California Mental Health Master Plan: A Vision for California

California Mental Health Planning Council

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TABLE OF CONTENTS

ACKNOWLEDGEMENTS i

TABLE OF CONTENTS iii

EXECUTIVE SUMMARY v

CHAPTER 1: MISSION AND PHILOSOPHY OF CALIFORNIA'S MENTAL HEALTH SYSTEM 1
- WHAT ARE THE VISION, MISSION, AND VALUES OF THE PUBLIC MENTAL HEALTH SYSTEM? 1

CHAPTER 2: COMMITMENT TO CULTURAL COMPETENCY 4
- WHY INTEGRATE CULTURAL COMPETENCE INTO CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM? 4
- WHAT IS CULTURAL COMPETENCE? 4
- SYSTEM LEVEL DESIGN ISSUES 5
- CONCLUSION 8
- APPENDIX 9
- REFERENCES 11

CHAPTER 3: UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES 12
- HOW MANY PEOPLE NEED PUBLIC MENTAL HEALTH SERVICES BUT ARE NOT RECEIVING THEM? 12
- HOW WERE THE ESTIMATES DEVELOPED? 13
- WHAT ARE THE LIMITATIONS OF THESE ESTIMATES? 13
- HOW CAN UTILIZATION OF PRIVATE SECTOR MENTAL HEALTH SERVICES BE ESTIMATED? 14
- WHAT IS THE CMHPC'S METHODOLOGY FOR DETERMINING UNMET NEED? 15
- WHAT IS THE EXTENT OF UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES AMONG RACIAL/ETHNIC AND CULTURAL GROUPS? 29
- REFERENCES 34

CHAPTER 4: THE PLANNED SYSTEM OF CARE FOR CHILDREN AND YOUTH 35
- WHAT ARE THE VISION, MISSION, AND VALUES FOR A SYSTEM OF CARE FOR CHILDREN AND YOUTH? 35
- WHY DOES A SYSTEM OF CARE WORK AND HOW IS IT STRUCTURED? 38
- WHAT INNOVATIVE PROGRAMS HAVE BEEN DEVELOPED FOR CHILDREN? 40
- WHAT POPULATIONS NEED SPECIAL ATTENTION? 44
- WHAT ARE THE BARRIERS TO EFFECTIVE OPERATION OF THE SYSTEM OF CARE? 52
- WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR CHILDREN AND YOUTH? 54
- APPENDIX 60
- REFERENCES 63

CHAPTER 5: THE PLANNED SYSTEM OF CARE FOR ADULTS 65
- WHAT ARE THE MISSION AND VALUES FOR THE SYSTEM OF CARE FOR ADULTS? 65
- WHAT ARE THE PRIORITY TARGET POPULATIONS IN THE SYSTEM OF CARE FOR ADULTS? 67
- WHAT PROBLEMS EXIST IN THE ADULT SYSTEM OF CARE? 68
- REFERENCES 88

CHAPTER 6: THE PLANNED SYSTEM OF CARE FOR OLDER ADULTS 91
- WHAT ARE THE VISION, MISSION, AND VALUES FOR THE SYSTEM OF CARE FOR OLDER ADULTS? 91
- WHAT SHOULD THE TARGET POPULATION BE FOR THE SYSTEM OF CARE FOR OLDER ADULTS? 92
- WHAT ARE THE MAJOR PROBLEMS AND NEEDS OF OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES? 95
- WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES? 96
- WHAT ARE THE INTERAGENCY PARTNERSHIPS FOR THE SYSTEM OF CARE FOR OLDER ADULTS? 105
- WHAT STATE-LEVEL INITIATIVES HAVE BEEN ESTABLISHED FOR OLDER ADULTS? 106
- WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR OLDER ADULTS? 108
- APPENDIX I 110
- APPENDIX II 112
- REFERENCES 114

CHAPTER 7: MANAGED MENTAL HEALTH CARE 115
BACKGROUND 115
CMHPC'S PRIORITIES 118
REFERENCES 122

CHAPTER 8: SYSTEM ACCOUNTABILITY AND OVERSIGHT 123
CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM 123
EVOLUTION OF OVERSIGHT OF THE PUBLIC MENTAL HEALTH SYSTEM 125
THEORETICAL PERSPECTIVE ON USE OF PERFORMANCE INDICATORS FOR QUALITY IMPROVEMENT 128
CONCEPT OF ACCOUNTABILITY 132
ROLE OF CMHPC IN SYSTEM OVERSIGHT AND ACCOUNTABILITY 133
ROLE OF MENTAL HEALTH BOARDS AND COMMISSIONS IN SYSTEM OVERSIGHT AND ACCOUNTABILITY 134
PRINCIPLES TO GUIDE CONTINUED DEVELOPMENT OF OVERSIGHT, ACCOUNTABILITY, AND USE OF DATA 135
NEXT STEPS IN THE USE OF PERFORMANCE INDICATORS FOR SYSTEM OVERSIGHT 135
APPENDIX 138
REFERENCES 164

EXECUTIVE SUMMARY

In October 2002 the President's New Freedom Commission on Mental Health revealed that in our nation one out every two persons who needs mental health treatment does not receive it. For ethnic and racial minorities, groups that comprise a significant segment of California's population, the situation is even worse. As reported in 2001 by the Surgeon General's Report, "Mental Health: Culture, Race, and Ethnicity," ethnic and racial minorities receive treatment at a rate that is even lower than that of the general population. In addition, ethnic minority populations bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity.

The responsibility of California's public mental health system is to serve children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses who are eligible for publicly funded mental health services. The *California Mental Health Master Plan* tries to do for this state what the President's Commission has done for the nation. Chapter 3 presents the unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses in California.

Approximately 600,000 adults, older adults, and children and youth in need of mental health treatment are not receiving services. In round numbers, this figure breaks down to 300,000 children and youth, 200,000 adults, and 100,000 older adults. To put this figure in perspective, the public mental health system served 460,000 clients in fiscal year 1997-98. Consequently, the public mental health system would have to double in size to serve all the persons in need of mental health treatment.

A crisis also exists in access to mental health care for persons who are indigent. In 2003 the Department of Mental Health issued a report pursuant to AB 328 (Salinas) outlining, among other things, changes in the current service delivery system of mental health programs that have occurred since the enactment of realignment. The report notes that, in fiscal year 1990-91, 45 percent of the clients in the mental health system were Medi-Cal beneficiaries and 55 percent were indigents. In contrast, in fiscal year 1999-00, 68 percent were Medi-Cal beneficiaries and 38 percent were indigents. During that same period, the number of Medi-Cal clients served increased by 131 percent, and the number of indigents served has decreased by 8 percent. In the years since fiscal year 1999-00, the availability of services for indigents has only gotten worse. For example, in Los Angeles County many organizations have limited access for adults and older adults to only emergency care. During the last several years, organizations have turned away several thousand indigent clients because these organizations did not have the fiscal resources.

The personal loss represented by unmet need for mental health services and the crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wraparound programs and strengths-based, family focused treatment planning, have brought breakthroughs in services to children and their families. When the public mental health system is not able to provide mental health services to children and youth, adults, and older adults in need, these individuals experience needless human suffering and lose the opportunity to achieve their full potential as human beings.

The public mental health system must confront the challenge of improving the capacity and effectiveness of its system in a time of unparalled fiscal crisis in California. In fiscal year 2002-03, the State's General Fund is running a deficit of $26-$35 billion. Unprecedented spending reductions in state programs are being anticipated. In the face of this challenge, however, the mental heath constituency should not despair. It should embrace the vision for the public mental health system provided by the *California Mental Health Master Plan* and, during these lean times, marshal its forces, and plan how to implement this vision when sufficient fiscal resources become available.

In Chapter 1 the *Master Plan* offers a vision for the public mental health system. It envisions a

society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent, and effective services from the mental health system. As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, and fulfilling lives.

The mission of the public mental health system is to enable all individuals to access services from a seamless system of care. A fundamental set of values guides the development and implementation of the mental health system. Foremost is the client-directed approach to services in which all services for children and their families and for adults and older adults should be guided by an individual's goals, strengths, needs, concerns, motivation, and disabilities. A focus on wellness, recovery, and resilience must also be paramount in designing treatment plans. Chapter 1 enumerates all the other values essential to implementation of the vision for the public mental health system.

Chapter 2 communicates the commitment of the public mental health system to cultural competence, including an explanation of why cultural competence needs to be integrated into the mental health system and what is meant by cultural competence. It presents national standards that health care organizations should adopt to achieve culturally and linguistically appropriate services. It also describes how the mental health system needs to be designed through various levels, including state government, county government, and service providers, to ensure that culturally competent services are provided to mental health clients of all ethnic, racial, cultural, and linguistic backgrounds.

Chapters 4, 5, and 6 describe the systems of care for children and youth, adults, and older adults respectively. Each chapter presents the mission and values unique to each target population. These chapters discuss who is eligible for services in each system of care and issues related to target population definitions. Each chapter presents the elements of a system of care, the unique problems systems of care face in providing mental health services, and recommendations to address those problems. The special needs of ethnic and racial minorities are highlighted in each chapter.

Chapter 7 describes the transition that the public mental health system made to managed mental health care in the mid-1990s. It also provides information on the history of the funding of the mental health system. Finally, it discusses the priorities of the California Mental Health Planning Council for on-going monitoring of managed mental health care implementation.

Chapter 8 highlights system accountability and oversight in California's realigned public mental health system. The chapter provides basic information about the clients served in the mental health system and the magnitude of expenditures. It also provides a definition of terms and explanation of concepts to be used in working with performance indicators so that all stakeholders share a common understanding of these complex topics. It describes the roles of the California Mental Health Planning Council and of local mental health boards and commissions in system oversight and accountability and provides principles for guiding continued development of oversight, accountability, and the use of data. Finally, the chapter looks ahead to next steps in the use of performance indicators for system oversight.

CHAPTER 1

MISSION AND PHILOSOPHY OF CALIFORNIA'S MENTAL HEALTH SYSTEM

WHAT ARE THE VISION, MISSION, AND VALUES OF THE PUBLIC MENTAL HEALTH SYSTEM?

The mental health constituency envisions a society in which persons of all ages, ethnicities, and cultures who experience serious mental illness or serious emotional disturbance receive high quality, culturally and linguistically competent, and effective services from the mental health system. As a result of the services, support, and rehabilitation they receive, these persons are able to lead happy, productive, and fulfilling lives.

The mission of California's public mental health system is to enable all individuals, including adults and older adults with serious mental illnesses and their families and children with serious emotional disturbances and their families, to access services from a seamless system of care. These services will assist them, in a manner tailored to each individual, to achieve their personal goals and optimal recovery and to develop skills that support living the most constructive and satisfying lives possible in the least restrictive environment. The mental health system shall help children achieve optimal development.

The following values should guide development and implementation of the public mental health system:

1. **Client-directed Approach**—All services designed for adults and older adults with serious mental illnesses and their families and for children and their families should be client-directed and guided by an individual's goals, strengths, needs, concerns, motivations, and disabilities.
   - Adults and older adults with serious mental illnesses:
     - Have all rights, privileges, opportunities, and responsibilities as do other members of society
     - Are the central and deciding figures in all planning for treatment and rehabilitation based on their individual needs. Planning may also include family members and significant others as a source of information and support
     - Should be fully informed, fully involved, and voluntarily agree to all treatment and rehabilitation provided. If an individual is legally found incapable of consenting to treatment, then he or she should be informed and involved to the greatest extent possible
     - Should be involved at the state and county levels in policy setting, system planning, program design, and evaluation of all elements of the service system
   - Children, youth, and their families:
     - Should be involved in designing their treatment plans
     - Should have treatment plans based on the strengths and resources of the child and family
     - Should have treatment plans that acknowledge the family as a resource and that empower the family system to operate effectively
     - Should be involved at the state and county levels in policy setting, system planning, program design, and evaluation of all elements of the service system
2. **Services for Target Populations**—Adults and older adults with serious mental illnesses and children with serious emotional disturbances have severe, disabling conditions giving them a right to effective treatment and a high priority for receiving services.
3. **Focus on Wellness and Recovery**—Mental health services should assist clients in their recovery to return to the most constructive and satisfying lifestyle of their own definition and choice. For some clients, spirituality may define well-being and should be incorporated into the recovery process.

4. **Systems of Care**—Systems of care should consist of coordinated, integrated, and effective services meeting the unique needs of children and their families and adults and older adults with serious mental illnesses. These systems of care must operate in conjunction with an interagency network of other necessary services. Clients must have available an identifiable and qualified person or team responsible for their support and treatment. Systems of care should provide treatment and rehabilitation in the most appropriate and least restrictive environment in a community of the client's choosing.

5. **Outreach**—All adults and older adults with serious mental illnesses and their families and children and their families should have access to crisis intervention on a 24-hour basis. Assertive outreach should make mental health services available to homeless and isolated individuals with serious mental illnesses.

6. **Equal Access to Mental Health Services**—Disparities in access to mental health services among ethnic groups must be eliminated. The mental health system can improve access for ethnic minority populations by enhancing the linguistic capacity of source providers, using flexible hours to accommodate clients' schedules, disseminating information about service availability, and performing active outreach to underserved communities.

7. **Multiple Disabilities**—Mental health services must address the special needs of children and youth, adults, and older adults, including persons with co-occurring psychiatric disabilities and substance abuse and persons with multiple disabilities.

8. **Qualified Staff**—Qualified individuals who are culturally and linguistically competent and trained in the client-directed approach must provide effective services based on clients' goals and deliver those services in environments conducive to helping clients achieve their goals.

9. **Involvement of Direct Consumers and Family Members in Delivering Mental Health Services**—The mental health system should maximize participation of direct consumers and family members as both paid and volunteer staff.

10. **Cultural and Linguistic Competence**—The mental health system at all levels must have the capacity to provide services that are sensitive and responsive to clients' gender, cultural and ethnic background, language, beliefs, and lifestyle.

11. **Peer Support Models**—The mental health system must promote the development and use of self-help, peer support, and peer education for all target populations, and their families. Self-help and peer support must be available in all areas of the State.

12. **System Accountability**—State and local mental health systems of care must be accountable for the quality of their mental health services. This accountability is provided when state and local mental health programs use culturally competent performance indicators to evaluate the effectiveness of their mental health services and to improve their quality.

13. **Administration**—State and local departments of mental health must manage programs in a culturally competent, efficient, timely, and cost-effective manner consistent with the vision, mission, and values of the *California Mental Health Master Plan*.

14. **Research**—The mental health system must encourage research into the nature and causes of mental illnesses along with effective prevention, intervention, and rehabilitation strategies. Research that identifies best practices and treatment should be disseminated. Research should address the effectiveness of treatment for racial, cultural, and ethnic populations. The mental health system should actively cooperate with research centers in efforts leading to improved treatment methods, service delivery, and quality of life for mental health clients of all ages. Mental health professional organizations should be encouraged to disseminate the most recent research findings on prevention, early intervention, and treatment of mental illness and serious emotional disturbances. Mental health research and evaluation should also be focused on issues critical to women and issues related to socioeconomic status, age, and sexual orientation.

15. **Education about Mental Illness and Serious Emotional Disturbances**—Family members, care givers, and consumers should receive education and training on an ongoing basis based on numerous models that have been developed by state and national organizations. This training and education should be culturally and linguistically appropriate. Differing views of wellness and illness across cultures should be included in the training.

16. **Anti-Stigma Campaigns**—The mental health community must work to eliminate the societal stigma associated with having mental illness or a serious emotional disturbance. State and local mental health departments, mental health organizations, and consumer and family advocates for mental health must be encouraged and assisted to inform the public about the nature of mental illness and serious emotional disturbances from their viewpoint and about the needs of consumers and families.

17. **Advocacy Services**—To assure the rights of persons with mental illnesses and of children and their families, the mental health system must be an advocate for patients' rights. The mental health system must also assure that consumers, families of adults, older adults, and children and their families are involved in providing advocacy at all levels.

18. **Respect and Dignity**—The social interaction between providers and clients should conform to the highest available standard of respect and dignity. A process for dialogue between clients and providers should be initiated. This process should address the moral role imbalance attendant upon the dominant social position of providers and compensate for it.

19. **Client Culture**—Client culture must be recognized and valued. Mental health clients bring a set of values, beliefs, and lifestyles that are molded as a result of their personal experiences with mental illness, the mental health system, and their own ethnic culture. When the mental health community embraces client culture, mental health clients can be better-understood and empowered to effect positive change.

20. **Collaboration and Partnership**—The State Department of Mental Health, the California Mental Health Planning Council (CMHPC), the mental health boards and commissions, and other mental health organizations should strive to create a partnership of cooperation and a shared vision for the mental health system.

21. **Primary Prevention**—In order to prevent or reduce disabling conditions, the mental health system should engage in proactive strategies to address factors related to preventing mental illness and severe emotional disturbance. Poverty and lack of access to resources, for example, are significant factors related to stress and mental illness.

22. **Early Intervention**—When the development of mentally disabling conditions is detected, early intervention services should be provided for children, youth, adults, and older adults. Intervening early in minimally intrusive ways can interrupt the otherwise downward spiraling cycle of problem development.

CHAPTER 2
COMMITMENT TO CULTURAL COMPETENCY

WHY INTEGRATE CULTURAL COMPETENCE INTO CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM?

The need for California to integrate and infuse cultural competence into California's public mental health system is imperative due to California's changing demographics. The extent of multilingual and multicultural diversity in this state are illustrated in Tables 1 and 2 in the Appendix to this chapter, which provide data on the race/ethnicity and primary language of clients in the State's mental health system in fiscal year 2000-01. In November 2000, the Little Hoover Commission reported that, as California's population has grown in size and diversity, the mental health system has strained to keep up with the need for care (Little Hoover Commission, 2000). Cultural and linguistic barriers to mental health care are particularly significant. The barriers to care can be as simple as not being able to communicate because mental health staff who speak a client's language are not available. The Surgeon General reported that other formidable barriers that discourage racial, ethnic, and cultural populations from using mental health care include cost of services, lack of health insurance, fragmentation of services, culturally mediated stigma or patterns of help-seeking, mistrust of mental health services, and the insensitivity of many mental health care systems (U.S. Department of Health and Human Services, 1999, p. 164).

The Surgeon General's Report, "Mental Health: Culture, Race, and Ethnicity," states "Culture influences many aspects of mental illness, including how patients from a given culture express and manifest their symptoms, their style of coping, their family and community supports, and their willingness to seek treatment" (p. 42). The cultural identities and worldviews of consumers shape health and healing beliefs, practices, behaviors, and expectations. Wellness is uniquely defined by each individual and each cultural group. Clearly, the commitment of the public mental health system to cultural competency is vital to meet the needs of all of its residents and to overcome the unique barriers many racial, ethnic, and cultural communities face.

WHAT IS CULTURAL COMPETENCE?

Cultural competence has been described generally as the ability to appreciate and recognize culturally different people and to be able to work effectively with them (Sue, 1998). As Sue, Zane, and Young (1994) explain, a client's culture is relevant to the provision of mental health services because it affects the assessment, etiology, and symptom expression of mental illness, and it affects the client's treatment preferences. Cross (1989) has defined cultural competence as a congruent set of attitudes, behaviors, and policies that enable a system, agency, or provider to treat culturally diverse clients effectively.

Defining the words "culture" and "competence" will further clarify this concept. "Culture" is the integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. Culture defines the preferred ways for meeting needs. Culture may involve parameters such as ethnicity, race, language, age, country of origin, acculturation, gender, socioeconomic class, disability, religious and spiritual beliefs, and sexual orientation (California Department of Mental Health, 2002). "Competence" implies having the capacity to function effectively within the context of culturally integrated patterns of human behavior as defined by each cultural group (Cross, Bazron, Dennis, & Isaacs, 1989).

A culturally and linguistically competent system of care acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs (Cross et al., 1989). A culturally and linguistically competent system of care promotes for itself and among its providers the following characteristics:

- Awareness of the value of diversity and developing adaptation to diversity
- The capacity for continuous self-assessment
- Institutionalized cultural knowledge

- Awareness of the dynamics inherent when cultures interact
- Congruent behaviors, attitudes, and policies enabling the system, agencies, and mental health professionals to function effectively in cross-cultural institutions and communities (Cross et al., 1989)

SYSTEM LEVEL DESIGN ISSUES

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health care were developed with input from a national advisory committee of policymakers, health care providers, and researchers (Office of Mental Health, U.S. Department of Health and Human Services, 2001). The following CLAS standards are intended as guidelines for providers, policymakers, accreditation and credentialing agencies, clients, family members, advocates, educators, and the general community:

1. Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
2. Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representatives of the demographic characteristics of the service area.
3. Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
4. Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
5. Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
6. Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer.)
7. Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered group and/or groups represented in the service area.
8. Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
9. Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.
10. Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.
11. Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.
12. Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

13. Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.
14. Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Developing cultural competence is an ongoing process that takes place over time through training, experience, guidance, and self-evaluation. "Towards a Culturally Competent System of Care" (March 1989) describes system components necessary to move toward cultural competence. Each level of the service delivery system contributes to the cultural competence of the mental health system. These levels are consumers and families, policymakers, administrators, and practitioners.

Consumer and Family Member Level

This level recognizes that families are the primary source of care and support for the majority of adults with serious mental illnesses and children with serious emotional disturbances. Efforts to reduce racial and ethnic disparities should include strategies to strengthen families to function at their fullest potential in caring for a relative with mental illness (U.S. Department of Health and Human Services, 2001, p. 168).

Consumers and family members are the reasons why the mental health system exists. In fact, a client-directed approach is one of the most important values of the public mental health system. When the system values the racial, ethnic, and cultural characteristics of individual clients and their family members, it empowers these individuals to contribute to their mental health, well being, and recovery, strengthened by their own communities.

Policymaking level

This level includes any entity having a role in shaping policy, such as the Governor, the Legislature, the State Department of Mental Health, and professional licensing bonds. At the state level, the Legislature should play an active role in establishing cultural competence by enacting laws that require state agencies and counties to implement culturally competent practices and that provide funding to do so.

2.1. Recommendation: The Governor and the Legislature should allocate resources to secondary and postsecondary institutions to train bicultural and bilingual staff.

2.2. Recommendation: The Governor and the Legislature should provide funds for loan forgiveness programs to recruit bilingual and bicultural students into training programs.

2.3. Recommendation: The Governor and the Legislature should provide sufficient funding for counties to recruit, hire, and retain bicultural and bilingual staff.

2.4. Recommendation: The Governor and the Legislature should provide funds to mental health providers to provide ongoing cultural competence training to existing staff.

State Department of Mental Health

The State Department of Mental Health (DMH) also plays a significant role in creating a culturally competent mental health system. It has convened a Cultural Competence Advisory Committee (CCAC), comprised of experts on cultural competence throughout California. The committee is chaired by the Chief of Multicultural Services, who is also a member of DMH executive staff. The CCAC was instrumental in developing the cultural competence plans that DMH requires counties to prepare as part of their mental health managed care plans. (More discussion on these plans is included in Chapter 7, Managed Care.) DMH conducts onsite reviews of the county mental health managed care plans (MHPs) to determine if the goals set forth in the cultural competence plans are being actively addressed. The DMH also collects data on many performance indicators related to service utilization and outcome and analyzes these data by race/ethnicity. Those counties with poor performance can be provided with technical assistance to increase the cultural competence of their service systems. The DMH has also convened a State Quality Improvement Council, which addresses many of the trends that have developed since the implementation of managed care and the onsite review process.

The goal of this committee is to advise the DMH on the performance of the mental health system and technical assistance MHPs need to improve their services.

2.5. Recommendation: The DMH should aggressively monitor the MHPs for compliance with the goals established in their cultural competence plans. Any corrective action plans should be given top priority by both DMH and the MHPs.

Professional and Licensing Boards

Professional licensing boards also have a role to play in improving the cultural competence of the mental health system. Many currently practicing professionals were trained in an era when the importance of cultural competence was not so widely understood. In order to accommodate the mental health needs of California's steadily growing diverse populations, this issue should be given a high priority.

2.6. Recommendation: Licensing boards should include training in culturally responsive treatment in their continuing education requirements.

Administrative Level

This level interprets and administers policy in addition to creating it on the local level. It consists of county mental health departments and community-based agencies. Counties are an important part of creating a culturally competent system. Each county in California is unique in its racial, ethnic, and cultural diversity and is responsible for developing a system of care that meets the needs of its community. Counties provide mental health services directly through county-operated programs or by contracting with community agencies. In addition to complying with the cultural competence plans that counties are required to submit and implement through the MHP, counties can enhance the cultural competence of their service systems in a variety of ways. One way is to provide "ecologically valid services" (Aponte & Johnson, 2000). Ecologically valid services enhance access by being provided in churches, housing projects, and other community facilities used by racial, ethnic, and cultural communities. This approach also makes it easier for members of racial, ethnic, and cultural communities to avail themselves of services. In addition, counties must facilitate interagency collaboration among social services, health, and mental health agencies to serve racial, ethnic, and cultural populations more effectively (Aponte & Johnson, 2000).

2.7. Recommendation: The county mental health departments should develop effective outreach strategies to locate services where clients of various racial, ethnic, and cultural groups will be most likely to access them.

2.8. Recommendation: The county mental health departments should actively facilitate the interagency collaboration among social services, health, and mental health agencies to serve racial, ethnic, and cultural populations more effectively.

Agencies that provide mental health services to clients of all races, ethnicities, and cultures are called "mainstream agencies." These agencies need to be able to serve clients of all cultures competently. First, they need to hire bicultural and bilingual staff of the racial, ethnic, and cultural groups in their service area (Sue, 1977). Hiring paraprofessionals from the racial, ethnic, and cultural groups being served is another way of meeting this need (Aponte & Johnson, 2000). These agencies also need to offer continuing education to their staff about issues related to serving diverse populations and culturally responsive treatment techniques (Sue, Zane, & Young, 1994). Finally, agencies should structure their services so that they take advantage of natural helping networks and support systems in the community, which can make mental health services more accessible to racial, ethnic, and cultural groups (Aponte & Johnson, 2000).

2.9. Recommendation: The DMH should encourage county mental health departments and the agencies with which they contract to structure services so clients can use natural support systems in their own racial, ethnic, and cultural communities.

Practitioner Level

This level consists of all staff involved in providing services to clients, including clinical, administrative, and clerical staff. The Center for Mental Health Services (2001) has developed standards for provider competencies, which include knowledge, understanding, skills, and attitudes (Center for Mental Health Services, 2001). The

introduction to these standards states, "These guidelines present overall system and clinical standards and implementation guidelines, placing a clear emphasis not only on cultural competence but also on the contribution of cultural competence to quality of care. The standards also reflect generally accepted principles for the best way to provide clinical care for persons with mental illnesses. They also describe expected levels of culturally competent systems and clinical behavior as well as courses of action necessary to achieve culturally competent care. These consensus-built standards also serve as a yardstick against which to measure managed care systems' cultural proficiency in meeting the mental health care needs of the target populations" (p. 1). The standards state that the essential components of core continuing education to ensure cultural competence among clinical staff and to promote effective response to the mental health needs of ethnically diverse individuals must include the following knowledge and skills:

- Understanding of consumer populations' backgrounds
- Clinical issues
- How to provide appropriate treatment
- Agency/provider role
- Communicating effectively across cultures
- Providing quality assessments
- Formulating and implementing quality treatment plans
- Providing quality treatment
- Using one's self and knowledge in the treatment process

2.10. Recommendation: Continuing education training in cultural competence for mental health practitioners must meet the standards published in "Cultural Competence Standards for Managed Care Mental Health Services."

Another type of practitioner has recently been developed, a "cultural broker." The term "cultural broker" was developed by Josie Romero, LCSW, and Evelyn Lee, EdD, members of the Department of Mental Health, Cultural Competence Advisory Committee, to use in training interpreters in behavioral health. Cultural brokers must have intimate knowledge of their ethnic community, including migration history, cultural values, social and power structures, community healers, and cultural views of health and illness. Cultural brokers must be familiar with the American culture as well as have the ability of make a cultural connection and have rapport with the client. The role of a cultural broker is to interpret with a linguistic and cultural perspective and be able to explain to a clinician why a suggestion from the clinician may or may not be acceptable or realistic to the client.

CONCLUSION

California's commitment to cultural competence should encompass all aspects of the mental health system. As emphasized in the Surgeon General's mental health supplement on culture, race, and ethnicity, the demographic changes anticipated over the next decades magnify the importance of eliminating differences in mental health burden and access to services. Ethnic minority groups are expected to grow as a proportion of the total U.S. population.

Based on findings from the Surgeon General's mental health supplement, programs in this State that deliver culturally, linguistically, and geographically accessible mental health services should be expanded and improved (U.S. Department of Health and Human Services, 2001).

2.11. Recommendation: California should expand research in the areas of epidemiology, evidence-based treatment, psycho-pharmacology, ethnic- and culture-specific interventions, diagnosis and assessment, and prevention and promotion.

2.12. Recommendation: California should improve access to treatment by providing high quality, culturally responsive, and language-appropriate mental health services in locations accessible to racial, ethnic, and cultural populations.

2.13. Recommendation: California should address barriers to treatment for racial, ethnic, and cultural populations by reducing financial barriers and making services more accessible to ethnic communities and educating ethnic communities about mental illness so that shame, stigma, discrimination, and mistrust will not prevent them from seeking treatment when it is needed.

APPENDIX

Race/Ethnicity	Number	Percent
White	261,270	46.63%
Hispanic	117,375	20.95%
Black	95,583	17.06%
American Native	5,684	1.01%
Filipino	4,909	0.88%
Amerasian	709	0.13%
Chinese	4,865	0.87%
Cambodian	2,953	0.53%
Japanese	1,215	0.22%
Korean	1,996	0.36%
Samoan	304	0.05%
Asian Native	578	0.10%
Hawaiian Native	182	0.03%
Guamanian	180	0.03%
Laotian	2,095	0.37%
Vietnamese	6,917	1.23%
Other Asian/Pacific Islander	7,766	1.39%
Other	8,020	1.43%
Unknown	37,685	6.73%
TOTAL	560,286	100.00%

Table 1: Unduplicated Count of Clients Served by Race/Ethnicity for Fiscal Year 2000-01

Primary Language	Number	Percent
English	434,516	77.55%
Spanish	41,572	7.42%
Vietnamese	6,413	1.14%
Cambodian	2,543	0.45%
Tagalog	1,969	0.35%
Other Chinese Language	1,968	0.35%
Armenian	1,832	0.33%
Korean	1,472	0.26%
Russian	1,256	0.22%
Hmong	1,240	0.22%
Lao	1,231	0.22%
Cantonese	940	0.17%
Mandarin	928	0.17%
American Sign Language	583	0.10%
Farsi	562	0.10%
Japanese	497	0.09%
Mien	390	0.07%
Thai	383	0.07%
Samoan	290	0.05%
Arabic	283	0.05%
Portuguese	208	0.04%
Ilacano	169	0.03%
Other Sign Language	119	0.02%
Hebrew	69	0.01%
Italian	64	0.01%
Turkish	60	0.01%
Polish	60	0.01%
French	54	0.01%
Unknown/Not Reported	48,541	8.66%
Other Non-English	10,074	1.80%
TOTAL	560,286	100.00%

Table 2: Primary Language for Unduplicated Clients Served in Fiscal Year 2000-01

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CHAPTER 3

UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES

HOW MANY PEOPLE NEED PUBLIC MENTAL HEALTH SERVICES BUT ARE NOT RECEIVING THEM?

In October 2002 the President's New Freedom Commission on Mental Health revealed that in our nation one out of every two persons who needs mental health treatment does not receive it. For ethnic and racial minorities, groups that comprise a significant segment of California's population, the situation is even worse. As reported in 2001 in the Surgeon General's Report, "Mental Health: Culture, Race, and Ethnicity," ethnic and racial minorities receive treatment at a rate that is even lower than that of the general population. In addition, ethnic minority populations bear a greater burden from unmet mental health needs and suffer a greater loss to their overall health and productivity.

The responsibility of California's public mental health system is to serve children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses who are eligible for publicly funded mental health services. The *California Mental Health Master Plan* tries to do for this state what the President's Commission has done for the nation by estimating the unmet need for mental health services among children and youth with serious emotional disturbances and adults and older adults with serious mental illnesses in California.

Approximately 600,000 adults, older adults, and children and youth in need of mental health treatment are not receiving services. In round numbers, this figure breaks down to 300,000 children and youth, 200,000 adults, and 100,000 older adults. To put this figure in perspective, approximately 460,000 persons were served by the public mental health system in fiscal year 1997-98[1]. Thus, the public mental health system would need to more than double to meet the needs of all children and youth with serious emotional disturbances and adults and older adults with serious mental illness.

A crisis also exists in access to mental health care for persons who are indigent. In 2003 the Department of Mental Health issued a report pursuant to AB 328 (Salinas) outlining, among other things, changes in the current service delivery system of mental health programs that have occurred since the enactment of realignment. The report notes that, in fiscal year 1990-91, 45 percent of the clients in the mental health system were Medi-Cal beneficiaries and 55 percent were indigents. In contrast, in fiscal year 1999-00, 68 percent were Medi-Cal beneficiaries and 38 percent were indigents. During that same period, the number of Medi-Cal clients served increased by 131 percent, and the number of indigents served has decreased by 8 percent. In the years since fiscal year 1999-00, the availability of services for indigents has only gotten worse. For example, in Los Angeles County many organizations have limited access for adults and older adults to only emergency care. During the last several years, organizations have turned away several thousand indigent clients because these organizations did not have the fiscal resources.

The personal loss represented by unmet need for mental health services and the crisis in access to services is brought into focus when one considers the advancements that have been made in understanding the nature of mental illness over the last two decades. Many effective treatments, both in terms of medication and psychosocial rehabilitation, have been found for major mental illnesses. Innovative programs, such as wraparound programs and strengths-based, family focused treatment planning, have brought breakthroughs in services to children and their families. When the public mental health system is not able to provide mental health services to children and youth, adults, and older adults in need, these individuals experience needless human suffering and lose the opportunity to achieve their full potential as human beings.

To develop long-range plans for improving the mental health system, policymakers and advocates need an estimate of the number of

[1] These unmet need calculations were made in fiscal year 1999-2000. At that time, the most recent data available on the number of clients served in the mental health system was for fiscal year 1997-98.

persons in need of mental health services from the public sector but who are not presently accessing those services. A number of methodologies exist for estimating how many people need public mental health services. The California Mental Health Planning Council (CMHPC) has reviewed several of these methodologies and applied them to California's population. Estimates using various assumptions are provided in this chapter. For statewide planning purposes, however, we believe that a reasonable estimate of unmet need for public mental health services is approximately 600,000 persons. Table 1 presents a summary of all the estimates in the chapter. These estimates vary from 436,435 to 2,027,157 depending on the assumptions used to generate the estimate.

Providing estimates of unmet need for mental health services assists county mental health programs and local mental health boards by giving them quantitative data necessary for advocating for increased state and federal funding for mental health services and efficiently distributing resources to address unmet needs. Additionally, due to a variety of factors, including human resource shortages, geographic location, population growth rates, and socioeconomic status, some counties have more difficulty providing services to their persons in need. These estimates also show which counties and regions are experiencing the most difficulty providing services to persons in need.

Table 1: Summary of Unmet Need Estimates by Age Group

Age Group	Lower Limit CMHS[1]	Lower Limit CMHS[2]	Lower Limit Meinhardt[1,3]	Lower Limit Meinhardt[2,3]
0-17	123,592	271,978	123,592	271,978
18-20	28,888	28,888	33,339	33,339
21-59	191,913	191,913	239,963	239,963
60+	92,042	92,042	104,164	104,164
Total	436,435	584,821	501,058	649,444
Age Group	**Upper Limit CMHS[1]**	**Upper Limit CMHS[2]**	**Upper Limit Meinhardt[1,3]**	**Upper Limit Meinhardt[2,3]**
0-17	493,593	864,000	493,593	864,000
18-20	76,889	76,889	87,925	87,925
21-59	699,403	699,403	820,316	820,316
60+	225,145	225,145	254,916	254,916
Total	1,495,030	1,865,437	1,656,750	2,027,157

[1] Unmet need for 0-17-year-olds is calculated based on children with SED and extreme functional impairment.
[2] Unmet need for 0-17-year-olds is calculated based on children with SED and substantial functional impairment.
[3] Meinhardt's estimates do not apply to 0-17-year-olds. In order to estimate total unmet need for all age groups, Meinhardt's prevalence rates were used for transition-age youth, adults, and older adults, and CMHS figures have been used for the 0-17-year-olds.

HOW WERE THE ESTIMATES DEVELOPED?

The CMHPC worked with the California Department of Mental Health (DMH) and the California Mental Health Directors Association (CMHDA) for more than a year to develop these estimates. The methodology draws on sound existing research and adapts the findings of that research to current conditions in both rural and urban regions of California. The initial draft was reviewed by the CMHDA Governing Board. Subsequently, county mental health directors were asked to comment on the estimates for their counties. The CMHPC's

Policy and System Development Committee reviewed the comments and decided how to incorporate them into the methodology. The CMHPC Children and Youth Committee reviewed the methodology for estimating unmet need among children with serious emotional disturbances (SED).

WHAT ARE THE LIMITATIONS OF THESE ESTIMATES?

Although the CMHPC tried to develop the most valid methodology possible given available data, any method for estimating unmet need has limitations that must be carefully considered when evaluating the results of the study. The following list enumerates those limitations.

1. Both the Meinhardt prevalence rates and the CMHS rate are derived from household surveys. As a result, they exclude the homeless and people in nursing homes, military barracks, correctional institutions, hospitals, and residential facilities for persons who are mentally ill or mentally retarded (Center for Mental Health Services, 1999, page 33895). Fischer and Breakey (1991) suggest that these groups constitute about five million people, or 2.7 percent of the U.S. adult population (Center for Mental Health Services, 1999). They estimate that the SMI prevalence rate for these groups is 50 percent. Because prevalence estimates do not include these segments of the population with the highest risk of SMI, the unmet need is underestimated.
2. San Francisco County has pointed out that a significant number of people drift into the county after acquiring a mental illness. Forty-five percent of mental health clients admitted to the inpatient unit at San Francisco General Hospital had arrived in San Francisco within two months of the admission (Presson, 2000).
3. People who have a mental illness resulting from HIV infection may not be included in prevalence rates (Presson, 2000).
4. Ethnic populations may be hesitant to report mental illness and to seek services. Although the ECA study does account for differences in reporting rates for non-Hispanic whites and all ethnic minorities, it does not make more detailed distinctions. This study used prevalence rates based on the ECA catchment data rather than more recent studies done that estimate the prevalence of mental illness for each racial, ethnic, and cultural population.
5. Meinhardt's county-specific prevalence rates are based on the counties' 1980 socio-demographic variables. Because of the increase in population, especially among non-white groups, from 1980 to 1990 they required adjustment upward to reflect increased population levels. This adjustment may not entirely account for differential migration by age or socio-demographic status (Meinhardt, Spitznagel, & Jerrell, 1990, page 17).
6. SED prevalence rates apply to children from 9 to 17 years of age. According to Friedman et al. (1996), "the data are presently inadequate to estimate prevalence rates for children under the age of nine" (page 84). Some studies have suggested prevalence rates of 7 to 22 percent for younger children (Knitzer, 2000). However, no reliable estimates are available for this age group. The CMHPC methodology most likely provides a conservative estimate for this age group.
7. Unmet need reflects the number of people who are not getting any mental health services at all. It does not reflect the number of people who are underserved.

HOW CAN UTILIZATION OF PRIVATE SECTOR MENTAL HEALTH SERVICES BE ESTIMATED?

Some clients access mental health services through the private sector. Because the CMHPC does not want to overstate unmet need for public services, a method for estimating private sector utilization had to be developed. Several studies offer estimates of the proportions of people with serious mental illnesses (SMI) who access services through the private sector. For example, Meinhardt, et al.

(1992) found that of children and youth treated for SED over a 12-month period 63.8 percent primarily used private services. The rest, 36.2 percent, relied on the public system. According to the same study, 57.9 percent of persons treated for SMI over a 12-month period used private services. The public system served the remaining 42.1 percent. Meinhardt et al.'s estimates were made in 1994, however, and many changes have occurred in the mental health system since that time. Some professionals in the field believe that the proportion of persons accessing the public system is now much greater than these estimates. For example, in a national study of mental health care use, Pacula and Sturm (2000) found that 65 percent of all persons with SMI living in the community accessed services through the public system; however, the sample size for California was too small to generalize the results to the state level (Pacula & Sturm, 2000).

Private sector access will also be affected by enactment of parity legislation. Many states have recently passed mental health parity mandates that require insurance coverage for mental illnesses to equal that for physical ailments. In California, Chapter 534, Statutes of 2000 (AB 88, Thomson) requires health care service plan contracts to provide coverage for the diagnosis and medically necessary treatment of severe mental illnesses of a person of any age and of serious emotional disturbances of a child under the same terms and conditions applied to other medical conditions. These benefits include outpatient services, inpatient hospital services, partial hospital services, and prescription drugs. The maximum lifetime benefits, co-payments, and deductibles applied to serious mental illness must be the same as those applied to other illnesses.

However, a nationwide study, Pacula and Sturm (2000) found that "those states that are able to pass parity legislation do not experience significant increases in the utilization of mental health services. This may be due in part to a loss of coverage for those people most at risk for mental health disorders" (Pacula & Sturm, 2000, p. 263). In California, however, most people who have private insurance are part of a group plan, and are unlikely to be dropped as a result of the new legislation. Indeed, two of the State's largest providers, Kaiser and PacifiCare, are already in the process of hiring new mental health professionals to accommodate the anticipated increase in demand for their behavioral health care services.

Understanding access to the private sector is a crucial issue for mental health planning. Considerable uncertainty about how to estimate private sector utilization exists due to changes in the mental health system since Meinhardt et al.'s study was done in 1992, California's increasing growing diversity, and how the enactment of the parity legislation will affect access to the private system.

The issue of disparities in mental health care is gaining national attention. More studies are documenting disparities in quality, availability, and service utilization rates of mental health care for racial, cultural, and ethnic populations. The methodology used in this chapter to estimate unmet need did not employ prevalence rates specific to each ethnic group. In addition, the Meinhardt et al. study about access to private sector services did not report access rates by ethnicity. Consequently, the findings of unmet need do not reflect disparities in access to mental health services for racial, cultural, and ethnic populations.

3.1. Recommendation: The State Department of Mental Health should commission a new study in fiscal year 2003-04 to determine the proportion of adults with SMI and children with SED in each major ethnic group who are able to access services in the private sector.

3.2. Recommendation: Once the DMH completes the recommended study of access to private sector mental health services for each major ethnic group, the CMHPC should update the determination of unmet need generating estimates for each ethnic group using prevalence rates identified for those groups.

WHAT IS THE CMHPC'S METHODOLOGY FOR DETERMINING UNMET NEED?

Children and Youth

Estimated Prevalence of Serious Emotional Disturbance

To determine unmet need, the number of children and youth with SED had to be estimated. This process was difficult for a variety of reasons. No reliable prevalence data

exist for children under the age of nine (Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1996, page 84). For children between the ages of 9 and 17, prevalence estimates vary. Variability in the prevalence estimates can be attributed, in part, to differing definitions of SED. Often, the question is not only "Who has a diagnosable disorder?" but also "Who are we required to serve?" Four different state and federal definitions need to be considered in evaluating the prevalence rate to use for children and youth: the eligibility criteria for Early, Periodic, Screening, Diagnoses, and Treatment (EPSDT), the California Welfare and Institution Code (WIC) target population definition for children and youth, the federal CMHS definition of serious emotional disturbance, and finally the definitions CMHS workgroups used to establish specific prevalence rates.

The first definition for EPSDT eligibility is quite broad. California Code Title 22 §51340 requires county mental health programs to treat all children under age 21 who have a mental illness that can be corrected or ameliorated with treatment, whose treatment requires specialty mental health services, and who qualify for full-scope Medi-Cal benefits.

The second definition for the target population for realignment funds and Children's System of Care services is narrower. The state WIC §5600.3 (a) defines target populations that should be given first priority for receiving services. WIC §5600.3 (a) (2) defines the children's target population as follows:

> For the purposes of this part, "seriously emotionally disturbed children or adolescents" means minors under the age of 18 years who have a mental disorder as identified in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, which results in behavior inappropriate to the child's age according to expected developmental norms. Members of this target population shall meet one or more of the following criteria:
>
> (A) As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following occur:
>
> (i) The child is at risk of removal from home or has already been removed from the home.
>
> (ii) The mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.
>
> (B) The child displays one of the following: psychotic features, risk of suicide, or risk of violence due to a mental disorder.
>
> (C) The child meets special education requirements according to Chapter 26.5 (commencing with §7570) of Division 7 of Title 1 of the Government Code.

The third definition was established by the CMHS, which allocates federal funds to states through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SED and a method for making estimates of the overall prevalence in the population, and states then use these estimates as part of their application for funds under the block grant program. The CMHS (1996) defines SED as follows:

> Children from birth to age 18 who currently or at any time during the past year have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the *Diagnostic and Statistical Manual (DSM)-III-R* and that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities. These disorders include any mental disorder (including those of a biological etiology) listed in *DSM-III-R* or their

> *International Classification of Disease (ICD)-9-CM* equivalent (and subsequent revisions) with the exception of *DSM-III-R* 'V' codes, substance abuse, and developmental disorders, which are excluded, unless they co-occur with another diagnosable serious emotional disturbance (Friedman et al., 1996, page 72).

Functional impairment is defined as follows:

> Difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included, unless they are temporary and expected responses to stressful events in their environment. Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition (Friedman et al., 1996, page 72).

A CMHS work group reviewed a number of studies estimating the prevalence of children exhibiting various levels of functional impairment. The Children's Global Assessment Scale (CGAS) was the most commonly used instrument in these studies. The CGAS rates children's level of functioning on a scale from 0 to 100 with narrative descriptions of functioning at various levels. Lower scores indicate greater impairment. The work group decided to establish two levels of functional impairment based on the CGAS. Both levels meet the CMHS definition of "seriously emotionally disturbed."

The work group estimated that 5 to 9 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 50 on the CGAS. These children are said to exhibit "extreme functional impairment." The narrative description for a score of 50 or lower is as follows:

> Moderate degree of interference in functioning in most social areas or severe impairment of functioning in one area, such as might result from, for example, suicidal preoccupations and ruminations, school refusal and other forms of anxiety, obsessive rituals, major conversion symptoms, frequent anxiety attacks, frequent episodes of aggressive or other anti-social behavior with some preservation of meaningful social relationships (Friedman et al., 1996, page 74).

The work group found that 9 to 13 percent of all children between the ages of 9 and 17 have a serious emotional disturbance and a level of functioning equal to or below a score of 60 on the CGAS. The narrative description for a score of 60 is as follows:

> Variable functioning with sporadic difficulties or symptoms in several but not all social areas. Disturbance would be apparent to those who encounter the child in a dysfunctional setting or time but not to those who see the child in settings where functioning is appropriate (Friedman et al., 1996, page 74).

Using this more inclusive criterion for functional impairment, 9 to 13 percent of all children are categorized as having a serious emotional disturbance accompanied by "substantial functional impairment." The CMHS definition of SED includes children with difficulties that substantially interfere with a child's functioning. Children with extreme impairment are subsumed in the substantial functional impairment definition of SED. The CMHS recommends that, from the standpoint of planning service needs, the 9-13 percent range should be used; however, according to the CMHS work group, "the…more conservative estimate can be used for more targeted efforts to plan on behalf of a more limited number of children whose level of functional impairment is especially severe" (Friedman et al., 1996, page 73).

The CMHPC decided to estimate the number of children suffering from SED based on both the CMHS prevalence rates for children with extreme functional impairment and for children with substantial functional impairment. Initially, the CMHPC only calculated unmet need using the more conservative prevalence estimates. Using the conservative range still produced very high estimates of unmet need: between 127,936 and 498,370 youth with

extreme functional impairment are not receiving any services at all. Some CMHPC members felt that presenting the conservative figures would be more effective and would allow for extrapolation. The alternative is to offer the more inclusive figures and run the risk that they will be considered inflated. However, some members pointed out that under EPSDT legislation counties are mandated to serve all children who meet the criteria for "medical necessity" in addition to those in the DMH target population. Children who have a substantial impairment according to the CMHS definition are likely to meet the EPSDT criteria for medical necessity. Thus, the higher figure based on the substantial functional impairment definition is also justified.

In addition to being a function of definition, prevalence rates are also affected by socioeconomic status. The CMHS work group found that the prevalence rate is higher for children living in low socioeconomic circumstances and makes the following recommendations:

> States with a poverty rate more than five percent higher than the national average should use an estimate at the upper end of the prevalence range provided here (13 percent), and States with a poverty rate of more than 2.5 percent but less than 5 percent higher than the national average should use a prevalence estimate of 12 percent. Similarly, States with a poverty rate more than five percent below the national average should use a prevalence estimate at the lower end of the range (9 percent), and States with a poverty rate between 2.5 percent and 5 percent lower than the national average should use a prevalence estimate of 10 percent. States within 2.5 percent of the national average should use estimates in the middle of this range (11 percent) (Friedman et al., 1996, page 85).

The CMHPC heeded the recommendation of the CMHS to account for the impact of poverty on mental health. The methodology developed by the CMHS was applied to each county using both the 9 to 13 percent prevalence rate range and the more conservative range of 5 to 9 percent. Table 2 shows the prevalence rates used for each county. The lowest rate in each range (5 percent for the conservative range and 9 percent for the more inclusive range) was applied to 12 counties with poverty rates ranging from 5.2 percent to 8.4 percent. The 6 percent and 10 percent rates were applied to 8 counties with poverty rates between 8.5 percent and 10.7 percent. The 7 percent and 11 percent rates were applied to 24 counties with poverty rates ranging from 11.3 to 15.7 percent. The 8 percent and 12 percent rates were applied to eight counties with poverty rates ranging from 16.9 percent to 18.5 percent. The remaining six counties, with poverty rates ranging from 18.9 percent to 23.8 percent, were estimated to have a 9 percent or 13 percent prevalence rate. For example, in Imperial County, the poverty rate (23.8 percent) is 10.3 percentage points higher than the national average (13.5 percent), so a 9 percent prevalence rate (or 13 percent from the more inclusive view) is assumed. In contrast, Marin County has a poverty rate of 5.2 percent, so a 5 percent prevalence rate (9 percent using the more inclusive range) is assumed. The population figures of children age 0-17 in each county (see Table 3) were multiplied by the corresponding prevalence rates to estimate the number of SED children with extreme functional impairment and with substantial functional impairment.

Number of Children and Youth Needing Public Mental Health Services

As already mentioned, some children with SED receive services from private providers. Currently, Meinhardt et al.'s 1994 study provides the most accurate data applicable to California. The CMHPC believes that the DMH must commission a study to update the percentage of children with SED who rely on the public sector for services. In order to account for the changes to the mental health system since Meinhardt's study, the CMHPC has provided a range for the number of children needing public services. To find the lower end of the range, the estimated number of children with SED was multiplied by 36.2 percent, the proportion of children expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of children with SED. This upper limit reflects the number of children who would need public services if no private services were available. For counties with populations under 200,000, a lower

estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of children served was subtracted from both the lower estimate and the upper estimate of children needing public mental health services. Table 2 shows the estimated number of children with extreme functional impairment who are not receiving services and the estimated number of children with substantial functional impairment who are not receiving services. The number of unduplicated clients reported by the DMH from the Client Data System excludes children with only one outpatient visit or only one inpatient visit less than four days. These exclusions were applied to the data so that the clients included in the utilization data were more likely to be long-term recipients of services as opposed to those needing only brief services.

Transition-Age Youth, Adults, and Older Adults

Estimated Prevalence of Serious Mental Illness

According to epidemiological studies, 6 percent of California's population suffers from schizophrenia, bipolar disorder, or major depression (Meinhardt et al., 1990). An estimated 13 percent have a diagnosis of dysthymia, panic disorder, phobia, obsessive-compulsive disorder, or antisocial personality disorder (Meinhardt et al., 1990). However, as with children, the question is often not "Who has a diagnosable disorder?" but "Whom are we required to serve?" California's WIC §5600.3 (b) defines the target population to be served by the public mental health system as follows:

> For the purposes of this part, "serious mental disorder" means a mental disorder which is severe in degree and persistent in duration, which may cause behavioral functioning which interferes substantially with the primary activities of daily living, and which may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time. Serious mental disorders include, but are not limited to, schizophrenia, as well as major affective disorders or other severely disabling mental disorders. This section shall not be construed to exclude persons with a serious mental disorder and a diagnosis of substance abuse, developmental disability, or other physical or mental disorder.

Table 2: Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County

COUNTY	SED with extreme functional impairment			SED with substantial functional impairment		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Statewide		**123,592**	**493,953**		**271,978**	**864,000**
Alameda	6%	5,002	18,926	10%	10,269	33,475
Alpine	8%	10	10	12%	19	19
Amador	5%	204	204	9%	464	464
Butte	9%	3,117	3,117	13%	5,089	5,089
Calaveras	6%	353	353	10%	704	704
Colusa	7%	296	296	11%	520	520
Contra Costa	5%	1,825	9,220	9%	5,182	18,491
Del Norte	7%	27	27	11%	312	312
El Dorado	5%	1,405	1,405	9%	2,913	2,913
Fresno	9%	5,902	20,547	13%	9,596	30,749
Glenn	1%	467	467	12%	792	792
Humboldt	8%	1,971	1,971	12%	3,239	3,239
Imperial	9%	3,295	3,295	13%	5,152	5,152
Inyo	7%	253	253	11%	428	428
Kern	8%	163	10,562	12%	3,113	18,712
Kings	8%	2,699	2,699	12%	4,177	4,177
Lake	7%	667	667	11%	1,199	1,199
Lassen	7%	285	285	11%	570	570
Los Angeles	7%	27,150	150,323	11%	67,086	260,643
Madera	8%	1,827	1,827	12%	3,163	3,163
Marin	5%	420	2,008	9%	1,141	4,001
Mariposa	7%	113	113	11%	254	254
Mendocino	7%	1,230	1,230	11%	2,123	2,123
Merced	9%	1,213	5,232	13%	2,227	8,032
Modoc	7%	68	68	11%	166	166
Mono	6%	151	151	10%	258	258
Monterey	7%	1,925	6,992	11%	3,568	11,530
Napa	5%	1,035	1,035	9%	2,179	2,179
Nevada	5%	741	741	9%	1,534	1,534
Orange	6%	8,657	37,298	10%	19,491	67,227
Placer	5%	637	2,458	9%	1,464	4,743
Plumas	7%	158	158	11%	338	338
Riverside	7%	4,400	23,444	11%	10,575	40,500
Sacramento	7%	3,729	18,169	11%	8,411	31,103
San Benito	6%	506	506	10%	1,056	1,056
San Bernardino	7%	6,565	30,116	11%	14,201	51,209
San Diego	7%	13,392	47,036	11%	24,300	77,169
San Francisco	7%	0	6,672	11%	2,264	12,515
San Joaquin	7%	1,904	9,275	11%	4,294	15,877
San Luis Obispo	7%	496	2,850	11%	1,259	4,958
San Mateo	5%	969	6,454	9%	3,459	13,333
Santa Barbara	7%	716	5,315	11%	2,207	9,435

Table 2 (cont'd): Prevalence Rates and Unmet Need Estimate for Ages 0-17 by County

COUNTY	SED with extreme functional impairment			SED with substantial functional impairment		
	Prevalence Rate	Lower Limit	Upper Limit	Prevalence Rate	Lower Limit	Upper Limit
Santa Clara	5%	3,071	16,853	9%	9,327	34,135
Santa Cruz	6%	417	2,828	10%	1,329	5,347
Shasta	7%	2,356	2,356	11%	4,085	4,085
Sierra	6%	24	24	10%	53	53
Siskiyou	7%	121	121	11%	549	549
Solano	5%	826	4,371	9%	2,435	8,817
Sonoma	5%	241	3,707	9%	1,814	8,053
Stanislaus	7%	1,133	7,060	11%	3,055	12,369
Sutter-Yuba	8%	2,640	2,640	12%	4,341	4,341
Tehama	7%	586	586	11%	1,157	1,157
Trinity	8%	187	187	12%	312	312
Tulare	9%	1,400	8,288	13%	3,137	13,086
Tuolumne	6%	304	304	10%	739	739
Ventura	5%	1,802	8,312	9%	4,757	16,474
Yolo	8%	2,541	2,541	12%	4,132	4,132

In 1990 the DMH funded Meinhardt, et al. to assess mental health needs throughout the State. The resulting study, *California Mental Health Needs Met by Local and State Hospital Services*, estimates county-specific prevalence rates of SMI. The rates are derived from the National Institute of Mental Health's Epidemiological Catchment Areas (ECA) Project. The ECA data were obtained through random household interviews in five sites in the United States. Interviews were conducted using the Diagnostic Interview Schedule (DIS), a highly structured interview that can be conducted by a trained non-professional. Interview results were analyzed to estimate the prevalence of disorders in the U.S. population as a whole. Since prevalence rates are affected by socio-demographic characteristics, Meinhardt determined the prevalence rate of each California county by adjusting the national prevalence figure to factors in each county's socio-demographic composition.

Meinhardt found that six percent of California's adult population suffers from schizophrenia, bipolar disorder, or major depression. The DMH estimates that one third of these adults, or two percent of the population, also has a major functional impairment related to the illness (California Department of Mental Health, 1999, page 116). This prevalence estimate is lower because the DMH does not include major depression as a diagnosis that would result in a major functional impairment.

In contrast, the federal CMHS estimates that 5.4 percent of adults suffer from a diagnosable mental disorder resulting in a serious role impairment (Center for Mental Health Services, 1999). The CMHS allocates federal funds to States through block grants for provision of community mental health services. The CMHS is required by law to establish a definition of SMI and a method for making estimates of the overall prevalence in the population. These estimates are then to be used by States as part of their application for funds under the block grant program.

The CMHS defines SMI as "the conjunction of a DSM mental disorder and a serious role impairment" (Center for Mental Health Services, 1999, page 33891). The following four criteria define SMI (Kessler et al., 1996, page 60-61):

1. A 12-month prevalence of schizophrenia, schizoaffective disorder, manic-depressive disorder, autism, and severe forms of major depression, panic

disorder, and obsessive-compulsive disorder. Severe forms of major depression and panic disorder are indicated by either hospitalization or the use of major psychotropic medications. This criterion includes people who would have been symptomatic in the absence of treatment.

2. Any DSM disorder in the past 12 months accompanied by planned or attempted suicide within the past 12 months.

3. Any DSM disorder in the past 12 months accompanied by a vocational capacity substantially below expected level of functioning. One group of people in this category consists of people who are unemployed or working part time, living below the poverty level, and whose background and education are such that they would be expected to have at least twice their actual incomes. Another group in this category consists of people with a 12-month DSM diagnosis who consistently miss at least one full day of work per month as a direct result of problems with their mental health.

4. Any DSM diagnosis and complete isolation or only having relationships that are devoid of intimacy, the ability to confide, or the sense of being cared for or supported.

For the purpose of this chapter, prevalence of SMI was estimated using both Meinhardt's county-specific prevalence rates and the standard rate published by the CMHS in the *Federal Register*. Some counties suggested using Kessler's 1997 report "Estimation of the 12-month Prevalence of Serious Mental Illness" (Kessler et al., 1997). However, Dr. Kessler's colleagues informed the CMHPC that they did not have much confidence in their county estimates because they lacked sufficient county-specific data.

The Meinhardt report (1990) provided county-specific rates for schizophrenia, bipolar disorder, and major depression. For each county, the combined county-specific rate for each of those illnesses (see Table 4) was multiplied by the population (see Table 3) for each adult age group, 18-21, 22-59, and 60 years and older. This calculation produced an estimate of the number of adults and older adults with SMI. The *Federal Register* estimates the 12-month prevalence rate of SMI to be 5.4 percent nationally (Center for Mental Health Services, 1999). The population figures for each age group (Table 3) were multiplied by 5.4 percent to provide another estimate of the number of adults and older adults with SMI (see Table 5).

Table 3: County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Statewide	**32,956,588**	**9,251,040**	**1,686,917**	**17,377,723**	**4,640,908**
Alameda	1,398,590	363,725	64,009	777,807	193,049
Alpine	1,205	237	70	737	161
Amador	33,430	6,495	1,501	16,881	8,553
Butte	198,484	49,307	9,793	95,375	44,009
Calaveras	37,894	8,756	2,090	17,385	9,663
Colusa	18,524	5,601	1,177	8,686	3,060
Contra Costa	896,214	231,790	43,829	481,816	138,779
Del Norte	28,391	7,106	1,691	14,452	5,142
El Dorado	147,386	37,711	7,814	76,525	25,336
Fresno	778,656	255,049	45,163	374,934	103,510
Glenn	26,889	8,144	1,646	12,444	4,655
Humboldt	126,070	31,696	6,719	67,563	20,092
Imperial	142,674	46,414	10,502	67,092	18,666
Inyo	18,264	4,384	973	8,436	4,471
Kern	634,333	203,751	35,779	308,832	85,971
Kings	117,747	36,952	7,303	61,106	12,386
Lake	55,034	13,313	2,845	23,690	15,186
Lassen	33,787	7,125	2,423	19,482	4,757
Los Angeles	9,524,767	2,758,008	452,579	5,089,394	1,224,786
Madera	113,462	33,404	7,384	54,960	17,714
Marin	243,301	49,809	9,336	141,363	42,793
Mariposa	15,976	3,507	776	7,623	4,070
Mendocino	85,956	22,340	5,068	43,438	15,110
Merced	201,962	69,993	12,229	94,802	24,938
Modoc	10,152	2,442	637	4,782	2,291
Mono	10,582	2,655	424	6,215	1,288
Monterey	377,828	113,458	19,966	194,652	49,752
Napa	121,093	28,615	5,862	62,481	24,135
Nevada	88,368	19,826	4,688	42,294	21,560
Orange	2,705,287	748,205	122,544	1,485,433	349,105
Placer	215,505	57,107	11,562	111,836	35,000
Plumas	20,422	4,491	1,228	9,576	5,127
Riverside	1,423,664	426,409	72,303	682,793	242,159
Sacramento	1,146,882	323,332	57,035	600,443	166,072
San Benito	46,151	13,738	2,746	22,985	6,682
San Bernardino	1,617,385	527,327	90,355	813,837	185,866
San Diego	2,763,318	753,323	171,187	1,451,288	387,520
San Francisco	777,492	146,077	27,748	456,108	147,559
San Joaquin	542,193	165,046	30,061	268,276	78,810
San Luis Obispo	234,661	52,698	19,353	118,847	43,763
San Mateo	711,723	171,964	30,165	390,218	119,376
Santa Barbara	400,788	102,989	26,975	207,291	63,533
Santa Clara	1,671,410	432,041	75,312	948,118	215,939
Santa Cruz	247,252	62,984	13,412	136,092	34,764
Shasta	163,254	43,205	9,322	80,023	30,704

Table 3 (cont'd): County Populations by Age Group for 1998

COUNTY	Total	0-17	18-20	21-59	60-UP
Sierra	3,412	742	173	1,645	852
Siskiyou	44,199	10,698	2,718	21,117	9,666
Solano	378,676	111,139	20,434	202,424	44,679
Sonoma	432,751	108,651	20,759	231,587	71,754
Stanislaus	425,316	132,715	24,618	208,906	59,077
Sutter-Yuba	137,302	42,513	7,565	65,992	21,232
Tehama	54,623	14,293	3,260	24,931	12,139
Trinity	13,245	3,118	765	6,453	2,909
Tulare	358,359	119,952	22,684	166,893	48,830
Tuolumne	52,151	10,855	2,941	26,178	12,177
Ventura	727,250	204,051	38,224	385,318	99,657
Yolo	154,898	39,764	17,192	77,868	20,074

Table 4: Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide		**33,339**	**87,925**	**239,963**	**820,316**	**104,164**	**254,916**
Alameda	6.53%	1,407	3,827	13,623	43,031	4,607	11,906
Alpine	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Amador	4.08%	46	46	424	424	321	321
Butte	6.06%	490	490	3,464	3,464	2,506	2,506
Calaveras	4.05%	68	68	432	432	363	363
Colusa	4.88%	51	51	274	274	131	131
Contra Costa	5.25%	673	2,003	5,517	20,135	2,565	6,775
Del Norte	5.28%	55	55	205	205	234	234
El Dorado	5.45%	378	378	3,344	3,344	1,319	1,319
Fresno	5.85%	540	2,070	1,665	14,365	1,819	5,325
Glenn	4.96%	60	60	249	249	201	201
Humbolt	6.59%	363	363	2,830	2,830	1,236	1,236
Imperial	5.83%	550	550	2,684	2,684	965	965
Inyo	4.62%	41	41	210	210	186	186
Kern	5.31%	426	1,526	1,192	10,687	1,519	4,162
Kings	5.78%	404	404	1,076	1,076	651	651
Lake	3.95%	85	85	420	420	548	548
Lassen	5.60%	108	108	796	796	255	255
Los Angeles	6.63%	9,101	26,474	81,365	276,735	27,710	74,726
Madera	5.10%	335	335	1,920	1,920	820	820
Marin	6.23%	202	539	2,409	7,508	999	2,543
Mariposa	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mendocino	5.38%	227	227	1,524	1,524	756	756
Merced	5.85%	176	590	369	3,580	399	1,244
Modoc	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Mono	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Monterey	6.16%	441	1,153	3,690	10,633	1,174	2,949
Napa	4.95%	258	258	2,214	2,214	1,078	1,078
Nevada	4.34%	181	181	1,309	1,309	881	881

Table 4 (cont'd): Unmet Need Estimate Based on Meinhardt's County-Specific Prevalence Rates

COUNTY	Prevalence Rate Used	18-20		21-59		60+	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Orange	5.88%	1,896	6,068	19,996	70,567	6,919	18,804
Placer	4.93%	181	511	850	4,043	618	1,618
Plumas	4.61%	42	42	152	152	219	219
Riverside	5.00%	541	2,634	3,352	23,119	4,340	11,351
Sacramento	6.13%	1,146	3,170	8,213	29,524	3,657	9,551
San Benito	5.39%	118	118	883	883	328	328
San Bernardino	5.49%	1,330	4,202	7,041	32,911	3,577	9,485
San Diego	6.35%	3,617	9,911	17,000	70,359	8,505	22,753
San Francisco	7.84%	0	849	1,624	22,329	2,041	8,740
San Joaquin	5.49%	509	1,464	258	8,785	810	3,315
San Luis Obispo	6.50%	449	1,177	1,828	6,301	1,098	2,745
San Mateo	5.43%	449	1,397	4,380	16,648	2,026	5,779
Santa Barbara	6.35%	328	1,320	2,193	9,814	1,372	3,708
Santa Clara	6.11%	1,519	4,184	15,558	49,099	4,050	11,689
Santa Cruz	6.26%	237	724	1,906	6,838	675	1,935
Shasta	5.21%	381	381	1,787	1,787	1,437	1,437
Sierra	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Siskiyou	4.67%	88	88	81	81	369	369
Solano	5.46%	314	960	2,151	8,550	760	2,172
Sonoma	5.42%	325	976	2,490	9,758	1,253	3,505
Stanislaus	5.37%	339	1,104	580	7,075	881	2,717
Sutter-Yuba	5.62%	385	385	2,452	2,452	1,037	1,037
Tehama	4.47%	110	110	337	337	449	449
Trinity	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available
Tulare	5.41%	393	1,103	1,366	6,594	878	2,408
Tuolumne	4.93%	100	100	486	486	479	479
Ventura	5.37%	658	1,847	5,339	17,320	1,780	4,879
Yolo	7.83%	1,218	1,218	4,455	4,455	1,363	1,363

Table 5: Unmet Need Estimate Based on CMHS Prevalence Rate

COUNTY	18-20		21-59		60+	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Statewide	**28,888**	**76,889**	**191,913**	**699,403**	**92,042**	**225,145**
Alameda	1,102	3,103	9,923	34,242	3,689	9,725
Alpine	2	2	23	23	9	9
Amador	66	66	647	647	434	434
Butte	426	426	2,834	2,834	2,215	2,215
Calaveras	96	96	667	667	494	494
Colusa	58	58	319	319	147	147
Contra Costa	702	2,073	5,842	20,906	2,658	6,997
Del Norte	57	57	222	222	241	241
El Dorado	374	374	3,305	3,305	1,306	1,306
Fresno	455	1,867	955	12,677	1,623	4,860
Glenn	67	67	304	304	221	221
Humbolt	283	283	2,026	2,026	997	997
Imperial	505	505	2,396	2,396	885	885
Inyo	49	49	276	276	220	220
Kern	439	1,558	1,309	10,965	1,551	4,239
Kings	376	376	844	844	604	604
Lake	127	127	763	763	768	768
Lassen	103	103	757	757	246	246
Los Angeles	6,757	20,907	55,010	214,135	21,367	59,661
Madera	357	357	2,085	2,085	874	874
Marin	169	461	1,915	6,335	850	2,188
Mariposa	32	32	191	191	199	199
Mendocino	228	228	1,533	1,533	759	759
Merced	153	535	189	3,153	352	1,132
Modoc	25	25	80	80	103	103
Mono	19	19	244	244	65	65
Monterey	377	1,001	3,067	9,153	1,015	2,571
Napa	285	285	2,495	2,495	1,186	1,186
Nevada	231	231	1,757	1,757	1,109	1,109
Orange	1,648	5,479	16,994	63,437	6,214	17,129
Placer	204	565	1,071	4,568	688	1,782
Plumas	51	51	228	228	260	260
Riverside	663	2,923	4,502	25,850	4,748	12,320
Sacramento	971	2,754	6,367	25,141	3,146	8,339
San Benito	118	118	885	885	329	329
San Bernardino	1,296	4,121	6,733	32,178	3,506	9,318
San Diego	2,933	8,285	11,196	56,572	6,955	19,071
San Francisco	0	172	0	11,200	526	5,139
San Joaquin	497	1,437	156	8,544	780	3,244
San Luis Obispo	359	964	1,278	4,994	895	2,263
San Mateo	445	1,388	4,330	16,531	2,011	5,743
Santa Barbara	220	1,064	1,364	7,845	1,118	3,105

Table 5 (cont'd): Unmet Need Estimate Based on CMHS Prevalence Rate

COUNTY	18-20		21-59		60+	
	Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Santa Clara	1,294	3,649	12,724	42,367	3,404	10,156
Santa Cruz	189	608	1,413	5,668	549	1,636
Shasta	398	398	1,939	1,939	1,495	1,495
Sierra	7	7	44	44	37	37
Siskiyou	108	108	235	235	440	440
Solano	309	947	2,100	8,429	749	2,146
Sonoma	323	972	2,471	9,712	1,247	3,491
Stanislaus	342	1,111	606	7,138	888	2,735
Sutter-Yuba	369	369	2,307	2,307	991	991
Tehama	140	140	569	569	562	562
Trinity	38	38	154	154	145	145
Tulare	392	1,101	1,359	6,577	876	2,403
Tuolumne	114	114	609	609	537	537
Ventura	663	1,858	5,388	17,435	1,793	4,908
Yolo	877	877	2,913	2,913	966	966

Each prevalence estimate has benefits and limitations. The CMHS rate is more current. In addition, comparisons with other states are possible using this standard rate. The Meinhardt data are useful because the rates are adjusted to account for county-level socio-demographic information.

Number of Persons Needing Public Mental Health Services

As already mentioned, some persons with SMI receive services from private providers. Currently, Meinhardt et al.'s 1994 study provides the most accurate data applicable to California. The CMHPC believes that the DMH must commission a study to update the percentage of persons with SMI who rely on the public sector for services. In order to account for the changes to the mental health system since Meinhardt's study, the CMHPC has provided a range for the number of persons needing public services. To find the lower end of the range, the estimated number of persons with SMI was multiplied by 42.1 percent, the proportion of adults expected to need public mental health services according to the Meinhardt study. The upper limit of the range is simply the estimated number of persons with SMI. This upper limit reflects the number of people who would need public services if no private services were available. For counties with populations under 200,000, a lower estimate was not calculated based on the assumption that a full range of private mental health services are not available in rural areas.

Unmet Need Calculation

The DMH provided the CMHPC with an unduplicated count of the number of clients served for fiscal year 1997-1998. In order to determine unmet need, the number of clients served was subtracted from both the lower end and the upper end of the estimated number of clients needing public mental health services. Tables 4 and 5 show the estimated range of clients suffering from SMI who are not receiving services. The unduplicated count of clients served excludes clients with only one outpatient visit or only one inpatient visit less than four days.

WHAT IS THE EXTENT OF UNMET NEED FOR PUBLIC MENTAL HEALTH SERVICES AMONG RACIAL/ETHNIC AND CULTURAL GROUPS?[2]

As noted in the Surgeon General's Supplement on Mental Health: Race, Culture, and Ethnicity, the causation of mental illness is a complex interaction among biological, social, and cultural factors (U.S. Department of Health and Human Services, 2001, p. 26). Considering the biological element, the report found that, "the overall prevalence rates for mental disorders in the United States are similar across minority and majority populations" (U.S. Department of Health and Human Services, 2001, p. 27). The report goes on to point out, however, that racial and ethnic minorities face a more stressful social and economic environment that increases the rate of mental disorders among those groups:

> Ethnic and racial minorities in the United States face a social and economic environment of inequality that includes greater exposure to racism and discrimination, violence, and poverty, all of which take a toll on mental health. Living in poverty has the most measurable impact on rates of mental illness. People in the lowest stratum of income, education, and occupation are about two to three times more likely that those in the highest stratum to have a mental disorder (U.S. Department of Health and Human Services, 2001, p. 42).

This section reports on the demographic and socio-economic factors that contribute to mental health needs and barriers to mental health services among African Americans, American Indians, Asian Americans and Pacific Islanders, and Hispanic/Latino Americans.[3]

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[2] This chapter did not include specific estimates of unmet need for racial/ethnic groups because at the time these estimates were calculated data were not available on the rates at which each racial/ethnic group accessed mental health services in the private sector. These figures were a critical step in the unmet need calculation.

[3] Unless otherwise noted, the data in the following sections on African Americans, American Indians, Asian and Asian Pacific Islanders, and Hispanics/Latinos were taken from *Mental Health:*

African Americans

According to the 2000 U.S. Census, African Americans living in the United States number approximately 34 million and represent 12 percent of the national population. Six percent of these African Americans are foreign born, including 1.5 million from the Caribbean (primarily the Dominican Republic, Haiti, and Jamaica) and from various African nations. African Americans occupy a unique niche in American history in that the legacy of slavery, racism, and discrimination continue to influence their social and economic standing that has significant bearing on their need for mental health services.

Social, Economic, and Educational Status of African Americans

- 62 percent of African American children grow up in single parent families (primarily with their mothers) with increasing gaps and limitations in extended family support.
- Approximately 22 percent of African American families live below the poverty line compared to 10 percent of families overall. African Americans are more likely than Caucasians to live in severe poverty with incomes at or below 50 percent of the poverty threshold.
- African Americans are overrepresented in Southern, rural, impoverished areas with limited access to safety nets providing mental health services.
- African Americans have a disproportionate number of health problems with high mortality and morbidity rates for adults.
- Up to 44 percent of the homeless population is African American with research documenting that the homeless population suffers from mental illness at a higher rate than the general population.
- Nearly 50 percent of all prisoners in state and federal jurisdictions are African American as well as 40 percent of juveniles in legal custody. African Americans are also overrepresented in local jails.
- African American children make up 45 percent of all children in public foster care and more than half of all children waiting to be adopted.
- African Americans are more likely to be victims of serious violent crime than whites with clear links between violence and psychiatric symptoms and illness. Over one quarter of African American youth exposed to violence have symptoms of mental illness.

Mental Health Needs Among African Americans

- Studies suggest that the prevalence rate of mental illness among adults is similar for African Americans and Caucasians. This finding, however, is questioned because of the overrepresentation of African Americans in high-need populations.
- The legitimacy of assessment procedures commonly used to assess mental illness is questionable for African Americans. Further, validity and reliability of common procedures used to assess and treat mental health conditions among African Americans has not been adequately addressed.
- African Americans have higher rates of mental illness than Caucasians due to demographic composition and social position.

Barriers to Service for African Americans

- Disparities in access to mental health services can be partially attributed to financial barriers. African Americans are overrepresented among the working poor, many of whom do not have private insurance and do not qualify for public assistance.
- African Americans often prefer African American mental health providers. Feelings of mistrust, stigma, and perceptions of racism prevent some African Americans from accessing treatment from non-African American providers.

Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General.

- Although African Americans are more likely to seek mental health treatment from primary care providers, many lack a usual source of health care. Mental health care often occurs in emergency rooms and psychiatric hospitals, which undermine delivery of high-quality mental health care.

American Indians

American Indians live in a complex and changing cultural and sociological environment of multiple risk factors linked to a number of behavioral-based health problems. They take a much more holistic approach to health than do most Euro-Americans. Health, including mental health, is considered not only a physical but a spiritual state. A person is considered to be made up of body, mind, and spirit; wellness is the harmony of these three components, illness being caused by disharmony.

Social, Economic, and Educational Status of American Indians

- National studies report that American Indians represent 45 percent of all persons below the poverty level. The 60 percent of American Indians living below poverty level reside in rural reservation areas.
- The prevalence of alcoholism among American Indians has been observed to have reached epidemic proportion and is considered by many to be the number one health problem. From 1980 to 1982, liver disease and cirrhosis death rates for Indians exceeded those for the total population by 420 percent.
- Accidents and violence, often a consequence of alcohol and/or substance abuse, account for 19 percent of Indian deaths, almost three times the national figure. Additionally, at least 80 percent of homicides, suicides, and motor vehicle accidents in the American Indian population are alcohol related (Bobo & Gilchrist, 1983).
- American Indians are twice as likely as whites to be unemployed. In 1999 about 26 percent of American Indians lived in poverty in comparison with 13 percent for the United States as a whole and eight percent for white Americans (U.S. Department of Health and Human Services, 2001).
- Removal from homelands, forced schooling at military-like boarding schools, racism, and overwhelming poverty have wreaked havoc through the traditionally strong, spiritual, and family-centered native culture. Much energy is focused on these problem behaviors associated with American Indian mental health while frequently the situational factors contributing to the psychosocial problems are overlooked (Hodge, 1997).

Mental Health Needs Among American Indians

- A survey associated with the American Indian Child Welfare Act reports 54 percent of the American Indian population has major mental health issues, primarily chronic depression, which affect family functioning and socialization (Hodge, 1997).
- A study of American Indian adults in Northern California found a depressive symptomatology of 42 percent, which is more than twice the U.S. general population rate of 16 percent (Hodge, 1997).
- Suicide is a particularly troubling problem among American Indian youth. Almost half (44.6%) of emotionally distressed adolescents have attempted suicide, compared to 16.9 percent of all youth (Hodge, 1997).

Barriers to Service for American Indians

- The ill-fitting measures of the DSM-IV limit the psychological community's ability to identify and measure problems accurately. Likewise, Eurocentric treatment modalities fail to recognize the strength of native culture and its victory over centuries of tragedy (Hodge, 1997).
- Because of high unemployment rates, many California Indians cannot afford to purchase health care independent of the Indian Health Service. Even those with Medi-Cal coverage find it increasingly difficult to find providers

willing to accept them because of the low reimbursement rates (Hodge, 1997).

- The long history of broken promises and treaties has led to a generalized feeling of mistrust between the white mainstream culture and American Indians. As a result of this lack of trust, American Indians are not willing to utilize the Western medical model or nontraditional methods of healing.
- Many rural American Indians have to travel considerable distances in order to receive health care services. It is not uncommon for American Indians in the northern part of the state to travel hundreds of miles to reach the closest Indian Health Service clinic (Hodge, 1997).
- Because many American Indians do not own reliable automobiles, factors such as distance, road conditions, climate, transportation, and cost of transportation, become major barriers to care (Hodge, 1997).

Asian Americans and Pacific Islanders

Asian Americans and Pacific Islanders (AAPIs) are the fastest growing racial/ethnic group in the United States. The population grew 95 percent from 3.7 million in 1980 to 7.2 million in 1990. From 1990 to 2000, the number of people identifying as Asian American, or Native Hawaiian or Other Pacific Islander grew by another 44 percent to 10 million for Asian Americans and 350,000 for Native Hawaiians and Other Pacific Islanders. The unmet mental health needs of AAPIs are complex due to the many subgroups within the AAPI community. This section will elaborate on the socio-economic and cultural context for AAPIs and the barriers that lead to their underutilization of mental health services, which is one significant characteristic of this racial/ethnic group.

Social, Economic, Educational Status of Asian Americans and Pacific Islanders

- A stereotype that AAPIs are a model minority persists when, in fact, poverty, acculturation, stress, juvenile justice, and substance abuse are problems among these communities.
- AAPIs are heavily represented among refugees and new immigrants.
- AAPIs represent over 46 different groups that speak over 100 languages.
- Overall, about 21 percent of AAPIs lack health insurance compared to 16 percent of all Americans.

Mental Health Needs Among Asian Americans and Pacific Islanders

- Less is known about the rates of psychiatric disorders for AAPIs using DSM categories than is known for most other major ethnic groups. Data that are available indicate that AAPIs are not "mentally healthier" than other populations.
- While depression, anxiety, and substance use/abuse have been documented in the AAPI community, expression of distress and views of normality and abnormality may very well be different in AAPI communities.
- Very little is known about the mental health needs of the diverse groups of AAPI adolescents, children and families.
- Little information is available on the prevalence of psychiatric disorders among older Asian Americans.
- AAPIs have the lowest rates of utilization of mental health services among ethnic populations. Among those who do utilize services, severity of disturbance is high. Individuals delay services until need is high and the resources of the family or community are greatly stressed.

Barriers to Service for Asian Americans and Pacific Islanders

- AAPI cultures often focus on groups or the family, rather than individuality. To seek services outside the home is not highly supported.
- Optimal interventions for AAPIs are limited by the striking lack of knowledge of rate and distribution of disorders and factors associated with health and illness.

- Low utilization of services is attributable to stigma and shame; lack of financial resources, including health insurance; different conceptions of health and treatment and cultural inappropriateness or "lack of fit" of services. AAPIs may use alternative resources or healing practices.
- Lack of providers who speak the same language or dialects as mental health clients is significant. Nearly one out of two AAPIs will have difficulty accessing mental health services because they do not speak English or cannot find services that meet their linguistic needs.

Hispanic/Latino Americans

The Hispanic/Latino American population is characterized by its rapid growth. The number is expected to increase to 97 million by 2050. Historical and socio-cultural factors suggest that, as a group, Hispanics/Latinos are in great need of mental health services.

Social, Economic, and Educational Status of Hispanic/Latino Americans

- Approximately two-thirds of Hispanic/Latino family households included children under the age of 18 in 1999.
- Overall, only 56 percent of Hispanics/Latinos 25 years of age and over have graduated from high school.
- The economic status of Hispanics/Latinos parallels their educational status. Poverty rates for this group are higher than any other group.
- Of the people who are incarcerated, 9 percent are Hispanic/Latino Americans as compared to 3 percent of non-Hispanic/Latino white Americans. Hispanic/Latino men are nearly four times as likely as white men to be imprisoned at some point during their lifetime.

Mental Health Needs Among Hispanic/Latino Americans

- Hispanics/Latinos suffer from more health disorders than white Americans.
- Mexican Americans who were born in the United States are at higher risk of mental disorders.
- Studies have found that Hispanic/Latino youth experience proportionately more anxiety-related and delinquency problem behaviors, depression, and drug use than do non-Hispanic/Latino white youth.
- Regarding older Hispanic/Latino Americans, one study found over 26 percent of its sample were depressed, but depression was related to physical health.
- High school Hispanic/Latino adolescents reported more suicidal ideation and attempts proportionally than non-Hispanic/Latino whites and African Americans.
- Rates of substance abuse are higher among U.S. born Mexican Americans as compared with Mexican born immigrants.

Barriers to Services for Hispanic/Latino Americans

- The system of mental health services currently in place fails to provide for the vast majority of Hispanic/Latino Americans in need of care.
- As many as 40 percent Hispanic/Latino Americans report having limited English proficiency. With few mental health providers identifying themselves as Spanish speaking, access to bilingual, bicultural services is limited.
- Poor penetration rates, access barriers, and poor quality of services have contributed to the underutilization of mental health services by Hispanic/Latino Americans.

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CHAPTER 4
THE PLANNED SYSTEM OF CARE FOR CHILDREN AND YOUTH

The system of care for children and youth must reflect the fact that children and youth are different from adults in terms of their needs and the interventions necessary to serve them. Children and youth, unlike adults, must negotiate a magnitude of developmental tasks resulting from their growth in physical, cognitive, cultural, social, and emotional domains. Another difference from adults is that children and youth are physically, emotionally, economically, and legally dependent upon adult family members and caretakers. Therefore, the system of care for children and youth must promote their growth and natural development through prevention services and treatment interventions. To be successful, the system of care for children and youth must recognize the importance of family members and caretakers and the impact of culture on access and utilizing mental health services. Every effort must be made to include the culture of the family members and caretakers in culturally aware service planning, treatment decisions, and long-term support of children and youth.[1]

WHAT ARE THE VISION, MISSION, AND VALUES FOR A SYSTEM OF CARE FOR CHILDREN AND YOUTH?

The mental health constituency envisions a society in which families[2] can raise happy, healthy, competent, and resilient children. The public mental health system promotes this vision through participation in a community-based system of care, which fosters optimal child development. The purpose of creating a public mental health system that collaborates with the larger Children's System of Care is to accomplish the following goals for children and their families:

- Children are healthy
- They are safe
- They live at home
- They are productive at school or at work
- They have supportive relationships with others
- They have meaningful connections to their communities
- They abide by the law

The following values guide development and implementation of children's mental health services components within the larger system of care:

1. **Cultural proficiency**—Cultural proficiency of the system of care is essential to assuring access, voice, choice, and ownership to children and their families.
2. **Basic rights**—Children and youth with serious emotional disturbances have all rights, privileges, opportunities, and responsibilities accorded to other minors. Advocacy to protect and insure those rights and access to resources should be an integral part of the system of care.
3. **Early identification and intervention**—Children with mental health needs should be identified early and provided with appropriate services. Serving infants and very young children at high risk of developing mental heath problems enhances the likelihood of positive outcomes in mother-infant bonding, family integration, and stability.
4. **Access, voice, choice, and ownership**—Children and their families should actively participate in and agree to all aspects of services they receive, including assessment, plan development, and treatment. They should participate in all aspects of policy development, program planning, services delivery, and oversight.
5. **One family, one plan**—All agencies involved with a child and family should join with the child and family to develop a single, coordinated service plan. Services should be delivered seamlessly with funding

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[1] The California Mental Health Planning Council (CMHPC) gratefully acknowledges the contributions of Charles Anders, dave neilsen, and Todd Sosna, PhD, to this chapter.

[2] The term "family" is used in its broadest sense to include any adults who have legal responsibility for the care of a child, such as biological parents, foster parents, relatives, and other guardians.

mechanisms invisible to the child and family.

6. **The more complex the need, the more unique the response**—Service plans should be individualized to meet the goals identified by the child and family while building on their strengths and resources. Families with the most complex needs should have services uniquely tailored to meet those needs.
7. **Success is the only way out**—Services should be unconditional with a no-eject, no-reject policy.
8. **Community based**—All services, including residential, should be provided in the home community unless no appropriate local resources are available. Although some children and youth may require more restrictive care at various times, promptly returning them to a more natural environment should be one of the main goals of service planning.
9. **School based**—Schools are vitally important to all children and youth. School-based mental health services not only respond to the needs of identified children and youth but also can address the needs of children and youth identified as potentially high risk.
10. **Recreation**—Playing sports, socializing with peers, and engaging in other recreational activities are important to children's development. Providing children and youth with after-school and summer programs is an integral component of a system of care.
11. **Natural supports**—In working with families, the mental health system should assist them to identify and develop natural supports in the community.
12. **Support for families**—Families with children and youth with serious emotional disturbances need supportive services, such as education about serious emotional disturbances and mental illnesses, respite care, after-school care, crisis services, support for siblings, training in accessing public benefits, and peer support groups for parents and foster parents with similar problems.
13. **Support during transitions**—Transitions are challenging. For most children and youth, changes in routines are difficult, and they and their families need planned support during transitions between programs. Youth in transition to adulthood may need special services to assist them in making that transition successfully.
14. **System accountability**—Policies, programs, and services should be ethical, legal, effective, and cost effective. Accountability is provided by specifying measurable goals and through regular evaluation of policy, program, and service outcomes.
15. **Funding**—State and local funding policies and mechanisms should support the concept of community-based systems of care. Fiscal incentives to mental health programs and other agencies should encourage the least restrictive, most appropriate services. Flexible funds should be available to allow special items or services to be purchased.

The Concept of an Inclusive System of Care

A clearly identified target population has been a fundamental element of the system of care planning model since its inception in the mid-1980s. By using a focused definition of the target population, local mental health departments and other child-serving agencies were able to maximize their limited service capacity for a fairly narrow population of high-risk children and youth with serious emotional disturbances. Especially in the earlier years of system of care development, this service, which focused on a small but well-defined target population, proved effective in diverting children and youth from restrictive, high-cost group homes and returning them to their own families. This initial success demonstrated the increased relevance of mental health services to other child-serving agencies and established local mental health departments as a key partner in building effective collaborations among public agencies. In the initial stages of Children's System of Care development, this narrowly defined target population was placed in statute as the group with the highest priority for receiving services and was consistent with a narrowly defined concept of system of care.

Now, fifteen years later, nearly all county mental health programs in the State are funded for Children's System of Care development.

The relevance of mental health services to public partner agencies and the access those agencies have to mental health services for their children and families are once again being examined. The historical Children's System of Care "target population" has become less critical as a screening tool due to stabilized funding for community mental health programs. At the same time, new evidence suggests that significant improvement in child and family well-being can be achieved through providing appropriate mental health services. For example, major initiatives launched by the Department of Social Services and probation agencies are highly dependent upon the successful integration of specialty mental health services into service plans for at-risk children and youth. In addition, new initiatives from entities outside traditional system of care partners, such as Healthy Families, have received much public attention in the field of services to children.

These initiatives underscore the need for expanding the involvement of the public mental health system to a broader range of children, youth, and families. Such expansion also calls for a more inclusive definition of the system of care target population. The population to be served by the Children's System of Care should include all children who receive services from the primary child-serving public agencies, including those children who are potentially eligible for services, such as children who are at risk of out-of-home placement. Priority should be placed on early identification of children and youth at risk so that their symptoms do not become so severe that they require more intensive service. Mental health services should be delivered to this expanded system of care population so that these children might be spared a whole array of negative life outcomes, including out-of-home placement, juvenile justice involvement, and school failure.

Another reason to adopt the inclusive system of care concept is that the narrower system of care concept does not promote the correct fiscal incentives. With the narrower system of care, pressures exist for cost-shifting and transferring responsibility for the care and treatment of children among county agencies serving children. This cost shifting occurs because some of the partner agencies in the Children's System of Care are facing significant challenges. In education, class size reductions have resulted in a shortage of space for support staff, special education classes, and collaborating agencies, such as mental health, probation, and social services staff. Schools are dealing with increasing pressure to improve standardized achievement test results. This pressure is contributing to a move toward "zero tolerance," ejection of students who misbehave sometimes for relatively minor infractions. Suspending or expelling students from school can create behavioral problems that put pressure on their families and other child-serving agencies. In the child welfare system, placements have risen with particular pressure on the most intensive level of placement: RCL 12-14. In the mental health system, Metropolitan State Hospital is now the only state hospital available for children. Community treatment facilities, which would provide secure placement options, are available only to a limited degree. Recent legislation requires that the Interstate Compact Placement Committee rigorously screen out-of-state placements by child welfare and juvenile probation. Mental health placements do not have this requirement, which puts additional pressure on children to be placed through the Chapter 26.5 process so that very disturbed children who are in need of contained settings can receive an appropriate placement.

A better strategy would be one in which a county as an administrative unit has ultimate responsibility for the clinical and fiscal outcome for children and their families. The concept of an inclusive system of care is based on shifting the point of responsibility from the individual child-serving agencies to the county level. The high degree of interdependency among agencies means that one agency cannot excel in achieving good outcomes unless it works collaboratively with other agencies to achieve goals that have been established in common. The locus of responsibility for managing care should be at the level of the county governing body. At that level, the goals are protection of the county general fund and improvement of community well-being. One of the strategies for achieving those goals is to improve outcomes for children and youth who are potentially high-risk and high-cost. Implementation of this approach has implications for increased partnership, particularly with education, but also with

informal supports for families, such as the faith community and grassroots organizations.

WHY DOES A SYSTEM OF CARE WORK AND HOW IS IT STRUCTURED?

California is a national leader in promoting mental health systems of care for children and their families. The system of care and its required components are specified in state legislation. Required components in a system of care include family partnership, cultural proficiency, a full continuum of community-based services and supports, cross-agency collaboration, and evaluation of outcomes. However, the manner in which Children's System of Care components is expected to address these requirements is not detailed. The success of systems of care is, in part, responsible for collaborative programs being promoted by other service systems, including child welfare, juvenile justice, schools, and public health. However, many communities have service delivery systems made up of collaborative, but fragmented, programs. This fragmentation typically results from rapid expansion and hurried strategic planning. In addition, the local collaboration sometimes loses its focus on how to integrate all these efforts.

Goodness of Fit Theory of Change

Mental health is critical to a person's success as an individual, a family member, and as part of the community. Mental health is necessary for critical functions, such as motivation, planning, learning from the consequences of one's actions, impulse control, social interactions, empathy, and altruism. Impairment in these important functions can result in severe impairment in many areas, such as employment, raising children, getting along with others, meeting basic needs for food, shelter, health, and clothing, learning in school, and abiding by the law. Public agencies have been established with dedicated resources and specialized staffing and expertise to address problems, such as homelessness, unemployment, child abuse and neglect, crime, access to health care, and failure to benefit from schooling. Specific services and programs available from county mental health departments are described in the appendix to this chapter.

Each of these agencies is successful with many of the children and families that they serve; however, a small percentage of children and families are not successful despite receiving services from the responsible agencies. This small percentage of children and families tend to account for a disproportionately large percentage of need. Failure to benefit from typical services offered by the responsible agencies can be explained by the profound effects of mental disorders and substance abuse. As a consequence, success with these children and families will require the combined efforts of several agencies working to address areas of impairment and underlying mental health disorders.

The Children's System of Care needs a "theory of change" that explains why these components individually or in combination will result in better outcomes for children and families. The relevance and significance of theories of change for collaborative programs is profound. Collaborative programs are formed to achieve better child and family outcomes at the same or lower cost. Collaboratives are successful when members of the collaborative work in concert to build on each other's strengths, resulting in a product that is greater than the sum of its parts. Collaboratives benefit from the enhanced decision making that results from teamwork. In order for a collaborative to make decisions successfully, the team benefits from having a shared theory of change that is a composite of the approaches that characterize the agencies that form the collaborative. The "goodness of fit" theory of change offers tremendous promise for children's mental health systems of care as well as collaboratives being promoted in other service systems.

The benefits of the children's mental health systems of care as well as similar reforms promoted by child welfare and juvenile justice systems (e.g. wraparound, family unity, and family group conferencing) can be explained by a "goodness of fit" theory. This theory is premised on individualized care that builds on child and family strengths. The term, goodness of fit, means that the services provided to a child and family fit well with their strengths and needs. This theory provides plausible explanations for why the systems of care are needed and why they work.

The best outcomes in terms of both child and family functioning and cost are directly related

to the goodness of fit between child and family strengths and needs and the level of care provided. In the absence of an appropriate and precise fit, a child will be over- or underserved. Imprecision or mismatch in service level is directly related to unachieved outcomes and waste.

The adverse consequences of over-serving include:

- Limited positive outcomes
- Exposing a child and family to overly intrusive and restrictive interventions
- Unnecessary costs
- Fostering dependence on service providers
- Undermining child and family autonomy

The adverse consequences of under-serving include:

- Absence of positive outcomes
- Wasted expenditure of time and resources
- Unrealized hopes
- Loss of confidence in effectiveness of future interventions

Achieving a good fit requires building on child and family strengths to promote meeting their needs and achieving their goals. The importance of each component of a system of care described below can be understood in terms of its relation to promoting strengths-based, individualized care or "goodness of fit."

- **Family partnership** is necessary to identify child and family strengths and the goals of the child and family and to promote hope, child and family participation, and sharing of information.
- **Collaboration** is necessary to promote coordination of care across agencies, access to cross-agency services, and expansion of the local continuum of care and to improve planning through cross-agency and interdisciplinary expertise.
- **A full continuum of community-based services and supports** is necessary to promote access, to build on family and community strengths and resources, and to improve generalization of gains.
- **Evaluation of outcomes** is necessary to promote informed decision-making about services and systems change, and to improve quality of care, advocacy, and sustainability of effective service delivery reforms.

Structure of the Children's System of Care

To implement individualized, strengths-based services, a system of care must have certain physical elements to perform its various functions. These functions include identifying children who need an individualized service plan, designing the interagency service delivery system, developing programs and services, providing individualized service planning and implementation, ensuring family member participation, and conducting system evaluation. These functions should be performed by the individual agencies participating in the Children's System of Care, the interagency policy council, the interagency case management committee, service providers, an evaluator, and youth and family member involvement. This section describes these physical elements and the functions they perform in the Children's System of Care.

The **interagency policy council** designs and guides the Children's System of Care. The director of each child-serving agency in the county and senior management staff should participate in the interagency policy council. The interagency policy council performs the same functions for the Children's System of Care that an agency director performs for his or her own agency. These functions include developing a vision for the system and imparting that vision to staff; designing new interagency programs and services; designing the manner in which children enter the system, receive services, and exit the system; and monitoring the system to improve performance.

The system must include a process for identifying and referring children and their families who need an individualized service plan to experience positive outcomes. The system of care should develop a screening tool that identifies those children who are most likely to experience poor outcomes if served by the traditional service delivery system. The

traditional delivery system refers to a single child-serving agency providing just its services to a child and family as opposed to multi-agency interventions for children and families with more complex needs. The children and families that come into contact with a public agency should be screened by that public agency and referred to either a single child-serving agency for traditional intervention or to the interagency case management committee to develop an individualized service plan.

The **interagency case management committee** includes staff from the major child serving agencies. The staff should have the authority to commit resources to a service plan. The interagency case management committee is responsible for developing and implementing the individualized service plan for the children and families who are referred to them. Families are referred to the interagency case management committee because they need services from more than one child-serving agency in the county.

Separate from the service planning and implementation process is an evaluation component. The Children's System of Care should employ an **evaluator** to monitor staff fidelity to the service planning and implementation process and to evaluate outcomes for children and their families. This information must be fed back to management so that it can improve service planning and delivery. The information must also be fed back to the interagency policy council so that it can improve adherence to system processes or adjust system processes to improve outcomes.

The Children's System of Care must also have **family members and youth** involved at the policy level, in service planning and implementation, and the evaluation process. The service delivery system is designed to meet the needs of children, youth, and their families. Family members have first-hand knowledge about what is and is not effective at the system and service delivery level. This input must be valued and incorporated into designing and operating the Children's System of Care. This type of information will help the evaluator better identify what needs to be evaluated as well as how to best implement the evaluation process to include other family members.

So far, this discussion has focused on formal elements of the system of care, such as service providers and county infrastructure for implementing the system of care approach. Of equal importance are the informal elements for supporting children and families in the community. These informal elements are sometimes referred to as natural supports and include extended family, churches, neighbors, schools, mentors, and co-workers.

Figure 1 on the following page clarifies the relationship of the formal and informal partners in a system of care. At the center of the system of care is the child, surrounded by the immediate family. This circle forms the heart of a family's support system. Extended family, friends, and neighbors are in the next two rings of the circle. These individuals are informal sources of support that a family can rely on when it needs assistance. Other natural resources, such as schools and faith communities, surround this group. The next circle represents the formal resources provided by public agencies. Finally, in the outermost circle are state and federal agencies that provide the statutory and fiscal framework for the formal support agencies. When children and their families need assistance, they use available resources in ever widening circles. A system of care will assist families to strengthen their natural resources so they can rely on informal supports, eventually reducing the need for public agency involvement.

WHAT INNOVATIVE PROGRAMS HAVE BEEN DEVELOPED FOR CHILDREN?

Federal, state, and county governments have been developing innovative programs that are consistent with the vision, mission, and goals of the Children's System of Care. This section highlights those initiatives.

Wraparound Services

Chapter 795, Statutes of 1997, (SB 163), allows counties in California to participate in a five-year pilot project. The purpose of the pilot project is to provide eligible children with family-based service alternatives to group home care. The wraparound pilot project focuses on a family-centered, strengths-based, needs-driven planning process for creating individualized services and supports for children, youth, and their families. These services facilitate access to normalized and

inclusive community options, activities, and opportunities. The legislation permits flexible use of state foster care funds and Adoption Assistance Program funds to pay for individualized, intensive wraparound services necessary to keep these children in family settings or to return them to families. The legislation targets children who are currently residing in or are at risk of being placed in the highest levels of group home care.

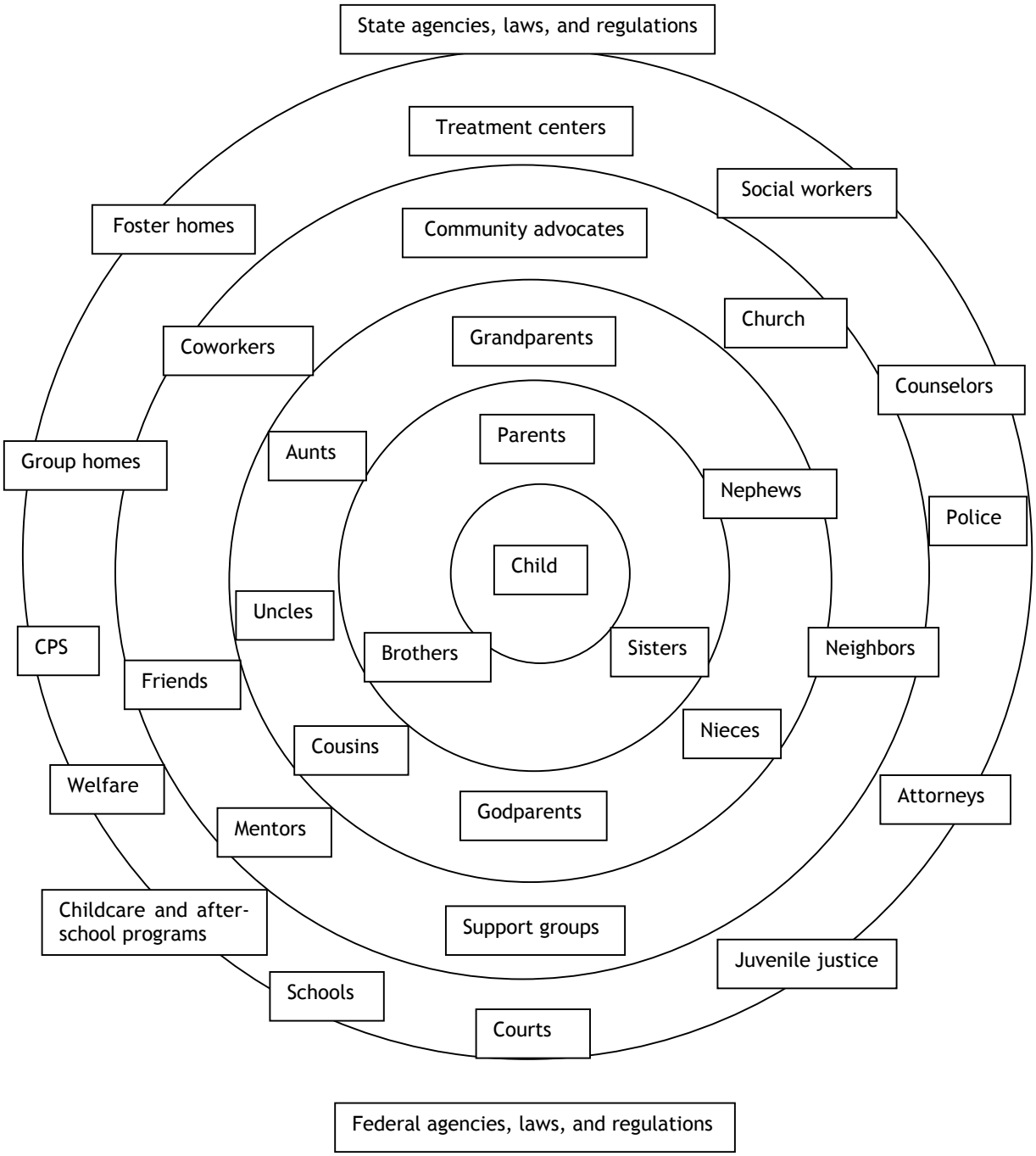

Figure 1: Formal and Informal Partners in the System of Care

Following are ten essential elements of wraparound services:

1. Families have a high level of decision-making power at every level of the wraparound process.
2. Team members persevere in their commitment to the child and family.
3. Wraparound efforts are based in the community and encourage the family's use of their natural supports and resources.
4. The wraparound approach is a team-driven process involving the family, child, natural supports, agencies, and community services working together to develop, implement, and evaluate the individualized service plan.
5. Services and supports are individualized, building on strengths and meeting the needs of children and families across the life domains to promote success, safety, and permanency in home, school, and the community.
6. The process is culturally competent, building on the unique values, preferences, and strengths of children, families, and their communities.
7. The plan is developed and implemented based on an interagency collaborative process with the community or neighborhood.
8. Wraparound plans include a balance of formal services and informal community and family resources, with eventually greater reliance on informal services.
9. Wraparound teams have adequate and flexible funding.
10. Outcomes are determined and measured for the system, for the program, and for the individual child and family (Burns & Goldman, 1998).

Balanced and Restorative Justice

Restorative justice is defined as a process whereby parties with a stake in a specific offense decide collectively how to deal with the aftermath of an offense and its implications for the future. Acknowledging that crime causes injury to people and communities, restorative justice aims to repair those injuries and enables the parties to participate in that process. Restorative justice programs, therefore, enable the victim, the offender, and affected members of the community to be directly involved in responding to the crime. They become central to the criminal justice process with state and legal professionals becoming facilitators of a system that promotes offender accountability; reparation to the victim; and full participation by the victim, offender, and community (Van Ness, 2000).

Restorative justice is different from contemporary criminal justice in several ways. First, it views criminal acts more comprehensively. Rather than defining crime as simply lawbreaking, it recognizes that offenders harm victims, communities, and themselves. Second, it involves more parties in responding to crime. Rather than giving key roles only to government and the offender, it includes victims and communities as well. Finally, it measures success differently. Rather than measuring how much punishment is inflicted, it measures how many harms are repaired or prevented (Van Ness & Brookes, 2000).

The National Center for State Courts reported that implementing a restorative justice approach is a major trend in the juvenile justice system, especially in Pennsylvania, Florida, and Minnesota (National Center for State Courts, 1998). Some counties in California, such as Shasta and Santa Cruz, are also implementing this approach to juvenile justice. A restorative justice approach provides a framework for systematic reform and offers hope for preserving and revitalizing the juvenile justice system. Implementing this new approach involves developing new missions and goals for juvenile justice; reallocating resources; redesigning job descriptions; developing new reporting measures and data collection systems to monitor effectiveness; giving priority to new programs and practices; and developing new roles for victims, citizens, and offenders in the justice process (Bazemore & Umbreit, 1997).

Challenge Grants

The Juvenile Crime Enforcement and Accountability Challenge Grant Program is administered by the Board of Corrections. The

purpose of this program is to reduce juvenile crime and delinquency. Counties were awarded grants based on developing and implementing a comprehensive, multi-agency action plan that provides for a continuum of responses to juvenile crime and delinquency. Counties also needed to demonstrate a collaborative and integrated approach for implementing a system of swift, certain, graduated responses and appropriate sanctions for at-risk youth and juvenile offenders.

To be eligible for a grant, a county must establish a multi-agency juvenile justice coordinating council that develops and implements a continuum of county-based responses to juvenile crime. The coordinating councils develop a comprehensive, multi-agency plan that identifies the resources and strategies for providing an effective continuum of responses for prevention, intervention, supervision, treatment, and incarceration of juvenile offenders, including strategies to develop and implement locally based or regionally based out-of-home placement options for youth.

Counties receiving grants are also required to identify outcome measures, including the rate of juvenile arrests, the rate of successful completion of probation, and the rate of successful completion of restitution and court-ordered community service responsibilities.

Healthy Families

The Healthy Families Program provides low-cost health insurance for uninsured children and youth up to their 19th birthday who are not eligible for no-cost, full-scope federal Medi-Cal and whose family incomes are below 250 percent of the federal poverty level. The Healthy Families Program provides health, dental, and vision coverage. For mental health services, the health plans are responsible for 20 outpatient visits per year for evaluation, crisis, and treatment for conditions that can benefit from relatively short-term intervention and 30 days of inpatient care. The health plan is also responsible for medication and laboratory services to treat those mental conditions.

Children with serious emotional disturbance enrolled in the program can receive additional mental health services. Upon determination by a county mental health program that an enrollee has a serious emotional disturbance, the full range of medically necessary services available through the Medi-Cal Rehabilitation Option and Targeted Case Management programs will be provided to the extent resources are available.

Healthy Start

The Healthy Start Support Services for Children Act, Chapter 759, Statutes of 1991 (SB 620, Presley) is California's first statewide effort to place comprehensive support services for children and families at school sites. Healthy Start brings together schools, school districts, county offices of education, health and human services agencies, county governments, nonprofit organizations, businesses, and others to focus their collective energy, expertise, and resources on responding to the needs presented by children, youth, and families in the school community. The intent of Healthy Start is to improve the lives of children and families by the following actions:

- Creating learning environments that are optimally responsive to the physical, emotional, and intellectual needs of each child
- Fostering local interagency collaboration and communication to deliver education and support services more effectively to children and their families
- Encouraging the full use of existing agencies, professional personnel, and public and private funds to ensure that children are ready and able to learn, and to prevent duplication of services and unnecessary expenditures
- Building on the strengths of children and families and providing and enhancing opportunities for parents and children to be participants, leaders, and decision-makers in their communities

Healthy Start does not necessarily pay for services. Rather, it provides coordinated service delivery that links children and families to needed supports and services. These school-linked supports and services that are being offered to meet the needs of Healthy Start children, youth, and families include:

- Child protection, parenting education, and child care

- Food, clothing, shelter, and transportation
- Vision care, hearing, dental care, acute care, and preventive health care
- Therapy, support groups, and substance abuse services
- Tutoring and dropout prevention
- Career counseling, job placement, and job training
- Recreation and youth development
- Income maintenance through Medi-Cal, Temporary Assistance for Needy Families, and food stamps

The first statewide evaluation revealed that from January 1993 through March 1995 schools experienced statistically significant school-wide improvements in standardized test scores for grades one through three, increased parent participation, and reductions in student mobility. Children and families intensively served through Healthy Start showed improved results in every area examined.

WHAT POPULATIONS NEED SPECIAL ATTENTION?

Although the California public mental health system has made great strides in the last 15 years developing a Children's System of Care, specific issues and groups of children should be examined to ensure that children, youth, and families benefit from the system of care outcomes. This section emphasizes some important issues and identifies certain categories of children, youth, and families with continuing or emergent needs for mental health services.

Conditions of Poverty for Children and Youth from Diverse Racial, Ethnic, and Cultural Populations

Conditions of poverty are a serious at-risk issue for families. The National Institute for Mental Health (NIMH) indicates that low-income individuals are two to five times more likely to suffer from a diagnosable mental disorder than individuals in the highest socioeconomic status (Bourdon, Rae, Narrow, Manderscheid, & Regier, 1994). Poverty also poses significant obstacles to getting help for these mental health problems.

In 1998, child poverty was at 18.9 percent in the United States, representing 13.5 million children. Although whites represented the largest single number of persons in poverty in 1998, ethnic groups were overrepresented with 26.1 percent of African Americans, 25.6 percent of Latinos, 12.5 percent of Asian American and Pacific Islanders, and 31 percent of American Indians on reservations who were living in poverty, compared with 8.2 percent of whites who were poor. The majority of poor families had a female as head of household.

The American Psychological Association's Public Interest Directorate, "Resolution on Poverty and Socioeconomic Status" listed the following findings about conditions of poverty:

- The effects of poverty on young children are significant and long-lasting resulting from substandard housing, homelessness, inadequate child care, unsafe neighborhoods, and lack of resources in schools
- Poor children are at greater risk than higher income children for a range of problems, including poor academic achievement, poor socioeconomic functioning, developmental delays, behavioral problems, poor nutrition, low birth weight, and medical illnesses
- Poor environmental factors have detrimental effects on mental and physical development
- Migrant families are by nature of their work and conditions, poorly served by health and mental health professionals
- Undocumented immigrants are vulnerable to legal actions that inhibit their access to health and mental health professionals

Refugee Children and Their Families

Between 1997 and 2001, according to the California Department of Social Services Refugee Programs Branch, 50,544 refugees arrived in California, including 12,157 children. These children are vulnerable physically and emotionally since they are exposed to multiple traumas, including torture and possibly death of parents, grandparents, and siblings; witnessing war firsthand; loss of their home, friends, and community; hunger and violence; and a sense of powerlessness to hold onto those

things that would normally give them comfort, security, and sustenance. Many of these children have physical problems caused by inadequate nutrition, inattention to chronic medical conditions, and injuries suffered before or during flight. Many children have emotional problems caused by loss or separation from parents and other family members, feelings of alienation from their country and community of origin, anxiety resulting from perceptions of parental powerlessness to protect them from the negative consequences of the refugee experience, and a sense of disorientation and loss of identity (CASSP Technical Assistance Center, 1989). After arriving in the United States, they must contend with the following issues:

- Reconfiguration of families with changes in the family unit due to death, divorce, or having a family member remain in the county of origin. One Los Angeles study noted that of 136 refugee families, 97 did not include both biological parents.
- Change in traditional gender roles where in countries of origin women generally care for the children and home while the males are the breadwinners of the family. In the United States, such roles are threatened. Refugee women often find work more easily than men causing considerable divisiveness between husband and wife with resultant stress on the children.
- Parent-child role reversal with children becoming cultural brokers, interpreters, and making or greatly influencing major social and economic decisions for their family.
- Intergenerational conflict with children adopting different behaviors, values, and expectations from those of their parents.
- Parental acculturation failure leading to parents having difficulty preparing children for adult life and difficulty retaining their children's attention and respect.
- Increased possibility of child neglect and abuse resulting from parental depression and sense of powerlessness.
- Difficulty mastering the English language leading to frustration, especially for teens, with resulting acting out behavior.
- Residence in low-income, high-crime areas with accompanying poverty, drugs, and violence resulting in corruption, exploitation, and mistrust of both community members and society at large. This setting and these attitudes become major barriers for families to overcome.

Given these issues, it is not surprising that many refugee children and adolescents exhibit, at least for a time during periods of stress, problems including anger, relationship difficulties, distorted value systems, and acting out behaviors. Prolonged stress during migration and acculturation result in high incidence of mental health problems, including post traumatic stress disorder; major depression; paranoid symptoms; mania; and "refugee neurosis," characterized by insomnia, nightmares, somatic complaints, problems with personal relationships, mistrust, and social isolation (CASSP Technical Assistance Center, 1989).

Although refugee families and their children have substantial need for mental health services, many barriers exist to the use of mental health services by refugee families, including:

- Non-existent or inadequate outreach efforts
- Lack of bilingual and bicultural staff who can overcome the fear of not being able to communicate physical or emotional problems due to lack of English skills
- Unwillingness to trust Western medicine or service providers
- Lack of money to pay for treatment
- Fear that seeking services might reveal illegal immigration status
- Differing cultural norms on expressing suffering and sensitive emotional concerns

To overcome some of these barriers, mental health service delivery systems for refugee children and families are best linked to health clinics that are the first providers of care for refugees. These health clinics provide baseline medical examination and screening for diseases common to the county of origin. Co-locating mental health facilities with health clinics allows families to become aware of other available services and encourages them to use the services as needed.

Children Age 0-5

The National Institute of Mental Health estimates that at least 7.5 million children have diagnosable psychological disorders that significantly affect the quality of their lives. Research has demonstrated the powerful role that early identification, intervention, and meaningful support and assistance can have for these children and their families. This knowledge has led to increasing awareness of the factors that contribute to adaptive and maladaptive patterns of development in infants (California Infant Mental Health Work Group, 1996).

The brain research literature provides striking evidence that an early focus on children can pay big dividends later in life. These findings support the idea that, although the shaping of the brain continues long after birth, the first years are critical for the full development of a child's cognitive abilities. Research on brain development provides important support to the research examining the relationship between family risk factors during childhood and poor life outcomes for children in such environments. These bodies of research point to ways in which families and society can ameliorate the effects of environmental stress on children (Illig, 1998).

Infant mental health refers to a comprehensive perspective on social and emotional well-being in infants and toddlers and the processes that support it. Infant mental health depends upon a number of factors, including the interactions between parents and a child and the child's relationships with other caregivers and siblings (California Infant Mental Health Work Group, 1996). Through positive interactions, the infant acquires pleasurable feelings about self and others, the capacity to relate to others, feelings of value and self-worth, a sense of having an impact on one's world, and a sense of belonging to family and community. The basic foundations of infant mental health include:

- Parent-infant-family attachments and positive interactions
- Caregiver capacity to read and respond to infant cues
- Infant capacity to initiate and respond to caregiver interactions
- Availability of social supports
- Parental capacity to use social supports (California Infant Mental Health Work Group, 1996)

The infant and family well-being can be affected by vulnerabilities within the family environment, such as poverty, biological and health factors, substance abuse, domestic discord, community violence, and other stress factors (California Infant Mental Health Work Group, 1996). Infants are born to parents with a range of capacities to initiate and respond to all aspects of their environment. Thus, a continuum of interventions must be available ranging from promotion of best parenting practices, anticipatory guidance, and development of parenting skills to critical interventions with severely dysfunctional infants and their families (California Infant Mental Health Work Group, 1996).

Delivery of effective, family-centered infant/toddler mental health services is dependent on well-trained health, mental health, education, developmental services, and social services professionals. Staff should be experienced in the care of children from birth to three years of age, able to facilitate child/caregiver relationships, assist in positive behavioral development, and provide grief and crisis counseling.

To expand the capacity of the public mental health system to serve this population, the Department of Mental Health (DMH) funded four counties as a pilot project. This initial effort is now being expanded due to an award of $3.6 million from Proposition 10's California Children and Families Commission. The framework and funding for the Infant Family Mental Health Initiative is based on existing efforts in training, model development, capacity building, and evaluation of the Infant Mental Health Development Project funded by

the Department of Developmental Services and coordinated by West Ed/CEITAN.

The goals of the Infant Family Mental Health Initiative are to:

- Identify the early childhood/infant and family mental health needs, resources, and services within pilot counties
- Increase the capacity of county mental health departments to identify and serve very young children and their families
- Facilitate interdisciplinary and interagency collaboration for services and staff training
- Provide models, resources, funding options, and replicable approaches for the delivery of effective mental health services for infants and their families

Evaluation is a significant part of this initiative and will involve developing procedures for both ongoing and overall evaluation of project outcomes, including:

- The results of a feasibility study based on screening and treating 10 infants and families in each county
- Changes in service delivery
- Personnel development
- County capacity to provide infant-family mental health services
- Staff training and supervision

Child Care and After-school Care

Children with serious mental health needs generally exhibit behaviors related to their condition at childcare and after-school care. In fact, such conditions may first be manifested in these settings. The children's symptoms and behaviors often result in frustration for the care provider who usually has had no training in identifying serious emotional disturbances or the skills for responding constructively to the child's needs. If the symptoms include aggressive, acting out behavior, the child is typically expelled by the care provider. This expulsion adds pressure to a family system that is likely struggling with the same behaviors. Such expulsions and loss of continuity result in increased stress to the child and further exacerbate the child and family's difficulties.

Childcare and after-school care are ideal places for early identification of serious emotional disturbances and intervention. Ideally, through training in mental health identification and referral and ongoing support, care providers will be able to maintain more children with serious emotional disturbances in their current care situations. At the same time the care provider will learn techniques and gain understanding that will benefit all children in the provider's care.

Risk Issues in Education

The 2000 US Census is a resource for studies that underscore risk issues for specific ethnic youth. School dropout rates reflect a particular problem. For example, a study conducted by the American Association of University Women revealed that Latina females drop out of school at a far greater rate than any other group of females in the United States. According to an analysis of the census data, 26 percent of Latina females leave school without a diploma compared to 13 percent of African American and 6.9 percent of white females. Latino males have an even higher dropout rate at 31 percent. Among other males, the dropout rate is 12.1 percent for African Americans and 7.7 percent for whites. Language barriers and poverty, especially for children of migrant workers, have been noted as sources of increased dropout rates (Canedy, 2001).

Children and Youth in Foster Care

The number of children entering the child welfare system and the percentage of those with significant mental health problems has increased significantly. In the last two decades, the number of children in the nation entering the foster care system has increased 60 percent. Studies suggest that the increase is due to rising rates of neglect related to parental drug and alcohol abuse, poverty, homelessness, AIDS, and domestic violence in at-risk families (Barbell, 1997). California has the largest child welfare system in the nation. Twenty percent of the nation's one-half million children in out-of-home care are dependents of the California child welfare system. The number of children in out-of-home placement in California increased 30 percent from 56,957 in 1994 to 87,387 in 1998 (Marsenich, 2002).

The age and ethnicity for children in foster care has also changed. Increase in parental

drug and alcohol involvement accounts for the growing number of children aged 0 to 5 entering foster care (Needell, Webster, Barth, Armijo, & Fox, 1998). In 1983, the average age for children in foster care was 10 years, 2 months. By 1990, the average decreased to 8 years, 3 months. By 1997, 33 percent of the children in out-of-home care in California were under 5 years of age. The representation of ethnic children in foster care has changed from 54 percent of the caseload in 1983 to 70 percent in 2001. African American children represent 36 percent, and Latino children represent 31 percent of children in out-of-home care.

The estimate for the proportion of children entering the foster care system with significant mental health problems ranges from 35 to 85 percent, depending on the study. Incidence of emotional, behavioral, and developmental problems among children in foster care is three to six times greater than that for other children (Brestan & Eyberg, 1998). The mental health service utilization rate for children in foster care generally is high relative to other children. One California study concludes that foster children represent only four percent of children on Medi-Cal but represent 41 percent of service users (Halfon, Berkowitz, & Klee, 1992).

Significant disparities in access to mental health services exist along ethnic and gender lines. Boys in foster care with severe psychiatric disorders are more likely to receive medication than girls. When problem severity is high, whites and African Americans of either gender have a higher service utilization rate than Latinos, Asians, and other ethnic groups. Whites have the highest rate of service utilization when the problem severity rate is low. Latinos have a low mental health service rate for all problem severity categories (Garland et al., 2000).

Youth in the Juvenile Justice System

Studies have shown that children in the juvenile justice system have high rates of mental illness (Evens, 1997). The prevalence of mental disorders among youth in juvenile justice facilities ranges from 50 to 75 percent in multiple, well-designed studies that used structured diagnostic interviewing techniques to determine children's diagnoses (National Mental Health Association, 1999). However, youth in the juvenile justice system, especially those incarcerated in juvenile justice facilities, face substantial barriers to receiving mental health services. Medi-Cal reimbursement is only available for youth in juvenile justice facilities that have been adjudicated and are awaiting placement. Other youth in juvenile justice facilities are not eligible for Medi-Cal; consequently, many counties are not able to fund the needed mental health services for these youth. Moreover, juvenile justice facilities and the California Youth Authority are experiencing widespread over-crowding. Caseloads for juvenile probation officers are often high, precluding the ability to provide individualized services involving the family. An overriding concern is that youth suffering from mental illness who have been incarcerated do not have access to adequate mental health services.

In addition to these problems facing all children in the juvenile justice system, racially and ethnically diverse youth are over represented in the juvenile justice system (Macallaire & Males, 1999) (Poe-Yamagata & Jones, 2000). Based on arrest data from Los Angeles County, "The Color of Justice" (1999) concludes the following:

- Racially and ethnically diverse youth are 2.7 times more likely than white youth to be arrested for a violent felony
- Once in the system, racially and ethnically diverse youth are 3.1 times more likely than white juvenile crime arrestees to be transferred to adult court
- Racially and ethnically diverse youth are 8.3 times more likely than white youth to be sentenced by an adult court to a California Youth Authority (CYA) facility. In 1980, white youth comprised 30 percent of the CYA population. By 1998, white youth comprised only 14 percent of the CYA population.
- CYA projects that Latino youth will represent 65 percent of the CYA population in the next several years

"And Justice for Some: Differential Treatment of Minority Youth in the Justice System" (2000) concludes that the juvenile justice system is

"separate but unequal," especially for African American and Latino youth. Major findings include the following:

- African Americans and Latinos are over represented in both prisons and secure juvenile facilities
- In 1998, African American youth were overrepresented in number of arrests in 26 of 29 offense categories documented by the FBI
- Although racially and ethnically diverse youth comprise one-third of the adolescent population in the United States, they comprise two-thirds of over 100,000 youth confined in local detention and state correctional systems
- When white youth and racially and ethnically diverse youth with no prior admissions were charged with the same offenses, African Americans were six times more likely and Latino youth three times more likely than white youth to be incarcerated in public facilities

The Children's System of Care should develop and support program strategies that will increase access to mental health services and divert racially and ethnically diverse children and youth from the juvenile justice system. Recent studies suggest causes for the under-utilization of the mental health system by ethnically and racially diverse families. Ethnic minority parents are less likely than white parents to choose formal mental health providers when deciding where their children should get help (Cauce et al., 2002). In one study of families who eventually came into contact with a mental health agency related to their children's emotional problems, white parents were more likely to have contacted mental health professionals themselves than African American or Latino parents (McMiller & Weisz, 1996). Research indicates that African American families may be less likely to seek mental health services voluntarily compared with other ethnic groups due to a perception that services may be ineffective or that barriers to services may exist (Neighbors, 1985).

Outreach efforts and establishing culturally responsive services in ethnic-specific service centers may be necessary to encourage voluntary service utilization among African Americans and Latinos. Evidence from a recent study of referral patterns in San Diego, California lends credence to the effectiveness of ethnic-specific services for increasing voluntary access to mental health services by ethnic families. Latino youth in San Diego were more likely to have been referred to mental health services by family and were less likely to have entered services through a mental health agency than were non-Hispanic whites (Yeh et al., 2002). The researchers speculate that this referral pattern may result from the availability of ethnic-specific outpatient clinics in the San Diego area.

The Report of the Surgeon General's Conference on Children's Mental Health recommends other actions that will help resolve these disparities:

- Develop strategies to serve uninsured children and youth across diverse populations and geographic areas
- Monitor access to mental health services through a continuing quality improvement process, which includes analyzing ethnic-specific data. The goal of this process is to equalize access to mental health services and to produce comparable outcomes of care across ethnic groups
- Identify and eliminate barriers to access based on ethnicity, culture, socioeconomic classes, gender, and sexual orientation to newly initiated or mandated programs
- Increase access to culturally competent services that are sensitive to youth and family strengths and needs
- Increase efforts to recruit and train providers who represent the racial, ethnic, and cultural diversity of the State (U.S. Public Health Service, 2000)
- Co-locate mental health services with other key service systems, such as education, welfare, and primary care, to improve access, especially in remote or rural communities
- Encourage and develop strategies to include and engage racially and ethnically diverse families in family

partnership, prevention, and intervention strategies

- Increase research on diagnosis, prevention, treatment, and service delivery to address disparities, especially among different racial, ethnic, gender, sexual orientation, and socioeconomic groups

Youth with Dual Diagnoses

All children and youth should be screened for potential alcohol and other drug use. If such use is identified, a substance use assessment should be completed, and a substance abuse treatment plan should be coordinated with the mental health plan, integrating mental health and drug and alcohol treatment. This combined treatment approach may require cross-training in screening, assessment, and treatment for mental health and alcohol and other drug staff as well as for education, probation, and other child serving agencies.

Results from the DMH's performance outcome system show that clinicians are reporting that approximately 15 percent of the youth they assess have moderate to severe impairment regarding substance use. However, estimates from national studies of co-occurring mental disorder and substance abuse among adolescents range from 22 to 82 percent (Substance Abuse and Mental Health Administration, 1999). The prevalence of co-occurring emotional and behavioral problems and addictive disorders varies across studies because of methodological complexities of studying this issue. However, this study by the Substance Abuse and Mental Health Administration (SAMHSA) also cites evidence that over 30 percent of 16- to 17-year-olds report using alcohol in the past month with past-month alcohol use being nearly twice as likely for adolescents with serious emotional disturbances. Dependence on substances, such as cocaine, crack, inhalants, hallucinogens, heroin, or abused prescription drugs was nearly 9 times as likely among adolescents with serious behavioral problems. Comparing national estimates of co-occurring emotional and behavioral problems and addictive disorders with results from California's performance outcome data on children and youth suggest that mental health clinicians may not be identifying all youth with substance abuse problems.

The need to diagnose substance use disorders among youth with serious emotional disturbances is underscored by the increased incidence of suicide among adolescents and young adults. In 1997, suicide was the third leading cause of death for persons age 10 to 24. Annual surveys indicate that up to 7 percent of high school youth have attempted suicide. Co-occurring mental and substance use disorders have been identified as precursors and risk factors for youth suicidal behavior. For adolescent males who complete suicide, comorbid conduct disorder, mood disorder, and substance use disorder are the most common diagnoses. For adolescent females, mood disorders predominate with lower rates of comorbid substance use disorders and conduct disorders compared to adolescent males. (National Institute of Mental Health & National Institute of Drug Abuse, 2000)

Transition-age Youth

The upper age limit for youth eligible for services in the Children's System of Care varies based on the funding source for the individual child. Children generally move to the adult system at age 18. Medi-Cal eligibility for some youth continues past age 18 because they are eligible for Supplemental Security Income or Temporary Assistance to Needy Families or because of their status as a child formerly in foster care. These youth are eligible for Medi-Cal funded mental health services up to age 21. Those with Healthy Families insurance can receive services through that source until age 22. Finally, students eligible for services through Chapter 26.5 are generally eligible for those services until they graduate from high school, get a General Education Diploma, or reach age 22, whichever comes first.

When youth with mental health needs become too old for services from the Children's System of Care, they often face overwhelming obstacles making a successful transition to adulthood. In disproportionate numbers, they become pregnant or develop substance abuse problems. Homelessness is also a significant risk for many youth with mental health conditions. They often try unsuccessfully to live with their families, then turn to living with friends in unstable arrangements, and too often end up in jail, the hospital, or homeless.

Like all young people, youth with mental health problems need assistance with income, safe and affordable housing, independent living skills, and educational and vocational planning. They also need assistance learning and integrating social skills and finding appropriate social activities and relationships. As they develop their identities, they need to experiment with different lifestyles and choices, sometimes making mistakes that teach life lessons. Unlike other youth, they need mental health services and must manage their symptoms while moving to independence. Some have little or no support from parents. Research has shown that mentoring is a powerful force in the lives of young people, especially those who have a disrupted relationship with parents.

Education for these youth is often interrupted and disjointed. Many do not reach their educational potential due to multiple changes in schools, including enrollment in special education and non-public school classes. They need support in the most normative educational settings possible. Innovative programs with community colleges can provide a welcome second chance in an environment more accepting of diversity than the public school systems.

Employment for young people can be a stabilizing and normalizing activity, providing the opportunity to learn work skills and identify interests and to see themselves as successful members of mainstream adult society. Youth need vocational counseling, job placement, and job coaching to choose, get, and keep desirable employment.

Peer relationships are important for adolescents and young adults as they separate from adult caretakers and develop their identity. Youth this age often need and welcome assistance with learning how to make and keep friends, how to form successful intimate relationships, how to develop a satisfying social life, and how to manage their emotions.

Transition-age youth are sensitive to the stigma attached to having a psychiatric disability. They generally prefer to have opportunities to participate in the normal activities of this age: attending school, dating, driving, working, and living in a place of their own. These wishes should be respected.

When providing services to youth in transition, the following guiding principles should be followed:

1. A single service coordinator should follow transition-age youth who are at risk of homelessness until age 25.
2. Clients should not be rejected or ejected from services for exhibiting the symptoms of their illness or for the experimentation that is a hallmark of this developmental stage.
3. Services should be provided in the community or at clients' homes, according to the preference and convenience of the client.
4. Peer support, self-help groups, and mentoring are essential to successful transition-age services.
5. All staff that work with transition-age youth should be trained in the developmental needs of this population, in community resources, and in operationalizing a recovery philosophy.

To meet the needs of these youth, mental health programs must work in partnership with the following child-serving agencies and adult agencies:

- Employment and training agencies
- Independent living programs
- The systems of care for children and adults
- Court advocates
- Probation
- Housing and redevelopment departments
- Homeless programs
- County Offices of Education and school districts
- Community college districts

Gender Issues

In 1999, the California Institute for Mental Health issued a report on issues related to mental health services and treatment for women. This report highlighted the needs of young girls, which are not addressed by the

Children's System of Care. The report states, "Current practice frequently discounts the significance of gender-linked issues such as abuse and trauma, and allocates insufficient attention and resources to mental health problems most prevalent among women, such as eating disorders, depression, and post-traumatic stress disorder" (California Institute for Mental Health, 1999, p. 7). To redress this imbalance in the system of care, county mental health departments should develop early identification and intervention strategies designed to reduce development of more serious mental health problems.

Another problem that the report identifies is that, in counties funded by Children's System of Care grants, more boys than girls are receiving services. The report speculates that this imbalance may result from a need to prioritize mental health services due to inadequate funding. Boys tend to exhibit problems related to externalizing behaviors, such as aggression; girls tend to have internalizing problems, such as depression. When determining who has the greatest need for services, clinicians would most likely identify externalizing problems as having higher priority. Now that the Children's System of Care has access to additional funding through EPSDT, clinicians need to assure that the mental health needs of young girls are addressed.

WHAT ARE THE BARRIERS TO EFFECTIVE OPERATION OF THE SYSTEM OF CARE?

Lack of State Level Coordination

Structures for interagency collaboration have been created at the county level; however, interagency coordination at the state level has never been addressed effectively. Over the past few years, interest in providing services to children and their families has increased dramatically. These initiatives have been developed by diverse state departments and agencies. For example, the Department of Social Services within the Health and Human Services Agency has responsibility for innovative wraparound programs for children at risk of out-of-home placement. The DMH administers many children's programs, including the system of care allocations. The Board of Prison Terms in the Youth and Adult Corrections Agency administers the probation challenge grants. The Department of Education has responsibility for the Healthy Start program administered through the school districts.

Although all these programs are very beneficial to children and their families, they also create challenges to local agencies due to incompatible administrative requirements that occur because the various state agencies do not work together to develop compatible programs. Moreover, these programs can also be burdensome to family members, who may be put in the position of having to provide duplicative information on the functioning of their children for assessment, treatment planning, and program evaluation purposes.

To address these concerns, the State should establish a Children's Council that would have the following goals:

- Establish a common vision for services to children and their families
- Ensure collaboration among state agencies and departments
- Establish a common data set and local accountability for child and family services

Membership should include:

- Secretary, Health and Human Services
- Chair, Board of Corrections
- State Superintendent of Public Instruction
- Governor's Education Advisor
- County Supervisors Association of California
- Judicial Council
- Secretary, Youth, Adult, and Correctional Agency
- Chief Probation Officer representative
- Attorney General
- Juvenile Justice Commissioners
- Parent and youth representatives that reflect the racial, cultural, and ethnic diversity of the population to be served

Many state policies and programs are actually implemented on the local level by county agencies. To assure that coordinated state initiatives are implemented with maximum

collaboration at the local level, the Children's Council of Statewide Associations should also be established. The purpose of the association would be to develop a shared vision and operationalize it through the following methods:

- Education and technical assistance
- Cross-training among local agencies
- Convening joint conferences and scheduling joint committee meetings
- Blending outcomes, funding, and the populations to be served

Membership should include:

- Chief Probation Officers of California
- California Conference of Local Health Officers
- County Health Executives Association of California
- County Alcohol and Drug Program Administrators Association of California
- County Mental Health Directors Association
- Child Welfare Directors Association
- Special Education Local Plan Area Directors Association
- Families and Youth that reflect the racial, cultural, and ethnic diversity of the population to be served

Flexible Use of Funds for Improved Child Outcomes

Improving access to necessary resources will help to ensure the success of children and families. One of the unintended outcomes of years of specifically focused funding streams has been the "barriers" created by the inability to develop "blended funding streams" that complement the service system integration efforts. Examples of this complex funding for children's mental health services include these sources:

- Medi-Cal, including EPSDT and managed care consolidation
- Chapter 26.5 (AB 3632)
- Allocations from the SAMHSA Block Grant
- Healthy Families
- DMH's Children's System of Care allocations
- Realignment
- Other federal grants

Additional fiscal resources for children include federal, state, and local public and private funds in various forms, such as the Supportive and Therapeutic Options Program (STOP) funds, Temporary Assistance for Needy Families, CalWORKS, Probation Challenge Grants, special education, Healthy Start, SB 163 Foster Care Waiver funds, grants, pilot projects, and other targeted funds that must be woven into the system of care.

Public funding for services for children tends to be categorical; that is, it is available through mandates or programs for the exclusive use of a relatively narrowly defined population. These funds are available for only a specific set of services rather than for any services appropriate to the needs of a child and family. Examples of categorical funding are Chapter 26.5 funds, which are entitlements for students who have been found to require mental health services in order to benefit from their educational program. Another example is Medi-Cal funds, an entitlement for children under the age of 21 who are Medi-Cal eligible and who have a mental health diagnosis. Healthy Families is for children who do not qualify for Medi-Cal but who live in families whose income is below 250 percent of the poverty rate.

Categorical funding is like a puzzle with some pieces missing: if a child or group of children does not fit into any of these categories, the only option is to fund services through county realignment funds. To protect these scarce non-categorical resources, a county may be forced to have a different, narrower set of criteria for services and a more limited range of service options for these children than for children eligible for services through Medi-Cal or Chapter 26.5.

Problems resulting from categorical funding are also evident when children are in need of out-of-home placement. Placement in a group home will be paid for by public funds if a child has been made a dependent of the court because of abuse or neglect by a parent or

caretaker, has been made a ward of the court because the child has broken the law and is under the supervision of the Probation Department, or is eligible for services under Chapter 26.5. To be eligible for services under Chapter 26.5, a child must need a mental health service in order to benefit from their education.

If a child does not meet any of these conditions and the parents cannot afford the high cost of group home care, which can cost $8,000 per month or more (including board and care, mental health services, and education), the child may fall through the cracks and not be able to access group home services. At this point, families may start to disintegrate as they attempt to find resources for a child squeezed out by federal and state policies that provide access to services only through categorical funding streams. Parents sometimes abandon their child in order to gain access to care. Systems sometimes look for any technicality they can find to make a child a ward or dependent. The most logical solution to this problem would be to increase non-categorical funding for services to children and families and to loosen the categorical restrictions on the various funding streams.

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR CHILDREN AND YOUTH?

GOAL 1: Redefine the Children's System of Care.

OBJECTIVE 1: Expand the definition of the population to be served by the Children's System of Care to include all children and youth who receive services from the primary child-serving agencies, including children who are potentially eligible for those services.

OBJECTIVE 2: Ensure that a cultural, ethnic, linguistic, and age-appropriate screening tool for assessing the needs of children and their families is developed and adopted by all child-serving agencies in the system of care.

GOAL 2: Advocate for more flexible, less categorical funding for the Children's System of Care.

OBJECTIVE 1: The State Legislature should appropriate a pool of non-categorical funds for each county system of care to be used flexibly by the child-serving agencies to meet the needs of children and their families.

OBJECTIVE 2: State agencies that oversee child-serving agencies in the counties should apply for waivers to federal agencies so that federal funds can be used to maximum benefit for children and their families.

OBJECTIVE 3: County government should establish a savings pool for funds that are saved by not placing children in high-cost, restrictive settings so that those funds can be redirected to meet the needs of children and their families.

GOAL 3: Ensure that Interagency Policy Councils and Interagency Case Management Councils function effectively.

OBJECTIVE 1: The membership of the Interagency Policy Council should be expanded to include parents of a minor child and youth representatives that reflect the racial, cultural, and ethnic diversity of the population to be served.

OBJECTIVE 2: The CMHPC should conduct a study of the existence and functioning of these councils. This study should include:

- Whether membership matches statutory mandate
- Whether parents and youth are represented
- Whether the councils function as described in statute

GOAL 4: Ensure that children, youth, and families that reflect the racial, cultural, and ethnic diversity of the populations to be served are involved in all aspects of planning, delivering, and evaluating services.

OBJECTIVE 1: Involve children, youth, and families in service delivery.

A. Children, youth, and their families should be fully involved in all stages of service delivery: assessment, establishing goals, treatment planning, referrals for ancillary services, evaluation of progress, and transition planning for service termination.

B. Supervision of provider staff should emphasize child and family involvement at all stages of treatment.

C. Quality improvement reviews should emphasize child and parent involvement.

OBJECTIVE 2: Involve children, youth, and families in county system of care policy, planning, and evaluation.

A. Mental health boards and commissions should include parents of children who have been served by the public mental health system.

B. Mental health boards and commissions should include youth up to age 25 who have been in the public mental health system.

C. Parents and youth should be included in all county mental health policy, planning, and advisory groups for mental health, including management teams.

D. Parents and youth should be included on the boards of directors or advisory boards of all agencies that have contracts to provide county mental health services to children and youth.

OBJECTIVE 3: Hire parent partners and youth advocates to provide peer support and advocacy to parents and youth receiving services.

A. Youth who have received mental health services should be hired as youth advocates/peer counselors by both county-operated programs and community agencies.

B. Parents of children who are now or have received mental health services should be hired as family advocates by both county-operated programs and community agencies.

OBJECTIVE 4: Ensure that youth and families are involved in all aspects of state mental health policy, planning, and evaluating services.

A. Youth up to the age of 25 who have been in the children's mental health system should be represented on all state committees and advisory groups, including the CMHPC.

OBJECTIVE 5: Ensure involvement of ethnically diverse children, youth, and families in the Children's System of Care.

A. When overseeing the process of facilitating involvement of children, youth, and families in service delivery, supervisors should be proficient in understanding the multicultural and multilingual needs of these clients.

B. The orientation and training components for children, youth, and families should address the multilingual and multicultural needs of clients.

C. All levels of management and supervision, including quality improvement programs, are responsible for ensuring the involvement of ethnically diverse children, youth, and families in the Children's System of Care.

D. County mental health programs must conduct outreach to ethnic communities for participation on community boards and commissions.

GOAL 5: Expand the Children's System of Care to meet the needs of refugee and immigrant children, youth, and their families.

OBJECTIVE 1: Outstation mental health services in non-traditional locations, such as public health clinics serving refugees.

OBJECTIVE 2: Develop ways to serve immigrant children who do not have access to Medi-Cal and to mental health services.

OBJECTIVE 3: Train clinicians, supervisors, and management in treatment modalities most appropriate to addressing the needs of immigrants and refugees.

OBJECTIVE 4: Recruit members of immigrant and refugee communities as volunteers and outreach workers to reach these children and youth in need.

OBJECTIVE 5: Perform ongoing research for evidence-based practices to address the needs of immigrant and refugee children, youth, and their families.

GOAL 6: Advocate for expansion of infant mental health pilot programs.

OBJECTIVE 1: The CMHPC shall assist the DMH in disseminating information about the need for culturally and linguistically appropriate infant mental health programs and strategies.

OBJECTIVE 2: If the infant mental health pilot program currently implemented by the DMH produces positive outcomes for young children and their families, the CMHPC will urge the Legislature to appropriate funds for all counties to provide infant mental health programs.

OBJECTIVE 3: If the infant mental health pilot program is expanded, efforts should be increased to identify those ethnically diverse children who are at the highest risk for mental health problems.

GOAL 7: Expand mental health services for children with serious emotional disturbances in childcare and after-school care by ensuring early identification, referral for assessment, and early intervention through training and consultation for care providers.

OBJECTIVE 1: Develop collaboration among the Departments of Education, Mental Health, Social Services, and Developmental Disabilities to address the behavioral and mental health needs of young children in child and after-school care and to provide training and resources for child care providers.

OBJECTIVE 2: Identify legislative and regulatory methods for developing and maintaining services within the county mental health service delivery system for young children, families, and child and after-school care providers.

OBJECTIVE 3: Develop sustainable, local infrastructures to facilitate training and provide supervision of county child care mental health consultants.

A. Establish a team of trained child and after-school care mental health consultants in each county with the capacity to provide support and direct services to the child care community

B. In collaboration with education and training institutions, develop a training-of-trainers model and curriculum for mental health professionals who wish to work as consultants to child and after-school care providers. This curriculum shall include the following topics:

- Child development
- Early childhood mental health issues
- How to provide consultation services within the context of child and after-school care

C. Include the following topics in training for child and after-school care providers:

- When to seek mental health consultation
- How to identify children who may need mental health services
- How to identify specific problematic behaviors
- How to communicate effectively with mental health professionals and parents
- How to access mental health services for children and their families

OBJECTIVE 4: Develop evaluation protocols for child and after-school care mental health and behavioral health consultation services in order to stimulate policy formation and program development.

OBJECTIVE 5: Develop procedures for billing child and after-school care mental health consultation services through Medi-Cal; Early Periodic Screening, Diagnosis and Treatment; and other funding streams, such as private insurance.

GOAL 8: Develop strategies for early identification and early intervention to prevent children and youth from entering the foster care system.

OBJECTIVE 1: Conduct studies of all components of the Children's System of Care to identify biases that lead to differential service referral patterns among ethnic groups and lack of sufficient availability of culturally and ethnically responsive services.

OBJECTIVE 2: At the local, state, and federal levels, systems must acknowledge the implications of the incompatible goals of the mental health and child welfare systems and work toward agreement on compatible, complementary alternatives to foster care.

GOAL 9: Expand the availability of mental health services for youth in juvenile justice facilities.

OBJECTIVE 1: The State should ensure greater coordination between the Board of Corrections, the California Youth Authority, and the DMH regarding oversight of juvenile justice facilities and the provision of mental health services to youth in juvenile justice facilities.

OBJECTIVE 2: The Legislature should increase appropriations for all funds that can be used for mental health services for youth in juvenile justice facilities.

OBJECTIVE 3: The DMH should participate in monitoring the provision of mental health services to youth in juvenile justice facilities to determine whether access to services is increasing.

GOAL 10: Reduce the overrepresentation of multicultural children in juvenile justice settings.

OBJECTIVE 1: The State should require each county to track the rate by race and ethnicity of their county's children in the juvenile justice system as a part of the county's quality improvement activities.

OBJECTIVE 2: If large overrepresentation exists in the number of racial and ethnic children involved in the juvenile justice system, counties should develop strategies in collaboration with other child serving agencies for early identification and early intervention to prevent children and youth from entering the juvenile justice system.

A. Conduct studies in all service settings to identify racial profiling, biases within systems, and lack of sufficient availability of culturally and ethnically responsive services.

B. Develope alternative strategies along with effective partnerships to break an otherwise increasingly punitive and more restrictive cycle of intervention.

C. Target mental health resources to meet the needs of these children.

GOAL 11: Increase the identification of substance abuse problems in children and youth.

OBJECTIVE 1: The State should adopt a screening tool to identify children and youth with substance abuse problems.

OBJECTIVE 2: The State should implement an extensive training program of staff in all child-serving agencies to enhance their ability to identify children and youth with substance abuse problems.

OBJECTIVE 3: The State must eliminate disincentives for children and youth to disclose their substance use problems. Child-serving agencies must be able to assure children and youth that their self-disclosure of substance use will remain confidential and will not result in negative consequences, such as arrest, incarceration, or revocation of probation.

GOAL 12: Develop a service system for transition-age youth in every county. The service system should have the following components:

OBJECTIVE 1: Every mental health provider, including the Adult and Child Access Teams, that serves youth age 14 to 25 should identify a minimum of one transition-age specialist who can be a resource on issues such as housing, income, vocational services, education, mentoring, and peer self-help.

OBJECTIVE 2: A transition-age coordinator should be hired to provide monitoring of mental health programs serving transition-age youth, oversight, coordination, and linkage between the child and adult systems, other partners, and the child and adult programs.

OBJECTIVE 3: When a youth receiving mental health services reaches age 14, a transition plan should be developed and implemented to assist in the transition to the adult system.

OBJECTIVE 4: Children's service coordinators should review all open mental health cases as their clients turn 17. Any necessary linkage and referrals to the Adult System of Care, housing, vocational services, and other services should be identified and carried out in a timely manner.

OBJECTIVE 5: Interagency case conferencing should be held on a regular basis to coordinate services for youth who are experiencing especially difficult challenges. Relevant partners should attend and coordinate necessary services to stabilize the youth.

OBJECTIVE 6: A specialized transition program should be developed to provide services, including rehabilitation services and service coordination, for youth ages 18 to 25 who have significant mental health needs and are at risk

of homelessness. The transition program should perform the following functions:

- Refer youth to specialists in housing, vocational services, education, income maintenance, socialization skills, alcohol and other drug services, and coordinate these services as needed.
- Provide system level coordination through case conferences.
- Support the development of self-help groups.
- Teach living skills, social skills, dating, and how to make and keep friends outside of institutional living by using directed experience in the community rather than a didactic approach and by discussing new experiences with the youth.

OBJECTIVE 7: Provide housing services with the following components:

- A revolving fund for lending money for deposits and first and last months' rent
- Support to assist youth to maintain subsidized housing
- Crisis respite housing
- Short-term shelter beds
- Apartment clusters

OBJECTIVE 8: Develop Youth Centers for all youth in the community to provide opportunities for socializing and recreation with a specific component of peer support for youth with mental health conditions.

OBJECTIVE 9: Assist clients to obtain their high school diploma or GED and to go as far as possible in higher education. Provide educational support in the form of tutoring, mentoring, and coordination with the education system.

OBJECTIVE 10: Develop partnerships with employment training agencies to provide job referrals, assistance with applications, and job coaching.

OBJECTIVE 11: Recruit, train, and coordinate volunteer mentors who represent the racial, ethnic, and cultural diversity of the population served.

OBJECTIVE 12: Establish a coalition of advocates and other stakeholders to monitor the adequacy of services for youth in transition to make recommendations to improve services.

GOAL 13: Advocate for creation of a state-level Children's Council and Children's Council of Statewide Associations

OBJECTIVE 1: The CMHPC should work with the California Institute for Mental Health (CIMH) and the California Mental Health Directors Association (CMHDA) to determine what steps have already been taken to implement this goal.

A. In collaboration with CIMH and CMHDA, the CMHPC should initiate contact with the Administration to urge the creation of a state-level Children's Council.

B. In collaboration with CIMH and CMHDA, the CMHPC should convene a meeting of statewide children's associations to plan for the creation of a Children's Council of Statewide Associations.

OBJECTIVE 2: These state-level groups should work to ensure that state regulations, required local advisory groups, outcome measures, and paperwork requirements are consistent and not duplicative for the child-serving agencies in a county implementing state-mandated programs.

OBJECTIVE 3: The state-level groups should work with local agencies to eliminate duplicative data gathering for families being served by more than one local agency.

GOAL 14: The state-level Children's Council should develop a statewide outreach campaign to eliminate disparities in mental health programs for children and youth and a parent education program about how to access services for children and their families.

OBJECTIVE 1: The state-level Children's Council should study the causes of disparities in access to services for ethnic children and youth and use the results of this study in developing their statewide campaign.

OBJECTIVE 2: At the local level, the Interagency Policy Councils should implement the campaign developed by the Children's Council to eliminate disparities in mental health programs and to educate parents about how to access mental health services.

GOAL 15: Eliminate racial, ethnic, and socioeconomic disparities in access to mental health care for children and youth with serious emotional disturbances.

OBJECTIVE 1: Require county mental health programs to use their quality improvement process to study access to mental health services among racial and ethnic groups to determine if disparities in access to services exist for multicultural children and their families.

A. County mental health programs should use performance indicators, such as penetration rates, expenditures per client for outpatient services, and units of service per client for outpatient services, to study access to mental health services.

B. The State should require that a quality improvement plan be implemented to correct the disparities in access to mental health services for multicultural children and their families.

- Identify barriers to access based on ethnicity, culture, or socioeconomic class to children's mental health programs, including any newly initiated or mandated programs.
- Develop strategies in program planning and service delivery that eliminate the historical barriers that racial and ethnic families face, including alienation, racism, and powerlessness, to access to mental health services for children and their families.

C. The State should require a plan of correction in counties with large disparities in access to services for multicultural children.

OBJECTIVE 2: Increase research on diagnosis, prevention, treatment, and service delivery to address disparities in access to mental health services for children and their families, especially among different racial, ethnic, immigrant, refugee, and socioeconomic groups.

OBJECTIVE 3: The State, in consultation with the CMHDA and the CIMH, should identify evidence-based practices to reduce disparities and to increase service access for multicultural children and youth.

OBJECTIVE 4: Increase efforts to recruit and train providers specializing in children's mental health services who represent the racial, ethnic, and cultural diversity of the State.

APPENDIX

SERVICES AND PROGRAMS PROVIDED BY COUNTY MENTAL HEALTH DEPARTMENTS

The mental health dimension of a system of care must have all the basic components available to meet the needs of children and their families. These components include screening, assessment, developing a client plan, service coordination, a full array of service options, flexible support services for the family, staffing, and advocacy. It must reflect the cultural and linguistic characteristics of the community. The planned system of care for children and youth should have components that integrate and infuse a cultural competency plan throughout. Cultural competency should be reflected in all of the areas that follow.

Screening

The mental health system of care must have a screening procedure to identify those children and youth that may need services. A Mental Health Screening Tool for use with children aged 5-18 provides professionals a simple way to identify children who should be referred for a full mental health assessment.

For those children and youth that do not meet the criteria, the system should make appropriate referrals so the child or youth accesses support elsewhere in the community. Thus, the system should perform the following functions for all children and families seeking services:

- Triage and crisis evaluation
- Consultation
- Information and referral
- Assistance in identifying appropriate services
- Outreach to identify children and youth through connections with other service systems and the community

Assessment

All services should be based upon a dynamic, comprehensive biopsychosocial client assessment, which results in a coordinated client service plan. A medical examination should be part of the assessment. The assessment must document that the client has a mental health diagnosis, has a functional impairment, and requires services.

The assessment shall ascertain psychiatric condition, living arrangements, individual and family strengths and needs, functioning in school and in the community, social relationships, and physical condition. The needs and wishes of the child and family must also be considered. All previously gathered relevant and available information on a child or youth should be reviewed to minimize unnecessary or duplicative testing.

The assessment shall be completed within 30 days unless the child or youth is in an emergency situation, i.e., the child or youth is dangerous to self or others or is unable because of a mental disturbance to take advantage of food, clothing, and shelter. In these instances, services may be provided without a full-scale assessment or plan.

Client Plan

Service planning will be done with age-appropriate participation of the child or youth, the family, representatives of other agencies with which the child and family are involved, and individuals who the child or family invite, such as a youth or family advocate, friend, or support person.

Services are planned across three dimensions: setting, intensity, and variety. Service settings could include any appropriate place for delivering care, such as home, school, a foster home, shelter care, juvenile justice facility, or other community location. Service intensity relates to the frequency with which the service is provided and to its duration. Service variety refers to the treatment and

supportive services available. In developing an individual treatment plan, all three dimensions must be addressed so that the plan meets the unique characteristics of the child and family.

Every child or youth in the system of care shall have a client assessment plan. It shall:

- Be developed within 60 days of the assessment
- Partner with the client, family members, legal guardian, significant others, and representatives of other agencies providing services
- Contain the client's long-term goals
- Contain specific objectives linked to the client's strengths and functional impairment
- Identify specific services the client will receive and who will provide them
- Utilize the least restrictive, most appropriate mental health setting for the child or youth at every stage of service delivery
- Be reviewed and updated at least every six months based on the child or youth's changing needs and conditions
- Provide for evaluating the child or youth's progress toward achieving the plan's goals
- Specify discharge readiness criteria, i.e., when services will no longer be necessary

Service Coordination

A system of care needs a comprehensive system for service coordination to provide services in accordance with the changing needs of a child and family. Each local mental health program shall develop a comprehensive system to accomplish the following goals:

- Always be the fixed point of responsibility for the child and family and be the interface with all service providers and agencies
- Partner with children and their families in planning for and deciding upon treatment options
- Assist families in obtaining necessary services for their children and themselves
- Assist the child and family to develop internal and external supports and to connect the child and family to natural resources in the community
- If indicated, assist families in applying for public entitlements, such as food stamps, scholarships, rent subsidies, and Supplemental Security Income, and in learning to use them
- Provide support to the client during transitions between programs utilizing interagency agreements and flexible funding as required by the individualized service plan
- Keep the family and client fully informed
- Advocate for the client's needs by identifying gaps in the system and bringing them to the attention of both management and the Interagency Children's Policy Council
- Protect and advocate for the rights of children and youth

Service Options

Service options are an array from which needed services may be selected. Services not already available in the community should be created. Services can be provided alone or in combination with each other. Combining various modes of treatment with services of other agencies can often generate creative uses of traditional treatment approaches. Coordinated treatment plans developed in concert with other agencies serving the child and family can enlist the aid of non-mental health professionals, such as special education teachers, probation officers, foster parents, or social service workers. Such concerted efforts by all the providers in a child's life increase the probability of positive treatment outcomes.

The array of services includes the following:

- Individual and group therapy
- Family therapy
- Medication and medication monitoring
- Day treatment
- Crisis intervention available 24 hours per day, seven days per week
- Secure community treatment facilities
- Acute hospital care
- Intensive in-home services
- Rehabilitative services
- Respite services for families
- Other services as identified by the child, family, and treatment team that will meet the individual and unique needs of the child and family

Staffing

Staffing standards should be based on the number of children and youth served and the children and youth's acuity levels. Each local program should develop such standards, and treatment providers should adhere to them. All treatment programs must provide and document a specific plan of supervision for children and youth being treated covering all hours that children and youth are present. Staffing patterns at all levels should reflect, to the maximum extent feasible, the cultural, linguistic, ethnic, and other social characteristics of the community. In addition to mental health professionals, staffing should also include peer providers, such as family advocates and youth advocates. Paraprofessionals should be enlisted to provide additional resources to assist in attaining goals.

Advocacy

Each local program must have a patients' rights office to ensure that the rights of children and youth and their families are protected, to bring deficiencies to the attention of the local mental health director, and to take remedial action. The patients' rights office shall have 1) access to children and youth and their records; 2) access to mental health providers; 3) authorization to invoke penalties for noncompliance with rights; and 4) an established grievance procedure for children and youth and their families.

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CHAPTER 5
THE PLANNED SYSTEM OF CARE FOR ADULTS

WHAT ARE THE MISSION AND VALUES FOR THE SYSTEM OF CARE FOR ADULTS?

The mental health constituency envisions a society in which adults with mental disabilities and their families can develop the skills and acquire the supports and resources they need to succeed where they choose to live, learn, and work and to be responsible members of the community. This vision is best achieved through the development of a culturally competent, community-based system of care that treats adults with mental disabilities with dignity and respect, empowers them to take an active role in their recovery, and is sensitive to the unique cultural and linguistic needs of the consumers it serves. The purpose of creating a public mental health system that promotes wellness is to assist adults with mental disabilities to accomplish the following goals:

- To be healthy
- To live where they choose
- To engage in school, work, and other satisfying and productive daily activities
- To have adequate income
- To be safe and abide by the law
- To have supportive relationships with others and meaningful connections to their communities

The development of the community mental health system began with deinstitutionalization in the 1960s. The mental health system was faced with the fact that people with mental illness have residential, vocational, educational, and social needs and wants. In the 1970s, the community support system was developed to identify the essential components needed by a community to provide adequate services and support to persons with mental illnesses (National Institute of Mental Health, 1987). The community support system was defined as "a network of caring and responsible people committed to assisting a vulnerable population meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community" (Turner & Shifren, 1979, p.2). In the 1980s, the concept of psychiatric rehabilitation began to emerge. The rehabilitation model emphasized that mental illness not only causes mental impairments but also causes the person significant functional limitations. The rehabilitation model emphasized treating both the illness and its social consequences.

Wellness and Recovery

> Education and training in the Recovery… [Vision] will help consumers acquire new skills and develop an understanding of their ability to make choices. They will learn to be less judgmental toward themselves and others as they learn to manage not only the functional aspects of their lives but also the biological, psychological, social, and spiritual dimensions of their experience (Mahler, Tavano, Gerard, & Baber, 2001).

California's mental health system is promoting wellness and recovery as a fundamental value for its Adult System of Care. A recovery-oriented system promotes a commitment to person-centered services that work toward an individual's needs, goals, and quality of life. Recovery emphasizes a shift from a provider-based system of care to a system that values a network of support that is both provider-based and client-directed. Providers engage clients to create and manage their own individual treatment plans actively rather than treating clients as passive, dependent recipients of care. William Anthony, one of the foremost authors to write about recovery for persons with mental illness, provides the following description of recovery:

> Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness (Anthony, 1993).

Shifting to a recovery philosophy in mental health treatment means helping clients to identify and pursue meaningful activities and active roles in the community by giving them both the hope and the expectation that they can be an integral part of society. Mary Ellen Copeland, a recovering client and national leader in the recovery movement, emphasizes the importance of hope in recovery:

> We don't need dire predictions about the course of our symptoms—something that no one else, regardless of their credentials, can ever know. We need assistance, encouragement, and support as we work to relieve the symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of (Mead & Copeland, 2000).

Resiliency or bouncing back from a relapse is one aspect of recovery. Tapping into a client's resilience can promote the healing process that is integral to recovery. According to Courtney Harding, Director of Boston University's Institute for the Study of Human Resilience, "Resilience is part of the human spirit. . . It's that natural urge people have toward health, and it's what people use when they dig deep to overcome a real crisis. It's a process of taking back control of your life and reinventing yourself" (Craig, 2001, p. 3).

Although the notion of recovery is being embraced by many clients, family members, and providers, some individuals may be concerned by this term. Some may feel pressured, and others may worry about meeting new expectations and losing access to services. Providers need to understand and respect that each individual is unique and achieves recovery differently. The concept and experience of recovery may also be different for clients with different cultural and ethnic backgrounds. The mental health system must explore how a recovery vision can reflect the experience and values of the diverse cultural and ethnic groups in the State. In its Adult System of Care Framework, the California Mental Health Directors Association observes that, "The cultural identities and worldviews of the consumers shape health and healing beliefs, practices, behaviors and expectations. Wellness is therefore, uniquely defined by each individual and each cultural group" (California Mental Health Directors Association, 2000, p. 2).

Problem: The public mental health system does not consistently promote recovery.

Providing mental health services may unintentionally foster ongoing dependence on the mental health system rather than promote recovery. Concerns have been raised that in many counties staff are not adequately trained to provide recovery-oriented services, including developing treatment plans with a wellness/recovery orientation. Many clients may lack access to or are denied ongoing support services that will help them to make progress toward their recovery. Providing services in a recovery-oriented system requires mental health staff to rethink what types of services may support recovery. In a recovery-oriented treatment system, traditional forms of treatment, such as medications and psychotherapy, are used as tools to help promote recovery rather than just to control the client's symptoms.

Several efforts are underway to address this problem. The California Mental Health Directors Association, working with representatives of the mental health constituency, has developed an Adult System of Care framework that embraces recovery-oriented services (California Mental Health Directors Association, 2000). This framework is intended to provide guidance on mental health policy and program development activities at the state, regional, and local levels of service delivery.

In the spring of 2002, the State Department of Mental Health and the California Institute for Mental Health (CIMH) developed and conducted four trainings throughout the State to teach clinicians and providers recovery-oriented service planning. In addition, the Department and CIMH conducted two more training sessions to train trainers in order to disseminate this approach in the counties. However, these "trainer training sessions" were attended by representatives from only 20 counties. More training sessions need to be held throughout the State. Although budget constraints may continue to hamper efforts to recruit trainers, more outreach needs to occur in those counties that have not participated in this training.

Many counties contract with and promote client-operated or peer support services.

These services are a very effective means of educating and encouraging clients about recovery. Clients who have experienced the challenges of mental illness can relate to other clients first hand and share their experiences in recovery. Providing peer-support services is very effective; however, difficulties arise in supporting consumer-run services because these services are paid for through realignment funding and cannot be matched for reimbursement through Medi-Cal. Because of budget constraints, some counties continue to fund traditional services, such as day treatment, because they receive a 50 percent match with Medi-Cal funds rather than fund a peer-support program that requires 100 percent state realignment funding.

Providing recovery-oriented mental health services is especially important for first-time users of the mental health system. Instead of receiving messages of stigma and despair, these new clients can be offered a positive vision of the future for themselves and a sense that they can have a meaningful role in life despite having a mental illness. Educational tools are being developed to convey hopeful messages of recovery. CIMH intends to develop training to teach clients and family members how to provide training on recovery in order to continue dissemination in the counties. However, the availability of resources may limit this effort. Mary Ellen Copeland has developed a program for clients called the Wellness Recovery Action Plan (WRAP). This program educates clients on how to develop increased self-awareness, improve self-care, and strengthen their supports. Similarly, the National Alliance for the Mentally Ill in California, with support from the DMH, has developed a training program for family members called "Family-to-Family." This program educates family members on mental illness and helps them understand what clients experience and the services that are available to help them. Many counties use both WRAP and Family-to-Family training in their mental health programs.

The National Association of State Mental Health Program Directors conducted a review of recovery literature and has summed up the ongoing challenge of fully integrating the recovery approach into the mental health system:

> Although recovery activities and literature are increasing at an enormous pace, it is still a young and tender concept that is not fully developed. Achieving a recovery-oriented public mental health system will take a tremendous amount of dialogue, study, listening to each other and implementing the actual precepts of recovery including working together; treating each other with respect and dignity; and allowing, helping and encouraging consumers/survivors to "stay in the driver's seat" and take control of their lives (Ralph, 2000).

5.1. Recommendation: County mental health staff, provider organizations, consumers, and family members should be trained in the values and principles of recovery and in the evidence supporting it. They should actively support recovery processes and the development of mental health services that enhance each consumer's recovery.

a. The DMH should place a high priority on funding training for county mental health staff on how to provide recovery-oriented services.

b. County mental health departments should make recovery and training programs, such as WRAP and "Family-to-Family," more widely available to clients, family members, and providers.

5.2. Recommendation: The DMH should convene a work group to evaluate the effectiveness of consumer-operated services, study the sources of funding for these services, examine the adequacy of resources for consumer-operated services, and research ways to increase funding for these services.

WHAT ARE THE PRIORITY TARGET POPULATIONS IN THE SYSTEM OF CARE FOR ADULTS?

Statutory Definition

The impetus to develop California's adult target population definition began as a result of limited resources in the 1970s and 80s. County mental health departments had only a fixed amount of resources to provide to persons with mental illnesses. In most cases, this fixed amount was not sufficient to provide services to everyone that needed them. Counties were

forced to prioritize service delivery so that only those clients whose symptoms were most severe were treated.

With the passage of the realignment legislation in 1991, the adult target population definition was put in statute. Welfare and Institutions Code Section 5600.3 describes the target population for adults with mental illness who are served by the public mental health system. That definition states that a client's mental illness must be severe in degree and persistent in duration; may cause behavioral functioning that interferes substantially with the primary activities of daily living; and may result in an inability to maintain stable adjustment and independent functioning without treatment, support, and rehabilitation for a long or indefinite period of time.

Medi-Cal Managed Care Medical Necessity Definition for Recipients of Specialty Mental Health Services

With the consolidation of fee-for-service Medi-Cal mental health services and public Short-Doyle Medi-Cal mental health services, a "medical necessity definition" was developed to apply to both groups of Medi-Cal beneficiaries who now receive mental health services through the public mental health system.

Medical Necessity for Inpatient Mental Health Services

Section 1820.205 of the regulations governing the Medi-Cal inpatient mental health services defines medical necessity for inpatient services. A beneficiary must have a specified diagnosis in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (DSM-IV) and require psychiatric inpatient hospital services as the result of a mental disorder due to certain symptoms or behaviors.

Medical Necessity for Outpatient Mental Health Services

Section 1830.205 defines medical necessity for outpatient, or "specialty," mental health services. Beneficiaries must have a DSM-IV diagnosis with a significant impairment related to the diagnosis or the probability of significant deterioration or lack of developmental progress. Eligible care for medically necessary services must be focused on the impairment, the client must be expected to benefit from the intervention, and the conditions should not be responsive to treatment that could be provided by the physical health care system.

Problems can arise for ethnically diverse populations when clinicians develop a diagnosis for the medical necessity definition. *Mental Health: Culture, Race, and Ethnicity--A Supplement to Mental Health: A Report of the Surgeon General* reports that minorities tend to receive less accurate diagnoses than whites. One reason for that phenomenon is the impact of culture, race, and ethnicity on the symptoms and expression of mental disorders. The *DSM-IV* acknowledges the role of culture on symptom expression with the inclusion of the "Outline for Cultural Formulation" and a "Glossary of Culture-Bound Syndromes." These sections describe the broader cultural context in which a multicultural client's symptoms must be evaluated and the ways they may differ from those of clients from Western cultures.

Clinicians must recognize and assess the different symptom presentations of multicultural populations and be careful when applying the definition of medical necessity across cultures. For example, some cultures express emotional distress through physical symptoms. Mexican American cultures may report stomach disturbances, chest pains, or palpitations (Escobar, Burnam, Karno, Forsythe, & Golding, 1987). Asian cultures tend to report cardiopulmonary symptoms, dizziness, vertigo or blurred vision (Hsu & Folstein, 1997). Multicultural clients must be assessed very carefully because they could be referred incorrectly to physical health care services or denied access to mental health care services as a result of an incorrect diagnosis.

5.3. Recommendation: The DMH and county mental health programs should develop strategies to ensure that the application of the medical necessity definition does not disproportionately restrict access to mental health services for multicultural groups.

a. Clinicians should be trained in the use of the "Outline for Cultural Formulation" in the *Diagnostic and Statistical Manual IV* when developing diagnoses for clients from ethnically diverse populations.

WHAT PROBLEMS EXIST IN THE ADULT SYSTEM OF CARE?

This section of the report addresses a variety of problems that exist in the Adult System of Care. These problems may limit access to mental health services and related services, such as education, employment, and housing; may affect the quality of mental health services; or may reduce the quality of life for adults with serious mental illnesses. Each problem is described and recommendations are offered to address the problem.

Access

Problem: Clients often do not have timely access to mental health services.

Access to mental health services is obviously a prerequisite for achieving positive outcomes for clients. Chapter 3 indicates that an overwhelming number of adults in need of public mental health services do not have access to them. At best, lack of access means that clients do not improve and may become more ill. At the other end of the spectrum, however, one of the worst possible outcomes from lack of access is the increased risk of clients committing suicide. The Suicide Prevention Advocacy Network (SPAN) of California states that, of the 30,000 suicides that occur each year, most of them result from depression or other forms of mental illness. In fact, SPAN reports that 90 percent of persons who commit suicide have a mental disorder or substance abuse disorder. However, the mental health system is limited by its lack of resources and services in the community.

Lack of resources to fund mental health services can be attributed to several factors. First, as discussed in the previous section, the public mental health system has two primary sources of funds for mental health services: Medi-Cal and realignment funding. Many clients are not eligible for Medi-Cal benefits. For these clients, counties must still prioritize services based on whether these clients meet the target population definition established in the realignment statute. Counties must pay for services provided to these clients through limited public mental health dollars that are allocated from realignment funding.

The second factor contributing to lack of resources is that any augmentations that have been appropriated by the Legislature over the last few years have been specific categorical augmentations that have improved access for some clients, such as clients who are homeless or who have been incarcerated. Although these programs are also needed, the mental health system really needs a substantial general augmentation to its funding so that timely access to services is available for all clients who seek mental health services. Local mental health programs also need additional unrestricted funding so that they can allocate funds to meet local priorities rather than develop programs only for specialized populations.

5.4. Recommendation: The State should appropriate additional non-categorical funds for mental health services for adults.

Problem: Persons of diverse cultural, racial, linguistic, and ethnic backgrounds lack access to health care services, which in turn restricts access to mental health services.

The Surgeon General's Supplement on Race, Culture, and Ethnicity points out that

> Many racial and ethnic consumers and families prefer to receive mental health services through their primary care physicians. Explanations of this preference may be that members of minority groups fear, feel ill at ease with, or are unfamiliar with the mental health system. Community health centers as well as other public and private primary health settings provide a vital frontline for the detection and treatment of mental illnesses and co-occurrence of mental illnesses with physical illnesses…Developing strong links between primary care providers and community mental health centers will also assure continuity of care when more complex or intensive mental health services are warranted (U.S. Department of Health and Human Services, 2001, p. 163).

However, the Surgeon General's report also indicates that health insurance coverage is a major problem for ethnic populations and describes shortfalls in insurance coverage for the four major ethnic groups. The report states that nationally 37 percent of Latinos are uninsured, which is more than double the percentage for whites. Medicaid and other public coverage reach 18 percent of Latinos

(Brown, Wyn, Hongjian, Valenzuela, & Dong, 1999). About 21 percent of Asian Americans and Pacific Islanders lack health insurance, and the rate of Medicaid coverage for most Asian American and Pacific Islander subgroups is well below that of whites. Only about half of American Indians and Alaska Natives have employer-based insurance coverage, which contrasts with 72 percent of whites with coverage. Medicaid is the primary source of coverage for 25 percent of American Indians and Alaska Natives. 24 percent of American Indians and Alaska Natives do not have health insurance. Nearly one-fourth of African Americans are uninsured, a percentage 1.5 times greater than the white rate (Brown, Ojeda, Wyn, & Levan, 2000). Medicaid…covers nearly 21 percent of African Americans (Snowden & Thomas, 2000).

5.5. Recommendation: Local mental health providers should develop specific strategies to encourage the delivery of integrated primary health and mental health services that match the needs of the diverse communities they serve.

5.6. Recommendation: Health care providers should be trained to identify and refer more complex cases to mental health providers and to improve liaison relationships between primary care providers and mental health providers.

5.7. Recommendation: Local mental health providers and physical health plans should educate ethnic communities on identifying mental health problems and accessing specialty mental health services.

Problem: Disparities exist in access, quality, and availability of mental health services for racial, cultural, and ethnically diverse populations.

The Surgeon General's Supplement on Mental Health: Race, Culture, and Ethnicity documents the existence of striking disparities for minorities in mental health services. Racial and ethnic minorities have less access to mental health services than do whites. A major finding of the Surgeon General's Supplement is that racial and ethnic minorities bear a greater burden from unmet mental health needs and, thus, suffer a greater loss to their overall health and productivity. The report states that

> …minorities are over-represented among the Nation's vulnerable, high-need groups, such as homeless and incarcerated persons. These subpopulations have higher rates of mental disorders than do people living in the community. Taken together the evidence suggests that the disability burden from unmet mental health needs is disproportionately higher for racial and ethnic minorities relative to whites. The greater disability burden to minorities is of grave concern to public health (p. 3).

The Surgeon General's report describes a number of barriers that contribute to these disparities in access, indicating that

> The foremost barriers include the cost of care, societal stigma, and fragmented organization of services. Additional barriers include clinicians' lack of awareness of cultural issues, bias, or inability to speak the client's language, and the clients fear and mistrust of treatment. More broadly, disparities also stem from minorities' historical and present day struggles with racism and discrimination, which affect their mental health and contribute to their lower economic, social, and political status (pp. 3-4).

As the U.S. population becomes more diverse, medical and mental health providers and other people involved in mental health care delivery are interacting with clients from many different cultural and linguistic backgrounds. Because culture and language are vital factors in how mental health care services are delivered and received, mental health providers must understand and respond with sensitivity to the needs and preferences that culturally and linguistically diverse clients bring to treatment. Providing culturally and linguistically competent services to diverse clients has the potential to improve access to care and quality of care and, thus, should produce positive mental health outcomes.

5.8. Recommendation: The DMH and county mental health programs should track utilization rates to determine if significant disparities in access and retention for multicultural communities exist in California. If so, plans

should be developed to correct these disparities.

5.9. Recommendation: The DMH and county mental health programs should design services to address differences in culture, race, ethnicity, gender, and age to reduce barriers to access and treatment.

5.10. Recommendation: Local mental health providers should implement strategies identified in their counties' Cultural Competency Plans to address disparities in access for ethnic populations.

a. Local mental health providers should conduct annual outreach campaigns to improve access consistent with the county's Cultural Competency Plans that are targeted to the underserved ethnic populations identified in their counties.

b. Local mental health providers should develop programs in settings where the overrepresentation of vulnerable, high-need, racial, ethnic, and cultural populations are found, such as jails, homeless shelters, and refugee resettlement programs.

Health

Physical Health Care

Problem: Clients' physical health problems often go undetected, untreated, or inappropriately diagnosed.

Many studies have shown a very high prevalence of serious physical illnesses in persons being treated for mental illness. These physical illnesses are often undetected or untreated because the client cannot effectively communicate the physical symptoms and physicians often attribute somatic symptoms to the mental illness. Kaplan, Sadock, and Grebb (1998) states that between 24 to 60 percent of persons who have been identified in the target population have been shown to suffer from associated physical disorders. In 1985, in response to Chapter 208, Statutes of 1982 (SB 929), Koran studied the prevalence of undiagnosed and untreated physical diseases in clients under the care of county mental health systems in four California counties (Koran, 1985). The study revealed that 45 percent of the clients had acute physical diseases. Twenty-two percent had their disease detected at the time of intake into the mental health system, and 23 percent of the clients had diseases that remained undiagnosed.

Kaplan et al. (1998) states:

> Among the most inappropriately treated patients in the mental health system are those who have medical problems that either cause or contribute to their psychiatric symptoms. Study after study has shown that psychiatric patients have more medical problems than the average members of society and that the most severely psychotic in this population have the most serious and/or the greatest numbers of medical problems (Kaplan, Sadock, & Grebb, 1998, page 152).

With the advent of managed mental health care in the public sector, California's mental health system "carved out" its services into specialty mental health services designed to serve Medi-Cal beneficiaries whose mental illnesses meet the medical necessity definition criteria. (See Chapter 7, Managed Mental Health Care, for more information on this system.) County managed health care plans, which are responsible for providing physical health care to Medi-Cal recipients, and county managed mental health plans have developed memoranda of understanding to coordinate care. This coordination includes providing clinical consultation and training, referral protocols, exchange of medical records information, and a process for resolving disputes between plans.

Egnew and Geary, describing the interface with health care in a carved-out mental health care system, report that the challenges of coordinating care include ensuring a timely process for referral, information sharing, consultation, and ensuring easy and timely access. They believe that "ensuring adequate access to both medical/surgical and behavioral healthcare is a critical public policy issue" (Egnew & Geary, 1996, p. 67).

Primary care providers actually see a large percentage of clients with significant psychiatric diagnoses. The California Medical Association estimates that about 80 percent of persons with mental illness are seen first by primary care physicians (California Medical Association, 1998). Primary care physicians

should be able to identify these illnesses accurately and make the appropriate diagnosis or refer clients to specialty mental health services. If mental illnesses are identified and treated in a timely manner, client outcomes are better and treatment is more cost-effective. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians (California Medical Association, 1998). Although the problem has been addressed, it has not been solved.

Gender issues in access to health care services also need to be addressed. Although women utilize health care services more than men do, they still face significant barriers, including lack of or inadequate health insurance coverage. Services to meet the needs of women who face trauma, severe depression, eating disorders, or other psychological disabilities are insufficient (California Institute for Mental Health, 1999).

5.11. Recommendation: Mental health clinicians should ensure that clients entering the mental health system receive thorough physical exams.

5.12. Recommendation: Mental health providers should encourage clients to use health care, especially education and prevention services, such as smoking cessation programs.

Co-occurring Mental Illness and Drug and Alcohol Use

The DMH estimates that approximately 60 percent of persons with serious mental illnesses have a substance abuse problem and that up to 90 percent of the highest cost users of mental health services also abuse substances (California Department of Mental Health, 1997a, page 16). The DMH describes the effect that co-occurring disorders are having on the mental health system:

> Within the last decade, it has become increasingly clear that substance abuse and mental illness when occurring simultaneously present a synergistic force that exacerbates both problems. Persons with a co-existing disorder are among the highest cost users within the publicly funded health care and criminal justice systems, and are a public safety concern when left untreated (California Department of Mental Health, 1997b, p. 1).

The Program for Assertive Community Treatment (PACT) Model describes the challenges faced by clients with co-occurring mental illness and alcohol and drug use:

> Clients with dual diagnosis present a substantial treatment challenge to mental health systems. As compared with other clients, their functioning is poorer (e.g., increased symptoms and impairment, hospitalization, incarceration, homelessness, physical problems), and they are more difficult to treat and rehabilitate (e.g., less adherent with mental health and substance abuse treatment services, showing a greater complexity of problems and needs) (Allness & Knoedler, 1998, page 58).

Problem: The mental health system lacks integrated treatment programs for co-occurring mental health and alcohol and drug use.

Historically, treatment of mental illness and substance abuse has been addressed by separate programs typically under separate government departments or agencies. Basic treatment philosophies between the two systems differ substantially. Many substance abuse treatment programs require total abstinence from any substance, which poses a problem for mental health clients with substance abuse problems who must take medications to control their mental illnesses. The DMH states that, "It is imperative that attempts to address issues of dual diagnosis take place as an integrated and unified program. Integrated service delivery for both problems has been shown to be highly cost-effective" (California Department of Mental Health, 1997b, p. 1).

In May 1995, the DMH and State Department of Alcohol and Drug Programs (ADP) formed the Dual Diagnosis Task Force. The purpose of the task force is to support the development of and promote effective programs for clients with dual diagnosis, to foster cooperative efforts in the treatment of this group of clients at the local level, and to promote access to those treatment programs. The DMH and ADP awarded $3 million over a three-year period in federal Substance Abuse and Mental Health

Services Administration (SAMHSA) funds to four projects. Each project is designed to demonstrate the efficacy of integrated mental health and alcohol and other drug treatment/recovery programs for persons with a dual diagnosis in a county system of care. The projects concluded in 2001, and the task force has completed its evaluation, which is currently in review. The evaluation will provide data on the effectiveness of integrated treatment, clinical outcomes, consumer satisfaction, client quality of life, costs, and cost savings or avoidance in the area of physical health care and criminal justice.

In 2001, the DMH also awarded two three-year demonstration grants to Sacramento and San Joaquin counties for dual diagnosis demonstration projects that target culturally diverse underserved populations. A major goal of these projects is to improve the coordination of mental health and substance abuse services between programs or across counties in order to maximize the utilization of supports and services and to minimize administrative, fiscal, and program barriers to services. However, due to budget constraints, the grant amounts were reduced and the third year of the projects was eliminated.

At the federal level, SAMHSA is beginning to expand its philosophy regarding treatment for clients with co-occurring disorders. A recently released report to Congress on co-occurring disorders outlines a five-year plan to ensure accountability, capacity, and effectiveness in services for persons with a dual diagnosis. One of the main points in the report is how to use available funding streams to serve people with dual diagnoses, which has been a point of contention between mental health and substance abuse providers for years. The policy under consideration would allow states to use federal block grant funds from both the mental health and substance abuse block grants to support integrated services although funding from both block grants would still have to be used in accordance with the purposes for which they are authorized by law. SAMHSA's intent is to ensure that clients receive the services they need and that states receive the most flexibility possible (Manisses Communications Group, 2002).

5.13. Recommendation: If the dual diagnosis pilot projects prove to be effective, the DMH and the ADP should seek funding to expand integrated treatment programs for clients with co-occurring diagnoses by offering incentives or matching funds to counties that replicate these models.

5.14. Recommendation: The DMH and the ADP should collaborate to explore all available options for using their federal SAMHSA block grants to fund integrated treatment programs for clients with co-occurring diagnoses, including taking advantage of new SAMHSA policy initiatives.

Living Situation

Problem: The mental health system lacks housing at all levels of the residential continuum.

The DMH reports that approximately

> …seven percent of the adult population in the United States, or about 12 million Americans, have been homeless at least once in their lives. More than three-quarters of homeless single adults have persistent mental or physical illnesses or substance abuse problems. In California, at least 150,000 people are homeless, and studies indicate that at least half are disabled with mental illness, medical problems, or other health conditions (California Department of Mental Health, 1998, p. 1).

A report prepared by the State Independent Living Council in April 1999 states that,

> Housing affordability is a major problem in California…There is a severe scarcity of low-income housing in communities throughout California, notably in major metropolitan areas. Individuals who rely exclusively on Supplemental Security Income (SSI) cannot pay the prevailing or market rental rate for any type of decent apartment or house…Given the lack of low-income, accessible housing, increasing numbers of people with disabilities are forced to choose between restrictive congregate settings and homelessness" (Tootelian & Gaedeke, 1999, p. vii).

In California, the Supplemental Security Income/State Supplemental Program (SSI/SSP) is only $692.00 per month for most clients,

which is an insufficient income in many counties. In fact, at the June 2000 meeting of the California Mental Health Planning Council, a client testified that in San Mateo County clients are living with four or more clients in a small two-bedroom apartment and giving up half or more of their SSI/SSP check for rent. The rest of the money goes to buy the food and other necessities they will need for the month.

Persons with mental illnesses face multiple barriers to finding and maintaining safe, affordable housing. Besides lacking adequate income, many people have co-occurring disorders, including alcohol and other drug abuse problems and acute or chronic physical health problems. They also face stigma associated with their illnesses and the fears of potential landlords or neighbors. Women who are homeless and mentally ill face additional gender/role barriers. They are more vulnerable to sexual trauma and violence. Some women are reluctant to access housing services for fear that their children may be taken away from them. Often, housing programs have rigid guidelines for women using the facilities. Women may not be able to comply with the rules if they have children in their care or other problems.

Persons with mental illnesses need the support of community mental health services to be able to maintain housing in the community. They also need access to a full continuum of housing, from crisis residential facilities through permanent supportive housing. The community residential treatment system, which was established in the 1980s, provides for a complete array of housing to meet the level of need of each client. The common thread among these programs is individualized focus on consumer needs and a rehabilitation and recovery-oriented philosophy. Some advocates, however, believe that although persons with mental illnesses have varying needs for support at different times in their illnesses, their housing does not necessarily have to change as those needs change. They believe that forcing an individual to move just when he or she has achieved some level of comfort and competence in a particular living situation may be detrimental and that housing arrangements should be permanent with flexible supports provided onsite or offsite for as long as the individual needs or desires them.

Regardless of what stakeholders believe is the best housing philosophy for mental health clients, the overall problem is lack of housing at all levels, which contributes to homelessness and inappropriate institutionalization. In some counties, housing is nonexistent, and clients must be sent to facilities in other counties to live. Many acute care hospitals must keep clients in an acute care setting for lack of placement in the community. This issue is becoming increasingly more critical. To make matters worse, California is experiencing a decline in board and care residences. Although board and care residences are viewed by many advocates as less than ideal housing for mental health clients, in many cases, these residences have been the only affordable and available housing option. The board and care rate under SSI is so inadequate that many board and care operators are evicting persons with mental illnesses who only receive SSI in order to provide services to persons who receive a county rate augmentation or "patch." Others are asking family members to pay the difference between SSI rates and market rates. Many providers are going out of business altogether, and many of the board and care residences that continue operate substandard programs that do not even meet minimum licensing requirements.

Although many clients want to live independently, some clients may have different goals due to cultural and ethnic differences. The mental health system needs to take into account how such differences might influence a client's preferred living arrangement. Housing should be culturally congruent. Independent housing may not be the ultimate goal of clients from different cultural backgrounds. For example, in some Asian families, young adults are expected to live with their families until they get married. In some Latino families, reintegration with the family may be the goal.

5.15. Recommendation: The State should provide more resources to mental health programs to provide for a full continuum of housing to mental health clients.

5.16. Recommendation: The DMH should encourage housing programs to reduce restrictions that present barriers to women with mental illness, including women with children. Programs should engage in outreach to women with mental illness, offer community support tailored to their needs as caregivers,

and be flexible in their requirements so that they do not preclude serving women with children.

Federal and State Efforts To Provide Housing

The DMH has received federal homeless funds through the Stewart B. McKinney Homeless Block Grant since 1985. Beginning in 1991, the funding came through the McKinney Projects for Assistance in Transition from Homelessness (PATH) formula grant. Each county with PATH programs has established one or more programs of outreach or services to persons who are homeless and have a mental illness.

In fiscal year 1998-1999, the DMH assumed an active role in the development of supportive housing for persons with serious mental illnesses who are homeless or at risk of homelessness. The DMH redirected increases from the PATH and SAMHSA programs to initiate a competitive grant process that resulted in mental health funding of 13 supportive housing demonstration projects in both rural and urban counties.

Additionally, pursuant to the California Supportive Housing Initiative Act, (Chapter 310, Statutes of 1998), the DMH became the lead agency in administering supportive housing grants for low-income persons with serious mental illnesses and/or other special needs populations. This legislation also established the Supportive Housing Program Council, which is comprised of representatives from state agencies, consumers, and family members who provide recommendations and support to the DMH in administering this grant program. Under the Supportive Housing Initiative Act, six supportive housing projects were funded in fiscal year 1999-2000, and five have been funded this year. The Budget Act for fiscal year 2000-2001 has provided an additional $25 million for additional new projects.

5.17. Recommendation: The DMH should continue its efforts in the statewide expansion and development of new supportive housing grants through both state and federal funding.

Olmstead v. L.C.

Problem: The number of residents in institutions for mental disease is increasing.

The United States Supreme Court ruling in the case of **Olmstead v. L.C.** issued in June 1999 stated that the Americans With Disabilities Act (ADA) requires that services be provided in the most integrated setting appropriate. The Olmstead decision requires that individuals who could benefit from community placement be identified and assessed for need of community services. These services must be made available in a reasonable period of time so that these individuals can transition to the community. California is obligated under the Olmstead decision to develop an effective working plan for transitioning individuals who can benefit from community services out of institutions and into the community. The Olmstead Plan is being developed by the Long-Term Care Council established by the California Health and Human Services Agency. The Long Term Care Council conducted local forums during September 2002 so members of the public and stakeholder organizations could provide input on community needs, preferences, and options for community living. It will convene the Olmstead Plan Work Group to address Olmstead implementation and intends to review recommendations that the Work Group generates from the local forums in January 2003.

In addition to the activities of the Long Term Care Council, the federal Center for Mental Health Services (CMHS) is assisting states to expand resources and opportunities for people with mental illness to live in their communities. The CMHS has offered annual grants for a total of three years to state mental health agencies for the purpose of organizing and supporting the activities of state-level coalitions to promote community-based care. To implement this grant, the DMH has contracted with the California Institute for Mental Health (CIMH) for a project coordinator to assist the Olmstead Plan Work Group in analyzing and reporting on the information and recommendations that are made at the local forums.

Many individuals in California who could benefit from community services remain institutionalized. As the number of civilly committed residents in state hospitals declines, the number of residents in institutions for mental diseases (IMD) is increasing. IMDs, which are primarily locked nursing facilities, have become a substitute form of institutionalization.

The State and the counties have an obligation under the Olmstead decision to reduce the use of IMDs. In addition, counties have a strong financial incentive to do this as well because mental health costs for most residents in IMDs are not reimbursable by Medi-Cal, and counties must fund these placements with 100 percent county dollars. Clearly, IMDs are not cost-effective. However, because local mental health programs lack a full array of residential treatment and affordable housing for mental health clients in California, they have difficulty placing many clients in less restrictive care.

One option for helping clients transition from IMDs into community placements is the IMD Transition Grant Program. This initiative was developed by the Long Term Care Council and is being implemented by the DMH, which will award grants to two programs. This program will address the expansion of community-based options for individuals currently residing in IMDs, including culturally competent, recovery-based services, protocols that can be replicated for determining placement readiness, community services needed, and the identification of barriers to placement. Unfortunately, the program, which was originally funded for three years, is being reduced to two years due to budget constraints. In fact, because the funding comes from the state General Fund, this program may be cut altogether from the budget for fiscal year 2002-03.

5.18. Recommendation: The DMH and county mental health departments should implement the Olmstead plan developed by the Long Term Care Council

5.19. Recommendation: The DMH should prepare a report with current data on IMDs, including their locations, populations, costs, average length of stay, residents' county of origin, and other relevant data. The report should make recommendations regarding options to reduce reliance on these facilities and to promote community integration and more cost-effective care.

5.20. Recommendation: If the IMD Transition Grant Program grants prove effective, they should be expanded to additional counties in California.

Productive Daily Activity

Productive daily activity includes engaging in meaningful daily activities, including education and training, volunteer activity, and competitive employment.

Education Supports and Reasonable Educational Accommodations

Problem: California lacks sufficient education supports and reasonable educational accommodations for persons with mental disabilities.

New opportunities to obtain a college education have opened up for mental health clients as Jackie Groshart, Psychological Disabilities Specialist, explains:

> Individuals with major mental illness often experience their first symptoms at the age when they would typically be entering college. In the past, depending on the severity of the symptoms, they have either been unable to pursue their education or have been severely limited in this area. Today with the advent of extremely effective medication and adjunct therapy to control symptoms and with the passage of legislation that ensures the right to accommodations, an increasing number of these students are able to attend school successfully (Groshart, 1997).

Educational accommodations and auxiliary aids that help to level the playing field for persons with disabilities in higher education must also be provided to qualified students with psychiatric disabilities. In addition to mandated accommodations, postsecondary education institutions provide varying degrees of educational support services depending on the segment, the individual campus, and whether funding is private or public.

Reasonable accommodations and support services encourage individuals with mental disabilities to enter or re-enter adult, postsecondary, and technical education institutions. Examples of reasonable accommodations include assistance with registration, testing accommodations (extended time or taking tests alone with a proctor) to alleviate difficulty during timed tests, tape recorders in class to remedy easy distractibility, note takers to compensate for

poor concentration, access to special parking, and seating arrangement modifications. Examples of supports include access to campus counselors trained in psychiatric disabilities, peer supports, advocacy skills training, access to special classes, such as stress management and memory enhancement, assistance accessing campus services and resources, such as financial aid, and assistance with retention-related problems while hospitalized.

Access to reasonable accommodations and related services for students with mental disabilities can help them be successful in higher education. Campus counselors must have a combination of counseling skills, a supportive and nonjudgmental attitude, and the knowledge of disability issues, but they do not necessarily need to be specialists in psychiatric disabilities (Parten & Tracy, in press). Some postsecondary institutions provide specialized counselors for students with mental disabilities, and a few community colleges offer specialized programs. However, most college counselors for students with disabilities and most adult education counselors may be unaware of the needs of this population. Adult and higher education institutions that have access to a wide range of counselors, services, and relevant curricula are able to successfully accommodate, serve, and support a wider range of students with mental disabilities (Parten & Tracy, in press).

5.21. Recommendation: County mental health departments should initiate education supports in collaboration with adult, technical, and postsecondary education institutions and expand existing on-campus and off-campus supported education programs.

5.22. Recommendation: County mental health departments should train staff in providing education accommodations and how to document a disability-related educational limitation.

5.23. Recommendation: Clients' interest in pursuing adult or postsecondary education or technical training should be assessed. Clients should be informed of their legal right to accommodations in higher education settings and of the specific accommodations, services, supports, and resources available.

5.24. Recommendation: County mental health departments should advocate for more funding, training, and education of adult and postsecondary education counselors who are specifically assigned to students with mental disabilities.

Employment

The Surgeon General Report on Mental Health states that people with severe mental illnesses tend to be poor (U.S. Department of Health and Human Services, 1999). Although the reasons are not understood, poverty is a risk factor for some mental disorders as well as a predictor of poor long-term outcome among people already diagnosed. People with serious mental illnesses often become dependent on public assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disabilities is approximately 90 percent. Women with mental disabilities have a lower employment rate than men with mental disabilities and appear to be underserved by rehabilitation services. Only 40 percent of people with mental illness who receive rehabilitation services are women (California Institute for Mental Health, 1999).

Problem: The mental health system lacks sufficient supported employment services for persons with mental illness.

The Surgeon General's Report also observes that an adequate standard of living and employment are associated with better clinical outcomes and quality of life. Although newer vocational rehabilitation and employment initiatives strive to remedy persistently high levels of unemployment, most consumers find themselves unable to work consistently or at all. This problem results from active symptoms, profound interruptions of education and employment caused by symptom onset and exacerbation, stigma and discrimination, lack of higher education programs, and being limited to low-paying, menial jobs.

The National Association of State Mental Health Program Directors (NASMHPD) describes the barriers to employment and the consequences of unemployment:

> The lack of jobs that provide flexibility for adults with serious mental illness is a major barrier to successful community living, a personal loss to people who wish to work, a societal loss to employers and taxpayers, and a barrier to successful recovery for those with mental illness.

> Chronic unemployment can lead to isolation, poverty, and a diminishing self-worth in any adult, hindering efforts at recovery. In addition, one residual effect of chronic unemployment for persons with psychiatric disabilities is the perpetuation of homelessness. The current high rate of unemployment among people with psychiatric disabilities—estimated at 85 percent—must be lowered. The focus should not only be on employment opportunities, but also on habilitation and rehabilitation, including integrated supported competitive employment to better enable individuals with mental illness to participate in the workforce (National Association of State Mental Health Program Directors, 2000).

Employment that is competitive, integrated, paid, and meaningful is of fundamental importance to the quality of life for persons with mental disabilities. The NASMHPD position statement on employment and rehabilitation makes the following points:

- State mental health authorities should assume a leadership role in significantly increasing the rate of employment among individuals with psychiatric disabilities.
- Vocational rehabilitation agencies and state mental health authorities should collaborate and design program linkages and develop a range of employment options to increase rehabilitation opportunities to individuals requiring mental health services.
- Mental health policymakers should work to maximize the availability of community supports and case management efforts that focus on employment issues early in the rehabilitation process.
- Employment support and rehabilitation standards must be flexible to accommodate the episodic nature of mental illnesses.
- Effective rehabilitation services must view successful rehabilitation for individuals with mental illness differently than for others, adapting to the needs of all individuals with psychiatric disabilities.
- Employment support must be an integral component of comprehensive community support programs (National Association of State Mental Health Program Directors, 2000).

5.25. Recommendation: County mental health departments should initiate new supported employment programs and expand existing programs for persons with mental disabilities.

Department of Mental Health/Department of Rehabilitation Cooperative Programs

County mental health departments and the California Department of Rehabilitation (DR) have joined together to provide an array of cooperative services throughout the State. These programs have been built with consumer and family member participation. They embrace the values of comprehensive service linkages; consumer career choice, placement in a competitive, integrated environment, reasonable accommodations, and ongoing support. Currently, 27 cooperative agreements exist. In addition, the DMH and the DR have an interagency agreement to provide coordinated vocational services for clients as they make the transition from state hospitals to local communities. Mental health professionals involved in these cooperatives continue to work with rehabilitation counselors through continuing education to identify the unique needs of persons with psychiatric disabilities.

5.26. Recommendation: The DMH/DR Cooperative model should be established in every county in California.

5.27. Recommendation: The DMH and DR should continue to provide staff with cross training about the needs of persons with mental disabilities.

Financial Status

Problem: Public assistance is not enough for clients to be able to afford anything other than the bare essentials.

Persons with mental illness should have an adequate income. According to the Department of Health and Human Services,

> …people with serious mental illnesses often become dependent on public

> assistance shortly after their initial hospitalization. The unemployment rate among adults with serious mental disorders hovers at 90 percent. Consequently, they must rely on government disability income programs, rent subsidies, and informal sources of economic support. Clients usually face such modest monthly budgets that there is no room for error. Funds are frequently depleted before the end of the month (U.S. Department of Health and Human Services, 1999, pp. 293-294).

5.28. Recommendation: The CMHPC should facilitate a coordinated advocacy campaign at both the federal and state level to increase income supports for persons with mental illness.

Problem: People have a disincentive or are afraid to work because they could lose their SSI/SSP or other benefits, such as Medi-Cal.

Being able to work does not preclude the need for long-term services and supports, such as counseling and medication. As the U.S. Department of Health and Human Services points out, those who work part-time, and even many with full-time jobs, may not be able to obtain adequate insurance through their employers to cover their ongoing medical needs. In addition, because of the long-term and fluctuating nature of some mental illnesses, people with psychiatric disabilities may continue to go through periods when they are unable to work, thus requiring the continuation of medical and other benefits (U.S. Department of Health and Human Services, 1999).

The National Council on Disability reports that a significant barrier to work is the possibility of losing benefits, "Many people with mental disabilities fear that if they work, the Social Security Administration (SSA) will declare them no longer disabled and therefore ineligible for further benefits, even though they have had no medical improvement. Because the probability of a recurrence is high, they are afraid to take the risk" (National Council on Disability, 1997, p. 2).

The National Alliance for the Mentally Ill (NAMI) has advocated at the federal level for flexibility in the Medicaid law to allow people with mental illness to remain working while accessing health benefits:

> People with severe mental illnesses and other disabilities should not be forced into (and stay in) poverty in order to access Medicare or Medicaid. At the same time, these programs need to remain in place as federal entitlements in order to ensure that persons whose symptoms or impairments are so severe that they cannot work are not at risk for losing cash benefits or health coverage (National Alliance for the Mentally Ill, 2000).

In 1999 the "Ticket to Work and Work Incentives Improvement Act" (PL 106-170) made improvements in disability programs, allowing Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) beneficiaries to work to the greatest extent of their abilities. This Act shifted the philosophy behind the nation's public disability programs, including SSI, SSDI, Medicaid, and Medicare, to programs that foster work, independence, and self-sufficiency for persons with mental illnesses.

PL 106-170 allows States to offer Medicaid coverage to SSI beneficiaries who go to work and allows a Medicaid buy-in for persons with disabilities who earn more than 250 percent of the poverty level. California enacted Chapter 820, Statutes of 1999, which implemented this provision. Any employed person whose income does not exceed 250 percent of the federal poverty level and who is disabled for specified purposes is eligible for Medi-Cal benefits subject to a sliding scale.

5.29. Recommendation: Providers, clients, and families should be educated about the reporting requirements if a client returns to work while in receipt of SSI or SSDI and the provisions that may be available to extend a client's benefits upon return to work or to reinstate benefits should the client be unable to continue working.

Legal Issues

Problem: Increased numbers of persons with mental illness are involved with the criminal justice system.

Factors contributing to the increase in persons with mental illness who are involved with the criminal justice system can be traced back to

the deinstitutionalization process of the 1960s as Izumi, Schiller, and Hayward (1996) explain:

> The expectation was that those persons not treated in the state hospitals would instead be treated in community settings. Unfortunately, reality did not live up to the plans of advocates and policymakers, and the mentally ill who previously would have been sent to state hospitals were instead often asked to fend for themselves, either on the streets or in the nominal care of relatives. Placed in this situation, the poor judgment, lack of control, and deteriorating living conditions of the mentally ill resulted, not surprisingly, in increased arrest rates (Izumi, Schiller, & Hayward, 1996).

Now 30 years later, community mental health resources are still inadequate. The mental health system is so overburdened that only those persons with the most serious mental illnesses are served. Chapter 3, Unmet Need for Public Mental Health Services, indicates that the public mental health system only serves approximately half of the total population in need of services. In many cases, the system does not have enough resources to use for anything other than acute hospitalization, which is the most costly, high-end intervention.

In 1993, the Los Angeles Board of Supervisors established the Task Force on the Incarcerated Mentally Ill. The task force studied the increasingly high rate of incarceration of persons with severe mental illness and provided recommendations. The task force delineated the factors contributing to criminalization of persons with mental illness:

> …it is clear that decreasing mental health resources and community support systems, increasing involvement of law enforcement officers with persons diagnosed with mental illness, insufficient intradepartmental and interagency collaboration, and very importantly, societal conditions disproportionately affecting persons with mental illness have resulted, at times, in the unnecessary criminalization of the target populations (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Chapter 617, Statutes of 1999 (AB 34) was enacted to provide outreach to adults with mental illness who are at risk of being homeless, who are homeless, or who frequently enter the criminal justice system. The goal of these programs is for communities to provide outreach, mental health care, and follow-up services for the homeless, including housing and employment assistance. Initially, funding was provided to three demonstration projects to determine the effectiveness of these programs. The success of these programs paved the way for increased funding, which was increased in the budget for fiscal year 2000-2001 to total approximately $55 million. Chapter 518, Statutes of 2000 (AB 2034) added additional language that allowed for expansions of the existing programs and permitted additional counties to participate in these programs. Currently, 26 counties have been funded, including the three initial pilot programs.

5.30. Recommendation: The State should fully fund programs that prove to be successful in providing outreach, mental health care, and follow-up services, such as the programs established by Chapter 617, Statutes of 1999 (AB 34) and Chapter 518, Statutes of 2000 (AB 2034).

Problem: The criminal justice system lacks law enforcement training, diversion programs, and discharge planning to treatment programs.

Mentally ill offenders (MIOs) are persons with mental illness who commit a crime and enter the criminal justice system. These people may become involved with the criminal justice system because of a lack of services, homelessness, or substance abuse. Many are detained or arrested for a variety of petty crimes, such as shoplifting or creating a public nuisance. Some may be detained for crimes that are more serious. Often, law enforcement officers will detain these persons in order to divert them into the mental health system rather than arresting them for a misdemeanor, such as disturbing the peace, trespassing, and vandalism. However, with the limited availability of mental health resources, law enforcement officers are frequently unable to find alternatives to incarceration.

The Los Angeles Task Force on the Incarcerated Mentally Ill also found that, "there are some persons that require secure correctional detention and who should receive appropriate mental health services within the jail. It is imperative, however, to develop cost-effective and humane strategies for diversion of minor offenders to mental health settings and to provide them with the necessary community support systems, including housing, to prevent recidivism" (Los Angeles County Task Force on the Incarcerated Mentally Ill, 1993, page 18).

Pre-Booking Interventions

Pre-booking interventions usually occur at the scene of an incident. Pre-booking interventions require that police officers be trained in crisis intervention. Some counties have developed accredited training through Peace Officers Standards and Training (POST). In Monterey and Santa Clara counties, this 40-hour training course teaches law enforcement officers to make appropriate decisions without having to resort to force when confronting a person with mental illness who is in crisis or who is acting dangerously. In addition, non-uniformed mental health professionals may be employed by or under contract to local law enforcement agencies to assist patrol officers to respond to incidents. Mobile community mental health center employees may respond to such incidents as part of a team with police. Mental health staff based at community mental health centers cooperate with police in responding to such incidents.

Post-Booking or Pre-Adjudication Diversion

Post-booking or pre-adjudication interventions take place once a person has been arrested or incarcerated. These diversion programs usually require an offender to comply with a plan in order to be released. A public defender, court officials, and mental health officials may develop a release plan and present it to the judge at the initial court hearing. The judge may withhold final disposition of the case for a period of time to ensure the client's compliance with the release plan.

5.31. Recommendation: Counties should advocate for all law enforcement officers to attend the POST-accredited 40-hour training course on mental health.

5.32. Recommendation: The DMH and other appropriate state entities should develop and provide grants to counties to implement diversion programs.

Problem: Mentally ill offenders in jails lack appropriate care.

The jail environment is not conducive to helping a person with mental illness. The local jail frequently does not have adequate staffing to provide the screening needed to identify offenders with mental illness. The jails are overcrowded, often exacerbating the problems being experienced by the mentally ill offender. Jail staff frequently lack training in dealing with persons with mental illness. During the booking process, most jail settings do not provide enough crisis management. The number of mental health staff in the jails is insufficient to provide mental health services; staff can only triage the most serious cases and dispense psychotropic medications. Many inmates are released before their request for mental health care can even be met. In addition, release planning is insufficient. Mentally ill offenders are often released unsupported into the community only to reoffend. Jail is meant to punish or control and is not meant for the care of a person with serious mental illness.

Another major problem for mentally ill offenders is that the prescription drug formulary for jail medical services is outdated and does not include the newer psychotropic medications. A change in medication can cause further destabilization and impede any progress that has been made if an offender was being treated with the newer psychotropic medications.

5.33. Recommendation: Counties should develop effective policies and procedures for securing the safety of individuals who have been diagnosed with mental illness to improve the quality of mental health services in their jails. These policies should include the following:

a) The local law enforcement agency should routinely screen all incoming detainees for mental illness.

b) Additional positions should be provided in jails to enable jail mental health staff to respond to requests for mental health services, provide mental health interventions, and participate more fully in release planning.

c) The jail medical formulary should include all of the latest psychotropic medications in order to ensure consistency with the client's current medication regimen and to ensure compliance.

5.34. Recommendation: Counties should adopt effective policies and procedures for screening and identifying all inmates for mental disorders, for providing appropriate mental health services, and for seamless transition into the community after release.

Mentally Ill Offender Crime Reduction Program

Chapter 501, Statutes of 1998 (SB 1485) established the Mentally Ill Offender Crime Reduction (MIOCR) program through the Board of Corrections with a $50 million appropriation. This program provided three-year grants to county sheriffs in 15 counties to help support mentally ill offenders during incarceration. It also provides appropriate support for these offenders upon release. These programs are helping to build relationships between law enforcement and mental health by providing community mental health services to people who would otherwise be released from jail with no mental health support and who would be likely to be re-arrested shortly thereafter.

The Budget Act for fiscal year 2000-2001 provided an additional $50 million to the Board of Corrections for this program, bringing the total amount of funding to $100 million and expanding the total number of programs to 30 in 26 counties. The first set of counties are in their third year of funding, and the second set are in their second year of funding. However, the last year of funding for the second set of counties is in danger of being cut due to the State's fiscal crisis. Evaluations will be completed on all of the programs and will be available in June of 2004.

5.35. Recommendation: If the MIOCR programs are proven effective, the State should fund these projects in any remaining counties that do not have a program.

Problem: The local court systems are not prepared to deal with persons with mental illnesses.

Most local court systems have limitations in their dealings with mentally ill offenders. Judges are often at a loss as to appropriate sanctions and punishment, and community treatment options are few or unavailable. A lack of coordination is evident when an inmate is released. For example, family members and community-based service providers are not informed of the date and time of a court hearing for a client they had supported or housed prior to incarceration. Many times, the judge will order an inmate's immediate release, which can take place in the early morning hours, without notifying anyone about the release.

5.36. Recommendation: Court officials should receive training to help identify, understand, and deal with persons with mental illness and with persons who have a co-occurring mental illness and substance abuse disorder.

5.37. Recommendation: All counties should establish an Interagency Policy Council, which includes the Mental Health Department, Alcohol and Drug Department, Sheriff's Department, Police Department, Probation Department, Superior Court, District Attorney, Public Defender, Housing Authority, Department of Social Services, Department of Health Services, Parole Department, Rehabilitation Department, clients, and family members. The duties of this council would be to coordinate discharge planning, provide consistent treatment of clients in jails, and implement and expand diversion programs.

Problem: Persons with mental illness are stereotyped by the public as being violent.

A study on violence and mental disability found that almost two-thirds of the public believes persons with schizophrenia are prone to violence against others (Monahan, Link, Stueve, & Kikuzawa, 1999). In many cases, people who have psychiatric diagnoses are being made scapegoats for society's violence when, in fact, these persons are more likely to be victims of crime or suicide. In actuality, persons with mental illnesses account for a very small percentage of the violence in American society. In a 1998 study, Monahan found that the prevalence of violence among people who have been discharged from a hospital and who do not have symptoms of substance abuse is about the same as the prevalence of violence among other people living in their communities who do not have symptoms of substance abuse (Monahan, 1998). In fact, the study concluded

that only 3 percent of violence in American society comes from persons with mental illnesses.

The public's perception that persons with mental illness are violent is exacerbated by the increasing number of persons with mental illness who are involved with the criminal justice system. In addition, some advocates believe that the association of violence with mental illness is being actively promoted publicly, playing off people's fears for public protection in order to increase resources and funding for the mental health system.

5.38. Recommendation: The Legislature and the DMH should implement a campaign to help educate the public about the misperception of the relationship between violence and mental illness.

Social Support Network

A program description from the Long Beach Village Integrated Services Agency, entitled "The Village Concept," observes that the needs of persons with mental illness for social support are no different from those of most people. After the basic needs of food, shelter, and clothing are met, the need for friendship and social interaction becomes apparent. When sufficient opportunity is provided to meet these needs, the individual has a sense of being embedded in a larger community. The individual develops a sense of dignity, self-worth, and belonging by having a definite role to play and a place in which to be and to grow.

Socializing and recreation teaches people social skills, provides them with leisure-time activities, and offers them involvement in community activities. Holshuh (1992) makes the following observation about how mental illness interferes with these natural processes:

> For persons with severe and persistent mental illnesses, onset of mental illness, acute episodes of symptoms, hospitalizations, and ongoing impairments have interfered with social development—forming relationships, making friends, getting married, getting and giving emotional support, and relating as adults with their families, employers, and landlords. In addition, these clients are a vulnerable group in need of but often lacking social support systems (Holshuh, 1992).

Spirituality

Problem: Clinicians need to increase their understanding of the importance of spirituality to a client's recovery.

Spirituality is an important part of the human experience. Every culture contains within it approaches to spirituality and its expression in the life of the members within. Spirituality is defined variously by different cultures. Primarily, spirituality deals with a person's orientation to transcendence and connection to a higher sense of being and meaning in life. At times clients may have distressing experiences that involve loss or questioning of faith, problems associated with conversion to a new faith, or questioning of other spiritual values that may not necessarily be related to an organized church or religious institution.

Many traditions present ways for individuals to access their spirituality and address some of these issues. Mental health providers should maintain respect for their clients' beliefs. Clinicians should obtain information on the religious or ideological orientation and beliefs of their clients so that they may consider the client's beliefs in the course of treatment. If an unexpected conflict arises in relation to such beliefs, it should be handled with a concern for the client's vulnerability to the attitudes of the clinician. Empathy for the client's sensibilities and particular beliefs is essential. Clinicians should maintain an open mind and attitude about spirituality in order to provide an opportunity for clients to bring their concerns into the treatment process.

5.39. Recommendation: Clinicians should become familiar with the Diagnostic and Statistical Manual IV section on religious or spiritual problems. Clinicians should not impose their own religious, anti-religious, or ideological systems of beliefs on their clients, nor should they substitute such beliefs or ritual for accepted diagnostic concepts.

Consumer-Operated Service Programs

Problem: Consumer-operated services should receive more support in local mental health programs.

The self-help movement grew out of the idea that individuals who have experienced similar problems, life situations, or crises can effectively provide support to one another. Consumer-operated service programs offer

support based on first-hand experiences with various issues, such as medication, social security and other income supports, housing, employment, human service agencies, families, and friends. These groups are formed by peers. They offer emotional support, friendship, individual advocacy, information about mental health issues, and a way to improve the mental health system. Long (1988) describes the range of programs that are consumer-run and their benefits:

> Consumer-operated programs include drop-in centers, case management programs, outreach programs, businesses, employment and housing programs, and crisis services, among others. Consumer staff are thought to gain meaningful work, to serve as role models for clients, and to enhance the sensitivity of the service system to the needs of people with mental disorders (Long, 1988).

A peer-run drop-in center provides an open, comfortable setting and often serves as the nucleus for a wide variety of support, service, and socialization activities. Services include self-help groups, training in independent living skills, advocacy and assistance in locating needed community resources and services, such as housing and financial aid, education about patients' rights, psychiatric drugs, and other topics of interest, social and recreational activities, and community or public education on mental illness.

5.40. Recommendation: The Governor and the Legislature should provide funding to ensure that consumer-run programs and peer supports are included as components in all local mental health services.

5.41. Recommendation: The State should provide training and technical assistance to local mental health programs to teach clients leadership, advocacy, and how to start and operate a peer support program.

5.42. Recommendation: The CMHPC should study the extent to which local mental health systems support opportunities for consumers to develop consumer-run services.

Families

Problem: Families of persons with mental illness need education and support.

The Adult System of Care must recognize the importance of families in the treatment and recovery of their adult family members with mental illnesses. Many persons with mental disabilities live with or in life-long contact with their families. Many look to their families for moral support as well as for specific help in their individual recovery. Families can make significant contributions in assisting clients in treatment planning, health and dental care, consumer rights and advocacy, crisis response, and housing. Many times, families act as unofficial "case managers."

The family's culture, which may include immediate family, extended family, and ethnic communities, should be recognized as part of the client's support system. Many multicultural clients live with their families and receive their support and strength through their families. Many of these families are non-English speaking and may need access to interpreters. These families need education on mental illness so they can provide their ill family member support and help in their treatment decisions and recovery. These families also need an orientation to the mental health system and how to access services.

Many county mental health departments have hired a "Family Advocate" to act as a coordinator and resource person for families. This action has helped to ensure that families are involved in all stages of service delivery when desired by the client.

5.43. Recommendation: Family Advocates should be employed by both county-operated mental health programs and community mental health agencies.

5.44. Recommendation: Local mental health programs should provide families education and support to help them understand their family member's illness and how best to provide support to that family member.

5.45. Recommendation: Local mental health programs should develop family education programs targeted to the needs of racial, cultural, and ethnic families.

Problem: Family members of persons with mental disabilities lack respite services.

Family members of persons with mental disabilities also need support and respite services. They are under a great deal of stress caring for and obtaining resources for their

family members who are mentally ill. Family members also feel stigmatized by society's attitude toward their family member's illness. Support organizations, such as NAMI California, help family members cope with the added stress and find available resources. In addition, family self-help groups result in better communication and interaction among family members.

In 2000 the Joint Committee on Mental Health Reform (JCMHR) held a series of public hearings throughout the State to gather information and make recommendations about the mental health system. These hearings revealed that respite care is one of the greatest unmet needs of family members who care for children and adults with serious mental illness. Lack of respite services results in caregiver "burnout."

5.46. Recommendation: The mental health system should provide respite services to family members of persons with mental disabilities.

Community Involvement

Problem: Clients and family members perceive a lack of involvement and partnership in the mental health system.

During the JCMHR hearings conducted in the spring of 2000, a recurrent theme kept surfacing that clients and family members felt a lack of respect and partnership in the mental health system as well as a lack of access and a meaningful role in system design and implementation. The JCMHR also heard repeatedly from clients and families who had benefited from peer support activities, including self-help programs and family support programs. Through the support of family and peers, clients begin to become more involved in their community. Many clients have become community activists, helping other clients to navigate the human services system in their community.

Clients are also becoming a political force. Campaigns to register to vote are underway as well as voter education to enable clients to vote for the candidates and measures that will benefit their lives the most. Clients are also volunteering in their communities for a variety of service-oriented tasks. Becoming involved in the community makes recovery a tangible goal.

5.47. Recommendation: The DMH and local mental health programs should provide training and resources to help clients and their families have meaningful involvement in the design and implementation of mental health programs.

5.48. Recommendation: The mental health system should develop specific ways to integrate persons with mental disabilities into the community, including joint projects with civic groups; education of the community by family, client, and professional organizations; and media coverage and presentations to legislators, civic and business organizations, community agencies, and schools concerning mental health issues.

Problem: The mental health system lacks community resources to support outreach and education to clients, families, and communities.

Community involvement and community-based supports are extremely important, especially for clients from multicultural communities. Each region in California has a different need for community support based on the demographics of that area. More coordination is needed between various community organizations and agencies so that prevention services can be offered rather than providing costly inpatient services. In order to accomplish this goal, more bilingual, bicultural, and ethnically diverse clinicians are needed. In the meantime, the existing mental health work force should be educated to be more sensitive to ethnic and cultural differences and to recognize strengths within each cultural and ethnic community.

5.49. Recommendation: The DMH should assess the needs of each region in California and provide more resources to local communities to provide appropriate services, especially prevention and intervention.

5.50. Recommendation: The DMH and local mental health programs should provide special focus to ethnic communities to educate them how to support clients with mental illnesses and to assist mental health organizations to provide support to multicultural clients.

Social and Cultural Stressors

Problem: Social and cultural stressors of racism and discrimination contribute to the poor levels of clients' mental health.

Article 1 of the United Nations Declaration on the Elimination of All Forms of Racial Discrimination indicts racism, stating that

discrimination on the grounds of race, color, or ethnic origin is an offense to human dignity and shall be condemned as a violation of human rights and fundamental freedoms (General Assembly, 1963).

In addition to having a pernicious affect on the societal level, racism affects the health and mental health of racial and ethnic minorities:

> Racism and discrimination are stressful events that adversely affect health and mental health. They place minorities at risk for mental disorders such as depression and anxiety. Whether racism and discrimination can by themselves cause these disorders is less clear, yet deserves research attention (U.S. Department of Health and Human Services, 2001, p. 42).

Research has shown the existence of striking disparities in access to mental health services among ethnic groups (U.S. Department of Health and Human Services, 2001). According to the Surgeon General's Supplement on Mental Health, Race, Culture, and Ethnicity (2001), "Most minority groups are less likely than whites to use services, despite having similar community rates of mental disorders" (p. 3). Moreover, when minority populations receive mental health services, these are poor in quality (U.S. Department of Health and Human Services, 2001). "Lower utilization and poorer quality of care, means that minority communities have a higher proportion of individuals with unmet mental health needs" (p. 3).

Table 1 illustrates a disparity between whites and minority groups in utilization of mental health services. In contrast, the non-white group, who are 40 percent of the clients, received only 34 percent of the services.

Table 1: Number of Outpatient Medi-Cal Clients and Outpatient Units of Services for Fiscal Year 1999-2000 for Whites and Non-Whites

Ethnicity	Clients Statewide	Percent	Outpatient Units	Percent
White	155,712	60.49	4,050,794	65.91
Non-White	101,685	39.50	2,094,644	34.08
Total	257,397	100.00	6,145,438	100.00

Controversy exists over the causes of these disparities in utilization between whites and minority groups. The Surgeon General's report examines one potential cause: the issue of clinician bias and stereotyping. It indicates that clinicians often reflect the attitudes and discriminatory practices of their society, also known as institutional racism (Whaley, 1998). While racism and discrimination have diminished over time, traces remain, which appear as less overt medical practices concerning diagnosis, treatment, prescribing medications, and referrals (Giles, Anda, Casper, Escobedo, & Taylor, 1995). For example, African American patients are subject to overdiagnosis of schizophrenia and are underdiagnosed for bipolar disorder (Bell & Mehta, 1980), (Bell & Mehta, 1981), (Mukherjee, Shukla, Woodle, Rosen, & Olarte, 1983). In another example, widely held stereotypes of Asian Americans as "problem free" may prompt clinicians to overlook their mental health problems (Takeuchi & Uehara, 1996).

The Surgeon General's report cautions that, although some of the racial and ethnic disparities it describes are likely the result of racism and discrimination by white clinicians, the limited research on this topic suggests that the issue is more complex. Mistrust of mental health services is also an important reason minorities do not seek treatment. Further study is needed on how to address issues of clinician bias and diagnostic accuracy (U.S. Department of Health and Human Services, 2001).

The Adult System of Care Framework developed by the California Mental Health Directors Association (CMHDA) articulates a vision of an ideal, fully funded, and culturally and linguistically competent, age appropriate, and

gender sensitive Adult System of Care.[1] Social and cultural stressors, including discrimination in employment, education and housing are identified. The framework provides numerous strategies that should be implemented to address these stressors directly. Implementation of the Adult System of Care Framework and training programs in the mental health system on the effects of racism will reduce and eventually eradicate the cases of racism and discrimination in the mental health system.

5.51. Recommendation: Local mental health programs should provide ongoing training to staff utilizing educational approaches on the effects and practices of racism. This training will increase awareness and cultural sensitivity of providers.

5.52. Recommendation: The DMH should ensure that training to combat racism is offered by local mental health programs in a timely fashion and meets acceptable standards relevant to cultural and ethnic issues.

5.53. Recommendation: The State Quality Improvement Council should monitor trends in the utilization of modes of services by ethnicity and develop recommendations to eliminate racial and ethnic disparities should they persist over time.

Problem: Mental health providers do not address the level of acculturation and the racial, cultural, and ethnic identity of ethnically diverse clients.

Acculturation refers to the process that leads to changes in a person's values, attitudes, and behaviors as a result of interaction with a second culture (Aponte & Johnson, 2000). Moving to a new culture may require adjustments in some or all of the aspects of daily living, including language, work, shopping, housing, children's schooling, health care, recreation, and social life. Acculturation is often considered to have an impact on the mental health of the individual who is experiencing the process of acculturation (Kvernmo, 1998). Some persons choose to acculturate by immigrating to a new country; others have been forced to take part in it, e.g., indigenous people and refugees. When individuals experience acculturation and the process is too overwhelming, creating problems that they cannot resolve, acculturation will result in stress and psychopathology (Kvernmo, 1998).

Another important concept in identifying the psychological needs of ethnically diverse clients is ethnic or racial identity. Ethnic or racial identity relates to the process and outcome of integrating ethnic and racial aspects into a person's overall self-concept and identity (Helms, 1990). Identity development is a psychological process in which individuals become aware of or ascribe meaning to racial or cultural material and integrate this information into their overall self-concept (Aponte & Johnson, 2000). Ethnic identity describes an individual's awareness and sense of self as a racial, ethnic, or cultural being.

To serve ethnically diverse clients, mental health practitioners must be culturally aware enough to respond effectively to those that they hope to serve. Clinicians need to be aware of the client's acculturation process and incorporate it into services provided to the client. Numerous tools to access an individual's level of acculturation are available, some of which are specific to particular ethnic groups and many of which have been translated into the major languages of California's diverse populations. The Acculturation Rating Scale for Mexican Americans developed by I. Cuellar is one of the most widely used instruments.

5.54. Recommendation: Local mental health programs should evaluate the awareness, sensitivity, and respect for the acculturation process of mental health providers and support staff in order to guarantee appropriate engagement with racially, culturally, and ethnically diverse mental health clients.

5.55. Recommendation: Local mental health programs should evaluate clinicians' therapeutic skills and cultural knowledge to ensure that it is compatible with the needs of ethnically diverse clients that the clinician serves.

5.56. Recommendation: Local mental health programs should increase training for clinicians to address the dynamics of the acculturation process and its relationship to diverse communities and their mental health treatment needs.

[1] The Adult System of Care Framework can be accessed online at www.cmhda.org/documents.html#assoc.

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CHAPTER 6

THE PLANNED SYSTEM OF CARE FOR OLDER ADULTS

WHAT ARE THE VISION, MISSION, AND VALUES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The mental health constituency envisions a society in which older adults live in families[1] that support and value their ability to be happy, healthy, and resilient. The public mental health system promotes this vision through participation in a culturally and linguistically competent community-based system of care, which fosters a life-span approach. The purpose of creating a public mental health system that collaborates with the social, health, and long-term care systems of care is to accomplish the following goals for older adults and their families:

- Older adults are healthy
- They are safe
- They live at home
- They engage in meaningful and productive activities
- They have supportive relationships with others
- They have meaningful connections to their communities
- They abide by the law

Counties may be in different stages of implementing an Older Adult System of Care or they may have different needs for mental health components outlined in this chapter. The following values should guide counties when implementing an Older Adult System of Care:

1. **Quality of Life**—The ultimate goal of the older adult system of care is to establish or re-establish quality of life as defined by the older adult in partnership with his or her family and community natural support system. Recovery is supported by timely access to high quality clinical services of demonstrated effectiveness delivered by skilled and motivated clinical personnel who can use culturally based interventions as defined by the clients' culture. Culturally based practices that are identified and selected by the client should be integrated components of quality clinical care.
2. **Client Strengths**—Services should focus on assets and strengths of older adults and on using those strengths to help older adults retain a sense of identity, dignity, and self-esteem.
3. **Empowerment**—Services should be provided in a manner promoting the fullest possible personal control over one's life.
4. **Self-help**—Continued effort should be made to develop service systems, such as peer counseling programs, that focus on self-help and use older persons as mental health service providers.
5. **Cultural and Linguistic Competence**—Services should be provided in a manner respecting a client's culture of origin, particularly for older adults who have strong ties to cultural approaches to mental and physical health care. Staff composition should reflect the ethnicity and language of the client population.
6. **Assessment and Treatment Protocols**—Assessment, treatment protocols, and guidelines should be age-appropriate and gender-appropriate. Services should meet the special needs of older women and reduce the barriers to services they face, including poverty, isolation, failing health, and substance abuse.
7. **Access to Community-based Services**—Access to services must include mobile outreach services because older adults have unique problems that limit their capacity to access services. These problems include lack of mobility, social isolation, sensory losses, and development of age-associated physical problems. Mental health services

[1] The term "family" is used in its broadest sense to include any adult engaged in supporting the older adult in his or her life.

should be provided in the least restrictive, most natural setting possible, including senior centers, housing programs, nutrition sites, nursing facilities, and other residential and community settings.

8. **Preventing Inappropriate Institutionalization**—Systems of care must place a high priority on providing services to older adults with serious mental illnesses at risk of inappropriate institutionalization, especially older women with mental illness who are at greater risk of institutionalization than their male counterparts. When institutionalization cannot be prevented, it should be for the minimum length of stay needed to achieve a therapeutic outcome.
9. **Preventing Suicide**—Services should provide for appropriate screening and assessment for depression and other risk factors, signs, and symptoms associated with suicide among older adults.
10. **Multidisciplinary Service Coordination**—Older persons with multiple problems, such as mental illness, physical disabilities, and substance abuse, may encounter multiple service providers; therefore, mental health planning requires multidisciplinary service coordination. Communities must establish formal linkages among providers of health care, social services, aging services, drug and alcohol programs, developmental disabilities services, and mental health services.
11. **Medical/Psychiatric Interface**—General medical conditions can cause or contribute to mental impairment. The system of care should strive for an integrated, cost-effective diagnostic and treatment interface between the physical health care system and the mental health care system. Difficult medical cases should be handled through appropriate referrals.
12. **Family and Community Involvement**—Involving families in planning, implementing, and evaluating programs for older adults is a crucial element. Services should take place in an environment that includes family, friends, clergy and the spiritual community, and other informal support groups.
13. **Support Services for Caregivers**—Support services should be provided for caregivers of older adults since burn out of caregivers has been identified as the single most important factor contributing to premature institutional care.
14. **Education and Prevention**—Mental health promotion and wellness activities should be available to older adults. Written materials should be understandable, in the person's primary language, and in large print.
15. **Multiple Funding Sources**—Service availability for older adults will require using all funding resources available to meet the mental health needs of older adults, including federal, state, local, and other third-party payers.

WHAT SHOULD THE TARGET POPULATION BE FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

Older adults in need of mental health services have three routes for establishing eligibility to receive publicly funded mental health services: the target population definition for realignment-funded services, the Medi-Cal medical necessity definition, and, if they live in four specific geographic catchment areas for the Older Adults System of Care Demonstration Project, the target population definition for that project.

Target Population Definitions

Target populations for mental health services funded by realignment revenue are contained in the Welfare and Institutions Code (WIC), Section 5600.3. This definition applies to both adults and older adults. To the extent resources are available, an adult or older adult who meets the following target population definition is eligible to receive mental health services from county mental health departments:

- A person who has a serious mental disorder who also meets the following criteria:

- Diagnosis of a mental disorder as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a substance abuse or developmental disorder or acquired traumatic brain injury unless that individual also has a serious mental disorder as defined in the statute,
- As a result of the mental disorder, the person has substantial functional impairments or symptoms, or a psychiatric history demonstrating that without treatment there is an imminent risk of decompensation to having substantial impairments or symptoms, and
- As a result of a mental functional impairment and circumstances the person is likely to become so disabled as to require public assistance, services, or entitlements.

- A person who requires or is at risk of requiring acute psychiatric inpatient care, residential treatment, or outpatient crisis intervention because of a mental disorder with symptoms of psychosis, suicidality, or violence, and
- A person who needs brief treatment as a result of a natural disaster or severe local emergency.

Mental health services are also funded through Medi-Cal. To be eligible for services reimbursed through Medi-Cal, Medi-Cal beneficiaries must meet the medical necessity criteria, which are described in Title 9, Chapter 11, Section 1830.205. The complete medical necessity definition is provided in Appendix I.

To satisfy the medical necessity definition, beneficiaries must meet three criteria: one related to diagnosis, one related to impairment, and one related to intervention criteria. A beneficiary must be diagnosed by the mental health plan with specific diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association (see Appendix I for the complete list of diagnoses).

As a result of the listed mental disorders, a beneficiary must have a significant impairment in an important area of life functioning or probability of significant deterioration in an important area of life functioning.

The final criteria for medical necessity relates to the intervention. Each of the intervention criteria listed below must be met:

(A) The focus of the proposed intervention is to address the identified impairment.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or
2. Prevent significant deterioration in an important area of life functioning.

(C) The condition would not be responsive to physical health care based treatment.

When all three of these criteria are met (diagnosis, impairment, and intervention criteria), beneficiaries shall receive specialty mental health services for an included diagnosis even if a diagnosis that is not included is also present. Thus, individuals with dementia could receive mental health services as long as they also have a mental disorder included in Appendix I.

The third target population definition is for the Older Adults System of Care Demonstration Project.[2] It has the following elements:

5689.2. (a) The target population to be served pursuant to this article shall be adults who are 60 years of age or older, diagnosed with a mental disorder, as defined by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, who have a functional impairment, and who meet any of the following criteria:

(1) Are severely and persistently disabled.

(2) Are acutely disabled.

(3) Are impacted by disasters or local emergencies.

(b) For purposes of this article, "functional impairment" means being substantially impaired in major life activities because of a

[2] This project is described more fully later in the chapter in the section entitled, *What State-Level Initiatives Have Been Established For Older Adults?*

mental disorder in at least two of the following areas on a continuing or intermittent basis:

(1) Independent living.

(2) Social and family relationships.

(3) Vocational skills, employment, or leisure activities.

(4) Basic living skills.

(5) Money management.

(6) Self-care capacities.

(7) Physical condition.

Eligibility and Funding Issues

Older adults in need of mental health services fall into three categories: some have only a mental disorder; some have co-occurring mental disorders, such as depression and dementia or depression and substance abuse; and some have dementia with psychological symptoms, such as psychotic symptoms or depressive symptoms, which respond to mental health treatment. Older adults who are severely and persistently disabled by a mental disorder listed in the medical necessity criteria will meet all three target population definitions.

Older adults with dementia face unique challenges accessing publicly funded mental health services, and each target population definition poses different challenges. The Medi-Cal medical necessity definition is the most restrictive. With this definition, an older adult must have co-occurring diagnoses of a mental disorder, such as depression or bipolar disorder, and dementia.

The problem is that for a significant proportion of older adults seeking mental health treatment the only mental disorder with which they can be diagnosed is dementia. As a result, they do not meet the Medi-Cal medical necessity definition. Noncognitive psychiatric disturbances are common in patients with dementia, with at least a third of them exhibiting psychotic and/or depressive symptoms (Dilip, Alexopoulos, & Bartels, 1999). The Stanislaus County Older Adult System of Care Demonstration Project substantiates this estimate. It reports that in its first year 71 (26%) of the 275 older adults who were assessed for need of mental health treatment had a dementia-only diagnosis (Mallock, 2002).

The target population definition for realignment-funded services in WIC Section 5600.3 is more inclusive than the medical necessity definition, but it poses different problems for access to mental health treatment. Older adults with co-occurring diagnoses of dementia and a mental disorder would be eligible for services as would an older adult with only a diagnosis of dementia who was experiencing psychological symptoms, such as depressive or psychotic symptoms. However, in reality realignment funds would rarely be used to treat older adults with dementia because county mental health departments for the most part have to use realignment funding for their required match to the federal Medi-Cal reimbursement they receive. Legally, counties are required to meet the needs of their Medi-Cal beneficiaries.

Moreover, county mental health departments are reluctant to serve clients with dementia because when these clients are admitted to acute psychiatric facilities they frequently remain in these facilities on administrative day status because appropriate residential placements cannot be found for them in the community.

In fiscal year 1999-2000, clients with dementia who were Medi-Cal beneficiaries were on administrative day status an average of 31 days per client before another placement could be found for them. This length of stay is more than double the average length of administrative day stays for most other diagnostic groups. Moreover, the average length of administrative day stays has been increasing for clients with dementia. In fiscal year 1998-99, it was 19.4 days for Medi-Cal beneficiaries with dementia. Clients are placed on administrative day status when they no longer require the acute level of care and are ready to be discharged.

Administrative day status is disadvantageous to the county mental health department because the administrative day reimbursement rate does not cover the cost of care. Combined with the lack of adequate residential placements in the community, the administrative day rate serves as a disincentive to treat clients with dementia needing mental health treatment. In addition, clients with dementia have ever increasing medical needs that the mental health system is not equipped to handle.

The Older Adults System of Care Demonstration Project is the most inclusive service system because of its target population definition and its funding sources. The target population definition does not place any restrictions on the mental disorders in the DSM that qualify a person for mental health services. Thus, an older adult with dementia and psychological symptoms is eligible for services.

The Older Adults System of Care Demonstration Project is funded with $2.015 million from the Substance Abuse and Mental Health Services Administration (SAMHSA) Block Grant. The pilot projects are operating in four counties: Humboldt, San Francisco, Stanislaus, and Tuolumne.

Staff from the pilot projects report that they assess all older adults requesting mental health services. Then, the diagnosis determines the treatment plan and funding stream. The pilot projects have three funding streams: the SAMHSA Block Grant, realignment funds, and Medi-Cal. Older adults with co-occurring diagnoses of dementia and a mental disorder meet the Medi-Cal medical necessity definition. Older adults with a diagnosis of dementia and psychological symptoms would be eligible for services funded by realignment or the SAMHSA Block Grant. The SAMHSA Block Grant funds that the pilot projects receive are the most flexible funding source that enables the pilot projects to respond to the needs of these older adults. Some pilot projects take advantage of all three sources of funds; others use only the SAMHSA Block Grant funds.

Recommended Target Population Definition

The target population definition in WIC Section 5689.2 for the Older Adults System of Care Demonstration Project should be the definition used for the Older Adult System of Care when sufficient resources become available. In addition, other populations should also receive publicly funded mental health services, including persons with adjustment or other disorders who do not have acute or high-risk symptoms. These persons would usually benefit from outpatient or peer counseling services. Unless they receive mental health services, they sometimes become members of the target population. Wellness programs reaching older adults who are not currently ill but who might become ill at some point would also be beneficial should additional funds become available. These programs might include educational efforts for older adults on how to deal with bereavement and other issues.

The Older Adult System of Care must have sufficient unrestricted fiscal resources to serve older adults meeting the recommended target population definition who need mental health services. The funding should not be limited to older adults with co-occurring mental disorders as it is for the Medi-Cal necessity definition. The State should design a comprehensive system of care to meet the needs of older adults for health care, mental health care, and residential care in their communities. Because adequate resources would be appropriated to fund this system of care, county mental health programs would not be reluctant to offer their services to clients with dementia because they would know that they would be reimbursed for services that they provide and that the other service components that older adults need would exist.

The target population definition and adequate funding are two of the basic components of a system of care. The remaining sections in this chapter describe the other essential elements for developing a system of care.

WHAT ARE THE MAJOR PROBLEMS AND NEEDS OF OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

Older adults are one of the most underserved groups in California's mental health system, yet they are the fastest growing segment of the State's population. The incidence of psychosis among older adults is more than double the rate for individuals 20 to 35 years of age (Cohen, 1980). Fourteen percent of California’s population is 60 years of age and older. By the year 2010, the first influx of baby boomers will constitute 29.2 percent of California’s total population over 60 years of age. By the year 2020, baby boomers will constitute 70.2 percent of California’s total population over 60 years of age. By the year 2020, older adults will represent 21 percent of California’s total population. The National Institute of Mental Health reports that about 15 to 25 percent of persons over age 60 will require some form of mental health services. In addition, the influx of immigrants who are indigent is increasing the utilization of public

mental health services. However, the actual rate at which older adults use mental health services nationally is unknown due to lack of adequate, valid data.

Older adults have special problems that must be considered in developing the types and mix of services to be provided. Among these problems are increasing cultural and linguistic isolation, substance abuse and misuse, sensory loss, homelessness, economic hardship, cognitive impairments, decreasing physical mobility, increasing physical and bio-chemical impairments, poor nutritional status, comorbidity, vulnerability to overmedication, and loss of interpersonal, social, and family support networks that make treatment more complex.

Older adults have a wide range of mental health problems, including depression, which if not properly diagnosed and treated frequently result in high suicide risk and a functional disorder resembling dementia. Indeed, men over the age of 75 have the highest suicide rate in the population. Despite the severity and prevalence of mental disorders among older adults, most of them do not access mental health services. Barriers to mental health care for older adults include:

- The stigma this age group associates with mental illness
- Cultural and linguistic barriers that are encountered by multicultural persons and their families when seeking mental health services
- Isolation of older adults
- Lack of accessibility, availability, and visibility of services
- Lack of transportation
- Lack of staff adequately trained to provide age-appropriate services
- Prevailing myths regarding inability of older adults to benefit from mental health intervention
- Lack of adequate integrated assessment of mental and physical problems that contribute to impaired mental functioning

As the demographics of California changes, the proportion of older adults who are bilingual and monolingual increases. These older adults have special problems as they age. Bilingual older adults, who previously may have been able to function in English, may experience a decrease in their English fluency and may revert to their primary language as a part of the normal aging process. Under stress and mental illness, this process becomes even more pronounced. Attention needs to be paid to this population who previously were able to address their needs in English. Provisions for increased bilingual, culturally competent staff and trained interpreters/cultural brokers needs to be made in the system of care for older adults.

Another problem that older adults with psychiatric disabilities face is that as they age they have an increase in illnesses and injuries, which often result in permanent or temporary physical disabilities. Since this population frequently lives alone or in group housing situations, family support is often unavailable to provide temporary or permanent care to allow them to remain in their own housing. As the amount of publicly funded in-home support services (funded under county social services departments) and home health services (funded by Medi-Cal or Medicare) is severely limited, older adults with psychiatric disabilities who experience illness or injury are frequently forced into residential care, institutions for mental disease, or convalescent hospitals to receive this level of care.

WHAT SERVICES AND PROGRAMS SHOULD BE PROVIDED TO OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES?

In developing a system of care, these minimum service standards are required: early detection and prevention, mobile and clinic-based outreach, assessment, and treatment, medical screening, crisis intervention, medication services, including education about medication management and symptoms, service coordination, day treatment services, 24-hour acute care, community support and rehabilitation, senior peer counseling, and residential services. All services provided should be culturally, racially, and linguistically respectful and competent.

A system of care for older adults must include a comprehensive medical and psychiatric model. For older adults suffering from multiple and severe illnesses, service coordination, including the interface with medical providers, will be

increasingly important. As symptoms increase in severity, older adults experience reduced mobility and have an increased need for mobile services. For older adults, home-based mental health services are most cost-effective compared to the high cost of hospitalization or emergency room visits.

Table 1, which follows, lists all the services that should be in place in each county in order to have a comprehensive system of care for older adults. This table describes the optimal system of care; however, no county has implemented such a full range of services. Service providers should be cognizant of ethnic, cultural, and linguistic issues and should integrate these issues into mental health and other services. The following principles should be considered in developing services for older adults:

- Degenerative brain disorders are a disease process and not a normal process of aging
- A complete psychiatric assessment for older persons must include a physical and psychosocial evaluation
- Older persons can respond to psychotherapy and other forms of counseling and rehabilitation treatment
- A comprehensive array of services will include service coordination and family support, when available, to ensure continuity of care throughout treatment and appropriate coordination with social support services and medical treatment
- A multidisciplinary team approach is essential in diagnosing and delivering mental health services
- Programs for older adults must provide transportation for clients and staff to ensure frail or homebound older adults receive services
- A comprehensive system of care for older adults must be culturally and linguistically competent and should include family members and other support systems, such as traditional and spiritual healers
- All programs should have available staff who are culturally and linguistically competent and specifically trained in caring for older adults
- Older adults need community-based, long-term care services. In-home mental health services should be provided and coordinated with physical health care resources. Adult day health care should be emphasized because it can help older adults remain in the community and also provides respite for family members.
- Counties should develop peer support groups and outpatient treatment programs to prevent older adults from falling through the cracks or becoming more seriously ill. These services should be tailored to consumers in their natural support system.

Table 1

NEEDED COMPONENTS IN THE PROPOSED SYSTEM OF CARE FOR OLDER ADULTS

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Level I (Prevention)																				
Information & Referral	X	X	X	X	X			X	X	X	X	X		X			X	X	X	X
Outreach/Aging Education	X	X	X		X			X	X		X	X		X			X	X	X	X
Outreach/Pre-Retirement Seminars		X			X				X								X		X	
Transportation		X					X		X	X										
Other Aging Services (e.g., Senior Center, Nutrition)		X							X		X			X					X	X
Friendship Phone Line	X	X						X	X			X		X			X			
Vocational Training/Senior Employment		X							X						X	X			X	

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Socialization		X			X				X			X		X			X			
Health Education		X	X					X	X	X	X	X			X	X	X		X	
Family Support Groups	X	X						X	X			X		X			X		X	
Medical Services for Differential Diagnosis	X		X					X	X		X	X								
Advocacy	X								X	X	X						X			
Money Management				X						X							X			
Assisted Living									X					X						

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Level II (Least Restrictive Intervention)																				
Peer Counseling	X	X	X					X	X					X			X		X	
Outpatient Treatment Services	X		X					X	X		X	X								
Individual & Group Therapy	X							X	X		X	X								
Mobile Crisis	X		X	X				X	X			X								
Walk-in Crisis	X							X	X		X	X								
Mental Health Services Advocacy	X	X						X	X	X							X	X	X	
Day Habilitative Treatment	X	X							X		X	X					X			
Social Day Care		X						X	X								X			

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Support Groups	X	X	X					X	X					X			X			
Respite Services	X	X			X				X		X			X			X			
In-home Supportive Services		X			X				X											X
Mental Health Services at Senior Centers	X	X						X	X								X			
Semi-independent/ Shared Housing	X	X				X	X		X											
Elder Abuse/ Neglect Interagency Team	X	X	X	X	X		X	X	X	X	X									X
Substance Abuse Services (Outpatient & Inpatient)	X		X					X	X		X						X			
Case Management	X	X	X	X	X			X	X	X	X	X		X						X

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Linkages Program		X							X					X					X	
Regional Resource Centers	X								X									X		
Rehabilitation Services										X		X		X	X					
In-Home Health Care									X			X								X
Partial Hospitalization											X	X	X							
Hospice					X							X								
Level III (Moderately Restrictive)																				
Intensive Day Treatment	X								X		X	X					X	X		

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Alzheimer's/ Directed Day Care		X							X		X	X					X		X	
Supervised Group Home	X	X			X			X	X											
Residential Care Facilities for Seniors	X	X			X			X	X											
Therapeutic Foster Care	X	X			X			X	X											
Crisis and Transitional Beds	X			X	X			X	X		X									
Money Management-Representative/ Sub-payee, Power of Attorney	X	X			X				X	X							X			X
Acute Care -- Gero/Medical Psychiatric. (Hospital or Psychiatric Health Facility)	X		X						X		X	X								
Adult Day Health Care		X							X								X	X	X	X

	County Mental Health	Area Agency on Aging	Local Health Services	County Adult Protective Services	Local Social Services/ Human Services	Local Housing Authority	Local Transportation Agency	Drug & Alcohol Services	Community-based Organizations	Public Guardian/ Conservator	Private Practice Provider	Health Maintenance Organizations	Law Enforcement	Faith-based Organizations	Vocational/ Social Rehabilitation	Higher Education	Caregiver Resource Centers	CA Department of Mental Health	CA Department of Aging	CA Department of Developmental Services
Multipurpose Senior Services Program/ Ombudsman/ Patients' Rights Advocate	X	X							X								X	X	X	X
LPS/Probate Conservatorships of Person or Estate	X			X	X				X	X										X
Level IV (Most Restrictive)																				
Skilled Nursing Facility	X		X						X		X							X		
Skilled Nursing Facility with Treatment Patch	X		X						X		X							X		
Secure Facility	X		X						X		X							X		
State Hospital	X																	X		

WHAT ARE THE INTERAGENCY PARTNERSHIPS FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

The need for coordination of services with a fixed point of responsibility is paramount. Many services to older adults with mental illness as well as physical health problems are delayed because of the lack of coordination between the mental health system and the medical system. Blended funding is needed to enable mental health providers to offer wraparound services to older adult clients. Concepts need to be changed to modify funding tracks, re-do carve outs with the State, and use blended funding at the local level.

There is broad agreement about the critical need to improve both the range and coordination of services delivered to older persons with mental health needs. Developing a comprehensive, culturally and linguistically competent, coordinated system of care is a major goal. This system of care must include program and service components as well as structures or processes to insure that services are provided in a coordinated, cohesive manner.

A system of care is a comprehensive spectrum of mental health services and other necessary services. These services should be organized into a coordinated network to meet the multiple and changing needs of older persons. The system of care must be more than a network of service components. Rather, it should embody a philosophy about how services should be provided to older persons and their families. The actual components, organization, and configuration of the system of care may differ from community to community. Despite such differences, the values outlined in this chapter should guide the system of care.

Each service dimension in a system of care addresses an area of need for older persons and describes a set of functions that must be performed to provide comprehensive services to meet these needs. Table 1 provides a comprehensive inventory of interagency programs and functions for older adults by level of intervention. This table highlights all the interagency partnerships and agreements that are necessary components in a model system of care to ensure that older adults receive the services they need. Although a county mental health program may not provide all of the services listed, it should work in partnership with the organizations that are listed to ensure that these services are provided in each county. In different communities, different agencies can provide the various types of services. Many of these services can be provided through multi-agency collaborative efforts rather than by a single agency. Such collaborations are important not only in identifying needs and planning services but also in developing, funding, and operating services.

Table 1 identifies the needed components for a proposed system of care for older adults from prevention services to the most restrictive level of services and the agencies that would provide those services. The table begins with Level IV, the most restrictive services. Level IV includes acute and subacute services, which would be provided by agencies, such as the State Department of Mental Health (DMH), private practitioners, county mental health, and community-based organizations. Level III includes moderately restrictive services that are provided by county mental health departments and their contract providers, and other resources at the local level, such as the Area Agencies on Aging (AAA) and caregiver resource centers. For Level II services, all partners previously described are involved in the service delivery at this level, but the system of care expands to include other partners, such as private practitioners, health maintenance organizations (HMOs), cultural and ethnic community support services, and faith organizations. Level I includes prevention services and involves the broadest scope of partners from local agencies to state agencies, such as the State DMH, higher education, and the Department of Aging.

Services to older adults require strong interagency partnerships between primary medical providers and mental health providers. Medication monitoring is an important part of this partnership. Private sector facilities and practitioners can also play a pivotal role in the system of care, providing a wide range of services. Other partnerships include the aging network, social services, adult protective services, the judicial system, and home health agencies. Advocacy is increasingly important in this environment, especially for historically underserved racial, ethnic, and cultural groups. Advocacy plays an active part in collaborative services with organizations that are less

informed on issues of cultural competence to help them become aware of cultural, linguistic, racial, and ethnic differences.

County Structures To Establish Interagency Partnerships

To encourage interagency collaboration with shared responsibility for services, each county needs to have an Interagency Policy and Planning Committee. The local mental health director should be responsible for facilitating the formation of a county interagency policy and planning committee. The members of the committee should consist of the leaders of participating local government agencies, including a member of the board of supervisors, the county counsel, and the directors of public health, social services, mental health, adult protective services, area agencies on aging, and in-home supportive services.

The committee should have the following duties:

(1) Identify those agencies that have a significant joint responsibility for the target population and ensure collaboration on countywide planning and policy

(2) Identify gaps in services to members of the target population, develop policies to ensure service effectiveness and continuity, and set priorities for interagency services

(3) Implement collaborative programs among public agencies and community-based organizations whenever possible to better serve the target population

Counties also need a mechanism for coordinating the care of specific clients. The local mental health director should facilitate the formation of a culturally and linguistically competent multidisciplinary care management team for older adults whose function shall be to coordinate resources to specific older adults who are using the services of more than one agency concurrently. The members of this team should reflect the racial, ethnic, cultural, and linguistic composition of the population to be served and should include representatives from senior social services, alcohol and drug abuse, the conservator's office, mental health services agencies, adult protective services, area agencies on aging, in-home supportive services, and senior centers. These staff must have the necessary authority to commit resources from their agencies to an interagency service plan for older adults. The roles, responsibilities, and operation of these teams should be specified in written interagency agreements or memoranda of understanding.

Formal interagency agreements are necessary to ensure that interagency partnerships operate smoothly. The local mental health director should develop written interagency agreements or memoranda of understanding with the agencies listed below. Written interagency agreements or memoranda should specify services to be provided jointly, staff tasks and responsibilities, facility and supply commitments, budget considerations, and linkage and referral services. The agreements should be reviewed and updated annually.

The interagency agreements may be needed with any of the following county agencies:

(1) Special senior service consortiums, boards, commissions and advisory councils

(2) The court probate and conservator department

(3) The county senior ombudsman office

(4) The county public health department

(5) The county department of drug and alcohol services

(6) Senior legal services

(7) Public transit authority

(8) Other local public, private, or community-based organizations serving older adults

WHAT STATE-LEVEL INITIATIVES HAVE BEEN ESTABLISHED FOR OLDER ADULTS?

The DMH and the California Department of Aging (CDA) are the two state departments with responsibility for initiating programs to serve older adults with mental health needs. This section will describe programs that both departments administer.

Department of Mental Health

The most significant initiative for older adults that the DMH administers is the Older Adults System of Care Demonstration Project. It was established in the Welfare and Institutions

Code (Section 5689 et seq.) in 2000. The DMH funded this project with $2.015 million from the Substance Abuse and Mental Health Services Administration Block Grant. The grants were awarded to pilot projects in four counties: Humboldt, San Francisco, Stanislaus, and Tuolumne. These grants run for three years through fiscal year 2003-04.

Section 5689(a) of the Welfare and Institutions Code requires that "the project be designed to encourage the development and testing of a coordinated, consumer-focused, comprehensive mental health system of care consistent with the recommendations contained in the *California Mental Health Master Plan's* Older Adult Chapter."[3] The legislation also establishes a target population for the pilot projects as well as requirements for evaluation at the state and local levels. In addition, the pilot projects are required to have an advisory structure and to collaborate with other older adult services in the county.

Department of Aging

Under the Older Americans Act, the California Department of Aging (CDA) serves as the State Unit on Aging responsible for the administration of various programs and services designed to meet the needs of adults and seniors through the efforts of 33 Area Agencies on Aging located throughout the State. In addition to serving in a leadership capacity, CDA is an advocate for home and community-based services for California's elderly population. The Area Agencies on Aging fund and monitor the provision of direct services in the areas of information and referral, legal services, nutrition (congregate and home delivered), in-home services, friendly visiting, escort and transportation, service coordination, day care, the nursing home ombudsman program, and respite. The CDA administers the Senior Employment Program, which is available to persons 55 years and over, the Multipurpose Senior Service Program serving persons over 65 who qualify for Medi-Cal, the Linkages program, which assists adults at risk of institutionalization, the Adult Day Health Care Program for persons 18 and over who require rehabilitative services, and the Alzheimer's Day Care Resource Center Program providing dementia-specific services to persons with cognitive impairments and respite for family caregivers. Other programs that could be supportive to persons with psychiatric disabilities include Senior Companions, Foster Grandparents, Brown Bag grocery distribution services, the Health Insurance Advocacy and Planning Program, and the Respite Registry Program. Local mental health departments could establish appropriate ties with these supportive services to assist older adults with psychiatric disabilities to function independently in the community.

Aging with Dignity Initiative

In the Budget Act for fiscal year 2000-01, the Administration committed $271.5 million for the Aging with Dignity Initiative to help elderly people remain at home or with their families rather than in nursing homes. The intent of this initiative is to increase dramatically the availability of innovative community-based alternatives to nursing home care and enhance the quality of care in California's nursing homes.

Caregiver Training Initiative

The Caregiver Training Initiative was established pursuant to Chapter 108, Statutes of 2000 and funded by the Budget Act of 2000-01. The intent of the legislation is to develop and implement proposals to recruit, train, and retain health care providers, such as certified nurse assistants, certified nurses, registered nurses, licensed vocational nurses, and other types of nursing and direct-care staff. The bill also creates an advisory council to develop goals, policies, and a general work plan for the initiative. Membership includes representation from federal, state, and local level government, the health care and home care industries, and organized labor.

Long-Term Care Innovation Grants

The Administration has challenged foundations and private sector communities to partner with the State in an effort to expand innovative

[3] This reference is an earlier draft of the *California Mental Health Master Plan*. Goal 1, to enact legislation to create a pilot project to implement an Older Adult System of Care, from the earlier version of the Older Adult chapter has been moved to Appendix II. This goal has been attained with the enactment of the demonstration project legislation; however, it needs to be retained in the new *Master Plan* because it contains the evaluation requirements for the Older Adults System of Care Demonstration Project.

strategies and alternatives to nursing home placement. The Budget Act of 2000-01 included a $14,250,000 one-time General Fund grant program to implement and expand community-based adult care alternatives to nursing homes. The Administration sought a commitment from private foundations to fund these innovation grants each year for the next ten years.

Long-term Care Council

Chapter 895, Statutes of 1999, established the Long-Term Care Council within the Health and Human Services Agency on June 2000 to coordinate long-term care policy development across multiple departments and programs and to develop a strategic plan for long-term care policy. The Council will also develop strategies to improve quality and accessibility of consumer information on available long-term care programs. It is chaired by the Agency Secretary and includes the Directors of the Departments of Aging, Developmental Services, Health Services, Mental Health, Rehabilitation, Social Services, Veterans Affairs, and the Office of Statewide Health Planning and Development. Since January 2001, the Directors of the Department of Alcohol and Drug Programs, Housing and Community Development, and Transportation have joined the Council.

The mission of the Long-Term Care Council is to provide state-level leadership in developing a coordinated long-term care system that includes a full array of services that promotes personal choice and independence while also assuring fiscal responsibility and equitable access to all long-term care consumers. As one step towards achieving its mission, the Executive Subcommittee of the Long-Term Care Council intends to collaborate with all long-term care stakeholders, including persons with disabilities, their families and representatives, service providers, counties, and public and private entities to expand cost-effective community supports and services to prevent unnecessary institutionalization. In addition, the Long-Term Care Council is organized into other workgroups focusing on specific projects.

SB 639 Task Force

The SB 639 Task Force is one of the projects working under the auspices of the Long-Term Care Council. Chapter 692, Statutes of 2001, (SB 639, Ortiz), required the California Health and Human Services Agency to develop a strategic plan for improving access to mental health services for persons with Alzheimer's Disease or related disorders who also have treatable mental health conditions. The plan will be completed and submitted to the Governor and the Legislature by January 1, 2003.

WHAT ARE THE GOALS AND OBJECTIVES FOR THE SYSTEM OF CARE FOR OLDER ADULTS?

GOAL 1: Ensure that every county mental health department has an Older Adult System of Care.

OBJECTIVE A: The Planning Council shall identify the county mental health departments with an Older Adult System of Care by conducting a survey during fiscal year 2002-03.

OBJECTIVE B: If the Older Adults System of Care Demonstration Project proves to be successful, the State should phase in an Older Adult System of Care for all the counties that do not currently have one. Funds should be appropriated each year and awarded on a competitive basis until all counties in the State have an Older Adult System of Care.

OBJECTIVE C: The Older Adult System of Care development process should include technical assistance and planning grants to those counties that need additional support and assistance in preparing to design and implement an Older Adult System of Care.

GOAL 2: Provide at the state and local levels training and education on the mental health of older adults to reduce stigma and increase public awareness, and improve mental health treatment.

OBJECTIVE A: Local and state mental health and aging programs shall sponsor training for public and private professionals emphasizing physical health, elder abuse prevention, substance abuse treatment, pharmacological issues, differential diagnosis, suicide prevention and ethnically, culturally, and linguistically relevant issues, among older adults.

OBJECTIVE B: Licensing boards for health care professionals who work with older adults shall establish continuing education requirements for geropsychiatric training, including cultural and linguistic competency issues.

OBJECTIVE C: Local and state mental health and aging programs shall sponsor training programs in nursing and residential care facilities on the mental health needs of their clients.

OBJECTIVE D: Local and state mental health and aging programs shall sponsor an annual training conference on issues related to providing culturally and linguistically relevant services to older adults who are members of ethnically diverse groups.

OBJECTIVE E: State and local mental health and aging programs shall develop annual educational programs for older adults that help them increase their understanding and awareness of mental health and aging issues.

OBJECTIVE F: Local and state mental health and aging programs shall sponsor annual training for senior peer counselors and trainers in every county.

GOAL 3: The DMH must work closely with the Department of Health Services to develop a coordinated response to the health needs of older adults.

GOAL 4: The State should develop an appropriate residential continuum for older adults with psychiatric disabilities to enable them to live in the least restrictive, most appropriate setting that meets their needs.

OBJECTIVE A: Housing should be developed which allows individuals to have a live-in caregiver.

OBJECTIVE B: The State should explore expansion of in-home support services, and home health benefits should be expanded to allow individuals to maintain their own housing when, due to illness or physical disability, the individual requires more assistance.

APPENDIX I

Medical Necessity Criteria are described in Title 9, Chapter 11, Section 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

(a) The following medical necessity criteria determine Medi-Cal reimbursement for specialty mental health services that are the responsibility of the MHP under this subchapter, except as specifically provided.

(b) The beneficiary must meet criteria outlined in (1), (2), and (3) below to be eligible for services:

(1) Be diagnosed by the MHP with one of the following diagnoses in the Diagnostic and Statistical Manual, Fourth Edition, published by the American Psychiatric Association:

(A) Pervasive Developmental Disorders, except Autistic Disorders

(B) Disruptive Behavior and Attention Deficit Disorders

(C) Feeding and Eating Disorders of Infancy and Early Childhood

(D) Elimination Disorders

(E) Other Disorders of Infancy, Childhood, or Adolescence

(F) Schizophrenia and other Psychotic Disorders

(G) Mood Disorders

(H) Anxiety Disorders

(I) Somatoform Disorders

(J) Factitious Disorders

(K) Dissociative Disorders

(L) Paraphilias

(M) Gender Identity Disorder

(N) Eating Disorders

(O) Impulse Control Disorders Not Elsewhere Classified

(P) Adjustment Disorders

(Q) Personality Disorders, excluding Antisocial Personality Disorder

(R) Medication-Induced Movement Disorders related to other included diagnoses.

(2) Must have at least one of the following impairments as a result of the mental disorder(s) listed in subdivision (1) above:

(A) A significant impairment in an important area of life functioning.

(B) A probability of significant deterioration in an important area of life functioning.

(C) Except as provided in Section 1830.210, a probability a child will not progress developmentally as individually appropriate. For the purpose of this section, a child is a person under the age of 21 years.

(3) Must meet each of the intervention criteria listed below:

(A) The focus of the proposed intervention is to address the condition identified in (2) above.

(B) The expectation is that the proposed intervention will:

1. Significantly diminish the impairment, or

2. Prevent significant deterioration in an important area of life functioning, or

3. Except as provided in Section 1830.210, allow the child to progress developmentally as individually appropriate.

(C) The condition would not be responsive to physical health care based treatment.

(c) When the requirements of this section are met, beneficiaries shall receive specialty mental health services for a diagnosis included in subsection (b)(1) even if a diagnosis that is not included in subsection (b)(1) is also present.

APPENDIX II

GOAL 1: To enact legislation creating a pilot program to implement an Older Adult System of Care.

OBJECTIVE A: Sections in this chapter on target population definition, range of mental health services, and interagency collaboration can be used as components for the Older Adult System of Care legislation.

OBJECTIVE B: For each county awarded a system of care grant, the Department of Mental Health (DMH) shall establish system performance goals and negotiate the expected levels of attainment for each year of participation. A county shall include expected levels of attainment in its proposal. These goals shall include the following:

1) Establish a baseline for the following performance indicators for clients:
   a) The extent to which the target population is served in proportion to their representation in the general population.
   b) The rate at which homeless persons accept services.
   c) The rate at which clients are actively engaged in some community support network as measured by participation in peer support or self-help groups, socialization center programs, or other activities.
   d) The rate at which clients are participating in a rehabilitation program as measured by membership in a psychiatric rehabilitation program, a supported employment program, volunteer programs, or adult day and adult day health care programs for at least one year.
   e) The rate at which multi-problem clients, including those with a secondary diagnosis of substance abuse and seniors with special needs, are receiving a comprehensive program of treatment that addresses their multi-diagnostic needs.
   f) Psychological impairment and functioning for clients in the target population.
   g) The rate at which clients receive income support entitlements.
   h) The rate at which clients remain in the least restrictive, most appropriate housing consistent with their capabilities for at least one year.
   i) The rate at which clients spend time in the local jails.
   j) The rate at which clients with a secondary diagnosis of substance abuse are abusing dangerous drugs, prescription drugs, and over-the-counter medications.
2) Cost effectiveness indicators:
   a) All major public costs for clients, including mental health, housing, social services, vocational and physical rehabilitation, health services (including Medi-Cal and Medicare), adult protective services, and public guardianship.
   b) Costs for state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, crisis residential, and medical facilities.
   c) Costs for criminal recidivism.
   d) Other short-term and long-term costs related to attaining client outcome goals.
3) Measure the extent to which the following system-level goals are attained:
   a) The percentage of clients who meet the target population definition.
   b) The extent to which the joint responsibilities specified in the interagency agreements has been fulfilled.
   c) The percentage of clients with individualized service plans that will facilitate interagency service delivery in the least restrictive environment.

d) To ensure access by older adults to state hospitals, local acute inpatient facilities, skilled nursing facilities, institutions for mental disease, and medical facilities.

e) To develop or provide access to a range of intensive services that will meet individualized service plan needs. These services shall include, but not be limited to, the list of services in Table 1.

f) To ensure the development and operation of the interagency policy and planning committee and the multidisciplinary care management team.

g) To develop caregiver education and support groups and linkages to ensure their involvement in the planning process and the delivery of services.

h) To gather, manage, and report data in accordance with state requirements.

i) To ensure the development of assessment protocols for concomitant physical problems either causing or contributing to mental health impairments.

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CHAPTER 7
MANAGED MENTAL HEALTH CARE

BACKGROUND

Over the last few years, the orientation of health care has changed from the delivery of episodic treatment of illness to the planned provision of primary care and other necessary services in an integrated, coordinated system of service delivery. This coordinated system of care is known as managed care. Managed care, broadly stated, is a planned, comprehensive approach to providing health care that combines clinical services and administrative procedures within an integrated, coordinated system. This system is carefully constructed to provide timely access to care and services in a cost-effective manner. In a managed care system, individual providers are linked together under the umbrella of a single entity: the managed care plan. Managed care's emphasis on access to health care is intended to increase the utilization of primary care services whenever possible and thus reduce the unnecessary use of emergency rooms and inpatient services. Similarly, managed care's focus on mental health preventive services concentrates on promotion of a person's ability to function in the community (California Department of Mental Health, 1997, page 18).

History of Mental Health Funding in California: the Short-Doyle Program

In 1957, state legislation created the Short-Doyle program, which established a county-based delivery system for mental health services. Initially, the program was voluntary, and each county was encouraged to start local community-based services. However, some counties did not take advantage of this opportunity to develop local services. To provide added incentive, the State implemented a matching formula and developed a 50-50 funding split, in which the State matched each county dollar expended. County participation was still slow in developing, so the State changed the formula to 75 percent from the State and 25 percent from the counties. The formula was changed once more to 90 percent state funds and 10 percent county funds, except for inpatient services, which were funded 85 percent state funds and 15 percent county funds in order to encourage counties to use less costly outpatient services. Eventually, the State required all counties to ensure delivery of mental health services.

Medi-Cal

In 1966, California enacted the Medicaid program, referred to as "Medi-Cal." This program allowed the State to receive federal financial participation to provide health care services, including mental health services, to eligible residents who were federal cash grant welfare recipients. These services, also known as Fee-for-Service Medi-Cal (FFS/MC), were provided by a voluntary network of private providers throughout the State. For mental health services, those providers would be psychiatrists and psychologists. The rates for FFS/MC have been significantly less than providers' usual and customary rates.

Short-Doyle Medi-Cal

In 1971, the Short-Doyle/Medi-Cal (SD/MC) program was established. It allowed counties to obtain a 50 percent federal match on their costs for providing certain mental health services to persons eligible for Medi-Cal. At this point, the Medi-Cal program split into two mental health service delivery systems: the existing FFS/MC program continued mainly as a system of private providers, and the SD/MC program was established as a system of public providers, primarily county mental health programs and their contracted community agencies. As previously noted, the FFS/MC system was primarily solo practitioners in psychiatry and psychology, whereas in the SD/MC program the services were provided in a clinic setting. Psychologists, social workers, marriage and family counselors, and other ancillary therapists who were under the auspices of a medical director of a clinic were able to provide a range of services to clients. The reason for establishing the SD/MC program was to allow for a wider variety of treatment options to adults with mental illness and children and youth with serious emotional disturbances than the office-based private practitioner of the FFS system was able to provide.

Equity of Mental Health Funding at the County Level

During the development of the State's Short-Doyle program in the late 1960s, some counties were aggressive in matching dollars and others were not. As a result, historical inequities in funding developed. These inequities were compounded when many counties also did not pursue the 50 percent federal match for Short-Doyle/Medi-Cal. As a result, those counties had far less resources for providing mental health services to the clients in their communities. These inequities continue to the present day because the funding formula for realignment reflects the original matching formulas and each county's individual level of participation prior to the enactment of realignment.

Although the need to achieve equity in funding among California counties has been an issue of contention, no under-equity county has ever been able to catch up. These historical and persistent inequities affect the level of Medi-Cal funds per capita available for each California county as well. Some counties have very little Medi-Cal funding, and others have a great deal. The result is a patchwork quilt of uneven levels of funding and uneven access to services throughout the State. Prior to realignment, a plan to reallocate these dollars, either Short-Doyle or Medi-Cal, was never attempted because of the political ramifications of taking from one county to give to another.

California's "Managed" Mental Health Program

California has had to "manage" the provision of public mental health services for many years due to limited resources and defined target populations. The bulk of funding for public mental health services, which came from the State General Fund, was discretionary. Goodwin and Selix describe the decline in mental health funding:

> The current level of funding to mental health is estimated to be less than half that which is needed to provide a basic level of care for the existing mentally ill population. Beginning with an inadequate funding base, state allocations to counties were severely diminished due to inflation throughout the 1970s and 1980s, inadequate cost of living increases, and increasing population with increasingly serious problems. From 1982 to 1987, there were no cost-of-living increases or caseload adjustments to community mental health. In 1988, funds were reduced, and in 1989, an additional fifteen percent was reduced from the base funding for community mental health.
>
> In 1990, California faced a $14.3 billion shortfall. Community mental health programs were already near collapse and overwhelmed with unmet need. Advocates feared massive budget cuts to programs that could be irreparable. Significant policy and fiscal decisions regarding the future of community mental health programs had to be made quickly (Goodwin & Selix, 1998).

In 1991, in an effort to stop the continued assault on mental health funding, California enacted a law (Chapter 89, Statutes of 1991) providing that a portion of the sales tax and revenues collected from vehicle licensing fees would be used to establish a Local Revenue Fund. This fund is restricted to expenditures for county health, mental health, and social services. This realignment of funding from the State to the counties saved the mental health system from financial disaster by removing funding for mental health services from the discretionary State General Fund. Counties now could rely on a constant funding base from which to plan for the provision of mental health services. In addition, this law also established target populations for adults, children and youth, and older adults that specified the diagnoses and functional limitations necessary for a client to meet the target population definition, ensuring that those clients with the most severe mental illnesses received services.

In the early 2000s, several county mental health programs have begun to experience shortfalls in realignment findings and are relying on a variety of methods to make up the difference. If counties are unable to fund their mental health programs adequately, they may be forced to return responsibility and control of the programs to the State. Because of the many policy and fiscal changes that have taken place over the last 10 years, Chapter 367, Statutes of 2001 (AB 328, Salinas) was enacted, which requires that the DMH, in cooperation

with the CMHDA and other relevant parties, reexamine realignment.

7.1. Recommendation: The State of California must increase base funding overall for mental health programs.

The Move to Medi-Cal Mental Health Managed Care in California -- the "Carve-Out"

In step with the national trend, the Department of Health Services (DHS), which is the single state agency overseeing Medi-Cal, made a commitment to refocus the delivery of healthcare from episodic treatment for illness to the planned provision of services in a managed care model of service delivery. Following the policies of DHS, the Department of Mental Health (DMH) implemented a managed mental health care system for Medi-Cal services.

The DMH decided to "carve out" mental health care from the physical health care system into an individual managed care plan. In other words, public mental health services funded by Medi-Cal are separate from the physical health services managed care system. The DMH believes that carving out mental health care ensures that mental health services will be provided more appropriately and more effectively.

The Design of California's Managed Mental Health Medi-Cal Program

The design of managed mental health care for California's Medi-Cal program is based on statewide implementation of a single managed mental health plan (MHP) in each county. The implementation of managed care with the county as the mental health plan is the logical extension of the state and county relationship. The counties are the primary sources of service to persons with mental illness and emotional disturbance and have the ability to provide culturally and linguistically competent continuity of care for those periods when persons are not eligible for Medi-Cal but still require "safety net" services to maintain themselves in the community. Additionally, the counties are responsible for the provision of many high-cost public services used by persons with mental illness, such as foster care, juvenile justice, indigent health care, and jail services.

The DMH operates under a "Freedom of Choice" waiver, under Section 1915(b) of the federal Social Security Act. This waiver, which is reviewed and approved by the Center for Medicare and Medicaid Services, allows California to limit a Medi-Cal beneficiary's choice of providers for mental health services as long as access and quality of services are ensured. This waiver is subject to review and must be renewed every two years. The most recent waiver was effective through November 2002. The DMH has applied for another renewal of this waiver and will know in early 2003 if it is granted.

Consolidation versus Capitation

California's mental health managed care system is not a capitated system in which MHPs would be paid a fixed amount for each beneficiary regardless of the amount or cost of services received by the beneficiary. Capitation would require the State to spread the full risk for provision of services to the MHPs. Spreading the risk evenly is problematic because of the great inequity in the historical base of allocation for both realignment funds and Medi-Cal dollars in the State. For this reason, the counties and State have begun to examine other ways to share risk that would still assure that the beneficiaries receive access to services and that providers, whether county-operated or contracted, do not go into bankruptcy.

California's Phase-In Approach to Implementation

California chose to phase in implementation in order to assure an orderly process. Implementation included two phases with the final phase of a pre-payment system to be implemented in the future when access and full risk management to the MHPs can be assured on a statewide basis.

Phase I: Consolidation of Psychiatric Inpatient Hospital Services

Consolidation under Phase I began in January 1995. Funds previously appropriated for DHS to pay for FFS/MC inpatient hospital mental health services were transferred to the MHPs, making the MHPs the single point of authorization and payment of Medi-Cal psychiatric inpatient hospital services. MHPs negotiate contract requirements and rates with inpatient hospital providers using state and

federal law and regulations as minimum requirements.

Phase II: Consolidation of Specialty Mental Health Services

In addition to assuming the risk for inpatient hospital services, MHPs are assuming the risk and funding for Medi-Cal specialty mental health services, which include outpatient and service coordination. Consolidation of hospital and outpatient services results in one system of care with a single fixed point of responsibility and accountability, thereby maximizing the chances for beneficiaries to receive appropriate care.

Phase III: Implementation of a Pre-payment System

The DMH will continue to explore the implementation of capitation. It believes that the development of a pre-payment system must be based on extensive analysis of data of a particular population to be served. This in-depth financial analysis is crucial to achieve reliable information on costs for risk-based contracting. For this reason, the counties and State have begun to look at other ways to share risk and to assure that beneficiaries receive access to services, as well as assure that county-operated and contracted providers remain financially viable. Types of alternative contracting include the following:

- **Case Rate Contract**. Under this model, contracted services are based on a type of group or population.
- **Partial Capitation**. Under this model, contracted services are based on the number of recipients expected to use a certain type of service.
- **Capitation with Risk Corridor**. This model incorporates a set-aside for costs exceeding the normal amount of risk. For example, a risk pool may be established in which a percentage of each premium goes into a fund, a provider may buy insurance to protect against catastrophic losses, or several counties might form a risk pool together.

CMHPC'S PRIORITIES

The California Mental Health Planning Council (CMHPC) chose its priorities for managed care by focusing on issues that would remain salient, as well as issues that other constituency groups were not already closely examining.

Meaningful involvement of clients and family members

The DMH has made a commitment to ensure that consumer and family involvement is an overriding value in planning, implementation, and oversight. Most significantly, the DMH established the Client and Family Member Task Force (CFMTF), consisting of clients and family members from around the State. The CFMTF has provided consultation and advice on all aspects of managed care implementation to the DMH and has been instrumental in establishing policy recommendations. The CFMTF has been an effective and accessible means of communication with policymakers in the mental health system and is now recognized widely for its broad involvement in statewide mental health initiatives.

7.2. Recommendation: All stakeholders should acknowledge that client and family member involvement is critical at both the state and local levels. All stakeholders must make a commitment to involve clients and family members at all levels of policy development by assuring funding for outreach, training, travel, and stipends.

7.3. Recommendation: The DMH and MHPs should conduct both state-level and ongoing local-level training for clients and family members in order to develop a large pool of qualified clients and family members who understand the issues and can advise and advocate effectively.

Access to culturally competent services for beneficiaries

In 1996, as part of the move to the Medi-Cal mental health managed care carve out, the DMH established a Cultural Competency Advisory Committee (CCAC) to advise on how to meet the specialty mental health needs of ethnically diverse communities. The CCAC was given the responsibility to establish cultural and linguistic standards and issue cultural competency plan requirements. In October 1997, the CCAC issued the "Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements." The purpose of the addendum was to establish

standards and plan requirements for MHPs to achieve cultural and linguistic competency under consolidation of specialty mental health services.

By July 1998, each MHP was required to develop and submit cultural competency plans consistent with the standards and requirements, which included a population, organization, and service provider assessment. The MHPs were also required to address standards and indicators in three major areas of access, quality of care, and quality management. The intent in issuing these standards and requirements was to assist MHPs to reduce potential disparities in access and services and to improve overall quality of care for multicultural and multilingual communities. The DMH reviewed and approved the initial cultural competence plans submitted by each MHP. MHPs are required to submit annual updates of their cultural competence plan requirements to DMH.

In 1998, at the recommendation of the CCAC, the DMH established the Office of Multicultural Services to support the implementation of the cultural competence plans and to provide leadership to the DMH and local MHPs in addressing the mental health needs of California's diverse communities. Moving mental health systems to become culturally and linguistically competent is viewed as a developmental process. The CCAC established that the cultural competence plans, which were revised and reissued in May 2002, would require periodic updates. The CCAC continues to serve as an advisory body to the DMH on cultural and linguistic issues in collaboration with the work of the DMH Office of Multicultural Services.

7.4. Recommendation: The State and MHPs must integrate cultural competence into all mental health public policy and new programs.

Grievance procedures and rights of beneficiaries

MHPs must comply with the requirements of the implementation plans. Client access to appropriate, culturally competent, coordinated services is the responsibility of the MHP. Clients should also be satisfied with the services they receive. Ideally, MHPs should assist consumers and family members in navigating the mental health system, including providing assistance through the complaint and grievance processes. A description of these processes is included in the regulations governing specialty mental health services (9, CCR, Section 1810.100 et seq.). Included in these regulations are requirements that counties provide written information to clients about grievance procedures. However, a constant concern of clients and advocates is the inconsistency with which this information is made available in each county.

7.5. Recommendation: The State Department of Mental Health should develop standards regarding grievance and appeal rights for a brochure that all MHPs would be required to use. All stakeholders need to continue to develop easily understood, consumer-friendly documents that are clear about procedures for identification and resolution of complaints and grievances, and information sources at both the state and local levels. Training and education should be provided at all levels of the mental health system so the system is user-friendly.

Adequacy of interface between health and mental health services

The interface with physical health care is a major concern of the CMHPC. How clients are referred between the systems, training of both physical health care and mental health care staff, clinical consultation, especially regarding medications, and the exchange of confidential client information must be carefully planned so that clients are assured of receiving all of the services to which they are entitled. Many adults, children, and youth served by the mental health system have serious co-occurring physical health problems. In addition, laboratory work is necessary with certain medications. Cultural and racial disparities in health outcomes should also be analyzed further. When psychiatric hospitalization occurs, medical histories must be taken and physicals performed. At times, when hospitalization for a medical problem occurs, a psychiatric consultation must be performed. All of these issues need to be clarified in terms of payment and responsibility.

7.6. Recommendation: The Chief of Multicultural Services for the DMH and the Chief, Office of Multicultural Health for the Department of Health Services should meet to coordinate efforts in addressing racial, ethnic, linguistic, and cultural disparities in physical health care.

Minimum Standards between Managed Care Plans and Mental Health Plans

The development of a written agreement that addresses the issues of interface in the delivery of Medi-Cal reimbursable services to beneficiaries who are served by a county's physical health managed care plan (MCP) and MHP is a shared responsibility between those entities. These two entities are required to execute a memorandum of understanding (MOU) that specifies the respective responsibilities of the MCP and MHP in delivering medically necessary Medi-Cal reimbursable physical health care services and specialty mental health services to beneficiaries. The DHS has issued a policy letter to the MCPs to provide a guideline for this responsibility.

7.7. Recommendation: MHPs should develop a collaborative effort with counties' MCPs to facilitate referrals between the two systems and to provide joint cross-system cultural competence training to ensure that all staff increase their knowledge and skills and improve their attitudes in providing services to ethnically and linguistically diverse populations.

7.8. Recommendation: MHPs should also develop an evaluation process to assess the effectiveness of such training.

Mental Health Training of Primary Care Physicians

A primary care physician should have enough information and training to detect, screen, and diagnose a mental illness and then to decide if he or she can appropriately treat the client or if the client should be referred to the mental health system. The medical community is addressing the need for training. In 1998, the California Medical Association adopted a resolution to collaborate with other organizations to provide mental health training for primary care physicians (California Medical Association, 1998).

7.9. Recommendation: MHPs should ensure that ongoing collaboration and communication with primary care physicians occurs.

Access to the Most Appropriate Medications

When MHPs assumed responsibility for specialty mental health services through the carve-out, the provision of pharmacy services remained with the physical health managed care plans. MCPs expressed concerns about the expense of these new, innovative antipsychotic medications. The amount of money allocated for pharmacy services in the MCPs is fixed, which could provide a disincentive to prescribe the newer, more costly medications. Mental health advocates feared that clients would not be prescribed the newer medications because their cost would become prohibitive to the MCPs. This concern prompted the DMH to establish an agreement with the DHS that most antipsychotic medication pharmacy benefits for mental health clients would be carved out of the MCPs and billed through fee-for-service Medi-Cal.

7.10. Recommendation: The DHS and the DMH should continue to find ways to assure that the most efficacious medications to treat mental illness are prescribed to clients regardless of cost.

Risk-based Contracting

Risk-based contracting and its alternatives described previously will provide MHPs the flexibility to create or contract for services that will be most appropriate and most cost-effective for their clients. However, no actuarial data for serious mentally ill populations are available from which to establish risk-based contracting. Providers that enter into risk-based contracting should be assured that they would receive the right volume of clients to balance out the risk. These data will be critical as the DMH begins exploring the implementation of a pre-payment system in Phase III.

7.11. Recommendation: The DMH should convene a task force of mental health professionals, actuaries, insurance industry representatives, and managed care providers to determine the assumptions upon which to base the mental health managed care system design. Furthermore, those assumptions must be tested so that a basis for risk can be established to obtain more definite information on costs. This discussion should include how changing populations will change risk factors.

Oversight by the Department of Mental Health

The State has developed an oversight system that involves on-site reviews of each MHP. Review teams include county peer reviewers,

direct consumers, family members, and DMH staff. These teams identify problems and then the DMH issues plans of correction to the MHPs. The DMH then monitors the MHP as it makes these corrections. In addition, to address statewide issues of system accountability and quality improvement, the DMH has established a State Quality Improvement Council, consisting of representatives from stakeholder organizations.

The CMHPC has the responsibility to ensure that the DMH is providing adequate oversight of the Medi-Cal managed care system. Discussion and recommendations regarding system accountability and oversight are in Chapter 8.

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CHAPTER 8
SYSTEM ACCOUNTABILITY AND OVERSIGHT

CALIFORNIA'S PUBLIC MENTAL HEALTH SYSTEM

California's public mental health system provides mental health services to persons with serious mental illnesses who have no recourse to services in the private health care sector. Many public mental health clients, through either poverty or the degree of disability caused by their mental illness, qualify for Medi-Cal and receive public services through that funding source. However, county mental health plans are also safety net providers and serve large numbers of persons not eligible for Medi-Cal. In fiscal year 2000-01, the mental health system served over 560,000 clients as shown in Table 1 below. Approximately one-third of the clients served were children and adolescents age 0-17, and slightly more than 5 percent were transition-age youth. Most clients were adults age 22-59. Only 6 percent of the clients were older adults over age 60.

Table 1: Clients Served by the Public Mental Health System by Age in Fiscal Year 2000-01

Age Range	Number	Percent
0 - 17	163,548	29.19%
18 - 21	31,054	5.54%
22 - 59	331,662	59.20%
60 - 64	14,954	2.67%
65 & UP	19,064	3.40%
Unknown	4	0.00%
TOTAL	560,286	100.00%

Substantial public funds are expended on the public mental health system. Table 2 summarizes funding for children's mental health services in fiscal year 2000-01, and Table 3 presents funding for the Adult System of Care in that year. Total funding for mental health services in fiscal year 2000-01 was over $2.2 billion. Expenditures for Children's mental health services of approximately $745 million represented 50 percent of that amount. Of the $2.2 billion in total funding, realignment revenue from sales tax and vehicle license fees totaled $1.1 billion, or 50 percent of the revenue in fiscal year 2000-01.

Table 2: Funding for Children's Mental Health Services for Fiscal Year 2000-01

Program	Funding
State Hospitals	3,400,000
Local Assistance	41,854,000
Managed Care	45,466,000
SAMHSA Block Grant	12,511,000
Early Mental Health Initiative	15,000,000
Special Education Program (AB 3632)	12,334,000
Healthy Families	5,705,000
Early Periodic Screening, Diagnosis, and Treatment	309,632,000
Short-Doyle/Medi-Cal Match[1]	107,364,000
Total DMH	**553,266,000**
Realignment Funds Base[2]	192,216,000
Total Resources for Children's Programs	**$745,482,000**

[1] Does not reflect the Federal Financial Participation for Managed Care Inpatient Services.
[2] Includes $11,396,000 for LPS state hospital beds or other alternatives.

Table 3: Funding for Adult Mental Health Services for Fiscal Year 2000-01

Program	Funding
Local Assistance	102,972,000
Managed Care	136,399,000
SAMHSA Block Grant	23,853,000
Projects for Assistance in Transition from Homelessness	3,850,000
Brain Impaired Adults	12,247,000
Short-Doyle/Medi-Cal Match[1]	295,084,000
Total DMH	**574,405,000**
Realignment Funds Base[2]	921,052,000
Total Resources for Adult Programs	**$1,495,457,000**

[1] Does not reflect the Federal Financial Participation for Managed Care Inpatient Services.
[2] Includes $86,288,000 for LPS state hospital beds or other alternatives.

Table 4, which provides the breakdown of clients' diagnoses for fiscal year 2000-01, reveals the serious nature of the mental illnesses treated by the mental health system. Schizophrenia comprised 12 percent of the diagnoses; bipolar disorder, 9 percent; and depressive disorders, 26 percent. These disorders typically require life-long management, frequently with the continuous use of medications. The diagnoses for children and adolescents in the mental health system are typically ADHD/ADD, conduct disorders, childhood disorders, and adjustment disorders, which together account for approximately 20 percent of the diagnoses.

Table 4: Unduplicated Count of Clients by Diagnosis for All Modes of Service in Fiscal Year 2000-01

Diagnosis	Number	Percent
Schizophrenia	65,515	11.69%
Dementia/Delirium	3,104	0.55%
Anxiety Disorders	23,180	4.14%
Depressive Illness	144,047	25.71%
Bipolar & Mood Disorders	52,375	9.35%
Personality Disorder	2,172	0.39%
ADHD/ADD	25,404	4.53%
Conduct Disorders	27,414	4.89%
Other Childhood Disorders	7,034	1.26%
Substance Abuse Disorder	20,245	3.61%
Adjustment Disorders	50,340	8.98%
Somatoform Disorders	341	0.06%
Dissociative Disorders	17,232	3.08%
Deferred	30,537	5.45%
No Mental Health Disorders	43,393	7.74%
Other Mental Health Diagnosis	46,850	8.36%
Unknown	584	0.10%
Blank	519	0.09%
TOTAL	560,286	100.00%

Because of the ethnic diversity in California, the public mental health system must meet the needs of a very diverse population. As Table 6 illustrates, nearly half the clients served in the mental health system in fiscal year 2000-01 were white; approximately 20 percent, Hispanic; 17 percent, African American; and approximately 6 percent, from Asian/Pacific Islander ethnic groups. Because the concept of mental illness and traditional treatments vary among cultures, providing culturally competent services to clients of such diverse racial and ethnic backgrounds is a major challenge for the

mental health system. Even more difficult is meeting the needs of monolingual clients.

Table 6 also illustrates disparities in access to services among ethnic groups, which is one of the major quality improvement challenges facing the State's mental health system. For example, Hispanics/Latinos are underutilizing mental health services. In the 0-17 age group, they comprise 44 percent of the population but are only 28 percent of that age group of mental health clients. That imbalance is also reflected in the 18-64 age group for Hispanics/Latinos. The data for Asian/Pacific Islanders also reflects a pattern of underutilization. Conversely, African Americans are over-utilizing mental health services. African Americans comprise 6 percent of the total population, but they represent 16 percent of the mental health clients.

EVOLUTION OF OVERSIGHT OF THE PUBLIC MENTAL HEALTH SYSTEM

Because of the magnitude of public expenditures, the serious nature of the mental illnesses, the need of mental health clients for on-going treatment and rehabilitation, and the challenges posed by the ethnic diversity in this State, the State Legislature, at the urging of the mental health advocates and providers of services, adopted a requirement that county mental health programs must collect and report to the Department of Mental Health (DMH) data on the performance of their mental health systems.

In 1991, the Legislature enacted a statute that realigned the funding and program responsibility for mental health services. Previously, the mental health system had been funded from general tax revenues. Because mental health services were not an entitlement, they fared poorly in the State's annual budget process. During the 1980s, the mental health system experienced serious erosion of its funding by not being able to keep up with inflation. It even experienced reductions in state funding during that period. Because of the system's serious fiscal problems, the mental health community was open to changing the funding strategy. The realignment legislation replaced the General Fund revenues with one-quarter cent of the Sales Tax, which was dedicated to county mental health services.

Because sales tax revenues are considered a local revenue source, this funding arrangement dramatically changed the governance of the public mental health system. Prior to realignment, the system had been centralized under the control of the DMH, which allocated funds to county mental health programs and directed the types of services to be provided. After realignment, the DMH's role was more one of providing technical assistance to local programs, managing the state hospitals, and administering the State's Medi-Cal program funding mental health services.

During the development of the realignment legislation, mental health advocates were concerned about the loss of centralized authority over the county mental health program. Realignment gave counties greater autonomy to design their own service systems and greater flexibility in how they spent the funds. Advocates wanted to ensure that a system was in place that held counties accountable for results of their management of local programs. As a result, the realignment legislation included a requirement that county mental health programs had to collect and report to the State performance outcome data on their clients.

Several years after the enactment of realignment and its performance outcome measure requirements, the DMH initiated a major system change: consolidating the Fee-for-Service Medi-Cal system with the Short-Doyle Medi-Cal system and moving the entire Medi-Cal mental health system to managed care. Chapter 7 on managed mental health care describes the evolution of this system. The managed care initiative necessitated that the DMH rethink its approach to oversight of the public mental health system. It issued a series of papers on oversight (California Department of Mental Health, 1998b), (California Department of Mental Health, 1998a).

Requirement To Collect Performance Outcome Data

In the realignment legislation, the DMH was given the responsibility to establish a committee that would specify the outcome measures. In subsequent legislation, the California Mental Health Planning Council (CMHPC) was given the authority to review and approve all outcome measures and to use the

data to review program performance annually. Additionally, the CMHPC is supposed to use the data to identify best practices in providing mental health services so that those services can be replicated in other counties. These statutory provisions are found in the Welfare and Institutions Code (WIC) Section 5772(c).

Mental health boards and commissions (MHBCs) are also given a role in the interpretation of their counties' performance outcome data. WIC Section 5604.2(a)(7) requires that MHBCs review and comment on the performance outcome data and communicate their findings to the CMHPC. The CMHPC developed a workbook format to facilitate this reporting process by MHBCs. Each MHBC received a workbook with that county's performance outcome data. The data were accompanied by a series of questions to assist the MHBC members in interpreting the results for each indicator. The workbook also contained additional demographic and socioeconomic data to assist the MHBCs in understanding the local context for its county's results. MHBCs were encouraged to collaborate with the local mental health program to complete the workbook. Once the CMHPC received all the workbooks, it prepared a statewide report, which by statute was distributed to the Legislature, the DMH, county governing bodies, and MHBCs. The CMHPC anticipates using a similar procedure with future performance outcome data.

In 1999 the DMH established the State Quality Improvement Committee (renamed State Quality Improvement Council in 2002). The purpose of this committee is to identify performance indicators to monitor and to develop special quality improvement studies focused on the Medi-Cal managed care program (California Department of Mental Health, 2001). The enactment of Chapter 93, Statutes of 2000, established the State Quality Improvement Committee (SQIC) in statute. This legislation broadened the SQIC's mandate for quality improvement to include the entire public mental health system and directed the DMH and the SQIC to develop specific types of performance indicators. Members of the SQIC consist of representatives from the DMH, the CMHPC, county mental health directors, consumers, and family members.

The SQIC has established a set of performance indicators drawn from those recommended by the CMHPC. The SQIC prioritized indicators related to access to mental health services as being the most important to study initially. Work began on data related to Medi-Cal beneficiaries using data from the Medi-Cal Paid Claims Files for fiscal year 1998-99 and 1999-2000. In fiscal year 2002-03, the SQIC began to study all clients receiving mental health services using data from the Client and Services Information System for fiscal year 1999-2000. In addition, the SQIC has been conducting special studies related to access to mental health services and in September 2002 released a report studying the increase in the rehospitilization rate between fiscal years 1993-94 and 1999-2000.

Over the years, the system to collect performance outcome data has evolved into a massive undertaking. Up until fiscal year 2002-03, data had been collected annually for all clients who receive services for more than 60 days. This requirement was essentially created through the political process for developing legislation. Its implementation was overseen by a collaboration of representatives from the CMHPC, the DMH, and county mental health programs. Implementation decisions were guided by what the CMHPC believed was necessary for it to provide oversight of the system tempered by the need to have an administratively workable system that was not too burdensome on county mental health programs.

In fiscal year 2001-02, the DMH and its stakeholders began to evaluate the effectiveness of the methodology for collecting performance outcome data. A number of problems had arisen with the way the performance outcome data were collected:

- Inability to develop and operationalize the target population definition
- Failing to measure the greatest amount of change in client outcomes due to delay in the initial measurement
- High levels of attrition over the 12-month data collection window so that second measurements were not obtained on clients to measure their outcomes
- Inability to enforce the data collection requirement

Table 5: 2000 Census Population and Number of Clients in County Mental Health Programs for Fiscal Year 2000-01 by Age and Race/Ethnicity

	TOTAL		0-17		18-64		65+	
	Population	Clients	Population	Clients	Population	Clients	Population	Clients
Hispanic or Latino of any race	10,966,556	115,624	4,050,825	46,129	6,442,962	66,877	472,769	2,618
White alone	15,816,790	255,526	3,222,858	61,040	10,077,793	183,374	2,516,139	11,112
Black alone	2,181,926	93,715	653,820	29,678	1,348,561	62,226	179,545	1,811
American Indian alone	178,984	4,933	49,112	1,656	117,279	3,200	12,593	77
Asian, Pacific Islander alone	3,752,596	34,566	887,553	6,140	2,507,883	26,767	357,160	1,659
Other race	71,681	7,732	24,579	1,521	43,375	5,703	3,727	508
Two or more races	903,115	12,726	361,082	6,092	488,308	6,485	53,725	149
Unknown, not reported	-	36,100	-	10,835	-	24,125	-	1,140
TOTAL	33,871,648	560,922	9,249,829	163,091	21,026,161	378,757	3,595,658	19,074

Table 6: Percent of 2000 Census Population and Clients in County Mental Health Programs for Fiscal Year 2000-01 by Age and Race/Ethnicity

	TOTAL		0-17		18-64		65+	
	Population	Clients	Population	Clients	Population	Clients	Population	Clients
Hispanic or Latino of any race	32.4%	20.6%	43.8%	28.3%	30.6%	17.7%	13.1%	13.7%
White alone	46.7%	45.6%	34.8%	37.4%	47.9%	48.4%	70.0%	58.3%
Black alone	6.4%	16.7%	7.1%	18.2%	6.4%	16.4%	5.0%	9.5%
American Indian alone	0.5%	0.9%	0.5%	1.0%	0.6%	0.8%	0.4%	0.4%
Asian, Pacific Islander alone	11.1%	6.2%	9.6%	3.8%	11.9%	7.1%	9.9%	8.7%
Other race	0.2%	1.4%	0.3%	0.9%	0.2%	1.5%	0.1%	2.7%
Two or more races	2.7%	2.3%	3.9%	3.7%	2.3%	1.7%	1.5%	0.8%
Unknown, not reported	0.0%	6.4%	0.0%	6.6%	0.0%	6.4%	0.0%	6.0%
TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Because of these factors, the DMH, in collaboration with the CMHPC and the county mental health directors, has developed a new methodology, which will be implemented in May 2003. Twice a year data would be collected on all clients during a window of a specified length, such as a week or two weeks. These windows would be six months apart. Clients in some treatment settings will likely be excluded from data collection: 24-hour settings (inpatient), crisis stabilization, and linkage and brokerage case management. Based on test runs using data from the Client and Services Information System, this methodology could produce samples for each county amounting to 20-30 percent of clients seen by the county during a fiscal year. This methodology could also yield a subset of approximately 5-10 percent of the clients within this sample for longitudinal analysis, meaning that these clients would be in both the first and second window of measurement so that comparisons could be made of their results over time.

In addition to performance outcome data, the DMH also has the following administration data systems available for system oversight:

- Client and Services Information System
- Cost Reporting/Data Collection System
- Medi-Cal Paid Claims

Chapter 738, Statutes of 1998, (SB 2098, Wright), required the DMH to develop unique client identifiers for its data systems. These identifiers will mean that demographic, service utilization, cost, and performance indicator data for each client can be linked across data sets. Generally, data are available from the DMH's data system 6 to 12 months after the close of the fiscal year.

THEORETICAL PERSPECTIVE ON USE OF PERFORMANCE INDICATORS FOR QUALITY IMPROVEMENT

Performance indicators are evaluative criteria. A set of indicators represents an explicit statement of expectation for the health care delivery system. They are intended to provide useful information relevant to whether their expectations are being met. A performance indicator must be an effective proxy for critical aspects of provider, health plan, or health care system functioning. Performance indicators operationalize evaluative criteria. Each indicator should be a valid and reliable measure that is both sensitive and specific. Indicators should also be effective in distinguishing high and low performers (Sofaer, 1995).

Definitions

The American College of Mental Health Administration (ACMHA), a national organization of mental health clinicians and administrators, has undertaken a project to develop a proposed set of performance indicators that can be used by both public and private behavioral health care providers. As a part of this project, it has developed a taxonomy of terms related to performance indicators (American College of Mental Health Administration, 2001):

- **Domain**: the most global category within which to identify indicators, such as structure, access, process, and outcome
- **Concern**: the most salient issue to be addressed by measurement strategies; describes the desired goal of service provision; e.g., "Clients can access services that they need" states a "concern"
- **Indicator**: something important to measure—the markers that could identify an indicator's target
- **Measure**: the mechanism used or data element identified to support a judgment on an indicator

Performance indicators are divided into four categories by the SQIC: structure, access, process, and outcome (California Department of Mental Health, 2001). Structure is the domain that addresses the resources and tools (human, physical, and organizational) that are needed to provide good quality care. Access addresses how consumers and family members get into care. It relates to the availability of culturally competent services to persons who need them in a manner that facilitates their use. Access includes the degree to which services are quickly and readily obtainable. It also relates to the availability of a wide array of relevant services to meet individual needs (Task Force on a Consumer-Oriented Mental Health Report Card, 1996).

Process is the domain that describes what happens during service provision. The word "appropriateness" is often used interchangeably with process (California Department of Mental Health, 2001). Appropriate services are those that are individualized to address a consumer's strengths and weaknesses, cultural context, service preferences, and recovery goals. Appropriateness of care refers to the best possible match between client's needs and (a) level of care, e.g., inpatient or outpatient, and setting, e.g., psychiatric ward, office, home; (b) the chosen treatment or intervention, e.g., medication or therapy; and (c) service utilization, e.g., length of stay, number of outpatient sessions, and appropriate transitions. Standards for assessing appropriateness are based on the best available efficacy, effectiveness, appropriateness, and quality of care research (Salzer, Nixon, Schut, Karver, & Bickman, 1997).

Two other domains of indicators are outcomes and cost-effectiveness. Outcomes are the domain that investigates the results of services. Outcome is the impact of care on health and well-being, the ultimate goals of providing services. These goals include improvement or stabilization in a client's symptoms and functioning and in client satisfaction with quality of life, health status, and community integration (California Department of Mental Health, 1998b). Cost effectiveness is a domain used by the CMHPC. It is the ability to use resources efficiently to achieve positive outcomes. An example would be using crisis stabilization or crisis residential services instead of acute inpatient hospitalization, if appropriate to a client's needs.

Appendix I to this chapter contains an example of indicator sets for each target population. Measures are included for each type of indicator: structure, access, process, cost-effectiveness, and outcomes. Appendix II contains additional measures that focus on aspects of the cultural competence of mental health services.

Characteristics of Valid Performance Indicator Sets

The process for developing and adopting performance indicators must have normative validity (Sofaer, 1995). When performance indicators have normative validity, all stakeholders would agree that the indicators reflect their shared values about the ideal nature of the mental health system. Selection of performance indicators is inherently value-laden. Different constituency groups bring different norms, values, and priorities to bear on the inclusion of particular indicators and the construction of indicator sets. The statutory role given to the CMHPC to approve performance outcome indicators should assure normative validity because its membership includes all key stakeholders:

- Direct consumers
- Family members
- Advocates
- Local mental health directors
- Community agencies
- Mental health professionals
- State agencies, including the DMH

Lack of Culturally and Linguistically Competent Performance Measures for Ethnic-Specific Populations

However, the values of ethnically diverse groups have not been reflected in the selection of these indicators because of insufficient representation of multicultural and ethnic communities on the CMHPC and other groups involved in the development of performance outcome systems and selection of data collection instruments. The current mental health field is facing major challenges in the development of performance measures that are culturally competent and that are truly relevant in the assessment with multicultural populations. In an effort to move the mental health field towards more effective accountability in mental health treatment interventions, ethnic communities have been left far behind. Several national efforts have been initiated to elucidate the issues and challenges related to mental health treatment for multicultural communities and to developing culturally competent standards. However, these efforts have not resulted in performance outcome indicators and instruments that are relevant and valid for multicultural communities.

Question 18, "I, not staff, decided my treatment goals," from the Mental Health Statistics Improvement Project (MHSIP) Consumer Survey provides an example of how value differences between cultures can affect performance measurement. The Appropriate-

ness/Quality Scale of the MHSIP Consumer Survey from which this question was taken, draws on the Western value of individualism, the assumption that the best way to be is to manage one's own life independently and to make one's own decisions autonomously. The MHSIP Consumer Survey explicitly incorporates concepts important to consumers, such as choice, personhood, and self-management (Teague, Ganju, Hornik, Johnson, & McKinney, 1997).

However, this question would clash with the cultural values of Hispanic or Asian clients, who may have a more interdependent world view. The interdependent worldview is characteristic of cultures in Japan, China, Korea, South Asia, and much of South America and Africa:

> According to this perspective, the self is not and cannot be separate from others and the surrounding social context. The self is interdependent with the surrounding social context and it is the self-in-relation-to-the-other that is focal in individual experience…. The cultural press in this alternative model of the self is not to become separate and autonomous from others but to fit in with others, to fulfill and create obligation, and, in general, to become part of various interpersonal relationships (Markus & Kitayama, 1994).

Clients from these cultures may not be inclined to agree with this question. First, the emphasis on interpersonal relationships in these cultures might incline the clients to place a greater value on the contributions of staff in helping them decide their treatment goals. Second, these cultures also involve their families in health care decisions and the treatment process (Sue, Zane, & Young, 1994) (Murase, 1977). For that reason, they may not even conceptualize the process of recovery or the process of making these decisions as something they do solely by themselves. Consequently, when racial and ethnic groups in the client population being studied do not have meaningful representation in the group of stakeholders developing the performance indicators, there is a substantial risk that the indicators selected may not be relevant or valid for specific racial and ethnic groups.

When developing performance measures, the recognition and inclusion of the culture of the client served must be addressed. Culture fills a pivotal role in the feelings, emotions, and behavior of the individual. Effective communication, treatment planning, and implementation require understanding and engagement between client and provider. Therefore, the performance measures must be culturally competent by incorporating cultural variables throughout. The American Psychological Association supports this issue with the following statement:

> ...the culturally competent psychologist carries the responsibility of combating the damaging effects of racism, prejudice, bias, and oppression in all their forms, including all of the methods we use to understand the populations we serve. It is also clearly recognized the psychology has been traditionally defined by and based upon Western, Eurocentric perspectives and assumptions that have governed the way in which research has been both conceptualized and implemented, including the general tendency to ignore the influence and impact of culture on cognition, emotion, and behavior. Thus, the effects of such biases, have, at times, been detrimental to the diverse needs of the populations we serve and the public interest and have compromised our ability to accurately understand the people that we serve. (Porche-Burke, 1999.)

Multiple mental health strategies used for and by multicultural communities must be evaluated instead of restricting evaluation only to the traditional medical model psychiatric approaches. These solutions must include culturally competent research, researchers, and programs. The field must be willing to move developmentally to challenge old ways of doing things that have not worked for multicultural communities and seek creative new solutions.

Relationship Among Indicators

Selected indicators should carry a great deal of information on important issues. Indicators should be chosen not only because they measure attributes that are important in

themselves, but also because these attributes correlate highly with other important characteristics. Identifying good proxies for system performance requires understanding the relationships between and among health care structures, access, process, and outcomes. A good performance indicator should be backed by empirical evidence of these relationships.

Performance indicators should also possess criterion-related validity (Salzer et al., 1997). Criterion-related validity is "the degree to which services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 1991, p. 1). Criterion-related validity pertains to the extent that structure and process indicators are linked with outcome and outcome indicators are linked to structure and process.

Inferences about the validity of a performance indicator can be drawn from the types of evidence listed below. Stronger inferences can be drawn from methods at the head of the list; weaker inferences from those methods near the end of the list.

- Meta-analyses
- Randomized clinical trials
- Nonrandomized clinical trials
- Expert panel judgment
- Individual practitioner judgment

The majority of indicators in contemporary efforts to develop indicator sets are based on "expert" opinion. Salzer (1997) explains that indicators based on expert opinion have normative validity. However, he cautions the following:

> …normative and consensual validity are weak forms of evidence for making conclusions about criterion-related validity…. This is a reasonable place to begin given the current dismal state of quality of care research, but it must be emphasized that these are unvalidated indicators. Care must be used when discussing results using indicators based on weak forms of inferential evidence (p. 299).

Performance indicators can be referred to as valid when the link between structure, process, and outcome has been established. This approach holds service providers accountable for developing quality service structures and processes that can be expected to produce positive outcomes. This approach is more appropriate than holding service providers responsible for poor outcomes that may have resulted despite high-quality service delivery. The value of a proposed structure or process indicator as a measure of quality is determined by the extent to which it is related to some outcome (Salzer et al., 1997). For example, coordination of services, a structural variable, may be found to be associated significantly with decreased symptoms and increased functioning. Coordination of services would then be viewed as a valid indicator of decreased symptoms and increased functioning. In another example, having bilingual and ethnic providers, a structural variable, may be associated with positive outcomes for multicultural populations.

Using scientific evidence to link performance indicators to outcomes is even more of a challenge when dealing with services to ethnically diverse populations because what studies that have been done on treatment effectiveness have rarely included ethnic populations. The Surgeon General's Supplement on Race, Culture, and Ethnicity states the following:

> Overall, minorities are not represented in studies that evaluate the impact of interventions for major mental disorders. Furthermore, when minorities are included, rarely are analyses conducted to determine whether the treatments are as effective for them as they are for white populations. Although a great deal is known about efficacy of a wide range of interventions for treating common mental disorders, specific information about the efficacy of these interventions for racial and ethnic minority populations is unavailable (p. 172).

The current climate in the mental health field of moving toward evidence-based treatment places at risk once again the relevance of how these approaches will truly meet the needs of multicultural communities. Evidence-based treatment has received strong support as a better way to do business; however, a strong and cautious view should be taken on the populations for which this "evidence-based

treatment approach" is developed. A call for national support for culturally specific evidence-based research is needed along with national support for identification of culturally competent treatment approaches. The Surgeon General's Supplement on Race, Culture, and Ethnicity states the following:

> …the research used to generate professional treatment guidelines for most health and mental health interventions does not include or report large enough samples of racial and ethnic minorities to allow group-specific determinations of efficacy. In the future, evidence from randomized controlled trials that include and identify sizable racial and ethnic minority samples may lead to treatment improvements, which will help clinicians to maximize real-world effectiveness of already-proven psychiatric medications and psychotherapies (p. 160).
>
> No empirical data are yet available as to what the key ingredients of cultural competence are and what influence, if any, they have on clinical outcomes for racial and ethnic minorities…. A common theme across models of cultural competence, however, is that they make treatment effectiveness for a culturally diverse clientele the responsibility of the system, not of the people seeking treatment (p. 36).

Future Direction

New theories and paradigms for quality improvement are continuing to be developed. In fiscal year 2001-02, The SQIC began to explore the work of the Committee on Quality Health Care in America. The Institute of Medicine formed this committee in 1998 to develop a strategy that would substantially improve the quality of health care over the next 10 years (Institute of Medicine, 2001). As a result of its deliberations, the committee published *Crossing the Quality Chasm*, which has stimulated new ways of thinking about quality improvement and accountability.

Crossing the Quality Chasm proposes six aims for quality improvement:

- **Safety**—avoiding injuries to patients from the care that is intended to help them
- **Effectiveness**—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse, respectively)
- **Patient-centered**—providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
- **Timeliness**—reducing waits and sometimes harmful delays for both those who receive and those who give care
- **Efficiency**—avoiding waste, including waste of equipment, supplies, ideas, and energy
- **Equity**—providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status

The SQIC believes that these six aims of quality improvement can be very useful in generating new performance indicators and in making the public mental health system more accountable and responsive to the needs of clients and their families. Efforts are underway to integrate this new paradigm with the existing "structure, access, process, outcome" method of categorizing performance indicators to produce a smooth transition to a new way of conceptualizing quality improvement in the public mental health system in California. The CMHPC concurs that this new approach is very promising and will work closely with the SQIC to accomplish this task.

CONCEPT OF ACCOUNTABILITY

The main purpose for creating performance indicators was to facilitate oversight of county mental health programs by the DMH, the CMHPC, and local mental health boards and commissions. The intention was also that local mental health programs could monitor their own performance and use the data in their quality improvement processes.

Although performance indicators hold great promise in helping to improve the quality of mental health programs, users of the data must be mindful of their methodological limitations. Much work needs to be done before unambiguous conclusions can be drawn from performance indicators. For example, measurement error and confounding variables affect the kinds of outcomes counties can report. These factors have no relationship to the quality of the services provided. Some of these limitations in interpreting performance outcome data were identified in the first attempts to analyze the data in the early 1990s. For example, the first analyses of the adult performance outcome data, which were collected in fiscal year 1992-93, ranked counties from the best to the worst outcomes on various indicators. However, a cursory analysis revealed the flaw of that approach: some outcome measures are strongly influenced by local conditions. For example, counties with the lowest rate of employment for consumers also had the highest rates of unemployment for their general populations.

These data must be interpreted within their local context taking into account client characteristics, socio-economic conditions, and resources. Risk adjustment is the process for adjusting performance indicators so comparisons among counties can be made. Without such adjustments that take into account differences among counties, direct comparison of counties' results is not possible. Until techniques for risk adjustment are developed, the CMHPC needs to use a different approach for accountability. That approach is to hold counties accountable for their use of the data in their quality improvement processes. Counties can demonstrate their accountability by using performance indicator data in their quality improvement processes. Performance indicator results can be used for a variety of purposes:

- Identifying gaps in the system of care
- Improving the quality of existing services
- Identifying opportunities for great efficiency and more cost-effective services

8.1. Recommendation: Because the performance indicators lack established criterion-related validity, cultural competence characteristics, risk adjustment to compensate for differences among counties, and benchmarks for minimum acceptable performance, the data must be used to describe the performance of the current system. System development should focus on the following actions:

- Assure that the indicator set has face validity and normative validity
- Generate data for each county from existing data systems for the indicators, which will stimulate productive discussions about their implications related to the quality of the service system
- Use local quality improvement systems to explore the relationships between the indicators and to understand variables that influence quality
- Encourage scientific studies to establish the criterion-based validity of the indicator set
- Ensure that local quality improvement systems include performance indicators that are ethnically and linguistically inclusive

ROLE OF CMHPC IN SYSTEM OVERSIGHT AND ACCOUNTABILITY

Section 5772 of the Welfare and Institutions Code (WIC) gives the CMHPC the authority to review, assess, and make recommendations regarding all components of California's mental health system. The statute, which was developed in the early 1990s, makes frequent reference to the term, "performance outcome measure," in describing the CMHPC's mandate. Only in the last few years has the public sector integrated the increased theoretical sophistication of oversight and quality review from the behavioral health care industry and the research literature. The term, "performance outcome measure," has come to refer to one type of performance indicator that measures the results of receiving services on a client's health and well-being. In using the term, "performance outcome measure," the authors of the legislation were referring to the broader class of indicators now understood to include structure, access, and process indicators. Specifically, data recommended to be collected in WIC Section 5612 relates to

structure, access, and process as the examples below illustrate:

- Number of persons in identified target populations served relates to access
- Treatment plan development for members of the target population relates to appropriateness
- Percentage of resources used to serve children and older adults relates to access
- Number of patients' rights advocates and their duties relates to structure
- Quality assurance activities relate to structure

8.2. Recommendation: In keeping with the intention of the statute, references in statute to "performance outcome measures" should be interpreted to mean "performance indicators." The CMHPC should assert its authority to approve all the performance indicators, not just the outcome indicators.

8.3. Recommendation: The CMHPC should continue to consult with the DMH on the development and implementation of current initiatives:

1. Managed care
2. Performance outcome measures
3. The State Quality Improvement Committee
4. The Compliance Advisory Committee
5. The DMH Cultural Competence Advisory Committee

8.4. Recommendation: The CMHPC should monitor the DMH oversight activities, including:

1. Assuring client and family member involvement in oversight activities
2. Reviewing and commenting on various oversight protocols and procedures
3. Assuring that plans of correction from onsite reviews are followed up on
4. Annual reviews of the cultural competence plans

8.5. Recommendation: The CMHPC should assist MHBCs with their oversight responsibilities, including:

1. Determining how to assure that MHBCs are involved in the local quality improvement system
2. Determining how to help MHBCs assess the adequacy of local quality improvement systems

8.6. Recommendation: The CMHPC should ascertain whether local mental health programs are using available data for quality improvement.

ROLE OF MENTAL HEALTH BOARDS AND COMMISSIONS IN SYSTEM OVERSIGHT AND ACCOUNTABILITY

MHBCs have an important role to play in system oversight and accountability. Section 5604.2 of the Welfare and Institutions Code authorizes MHBCs to engage in various oversight activities, such as evaluating the community's mental health needs, services, and facilities; advising the governing body and the local mental health director about the local mental health program; and submitting an annual report to the governing body on the needs and performance of the county's mental health system. In addition, Section 5604 states that the board membership should reflect the ethnic diversity of the client population in the county.

MHBCs are essential partners of the CMHPC in the process of using performance indicator data for system oversight. Particularly relevant is Section 5604.2 (a)(7), which requires that the mental health board review and comment on the county's performance indicator data and communicate its findings to the CMHPC. Because understanding the local context is so central to understanding the performance of a county mental health program, MHBCs have a very important role to play in the process of using performance indicator data to evaluate local programs.

8.7. Recommendation: The CMHPC should provide performance indicator data to MHBCs along with material to assist them in understanding and interpreting the data.

8.8. Recommendation: The CMHPC should also provide a consistent statewide format that MHBCs should use to report their findings to the CMHPC.

8.9. Recommendation: The CMHPC should use the reports from the MHBCs along with its own analysis of the results to prepare reports

to the Legislature, the Department of Mental Health, and other stakeholders about the performance of the public mental health system.

PRINCIPLES TO GUIDE CONTINUED DEVELOPMENT OF OVERSIGHT, ACCOUNTABILITY, AND USE OF DATA

The DMH, the CMHPC, and local mental health programs should adopt the following principles to guide development of oversight and the use of performance indicators:

1. Consumers and family members, reflective of the population served, should be involved in development and implementation of oversight. This involvement can be ensured through the following means:
   - CMHPC representation on policy development committees
   - Continued involvement of the Client and Family Member Task Force
   - Client and family member representation on on-site reviews
2. The oversight paradigm and performance indicators currently in use are derived from national models, such as the American College of Mental Health Administration and the Mental Health Statistics Improvement Project Consumer Oriented Report Card. However, these models are very limited because they do not include ethnic-specific performance indicators. New models should be developed that are inclusive of ethnic, cultural, and linguistic diversity.
3. Data sets have been created for the public mental health system. Stakeholders should master the use and interpretation of these data before developing additional requirements. However, as improved performance indicators are developed for ethnically diverse clients, additional data elements need to be added.
4. Current and future research to determine the key ingredients of clinical practice that make for culturally competent services should be used to assist individuals and programs to provide services to diverse communities. The instruments developed from this urgently needed research should be used as an integral component of a comprehensive plan to develop individual and system cultural competence proficiency.
5. Performance indicators should provide data that are useful to the clinician in assessment and treatment planning and should enable the clinician to assess his or her own effectiveness.
6. When using the data, the DMH and the CMHPC should take an incremental approach to reporting the data. The goal of reporting results for performance indicators is to enable local mental health programs, mental health boards and commissions, and the CMHPC to understand the implications of the data analysis for system performance and improvement. Providing focused reports on aspects of performance rather than comprehensive reports on the entire system will likely result in better use of the data.
7. Ethnic-specific data should be collected to review and track potential disparities by ethnic populations in access to mental health services and quality of care.
8. To improve the cultural competency of oversight activities, the DMH should place high priority on developing proper translations of outcome instruments, obtaining sufficient back translations to produce more valid instruments.

NEXT STEPS IN THE USE OF PERFORMANCE INDICATORS FOR SYSTEM OVERSIGHT

Risk Adjustment

Outcome indicators are influenced by many factors beyond the control of local mental health programs. The purpose of risk adjustment is to isolate the aspects of providing mental health services that are under the control of local mental health programs. To understand the performance of local mental

health programs, the effects of those confounding variables beyond the control of mental health programs must be eliminated. This statistical process is referred to as risk adjustment. Examples of variables to be used for risk adjustment include client characteristics, socioeconomic conditions in each county, and fiscal resources available to fund mental health services. Risk adjustment should facilitate the identification of best practices in the provision of mental health services.

At this point, risk adjustment techniques are highly theoretical and experimental. However, the field of risk adjustment is becoming better defined. For example, payors in the private behavioral health care field are using risk adjustment in provider profiling. Some state governments are using risk-adjusted performance indicators to make decisions about whether to fund specific mental health providers. Key principles for selecting risk adjustment variables are being proposed (Boaz & Dow, 1999), (Hendryx, 1999):

- They should be prognostic indicators of disease course
- They should be substantively related to the outcome
- They should be outside the control of providers to affect through treatment
- They should be able to be measured reliably and validly
- They should account for variance in the outcome indicator (dependent variable)
- They should not interact with the provider groups, i.e., the relationships between risk adjustment variables and dependent variables are consistent across the providers

Once the correct risk adjustment variables have been selected for each performance indicator and their effects on the indicators thoroughly analyzed, the data for each county should be adjusted to the statewide average for the risk adjustment variable under consideration. As risk adjustment analyses become more sophisticated, multivariate risk adjustment techniques should be used so that performance indicators can be adjusted simultaneously for more than one variable.

8.10. Recommendation: The DMH, CMHPC, and California Mental Health Directors Association (CMHDA) need to begin the process of developing risk-adjustment techniques so that the performance of local mental health programs can be compared to the statewide and regional averages.

1. A thorough literature review needs to be conducted to identify the independent variables besides mental health treatment that can affect each performance indicator.
2. The State's databases need to be evaluated to determine whether they contain data on the relevant risk adjustment variables.
3. Data analyses need to be conducted to select the best risk adjustment variables for each outcome measure.
4. County mental health programs need to be involved in the selection and testing of risk adjustment variables to ensure that all the relevant factors that affect their performance are taken into account.
5. Once the risk adjustment variables have been selected and evaluated, each county's outcome data for each indicator need to be risk adjusted to the statewide average to facilitate comparisons with the statewide average and regional averages.

Decision Rules for Evaluating Performance

Risk adjustment is designed to eliminate differences among counties that cannot be attributed to delivery of mental health services. Once that step has been completed, the next logical step is to develop decision rules to identify high and low performers (Kamis-Gould & Hadley, 1996). Comparing results of counties on an indicator to determine which is higher and which is lower is relatively easy. However, whether demonstrated variance means high performance or only a minor difference is not as self-evident. Because behaviors and performance levels vary and fluctuate over time, existing data must be analyzed to decide whether high levels will be determined by quartiles, percentiles, or better

yet, standard deviations above and below the mean.

This approach for developing decision rules advocated by Kamis-Gould (1996) is consistent with the DMH's advocacy in its oversight white paper for "fence posts" or "parameters" for indicators (California Department of Mental Health, 1998b). A multidimensional system of performance indicators requires decision rules that possess the following features:

- Determination of high and low performance on any one indicator (e.g., in terms of standard deviations from the mean)
- Determination of high and low performance on any one domain (e.g., at least two high performance indicators and no low one)
- A decision about whether stability over time should be built-in (i.e., whether some levels should be demonstrated more than once)
- Integration of levels across domains and determination of highs and lows on total performance

Kamis-Gould (1996) provides the following example of decision rules used in New Jersey. New Jersey defines high performance as two standard deviations above the means on at least two performance indicators in at least two domains for two consecutive quarters and no low performance on any one domain. This standard is designed to exclude one-time spikes in performance and to keep highly efficient but ineffective providers from being considered high performers.

8.11. Recommendation: Once the DMH can reliably risk adjust the performance indicators, decision rules should be established to identify high and low performers.

APPENDIX I

INDICATORS FOR SYSTEM OVERSIGHT FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCES[1]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[2]

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Differences among Counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made.	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for children age 0-17	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans

[1] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the Children's System of Care is in transition, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once new instruments are selected.

[2] These variables are being introduced for purposes of discussion only.

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for children and families and provides continuity of care	**Structure 4:** Under consideration	
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which children and families need to interact	**Structure 5:** Under consideration	
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring children's performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population age 0-17 who receive mental health services in one year by modes of service as defined by Client Services and Information System (CSIS), gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles age 0-17 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Service Options Available		
Concern: Children and families can access services that they need	**Access 3:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 4: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS & CR/DC
	Access 5: Percentage of respondents who report that services they need are readily available by ethnicity	YSS & YSS-F Access Score
Cultural and Linguistic Access		
Concern: Children and families have access to a mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 6:** Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: Children using mental health services do so voluntarily and in collaboration with their families and service providers. The use of involuntary mental health intervention is minimized.	**Process 1:** Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 2:** Percentage of children discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 3: Percentage of children in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: Children experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 4:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS
Family and Youth Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: Families and youth using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 5:** Percentage of full-time equivalent staff positions that are occupied by family members of children who have received public mental health services by ethnicity	Special Studies
	Process 6: Percentage of youth on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 7: Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:** Proportion of total expenditures for services spent on placements in ♦ State hospitals ♦ Group homes ♦ Foster homes ♦ Acute psychiatric hospitals	Various state data systems collected for system of care counties
	CE 2: Number of placements in ♦ State hospitals ♦ Group homes ♦ Foster homes	*State hospitals*: Various state data systems collected for system of care counties *Group homes*: Client Information Sheet I. 6. *Foster Homes*: Client Information Sheet I. 6.
	CE 3: Length of stay in State hospitals for children age 0-17	Various state data systems collected for system of care counties
	CE 4: Number of bed days in acute psychiatric hospitals for children age 0-17	Various state data systems collected for system of care counties

DOMAIN: OUTCOMES

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
Living Situation		
Concern: Children and adolescents who are seriously emotionally disturbed should remain in their homes whenever possible or should be placed in the least restrictive, most appropriate, natural environment as close to home as possible	**Outcome 1:** Number of days in each placement during the year by ethnicity	Foster Children: Department of Social Services Special Education Non-public Schools: State Department of Education
	Outcome 2: Living situation reported by percentage of children in each predominant living situation by ethnicity	Client Information Sheet I. 6.
	Outcome 3: Percentage of children in out-of-home placement by ethnicity	Client Information Sheet I. 6.
Concern: Children and adolescents who are seriously emotionally disturbed should be afforded maximum stability in their living situations, moving during the year as few times as possible consistent with their treatment needs	**Outcome 4:** Number of places a child has lived during the last six months by ethnicity	Client Information Sheet I. 6.
	Outcome 5: Subjective satisfaction of children and families with the children's living situation by ethnicity[3]	Not available
Psychological Health		
Concern: The level of psychological distress from symptoms experienced by a child or adolescent is minimized	**Outcome 6:** Percentage of children and adolescents by ethnicity who experience a reliable reduction in psychological distress as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	*Child:* YSS Outcome Score *Parent:* YSS-F Outcome Score
	Outcome 7: Suicide rate among children and adolescents with serious emotional disturbances by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain

[3] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
	Outcome 8:	Percentage of children and adolescents by ethnicity whose psychological distress improves to the degree that they are no longer in the clinical range as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
Concern: The level of distress experienced by a family with children or adolescents with serious emotional disturbances is minimized	**Outcome 9:**	Percentage of children and adolescents by ethnicity whose families experience improved functioning or a reduction in family distress	Not available
Physical Health and Safety			
Concern: Children and adolescents who are seriously emotionally disturbed should have an individualized plan of coordinated care that anticipates and addresses their unique and multiple needs, including physical health and need for medication	**Outcome 10:**	Percentage of children and adolescents by ethnicity with serious emotional disturbances whose health is affected by collateral physical health problems who are receiving comprehensive services coordinated between their mental health care and physical health care provider	Not available

INDICATORS FOR CHILDREN	MEASURES	DATA SOURCE
	Outcome 11: For children and adolescents on psychiatric medication: ♦ Clinician's evaluation of the effectiveness of the medication by ethnicity ♦ Clinician's evaluation of whether they have adequate access to the physician prescribing the medication by ethnicity ♦ Children's evaluation of whether the medication is making them feel better by ethnicity ♦ Parent's evaluation of whether the medication is improving the children's psychological health by ethnicity	First two bullets: County Quality Improvement & Utilization Review Processes
Concern: Children and adolescents who are seriously emotionally disturbed should feel safe in all aspects of their lives	**Outcome 12:** Children and adolescents' subjective assessment of whether they feel safe in the following environments by ethnicity:[4] ♦ At home ♦ In school ♦ In the community	Not available
Social Involvement and Functioning		
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in developing or maintaining nurturing relationships with their families	**Outcome 13:** Percentage of children and adolescents who have age-appropriate family relationships by ethnicity	YSS & YSS-F Q 17
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to maintain a social support system and engage in meaningful activities, including playing, sports, socializing with peers, and other recreational activities	**Outcome 14:** Percentage of children and adolescents who have age-appropriate social relationships by ethnicity	YSS & YSS-F Q 18
	Outcome 15: Percentage of children and adolescents who have age-appropriate interests and activities by ethnicity	Not available

[4] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
Concern: Children and adolescents who are seriously emotionally disturbed function well in their family and social relationships	**Outcome 16:**	Percentage of children and adolescents who experience a reliable improvement in functioning as reported by the following informants by ethnicity: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
	Outcome 17:	Percentage of children and adolescents by ethnicity whose functioning improve to the degree that they are no longer in the clinical range as reported by the following informants: ♦ Child or adolescent ♦ Parent ♦ Clinician	Not available
School Involvement and Functioning			
Concern: Children and adolescents who are seriously emotionally disturbed belong in school so that they may benefit from their educational program and are encouraged to achieve their maximum educational potential	**Outcome 18:**	Percentage of children and adolescents by ethnicity who attend school with the following frequency per week: ♦ Zero ♦ One ♦ Two ♦ Three ♦ Four ♦ Five ♦ Home school	Client Information Sheet IV. B.
	Outcome 19:	For children not being home schooled, average number of days per week they attend school by ethnicity	Client Information Sheet IV. B.
	Outcome 20:	Percentage of children and adolescents who have increased per week school attendance by ethnicity	Client Information Sheet IV. B.
	Outcome 21:	Percentage of children and adolescents in special education by ethnicity	Client Information Sheet. I. 6.
	Outcome 22:	Percentage of children and adolescents by ethnicity who are attending school regularly according to: ♦ The child or adolescent ♦ The parent ♦ The clinician	Client Information Sheet IV. B. from clinician only

INDICATORS FOR CHILDREN	MEASURES		DATA SOURCE
	Outcome 23:	Assessment of academic performance by ethnicity according to: ♦ The child or adolescent ♦ The parent ♦ The clinician	Not available
	Outcome 24:	Subjective satisfaction of the child or adolescent with attending school by ethnicity[5]	Not available
Legal			
Concern: Children and adolescents who are seriously emotionally disturbed should be supported in their efforts to develop and maintain socially responsible behavior, avoid involvement with the juvenile justice system, and remain free of substance abuse and addiction	**Outcome 25:**	Reduction in the percentage of children and adolescents who have a substance abuse problem by ethnicity	CSIS
	Outcome 26:	Reduction in the percentage of children and adolescents involved in the juvenile justice system by ethnicity	Client Information Sheet I. 6
	Outcome 27:	Reduction in the recidivism of children and adolescents involved in the juvenile justice system by ethnicity	Not readily available; collected by juvenile justice system
	Outcome 28:	Reduction in the percentage of children and adolescents engaging in at-risk behaviors, including vandalism, property destruction, and physical assault by ethnicity	Pursue availability from SDE

[5] The idea is to develop subjective satisfaction scales modeled after those on the CA-QOL and QL-SF.

INDICATORS AND MEASURES FOR SYSTEM OVERSIGHT FOR ADULTS WITH SERIOUS MENTAL ILLNESSES

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[6]

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for clients age 18-59	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels, skills, and training are appropriate for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County Administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans

[6] These variables are being introduced for purposes of discussion only.

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for clients and provides continuity of care	**Structure 4:** Under consideration	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact	**Structure 5:** Under consideration	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitor the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring adult performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined, and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population ages 18-59 that receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 18-59 who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient	**Access 3:** Percentage of respondents who report that the location of services is convenient by ethnicity [7]	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents who report that services are available at times that are convenient by ethnicity	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours by ethnicity	MHSIP Consumer Survey Q6
Range of Service Options Available		
Concern: Clients can access services that they need	**Access 6:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available by ethnicity	MHSIP Consumer Survey Q5 & 8

[7] Positive response to the MHSIP Consumer Survey is operationalized as answering 4 (agree) or 5 (strongly agree).

Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnic culture reported by ethnicity and language	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized	**Process 1:** Percentage of respondents who report actively participating in decisions concerning their treatment by ethnicity and language	MHSIP Consumer Survey Q17 & 18
	Process 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery	**Process 3:** Percentage of Medi-Cal clients by ethnicity for whom medication is prescribed who received prescriptions for: a. Atypical antipsychotics b. Newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Process 4: Percentage of respondents who report receiving services that support recovery by ethnicity	MHSIP Consumer Survey Q9 & 14
	Process 5: Percentage of respondents who report being involved in self-help activities by ethnicity	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 8:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services by ethnicity	Special Studies
	Process 10: Percentage of mental health consumers on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care	**Process 12:** Percentage of respondents who report receiving adequate information to make informed choices by ethnicity and language	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR ADULTS	MEASURES		DATA SOURCE
Living Situation			
Concern: Persons with mental disabilities have the right to choice, privacy, and independence in their living situation	**Outcome 1:**	Percentage of consumers with serious mental illnesses living in their own house or apartment by ethnicity	CSIS[8]
	Outcome 2:	Percentage of consumers who move to less restrictive settings by ethnicity	CSIS[8]
	Outcome 3:	Percentage of consumers who report being satisfied with their living situation reported by living situation by ethnicity[9]	QOL 2a, b, c
	Outcome 4:	Mean satisfaction with living situation reported by living situation by ethnicity	QOL 2a, b, c
Financial Status			
Concern: Persons with serious mental illnesses should have an adequate income	**Outcome 5:**	Percentage of consumers by ethnicity who are receiving the benefits to which they are entitled	County Universal Method of Determining Ability to Pay Systems
	Outcome 6:	Percentage of consumers by ethnicity who report having enough money for each of these necessities: ♦ Food ♦ Clothing ♦ Housing ♦ Transportation ♦ Social activities	QOL 10
	Outcome 7:	Percentage of consumers who report being satisfied with their finances by ethnicity	QOL 11a, b, c
	Outcome 8:	Mean satisfaction with finances by ethnicity	QOL 11a, b, c

[8] This measure would be analyzed for clients for whom performance outcome data has been collected.

[9] For all outcome indicators, satisfaction is operationalized as answering with categories 5 (mostly satisfied), 6 (pleased), or 7 (delighted) on the instrument.

Productive Daily Activity			
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 9:**	Percentage of clients with serious mental illnesses involved in competitive employment (part-time or full-time) by ethnicity	CSIS[10]
	Outcome 10:	Percentage of clients with serious mental illnesses involved in volunteer activity by ethnicity	CSIS[10]
	Outcome 11:	Percentage of clients with serious mental illnesses involved in education by ethnicity	CSIS[10]
Symptoms			
Concern: The level of psychological distress from symptoms is minimized	**Outcome 12:**	Percentage of consumers experiencing a decreased level of psychological distress by ethnicity	GAF score, & MHSIP Q26
	Outcome 13:	Suicide rate among persons with serious mental illnesses by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning			
Concern: Service recipients experience increased independent functioning	**Outcome 14:**	Percentage of consumers who report increased functioning by ethnicity	MHSIP Q20-25
Physical Health			
Concern: Mental health services recipients should have good health and equal access (relative to the general population) to effective general health care	**Outcome 15:**	Percentage of Medi-Cal clients who receive mental health services during the year who also received physical health care services through Medi-Cal by ethnicity	CSIS or Medi-Cal Paid Claims & DHS Medi-Cal Data
	Outcome 16:	Mean score on quality of health reported by consumers by ethnicity	QOL 15
	Outcome 17:	Percentage of consumers who report being satisfied with their health by ethnicity	QOL 16a, b, c
	Outcome 18:	Mean satisfaction with health by ethnicity	QOL 16a, b, c

[10] This measure would be analyzed for clients for whom performance outcome data has been collected.

Substance Abuse			
Concern: Clients experience minimal impairment from use of substances	**Outcome 19:**	Rate of all adults receiving services who are identified with substance abuse problems by ethnicity [11]	CSIS[12]
Avoiding Legal Problems			
Concern: Clients should be assisted in their efforts to maintain socially responsible behavior	**Outcome 20:**	Percentage of consumers who report being arrested in the last month by ethnicity	QOL 13
Personal Safety			
Concern: Persons with serious mental disabilities have a right to personal safety and freedom from exploitation	**Outcome 21:**	Percentage of consumers who report being a victim of a violent crime in the past month by ethnicity	QOL 12a
	Outcome 22:	Percentage of consumers who report being a victim of a non-violent crime in the past month by ethnicity	QOL 12b
	Outcome 23:	Percentage of consumers who report being satisfied with their personal safety by ethnicity	QOL 14a, b, c
	Outcome 24:	Mean satisfaction with personal safety by ethnicity	QOL 14a, b, c
Social Support Networks			
Concern: Service recipients experience increased natural supports and social integration	**Outcome 25:**	Percentage of consumers who experience increased activities with family by ethnicity	QOL 4, 5
	Outcome 26:	Percentage of consumers who report being satisfied with their family contact by ethnicity	QOL 6a, b
	Outcome 27:	Mean satisfaction with family contact by ethnicity	QOL 6a, b
	Outcome 28:	Percentage of consumers who experience increased activities with friends, neighbors, or social groups by ethnicity	QOL 7a, b, c, d
	Outcome 29:	Percentage of consumers who report being satisfied with their social relations by ethnicity	QOL 8a, b, c, d
	Outcome 30:	Mean satisfaction with social relations by ethnicity	QOL 8a, b, c, d

[11] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[12] This measure would be analyzed for clients for whom performance outcome data has been collected.

INDICATORS FOR SYSTEM OVERSIGHT FOR OLDER ADULTS WITH SERIOUS MENTAL ILLNESSES[13]

CONTEXT, RISK ADJUSTMENT, OR CASE MIX VARIABLES[14]

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Differences among counties		
Concern: Differences among counties in resources, socioeconomic conditions, demographics, and client characteristics must be considered before any comparisons of performance indicator results can be made	**Risk Adjust. 1:** County poverty rate	Statistical Abstract
	Risk Adjust. 2: Per capita funding for mental health services for ages 60 and older	DMH and County Fiscal Systems
	Risk Adjust. 3: Degree of ethnic diversity in county population	DOF Population Data

DOMAIN: STRUCTURE

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Staffing		
Concern: Staffing levels and training are appropriate for delivery of the array of services and provide for meeting the diverse needs of the individuals served, including linguistic and cultural competency	**Structure 1:** Number of staff per 1,000 clients by personnel classification	County Administration
	Structure 2: Percentage of staff who are bicultural by ethnicity	County Administration Cultural Competency Plans

[13] The intention of the CMHPC is to recommend measures for which data are available. Because the set of instruments for collecting data in the Older Adult System of Care is under development, data sources have not been specified for some measures. Modifications will have to be made to these proposed measures once instruments are selected.

[14] These variables are being introduced for purposes of discussion only.

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
	Structure 3: Percentage of staff who are bilingual by language	County Administration Cultural Competency Plans
Continuity of Care		
Concern: The organization has a single, fixed point of responsibility for consumers and provides continuity of care	**Structure 4:** Under consideration	None identified
Coordination of Care		
Concern: The organization provides effective linkages to other service systems with which consumers need to interact	**Structure 5:** Under consideration	Available only for physical health care from on-site review process
Quality Improvement		
Concern: The organization uses a quality improvement approach to monitoring the performance of its system of care	**Structure 6:** The organization has a quality improvement system in place	On-site reviews
	Structure 7: Counties are measuring older adult performance outcomes and submitting the data to the DMH in a timely fashion	DMH Performance Outcome Data System
Rights and Complaint Resolution		
Concern: Consumer rights are clearly defined and procedures for resolution of complaints and grievances are in place and easy to use	**Structure 8:** Number of formal grievances filed by consumers	Not collected
	Structure 9: Number of fair hearings filed by consumers	DMH Ombudsman Office

DOMAIN: ACCESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Services Are Reaching the Intended Population		
Concern: Penetration rates demonstrate that services are reaching the intended populations, including culturally and linguistically diverse populations	**Access 1:** Percentage of county population ages 60 and older who receive mental health services in one year by modes of service as defined by CSIS, gender, ethnicity, and diagnosis	CSIS
	Access 2: Percentage of the county's monthly average Medi-Cal eligibles ages 60 and older who receive mental health services in one year for all aid codes by modes of service, gender, ethnicity, and diagnosis	Medi-Cal Paid Claims
Quick and Convenient Entry into Services		
Concern: Entry into mental health services is quick, easy, and convenient	**Access 3:** Percentage of respondents for whom the location of services is convenient by ethnicity	MHSIP Consumer Survey Q4
	Access 4: Percentage of respondents for whom services are available at times that are convenient by ethnicity	MHSIP Consumer Survey Q7
	Access 5: Percentage of respondents who report that mental health staff returned their calls within 24 hours by ethnicity	MHSIP Consumer Survey Q6
Range of Service Options		
Concern: Clients can access services that they need	**Access 6:** Units of service per client for each mode of service by ethnicity	CSIS
	Access 7: Percentage of resources expended on mental health services provided in the field (natural setting, such as home, school, and work) by ethnicity	CSIS
	Access 8: Percentage of respondents who report that services they need are readily available by ethnicity	MHSIP Consumer Survey Q5 & 8
Cultural and Linguistic Access		
Concern: Clients have access to a primary mental health provider who meets their needs in terms of ethnicity, language, and culture	**Access 9:** Percentage of respondents who report that staff are sensitive to their ethnicity and culture reported by ethnicity and language	MHSIP Consumer Survey Q13
	Access 10: Percentage of new clients who do not receive a second service within six months of entry in the CSIS reported by ethnicity and language	CSIS

DOMAIN: PROCESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Voluntary Participation in Services		
Concern: People using mental health services do so voluntarily and in collaboration with service providers. The use of involuntary mental health intervention is minimized	**Process 1:** Percentage of respondents who report actively participating in decisions concerning their treatment by ethnicity and language	MHSIP Consumer Survey Q17 & 18
	Process 2: Percentage of admissions for psychiatric inpatient treatment that are involuntary by ethnicity	CSIS
Services that Promote Recovery		
Concern: The mental health provider or system offers services that promote the process of recovery	**Process 3:** Percentage of Medi-Cal clients by ethnicity for whom medication is prescribed who received prescriptions for: a. Atypical antipsychotics b. Newer generation anti-depressants	CSIS & Medi-Cal Pharmacy Claims Data
	Process 4: Percentage of respondents who report receiving services that support recovery by ethnicity	MHSIP Consumer Survey Q9 & 14
	Process 5: Percentage of respondents who report being involved in self-help activities by ethnicity	MHSIP Q29
Services that Maximize Continuity of Care		
Concern: The mental health provider or system maximizes continuity of care	**Process 6:** Percentage of people discharged from inpatient services that receive ambulatory services within 7 days by ethnicity	CSIS
	Process 7: Percentage of clients in acute psychiatric inpatient care who have a visit from a case manager while in the hospital by ethnicity	CSIS, but could be difficult to obtain
Minimal Recurrence of Problems		
Concern: People experiencing an episode of acute psychiatric illness receive care that reduced the likelihood of a recurrence within a short period of time	**Process 8:** Percentage of inpatient readmissions that occur within 30 days of discharge by ethnicity	CSIS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Consumer Involvement in Policy Development, Planning, and Quality Assurance Activities		
Concern: People using mental health services have meaningful involvement in program policy, planning, evaluation, quality assurance, and service delivery	**Process 9:** Percentage of full-time equivalent staff positions that are occupied by consumers of mental health services age 60 and over by ethnicity	Special Studies
	Process 10: Percentage of mental health consumers age 60 and over on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
	Process 11: Percentage of family members on mental health boards and commissions and Quality Improvement Committees by ethnicity	Special Studies
Adequate Information to Make Informed Choices		
Concern: Service recipients receive information that enables them to make informed choices about their care	**Process 12:** Percentage of respondents who receive adequate information to make informed choices by ethnicity and language	MHSIP Consumer Survey Q11, 16, & 19

DOMAIN: COST EFFECTIVENESS

INDICATORS FOR OLDER ADULTS	MEASURES	DATA SOURCE
Scarce Resources Expended Efficiently		
Concern: Use of most restrictive and most costly services is minimized to the extent feasible	**CE 1:** Proportion of total expenditures on services spent on acute inpatient, subacute, and state hospital services	CSIS & CR/DC

DOMAIN: OUTCOMES

INDICATORS FOR OLDER ADULTS	MEASURES		DATA SOURCE
Physical Health			
Concern: Mental health services recipients should have equal access (relative to the general population) to effective general health care	**Outcome 1:**	Percent of Medi-Cal clients age 60 and older who receive mental health services during the year that also received physical health care services through Medi-Cal by ethnicity	CSIS & DHS Medi-Cal Data
	Outcome 2:	Percentage of consumers who report being satisfied with their health by ethnicity	
Symptoms			
Concern: The level of psychological distress from symptoms is minimized	**Outcome 3:**	Percentage of consumers who experience a decreased level of psychological distress by ethnicity	GAF score, & MHSIP Q26
	Outcome 4:	Suicide rate among persons with serious mental illnesses by ethnicity	CSIS & Vital Statistics, but could be difficult to obtain
Psychological Functioning			
Concern: Service recipients experience increased independent functioning	**Outcome 5:**	Percentage of consumers who report increased functioning by ethnicity	MHSIP Q20-25
Substance Abuse			
Concern: Clients experience minimal impairment from use of substances	**Outcome 6:**	Rate of all adults receiving services who are identified with substance abuse problems by ethnicity[15]	CSIS[16]
Productive Daily Activity			
Concern: Persons with serious mental disabilities should have the opportunity to engage in meaningful daily activities, e.g., employment, training, education, etc.	**Outcome 7:**	Proportion of older adults with serious mental illnesses involved in competitive employment by ethnicity	CSIS[16]

[15] As long as under-reporting of substance abuse is a problem, this rate should be compared with the known prevalence rate of dual diagnosis among persons with serious mental illnesses.

[16] This data would be analyzed for clients for whom performance outcome data has been collected.

	Outcome 8:	Proportion of older adults with serious mental illnesses involved in volunteer activity by ethnicity	CSIS[17]
Capacity for Independent Community Living			
Concern: Clients function in community settings with optimal independence from formal service systems	**Outcome 9:**	Percentage of older adults with serious mental illnesses living in their own home or apartment by ethnicity	CSIS[17]
Social Support Network			
Concern: Service recipients experience increased natural supports and social integration	**Outcome 10:**	Percentage of consumers who experience increased activities with family, friends, neighbors, or social groups by ethnicity	

[17] This data would be analyzed for clients for whom performance outcome data has been collected.

APPENDIX II

MEASURES TO IMPROVE CULTURAL COMPETENCE OF SYSTEM OVERSIGHT

DOMAIN: PROCESS

TARGET POPULATION	MEASURES	DATA SOURCE
All	Length of service per client for each mode of service by ethnicity	CSIS
All	Retention rate in outpatient services for new client by ethnicity	CSIS
Children	Consumer perception of involvement in treatment planning by ethnicity	Participation in Treatment Scale, YSS, YSS-F
Adults, Older Adults	Consumer perception of involvement in treatment planning by ethnicity	MHSIP Q17-18
Children	Satisfaction with care plan by ethnicity	Appropriateness Scale, YSS, YSS-F
Adults, Older Adults	Satisfaction with care plan by ethnicity	General Satisfaction Scale, MHSIP
Adults, Older Adults	Satisfaction with mental health education and literature by ethnicity	MHSIP Q11 & 19
Children	Satisfaction with cultural sensitivity by ethnicity	Cultural Sensitivity Scale, YSS, YSS-F
Adults, Older Adults	Satisfaction with cultural sensitivity by ethnicity	MHSIP Q13
Children	Satisfaction with linguistic competence by ethnicity	YSS, YSS-F Q14
Children	Satisfaction with range of services by ethnicity	YSS, YSS-F Q10-11
Adults, Older Adults	Satisfaction with range of services by ethnicity	MHSIP Q8
Adults, Older Adults	Attending self-help programs by ethnicity	MHSIP Q29
Adults, Older Adults	Frequency of participation in self-help programs by ethnicity	MHSIP Q30

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