Proposed Mental Health Surveillance Projects for 2017
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Introduction

Currently, the MHSOAC does not support statewide data collection efforts to assess the prevalence of outcomes identified in the Mental Health Services Act (MHSA) and the risk factors associated with those outcomes. These data could be used for a variety of purposes, such as publicizing to maintain public support for the need for publicly-funded mental health services; to evaluate the effectiveness of services; and to target services at the statewide or county-levels to those populations identified as most in need.

Accordingly, two proposed mental health surveillance projects are presented below. Both would be in accordance with the MHSA and the goals of the MHSOAC to support increased access to mental health services among underserved populations. These projects will be put forth to Evaluation Committee members and the public for discussion at the December 14, 2016 meeting. With the support of the chair, co-chair, and members, staff within the Research and Evaluation Unit will move forward on developing comprehensive proposals with detailed budgets for these projects to bring to the Committee for vote in early 2017.

Proposed Project #1. **Assessing Unmet Mental Health Needs in California**

Objectives: To estimate levels of mental health need within selected populations in California, overall and across racial/ethnic and other groups. To assess levels of unmet need based on standard treatment for severe mental illness, including the diverse types of services provided through Prevention and Early Intervention (PEI) programs.

Background & Rationale: Previous studies have estimated levels of need in California based on severe mental health disorders (serious emotional disturbance or serious mental illness).[1,2] High benchmarks have also been set for operationalizing levels of met need (and conversely levels of unmet need). For example, in one study, met need was defined as having four or more visits with a health professional in the past 12 months and use of prescription medications for mental health problems during this same period of time.[2] The utility of published rates of unmet need from the National Survey on Drug Use and Health are limited in the frequency to which these data are collected and available, and because unmet need is not fully represented by those services available through PEI.[3]

PEI activities and services are designed to provide an early response to emerging needs before they become severe and disabling. PEI programs offer a variety of non-clinical services, as required by the MHSA, such as outreach and referrals. The investment in PEI is substantial; each year over $350 million MHSA funds support services to prevent or intervene before disorders progress in severity. Yet, the extent to which these services reach selected populations has not been documented.

Transition age youth should be considered a population for this proposed study given the MHSA directive that counties must provide services to address the needs of those 15 to 25 years old. The research literature shows that half of all mental health disorders begin before the age of 14.[4] Moreover, the median age of onset for many disorders occurs during the transition phase; including obsessive-compulsive disorder, substance use disorders, agoraphobia, post-traumatic stress disorder, panic disorder, and bipolar disorder.[4] The National Comorbidity Survey-Adolescent Supplement (NCS-A), a

nationally representative survey, found that 22.2% of 13 to 18 year olds met the criteria for a mental disorder with severe role impairment and distress.[5] In terms of disparities, one study found that African American and Latino young adults accessed mental health services at less than half the rate of Non-Hispanic White young adults, even though all three groups had similar rates of mental health needs.[6] Specifically, the rate of annual mental health visits was 425 per 1,000 for Non-Hispanic White young adults, compared to 138 per 1,000 for African American and 160 per 1,000 for Hispanic young adults.

Proposed Methodology: Population-based telephone survey.

The sampling frame will be the Medi-Cal Eligibility Data System (MEDS) from the Department of Healthcare Services (DHCS), which consists of eligibility information of beneficiaries for Medi-Cal and other public programs such as CalWORKs and CalFresh. Information in the MEDS is entered at the household-level, and is quite detailed: the full name, gender, age, race ethnicity, and primary language for all family members are available. Contact information includes the complete mailing address and phone numbers; in some cases more than one phone number is available and can include the cell numbers for all persons 18 years of age and older. As such, MEDS represents an ideal sampling frame for this proposed study in terms of the detailed information available to facilitate recruitment of persons within households that are more likely to rely on county mental health services.

Staff from the DHCS Medi-Cal Eligibility Division have confirmed that they can provide current MEDS data files to the MHSOAC through an Inter-agency Agreement at a cost of roughly $1,500.

The sampling unit will be the household, stratified by age (minors versus 18 to 25 year olds) and race/ethnicity (over-sample of Latinos and African Americans). Within households with more than one member from the target population, one minor or young adult will be selected via a random process.

Recruitment procedures will include mailing letters of introduction to the households before telephone contact. The letters will be addressed to the parent/caregiver for households with minors, and addressed by name to those 18 through 25 years of age.

Telephone recruitment procedures will also differ by household type, with parent consent and then assent obtained from households with minors and verbal consent obtained directly from adult survey participants. For households with 18 to 25 year olds, a standardized script will be developed and presented to parents/caregivers reached during initial telephone calls to request contact information, as needed, from the target adult survey respondents.

The proposed number of completed interviews is 3,500. The data collection period would be six months. The estimated cost for the survey is $881,000, and is based on 45-minute interviews with up to eight recruitment calls made to the household/potential respondent, and a $10 gift card offered as an incentive and mailed to those who complete the interview.

The estimated cost of the survey comes from the Public Health Survey Research Program (PHSRP) at California State University Sacramento. Before coming to the MHSOAC, Fred Molitor worked with the PHSRP to design and implement annual surveys that in some cases included recruitment of over 10,000 adults, teenagers, and children as young as 5 years. This survey protocol would be submitted for approval to the California Committee for the Protection of Human Subjects.

Analyses and Reporting: Rates for need, and estimates for unmet need would be distinguished between those needs and services encompassing PEI and those representative of more severe mental health disorders. Comparisons across racial/ethnic groups would provide for estimated disparities in levels of need and unmet need.

With the support of the Commission, future cross-sectional surveys could be used to estimate levels of need and unmet need among the same population to assess changes over time, or within different populations such as children or adults. Moreover, behavioral health departments would be invited to cover the increased costs of oversampling within their jurisdictions to obtain statistically-stable county-level estimates for local program planning and evaluation purposes.

Stakeholder Involvement: Staff from county behavioral health departments, researchers, those with lived experiences, and others would be invited to participate in a workgroup to develop the series of interview items to assess mental health needs including self-reported diagnosis and to assess potential exposure to the diverse types of PEI services. Workgroup members would also be invited to provide feedback on and assist in interpreting the survey findings.

Estimated Costs: Overall, the proposed study (sampling frame and data collection) would require $882,500.

References

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Proposed Project #2. **Annual Mental Health of California Report Card**

Objectives: To produce, release, and publicize on an annual basis a comprehensive summary of the status of mental health needs and the consequences of unmet needs (e.g., suicide) along with the number and characteristics of persons receiving mental health services in California, as derived from existing and possibly new data collection activities. These data would be presented by age, race/ethnicity, and other subgroups, and released on the MHSOAC website.

Background & Rationale: Mental health surveillance data for California populations are available from a number of sources, and when collated and presented with additional survey data and descriptive information on persons receiving mental health services, would provide the general public, stakeholders, and other interested parties one source for assessing the extent of the need for mental health services, the number and characteristics of those receiving such services, and to a limited extent the relationship between services and outcomes.

Proposed Methodology: Descriptive and inferential data for this project would come from four sources: Existing surveys and data reporting systems; new and expanded data collection activities supported by the MHSOAC; descriptive information on mental health consumers; and analyses of data on mental health consumers linked with other state-level data.

1. Existing Surveys and Data Reporting Systems. A number of ongoing surveys provide prevalence estimates that could be retrieved for this project, such as national surveys that provide summary statistics for California, such as the National Survey on Drug Use and Health (SAMHSA), and those specific to California, such as the California Healthy Kids Survey (California Department Education).

   Information from federal and state data reporting systems would also be used for this project, such as suicide rates provided by the National Vital Statistics System (CDC), and emergency department visits and hospitalizations from suicide or self-harm from the Safe and Active Communities Branch of the California Department of Public Health. Summary information for Californians participating in the Mental Health American screenings could also be used. Currently, Research and Evaluation Unit staff are developing a table to display all pertinent mental health-related survey items and available descriptive data by age groups and are noting the frequency to which these data are released online and made available to the public by other means.

2. New Data Collection Activities. The Material, Child, and Adolescent Division of the California Department of Public Health, has requested support to expand their Maternal Infant Health Assessment (MIHA) survey of mothers who recent gave birth to develop a module to assess woman's mental health before, during, and after pregnancy; her experiences finding and receiving quality services; and the impact that mental health status has on daily functions. The current sample size for the MIHA is 6,800 respondents with county level estimates for up to 35 counties. Additional funds from the MHSOAC could also be used to expand the sample size to facilitate obtaining data from all California counties.

   In addition, the comprehensive assessment of existing surveys and data reporting systems discussed above could reveal gaps in the availability of MHSA-related outcomes. In response, the MHSOAC could partner with those overseeing ongoing population-based surveys and cover

the costs associated with adding relevant survey items, such as to the California Health Interview Survey (CHIS).

3. Descriptive Information on Mental Health Consumers. Through a data sharing agreement with the DHCS, the MHSOAC has access to the Client and Services Information (CSI) and Data Collection Reporting (DCR) data providing client characteristic for persons receiving publicly-funded mental health services in California, and outcomes for those receiving Full Service Partnership services. The Research and Evaluation Unit currently has access to these data and the statistical software to clean and analyze these data. We anticipate that in the near future we will have additional staff who will have the expertise to analyze these data and develop ongoing reporting processes.

Data Linkages Projects. The outcome of analyses obtained from linking mental health data, specifically the CSI, with other state-level data represents the fourth type of data that could be included for annual statewide reporting. As a part of the Mental Health and Criminal Justice project, staff from the Research and Evaluation Unit have been working with the Department of Justice to obtain the Monthly Arrest and Citation Register (MACR) and Automated Criminal History System (ACHS) databases. Merging these data will allow for addressing research question such as to what extend to those with a history of receiving mental health services have criminal justice involvement. Moreover, the MHSOAC has recently contacted the Director of the California Employment Development Department to request collaboration on a data linkage project to better understand how mental health programs are supporting employment outcomes for consumers.

Estimated Costs: Overall: Preliminary estimates provided by the Material, Child, and Adolescent Division are that adding a new module to the MIHA could cost approximately $100,000.