Performance Measure Results on California's Community Mental Health Performance Outcome Systems

ANNUAL REPORT TO THE FISCAL AND POLICY COMMITTEE OF THE LEGISLATURE IN RESPONSE TO

CHAPTER 89, STATUTES OF 1991
ASSEMBLY BILL 1288, WIC 5613

CALIFORNIA DEPARTMENT OF
Mental Health

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Executive Summary

This report is written in fulfillment of Chapter 89, Statutes of 1991, (AB 1288), WIC 5613 and covers the status and findings to date from California's Community Mental Health Performance Outcome Systems which continue to be implemented through a collaboration between the Department of Mental Health (DMH), California Mental Health Directors Association (CMHDA), and the California Mental Health Planning Council.

Three separate and age-specific outcome systems are either in full-scale implementation or are in the planning phase. The Children and Youth Performance Outcome System was implemented in April 1998 and as of the writing of this report, over two full years of data are available for analytical purposes. The Adult Performance Outcome System began statewide implementation in July 1999. Therefore, over one full year of data are available for analytical purposes. A pilot test which will result in a system designed to more effectively evaluate programs targeted toward older adults and takes into account their specific needs and health issues is nearly complete and implementation should take place in mid 2001.

Each of the performance outcome systems listed above is designed to provide data to the Department's Quality Improvement Committee (QIC). The QIC is comprised of DMH representatives, representatives of mental health consumer advocacy groups, and representatives of local mental health programs. Analyses of performance outcome data are utilized by the QIC to collaboratively identify issues and strategies that impact program quality and facilitate program improvement.

The performance outcome systems envisioned by the Legislature were to be designed to target the more seriously impaired adults and children who tend to receive services for extended periods of time from the public mental health system. As a result, these data are restricted to a "target population" of clients that has been defined as "those clients who will or have received services for at least 60 days, have a serious and persistent mental illness (adults) or a serious emotional disorder (children), excluding those clients who receive only medication-related services and those who are seen through a county's individual provider network."

In addition to the client-specific performance outcome data presented in this report, an important component is data from the Department's Client Services Information System (CSI) which is currently being implemented statewide. Implementation of the CSI is nearly complete and, beginning with next year's legislative report, these data will be more fully included.

Key Findings:

Child and Youth Performance Outcome System (CPOS)

Demographic Data

- Data are available for 38,283 individual child and adolescent clients for fiscal year 1999-2000.
- More data are reported for males (64%) than females (36%).
- For those clients where ethnicity data are available over 69% are accounted for by the ethnic groups of White, African American, or Hispanic with all other ethnic groups accounting for the remaining 6.1%. Fully 25.8% were accounted for by those for whom ethnicity was not available. There should be far fewer "unknowns" in future reports due to the availability of data from the Department's Client Services Information data system.
- The diagnostic categories accounting for the greatest percentage of youth are: Attention Deficit Hyperactive Disorder (23.7%), Mood and Affective Disorders (21.2%) and Disruptive Behavioral Disorders (20.6%).

Outcomes

- **Living Situation –** Data indicate there is a trend that, during the course of receiving county services, the most severely impaired children are either stabilizing or moving toward less restrictive living situations.

- **Psychological Health**
  - From both the parent's and child's perspective, children are experiencing fewer problems related to their psychological or emotional health as well as their external acting out behaviors during the course of receiving county services.
  - Mental health staff corroborate the perceptions of children and families that children are improving in their psychological functioning during the course of receiving county services. This finding holds true across gender, age, ethnic, and diagnostic groupings of child and adolescent clients.

- **Physical Health And Safety**
  - Although relatively few children are reported to be engaging in extensive self-harmful behaviors, for those that do, data indicate that they are engaging in fewer of such behaviors during the course of receiving county services.
  - Very few children have primary diagnoses that indicate substance abuse as a key factor. Additionally, clinicians are reporting relatively few children as experiencing functional impairments related to substance use. This is surprising given the widely accepted view that many children in need of, or receiving mental health services, also have co-occurring substance use problems. Some research has

indicated that while a large proportion of those children who have a substance abuse problem also have a diagnosable mental disorder, a much smaller proportion of children who have a diagnosable mental disorder also have a substance abuse problem.

More research is needed to understand this phenomenon and to identify if it is reflective of a data reporting problem, a training-related problem where staff are not effectively identifying substance use, or if there are some other reasons why children with substance use disorders are not accessing services in community mental health programs.

- **Social Involvement And Functioning**
  - Data indicate that relatively few child and adolescent clients are getting into significant trouble in the community (e.g., arrests, vandalism, fighting, etc.). However, for those who do, there appears to be a trend toward improved functioning in the community.

    Comparatively speaking, many child and adolescent clients are experiencing functional impairments related to their behavior in school. These data suggest that children are more likely to complete class work, improve in their behavior in the classroom, increase in their educational performance, and get along better with teachers during the course of receiving county mental health and other county service agencies.

- **Consumer Satisfaction**
  - Parents and caregivers are generally reporting that they are quite satisfied with the services that they are receiving from county mental health programs.

Adult Performance Outcome System (APOS)

Demographic Data

- During the first fiscal year of implementation, over 33,000 records have been reported. These 33,000 clients represent a preliminary sample of the larger adult target population since many of the larger counties were forced to implement the APOS in a phase-in approach. Therefore, these preliminary data should be interpreted with caution. As opposed to the Child And Youth Performance Outcome System, more data are being reported for females (56%) than for males (44%).
- Similarly to the Child And Youth Performance Outcome System, the greatest proportion of the client population are accounted for by the ethnic groups of White (64,6%), Hispanic (16.9%), and African American (13%).

- In terms of primary diagnosis, the majority of clients are reported to have Schizophrenia and/or other psychotic disorders (35.5%) or mood disorders (49.8%).

Outcomes

- **Functioning**
  - Most of the clients this first year received Global Assessment of Functioning (GAF) scores in the range of 31 to 60 which indicates moderate symptoms to major impairment.
  - Females (47) were reported to have a very slightly higher level of functioning, according to the rating clinician, than males (45).
  - Reported levels of functioning differed only very slightly by ethnicity including: Whites (47), those grouped into a category called "Asian and Pacific Islanders" (46), Hispanics (45), and African Americans (44).
  - Those individuals diagnosed with Mood Disorders (47) had a slightly higher rated level of functioning than those with Schizophrenia or other Psychotic Disorders (44).

- **Quality of Life**
  - *Subjective Scales* - Overall, clients report they feel "mostly dissatisfied" to "mixed" in the areas of a) General Life Satisfaction, b) Living Situation, c) Leisure Activities, d) Daily Activities, e) Family Relations, f) Social Relations, g) Finances, h) Safety, and I) Health.
  - Objective Scales – In general, clients are reporting having contact with their family members at least once per month. The same is generally true with their non-family social contacts. Clients report to have between $25 to $50 available for spending money. Nearly half feel that they do not have sufficient financial resources to cover their living needs. Nine percent reported being a victim of a crime. Twelve percent reported being either arrested or "picked up." And most clients reported that their general health status was fair to good.

- **Satisfaction With Services**
  - In general, clients were quite satisfied with the services that they received from county mental health programs (4.27 out of a possible rating of 5) .
  - Females were generally more satisfied than males, but only slightly.
  - White clients were generally less satisfied than Hispanics, African Americans, and those grouped under the category of Asian and Pacific Islanders.
  - Older clients were generally more satisfied than younger clients.

- **System Modifications**
  - After one year of implementation, it was discovered that one of the APOS instruments, the Behavior and Symptom Identification Scale (BASIS-32) was not working as expected. While it was hoped that this instrument would empower the client to express the extent to which their symptoms were affecting their daily functioning, it proved not to be the case. After careful review and comparisons with other populations and data sets, it became evident that the BASIS-32 was not effectively measuring symptoms and functional impairments.
  - Additionally, the Department's QIC did not find the information from the BASIS-32 to be critical to assessing program effectiveness and improving quality.
  - Therefore, after consulting with representatives of the mental health consumer community, representatives of the CMHDA and other DMH staff, it was agreed that the BASIS-32 should be dropped from the set of required APOS instruments.

Older Adult Performance Outcome System (OAPOS)

- Eight county mental health programs have volunteered to participate in a pilot project designed to select assessment tools that are appropriate for gathering client-level information from older adult clients with serious and persistent mental illnesses.
- A variety of assessment tools including health measures, symptom scales, and functional scales are being tested to collect the client-level data that will augment system level data and which will be used to assess the effectiveness of programs designed to provide services to older adults.
- Data collection has been completed and the final analysis phase has begun. Direct feedback from clinicians, program managers, and consumers is being collected and documented by each county and will be included in the final report.
- Final recommendations for instrument selection should be complete by April 2001 with implementation of the full system beginning in mid 2001.

Conclusion

The challenges to implementing statewide performance outcome systems are enormous. Perhaps the greatest accomplishment so far has been the building of effective collaborative relationships whereby state and county staff, as well as members of the mental health consumer community, enthusiastically and regularly work to build systems that monitor community mental health program performance and foster an atmosphere of continuous quality improvement. On a statewide level, these measures have been accepted and are being used by the Department's Quality Improvement Committee (QIC) to facilitate system

improvement. Finally, a more complete understanding of which data are effective and useful for program evaluation and development is emerging.

Challenges and methodological issues relating to the performance outcome systems are continuing to be assessed. The goal of the DMH is to build systems that can react flexibly to changing understandings and the state-of-the-art in measuring outcomes in mental health.

To this end, a task force has been convened to facilitate the development of the next evolutionary step of the Child and Youth Performance Outcome System. A pilot test of the proposed system is underway with final recommendations to be made in mid-to-late 2001. This system, when it is eventually implemented, will collect information that is more effective in evaluating the entire system of care rather than being directed only at mental health systems. This is because improvements in a child's functioning is likely the result of a collaborative venture between and among a wide variety of county agencies including Child Protective Services, Probation, Social Services, Health Services, and local Departments of Education.

Performance Measure Reports

Goals
1. Collect data that enhances and facilitates the provision of effective clinical care.
2. Collect data that counties can use to evaluate their systems of care and foster a climate of continuous quality improvement.
3. Collect data that addresses the outcome domains and indicators as identified by the California Mental Health Planning Council and the Department's Quality Improvement Committee.
4. Create a collaborative and interactive system whereby data are collected, analyzed and rapidly made available to state and county staff as well as mental health consumers for use in decision support activities that support and facilitate the construction of efficient, effective, collaborative, and state-of-the-art systems of care.

BACKGROUND

In response to initiatives and discussions at national, state, and local levels, there is increasing interest in developing and implementing measures of system and client-level outcomes in community mental health programs. National organizations, state mental health agencies, and county mental health authorities are currently in the process of developing and implementing mental health performance outcome measurement systems to ensure accountability for the expenditure of public behavioral healthcare dollars and for ensuring high quality and effective care to mental health consumers.

Efforts toward performance measurement for mental health services on the national level include, among others, the Mental Health Statistics Improvement Program (MHSIP), Performance Measures for Managed Behavioral Healthcare Programs (PERMS), and Candidate Indicators for County Performance Outcomes. Table 1-1 (page 3) summarizes the proposed domains and measures for each of these national programs currently under development.

At the State level, performance measures are being developed in states that have, as well as those that have not, introduced managed care reforms. Serious efforts have been underway for a number of years to develop system and client measures to facilitate the monitoring of contracts and to assist in continuous quality improvement. Approximately half of the states in the country have developed, or are in the process of developing, report cards or performance outcome measurement systems.

Realignment Legislation

For many years, mental health funding in California was on a fiscal roller coaster, subject to the vagaries of the state budget. In 1991, legislation referred to as "Realignment" (Chapter 89, Statutes of 1991, also known as the Bronzan-McCorquodale Act) created a more stable funding source by earmarking a certain percentage of the sales tax and vehicle license fees for county mental health funding. Realignment Legislation also specifies the maintenance and oversight of a public mental health service system for a target population of persons who are seriously mentally ill which is "client-centered, culturally competent, and fully accountable". The Realignment Legislation requires the development of a uniform, statewide client-based information system that includes performance outcome measures.

Realignment Legislation requires that all counties report data on performance outcome measures to the State Department of Mental Health (DMH) which, in turn, is to make those data available to the California Legislature, local mental health boards and commissions, and the California Mental Health Planning Council (CMHPC).

Collaborative Process

The CMHDA, CMHPC, DMH, and individuals representing the mental health consumer community have collaborated on every step of the process for developing California's mental health performance outcome system.

The central feature of the process was the Performance Outcome Advisory Group (POAG). The POAG was comprised of members drawn from the CMHDA, CMHPC, DMH, direct consumers, family members, and representatives of mental health consumer advocacy groups. The POAG, which was a policy level work group, reviewed recommendations from the Performance Outcome Technical Work Group (POTWG) and made recommendations to DMH for final decision. The POTWG was composed of some members of the POAG as well as other individuals with specific clinical, policy, fiscal or data management expertise. The work group was co-chaired by the DMH, CMHDA, and CMHPC and all interested parties were welcome to attend workgroup meetings. Together, these groups attempted to represent a balanced voice from all of the major constituencies. Their recommendations were presented to the DMH which, upon considering the issue from the State perspective, made informed policy decisions.

Once the POAG had completed its function (laying the groundwork for the outcomes implementation process), the group was disbanded. In an effort to facilitate a more unified and cohesive system for statewide oversight of the mental health system, DMH has established a Statewide Quality Improvement Committee (QIC). This committee established a Performance Outcomes Work

Group that is intended to pick up the responsibilities of the original POAG and POTWG groups and make procedural and policy recommendations to the QIC.

TABLE 1-1: National Performance Outcome Systems in Development

National Program	Domains	Measures
MHSIP* is a collaborative and cooperative venture between the Federal Government and the States to work towards achieving program, management, and performance monitoring improvement through the use of data. MHSIP provides guidance and technical assistance regarding mental health information systems, promotes uniformity through standards, and facilitates meaningful comparisons of costs, performance and services.	The MHSIP Report Card, a consumer-centered managed care report card, covers the general domains of access, quality and appropriateness, promotion/ prevention and outcomes.	The MHSIP Report Card's proposed measures include speed and access to services, affordability, parity of coverage, consumer access to information, absence of cultural barrier, consumer health, quality of life, reduction in psychological stress, and consumer productivity and independence.
The American Managed Behavioral Healthcare Association, representing private managed behavioral healthcare providers on a national level, has field-tested PERMS** 1.0 utilizing data collected from MediCal records, administrative data and client surveys.	PERMS** organizes performance measures into access, consumer satisfaction and quality of care domains.	PERMS** includes measures of service utilization, cost, penetration rates, call abandonment rates, and consumer satisfaction with access to clinical care, efficiency, and effectiveness.
Candidate Indicators for County Performance Outcomes are being developed by the Evaluation Center @ HSRI under a contract with the National Association of County Behavioral Healthcare Directors (NACBHD).	The NACBHD's proposed system includes access, consumer satisfaction, consumer outcomes, intersystem outcomes, and utilization domains.	Individual indications and measures of service include: level of staff cultural competence; location; speed, ease and timeliness; consumer satisfaction with comprehensiveness; integration of services with social supports; symptom management and level of wellness; level of independence; self-reliance and self esteem; level of consumer involvement in work, school, social and family relationships, contacts with other community providers; use of hospital care; and cost of services.

* MHSIP is an acronym for Mental Health Statistics Improvement Program
* PERMS is an acronym for Performance Based Measures for Managed Behavioral Healthcare Programs

Development of California's Performance Outcome Measurement System

Previous Adult Performance Outcome Efforts

The first attempt at collecting performance outcome data was based on a custom-designed survey, the Adult Performance Outcome Survey (APOS), developed by DMH in conjunction with county and consumer representatives. This custom survey was designed to be administered to a representative sample of seriously mentally ill adult clients at a beginning time, six months later, and finally at the end of 12 months from the beginning time.

This more "scientific" approach was only marginally effective due to several factors that were identified during the course of the study. These factors affected both the quality of the data collected and the subsequent ability of DMH to use that data to evaluate program outcomes.

The first of the factors that was identified was the fact that maintaining a representative sample of clients with severe mental illness over the course of a year is very difficult. This is primarily because many clients drop out of services without completing a planned discharge. Exactly what happens to these clients and why they drop out is often not clear. Some of the clients may move out of the area while others discontinue services because their functioning may deteriorate to the point where they can no longer access the services. On the other hand, some clients may feel like they have "improved" and no longer need mental health services and stop coming in. Additionally, clients may be so dissatisfied with the services they have been receiving that they discontinue them. With children this problem may be particularly acute because children are frequently reliant on their parents to bring them to services and if the parent refuses to bring the child, little can be done to continue those services.

In an effort to maintain a sample that was as representative as possible, county staff were required to spend time looking for these missing individuals. These efforts were time-consuming, not particularly cost-effective, and took valuable time away from providing direct client services. Clinical staff expressed significant displeasure at being diverted from what they perceived was their primary responsibilities. Additionally, since the custom-designed survey was only administered to a sample of county mental health clients, clinicians administering the survey viewed it as "just more paperwork" because it did not add to their ability to provide quality services to clients.

In terms of making valid comparisons that could help evaluate whether one program was more effective than another program, since the survey was custom-designed and not a standardized instrument, the data were not comparable to data from other states or entities. Since that time, ensuring that data is comparable is becoming increasingly important in an era of national focus on performance measures.

Data collected from the APOS did have some usefulness. First, the CMHPC created workbooks that were sent to each county's mental health board/commission. The mental health board was encouraged to meet with county staff and complete the workbook in an effort to help interpret the data. Thus, the APOS resulted in increased communication between mental health boards/commissions and county mental health programs. Additionally, the APOS project helped identify potential problems and shortcomings that could be corrected in future outcome efforts.

Based upon the results from the APOS, the CMHDA, and CMHPC, the DMH established several criteria for future studies. These criteria, which were intended to guide in the design of California's performance outcome systems and the selection of instrumentation that would ultimately be used to collect outcome data included recommendations that any data collected should:

- be useful to clinicians for treatment planning (although more recent reviews of the systems indicates that this is less important to stakeholders than the remaining criteria);
- be useful to counties for quality management purposes;
- meet the requirements of the State for performance outcome data; and
- allow comparison of California's public mental health programs with those of other states/entities.

Child And Youth Performance Outcome System

In an effort to design a Child and Youth Performance Outcome System (CYPOS) that did not suffer from the same shortcomings of the APOS, a system was developed that made use of either standardized and/or widely recognized instruments to collect client-level outcome data. These instruments were selected based on the experiences of California's grant funded Children's System of Care (CSOC) counties and upon the recommendation of both the University of California, San Francisco Child Services Research Group and Representatives of the CMHDA.

The specific instrumental recommendation to the State to collect client outcome data included seven assessment instruments. Some of these instruments are intended to be completed by the client, others by the parent or primary caregiver, and one by the clinician. Of the seven instruments, five are considered to be "core" or required, while two are optional but recommended. A more detailed description of the Children's Performance Outcome System as well as preliminary first year data are presented on page 8.

Adult Performance Outcome Pilot

Under the leadership of DMH, and in collaboration with the CMHPC and the CMHDA, nine counties volunteered to participate in a pilot project to assess several instruments for use in the implementation of the Adult Performance Outcome System in California. The pilot counties were: Los Angeles, San Francisco, San Joaquin, San Mateo, Santa Barbara, Stanislaus, Tehama, Tulare, and Ventura. The piloted instruments were evaluated on administrative, psychometric, and qualitative factors. In addition, discussions were held regarding the minimum set of instruments necessary to adequately measure several important quality of life domains. Pilot counties also evaluated the automated or manual data entry/scoring systems they used to report performance outcome data to clinicians, county management, and DMH.

Each pilot county administered a selection of assessment instruments to a sample of their clients representing the performance outcome target population (adult clients with a serious mental illness who have or are expected to be in service more than 60 days) at time one and then again six months later. Each county then forwarded its pilot data to the DMH for analysis, along with an evaluative report. The report described their sample of clients; the training, selection, and administration procedures used; and provided narrative evaluations of the instruments and data collection/scoring system used. Qualitative evaluations of instruments included: time to administer and score, clinical usefulness of the data generated, usefulness of the data for quality improvement or program evaluation, cultural competence of the instrument, and acceptability to consumers and/or family members. Qualitative evaluations of data information systems included cost of the system, optimal system requirements, ease of the system to set up and use, stability of the system, and customer service and technical support from the developers of the system.

Recommendation

Through a collaborative process and taking into account the adult pilot results as well as other factors, the POAG recommended the following set of instruments for the APOS:

- the Global Assessment of Functioning *(GAF*)
- the Behavior and Symptom Identification Scale (*BASIS-32)*
- a quality of life instrument (**either** the California Quality of Life (*CA-QOL)* **or** Lehman's Quality of Life - Short Form (*QL-SF*)
- the *MHSIP* Consumer Survey (26-item version)

Each of the above tools as well as additional detail on the APOS is provided later in this report.

Older Adult Performance Outcome System

Originally, outcomes for older adult mental health clients were going to be collected using the same system as used for adults. However, upon a more careful review it became clear that older adults had a number of unique characteristics that necessitated that a separate pilot test be conducted to select the best measures for collecting data on these individuals. Some of these unique characteristics include an increased physical fragility and concomitant physical healthcare needs associated with it. Such physical illnesses often interact with the client's psychological health and frequently affect the client's ability to perform activities of daily living. Older adult clients also are much more likely to experience various forms of dementia or other degenerative brain disorders that affect what kinds of outcomes may be expected as a result of receiving treatment from community mental health programs.

Currently, DMH is collaborating with a number of volunteer counties as well as representatives of the CMHPC to conduct a pilot test of potential instruments that may be used to collect client-level outcome data for older adults. Additional information on the Older Adult Pilot Project as well as preliminary information of pilot participants that has been collected to date is presented later in this report.

Child And Youth Performance Outcome System (CPOS)

OBJECTIVES

The California Mental Health Planning Council (CMHPC) has been assigned the authority by legislature to establish performance outcome domains that will be used to assess services provided to severely emotionally disturbed (SED) children and youth in the California public mental health system and to approve the specific indicators to be used to measure these outcome domains. The performance outcome *domains* and *values* approved by the CMHPC for children and youth clients with SED are listed below, and the desired *outcomes*, *indicators*, and *sources of data* are specified on the following pages. Although data are not currently available for some of these domains, it is generally agreed upon that they are important. Furthermore, they provide an overall framework to guide in the ongoing evolution and development of the CPOS.

Domains and Values

I. Outcome Domain: Living Situation

Value: Children and adolescents who are seriously emotionally disturbed should remain in their homes whenever possible or should be placed in the least restrictive, most appropriate, natural environment as close to home as possible. Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations; moving during the year as few times as possible consistent with their treatment needs.

II. Outcome Domain: Psychological Health

Value: The level of psychological distress from symptoms experienced by a child or adolescent should be minimized. The level of distress experienced by a family with children or adolescents with serious emotional disturbances should be minimized.

III. Outcome Domain: Physical Health and Safety

Value: Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication. Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives.

IV. Outcome Domain: Social Involvement and Functioning

Value: Children and adolescents who are seriously emotionally disturbed should be supported in developing or maintaining nurturing relationships with their families. Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities.

V. Outcome Domain: School Involvement and Functioning

Value: Children and adolescents who are seriously emotionally disturbed belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential.

VI. Outcome Domain: Legal

Value: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction.

I. Outcome Domain: Living Situation

Desired Outcome #1
Children and adolescent clients with SED are remaining in their homes whenever possible or are in the least restrictive, most appropriate, natural environment as close to home as possible.

Indicator 1
Evaluation of changes over time in the percentage of SED children and adolescent clients in various living situations.

What source will we use to measure performance on this indicator?
Client Living Environments Profile (CLEP) data reported by county staff on the current and predominant annual living situation of the client.

Indicator 2
Evaluation of changes over time in the percentage of SED children and adolescent clients in less restrictive versus more restrictive living situations.

What source will we use to measure performance on this indicator?
Client Living Environments Profile (CLEP) data reported by county staff on the current and predominant annual living situation of the client.

Desired Outcome #2
Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations, moving during the year as few times as possible consistent with their treatment needs.

Indicator 1
Evaluation of changes over time in the annual number of changes in living situation for SED children and adolescent clients.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 2
Evaluation of changes over time in the number of days in each placement for SED children and adolescent clients.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

I. Outcome Domain: Living Situation (cont.)

Desired Outcome #3
Children and adolescents who are seriously emotionally disturbed and their families should be afforded optimum satisfaction levels with the child's living situation.

Indicator 1
Evaluation of changes over time in the subjective satisfaction level of the children with their living situation.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 2
Evaluation of changes over time in the subjective satisfaction level of the parent/caregiver with their child's living situation.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

II. Outcome Domain: Psychological Health

Desired Outcome #1
The level of psychological distress from symptoms experienced by a severely emotionally disturbed child or adolescent is minimized.

Indicator 1
Evaluation of changes over time in the percentage of SED children and adolescent clients exhibiting symptoms of psychological distress.

What source will we use to measure performance on this indicator?
Internalizing and externalizing scales on the YSR (youth perception); the Role Performance in the Home CAFAS sub-scale, the Moods/Emotions CAFAS sub-scale, and the 5-scale CAFAS total score (clinician perception).

Desired Outcome #2
The level of distress experienced by a family with a child or adolescent with serious emotional disturbances is minimized.

Indicator
Increases over time in the percentage of children and adolescents whose families experience improved functioning or a reduction in family stress.

What source will we use to measure performance on this indicator?
Internalizing and externalizing scales on the CBCL (parent/caregiver perception).

III. Outcome Domain: Physical Health and Safety

Desired Outcome #1
Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives.

Indicator 1
Decreases over time in the percentage of SED child and adolescent clients who exhibit self-harmful and substance abuse behavior.

What source will we use to measure performance on this indicator?
The Self-Harmful Behavior CAFAS sub-scale (clinician perception).

Indicator 2
Increase over time in the percentage of SED child and adolescent clients who indicate they feel safe at home, in school, and in the community.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Desired Outcome #2
Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication.

Indicator 1
Evaluation of changes over time in the percentage of SED child and adolescent clients whose health is affected by collateral physical health problems who are receiving comprehensive services coordinated between their mental health care and physical health care provider.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 2
Evaluation of the effectiveness of psychiatric medication, if applicable.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

IV. Outcome Domain: Social Involvement and Functioning

Desired Outcome #1
Child and youth clients with SED should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities.

Indicator 1
Decrease over time in the percentage of child and youth clients with SED who exhibit functional impairments in their interactions with others and in the community.

What source will we use to measure performance on this indicator?
The Role Performance in the Community CAFAS sub-scale and the Behavior Toward Others CAFAS scale (clinician perception).

Indicator 2
Increase over time in the percentage of child and youth clients with SED who have age-appropriate social relationships, interests and activities.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Desired Outcome #2
Child and youth clients with SED should be supported in developing or maintaining nurturing relationships with their families.

Indicator
Increase over time in the percentage of child and youth clients with SED who have age-appropriate family relationships.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

V. Outcome Domain: School Involvement and Functioning

Desired Outcome #1
Child and youth clients with SED belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential.

Indicator 1
Decreases over time in the functional impairments exhibited in the school environment.

What source will we use to measure performance on this indicator?
The Role Performance in the School CAFAS sub-scale (clinician perception).

Indicator 2
Increase over time in the percentage of child and youth clients with SED who are attending school regularly.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 3
Evaluation of changes over time in the percentage of child and youth clients with SED who are in special education.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 4
Evaluation of changes over time in the assessment of academic performance for SED child and youth clients.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 5
Evaluation of changes over time in the subjective satisfaction level of the child or adolescent with attending school.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

VI. Outcome Domain: Legal

Desired Outcome
Child and youth clients with SED should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction.

Indicator 1
Decreases over time in the percentage of SED children and adolescents who have a substance abuse problem.

What source will we use to measure performance on this indicator?
The Self-Harmful Behavior CAFAS sub-scale and the Substance Use CAFAS scale (clinician perception). *(Note: Since unusually low percentages of SED children are identified on this scale as having a substance abuse problem, this may not be an adequate indicator for this outcome.)*

Indicator 2
Decreases over time in the percentage of SED children and adolescents involved in the juvenile justice system and with recidivism of SED children and adolescents.

What source will we use to measure performance on this indicator?
None -- there is no existing reliable or accessible source for these type of data.

Indicator 3
Decreases over time in the percentage of SED children and adolescents engaging in at-risk behaviors, including vandalism, property destruction, and physical assault.

What source will we use to measure performance on this indicator?
The role performance in the community CAFAS sub-scale and the behavior toward others scale is already reported under the social involvement and functioning outcome domain. The moods/self-harmful behavior CAFAS sub-scale is already reported under the physical health and safety outcome domain.

METHODOLOGY

Implementation

Implementation of CYPOS began in April 1, 1998. Data from county mental health programs are submitted to DMH bi-annually.

Target Population

The target population for California's Children and Youth Performance Outcome System (CYPOS) is youth who are less than 18 years of age and who have received (or are expected to receive) services for 60 days or longer, excluding children receiving medication only services and children receiving services through the county's individual provider network.

Instruments Administered

The instruments administered to children and youth for which DMH collects data include the:

- Child & Adolescent Functional Assessment Scale for Ages 7-18 (*CAFAS*)
  (a clinician-rated scale which measures a client's functional level for the domains of role performance in the school, at home, and in the community; behavior toward others; moods and self-harmful behavior; substance use, and thinking)

- Child Behavior Checklist for Ages 4-18 (*CBCL*)
  (a standardized assessment instrument which measures competencies and problems from the parent's perspective)

- Youth Self Report for Ages 11-18 (*YSR*)
  (a standardized assessment instrument which measures competencies and problems from the youth's perspective)

- Client Living Environments Profile (*CLEP*)
  (an indicator of the client's living situation and restrictiveness of the living situation)

- Client Satisfaction Questionnaire (*CSQ-8*)
  (an 8-item survey to measure consumer satisfaction with services received from the parent's perspective)

The schedule for completing the child and youth instruments is:

Assessment Instruments

- within 60 days of the client's involvement with county mental health (sometimes referred to as "intake" for the target population);
- annually (i.e., annual case review), and
- upon discharge.

Satisfaction Instrument

- annually, and
- upon discharge.

Current Status/Future Direction

Currently, a pilot project is being completed to examine potential alternative instruments for the CYPOS. Alternative instruments will be compared to existing instruments based on the type and value of data generated, the time and cost impacts to counties, and the relative cost effectiveness of the instruments. The existing system may be revised if analyses of the pilot data indicate that sufficient or better outcome data can be obtained while also minimizing the impact on counties for administering the instruments, collecting the data, and analyzing the results.

FINDINGS

The DMH has collected data for the first and second fiscal years (July 1, 1998 through June 30, 2000) of the Children and Youth Performance Outcome System (CPOS). The following pages present descriptive information (diagnosis, age, ethnicity, and gender) about clients and the cross-sectional results from instrument data. This report contains information based on 41,564 child and adolescent clients for the statewide fiscal year of 1998/99 (SFY 98/99) and 38,283 child and adolescent clients for the statewide fiscal year of 1999/00 (SFY 99/00).

Limitations on Data Interpretation

There are a variety of factors that affect the interpretability of these data. For example, the extent to which counties strictly comply with data collection and reporting protocols may affect the usefulness of these data in making comparisons between county programs. Additionally, there are unique conditions within individual counties (such as local policies and procedures, different management information systems, etc.) which make strict comparisons difficult due to differences in methods of instrument administration, collection of the data and tracking procedures. The child and youth performance outcome target population are children who receive county mental health services for 60 days or longer, excluding children who receive medication only services or services through a county's private provider network. Further, not all counties have provided complete data for all of their target population children while other counties are providing additional data on non-target population children. Finally, because mental health consumers are able to refuse to complete one or more of the outcome surveys, a certain amount of response bias could directly affect the results of the data analysis. For these reasons, any interpretations based solely on these data should be viewed with caution.

Summary of Demographic Data

DIAGNOSIS

The following table shows the statewide diagnostic categories reported on non-duplicated child and adolescent clients. (Note: The valid percent column excludes missing data.) The CPOS currently relies on linking to client records from another DMH database to identify diagnostic categories. Since the performance outcome system reports data more frequently and on a much more current time period than is currently available from the linking database, diagnostic categories are missing for the majority of the performance outcome clients records. However, for those clients with primary diagnostic information, which would represent clients who have been in the mental health system for some time, the four predominant diagnostic categories identified included Mood & Affective Disorders, ADHD, Disruptive Behavioral Disorders, and Anxiety Disorders.

Diagnostic Category	SFY 1998/99 Frequency	SFY 1998/99 Percent	SFY 1998/99 Valid Percent	SFY 1999/00 Frequency	SFY 1999/00 Percent	SFY 1999/00 Valid Percent
Developmental Disorders	284	0.7%	3.3%	204	0.5%	3.4%
ADHD	1,794	4.3%	21.1%	1,429	3.7%	23.7%
Disruptive Behavioral Disorders	1,605	3.9%	18.9%	1,245	3.3%	20.6%
Adjustment Disorders	855	2.1%	10.1%	524	1.4%	8.7%
Anxiety Disorders	1,001	2.4%	11.8%	704	1.8%	11.7%
Mood & Affective Disorders	1,937	4.7%	22.8%	1,279	3.3%	21.2%
Substance Abuse Disorders	35	0.1%	0.4%	21	0.1%	0.3%
Other Disorders	349	0.8%	4.1%	186	0.5%	3.1%
No Specific Diagnosis	641	1.5%	7.5%	450	1.2%	7.4%
Unknown/Missing	33,063	79.5%		32,241	84.2%	
TOTAL	41,564	100.0%	100.0%	38,283	100.0%	100.0%

AGE

The following table illustrates the statewide age categories reported on non-duplicated child and youth program mental health consumers aged 0 through 21. The highest percentage of clients, per the reported data, were in the 11 to 15 age category (approximately 45%). There are very few records for the 19 to 21 year old "transition age" youth, since adult instruments are to be completed for this population rather than the child and adolescent instruments; however, because some of these clients would not qualify for county adult system services, children/youth county staff continue to treat these "transition age" youth under children/youth services and submit the children's instrument data.

Age Category	SFY 1998/99 Frequency	SFY 1998/99 Percent	SFY 1998/99 Valid Percent	SFY 1999/00 Frequency	SFY 1999/00 Percent	SFY 1999/00 Valid Percent
0 to 5 Years	1,248	3.0%	4.1%	1,099	2.9%	3.8%
6 to 10 Years	10,159	24.4%	33.5%	9,315	24.3%	32.1%
11 to 15 Years	13,378	32.2%	44.2%	13,224	34.5%	45.6%
16 to 18 Years	5,357	12.9%	17.7%	5,157	13.5%	17.8%
19 to 21 Years	145	0.3%	0.5%	225	0.6%	0.8%
Unknown/Missing	11,277	27.1%		9,263	24.2%	
TOTAL	41,564	100.0%	100.0%	38,283	100.0%	100.0%

ETHNICITY

The following table shows the statewide ethnicity categories on children and youth receiving county mental health services. The table below presents non-duplicated client information. White, African American and Hispanic ethnicity groupings account for 93.5% of the children for whom ethnicity data was reported.

	SFY 1998/99			SFY 1999/00		
Ethnicity Category	Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
White	14,239	34.3%	48.2%	13,780	36.0%	48.5%
Spanish/Hispanic	8,576	20.6%	29.0%	8,117	21.2%	28.6%
African American	4,827	11.6%	16.3%	4,650	12.1%	16.4%
Asian/Pacific	371	0.9%	1.3%	317	0.8%	1.1%
Native American	482	1.2%	1.6%	405	1.1%	1.4%
Southeast Asian	246	0.6%	0.8%	248	0.6%	0.9%
Filipino	146	0.4%	0.5%	135	0.4%	0.5%
Other	637	1.5%	2.2%	763	2.0%	2.7%
Unknown/Missing	12,040	29.0%		9,868	25.8%	
TOTAL	41,564	100.0%	100.0%	38,283	100.0%	100.0%

GENDER

The following table shows the statewide gender categories for non-duplicated client information. Approximately 63% of the clients are male and 37% are female.

	SFY 1998/99			SFY 1999/00		
Gender Category	Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Male	19,143	46.1%	63.3%	18,448	48.2%	63.6%
Female	11,119	26.8%	36.7%	10,545	27.5%	36.4%
Unknown/Missing	11,302	27.2%		9,290	24.3%	
TOTAL	41,564	100.0%	100.0%	38,283	100.0%	100.0%

ADMINISTRATION TIMEFRAMES

The following table shows the frequency and percent of the time frames for the clinician administered CAFAS instrument. The majority of the administrations represent intake clients with new episodes. Discharge administrations for clients leaving county mental health services represented approximately 20% of each year's data. In examining the results of the data, it is important to note that the discharge data include not only the

clients officially approved for discharge by county mental health staff, but also those clients who self-discharge and some that are discharged to a juvenile justice, probation, or other type of agency.

	SFY 1998/99			SFY 1999/00		
Timeframe Category	Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Intake	26,843	56.2%	56.5%	23,333	53.9%	54.3%
Periodic	11,652	24.4%	24.5%	10,952	25.3%	25.5%
Discharge	8,987	18.8%	18.9%	8,659	20.0%	20.2%
Unknown/Missing	284	0.6%		348	0.8%	
TOTAL	47,766	100.0%	100.0%	43,292	100.0%	100.0%

Summary of Outcomes for Children and Youth

Client Living Environments Profile (CLEP)

The Client Living Environments Profile (CLEP) records the client's current living situation at the time of administration, as well as their predominant living environment over the prior 12 months. The following tables display the placement settings for the clients as reported in the fiscal year 98/99 and 99/00 data records. The majority of youth were reported to reside in a home environment, which corresponds with the system of care priority to place youth in less restrictive settings and provide wraparound services. However, a pilot study using a revised CLEP with more exclusive categories has indicated the CLEP “Home Setting” category may include some foster care placements that are in a home environment setting. If implemented, the revised CLEP could provide more detailed information regarding placement settings for children and youth clients.

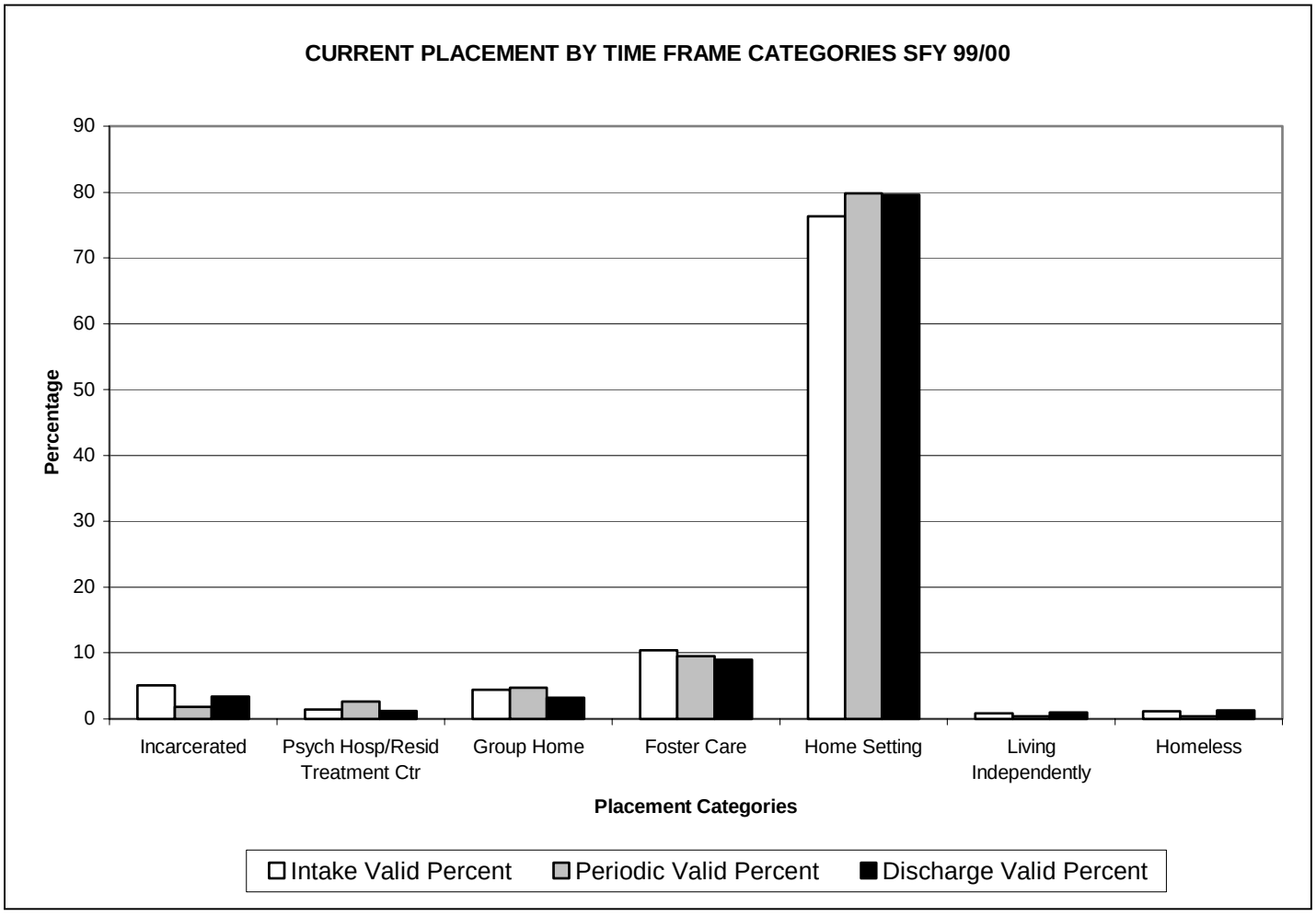
CURRENT PLACEMENT SETTING AT TIME OF INSTRUMENT ADMINISTRATION

	SFY 98/99			SFY 99/00		
	Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Incarcerated	1,596	3.5%	4.0%	1,856	3.9%	4.0%
Psych Hosp/Resid Treatment Ctr	915	2.0%	2.3%	859	1.8%	1.8%
Group Home	1,815	4.0%	4.5%	2,002	4.3%	4.3%
Foster Home	4,025	8.8%	10.0%	4,677	10.0%	10.0%
Home Setting	31,137	68.3%	77.5%	36,479	77.6%	78.2%
Living Independently	304	0.7%	0.8%	338	0.7%	0.7%
Homeless	365	0.8%	0.9%	447	1.0%	1.0%
Unknown/Missing	5,427	11.9%		333	0.7%	
TOTAL	45,584	100.0%	100.0%	46,991	100.0%	100.0%

PREDOMINANT PLACEMENT SETTING AT TIME OF INSTRUMENT ADMINISTRATION

	SFY 98/99			SFY 99/00		
	Frequency	Percent	Valid Percent	Frequency	Percent	Valid Percent
Incarcerated	460	1.0%	1.4%	532	1.1%	1.2%
Psych Hosp/Resid Treatment Ctr	647	1.4%	1.9%	697	1.5%	1.6%
Group Home	1,132	2.5%	3.4%	1,452	3.1%	3.4%
Foster Home	3,168	6.9%	9.5%	4,172	8.9%	9.7%
Home Setting	27,391	60.1%	82.4%	35,447	75.4%	82.7%
Living Independently	146	0.3%	0.4%	191	0.4%	0.4%
Homeless	288	0.6%	0.9%	368	0.8%	0.9%
Unknown/Missing	12,352	27.1%		4,132	8.8%	
TOTAL	45,584	100.0%	100.0%	46,991	100.0%	100.0%

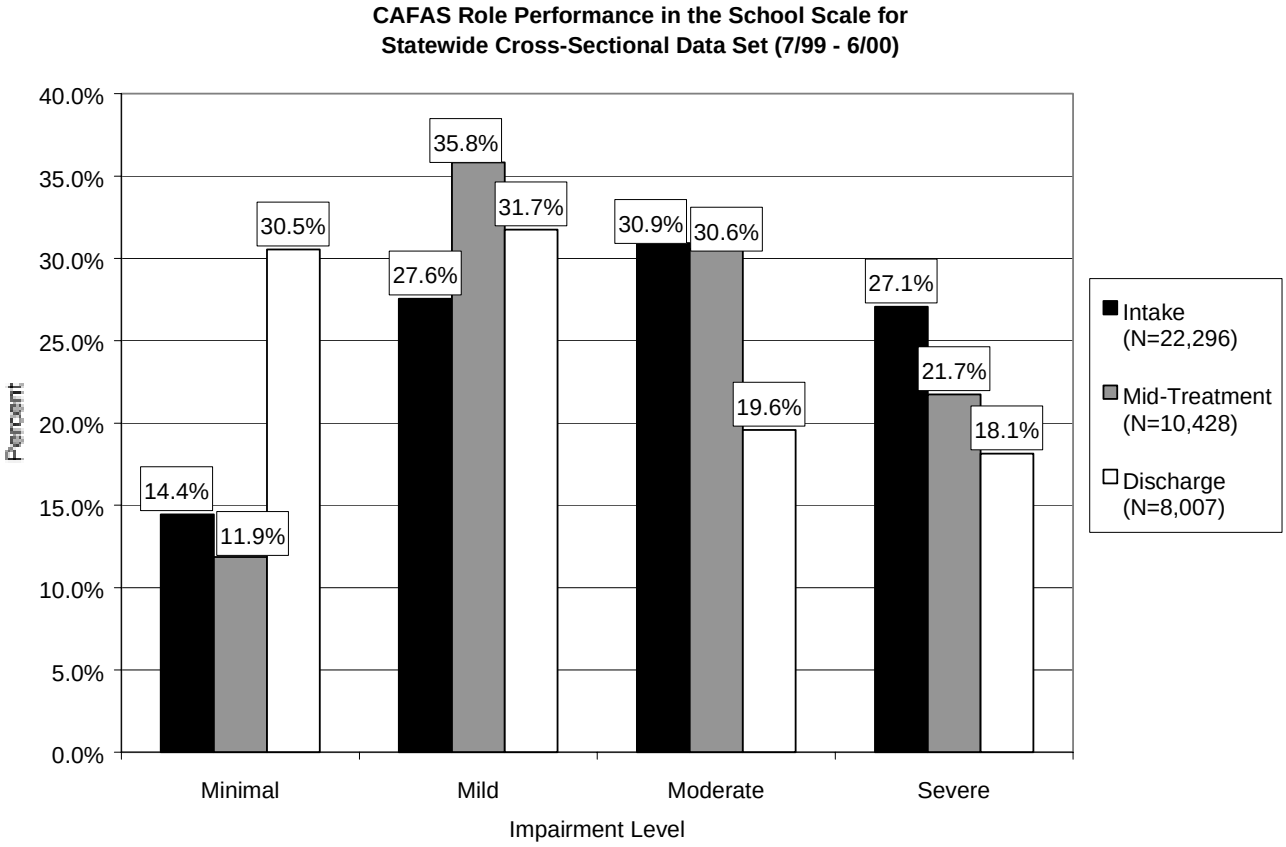
The following graph provides the current placement settings by time frame for the 99/00 fiscal year. These data indicate a reduction from more restrictive settings to less restrictive settings between intake and discharge from county mental health services.



Child and Adolescent Functional Assessment Scale (CAFAS)

Role Performance – School Subscale

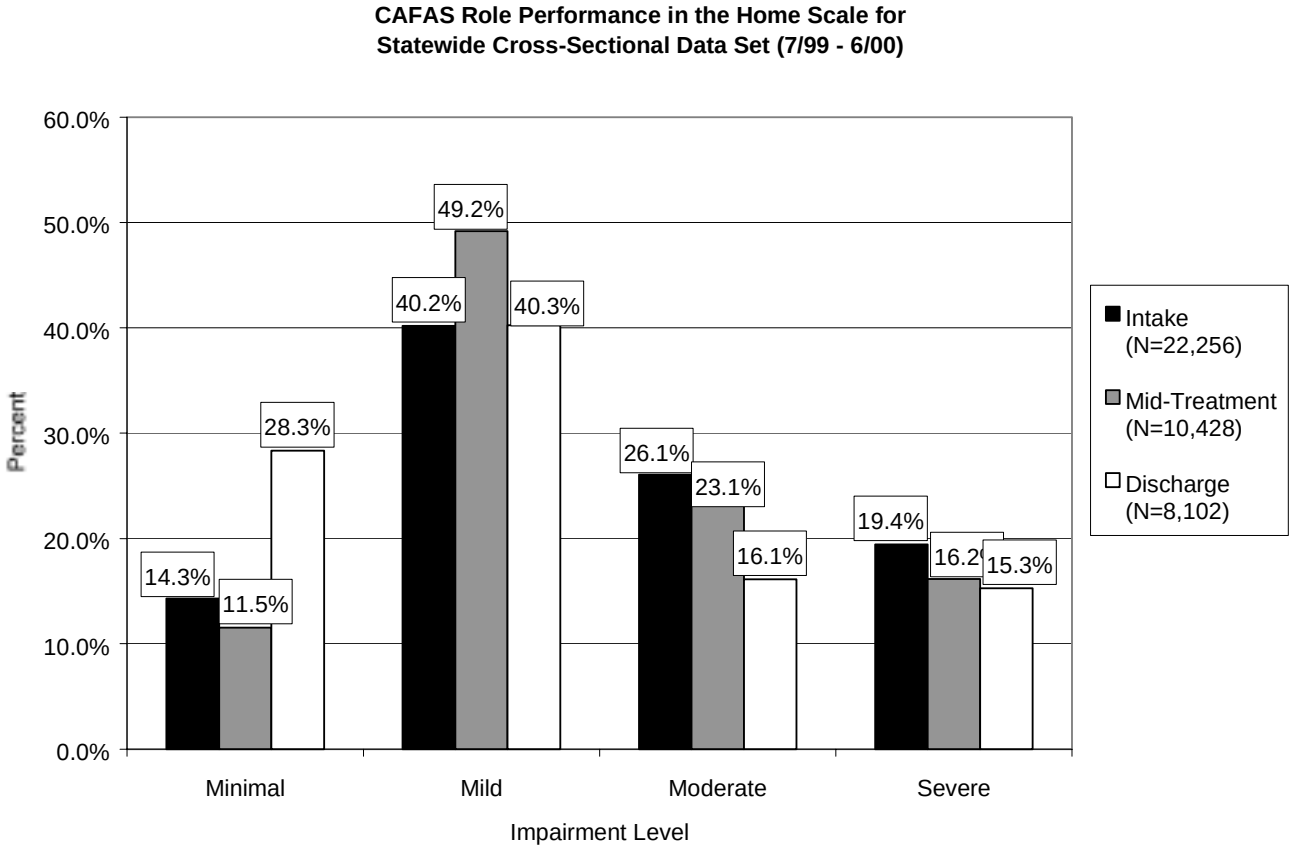
The Child and Adolescent Functional Assessment Scale (CAFAS) Role Performance - School subscale provides an indicator measure related to school involvement and functioning. As the following graph indicates, clinicians rated a much larger percentage of the discharging clients at a minimal impairment level than those clients with new episodes or in mid-treatment. There were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames.



These data indicate a strong positive trend with clients experiencing less functional impairments related to school during the time they are receiving services from county mental health/other agency programs.

Role Performance – Home Subscale

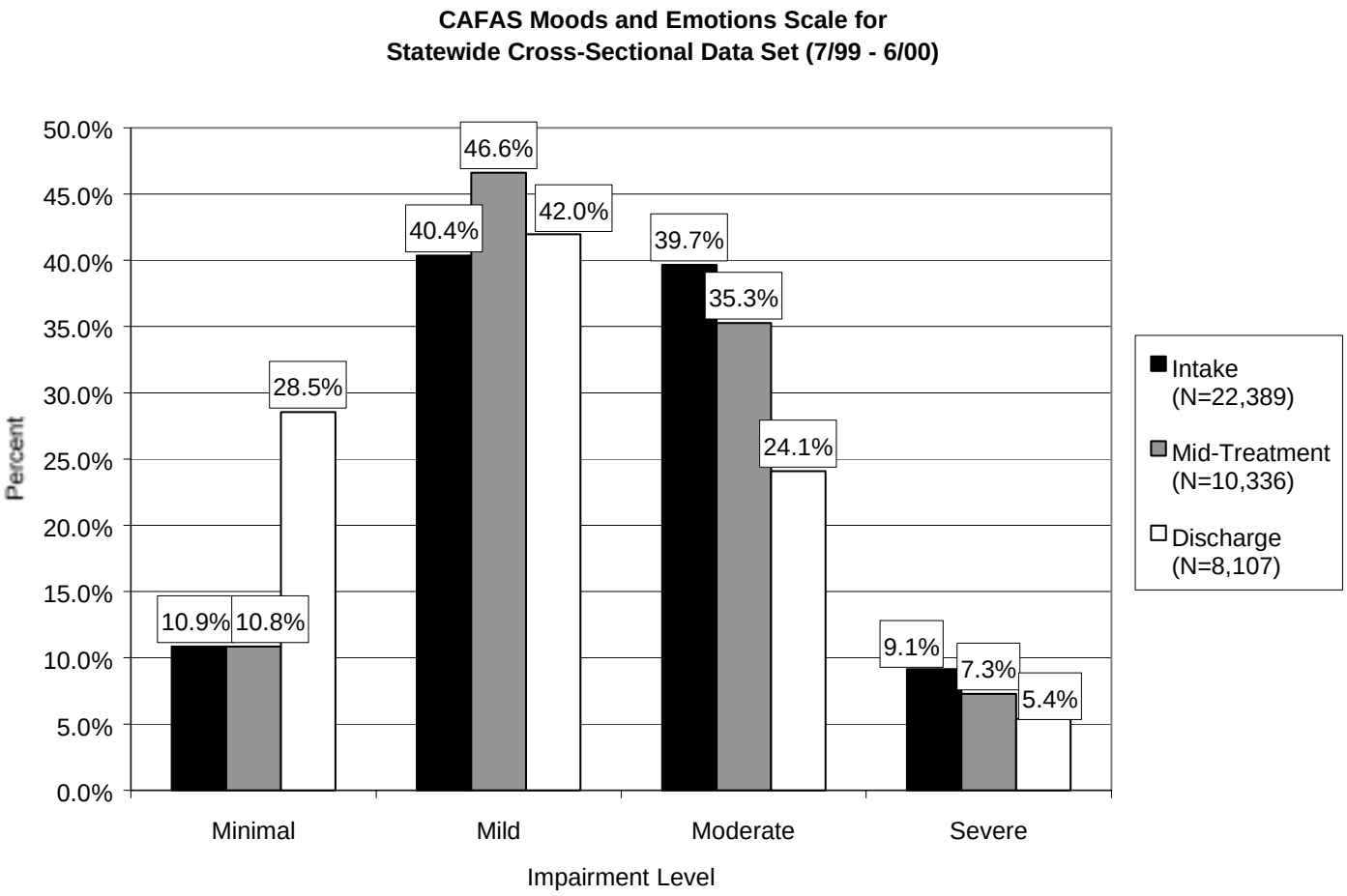
The Child and Adolescent Functional Assessment Scale (CAFAS) Role Performance - Home subscale provide indicator measures related to psychological health from the perspective of the clinical staff. As the following graphs indicate, clinicians rated a larger percentage of the discharging clients at a minimal impairment level than those clients with new episodes or in mid-treatment. There were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames.



These data indicate that county mental health/other agency staff are assisting clients and families to reduce client impairments exhibited in the home during the time they are receiving county services.

Moods and Emotions Subscale

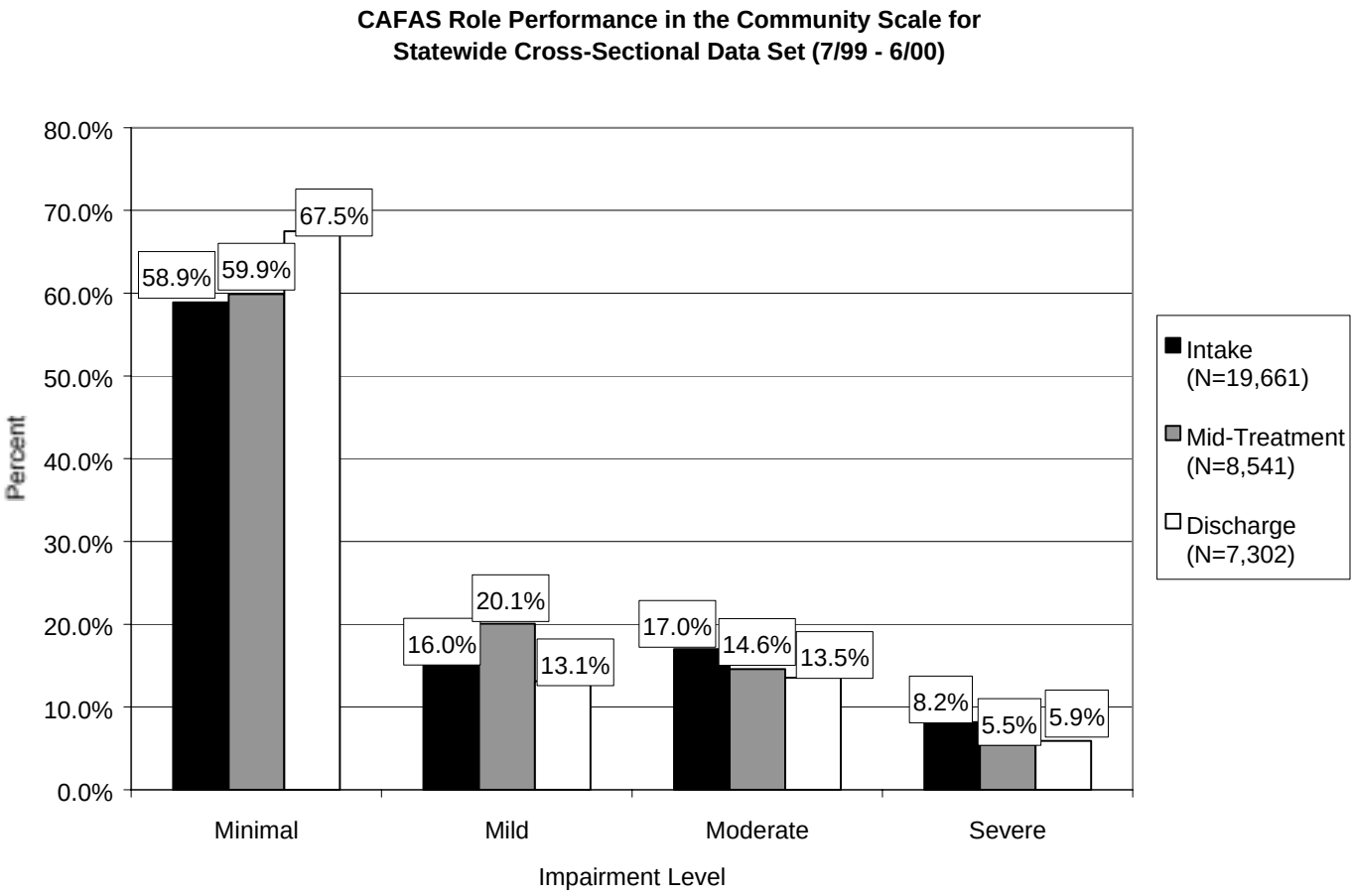
The Child and Adolescent Functional Assessment Scale (CAFAS) Moods and Emotion subscale also provides an indicator measure related to psychological health from the perspective of the clinical staff. As the following graph indicates, clinicians rated a larger percentage of the discharging clients at a minimal impairment level than those clients with new episodes or in mid-treatment. There were statistically significant differences in the impairment levels for children and youth by time frame grouping for the moods and emotion scale.



These data indicate that county mental health/other agency staff are assisting clients and families to improve the psychological health of children during the time they are receiving county services.

Role Performance – Community Subscale

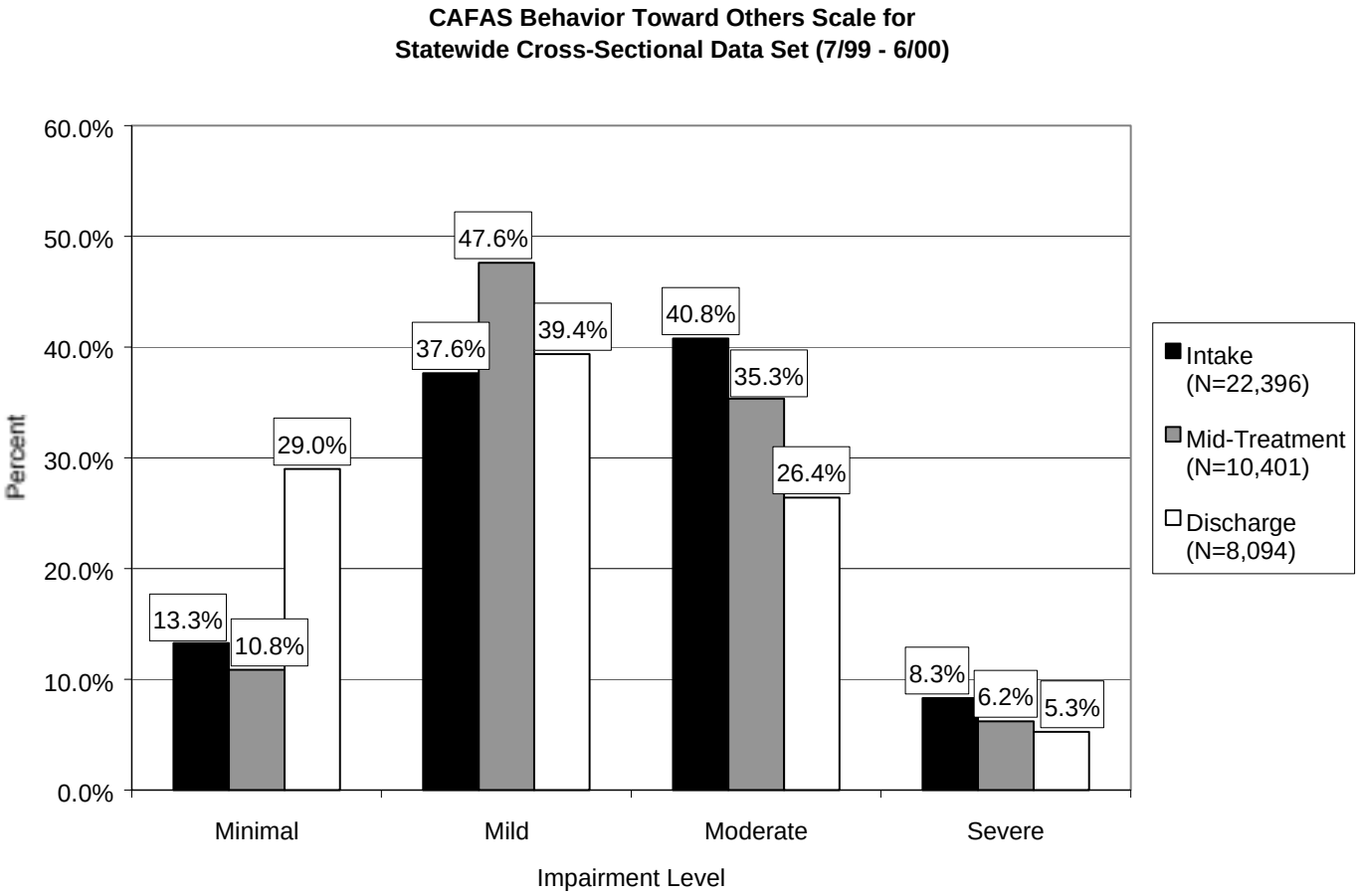
The Child and Adolescent Functional Assessment Scale (CAFAS) Role Performance - Community subscale provides an indicator measure related to social involvement and functioning. As the following graph indicates, over 50% of the children and youth clients were not experiencing impairments related to their functioning in the community. Of those that were rated as more highly impaired on this scale, there were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames. This suggests that children are improving over time.



For children and youth receiving services from county mental health/other agencies, these data indicate a positive trend with clients not typically getting into trouble in the community and, for those that do, there appears to be a decrease in troubled behavior during the time they are receiving services.

Behavior Toward Others Scale

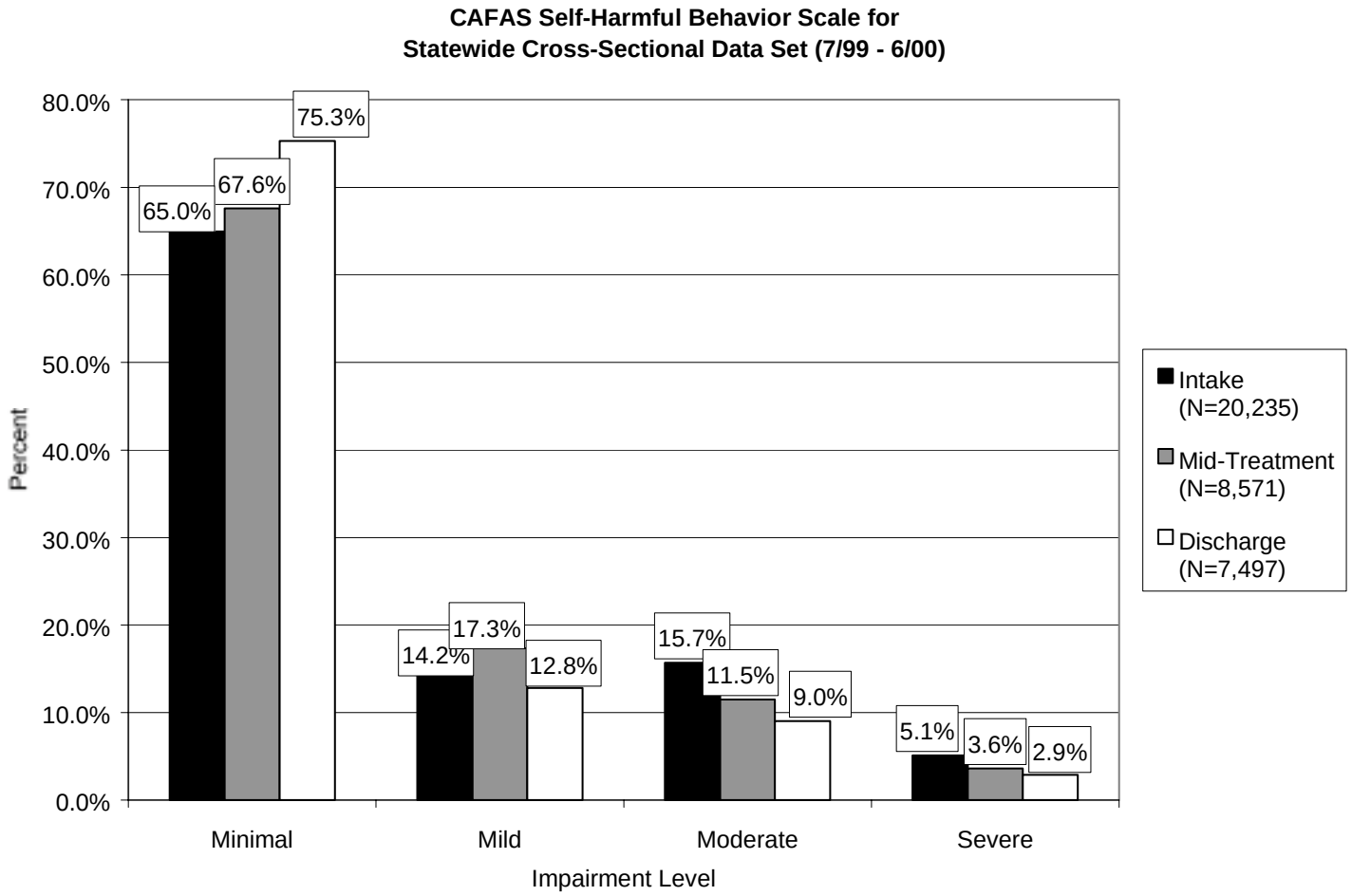
The Child and Adolescent Functional Assessment Scale (CAFAS) Behavior Toward Others Scale provides an additional indicator measure related to social involvement and functioning. As the following graph indicates, clinicians rated a much larger percentage of the discharging clients at a minimal impairment level in their behavior toward others than those clients with new episodes or in mid-treatment. There were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames.



These data indicate a positive trend with client's experiencing less functional impairments related to behavior toward others during the time they are receiving services from county mental health/other agency programs.

Self-Harmful Behavior Subscale

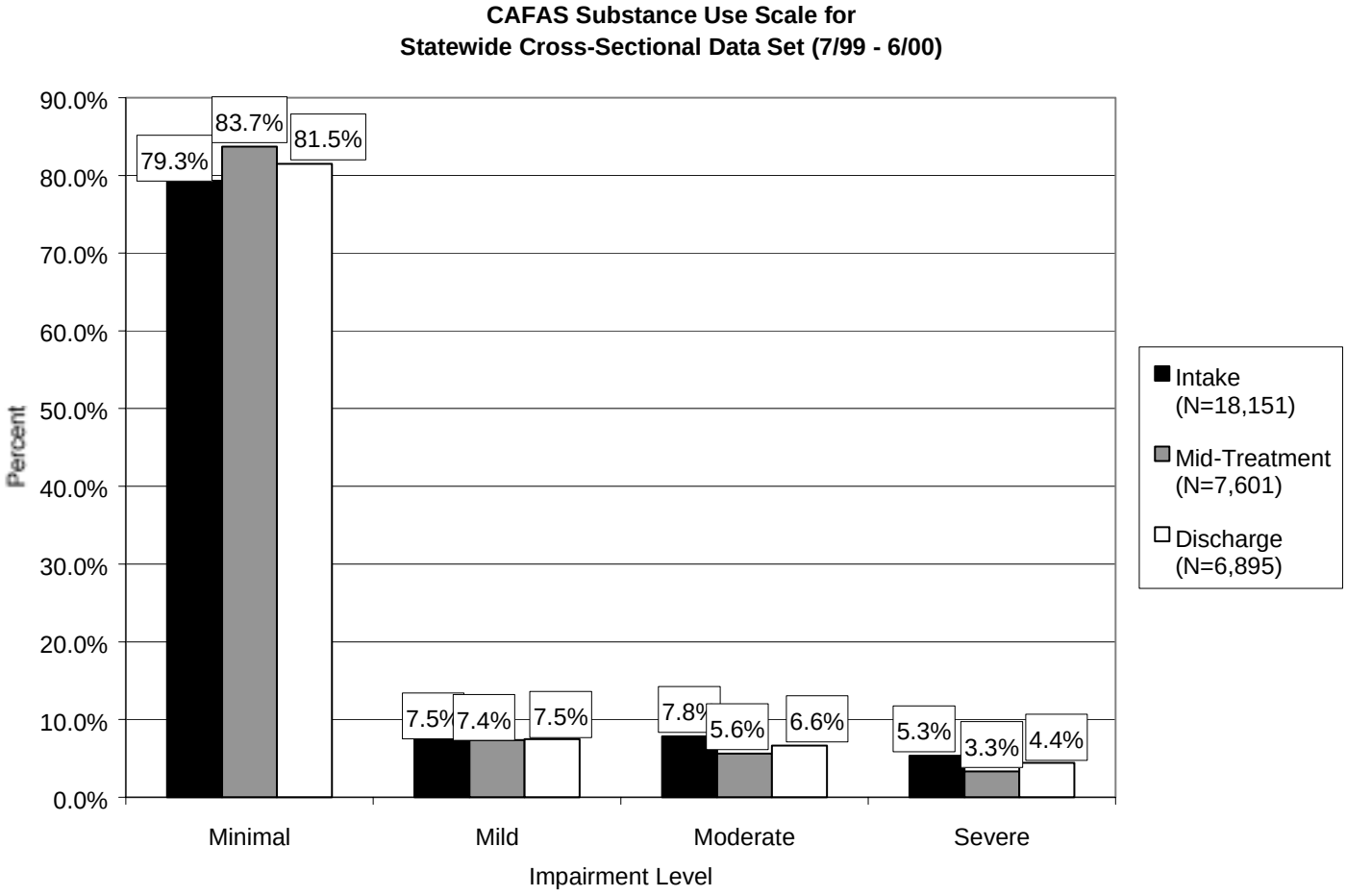
The Child and Adolescent Functional Assessment Scale (CAFAS) Self-Harmful Behavior subscale provides an indicator measure of the extent to which the client is involved in risky behaviors related to physical health. As the following graph indicates, over 60% of the clients were *not* rated by clinicians as exhibiting self-harmful behavior. Of those that were rated as engaging in such behavior, there were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames.



Although relatively few children are reported to exhibit self-harmful behavior, those that do, appear to get better during the time they receive county services.

Substance Use Scale

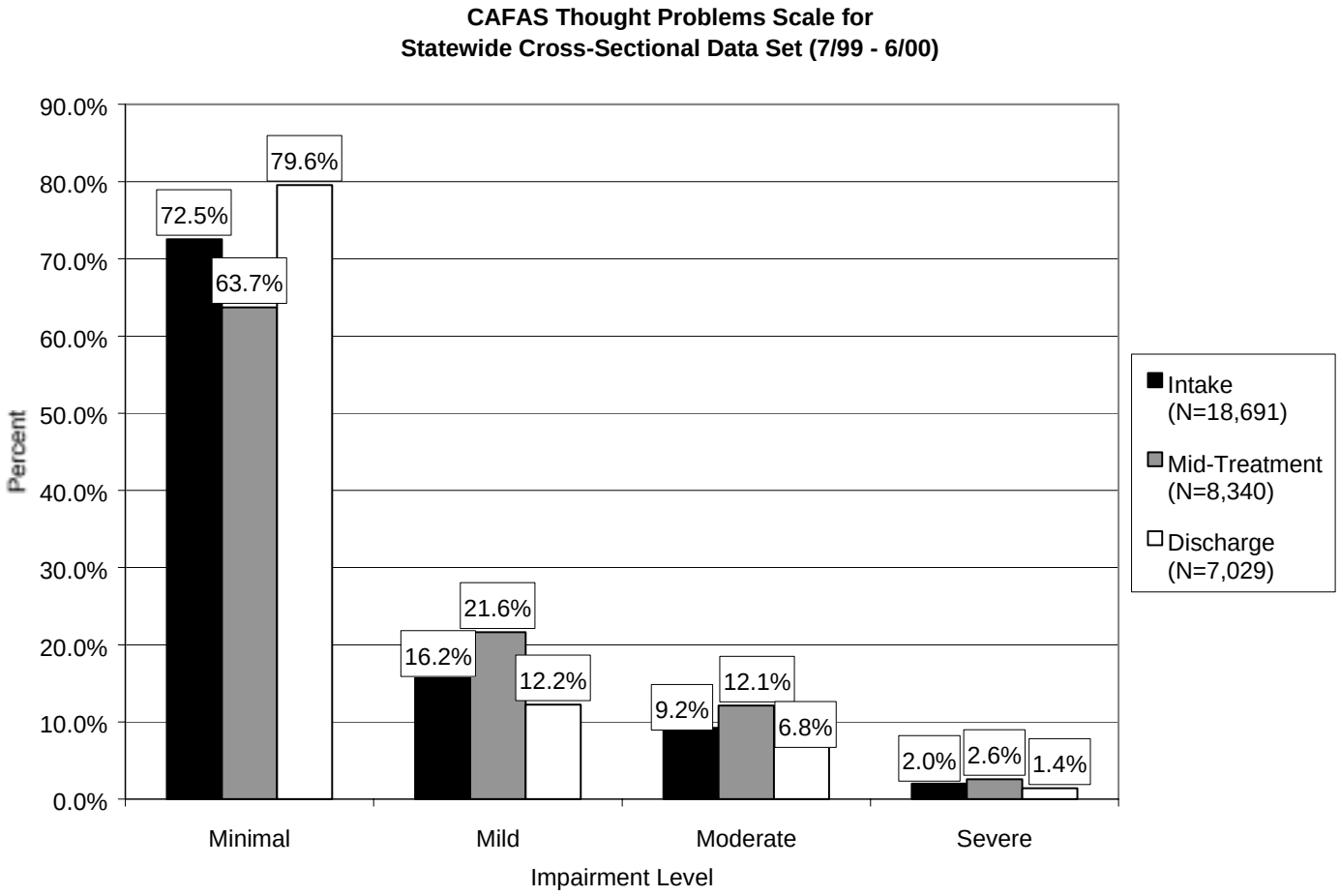
The Child and Adolescent Functional Assessment Scale (CAFAS) Substance Use scale provides an indicator measure of the extent to which the client is experiencing functional impairment related to substance use. As the following graph indicates, over 79% of the children and youth clients were *not* rated by clinicians as exhibiting functional impairments related to substance use. However, It should be noted that substance use detection is problematic for clinicians since they have limited exposure to the client (unless the client or family provides disclosure, or substance abuse is related to admission to county mental health services).



Although relatively few children are reported to exhibit substance use behavior, those that do, appear to improve during the time they receive county services.

Thinking Scale

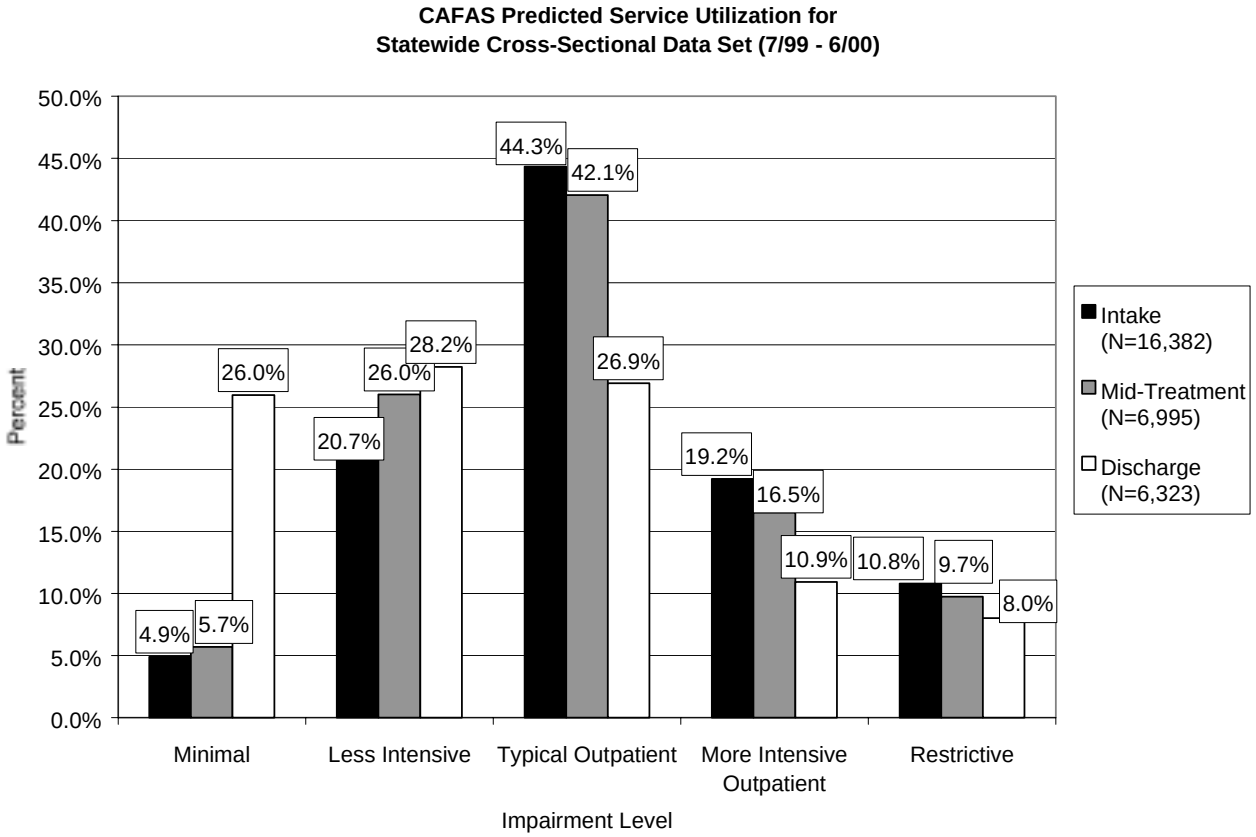
The Child and Adolescent Functional Assessment Scale (CAFAS) Thinking scale provides an indicator measure related to cognitive functioning. As the following graph indicates, clinicians rated over 60% of the children and youth clients as not exhibiting cognitive impairments. More clients are identified with thought problems at mid-treatment than at intake, reflecting the difficulty in determining cognitive impairments until further observation/tests can be made. Of those that were rated as more highly impaired on this scale, there were statistically significant differences in the impairment levels between the intake, mid-treatment and discharge time frames.



Although relatively few children are reported to exhibit cognitive impairments, those that do, appear to improve during the time they receive county services.

Predicted Service Utilization

The total score that results from summing the individual scale scores on the CAFAS has been shown, according to the instrument's author, to be predictive of the placement level a client is likely to require six to twelve months in the future. Change in this total score was used to evaluate the potential reductions in required services for a client after having received treatment from county mental health programs. Based on a cross-sectional analysis of the data, there appears to be a trend toward clients being predicted to require less intensive services if they have received services from county mental health programs.



Additionally, there were statistically significant differences ($p<0.05$) for the cross-sectional group changes in CAFAS scores between intake, mid-treatment and discharge. Higher scores indicate greater levels of functional impairment. As seen in the chart below, the mean score at intake was 53.99, which decreased to a mean of 50.97 for those in mid-treatment, and to a mean of 38.91 for those being discharged.

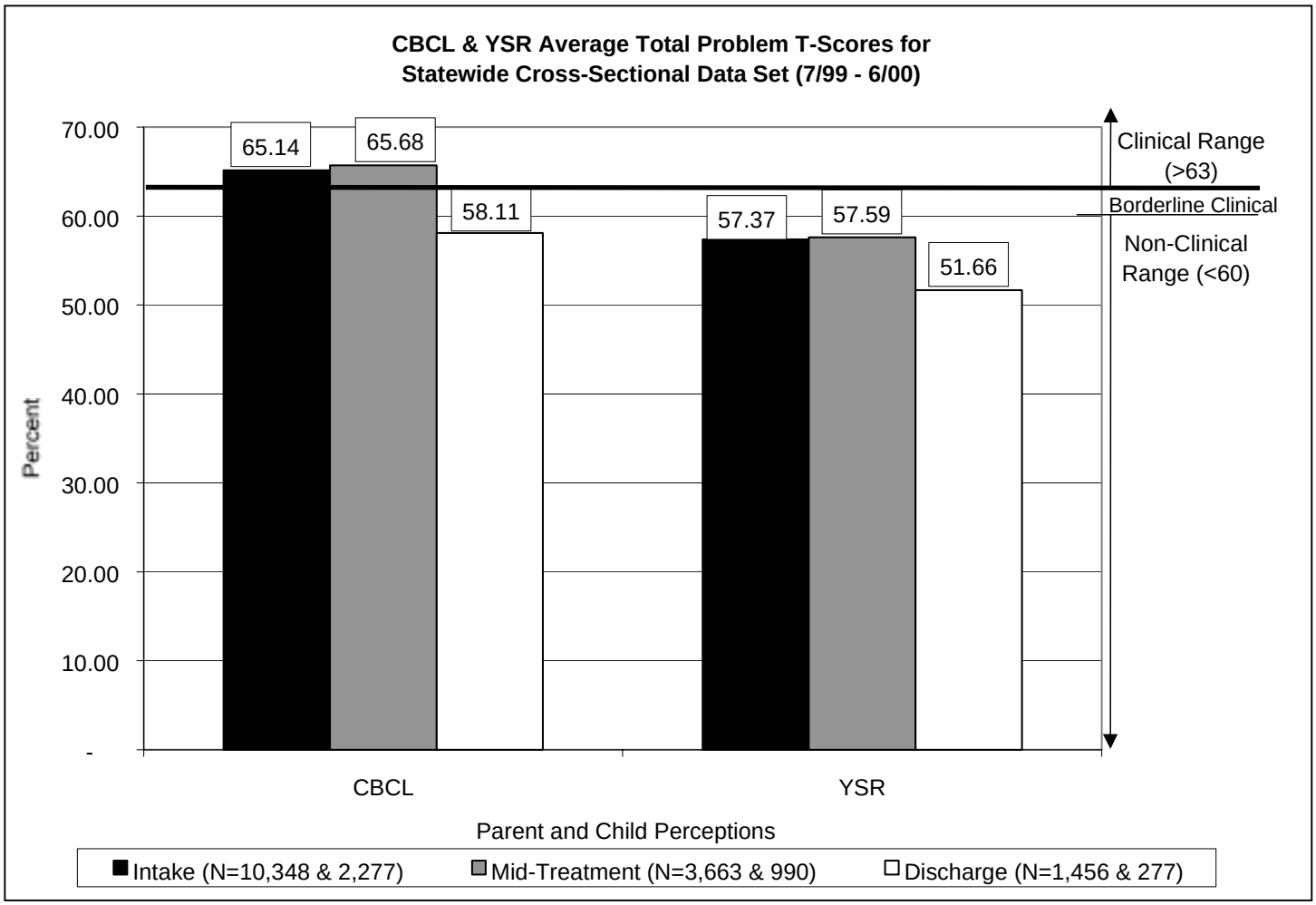
MEAN CAFAS SCORES (99/00)	
Intake (N=16,716)	53.99
Mid-Treatment (N=7,119)	50.97
Discharge (N=6,429)	38.91

These data indicate that clients experience significant improvement in functioning while they receive county mental health services.

Child Behavior Checklist (CBCL) and Youth Self-Report (YSR)

The Child Behavior Checklist (CBCL) and Youth Self-Report (YSR) data provide broadband syndrome groupings for internalizing and externalizing syndromes. The CBCL provides the parent's perspective and the YSR provides the youth's perspective. The internalizing syndrome is comprised of the withdrawn, somatic complaints and anxious/depressed scales. The externalizing syndrome is comprised of delinquent and aggressive behavior scales. The higher the scale score, the more significant the problem being indicated.

As the following graph indicates, based on a cross-sectional analysis of the data, there appear to be significant reductions in both the parent's and the child's total problem T-scores during the time they are receiving services from county mental health programs.



There were statistically significant differences in the internalizing, externalizing, and total problem scores by cross-sectional time frame groupings. The CBCL scores showed a statistically significant decrease in the means between the intake group and the discharge group.

MEAN CBCL SCORES			
	Intake	Periodic	Discharge
Internalizing Problems	61.47	61.31	54.93
Externalizing Problems	64.19	64.76	58.41
Total Problems	65.14	65.68	58.11

These data indicate that, from the parent's perspective, Youth are exhibiting fewer problems related to psychological health upon discharge than they exhibit initially at intake.

The YSR scores also showed a statistically significant decrease in the means, though not as large as those seen in the CBCL, between the intake group and the discharge group.

MEAN YSR SCORES			
	Intake	Periodic	Discharge
Internalizing Problems	55.65	55.57	50.82
Externalizing Problems	57.93	58.20	54.88
Total Problems	57.37	57.59	51.66

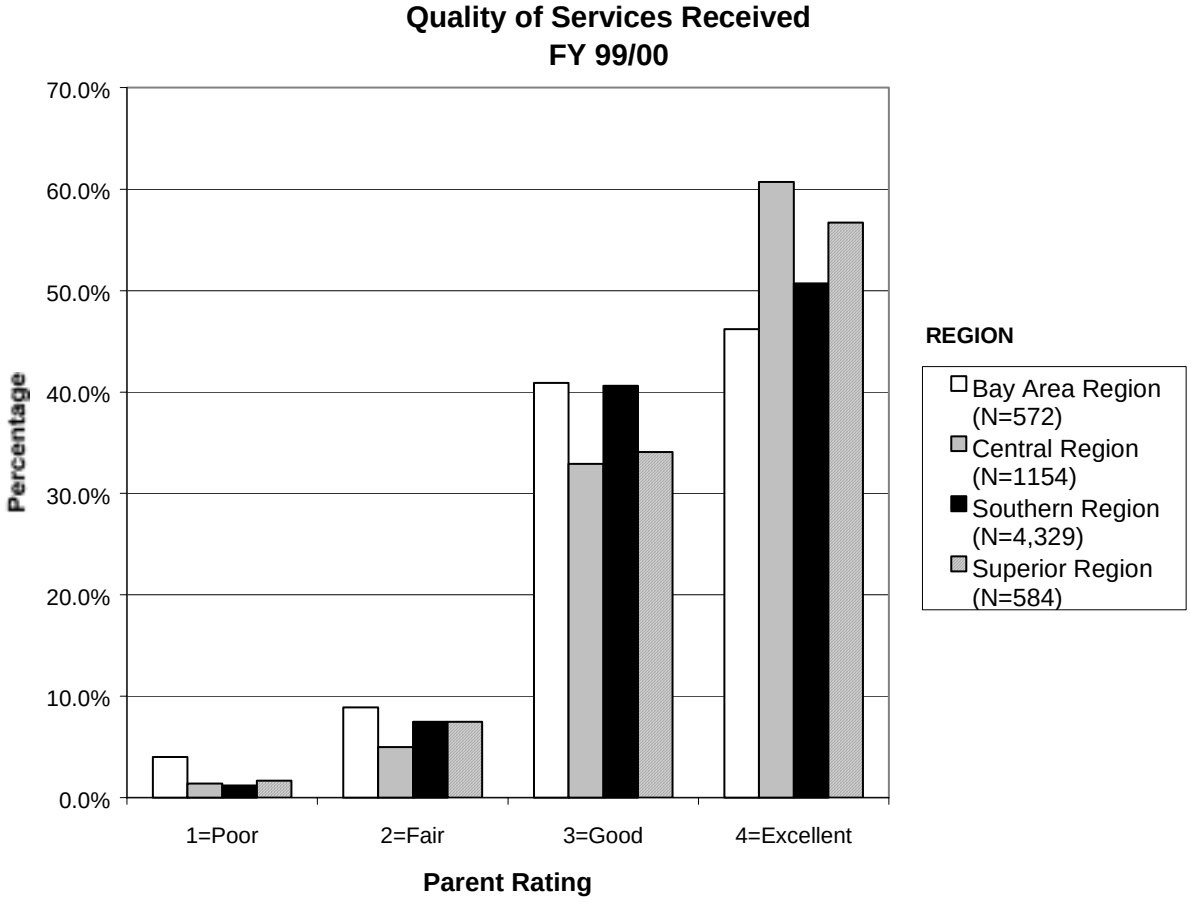
These data indicate that, from the youth's perspective, youth are experiencing fewer problems related to psychological health upon discharge than they experienced initially at intake.

Client Satisfaction Questionnaire (CSQ-8)

The Client Satisfaction Questionnaire (CSQ-8) is to be administered to parents/ caregivers annually and at discharge for the target population clients to assess consumer satisfaction with county mental health services. The CSQ-8 was designed to rate the level of satisfaction with services provided for their child using a Likert 5-point rating scale. The data results are discussed individually for each of the eight questions on the instrument, along with an overall average, by region (Note: Los Angeles is included in the Southern Region group). Since the CSQ-8 is administered confidentially and is not linked to the other CPOS instruments, there are significantly fewer records for this instrument (e.g., 13,024 compared to over 40,000 responses for the CAFAS).

CSQ-8 #1 - Quality of Services Received

The first question on the CSQ-8 is "How would you rate the quality of service you have received?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,639 respondents was 3.42, indicating a high level of satisfaction statewide with the quality of services received.

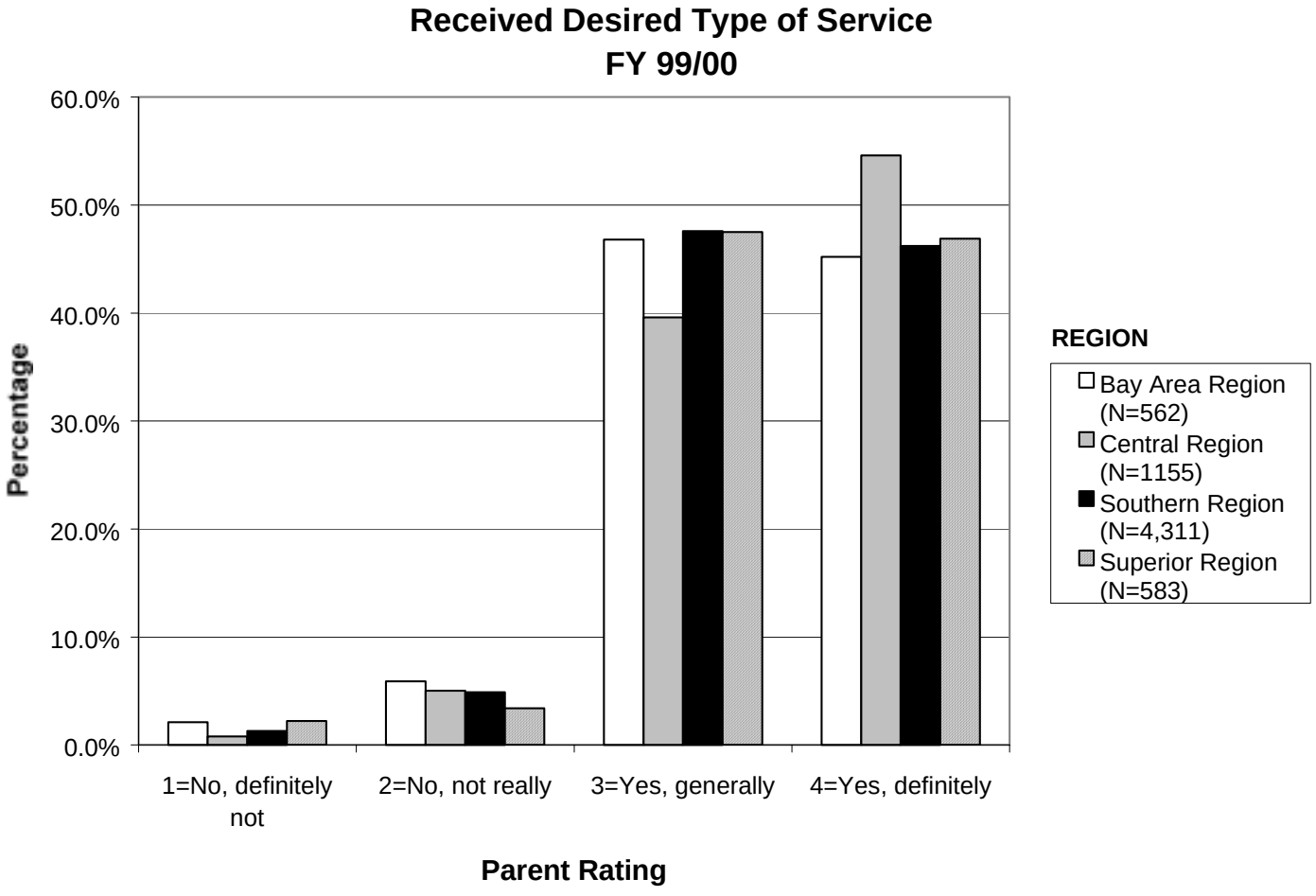


There were statistically significant differences between the region's means.

CSQ-8 #1 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.29	572	0.79
Central Region	3.53	1,154	0.66
Southern Region	3.41	4,329	0.68
Superior Region	3.46	584	0.71
Total	3.42	6,639	0.69

CSQ-8 #2 - Received Desired Type of Services

The second question on the CSQ-8 is "Did you get the kind of service you wanted?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,611 respondents was 3.40, indicating a fair level of satisfaction statewide with receiving the type of services wanted.

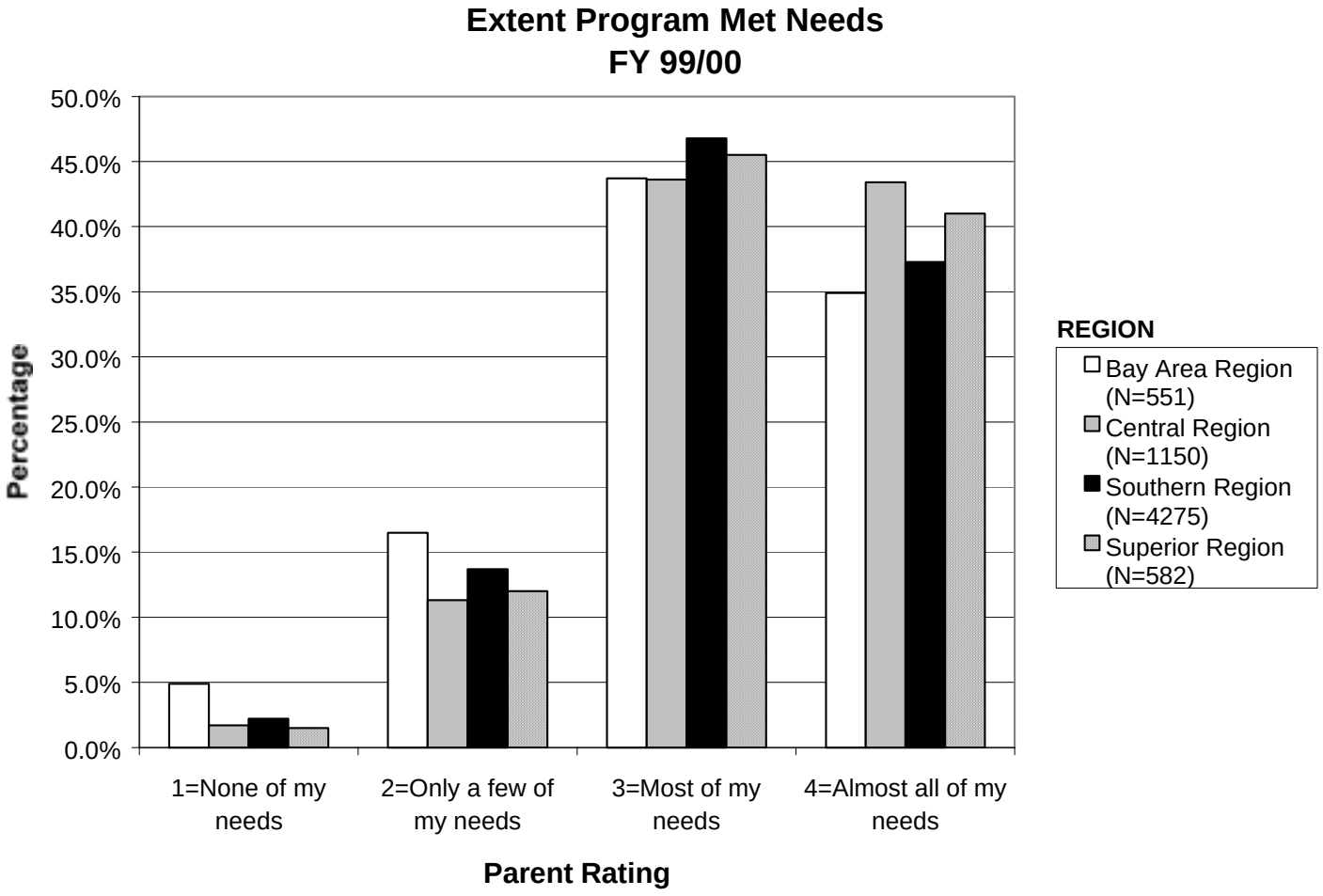


There were statistically significant differences between the region's means.

CSQ-8 #2 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.35	562	0.69
Central Region	3.48	1,155	0.63
Southern Region	3.39	4,311	0.64
Superior Region	3.39	583	0.66
Total	3.40	6,611	0.65

CSQ-8 #3 - Extent Program Met Needs

The third question on the CSQ-8 is "To what extent has our program met your needs?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,558 respondents was 3.21, indicating a fair level of satisfaction statewide with the extent the county mental health program met their needs.

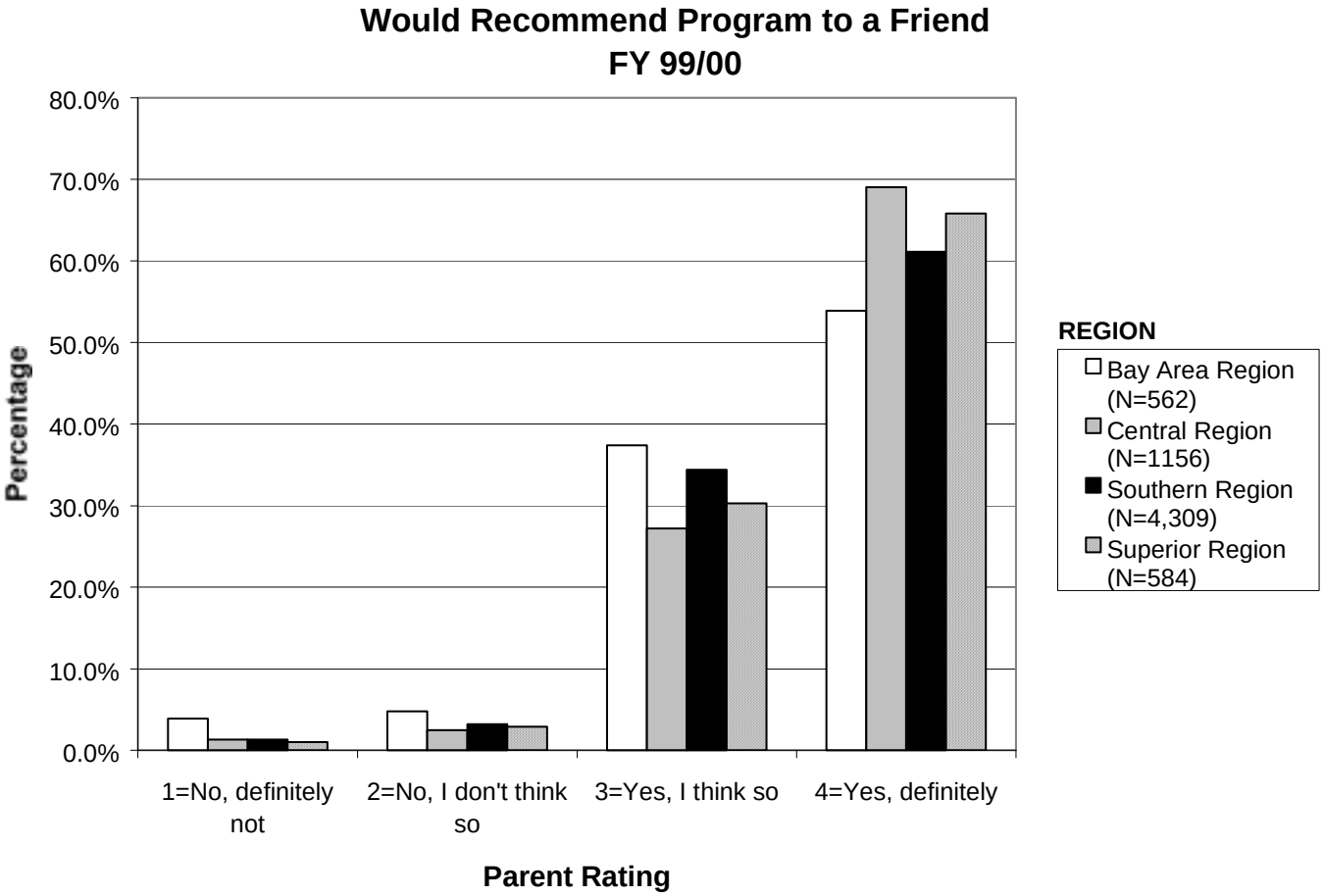


There were statistically significant differences between the region's means.

CSQ-8 #3 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.09	551	0.84
Central Region	3.29	1,150	0.73
Southern Region	3.19	4,275	0.75
Superior Region	3.26	582	0.72
Total	3.21	6,558	0.75

CSQ-8 #4 - Would Recommend Program to Friend

The fourth question on the CSQ-8 is "If a friend were in need of similar help, would you recommend our program to him or her?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,611 respondents was 3.56, indicating a high level of positive response that the parent/caregiver would recommend the county program to a friend.

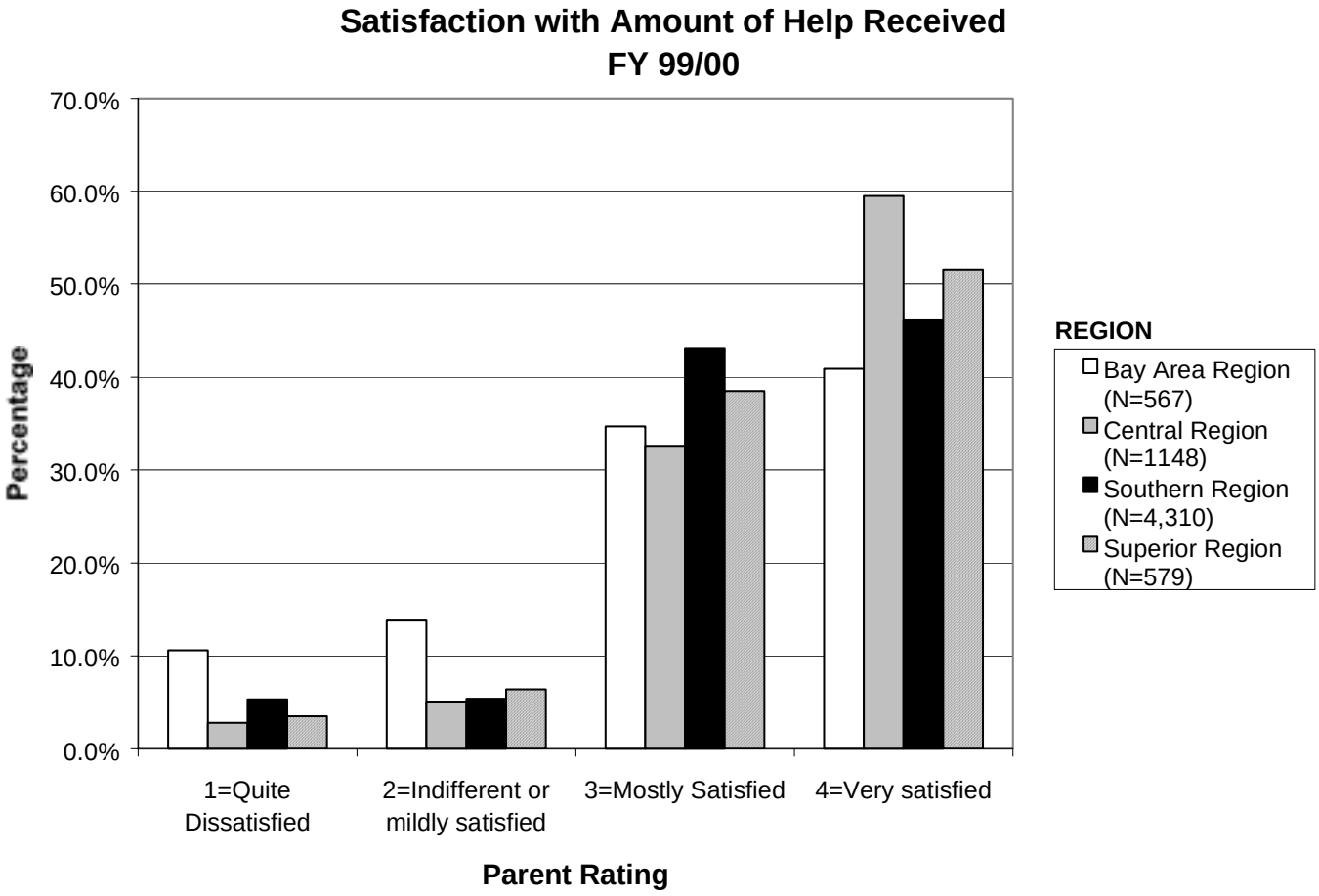


There were statistically significant differences between the region's means.

CSQ-8 #4 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.41	562	0.76
Central Region	3.64	1,156	0.60
Southern Region	3.55	4,309	0.62
Superior Region	3.61	584	0.60
Total	3.56	6,611	0.63

CSQ-8 #5 - Satisfaction with Amount of Help Received

The fifth question on the CSQ-8 is "How satisfied are you with the amount of help you have received?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,604 respondents was 3.32, indicating a fair level of satisfaction by the parent/caregivers with the amount of help received from county mental health services.

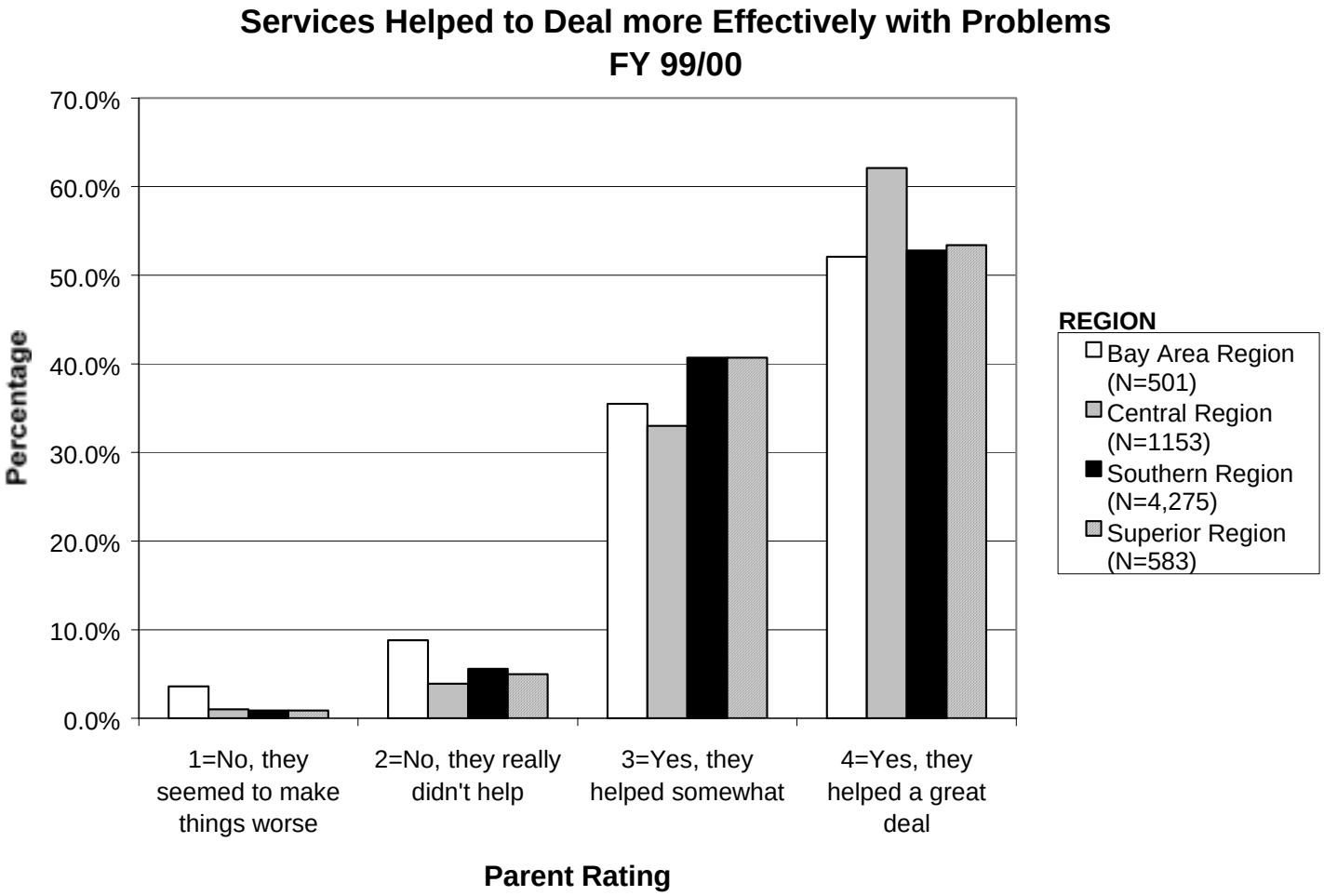


There were statistically significant differences between the region's means.

CSQ-8 #5 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.06	567	0.98
Central Region	3.49	1,148	0.72
Southern Region	3.30	4,310	0.80
Superior Region	3.38	579	0.76
Total	3.32	6,604	0.81

CSQ-8 #6 - Services Helped to Deal More Effectively with Problems

The sixth question on the CSQ-8 is "Have the services you received helped you to deal more effectively with your problems?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,512 respondents was 3.47, indicating a high level of agreement by the parent/caregivers that county mental health services helped with dealing more effectively with the child/youth client's problems.

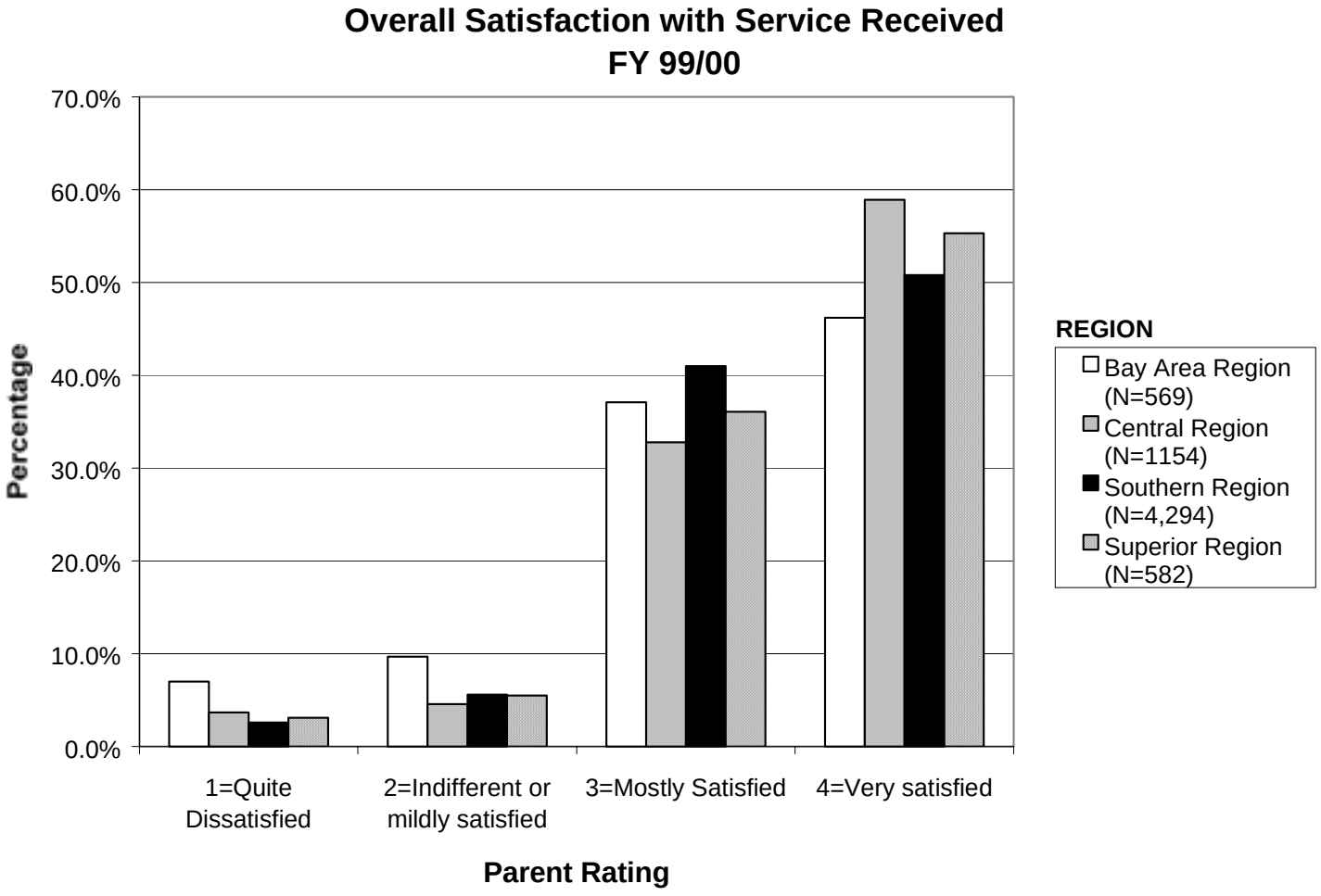


There were statistically significant differences between the region's means.

CSQ-8 #6 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.36	501	0.79
Central Region	3.56	1,153	0.62
Southern Region	3.45	4,275	0.65
Superior Region	3.47	583	0.63
Total	3.47	6,512	0.65

CSQ-8 #7 - Overall Satisfaction with Service Received

The seventh question on the CSQ-8 is " In an overall, general sense, how satisfied are you with the service you have received?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,599 respondents was 3.40, indicating a high level of overall satisfaction with county mental health services by the parent/caregivers.

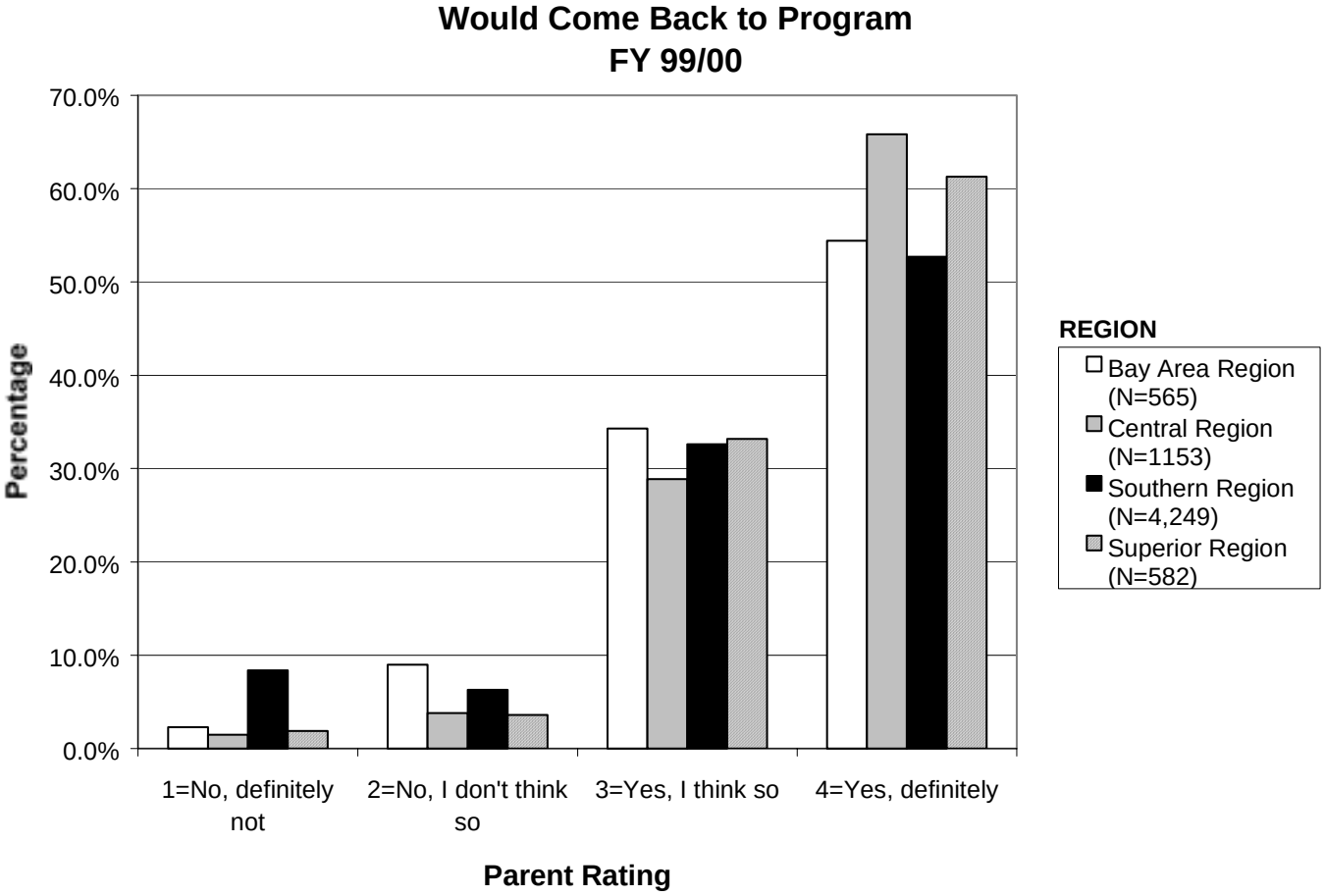


There were statistically significant differences between the region's means.

CSQ-8 #7 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.22	569	0.89
Central Region	3.47	1,154	0.75
Southern Region	3.40	4,294	0.71
Superior Region	3.44	582	0.74
Total	3.40	6,599	0.74

CSQ-8 #8 - Would Come Back to Program

The eighth question on the CSQ-8 is "If you were to seek help again, would you come back to our program?" The following graph and table summarize the statewide and CMHDA regional responses. The statewide mean score for the 6,549 respondents was 3.38, indicating that the majority of the parent/caregivers would return to county mental health services if help were needed.



There were statistically significant differences between the region's means.

CSQ-8 #8 Mean Scores by Region			
FY 99/00			
Quality of Services Received			
Region	Mean	N	Std. Deviation
Bay Area Region	3.41	565	0.75
Central Region	3.59	1,153	0.64
Southern Region	3.30	4,249	0.92
Superior Region	3.54	582	0.66
Total	3.38	6,549	0.85

CSQ-8 Average of the 8-Item Scale Scores

The following table presents a summary of the 8-item scale score averages statewide and for the CMHDA regions.

CSQ-8 8-Item Average	
FY 99/00	
Region	Mean
Bay Area Region	3.27
Central Region	3.51
Southern Region	3.37
Superior Region	3.44
Statewide Totals	3.40

These data indicate that parents/caregivers are generally quite satisfied with the county mental health services their children are receiving.

Adult Performance Outcome System

OBJECTIVES

The California Mental Health Planning Council (CMHPC) has been assigned by the Legislature the authority and responsibility for establishing performance outcome domains for adults with serious mental illness(es) (SMI) in the California public mental health system and to approve the specific indicators to be used to measure these outcome domains. The performance outcome *domains* and *values* approved by the CMHPC for adults with SMI are listed below. Desired *outcomes*, *indicators*, and *sources of data* for each domain appear on subsequent pages.

Domains and Values

I. Outcome Domain: Living Situation

Value: Adult clients with serious mental illnesses have the right to live in a satisfying environment with as much privacy and independence as possible given their mental or physical illness(es).

II. Outcome Domain: Financial Status

Value: Adult clients with serious mental illnesses should have sufficient income for food, clothes, housing, transportation, and fun.

III. Outcome Domain: Productive Daily Activity

Value: Adult clients with serious mental illnesses have the right to be involved in meaningful and satisfying activities, including educational, volunteer, and work programs.

IV. Outcome Domain: Psychological and Physical Health

Value: The amount of psychological distress that adult clients with serious mental illnesses experience should be minimized.

V. Outcome Domain: Avoiding Legal Problems

Value: Adult clients with serious mental illnesses have the right to be free from physical and social exploitation and live in a safe and secure environment.

VI. Outcome Domain: Social Support Network

Value: Adult clients with serious mental illnesses should have a satisfying social support network of family and friends.

1. Outcome Domain: Living Situation

Desired Outcome #1
Adult clients with SMI are living in the most appropriate setting (i.e., privacy, independence, etc.) given their functional ability and mental and physical health.

Indicator 1
Evaluation of changes over time in the percentage of adult clients with SMI in various living situations by level of psychological functioning and level of physical functioning.

What source will we use to measure performance on this indicator?
Client self-report surveys and departmental data bases

Indicator 2
Evaluation of changes over time in the percentage of adult clients with SMI in less restrictive versus more restrictive living situations.

What source will we use to measure performance on this indicator?
Departmental data bases

Desired Outcome #2
Adult clients with SMI report acceptable levels of satisfaction with their living situation.

Indicator
Increase over time in the percentage of adult clients with SMI who report being satisfied with their living situation.

What source will we use to measure performance on this indicator?
Client self-report surveys

II. Outcome Domain: Financial Status

Desired Outcome #1
Adult clients with SMI report having sufficient income for food, clothes, housing, transportation, and fun.

Indicator 1
Evaluation of changes over time in the amount of available income reported (after paying for housing and food).

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 2
Evaluation of changes over time in the percentage of adult clients with SMI who report having sufficient income for food, clothes, housing, transportation, and fun

What source will we use to measure performance on this indicator?
Client self-report surveys

Desired Outcome #2
Adult clients with SMI report acceptable levels of satisfaction with their financial status.

Indicator
Increase over time in the percentage of adult clients with SMI who report that they are satisfied with their financial situation.

What source will we use to measure performance on this indicator?
Client self-report surveys

III. Outcome Domain: Productive Daily Activity

Desired Outcome
Adult clients with SMI are participating in productive activities such as educational, volunteer, and work programs.

Indicator 1
Increase over time in the percentage of adult clients with SMI who report participation in productive activities (i.e., educational, volunteer, or work programs).

What source will we use to measure performance on this indicator?
Client self-report surveys and departmental data bases

Indicator 2
Increase over time in the percentage of adult clients with SMI who report having less difficulty with daily activities (i.e., educational, volunteer, or work programs).

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 3
Increase over time in the percentage of adult clients with SMI who report acceptable levels of satisfaction with leisure activities.

What source will we use to measure performance on this indicator?
Client self-report surveys

IV. Outcome Domain: Psychological and Physical Health

Desired Outcome #1
Adult clients with SMI are experiencing less psychological distress.

Indicator
Increase over time in the percentage of adult clients with SMI who report a decreased level of psychological distress.

What source will we use to measure performance on this indicator?
Client self-report surveys and departmental data bases

Desired Outcome #2
Adult clients with SMI are functioning better.

Indicator
Increase over time in the percentage of adult clients with SMI who report having less difficulty with areas of life functioning.

What source will we use to measure performance on this indicator?
Client self-report surveys and departmental data bases

IV. Outcome Domain: Psychological and Physical Health (cont.)

Desired Outcome #3
Adult clients with SMI are experiencing reduced physical distress.

Indicator 1
Decrease over time in the percentage of adult clients with SMI who report physical health problems.

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 2
Increase over time in the percentage of adult clients with SMI who report satisfaction with their physical health

What source will we use to measure performance on this indicator?
Client self-report surveys

Desired Outcome #4
Adult clients with SMI are experiencing reduced impairment from substance abuse or misuse.

Indicator
Decrease over time in percentage of adult clients with SMI who report impairment resulting from substance abuse or misuse.

What source will we use to measure performance on this indicator?
Client self-report surveys and departmental data bases

V. Outcome Domain: Avoiding Legal Problems

Desired Outcome #1
Adult clients with SMI are experiencing fewer arrests.

Indicator
Decrease over time in the percentage of adult clients with SMI who report being arrested.

What source will we use to measure performance on this indicator?
Client self-report surveys

Desired Outcome #2
Adult clients with SMI are experiencing less victimization.

Indicator 1
Decrease over time in percentage of adult clients with SMI who report being victimized.

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 2
Increase over time in the percentage of adult clients with SMI who report acceptable levels of satisfaction with their safety.

What source will we use to measure performance on this indicator?
Client self-report surveys

VI. Outcome Domain: Social Support Network

Desired Outcome
Adult clients with SMI are building effective support networks through increased activities with family, friends, neighbors, or other social groups.

Indicator 1
Increase over time in the frequency/amount of social contacts for adult clients with SMI.

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 2
Increase over time in the percentage of adult clients with SMI who report less difficulty with their social contacts (family, friends, social groups, etc.).

What source will we use to measure performance on this indicator?
Client self-report surveys

Indicator 3
Increase over time in the percentage of adult clients with SMI reporting acceptable levels of satisfaction (*mean score of 5+ on D/T scale) with their social contacts (family, friends, social groups, etc.)*

What source will we use to measure performance on this indicator?
Client self-report surveys

METHODOLOGY

Overall Approach

The Department of Mental Health (DMH), the California Mental Health Directors Association (CMHDA), and the California Mental Health Planning Council (CMHPC) collaborated on every step of the process for developing California's Adult Performance Outcome System (APOS).

As with the Children and Youth Performance Outcome System (CPOS), APOS is designed to generate data that:

- are useful to clinicians for treatment planning;
- are useful to counties for quality management purposes;
- meet the requirements of the state for performance outcome data; and
- allow comparison of California's public mental health programs with those of other states/entities.

Target Population

The target population for APOS is seriously mentally ill adults, ages 18 through 59, receiving (or expected to receive) services for 60 days or longer.

Instruments Selected

The instruments selected were the:

- Global Assessment of Functioning (*GAF*) Scale
  (a clinician-rated scale indicating a client's general level of functioning on a continuum from 1 to 100 (mental illness to mental health))

- Choice of one of the following quality of life instruments:
  (scale scores on the two quality of life instruments can be statistically equated)
  - California Quality of Life (*CA-QOL*)
  - Lehman's Quality of Life Short Form (*QL-SF*)

- Mental Health Statistics Improvement Program (*MHSIP*) Consumer Survey
  (a 26-item consumer survey that collects consumer perceptions of access to care, appropriateness of care, perceived outcomes of care, and satisfaction with services.)

Note: the Behavior and Symptom Identification Scale (*BASIS-32*), originally selected as part of APOS, has been eliminated as a required instrument due to the ineffectiveness of the resulting data and the imposition of user fees by the author.

Implementation

Implementation of APOS began on July 1, 1999. Quarterly reports were requested the first year in order to test out both the DMH and county systems. Several counties experienced initial technology problems, but after one year of implementation (i.e., as of July 2000), 56 counties and two city programs were able to successfully submit data. The remaining three counties have all been attempting to transmit data, but are still experiencing difficulties. Data are now being transmitted semi-annually, and it is expected that all counties will be implemented on or about the next deadline (January 30, 2001).

Full implementation of APOS is defined as:

- Clinicians are assuring the completion of the required performance outcome instruments: the *GAF*, one of the two quality of life instruments (*CA-QOL or QL-SF)*, and the *MHSIP* Consumer Survey.

- Clinicians are adequately trained so that they are able to understand and use the reports and data generated from the instruments to aid in treatment planning and service provision;

- Counties have an established methodology for using data from the performance outcome instruments for aiding in program evaluation and quality improvement;

- Counties are providing scored reports generated from the instruments to clinicians (and clients when appropriate) within two weeks of completion; and

- Counties have operationally established a system that will allow the county to provide specified reports and client level data in electronic format to DMH.

Instrument Administration Schedule

The schedule for completing the adult instruments is:

Assessment Instruments

- within 60 days of the client's involvement with county mental health (sometimes referred to as "intake" for the target population);
- annually (i.e., annual case review), and
- upon discharge.

Satisfaction Instrument

- annually and upon discharge.

Data Collection

Counties received full-day regional training before actual implementation of APOS. Training packets included detailed manuals which included descriptions of various technologies available, as well as a data dictionary describing the format of the data to be transmitted. Counties were given the flexibility of selecting the technology that best suited their particular situation. Currently, counties are using a variety of types of technology to transmit their data - ranging from hand entry, fax-based software, telephone-based systems, and card reader methodologies.

Current Status/Analysis

DMH has attempted to provide a timely return of information to each county describing their county's results and comparing them with regional and statewide results for each instrument (see Appendix for examples of these reports).

The following analyses provide descriptive results for client demographics and some analyses related to instrument results. As DMH becomes more comfortable with the accuracy and representativeness of the data, more complex analyses will be provided.

FINDINGS

The Department of Mental Health (DMH) is in its second year of data collection for the Adult Performance Outcome System (APOS). Data were gathered quarterly the first year (SFY 1999-2000) in order to test state and county performance outcome data management systems, verify the accuracy of data transmissions, collect county feedback on the reports provided by DMH, address staff training issues, and obtain baseline data. Data are now being gathered semi-annually for most counties. DMH reports to counties will be expanded and refined over time as feedback is obtained regarding their usefulness.

Measurement of Objectives

This section contains descriptive information based on first year data from a little over 33,000 non-duplicated adult clients. These data are based on one year of implementation and should be fairly representative of the statewide performance outcome "target population" (adults with serious mental illnesses expected to be in service 60 days or more), but may not be representative of individual county performance at this early stage. There are still three counties that have not submitted adult performance outcome data, but it is expected that they will be implemented in the near future.

Sufficient data are now available to explore issues such as whether differences found among groups are statistically significant, and if so, are these meaningful differences. Eventually analyses will be completed exploring how that information could be translated into program improvement.

The previous section (Objectives) described the desired outcomes for APOS as well as the indicators and data sources available to measure these outcomes. DMH has operationalized how these indicators will be measured and baseline data will be gathered over the course of the next year. Once sufficient repeat data (time two) are available, change comparisons can be made.

Limitations/Weaknesses of Data

As can be expected in complex projects involving so many constituencies, everyone involved has had to compromise on their expectations. However, accurate and timely data are key to an effective program. Initially several weaknesses were identified and some of these have been resolved (e.g., obtaining timely data from the main DMH database systems has become closer to a reality).

There are also additional factors that affect the interpretability of these data. The extent to which counties strictly comply with data collection and reporting protocols, for example, may affect the usefulness of these data in making comparisons between county programs. Additionally, the fact that many conditions are unique to each county make strict comparisons difficult. Finally, mental health consumers are able to refuse to

complete the survey which may lead to a certain amount of response bias that could directly affect the results of data analysis. Therefore, any interpretations based on these data should be viewed with caution.

Highlights of Current Findings

The Adult Performance Outcome System has received performance outcome data from the vast majority of counties (56 of 59). The following pages present certain descriptive information (diagnosis, age, ethnicity, and gender) about clients, as well as initial results from the instrument data, *based on first year data*. Some of the analyses investigate whether group differences are statistically significant and, if so, are these differences meaningful. Note: the following tables describe the adult performance outcome "target population", which is a subset of the larger Client and Service Information (CSI) database.

Diagnosis

The table below shows the frequency and percent of the respondents to the APOS surveys, grouped by diagnostic category. Note: the valid percent column excludes missing data. Approximately half of these clients (49.8%) are categorized as having a "Mood Disorder", which includes such diagnoses as bipolar disorders and depressive disorders. The other diagnostic category which includes a large percentage of clients is "Schizophrenia and Other Psychoses" (35.5%). A much smaller percentage of the clients have disorders categorized as "Anxiety Disorders" (5.2%), which includes such things as panic disorders, certain phobias, obsessive compulsive disorders and stress disorders) and "Other Diagnoses" (9.5%).

Diagnostic Categories - Adult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Schizo/Othr Psychotic	11698	35.2	35.5	35.5
	Mood Disorders	16414	49.3	49.8	85.3
	Anxiety Disorders	1715	5.2	5.2	90.5
	Other Diagnoses	3131	9.4	9.5	100.0
	Total	32958	99.1	100.0	
Missing	Missing (9)	313	.9		
Total		33271	100.0		

Age

APOS encompasses the state's seriously mentally ill adult clients ages 18 through 59. The table below shows the frequency and percent of these responses, grouped into age categories. The highest percentage of clients are in the 40 to 49 age category (33.6%) and the next highest in the 30 to 39 age category (28.7%). Ages 18 – 20 (transition age youth) are grouped separately for initial analyses because they often have different results than the older age groups. A few counties mistakenly submitted records for clients less than age 18 or over age 60. Both of these groups were considered missing data for the purpose of this section of the report.

Age Categories - Adult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	18 - 20	838	2.5	2.7	2.7
	21 - 29	4872	14.6	15.7	18.4
	30 - 39	8907	26.8	28.7	47.2
	40 - 49	10415	31.3	33.6	80.8
	50 - 59	5952	17.9	19.2	100.0
	Total	30984	93.1	100.0	
Missing	60+	2041	6.1		
	Less than 18	29	.1		
	Missing	217	.7		
	Total	2287	6.9		
Total		33271	100.0		

Ethnicity

The table below shows the frequency and percent of clients reported to the state's APOS, categorized by ethnicity. While DMH is actually collecting data for more than twenty different ethnicities, currently most of these have too few numbers for individual analysis. According to first year data, APOS has somewhat more White clients and somewhat fewer Hispanic and African American clients than found in tentative statewide percentages of county mental health clients reported in the Department's broader CSI database (not shown).

Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	20060	60.3	62.3	62.3
	Hispanic	5255	15.8	16.3	78.6
	African American	4039	12.1	12.5	91.1
	Other Asian/Pac Isl	444	1.3	1.4	92.5
	Native American	388	1.2	1.2	93.7
	Filipino	296	.9	.9	94.6
	Other	464	1.4	1.4	96.1
	Amerasian	44	.1	.1	96.2
	Chinese	339	1.0	1.1	97.3
	Cambodian	47	.1	.1	97.4
	Japanese	121	.4	.4	97.8
	Korean	72	.2	.2	98.0
	Samoan	6	.0	.0	98.0
	Asian Indian	31	.1	.1	98.1
	Hawaiian Native	29	.1	.1	98.2
	Guamanian	15	.0	.0	98.3
	Laotian	144	.4	.4	98.7
	Vietnamese	154	.5	.5	99.2
	Multiple	262	.8	.8	100.0
	Total	32210	96.8	100.0	
Missing	Unknown/Missing	1061	3.2		
Total		33271	100.0		

The ethnic categories used for analysis in this report are shown in the table below.

Ethnic Categories - Adult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	20060	60.3	64.6	64.6
	Hispanic	5255	15.8	16.9	81.5
	African American	4039	12.1	13.0	94.5
	Asian/Pac Isl	1698	5.1	5.5	100.0
	Total	31052	93.3	100.0	
Missing	Other	1158	3.5		
	Missing	1061	3.2		
	Total	2219	6.7		
Total		33271	100.0		

Gender

The table below shows the frequency and percent of clients reported the state's APOS, categorized by gender. According to first year data, 56% of the clients are female and 44% are male. Other analyses on similar data indicate that the percentage of females increases as age increases.

Gender Categories - Adult

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Male	14614	43.9	44.0	44.0
	Female	18563	55.8	56.0	100.0
	Total	33177	99.7	100.0	
Missing	Other/Missing	94	.3		
Total		33271	100.0		

Instrument Results

Four DMH quarterly reports have now been sent to county mental health directors. These reports describe in more detail results from the adult instruments (See example reports in Appendix 1 and Appendix 2). The reports provide county, regional, and statewide comparisons. Note: the results reported below include all clients in the database and should be interpreted cautiously. Once sufficient repeat data (time two) are available, change comparisons between first and second administrations will be made.

GAF SCORES

The *Global Assessment of Functioning* (*GAF*) *Scale* is a rating scale used by clinicians to indicate a client's general level of functioning. GAF scores can range from 1 (most serious) to 100 (no symptoms). Most of the clients this first year received GAF scores in the range of 31 to 60 which indicates moderate symptoms to major impairment. This file contains some second administration data.

GAF Categories (deciles)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	01 - 10	945	2.7	3.0	3.0
	11 - 20	287	.8	.9	3.9
	21 - 30	1612	4.6	5.1	8.9
	31 - 40	7090	20.1	22.3	31.2
	41 - 50	12747	36.2	40.1	71.3
	51 - 60	7389	21.0	23.2	94.6
	61 - 70	1461	4.1	4.6	99.2
	71 - 80	208	.6	.7	99.8
	81 - 90	32	.1	.1	99.9
	91 - 100	23	.1	.1	100.0
	Total	31794	90.2	100.0	
Missing	Can't Score	3450	9.8		
	Missing	7	.0		
	Total	3457	9.8		
Total		35251	100.0		

The following five tables report differences in average GAF score by region, gender, ethnicity, diagnosis, and age. The statewide average GAF score was 45.88 (indicating serious symptoms). The largest differences in GAF scores were found for region and for diagnostic category. Most other group differences were slight and not of practical significance. On average, clients in Superior region received higher GAF scores than did clients in the other regions (higher indicates fewer symptoms), females received higher scores than males, Whites received higher scores than the other ethnic groups,

clients diagnosed with Mood disorders received higher scores than did those diagnosed with Schizophrenia/Other Psychoses, and the youngest age group (18 – 20) received higher scores than did the older age groups. The difference for diagnosis was statistically significant. For all other groups, sample sizes were too different to test for significance.

Regional Differences on Average Current GAF Score

	Statewide (n=35,250)	Bay Area (n=2,998)	Central (n=13,529)	Southern (n=16,503)	Superior (n=2,219)
Average GAF Score	45.88	44.95	48.46	43.12	51.49

Gender Differences on Average Current GAF Score

	Female (n=19,538)	Male (n=15,474)
Average GAF Score	46.67	44.85

Ethnic Differences on Average Current GAF Score

	White (n=20,876)	Hispanic (n=5,430)	African American (n=4,838)	Asian/Pac Islander (n=1,568)
Average GAF Score	46.51	45.01	44.02	46.03

Diagnostic Differences on Average Current GAF Score

	Schizophrenia/ Other Psychoses (n=12,671)	Mood Disorders (n=17,387)
Average GAF Score	43.63	46.78

Age Differences on Average Current GAF Score

	18 – 20 (n=789)	21 – 29 (n=5,035)	30 – 39 (n=9,384)	40 – 49 (n=11,094)	50 – 59 (n=6,476)
Average GAF Score	46.25	45.83	45.96	45.81	45.59

QUALITY OF LIFE

Primarily due to technology issues, counties have been given the flexibility to *choose one* of the following quality of life instruments:

- California Quality of Life (*CA-QOL*), or
- Lehman's Quality of Life - Short Form (*QL-SF*)

The subscales measured by both instruments include general living situation, daily activities and functioning, family and social relationships, finances, work and school, legal and safety issues, and health. Reports are in the format of CA-QOL equivalent scores. QL-SF scores are transformed through the use of a regression equation developed during a pilot test of both the CA-QOL and QL-SF.

Both instruments are comprised of two kinds of scales: subjective scales and objective scales. The subjective scales ask the client to report satisfaction with a number of areas related to quality of life. The objective scales ask the client to report specific objective data that may directly affect his or her quality of life.

Both instruments are client self-reports. It is important to remember that a variety of factors may influence a client's quality of life and many of these factors are beyond the control of county mental health programs. Additionally, a client's symptoms, physical health, medication, etc. could affect ratings.

Subjective Scales

All of the items measuring subjective scales use the same 7-point ordinal scale.

1	=	Terrible
2	=	Unhappy
3	=	Mostly Dissatisfied
4	=	Mixed
5	=	Mostly Satisfied
6	=	Pleased
7	=	Delighted

The average scores on each of the subjective subscales for first year data overall and by region are:

Satisfaction with:	Overall Average	Region 1 Bay Area	Region 2 Central	Region 3 Southern	Region 4 Superior
General Life	3.79	4.31	3.80	3.66	3.76
Living Situation	4.39	4.64	4.42	4.29	4.41
Leisure Activities	4.04	4.49	4.08	3.89	3.98
Daily Activities	4.03	4.46	4.06	3.90	3.98
Family Relations	4.19	4.48	4.18	4.13	4.24
Social Relations	4.16	4.48	4.16	4.07	4.19
Finances	3.18	3.58	3.24	2.98	3.15
Safety	4.69	4.95	4.65	4.62	5.06
Health	3.75	4.16	3.77	3.65	3.67

Overall, these satisfaction subscale averages indicate clients report they feel "mostly dissatisfied" to "mixed" in these areas. Again, although a subscale score may be toward the lower or higher end, the client may have actually reported very strong feelings about one item and not others. Clinicians are encouraged to examine item as well as subscale results.

Objective Scales

The *CA-QOL* objective scales are scored differently than the subjective scales. Each scale score should be considered in light of its specific rating scale. At this point results are being presented in terms of mean (average) scores for ease in comparison of data. Some of these scales should actually be interpreted as percents in each category. The yes/no ratings can be interpreted as percent who answered yes (e.g., statewide approximately 9 percent of the respondents reported they were a victim of crime in the past month).

The scores on each of the objective subscales for first year data overall and by region are:

Objective Subscales	Possible Ratings	Overall Average	Region 1 Bay Area	Region 2 Central	Region 3 Southern	Region 4 Superior
Frequency of Family Contacts	0 = no family 1 = not at all 2 = < once a month 3 = at least once month 4 = at least once a week 5 = at least once a day	2.93	3.04	2.83	3.02	3.15
Frequency of Social Contacts	1 = not at all 2 = < once a month 3 = at least once month 4 = at least once a week 5 = at least once a day	2.90	2.93	2.89	2.88	3.04
Amount of Spending Money	1 = less than $25 2 = $25 to $50 3 = $51 to $75 4 = $76 to $100 5 = more than $100	2.41	2.84	2.45	2.27	2.23
Adequacy of Finances	0 = No 1 = Yes	.65	.75	.63	.66	.64
Victim of Crime	0 = No 1 = Yes	.09	.08	.08	.09	.10
Number of Arrests	0 = 0 arrests 1 = 1 arrests 2 = 2 arrests 3 = 3 arrests 4 = 4 arrests 5 = 5 arrests 6 = 6 arrests	.12	.05	.12	.15	.07
Health Status	1 = excellent 2 = very good 3 = good 4 = fair 5 = poor	3.43	3.16	3.46	3.45	3.41

Mental Health Statistics Improvement Program (MHSIP) Consumer Survey

The *MHSIP Consumer Survey* is a 26-item public domain instrument and is being used by a number of other states. The MHSIP Consumer Survey asks questions relating to general satisfaction, access to services, appropriateness of treatment, and outcomes of care.

The MHSIP item scores are based on a 5-point scale that ranges from 1 to 5. Additionally, a zero rating is available for a client to identify items that do not apply. Ratings are defined as follows:

0	=	Not Applicable
1	=	Client strongly disagrees with item
2	=	Client disagrees with item
3	=	Client is neutral
4	=	Client agrees with item
5	=	Client strongly agrees with item

The ratings that each consumer gives to the individual items that make up a scale are averaged by adding the ratings together and then dividing by the number of questions answered. A general rule of thumb that can be used to evaluate consumer satisfaction with access to services is found below:

- ✓ 1.00 to 1.54 = Very Dissatisfied
- ✓ 1.55 to 2.54 = Dissatisfied
- ✓ 2.55 to 3.54 = Neutral or Mixed
- ✓ 3.55 to 4.54 = Satisfied
- ✓ 4.55 to 5.00 = Very Satisfied

When interpreting MHSIP subscale scores, higher scores are better and represent the client's positive perceptions of that aspect of the county's services. MHSIP scores are client self-reports. Sometimes factors other than the client's immediate perceptions of care can influence ratings of services (e.g., client is required to participate). As with all self reports, a client's symptoms, health, medication, etc., can also affect ratings. Items on satisfaction instruments typically tend to receive relatively high ratings and to show little variability. Although a subscale score may be toward the lower or higher end, the client may have actually reported very strong feelings about one item and not others. Clinicians are encouraged to examine item as well as subscale results.

The table below shows statewide results for first year MHSIP scale scores.

Statewide Results for Average MHSIP Scale Scores

	Access to Care	Appropriateness of Care	Perceived Outcomes	Satisfaction with Services
Statewide	4.21	4.17	3.76	4.27

The average statewide scores for the four scales indicate that overall consumers are satisfied or very satisfied with services. The highest statewide score (indicating most satisfaction) was for the "Satisfaction with Services" scale (4.27). The lowest statewide score was for the "Perceived Outcomes" scale (3.76).

The following tables in this section report differences in average MHSIP scale scores by region, gender, ethnicity, diagnosis, and age. Statistically significant differences are reported where appropriate. Note, however, that statistical significance does not mean practical significance.

The table below shows regional differences in MHSIP scale scores.

Regional Differences on Average MHSIP Scale Scores

Subscales	Statewide	Region 1 Bay Area	Region 2 Central	Region 3 Southern	Region 4 Superior
Access to Care	4.21	4.16	4.25	4.22	4.05
Appropriateness of Care	4.17	4.10	4.20	4.18	4.07
Perceived Outcomes	3.76	3.78	3.79	3.71	3.67
Satisfaction with Services	4.27	4.30	4.20	4.29	4.13

While results for all four regions showed that consumers were satisfied or very satisfied on all four scales, there were some consistent differences. The Central Region received the highest average scores on all scales and the Superior Region had the lowest scores on all scales.

The pattern of scores regionally was similar to the pattern statewide. "Satisfaction with Services" was rated highest in all regions except the Central Region (in which "Access to Care" was rated highest)., while the "Perceived Outcomes" scale was rated lowest in all regions.

The table below shows gender differences in MHSIP scale scores.

Gender Differences on Average MHSIP Scale Scores

Subscales	Statewide	Female	Male
Access to Care	4.21	4.24	4.18
Appropriateness of Care	4.17	4.21	4.13
Perceived Outcomes	3.76	3.72	3.80
Satisfaction with Services	4.27	4.32	4.21

While both males and females reported that on average they were satisfied or very satisfied on all scales, males had lower average scores than females on all scales except "Perceived Outcomes". This difference was statistically significant on the "Satisfaction with Services" scale. There was little practical difference between any of these average scale scores.

The table below shows ethnic differences in MHSIP scale scores.

Ethnic Differences on Average MHSIP Scale Scores

Subscales	Statewide	White	Hispanic	African American	Asian/Pacific Islander
Access to Care	4.21	4.19	4.27	4.26	4.27
Appropriateness of Care	4.17	4.15	4.22	4.18	4.24
Perceived Outcomes	3.76	3.75	3.78	3.73	3.80
Satisfaction with Services	4.27	4.26	4.32	4.28	4.34

All ethnic groups reported that on average they were satisfied or very satisfied on all scales. The White group had the lowest average scores on all scales except "Perceived Outcomes". This difference was statistically significant on the "Access to Care" scale. The African American group reported the lowest mean score on the "Perceived Outcomes" scale. There was little practical difference among any of these average scale scores.

The table below shows diagnostic differences in MHSIP scale scores.

Diagnostic Differences on Average MHSIP Scale Scores

Subscales	Statewide	Schizophrenia/ Other Psychoses	Mood Disorders
Access to Care	4.21	4.21	4.23
Appropriateness of Care	4.17	4.14	4.20
Perceived Outcomes	3.76	3.89	3.64
Satisfaction with Services	4.27	4.24	4.31

This analysis includes only the two major diagnostic categories. Consumers in the Schizophrenia/Other Psychoses group reported the lowest average scores for all scales, except "Perceived Outcomes". These differences were statistically significant on the "Satisfaction with Services" scale. Again, there was little practical difference between either of these average scale scores.

The table below shows differences in MHSIP scale scores by age category.

Differences by Age Category on Average MHSIP Scale Scores

Subscales	Statewide	18 - 20	21 – 29	30 - 39	40 - 49	50- 59
Access to Care	4.21	4.03	4.15	4.19	4.22	4.24
Appropriateness of Care	4.17	4.11	4.13	4.15	4.16	4.21
Perceived Outcomes	3.76	3.67	3.73	3.76	3.73	3.77
Satisfaction with Services	4.27	4.16	4.17	4.25	4.27	4.33

All age groups reported on average that they were satisfied or very satisfied on all four scales. The youngest age category (18 – 20) had the lowest average score on all scales. There were statistically significant differences on all scales except "Perceived Outcomes". The specific statistically significant difference was generally between the 18 to 20 year old group and some or all of the older groups. Again, there was little practical difference among any of these average scale scores although the spread was somewhat bigger than in the earlier tables.

Older Adult Performance Outcome System

OBJECTIVES

The CMHPC has been assigned by the Legislature the authority and responsibility for establishing performance outcome domains for older adults with serious mental illnesses (SMI) in the California public mental health system and to approve the specific indicators to be used to measure these outcome domains. The performance outcome *domains* and *values* approved by the CMHPC for older adult clients with SMI are listed below. Desired *outcomes and indicators* for each domain appear on subsequent pages. Since several possible older adult performance outcome instruments are still being piloted and the final set has not yet been selected, specific sources of data cannot be provided.

Domains and Values

I. Outcome Domain: Living Situation

*Value***:** Older adult clients with serious mental/physical disabilities have the right to as much privacy and independence in their living situation as is possible given their mental or physical illness(es).

II. Outcome Domain: Financial

Value: Older adult clients with serious mental/physical disabilities should have access to the financial benefits for which they are eligible.

III. Outcome Domain: Psychological and Physical Health

Value: The amount of excessive psychological distress that older adult clients with serious mental illnesses experience should be minimized.

Value: Because of the many physical illnesses co-occurring with mental illnesses in older adults, older adult clients with serious mental disabilities should have access to the physical health care which they need and to which they are entitled.

Value: Older adult clients with serious mental illnesses should have the opportunity to live life free from substance abuse and misuse (alcohol, street drugs, prescription drugs, over-the-counter medications), drug interactions, and adverse side effects.

IV. Outcome Domain: Social Support and Activities

Value: Older adult clients with serious mental/physical disabilities have the right to be involved in meaningful activities and relationships that make them feel empowered, including educational, volunteer opportunities, and work programs.

I. Outcome Domain: Living Situation

Desired Outcome #1 Older adult clients are living in the most appropriate setting (i.e., independence, privacy, etc.) given their functional ability, mental and physical health.
Indicator 1 *Increase in the percent of older adult clients satisfied with their living situation over time.* **Indicator 2** *Evaluation of changes in the percent of older adult clients living in various living situations by level of psychological functioning and by level of physical functioning.*

II. Outcome Domain: Financial

Desired Outcome #1 *Older adults are aware of financial entitlement programs for which they are eligible.*
Indicator 1 *Increase in the percent of clients who are eligible for Social Security, Social Security Supplemental Income (SSI), and/or private pensions, who are receiving these benefits.*

III. Outcome Domain: Psychological and Physical Health

Desired Outcome #1
Older adult clients experience reduced psychological distress.

Indicator 1
Increase in the percent of older adult clients who report a decreased level of psychological distress over time.

Desired Outcome #2
Older adult clients experience increased levels of functioning.

Indicator 1
Increase in the percent of older adult clients who report an increased level of functioning.

Desired Outcome #3
Older adult clients are appropriately accessing primary health care.

Indicator 1
Increase in the percent of older adult clients who report having a primary care physician over time.

Indicator 2
Increase in the percent of older adult clients who saw a medical care professional in the last year.

III. Outcome Domain: Psychological and Physical Health (cont.)

Desired Outcome #4 *Older adult clients experience reduced physiological distress.*
Indicator 1 *Increase in the percent of older adult clients who report experiencing a reduced level of physiological functioning over time*.

Desired Outcome #5 *Older adult clients report reduced impairment from substance abuse or misuse.*
Indicator 1 *Decrease in percent of older adult clients who report impairment resulting from substance abuse or misuse over time.*

IV. Outcome Domain: Social Support and Activities

Desired Outcome #1 *Older adult clients report decreases in the extent to which physical, emotional or mental health problems interfere with productive daily activities*.
Indicator *Increase in the percent of older adults participating in productive daily activities over time.*

Desired Outcome #2
Older adult clients are building effective support networks through increased activities with family, friends, neighbors, or other social groups.

Indicator 1
Decrease in the percentage of older adult clients who report that their physical or mental illness is interfering with their social activities with family, friends, neighbors, or other social groups.

Indicator 2
Increase in the percentage of older adults reporting satisfaction with social contacts (family, friends, social groups, etc.) over time.

Indicator 3
Increase in the frequency/amount of social contacts for older adults over time.

METHODOLOGY

Overall Approach

Older adults were originally included as part of the Adult Performance Outcome System (APOS). However, older adult coordinators who worked on the APOS expressed the belief that the instruments that were ultimately selected for use with adults may not be appropriate for older adults. They believed that the adult instruments were hard for many older adults to complete due to difficulties in their physical, mental, or cognitive functioning (e.g., Alzheimer's). In addition, the adult instruments did not address some of the critical issues for older adults with mental illness, but focused more on measuring improvement in functional areas like work or school or increasing independence, which may not be realistic for many older adults.

As a result, several counties in the Los Angeles and Southern California Regions of the CMHDA began investigating alternative instruments more appropriate for use with older adults. After considerable effort on the part of these counties, it was agreed that a wider pilot study would be conducted under the leadership of the DMH. The advantages of DMH leadership were: (1) greater involvement by California counties, (2) representation of a wider variety of clients and service delivery systems, and (3) the coordination of data collection in a consistent format. For these reasons, DMH began devoting resources to the development of a performance outcome system specifically designed for older adults – the Older Adult Performance Outcome System (OAPOS).

In early 1998, the DMH and the CMHPC convened an Older Adult Performance Outcome Committee to develop a system for the evaluation of county mental health programs specifically for older adults. The committee is comprised of staff from DMH and the CMHPC, older adult coordinators, clinicians, and evaluators from a variety of counties, and individuals representing older adult direct consumers. This committee developed a framework for measuring the impact of county mental health services, building on the domains approved earlier by the CMHPC (see Objectives Section). The committee first identified the most relevant issues for the older adult population, then developed a list of outcome measures and indicators based on these issues and knowledge of the mental health service delivery system. Participants then evaluated and selected the best outcome measures and indicators in terms of relevance to older adults, measurement of county mental health services, available data sources, and expected interpretation of the data.

These OAPOS measures and indicators will serve as a guide in the identification of data to be collected, how it will be used, and appropriate data sources. Data sources will include outcome instruments, data currently collected at the State or county level, and client data collected on a face sheet at each administration. Similar to APOS, county managers will use the data for quality improvement, clinicians will use the data for assessment and treatment planning, and the State will use the data to evaluate county mental health programs and to provide reports to the Legislature as required by legislation. Eventually, reports and other information will be provided to counties for use in their ongoing quality management programs.

Target Population

The target population for OAPOS has not been officially identified. However, tentatively, it is generally considered to include seriously mentally ill adults, ages 60 and up, who are receiving (or are expected to receive) public mental health services for 60 days or longer and excluding those who are seen through a county's individual provider network. Whether or not medications only clients will be excluded has not been decided. As with APOS, this population represents those older adults who are experiencing the greatest difficulties relating to their mental illnesses and who constitute those requiring the greatest proportion of county mental health staff, programmatic, and financial resources in order to address their needs.

Instruments Piloted

Screening Instrument (completed by all counties)

- Mini-Mental State Examination (MMSE)
  A widely used thirty-point screening test to assess cognitive mental status (orientation, attention, immediate and short-term recall, language, and the ability to follow simple verbal and written commands).

Face Sheet (completed by all counties)

- A two-page survey gathering information about client demographics, administrative details, and client status that may change between administration dates.

Assessment Instruments (Counties were given the flexibility to choose which and how many of the following to pilot)

- Behavior and Symptom Identification Scale (BASIS-32)
  A 32-item inventory measuring behavioral functioning and symptomatology from the consumer's perspective.

- Mental Health Statistics Improvement Program (MHSIP) Consumer Survey
  A 26-item consumer satisfaction survey.

- Brief Symptom Inventory (BSI)
  A 53-item self-report symptom inventory designed to measure psychological Distress.

- SF-12 Health Survey
  A multipurpose generic measure of health status (Short form of the SF-36).

- Activities of Daily Living (ADL)

An assessment of functional abilities essential for self-care (e.g., bathing, dressing, feeding).

- Instrumental Activities of Daily Living (IADL)
  An assessment of functional abilities necessary to adapt independently to the environment (e.g., shopping, housekeeping, transportation).

- OARS Social Support Subscale
  A 21-item self-report of a client's views about family and friends.

- CAGE
  A 4-item self-report on alcohol use/abuse.

- Senior Outcomes Checklist (SOC-10)
  A 10-item self-report of a client's views about his or her health, problems in daily activities, and expectations of the agency's services.

New Face Sheet

Partway through the pilot, in reaction to some criticisms of the adult instrument set and in order to properly interpret the instrument data, the committee decided that there was a need for more clinician input. A more extensive face sheet is currently being developed and will soon be undergoing a brief pilot.

Implementation of Pilot

Staff from seven counties volunteered to administer one or more outcome instruments to a sample of mentally ill older adult mental health clients over a six-month period. County participants include: Los Angeles, Riverside, Sacramento, Santa Clara, Shasta, Sonoma, and Tuolumne. Representatives from each county participating in the study will assist in the evaluation and selection of instruments to be tested during the pilot, along with other committee members. The pilot instruments will be evaluated on the following criteria:

Performance Domain Coverage

The set of instruments must measure the domains identified by the CMHPC and the issues relevant to older adults identified by the older adult performance outcome committee.

Psychometric qualities

The instrument should exhibit adequate psychometric properties including:

- Reliability - provides consistent results across raters and participants
- Validity - measures what it proposes to measure
- Sensitivity to change over time

- Normed, standardized, or widely used for older adult mental health clients
- Operates similarly for subgroups of the population

Logistical Constraints

The instrument should be feasible to administer including:

- Affordable to purchase and report - preferably public domain
- Reasonable time to administer for older adults with mental and physical disorders or other limitations
- Acceptable time to administer and score from viewpoint of county staff
- Available in a wide variety of formats to accommodate the technology used by counties for data input and report generation
- Accommodates cultural diversity - where feasible, available in languages appropriate for a variety of cultures

Data Collection Protocols

Counties received training before beginning the OAPOS pilot. Counties administered each selected instrument to each client at the beginning of a six-month period (Note: counties began collection at different times). Time 1 data were collected over at least three months (with a deadline of March 31, 2000). Time 2 data were collected six months later. To increase the likelihood that results of the study had statewide application, each county was encouraged to include adequate numbers of individuals for age, gender, ethnicity, and diagnosis.

Counties first screened each client for significant cognitive deficits, using the Mini-Mental State Exam, to determine which clients will proceed with the outcome instruments using established scores by age and educational level. Then clinicians completed the face sheet information and the selected assessment instruments. Once completed, pilot instrument data were sent to DMH for key entry into a data file.

Current Status

Data collection has taken longer than originally anticipated. The pilot is currently nearing the end of the Time 2 data collection period. Initial Time 1 data have been analyzed to verify accuracy, Time 2 data collection should be completed by the end of January 2001, and the pilot of the new face sheet should be completed by March 2001. A final report describing the pilot, including pilot county and clinician reactions, should be ready by June 2001. The report will provide recommendations regarding the set of instruments that should be adopted statewide to assess outcomes in the older adult target population.

FINDINGS

The Department of Mental Health (DMH) is still in the developmental phase of the Older Adult Performance Outcome System (OAPOS). Under the guidance of DMH, data are being gathered by seven pilot counties. Each pilot county is testing one or more of nine different assessment instruments (protocols and instruments are described in the Methodology Section). Selection of the final set of instruments for implementation of OAPOS will occur at the end of the data collection period (March 2001) and after discussion of the evaluation criteria (described in the Methodology Section).

Measurement of Objectives

The OAPOS measures and indicators (described in the Objectives Section) will serve as a guide in the identification of data to be collected, how they will be used, and appropriate data sources. Data sources will include outcome instruments, data currently collected at the State or county level, and client data collected on a face sheet at each administration. Similar to the adult program, county managers will use the data for quality improvement, clinicians will use the data for assessment and treatment planning, and the State will use the data to evaluate county mental health programs and to provide reports to the Legislature as required by legislation.

Once the final set of older adult instruments has been selected, DMH will operationalize how these indicators will be measured and pinpoint specific data sources.

Limitations/Weaknesses of Data

The older adult pilot has benefited from data problems experienced in the children's and adult performance outcome programs, as well as from initial feedback in the current pilot. Some of the most important lessons were:

- *Face sheet* – It has become obvious that there is a need to obtain adequate, valid information about a client in order to interpret the instrument data. This information should include demographic characteristics as well as variables needed to correctly adjust for risk and evaluate changes in functioning in light of realistic expectations. In order to obtain this information, a more extensive face sheet than originally planned is now being developed, with a short pilot planned for February and March 2001.

- *Clinician input* – Although it is important to collect information from clients regarding their satisfaction with services, it is also important to remember that this is a population whose illness impacts its ability to respond to surveys. Therefore, it is also important to obtain information from clinicians - particularly on questions related to symptoms and functioning. The new face sheet will be completed by the clinician and is intended to provide this information.

Highlights of Current Findings

The Older Adult Performance Outcome Pilot has now received all first administration and almost all second administration instrument data from the volunteer counties. First administration results are currently being analyzed; second administration results will be available soon. Information from the revised face sheet will be available at the conclusion of an abbreviated pilot.

Summary of Demographic Data

Demographic information from the original face sheet describing first administration pilot participants receiving services from county older adult mental health programs is provided below. The following tables present diagnosis, age, ethnicity, and gender information for over 850 older adult clients. Note: these data are based on limited numbers from only seven counties and may not be representative statewide.

Diagnosis

The table below shows the frequency and percent of older adult clients in the pilot categorized by diagnosis. Note: the valid percent column excludes missing data. Almost equal numbers of the older adult clients are categorized under either "Schizophrenia" / "Other Psychoses" (44.4%) or "Mood Disorder" (45.9%). Mood Disorders include such diagnoses as bipolar disorders and depressive disorders. A much smaller percentage of the clients have disorders categorized as "Anxiety" or "Other Non-Psychotic Disorders" (9.5%). The latter includes such things as panic disorders, certain phobias, obsessive compulsive disorders and stress disorders.

Primary Diagnosis

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Schizophrenia	274	32.0	32.7	32.7
	Other Psychoses	98	11.4	11.7	44.4
	Depressive/Bipolar	385	45.0	45.9	90.3
	Anxiety Disorder	40	4.7	4.8	95.1
	Other Non-Psychotic	39	4.6	4.7	99.8
	Unknown	2	.2	.2	100.0
	Total	838	97.9	100.0	
Missing	Missing (9)	18	2.1		
Total		856	100.0		

Age

The table below shows the frequency and percent of older adult clients in the pilot categorized by age (the older adult system includes ages 60 and up). The highest percentage of clients are in the age category 60 to 69 (61.9%).

Age Category

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	60 - 69	527	61.6	61.9	61.9
	70 - 79	219	25.6	25.7	87.6
	80 - 89	90	10.5	10.6	98.1
	90+	16	1.9	1.9	100.0
	Total	852	99.5	100.0	
Missing	Missing (0)	4	.5		
Total		856	100.0		

Ethnicity

The table below shows the frequency and percent of older adult clients in the pilot, categorized by ethnicity. While the face sheet actually collected ethnic data for eight ethnic categories, currently most of these have too few numbers for individual analysis. When compared with actual statewide percentages of older adult county mental health clients obtained from the CSI database, the percentages in the White and African American groups in the pilot are relatively similar. The percentage of Hispanic clients in the pilot is higher than in CSI. The White, Hispanic, and African American groups account for 90% of the pilot data.

Client Ethnicity

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White	599	70.0	70.7	70.7
	Hispanic	103	12.0	12.2	82.9
	African American	61	7.1	7.2	90.1
	Other Asian/Pac Isl	19	2.2	2.2	92.3
	Native American	4	.5	.5	92.8
	Southeast Asian	28	3.3	3.3	96.1
	Filipino	1	.1	.1	96.2
	Other	32	3.7	3.8	100.0
	Total	847	98.9	100.0	
Missing	Unknown/Missing	9	1.1		
Total		856	100.0		

Gender

The table below shows the frequency and percent of older adult clients in the pilot, categorized by gender. Pilot data indicate that 73.2% of the clients are female and 26.8% are male. These proportions are similar to, but more pronounced than, those found in the statewide CSI database for older adults. Other analyses on similar data indicate that the percentage of females increases as age increases.

Gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Female	612	71.5	73.2	73.2
	Male	224	26.2	26.8	100.0
	Total	836	97.7	100.0	
Missing	Missing (9)	17	2.0		
	Unknown	3	.4		
	Total	20	2.3		
Total		856	100.0		

More extensive analyses of pilot demographic results can be found on the RPOD web page http://www.dmh.cahwnet.gov/rpod/olderadult/htm. Documents available include a report entitled "A Comparison of Older Adults with Serious Mental Illness with Adults in the General Population" which compares the gender, ethnicity, marital status, education, and living arrangements of pilot participants with various state and national prevalence data. Additionally, there is a PowerPoint presentation available entitled "Older Adult Performance Outcome Pilot: First Administration Results" which compares various demographic results for significant differences by gender, diagnosis, and ethnicity.

Pilot Instrument Results

The instruments being tested by the Older Adult Performance Outcome Pilot and how they will be evaluated are described in the Methodology Section. An evaluation of the piloted instruments will be made at the conclusion of the pilot and will include both objective results as well as subjective reactions to the instruments from clinicians and clients.

At this point, it appears likely that, in addition to an extensive face sheet, the OAPOS will include the Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, a consumer satisfaction instrument. The State Quality Improvement Committee has found the MHSIP scores from the Adult Performance Outcome System to be very useful as a source of information for improving mental health services.

MHSIP Results

The MHSIP is a 26-item public domain instrument and is being used in California's Adult Performance Outcome System as well as by a number of other states. Five pilot counties (Total N=367) tested the MHSIP. Certain overall pilot results for the MHSIP are presented below, with more detailed information to be provided in subsequent reports.

The MHSIP Consumer Survey asks questions relating to general satisfaction, access to services, appropriateness of treatment, and outcomes of care. The MHSIP item scores are based on a 5-point scale that ranges from 1 to 5. Additionally, a zero rating is available for a client to identify items that do not apply. Ratings are defined as follows:

0 = Not Applicable
1 = Client strongly disagrees with item
2 = Client disagrees with item
3 = Client is neutral
4 = Client agrees with item
5 = Client strongly agrees with item

When interpreting MHSIP subscale scores, higher scores are better and represent the client's positive perceptions of that aspect of the county's services. MHSIP scores are client self-reports. Sometimes factors other than the client's immediate perceptions of care can influence ratings of services (e.g., client is required to participate). As with all self-reports, a client's symptoms, health, medication, etc., can also affect ratings. Items on satisfaction instruments typically tend to receive relatively high ratings and to show little variability.

MHSIP subscale scores are derived by averaging the scores of the items associated with that subscale. The results in the table below are very similar to those obtained in the Adult Performance Outcome System. Overall, older adult clients were generally satisfied, and there was little practical difference in average subscale ratings. The lowest average score was for "Perceived Outcomes", and the highest average score was for "Satisfaction with Services".

MHSIP Average Scores

Overall	Access to Care	Appropriateness of Care	Perceived Outcomes	Satisfaction with Services
4.09	4.16	4.14	3.83	4.30

First administration MHSIP results were also analyzed to determine if there were any statistically significant differences for primary diagnosis, age, gender, or ethnicity. Because of the small numbers in some groups, variables often had to be grouped into broad categories. More in-depth statistical analyses will be done once OAPOS is implemented and the number of records increases. Although some of the differences mentioned below may become significantly different statistically as client numbers increase, it will be important to consider whether the differences are big enough to be considered meaningful.

Diagnosis. Three diagnostic categories were used for analysis: Schizophrenia/Other Psychoses, Mood Disorders, and Anxiety/Other Non-Psychotic Disorders. Clients in all three diagnostic categories reported general satisfaction both overall and on all four scales. There was no consistent pattern as to which group had the lowest mean (average) score (indicating least satisfaction) on the scales. A statistically significant difference was found for the "Satisfaction Scale" (the Schizophrenia/Other Psychoses group had the lowest score).

Age. Three age groups were used for analysis: 60 – 69, 70 – 79, and 80 – 99. Clients in all three groups reported general satisfaction overall and on all four scales. The oldest age group had the lowest mean score on all scales except "Satisfaction with Outcomes". The differences were not statistically significant.

Ethnicity. Three ethnic groups were used for analysis: White, Hispanic, and African American. Clients in all three groups reported general satisfaction overall and on all four scales. The White group consistently had the lowest mean score on all scales, but the differences were not statistically significant.

Gender. Both males and females reported general satisfaction overall and on all four scales. Males had lower mean scores on all four of the scales, but not overall. These differences were not statistically significant.

APPENDICES

California Department of Mental Health
Adult Performance Outcome System
California Quality of Life (CA-QOL) Survey Report

CMHDA Region: *Central*
Report period: 20000701 to 20010630

Purpose Of This Report

The purpose of this report is to provide regional and statewide data for the State of California's Adult Performance Outcome System.

Consumers and family members rated the measurement of quality of life as one of their highest priorities. In the selection of a survey to assess quality of life, counties were given the choice of using either the California Quality of Life (CA-QOL) Survey or the Lehman Quality of Life Short Form (QLSF). This report is designed to present all data in the form of CA-QOL equivalent scores. QLSF scores are transformed through the use of a regression equation developed during a pilot test of both the CA-QOL and QLSF. Such transformations are necessary to allow for statewide reporting and aggregate data analysis.

For informational purposes, the total number of CA-QOL and QLSF surveys that have been completed are reported below:

Total Number Of Survey Responses Included In Report

CA-QOL Surveys:	*33041*	**QLSF Surveys:**	*8488*

About the CA-QOL

The CA-QOL is a 40-item quality of life survey. It is designed to measure objective and subjective domains related to quality of life from a consumer's self-reported perspective. These domains include: a) general living situation, daily activities and functioning, family and social relationships, finances, work and school, legal and safety issues, and satisfaction with health.

As with several other Adult Performance Outcome Instruments, it is critical to remember that the ratings on the CA-QOL represent a consumer's perceptions. A variety of factors can affect a consumer's quality of life and many of these are out of the control of county mental health programs. However, in our efforts to continually improve our services, the CA-QOL provides an excellent source of information on issues that are important to consumers and which may have a direct impact of service outcomes.

What Is In This Report

California Department of Mental Health
Adult Performance Outcome System
CAQOL Survey Report

CMHDA Region: *Central*
Report Period: 20000701 to 20010630

Demographic Information For Respondents

Total Number of Respondents	
CMHDA Region	*Statewide*
4051	*33041*

NOTE:
In some cases, the percentage of cases reported does not sum to 100%. In such cases, the remaining percentage is comprised of non-respondents or invalid responses.

Gender	*CMHDA Region*	*Statewide*
Male	*1667*	*14009*
Female	*2244*	*18316*

Ethnicity	*CMHDA Region*	*Statewide*
Amerasian	*6*	*44*
Nat. Amer.	*52*	*411*
Asian Indian	*10*	*38*
African Am.	*446*	*3494*
Cambodian	*10*	*48*
Chinese	*22*	*150*
Filipino	*30*	*311*
Guamanian	*2*	*16*
Hawaiian	*3*	*36*
Hispanic	*515*	*4713*
Japanese	*10*	*95*
Korean	*11*	*65*
Laotian	*27*	*122*
Other Asian	*105*	*472*
Samoan	*0*	*11*
Vietnamese	*40*	*309*
White	*2424*	*20544*
Other Eth.	*197*	*524*
Unknown	*141*	*256*

Diagnosis	*CMHDA Region*		*Statewide*	
Schizophrenia and other Psychotic Diagnoses	*1349*	*33.30%*	*11588*	*35.07%*
Mood Disorder Diagnoses	*2037*	*50.28%*	*15847*	*47.96%*
Anxiety Related Diagnoses	*169*	*4.17%*	*1737*	*5.26%*
Other Diagnoses	*319*	*7.87%*	*3018*	*9.13%*
Substance Abuse Related Diagnoses	*39*	*0.96%*	*405*	*1.23%*

How To Interpret CA-QOL Scores

Always remember that CA-QOL scores are client self-reports. A variety of factors may influence a client's quality of life. Many of these factors are beyond the control of county mental health programs. Additionally, a client's symptoms, physical health, medication, or attitude could possible affect ratings.

The CA-QOL is comprised of two kinds of scales: subjective scales and objective scales. The subjective scales ask the client report his or her satisfaction with a number of areas related to quality of life. The objective scales ask the client to report specific objective data (e.g., amount of spending money) that may directly affect his or her quality of life.

The CA-QOL subjective scales are reported using a seven point scale. Ratings are defined as follows:

Ratings	*Scales*
1 = Terrible *2 = Unhappy* *3 = Mostly Dissatisfied* *4 = Mixed* *5 = Mostly Satisfied* *6 = Pleased* *7 = Delighted*	**General Life Satisfaction** **Satisfaction with Living Situation** **Satisfaction with Leisure Activities** **Satisfaction with Daily Activities** **Satisfaction with Family Relationships** **Satisfaction with Social Relations** **Satisfaction with Finances** **Satisfaction with Safety** **Satisfaction with Health**

The CA-QOL objective scales are scored differently than the subjective scales. Therefore, each scale score should be considered in light of its specific rating scale. These are presented below:

Scales

Frequency of Family Contacts
Scale: 0 = no family, 1 = not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week, 5 = daily

Frequency of Social Contacts
Scale: 1 = not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week, 5 = daily

Amount of Spending Money
Scale: 1 = less than $25, 2 = $25 - $50, 3 = $51 - $75, 4 = $76 - $100, 5 = More than $100

Adequacy of Finances
Scale: 0 = no, 1 = yes (Score is proportion of "yes" so the subscale score is the average percent who responded "yes")

Victim of Crime
Scale: 0 = no, 1 = yes (Score is proportion of "yes" so the subscale score is the average percent who responded "yes")

Arrested
Scale: 0 = no arrests, 1 = one arrest, 2 = two arrests, 3 = three arrests, 4 = four arrests, 5 = five arrests, 6 = six or more arrests

General Health Status
Scale: 1 = excellent, 2 = very good, 3 = good, 4 = fair, 5 = poor

How To Interpret CA-QOL Scores

The CA-QOL subscale scores below are the result of averaging the scores of the items associated with that subscale. Therefore, at a clinical level, it is important to note that although a subscale score may be toward the lower or higher end, the client may have actually reported very strong agreement or disagreement with a particular item but not others. It is frequently useful to also look at average scores by individual item to gain a fuller understanding of specific aspects of clients' quality of life.

When interpreting CA-QOL subscales, in general "Higher Scores Are Better" (1 = Terrible to 7 = Delighted) and represents the client's positive perspective of that aspect of the quality of their life.

Subscale Averages and Standard Deviations

CA-QOL Subjective Subscales	*CMHDA Region*	*Statewide*
General Life Satisfaction	*3.6738 (1.5451)*	*3.7649 (1.5391)*
Satisfaction With:		
Living Situation	*4.2680 (1.5703)*	*4.3596 (1.5532)*
Leisure Activities	*3.9609 (1.4770)*	*4.0129 (1.4835)*
Daily Activities	*3.9194 (1.5438)*	*4.0106 (1.5612)*
Family Relationships	*4.1080 (1.6504)*	*4.1743 (1.6486)*
Social Relations	*4.0667 (1.3972)*	*4.1488 (1.3841)*
Finances	*3.1229 (1.6356)*	*3.1389 (1.6468)*
Safety	*4.6449 (1.4318)*	*4.7177 (1.4080)*
Health Status	*3.6479 (1.4774)*	*3.7361 (1.4895)*

CA-QOL Objective Subscales	*CMHDA Region*	*Statewide*
Frequency of Family Contacts	*3.3114 (1.2378)*	*3.1878 (1.2241)*
Scale: 0 = no family, 1 = not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week, 5 = daily		
Frequency of Social Contacts	*2.9072 (1.0383)*	*2.9054 (1.0342)*
Scale: 1 = not at all, 2 = less than once a month, 3 = at least once a month, 4 = at least once a week, 5 = daily		
Amount of Spending Money	*2.4043 (1.4764)*	*2.4032 (1.4673)*
Scale: 1 = less than $25, 2 = $25 - $50, 3 = $51 - $75, 4 = $76 - $100, 5 = More than $100		
Adequacy of Finances	*0.6303 (0.3407)*	*0.6437 (0.3458)*
Scale: 0 = no, 1 = yes (Score is proportion of "yes" so the subscale score is the average percent who responded "yes")		
Victim of Crime	*0.0862 (0.2271)*	*0.0854 (0.2249)*
Scale: 0 = no, 1 = yes (Score is proportion of "yes" so the subscale score is the average percent who responded "yes")		
Number of Arrest	*0.0637 (0.3962)*	*0.1127 (0.5108)*
Scale: 0 = no arrests, 1 = one arrest, 2 = two arrests, 3 = three arrests, 4 = four arrests, 5 = five arrests, 6 = six or more arrests		
Health Status	*3.5137 (1.1151)*	*3.4217 (1.1408)*
Scale: 1 = excellent, 2 = very good, 3 = good, 4 = fair, 5 = poor		

Following are the average ratings given by clients to individual CA-QOL items. This information can be used to gain insight into client perceptions of quality of life as it relates to specific life domains.

The scale for the following items is:
1 = Terrible, 2 = Unhappy, 3 = Mostly Dissatisfied, 4 = Mixed, 5 = Mostly Satisfied, 6 = Pleased, 7 = Delighted

Items Comprising Individual CA-QOL Subjective Subscales

	Average Scores	
	Region	**State**
General Life Satisfaction		
1. How do you feel about your life in general (1-7)	*3.6798*	*3.7662*
17. How do you feel about your life in general (1-7)	*3.6714*	*3.7700*
Satisfaction With Living Situation		
2a. Living arrangements where you live (1-7)	*4.2558*	*4.3381*
2b. The privacy you have there (1-7)	*4.2558*	*4.5055*
2c. The prospect of staying on where you live for a long time (1-7)	*4.1439*	*4.2257*
Satisfaction With Leisure Activities		
3b. The chance you have to enjoy beautiful things (1-7)	*4.1684*	*4.2630*
3c. The amount of fun you have (1-7)	*3.7867*	*3.8096*
3d. The amount of relaxation in your life (1-7)	*3.9357*	*4.0034*
Satisfaction With Daily Activities		
3a. The chance you have to enjoy beautiful things (1-7)	*3.9194*	*4.0106*
Satisfaction With Family Relationships		
6a. The way you and your family act toward each other (1-7)	*4.0894*	*4.1637*
6b. The way things are in general between you and your family (1-7)	*4.1293*	*4.1863*
Satisfaction With Social Relations		
8a. The things you do with other people (1-7)	*4.2691*	*4.3613*
8b. The amount of time you spend with other people (1-7)	*4.0480*	*4.1206*
8c. The people you see socially (1-7)	*4.1623*	*4.2732*
8d. The amount of friendship in your life (1-7)	*3.8142*	*3.8975*

Following are the average ratings given by clients to individual CA-QOL items. This information can be used to gain insight into client perceptions of quality of life as it relates to specific life domains.

The scale for the following items is:
1 = Terrible, 2 = Unhappy, 3 = Mostly Dissatisfied, 4 = Mixed, 5 = Mostly Satisfied, 6 = Pleased, 7 = Delighted

Items Comprising Individual CA-QOL Subjective Subscales

	Average Scores	
Satisfaction With Finances	**Region**	**State**
11a. The amount of money you get (1-7)	*3.3482*	*3.3811*
11b. How comfortable and well off you are financially (1-7)	*3.0386*	*3.0445*
11c. The amount of money you have available to spend for fun (1-7)	*2.9737*	*2.9952*
Satisfaction With Safety		
14a. How safe are you on the streets of your neighborhood (1-7)	*4.5330*	*4.6073*
14b. How safe are you where you live (1-7)	*4.8253*	*4.9458*
14c. The protection you have against being robbed (1-7)	*4.5822*	*4.6247*
Satisfaction With Health		
16a. Your health in general (1-7)	*3.8697*	*3.9466*
16b. Your physical condition (1-7)	*3.6879*	*3.7699*
16c. Your emotional well-being (1-7)	*3.3803*	*3.4741*

Following are the average ratings given by clients to individual CA-QOL items. This information can be used to gain insight into client perceptions of quality of life as it relates to specific life domains.

Many of the objective scales have their own unique scale properties, therefore, the scale used by the client is listed under each item.

Items Comprising Individual CA-QOL Objective Subscales

	Average Scores	
Frequency of Family Contacts	**Region**	**State**
4. In general, how often do you talk to a member of your family on the telephone? 0=No Family, 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*3.4663*	*3.3426*
5. In general, how often do you get together with your family? 0=No Family, 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*3.1641*	*3.0661*
Frequency of Social Contacts		
7a. Visit with someone who does not live with you? 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*3.0602*	*3.0443*
7b. Telephone someone who does not live with you? 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*3.3114*	*3.2591*
7c. Do something with another person that you planned ahead of time? 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*2.5243*	*2.5914*
7d. Spend time with someone you consider more than a friend, like a spouse, a boyfriend or a girlfriend? 1=Not At All, 2=Less Than Once A Month, 3=At Least Once a Month, 4=At Least Once A Week, 5=Daily	*2.7233*	*2.7167*
Amount of Spending Money		
9. On average, how much money did you have to spend on yourself in the PAST MONTH, not counting money for room and meals? 1=Less than $25, 2=$25 to $50, 3=$51 to $75, 4=$76 to $100, 5=More Than $100	*2.4043*	*2.4032*
Victim of Crime (Part of the Legal and Safety Subscale)		
In the PAST MONTH were you a victim of:		
12a. Any violent crimes such as assault, rape, mugging or robbery? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.0586*	*0.0596*
12b. Any non-violent crimes such as burglary, theft of your property or money or being cheated? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.1236*	*0.1290*

Following are the average ratings given by clients to individual CA-QOL items. This information can be used to gain insight into client perceptions of quality of life as it relates to specific life domains.

Many of the objective scales have their own unique scale properties, therefore, the scale used by the client i listed under each item.

Items Comprising Individual CA-QOL Objective Subscales

	Average Scores	
Adequacy of Finances	**Region**	**State**
During the PAST MONTH did you:		
10a. Generally have enough money for Food? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.7941*	*0.7911*
10b. Generally have enough money for Clothing? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.5843*	*0.5913*
10c. Generally have enough money for Housing? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.7976*	*0.7942*
10d. Generally have enough money for traveling around for things like shopping, medical appointments, or visiting friends and relatives? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.5835*	*0.6026*
10d. Social activities like movies or eating at restaurants? 0 = No, 1 = Yes (Average represents the % who responded yes.)	*0.3897*	*0.4018*
Arrested (Part of Legal and Safety Scale)		
13. In the PAST MONTH, have you been arrested or picked up for any crimes? 0=No arrests, 1=One arrest, 2=Two arrests, 3=Three arrests, 4=Four arrests, 5=Five arrests, 6=Six or more arrests	*0.0637*	*0.1127*
General Health Status		
15. In general, how would you rate your health? 1=Excellent, 2=Very good, 3=Good, 4=Fair, 5=Poor	*3.5137*	*3.4217*

The information in this report was not intended to take the place of a thorough and analytical evaluation of the data resulting from the CA-QOL as well as the other Adult Performance Outcome instruments. The goal of this report was to provide timely and informative feedback that can be used in conjuction with other system and client-level data to evaluate and improve public mental health services.

If you have recommendations on how this report can be improved or for report topics that will provide more meaningful assistance with program improvement, please email Karen Purvis, Lead Staffperson for Adult and Older Adult Performance Outcomes at:

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