California's Community Mental Health Performance Outcome Report

Fiscal Year 2005-06

A Report to the Legislature in Response to

AB 1288, Bronzan
Chapter 89, Statutes of 1991

(Welfare and Institutions Code Section 5613)

CALIFORNIA DEPARTMENT OF
Mental Health

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EXECUTIVE SUMMARY

This report summarizes local mental health outcome data obtained over two fiscal years, FY 2004-05 and FY 2005-06. Findings are generally quite positive with respect to consumer and family/caregiver appraisal of services and outcomes associated with publicly funded mental health programs. Some minimal differences in results across age groups and specific outcome areas are addressed in the report. General findings are as follows:

- The majority of youth and family members/caregivers of youth reported improvement in family life and connectedness, coping ability, school functioning, social connectedness/competency, and general life functioning as a result of the mental health services. The majority of youth and family members/caregivers of youth were also satisfied with services as measured across four dimensions: Access to services, general satisfaction with services, perception of cultural appropriateness and perception of treatment involvement. Generally, youth reported slightly better outcomes and slightly lower satisfaction with services than family members/ caregivers.

- Regarding adult and older adult consumers, 56.3% to 74.8% of adults, and 63.6% to 85.1% of older adults reported improvement in both survey years as a result of services received, including, improved housing, reduction in symptoms, improved work/school functioning, increased social connectedness, increased family connectedness, improved ability in dealing with crises, improved ability to deal effectively with daily problems, and improved ability to control one's life. For both adults and older adults, the areas most positively impacted by services were abilities to deal with daily problems and to control one's life.

- Adult and older adult levels of satisfaction were measured across the following seven quality of life indicators: General life satisfaction, living situation, daily activities, family relationships, social relationships, safety, and health. For both age groups, the largest percentages of consumers were satisfied with living situation and safety. The large majority of adult and older adult consumers also positively evaluated mental health services as measured across four dimensions: Access to services, appropriateness of care, participation in treatment, and general satisfaction with services.

- Overall, older adults reported slightly better outcomes and slightly higher levels of satisfaction than adults. A slight decrease in older adult reports of quality of life in the most recent evaluation year were identified; although this decrease is minimal, efforts to understand its cause(s) and strategies to reduce the potential for further decrease are currently being considered.

- Future directions include MHSA-supported opportunities to advance with respect to performance measurement strategies and supporting information technology solutions. These include the MHSA Full Service Partnership outcomes assessment process and the Data Collection and Reporting System that has been designed to support it.

ISSUE STATEMENT

This document is a report to the Legislature as required by AB1288 (Bronzan, Chapter 89, Statutes of 1991), WIC Section 5613 which stipulates the following:

> *The Director of Mental Health shall annually make available to the Legislature data on county performance with regard to the performance measures established pursuant to WIC Section* 5612.

BACKGROUND

The Department of Mental Health (DMH) oversees public sector mental health service delivery throughout the State of California. State, county and community-level mental health service delivery organizations are expected to be accountable for the receipt of mental health service dollars and provide appropriate, cost-effective, and efficient solutions for individuals with serious mental illness, and those at risk for serious emotional, and consequent functional impairment.

DMH views accountability and quality improvement as critical components in achieving its mission. The passage of the Mental Health Services Act (MHSA), with its focus on accountability, has put additional emphasis on measuring the effects of transformative strategies and programs. DMH, as well as local mental health systems have embraced the spirit of the MHSA while realizing that performance measurement is a multifaceted and complex process. Measurement of consumer and system outcomes requires a sustained commitment to the continuous quality improvement process, and multi-stakeholder involvement. Consumers and family members, services providers, County and DMH Policy and Operations Units, Fiscal Auditors, the Mental Health Services Oversight and Accountability Commission, the Performance Measurement Advisory Committee, the State Quality Improvement Council, the California Mental Health Planning Council, and local (county) mental health boards and commissions all have key roles in the establishment of performance indicators, quality improvement strategies, and assurances of accountability.

This report describes findings obtained through surveys and other current information system data collection processes. The report also provides an overview of some of the more recent developments in performance measurement strategies, as well as information technology solutions that are in the process of being developed to better support these new efforts.

OBJECTIVE

The objective of this Annual Report is to provide the Legislature with performance information regarding California's county-based mental health programs. It is intended to fulfill the requirements of Welfare and Institutions Code Section 5613, which specifies that DMH must annually report to the Legislature on the impact of mental health services using uniform performance measures.

STUDY METHODOLOGY

This report summarizes performance outcome data obtained over two fiscal years, FY 2004-05 and FY 2005-06. During semi-annual, two-week sampling periods each fiscal year, consumers who received face-to-face community mental health services from county-operated and contract providers (and/or caregivers of child/youth consumers) completed surveys which measured their satisfaction and perception of the impact of services on their functioning and quality of life. The specific surveys administered during these sampling periods included the nationally developed Youth Services Survey for Youth (YSS-Y), Youth Services Survey for Families (YSS-F), Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, as well as California- adapted Quality of Life (QOL) measures. The surveys were available in the following languages: English, Spanish, Tagalog, Chinese, Korean and Vietnamese.

Most counties and providers reported the survey data to the California Department of Mental Health (DMH) using the integrated Web-Based Data Reporting System (WBDRS). This system provides internet-based, data entry methods including direct key-board/mouse entry, as well as a paper form scanning and verification option for larger volume, direct data submissions. This technology, in place for nearly four years, continues to be a reliable option for counties collecting and submitting data to DMH. It has also improved data quality and provided flexibility to survey item changes. Due to its ongoing success, DMH intends to upgrade this system in the near future (in addition to developing other performance measurement supporting information technology infrastructure) in order to be responsive to increasing accountability demands and quality assessment needs.

FINDINGS

Description of Populations

The following tables show gender and race/ethnicity information for the samples of children/youth, adult, and older adults who were surveyed across the two fiscal years covered in this report. The tables also display gender and race/ethnicity percentages of the broader mental health services population and the general California population within each age group. These side-by-side comparisons allow us to see the extent to which survey respondents were representative of the greater populations from which they were sampled, and thus, how generalizable we can consider survey results to be. Also, these data may be used as a rough measure of the degree to which the mental health system is meeting community needs with respect to gender, race, ethnicity and age, thereby informing mental

health system strategic planning. Parity among all demographic groupings with respect to service access is a critical objective for mental health service delivery in California.

Gender

The three tables below show gender distributions across age groups in the survey sample, services population and general population. The youth survey sample numbers are very consistent with the youth services population. The adult and older adult samples have slightly higher numbers of females versus males than the mental health services populations, which may be explained in part by the notion that women may be more willing than men to participate in the survey process. Overall, however, with respect to gender, the findings of this report should be considered generally representative of the larger, mental health services population from which respondents were selected.

The tables also demonstrate some differences with respect to gender between the general California population and the mental health services population. For example, there is relatively greater representation of males in the youth services population compared to the general population (Table 1). This has been a consistent finding in our report series [1] and may be explained by the fact that emotional disorders in male children/youth are often exhibited externally (e.g., aggressive acting out, delinquency) and, consequently, are more likely to come to the attention of mental health professionals than emotional disorders exhibited by female children/youth, which tend to be more internal (e.g., withdrawal, depression)[2].

For adults (Table 2), and especially older adults (Table 3), the pattern differs such that the percentage of females in the service population is larger than that of the general population. Also consistent with previous results,[1] this finding may be influenced by the observation of professionals that women, and, in particular, those of older generations, are more likely to verbalize emotional distress and seek services than their male counterparts.

Table 1

Gender	Youth in Survey Sample		All Youth Served	California Population Youth
	FY 2004/05 N=30,414*	**FY 2005/06** n=34,785*	**(FY 2005-06)** n=209,942*	**(Census 2005)** N=9,620,511*
Female	39.6%	39.7%	39.3%	48.8%
Male	60.3%	60.3%	60.7%	51.2%
Other	0.1%	0.0%	0.0%	N/A
% of Total Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

[1] Similar results have been discussed in previous legislative reports of this nature (http://www.dmh.ca.gov/POQI/reports.asp).

[2] Although the differential expression of mental health issues by female and male children/youth is generally consistent in aggregate, a particular child/youth may exhibit internalizing and/or externalizing symptoms regardless of gender.

Table 2

Gender	Adults in Survey Sample		All Adults Served	California Population Adults
	FY 2004/05 n=36,921*	**FY 2005/06** n=38,098*	**(FY 2005-06)** n=397,511*	**(Census 2005)** N=21,726,546*
Female	55.4%	55.9%	51.4%	49.2%
Male	44.6%	44.1%	48.6%	50.8%
Other	0.0%	0.1%	0.0%	N/A
% Total of Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

Table 3

Gender	Older Adults in Survey Sample		All Older Adults Served	California Population Older Adults
	FY 2004/05 n=3,817*	**FY 2005/06** n=3,733*	**(FY 2005-06)** n=39,408*	**(Census 2005)** N=5,507,167*
Female	67.6%	65.2%	63.1%	55.6%
Male	32.4%	34.7%	36.9%	44.4%
Other	0.0%	0.1%	0.0%	N/A
% of Total Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

Race/Ethnicity

Tables 4-6 display race/ethnicity percentages for each age group of sample respondents, the corresponding mental health services population and the general California population. Some slight differences in the percent contribution of each race/ethnicity to the totals between the two survey years (FY 2004-05 and FY 2005-06) are noteworthy. Most noticeable is the increase in older adult (and to some extent adult) Asian/Pacific Islander clients in the survey sample between the two years. This is likely to be due to the greater use of Asian/Pacific Islander language surveys (i.e., Chinese, Korean, Vietnamese, Tagalog) during the latter year.

Race/ethnicity differences between the survey samples and the total mental health services population shown in these tables may, in part, be attributed to differences in data collection methods. For example, while the surveys allow multiple racial categories to be indicated, and have a separate Hispanic/Latino ethnicity designation,[1] this level of detail was not captured for the larger mental health services population as tracked through DMH's Client and

[1] The survey uses the race/ethnicity categories and definitions of the Federal Office of Management and Budget: http://www.whitehouse.gov/omb/fedreg /1997standards.html

Services Information (CSI) system[1]. The apparent over or under-representation of particular races/ethnicities in the survey sample (e.g., fewer African-American/Black youth and adults and more Hispanic/Latino youth and older adults in the sample populations compared to the mental health service populations) may have resulted from the fact that individuals who are only able to indicate one race in a single-choice situation (i.e., CSI) may self-identify as being of more than one race when presented with more options (i.e., in the surveys).

Overall, the aggregated survey findings in this report should be interpreted as being roughly representative of the mental health services population in terms of race/ethnicity. However, minimal to moderate under-representation in the survey samples of African American clients across age groups and some under-representation in the survey samples of Asian/Pacific Islander clients across youth and older adults samples, as well as slight under-representation of White clients across the youth samples should be considered when interpreting the performance measurement data in this report with respect to their generalizability to the larger service population.

Some differences in relative percentages of race/ethnicity groups in the mental health services populations versus the general state population are also evident, including lower percentages in Hispanic and Asian/Pacific Islander youth and adults served, and higher percentages in African-Americans served across all age groups. These percentage differences are likely to be due to a combined function of a number of variables, including the degree to which culturally appropriate services and culture-specific outreach strategies are available.

Table 4

Race/Ethnicity	Youth in Survey Sample		All Youth Served	California Population Youth
	FY 2004/05 n = 30,272*	**FY 2005/06** n = 34,536*	**FY 2005-06** n = 177,468*	**Census 2005** N = 9,620,511*
African American	14.4%	14.5%	20.2%	7.2%
Asian/Pacific Islander	2.8%	2.7%	3.4%	9.8%
Hispanic	43.9%	46.1%	40.7%	47.4%
Native American	0.9%	0.9%	1.1%	0.8%
White	27.8%	26.5%	33.3%	31.4%
Other	2.3%	2.2%	1.3%	N/A
More than 1 race indicated	7.9%	7.1%	N/A	3.4%
% of Total Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

[1] The CSI system is migrating to the same data format currently used for the capture of race/ethnicity information in the surveys. This change in format is likely to be achieved during 2007, making more direct comparisons between the survey sample and the larger mental health services population race/ethnicity characteristics possible.

Table 5

Race/Ethnicity	Adults in Survey Sample		All Adults Served	California Population Adults
	FY 2004/05 n = 36,729*	**FY 2005/06** n = 37,852*	**FY 2005-06** n = 356,532*	**Census 2005** N = 21,726,546*
African American	13.1%	13.0%	19.3%	6.7%
Asian/Pacific Islander	5.6%	7.1%	6.9%	12.4%
Hispanic	24.8%	24.8%	23.1%	35.6%
Native American	1.4%	1.5%	1.1%	0.8%
White	47.2%	46.3%	47.9%	42.8%
Other	2.7%	2.8%	1.8%	N/A
More than 1 race indicated	5.2%	4.5%	N/A	1.6%
% of Total Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

Table 6

Race/Ethnicity	Older Adults in Survey Sample		All Older Adults Served	California Population Older Adults
	FY 2004/05 n = 3,805*	**FY 2005/06** n = 3,712*	**FY 2005-06** n = 33,720*	**Census 2005** N = 5,507,167*
African American	8.7%	9.0%	11.8%	5.5%
Asian/Pacific Islander	6.5%	11.8%	14.1%	11.9%
Hispanic	21.9%	19.4%	16.9%	16.6%
Native American	0.8%	1.0%	0.7%	0.7%
White	56.2%	51.9%	53.1%	64.2%
Other	2.2%	2.5%	3.4%	N/A
More than 1 race indicated	3.7%	4.4%	N/A	1.1%
% of Total Completed Responses	100.0%	100.0%	100.0%	100.0%

* Completed Responses Only

Consumer Improvement, Quality of Life, and Satisfaction

Family members/caregivers of youth, youth of sufficient age to reliably complete a survey (at least age 13), adults (age 18-59) and older adults (age 60+) receiving community mental health services were surveyed during two sampling periods each fiscal year: May 1-15, 2004; November 3-17, 2004; November 1-15, 2005; and May 2-13, 2005. The data collected during the two sample periods in each fiscal year are averaged for ease of interpretation. Comparative results between the fiscal years, FY 2004-05 and FY 2005-06 are presented below. As has been found in previous years' analyses of similar data, there is relative consistency among survey periods in the percentages of those reporting improvement, quality of life and satisfaction. If statewide funding, administrative, and service

practices are reasonably consistent across assessment time periods, the relative uniformity of results reported here are to be expected, especially considering the broad-spectrum, large-scale nature of state-level measurement and analysis. Greater variation in data and potential differences in percentages of individuals reporting improvement/satisfaction are likely to be more evident at the local or county level. Impacts of local variations in service priorities, direction of resources, and quality improvement strategies are often better detected through smaller-scale studies and local evaluation projects.

Although the impact of small-scale, local program efforts are likely to go undetected when statewide data are compiled, it might be expected that large-scale program implementations directed at all or most community mental health services within California could be observable in state-level evaluations. One example is the transformational agenda of the Mental Health Services Act/Proposition 63[1].

Youth Improvement:

Figures 1 and 2, below, illustrate the percentages of family members/caregivers of child/youth consumers, and youth consumers themselves, who reported improvement in six areas of child/youth personal functioning (family life and family connectedness, coping ability, school functioning, social connectedness/competency, and general life functioning)[2]. The results over both survey years are quite consistent (less than two percent variation between years), with the majority of both family members/caregivers and youth reporting improvement in all six areas. Depending upon the area of functioning and survey period examined, 61.1% to 71.8% of family members/caregivers, and 62.9% to 75.4% of youth reported improvement as a result of services received. According to both youth and family members/caregivers, over time, services consistently showed the greatest positive impact on child/youth ability to get along with friends/other people (i.e., social connectedness/competency).

Slightly different perceptions of improvement were evident between youth and family member/caregivers. Caregivers reported slightly greater ability of youth to get along with family members than youth did themselves, while youth expressed slightly higher improvement than caregivers in all other areas measured. Although the percentage-point differences are small and should not be over-interpreted, it may be that youth generally have service goals that are less ambitious than those of their families/caregivers, and as a result may have a slight tendency to perceive improvements where their families do not. Additionally, the lower appraisal by youth regarding their ability to get along with family members may be associated with adolescent perceptions of family tensions consistent with their maturational processes.

[1] http://www.dmh.ca.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf

[2] Child/youth functioning, as a result of services, was assessed with the Youth Services Survey for Families (YSS-F) and the Youth Services Survey for Youth (YSS). Results reflect the percentage of respondents with respect to each survey period who indicated that they 'Agreed' or 'Strongly Agreed' with each item.

Figure 1. Family Member/Caregiver Evaluation of Youth Outcomes

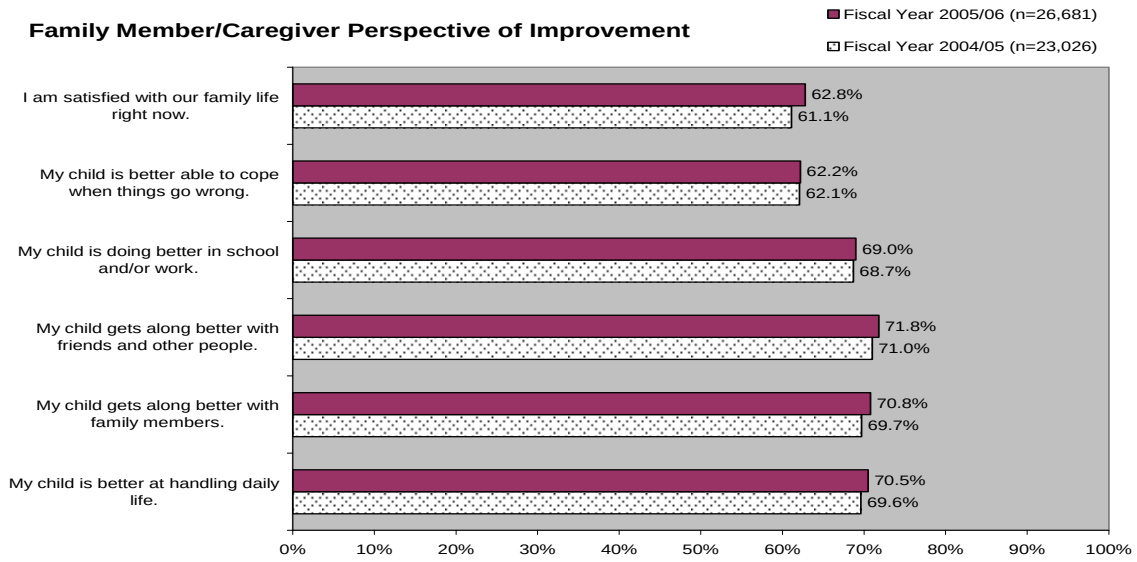
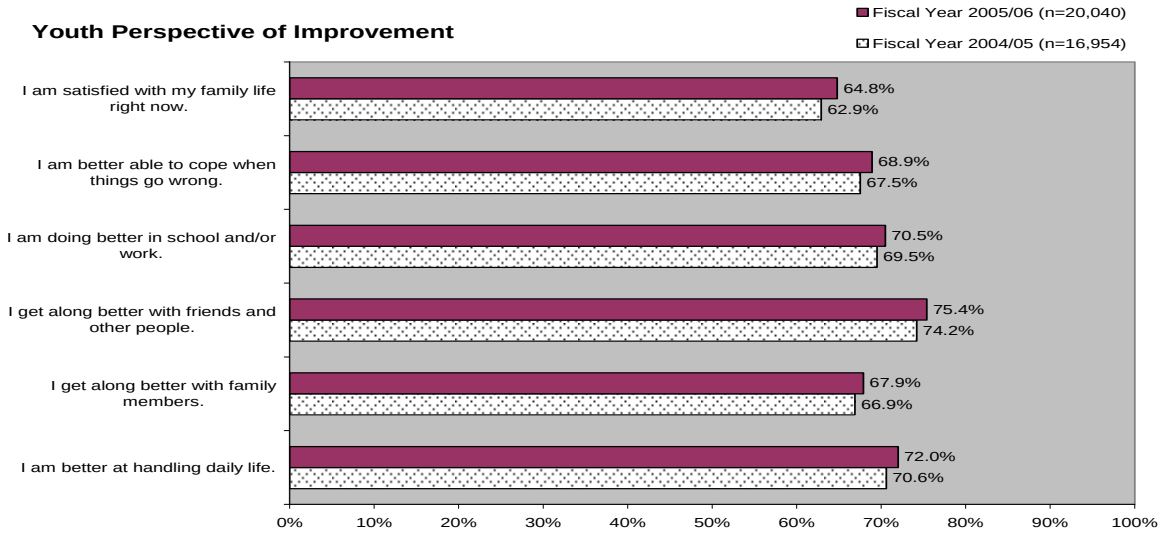


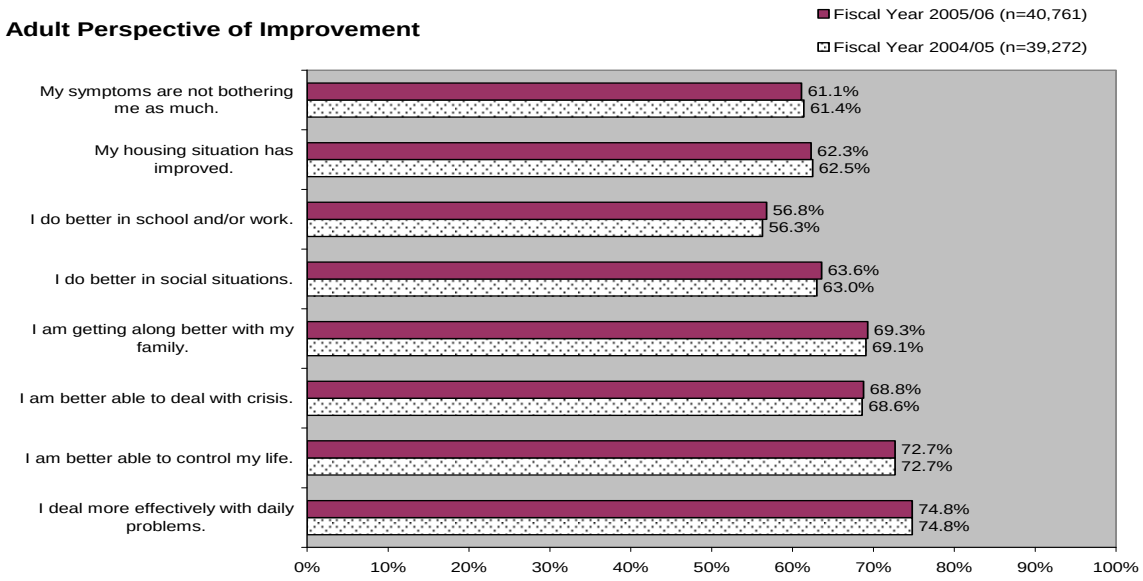
Figure 2. Youth Evaluation of Outcomes



Adult/Older Adult Improvement:

Figures 3 and 4 illustrate that a substantial majority of adults and older adults surveyed across both survey years reported improvement in eight outcome areas as a result of mental health services[1]. These positive outcomes areas are housing, reduction in symptoms, improved work/school functioning, social and family connectedness, ability to deal with crises and daily problems, and ability to control one's life. Across the eight outcome areas and survey years, 56.3% to 74. 8% of adults, and 63.6% to 85.1% of older adults surveyed reported improvement as a result of services received. Although some variability exists among the eight outcome areas in terms of adult versus older adult improvement, respondents in both age groups reported the greatest positive impact on their ability to deal with daily problems and to control their lives. Across all outcome areas, however, a greater relative percentage of older adults reported improvement, a finding that is corroborated by other evaluations of older adult service impact[2].

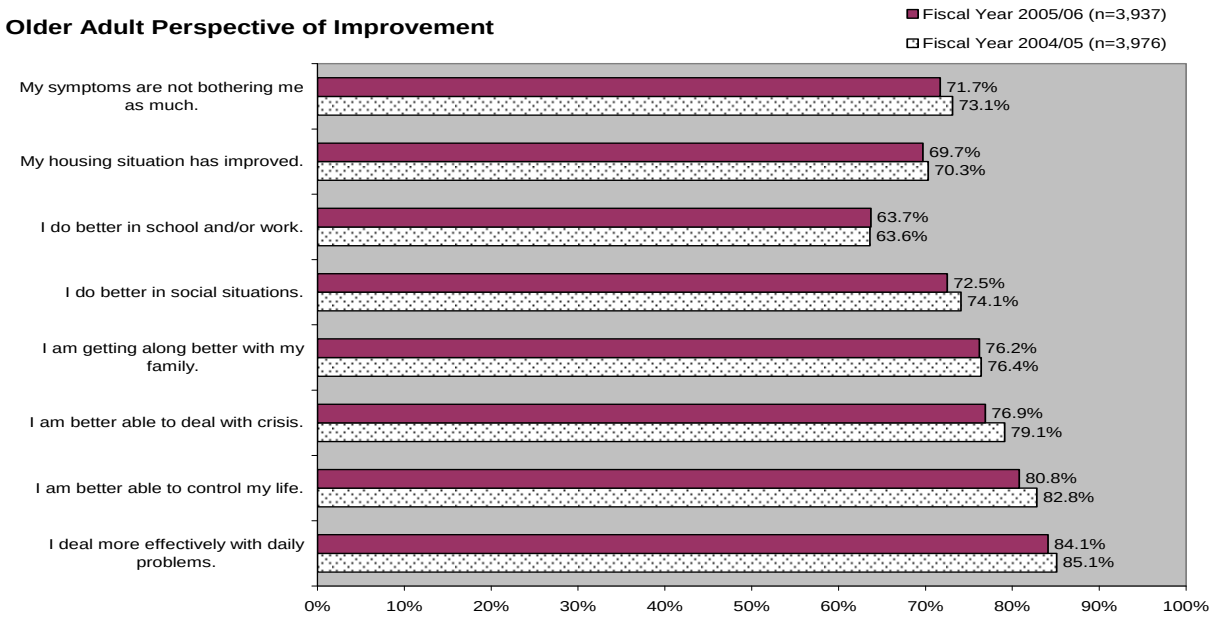
Figure 3. Adult Outcomes



[1] Data were collected using the revised 28-item MHSIP Consumer Perception Survey for adults and older adults. Results reflect the percentage of respondents with respect to each survey period who indicated that they 'Agreed' or 'Strongly Agreed' with each item.

[2] See Older Adult Demonstration Project Results: www.dmh.ca.gov/AOAPP/OASOC/reports.asp.

Figure 4. Older Adult Outcomes



Quality of Life:

Figures 5 and 6 show the extent to which adult and older adult consumers who received six months or more of mental health services reported satisfaction across seven quality of life domains. These domains included general life satisfaction, living situation, daily activities, family relationships, social relationships, safety issues and health.[1] Consistent with the above results is the finding that slightly greater percentages of older adults compared to adults reported satisfaction across all quality of life domains and survey time frames. However, there were similar patterns in the way the two age groups responded. For both age groups, the largest percentages of consumers were satisfied with living situation and safety; considerably fewer consumers in each age group reported general life satisfaction and satisfaction with their health – with results on the other quality of life domains falling somewhere in between. An emphasis on housing and supportive housing services for mental health consumers may be influencing the relatively more positive results obtained for consumers' living situation and consequent feelings of safety. Although results are consistently higher for older adults compared with the adult age group, slight decreases (more than two percent for health, social relationships, daily activities, living situation) are noticeable in FY 2005-06 compared to FY 2004-05 in the older adult group. Although this decrease is minimal, efforts to understand its cause(s) and strategies to reduce the potential for further decrease are currently being considered.

[1] The Quality of Life (QOL) instrument provides information about consumers' satisfaction with several quality of life areas. Subjective scales use a seven-point scale: 1 = 'Terrible', 2 = 'Unhappy', 3 = 'Mostly Dissatisfied', 4 = 'Mixed', 5 = 'Mostly Satisfied', 6 = 'Pleased', and 7 = 'Delighted'. The QOL results presented in Figures 5 and 6 show the percentages of adult and older adult consumers who rated the quality of life areas with a score of "5" of higher.

Figure 5: Adult Perception of Quality of Life

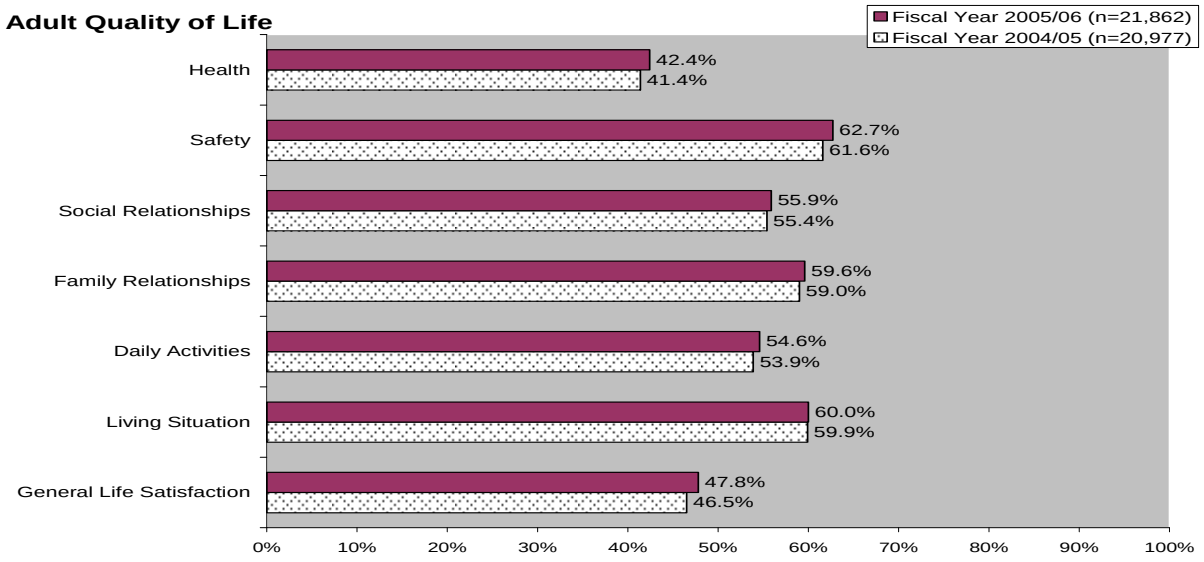
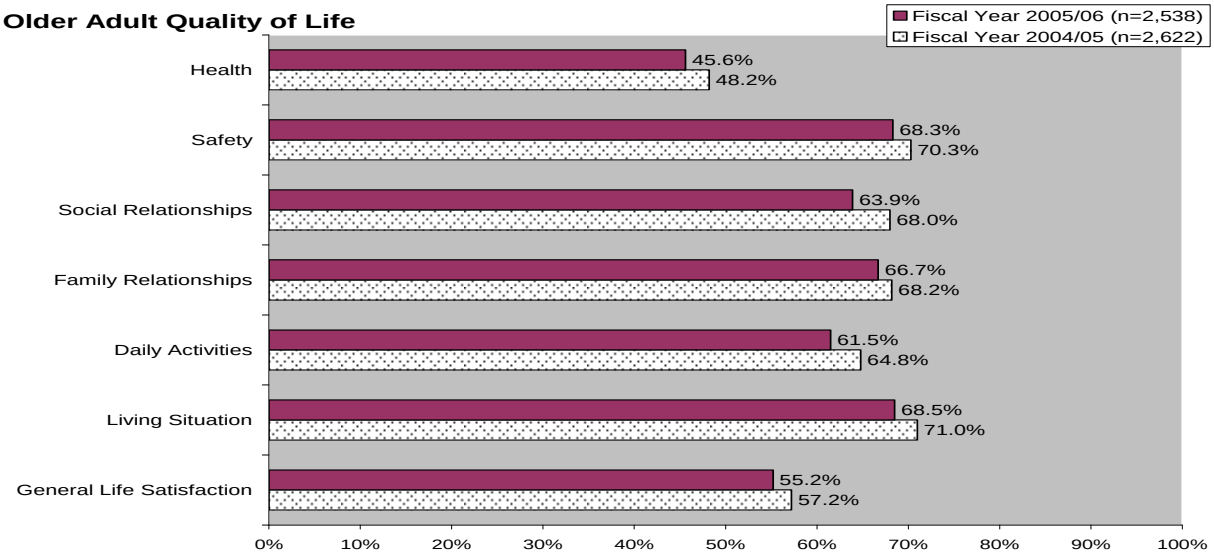


Figure 6: Older Adult Perception of Quality of Life

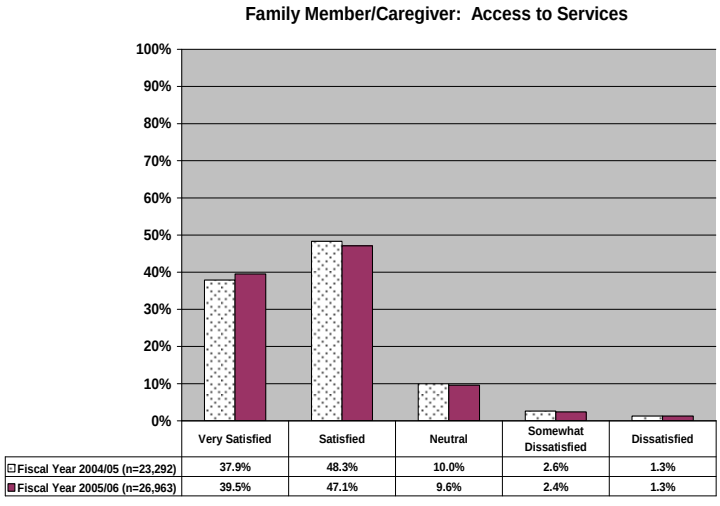


Satisfaction with Child/Youth Services:

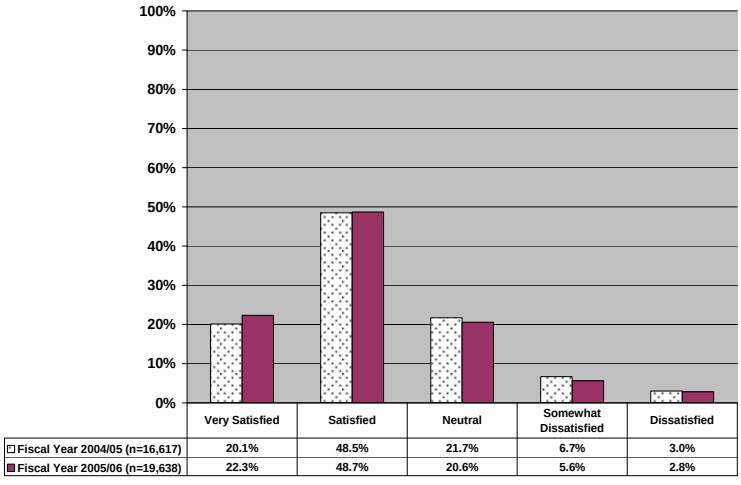
The majority of family members/caregivers and youth who responded to the survey (during FY 2004-05 and FY 2005-06) were satisfied with services. Figures 7-16, below, reflect survey results along the following four dimensions: access to services, cultural appropriateness, treatment involvement/participation, and general satisfaction with services. The first four sets of figures (Figures 7-14), below, show the percentages of family members/caregivers and youth who were "very satisfied", "satisfied", "neutral", "somewhat dissatisfied" or "dissatisfied" with respect to the four dimensions. Figures 15 and 16 show the average scores obtained for family members/caregivers and youth along the four dimensions[1].

Results are quite positive and consistent between survey periods. The distributions shown in Figures 7-14, as well as the average scores depicted in Figures 15 and 16, demonstrate a consistent tendency for family members/caregivers to report somewhat higher satisfaction with services than youth. These differences are in the opposite direction of the differences obtained in items assessing service outcomes, described earlier, in which for most areas measured, slightly higher proportions of youth reported positive outcomes than did family members/caregivers. One explanation of this finding is that the higher self-appraisal of functioning found among youth is associated with a lesser perceived need for, and therefore satisfaction with treatment.

Figures 7 and 8: Family Member/Caregiver and Youth Results on Access to Services



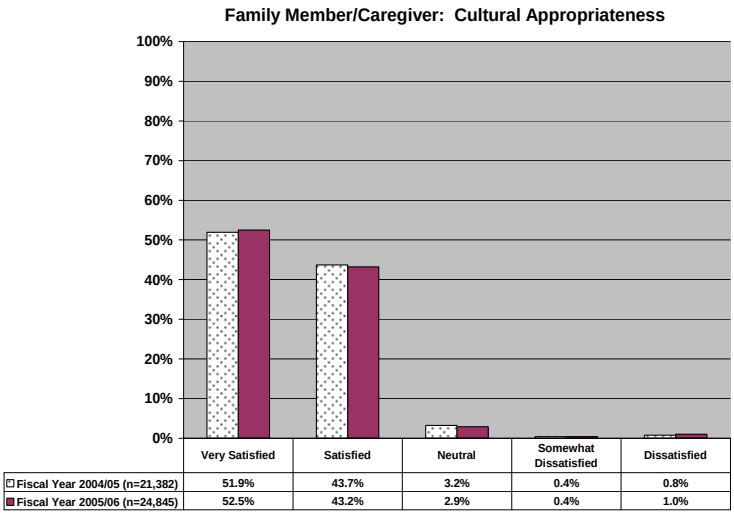
	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=23,292)	37.9%	48.3%	10.0%	2.6%	1.3%
Fiscal Year 2005/06 (n=26,963)	39.5%	47.1%	9.6%	2.4%	1.3%



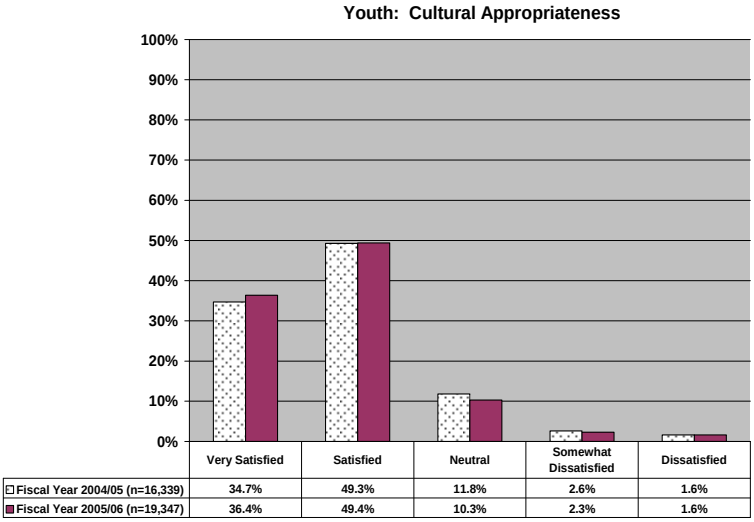
	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=16,617)	20.1%	48.5%	21.7%	6.7%	3.0%
Fiscal Year 2005/06 (n=19,638)	22.3%	48.7%	20.6%	5.6%	2.8%

[1] The Youth Services Survey for Families (YSS-F) and Youth Services Survey for Youth (YSS) items are rated on a five-point scale; "5" indicates the greatest satisfaction. Averages are presented in Figures 15 and 16 for each dimension on both the YSS-F and YSS surveys across survey periods. As a general guideline determined by the Center for Mental Health Services at the Federal Substance Abuse and Mental Health Services Administration, an overall scale score over 3.5 indicates consumer/caregiver satisfaction with mental health services.

Figures 9 and 10: Family Member/Caregiver and Youth Results on Cultural Appropriateness

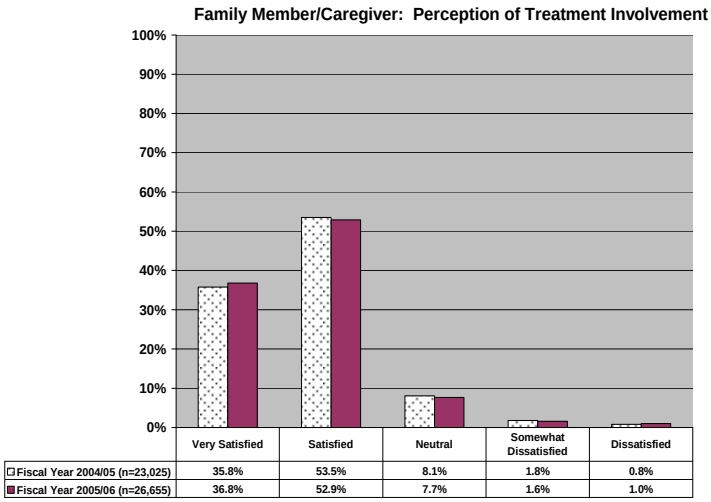


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=21,382)	51.9%	43.7%	3.2%	0.4%	0.8%
Fiscal Year 2005/06 (n=24,845)	52.5%	43.2%	2.9%	0.4%	1.0%

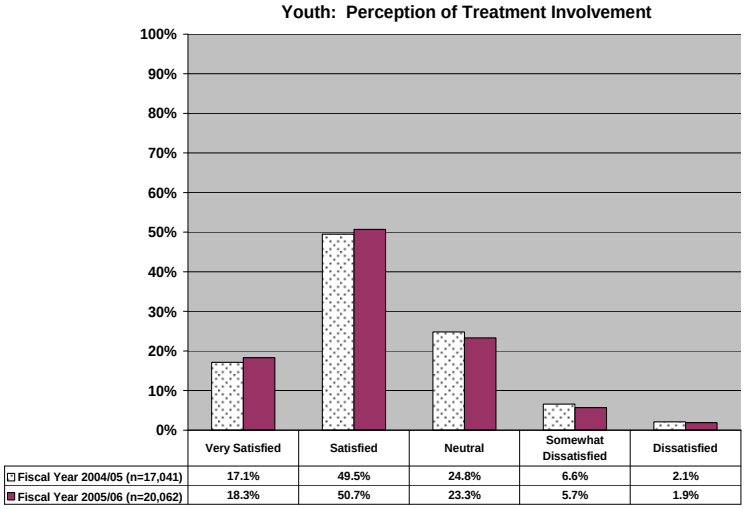


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=16,339)	34.7%	49.3%	11.8%	2.6%	1.6%
Fiscal Year 2005/06 (n=19,347)	36.4%	49.4%	10.3%	2.3%	1.6%

Figures 11 and 12: Family Member/Caregiver and Youth Results on Treatment Involvement/Participation

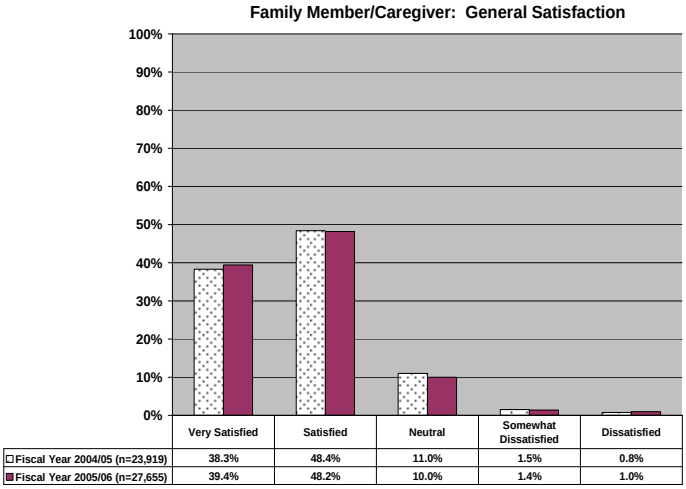


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=23,025)	35.8%	53.5%	8.1%	1.8%	0.8%
Fiscal Year 2005/06 (n=26,655)	36.8%	52.9%	7.7%	1.6%	1.0%

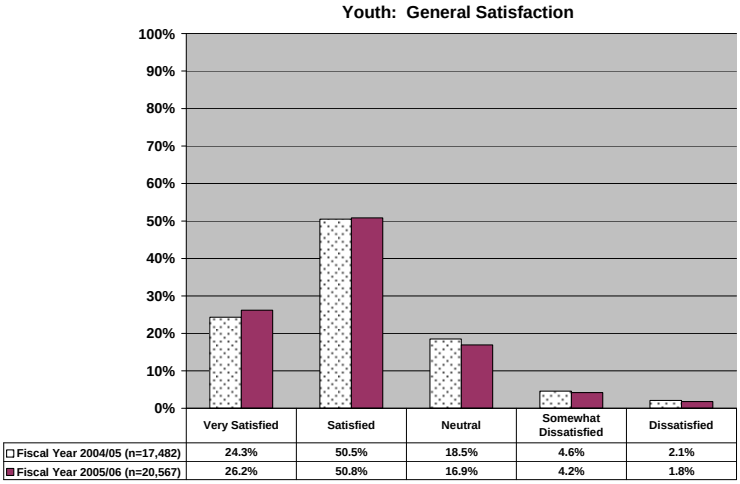


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=17,041)	17.1%	49.5%	24.8%	6.6%	2.1%
Fiscal Year 2005/06 (n=20,062)	18.3%	50.7%	23.3%	5.7%	1.9%

Figures 13 and 14: Family Member/Caregiver and Youth Results on General Satisfaction



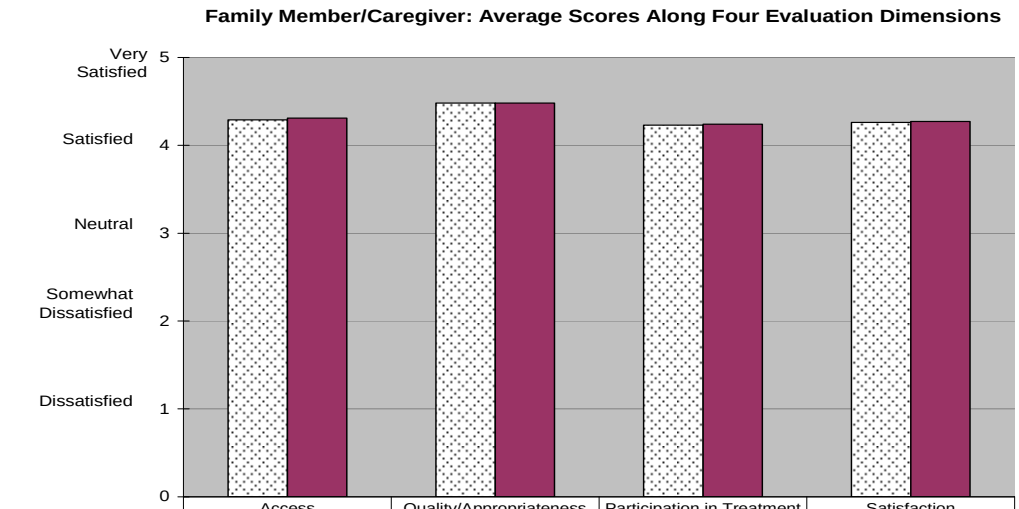
	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=23,919)	38.3%	48.4%	11.0%	1.5%	0.8%
Fiscal Year 2005/06 (n=27,655)	39.4%	48.2%	10.0%	1.4%	1.0%



	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=17,482)	24.3%	50.5%	18.5%	4.6%	2.1%
Fiscal Year 2005/06 (n=20,567)	26.2%	50.8%	16.9%	4.2%	1.8%

Both family members/caregivers and youth reported the greatest satisfaction with the quality/appropriateness of care (Figures 15 and 16). The other three dimensions were also rated quite high, with youth responses showing slightly more variation than those of family members/caregivers.

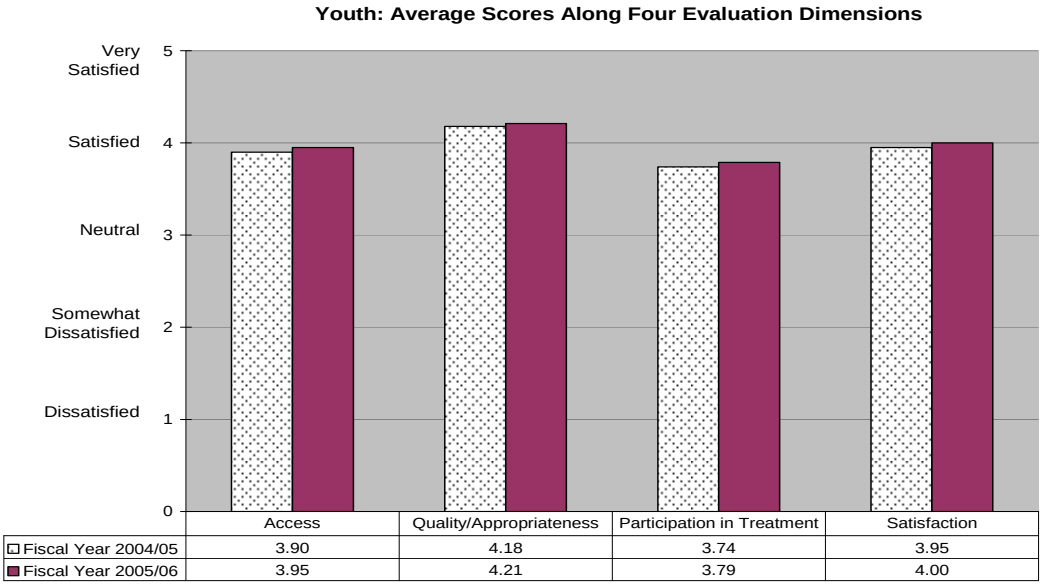
Figure 15: Family Member/Caregiver Average Scores Along Four Evaluation Dimensions[1]



	Access	Quality/Appropriateness	Participation in Treatment	Satisfaction
Fiscal Year 2004/05	4.29	4.48	4.23	4.26
Fiscal Year 2005/06	4.31	4.48	4.24	4.27

[1] See Figures 7-14 for the number of family member/caregiver and youth survey responses included in each of the four dimension averages for each survey period. The numbers of survey responses used to compute the average scores in Figures 15 and 16 are identical to the numbers used to compute the percentages in the previous figures.

Figure 16: Youth Average Scores Along Four Evaluation Dimensions



	Access	Quality/Appropriateness	Participation in Treatment	Satisfaction
Fiscal Year 2004/05	3.90	4.18	3.74	3.95
Fiscal Year 2005/06	3.95	4.21	3.79	4.00

An analysis of individual survey items (Table 7) reveals that the average ratings on all items were relatively high, ranging from 3.42 to 4.56 out of a possible score of 5. Inspection of items rated relatively lower than others provides direction for future quality strategies and program developments. For example, the information gleaned from the youth survey items (especially those for which the average score is less than 4.0, shaded below)[1] suggests that greater creativity might be needed in developing services for youth. Possible innovations could include providing services and supports in more natural settings, at atypical hours, and by adults or peers who have specific expertise in youth issues and needs. This suggestion is consistent with youth recommendations obtained through recent Mental Health Services Act stakeholder input processes. Future data gathering efforts will shed light on how such transformative efforts have better engaged California youth.

[1] Although average scores above 3.5 are generally considered a "satisfied" response, DMH is interested in examining and potentially addressing through a quality improvement process, issues for which average scores are less than 4.0.

Table 7. Family Member/Caregiver and Youth Satisfaction Item-Analysis[1]

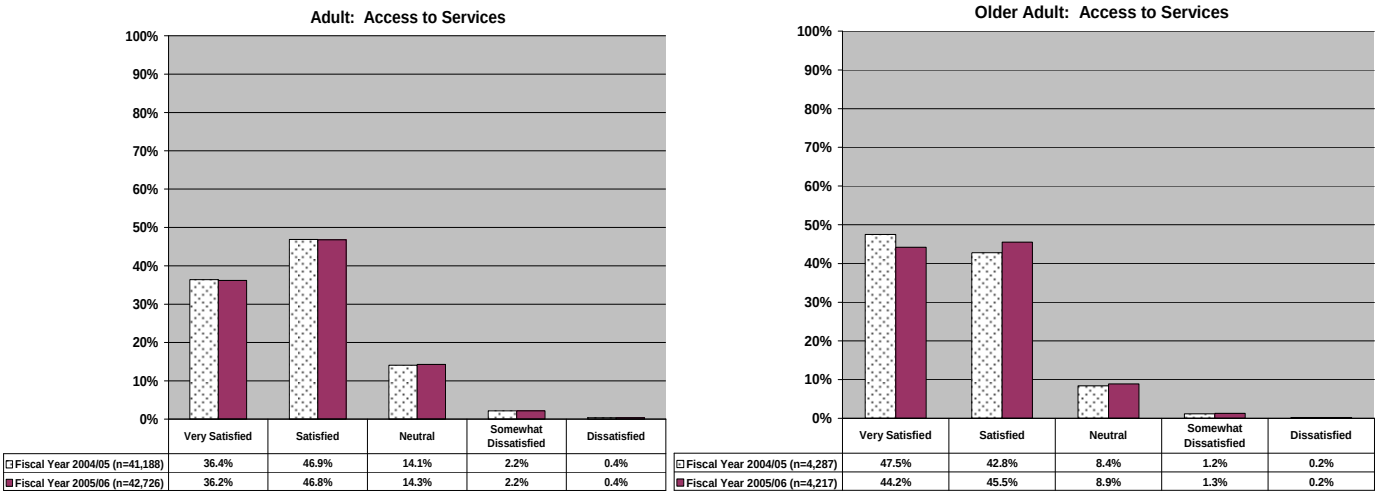
Individual Items		Family Member/ Caregiver		Youth	
		Average Score		Average Score	
		FY 2004/05	FY 2005/06	FY 2004/05	FY 2005/06
Access to Services	The location of services was convenient for us.	4.27	4.28	3.90	3.96
	Services were available at times that were convenient for us.	4.31	4.32	3.89	3.94
Cultural Appropriateness	Staff treated me with respect.	4.55	4.56	4.23	4.27
	Staff respected my family's religious/spiritual beliefs.	4.44	4.45	4.20	4.23
	Staff spoke with me in a way that I understood.	4.51	4.52	4.21	4.23
	Staff were sensitive to my cultural/ethnic background	4.41	4.42	4.08	4.11
Participation in Treatment	I helped to choose my/my child's services.	4.11	4.14	3.42	3.47
	I helped to choose my/my child's treatment goals.	4.22	4.24	3.86	3.90
	I participated in my/my child's treatment.	4.37	4.36	3.94	3.98
General Satisfaction	Overall, I am satisfied with the services I/my child received	4.38	4.39	4.05	4.10
	The people helping me/my child stuck with us no matter what.	4.32	4.33	4.00	4.04
	I felt I/my child had someone to talk to when I/he/she was troubled.	4.31	4.32	3.97	4.02
	The services I/my child and/or family received were right for us.	4.26	4.27	3.94	3.98
	I/my family got the help we wanted (for my child).	4.21	4.22	3.91	3.95
	I/my family got as much help as we needed (for my child).	4.09	4.12	3.85	3.90

[1] The Youth Services Survey for Families (YSS-F) and Youth Services Survey for Youth (YSS) items are rated on a five-point scale; "5" indicates the greatest satisfaction. As a general guideline, an average item score over 3.5 indicates consumer/caregiver satisfaction with mental health services.

Satisfaction with Adult and Older Adult Services

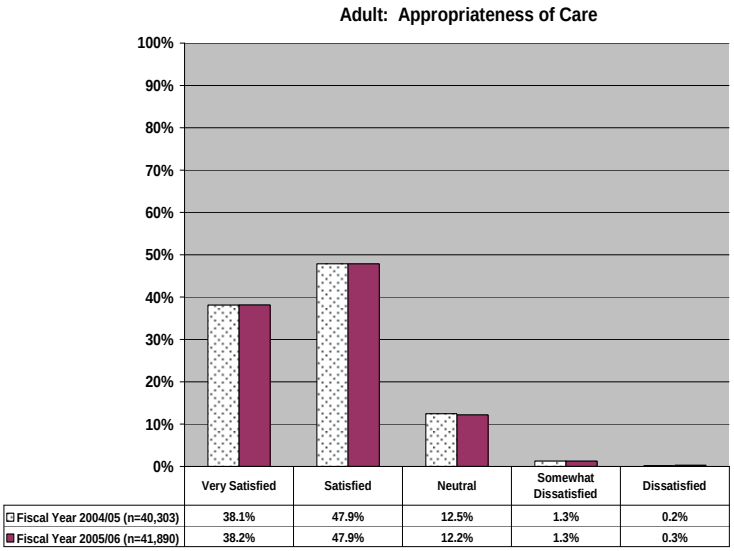
Results shown in Figures 17-26 indicate that overall, the large majority of consumers positively evaluated the mental health services they received. These figures show adult and older adult consumers' evaluations of mental health services during FY 2004-05 and FY 2005-06 along four dimensions: access to services, appropriateness of care, participation in treatment, and satisfaction with services. The first four sets of figures, below, show the percentages of adults and older adults who were "very satisfied", "satisfied", "neutral", "somewhat dissatisfied" or "dissatisfied" with respect to the four dimensions, while Figures 25 and 26 show the average scores obtained from adult and older adult consumers along the same four dimensions[1]. Consistent with previous sections of this report, a greater percentage of older adults compared to adults rated services positively. The "satisfaction with services" dimension was rated most positively by consumers in both the adult and older adult consumer groups.

Figures 17 and 18: Adult and Older Adult Results on Access to Services

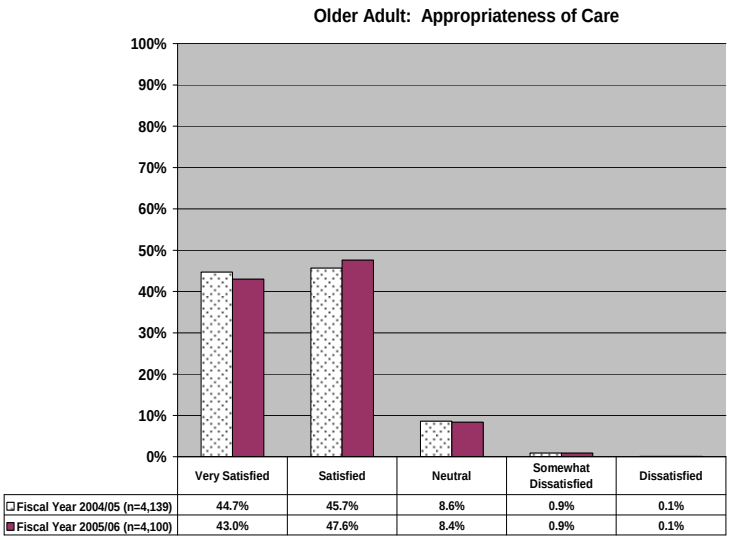


[1] The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey is a 28-item public domain instrument. The MHSIP items are rated on a five-point scale; "5" indicates the greatest satisfaction. Averages are presented in Figures 25 and 26 for each dimension on the MHSIP survey across survey periods. As a general guideline, determined by the Center for Mental Health Services at the Federal Substance Abuse and Mental Health Services Administration, an overall scale score over 3.5 indicates consumer satisfaction with mental health services.

Figures 19 and 20: Adult and Older Adult Results on Appropriateness of Care

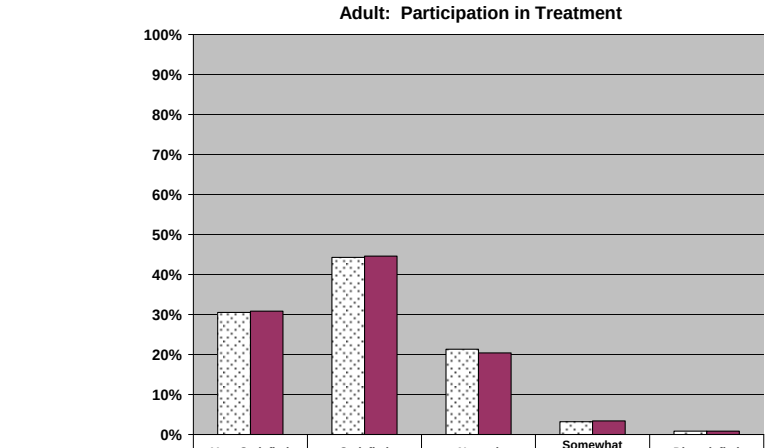


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=40,303)	38.1%	47.9%	12.5%	1.3%	0.2%
Fiscal Year 2005/06 (n=41,890)	38.2%	47.9%	12.2%	1.3%	0.3%

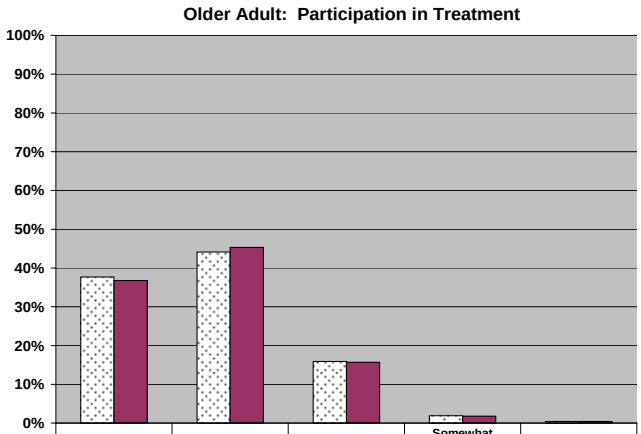


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=4,139)	44.7%	45.7%	8.6%	0.9%	0.1%
Fiscal Year 2005/06 (n=4,100)	43.0%	47.6%	8.4%	0.9%	0.1%

Figures 21 and 22: Adult and Older Adult Results on Participation in Treatment

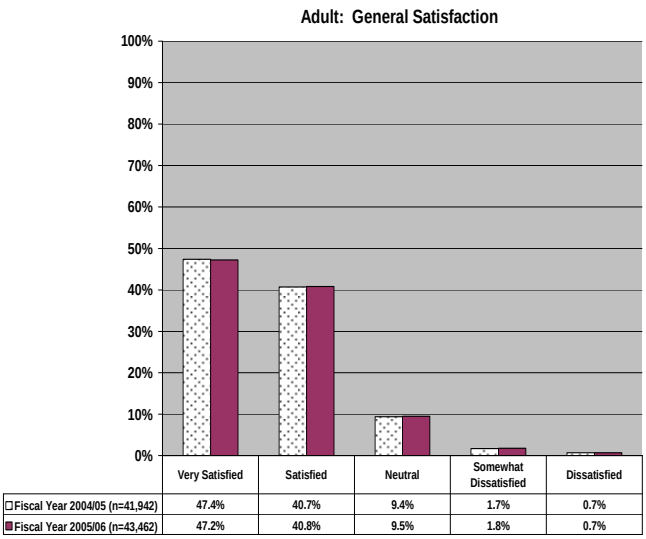


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=38,548)	30.5%	44.3%	21.3%	3.2%	0.8%
Fiscal Year 2005/06 (n=40,194)	30.8%	44.6%	20.4%	3.4%	0.8%

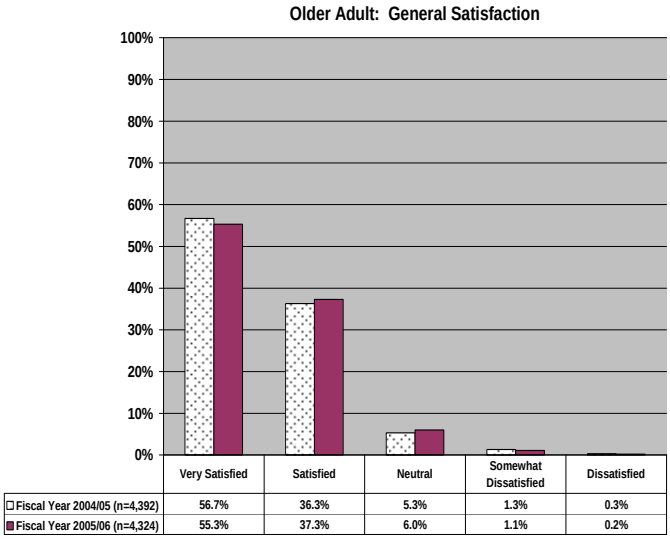


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=3,899)	37.7%	44.1%	15.9%	1.9%	0.4%
Fiscal Year 2005/06 (n=3,945)	36.8%	45.3%	15.7%	1.8%	0.4%

Figures 23 and 24: Adult and Older Adult Results on General Satisfaction

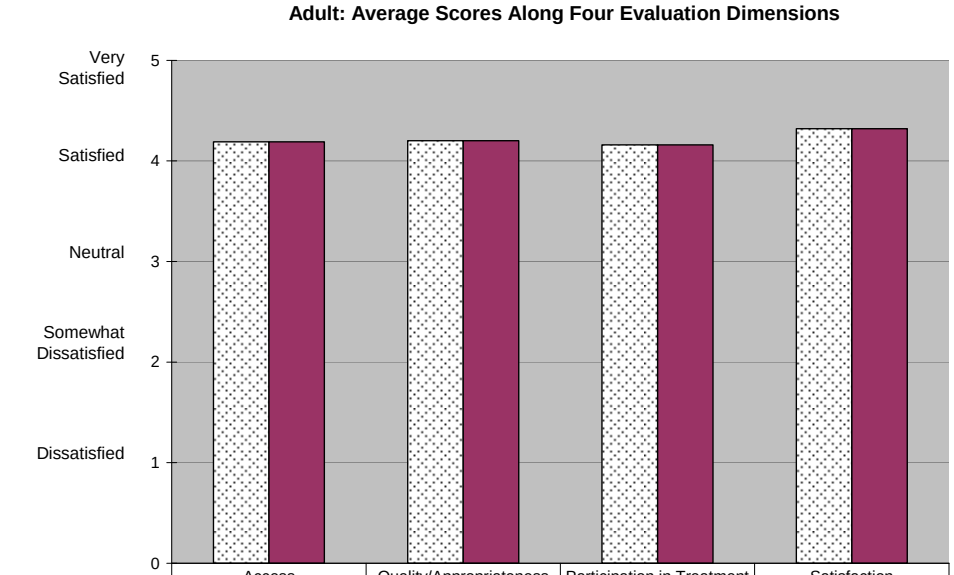


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=41,942)	47.4%	40.7%	9.4%	1.7%	0.7%
Fiscal Year 2005/06 (n=43,462)	47.2%	40.8%	9.5%	1.8%	0.7%



	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Fiscal Year 2004/05 (n=4,392)	56.7%	36.3%	5.3%	1.3%	0.3%
Fiscal Year 2005/06 (n=4,324)	55.3%	37.3%	6.0%	1.1%	0.2%

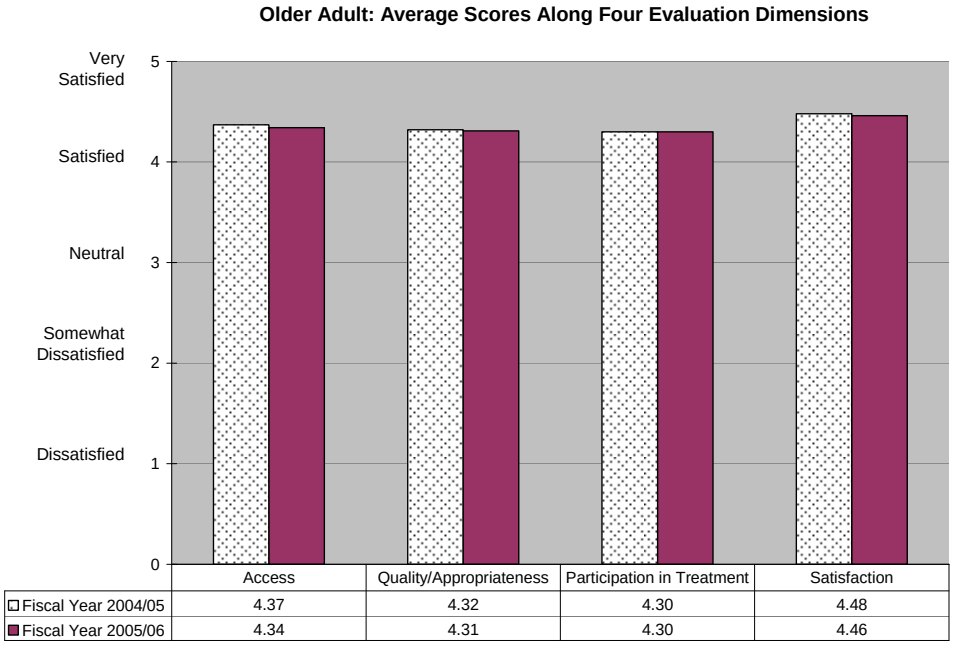
Figure 25: Adult Average Scores Along Four Evaluation Dimensions[1]



	Access	Quality/Appropriateness	Participation in Treatment	Satisfaction
Fiscal Year 2004/05	4.19	4.20	4.16	4.32
Fiscal Year 2005/06	4.19	4.20	4.16	4.32

[1] See Figures 17-24 for the number of adult and older adult survey responses included in each of the four dimension averages for each survey period. The numbers of survey responses used to compute the average scores in Figures 25 and 26 are identical to the numbers used to compute the percentages in the previous figures.

Figure 26: Older Adult Average Scores Along Four Evaluation Dimensions



	Access	Quality/Appropriateness	Participation in Treatment	Satisfaction
Fiscal Year 2004/05	4.37	4.32	4.30	4.48
Fiscal Year 2005/06	4.34	4.31	4.30	4.46

An item analysis of the survey dimensions (Table 8) allows DMH to identify issues in need of further examination[1]. One item, shaded in the table, is of some concern because its average score was less than 4.0 for adults in FY 2004-05: "I, not staff, decided my treatment goals." This was also the lowest scored item for older adults. With the current emphasis on recovery and wellness philosophies, identification of goals should be the result of true partnerships between consumers and service providers. The Mental Health Services Act is emphasizing such a partnership philosophy within Full Service Partnership agreements. It is hoped that this recovery-oriented service planning and delivery process will result in an increase in consumer-directed care and satisfaction in this area.

[1] Although average scores above 3.5 are generally considered a "satisfied" response, DMH is interested in examining and potentially addressing through a quality improvement process, issues for which average scores are less than 4.0.

Table 8. **Adult / Older Satisfaction Item-Analysis[1]**

Individual Items		Adult Average Score		Older Adult Average Score	
		FY 2004/05	FY 2005/06	FY 2004/05	FY 2005/06
Access to Services	The location of services was convenient.	4.19	4.18	4.32	4.29
	Staff were willing to help as often as I felt it was necessary.	4.27	4.27	4.44	4.40
	Staff returned my calls within 24 hours.	4.13	4.13	4.35	4.30
	Services were available at times that were good for me.	4.32	4.30	4.47	4.43
	I was able to get all the services I thought I needed.	4.18	4.19	4.37	4.35
	I was able to see a psychiatrist when I wanted to.	4.05	4.06	4.29	4.27
Appropriateness of Care	Staff here believed that I could grow, change, and recover.	4.29	4.29	4.33	4.31
	I felt free to complain.	4.12	4.13	4.35	4.32
	Staff told me what side effects to watch out for.	4.08	4.09	4.19	4.19
	Staff respected my wishes about who is, and is not, to be given information about my treatment.	4.33	4.32	4.41	4.40
	Staff were sensitive to my cultural/ethnic background.	4.21	4.21	4.36	4.33
	Staff helped me so that I could manage my life and recover.	4.19	4.19	4.32	4.31
	I was given information about my rights.	4.29	4.29	4.41	4.38
	Staff encouraged me to take responsibility for how I live my life.	4.26	4.26	4.36	4.35
	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	4.07	4.07	4.14	4.15
Participation in Treatment	I felt comfortable asking questions about my treatment and medication.	4.32	4.32	4.46	4.46
	I, not staff, decided my treatment goals.	3.99	4.00	4.14	4.13
General Satisfaction	I like the services that I received here.	4.41	4.40	4.55	4.53
	If I had others choices, I would still choose to get services from this agency.	4.22	4.22	4.39	4.39
	I would recommend this agency to a friend or family member.	4.35	4.34	4.49	4.47

[1] The Mental Health Statistics Improvement Program (MHSIP) Consumer Survey items are rated on a five-point scale; "5" indicates the greatest satisfaction. As a general guideline, an average item score over 3.5 indicates consumer satisfaction with mental health services.

IMPLICATIONS AND FUTURE DIRECTIONS

Implications

A substantial majority of consumers in all age groups reported being satisfied with the services they received, and indicated that those services led to improvements in key aspects of their functioning and quality of life. Working within a quality improvement framework, DMH is implementing strategies to improve in the areas measured in this report that had relatively lower ratings (e.g., consumer involvement in service decisions) and to increase age/ethnic/racial parity with respect to service access. Specifically, due to a collaborative stakeholder process as part of Mental Health Services Act (MHSA) implementation, Full Service Partnerships, designed to foster consumer/family directed care, are now being established between hundreds of consumers/families and mental health service providers. Simultaneously, in order to increase access parity, the MHSA has introduced innovative outreach programs that address local needs and reach historically underserved populations.

Future Directions

The MHSA has provided DMH with opportunities to advance with respect to performance measurement strategies and supporting information technology solutions. These include the MHSA Full Service Partnership outcomes assessment process and the Data Collection and Reporting System that has been designed to support it.

MHSA Full Service Partnership Outcome:
Highlighted in Realignment legislation and re-emphasized in the Mental Health Services Act, client-level outcome measures are an important means of demonstrating mental health system accountability. For the MHSA, a new client-level outcomes assessment process for Full Service Partnership programs has been developed. The MHSA Full Service Partnership outcomes assessment process produces client-level data on housing stability, education, employment, justice system involvement, sources of financial support, etc. This information is collected for clients across time, allowing DMH to measure progress achieved by individuals in these key aspects of life as clients make their individual journeys toward recovery. This information, coupled with the data collected through the Consumer Perception Surveys and the Client Services Information system (described in this report), will provide a more detailed view of individual outcomes related to services received through the MHSA Full Service Partnership programs.

Data Collection and Reporting System:
The current age of increasing technological sophistication also supports opportunities for more extensive data collection and informative reporting than was previously feasible. Consequently, strategies surrounding performance measurement must include consideration of data element content, improved evaluation methods, and work flow streamlining through the use of computer and communications technologies.

In order to streamline outcomes reporting for Full Service Partnership programs, DMH released the centralized, web-based Data Collection and Reporting system (DCR) in January 2006. This system allows direct county submission of all outcomes information associated

with Full Service Partnerships. An enhanced version of the DCR, to be released in mid-2007, will increase data quality. The enhanced system will validate data as it is being entered, will provide reminders to county staff of when assessments are due, and will allow previously submitted data to be edited and corrected. The enhanced system is based on standards for data collection and exchange that counties can also use to develop local systems. This standardization insures that different data systems will be able to produce and report consistent data throughout the state, thereby increasing the usefulness of statewide data for accountability, quality and decision support purposes.