



Statewide Overview: Data Notebook 2014 for  
California Mental Health Boards and Commissions

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Prepared for: The Continuous System Improvement Committee of  
The California Mental Health Planning Council

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## INTRODUCTION: Purpose, Goals, and Data Resources

What is the “Data Notebook?”

It is a structured format for reviewing information and reporting on the mental health services in each county. The Data Notebook supplies individualized reports containing data for each county from public resources. These sources included, for example, the behavioral health External Quality Review Organization (EQRO/APS Healthcare) and CIBHS (California Institute for Behavioral Health Solutions). For some questions, we requested that local mental health boards obtain data from their county mental health department because there was no public source available.

The Data Notebook was developed for the use of the local mental health (MH) boards and commissions by a workgroup comprised of members from:

- California Association of Local Mental Health Boards and Commissions (CALMHB/C)
- Napa County Mental Health Board
- EQRO/APS Healthcare (External Quality Review Organization)
- California Mental Health Planning Council (CMHPC)

In addition, we sought informal consultation from several county mental health directors and quality improvement coordinators on specific issues that arose during the development of this project. We took inspiration for our report style and format from some of the best examples of county mental health reports prepared for the general public.

The Data Notebook is designed to meet these goals:

- assist local boards to meet their legal mandates<sup>1</sup> to review the local county mental health needs and report on performance
- function as an educational resource about mental health data for local boards
- enable the CMHPC fulfill its mandates<sup>2</sup> to review and report on the public mental health system in California

It has been said that data drives policy and policy drives funding. For that to work, the data must be both recent and available. Otherwise, it does not inform policy or program funding decision making. To ensure the data provided in the 2014 Data Notebook is recent and relevant, the CMHPC chose to extract examples of local data from current public reports. We focused on two broad areas: (1) evaluation of program performance, and (2) indicators of client outcomes.

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<sup>1</sup> W.I.C. 5604.2, regarding mandated reporting roles of MH Boards and Commissions in California.

<sup>2</sup> W.I.C. 5772 (c), requires annual reports from the California Mental Health Planning Council.

We recognize that each county has unique demographics, resources, strengths, and needs. Thus, it is not possible for any single data resource to answer all the important questions about mental health services. However, the following resources were expected to help board members answer questions in this Data Notebook:

- knowledge, experience and opinions of the local mental health board members
- recent reviews of county mental health programs<sup>3</sup> from APS Healthcare/EQRO
- data requested from each county Quality Improvement Coordinator and/or their Behavioral Health Director
- client outcomes data provided by the California Institute of Behavioral Health Solutions (CIBHS) in their analysis of the recent Consumer Perception Survey

The most significant challenge faced in the development of the Data Notebook was a lack of recent, publically-available data. This challenge was exacerbated by the statewide re-organization of mental health services in 2012 when the previous state Department of Mental Health was eliminated and the community mental health functions were moved to the Department of Health Care Services. Efforts are underway to develop a new data collection and reporting system; however, that data was not available for this Data Notebook.

Given the limitations of data resources, each Data Notebook report contained the most current data available and included both quantitative questions (numbers) and qualitative questions (narrative, procedures, programs). Each report was designed to be about the local community in each county and to reflect what the local MH boards and their stakeholders chose to highlight.

Examining the data can indeed “tell a human story.” We recognize that quantitative data (numbers) provides an important part of the picture, e.g.:

- measures of whether the quality of program services improve over time
- whether more people from different groups are receiving services
- how many clients got physical healthcare, or needed substance use treatment

In two of the Data Notebook questions, we requested data from the counties about the numbers of “new clients” served in the prior year and numbers of clients referred to primary health care. These items are important to our understanding of two major policy areas: (a) timeliness of service access and follow-up with new clients, and (b) implementation of integrated health care. We drew preliminary conclusions on these areas which are presented in this report.

The other part of the story is needed to give human context to the numbers. Such qualitative data (narrative, program descriptions, policies and procedures) would tell more of the story, because we can:

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<sup>3</sup> EQRO reviews covered Medi-Cal funded Specialty Mental Health (Short-Doyle) services for seriously mentally ill (SMI) adults, and for children 17 and under with serious emotional disorders (SED).

- describe special programs targeted for outreach to specific groups
- examine how the programs are actually implementing their goals
- list concrete steps that are taken to improve services, and
- tell what is being done to increase client engagement with continued treatment

We expect that the experience of collecting data, discussing information, and preparing this Data Notebook will serve as a springboard for future discussion about all areas of the mental health system, not just those topics highlighted. Our goal is to promote ongoing quality improvement (QI) in mental health services because:

- needs change over time
- creativity gives rise to new ideas
- examples of successful programs can be shared to help other communities

We welcomed supplemental reports about successful projects and copies of additional data reports which the local county administration prepared to inform their public. We received a number of excellent, highly informative supplements. Some describe examples of broad wellness programs which help mental health clients access physical health supports and greater social connectedness. Many of these supplements provide evidence of a robust culture of data-driven quality improvement. We enthusiastically celebrate county efforts to communicate their program data to the general public. After internal review, we plan to include many of the supplemental reports in the data appendices to this current report.<sup>4</sup>

We thank all the county behavioral health departments who assisted the local advisory boards by providing data and key information about programs and policies. We also deeply appreciate the work and thoughtful discussion prepared by the local mental health boards and commissions who participated. Due to all your efforts, we achieved an overall county response rate of just over 67%.

The counties which submitted Data Notebook reports during 2014 comprise the dataset from which we prepared this report. The 39 Data Notebooks received represent data from 41 counties and reflect information from a geographic area containing 83% of our state population. These counties are summarized in Table #1 (next page), grouped by population size and response.

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<sup>4</sup> Reports which are clearly intended only for internal review, or which contain detailed data that may not meet current regulations for public release, will be held confidential within the state entity.

Table 1. Data Notebook 2014 Project Summary

**RECEIVED REPORTS: (39 reports, covering 41 counties)<sup>5</sup>**

<b>Small population: (20 counties)</b>	<b>Medium: (10 counties)</b>	<b>Large: (11 counties)</b>
Amador		
Calaveras	Merced	Fresno <sup>6</sup> ( <i>BoS report only</i> )
El Dorado	Monterey	Kern
Glenn	Placer/Sierra	Los Angeles
Humboldt	San Joaquin	Orange
Imperial	San Luis Obispo	Sacramento
Lake	Santa Barbara	San Bernardino
Lassen	Solano	San Diego
Madera	Stanislaus	San Francisco
Mariposa	Tulare	San Mateo
Mendocino		Santa Clara <sup>7</sup> ( <i>DN+ BoS</i> )
Napa		Ventura
Nevada		
San Benito		
Shasta		
Siskiyou		
Sutter/Yuba		
Trinity		
Tuolumne		

**NO REPORT SUBMITTED in 2014:<sup>8</sup> (17 counties)**

Alpine	Butte	Alameda
Colusa	Marin	Contra Costa
Del Norte	Santa Cruz	Riverside
Inyo	Sonoma	
Kings	Yolo	
Modoc		
Mono		
Plumas		
Tehama		

**METHODS: Development and Implementation**

The development of topics and question items took place using a stakeholder-input type process. We held initial meetings with the California Association of Mental Health Boards and Commissions, coordinating with our quarterly Planning Council meetings.

<sup>5</sup> Sutter and Yuba counties are combined into one MH Plan, as are Placer and Sierra counties.

<sup>6</sup> While the MH Board declined to participate in the Data Notebook, they did submit a copy of their annual report to their County Board of Supervisors.

<sup>7</sup> MH Board submitted the Data Notebook with most data filled in by county staff, but declined to answer board-specific questions; they also submitted a copy of their annual report to their County Board of Supervisors.

<sup>8</sup> Note added in final revision: Reports were received between January 1 and February 15, 2015 from these counties: Del Norte, Kings, Marin, Riverside, Sonoma, and partial data from Butte County.

In those meetings we asked questions of the association members and collected many informative comments and critiques.

### **Outreach:**

Later, we were invited to give presentations about data to the CALMHB/C. Members of the Planning Council and in-house staff presented about mental health data, where to find data, and what certain data items actually mean for delivery of services. We discussed basic concepts of quality improvement emphasizing the foundational principle<sup>9</sup>, “If you can’t measure it, you can’t improve it.”

We used these teaching sessions to stimulate discussion and questions to help us further understand what was important to mental health board members. This process also taught us more effective ways to speak about data in a clear, simple manner and how to present the important issues being analyzed. These experiences informed many aspects of the new, completely revised Data Notebook 2014.

### **Discussion and Review:**

In parallel with those meetings, we formed a work group, a subcommittee of the Continuous System Improvement Committee (CSI) of the California Mental Health Planning Council. Members of our work group came from the CSI Committee, the CALMHB/C, and Napa County Mental Health Board. We also consulted three county mental health directors, several county quality improvement coordinators and staff of EQRO/APS Healthcare.

As a result of literature reviews and extensive reading of reports on older data from various California state agencies, we proposed a number of questions derived from reports prepared by the EQRO/APS Healthcare, Consumer Perception Survey data collected by CIBHS, and “Priority Performance Indicators” identified by the Planning Council which had been further researched by the Mental Health Oversight and Accountability Commission. Most of the “Performance Indicator” data available at that time was considered not sufficiently recent to be meaningful to mental health board members.

### **Formulation:**

After much review and discussion, the ultimate result is an 18-question Data Notebook broken into six subject areas plus a county data page. The topics were selected to provide a broad cross-section of important issues. There are many other important

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<sup>9</sup> W. Edwards Deming, founder of “Quality Improvement” Research.

questions in the universe of what could be asked, but we intentionally kept this set as concise as possible. The subject areas include:

- Basic County Data Page:
  - County population
  - Numbers of Medi-Cal eligible persons in the county, and
  - Total Clients served in Specialty Mental Health, by age group
- Treating the Whole Person: Integrating Behavioral and Physical Health Care
- New Clients: One Measure of Access
- Reducing Re-hospitalization: Access to Follow-up Care (and Barriers to Access)
- Access by Unserved and Under-served Communities
- Client Engagement in Services
- Client Outcomes: Perceived Effectiveness of Services (Consumer Perception Survey Data, August 2013), including Suggestions regarding:
  - Unmet Needs or gaps in service
  - Improvements to existing services
  - New programs that are needed for your county

The “Basic County Data Page” listed the most recent county population and the number of their Medi-Cal eligible clients. Next, we presented data for the Specialty Mental Health clients served in the most recent year. Both of these groups were broken down into percentages by age category for children 0-17, adults 18-59, and older adults, 60 and over. The purpose was to give some idea of scale and the overall numbers of adults and children served in at least one part of the mental health system relative to the size of their county population. These data provide further context for other data presented in the Data Notebook.

We asked no program-related questions in that section, other than a request to list the website for county behavioral health and any public reports. However, we were pleased to receive several expressions of appreciation from mental health board members for the county data page, because it made the project unique and “owned” by each community. Without the information, most people would have no idea how many individuals received mental health services from any part of the public system.

## Data Analysis:

We approached most of the analysis in a descriptive fashion: (a) tabulating data similarly to survey methods, and (b) listing the qualitative responses collected as done in processes for getting stakeholder input. Where appropriate, we organized the data in simple tables. However, this report is not designed to be an academic research study nor does it include formal statistical analyses. Rather, this report is intended to be a broad overview of specific aspects of the public mental health system, as understood through the unique perceptions of local mental health boards and their review of their county data.

## RESULTS: Rationale and Responses to Questions

This section provides a listing of the questions, the rationale for each question, and some of the most common types of responses. Most of the information collected reflects qualitative responses about specific types of programs or procedures, suggestions for improved outreach and engagement, and perceptions of important barriers to access or unmet needs in mental health programs.

As mentioned previously, there is enormous diversity in the populations, sizes, needs and resources of the different counties, and in the strategies employed to meet the unique needs of each county. There is a wealth of detail in the responses from many counties which will provide an excellent resource for future, more detailed reports on specific topic areas.

We present the following results grouped under six main topic areas contained in the Data Notebook. For each topic area, we present a brief rationale describing the importance of the topic and why it was selected. Next, we present examples of the data specific to each county (as presented in the Data Notebook customized for each county). Then, we summarize the information received in response to the main question and briefly discuss special features or limitations, as appropriate.

## **TREATING THE WHOLE PERSON:**

### **Integrating Behavioral and Physical Health Care**

Studies have shown that individuals with serious mental illness die, on average, 25 years earlier than the general population. This information makes improving the physical health of clients of great importance and should be a goal of county mental health departments along with providing effective and appropriate mental health services. Coordination of care for mental health, substance abuse and physical health is one way of accomplishing the goal.

The California Mental Health Planning Council did not have any public data to provide about county programs that connect mental health clients with physical health care. We asked that the local mental health board request this information from their county mental health department for any data on numbers (or percent) of total mental health clients who are referred to, or connected with, physical health providers to assess, treat and monitor physical health issues.

One goal of this set of questions is that the MH board members and other stakeholders become better informed about the various wellness programs available in their local community and/or the need to create them. We hoped that this process of education would encourage more counties to think about how they could promote community programs that encourage clients to take active care of one's own health to positively change the death rate statistic.

**We asked: "If your county has data on numbers or percentages of clients who are also receiving physical health care, please include it in the Data Notebook you submit to the Council."**

**Results:** We found that most counties were not able to provide summary data of how many of their clients had been referred to primary care, either a family doctor or nurse practitioner, within the last year. A few stated that they were in the process of implementing new electronic health records or new data reporting systems, and that the ability to report this type of data was one of their goals in the future. In contrast to providing summary data, many more counties indicated that the client's individual mental health record contained information about whether that client had been referred to primary care within the last year. Therefore, one could determine whether that client still needed a referral, or had already been referred to primary care, even though group data for all clients could not be obtained. A few counties provided no response to this question.

**Table 2. Counties able to provide numbers for primary care referrals**

Items Queried	Small population counties	Medium-sized counties	Large population counties
Can summarize or aggregate this data	3	1	2
Collect this data for individuals, but cannot aggregate it	4	2	5
Don't or can't collect this data right now	12	6	2

These results were interesting to us because, for many years, the Full Service Partnership (FSP) data system has been able to report numbers of clients who report that they have access to a regular primary care provider or clinic. However, we note that the FSP group represents a small subset of all mental health clients served in any given county. The FSP data have been analyzed and reported by the MHSOAC and their UCLA contractors, and show a steady increase in the percent of clients reporting access to primary health care in recent years.<sup>10</sup> The FSP data represents one piece of good news and a success that we had predicted would be replicated across most county mental health systems.

In the Data Notebooks, a great many counties described very specific, active policies to make referrals to primary care. Others cited an ongoing county performance improvement project or participation in CiBHS-sponsored “learning collaboratives” for improved integration of care.<sup>11</sup>

### **Linking Mental Health to Primary Care:**

**We asked: “Please describe any efforts in your county to improve the physical health of clients.”**

### **Results:**

While many counties do not have the data to validate direct referrals to health care, most counties identified a concerted effort to inform mental health clients about their integrated care programs. Such programs included public media campaigns, information brochures, or other means of informing clients about the importance of linking to primary care, including conducting health information fairs. Sometimes

<sup>10</sup> “Priority Indicator Trends Report,” Mental Health Oversight and Accountability Commission, [www.mhsoac.ca.gov](http://www.mhsoac.ca.gov).

<sup>11</sup> Reports on Learning Collaboratives about Health Care Integration, see: [www.cibhs.org](http://www.cibhs.org).

programs were held in local “wellness centers,” which may have been the local drop-in center where various activities were coordinated including information about job skills training. Major policies include improved organization-level efforts at case coordination, linkage of more clients with new “federally qualified health care centers” (FQHCs), and connecting clients with substance use treatment.

### **Implementing Physical Health Care Goals:**

**In the Data Notebook, at least 26 counties described clear, specific goals for improving the physical health of their behavioral health clients.**

At least 23 counties reported having some type of wellness center, community center, or drop-in center which facilitated the presentation of a variety of wellness activities and classes. At least 20 counties described the wellness activities they offer.

The good news is that a substantial number of counties are implementing a variety of procedures and practices to facilitate linkage of clients with primary care or substance use treatment. The following list illustrates some of these efforts. In parentheses are the numbers of counties which referred to specific practices.

- Defined procedures for referral to primary care, and/or to ask client whether they currently have a primary care provider (enter info in chart) (29)
- Described procedures for screening and referral for substance use treatment (16)
- Staff involved in outreach (i.e. to sign MH clients up for Medi-Cal), case management, care coordination, links to other social services (e.g. food stamps, housing) (16)
- Received grant funding (e.g. SAMHSA, or Rural Health Network, or other) (12)
- Health screenings, vital signs taken, or routine lab work at BH site (9)
- Used health navigators, promotores<sup>12</sup>, or peer mentors to link to services (6)
- Linkage of MH Plan to FQHC or FQHC-look-alike clinics (6)
- Care integration is/was part of a Performance Improvement Project (5)
- Outreach to link Latino population to primary care (5)
- Participated in a CIBHS Learning Collaborative (4)
- Health educator or RN on staff to teach clients or lead wellness classes (4)
- Links to tribal health (3)

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<sup>12</sup> In the Hispanic/Latino community, these are health ‘promoters’ and representatives who may also assist in navigating the complexities of the health system.

- Training primary care providers about the Affordable Care Act and linking health care with behavioral health care (2)

The responses above only provide a snapshot of such activities. They merely show a sample of what the respondents chose to highlight at this point in time. One example is that only four counties mentioned participating in a CIBHS Learning Collaborative about Integrative Health Care, yet we know from other sources that a great many counties have done so in recent years. Thus, all of the responses above represent an underestimate of how many counties engage in these specific programs.

### **Motivating for Positive Change:**

**We asked: “How does your county address wellness programs to engage and motivate clients to take charge of improving their physical health?”**

#### **Examples:**

- **Exercise**
- **Nutrition**
- **Healthy cooking**
- **Stress management**
- **Quitting smoking**
- **Managing chronic disease**
- **Maintaining social connectedness**

#### **Results:**

The responses to this question in the Data Notebooks indicated that nearly all the responding counties have implemented a number of wellness activities. The results are tabulated below. Again, it is very likely that these data are an underestimate for each specific type of program. For example, some programs do not list the specific activities included in a broadly-targeted wellness program, like the Whole Health Action Management (WHAM) courses, “Live Well! San Diego,” or other generic programs in “healthy living.” Although not specified, many of these programs include (at minimum), healthy eating, exercise, stress management, and social connectedness.

### **Co-locating Activities and Services:**

A major strategy to assist clients with wellness and recovery activities is to locate some of them in a Wellness Center, Community Center, or other type of drop-in center. At least 23 counties referenced these or similar centers as a locus of activities or short courses for their mental health clients.

The following list is a summary of the most commonly mentioned wellness activities and functions. Some responses overlap with those for the previous question. The number of counties that mentioned an activity is shown in parentheses.

- Exercise (walking, Zumba, dance, weights, etc.) (32)
- Nutrition/healthy eating (30)
- Smoking cessation (26)
- Social connectedness, social skills, group activities (23)
- Healthy cooking/meal planning (22)
- Stress management (19)
- Management of chronic disease (18)
- Links to benefits: housing, food stamps, employment supports (10)
- Yoga (8)
- Mindfulness/anxiety management (7)
- Understanding and managing one's medications (7)
- Recovery from co-occurring substance use issues (7)
- Group therapy (including art and music groups) (5)
- Gardening (may be coordinated with healthy cooking classes) (3)
- Health fairs (3)
- Animal-assisted therapy (2)
- Vital signs taken (2)

Some of these activities were targeted or culturally-adapted for Hispanic/Latino groups, Native Americans, or Southeast Asian groups. Other types of activities included use of promotores, an immunization clinic, and groups for trauma and grief/loss.

## **ACCESS: New Clients, One Measure of Access**

This next section asked the mental health boards how their county defines a 'new client'. Tracking the number of individuals who come in for services, specifically, those who have never received services before, can tell us about the accessibility of services in the county and the effectiveness of outreach. We also can get some idea of whether new clients can be identified for follow-up and to find out whether services are meeting their needs so that they continue in treatment. Individuals who return for services after a period of time without services are oftentimes also called a 'new client.' It is important to distinguish the definitions because many counties do things quite differently and it is difficult to roll this data up into any meaningful statewide measure.

One way to evaluate the quality of service outreach is to measure how many clients receive services but have never been part of the service system before ("brand new" clients). Another measure is how many clients return for services after a period of time with no services ("new" or "returning" clients).

### **Who Comes In and Who Comes Back?**

The California Mental Health Planning Council is exploring how each county mental health department defines "new" clients, and how a client is identified when they return for additional services. This information is important in determining whether an individual county has a "revolving door," that is, clients who are in and out of mental health services repeatedly. This data can provide one indicator of the success of a county's programs in closing cases appropriately and providing adequate discharge planning to clients.

This data is not reported by the counties to the state and currently there is no public source for this data. Therefore, we requested that the mental health boards obtain this information from their county behavioral health departments.

**We asked: "How does your county define 'new' client for those individuals who have previously received services but who have not received services for a while? (e.g., 6 months, 12 months, 2 years?)"**

### **Results:**

#### **How many counties are able to identify which clients are new or "brand new" to their system?**

- Small counties: (13) brand new
- Medium sized counties (7) brand new

- Large counties: (5) but, one indicated that they track other data in this area

What definition of time since last service (or never received services) does your county use for new clients?

- Three months: 5 counties
- Six months: 11 counties
- Twelve months: 5 counties
- Eighteen months: 0 counties reported this choice.
- Two, three, or five years: 1 county each
- “Never” been seen in system: 8 counties

### **Defining Access Patterns More Precisely:**

One county stated near-future plans to be able to track new clients with upcoming software changes. Currently they track the reason for discharge from service and the number of clients in each discharge category (Administrative, Client Withdrew, Deceased, Achieved Goals, Incarcerated, Moved, Noncompliant with Treatment, Referred to other System, Patient Guardian withdrew client). Another county was able to differentiate clients only in these groups: New, Open, Inactive. Two different definitions depending on service type was used in another county: 3 months for not having received outpatient services, but 6 months for medication management services. One county was in the midst of a data system conversion so all clients in the new system are defined as ‘new clients.’

For medium and large population counties, the responses were dispersed across the time frames noted above. One county defined new clients as having no services in the last 5 years. Three large counties (Los Angeles, Orange, and San Diego) stated that they do not currently define “new clients” or summarize data counting new clients. These three counties are otherwise notable for their expertise with MH data and their ability to get substantial useful information out of their data systems. There was no response to this question from three other large counties.

**We asked: “Please provide any data your county has on the number of 'new' clients last year. And if you have it, how many of those new clients were brand new clients? You may need to ask your county mental health department for this data.”**

Here is an example of data from Kern County for the most recent fiscal year. This county defines “new client” as one who has not received services for 12 months.

<b>Information from Kern County Mental Health Plan:</b>	<b>N =</b>	<b>Percent</b>
# new children/youth (0-17 yrs):	<b>4,953</b>	(n/a)
of these, how many (or %) are ‘brand new’ clients:	<b>3,815</b>	<b>77%</b>
# new adults (18-59 yrs):	<b>9,810</b>	(n/a)
of these, how many (or %) are ‘brand new’ clients:	<b>5,726</b>	<b>58%</b>
# new older adults (60+ yrs):	<b>548</b>	(n/a)
of these, how many (or %) are ‘brand new’ clients:	<b>364</b>	<b>66%</b>

### **Results:**

Responses to this question tell us not only whether a county was able to identify new clients, but also information about the capability of the counties’ data reporting and information systems. This latter point is interesting and important, but was not the original goal of our inquiry. We had intended to identify percentages of clients who are truly “brand new” to the system, and to get some picture of these numbers within each county and the state. At present, the variety of definitions employed by counties for a ‘new client’ prevent summarizing this data into a statewide total for numbers of new clients.

### **Understanding the Statewide Picture:**

Nearly all of the counties who submitted Data Notebooks were able to provide some data for new clients and to differentiate these clients from “brand new” clients:

- Small counties (14)
- Medium sized counties (8)
- Large counties (5)

These data are summarized in Table 3, next page.

Table 3. Categories for 'New' Clients Based on Time of Last MH Service

Counties by Size of Population:	<u>Provided # of New Clients?</u>	<u># of Months?</u>	<u># Years?</u>	<u>Never Seen Before?</u>
<i>Small Counties</i>				
Calaveras		6		
El Dorado				All = 'new'
Glenn	Y	6		
Humboldt	Y	6		
Imperial	Y			X
Lake	Y			
Lassen			1	
Madera	Y	6		
Mariposa	Y	6		
Mendocino	Y	3 (OP), 6 (Rx)		
Napa	Y	6		
Nevada	Y			X
San Benito	Y	6		
Shasta	Y	6		
Siskiyou	Y			X
Sutter/Yuba	Y		1	
Trinity	Y	3		
Tuolumne				X
<b><u>Medium-sized:</u></b>				
Merced	Y			X
Monterey	Y		5	
Placer/Sierra	Y		1	
San Joaquin	Y			X
San Luis Obispo	Y	3		
Santa Barbara	Y		2	
Solano		6~12		
Stanislaus	Y			X
Tulare	Y	3		
<b><u>Large Counties:</u></b>				
Kern	Y		1	
Sacramento	Y		3	
San Bernardino	Y			X
San Francisco	Y		1	
Ventura	Y	6		

## **REDUCING RE-HOSPITALIZATION:**

### **Timely Access to Follow-up Care**

Sometimes an individual experiences acute symptoms of mental illness or substance abuse which can result in a brief stay in an acute care hospital. Therefore, in this section of the Data Notebook, we provided data regarding follow-up services 7 days and 30 days after hospital discharge. The figures show both the county's data and the statewide data for comparison. These data were extracted from EQRO/APS Healthcare reports for the years 2011 and 2012. These data only include Medi-Cal funded services which mean that it does not include hospitalization services funded from other sources.

It is important to know about the level of follow-up services because receiving timely follow-up after discharge from a short-term (3-14 day) hospitalization can be critical to preventing a return to the hospital, as well as assisting a patient in their road to recovery. Success in these measures also helps the counties to increase the availability of outpatient services, in that the counties can use the funds that otherwise would have been used on expensive re-hospitalizations to meet other mental health needs in the community.

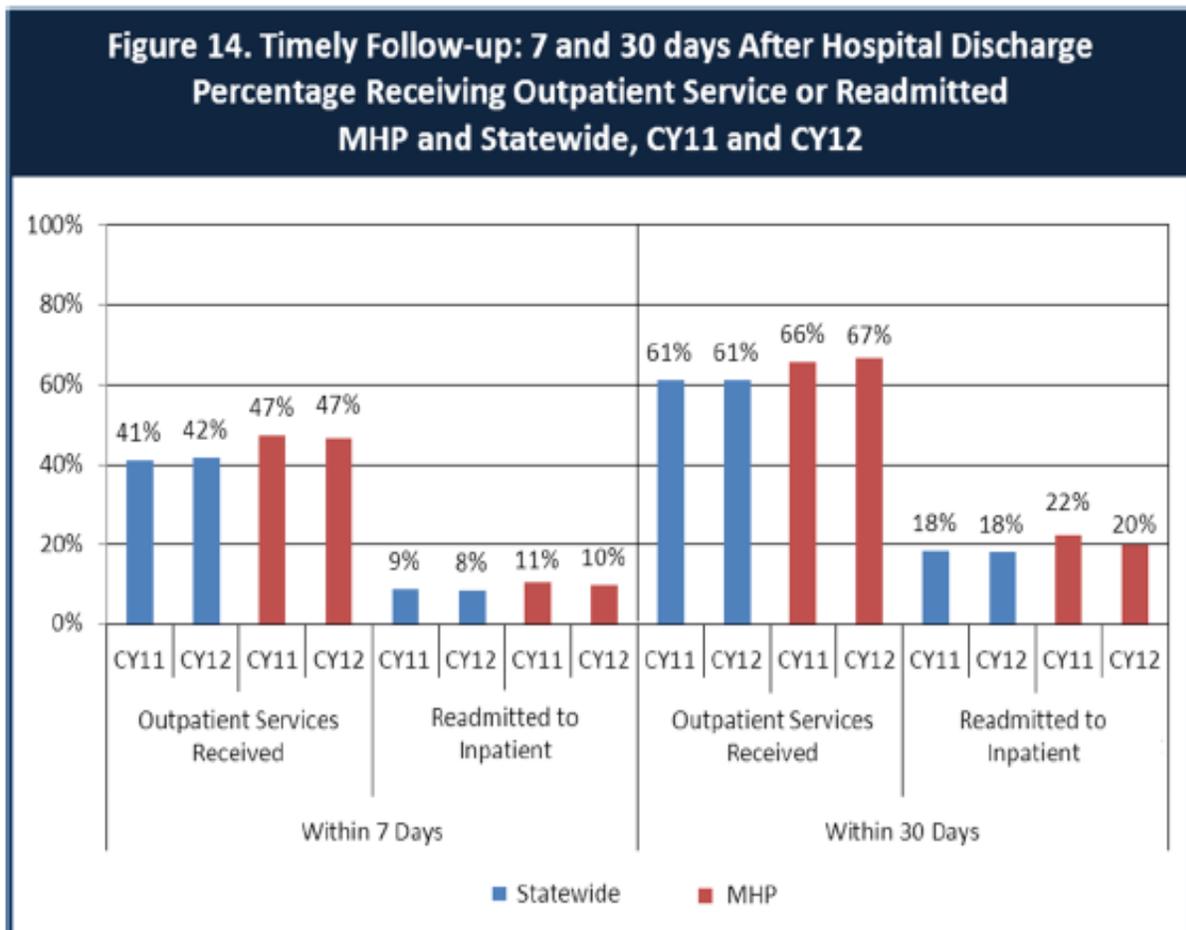
### **Comparing Counties to Statewide Averages:**

In this section, we asked the mental health boards to look at their county's re-hospitalization data and indicate whether their county was doing better or worse than the overall state in ensuring that timely follow-up services occur after release. We also asked for their suggestions on how their county could improve follow-up as a way to reduce re-hospitalization.

We show below an example of the type of individual data supplied in each county's Data Notebook. Here, we use data from Alameda County for purposes of illustration.

The chart below shows the percentage of people discharged in the county who received at least one service within 7 days of discharge. Also shown is the percentage of those same people who were readmitted to the hospital. The chart also shows the same information for receiving services and being readmitted to the hospital within 30 days. Red indicates the numbers for an individual county and the blue indicates the percentage for the state of California.

Example shown below: Alameda County



**We asked: “Looking at the chart, is your county doing better or worse than the state? Discuss why (e.g., your county has programming available that specifically ensures a warm handoff for follow-up services).”**

**Results:**

All Data Notebook respondents made comments that show that they examined their data and drew conclusions relevant to patient care and outcomes. Notably, a few counties concluded that there were insufficient numbers of cases to draw any reliable conclusions. In most counties, a quality improvement coordinator analyzes their re-hospitalization data with the goal of determining what factors or follow-up services may help reduce rates of re-hospitalization in their community.

Such local performance improvement efforts are mirrored in the analyses of data at the state level. Statewide Medi-Cal data (FY2011-12, FY2012-13) were analyzed by APS

Healthcare/EQRO. These data showed evidence that timely linkage of clients to medication appointments is one of the most important factors in reducing rates of re-hospitalization. Timely access to outpatient services also improved the likelihood of client success in avoiding re-hospitalization.

### **Common Successful Practices:**

The comments received in the Data Notebooks indicate that nearly all counties place a high priority in their policies and practices to provide services as soon as possible after hospital discharge. Common responses included the following:

- Discharge planning starts on Day #1 of the hospitalization with linkage to case workers or other staff who begin setting up connections to anticipated services or care providers.
- Staff members provide a welcoming environment. There is an emphasis on multi-disciplinary care, with links to housing or housing supports, social services including food stamps, or other needs. There is the ability to provide intensive case management, as needed.
- The client may be connected to “step-down” services through crisis residential agencies or to substance use treatment services.
- In one county, “Crisis Management Teams” assist with the transition from the hospital and they incorporate the case management and integrated care approach described in many other counties.
- Legal MOUs (agreements) between agencies, or patient consent forms (if available), provide a legal basis for sharing of information between providers to plan post-discharge services. The ability to share information, within the constraints permitted, is perceived as essential to serving the client’s mental health and recovery.
- In some counties, severely ill clients perceived to be at greatest risk may be linked with an Assertive Community Treatment program. Their goal is to reduce the need for re-hospitalization.
- County staff members arrange transportation to their offices the day of discharge where they can assist the client and make follow-up appointments for medication and out-patient therapy. Reminder phone calls for appointments and follow-up if they are missed are made, to ensure the patient gets what is needed for recovery. Nonetheless, some clients do not want further services especially if hospitalization was involuntary.

- In some places, the client receives services the same day of discharge with a priority placed on medication services. Clinicians provide or review prescriptions and staff help ensure the client gets their prescriptions filled.
- MHSA–funded programs are used to help with recovery services post-hospitalization.
- Wellness center-based activities help put the client in touch with peer mentors, health education focused on recovery practices, or provide information about therapy groups and other resources in the community.
- One county (Monterey) reported, remarkably, that 91% of their clients received services within 7 days after hospital discharge. Only 21% of their clients were re-hospitalized within 30 days. This county’s Quality Improvement group examines data separately for adults, children age 0-15, and youth age 16-25.

We note that only post-hospitalization data from the state Medi-Cal system were provided in each county Data Notebook. Therefore our conclusions are limited, and may not reflect fully the efforts in the overall public mental health system.

**Identifying Opportunities for Improvement:**

**We asked: “Do you have any suggestions on how your county can improve follow-up and reduce re-hospitalizations?”**

**Results:**

There was a certain amount of overlap for responses to Question #6 regarding strategies currently used to engage and follow-up with clients after release from a psychiatric hospitalization.

The most common responses we received involved: early/timely connection to outpatient services and medication management appointments, case management to connect to other needed services including food and supported housing or shelter and more effectively integrate drug and alcohol treatment services with mental health programs. For homeless clients, some counties found it helpful to provide the client with a cell phone, so that the individual could more easily access county services for both ongoing needs as well as for crisis needs. Other frequent comments listed a county’s use of Senate Bill 82 grants to fund crisis treatment services or the use of MHSA-funded Prevention and Early Intervention grants. One interesting perspective suggested learning more about what does or does not work for clients from the chart reviews that the mental health plans use in their quality and utilization review process. One suggestion highlighted the need for more intermediate care facilities, and

especially those that can take aging MH clients with their physical needs, a need likely to become of increasing concern given current population trends.

One practical way to analyze strategies used by any one county or group of counties could build on the outline presented of six major areas of “Best Practices” for San Diego County’s Performance Improvement Project in FY 13-14. Their goal was to decrease the rate of re-hospitalizations. Most of the responses above could be grouped under one or more of these organizing principles:

- Support from Peers with Lived Experience
- Connection to Services
- Coaching and Social Support
- Engaging Support Systems
- Connecting with Homeless Clients
- Connecting with Appropriate (and Less Expensive) Services

### **Identifying Barriers in Access to Care:**

In the next section, we asked the mental health board members to list the top three barriers to accessing services in their county. We welcomed responses which included additional items besides those we had suggested.

**We asked: “What are the three most significant barriers to service access?”**

**Examples:**

- **Transportation**
- **Child care**
- **Language barriers or lack of interpreters**
- **Specific cultural issues**
- **Too few child or adult therapists**
- **Lack of psychiatrists or tele-psychiatry services**
- **Delays in service**
- **Restrictive time window to schedule an appointment**

**Results:** The overall patterns of response appeared very similar across small, medium and large counties. Geography was seen as a major barrier to access because of transportation issues, rural isolation combined with poverty, and perception of too few locations for services (i.e., need more than one site in a county with a large land area). It was not a surprise to find transportation issues cited for nearly every small-population

county, as many are geographically large and have limited county resources. However, nearly all the large and medium-sized counties also ranked transportation issues in their top three barriers to access. Some medium- and large-population counties have, besides their more urban regions, a significant rural area with a physically dispersed population. However, a client's location in, or near, an urban area does not necessarily facilitate access to services, if time schedules are limited and several bus transfers (or other mass transit) are needed.

Workforce issues also ranked high across all counties, with variation in the type of professionals perceived as most critically needed, and the need for bilingual/bicultural service providers and interpreters. In some cases, workforce was listed in a more generic fashion, as in a comment referring to high caseload to provider ratios, without specifying type of provider (8 responses).

### **Common Barriers to Access to Care:**

Below is a summary of the most common barriers to access in the Data Notebook responses. Although the instructions said to list the top three, a number of respondents listed more than three due to the perceived urgency of need in their counties. In parentheses are the numbers of counties who listed this item in their response.

- Transportation (30)
- Workforce: psychiatrists (21)
- Stigma and cultural issues (14)
- Workforce: child therapists (12)
- Workforce: adult therapists (11)
- Workforce: bilingual care providers (11)
- Language/lack of interpreters (10)
- Lack of tele-psychiatry services (8)
- Delays in access to services (8)
- Homelessness/lack of supported housing (7)
- Rural isolation (7)
- Restricted/limited times available for appointments (5)

- Lack of child care (3)
- Denial of illness by client (3)
- Lack of psych beds for adults and youth (2)
- Workforce: lack of psychiatric nurses (2)
- Difficulty navigating complex health system (2)
- Limited location(s) where services provided (2)

### **Additional Perceived Barriers:**

Not all responses from each county are listed. But a few comments were identified as notable barriers which likely apply to other counties:

- screening and assessment appointments (or orientation meetings before assessment) which delay access to therapeutic services
- medication side effects and inadequate efficacy
- costs of services
- regulatory barriers which prevent professionals from sharing information
- incarceration of mentally ill persons
- need for training of staff in evidence-based practices, and
- lack of understanding of healthcare reform, which affects the referral process

The statewide workforce issues are being addressed by programs in several state agencies, in particular, the Office of Statewide Health Planning and Development (OSHPD). The OSHPD has been engaged in a 2-year process with the California Mental Health Planning Council and other stakeholders to shape state-level policies to support workforce needs in behavioral health in the Workforce Education and Training 5-Year Plan.

## ACCESS BY UNSERVED AND UNDER-SERVED COMMUNITIES

California is one of the most culturally diverse states in the nation. This wonderful variety requires businesses and government to accommodate many cultural communities with products and services in a variety of languages, in a culturally relevant manner, and with staff who know and understand the culture. So it is important to measure how many people of different cultural or ethnic groups are being served in a given county. We again used the data from APS Healthcare/EQRO for the number of individuals eligible for Medi-Cal in the county and the number who were actually served in county Specialty Mental Health programs. This tells us something about how effective outreach programs may be, and may indicate something about barriers such as language, or culturally-prevalent stigma regarding mental health issues.

One goal of the Mental Health Services Act (MHSA) is to reach unserved and underserved communities, especially communities of color. The MHSA promotes outreach to engage these communities in services. If individuals and families in these communities are not accessing services, then we may need to explore new ways of reaching them. Or, we may need to change programming to meet their mental health needs in ways that better complement their culture.

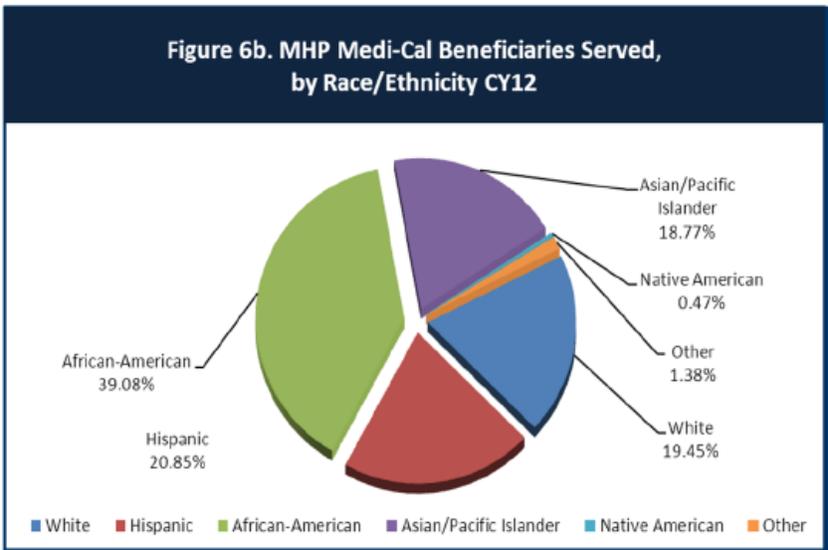
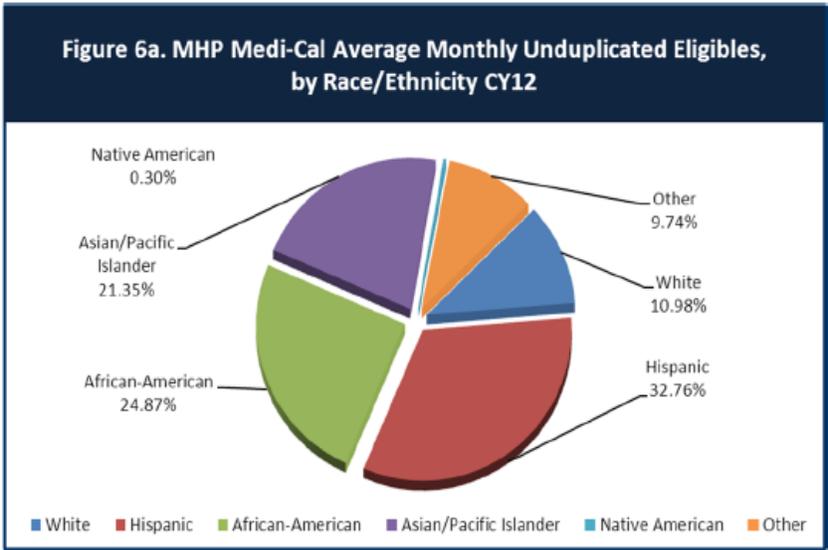
### **Using Data to Increase Access to Services:**

From data the counties reported to the state, we can determine how many individuals living in each county are eligible for Medi-Cal, and of those individuals, how many receive mental health services. Our goal was to get the mental health boards to consider this issue: “Are you serving all the Medi-Cal clients who need your services?”

We provided data specific for each county in the Data Notebook.

As an illustration of the type of data presented, we show the example of Alameda County below.

**Alameda County:**



	Asian/ Pacific	African- American	Hispanic	White	Other	Native American
<b>Medi-Cal Eligible</b>	<b>21.35 %</b>	<b>24.87 %</b>	<b>32.76 %</b>	<b>10.98 %</b>	<b>9.74 %</b>	<b>0.30 %</b>
<b>Medi-Cal MH Services</b>	<b>18.77 %</b>	<b>39.08 %</b>	<b>20.85 %</b>	<b>19.45 %</b>	<b>1.38 %</b>	<b>0.47 %</b>

**We asked: “Is there a big difference between the race/ethnicity breakdowns on the two charts? Do you feel that the cultural group(s) that need services in your county are receiving services?”**

**Results:**

The majority of responses indicated that there was a mismatch between the percentage of Hispanic Medi-Cal beneficiaries eligible for services, and the number of Hispanics who received Specialty Mental Health services. Many comments indicated that ongoing efforts for outreach have been underway for several years, and that there has been slow but steady progress in reaching and engaging more Hispanic clients in services. These observations are consistent with reports on increasing service penetration rates for Hispanic mental health clients in recent years, although the rates are still lower than for whites and other demographic groups.

Depending on the county and its demographic trends, others also commented on Asian populations and/or Native Americans being underserved in their county and the role of stigma in presenting barriers to engaging in services for the groups perceived to be underserved and in need of services.

**We asked about local programs and policies: “What outreach efforts are being made to reach minority/underserved groups in your community?”**

**Results:**

The responses here were as varied as the counties, with their unique demographics and needs, in our extraordinarily diverse state.

The most common responses included:

- Spanish speaking staff conduct outreach to the Hispanic community, and other bilingual staff are available in the office to make appointments and provide help navigating the system
- The county hires or contracts with a Spanish speaking “fee for service” provider for therapy and psychiatry/medication management
- Programs that focus on outreach to specific populations, such as healthy parenting classes, community gardens, or wellness activities adapted for specific cultural groups, and when possible, offered in another language. There is a Cultural Competency Committee that meets to identify service needs and resources available or that could be made available

- Recommendation to add outreach to faith-based groups and churches
- Suggestions for methods of outreach and support to LGBTQ community clients
- Bilingual and culture-specific approaches to the goal of integrating mental health services with alcohol and substance use treatment.

**We asked the mental health board for their perspective “Do you have suggestions for improving outreach to and/or programs for underserved groups?”**

**Results:**

Suggestions for improving outreach to underserved groups largely overlapped with responses to the previous question. Some counties listed those strategies as goals they are trying to achieve while others suggest these programs as goals that need to be implemented. Overall, many counties are employing a number of good strategies, as outlined above, and are trying to improve and expand those outreach efforts.

There were also comments that placed emphasis on designing programs and services appropriate to different age groups (children, parents of children, youth, adults, older adults) within different cultural and ethnic groups. The needs encompass language and the need for bilingual service providers or interpreters, but just as often, the responses expressed the need for specific culturally-adapted programs and services. Some approaches that improve initial access also support continued engagement with services and are discussed in the next section.

## CLIENT ENGAGEMENT IN SERVICES

One important MHSA<sup>13</sup> goal is to connect individuals to services they need to be successful. Clients who stop services too soon may not achieve much improvement, nor is it likely to last. So it is important to measure not only who comes in for treatment, but also how long they stay in services. We recognize that some individuals only need a few services, but here we consider those with severe mental illness. Research shows that when someone with severe mental illness continues to receive services over time, their chances of recovery increase.

Engagement in services, also called ‘retention rate’, is important to review. If individuals come in, receive only one or two services and never come back, it may mean the services were not appropriate or that the individual did not feel welcome, or some other reason that should be explored. Our goal is to ensure that they are getting the services needed to help them on the road to recovery. But we cannot know that unless we look at how many services individuals receive over time.

In this section of the Data Notebook, we provided data specific to each county taken from the most recent available report from the EQRO/APS Healthcare. For purposes of illustration, we show the data from Alameda County below as an example of what was supplied in the Data Notebook.

### **Counting the Visits:**

The chart below shows the number of Medi-Cal beneficiaries in the county who received 1, or 2, or 3, or 4, or 5-15, or more than 15 mental health services during the year. For individuals experiencing severe mental illness, the more engaged they were in services, the greater the chance for lasting improvements in mental health. For comparison to statewide results, the four columns at the right show data for the entire state of California.

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<sup>13</sup> Mental Health Services Act, “Proposition 63,” enacted by California voters in 2004.

## ALAMEDA County MHP Medi-Cal Services Retention Rates CY12

Number of Services Approved per Beneficiary Served	ALAMEDA			STATEWIDE			
	# of beneficiaries	%	Cumulative %	%	Cumulative %	Minimum %	Maximum %
1 service	2,019	8.85	8.85	9.38	9.38	4.90	18.87
2 services	1,320	5.79	14.64	6.29	15.67	0.00	12.84
3 services	1,206	5.29	19.92	5.38	21.06	2.94	11.11
4 services	1,051	4.61	24.53	4.93	25.98	1.93	9.40
5 - 15 services	5,732	25.13	49.66	32.38	58.36	21.24	40.93
> 15 services	11,484	50.34	100.00	41.64	100.00	23.68	60.48

Prepared by APS Healthcare / CAEQRO

Source: Short-Doyle/Medi-Cal approved claims as of 11/22/2013; Inpatient Consolidation approved claims as of 12/28/2013

Note: Number of services is counted by days for any 24 hours and day services, and by visits or encounters for any outpatient services

**Based on the data provided, we asked: “Do you think your county is doing a good job at keeping clients engaged in services? If yes, how? If not, why?”**

### Results:

Some Data Notebook responses indicated that their county is doing a good job in this area, but that there is always room for improvement. A few commented that their Cultural Competence Committee also reviewed and discussed this data. More specific suggestions or comments tended to show up in response to the following question(s) below.

Most Data Notebook responses included a look at the data for those receiving 5-15 services and those receiving more than 15 services in a year then adding the percentages for those two groups. They then compared that number to the percentage of all statewide clients that received 5-15 or more than 15 services in a year. This provided a way to evaluate whether an individual county is doing better than, worse than, or about the same as the state as a whole. Examining the data in this way is a very limited analysis as it does not break the data down by type of services or by age group or by race/ethnicity.

Some counties examine their “retention” data in more detail to try to understand how well they are serving different age or demographic groups or to identify what areas of service may need a different focus for outreach or other improvement.

**We asked about outreach procedures: “For those clients receiving less than 5 services, what is your county doing to follow-up and re-engage those individuals for further mental health services?”**

**To further this discussion, we also asked: “Looking back at the previous chart of who is being served by race/ethnicity in your county, do you have any thoughts or ideas to share regarding your county’s engagement of underserved communities?”**

**Results:**

We address the responses of these two questions together as the programs and policies for each are deeply intertwined. The responses in the Data Notebooks tended to overlap for these two questions as well as for some earlier questions about access by underserved groups and strategies for outreach.

We received a great variety of responses, some very brief, others extensively detailed. To facilitate continued client engagement with services or programs, many counties employ MHSa funded programs (or portions of those programs) for Prevention and Early Intervention, Innovation, Community Services and Supports, and those for Full Service Partnership clients.

The listing below is based largely on the submission by Orange County, because their response appears to encompass most of the strategies identified in other Data Notebooks as a group although we have added some responses from others that identify additional methods for engaging clients in continued therapy.

Re-engagement and follow-up strategies included the following:

- Home and site visits
- Family and other support contacts (with consent of client)
- Motivational interviewing
- Meeting the clients “where they are”, whether at their home, or if homeless, their customary places for sleeping or spending time
- Being patient and accepting
- Agreeing to ‘back off’ and give the client space to reconsider
- Reminding consumer of the ‘open door’ policy
- Phone calls and/or reminder texts, letters as appropriate

- Partnering the client with Peer mentors
- Utilize an Outreach and Engagement Team
- Appropriate referrals and case management efforts
- Full Service Partnership program enrollments
- County “Outreach and Engagement Collaborative” a program that provides mental health preventative services to un-served and underserved populations at risk of mental health problems.
- Veterans’ programs
- Programs for released offenders
- Anti- stigma programs for Latino and Asian communities (and others)
- Cell phones for clients especially those who are homeless or often in shelters
- Culturally sensitive programs and recruitment of experienced ethnic professionals
- Studying where the needs are greatest in the county and locating more services at those locations

## CLIENT OUTCOMES: Consumer Perception Survey (August 2013)

Ultimately, the reason we provide mental health services is to help individuals recover and lead productive lives. We have selected two questions from the Consumer Perception Survey which capture this intention. One question is directed toward adults of any age, and the other is for children and youth under the age of 18.

Below are sample data for the client responses. Here, for purposes of illustration, we show the data from Alameda County for these two questions.

### **Q1. Adults. “As a direct result of the services I received, I deal more effectively with daily problems.”**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>	<b>Total</b>
<b>Number of Responses</b>	10	20	124	271	216	641
<b>Percent of Responses</b>	1.6 %	3.1 %	19.3 %	42.3 %	33.7 %	100.0 %

### **Q2. Children/Youth. “As a result of services my child and/or family received, my child is better at handling daily life.”**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly Agree</b>	<b>Total</b>
<b>Number of Responses</b>	11	22	126	320	217	696
<b>Percent of Responses</b>	1.6 %	3.2 %	18.1 %	46.0 %	31.2 %	100.0 %

### **How Counties Rate Their Effectiveness:**

We provided the specific data for each county Data Notebook in a format identical to the sample information shown above. The goal was to have each mental health board examine their data and discuss its implications for services in their county. For general comparison, statewide reference data for similar-sized counties were provided in the tables at the end of this section of the Data Notebook (see Tables, following).

### **We asked: “Are the data consistent with your perception of the effectiveness of mental health services in your county?”**

**Results:** The overwhelming response was “Yes”, in 33 of 39 Data Notebook reports. However, a frequent comment from nine that said “Yes” and the five that said “No” was that the sample size was too small to draw conclusions (14 counties). Another

responded that the survey was not sensitive to “non-reporting” individuals. One response said that staff believed their clients were more dissatisfied than the sample indicated.

In additional comments, 17 counties either stated they had analyzed additional consumer perception data or they had presented additional data in the Notebook (or in an Appendix). Another 8 counties referred to other surveys and/or data which they had conducted. In some cases, these were questions developed by the county or else comprised a shorter subset of 6-10 questions taken from the Consumer Perception Survey. An additional county indicated plans to develop other surveys. These responses, taken together, show that counties place a high priority on obtaining consumer feedback and getting some measure of overall consumer satisfaction with services and outcomes.

### **Recognizing Potential Process Improvement Measures:**

**We asked: “Do you have any recommendations for improving the effectiveness of services?”**

**Results:** Responses varied, but overall there were no apparent differences in the pattern of responses received from small counties compared to medium and large population counties. The most common responses are listed below with the number of counties giving that response shown in parentheses.

- Better care coordination (10)
- Analyze data and outcomes (10)
- Improve information sharing (9)
- More bilingual (and bi-cultural) services (or workforce) (7)
- Timely access to services (6)
- Consumer involvement in program design (6)
- Access to physical healthcare (4)
- Access to treatment for substance use (3)
- Change in surveys, either content, length, or frequency (3)
- Family focus groups (2)
- Shared medical records (between different care providers) (2)
- Follow-up phone calls (2)

- Employment supports or access to school/training (2)
- Access to housing (1)
- Conduct site visits (1)
- Increase service to veterans (1)

### **Increasing Survey Participation Rates:**

**We asked: “Many counties experience very low numbers of surveys completed. Do you have suggestions to increase the response rate?”**

**Results:** We received an abundance of suggestions from across the state as well as a common admonition. Many respondents said that the surveys were too lengthy. Many clients found it burdensome and time-consuming to answer all the questions.

Here again, responses varied, but there were no apparent differences in the responses received from counties of different population size. The most common responses are listed below with the number of counties giving that response shown in parentheses.

#### Suggestions included:

- Decrease the total number of questions (or survey too long) (15)
- Use peers, promotores, wellness coaches, family or student volunteers (11)
- Incentives: gift cards, prize drawing entry, lotto scratchers, snacks, free pens (9)
- Increase provider locations where survey is available (8)
- Increase the duration of the survey period (7)
- Staff assistance (client difficulty understanding complex questions) (7)
- Make survey available online, i.e. ‘survey monkey’ or other (5)
- Publicize survey in advance: posters, announcements, supervisor meetings (5)
- Share the results of recent surveys with the public (4)
- Complete survey as part of regular assessments (3)
- Hand it out at front desk/ assure everyone completes (3)
- Assure clients of anonymity (3)

These were the most common responses. A few counties indicated that they get a greater participation rate when they use a smaller subset of questions (6-10), because their clients complain about the length of the Consumer Perception Survey.

### **Understanding and Meeting Unmet Needs:**

**We asked a final group of questions intended to elicit broader input to help assess unmet needs.**

**Specifically, we asked: “Lastly, but perhaps most important overall, with respect to delivery of services, do you have suggestions regarding any of the following:**

- a. Specific unmet needs or gaps in services**
  
- b. Improvements to, or better coordination of, existing services**
  
- c. New programs that need to be implemented to serve individuals in your county?”**

### **Results:**

Many of these responses reflect information which has been touched upon in other questions that identified barriers to access or suggestions for increased outreach and sustained engagement of clients. In the responses to this question, there was often not a clear delineation between unmet needs/gaps, suggested improvements for existing programs, or new programs needed.

- Decrease wait time for psychotropic medication appointments
- Elders should get all meds evaluated (interactions, side effects, appropriate drug or dose)
- Increase resources for drug and alcohol treatment and ‘dual diagnosis’ clients
- More groups (therapy, etc.)
- Better supports for post-crisis follow-up
- Improve service delivery practices and number of locations
- Improve jail psychiatry/psychology services

- Increase number of psychiatric beds and facilities so that clients (including children and youth) can be treated in their own county which makes it easier for clients to access post-hospital support services and build on supportive family relationships, where appropriate
- Increase access to crisis support services to reduce likelihood of hospitalization
- More case management needed in some counties
- Expand mental health courts, including veteran's courts
- Respite care services
- Implement MHSA programs for stigma reduction and suicide prevention across all age groups
- Increase education about mental health in the schools, especially in high school, and include anti-bullying and anti-stigma efforts.
- Programs to promote job skills, links to training, links to employment
- Increase number of integrated clinics for mental health and physical health
- Recruitment of more psychiatrists, adult and child therapists, more bilingual therapists.

## CONCLUSIONS AND FUTURE IMPLICATIONS

Ultimately, the discussions of barriers to access, together with descriptions of unmet needs in the last section, combined to yield the most informative sections of our report regarding the most urgent issues.

While these items are rooted in unique local needs and will contribute to local community planning processes, there are similarities across many counties as well. These similarities contribute important perspectives for other efforts at the state level to help with formal “needs assessment” processes, which also help the local and state government to plan for future programs and areas of focus.

However, in this report we found there are so many identified needs and areas for expansion of services that it could be difficult for any county (or for the state) to prioritize which program areas should be addressed first. The abundance of qualitative input, even though lacking specific data, does serve to highlight many needs and gives voice to the local community. However, qualitative responses do not suffice for the process of prioritization.

### **Data Drives Policy and Planning:**

Basic, quantitative, county level data is essential for needs assessment and policy decisions at the community level and for addressing our statewide needs. We need to know, how many people have a need for certain types of services? How much do we anticipate it will cost? How many, and what type, of professional staff would we need to hire? If we direct our program efforts in a certain area, will it help us avoid other costs, such as hospitalization or costs to the judicial and jail systems?

This report was indeed intended to provide an overview of the community level perception of mental health programs and services. But this report lays a foundation for future research reports grounded in more extensive quantitative data and placed in a broader context (e.g., literature review) relating our information to reports published by other groups, public and private.

We also hope to promote further discussion in local advisory boards and other stakeholders about quality improvement, and how that might take place in their local county. In this 2014 edition of the Data Notebook, we limited our presentation of data and asked very broad, open-ended questions that elicited a lot of qualitative information. That approach can certainly stimulate discussion, as we intended, but it is fairly difficult to construct a meaningful and organized analysis of all the information. We thank everyone who participated in the development of the Data Notebook, and all the mental health boards and commissions who participated in preparing their responses in the Data Notebook. We also thank the county behavioral health departments who provided

data and otherwise supported the efforts of their local advisory boards in ways too numerous to count.

**REFERENCE DATA: for Consumer Perception Survey items (August 2013)**

**Youth & Family Results Combined by CountySize: I/my child am/is better at handling daily life**

			I/my child am/is better at handling daily life					
			Strongly Disagree	Disagree	I am Neutral	Agree	Strongly Agree	Total
CountySize	Large	Count	179	414	2195	5046	2983	10817
		% within CountySize	1.7%	3.8%	20.3%	46.6%	27.6%	100.0%
	Los Angeles	Count	98	183	898	2598	1409	5186
		% within CountySize	1.9%	3.5%	17.3%	50.1%	27.2%	100.0%
	Medium	Count	41	102	516	1330	636	2625
		% within CountySize	1.6%	3.9%	19.7%	50.7%	24.2%	100.0%
	Small	Count	17	33	158	372	188	768
		% within CountySize	2.2%	4.3%	20.6%	48.4%	24.5%	100.0%
	SmallRural	Count	0	5	37	61	39	142
		% within CountySize	.0%	3.5%	26.1%	43.0%	27.5%	100.0%
Total		Count	335	737	3804	9407	5255	19538
		% within CountySize	1.7%	3.8%	19.5%	48.1%	26.9%	100.0%

**County Mental Health Plan Size: DHCS categories defined by county population.**

- Small-Rural MHPs = Alpine, Amador, Calaveras, Colusa, Del Norte, Glenn, Inyo, Lassen, Mariposa, Modoc, Mono, Plumas, Siskiyou, Trinity
- Small MHPs = El Dorado, Humboldt, Imperial, Kings, Lake, Madera, Mendocino, Napa, Nevada, San Benito, Shasta, Sutter/Yuba, Tehama, Tuolumne
- Medium MHPs = Butte, Marin, Merced, Monterey, Placer/Sierra, San Joaquin, San Luis Obispo, San Mateo, Santa Barbara, Santa Cruz, Solano, Sonoma, Stanislaus, Tulare, Yolo
- Large MHPs = Alameda, Contra Costa, Fresno, Kern, Orange, Riverside, Sacramento, San Bernardino, San Diego, San Francisco, Santa Clara, Ventura
- Los Angeles' statistics are excluded from size comparisons, but are included in statewide data.

Total Values (in Tables above) = include all statewide data received by CiMH for those survey items.

## BIBLIOGRAPHY: References for further reading

APS Healthcare/EQRO: Statewide and County Mental Health Plan reports, by year: [www.CALEQRO.com](http://www.CALEQRO.com); see Archives files for data used in 2014 Data Notebook.

California Healthcare Foundation reports:

*California Healthcare Almanac: Mental Healthcare in California: Painting a Picture*, July 2013

<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MentalHealthPaintingPicture.pdf>

*Mapping the Gaps: Mental Health in California*, July 2013 (companion to above)  
<http://www.chcf.org/publications/2013/07/data-viz-mental-health>

*A Complex Case: Public Mental Health Delivery & Financing in California*, 2013  
<http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/C/PDF%20ComplexCaseMentalHealth.pdf>

### **California Institute of Behavioral Health Services:**

See [www.cibhs.org](http://www.cibhs.org) for reports on their programs, research studies, and county training collaboratives, especially those relating to integration of physical health care and behavioral health care.

California Mental Health Services Authority (“CalMHSA,” [www.calmhsa.org](http://www.calmhsa.org)); reports: <http://calmhsa.org/programs/evaluation/>

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<http://healthpolicy.ucla.edu/publications/Documents/PDF/MentalHealthreportnov2011.pdf>

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**Department of Health Care Services, State of California:**

1115 Waiver Behavioral Health Services Needs and Service Plan Assessment Archive.

<http://www.dhcs.ca.gov/provgovpart/Pages/BehavioralHealthServicesAssessmentPlan.aspx>

*California Mental Health and Substance Use System Needs Assessment Final Report*, February 2012.

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

*California Mental Health and Substance Use System Needs Assessment Appendices*, February 2012

<http://www.dhcs.ca.gov/provgovpart/Documents/Data%20Appendices%203%201%2012.pdf>

*California Mental Health and Substance Use Prevalence Estimates*.

<http://www.dhcs.ca.gov/provgovpart/Documents/California%20Prevalence%20Estimates%20-%20Introduction.pdf>

*1915(b) Medi-Cal Specialty Mental Health Services Consolidation Waiver (approved through June 30, 2015)*.

<http://www.dhcs.ca.gov/services/MH/Pages/MCMHP.aspx>

DHCS Reports: *Health Disparities in the Medi-Cal Population*:

<http://www.dhcs.ca.gov/dataandstats/reports/Pages/HealthDisparities.aspx>

**Mental Health Services Oversight and Accountability Commission:**

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

[http://www.mhsoac.ca.gov/Evaluations/docs/CompilingCSSDataToProducePriorityIndicators\\_2FPhase2\\_121812.pdf](http://www.mhsoac.ca.gov/Evaluations/docs/CompilingCSSDataToProducePriorityIndicators_2FPhase2_121812.pdf), and also see individual county reports at:

<http://www.mhsoac.ca.gov/Evaluations/CSS-Outcomes.aspx>

**Monterey County:** *IQ Report* (re: Improving Quality, designed for general public, as well as policy makers).

[http://www.mtyhd.org/QI/images/stories/QI\\_Doc\\_2/08012013FinalDraft.pdf](http://www.mtyhd.org/QI/images/stories/QI_Doc_2/08012013FinalDraft.pdf)

**San Diego County:** *Behavioral Health Outcomes: Working Towards the Integration of Behavioral Health and Drug & Alcohol Services*

[http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Behavioral\\_Health\\_Outcomes\\_Report.pdf](http://www.sdcounty.ca.gov/hhsa/programs/bhs/documents/Behavioral_Health_Outcomes_Report.pdf)