WELLNESS • RECOVERY • RESILIENCE

Mental Health Services
Oversight & Accountability Commission

November 21, 2019
PowerPoint Presentations and Handouts

Tab 2:	• **PowerPoint:**	**Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020 - 2025**
Tab 3:	• **PowerPoint:**	**Mental Health Student Services Act Request for Proposal Outline**
Tab 4:	• **PowerPoint:**	**Stakeholder Request for Proposals Outline**
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Mental Health Services
Oversight & Accountability Commission

Striving for Zero:

California's Strategic Plan for Suicide Prevention, 2020 – 2025

November 21, 2019
Ashley Mills, M.S.
Senior Researcher
Suicide Prevention Project Lead

Project Overview

- Assembly Bill 114
- Suicide Prevention Subcommittee
- Overview of project activities
  - Subcommittee Meetings
  - Community Forums
  - Site Visits
  - Public Hearings
  - Local and National Initiatives

Report Overview

- Strategic Aims and Goals
- Background
- State Workplan

Strategic Aim 1: Establish suicide prevention infrastructure

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation

Strategic Aim 2: Minimize risk for suicidal behavior by promoting safe environments, resiliency, and connectedness

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families and communities to reach out for help when behavioral health needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology

Strategic Aim 3: Increase early identification of suicide risk and connection to services based on risk

- Goal 8: Increase detection and screening to connect people to services
- Goal 9: Deliver a continuum of crisis services within and across counties

Strategic Aim 4: Improve suicide-related services and supports

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss

Strategic Aim 1

- Goal 1: Enhance visible leadership and networked partnerships
- Goal 2: Increase development and coordination of suicide prevention resources
- Goal 3: Advance data monitoring and evaluation

Strategic Aim 2

- Goal 4: Create safe environments by reducing access to lethal means
- Goal 5: Empower people, families and communities to reach out for help when behavioral health needs emerge
- Goal 6: Increase connectedness between people, family members, and community
- Goal 7: Increase the use of best practices for reporting of suicide and promote healthy use of social media and technology

Strategic Aim 3

- Goal 8: Increase detection and screening to connect people to services

- Goal 9: Deliver a continuum of crisis services within and across counties

Strategic Aim 4

- Goal 10: Deliver best practices in care targeting suicide risk
- Goal 11: Ensure continuity of care and follow-up after suicide-related services
- Goal 12: Expand support services following a suicide loss

Background

- Plan Development
- Suicidal Behavior and Suicidal Behavior in California
- Risk and Protective Factors
- Best Practices
  - Universal Prevention
  - Selective Prevention
  - Indicated Prevention

State Workplan

- State Objectives and Implementation Schedule to achieve the 12 goals outlined under the four strategic aims

- Comprehensive Suicide Prevention Using:
  - Leadership
  - Data
  - Training
  - Policy

Next Steps

- If the proposed motion is adopted today, Staff will:
  - Work with State leaders, including the Governor's Office, Administration, and the Legislature to begin to implement next steps as outlined
  - Implement a communications strategy to guide suicide prevention efforts and investments
  - Provide technical assistance to support local planning and development

Proposed Motion

The MHSOAC adopts Striving for Zero: California's Strategic Plan for Suicide Prevention, 2020-2025

MHSOAC
Mental Health Services
Oversight & Accountability Commission

Mental Health Student Services Act

Request for Proposal (RFP) Outline

November 21, 2019

Tom Orrock, Chief of Stakeholder Engagement and Grants

Mental Health Student Services Act (MHSSA)

- Senate Bill 75
- $40 million one time and $10 million ongoing
- Establish partnerships between county or city behavioral health departments, school districts, and a County Office of Education or charter school within the county

Objectives of the MHSSA

- Incentivize partnerships
- Increase access to mental health services
- Provide support services
- Outreach to high-risk youth

Role of Commission

- Commission shall
  - Award grants
  - Establish criteria for grant programs including allocation of funds
  - Require that applicants comply with all stated requirements
  - Determine the amount of grants
  - Develop metrics and a system to measure and publicly report on performance outcomes
  - Provide status report to the legislature by March 1st, 2022

Role of Commission (cont.)

- Commission may
  - Establish incentives to provide matching funds
  - Enter into exclusive or non-exclusive contracts, or amend existing contracts on a bid or negotiated basis

MHSSA Listening Sessions

- Sessions held in Sacramento, El Cerrito, Fresno and Downey
- Over 230 participated
  - Behavioral Health Departments
  - School Districts
  - Education Associations
  - Parents
  - Students
  - Teachers
  - Community-Based Organizations

MHSSA Listening Sessions (cont.)

- Common themes
  - Established partnerships are more prepared to respond to RFP
  - Favoring established partnerships may be a deterrent to those forming new partnerships
  - Incentives for matching funds may be challenging for rural or small counties
  - Many favor grouping grant applications by county size

Grant Apportionment

- One RFP with two categories
  - Existing partnership (two or more years)
  - New or emerging partnership (less than two years)
- $75 million over four years and 18 grants total
  - $45M to existing partnerships
  - $30M to new or emerging partnerships
- Three funding levels based on county population
  - Small (less than or equal to 200,000)
    = 6 grants @ $2.5M ea
  - Medium (greater than 200,000-750,000)
    = 6 grants @ $4M ea
  - Large (greater than 750,000)
    = 6 grants @ $6M ea

Allowable Costs

- Grant funds
  - Must be used for stated purpose of the grant
  - May supplement but not supplant existing programs
  - Cannot be transferred to any other program

Allowable Costs (cont.)

- Include personnel, administration and program costs
  - Personnel and peer support dedicated to delivering services
  - Administration costs not to exceed 15% of total budget grant amount
  - Program costs may include training, technology, facilities improvement and transportation

Program Plan

- Create in conjunction with the identified educational entities
- Demonstrate ability to meet RFP requirements
- Include needs assessment; proposed use of funds to include at a minimum, providing personnel or peer support; linkage and access to ongoing/sustained services
- Include ability to obtain federal Medicaid or other reimbursement
- Include ability to provide services after grant funding is expended

Program Plan (cont.)

- Address goals regarding mental illness
  - Prevent becoming severe and disabling
  - Timely access to services
  - Outreach to recognize early signs
  - Reduce stigma
  - Reduce discrimination
  - Prevent negative outcomes

Program Implementation Plan

- Required as part of proposal
- Illustrate critical steps in starting proposed programs
- Identify implementation challenges

Key Action Dates

- RFP Release
  - December 2, 2019
- Intent to Apply
  - December 9, 2019
- Application Deadline
  - February 14, 2020 for existing
  - April 30, 2020 for new and emerging
- Intent to Award
  - March 26, 2020 for existing
  - June 2020 for new and emerging

Proposed Motion

- Commission approves the proposed outline of the MHSSA RFP
- Commission authorizes the Executive Director to initiate a competitive bid process

Mental Health Services
Oversight & Accountability Commission

Stakeholder Request for Proposals (RFPs) Outline

Tom Orrock, Chief, Commission Grants and Operations
November 21, 2019

Background

- The Commission's Budget includes $5.4 million annually to support stakeholder advocacy, training and education, and outreach and engagement for eight different populations.

- The Transition Age Youth and Immigrant and Refugee Stakeholder RFPs were awarded earlier this year.

- The proposed RFP outline applies to remaining six stakeholder populations.
  - Clients/Consumers
  - Diverse Racial and Ethnic Communities
  - Families of Clients/Consumers
  - LGBTQ Communities
  - Parents/Caregivers
  - Veteran Communities

Community Engagement

Information was gathered to prepare the outline from three main sources.

- Information Survey
  - Received responses from 48 organizations or individuals across the state.
- Six Listening Sessions
  - Stanislaus, Sacramento(2), Alameda, Los Angeles, and a Virtual Town Hall
  - 50+ participants
- Review of current State of the Community reports

Contract Structure:
State and Local Advocacy, Training and Education, and Outreach and Engagement

- Award one contract to a State-Level Advocacy Organization for each of the six populations.

- Community Engagement Plan is required to ensure partnerships between the state level contractor and local level entities.

Proposed Scope of Work: State Level Contractor

- Plan and conduct 3 statewide events
- Plan and conduct 15 community events
- Provide post-event follow-up information
- Provide state-level, statewide advocacy
- Annual State of the Community Report

Contract Funding

A total of $2,010,000 for a 39-month term awarded for each of the six contracts.

A total of $12,060,000 awarded through the six contracts

Proposed Minimum Qualifications for State-Level Contractor

- Be an established state-level organization in operation for 2 years and have experience with programs and services related to the unique mental health needs of California's Stakeholder population for which a proposal is being submitted.
- Have experience and capacity to partner with local community-based organizations working on mental health issues for the specific population stated in the RFP.

Proposed Minimum Qualifications for State-Level Contractor (cont'd)

- Be a non-profit organization, registered to do business in California.
- Have program staff *or* board members that include more than 50 percent stakeholders of the population to be served.
- For Clients/Consumers, bidders must have more than 50 percent staff *and* board members who have lived experience as a consumer.
- For Families of Clients/Consumers bidders must have more than 50 percent staff *and* board members who have lived experience as a family member.

Next Steps

- December 2, 2019: RFPs released to the public
- January 24, 2020: Deadline to submit proposals for Veterans, Clients/Consumers, and Families
- January 31, 2020: Deadline to submit proposals for Parents/Caregivers, Diverse Racial and Ethnic Communities, and LGBTQ
- February 27, 2020: Commission issues Notice of Intent to Award

Proposed Motion

- The Commission approves the proposed outline of the scope of work for six stakeholder RFPs to support advocacy, training, and outreach efforts on behalf of Clients/Consumers, Diverse Racial and Ethnic Communities, Families of Clients/Consumers, LGBTQ , Parents of Children and Youth, and Veteran Communities

- The Commission authorizes the Executive Director to initiate a competitive bid process.

November 13, 2019

Khatera Aslami-Tamplen

Chair

Mental Health Services Oversight and Accountability Commission

1325 J Street Suite 1700

Sacramento, CA 95814

Re: RFP Framework – MHSOAC Meeting on November 21, 2019

Dear Chair Aslami-Tamplen and Commissioners,

Native Directions Inc., Three Rivers Indian Lodge has been serving people from the Native American community since 1972 and have been an active member since Native Directions is a Residential Treatment Center and serves the Native Americans from all over. We have learned that MHSOAC will be voting on the framework of the RFP for the stakeholder advocacy grant for diverse racial and ethnic communities at your meeting on November 21,2019.

We urge you to keep the focus of this RFP on state level advocacy. On the horizon are many crucial mental health policy and administration issues at the state level. All of the diverse racial and ethnic communities need to have a strong and united voice at these state policy and decision-making tables. Breaking this grant up into local awards alone will make it difficult for effective advocacy at the state level.

Of course, the state wide organization that receives the award should have deep connections with local organizations serving specific racial/ethnic communities, and strong relationships with local cultural brokers. While training experience is beneficial, it is equally or even more important that the state wide organization have a strong record of specific policy initiatives and advocacy efforts that addressed the reduction of mental health disparities.

We urge you to listen to the experienced advocates who are most familiar with and represent our respective communities. Thank you for considering our input into this important matter.

Sincerely,

Ramona Valadez

Executive Director

Native Directions Inc., Three Rivers Indian Lodge

Cc: Toby Ewing, Executive Director, MHSOAC

Tom Orrock, Chief, Commission Operations and Grants, MHSOAC

NAMI California
National Alliance on Mental Illness

NAMI California
1851 Heritage Lane # 150
Sacramento, CA 95815
916-567-0163

TO: Mental Health Services Oversight and Accountability Commission Members and Staff; California State Legislature

FROM: Jessica Cruz, CEO, National Alliance on Mental Illness - California

DATE: November 14, 2019

SUBJECT: Use of State Administrative Mental Health Services Act (MHSA) Funds - CONCERNS

On behalf of the National Alliance on Mental Illness California (NAMI-CA), I am writing to express concerns with recent proposals to utilize Mental Health Services Act (MHSA) funding intended for State Administrative purposes to support local, *rather than statewide*, initiatives and organizations.

NAMI-CA supports the Mental Health Services Oversight and Accountability's (Commission) recent community listening sessions and appreciates the opportunity to provide feedback regarding the development of the next round of stakeholder advocacy grants. Feedback gathered directly from the community plays a vital role in supporting the effective design and implementation of appropriate mental health programs and supports and ensures better outcomes for family members and individuals.

We applaud the Commission for hosting these sessions in varied locations across the state. However, we are concerned that the minimal attendance will result in the development of RFPs that do not reflect the needs of our communities as a whole. This includes the notable shift outlined by Commission staff to move away from a shared state and local focus to one that emphasizes local activities. **We encourage the Commission to reconsider diverting State Administrative funds and retain the shared state and local scope that was developed by community stakeholders and implemented by all advocacy contractors.**

The current engagement efforts to gather community input has not been as robust as prior activities completed in 2015-2016. While drafting the first round of RFPs, the Commission engaged in a six month intensive effort that included contractor interviews and multiple public meetings where information was not just collected but shared, discussed and evaluated by staff and community members to collectively establish priorities for use of state MHSA funds. That process resulted in contracts that called for both state and local activities to support necessary state level work while also building the capacity and infrastructure of local level organizations.

However, we are concerned about some of the MHSOAC's recent proposals to utilize MHSA State Administrative funds appropriated to the Commission by the Legislature. Specifically, the Immigrant/Refugee RFP and the Transition Age Youth (TAY) RFP. In both of these processes, relevant community input submitted through public comment and in writing to the Commission was neither considered nor incorporated into the resulting RFPs and contract work.

The TAY RFP was developed by the Commission and awarded in August of 2019, utilizing feedback received during a 2017 public meeting specifically designed to discuss the need for TAY events across the state. This discussion was not inclusive of the broader needs of youth mental health and did not factor in any recent information gleaned from the Commission's contract with California Youth Connection or the current Youth Innovation Project Planning Committee.

The Immigrant/Refugee RFP awarded in April 2019, completely eliminated the scope of work for a statewide entity, instead focusing solely on funding local level organizations. This decision was made by Commissioners despite overwhelming public feedback received by numerous community partners calling for the preservation of state level funding to provide the support needed for a cohesive state effort to elevate the needs of immigrant and refugee mental health in state level advocacy efforts.

We are concerned that despite requests from stakeholder partners to create RFPs that are reflective of the specific needs of the eight populations served with these funds, the Commission will adopt a uniform set of RFPs that call for the same "one size fits all" work to be done across all populations. The scope of work as developed by Commission staff and not by the community will result in work that does not address the unique needs of each population and will not yield meaningful outcomes for individuals and family members. We support the requests by state partners to maintain the shared state and local focus that appears to have been dismissed by Commission staff in favor of a more localized investment.

We would support efforts by the Commission to revise and expand their approach to this process. The spirit and intent of the MHSA is that the meaningful participation of consumers and family members in all levels of decision-making is crucial to ensure that programs and services are client and family-driven. As such, NAMI-CA strongly feels that the proposed scope of work in the next round of contracts will not adequately support the engagement of consumers and family members across the state.

We believe actions such as this would be inconsistent with the intent and purpose of MHSA State Administrative funding. As you recall, MHSA state statutes describe *very specific purposes* of MHSA State Administrative Funds. Specifically, Welfare and Institutions Code Section 5892, subdivision (d) states:

> *(d)* ***Prior to making the allocations pursuant to subdivisions (a), (b), and (c),*** *funds shall be reserved for the costs for the State Department of Health Care Services, the California Behavioral Health Planning Council, the Office of Statewide Health Planning and Development, the Mental Health Services Oversight and Accountability Commission, the State Department of Public Health, and any other state agency to implement all duties* ***pursuant to the programs set forth in this section****. These costs shall not exceed 5 percent of the total of annual revenues received for the fund****. The administrative costs shall include funds to assist consumers and family members to ensure the appropriate state and county agencies give full consideration to concerns about quality, structure of service delivery, or access to services. The amounts allocated for administration shall include amounts sufficient to ensure adequate research and evaluation regarding the effectiveness of services being provided and achievement of the outcome measures*** *set forth in Part 3 (commencing with Section 5800), Part 3.6 (commencing with Section 5840), and Part 4 (commencing with Section 5850). The amount of funds available for the purposes of this subdivision in any fiscal year is subject to appropriation in the annual Budget Act.*

The vast majority of the nearly $2 billion generated by MHSA each year is already provided to local communities. When combined with the provision that allows counties to use up to 5% of their total annual MHSA revenues for planning and supporting family members, consumers, stakeholders and contractors in local planning processes, it is clear there exists an abundance of local funds that can be invested in strengthening local activities. Additionally, with more than $231 million in unspent local county funds it is apparent that the need for the state to distribute the MHSA State Administrative funds to local agencies is not needed. Rather, collaborating with state-wide agencies that have local connections is the best way to utilize the funds to ensure the development and sustainability of programming that is reflective of the needs of the community more broadly across the state.

State Administrative funds should be invested in strategies that not only build the capacity of local communities, but that fortify partnerships across the state. Statewide organizations play a vital role in strengthening local and state-level efforts to create a better system of support across the state through local partnerships. While local partners are able to be the “boots on the ground” in a community, state level partners can provide the scaffolding necessary to support local activities through education, coalition building with other statewide stakeholder groups, as well as ongoing participation and engagement with state and local decision makers to support a more responsive system that can meet the needs of family members and individuals at all levels.

We urge you to please consider these concerns as you evaluate proposals to utilize MHSA State Administrative funds. I would appreciate an opportunity to speak with you about these concerns and answer any questions you may have. I may be reached at 916-567-0163.

NAMI-CA is the statewide affiliate of the country’s largest mental health advocacy organization, the National Alliance on Mental Illness. Our 19,000 members and 62 affiliates include many people living with serious mental illnesses, their families, and supporters. NAMI-CA advocates on their behalf, providing education and support to its members and the broader community.

The Community Wellness and Outcomes Project:

Reporting on Outcomes that Matter for Communities

Prepared for the Mental Health Services Oversight and Accountability Commission
Project Update
November 21st, 2019

Acknowledgments

The UCLA Team would like to extend our gratitude to

- MHSOAC Commissioners and Staff
- The Community Partnered Advisory Group, whose breadth of experience and feedback have been invaluable
- The individuals who have participated in the project thus far and provided critical data for the report

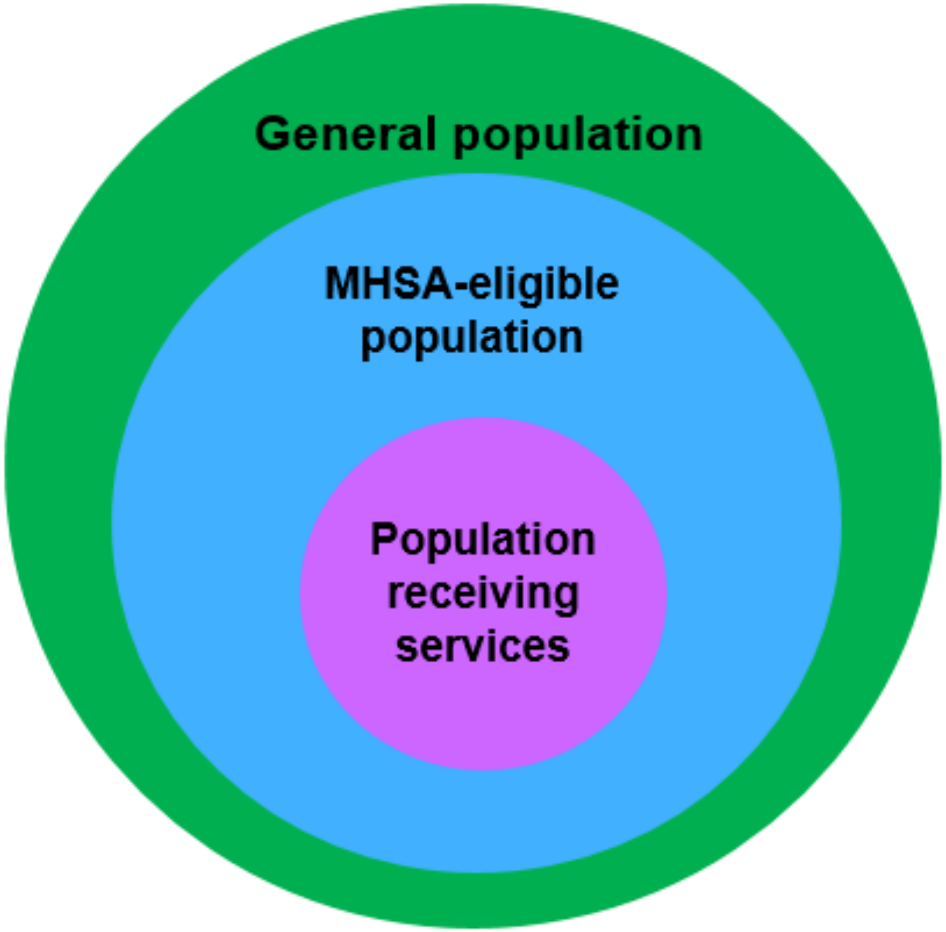
MHSA: Objective and Outcomes

- **Objective**: to reduce the long-term, adverse impact of serious mental illness
- **7 negative outcomes** of untreated, undertreated or inappropriately treated mental illness:
  - Suicide
  - Incarceration
  - School failure
  - Unemployment
  - Prolonged suffering
  - Homelessness
  - Removal of children from their homes

Significance of Tracking Outcomes

- How do we know if these MHSA outcomes are getting better in our state? Counties?
  - Systematically collect and monitor outcomes
  - Measure prevalence and monitor changes over time
  - Identify disparities and at-risk populations
- Leads to public health action and identification of areas of need for MHSA services

Populations of Interest



Primary Objectives

- **To identify publicly available data sources** that can allow MHSOAC to develop a statewide dashboard to track estimates on the 7 negative outcomes outlined in the MHSA and additional outcomes related to mental health services
- This future **dashboard** is envisioned as an early step in building capacity to improve the measurement and reporting of mental health care needs


Literature Review
Focus Groups & Interviews
Environmental Scan
Identify Best Practices to Measure the 7 MHSA Outcomes:
Suicide
Incarceration
Homelessness
Unemployment
Prolonged Suffering
School Failure/Dropout
Child Removal from Home
Observations
Statewide Survey
ADVISORY BOARD

Project Deliverables

1. **Outcomes Report**
   a. Includes 7 chapters, each on one of the 7 negative outcomes
   b. Audience: county administrators, researchers, others interested in methods and reasoning behind dashboard indicators
2. **Data library, management plan, suggestions on visualizations**
3. **Data fact sheets and briefs**
   a. Audience: general public

Data Sources: Eligibility Criteria

- Publicly available, downloadable, free
- Includes the State of California, may include some or all counties in CA
- Includes at least one of the 7 MHSA outcomes
- May include data elements important in tracking of the outcome

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UCLA Semel Institute
HSS | Center for Health Services and Society

Draft Results: Suicide, Removal From Home and Unemployment

Suicide Data Elements

- **Suicide rate:**
  - Deaths caused by self-directed injurious behavior with any intent to die as a result of the behavior
- **Suicide attempt:**
  - Non-fatal, self-directed, potentially injurious behavior with the intent to die. A suicide attempt may or may not result in injury
- **Suicide ideation:**
  - Serious thoughts about dying by suicide

Suicide Rates: *EpiCenter (California Dept. of Public Health)*

- **Where does data come from?**
  - Data from several injury-related searchable databases for California
  - Includes data from death certificates, hospitalizations ER admissions
- **What measures of suicide does it include?**
  - Death by Suicide; Suicide Attempt
  - By 5 most common means
- Available by county, year, gender, age, and race/ethnicity

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Age-Adjusted Death Rate due to Suicide

Measurement Period: 2015-2017

8.0

deaths/ 100,000 population

Source: California Department of Public Health
Measurement period: 2015-2017
Maintained by: Conduent Healthy Communities Institute
Last update: May 2019

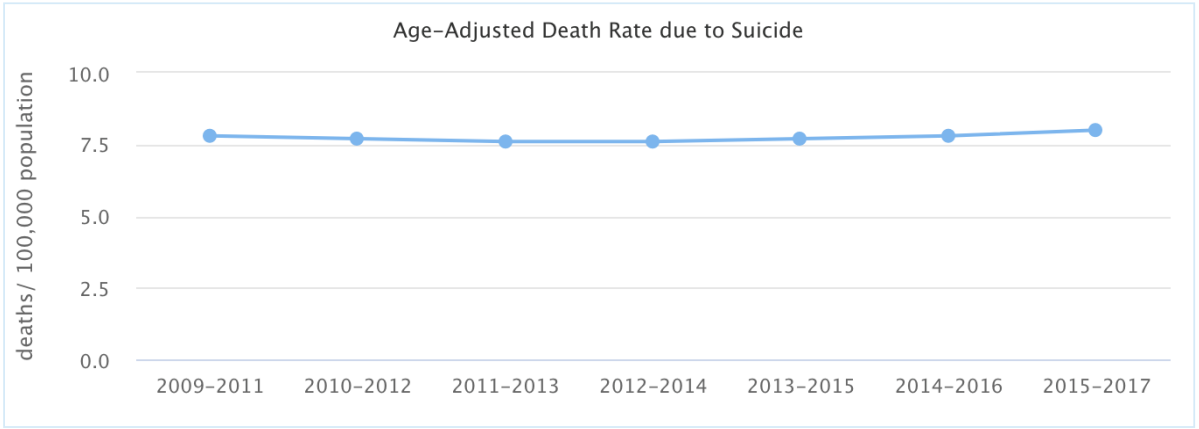
COMPARED TO

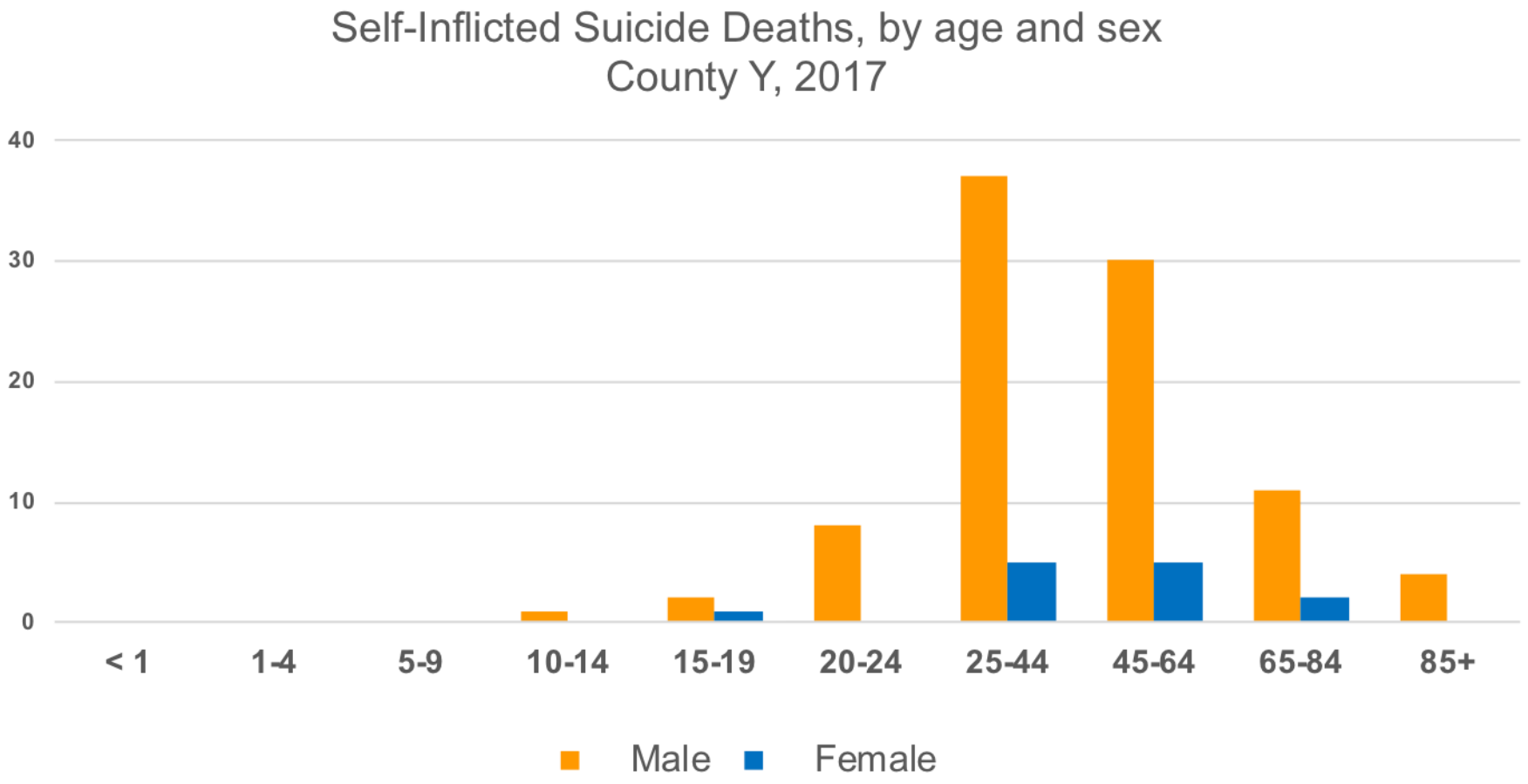
CA Counties	CA Value	US Value	Prior Value	Trend	HP 2020 Target
	(10.4)	(13.6)	(7.8)		(10.2)

Graph Selections

INDICATOR VALUES

- [x] Change over Time



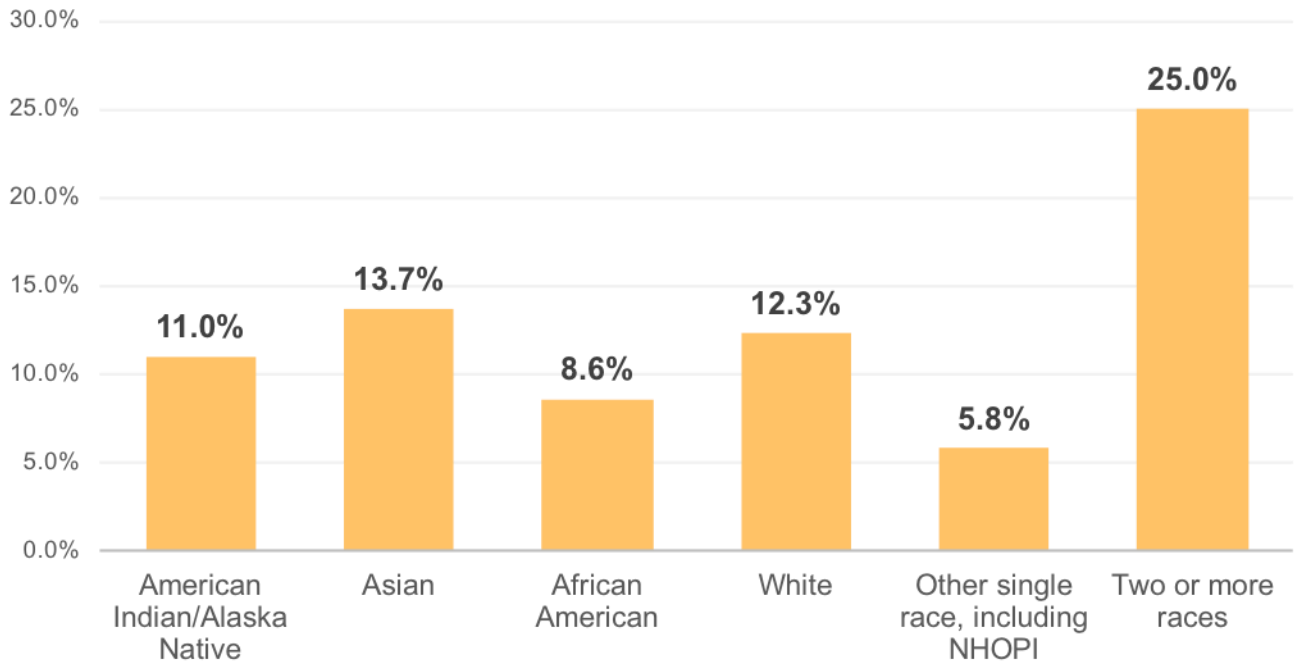


Source: CDPH Vital Statistics Death Statistical Master Files

Suicide Behaviors: *CHIS (California Health Interview Survey)*

- **Where does data come from?**
  - Household survey of adults and adolescents drawn from a random sample of California addresses
- **What measures of suicide behavior does it include?**
  - Lifetime and past-year suicide attempt
  - Lifetime, past-year, and recent suicide ideation
- Available by county, year, gender, age, and race/ethnicity, clinical and social circumstances, and special populations

Ever seriously thought about committing suicide by race
County X, 2016-2018



Source: 2016, 2017, 2018 California Health Interview Survey

Removal from Home: Data Elements

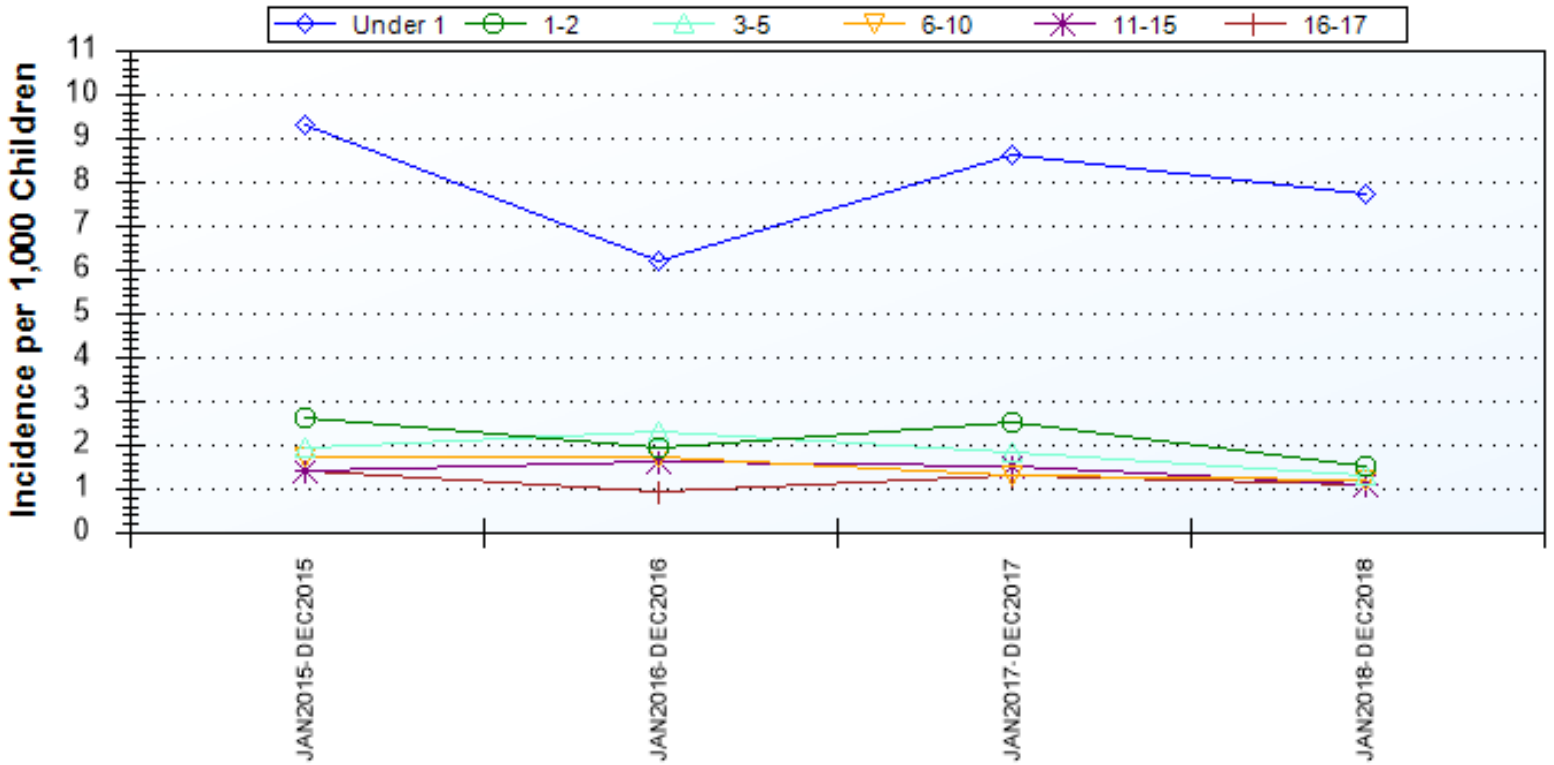
- **Referrals**
  - Reports of suspected child abuse and neglect
- **Repeat referrals**
- **Substantiated allegations**
  - CPS investigation determines that maltreatment occurred.
- **Removal from home**
  - Child is removed from the home and placed in out-of-home or substitute care.

Removal from Home: *CCWIP (CA Child Welfare Indicators Project)*

- **Where does data come from?**
  - Data are from the Child Welfare Services/Case Management System (CWS/CMS), CA's child welfare administrative data system.
- **What measures of removal from home does it include?**
  - Referrals
  - Repeat referrals
  - Substantiated allegations
  - Removal from home
- Available by county, year, gender, age, and race/ethnicity.

Children with Entries to Foster Care, Child Population (0-17), and Incidence Rates
Incidence per 1,000 Children
Agency Type=Child Welfare
Selected Subset: Episode Count: All Children Entering

Contra Costa



Based on an unduplicated count of entries during time period.
Data Source: CWS/CMS 2019 Quarter 2 Extract.
Population Data Source:
2000-2009 - CA Dept. of Finance: 2000-2010 - Estimates of Race/Hispanics Population with Age & Gender Detail.
2010-2018 - CA Dept. of Finance: 2010-2060 - Pop. Projections by Race/Ethnicity, Detailed Age, & Gender.
Program version: 2.00 Database version: 7033C6B4

California Child Welfare
Indicators Project (CCWIP)
University of California at Berkeley

Unemployment: Data Elements

- Unemployment rate
- Employee absenteeism due to mental illness or emotional distress
- Level of psychological distress among employed, unemployed, and those not in the labor force

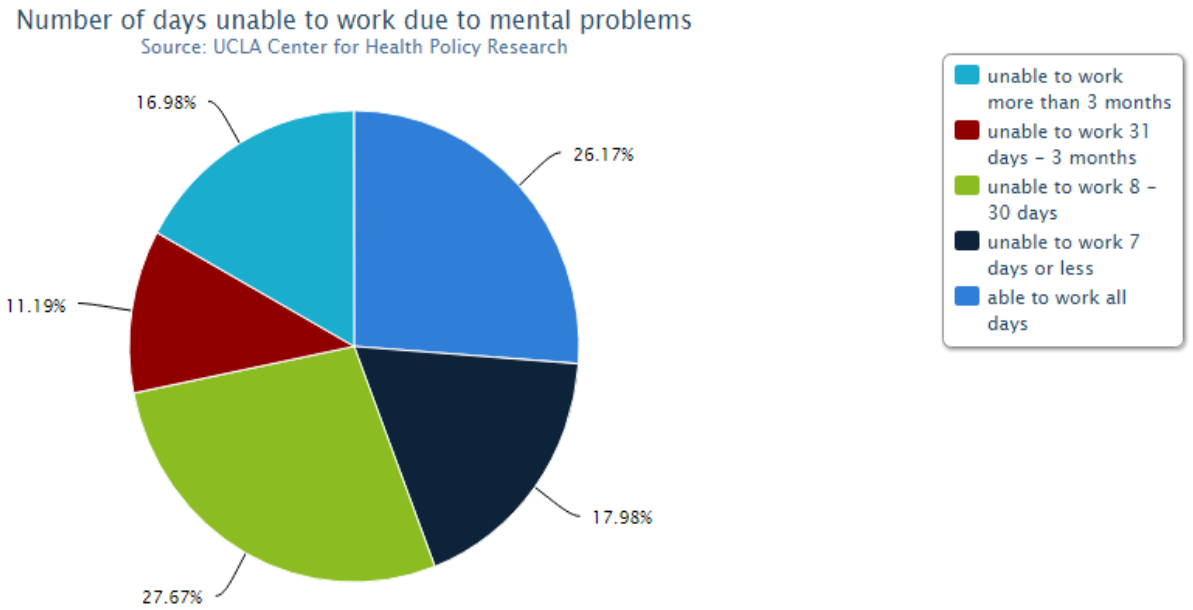
Unemployment: *BLS* *(Bureau of Labor Statistics)*

- **Where does data come from?**
  - Current Population Survey
  - Current Employment Statistics Survey
  - State unemployment insurance systems
  - American Community Survey
- **What measures of unemployment does it include?**
  - Unemployment rate
- Available by county, year, gender, age, and race/ethnicity.

Unemployment: *CHIS (California Health Interview Survey)*

- **Where does data come from?**
  - Household survey of adults and adolescents drawn from a random sample of California addresses
- **What measures of unemployment does it include?**
  - Unemployment rate
  - Employee absenteeism due to mental illness or emotional distress
  - Level of psychological distress among employed, unemployed, and those not in the labor force
- Available by county, year, gender, age, and race/ethnicity, clinical and social circumstances, and special populations

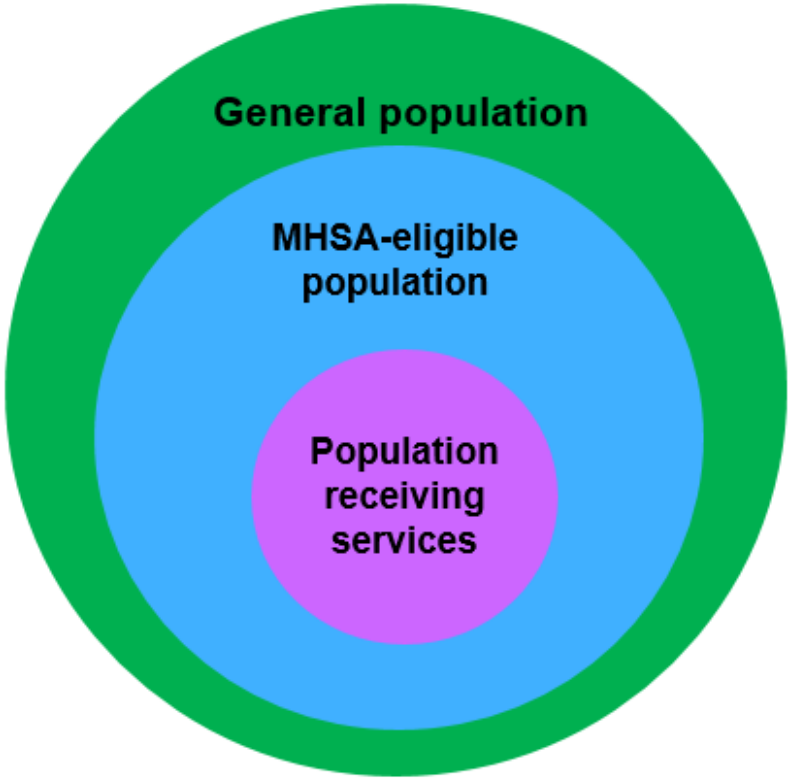
Employee Absenteeism due to Mental Problems



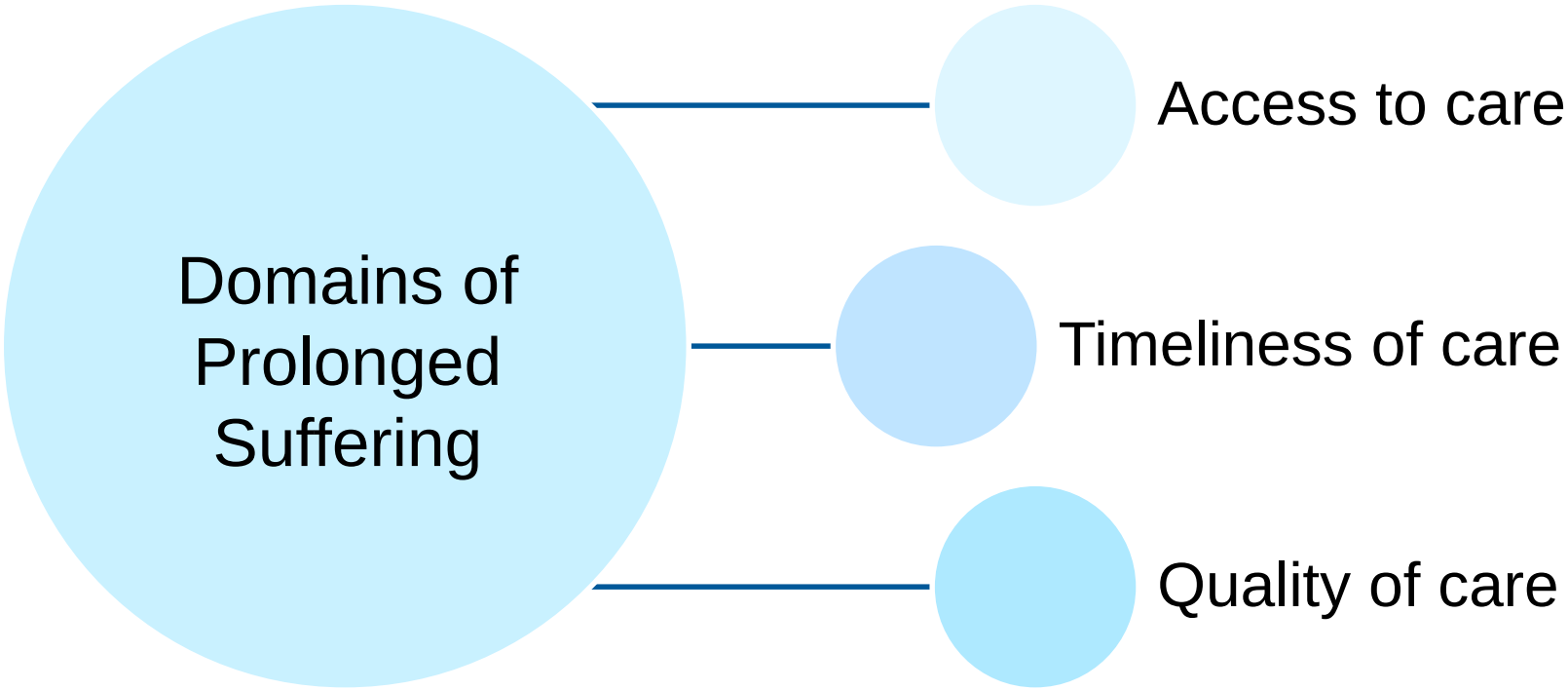
- 17% unable to work more than 3 months
- 11% unable to work 1-3 months
- 28% unable to work 8-30 days
- 18% unable to work 7 days or less
- 26% able to work all days

Decision Points

- Population levels to address?
  - Variation by outcome?



Decision Points



Next Steps

- Next 4 outcomes:
  - School failure
  - Incarceration
  - Homelessness
  - Prolonged suffering
- Synthesis of findings across outcomes
- Development of final rating system
- Create data library and management plan
- Create the data fact sheets and briefs

Questions?

- Sheryl H. Kataoka, MD, MSHS
  SKataoka@mednet.ucla.edu
- Bonnie T. Zima, MD, MPH
  BZima@mednet.ucla.edu

- hss.semel.ucla.edu/communitywellness/

ADDITIONAL SLIDES FOR DISCUSSION

Data Elements

- Geographic level
  - Census tract & county
  - All counties & state
  - Some counties & state
  - State only
- Frequency of data collection
  - More than annual; Annual; or Less than annual
- Demographics
  - Age
  - Gender

Data Elements

- Racial and Ethnic Groups
- Immigrant
- Undocumented
- Refugee
- LGBTQ
- Disability
- Urban/Rural
- Military Status
- Unemployed
- Homeless
- Poor and Near Poor
- Justice-Involved
- Child Welfare-Involved
- Mental Health Problem

Data Elements

- Clinical circumstances
  - Clinical severity
  - More than one disorder
  - Substance use/abuse disorder
  - Physical health
- Social circumstances
  - Discrimination
  - Educational attainment
  - Financial, housing, and food insecurity
  - Trauma exposure