services**



Consumers Served/Holzer Target	
<b>FY 2008-09</b>	(686,876/1,018,138)
<b>FY 2009-10</b>	(662,409/1,027,663)

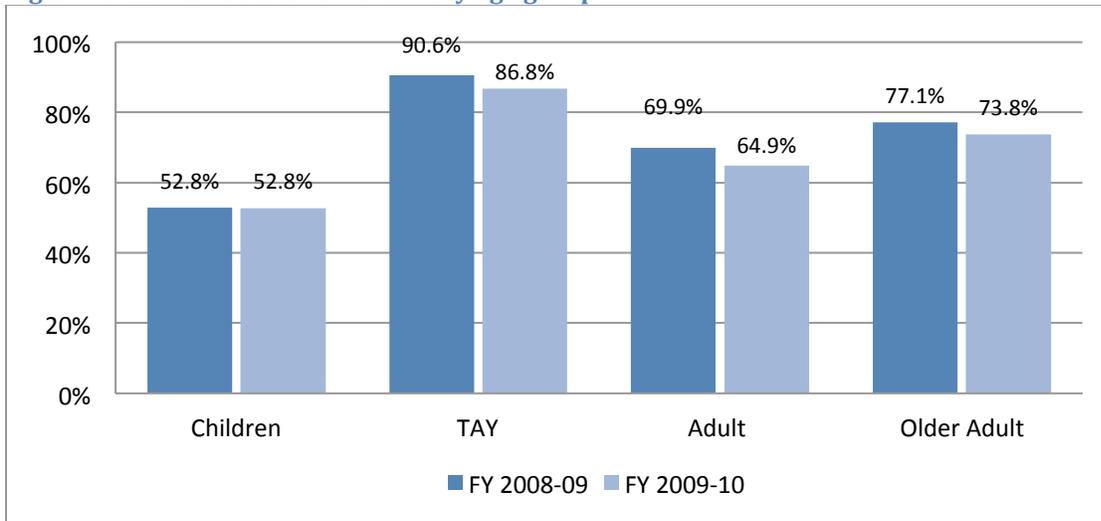
**Figure 7.2 – Penetration of services by gender**



FY 2008-09 Other/Unknown/Missing = 0.3% (*n* = 2,107); FY 2009-10 Other/Unknown/Missing = 0.2% (*n* = 1,174)

	FY 2008-09	FY 2009-10
<b>Female</b>	(326,589/585,467)	(358,180/432,671)
<b>Male</b>	(317,101/591,431)	(344,164/436,233)

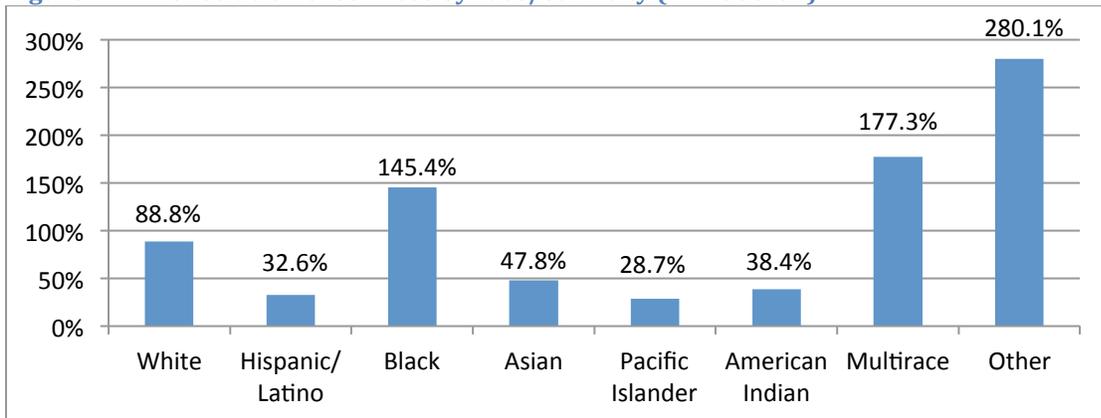
**Figure 7.3 – Penetration of services by age group**



	FY 2008-09	FY 2009-10
<b>Children</b>	(180,184/341,225)	(180,283/341,702)
<b>TAY</b>	(128,066/141,346)	(125,213/144,214)
<b>Adult</b>	(334,916/479,007)	(313,465/483,073)
<b>Older Adult</b>	(43,605/56,559)	(43,287/58,674)

The rate at which consumers were served compared to estimates of need for service was greater among TAY consumers than any other age group in each fiscal year analyzed. A similar pattern is reflected among female and male consumers (see Figure 7.2).

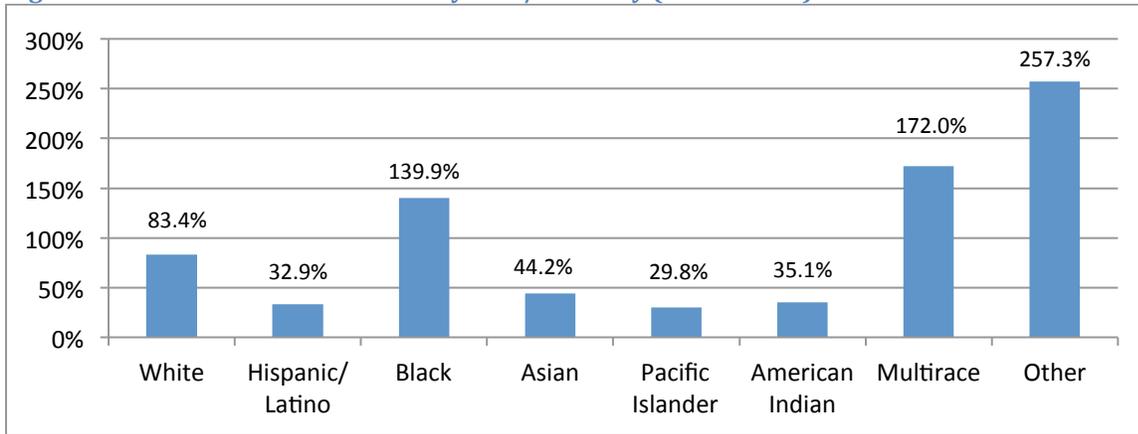
**Figure 7.4 – Penetration of services by race/ethnicity (FY 2008-09)**



FY 2008-09 Unknown/Missing = 7.9% (n = 54,169)

	FY 2008-09	FY 2009-10
<b>White</b>	(246,084/277,091)	(230,147/276,046)
<b>Hispanic/ Latino</b>	(183,432/561,860)	(188,121/571,226)
<b>Black</b>	(113,067/77,784)	(108,649/77,677)
<b>Asian</b>	(28,102/58,804)	(26,340/59,607)
<b>Pacific Islander</b>	(800/2,783)	(849/2,851)
<b>American Indian</b>	(3,806/9,908)	(3,538/10,078)
<b>Multirace</b>	(45,415/25,622)	(44,542/25,893)
<b>Other</b>	(12,001/4,285)	(11,024/4,285)

**Figure 7.5 - Penetration of services by race/ethnicity (FY 2009-10)**



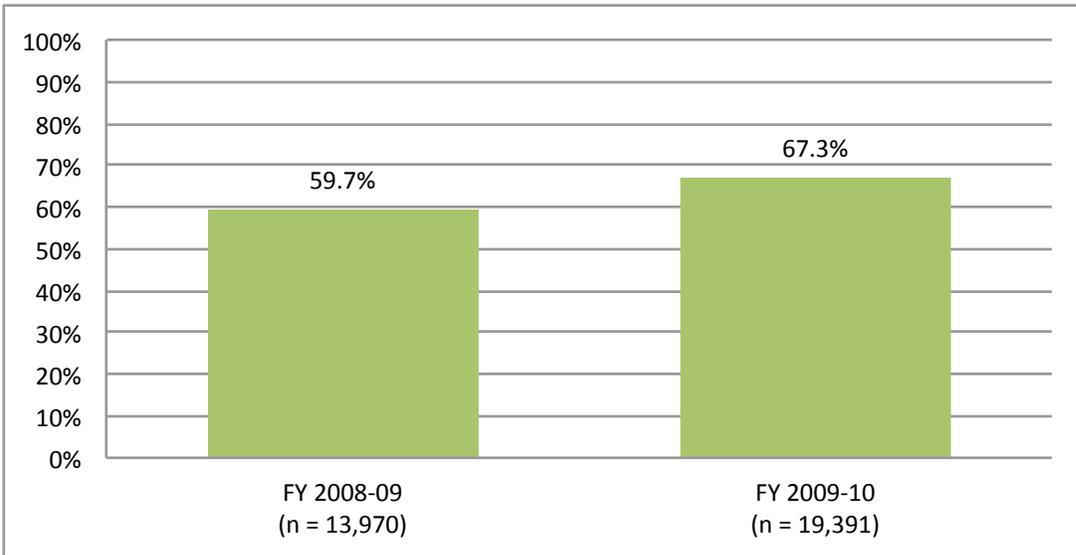
FY 2009-10 Unknown/Missing = 7.4% ( $n = 49,199$ )

Overall, rates of penetration of services were relatively stable across the two fiscal years analyzed. The rate of penetration overall and among demographic groups can provide an indication of the extent to which service levels are in line with the level of need. As estimates of the need for mental health services statewide become more accurate and additional service years are analyzed, this indicator may become more informative for those planning operating and monitoring services.

## Priority Indicator 8: Access to a Primary Care Physician

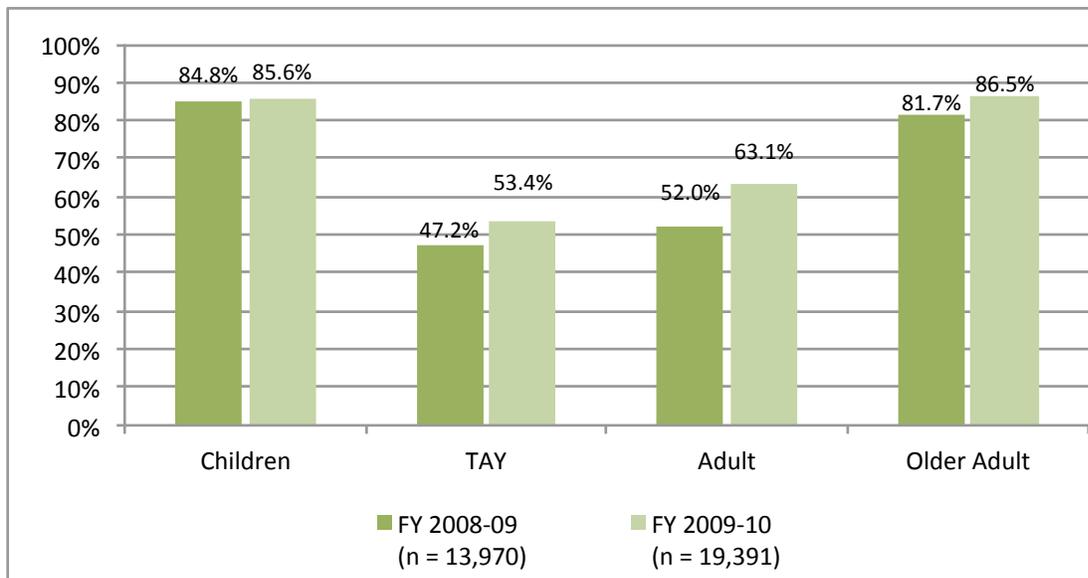
<b><i>Indicator Summary</i></b>
This indicator details the level of access to a primary care physician reported among FSP consumers, during FYs 2008-09 and 2009-10.
<b><i>Indicator Calculation</i></b>
The ratio of FSP consumers indicating access to a primary care physician at any point during a fiscal year to all FSP consumers served during a fiscal year was calculated (see Figure 8.1). This ratio was also calculated within demographic categories (i.e., race/ethnicity, age, and gender) for each FY (see Figures 8.2-8.4 below).
<b><i>Data Sources</i></b>
<i>Data Collection and Reporting (DCR) Data Fields:</i> 1.01 Global ID; 1.02 Assessment ID; 1.04 Date Partnership Status Change; 1.05 Partnership Status; 1.07 Age Group; 1.08 Assessment Type; 2.01 CSI Date of Birth; 2.02 Gender; 2.03 CSIRace1; 2.04 CSIRace2; 2.05 CSIRace3; 2.06 CSIRace4; 2.07 CSIRace5; 2.10 CSI Hispanic; 3.01 County ID; 3.05 Partnership Date; 3.06 Assessment Date; 11.01 PhysicianCurr.
<b><i>Review of Existing Data</i></b>
<ul style="list-style-type: none"><li>• Data source likely to be sustained</li><li>• Data relevant to population of interest (FSPs). Relevant data not available to assess primary care access among all mental health consumers (e.g., CSI).</li><li>• Data available across multiple service years</li><li>• More than 10% missing or unknown values within key DCR fields (see Appendix D for details of recoding race/ethnicity data fields)</li></ul>
<b><i>Analytic Potential of Indicator</i></b>
<ul style="list-style-type: none"><li>• Analysis across time possible</li><li>• Analysis among specific service populations possible (e.g., all consumers, FSPs, demographic groups)</li><li>• State- and county-level analysis possible</li></ul>

**Figure 8.1 – FSP access to a primary care physician**



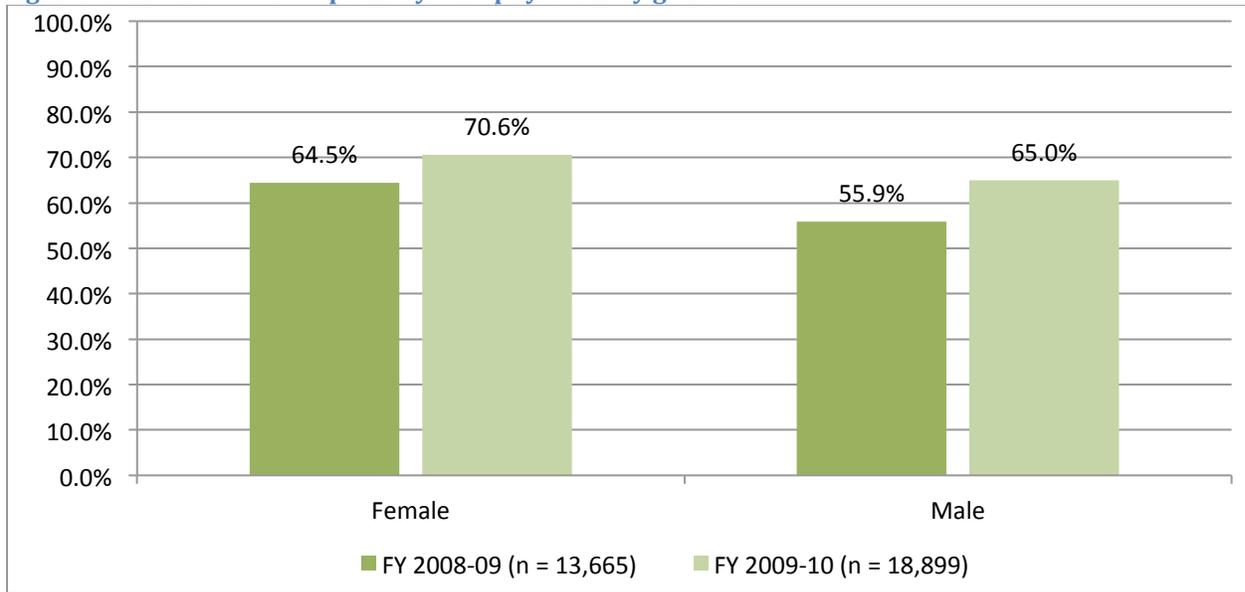
FY 2008 -09 Unknown/Missing = 35.3% (n = 7,629); FY 2009-10 Unknown/Missing = 35.4% (n = 10,626)

**Figure 8.2 – FSP access to a primary care physician by age group**



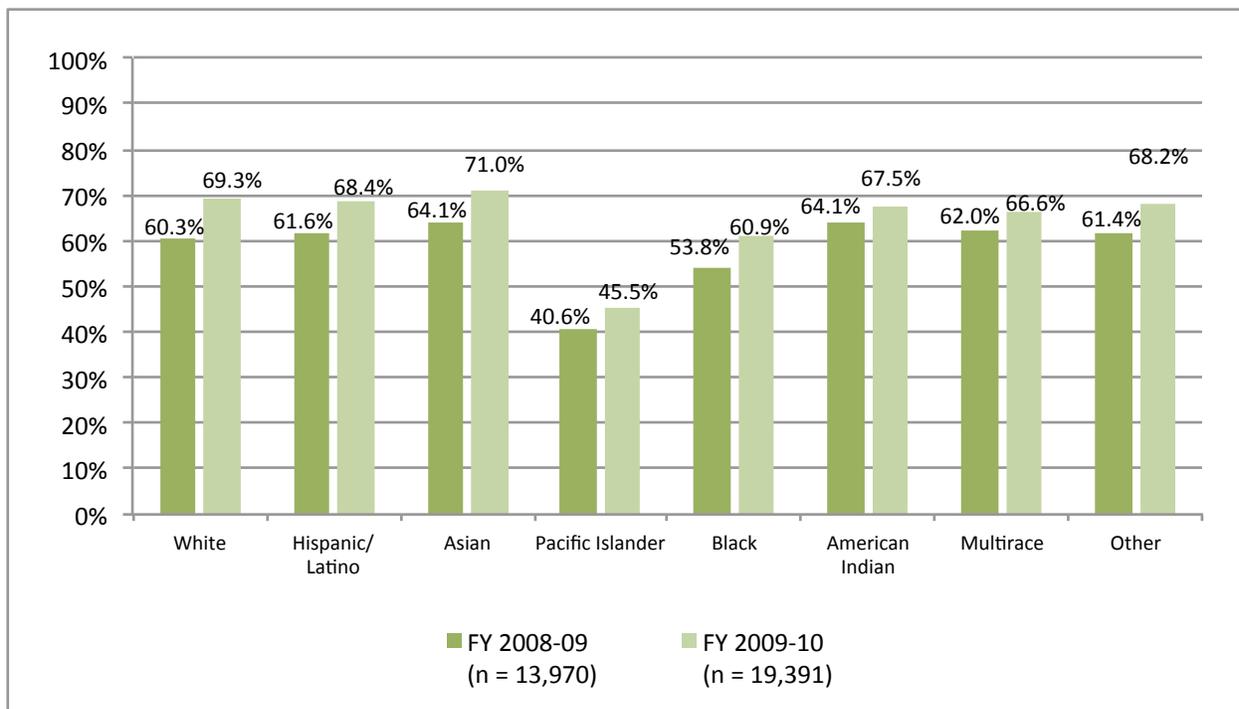
FY 2008 -09 Unknown/Missing: 37.1% (n = 8,016); FY 2009-10 Unknown/Missing 37.5% (n = 11,258)

**Figure 8.3 –FSP access to a primary care physician by gender**



FY 2008 -09 Unknown/Missing: 36.2% (n = 7,810); FY 2009-10 Unknown/Missing: 36.4% (n = 10,931)

**Figure 8.4 – FSP access to a primary care physician by race/ethnicity**



FY 2008-09 Unknown/Missing 36.7% (n = 7,924); FY 2009-10 Unknown/Missing 37.0% (n = 11,112)

Information regarding primary care access overall and among various demographic groups can provide insight into the relative success of FSP programs in connecting consumers to primary health care.

## Priority Indicator 9: Perceptions of Access to Services

### Indicator Summary

This indicator provides insight into consumer and family perceptions of access to mental health services, among a sample of those currently accessing the community mental health system.

### Indicator Calculation

- Family members/caregivers and TAY respondents' ratings (1–*Strongly Disagree* to 5–*Strongly Agree*) of two self-report items (specified in the *Data Sources* section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services (see Figures 9.1-9.2 and Tables 9.1-9.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation method is in line with previous DHCS practices.
- Adult and Older Adult respondents' ratings (1–*Strongly Disagree* to 5–*Strongly Agree*) of 14 self-report items (specified under the *Data Sources* section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services (see Figures 9.1-9.2 and Tables 9.1-9.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation method is in line with previous DHCS practices.

### Data Sources

#### Consumer Perception Surveys

- Family members/caregivers and TAY self-report items analyzed (Youth and Family Member Surveys):
  - The location of services was convenient for us.
  - Services were available at times that were convenient for us.
- Adult and older adult self-report items analyzed (MHSIP):
  - The location of services was convenient (parking, public transportation, distance, etc.).
  - Staff were willing to see me as often as I felt it was necessary.
  - Staff returned my call in 24 hours.
  - Services were available at times that were good for me.
  - I was able to get all the services I thought I needed.
  - I was able to see a psychiatrist when I wanted to.

Note: Data collected in FYs 2008-09 and 2009-10 must be interpreted separately because a convenience sampling method was employed to gather FY 2008-09 data and a random sampling method employed to gather data in FY 2009-10.<sup>8</sup>

### Review of Existing Data

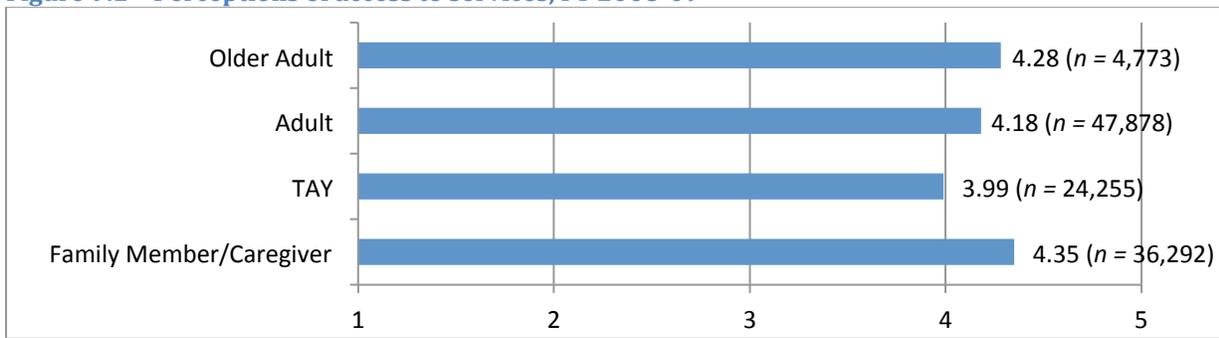
- Data source likely to be sustained
- Data relevant to population of interest (i.e., convenience or random sample of all mental health consumers)
- Data available across multiple service years
- More than 10% missing or unknown values within key CPS scales

### Analytic Potential of Indicator

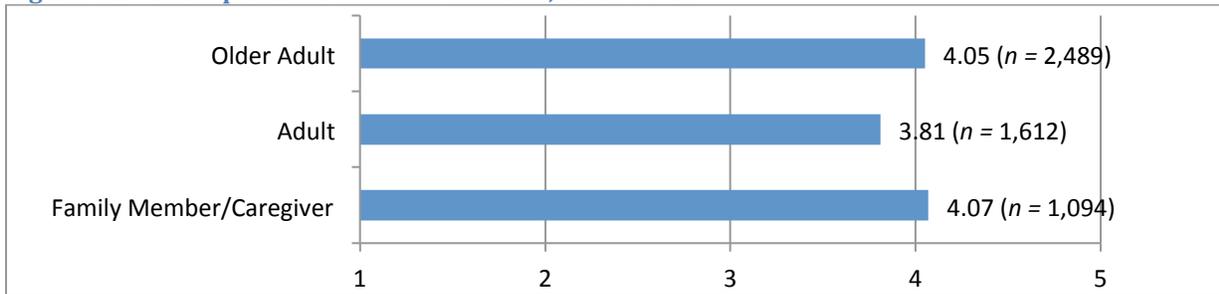
- Analysis across time will be possible if the sampling methodology and instrument used are used consistently each year.
- Analysis among specific service populations possible (e.g., all consumers, demographic groups)
- State and county analysis possible for FY 2008-09 (convenience sample), but only state-level analysis is possible in FY 2009-10 (random sample)

<sup>8</sup> Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.

**Figure 9.1 – Perceptions of access to services, FY 2008-09**



**Figure 9.2 – Perceptions of access to services, FY 2009-10**



**Table 9.1 – Perceptions of access to services by race/ethnicity**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10 <sup>9</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>White</b>	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)
<b>Hispanic / Latino</b>	4.38 (n=17,783)	4.12 (n=490)	4.04 (n=10,708)		4.27 (n=11,400)	3.95 (n=370)	4.44 (n=893)	4.20 (n=414)
<b>Asian</b>	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)
<b>Pacific Islander</b>	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)
<b>Black</b>	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)
<b>American Indian</b>	4.32 (n=1,742)	4.24 (n=69)	4.01 (n=1,748)		4.14 (n=2,634)	3.62 (n=108)	4.26 (n=185)	3.87 (n=114)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 10.9% (n = 4,940), TAY 15.3% (n = 4,740), Adult 19.7% (n = 11,195), Older Adult 22.3% (n = 1,237); FY 2009-10 Unknown/Missing Values: Family Member/Caregiver 6.8% (n = 100), Adult 11.6% (n = 227), Older Adult 14.3% (n = 417)

<sup>9</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10.

**Table 9.2 – Perceptions of access to services by gender**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009- 10 <sup>10</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>Female</b>	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)
<b>Male</b>	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)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 5.9% (n = 2,125), TAY 8.0% (n = 1,933), Adult 13.5% (n = 6,477), Older Adult 14.0% (n = 668); FY 2009-10 Unknown/Missing Values: Family Member/Caregiver 3.8% (n = 42), Adult 2.9% (n = 47), Older Adult 5.3% (n = 132)

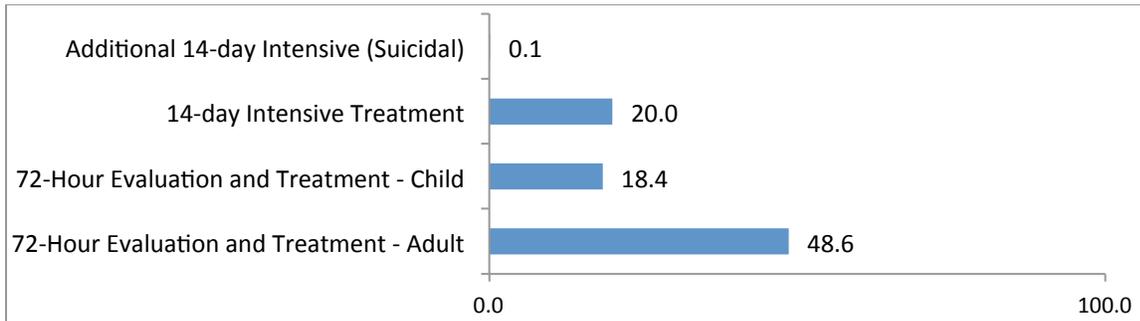
Average ratings among most respondent groups, in both fiscal years analyzed, were greater than 3.5, suggesting positive perceptions of access to services. Such consumer-driven feedback regarding the community mental health system provides vital indication of system performance from those who have received services.

<sup>10</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10.

## Priority Indicator 10: Involuntary Status

<b><i>Indicator Summary</i></b>
This indicator provides insight into the rates of involuntary status among all mental health consumers during FY 2008-09. Involuntary status refers to a legal designation that can be applied to individuals who are found to be a danger to themselves and/or others, and/or gravely disabled.
<b><i>Indicator Calculation</i></b>
The California Department of Health Care Services (DHCS) reports incidents of involuntary status per 10,000 consumers. Such rates are reported here (see Figure 10.1, below).
<b><i>Data Sources</i></b>
The California Department of Health Care Services provides reports of incidents of involuntary status (see <a href="http://www.dmh.ca.gov/statistics_and_data_analysis/Involuntary_Detention.asp">http://www.dmh.ca.gov/statistics_and_data_analysis/Involuntary_Detention.asp</a> )
<b><i>Review of Existing Data</i></b>
<ul style="list-style-type: none"><li>• Data source likely to be sustained</li><li>• Data relevant to population of interest (all mental health consumers). Relevant data are not available to specifically assess involuntary status among FSP consumers.</li><li>• Data available across multiple service years</li></ul>
<b><i>Analytic Potential of Indicator</i></b>
<ul style="list-style-type: none"><li>• Analysis across time will be possible as information from additional fiscal years becomes available from DHCS</li><li>• Aggregate data do not allow for analysis among specific (e.g., demographic) service populations</li><li>• State- and county-level analysis possible</li></ul>

**Figure 10.1 – Involuntary status per 10,000 consumers, FY 2008-09 (NOTE: horizontal scale reduced for ease of viewing)**



This indicator shows the rate at which these legal designations are used. Further disaggregated of involuntary status information (e.g., demographics) can provide an indication of the extent to which these legal status designations may be applied at different rates among various consumer populations.

## Priority Indicator 11: Consumer Perceptions of Improvement in Well-Being as a Result of Services

### Indicator Summary

This indicator provides insight into consumer and family perceptions of well-being (i.e., outcomes, functioning, and social connectedness) as a result of mental health services.

### Indicator Calculation

- Family members/caregivers and TAY respondents' ratings (1–*Strongly Disagree* to 5–*Strongly Agree*) of 11 self-report items (specified in the *Data Sources* section below) were averaged to calculate aggregate ratings of perceptions of well-being as a result of mental health services (see Figures 11.1-11.2 and Tables 11.1-11.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation was developed to approximate domains of well-being many respondents noted in their feedback to our initial reports.
- Adult and older adult respondents' ratings (1–*Strongly Disagree* to 5–*Strongly Agree*) of 14 self-report items (specified in the *Data Sources* section below) were averaged to calculate aggregate ratings of perceptions of well-being as a result of mental health services (see Figures 11.1-11.2 and Tables 11.1-11.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation was developed to approximate domains of well-being many respondents noted in their feedback to our initial reports.

### Data Sources

#### Consumer Perception Surveys

- Family members/caregivers and TAY self-report items analyzed (YSS/YSS-F):
  - My child is better at handling daily life.
  - My child gets along better with family members.
  - My child gets along better with friends and other people.
  - My child is doing better in school and/or work.
  - My child is better able to cope when things go wrong.
  - I am satisfied with our family life right now.
  - My child is better able to do things he or she wants to do.
  - I know people who will listen and understand me when I need to talk.
  - I have people that I am comfortable talking with about my child's problems.
  - In a crisis, I would have the support I need from family or friends.
  - I have people with whom I can do enjoyable things.
- Adult and older adult self-report items analyzed (MHSIP):
  - I deal more effectively with daily problems.
  - I am better able to control my life.
  - I am better able to deal with crisis.
  - I am getting along better with my family.
  - I do better in social situations.
  - I do better in school and/or work.
  - I do things that are more meaningful to me.
  - I am better able to take care of my needs.
  - I am better able to handle things when they go wrong.
  - I am better able to do things that I want to do.
  - I am happy with the friendships I have.
  - I have people with whom I can do enjoyable things.

- I feel I belong in my community.
- In a crisis, I would have the support I need from family or friends.
- Note: Data collected in FYs 2008-09 and 2009-10 must be interpreted separately because a convenience sampling method was employed to gather FY 2008-09 data and a random sampling method employed to gather data in FY 2009-10.<sup>11</sup>

### *Review of Existing Data*

- Data source likely to be sustained (i.e., most items analyzed for this indicator are included in the August 2012 survey administration)
- Data relevant to population of interest (i.e., convenience or random sample of all mental health consumers)
- Data available across multiple service years
- More than 10% missing or unknown values within key CPS scales

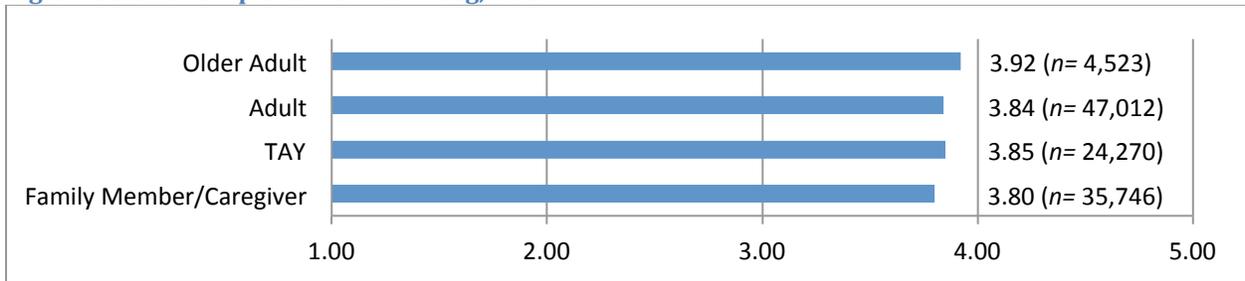
### *Analytic Potential of Indicator*

- Analysis across time will be possible if the sampling methodology and instrument used is employed in a consistent manner each year
- Analysis among specific service populations possible (e.g., all consumers, demographic groups)
- State and county analysis possible for FY 2008-09 (convenience sample), but only state-level analysis is possible in FY 2009-10 (random sample)

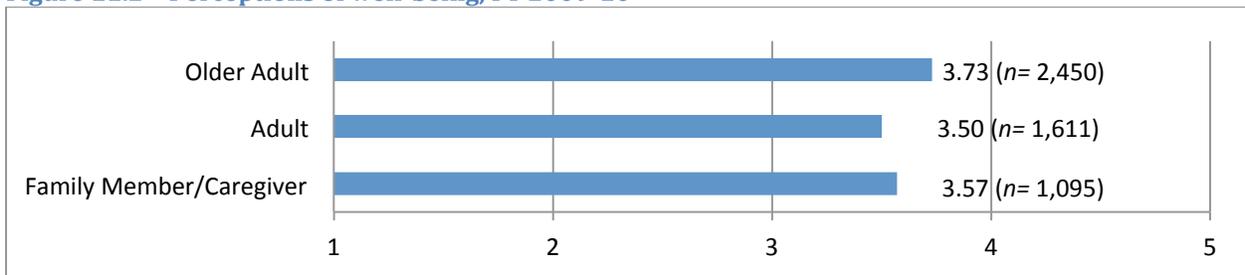
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<sup>11</sup> Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.

**Figure 11.1 – Perceptions of well-being, FY 2008-09**



**Figure 11.2 – Perceptions of well-being, FY 2009-10**



**Table 11.1 – Perceptions of well-being by race/ethnicity**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10 <sup>12</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>White</b>	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)
<b>Hispanic / Latino</b>	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)
<b>Asian</b>	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)
<b>Pacific Islander</b>	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)
<b>Black</b>	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)
<b>American Indian</b>	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)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 12.4% (n=4,852), TAY 15.3% (n=4,753), Adult 18.8% (n=10,528), Older Adult 20.2% (n=1,063); FY 2009-10 Unknown/Missing Values: Family Member / Caregiver 6.7% (n=98), Adult 26.7% (n=631), Older Adult 13.5% (n=390)

<sup>12</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10

**Table 11.2 – Perceptions of well-being by gender**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10 <sup>13</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>Female</b>	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)
<b>Male</b>	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)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 5.8% (n=2,077), TAY 8.0% (n=1,943), Adult 12.3% (n=5,800), Older Adult 11.3% (n=511); FY 2009-10 Unknown/Missing Values: Family Member/Caregiver 3.8% (n=42), Adult 2.7% (n=44), Older Adult 4.3% (n = 106)

Average ratings among most respondent groups in both fiscal years analyzed were greater than 3.5, suggesting positive perceptions of well-being as a result of services received. Such consumer-driven feedback regarding the community mental health system provides a vital indication of system performance from those who have received services.

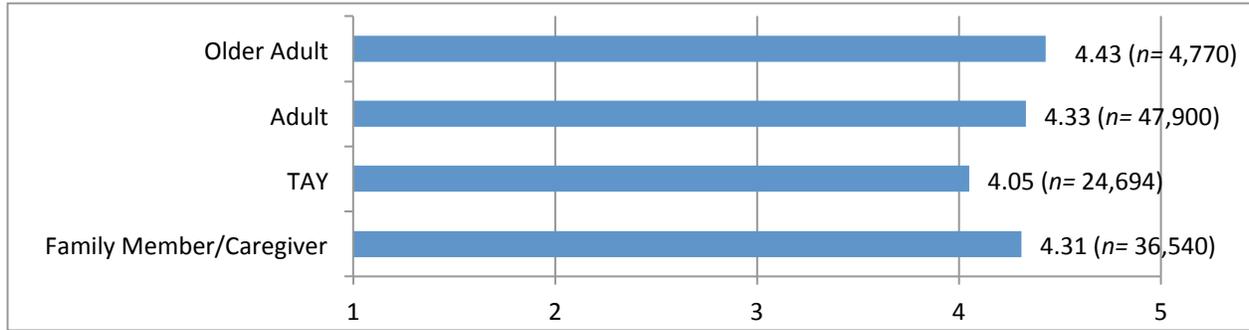
<sup>13</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10.

## Priority Indicator 12: Satisfaction With Services

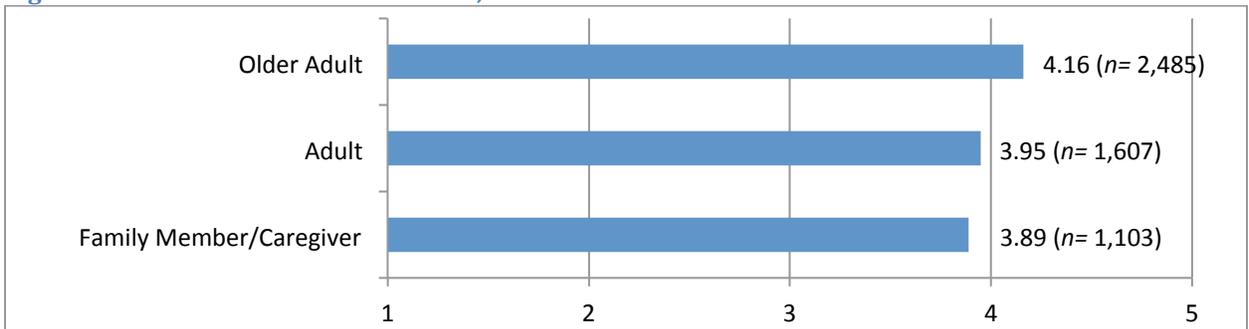
<i>Indicator Summary</i>
This indicator provides insight into consumer and family perceptions of satisfaction with mental health services.
<i>Indicator Calculation</i>
<ul style="list-style-type: none"><li>Family members/caregivers and TAY respondents' ratings (1–<i>Strongly Disagree</i> to 5–<i>Strongly Agree</i>) of two self-report items (specified in the <i>Data Sources</i> section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services (see Figures 12.1-12.2 and Tables 12.1-12.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation method is in line with previous DHCS practices.</li><li>Adult and older adult respondents' ratings (1–<i>Strongly Disagree</i> to 5–<i>Strongly Agree</i>) of 14 self-report items (specified in the <i>Data Sources</i> section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services (see Figures 12.1-12.2 and Tables 12.1-12.2 below). Aggregate ratings were calculated for each fiscal year. Ratings of 3.5 or greater generally indicate positive perceptions. This calculation method is in line with previous DHCS practices.</li></ul>
<i>Data Sources</i>
<p><i>Consumer Perception Surveys</i></p> <ul style="list-style-type: none"><li>Family members/caregivers and TAY self-report items analyzed (YSS/YSS-F):<ul style="list-style-type: none"><li>Overall, I am satisfied with the services my child received.</li><li>The people helping my child stuck with us no matter what.</li><li>I felt my child had someone to talk to when he/she was troubled.</li><li>The services my child and/or family received were right for us.</li><li>My family got the help we wanted for my child.</li><li>My family got as much help as we needed for my child.</li></ul></li><li>Adult and older adult self-report items analyzed (MHSIP):<ul style="list-style-type: none"><li>I like the services that I received here.</li><li>If I had other choices, I would still get services from this agency.</li><li>I would recommend this agency to a friend or family member.</li></ul></li><li>Note: Data collected in FY 2008-09 and 2009-10 must be interpreted separately because a convenience sampling method was used to gather FY 2008-09 data and random sampling was used to gather data in FY 2009-10.<sup>14</sup></li></ul>
<i>Review of Existing Data</i>
<ul style="list-style-type: none"><li>Data source likely to be sustained</li><li>Data relevant to population of interest (i.e., convenience or random sample of all mental health consumers)</li><li>Data available across multiple service years</li><li>More than 10% missing or unknown values within key CPS scales</li></ul>
<i>Analytic Potential of Indicator</i>
<ul style="list-style-type: none"><li>Analysis across time possible if the sampling methodology and instrument used is consistent each year</li><li>Analysis among specific service populations possible (e.g., all consumers, demographic groups)</li><li>State and county analysis possible for FY 2008-09 (convenience sample), but only state-level analysis is possible in FY 2009-10 (random sample)</li></ul>

<sup>14</sup> Cowles, E. L., Harris, K., Larsen, C., and Prince, A. (2010). *Assessing Representativeness of the Mental Health Services Consumer Perception Survey*.

**Figure 12.1 – Satisfaction with services, FY 2008-09**



**Figure 12.2 – Satisfaction with services, FY 2009-10**



**Table 12.1 – Satisfaction with services by race/ethnicity**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10 <sup>15</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>White</b>	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)
<b>Hispanic / Latino</b>	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)
<b>Asian</b>	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)
<b>Pacific Islander</b>	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)
<b>Black</b>	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)
<b>American Indian</b>	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)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 11.2% (n=5,109), TAY 15.9% (n=5,012), Adult 19.8% (n=11,262), Older Adult 22.5% (n=1,247); FY 2009-10 Unknown/Missing Values: Family Member/Caregiver 6.9% (n=102), Adult 11.8% (n=230), Older Adult 14.4% (n=420)

<sup>15</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10.

**Table 12.2 – Satisfaction with services by gender**

	Family Member/ Caregiver of Children and/or TAY		TAY		Adult		Older Adult	
	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10 <sup>16</sup>	FY 2008-09	FY 2009-10	FY 2008-09	FY 2009-10
<b>Female</b>	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)
<b>Male</b>	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)

FY 2008-09 Unknown/Missing Values: Family Member/Caregiver 6.2% (n=2,282), TAY 8.6% (n=2,134), Adult 13.7% (n=6,552), Older Adult 14.1% (n=672); FY 2009-10 Unknown/Missing Values: Family Member/Caregiver 4.0% (n=44), Adult 3.0% (n=48), Older Adult 5.4% (n=134)

Average ratings among most respondent groups, in both fiscal years analyzed, were greater than 3.5, suggesting positive perceptions of satisfaction with services. Such consumer-driven feedback regarding the community mental health system provides a vital indication of system performance from those who have received services.

<sup>16</sup> Consumer Perception Surveys were not completed by youth during FY 2009-10.

## Discussion: Community Mental Health System Indicators

This report represents an important step toward refining priority performance indicators of the community mental health system. System indicators were designed to provide a multidimensional understanding of how the mental health system overall, and Full Service Partnerships specifically, are serving consumers and their families, providers, and other stakeholders. The system indicator results presented in this report suggest several conclusions and implications regarding the reliability, diagnostic utility, and sustainability of each indicator.

**Demographic Profile of Consumers Served** – This indicator provides important understanding of the extent to which the community mental health system statewide is serving various populations, including racially and ethnically diverse and other traditionally underserved or unserved groups. However, the two fiscal years presented in this report represent only a snapshot of mental health service populations. Additionally, this indicator must be interpreted carefully because of data inconsistencies across years and among counties that were noted by stakeholders and seen during the data quality review. Further analysis of service information from additional fiscal years will provide greater insight concerning the changing demographic composition of the mental health service population.

**New Consumers** – This indicator summarizes who new mental health consumers are, and when considered relative to all consumers can provide insight regarding changes in the composition of service populations. It will provide greater understanding of the direction and magnitude of changes in the composition of service populations as information from additional service years is analyzed.

**Penetration of Mental Health Services** – This indicator estimates the extent to which mental health services are reaching those in need and is 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 (e.g., National Comorbidity Survey or California Health Information Survey), the rate of penetration of services will become more reliable and instructive. Additionally, analysis of penetration rates over longer periods can provide insight regarding changes in the extent to which services are reaching those in need.

**Access to a Primary Care Physician** – This indicator provides insight into the extent to which consumers are connected with a key point of access to physical health care. More complete and regular tracking of this factor among FSP consumers, and initiating tracking of this factor among all mental health consumers, will improve the diagnostic potential of this indicator.

**Perceptions of Access to Services** – This indicator provides important insight regarding perceptions of access to services among those who have received services. Ratings suggest that on average, consumers held positive perceptions of their access to mental health services. As noted previously, concerns regarding the sampling methods used to collect consumer perception information reduce confidence in the representative nature of this data and do not allow for reliable comparisons across the two fiscal years analyzed. Implementation of a sampling methodology that can produce information that is representative of consumer perceptions statewide and in each county will improve the accuracy and explanatory potential of this indicator.

**Involuntary Status** – Investigations of involuntary status patterns over time are necessary to provide a fuller picture of their use. The aggregate involuntary status information available from

DHCS does not allow for a statistical breakdown among specific populations (e.g., FSPs). However, this indicator has the potential to monitor the use of this legal status designation.

**Consumer Well-Being** – This indicator provides important insight regarding consumer perceptions of well-being as a result of services (i.e., outcomes, functioning, social connections) among those who engaged the mental health service system. Ratings indicate that on average during FY 2008-09 and 2009-10, consumers and family members held positive perceptions of improvements in their well-being as a result of the services. These perceptions provide another indication of the quality and appropriateness of the care consumers receive.

**Satisfaction** – This indicator provides important insight regarding service satisfaction among those who engaged the mental health service system. Ratings suggest that on average, consumers and family members were generally satisfied with the services they received. This indicator provides another important signal of service quality and offers a counterpoint to system indicators that are not consumer-driven.

### *System Indicator Conclusions and Future Directions*

The system-level priority indicators presented in this report provide a multidimensional assessment of community mental health service system access, performance, and quality. Analyses presented and discussed provide greater understanding of the feasibility, reliability, and information potential of system indicators going forward, built upon existing data systems and sources. However, stakeholder feedback to previous evaluation team reports (see the *Previous work of the UCLA-EMT Evaluation Team leading to this report* section above) and the present evaluation of system indicators suggests additional performance guides may provide more comprehensive monitoring of the mental health system.

Several additional indicators were suggested by stakeholders and explored by the evaluation team but were not included in this report due to their tentative underlying data, calculations, and format. Exploratory system indicators that may prove informative in the future include:

- Recovery orientation – intended to monitor the extent to which community mental health systems are structured around providing services focused on the ongoing recovery of the consumer. Sufficient data are not available to create such an indicator.
- Evidence-based practices and programs – intended to monitor the extent to which such proven services are used throughout the community mental health system. Relevant data collected through existing systems (e.g., CSI) are incomplete or unreliable and cannot support such an indicator as currently reported.

Several other indicators were also explored but will not be included in formal reporting until sufficient data exist to accurately and reliably sustain additional monitoring tools and the MHSOAC approves additional indicators as part of its ongoing oversight process.

Overall, system indicators evaluated in the present report were found to be informative regarding the performance of community mental health systems. However, several indicators were also found to require additional development or supporting information. As such, this report represents an important initial step, necessary to arrive at a more focused, reliable, and instructive mental health performance monitoring system.

## 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. Feedback about an earlier version of this document was collected in the following ways:

1. During report development, research analysts interpreted and provided historical context about statewide data (CSI, DCR, CPS).
2. During report development, representatives from California State University, Sacramento, provided insights about data quality based on their ongoing efforts to evaluate a different facet of the MHSA.
3. During report development, representatives from California counties provided feedback about the accuracy of data to be included in priority indicator calculations.
4. Stakeholders and the general public were invited to comment on a report draft made available online (at UCLA and MHSOAC websites) and through two webinars that offered a forum for stakeholders to comment and assist the evaluation team in improving the report.
5. Consumer stakeholders reviewed key report excerpts for accessibility during a facilitated webinar.

Stakeholder feedback received through process #4 is summarized in Appendix F, and feedback from all five processes is noted throughout the report where possible. Stakeholder insights are treated as an integral part of the conversation about priority indicators. Such feedback will continue to be required in subsequent reports to involve all interested persons in improving the quality of mental health services.

For the present report, consumers were invited to participate in a series of focus groups to clarify particular features, including language, displays, and report organization. The goal of such work was to ensure the document's accessibility to a wide range of stakeholders, including those with limited understanding of statistics and methods.

## Next Steps

The evaluation team will move forward with developing new state- and county-level reports using the priority indicators summarized here. Reports will present 1) priority indicators that are refined based on stakeholder feedback and MHSOAC guidance, 2) analyses of the most recent data available, and 3) lessons learned from this initial report. These reports are scheduled for release during March 2013. The MHSOAC will simultaneously vet the appropriateness of the first proposed indicator set and additional indicators proposed by stakeholders. The MHSOAC will make all final decisions about priority indicators, their definitions, and their computation.

## Appendix A – California Mental Health Planning Council’s Proposed Indicators and Definitions

### Matrix of California’s Public Mental Health System Prioritized Performance Indicators

To Begin Implementation of California Mental Health Planning Council’s Approved Performance Indicators

Type of Indicator	DOMAIN			
	Age Group	Education/Employment	Homelessness/Housing	Justice Involvement
<b>Individual Client Outcomes* (for Full Service Partnerships)</b>	Children	Indicator #2: Average Attendance—Score per year	Indicator #1: Housing Situation/Index--Score	Indicator #1: Number of Arrests
	TAY	Indicator # 8: Under 18 years—Average Attendance--Score per year 18+ --Proportion participating in paid and unpaid employment*	Indicator #7: Housing Situation/Index--Score	Indicator #7: Number of Arrests
	Adults	Indicator #13: Proportion participating in paid and unpaid employment*	Indicator #12: Housing Situation/Index--Score	Indicator #12: Number of Arrests
	Older Adults	Indicator #13: Proportion participating in paid and unpaid employment* (Explore feasibility of Indicator #20--Instrumental Activities of Daily Living)	Indicator #17: Housing Situation/Index--Score	Indicator #17: Number of Arrests
<b>County Mental Health System Performance</b>	Indicators #5, 6, 11, 16, 21: Family/Youth/Client Perception of Well-Being Indicator # 30: Age, Gender, Race/Ethnicity of entire FSP population Indicator # 31: Access of FSPs to Primary Care Physician Indicator # 33: Penetration Rate → 03/04 and 06/07 data already provided from CSI Indicator # 34: New Clients by county by age, gender, race ethnicity for FY 04/05 and FY 07/08 from CSI. (New clients are those without service for prior 6 months.) Indicator # 35 or # 37: Involuntary Care—3 day and 14 day commitments Indicator # 43: Annual Numbers Served through CSS from Exhibit 6 of FSPs, General System Development and Outreach/Engagement. Workforce Indicators #s 45 & 46: To Be Requested for the Development of Five-Year Plan			
<b>Community Indicators</b>	None At This Time			

Frequency of Data Request: Individual: Baseline and Annual Data (Y1, Y2, etc.); System: Annually Beginning 04/05; Begin with statewide and regional reports; then produce county specific reports.

\* Participation in Education not available.

*This Matrix contains selected indicators from the "California Mental Health Planning Council's Performance Indicator Proposal for the Mental Health Services Act, September 2009"*

## Appendix B – Priority Indicator Updates

Decisions made about previously proposed indicators, based on data limitations. (Strikethrough specifies indicators not previously approved by the MHSOAC)

CONSUMER INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	CHANGE FROM INITIAL 2F DRAFT REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS CONTRACT DELIVERABLE 2F, PHASE II
<i>Indicator 1.1. School Attendance (Expulsions and suspensions)</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. School Attendance (Rate of attendance compared to previous year)</i>	DCR		Total # of youth reporting that they attended school “always” and “most of the time” suggested by MHSOAC ad-hoc committee
<i>Indicator 2. Proportion participating in paid and unpaid employment</i>	DCR	Total # of employed-paid consumers by total # of work-eligible FSP consumers  Total # of employed-unpaid consumers by total # of work-eligible FSP consumers	No change
<i>Indicator 3. Proportion homeless annually; Proportion housed (not homeless) annually</i>	CSI; DCR	Total # of children, TAY, adults, or older adults (all consumers and FSP consumers) homeless or housed during the FY by total # of consumers	This is a version of Recommended Ratio 5 in 2D. While housed/not homeless responses were regularly reported, days homeless were inconsistently tracked in data.
<i>Indicator 4. Arrest rate</i>	CPS; DCR	Total # of arrests per total # of unique consumers  Total # of arrests (jail time) per total # of unique FSP consumers	No change. This is Recommended Ratio 2 in 2D.  This is a version of Recommended Ratio 2 in 2D.
<i>Proportion incarcerated</i>	CSI; DCR		<del>New data collection was proposed, thus this has been removed from the report.</del>
<i>Emergency intervention for mental health episodes</i>	CSI	Total # of hospitalizations per total # of unique mental health consumers	<del>This is a version of Recommended Ratio 1. Total number of hospital visits is unavailable in datasets. The denominator was changed.</del>
<i>Emergency intervention for co-occurring physical injury</i>			<del>New data collection was proposed, thus this indicator is not included in the report.</del>
<i>Proportion who identify family support</i>			<del>New data collection was proposed, thus this has been removed from the report.</del>

CONSUMER INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	CHANGE FROM INITIAL 2F DRAFT REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS CONTRACT DELIVERABLE 2F, PHASE II
<i>Proportion who identify community support</i>			<del>New data collection was proposed, thus this has been removed from the report.</del>

SYSTEM INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	CHANGE FROM INITIAL 2F DRAFT REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS CONTRACT DELIVERABLE 2F, PHASE II
<i>Indicator 5. 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. 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
<i>Indicator 7. 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 & 200% of poverty level)	Estimate of need revised to focus on individuals living within 200% of the federal poverty line.
<del><i>High need consumers served</i></del>			Indicator removed due to redundancy with Consumer Indicators.
<i>Indicator 8. Access to Primary Care Physician</i>	DCR	% of FSP consumers indicating access to a primary care physician	No Change
<i>Indicator 9. Perceptions of Access to Services</i>	CPS	Mean aggregate ratings of consumer perception of access to services	No Change
<i>FSP Consumers Served</i>	DCR; County Plans / Annual Updates	Ratio of FSP consumers served to planned service levels	<ul style="list-style-type: none"> <li>Formerly titled “Consumers Served Annually through CSS”. Title changed for accuracy/specificity of data available.</li> <li>CSS Exhibit 6 data was reported to be unreliable by many experts and stakeholders. So, service levels planned by counties were used as the denominator for this indicator calculation.</li> </ul>

SYSTEM INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	CHANGE FROM INITIAL 2F DRAFT REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS CONTRACT DELIVERABLE 2F, PHASE II
<i>Indicator 10. Involuntary Status</i>	California DMH Reports of Involuntary Status	Rate of involuntary services per 10,000 served.	<ul style="list-style-type: none"> <li>Involuntary Status information only available from DHCS through FY 2008-09, thus 2009-10 is not available as of the preparation of this report</li> <li>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.</li> </ul>
<del>24-hour care</del>	CSI; DCR	% of Overall and FSP consumers who received 24-hr services	No Change
<del>Consumer and Family Centered Care</del>	CPS	Mean aggregate ratings of consumer/family centered care	Formerly titled “Appropriateness of Care”. Title changed for accuracy/specificity of data available.
<del>Integrated Service Delivery</del>	County Plans / Annual Updates	Prevalence of planned county strategies for achieving integrated service delivery.	<ul style="list-style-type: none"> <li>Formerly titled “Continuity of Care”. Title changed in response to expert/stakeholder feedback and for accuracy/specificity of data available.</li> <li>CSI and DCR data fields proposed for analysis in Deliverable 2D were found incomplete and unreliable. As Integrated Service Delivery is an MHA service goal, county plans were systematically coded to assess the prevalence of county strategies for achieving integrated service delivery.</li> </ul>
<i>Indicator 11. Consumer wellbeing</i>	CPS	Aggregate mean consumer/family ratings of wellbeing	No Change
<i>Indicator 12. Satisfaction</i>	CPS	Aggregate mean consumer/family ratings of satisfaction with services	No Change
<del>Workforce composition</del>			Indicator removed due to redundancy with the work of other contractors (per MHAOC request).
<del>Evidence-based Practice Programs</del>	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.
<del>Cultural Appropriateness of Services</del>	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.

SYSTEM INDICATORS	DATA SOURCE(S)	INDICATOR CALCULATION	CHANGE FROM INITIAL 2F DRAFT REPORT – MENTAL HEALTH SERVICES ACT EVALUATION: COMPILING DATA TO PRODUCE ALL PRIORITY INDICATORS CONTRACT DELIVERABLE 2F, PHASE II
<i>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 C – Stakeholder (Consumer/Client) Webinar Feedback

Notes from September 17, 2012

Green font indicates suggestions that were incorporated into the report.

### Regarding the Executive Summary

p. 1

- The term consumer/client might be considered
- The term "efficacy" could be difficult for readers to understand. Perhaps stick with the term "use."
- "Actionable" could be difficult for readers to understand. Does this really mean "system improvement?"
- Is there a term or punctuation missing in the phrase consumer and system level priority indicators?
- It is easier to understand "use" rather than "utility."
- Instead of "lack," can the phrase "hasn't yet been developed for statistical and practical use" be used?

p.2

- Can we include "volunteer contribution" when discussing employment? It could be a parenthetical like "employment (including volunteer contribution)"
- Spell out FSP if this is the first time it is mentioned in the report.
- The sentence that begins with "Overall, employment data" is confusing.
- Spell out CSI if this is the first time it is mentioned in the report.

p. 3

- The sentence that begins "Rates of Involuntary Status seem to suggest" is confusing.
- Adding examples following the sentences that begin with "Perceptions of consumer wellbeing" and "Consumer perceptions of satisfaction" would be helpful.
- In the third point within the conclusion section, changing "may" to "can" could leave the door open to future changes.

### Regarding Priority Indicator Description

- Consider using the term consumer/client

### Regarding Priority Indicator Cover (Summary) Page

- "Frequency of Arrest" carries a stigma. Can we say "reducing recidivism?"
- CPS also stands for Child Protection Services. Is there a way to change its appearance when differentiating between Youth, Youth-Family, Adult, and Older Adult Forms?
- Can ethnicity be included in the arrest breakdown? If not, can the presence of analysis by ethnicity be noted in the indicator section?

### **Regarding Housing Indicator Graphs**

- Some people will need "n" defined as a sample number. Maybe this should be attached to each chart like a key.
- Green shades are very close and need more distinction.

### **Regarding One Full Indicator Section (Satisfaction)**

- The references to figures and tables in one description are heavy. Can you say "see charted data below?"
- "n =" is missing from this page.
- Table 12.2 - Where are transgender respondents? Can you add a note that there is no transgender category to choose?

### **Other Discussion Topics**

- What is the importance of including Missing/Unknown values?
- In the tables, please note that Family Member/Caregiver refers to children and TAY.
- Race and ethnicity need to be peeled farther so that services can be fine-tuned (e.g., who is in the White race and how can services accommodate those ethnic groups?).
- "Lived experience" will need to be explained. You might get different responses from people based on their length of LE and/or their cultures.

## Appendix D – Recoding Pre-DIG Race Data to Post-DIG Format

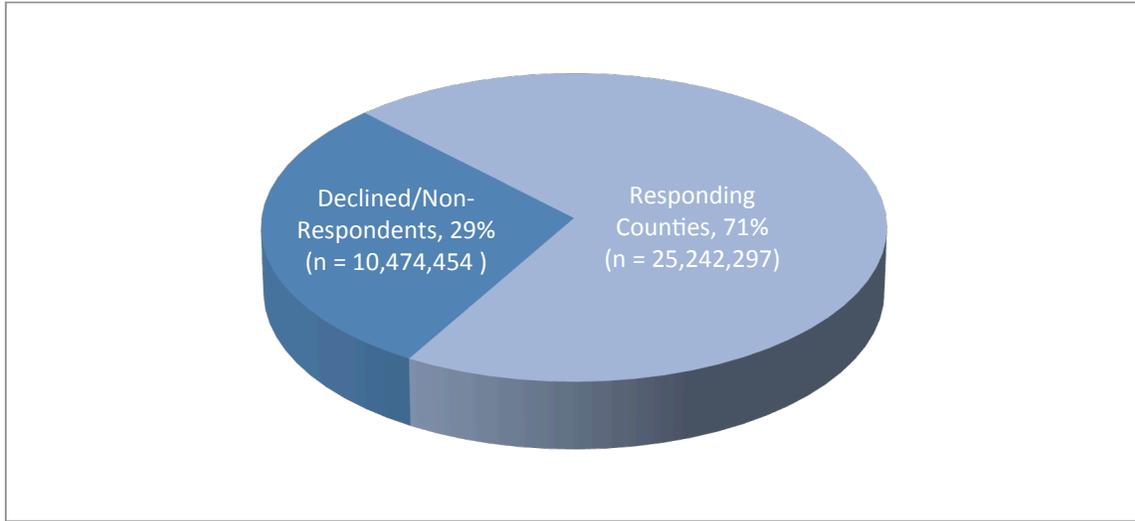
Stakeholder feedback to previous evaluation team reports suggested inconsistency and potential inaccuracy among Race and Ethnicity data fields may be due in part to changes in the format of these fields in the CSI and DCR data systems. In 2006, DMH implemented changes to the Race and Ethnicity fields due to Uniform Data System/Data Infrastructure Grant (DIG) requirements from the federal government (see *DMH Information Notice: 06-02*). Although DMH provided training about these changes, Race and Ethnicity information seems to be reported inconsistently across counties. 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 ameliorate potential shortcomings of this change, the evaluation team used pre-DIG information to fill gaps in missing post-DIG Race and Ethnicity fields for analyses involving demographic information. The table below details the recoding process.

Before Recode			After Recode (if Post-DIG field empty)		
Pre-DIG Field	Definition	Data Value	Post-DIG Field	Definition	Data Value
Empty formerly Ethnicity / Race	White	1	Race	White or Caucasian	1
Empty formerly Ethnicity / Race	Hispanic	2	Ethnicity	Yes (Hispanic or Latino)	Y
Empty formerly Ethnicity / Race	Black	3	Race	Black or African American	3
Empty formerly Ethnicity / Race	American Native	5	Race	American Indian or Alaska Native	5
Empty formerly Ethnicity / Race	Amerasian	A	Race	Other Asian	0
Empty formerly Ethnicity / Race	Hawaiian Native	P	Race	Native Hawaiian	P
Empty formerly Ethnicity / Race	Multiple	X	Race	Multiracial	Multiracial
Empty formerly Ethnicity / Race	Other Asian or Pacific Islander	4	Race	Other Asian	0

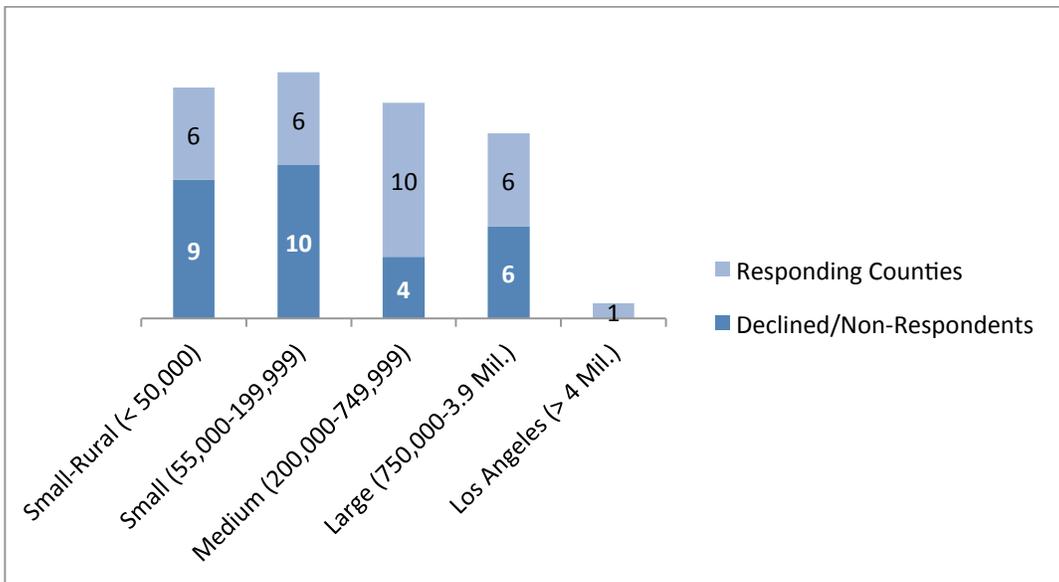
## Appendix E – Counties Responding to Data Quality Assurance Reports, Comparison to Declined/ Non-Respondents

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)Shasta	45
23)Sierra	46
24)Siskiyou	47
25)Solano	48
26)Stanislaus	50
27)Trinity	53
28)Tulare	54
29)Tuolumne	55

**Figure E - 1. Population of counties responding/not responding to data quality assurance reports**



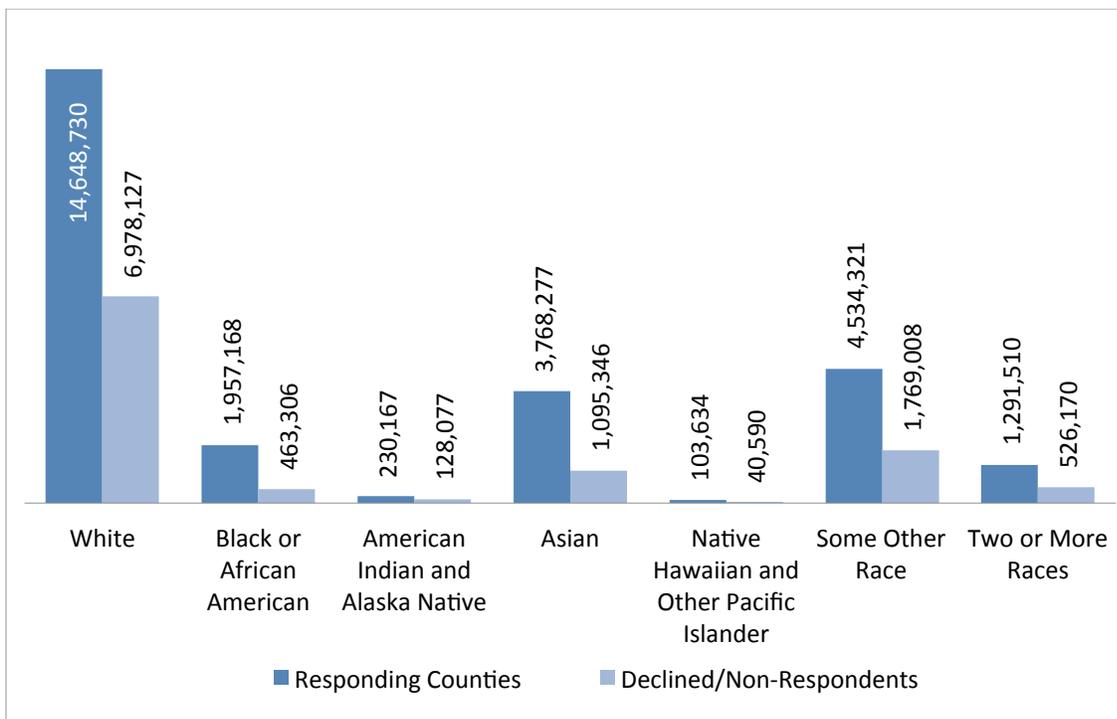
**Figure E - 2. Counties responding/not responding to data quality assurance reports, by size category**



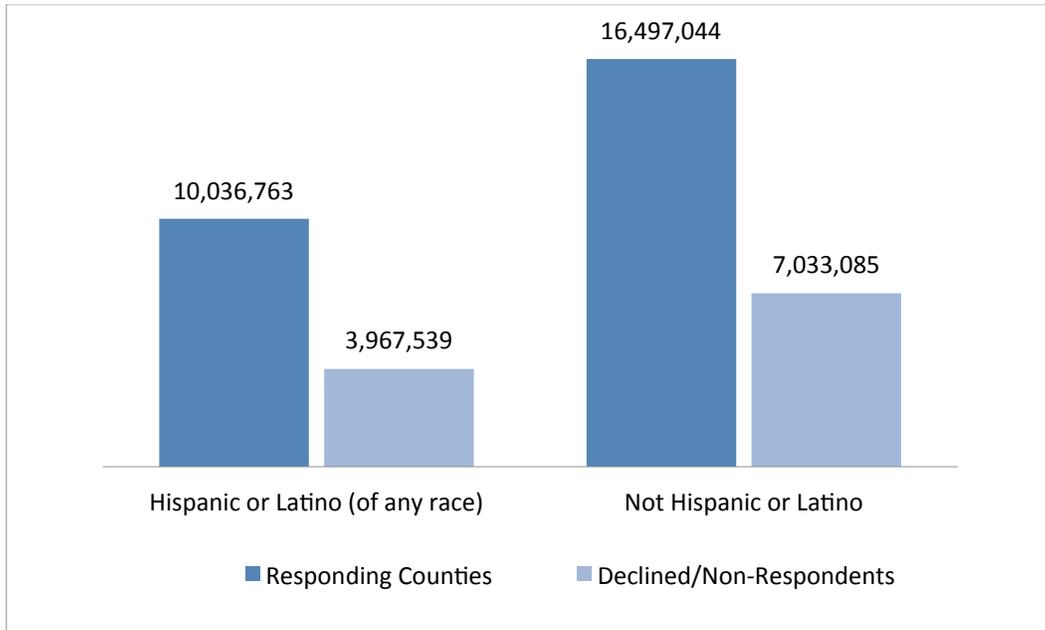
**Figure E - 3. Counties responding/not responding to data quality assurance reports, by region**



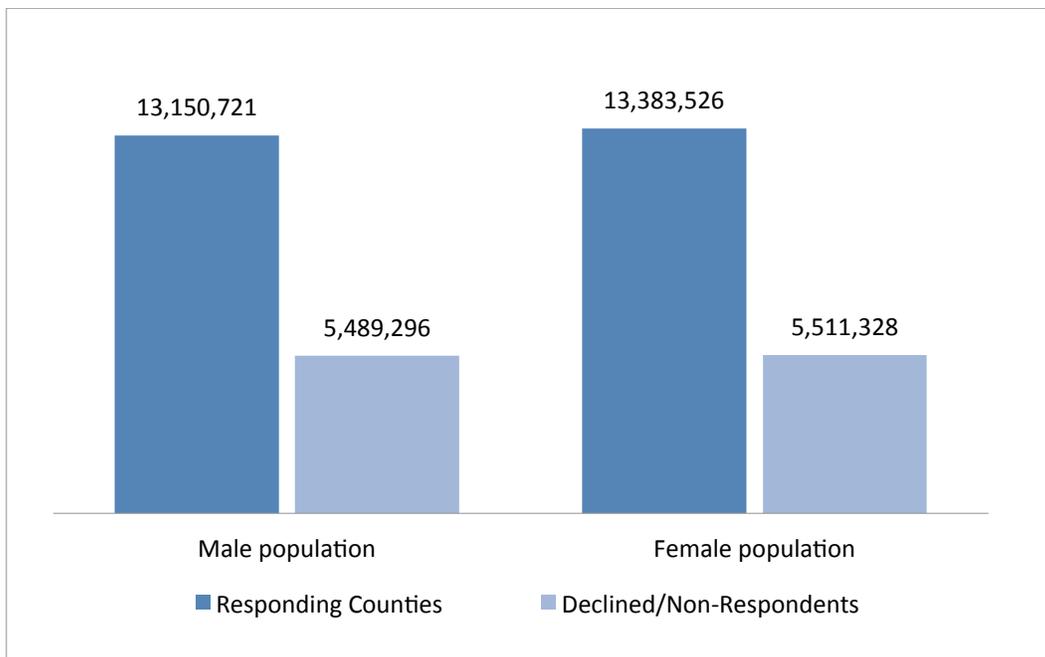
**Figure E - 4. Race dispersion of counties responding/not responding to data quality assurance reports**



**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 F – Summary of Stakeholder Feedback to the Previous Version of This Report

Note: Immediate actions taken by the evaluation team in response to feedback are contained in brackets.

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<b>Life Reaching Across to Life</b>	8.3 Recovery, Wellness, and Resilience Orientation / 7.6 Consumer Well-Being / 7.4 Consumer/ Family-Centered Care / 5.2 Proportion who Identify Community Support. These factors define how consumers and their families view their lives and recovery -- how successful they think they are.	4.1 Emergency Intervention for Mental Health Episodes / 6.1 Demographic Profile of Consumers Served. These are statistics and do not relate to how people see their own lives.	<p>My concern is that spirituality is not addressed in this document at all. Studies show that it can be the single most important factor in recovery. Please see the Alameda County Behavioral Health Care Services Spirituality Statement, dated April 2012, for a good explanation of spirituality and its importance in recovery. This simply cannot be left out of this document.</p> <p>Second entry: Spirituality needs to be considered. It is often the single most important factor in recovery. Please see the Alameda County Behavioral Healthcare statement on Spirituality for a good explanation of this factor. It simply must be included in this document.</p> <p>{Not a vetted indicator}</p>	<p>Spirituality is a person's deepest sense of purpose, belonging and connection. It is often the single most important factor in recovery. It cannot be left out of this document. Please see Alameda County Behavioral Health Care Services Statement on Spirituality.</p> <p>{Not a vetted indicator}</p>	
n/a		The lack of ability to compare data over time makes the report somewhat useless at this time. The lack of reporting statistical significance/insignificance of differences between measures over time also makes the report somewhat useless. Not clear what the intention of the report is. MHSOAC should have REQUIRED ALL COUNTIES to submit data. Makes me question why some did not submit.	<p>not related to page number but to overall helpfulness and purpose of the report--- needs to be stated CLEARLY so people understand its value or lack of value or intent for future value {Addressed in discussion}</p>		

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Mental Health Services Oversight and Accountability Commission's Cultural and Linguistic Competence Committee (CLCC)</b></p>			<p>P. 92: Break down by type of program-- more than just Full Service Partnerships (FSP), need more program categories. / Define the all consumers category. {FSP programs not available in datasets}</p> <p>P.34: Collect/display LGBTQ data throughout the report and compile this data at the state level. /LGBTQ data should be disaggregated to display lesbian, gay, bisexual categories, and at least two of the transgendered or variant people categories. / {Sexual orientation unavailable in datasets}</p> <p>P. 58: "As compared to males, female consumers indicated greater satisfaction with services across most age groups and both fiscal years examined"-- Services to males call for greater attention to unique age-appropriate and cultural needs that are relevant to that gender population. These needs should be considered as equally effective and delivery-responsive, as with services for the female gender from same age and cultural groups. {No action}</p>	<p>P. 98: Identify an indicator that is not only tracking increases in access to, but compares to a baseline that displays how well counties are towards closing the gap in access to care. / Identify a different way to measure penetration rates apart from the Holtzer Model. Maybe use California Health Information Survey (CHIS) data for indicator of unmet needs instead. {No action taken to point 1; CHIS proposed to MHSOAC}</p> <p>P. 62: Cultural Competence Plans (CCP) should be used as a data source. The CCP provide a more realistic picture of what has and is occurring at the county level. / Maybe then using CCP plan or future versions of it can have indicators like: / o Percent of clients needing language assistance services that received it / o Staff demographic statistics per county compared to population demographics / o Percent of public information made available in county threshold languages {New data source noted}</p> <p>P. 62: Disparities broadened beyond race and ethnicity need to call out age, cultural heritage and identification, special needs (e.g., relationship status -- unattached single, in a committed relationship,</p>	<p>P. 34: Need to understand what the unknown/other column includes and means. / Why is there a large difference in FSP clients and other mental health consumers marking unknown? FSP 2009-10: 41.6% and Other MH Consumers 7.1%. / Break down the demographic information into more pieces than FSP and Mental Health Consumers. /Add age groups to this chart. {Point 1 incorporated}</p> <p>P. 62: Cultural Competence Plans (CCP) should be used as a data source / The idea is to change the indicators from being based on what they plan and instead look at what is available, what they have done or are doing. {No action taken}</p> <p>P. 62: To close the gaps, there needs to be a general understanding of cultural belief systems/traditions and historical trauma experienced by different groups in order to break the barriers of stigma and honor/engage all communities, especially under-represented populations. {No action taken}</p>

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
				<p>widowed, etc. -- sexual and gender orientation, faith/beliefs, veteran background, physical limitations, single parents, etc.). A wider lens would address age and multidimensional needs for individuals to access services and, more importantly, utilize prevention/early intervention. {Limited demographic information collected. No action taken}</p>	

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Mental Health Department</b></p>	<p>Most instructive at consumer level: School Attendance, Emergency Care Visits &amp; Intervention for Co-occurring Physical Injury, Social Connection &amp; Employment. Engaged clients &amp; their social support (with tailored health care program) will have personal control &amp; can be expected to show behavioral improvements by these indicators. Employment could be refined by type of paid/unpaid work to gauge clients' long-term stability. System-level indicators are instructive. Access gives a quick sense of where the gap is. Access to PCP is informative. In a Medical Model, at least one health care visit with the PCP suggests the person is in care. It is unclear if access means at least 1 visit in a year. Performance as service rate vs target for FSP services, involuntary status rate, use of 24-hour care are helpful for resource mgmt. Structure in terms of EBPs, cultural appropriateness &amp; RWR orientation ground clinical mgmt on principles &amp; long-term direction of MH services.</p>	<p>Least instructive at consumer level: ↯ Homelessness &amp; Housing because the definition of homelessness varies across the nation, the criteria for housing eligibility vary widely, &amp; consumers do not have control over the number of housing units and placements that are available; &amp;, Justice Involvement because the number of arrests depends on officers in some ways &amp; clients do not have full control of systems procedures. Officers' training about mental illness &amp; where to drop off the person who exhibits mental illness-related behaviors are beyond a client's ability to manage. Least instructive at system level are the Performance indicators based on the Consumer Perception Surveys. The ratings tend to be positive, meaning, the clients are generally appreciative of their providers, &amp; from quality improvement purposes the results do not highlight areas for improvement. If data can be broken down by preferred clinical language, maybe areas for improvement will surface.</p>	<p>P. 118: Instead of mean average number of visits, maybe report in terms of mode or median; less than 1 visit or a fraction of a visit does not make sense (For example, see P. 69: Emergency Intervention for Mental Health Episodes). {Indicator removed, not vetted by MHSOAC}</p> <p>P. "0": I think the indicator Access: 1) must track tailored (EBP) program completion in addition to at least 1-5 visits, broken down by race/ethnicity, age, gender, preferred clinical language 2) need clarifications -- who are the New Consumers (i.e., Totally New/Brand New or Returning after how many years without service?). Are those transferring from another state &amp; registering with county considered new? 3) would be more meaningful if data on severity by Dx (type of illness) at intake can be collected for all {No action taken}</p>	<p>P. 118: How about discussions about the goal: equity/parity, identifying disparities, as well as on what's a significant change &amp; what the improvement targets are? Given that MHSA funds boosted services, it would be nice to see changes from before MHSA, how California is doing compared to national/regional/comparable states. How about adding incidence rates against response rates regardless of funding streams, especially for incidence &amp; response rates for new eligible cases? (See P. 40 on pen rates) {Non-scope of work (SOW)}</p> <p>P. 73: To assess system-wide collaboration: descriptive profile of the extent of data sharing that does not violate individuals' need/right to privacy will help. There is tacit understanding that the departments that need to be involved are: HHS, Social Services, Education, Labor/ Employment, Housing, &amp; Justice. The CA system can be monitored in its infrastructure development to capture data to identify disparities, error correction &amp; data quality (e.g., # of missing, unknown, incomplete). {No action taken}</p>	<p>There's room for refinements. *Break down employment beyond paid/unpaid.*Definition of homelessness needs standardization. Argument: Crowded living conditions should be considered in policies/procedures on housing/ homelessness. It may be culturally acceptable in Asian households to have several generations live in one but not by American standards. Such conditions prevent recovery from mental illness. *Refine Justice Involvement by type of violations, # of days in jail, &amp; adjudicated arrests. {Action pending}</p>

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Tulare County Department of Mental Health</b></p>	<p>A. Housing It is important to capture the type of housing and living conditions in that setting as research shows strong correlations between housing type/quality and mental health functioning. / B. Emergency Care Rates of mental health and physical health related emergency visits measure consumer functioning, service need, and access to appropriate levels of care (e.g., outpatient vs. inpatient mental health treatment, and connection to PCP). / C. Connectivity. Engagement in services and degree of family support are critical indicators in the measure of service effectiveness. Tulare County has implemented self-report measures to gather data on how services might have impacted family relationships for FSP consumers. An additional assessment tool has been implemented within service team meetings to measure the degree of consumer engagement and family inclusion in treatment planning. /</p>	<p>A. Justice Involvement. Data show low arrest rates (&lt;1) 12 months prior to services, but do not provide data 12 months post-services. / B. Education/ Employment. The difference in variable types across data categories (e.g., DCR data measures categorically always attends, infrequently attends) makes drawing comparisons difficult. / C. Structure. County MHSA plans often do not detail each wellness &amp; recovery related or culturally competent activity/service within a program, therefore qualitative analysis would need strict inclusion parameters. Researchers should allow counties to indicate which of their programs contain these important elements. /</p>	<p>Indicators commented on were located on multiple pages.</p>	<p>A. Structure. Counties might consider collecting this data using Dr. Mark Ragins Recovery Progress Report. Tulare County established a baseline measurement of its mental health system using a modified version of the progress report before implementing multiple wellness &amp; recovery focused activities. Assessments of system improvement are conducted yearly to measure change over time. / {No action taken}  Q. Do you have suggestions for alternate ways of presenting specific indicators presented in this report? / A. Indicate the number of consumers in each sample and outcomes for discrete data periods. Also, please indicate whether the sample contains a duplicated or unduplicated pool of consumers. / {Point 1 incorporated}  Q. Do the indicators presented in this report provide an accurate representation of consumer outcomes? / A. No, these indicators do not appear to measure true outcomes as there is no comparison between baseline and a follow-up, and no consideration of type/frequency of services received. Measuring between fiscal years alone does not seem sufficient given the variance in service</p>	

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
				<p>lengths for consumers. {No action taken}</p> <p>Q. Do the indicators presented in this report provide an accurate representation of mental health system performance? / A. The ratio of continuous vs. new consumers by fiscal year was helpful, and it was interesting to see the proportions of consumers of different ethnicities accessing services over time. Overall, indicators measuring system performance seemed much more accurate and appropriate than those measuring consumer-level outcomes. /{No action taken}</p>	
<p><b>Family member of a consumer</b></p>			<p>Present the county indicators on an interactive Web page. User selects county and fiscal year. Then provide the total mental health budget, funding from MHSA, total population, and number of consumers served (individuals). Then provide the indicators. See first report by the CA Chief Probation Officers on prisoner realignment (Web page). See report CMHDA 2008, Transforming Local Mental Health Systems, for 06/07 data on first four items (provide through most current year data available). {Non-SOW}</p>		

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Family member of a consumer</b></p>			<p>P.4: Delete "using prevention and early intervention programs" in first sentence. "Prevention and Early Intervention" is one of several programs defined in the Mental Health Services Act. <b>{No action taken}</b></p> <p>P.8: Data Sources brings to mind the External Quality Review Organization (EQRO) yearly reviews of the county mental health agencies. Consider reviewing, compiling, and summarizing these reviews. With the next year's review, some measure of progress towards addressing the issues identified may be made. / "Not categorized as 'medication only'" suggests a diagnostic profile of some type. For example # meds only, remainder, # above some \$ value of services. OR mental illness diagnosis. <b>{No action taken}</b></p>	<p>P.5: Just above the heading "Background," an evaluation team is mentioned. List the team members in the Appendix. / Inform the reader where the footnotes are located in the report. <b>{No action taken.}</b></p> <p>P.9: Rand Corp. is evaluating the Prevention and Early Intervention Program under contract with CalMHSA. It is possible that Rand could make use of the data/analysis for the Three Year Plans &amp; Updates, WET Plans, estimates of need for mental health services, and involuntary status. <b>{Find requester}</b></p>	<p>P. 6: Define Children, TAY, Adults, and Older Adults. <b>{Action pending}</b></p> <p>P.11: State the source and year of the race data. "Some Other Race" and "Two or More Races" equal 21.6% of the total population. After the 2010 Census, the Census Bureau concluded that this is a growing trend. This has data reliability implications. Perhaps we should look more to socio-economic data. Dr. Holzer uses poverty data to arrive at his estimate of mental health needs. <b>{No action taken}</b></p>

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<b>Lake County Mental Health</b>	LCMH found all of the indicators instructive.	None.	<p>P. 18: As Justice involvement is not tracked within the LCMH EHR, data relating to justice involvement as entered into the DCR is only as accurate as recalled/reported by the FSP and entered by the PSC. {No action taken}</p> <p>P. 19: As some of the DCR data consist of subjective estimates (Always/Most of the time/ Sometimes/ Infrequently/Never or Very good/ Good/ Average/ verage/ Poor), redefining how that data are collected (i.e., collecting quantifiable data) may allow for improved analysis. / / Average school attendance per year may be better calculated if the question “How many days has s/he been absent from school?” were added to the quarterly report (for youth who are required by law to attend school). {Proposed in earlier reports}</p> <p>P. 32: LCMH supports the addition of the Social Connection Domain. How many times/hours a month do you see/spend time with family/ friends/community organizations may be additional data points for this indicator. / {Proposed to MHSOAC}</p>	<p>P. "0": Overall, the indicators presented in this report provide an accurate representation of consumer outcomes and mental health system performance. {No action taken}</p> <p>P. 6: ADL data for TAY and Adults may be a good additional indicator of recovery. / / A measure of recovery/level of engagement (i.e. MORS) could also be helpful. {No action taken}</p>	<p>Data entered into the DCR is only as accurate, reliable, and complete as recalled/disclosed by the FSP/family member and entered by the PSC. / / As much as possible, CSI data should be used (i.e., Crisis/ Hospitalization services/dates) for purposes of maximizing the use of existing data and minimizing duplicate entry into the DCR and the potential for inconsistencies due to data entry errors/omissions. {No action taken}</p> <p>P. 75: LCMH would find helpful a County-Level Compared to State- Level Priority Indicator report. {No action taken. Future reports in SOW}</p>

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Letter, Debbie Innes-Gomberg, Los Angeles County</b></p>			<p>Rather than stacked graphs for employment and housing, simply stating the percent of currently enrolled FSP clients who are employed and the percent of clients in nonpaid work (volunteering, interning) would be more useful. Similarly, the percent of clients who are homeless, living independently, etc., would be most useful.  {Already addressed with MHSOAC}</p> <p>Arrest rate is not a useful metric. Generally the value of FSP services are seen in the reductions of incidents as well as days incarcerated, so within-subjects analysis is usually more beneficial. For a dashboard I would recommend # of clients currently incarcerated.  {Recommended in earlier reports, not vetted by MHSOAC}</p> <p>Integrated service delivery cannot be adequately measured via the documents reviewed by UCLA-EMT. {No action taken}</p>	<p>Evidence-based or promising practices is incomplete and not adequately measured via the documents reviewed by UCLA-EMT and is specific to individual providers of FSP services. In order to determine whether a county has FSP programs providing specific practices, a site visit would need to be conducted.  {No action taken}</p>	<p>Finally, in order for counties to use a priority indicators report for quality improvement purposes, reports must be ongoing so that data can be tracked and used over time.  {Addressed in report introductions}</p> <p>Several counties have established performance dashboards for quality improvement purposes and could be used as models in developing a statewide dashboard. {Request dashboards identified by MHSOAC}</p>

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
<p><b>Patricia Ryan, Executive Director, California Mental Health Directors Association</b></p>			<p>As background, earlier this year UCLA, in partnership with EMT Associates, Inc., distributed a Web-based survey asking counties to validate Client &amp; Service Information System (CSI) and Data Collection Reporting System (DCR) data. There were significant limitations to the survey design that were raised by CMHDA and individual counties and brought to the attention of the Mental Health Services Oversight and Accountability Commission (MHSOAC). While CMHDA and counties were and are strongly committed to ensuring the availability of critical data at the state level to inform important evaluation activities to help demonstrate the value of the MHSAs, the survey design did not account for the significant variance between counties and the myriad of nuances that are intrinsic to MHSAs programs. Because of the design, many counties necessarily left certain questions unanswered (when the offered choices did not appropriately capture the county's experience) and/or indicated on the survey that certain information was not accurate, based on the reporting format. These sorts of responses were catalogued by the evaluators as "not reported." However, had the survey been constructed in another manner, it is possible</p>	<p>Access to quality, appropriate, timely data is essential for state and county evaluation activities, including those facilitated by the MHSOAC. Inadequate state-level systems continue to pose serious challenges to state-level evaluation efforts. The challenges faced by the researchers to identify and utilize current and accurate data from all counties in the development of this report underscores the need to focus on modernizing the data systems and platforms available to the state, the counties and their subcontractors as we move toward health care reform and integration. CMHDA strongly supports efforts that will result in an accurate presentation of data from all counties, through both the improvement of data systems and state-county collaboration to identify and design alternative solutions, such as the aforementioned survey tool. <b>{Non-SOW}</b></p>	

Responding organization or individual	What indicators do you find most instructive and why?	What indicators do you find least instructive and why?	Brief comment	Brief comment, continued	Brief comment, continued
			<p>that much of the information that counties either left unanswered or indicated to be inaccurate may have been captured. CMHDA is concerned that the challenging survey design may have inadvertently impacted the accuracy of information collected. {No longer applies to method}</p>		