California Mental Health and Substance Use Service System Needs Assessment

Summary of Major Themes from Stakeholder Review and Comment
Prepared by TAC/HSRI
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The Technical Assistance Collaborative (TAC) and the Human Services Research Institute (HSRI) are grateful for the feedback and input we received on the draft of the California Mental Health and Substance Use System Needs Assessment report.

Numerous individuals and organizations submitted comments via email through the DHCS 1115 website. In addition, numerous stakeholders including consumers, family, members, provider groups, advocacy organizations, and county mental and substance use staff persons, participated in a series of public meetings, convened during the week of February 6, and follow-up calls scheduled the week of February 13, to offer their opinions and feedback on the report. We are particularly grateful to the California Institute for Mental Health (CIMH) for convening mental health and substance use expert panels to provide comments and to facilitate discussion of the findings of the report.

TAC/HSRI realizes that the time allotted for public feedback and review was brief, so we sincerely appreciate the time and effort taken not only to read the report but to offer feedback as well. We regret that due to the large volume of comments received, we are unable to respond to each comment individually. However, we have attempted to address some of the major themes and issues that emerged from this public review process below.

Major themes that emerged from the public review and feedback process included:

1. Several people noted that the data used for the analysis was not the most recent data available[1] and thus may not accurately reflect the current needs or strengths of the mental health and substance use systems. This is of course the reality when using claims and encounter-based data. We attempted to mitigate some of this problem by analyzing three years of available data to show trends in system performance over time and use data from DMH and DADP that had more current data available. In addition, we used key informant interviews to help obtain more

[1] Data available for DHCS Medicaid data was through calendar year 2009, DMH data was available through calendar year 2010 and ADP data was available through fiscal year 2010.

up to date information about the needs and strengths of the system and to highlight emergent issues or problems in the system. Use of key informants was also helpful in cases where there was limited available data, such as for special populations.

2. Several stakeholders highlighted the discrepancy in funding for mental health versus substance use services. TAC/HSRI agrees that a greater emphasis on the imbalance in funding should be included in the report and have made revisions to the report to reflect this reality.

3. It was suggested that the discussion of evidence-based practices (EBPs) did not capture some of the innovative work occurring throughout the state on implementing EBPs, particularly for youth and families. While our analysis of mental health EBP utilization as reported in DMH's CSI database did indicate that rate of individuals receiving an EBP was low (1% in 2010), we understand that the data captured in this database does not reflect other mental health EBP projects funded through other sources. While available DADP data on substance use EBP's was cited, we also know that use of substance use EBP's may not be fully captured as part of that reporting process. Edits to the report were made to more accurately describe the work being done to implement EBPs in the state; and to acknowledge that available data may not capture the full use of EBP's in California.

4. Concerns were raised by several stakeholders regarding the need for a greater focus on use of alternatives to emergency department (ED) and inpatient/medical detoxification care. TAC/HSRI agree that services such as peer support, crisis residential, mobile crisis intervention, and ASAM level 3.5 and 3.7 residential services are important components of a recovery-oriented mental health and substance use continuum of care that can be more cost-effective than ED or inpatient care. Language was added in several places throughout the report to highlight the need for alternatives to ED and inpatient care.

5. TAC/HSRI also heard clearly from key informants that ED utilization has increased significantly in the past year. At the time of this report, we did not have complete claims data from 2010 or data from 2011 to confirm these reports; understanding also that Medi-Cal claims data only captures a portion of the mental health and substance use ED encounters. This is due to the fact that people with other insurance products or those who are uninsured also use the ED and their utilization will not show up in Medi-Cal claims data; nor does it capture the reality that much of the behavioral health interventions provided by

emergency departments go unreported as there are no formal contractual, billing or notification systems in place. While ED use is not a specific focus of the 1115 Waiver behavioral health services plan, we understand that DHCS, DMH and DADP will continue to review this issue as part of their broader mental health and substance use system planning efforts.

6. TAC/HSRI received several comments related to the prevalence estimates for mental health and substance use conditions and in particular the SMI rates for adults, and alcohol / drug abuse and dependence for both youth and adults. Specifically, reviewers noted that the needs assessment relied on demographics and not geographic identifiers (this was done in order to construct county level estimates with available data) and this can lead to a likely underreported prevalence number in California. Secondly, reviewers noted that the data available on prevalence and total population for persons not residing in households (e.g. unsheltered homeless) could add to the likely undercount on prevalence estimates.. We have compared our estimates with other information provided by stakeholders in CA and federal sources, and believe the impact on penetration rates would be minimal. Table 1 below shows the differences based on recent national SAMHSA reports based on NSDUH data.

Table 1 Prevalence Estimates Comparison

Age and Diagnosis	TAC/HSRI Report Prevalence (2009)	NSDUH Prevalence (2008/2009)
SMI (18+)	4.28%	4.3%
Youth (12-17) Alcohol Or Drug Dependence or Abuse	8.15%	8.17%
Adult (18+) Alcohol Or Drug Dependence or Abuse	8.83%	9.64%

7. We recognize that there are several methodologies for estimating substance use prevalence, and believe the science of prevalence estimation can be advanced by continuing to review the TAC/HSRI methodology in the context of new SAMHSA approaches and the excellent work being done by DADP and UCLA. The entire field can benefit from improving these approaches and we are committed to continuing to work with the involved parties to assure the prevalence estimates are as accurate as possible.

8. At the same time, we are cognizant that the treatment gap for substance use services is so large[2] that quantification of the lower and upper ranges of the prevalence estimates is relevant but not critical to initial planning processes addressing this treatment gap. Even with added resources and successful engagement efforts, the treatment gap remains high everywhere. Thus, we believe DHCS and DADP can successfully implement initial strategies to address the documented treatment gaps while at the same time working to refine the prevalence estimates.

9. Several stakeholders commented that Schizophrenia was not included as a diagnosis in our prevalence estimates. However, while specific diagnostic categories were not the basis for the prevalence estimates, people with schizophrenia and other serious mental illnesses are most definitely included in the prevalence estimates we produced for California. We note that the TAC/HSRI estimates for the serious mental illness population are quite consistent with SAMHSA's national estimates of youth with serious emotional disturbance and adults with serious mental illness. This should give DHCS and DMH confidence in using the estimates for planning purposes. In addition, as we note in the report and below, the TAC/HSRI methodology allows for differentiation of needs among special populations, and also can be used with some confidence at the county level.

10. TAC/HSRI also received a number of comments about the use of prevalence estimates to calculate penetration rates. Similar to the calculation of prevalence estimates, there are a variety of different approaches to calculating penetration rates. The approach used depends on the question being asked of the data. For the purpose of this needs assessment, TAC/HSRI were interested in understanding, "How much of the overall need for mental health and substance use treatment is being met by Medi-Cal, county mental health/substance use departments, and non Medi-Cal DADP resources?" This meant basing the penetration rate analyses on the prevalence estimates for serious mental illness or substance use among Californians, as opposed to using the total population (that includes people who do not have mental illness or a substance use disorder) or the Medi-Cal population, which too includes people who do not have a mental illness or a substance use disorder. Calculating the penetration rates in this way permits a more accurate representation of the "need" side of the equation; while acknowledging that not everyone included in the prevalence estimate is eligible for Medi-Cal and/or may have their treatment needs met by

[2] In California and in every other jurisdiction in the United States.

sources other than Medi-Cal, DADP, or county mental health/substance use departments such as commercial insurance payers.

We also know from experience in other states that not all people in the need cohorts ever present or ask for services in either the public or private systems. The purpose of the gaps analysis is not to quantify absolute need, but rather to provide a defensible set of benchmarks through which the relative gap between needs and service access can be documented and trended over time.

The methodology we used for prevalence estimates is sensitive for racial/ethnic groups and is also sensitive enough to be applied at the county level. We believe both of these factors enhance the utility of the penetration analyses in our report.

TAC/HSRI has conducted mental health and substance use needs assessments and gaps analyses in several other state and local jurisdictions. Such studies are intended to stimulate questions, to challenge existing data, to inform and to enhance strategic planning for system improvements. In every case, the needs assessments have resulted in: (a) identification of issues related to the collection and analysis of data, which in turn have lead over time to improved data collection and reporting; and (b) identification of numerous issues and priorities related to system-wide planning and improvements, which in turn have resulted in a variety of interrelated strategies to improve and enhance substance use and mental health services beyond the original scope of the needs assessment projects.

TAC and HSRI's experience with the California substance use and mental health services needs assessment has been similar to our experiences in other jurisdictions. We expect that data collection and analysis processes will be improved over time as a result of issues raised in the course of this needs assessment. We also expect that long term system planning for mental health and substance use services will be better informed by responding to the issues raised by this report. In addition, the many issues raised and suggestions made by stakeholders commenting on the draft report provides a rich and highly relevant agenda to be addressed in subsequent planning processes.

TAC/HSRI have emphasized that planning mental health and substance use benefits for the Medi-Cal expansion population must be done in the context of the resources and functioning of the larger system. It is also true that enhancing the larger system can result from the analyses in the needs assessment, even though the immediate purpose of the needs assessment report is to focus on the Medi-Cal expansion population.