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TECHNICAL REPORT

Evaluating the Impact of Prevention and Early Intervention Activities on the Mental Health of California's Population

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Sponsored by the California Mental Health Services Authority

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The research described in this report was sponsored by the California Mental Health Services Authority and was conducted within RAND Health, a unit of the RAND Corporation.

The California Mental Health Services Authority (CalMHSA) is an organization of county governments working to improve mental health outcomes for individuals, families and communities. Prevention and Early Intervention (PEI) programs implemented by CalMHSA are funded through the voter-approved Mental Health Services Act (Prop 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

It is our hope that the work we have conducted to develop a Prevention and Early Intervention evaluation framework will prove useful to state and county decisionmakers, providers, and advocates for mental health system transformation and improvement. While we benefited greatly from the insights and advice of the Mental Health Services Oversight and Accountability Commission (MHSOAC), the California Mental Health Services Authority (CalMHSA), the Statewide Evaluation Experts (SEE) and from diverse stakeholders, the approach and views expressed in this document are the authors', and we are solely responsible for any errors or omissions.

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Preface

The Mental Health Services Act, passed by California voters in 2004, provides the funding and framework to expand mental health services to previously underserved populations and all of California's diverse communities. Twenty percent of the funding was dedicated to prevention and early intervention (PEI) programs and initiatives. The Act also established the Mental Health Services Oversight and Accountability Commission, which was given statutory mandates to evaluate how PEI funding was being used, what outcomes have resulted from those investments, and how services and programs could be improved. Consistent with this role, the Commission coordinated with the California Mental Health Services Authority (CalMHSA) to seek development of a statewide framework for evaluating and monitoring the short- and long-term impact of PEI funding on the population of California. CalMHSA selected the RAND Corporation to develop a framework for the statewide evaluation. CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities.

The information contained in this report should be of interest to a wide range of stakeholders both within and outside the state of California, from organizations and counties implementing PEI programs to policymakers making key funding decisions in this area. It will help stakeholders decide whether and how to evaluate the impact of this historic funding and the existing resources that could be used to support an evaluation.

This document was prepared with the input of stakeholders across the state of California. Forty-eight individual stakeholders were interviewed, including technical subject-matter experts, consumers, and representatives of state and local governments. In addition, members of the CalMHSA Statewide Evaluation Experts (SEE) Team and the Mental Health Services Oversight and Accountability Commission staff and evaluation subcommittee provided input to guide the development of the document and feedback on a draft of the report. The SEE is a diverse group of CalMHSA partners and community members, including CalMHSA board members, representatives of counties of varied sizes, representatives of the California Mental Health Directors Association, a representative from the California Institute for Mental Health, members of the Mental Health Services Oversight and Accountability Commission, a representative from the California State Department of Mental Health, individuals with expertise in cultural and diversity issues, behavioral scientists with evaluation expertise, and consumers and family members who have received mental health services.

Contents

Executive Summary

Background

In 2004, California voters passed the Mental Health Services Act. The Act was intended to transform California's community mental health system from a crisis-driven system to one that included a focus on prevention and wellness. The vision was that prevention and early intervention (PEI) services marked the first step in a continuum of services designed to identify early symptoms and prevent mental illness from becoming severe and disabling. Twenty percent of the Act's funding was dedicated to PEI services. The Act identified seven negative outcomes that PEI programs were intended to reduce: suicide, mental health–related incarcerations, school dropout, unemployment, prolonged suffering, homelessness, and removal of children from the home.

The Mental Health Services Oversight and Accountability Commission coordinated with the California Mental Health Services Authority (CalMHSA), an independent administrative and fiscal intergovernmental agency, to seek development of a statewide framework for evaluating and monitoring the short- and long-term impact of PEI funding on the population. CalMHSA selected the RAND Corporation to develop a framework for the statewide evaluation.

Approach

Interviewing Key Stakeholders

In order to develop the goals for the evaluation framework, RAND researchers conducted interviews with 48 key stakeholders and elicited their perspectives on how the frameworks might be used as well as their ideas for attributes that would make the frameworks useful.

Developing Frameworks

We used a widely accepted model of how health services affect health to develop our overall framework and applied it to the specifics of PEI implementation.

We created two types of frameworks: an "overall approach" framework and specific frameworks for each of the key outcomes specified by the Act. The frameworks identify, at the conceptual level, the key components that should be measured and tracked over time, and they can provide information that would be useful to a broad range of stakeholders and decisionmakers (including state planners interested in the mental health of California's population), consumers and individual providers.

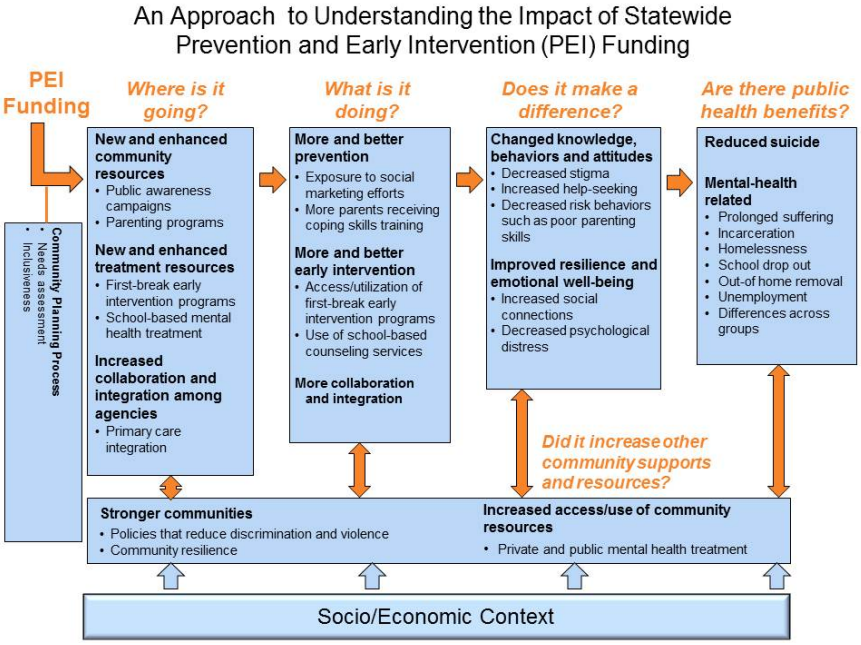
The frameworks include individual and family outcomes (population-level measures of emotional well-being and family functioning), program and service-system outcomes (the quality and timeliness of treatment and increased collaboration across agencies), and community outcomes (stronger and more resilient communities, as well as population-level measures of negative outcomes, such as unemployment or suicide).

Evaluation Frameworks

Overall Approach Framework

Figure S.1 depicts the overall approach framework for the evaluation. The framework asks a series of questions about PEI funding: Where is the funding going, what it is being used for, does the funding make a difference, and are there resulting public health benefits?

Figure S.1
An Approach to Understanding the Impact of Prevention and Early Intervention Funding



Moving from left to right in the figure, we see the following:

- **Box 1, "PEI Funding":** The initial community planning process in each county to determine funding priorities.
- **Box 2, "Where is it going?":** The types of programs that were funded using PEI resources and the programmatic capacity that was developed.
- **Box 3, "What is it doing?":** The "process" of delivering the programs—determining what prevention activities reached which target populations.
- **Box 4, "Does the funding make a difference?"** The direct, short-term outcomes that PEI is intended to bring about—changed knowledge, behaviors, and attitudes, as well as improved resilience and emotional well-being—measured at the population level.
- **Box 5, "Are there public health benefits?":** The ultimate outcomes measured at the population level. Changes in short-term outcomes are intended to reduce these seven negative outcomes identified by the Act.

In most cases, the data relevant to boxes 2 and 3 would be provided by programs and counties. Data relevant to boxes 4 and 5 would come from existing national or statewide surveys or vital statistics. The social and economic contexts influence how PEI was implemented and what it is accomplishing; therefore, socioeconomic context is shown at the bottom of the figure as affecting all of the components.

Examples of Outcome-Specific Frameworks

We developed an evaluation framework for each of the key outcomes identified by the Act.

Data Sources and Measures

Appendixes to this report contain detailed descriptions of existing databases relevant to the evaluation, as well as potential measures for each component in the evaluation frameworks, including the numerator and denominator, data source, and other relevant notes.

Analytic Approaches to Evaluating the Impact of Prevention and Early Intervention

Inherent Limitations of a Prevention and Early Intervention Evaluation

A PEI evaluation has some important inherent limitations. Because the programs and activities were not randomly implemented and there are no geographic areas or populations within California that were not exposed to PEI activities, it would be technically difficult (although not impossible) to estimate the causal impact of PEI on outcomes. What can be done more easily is to relate changes in PEI program activity to changes in outcomes, without establishing causality. A second limitation is the fact that PEI programs and services were meant to function as part of a continuum of services that included treatment and recovery services. Unless some population groups were systematically exposed to one program but not the others, it is not analytically possible to separate the impact of PEI from those of other treatment and recovery services.

Evaluation Designs

There are three evaluation designs that could be used to estimate the impact of PEI funding on outcomes:

Time-Trend Analysis of Observational Data (Before-After Design)

In this design, the evaluator compares outcomes for the study population before and after a program is implemented. This evaluation design is simple and often easy to implement, but it is also not as robust as other designs. The principal limitation is that it is difficult to distinguish the "causal" effect of the program from the effect of overall time trends.

Difference-in-Differences Design

This approach compares what happens in California with what happens in other states that are similar to California and assumes that time trends would be the same in the treated and comparison groups. If data were collected each year, it would be possible to document the

yearly “benefit” of PEI program activity and to assess how utilization and outcomes are affected by changes in the social and economic context.

Synthetic Control Method

This method modifies the difference-in-differences (D-in-D) framework to make it particularly suitable for evaluating programs in which, like PEI, there is only one “treated” unit—in this case, California. This approach produces a much better comparison group than one in which all the untreated units are essentially given the same weight.

Using Descriptive Statistics for Inference

Our evaluation framework can also be used to monitor the effects of PEI programs by collecting and reporting descriptive information or statistics. Descriptive data can help policymakers to continuously monitor progress toward benchmarks and can serve as “early warning” indicators of implementation failures. An effective and efficient way to provide descriptive data about PEI programs is to create a web tool.

Conclusions

Usefulness of the Evaluation Framework

The negative outcomes identified by the Act are broad social outcomes that are affected by many different social forces, and changes in these outcomes will take years to observe. Although it is analytically possible to evaluate the causal impact of the Act on population-level outcomes, we do not recommend this approach. Rather, we suggest using existing data to track over time the population-level outcomes identified in the Act and ultimately to provide the data needed to estimate how this historic initiative has affected the mental health of California’s population. This is an excellent time to establish a surveillance system that can be used to provide important information about the early phase of PEI activity. We recommend using resilience and emotional well-being to monitor and track changes at the population level.

Data Development

We recommend additional data development to support implementation of the evaluation framework:

Immediate Prevention and Early Intervention Program Information Needs

It is essential to develop standardized, core information about the programs funded under the Act’s PEI initiatives, the activities carried out by these programs, and the individuals reached by these activities. At minimum, all programs should report on the number of individuals served or exposed to the intervention, the type of program, and the target population. A next step would be for programs to report on the demographic and social characteristics of the individuals they reach. The last (and significantly more difficult) step would be to implement data systems that can track individuals across programs and service systems.

Prevention and Early Intervention Performance Indicators

Currently, there are few standardized and widely accepted measures of the quality of PEI services, but measures could be developed over time. Some examples of potential performance indicators include: whether a program meets certification standards, client satisfaction with program activities, and whether training or other interventional activities are delivered with fidelity to evidence-based protocols.

Maintaining and Improving Tracking of Population Outcomes

Existing data sources can be used to populate constructs in the PEI evaluation framework, but in some cases, these data sources could be improved. A key example is suicide statistics. National standards provide guidelines for more-consistent reporting, and these could be adopted to improve suicide statistics and their utility for PEI evaluation.

Other Important Evaluation Issues

Evaluating Program Efficacy

In many cases, the literature provides insufficient evidence on the efficacy of specific PEI activities. We recommend that the state or counties strategically develop the evidence base for PEI programs by conducting rigorous evaluations of strategically selected promising programs.

Evaluating Cultural Competence

There are currently no broadly accepted and reliable measures of cultural competence that could serve as performance indicators in an ongoing statewide monitoring system. If the development of cultural-competence assessments at the program level is a priority, we recommend obtaining advice from national experts.

Developing Program Capacity for Quality Improvement

Although routinely assessed outcomes are not useful to evaluate the comparative effectiveness of programs, they can and should be used for ongoing quality improvement efforts. We recommend developing program capacity for quality improvement.

Next Steps

We suggest a three-year phased implementation of the statewide evaluation framework.

The first year would include (1) demonstration of development and reporting of PEI program-level information; (2) psychometric assessment and refinement of program-level and population-level measures, which would also include pilot testing new measures; (3) development of descriptive analytic and reporting templates; and (4) proposed work plan and resources required for full implementation and ongoing maintenance. The second and third years would focus on implementing the full evaluation framework, including the infrastructure required to acquire, store, analyze, and routinely report data.

Acknowledgments

The authors would like to thank Joel Braslow, Teryn Mattox and Sarah Starks for their help on this project. They provided important insights and were invaluable in identifying and describing the databases, conducting key informant interviews and providing an understanding of the context surrounding the legislation.

Sandra Berry and Nicole Eberhart provided advice and support that was invaluable, and carefully read and commented on previous presentations of the results. The Statewide Evaluation Experts team and the evaluation subcommittee of the Mental Health Services Oversight and Accountability Commission, as well as numerous stakeholders, contributed their time and insights to the work.

The report could not have been completed without the graphics, editing and administrative help from Bernie Beltran, Sandra Petitjean and Mary Vaiana.

Lastly we wish to thank our quality assurance reviewers, Sergio Aguilar-Gaxiola and Joshua Breslau, who provided detailed reviews of a previous draft that greatly improved the content and presentation of the report.

Abbreviations

CalMHSA	California Mental Health Services Authority
D-in-D	difference-in-differences
MHSA	Mental Health Services Act
PEI	prevention and early intervention

Chapter One

Background

The Mental Health Services Act (hereafter, the Act), passed by California voters in 2004, called for transforming California's community mental health system from a crisis-driven system to one that included a focus on prevention and wellness. Transformation was to be accomplished in part by dedicating a portion of the Act's revenues to Prevention and Early Intervention (PEI) services. The focus on prevention and wellness represented a historic change in the way that California addressed the problem of serious mental illness and the consequences of mental illness for individuals, families, and communities.

The Act was intended to convert the public mental health system from a "fail-first" system to a system in which people would get the services and community supports they need as early as possible. It was to prevent the development or worsening of a mental illness and reduce the negative consequences of mental illness, including suicide, homelessness, incarceration, and school failure. The vision was that prevention and early intervention made up the first step in a continuum of services designed to reduce stigma and discrimination associated with mental illness, to identify early symptoms and prevent mental illness from becoming severe and disabling, and ultimately to contribute to stronger and healthier communities.

This vision is well aligned with research evidence from the Institute of Medicine's Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities report (O'Connell, Boat, and Warner, 2009), which emphasized that the "first symptoms typically occur two to four years before the onset of a full-blown disorder—creating a window of opportunity when preventive programs might make a difference" (pp. 50, 55, 72). There is a wide range of evidence-based prevention programs that can reduce the risk of mental illness and decrease psychiatric symptoms and disability (World Health Organization, 2004). The Act also explicitly emphasized expanding services to reach historically underserved populations and developing culturally and linguistically appropriate services to meet the unmet mental health needs of California's diverse communities.

The Act required that 20 percent of revenues be allocated toward PEI programs. The programs should (1) prevent mental illnesses from becoming severe and disabling; (2) improve timely access to underserved populations; (3) offer outreach to families, employers, primary care health care providers, and others to help them recognize the early signs of potentially severe and disabling mental illnesses; (4) provide access and linkage to medically necessary care provided by county mental health programs for children, adults, and seniors with severe mental illness as early in the onset of these conditions as practicable; and (5) reduce stigma and discrimination associated with either being diagnosed with a mental illness or seeking mental health services (California Department of Mental Health, as of September 17, 2012).

The Act identified seven negative outcomes, also referred to as *key outcomes* in this report (see Figure 1.1), associated with untreated or inadequately treated mental illness that PEI programs

were intended to reduce: suicide and, to the extent that they are related to underlying mental illness, incarcerations, school failure, unemployment, prolonged suffering, homelessness, and removal of children from the home.

Figure 1.1.
Seven Negative Outcomes (Key Outcomes) Identified in the Mental Health Services Act

1. Suicide

The following outcomes to the extent that they are related to underlying mental illness:

2. Incarcerations
3. School failure
4. Unemployment
5. Prolonged suffering
6. Homelessness
7. Removal of children from the home

In addition to these population health–level outcomes, the Act specified goals for the process of decisionmaking regarding use of the Act's funds. Stakeholders, particularly consumers of services, family members, parents, and caregivers, were to participate in planning, implementing, and overseeing the Act's programs at the state and local levels.

The legislation also established the Mental Health Services Oversight and Accountability Commission (hereafter, the Commission), which was given statutory mandates to evaluate how funding provided by the Act was being used, what outcomes have resulted from those investments, and how services and programs could be improved. Consistent with this role, the Commission coordinated with the California Mental Health Services Authority (CalMHSA), an independent administrative and fiscal intergovernmental agency, to seek development of a statewide framework for evaluating and monitoring the short- and long-term impact of PEI funding on the population. In general, the evaluation would ensure that the process of deciding how PEI funds were allocated reflected the Act's principles—e.g., was the process open to all stakeholders? Did it address the Act's goals appropriately? Were programs selected on the basis of evidence that they work? In addition, the evaluation would provide information about whether quality services were delivered to the targeted populations. Finally, the evaluation would make it possible to assess the public health impact of PEI spending on targeted outcomes. CalMHSA selected the RAND Corporation to develop a framework for the statewide evaluation.[1]

[1] RAND was tasked with five specific activities. In this report, information relevant to each task is covered in one or more sections and, in most cases, one or more appendixes: (1) Identify a consolidated list of overall goals across PEI programs and conceptualize each goal in terms of potential outcome measures that could be used for evaluation purposes (Section Four and Appendix A); (2) identify data sources that are either available or could be

In this document, we describe the work we conducted to develop the evaluation framework. Our discussion is organized as follows. We begin by presenting the rationale for our approach. We then describe the methods used to develop the frameworks—both the overall framework and frameworks for each specific negative outcome identified by the Act—and we identify the data sources and measures with which to populate the frameworks. We describe the components of the frameworks and summarize the descriptive and inferential analytic approaches that could be used to track program capacity development, reach, and statewide population outcomes. Appendixes provide descriptions of each data source, measure specifications, and technical details of our analytic approach. We conclude with a discussion of potential next steps and recommendations for data development.

available to populate potential measures, and investigate the utility of PEI evaluation frameworks and data sources that counties have developed (Sections Three and Five and Appendix B); (3) develop a conceptual PEI statewide evaluation framework and analytic approach that logically link programs and program strategies with outcome measures (Sections Four and Six and Appendixes A and D); (4) develop measure specifications, including the data sources required to implement measures, and detail the strengths and limitations of the data sources and measures (Section Five and Appendixes B and C); and (5) identify ways to link PEI evaluation to the overall evaluation of the act (Section Seven).

Chapter Two
Goals and Approach

A first step of the project was to more fully develop the goals for the evaluation framework. To accomplish this, we conducted interviews with 48 key stakeholders, as described in Chapter Three. During the discussions, many stakeholders observed that the seven negative outcomes identified in the Act are typically not directly and immediately affected by individual PEI programs; rather, these outcomes should be reduced over the long run if the entire system (the continuum of prevention, early intervention, and treatment) is strengthened. There was broad recognition that system changes take time and that the benefits of PEI efforts are likely to accumulate over years.[2] For example, the benefits from parent training programs or social media campaigns to educate the public about suicide prevention are likely to have some immediate effects on the knowledge and attitudes of those exposed to them; however, effects on suicide rates or school dropout rates can be distant in time. Some programs might also benefit individuals who did not directly participate in the program—for example, a program for at-risk teens might affect a school's overall climate, which might, in turn, benefit teens at the school who were not exposed to the program.

In addition, the benefits of PEI programs often logically depend on access to and use of appropriate interventions or resources. For example, screening and early detection of child behavioral and emotional problems is an effective early intervention strategy only if these children and their families are linked to appropriate treatment services. Hotlines can prevent suicide through timely support and interventions that encourage callers to get treatment that alleviates their suffering (Gould et al., 2012). Other interventions or resources might include the availability of affordable housing or entry-level jobs.

We believe that the statewide evaluation approach should reflect expectations that reductions in the seven negative outcomes are longer-term, system-wide effects, rather than direct and immediate effects of PEI programs. There are three important implications of this expectation:

- The negative outcomes should be measured for the population as a whole, rather than only among individuals participating in or exposed to any particular PEI program.
- The effects that PEI programs can have on these outcomes cannot logically be distinguished from effects of treatment and can be thought of only as broader system transformation effects. This means that, although the frameworks we developed (both the overall framework and the area-specific frameworks focused on the seven negative outcomes) are focused on PEI, the proposed approach could and should be extended to include the continuum of treatment and recovery services, funded by Community

[2] One analogy for how PEI effects accumulate is the example of the significant reductions in cigarette smoking; these are small in any given year but have been sustained over decades and have resulted in many health benefits, such as reduced incidence of lung cancer and emphysema. Educational campaigns, policy changes, and smoking-cessation treatments are all believed to play a part in this public health success story.

Services and Supports. Measuring the provision of PEI services can help to determine whether there are gaps in the treatment system.

- Long-term tracking of the seven negative outcomes is essential: The benefits of system transformation are likely to be small and probably undetectable in the short run; however, with sustained programmatic efforts, small effects should accumulate and result in a positive trend over time.

Although the measurement and tracking of outcomes should be done at the level of the population, the evaluation framework must also include information about the specific programs that were funded and the utilization and quality of these programs. Although it may be difficult to identify the short-term impact of PEI funding at the population level, the approach we offer should be able to answer these important questions in the short run: Is the state putting into place the kinds of PEI programs and interventions that were intended? Are these programs reaching the state's diverse and high-risk populations as intended? Evaluating and monitoring these intermediate steps should provide important information that could be used to ensure that the programs implemented are reflective of stakeholder priorities.

Chapter Three

Methods

In this chapter, we describe how we developed and refined our evaluation frameworks and how we identified the databases that would be relevant for a statewide PEI evaluation.

Interviewing Key Stakeholders

To develop the overall evaluation framework, we first needed to understand the goals of the legislation, how the goals were implemented, who the target population for PEI program activities was, and how the results would be used. We began by conducting key informant interviews with 48 individuals. Half were subject-matter experts with academic credentials in evaluation research or in measuring the key outcomes; the rest were either consumers or state or county administrators.

Interviews with subject-matter experts focused on defining key outcomes and constructs identified by the Act and by the Commission, as well as identifying available state data sets and existing measures. Interviews with consumers and administrators elicited their perspectives on how the frameworks might be used, as well as their ideas for attributes that would make the frameworks useful.

We solicited input on the intent behind the legislation and, in the case of county respondents, how the county they represented had developed and implemented PEI programs. We asked how (and who) they anticipated using the information from the framework. We also asked about specific data sets that could be used to assess PEI activities. In interviews conducted during the latter part of the interview process, informants reviewed and provided feedback on draft versions of the relevant frameworks.

Developing Frameworks

In our discussions with stakeholders, it became clear that the evaluation frameworks needed to accomplish three objectives:

- Enable tracking and accountability over time.
- Monitor progress toward mental health equity.
- Take a public health perspective and look at the mental health of the population of California while also providing useful data for local performance improvement.

We used a widely accepted model (Donabedian, 1980) of how health services affect health to develop our overall framework and applied it to the specifics of PEI implementation. The model provides an approach for examining how PEI funding led to programs and activities that resulted in improved individual, family, service-system, and community outcomes. We refined the model using the results of our key informant interviews and by reviewing the model with the Statewide Evaluation Experts Team, CalMHSA, and the Commission.

We created two types of frameworks: an "overall approach" framework and specific frameworks for each of the key outcomes specified by the Act. In Chapter Four, we describe the components of the overall approach framework and give two examples of "key outcome" frameworks in detail. Appendix A provides an illustration of the logic model for each framework.

The evaluation frameworks provide a theory-based approach to answering the question "Are we putting in place the kinds of interventions we wanted to, and are they reaching the populations we thought they should?" Use of the frameworks over time should enable tracking and accountability and provide an assessment of the Act's impact on the mental health of California's population. The frameworks are intended to capture the extent to which the system is being transformed from a "fail-first" system to one in which PEI becomes part of a public health–oriented continuum of services linking, as needed, to treatment and other Community Services and Supports. In addition, the frameworks can help assess how well PEI activities are reaching underserved populations and improving their outcomes. Finally, the frameworks can provide information that would be useful to a broad range of stakeholders and decisionmakers (including state planners interested in the mental health of California's population), consumers/family members, and individual providers.

The frameworks are flexible and include individual and family outcomes (population-level measures of emotional well-being and family functioning), program and service-system outcomes (the quality and timeliness of treatment and increased collaboration across agencies), and community outcomes (stronger and more resilient communities, population-level measures of negative outcomes, such as unemployment or suicide). The frameworks identify, at the conceptual level, the key components that should be measured and tracked over time. Individual, family, and community outcomes are measured, and the unit of analysis is identified as the state, region, or county, depending on the data source and measure. (When national data are available, it will be useful to compare California's performance with that of the nation.) Program and service-system outcomes are measured by aggregating measures across programs. An example of this type of measure is one that reports the proportion of suicide hotlines that have received national accreditation.

Identifying Databases

We used our key informant interviews to identify state or national databases or vital statistics that could be used to measure individual or family outcomes at a population level. To be included, each database had to contain data relevant to at least one of the PEI outcomes, and the data had to have been collected at more than a single point in time to allow for comparisons over time.

We described each database in terms of its content; the populations that it covered and to which it could be generalized; the instrument type; years for which the data were available; the frequency with which the survey or interview producing the data were repeated; information about reliability and validity, availability, and cost; information about administration and

scoring; and contact information. We also provided links to the instruments and to the data when such links were available.

Detailed descriptions of the databases available for the PEI evaluation appear in Appendix B.

Chapter Four

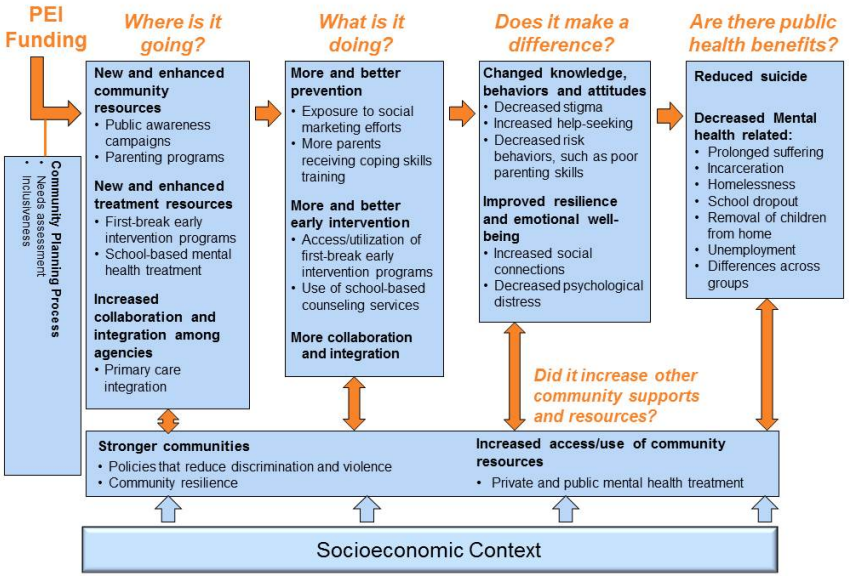
Evaluation Frameworks

We created two types of frameworks: an overall approach framework, as described in Chapter One and shown in Figure 4.1, and specific frameworks for each of the key outcomes specified by the Act, examples of which appear in Figures 4.2 (suicide prevention) and 4.3 (reduced suffering). As noted earlier, the key outcomes are broad social outcomes with multiple determinants. Therefore, in addition to looking at specific measures of each outcome, the frameworks also identified antecedent factors that were either known to, or that we hypothesized would, affect each outcome and that we posited to be influenced by PEI funding. That is, PEI programs directly affect short-term, or intermediate outcomes, which, in turn, can influence broad social outcomes, all other things being equal. For example, PEI programs could improve parenting skills, which is known to improve child well-being and resiliency, which, in turn, is hypothesized to lead to decreased school dropout rates.

Overall Approach Framework

The evaluation frameworks are based on a model of how spending on specific programs ultimately affects population health. In many cases, especially for PEI programs, the connection between spending and population health is complex, involving multiple steps that play out over time. To understand the impact of PEI programs and activities, one must first understand what the funding was intended to accomplish and how the funding was used. Our overall approach conceptual framework highlights these issues. The overall approach framework, depicted in Figure 4.1, is meant to be read from left to right. In effect, the framework asks a series of questions about the funding provided by PEI: Where is it going, what it is being used for, does it make a difference (primarily in short-term or intermediate outcomes), and are there resulting public health benefits? Although the framework was developed to understand the impact of PEI funding, it could be used to understand the impact of all Mental Health Services Act funding.

Figure 4.1.
An Approach to Understanding the Impact of Statewide Prevention and Early Intervention Funding



With the exception of the community planning process, which occurred before the initial distribution of PEI funding, the overall approach framework shows the factors that should be measured as part of the evaluation process. In most cases, data for the second and third boxes ("Where is it going?" and "What is it doing?") would be provided by programs and counties; data for the fourth and fifth boxes ("Does it make a difference?" and "Are there public health benefits?") would be available from existing national or statewide surveys or vital statistics.

The social and economic context influences how PEI was implemented and what it is accomplishing; therefore, we show socioeconomic context at the bottom of the figure as affecting all of the boxes. However, although context is important, we do not include specific measures of the social and economic context because this will vary based on the specific analysis being conducted. And, because PEI funding was posited to have indirect effects on use of community resources, we include those in the frameworks as well. Where possible, we include measures of community supports and resources in the specific frameworks.

The content of each box in the overall approach framework is as follows, proceeding from left to right:

- **Box 1, "PEI Funding":** Initially, each county undertook a community planning process to determine funding priorities.[3] In most cases, this process also included a needs assessment.

[3] Information about the initial community planning process is contained in the document "The PEI Component of the Three-Year Program and Expenditure Plan" produced by each county.

- **Box 2, "Where is it going?":** This question addresses the types of programs that were funded using PEI resources. PEI funding went to new and enhanced community resources, new and enhanced treatment (primarily early intervention) resources, and support for increased collaboration and coordination among agencies. The activity indicated by this box assesses the "structure" of the programs—that is, the programmatic capacity that was developed.
- **Box 3, "What is it doing?":** This question addresses the specific ways in which the programs engaged the target population. PEI-funded programs and activities were intended to provide more and better prevention programs and resources, more and better early intervention treatment and resources, and more collaboration and integration among social service agencies and between mental health and primary care providers. This part of the framework assesses the "process" of delivering the programs—what prevention activities reached which target populations.
- **Box 4, "Does it make a difference?":** This question addresses the key outcomes that the program is intended to affect among the target population, which may be intermediate outcomes with respect to public health. The framework identifies the direct, short-term outcomes that PEI is intended to bring about—changed knowledge, behaviors, and attitudes and improved resilience and emotional well-being. Note that these outcomes could be measured at the program and the population levels, although the population level is the most relevant for assessing the Act's impact on the mental health of California's population.
- **Box 5, "Are there public health benefits?":** These are the ultimate outcomes measured at the population level. Changes in short-term outcomes are intended to affect the broader, long-term public health benefits identified by the Act. These include reducing the suicide rate and decreasing mental health–related prolonged suffering, incarcerations, homelessness, school dropout rates, removal of children from the home, unemployment, and disparities across these outcomes.

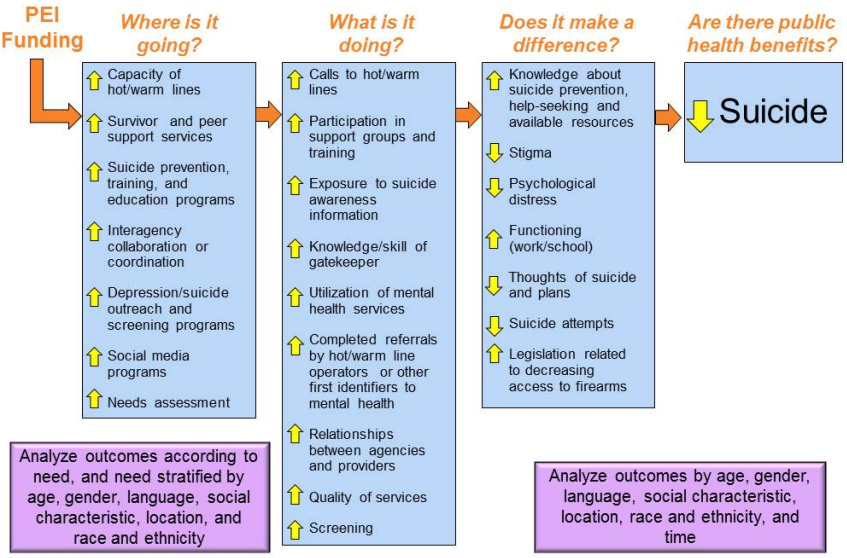
The public health benefits are the ultimate targets for PEI activities. However, these long-term outcomes are difficult to measure and to directly link with PEI funding. What can be measured more easily are the processes and consequences of funding programs; the ways in which the programs involved the intended populations; and the direct, short-term outcomes that PEI is intended to bring about—changed knowledge, behaviors, and attitudes and improved resilience and emotional well-being.

PEI programs were expected not only to improve individual and family outcomes but also to indirectly result in healthier and more resilient communities and more use of privately funded mental health treatment. We show these outcomes below the five boxes. There are arrows between this box and each of the five upper boxes because we hypothesize that these indirect effects are reciprocally related to each of the other five boxes. As mentioned above, we also include the socioeconomic context, which is posited to affect every aspect of the overall approach framework.

Outcome-Specific Frameworks

In addition to the overall approach framework, we developed an evaluation framework for each of the key outcomes identified by the Act. We briefly discuss the Suicide-Prevention Framework (Figure 4.2) and the Reduced-Suffering Framework (Figure 4.3) as examples; illustrations of logic models for all outcome-specific frameworks appear in Appendix A.

Figure 4.2.
Suicide-Prevention Framework



Suicide-Prevention Framework

We obtained information about the content of each component of the Suicide-Prevention Framework from our key informant interviews and from reviewing program description documents.

PEI funding for suicide prevention programs has been allocated to increase the capacity of hot/warm lines; survivor and peer support services; suicide prevention, training, and education programs; and the other activities shown in the second box ("Where is it going?") in Figure 4.2. Note that this is not an exhaustive list of suicide prevention programs, and new suicide prevention programs could be developed in the future. In the evaluation framework, these activities should lead to increased calls to hot/warm lines, participation in survivor support groups and training, exposure to suicide awareness information, and the other factors described in the third box ("What is it doing?").

The short-term effects of PEI funding for suicide prevention include increased knowledge about suicide prevention, help-seeking, and available resources; decreases in self-stigma,

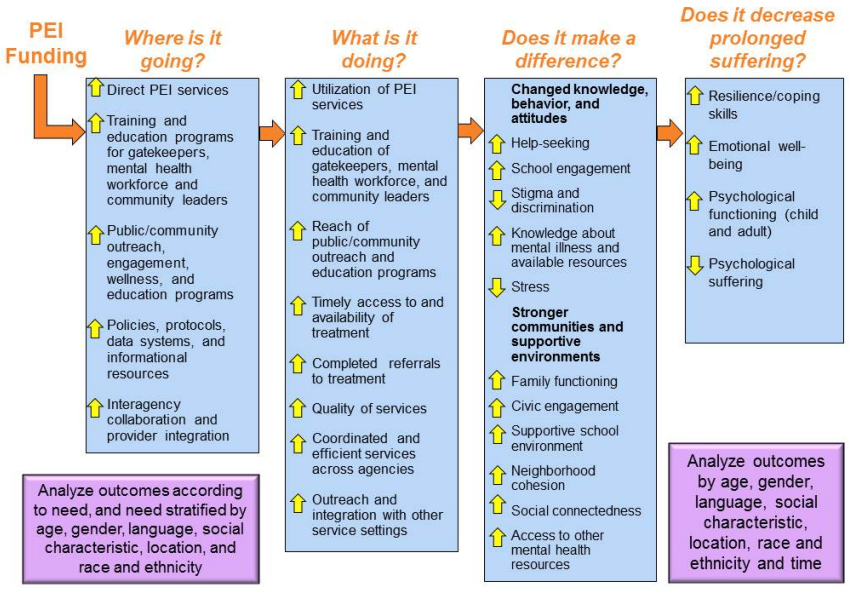
psychological distress, and thoughts of suicide; and the other outcomes shown in the fourth box ("Does it make a difference?").

The public health benefit of PEI funding in the suicide area is straightforward: reduction in the rate and number of suicides and of suicide attempts.

Reduced-Suffering Framework

One of the key outcomes identified by the Act is "reduction of prolonged suffering." Because of the difficulty measuring the length of time associated with suffering and establishing whether suffering has been "prolonged," we focused instead on measuring "reduced suffering," and we suggest measuring the timeliness of treatment access as a component of the duration of suffering (see Figure 4.3). Note that the types of programs funded are examples and not a complete list.

Figure 4.3.
Reduced-Suffering Framework



Included in the Reduced-Suffering Framework are the related concepts of resilience and well-being. Because resilience and well-being are related to suffering and are key intermediate outcomes related to all the long-term outcomes identified by the Act, we believe that it is the most important outcome to track longitudinally at the level of the population. Changes in resilience and emotional well-being are hypothesized to precede changes in all the negative outcomes and thus can be used to monitor the Act's overall impact on public mental health. Although we are not aware of any population studies that have tested this hypothesis, one could argue from first principles that, for example, in order to reduce mental health–related school failures, resilience and well-being, which are recognized protective factors for school failures, would have to be increased.

Chapter Five

Data Sources and Measure Specifications

As noted above, the data used to measure where funding from the Act is going (the second box) and how it is being used (the third box) will come primarily from programs and counties. Some programs and counties are already collecting this information; however, it is not collected in uniform ways across programs and counties, and counties do not provide these data to the state for analysis. One of the recommendations we make is that program-level data be collected using a uniform template so that the information can be aggregated and used for comparisons.

In some cases, data not currently being collected from programs and counties should be relatively simple to collect and report—for example, data on how many individuals received a particular early intervention program or how many calls were received by the suicide hotline. In other cases, the new data will be more difficult to collect, either because there are not good measures (e.g., there are few reliable and valid measures of PEI program quality) or because the data would be difficult to collect (e.g., measuring completed referrals or the timeliness of access). A common problem for counties is the lack of a data-collection infrastructure to track PEI services.

To measure the contents of the fourth box ("Does it make a difference?") and the fifth box ("Are there public health benefits?") in the frameworks, we use population-based measures of outcomes. Some of these data already exist; others do not. In either case, the burden of collecting or creating the data varies substantially. For example, in some cases, data exist only at the state level; in others, data are available at the county level. Where possible, we also identified where comparable national or regional data exist. As noted above, a detailed description of existing databases relevant to the evaluation appears in Appendix B.

Appendix C shows the potential measures for each component in the evaluation frameworks, including the numerator and denominator, and data source. Where possible, for convenience and cost considerations, we have recommended using existing measures and specifications. Using existing measures also permits comparisons with other populations and with previous years.

We recommend pilot testing any new measure before it is used to determine the sample size needed for a meaningful evaluation and the statistical power each sample size will have to determine causal relationships between program elements and outcomes. The pilot test would also establish the reliability of the data, consistency of reporting across counties, and the extent to which missing data should be anticipated.

Chapter Six

Analytic Approaches to Evaluating the Impact of Prevention and Early Intervention Programs

The standard program evaluation framework considers the effect of a particular intervention or "treatment" on one or more outcomes. The challenge for the program evaluator is usually threefold: (1) to determine which outcomes are expected to be affected by the intervention, (2) to detect and measure changes in the outcomes of interest, and (3) to credibly attribute cause to effect (in other words, to determine *how much* of the observed change in the outcomes can be attributed to the intervention). The use of appropriate conceptual frameworks, theories of change, or more-complex theoretical models can help the evaluator in defining the relevant outcomes, while appropriate data collected from a sufficient number of "treated" units (individuals or communities that received the services) can help to address the second concern. Establishing causality is much more difficult, especially in the context of social programs in which other variables associated with the outcomes of interest might also be changing.

We have laid out a conceptual framework for thinking about the possible effects of PEI programs and activities (Figure 4.1). Building on the insights from this overall approach framework, we have identified several intermediate and long-term outcomes that can be monitored to assess the impact of PEI and the Act. The primary outcomes of interest as shown in the specific evaluation frameworks are included in boxes 4 and 5 and include resilience and emotional well-being; suicide rates; attempted suicides; and mental health–related rates of homelessness, incarceration, unemployment, removal of children from the home, and school dropout.

Before considering different evaluation designs, it is important to acknowledge the inherent limitations of a PEI evaluation. Because the programs and activities were not randomly implemented and there are no geographic areas or populations within California that were not exposed to PEI activities, it would be technically difficult (although not impossible) to estimate the *causal* impact of PEI on outcomes. What can be done more easily is to relate changes in PEI program activity to changes in outcomes, without establishing causality.

Although it may be tempting to estimate causality using a simple before-and-after study design, we believe that this would be hazardous and could lead to incorrect conclusions, making it appear either that effective programs are ineffective or that ineffective programs are effective. An invalid design defeats the purpose of evaluation. Many specific factors might affect both program-level and population-level outcomes—in particular, the recession, cuts to other mental health programs, and cuts to education. In addition, one must consider the reverse side of the coin. For example, even if school dropouts associated with mental illness increased during the period of PEI implementation, it is possible that the increase would have been even greater if the PEI programs had not been in place. Drawing the conclusion that the PEI programs were not effective simply on the basis of the historical trend could point policymakers in the wrong direction.

A second limitation is the inability of the analysis to separate the impact of PEI funding from the impact of funding for Community Services and Supports, which funded treatment and recovery services. PEI programs and services were meant to function as part of a continuum of services that included treatment and recovery services, and both PEI and treatment are meant to affect outcomes. Long-term treatment and recovery services were generally not funded by PEI monies (apart from short-term early intervention services, an important component of PEI). However, implementation of Community Services and Supports, also funded by the Act, occurred at the same time as implementation of PEI programs and activities. When we discuss estimating the impact of PEI on population health, what we are actually doing is estimating the impact of the entire Act, assuming that we can take into account changes in the social and economic context. Unless some population groups were systematically exposed to one program but not the other, it is not analytically possible to separate the impact of PEI from those of treatment and recovery services funded by the Act.

We now consider three evaluation designs that could be used to estimate the impact of PEI funding on outcomes. The technical details of the statistical analysis are described in Appendix D. We follow the discussion of evaluation designs with an assessment of how descriptive data could be used to make inferences about PEI impact.

Time-Trend Analysis of Observational Data (Before-and-After Design)

In this design, the evaluator compares outcomes for the study population before and after a program is implemented. For example, one might measure overall or age-specific suicide rates in California before the PEI and again after the PEI and assess whether there is a "meaningful" change in the suicide rates.

This evaluation design is simple and often easy to implement, but it is also not as robust as the other designs we discuss in this chapter. The principal limitation of the simple before-after comparison is that it is difficult to distinguish the "causal" effect of the program from the effect of overall time trends.[4] As an example, homelessness is one of the outcomes that might be affected by PEI funding, but homelessness also fluctuates over time in response to other factors, such as economic conditions. If we find that homelessness rates have fallen since the PEI program was implemented, we cannot conclusively say that the falling rates were due to the PEI program rather than to the economic climate. In this example, homelessness rates would still have fallen even if the PEI had not been implemented. The next two designs address this limitation of the before-after design.

Difference-in-Differences Design

In order to disentangle the effects of the PEI program from the effects of other confounding variables, an evaluator needs a comparison group—i.e., another population with similar

[4] There are advanced econometric techniques that rely on only time-series data, but these methods typically require many years of data and rely on very strong assumptions.

characteristics that is also affected by overall time trends but was *not* exposed to the PEI program. With such a group, the evaluator can then compare changes in the outcomes for the population exposed to the PEI program (treated group) with changes in the same outcomes for the non-PEI group ("untreated" or comparison group). The outcomes will change in the latter group simply as a result of overall trends, while changes in the outcomes of the treated group will include the effects of the PEI program *plus* the effects of time trends. Because we know the size of the time-trend effect (from the comparison group), the evaluator can simply subtract the time-trend effect from the estimate obtained for the treated group. If data were collected each year, it would be possible to document the yearly "benefit" of PEI program activity and to assess how utilization and outcomes are affected by changes in the social and economic context.

Table 6.1 illustrates the difference-in-differences (D-in-D) design with a case in which the before-after difference was 4 percent in the treated group and 1 percent in the comparison group. The "net" effect of the program, i.e., the difference between the before-after differences, is therefore 3 percent.

Table 6.1.
An Illustration of the Difference-in-Differences Design: Suicide Rates (%)

Measurement	Before the PEI	After the PEI	Before-After Estimate
Treated group	10	6	4
Comparison group	9	8	1
D-in-D estimate			3

Because potentially everyone is California was exposed to the PEI program, it is challenging to identify a comparison group. One alternative is to compare outcomes in California with the outcomes for surrounding states, e.g., Arizona, Nevada, and Oregon. This tactic assumes that comparable data are available for the other states and that none of the other states implemented a similar program.

An important assumption underlying the D-in-D design is that of commonality in time trends. In other words, if other states' populations are used as the comparison group in a D-in-D design, one must assume that, in the absence of the PEI program, the trends in suicide rates for California would resemble the trends in the comparison states. This raises the important issue of comparability between the treated and untreated units. The more dissimilar the treated and comparison groups, the more implausible the assumption that the trends over time would be similar. For example, North Dakota might not be an appropriate comparison for California, but neighboring states should be. However, using neighboring states' populations also raises the potential for spillover or contamination effects because events in California may have effects that extend to adjoining states. As a simple example, the implementation of the PEI program in

California might attract mental health providers from neighboring states, which might, in turn, affect the outcomes in those states.

To avoid the problem of contamination, an evaluator could select for comparison any state within the continental United States, provided that the state was sufficiently similar to California.[5] However, this would mean identifying the relevant characteristics on which to base a selection. For example, should the evaluator pick states with a similar population size and composition, states with a similar rate of homelessness or suicides, states with a similar number of mental health providers, or perhaps some combination of these?

A new econometric technique described in the next chapter removes some of the subjectivity from this choice. Instead, it uses a data-driven method for selecting similar comparison units.

Synthetic Control Method

The synthetic control method, outlined in Abadie, Diamond, and Hainmueller (2010), is based on the D-in-D framework but with modifications that make it particularly suitable for evaluating programs that, like PEI, have only one treated unit—in this case, California. The key insight of the synthetic control method is to use a weighted average of untreated units. Higher weights are assigned to untreated units that are more similar on explicit quantifiable dimensions to the treated unit. This approach produces a much better comparison group than one in which all the untreated units are essentially given the same weight.[6]

The weights are chosen to replicate as closely as possible the outcomes in California before the PEI program was implemented. Using suicide rates as an example, the evaluator attempts to match as closely as possible the values of a set of predictors of suicide rates for California before implementation of the PEI. The determinants of state-level suicide rates may include the age composition of the population, the state unemployment rate, divorce rates, average income levels, alcohol consumption per capita, and whatever other factors the evaluator deems relevant. In most cases, these predictors are informed by the literature. This method has been successfully used to evaluate various state programs (Abadie and Gardeazabal, 2003; Buchmueller, DiNardo, and Valletta, 2011).

The discussion above assumes only state-level variation: In other words, because the PEI is a state program, we assume that *all* of California was treated. This is the reason why we use other "unexposed" states as a comparison group. However, it is possible that there is meaningful variation *within* California that an evaluator can exploit to learn something about the effect of PEI programs. For example, one might expect variation at the county level because the amount of PEI funding varied from county to county (one can think about this as different intensities of treatment) or, alternatively, because different counties implemented different types of programs.

[5] The evaluator could also use all of the states.
[6] This is the same intuition behind propensity weighting methods.

To the extent that an evaluator is interested in assessing county-level variation, some of the methods described here can also be used. As we discuss in the next paragraph, the before-after and D-in-D designs, in particular, are quite general and can be applied easily.

If there were variation in the amount of PEI funding per capita at the county level, then an evaluator could use a D-in-D design to compare changes in outcomes in counties with higher levels of per capita funding (high-PEI-intensity counties) to changes in outcomes in counties with lower levels of per capita funding (low-PEI-intensity counties). The expectation would be that counties that received more funding per capita would have better outcomes, all else equal. Continuing with our illustration in Table 6.1, treated and comparison groups would then be replaced with high-PEI-intensity and low-PEI-intensity counties, respectively. Alternatively, if there were variation in the *types* of PEI programs implemented—for example, if some counties focused on programs of a certain type (call it *Type A*) while other counties implemented predominantly *Type B* programs—then an evaluator could assess differences in outcomes between counties that implemented Type A versus Type B programs to learn something about which programs are more effective.

More generally, an evaluator might simply be interested in whether some counties outperform other counties and, if they do, he or she may then want to understand *why* those counties performed better. For example, do counties with better outcomes share particular characteristics, such as better management and oversight or a focus on certain types of programming? The results from this kind of analysis can be very useful and can help policymakers to identify what works. Such knowledge can inform future program refinements.

Note that the use of any one of these designs does not preclude use of any of the others. In general, it is good practice to use multiple ways of assessing how robust the estimates of program effects are with respect to the choice of evaluation design. If all the methods produce similar results, that similarity increases confidence in the reliability of the estimate. If methods produce divergent results, then more weight should be given to estimates from the most rigorous assessment design.

Using Descriptive Statistics for Inference

The evaluation framework we have developed can also be used more generally to monitor the effects of PEI programs by collecting and reporting descriptive information or statistics. This information can range from very basic—such as counts of people served by various programs at the state level—to more-detailed information, such as program outcomes disaggregated by population subgroup or geographic area. Descriptive data have their inherent limitations and cannot, or at least should not, be used to make causal statements about the impact of PEI programming. However, they can help policymakers to continuously monitor progress toward benchmarks and can serve as “early warning” indicators of implementation failures. Descriptive data are relatively easy to produce and relatively easy to digest, particularly if presented in consumer-friendly ways, such as in simple figures and charts. Data should be reported at regular intervals, such as annually or quarterly.

An effective and efficient way to provide descriptive data about PEI programs is to create a web tool from which individuals can obtain descriptive statistics on various program indicators for their areas, as well as for the state as a whole. Data that can be reported via this web tool may include data on the cost of individual PEI program activities, the types of services provided, and the number of individuals using or exposed to various PEI-funded services. These data can also be benchmarked against data from other programs in the state or from similar programs in other states. The web tool could include data on program utilization and performance, ideally disaggregated by geographic area, by population subgroups (e.g., gender, age group, or race and ethnicity), or by other characteristics, such as the lesbian, gay, bisexual, transgender, and questioning subpopulations. It is important that the results be reported in a simple way for public consumption. Such reporting can be done using graphs, bars, or pie charts or with an interactive, online geographic information system map. The web tool should also be easily customizable so that public users can choose indicators in which they are interested and can drill down to specific groups or areas of interest. Users should also be able to specify the time period for which they want data.

Although useful, this reporting system has additional implications that should be considered. The main one is the size of the population in the area of the user's interest. Because some of the mental health outcomes being studied are rare, estimates for areas with a small population can be unstable, with extreme variability or large confidence intervals around any estimates. Such estimates could easily be misinterpreted and should not be made available for public use. It will be necessary to decide at what level of variability this restriction should be put into effect.

Establishing such restrictions will also alleviate potential threats to participant privacy: If only one or two people in a small area have a reported outcome, they will not be perfectly deidentified in a user's request in the tool. For example, if there were only a single suicide by someone of Hispanic ethnicity in a given area, it might be possible to identify him or her. When dealing with rare outcomes, such as suicides, advanced statistical techniques, such as empirical Bayes methods (Carlin and Louis, 2000), can be used to smooth estimates. The method of the modified Kalman filter developed at RAND (Lockwood et al., 2011; Setodji et al., 2011) can also be used to smooth estimates over time when the outcome is rare.

Chapter Seven

Conclusions

In this chapter, we provide concluding comments on the utility of the evaluation framework if it were to be implemented using existing data sources and core program-level data, and we discuss the applicability of the framework to the broader evaluation of the Mental Health Services Act. We make recommendations for additional data development to support the evaluation framework. We also identify some areas in which supplemental evaluation activities could address important system evaluation priorities that cannot feasibly be addressed as part of an ongoing statewide data monitoring and evaluation capability. We conclude by recommending next steps for developing and implementing the PEI evaluation framework.

Usefulness of the Evaluation Framework

It is analytically possible to evaluate the Act's causal impact on population-level outcomes. However, we believe that it would be a mistake to make evaluating causality the focus of a statewide evaluation plan. Because the negative outcomes identified by the Act are broad social outcomes that are affected by many different social forces, and because the expectation is that changes in these outcomes will take years to observe, it is possible that such changes will not be apparent at the population level, leading to a potentially false conclusion that PEI and the Act's monies have not improved outcomes. In addition, establishing causality would involve technically complex analyses that might be difficult to interpret.

If CalMHSA and the Commission feel that establishing causality is essential, we recommend that the evaluation focus on changes in resilience and emotional well-being. Resilience and emotional well-being are intermediate outcomes that are logically antecedent to the seven negative outcomes, and changes in resilience and well-being should eventually result in changes in these longer-term outcomes. Because most PEI activities have the common goal of increasing resilience and emotional well-being, it is likely that changes in this outcome will both precede and be larger (and thus more easily observed at the population level) than changes in longer-term outcomes, such as unemployment or homelessness.

However, despite the difficulty in establishing causality, there are tremendous opportunities to use existing data to track over time the population-level outcomes identified in the Act and ultimately to provide the data needed to estimate how this historic initiative has affected the mental health of California's population. We believe that the frameworks we have developed and the associated measures we have defined can produce useful descriptive information—based on existing data, without the investment of significant new funding. This is an excellent time to establish a surveillance system that can be used to provide important information about the early phase of PEI activity—who is being reached, who is using PEI services, whether disparities in access have changed, what kinds of programmatic activities are being carried out, and by whom. In sum, the evaluation frameworks provide a theory-based way to answer the question "Are we putting in place the kinds of interventions we wanted to, and are they reaching the populations we thought they should?"

The surveillance system should also monitor changes in outcomes at the population level, so as to identify early movement in these outcomes. Similar to our recommendation to use resilience and emotional well-being to measure the causal impact of PEI, we recommend using these same measures to monitor and track changes at the population level. Changes in resilience and emotional well-being are likely to be the most sensitive to the new programmatic activities funded by the Act.

There is another, perhaps even more important, reason to monitor changes in outcomes at the population level. Even small changes in the average mental health of the population as a whole could greatly reduce the number of individuals who develop a new mental illness in a given time period (Rose, 1992). This is because epidemiologic studies suggest that the prevalence of mental illness and emotional well-being is distributed in the population in the form of a bell-shaped curve. Most individuals have an "average" amount of emotional well-being, with very few having either very low or very high emotional well-being. A shift in the whole distribution of population values toward more emotional well-being necessarily implies a decrease in the occurrence of extreme values (individuals with very low emotional well-being).

In other areas of health, it has been shown that prevention programs focusing on high-risk individuals have had disappointing impacts on the total burden of disease in the population because most of the incidence of new disease arises from the many individuals at low risk rather than the few individuals who are at high risk (Rose, 1992). Because primary prevention programs are population-based and focus on providing many individuals with a little benefit (e.g., public service announcements), and because PEI programs are meant to build synergistically upon each other (e.g., school- and community-based after-school programs for transitional-aged youth), the cumulative impact of PEI may shift the distribution of risk for all members of society. This shift may have a large benefit at the population level, and, unless one monitors impact at the population level, this benefit will not be identified.

Applying the Framework to the Broader Evaluation of the Mental Health Services Act

As we noted in Chapter Six, it is not possible to disentangle the impact of PEI initiatives on key population-level outcomes of interest from the impact of the broader treatment system. This is because PEI initiatives, by design, are intended to complement and promote equitable access to and early use of treatment and because PEI was implemented at the same time as other new treatment services.

Our development of an evaluation framework and consideration of data sources and measures focused on PEI program activities because we were tasked to develop a PEI evaluation framework. However, we believe that the framework we developed could readily be extended to apply broadly to programs funded by the Act. This broader evaluation would require additional work to identify key concepts, other relevant data sources, and indicators. Because treatment service information systems and performance indicators have been in use for many

years at the statewide and county levels, there is extensive service-level information on which to build.

Data Development

We recommend additional data development to support implementation of the evaluation framework. Some of the recommendations focus on near-term data needs; others suggest ways to improve data collection to support ongoing evaluation.

Immediate Prevention and Early Intervention Program Information Needs

It is essential to develop standardized, core information about the programs funded under the Act's PEI initiatives, the activities carried out by these programs, and the individuals reached by these activities. This information is needed to populate the constructs in the evaluation framework that answer the questions "Where is it going?" and "What is it doing?"

It is a challenging task to develop and implement data definitions and data systems that can capture this information. However, we believe that the key information can be developed relatively quickly (over one or two years). Because PEI programs are relatively new and are not embedded in existing treatment system data systems, the state and counties have before them a unique opportunity and a window of time in which to develop consistent definitions and data-capture systems across PEI programs and across counties. At minimum, all programs should report on the number of individuals served or exposed to the intervention, the type of program, and the target population. A next step would be for programs to report on the demographic and social characteristics of the individuals they reach. The last (and significantly more difficult) step would be to implement data systems that can track individuals across programs and service systems.

Prevention and Early Intervention Performance Indicators

Important information about the quality or performance of PEI programs is not easy to develop for routine use in an ongoing statewide evaluation framework. Currently, there are few standardized and widely accepted measures of the quality of PEI services. But these could be developed over time. Some examples of potential performance indicators include whether a program meets certification standards (e.g., suicide hotline certification), client satisfaction with program activities, and whether training or other interventional activities are delivered with fidelity to evidence-based protocols. Developing reliable and valid performance indicators is an important area for further research.

Maintaining and Improving Tracking of Population Outcomes

This report has cataloged existing data sources that can be used to populate constructs in the PEI evaluation framework. In some cases, these data sources have limitations and could be improved. A key example is suicide statistics. Currently, there are variations in the way that deaths by suicide are reported across counties in California. National standards provide guidelines for more-consistent reporting, and these could be adopted to improve suicide statistics and their utility for PEI evaluation. Another example is surveys of school-aged

children. Not all schools participate in the California Healthy Kids Survey, and even fewer collect data using the optional modules, a significant limitation to the use of these surveys for population surveillance and monitoring.

In other cases, existing data sources could potentially be enhanced to be more useful for PEI evaluation. For example, there are currently no good measures of stigma and discrimination that are collected at a population level. However, it would be feasible to add these measures to the California Health Interview Survey or the California Healthy Kids Survey. Consistent measures of resiliency and emotional well-being could be included in most (if not all) population-based surveys, which would allow for comparisons across different priority populations.

Other Important Evaluation Issues

Evaluating Program Efficacy

Existing research provides information on the efficacy of some specific PEI interventions and the effectiveness of some multicomponent PEI campaigns. The evidence base for the efficacy of specific program interventions can be used to support the development of performance indicators that could be incorporated into ongoing assessment of program activities.

In many cases, however, the literature provides insufficient evidence regarding the efficacy of PEI program activities. PEI programs may be innovative, or existing programs may be modified for new target populations. And some broadly disseminated programs have not been well evaluated.

In this report, we do not recommend attempting to determine the comparative effectiveness of different programs through routine monitoring of client or participant outcomes. Routine assessment of relevant client and participant outcomes can be important as part of a program-specific quality improvement process. However, appropriately evaluating and comparing the effectiveness of programs would require well-designed and controlled studies. We recommend that the state or counties strategically develop the evidence base for PEI programs by conducting rigorous evaluations of strategically selected promising programs.

Evaluating Cultural Competence

The cultural competence of programs is a very important issue given the diversity of California's population and the importance of reaching traditionally underserved groups through PEI programs. The importance of cultural competence is broadly accepted, and it is supported by extensive literature describing culture-specific barriers and needs. However, there are currently no broadly accepted and reliable measures of cultural competence that could serve as performance indicators in an ongoing statewide monitoring system.

It may be a priority for the Commission, CalMHSA, and other stakeholders to pursue development of cultural-competence assessments at the program level. If so, we recommend

obtaining advice from national experts who can provide a review of state-of-the-art approaches to cultural-competence definitions and assessment and assist in exploring the most-appropriate strategies.

Developing Program Capacity for Quality Improvement

Programs can develop capacity for ongoing evaluation and quality improvement by developing reports that describe the delivery and reach of program activities and the demographic characteristics of program participants. Standardized information systems, measures, data definitions, data-entry protocols, and reporting formats can facilitate the development of this capacity.

We have argued that routinely assessed outcomes are not useful for comparing effectiveness of programs or evaluating the efficacy of PEI programs, given the limitations of observational data. However, observational data can be very useful at the program level for evaluating program implementation and reach, understanding program clients and audiences, targeting and trying improvements, and creating an organizational climate for continuous quality improvement.

Next Steps

We suggest a phased implementation of the statewide evaluation framework. An initial three-year phase would allow for implementation of a basic framework that would be extremely useful for evaluating current PEI activities and would establish a basis for longer-term monitoring of program activities and key outcomes.

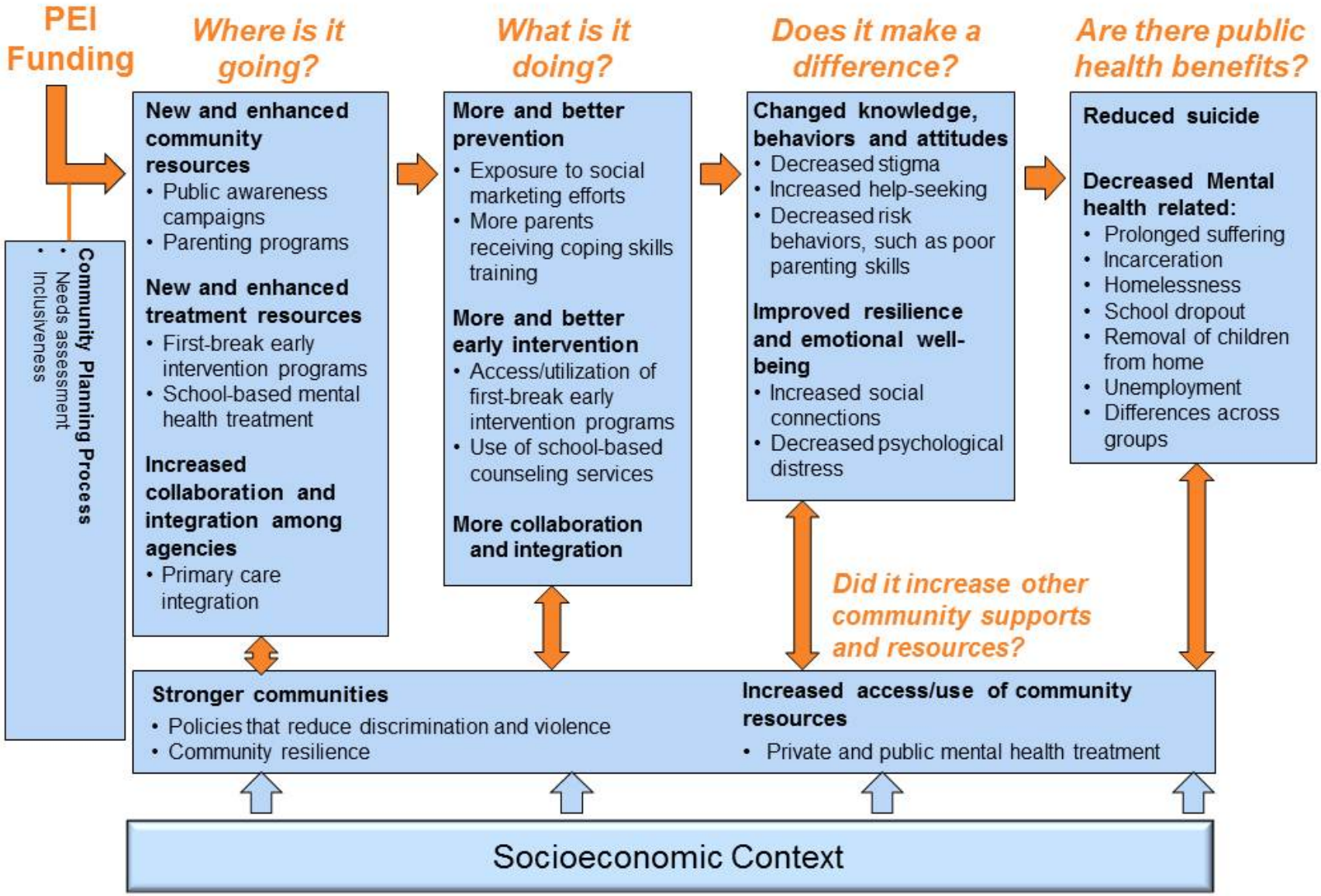
We recommend that several tasks be accomplished in the initial year: (1) demonstration of development and reporting of PEI program-level information, in collaboration with interested counties, corresponding to boxes 2 and 3 of the frameworks; (2) psychometric assessment and refinement of program-level and population-level measures, which would also include pilot testing new measures to determine sample size and, where needed, reliability and validity (this would probably need to occur over a two-year period); (3) development of descriptive analytic and reporting templates; and (4) proposed work plan and resources required for full implementation and ongoing maintenance. The second and third years would be focused on implementing the full evaluation framework, including implementation of infrastructure required to acquire, store, analyze, and routinely report data. Development of a web-based reporting system could be included as part of years 2 and 3.

Subsequent phases beyond the first three years could focus on improvements, such as development of performance indicators. It would be important for the Commission, CalMHSA, county mental health departments, and other stakeholders to consider longer-term priorities for improvements in ongoing evaluation and to establish priorities for special studies.

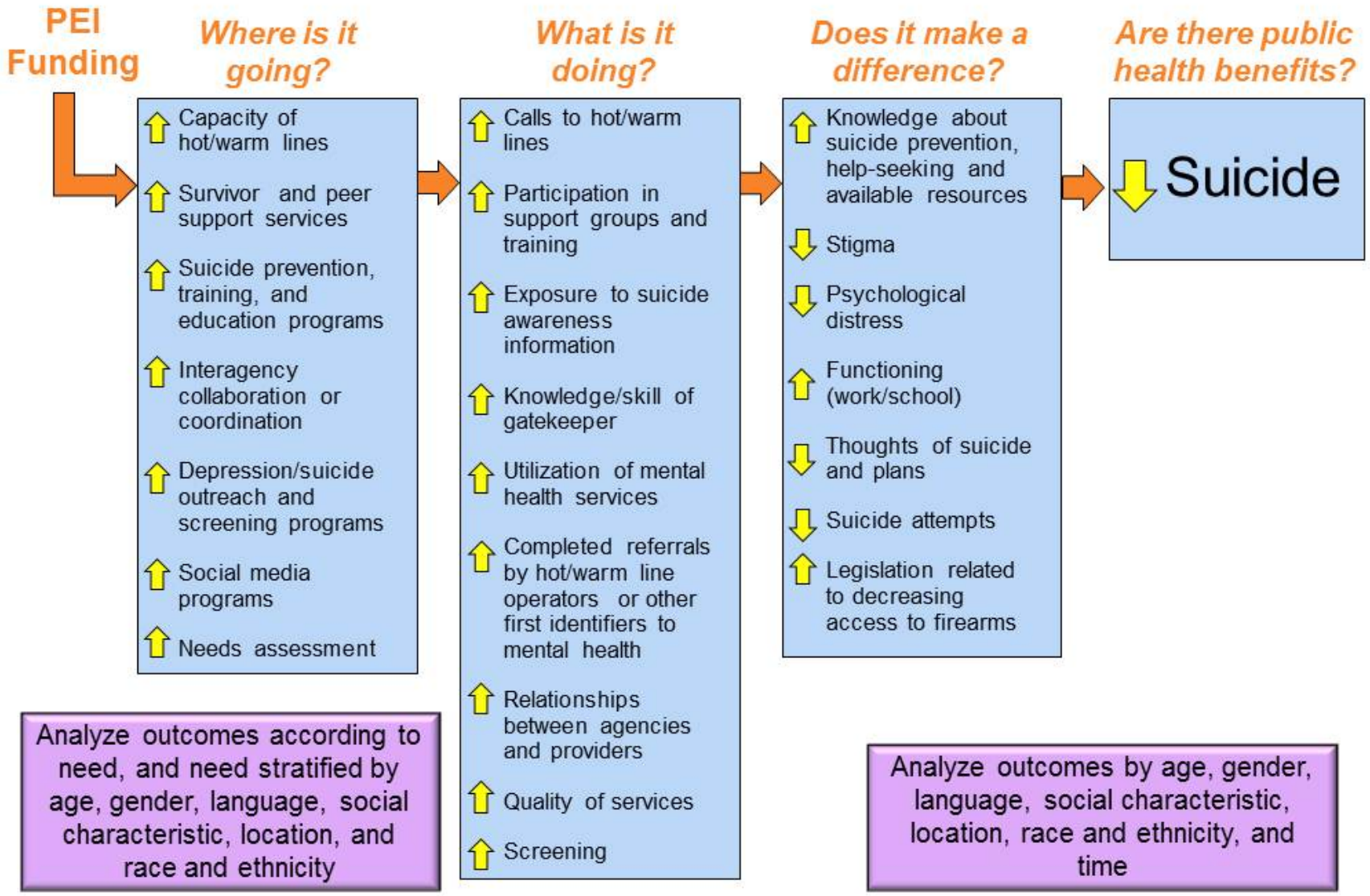
Appendix A.

Framework Logic Models

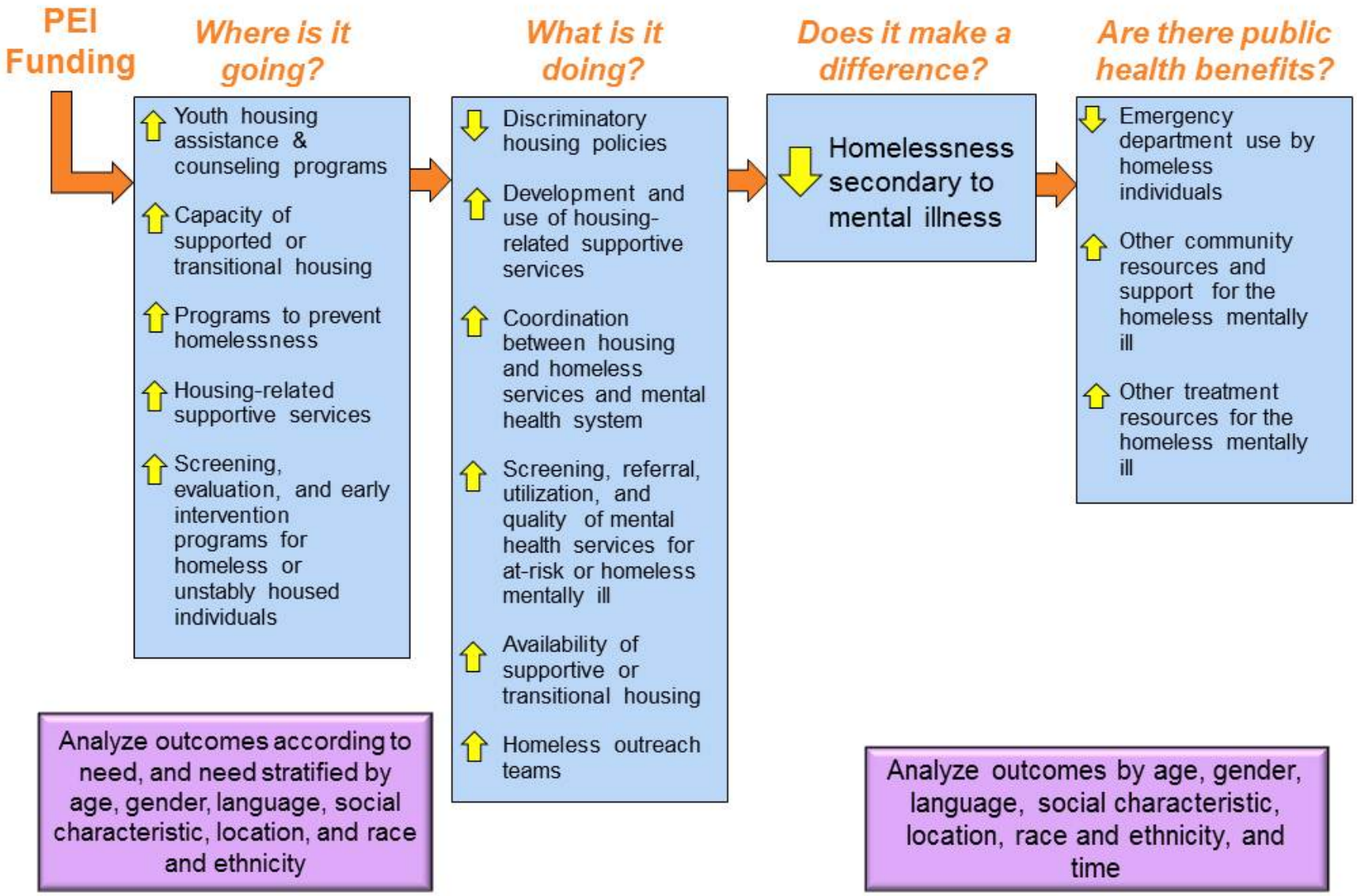
An Approach to Understanding the Impact of Statewide Prevention and Early Intervention (PEI) Funding



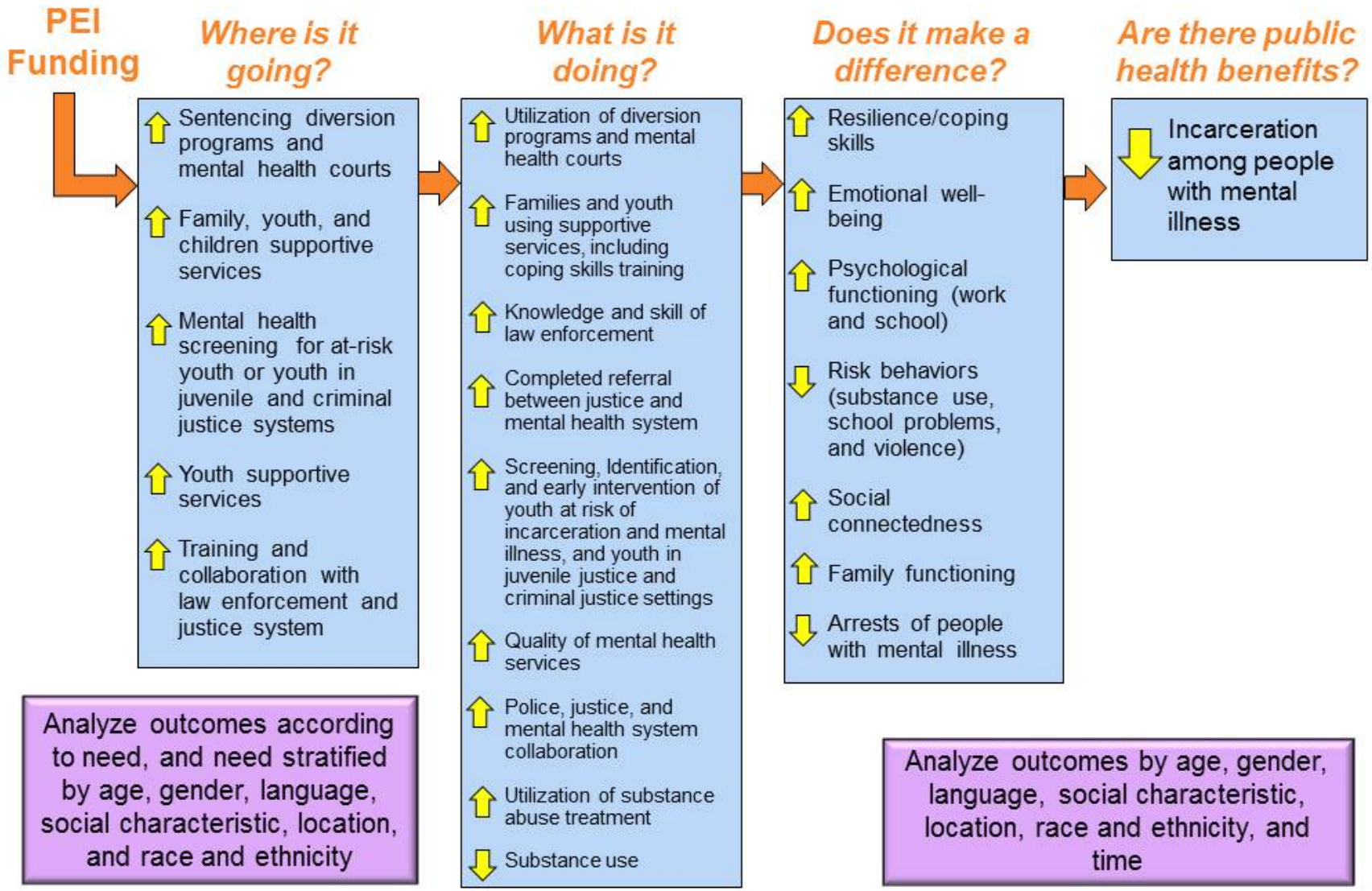
Suicide Prevention Framework



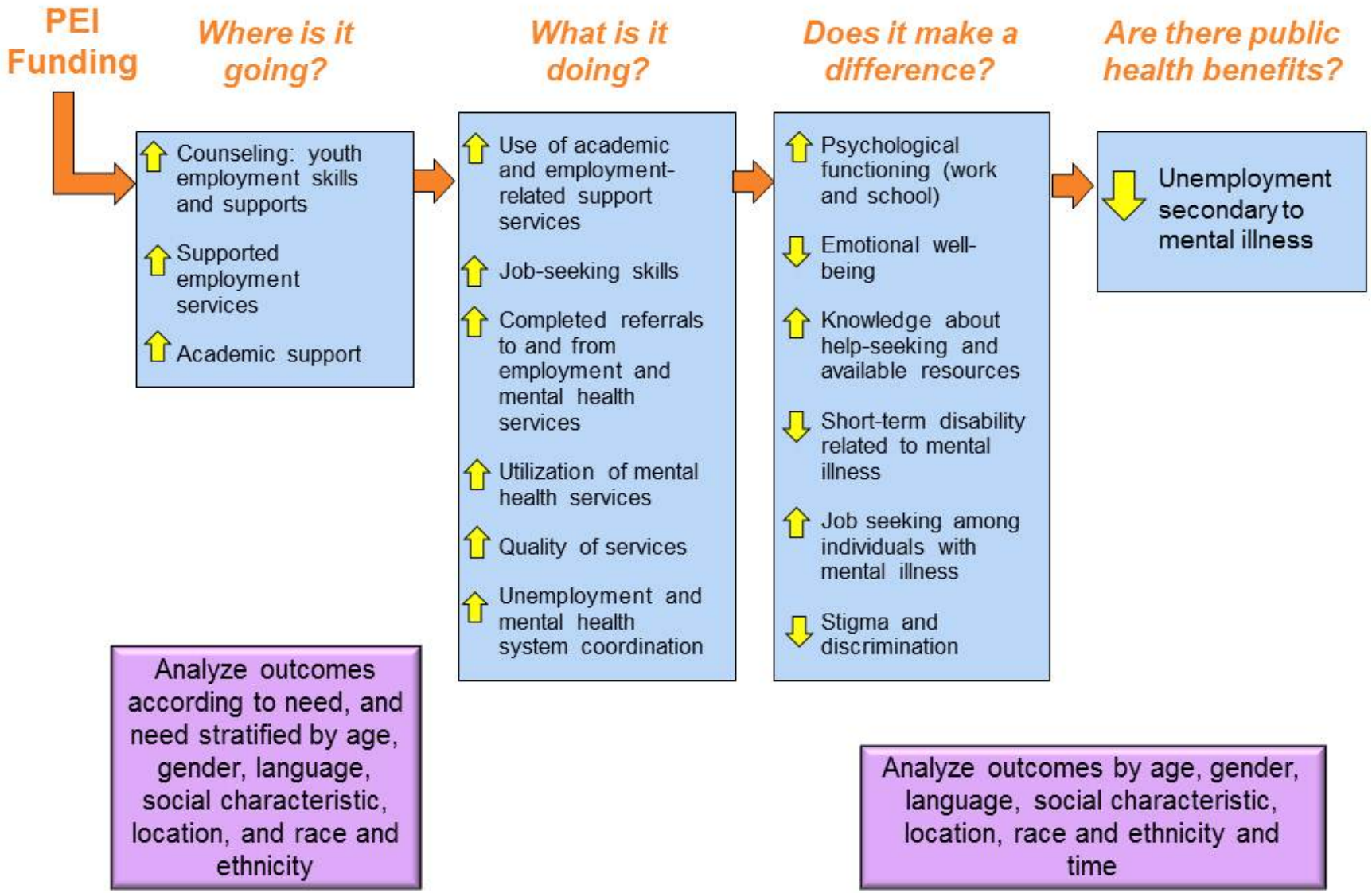
Homelessness Prevention Framework



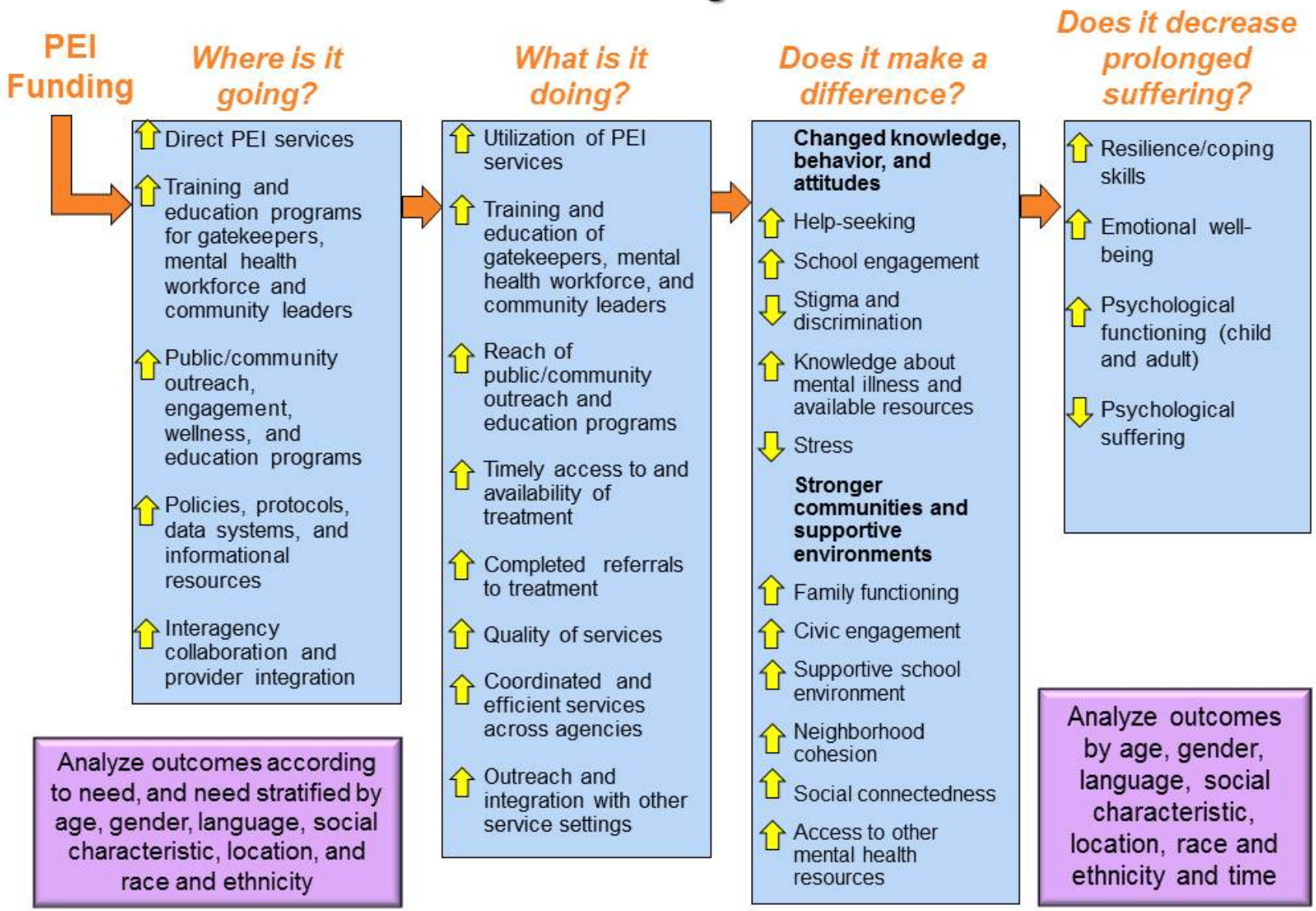
Incarceration Prevention Framework



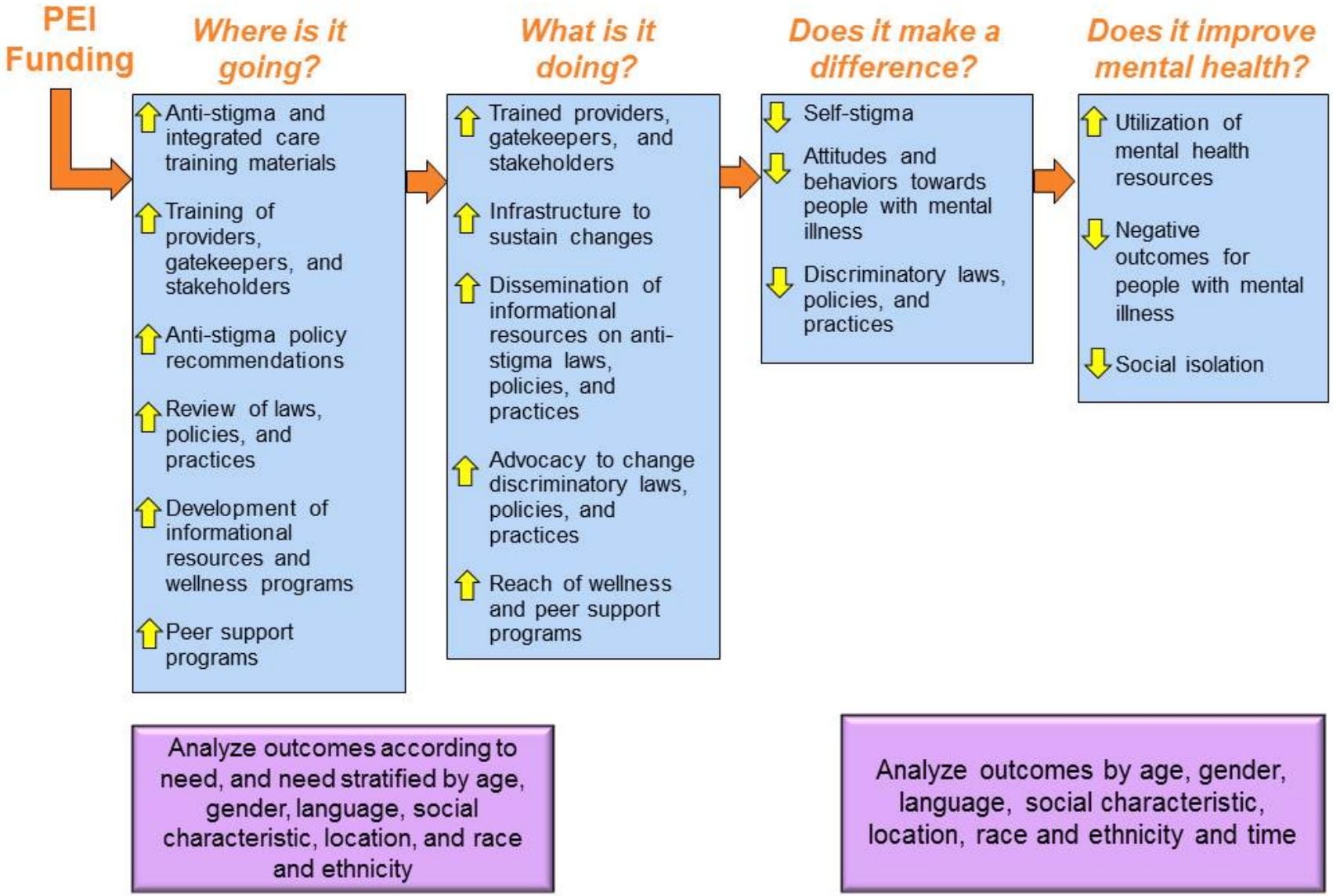
Unemployment Prevention Framework



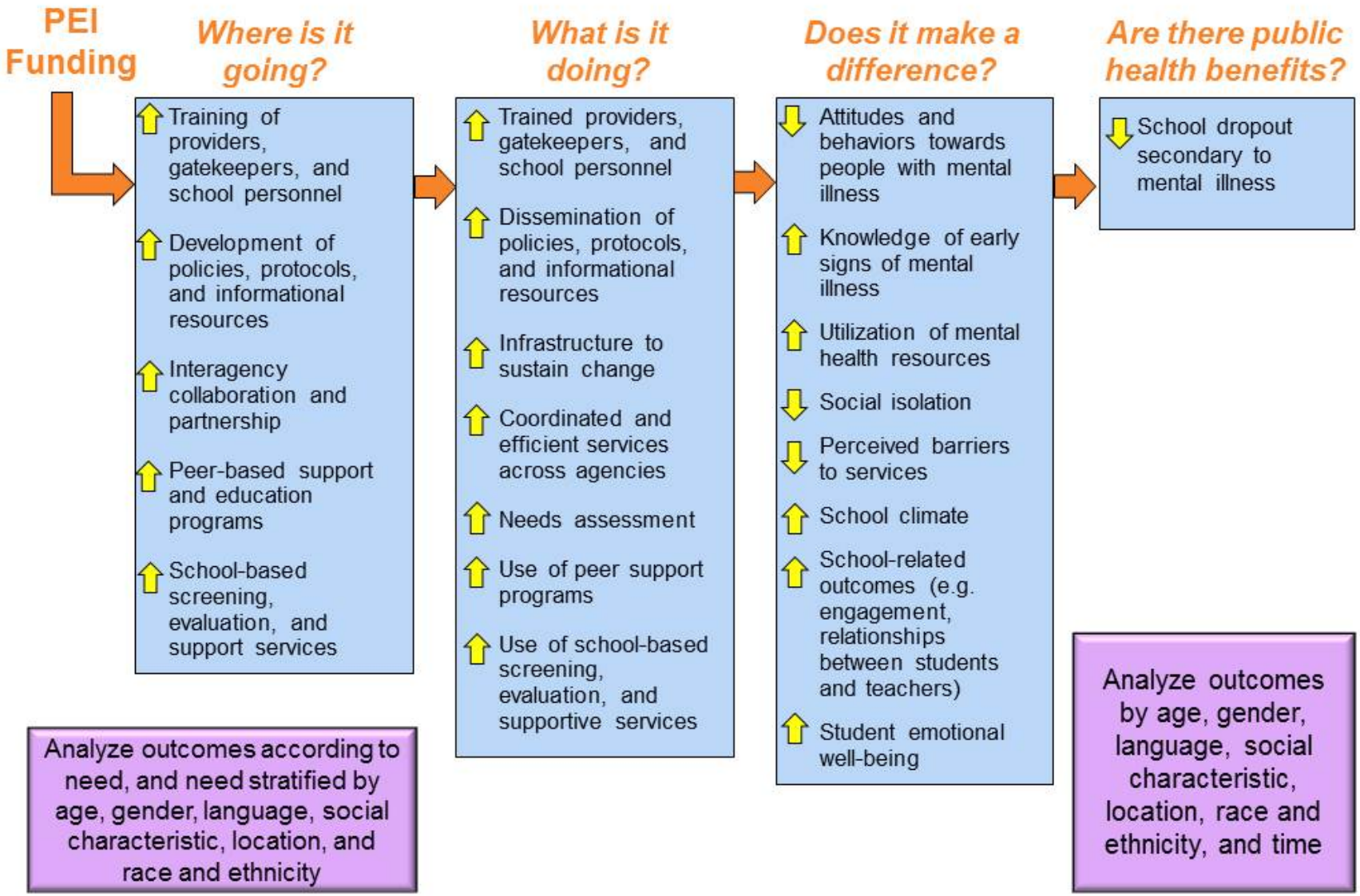
Reduced Suffering Framework



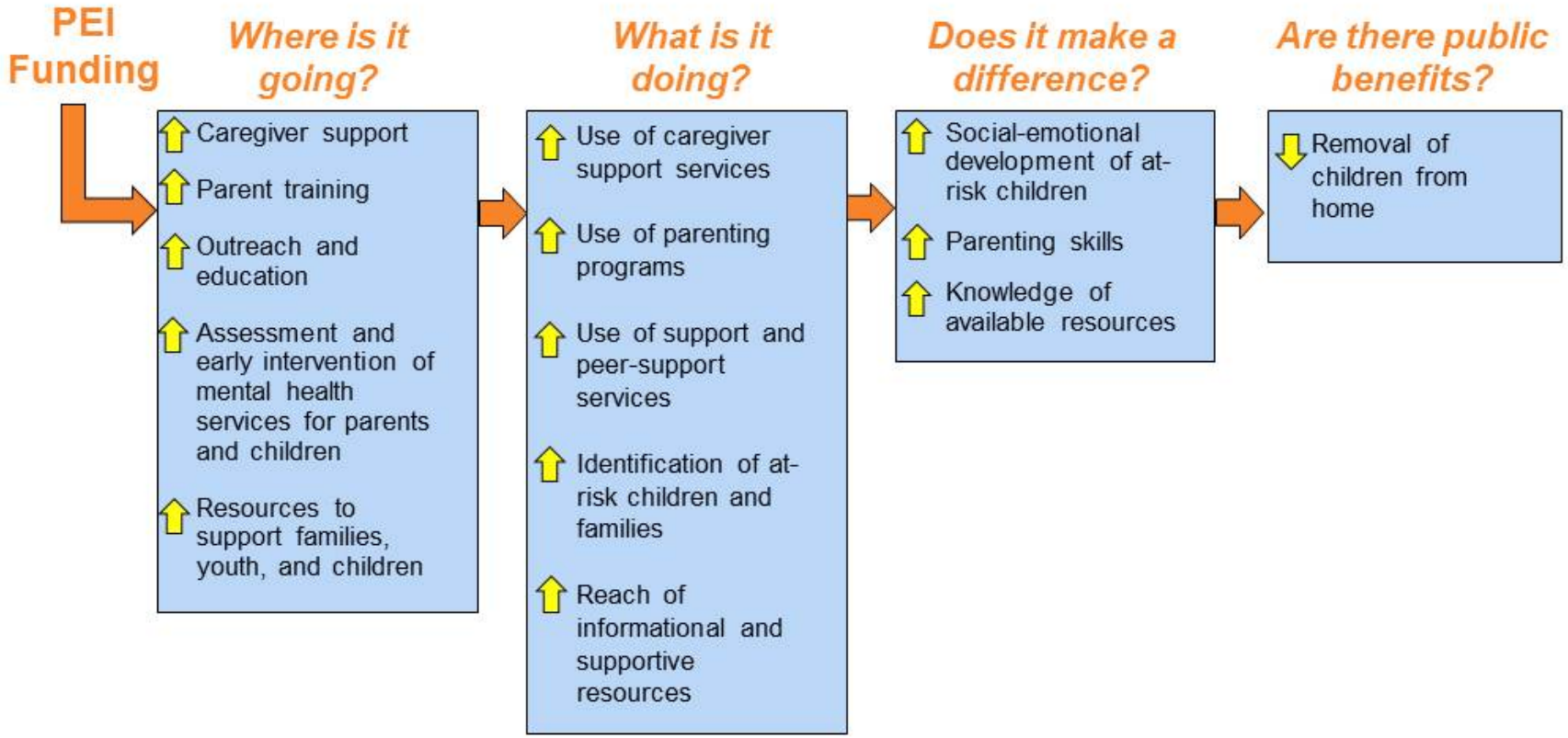
Stigma and Discrimination Prevention Framework



School Dropout Prevention Framework



Out of Home Removal Prevention Framework



Analyze according to need, and need stratified by age, gender, language, social characteristic, location, and race and ethnicity

Analyze outcomes by age, gender, language, social characteristic, location, race and ethnicity, and time

Appendix B.

Database Descriptions

Data Source List

1. American College Health Association–National College Health Assessment (ACHA-NCHA)
2. Behavioral Risk Factor Surveillance System (BRFSS)
3. California Consumer Perception Survey (CCPS) and Mental Health Statistics Improvement Program (MHSIP): part of the Uniform Reporting System
4. California's Electronic Violent Death Reporting System (CalEVDRS)
5. California Health Interview Survey (CHIS)
6. California Healthy Kids Survey (CHKS)
7. California School Climate, Health, and Learning Survey (Cal-SCHLS)
8. California School Climate Staff Survey (CSCS)
9. California School Parent Survey (CSPS)
10. California Work Opportunity and Responsibility to Kids (CalWORKs) Welfare-to-Work Monthly Activity Report
11. California Quality of Life Survey (CAL-QOL)
12. Client and Services Information System (CSI)
13. Common Core of Data (CCD)
14. Data Collection and Reporting System (DCR)
15. Data Quest (DQ)
16. Health Professional Shortage Area (HPSA)
17. Housing Inventory Count (HIC)
18. Involuntary Detention Reports (IDRs)
19. Jail Profile Survey (JPS)
20. Juvenile Detention Profile Survey (JDPS)
21. National Ambulatory Medical Care Survey (NAMCS)
22. National Comorbidity Survey (NCS), NCS Replication (NCS-R), and NCS-R adolescent supplement (NCS-A)
23. National Death Index (NDI)
24. National Epidemiologic Survey on Alcohol and Related Conditions (NESARC)
25. National Health Interview Survey (NHIS)
26. National Hospital Ambulatory Medical Care Survey (NHAMCS)
27. National Outcome Measures Survey (NOMs)
28. National Profile of Local Health Departments (NPLHD)
29. National Survey of Children's Exposure to Violence (NatSCEV)
30. National Survey of Substance Abuse Treatment Services (N-SSATS)
31. National Survey on Drug Use and Health (NSDUH)
32. Office of Statewide Health Planning and Development (OSHPD)
33. Point-in-Time Homeless Persons Count (PIT)
34. School Health Policies and Practices Study (SHPPS)
35. Survey of Inmates in Federal Correctional Facilities (SIFCF) and Survey of Inmates in State Correctional Facilities (SISCF)

36. Survey of Inmates in Local Jails (SILJ)
37. Treatment Episode Data Set (TEDS)
38. Uniform Data System (UDS)
39. Uniform Reporting System (URS)
40. University of California Undergraduate Experience Survey (UCUES)
41. Youth Risk Behavior Surveillance System (YRBSS)

Details on Data Sources

American College Health Association–National College Health Assessment

Acronym	**ACHA-NCHA**
Developer	Developed by an interdisciplinary team of college health professionals
Description	Since 2000, the ACHA-NCHA survey has tracked changes in health issues and trends, enabling both ACHA and institutions of higher education to adequately identify factors affecting academic performance, respond to questions and concerns about the health of the nation's students, develop a means to address these concerns, and ultimately improve the health and welfare of those students.
Population	More than 825,000 students at 550+ colleges and universities across the country have already taken the survey. The NCHA has been used by two-year and four-year public and private institutions from varied geographical regions, Carnegie Foundation Classifications, and campus settings.
Instrument Type	Survey
Availability (Years)	Annually, fall and spring, 2000-2011
Latest Year	2011
Instrument Frequency	Twice annually
Data Coverage	School
Reliability/Validity	http://www.acha-ncha.org/grvanalysis.html To receive a copy of the NCHA Reliability and Validity Analyses, contact ACHA Research Director E. Victor Leino, PhD, at vleino@acha.org
PEI Goal(s)	Mental and Physical Health

Example Questions	• Within the last school year/12 months how many times have you felt things were hopeless?
	• Within the last school year/12 months how many times have you felt very sad?
	• Within the last school year/12 months how many times have you felt so depressed that it was difficult to function?
	• Within the last school year/12 months how many times have you seriously considered attempting suicide?
	• Within the last school year/12 months have you had any of the following mental or physical health problems? (Subjects were given a list of 29 choices, top 10 responses are presented.)
	Impediments to Academic Performance
	• Within the last school year/12 months have any of the following mental or physical health problems affected your academic performance (received a lower grade on an exam or important project, received a lower grade in the course, received an incomplete or dropped the course)?
	  ○ Stress
	  ○ Sleep difficulties
	  ○ Concern about family/friend
	  ○ Relationship difficulties

Acronym	**ACHA-NCHA** ○ Sinus infection ○ Cold/Flu/Sore throat ○ Death of a friend or family member ○ Alcohol use ○ Depression/anxiety
Website	http://www.acha-ncha.org/
Source Reference	ACHA-NCHA 2005. American College Health Association- National College Health Assessment (ACHA-NCHA) Web Summary. http://www.acha.org/projects_programs/ncha_sampledata.cfm.
Other References	
Availability and Cost	Portions of the ACHA-NCHA Reference Group data set may be made available for independent analysis. Interested investigators are encouraged to submit proposals. Research is being conducted in the areas of nutrition, weight and eating disorders; blood alcohol content (BAC) and binge drinking; alcohol and marijuana as impediments to academic performance; and depression and suicide ideation.
Link to Instrument(s)	Current survey instrument: http://www.acha-ncha.org/docs/ACHA-NCHAII_sample.pdf
Link to Data	Published results: http://www.acha-ncha.org/pubs_rpts.html
Contact Information	*ACHA Research Director E. Victor Leino, vleino@acha.org*
Administration/ Scoring	N/A

Behavioral Risk Factor Surveillance System

Acronym	**BRFSS**
Developer	CDC
Description	The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based system of health surveys that collects information on health risk behaviors, preventive health practices, and health care access primarily related to chronic disease and injury. For many states, the BRFSS is the only available source of timely, accurate data on health-related behaviors.
Population	U.S. civilian noninstitutionalized population aged 18 years and older residing in households.
Instrument Type	Telephone interview survey

Availability (Years)	1984- present (Not all states participating prior to 2001)
Latest Year	2010
Instrument Frequency	Annual for core module; optional modules generally not repeated by CA.
Data Coverage	National. The questionnaire consists of three parts: (1) a core component of questions used by all states, which includes questions on demographics, and current health-related conditions and behaviors; (2) optional CDC modules on specific topics (e.g., cardiovascular disease, arthritis) that states may elect to use; and (3) state-added questions, developed by states for their own use. The state-added questions are not edited or evaluated by CDC.
Reliability/Validity	The BRFSS is conducted independently by each state and therefore methodologies may vary. Pooled national estimates may not take into account these differences and so may differ from estimates obtained using data sources that use methodologies designed to produce national estimates. Also, the BRFSS was not designed for county-specific estimates in most states although county-specific estimates may be presented if there are more than 50 respondents in a county. http://www.cdc.gov/brfss/technical_infodata/quality.htm
PEI Goal(s)	Mental health [outcomes]
Example questions	Core Sections: • 1.1 Would you say that in general your health is—? • 2.1 Now thinking about your physical health, which includes physical illness and injury, for how many days during the past 30 days was your physical health not good? • 2.2 Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good? • 2.3 During the past 30 days, for about how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?

Acronym	**BRFSS** • 6.10 (Ever told) you have a depressive disorder (including depression, major depression, dysthymia, or minor depression)? • 11.1 Are you limited in any way in any activities because of physical, mental, or emotional problems? Optional modules: California administered the following modules, but only in the years specified. Questions from these modules available online in each year's questionnaire. • Mental illness & stigma (2007) (27 states administered module that year: Alaska, Arkansas, California, Connecticut, District of Columbia, Georgia, Hawaii, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, Oklahoma, Puerto Rico, Rhode Island, South Carolina, Vermont, Virginia, Wyoming) • Anxiety & depression (2006) (36 states administered module that year: Alabama, Alaska, Arkansas, California, Delaware, District of Columbia, Florida, Georgia, Hawaii, Indiana, Iowa, Louisiana, Maine, Michigan, Minnesota, Mississippi, Missouri, Montana, Nevada, New Hampshire, New Mexico, North Dakota, Oklahoma, Oregon, Puerto Rico, Rhode Island, South Carolina, Tennessee, Texas, Utah, Vermont, Virgin Islands, Virginia, West Virginia, Wisconsin, Wyoming) • Healthy days (2002) (21 states administered module that year: Alaska, California, Guam, Hawaii, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, North Carolina, Oregon, Rhode Island, South Carolina, Utah, Washington, Wyoming) • Alcohol consumption (1998) (12 states administered module that year: Alaska, California, Idaho, Illinois, Iowa, Minnesota, Nevada, New Mexico, Oklahoma, Tennessee, Virgin Islands, Wisconsin)
Website	http://www.cdc.gov/brfss/
Source Reference	
Other References	
Availability and Cost	Freely available online.
Link to Instrument(s)	http://www.cdc.gov/brfss/questionnaires/english.htm
Link to Data	http://www.cdc.gov/brfss/technical_infodata/surveydata.htm
Contact Information	http://apps.nccd.cdc.gov/BRFSSCoordinators/coordinator.asp California site: http://www.surveyresearchgroup.com/sub.php?page=projects_behavioral http://www.surveyresearchgroup.com/sub.php?page=data

Acronym	**BRFSS**
Administration/Scoring	Data collection is conducted separately by each state. The design uses state-level, random digit dialed probability samples of the adult (aged 18 and older) population. All projects use a disproportionate stratified sample design except for Guam, Puerto Rico, and the U.S. Virgin Islands, which use a simple random sample design. Interviews are generally conducted using computer-assisted telephone interviewing (CATI) systems. Data are weighted for noncoverage and nonresponse.

California Consumer Perception Survey and Mental Health Statistics Improvement Program: Part of the Uniform Reporting System

Acronym	**CPS & MHSIP**
Developer	SAMHSA. The Center for Mental Health Services (CMHS) at SAHMSA collects data from all states via the CMHS Uniform Reporting Survey (URS). This includes administrative data as well as the results of the MHSIP URS.
Description	The Consumer Perception Survey is CA DMH's implementation of the MHSIP. "The Mental Health Statistics Improvement Program is a community of people who share the belief that improvements in mental health services can occur when decision-makers--be they service providers, those who pay for services, or those who receive them--make rational decisions based on objective, reliable and comparable information about those services. When it was organized back in the 70s, members of the MHSIP community were mostly representatives of three groups: federal, state and local governments; public and private, non-profit service providers; and researchers. The MHSIP Ad Hoc Committee, now referred to as the MHSIP Ad Hoc Group, was established with representatives from these three groups to develop rules for collecting mental health data, to advise the federal government on data issues, and to develop and implement projects to improve mental health data nationwide. Since that time, membership has expanded to include recipients of mental health treatment, advocacy group representatives, and delegates from related social service providers." The versions of the MHSIP approved surveys we are interested in are the Uniform Reporting System (URS) surveys with Social Connectedness and Functioning Questions, which are the versions used by states as part of SAMHSA's Uniform Reporting System. "The Uniform Reporting System (URS) was developed in response to the need for accountability for the expenditure of community mental health block grant funds received by States from the Federal Government. The intent of the URS tables is to allow both (1) the tracking of individual State performance over time, and (2) the aggregation of State information to develop a national picture of the public mental health systems of the States." These surveys are available in both English and Spanish and include a version for adults, for youth (Youth Services Survey or YSS), and for a youth's family member to fill out (Youth Services Survey for Families, or YSS-F). California administers what it calls the Consumer Perception survey, which consists of the MHSIP URS surveys *along with additional sections*. The adult and older adult versions contain: • The URS versions of the MHSIP (which include Social Connectedness

Acronym	**CPS & MHSIP**
	and Functioning questions). These questions therefore can be compared across states. • A section titled Quality of Life Questions; these are from the Lehman Quality of Life Interview/Scale, and are not part of the URS. • A final section with questions about duration of services received, arrests or other law enforcement encounters, demographics, whether services and materials were in preferred language, reason for becoming involved with the program, who helped complete survey, and a field for additional comments. Again, not part of the URS. • Older adult differs from adult only in that the font is bigger and the QOL questions are a bit streamlined. The YSS and YSS-F versions contain: • The URS versions of the MHSIP YSS URS (includes Social Connectedness and Functioning questions). These questions can be compared across states. • [No Quality of Life questions, unlike the adult/older adult.] • A final section that includes questions about who child lives with; service duration; arrests or law enforcement contacts; school attendance or being suspended or expelled from school; having seen a medical doctor, and whether on medication for diagnosis of behavioral problem (in YSS-F only); demographics; language of services; Medi-Cal; help completing survey. No questions about why sought services. Again, not part of the URS.
Population	CPS: Adult, older adult, and youth clients receiving face-to-face mental health services through county departments of mental health in California. Data are submitted via the web by individual county departments of mental health. Estimates by county should be possible (see Availability and Cost). California's response rate is particularly low, and much lower than the national average. Rates not shown by county. Response rates from 2010: • California children: 10.4% (1,116 completed surveys) • California adults: 19.7% (4,169 completed surveys) • US children: 44.5% (41,002 completed surveys) • US adults: 49.9% (107,182 completed surveys) Consumers receiving the following services from county-operated and contract organization providers during the sampling period should be INCLUDED in the survey process: • face-to-face mental health services • case-management • day treatment • medication services

Acronym	**CPS & MHSIP** Note: All consumers should complete Consumer Perception Surveys regardless of funding source. In addition, ALL clients enrolled in MHSA Full Service Partnerships should complete a survey. Note: Consumers who receive services outside of the office, for example a home visit, should be given a survey if they meet the target population criteria. Consumers served in the following settings should be EXCLUDED from the survey process: • acute hospitals • Psychiatric Health Facility (PHF) • crisis (stabilization, residential and intervention) • jail and jail hospital settings • long-term care institutional placements [e.g., State hospitals, Institute for Mental Disease (IMD)] Surveys are available in English, Spanish, Tagalog, Chinese, Korean, Vietnamese, and Russian, though in 2007 there was a lapse in availability of some languages due to revisions from SAMHSA. MHSIP URS Surveys in other states: Administration may vary.
Instrument Type	Survey
Availability (Years)	CPS: Current semi-annual approach initiated in 2003. Ongoing.
Latest Year	SAMHSA has URS reports online through 2010.
Instrument Frequency	CPS: two times a year; administered during a two-week period in May and again in November.
Data Coverage	National (MHSIP URS); State (CPS); County (CPS)
Reliability/Validity	As of 2000: http://www.mhsip.org/Ckaufman.pdf
PEI Goal(s)	Mental Health [Outcomes] Timely Access [Outcomes] Outreach [Outcomes] Incarceration [Process] and Incarceration [Outcomes] Homelessness [Outcomes] Removal of Children [Outcomes] School Dropout [Process, Outcomes] Stigma [Process, Outcomes]? Not really, but possible questions listed below. Unemployment [Outcomes]
Example questions	NOTE: • (C) indicates available in CPS: California's implementation of the URS, which includes additional questions not in the URS. • (M) indicates available in MHSIP URS and therefore comparable across states. • Everything in M is in C; there are things in C that are not in M.

Acronym	**CPS & MHSIP**
	• Items are in all versions of the noted surveys (i.e., Adult, Older Adult, YSS, YSS-F) unless noted as A, OA, YSS, YSS-F.
	
	DEMOGRAPHIC AND IDENTIFYING DATA COLLECTED:
	• (C) County Code (a 2-digit code, filled out by staff)
	• (C) CSI County Client Number (client identifier, filled out by staff; means you can link to service data, service location, home zip code)
	• (C,M) Spanish/Hispanic/Latino origin [Yes / No; CPS also includes option "Unknown"]
	• (C,M) Race, mark one or more [American Indian or Alaska Native / Asian / Black (African American) / Native Hawaiian or Other Pacific Islander / White (Caucasian) / Other: Describe; CPS doesn't put a "describe" field after "Other"; CPS includes option "Unknown"]
	• (C,M): Gender [Male / Female; CPS also includes option "Other"]
	• (C,M): Birth Date
	
	Mental Health [Outcomes]: Note these outcomes are only relevant to people receiving services, but it could be possible to ID people who got PEI services from a clinic and look at their outcomes.
	• (C,M:A/OA) [As a direct result of the services I received] My symptoms are not bothering me as much. [And many similarly structured questions about ability to function.]
	• (C:A/OA) How do you feel about your life in general? [Terrible / … / Delighted] (Lehman QOL)
	• (C:A/OA) How do you feel about [Terrible/…/Delighted] (Lehman QOL)
	  • Your physical condition?
	  • Your health in general?
	  • Your emotional well-being?
	  • The way you spend your spare time?
	  • The change you have to enjoy beautiful or pleasant things?
	  • The amount of fun you have?
	  • The amount of relaxation in your life?
	  • The way you and your family act toward each other?
	  • The way things are in general between you and your family?
	  • The things you do with other people?
	  • The amount of friendship in your life?
	• (C,M) Social connectedness questions [Strongly Agree / … / Strongly Disagree / N/A]
	  • I am happy with the friendships I have.
	  • I have people with whom I can do enjoyable things.
	  • I feel I belong in my community.

Acronym	**CPS & MHSIP** • In a crisis, I would have the support I need from family or friends. Timely Access [Outcomes] • (C,M) Staff were willing to see me as often as I felt it was necessary. • (C,M) Staff returned my calls within 24 hours. • (C,M) Services were available at times that were good for me. • (C,M) I was able to get all the services I thought I needed. • (C,M) I was able to see a psychiatrist when I wanted to. Outreach [Outcomes] • (C:A/OA) What was the primary reason you became involved with this program? (Mark one): [I decided to come in on my own. / Someone else recommended that I come in. / I came in against my will.] Incarceration [Process] and Incarceration [Outcomes] • (C:A/OA) In the past MONTH, how many times have you been arrested for any crimes? [No arrests / 1 / 2 / 3 / 4 or more arrests] • (C,M) Were you arrested since you began to receive mental health services (or, if receiving services for more than one year, were you arrested during the last 12 months)? • (C,M) Were you arrested in the 12 months prior to that? • (C,M) Since you began to receive mental health services (or, if receiving services for more than one year, over the last year), have your encounters with police: [Been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program) / Stayed the same / Increased / Not applicable (I had no police encounters this year or last year)] Homelessness [Outcomes] • (C,M:A/OA) [As a direct result of the services I received] my housing situation has improved. • (C:A/OA) How do you feel about: The living arrangements where you live? • (C:A/OA) How do you feel about: The privacy you have there? • (C:A/OA) How do you feel about: The prospect of staying on where you currently live for a long period of time? • (C:A/OA) During the past month, did you generally have enough money to cover the following items: Food; Clothing; Housing; Traveling around for things…; Social activities…? (5 separate yes/no questions) • (C,M:YSS/YSS-F) Have you lived in any of the following places in the last 6 months? (Mark all that apply). [With one or both parents / With another family member / Foster home / Therapeutic group home / Crisis shelter / Homeless shelter / Group home / Residential treatment center / Hospital / Local jail or detention facility / State correctional facility / Runaway/homeless/streets / Other (describe)] Removal of Children [Outcomes]

Acronym	**CPS & MHSIP** • (C,M:YSS/YSS-F) Have you lived in any of the following places in the last 6 months? (Mark all that apply). [With one or both parents / With another family member / Foster home / Therapeutic group home / Crisis shelter / Homeless shelter / Group home / Residential treatment center / Hospital / Local jail or detention facility / State correctional facility / Runaway/homeless/streets / Other (describe)] School Dropout [Process, Outcomes] • (C,M:YSS/YSS-F) Were you expelled or suspended since beginning services (or, if receiving services for more than one year, during the last 12 months? • (C,M:YSS/YSS-F) Were you expelled or suspended during the 12 months prior to that? • (C,M:YSS/YSS-F) Since you began to receive mental health services (or, if receiving services for more than one year, over the last year), the number of days you were in school is: [Greater / About the same / Less / Does not apply (please select why this does not apply: I did not have a problem with attendance before starting services / I was expelled from school / I am home schooled / I dropped out of school / Other (specify))] Stigma [Process, Outcomes] • (C,M) Staff treated me with respect. • (C,M) [As a result of the services I received] In a crisis, I would have the support I need from family or friends. • (C,M:YSS/YSS-F) [As a result of the services I received] I know people who will listen and understand me when I need to talk. • (C,M:YSS/YSS-F) [As a result of the services I received] I have people that I am comfortable talking with about my problem(s). Unemployment [Outcomes] • (C,M:A/OA) [As a direct result of the services I received] I do better in school and/or work. (Also: I am better able to deal with crisis; I am better able to handle things when they go wrong.)
Website Source Reference **Other References** Availability and Cost	http://www.mhsip.org/ http://www.samhsa.gov/dataoutcomes/urs/ http://www.dmh.ca.gov/POQI/ As a CA DMH dataset, the CPS should be freely available for a state evaluation. The Petris center used it in its state-contracted MHSA evaluation. It was able to link individual responses to service use data in order to identify clients who received FSP services. SAMHSA publishes tables from the URS, by state; see link to data below. Need

Acronym	**CPS & MHSIP**
	to look into what it would take to get actual datasets if we wanted to run things differently than reported in their tables.
Link to Instrument(s)	MHSIP: http://www.mhsip.org/surveylink.htm#mhsipapprovedsurveys; http://www.mhsip.org/surveylink.htm#URSSurveywithSocialConnectedness
Link to Data	CA's CPS: http://www.dmh.ca.gov/POQI/Consumer_Perception_Surveys.asp URS: Actual datasets not online. Tables by state are available for years 2007-2010 here: http://www.samhsa.gov/dataoutcomes/urs/
	CPS: Actual datasets not online. Tables available through URS reports. CA-specific reports here: http://www.dmh.ca.gov/POQI/Reports.asp
Contact Information	CA's Performance Outcomes and Quality Improvement (POQI): POQI.support@dmh.ca.gov
Administration/Scoring	CPS Training Manual: http://www.dmh.ca.gov/POQI/docs/CPSTrainingManual.pdf
	During the targeted 2-week periods all clients, not just a sample, are expected to complete the surveys. In our LA County clinic-based MHSA evaluation, our field staff observed that the administration of the CPS is pretty haphazard.

California's Electronic Violent Death Reporting System

Acronym	**CalEVDRS**
Developer	California Department of Public Health
Description	CalEVDRS is modeled on CDC's National Violent Death Reporting System and contains detailed data on violent death circumstances from several sources. Includes homicides, suicides, unintentional firearm deaths, and deaths of undetermined intent.
Population	All deaths occurring in 14 California counties (Alameda, Kern, Los Angeles, Monterey, Riverside, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Shasta, Solano, Stanislaus, Yolo)
Instrument Type	Administrative data CalEVDRS took advantage of California's Electronic Death Registration System (CA-EDRS), created in 2005 to allow counties to file death certificates online. DPH created a violent death supplement to death certificates in CA-EDRS, which captures information from coroners on violent death. CalEVDRS data elements were created according to NVDRS specifications and can be transmitted to NVDRS if CDC desires them. Law enforcement data for homicides are linked using Supplementary Homicide Reports (SHRs) from the California Department of Justice.
Availability (Years)	2005–2010
Latest Year	2009
Instrument Frequency	Annual
Data Coverage	3 counties in 2005 (Oakland, San Francisco, and Santa Clarita), expanded to 6 counties in 2006/2007 (Alameda, Los Angeles, Riverside, San Francisco, Santa Clara, and Shasta Counties) until 2006 when it was expanded to 14 (Alameda, Kern, Los Angeles, Monterey, Riverside, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Clara, Shasta, Solano, Stanislaus, Yolo). It now captures capturing detailed information on two-thirds of all homicides in California and 57% of all violent deaths.
Reliability/Validity	No information found
PEI Goal(s)	Suicide
Example questions	The database can be selected based on Year Death Type: *Homicide; Suicide; Undetermined intent; legal intervention; unintentional firearm death* Event Type: *Single victims; Multiple victims (except H/S); Homicide/Suicide incidents* Residents of California Ages Sex Marital Status Veteran Status Race/Ethnicity

Acronym	**CalEVDRS** Weapon/Mechanism: *All firearms; Hand guns; Long guns; Sharp instruments; hanging/suffocation; fall/jump; personal weapon (hands/feet); Poison*
Website	http://www.cdph.ca.gov/programs/Pages/CalEVDRS.aspx
Source Reference	
Other References	
Availability and Cost	Data are publicly available for free
Link to Instrument(s)	Under NVDRS, county health departments collect data on violent deaths from four data sources—death certificates, coroner/medical examiner records, police reports, and crime laboratory records. http://www.cdph.ca.gov/programs/cclho/Documents/VanCourtViolentDeathHealthInfo2008.pdf
Link to Data	http://epicenter.cdph.ca.gov/ReportMenus/ViolentDeathTable.aspx
Contact Information	Steve Wirtz at (916) 552-9831 or Steve.Wirtz@cdph.ca.gov
Administration/Scoring	

Notes	From 2005 through 2008, California was one of 17 states participating in the National Violent Death Reporting System (NVDRS), funded by the Centers for Disease Control and Prevention (CDC). Unfortunately, due to its size, decentralized government, privacy concerns and lack of resources among law enforcement agencies, California was unable to obtain law enforcement records required by NVDRS and could not reapply for funding. CalEVDRS is funded by the California Wellness Foundation, the California Research Bureau (CRB) of the California State Library, and the Department of Pathology and Laboratory Medicine, UC Davis School of Medicine.

California Health Interview Survey

Acronym	**CHIS**
Developer	UCLA Center for Health Policy Research
Description	The California Health Interview Survey CHIS is a population-based random-digit dialing telephone survey of households in California. It has been implemented since 2001 in partnership with the University of California, Los Angeles, the Department of Health Care Services and the California Department of Public Health. There are 3 versions of the survey: adults (ages 18+); adolescents (ages 12-17); and, children (below age 12 - answered by an adult proxy). CHIS is conducted in all 58 counties of California.
Population	Adults (18+), adolescents (12-17) and children (below age 12) (representative)
Instrument Type	Interview
Availability (Years)	2001, 2003, 2005, 2007, 2009
Latest Year	2009 (pending additional data), 2011 is in the field; have switched to continuous data collection in 2011
Instrument Frequency	Biennially until 2011, then continuous
Data Coverage	State, county
Reliability/Validity	http://www.chis.ucla.edu/dataquality.html
PEI Goal(s)	Mental health (adult, adolescent, child; not all questions asked in 2003) Access (adult, adolescent, child – need, access, use of mental health services) Unemployment (adult, adolescent) School dropout (adolescent – missed school due to health) Discrimination (adult – health care discrimination due to race; not asked in 2007 and 2009) Suicide (adult – ideation and attempts; asked in 2009 only)
Example questions	Mental health • {He/She} is generally well behaved, usually does what adults request [...during the past 6 months]; {He/She} has many worries or often seems worried; {He/She} is often unhappy, depressed or tearful; {He/She} gets along better with adults than with other children; {He/She} has good attention span, sees chores or homework through to the end; Overall, do you think your child has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?; Are these difficulties minor, definite, or severe? (Child 2009) • In the past 12 months did you think you needed help for emotional or mental health problems, such as feeling sad, anxious, or nervous? • Kessler-6 (K-6): About how often during the past 30 days did you feel nervous—Would you say all of the time, most of the time, some of the time, a little of the time, or none of the time?; During the past 30 days, about how often did you feel hopeless; how often did you feel

Acronym	**CHIS**

restless or fidgety?; How often did you feel so depressed that nothing could cheer you up?; How often did you feel that everything was an effort?; How often did you feel worthless? (Adol and Adult 2009; the adult qx also ask these questions about the worst month in the past year)

Access

- During the past 12 months, did (CHILD) receive any psychological or emotional counseling? (Child 2009)
- Is there a place that you usually go to when you are sick or need advice about your health; In the past 12 months, have you received any psychological or emotional counseling?; In the past 12 months, did you receive any professional help for your use of alcohol or drugs? (Adol 2009)
- Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or your use of alcohol or drugs?; Does your insurance cover treatment for mental health problems, such as visits to a psychologist or psychiatrist?; In the past 12 months, have you seen your primary care physician or general practitioner for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?; In the past 12 months, have you seen any other professional, such as a counselor, psychiatrist, or social worker for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?; In the past 12 months, how many visits did you make to a professional for problems with your {mental or emotional health/use of alcohol or drugs/mental or emotional health and your use of alcohol or drugs}? Do not count overnight hospital stays.; Are you still receiving treatment for these problems from one or more of these providers?; Did you complete the recommended full course of treatment?; What is the MAIN REASON you are no longer receiving treatment?; During the past 12 months, did you take any prescription medications, such as an antidepressant or sedative, almost daily for two weeks or more, for an emotional or personal problem?; Here are some reasons people have for not seeking help even when they think they might need it. Please tell me “yes” or “no” for whether each statement applies to why you did not see a professional…concerned about the cost of treatment, did not feel comfortable talking with a professional, concerned about what would happen if someone found out, had a hard time getting an appointment) (Adult 2009).

Unemployment or other functioning

- Did your emotions interfere a lot, some, or not at all with your performance at work? Did your emotions interfere a lot, some, or not

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	at all with your household chores? Did your emotions interfere a lot, some, or not at all with your social life? Did your emotions interfere a lot, some, or not at all with your relationship with friends and family? Now think about the past 12 months. About how many days out of the past 365 days were you totally unable to work or carry out your normal activities because of your feeling nervous, depressed, or emotionally stressed? (Adult 2009) School dropout • During the last four school weeks, how many days of school did you miss because of a health problem? (Adol 2009) Discrimination • Thinking about your race or ethnicity, how often have you felt treated badly or unfairly because of your race or ethnicity? Was there ever a time when you would have gotten better medical care if you had belonged to a different race or ethnic group? (Adult 2001, 2003, and 2005 only) • Here are some reasons people have for not seeking help even when they think they might need it. Please tell me "yes" or "no" for whether each statement applies to why you did not see a professional…concerned about what would happen if someone found out (Adult 2009). Suicide • Have you ever seriously thought about committing suicide?; Have you seriously thought about committing suicide at any time in the past 12 months? Have you seriously thought about committing suicide at any time in the past 2 months?; Have you ever attempted suicide?; Have you attempted suicide at any time in the past 12 months? (Adult 2009; Adult and Adolescent 2011)
Website	http://www.chis.ucla.edu/default.asp
Source Reference	California Health Interview Survey. CHIS 2005 Adult Public Use File. Release 1 [computer file]. Los Angeles, CA: UCLA Center for Health Policy Research, January 2007. *(Note: customize to the year data used)*
Other References	Ponce, N. A., Lavarreda, S. A., Yen, W., Brown, E. R., DiSogra, C., & Satter, D. E. (2004). The California Health Interview Survey 2001: Translation of a Major Survey for California's Multiethnic Population. *Public Health Reports, 119* (4), 388-395.
Availability and Cost	There are publically available data files you can download off the website after registering. To obtain city, county, and zip code information, you have to fill out an application http://www.chis.ucla.edu/main/DAC/default.asp. The minimum project cost is $1K to set this up and expires after two years. http://www.chis.ucla.edu/pdf/DAC_FS.pdf

Acronym	**CHIS**
Link to Instrument(s)	http://www.chis.ucla.edu/questionnaires.html
Link to Data	http://www.chis.ucla.edu/questionnaires.html
Contact Information	dacchpr@ucla.edu; (310) 794-8319
Administration/Scoring	Sample weights need to be used. Constructed variables already calculated.

Notes	The California Quality of Life Survey-III (CAL-QOL-III) is a follow-up to the California Health Interview Survey (CHIS) and collects DSM IV diagnosable disorders. The CAL-QOL oversamples LGBT respondents. It is currently collecting its third wave of data (2011-2012). Wave 1 was in 2004 and wave 2 was in 2007. https://www.calqol.org/default.asp

California Healthy Kids Survey

Acronym	**CHKS**
Developer	California Department of Education
Description	The California Healthy Kids Survey (CHKS) is the largest statewide survey of resiliency, protective factors, and risk behaviors in the nation administered in grades 5, 7, 9, and 11. The survey includes a general, core set of questions, plus a series of supplementary modules covering specific topics. Public schools can participate in the survey for a fee, some school districts that receive state funding are required to do a survey like the CHKS. The use of the survey was more popular when schools could use Title IV funding, but now that this funding mechanism is discontinued, WestEd has tried to keep the sample as representative of California as possible. Currently, they conduct a random sampling of K-12 schools in California and provide financial incentives to those schools to administer the survey on a biennial basis. Some schools that still receive California Tobacco Use Prevention Education (TUPE) funding and are mandated to complete the survey annually. Schools/researchers can add questions for a nominal fee (see cost section below). The CHKS is part of the California School Climate, Health, and Learning Survey (CalSCHLS), a compendium of surveys that also includes the California School Climate staff survey (CSCS) and the California School Parent Survey (CSPS). Questions from these surveys assess changes in the mental health-related climate on school campuses and the community. The CSPS contains items similar to the CSCS (e.g., school provides counseling to help students with needs), allowing evaluators to better understand how parent and staff perceptions of school climate compare.
Population	California public elementary, middle, and high school
Instrument Type	Survey

Availability (Years)	2002-2010 (Elementary), 2003-2010 (Middle school and high school)
Latest Year	2010 (pending additional data)
Instrument Frequency	Biennially
Data Coverage	State, county, district
Reliability/Validity	http://chks.wested.org/resources/REL_RYDM2007034.pdf
PEI Goal(s)	Suicide Mental Health School dropout Access Resilience Also modules on

Acronym	**CHKS** - Safe and supportive schools - School health centers
Example questions	Suicide • During the past 12 months, did you ever think about killing yourself?; did you make a plan about how you would like to kill yourself?; Have you ever tried to kill yourself? (Alcohol and other drug use [AOD] Middle School, 2011) • During the past 12 months, did you ever seriously consider attempting suicide?; did you make a plan about how you would attempt suicide?; how many times did you actually attempt suicide?; If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse? (AOD High School, 2011) Mental Health • During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more that you stopped doing some usual activities? (Core Middle School, 2011; Core High School, 2011) School Dropout • During the past 12 months, about how many times did you skip school or cut classes? (Core Middle School, 2011; Core High School, 2011) • In the past 30 days, about how many days of school did you miss because you had a health problem (like being hurt or sick), you had a problem with your teeth, you felt too sad or anxious, or you just did not feel well? In the past year, how often did you get the following types of care when you needed it?…Counseling to help you deal with problems like stress, depression, family issues, or alcohol or drug use (BHC Module High School) Access • In your opinion, how likely is it that a student would find help at your school from a counselor, teacher, or other adult to stop or reduce using alcohol or other drugs? (AOD High School, 2011) • Where do you usually go for help when you are sick, need medical care, or advice about health?; Does your school have a place on campus where you can go for help when you are sick, need medical care, or need to get advice about health? (AOD High School, 2011) • Which of the following services have you received from the School Health Center? …Counseling to help you deal with issues like stress, depression, family problems or alcohol or drug use; The School Health Center has helped me to …Get help I did not get before; Get help sooner than I got before; Get information and resources I need; Use tobacco, alcohol or drugs less; Deal with personal and/or family issues; Do better in school; Feel more connected to people at my school (SHC

Acronym	**CHKS**

High School, 2011)

- Have you ever felt that you needed help (such as counseling or treatment) for your alcohol or other drug use? (California Student Survey [CSS] High School, 2011)
- If you use alcohol, marijuana, or another drug, have you had any of the following experiences?... Attended counseling, a program, or group to help you reduce or stop use (Core High School, 2011)

Resilience/School and Community Climate (note that the CHKS also has a separate resilience module that is optional and not all schools complete it – see below for link; the questions below are on the core survey):

- School environment (I feel close to people at this school, I am happy to be at this school, I feel like I am part of this school, The teachers at this school treat students fairly, I feel safe in my school; At my school, there is a teacher or some other adult who… really cares about me, tells me when I do a good job, notices when I'm not there, always wants me to do my best, listens to me when I have something to say, believes that I will be a success; Core Middle School, 2011; Core High School, 2011)
- Community environment (Outside of my home and school, there is an adult who… really cares about me, tells me when I do a good job, notices when I am upset about something, believes that I will be a success, always wants me to do my best, whom I trust; Core Middle School, 2011; Core High School, 2011)

School Health Center Supplementary Module (not completed by all schools)

- If you HAVE used the School Health Center, which of the following services have you received from the School Health Center?
  - *…Counseling to help you deal with issues like stress, depression, family problems or alcohol or drug use*
  - *…Referrals for medical care or treatment outside the school*
- The School Health Center has helped me to …
  - *Get help I did not get before.*
  - *Get help sooner than I got before.*
  - *Get information and resources I need.*
  - *Use tobacco, alcohol or drugs less*
  - *Use birth control or condoms more often*
  - *Eat better or exercise more*
  - *Deal with personal and/or family issues*
  - *Do better in school*
  - *Feel more connected to people at my school.*

Building Healthy Communities Supplementary Module (not completed by all schools)

Acronym	**CHKS** • In the past 30 days, did you miss one or more days of school for any of the following reasons? (Mark all that apply) *A) Asthma or other problem with breathing, coughing, chest pains, or wheezing when you didn't have a cold* *B) An injury* *C) Illness (feeling physically sick)* *D) Felt very sad, hopeless, anxious, stressed, or angry* *E) Tooth pain or other dental problem* *F) I did not miss school for any of these reasons* • In the past year, how often did you get the following types of care when you needed it? *…Counseling to help you deal with problems like stress, depression, family issues, or alcohol or drug use*

Website	http://chks.wested.org/
Source Reference	California Healthy Kids Survey, California Department of Education (Safe and Healthy Kids Program Office) and WestEd (Health and Human Development Department).
Other References	Research on the CHKS can be found at http://chks.wested.org/resources/hksc-surveyreader.pdf
Availability and Cost	Raw data per grade can be sent in SPSS or delimited format for $50-125 per grade in a given year. For a low-cost fee, items can be added to the survey retrospective data can be analyzed and aggregated at the school level. Specific items from the surveys could also be used in RAND's statewide survey by paying a licensing fee.
Link to Instrument(s)	CHKS (core and supplemental modules): http://chks.wested.org/administer/download; http://chks.wested.org/resources/chks_guidebook_1_admin.pdf CHKS Resilience supp module: http://chks.wested.org/using_results/resilience Parent survey: http://csps.wested.org/resources/csps-1213.pdf Staff survey: http://cscs.wested.org/resources/cscs-1213.pdf
Link to Data	
Contact Information	http://chks.wested.org/contact; (888) 841.7536
Administration/Scoring	The master data file that contains data for all the years is not weighted. The two-year data files are weighted by grade to the district enrollments. The weights are then adjusted so the weighted total counts by grade match the number of respondents. However, the counts for other levels (e.g., school, district, county) will not match.

Acronym	**CHKS**
Notes	Bilingual surveys exist as well. Reports typically become public on the website the November following a survey administration. This gives districts an opportunity to understand their own data before they are made accessible to the public. Reports can be downloaded at http://chks.wested.org/reports/. Greg Austin says that staff and parent response rates are variable and depend on school leadership. The CHKS is also available online and high school students respond well to this medium.

California School Climate, Health, and Learning Survey (CalSCHLS)

The California School Climate, Health, and Learning Survey (CalSCHLS) is a compendium of surveys that also includes the California Healthy Kids Survey (CHKS), California School Climate staff survey (CSCS) and the California School Parent Survey (CSPS). The student survey is administered biennially to 5th, 7th, and 9th graders in California (last administered in 2011-2012), and schools may also opt to survey staff and parents during the same period. Schools pay to participate in the survey. Title IV funding used to encourage more schools to complete the survey, but this funding has discontinued and currently WestEd is conducting a random sample of K-12 schools in California and providing financial incentives to those schools to administer the survey on a biennial basis (G. Austin, personal communication, 4/16/12). Some schools still receive California Tobacco Use Prevention Education (TUPE) funding and are mandated to complete the survey annually. The response rates to staff and parent response rates are variable and depend on school leadership (G. Austin, personal communication, 4/16/12). Surveys are also available online though high school students have responded best with this medium. Surveys are translated in a variety of languages (e.g., the parent survey is available in 26 languages).

Questions from CHKS that may be most relevant to RAND may include questions related to student mental health, mental health-related consequences, resilience, school/neighborhood climate, and access to school-based care. Questions that may be most relevant from the staff and parent surveys are those related to school climate. These items are described in more detail below.

California School Climate staff survey (CSCS)

Acronym	**CSCS**
Reliability/Validity	You, Sukkyung, O'Malley, M., & Furlong, M. (Under review). *Brief California School Climate Survey: Dimensionality and measurement invariance across teachers and administrators*. Submitted to *Educational and Psychological Measurement.* You, Sukkyung, & Furlong, M. (nd) A psychometric evaluation of staff version of school climate survey. University of California, Santa Barbara (Abstracts for above refs located here: http://chks.wested.org/resources/hksc-surveyreader.pdf)
Example Questions	School climate • This school…(is a supportive and inviting place for students to learn, sets high standards for academic performance for all students, provides adequate counseling and support services for students, promotes trust and collegiality among staff, fosters an appreciation of student diversity and respect for each other, effectively handles student discipline and behavioral problems, is a safe place for students, is a safe place for staff; motivates students to learn, encourages parents to be active partners in educating their child,) • How many adults at this school ... (really care about every student, listen to what students have to say, treat every student with respect) • Do you feel that you need more professional development, training, mentorship or other support to do your job in any of the following areas? (positive behavioral support and classroom management, meeting the social, emotional, and developmental needs of youth (e.g., resilience promotion)) • How much of a problem AT THIS SCHOOL is ...(student alcohol and drug use, disruptive student behavior, student depression or other mental health problems, lack of respect of staff by students, cutting classes or being truant) • The following questions are ONLY for staff at this school who have responsibilities for services or instruction related to health, prevention, discipline, counseling and/or safety. This school ...(collaborates well with community organizations to help address substance use or other problems among youth, has sufficient resources to create a safe campus, provides effective confidential support and referral services for students needing help because of substance abuse, violence, or other problems, considers substance abuse prevention an important goal, emphasizes helping students with their social, emotional, and behavioral problems) • To what extent does this school …(foster youth development, resilience, or asset promotion, provide conflict resolution or behavior management instruction, provide harassment or bullying prevention, provide services for students with disabilities or other special needs)

Acronym	**CSCS** • The following items are for school personnel with responsibilities for teaching or providing related services to students with Individualized Education Programs (IEPs). (works to reduce interruptions to instruction for students with Individualized Education Programs (IEPs), provides a positive working environment for staff who serve students with IEPs, has a climate that encourages me to continue in my role of service to students with IEPs, provides adequate access to technology for staff who serve students with IEPs)
Availability and Cost	http://csps.wested.org/resources/CalSCHLS-infoandfees.pdf
Link to Instrument(s)	Staff survey: http://cscs.wested.org/resources/cscs-1213.pdf

California School Parent Survey (CSPS)

Acronym	**CSPS** School climate • This school…(promotes academic success for all students, treats all students with respect, gives all students opportunity to "make a difference" by helping other people, the school, or the community, clearly tells students in advance what will happen if they break school rules, provides adequate counseling and support services for students, is an inviting place for students to learn, has quality programs for my child's talents, gifts, or special needs, is a safe place for my child, keeps me well–informed about my child's progress in school, promptly responds to my phone calls, messages, or emails, encourages me to be an active partner with the school in educating my child • Based on your experience, how much of a problem at this school is …(student alcohol and drug use, harassment or bullying of students, physical fighting between students) • Please indicate how much you agree or disagree with the following statements about this school. (has a supportive learning environment for my child, has adults that really care about students)
Availability and Cost	http://csps.wested.org/resources/CalSCHLS-infoandfees.pdf
Link to Instrument(s)	Parent survey: http://csps.wested.org/resources/csps-1213.pdf

CalWORKs Welfare-to-Work Monthly Activity Report

Acronym	**CalWORKs**
Developer	California Department of Social Services (CDSS)
Description	The CalWORKs Welfare to Work (WTW) program is designed to assist welfare recipients to obtain or prepare for employment. Most WTW participants receive assistance in finding a job. Additional employment-related services are provided based on an individual's education and work history, including unpaid work experience/preparation, vocational training placements, and adult education or community college programs. The WTW program serves all 58 counties in the state and is operated locally by each county welfare department or its contractors. The units are all county welfare departments; there is no sampling among welfare departments. The data are reported monthly. Demographic information is not available.
Population	Adult; unclear if representative because methodology and reporting information is not available
Instrument Type	Administrative data

Availability (Years)	1999-2012
Latest Year	January 2012; pending additional data
Instrument Frequency	Monthly
Data Coverage	State, county (all 58)
Reliability/Validity	No information found
PEI Goal(s)	Improved mental health/decreased prolonged suffering; reduce unemployment
Example questions	• Improved mental health/decreased prolonged suffering Item 29 in data reports – Number of individuals from two-parent families enrolled in CalWORKs welfare-to-work program who were referred to a county mental health agency (form 25A) – Number of individuals from all other families enrolled in CalWORKs welfare-to-work program who were referred to a county mental health agency (form 25)

Website	http://www.dss.cahwnet.gov/research/PG292.htm (two-parent families) http://www.dss.cahwnet.gov/research/PG291.htm (all other families)
Source Reference	Not found
Other References	http://www.cdss.ca.gov/cdssweb/PG141.htm
Availability and Cost	Data are publicly available at no cost.
Link to Instrument(s)	http://www.dss.cahwnet.gov/research/res/pdf/blankforms/WTW25Av10_06.pdf (two-parent families) http://www.dss.cahwnet.gov/research/res/pdf/blankforms/WTW25v10_06.pdf (all other families)
Link to Data	http://www.dss.cahwnet.gov/research/PG292.htm (two-parent families) http://www.dss.cahwnet.gov/research/PG291.htm (all other families)

California Quality of Life Survey

Acronym	**CAL-QOL**
Developer	UCLA Bridging Research, Innovation, Training and Education (BRITE) Center
Description	Mental health follow-back study based on CHIS sample. The survey is attempting to collect population-based data from approximately 3,000 Californians in order to assess mental health morbidity, experiences with hate crimes and victimization, everyday experiences with discrimination, and levels of social support and involvement. In addition to identifying racial/ethnic diversity in the data set the center also oversampled the vulnerable population of sexual minorities to form the largest-to-date population-based survey on mental health issues in this population where there is a co-occurring heterosexual comparison group.
Population	Non-institutionalized adults (who responded to the CHIS telephone survey and were willing to be re-contacted for the follow-up survey)
Instrument Type	Survey (computer-assisted telephone survey)

Availability (Years)	Follow-backs on CHIS 2004, 2007, 2011
Latest Year	2007; 2011 is in the field now and will be completed by September 2012.
Instrument Frequency	Roughly every 4 years. Funding not yet lined up for a 4th wave, but likely.
Data Coverage	California. Can get county estimates only for the very largest counties. Oversampling used to get adequate numbers of sexual and racial/ethnic minorities; survey weights available to re-weight to California population.
Reliability/Validity	
PEI Goal(s)	Timely Access [Outcomes] Mental Health [Outcomes] Suicide [Outcomes] Stigma, Discrimination [Process, Outcomes]: questions aren't specific to mental health.
Example questions	Exact questions not available at this time. They aren't comfortable sharing the survey while still in the field. Timely Access [Outcomes] • Service utilization questions are part of Wave 2 and Wave 3. • Lots of questions about health insurance, perceived access to services, actual utilization. Some questions ask specifically about mental health or substance abuse services. • Includes questions about delays in accessing mental health or substance abuse services. Mental Health [Outcomes] • Composite International Diagnostic Interior–Short Form (CIDI-SF) (yields

Acronym	**CAL-QOL** probable DSM IV diagnoses) Suicide [Outcomes] • Suicide questions, Wave 2 and Wave 3 only. They have written some papers regarding suicide attempts among sexual minorities. Stigma and Discrimination [Process, Outcomes] • No questions asking about stigma or discrimination due to mental health condition. • General questions about stigma, and whether discrimination affected seeking/receipt of mental health care, but the stigma/discrimination asked about are related to sexual orientation or race/ethnicity. In Waves 2 & 3 African Americans are oversampled and complete a special discrimination module (in addition to the other discrimination questions in the survey). • Dr. Mays suggested that a back-door approach is possible, in which we could examine whether people with a probable mental health diagnosis reported more stigma/discrimination, but that's the best that could be done with the questions. (Seems that there could be a reverse causality problem with this, with people who are subjected to more discrimination being more likely to experience mental distress.)
Website	https://www.calqol.org http://www.britecenter.org/current-projects/ca-quality-of-life-survey/
Source Reference	
Other References	
Availability and Cost	Open to collaboration; costs would be any administrative and analyst time needed to analyze data or export a limited data set.
Link to Instrument(s)	Full instrument not online. Topics covered listed here: https://www.calqol.org/docs/CalQOL_Questionnaire_Topics_Table_120211.pdf
Link to Data	
Contact Information	Vickie Mays, UCLA professor, maysv@nicco.sscnet.ucla.edu, 310-206-5159
Administration/Scoring	

Client and Services Information System

Acronym	**CSI**
Developer	California Department of Mental Health
Description	The Department of Mental Health's (DMH's) Client and Services Information (CSI) System is the central repository for data pertaining to individuals who are the recipients of mental health services provided at the county level. The data is processed and stored on a secure server at the DMH Headquarters. The 58 county mental health plans (MHPs) are required to send a CSI submission file to DMH monthly. The CSI system includes Client, Service, and Periodic client records. • Client records are uniquely identified by the CLIENT KEY, which is composed of the Submitting County Code and the County Client Number (CCN). • Service records are uniquely identified by the combination of the CLIENT KEY and a Record Reference Number (RRN), which must be unique and must remain the same over time. • Periodic records are uniquely identified by the combination of the CLIENT KEY and the Date Completed. Reasons for counties to fall behind in data reporting include: • Rollout of new or modified vendor reporting systems • Testing required to pass basic data quality intake edits, often necessitated by changes to county or state • Reporting systems • Incomplete county provider and/or case manager reporting • Low priority within county • County staff limitations CSI Strengths: • Most complete report of California county mental health services • Allows DMH to respond to federal reporting requirements • Source of client demographic information • Provides data for academic research and analyses
Population	Adult and child. The CSI system includes both Medi-Cal and non-Medi-Cal recipients of mental health services provided by County/City/Mental Health Plan program providers. Mental Health Program providers include legal entities that are reported to the County Cost Report under the category Treatment Program, and individual and group practitioners, most of which were formerly included in the Medi-Cal "Fee-for-Service" system.
Instrument Type	Administrative

Availability (Years)	1998-present. Some fields changed in 2006. Not clear what happens when CA DMH goes away. Presumably these data will still be submitted, possibly to the division of Department of Health Care Services (DHCS) that takes responsibility for some of DMH's former scope.

Acronym	**CSI**
Latest Year	Some counties fall substantially behind in their reporting, by as much as 25 months: http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/County/CSI_County Status_Chart_Aug%202011.pdf For national comparisons, the most recent URS tables available on the SAMHSA website are from 2010.
Instrument Frequency	Data collected by counties on an ongoing basis and submitted to California DMH monthly.
Data Coverage	State, county
Reliability/Validity	
PEI Goal(s)	Referrals [Outcome], possibly Timely access [Outcome], possibly Mental health [Process]: appears that it's possible to identify which clients were receiving PEI services. Homelessness [Outcome], among county clients only Unemployment [Outcome], among county clients only
Example questions	Record Control Data Elements (Reported on every record) • H-01.0 County/City/Mental Health Plan Submitting Record (Submitting County Code) • H-02.0 County Client Number (CCN) • H-03.0 Record Type • H-04.0 Transaction Code Client Data Elements (Reported once but corrected as needed) • C-01.0 Birth Name • C-02.0 Mother's First Name • C-03.0 Date of Birth • C-04.0 Place of Birth • C-05.0 Gender • C-07.0 Primary Language • C-08.0 Preferred Language • C-09.0 Ethnicity • C-10.0 Race • C-11.0 Data Infrastructure Grant Indicator Periodic Data Elements (Reported at admission, annually, and at formal discharge) • P-01.0 Date Completed • P-02.0 Education • P-03.0 Employment Status • P-08.0 Conservatorship / Court Status • P-09.0 Living Arrangement

Acronym	**CSI** • P-10.0 Caregiver Service/Encounter Data Elements (Reported for each contact/service) Service Records: • S-01.0 Record Reference Number (RRN) • S-02.0 Current Legal Name / Beneficiary Name • S-03.0 Social Security Number • S-05.0 Mode of Service • S-06.0 Service Function • S-07.0 Units of Service • S-08.0 Units of Time • S-12.0 Special Population • S-13.0 Provider Number • S-14.0 County/City/Mental Health Plan with Fiscal Responsibility for Client • S-25.0 Evidence-Based Practices / Service Strategies • S-26.0 Trauma • S-27.0 Client Index Number (CIN) • S-28.0 Axis I Diagnosis • S-29.0 Axis I Primary • S-30.0 Additional Axis I Diagnosis • S-31.0 Axis II Diagnosis • S-32.0 Axis II Primary • S-33.0 Additional Axis II Diagnosis • S-34.0 General Medical Condition Summary Code • S-35.0 General Medical Condition Diagnosis • S-36.0 Axis V / Global Assessment of Functioning (GAF) Rating • S-37.0 Substance Abuse / Dependence • S-38.0 Substance Abuse / Dependence Diagnosis • S-39.0 District of Residence 24-Hour Mode of Service • S-15.0 Admission Date • S-16.0 From/Entry Date • S-17.0 Through/Exit Date • S-18.0 Discharge Date • S-19.0 Patient Status Code Hospital, PHF, and SNF • S-20.0 Legal Class - Admission • S-21.0 Legal Class - Discharge • S-22.0 Admission Necessity Code

Acronym	**CSI** Non-24-Hour Mode of Service • S-23.0 Date of Service • S-24.0 Place of Service

Website	http://www.dmh.ca.gov/Statistics_and_Data_Analysis/CSI.asp
Source Reference	
Other References	
Availability and Cost	Available; no cost anticipated. Was used by the Petris Center for its MHSA evaluation, as a source of individual client diagnosis.
Link to Instrument(s)	http://www.dmh.ca.gov/Statistics_and_Data_Analysis/docs/Cnty_MH-CSI-Rpts/CSI_DataElements2.pdf
Link to Data	CA DMH reports data to SAMHSA's Center for Mental Health Services (CMHS) via the Uniform Reporting System (URS). URS reports, for California and other states, can be viewed here: http://www.samhsa.gov/dataoutcomes/urs/ Some minor reports covering 2003-04, 2006-07, and 2007-08 can be viewed here: http://www.dmh.ca.gov/Statistics_and_Data_Analysis/RetentionPenetrationData.asp
Contact Information	For questions regarding County Mental Health Programs Reports and Statistical Information, please call (916) 653-6257, or email POQI.Support@dmh.ca.gov.
Administration/Scoring	

Common Core of Data

Acronym	**CCD**
Developer	U.S. Department of Education's National Center for Education Statistics
Description	The Common Core of Data (CCD) is a program of the U.S. Department of Education's National Center for Education Statistics that annually collects fiscal and non-fiscal data about all public schools, public school districts and state education agencies in the United States. The data are supplied by state education agency officials and include information that describes schools and school districts, including name, address, and phone number; descriptive information about students and staff, including demographics; and fiscal data, including revenues and current expenditures.
Population	Information is collected annually from approximately 100,000 public elementary and secondary schools and approximately 18,000 public school districts (including supervisory unions and regional education service agencies) in the 50 states, the District of Columbia, Department of Defense Schools, and the outlying areas. *Approximately 927 public schools in California included in the most recent year.*
Instrument Type	CCD is made up of a set of five surveys sent to state education departments. The data are obtained from administrative records maintained by the state education agencies (SEAs). The SEAs compile CCD requested data into prescribed formats and transmit the information to NCES.

Availability (Years)	1993 to 2009
Latest Year	2009 - 2010
Instrument Frequency	Annual
Data Coverage	Covers public elementary and secondary education nationally
Reliability/Validity	Not available
PEI Goal(s)	School failure and dropout; Mental health workforce
Example questions	Tables available can be sorted by ethnicity and gender 1. Public School Graduates and Dropouts 2. Averaged Freshman Graduation Rates 3. Number of Children in Special Education

Website	http://nces.ed.gov/ccd/index.asp
Source Reference	
Other References	
Availability and Cost	The data files on school failure and drop out are restricted use requiring a separate application. No indication of costs given
Link to Instrument(s)	N/A
Link to Data	http://nces.ed.gov/ccd/elsi/ ; http://nces.ed.gov/ccd/ccddata.asp State-level dropout data
Contact Information	California State non-fiscal data coordinator Karl Scheff: kscheff@cde.ca.gov, 916-327-0192

Acronym Administration/Scoring	**CCD**

Notes	• The restricted-use data file contains data on dropouts and high school completers at the local education agency (LEA) or school district level. The state level data are available publicly in aggregated as from 2005-06. The school dropout rates reported are the ***event dropout rate*** and the *average freshman graduation rate*. *Event dropout rate* estimates the percentage of high school students who left high school between the beginning of one school year and the beginning of the next without earning a high school diploma or its equivalent (e.g., a GED). ***Averaged freshman graduation rate*** estimates the proportion of public high school freshmen who graduate with a regular diploma 4 years after starting 9th grade. The rate focuses on public high school students as opposed to all high school students or the general population and is designed to provide an estimate of on-time graduation from high school. • Also contains information on size of school district and number of special education students. Relevant category under special education is "Individualized Education Program Students" as defined by the Individuals with Disabilities Education Act (IDEA) act. Available by selecting enrollment at the district level in the data tool.

Data Collection and Reporting System

Acronym	**DCR**
Developer	California Department of Mental Health
Description	The DCR is the system used for reporting outcomes for clients enrolled in Full Service Partnership (FSP) programs. It is the repository for data from the forms completed by FSP staff about their FSP clients. Some counties (e.g., Los Angeles County) are too large or for whatever other reason unable to submit their data via the DCR. They collect the same data but submit the data differently. LA County enters their data into the OMA. http://www.dmh.ca.gov/POQI/MHSA_Training.asp
Population	Individuals enrolled in FSP programs: older adults (60+), adults (26-59), transitional-aged youth (16-25), children (0-15)
Instrument Type	Administrative/forms filled out about FSP clients
Availability (Years) Latest Year	Ongoing collection since start of FSP programs.
Instrument Frequency	The Partnership Assessment Form (PAF), completed when the partnership is established, captures history and baseline data. The Key Event Tracking (KET) is completed when a change occurs in key areas. The Quarterly Assessment (3M) is completed every three months.
Data Coverage	State, County
Reliability/Validity	
PEI Goal(s)	Does not seem applicable since collected only on FSP clients.
Example questions	The following domains are collected for each assessment type: Partnership Assessment Form (PAF) • Administrative Information • Residential (includes hospitalization & incarceration) • Education • Employment • Sources of Financial Support • Legal Issues / Designations • Emergency Intervention • Health Status • Substance Abuse • Activities of Daily Living / Instrumental Activities of Daily Living (ADL / IADL) – Older Adults Only Key Event Tracking (KET) • Administrative Information • Residential (includes hospitalization & incarceration) • Education

Acronym	**DCR** • Employment • Legal Issues / Designations • Emergency Intervention Quarterly Assessment (3M) • Administrative Information • Education • Sources of Financial Support • Legal Issues / Designations • Health Status • Substance Abuse • ADL / IADL – Older Adults Only

Website	http://www.dmh.ca.gov/POQI/
Source Reference	
Other References	
Availability and Cost	Available; no cost anticipated. Was used by the Petris Center for its MHSA evaluation, as a source of information on which clients were enrolled in FSPs.
Link to Instrument(s)	http://www.dmh.ca.gov/POQI/Full_Service_Forms.asp
Link to Data	
Contact Information	Address: California Department of Mental Health Attn: Performance Outcomes and Quality Improvement 1600 9th Street, Room 130 Sacramento, CA 95814 **Unit Email:** POQI.Support@dmh.ca.gov (accessible by all POQI staff) **Fax:** (916) 653-5500
Administration/Scoring	

Notes	These data are only collected for clients enrolled in FSP programs. It seems unlikely that they would be relevant to a PEI evaluation.

Data Quest

Acronym	**DQ**
Developer	California Department of Education
Description	DataQuest is a system that provides reports on California's schools and school districts. It is a database of school performance reports. The database includes information on school performance indicators, student and staff demographics, expulsion, suspension, and truancy information and a variety of test results so as to easily compare schools, districts and counties.
Population	School aged children and adolescents
Instrument Type	Administrative data, surveys

Availability (Years)	Depends on indicator; ranges from 1992-2011
Latest Year	2011
Instrument Frequency	Reporting schedule depends on indicator; For example, Academic Performance Index (API) is released in March.
Data Coverage	State, county, district, school, Special Education Local Planning Areas (SELPA) and others such as school level (elementary, high school, charter etc.)
Reliability/Validity	N/A
PEI Goal(s)	Mental Health School expulsion and dropout Access Special Education
Example questions	• Absenteeism and truancy rates – -Overall rates available but cannot identify cause of absence. Not specific to the Special Education population – -Can also use the Resilience module question "in the past 30 days, did you miss school (because you)… felt very sad, hopeless, stressed, or angry?" • Number of expulsions and number of violence and drug related expulsions • Number of suspensions and number of violence and drug related suspensions • Number of special education students and number graduating

Website	http://dq.cde.ca.gov/dataquest/
Source Reference	
Other References	http://dq.cde.ca.gov/dataquest/whatsindq.asp
Availability and Cost	Data are publicly available at no cost.
Link to Instrument(s)	N/A
Link to Data	http://dq.cde.ca.gov/dataquest/

Acronym	**DQ**
Contact Information	dataquest@cde.ca.gov; (916) 319-0947 or (916) 327-0193
Administration/Scoring	

Notes	• Data can be broken down by gender and ethnic designation • Data can be pull per academic year from 1994 onwards, depending on availability of individual performance reports

Health Professional Shortage Area

Acronym	**HPSA**
Developer	Health Resources and Services Administration (HRSA), a division of the U.S. Department of Health and Human Services
Description	The purpose of a Health Professional Shortage Area (HPSA) is to identify areas of greater need for health care services in order to direct limited health care professional resources to people in those areas. It has been implemented since 1980 and is updated daily. The units are sampled based on individual application for designation or withdrawal as an HPSA. The HPSA designation process includes (1) urban and rural geographic areas with shortages of health professionals, (2) population groups with such shortages, and (3) facilities with such shortages. These three entities can apply for designation or withdrawal as an HPSA. HPSA is distinct from Medically Underserved Areas and Populations (MUA/P), which are also covered here.
Population	Adult, juvenile; representative
Instrument Type	Administrative data

Availability (Years)	1980 – present
Latest Year	Current date; pending additional data
Instrument Frequency	Daily
Data Coverage	National, state, county (all 58)
Reliability/Validity	No information found
PEI Goal(s)	Timely access
Example questions	Criteria for Determining Mental Health HPSAs of Greatest Shortage: • Score for population-to-full-time-equivalent provider ratio • Score for percent of population with incomes below poverty level • Score for travel distance/time to nearest source of accessible care outside the HPSA • Scores for Additional Factors – Youth Ratio: Ratio of Children under 18 to Adults 18-64 – Elderly Ratio: Ratio of Adults over 65 to Adults 18-64 – Substance Abuse prevalence: Area's rate is in worst quartile for nation/region/ state – Alcohol Abuse prevalence: Area's rate is in worst quartile for nation/region/or state

Website	http://bhpr.hrsa.gov/shortage/
Source Reference	Not found
Other References	http://www.gpo.gov/fdsys/pkg/FR-2011-11-03/pdf/2011-28318.pdf
Availability and Cost	Data are publicly available at no cost. HPSA can be downloaded, while both HPSA and MUA/P can be queried online.
Link to Instrument(s)	http://edocket.access.gpo.gov/2003/03-13478.htm (HPSA) http://bhpr.hrsa.gov/shortage/muaps/index.html (MUA/P)

Acronym	**HPSA**
Link to Data	http://datawarehouse.hrsa.gov/HPSADownload.aspx (HPSA download) http://hpsafind.hrsa.gov/ (HPSA online querying tool; using Advanced Search, the "Last Updated" option can be selected to show the date an area received its HPSA or was last updated) http://ersrs.hrsa.gov/ReportServer?/HGDW_Reports/BCD_HPSA/BCD_HPSA_SCR50_Smry&rs:Format=HTML3.2 (HPSA online querying tool) http://datawarehouse.hrsa.gov/customizereports.aspx (HPSA online querying tool) http://muafind.hrsa.gov/ (MUA/P online querying tool)
Contact Information	Andy Jordan: (301) 594-0816 Office of Shortage Designation, Bureau of Health Professions, Health Resources and Services Administration sdb@hrsa.gov; (888) 275-4772, press option 1, then option 2
Administration/Scoring	

Notes	The following groups automatically receive HPSA designation: (1) all Indian tribes that meet the definition of such Tribes in the Indian Health Care Improvement Act of 1976; (2) all federally qualified health centers; and (3) rural health clinics that offer services regardless of ability to pay.

Housing Inventory Count

Acronym	**HIC**
Developer	U.S. Department of Housing and Urban Development
Description	The HIC is a snapshot of a Continuum of Care's (CoC's) housing inventory on a single night during the last ten days in January (same night as the PIT). It should reflect the number of beds and units available on the night designated for the count that are dedicated to serve persons who are homeless. Beds and units included on the HIC are considered part of the CoC homeless system. CoCs are required to include in the HIC all programs in the CoC that are categorized as one of these program types, not just those contributing client-level data in the local Homeless Management Information System (HMIS) or receiving HUD funding. This includes programs funded by the VA, faith-based organizations, and other public and private funding sources. The five program types included in the HIC are: • Emergency Shelter • Transitional Housing • HPRP (Rapid Re-housing) • Safe Haven • Permanent Supportive Housing Every CoC must report the level of unmet need for homeless assistance that exists in its community. To complete the unmet-need estimates, the CoC needs to know the total number of existing emergency shelter, transitional housing, and Safe Haven beds, as well as the number of emergency shelter, transitional housing, and Safe Haven beds that are under development. In addition, the CoC should determine the number of vacant permanent supportive housing beds on the night of the HIC. More guidance on using this information to determine the CoC's unmet need can be found in a separate document on the HUD Homelessness Resource Exchange (HRE) website.
Population	Housing inventory that is available to serve those identified through the PIT.
Instrument Type	Administrative data

Availability (Years)	2005-2011
Latest Year	2011 (2012 counts should be completed but data are not online)
Instrument Frequency	Annual
Data Coverage	National, by state, and by CoC (county or aggregate of smaller counties)
Reliability/Validity	
PEI Goal(s)	Homelessness [Structure] – but we can only see beds by facility, not by subpopulation, so to tease out which facilities serve people w/ SMI or substance abuse would be very challenging.
Example questions	**Completing the Bed Inventory**

Acronym	**HIC** The following sections identify the data elements needed to complete the HIC, along with a brief description. If relevant, the data element number from the March 2010 HMIS Data Standards is included in brackets, e.g. Program Name [2.4]. Note that while not all of these data elements apply to every program or are entered in the HIC for each program, they are all needed in order to generate an accurate HIC. Organization and Program Information • Organization Name [2.2]: Identify the name of the organization providing shelter or housing to homeless persons. • Program Name [2.4]: Identify the name of the specific program. Only programs that have beds available and/or under development on the night of the count should be included on the HIC. Note that for programs that are funded by VA – even partially – the program name MUST begin with the appropriate prefix (see Appendix A). • Program Type [2.8]: Identify one of the five relevant program types described above (e.g., Emergency Shelter, Transitional Housing). • Target Population A [2.10] (optional): Identify the target population served by each program. A population is considered a "target population" if the program is designed to serve that population and at least three-fourths (75%) of the clients served by the program fit the target group descriptor. Note that a single program may not have more than one Target Population A. Programs that do not target specific populations or that have opted not to track Target Population A may leave this data field blank. The following list details Target Population A categories and their descriptions: [Single Males / Single Females / Single Males and Females / Couples Only, No Children / Households with Children / Single Males and Households with Children / Single Females and Households with Children / Single Males and Females plus Households with Children / Unaccompanied Males under 18 years old / Unaccompanied Females under 18 years old / Unaccompanied Males and Females under 18 years old] • Target Population B [2.11]: Identify the subpopulation served by each program. A population is considered a "target population" if the program is designed to serve that population and at least three-fourths (75%) of the clients served by the program fit the target group descriptor. Note that a single program may not have more than one Target Population B. Programs that do not target specific subpopulations may leave the Target Population B column blank. [Domestic violence victims / Veterans / Persons with HIV/AIDS] • Geocode [2.6C]: Identify the geocode associated with the geographic location of the principal program service site. Geocodes must be

Acronym	**HIC**

updated annually. Scattered-site housing programs should record the Geocode where the majority of beds are located or where most beds are located as of the inventory update. A list of geocodes can be found: http://www.hudhre.info/documents/FY2011_PPRNAmts.pdf.

- HUD McKinney-Vento Funded?: Identify whether or not the program receives any HUD McKinney-Vento funding. HUD McKinney-Vento programs include: Emergency Shelter Grant (ESG), Shelter plus Care (S+C), Section 8 Moderate Rehabilitation Single-Room Occupancy (SRO), Supportive Housing Program (SHP). HPRP programs are not funded under the McKinney-Vento Act. Note that there was no data element defined for this in the March 2010 HMIS Data Standards; relevant information may need to be tracked outside of HMIS.

Bed and Unit Inventory Information

- Inventory Type: Determine if the bed inventory is current (C), new (N), or under development (U).
- Household Type [2.9A]: Identify the number of beds and units available for each of the following household types: [Households without children / Households with at least one adult and one child / Households with only children]
- Bed Type [2.9B] (Emergency Shelter and Transitional Housing only): The Bed Type describes the type of program beds based on whether beds are: located in a residential homeless assistance program facility (including cots or mats); provided through a voucher with a hotel or motel; other types of beds. Although the HMIS Data Standards specify that these data are to be collected for all program types, reporting them on the HIC was previously limited to emergency shelter programs. For 2012, this data will also be reported for transitional housing programs in order to distinguish between beds (and units) that a client must vacate when he or she exits the program and beds (and units) that a client may continue to occupy after program exit (e.g., conventional rental housing leased by the client). The latter type is often referred to as “transition-in-place.” Identify the bed type as follows: [Facility-based / Voucher (beds in a hotel or motel and made available through vouchers) / Other (beds in a church or facility not dedicated for use by people who are homeless; N/A to transitional housing programs)]
- Bed and Unit Availability [2.9C]: Identify the number of beds and units that are available on a planned basis year-round, seasonally (during a defined period of high demand), or on an ad hoc or temporary basis as demand indicates.
- Bed Inventory [2.9D]: The total number of beds available for

Acronym	**HIC**

occupancy on the night of the count.

- Chronically Homeless Beds [2.9E] (Permanent Supportive Housing Only): Identify the number of permanent supportive housing beds that are readily available and targeted to house chronically homeless persons. The number of beds for chronically homeless persons is a subset of the total permanent supportive housing bed inventory for a given program and must be equal to or less than the total bed inventory.
- Unit Inventory [2.9F]: Identify the total number of units available for occupancy as of the inventory start date.
- Inventory Start Date [2.9G]: The inventory start date is the date when the bed and unit inventory information first applies. This may represent the date when a change in household type, bed type, availability, bed inventory or unit inventory occurs for a given program. For seasonal beds, this reflects the start date of the seasonal bed inventory.
- Inventory End Date [2.9H]: The inventory end date is the date when the bed and unit inventory information as recorded is no longer applicable (i.e., the day after the last night when the record is applicable). This may be due to a change in household type, bed type, availability, bed inventory or unit inventory. For seasonal beds, this should reflect the projected end date for the seasonal bed inventory.

Website	http://sandbox.hudhdx.info/
Source Reference	
Other References	
Availability and Cost	Reports available freely on the web: nationally, by state, and by CoC: http://www.hudhre.info/index.cfm?do=viewHomelessRpts

- Select a year (2005-2011), then select “Housing Inventory.”
- Select scope: national; state; or Continuum of Care (CoC).
- If CoC, can select California, and then choose from a list of CoCs. There are 42 CoCs in CA; some are single counties (e.g., LA City + County is a single CoC) and others combine a few small counties.

Data truly just have number of beds of different types (family units / family beds / individual beds / total year-round beds / seasonal beds / overflow or voucher beds). If CoC level, those data are by facility; if state level, they are summarized within each CoC, aggregated within housing type (Emergency Shelter / Safe Haven / Transitional / HPRP-Rapid Rehousing / Permanent Supportive Housing); if national, they are summarized within each state, aggregated as above.

Acronym	**HIC**
	No data on which beds are available specifically to people w/ SMI, etc. To figure that out we would have to look up each facility. Some jump out from the list, e.g., Lamp Community, but this would not be an easy task.
Link to Instrument(s)	http://hudhre.info/documents/2012HICandPITGuidance.pdf
Link to Data	http://www.hudhre.info/index.cfm?do=viewHomelessRpts
Contact Information	Contacts by CoC: http://www.hudhre.info/index.cfm?do=viewCocContacts
Administration/Scoring	

Involuntary Detention Reports

Acronym	**IDR**
Developer	California Department of Mental Health (DMH)
Description	As required by the Welfare and Institutions Code Section 5402, the California DMH collects quarterly data from each county mental health program or facility on the number of involuntary detentions, the number of temporary and permanent conservatorships established, and the number of persons served while in detention in a jail. The data are reported annually. The units are all jails in the state of California; there is no sampling among jails. Demographic information is not available.
Population	Adult (18+), juvenile (under 18); non-representative
Instrument Type	Administrative data

Availability (Years)	2005-06 – 2008-09
Latest Year	2008-09; pending additional data
Instrument Frequency	Annual
Data Coverage	State, county (all 58, but Sutter and Yuba are reported together)
Reliability/Validity	No information found
PEI Goal(s)	Incarceration
Example questions	Incarceration • Table 8 in data reports – Number of transfers from jails for admission to local inpatient facilities pursuant to PC 4011.6 or 4011.8 (both involuntary and voluntary) – Number of admissions to a Lanterman-Petris-Short (LPS) approved inpatient treatment program within a jail (both involuntary and voluntary) – Sum of quarterly counts of persons receiving outpatients services provided in a jail facility

Website	http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Involuntary_Detention.asp
Source Reference	Not found
Other References	
Availability and Cost	Data are publicly available at no cost.
Link to Instrument(s)	http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Involuntary_Detention.asp
Link to Data	http://www.dmh.ca.gov/Statistics_and_Data_Analysis/Involuntary_Detention.asp
Contact Information	Bryan Fisher: bryan.fisher@dmh.ca.gov; (916) 653-5493
Administration/Scoring	

Notes	• Table 8 is data for inmates residing in jails for any length of time, not

Acronym	**IDR**

just 72-hour detentions; this data cannot distinguish 72-hour detentions from the rest of jail inmates. Thus, Table 8 stands alone from the rest of the report.

- "Number of transfers from jails for admission to local inpatient facilities pursuant to PC 4011.6 or 4011.8" and "Number of admissions to an LPS approved inpatient treatment program within a jail" are both duplicated counts of admissions.
- "Sum of quarterly counts of persons receiving outpatients services provided in a jail facility" is an unduplicated count of persons.
- According to Bryan Fisher, the data that comprise Table 8 are largely unreliable because reporting is poor and jails make individual decisions about when to refer inmates to inpatient facilities both within and outside of jails.

Jail Profile Survey

Acronym	**JPS**
Developer	Corrections Standards Authority (CSA), a division of the California Department of Correction and Rehabilitation (CDCR)
Description	The JPS is an ongoing statewide survey in all 58 counties of approximately 135 type II, III, and IV jails (defined in notes). All type II, III, and IV jails in the state of California are included in the survey; there is no sampling among jails. The JPS has been implemented since 1995. It tracks basic jail-system information, such as the average daily jail population, and also gathers information required to monitor issues such as jail crowding, early releases, and increasing numbers of juvenile adjudicated as adults. Information on gender is available in some measures (but none of the mental health measures); no other demographic information is available.
Population	Adults (18+, but also includes variables for under 18); theoretically representative, although mental health data may be inaccurate (see notes)
Instrument Type	Administrative data

Availability (Years)	1995 – 2011
Latest Year	3rd quarter 2011; pending additional data
Instrument Frequency	Monthly or quarterly, depending on the variable
Data Coverage	State, county (all 58)
Reliability/Validity	No information found
PEI Goal(s)	Incarceration (adult)
Example questions	Mental health cases opened last day of the month; new mental health cases opened during this month; inmates, last day of the month, receiving psych medication; inmates assigned to mental health beds last day of month; money spent on psych medication during previous quarter. Note on open mental health cases: An open mental health case is defined as an open mental health "chart" or "file." A mental health "case" is the record of mental health services provided when an inmate is in need of and actively receiving mental health care. The JPS is not concerned with initial mental health screening upon intake—this should not count as an "open mental health case." If, however, after an initial mental health screening, a mental health case is opened, this could become an open mental health case. Both Peg Symonik and Ron Bertrand (contacts at CSA) confirmed that once a mental health case is opened for an inmate, it is unlikely to be closed until that inmate is discharged, making "mental health cases opened last day of the month" and "new mental health cases opened during this month" unduplicated variables. Note on mental health beds: A mental health bed is defined as a dedicated bed

Acronym	**JPS** where inmates who are in need of mental health care are admitted. There are two types of mental health beds for purposes of the JPS: (1) in-patient beds, which can also be considered a hospital bed where inmates are actually admitted and acute levels of mental health care are given and (2) mental health classification beds, which are found in facilities that may not have in-patient mental health units, but may house those inmates who require mental health treatment separately from the general population. Additionally, facilities with a "jail ward" in a mental health hospital where uniformed department staff run the unit may also be considered mental health beds.
Website	http://www.bdcorr.ca.gov/fsod/jail%20profile%20summary/jail_profile_survey.htm
Source Reference	Not found
Other References	
Availability and Cost	The data can be publicly queried through an online querying page.
Link to Instrument(s)	2008 instrument available on the SharePoint site
Link to Data	http://www.bdcorr.ca.gov/joq/jps/QuerySelection.asp
Contact Information	Peg Symonik: Peg.Symonik@cdcr.ca.gov; (916) 323-9704 Knowledgeable about survey basics Ron Bertrand: Ron.Bertrand@cdcr.ca.gov; (916) 445-1322 Knowledgeable about mental health variables
Administration/Scoring	
Notes	Ron Bertrand expressed concern about the reliability and validity of variables involving mental health cases. According to him, jails make individual decisions about what to label a mental health case. In addition, mental health cases are more reflective of available resources than need for mental health attention: Some halls and camps are reluctant to open them because they lack resources, while others open them on virtually all inmates because they have numerous resources. Finally, a large shift in the number of open mental health cases from one month to the next is likely indicative of some shock to the system (e.g., a psychiatrist was fired) rather than a true change in mental health needs among inmates. Ron also said that some jails do not have mental health beds, so when an inmate requires a mental health bed they put him or her in a regular bed and report it as a mental health bed. Thus, "inmates assigned to mental health beds last day of month" is not an accurate representation of capacity, but it is an accurate representation of inmates who require mental health attention in a bed. According to Ron, "inmates, last day of the month, receiving psych medication"

Acronym	**JPS** may be a better measure because it is more concrete, although it is unclear if the number of mental health cases requiring psych medication is a constant proportion of total mental health cases over time. Definitions of facility types: Type I (NOT included in this survey): a local detention facility used for the detention of persons not more than 96 hours excluding holidays after booking. Such a Type I facility may also detain persons on court order either for their own safekeeping or sentenced in a city jail as an inmate worker, and may house inmate workers sentenced to the county jail provided such placement in the facility is made on a voluntary basis on the part of the inmate. Type II: a local detention facility used for the detention of persons pending arraignment, during trial, and upon a sentence of commitment. Type III: a local detention facility used for the detention of convicted and sentenced persons. Type IV: a local detention facility or portion thereof designated for the housing of inmates eligible under Penal Code Section 1208 for work/education furlough and/or other programs involving inmate access into the community.

Juvenile Detention Profile Survey

Acronym	**JDPS**
Developer	Corrections Standards Authority (CSA), a division of the California Department of Corrections and Rehabilitation (CDCR)
Description	The JDPS is an ongoing statewide survey in 51-54 counties of approximately 125 juvenile halls and camps as well as juveniles on home supervision (with and without monitoring) and juveniles in alternative confinement programs. In order to qualify for the latter two categories, juveniles must be sentenced to 30 days of home supervision with custody credit. All juvenile halls and camps in the state of California, as well as juveniles on home supervision and in alternative confinement programs, are included in the survey; there is no sampling among any of these groups. The JDPS has been implemented since 1999. The survey tracks variables such as average daily population, average length of stay, and number of early releases in juvenile detention facilities. It also gathers data on the characteristics of detained juveniles that are critical in making decisions about what programs to provide and where to allocate resources. Information on gender is available in some measures (but none of the mental health measures); no other demographic information is available.
Population	Juveniles (under 18, but also includes variables for 18+); theoretically representative, although mental health data may be inaccurate (see notes)
Instrument Type	Administrative data

Availability (Years)	1999 – 2011
Latest Year	3rd quarter 2011; data from 1st quarter 2010 and later have not been made publicly available yet but are available through CSA; pending additional data
Instrument Frequency	Monthly or quarterly, depending on the variable
Data Coverage	State, county (between 51 and 54, depending on the year and quarter)
Reliability/Validity	No information found
PEI Goal(s)	Incarceration (juvenile)
Example questions	Number of open mental health cases on this day; number of juveniles receiving psychotropic medications this day; hospitalized outside detention facility for mental health care; suicide attempts; suicides. Note on open mental health cases: The Jail Profile Survey (JPS), which uses similar methodology, defines an open mental health case as an open mental health “chart” or “file.” A mental health “case” is the record of mental health services provided when an inmate is in need of and actively receiving mental health care. The JPS is not concerned with initial mental health screening upon intake—this should not count as an “open mental health case.” If, however, after an initial mental health screening, a mental health case is opened, this could become an open mental health case.

Acronym	**JDPS** Both Peg Symonik and Toni Gardner (contacts at CSA) confirmed that once a mental health case is opened for an inmate, it is unlikely to be closed until that inmate is discharged, making "number of open mental health cases on this day" an unduplicated measure.
Website	http://www.bdcorr.ca.gov/fsod/juvenile_detention_survey/juvenile%20detention%20survey.htm
Source Reference	Not found
Other References	
Availability and Cost	The data can be publicly queried through an online querying page.
Link to Instrument(s)	2010 instrument available on the SharePoint site
Link to Data	http://www.bdcorr.ca.gov/joq/jds/QuerySelection.asp
Contact Information	Peg Symonik: Peg.Symonik@cdcr.ca.gov; (916) 323-9704 Knowledgeable about survey basics Toni Gardner: Toni.Gardner@cdcr.ca.gov; (916) 322-1638 Knowledgeable about mental health variables
Administration/Scoring	
Notes	Toni Gardner expressed concern about the reliability and validity of variables involving mental health cases. According to her, halls and camps make individual decisions about what to label a mental health case. In addition, mental health cases are more reflective of available resources than need for mental health attention: Some halls and camps are reluctant to open them because they lack resources, while others open them on virtually all inmates because they have numerous resources. Finally, a large shift in the number of open mental health cases from one month to the next is likely indicative of some shock to the system (e.g., a psychiatrist was fired) rather than a true change in mental health needs among inmates. According to Toni, "number of juveniles receiving psychotropic medications this day" may be a better measure because it is more concrete, although it is unclear if the number of mental health cases requiring psych medication is a constant proportion of total mental health cases over time.

National Ambulatory Medical Care Survey

Acronym	**NAMCS**
Developer	Centers for Disease Control and Prevention
Description	The National Ambulatory Medical Care Survey (NAMCS) is a national survey of physicians designed to obtain information about the provision and use of ambulatory medical care services in the United States. Findings are based on a sample of visits to non–federally employed office-based physicians who are primarily engaged in direct patient care. Each physician is randomly assigned to a 1-week reporting period. During this period, data for a systematic random sample of patient visits are recorded by the physician or office staff on a Patient encounter form. Data are obtained on patients' symptoms, physicians' diagnoses, and medications ordered or provided. The survey also provides statistics on the demographic characteristics of patients and services provided, including information on diagnostic procedures, patient management, and planned future treatment.
Population	Patients (all ages) (non-representative)
Instrument Type	Survey/data extraction

Availability (Years)	1973-2011
Latest Year	2011 (additional data pending)
Instrument Frequency	Annual
Data Coverage	Region (Northeast, Midwest, South, and West); Metropolitan/Non-Metro
Reliability/Validity	http://www.cdc.gov/nchs/ahcd/ahcd_estimation_reliability.htm
PEI Goal(s)	Mental Health Suicide Referrals Other
Example questions	Mental Health • Patient's age, gender, race, ethnicity (Patient Form, 2011) • As specifically as possible, list diagnoses related to this visit including chronic conditions; does the patient now have…depression; Screening services for depression provided; Psychotherapy provided; Other mental health counseling provided; medications that are new/continued including Px and OTC; who the provider was; time spent with provider (Patient Form, 2011) Suicide • Is this visit related to any of the following (intentional injury/poisoning)? (Patient Form, 2011) Referrals • Visit disposition (refer to other physician, return at a specified time, refer to ER/Admit to hospital, other; Patient Form, 2011) Other • At the reporting location, what percentage of your current patients have

Acronym	**NAMCS**
	Medicaid/Children's Health Insurance Program (CHIP)? (Patient Form, 2011) • At the reporting location, what percent of your patient care revenue comes from the following? (Electronic Record) • Do you exchange patient clinical summaries electronically with any other providers? (Electronic Record)
Website	http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS
Source Reference	http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NAMCS
Other References	2009 data file documentation: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NAMCS/doc09.pdf
Availability and Cost	Some data are available publicly, while other restricted data can be requested by application (e.g., physician practices, number of visits, hospital and patient zip code, census variables) http://www.cdc.gov/nchs/data/ahcd/Availability_of_NAMCS_and_NHAMCS_Restricted_Data.pdf; http://www.cdc.gov/rdc .
Link to Instrument(s)	http://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm Patient Form (2011): http://www.cdc.gov/nchs/data/ahcd/2011_NAMCS30.pdf Electronic Records Form (2011): http://www.cdc.gov/nchs/data/ahcd/2011_EMR_Survey.pdf Survey items: http://www.cdc.gov/nchs/data/ahcd/body_NAMCSOPD_072406.pdf
Link to Data	http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm (public-use data files)
Contact Information	cdcinfo@cdc.gov; (301) 458-4600
Administration/Scoring	Data users who wish to combine years of data from 2003 and beyond with years prior to 2002 will need to create these two variables for each file prior to 2002. http://www.cdc.gov/nchs/data/ahcd/ultimatecluster.pdf
Notes	Surveys are not designed to sample ambulatory care visits in every state, and meaningful estimates cannot be made on a State-level basis. The survey was conducted annually from 1973 to 1981, in 1985, and annually since 1989. Starting from 1992, one data file is produced annually that contains both patient visit and drug information. Example report: http://www.cdc.gov/nchs/data/nhsr/nhsr027.pdf

National Comorbidity Survey

Acronym	**NCS, NCS-R, NCS-A**
Developer	Ronald C. Kessler (PI), Harvard School of Medicine
Description	The baseline National Comorbidity Survey (NCS), fielded from the fall of 1990 to the spring of 1992, was the first nationally representative mental health survey in the U.S. to use a fully structured research diagnostic interview to assess the prevalence and correlates of Diagnostic and Statistical Manual of Mental Disorders-III-Revised (DSM-III-R) disorders. The baseline NCS respondents were reinterviewed in 2001-02 (NCS-2) to study patterns and predictors of the course of mental and substance use disorders and to evaluate the effects of primary mental disorders in predicting the onset and course of secondary substance disorders. In conjunction with this, an NCS Replication survey (NCS-R) was carried out in a new national sample of 10,000 respondents. The goals of the NCS-R are to study trends in a wide range of variables assessed in the baseline NCS and to obtain more information about a number of topics either not covered in the baseline NCS or covered in less depth than we currently desire. A survey of 10,000 adolescents (NCS-A) was carried out in parallel with the NCS-R and NCS-2 surveys. The goal of NCS-A is to produce nationally representative data on the prevalence and correlates of mental disorders among youth.
Population	NCS (15-54); NCS-R (18 and older); NCS-A (13-17) (representative)
Instrument Type	Household interview

Availability (Years)	1990-1992; 2001-2002: NCS-1 and NCS-2 2001-2002: NCS-R 2001-2002: NCS-A
Latest Year	1992 or 2002 depending on version of survey (no subsequent data to be collected)
Instrument Frequency	Once (see above for years)
Data Coverage	National
Reliability/Validity	Wiggchen, H.U. (1994). Reliability and validity studies of the WHO-Composite International Diagnostic Interview (CIDI): a critical review. *Journal of Psychiatric Research 28*, 57-84. http://www.hcp.med.harvard.edu/ncs/Bib_151.php http://www.hcp.med.harvard.edu/ncs/ftpdir/SDQ%20Validation%20Study%20Final%20Report.pdf
PEI Goal(s)	Mental Health, Suicide
Example questions	See interview below (Several diagnostic instruments administered including the UM-CIDI and SCID to assess for lifetime and 12-monthe prevalence of DSM III-R, International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10), and IV diagnoses depending on survey version). Only 12-month prevalence assessed in NCS-A.

Website	http://www.hcp.med.harvard.edu/ncs/

Acronym	**NCS, NCS-R, NCS-A**
Source Reference	Kessler, Ronald C. National Comorbidity Survey: Baseline (NCS-1), 1990-1992 [Computer file]. ICPSR06693-v6. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2008-09-12. doi:10.3886/ICPSR06693.v6
Other References	Publications from the dataset: http://www.hcp.med.harvard.edu/ncs/publications.php
Availability and Cost	The NCS data are archived by the Inter-university Consortium of Political and Social Research (ICPSR) at the University of Michigan.
Link to Instrument(s)	NCS: http://www.hcp.med.harvard.edu/ncs/ftpdir/Baseline%20NCS.pdf NCS-R: http://www.hcp.med.harvard.edu/ncs/replication.php NCS-A: http://www.hcp.med.harvard.edu/ncs/instruments.php
Link to Data	http://www.hcp.med.harvard.edu/ncs/ncs_data.php http://www.icpsr.umich.edu/icpsrweb/CPES/studies/20240/system (need to register on the UMICH website. NCS-A (2001-2004): http://dx.doi.org/10.3886/ICPSR28581.v4 NCS-R (2001-2004): http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/189?archive=ICPSR&q=NCS-R
Contact Information	NCS: samhda-support@icpsr.umich.edu; NCS-R: cpes@icpsr.umich.edu; Other questions: NCS@hcp.med.harvard.edu.
Administration/Scoring	Weights and algorithms may be needed, see codebook http://www.icpsr.umich.edu/icpsrweb/CPES/files/cpes

Notes	World Health Organization's World Mental Health (WMH) Survey instrument is a replication of the NCS-R in 29 countries around the world. http://www.hcp.med.harvard.edu/wmh/

National Death Index

Acronym	**NDI**
Developer	Centers for Disease Control and Prevention
Description	The National Death Index (NDI) is a central computerized index of death record information on file in the State vital statistics offices. It assists investigators in determining whether persons in their studies have died and, if so, provides the names of the States in which those deaths occurred, the dates of death, and the corresponding death certificate numbers. Investigators can also obtain cause of death codes using the NDI *Plus* service. Investigators submit at least one of 7 conditions to the NDI Matching Service per person (e.g., his or her social security number, date of birth) and receive a retrieval report if there is a match with NDI records. Identifiable information from other national surveys (e.g., NHIS) can be matched to the NDI (see example publications in Notes below). Death records are added to the NDI file annually, approximately 12 months after the end of a particular calendar year.
Population	All (representative)
Instrument Type	Administrative Data

Availability (Years)	1979-2009
Latest Year	2009 (pending additional data)
Instrument Frequency	Annually
Data Coverage	National
Reliability/Validity	Not available
PEI Goal(s)	Suicide
Example questions	State of death, date of death, death certificate number, cause of death (in *Plus* queries only)

Website	http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/189?archive=ICPSR&q=NCS-R
Source Reference	
Other References	Application step-by-step process: http://www.cdc.gov/nchs/data_access/ndi/ndi_user_guide.htm
Availability and Cost	To use the system, investigators first must submit an NDI application form to the National Center for Health Statistics (NCHS). Applicants should allow about 2 months for their applications to be reviewed and approved. Once approved, users may submit their study subjects' names, social security numbers, dates of birth, and related information to NCHS on diskette or CD-ROM. Routine searches (no cause-of-death codes): $350.00 service charge plus $0.15 per user record for each year of death NDI *Plus* searches (provides cause-of-death codes): $350.00 service charge plus $0.21 per user record for each year of death

Acronym	**NDI** For both types of data queries, there are different prices depending on whether the records of decedents are already known (e.g., lower rates if you just want to know cause of death codes through NDI *Plus* and have all other data such as death date and certificate number). For more details: http://www.cdc.gov/nchs/data/ndi/Users_Fees_Worksheet.pdf
Link to Instrument(s)	N/A
Link to Data	See retrieval report for example: (http://www.cdc.gov/nchs/data/ndi/NDI_Retrieval_Back.pdf)
Contact Information	301-458-4444; ndi@cdc.gov; For large record requests, contact Robert Bilgrad on 301-458-4101
Administration/Scoring	N/A

Notes	2010 Deaths will be available in Spring 2012 Individuals requesting information request it at the individual level (i.e., through social security number) Publications using the NDI and other National (NCHS) databases: http://www.cdc.gov/nchs/data/ndi/citation_lists_nchs_surveys_linked_ndi.pdf http://www.cdc.gov/nchs/data_access/data_linkage/mortality.htm

National Epidemiologic Survey on Alcohol and Related Conditions

Acronym	**NESARC**
Developer	National Institute on Alcohol Abuse and Alcoholism (NIAAA)
Description	The National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) was designed to determine the magnitude of alcohol use disorders and their associated disabilities in the general population and in subgroups of the population and to examine changes over time in alcohol use disorders and their associated disabilities. It is a longitudinal survey with its first wave of interviews fielded in 2001-2002 and second wave in 2004-2005.
Population	The NESARC is a representative sample of the non-institutionalized U.S. population 18 years of age and older.
Instrument Type	Survey Data are collected through computer-assisted personal interviews (CAPIs). The NESARC used a three-stage sampling design. The sampling frame for the NESARC sample of housing units is the Census 2000/2001 Supplementary Survey (C2SS), a national survey of 78,300 households per month. A group quarters frame was also used. Stage 1 was primary sampling unit (PSU) selection using the C2SS PSUs. Stage 2 was household selection from the sampled PSUs. In Stage 3, one sample person was selected from each household.
Availability (Years)	2001/2002
Latest Year	2004/2005 (2nd wave)
Instrument Frequency	One time study in two waves
Data Coverage	The survey collects demographic information on the people interviewed as well as the following types of information about them: Alcohol Use • Initiation of use • Consumption patterns (frequency of drinking and of intoxication, amounts consumed) over the last 12 months and throughout the lifetime • Circumstances surrounding drinking • Beverage-specific consumption • Alcohol experiences (effects and consequences of drinking, development of tolerance, attempts to stop drinking) • Experiences with treatment for alcohol abuse and dependence • Family history of alcoholism Tobacco Use • Initiation of use • Consumption patterns (amount, frequency, duration) • Consequences of tobacco use • Attempts to stop using tobacco

Acronym	**NESARC**
	Use of Other Medications and Drugs • Sedatives, tranquilizers, painkillers, stimulants • Marijuana • Cocaine, hallucinogens, inhalants, heroin • Other medications and drugs (psychoactive drugs, steroids) • Initiation of use • Usage patterns (during the last 12 months and across the lifetime) • Consequences of use – Physical and mental effects – Signs of dependency – Attempts to stop or cut down on use • Use of treatment • Family history of substance use and abuse Psychological Disorders • Major depression • Low mood (dysthymia) • Mania and hypomania (a mild degree of mania) • Panic disorders (with or without agoraphobia) • Social phobia • Specific phobias • Generalized anxiety disorder • Personality disorders (such as antisocial personality disorder) Family History • Of drug use • Of major depression • Of personality disorders, gambling, medical conditions/victimization
Reliability/Validity	
PEI Goal(s)	Of questionable relevance
Example questions	

Website	http://aspe.hhs.gov/hsp/06/Catalog-AI-AN-NA/NESARC.htm
Source Reference	http://pubs.niaaa.nih.gov/publications/arh29-2/74-78.pdf
Other References	http://pubs.niaaa.nih.gov/publications/AA70/AA70.htm
Availability and Cost	Due to increasing concerns for confidentiality of individuals participating in U.S. government and other surveys, NIAAA has determined that the Wave 1 and 2 NESARC be designated as limited access data files. Information on procedures for accessing the Wave 1 and 2 Data are currently being developed.
Link to Instrument(s)	http://pubs.niaaa.nih.gov/publications/NESARC_DRM2/NESARC2DRM.pdf
Link to Data	Data link broken
Contact Information	Nekisha Lakins, nlakins@csrincorporated.com

National Health Interview Survey

Acronym	**NHIS**
Developer	Centers for Disease Control and Prevention
Description	The main objective of the NHIS is to monitor the health of the United States population through the collection and analysis of data on a broad range of health topics. A major strength of this survey lies in the ability to display these health characteristics by many demographic and socioeconomic characteristics. Examples of persons excluded are patients in long-term care facilities; persons on active duty with the armed forces (though their dependents are included); persons incarcerated in the prison system; and U.S. nationals living in foreign countries. Various probability sample techniques are done year-round to ensure a representative sample.
Population	Youth (4-17); Adults (18 and older) (representative)
Instrument Type	Household Interview

Availability (Years)	1963-2011
Latest Year	2011 (pending additional data)
Instrument Frequency	Annual
Data Coverage	National, State
Reliability/Validity	http://www.cdc.gov/brfss/pubs/quality.htm
PEI Goal(s)	Mental health, Access, Employment, School
Example questions	Mental health • DURING THE PAST 30 DAYS, how often did you feel ... So sad that nothing could cheer you up? Nervous? Restless or fidgety? Hopeless? That everything was an effort? Worthless? How MUCH did these feelings interfere with your life or activities: a lot, some, a little, or not at all? • Compared with 12 MONTHS AGO, would you say your health is better, worse, or about the same? • How long have you had depression, anxiety, or an emotional problem? (Adult/Family, 2011) • Has a representative from a school or a health professional ever told you that [fill: S.C. name] had a learning disability? I am going to read a list of items that describe children. Has been unhappy, sad, or depressed? Has been nervous or high-strung?; Overall, do you think that [fill1: S.C. name] has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people? DURING THE PAST 6 MONTHS, was [fill1: S.C. name] prescribed medication or taking prescription medication for difficulties with emotions, concentration, behavior, or being able to get along with others?; During the past 6 months, how much has this prescription medication helped; Who FIRST prescribed the medication? (Child, 2011) • How long [fill: have you/has ALIAS] had attention deficit/hyperactivity

Acronym	**NHIS**
	disorder? What conditions or health problems cause [fill: your/ALIAS's] limitations? – Depression/anxiety/emotional problem (Family, 2011) Access • Is there a place that you USUALLY go to when you are sick or need advice about your health?; What kind of place is it - a clinic, doctor's office, emergency room, or some other place?; Is that {fill: place from (APLKIND)} the same place you USUALLY go when you need routine or preventive care, such as a physical examination or check up?; DURING THE PAST 12 MONTHS, did you have any trouble finding a general doctor or provider who would see you?; DURING THE PAST 12 MONTHS, were you told by a doctor's office or clinic that they would not accept you as a new patient?; Have you delayed getting care for any of the following reasons in the PAST 12 MONTHS? (couldn't get an appointment soon enough; Once you get there, you have to wait too long to see the doctor; The (clinic/doctor's) office wasn't open when you could get there; didn't have transportation; • DURING THE PAST 12 MONTHS, was there any time when you needed any of the following, but didn't get it because you couldn't afford it? couldn't afford prescription medicines? Couldn't afford Mental health care or counseling; couldn't afford follow-up care; In regard to your health insurance or health care coverage, how does it compare to a year ago? Is it better, worse, or about the same? DURING THE PAST 12 MONTHS, that is since {12 month ref. date}, have you seen or talked to any of the following health care providers about your own health? ...A mental health professional such as a psychiatrist, psychologist, psychiatric nurse, or clinical social worker. (Adult/Child, 2011) • DURING THE PAST 12 MONTHS, HOW MANY TIMES have you gone to a HOSPITAL EMERGENCY ROOM about your own health (This includes emergency room visits that resulted in a hospital admission.)?; Did this emergency room visit result in a hospital admission?; Tell me which of these apply to your last emergency room visit?; … You didn't have another place to go; Your doctor's office or clinic was not open; Your health provider advised you to go; The problem was too serious for the doctor's office or clinic; Only a hospital could help you; the emergency room is your closest provider; you get most of your care at the emergency room; you arrived by ambulance or other emergency vehicle? (Adult/Child, 2011) • Thinking about your last visit for any type of medical care, where did you go? Did you see a general doctor, a specialist, or someone else? For this visit, how long did you have to wait between the time you made the appointment and the day you actually saw the doctor or other health

Acronym	**NHIS**

professional? How long did you have to wait in the waiting room before you saw a doctor or other health professional for this visit?

- Why doesn't [fill: alias] have a usual source of medical care? (Adult/Child, 2011)
- DURING THE PAST 12 MONTHS, did you have any trouble finding a general doctor or provider who would see [fill: alias]? (Child, 2011)
- Sometimes students get treatment or counseling through the school system for DIFFICULTIES WITH emotions, concentration, behavior, or being able to get along with others. DURING THE PAST 6 MONTHS, did [fill: S.C. name] receive any treatment or counseling FROM A SCHOOL SOCIAL WORKER, SCHOOL PSYCHOLOGIST, SCHOOL NURSE, SCHOOL COUNSELOR, SPECIAL ED TEACHER, OR SCHOOL SPEECH, OCCUPATIONAL OR PHYSICAL THERAPIST?

Employment

- What is the main reason you did not work last week? (Temporarily unable to work for health reasons; disabled) Adult 2011
- During the PAST 12 MONTHS…ABOUT how many days did you miss work at a job or business because of illness or injury (do not include maternity leave)?
- During the PAST 12 MONTHS, that is, since {12-month ref. date}, ABOUT how many days did illness or injury keep you in bed more than half of the day (include days while an overnight patient in a hospital)? DURING THE PAST 6 MONTHS, did [fill1: S.C. name] receive treatment or counseling for these difficulties... In a hospital emergency room, crisis center, or emergency shelter?
- Does a physical, mental, or emotional problem NOW keep [fill: you/any of these family members] from working at a job or business? (Family, 2011)
- What is the main reason [fill1: you/ALIAS] did not [fill2: work last week/have a job or business last week]? - Taking care of house or family (Family, 2011)

School

- DURING THE PAST 12 MONTHS, that is, since [fill1: 12-month ref. date], about how many days did [fill2: S.C. name] miss school because of illness or injury? DURING THE PAST 6 MONTHS, did the difficulties interfere with or limit [fill1: S.C. name] being able to get along in your family, in school, or in daily activities? How much did these difficulties interfere with [fill: S.C. name] being able to get along in your family, in school, or in daily activities?; How long have these difficulties been present?; Who provided the treatment or counseling?; At any time DURING THE PAST 6 MONTHS did [fill1: S.C. name] attend a school for students with difficulties with emotions, concentration, behavior, or being able to get along with

Acronym	**NHIS**
	others? (Child, 2011) • Because of a physical, mental, or emotional condition, does {S.C. name} have serious difficulty concentrating, remembering, or making decisions? Because of a physical, mental, or emotional condition, does {S.C. name} have difficulty doing errands alone such as visiting a doctor's office or shopping (for 15-17-year-olds only)? (Child, 2011) Other • Because of a physical, mental, or emotional problem, [fill1: do you/does anyone in the family] need the help of other persons with PERSONAL CARE NEEDS, such as eating, bathing, dressing, or getting around inside this home? need the help of other persons in handling ROUTINE NEEDS, such as everyday household chores (Family, 2011)

Website	NHIS: http://www.cdc.gov/nchs/nhis/about_nhis.htm
Source Reference	http://www.cdc.gov/nchs/nhis/about_nhis.htm
Other References	http://www.cdc.gov/nchs/nhis/about_nhis.htm
Availability and Cost	Free
Link to Instrument(s)	http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm Adult Core Interview 2011: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2011/english/qadult.pdf Child Core Interview 2011: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2011/english/qchild.pdf Family Core Interview 2011: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Survey_Questionnaires/NHIS/2011/english/qfamily.pdf Supplement interviews: http://www.cdc.gov/nchs/nhis/supplements_cosponsors.htm
Link to Data	http://www.cdc.gov/nchs/nhis/quest_data_related_1997_forward.htm ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Datasets/NHIS/summary.pdf
Contact Information	nhis@cdc.gov; cdcinfo@cdc.gov; (301) 458-4901; (301) 458-4001
Administration/Scoring	2010 Survey description document: ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2010/srvydesc.pdf

Notes	Although the NHIS sample is too small to provide State level data with acceptable precision for each State, selected estimates for most states may be obtained by combining data years.

National Hospital Ambulatory Medical Care Survey

Acronym	**NHAMCS**
Developer	Centers for Disease Control and Prevention
Description	The National Hospital Ambulatory Medical Care Survey (NHAMCS) is designed to collect data on the utilization and provision of ambulatory care services in three components of hospitals: (1) emergency, (2) outpatient departments, and (3) ambulatory surgery centers (hospital-based centers as of 2009 and freestanding centers as of 2010). Staff are instructed to complete Patient Record forms for a systematic random sample of patient visits during a randomly assigned 4-week reporting period. Data are obtained on demographic characteristics of patients, expected source(s) of payment, patients' complaints, diagnoses, diagnostic/screening services, procedures, medication therapy, disposition, types of providers seen, causes of injury (emergency department and ambulatory surgery center only), and certain characteristics of the facility, such as geographic region and metropolitan status. Data are used to statistically describe the patients that utilize hospital outpatient and emergency department services, the conditions most often treated, and the diagnostic and therapeutic services rendered, including medications prescribed.
Population	Patients (all ages) (non-representative)
Instrument Type	Survey/data extraction

Availability (Years)	1973-2011
Latest Year	2011 (additional data pending)
Instrument Frequency	Annual
Data Coverage	Region (Northeast, Midwest, South, and West)
Reliability/Validity	http://www.cdc.gov/nchs/ahcd/ahcd_estimation_reliability.htm
PEI Goal(s)	Mental Health Suicide Referrals Other
Example questions	Mental Health • Patient's age, gender, race, ethnicity (Patient Form Emergency Department/Outpatient/Ambulatory Survey [ED/OP/AS-, 2011) • Patient's complaint, symptoms, diagnosis (Patient ED/OP/AS, 2011); • Has this patient been seen in this clinic before (Patient OP Form, 2011) • Episode of care – initial visit to ED for this problem, follow-up, unknown; is this visit related to an injury, poisoning, or adverse effect of medical treatment? Provider's diagnosis; medications; providers; visit disposition (no follow-up planned, return, died, transfer to psychiatric hospital, admit, etc.; (Patient ED Form, 2011) • Major reason for visit – new problem, chronic problem, preventative care (Patient OP Form, 2011) • As specifically as possible, list diagnoses related to this visit including

Acronym	**NHAMCS** chronic conditions; does the patient now have…depression; Screening services for depression provided; Psychotherapy provided; Other mental health counseling provided; medications that are new/continued including Px and OTC; who the provider was; time spent with provider (Patient OP Form, 2011) • As specifically as possible, describe the injury; medications; disposition (discharge, admit, referred to ED, etc.); did someone attempt to follow-up with the patient within 24 hours after the surgery; what was learned from that follow-up (Patient AS Form, 2011) Suicide • Is this injury poisoning intentional? (Yes, self inflicted; Patient ED form, 2011) • Is this visit related to any of the following (intentional injury/poisoning)? (Patient OP Form, 2011) Referrals • Has patient been seen in this ED within the last 72 hours; discharged from any hospital within the last 7 days?; how many times has this patient been seen in the last 12 months? • Visit disposition (refer to other physician, return at a specified time, refer to ER/Admit to hospital, other; Patient OP Form, 2011) Other • Expected source(s) of payment (Patient ED/OP Form, 2011)
Website	http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NHAMCS
Source Reference	http://www.cdc.gov/nchs/ahcd/about_ahcd.htm#NHAMCS
Other References	
Availability and Cost	Some data are available publicly, while other restricted data can be requested by application (e.g., hospital and patient zip code (patient zip codes collected 1995-1996; 1999+, census variables) http://www.cdc.gov/nchs/data/ahcd/Availability_of_NAMCS_and_NHAMCS_Restricted_Data.pdf; http://www.cdc.gov/rdc .
Link to Instrument(s)	http://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm#nhamcs Patient ED Form: http://www.cdc.gov/nchs/data/ahcd/2011_NHAMCS-100ed.pdf Patient OP Form: http://www.cdc.gov/nchs/data/ahcd/2011_NHAMCS-100opd.pdf Patient AS Form: http://www.cdc.gov/nchs/data/ahcd/2011_NHAMCS-100asc.pdf Survey items: http://www.cdc.gov/nchs/data/ahcd/body_NAMCSOPD_072406.pdf

Acronym	**NHAMCS**
Link to Data	http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm (public-use data files)
Contact Information	cdcinfo@cdc.gov; (301) 458-4600
Administration/Scoring	The data can be used to find out how many ambulatory care visits were made involving a certain diagnosis. To get an idea of utilization of ambulatory care in the population, the number of visits can be divided by the population of interest to get a rate of visits for a diagnosis of interest. Data users who wish to combine years of data from 2003 and beyond with years prior to 2002 will need to create these two variables for each file prior to 2002. http://www.cdc.gov/nchs/data/ahcd/ultimatecluster.pdf

Notes	Surveys are not designed to sample ambulatory care visits in every State, and meaningful estimates cannot be made on a State-level basis.

National Outcome Measures Survey

Acronym	**NOMs**
Developer	SAMHSA
Description	Within NOMS there are 11 priority areas, one of which addresses co-occurring disorders (COD). Each area is subdivided into three areas: Mental health services, Substance abuse treatment, and Substance abuse prevention. Each area is further subdivided into ten domains. The first 4 are available for the co-occurring disorders population and additional research is being conducted to see which data sources fit the remaining domains. • •Reduced Morbidity • •Social Connectedness • •Access/Capacity • •Retention • •Employment/Education • •Crime and Criminal Justice • •Stability in Housing • •Perception of Care (or services) • •Cost Effectiveness • •Use of Evidence-Based Practices Outcomes are populated with three national-level SAMHSA data sets: National Survey on Drug Use and Health (NSDUH) and National Survey of Substance Abuse Treatment Services (N-SSATS) – data defined by the Treatment Episode Data Set (TEDS); Center for Mental Health Services (CMHS) Uniform Reporting System (URS); and Drug Abuse Warning Network (DAWN).
Population	Adolescents (12-17) and adults (18 and older) (representative)
Instrument Type	Administrative Data

Availability (Years)	2001-2007
Latest Year	2007 (pending additional data)
Instrument Frequency	Annual
Data Coverage	National, State, Region
Reliability/Validity	See specific data sets
PEI Goal(s)	Employment/School, Homelessness, Access, Incarceration, Referrals?
Example questions	Access (see NSDUH) Referrals (see TEDS)

Website	http://www.samhsa.gov/data/NOMsCoOccur2k6.pdf
Source Reference	http://www.samhsa.gov/data/NOMsCoOccur2k6.pdf
Other References	n/a
Availability and Cost	Unclear
Link to Instrument(s)	http://www.adp.ca.gov/CalOMS/pdf/Reports_Overview.pdf

Acronym	**NOMs**
Link to Data	http://www.adp.ca.gov/CalOMS/pdf/Reports_Overview.pdf
Contact Information	California Outcome Measurement System (CalOMS): ADP's Data Management Services office at (916) 327-3010 or 1-877-517-3329; CalOMSHelp@adp.ca.gov
Administration/Scoring	Unclear

Notes	The data files and reports are difficult to find, it may be best to go directly to the raw data files (e.g., TEDS or NSDUH). The focus of this data source is to examine individuals with primary substance use concerns. http://www.adp.ca.gov/CalOMS/CalOMSmain.shtml

National Profile of Local Health Departments

Acronym	**NPLHD**
Developer	National Association of County & City Health Officials (NACCHO)
Description	The NPLHD is the most comprehensive and accurate source of information about the infrastructure and practice of Local Health Departments (LHDs) in the United States. It has been implemented since 1989. The units are all LHDs in the US; there is no sampling among LHDs. In 2008, the NPLHD surveyed 2,794 LHDs and received responses from 2,332 of them. The LHDs are surveyed about their structure, function, and capacities. Topics covered include jurisdictional information, funding, workforce, LHD activities, health disparities, and community health assessment and planning.
Population	Adult, juvenile; representative
Instrument Type	Survey

Availability (Years)	1989-90, 1992-3, 1996-7, 2005, 2008, 2010
Latest Year	2010; pending additional data
Instrument Frequency	Periodically
Data Coverage	National, state, county (number of counties unavailable until data are obtained)
Reliability/Validity	No information found
PEI Goal(s)	Timely access, outreach
Example questions	*Occupation definitions*. One choice is behavioral health professional, which is defined as "Behavioral health professional (e.g., public health social workers, HIV/AIDS counselors, mental health and substance abuse counselors, and community organizers)." Timely access • *Other health services*. Two choices are "Behavioral/mental health services" and "Substance abuse services." Options are "Performed by LHD directly," "Contracted out by LHD," and "Performed NEITHER by LHD directly NOR contracted out by LHD." • • *Access to Health Care Services*. "Check each activity below in which your LHD has participated in the past year to assure access to health care services in your jurisdiction." One activity is "Behavioral (including psychological, substance abuse, mental health)." The four categories are "Assessed the gaps in access to services in this healthcare category," "Addressed gaps through direct provision of clinical services in this healthcare category," "Implemented strategies to increase accessibility of existing services (e.g. referrals) in this healthcare category," and "Implemented strategies to target healthcare needs of under-served populations in this healthcare category."

Acronym	**NPLHD** Outreach *Population-based Primary Prevention Activities*. Two choices are "Mental illness" and "Substance abuse." Options are "Performed by LHD directly," "Contracted out by LHD," and "Performed NEITHER by LHD directly NOR contracted out by LHD."
Website	http://www.naccho.org/topics/infrastructure/profile/
Source Reference	For 2008: Leep, Carolyn J. National Profile of Local Health Departments, 2008 [Computer file]. ICPSR26962-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2010-05-05. doi:10.3886/ICPSR26962.v1 Other years not found.
Other References	
Availability and Cost	Some 2010 data can be publicly queried through an online querying tool. A NACCHO login is required. 2008 and 2010 data are available at no charge through the Inter-University Consortium for Political and Social Research (ICPSR) at the University of Michigan. A form must be submitted, and the data are sent out on a CD. (Note: NACCHO claims that 2010 data are available in this fashion, but ICPSR has no record of the 2010 data set.) All data sets, including 2008 and 2010, are available from NACCHO directly for $200 per data set. 1989-90 data do not include individually identified data as per an agreement between NACCHO and LHDs. More information can be found at under "Profile of Local Health Departments Data Use Policy," "ICPSR data use agreement form instructions," and "Profile Data Request Application Form" at http://www.naccho.org/topics/infrastructure/profile/techdoc.cfm.
Link to Instrument(s)	Links to instruments for all years can be found at: http://www.naccho.org/topics/infrastructure/profile/techdoc.cfm
Link to Data	http://profile-iq.naccho.org/ (2010 querying tool) http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/26962 (2008)
Contact Information	**Carolyn Leep**: cleep@naccho.org; (202) 507-4241 Senior Director of Research & Evaluation **Reba Novich**: rnovich@naccho.org; (202) 756-0161 Senior Project Management Specialist, Profile Study **Nathalie Robin**: nrobin@naccho.org; 202-507-4254 Specialist, R&E **General**: ProfileTeam@naccho.org

National Survey of Children's Exposure to Violence

Acronym	**NatSCEV**
Developer	Office of Juvenile Justice and Delinquency Prevention and the Centers for Disease Control and Protection
Description	This survey was conducted with the intent to estimate the incidence ad prevalence of child exposure to violence in the United States. Its goals and objectives were to do the following: • Document the incidence and prevalence of children's exposure to violence in the United States in areas including family violence (with particular attention to domestic violence), community violence, and school violence. • Evaluate how rates of violence exposure vary across demographic characteristics such as gender, race, age, and family structure. • Assess characteristics of each violence exposure, such as the severity of the event and the child's relationship to the perpetrator. • Specify how different forms of violence exposure "cluster" or co-occur. • Identify individual, family, and community characteristics that might be related to violence exposure. Examples include: – Parent-child relationship characteristics, such as the degree to which they are stable and nurturing – Parental supervision and monitoring – Neighborhood characteristics, such as the presence of gangs – Nature of peer relationships, including level of social support and associations with delinquent peers • Examine associations between levels and types of violence exposure and child mental health. • Evaluate the extent to which children disclose incidents of violence to various individuals and, when applicable, the nature and source of assistance or treatment given to the child.
Population	Children ages 17 and younger living in the continental US. It measures past-year and lifetime exposure to violence for children age 17 and younger across several major categories: conventional crime, child maltreatment, victimization by peers and siblings, sexual victimization, witnessing and indirect victimization, school violence and threats, and Internet victimization.
Instrument Type	Survey conducted by phone interviews. Interviews were conducted with one target child randomly selected from each eligible household. Interviewers first conducted a short interview with the caregiver and then the main interview for the target child. For children younger than 10, proxy interviews were conducted with the adult in the household who is most familiar with the child's activities.

Availability (Years)	2008
Latest Year	2008
Instrument Frequency	A one-time survey

Acronym	**NatSCEV**
Data Coverage	Random digit dialing was used to construct a sample of 4,500 households with children aged birth to 17 years. The interview sample (n= 4,549) consisted of 2 groups: a nationally representative sample of telephone numbers within the contiguous U.S. (n=3,053) and an oversample of telephone exchanges with 70% or greater African American, Hispanic, or low-income households (n=1,496).
Reliability/Validity	-
PEI Goal(s)	NONE
Example questions	-

Website	http://www.unh.edu/ccrc/projects/natscev.html
Source Reference	Finkelhor D et al. Children's Exposure to Violence: a Comprehensive National Study. Juvenile Justice Bulletin. October, 2009
Other References	-
Availability and Cost	-
Link to Instrument(s)	-
Link to Data	-
Contact Information	-
Administration/Scoring	-

National Survey of Substance Abuse Treatment Services

Acronym	**N-SSATS**
Developer	Substance Abuse and Mental Health Services Administration (SAMHSA)
Description	N-SSATS is designed to collect information from all facilities in the United States, both public and private, that provide substance abuse treatment. The objectives of N-SSATS are to collect multipurpose data that can be used to assist SAMHSA and state and local governments in assessing the nature and extent of services provided and in forecasting treatment resource requirements, to update SAMHSA's Inventory of Substance Abuse Treatment Services (I-SATS), to analyze general treatment services trends, and to generate the National Directory of Drug and Alcohol Abuse Treatment Programs and its online equivalent, the Substance Abuse Treatment Facility Locator.
Population	The surveys were designed to collect data on the location, characteristics, and utilization of alcohol and drug treatment facilities and services throughout the 50 States, the District of Columbia, and other U.S. jurisdictions.
Instrument Type	Mail survey with mail, telephone, and web-based response options.

Availability (Years)	1997 - 2010
Latest Year	2010
Instrument Frequency	Annual
Data Coverage	National
Reliability/Validity	All mail questionnaires were reviewed manually for consistency and for missing data. Calls were made to facilities to clarify questionable responses and to obtain missing data. If facilities could not be reached during the edit callbacks, responses that were clearly in error were replaced by imputation. After data entry, automated quality assurance reviews were conducted. The reviews incorporated the rules used in manual editing, plus consistency checks and checks for data outliers not readily identified by manual review. The web questionnaire was programmed to be self-editing; that is, respondents were prompted to complete missing responses and to confirm or correct inconsistent responses. Item non-response was minimized through careful editing and extensive follow-up. The item response rate for the 2010 N-SSATS averaged 98.5 percent across 192 separate items. Appendix C details item response rates and imputation procedures. The response rate in California last year was 95.5%.
PEI Goal(s)	Focused on substance abuse
Example questions	

Website	http://wwwdasis.samhsa.gov/dasis2/nssats.htm

Acronym	**N-SSATS**
Source Reference	
Other References	
Availability and Cost	Data are publicly available at no cost
Link to Instrument(s)	http://www.icpsr.umich.edu/cgi-bin/file?comp=none&study=32722&ds=1&file_id=1073763 http://www.icpsr.umich.edu/cgi-bin/file?comp=none&study=32723&ds=1&file_id=1074847 http://www.icpsr.umich.edu/icpsrweb/SAMHDA/ssvd/series/58/variables
Link to Data	http://www.icpsr.umich.edu/icpsrweb/SAMHDA/
Contact Information	California State contact: Phillis Soresi (916) 327-8370
Administration/Scoring	

Notes	The Inventory of Substance Abuse Treatment Services (I-SATS) provides the sampling frame for N-SSATS. The Inventory of Substance Abuse Treatment Services (I-SATS) is a listing of all known public and private substance abuse treatment facilities in the United States and its territories. Before 2000, the I-SATS was known as the National Master Facility Inventory.

National Survey on Drug Use and Health

Acronym	**NSDUH**
Developer	Substance Abuse and Mental Health Services Administration
Description	The National Survey on Drug Use and Health (NSDUH) series (formerly titled National Household Survey on Drug Abuse) primarily measures the prevalence and correlates of drug use in the United States. The sample was stratified into 900 regions and then addresses were selected. The surveys are designed to provide quarterly, as well as annual, estimates. Information is provided on the use of illicit drugs, alcohol, and tobacco among members of United States households aged 12 and older. The survey covered substance abuse treatment history and perceived need for treatment, and included questions from the Diagnostic and Statistical Manual (DSM) of Mental Disorders that allow diagnostic criteria to be applied. The survey included questions concerning treatment for both substance abuse and mental health-related disorders.
Population	Adolescents (12-17) and adults (18 and older) (representative)
Instrument Type	Household in-person interview

Availability (Years)	1988-2013 (projected)
Latest Year	2010 (pending additional data)
Instrument Frequency	Annual
Data Coverage	National, State, Region
Reliability/Validity	http://www.samhsa.gov/data/NSDUH/2k6ReliabilityP.pdf
PEI Goal(s)	Access, Mental Health, Unemployment, School, Suicide
Example questions	Access • These next questions are about treatment and counseling for problems with emotions, nerves or mental health. Please do not include treatment for alcohol or drug use.; During the past 12 months, have you stayed overnight or longer in a hospital or other facility to receive treatment or counseling for any problem you were having with your emotions, nerves, or mental health?; Where did you stay overnight or longer to receive mental health treatment or counseling during the past 12 months? (A private or public psychiatric hospital; A psychiatric unit of a general hospital; A medical unit of a general hospital; Another type of hospital; A residential treatment center; Some other type of facility); How many nights; Who paid or will pay for the inpatient mental health care you received; Who paid or will pay most of the cost for the inpatient mental health care you received; How much did you or your family pay; During the past 12 months, did you receive any outpatient treatment or counseling for any problem you were having with your emotions, nerves, or mental health at any of the places listed below? (An outpatient mental health clinic or center; The office of a private therapist, psychologist, psychiatrist, social worker, or counselor that was not part of a clinic; A doctor's office that was not part of a clinic; An

Acronym	**NSDUH**

outpatient medical clinic; A partial day hospital or day treatment program; Some other place) (Adult, 2010; similar questions in Youth, 2010 survey)

- Which of these statements explains why you did not get the mental health treatment or counseling you needed?; During the past 12 months, how much has treatment or counseling helped you? (Adult, 2010; Youth, 2010)
- During the past 12 months, that is, since [DATEFILL], did you receive any treatment or counseling from a school social worker, a school psychologist, or a school counselor for emotional or behavioral problems that were not caused by alcohol or drugs?; At any time during the past 12 months, did you participate in a school program that was just for students with emotional or behavioral problems? (Youth, 2010)

Mental Health

- During the past 30 days, how often did you feel nervous?; did you feel hopeless?; did you feel restless or fidgety?; did you feel so sad or depressed that nothing could cheer you up?; did you feel that everything was an effort?; did you feel down on yourself, no good or worthless?; in the past 12 months when you felt more depressed, anxious, or emotionally stressed than you felt during the past 30 days?; During that one month when your emotions, nerves or mental health interfered most with your daily activities . . . how much difficulty did you have remembering to do things you needed to do?
- Have you ever in your life had a period of time lasting several days or longer when most of the day you felt sad, empty or depressed?; Have you ever had a period of time lasting several days or longer when most of the day you were very discouraged about how things were going in your life? (additional questions to assess Adult Depression; similar questions for Youth Survey, 2010)

Unemployment

- During that one month when your emotions, nerves or mental health interfered most with your daily activities . . . how much difficulty did you have taking care of your daily responsibilities at work or school?; Did problems with your emotions, nerves, or mental health keep you from working or going to school?; how much difficulty did you have getting your daily work done as quickly as needed? (Adult, 2010)
- About how many days out of 365 in the past 12 months were you totally unable to work or carry out your normal activities because of your [depression]? (Adult, 2010)
- How much did your [depression] interfere or cause problems with your school work, your job, or your relationships with family and friends? (Youth, 2010)

Acronym	**NSDUH** School • What was the other emotional or behavioral problem for which you last visited a partial day hospital or day treatment program? (You had problems at school) (Youth, 2010) Suicide • The next few questions are about thoughts of suicide. At any time in the past 12 months, that is from [datefill] up to and including today, did you seriously think about trying to kill yourself?; did you make any plans to kill yourself?; did you try to kill yourself?; did you get medical attention from a doctor or other health professional as a result of an attempt to kill yourself?; Did you stay in a hospital overnight or longer because you tried to kill yourself? (Adult, 2010; Youth, 2010)

Website	http://oas.samhsa.gov/NSDUH.htm; https://nsduhweb.rti.org/
Source Reference	United States Department of Health and Human Services. Substance Abuse and Mental Health Services Administration. Office of Applied Studies. National Survey on Drug Use and Health, 2009 [Computer file]. ICPSR29621-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [distributor], 2012-02-10. doi:10.3886/ICPSR29621.v2
Other References	Information on State Data: http://oas.samhsa.gov/statesIndex.htm AOD rates within CA: http://oas.samhsa.gov/substate2k10/StateFiles/CA.pdf; http://oas.samhsa.gov/substate2k10/toc.cfm
Availability and Cost	Free
Link to Instrument(s)	http://www.icpsr.umich.edu/files/SAMHDA/survey-inst/32722-0001-Questionnaire-specifications.pdf
Link to Data	http://www.icpsr.umich.edu/icpsrweb/SAMHDA/series/64
Contact Information	800-848-4079; tgv@rti.org; https://nsduhweb.rti.org/RespWeb/about_rti.html
Administration/Scoring	Data need to be weighted, but reports are already weighted

Notes	SAMHSA selected Research Triangle Institute (RTI) to conduct the NSDUH through 2013. RTI has successfully conducted the survey since 1988. RTI's role in this long-term national effort includes study design, sample selection, data collection, data processing, analysis, and reporting. NSDUH randomly samples households across the U.S.

Office of Statewide Health Planning and Development

Acronym	**OSHPD**
Developer	California Health and Human Services Agency
Description	OSHPD was created in 1978 to provide the state of California an enhanced understanding of the structure and function of its healthcare system. It consists of six divisions of which two are relevant to the CalMHSA project: Administrative services Cal-mortgage Facilities Development Health care information Health care workforce development (see separate sheet) Health Professions Education Foundation The information division houses four databases: Emergency department & Ambulatory surgery Patient Discharge (Inpatient) Financial Utilization The emergency department and ambulatory surgery, and patient discharge data are reported by hospitals using the Medical Information Reporting for California (MIRCal). OSHPD is also responsible for producing The California Healthcare Atlas, which is an interactive Internet geographic information system mapping application that can be used to visualize healthcare information, such as Agency for Healthcare Research and Quality (AHRQ) Volume & Utilization at Hospitals, Common Surgery Charges, Hospital Financial Margins, Vital Record Statistics, Practitioner density, Small Area Health Insurance estimates, critical access hospitals, disproportionate share hospitals, trauma centers (levels 1,2,3,4), and Mental health - Health Professional Shortage Area, etc. Automated Licensing Information and Report Tracking System (ALIRTS), which enables health facilities to report annual utilization data and customers to access timely utilization and other health facility information. Utilization data is divided into (1) hospitals, (2) long-term care facilities, (3) primary care clinics, (4) specialty clinics, and (5) home health agencies/hospices. Psychiatric health facilities are in this reporting program *(36 in 2011, 6 chemical dependency recovery hospitals and 25 Psychology clinics).* Cardiac On-Line Reporting for California (CORC), the mandatory system for reporting coronary artery bypass graft (CABG) surgeries to California CABG Outcomes Reporting Program (CCORP).
Population	All non-federal hospitals in California report information to OSHPD.

Acronym	**OSHPD**
Instrument Type	Administrative database
Availability (Years)	ALIRTS (2001 – ongoing) California Healthcare Atlas (2000 – ongoing) Hospital Discharge (1999- ongoing) Emergency department & Ambulatory Surgery (2005 – ongoing)
Latest Year	ALIRTS – 2010 California Healthcare Atlas – 2010 Hospital Discharge - 2010 Emergency department & Ambulatory Surgery - 2010
Instrument Frequency	MIRCal data are submitted quarterly between 6 weeks and 3 months after the quarter. ALIRTS data are submitted yearly by February 15 for the previous year.
Data Coverage	All hospitals with county level estimates available
Reliability/Validity	Hospital Discharge Emergency and Ambulatory Surgery Utilization data undergo a two-stage screening procedure to ensure the accuracy of the estimates. Mathematical checks are built into the reporting system.
PEI Goal(s)	Suicide; Access; Utilization; Health workforce
Example questions	**Data elements included in the patient discharge dataset are** • Abstract Record Number • Admission Date • Date of Birth • Discharge Date • Disposition of Patient • Expected Source of Payment • External Causes of Injury • Other Diagnosis and Present on Admission Indicator • Other Procedures and Dates • Patient Social Security Number • Prehospital Care and Resuscitation (DNR) • Principal Diagnosis and Present on Admission Indicator • Principal Language Spoken • Principal Procedure and Date • Race • Sex • Source of Admission • Total Charges • Type of Admission • Zip **Data elements in the Emergency Department and Ambulatory Surgery dataset**

Acronym	**OSHPD** **are** • Abstract Record Number • Date of Birth • Disposition of Patient • Ethnicity • Expected Source of Payment • Other Diagnoses • Other External Causes of Injury • Other Procedures • Patient Social Security Number • Principal Diagnosis • Principal External Causes of Injury • Principal Language Spoken • Principal Procedure • Race • Service Date • Sex • Zip **Data elements available in the Hospital file ALIRTS are** SECTION 1 - General Information 1. Facility Name and Address 2. Facility Telephone Number, Administrator Name, and email Address 3. Operation Status 4. Dates of Operation 5. Parent Corporation Information 6. Person Completing the Report (Report Contact Person) 7. Submitted By and Submitted Date and Time 8. License Category (Type) 9. Licensee Type of Control 10. Principal Service Type SECTION 2 - Inpatient 1. Licensed Beds 2. Licensed Bed Days 3. Hospital Discharges 4. Intra-Hospital Transfers 5. Patient (Census) Days 6. Average length of stay (LOS) Current Year 7. Average LOS Prior Year.

Acronym	**OSHPD** 8. Total Inpatient Bed Utilization 9. Chemical Dependency Recovery Services in Licensed General Acute Care (GAC) and Acute Psychiatric Beds a) Licensed Beds b) Hospital Discharges c) Patient (Census) Days d) Average LOS Current Year e) Average LOS Prior Year 10. Newborn Nursery Information 11. Acute Psychiatric Patients by Unit on December 31 a) Acute Psychiatric Total (By Unit) b) Acute Psychiatric Patients by Age on December 31 c) Acute Psychiatric Total (By Age) 12. Acute Psychiatric Patients by Primary Payer on December 31 a) Acute Psychiatric Total (By Primary Payer) b) Short Doyle Contract Services 13. Inpatient Hospice Program 14. Inpatient Hospice Program Bed Classifications SECTION 3 - Emergency Department Services 1. Emergency Medical Services Authority (EMSA) Trauma Center Designation 2. Licensed Emergency Department Level 3. Services Available on Premises a) 24 Hour b) On-Call 4. Emergency Department Services a) ED Visits Not Resulting in Admission b) Visits Resulting in Inpatient Admissions c) Total 5. Emergency Medical Treatment Stations on December 31 6. Non-Emergency (Clinic) Visits Seen in Emergency Department 7. Emergency Registrations, but Patient Leaves Without Being Seen 8. Emergency Department Ambulance Diversion Hours 9. Number of Ambulance Diversion Hours Occurred at Emergency Department 10. Total Hours SECTION 4 - Surgery and Related Services SECTION 5 - Major Capital Expenditures
Website Source Reference	http://www.oshpd.ca.gov/

Acronym	**OSHPD**
Other References	
Availability and Cost	OSHPD healthcare dataset is available freely as public files and, for a fee, the restricted files.
Link to Instrument(s)	Patient discharge 2010 (manual abstraction) Emergency department (manual abstraction) Ambulatory surgery (manual abstraction) ALIRTS 2011
Link to Data	http://www.oshpd.ca.gov/HID/DataFlow/index.html
Contact Information	Healthcare Information Resource Center 400 R Street, Suite 250 Sacramento, CA 95811-6213 Tel: (916) 326-3802 Fax: (916) 324-9242 Email HIRC Angela L. Minniefield, Deputy Director Healthcare Workforce Development Division Phone: (916) 326-3700 Email: HWDDNews@oshpd.ca.gov
Administration/Scoring	

Notes	Utilization data are available at the state and county levels. Utilization data also include psychiatric beds.

Point-in-Time Homeless Persons Count

Acronym	**PIT**
Developer	U.S. Department of Housing and Urban Development
Description	The Point-in-Time Count provides a count of sheltered homeless persons on a single night during the last 10 days in January each year, and a count of unsheltered homeless persons on a single night during the last 10 days in January every other year (odd years). Conducted on the same night as HIC. Each program recorded in the HIC must provide a PIT count. This number should be the unduplicated number of persons served on the night of the count in the beds reported for the program. This includes all persons who entered the program on or before the date of the HIC and PIT count, and who are either still in the program or exited after the date of the count. As discussed earlier, the HIC and the PIT are integrally related. The number of persons reported in each program type (Emergency Shelter, Safe Havens, and Transitional Housing) on the PIT should match the sum total of sheltered persons reported in the PIT count on the HIC for programs of that type. *Data are collected on subpopulations, including Severely Mentally Ill and Chronic Substance Abuse. However, while data on these subpopulations are required for sheltered person counts, they are optional for unsheltered person counts. That said, every CA Continuum of Care (CoC – these are large geographical units of about 1-3 counties) I looked at did report both sheltered & unsheltered by subpopulation.*
Population	Counts are based on: 1. Number of persons in households without children; 2. Number of persons in households with at least one adult and one child; and 3. Number of persons in households with only children (this last category is new for 2012). This includes only persons age 17 or under, including unaccompanied children, adolescent parents and their children, adolescent siblings, or other household configurations composed only of children. HPRP participants (Homelessness Prevention or Rapid Re-housing) who are in conventional housing (i.e. housing in the private rental market) on the night designated for the count should not be included in the PIT count.
Instrument Type	Administrative data

Availability (Years)	2005-2011
Latest Year	2011 (2012 counts should be completed but data are not online)
Instrument Frequency	Sheltered count is annual; unsheltered count is biennial (odd years). However, CoCs may choose to conduct an unsheltered count in even years as well and submit PIT data for both sheltered and unsheltered persons.
Data Coverage	National, by state, and by CoC (county or aggregate of smaller counties)

Acronym	**PIT**
Reliability/Validity	
PEI Goal(s)	Homelessness [Outcome]: Can get counts of sheltered & unsheltered homeless w/ SMI and w/ chronic substance abuse, by state and by CoC.
Example questions	Sheltered Homeless Persons: CoCs need to record the number of persons and households sleeping in emergency shelters, transitional housing, and Safe Haven programs on the night designated for the count. All programs in these categories that are included in the HIC should be included in the PIT count. Unsheltered Homeless Persons: For 2012 [or other even years], CoCs may collect and report the number of people living in a place not meant for human habitation, such as cars, parks, sidewalks abandoned buildings, or on the street. For CoCs that do not collect unsheltered data in 2012, HUD will use 2011 [or most recent odd year] unsheltered counts for reporting purposes. Subpopulation Data: HUD requires that CoCs identify counts of specific subpopulations for all sheltered persons. While the unsheltered count is optional in 2012, if a count is submitted, required subpopulation data should also be submitted. The subpopulations are: • Chronically Homeless Individuals: Required for sheltered and unsheltered persons. • Chronically Homeless Families: Required for sheltered and unsheltered persons. • Veterans: Required for sheltered and unsheltered persons. • **Severely Mentally Ill: Required for sheltered persons; optional for unsheltered persons.** • **Chronic Substance Abuse: Required for sheltered persons; optional for unsheltered persons.** • Persons with HIV/AIDS: Required for sheltered persons; optional for unsheltered persons. • Victims of Domestic Violence: Required for sheltered persons; optional for unsheltered persons. • Unaccompanied Child (under 18): Required for sheltered persons; optional for unsheltered persons. Definitions of selected subpopulation categories: • Chronic Substance Abuse – This category on the PIT includes persons with a substance abuse problem (alcohol abuse, drug abuse, or both) that is expected to be of long-continued and indefinite duration and substantially impairs the person's ability to live independently. • Chronically Homeless Individual - An unaccompanied homeless adult individual (persons 18 years or older) with a disabling condition (see definition below) who has either been continuously homeless for a year

Acronym	**PIT**

or more OR has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter/Safe Haven during that time. Persons under the age of 18 are not counted as chronically homeless. For purposes of the PIT, persons living in transitional housing at the time of the PIT count should not be included in this subpopulation category.

- Disabling Condition – Any one of (1) a disability as defined in Section 223 of the Social Security Act; (2) a physical, mental, or emotional impairment which is (a) expected to be of long continued and indefinite duration, (b) substantially impedes an individual's ability to live independently, and (c) of such a nature that such ability could be improved by more suitable housing conditions; (3) a developmental disability as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act; (4) the disease of acquired immunodeficiency syndrome or any conditions arising from the etiological agency for acquired immunodeficiency syndrome; or (5) a diagnosable substance abuse disorder.
- Severely Mentally Ill (SMI) – This subpopulation category of the PIT includes persons with mental health problems that are expected to be of long-continued and indefinite duration and substantially impairs the person's ability to live independently.

People Who Should be Included in the PIT: For the sheltered count, include all persons who – on the night of the count – were sleeping in beds that are designated for persons who are homeless and are provided or funded by emergency shelter, transitional housing, or Safe Haven programs.

If conducting an unsheltered count, include all homeless persons who were on the street or in a place unfit for habitation on the night of the count. HUD requires that CoCs identify the date on which the count was conducted; however, the term "night" signifies a single period of time from sunset to sunrise that spans two actual dates. The "night of the count" begins at sunset on the date of the count and ends at sunrise on the following day.

People Who Should NOT be Included in the PIT: Persons residing in the following settings on the night of the count should not be included in the sheltered PIT count:

- Persons residing in permanent supportive housing programs, including persons housed using Veterans Affairs Supportive Housing (VASH) vouchers
- Persons residing in their own unit with HPRP assistance (e.g., HPRP rental assistance) as part of a Homeless Assistance program (i.e. Rapid Re-

Acronym	**PIT**
	housing) or Homelessness Prevention program • Persons counted in any location not listed on the HIC (e.g., staying in programs with beds/units not dedicated for persons who are homeless or staying with family or friends).
Website	http://sandbox.hudhdx.info/
Source Reference	
Other References	
Availability and Cost	Reports available freely on the web: nationally, by state, and by CoC: http://www.hudhre.info/index.cfm?do=viewHomelessRpts • Select a year (2005-2011), then select "Population/Subpopulation." • Select scope: national; state; or Continuum of Care (CoC). • If CoC, can select California, and then choose from a list of CoCs. There are 42 CoCs in CA; some are single counties (e.g., LA City + County is a single CoC) and others combine a few small counties. By CoC, by state, or nationally: • 3 categories: Emergency Shelter; Transitional Housing; Unsheltered: Number of households, number of persons; reported by households w/ only individuals, and households w/ adults & children. • Two categories: Sheltered; Unsheltered. Number of persons by subpopulation, including chronically homeless, severely mentally ill, chronic substance abuse, veterans, persons with HIV/AIDS, victims of domestic violence, unaccompanied youth (under 18). While HUD does not require subpopulations to be reported for unsheltered persons, every CA CoC I looked at did report unsheltered persons by subpopulation. • Only difference between CoC, State, and National are the level at which the data are aggregated. Categories are identical, including having sheltered & unsheltered both by subpopulation.
Link to Instrument(s)	http://hudhre.info/documents/2012HICandPITGuidance.pdf
Link to Data	http://www.hudhre.info/index.cfm?do=viewHomelessRpts
Contact Information	Contacts by CoC: http://www.hudhre.info/index.cfm?do=viewCocContacts
Administration/Scoring	

School Health Policies and Practices Study

Acronym	**SHPPS**
Developer	Division of Adolescent and School Health (DASH), National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention (CDC)
Description	SHPPS examines 8 components of school health programs across the nation. They are (1) health education, (2) physical education and activity, (3) health services, (4) mental health and social services, (5) nutrition services, (6) healthy and safe school environment, (7) faculty and staff health promotion, and (8) family and community involvement. The 2006 version included 23 questionnaires; 3 questionnaires were developed for the mental health component, one each for the state, district, and school levels. The district and school level questionnaires were introduced in 2006. The study aims to answer the following questions: • - What are the characteristics of each school health program component at the state, district, school, and classroom (where applicable) levels and across elementary, middle, and high schools? • - Are there persons responsible for coordinating and delivering each school health program component and what are their qualifications and educational backgrounds? • - What collaboration occurs among staff from each school health program component and with staff from outside agencies and organizations? • - How have key policies and practices changed over time?
Population	The survey is aimed at the elementary, middle and high school levels. The survey includes a nationally representative sample of public school districts, public and private schools, and classes or courses covering required health instruction or physical education.
Instrument Type	Questionnaires administered via computer-assisted personal interview or computer-assisted telephone interview

Availability (Years)	1994 (no mental health questionnaire), 2000, 2006
Latest Year	2006 (State and district level data collection is under way for 2012. School and classroom level data planned for 2014)
Instrument Frequency	Intermittent (Approximately every 6 years – current round ongoing)
Data Coverage	National (Nationally representative sample)
Reliability/Validity	Details of the reliability and validity can be found in a report of the methodology
PEI Goal(s)	Mental health (PEI) workforce (Education)/Policies
Example questions	1. Do mental health or social services staff provide… a. Tobacco use cessation? b. Alcohol or other drug use treatment c. Counseling after a natural disaster or other emergency or crisis situation?

Acronym	**SHPPS** d. Crisis intervention for personal problems? e. Identification of emotional or behavioral disorders, such as anxiety, depression, or ADHD? f. Counseling for emotional or behavioral disorders, such as anxiety, depression, or ADHD? g. Stress management h. Weight management? 2. Do mental health or social services staff provide... a. Nutrition and dietary behavior counseling? b. Physical activity and fitness counseling? c. Pregnancy prevention d. HIV prevention e. STD prevention? f. Suicide prevention g. Tobacco use prevention? h. Alcohol or other drug use prevention? i. Violence prevention, for example bullying, fighting, or homicide? j. Injury prevention and safety counseling?

Website	http://www.cdc.gov/HealthyYouth/shpps/index.htm
Source Reference	Brener ND, Weist M, Adelman H, Taylor L, Vernon-Smiley M. Mental health and social services: results from the School Health Policies and Programs Study 2006. J Sch Health. 2007; 77: 486-499
Other References	
Availability and Cost	
Link to Instrument(s)	2006 - State; 2006 - District; 2006 - Classroom; 2000 - State; 2000 - District; 2000 - School;
Link to Data	Data files and documentation; State level mental health 2006; CA mental health 2006; San Bernardino mental health 2006; San Diego mental health 2006; San Francisco mental health 2006; Los Angeles mental health 2006
Contact Information	Division of Adolescent and School Health 4770 Buford Hwy, NE MS K29 Atlanta, GA 30341 cdcinfo@cdc.gov
Administration/Scoring	State-level estimates are based on a census and are not weighted. District-, school-, and classroom level data are based on representative samples and are weighted to produce national estimates.

Survey of Inmates in Federal Correctional Facilities and Survey of Inmates in State Correctional Facilities

Acronym	**SIFCF / SISCF**
Developer	Bureau of Justice Statistics (BJS), Federal Bureau of Prisons
Description	The SIFCF and SISCF are nationwide, stratified two-stage surveys of inmates in federally owned and operated (SIFCF) and state (SISCF) correctional facilities. The SIFCF has been implemented since 1974 and the SISCF since 1991. Prisons are selected in the first stage and inmates to be interviewed are selected in the second stage. The units (correctional facilities and inmates) are sampled based on sampling criteria laid out in the reliability/validity section. The SIFCF and SISCF are joint efforts by the Bureau of Justice Statistics (BJS) and the Federal Bureau of Prisons. Both surveys are conducted concurrently and include the same data items. They are similar to the Survey of Inmates in Local Jails (SILJ); the mental health history section of all three surveys is identical.
Population	Adults (18+); representative
Instrument Type	Interview

Availability (Years)	1991, 1997, 2004 (SIFCF) 1974, 1979, 1986, 1991, 1997, 2004 (SISCF)
Latest Year	2004; pending additional data (survey collection has been suspended but is expected to resume in 2014)
Instrument Frequency	Periodically
Data Coverage	National, state
Reliability/Validity	http://www.icpsr.umich.edu/icpsrweb/NACJD/support/faqs/2010/10/survey-of-inmates-in-state-and-federal http://www.icpsr.umich.edu/cgi-bin/file?comp=none&study=4572&ds=0&file_id=898493 (2004)
PEI Goal(s)	Incarceration (adult; enhanced questions on mental health histories included in 2004)
Example questions	• During the last year: Have you lost your temper easily, or had a short fuse more often than usual? Have you been angry more often than usual? Have you hurt or broken things on purpose, just because you were angry? Have you thought a lot about getting back at someone you have been angry at? Have you had difficulty feeling close to friends or family members? Have there been times when your thoughts raced so fast that you had trouble keeping track of them? Have you given up hope for your life or your future? • Have you ever been told by a mental health professional, such as a psychiatrist or psychologist, that you had: A depressive disorder; Manic-depression, bipolar disorder, or mania; Schizophrenia or another psychotic disorder; Post-traumatic stress disorder; (etc.) When were you most recently told that you had this (*these*)

Acronym	**SIFCF / SISCF**

conditions?

- Because of an emotional or mental problem, have you EVER taken a medication prescribed by a psychiatrist or other doctor? Were you taking medication prescribed by a doctor for a mental or emotional problem?
- Because of an emotional or mental problem, have you EVER been admitted to a mental hospital, unit or treatment program where you stayed overnight? Because of a mental or emotional problem have you EVER received counseling or therapy from a trained professional? Because of a mental or emotional problem have you EVER received any other mental health treatment or services?
- Have you ever attempted suicide? Have you ever considered suicide?

Website	http://bjs.ojp.usdoj.gov/index.cfm?ty=dcdetail&iid=273 (SIFCF) http://bjs.ojp.usdoj.gov/index.cfm?ty=dcdetail&iid=275 (SISCF)
Source Reference	U.S. Dept. of Justice, Bureau of Justice Statistics. SURVEY OF INMATES IN STATE AND FEDERAL CORRECTIONAL FACILITIES, 2004 [Computer file]. ICPSR04572-v1. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor], 2007-02-28. doi:10.3886/ICPSR04572.v1
Other References	
Availability and Cost	Most of the data are publicly available for download after logging in with a Google or Facebook account. Certain variables are restricted from general dissemination to protect respondent privacy. A list of these variables for the 2004 survey can be found at http://www.icpsr.umich.edu/icpsrweb/NACJD/studies/4572/detail. To obtain these data, a Restricted Data Use Agreement form must be submitted to the Inter-University Consortium for Political and Social Research at the University of Michigan. More details can be found at the above link.
Link to Instrument(s)	http://bjs.ojp.usdoj.gov/content/pub/pdf/sisfcf04_q.pdf (2004) http://bjs.ojp.usdoj.gov/content/pub/pdf/sisfcfq.pdf (1997)
Link to Data	http://www.icpsr.umich.edu/icpsrweb/NACJD/series/70/studies?sortBy=7
Contact Information	Tracy Snell: Tracy.L.Snell@usdoj.gov
Administration/Scoring	

Survey of Inmates in Local Jails

Acronym	**SILJ**
Developer	Bureau of Justice Statistics
Description	The SILJ is a nationwide, stratified two-stage survey of inmates in local jails. The SILJ was implemented in 1978. Jails are selected in the first stage and inmates to be interviewed are selected in the second stage. The units (local jails and inmates) are sampled based on sampling criteria laid out in in the reliability/validity section. The SILJ is similar to the Survey of Inmates in Federal Correctional Facilities (SIFCF) and the Survey of Inmates in State Correctional Facilities (SISCF). The mental health history section of all three surveys is identical.
Population	Adults (18+), juveniles (under 18); representative
Instrument Type	Interview

Availability (Years)	1978, 1983, 1989, 1996, 2002
Latest Year	2002; no subsequent data to be collected (survey collection has been suspended but is expected to resume at an unspecified future time)
Instrument Frequency	Periodically
Data Coverage	National, state
Reliability/Validity	http://www.icpsr.umich.edu/cgi-bin/file?comp=none&study=4359&ds=0&file_id=890743 (2002)
PEI Goal(s)	Incarceration (adult; enhanced questions on mental health histories included in 2002)
Example questions	• During the last year: Have you lost your temper easily, or had a short fuse more often than usual? Have you been angry more often than usual? Have you hurt or broken things on purpose, just because you were angry? Have you thought a lot about getting back at someone you have been angry at? Have you had difficulty feeling close to friends or family members? Have there been times when your thoughts raced so fast that you had trouble keeping track of them? Have you given up hope for your life or your future? • Have you ever been told by a mental health professional, such as a psychiatrist or psychologist, that you had: A depressive disorder; Manic-depression, bipolar disorder, or mania; Schizophrenia or another psychotic disorder; Post-traumatic stress disorder; (etc.) When were you most recently told that you had this (*these*) conditions? • Because of an emotional or mental problem, have you EVER taken a medication prescribed by a psychiatrist or other doctor? Were you taking medication prescribed by a doctor for a mental or emotional problem? • Because of an emotional or mental problem, have you EVER been admitted to a mental hospital, unit or treatment program where you stayed overnight? Because of a mental or emotional problem have you

Acronym	**SILJ**
	EVER received counseling or therapy from a trained professional? Because of a mental or emotional problem have you EVER received any other mental health treatment or services? • Have you ever attempted suicide? Have you ever considered suicide?

Website	http://bjs.ojp.usdoj.gov/index.cfm?ty=dcdetail&iid=274
Source Reference	U.S. Dept. of Justice, Bureau of Justice Statistics. SURVEY OF INMATES IN LOCAL JAILS, 2002 [UNITED STATES] [Computer file]. Conducted by U.S. Dept. of Commerce, Bureau of the Census. ICPSR04359-v2. Ann Arbor, MI: Inter-university Consortium for Political and Social Research [producer and distributor], 2006-11-21. doi:10.3886/ICPSR04359.v2
Other References	
Availability and Cost	Most of the data are publicly available for download after logging in with a Google or Facebook account. Certain variables are restricted from general dissemination to protect respondent privacy. To obtain these data, a Restricted Data Use Agreement form must be submitted to the Inter-University Consortium for Political and Social Research at the University of Michigan. More details can be found at http://www.icpsr.umich.edu/icpsrweb/ICPSR/access/restricted/agreement.jsp
Link to Instrument(s)	http://bjs.ojp.usdoj.gov/content/pub/pdf/quest_archive/siljq02.pdf (2002) http://bjs.ojp.usdoj.gov/content/pub/pdf/siljq.pdf (1996)
Link to Data	http://www.icpsr.umich.edu/icpsrweb/ICPSR/studies/4359 (2002)
Contact Information	Tracy Snell: Tracy.L.Snell@usdoj.gov
Administration/Scoring	

Treatment Episode Data Set

Acronym	**TEDS**
Developer	Substance Abuse and Mental Health Services Administration
Description	TEDS is part of SAMHSA's Drug and Alcohol Service Information System. TEDS is a compilation of data on the demographic and substance abuse characteristics of admissions to (and more recently, on discharges from) substance abuse treatment. TEDS is comprised of two separate components, the Admissions Data System and the Discharge Data System. The Admissions Data System has two components: a minimum data set that includes demographic and drug history data, and a supplemental data set that includes related data items.
Population	Individuals admitted for substance abuse treatment in one of the 50 states.
Instrument Type	Administrative data. The data are routinely collected by State administrative systems and then submitted to SAMHSA in a standard format.

Availability (Years)	1992 -2010
Latest Year	2009
Instrument Frequency	Annual
Data Coverage	This source includes data on almost 2 million admissions reported by more than 10,000 facilities to the 50 States, the District of Columbia, and Puerto Rico over the 12-month period. Treatment facilities that are operated by private for-profit agencies, hospitals, and the State correctional system, if not licensed through the State substance abuse agency, may be excluded from TEDS. TEDS does not include data on facilities operated by agencies (the Bureau of Prisons, the Department of Defense, and the Veterans Administration). *California - It includes admissions to facilities that are licensed or certified by the State substance abuse agency to provide substance abuse treatment (or are administratively tracked for other reasons). In general, facilities reporting TEDS data are those that receive State alcohol and/or drug agency funds (including Federal Block Grant funds) for the provision of alcohol and/or drug treatment services.*
Reliability/Validity	States continually review the quality of their data processing. When systematic errors are identified, States may revise or replace historical TEDS data files. TEDS continues to accept data revisions for admissions occurring in the previous five years. While this process represents an improvement in the data, the numbers of admissions reported here may differ slightly from those in earlier or subsequent reports and tables. http://www.samhsa.gov/data/About.aspx
PEI Goal(s)	Homelessness
Example questions	Contents of the data set 1. TEDS discharge data system • Type of service at discharge • Date of last contact • Date of Discharge

Acronym	**TEDS** • Reason for discharge, transfer, or discontinuance of treatment 2. TEDS Admission: Minimum Data Set • Client/codependent • Transaction type (admission or transfer) • Date of admission • Type of service at admission • Age • Sex • Race • Ethnicity • Number of prior treatment episodes • Principal source of referral • Education • Employment status • Substance problem (primary, secondary, and tertiary) • Usual route of administration • Frequency of use • Age at first use • Use of methadone planned as part of treatment 3. TEDS Admissions: Supplemental data Set • Pregnancy status at time of admission • Veteran status • **Psychiatric problem in addition to alcohol or drug problem** • **DSM diagnosis** • Marital status • **Living arrangement** • Source of income/support • Health insurance • Expected/actual primary source of payment • Detailed "Not in labor force" • Detailed criminal justice referral • Days waited to enter treatment • Detailed drug code (primary, secondary, and tertiary)
Website	http://oas.samhsa.gov/dasis.htm - teds2
Source Reference	
Other References	
Availability and Cost	Publicly available at no cost
Link to Instrument(s)	http://www.samhsa.gov/data/DASIS.aspx – TEDS

Acronym	**TEDS**
Link to Data	SAMDHA
Contact Information	CA state contact: Wee The (916) 324-5965
Administration/Scoring	

Notes	TEDS is an admission-based system, and TEDS admissions do not represent individuals. Thus, for example, an individual admitted to treatment twice within a calendar year would be counted as two admissions.

Uniform Data System

Acronym	**UDS**
Developer	Health Resources and Services Administration, Bureau of Primary Health Care (HRSA, BPHC)
Description	"The UDS is a reporting requirement for grantees of the following HRSA primary care programs, as defined in the Public Health Service Act: • • Community Health Center, Section 330 (e) • • Migrant Health Center, Section 330 (g) • • Health Care for the Homeless, Section 330 (h) • • Public Housing Primary Care, Section 330 (i) All new grantees that receive Health Center grant awards and are operational by October of the reporting year are required to submit UDS reports." "The Uniform Data System (UDS) tracks a variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues. UDS data are collected from grantees and reported at the grantee, state, and national levels." "The data are reviewed to ensure compliance with legislative and regulatory requirements, improve health center performance and operations, and report overall program accomplishments. The data help to identify trends over time, enabling HRSA to establish or expand targeted programs and identify effective services and interventions to improve the health of underserved communities and vulnerable populations. UDS data are compared with national data to review differences between the U.S. population at large and those individuals and families who rely on the health care safety net for primary care. UDS data also inform Health Center Program grantees, partners, and communities about the patients served by Health Centers." Quoted from http://bphc.hrsa.gov/healthcenterdatastatistics/index.html
Population	All individuals of any age (adult or child) receiving services in HRSA primary care clinics. All HRSA primary care clinics are included each year, and new HRSA grantees are included if they were operational by October of the calendar year. Comparisons over time are possible.
Instrument Type	Administrative Data

Availability (Years)	1996-ongoing; reports freely available online for 2006-2010
Latest Year	2010
Instrument Frequency	Each calendar year; final submission is March 31 of following year
Data Coverage	Reported at grantee, state, and national levels
Reliability/Validity	
PEI Goal(s)	Access [structure] (public MH service availability in public *health* clinics) Mental health [structure] (workforce capacity in public *health* clinics)

Acronym	**UDS** Mental health [process] (utilization of MH services in public *health* clinics)
Example questions	Access [structure] / Mental health [structure]: • Number of mental health service providers, by category: psychiatrists; licensed clinical psychologists; LCSWs, other licensed providers; other staff [Table 5] • Number of substance abuse service providers [Table 5] • All direct costs for the provision of mental health services, other than substance abuse services, including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel [Table 8] • All direct costs for the provision of substance abuse services including but not limited to staff, fringe benefits, supplies, equipment depreciation, and related travel [Table 8] • State government grants and contracts, specify, and $ amt [Table 9E] • Local government grants and contracts, specify, and $ amt [Table 9E] • Mental health [process]: • Number of MH services visits, by provider type [Table 5] • Number of MH services patients (total; not by provider type) [Table 5] • Number of substance abuse visits [Table 5] • Number of substance abuse services patients [Table 5] • By primary diagnosis category (alcohol-related; other substance; tobacco use; depression & other mood d/o; anxiety d/o including PTSD; attention deficit & disruptive behavior d/o; other mental d/o, excluding drug/alcohol but INCLUDING mental retardation): • Number of visits per primary diagnosis [Table 6] • Number of patients per primary diagnosis [Table 6]

Website	http://bphc.hrsa.gov/healthcenterdatastatistics/index.html
Source Reference	
Other References	
Availability and Cost	Reports at state and national level available online at no cost. State reports include list of grantees in each state.
Link to Instrument(s)	Reporting instructions for grantees: http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2011manual.PDF
Link to Data	National: http://bphc.hrsa.gov/healthcenterdatastatistics/nationaldata/index.html State: http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/index.html Note that within each data display page (year/national or year/state) there is a link to the full PDF report for that year and location.

Acronym	**UDS**
Contact Information	**UDS Help Desk: UDS content questions** udshelp330@bphcdata.net or 1-866-837-4357 (866-UDS-HELP) Monday through Friday (except federal holidays) 8:30 AM to 5:30 PM (ET)
Administration/Scoring	Reporting instructions for grantees: http://bphc.hrsa.gov/healthcenterdatastatistics/reporting/2011manual.PDF

Notes	Probably not useful for homelessness: • Table 4 asks for data on how many clients were homeless; however, this is not disaggregated into clients receiving mental versus other health services. • More-elaborate data on homelessness are collected only from Health Care for the Homeless grantees. All of this is explained under "CHARACTERISTICS OF TARGETED SPECIAL POPULATIONS" on pages 28-29 of the manual. Some health centers are receiving funding under the American Recovery and Reinvestment Act (ARRA). • "The ARRA, signed into law February 17, 2009, provides approximately $500 million in grants to: support new health center sites and service areas; increase services and providers at existing sites; and address spikes in uninsured patients. It also provides $1.5 billion in grants to support health center construction, renovation and equipment, and the acquisition of health information technology systems." • This is something to be aware of, to the extent that health center improvements due to the ARRA could be misattributed to the MHSA. Whether that could happen will depend on where the ARRA grants were awarded and whether any of the grants funded improvements in MH staffing at these health centers. • Quarterly reporting requirements for ARRA grantees do track mental health clients and mental health staff (psychiatrists, psychologists, LCSWs, other licensed MH providers, and other MH staff). http://bphc.hrsa.gov/recovery/hcqr11manual.pdf

Uniform Reporting System

Acronym	**URS**
Developer	Center for Mental Health Services (CMHS), a division of Substance Abuse and Mental Health Services Administration (SAMHSA)
Description	The URS is intended to provide uniform reporting of state-level data to describe the public mental health system and the outcomes of its programs. It has been implemented since 2002. The units are all states in the US; there is no sampling among states. Topics covered include funding sources, persons in community mental health programs and in state psychiatric hospitals, demographic characteristics of persons served, and homeless persons served. These data are used to track individual states' performance over time and to develop a national picture of the public mental health systems of the states.
Population	Adult, juvenile; representative
Instrument Type	Administrative data

Availability (Years)	2007 – 2010
Latest Year	2010; pending additional data
Instrument Frequency	Annual
Data Coverage	National with state-specific reports
Reliability/Validity	No information found
PEI Goal(s)	Improved mental health / decreased prolonged suffering, timely access, school dropout, homelessness, unemployment
Example questions	The following are broad categories covered in the survey (PEI goals are included in bold where appropriate): • Estimated Prevalence of State Population with serious mental illness (SMI) and serious emotional disturbance (SED) • Profile of Persons Served – All Programs by Age, Gender and Race/Ethnicity • Profile of Persons Served in the Community Mental Health Setting, State Psychiatric Hospitals and Other Settings • Profile of Adult Clients by Employment Status (**unemployment**) • Profile of Adult Clients by Employment Status: by Primary Diagnosis Reported (**unemployment**) • Profile of Clients by Type of Funding Support • Profile of Clients Turnover • Profile of Mental Health Service Expenditures & Sources of Funding • Profile of Community Mental Health Block Grant (MHBG) Expenditures for Non-Direct Service • SAMHSA NOMs: Social Connectedness & Improved Functioning • Profile of Agencies Receiving Block Grant Funds Directly from the SMHA • Summary Profile Client Evaluation of Care (**timely access**) • Consumer Evaluation of Care by Consumer Characteristics • State Mental Health Agency Profile

Acronym	**URS** • Profile of Unmet Need of the State Population • Profile of Persons with SMI/SED Served by Age, Gender, and Race/Ethnicity • Profile of Persons Served, All Programs by Age, Gender and Race/Ethnicity • Living Situation Profile (**homelessness**) • Guidelines for Reporting Evidence-Based Practices • Profile of Adults with Schizophrenia Receiving New Generation Medications during the Year (Optional) • Profile of Criminal Justice or Juvenile Justice Involvement • Profile of Change in School Attendance (**school dropout**) • Readmission to any State Psychiatric Inpatient Hospital within 30/180 Days of Discharge
Website	http://www.samhsa.gov/dataoutcomes/urs/
Source Reference	Not found
Other References	http://www.nri-inc.org/projects/SDICC/urs_forms.cfm
Availability and Cost	State-specific reports provide comprehensive data, but raw data cannot be downloaded
Link to Instrument(s)	http://www.nri-inc.org/projects/SDICC/Forms/2011_URS_instructions.pdf (2011)
Link to Data	http://www.samhsa.gov/dataoutcomes/urs/2010/California.pdf (2010 California report) http://www.samhsa.gov/dataoutcomes/urs/ (all state reports for all years can be found here)
Contact Information	Mark Sticklin: mark.sticklin@dmh.ca.gov; (916) 651-3440 Point of contact for California URS Each state has its own point of contact, whose information is available in each state-specific report
Administration/Scoring	
Notes	This data are collected voluntarily by states with most data derived from public mental health systems. Large variation ranges exist in this data due to variations in systems, capacity, collection methods, and variable definitions.

University of California Undergraduate Experience Survey

Acronym	**UCUES**
Developer	The UCUES Work Group consists of the SERU principal researchers, representatives from each of the nine undergraduate campuses and UC Office of the President staff.
Description	The University of California Undergraduate Experience Survey (UCUES) solicits student opinions on all aspects of the UC experience. The survey is broad and covers most aspects of students' academic and co-curricular experience, including instruction, advising and student services. UCUES also collects information about student behavior—their study habits and how they use their time. The survey is also a way of documenting student attitudes, self-perceptions and goals. Finally, UCUES presents demographic information not available through other data sources, and helps assess the impact UC has had on student academic skills, knowledge and behavior, as well as academic motivation and satisfaction. Here are the highlights on what UCUES tells us about UC undergraduates.
Population	University of California students at the following campuses: UC Berkeley UC Davis UC Irvine UC Merced UC Santa Barbara UC Santa Cruz UC Riverside UC Los Angeles UC San Diego
Instrument Type	Survey

Availability (Years)	2006,2008,2010
Latest Year	2010
Instrument Frequency	Biennially
Data Coverage	State, UC campus
Reliability/Validity	http://cshe.berkeley.edu/publications/docs/Chatman.TechReport.10.29.09.pdf Chatman, S. P. (2009, October). Factor structure and reliability of the 2008 and 2009 SERU/UCUES questionnaire core. Research and Occasional Paper Series. CSHE 10.09. Center for Studies in Higher Education. Berkeley, CA. Also see: http://studentsurvey.universityofcalifornia.edu/about/method/validity.html http://studentsurvey.universityofcalifornia.edu/about/method/reliability.html

Acronym	**UCUES**
PEI Goal(s)	Student development module, reviewing student goals, growth, and campus climate, and awareness of mental health and wellness resources (25% of students).
Example questions	Mental Health and Wellness During this academic year, how often has feeling depressed, stressed, or upset been an obstacle to your school work or academic success? Never Rarely Occasionally Somewhat Often Very Often In this academic year, what was your experience with campus counseling and psychological services? Didn't need Needed but didn't use Used the service at least once If you might have needed this service but didn't use this service, why not? I had never heard of it I didn't know what it offered I didn't know if I was eligible I didn't know how to access it I didn't think it would help I had concerns about possible costs I had concerns about possible lack of confidentiality I was embarrassed to use it I didn't have enough time It has a poor reputation The hours are inconvenient The location is inconvenient The wait for an appointment was too long I got help from another university service or staff person I got help off campus Was the treatment that you received effective? Very Effective Effective Not Effective Not Applicable Please rate the quality of service that you received. Excellent Good Fair Poor How could the UCI counseling service better serve your needs? Please be

Acronym	**UCUES** specific. (open response)
Website	http://www.assessment.uci.edu/undergraduate/UCUES.asp http://studentsurvey.universityofcalifornia.edu/
Source Reference	
Other References	
Availability and Cost	Submit proposal to the UCUES principal investigators and steering committee
Link to Instrument(s)	2010 instrument: http://www.assessment.uci.edu/UCUES/UCUES2010/documents/UCUES2010FinalSurveyInstrument.pdf 2008 instrument: http://www.assessment.uci.edu/undergraduate/UCUES2008.asp#SurveyInstrument 2006 instrument: http://www.assessment.uci.edu/undergraduate/documents/UCUES_2006_Survey_Instrument.pdf
Link to Data	2010 core results table: http://www.assessment.uci.edu/UCUES/UCUES2010/documents/UCUESCoreResultTables2010.pdf 2008 core results table: http://www.assessment.uci.edu/undergraduate/documents/UCI_UCUES_2008_Core_Results_000.pdf 2006 core results tables: http://www.assessment.uci.edu/undergraduate/documents/LowerDivisionCoreQuestions.pdf http://www.assessment.uci.edu/undergraduate/documents/UpperDivisionCoreQuestions.pdf
Contact Information	UCUES project manager Paula Zeszotarski can be contacted at paula.zeszotarski@ucop.edu SERU/UCUES project director Steve Chatman can be contacted at steve_chatman@berkeley.edu
Administration/ Scoring	N/A

Youth Risk Behavior Surveillance System

Acronym	**YRBSS; sometimes just YRBS**
Developer	CDC
Description	The Youth Risk Behavior Surveillance System (YRBSS) monitors six types of health-risk behaviors that contribute to the leading causes of death and disability among youth and adults, including— Behaviors that contribute to unintentional injuries and violence; Tobacco use; Alcohol and other drug use; Sexual risk behaviors; Unhealthy dietary behaviors; Physical inactivity. YRBS includes a national school-based survey conducted by CDC and state, territorial, tribal, and local surveys conducted by state, territorial, and local education and health agencies and tribal governments. State and local agencies that conduct a YRBS can add or delete questions to meet their policy or programmatic needs. Specific guidance on the parameters that must be followed during questionnaire modification is provided to those agencies funded by CDC to conduct a YRBS.
Population	High school survey: students in grades 9-12. Middle school survey: students in grades 6-8?
Instrument Type	Telephone interview survey

Availability (Years)	1991-2011 However, for the state surveys, not all states participated every year. For the high school state survey, California did not participate from 2001-2007. For those years that CA did participate (1991-1999, 2009, maybe 2011? Only reported through 2009 so far), its data were unweighted. CA has never participated in the middle school state survey. For the school-based survey for high school students, CA school districts did participate more regularly, and with weighted data: LA has weighted data for 1997, 2001-2009 San Bernardino has weighted data from 2001-2009 San Diego has weighted data from 1991-2009 San Francisco has weighted data from 1997, 2001, 2005-2009 For the school-based survey for middle school students: LA has never participated. San Bernardino has weighted data from 2001-2009 San Diego has weighted data from 1995 only. San Francisco has weighted data from 1997-2009

Acronym	**YRBSS; sometimes just YRBS**
	Participation tables shown here: http://www.cdc.gov/healthyyouth/yrbs/history-states.htm http://www.cdc.gov/healthyyouth/yrbs/history-states_ms.htm
Latest Year	2009; 2011 results will be available in summer 2012
Instrument Frequency	Biannual.
Data Coverage	National, state, and school district (depending on the survey), but participation by states can be sparse (see above).
Reliability/Validity	http://www.cdc.gov/mmwr/PDF/rr/rr5312.pdf
PEI Goal(s)	Suicide [Outcomes] Mental Health / Prolonged Suffering [Outcomes] School Dropout [Process] Incarceration [Process]
Example questions	Demographics How old are you? [A. 12 years old or younger / B. 13 years old / C. 14 years old / D. 15 years old / E. 16 years old / F. 17 years old / G. 18 years old or older] What is your sex? [A. Female / B. Male] In what grade are you? [A. 9th grade / B. 10th grade / C. 11th grade / D. 12th grade / E. Ungraded or other grade] Are you Hispanic or Latino? [A. Yes / B. No] What is your race? (Select one or more responses.) [A. American Indian or Alaska Native / B. Asian / C. Black or African American / D. Native Hawaiian or Other Pacific Islander / E. White] Suicide [Outcomes] and Mental Health [Outcomes] The next 5 questions ask about sad feelings and attempted suicide. Sometimes people feel so depressed about the future that they may consider attempting suicide, that is, taking some action to end their own life. 24. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities? [A. Yes / B. No] 25. During the past 12 months, did you ever seriously consider attempting suicide? [A. Yes / B. No] 26. During the past 12 months, did you make a plan about how you would attempt suicide? [A. Yes / B. No] 27. During the past 12 months, how many times did you actually attempt suicide? [A. 0 times / B. 1 time / C. 2 or 3 times / D. 4 or 5 times / E. 6 or more times] 28. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse? [A. I did not attempt suicide during the past 12 months / B. Yes / C. No] Mental Health [Outcomes], School Dropout [Process], Incarceration [Process]

Acronym	**YRBSS; sometimes just YRBS** The next 10 questions ask about violence-related behaviors. 12. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club? [A. 0 days / B. 1 day / C. 2 or 3 days / D. 4 or 5 days / E. 6 or more days] 13. During the past 30 days, on how many days did you carry a gun? [A. 0 days / B. 1 day / C. 2 or 3 days / D. 4 or 5 days / E. 6 or more days] 14. During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club on school property? [A. 0 days / B. 1 day / C. 2 or 3 days / D. 4 or 5 days / E. 6 or more days] 15. During the past 30 days, on how many days did you not go to school because you felt you would be unsafe at school or on your way to or from school? [A. 0 days / B. 1 day / C. 2 or 3 days / D. 4 or 5 days / E. 6 or more days] 16. During the past 12 months, how many times has someone threatened or injured you with a weapon such as a gun, knife, or club on school property? [A. 0 times / B. 1 time / C. 2 or 3 times / D. 4 or 5 times / E. 6 or 7 times / F. 8 or 9 times / G. 10 or 11 times / H. 12 or more times] 17. During the past 12 months, how many times were you in a physical fight? [A. 0 times / B. 1 time / C. 2 or 3 times / D. 4 or 5 times / E. 6 or 7 times / F. 8 or 9 times / G. 10 or 11 times / H. 12 or more times] 18. During the past 12 months, how many times were you in a physical fight in which you were injured and had to be treated by a doctor or nurse? [A. 0 times / B. 1 time/ C. 2 or 3 times / D. 4 or 5 times / E. 6 or more times] 19. During the past 12 months, how many times were you in a physical fight on school property? [A. 0 times / B. 1 time / C. 2 or 3 times / D. 4 or 5 times / E. 6 or 7 times / F. 8 or 9 times / G. 10 or 11 times / H. 12 or more times] 20. During the past 12 months, did your boyfriend or girlfriend ever hit, slap, or physically hurt you on purpose? [A. Yes / B. No] 21. Have you ever been physically forced to have sexual intercourse when you did not want to? [A. Yes / B. No] The 2 next questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way. 22. During the past 12 months, have you ever been bullied on school property? [A. Yes / B. No] 23. During the past 12 months, have you ever been electronically bullied? (Include being bullied through email, chat rooms, instant messaging, Web sites, or texting.) [A. Yes / B. No] The next 6 questions ask about drinking alcohol. This includes drinking beer, wine, wine coolers, and liquor such as rum, gin, vodka, or whiskey. For these questions, drinking alcohol does not include drinking a few sips of wine for

Acronym	**YRBSS; sometimes just YRBS**

religious purposes.
40. During your life, on how many days have you had at least one drink of alcohol? [A. 0 days / B. 1 or 2 days / C. 3 to 9 days / D. 10 to 19 days / E. 20 to 39 days / F. 40 to 99 days / G. 100 or more days]
41. How old were you when you had your first drink of alcohol other than a few sips? [A. I have never had a drink of alcohol other than a few sips / B. 8 years old or younger / C. 9 or 10 years old / D. 11 or 12 years old / E. 13 or 14 years old / F. 15 or 16 years old / G. 17 years old or older]
42. During the past 30 days, on how many days did you have at least one drink of alcohol? [A. 0 days / B. 1 or 2 days / C. 3 to 5 days / D. 6 to 9 days / E. 10 to 19 days / F. 20 to 29 days / G. All 30 days]
43. During the past 30 days, on how many days did you have 5 or more drinks of alcohol in a row, that is, within a couple of hours? [A. 0 days / B. 1 day / C. 2 days / D. 3 to 5 days / E. 6 to 9 days / F. 10 to 19 days / G. 20 or more days]
44. During the past 30 days, how did you usually get the alcohol you drank? [A. I did not drink alcohol during the past 30 days / B. I bought it in a store such as a liquor store, convenience store, supermarket, discount store, or gas station / C. I bought it at a restaurant, bar, or club / D. I bought it at a public event such as a concert or sporting event / E. I gave someone else money to buy it for me / F. Someone gave it to me / G. I took it from a store or family member / H. I got it some other way]
45. During the past 30 days, on how many days did you have at least one drink of alcohol on school property? [A. 0 days / B. 1 or 2 days / C. 3 to 5 days / D. 6 to 9 days / E. 10 to 19 days / F. 20 to 29 days / G. All 30 days]

The next 4 questions ask about marijuana use. Marijuana also is called grass or pot.
46. During your life, how many times have you used marijuana? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 to 99 times / G. 100 or more times]
47. How old were you when you tried marijuana for the first time? [A. I have never tried marijuana / B. 8 years old or younger / C. 9 or 10 years old / D. 11 or 12 years old / E. 13 or 14 years old / F. 15 or 16 years old / G. 17 years old or older]
48. During the past 30 days, how many times did you use marijuana? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times]
49. During the past 30 days, how many times did you use marijuana on school property? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times]

The next 10 questions ask about other drugs.
50. During your life, how many times have you used any form of cocaine,

Acronym	**YRBSS; sometimes just YRBS**
	including powder, crack, or freebase? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 51. During the past 30 days, how many times did you use any form of cocaine, including powder, crack, or freebase? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 52. During your life, how many times have you sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 53. During your life, how many times have you used heroin (also called smack, junk, or China White)? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 54. During your life, how many times have you used methamphetamines (also called speed, crystal, crank, or ice)? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 55. During your life, how many times have you used ecstasy (also called 3,4-methylenedioxymethamphetamine or MDMA)? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 56. During your life, how many times have you taken steroid pills or shots without a doctor's prescription? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 57. During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription? [A. 0 times / B. 1 or 2 times / C. 3 to 9 times / D. 10 to 19 times / E. 20 to 39 times / F. 40 or more times] 58. During your life, how many times have you used a needle to inject any illegal drug into your body? [A. 0 times / B. 1 time / C. 2 or more times] 59. During the past 12 months, has anyone offered, sold, or given you an illegal drug on school property? [A. Yes / B. No] The next 7 questions ask about sexual behavior. 60. Have you ever had sexual intercourse? [A. Yes / B. No] 61. How old were you when you had sexual intercourse for the first time? [A. I have never had sexual intercourse / B. 11 years old or younger / C. 12 years old / D. 13 years old / E. 14 years old / F. 15 years old / G. 16 years old / H. 17 years old or older] 62. During your life, with how many people have you had sexual intercourse? [A. I have never had sexual intercourse / B. 1 person / C. 2 people / D. 3 people / E. 4 people / F. 5 people / G. 6 or more people] 63. During the past 3 months, with how many people did you have sexual intercourse? [A. I have never had sexual intercourse / B. I have had sexual intercourse, but not during the past 3 months / C. 1 person / D. 2 people / E. 3 people / F. 4 people / G. 5 people / H. 6 or more people]

Acronym	**YRBSS; sometimes just YRBS** 64. Did you drink alcohol or use drugs before you had sexual intercourse the last time? [A. I have never had sexual intercourse / B. Yes / C. No] 65. The last time you had sexual intercourse, did you or your partner use a condom? [A. I have never had sexual intercourse / B. Yes / C. No] 66. The last time you had sexual intercourse, what one method did you or your partner use to prevent pregnancy? (Select only one response.) [A. I have never had sexual intercourse / B. No method was used to prevent pregnancy / C. Birth control pills / D. Condoms / E. Depo-Provera (or any injectable birth control), Nuva Ring (or any birth control ring), Implanon (or any implant), or any IUD / F. Withdrawal / G. Some other method / H. Not sure]

Website	http://www.cdc.gov/HealthyYouth/yrbs/index.htm
Source Reference	
Other References	http://www.cdc.gov/healthyyouth/yrbs/publications.htm
Availability and Cost	Data are freely available online.
Link to Instrument(s)	http://www.cdc.gov/healthyyouth/yrbs/questionnaire_rationale.htm
Link to Data	http://www.cdc.gov/healthyyouth/yrbs/data/index.htm
Contact Information	http://www.cdc.gov/healthyyouth/yrbs/contactyrbs.htm
Administration/Scoring	Methodology: http://www.cdc.gov/mmwr/PDF/rr/rr5312.pdf

Appendix C

Measure Descriptions

Legislative Goal 1: Suicide Evaluation

WHERE IS IT GOING?

Aim 1: Increase the capacity of hot/warm lines

INDICATOR 1A: NUMBER OF SUICIDE PREVENTION HOT/WARM LINES

Numerator: Number of accredited crisis centers serving California residents that provide suicide prevention hotline services

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of accredited California crisis centers**:** Centers listed by the American Association of Suicidology list of AAS-accredited crisis centers
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler, Andrews, Colpe et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- These are national crisis centers that are located in CA, as well as centers located outside of CA that serve CA residents.
- See this report: http://www.dmh.ca.gov/peistatewideprojects/docs/SuicidePrevention/HotlineSurveyReport.pdf
    - However, the survey looks like it has only been done once in 2010 and it is unclear whether it is being repeated. We would need to recommend conducting this survey regularly.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 1B: CAPACITY OF SUICIDEPREVENTION HOT/WARM LINES

Numerator: Number of staff FTEs at hot/warm lines

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of staff FTEs at hot/warm lines as reported in California Suicide Prevention Hotline Survey Report
    - Note that this survey is not currently being replicated
    - Data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area

        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- See this report: http://www.dmh.ca.gov/peistatewideprojects/docs/SuicidePrevention/HotlineSurveyReport.pdf
    - However, the survey looks like it has only been done once in 2010 and it is unclear whether it is being repeated
- In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.
- Both denominators have relevant policy implications.

INDICATOR 1C: NUMBER OF CALLS TO CRISIS HOTLINES

Numerator: Number of calls to crisis hotlines

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of calls from California callers to crisis hotlines from the National Suicide Prevention Lifeline
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Available as calls per crisis center, month, county.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 1D: PERCENT OF HOT/WARMLINE CALLS RESULTING IN MENTAL HEALTH TREATMENT

Numerator: Number of hot/warmline calls resulting in mental health treatment

Denominator: Total number of hot/warmline callers who were given a referral

Definitions and data sources:

- Data source to be recommended

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- The data source in this indicator is to be recommended. This information is not routinely tracked by the National Suicide Prevention Lifeline.

- In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.

Aim 2: Increase survivor and peer support services

INDICATOR 2A: NUMBER OF PEER SURVIVOR SUPPORT GROUPS

Numerator: Number of peer survivor support groups

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of peer survivor support groups data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 2B: NUMBER AND CAPACITY OF PEER SURVIVOR SUPPORT GROUPS

Numerator: Number of staff FTEs at peer survivor support groups

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of staff FTEs at peer survivor support groups: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Aim 3: Increase the number of suicide prevention, training and education programs

INDICATOR 3A: NUMBER OF SUICIDE AWARENESS PROGRAMS

Numerator: Number of suicide awareness programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of suicide awareness programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county

    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 3B: CAPACITY OF SUICIDE AWARENESS PROGRAMS

Numerator: Number of staff FTEs at suicide awareness programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of staff FTEs at suicide awareness programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison

    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 3C: NUMBER OF SUICIDE PREVENTION TRAINING PROGRAMS

Numerator: Number of suicide prevention training programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of suicide prevention training programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:

- Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 3D: CAPACITY OF SUICIDE PREVENTION TRAINING PROGRAMS

Numerator: Number of staff FTEs at suicide prevention training programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of staff FTEs at suicide prevention training programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:

- Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
  OR:
- Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Will conduct these analyses by location as well (e.g., geographic reach of these programs)
- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Aim 4: Improved interagency collaboration/coordination

See related indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being, Aim3: Improved interagency collaboration/coordination.*

Aim 5: Improve media portrayals of people with mental illness

This is an aspirational aim. Further work needs to be conducted to identify data sources for media portrayals of people with mental illness.

WHAT IS IT DOING?

Aim 6: Increase exposure to suicide awareness services and programs

INDICATOR 6A: NUMBER OF PEOPLE REACHED BY SUICIDE AWARENESS PROGRAMS

Numerator: Number of people reached by suicide awareness programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of people reached by suicide awareness programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

INDICATOR 6B: NUMBER OF PEOPLE REACHED BY PEER SURVIVOR SUPPORT GROUPS

Numerator: Number of people reached by peer survivor support groups

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Number of people reached by peer survivor support groups: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Aim 7: Improve knowledge and skills of gatekeepers

This is an aspirational goal. Further work needs to be conducted to identify data sources for number of first identifiers and hot/warm-line staff with knowledge of suicide protocols.

Aim 8: Increase utilization and uptake of mental health services

INDICATOR 8A: INCREASED UTILIZATION OF SUICIDE PREVENTION PROGRAMS

Numerator: Utilization of suicide prevention programs

Denominator:

a. Population of CA
b. Population in need as defined by CHIS

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Utilization of suicide prevention programs: data source to be recommended
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison

    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- The data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

DOES IT MAKE A DIFFERENCE?

Aim 9: Decreased psychological distress and psychological suffering over time

See related psychological distress indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time*:

- Indicator 23A: Percentage of individuals with serious psychological distress (SPD)

Aim 10: Improved psychological functioning

See related functioning indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23B: Impact of mental health on functioning
- Indicator 23C: Frequency of impaired functioning in the past month
- Indicator 23F: Rates of improved functioning as a result of mental health services

Aim 11: Reduced thoughts and plans of suicides

See related thoughts and plans of suicide indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23D: Percent of youth and adults considering suicide

Aim 12: Decrease in number of suicide attempts

See related suicide attempts indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23E: Percent of youth and adults attempting suicide

Aim 13: Increased legislation related to decreasing access to lethal means

INDICATOR 13A: ANNUAL NUMBER OF INTRODUCED BILLS RELATED TO GUN CONTROL OR PRESCRIPTION DRUG ACCESS

Numerator: Number of introduced bills involving any of the following:

- Gun control, including
    - bans on specified firearms or ammunition
    - restrictions on firearm acquisition,
    - waiting periods for firearm acquisition
    - firearm registration and licensing of firearm owners
    - child access prevention laws
    - zero tolerance laws for firearms in schools
    - combinations of firearms laws described above
- Prescription drug control

Denominator: Year

Definitions and data sources:

- Information on number of introduced bills not available in databases but could be obtained.

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Legal Community Against Violence (LCAV) tracks introduced legislation related to firearms

- Prescription drug legislation would need to be searched for in the database of the CA state legislature: http://www.legislature.ca.gov/port-bilinfo.html

ARE THERE PUBLIC HEALTH BENEFITS?

Aim 14: Reduction in suicide rate

INDICATOR 14A: SUICIDE RATE

Numerator: Number of suicides

Denominator: Population of CA

Definitions and data sources:

- Number of suicides in California available through California's Electronic Violent Death Reporting System (CalEVDRS)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- National level comparison data available through the Center for Disease Control (CDC) Web-based Injury Statistics Query and Reporting System (WISQARS)
- CalEVDRS covers 14 counties and only 57% of all violent deaths in California. Please see the dataset description for more information.

Legislative Goal 2: Homelessness

WHERE IS IT GOING?

Aim 1: Increase youth housing assistance and counseling programs

This is an aspirational goal. Further work needs to be conducted to identify data sources for number of youth housing assistance and counseling programs. This is information that could be provided by counties to a centralized data repository for analysis.

Aim2: Increase capacity of supported or transitional housing programs

This is an aspirational goal. Further work needs to be conducted to identify data sources for capacity of supported or transitional housing. This is information that could be provided by counties to a centralized data repository for analysis.

Aim 3: Increase number of programs to prevent homelessness

INDICATOR 3A: NUMBER OF PEI-FUNDED PROGRAMS THAT PROVIDE HOUSING-RELATED SERVICES TO PEOPLE WITH MENTAL ILLNESS AND/OR TAKE MENTALLY ILL INDIVIDUALS OUT OF SHELTERS

Numerator: Number of PEI-funded programs that provide housing-related services to people with mental illness and/or take mentally ill individuals out of shelters

Denominator:

a. Number of individuals with SMI who have residential instability
b. Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered

Definitions and data sources:

- Number of PEI-funded programs that provide housing-related services to people with mental illness and/or take mentally ill individuals out of shelters: Data source to be recommended
- Number of individuals with SMI who have residential instability: Data source to be recommended
- Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered: Point-in-Time Homeless Persons Count (PIT), U.S. Department of Housing and Urban Development.
    - Variable: “Summary of homeless persons by subpopulation reported.”
    - Two relevant subpopulations are “Severely Mentally Ill” and Chronic Substance Abuse”

Analysis:

- Level of comparison
    - TBD
- Timeframe
    - TBD

Notes:

- PIT reports homelessness by subpopulation, including severe mental illness and substance abuse, for both sheltered and unsheltered homeless.
- Data source for number of PEI-funded programs that provide housing-related services to people with mental illness and/or take mentally ill individuals out of shelters and individuals with SMI who have residential instability is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. This is data that could be provided by programs to the county and then to a centralized data repository for analysis.

Aim 4: Increase screening, evaluation and early intervention programs for homeless or unstably housed individuals

This is an aspirational aim. Further work needs to be conducted to identify data sources for screening, evaluation and early intervention programs for homeless or unstably housed individuals. This is data that could be provided by programs to the county and then to a centralized data repository for analysis.

WHAT IS IT DOING?

Aim 5: Reduce discriminatory housing policies

This is an aspirational aim. Further work needs to be conducted to identify data sources related to:

- public housing policies for people with mental illness, and
- county laws around vagrancy, and
- county laws around use of public space

Aim 6: Increase use of housing-related supportive services

INDICATOR 6A: TOTAL NUMBER OF MENTALLY ILL INDIVIDUALS SERVED BY PEI-FUNDED HOMELESSNESS PREVENTION PROGRAMS

Numerator: Total number of individuals served by PEI-funded homelessness prevention programs

Denominator:

a. Number of individuals with SMI who have residential instability
b. Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered

Definitions and data sources:

- Number of individuals served by PEI-funded homelessness prevention programs: Data source to be recommended
- Number of individuals with SMI who have residential instability: Data source to be recommended
- Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered: Point-in-Time Homeless Persons Count (PIT), U.S. Department of Housing and Urban Development.
    - Variable: "Summary of homeless persons by subpopulation reported."
    - Two relevant subpopulations are "Severely Mentally Ill" and Chronic Substance Abuse"

Analysis:

- Level of comparison
    - TBD
- Timeframe
    - TBD

Notes:

- PIT reports homelessness by subpopulation, including severe mental illness and substance abuse, for both sheltered and unsheltered homeless.
- Data source for individuals with SMI who have residential instability is to be recommended, as is the data source for number of individuals served by PEI-funded homelessness prevention programs
- In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. This is data that could be provided by programs to the county and then to a centralized data repository for analysis.

Aim 7: Increase coordination between housing/ homeless services and mental-health system

See related indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, Aim4: Improved interagency collaboration/coordination.

Aim 8: Increase screening, referral, utilization and quality of mental health services for at-risk or homeless mentally ill

This is an aspirational aim. At this point measures and population-level data sources do not exist to capture this item.

Aim 9: Increase availability of supportive or transitional housing

INDICATOR 9A: TOTAL NUMBER OF HOUSING UNITS AVAILABLE TO INDIVIDUALS WITH SEVERE MENTAL ILLNESS OR CHRONIC SUBSTANCE ABUSE

Numerator: Total number of housing units available to individuals with severe mental illness or chronic substance abuse

Denominator:

a. Number of individuals with SMI who have residential instability
b. Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered

Definitions and data sources:

- Total number of housing units available to individuals with severe mental illness or chronic substance abuse: Housing Inventory Count (HIC), US Department of Housing and Urban Development
- Number of individuals with SMI who have residential instability: Data source to be recommended
- Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered: Point-in-Time Homeless Persons Count (PIT), U.S. Department of Housing and Urban Development.
    - Variable: "Summary of homeless persons by subpopulation reported."
    - Two relevant subpopulations are "Severely Mentally Ill" and Chronic Substance Abuse"

Analysis:

- Level of comparison
    - TBD
- Timeframe
    - TBD

Notes:

- HIC reports beds by facility, not by subpopulation (e.g., SMI, substance use), so it would be very challenging to tease out which facilities serve these subpopulations.
- PIT reports homelessness by subpopulation, including severe mental illness and substance abuse, for both sheltered and unsheltered homeless.

- Data source for individuals with SMI who have residential instability is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Aim 10: Increase homeless outreach teams

This is an aspirational aim. Further work needs to be conducted to identify county-level data sources that could be aggregated to capture this item at the level of the community.

DOES IT MAKE A DIFFERENCE?

Aim 11: Decrease homelessness among the mentally ill

INDICATOR 11A: PERCENTAGE OF INDIVIDUALS ENTERING MENTAL HEALTH OR SUBSTANCE USE TREATMENT WHO ARE HOMELESS (COUNTY COMPARISONS WITHIN CA)

Numerator: Number of individuals entering mental health or substance use treatment who are homeless

Denominator: Number of individuals entering mental health or substance use treatment

Definitions and data sources:

- Number of individuals entering mental health or substance use treatment who are homeless: Client and Service Information System (*CSI*)

Analysis:

- *Level of comparison*
  - *Priority populations*
    - *Overall*
    - *By county*
- *Timeframe*
  - *Annual*

Notes:

- Variables would have to be calculated from data on new admissions. Homelessness can be determined from variable P-09.0, Living Arrangement.

INDICATOR 11B: NUMBER OF PEOPLE RECEIVING MEDICAID SERVICES (MENTAL HEALTH OR MEDICAL) IN A HOMELESS SHELTER

Numerator: Number of people receiving Medicaid services (mental health or medical) in a homeless shelter

Denominator: Number of people in homeless shelters

Definitions and data sources:

- Number of people receiving Medicaid services (mental health or medical) in a homeless shelter: This is not currently collected by Medicaid but could conceivably be added. It may also be possible to use the Homeless Management Information System http://portal.hud.gov/hudportal/HUD?src=/program_offices/comm_planning/homeless/hmis

Analysis:

- Level of comparison
  - TBD
- Timeframe
  - TBD

Notes:

- Consider whether it is possible to capture homeless-related services using Medi-Cal data.
- Data source is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

INDICATOR 11C: NUMBER OF INDIVIDUALS WITH SMI OR SUBSTANCE ABUSE WHO ARE HOMELESS

Numerator: Number of individuals with SMI or substance abuse who are homeless

Denominator: Population of CA

Definitions and data sources:

- Number of individuals with SMI or chronic substance abuse who are homeless, whether sheltered or unsheltered: Point-in-Time Homeless Persons Count (PIT), U.S. Department of Housing and Urban Development.
  - Variable: "Summary of homeless persons by subpopulation reported."
  - Two relevant subpopulations are "Severely Mentally Ill" and Chronic Substance Abuse"

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Both data sources permit national comparisons.

ARE THERE PUBLIC HEALTH BENEFITS?

Aim 12: Decrease Emergency Department use by homeless individuals

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Notes:

- The California Office Of Statewide Health Planning And Development reports homeless data as 00 which is used to indicate that the patient's zip code was unknown, outside California, outside the U.S., or homeless as part of the Emergency Department / Ambulatory Surgery data. If this data can be disaggregated, it can be used for the purpose of measuring emergency department use by homeless individuals.

Aim 13: Increase other treatment resources for the homeless mentally ill

INDICATOR 13A: NUMBER OF SOCIAL WORKERS IN HOSPITAL SETTINGS

Numerator: Number of social workers working in hospital settings

Denominator: Number of hospital discharges per unit of time

Definitions and data sources:

- Social workers, as defined by the Bureau of Labor Statistics (Statistics, 2011): Social workers (21-1021, 21-1022, 21-1023, 21-1029)

- Hospital setting includes private, state, and local government hospitals as defined by the Bureau of Labor Statistics (North American Industry Classification System [NAICS] 622000) http://www.bls.gov/oes/current/naics3_622000.htm
- Number of hospital discharges per unit of time: Available from OSHPD

Analysis:

- Level of comparison
    - National
    - Priority populations
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- NA

Legislative Goal 3: Incarceration

WHERE IS IT GOING?

Aim 1: Increase in sentencing diversion programs and mental-health courts

INDICATOR 1A: NUMBER OF PROGRAMS WITH A FOCUS ON DECREASING THE INCARCERATION OF INDIVIDUALS WITH MENTAL ILLNESS

Numerator: Number of programs with a focus on decreasing the incarceration of individuals with mental illness, including recidivism and sentencing diversion programs

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Number of programs with a focus on decreasing the incarceration of individuals with mental illness, including recidivism and sentencing diversion programs: Data source to be recommended

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and

standardized definitions for program level data on structure and process. This is information that could be provided by the county to a central data repository for analysis.

INDICATOR 1B: CAPACITY OF PROGRAMS WITH A FOCUS ON DECREASING THE INCARCERATION OF INDIVIDUALS WITH MENTAL ILLNESS

Numerator: Capacity of programs with a focus on decreasing the incarceration of individuals with mental illness, including recidivism and sentencing diversion programs
Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of programs with a focus on decreasing the incarceration of individuals with mental illness, including recidivism and sentencing diversion programs: Defined as staff FTEs; Data source to be recommended

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. This is information that could be provided by the county to a central data repository for analysis.

Aim 2: Increase in support services

INDICATOR 2A: NUMBER OF PROGRAMS DIRECTED AT REDUCING RISK FOR INCARCERATION AMONG TRANSITIONAL AGE YOUTH

Numerator: Number of programs with a focus on decreasing the incarceration of individuals with mental illness, including recidivism and sentencing diversion programs
Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Number of programs directed at reducing risk for incarceration among transitional age youth: Data source to be recommended

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

INDICATOR 2B: CAPACITY OF PROGRAMS WITH A FOCUS ON DECREASING THE INCARCERATION OF INDIVIDUALS WITH MENTAL ILLNESS

Numerator: Capacity of programs directed at reducing risk for incarceration among transitional age youth
Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of programs directed at reducing risk for incarceration among transitional age youth: Defined as staff FTEs; Data source to be recommended

Analysis:

- Level of comparison
  - Priority populations
    - Overall
    - By county
  - Land Area
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Data source for this indicator is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Aim 3: Improve mental-health screening for at-risk youth or youth in juvenile and criminal justice systems

This is an aspirational aim. Population-level data sources do not currently exist to assess this aim.

Aim 4: Promote training and collaboration with law enforcement and justice system

This is an aspirational aim. Population-level data sources do not currently exist to assess this aim.

WHAT IS IT DOING?

Aim 5: Increase in capacity and knowledge of law enforcement personnel

This is an aspirational aim. Data sources do not currently exist to assess this aim.

Aim 6: Improvement in the quality of mental health services in the criminal justice system

This is an aspirational aim. Data sources and measures do not currently exist to assess this aim.

Aim 7: Increase referral between justice and mental health system

See related indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim3: Improved interagency collaboration/coordination* for indicator specifications. Relevant collaborative relationships to measure include the following:

- collaboration between criminal justice system agencies and mental health system agencies
- collaboration between criminal justice system agencies and social service agencies providing services to criminal justice population, and
- collaboration between mental health system agencies and social service agencies providing services to criminal justice population

Aim 8: Increased utilization of diversion programs

This is an aspirational aim. Data sources do not currently exist to assess this aim.

DID IT IMPACT OUTCOMES?

Aim 9: Improved resilience and emotional well-being

See related psychological distress indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time*:

- Indicator 23A: Percentage of individuals with serious psychological distress (SPD)

Also see related resilience indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, Aim 21: Increased resilience among youth

- Indicator 21A: Increased resilience among youth

Aim 10: Improved psychological functioning

See related functioning indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23B: Impact of mental health on functioning
- Indicator 23C: Frequency of impaired functioning in the past month
- Indicator 23F: Rates of improved functioning as a result of mental health services

Aim 11: Reduction in risk behaviors such as substance abuse, violence etc.

INDICATOR 11A: PROPORTION OF HIGH SCHOOL STUDENTS WHO CARRY A WEAPON

Numerator: Number of high school student YRBSS respondents who carried a weapon such as a gun, knife, or club in the past 30 days

Denominator: YRBSS survey respondents

Definitions and data sources:

- Number of high school student YRBSS respondents who carried a weapon: Data will come from YRBSS High school module (Question #12), including all respondents who answer greater than zero days to the following question:
    - During the past 30 days, on how many days did you carry a weapon such as a gun, knife, or club?

Analysis:

- Level of comparison
    - National
    - District
    - School (depending on sample size)
- Timeframe
    - Annual

Notes:

- Can assess at school district and national level, although state participation can be sparse
- Number of days can be 0; 1; 2 or 3; 4 or 5; 6 or more
- Several variants of the numerator can be formulated based on different questions in the YRBSS survey; see questions 12-14
- The Youth Risk Behavior Surveillance System (YRBSS) measures health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

INDICATOR 11B: PROPORTION OF HIGH SCHOOL WHO ARE IN PHYSICAL FIGHTS
Numerator: Number of high school student YRBSS respondents who were in a physical fight in the last 12 months

Denominator: YRBSS survey respondents

Definitions and data sources:

- Number of high school student YRBSS respondents who were in a physical fight in the last 12 months: Data will come from YRBSS High school module (Question #17), including all respondents who answer greater than zero times to the following question:
    - During the past 12 months, how many times were you in a physical fight?

Analysis:

- Level of comparison
    - Priority populations
    - National
    - District
- Timeframe
    - Annual

Notes:

- Can assess at school district and national level, although state participation can be sparse
- Number of times can be 0; 1; 2 or 3; 4 or 5; 6 or 7; 8 or 9; 10 or 11; 12 or more
- Several variants of the numerator can be formulated based on different questions in the YRBSS survey; see questions 17-19
- The Youth Risk Behavior Surveillance System (YRBSS) measures health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

INDICATOR 11C: PROPORTION OF HIGH SCHOOL STUDENTS WHO DRINK ALCOHOL
Numerator: Number of high school student YRBSS respondents who had at least one drink of alcohol in the last 30 days

Denominator: YRBSS survey respondents

Definitions and data sources:

- Number of high school student YRBSS respondents who had at least one drink of alcohol in the last 30 days: Data will come from YRBSS High school module (Question #42), including all respondents who answer greater than zero days to the following question:

- During the past 30 days, on how many days did you have at least one drink of alcohol?

Analysis:

- Level of comparison
  - Priority populations
  - National
- Timeframe
  - Annual

Notes:

- Can assess at school district, state, and national level, although state participation can be sparse
- Number of days can be 0; 1 or 2; 3 to 5; 6 to 9; 10 to 19; 20 to 29; all 30
- Several variants of the numerator can be formulated based on different questions in the YRBSS survey; see questions 40-45
- The Youth Risk Behavior Surveillance System (YRBSS) measures health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

INDICATOR 11D: HIGH SCHOOL STUDENTS' DRUG USE

Numerator: Number of high school student YRBSS respondents that have used drugs in their lifetime

Denominator: YRBSS survey respondents

Definitions and data sources:

- Number of high school student YRBSS respondents that have used drugs in their lifetime: Data will come from YRBSS High school module (Questions 46, 50, 52-58), including all respondents who answer greater than zero days to any of the following questions:
  - 46. During your life, how many times have you used marijuana?
  - 50. During your life, how many times have you used any form of cocaine, including powder, crack, or freebase?
  - 52. During your life, how many times have you sniffed glue, breathed the contents of aerosol spray cans, or inhaled any paints or sprays to get high?
  - 53. During your life, how many times have you used heroin (also called smack, junk, or China White)?
  - 54. During your life, how many times have you used methamphetamines (also called speed, crystal, crank, or ice)?
  - 55. During your life, how many times have you used ecstasy (also called MDMA)?
  - 56. During your life, how many times have you taken steroid pills or shots without a doctor's prescription?

- 57. During your life, how many times have you taken a prescription drug (such as OxyContin, Percocet, Vicodin, codeine, Adderall, Ritalin, or Xanax) without a doctor's prescription?
- 58. During your life, how many times have you used a needle to inject any illegal drug into your body?

Analysis:

- Level of comparison
  - Priority populations
  - National
- Timeframe
  - Annual

Notes:

- Can assess at school district, state, and national level, although state participation can be sparse
- Drugs include marijuana, cocaine, inhalants, heroin, methamphetamines, ecstasy, steroids, prescription drugs, needles to inject any illegal drugs
- Several variants of the numerator for marijuana and cocaine can be formulated based on different questions in the YRBSS survey; see questions 46-49 and 50-51, respectively
- The Youth Risk Behavior Surveillance System (YRBSS) health-risk behaviors that contribute to the leading causes of death and disability among youth and adults.

Aim 12: Increased social connectedness and family functioning

See related social connectedness indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, Aim 13: Increased neighborhood cohesion and social connectedness:

- Indicator 13A: Ratings of neighborhood cohesion among adults
- Indicator 13B: Social connectedness among youth
- Indicator 13C: Social connectedness among adults

See related family functioning indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being, Aim 14: Improved family functioning:*

- Indicator 14A: Rate of adolescents confiding plans to parents
- Indicator 14B: Adolescents with caring relationships at home
- Indicator 14C: Adolescents with high expectations at home

Aim 13: Decrease in arrests of people with mental illnesses

INDICATOR 13A: PROPORTION OF POPULATION RECEIVING PUBLIC MENTAL HEALTH SERVICES FOR ONE YEAR OR LESS WHO WERE ARRESTED IN THE 12 MONTHS PRIOR TO THE START OF SERVICES

Numerator: Population of CPS respondents receiving public mental health services for one year or less arrested in the 12 months prior to the start of services
Denominator: Population of CPS respondents receiving public mental health services for one year or less

Definitions and data sources:

- Population receiving public mental health services for one year or less arrested in the 12 months prior to the start of services: Data come from California Consumer Perception Survey (CPS), answer to the following question:
    - (C,M) Were you arrested in the 12 months prior to that [start of services]?

Analysis:

- Level of comparison
    - National
    - Priority populations
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Can assess at county and state level
- Population can be adults, older adults, children, or families answering for children, depending on which survey is used
- Demographic data available (age, gender, ethnicity)
- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.

INDICATOR 13B: PROPORTION OF POPULATION RECEIVING PUBLIC MENTAL HEALTH SERVICES FOR ONE YEAR OR MORE WHO WERE ARRESTED IN THE LAST 12 MONTHS

Numerator: Population of CPS respondents receiving public mental health services for one year or more arrested in the last 12 months

Denominator: Population of CPS respondents receiving public mental health services for one year or more

Definitions and data sources:

- Population of CPS respondents receiving public mental health services for one year or more arrested in the last 12 months: Data come from California Consumer Perception Survey (CPS), answers to the following question:
    - Since you began to receive mental health services (or, if receiving services for more than one year, over the last year), have your encounters with police: [Been reduced (for example, I have not been arrested, hassled by police, taken by police to a shelter or crisis program) / Stayed the same / Increased / Not applicable (I had no police encounters this year or last year)]

Analysis:

- Level of comparison
    - National
    - Priority populations
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Can assess at county and state level
- Population can be adults, older adults, children, or families answering for children, depending on which survey is used
- Demographic data available (age, gender, ethnicity)
- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.

INDICATOR 13C: PROPORTION OF POPULATION RECEIVING PUBLIC MENTAL HEALTH SERVICES FOR ANY LENGTH OF TIME WHO WERE ARRESTED IN THE LAST MONTH

Numerator: Population of CPS respondents receiving public mental health services for any length of time arrested in the last month

Denominator: Population of CPS respondents receiving public mental health services for any length of time

Definitions and data sources:

- Population of CPS respondents receiving public mental health services for any length of time arrested in the last month: Data come from California Consumer Perception Survey (CPS), answers to the following question:

- In the past MONTH, how many times have you been arrested for any crimes?

Analysis:

- Level of comparison
  - National
  - Priority populations
    - Overall
    - By county
- Timeframe
  - Annual

Notes:

- Can assess at county and state level
- Population can be adults, older adults, children, or families answering for children, depending on which survey is used
- Demographic data available (age, gender, ethnicity)
- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.

INDICATOR 13D: PROPORTION OF POPULATION RECEIVING PUBLIC MENTAL HEALTH SERVICES FOR ONE YEAR OR LESS WHO HAVE BEEN ARRESTED SINCE SERVICES BEGAN

Numerator: Population of CPS respondents receiving public mental health services for one year or less arrested since services began

Denominator: Population of CPS respondents receiving public mental health services for one year or less

Definitions and data sources:

- Population of CPS respondents receiving public mental health services for one year or less arrested since services began: Data come from California Consumer Perception Survey (CPS), answers to the following question:
  - Were you arrested since you began to receive mental health services (or, if receiving services for more than one year, were you arrested during the last 12 months)?

Analysis:

- Level of comparison
  - National
  - Priority populations

        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Can assess at county and state level
- Population can be adults, older adults, children, or families answering for children, depending on which survey is used
- Demographic data available (age, gender, ethnicity)
- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.

ARE THERE PUBLIC HEALTH BENEFITS?

Aim 14: Decrease in incarceration of persons with mental illnesses

INDICATOR 14A: PERCENT OF ALL INPATIENT ADMISSIONS FOR MENTAL HEALTH PROBLEMS THAT ARE JAIL INPATIENT ADMISSIONS TO FACILITIES BOTH WITHIN AND OUTSIDE JAILS

Numerator: TOTAL OF BOTH: Number of transfers from jails for admission to local inpatient facilities pursuant to PC 4011.6 or 4011.8 (both involuntary and voluntary) AND Number of admissions to an LPS approved inpatient treatment program within a jail (both involuntary and voluntary)

Denominator:

a. All inpatient admissions for primary diagnosis of mental health problem

Definitions and data sources:

- Numerator: Data come from California Department of Mental Health Involuntary Detention Reports.
- All inpatient admissions for primary diagnosis of mental health problem: Data come from California Office of Statewide Health Planning and Development (OSHPD), Annual Utilization Report of Hospitals

Analysis:

- Level of comparison
    - National
    - Priority populations
        - Overall
        - By county
- Timeframe

- Annual

Notes:

- Can assess at county and state level
- Numerator is duplicated count of admissions
- Numerator data source is reportedly poor: the data is haphazardly reported to the state by individual counties, and there is no standardization across counties for when to admit patients to programs within jails or when to refer patients to local facilities
- The numerator and denominator come from different data sources, but OSHPD reportedly contains individuals in the numerator as well. If this assumption is found to be incorrect, then could either:
  - Analyze the "number" of transfers from jails directly instead of the proportion thereby eliminating the need for a denominator.
  - Change the denominator into the full population of California and in which case the people in the jail transfers are also part of the California population i.e. the denominator.

INDICATOR 14B: PROPORTION OF ADULT INMATES IN TYPE II, III, AND IV JAILS ASSIGNED TO MENTAL HEALTH BEDS

Numerator: Number of adult inmates assigned to mental health beds last day of month in type II, III, and IV jails

Denominator: Total adult average daily population (ADP) in type II, III, and IV jails (per facility)

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Jail Profile Survey

Analysis:

- Level of comparison
  - County
  - Facility
- Timeframe
  - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health bed and type II, III, and IV facilities

- The Jail Profile Survey is a query that provides highest daily jail populations at the county level.

INDICATOR 14C: POINT PREVALENCE OF ADULT MENTAL HEALTH CASES IN TYPE II, III, AND IV JAILS

Numerator: Adult mental health cases opened last day of the month in type II, III, and IV jails

Denominator: Total adult average daily population (ADP) in type II, III, and IV jails

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Jail Profile Survey

Analysis:

- Level of comparison
  - County
  - Facility
- Timeframe
  - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health case and type II, III, and IV facilities
- The Jail Profile Survey is a query that provides highest daily jail populations at the county level.

INDICATOR 14D: RATE PER MONTH OF NEW ADULT MENTAL HEALTH CASES IN TYPE II, III, AND IV JAILS PER TOTAL AVERAGE DAILY POPULATION

Numerator: New adult mental health cases opened during this month in type II, III, and IV jails
Denominator:

Total adult average daily population (ADP) in type II, III, and IV jails

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Jail Profile Survey

Analysis:

- Level of comparison
    - County
    - Facility
- Timeframe
    - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health case and type II, III, and IV facilities
- The Jail Profile Survey is a query that provides highest daily jail populations at the county level.

INDICATOR 14E: PROPORTION OF ADULT INMATES IN TYPE II, III, AND IV JAILS RECEIVING PSYCHIATRIC MEDICATION

Numerator: # adult inmates in type II, III, and IV jails receiving psych medication last day of month

Denominator: Total adult average daily population (ADP) in type II, III, and IV jails

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Jail Profile Survey

Analysis:

- Level of comparison
    - County
    - Facility
- Timeframe
    - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health case and type II, III, and IV facilities

- The Jail Profile Survey is a query that provides highest daily jail populations at the county level.

INDICATOR 14F: PREVALENCE OF CHILD MENTAL HEALTH CASES AMONG JUVENILES INVOLVED IN THE JUSTICE SYSTEM

Numerator: Number of open child mental health cases among juvenile halls/camps, juveniles on home supervision (with and without monitoring), and juveniles in alternative confinement programs

Denominator: Total average daily population (ADP) among juvenile halls/camps, juveniles on home supervision (with and without monitoring), and juveniles in alternative confinement programs

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Juvenile Detention Survey

Analysis:

- Level of comparison
  - County
  - Facility
- Timeframe
  - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health case and type II, III, and IV facilities.

INDICATOR 14G: PROPORTION OF JUVENILE INMATES IN JUVENILE HALLS/CAMPS, JUVENILES ON HOME SUPERVISION (WITH AND WITHOUT MONITORING), AND JUVENILES IN ALTERNATIVE CONFINEMENT PROGRAMS RECEIVING PSYCHIATRIC MEDICATION

Numerator: # juvenile inmates in juvenile halls/camps, juveniles on home supervision (with and without monitoring), and juveniles in alternative confinement programs receiving psychotropic medication this day

Denominator: Total average daily population (ADP) among juvenile halls/camps, juveniles on home supervision (with and without monitoring), and juveniles in alternative confinement programs (per facility)

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Corrections & Rehabilitation Juvenile Detention Survey

Analysis:

- Level of comparison
  - County
  - Facility
- Timeframe
  - Annual

Notes:

- Can assess at county and state level
- ADP can be summed across all facilities in a single county to convert the denominator into the numerator's units
- Mental health information in this survey may be unreliable; see notes in JPS data file
- See JPS data file for definitions of mental health case and type II, III, and IV facilities
- The Juvenile Detention Survey provides monthly and quarterly data reports on juvenile mental health, average length of stay, bookings and detention behavior.

Legislative Goal 4: Unemployment

WHERE IS IT GOING?

Aim 1: Increased counseling in employment skills for youth

This is an aspirational aim. Population-level data sources do not currently exist to assess this aim. This could be information reported by programs to the county and then to a centralized data repository for analysis.

Aim 2: Increase in supported employment services and programs

INDICATOR 2A: NUMBER OF PROGRAMS TO HELP PEOPLE WITH MENTAL ILLNESS GET AND KEEP EMPLOYMENT

Numerator: Number of programs to help people with mental illness obtain and keep employment
Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California**:** California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Total number of programs to help people with mental illness obtain and keep employment: Data source to be recommended
    - This includes all programs that provide direct employment services to individuals at risk for or currently experiencing mental health-related issues

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. We recommend that this information be provided by programs to the county and then to a centralized data repository.

INDICATOR 2B: CAPACITY OF PROGRAMS TO HELP PEOPLE WITH MENTAL ILLNESS GET AND KEEP EMPLOYMENT

Numerator: Capacity of programs to help people with mental illness obtain and keep employment

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California**:** California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of programs to help people with mental illness obtain and keep employment: Defined as staff FTEs; Data source to be recommended
    - This includes all programs that provide direct employment services to individuals at risk for or currently experiencing mental health-related issues

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process. This is data that could be collected by the programs and then reported to counties and then to a centralized data repository for analysis.

Aim 3: Increase in academic support for youth with emotional or behavioral difficulties

This is an aspirational aim. Population-level or public-school based data sources do not currently exist to assess this aim.

WHAT IS IT DOING?

Aim 4: Improvement in job seeking skills

This is an aspirational aim. Population-level data sources do not currently exist to assess this aim.

Aim 5: Increase quality of mental health services

This is an aspirational aim. Population-level data sources and measures do not currently exist to assess this aim.

Aim 6: Increased interagency coordination between employment and mental health services

INDICATOR 6A: RATES OF REFERRAL TO EMPLOYMENT RELATED SERVICES FOR PEOPLE WITH MENTAL ILLNESS (E.G. WELFARE TO WORK SERVICES)

Numerator: Rates of referral to employment related services for people with mental illness (e.g. welfare to work services)

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California**:** California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Rates of referral to employment related services for people with mental illness (e.g. welfare to work services): Data source to be recommended

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this numerator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

INDICATOR 6B: PROPORTION OF INDIVIDUALS FROM TWO-PARENT FAMILIES ENROLLED IN CALWORKS WELFARE-TO-WORK PROGRAM WHO WERE REFERRED TO A COUNTY MENTAL HEALTH AGENCY

Numerator: Number of individuals from two-parent families enrolled in CalWORKs welfare-to-work program who were referred to a county mental health agency
Denominator: Number of individuals from two-parent families enrolled in CalWORKs welfare-to-work program

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Social Services CalWORKs Welfare-To-Work Monthly Activity Report

Analysis:

- Level of comparison
    - County

- Timeframe
    - Monthly

Notes:

- Can be assessed at county and state level
- Could be combined with indicator 6C and the level of analysis can be family structure.
- Population of interest is families enrolled in CalWORKs welfare-to-work program

INDICATOR 6C: PROPORTION OF INDIVIDUALS FROM ALL OTHER FAMILIES ENROLLED IN CALWORKS WELFARE-TO-WORK PROGRAM WHO WERE REFERRED TO A COUNTY MENTAL HEALTH AGENCY

Numerator: Number of individuals from all other families enrolled in CalWORKs welfare-to-work program who were referred to a county mental health agency

Denominator: Number of individuals from all other families enrolled in CalWORKs welfare-to-work program

Definitions and data sources:

- Numerator and Denominator: Data come California Department of Social Services CalWORKs Welfare-To-Work Monthly Activity Report

Analysis:

- Level of comparison
    - County
- Timeframe
    - Monthly

Notes:

- Can be assessed at county and state level
- Population of interest is families enrolled in CalWORKs welfare-to-work program

DOES IT MAKE A DIFFERENCE?

Aim 7: Decreased short term disability due to mental illness

See related functioning indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23B: Impact of mental health on functioning

INDICATOR 7A: DECREASE RATES OF SHORT TERM DISABILITY FOR MENTAL ILLNESS

Numerator: Number of individuals taking short term disability due to mental illness

Denominator:

1. Population of CA
2. Population in need

Definitions and data sources:

- Number of individuals taking short term disability due to mental illness: this data is currently not collected, so data source is to be recommended.
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
    - TBD
- Timeframe
    - TBD

Notes:

- According to the California Employment Development Department, there is no short term disability database aggregated across counties that tracks diagnoses of any kind, so the data source is to be recommended. In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Aim 8: Increased job seeking among individuals with disabilities

This is an aspirational aim. Data sources do not currently exist to assess this aim.

Aim 9: Reduced stigma and discrimination

See related stigma and discrimination measures under Legislative *Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 16: Decreased Stigma and Discrimination*

- Indicator 16A: Rates of adults not seeking help with a mental health issue due to stigma
- Indicator 16B: Rates of children being bullied due to a physical or mental disability
- Indicator 16C: Rates of discrimination due to health problems
- Indicator 16D: Public attitudes towards mental illness

Aim 10: Improve psychological functioning (work or school)

See related functioning indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time:*

- Indicator 23B: Impact of mental health on functioning
- Indicator 23C: Frequency of impaired functioning in the past month
- Indicator 23F: Rates of improved functioning as a result of mental health services

Aim 11: Improve emotional well-being

See related psychological distress indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 23: Decreased psychological distress and psychological suffering over time*:

- Indicator 23A: Percentage of individuals with serious psychological distress (SPD)

Aim 12: Increased help seeking and access to mental health care

See related help-seeking measures under Legislative *Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 15: Increased help seeking and access to mental health care*

- Indicator 15A: Rate of general help seeking
- Indicator 15B: Rate of help seeking for mental health problems
- Indicator 15C: Access to Primary care mental health services
- Indicator 15D: Access to mental health services

ARE THERE PUBLIC HEALTH BENEFITS?

Aim 13: Reduced unemployment among individuals with mental illness

INDICATOR 13A: UNEMPLOYMENT RATE FOR ADULT COMMUNITY MENTAL HEALTH CONSUMERS

Numerator: Number of adult mental health consumers served who are unemployed at the time of admission to mental health treatment

Denominator: Total number of adult mental health consumers served

Definitions and data sources:

- Numerator and denominator come from California Department of Mental Health (DMH) Client and Services Information (CSI) System
    - P-03.0 Employment Status (Reported at admission, annually, and at formal discharge)
    - Other client data elements will be necessary to identify unique clients

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- N/A

INDICATOR 13B: EMPLOYMENT RATE FOR INDIVIDUALS WITH PSYCHIATRIC PROBLEMS ADMITTED TO SUBSTANCE ABUSE TREATMENT FACILITIES

Numerator: Number of employed individuals with psychiatric problems admitted to substance abuse treatment facilities

Denominator: Total number of individuals with psychiatric problems admitted to substance abuse treatment facilities

Definitions and data sources:

- Numerator and Denominator: Data come from the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Episode Data Set (TEDS).

Analysis:

- Level of comparison
    - National
    - Priority population
- Timeframe

- Annual

Notes:

- Can be assessed at state and national level
- Need to combine employment and psychiatric information for this indicator to be possible
- Duplicated count of admissions
- Demographic data available (age, gender, race, ethnicity).

Legislative Goal 5: Improved Resilience and Emotional Well-Being

WHERE IS IT GOING?

Aim 1: Increase in the number of PEI-related programs

INDICATOR 1A: TOTAL NUMBER OF PROGRAMS DELIVERING MENTAL HEALTH PREVENTION AND EARLY INTERVENTION SERVICES TO CLIENTS

Numerator: Total number of programs delivering mental health prevention and early intervention services to clients in the state of California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California**:** California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Total number of programs delivering mental health prevention and early intervention services to clients: Data source to be recommended
    - This includes all programs that provide direct services to individuals at risk for or currently experiencing mental health-related issues

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

INDICATOR 1B: TOTAL NUMBER OF PEI-FUNDED PROGRAMS DOING PUBLIC/COMMUNITY OUTREACH AND EDUCATION

Numerator: Total number of programs doing public/community outreach and education related to mental health in California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Total number of PEI-funded programs dong public/community outreach and education related to mental health in California: Data source to be recommended;
    - This will include campaigns developing materials for the Internet, print, radio, television or related outlets aimed at improving public awareness of mental health related issues

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

INDICATOR 1C: TOTAL NUMBER OF PEI-FUNDED EDUCATION AND TRAINING PROGRAMS

Numerator: Total number of PEI-funded education and training programs

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Total number of PEI-funded education and training related to mental health**:** Data source to be recommended
    - This includes programs that conduct training interventions that involve communication between an expert educator/speaker and mental health service providers or educate friends, family members, clergy and employees in work and school settings in California

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.
-

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)

- ("State and County Quickfacts," 2012)

INDICATOR 1D: TOTAL NUMBER OF PEI-FUNDED PROGRAMS FOCUSED ON ENHANCING MENTAL HEALTH-RELATED POLICIES, PROTOCOLS, DATA SYSTEMS AND INFORMATIONAL RESOURCES

Numerator: Total number of PEI-funded programs focused on enhancing mental health-related policies, protocols, data systems and informational resources in California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Total number of programs focused on enhancing mental health-related mental health-related policies, protocols, data systems and informational resources in California: Data source to be recommended
    - Examples of policy-related programs include programs aimed at changing discriminatory policies related to mental health
    - Examples also include programs to provide technical assistance and/or infrastructure improvements such as defining protocols and procedures or developing informational resources. May also include programs whose goal is to enhance interagency collaboration and coordination.

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

Aim 2: Increase the capacity of programs

INDICATOR 2A: CAPACITY OF PROGRAMS DELIVERING MENTAL HEALTH PREVENTION AND EARLY INTERVENTION SERVICES TO CLIENTS

Numerator: Capacity of programs delivering mental health prevention and early intervention services to clients in the state of California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of programs delivering mental health prevention and early intervention services to clients: Defined as staff FTEs; Data source to be recommended
    - This includes all programs that provide direct services to individuals at risk for or currently experiencing mental health-related issues

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

INDICATOR 2B: CAPACITY OF PEI-FUNDED PROGRAMS DOING PUBLIC/COMMUNITY OUTREACH AND EDUCATION

Numerator: Capacity of PEI-funded programs doing public/community outreach and education related to mental health in California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of PEI-funded programs doing public/community outreach and education related to mental health in California: Defined as staff FTEs; Data source to be recommended;
    - This will include campaigns developing materials for the Internet, print, radio, television or related outlets aimed at improving public awareness of mental health related issues, decreasing stigma or providing information about resources

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

INDICATOR 2C: CAPACITY OF PEI-FUNDED EDUCATION AND TRAINING PROGRAMS

Numerator: Capacity of PEI-funded education and training programs related to mental health in California

Denominator:

a. Population of CA
b. Land area (e.g., square mile, per county, etc.)

Definitions and data sources:

- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- Land area: California Census Bureau, "State and County Quick Facts", revised Jan 2012 http://quickfacts.census.gov/qfd/states/06000.html
- Capacity of PEI-funded education and training programs related to mental health in California: Defined as staff FTEs; Data source to be recommended
    - This includes programs that conduct PEI-funded education and training programs that involve communication between an expert educator/speaker and mental health service providers or educate friends, family members, clergy and employees in work and school settings in California

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)
- ("State and County Quickfacts," 2012)

Aim 3: Improved interagency collaboration/coordination

INDICATOR 3A: NUMBER OF FORMAL COMMUNITY LINKAGES
Numerator: Number of formal community linkages between the county Department of Mental health and any publicly funded social service or community based agency dealing with the population of interest

Denominator: Number of publicly funded social service or community based agencies dealing with the population of interest

Definitions and data sources:

- Formal relationship defined as having at least one Memorandum of Understanding (MOU); Data source to be recommended
- Publicly funded social service or community based agency: Data source to be recommended; includes specialty mental health, family preservation services, substance abuse treatment, individual and family therapy and mental health services, housing, income, and employment assistance, education
- Level of collaboration: Total number of MOUs between the county Department of Mental health and any publicly funded social service or community based agency dealing with the population of interest

Analysis:

- Level of comparison
    - County
- Timeframe
    - Denominator 1 - TBD
    - Denominator 2 - Annual
- Add up expenditures from annual plans

Notes:

- N/A

INDICATOR 3B: OVERALL LEVEL OF COLLABORATION ACROSS AGENCIES
Numerator: Level of collaboration between the Department of Mental health and publicly funded social service or community based agencies

Denominator: Number of publicly funded social service or community based agencies dealing with the population of interest

Definitions and data sources:

- Publicly funded social service or community based agency: Data source to be recommended; includes specialty mental health, family preservation services, substance abuse treatment, individual and family therapy and mental health services, housing, income, and employment assistance, education
- Level of collaboration: Levels of collaboration scale (Frey, Lohmeier, Lee et al., 2006), data not currently collected, to be recommended

Analysis:

- Level of comparison
  - County
- Timeframe
  - Denominator 1 - TBD
  - Denominator 2 - Annual
- Add up expenditures from annual plans

Notes:

- N/A

Relevant citations:

- Frey et al., 2006

WHAT IS IT DOING?

Aim 4: Increased number of mental health professionals in California

INDICATOR 4A: NUMBER OF MENTAL HEALTH PROFESSIONALS HIRED

Numerator:

a. Overall number of professionals hired
b. Number of professionals hired by occupation
c. Number of professionals hired by industry

Denominator:

1. Population of CA (or relevant sub-regions)
   a. per 100,000 residents
   b. per square mile
2. Population in need

Definitions and data sources:

- Professionals include the following, as defined by the Bureau of Labor Statistics (Statistics, 2011):
  - Psychiatrists (29-1066)

- Psychologists (19-3031, 19-3039)
- Social workers (21-1021, 21-1022, 21-1023, 21-1029)
- Marriage and Family Therapists (21-1013)
- Mental Health Counselors (21-1014)
- Substance Abuse Counselors (21-1011)
- Psychiatric Technicians (29-2053)

- Occupation is defined as each of the above-listed sub-categories of "Professionals" (i.e., psychiatrists is an "occupation"), as defined by the Bureau of Labor Statistics: www.bls.gov/oes/current/oes_ca.htm
- Industry is defined as the setting or type of business in which individuals work as defined by the Bureau of Labor Statistics (e.g., NAICS 622200 - Psychiatric and Substance Abuse Hospitals); www.bls.gov/oes/current/oes_ca.htm
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
  - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
    OR:
  - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php
- .

Analysis:

- Level of comparison
  - National (Denominator 1 only)
  - Rural/Urban
  - Sub-region as defined by BLS
- Timeframe
  - Annual

Notes:

- Additional related datasets to monitor:
  - OSHPD Workforce Clearinghouse
  - National Uniform Minimum Dataset (MDS) for Behavioral Health Professions
- Here we are including two definitions of need which capture slightly different populations. Depending on the goal of the analysis, can choose one or the other.
- The CHIS and BLS data points will not be at the same point in time, i.e., the CHIS is past 12 months for the Respondent (which could be any 12 months) and the BLS is at one time point, in May

- Data from the CHIS will be extrapolated for 12 months which means an equal distribution over the 12 month period. Over the same time period, the number of mental health professionals per 10,000 persons in need will be obtained from the BLS data.

Relevant citations:

- (Statistics, 2011)
- (McRee, Dower, Briggance et al., 2003)
- ((CHIS), 2012)
- (Kessler et al., 2002)

Aim 5: Increase exposure to and utilization of mental health programs

INDICATOR 5A: RATES OF PUBLIC MENTAL HEALTH ADMISSIONS

Numerator: Number of public mental health admissions

Denominator:

1. Population of CA
2. Population in need

Definitions and data sources:

- Number of public mental health admissions: Client and Service Information System (CSI)
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County

- Race/Ethnicity
- Priority PEI programs

- Timeframe
  - Annual

Notes:

- Here we are including two definitions of need which capture slightly different populations. Depending on the goal of the analysis, can choose one or the other.

INDICATOR 5B: REACH OF PEI-FUNDED PROGRAMS DOING PUBLIC/COMMUNITY OUTREACH AND EDUCATION

Numerator: Number of individuals reached by PEI-funded programs doing public/community outreach and education campaigns

Denominator:

1. Population of CA
2. Population in need

Definitions and data sources:

- Number of individuals reached by PEI-funded programs doing public/community outreach and education in California: Data will come from available audience metrics, depending on specific type of social marketing campaign.
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
  - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
    OR:
  - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
  - Programmatic focus
  - Priority population
  - P/EI
  - Rural/Urban
  - County

    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- Here we are including two definitions of need which capture slightly different populations. Depending on the goal of the analysis, can choose one or the other.
- Audience metrics can be expensive to purchase/obtain; consideration should be given to value of metric.
- State would need to collect pre/post data close to when a social marketing campaign would be implemented (e.g. # of people in their target audience)
    - Note that First 5 California uses LA County Health Survey to collect data on the reach of its social marketing, might look there for questions format

Relevant citations:

- Farrelly, Healton, Davis et al., 2002
- Huhman, Potter, Wong et al., 2005
- "Interim Population Projections for California and Its Counties 2010-2050," 2012

INDICATOR 5C: UTILIZATION OF PEI-FUNDED EDUCATION AND TRAINING PROGRAMS

Numerator: Number of individuals receiving PEI-funded education and training

Denominator:

3. Population of CA (or relevant sub-regions)
    a. per 100,000 residents
    b. per square mile
4. Population in need

Definitions and data sources:

- Individuals receiving PEI-funded education and training: Data source to be recommended; Training programs include programs that conduct training interventions that involve communication between an expert educator/speaker and mental health service providers or educate friends, family members, clergy and employees in work and school settings in California. In contrast to indicator 6B, these are in-person education and training programs.
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered “yes” to the question: “During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?” (QT09_I18)
      OR:

    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Population of California: California Department of Finance "Interim Population Projections for California and Its Counties 2010-2050," released in May 2012 http://www.dof.ca.gov/research/demographic/reports/projections/interim/view.php

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- Here we are including two definitions of need which capture slightly different populations. Depending on the goal of the analysis, can choose one or the other.

Relevant citations:

- ("Interim Population Projections for California and Its Counties 2010-2050," 2012)

INDICATOR 5D: TREATMENT BY PROFESSIONAL FOR MENTAL HEALTH ISSUE

Numerator: Number of students seeking mental health services
Denominator: Total population

Definitions and data sources: Number of students answering "yes" to any of the following questions, including "yes, diagnosed but not treated", "yes, treated with medication", "yes, treated with psychotherapy", "yes, treated with medication and psychotherapy":

- Within the last 12 months, have you been diagnosed or treated by a professional for any of the following?
    - Anxiety
    - Attention Deficit and Hyperactivity Disorder (ADHD)
    - Bipolar Disorder
    - Depression
    - Obsessive Compulsive Disorder (OCD)
    - Panic attacks

    - Phobia
    - Schizophrenia
    - Substance abuse or addiction (alcohol or other drugs)
    - Other addiction (e.g., gambling, internet, sexual)
    - Other mental health condition

Analysis:

- Level of comparison
    - Race/Ethnicity
    - National
- Timeframe
    - Annual

Notes:

- NA

Citation: ((ACHA-NCHA), 2012)

Aim 6: Ensure timely access to services

INDICATOR 6A: TIMELY ACCESS TO PUBLICLY FUNDED MENTAL HEALTH SERVICES

Numerator: Average wait time between admission and date seen by a psychiatrist for an initial evaluation in county-funded mental health treatment programs
Denominator: None

Definitions and data sources:

- Average wait time: Data source to be recommended
- County-funded mental health treatment programs: This includes all county department of mental health programs that provide direct services to individuals at risk for or currently experiencing mental health-related issues

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe

- Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

INDICATOR 6B: PERCEIVED TIMELINESS OF ACCESS TO MH SERVICES

Numerator: Number of youth/adults who received services in a timely manner

Denominator: Number of individuals completing the Consumer Perceptions Survey (CPS)

Definitions and data sources:

- Number of youth/adults who received services in a timely manner: From the California Consumer Perceptions Survey (CPS), sum the responses to the following:
  - (C,M) Staff were willing to see me as often as I felt it was necessary.
  - (C,M) Staff returned my calls within 24 hours.
  - (C,M) Services were available at times that were good for me.
  - (C,M) I was able to get all the services I thought I needed.
  - (C,M) I was able to see a psychiatrist when I wanted to.

Analysis:

- Level of comparison
  - Rural/Urban
  - County
  - Race/Ethnicity
- Timeframe
  - Annual

Notes:

- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.

INDICATOR 6C: RATES OF NON-UTILIZATION DUE TO UNTIMELY ACCESS TO SERVICES

Numerator: Number of adults who did not seek treatment because they had a hard time getting an appointment

Denominator: Number of adults with perceived need who responded to the CHIS

Definitions and data sources:

- Number of adults who did not seek treatment because they had a hard time getting an appointment: Data will come from CHIS Adult (QA09_F32):
    - Here are some reasons people have for not seeking help even when they think they might need it. Please tell me "yes" or "no" for whether each statement applies to why you did not see a professional….You had a hard time getting an appointment (Yes/No/Refused/DK)
- Number of adults with perceived need: Data will come from CHIS Adult (QA09_F19):
    - Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or your use of alcohol or drugs?

Analysis:

- Level of comparison
    - Rural/Urban
    - County
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Aim 7: Increase in completed referrals to treatment

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 8: Improved quality of care

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 9: Improved coordination and efficiency of services across agencies

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

DID IT MAKE A DIFFERENCE?

Aim 10: Increased civic engagement

INDICATOR 10A: INCREASE CIVIC ENGAGEMENT

Numerator:

1. Number of adolescents who have done volunteer work in past year
2. Number of adults who have done volunteer work in the past year

Denominator:

1. Total number respondents to the CHIS Adolescent
2. Total number respondents to the CHIS Adult

Definitions and data sources:

- Number of adolescents who have done volunteer work in past year: Data will come from CHIS Adolescent (QT09_J10):
    - In the past 12 months, have you done any volunteer work or community service that you have not been paid for?
- Number of adults who have done volunteer work in past year: Data will come from CHIS Adult (QA09_M9):
    - In the past 12 months, have you done any volunteer work or community service that you have not been paid for?

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Relevant citations:

- ((CHIS), 2012)

Aim 11: Increased access to non-public mental health services

This is an aspirational aim. At this point population-level data sources do not exist to capture this item.

Aim 12: Create stronger school and community environments

INDICATOR 12A: RATINGS OF SCHOOL AND COMMUNITY ENVIRONMENTS

Numerator: Average overall scale score for CHKS "school and community environments"
Denominator: None

Definitions and data sources:

- CHKS School environment (note that these are the same items that we are using for resilience)
    - Required CHKS questions:
    - I feel close to people at this school, I am happy to be at this school, I feel like I am part of this school, The teachers at this school treat students fairly, I feel safe in my school;
    - At my school , there is a teacher or some other adult who… really cares about me, tells me when I do a good job, notices when I'm not there, always wants me to do my best, listens to me when I have something to say, believes that I will be a success
    - Outside of my home and school, there is an adult who… really cares about me, tells me when I do a good job, notices when I am upset about something, believes that I will be a success, always wants me to do my best, whom I trust;

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- These items are included in the middle school and high school core modules (not elementary)

Relevant citations:

- (Austin, Bates and Duerr, 2011)

Aim 13: Increased neighborhood cohesion and social connectedness.

INDICATOR 13A: RATINGS OF NEIGHBORHOOD COHESION AMONG ADULTS
Numerator: Average overall scale score for CHIS "neighborhood cohesion"
Denominator: N/A

Definitions and data sources:

- Average overall scale score for CHIS "neighborhood cohesion": Sum of the following CHIS items with reverse coding of 1, 3 and 5, see (Kandula, Wen, Jacobs et al., 2009)
  Tell me if you strongly agree, agree, disagree, or strongly disagree with the following statements:
  1. QA09_M4 People in my neighborhood are willing to help each other.
  2. QA09_M5 People in this neighborhood generally do NOT get along with each other.
  3. QA09_M6 People in this neighborhood can be trusted
  4. QA09_M7 You can count on adults in this neighborhood to watch out that children are safe and don't get in trouble.
  5. QA09_M8 Do you feel safe in your neighborhood…

Analysis:

- Level of comparison
  - County
  - National
  - Rural/Urban
  - Priority population
  - Race/Ethnicity
- Timeframe
  - Annual

Notes:

- NA

Relevant citations:

- (Kandula et al., 2009)
- ((CHIS), 2012)

INDICATOR 13B: SOCIAL CONNECTEDNESS AMONG YOUTH
Numerator: Total scale score for CHKS social connectedness items
Denominator: N/A

Definitions and data sources:

- Total scale score for the following CHKS items:
  Outside of my home and school, ...
    - A30. I am part of clubs, sports teams, church/temple, or other group activities.
    - A31. I am involved in music, art, literature, sports, or a hobby.
    - A32. I help other people.

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- These items are from middle school and high school core modules
- It is recommended that before these questions can be put into a scale and summed that the psychometric properties would need to be studied to show if it is a single construct.

Relevant citations:

- (Austin, Bates and Duerr, 2011)

INDICATOR 13C: SOCIAL CONNECTEDNESS AMONG ADULTS

Numerator: Total scale score for NCS social connectedness items
Denominator: N/A

Definitions and data sources:

- NCS social connectedness items (scored on 1-5 Likert scale):
    - I have people that I am comfortable talking with about my child's problems
    - I have people with whom I can do enjoyable things.
    - I am happy with the friendships I have.
    - I feel I belong in my community.
    - In a crisis, I would have the support I need from family or friends.
    - How do you feel about: The people you see socially?
    - How do you feel about: The amount of time you spend with other people?
    - How do you feel about: The things you do with other people?

        - How do you feel about: The way you and your family act toward each other?
        - How do you feel about: The way things are in general between you and your family?
        - I do things that are more meaningful to me.
        - I am better able to take care of my needs.
        - I am better able to handle things when they go wrong"
        - I am better able to do things that I want to do"
        - My child is better able to do things he or she wants to do
- NCS social cohesion and trust items (scored on 1-5 Likert scale):
    - People around here are willing to help their neighbors (5-point Likert)
    - People in this neighborhood look out for each other (5-point Likert)

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- There are currently no definite plans to repeat the NCS and so it is unclear whether this indicator could be monitored over time.

Relevant citations:

- (Kessler and Merikangas, 2004)

Aim 14: Improved family functioning

INDICATOR 14A: RATE OF ADOLESCENTS CONFIDING PLANS TO PARENTS

Numerator: CHIS adolescent respondents whose parents know where they go at night
Denominator: CHIS adolescent respondents

Definitions and data sources:

- CHIS adolescent respondents whose parents know where they go at night is defined as those California Health Interview Survey ((CHIS), 2012) adolescent respondents who answered “a lot” to the question: “How much do your parents really know about where you go out at night?” (QT09_J4)

Analysis:

- Level of comparison

    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Relevant citations:

- ((CHIS), 2012)

INDICATOR 14B: ADOLESCENTS WITH CARING RELATIONSHIPS AT HOME

Numerator: CHKS respondents' subscale scores for caring relationships at home
Denominator: N/A

Definitions and data sources:

- Subscale scores for caring relationships at home: Defined as, CHKS high School resiliency module respondents' subscale scores (rated on a scale of 1-5) for caring relationships at home defined as responses to the following CHKS items:
    - In my home, there is a parent or some other adult ...who talks with me about my problems.
    - In my home, there is a parent or some other adult ...who is interested in my school work.
    - In my home, there is a parent or some other adult ...who listens to me when I have something to say.

Analysis:

- Level of comparison
    - Priority population
    - Rural/Urban
    - County
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- Note that the CHKS high school resiliency module is an optional module for schools to complete. Results will not be generalizable to the population of CA.

Relevant citations:

- (Austin, Bates and Duerr, 2011)

INDICATOR 14C: ADOLESCENTS WITH HIGH EXPECTATIONS AT HOME
Numerator: CHKS respondents' subscale scores for high expectations at home
Denominator: N/A

Definitions and data sources:

- Subscale scores for high expectations at home: CHKS high School resiliency module respondents' subscale scores (rated on a scale of 1-5) for high expectations at home, defined as responses to the following CHKS items:
    - In my home, there is a parent or some other adult ...who expects me to follow the rules.
    - In my home, there is a parent or some other adult ...who believes that I will be a success.
    - In my home, there is a parent or some other adult ...who always wants me to do my best.

Analysis:

- Level of comparison
    - Priority population
    - Rural/Urban
    - County
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- Note that the CHKS high school resiliency module is an optional module for schools to complete. Results will not be generalizable to the population of CA.

Relevant citations:

- (Austin, Bates and Duerr, 2011)

Aim 15: Increased help seeking and access to mental health care

INDICATOR 15A: RATE OF GENERAL HELP SEEKING

Numerator: Frequency respondents sought help with a problem or worry
Denominator: NCS respondents

Definitions and data sources:

- Frequency respondents sought help with a problem or worry is defined as those National Comorbidity Survey respondents who answered "yes" to the question: "'When you have a problem or worry, how often do you let someone (else) know about it – always, most of the time, sometimes, rarely, or never?"

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- There are currently no definite plans to repeat the NCS and so it is unclear whether this indicator could be monitored over time.
- The National Comorbidity Survey (NCS) is a nationally representative mental health survey of both adults and youth.

Relevant citations:

- (Kessler and Merikangas, 2004)

INDICATOR 15B: RATE OF HELP SEEKING FOR MENTAL HEALTH PROBLEMS

Numerator: Respondents who sought help with a mental health problem
Denominator:

1. CHIS respondents
2. CHIS respondent population in need

Definitions and data sources:

- Respondents who sought help with a mental health problem is defined as EITHER:
    - those California Health Interview Survey((CHIS), 2012) Adult respondents who answered "yes" to the question: "Did you seek help for your mental or emotional health or for an alcohol or drug problem?" (QA09_F23)

    - those California Healthy Kids Survey respondents who
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012)respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Respondents who sought help with a mental health problem is defined as
    - Those ACHA-NCHA (*American College Health Association - National College Health Assessment (ACHA-NCHA) American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary*, 2007) respondents who answered "yes" to the question: "If in the future you were having a personal problem that was really bothering you, would you consider seeking help from a mental health professional?"

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.

Relevant citations:

- ((CHIS), 2012)
- (*American College Health Association - National College Health Assessment (ACHA-NCHA) American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary*, 2007)
- (Kessler et al., 2002)

INDICATOR 15C: ACCESS TO PRIMARY CARE MENTAL HEALTH SERVICES

Numerator: Increase access to primary care mental health treatment

Denominator:

1. CHIS adult respondents
2. CHIS respondent population in need

Definitions and data sources:

- Access to primary care mental health treatment is defined as those California Health Interview Survey ((CHIS), 2012) respondents who:
    - Answered "yes" to the question: "In the past 12 months, have you seen your primary care physician or general practitioner for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?" (QA09_F21)
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.
-

Relevant citations:

- ((CHIS), 2012)

- (Kessler et al., 2002)

INDICATOR 15D: ACCESS TO MENTAL HEALTH SERVICES

Numerator: Increase access to mental health services

Denominator:

1. CHIS respondents
2. CHIS respondent population in need

Definitions and data sources:

- Access to mental health care is defined as those California Health Interview Survey ((CHIS), 2012) respondents who:
    - ADULTS: Answered "yes" to the question: "In the past 12 months, have you seen any other professional, such as a counselor, psychiatrist, or social worker for problems with your mental health, emotions, nerves, or your use of alcohol or drugs?" (QA09_F22)
    - ADOLESCENTS: Answered "yes" to the question: "In the past 12 months, have you received any psychological or emotional counseling?" (QT09_I19)
    - CHILDREN: Answered "yes" to the question: "During the past 12 months, did (CHILD) receive any psychological or emotional counseling?" (QC09_F24)
- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe

- Annual

Notes:

- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.
-

Relevant citations:

- ((CHIS), 2012)
- (Kessler et al., 2002)

Aim 16: Decreased stigma and discrimination

INDICATOR 16A: RATES OF ADULTS NOT SEEKING HELP WITH A MENTAL HEALTH ISSUE DUE TO STIGMA

Numerator: Survey respondents indicating that they did not seek help with an issue related to mental or emotional health or for an alcohol or drug problem due to stigma
Denominator: Survey respondents indicating that they had an issue related to mental or emotional health or for an alcohol or drug problem

Definitions and data sources:

- Numerator is defined as those California Health Interview Survey ((CHIS), 2012) respondents who answered "yes" to the question: "Here are some reasons people have for not seeking help even when they think they might need it. Please tell me "yes" or "no" for whether each statement applies to why you did not see a professional." (QA09_F29)
    - QA09_F30: You did not feel comfortable talking with a professional about your personal problems.
    - QA09_F31: You were concerned about what would happen if someone found out you had a problem.
- Denominator is defined as those California Health Interview Survey (CHIS) respondents who answered "yes" to the question: "Was there ever a time during the past 12 months when you felt that you might need to see a professional because of problems with your mental health, emotions, nerves, or your use of alcohol or drugs?" (QA09_F19)

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity

- Timeframe
    - Annual

Notes:

- N/A

Relevant citations:

- ((CHIS), 2012)

INDICATOR 16B: RATES OF CHILDREN BEING BULLIED DUE TO A PHYSICAL OR MENTAL DISABILITY

Numerator: Survey respondents indicating that they were bullied due to a mental or physical disability
Denominator: Survey respondents

Definitions and data sources:

- Numerator is defined as those California Healthy Kids Survey respondents who answered "yes" to the question:
    - During the past 12 months, how many times on school property were you harassed or bullied for any of the following reasons? [You were bullied if repeatedly shoved, hit, threatened, called mean names, teased in a way you didn't like, or had other unpleasant things done to you. It is not bullying when two students of about the same strength quarrel or fight.]
        - A physical or mental disability

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- N/A

Relevant citations:

- (Austin, Bates and Duerr, 2011)

INDICATOR 16C: RATES OF DISCRIMINATION DUE TO HEALTH PROBLEMS

Numerator: Survey respondents indicating that they experienced discrimination due to a health problem

Denominator: Survey respondents indicating that they have a mental health issue

Definitions and data sources:

- Numerator is defined as those National Comorbidity Survey (Kessler and Merikangas, 2004) respondents who answered "some, a lot, or extreme" to the question:
    - How much discrimination or unfair treatment did you experience because of your health problems during the past 30 days – none, a little, some, a lot, or extreme unfair treatment?
- Denominator is those National Comorbidity Survey respondents who were asked the question specified above

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- There are currently no definite plans to repeat the NCS and so it is unclear whether this indicator could be monitored over time.
- The National Comorbidity Survey (NCS) is a nationally representative mental health survey of both adults and youth.

Relevant citations:

- (Kessler and Merikangas, 2004)

INDICATOR 16D: PUBLIC ATTITUDES TOWARD MENTAL ILLNESS

Numerator: Survey respondents' attitudes toward mental illness
Denominator: N/A

Definitions and data sources:

- Survey respondents' attitudes toward mental illness: Data come from the Behavioral Risk Factor Surveillance System (BRFSS) ("Behavioral Risk Factor Surveillance System Survey Data," 2012)average value endorsed by respondents on these two items (5-point scale):
    - Treatment can help people with mental illness lead normal lives. Do you –agree slightly or strongly, or disagree slightly or strongly? [2007, Module 16, Item 9]

- People are generally caring and sympathetic to people with mental illness. Do you – agree slightly or strongly, or disagree slightly or strongly? [2007, Module 16, Item 10]

Analysis:

- Level of comparison
  - National (only among states that administer the Mental Illness and Stigma Module, see note)
  - Priority population
  - County
- Timeframe
  - Annual

Notes:

- California administered the optional Mental Illness and Stigma module in 2007 only. We recommend that it be re-administered in a future year in order to obtain longitudinal data.

Relevant citations:

- ("Behavioral Risk Factor Surveillance System Survey Data," 2012)

Aim 17: Increased school engagement

This is an aspirational aim. At this point population-level measures and data sources do not exist to assess this aim.

Aim 18: Increased knowledge about mental illness and available resources

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

INDICATOR 18A: KNOWLEDGE ABOUT AVAILABLE RESOURCES

Numerator: Survey respondents indicating that they knew where to go for help with a problem
Denominator: Survey respondents

Definitions and data sources:

- Numerator is defined as those California Healthy Kids Survey respondents who answered “very much true”, “pretty much true” or “a little true” to the question:
  - I know where to go for help for a problem

Analysis:

- Level of comparison
  - County

    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- This question is part of an optional module. It is recommended that it be made part of the core module.

Aim 19: Decreased stress

INDICATOR 19A: LEVEL OF STRESS
Numerator: Average overall level of stress experienced in the past 12 months
Denominator: None

Definitions and data sources:

- Level of Stress is defined by amount of stress indicated in the ((ACHA-NCHA), 2012):
    - Within the last 12 months, how would you rate the overall level of stress you have experienced?
        - No stress
        - Less than average stress
        - Average stress
        - More than average stress
        - Tremendous stress

Analysis:

- Level of comparison
    - Race/Ethnicity
    - National
- Timeframe
    - Annual

Notes:

- NA

Relevant citations:

- (*American College Health Association - National College Health Assessment (ACHA-NCHA) American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary*, 2007)

DOES IT IMPROVE EMOTIONAL WELL-BEING?

Aim 20: Decreased prolonged suffering

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 21: Increased resilience among youth

INDICATOR 21A: INCREASED RESILIENCE AMONG YOUTH

Numerator: Average overall scale score for CHKS "school and community environments"
Denominator: None

Definitions and data sources:

- CHKS School environment
    - I feel close to people at this school, I am happy to be at this school, I feel like I am part of this school, The teachers at this school treat students fairly, I feel safe in my school;
    - At my school , there is a teacher or some other adult who… really cares about me, tells me when I do a good job, notices when I'm not there, always wants me to do my best, listens to me when I have something to say, believes that I will be a success
    - At school, ...I do interesting activities, I help decide things like class activities or rules, I do things that make a difference
    - Outside of my home and school, there is an adult who… really cares about me, tells me when I do a good job, notices when I am upset about something, believes that I will be a success, always wants me to do my best, whom I trust;
    - Outside of my home and school, …I am part of clubs, sports teams, church/temple, or
      other group activities, I am involved in music, art, literature, sports, or a hobby, I help other people.

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
- Timeframe
    - Annual

Notes:

- N/A

Relevant citations:

- (Austin, Bates and Duerr, 2011)

Aim 22: Improved social-emotional development

INDICATOR 22A: PARENTS CONCERNED WITH CHILD'S PROBLEMS

Numerator: CHIS Child parent respondents who are concerned a lot, or who think their child has definite or severe problems with development or behavior
Denominator: CHIS Child respondents

Definitions and data sources:

- CHIS Child parent respondents who concerned a lot, or who think their child has definite or severe problems with development or behavior is defined as the number of parents that responded "yes" to EITHER:
    - QC09_F10 How your child gets along with others? [Are you concerned a lot, a little, or not at all?]
    - QC09_F12 How your child behaves? [Are you concerned a lot, a little, or not at all?]

  OR responded yes to F22 and think that their child has definite or severe problems (F23):
    - QC09_F22 Overall, do you think your child has difficulties in any of the following areas: emotions, concentration, behavior, or being able to get along with other people?
    - QC09_F23 Are these difficulties minor, definite, or severe?

Analysis:

- Level of comparison
    - Programmatic focus
    - Priority population
    - P/EI
    - Rural/Urban
    - County
    - Race/Ethnicity
    - Priority PEI programs
- Timeframe
    - Annual

Notes:

- Improvement in this indicator would be reflected by a decrease in parental concern about their child.
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.
-

Relevant citations:

- ((CHIS), 2012)

Aim 23: Decreased psychological distress and psychological suffering and improved emotional well-being

INDICATOR 23A: PERCENTAGE OF INDIVIDUALS WITH SERIOUS PSYCHOLOGICAL DISTRESS (SPD)

Numerator: # of individuals with SPD in the past month according to the CHIS and/or BRFSS
Denominator: Number of CHIS respondents/Number of BRFSS respondents

Definitions and data sources:

- Serious psychological distress
    - ((CHIS), 2012)respondents who scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (CHIS QA09_F1 - QA09_F6)
    - BRFSS respondents who scored who scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (Mental Illness & Stigma Optional Module, first 6 questions)

Analysis:

- Level of comparison
    - County
    - National
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
    - Child/Adult/Elderly
- Timeframe
    - Annual

Notes:

- Serious psychological distress as defined by the Kessler 6 questions (score of 10 or more)

- CHIS allows county-level information, can compare to national rates from the Behavioral Risk Factor Surveillance System (BRFSS)
    - The BRFSS and CHIS both use random digit dial sampling, however the BRFSS is national
- CHIS is a state household survey aimed at adults, adolescents and children conducted on a wide range of health topics. CHIS collects data in six-month replicates on a two-year cycle.
- The Behavioral Risk Factor Surveillance System (BRFSS) is an annual statewide telephone surveillance system that monitors modifiable risk behaviors and other factors contributing to the leading causes of morbidity and mortality among non-institutionalized adult household populations, aged 18 years and older.
-

Relevant citations:

- ((CHIS), 2012)
- ("Behavioral Risk Factor Surveillance System Survey Data," 2012)

INDICATOR 23B: IMPACT OF MENTAL HEALTH ON FUNCTIONING

Numerator: Number of adult/adolescent/youth survey respondents with functioning problems as defined by the Sheehan Disability Scale

Denominator: Adult/adolescent/youth population of survey respondents with indicated mental health need

Definitions and data sources:

- Functioning problems defined by the following:
    - CHIS Adult items (SHEEHAN disability scale):
        - QA09_F14 Did your emotions interfere a lot, some, or not at all with your performance at work?
        - QA09_F15 Did your emotions interfere a lot, some, or not at all with your household chores?
        - QA09_F16 Did your emotions interfere a lot, some, or not at all with your social life?
        - QA09_F17 Did your emotions interfere a lot, some, or not at all with your relationship with friends and family?
    - CHIS Adolescent
        - QT09_B4During the last four school weeks, how many days of school did you miss because of a health problem? (# days)
    - CHKS Middle School (A108) and High School (A126)
        - During the past 12 months, about how many times did you skip school or cut classes?
            - (A) 0 times
            - B) 1–2 times

- C) A few times
- D) Once a month
- E) Once a week
- F) More than once a week

Analysis:

- Level of comparison
  - County
  - State
  - Rural/Urban
  - Priority population
  - Race/Ethnicity
  - Child/Adult/Elderly
- Timeframe
  - Annual

Notes:

- NA

Relevant citations:

- ((SDS), 2012)

INDICATOR 23C: FREQUENCY OF IMPAIRED FUNCTIONING IN THE PAST MONTH

Numerator: Number of days in the past year with impaired functioning

Definitions and data sources:

- Number of days in the past year with impaired functioning: From the CDC Health-Related Quality of Life (HRQOL) Healthy Days Scale (*Measuring Healthy Days*, 2000)
  - Now thinking about your physical health, which includes physical illness and injury, how many days during the past 30 days was your physical health not good?
  - Now thinking about your mental health, which includes stress, depression, and problems with emotions, how many days during the past 30 days was your mental health not good?
  - During the past 30 days, approximately how many days did poor physical or mental health keep you from doing your usual activities, such as self-care, work, or recreation?
- General Health Rating: From the CDC HRQOL Healthy Days Scale:
  - Would you say that in general your health is excellent, very good, good, fair or poor?

Analysis:

- Level of comparison
    - County
    - State
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
    - Child/Adult/Elderly
- Timeframe
    - Annual

Notes:

- The Kessler 6 (K6) scale is a quantifier of non-specific psychological distress.
- The CDC HRQOL measure is a broad multidimensional self-reported measure of physical and mental health among both youth and adults.

Relevant citations:

- (*Measuring Healthy Days*, 2000)

INDICATOR 23D: PERCENT OF YOUTH AND ADULTS CONSIDERING SUICIDE

Numerator: Number of youth and adults considering suicide
Denominator: Survey population

Definitions and data sources:

- Suicide thoughts can be from one of these data sources:
    - YRBSS suicide questions:
        - 25. During the past 12 months, did you ever seriously consider attempting suicide?
        - 26. During the past 12 months, did you make a plan about how you would attempt suicide?
    - CHKS:
        - A124. During the past 12 months, did you ever seriously consider attempting suicide?
    - CHIS Adult:
        - QA09_S2 Have you seriously thought about committing suicide at any time in the past 12 months?
        - QA09_S3 Have you seriously thought about committing suicide at any time in the past 2 months?

Analysis:

- Level of comparison
    - County
    - State
    - Rural/Urban

    - Priority population
    - Race/Ethnicity
    - Child/Adult/Elderly
- Timeframe
    - Annual

Notes:

- Here we are including three definitions of suicide which capture different populations (National population, California children, California adults). Depending on the goal of the analysis, can choose one or the other. Will use the national YRBSS data as a national comparison.

Relevant citations:

- ((CHIS), 2012)
- ("Behavioral Risk Factor Surveillance System Survey Data," 2012)
- (Austin, Bates and Duerr, 2011)

INDICATOR 23E: PERCENT OF YOUTH AND ADULTS ATTEMPTING SUICIDE

Numerator:

a) Number of youth and adults attempting suicide
b) Number of youth and adults attempting suicide which results in an injury

Denominator:

1. Population of CA (or relevant sub-regions)
    a. per 100,000 residents
    b. per square mile
2. Population in need

Definitions and data sources:

- Population in need is defined as those California Health Interview Survey ((CHIS), 2012) respondents who EITHER:
    - Answered "yes" to the question: "During the past 12 months, did you think you needed help for emotional or mental health problems, such as feeling sad, anxious or nervous?" (QT09_I18)
      OR:
    - Scored 10 or above on the Kessler-6 (K6) – six questions designed to estimate the prevalence of diagnosable mental disorders within a population (QT09_G2 through QT09_G6) (Kessler et al., 2002)
- Suicide attempts can be from one of these data sources:
    - YRBSS suicide questions:

        - 27. During the past 12 months, how many times did you actually attempt suicide?
    - CHIS Adult:
        - QA09_S5 Have you attempted suicide at any time in the past 12 months?
- Suicide attempts resulting in injury
    - YRBSS suicide questions:
        - 28. If you attempted suicide during the past 12 months, did any attempt result in an injury, poisoning, or overdose that had to be treated by a doctor or nurse?
    - Non-fatal self-inflicted injury hospitalization data from the California Office of Statewide Health Planning and Development (OSHPD) Patient Discharge Data files 2005-2007, http://www.oshpd.ca.gov/, Healthcare Quality and Analysis Division, Health Care Information Resource Center.

Analysis:

- Level of comparison
    - County
    - State
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
    - Child/Adult/Elderly
- Timeframe
    - Annual

Notes:

- Here we are including two definitions of need which capture slightly different populations. Depending on the goal of the analysis, can choose one or the other.

Relevant citations:

- ((CHIS), 2012)
- ("Behavioral Risk Factor Surveillance System Survey Data," 2012)
- (Kessler et al., 2002)

INDICATOR 23F: RATES OF IMPROVED FUNCTIONING AS A RESULT OF MENTAL HEALTH SERVICES

Numerator: Number of CPS respondents who had improved functioning
Denominator: Total CPS respondents

Definitions and data sources:

- California Consumer Perception Survey: sum the following questions as a direct result of the services I received…

    - I deal more effectively with daily problems.
    - My symptoms are not bothering me as much.
    - [And many similarly structured questions about ability to function, Qs 21-32]

Analysis:

- Level of comparison
    - County
    - State
    - Rural/Urban
    - Priority population
    - Race/Ethnicity
    - Child/Adult/Elderly
- Timeframe
    - Annual

Notes:

- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)
- Consumer Perception Survey provides data on healthcare utilization satisfaction.
- There is no psychometric information on whether the survey responses can be summed. We recommend that this be studied so that we can create a scale score.

Legislative Goal 6: Decreased Stigma and Discrimination

WHERE IS IT GOING?

Aim 1: Increase in anti-stigma and integrated care training materials

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 2: Increase in training of providers, gatekeepers and stakeholders

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 3: Increase in anti-stigma policy recommendations and review of laws and/or policies

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 4: Increased development of informational resources and wellness programs

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item. This is data that could be collected by the counties and aggregated to create a state-wide measure.

Aim 5: Increase in the number of peer support programs

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item. This is data that could be collected by the counties and aggregated to create a state-wide measure.

WHAT IS IT DOING?

Aim 6: Increase in advocacy to change discriminatory laws, policies and practices

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 7: Improvements in infrastructure to support change

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 8: Increased reach of wellness and peer support programs

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

DOES IT MAKE A DIFFERENCE?

Aim 9: Reduction in self-stigma

See related stigma indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, Aim 19: Decreased stigma and discrimination:

- Indicator 19A: Rates of adults not seeking help with a mental health issue due to stigma

Aim 10: Improvement in attitudes and behaviors towards people with mental illness

See related stigma indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, Aim 19: Decreased stigma and discrimination:

- Indicator 19B: Rates of children being bullied due to a physical or mental disability
- Indicator 19C: Rates of discrimination due to health problems
- Indicator 19D: Public attitudes toward mental illness
- Indicator 19E: media portrayals of people with mental illness

Aim 11: Decrease in discriminatory laws, policies and practices

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

DOES IT IMPROVE MENTAL HEALTH?

Aim 12: Increased utilization of mental health services

See related utilization indicators under *Legislative Goal 5: Improved Resilience and Emotional Well-Being*, *Aim 5: Increase exposure to and utilization of mental health programs*:

- Indicator 5A: Rates of public mental health admissions
- Indicator 5B: Reach of PEI-funded programs doing public/community outreach and education
- Indicator 5C: Utilization of PEI-funded education and training programs
- Indicator 5D: Treatment by professionals for mental health issue

Aim 13: Reduction in social isolation

INDICATOR 13A: IMPROVEMENT IN SOCIAL SUPPORT DUE TO MENTAL HEALTH SERVICES:
Numerator: Average value endorsed by clients regarding whether, as a result of the services received:

- "In a crisis, I would have the support I need from family or friends." [All ages]
- "I know people who will listen and understand me when I need to talk." [Youth only]
- "I have people that I am comfortable talking with about my problem(s)." [Youth only]

Denominator: N/A

Definitions and data sources:

- Data come from the Consumer Perceptions Survey

Analysis:

- Level of comparison
    - Priority populations
    - County
- Timeframe
    - Annual

Notes:

- NA

Legislative Goal 7: Student Mental Health

WHERE IS IT GOING?

Aim 1: Increase in capacity of providers, gatekeepers and school personnel

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 2: Increase in development of policies, protocols and informational resources

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 3: Increase in interagency collaboration and partnership for school mental health

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 4: Increase in support and education programs

This is an aspirational aim. At this point population-level measures do not exist to capture this item. This is data which could be collected by the counties and aggregated at the state-level.

Aim 5: Increase in school-based screening, evaluation and support services

This is an aspirational aim. At this point population-level or school-based measures or data sources do not exist to capture this item.

WHAT IS IT DOING?

Aim 6: Improved infrastructure to sustain change

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 7: Increase in the number of needs assessments

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 8: Increased use of support programs

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

DOES IT MAKE A DIFFERENCE?

Aim 9: Improvement in attitudes and behaviors towards people with mental illness

See related stigma and discrimination measures under Legislative *Goal 5: Improved Resilience and Emotional Well-Being, Aim 16: Decreased Stigma and Discrimination*

- Indicator 16A: Rates of adults not seeking help with a mental health issue due to stigma
- Indicator 16B: Rates of children being bullied due to a physical or mental disability
- Indicator 16C: Rates of discrimination due to health problems
- Indicator 16D: Public attitudes towards mental illness

Aim 10: Increase in knowledge of early signs of mental illness

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 11: Increase in utilization of school mental health resources

This is an aspirational aim. At this point population-level or public school based measures do not exist to capture this item.

Aim 12: Reduction in social isolation

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 13: Reduction in perceived barriers to services

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

Aim 14: Improved school-related outcomes (e.g. engagement, relationships between students and teachers) and climate

INDICATOR 14A: TEST SCORES AMONG STUDENTS WITH DISABILITIES
Numerator: Test scores among students with disabilities
Denominator: Number of students with disabilities

Definitions and data sources:

- CA department of education API data (*2010 Adequate Yearly Progress Report*, 2010)

Analysis:

- Level of comparison
  - National
  - County
  - District
- Timeframe
  - Annual

Notes:

- API is reported by race, English Learner Status, students with disabilities, and socioeconomically disadvantaged pupils.
- Data on students in special education with an emotional disturbance are available at the county, district, and Special Education Local Plan Area (SELPA) levels.
-

Relevant citations:

- (*2010 Adequate Yearly Progress Report*, 2010)

INDICATOR 14B: RATES OF ABSENTEEISM AND TRUANCY
Numerator:

a) Absenteeism rates
b) Truancy (unexcused absence of 3 or more days)

Denominator: School population

Definitions and data sources:

- Absenteeism and truancy rates data from CA Dept. of Education Data Quest ("California Department of Education," 2010)

Analysis:

- Level of comparison

    - County
    - District
    - School
- Timeframe
    - Annual

Notes:

- Overall rates available but cannot identify cause of absence. Not specific to the Special Education population
- Can also use the Resilience module question “in the past 30 days, did you miss school (because you)… felt very sad, hopeless, stressed, or angry?”

Relevant citations:

- ("California Department of Education," 2010)

INDICATOR 14C: NUMBER OF EXPULSIONS

Numerator:

a) Number of expulsions overall
b) Number of violence/drug related expulsions

Denominator: Total school population

Definitions and data sources:

- Number of expulsions and number of violence and drug related expulsions data from CA Dept. of Education Data Quest ("California Department of Education," 2010)

Analysis:

- Level of comparison
    - County
    - District
    - School
- Timeframe
    - Annual

Notes:

- Not specific to the Special Education or mental health population, but violence/drug probably gets us closer

Relevant citations:

- ("California Department of Education," 2010)

INDICATOR 14D: NUMBER OF SUSPENSIONS

Numerator:

a) Number of suspensions overall
b) Number of violence/drug related suspensions

Denominator: Total school population

Definitions and data sources:

- Number suspensions and number of violence and drug related suspensions data from CA Dept. of Education Data Quest ("California Department of Education," 2010)

Analysis:

- Level of comparison
  - County
  - District
  - School
- Timeframe
  - Annual

Notes:

- Not specific to the Special Education or mental health population, but violence/drug probably gets us closer

Relevant citations:

- ("California Department of Education," 2010)

INDICATOR 14E: STUDENTS' PERCEPTIONS OF ADEQUACY OF SUPPORT AND REFERRAL SERVICES

Numerator: Student responses to CHKS question on School Health Center question (see notes)

Denominator:

- Population of students
- Students in need

Definitions and data sources:

CHKS

Analysis:

- Level of comparison (see the indicator by level of comparison matrix for more information)
  - Priority populations

        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- The results may not be generalizable as it was derived from a supplementary module. It is recommended that this indicator be made part of the core module.

From the School Health Center supplementary module:

If you HAVE used the School Health Center, Which of the following services have you received from the School Health Center?

…Counseling to help you deal with issues like stress, depression, family problems or alcohol or drug use

…Referrals for medical care or treatment outside the school

The School Health Center has helped me to …

Get help I did not get before.

Get help sooner than I got before.

Get information and resources I need.

Use tobacco, alcohol or drugs less

Use birth control or condoms more often

Eat better or exercise more

Deal with personal and/or family issues

Do better in school

Feel more connected to people at my school.

Relevant citations:

- N/A

Aim 15: Increase in student emotional well-being

This is an aspirational aim. At this point population-level or school-based measures do not exist to capture this item.

DOES IT IMPROVE MENTAL HEALTH

Aim 16: Reduction in school drop-out among people with mental illness

INDICATOR 16A: DROPOUT RATES AMONG SPECIAL EDUCATION STUDENTS
Numerator: Number graduating from high school in special education cohort

Denominator: Total number of special education students in cohort

Definitions and data sources:

- Number of special education students and number graduating come from CA Dept. of Education Data Quest ("California Department of Education," 2010)

Analysis:

- Level of comparison
  - County
  - District
  - School
- Timeframe
  - Annual

Notes:

- Additional information available about Special Ed students still enrolled and those obtaining a GED.
-

Relevant citations:

- ("California Department of Education," 2010)

Legislative Goal 8: Out of Home Removal

WHERE IS IT GOING?

Aim 1: Improved caregiver support and training

INDICATOR 1A: NUMBER OF FAMILY SERVICES PROVIDED TO INCREASE REUNIFICATION

Numerator: Number of child cases where reunification services were provided to family

Denominator: # of open cases in child welfare system where reunification was the goal 12 months or less from removal

Definitions and data sources:

- Family Service Plans, see notes below

Analysis:

- Level of comparison
    - Priority populations
        - Overall
        - By county
    - Land Area
        - Overall
        - By county
- Timeframe
    - Annual

Notes:

- CDSS could extract these data. Note that the data are not always comprehensive re: the number of services given because it's based on what the case workers enter into the system (e.g., court-ordered services/drug testing is more accurate because they need to log that for the court and it's mandatory).
- Can compare to national estimates from the National Survey of Child and Adolescent Well-Being (NSCAW), but this dataset cannot be aggregated at the state level.

Aim 2: Increase in outreach and education

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 3: Increase in assessment and early intervention mental health services for parents and children

INDICATOR 3A: PERCENT OF CHILDREN REMOVED FROM THE HOME WHO RECEIVED EARLY INTERVENTION SERVICES

Numerator: Number of children under age 3 who receive early intervention services
Denominator: Number of children under age 3 who have been removed from the home during the specified year

Definitions and data sources:

- NSCAW or Family Service Plans

Analysis:

- Level of comparison
- Timeframe
    - Annual

Notes:

- Extract from the county level (explore feasibility of measuring through family service Part C plans)
- The National Survey of Child and Adolescent Well-Being (NSCAW) is nationally representative longitudinal data drawn from first-hand reports from children, parents, and other caregivers, as well as reports from caseworkers, teachers, and data from administrative records.

INDICATOR 3B: PERCENT OF CHILDREN WITH MENTAL HEALTH ISSUES WHO RECEIVED SPECIALTY MENTAL HEALTH CARE

Numerator: Number of children in the welfare system who receive specialty mental health care within a year of case initiation

Denominator: Total number of children with a mental health diagnosis during the specified year

Definitions and data sources:

- Numerator and denominator from the National Survey of Child and Adolescent Well-Being (*National Survey of Child and Adolescent Well-Being (NSCAW) Cps Sample*, 2005)

Analysis:

- Level of comparison
    - National
    - Priority population
- Timeframe
    - Annual

Notes:

- The National Survey of Child and Adolescent Well-Being (NSCAW) is nationally representative longitudinal data drawn from first-hand reports from children, parents, and other caregivers, as well as reports from caseworkers, teachers, and data from administrative records.

Relevant citations:

- (Leslie, Hurlburt, James et al., 2005)
- (*National Survey of Child and Adolescent Well-Being (NSCAW) Cps Sample*, 2005)

INDICATOR 3C: PERCENT OF CHILDREN WITH MENTAL HEALTH ISSUES WHO RECEIVED MENTAL HEALTH CARE ELSEWHERE

Numerator: Number of children in the welfare system who receive mental health care elsewhere (e.g., school, primary care) within a year of case initiation

Denominator: Total number of children with a mental health diagnosis during the specified year

Definitions and data sources:

- Numerator and denominator from the National Survey of Child and Adolescent Well-Being (*National Survey of Child and Adolescent Well-Being (NSCAW) Cps Sample*, 2005)

Analysis:

- Level of comparison
    - National
    - Priority population
    -
- Timeframe
    - Annual

Notes:

- The National Survey of Child and Adolescent Well-Being (NSCAW) is nationally representative longitudinal data drawn from first-hand reports from children, parents, and other caregivers, as well as reports from caseworkers, teachers, and data from administrative records.

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Relevant citations:

- (Leslie et al., 2005)
- (*National Survey of Child and Adolescent Well-Being (NSCAW) Cps Sample*, 2005)

INDICATOR 3D: RATES OF CHILDREN LIVING WITH FAMILY WHILE RECEIVING MENTAL HEALTH SERVICES

Numerator: Number of children living with one or both parents or a family member

Denominator: Number of children receiving mental health services

Definitions and data sources:

- Numerator and denominator from the California Consumer Perception Survey ("California Department of Mental Health (DMH) ", 2011)

Analysis:

- Level of comparison
  - County (see notes)
  - Priority population
- Timeframe
  - Annual

Notes:

- Note that California response rates are low (10.4% for children and 19.7% for adults) compared to US averages (~45 and 50%, respectively)

Relevant citations:

- ("California Department of Mental Health (DMH) ", 2011)

Aim 4: Increase in resources to support families, youth and children

INDICATOR 4A: NUMBER OF AND CAPACITY OF PEI-FUNDED PARENTING AND FAMILY-FOCUSED PROGRAMS

Numerator:

a) Number of PEI-funded parenting and family-focused programs
b) Number of staff employed at PEI-funded parenting and family-focused programs

Denominator: Number of families with children under 18 years of age in California

Definitions and data sources:

- Number of families with children under 18 years of age in California data come from the American Community Survey ("American Community Survey," 2012)
- Data on number of PEI-funded parenting and family-focused programs and staff therein is to be recommended.

Analysis:

- Level of comparison
  - TBD
- Timeframe
  - TBD

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("American Community Survey," 2012)

INDICATOR 4B: NUMBER OF PARENT-CHILD VISITS PER CHILD IN A GIVEN YEAR

Numerator: Number of visits per child with biological family per child

Denominator: Total number of open cases in the child welfare system per child during the specified year

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
  - National
- Timeframe
  - Annual

Notes:

- N/A

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 4C: INCREASE THE NUMBER OF CHILDREN SERVED BY PEI-FUNDED PARENTING AND FAMILY-FOCUSED PROGRAMS, ORGANIZED BY TYPE OF PROGRAM

Numerator: Number of children served

Denominator: Number of families with children under 18 years of age in California

Definitions and data sources:

- Number of families with children under 18 years of age in California data come from the American Community Survey ("American Community Survey," 2012)
- Data on number of children served is to be recommended.

Analysis:

- Level of comparison
  - TBD
- Timeframe
  - TBD

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.

Relevant citations:

- ("American Community Survey," 2012)

INDICATOR 4D: COMMUNITY LINKAGES BETWEEN SOCIAL SERVICE AND CHILD WELFARE AGENCIES

Numerator: Number of social service organizations with formalized relationships with the CWS [e]

Denominator: Number of families with children under 18
Definitions and data sources:

- TBD

Analysis:

- Level of comparison
- Timeframe
  - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.
- Examples of social service organizations include specialty mental health, family preservation services, substance abuse treatment, individual and family therapy and mental health services, housing, income, and employment assistance, parenting education
- Data source for number of families with children under 18 is from http://www.nationalchildbenefit.ca/eng/07/table6_eng.shtml
- Note of future data to look into:
    - It may be possible to extract the types of services delivered to families through California Department of Social Services (CDSS).
- Deborah Williams at CDSS says they just received a contract from Dept. of Education to examine community linkages between the child welfare system and social service partners (e.g., drug and alcohol, developmental disabilities, mental health).
    - Recommend counties complete this data for the state
- This indicator can be used either as number of social service organizations with relationship with CWS per 1,000 families with children under 18, or per total population with children under 18.

INDICATOR 4E: RATIO OF NUMBER OF OPEN CASES IN THE CHILD WELFARE SYSTEM TO THE NUMBER OF CASE WORKERS

Numerator: Number of FTE case workers employed by child welfare system

Denominator: Total number of open cases in the child welfare system during the specified year

Definitions and data sources:

- Numerator and denominator data sources are to be recommended

Analysis:

- Level of comparison
- Timeframe
    - Annual

Notes:

- Data source for this indicator is to be recommended; In order to aggregate data across programs and counties it will be necessary to create a uniform reporting template and standardized definitions for program level data on structure and process.
- Note for analyses: Would need to contact county-level data analysts to examine and assess this at the county level. Caveat: Each county defines “case worker” differently

(e.g., some have bachelors' degrees while others have social work degrees). The recommendation of CDSS is no more than 54 cases/FTE Case Worker.

INDICATOR 4F: PERCENTAGE OF CHILDREN REQUIRING A CASEWORKER CONTACT WHO RECEIVED THE CONTACT IN A TIMELY MANNER

Numerator: Number of children who received contact from a caseworker as identified by California Safe Schools Report (CSSR) (see note)

Denominator: Total number of open cases in the child welfare system in a given month

Definitions and data sources:

- Already analyzed by CSSR California Child Welfare Performance Indicators Project at state and county levels

Analysis:

- Level of comparison
  - County
  - State
- Timeframe
  - Annual

Notes:

- The numerator is the count of non-exempt children with:
  - A completed contact
  - An in-person contact
  - A contact type of "staff person to child"
  - A contact after the child's case start date; and
  - A contact made in accordance with required frequencies

WHAT IS IT DOING?

Aim 5: Increase in identification of at-risk children and families

INDICATOR 5A: NUMBER OF CHILDREN AT RISK OF REMOVAL WHO ARE RECEIVING MH SERVICES OR FAMILY THERAPY SERVICES

Numerator: Number of children in child welfare supervised foster care

Denominator: Population of children

Definitions and data sources:

- Already analyzed by CSSR California Child Welfare Performance Indicators Project at state and county levels

Analysis:

- Level of comparison
  - State
  - County
- Timeframe
  - Annual

Notes:

- TNA

Aim 6: Increased use and reach of support services, resources and programs

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

DOES IT MAKE A DIFFERENCE?

Aim 7: Improved social-emotional development of at-risk children

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

Aim 8: Increase in knowledge of available resources

This is an aspirational aim. At this point population-level measures and data sources do not exist to capture this item.

INDICATOR 12D: INCREASED KNOWLEDGE ABOUT MENTAL HEALTH ISSUES

Numerator: Number of students receiving information about mental health services
Denominator: Total population

Definitions and data sources:

- Number of students receiving information about mental health services data come ACHA-NCHA surveys(*American College Health Association - National College Health Assessment (ACHA-NCHA) American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary*, 2007),
  Number of students answering "yes" to any of the following questions:

- Within the last 12 months, have you received information on the following topics from your college or university?
  - Alcohol and other drug use
  - Depression/Anxiety
  - Grief and loss
  - How to help others in distress
  - Sleep difficulties
  - Stress reduction
  - Suicide prevention
  - Violence prevention

Analysis:

- Level of comparison
  - Race/Ethnicity
  - National
- Timeframe
  - Annual

Notes:

- NA

Relevant citations:

- ((ACHA-NCHA), 2012; American College Health Association - National College Health Assessment (ACHA-NCHA) American College Health Association - National College Health Assessment (ACHA-NCHA) Web Summary, 2007)

Aim 9: Improved parenting skills

This is an aspirational aim. At this point population-level measures do not exist to capture this item.

DOES IT IMPROVE MENTAL HEALTH?

Aim 10: Reduction in removal of children from homes

INDICATOR 10A: CHILDREN REMOVED FROM HOME DUE TO CHILD ALCOHOL OR DRUG USE
Numerator: Number children removed from home due to child alcohol or drug use
Denominator: Among open cases where the child has a mental illness or substance use problem

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
  - National
- Timeframe
  - Annual

Notes:

- #19, 31-32 of AFCARS Data Elements File
- Notes for analyses: Compare with rates of parental PEI utilization

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 10B: CHILDREN REMOVED FROM HOME DUE TO CHILD BEHAVIORAL PROBLEMS

Numerator: Number of children removed from home in a year due to child behavioral problems
Denominator: Number of children in foster care with emotional disturbance during the specified year

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
  - National
- Timeframe
  - Annual

Notes:

- #19, 34 of AFCARS Data Elements File
- Notes for analyses: Compare with rates of parental PEI utilization
- Behavioral problem is not interchangeable with emotional disturbance, but a close proxy for it.

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 10C: MEDIAN LENGTH OF STAY FROM REMOVAL TO REUNIFICATION

Numerator: Length of stay is calculated as the date of discharge from foster care minus the latest date of removal from the home

Denominator: N/A

- Numerator comes from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
  - National
- Timeframe
  - Annual

Notes:

- #19, 34 of AFCARS Data Elements File
- Notes for analyses: Compare with rates of parental PEI utilization
- Behavioral problem is not interchangeable with emotional disturbance, but a close proxy for it.

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 10D: REASON FOR CHILD REMOVAL

Numerator: Number of children removed from home due to parental alcohol or drug use [b, d-g]

Denominator: Among open cases where one parent has a mental illness or substance use problem

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
    - National
- Timeframe
    - Annual

Notes:

- #19, 29-30 of AFCARS Data Elements File
- Notes for analyses:
    - Compare with rates of parental PEI utilization (i.e., as rates of help seeking improves, removal of children should decrease)
    - Compare with national rates from NSDUH

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 10E: PERCENTAGE OF CHILDREN DISCHARGED TO REUNIFICATION WITHIN 12 MONTHS OF REMOVAL

Numerator: Number of children who were reunified, where reunification occurred in 12 months or less from removal

Denominator: Total number of children who exited foster care to reunification during the specified year

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
    - National
- Timeframe
    - Annual

Notes:

- Source reference
- Already analyzed by CSSR at state and county levels. May also obtain from AFCARS to compare across states.

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

INDICATOR 10F: PERCENT OF CHILDREN WITH 3 OR MORE TRANSITIONS IN FOSTER CARE OF TOTAL NUMBER OF CHILDREN

Numerator: Number of children with 3 or more placements

Denominator: Total number of children who were in foster care during the specified year

Definitions and data sources:

- Numerator and denominator come from the adoption and Foster Care Analysis and Reporting System (AFCARS)

Analysis:

- Level of comparison
  - National
- Timeframe
  - Annual

Notes:

- NA

Relevant citations:

- ("California Afcars Assessment Review Report," 2004)

Appendix D

Technical Approach

Technical Details of a Time-Trend Analysis of Pooled Cross-Sectional Data

This analysis framework assumes that observations on different people or areas are obtained over time, in a pooled cross-sectional design and that only a time-trend analysis can be conducted. However, the proposed analytic strategies can be modified to work for longitudinal designs in which baseline data are available; they can also be adapted for a treatment-control design in which a comparable state can be used as a comparison group to estimate the impact of PEI in California. None of these analyses can definitively establish a causal relationship between a PEI program element and a health outcome. This limitation should be acknowledged in the evaluation, but observed PEI effects still can have constructive policy implications.

Analytic Methods for Longitudinal or Pooled Cross-Sectional Observations with No Baseline

We start with the straightforward case of longitudinal data and then discuss the pooled cross-sectional data of interest in this study. In the analysis of observational data, use of longitudinal data assumes that observations on different people or areas are obtained over time. Assuming that the outcome of interest is denoted Y_{it} for each participant i at time t (t = 1, 2, 3, …), the individual improvement in the outcome from time 1 to time 2 (or any time trend in general) can be estimated as $Y_{i2} - Y_{i1}$, assuming that every study participant is observed at both time 1 and 2 (or longitudinally). The average of such improvement over time across all participants will provide an estimate of the overall average treatment effect from time 1 to time 2. With n assumed to be the number of study participants, the estimated time-trend effect will be the average treatment effect:

$$ATE = \frac{1}{n}\sum_{i=1}^{n}(Y_{i2} - Y_{i1}).$$

This estimated time trend will not necessarily be causal because it can be confounded by many factors as discussed below, but it can produce an estimated treatment (or PEI) effect. In the specific case of pooled cross-sectional data in which participants observed at time 1 are different from the participants observed at time 2 (and possibly all other time points), the analysis assumes that there is a participant in the other time point who is similar to the first participant and can serve as his or her counterfactual. Participants at time 1 are denoted by the j subscript and participants at time 2 are denoted by the i subscript. So if n_1 participants were in time 1 and n_2 participants were in time 2, the PEI treatment effect (again not necessarily causal) will be estimated as the difference in the average between the time 1 and time 2 data:

$$ATE = \frac{1}{n_2}\sum_{i=1}^{n_2}Y_{i2} - \frac{1}{n_1}\sum_{j=1}^{n_1}Y_{j1}.$$

This is equivalent to estimating the change in the average outcome (e.g., stigma) level in the population observed from time 1 to time 2; the same analysis is conducted to compare other time points.

A critical question when analyzing this type of data is the denominator of the estimates. Two different denominators are possible, and each would provide different estimates of PEI effects. One potential denominator is the California population as a whole. A second potential denominator is the population of California who are in need of mental health care (either because they self-identify as needing help or because they have a level of symptoms that puts them at risk of a serious mental disorder). The method of analysis is the same for both denominators, but the *meaning* of the treatment effect will differ, depending on whether one is interested in the treatment effect on the entire population or only on the population in need. With these effects estimated, a hypothesis test (usually using a t-test, a z-test, or a chi-squared test) will be conducted to assess whether the PEI effect was positive (an improvement in the outcome), negative (the mental health outcome got worse), or zero, and to assess the impact of PEI.

In cases in which one believes there are *known* confounders of the PEI effect, the confounders should be controlled for through (regression) modeling in order to assess whether the estimated impact of the PEI, even if not causal, is unbiased. For example, imagine a case in which, for time 1, the population contains only a few individuals who have a mental disorder (say 5 percent), while at time 2, the number is larger (say 50 percent). Because people with mental disorders are more likely than people without mental disorders to experience incarceration (an outcome of interest), one will expect the average rate of incarceration measured in the time 2 cross-sectional participants to be larger than the average rate of incarceration in the time 1 cross-sectional participants, regardless of whether there was exposure to a PEI intervention in the population, just because of the sampling bias. So, if this confounding factor is not accounted for properly, one might wrongfully infer that PEI is increasing the rate of incarceration over time.

To control for confounders, the evaluation will estimate the PEI effect by modeling

$$Y_{it} = \beta_0 + \beta_1 Time_{it} + \beta_2 Mental.Disorder_{it} + \varepsilon_{it} \qquad (1)$$

where $Mental.Disorder_{it}$ is the confounder of whether a participant has a mental disorder and β_1 estimates the PEI's adjusted (or confounder controlled for) average treatment effect. Many confounders or case-mixed adjusters can be included in equation (1). Most of these confounders should be chosen from participant characteristics that one believes can be related to the requirement to be part of the data used (e.g., in claim data, only people with insurance are observed and having insurance can be a confounder) and at the same time related to the mental health outcome of interest. In particular, some of these confounders will be participants' socioeconomic status, such as age, gender, race, family status, network of friends, and family history of mental disorder (if they are observed in the retrospective data sets to be used for the evaluation). Even area-level characteristics or proxy variables can be used for case-

mixed adjustment. Commonly, when a participant's income is not known, but one believes that it should be controlled for, the average or median income in the participant's zip code (obtained from census data) will be used as a proxy for person-level income. Similar proxies can be used for race, education, and other characteristics and can be obtained from outside sources as long as they can be linked to a participant through identifiers, such as zip code. Similar to the simple case, the PEI β_1 effect in equation (1) can also be tested for significance using a t-test, a z-test, or a chi-squared test, depending on the type of outcome being used.

Models with other designs can also be used. For example, one of the goals of the MHSA is to reduce disparities between different groups (e.g., race, gender, urban/rural, socioeconomic status, or underserved populations). A D-in-D analytic approach can help to assess the difference in how PEI affects different groups. Even though there is no treatment group in the evaluation, when trying to assess whether the impact of PEI in rural areas is different from the impact of PEI in urban areas (i.e., disparity in impact), rural areas can be considered a treatment group and urban areas a control group. Keep in mind that this method can assess the disparity in the improvement over time (e.g., from time 1 to time 2) only when no baseline data exist. For comparing rural and urban areas, equation (1) can be reformulated as

$$Y_{it} = \beta_0 + \beta_1 Time_{it} + \beta_2 Rural_{it} + \beta_3 Rural_{it} \times Time_{it} + \beta_4 Mental.Disorder_{it} + \varepsilon_{it} \qquad (2).$$

In this model, the interaction term β_3 will estimate the disparity between urban and rural area, by first looking at the pure improvement in outcomes from time 1 to time 2 separately for urban and rural areas, and then taking the difference of those two improvements. In the case in which longitudinal data are available on the same individual, the analyses can control for time-invariant confounders. In this case, participants are compared with themselves, so it can be assumed that any time-invariant confounder, known or unknown, is controlled. Instead of analysis of disparity, this analytic method can also be used to compare different counties (if that is of interest) where urban/rural will be replaced by different counties or different regions in California. If data from other states can be used to establish comparison groups, the D-in-D approach can also be used to assess PEI's effect with a real counterfactual for California that can lead to causal inference about the PEI impact.

Technical Details of Synthetic Control Design

In a setup in which data can be obtained from other states, those states can be used as counterfactuals to California and be used as a synthetic control group for the causal estimation of the impact of PEI.

Let *j* represent all the states in the sample in which a state will be indexed *j* = 1, 2, …, *j*. . In the ideal situation of treatment and control setting, let *E* denote exposure to the PEI program (called *P*), and let *U* denote lack of exposure. Let T_0 represent the pre-intervention period and T_1 represent the postintervention period in which a time point will be denoted *t* = 1, 2, …, T_1 with 1 and $1 \le T_0 \le T_1$. Let *Y* represent the outcome of interest. Without loss of generality, if we assume that State 1 is California, then the impact of *P* in a treatment control setting is given by

$$\alpha_{1t} = Y_{1t}^{E} - Y_{1t}^{U}, \quad \forall t > T_0 .$$

The problem in this evaluation is that we observe only the first term but not the second, often referred to as the counterfactual, because California cannot be both exposed and unexposed at the same time. The key contribution of Abadie, Diamond, and Hainmueller (2010) is to show that, under certain conditions, the weighted average $\sum_{j=2}^{J} w_j Y_{jt}$ of the outcome over all the other states is a good approximation of Y_{it}^{U}. The w_j's are an optimally chosen vector of weights in order to obtain the optimal synthetic control group and with $\sum_{j=2}^{J} w_j = 1$. The impact of the intervention, *P*, can therefore be estimated by

$$\alpha_{1t} = Y_{1t}^{E} - \sum_{j=2}^{J} w_j Y_{jt}, \quad \forall t > T_0 .$$

The insight here is that one can construct a counterfactual (synthetic) California *without* the PEI program from a weighted average of all the other unexposed states in the sample, and then compare the outcomes in this synthetic California (without the PEI program) with the actual outcomes observed in California following the implementation of the PEI program. The optimal vector of weights *W** is one that re-creates, as closely as possible, the outcomes in California *before* the implementation of the PEI program. More accurately, it attempts to match as closely as possible the values of *a set of predictors for each outcome* for California before implementation of the PEI. More formally, *W** is chosen from the universe of all possible *W*'s in order to minimize the following function $(X_1 - X_0 W)' V (X_1 - X_0 W)$, where $w_j \geq 0$ and $\sum_{j=2}^{J} w_j = 1$. *X* is a matrix of *K* state characteristics that predict each outcome, typically defined for $t \in \{1, \ldots, T_0\}$. The subscripts 0 and 1 denote unexposed and exposed states, respectively. Clearly, all determinants are not created equal, and so a matrix *(V)* assigns weights to each determinant in relation to how strongly it predicts the outcome of interest, e.g., suicide rates. *V** is chosen to minimize the mean square prediction error of the estimator, i.e., $E[(Y_1 - Y_0 W^*)'(Y_1 - Y_0 W^*)]$. In the absence of strong priors regarding the relative importance of each predictor, *V** can be chosen to minimize $E[(Y_1 - Y_0 W^*)'(Y_1 - Y_0 W^*)]$ for $t < T_0$ i.e. for the pre-intervention period.

Limitations

The limitations of these models should be taken into account when drawing inferences from the analyses:

- Even though all data participants will potentially have been exposed to the PEI services, in some cases, historical data can be used to establish a baseline, even if they are just pooled cross-sectional baseline data. However, with many other data sets, only retrospective data after the implementation of the PEI will be collected. Thus, the evaluation will not say where participants start from in terms of the outcome of interest before they were exposed to PEI programs and activities. If exposure to PEI provides only a one-time shock right after exposure, the evaluation could show that there is no treatment effect between time 1 and time 2, but that does not mean that the program did not have any impact. The time when the impact is more likely to be observed could have been different from the time at which the data are observed. A null finding on improvement does not necessarily confirm that the PEI was not effective.

One way to address the limitation of having no baseline is to use census data or historical data sets, such as the California Health Interview Survey (CHIS), which was fielded on a biennial basis prior to the passage of the MHSA. Because the CHIS collects mental health information on the non-institutionalized population of California, it can provide a baseline understanding of the mental health of the population before PEI implementation. Because these are just pooled cross-sectional data, the CHIS before-program implementation can be used as another time point (e.g., time 0) and the techniques in equation (2) can be used to estimate the impact of PEI from baseline to a specific time point. Even in cases in which there are no individual-level baseline data, if there is a baseline average known for an outcome from other data sources, the simple average treatment effect at time 2 can be estimated as

$$ATE = \frac{1}{n}\sum_{i=1}^{n} Y_{i2} - Y_{Known.Baseline},$$

where $Y_{Known.Baseline}$ is the average known outcome estimate before the PEI implementation. Testing the hypothesis of whether the PEI is effective at improving this mental health outcome will be conducted using a one-sample t-test.

- Because MHSA funded other programs and activities in addition to PEI (e.g., community supports and services), estimated effects using pooled cross-sectional or longitudinal data cannot disentangle the PEI effect from the effects of those services or the effects of other programs implemented at the same time. This is a limitation that should be acknowledged in the evaluation, and it would be preferable to talk about observed effects as the effects of the PEI and other programs that might be out there. One corollary of this limitation is that if another program is actually having a negative impact on the population's outcome and the PEI is having a positive impact, the average

observed impact through this evaluation can be null. In this situation, the null finding does not mean that the PEI is not effective, unless one can make the assumption that all MHSA-funded programs should either have no impact or result in improved outcomes.

- Currently, PEI services are being implemented with different intensities over a period of several years. This leaves the possibility that some regions will have PEI services long before some others; however, data collection will occur at the same time in all areas. Estimated PEI impacts will probably be attenuated estimates of the true impacts (even if noncausal) because some participants will have had a high dose of PEI while others will have had only a low dose. To this end, for the evaluation, the intensity of the PEI implementation should be measured in each area, or the intensity associated with each participant should be measured. Intensity can be measured in terms of the length of time since the implementation or the level of penetration of the PEI (e.g., the number of radio broadcasts about the program) or even the estimated number of people the PEI may have reached (e.g., utilization data). The intensity can then be categorized during analysis (for example, into low, medium, and high) and the different category of intensity should be compared using the notions discussed in equations (1) and (2). Inferences can be made about whether the impact of PEI in low-intensity implementation areas is different from the impact in medium-intensity or even in high-intensity areas.

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