

**Mental Health Services Act Evaluation:
Compiling Data to Produce All Priority Indicators
Contract Deliverable 2D, Phase II**



UCLA Center for Healthier Children, Youth and Families



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Mental Health Services Oversight and Accountability Commission.

Focus

The Mental Health Services Act (MHSA) evaluation team was charged with developing templates and reports on statewide and county specific data that would improve understanding of how the MHSA impacted consumers. Per contract language, the team will:

Design and complete statistical analyses and reports that measure impact of MHSA at individual and system levels on indicators specified in the Matrix of the California Public Mental Health System Prioritized Performance Indicators at the state and county levels. Draft templates, documentation of analysis, and initial statewide reports will be circulated to key stakeholders and made available to the public for input by posting on the web and making a hard copy available upon request.

Individual client outcomes for full service partnerships (FSPs) by age group must be addressed for each domain (education/employment, homelessness/housing and justice involvement) as specified. Note: this impact analysis at the individual level is limited to available data (i.e., a small segment of public mental health clients, full services partners, is reflected in this data). Mental Health system performance must address family/client/youth perception of well-being, demographics of FSP population, FSP access to primary care, penetration rate and changes in admissions for the entire public community mental health population, involuntary care, and annual numbers served through [Community Services and Supports programs] CSS.

The evaluation team submits the following report, which incorporates stakeholder insights, in fulfillment of this charge.

Stakeholder Feedback

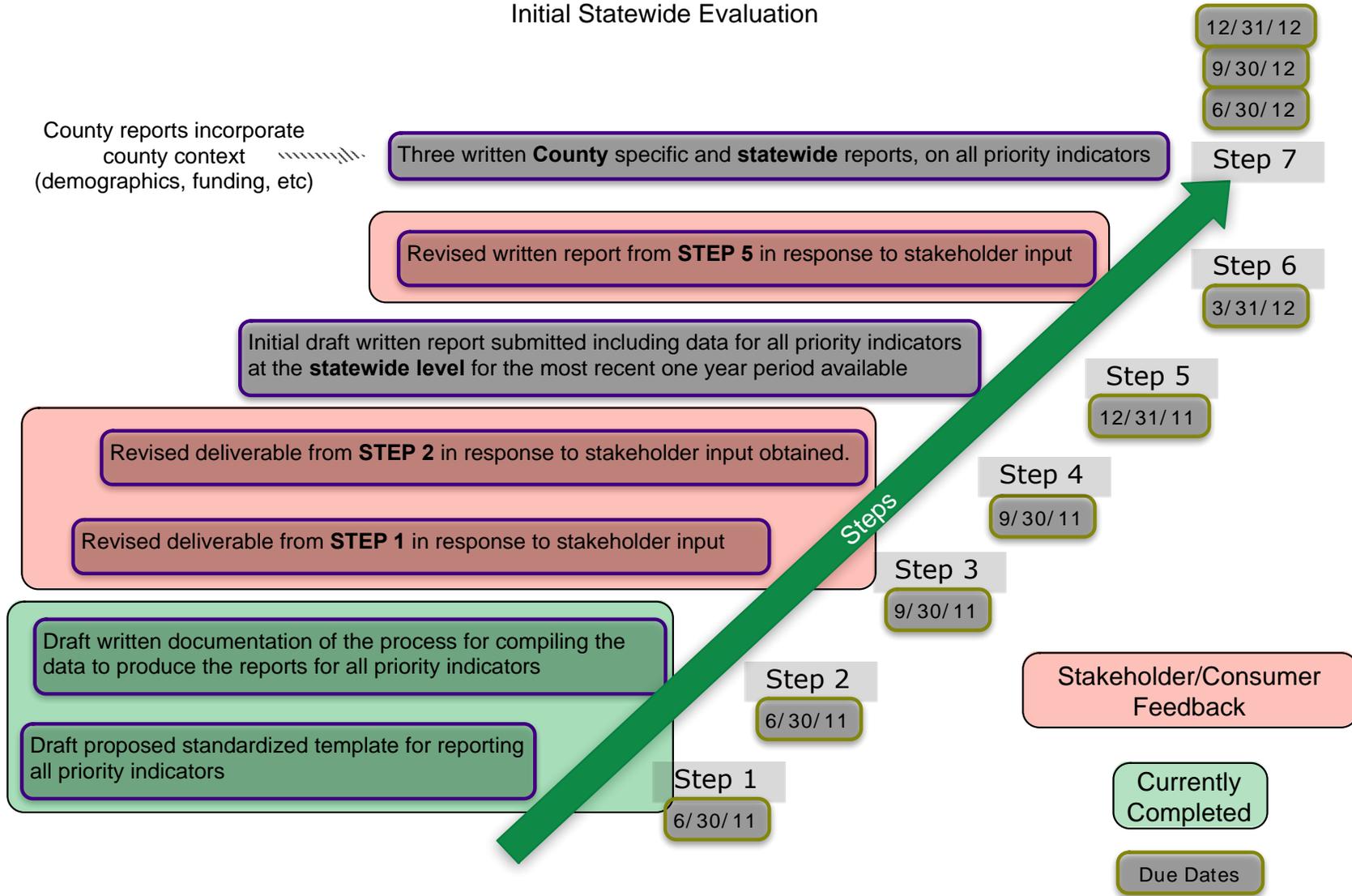
As noted in the contract language, input from key stakeholders and mental health service advocates is key to developing final reports. To this end, all reports (i.e., contract deliverables 2A and 2C) that the evaluation team submits to the Mental Health Services Oversight and Accountability Committee (MHSOAC) are considered drafts until such input is received and incorporated, to a reasonable extent, into subsequent reports. The evaluation team enlisted feedback from a wide range of stakeholders from July 29, 2011 through August 31, 2011 to create a more comprehensive, accurate report. Stakeholders received an e-mail announcing the availability of deliverables on the MHSOAC¹ and UCLA² web sites. A call for feedback and an illustration of how the evaluation team would develop deliverables using stakeholder input were embedded within report introductions to clarify stakeholders' roles in report creation and increase transparency about this process (see Illustration 1).

¹ <http://www.mhsoac.ca.gov/Announcements/announcements.aspx>

² http://healthychild.ucla.edu/MHSA_evaluation.asp

Illustration 1

Steps Leading to Statewide and County Specific Data Reports Initial Statewide Evaluation



A complete account of organizations whose representatives responded to correspondence is included at the end of this report (see Appendix A).

Webinars were also conducted for MHSA stakeholders and the California Mental Health Directors Association (CMHDA) Indicators, Data, Evaluation and Accountability (IDEA) Ad-Hoc Committee. Webinars described the reports' purposes, input needs, and feedback process. Webinars were not designed to collect feedback; rather they were intended to provide a synopsis of deliverables. Given the number of webinar participants, it was not feasible to account for all stakeholders' comments. The evaluation team requested that all feedback was ultimately written and shared with the evaluation team through e-mail correspondence. The evaluation team encouraged all stakeholders to respond to points of interest in the reports as well as use the accompanying guidance document to think critically about questions posed by the evaluation team. Groups were invited to use their existing internal processes for reviewing and responding to mental health-related reports; the evaluation team did not impose any review protocol. The team requested that feedback be specific (e.g., noting page numbers, specific priority indicators, or specific measures), rather than a set of general comments, to optimize feedback use. Stakeholders largely obliged this request.

The nature of responses ranged greatly. A table illustrating the types of feedback garnered by each indicator and measure is located in Appendix B. Among stakeholder input were direct responses to guidance questions, feedback that provided historical context for data issues, concern about the accuracy of particular indicators given data quality, and potential ramifications of a university group assessing mental health service consumer outcomes instead of the consumers themselves. The evaluation team anticipated feedback diversity – particularly recommendations that would be at odds with each other – and devoted ample time to negotiating what could and could not be addressed given the available time and data with which we were provided to conduct the evaluation. The team articulated this point early in the reports in the service of transparency and to ground expectations.

Overview

This draft report proposes processes for creating useful measures of priority indicators that can be used to monitor how the Mental Health Services Act (MHSA) impacts consumer outcomes and mental health service system performance statewide and at the county level. The *priority indicators* were proposed in a preceding report (*Templates for Reporting Priority Indicators, Deliverable 2A*). These indicators were intended to identify measurable Community Services and Supports (CSS) program outcomes, including consumer outcomes and measurable characteristics of mental health service system capacity and performance.

This report details how each priority indicator can be represented using survey and service description (e.g., outputs) data already collected within each county. Guided by stakeholder insights, the report identifies data sources and items (variables) relevant to the evaluation; data limitations per stakeholder feedback; and methods of combining data into more adequate indicators where appropriate. Criteria for testing individual or multiple-item measures of indicators are also identified. These quality tests will be applied to cull and refine proposed

measures once access to the necessary data is acquired. No analyses are included in this report; rather data is organized in preparation for analyses that will take place subsequent to this report.

The report is organized by the following topics.

- Brief discussion of indicator development prior to this project
- Profile of the data sources used for this project – mental health-related surveys and reports that are regularly submitted by California counties
- Discussion of the criteria used to select, review, and refine measures
- Explication of the calculations proposed to create priority indicator measures
- Notes on examining data for quality and completeness
- Description of consumer stakeholder group roles in refining measures and calculations

Two templates are presented that summarize MHSA domains, priority indicators (i.e., consumer and system level), measures, relevant data sources and items, and necessary calculations. Where data quality concerns can be anticipated, or gaps are evident, recommendations for new data collection to attain measurement goals are included. Stakeholder feedback about data quality and measurement feasibility is incorporated throughout.

The report concludes with next steps in refining the measure and indicators to ensure accurate and comprehensive monitoring of consumer outcomes and mental health service system performance.

Background

The California Mental Health Planning Council (referred to throughout as *The Planning Council*) proposed a set of priority indicators to assess the impact of the MHSA on consumers and county service systems statewide. Council members designed individual-level priority indicators to create greater clarity about consumers' dispositions (e.g., employment, education, housing, justice involvement) following interventions coordinated through the MHSA. Similarly, council members proposed that system-level priority indicators (related to consumer access, agency performance, agency structure) would explain how operations changed or were enhanced (if at all) by the Act. These indicators were ultimately adopted by the MHSOAC.

As part of ongoing efforts to define priority indicators and identify how these indicators might be measured using data currently collected by counties, the evaluation team reviewed existing datasets to identify appropriate data sources and items. This process began with the set of indicators identified in *Templates for Reporting Priority Indicators, Deliverable 2A*. This document defines and provides the rationale for indicators recommended for monitoring county use of MHSA funds, and performance of MHSA initiatives. In this report, the evaluation team outlines a data extraction and measurement process to operationalize conceptually complete indicators of consumer outcomes and system performance related to the MHSA.

Objectives

The evaluation team conducted a search of available data with two goals: to 1) locate variables, relevant to each priority indicator, that are regularly collected; and 2) outline short protocols for converting existing data into priority indicators. The present report briefly documents this process, in which we provide guidelines about how to create relevant measures using existing data to the extent possible. Throughout the report we note challenges in calculation, and areas in which new data might need to be collected.

Process for Reviewing Available Data

We reviewed several data dictionaries and instruments (e.g., surveys, forms) associated with their respective existing datasets or reports. The datasets and reports, listed below, reflect information that is regularly collected across counties at present. In the absence of access to raw data, we closely examined the qualities (e.g., item wording, response options, intended response population) of each item (variable), sorting which would be most appropriate to represent each priority indicator.

Client & Service Information (CSI)

The CSI system is a repository of county, client (e.g., age, gender, preferred language, education, employment status, living arrangement, etc.), and service information (number and length of service contact). The data is collected from all consumers who receive mental health services, including consumers involved in Full Service Partnerships.

Data Collection and Reporting (DCR) System

The DCR system houses data for consumers who are served through Full Service Partnership 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 and baseline information, including consumer education and/or employment, housing situation, legal issues, health status, and substance use. The KET reflects any important changes in the consumer’s life such as housing, education and/or employment, and legal issues during service receipt. The 3M collects follow-up information on key areas such as education, health status, substance use, and legal issues each quarter.

Consumer Perception Surveys (YSS for youth responses, YSS-F for family responses)

These consumer surveys are instrument sets customized for consumer groups (e.g., youth, adults, and older adults). Instruments are composed of widely validated tools such as the Child Behavior Checklist, Youth Self Report, and Restrictiveness of Living Environment Scale for youth assessment; the Global Assessment of Functioning, Behavior and Symptom Identification Scale, and the California Quality of Life for adults; and the Brief Symptom Inventory, Senior Outcomes Checklist 10, and Index of Independent Activities of Daily Living for older adults. The data, designed to inform treatment planning and service management, is collected from individuals with “serious, persistent” mental illness, have received services for 60 days or more, and are not categorized as “medication only.” At minimum, data is customarily collected at intake, annually, and at discharge, however this schedule has changed in recent years. Findings are reported to the Department of Mental Health semi-annually.

Mental Health Statistics Improvement Program (MHSIP for adult responses and MHSIP for older adult responses)

The MHSIP consumer surveys are designed to assess client satisfaction, service accessibility, quality, and outcomes. Adult consumers and older adult consumers respond to the survey questions using a 5-point scale of agreement (e.g., 5 = strongly agree and 1 = strongly disagree).³

Quarterly Reports (Exhibit 6)⁴

Quarterly reports, including Exhibit 6, reflect consumer counts—the number of people who were targeted and receive MHSA services. Counts are aggregated from different consumer pools, including Outreach and Engagement, and Community Services and Supports (CSS), among others. Service types and demographics are not included in reports. Data is reported quarterly then compiled into annual reports.

Involuntary Services (Jail Services, Conservatorships, Involuntary Detentions, Seclusion and Restraint)

The California Department of Mental Health tracks several involuntary services by County and across the State, including: 72-hour evaluation and treatment (Adults and Children), 14-day intensive treatment (including suicidal treatment), 30-day intensive treatment, 180-day post certification treatment, temporary conservatorships, and permanent conservatorships.

Calculation of Measures

Meaningful and useful measures must be carefully conceptualized, designed, and constructed. Doing so facilitates how variables are combined or calculated then interpreted. The indicators included in the measurement template proposed in *Templates for Reporting Priority Indicators, Deliverable 2A* were expressed as absolute figures (e.g., counts, frequencies) or ratios (e.g.,

³ Key informants have informed the evaluation team that the MHSIP surveys are sometimes also referred to as “POQI-Adult” and “POQI-Older Adult.”

⁴ In the previous deliverable (2A), we noted that key informants preferred the use of Annual Updates instead of Quarterly Reports although the state of Annual Updates was uncertain due to Assembly Bill 100. At the time of this report, the data dictionary associated with Annual Updates was unavailable, limiting what we are able to report here. The recommendation is described more fully in the discussion.

normalized data). These two types of indicators have distinct requirements for the data used to operationalize them, and implications for stakeholders who would use indicators to drive quality improvement. The following table outlines the implications for these two types of indicators.

Absolute Indicators

Counties often report data in terms of absolute figures, which might be expressed as the frequency (count) of a specific event or an indication of consumer status (e.g., attendance in school, employment status, housing status, receipt of service, type of service, etc.). Absolute figures can provide 1) a description of a services or outcomes at points in time, and 2) the basis for critical analyses of differences across consumer groups, across time, and attribution of impact.

Absolute figures are essential to any assessment of the parameters (e.g., carrying capacity, limits, or sustainability) of mental health systems and services, and the impact on consumers and families. For example, at the mental health system level, the total number of consumers receiving 24-hour care provides the possibility to consider service levels relative to a county's overall resource capacity. Similarly, absolute measures of consumer outcomes, such as the number of consumers attending school, will allow for comparison to other populations or mental health systems. Absolute figures can provide an important perspective of the capacity, performance, and impact of mental health systems. When information regarding local MHSA context is lacking, absolute indicators can also be useful for stakeholders trying to understand the relative magnitude of county services and impacts, or reasons for prioritizing efforts. For example, identifying the 10 counties with fewest consumer arrests would require absolute figures, whereas ratios (e.g., normalized data) are more useful when making comparisons between counties.

Absolute measures of MHSA performance and impact provide for:

- consistent tracking;
- data aggregation to key levels (e.g., county, state); and
- ability to form additional ratios other than those included in the priority indicator template.

Ratio Indicators

Ratios relate two absolute figures to each other and provide context to both. For example, the efficiency of Community Services and Supports (CSS) can be expressed in terms of the number of consumers served through CSS relative to those who were targeted for service. Alternatively, to shift focus to the impact of the CSS program, the number of consumers served through CSS could be compared to all consumers receiving mental health services.

Ratio indicators serve to:

- relate two absolute figures to each other;

- make relationships visible and interpretable by a broad audience; and,
- provide for comparison of different scales of operation relative to a specific service (e.g., number of incarcerated consumers per individual served).

Ratios may also be particularly useful for comparing counties or regions. Absolute figures sometimes do not provide the context in which performance or impact may be best understood. This may be particularly true among the diverse counties and regions of California. For example, the magnitude of a service will not always correlate with the size of the county in which it was administered. As illustration, it may be factually correct that county A served twice as many consumers as county B, but this would be misleading if county B were a quarter that size and twice as efficient in the administration of their services. For some indicators, an absolute figure may be the most meaningful piece of information, but for others additional context is needed to accurately understand the implications of figures.

Single vs. Multiple Item Measures

To produce adequately robust measures, we applied a process to construct single or multiple-item measures as appropriate. In some cases a single data item is adequate to capture an indicator, such as when its meaning is clear and it has adequate variance and precision. For example, the rating of children or TAY consumers' school attendance in the past year may only require a single item (e.g., ATTENDANCEPAST12 – PAF). But often, single items are not adequate, or can be improved by combining several data items that express different empirical facets of an indicator. For example, to construct a robust and accurate measure of consumer or family perceptions of improvement in functioning, multiple survey (e.g., MHSIP) items are necessary to ensure several facets of this measure are assessed. When carefully constructed, multi-item indicators can improve the reliability, validity and variance characteristics of a resulting measure.

Orientation to the Templates

The subsequent templates detail how the proposed priority indicators could be constructed. The templates are divided at the individual (Template 1) and system (Template 2) levels, and are intended to present options for constructing measures using existing data or, where existing data was not sufficient, options for future data collection are proposed.⁵ Although the Planning Council and MHSOAC envisioned consumer outcomes to be measured across Full Service Partnership consumers and system outcomes to be measured across all mental health service consumers (see Appendix C), data sources in both templates reflect possibilities for outcome calculations across all mental health services consumers (via the Consumer Services and

⁵ Contractually, the evaluation team is responsible for coordinating data collection related to the Participatory Research component of this project (Phase 3, Deliverables 2.a.1 and 2.b.2.). Beyond this requirement, the team only offers suggestions about where new data collection can create more complete mental health service datasets.

Information [CSI] system) as well as persons enrolled in Full Service Partnerships (via the Data Collection and Reporting [DCR] system).

The columns from left to right detail measurement domains, performance indicators, possible calculation of measures based on what is available (recommended and alternative), the databases or reports from which relevant items can be drawn, and the specific items within each dataset or report which may be used to construct measures. Not all data sources provide accurate indicator measurement; however, we list these sources and their associated variables to generate discussion about how existing data might be re-envisioned or manipulated to represent a priority indicator.

How to Read the Templates. The Measure Calculation(s), Data Source(s), and Dimension columns list all proposed methods for calculating or estimating a measure. No one measure has been selected as of this report. Only after the evaluation team gains access to and reviews existing data will measures be selected. These columns should be considered an inventory of possible measures. In the absence of appropriate data sources, or as supplement to existing sources, we recommend new data collection. For example, in Template 1 the Average Attendance – score per year indicator could be measured using the Recommended Ratio, Alternative Estimate 1, *or* Alternative Estimate 2. The information that the evaluation team needs to calculate any of these can be located in the DCR, YSS, YSS-F, may require new data collection, *or* a combination thereof. The templates do not reflect a one-to-one relationship between measure calculations and data sources.

To make the most efficient use of existing and proposed additional data and data collection processes and provide flexible performance measurement options at the state and county levels, we present “recommended” and “alternative” measures of priority indicators in the Measure Calculation(s) column. *Recommended* measures are those that would most accurately reflect indicators, while attempting to take advantage of existing data systems. We consider these calculations optimal. *Alternative* calculations, considered as substitutes or supplements to the recommended calculation, are based on variables that currently exist within at least one of the Department of Mental Health datasets, and with manipulation can provide an approximate measure of the desired performance indicator. In the event that existing data can only provide an approximate measure of an indicator, additional data collection is proposed. The following templates detail how measures of each priority indicator can be constructed from existing or proposed additional data collection.

To the extent possible, we have highlighted stakeholder input (blue fields) throughout the templates. More detailed revisions, such as suggested revisions to ratio denominators, have not been highlighted but are described in stakeholder feedback in the report’s Measurement Detail (pp. 23-32).

Template 1. Process for Compiling Data and Calculating Priority Indicators: Individual-level (Consumer) Outcomes for Full Service Partnerships⁶

Blue fields indicate stakeholder feedback.

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
1. Education/ Employment	1.1 Average attendance – score per year (Children, TAY)	Recommended Ratio Numerator: Number of days at school during a consumer’s school year* / Denominator: Number of days during a consumer’s school year Alternative Estimate 1 Number of days during consumer’s school year* – Number of expulsions or suspensions during the year Alternative Estimate 2 Attendance rate estimate for three quarters	Proposed new data collection	Children and TAY <ul style="list-style-type: none"> Number of days absent Total number of school year days at consumers’ school
			YSS	Children (Youth Report) <ul style="list-style-type: none"> <i>Current and previous expulsions</i> – LES12EXPSUS, LES12PSTEXPSUS, MOR12EXPSUS, MOR12PSTEXPSUS
			YSS-F	Children (Parent or Guardian Report) <ul style="list-style-type: none"> <i>Current and previous expulsions</i> – LES12EXPSUS, LES12PSTEXPSUS, MOR12EXPSUS, MOR12PSTEXPSUS
			DCR	Children <ul style="list-style-type: none"> <i>Attendance Rate Estimate</i> – ATTENDANCECURR (PAF) (3M) ATTENDANCEPAST12 (PAF)
				TAY <ul style="list-style-type: none"> <i>Attendance Rate Estimate</i> – ATTENDANCECURR (PAF) (3M) ATTENDANCEPAST12 (PAF)
	1.2 Proportion participating in paid and unpaid employment (TAY over 18, adults, and older adults)	Recommended Ratio 1 Numerator: Number of employed consumers (reporting work hours) / Denominator: Total number of consumers eligible for employment (over 18 years old) Recommended Ratio 2 Numerator: Number of employed consumers	DCR	TAY <ul style="list-style-type: none"> <i>Paid employment</i> – Current_In-HouseAvgHrWeek (PAF), Current_OtherEmploymentAvgHrWeek (PAF), Current_SupportedAvgHrWeek (PAF), Current_TransitionalAvgHrWeek (PAF), Past12_Competitive (PAF), Past12_In-House (PAF), Past12_In-HouseAvgHrWeek (PAF), Past12_OtherEmployment (PAF), Past12_OtherEmploymentAvgHrWeek (PAF), Past12_Supported (PAF), Past12_SupportedAvgHrWeek (PAF), Past12_Transitional (PAF), Past12_TransitionsIavgHrWeek (PAF) <i>Unpaid employment</i> – Current_Non-paidAvgHrWeek (PAF), Past12_Non-paid (PAF), Past 12_Non-paidAvgHrWeek (PAF)

⁶ Data sources that reflect all mental health service consumers (e.g., CSI) have been added in the event that broader information than what is learned about Full Service Partnership consumers is sought.

*Asterisk indicates information from new data collection or a data source not yet identified.

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
		<p>receiving pay for work / Denominator: Total number of consumers eligible for employment (over 18 years old)</p> <p>Recommended Ratio 3 Numerator: Number of employed consumers not receiving pay for work / Denominator: Total number of consumers eligible for employment (over 18 years old)</p> <p>Recommended Count 1 Number of days employed</p>		<p>Adults</p> <ul style="list-style-type: none"> <i>Paid employment</i> – Current_In-HouseAvgHrWeek (PAF), Current_OtherEmploymentAvgHrWeek (PAF), Current_SupportedAvgHrWeek (PAF), Current_TransitionalAvgHrWeek (PAF), Past12_Competitive (PAF), Past12_In-House (PAF), Past12_In-HouseAvgHrWeek (PAF), Past12_OtherEmployment (PAF), Past12_OtherEmploymentAvgHrWeek (PAF), Past12_Supported (PAF), Past12_SupportedAvgHrWeek (PAF), Past12_Transitional (PAF), Past12_TransitionsIavgHrWeek (PAF) <i>Unpaid employment</i> – Current_Non-paidAvgHrWeek (PAF), Past12_Non-paid (PAF), Past 12_Non-paidAvgHrWeek (PAF) <p>Older Adults</p> <ul style="list-style-type: none"> <i>Paid employment</i> – Current_In-HouseAvgHrWeek (PAF), Current_OtherEmploymentAvgHrWeek (PAF), Current_SupportedAvgHrWeek (PAF), Current_TransitionalAvgHrWeek (PAF), Past12_Competitive (PAF), Past12_In-House (PAF), Past12_In-HouseAvgHrWeek (PAF), Past12_OtherEmployment (PAF), Past12_OtherEmploymentAvgHrWeek (PAF), Past12_Supported (PAF), Past12_SupportedAvgHrWeek (PAF), Past12_Transitional (PAF), Past12_TransitionsIavgHrWeek (PAF) <i>Unpaid employment</i> – Current_Non-paidAvgHrWeek (PAF), Past12_Non-paid (PAF), Past 12_Non-paidAvgHrWeek (PAF)
2. Homelessness/ Housing	2.1 Housing situation/ Index- score (Children, TAY, adults, and older adults)	<p>Recommended Ratios 1 Numerator: Number of days that children or TAY (under 18) live in a family home annually/ Denominator: 365 days</p> <p>Recommended Ratios 2 Numerator: Number of days that children or TAY (under 18) live in a foster home annually/ Denominator: 365 days</p>	DCR	<p>Children</p> <ul style="list-style-type: none"> <i>Current housing situation</i> – CURRENT (PAF) (KET) <i>Previous housing situations (week, month)</i> – EMERGENCYHELPER-PASTTWELVEDAYS, EMERGENCYHELPER_PASTTWELVEOCCURENCES, EMERGENCYHELPER_PRIORTWELVE (PAF), HOMELESS_PASTTWELVEDAYS (PAF), HOMELESS_PASTTWELVEOCCURENCES (PAF), YESTERDAY (PAF)
			DCR	<p>TAY</p> <ul style="list-style-type: none"> <i>Current housing situation</i> – CURRENT (PAF) (KET) <i>Previous housing situations (week, month)</i> – EMERGENCYHELPER-PASTTWELVEDAYS, EMERGENCYHELPER_PASTTWELVEOCCURENCES, EMERGENCYHELPER_PRIORTWELVE (PAF), HOMELESS_PASTTWELVEDAYS (PAF),

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
2. Homelessness/ Housing (cont'd)	2.1 Housing situation/ Index- score (Children, TAY, adults, and older adults)	Recommended Ratios 3 Numerator: Number of days TAY, adults, or older adults are homeless/ Denominator: 365 days		HOMELESS_PASTTWELVEOCCURENCES (PAF), YESTERDAY (PAF)
		Recommended Ratios 4 Numerator: Number of TAY or adults with independent residential statuses/ Denominator: Total number of FSP, TAY, and FSP adults		Adults <ul style="list-style-type: none"> • <i>Current housing situation</i> – CURRENT (PAF) (KET) • <i>Previous housing situations (week, month)</i> – EMERGENCYSHELTER-PASTTWELVEDAYS, EMERGENCYSHELTER_PASTTWELVEOCCURENCES, EMERGENCYSHELTER_PRIORTWELVE (PAF), HOMELESS_PASTTWELVEDAYS (PAF), HOMELESS_PASTTWELVEOCCURENCES (PAF), YESTERDAY (PAF)
		Recommended Ratios 5 Number of TAY, adults, and older adults who are not homeless/ Denominator: Total number of FSP TAY, FSP adults, or FSP older adults		Older Adults <ul style="list-style-type: none"> • <i>Current housing situation</i> – CURRENT (PAF) (KET) • <i>Previous housing situations (week, month)</i> – EMERGENCYSHELTER-PASTTWELVEDAYS, EMERGENCYSHELTER_PASTTWELVEOCCURENCES, EMERGENCYSHELTER_PRIORTWELVE (PAF), HOMELESS_PASTTWELVEDAYS (PAF), HOMELESS_PASTTWELVEOCCURENCES (PAF), YESTERDAY (PAF)
		Recommended Count 1 Number of days in housing	YSS	Children <ul style="list-style-type: none"> • <i>Specific housing</i>⁷ – FAMILYMEM, FOSTERHM, THERAPEUTIC, SHELTER, HOMESHELT, GROUPTHM, RESIDENTX, HOSPITAL, JAIL, CORRECTIONS, HOMELESS, LIVEOTHER, *WHERE (follow-up to LIVEOTHER)
			YSS	TAY <ul style="list-style-type: none"> • <i>Specific housing</i> – FAMILYMEM, FOSTERHM, THERAPEUTIC, SHELTER, HOMESHELT, GROUPTHM, RESIDENTX, HOSPITAL, JAIL, CORRECTIONS, HOMELESS, LIVEOTHER, *WHERE (follow-up to LIVEOTHER)

⁷ Stakeholders shared that without verification of parents' housing statuses, children who are identified as living with parents could be homeless if parents are of that status. For this reason, the PARENT variable has been removed from potential items that might be used to assess Homelessness/Housing.

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
			CSI ⁸	<p>TAY</p> <ul style="list-style-type: none"> PATIENT STATUS CODE (consumer’s housing if recently discharged) <p>Adult</p> <ul style="list-style-type: none"> PATIENT STATUS CODE (consumer’s housing if recently discharged) <p>Older Adult</p> <ul style="list-style-type: none"> PATIENT STATUS CODE (consumer’s housing if recently discharged)
3. Justice Involvement	3.1 Justice Involvement (Children, TAY, adults, and older adults)	<p>Recommended Ratio 1 Numerator: Number of consumer arrests annually / Denominator: 365 days</p> <p>Recommended Ratio 2 – by age group Numerator: Number of child, TAY, adult, or older adult arrests/ Denominator: Total number of FSP children, FSP TAY, FSP adults, or FSP older adults</p> <p>Recommended Ratio 3 – by age group Numerator: Number of child, TAY, adult, or older adult arrests / Denominator: County estimate of all children, all TAY, all adults, or all older adults</p> <p>Recommended Count 1 Number of incarcerations*</p>	DCR	<p>Children</p> <ul style="list-style-type: none"> Recent arrest – DATEARRESTED (PAF) <p>TAY</p> <ul style="list-style-type: none"> Previous arrests (year) – ARRESTPRIOR12 (PAF) <p>Older Adults</p> <ul style="list-style-type: none"> Recent arrest – DATEARRESTED (PAF)
			YSS	<p>TAY</p> <ul style="list-style-type: none"> Previous arrests (year) – MOR12AREST, MOR12PSTAREST
			YSS-F	<p>Children (Parent or guardian response)</p> <ul style="list-style-type: none"> Previous arrests (year) – LES12AREST, LES12PSTAREST
			CSI	<p>TAY</p> <ul style="list-style-type: none"> P-08.0 CONSERVATORSHIP/ COURT STATUS (if consumer is a ward of the court)
				<p>Older Adults</p> <ul style="list-style-type: none"> S-20.0 LEGAL CLASS ADMISSION (if consumer has been admitted to acute 24-hour mental health services)
			MHSIP Adult	<p>Adults</p> <ul style="list-style-type: none"> Recent arrests – ARREST Previous arrests – LES12AREST, LES12PSTAREST
			MHSIP Older adult	<p>Older Adults</p> <ul style="list-style-type: none"> Recent arrests – ARREST Previous arrests – LES12AREST, LES12PSTAREST
			Proposed new data collection	<p>Children, TAY, Adults, Older Adults</p> <ul style="list-style-type: none"> Number of incarcerations

⁸ Key informants have expressed concerns that CSI data designed to capture all mental health service consumers is of questionable quality.

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
4. Emergency Care	4.1 Emergency intervention for mental health episodes (Children, TAY, adults, and older adults)	<p>Recommended Ratio 1 Numerator: Number of mental health episode-related hospitalizations annually/ Denominator: Number of consumer visits to the hospital for any reason annually</p> <p>Recommended Ratio 2 Numerator: Number of emergency psychiatric interventions / Denominator: Number of consumer visits to a non-hospital intervention center annually</p>	CSI	<p>Children</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>TAY</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>Adults</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>Older Adults</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service)
			Proposed new data collection	<p>Children, TAY, Adults, Older Adults</p> <ul style="list-style-type: none"> Number of non-psychiatric hospital visits Number of visits to a non-hospital facility for mental health interventions
	4.2 Emergency intervention for co-occurring physical injury	<p>Recommended Ratio 1 Numerator: Number of consumer visits to the hospital for physical injuries or physical health disorders that co-occur with mental health episodes/ Denominator: Number of consumer visits to the hospital for any reason annually</p>	CSI	<p>Children</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>TAY</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>Adults</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service) <p>Older Adults</p> <ul style="list-style-type: none"> S-06.0 SERVICE FUNCTION (Identifies the specific type of service received by the client within 24 Hour, Day, and/or Outpatient mode of service)
5. Social Connections	5.1 Proportion who identify family support ⁹	<p>Recommended Ratio 1 Numerator: Number of family members the consumer identifies as</p>	Proposed new data collection	<p>Children, TAY, Adults, Older Adults</p> <ul style="list-style-type: none"> Number of persons who are related to the consumer who the consumer identifies as supportive

⁹ “Family” may or may not include caregivers depending on each consumer’s designation.

Domain	Indicator	Measure Calculation(s)	Data Source(s)	Dimension – Potential Items
		reliable supporters, or persons who are consistently present for the consumer*/ Denominator: Number of consumers		
	5.2 Proportion who identify community support	<p>Recommended Ratio 1 Number of community (non-family) members that the consumer identifies as reliable supporters*/ Denominator: Number of consumers</p> <p>Recommended Count 2 Number of mental health service organizations and other support services the consumer identifies as being a core resource when needed*/ Denominator: Number of consumers</p>	Proposed new data collection	<p>Children, TAY, Adults, Older Adults</p> <ul style="list-style-type: none"> Number of persons who are not related to the consumer who the consumer identifies as supportive Number of organizations that the consumer visits voluntarily and regularly that the consumer identifies as providing appropriate and high quality services

Template 2. Process for Compiling Data and Calculating Priority Indicators: System-Level Outcomes for All Mental Health Consumers¹⁰

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items
6. Access	6.1 Demographic Profile of Consumers Served	Recommended Descriptives Mean/median, mode, range, and change over time for age, gender, language, race/ethnicity of consumer population (overall and FSP), in comparison to State and County population demographics	CSI	<ul style="list-style-type: none"> Age – C-03.0 Date of Birth Gender – C-05.0 Gender Race/ethnicity – C-09.0 Ethnicity; C-10.0 Race
			DCR	<ul style="list-style-type: none"> Age – Date of Birth Gender – Gender Race/ethnicity – Ethnicity_A; Ethnicity_B
		Alternate Descriptives 1 Mean, mode, range, and change over time for age, gender, race/ethnicity of individuals living below the poverty line or unemployed	CSI	<ul style="list-style-type: none"> Employment Status – P-03.0 Employment Status
			DCR	<ul style="list-style-type: none"> Income – Wages-Curr; Wages_Past12
		Alternate Descriptives 2	CSI	<ul style="list-style-type: none"> Homelessness – P-09.0 Living Arrangement

¹⁰ Data sources that reflect Full Service Partnership consumers have been added in the event that specific knowledge about systems from this population is sought.

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items
		Mean, mode, range, and change over time for age, gender, race/ethnicity of homeless	DCR	<ul style="list-style-type: none"> • <i>Homelessness</i> – Homeless Yesterday¹¹; Homeless_PastTwelveDays; Homeless_PastTwelveOccurrences; Homeless_PriorTwelve
	6.2 New Consumers by Demographic Profile	Recommended Descriptives Mean, mode, range, and change over time for age, gender, race/ethnicity of new consumers (< 6 months)	DCR	<ul style="list-style-type: none"> • <i>Age</i> – Age_Group • <i>Gender</i> – Gender • <i>Race/ethnicity</i> – Ethnicity_A; Ethnicity_B • <i>Length of Service</i> – PartnershipDate
		Additional Descriptives Mean, mode, range, and change over time for age, gender, race/ethnicity of existing consumers (> 6 months, 1 year, > 1 year)	CSI	<ul style="list-style-type: none"> • <i>Age</i> – Age_Group • <i>Gender</i> – Gender • <i>Race/ethnicity</i> – Ethnicity_A; Ethnicity_B • <i>Length of Service</i> – S-15.0 Admission Date; S-16.0 From/Entry Date; S-17.0 Through/Exit Date; S-18.0 Discharge Date
			DCR	<ul style="list-style-type: none"> • <i>Age</i> – Age_Group • <i>Gender</i> – Gender • <i>Race/ethnicity</i> – Ethnicity_A; Ethnicity_B • <i>Length of Service</i> – PartnershipDate
		6.3 High Need Consumers Served	Recommended Count 1 Total homeless - FSP consumers served ¹²	DCR
	Recommended Count 2 Total homeless - all consumers served		CSI	<ul style="list-style-type: none"> • <i>Homeless</i> – P-09.0 LIVING ARRANGEMENT
	Recommended Count 3 Total unemployment - FSP consumers served		DCR	<ul style="list-style-type: none"> • <i>Unemployed</i> – Current_Unemployed
	Recommended Count 4 Total unemployment - all consumers served		CSI	<ul style="list-style-type: none"> • <i>Unemployed</i> – P-03.0 EMPLOYMENT STATUS
	Recommended Count 5 Total consumers with justice involvement served		DCR	<ul style="list-style-type: none"> • <i>Arrests</i> – ArrestPast12
	Recommended Count 6 Total consumers with multiple psychiatric hospitalizations served		CSI	<ul style="list-style-type: none"> • <i>Hospitalization</i> – S-06.0 SERVICE FUNCTION
	6.4 Access to Primary Care Physician	Recommended Ratio 1 Numerator: FSP consumers who have a primary care physician currently and over the past 12 months/Denominator: Total number of FSP consumers	DCR	<i>Primary Care Physician</i> – PhysicianCurr; PhysicianPast12

¹¹ Item collected with Partnership Assessment Form (PAF), but not included in DCR data dictionary.

¹² Homelessness has customarily been a challenge to measure, particularly beyond the mental health service consumer population. Should housing information about mental health service consumers remain of questionable quality, new data collection strategies (e.g., new surveys of *literal* and *functional* homelessness or shelter counts) could be suggested.

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items
		Recommended Ratio 2 Numerator: Consumers who have a primary care physician currently and over the past 12 months/Denominator: Total number of consumers	Additional Data Collection	<ul style="list-style-type: none"> An item to collect data regarding all mental health consumers' access to a primary care physician may be added to the CSI or incorporated into another data collection mechanism
	6.5 Consumer / Family Perceptions of Access to Services	Recommended Rating Average items to create an aggregate measure of Perceived Access to Services	MHSIP surveys	<ul style="list-style-type: none"> Access to Services – LOCATION; TIMEGOOD; HELPWANT; HELPNEED
		Alternative Description Qualitative and quantitative analysis of several dimensions of access to services	Proposed new data collection	<ul style="list-style-type: none"> e.g., surveys, interviews, focus groups; proposed data collection
7. Performance	7.1 Consumers Served Annually through CSS	Recommended Ratio Numerator: CSS/FSP consumers served / Denominator: CSS/FSP consumers targeted	Quarterly Progress Reports; Annual Updates	<ul style="list-style-type: none"> CSS exhibit 6
			DCR	<ul style="list-style-type: none"> FSP Identifier - GlobalID
	7.2 Involuntary Care	Recommended Ratio Numerator: Involuntary Services / Denominator: Consumers served	Annual Report on Involuntary Detentions	<ul style="list-style-type: none"> 72 hr Evaluation and Treatment (Adults, Children) 14 & 30-day Intensive Treatment 180-day Post Certification Treatment Temporary & Permanent Conservatorships Seclusion and Restraint
			CSI	<ul style="list-style-type: none"> County Client Number (CCN)
			Annual Report on Involuntary Detentions	<ul style="list-style-type: none"> 72 hr Evaluation and Treatment (Adults, Children) 14 & 30-day Intensive Treatment 180-day Post Certification Treatment Temporary & Permanent Conservatorships Seclusion and Restraint
			Census Population Projection Data	<ul style="list-style-type: none"> Total Statewide Population (projected)
	7.3 24-hour Care	Recommended Ratios 1 Numerator: Utilization of MHRC, SNF, SH among TAY, Adults, or Older Adults/ Denominator: State/county population, FSP, TAY, Adult, Older Adults	Recommended Ratio 2 Numerator: Utilization of CTF, RCL 14, MHRC / Denominator: Total FSP children or total county child population	CSI
DCR				<ul style="list-style-type: none"> Residential Information – Long-TermCare_PastTwelveOccurrences; Long-TermCare_PriorTwelve; NursingPhysical_PastTwelveDays; NursingPhysical_PastTwelveOccurrences; NursingPhysical_PriorTwelve; Yesterday; Current; PsychiatricHospital_PastTwelveDays; PsychiatricHospital_PastTwelveOccurrences; PsychiatricHospital_PriorTwelve Age – Age_Group

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items	
		Alternate Count 1 Consumers in IMD, MHRC, SNF, SH by race/ethnicity	DCR	<ul style="list-style-type: none"> • Residential Information – See above • Race/Ethnicity – CSIRace1-5 	
			CSI	<ul style="list-style-type: none"> • Residential Information – See above • Race/Ethnicity – Race(C-10.0) 	
		Alternate Counts 2 Readmission to acute care facility within 30 and 180 days (Overall and FSP)	DCR	<ul style="list-style-type: none"> • Acute Care – MedicalHospital_PastTwelveDays; MedicalHospital_PastTwelveOccurrences; PsychiatricHospital_PastTwelveDays; PsychiatricHospital_PastTwelveOccurrences; PsychiatricHospital_PriorTwelve 	
			CSI	<ul style="list-style-type: none"> • Acute Care – 24 Hour Mode of Service (S-15.0 – S-19.0) 	
	7.4 Appropriateness of Care	Recommended Rating Consumer/family perceptions of appropriateness of care	MHSIP surveys	<ul style="list-style-type: none"> • Appropriateness of Care – RESPECT; RELIGION; UNDRSTD; CULTURE 	
			Alternative Rate 1 Number and percent of consumers (Overall and FSP) readmitted to a hospital	CSI	<ul style="list-style-type: none"> • Hospital, PHF, SNF, and 24 hr Care (S-15 – S-22)
				DCR	<ul style="list-style-type: none"> • Hospital Admission - MedicalHospital_PastTwelveDays; MedicalHospital_PastTwelveOccurrences; PsychiatricHospital_PastTwelveDays; PsychiatricHospital_PastTwelveOccurrences
			Alternate Descriptive 2 Average length of stay in acute care (Overall and FSP)	DCR	<ul style="list-style-type: none"> • Acute Care – MedicalHospital_PastTwelveDays; MedicalHospital_PastTwelveOccurrences
				CSI	<ul style="list-style-type: none"> • Acute Care – 24 Hour Mode of Service (S-15.0 – S-19.0)
	Alternate Count 3 Treatment protocols for co-morbidity	Proposed new data collection	<ul style="list-style-type: none"> • e.g., document review, interviews; proposed data collection 		
7.5 Continuity of Care	Recommended Count 1 Emergency Care (Overall and FSP)	DCR	<ul style="list-style-type: none"> • Emergency Care – MenRelated; PhyRelated; ReferredBy; 		
		CSI	<ul style="list-style-type: none"> • Emergency Care – Acute 24-hour mental health services (S-20.0, S-21.0, S-22.0) 		
	Recommended Count 2 Services provided in community settings	DCR	<ul style="list-style-type: none"> • Residential Information –Yesterday; Current; ApartmentAlone; AssistedLiving; CommunityCare; CongregatePlacement; FosterHomeNon-relative; GroupHome; IndividualPlacement; ResidentialTreatment 		
		Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection 		
	Recommended Count 3 Documented discharge plans	Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection 		
7.6 Penetration Rate	Recommended Ratio Numerator: All Consumers / Denominator: Consumers targeted for service or populations of interest (e.g., age, gender, race/ethnicity, socioeconomic status)	Quarterly Progress Reports; Annual Updates	<ul style="list-style-type: none"> • CSS exhibit 6 		
		California Health Interview Survey (CHIS; proposed external data source)	<ul style="list-style-type: none"> • Demographic Information 		

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items
		Alternate Ratio Numerator: Consumers / Denominator: Holzer Targets	DCR	<ul style="list-style-type: none"> • CSS exhibit 6
			Census Data	<ul style="list-style-type: none"> • <i>Holzer Targets</i> - estimates of the prevalence of serious mental illness/serious emotional disturbance in California
	7.7 Consumer Wellbeing	Recommended Rating Client/family perception of improvement in functioning (current, over time, among high need groups)	MHSIP surveys	<ul style="list-style-type: none"> • <i>Functioning</i> – DAILYPRB; CONTROL; CRISIS; BETTRFAM; BETTRSCH; MEANINGFUL; BETTRNEED; BETTRHANDLE; DOWANTS; HAPYFRIEND; DOTHINGS; BELONG; SUPPORT
			Primary data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection
		Recommended Rating Client/family perceptions of quality of life (current, over time, among high need groups)	MHSIP surveys	<ul style="list-style-type: none"> • <i>Quality of Life</i> – LIFESAT; LIVRANG; PRIVACYL STAYLONG; SPARETIM; ENJOY; FUN; RELAX; SEEFAMILY; FAMCT; FAMGEN; VISIT; TIMERND; DOPEOPLE; TIMEPEOP; SEEPEOP; AMTFREND
7.8 Satisfaction	Recommended Rating Consumer/family satisfaction with care or service	MHSIP surveys	<ul style="list-style-type: none"> • <i>Satisfaction</i> – LIKESVCS; CHOICES; RECOMMEND; STAFWILL; COMFQUEST; COMPLAIN; 	
8. Structure	8.1 Workforce Composition	Recommended Ratio Numerator: Number of staff / Denominator: Number of consumers	Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection
		Alternate Ratio 1 Compare demographic composition of MH workforce to that of the consumer population	Cultural Competence Plans	<ul style="list-style-type: none"> • <i>Demographic Profile of Workforce</i> – Document review
		Alternate Count 2 Consumer/family member employment (i.e., number, FTE, % of workforce)	WET Plans	<ul style="list-style-type: none"> • <i>Consumer/family member employment</i> – Document review
	8.2 Evidence-Based/Best Practice Programs and Services	Recommended Count Use of evidence-based practices	CSI	<ul style="list-style-type: none"> • <i>Best Practices</i> – S-25.0 Evidence-Based Practices / Service • <i>Strategies</i>
		Recommended Additional Data Collection Fidelity of best practices to established models	Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection
		Alternate Additional Data Collection Receipt and experience of best practice services/supports among consumers/families	Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection
	8.3 Cultural Appropriateness of Services	Recommended Rating Client and family perceptions of cultural appropriateness	MHSIP surveys	<ul style="list-style-type: none"> • <i>Cultural Appropriateness</i> – CULTURE
			Proposed new data collection	<ul style="list-style-type: none"> • e.g., surveys, interviews, or focus groups; proposed data collection

Domain	Indicator	Calculation of Measure(s)	Data Source(s)	Dimension – Potential Items
	8.4 Recovery, Wellness, and Resilience Orientation	Recommended Additional Data Collection Consumer, family member, and staff perceptions of recovery orientation of system and services	Recovery Oriented Systems Indicators Measure (ROSI; proposed data collection)	<ul style="list-style-type: none"> • <i>Recovery Orientation</i>
			Developing Recovery Enhancing Environments Measure (DREEM; proposed data collection)	<ul style="list-style-type: none"> • <i>Recovery Orientation</i>

Mental Health Indicator Measurement Detail

To clarify the rationale and potential utility of measures for each indicator, this section provides detailed descriptions of the calculations summarized in the templates. This discussion is based on a thorough review of all relevant existing data and, where appropriate, some alternative data sources. Stakeholder Informed Challenges and Limitations, enclosed in blue text boxes, guided many of the revisions seen in Templates 1 and 2.

Individual-level (Consumer) Outcomes for Full Service Partnerships Measurement Detail

Consumer indicators are individual-level priority indicators designed to create greater clarity about consumers' dispositions (e.g., employment, education, housing, justice involvement) following interventions coordinated through the MHSA.¹³

Domain 1: Education/ Employment

1.1 Indicator: Average Attendance – Score Per Year

Rationale for measure: Dividing the number of consumers' days at school during a 9-month school year (numerator) by the total number of days during consumers' school year (denominator) will yield attendance rates for child consumers and TAY consumers 18 and younger within each county. The rates will then be averaged across all counties to identify statewide average attendance rates for each age group.

Stakeholder Informed Challenges & Limitations: Stakeholders reported that accurate school data was difficult to access and normalize due to the types of programs in which consumers were enrolled. For example, alternative education and home schooling would have different attendance requirements. A ratio of school days attended to total school days would address this issue; however, no strategy exists yet to collect the total number of school days from each school district in the state.

1.2 Indicator: Proportion Participating in Paid and Unpaid Employment

Rationale for measures: Employment is measured in three ways: 1) Dividing the number of employed consumers over 18 years old (numerator) by the total number of all consumers over 18 years old who are eligible for employment (denominator) will provide the statewide proportion

¹³ In early planning, consumer indicators were designed for FSP clients only. However, RFP language for this project suggests that community activities around consumer mental health, which extend beyond FSP, are equally important to consider in MHSA reach and impact. Thus, consumer indicators may be relevant to FSP clients and non-FSP clients in the current report.

of eligible consumers who are employed at the time of data collection. 2) Dividing the number of consumers over 18 years old who are employed for pay (numerator) by total number of consumers who are eligible for employment (denominator) will provide statewide employment-for-pay proportions. 3) Dividing the number of consumers over 18 years who are employed without pay (numerator) by total number of consumers who are eligible for employment (denominator) will provide statewide employment-without-pay proportions for TAY (18 years and older) and adult groups.

Stakeholder Informed Challenges and Limitations: Stakeholders suggested adding the number of days or period of time during which a consumer was employed. Stakeholders also noted that employment information in the DCR system was very limited, unlike the CSI system, which accounts for all types of employment (part-time, volunteer, etc.). The evaluation team would only have a robust understanding of consumer employment for persons who were not enrolled in FSPs – those who are more likely to be employed in part-time and volunteer work. Lastly, stakeholders offered that employment rates, like the economy, occur in cycles that could be overlooked in analyses if unaccounted for.

Domain 2: Homelessness/Housing

2.1 Indicator: Housing Situation/ Index-Score

Rationale for measures: To capture the variety of consumers' housing situations, five counts should be conducted. Among these, we recommend a count of days that 1) child consumers and TAY consumers under the age of 18 (considered herein as dependent youth) live in a family home annually; 2) child consumers and TAY consumers under the age of 18 live in a foster home annually; 3) TAY over 18 (legally considered adults), adult consumers, and older adults are homeless. Further, we recommend 4) a count of TAY over 18 and adults with independent residential statuses as well as 5) a count of TAY over 18, adults, and older adults who are not homeless (have any type of housing). Counts are not summative; rather, they provide statewide statuses of the housing types being used by consumers, to what extent, and the level of need (homelessness).

Stakeholder Informed Challenges & Limitations: Stakeholders noted three challenges: 1) both homelessness and housing can change often among the group, yielding complex data. Stakeholders suggested becoming familiar with this particular data before conducting analyses because of its ever-changing nature. 2) Housing data from the CSI system is not updated as regularly as data from the DCR system, and lag might create inaccuracies in the evaluation. 3) Children who are homeless by way of homeless parents are not captured by the DCR. That is, a child who is with one or both parents can be categorized as “housed” without any indication or measure of his or her parents’ living situation. Thus, housing information in the DCR is inaccurate. Beyond data challenges, stakeholders offered that adding the number of days a consumer is housed would be useful to understand housing stability.

Domain 3: Justice Involvement

3.1 Indicator: Justice Involvement

Rationale for measure: Number of consumer arrests within 12 months will be collected to track statewide rates that may or may not be related to consumers’ mental health episodes.

Stakeholder Informed Challenges & Limitations: Stakeholders described different ways to conceptualize “arrests” to create a more specific indicator definition. Some suggested counting incarcerations instead of arrests given that intercession by FSP teams sometimes prevents incarceration. Others suggested counting new arrests given that consumers might be re-arrested for the same offense due to probation violations. Also, the term “episode” was contested as it did not account for chronic mental health issues. In sum, further revision of what is meant by Justice Involvement is needed. In addition to clarifying the indicator, stakeholders suggest adding the number of days a consumer is held to create a rate that can be followed over time.

Domain 4: Emergency Care

4.1 Indicator: Emergency Interventions for Mental Health Episodes

Rationale for measures: Dividing the number of mental health-related hospitalizations (numerator) by the number of consumers’ hospital visits within 12 months will give an indication of episode severity, crisis, and rate of acute hospitalization for mental health management/intervention. Indirectly, the ratio will give an indication of consumers’ quality of life related to mental health.

Stakeholder Informed Challenges & Limitations: Stakeholders suggested that creating an appropriate Emergency Care indicator could be difficult given that 1) visits to the emergency room and hospitalization are distinct in the DCR system, and 2) the CSI is not regularly updated with visits and releases from medical facilities. Among additions to the proposed priority indicator, stakeholders proposed adding the number of days a consumer spends in emergency care given that FSP interventions might yield a shorter psychiatric stay.

4.2 Indicator: Emergency Interventions for Co-occurring Physical Injury

Rationale for Inclusion: Dividing the number of physical injury or physical health-related hospitalizations (numerator) by the number of consumers' hospital visits within 12 months will give an indirect measure of mental health crisis given that mental and physical health are often interrelated (per stakeholder feedback). The ratio is a secondary measure of consumers' quality of life related to mental health.

Domain 5: Social Connections

5.1 Indicator: Proportion Who Identify Family Support

Rationale for measures: Dividing the number of family members the consumer identifies as reliable supporters, or persons who are consistently present for the consumer, by the total number of mental health consumers annually will help identify the breadth of a consumer's local (family) network – one that optimally provides ongoing and immediate support even in times of mental health distress.

5.2 Indicator: Proportion Who Identify Community Support

Rationale for measures: Dividing the number of non-family members the consumer identifies as reliable supporters by the total number of consumers, and the number of organizations from which the consumer receives regular, voluntary, and quality services by the total number of consumers, will provide a measure of consumers' social network. The social network is one that should provide consumers steadfast support toward sustaining mental health.

Mental Health System-level Outcomes for All Consumers Measurement Detail

System-level priority indicators (related to consumer access, agency performance, and agency structure) explain how operations changed or may have been enhanced by the MHSA.

Domain 6: Access

6.1 Indicator: Demographic Profile of Consumers Served

Rationale for measure: Descriptive statistics of the age, gender, and race/ethnicity of the service population (overall and specific to FSP consumers) will provide demographic description of

those receiving services within and across counties, and allow for examination among populations in need (e.g., homeless, unemployed).

Stakeholder Informed Challenges & Limitations: Demographic information (i.e., ethnicity, gender) contained in the DCR is imported from the CSI database. Thus, any FSP consumer not registered in the CSI system will have incomplete demographic information in the DCR database.

6.2 Indicator: New Consumers by Demographic Profile

Rationale for measure: Descriptive statistics concerning the age, gender, race/ethnicity of new consumers (i.e., less than 6 months of service receipt) will provide an understanding of who new consumers are and some indication of the populations which are being reached. Additionally, demographic descriptions of existing consumers (i.e., more than 6 months of service receipt) will provide context for evaluating the makeup of new consumers and might give indication that historically underrepresented groups are seeking and/or receiving services.

6.3 Indicator: High Need Consumers Served

Rationale for measure: Accurate counts of homeless and unemployed consumers served through the FSP program can provide understanding of the extent to which these high need consumer groups are being served. Alternately, the numbers of homeless and unemployed among all mental health consumers will provide evidence of service to these groups overall, and provide a relative basis with which to evaluate the extent of service to high need consumer groups through FSP.

Stakeholder Informed Challenges & Limitations: Stakeholders expressed concerns that variables included in the CSI database, such as Living Situation and Employment, may not be updated regularly for non-FSP consumers. If these items are found to be unreliable, high need consumer served through non-FSP programs may not be accurately described.

6.4 Indicator: Access to Primary Care Physician

Rationale for measure: Tracking the number of FSP consumers with access to a primary care physician will provide evidence of the extent to which FSP services may be helping to connect consumers with the health care they need.

Stakeholder Informed Challenges & Limitations: Stakeholders expressed concerns that CSI data regarding access to a primary care physician may not be reliable. If this information is not reliably reported, access to a physician among all mental health consumers cannot be accurately assessed and comparisons to FSP consumers cannot be made.

6.5 Indicator: Consumer / Family Perceptions of Access to Services

Rationale for measure: Aggregate ratings of consumer and family perceptions of the extent to which they are able to connect with the services they need will provide evidence of the accessibility of MHSA services from the perspective of the consumer.

Domain 7: Performance

7.1 Indicator: Consumers Served Annually through CSS

Rationale for measure: The number of consumers served annually through CSS (i.e., consumers overall, FSP consumers) relative to those who were targeted for service will allow for CSS service rates to be understood in the context (e.g., type and extent of need among various consumer populations) of the county in which the services were provided. In this case, grounding service rates in county context will provide a more accurate account of service levels/performance than a simple count of consumers.

Stakeholder Informed Challenges & Limitations: Stakeholders expressed concerns that Exhibit 6 is not a reliable source for information regarding consumers targeted or served through CSS programs due to the various ways in which counties define these categories. If data regarding consumers targeted or served is found unreliable across counties, the ratio of those served to targeted consumers statewide cannot be accurately estimated.

7.2 Indicator: Involuntary Care

Rationale for measure: The ratio of those who received Involuntary Services (e.g., Evaluation and Treatment, Temporary or Permanent Conservatorships, Seclusion and Restraint) to all consumers served will allow for greater understanding of this service relative to the consumer population. Such measures provide for more accurate evaluation of services within and between counties as well as statewide. Alternatively, the ratio of those receiving Involuntary Services to populations of interest (i.e., adults, homeless, unemployed) will allow for evaluation of the performance of these services within and between consumer groups.

7.3 Indicator: 24-hour Care

Rationale for measure: The ratio of 24-hour care to consumer populations (i.e., Statewide, by County, TAY, Adult, Older-adult populations – MHRC, SNF, SH; Child populations – CTF, RCL 14, MHRC) will provide an accurate assessment of the performance/extent of these services relative to the size of population for which they were intended. As an alternative, demographic profiles of consumers (consumers overall and FSP consumers specifically) receiving these services may provide useful information regarding the consumer groups who utilize such intense services most. Another measurement option would involve counts of readmissions to acute care facilities (among consumers overall and FSP consumers specifically), which can provide indication of how often consumers require this type of care.

7.4 Indicator: Appropriateness of Care

Rationale for measure: Aggregate consumer and family ratings of appropriateness of care will provide an understanding of how services are perceived on average. As an alternative, average length of stay in acute care (among consumers overall and FSP consumers specifically) can provide evidence of the extent to which such intensive services are utilized, which may be more or less appropriate for different consumer groups. Another alternative would be the existence of standard protocols for treating co-morbidity. Issues such as substance abuse often co-occur with mental health issues, thus the existence of treatment protocols for co-morbidity will provide evidence of the existence of appropriate care for such consumers.

Stakeholder Informed Challenges & Limitations: Assessing treatment protocols for co-morbidity would require extensive document review to establish their existence in each county, and additional data collection (e.g., surveys or interviews) to assess whether they are appropriately applied.

7.5 Indicator: Continuity of Care

Rationale for measure: Use of emergency services among consumers (consumers overall and FSP consumers specifically) may provide evidence of the connection of such services with those they have previously received or are currently receiving. A measure of services provided in community settings may be created from data regarding residential status and living situation. The existence of discharge plans may provide evidence to the continuity of consumers' paths to recovery. However, the later measures may require additional data collection.

Stakeholder Informed Challenges & Limitations: Comprehensively assessing continuity of care may require extensive document review or additional data collection (e.g., surveys or interviews).

7.6 Indicator: Penetration Rate

Rationale for measure: The ratio of consumers who receive mental health services to the number of persons considered “high need” (e.g., homeless, unemployed) will present the reach of CSS programs into various populations within each county. Alternately, the ratio of mental health consumers served to Holzer Targets in each county would provide indication of the extent to which CSS services are reaching those with serious mental illness/serious emotional disturbance.

Stakeholder Informed Challenges & Limitations: Stakeholders have expressed concern about the reliability of Exhibit 6 data. If such data proves unreliable, the penetration of CSS services among populations in need cannot accurately be assessed.

7.7 Indicator: Consumer Wellbeing

Rationale for measure: Consumer and family member aggregate ratings of improvement in functioning and quality of life will provide important measures of the perceived impact of services on average from the consumer perspective. As these measures only tap two elements of wellbeing, additional qualitative primary data collection may supplement these ratings by providing more rich understanding of how services impact consumers’ wellbeing.

Stakeholder Informed Challenges & Limitations: Different sampling methods for consumer perception survey respondents have been employed over time, which may have implications for analysis and any conclusions drawn. Additional qualitative and quantitative data collection may be needed to create an indicator of wellbeing, which is sensitive to county context and the backgrounds of consumers and their families.

7.8 Indicator: Satisfaction

Rationale for measure: Aggregate consumer and family member ratings of satisfaction with care or service will provide an indication of consumers’ perceived services on average.

Domain 8: Structure

8.1 Indicator: Workforce Composition

Rationale for measure: The ratio of staff to consumers will generate a measure of the size of the workforce relative to the consumer population in each county. As an alternative, comparison of the demographic makeup of the workforce and consumer populations will provide insight into how well the workforce reflects those they serve. Another option would be to consider consumer and family member employment in the mental health system (i.e., number, FTE, percent of workforce), which would provide evidence of the extent to which consumers have been integrated into the service process.

Stakeholder Informed Challenges & Limitations: Stakeholders expressed concern about the reliability of workforce data in Cultural Competence Plans and WET Plans over time at the program level. Without a valid source of data regarding workforce makeup, the appropriateness of the workforce for serving the current consumer population cannot be assessed.

8.2 Indicator: Evidence-Based/Best Practice Programs and Services

Rationale for measure: The type and number of evidence based or best practice programs implemented in each county would provide indication of the extent to which established high quality programs are being implemented within counties and across the state. Additionally, the extent to which evidence based or best practice programs are being implemented with fidelity would provide indication of the quality of these programs as implemented. Alternatively, the frequency and experience of evidence based or best practice services would provide important evidence of the usefulness of these programs from the consumer perspective. However, the latter measures would require additional data collection.

Stakeholder Informed Challenges & Limitations: Stakeholders expressed concern that the fidelity with which evidence-based services are implemented is not captured by the relevant CSI item. Thus, it is recommended that additional data collection (e.g., surveys, interviews, or focus groups) be conducted to assess the fidelity of reported evidence-based program implementation.

8.3 Indicator: Cultural Appropriateness of Services

Rationale for measure: Consumer and family member aggregate ratings of cultural appropriateness of services will provide an important measure of the perceived adequacy of services with regard to consumers' cultural needs. However, only a single survey item directly taps cultural appropriateness of services, thus it will be necessary to augment existing data collection or consider additional data collection in order to create an adequately robust measure.

8.4 Indicator: Recovery, Wellness, and Resilience Orientation

Rationale for measure: Measurement of recovery, wellness, and resilience orientation may provide evidence of the extent to which county mental health systems and the state overall are adhering to and achieving stated values and goals. No comprehensive measure of the recovery, wellness, and resilience orientation is currently collected; however, options for established measures exist (e.g., Recovery Oriented Systems Indicators Measure, Developing Recovery Enhancing Environments Measure).

Stakeholder Informed Challenges & Limitations: Any measure of recovery orientation must be sensitive to, and informed by, the unique needs and circumstances of diverse cultural, ethnic, regional, and age groups across the state.

Stakeholder Feedback

Through the feedback process detailed earlier in this report, stakeholders across the state provided unique and well informed perspectives, thoughtful reaction and insight regarding the proposed data sources and methods for calculating all priority indicators. Stakeholders' specific concerns regarding limitations or challenges of individual indicators can be found in the *Mental Health Indicator Measurement Detail* section. A table of categorized stakeholder feedback is located in Appendix B. Feedback regarding proposed data sources and methods for calculating all priority indicators presented to stakeholders in the initial draft of this report fell largely into the two domains below:

Types of Stakeholder Feedback and Corresponding Revisions

- *Data source availability and quality.* Possibly the most common feedback theme was centered on the availability, accuracy, and reliability of data to inform the proposed indicators. Repeatedly, the evaluation team was warned about the completeness and accuracy of existing data (e.g., DCR, CSI, Exhibit 6, and client perception surveys). While many stakeholder concerns in this regard will be verified by a thorough review of existing data, the unique insights and historical knowledge of data integrity within specific counties and throughout the state was central to our revisions of the proposed sources of data to be used to compose priority indicators. As an example, stakeholders expressed concern that many indicators could require additional primary data collection in order to comprehensively capture factors such as Workforce Composition, as they suggested existing sources were incomplete or unreliable.
 - *Corresponding revisions.* Based upon feedback regarding data concerns, several indicators were revised to include alternative existing data sources, potential external data sources (e.g., census data), or proposals for additional primary data collection. Additionally, a data quality review process, outlined in the next section, will provide more detailed knowledge of where the inconsistencies or irregularities may be among existing data sources and present logical and practical possibilities for rectifying them.
- *Appropriate indicator calculations.* The indicator calculations proposed in the initial draft of this report were largely supported; however, alternative methods of calculation were suggested for a handful of indicators. For example, Holzer Targets were suggested as accurate estimates of the prevalence of serious mental illness or serious emotional disturbance in California, for use in calculating penetration rate.

- *Corresponding revisions.* Based upon feedback regarding alternative calculations, several indicator calculations proposed in this report reflect revisions to ensure they are most appropriate for providing accurate estimation of their respective element of the MHSA system or consumer experience. One such revision was including Holzer Targets as part of an alternative method for calculating penetration rate. Many such revisions to incorporate stakeholder feedback regarding alternative indicator calculation or data sources have been integrated throughout this report.

Conclusions

Per our objectives, the evaluation team located survey items (variables) that could be used to construct priority indicators and outlined protocols and rationale for calculating each measure. Also, where existing data was not sufficient, measures and indicators for which additional data collection may be helpful (i.e., supplementary) or necessary were noted. This information was guided by stakeholders' historical knowledge of data sources. All measurement domains, priority performance indicators, calculation of measures (recommended and alternative), the databases or reports from which items can be drawn, and the specific items within each dataset or report were displayed in a series of templates.

Overall, this report was an important step in defining and refining the priority performance indicators to the very practical item level. While this framework for constructing indicators is comprehensive of all priority performance indicators, flexibility exists with regard to how each measure may be constructed, which is reflected in the *alternate* measures and methods of calculation highlighted throughout the templates. To refine the measure of each indicator and solidify the methods of calculation for each measure, the UCLA/EMT team must conduct a thorough data quality review.

Next Steps

Data Quality Review

As of this report, access to most data sources listed in the report templates has not been granted. Once data associated with each item (variable) can be reviewed, we will systematically determine data quality and completeness as well as item appropriateness for each measure/indicator using the following criteria. The data quality review will also take into account input from experts in the field who hold expertise regarding data collection and analysis generally and specific to the data sources specified in this report. This process will drive further development of the indicator template and recommendations regarding existing and additional data collection. The criteria, also outlined in the report *Templates for Reporting Priority Indicators, Deliverable 2A*, must include:

- Adequate base rate (i.e., the rate at which an event occurs or level at which a scaled response is given on average, must not be so low as to make the indicator useless or meaningless)
- Adequate variance (i.e., values of a given measure must be sufficiently distributed through the range of the measure to support analysis)
- Validity
 - The measure is *face valid*, can conceptually and logically be said to measure what it was intended to
 - The performance measure is *internally valid* and can logically be tied to a particular program intervention or outcome
 - The indicator is *externally valid* and can logically be generalized to other populations or programs
- Reliability (i.e., the indicator is consistent over time and cases)
- Availability and completeness of indicator relevant data which is obtainable and complete for populations of interest (e.g., age groups, gender, race/ethnicity, socioeconomic status) for the period of time under study
- Ability to be aggregated to county and state levels

Further, templates are not analysis plans that describe what can be learned for specific mental health consumer groups (e.g., women, Native Americans, "high need," etc.). Rather, they present priority indicators and their proposed measurement across four prescribed age groups – children, TAY, adults, and older adults. Attention to consumers by demographic group exists within system level indicators (refer to Template 2), but exactly what information indicators can provide cannot be stated without a full review of mental health service data. Following review of the data, the evaluation team can make more definitive statements about which demographic groups (age groups excepted) can be described.

Initial Reporting of Results for Priority Indicators & Stakeholder Input

This report and its companion document (“Templates for Reporting Priority Indicators”, deliverable 2B) will be the foundation for a forthcoming report (deliverable 2E), which details results for all priority indicators at the statewide level and three subsequent county level reports. For each of these subsequent reports, stakeholder input will continue to be a vital part of the report development and revision process, so as to ensure appropriate and accurate monitoring of MHSA consumer outcomes and mental health system processes.

Appendix A

Participating Organizations and Agencies (In Alphabetical Order)

Individuals and groups from the following entities received an e-mail announcing the availability of MHSA Evaluation Team contract deliverables 2A and 2C. It is possible that more persons than are listed received the call through message forwarding. Thus, the following list was created to the best of the team's knowledge and e-mail verification.

- APS Healthcare
- Association of Community Human Services Agencies
- Bonita House
- California Association of Social Rehabilitation Agencies
- California Community Colleges Chancellor's Office
- California Department of Aging
- California Department of Mental Health
- California Institute for Mental Health
- California Mental Health Director's Association
- California Mental Health Planning Council
- California Network of Mental Health Clients
- Contra Costa County Health Services Department
- California Council of Community Mental Health Agencies
- EMQ Families First
- Humboldt County
- California Mental Health Directors Association Indicators, Data, Evaluation Accountability (IDEA) Committee
- Los Angeles County Department of Mental Health
- Mental Health America of California
- Mental Health America of Los Angeles
- MHSA Partners
- Mental Health Services Oversight and Accountability Commission
- Monterey County
- National Alliance on Mental Illness – California
- Nevada County
- Orange County Behavioral Health Services
- San Bernardino County Department of Behavioral Health
- San Diego County
- San Francisco Department of Public Health
- San Joaquin County Mental Health Board
- Seeds of Hope
- Shasta County Health and Human Services
- Turning Point Community Programs
- United Advocates for Children and Families

Appendix B

Table 1: Types of Stakeholder Feedback Received (Summary)

Domain	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Domains incomplete (changes suggested)	Domains incomplete (additions suggested)	Request for clarification
1. Employment/ Education			●	●	●	●
2. Homelessness/ Housing Situation			●		●	●
3. Justice Involvement			●	●	●	
4. Emergency Care			●		●	
5. Access			●			●
6. Performance			●			
7. Structure	●	●	●	●	●	●

Additional domains suggested:

Alcohol and Other Drug Use (AOD)
 Co-occurring physical health disorders
 Social connections

Additional data sources:

Claiming process
 Recovery Oriented Systems Indicators Measure (ROSI) / Developing
 Recovery Enhancing Environments Measure (DREEM)

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
1. Employment/ Education						●
<i>1.1 Education</i>			●	●		
<i>1.2 Employment</i>			●	●	●	
2. Homelessness/ Housing Situation			●		●	●
3. Justice Involvement				●	●	
4. Emergency Care			●	●	●	
5. Access						
<i>5.1 Demographic Profile</i>			●			
<i>5.2 New Consumers by Demographic Profile</i>			●		●	

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
<i>5.3 High Needs Consumers Served</i>			●	●		●
<i>5.4 Access to Primary Care Physicians</i>	●		●			●
<i>5.5 Consumer/ Family Perceptions of Access to Services</i>						
6. Performance						
<i>6.1 Consumers Served Annually Through CSS</i>			●			
<i>6.2 Involuntary Care</i>						
<i>6.3 24-Hour Care</i>						
<i>6.4 Appropriateness of Care</i>			●	●		
<i>6.5 Continuity of Care</i>			●	●		

Table 2: Types of Stakeholder Feedback Received (Detailed)

Indicator	Alternative domain/measures suggested	Alternative data sources suggested	Challenges with associated data noted	Indicator incomplete (changes suggested)	Indicator incomplete (additions suggested)	Request for clarification
<i>6.6 Penetration Rate</i>			●	●		
<i>6.7 Consumer Wellbeing</i>			●			
<i>6.8 Satisfaction</i>						
7. Structure						
<i>7.1 Workforce Composition</i>	●		●			●
<i>7.2 Evidence Based/Best Practice Programs and Services</i>	●		●	●		
<i>7.3 Cultural Appropriateness of Services</i>		●	●			●
<i>7.4 Recovery, Wellness, and Resilience Orientation</i>			●		●	

Appendix C

Matrix of California's Public Mental Health System Prioritized Performance Indicators

To Begin Implementation of California Mental Health Planning Council's Approved Performance Indicators

Type of Indicator	DOMAIN			
	Age Group	Education/Employment	Homelessness/Housing	Justice Involvement
Individual Client Outcomes* (for Full Service Partnerships)	Children	Indicator #2: Average Attendance—Score per year	Indicator #1: Housing Situation/Index--Score	Indicator #1: Number of Arrests
	TAY	Indicator # 8: Under 18 years—Average Attendance--Score per year 18+ --Proportion participating in paid and unpaid employment*	Indicator #7: Housing Situation/Index--Score	Indicator #7: Number of Arrests
	Adults	Indicator #13: Proportion participating in paid and unpaid employment*	Indicator #12: Housing Situation/Index--Score	Indicator #12: Number of Arrests
	Older Adults	Indicator #13: Proportion participating in paid and unpaid employment* (Explore feasibility of Indicator #20--Instrumental Activities of Daily Living)	Indicator #17: Housing Situation/Index--Score	Indicator #17: Number of Arrests
County Mental Health System Performance	Indicators #5, 6, 11, 16, 21: Family/Youth/Client Perception of Well-Being Indicator # 30: Age, Gender, Race/Ethnicity of entire FSP population Indicator # 31: Access of FSPs to Primary Care Physician Indicator # 33: Penetration Rate → 03/04 and 06/07 data already provided from CSI Indicator # 34: New Clients by county by age, gender, race ethnicity for FY 04/05 and FY 07/08 from CSI. (New clients are those without service for prior 6 months.) Indicator # 35 or # 37: Involuntary Care—3 day and 14 day commitments Indicator # 43: Annual Numbers Served through CSS from Exhibit 6 of FSPs, General System Development and Outreach/Engagement. Workforce Indicators #s 45 & 46: To Be Requested for the Development of Five-Year Plan			
Community Indicators	None At This Time			

Frequency of Data Request: Individual: Baseline and Annual Data (Y1, Y2, etc.); System: Annually Beginning 04/05; Begin with statewide and regional reports; then produce county specific reports.

* Participation in Education not available.

This Matrix contains selected indicators from the "California Mental Health Planning Council's Performance Indicator Proposal for the Mental Health Services Act, September 2009"