

# California's Mental Health Services Act— Statewide Evaluation

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Priority Indicators Trends Report – Executive Summary  
(Deliverable 2.G.2)

Prepared by



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# Executive Summary

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## Purpose & Goals

The Mental Health Services Oversight and Accountability Commission (MHSOAC) charged the UCLA Evaluation Team with tracking the impact of Mental Health Services Act (MHSA) Community Services and Supports (CSS) programs. Analysis of relevant existing data was conducted in order to create Priority Indicators of mental health service consumer outcomes and community mental health service system performance. This executive summary provides brief description and analysis of trends among these Priority Indicators across Fiscal Years (FYs) 2004–05 through 2011–12.

The central goals of this report are to:

1. Describe trends among Priority Indicators over time, as existing data allows, and
2. Provide interpretation and discuss implications of longitudinal trends among these indicators of consumer outcomes and community mental health system performance.

Accomplishing these goals will provide the MHSOAC and other interested MHSA stakeholders with useful information for planning, quality improvement, and other applications that stakeholders deem important. In this way, the current report is intended to provide support for a continuous quality improvement process, involving a variety of stakeholders.

## What are Priority Indicators and What are They Intended to Do?

Two central functions of priority consumer outcome and system performance indicators are 1) accountability and 2) continuous quality improvement. These functions can be served by developing a set of standard indicators to measure performance at multiple levels (e.g., statewide, county, and individual) and across time. The California Mental Health Planning Council proposed and defined a set of performance indicators, referred to as *Priority Indicators*, designed to assess how the MHSA has impacted mental health consumers and the mental health system in areas that may be most changed through MHSA implementation. Indicators can help track progress among consumers and across the community mental health system. At the consumer level, outcomes such as education and employment are tracked, while outcomes including mental health service penetration rate and consumer demographics are examined at the broader system level. As described in the next section, this report presents longitudinal trends within a set of 12 Priority Indicators, including interpretation of trends and discussion of implications for practical improvement.

### Priority Indicators Defined

Through careful deliberation on the part of MHSOAC (in collaboration with the UCLA Evaluation Team), a set of 12 Priority Indicators was developed. These indicators can be categorized as follows:

- **Consumer Outcomes Indicators**, which provide insight into the outcomes of those who have received mental health service; and
- **System Performance Indicators**, which monitor the performance of the community mental health system more broadly.

Four of the Priority Indicators focus on consumer-level data, and the remaining eight pertain to the mental health care system on a broader scale. The Priority Indicators are defined as displayed in

the following table. These definitions were used to guide the analyses that are described in this report.

PRIORITY INDICATOR	DEFINITION
<b>CONSUMER OUTCOMES INDICATORS</b>	
<i>Indicator 1: School Attendance</i>	School attendance rates among mental health service consumers.
<i>Indicator 2: Employment</i>	Proportion of transition-age youth, adult, and older adult mental health service consumers who are employed and not employed.
<i>Indicator 3: Homelessness and Housing</i>	Housing status (i.e., independent, group care, foster care, or homeless) of mental health service consumers.
<i>Indicator 4: Arrests</i>	Proportion of transition-age youth, adult, and older adult mental health service consumers with reported arrests.
<b>SYSTEM PERFORMANCE INDICATORS</b>	
<i>Indicator 5: Demographic Profile of Consumers Served</i>	Demographic composition of the mental health service consumer population.
<i>Indicator 6: Demographic Profile of New Consumers</i>	Demographic profile of new mental health consumers (i.e., not served in the previous FY).
<i>Indicator 7: Penetration of Mental Health Services</i>	Public mental health service access relative to estimates of need for mental health service among Californians earning less than 200% of the federal poverty income level.
<i>Indicator 8: Access to a Primary Care Physician</i>	Proportion of mental health service consumers with access to a primary care physician.
<i>Indicator 9: Perceptions of Access to Services</i>	Consumer and family perceptions of access to mental health services.
<i>Indicator 10: Involuntary Status</i>	Rates of involuntary statuses among mental health service consumers.
<i>Indicator 11: Consumer Well-Being</i>	Consumer and family perceptions of well-being (e.g., outcomes, functioning, and social connectedness) as a result of mental health services.
<i>Indicator 12: Satisfaction with Services</i>	Consumer and family satisfaction with mental health services received.

## Service Populations Addressed by Priority Indicators

For the purposes of this report, the working definition of “all mental health consumers” is individuals served during FYs 2004–05 through 2011–12, primarily tracked in the CSI and CPS data systems. The working definition of “Full Service Partnership (FSP) consumers” is individuals served by county FSP programs during FYs 2004–05 through 2011–12, tracked in the DCR data system.

Priority Indicators address four consumer age groups, as appropriate based upon assessment focus. Specifically, children 0-15 years of age, transition age youth (TAY) 16-25 years of age, adults 26-59 years of age, and older adults 60 year of age or older.

## Data Sources

A description of each key data source and important considerations and limitations regarding each are summarized in the following table.

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

The CSI system is a repository of county, client (e.g., age, gender, preferred language, education, employment status, living arrangement, etc.), and service (e.g., type, number, and length of service

contact) information. CSI records, collected from all consumers who receive CSS mental health services (including FSP consumers) are categorized into three distinct types: client, service, and periodic. Client records include basic information about each consumer, including demographics. A service record is created for each service instance, and includes information about service type and duration. Periodic records provide information about the current status and characteristics of consumers. These are generally created quarterly, but collection and reporting of this information varies by county.

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

The DCR system houses data for consumers served through Full Service Partnership (FSP) programs. Data from assessments—the Partnership Assessment Form (PAF), Key Event Tracking (KET), and Quarterly Assessment (3M)—are collected for consumers in specific age categories. The PAF reflects consumer history prior to enrollment and baseline information, including consumer education and/or employment, housing situation, legal issues, health status, and substance use. The KET is intended to capture any important changes in consumers’ lives, such as housing, education and/or employment, and legal issues while receiving FSP services. The 3M is used to collect information on a quarterly basis regarding key areas such as education, health status, substance use, and legal issues.

### *Performance Outcomes and Quality Improvement (POQI)—Consumer Perception Survey (CPS)*

Consumer perception survey instruments are designed for specific mental health consumer groups (e.g., family members/caregivers, youth, adults, and older adults). Instruments are composed of widely validated measures of several domains, including satisfaction with services, access to services, quality/appropriateness of services, outcomes that may result from engagement in services, functioning, and social connectedness. The data, designed to inform treatment planning and service management, are collected from a sample of individuals with “serious, persistent” mental illness who have received services for 60 days or more and are not categorized as “medication only.”

### *Other Sources*

#### **Estimates of Need for Mental Health Services**

To achieve a standardized rate for penetration of mental health services, the evaluation team contracted with Dr. Charles Holzer for statewide and county mental health service need estimates. Dr. Holzer previously developed penetration rate estimates for the California DHCS. An indirect estimation approach was used to estimate the proportion of persons with serious mental illness among those whose income falls within 200% of the federal poverty level.<sup>1</sup> The California Department of Health Care Services provides a brief synopsis of the indirect estimation approach in the *California Mental Health and Substance Use System Need Assessment—Final Report: February 2012*.<sup>2</sup>

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<sup>1</sup> For additional details, see: [www.charlesholzer.com](http://www.charlesholzer.com).

<sup>2</sup> See:

<http://www.dhcs.ca.gov/provgovpart/Documents/1115%20Waiver%20Behavioral%20Health%20Services%20Needs%20Assessment%203%201%2012.pdf>

## Involuntary Status

Involuntary status information was provided by DHCS for the following service categories: 72-hour evaluation and treatment (adults, children); 14- and 30-day intensive treatment.

## Priority Indicator Data Sources

The data systems utilized to calculate the findings for each Priority Indicator are summarized in the table below.

	SERVICE POP.	DATA SOURCE			
		CSI	DCR	CPS	OTHER
<b>CONSUMER OUTCOMES INDICATORS</b>					
<i>Indicator 1: School Participation</i>	FSP Consumers				
<i>Indicator 2: Employment</i>	All & FSP Consumers				
<i>Indicator 3: Homelessness and Housing</i>	All & FSP Consumers				
<i>Indicator 4: Arrests</i>	All & FSP Consumers				
<b>SYSTEM PERFORMANCE INDICATORS</b>					
<i>Indicator 5: Demographic Profile of Consumers Served</i>	All & FSP Consumers				
<i>Indicator 6: Demographic Profile of New Consumers</i>	All & FSP Consumers				
<i>Indicator 7: Penetration of Mental Health Services</i>	All Consumers				Holzer Targets
<i>Indicator 8: Access to a Primary Care Physician</i>	FSP Consumers				
<i>Indicator 9: Perceptions of Access to Services</i>	All Consumers				
<i>Indicator 10: Involuntary Status</i>	All Consumers				Aggregate reports provided by DHCS
<i>Indicator 11: Consumer Well-Being</i>	All Consumers				
<i>Indicator 12: Satisfaction</i>	All Consumers				

This executive summary provide brief descriptions and analyses of longitudinal trends at the statewide level for FYs 2004–05 through 2011–12 as supported by available data among consumer outcome and system performance Priority Indicators. Conclusions and implications of the trends observed are discussed within each Priority Indicator section.

# Priority Indicator Trends: Consumer Outcomes

## Priority Indicator 1: School Attendance

### Definition

Child and transition-age youth (TAY) participation in school.

### Calculation

Average ratings of school attendance among child and TAY Full Service Partnership consumers.

### Results: Ratings of School Attendance among Child and TAY FSP Consumers

*Note:* Attendance information (DCR) is presented only for child and TAY FSP consumers (i.e., those 18 years of age and younger), as this indicator is not applicable to most adults and older adults.

### Change in Attendance Ratings

Table 1 displays the percentages of child and TAY FSP consumers with valid attendance data in each FY who reported increases, no changes, and decreases in attendance ratings from program intake to most recent quarterly assessment (3M).

**Table 1. Change in FSP consumer school attendance by age group**

	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
<b>Children</b>					
<b>Increased attendance</b>	22.7%	23.4%	21.7%	23.1%	23.1%
<b>No change</b>	54.9%	54.4%	55.5%	55.5%	54.9%
<b>Reduced attendance</b>	22.4%	22.3%	22.8%	21.5%	22%
Total	1,380	2,411	3,415	4,440	4,677
<b>Transition-Age Youth</b>					
<b>Increased attendance</b>	26.8%	26.7%	22%	23.6%	27.6%
<b>No change</b>	39.9%	42%	41.3%	45%	42.1%
<b>Reduced attendance</b>	33.3%	31.3%	36.7%	31.4%	30.3%
Total	228	367	583	791	855

Results indicate that among child FSP consumers, in each FY a majority did not report changes in attendance ratings from intake (PAF) to most recent valid quarterly assessment (3M). In each FY, however, a slightly larger proportion of child FSP consumers reported increased attendance ratings than decreased attendance ratings, with the exception of 2009–10. Among TAY FSP consumers, the largest proportion of participants reported no change in attendance ratings from intake (PAF) to most recent assessment (3M) in each FY. In each FY, however, a larger proportion of TAY FSP consumers reported reduced attendance than reported increased attendance (see Table 1).

### Conclusions & Implications

Overall, across age groups, genders, and fiscal years, average attendance ratings were generally high, indicating FSP consumers attended school all or most of the time. Notably, male children

tended to have higher average attendance ratings compared to female children, while this pattern was reversed among TAY FSP consumers. This interaction suggests that different maturation patterns of the genders may have contributed to average attendance ratings.

Patterns of change in attendance ratings were also relatively stable across years and genders within each age group considered. Specifically, the attendance ratings of most FSP consumers did not change from intake to most recent assessment point, regardless of age group, gender, or year examined. Thus, evidence does not support a distinct impact of FSP program participation. However, the limitations of the attendance measure should be noted as a potential contributor to the lack of evidence of program impact.

The restricted range of attendance ratings found in each FY suggests the categorical response scale used to measure school attendance via the intake (PAF) and quarterly assessment (3M) forms may not allow for sufficient variation in attendance to be captured. It is possible that recording the number of days of school attendance as a function of all possible school days would provide a more accurate assessment of attendance. Recording other aspects of school participation (e.g., engagement, social connection, and/or academic achievement) to create a multi-dimensional measure of school attendance might provide a more holistic assessment of this FSP outcome, and should be considered. Given the data available at this time, no strong practical conclusions can be drawn.

## Priority Indicator 2: Employment

### Definition

The employment status (employed or unemployed) of transition-age youth (TAY), adult, and older adult mental health consumers (FSP and all mental health consumers).

### Calculation

In each FY, the number of employed and not employed consumers (FSP consumers and all mental health consumers) proportionate to the total number of consumers. Among FSP consumers only, DCR data supported examination of change in employment status from intake (PAF) to most recent assessment (KET) with valid employment data. When valid employment data were not available in an FSP consumer’s most recent assessment (KET), then employment status defaulted to a consumer’s previous status.

### Results: FSP Consumer Employment

#### Change in Employment Status

Across age groups and years, a majority of FSP consumers did not change employment status. Across FYs, TAY FSP consumers consistently reported the highest rate of change in employment status among all relevant age groups (see Table 2).

**Table 2. Change in FSP consumer employment status by age group**

	No Change (Unemployed)	Change to Employed	Change to Unemployed	No Change (Employed)	Total
<b>Transition-Age Youth</b>					
<b>FY 2006-07</b>	82.5%	6.2%	0.9%	10.3%	949
<b>FY 2007-08</b>	86.0%	4.5%	1.4%	8.1%	2,607
<b>FY 2008-09</b>	88.0%	4.0%	0.8%	7.2%	4,194

	No Change (Unemployed)	Change to Employed	Change to Unemployed	No Change (Employed)	Total
<b>FY 2009-10</b>	88.7%	3.8%	0.5%	7.0%	5,719
<b>FY 2010-11</b>	89.8%	3.7%	0.4%	6.1%	6,075
<b>FY 2011-12</b>	90.6%	3.5%	0.3%	5.5%	6,047
<b>Adults</b>					
<b>FY 2006-07</b>	94.6%	2.3%	0.2%	2.9%	2,142
<b>FY 2007-08</b>	93.3%	1.5%	0.4%	4.8%	6,115
<b>FY 2008-09</b>	93.1%	1.8%	0.3%	4.7%	9,541
<b>FY 2009-10</b>	93.4%	1.4%	0.2%	5.0%	12,632
<b>FY 2010-11</b>	93.6%	1.7%	0.3%	4.4%	13,437
<b>FY 2011-12</b>	94.2%	1.7%	0.2%	4.0%	13,443
<b>Older Adults</b>					
<b>FY 2006-07</b>	96.1%	0.7%	0.5%	2.7%	408
<b>FY 2007-08</b>	94.4%	2.3%	0.7%	2.7%	1,053
<b>FY 2008-09</b>	96.6%	1.0%	0.0%	2.4%	1,468
<b>FY 2009-10</b>	96.9%	0.5%	0.0%	2.6%	1,841
<b>FY 2010-11</b>	97.1%	0.2%	0.1%	2.6%	2,116
<b>FY 2011-12</b>	96.8%	0.8%	0.0%	2.4%	2,114

## Results: Employment Among All Mental Health Consumers

### Employment by Age Group and Gender

Employment rates for all mental health consumers were relatively stable for each age group across FYs (see Table 3), with adults reporting the highest employment rate in most years, compared to TAY and older adults.

**Table 3. Employment of all mental health consumers by age group**

	Transition-Age Youth			Adults			Older Adults		
	Employed	Not Employed	Total	Employed	Not Employed	Total	Employed	Not Employed	Total
<b>2004-05</b>	12.4%	87.6%	58,023	12.7%	87.3%	201,858	6.2%	93.8%	17,445
<b>2005-06</b>	14.0%	86.0%	36,345	11.2%	88.2%	184,695	5.8%	94.2%	18,946
<b>2006-07</b>	13.0%	87.0%	36,470	11.6%	88.4%	177,593	6.3%	93.7%	17,993
<b>2007-08</b>	11.7%	88.3%	38,222	11.6%	88.4%	172,389	6.4%	93.6%	17,198
<b>2008-09</b>	10.4%	89.6%	41,756	11.5%	88.5%	171,653	6.7%	93.3%	17,159
<b>2009-10</b>	9.7%	90.3%	42,137	11.3%	88.7%	161,004	6.8%	93.2%	15,322
<b>2010-11</b>	10.0%	90.0%	40,608	11.2%	88.8%	150,690	6.8%	93.2%	12,909
<b>2011-12</b>	10.4%	89.6%	38,910	11.0%	89.0%	153,623	6.9%	93.1%	12,321

## Conclusions & Implications

For FSP consumers, employment rates were relatively stable across fiscal years for all age groups and genders, with TAY and female FSP consumers consistently reporting the highest rates of employment. Most FSP consumers reported little change in employment status from intake (PAF)



to most recent assessment (KET) in each FY. That said, TAY FSP consumers reported the highest rate of change to employed status, which is likely an artifact of TAY FSP consumers entering the workforce for the first time. These results do not suggest a substantial impact of FSP program participation on employment. However, as noted previously, the data collection strategy of the KET form in the DCR system (i.e., reporting as status changes warrant) seems to generate disproportionately high rates of unknown or missing data in many fiscal years, calling into question the reliability of employment data collection among FSP consumers. As such, the employment patterns displayed here should be viewed in light of these data reliability concerns.

For all mental health consumers, employment rates were relatively stable across years, with adults and females reporting the highest rates of employment across years. CSI data did not support assessment of change in employment status among all mental health consumers. Results do not suggest a substantial impact of mental health service on employment status among all consumers. Similar to the DCR data system, CSI periodic assessments did not appear to be reliably collected across consumers, thus these employment patterns for all mental health consumers must be viewed in a tentative light.

### Priority Indicator 3: Homelessness and Housing

#### Definition

The housing status (i.e., independent, group care, family, foster care, or homeless) of FSP and all mental health consumers.

#### Calculation

Proportion of FSP and all mental health consumers reporting each housing status (independent, group care, family, foster care, homeless, and unknown).

Proportion of consumers (FSP) in service for at least six months reporting changes in housing status from prior, to intake, to most recent status, in each FY.

#### Results: Housing Status of Full Service Partnership Consumers

##### Housing Status by Age Group

Housing status of FSP consumers fluctuated in the first three to four years of program operation, but stabilized in later years (see Table 4). Most child/youth and TAY FSP consumers reported residing with family in each FY, and most adults and older adults reported residing in group care settings in nearly all FYs.

Table 4. FSP consumer housing status by age group

	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
<b>Children</b>							
<b>Family</b>	73.9%	79.5%	78.7%	80.0%	78.6%	78.7%	80.4%
<b>Foster Care</b>	8.7%	7.4%	7.4%	8.2%	10.9%	11.3%	11.1%
<b>Group Care</b>	13.0%	8.0%	6.1%	5.2%	5.6%	5.8%	5.2%
<b>Homeless</b>	0.0%	2.0%	2.5%	1.6%	1.1%	0.9%	0.7%
<b>Independent</b>	4.3%	0.7%	1.1%	0.9%	0.8%	0.4%	0.4%
<b>Unknown</b>	0.0%	2.3%	4.1%	4.2%	3.0%	3.0%	2.3%
<b>Total</b>	23	699	2,436	3,607	5,056	5,910	5,937
<b>Transition-Age Youth</b>							

	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
<b>Family</b>	55.7%	38.5%	42.4%	45.2%	51.4%	55.0%	55.9%
<b>Foster Care</b>	3.3%	1.9%	2.4%	2.6%	3.2%	3.4%	3.5%
<b>Group Care</b>	19.7%	31.7%	25.1%	23.1%	20.1%	19.8%	19.3%
<b>Homeless</b>	9.8%	9.8%	10.2%	9.3%	7.2%	7.0%	6.8%
<b>Independent</b>	9.8%	12.3%	12.3%	13.4%	13.5%	11.6%	10.9%
<b>Unknown</b>	1.6%	5.8%	7.6%	6.4%	4.6%	3.2%	3.6%
<b>Total</b>	61	1,013	2,883	4,704	6,358	6,859	6,751
<b>Adults</b>							
<b>Family</b>	15.0%	9.9%	9.3%	11.0%	12.1%	13.1%	13.1%
<b>Foster Care</b>	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Group Care</b>	27.3%	43.1%	37.4%	36.5%	37.2%	37.2%	36.8%
<b>Homeless</b>	14.4%	21.6%	18.0%	14.4%	12.4%	11.7%	12.9%
<b>Independent</b>	39.6%	21.5%	31.0%	33.8%	34.8%	34.4%	33.1%
<b>Unknown</b>	3.7%	3.9%	4.3%	4.2%	3.4%	3.6%	4.0%
<b>Total</b>	187	2,239	6,201	10,023	13,170	13,985	13,935
<b>Older Adults</b>							
<b>Family</b>	0.0%	4.7%	5.6%	5.4%	5.2%	4.7%	5.0%
<b>Foster Care</b>	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Group Care</b>	37.5%	35.4%	34.2%	34.2%	37.1%	40.2%	39.3%
<b>Homeless</b>	25.0%	17.6%	11.4%	9.9%	8.7%	8.7%	8.2%
<b>Independent</b>	31.3%	36.5%	43.1%	46.8%	45.1%	42.2%	41.5%
<b>Unknown</b>	6.3%	5.9%	5.7%	3.6%	3.8%	4.3%	6.0%
<b>Total</b>	16	427	1,168	1,727	2,255	2,728	2,885

## Results: Housing Status of All Mental Health Consumers

### Housing Status by Age Group

Housing status among all mental health consumers within each age group was largely stable across years (see Table 5). Most consumers reported residing independently.

**Table 5. Housing status of all mental health consumers by age group**

	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
<b>Children</b>								
<b>Foster Care</b>	6.3%	5.9%	3.4%	3.6%	4.0%	4.3%	4.6%	4.7%
<b>Group Care</b>	5.9%	5.7%	3.1%	3.0%	3.8%	3.9%	2.9%	2.4%
<b>Homeless</b>	0.1%	0.1%	0.1%	0.1%	0.2%	0.3%	0.2%	0.2%
<b>Independent</b>	40.7%	39.2%	23.9%	26.6%	33.0%	36.2%	39.5%	41.0%
<b>Unknown</b>	7.0%	5.3%	6.6%	6.6%	7.6%	8.9%	11.6%	12.8%
<b>Total</b>	124,677	176,367	175,396	182,294	194,159	199,690	210,635	218,499
<b>Transition-Age Youth</b>								
<b>Foster Care</b>	1.5%	1.5%	0.9%	0.9%	1.1%	1.2%	1.4%	1.3%

	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
<b>Group Care</b>	11.4%	12.2%	5.6%	5.6%	7.5%	8.9%	9.5%	10.7%
<b>Homeless</b>	1.4%	1.3%	1.0%	1.0%	1.3%	1.5%	1.5%	1.7%
<b>Independent</b>	31.2%	29.6%	22.1%	24.4%	30.5%	33.9%	37.3%	39.1%
<b>Unknown</b>	14.4%	12.1%	5.8%	6.3%	7.1%	8.1%	10.7%	12.9%
<b>Total</b>	73,857	129,523	129,988	141,521	152,644	157,185	166,572	178,226
<b>Adults</b>								
<b>Foster Care</b>	0.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.0%	0.0%
<b>Group Care</b>	5.1%	4.5%	2.9%	2.9%	4.4%	4.7%	5.2%	6.8%
<b>Homeless</b>	3.1%	3.6%	1.9%	2.0%	3.0%	3.7%	4.0%	4.5%
<b>Independent</b>	32.8%	31.4%	22.1%	23.2%	30.4%	33.3%	35.6%	36.1%
<b>Unknown</b>	16.5%	16.1%	5.4%	6.0%	7.6%	8.4%	12.3%	13.9%
<b>Total</b>	246,267	342,478	337,761	352,770	351,870	342,923	355,223	387,504
<b>Older Adults</b>								
<b>Foster Care</b>	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Group Care</b>	4.8%	5.0%	4.2%	3.7%	5.2%	5.7%	6.4%	7.3%
<b>Homeless</b>	1.1%	1.7%	1.0%	1.1%	1.5%	1.7%	2.1%	2.3%
<b>Independent</b>	31.9%	31.8%	19.6%	20.1%	25.4%	28.5%	32.7%	35.0%
<b>Unknown</b>	8.5%	10.2%	7.3%	7.2%	9.1%	10.1%	15.4%	16.8%
<b>Total</b>	27,825	42,358	43,089	46,945	50,055	51,271	53,823	59,046

## Conclusions & Implications

Among FSP consumers, in most years the majority or plurality of child and TAY FSP consumers reported residing with family, and the majority or plurality of adults and older adults reported residing in group care settings in most FYs. Across age groups, most FSP consumers did not report changes in housing status. But among those that did report change, proportionally more reported transition out of homelessness than the reported transition into homelessness. Thus, analysis of this indicator over time demonstrated largely stable housing status, with some suggestions of positive FSP impact such as the proportion of FSP consumers transitioning out of homelessness compared to those reporting transition into homelessness.

However, trends in the percentages within each housing category across FYs should be viewed in light of the development of the FSP program. Note, for example, the dramatic increase in the total number of FSP consumers across the first four years of operation. Few counties initiated FSP services in 2005–06, and several started programs in later years. Thus, trends across the first four years of operation likely indicative of the program gearing up, rather than of normal full operation. The rate of increase in number of consumers slowed in FY 2009–10 and leveled off in FYs 2010–11 and 2011–12. It is therefore difficult to decipher trends in the percentages for each housing category in these three fiscal years. Interpretation of trends is made more difficult by the fact that, for all age groups other than adults, the percentage of consumers for whom housing status was unknown is of similar magnitude to other categories. Thus, in order to make claims about the trends in other categories, we would need to assume that the reasons for unknown housing statuses are completely independent of actual housing status. This seems unlikely, however, as some housing statuses, such as homelessness, are notoriously difficult to track reliably.

Among all mental health consumers, housing status was largely stable across years, with the plurality of consumers reporting residing independently. Across age groups the proportion of consumers living independently increased each FY since 2007-08. But, among adults and older adults, the proportion of consumers who reported being homeless or in a group care setting also increased each FY since FY 2007-08. However, similar to housing information among FSP consumers, rates of missing or unknown housing information make interpretation of trends difficult among all mental health consumers.

Examining the housing data of all mental health consumers, the proportion of consumers with relevant valid data improves by 58%, from 38.3% (257,987 of 673,499) in FY 2004–05 to 60.4% (500,158 of 827,729) in FY 2011–12. If the missing data were random, as more information on consumer housing statuses becomes available we would expect the percentages in every category to rise proportionally. In each age group, however, the increases tended to fall heavily in the “independent” and “unknown” categories. This suggests that the missing data were not random, and therefore not independent of housing status. Indeed, similar to issues with housing status tracking for FSP consumers, it is reasonable to expect that certain housing statuses would cause more difficulty for data collection than others (e.g., homelessness). This suggests that a validity study should be performed to assess the accuracy and reliability of these data.

## Priority Indicator 4: Arrests

### Definition

The proportion of children, transition-age youth, adults, and older adults (FSP consumers and all mental health service consumers) with reported arrests.

### Calculation

Proportion of FSP consumers (DCR) with a reported arrest during the current service year, during the year prior to intake, during the year prior to intake but not previously, and previous to the year prior to intake.

Proportion of sample of all mental health service consumers (CPS) in services for one year or less and with a reported arrest during the 12 months prior to the start of services, and in services for more than one year and with a reported arrest during the last 12 months.

## Results: Arrests Among Full Service Partnership Consumers

### Arrest Rates by Age Group

Table 6 shows the percentage of FSP consumers who were arrested in each FY, by age group. Because the total number of FSP consumers dramatically increased through FY 2009–10, comparisons across these years mask the fact that the actual counts within each category also increased. However, the total number of FSP consumers stabilized between FYs 2009–10 and 2011–12. Across the three most recent years, there appears to have been a general downward trend in the percentage of arrests in every age category. Considering prior arrest rates of new FSP consumers entering the program in each FY (see full report for prior arrest rates of FSP consumers), however, it is not clear if this trend is attributable to the effect of services provided or is instead a consequence of proportionally more consumers added in these later years not having prior arrests, making them less likely to be arrested.

**Table 6. Current arrest rates of FSP consumers by age group**

	FY 2005-06 % (N)	FY 2006-07 % (N)	FY 2007-08 % (N)	FY 2008-09 % (N)	FY 2009-10 % (N)	FY 2010-11 % (N)	FY 2011-12 % (N)
<b>Children</b>	48.0% (23)	15.7% (699)	8.8% (2,436)	7.9% (3,607)	7.4% (5,056)	6.7% (5,910)	5.2% (5,937)
<b>TAY</b>	23.0% (61)	31.7% (1,013)	24.6% (2,883)	20.9% (4,704)	19.1% (6,358)	15.4% (6,859)	15.8% (6,751)
<b>Adults</b>	27.8% (187)	35.1% (2,239)	21.8% (6,401)	14.8% (10,023)	10.7% (13,170)	9.7% (13,985)	9.4% (13,935)
<b>Older Adults</b>	6.3% (16)	5.4% (427)	5.2% (1,168)	2.9% (1,727)	2.6% (2,255)	2.5% (2,728)	1.7% (2,885)

**Results: Arrests Among All Mental Health Consumers**

**Arrest Rates by Age Group**

*Note:* Due to changes in sampling methodology across fiscal years, results are presented in three separate data ranges corresponding to the use of different sampling approaches (i.e., FYs 2006–07 to 2008–09; FY 2009–10; and FYs 2010–11 to 2011–12).

**Table 7. Arrest rates of all mental health consumers by age group (FYs 2006-07-2008-09)**

	Year Prior to Services % (N)	During Services % (N)
<b>FY 2006-07</b>		
<b>Youth</b>	3.8% (26,898)	1.2% (26,898)
<b>Family</b>	0.0% (41,119)	0.5% (41,119)
<b>Adults</b>	1.9% (64,563)	1.1% (64,563)
<b>Older Adults</b>	0.8% (4,926)	0.4% (4,926)
<b>FY 2007-08</b>		
<b>Youth</b>	7.3% (29,228)	2.6% (29,228)
<b>Family</b>	0.0% (43,577)	1.1% (43,577)
<b>Adults</b>	3.8% (66,887)	2.1% (66,887)
<b>Older Adults</b>	0.7% (5,900)	0.8% (5,900)
<b>FY 2008-09</b>		
<b>Youth</b>	6.7% (29,908)	2.5% (29,908)
<b>Family</b>	0.0% (49,859)	1.0% (49,859)
<b>Adults</b>	3.8% (67,792)	2.3% (67,792)
<b>Older Adults</b>	0.8% (9,646)	0.9% (9,646)

**Table 8. Arrest rates of all mental health consumers by age group (FY 2009-10)**

	Year Prior to Services % (N)	During Services % (N)
<b>FY 2009-10</b>		
<b>Family</b>	2.6% (1,118)	2.7% (1,118)
<b>Adults</b>	4.2% (1,623)	3.0% (1,623)
<b>Older Adults</b>	0.6% (2,522)	1.0% (2,522)

**Table 9. Arrest rates of all mental health consumers by age group (FYs 2010-11-2011-12)**

	Year Prior to Services % (N)	During Services % (N)
<b>FY 2010-11</b>		
<b>Youth</b>	7.1% (2,576)	1.9% (2,576)
<b>Family</b>	2.3% (8,552)	0.6% (8,552)
<b>Adults</b>	4.2% (6,344)	3.0% (6,344)
<b>Older Adults</b>	1.9% (749)	1.3% (749)
<b>FY 2011-12</b>		
<b>Youth</b>	10.2% (2,733)	3.5% (2,733)
<b>Family</b>	3.3% (3,428)	1.3% (3,428)
<b>Adults</b>	6.9% (10,665)	3.2% (10,665)
<b>Older Adults</b>	1.7% (1,278)	0.9% (1,278)

Tables 7 through 9 display rates of arrest reported via the Consumer Perception Survey (CPS), by age group. The data suggest an increase from FY 2006–07 to FY 2007–08, and little change from FY 2007–08 to FY 2008–09. Due to changes in sampling methodology, however, these results are not comparable with those from FY 2009–10 or later. Results from FYs 2010–11 and 2011–12 among youth, family, and adults suggest increasing rates of arrests prior to beginning service for new consumers and arrests during the past year for existing consumers.

## Conclusions & Implications

Across all age categories, the percentages of new FSP consumers with arrest histories show a downward trend. The causes for such a decline cannot be determined from these data. However, as these data reflect the arrest histories for new FSP consumers at intake, the trend does suggest a shift in the characteristics of consumers enrolled. This merits further investigation into whether the shift is due to self-selection by potential consumers or a change in program recruitment procedures.

During the first three years analyzed, a general increase was found in the proportion of all mental health consumers reporting arrest, but reported arrests during services in these years also tended to be less than reported arrests prior to services among most age groups. This trend provides initial indications of a positive impact of service participation. However, data regarding all mental health consumers via differing approaches across all years yield somewhat contradictory results that unfortunately are not comparable. The representative nature of samples in each year should be considered in sampling approaches moving forward. It may be the case that the convenience sampling approach that is currently utilized yields results that are more or less representative of the service population in individual counties but not the state overall, and thus results are more informative locally than statewide.

# Priority Indicator Trends: System Performance

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## Priority Indicator 5: Demographic Profile of Consumers Served

### Definition

This indicator describes the demographics (race/ethnicity, age, and gender) of Full Service Partnership (FSP) consumers served during FYs 2005–06 through FY 2011–12 and all mental health consumers served during FYs 2004–05 through 2011–12. Demographics for FSP consumers are not reported prior to FY 2005–06 because the FSP program launched in FY 2005–06 under the Mental Health Services Act.

Due to rates of missing data that exceed acceptable limits, race/ethnicity data are presented solely for the purpose of highlighting the need for quality improvement efforts at county and state levels. Race/ethnicity data should not be interpreted as descriptive of consumers served because of concerns about generalizability to all consumers.

### Calculation

The operational definition of “all mental health consumers” served during FYs 2004–05 through 2011–12 is individuals in the CSI. The operational definition of “Full Service Partnership consumers” served during FYs 2005–06 through 2011–12 is individuals in the DCR.

The frequencies of all mental health consumers and Full Service Partnership (FSP) consumers served in each fiscal year were calculated overall. Additionally, the proportion of consumers represented in each race/ethnicity, age, and gender category was calculated by dividing the number of consumers within the category by all consumers served. Proportions were calculated for service population (all consumers and FSP consumers) and fiscal year.

## Results: Full Service Partnership Consumers

Demographic findings (race/ethnicity and age group) are detailed in this Executive Summary under Indicator 6 (see the full report for Indicator 5 results).

### Race/Ethnicity

Race/ethnicity is presented in each fiscal year for FSP consumers. Due to unacceptably high rates of missing data, race/ethnicity information is presented for descriptive purposes only, with the intent to drive quality improvement efforts statewide and by county.

Table 11 presents the number and percentage of FSP consumers with race/ethnicity data and the number and percentage with missing data (FYs 2005–06 through 2011–12). Table 10 presents the race/ethnicity of FSP consumers with complete and valid data (FYs 2005–06 through 2011–12).

*Note:* In order to protect confidentiality, where cell sizes equal five or fewer cases, the information is redacted and combined with other race/ethnicity categories that also have cell sizes of five or fewer cases. The resulting category is labeled ‘redacted’ for descriptive purposes.

**Table 10. FSP consumers with valid and missing race/ethnicity data**

	Total Valid		Race/Ethnicity			
	N	Valid		Missing		
		N	%	N	%	
<b>FY 2005-06</b>	285	209	73.3%	76	26.7%	
<b>FY 2006-07</b>	4,346	3,368	77.5%	978	22.5%	
<b>FY 2007-08</b>	12,786	9,781	76.5%	3,005	23.5%	
<b>FY 2008-09</b>	20,023	13,252	66.2%	6,771	33.8%	
<b>FY 2009-10</b>	26,880	21,542	80.1%	5,338	19.9%	
<b>FY 2010-11</b>	29,452	23,641	80.3%	5,811	19.7%	
<b>FY 2011-12</b>	29,466	22,851	77.6%	6,615	22.4%	

**Table 11. Race/ethnicity of FSP consumers**

	FY 2005-06		FY 2006-07		FY 2007-08	
	#	%	#	%	#	%
<b>White</b>	111	38.9%	1,563	36.0%	4,210	32.9%
<b>Hispanic/Latino</b>	56	19.6%	925	21.3%	2,716	21.2%
<b>Asian</b>	9	3.2%	134	3.1%	514	4.0%
<b>Pacific Islander</b>			11	0.3%	27	0.2%
<b>Black</b>	27	9.5%	505	11.6%	1,611	12.6%
<b>American Indian</b>			30	0.7%	96	0.8%
<b>Multiracial</b>			139	3.2%	470	3.7%
<b>Other</b>			61	1.4%	137	1.1%
<b>Redacted</b>	6	2.1%				
<b>Missing</b>	76	26.7%	978	22.5%	3,005	23.5%
<b>Total</b>	285	100%	4,346	100%	12,786	100%
	FY 2008-09		FY 2009-10		FY 2010-11	
	#	%	#	%	#	%
<b>White</b>	5,791	28.9%	8,847	32.9%	9,576	32.5%
<b>Hispanic/Latino</b>	3,654	18.3%	6,634	24.7%	7,661	26.0%
<b>Asian</b>	724	3.6%	1,019	3.8%	1,007	3.4%
	FY 2008-09		FY 2009-10		FY 2010-11	
	#	%	#	#	%	#
<b>Pacific Islander</b>	45	0.2%	67	0.2%	55	0.2%
<b>Black</b>	1,879	9.4%	3,289	12.2%	3,553	12.1%
<b>American Indian</b>	129	0.7%	178	0.7%	202	0.7%
<b>Multiracial</b>	868	4.3%	1,235	4.6%	1,229	4.2%
<b>Other</b>	162	0.8%	273	1.0%	358	1.2%
<b>Redacted</b>						
<b>Missing</b>	6,771	33.8%	5,338	19.9%	5,811	19.7%
<b>Total</b>	20,023	100%	26,880	100%	29,452	100%



**Table 121. (continued)**

	FY 2011-12	
	#	%
<b>White</b>	9,341	31.7%
<b>Hispanic/Latino</b>	7,173	24.3%
<b>Asian</b>	1,181	4.0%
<b>Pacific Islander</b>	60	0.2%
<b>Black</b>	3,374	11.5%
<b>American Indian</b>	192	0.7%
<b>Multiracial</b>	1,184	4.0%
<b>Other</b>	346	1.2%
<b>Redacted</b>		
<b>Missing</b>	6,615	22.4%
<b>Total</b>	29,466	100%

*Note:* Categories in the created race/ethnicity variable are mutually exclusive. Cell sizes in which the sample size was five or fewer are not displayed. Total percentages are rounded.

When missing data are above 10%, it is generally considered unacceptable to interpret the remaining data as generalizable to the broader population. For DCR, the percentage of missing race/ethnicity data exceeded acceptable limits. Therefore, no conclusions can be drawn about the race/ethnicity makeup of FSP consumers until the missing data issue is resolved.

### Age Group

Age group is presented in each fiscal year for FSP consumers in Table 12 (FYs 2005–06 through 2011–12). Because the percentage of missing age group data was within acceptable limits, this category is excluded from the table.

**Table 132. Age groups of FSP consumers**

	FY 2005-06		FY 2006-07		FY 2007-08	
	#	%	#	%	#	%
<b>Children</b>	13	4.6%	515	11.9%	1,942	15.3%
<b>TAY</b>	50	17.5%	944	21.8%	2,706	21.2%
<b>Adults</b>	186	65.3%	2,104	48.6%	5,939	46.6%
<b>Older Adults</b>	36	12.6%	769	17.8%	2,157	16.9%
<b>Total</b>	285	100%	4,332	100%	12,744	100%
	FY 2008-09		FY 2009-10		FY 2010-11	
	#	%	#	%	#	%
<b>Children</b>	3,018	15.1%	4,255	15.9%	5,073	17.3%
<b>TAY</b>	4,366	21.8%	6,063	22.6%	6,720	22.9%
<b>Adults</b>	9,289	46.5%	12,062	45.0%	12,650	43.0%
<b>Older Adults</b>	3,324	16.6%	4,454	16.6%	4,964	16.9%
<b>Total</b>	19,997	100%	26,834	100%	29,407	100%

**Table 142. (continued)**

FY 2011-12		
	#	%
<b>Children</b>	5,102	17.4%
<b>TAY</b>	6,698	22.8%
<b>Adults</b>	12,561	42.7%
<b>Older Adults</b>	5,042	17.1%
<b>Total</b>	29,403	100%

Note: Total percentages are rounded.

Among FSP consumers, the proportion of adults grew smaller over time, and the proportion of the other age groups (children, transition-age youth, older adults) increased.

### Results: All Mental Health Consumers

Demographic findings (race/ethnicity and age group) are detailed in this Executive Summary under Indicator 6 (see the full report for Indicator 5 results).

#### Race/Ethnicity

Demographics are presented in each fiscal year for all mental health consumers. Due to unacceptably high rates of missing data, race/ethnicity information is presented for descriptive purposes only, with the intent to drive quality improvement efforts statewide and by county.

Table 13 presents the number and percentage of all mental health consumers with valid race/ethnicity data and the number and percentage with missing data (FYs 2004–05 through 2011–12). Table 14 presents the number and percentage of all mental health consumers in each race/ethnicity category in each fiscal year.

**Table 13. All mental health consumers with valid and missing race/ethnicity data**

	Total Valid		Race/Ethnicity			
	N	Valid		Missing		
		N	%	N	%	
<b>FY 2004-05</b>	663,882	460,044	69.3%	203,838	30.7%	
<b>FY 2005-06</b>	666,333	617,647	92.7%	48,686	7.3%	
<b>FY 2006-07</b>	656,344	555,544	84.6%	100,800	15.4%	
<b>FY 2007-08</b>	673,795	573,601	85.1%	100,194	14.9%	
<b>FY 2008-09</b>	674,333	579,603	86.0%	94,730	14.0%	
<b>FY 2009-10</b>	651,238	557,865	85.7%	93,373	14.3%	
<b>FY 2010-11</b>	640,395	542,098	84.7%	98,297	15.3%	
<b>FY 2011-12</b>	663,803	504,424	76.0%	159,379	24.0%	

Note: The number of cases remained unchanged for FY 2004–05 and FY 2005–06 (following DHCS update of the data). Therefore, the data were not reanalyzed and the results presented are reflective of the data as submitted to DMH.

**Table 14. Race/Ethnicity of all mental health consumers**

	FY 2004-05		FY 2005-06		FY 2006-07	
	#	%	#	%	#	%
<b>White</b>	172,302	26.0%	252,762	37.9%	227,984	34.7%
<b>Hispanic/Latino</b>	147,531	22.2%	182,190	27.3%	170,264	25.9%
<b>Asian</b>	18,803	2.8%	30,707	4.6%	28,685	4.4%
<b>Pacific Islander</b>	2,674	0.4%	5,022	0.8%	1,234	0.2%
<b>Black</b>	96,178	14.5%	111,226	16.7%	90,679	13.8%
<b>American Indian</b>	3,362	0.5%	4,657	0.7%	4,149	0.6%
<b>Multiracial</b>	11,987	1.8%	20,397	3.1%	18,790	2.9%
<b>Other</b>	7,207	1.1%	10,686	1.6%	13,759	2.1%
<b>Missing</b>	203,838	30.7%	48,691	7.3%	100,800	15.4%
<b>Total</b>	663,882	100%	666,338	100%	656,344	100%
	FY 2007-08		FY 2008-09		FY 2009-10	
	#	%	#	%	#	%
<b>White</b>	227,077	33.7%	221,772	32.9%	205,603	31.6%
<b>Hispanic/Latino</b>	186,178	27.6%	196,979	29.2%	199,917	30.7%
<b>Asian</b>	28,556	4.2%	28,562	4.2%	26,997	4.2%
<b>Pacific Islander</b>	1,304	0.2%	1,332	0.2%	1,362	0.2%
<b>Black</b>	92,697	13.8%	91,307	13.5%	87,250	13.4%
<b>American Indian</b>	4,102	0.6%	4,101	0.6%	3,692	0.6%
<b>Multiracial</b>	19,485	2.9%	20,228	3.0%	19,179	2.9%
<b>Other</b>	14,202	2.1%	15,322	2.3%	13,865	2.1%
<b>Missing</b>	100,194	14.9%	94,730	14.1%	93,373	14.3%
<b>Total</b>	673,795	100%	674,333	100%	651,238	100%
	FY 2010-11		FY 2011-12			
	#	%	#	%		
<b>White</b>	202,853	31.7%	188,453	28.4%		
<b>Hispanic/Latino</b>	199,004	31.1%	182,926	27.6%		
<b>Asian</b>	23,209	3.6%	22,090	3.3%		
<b>Pacific Islander</b>	1,332	0.2%	1,225	0.2%		
<b>Black</b>	81,472	12.7%	76,404	11.5%		
<b>American Indian</b>	3,513	0.6%	3,307	0.5%		
<b>Multiracial</b>	18,991	3.0%	18,733	2.8%		
<b>Other</b>	11,724	1.8%	11,286	1.7%		
<b>Missing</b>	98,297	15.3%	159,379	24.0%		
<b>Total</b>	640,395	100%	663,803	100%		

Note: Categories in the created race/ethnicity variable are mutually exclusive. Total percentages are rounded.

### Age Group

Age group is presented in each fiscal year for all mental health consumers in Table 15 (FYs 2004–05 through 2011–12). Because the percentage of missing age group data was within acceptable limits, this category is excluded from the table.

**Table 15. Age groups of all mental health consumers**

	FY 2004-05		FY 2005-06		FY 2006-07	
	#	%	#	%	#	%
<b>Children</b>	122,733	27.3%	175,126	26.3%	172,207	26.2%
<b>TAY</b>	63,936	14.2%	117,658	17.7%	116,535	17.8%
<b>Adults</b>	237,294	52.9%	334,145	50.2%	328,432	50.1%
<b>Older Adults</b>	24,978	5.6%	39,293	5.9%	38,991	5.9%
<b>Total</b>	448,941	100%	666,222	100%	656,165	100%
	FY 2007-08		FY 2008-09		FY 2009-10	
	#	%	#	%	#	%
<b>Children</b>	174,877	26.0%	181,257	26.9%	183,023	28.1%
<b>TAY</b>	122,694	18.2%	126,796	18.8%	124,372	19.1%
<b>Adults</b>	334,364	49.6%	322,860	47.9%	301,254	46.3%
<b>Older Adults</b>	41,680	6.2%	43,247	6.4%	42,373	6.5%
<b>Total</b>	673,615	100%	674,160	100%	651,022	100%
	FY 2010-11		FY 2011-12			
	#	%	#	%		
<b>Children</b>	184,468	28.8%	187,701	28.3%		
<b>TAY</b>	122,367	19.1%	123,143	18.6%		
<b>Adults</b>	292,240	45.7%	308,548	46.6%		
<b>Older Adults</b>	40,589	6.4%	42,723	6.5%		
<b>Total</b>	639,664	100%	662,115	100%		

Note: Total percentages are rounded.

## Conclusions & Implications

Under the MHSA there appears to have been a shift over the years toward expansion of services for under-represented age groups (children/youth, transition-age youth, and older adults). Although adults represented the majority age group in each fiscal year, their proportion overall shrank in each successive fiscal year as other age groups increased.

The rate of missing race/ethnicity data is problematic because it prevents examination of progress for underserved populations on all indicators. The sources of the problem should be quickly determined and technical assistance provided whenever and wherever needed in order to meet this fundamental reporting requirement.

## Priority Indicator 6: Demographic Profile of New Consumers

### Definition

This indicator profiles new mental health consumers (i.e., not served during the previous FY). The demographics (i.e., age and gender) of all new mental health consumers served during FYs 2005–06 through 2011–12 and new Full Service Partnership consumers served during FYs 2006–07 through 2011–12 are compared to the demographics of continuing consumers.

## Calculation

The operational definition of “all mental health consumers” served during FYs 2004–05 through 2011–12 is individuals in the CSI. The operational definition of “Full Service Partnership (FSP) consumers” served during FYs 2005–06 through 2011–12 is individuals in the DCR.

The operational definition of “new consumer” is a mental health consumer who did not receive service during the previous fiscal year (and is therefore new to mental health services in the FY analyzed). FY 2004–05 (all mental health consumers) is not presented in terms of new and continuing consumers because there is not a previous fiscal year of CSI data for comparative purposes. FY 2005–06 is not presented in terms of new and continuing Full Service Partnership (FSP) consumers because the N for FY 2004–05 is too small to facilitate meaningful comparison.

The frequencies of all mental health consumers and Full Service Partnership (FSP) consumers served in each fiscal year were calculated for new and continuing consumers. Additionally, the proportion of consumers represented by age and gender categories was calculated by dividing the number of consumers within each demographic category by new consumers served and by continuing consumers served. Proportions were calculated for service population (all consumers and FSP consumers) and fiscal year.

## Results: Full Service Partnership Consumers

### New and Continuing Consumers

Table 16 presents the number and percentage in each fiscal year. The proportion of new FSP consumers declined over time, as the percentage of continuing consumers in the program naturally accumulates.

**Table 156. Enrollment status of FSP consumers**

	FY 2006-07		FY 2007-08		FY 2008-09	
	#	%	#	%	#	%
<b>Continuing</b>	86	2.0%	3,691	28.9%	9,577	47.8%
<b>New</b>	4,260	98.0%	9,090	71.1%	10,446	52.2%
<b>Total</b>	4,346	100%	12,781	100%	20,023	100%
	FY 2009-10		FY 2010-11		FY 2011-12	
	#	%	#	%	#	%
<b>Continuing</b>	13,893	51.7%	18,096	61.4%	18,750	63.6%
<b>New</b>	12,987	48.3%	11,356	38.6%	10,716	36.4%
<b>Total</b>	26,880	100%	29,452	100%	29,466	100%

*Note:* Percentages are rounded.

### Gender

Table 17 displays the number and percentage of new FSP consumers in each gender category in each fiscal year.

**Table 17. Gender of new FSP consumers**

	FY 2006-07		FY 2007-08		FY 2008-09	
	#	%	#	%	#	%
<b>Female</b>	1,797	43.0%	3,866	44.1%	4,506	44.7%
<b>Male</b>	2,381	57.0%	4,897	55.9%	5,575	55.3%
<b>Total</b>	4,178	100%	8,763	100%	10,081	100%
	FY 2009-10		FY 2010-11		FY 2011-12	
	#	%	#	%	#	%
<b>Female</b>	5,419	43.7%	4,830	44.9%	4,460	44.6%
<b>Male</b>	6,989	56.3%	5,928	55.1%	5,550	55.4%
<b>Total</b>	12,408	100%	10,758	100%	10,010	100%

Note: Total percentages are rounded.

### Age Group

Table 18 graphically displays the number and percentage of new FSP consumers in each age group in each fiscal year.

**Table 16. New FSP consumers by age group**

	2006-07		2007-08		2008-09	
	#	%	#	%	#	%
<b>Children</b>	516	12.1%	1,529	16.9%	1,689	16.2%
<b>TAY</b>	938	22.1%	1,989	22.0%	2,576	24.7%
<b>Adults</b>	2,035	47.9%	4,084	45.1%	4,563	43.7%
<b>Older Adults</b>	760	17.9%	1,459	16.1%	1,603	15.4%
<b>Total</b>	4,249	100%	9,061	100%	10,431	100%
	2009-10		2010-11		2011-12	
	#	%	#	%	#	%
<b>Children</b>	2,398	18.5%	2,628	23.2%	2,524	23.6%
<b>TAY</b>	3,416	26.4%	3,257	28.7%	3,149	29.5%
<b>Adults</b>	5,202	40.1%	3,837	33.9%	3,624	33.9%
<b>Older Adults</b>	1,942	15.0%	1,611	14.2%	1,388	13.0%
<b>Total</b>	12,958	100%	11,333	100%	10,685	100%

Note: Total percentages are rounded

## Results: All Mental Health Consumers

### New and Continuing Consumers

Table 19 presents the number and percentage of all mental health consumers who were new in the fiscal year or who were continuing from the previous fiscal year. As this table shows, the proportion of new consumers remained steady, at around 43%, among all mental health consumers across fiscal years.

**Table 19. Enrollment status of all mental health consumers**

	FY 2005-06		FY 2006-07		FY 2007-08	
	#	%	#	%	#	%
<b>Continuing</b>	383,789	57.6%	378,827	57.7%	385,174	57.2%
<b>New</b>	282,544	42.4%	277,517	42.3%	288,621	42.8%
<b>Total</b>	666,333	100%	656,344	100%	673,795	100%
	FY 2008-09		FY 2009-10		FY 2010-11	
	#	%	#	%	#	%
<b>Continuing</b>	389,333	57.7%	383,089	58.8%	357,447	55.8%
<b>New</b>	285,000	42.3%	268,149	41.2%	282,948	44.2%
<b>Total</b>	674,333	100%	651,238	100%	640,395	100%
FY 2011-12		#	%			
<b>Continuing</b>	368,017	55.4%				
<b>New</b>	295,786	44.6%				
<b>Total</b>	663,803	100%				

Note: Total percentages are rounded.

## Gender

Table 20 displays the number and percentage of male and female new mental health consumers in each fiscal year.

**Table 20. Gender of new mental health consumers**

	FY 2005-06		FY 2006-07		FY 2007-08	
	#	%	#	%	#	%
<b>Female</b>	132,344	47.0%	128,543	46.5%	132,173	46.0%
<b>Male</b>	149,304	53.0%	147,827	53.5%	155,229	54.0%
<b>Total</b>	281,648	100%	276,370	100%	287,402	100%
	FY 2008-09		FY 2009-10		FY 2010-11	
	#	%	#	%	#	%
<b>Female</b>	133,464	46.9%	125,323	46.9%	134,482	47.6%
<b>Male</b>	150,873	53.1%	142,163	53.1%	147,889	52.4%
<b>Total</b>	284,337	100%	267,486	100%	282,371	100%
FY 2011-12		#	%			
<b>Female</b>	177,326	48.2%				
<b>Male</b>	190,324	51.8%				
<b>Total</b>	367,650	100%				

Note: Total percentages are rounded.

## Age Group

Table 21 displays the number and percentage of new mental health consumers in each age group in each fiscal year.

**Table 21. Age group of new mental health consumers**

	2005-06		2006-07		2007-08	
	#	%	#	%	#	%
<b>Children</b>	81,910	29.0%	80,409	29.0%	82,222	28.5%
<b>TAY</b>	59,908	21.2%	59,114	21.3%	62,645	21.7%
<b>Adults</b>	128,219	45.4%	125,746	45.3%	130,796	45.3%
<b>Older Adults</b>	12,464	4.4%	12,151	4.4%	12,859	4.5%
<b>Total</b>	282,501	100%	277,420	100%	288,522	100%
	2008-09		2009-10		2010-11	
	#	%	#	%	#	%
<b>Children</b>	86,050	30.2%	86,158	32.2%	91,193	32.3%
<b>TAY</b>	64,669	22.7%	60,364	22.5%	59,984	21.2%
<b>Adults</b>	121,374	42.6%	110,280	41.1%	118,836	42.1%
<b>Older Adults</b>	12,797	4.5%	11,207	4.2%	12,297	4.4%
<b>Total</b>	284,890	100%	268,009	100%	282,310	100%
	2011-12					
	#	%				
<b>Children</b>	91,765	31.2%				
<b>TAY</b>	60,157	20.4%				
<b>Adults</b>	129,535	44.0%				
<b>Older Adults</b>	12,890	4.4%				
<b>Total</b>	294,347	100%				

Note: Total percentages are rounded.

## Conclusions & Implications

In the public mental health system and under the MHSA, the majority of people served were continuing consumers. The emphasis on continuing service is due in part to the natural accumulation of consumers as expected, but may also reflect movement toward consumer-driven services—i.e., the transition out of public mental health services may occur in partnership with the client, rather than according to an artificially imposed timeline.

Under the MHSA, for new clients there appears to have been a shift over the years toward expansion of services for under-represented age groups (children/youth and transition-age youth). Although adults represented the majority age group in each fiscal year, their proportion overall shrank in each successive fiscal year as the proportion of younger age groups increased.

The majority of new consumers (public mental health system and under the MHSA) are male.

## Priority Indicator 7: Penetration of Mental Health Services

### Definition

This indicator describes rates of public mental health service access relative to estimates of need for service among Californians earning less than 200% of the federal poverty income level. This metric is intended to show the extent to which service access is in line with the level of need for public mental health services.



## Calculation

To calculate the rate of penetration of mental health services the number of all public mental health consumers served (i.e., received at least one service during the given fiscal year, as documented in the CSI database) was divided by the number of Californians estimated to be in need of mental health services and earning less than 200% of the federal poverty income level.

## Results: Penetration of Mental Health Services

Penetration of mental health services is presented overall and for each gender and age group. Correlation analyses were conducted to determine if there was a significant relationship between rate of penetration of mental health services and time (fiscal years).<sup>3</sup>

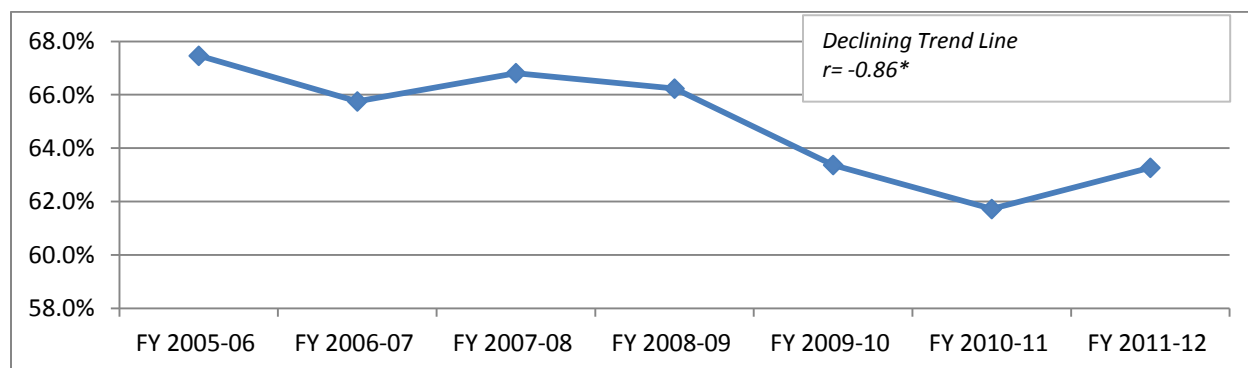
### Overall Penetration Rate

Table 22 presents the penetration rate overall in each fiscal year (FYs 2004–05 through 2011–12), followed by Figure 1, which shows the trend over time (FYs 2005–06 through 2011–12). Table 21 displays the percentage point change from year to year (FYs 2005–06 through 2011–12).

**Table 22. Penetration rate of mental health services**

	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
Holzer N	976,073	987,725	998,219	1,008,487	1,018,138	1,027,663	1,037,560	1,049,220
CSI N	663,882	666,333	656,344	673,795	674,333	651,238	640,395	663,803
<b>Penetration Rate</b>	<b>68.0%</b>	<b>67.5%</b>	<b>65.8%</b>	<b>66.8%</b>	<b>66.2%</b>	<b>63.4%</b>	<b>61.7%</b>	<b>63.3%</b>

**Figure 1. Trend in penetration rate of mental health services**



<sup>3</sup> \* $p < .05$ ; \*\* $p < .01$

**Table 23. Change in penetration rate of mental health services**

Fiscal Years	Percentage Point Change
FY 2005–06 to FY 2006–07	-1.71
FY 2006–07 to FY 2007–08	1.06
FY 2007–08 to FY 2008–09	-0.58
FY 2008–09 to FY 2009–10	-2.86
FY 2009–10 to FY 2010–11	-1.65
FY 2010–11 to FY 2011–12	1.55

From FY 2005–06 through FY 2011–12, the penetration rate overall for public mental health services in California declined significantly. In terms of practical significance, however, the decline was minimal.

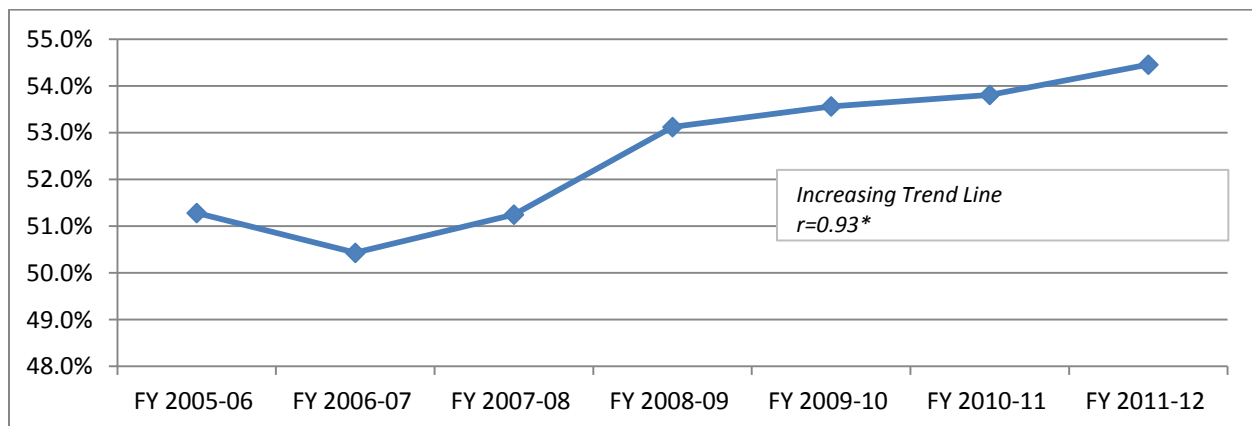
**Penetration Rate by Age Group**

Table 24 presents the penetration rate by age group (FYs 2004–05 through 2011–12). Figure 2 displays the trend line for the rate over time (FYs 2005–06 through 2011–12) for children/youth (ages birth up to, but not including 16 years). Table 25 displays the percentage point change from year to year (FYs 2006–07 through 2011–12) for children/youth.

**Table 24. Penetration rate of mental health services by age group**

Age Group & Category	FY 2004-05	FY 2005-06	FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
Child/Youth Holzer N	338,952	341,502	341,487	341,245	341,225	341,702	342,827	344,697
Child/Youth (CY) CSI N	122,733	175,126	172,207	174,877	181,257	183,023	184,468	187,701
<b>C/Y Penetration Rate</b>	<b>36.2%</b>	<b>51.3%</b>	<b>50.4%</b>	<b>51.2%</b>	<b>53.1%</b>	<b>53.6%</b>	<b>53.8%</b>	<b>54.5%</b>
TAY Holzer N	125,142	128,882	133,480	137,855	141,346	144,214	147,113	150,321
TAY CSI N	63,936	117,658	116,535	122,694	126,796	124,372	122,367	123,143
<b>TAY Penetration Rate</b>	<b>51.1%</b>	<b>91.3%</b>	<b>87.3%</b>	<b>89.0%</b>	<b>89.7%</b>	<b>86.2%</b>	<b>83.2%</b>	<b>81.9%</b>
Adult Holzer N	462,432	466,484	470,926	474,915	479,007	483,073	486,590	491,008
Adult CSI N	237,294	334,145	328,432	334,364	322,860	301,254	292,240	308,548
<b>Adult Penetration Rate</b>	<b>51.3%</b>	<b>71.6%</b>	<b>69.7%</b>	<b>70.4%</b>	<b>67.4%</b>	<b>62.4%</b>	<b>60.1%</b>	<b>62.8%</b>
Older Adult Holzer N	49,547	50,857	52,325	54,471	56,559	58,674	61,030	63,194
Older Adult (OA) CSI N	24,978	39,293	38,991	41,680	43,247	42,373	40,589	42,723
<b>OA Penetration Rate</b>	<b>50.4%</b>	<b>77.3%</b>	<b>74.5%</b>	<b>76.5%</b>	<b>76.5%</b>	<b>72.2%</b>	<b>66.5%</b>	<b>67.6%</b>

**Figure 2. Trend in penetration rate of mental health services for children and youth**



**Table 25. Change in penetration rate of mental health services for children and youth**

Fiscal Years	Percentage Point Change
FY 2005–06 to FY 2006-07	-0.85
FY 2006–07 to FY 2007-08	0.82
FY 2007–08 to FY 2008-09	1.87
FY 2008–09 to FY 2009-10	0.44
FY 2009–10 to FY 2010-11	0.25
FY 2010–11 to FY 2011-12	0.65

## Conclusions & Implications

The statistically significant increase in the penetration rate for children and youth is encouraging, and may reflect a positive impact from the MHSA. Indeed, analysis of numbers served by age group suggests that the proportion of children and youth served increased in each fiscal year following passage of the MHSA.

Review of the overall numbers of those who were estimated to be in need of public mental health services showed growth in each fiscal year, yet the numbers served by the public mental health system did not show corresponding enrollment to keep pace. Various factors may account for the inability to keep pace with need, including, but not limited, to:

- Challenges identified in earlier fiscal years related to timely processing and payment of Short-Doyle/Medi-Cal. The problems culminated in a 2007 report calling for widespread reform in processing and claims payment.<sup>4</sup>
- Drastic general fund budget cuts in the area of mental health services. Between 2009 and 2011, California cut \$587.4 million from the budget for mental health services, impacting all age groups.<sup>5</sup>

In light of healthcare reform and parity for behavioral health, MHSOAC should consider exploring potential reasons for the decline over time. The goal should be to ameliorate factors within their control in order to increase the penetration rate for public mental health services.

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

### Definition

This indicator describes the proportion of FSP consumers with access to a primary care physician during FYs 2005–06 through 2011–12. Access is not reported prior to FY 2005–06 because FSP launched in that year under the Mental Health Services Act.

### Calculation

FSP consumers indicating access to a primary care physician at any point during a fiscal year as a percentage of all FSP consumers served during that fiscal year was calculated, as was the rate of access per 100 FSP consumers (FYs 2006–07 through 2011–12 only). This percentage and rate were also calculated within demographic categories (i.e., age and gender) for each fiscal year.

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<sup>4</sup> California Department of Finance, *Final Report: Review of Claims Processes for the California Department of Mental Health's Short-Doyle/Medi-Cal programs* (Sacramento, CA: Author, 2007).

<sup>5</sup> National Alliance on Mental Illness, *State Mental Health Cuts: A National Crisis* (Arlington, VA: Author, 2011).

## Results: Access to a Primary Care Physician

Access to a primary care physician is presented for each fiscal year overall, then by age group (see the full report for findings by gender). The tables in this section present the percentage of FSP consumers with access to a primary care physician (FYs 2005–06 through 2011–12). Each figure displays the trend line for the rate of access to a primary care physician per 100 FSP consumers for FYs 2006–07 through 2011–12. The correlation between fiscal year and rate is displayed within each of the trend charts.<sup>6</sup>

### Overall

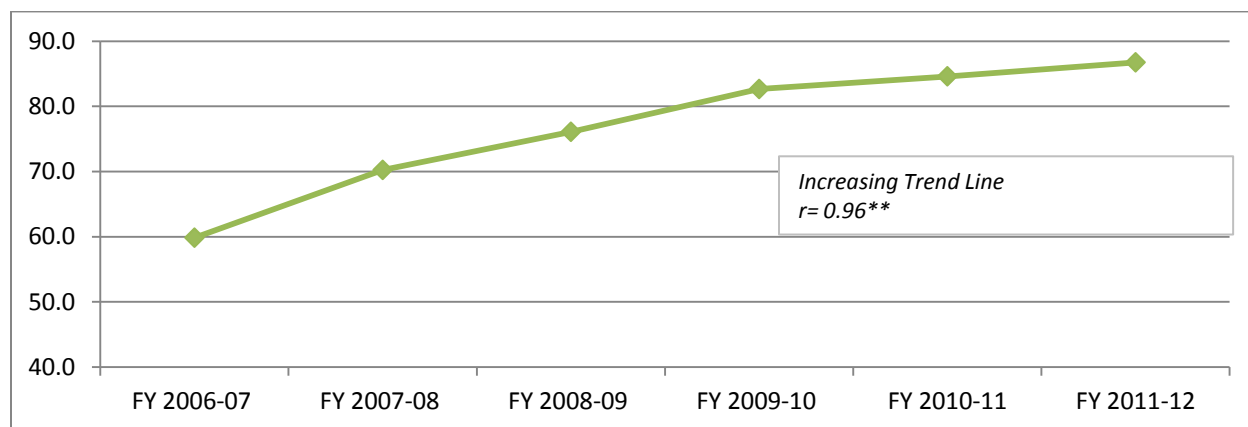
Table 26 presents the percentage of FSP consumers with access to a primary care physician (FYs 2005–06 through 2011–12).

**Table 26. FSP consumer physician access**

Fiscal Year	Percent with Physician Access
FY 2005-06	61.6%
FY 2006-07	59.8%
FY 2007-08	70.2%
FY 2008-09	76.1%
FY 2009-10	82.6%
FY 2010-11	84.6%
FY 2011-12	86.7%

*Note:* FY 2005–06 only includes DCR data from five large counties. Therefore, data from FY 2005–06 are excluded from the trend analysis presented in Figure 3.

**Figure 3. Physician access per 100 FSP consumers**



From FY 2006–07 through FY 2011–12, the rate per 100 FSP consumers who had access to a primary care physician increased significantly.

### Access to a Primary Care Physician by Age Group

Table 27 presents the percentage of FSP consumers with access to a primary care physician by age group (FYs 2005–06 through 2011–12). Each of the related figures (Figures 4 through 7) displays

<sup>6</sup> \* $p < .05$ ; \*\* $p < .01$

the trend line for the rate of access per 100 FSP consumers in each age group (for FYs 2006–07 through 2011–12).

**Table 27. FSP consumer physician access by age group**

Fiscal Year	Age Group	Percent with Physician Access
FY 2005-06	Family	87.5%
	Youth	61.7%
	Adults	57.1%
	Older Adults	73.3%
FY 2006-07	Family	81.1%
	Youth	65.3%
	Adults	50.1%
	Older Adults	67.9%
FY 2007-08	Family	91.2%
	Youth	67.0%
	Adults	60.8%
	Older Adults	80.6%
FY 2008-09	Family	93.0%
	Youth	69.4%
	Adults	70.3%
	Older Adults	85.1%
FY 2009-10	Family	94.9%
	Youth	78.1%
	Adults	77.6%
	Older Adults	90.7%
FY 2010-11	Family	95.4%
	Youth	79.3%
	Adults	80.5%
	Older Adults	91.6%
FY 2011-12	Family	96.8%
	Youth	82.8%
	Adults	82.5%
	Older Adults	92.5%

*Note:* FY 2005–06 only includes DCR data from five large counties. Therefore, FY 2005–06 data are excluded from the trend analysis in Figures 4–7.

Figure 4. Physician access per 100 FSP consumers (family)

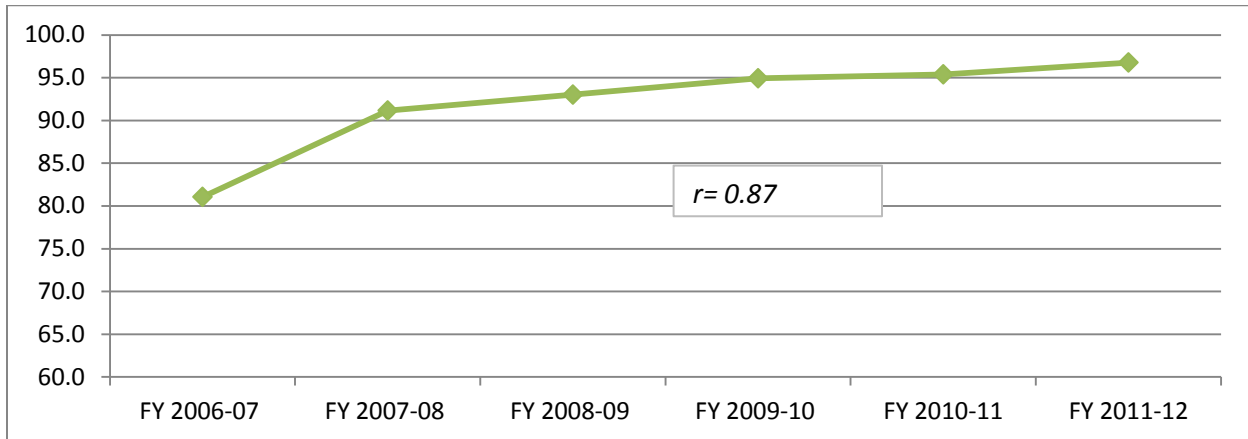


Figure 5. Physician access per 100 FSP consumers (youth)

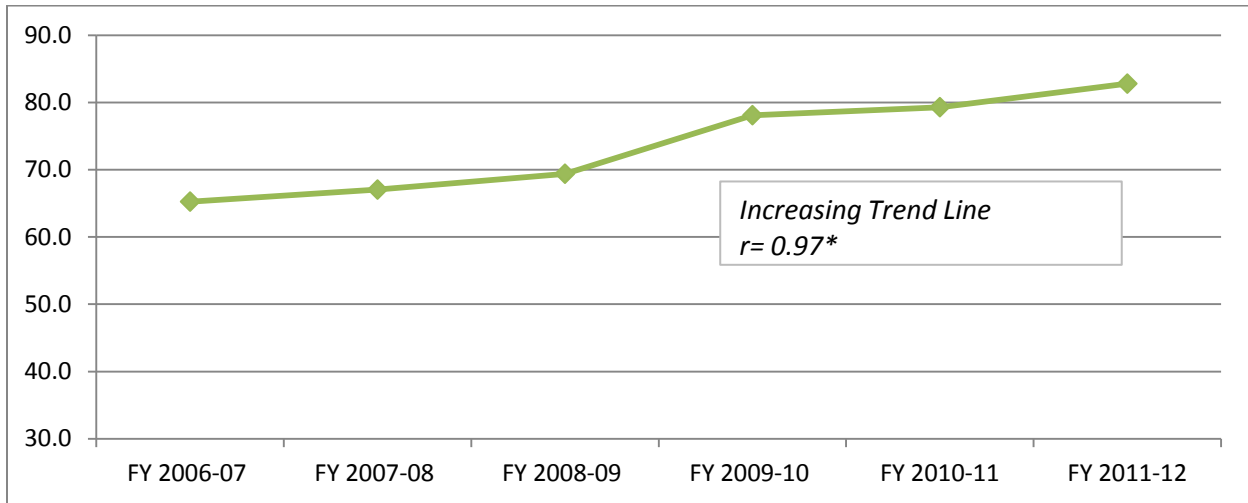


Figure 6. Physician access per 100 FSP consumers (adults)

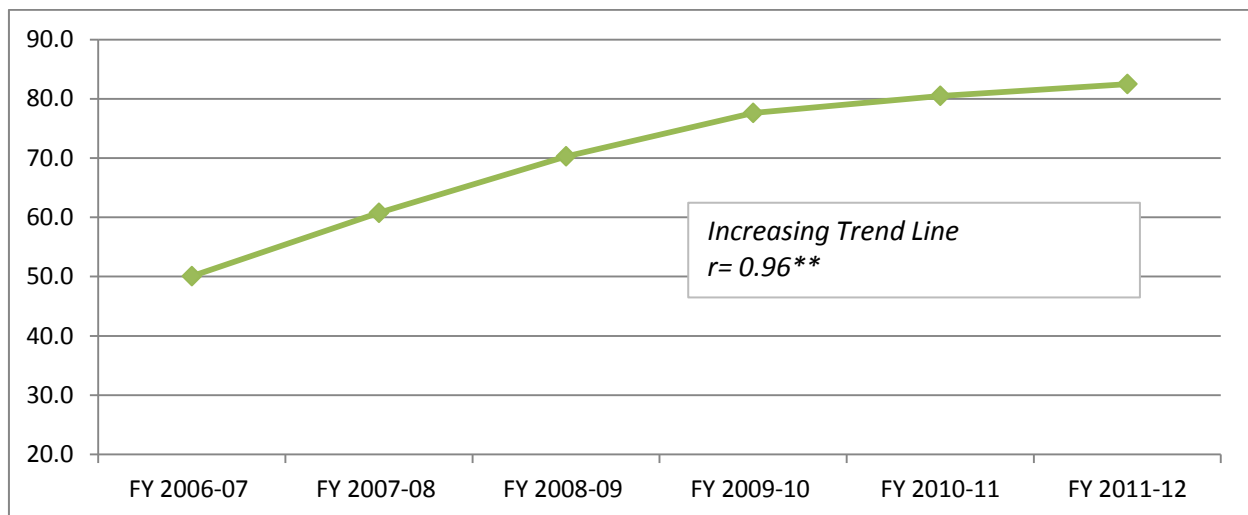
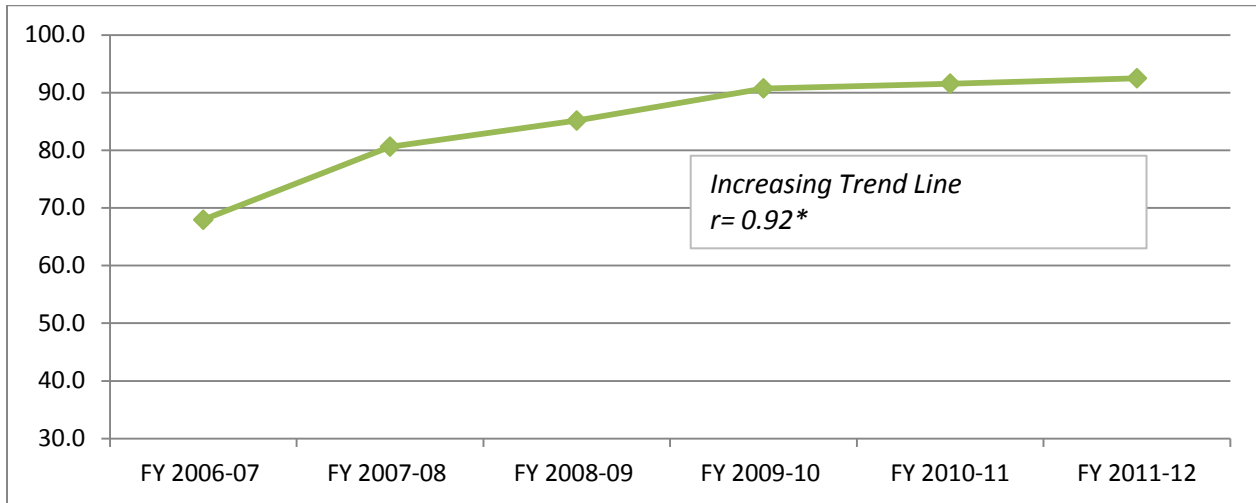


Figure 7. Physician access per 100 FSP consumers (older adults)



From FY 2006–07 through FY 2011–12, the rate per 100 FSP transition-age youth, adult and older adult consumers with access to a primary care physician increased significantly. The rate per 100 FSP children/youth also increased during that time period, but the increase was not statistically significant.

### Conclusions & Implications

From FY 2006–07 to FY 2011–12, the rate of access to primary care physicians per 100 FSP consumers overall and among transition age youth, adult and older adult consumers increased significantly. The age-related finding is particularly important when the challenges in finding healthcare options for adults and older adults are considered. Whereas those under 18 have much broader access due to health insurance coverage under Medicare, Healthy Families, and coverage offered through First 5 (e.g., First 5 LA’s Healthy Kids program), adults have fewer health insurance options; those who do not qualify for Medi-Cal often remain uninsured.

The rate per 100 FSP children/youth also increased during this time period. Although this finding was ultimately not statistically significant, the trend may be due to the array of health insurance options available to minors (and the subsequent high rates of coverage in each fiscal year).

However, high rates of missing data when access to a primary care physician and demographic data are considered together should be considered. The percentage of respondents with missing data for either access to a primary care physician and/or age group ranged from 13.9 to 44.5 percent (depending upon the fiscal year and age group). Rates of missing data exceeding 10 percent are generally considered unacceptable. Because it is not known if these respondents have access to a primary care physician, the impact of high rates of missing data on this indicator is unknown.

## Priority Indicator 9: Perceptions of Access to Services

### Definition

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

### Calculation

Family members/caregivers and youth respondents' ratings (1 = strongly disagree to 5 = strongly agree) on two self-report items (specified in the "Data Sources" section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services.

Adult and older adult respondents' ratings (1 = strongly disagree to 5 = strongly agree) on six self-report items (specified in the "Data Sources" section below) were averaged to calculate aggregate ratings of perceptions of access to mental health services.

For all four groups (family, youth, adults, older adults), aggregate ratings were calculated for each fiscal year. Only respondents with complete data (i.e., no missing responses on any of the questions) were included. Ratings of 3.5 or greater indicate positive perceptions. This calculation method is in line with previous DHCS practices.

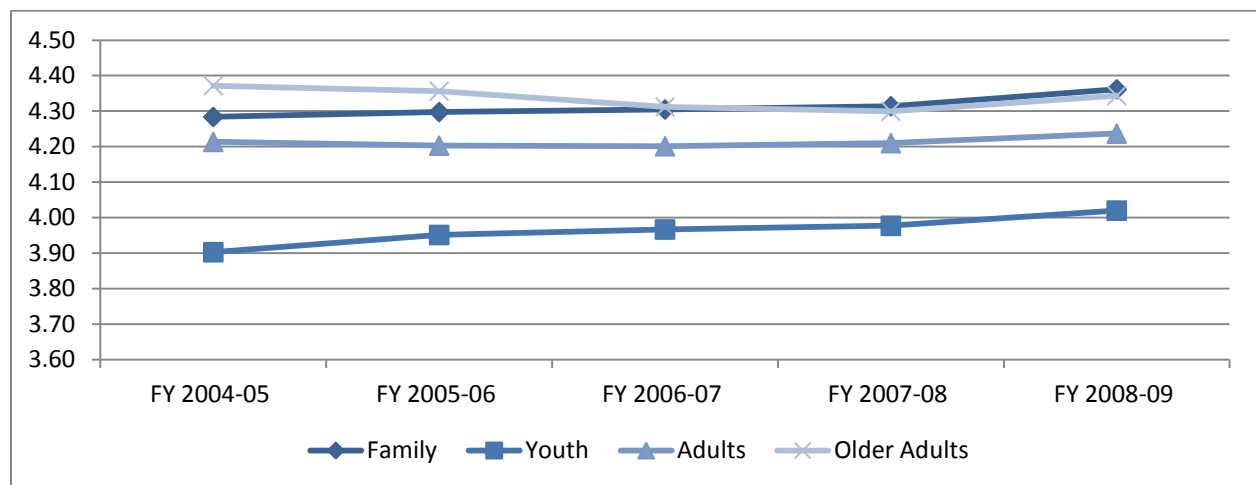
### Results: Perceptions of Access to Mental Health Services

Consumer and family perceptions of access to public mental health services are presented by age group. FYs 2009-10, 2010-11, and 2011-12 are not displayed in this summary due to methodological changes that impacted scores.

#### Perceptions of Access to Services by Age Group

Figure 8 displays average ratings of perceived access by age group, over time (FYs 2004-05 through 2008-09).

Figure 8. Perceived access to services by age group



During the fiscal years in which survey administration methodology was consistent (FYs 2004-05 through 2008-09), average ratings of perceived access among respondent groups (all age groups) were greater than 3.5. This suggests satisfaction with access to public mental health services.

When satisfaction with access to services is examined by age group, the ratings tend to remain fairly stable over time. Average ratings were highest among older adults, followed by families,



adults, and then youth. At the point of greatest difference, the spread between older adults and youth was still minimal (0.5). None of the trends were statistically significant.

## Conclusions & Implications

During the fiscal years in which survey administration methodology was consistent (FYs 2004–05 through 2008–09), average ratings of perceived access, across age groups were greater than 3.5. This average rating suggests satisfaction with access to public mental health services among all age groups examined.

When satisfaction with access to services is examined by age group, the ratings tend to remain fairly stable over time. Average ratings were highest among older adults, followed by families, adults, and then youth. At the point of greatest difference, the spread between older adults and youth was relatively minimal (0.5). These results suggest little practical difference between age groups with regard to this average satisfaction with access to services.

During fiscal years in which survey administration methodology was consistent for families and youth (FYs 2004–05 through 2008–09), perceived access ratings tended to increase over time among both males and females. For adults and older adults, ratings decreased modestly before rebounding in FY 2008–09. With the exception of family respondents, females were more satisfied with access than their male counterparts. These patterns suggest females were consistently more satisfied with access to services compared to males, with the exception of family respondents. However, both gender groups reported satisfaction with services on average in each FY examined.

During fiscal years in which survey administration methodology was consistent (FYs 2004–05 through 2008–09), ratings of perceived access among individual racial/ethnic groups tended to cluster closely, with little meaningful variation between groups or fiscal years. Overall, all racial/ethnic groups reported satisfaction with access to services in each FY examined.

The reasons that some demographic groups are less satisfied with access to services compared to others (e.g., consistent gender differences) should be explored further. MHSOAC should consider developing and funding an RFP for an exploratory study in order to learn more about the reasons for these differences. The RFP should seek to specifically address:

**Age Group:** Why do youth report the lowest perceived access ratings on average among all age groups?

**Gender:** Why are male youth, adults, and older adults consistently less satisfied with access to public mental health services than their female counterparts?

An exploratory study of this nature could inform service delivery so that the needs of those receiving public mental health services are better met.

## Priority Indicator 10: Involuntary Status

### Definition

This indicator provides insight into the rates of involuntary status among all mental health consumers. Involuntary status refers to a legal designation that can be applied to individuals who are found to be a danger to themselves and/or others, and/or who are gravely disabled.

### Calculation

The California Department of Health Care Services (DHCS) reports incidents of involuntary status per 10,000 mental health consumers. Variables include:

- Number of Adults in 72-Hour Inpatient Treatment Facilities
- Number of Children in 72-Hour Inpatient Treatment Facilities
- Number of Individuals in 14-Day Treatment Facilities
- Number of Individuals Receiving 14-Day Intensive Treatment (Suicide)

## Results: Involuntary Status

### Adults in 72-Hour Inpatient Treatment Facilities

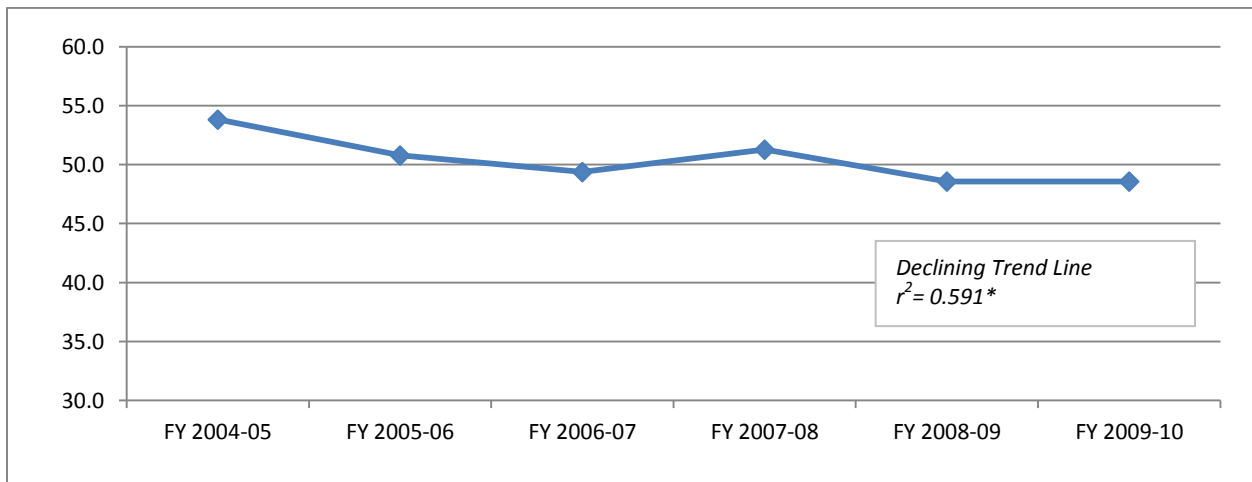
Table 28 presents the rate per 10,000 adult mental health care consumers in 72-hour inpatient treatment facilities for FYs 2004–05 through 2010–11.

**Table 28. Adults in 72-hour inpatient facilities (rate per 10,000 adult consumers)**

Fiscal Year	Rate per 10,000 adult mental health consumers
FY 2004-05	53.8
FY 2005-06	50.8
FY 2006-07	49.4
FY 2007-08	51.3
FY 2008-09	48.6
FY 2009-10	48.6
FY 2010-11	47.7

Note: FY 2010–11 does not include rates from five large counties: Contra Costa, Fresno, Merced, Riverside, and Santa Barbara. Therefore, FY 2010–11 is excluded from the trend analysis presented in Figure 9 below.

**Figure 9. Adults in 72-hour inpatient facilities (rate per 10,000 consumers)**



From FY 2004–05 through FY 2009–10, the rate per 10,000 adults involuntarily confined to 72-hour treatment facilities declined significantly.

### Number of Children in 72-Hour Inpatient Treatment Facilities

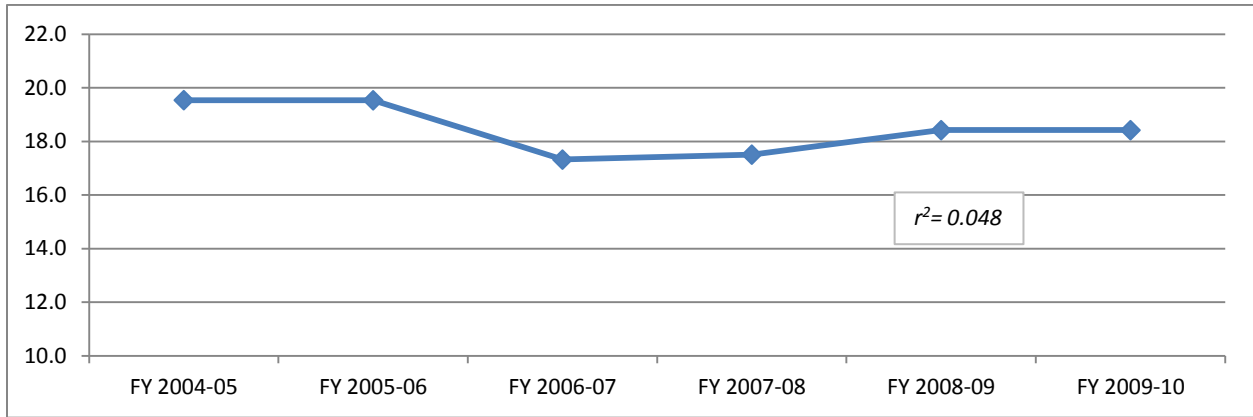
Table 29 presents the rate per 10,000 child mental health consumers in 72-hour inpatient treatment facilities for FYs 2004–05 through 2010–11.

**Table 29. Children in 72-hour inpatient facilities (rate per 10,000 child consumers)**

Fiscal Year	Rate per 10,000 child mental health consumers
FY 2004-05	19.5
FY 2005-06	19.5
FY 2006-07	17.3
FY 2007-08	17.5
FY 2008-09	18.4
FY 2009-10	18.4
FY 2010-11	21.4

Note: FY 2010–11 does not include rates from five large counties: Contra Costa, Fresno, Merced, Riverside, and Santa Barbara. Therefore, FY 2010–11 is excluded from the trend analysis presented in Figure 10 below.

**Figure 10. Children in 72-hour inpatient facilities (rate per 10,000 child consumers)**



From FY 2004-05 through FY 2009–10, the rate per 10,000 children involuntarily confined to 72-hour treatment facilities fluctuated, but did not change significantly.

### Number of Individuals in 14-Day Treatment Facilities

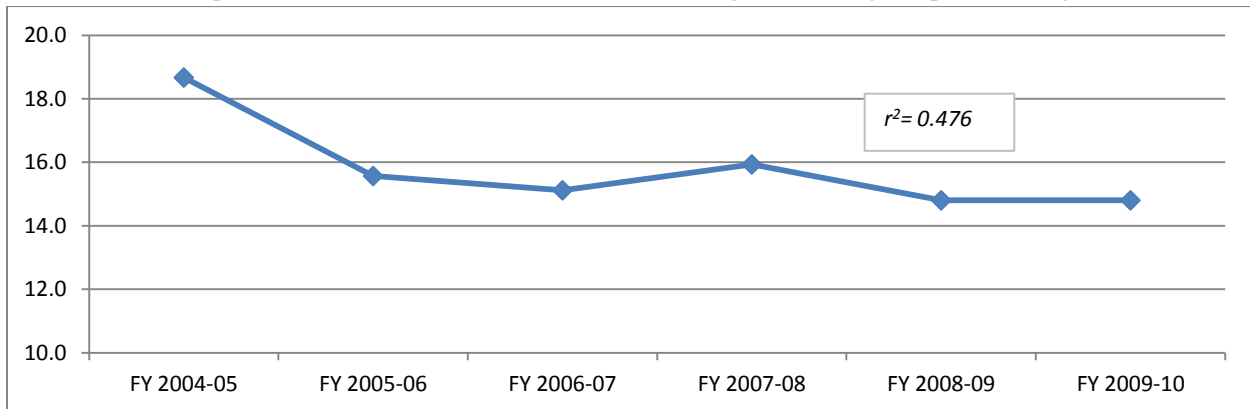
Table 30 presents the rate per 10,000 mental health consumers in 14-day treatment facilities for FYs 2004–05 through 2010–11.

**Table 30. Mental health consumers in 14-day facilities (rate per 10,000 consumers)**

Fiscal Year	Rate per 10,000 mental health consumers
FY 2004-05	18.7
FY 2005-06	15.6
FY 2006-07	15.1
FY 2007-08	15.9
FY 2008-09	14.8
FY 2009-10	14.8
FY 2010-11	18.3

Note: FY 2010–11 does not include rates from five large counties: Contra Costa, Fresno, Merced, Riverside, and Santa Barbara. Therefore, FY 2010–11 is excluded from the trend analysis presented in Figure 11 below.

**Figure 11. Mental health consumers in 14-day facilities (rate per 10,000)**



From FY 2004–05 through FY 2009–10, the rate per 10,000 individuals involuntarily confined to 14-day treatment facilities fluctuated but did not change significantly.

### Number of Individuals in 14-Day Intensive (Suicide) Treatment Facilities

Table 31 presents rate per 10,000 mental health consumers in 14-day intensive (suicide) treatment facilities for FYs 2004–05 through 2010–11. No figure is provided because the rate did not change from one fiscal year to the next.

**Table 31. Mental health consumers in 14-day intensive facilities (rate per 10,000)**

Fiscal Year	Rate per 10,000 mental health consumers
FY 2004-05	0.1
FY 2005-06	0.1
FY 2006-07	0.1
FY 2007-08	0.1
FY 2008-09	0.1
FY 2009-10	0.1
FY 2010-11	0.1

*Note:* FY 2010–11 does not include rates from five large counties: Contra Costa, Fresno, Merced, Riverside and Santa Barbara.

From FY 2004–05 through FY 2009–10 the rate per 10,000 individuals involuntarily confined to 14-day intensive (suicide) treatment facilities did not change.

### Conclusions & Implications

The statistically significant decline in the number of adults involuntarily confined to 72-hour inpatient treatment is encouraging, and may reflect a positive impact from the Full Service Partnership (FSP) program. Indeed, this pattern is consistent with a separate study of FSP expenditures and offsets from FY 2008–09 to FY 2009–10 that found substantial cost offsets due to reductions in inpatient hospitalization among adults.<sup>7</sup> Taken together these results may suggest

<sup>7</sup> Harris, E.J., Springer, J.F., Mapp, A. & Echighian, K. (2012). *Full Service Partnerships: California's Investment to Support Children and Transition-Age Youth with Serious Emotional Disturbance and Adults and Older Adults with Severe Mental Illness*. Sacramento, California: Mental Health Services Oversight and Accountability Commission.

[http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC\\_111512\\_Tab4\\_MHSA\\_CostOffset\\_Report\\_FSP.pdf](http://mhsoac.ca.gov/Meetings/docs/Meetings/2012/Nov/OAC_111512_Tab4_MHSA_CostOffset_Report_FSP.pdf)

that services, such as the FSP program, are impacting involuntary service rates. More detailed analysis of consumer paths through the community mental health system will be necessary to fully understand how such services may contribute to declines in involuntary service rates.

## Priority Indicator 11: Consumer Well-Being

### Definition

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

### Calculation

Family members/caregivers and youth respondents' ratings (1 = strongly disagree to 5 = strongly agree) on 11 self-report items (specified in the "Data Sources" section below) were averaged to calculate aggregate ratings of well-being.

In FYs 2004–05 and 2005–06, only six of the 11 self-report items that comprise the indicator were included on the Consumer Perception Survey (CPS).

Adult and older adult respondents' ratings (1 = strongly disagree to 5 = strongly agree) on 14 self-report items (specified in the "Data Sources" section below) were averaged to calculate aggregate ratings of perceptions of well-being.

In FYs 2004–05 and 2005–06, only six of the 14 self-report items that comprise the indicator were included on the Consumer Perception Survey (CPS).

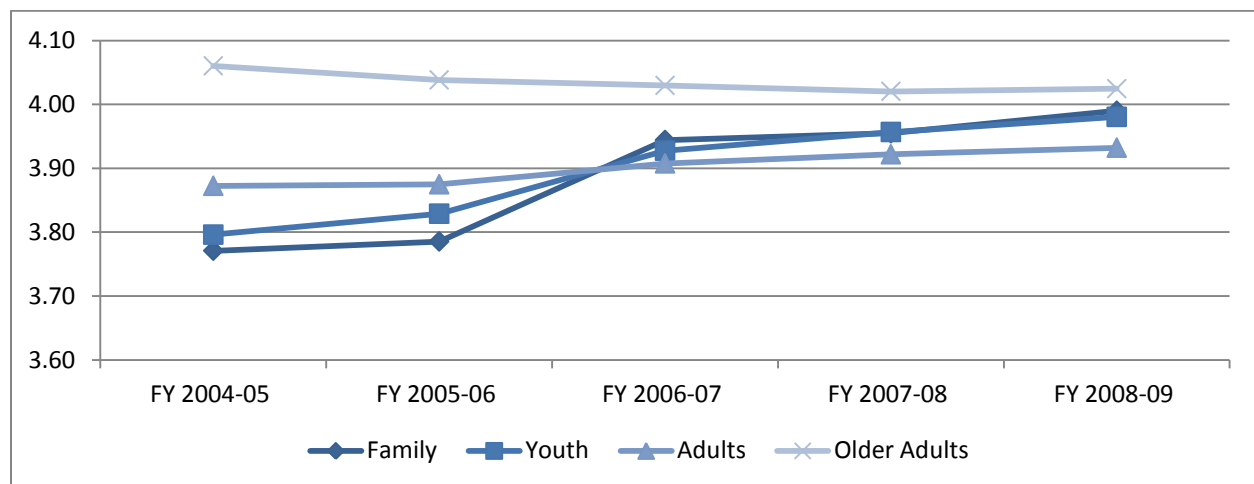
For all four age groups, aggregate ratings were calculated for each fiscal year. Only respondents with complete data (i.e., no missing responses on any item) were included. Average ratings of 3.5 or greater indicate positive perceptions. This calculation method is in line with previous DHCS practices.

## Results: Perceptions of Well-Being as a Result of Services

### Perceptions of Well-Being as a Result of Service by Age Group

Figure 12 displays average ratings of well-being by age group (FYs 2004–05 through 2008–09).

Figure 12. Trend in ratings of well-being by age group (FYs 2004-05–2008-09)



During fiscal years in which survey administration methodology was consistent (FYs 2004–05 through 2008–09), average ratings among all age groups were greater than 3.5. This finding suggests positive average perceptions of well-being as a result of mental health services across age groups. When perceived improvement in well-being as a result of access to services is examined by age group, the trend of improving ratings over time is statistically significant for families and youth.<sup>8</sup>

## Conclusions & Implications

During fiscal years in which survey administration methodology was consistent (FYs 2004–05 through 2008–09), average ratings among all age groups were greater than 3.5, indicating generally positive average perceptions of well-being. When perceived well-being as a result of services was examined by age group, ratings clustered in later fiscal years. A general increasing trend in average ratings was found among all age groups, with the exception of older adult ratings that decreased slightly over time. These results indicate generally positive average perceptions of well-being as a result of mental health services across age groups.

Average well-being ratings for families, youth, and adults tended to increase over time among both males and females. For older adults ratings fluctuated, but only slightly (maximum difference of 0.1 in FY 2007-08). Among youth and adults, females tended to report lower average levels of well-being as a result of services, compared to their male counterparts. These results indicated generally positive trends and little difference between genders.

Average ratings of well-being among racial/ethnic groups tended to cluster closely. Among families and youth, ratings tended to improve slightly over time for all racial/ethnic groups. Among youth and adults, ratings tended to be lowest among American Indians; ratings for American Indian older adults in FY 2006–07 fell below the rating benchmark of 3.5. While largely positive trends in perceptions of well-being as a result of services were found across racial/ethnic groups, lower average ratings among some groups indicate such difference warrant further investigation.

The MHSOAC should consider developing and funding an RFP for an exploratory study in order to learn more about the reasons for these differences between demographic groups. The RFP should specifically seek to address:

**Gender:** Why are female youth and adults less satisfied with perceived improvements in well-being?

**Racial/ethnic Group:** Why is perceived well-being as a result of access to services lower among American Indians? Why is the rating below the acceptable threshold in one fiscal year among American Indian older adults? Why did it rebound in subsequent fiscal years?

An exploratory study of this nature could inform service delivery so that the needs of those receiving public mental health services are better met.

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<sup>8</sup> \*\* $p < .01$

## Priority Indicator 12: Satisfaction with Services

### Definition

This indicator provides insight into consumer and family perceptions of satisfaction with mental health services.

### Calculation

Family members/caregivers and youth respondents' ratings (1 = strongly disagree to 5 = strongly agree) of six self-report items (specified in the "Data Sources" section below) are averaged to calculate aggregate ratings of satisfaction with public mental health services.

Adult and older adult respondents' ratings (1 = strongly disagree to 5 = strongly agree) of three self-report items (specified in the "Data Sources" section below) are averaged to calculate aggregate ratings of satisfaction with public mental health services.

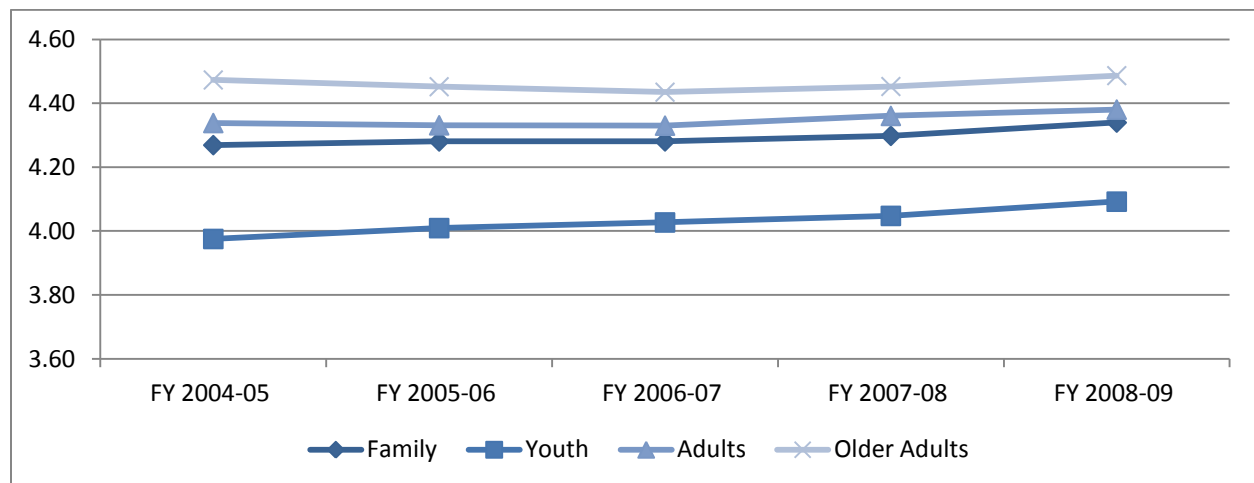
For all four age groups, aggregate ratings were calculated for each fiscal year. Only respondents with complete data (i.e., no missing responses on any of the questions) were included. Ratings of 3.5 or greater indicate positive perceptions. This calculation method is in line with previous DHCS practices.

### Results: Satisfaction with Services

#### Satisfaction with Services by Age Group

Figure 13 displays average ratings of satisfaction with services over time (FYs 2004-05 through 2008-09).

Figure 13. Satisfaction ratings by age group (FYs 2004-05-2008-2009)



During fiscal years in which survey administration methodology was consistent (FYs 2004-05 through 2008-09), average ratings among all age groups were greater than 3.5. This finding suggests satisfaction with public mental health services.

When satisfaction was examined by age group, the ratings tended to cluster in later fiscal years. With the exception of older adults, ratings increased slightly over time. The decline among older adults was minimal (less than .05 points), however. Older adults were the most satisfied, followed by adults, families, and then youth. None of the trends over time was statistically significant.

## Conclusions & Implications

During fiscal years in which survey administration methodology was consistent (FYs 2004–05 through 2008–09), average ratings among all age groups were greater than 3.5, indicating overall satisfaction with public mental health services. When satisfaction ratings were examined by age group they tended to cluster in later fiscal years. With the exception of older adults, ratings increased slightly over time. The decline among older adults was minimal (less than .05 points), however. Older adults were the most satisfied, followed by adults, families, and then youth.

Average satisfaction ratings for family members, youth, and adults tended to increase over time among both males and females. For older adults, ratings fluctuated, but only slightly (0.1 point). Among youth, adults, and older adults, males tended to be less satisfied when compared to their female counterparts.

Average satisfaction ratings of specific racial/ethnic groups tended to cluster closely. Ratings for all age and ethnic groups were above the acceptable 3.5 mark in all fiscal years.

The reasons that specific demographic groups (e.g., youth and males) are less satisfied on average when compared to other groups should be explored further. MHSOAC should consider developing and funding an RFP for an exploratory study in order to learn more about the reasons for these differences in satisfaction. The RFP should seek to specifically address:

**Age Group:** Why are youth the least satisfied with services when compared with other age groups?

**Gender:** Why are males less satisfied with services than females?

An exploratory study of this nature could inform service delivery so that the needs of those receiving public mental health services are better met.

## Overall Discussion & Conclusions

### Consumer Outcomes Indicators

Trends across consumer outcomes indicators were largely stable with some positive signs among specific populations and indicators. However, several factors limited the ability of consumer outcomes indicators to address all relevant service populations or detect impact of service participation at the individual level. Trends found among consumer outcomes indicators presented in this report, and discussed briefly below, should be interpreted in the context of the limitations of these indicators. These limitations are due in large part to the existing data sources utilized to calculate them.

FSP consumers reported positive attendance ratings, stable employment rates, stable housing status rates, and moderately declining rates of reported arrests across years among new consumers. Detection of change in consumer outcomes among FSP consumers was restricted due to the limited availability of information post program intake.

Among all mental health consumers, employment rates and housing status were relatively stable across years. Arrest outcomes were not comparable across years, due to changes in the sampling approach used to generate CPS data. Relevant and reliable data was not available to assess the consumer outcomes indicator School Attendance. Available data did not support assessment of change in outcomes among all mental health consumers. Some conclusions regarding each consumer outcomes indicator can be drawn, but should be understood in the context of the data utilized to calculate them.



## School Attendance

Overall, average ratings indicate FSP consumers attended school all or most of the time. Notably, male children tended to have higher average attendance ratings compared to female children, while this pattern was reversed among TAY FSP consumers. This interaction suggests several possible causal factors, including the possibility that the different maturation patterns of the genders may have contributed to average attendance ratings. Such possibilities should be investigated in future research focused on how FSP services may interact with the different developmental patterns of each gender to impact school participation.

Relatively little change in attendance ratings was observed across years and genders within each age group. The restricted range of attendance ratings found in each FY suggests the categorical response scale used to measure school attendance via the intake (PAF) and quarterly assessment (3M) forms may not allow for sufficient attendance variation to be captured. It is possible that recording the number of days of school attendance as a function of all possible school days would provide a more accurate assessment of attendance. Further, capturing other aspects of school participation (e.g., engagement, social connection, and/or academic achievement) would create a multi-dimensional measure of school participation or engagement, and would likely be more sensitive to changes in educational engagement. Beyond FSP consumers, assessment of school attendance or engagement using similar multidimensional methods should also be conducted among all child and TAY mental health consumers.

## Employment

Among FSP consumers, employment rates were relatively stable across fiscal years for all age groups and genders. FSP consumers reported little change in employment status post program intake, in each FY. TAY FSP consumers reported the highest rate of change to employed status, which likely reflects this age group entering the workforce for the first time. Employment trends do not suggest a substantial impact of FSP program participation. However, the disproportionately high rates of unknown or missing employment data found post program intake, likely due to the data collection strategy of the KET form (i.e., reporting as status changes warrant) in the DCR system, suggest change in employment status may be underreported.

Among all mental health consumers, adults and females reported the highest rates of employment across years. CSI data did not support assessment of change in employment status among all mental health consumers. Results do not suggest a substantial impact of mental health service on employment. But, similar to the circumstance described regarding the DCR data system, CSI periodic assessments did not appear to be reliably collected across consumers, thus employment may have been underreported.

As employment can be an important indicator of the progress of consumers, further investigation of the reliability of the tracking of employment status among these service populations should be considered. There may be data quality assurance approaches (e.g., automated reporting, accountability policies, and technical assistance and training) that may support more efficient and complete tracking of this consumer outcome.

## Homelessness & Housing

The majority or plurality of child and TAY FSP consumers reported residing with family in each FY, and the plurality of adults and older adults reported residing in group care settings in nearly all FYs. Across age groups, most FSP consumers did not report changes in housing status. But among those that did report change, proportionally more reported transition out of homelessness than the

reported transition into homelessness. Thus, housing status was found largely stable over time, with some indications of a positive trend of transitioning out of homelessness.

However, housing status trends should be viewed in the context of the development of the FSP program. Trends across the first four years of operation are likely indicative of the program gearing up, rather than of normal full operation. It is difficult to draw clear conclusions regarding these early trends in housing status. Interpretation of housing trends is also made difficult because, for all age groups other than adults, the percentage of consumers reporting unknown housing status is of similar magnitude to other housing categories. Thus, in order to make claims about the trends in other categories, the assumption must be made that the reasons for unknown housing statuses are completely independent of participants' actual housing status. This seems unlikely, as housing statuses such as homelessness are difficult to track reliably. More complete tracking of housing status will need to be pursued in order to more clearly inform the impact of FSP participation on homelessness and housing.

Among all mental health consumers, housing status was largely stable across years, with the plurality of consumers reporting residing independently. Across age groups the proportion of consumers living independently increased each FY since 2007-08. But, among adults and older adults, the proportion of consumers who reported being homeless or in a group care setting also increased each FY since FY 2007-08. This slight trend toward homelessness among adult and older adult consumer is concerning, but should be interpreted in light of the high rates of missing or unknown housing information, similar to the situation discussed among FSP housing data.

## Arrests

Across all age categories, the percentages of new FSP consumers with arrest histories indicated a downward trend. The arrest data reported by new FSP consumers suggests a shift in the characteristics of incoming consumers. This pattern merits further investigation into whether the shift is due to self-selection by potential FSP consumers or a change in program recruitment procedures.

A general increase was found in the proportion of all mental health consumers reporting arrest during the first three comparable years analyzed, but reported arrests during services also tended to be less than reported arrests prior to services among most age groups. This trend provides initial indications of a positive impact of service participation. As arrest information collected in later years was gathered using different sampling approaches, this data produced somewhat contradictory results that unfortunately are not comparable. Clear conclusions are not interpretable from this limited information. The continuity of the collection of arrest information moving forward will be imperative to clarify the impact of mental health services on the justice involvement of all consumers.

## System Performance Indicators

### Indicator 5: Demographic Profile of Consumers Served

Demographic information is foundational to most individual-level and system-level indicators because of the desire to examine the impact of the MHSA on various priority populations. Therefore, accuracy, completeness and data quality becomes paramount in building a solid foundation for which later analyses can be conducted with confidence. The inability to report race/ethnic data due to high rates of missing data undermines the effort. Ensuring access to this most basic level of consumer information must be a priority in the coming years, among all public mental health consumers (currently in the form of the CSI data) and MHSA consumers. Although the focus of this report is Full Service Partnership consumers (FSP), accurate demographic data should

not be limited to FSPs. The current effort underway to pilot a data collection for Community Services and Supports has the potential to build upon the lessons learned from the DCR in order to produce valid, reliable demographic data accessible in a timely manner.

#### Indicator 6: Demographic Profile of New Consumers

Because the majority of consumers are continuing consumers, MHSOAC may want to consider the implications of shrinking proportions of new consumers and how the public mental health system (and the MHSA) will accommodate new consumers in the coming years.

There is great variation in the proportion of new consumers by age and gender, depending upon the county. It may behoove MHSOAC to consider funding a cross-site evaluation study to explore the factors that contribute to the following clusters observed among counties:

##### New and continuing consumers

- Fairly even split between new and continuing consumers
- Majority continuing consumers
- Fluctuation over the years and no clear pattern emerges

##### Under-represented age groups

- Proportion of under-represented age groups increases over time as proportion of adults declines
- Adults are plurality or majority in every (or nearly every) fiscal year
- Fluctuation over the years and no clear pattern emerges

##### Gender

- Fairly even split between males and females
- Majority male
- Fluctuation over the years and no clear pattern emerges

There are likely relevant questions related to race/ethnicity, but unfortunately these patterns could not be explored at the county level due to concerns about data accuracy.

MHSOAC may first want to set forth desirable goals with respect to the proportion of new versus continuing consumers. The discussion of a desirable proportion of new consumers is beyond the scope of this report and will be determined by funding, county considerations, the needs of current consumers, etc.

Desired proportions by age, gender and race/ethnicity should likewise not be determined by Indicator 7 (see below). The penetration rate was developed to indicate need for public mental health services. Goal-setting for desired proportions of new and continuing consumers by demographic group should be a broader discussion that takes into account the factors described above.

#### Indicator 7: Penetration of Mental Health Services

Although the statewide penetration rate declined over time, there is considerable variation in the rate when examined at the county level. Counties with exemplary penetration rates (near, at or above the 100% mark) include:

- Alameda
- Butte
- Contra Costa
- San Mateo

Should MHSOAC consider funding a cross-site study (as suggested above, under Indicator 6), additional questions of interest could be included with respect to the penetration rate. Of particular interest are the factors related to the following clusters observed among counties:

- Meeting or exceeding the penetration rate among all or nearly all groups
- Penetration rates at or above 70 percent and increases over time among under-served age groups
- Penetration rates in the range of 60 to 70 percent and little change over time
- Penetration rates around or below 50 percent and declines over time
- Fluctuation over time and no clear pattern emerges

Findings from such a cross-site study may help inform policies that can support penetration rate improvements in struggling counties.

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

Increasing proportions of consumers with access to a primary care physician as the MHSA matures demonstrates the potential impact of treating the needs of the 'whole person.' This finding suggests that the MHSA may have an impact on the physical health outcomes of Full Service Partners. There is a long, well-established literature regarding related health problems associated with SMI. Improved health outcomes among individuals with SMI support people in attaining recovery outcomes by more strongly supporting the ability to seek further education, volunteer opportunities, community engagement and employment.

Funding to examine this possibility could be solicited from non-profit foundations, such as Robert Wood Johnson and the California Endowment. For example, select counties in which primary care integration efforts have launched could be recruited to participate in a proposal to examine physical health outcomes.

#### Indicator 10: Involuntary Status

As suggested under Indicator 10, more detailed analysis of consumer paths through the community mental health system will be necessary to fully understand how such services may contribute to declines in involuntary service rates. There is considerable variation in involuntary confinement by county. A cross-site study to examine the factors contributing to following county clusters would be instructive:

- Declining involuntary confinement rates
- Little to no change in involuntary confinement rates
- Increasing rates of involuntary confinement
- Fluctuation over time and no clear pattern emerges

#### Indicators 9, 11 and 12: Consumer Perception

Although the calculation method is consistent with DHCS practices, there is not much change over time and ceiling effects are observed. Ceiling effects are typical with satisfaction surveys. Even when change over time is statistically significant (as with family and youth wellbeing), average scores were above the 3.5 benchmark to begin with and therefore not much new information is gained about satisfaction among these age groups.

Another method of analysis that MHSOAC may want to explore is one endorsed by the federal government with regard to its national consumer response services centers. This method involves examining the proportion of individuals that endorse a desirable rating (Satisfied or Very Satisfied). Rather than tracking mean scores, the goal is instead for 75 percent of respondents to endorse a

desirable rating (75 percent is the current national benchmark). The 'gold standard' among satisfaction surveys sets the bar at 80 percent of respondents endorsing a desirable rating. By tracking the proportion of respondents endorsing desirable ratings, the following advantages are gained:

- Greater change over time
- Ability to show impact
- Communication of results in a manner that is understandable by the lay person