



CALIFORNIA'S MENTAL HEALTH SERVICES ACT—STATEWIDE EVALUATION
“PRIORITY INDICATORS TRENDS REPORT”
INTERPRETATION PAPER

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MENTAL HEALTH SERVICES OVERSIGHT & ACCOUNTABILITY COMMISSION
“PRIORITY INDICATORS TRENDS REPORT”
INTEPRETATION PAPER

The Mental Health Services Act (MHSA), passed by voters in 2004 and implemented in 2005, was designed to improve the quality of life for Californians living with mental illness and support transformation of the public mental health system. The Mental Health Services Oversight and Accountability Commission (MHSOAC) was established to oversee programs and services funded through the MHSA. As part of this role, the MHSOAC is committed to carrying out meaningful evaluation focused on the MHSA and the broader public community-based mental health system. The MHSOAC partners with State and local agencies to access available data and information to use for evaluation purposes. The Evaluation Master Plan, adopted by the MHSOAC in 2013, highlights the importance of implementing a system to continuously monitor mental health system performance and support quality improvement efforts of systems and services over time. The “Priority Indicators Trends Report” represents a critical step forward in understanding the strengths and limitations of existing data and implementing a reliable and meaningful system to monitor performance of California’s publicly funded mental health system and support ongoing continuous quality improvement efforts at the State and local level.

What are priority indicators and how are they used?

In 2010, the California Mental Health Planning Council (CMHPC), in collaboration with key stakeholders, adopted a set of performance indicators designed to measure outcomes at the individual and system levels in relation to MHSA funded programs and services within the Community Services and Supports (CSS) component. Following extensive assessment of the initial performance indicators, a core set of 12 “priority indicators” was identified. The selection of these 12 priority indicators was informed by stakeholder and consumer input and guided by a number of assessment criteria including the quality and completeness of available data. The *Priority Indicators Trends Reports* prepared by the University of California, Los Angeles Center for Healthier Children, Families and Communities in collaboration with Trylon Associates is the second set of reports using these 12 priority indicators to monitor the performance of MHSA funded programs over time at the State and county levels. The first set focused on indicators for fiscal years 2008/09 and 2009/10 and was released in October 2012. The current set—the Priority Indicator Trends Reports—focuses on fiscal years 2004/05 through 2011/12. Both sets of reports include a

Priority Indicators

- Consumer Outcomes
 - School Attendance
 - Employment
 - Homelessness and Housing
 - Arrests
- System Performance
 - Demographic Profile of Consumers Serviced
 - Demographic Profile of New Consumers
 - Penetration of Mental Health Services
 - Access to a Primary Care Physician
 - Perceptions of Access to Services
 - Involuntary Status
 - Consumer Well-Being
 - Satisfaction with Services

statewide summary, as well as individual county-level reports. Information presented in these reports is intended to support ongoing quality improvement and data strengthening efforts throughout California's publicly funded mental health system.

The Priority Indicator Trends Reports provide descriptive information regarding consumers served through MHSA funded programs with the CSS component for fiscal years 2004/05 through 2011/12. This information provides an understanding of the history, needs, and demographic composition of the service population throughout California communities and statewide. Additionally, the reports are intended to provide insight into how this consumer population may have changed over time, as programs and services matured and expanded to include new population groups and service models. However, severe limitations with the currently available data hinder the confidence with which solid conclusions can be drawn from the results described within the reports.

How useful has the currently available data been in calculating the priority indicators?

To calculate priority indicators, the MHSOAC is reliant on data made available by the Department of Health Care Services (DHCS), who were given ownership of mental health datasets (e.g., the Data Collection and Reporting system for Full Service Partnerships, the Client and Services Information system for all consumers served via CSS) in January of 2013. The MHSOAC has identified significant problems with this data that limit its accuracy and utility for performance monitoring and other evaluation. DHCS have acknowledged these issues and have begun to work with the MHSOAC to identify ways to address our concerns. Until these concerns are fully addressed, the MHSOAC are reliant upon use of the DHCS data systems. As such, we have taken precautionary steps as we've guided the evaluators from UCLA as they have used the available data to calculate indicators and develop the Trends Reports. For example, a workgroup was established and charged with assessing the available data and considering how best to use it to calculate each of the 12 priority indicators. The UCLA evaluators were first asked to develop a data quality report that described the available data and proposed possible calculation methods. In an ideal situation, the same calculation methods for each indicator would be identified for use across fiscal years and service populations (e.g., for Full Service Partnership clients and CSS clients). Exploration of the available data by the evaluators and workgroup members led to the conclusion that this was not always a possibility, due to varying sample sizes and even varying survey methodologies across years. In addition, highly concerning issues were identified with some specific variables/data elements (e.g., race/ethnicity). After exploring such issues and considering how best to address them, in some instances, it was decided that the most cautious way to proceed would be to simply not use questionable variables (which is what occurred with race/ethnicity). This highlights the significant challenges that were faced—and in some cases challenges that have yet to be overcome—as we've moved forward to try to use currently available data to calculate the priority indicators. In sum, results of the Trends Reports must be interpreted with extreme caution due to significant limitations with the currently available data.

What do the priority indicators tell us?

Trends across fiscal years at the state and county level reveal some positive developments among specific indicators and populations; however, the large amount of missing or incomplete data make it difficult to draw comprehensive conclusions regarding the impact of MHSA or confidently make comparisons across years or between service areas. The Trends Reports provide a critical next step in understanding the extent and potential sources of data quality issues while underscoring the critical need for improved data collection and data management strategies at the state and county level. Despite these limitations, some notable findings do emerge from the reports; a few of which are highlighted below.

- There was a dramatic increase in the number consumers served through Full Service Partnerships (FSPs) during the first four years following passage of the MHSA.
- During the study period, there was an increasing trend in the proportion of children/youth, transition-age-youth, and older adults served by the mental health system. This trend suggests that the MHSA is supporting the expansion of services to previously underserved populations.
- There is some suggestion that FSP programs are supporting consumers' transition out of homelessness, although the large amount of missing data regarding housing status for FSP and non-FSP consumers makes it difficult to confidently draw conclusions regarding the impact of the MHSA on improved housing stability.
- There appears to be a positive relationship between time in service and improved housing stability for some consumer populations. The longer TAY and older adult consumers were engaged in FSP services, the less likely they were to report homelessness.
- The proportion of new FSP consumers with reported arrests in the year prior to service trended down across years, indicating a potential shift in the characteristics of new consumers as the programs matured.
- Statewide, there was a significant increase in the penetration rate for children and youth served by the publicly funded mental health system. This finding is encouraging, and appears to reflect a positive impact of the MHSA on system improvement for these populations.
- For all consumers, the estimated numbers of individuals in need of public mental health services expanded in each fiscal year, yet the total number of consumers served at the state level did not increase at a rate required to keep pace with the expanding need.
- The percentage of FSP consumers (particularly for adults and older adults) reporting access to a primary care physician increased significantly between fiscal year 2006/07 and 2011/12. This age-related finding is particularly important when considering the challenges faced by adults and older adults in finding healthcare options.
- The percentage of children and transition age youth reporting access to a primary care physician while participating in FSPs also increased during the reporting period.

The Trends Reports provide detailed information regarding data quality issues and reinforce the importance of continued investment in improved data collection systems, processes, and quality assurance efforts.

- Based on data collected bi-annually through the Consumer Perception Survey (MHSIP Consumer Survey), arrest rates during services tended to be lower than arrest rates prior to service across age groups for the majority of fiscal years. Youth tended to see the largest decline in arrest rates before and during services.
- Statewide, there was a statistically significant decline in the rate of adults involuntarily confined to 72-hour inpatient psychiatric treatment. However, the rate of involuntary detention for children remained fairly constant over the study period.
- Survey responses regarding consumers' perceptions of "access to" and "satisfaction with" services statewide and at the individual county level suggest that consumers agree that they have access to services and are satisfied with those services.
- When asked to rate their perception of well being as a result of mental health services, most consumers indicated positive ratings.

What trends stand out at the county level?

The county level Priority Indicator Trends Reports provide valuable information regarding a range of challenges and opportunities for enhancing service delivery and improving data quality among California's diverse county landscape. By consolidating available information regarding consumer outcomes and system performance, the individual county reports represent a valuable resource for providers, mental health administrators, consumers, and other stakeholders. A few notable patterns emerging from the county level reports are highlighted below.

- Consumers in several counties tended to transition overtime out of homelessness and into independent or group care living situations while participating in FSP services. This finding appears to provide support for the positive impact of FSPs on reducing homelessness among consumers.
- Penetration rates for mental health services vary substantially between counties. Several individual counties made considerable progress regarding the penetration rate of mental health services (e.g., the number of consumers receiving direct services in relation to the estimated number likely to be in need of publicly funded mental health services within a particular county). Progress made in those counties which exceed penetration rate goals for all demographic groups is encouraging, and may reflect a positive impact from the MHSA. However, based on available data, there were several counties that did not experience a growth in mental health services in line with the corresponding increase in the estimated need across years. Additional study within these counties is needed to determine whether this trend is the result of poor data quality or other dynamics.
- There was substantial variation between counties in the rate of involuntary confinement in psychiatric facilities. While the rate of involuntary detentions remained constant or increased in several counties, a number of counties experienced significant declines in their use of involuntary detention. This is an area which deserves additional examination to identify the factors impacting the use of involuntary detention and the different approaches implemented across counties. Additionally, missing or incomplete data submitted to the State by many counties makes it difficult to assess the reliability of these trends.

What are the gaps and limitations in the existing data and measures?

Limitations regarding the quality and completeness of existing data at the State level continue to present a significant challenge to the MHSOAC and hinder our ability to effectively monitor program performance and support ongoing quality improvement efforts. Statewide mental health data quality issues have been recognized for some time; however, completion of the Priority Indicator Trends Reports provided valuable details regarding the specific challenges and limitations of existing data, as well as recommendations for moving the State forward in this area.

- The large amounts of missing data in general limits the utility of the data and the results presented in the Trends Reports. It is recommended that the MHSOAC continue to support DHCS and the counties in helping all entities strengthen their historical and current mental health data, including the processes through which the data are collected, verified/validated/corrected, and submitted to the MHSOAC.
- Issues pertaining to consumers' race and ethnicity (e.g., missing and inconsistent data) prohibited meaningful analysis for many of the priority indicators that depended on these variables. It is recommended that the MHSOAC continue to work with DHCS and relevant counties to identify how to strengthen these very important data elements, including those from past, current, and forthcoming years, so that they can be used for statewide and individual county analyses in the future.
- Analysis of indicators for FSP consumers was not possible for a number of counties since they had not submitted records to the DCR at the time the data was made available to the evaluation contractor. Lack of available DCR data for MHSOAC use was attributable to problems at the county level in some instances, and problems at the DHCS (e.g., inability to certify XML counties until recently, which left non-certified XML counties without the ability to submit DCR data to DHCS). It is recommended that the MHSOAC continue to identify the challenges that contribute to poor data quality and keep working with counties and DHCS to overcome those challenges.
- Measuring change in individual consumer outcomes is substantially limited due to inconsistencies in the way that information is collected following program intake. For example, high levels of missing information post-intake for data needed to calculate indicators for FSPs and all consumers (e.g., education, housing, and access to a primary care physician) raise a number of concerns regarding the utility of these indicators to support policy or programmatic changes. In addition, current data collection procedures at the State level do not support the use of a standardized follow-up period (e.g. 6-, 12-, or 24-months after service initiation) to calculate change in individual consumer progress in many domains (e.g. education, employment, and housing).
- The ability to understand if consumer functioning actually changes as a result of service initiation will also continue to remain limited unless this issue is addressed. It is recommended that the MHSOAC explore the possibility of strengthening its ability to evaluate change in outcomes over time as a result of CSS services.

Post-intake consumer information is not consistently collected, making it difficult to measure individual change over time.

- County level data on the use of involuntary detentions is incomplete for most fiscal years. If the MHSOAC intends to continue to use this data as an indicator of the extent to which the recovery vision has been implemented, it is recommended that we work with DHCS to ensure our receipt of individual county-level data.
- Changes in the sampling approach used in the Consumer Perception Survey (CPS) prevented direct comparison of trends across multiple fiscal years. Additionally, the inability to link CPS survey data to a single consumer prohibits the ability to assess individual change in outcomes among all mental health consumers over time (e.g., school attendance, arrest rates). The current CPS survey methodology appears to be out of compliance with current federal administration requirements. It is recommended that MHSOAC encourage DHCS to work toward getting the CPS methodology in compliance with federal standards as soon as possible. Until the methods are solidified, it is unlikely that the CPS will be a useful source of data at the county or State levels.
- It is not currently possible to calculate all priority indicators in meaningful ways that are consistent across service programs and populations, or fiscal years. As such, comparisons made across programs, populations, and fiscal years may not be meaningful or useful within the context of understanding the performance of our mental health system. Until this issue is rectified, the ability for the MHSOAC to use currently available data to identify what aspects of the mental health system are working versus those parts that need improvement is jeopardized. It is recommended that the MHSOAC keep this bigger picture perspective in mind within its current and forthcoming data strengthening efforts. It may be time to consider whether our current data collection and reporting systems will ever be able to provide the MHSOAC with data that will meet its needs in their current form. This consideration should be based on an understanding of the degree of malleability inherent in the current systems, the extent to which they do and do not meet our current needs, alternative data sources that may be able to meet those needs, as well as the costs and risks associated with continued reliance on the currently available systems.

Where do we go from here?

Give the current status of statewide data available to the MHSOAC, the greatest potential value of the Priority Indicators Trends Report is that it provides a comprehensive picture regarding the strengths and limitations of existing data at the State and county levels, and identifies specific needs and potential direction for improving the quality and completeness of data in future years. Several high-level recommendations for improving existing data quality and increasing performance monitoring capacity at the State level surfaced during this evaluation effort.

- The trends reports provide detailed information on existing gaps and limitations. Additional work should be done to understand the source of the data limitations and what steps, both short and long term, can be taken to address these issues. For example, determining which gaps can be partially addressed through renewed emphasis on data collection processes, procedures, and quality assurance efforts; and which limitations are the result of system design issues and will require longer term system modification and development work.
- In order to meet the diverse needs and challenges faced by California counties, technical assistance related to data collection and reporting should be offered in a number of forms, including, for example, online training modules (e.g., to provide individual 24/7 access),

regular in-person meetings and trainings, and in-depth personalized training and technical assistance that is provided to counties upon request.

- Continue to work collaboratively with federal, State, county, and provider agencies to identify potential new data sources to develop a more robust and comprehensive system of performance monitoring and quality improvement.
- Continue to partner with DHCS to identify ways to overcome the many challenges with the current statewide data collection and reporting systems.
- The MHSOAC in partnership with the CMHPC should continue to identify, evaluate, and implement new indicators using existing data sources at the State and local level. Potential data sources at the State level include California Department of Education, Department of Justice, Department of Social Services, and the Office of Statewide Health Planning and Development. Additional community mental health measures could incorporate data collected by the California Health Information Survey. Examples of county level data sources include consumer level outcome measurement tools such as the Milestones of Recovery Scale (MORS).