

The 2009 California Health Interview Survey

Proposal to The California Department of Mental Health

E. Richard Brown, PhD
Principal Investigator

Director, UCLA Center for Health Policy Research
Principal Investigator, California Health Interview Survey

David Grant, PhD
Co-Principal Investigator

Director, California Health Interview Survey

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UCLA Center for Health Policy Research



Introduction

The California Health Interview Survey (CHIS) is the largest state health survey in the nation. Conducted every two years since 2001, CHIS is a population-based telephone survey designed to assess public health and health care indicators for California's racially, ethnically, and geographically diverse population. CHIS data are used extensively by many state agencies, local public health agencies, community-based agencies, health care service providers, advocacy organizations, federal agencies, foundations, and researchers. They use these data in analyses and publications to assess public health and health care needs, to advocate and develop health policies, and to develop programs and services to meet health needs of all Californians, but especially vulnerable and underserved populations.

These features make CHIS an invaluable tool for tracking mental health and service use in California. CHIS 2005, for example, demonstrated that nearly 1 in 5 adults in California—4.8 million people—reported the need for help with an emotional or mental health problem in the past year yet less than one-third of them actually visited a mental health professional for treatment. CHIS provides the opportunity to:

1. Identify populations by socioeconomic, race/ethnic, or geographic characteristics that are *underserved*.
2. Help specify the *barriers* that contribute to disparities in treatment utilization, including stigma, cost, and adverse experiences with treatment.
3. Inform the California mental health policy debate with population data on mental health status and its links to physical health status, health insurance, and economic well-being.
4. Highlight *trends over time* in mental health status and use of mental health services.

Understanding mental health is important because of its documented association with disability, work productivity, and overall quality of life. The recent enactment of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, which bans employers and insurers from imposing stricter limits on coverage for mental health and substance-use conditions than those set for other health problems, is a significant step forward towards health care reform. The legislation recognizes the importance of mental health to overall health. CHIS data can help illuminate the continued economic impact of mental health on California, from lost worker productivity to societal burden associated with increased psychiatric, health, and social care service expenditures, such as emergency room use.

The enactment of Proposition 63, now the Mental Health Services Act (MHSA), in November 2004 provides increased funding for programs to expand service programs for children, adults and seniors with serious mental illness, including “culturally and linguistically competent approaches for underserved populations” (Ref: MHSA). The MHSA also contains a Prevention and Early Intervention (PEI) component, which provides funding to help prevent the development of serious emotional disorders and mental illness. PEI policies emphasize “the need for prevention efforts to be directed toward California’s multicultural and multilingual communities where disparities are evident in the community members’ access to mental health services, their quality of care received, and the outcomes of their mental health services and supports” (Ref: MHSOAC PEI County and State Level Policy Direction.) Hence, implicit in these policies is a mandate to identify and understand mental health disparities in the state: differences in mental health need, barriers to services, differential access to services, and inequities in mental health care and supporting services. CHIS data can be instrumental in establishing benchmarks for the current state of mental health care and in monitoring the progress of the statewide goals for children, transition age youth, adults, older adults and families under the MHSA.

I. Proposal Overview

The UCLA Center for Health Policy Research (UCLA-CHPR) seeks funding from the California Department of Mental Health (DMH) to i) support mental health content in the 2009 California Health Interview Survey (CHIS 2009), ii) to analyze, interpret, and prepare a number of reports based on previously collected CHIS mental health data, and iii) to disseminate CHIS 2009 data files, including mental health content, through multiple channels to maximize use of these data. If this proposed collaboration between UCLA-CHPR and DMH is approved, it will begin December 1, 2008 and end on June 30, 2010. The total cost for the CHIS 2009 data collection, the mental health analyses and publications using CHIS data, and the dissemination of CHIS 2009 data is \$1,618,381, including both direct costs and indirect costs. The final page of this proposal includes a summary budget by fiscal year.

II. CHIS 2009: Data Collection

Summary

DMH funding will support the collection of data on mental health in the adult and adolescent surveys¹, as well as data analysis and products related to mental health and access to, and utilization of, mental health services. To facilitate the analysis of trends in key mental health indicators across CHIS cycles, the adult interview will include a mental health module and the adolescent interview will include several items about mental health status and utilization of mental health alcohol/drug treatment. Consistent with the goals of the Mental Health Services Act (MHSA) towards addressing “a broad continuum of prevention, early intervention and service needs,” DMH funding will support the collection of information on mental health indicators that provide continuity with previous CHIS surveys, which were also supported by DMH, and fund the addition of questions related to suicide ideation, planning, and attempts.

Below, we describe a number of mental health survey content areas that can be included in CHIS 2009 with the support of DMH. The content described is similar to the content that DMH sponsored in CHIS 2007, with the addition of a new proposed module on suicide. Cost estimates for each content module are provided. Please note that these costs are approximate, can generally be scaled up or down, and do not include additional project costs including University indirect charges, administrative, and staff costs.

The total costs of data collection are \$1,435,545, including the individual module estimates below and necessary staffing, dissemination activities described in section III, and indirect costs. We welcome the opportunity to collaborate with DMH to refine these options to best meet the agency’s needs for county and state population-based data on mental health related information in California.

CHIS 2009 Adult survey content (ages 18 and up)

- Mental health assessment (\$700,000)
- Perceived need and utilization of mental health services (\$243,000)
- Mental/emotional health disability and severity (\$140,400)
- Stigma as a barrier to service utilization (\$15,000)
- Suicide (\$144,400)

CHIS 2009 Adolescent survey content (ages 12 to 17)

- Mental health assessment (\$48,600)
- Perceived need and utilization of mental health services (\$27,000)
- Suicide (\$16,000)

¹ TBD in consultation with DMH

CHIS 2009 Child survey content (ages 0 to 11)

Note: There is no cost to DMH for the child mental health content because it is supported by First 5 California.

- Developmental/mental health conditions (ADD, ADHD, Asperger's syndrome, autism, other developmental delay)
- Parent's Evaluation of Developmental Status (PEDS), children age 4 months to 5 years
- Strengths and Difficulties Questionnaire (SDQ), children ages 4 to 11 years
- Child receive psychological/emotional counseling in past 12 months

Details

A1. Mental health assessment in the adult survey is measured using specific indicators that provide overall mental health status. These measures provide information about the likely presence of symptoms indicating serious psychological distress. Specific items are the following:

1. The Kessler K6 scale, which is an assessment of severe psychological distress over the past 30 days;
2. Assessment of severe psychological distress over the past 12-months using a re-ask of the K6 for the "worst month" among the subsample that reported a worse month in past year (1 item to assess worst month, 6 items to re-ask K6);

The K6 is used in the annual National Health Interview Survey and in other state surveys; this allows important comparisons to be made between California and the United States as a whole as well as with other states.

A2. Mental health service need and utilization is determined by asking a set of questions about self-perceived need for help with a mental health or drug/alcohol problem, whether or not the respondent has received services from a mental health professional in the past 12 months, and the type of treatment received (mental/emotional health, drug/alcohol, or both). Specific items include:

1. Whether the respondent felt the need to visit a professional for help with emotions, nerves or an alcohol or drug problem (among those who did not receive treatment in the past year, yet meet a threshold indicating mental distress based on the K6; 1 item)
2. Whether the respondent visited a primary care physician/general practitioner for mental health, emotions, nerves or use of alcohol or drugs (1 item);
3. Whether the respondent visited other professionals, such as a counselor, psychiatrist, or social worker for mental health, emotions, nerves, or use of alcohol or drugs (1 item);
4. Reason for seeking help in past year (mental/emotional or drugs/alcohol; 1 item);
5. Number of visits in the past year to a professional for mental health, drug or alcohol treatment (among those who sought treatment within the past year; 1 item);
6. Determination whether s/he is still in treatment for a mental or drug/alcohol problem (1 item);
7. Determination whether s/he is taking daily prescription medication for an emotional or personal problem (1 item).

A3. Disability due to mental health is measured using several items based on the Sheehan Disability Scale as well as an item that assesses the extent to which mental health has interfered with work productivity, self-care, and social relationships. Specific items are:

1. Series of questions about the extent to which mental/emotional health interfered with the respondent's ability to work, do household chores, social life, relationships with family and

2. Number of days in the past year s/he was unable to work/carry out normal activities due to mental health (1 item).

A4. Adult mental health stigma is measured by asking items related to personal or cultural barriers in seeking mental health treatment for a perceived need. Specific items are:

1. The main reason s/he is no longer in treatment (1 item);
2. Series of questions about reasons for not seeking help even when s/he thinks might need it, including cost of treatment, discomfort in discussing problems with a professional, concern about having someone find out s/he has a mental or emotional health problem, and difficulty getting an appointment (4 items).

A5. Adult suicide is a new content area for CHIS mental health data collection and addresses three areas of suicide, including ideation, planning and attempts. These questions are adaptable to both the adult and adolescent surveys. Specific items are:

1. Ideation: Ask if ever seriously thought about suicide and thought about suicide in the past year (2 items);
2. Planning: Ask if ever made a plan for suicide and made a plan for suicide in the past year (2 items);
3. Attempts: Ask if ever attempted suicide, attempted suicide in the past year, and agreement with statements about last attempted suicide (3 items).

Additional funding for the suicide module will support protocol compliance and implementation. In accordance with the UCLA Institutional Review Boards (IRBs) recommendations, the CHIS survey contractor will adhere to strict protocols to appropriately respond if a respondent appears to be in psychological distress. A portion of the DMH funding will provide adequate interviewer training as well as the availability of professional staff to assess and appropriately respond to protect the safety of distressed respondents.

B1. Adolescent mental health assessment (ages 12-17) is measured using items that provide information about the presence of symptoms indicating serious psychological distress. Specific items are:

1. Kessler-6 (K6) questions to determine mental health status over the past 30 days (6 items).

B2. Adolescent mental health service need and utilization refers to utilization of professional services for both mental health and drug/alcohol problems:

1. Perceived need for help with emotional/mental health problems (1 item).
2. Receipt of emotional/psychological counseling in the past year (1 item);
3. Receipt of counseling for alcohol and/or drug use in the past year (1 item).

B5. Adolescent suicide items mirror those found in the adult survey and a similar protocol will be implemented to adequately train interviewers and protect respondent safety. Items include:

1. Ideation: Ask if ever thought about suicide and thought about suicide in the past year (2 items);
2. Planning: Ask if ever made a plan for suicide and made a plan for suicide in the past year (2 items);
3. Attempts: Ask if ever attempted suicide, attempted suicide in the past year, and agreement with statements about last attempted suicide (3 items).

C1. Child developmental/mental health conditions

1. Parent report of doctor diagnosed ADD, ADHD, autism, Asperger's Syndrome, other development delay, other condition that limits child's usual activities (5 items)

C2. Parent's Evaluation of Developmental Status (PEDS). The PEDS was designed to screen for parent's concerns about their child's development and behavior in a clinically-based setting. More recently, the PEDS has been adapted for use in population-based surveys. In CHIS 2003, 2005 and 2007, parents of children ages 4 months to 5 years were asked age-specific questions based on their concerns in these developmental areas. Depending on age, a complex algorithm was applied to assign overall risk of problematic child development (i.e. no risk, low risk moderate risk, high risk). The PEDS module is comprised of 19 age-specific items.

C3. Strengths and Difficulties Questionnaire (SDQ). The SDQ is a brief behavioral screening questionnaire used to predict the likely presence of child psychiatric disorders in a community. The SDQ taps several psychological attributes of children using five subscales: emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems and prosocial behavior. Using the shortened version of the SDQ, six questions were asked of the most knowledgeable parent of children 6-11 years in CHIS 2003, and 4-11 years in 2005 and 2007. These scales (excluding the prosocial scale) were summed to produce an overall impact score (range 0-10) that assigns three levels of likely mental health development: normal, borderline, and abnormal. Normal suggests no difficulties in psychological or mental development and abnormal suggests the likely presence of a mental health condition. The SDQ module is comprised of 7 items.

C4. Child receive psychological/emotional counseling in past 12 months (1 item)

III. Analysis and Products²

Summary

We will produce several publications using CHIS data that will be developed in collaboration with DMH staff and affiliated experts and researchers. In this section, we describe a number of potential products based on previously collected CHIS mental health indicators, predominantly from CHIS 2007, that suggest some directions that we could take. These are brief descriptions that would be further developed and refined in collaboration with DMH. Data analyses, interpretation, write-up, design, layout, and production of printed products would be done by UCLA-CHPR in collaboration with consultants providing mental health and statistical expertise. We do not expect DMH to support all of the items described below, but attempt to provide a number of options so that DMH can select those items that best fit the agency's needs. We have budgeted for the Mental Health *healthSNAPSHOTs*, two policy research reports, and two policy research briefs.

- Internet-based Mental Health *healthSNAPSHOTs*
- CHIS 2007 policy research brief that highlights new adult mental health content in CHIS: Mental Health Status, Perceived Need, and Service Utilization Among Adults in California
- CHIS2007 policy research report: Mental Health Disparities in California
- CHIS 2005 & 2007 policy research brief: Factors Associated with Mental Distress among California's Older Population
- CHIS 2007 policy research brief: Psychological Distress and Health Behaviors among Adolescents

² More detailed proposals can be submitted separately for each product summarized.

- CHIS 2005 & 2007 policy research brief Child Well-being, Development and Emotional Health in California
- CHIS 2005 & 2007 policy research report: Using CHIS to Assess Mental Health Trends and to Support MHSA Planning and Goals

The total costs of developing and producing the Mental Health *healthSNAPSHOTs*, 2 policy research reports, and 2 policy research briefs are \$182,836, including analysis, writing, production, and internet dissemination. This budget includes a subcontract to Dr. Sergio Aguilar-Gaxiola at UC Davis, who will collaborate on the analyses and development of the publications.

Details

The suggested report and policy brief topics include:

D1. The Mental Health *healthSNAPSHOTs* online application will provide easily accessible profiles of mental health at the state, regional, and county levels for the California adult population. The UCLA-CHPR website currently includes *healthSNAPSHOTs* for General Health and Young Children's Health in California. The proposed Mental Health version will include a number of indicators including mental health status, disability due to mental or emotional health, and access to and utilization of mental health services. Service access and utilization as the result of alcohol and/or drugs will be considered separately. The product will utilize CHIS 2007 data and beyond.

D2. Utilizing CHIS 2007 data, a 5-7 page policy research brief is proposed that highlights new adult mental health content. This report will give a detailed picture of mental health status (including prevalence of suicide ideation and attempts), needs, barriers to care, and mental health service use among various socio-demographic and racial/ethnic subgroups. CHIS 2005 data may be pooled to achieve greater statistical stability as needed.

D3. A comprehensive policy research report (15-25 pages) is proposed that provides detailed analyses of mental health disparities in California. It will focus on mental health status, need for mental health care as well other care, access and barriers to care, and service use and the relationship of these outcome measures to physical health status, health insurance, socio-economic status, race/ethnicity, citizenship and immigration status, and cultural indicators such as language use for adults and youth in California. This report will serve multiple goals: 1) to facilitate the strategic targeting of vulnerable populations currently in need of mental health services, 2) to estimate and understand the needs of these populations, both for mental health care and other care, 3) to understand the barriers to care among these populations and to examine any differences in barriers between different populations, and 4) to examine disparities in service use and understand the relationship between service utilization and other factors (e.g., income, insurance, citizenship and immigration status, and language). These analyses will assist in formulating targets and strategies for the PEI component of MHSA and also tracking the overall goals of MHSA. Using the results of these analyses as a guide, this report will also make recommendations for possible future enhancements to CHIS to optimally track changes in these vulnerable populations over time in keeping with the goals of MHSA.

D4. A 4-8 page policy research brief is proposed that investigates the factors associated with mental health status among California's older population (65+). National statistics indicate an alarming rise in suicide rates among older white males. Using CHIS 2005 and 2007 data, analyses will be conducted to inform policy regarding the factors associated with increased psychological distress and self-reported need among California's older population. Potential indicators for analysis include physical and chronic health conditions, socio-economic status, work disposition, family structure, immigration status, co-morbid conditions (e.g., smoking, alcohol consumption), and access to, and use of, mental health services.

D5. A 4-8 page policy research brief is proposed that utilizes CHIS 2007 adolescent data to understand the association between increased mental distress and health behaviors among those 12-17 years. These health indicators include sexual behavior, birth control practices, smoking, binge drinking and drug use. The availability of data on diverse racial/ethnic and demographic sub-groups will also allow us to better explore the link between psychological distress and risk behaviors among California's adolescent population.

D6. CHIS 2005 and 2007 data provide information concerning children (ages 0 to 11) at risk for potentially serious mental, social and developmental delays. A 5-7 page policy research brief is proposed that investigates the contextual factors associated with developmental delay among children at risk in California. Measures of interest include the diagnosis of ADD/ADHD, the presence of other conditions that limit activities, screening for developmental delay, and receipt of psychological/emotional counseling. We anticipate that First 5 California would be interested in co-funding this research brief.

D7. We will develop a policy research report that can serve as a guide in the use of CHIS 2005 and 2007 data to assess mental health trends and to support MHSA planning and goals. This report will be a valuable tool both statewide and at the county level in implementing key provisions of the MHSA.

IV. Dissemination of CHIS 2009 Mental Health Data Files

The active dissemination of data through multiple channels is a hallmark of the CHIS project. The data collected about mental health sponsored by DMH will be made widely and easily accessible through a number of different outreach methods described below.

- Confidential CHIS 2009 data files for adults, adolescents, and children will be provided to DMH that include mental health indicators, various health, health behaviors and insurance variables, as well as sensitive information on racial, ethnic, demographic and geographic subgroups. The delivery of these confidential data files is subject to the completion of a mutually acceptable data sharing agreement.
- Public Use Files (PUFs) will contain non-sensitive mental health content and will be available to download to the general public. These files are easily accessible and provide relevant constructs and re-codes to facilitate analysis.
- *AskCHIS*, an easy-to-use online query system, will support the CHIS 2009 mental health content. It provides population-level estimates at the state, regional and local county levels, as well as several other health, insurance, and access indicators.
- Local health departments (LHDs) will have access to customized CHIS 2009 data files for their county. The standard data files made available to counties do not include sensitive content (such as use of mental health services), but counties have the opportunity to request confidential data files.

The cost of dissemination of CHIS 2009 data files is shared by all CHIS funders. Because the California Department of Public Health and The California Endowment support disproportionate shares of dissemination costs, a small share of these costs is included in the DMH data collection costs.

V. Budget

California Health Interview Survey Budget Category	January to June 2009	July 2009 to June 2010	July to December 2010	CHIS 2009 TOTAL
Personnel Payroll (including payroll benefits)	-	93,230	22,014	115,243
Operating Expenses	-	11,785	3,316	15,101
Software and Equipment Expenses	-	-	-	-
Publications	-	45,000	-	45,000
Travel and Per Diem	-	1,500	-	1,500
Subcontractors/Professional Services:				-
Survey Contractor (Translation and data collection)	43,500	1,281,500	-	1,325,000
Subcontract: UC Davis (PI - Sergio Aguilar-Gaxiola)	-	60,000	-	60,000
				-
Total Direct Costs	43,500	1,493,015	25,330	1,561,845
Exclusions from Indirect Costs	(18,500)	(1,323,824)	(2,074)	(1,344,397)
Indirect (26% Total Modified Direct Costs)	6,500	43,990	6,047	56,536
Total Costs	\$ 50,000	\$ 1,537,005	\$ 31,376	\$ 1,618,381