Santa Clara County Mental Health Department
Health Agenda Report 2009

Executive Summary

The Prevalence and Impact of Mental Illness

A large-scale epidemiological study shows that less than 30% of Americans with psychiatric disorders seek treatment.[1] A review of Santa Clara County Mental Health Department (MHD) Call Center records show that less than 30% of the people who seek services from the MHD system receive mental health treatment. Taken together— less than 30% of those who need services seek services—and—less than 30% of those who seek services receive services—it is readily apparent that there is a significant unmet need.

Context for Decision-Making: Funding and Mandated Service Overview

The benefits and restrictions of each of the programs that finance public mental health greatly impact who is served through the County system and what services are offered. These parameters were laid out in the Mandate Study completed several years ago by Harvey M. Rose Associates in conjunction with the departments. The MHD's mandated functions include:

- Emergency and crisis services
- Inpatient
- Sub-acute inpatient
- Adult residential
- Children's residential services
- Day treatment
- Day rehabilitation

- Outpatient
- CalWORKs outpatient
- Juvenile Hall/Ranches outpatient
- Pharmacy services
- Quality Improvement
- Disaster response
- 24-Hour Call Center

Data and Values-Driven Decision-making

In addition to insuring programs meet legislative and regulatory requirements, the MHD has established a Decision Support Unit within the Learning Partnership Division to support the department's efforts to assure that recommendations and decisions about the deployment of resources are backed by objective information. This information is interpreted in relation to foundational philosophical principles and values as well as mandates and state requirements.

The MHD decision-making process involves two approaches. Each utilizes data to evaluate programs as measured by various sets of criteria, and each approach provides an important "lens" through which mental health programs and services are assessed. One is particularly useful for immediate or near-term decisions, and one helps to set strategic, longer term objectives for the system. The first decision-making approach is

employed during annual budget planning and assists the department in formulating budget recommendations. The second approach is utilized to articulate longer term strategic goals of the department; and while related to the first approach, this approach sets a course that guides the course of the system over time.

Planning and Decision-making Approach One

Each time budget proposals must be formulated, the entire MHD system of care is subjected to measurement against established criteria that constitute approach one. Specific recommendations, with their accompanying budget implications, result from the process of answering the following questions about each MHD program and service:

1. Is the program required by state or federal law or mandate?

2. Is it fully funded through some public or private source?

3. How likely is a reduction or termination of the services to result in serious harm to the consumer or to others?

4. How great an impact does the program have on life, liberty and independence?

5. How well does the program perform in terms of producing the best outcomes for the lowest cost and avoiding more intensive or costly service utilization?

6. How high are its consumer preference and satisfaction ratings?

7. How well does it support established local, state and national health objectives?

8. How effectively does it promote equitable utilization by all racial, ethnic, cultural and linguistic communities?

9. How significantly does the program impact other governmental and societal systems and costs, for example, involvement in the dependency and justice systems?

10. To what extent does the program recognize and respond to the prevalence of co-occurring health problems (e.g., substance abuse and other chronic and acute health conditions)?

11. Is it partially funded through some public or private source?

Planning and Decision-making Approach Two

Five overarching priority areas for action have been identified by the MHD as critical to the future effectiveness of Santa Clara County's public mental health system.

1. Expand the focus of public mental health service delivery to incorporate an expanded "band width" of activity that includes three new dimensions of care:

a) A broader range of developmentally appropriate interventions from promotion, prevention, early intervention and treatment across the lifespan;

b) A changed perspective on treatment of persistent mental illness that shifts from an episodic-based service to a longitudinal "life course" service that considers treatment outcomes across the lifespan of the individual; and

c) An expanded view of the recipient of mental health interventions to include social-ecological systems around the individual.

2. Introduce capacity-building strategies with key system partners to assure basic mental health competency, improved access to mental health interventions, and better coordination of care.

3. Employ new and innovative strategies to improve ethnic and cultural population access to and engagement in services.

4. Increase mental health knowledge and understanding in order to prevent problems, reduce stigma, and support appropriate responses to mental health concerns.

5. Improve the system infrastructure to include more robust quality and accountability systems that offer reliable measures of practice and program effectiveness and valid outcome information.

Summary

In conclusion, near-term and long-term priorities include the following:

1. Preserve treatment safety net through maximization of resources and continued improvements in benefit assistance and care delivery strategies that achieve better long-term results for children, youth, adults, and seniors;

2. Continue partnerships with key County agencies to minimize negative human and fiscal outcomes from untreated mental health concerns, particularly through collaboration with health system partners (VMC, Public Health, DADS); Social Services, Probation, Courts, and Law Enforcement.

3. Champion and implement strategies that raise community awareness of mental health and natural self-care competencies.

4. Champion and implement culturally specific models of mental health promotion, prevention and treatment.

5. Continue development of a decision support infrastructure to insure that decisions are data-driven and that data is available to guide ongoing improvements in quality of service provided.

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Introduction

The Santa Clara County Mental Health Department (MHD) has established objectives for the *promotion* of mental health and wellbeing, for the *prevention* of mental illness, and for the *treatment* of mental health disorders. This report, the MHD Health Agenda, will touch on each of these areas and provide information about prioritization criteria that address near and long-term objectives for the system. Pursuant to the Department's understanding of an important focus of this report, it also will include more specific information about mental health prevention. Should any further information be desired, the Department will be pleased to provide it.

The Prevalence and Impact of Mental Illness

About 450 million people alive today suffer from mental disorders.[2] In the U.S., the Surgeon General has estimated that about one in five Americans experience a mental disorder in the course of a year.[3] In contrast, a large-scale epidemiological study shows that less than 30% of people with psychiatric disorders seek treatment.[4] A review of Santa Clara County MHD Call Center records shown that less than 30% of the people who seek services from the MHD system receive mental health treatment. Taken together—less than 30% of those who need services seek services—and—less than 30% of those who seek services receive services—it is readily apparent that there is a significant unmet need.

Data developed by the massive *Global Burden of Disease* study conducted by the World Health Organization, the World Bank, and Harvard University, reveal that mental illness, including suicide, accounts for more than 15% of the burden of disease in established market economies such as the United States. This study developed a single measure to allow comparison of the burden of disease across many different disease conditions. This measure, called Disability Adjusted Life Years (DALYs), measures lost years of healthy life.[5]

Disease Burden by Selected Illness Categories in Established Market Economies[6]

	Percent of Total DALYs*
All cardiovascular conditions	18.6
All mental illness**	**15.4**
All malignant disease (cancer)	15.0
All respiratory conditions	4.8
All alcohol use	4.7
All infectious and parasitic disease	2.8
All drug use	1.5

The study found that disability caused by major depression is equivalent to blindness or paraplegia, whereas active psychosis found in schizophrenia produces disability equal to quadriplegia.[7]

Mental illness reduces quality of life, decreases the ability of people to care for themselves and others, and increases the risk of substance abuse, school and work failure, criminality, and suicide. The National Alliance on Mental Illness (NAMI) reports that mental illness results in workplace costs of more than $34 billion per year in direct and indirect costs.[8] In addition, because mental disorders are disabling and can last for many years, they often take a tremendous toll on the emotional and socioeconomic well being of family members caring for the people suffering from mental disorders.

Prevalence estimates of serious mental illness among residents of Santa Clara County who live at or below 200% of the Federal Poverty Level (and, therefore, are thought to be the individuals who depend on a public mental health system) are as follows:

Estimates of Need for Public Mental Health Services in Santa Clara County[9]

Age Group	Estimated Number with SMI/SED
0 through 15	6,494
16 through 25	4,434
26 through 59	14,220
60 and above	3,727
Total of all ages	**28,875**

This estimate of need—28,875—is considerably higher than the number currently served by the MHD—21,750 in FY09. However, the disparity in need and service is greater than the 7,125 individuals who are unserved based on this calculation. The 28,875 is considered a significant underestimation of need in Santa Clara County for several reasons: 1) Poverty level status does not take into consideration the county's extremely high cost of living. The numbers of residents likely to rely on public systems is significantly greater than only those living at or below 200% of the Federal Poverty Level due to the heavy burden on Santa Clara County residents to cover their basic living expenses, leaving them with no disposable income to pay for services. Therefore, it is thought that based on this alone, the numbers of need may be 10% to 20% higher than shown in the table above. 2) Thousands of clients served are actually not served beyond one to three contacts with the system, which is not considered actual engagement in treatment. 3) The data on mental health need among individuals and families served by County agencies (Social Services, Probation, and other justice services) indicate a vastly greater level of need among those populations than suggested by need levels in the general population.

Another noteworthy indicator of unmet need, as referenced previously, is the number of people requesting service through the MHD's Call Center versus the number of people who are referred into the MHD service system. An examination of the Call Centers' monthly logs from January through August of this year reveal 8,312 requests for mental health services—an average of 1,039 calls per month. Of those, only 2,394 were referred
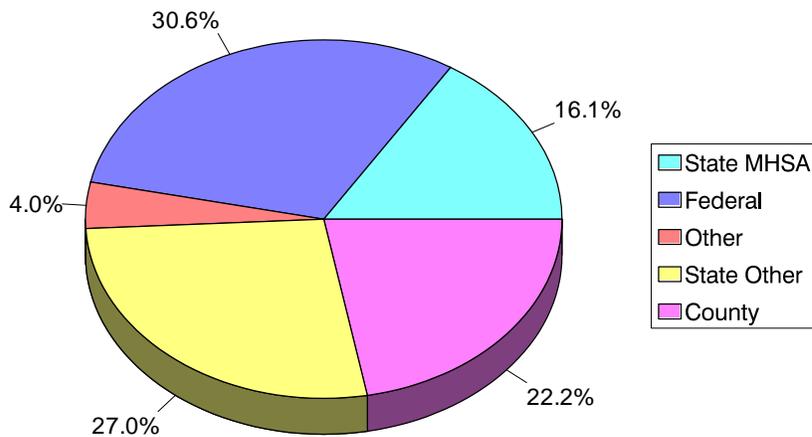
to MHD (County or contract agency) services—an average of 299 mental health service linkages per month. That equates to 28.8% of requests for mental health services resulting in a connection to the MHD system. The remainder received a referral to some other community resource.

Context for Decision-Making: Funding and Mandated Service Overview

Currently in California, mental health care for those who rely on public services is administered by local county systems through various state and federal programs, such as Medi-Cal, Medicare, Mental Health Services Act (MHSA), Healthy Families, Realignment, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and Special Education AB3632, as well as County General Funds. The MHD FY10 budget is $248.6 million. The table and chart below show the various sources of MHD revenue.

MENTAL HEALTH DEPARTMENT
FY10 APPROVED REVENUE BUDGET as of 07/13/09

Revenue Source	Amount
State MHSA (excludes Awards Pending State Approval)	$40,108,225
Federal (Medi-Cal, Medicare, IDEA, SAMHSA/PATH)	$76,154,584
State Other (Short Doyle, SB90, Realignment)	$67,044,429
Other Revenue (Fees, Grants, Reimbursements)	$10,185,050
Local County General Funds	$55,199,620
	$248,691,908

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In addition to insuring programs meet legislative and regulatory requirements, the MHD has established a Decision Support Unit within the Learning Partnership Division to support the department's efforts to assure that recommendations and decisions about the deployment of resources are backed by objective information. This information is interpreted in relation to foundational philosophical principles and values as well as mandates and state requirements.

The MHD's Learning Partnership's Decision Support Unit analyzes available prevalence, utilization, and outcome data that guide decision-making and help providers maintain a high level of proficiency in order to effectively meet the needs of those they serve. System surveillance is facilitated by data and analysis of need and use by disorder, service utilization, age group, racial and ethnic background, linguistic preference, area of residence, payment source, etc. To a growing extent, the MHD is beginning to capture additional information concerning client outcomes, such as regaining employment, improved living situation, and reduction in hospital admissions and days of homelessness. Further, the unit is working to gain access to data which will allow the analysis of health care usage patterns and criminal justice involvement.

In addition, the department continues to develop new outcome measures which are recovery oriented and consumer focused. To this end, the MHD has begun using the Milestones to Recovery Scale (MORS) and is pilot testing the Client Informed Outcomes Measure (CIOM). Each scale represents a unique way of assessing clients and determining where they are in the recovery process. The MORS is completed by clinicians and indicates the client's progress from needed acute care to living independently using community resources. As more clients are assessed with the MORS on a regular basis, trend analysis of how people progress through the system can be developed. These analyses can be linked to the prevalence and utilization data to better understand what type and intensity of service help move people to different recovery levels. Coupled with demographic, payment sources and area of residence data, meaningful outcomes for clients participating in the system can be developed. While only in the pilot stage, the CIOM also will enhance the MHD's ability to understand clients' needs and further evaluate how its services meet those needs. The CIOM is completed by the client, so it provides a client-level perspective on how the system is meeting their recovery goals. The information gathered is not only useful as a clinical tool, for treatment planning and intervention guidance, but as an evaluation tool when used with existing outcomes and assessment measures.

The MHD decision-making process involves two approaches. Each utilizes data to evaluate programs as measured by various sets of criteria, and each approach provides an important "lens" through which mental health programs and services are assessed. One is particularly useful for immediate or near-term decisions, and one helps to set

strategic, longer term objectives for the system. The first decision-making approach is employed during annual budget planning and assists the department in formulating budget recommendations. The second approach is utilized to articulate longer term strategic goals of the department; and while related to the first approach, this approach sets a course that guides the course of the system over time.

Planning and Decision-making Approach One

The context in which the MHD makes budget recommendations and decisions is influenced by a variety of environmental factors that include local, statewide, and national economic conditions, as well as local policy priorities and social conditions. Programs are prioritized in the framework of their funding sources with their accompanying requirements and restrictions which often change over time. Funding shrinks or grows. Funding sources become available or cease to exist. Likewise, prevalence and need change, as do demographics. Research leads to new evidence that shifts the prevailing recognition of what constitutes best practices. Treatment advancements produce better outcomes. Technological innovation allows for the collection and interpretation of more and better data. Consumer preference changes, and consumers and their family members play an increasing role in advocacy and planning. Thus, a plethora of changing factors influence prioritization and decision-making.

Each time budget proposals must be formulated, the entire MHD system of care is subjected to measurement against established criteria that constitute approach one. Specific recommendations, with their accompanying budget implications, result from the process of answering the following questions about each MHD program and service:

1. Is the program required by state or federal law or mandate?

2. Is it fully funded through some public or private source?

3. How likely is a reduction or termination of the services to result in serious harm to the consumer or to others?

4. How great an impact does the program have on life, liberty and independence?

5. How well does the program perform in terms of producing the best outcomes for the lowest cost and avoiding more intensive or costly service utilization?

6. How high are its consumer preference and satisfaction ratings?

7. How well does it support established local, state and national health objectives?

8. How effectively does it promote equitable utilization by all racial, ethnic, cultural and linguistic communities?

9. How significantly does the program impact other governmental and societal systems and costs, for example, involvement in the dependency and justice systems?

10. To what extent does the program recognize and respond to the prevalence of co-occurring health problems (e.g., substance abuse and other chronic and acute health conditions)?

11. Is it partially funded through some public or private source?

Planning and Decision-making Approach Two

Five overarching priority areas for action have been identified by the MHD as critical to the future effectiveness of Santa Clara County's public mental health system. The priorities draw upon the results of the local five-year planning process following from the enactment of the Mental Health Services Act (MHSA) on January 1, 2005. These criteria complement the locally developed "critical mental health concerns" (see Appendix 1), and they form a second valuable framework for evaluation and decision-making.

Each of the five priority areas is accompanied by a brief explanation, including the rationale for its importance.

1. **Expand the focus of public mental health service delivery to incorporate an expanded "band width" of activity that includes three new dimensions of care:**

   a) **A broader range of developmentally appropriate interventions from promotion, prevention, early intervention and treatment across the lifespan;**

   b) **A changed perspective on treatment of persistent mental illness that shifts from an episodic-based service to a longitudinal "life course" service that considers treatment outcomes across the lifespan of the individual; and**

   c) **An expanded view of the recipient of mental health interventions to include social-ecological systems around the individual.**

Promotion, Prevention and Early Intervention. Consistent with the U.S. Substance Abuse and Mental Health Services Agency's June 2009 report urging that healthcare reform must prioritize treatment for addictions and mental health, the MHD strives to promote wellness and resilience, prevent risky and unhealthy behaviors before they occur, and address symptoms when they first emerge rather than waiting until they become acute or chronic. Evidence strongly suggests that certain mental illnesses can be prevented, while for others the onset may be delayed and severity of symptoms decreased. Along with this, there is understanding that prevention efforts are most successful when they use multifaceted solutions that address not only individuals but also their "social ecological environments," including home, friends, community, school and work.

With the passing of the Mental Health Services Act (MHSA) in November 2004, public mental health systems received the legislative mandate to provide prevention and early

intervention services for the first time in several decades. Therefore, the MHD's current plan for prevention and early intervention was developed within the parameters developed by the California Mental Health Services Oversight and Accountability Commission with support from the State Department of Mental Health.

Prevention is concerned with avoiding disease, while promotion is about advancing health and well being. While there is no precise, universally accepted definition of mental health promotion, the MHD utilizes the characterization of mental health promotion as "the enhancement of the capacity of individuals, families, groups or communities to strengthen or support positive emotional, cognitive and related experiences."[10] Strategies for mental health promotion are related to improving the quality of life and potential for health rather than amelioration of symptoms and deficits. Promotion and prevention overlap and should be complementary activities.

"To prevent," of course, means "to keep something from happening." The Institute of Medicine prevention category is divided into three classifications—universal, selective and indicated. Universal prevention strategies address the entire population (local communities, schools, neighborhoods). Selective prevention strategies target subsets of the total population that are deemed to be at risk for mental illness by virtue of their membership in a particular population segment (victims of child abuse, witnesses to traumatic events, etc.) Indicated prevention strategies are designed to prevent the onset of mental illness in individuals who do not meet diagnostic criteria for mental illness but who are showing early signs of distress (changes in thoughts, emotions or conduct).

Santa Clara County's PEI Plan was designed to address the range of mental health disorders, from biologically and genetically originating illnesses (schizophrenia, bipolar, ADHD, etc.), to environmentally and developmentally influenced conditions (attachment disorders, grief reactions, mood/self-regulatory problems, conduct disorder, anxiety, depression, and PTSD). The primary outcomes expected are a reduction in the prevalence and severity of these conditions. As additional benefits, it is expected that outcomes also will include such things as reduced levels of child maltreatment and foster care placements, reduced criminal behavior, reduced incidence of suicide attempts, improved school performance, improved social-emotional functioning, and improved family functioning.

While many of the PEI strategies will be implemented countywide, the PEI Plan places a significant emphasis on high risk areas that are the most burdened by problems as illustrated by a series of key indicators of high need. Proxy indicators such as the following were measured and compared:

- Low income,
- Numbers of single heads of household,
- Entrants into the juvenile justice system,

- Sustained cases of child abuse and neglect and entry into foster care,
- Occurrence of domestic violence,

- Felony arrests,
- MHD clients,
- Poor school performance, and
- School drop-out rates

This approach is supported by research which reveals that reactive and situational mental illnesses are more prevalent among populations that experience multiple stressors and trauma. The geographically oriented initiatives are intended to reach stressed children and families through the schools and in various community venues and reach adults and older adults primarily through primary care clinics. The geographically based projects represent investment plans by the MHD into the affected communities. Further, collaborative decision-making combined with resource-sharing and leveraging will have the greatest impact on root causes of environmental conditions that cause or exacerbate mental illness.

However, while some of the vulnerability and risk can be mediated by health-promoting interventions, it is essential that mental health service systems are designed to be optimally responsive to an individual's needs during every developmental phase of life and every phase in the course of mental illness.

The chart below provides a visual model of the scope of the public mental health system before and after planning initiated with passage of MHSA. The darker gray shaded triangle labeled as "intervention" represents the limited population served by the pre-MHSA system, while the lighter gray and the gray and white striped areas represent the expanded purview envisioned in a transformed mental health system. This expanded perspective reveals the vast area of "uncharted territory" for mental health interventions, education and advocacy.

Expanded Perspectives on Mental Health:
Multiple Intervention Levels and Multiple Social
Ecologies Across the Lifespan
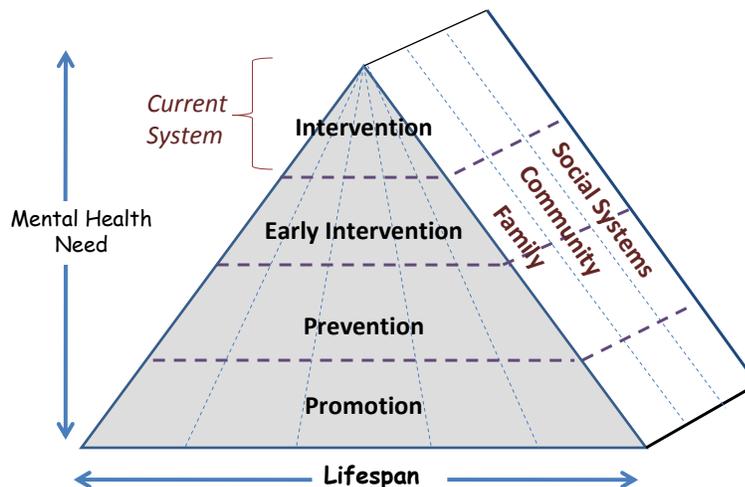
Changing Perspectives on Treatment. The MHSA also charges local systems with the task of expanding and improving intervention practices and programs, utilizing new evidenced-based practice models in lieu of traditional models of care that have not yielded optimal individual and societal outcomes. Care, as it has been provided, has left hundreds of thousands of individuals suffering from serious and persistent mental illness, with a life expectancy 25 to 30 years shorter than the general population and with high rates of unemployment, poverty, homelessness, institutionalization, criminal justice involvement, social isolation, personal despair and suicide.

New perspectives on mental illness provide a complete change in approaches to treatment. These new approaches are designed to include the consumer as a partner in their own care, guided by their own perspectives on their well-being and preferences of treatment, inclusive of family and loved ones in their support network, and empowering their role in their own care through education, knowledge, and shared decision-making. This new perspective on care is referred to in the primary health care field as patient-centered care, which is delivered through "medical home" service structures. These new service delivery models take a longitudinal "lifespan" view of chronic health conditions, such as asthma, diabetes, heart disease, etc. and seek to engage the patient in a coordinated team of ongoing medical, social, and self-support in order to maximize life expectancy and well-being and minimize cost and suffering.

This new field of medical care is applicable to those who suffer from persistent and often lifelong psychiatric conditions and is often referred to as "person-centered" care provided through a behavioral medical home. The MHD is moving in this direction with new service delivery models that seek to shift the outlook of care to one that includes a new, meaningful role for the consumer (engaged, in charge, and a part of the team) and new roles and expectations for those in the social-ecological systems that surround the person (family, friends, school, work and community).

Continued development of practice models that offer a recovery course for mental illness, including serious psychiatric illnesses such as schizophrenia and other psychoses, must be pursued over the next decade. These new practices must be integrated into the primary care system to insure maximum health care for those suffering from severe and persistent mental illnesses. Likewise, the domain of mental health practice and support must reach into natural social systems, such as education, social services, employment, faith, and law and justice, to assure the maximum mental health of all Americans.

2. **Introduce capacity-building strategies with key system partners to assure basic mental health competency, improved access to mental health interventions, and better coordination of care**

There is growing evidence that behavioral health issues have a significant impact on every aspect of society and influence the overall effectiveness of social institutions that make up the foundation of American society. Schools, health care systems, social service systems, faith communities, law and justice institutions, and local governments

all voice concerns about the emotional, behavioral and substance abuse problems of those they serve. All express frustration at the lack of adequate support and services available to help those with obvious need. The following data highlight the profound effect of mental health problems on County and other service sectors and underscore the vital importance of:

- better understanding by service system personnel of mental and emotional problems,
- improved skills in dealing with individuals and families struggling with mental illness,
- strengthened communications between systems, and
- expanded access to mental health services:

Primary health care: Mental illness often goes undiagnosed or inadequately treated in primary health care settings. According to an assessment by the Santa Clara County Community Health Partnership, the patients seen in its 27 clinics "are coming to their primary care providers with significant mental health needs." A survey of recorded ICD-9 codes for client visits showed that at least 30% of all clinic patients are seen for mental health services in combination with primary care services. However, a Community Health Partnership report concludes, "primary care providers at community health clinics often don't have the training or the resources to treat their patients with mental illnesses."[11]

Moreover, data suggest that physical health and health care is diminished for individuals with a mental health disorder. It has been reported that adults with serious mental illness treated in public systems die about 25 years earlier than Americans overall.[12] Kenneth Duckworth of the National Alliance on Mental Illness postulates that internists sometimes disregard medical symptoms of the mentally ill, chalking them up to the patient's disorder. He suggests that needed treatment may be harder to get, pointing to a study showing that after the mentally ill suffer heart attacks, they are less likely than other patients to get state-of-the-art care.[13] In addition, "because of their mental disorder, patients often aren't good health advocates for themselves," according to Andrew Leuchter of the UCLA School of Medicine.[14] One of the best ways to accomplish this goal is to further integrate behavioral and physical health care. Service integration can range from providing educational resources to clinicians to facilitate referrals, co-locating clinicians in the same setting, coordinating care across providers and systems, collaborating and jointly deciding on treatment, and jointly planning and financing services.[15]

Education: The Surgeon General has reported that more than one in five U.S. children aged nine to 17 have a mental or addictive disorder that causes impairment. [16] According to the National Institutes of Mental Health, "no other illnesses damage so many youths so seriously."[17] National experts estimate that approximately three out of every 100 young people will experience a psychotic episode—making psychosis more common than diabetes in young people.[18] There were 226,695 young people between the ages of 16 and 25 in Santa Clara County as of the 2000 U.S. Census. Applying the

rate of occurrence of a psychotic episode at three out of every 100 young people would mean that 6,800 Santa Clara County youth and young adults have experienced or will experience a psychotic illness.[19]

Among Santa Clara County youth surveyed in the California Healthy Kids Survey, one-quarter to one-third of seventh, ninth and eleventh graders reported symptoms of depression (feeling so sad or hopeless for at least two weeks during the previous year that they stopped doing some regular activities).[20] Further, 16.3% of the seventh, ninth and eleventh graders reported they seriously considered, and 8.2% reported they actually attempted, suicide during the previous year.[21] Santa Clara County ranks 54th out of California's 58 counties (with 58 being the worst) in the rate of adolescent self-inflicted injury.[22] Suicide is the third leading cause of death among teenagers ages 15 to 19.[23]

Within the context of recent Santa Clara County research, school districts report that approximately 20% of their students need mental health prevention or early intervention support services or counseling. That 20% estimate translates to be 51,144 students that their teachers or principals consider "at risk." Local educators also reported that most of those students needing support have a tremendous impact on their fellow students and the school environment.[24]

Moreover, it is not just K through 12 students who are experiencing mental health problems. According to a 2006 report conducted by the University of California, university students are presenting mental health issues with greater frequency and complexity. These issues have been reported to be equally urgent for the California State University System and for students attending California Community Colleges.[25]

The Child Welfare System: The dependency system is deeply affected by trauma, mental illness, and substance abuse. National studies have shown that more than 80% of children in foster care have developmental, emotional, or behavioral problems,[26] and from 40% to 85% of children in foster care have diagnosed mental health disorders.[27]

Children who have been abused or neglected experience higher rates of suicide, depression, substance abuse, difficulties in school and other behavioral problems later in life; and they also are at greater risk of later mistreating their own children.[28] A history of abuse can be associated with nearly all common syndromes but particularly with self-harm, suicide, dissociation, and revictimization.[29] Many of these children may demonstrate impulsive behaviors or, conversely, become very resistant to change. They may exhibit detachment and emotional distance or an excessive need for physical attention. They may show evidence of anxiety, PTSD, depression, high activity levels, irritability, acting out, and problems with sleeping, eating and elimination.

A pilot program at the Santa Clara County Children's Shelter, through which all children aged six to 11 who enter the foster care system are screened for mental health problems, has been operational since January 2005. From January 2005 through March 2008, 823 children were assessed. *Of those 823 children, only 56 did not meet medical necessity for mental health services.*

However, it is not just the children in the dependency system but also their parents who have experienced trauma and have mental health and substance abuse disorders. A demographic snapshot of the participants in the Santa Clara County Dependency Drug Treatment Court in 2007 showed that, while all abuse drugs or alcohol, 38.8% of the parents (who are predominantly mothers) have mental health problems and a mental health diagnosis; 64% have a history of domestic violence involvement; and 40.8% experienced victimization as a child.

Employment and Benefit Services: A Santa Clara County CalWORKs' pilot project confirmed high levels of stress and significant mental health problems among the majority of its clients. Clients were interviewed upon entry into the CalWORKs program and 63% admitted behavioral health issues, 6.5% were already receiving treatment, 19.4% had issues but did not want assessment referrals, and 37.5% accepted assessment referrals. Of those entering treatment, the diagnoses included adjustment disorders, major depressive disorders, PTSD, anxiety disorders, personality disorders, dual diagnosis, and various others.

The Juvenile Justice System: Detention admission screening data indicate that more than 60% of detained youth have significant mental health problems, close to 80% have had significant exposure to trauma, and 30% have psychiatric disturbances that impair thinking.[30] MHD data indicate that 50% of detained youth have had previous service contacts with the public mental health system, with an additional 30% receiving services for the first time while in detention.

Nearly one-quarter of all girls surveyed as they entered juvenile hall said they wished they were dead. Forty percent of boys and 58% of girls said "something very bad or terrifying" had happened to them.[31] Emotional problems were cited as the most significant factor contributing to their delinquency by both boys and girls in custody with the Probation Department, with 91.7% of the girls and 81% of the boys having experienced trauma.[32] Among out-of-custody boys on probation supervision, 95.6% had at least one trauma factor noted, while more than one-quarter (26.7%) had three or more trauma factors noted. *All* out-of-custody girls on probation supervision reported at least one trauma factor, and 72.7% noted four or more trauma factors in their histories.[33]

The Adult Justice System: Jails typically house a larger volume of mentally ill people than all other programs combined.[34] Approximately 18 to 20% of the average 4,500 Santa Clara County adult jail population receives mental health services while in custody. Custody Mental Health FY09 data show that staff responded to 28,620 crisis referrals; psychiatrists and nurse practitioners provided 7,454 outpatient visits to inmates; and 1,027 inmates were admitted to the custody acute psychiatric facility.

3. **Employ new and innovative strategies to improve ethnic and cultural population access to and engagement in services.**

As evidenced above, most social institutions serve populations that present disproportionately high mental health need. What is equally concerning is data which

indicate that many of these social systems are disproportionately serving racial and ethnic minority populations.

For example, at Santa Clara County Juvenile Hall, as of September 14, 2009, almost 74% of youth in detention were Hispanic, more than 10% were Black, fewer than 8% were White, approximately 6% were Asian, and 2.3% were "Other." As of the same date at the Juvenile Ranches, 83% of the youth were Hispanic, 6.6% of the youth were White, 4.7% were Black, 4.7% were Asian, and less than 1% was "Other." This tremendous overrepresentation, particularly of Hispanics and Blacks in relationship to their proportion of the population, is of considerable concern for a variety of reasons including the high levels of trauma and mental illness among youth in the justice system, as previously explained.

Likewise, among adults in custody at Santa Clara County Department of Correction facilities, 53% of males are Hispanic and 45% of females are Hispanic; and again, mental illness as well as substance abuse are extremely prevalent among the adult in-custody population.

The patterns of disproportionate representation of minority group members in the child welfare population are similar, as are high percentages of those involved who have mental health disorders, substance abuse disorders, or both. Santa Clara County Social Services Agency's FY07 data show that among substantiated referrals of child abuse and neglect, 10.3% were African American in contrast with their 2.3% of the child population; 1.2% were Native American in contrast with their .4% of the child population; and 62.9% were Hispanic in contrast with their 37.2% of the child population. Conversely, 16% were White in contrast with their 31.7% of the child population; and 8.3% were Asian in contrast with their 28.4% of the child population.[35]

The need is further demonstrated by other local data. For example, the results of a random sample survey conducted by the Santa Clara County Office of Human Relations on the top five immigrant groups in Santa Clara County (immigrants from Mexico, Vietnam, China, the Philippines, and India) indicated that immigrants appear to have higher rates of mental health symptoms or behaviors than the U.S. born. Compared to the U.S. born, immigrants report higher rates of sadness (32% vs. 25%), anger (25% vs. 22%), isolation (20% vs. 10%), fear (15% vs. 6%), flashbacks (7.1% vs. 2.6%), nightmares (6% vs. 1.7%), hallucinations (6% vs. 1%), and self-destructive behaviors (3.3% vs. 2.6%).[36]

In addition, people who are lesbian, gay, bisexual, transgender or questioning their sexual orientation (LGBTQ) are at high risk of mental health problems because of their experience of multiple forms of prejudice, frequently becoming the target of stigma and discrimination.[37] When interviewed for the "Stressed Families Report" that was prepared as a part of the Santa Clara County MHD's PEI planning process, members of the Social Service Agency's Gay, Lesbian, Bisexual and Transgender Employee Concerns Committee noted that gay, lesbian, bisexual and transgender young people experience intolerance and difficulties ranging from self-isolation based on keeping a big secret, to

bullying, name calling, and physical abuse. The result is frequently depression, low self-esteem, fear, poor grades, sometimes self-medication, and running away.[38]

Overall, the MHD's system service data show that the largest disparity between prevalence estimates and service utilization (MHD categorization: unserved) is among Asians. Comparing the prevalence estimates to numbers served, only 37.5% of Asians who need mental health services are receiving any services whatsoever. Overall, 2,909 Asians received mental health services in contrast to their prevalence estimate of 7,749. However, this is better than the national pattern: Nationally, Asian Americans are only one-quarter as likely as Whites to seek outpatient treatment.[39]

Among those who are considered underserved, the largest numbers in relationship to their population size are among Latinos; and this is particularly true for children and youth. Among the 1,304 children aged zero to five who are considered "underserved" by the Santa Clara County MHD service system, 53.3% were Hispanic. Of the underserved youth aged 16 through 25, Hispanics were again the largest group at 34%.

The MHD must continue efforts to work with system partners to implement programs that address the emotional and mental health issues that contribute to the system realities described above. The strategies must be developed in collaboration with system partners, utilizing shared resources and joint planning.

4. **Increase mental health knowledge and understanding in order to prevent problems, reduce stigma, and support appropriate responses to mental health concerns.**

Data underscore the importance and urgency of treating and preventing mental disorders and promoting mental health in our society; however, as mentioned earlier, approximately two-thirds of all people with diagnosable mental disorders do not seek treatment.[40] Stigma surrounding the receipt of mental health treatment is among the significant barriers that discourage people from seeking help.[41]

A public perception that exacerbates stigma concerns the correlation between mental illness and violence has been shown through surveys to be significantly exaggerated beyond the factual association and has lead to unfounded fear and bias.[42] In fact, "a significant body of research concludes that people with mental disabilities are actually much more likely to be victims of crime."[43] Many people also believe that mental disorders are somehow the result of moral failings or limited will power. When they understand that, instead, mental disorders are legitimate illnesses that are responsive to specific treatments, it is hoped that much of the negative stereotyping may dissipate.[44]

Individuals who have experienced mental illness also are at high risk of internalizing stigma and suffering diminished self-esteem.[45] The combined effects of societal stigma internalized by adults and children with mental illness can lead both to substance abuse and suicide.[46]

Anti-stigma and discrimination activities have been selected as a focus of Santa Clara County PEI Plan's Project 1, Community Engagement and Capacity Building for Stigma Reduction and Discrimination. The primary goal of this project is to reduce disparities in access to mental health interventions due to stigma, discrimination, and lack of knowledge about mental health services, particularly among underserved cultural populations. The project's supplementary goal is to develop within underserved cultural populations a robust network and infrastructure capable of developing and sustaining ongoing PEI and related services. As an overarching strategy, programs under this project will primarily be developed and implemented by consumers and family members from underserved cultural communities.

These local projects will support the statewide MHSA stigma and discrimination programs that will include activities targeting youth; violence and bullying prevention; peer-to-peer support on higher education campuses; adult consumer empowerment strategies; and a campaign that combats stereotypes and focuses attention on employing people with mental health disabilities, accessing mental health care through primary care, communicating with school principals regularly on mental health issues, collaborating more closely with law enforcement, and influencing the media to be more accurate and less biased toward persons with mental illness.

5. **Improve the system infrastructure to include more robust quality and accountability systems that offer reliable measures of practice and program effectiveness and valid outcome information.**

The evaluation of mental health service outcomes is concerned with documenting benefit and informing decision-making concerning the value and significance of programs. The number of consumers seen, the number of units of service delivered, and cost per unit of service are no longer sufficient indices of the effectiveness of mental health services. It is critical to know if services are effective and to implement systems that provide this feedback continuously so that services can be adjusted in real time in order to achieve desired client outcomes.
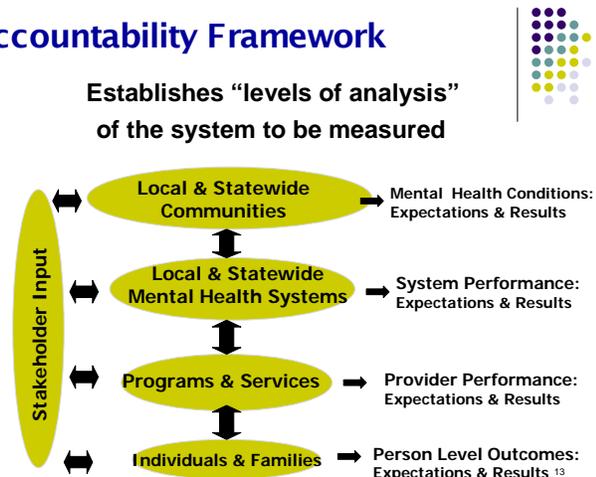
The MHD must develop a more sophisticated accountability system that offers the means by which consumers and families, providers, policy makers, administrators, local and state stakeholders, and the general public will know how the pubic mental health system is performing. In this context, performance is defined in two ways: 1) as *changes and improvements* in the lives of those served; and 2) in the quality and effectiveness of *processes and practices* utilized in the system to achieve those changes. An effective accountability system articulates clear parameters of performance expectations and provides performance information that is accessible, meaningful, and understandable to all stakeholders.

During the MHSA planning process, the MHD defined an effective accountability system as one that measures performance at multiple levels of analysis (statewide, county, program/practice, and person levels), utilizing a set of consistent "best measures" of client status in functional life domain areas. It was further agreed that the system must
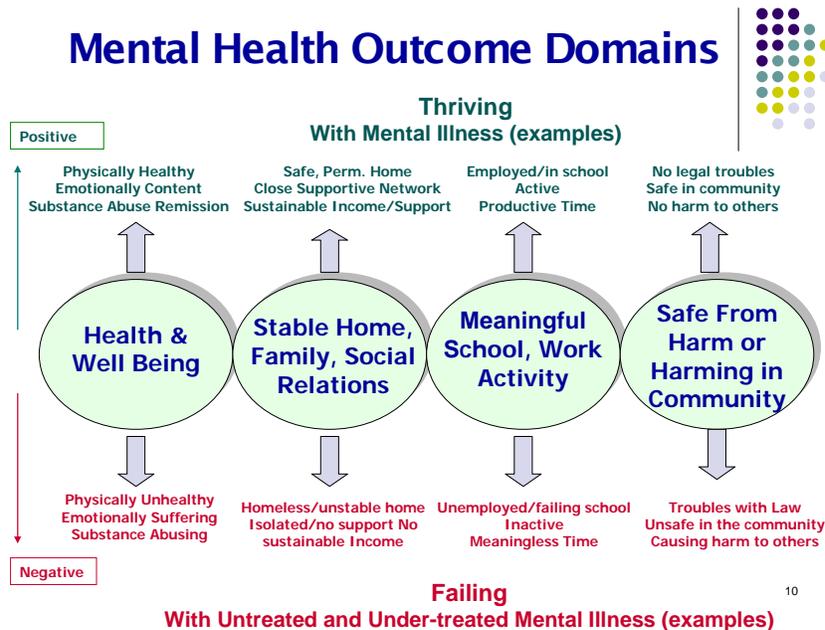
be supported by adequate technological and staff resources to achieve evaluation objectives and facilitate the use of performance information in order to continually inform changes needed at the practice, local, and state levels of the system, thus supporting the objective of continuous system improvement.

The following two charts depict conceptual elements of the MHD accountability framework, the first indicating four suggested levels of analysis and the second portraying four quality of life domains impacted by mental illness. The later provides examples of indicators to measure client status in the functional areas of physical health and well being, housing and social supports, work/school, and safety in the community. Each indicator would need to be reliably available from a specific data source. For example, "physical health" could be measured through use of a standardized health assessment tool administered upon initial program entry and at regular intervals while clients are receiving mental health services. The development of individual indicators, however, is no small task and requires significant ongoing staff resources to define, collect and analyze.

Accountability Framework

Establishes "levels of analysis"
of the system to be measured

Stakeholder Input

Local & Statewide Communities	→	Mental Health Conditions: Expectations & Results
Local & Statewide Mental Health Systems	→	System Performance: Expectations & Results
Programs & Services	→	Provider Performance: Expectations & Results
Individuals & Families	→	Person Level Outcomes: Expectations & Results [13]

Mental Health Outcome Domains

Thriving
With Mental Illness (examples)

Positive

| Physically Healthy Emotionally Content Substance Abuse Remission | Safe, Perm. Home Close Supportive Network Sustainable Income/Support | Employed/in school Active Productive Time | No legal troubles Safe in community No harm to others |

| Health & Well Being | Stable Home, Family, Social Relations | Meaningful School, Work Activity | Safe From Harm or Harming in Community |

| Physically Unhealthy Emotionally Suffering Substance Abusing | Homeless/unstable home Isolated/no support No sustainable Income | Unemployed/failing school Inactive Meaningless Time | Troubles with Law Unsafe in the community Causing harm to others |

Negative

Failing [10]
With Untreated and Under-treated Mental Illness (examples)

Within this framework, for each level of the system as well as each life domain area to be evaluated, measures or indicators need to be identified and performance

expectations need to be established. Local and statewide **community level** indicators must be measurable and judged to have the potential to be influenced by the promotion, prevention, early intervention and/or intervention activities of the public mental health system. Examples may include rates of suicide, homeless mentally ill, mentally ill in jails and juvenile custody, and mentally ill in foster care.

Local and statewide mental health **system level** accountability indicators also must be measurable and determined to be gauges of system performance and improvement over time. They may incorporate rates of homeless mentally ill receiving services and moved out of homelessness, reductions in rates of mentally ill in custody populations, reductions in restrictiveness of placements and placement changes of mentally ill foster youth, reductions in disparity of service utilization by underserved populations, and consumer satisfaction with services.

Practice and program level accountability indicators must be measurable and determined to be influenced by the specific program or practice. They may include, for illustration, client improvement in life domains relative to other programs serving clients with similar needs, client satisfaction with the provider and service model relative to other programs, reduction of client use of hospital and other restrictive services, and level of involvement of consumers and families.

Finally, **person level** accountability indicators must be measurable and determined to be influenced by the specific mental health services provided, such as client-measured improvement in each of the life domains while in service, accomplishment of client recovery goals while in service, and client movement out of, or improvement in, other systems: criminal justice, foster care, welfare, education, and employment.

The MHD envisions a continually improving accountability system that is data supported, stakeholder involved, and informed by the most current knowledge available regarding effective mental health service delivery. Over the next five years, the MHD will utilize MHSA technology and system development funds to further develop departmental leadership, expertise and infrastructure through its Learning Partnership Division.

Summary

The above report seeks to demonstrate the multiple considerations that go into the identification of short and long-term priorities for the County's public mental health system. In the end, priorities are determined by state, federal, and local policies and directives and are influenced by available resources, system design, and relative importance to stakeholders. Recent MHSA legislation has strongly influenced the public system by mandating that this new funding stream be utilized to "transform" the current system to incorporate a culturally competent, recovery and client-driven care system that is delivered through effective, evidenced-based practices and is supported and guided by quality practice and a robust accountability system.

Considering the range of factors discussed, the MHD has determined that near-term and long-term priorities include the following:

1. Preservation of treatment safety net through maximization of resources and continued improvements in benefit assistance and care delivery strategies that achieve better long-term results for children, youth, adults, and seniors;

2. Continued partnerships with key County agencies to minimize negative human and fiscal outcomes from untreated mental health concerns, particularly through collaboration with health system partners (VMC, Public Health, DADS); Social Services, Probation, Courts, and Law Enforcement;

3. The implementation of new strategies that raise community awareness of mental health and natural self-care competencies.

4. Continued efforts to implement culturally specific models of mental health promotion, prevention and treatment.

5. Continued development of a decision support infrastructure to insure that decisions are data-driven and that data is available to guide ongoing improvements in the quality of service provided.

Appendix 1. Local, State and National Guidance for MHD Decision-making

In terms of local, state and national objectives (question/criterion 7 in decision-making approach one), other **local guidance** comes from the Santa Clara County MHSA planning processes that resulted in the development of the following priority "critical mental health concerns," which in several instances duplicate or closely parallel the prioritization criteria listed in approach one:

1. Most important to consumers and families and other stakeholders as revealed through MHSA inreach and outreach efforts;

2. Most related to basic human needs (safety, physical health, housing, primary relationships, meaningful school/work/activity);

3. Most related to inequity of service access for cultural and other underserved populations;

4. Most related to consumer loss of liberty and independence;

5. Have the greatest impact on development and life course;

6. Have the greatest impact on families and primary relationship systems;

7. Have the greatest relationship to individual and community safety; and

8. Have the greatest societal costs (incarceration, institutionalization, placement, hospitalization).

State guidance comes from the *California Mental Health Master Plan,* such as a statement of values that are intended to guide development and implementation of the public mental health system. They include the following recommendations: use a client-directed approach, serve target populations, focus on wellness and recovery, advance systems of care, include outreach, provide equal access to mental health services, address multiple disabilities, furnish services by qualified staff, involve consumers and family members in service delivery, be culturally and linguistically competent, utilize peer support models, have system accountability, employ cost effective and competent management, and encourage research and identification of best practices.

In addition, the statewide MHSA has established various objectives, priorities, and planning principles that provide a framework for the review of county mental health programs and services:

1. Collaborates with other systems, is based in system partnerships, and links individuals to services across systems;

2. Is delivered in natural community settings;

3. Recognizes underlying role of poverty and other environmental and social factors impacting an individual's wellness;

4. Honors the voice of those in need;

5. Is consumer and family driven;

6. Is culturally competent;

7. Is grounded in respect, hope, self-help, and empowerment;

8. Considers need across the lifespan;

9. Has a social ecology focus;

10. Is recovery and resiliency guided;

11. Selects strategies with an evidence base and utilizes research findings to develop practical strategies for use in real world service agencies;

12. Leverages other community resources;

13. Is community engaged and supported;

14. Builds a comprehensive system;

15. Follows transformation pathways;

16. Emphasizes quality and continuous learning; and

17. Stresses outcomes and accountability.

Federal guidance is found in Healthy People 2010 which was developed by the U.S. Department of Health and Human Services. Healthy People provides science-based, ten-year national objectives for promoting health and preventing disease. Since 1979, Healthy People has set and monitored national health objectives to meet a broad range of health needs, encourage collaborations across sectors, guide individuals toward making informed health decisions, and measure the impact of its prevention activities. The table below shows the mental health-related Healthy People 2010 objectives, targets, and the local status if data sources allow. It is important to note that many of the objectives relate to conditions that may not be eligible for services in the current County MHD system of care due to criteria related to the severity of illness.

Objectives for Healthy People 2020 are expected in 2010, and it is thought that targeted outcomes will be reshaped to reflect changing public health priorities and emerging technologies related to our nation's health preparedness and prevention. The MHD will monitor its progress relative to the new targets as they become available.

Healthy People 2010 Objective	National Baseline	Target	SCC Status	Meets Target Y/N/NA
6-2 Reduce the proportion of children and adolescents with disabilities who are reported to be sad, unhappy, or depressed.	31%	17%	The MHD does not collect or maintain applicable baseline and performance data. However, it is known that 10.2% of public school students, equating to 26,592 students, have disabilities that cause them to be in special education.[47] During FY09, the MHD served 1,527 children and youth with disabilities.	NA

Healthy People 2010 Objective	National Baseline	Target	SCC Status	Meets Target Y/N/NA
6-3 Reduce the proportion of adults with disabilities who report feelings such as sadness, unhappiness, or depression that prevent them from being active.	28%	7%	The MHD does not collect or maintain applicable baseline and performance data. The U.S. Census 2000 indicates that there are 231,165 individuals over age 21 in Santa Clara County have a disability. In FY09 the MHD served 4,128 adults and older adults with disabilities.	NA
6-5 Increase the proportion of adults with disabilities reporting sufficient emotional support.	71%	79%	The MHD does not collect or maintain applicable baseline and performance data.	NA
6-6 Increase the proportion of adults with disabilities reporting satisfaction with life.	87%	96%	The MHD does not collect or maintain applicable baseline and performance data.	NA
7-11 r. Increase the proportion of local health departments that have established culturally appropriate and linguistically competent community health promotion and disease prevention programs – related to mental health and mental disorders.	18%	50%	The MHD has an overall plan for cultural competency, and the MHSA Prevention and Early Intervention Plan includes culturally appropriate and linguistically competent strategies.	Y
16-5 Reduce maternal illness and complications due to pregnancy, including postpartum depression.	No baseline provided	No target provided	The MHD does not collect or maintain applicable baseline and performance data.	NA
18-1 Reduce the suicide rate.	11.3 suicides per 100,000 population	5.0 suicides per 100,000 population	6.7 per 100,000 population (County Health Status Profiles, California Department of Public Health 2009).	N
18-2 Reduce the rate of suicide attempts by adolescents.	12-month average of 2.8% of adolescents in grades 9 through 12	12-month average of 1%	Suicide is the third leading cause of death among SCC teenagers ages 15-19.[48] The rate of suicides in SCC per 100,000 children/youth ages 15 through 24 is 7.0.[49]	N

Healthy People 2010 Objective	National Baseline	Target	SCC Status	Meets Target Y/N/NA
18-3 Reduce the proportion of homeless adults who have serious mental illness (SMI).	25%	19%	47% of respondents to the 2009 Homeless Census and Survey stated they had a mental health disorder.	N
18-4 Increase the proportion of persons with serious mental illness (SMI) who are employed.	43%	51%	1.8% of adult consumers of MHD services are employed.	N
18-5 Reduce the relapse rates for persons with eating disorders including anorexia nervosa and bulimia nervosa.	No baseline provided	No target provided	The MHD does not collect or maintain applicable baseline and performance data.	NA
18-6 Increase the number of persons seen in primary health care who receive mental health screening and assessment.	No baseline provided	No target provided	The MHD does not collect or maintain applicable baseline and performance data. However, the MHD joined with the SCVHHS to provide MH services in FQHCs, and the PEI Plan provides a significant expansion of MH screening and treatment services in community clinics.	NA
18-7 Increase the proportion of children with mental health problems who receive treatment.	No baseline provided	No target provided	7,293 children and youth receive services through the MHD (FY09).	Y
18-8 Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.	No baseline provided	No target provided	100% of youth admitted to Juvenile Hall are screened for MH and substance abuse problems using the MAYSI I screening instrument.	Y
18-9 Increase the proportion of adults with mental disorders who receive treatment.	No baseline provided	No target provided	14,457 adults receive treatment through the MHD system (FY09).	Y
18-10 Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.	No baseline provided	No target provided	25% of MHSA Full Service Partnership service slots are filled by individuals receiving treatment for both disorders (FY09 data). Overall, 8% of MHD consumers are treated in both the MHD and DADS service systems (FY08 data).	Y – The percentage of MHD consumers also receiving services from DADS has doubled since FY00. However, work remains: Co-occurrence estimates generally range from 50 to 80%.[50][51]

Healthy People 2010 Objective	National Baseline	Target	SCC Status	Meets Target Y/N/NA
18-11 Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness (SMI).	No baseline provided	No target provided	The MHD does not collect or maintain applicable baseline and performance data. However, the MHD contributes resources to the SCC Drug and Mental Health Courts as well as the Dependency Drug Treatment Court and the Family Wellness Court. Through MHSA funding, the MHD retains a Criminal Justice Service Coordinator and Law Enforcement Liaisons and promotes law enforcement Crisis Intervention Team training.	NA
18-12 Increase the number of States and the District of Columbia that track consumers' satisfaction with the mental health services they receive.	36 States tracked consumers' satisfaction	50 States and the District of Columbia	The MHD tracks consumers' satisfaction through annual surveys.	Y for SCC
18-13 Increase the number of States, Territories, and the District of Columbia with an operational mental health plan that addresses cultural competence.	No baseline provided	No target provided	The MHD has a cultural competency plan.	Y for SCC
18-14 Increase the number of States, Ter-ritories, and the District of Columbia with an operational mental health plan that ad-dresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.	24 States had plans	50 States and the District of Columbia	The MHD has an Older Adults system of care with screening, treatment and crisis intervention services. Older adults also are a specific focus of MHSA CSS and PEI services.	Y for SCC
20-9 Increase the proportion of worksites employing 50 or more persons that provide programs to prevent or reduce employee stress.	37% of worksites with 50 or more employees provided programs	50%	Santa Clara's Employee Assistance Program (EAP) is a labor-management sponsored, confidential, professional counseling service for employees and their families.	Y for SCC government

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