California's Community Mental Health Performance Outcome Report

Fiscal Year 2004-05

A Report to the Legislature in Response to

AB 1288, Bronzan
Chapter 89, Statutes of 1991

(Welfare and Institutions Code Section 5613)

CALIFORNIA DEPARTMENT OF
Mental Health

Stephen W. Mayberg, Ph.D.
Director

March 2006

California's Community Mental Health Performance Outcome Report

Fiscal Year 2004–05

TABLE OF CONTENTS

EXECUTIVE SUMMARY....2

ISSUE STATEMENT....5

BACKGROUND....5

OBJECTIVE....6

STUDY METHODOLOGY....6

FINDINGS....7

- Description of Populations....7
- Consumer Improvement, Quality of Life, and Satisfaction....11

IMPLICATIONS AND FUTURE DIRECTIONS....28

EXECUTIVE SUMMARY

This report summarizes data obtained during Fiscal Year (FY) 2004-05 from two semi-annual, two-week sampling periods, and compares this data to that collected during one two-week sampling period from FY 2003-04. Data was obtained through a survey given to consumers receiving face-to-face community mental health services from county-operated and contract providers during the sampling periods. The counties and providers reported the data to the Department of Mental Heath (DMH) using the integrated Web-Based Data Reporting System, developed by DMH. For nearly three years, this system has provided online, internet-based data capture methods that have streamlined data collection and submission processes, improved data quality and provided low-cost flexibility to necessary changes in data elements and reporting requirements over time.

Major findings include:

1. Overall performance measurement results obtained from samples of consumer/caregiver surveys are positive and demonstrated consistency across the three sampling periods. This consistency is a reflection of consistency in statewide funding and administrative and service practices during the assessment time periods. Results may become less consistent once the transformational agenda of the Mental Health Services Act/Proposition 63, which could elicit changes in recovery and service outcomes, is realized.

2. Differences in gender and race/ethnicity in the mental health services population as compared to the general California population (evaluated by age group: youths, adults and older adults) are likely due to individual propensity toward service utilization as well as a function of service access, outreach and culture-specific issues.

3. For each of the three sampling periods, the majority of family members/caregivers of youth and youth themselves reported improvement in family life functioning, coping ability, school functioning, social connectedness/competency, family connectedness and general life functioning as a result of the mental health services they received. Youth generally reported greater improvements than family members/caregivers, which is likely a function of different goals, expectations and developmental levels between the two groups.

4. Across the three sampling periods and the eight outcome areas listed below, 56.1% to 75.0% of adults, and 61.1% to 85.6% of older adults surveyed reported improvement as a result of services received, as follows:

- ✓ Improved housing
- ✓ Reduction in symptoms
- ✓ Improved work/school functioning
- ✓ Increased social connectedness
- ✓ Increased family connectedness
- ✓ Improved ability in dealing with crises
- ✓ Improved ability to deal effectively with daily problems
- ✓ Improved ability to control one's life

Services showed the greatest positive impact on both age groups' ability to deal with daily problems and ability to control their lives. Across all outcome areas, a greater relative percentage of older adults compared to adults reported improvement. This finding is corroborated by other evaluations of older adult service impact, and suggests that when services are specifically tailored to older adult issues, a greater percentage of older adults may experience improvement, as compared with younger, adult clients.

5. Adults and older adults (in each of the three sampling periods) reported level of satisfaction with respect to the following seven quality of life indicators:

- ✓ general life satisfaction
- ✓ living situation
- ✓ daily activities
- ✓ family relationships
- ✓ social relationships
- ✓ safety
- ✓ health

For both age groups the largest percentages of consumers were satisfied with living situation and safety; considerably fewer consumers in each age group reported general life satisfaction and satisfaction with their health – with results on the other quality of life domains falling somewhere in between. Variability in results over time reflects recent variability in the mental health system's capacity to meet consumers' community housing needs, as well as the importance of increased coordination and integration of mental health services with other partnering agencies. The upcoming implementation of the Mental Health Service Act, which emphasizes housing and interagency coordination, is likely to positively impact the quality of life dimensions reported here.

6. Survey results for each sampling period along the following four dimensions - access to services, general satisfaction with services, perception of cultural appropriateness and perception of treatment involvement - showed that the majority of youth and family members/caregivers of youth were satisfied with services they received. Results on all dimensions are quite consistent across sampling time periods. Generally, youth reported relatively lower satisfaction with services than family members/caregivers, and the dimension with the lowest

satisfaction was "perception of treatment involvement". Results suggest a need for non-traditional youth services and supports, available in more normalized/natural settings, at atypical hours, and provided by people (and perhaps peers) who have a better understanding of youth issues and needs. Recent community services/supports planning efforts for youth and transition-age youth, catalyzed by the stakeholder engagement processes of the Mental Health Services Act implementation, will likely lead to the availability of more of the above needed services.

7. Adult and older adult consumers' evaluation of mental health services (during the three survey periods) along four dimensions - access to services, appropriateness of care, participation in treatment, and satisfaction with services - indicated that overall, the large majority of consumers positively evaluated the mental health services they received. Whereas satisfaction results for adults are quite consistent across survey periods, older adult results show increasing percentages over time of those satisfied with access to services, appropriateness of care, and participation in treatment. Older adult results are also consistently more positive than those of adults. The "satisfaction with services" dimension was consistently rated most positively by consumers in both the adult and older adult consumer groups. Though still quite positively rated, the "participation in treatment" dimension and in particular the survey item, "I, not staff, decided my treatment goal" received the lowest scores relative to others reported. Increased resources and recovery-oriented programming with respect to the Mental Health Services Act implementation are likely to increase the development of consumer-provider partnerships and greater consumer involvement in goal setting and the service delivery process.

8. The performance measurement system (i.e., Web-Based Data Reporting System), which has been successful over the past several years in providing flexibility to changes in the measurement of performance indicators and in producing standardized, quality data, is currently a point of departure for the imminent design and implementation of a comprehensive electronic mental health information system. The vision for such a system that reduces data silos and offers a supporting information technology infrastructure combining electronic charting, performance evaluation, decision support, personal health records, and more, is likely to be realized in the near future due to state-level and national mental health system transformational agendas. This technology, as well as state-level leadership and coordination with regard to local/county and statewide quality improvement and evaluation efforts will provide mechanisms through which performance and quality for mental health consumers will be accelerated.

ISSUE STATEMENT

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

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

BACKGROUND

DMH oversees public sector mental health service delivery throughout the State of California. State, county and community-level mental health service delivery organizations are expected to demonstrate accountability for the receipt of mental health service dollars by providing appropriate, cost-effective, and efficient solutions for individuals with serious mental illness, and those at risk for serious emotional, and consequent functional impairment.

DMH views accountability and quality improvement as critical components in achieving its mission. The Department is accountable to all stakeholders, including the California Legislature, consumers and their family members, taxpayers, communities, funding agencies, and service providers, and is dedicated to achieving a balance in addressing stakeholder priorities. Fiscal, administrative and service oversight is accomplished through the work of multiple entities within (and in affiliation with) DMH. DMH Performance Outcomes and Quality Improvement, Medi-Cal Oversight, and County Policy and Operations Units, Fiscal Auditors, Performance Measurement Advisory Committee, State Quality Improvement Council, California Mental Health Planning Council, and local (county) mental health boards and commissions all have a role in the establishment of performance indicators, quality improvement strategies, and assurance of accountability.

The current age of increasing technological sophistication affords opportunities for more extensive data collection and informative reporting than previously feasible. Therefore, strategies surrounding performance measurement, now, not only include consideration of data element content and evaluation methods, but also work flow/business process streamlining through the use of computer and communications technologies. For example, this report summarizes Consumer Perception Survey data that were captured using DMH's Web-Based Data Reporting System (WBDRS)[1], which was specifically designed to provide users with performance outcome data reporting options, and to be flexible to changes in reporting needs over time.

---

[1] Please see the California Community Mental Health Performance Outcome Report for FY 2002-03 for more information on the Web-Based Data Reporting System: http://www.dmh.ca.gov/POQI/reports.asp.

OBJECTIVE

The objective of this Annual Report is to provide the Legislature with detailed information regarding the results of performance outcome measurements in accordance with Welfare and Institutions Code Section 5613.

STUDY METHODOLOGY

This report summarizes data obtained during Fiscal Year 2004-05, from two semi-annual, two-week sampling periods (November 1-15, 2004 and May 2-13, 2005), and compares data from these sampling periods to the data collected during the previous Fiscal Year 2003-04 (November 3-17, 2003 sampling period). Consumers receiving face-to-face community mental health services from county-operated and contract providers during the sampling periods were included in a survey process. The nationally developed Youth Services Survey for Youth (YSS-Y), Youth Services Survey for Families (YSS-F), Mental Health Statistics Improvement Program (MHSIP) Consumer Survey, as well as Quality of Life (QOL) measures were used to capture consumer/caregiver perceptions of services.

The data were reported by counties/providers to the State Department of Mental Health using the DMH-developed, integrated Web-Based Data Reporting System (WBDRS). This system provides on-line, internet-based, data capture methods including direct key-pad/mouse data entry, and a paper-form scanning and verification option for larger volume, direct data submissions. This technology, which has been in place for nearly three years, has streamlined data collection and submission processes, has improved data quality, and provided low-cost flexibility to necessary changes in data elements and reporting requirements over time.

FINDINGS

This section provides a description of the characteristics of consumers surveyed during two survey time periods in FY 2004-05, with respect to those surveyed during a two-week period in FY 2003-04, and with respect to the larger public mental health services consumer and general populations. Performance outcome survey results on consumer improvement, satisfaction, and quality of life are also presented. Findings are interpreted within the quality improvement process and in light of existing knowledge with regard to services/supports utilization and delivery.

Description of Populations

The following tables show descriptive gender and race/ethnicity category information for the samples of children/youth, adults, and older adults surveyed. The tables provide comparisons among the consumers surveyed across three time periods (i.e., November 2003, November 2004, and May 2005), the mental health services population, and the general population for each age group. The degree to which the survey samples are representative of the entire mental health services population can be determined by examining the samples' demographic distributions with respect to those of the service population. Such comparisons are important toward understanding the generalizability of the data presented in this report to the larger mental health services population in California.[1] Also, the degree to which the mental health system is meeting community needs with respect to population demographic dimensions may be used as a guide for mental health system strategic planning. Efforts are continually applied to provide access to services/supports relative to community need and the demographic distributions within the population.

Gender

Tables 1, 2, and 3, below, show similarities between gender distributions of the samples of mental health consumers surveyed, and the mental health services population. These similarities imply some degree of generalizability of sample findings to the larger, mental health services population.

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

[1] With respect to most of the demographic dimensions collected for this report, the samples are generally representative of the larger mental health service population. Where more substantial differences exist between the sample and the service population, their impact on the generalizability of the findings is discussed.
[2] Similar results have been discussed in previous legislative reports of this nature (http://www.dmh.ca.gov/POQI/reports.asp).

the attention of mental health professionals than emotional disorders exhibited by female children/youth, which tend to be more internal (e.g., withdrawal, depression)[1].

For adults, and in particular, older adults, there is a larger percentage of females in the service population compared to the general population. Also consistent with previous results[2], this finding may be influenced by the general fact that women, and, in particular, those of the older generations, are more likely to verbalize emotional distress and seek services than their male counterparts.

Table 1 YOUTH DEMOGRAPHICS: GENDER

Gender	Youth in Survey Sample			All Youth Served[2]	California Population Youth
Date No. Surveyed	Nov. 2003[3] 15,138	Nov. 2004 16,808	May 2005 17,840	(FY 2004-05) 197,393	(Census 2004) 9,575,520
Female	38.5%	39.2%	39.3%	39.3%	48.8%
Male	60.8%	60.1%	60.3%	60.6%	51.2%
Other	0.1%	0.1%	0.0%	0.0%	N/A
Unknown/No Response	0.6%	0.6%	0.4%	0.1%	N/A
Total	100%	100%	100%	100%	100%

Table 2 ADULT DEMOGRAPHICS: GENDER

Gender	Adults in Survey Sample			All Adults Served	California Population Adults
Date No. Surveyed	Nov. 2003 17,553	Nov. 2004 20,698	May 2005 21,192	(FY 2004-05) 374,974	(Census 2004) 21,407,284
Female	54.4%	54.5%	54.8%	51.7%	49.2%
Male	44.9%	44.8%	44.4%	48.2%	50.8%
Other	0.1%	0.0%	0.1%	0.0%	N/A
Unknown/No Response	0.6%	0.7%	0.7%	0.1%	N/A
Total	100%	100%	100%	100.0%	100%

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

[2] The numbers of youth, adults and older adults in the service population reflect all of data received to date by DMH for the Fiscal Year 2004-05 service period. However, data continue to be received. Therefore, the numbers in the table likely under-represent the total number of clients served during this time frame.

[3] Samples described here for the November 2003 survey period reflect slightly higher numbers of clients than those described in the previous FY 2003-04 Legislative report; late data were added to the database since the analyses were last performed.

Table 3	OLDER ADULT DEMOGRAPHICS: GENDER				
Gender	**Older Adults in Survey Sample**			**All Older Adults Served**	**California Population Older Adults**
Date No. Surveyed	Nov. 2003 1,849	Nov. 2004 2,159	May 2005 2,227	(FY 2004-05) 34,523	(Census 2004) 5,393,607
Female	66.8%	66.7%	65.6%	63.0%	55.8%
Male	32.2%	32.8%	33.4%	36.8%	44.2%
Other	0.0%	0.0%	0.0%	0.0%	N/A
Unknown/No Response	0.9%	0.5%	0.9%	0.2%	N/A
Total	100%[1]	100%	100%[1]	100%	100%

Race/Ethnicity

Tables 4, 5, and 6, below, show relative percentages of race/ethnicity groups in the survey samples, the mental health services population, and the general California population for each age group. Each race/ethnicity group within the mental health services population and the general population is represented in the samples, but with some relative differences in the percent contribution of each race/ethnicity to the totals. Differences between the samples and the total service population with respect to race/ethnicity are also shown, and may be attributed to a large extent, to differences in data collection methods[2] and the amount of unknown race/ethnicity information in the total service population[3]. Thus, the aggregated findings in this report may be interpreted as being roughly representative of the mental health services population in terms of race/ethnicity. Minimal to moderate under-representation in the samples of African American and Asian/Pacific Islander clients across the age groupings, as well as slight under-representation of White clients across the youth samples should be

[1]Total percentage may not equal precisely 100% due to rounding.

[2]It should be noted that the surveys capture detailed information on race/ethnicity, including multiple race categories and a Hispanic/Latino ethnicity designation, whereas that level of detail was not captured within the larger Client and Services Information (CSI) system which tracks the mental health services population. (The survey follows the race/ethnicity data capture methodology specified by the Federal Office of Management and Budget: http://www.whitehouse.gov/omb/fedreg /1997standards.html). Therefore, apparent over or under-representation of particular races/ethnicities in the survey sample (e.g., fewer African-American/Black youth and adults and more Hispanic/Latino youth and older adults in the sample populations compared to the mental health service populations) may be a function of the different data capture formats. The “more than one race” category for the survey sample, may also address some of the discrepancies between the sample and service population percentages, as individuals who were only able to indicate one race in a single-choice situation (i.e., CSI) may have self-identified as being of more than one race when presented with more options (i.e., in the surveys). The CSI system is migrating to the same data format that the surveys currently use for the capture of race/ethnicity information. This change in format is likely to be achieved by 2007, at which time more direct comparisons between the survey sample and the larger mental health services population race/ethnicity characteristics will be made.

[3]Clients provide race/ethnicity information on a voluntary basis. Clients who choose to complete the surveys and be part of the survey samples are also more likely to be forthcoming about race/ethnicity information. Therefore, the amount of unknown race/ethnicity information within the survey samples is less than that within the total service population. The larger amount of unknown race/ethnicity information in the total service population reduces the relative percent-to-total representations of each race/ethnicity in the “All Served” columns in the tables. If all the race/ethnicity data were known for the total service population, the percent-to-total representations would be higher. Therefore, general comparisons between the samples, general population and total service population should be made considering a slightly higher percent-to-total representation of each race/ethnicity group within the “All Served” columns.

considered when interpreting the performance measurement data in this report with respect to their generalizability to the larger service population.

Some differences in relative percentages of race/ethnicity groups in the mental health services populations versus the general state population are also evident. Notable are the lower percentages of Hispanic and Asian/Pacific Islander youth and adults, lower percentage of White older adults, and higher percentages of African-American youth, adults and older adults that are in the service populations relative to their percentages in the general population. These percentage differences are likely to be a function of a number of variables, including access to services, degree of cultural competency of service providers, as well as culture-specific and individual consumer propensity toward service utilization.

Table 4 YOUTH DEMOGRAPHICS: RACE/ETHNICITY

Race/Ethnicity	Youth in Survey Sample			All Youth Served	California Population Youth
Date No. Surveyed	Nov. 2003 15,138	Nov. 2004 16,808	May 2005 17,840	(FY 2004-05) 197,393	(Census 2004) 9,575,520
African American	13.8%	15.0%	13.8%	18.7%	7.3%
Asian/Pacific Islander	2.8%	2.6%	2.8%	2.9%	9.7%
Hispanic	38.7%	43.0%	42.9%	35.6%	46.7%
Native American	1.1%	1.0%	0.9%	1.0%	0.8%
White	31.9%	26.8%	28.5%	31.4%	32.1%
Other	2.3%	2.2%	2.5%	1.0%	N/A
More than 1 race indicated	8.5%	8.5%	7.8%	N/A	3.4%
Unknown/No Response	0.9%	1.0%	0.8%	9.5%	N/A
Total	100%	100%[1]	100%[1]	100%[1]	100%

Table 5 ADULT DEMOGRAPHICS: RACE/ETHNICITY

Race/Ethnicity	Adults in Survey Sample			All Adults Served	California Population Adults
Date No. Surveyed	Nov. 2003 17,553	Nov. 2004 20,698	May 2005 21,192	(FY 2004-05) 374,974	(Census 2004) 21,407,284
African American	12.1%	12.6%	13.3%	18.2%	6.7%
Asian/Pacific Islander	5.3%	5.1%	5.9%	6.2%	12.2%
Hispanic	22.4%	24.2%	23.9%	21.2%	34.9%
Native American	1.8%	1.4%	1.4%	1.0%	0.8%
White	49.4%	47.4%	46.7%	44.8%	43.8%
Other	2.5%	2.6%	2.6%	1.5%	N/A
More than 1 race indicated	5.6%	5.5%	5.0%	N/A	1.6%
Unknown/No Response	1.0%	1.1%	1.2%	7.0%	N/A
Total	100%[1]	100%[1]	100%	100%[1]	100%

Table 6 OLDER ADULT DEMOGRAPHICS: RACE/ETHNICITY

Race/Ethnicity	Older Adults in Survey Sample			All Older Adults Served	California Population Older Adults
Date No. Surveyed	Nov. 2003 1,849	Nov.2004 2,159	May 2005 2,227	(FY 2004-05) 34,523	(Census 2004) 5,393,607
African American	9.7%	7.7%	9.8%	10.9%	5.5%
Asian/Pacific Islander	3.6%	5.0%	7.5%	11.2%	11.5%
Hispanic	20.8%	22.0%	20.5%	15.5%	16.1%
Native American	0.8%	1.0%	0.6%	0.6%	0.6%
White	55.6%	56.0%	55.1%	48.9%	65.1%
Other	2.8%	2.3%	2.1%	3.2%	N/A
More than 1 race indicated	5.8%	4.9%	3.4%	N/A	1.1%
Unknown/No Response	0.9%	1.0%	0.9%	9.8%	N/A
Total	100%	100%[1]	100%[1]	100%[1]	100%[1]

Consumer Improvement, Quality of Life, and Satisfaction

Family members/caregivers of youth, youth of sufficient age to reliably complete a survey (at least age 13), adults (age 18-59) and older adults (age 60+) receiving community mental health services were surveyed during three sampling periods: November 3-17, 2003; November 1-15, 2004; and May 2-13, 2005. The comparative results from these survey periods are presented below[2]. Relative consistency among survey periods in the percentages of those reporting improvement/ quality of like/satisfaction across all areas can be observed. If statewide funding, administrative, and service practices are reasonably consistent across assessment time periods, the relative uniformity of data results (as reported here) are expected and reasonable – due to the broad-spectrum, large-scale nature of state-level measurement and analysis. Greater variation in data and potential increases in percentages of individuals reporting improvement/satisfaction are likely to be more evident at the local or county level. Impacts of local prioritization and direction of resources and/or quality improvement strategies can be better appreciated on a smaller-scale, and through smaller evaluation projects that target specific, local implementations/interventions. Although small-scale, local impacts are likely to go undetected, or be only minimally detectable when large amounts of data are aggregated, statewide implementations that potentially impact all or most community mental health services and consumers within California (e.g., emphasis on reducing long term hospitalization/restrictive levels of care, the transformational agenda of the Mental Health Services Act/Proposition 63[3], etc.) may

[1] Total percentage may not equal precisely 100% due to rounding.
[2] Values for the November 2003 survey period throughout this report may be slightly different than the values reported in the previous year's (Fiscal Year 2003-04) report to the Legislature which provides data from that survey period. Late data were added to the database since the analyses were last performed. Also, the numbers of survey responses that make up the aggregated percentages and averages in the figures that follow vary depending upon the domain being measured. This is because at least two-thirds of the domain responses are needed for a reliable domain score. In some cases the requisite numbers of survey items were not completed; thus, those cases were removed from the analyses.
[3] http://www.dmh.ca.gov/MHSA/docs/meeting/12-17-2004/Mental_Health_Services_Act_Full_Text.pdf

indeed be observable through state-level evaluations. Where applicable, data in this report are interpreted in light of such issues.

Youth Improvement:

Figures 1 and 2, below, illustrate the percentages of family members/caregivers of child/youth consumers, and youth consumers themselves, who reported improvement with respect to six areas of child/youth personal functioning (i.e. family life functioning, coping ability, school functioning, social connectedness/competency, family connectedness, and general life functioning)[1]. The results from each of the three survey periods are quite consistent, with the majority of both family members/caregivers and youth reporting improvement in all six areas. Depending upon the area of functioning and survey period examined, 59.6% to 71.3% of family members/caregivers, and 62.6% to 74.6% of youth reported improvement as a result of services received. According to both youth and family members/caregivers, over time, services consistently showed the greatest positive impact on child/youth ability to get along with friends/other people (i.e., social connectedness/competency).

Consistently different perceptions of improvement were evident between the youth and family member/caregiver reported information, with more youth expressing improvement than caregivers in each area, with the exception “family connectedness”. These findings may be explained by the fact that youth may underestimate their own problems, and/or may have service goals that are less ambitious than those of their families/caregivers. As a result, youth may perceive improvements where their families do not. The lower percentage of youth rating family relationships positively may be associated with the general developmentally-based conflict that exists between adolescents and their parents/caregivers.

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

Figure 1. Family Member/Caregiver Evaluation of Youth Outcomes

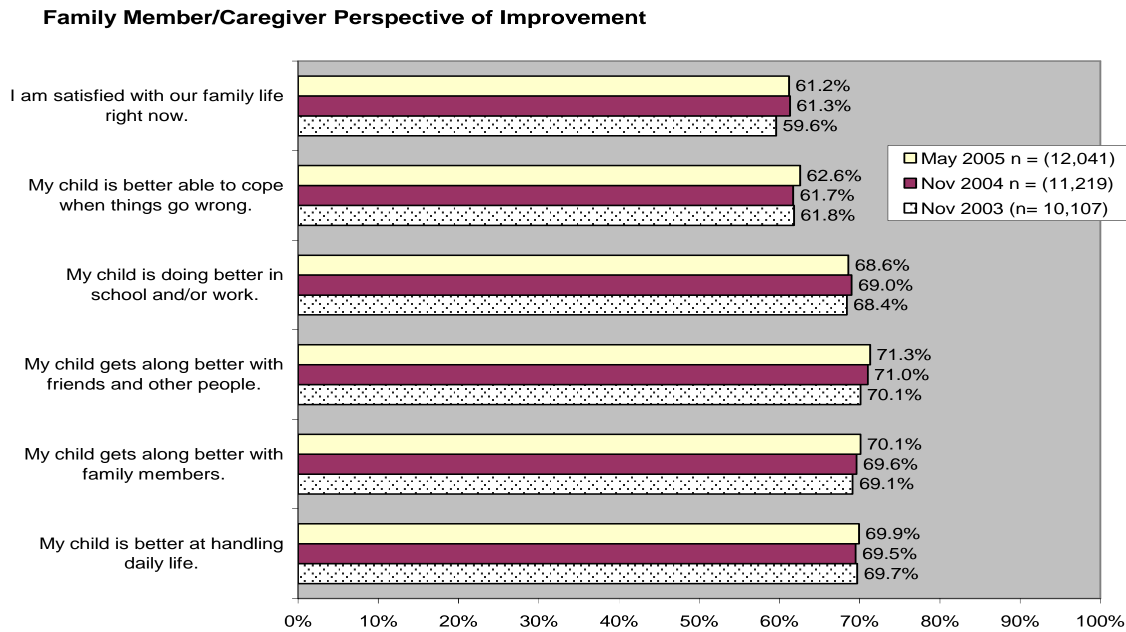
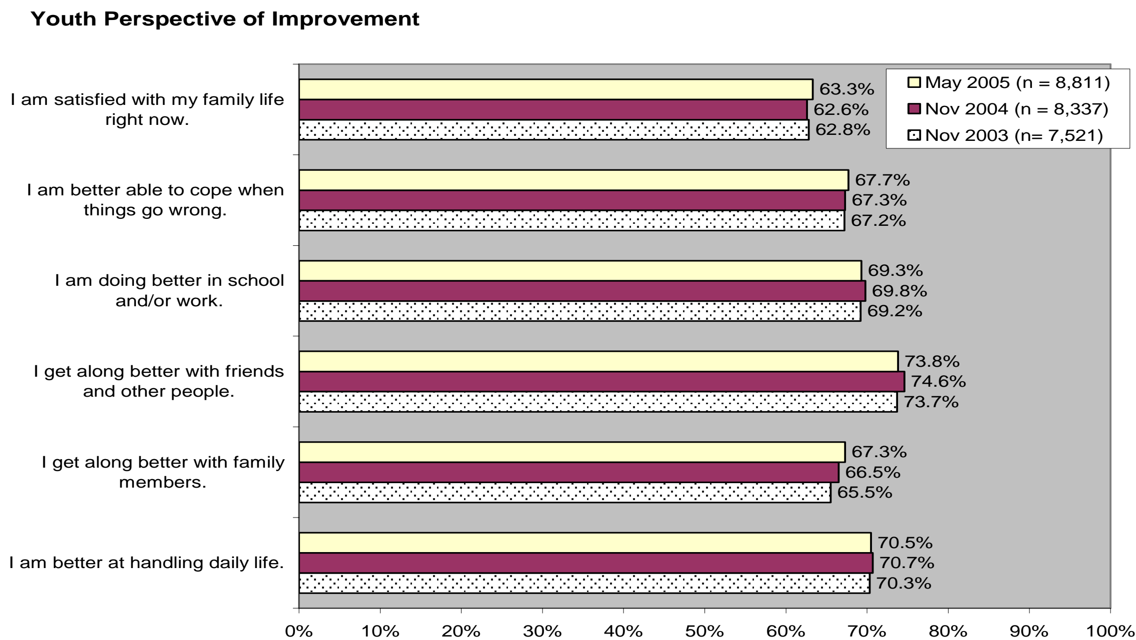


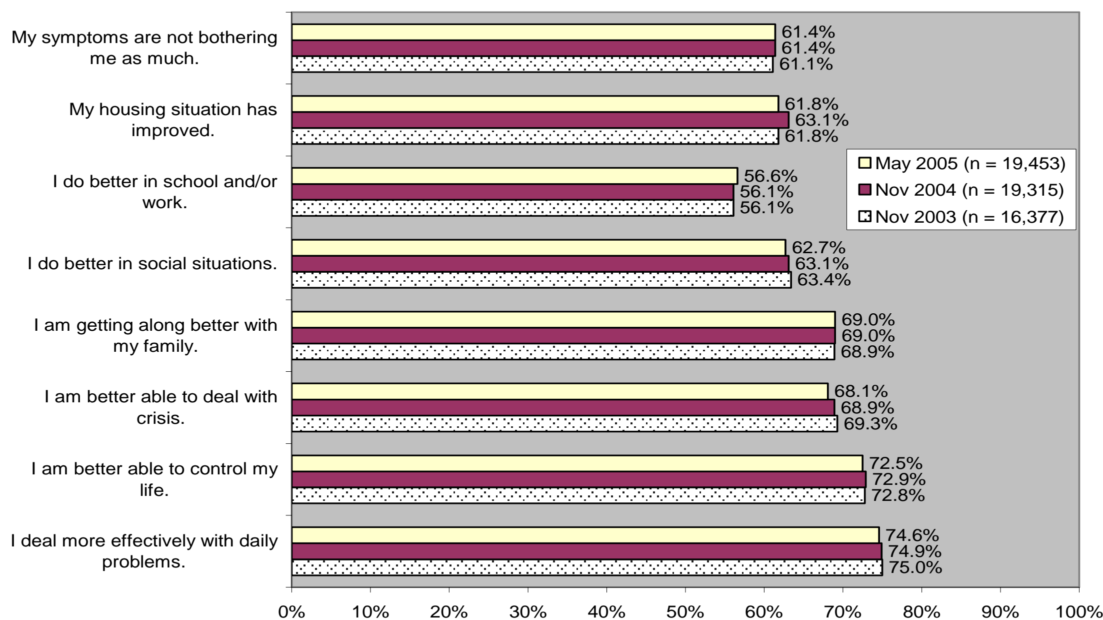
Figure 2. Youth Evaluation of Outcomes



Adult/Older Adult Improvement:

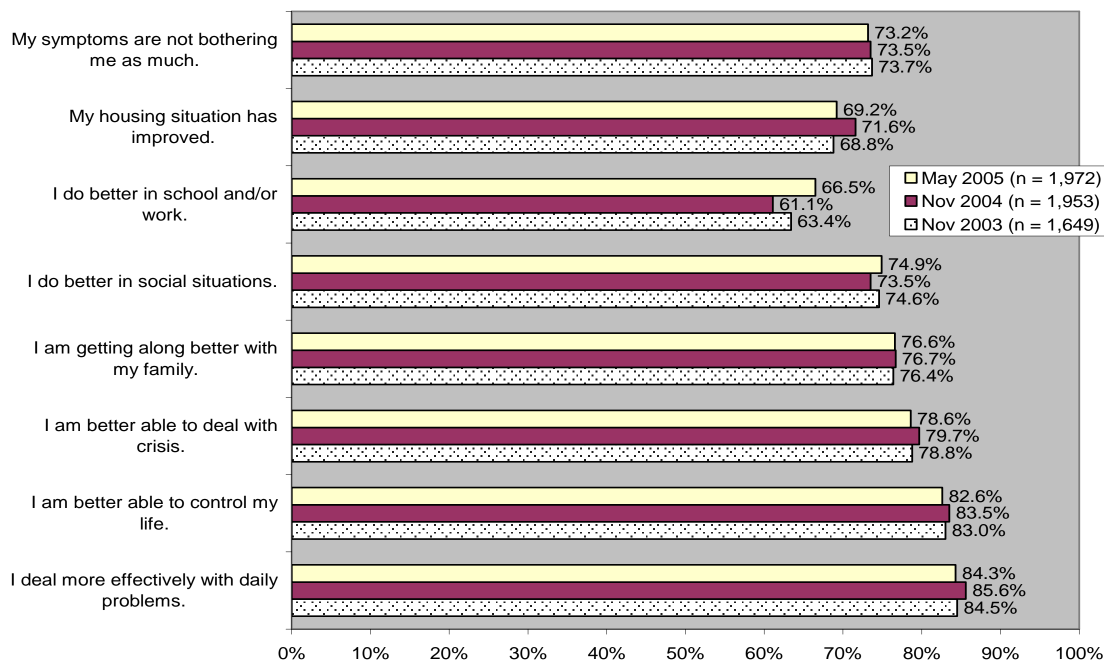
Figures 3 and 4 illustrate improvement in eight outcome areas as a result of services for the majority of adults and older adults surveyed across the three survey periods[1]. Outcomes include improved housing, reduction in symptoms, improved work/school functioning, social and family connectedness, ability to deal with crises and daily problems, and ability to control one's life. Across the eight outcome areas and three survey time frames, 56.1% to 75.0% of adults, and 61.1% to 85.6% of older adults surveyed reported improvement as a result of services received. Although some variability exists among the eight outcome areas in terms of adult versus older adult improvement, services showed the greatest positive impact on both age groups' ability to deal with daily problems and ability to control their lives. Across all outcome areas, however, a greater relative percentage of older adults reported improvement. This finding is corroborated by other evaluations of older adult service impact[2], and suggests that when services are specifically tailored to older adult issues, a greater percentage of older adults may experience improvement, as compared with younger, adult clients (ages 18-59).

Figure 3. Adult Outcomes



[1] Data were collected using the revised 28-item MHSIP Consumer Perception Survey for adults and older adults. Results reflect the percentage of respondents with respect to each survey period who indicated that they 'Agreed' or 'Strongly Agreed' with each item.
[2] See Older Adult Demonstration Project Results: www.dmh.ca.gov/AOAPP/OASOC/reports.asp.

Figure 4. Older Adult Outcomes



Quality of Life:

Figures 5 and 6, below, show the percentages of adult and older adult consumers in each of the three sample periods, who after receiving six months (or more) of mental health services, reported satisfaction with respect to seven quality of life domains (i.e., general life satisfaction, living situation, daily activities, family relationships, social relationships, safety issues and health).[1] Consistent with the above results is the fact that a greater percentage of older adults compared to adults reported satisfaction across all quality of life domains and survey time frames. Simultaneously, some similarities exist between the patterns of quality of life results for adults and older adults. For both age groups, the largest percentages of consumers were satisfied with living situation and safety; considerably fewer consumers in each age group reported general life satisfaction and satisfaction with their health – with results on the other quality of life domains falling somewhere in between. An emphasis on housing and supportive housing services for mental health consumers may be influencing the relatively more positive results obtained for consumers' living situation and consequent feelings of safety. However, the variability demonstrated to some extent in the housing and safety results across survey periods may also be reflective of the recent variability in the

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

mental health system's capacity to meet consumers' community housing needs - due to resource issues and a commitment to reduce restrictive care/institutionalization. Statuses with regard to health, general life satisfaction, and social, family and activities are variable as a result of numerous factors and life circumstances; they are difficult to impact and require increased coordination and integration of mental health services with other partnering agencies. The resources and transformational opportunities provided through the upcoming implementation of the Mental Health Service Act - and in particular the Act's emphases on housing and interagency coordination - are likely to positively impact the quality of life dimensions reported here.

Figure 5: Adult Perception of Quality of Life

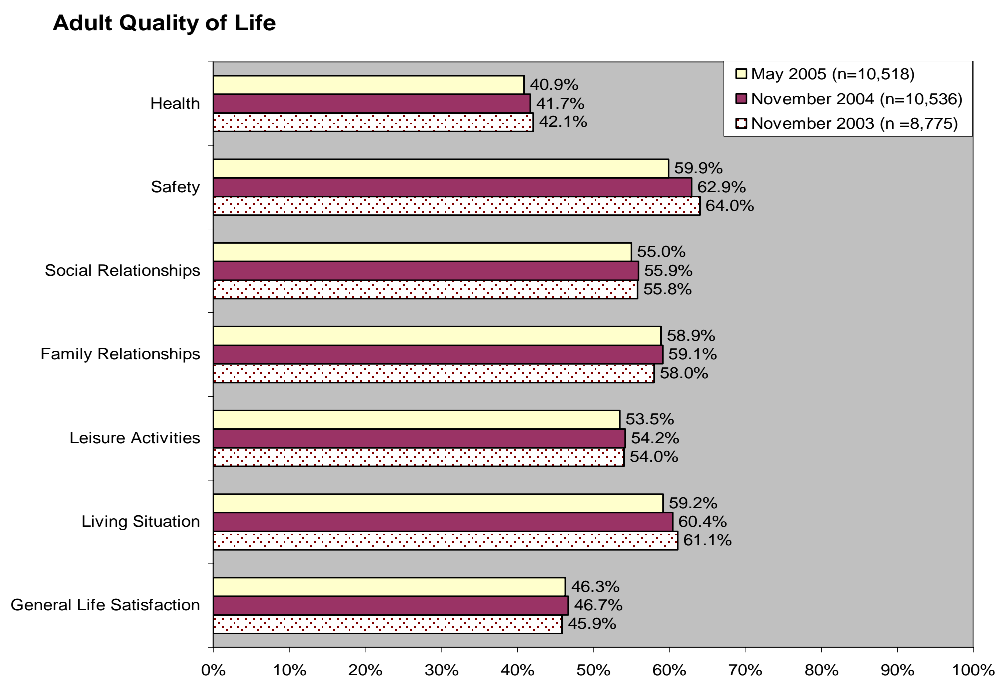
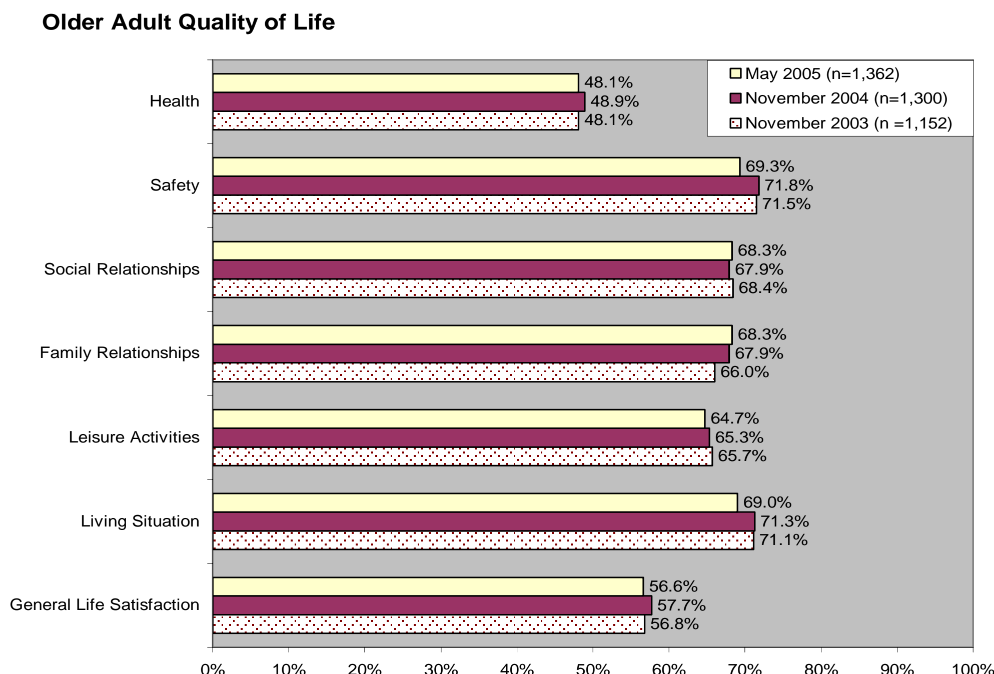


Figure 6: Older Adult Perception of Quality of Life



Satisfaction with Child/Youth Services:

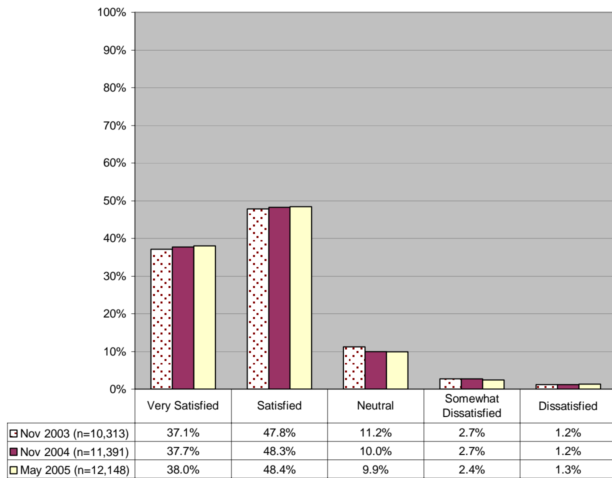
The majority of family members/caregivers and youth who responded to the survey (during three survey periods) were satisfied with the services their children received during FY 2003-04 and FY 2004-05. Figures 7-16, below, reflect survey results along the following four dimensions: access to services, cultural appropriateness, treatment involvement/participation, and general satisfaction with services. The first four sets of figures, below, show the percentages of family members/caregivers and youth who were "very satisfied", "satisfied", "neutral", "somewhat dissatisfied" or "dissatisfied" with respect to the four dimensions. Figures 15 and 16 show the average scores obtained for family members/caregivers and youth along the four dimensions[1].

All results are quite consistent across survey periods. The distributions shown in Figures 7-14, as well as the average scores depicted in Figures 15 and 16, demonstrate, that consistently, youth reported lower satisfaction with services than family members/caregivers. This finding is the opposite of the result obtained for service outcomes (above) where more youth reported positive outcomes than did family members/caregivers. Although these results would at first appear to be inconsistent, they actually complement one another. Youth's relatively lower satisfaction with

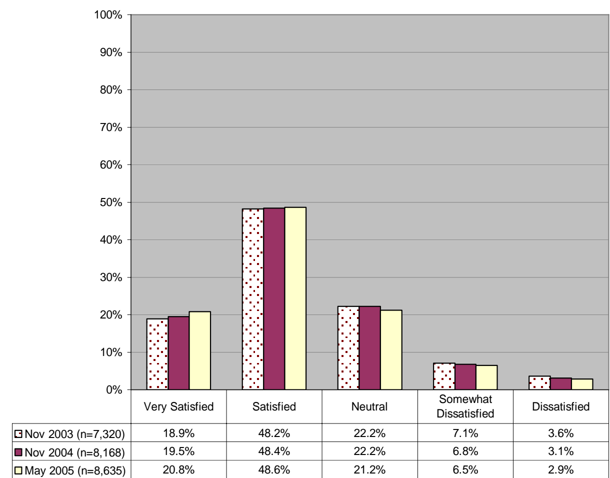
[1] The Youth Services Survey for Families (YSS-F) and Youth Services Survey for Youth (YSS) items are rated on a five-point scale; "5" indicates the greatest satisfaction. Averages are presented in Figures 15 and 16 for each dimension on both the YSS-F and YSS surveys across survey periods. As a general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

services and associated lower desire to be in treatment is consistent with a more positive self-appraisal of functioning that (if true) would necessitate a lesser need for treatment.

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

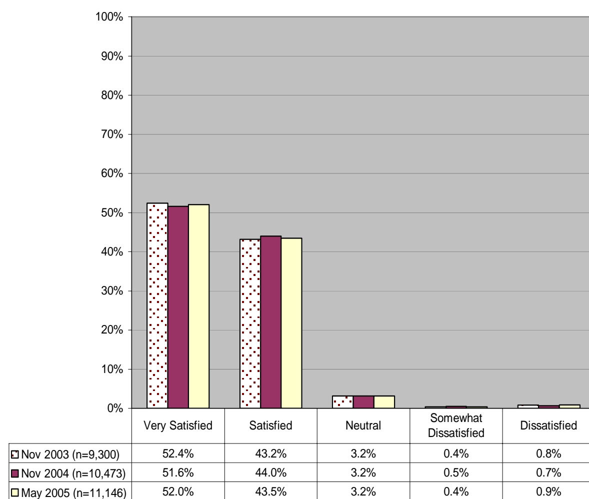


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=10,313)	37.1%	47.8%	11.2%	2.7%	1.2%
Nov 2004 (n=11,391)	37.7%	48.3%	10.0%	2.7%	1.2%
May 2005 (n=12,148)	38.0%	48.4%	9.9%	2.4%	1.3%

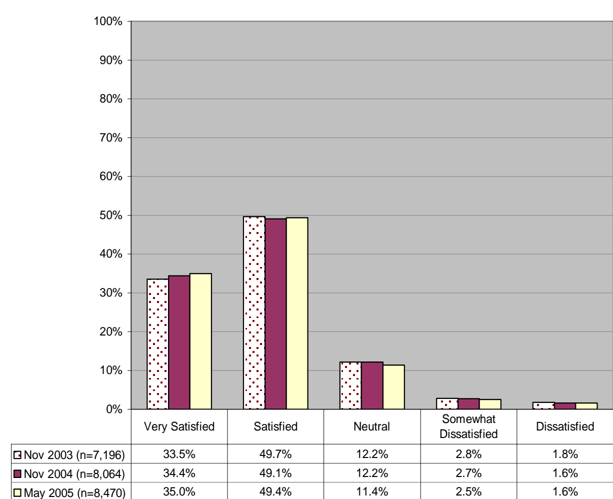


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=7,320)	18.9%	48.2%	22.2%	7.1%	3.6%
Nov 2004 (n=8,168)	19.5%	48.4%	22.2%	6.8%	3.1%
May 2005 (n=8,635)	20.8%	48.6%	21.2%	6.5%	2.9%

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

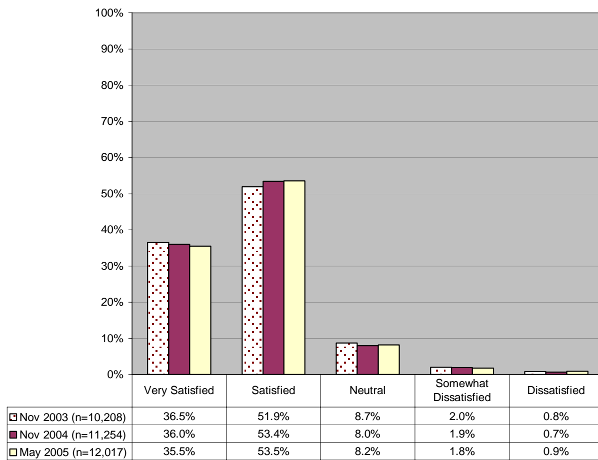


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=9,300)	52.4%	43.2%	3.2%	0.4%	0.8%
Nov 2004 (n=10,473)	51.6%	44.0%	3.2%	0.5%	0.7%
May 2005 (n=11,146)	52.0%	43.5%	3.2%	0.4%	0.9%

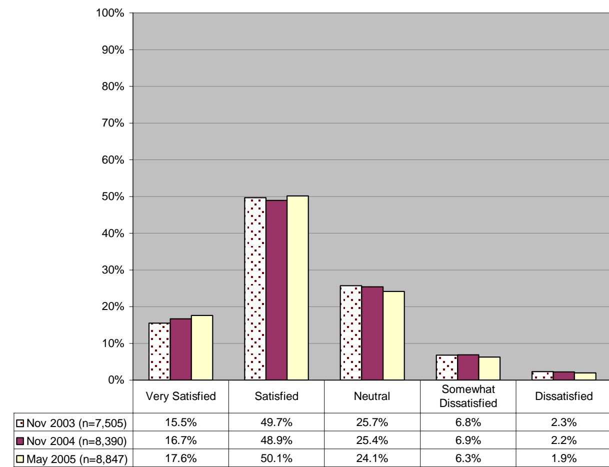


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=7,196)	33.5%	49.7%	12.2%	2.8%	1.8%
Nov 2004 (n=8,064)	34.4%	49.1%	12.2%	2.7%	1.6%
May 2005 (n=8,470)	35.0%	49.4%	11.4%	2.5%	1.6%

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

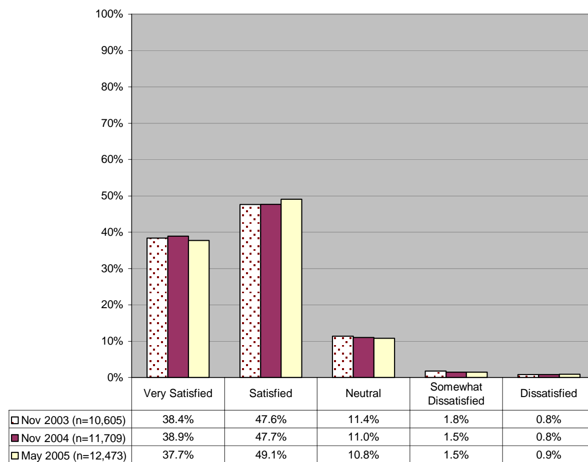


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=10,208)	36.5%	51.9%	8.7%	2.0%	0.8%
Nov 2004 (n=11,254)	36.0%	53.4%	8.0%	1.9%	0.7%
May 2005 (n=12,017)	35.5%	53.5%	8.2%	1.8%	0.9%

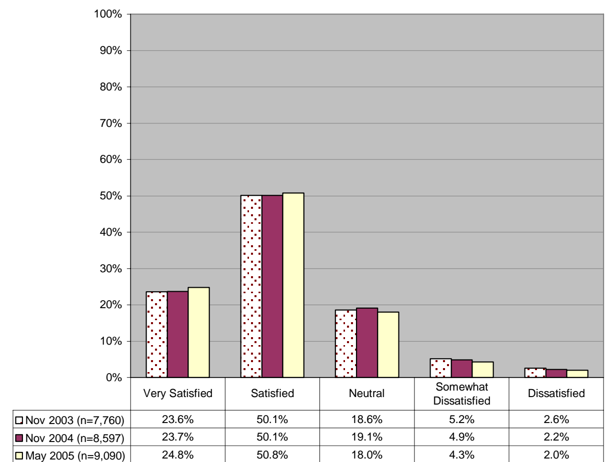


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=7,505)	15.5%	49.7%	25.7%	6.8%	2.3%
Nov 2004 (n=8,390)	16.7%	48.9%	25.4%	6.9%	2.2%
May 2005 (n=8,847)	17.6%	50.1%	24.1%	6.3%	1.9%

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

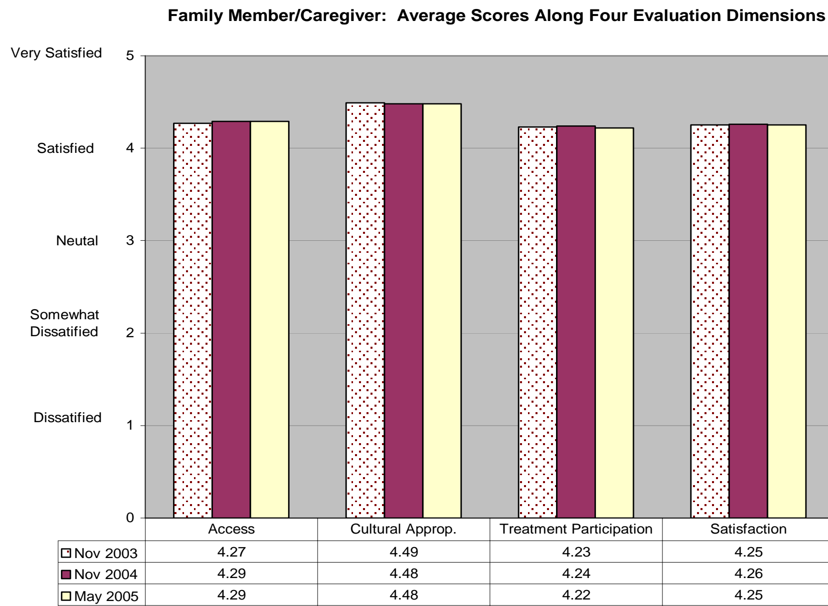


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=10,605)	38.4%	47.6%	11.4%	1.8%	0.8%
Nov 2004 (n=11,709)	38.9%	47.7%	11.0%	1.5%	0.8%
May 2005 (n=12,473)	37.7%	49.1%	10.8%	1.5%	0.9%



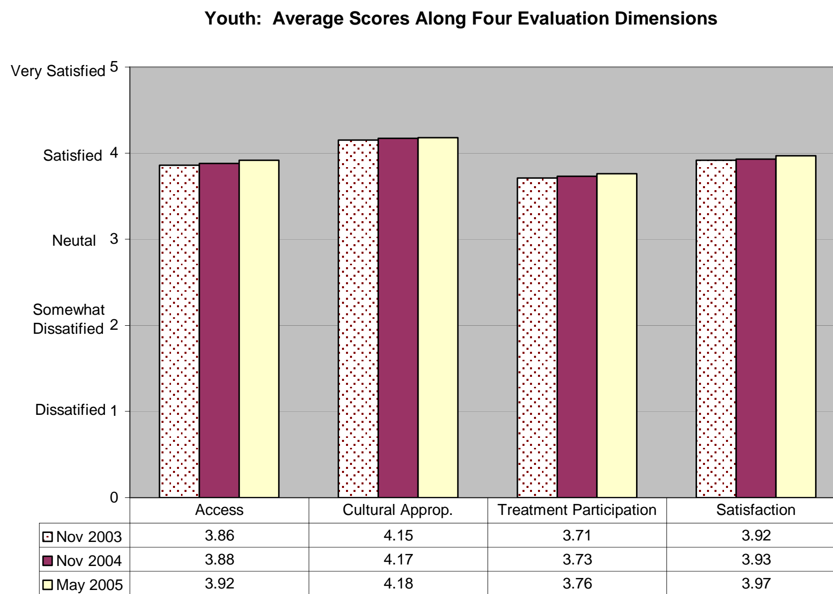
	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=7,760)	23.6%	50.1%	18.6%	5.2%	2.6%
Nov 2004 (n=8,597)	23.7%	50.1%	19.1%	4.9%	2.2%
May 2005 (n=9,090)	24.8%	50.8%	18.0%	4.3%	2.0%

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



	Access	Cultural Approp.	Treatment Participation	Satisfaction
Nov 2003	4.27	4.49	4.23	4.25
Nov 2004	4.29	4.48	4.24	4.26
May 2005	4.29	4.48	4.22	4.25

Figure 16: Youth Average Scores Along Four Evaluation Dimensions



	Access	Cultural Approp.	Treatment Participation	Satisfaction
Nov 2003	3.86	4.15	3.71	3.92
Nov 2004	3.88	4.17	3.73	3.93
May 2005	3.92	4.18	3.76	3.97

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

Both family members/caregivers and youth consistently reported the greatest amount of satisfaction on the cultural appropriateness dimension, indicating that they felt staff were respectful and sensitive to their beliefs and backgrounds. Family members/caregivers rated the other three dimensions somewhat similarly, while youth ratings along those dimensions were somewhat more variable, with the lowest youth satisfaction rating being associated with “perception of treatment involvement”.

The items that make up the four dimension scores reported above may be examined individually, and thereby provide greater detail into specific areas where satisfaction is relatively lower. Table 7, below, shows the results for these individual items. In particular, the response values for the item, “I helped to choose my services” may further explain youth’s lesser relative satisfaction on the treatment involvement/participation dimension. It is evident that youth may experience a sense of diminished control in the treatment process, especially if services are sought for them by their family members and/or other caregivers. The information gleaned from the youth survey items (especially those for which the average score is less than 4.0, shaded below)[1] suggest a need for non-traditional services and supports, available in more normalized/natural settings, at atypical hours, and provided by people (and perhaps peers) who have a better understanding of youth issues and needs. Recent community services/supports planning efforts for youth and transition-age youth, catalyzed by the stakeholder engagement processes of the Mental Health Services Act implementation, will likely lead to the availability of more of the above needed services.

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

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

	Individual Items	Family Member/ Caregiver			Youth		
		Average Score			Average Score		
		Nov 2003	Nov 2004	May 2005	Nov 2003	Nov 2004	May 2005
Access to Services	The location of services was convenient for us.	4.26	4.27	4.27	3.86	3.88	3.92
Access to Services	Services were available at times that were convenient for us.	4.27	4.30	4.31	3.84	3.88	3.91
Cultural Appropriateness	Staff treated me with respect.	4.56	4.55	4.55	4.20	4.23	4.24
Cultural Appropriateness	Staff respected my family's religious/spiritual beliefs.	4.45	4.45	4.44	4.19	4.19	4.20
Cultural Appropriateness	Staff spoke with me in a way that I understood.	4.53	4.52	4.51	4.18	4.20	4.21
Cultural Appropriateness	Staff were sensitive to my cultural/ethnic background	4.41	4.41	4.41	4.07	4.07	4.09
Participation in Treatment	I helped to choose my/my child's services.	4.10	4.10	4.11	3.36	3.40	3.44
Participation in Treatment	I helped to choose my/my child's treatment goals.	4.22	4.22	4.21	3.83	3.84	3.88
Participation in Treatment	I was frequently involved in my/my child's treatment.	4.37	4.38	4.35	3.91	3.92	3.96
General Satisfaction	Overall, I am satisfied with the services I/my child received	4.39	4.39	4.38	4.02	4.03	4.07
General Satisfaction	The people helping me/my child stuck with us no matter what.	4.31	4.32	4.32	3.96	3.98	4.02
General Satisfaction	I felt I/my child had someone to talk to when I/he/she was troubled.	4.30	4.31	4.31	3.94	3.96	3.98
General Satisfaction	The services I/my child and/or family received were right for us.	4.25	4.27	4.25	3.90	3.91	3.96
General Satisfaction	I/my family got the help we wanted (for my child).	4.20	4.21	4.20	3.87	3.89	3.93
General Satisfaction	I/my family got as much help as we needed (for my child).	4.07	4.09	4.08	3.82	3.84	3.87

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

Satisfaction with Adult and Older Adult Services

Figures 17-26, below, show adult and older adult consumers' evaluation of mental health services (during the three survey periods) along four dimensions: access to services, appropriateness of care, participation in treatment, and satisfaction with services. The first four sets of figures, below, show the percentages of adults and older adults who were "very satisfied", "satisfied", "neutral", "somewhat dissatisfied" or "dissatisfied" with respect to the four dimensions. Figures 25 and 26 show the average scores obtained from adult and older adult consumers along the four dimensions[1].

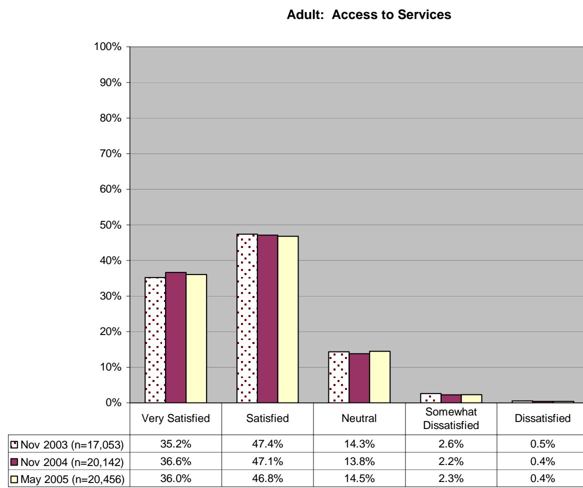
Results indicate that overall, the large majority of consumers positively evaluated the mental health services they received. Consistent with previous sections of this report, a greater percentage of older adults (compared to adults) rated services positively, as reflected in the four dimensions illustrated. The distributions in Figures 17 though 22 show that whereas satisfaction results for adults are quite consistent across survey periods, older adult results show increasing percentages over time of those satisfied with access to services, appropriateness of care, and participation in treatment. (The "satisfaction with services" dimension for older adults appears to be relatively more consistent over time, however, as shown in Figure 24.)

The "satisfaction with services" dimension was consistently rated most positively by consumers in both the adult and older adult consumer groups. Though still quite positively rated, the "participation in treatment" dimension received the lowest score relative to the other dimensions, and may benefit from further exploration. (See item analysis, below.)

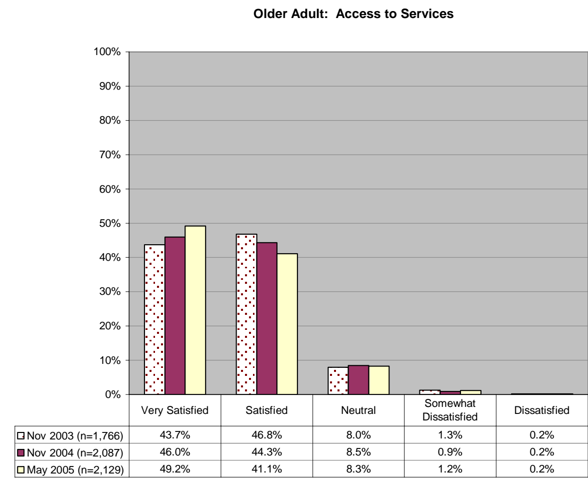
---

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

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

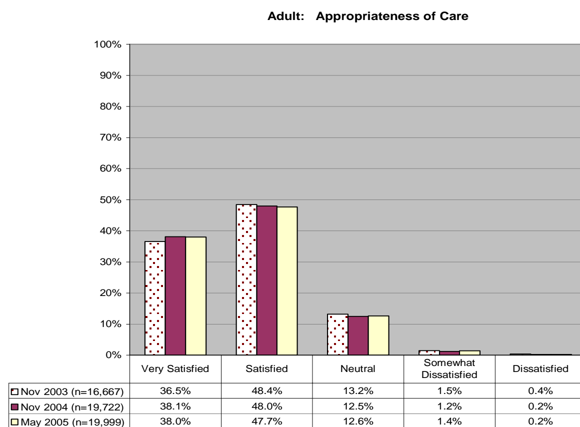


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=17,053)	35.2%	47.4%	14.3%	2.6%	0.5%
Nov 2004 (n=20,142)	36.6%	47.1%	13.8%	2.2%	0.4%
May 2005 (n=20,456)	36.0%	46.8%	14.5%	2.3%	0.4%

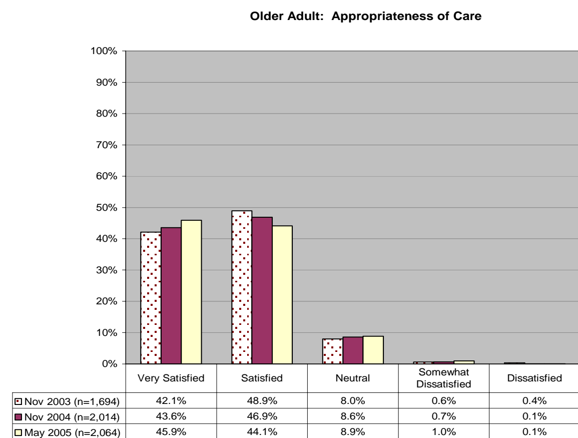


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=1,766)	43.7%	46.8%	8.0%	1.3%	0.2%
Nov 2004 (n=2,087)	46.0%	44.3%	8.5%	0.9%	0.2%
May 2005 (n=2,129)	49.2%	41.1%	8.3%	1.2%	0.2%

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

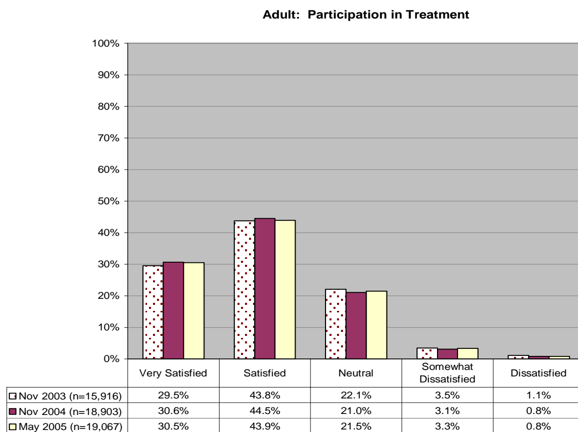


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=16,667)	36.5%	48.4%	13.2%	1.5%	0.4%
Nov 2004 (n=19,722)	38.1%	48.0%	12.5%	1.2%	0.2%
May 2005 (n=19,999)	38.0%	47.7%	12.6%	1.4%	0.2%

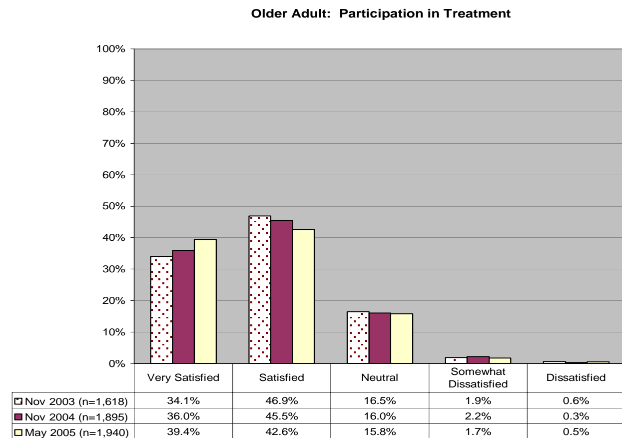


	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=1,694)	42.1%	48.9%	8.0%	0.6%	0.4%
Nov 2004 (n=2,014)	43.6%	46.9%	8.6%	0.7%	0.1%
May 2005 (n=2,064)	45.9%	44.1%	8.9%	1.0%	0.1%

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



	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=15,916)	29.5%	43.8%	22.1%	3.5%	1.1%
Nov 2004 (n=18,903)	30.6%	44.5%	21.0%	3.1%	0.8%
May 2005 (n=19,067)	30.5%	43.9%	21.5%	3.3%	0.8%



	Very Satisfied	Satisfied	Neutral	Somewhat Dissatisfied	Dissatisfied
Nov 2003 (n=1,618)	34.1%	46.9%	16.5%	1.9%	0.6%
Nov 2004 (n=1,895)	36.0%	45.5%	16.0%	2.2%	0.3%
May 2005 (n=1,940)	39.4%	42.6%	15.8%	1.7%	0.5%

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

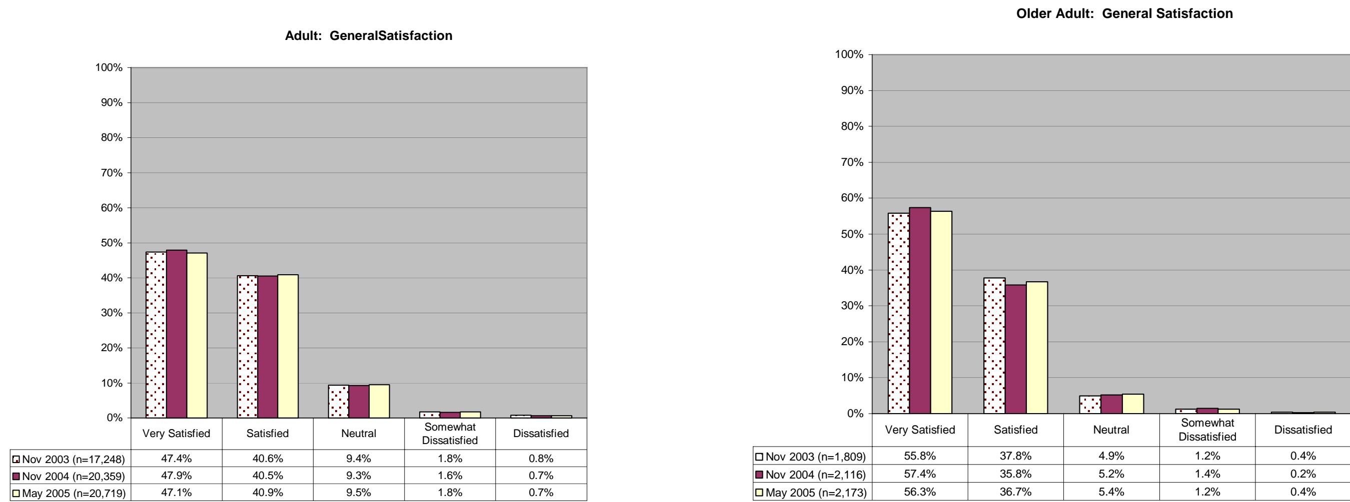
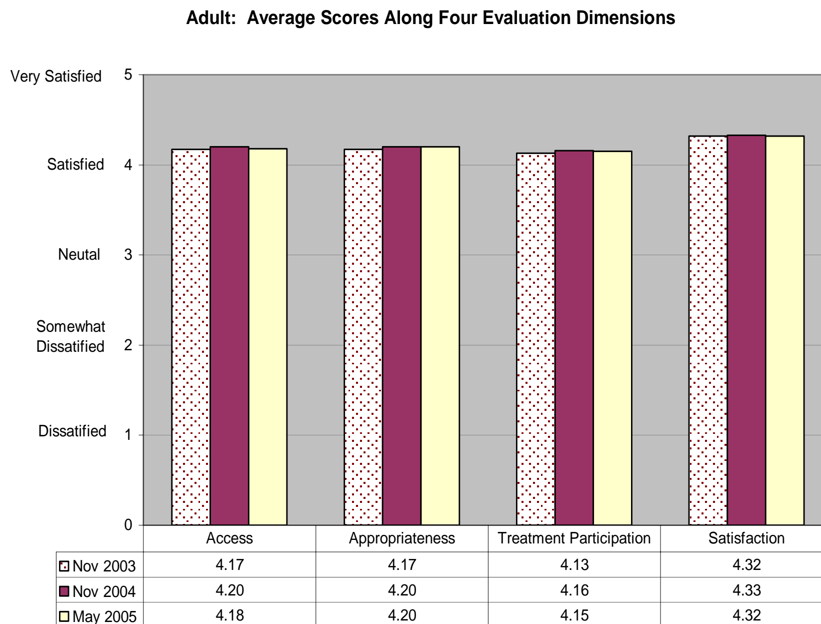
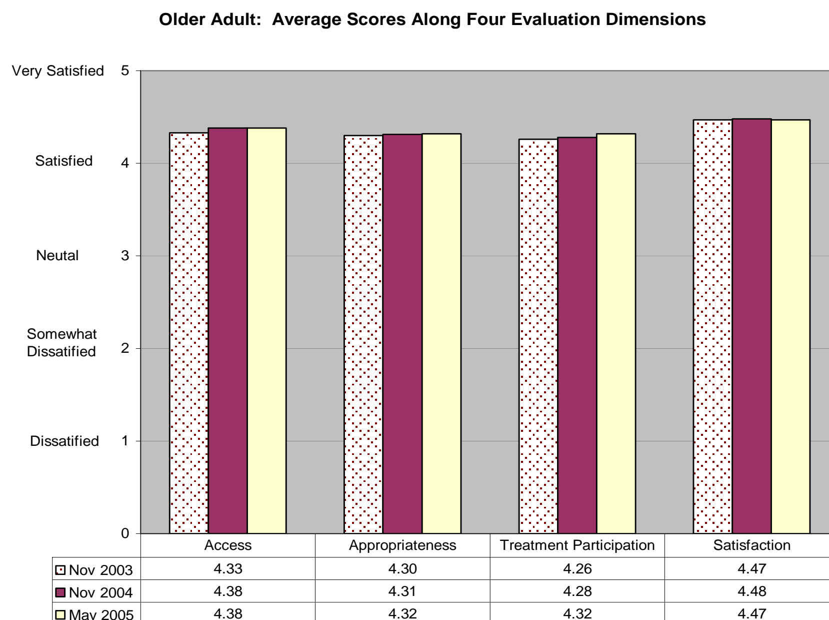


Figure 25: Adult Average Scores Along Four Evaluation Dimensions[1]



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

Figure 26: Older Adult Average Scores Along Four Evaluation Dimensions



	Access	Appropriateness	Treatment Participation	Satisfaction
Nov 2003	4.33	4.30	4.26	4.47
Nov 2004	4.38	4.31	4.28	4.48
May 2005	4.38	4.32	4.32	4.47

An item analysis of the satisfaction dimensions (see Table 8, below) allows DMH to identify issues worthy of further examination (i.e., items where the average is less than 4.0)[1]. One item (shaded in the table) is consistently associated with an average score less than 4.0 for adults: "I, not staff, decided my treatment goals." This is also the lowest scored item for older adults. With the current emphasis on recovery and wellness philosophies, identification of goals should be the result of partnerships between consumers and services/support providers (as well as appropriate others). Increased resources and recovery-oriented programming with respect to the Mental Health Services Act implementation are likely to increase the development of consumer-provider partnerships and greater consumer involvement in the service delivery process.

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

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

	Individual Items	Adult Average Score			Older Adult Average Score		
		Nov 2003	Nov 2004	May 2005	Nov 2003	Nov 2004	May 2005
Access to Services	The location of services was convenient.	4.16	4.19	4.18	4.25	4.32	4.33
	Staff were willing to help as often as I felt it was necessary.	4.26	4.08	4.26	4.40	4.43	4.44
	Staff returned my calls within 24 hours.	4.12	4.14	4.12	4.32	4.35	4.36
	Services were available at times that were good for me.	4.29	4.32	4.31	4.45	4.47	4.47
	I was able to get all the services I thought I needed.	4.16	4.19	4.17	4.34	4.38	4.37
	I was able to see a psychiatrist when I wanted to.	4.02	4.06	4.05	4.24	4.29	4.30
Appropriateness of Care	Staff here believed that I could grow, change, and recover.	4.26	4.28	4.29	4.30	4.33	4.33
	I felt free to complain.	4.09	4.12	4.11	4.31	4.35	4.35
	Staff told me what side effects to watch out for.	4.05	4.08	4.09	4.17	4.17	4.21
	Staff respected my wishes about who is, and is not, to be given information about my treatment.	4.30	4.33	4.32	4.39	4.40	4.42
	Staff were sensitive to my cultural/ethnic background.	4.18	4.20	4.21	4.31	4.36	4.36
	Staff helped me so that I could manage my life and recover.	4.15	4.19	4.18	4.28	4.32	4.33
	I was given information about my rights.	4.28	4.29	4.28	4.38	4.39	4.42
	Staff encouraged me to take responsibility for how I live my life.	4.24	4.26	4.26	4.34	4.35	4.36
	I was encouraged to use consumer-run programs (support groups, drop-in centers, crisis phone line, etc.).	4.04	4.08	4.05	4.13	4.15	4.13
Participation in Treatment	I felt comfortable asking questions about my treatment and medication.	4.30	4.33	4.31	4.42	4.46	4.46
	I, not staff, decided my treatment goals.	3.95	3.99	3.98	4.09	4.10	4.17
General Satisfaction	I like the services that I received here.	4.40	4.42	4.40	4.54	4.56	4.54
	If I had others choices, I would still choose to get services from this agency.	4.22	4.22	4.21	4.42	4.40	4.39
	I would recommend this agency to a friend or family member	4.34	4.35	4.34	4.47	4.49	4.49

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

IMPLICATIONS AND FUTURE DIRECTIONS

Results show positive performance of the California public mental health system and positive impact of services on consumer outcomes. Presented in greater detail in the body of this report, Fiscal Year (FY) 2004-05 data showed that the majority of mental health consumers and/or their family members/caregivers reported satisfaction across all service dimensions, and indicated a positive impact of services on most quality of life indicators and all functioning outcomes. As expected, data comparisons across three survey periods within FY 2003-04 and FY 2004-05 showed considerable consistency in performance outcomes over time due to consistencies in statewide funding, administrative, and service practices during the assessment time periods. Once the transformational agenda of the Mental Health Services Act/Proposition 63 is realized, results may become less consistent across time, as changes with respect to recovery and service outcomes are likely to be observable through state-level evaluations similar to those presented in this report.

The performance measurement system (i.e., Web-Based Data Reporting System) which has been successful over the past several years in providing flexibility to changes in the measurement of performance indicators and in producing standardized, quality data, is currently a point of departure for the imminent design and implementation of a comprehensive electronic mental health information system[1]. The vision for such a system that reduces data silos and offers a supporting information technology infrastructure combining electronic charting, performance evaluation, decision support, personal health records, and more, is likely to be realized in the near future due to state-level and national mental health system transformational agendas (as outlined in the Presidents New Freedom Commission Report on Mental Illness[2] and the California Mental Health Service Act - Proposition 63). This technology, as well as state-level leadership and coordination with regard to local/county and statewide quality improvement and evaluation efforts will provide mechanisms through which performance and quality for mental health consumers will be accelerated.

[1] ww.dmh.ca.gov/mhsa/docs/meeting/05jun23/IT%20Draft%20Doc%20for%20Stakeholder%20Meeting%20June%2023%202005.pdf
[2] www.mentalhealthcommission.gov/reports/reports.htm