Needs Assessment Report
Executive Summary

CALIFORNIA MENTAL HEALTH NEEDS

EXECUTIVE SUMMARY

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The California Mental Health Needs Assessment Project

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Executive Summary

I. Overview of This Study

This study, funded by the California Department of Mental Health, and carried out by the Santa Clara Services Research Center is the most comprehensive study to date of the per capita rate of treatment of clients of all local Short-Doyle mental health programs. The period studied extended from July, 1987 through June, 1988. It provides service rates for each of the 59 local mental health programs and includes state hospital services as well. The level of occurrence of mental disorder in the nation, and of key severe disorders in each California county are included as a frame of reference. Analysis of rate trends resulted in a number of recommendations for public mental health services policy consideration. The study is intended to be of immediate use, as well as a reference as questions arise in the future.

II. The Role of Public Mental Health Services

Public mental health services have a special role to perform for Californians. At the most general level, they maintain a sense of social order through mental health prevention and treatment services. Eight major goals of local and state hospital services are listed in Figure One.

III. Available Information

Not all of these goals are documented by the current Department of Mental Health data reporting systems, the Client Data System (CDS), annual Cost Reports, and the state hospital data system. Only direct services are reported in enough detail to study, and in the fiscal year 1987/88 used for this report, only the most traditional treatment services were uniformly present. Community supports, such as case management, housing, self help activities, etc. were not present, or not reported completely enough to study. No prevention activities such as suicide prevention or school based preventive services, nor disaster responses were present in the data. The sources of data used in this study are listed in Figure Two. In addition to Department of Mental Health data, this report used data from the 1980 U.S. Census, and census updates for 1989 and for 1994.

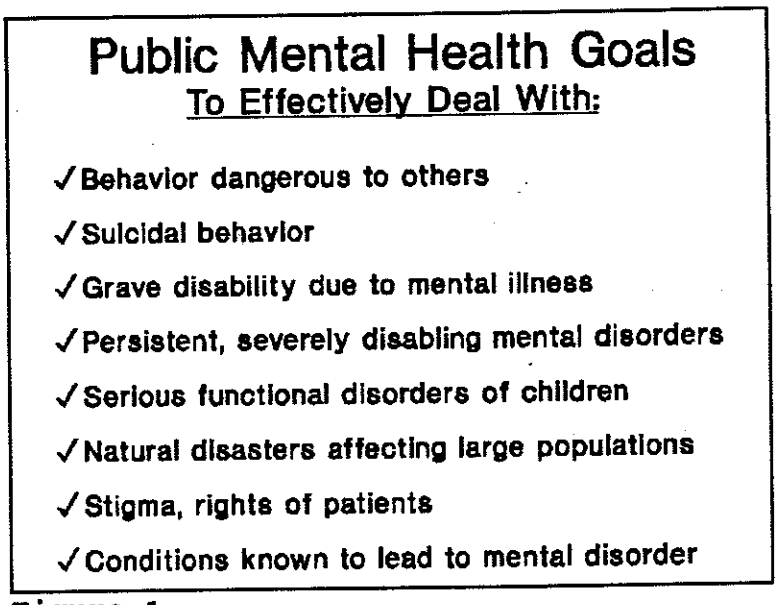

Figure 1

IV. The Prevalence of Disorders

Prevalence is the frame of reference for this report. It is the level of occurrence of serious mental disorders in the population. Prevalence information from published scientific papers and new estimates of prevalence of schizophrenia, mania, and major depression in

California provide the context for evaluating the rate of mental health services.The prevalence of serious mental disorder in the population is an objective measurement of need for services. Prevalence is measured by interviewing members of the population regarding symptoms. The answers can be used to score the nuber of symptoms present, or to determine whether the criteria for a diagnosis are present. The first method places individuals on a scale ranging from health to disorder. The second method divides the population into those with a diagnosis of mental disorder and those without. Studies of the first kind in Santa Clara County, California were used for prevalence level determinations among ethnic, age, and other population groups. The national ECA, or Epidemiologic Catchment Area studies are of the second type, and were used for the prevalence of diagnostic groups. These ECA studies of adults in five areas of the United States measured the occurrence of a large number of mental disorders in the general population in a uniform controlled way. No equivalent information is currently available for disorders in those under 18, but one study is cited for the prevalence of conduct disorders, one of the most frequently treated in this age group.

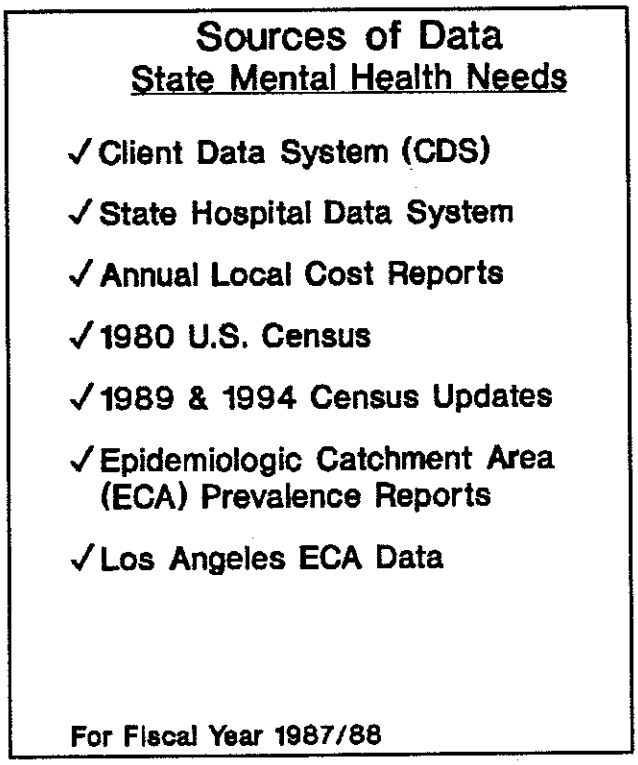

Figure 2

In general, the most disabling disorders are also the least frequent. For example, in California the ECA study estimates schizophrenia has a prevalence of 96 cases per 10,000 adult population. Prevalence of mania is estimated at 90 per 10,000 population. By contrast, major depressive disorder occurs in 458 per 10,000 population. Dysthymia, or moderate depression, nationally has a prevalence of 330 per 10,000. Anxiety disorders have a national prevalence of 890 per 10,000.

Serious mental disorder is often complicated by concurrent drug and alcohol disorders. ECA studies found alcohol disorders occur in 6 percent of the adult population, and drug abuse or dependence in 4.7 percent. Thirteen percent of adults who have either schizophrenia, mania, or major depression also have a diagnosable alcohol abuse or dependence disorder. Sixteen percent of adults with one of these mental disorders in addition have a drug abuse or dependence isorder.

V. Prevalence in Population Groups

Affective disorders occur more often among women, and anxiety disorders are about twice as common among women. On the other hand, antisocial personality (prevalence 0.8 percent) occurs four times as often among men.

Disorders do not occur at the same rate in all age groups. ECA studies found there is a significantly lower rate of occurrence of schizophrenia, and major affective disorders below the age of 18 and in those over 64. Antisocial personality appears mainly below the age of 45. Only severe cognitive impairment (national prevalence 1.3 percent) increases with age.

VI. The Percentage of Cases Treated by Public Mental Health

Figure Three contrasts the prevalence of five disorders with their rate of treatment by the combined local mental health programs and state hospitals. Figure Four graphs the percentage of the prevalence of disorders in the population seen by local and state hospital programs in the year studied. The focus of these programs on schizophrenia, and bipolar psychoses is clearly evident. In 1987/88 34.5 percent of adults with schizophrenia were seen by local or state hospital programs, 11.6 percent of those with bipolar disorder, 3.1 percent with major depression, 3 percent with dysthymia, and 0.6 percent with anxiety disorders. With the notable exception of schizophrenia, local programs see a very small portion of those with mental disorders in the community in the period of a single year.

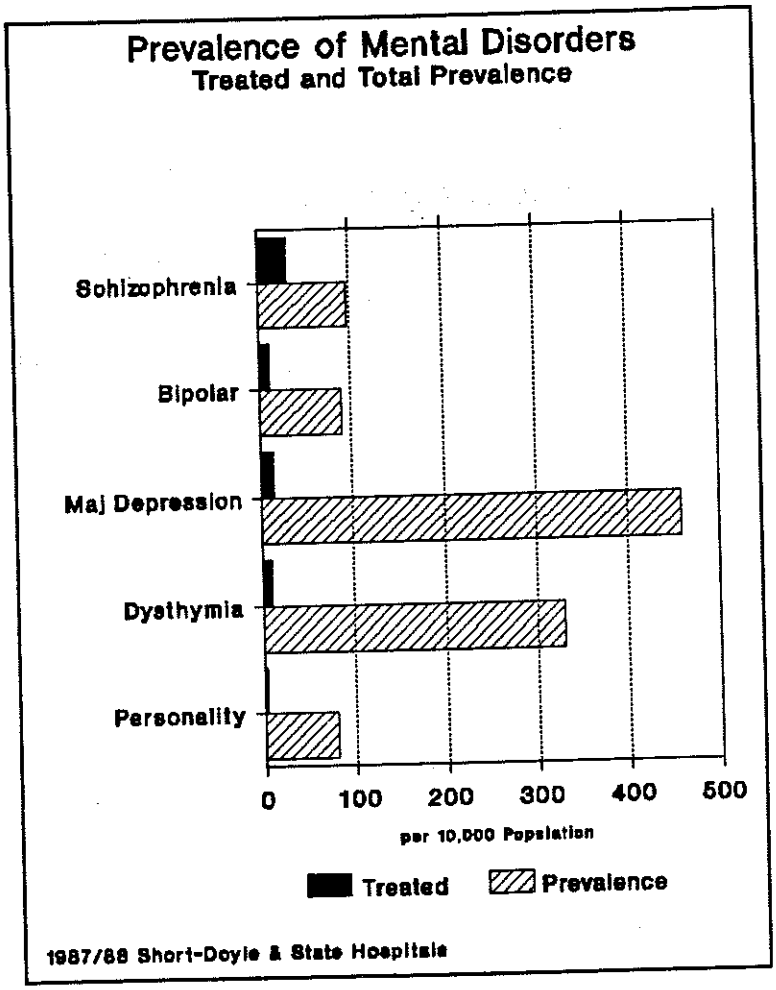

Figure 3

Conduct Disorder (Figure 5) is one of the most prevalent disorders of youth. In the

4 to 11 age group conduct disorder appears in 6.5 percent of boys and 1.8 percent of girls in a Canadian community survey. Among those 12 through 16, 10.4 percent of boys and 4.1 percent of girls have conduct disorder.

The full report includes estimates for the prevalence of schizophrenia, mania, and major depression for each California county, and for the state as a whole, based on the ECA studies.

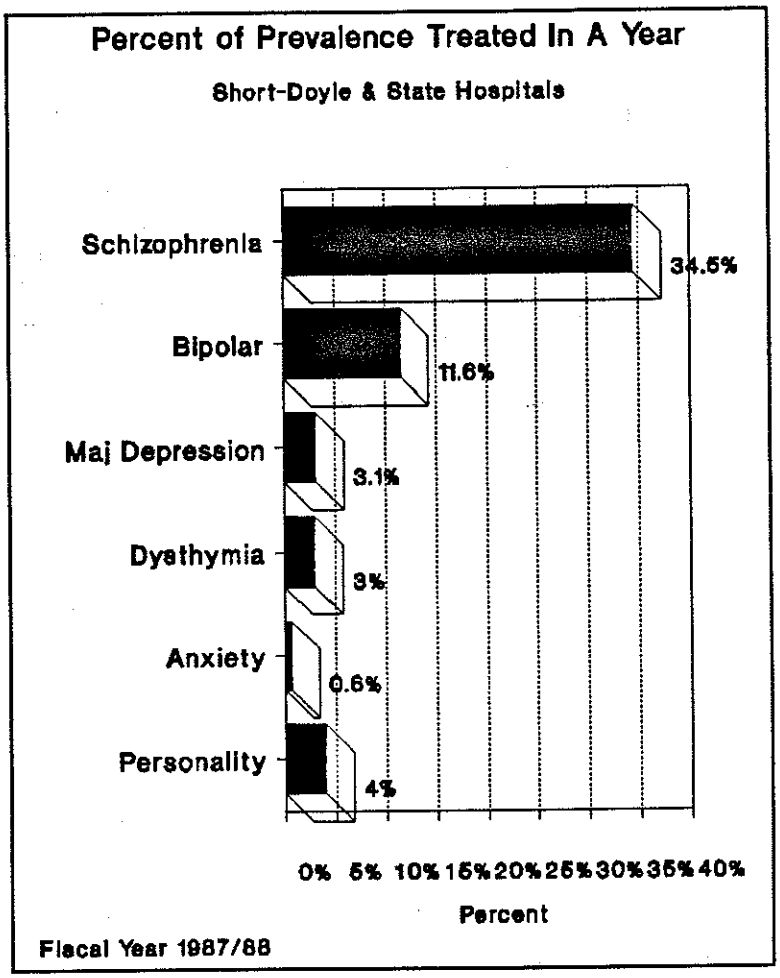

Figure 4

VII. Treatment Rates

Certain California population facts have important bearing on the future of mental health services.

1. It is the most populous state, and will grow another ten percent between 1989 and 1994. **Consequently a 10 percent growth in the number of people with mental disorders in the next five years can be expected.**

2. **Population growth will be mainly among young Hispanics and Asians.** In the near future

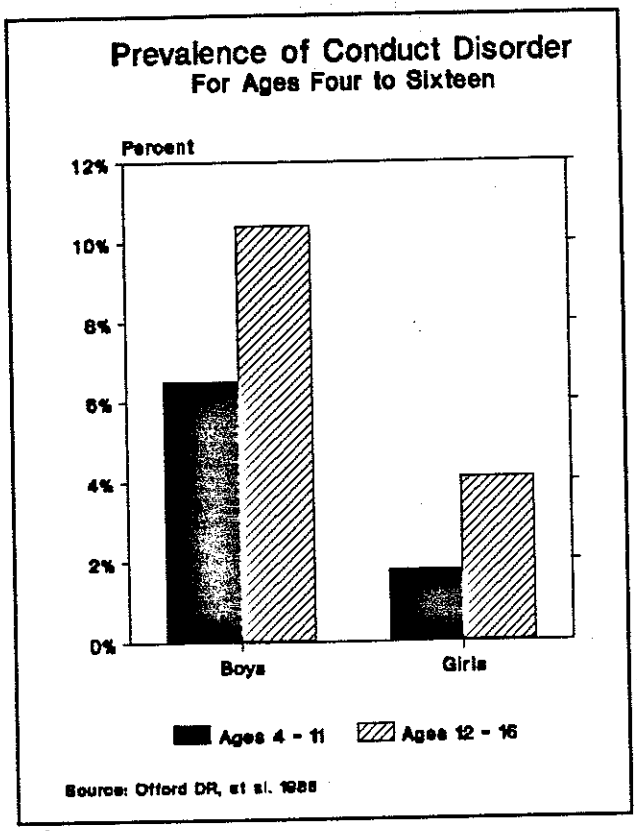

Figure 5

the non-Hispanic white population will be in the minority in the state. Planning for services to these ethnic populations is critically important.

3. **Those below 18 years of age will be the fastest growing age group in the future,** exceeding growth in adult and senior groups. Services planning for these children and adolescents is essential.

Each county has its own population characteristics that are related to the prevalence of mental disorder. The body of the report gives a detailed picture of these socioeconomic factors, and the expected growth of each county. The report also provides detailed treatment rates for each county, and for the state.

Service rates for diagnostic groups of youth and adults statewide and for counties are included. For adults, Schizophrenia has the highest rate (Figure Six), followed by major depression and adjustment disorders. Many of the adult disorders with the high prevalence in the community have very low treatment rates.

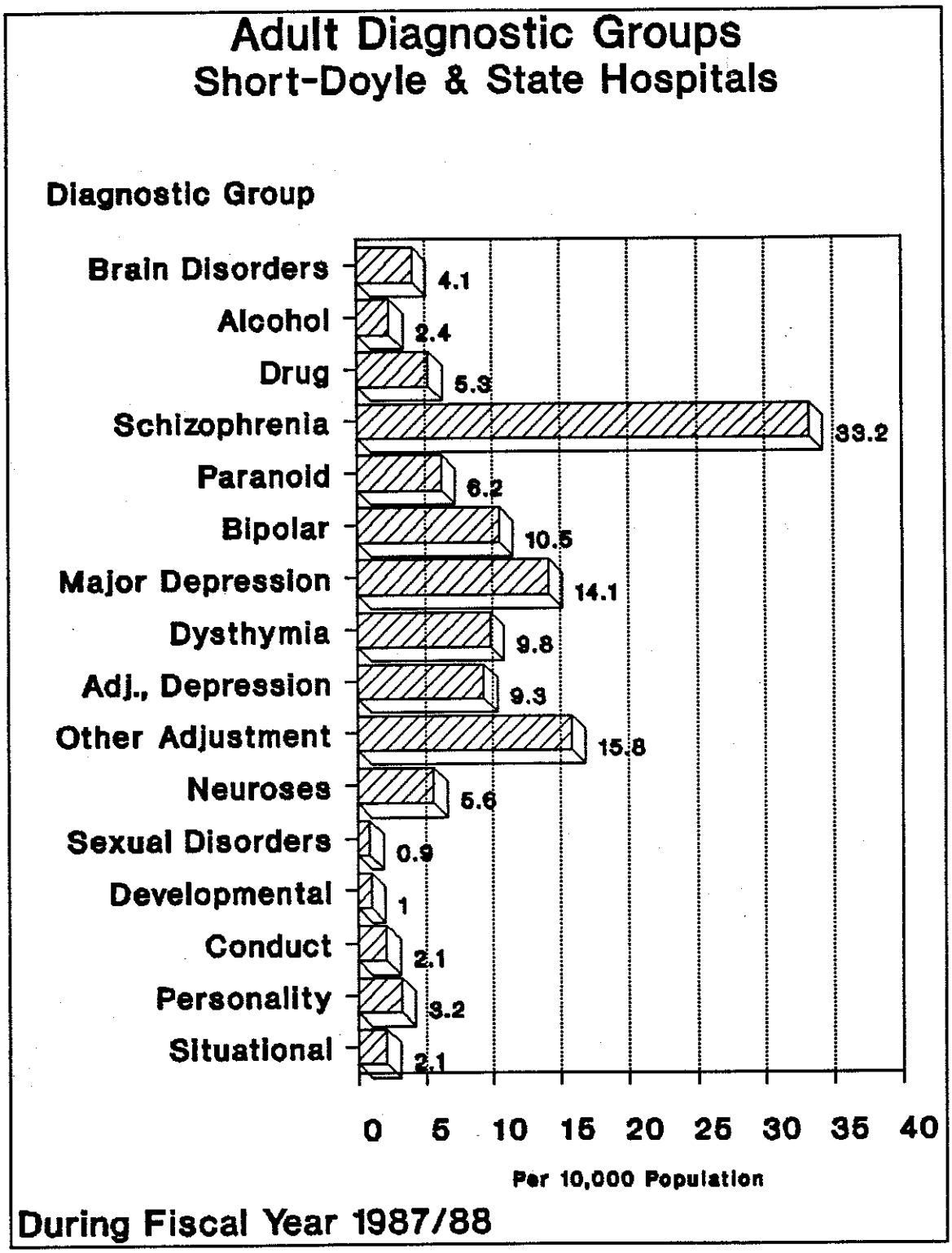
Adult Diagnostic Groups
Short-Doyle & State Hospitals
Diagnostic Group
Brain Disorders
Alcohol
Drug
Schizophrenia
Paranoid
Bipolar
Major Depression
Dysthymia
Adj., Depression
Other Adjustment
Neuroses
Sexual Disorders
Developmental
Conduct
Personality
Situational
4.1
2.4
5.3
33.2
6.2
10.5
14.1
9.8
9.3
15.8
5.6
0.9
1
2.1
3.2
2.1
0 5 10 15 20 25 30 35 40
Per 10,000 Population
During Fiscal Year 1987/88

Figure 6

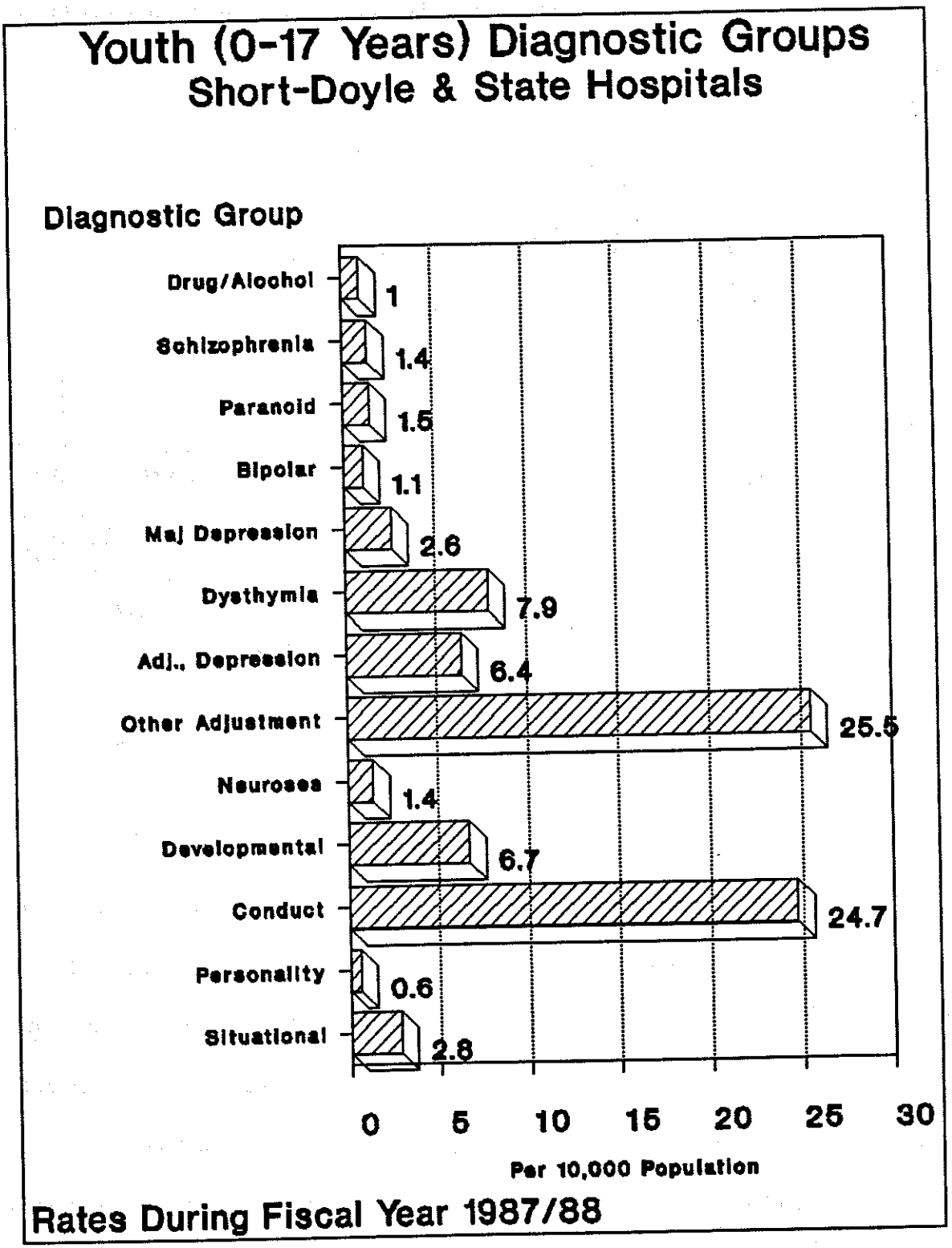
Youth (0-17 Years) Diagnostic Groups
Short-Doyle & State Hospitals
Diagnostic Group
Drug/Alcohol
1
Schizophrenia
1.4
Paranoid
1.5
Bipolar
1.1
Maj Depression
2.6
Dysthymia
7.9
Adj., Depression
6.4
Other Adjustment
25.5
Neuroses
1.4
Developmental
6.7
Conduct
24.7
Personality
0.6
Situational
2.8
0
5
10
15
20
25
30
Per 10,000 Population
Rates During Fiscal Year 1987/88

Figure 7

These include the anxiety disorders, personality disorders, and situational disorders. The focus is on the most severely disabling conditions.

Highest statewide treatment rates for those under 18 (Figure Seven) are for adjustment disorder followed by conduct disorder.

VIII. Treatment Rates That Fit Prevalence Patterns

Treatment rates were found to follow well known patterns of occurrence of mental disorder in marital and in educational groups, as exemplified by prevalence patterns found in Santa Clara County. For educational groups (Figure Eight), those with less than high school had highest treatment rates, followed by high school graduates, one to four years college, and five or more years college. Prevalence of symptomatology is regularly associated with educational attainment, with higher prevalence among those with less education. The local programs reflect this prevalence pattern quite well in their treatment rates. Similarly, it is typically found that the married have the lowest rates of symptomatology. The separated have the highest prevalence, followed by the single and divorced. The treatment rates reflect this typical pattern of prevalence closely, as indicated in Figure Nine.

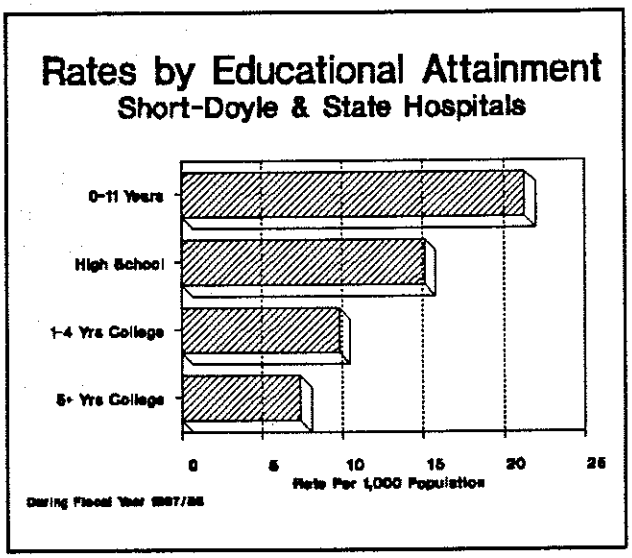

Figure 8

Treatment rates for age groups (Figure Ten) reflect the prevalence pattern found

among adults, with highest treatment rates in those in their twenties, with a gradual decline of rate of treatment with increasing age.

IX. Treatment Rates That Do Not Follow Prevalence Patterns

Rates for ethnic groups (Figure 11) were found to deviate widely from survey data about the prevalence of mental symptoms. Survey data indicates the prevalence of symptomatology among most ethnic minority populations is significantly greater than in the non-Hispanic white population. In California this was confirmed by epidemiologic surveys of the population of Santa Clara County carried out by Meinhardt, Warheit, Vega, et al. in 1980 and 1983. The treatment rates found for California are in line with prevalence patterns only for the black population. Statewide rates for blacks are about twice rates for non-Hispanic whites. However, rates for Hispanics, Asians and others are well below the non-Hispanic white rates. Rates for Hispanics are only about two

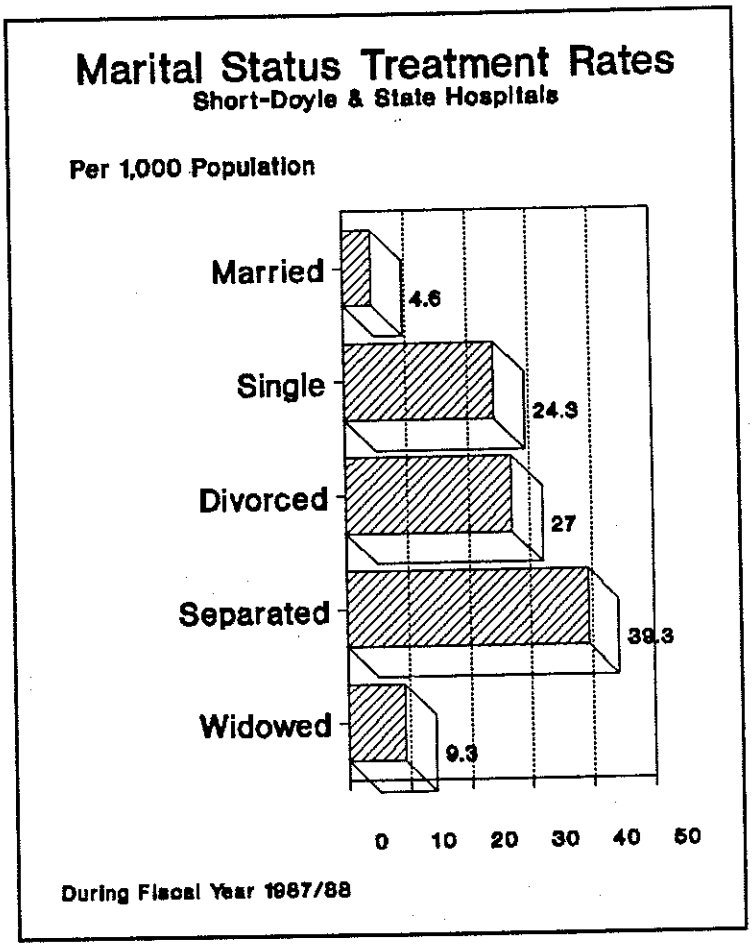

Figure 10

thirds that for non-Hispanic whites, and for the other ethnic groups (primarily Asian) their rate is only about four fifths the non-Hispanic white rate. In contrast, prevalence for these groups ranged from about double to five times that of non-Hispanic whites in Santa Clara county.

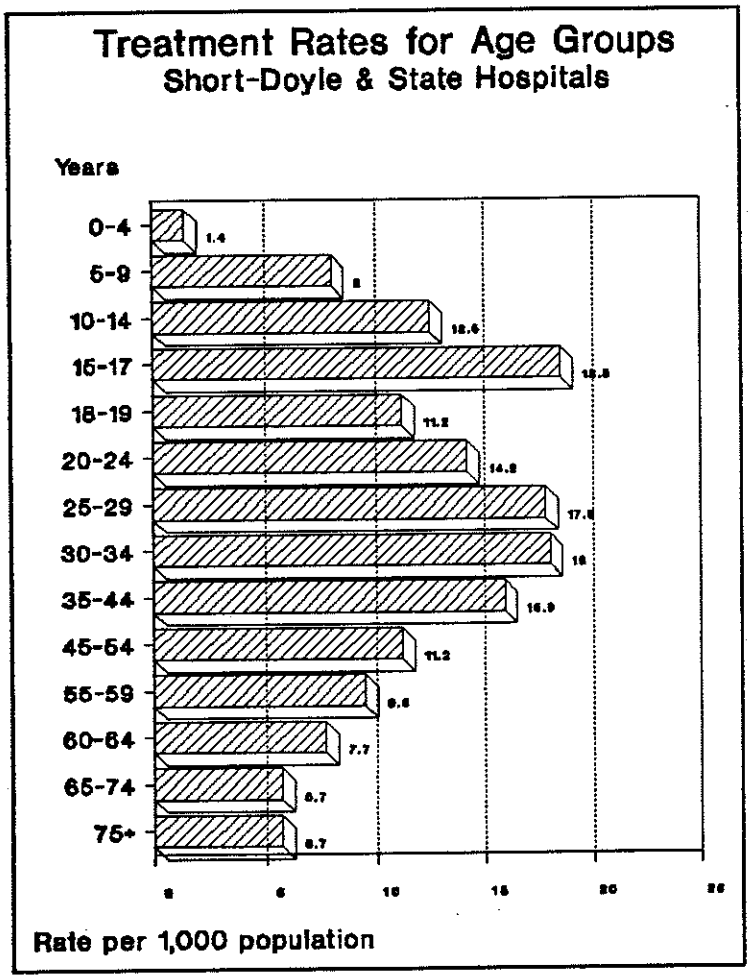

Figure 9

In the full report there are tables of the amount of service provided by each local program, including the resources allocated to core sevices for youth and for adults. Statewide, the largest per capita expenditure for adults for a single treatment type remains the state hospital, followed by local outpatient, and then local hospital services. For those under 18 the highest rate of expenditure statewide is for local outpatient services, followed by local hospital and day treatment. Per capita expenditure for adults is about twice the expenditure for those under 18. Analysis of expenditures by broad target groups demonstrates a focus of expenditures for adults on the seriously, persis-

tently ill, and for youth on adjustment and conduct disorders.

X. The Pattern Underlying Differences in Service Levels Among Counties

Treatment rates vary enormously from county to county. The lowest rate is in Orange county at 6.49 patients per 1,000 county population. The highest rate is in Inyo county at 38.74 patients per 1.000 county population. This wide variation in treatment rates among local programs exhibits an underlying pattern that has importance for planning and managing mental health services. Using multiple regression analysis higher county patient rates of treatment were found to be associated with five factors (Figure 12).

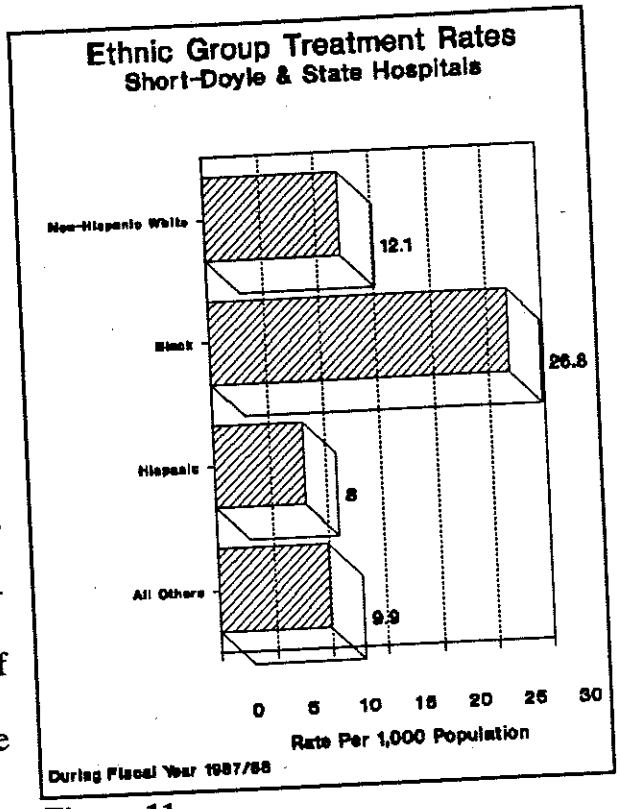

Figure 11

Two Factors Related to Prevalence of Disorder

Lower per capita income is typically associated with higher prevalence of disorder in the population. This relationship also exists for for California treatment rates, and establishes there is a relationship between need for services and treatment rates. College enrollment can be looked on as a correction to census data on per capita income. Those in college do have low income, but they also have higher socioeconomic status than is indicated by their current income. Consequently they contribute less to the county mental

health need than an equal number of low income people not in college.

Three Factors Unrelated to Prevalence of Disorder

The other three factors are the direct or indirect result of public policies.

1. There is long standing wide variation in per capita funding of local mental health programs in California. **This study confirms that it is a major determinant of the variation in the level of services available to residents of different counties.**

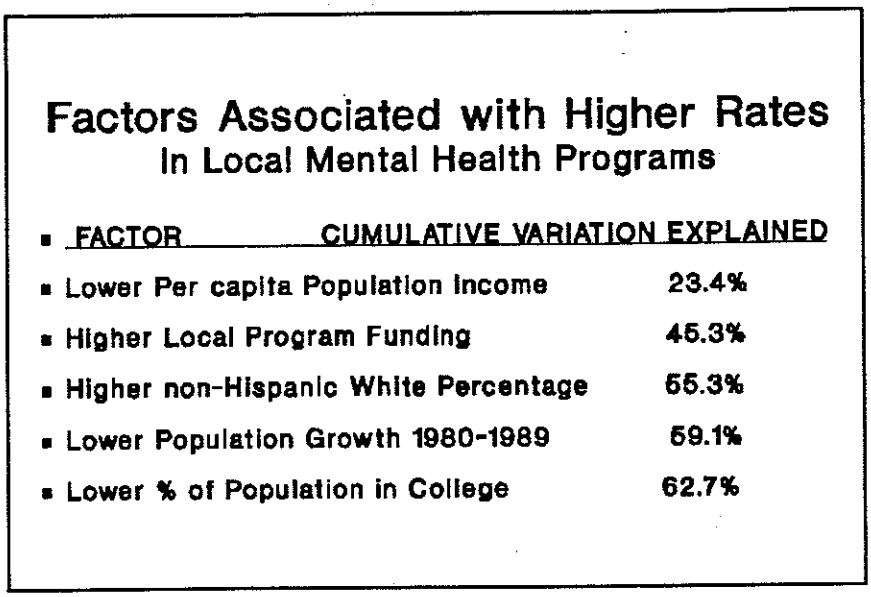

Figure 12

2. **There are inequitable rates of service delivery to certain ethnic populations, Hispanic and Asian primarily.** As a result there is an association of higher service rates with those counties having a larger percentage of non-Hispanic white population.

3. There is no policy mandate to provide mental health resources that keep pace with population growth. As a consequence, **those counties that have experienced rapid growth in the past decade have lower services rates,** compared to those with low growth.

These findings should be reviewed in the light of public policies.

Maps of California counties are provided in the report, to display the statewide

pattern of single factors, such as total rates, the five factors listed above, and major diagnostic groups. These enable visualization of the regional distribution of services for the mentally ill.

XI. Where to Find More Information

Additional information can be found in Volume One on the following topics:

For a discussion of the role of public mental health services and its goals, see Chapter One.

For an understanding of the level of occurrence (prevalence) of mental disorders in the United States and in California, read Chapter Two.

More details of the rate of treatment of these disorders by local California programs, and the state hospitals can be found in Chapter Three.

To understand the basic patterns of services across California in the 59 local programs, see Chapter Four.

For a description of the needs assessment methods used in this project, see Chapter Five.

For a basic theory about how those potentially in need of mental health serices go through a process of inclusion and exclusion that leads to a smaller group that receive services from local porgrams and state hospitals, see Chapter Six.

For the details of the data set used in the study, with recommendations for future improvements in this data and the way it is stored, read Chapter Seven.

For the details of the mathematical method used to estimate prevalence of major mental disorders from ECA data in this study, see Chapter Eight.

For a listing of the data elements used, see Chapter Nine.

For details about the discrepancies found between the two main sources of data about local program services, the Client Data System and the annual Cost Report, see Chapter Ten.

For the definition of diagnostic groupings, see Chapter Eleven

To find information about a single local program, consult Volume Two. In this second volume of the report there are 59 sections, one for each of the local Short-Doyle programs. Each section has a standard set of tables that give detailed information about service rates, and about the allocation of resources to various types of treatment and to broad target groups, with a brief description of the county, or city area served.