

MHSOAC Evaluation Interpretation Paper:
Use of PEI Funds for Prevention and Early Intervention Efforts



Evaluation Interpretation Paper

**Interpretation of UCLA PEI Contract #MHSOAC-12-007
Deliverable 1: Use of PEI Funds for Prevention and Early
Intervention Efforts**

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As part of its Welfare & Institution Code (WIC) Section 5845 oversight responsibilities, and consistent with the vision of the Mental Health Services Oversight and Accountability Commission (MHSOAC) Evaluation Master Plan, the MHSOAC entered into an evaluation-focused contract with a group of researchers at the University of California, Los Angeles (UCLA) Center for Healthier Children, Youth, and Families on June 26, 2012. The contract requires the researchers to evaluate the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA).

The first major report (Deliverable 1) completed via this contract, titled “Prevention and Early Intervention: California’s Investment to Prevent Mental Illness from becoming Severe and Disabling”, was submitted to the MHSOAC on October 31, 2013. The report focused on achieving the following objectives:

- Assess who is being served by both prevention and early intervention efforts for fiscal year (FY) 2011/12, including a break out of target populations;
- Assess the use of PEI funds for purposes specified in the MHSA (i.e., Welfare and Institutions Code Section 5840);
- Identify the total amount of MHSA PEI funds spent on prevention and early intervention efforts at the State and county level for FY 2011/12.

The results of this evaluation that address each of these three main issues are detailed within the report and associated Executive Summary. This MHSOAC evaluation interpretation paper provides a high-level summary of the findings and focuses on issues that the MHSOAC may wish to consider based on the study findings.

Summary

Overall, findings from this report demonstrate that counties achieved the goals of serving individuals who are at risk of mental illness/emotional disturbance via Prevention efforts, as well as those who show early signs and symptoms of mental illness/emotional disturbance via Early Intervention efforts. Most counties provided Prevention (45 counties; 76.3%) and Early Intervention (40 counties; 67.8%) services to a diverse group of individuals in FY 2011/12. Approximately 134,797 individuals at risk for mental illness were served directly via Prevention services; the majority of those served via Prevention services were children/youth (64.9%) and Caucasian (38.1%). Approximately 230,426 individual showing early signs and symptoms of mental illness were served directly via Early Intervention services; the majority of those served via Early Intervention services were children/youth (36.4%), female (60.2%), and Hispanic/Latino (42.5%).

In addition, all counties engaged in efforts to achieve other goals mandated by the MHSA pertaining to PEI activities, including offering screening, assessment, and referrals; outreach, education, and training to people in a position to recognize the signs and symptoms of mental illness; campaigns and other strategies aimed at reducing stigma and discrimination related to

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having a mental illness or seeking services; and campaigns and other strategies aimed at reducing suicide. Such efforts were carried out within direct services that were offered to individuals at risk of mental illness (i.e., within direct Prevention services) and those showing early signs and symptoms of mental illness (i.e., within direct Early Intervention services), as well as more broadly via strategies not linked to direct services for individuals.

In FY 2011/12, approximately \$317,940,706 was expended by counties on PEI efforts. Of this total, approximately \$40,197,494 (12.6%) was expended on Prevention services, and \$172,943,344 (54.4%) on Early Intervention services. Approximately \$82,134,885 (25.8%) of PEI funds were expended on achievement of other goals mandated by the MHSA via efforts that did not include provision of direct services to individuals, including screening, outreach efforts, training, and broad-based efforts to reduce stigma and discrimination, and prevent suicide.

Via supplemental analysis that the UCLA contractors performed, the potential for a large return on investment via offering Prevention and Early Intervention services for individuals that are evidence-based was highlighted. Approximately 15 PEI services for individuals being offered by California counties were identified by an external policy institute in Washington State as among those meeting that organization's highly stringent criteria for "evidence-based practices". Using information generated by this organization, the UCLA contractors were able to identify the expected per participant net monetary benefit for offering these services to individuals in California. This monetary benefit for each of the 15 PEI services was then multiplied by the total number of individuals served via those services by MHSA PEI funds in FY 2011/12 (i.e., 24,766 individuals served) to obtain a total annual expected monetary benefit for each service. Summed, approximately \$206,527,041 in savings/monetary benefits were identified (i.e., the total amount of savings that could be realized after accounting for the cost of offering the services). This finding speaks to the potential financial benefits of offering sound PEI services to individuals and the value of demonstrating that benefit among more programs through effective research.

Potential Issues for the MHSOAC to Consider

Although, based on the results of this evaluation, almost all counties throughout California are meeting the specifications of the MHSA that pertain to PEI, the results of this evaluation highlight areas that could be strengthened. Such strengthening could ensure that 1) forthcoming PEI regulations support counties in adhering fully to the MHSA with regard to PEI and to demonstrate outcomes, and 2) that counties and the State have ample information to carry out ongoing efforts to improve upon the quality of PEI-funded services and programs. Examples of such issues are noted below:

- As detailed within the report, three counties offered four Prevention programs that were defined by the UCLA contractors as being outside the scope of this study. This categorization was based on the fact that these programs did not meet criteria to be classified as Prevention, Early Intervention, a mix of Prevention and Early Intervention

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programming, or as aiming to meet broader PEI goals via efforts that are not direct services to individuals. The four Prevention programs in question did provide direct services to individuals, but they did not appear to serve a target population that was at risk for mental illness/emotional disturbance and, as such, were not classifiable as Prevention programs. The MHSA clearly specifies that Prevention and Early Intervention efforts are intended to “prevent mental illness from becoming severe and disabling”. This implies that PEI efforts should target individuals at risk for, in the early stages of, or with mental illness. However, the Department of Mental Health (DMH) PEI Guidelines that were previously disseminated to direct counties’ PEI programs designated “underserved cultural populations” as one of a menu of “priority populations” that could be the focus of intended outcomes for PEI programs. This presents a potential contradiction, in that not all underserved cultural groups are necessarily (in and of themselves) at risk for mental illness. As such, those counties administering programs targeted at such populations without additional risk factors are in compliance with the DMH Guidelines, but not in line with the MHSA intentions for the populations that PEI funds should be used to serve. This issue has been corrected in the draft PEI Regulations that the MHSOAC approved in December 2013. The evaluation also documented that some of the “out of study scope” programs were not serving “underserved cultural populations”. Counties may need additional guidance to ensure that they are identifying and serving target populations (via PEI funds) for whom there is a documented risk of a potentially serious mental illness.

- There is a need to ensure that counties are able to consistently define and parse out Prevention versus Early Intervention activities that directly serve individuals at risk of or with early onset of a mental illness. This need pertains to two potential issues that arise when this cannot be readily accomplished:
 - Twenty-seven (45.8%) counties were identified as having “mixed” programs that included services for those at risk for mental illness (i.e., Prevention) and those showing early signs and symptoms (i.e., Early Intervention). In such cases (when programs were defined as mixed), counties were not able to separate out the funds expended on Prevention versus Early Intervention efforts, or provide separate counts for individuals served by Prevention versus Early Intervention efforts. This inability to parse out expenditures and clients served is problematic since it prohibits the ability to fully understand what PEI funds are being used for, as well as the potential impacts of those specific programs (including potential cost benefits). Without the ability to understand the impact of individual activities, it would be challenging for counties to use evaluation techniques for quality improvement purposes.
 - In addition, four (4) programs in four (4) counties had programs classified as mixed since a Prevention and/or Early Intervention activity could not be separated from an activity that was deemed to be out of the study’s scope (i.e., a clearly-

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defined target group of individuals at risk of mental illness was not identified by the UCLA contractors). The inability to parse out Prevention and Early Intervention activities from such activities is problematic since those activities that do not have a clearly-defined target population of individuals at risk of a mental illness may not be in line with the MHSA (and would, thus, need to be delineated from those activities that do serve clearly-defined target populations that are at risk for mental illness). Such requirements to differentiate reporting for Prevention distinct from Early Intervention programs are included in the MHSOAC-approved draft PEI Regulations.

- The report notes that 40 (67.8%) of counties provided Early Intervention services in FY 2011/12. The MHSA intends for all counties to provide Early Intervention services for individuals who show early signs and symptoms of mental illness, as is demonstrated within the following language: “The [PEI] program shall include...components similar to programs that have been successful in...assisting people in quickly regaining productive lives”. Current DMH PEI Guidelines do not include a requirement for counties to offer Early Intervention programs. To address this issue, draft PEI Regulations require counties to include at least one Early Intervention program.
- Not all counties were able to provide the requested data on clients served and expenditures associated with PEI for FY 2011/12. In the instance of expenditures, one (1) county did not report any expenditure data for its one (1) Prevention activity and two (2) Early Intervention activities. In addition, only 65.5% of counties provided what they believed was “actual” or fully accurate expenditure data; other counties provided estimates when numbers were provided. In the instance of clients served, not all counties were able to provide the demographic profiles of the clients served via Prevention or Early Intervention services. Especially in the case of services to discreet individuals at risk of or with early onset of a mental illness, it seems plausible that all counties should have the opportunity to collect such data. As noted earlier, the lack of accurate data on such fundamental items limits the ability to accurately track and evaluate the impact of PEI programs and funding. This issue is addressed in draft PEI Regulations, which provides for more consistent reporting. The MHSOAC should consider implementation—in collaboration with counties and other partners and stakeholders—of a new integrated statewide system that would provide counties with guidance (and advanced notice) regarding State and county data needs. As discussed in the UCLA report, this level of information—when/if requested—has been requested via Annual Updates and the Annual Revenue and Expenditure Reports (RER). Due to lack of instructions that clearly request such information to be provided to the State in systematic ways by all counties coupled with significant variation in how the Annual Updates and RER are filled out and submitted by counties, the Updates and RER do not provide data that is generally helpful for understanding fundamental concepts, such as expenditures, numbers of clients served,

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and demographic profiles of clients served for all Prevention and Early Intervention activities, including Prevention and Early Intervention services and indirect activities. These issues regarding the type of data that is collected by counties and how data is then reported to the State has been addressed in draft PEI Regulations, which will supersede the need for specific Annual Update, RER, and Three-Year Program and Expenditure Plan instructions. Reporting and data needs must continue to be addressed in order to ensure a full understanding of the use of PEI funds and their impact as an integrated MHSA component that, with later-onset treatment, contributes to the overall impact of the MHSA.

- The UCLA contractors highlighted interesting findings regarding the cost benefits associated with offering PEI services that are deemed to be evidence-based practices, according to a policy institute in Washington State. The MHSA also places an emphasis on the use of effective practices (in general), although no clear definition of what constitutes evidence of success or effectiveness is identified. The MHSOAC may wish to consider taking steps to ensure that counties are readily able to use effective PEI practices, and that such practices can readily be identified. Both PEI Guidelines and draft PEI Regulations require counties to use practices with evidence of their effectiveness; draft regulations require that this evidence be based specifically on the intended population for the program. Overall, the MHSOAC may wish to continue supporting counties' use of effective practices and begin highlighting the benefits of using cost-effective practices. Counties may benefit from recommendations regarding how to identify and establish both effective and cost-effective practices within PEI and in general.

By taking the steps outlined above, which are based on results of an MHSOAC-sponsored evaluation effort, the MHSOAC has the opportunity to continue to strengthen the use of PEI funds to prevent mental illnesses from becoming severe and disabling and to improve timely access to services for underserved populations, consistent with MHSA goals and priorities. In addition, the MHSOAC has the opportunity to ensure that counties and the State have ample information to carry out ongoing efforts to track use of PEI funds, measure outcomes, and improve upon the quality of PEI-funded services and programs. These recommendations are in line with the MHSOAC-adopted Logic Model that speaks to oversight and accountability strategies that the MHSOAC undertakes, including ensuring collecting and tracking of relevant data/information, ensuring that counties are provided with appropriate support, ensuring that MHSA funding and services comply with relevant statutes, and use of evaluation results for quality improvement purposes. The recommendations are also consistent with recently adopted draft regulations for the MHSA PEI component and recommendations to the Department of Healthcare Services regarding their development of MHSA regulations that affect PEI.