

Prevention and Early Intervention: California's Investment to Prevent Mental Illness from becoming Severe and Disabling

Executive Summary

Prepared by:



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The purpose and intent of the Mental Health Services Act is:

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

Mental Health Services Act (2011, amended after AB 100). Retrieved on September 26, 2013 from:
http://www.dmh.ca.gov/prop_63/mhsa/docs/MHSAafterAB100.pdf

Executive Summary

Proposition 63 (2004) established the Mental Health Services Act (MHSA). In the MHSA, Prevention and Early Intervention (PEI) programs are explicitly designed to “...prevent mental illness from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.”¹ The MHSA requires that 20 percent of funds distributed to counties be used for PEI,² representing a historic transformation of the mental health system to a “help first” approach.³

Prevention and Early Intervention Programs

UCLA collected information about PEI expenditures, programs/activities and participant demographics for FY 2011-12 from counties through a process developed in collaboration with an Evaluation Advisory Group comprised of county department of mental health representatives. This report documents PEI expenditures, programs/activities and the demographics of people that participated during FY 2011-12.

For the purpose of this Executive Summary, commonly-used terms are defined as follows:

- ***Seriously Emotionally Disturbed Children or Adolescents*** means minors under the age of 18 who have a mental disorder as identified in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance abuse disorder or developmental disorder, which results in behavior inappropriate to the child’s age according to expected developmental norms (see the text box below for further details from California’s Welfare and Institution’s Code).⁴
- ***Adults and Older Adults*** who have a ***Serious Mental Disorder/Serious Mental Illness*** means a mental disorder that is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, bipolar disorder, post-traumatic stress disorder, as well as major affective disorders or other severely disabling mental disorders. According to California’s Welfare and Institution’s Code (WIC), “This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical and mental disorder.” See the text box below for further details from WIC.⁵

<p><i>Seriously Emotionally Disturbed Children or Adolescents:</i></p> <p>a) As a result of having the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:</p> <p>(i) The child is at risk of removal from home or has already been removed from the home.</p> <p>(ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than a year without treatment.</p> <p>b) The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder.</p> <p>c) The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.</p>	<p><i>Adults or Older Adults who have a Serious Mental Disorder:</i></p> <p>a) The person has a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance abuse or developmental disorder or acquired traumatic brain injury pursuant to subdivision (a) of Section 4354 unless that person also has a serious mental disorder as defined in paragraph (2).</p> <p>b)</p> <p>(i) As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms.</p> <p>(ii) For the purposes of this part, “functional impairment” means being substantially impaired as the result of a mental disorder in independent living, social relationships, vocational skills or physical condition.</p> <p>c) As a result of a mental functional impairment and circumstances, the person is likely to become so disabled as to require public assistance, services or entitlements.</p>
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- A Prevention or Early Intervention **Activity** is defined as services implemented by a county (or county-funded contractor) with intended outcomes for discreet individuals.
- A **Program** is defined as one or more activities offered by a county (or county-funded contractor).
- **Prevention** programs/activities are defined for the purpose of this evaluation as activities that intend positive mental health outcomes for individuals at risk of serious mental illness. ‘At risk of serious mental illness’ was defined for the purpose of this study as a risk factor with either a documented direct or a mediating/moderating relationship to later onset of mental illness (see page iv for risk factors identified by counties during the study time period that met study criteria). Evidence for risk factor status was defined as documentation in the scientific peer-reviewed literature, within the last five years, in at least three (3) articles.⁶ Potential risk factors were selected and examined for evidence in the literature based upon participant recruitment and/or selection criteria reported by counties during the study data collection process and in PEI plans and the FY 2013-14 Annual Update. The FY 2013-14 Annual Update documents MHPA implementation during FY 2011-12, the year of focus for the PEI evaluation study.⁷
- **Early Intervention** programs/activities, as defined for the purpose of this evaluation, are those that intend positive mental health outcomes for individuals with early onset of a serious emotional disturbance (children/youth) or serious mental illness (adults/older adults). See the definitions in statute for serious emotional disturbance and serious mental illness on page i.
- **Indirect** programs/activities are defined as broad-based efforts that counties carry out in response to specific MHPA mandates for PEI that typically do not provide direct service to individuals (see California’s Welfare and Institutions Code, *item b*, below). These efforts include screening, assessment and referrals; outreach, education and training to people in a position to recognize signs and symptoms of mental illness; campaigns and other efforts to reduce stigma and discrimination related to having mental illness or seeking mental health services; and campaigns and other efforts to prevent suicide.⁸

Per California’s Welfare and Institutions Code:⁹

- a) The State Department of Health Care Services, in coordination with counties, shall establish a program designed to prevent mental illness from becoming severe and disabling. The program shall emphasize improving timely access to services for underserved populations.
- b) The program shall include the following components:
 - 1) Outreach to families, employers, primary care health care providers, and others to recognize the early signs of potentially severe and disabling mental illnesses.
 - 2) Access and linkage to medically necessary care provided by county mental health programs for children with severe mental illness,¹⁰ and for adults and seniors with severe mental illness,¹¹ as early in the onset of these conditions as practicable.
 - 3) Reduction in stigma associated with either being diagnosed with a mental illness or seeking mental health services.
 - 4) Reduction in discrimination against people with mental illness.
- c) The program shall include mental health services similar to those provided under other programs effective in preventing mental illnesses from becoming severe, and shall also include components similar to programs that have been successful in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives.
- d) The program shall emphasize strategies to reduce the following negative outcomes that may result from untreated mental illness:
 - 1) Suicide.
 - 2) Incarcerations.
 - 3) School failure or dropout.
 - 4) Unemployment.
 - 5) Prolonged suffering.
 - 6) Homelessness.
 - 7) Removal of children from their homes.
- e) Prevention and early intervention funds may be used to broaden the provision of community-based mental health services by adding prevention and early intervention services or activities to these services.¹²

- **Out of Study Scope** programs/activities are defined for the purpose of the evaluation as programs/activities that did not meet study inclusion criteria for a prevention or early intervention program or for indirect activities consistent with MHSA purposes for PEI.
- **Mixed** programs/activities are defined for the purpose of the evaluation as occasions when the same activity or activities were offered to two or more of the following target populations: a) individuals with early onset of mental illness, b) individuals defined for the purpose of this study as evidencing risk factors placing them at high risk for mental illness, and/or c) individuals out of the study's scope because they do not meet the criteria in a) or b). In 'mixed' programs/activities, counties were unable to break out the numbers served and expenditures by target population. The inability to **separate out expenditures and/or numbers** served is the criteria for placement in the 'Mixed' category.

Among the counties ¹³ implementing PEI programming in FY 2011-12:

- Prevention programs/activities were provided in 45 (76.3%) counties
- Early intervention programs/activities were provided in 40 (67.8%) counties
- Stand-alone 'indirect' programs/activities were provided in 42 counties (71.2%)
- 'Out of study scope' programs/activities were provided in three counties (5.1%)
- 'Mixed' programs were provided in 27 counties (45.8%)

Table 1. Summary of PEI Categories:
Number of Counties Implementing
FY 2011-12

	Counties (N=59)	
	N	%
Prevention	45	76.3%
Early Intervention	40	67.8%
Indirect	42	71.2%
Out of Study Scope	3	5.1%
Mixed	27	45.8%

The data displayed in Table 1 illustrate that the majority of counties provide prevention, early intervention, and 'indirect' programs/activities (76.3%, 67.8% and 71.2%, respectively). 'Out of study scope' programs/activities are not the norm (5.1%).

Among counties implementing PEI programs/activities in FY 2011-12, each program/activity was documented and classified into **one** of the following categories: prevention, early intervention, stand-alone 'indirect', 'out of study scope', or 'mixed'. Table 2 summarizes programs/activities implemented in FY 2011-12 by study category. A program/activity appears in one category in Table 2, according to its study classification. Counties implemented a total of **467** programs/activities:

- Prevention programs/activities represented a quarter of PEI programming (n=119; 25.5%)
- Approximately one third of programs/activities focused on early intervention (n=158; 33.8%)
- Stand-alone 'indirect' programs/activities represented approximately 29 percent of PEI programming (n=135)
- 'Out of study scope' programs/activities were few in number (n=4; 0.9%)
- 'Mixed' programs/activities represented a minority (n=51; 10.9%)

Table 2. Summary of PEI Categories:
Number of Programs/Activities
FY 2011-12

	Programs/Activities (N=467)	
	N	%
Prevention	119	25.5%
Early Intervention	158	33.8%
Indirect	135	28.9%
Out of Study Scope	4	0.9%
Mixed	51	10.9%
TOTAL	467	100.0%

Prevention

For the purpose of this PEI evaluation, programs/activities were classified as ‘prevention’ if participants were recruited and/or selected on the basis of a documented risk factor(s) identified in the scientific, peer-reviewed literature as being directly related to later onset of mental illness, or contributing to later onset of a mental illness because of a mediating or moderating influence on risk factors directly related to later onset of mental illness. Based upon the PEI study criteria, the prevention program/activity risk factors addressed by counties during the study time period are displayed in Table 3. The data displayed in Table 3 illustrate the fact that counties did not limit the number of risk factors when recruiting and defining eligibility for participants. Therefore, a total is not included for the percent row because it would add to more than 100 percent.

Table 3. Prevention Programs/Activities: Risk Factor Related to Later Onset of Mental Illness
FY 2011-12
(Prevention Program/Activity N=119)

Risk Factor Related to Later Onset of Mental Illness	Number of Programs/Activities	Percentage of Prevention Programs/Activities
Adults/transition-age youth exposed to combat trauma	1	0.8%
Adult/older adult Immigrants fleeing to trauma, violence, war	1	0.8%
Adult/older adult overuse of emergency room/inpatient hospitalization	1	0.8%
Children/ youth victimized by bullying	28	23.5%
(All ages) engaging in self-harm behaviors/experiencing suicidal ideation	5	4.2%
(All ages) cumulative impact of historical trauma (Native Americans)	5	4.2%
(All ages) exposure to trauma as a result of domestic violence	11	9.2%
(All ages) exposure to trauma as a result of physical abuse/sexual abuse	3	2.5%
(All ages) social stress / social exclusion because of sexual identity (Gay, Lesbian, Bisexual, Transgender)	4	3.4%
(All ages) homelessness	5	4.2%
(All ages) living in neighborhoods with high concentrations of poverty	8	6.7%
(All ages) living in neighborhoods with high concentrations of violence	7	5.9%
(All ages) substance misuse (alcohol and other drugs)	12	10.1%
Children/ youth exhibiting bullying behavior/aggression	29	24.4%
Children/youth exhibiting disruptive/defiant/oppositional-defiant behavior	21	17.6%
Children/ youth exposed to stress due to parental mental illness	9	7.6%
Children/youth exposed to stress due to parental substance abuse	12	10.1%
Children/youth involved in the Child Welfare system	23	19.3%
Children/youth involved in the Criminal Justice system	15	12.6%
Grandparents experiencing stress due to raising grandchildren	2	1.7%
Young children displaying defiant and /or aggressive behaviors	2	1.7%
Young children experiencing attachment problems	3	2.5%
Young children with disabilities, developmental delays	2	1.7%

Although no one risk factor represents the majority of recruitment and/or selection criteria among prevention programs/activities, five emerge as the most common. All five risk factors are focused on children-youth:

- Children/youth exhibiting bullying/aggressive behavior (n=29; 24.4%)
- Children/youth victimized by bullying (n=28; 23.5%)
- Children/youth involved in the Child Welfare system (n=23; 19.3%)
- Children/youth exhibiting defiant/oppositional-defiant behavior (n=21; 17.6%)
- Children/youth involved in the Criminal Justice system (n=15; 12.6%)

Early Intervention

For the purpose of this PEI evaluation, programs/activities were classified as ‘early intervention’ if participants were recruited on the basis of intervening early in the onset of a serious emotional disturbance (children/youth) or serious mental illness (adults/older adults). See the definitions in statute for serious emotional disturbance and serious mental illness on page i.

Counties sought to intervene early with either “Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence” or “Axis I Disorders.” The number of early intervention programs/activities with recruitment and/or selection criteria based upon “Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence” or “Axis I Disorders” is displayed in Table 4. Because county programs/activities focused on one diagnostic class (either Axis I Disorders or Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence), the percentage row totals 100 percent.

Table 4. Early Intervention Programs/Activities:
Mental Illness – Focus of Early Intervention
FY 2011-12
(Early Intervention Program/Activity N=158)

Mental Illness: Focus of Early Intervention Program	Number of Programs/Activities	Percentage of Programs/Activities
Axis I Disorder	147	93.0%
Disorder Usually First Diagnosed in Infancy, Childhood or Adolescence	11	7.0%
TOTAL	158	100.0%

Among the 158 early intervention programs/activities, the majority focused on Axis I Disorders (n=147; 93.0%), including programs/activities that focused solely on mood disorders, psychotic disorders and anxiety disorders. Among the minority that focused on Disorders Usually First Diagnosed in Infancy, Childhood or Adolescence (n=11; 7.0%), disorders included Conduct Disorder and Oppositional-Defiant Disorder.

Indirect

Indirect programs/activities are defined as broad-based efforts that counties carry out in response to specific MHSAs mandates for PEI that typically do not provide direct service to individuals (see California’s Welfare and Institutions Code, *item b*, page ii). These efforts include screening, assessment and referrals; outreach, education and training to people in a position to recognize signs and symptoms of mental illness; campaigns and other efforts to reduce stigma and discrimination related to having mental illness or seeking mental health services; and campaigns and other efforts to prevent suicide.

When screening, assessment and referrals; outreach, education and training to people in a position to recognize signs and symptoms of mental illness; efforts to reduce stigma and discrimination; and efforts to prevent suicide are incorporated into programs/activities **involving direct services to individuals**, these strategies were documented in one of the other PEI study categories. They are ‘embedded’ into programs/activities providing direct services to individuals at risk of a mental illness (prevention), with early onset of a mental illness (early intervention), or to individuals out of the study’s scope because they do not meet the criteria for prevention or early intervention. For example, an early intervention program that intervenes to prevent suicide among individuals with early onset of a mental illness or prevention programs that serve specific individuals at risk for later onset of mental illness because they are exhibiting self-harm behaviors and experiencing suicidal ideation. Direct services to prevent suicide for specific individuals at risk of or with early onset of a mental illness were categorized under prevention or early intervention programs/activities because suicide prevention is embedded into prevention or early intervention programming (respectively). Every county documented incorporation of the required activities (see California’s Welfare and Institutions Code, *item b*, page ii) into one or more of their prevention, early intervention, and/or ‘out of study scope’ programs/activities.

The distinction between stand-alone ‘indirect’ programs/activities and the other study categories is stand-alone **‘indirect’ programs/activities don’t involve direct services to individuals**. Stand-alone indirect program/activity strategies are displayed in Table 5.

Because these activities can be incorporated/embedded into prevention, early intervention and/or ‘out of study scope’ programs/activities or stand-alone when they don’t involve direct services to individuals, the number and percentage of ‘Indirect’ programs/activities shown in Table 5 is an undercount and does not represent the full extent of implementation of these MHSA-PEI-mandated efforts.

Table 5. Indirect Programs/Activities:
FY 2011-12
(Indirect Program/Activity N=135)

Indirect Program/Activity	Number of Programs/Activities	Percentage of Programs/Activities
Screening, assessment and referrals	63	46.7%
Outreach, education and training (signs and symptoms of mental illness)	74	54.8%
Stigma and discrimination reduction campaign	16	11.9%
Suicide prevention campaign	23	17.0%

County programs/activities sometimes focused on more than one stand-alone ‘indirect’ activity. Therefore, a total is not included for the percent row because it would add to more than 100 percent. The most common stand-alone indirect activity was outreach, education and training to individuals in a position to recognize the signs and symptoms of mental illness (n=74; 54.8%).

Outreach to provide training about how to recognize the early signs of potentially severe and disabling mental illnesses included the following professions in FY 2011-12:

- preschools and daycare providers
- elementary, middle and high schools
- law enforcement, judges, prosecutors, probation officers
- first responders
- social services, social welfare and child protective services

Out of Study Scope

Programs/activities were categorized for the purpose of the evaluation as ‘out of study scope’ if the target population did not meet study criteria for a prevention, early intervention, or stand-alone indirect program/activity. The three counties that offered PEI-funded programs or activities that did not meet study criteria and therefore were ‘out of study scope’ all served individuals defined solely as an underserved racial/cultural group without designation of risk factors supported in the scientific, peer reviewed literature related to later onset of mental illness (see *prevention* study criteria, defined previously). ‘Out of study scope’ programs/activities were few in number (n=4; 0.9%). These ‘out of study scope’ programs/activities were in compliance with the Department of Mental Health (DMH) *Guidelines for PEI Programs* because “Underserved Cultural Groups” was one of the designated priority PEI populations that counties could select, defined as follows: ¹⁴

PEI projects address those who are unlikely to seek help from any traditional mental health service whether because of stigma, lack of knowledge, or other barriers (such as members of ethnically/racially diverse communities, members of gay, lesbian, bisexual, transgender communities, etc.) and would benefit from Prevention and Early Intervention programs and interventions.

Counties were also required to select from a menu of Key Community Needs, one of which was “Disparities in Access to Mental Health Services,” defined as follows:

PEI efforts will reduce disparities in access to early mental health interventions due to stigma, lack of knowledge about mental health services or lack of suitability (i.e., cultural competency) of traditional mainstream services.

PEI Guidelines also provided the following general guidance for counties’ PEI efforts:

Programs recognize the underlying role of poverty and other environmental and social factors that impact individuals’ wellness...

Criteria for inclusion in the prevention program/activity category were developed solely for the purpose of this evaluation.

Mixed

Among the 51 programs/activities defined for the purpose of the evaluation as ‘mixed’:

- The same activity or activities are offered to two or more of the following target populations: a) individuals with early onset of mental illness, b) individuals defined for the purpose of this study as evidencing risk factors placing them at high risk for mental illness, and/or c) individuals out of the study’s scope because they do not meet the criteria in a) or b). In ‘mixed’ programs/activities, counties were unable to break out the numbers served and expenditures by target population. This was the case for each of the 51 programs/activities.
 - Four of the 51 ‘mixed’ programs/activities served a target population ‘out of the study scope’ (7.8% of the ‘mixed’ programs/activities). These four programs/activities were implemented by four different counties. These four programs/activities were not classified with the ‘out of study scope’ programs/activities described previously because the expenditures and numbers served cannot be separated out from the other programs/activities reported by these counties. The inability to **separate out expenditures and/or numbers** served is the criteria for placement in the ‘mixed’ category. See the ‘Discussion’ section at the conclusion of this summary for some of the challenges counties encountered when documenting PEI expenditures and numbers served.

Populations Served by PEI Program/Activities

Table 6 shows the number and percentage of participants in three (3) of the five (5) study categories (prevention, early intervention, and ‘out of study scope’). The numbers served by prevention, early intervention and ‘out of study scope’ programs/activities are unduplicated counts. ‘Unduplicated’ means that a person is counted only once.

‘Numbers served’ are not presented for stand-alone ‘indirect’ and ‘mixed’ programs/activities because direct comparison cannot be made with the unduplicated counts reported for prevention, early intervention and ‘out of study scope’ programs/activities. For stand-alone ‘indirect’ programs/activities, the numbers represent a duplicated count, meaning that the same people are sometimes counted more than once (e.g., visitors to a website, repeat callers to a hotline). Because populations/activities cannot be disentangled in ‘mixed’ programs/activities, the ‘total number served’ by ‘mixed’ programs is not useful.

The percentages displayed in Table 6 are the percentages within the categories for which there are unduplicated counts of participants.

Table 6. PEI Programs/Activities:
Number of Participants
FY 2011-12

	Number of PEI Participants	
	N	%
Prevention	134,797	36.8%
Early Intervention	230,426	63.0%
Out of Study Scope	625	0.2%
TOTAL	365,848	100.0%

Prevention, early intervention and ‘out of study scope’ programs/activities were provided to 365,848 people in FY 2011-12.

Prevention

Among the 134,797 individuals at risk of a mental illness that participated in prevention programs /activities in FY 2011-12:

- Age group data was provided for 130,045 participants. Of these 130,045 participants, the majority age group served by prevention programs/activities was children/youth (n=84,405; 64.9%).¹⁵ Adults were 19.0 percent of prevention program/activity participants (n=24,734), followed by transition-age youth (n=18,954; 14.6%) and older adults (n=1,952; 1.5%).
- Data on gender was provided for only 123,456 of the 134,797 individuals served by prevention programs/activities. Of these 123,456, the percentage of males and females served was approximately the same (males = 61,679; 49.9% and females = 61,180; 49.6%, respectively, with other = 597; 0.5%).
- Race/ethnic data was provided for only 86.5 percent of participants (n=116,576 of the 134,797 individuals served by prevention programs/activities). Of the 116,576 participants, the plurality ethnic group served was Caucasian (n=44,426; 38.1%), followed by Hispanic/Latino (n=34,078; 29.2%) and African Americans (n=17,747; 15.2%). The remaining racial/ethnic groups each represented nine percent or less of those served by Prevention programs/activities.

Early Intervention

Early intervention programs/activities were provided to 230,426 individuals in FY 2011-12:

- Data on age group was provided for 97.9 percent of the 230,426 participants in early intervention programs/activities (n=225,493). Of those 225,493, the plurality age group served by early intervention programs/activities was children/youth (n=82,061; 36.4%),¹⁶ followed by adults (n=73,316; 32.5%). Transition-age youth represented 18 percent of early intervention participants (n=40,664) and older adults 13.1 percent (n=29,452).
- Data on gender was provided for 79.6 percent of the 230,426 participants in early intervention programs/activities (n=183,388). Of those 183,388, the majority gender group served by early intervention programs/activities was females (n=110,419; 60.2%). Males represented 39.6 percent of individuals served by early intervention programs/activities in FY 2011-12 (n=72,564). ‘Other’ represented 0.2 percent (n=405).
- Data on race/ethnicity was provided for 86.1 percent of individuals participating in early intervention programs/activities in FY 2011-12 (n=198,444). Of those 198,444, Hispanic/Latinos represent the plurality of individuals participating in early intervention programs/activities in FY 2011-12 (n=84,419; 42.5%), followed by Caucasians (n=63,218; 31.9%) and African Americans (n=19,546; 9.8%). The remaining racial/ethnic groups each represented less than nine percent.

Out of Study Scope

‘Out of study scope’ programs/activities were provided to 625 individuals in FY 2011-12:

- Age group data was provided for 588 of the 625 individuals participating in ‘out of study scope’ programs/activities (87.4%). Of those 588, the majority age group served by ‘out of study scope’ programs/activities was children/youth (n=514; 87.4%).
- Participant gender was nearly a 50/50 split between males and females (n=318; 50.9% and n=307; 49.1%). Gender data was provided for all 625 individuals.
- Although these programs/activities were classified as ‘out of study scope’ due to sole focus on “Underserved Racial/Cultural Populations” in the absence of risk factors supported in the scientific, peer reviewed literature related to later onset of mental illness, the majority age group served was Caucasian (n=336; 53.8%). Hispanic/Latinos represented 35.7 percent of individuals served by ‘out of study scope’ programs/activities (n=223). ‘Other’ represented 10.6 percent (n=66). Race/ethnic data was provided for all 625 individuals.

Indirect

Because participant counts in stand-alone ‘indirect’ programs/activities are duplicated (participants are, in some instances, counted more than once), information summarized below represents county reports of groups served rather than demographic breakouts. Among counties reporting stand-alone ‘indirect’ efforts such as stigma and discrimination reduction campaigns, training on recognizing the signs and symptoms of early onset mental illness, screening and referral for behavioral health care and other broad-based efforts:

- The majority of counties reported providing stand-alone indirect programs/activities to all age groups, ranging from 31 counties reporting stand-alone indirect programs/activities for older adults (73.8%) to 34 counties reporting stand-alone indirect programs/activities for transition-age youth and/or adults (81.0%). Stand-alone indirect programs/activities for children/youth were reported by 33 counties (78.6%).
- Among the 42 counties providing stand-alone indirect programs/activities, 37 (88.1%) reported services for males and females.

- Among the counties providing stand-alone indirect programs/activities, the majority documented provision of stand-alone indirect programming to Hispanics/Latinos (36 counties; 85.7%) and Caucasians (34 counties; 81.0%).

Mixed

Because populations/activities cannot be disentangled in ‘mixed’ programs/activities, demographic information is difficult to interpret and therefore is not presented in this Executive Summary.

PEI Expenditures

Among the 59 counties, 58 (98.3%) submitted FY 2011-12 PEI expenditure data for this study. Among the 58 counties that submitted FY 2011-12 PEI expenditure data, 38 (65.5%) indicated that the data submitted was based upon actual expenditures rather than estimated expenditures. A common reason noted for reporting estimated expenditures was that the FY 2011-12 Revenue and Expenditure Report was either in process or had not yet been approved at the county level or submitted to MHSOAC.¹⁷ Table 7 displays PEI expenditures by study category.

Table 7. PEI Amount Expended: Overall and by Category
FY 2011-12

	Expenditures (N=58 counties)	
	N	%
Prevention	\$ 40,197,494.06	12.6%
Early Intervention	\$172,943,344.79	54.4%
Out of Study Scope	\$ 133,614.95	<0.1%
Indirect	\$ 82,134,885.35	25.8%
Mixed	\$ 22,531,367.04	7.1%
TOTAL	\$317,940,706.19	100.0%

Of the \$317,940,706.19 that counties documented expending, early intervention represented the majority (54.4%). Stand-alone ‘indirect’ program/activities represented 25.8 percent of expenditures, followed by prevention programs/activities (12.6%) and ‘mixed’ (7.1%). Programs/activities classified as ‘out of study scope’ represented less than one percent.

Return on Investment

Per California’s Welfare and Institutions Code:¹⁸

- c) The program shall include mental health services **similar** to those provided under other programs **effective** in preventing mental illnesses from becoming severe, and shall also include components **similar** to programs **that have been successful** in reducing the duration of untreated severe mental illnesses and assisting people in quickly regaining productive lives. **[emphasis added]**

Clearly, the MHSA requires the use of effective programs/activities; the expectation is that MHSA funds (including PEI) will be expended on activities and programs that have shown to be successful. However:

- MHSA does not mandate any specific standards to demonstrate success or effectiveness under PEI.¹⁹
- Although there is much discussion in the field on the value of evidence-based practices (EBPs), there are many different definitions of EBPs and a range of evidence can be used to document that a program has been “**effective and successful.**”

- Flexibility in the standard required for evidence for “successful and effective” PEI activities and programs is particularly important because there are no EBPs, by any of the definitions used in the field, for many prevention and early intervention priority areas.
- Many EBPs have not adequately been demonstrated as effective for communities of color.
- Many client-focused, family-focused and recovery-oriented practices have not yet been adequately evaluated.
- Consistency with cultural and client preferences represent critical criteria for determining whether a practice is ‘evidence-based’ when considering implementation in communities of color and by people with lived experience of a mental illness.

With these caveats in mind, the Washington State Institute for Public Policy (WSIPP) has compiled a list of EBPs using narrowly-defined criteria, and has conducted independent research on these EBPs to determine whether there is a return on investment. ‘Return on investment’ is defined as the total monetary benefit, per person over a 12 month period after typical program/activity expenses are deducted.²⁰

Although this was not the focus of UCLA’s PEI activities and expenditures study, information about counties that have implemented EBPs on the WSIPP list and the number of participants in WSIPP-listed EBPs in California’s MHSA-funded PEI programs was readily available and it seemed a wise use of resources to examine the potential expected net per-participant monetary benefit from the WSIPP-listed EBPs through reliance upon WSIPP’s national database. In order to avoid confusion when discussing cost-benefit findings, the PEI EBPs that are documented in the WSIPP national database will be referred to as ‘*WSIPP-documented EBPs*.’²¹

It is important to note before reviewing the results in Table 8 that WSIPP maintains *very strict inclusion criteria* for studies documented in its national database. In order to be included in the WSIPP definition of EBP, evidence-based practices must have undergone rigorous national research. ‘Rigorous’ includes use of a control group. If a control group was not included in the study design, the comparison group must meet scientific standards in terms of being comparable to the intervention group. Sample sizes for both the intervention and control/comparison groups must be large enough to draw inferences and effect sizes **must** be reported in the peer reviewed journal article. These criteria were necessary in order for WSIPP to conduct *independent analyses*, allowing WSIPP to calculate:²²

- Annual per-person cost to deliver the program; and
- Annual cost-benefit, after the cost of delivering the program is accounted for.

If any one of the necessary criteria were missing, WSIPP could not conduct independent analyses. Because the criteria are very strict, there are **many** nationally-recognized evidence-based practices that are not included in WSIPP’s database. Common reasons for lack of inclusion are that the practice is too new (not enough studies have been completed) and/or effect size is not included. One example of a PEI EBP that is not included in WSIPP is *IMPACT: Evidence-Based Depression Care*. IMPACT is provided as an example to be kept in mind when reviewing the findings in Table 8: the EBPs shown **do not represent all of the EBPs implemented under PEI**, only those using a particular definition that, in addition, are documented in the WSIPP national database. In addition, the sophisticated, independent analytic work conducted by WSIPP in estimating cost-benefits for EBPs sets the WSIPP registry apart from other national EBP databases.

The total expected net monetary per-person benefit reported for the EBPs that met WSIPP criteria is likely an **under-estimate of the overall money-saving potential of PEI programs overall**. Findings with regard to WSIPP-documented EBPs do not address the possible net monetary per-person benefit for PEI participants in

programs/activities that counties selected using other standards for evidence-based practices, promising practices or community-defined evidence.

A county’s program and participants are only included in Table 8 if the program/activity was implemented with the **same target population** reported in the WSIPP study because UCLA cannot assume similar benefits for age groups and target populations other than those included in WSIPP’s analyses.²³ Only prevention and early intervention participants were included in the calculations for Table 8:

- Because populations/activities cannot be disentangled in ‘mixed’ programs/activities, ‘mixed’ programs/activities were not included.
- ‘Out of study scope’ programs and activities are not included because no WSIPP-documented EBPs were implemented.
- Because ‘indirect’ programs/activities do not provide ongoing, direct service to individuals, no WSIPP-documented EBPs (as EBPs are defined for the purpose of this study, see previous) were provided.

Table 8. Expected Net per Participant Monetary Benefit from PEI WSIPP-documented Evidence-Based Practices: FY 2011-12

Evidence-Based Program/Practice documented in WSIPP	Expected Net Per Participant	Number of Individuals	Total (12 month period)
	Monetary Benefit	Total Number	Monetary Benefit
Aggression Replacement Training	\$14,846	102	\$1,514,292
Brief Strategic Family Therapy	\$2,601	625	\$1,625,625
Cognitive-Behavioral Therapy-Based Models for Child Trauma	\$9,246	9,103	\$84,166,338
Cognitive-Behavioral Therapy for Adolescent Depression	\$2,957	23	\$68,011
Cognitive Behavioral Therapy – Adult Depression	\$15,405	4,459	\$68,690,895
Families and Schools Together	\$851	197	\$167,647
Functional Family Therapy – Youth	\$26,216	1,421	\$37,252,936
Incredible Years Parent Training	\$408	142	\$57,936
Incredible Years Parent and Child Training	\$295	721	\$212,695
Mentoring	\$3,534	34	\$120,156
Promoting Alternative Thinking Strategies (PATHS)	(\$134)	686	(\$91,924)
SafeCare	\$1,399	402	\$562,398
Strengthening Families	\$5,805	67	\$388,935
Triple P Positive Parenting Program (group)	\$1,737	6,641	\$11,535,417
Triple P Positive Parenting Program (individual)	\$1,788	143	\$255,684
TOTAL		24,766	\$206,527,041

*WSIPP did not include cents in their monetary benefit calculations so they are excluded from this table

A conservative estimate of the monetary benefit of WSIPP-validated prevention and early intervention programs and activities yields **\$206.5 million** after program/activity costs are accounted for.

Discussion

This Executive Summary concludes with study implications and associated recommendations for PEI.

Defining Populations at Risk of a Mental Illness for Prevention Programs

Defining prevention services as intended for those at risk of a serious mental illness can be interpreted many different ways. For the purpose of this study, UCLA applied a definition grounded in the scientific, peer-reviewed literature. The study’s definition led to underserved racial/cultural populations (in the absence of other risk factors) assigned to ‘out of study scope’ due to no documented link to later onset of mental illness. Based upon this finding, the following is recommended:

Recommendation #1: MHSOAC to consider providing standard definitions for ‘at risk of a mental illness,’ in order for MHSOAC to ensure that appropriate populations are being served. For example, underserved cultural populations are included only when there are additional literature-documented risk factors. Guidance can be provided about the basis for the ‘underserved’ part of the definition, for purposes of tracking, reporting and evaluation. The PEI report findings suggest that MHSOAC may wish to examine the basis upon which “Underserved Racial/Cultural Group” is determined, tracked over time and documented in the PEI section of the Annual Update and Three-Year Plan.

Data Limitations Reported by Counties with ‘Mixed’ Priority Populations

For the purpose of this study, nearly half of the counties (n=27; 45.8%) were unable to document the numbers served and expenditures by target population within a program/activity. Because of the inability to disentangle numbers served and/or expenditures by target population, these programs/activities were classified into a ‘mixed’ category.

Although nearly half of the counties reported an inability to separate numbers served and/or expenditures for priority populations for at least one program/activity, the actual number of programs/activities that fell into the ‘mixed’ category was relatively small (n=51; 10.9%) in comparison to the overall total number of programs/activities implemented in FY 2011-12 (n=467). Reasons for data limitations reported by the 27 counties with one or more programs/activities classified as ‘mixed’ included:

- Program/contractor was only required to report the total number of persons served under their contract and not track persons served by priority population:
 - For example, if a school district entered into a contract with the county to deliver a Student Assistance Program, the district may have only been required to report the *total number* of students referred and/or assessed, but not assessment results (how many were in need of prevention versus early intervention), nor the number referred on to counseling, family therapy, etc.
- County mental health data systems are set up to track individuals that have been diagnosed with a mental illness (for billing purposes). Therefore, only individuals receiving early intervention services could be tracked using traditional county data systems.
 - Unless the county already developed an add-on management information system (MIS) or separate MIS to specifically track PEI participants and priority population status (at risk of mental illness or with early onset), participant records may be located at the program/activity site and in a format not compatible with an electronic database (e.g., paper and pencil notes in a case file).

Given the new draft PEI regulations and the existing requirement for outcomes-based planning, clear identification and reporting about the population for whom outcomes are intended will be critical. With this in mind, the following recommendations are suggested:

Recommendation #2: MHSOAC consider clearly defining ‘program’ and ‘activity.’ The PEI report findings suggest that MHSOAC may wish to examine the basis upon which ‘program’ is determined, tracked over time and documented. Reporting at the ‘activity’ level may be more meaningful, particularly when a ‘program’ includes many activities.

Recommendation #3: MHSOAC consider piloting a statewide PEI process and outcome monitoring system. Through an RFP process, the MHSOAC can support a collaborative process in partnership with the counties, whereby a PEI

process and outcome monitoring system is piloted. Considerations for the ‘process’ part of the system include (these are examples, for additional details please refer to the full report):

- Priority population (at risk of a mental illness and the basis of risk status; with early onset of a mental illness and the specific serious mental illness)
- Type of program/activity
- Entry and exit dates

Considerations for the ‘outcome’ part of the system include:

- Seven negative outcomes defined in statute
- Other outcomes defined through a logic model or similar logical process

Other considerations include methods for documenting provision of stand-alone ‘indirect’ programs/activities. The results of the pilot study can be used to determine if the PEI pilot system can be adopted statewide.

Should the MHSOAC design a statewide PEI performance monitoring system in the future, county input related to challenges will be useful in terms of identifying, in advance, potential pitfalls and areas where technical assistance and training will be needed. In addition, examination of data collection systems developed by counties successfully tracking and evaluating PEI efforts will enhance and inform any statewide effort.

‘Evidence-Based Practices’ Implemented under PEI

Given the exciting findings from the WSIPP-documented EBPs implemented in FY 2011-12 under PEI, the following recommendations are offered:

Recommendation #4: MHSOAC consider supporting a study of evidence-based, promising and community-defined practices that involves using research evidence standards more common to EBPs (i.e., standards currently defined in the Substance Abuse and Mental Health Services Administration’s National Registry of Evidence-Based Programs and Practices - NREPP).²⁴ NREPP uses very specific standardized criteria to rate interventions and the evidence supporting their outcomes. These six standardized criteria can be built into PEI evaluation RFP design:²⁵

1. [Reliability of measures](#)
2. [Validity of measures](#)
3. [Intervention fidelity](#)
4. [Missing data and attrition](#)
5. [Potential confounding variables](#)
6. [Appropriateness of analysis](#)

For feasibility considerations, UCLA recommends focusing on a particular subset of:

- early intervention practices
- prevention practices

For example, peer-to-peer education and peer support could be the focus of a cross-county evaluation in order to determine potential effectiveness as stand-alone practices, or as a mediator (in combination with other practices).

The potential result of MHSOAC-supported evaluation (depending upon the findings) could be nomination of one or more PEI models of peer-to-peer education and peer support to NREPP as EBPs.

The practices to be evaluated should be those in which counties have expressed enthusiasm and willingness to participate. Narrowing the focus to a limited number of practices avoids the potential pitfall of spreading evaluation resources too thin. Success in documenting the outcomes of one subset of practices in each priority area may generate excitement and enhance future opportunities for evaluation collaboration.

UCLA is not recommending a study of cost-effectiveness at this time because foundational evaluation research must first be completed before taking the next step of examining costs and benefits.

Recommendation #5: MHSOAC consider supporting a study of current practices, for which there is only research evidence, to be tested for consistency with client and cultural preferences. For example, participants in any of the WSIPP-documented EBPs could be surveyed in order to determine if the EBP focuses on empowerment, recovery and resiliency (client-focus), and if the EBP's values and teachings are consistent with the values and teachings of their culture (this is an over-simplification of complex concepts for example purposes; any RFP must, by necessity, lay out the nuance of client-focused practices and cultural competence).

UCLA recommends that such a study be designed as a participatory evaluation in order to ensure the participation of people with lived experience in the design, data collection, interpretation and presentation of results.

Executive Summary End Notes

¹ Mental Health Services Act (2011, amended after AB 100). Retrieved on September 26, 2013 from: http://www.dmh.ca.gov/prop_63/mhsa/docs/MHSAafterAB100.pdf

² California Welfare and Institutions Code (WIC), Division 5. Community Mental Health Services, Part 4.5. The Mental Health Services Fund (5890 – 5899).

5892. (a) In order to promote efficient implementation of this act, the county shall use funds distributed from the Mental Health Services fund as follows: (3) Twenty percent of funds distributed to the counties pursuant to subdivision (c) of Section 5891 shall be used for prevention and early intervention programs in accordance with Part 3.6 (commencing with Section 5890) of this division.

Note that the direct web link to CCR specific to the Mental Health Services Act requires search onsite, using the link below. The direct link to each code cannot be reproduced, and will not lead directly to the specific CCR. The only way to retrieve each CCR is to search the site,

<http://government.westlaw.com/linkedslice/default.asp?RS=GVT1.0&VR=2.0&SP=CCR-1000&Action=Welcome>

³ California Department of Mental Health (2007). DMH Information Notice No. 07-19, Enclosure 1. Mental Health Services Act Proposed Guidelines: Prevention and Early Intervention component of the three-year program and expenditure plan, fiscal years 2007-08 and 2008-09. Sacramento, CA. Quoted p. 2. Retrieved on September 15, 2013 from: http://www.dmh.ca.gov/dmhdocs/docs/notices07/07_19_Enclosure1.pdf

⁴ California Welfare and Institutions Code (WIC), Division 5. Community Mental Health Services, Part 2. The Bronzan-McCordquodale Act (5600 – 5623.5).

5600.3. To the extent resources are available, the primary goal of the use of funds deposited in the mental health account of the local health and welfare trust fund should be to serve the target populations identified in the following categories, which shall not be construed as establishing an order of priority...

⁵ Ibid.

⁶ Please see the full report, Chapter II, for the literature citations.

⁷ Limiting the literature review to potential risk factors documented and reported by counties was necessary because an exhaustive literature search and review for all antecedents of mental illness was beyond the scope of this evaluation, and not necessary in order to answer the study question of whether county programs/activities were recruiting populations at risk for later onset of mental illness.

⁸ The study differentiates between broad suicide prevention efforts that don't target specific individuals, as opposed to an early intervention program that could intervene to prevent suicide among individuals with early onset of a mental illness or prevention programs that serve specific individuals at risk for later onset of mental illness because they are exhibiting self-harm behaviors and experiencing suicidal ideation.

⁹ Per the Mental Health Services Act, Section 4. Part 3.6 (commencing with Section 5840) is hereby added to Division 5 of the Welfare and Institutions Code, to read: Part 3.6 Prevention and Early Intervention Programs.

¹⁰ As defined in Section 5600.3.

¹¹ Ibid.

¹² (f) In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the Department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and early intervention programs for children, adults, and seniors.

¹³ The term 'county' is used to refer collectively to California's 58 counties (two of which operate in joint county partnership) and two municipalities that implemented PEI programs/activities in FY 2011-12.

¹⁴ California Department of Mental Health (2007). DMH Information Notice No. 07-19, Enclosure 1. Mental Health Services Act Proposed Guidelines: Prevention and Early Intervention component of the three-year program and expenditure plan, fiscal years 2007-08 and 2008-09. Sacramento, CA. Quoted pp. 5, 9. Retrieved on September 15, 2013 from: http://www.dmh.ca.gov/dmhdocs/docs/notices07/07_19_Enclosure1.pdf

¹⁵ California Department of Mental Health (2010). *DMH Information Notice No. 10-04*. Clarification and modifications to Enclosures for the Proposed Guidelines for the Mental Health Services Act (MHSA) Fiscal Year 2010/11 Annual Update to the Three-Year Program and Expenditures Plan. Quoted p. 4. Sacramento, CA. Retrieved on September 15, 2013 from: <http://www.dmh.ca.gov/dmhdocs/docs/notices10/10-04.pdf>

Consistent with the PEI Guidelines, the County must include in its annual update programs that address all age groups, and a minimum of 51 percent of the County's total PEI funds must be used to serve individuals who are under 25 years of age. Small counties are exempt from these requirements.

Small counties: As defined in Title 9 of the California Code of Regulations section 3200.260.

California Code of Regulations (Barclays Official), Title 9, Division 1, Chapter 14, Mental Health Services Act. Article 2, Definitions. 3200.260. Small County. "Small County" means a county in California with a total population of less than 200,000, according to the most recent population by the California State Department of Finance.

¹⁶ California Department of Mental Health (2010). *DMH Information Notice No. 10-04*. Clarification and modifications to Enclosures for the Proposed Guidelines for the Mental Health Services Act (MHSA) Fiscal Year 2010/11 Annual Update to the Three-Year Program and Expenditures Plan. Quoted p. 4. Sacramento, CA. Retrieved on September 15, 2013 from: <http://www.dmh.ca.gov/dmhdocs/docs/notices10/10-04.pdf>

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¹⁷ Guidance was released for the FY 2011-12 RER by the Department of Health Care Services on August 23, 2013. PEI wave 2 data collection was scheduled to conclude on August 31, 2013.

MHSD Information Notice 13-17. Mental Health Services Act (MHSA) Revenue and Expenditure Report for FY 2011-12.

¹⁸ (f) In consultation with mental health stakeholders, and consistent with guidelines from the Mental Health Services Oversight and Accountability Commission, pursuant to Section 5846, the Department shall revise the program elements in Section 5840 applicable to all county mental health programs in future years to reflect what is learned about the most effective prevention and early intervention programs for children, adults, and seniors.

¹⁹ The MHSA mandates use of practices that have been shown to be effective and successful. It does not mandate a specific way to demonstrate the programs are effective and successful. DMH PEI Guidelines provide a range of acceptable evidence that counties could use to document the basis for their choice of PEI programs. There are MANY different definitions for EBPs. Some are so broad that they probably would be a common-sense (to many but not all) way of demonstrating that a program was effective and successful. Other definitions of EBPs are so narrow that many (but not all) would argue they could rarely (if ever) be applied usefully to a public health prevention and early intervention program. Many communities of color argue that not only are EBPs not available for effective practices for their communities but the ways that EBPs are demonstrated (scientific, peer-reviewed academic journals, random assignment, fidelity of replication, western definitions of mental health and mental illness) are incompatible with their cultural values.

²⁰ The expended amount is not included because programmatic costs were factored into the WSIPP analyses and subtracted from the monetary benefit.

²¹ Expected net per participant monetary benefit was drawn from two WSIPP briefs:

Washington State Institute for Public Policy, (2012, April). *Return on investment: Evidence-based options to improve statewide outcomes* (Document No. 12-04-1201). Olympia, WA: Author.

Washington State Institute for Public Policy, (2004, September). *Benefits and costs of prevention and early intervention programs for youth* (Document No. 04-07-3901). Olympia, WA: Author.

²² Washington State Institute for Public Policy, (2013). *Benefit-Cost Technical Manual: Methods and User Guide*. (Document No. 13-10-1201b). Olympia, WA: Author. Retrieved on January 3, 2014 from:

<http://www.wsipp.wa.gov/TechnicalManual/WsippBenefitCostTechnicalManual.pdf>

²³ For example, Amador and Los Angeles counties also offered Aggression Replacement Training (ART) but their numbers served are not included in the ROI calculation because the WSIPP study only focused on youth involved in the juvenile justice system and this was not the target population for either the Amador or the Los Angeles county ART.

²⁴ <http://nrepp.samhsa.gov/>

²⁵ <http://www.nrepp.samhsa.gov/ReviewQOR.aspx#ROM>

DEFINITION OF TERMS	
3M	Quarterly Assessment
AB	Assembly Bill
CF	Capital Facilities
CF-TN	Capital Facilities and Technological Needs
CMHDA	California Mental Health Directors Association
CSA	Corrections Standards Authority
CSI	Client Services Information System
CSS	Community Services and Support
CYF	Children, Youth and Families
DCR	Data Collection and Reporting System for MHSA FSP
DJJ	Division of Juvenile Justice
DMH	Department of Mental Health
DNR	Agency did not report costs
DOF	Department of Finance
EAG	Evaluation Advisory Group
ER	Emergency Room
FFP	Federal Financial Participation
FSP	Full Service Partner
FY	Fiscal Year
GSD	General System Development
IMD	Institution for Mental Diseases
IMPACT	Improving Mood--Promoting Access to Collaborative Treatment
JHC	Juvenile Halls and/or Camps
KET	Key Event Tracking
LAO	Legislative Analyst's Office
LGBTQ	Lesbian, Gay, Bi-Sexual, Transsexual/Transgender and Questioning
MH	Mental Health
MHRC	Mental Health Rehabilitation Centers
MHSA	Mental Health Services Act
MHSOAC	Mental Health Services Oversight and Accountability Commission (also OAC)
OA	Older Adults
OSHPD	Office of Statewide Health Planning and Development
PAF	Partnership Assessment Form
PEI	Prevention and Early Intervention
POQI	Performance Outcomes and Quality Improvement
RER	Revenue and Expenditure Reports
RFA	Request for Applications
RFP	Request for Proposal
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SED	Seriously Emotionally Disturbed
SGF	State General Fund
SMA	Statewide Maximum Allowance
SMHA	State Mental Health Authority
SPSS	Statistical Package for the Social Sciences
TAY	Transition-Age Youth
TN	Technological Needs
WET	Workforce Education and Training
WIC	Welfare and Institutions Code
YSS	Youth Services Survey
YSS-F	Youth Services Survey for Families

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