

Outcomes

of CalWORKs

Supportive Services

in Los Angeles County

Mental Health

Year Two

California Institute
for Mental Health

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Staff for the outcomes monitoring effort include Dan Chandler, Pat Jordan, Joan Meisel, and CarolAnn Peterson. We are indebted to the assistance of many staff members working with supportive services, including:

DEPARTMENT OF MENTAL HEALTH

Marvin J. Southard
Dennis Murata
Dolores Daniel
Randall Ahn

DEPARTMENT OF HEALTH SERVICES, ALCOHOL AND DRUG PROGRAM ADMINISTRATION

Patrick Ogawa
Richard Browne
Linda Dyer
Leona Anderson

COMMUNITY AND SENIOR SERVICES, DOMESTIC VIOLENCE UNIT

Roseann Donnelly
Lisa Hamilton
Sheila Hazlett
Chris Frau

DEPARTMENT OF PUBLIC SOCIAL SERVICES

Margaret Quinn
Nadia Mirzayans
Siphon Van
Deborah Gotts
Michael Bono
Mayindi Mokwala

This report is dedicated to Barbara Sullivan, who died in the spring of 2004. She was an exemplary public servant, and those of us listed on this page miss her greatly.

¹ California Institute for Mental Health, 2030 J Street, Sacramento, CA; (916) 556-3480

TABLE OF CONTENTS

INTRODUCTION	1
THE INTERAGENCY CONTEXT OF CALWORKS SUPPORTIVE SERVICES.....	1
SUPPORTIVE SERVICES OUTCOMES	2
CONTEXT FOR SUPPORTIVE SERVICE WORK OUTCOMES: EMPLOYMENT AND WORK ACTIVITIES IN THE CALWORKS POPULATION OVERALL	2
INFORMATION PRESENTED IN THIS REPORT.....	3
PART 1: CHARACTERISTICS OF CURRENT AND DISCHARGED CALWORKS MENTAL HEALTH CLIENTS	6
PART 2: ACCESS	9
PART 3: ENGAGEMENT	12
SATISFACTION WITH AND PARTICIPATION IN SERVICES.....	14
REASONS FOR TERMINATING SERVICES.....	16
FACTORS ASSOCIATED WITH COMPLETING SERVICES.....	18
PART 4: MENTAL HEALTH TREATMENT OUTCOMES	18
PART 5: EMPLOYMENT-RELATED OUTCOMES	20
STAFF AND CLIENT VIEWS OF HOW SERVICES AFFECT EMPLOYABILITY.....	20
EMPLOYMENT AND WORK ACTIVITY WHILE RECEIVING MENTAL HEALTH SERVICES.....	21
EMPLOYMENT AND WORK ACTIVITIES AT END OF MENTAL HEALTH SERVICES.....	22
CALWORKS ELIGIBILITY, EMPLOYMENT, AND WORK ACTIVITIES FOLLOWING END OF MENTAL HEALTH SERVICES.....	23
EFFECT OF MENTAL HEALTH ISSUES AND SERVICES ON EMPLOYMENT IN THE POPULATION DATA FROM 1998-2001.....	25
LENGTH AND COSTS OF SERVICES.....	28
SUMMARY	29
METHODOLOGICAL APPENDIX	30
SAMPLING METHODS.....	30
<i>Clients whose services had ended</i>	30
<i>Clients currently receiving MH/SA/DV services</i>	30
<i>1998-2001 population data</i>	30

Other reports and technical assistance materials from the CalWORKs Project are available at the California Institute for Mental Health website: www.cimh.org/calworks

INTRODUCTION

Research in California counties has shown a high prevalence of mental health (MH), substance abuse (SA), and domestic violence (DV) issues in the CalWORKs population. These issues negatively affect participants' abilities to obtain and maintain employment. Additionally, they can threaten the well-being of children in the family.²

To address these barriers to achieving the goals of CalWORKs, the California Legislature has designated CalWORKs funds to be used for the provision of MH and SA services for CalWORKs participants. Many counties have designated funds for DV issues, as well, and Los Angeles County has been particularly generous in this regard. This funding has enabled counties to develop systems to identify and serve clients with MH/SA/DV problems—collectively called “supportive services” in Los Angeles.

The Department of Mental Health in Los Angeles County, with additional support from funds contributed by the Department of Health, Alcohol and Drug Administration, contracted with the California Institute for Mental Health (CIMH) to work with the county in designing a system to measure the effectiveness of CalWORKs supportive services. Over the past two years, four departments have cooperated with each other and with CIMH to study and improve supportive services in Los Angeles: the Department of Mental Health (MH), the Department of Public Social Services (representing CalWORKs), the Department of Health Services (SA), and Community and Senior Services (DV).

In May of 2003 we issued a first report profiling service outcomes, including client satisfaction and the achievement of work-related goals.³ This is the second project report. It is presented in different formats for different audiences. This format is for mental health system stakeholders. Similar reports are available for SA and DV stakeholders. A combined report is oriented to policy makers. All are available at: www.cimh.org/calworks.

The Interagency Context of CalWORKs Supportive Services

The CalWORKs supportive services—mental health, substance abuse and domestic violence—pose a unique challenge and opportunity. These services rely inherently on interagency cooperation. CalWORKs staff must identify persons with MH/SA/DV problems and provide employment-related supports, but the mental health, substance abuse, or domestic violence agencies provide the services necessary for clients to make use of the opportunities CalWORKs offers.

² These findings are from CalWORKs Project reports. Reports and technical assistance materials from the CalWORKs Project are available at the California Institute for Mental Health website: www.cimh.org/calworks

³ The CalWORKs Project. (2003). *Outcomes of CalWORKs Supportive Services in Los Angeles County: Mental Health, Substance Abuse, Domestic Violence*. Sacramento, California Institute for Mental Health.

While service linkage offers an otherwise unavailable opportunity to help CalWORKs participants with MH/SA/DV barriers, developing interagency programs is a challenge. Los Angeles County has had a strong interagency focus for these services since the initial implementation of welfare reform in 1998. Program managers from all four agencies have met regularly to work out policy, operations and funding issues. During the past two years, they have cooperated in designing a system for measuring and monitoring service outcomes.

Supportive Services Outcomes

We looked at four types of outcomes.

- **Access:** Is the system able to overcome barriers to identification and to facilitate the entry into services of participants with MH, SA, and DV issues?
- **Engagement:** Has Los Angeles County developed services that are relevant, accessible, and offered to the CalWORKs population in ways that enable and encourage participants to become and remain engaged in services?
- **MH/SA/DV Outcomes:** Do the services alleviate the specific MH/SA/DV symptoms or problems that serve as barriers to independence. Persons with these issues are likely to have problems with daily living tasks, parenting, and learning. Improvements in coping with these problems constitute critical “milestones.”
- **Work-Related Outcomes:** Do the services enhance the participant’s ability to be self-sufficient? Although getting a job with a living wage is the ultimate goal, CalWORKs promotes many related objectives—such as getting a general equivalency diploma (GED), obtaining needed training, and learning job search skills.

Context for Supportive Service Work Outcomes: Employment and Work Activities in the CalWORKs Population Overall

Because the number of persons using welfare has declined so much since the early 1990s, we tend to think of welfare reform as a success. However, the employment and service related outcomes of those who are currently receiving CalWORKs are limited. This report contains highlights from recent reports regarding Los Angeles County.⁴

⁴ These data are from different DPSS sources including a 2003 research study by DPSS (we use data from the cohort drawn in the second quarter of 2000) and from the most recent state data. Moreno, M. H., H. Toros, et al. (2003). *Employment and Earnings Among Welfare-to-Work Participants in Los Angeles County, 1998-2001*. Los Angeles, Department of Public Social Services. Available at: http://dpss.co.la.ca.us/dpss/dss/research_papers.cfm. CalWORKs Adult Recipients Quarterly Wage Earning Reports for Quarter Two, 2003. http://www.dss.cahwnet.gov/research/CalWORKsDa_388.htm

A recent Department of Public Social Services (DPSS) study examined the period 1998-2001.

- Participation in Job Club (the “first step” for most work activities) was very low. A total of 54% of GAIN participants did not attend Job Club at all, and only 25% completed it.
- In the same study, only 12.5% of participants took part in a training activity, and only 34% of these finished.
- However, the study showed that participation in either Job Club or training, when it occurred, was associated with better chances of finding and retaining jobs as well as earning wages over the poverty level.
- The DPSS research report concludes that “only a quarter of all greater awareness to independence (GAIN) participants were able to cross poverty thresholds on the basis of earnings alone and become self-sufficient. Even for participants who obtained stable employment, only about half were able to earn above poverty thresholds.”

Very recent data shows limited welfare-to-work participation.

- California Department of Social Services data for Los Angeles reveal that in the second quarter of FY 2003-04, 28% of adults enrolled in Welfare-to-Work were employed. A total of 20% were in training or school, and 50% had at least one work-related activity. However, 25% were exempt, and one-third had been sanctioned and only their children received aid.

Since CalWORKs participants having MH/SA/DV problems have *more* barriers to employment than do other participants,⁵ we consider MH/SA/DV service outcomes successful if they show outcomes similar to these results for participants overall.⁶

Information Presented in This Report

The goal of our efforts is to create an ongoing process to assess the performance of Los Angeles’ supportive services.

We have identified three requirements for the Los Angeles supportive services outcome system:

⁵ Chandler, D. and J. Meisel (2002). Alcohol & Other Drug, Mental Health, and Domestic Violence Issues: Effects on Employment and Welfare Tenure After One Year, California Institute for Mental Health. Sacramento, CA.

⁶ The DPSS research used data on earnings, job turnover and sustained employment from the Employment Development Department which are not available on a routine basis. We use alternative measures included in GEARS, particularly the number of hours working.

- The outcomes system must be interagency in nature, using data from CalWORKs and the MH, SA, or DV agencies.
- The outcome system must record objective progress on a set of milestones toward the ultimate goal of economic self-sufficiency. These milestones will be specific to both CalWORKs and to the MH/SA/DV problems confronting clients.
- Finally, outcomes must include the perspective and feelings of clients, which represent a significant part of any outcome measurement system. While making progress on objective milestones as a result of receiving supportive services is important, the ultimate goal of services is to improve the quality of clients' lives and the lives of their children.

We have used multiple data sources for this report.

This year's report relies on more data sources than last year's, and the methodology is also considerably improved in the drawing of samples of current and discharged clients. The following sections cover the various data sources: the two sample of mental health clients (current and discharged clients), the matched DPSS data on these same clients (new in 2004), and information⁷ pertaining to the entire population of CalWORKs mental health clients in the years 1998 -2001 (new in 2004). The addition of new data sources allows for a more comprehensive look at the issues and outcomes surrounding supportive services, but creates complexities in the reporting of results.

Random samples. As in the first year's report, we drew samples randomly.

Discharged client sample: By implication, an "outcome" occurs at the end of services. Thus we needed to sample a set of clients who had received supportive services in the recent past but were no longer receiving them. We selected the clients who had a MH service listed as a "work activity" in the GEARS data system Welfare-to-Work plan between the months of October 2003 through February 2004. That is, they had received one of these supportive services but had terminated it at some point between October 2003 and February 2004.

Current client sample: It would have been ideal to obtain the views of the above subset of "discharged" clients themselves. However, access to discharged clients is very difficult to obtain and recent efforts to use mail or phone follow-up calls

⁷ In 2003, the Los Angeles Economic Roundtable published *Prisoners of Hope*, an extensive analysis of welfare reform outcomes using a combination of data obtained from DPSS and from the state Unemployment Insurance system. CIMH subcontracted with the Economic Roundtable to generate detailed tables on MH, SA, and DV service participants using the 1998-2001 data on which their report is based. See: Burns, P., Drayse, M., Flaming, D., & Haydamack, B. (2003). *Prisoners of Hope: Welfare-to-Work in Los Angeles*. Los Angeles: The Economic Roundtable, 315 West Ninth Street, Suite 1209, Los Angeles, California 90015, www.economicrt.org.

have been unsuccessful.⁸ As an alternative, we have used a survey of a representative sample of “current” clients—that is, clients still receiving services. While their views may not be the same as those of persons who have terminated services, they are valid in themselves and highly useful to service providers seeking to improve the care they provide.⁹

How representative are the sampled clients? A major improvement in this second Outcome report is the better methodology used to select clients for the two samples. The sample for “discharged” clients was selected systematically from the GEARS data for the MH participants. This eliminated any bias in the selection of clients that might have resulted in the first year’s methodology where we sampled clients using the provider’s data systems. We believe the final sample of discharged clients for which we present outcomes data are highly representative of the supportive services populations whose services ended between October 2003 and February 2004.

Additionally the “current” clients were randomly selected in advance from a list of open cases with directions to agency staff to have those specific clients complete the forms. This was more objective than the methodology used previously in which service providers gave forms to clients who happened to come to the center during the sample period, leading potentially to a positive bias in the results.

Linked DPSS and DMH administrative data. The Department of Mental Health developed a method for matching data on specific clients across the data systems without infringing on client confidentiality. This was a major accomplishment that allowed for the inclusion in the analysis of significant information from the GAIN system. This allowed us to merge data for the specific clients in the discharged sample from all three data sources – GEARS work-related information, mental health information system data, and staff surveys.¹⁰

1998-2001 Data on the Entire MH/DV/SA Supportive Services Population. As noted above, CIMH subcontracted with the Economic Roundtable to generate detailed tables on

⁸ In Los Angeles the Didi Hirsch CalWORKs mental health program was highly proactive and attempted such a phone- and mail-based system in 2003. The response rate was far below what is necessary to have any confidence the information was representative of all clients.

⁹ A second approach to obtaining client views, new in 2004, is to attempt to “intercept” at the welfare office persons who have either been referred to a supportive service and didn’t go, or those who actually went to services but no longer do so. Once intercepted, the participants are asked to fill out a survey about their experiences. The Department of Public Social Services conducted a pilot project in 2004 to determine whether collecting this information on an ongoing basis will be feasible and useful.

¹⁰ The process of data matching was also helpful in revealing a number of ways in which the MIS data from the agencies fails to accurately correspond to the picture in reality.¹⁰ When discrepancies between case files and information system data were found, the reasons were documented by agency staff. To some extent, these differences reflect temporal discontinuities—the situation changed between the time the samples were drawn and the time staff or clients sat down to fill out the surveys. In other cases they reflect lags in data entry (for example, some cases on the current client list had actually been discharged but the case closure paperwork had not been completed). In addition, some errors and inconsistencies were found, as is typical of large information systems that are not used primarily for billing. DMH is in the process of implementing a new MIS for all mental health services that should reduce these discrepancies.

MH, SA, and DV service participants using the 1998-2001 data on which their *Prisoners of Hope* report is based. Even though it is from an earlier period of time, the fact that all supportive service cases are included and that independent information on earnings is available makes this information very useful. We refer to information from this source as “population data from 1998-2001” in order to indicate the different time period and that all mental health CalWORKs cases are included—not just a sample.

PART 1: CHARACTERISTICS OF CURRENT AND DISCHARGED CalWORKs MENTAL HEALTH CLIENTS

Diagnosis, level of functioning, race/ethnicity and service modality constitute important contextual information for understanding outcomes in discharged clients.

Diagnosis. About three-quarters of the 295 discharged clients were diagnosed with depressive or anxiety disorders. Major depression or chronic depression (dysthymic disorder) make up about 60% of the diagnoses. Anxiety disorders including post-traumatic stress disorder make up another 15%. Adjustment disorders comprise 8%. And 4% have relationship or occupational problems that do not meet a diagnostic threshold. A total of 8% were diagnosed with a psychotic disorder, most commonly bipolar disorder. (See Table 1.)

Table 1: Admit Diagnosis for Each CalWORKs Mental Health Episode for Discharged Sample

Diagnosis	N	Percentage
Adjustment Disorder	23	8%
Anxiety Disorder (not Post-Traumatic Stress Disorder)	25	8%
Post-traumatic Stress Disorder	24	8%
Dysthymic Disorder (depression for two or more years)	25	9%
Major Depressive/Other Depressive Disorder	139	47%
Bipolar Disorder	15	5%
Schizophrenia/Other Psychotic Disorder	10	3%
Other Disorder	23	8%
Relational/Occupational Problem—No Diagnosis	11	4%
TOTAL	295	100%¹¹

Level of functioning at admission. The Global Level of Functioning (GAF) scale is used by clinicians to rate clients from 0 to 100 on several dimensions of functioning—from symptoms, to relationships, to employment. Of the CalWORKs clients in the discharged sample, 77% are between 40 and 60 at admission. (See Table 2.) Here are the standards for assigning these ratings:

¹¹ Here and throughout table totals are based on summing the percentages with more decimal places than shown here; percentages shown may not sum to 100 due to rounding.

51-60 Moderate symptoms (e.g., flat affect and circumstantial speech, occasional panic attacks) OR moderate difficulty in social, occupational, or school functioning (e.g., few friends, conflicts with peers or co-workers).

41-50 Serious symptoms (e.g. suicidal ideation, severe obsessional rituals, frequent shoplifting) OR any serious impairment in social, occupational or school functioning (e.g., no friends, unable to keep a job).

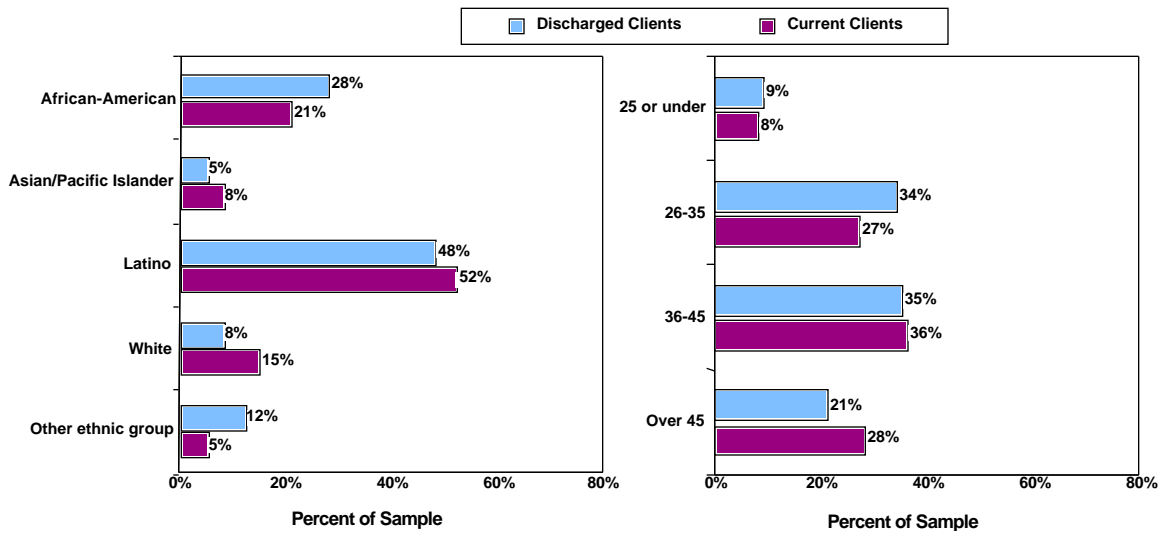
Persons under a rating of 40 have impairments in multiple functional areas, psychotic symptoms, or presence of danger to self or others. Ratings over 60 indicate mild symptoms and some impairment in daily activities.

Table 2: Functioning Level of CalWORKs Mental Health Clients in Discharged Sample

GAF Group	N	Percentage
Under 40	35	12%
40-49	95	31%
50-59	128	44%
60 and Over	39	13%
TOTAL EPISODES	297	100%

Race/ethnicity. Figure 1 shows that for the most part the race/ethnicity and age are similar for the discharged and current clients. Roughly half of each group is Latino, around a quarter is African American, with much smaller percentages of Asian/Pacific-Islander and Caucasian. Few clients are under 25, with the great preponderance aged 26-45; nonetheless at least a fifth are over age 45.

Figure 1: Race/ethnicity and age for Discharged and Current Clients



Type of service. Table 3 shows the types of services discharged clients had received in the period July 1, 2002, through March 31, 2004.¹²

Table 3: Types of Services Received by the Discharged Sample

Type of Service	N=293 Percentage
Crisis	14%
Targeted Case Management	94%
Individual	98%
Group	37%
Collateral	24%
Medications assessment	59%
Other types of service	2%

A total of 84% of the clients in the discharge sample had received CalWORKs assistance for more than three years.

Table 4 indicates the length of time that the clients in the discharge sample had been receiving CalWORKs. The data suggests that the sample is primarily made up of persons who have been reliant on public assistance for relatively long periods of time.

Table 4: Time Receiving CalWORKs (Discharge Sample Matched with DPSS Data System)

Time Receiving CalWORKs	Percentage (N=248)
Less than 6 months	5%
6 – 12 months	13%
1 – 3 years	35%
3 – 10 years	35%
10 – 20 years	11%
Over 20 years	1%

Summary of service patterns and client characteristics. Only 8% of the clients discharged are white. Fewer than 10% are under 25 years of age; but a fifth are over 45. For the most part, clients in the discharged sample show characteristics indicative of fairly serious problems that can and do interfere with their daily lives. In addition, about 10% have diagnoses associated with severe and persistent mental illness such as bipolar disorder and

¹² A very few clients had inpatient or day treatment episodes, as well. They are not billed to CalWORKs and not shown here. Service patterns for our sample varies somewhat from the entire CalWORKs caseload (open and closed cases seen during FY 03-04). For example, 54% of our sample had at least one medications visit vs. 43% in the population as a whole, and 33% of our sample had at least one group episode vs. 25% overall. The overall figures are not of discharged cases only and extend back only to July 1, 2004, whereas our sample includes services starting in FY 02-03.

11% have admit GAF scores below 40. The most frequent types of services received were case management and/or individual treatment; but 14% needed crisis services.

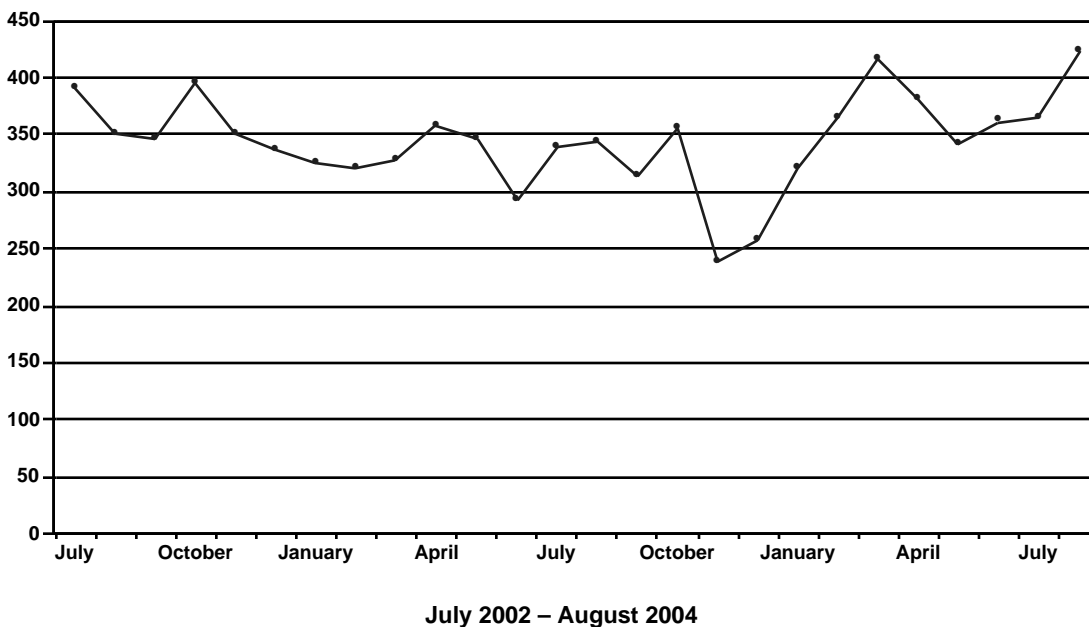
PART 2: ACCESS

Referrals early in 2003-2004 dropped off but reached a high in August 2004.

Figure 2 shows the mental health referrals from the DPSS system over the period from July 2002 through August 2004.¹³ It should be noted that the number of CalWORKs participants, particularly those with welfare-to-work plans, have been declining for several years, resulting in a smaller pool from which to draw referrals.

The very large drop in November 2003 coincides with the public transit workers strike in Los Angeles which made it difficult for persons to get to the CalWORKs offices for appointments.

Figure 2: DPSS Data on the Number of Mental Health Referrals, by Month



Almost three-quarters of those referred show up for an assessment.

When clients are identified at welfare offices as needing mental health or substance abuse supportive services, they are referred to one of a network of Community Assessment and Services Centers (CASCs), whose function is to assess clients for service need. In the six months from July to December of 2003, the average number of mental health referrals each month was 351, while the number of assessments averaged 256. Thus, 73% of referrals are actually getting an assessment. (This figure is quite constant each month.) Of those assessed, only 6% do not need treatment (again, very stable from month to month). A very small number of clients who are referred for treatment refuse the referral (less than

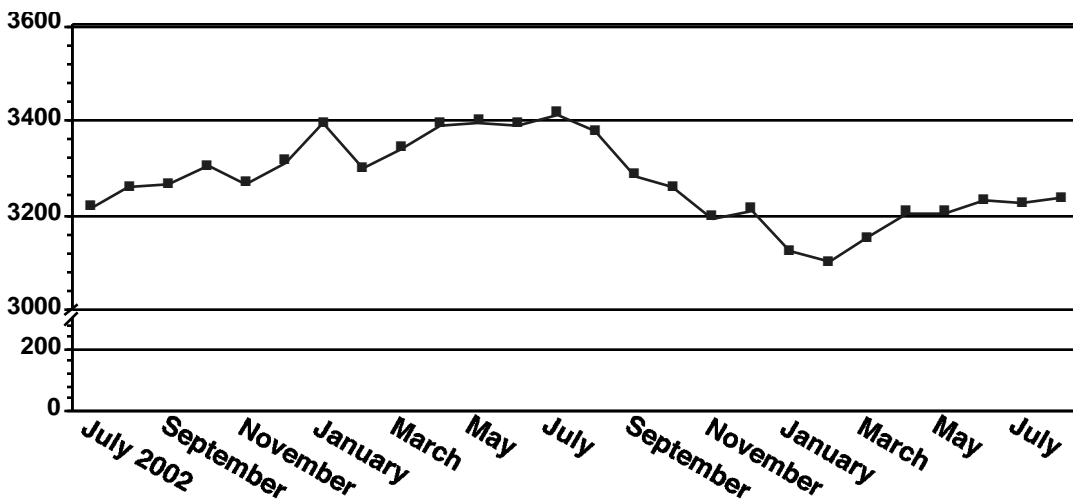
¹³ GEARS data.

a tenth of one percent). However, we do not know the percentage of those referred to treatment by CASCs who actually go on to receive services.¹⁴

For unexplained reasons, the number of clients with a MH service in their welfare-to-work plan decreased for most of the year but then increased in the spring of 2004.

Figure 3 shows the number of CalWORKs mental health clients with a MH service in their welfare-to-work plan since July 2002, based on data from the DPSS information system called GEARS. A long upward trend starting with the program’s inception in 1999 (not shown) ended as the number of cases peaked in July 2003 and declined during August through February of 2004. The numbers began rising again in March and April of 2004. Note that the graph *focuses on the monthly variation over 26 months* (within 200 cases per month higher or lower); the Y axis is omitted between 200 and 3,000.

Figure 3: CalWORKs Mental Health Clients Served Each Month July 2002 to August 2004



July 2002 – April 2004

The percentage of welfare-to-work (WTW) enrollees with MH services in their plan leveled off in FY03-04 at 5%, after climbing steadily since the beginning of the program

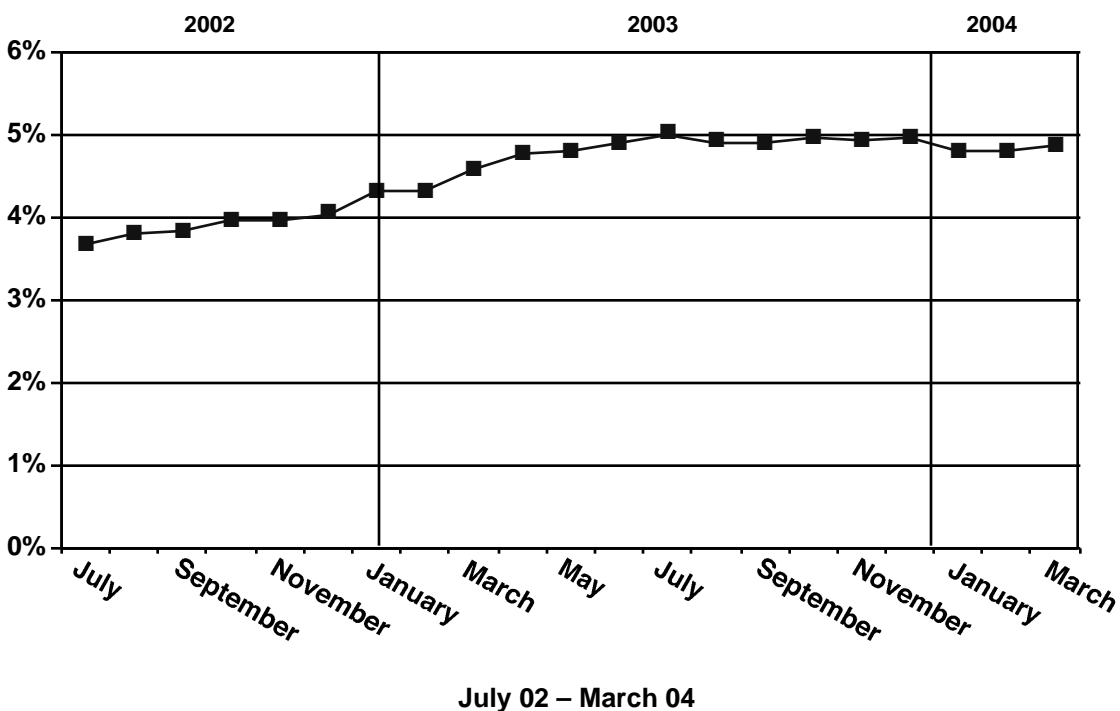
The downward trend (but not the rise in spring 2004) is partially explainable by an overall reduction in the number of persons eligible for GAIN welfare-to-work services. Between July 2002 and March 2004, the monthly enrollees decreased from 87,489 to 64,711.

An issue of concern for policy makers has been how long the percentage of CalWORKs clients who are identified as having a mental health need and served will continue to

¹⁴ The Department of Mental Health is working on a better method of tracking referrals to CASCs.

increase. Because of its size, Los Angeles is a good bellwether for the point at which further increases in serving the population will not be found. As shown in Figure 4, the long-term rise in percentage served was still increasing in July 2002, but in 2003 and 2004 this increase appears to have reached its likely maximum at 5% of all GAIN enrollees. The “leveling off” reflects a decrease in *both* number of GAIN enrollees and the number receiving mental health services funded by CalWORKs. It should be emphasized, however, that the graph and the percentage refer only to clients whose services are billed to CalWORKs. Roughly an equal number of CalWORKs recipients choose to obtain mental health services that are not part of their welfare-to-work plan and are billed through Medi-Cal rather than CalWORKs. These services are in general, however, not delivered by the same specialized providers who bill CalWORKs.

Figure 4: CalWORKs MH Clients As a Percentage of All GAIN Enrollees



A goal of the mental health system’s supportive services has been to reach clients in need who might otherwise not be served.

The overall public mental health system has increasingly had to focus on the population of clients with the most serious mental illness due to limited resources. One benefit of the CalWORKs MH supportive services has been to open up services to a population of clients who, while having disabling symptoms and problems, might not otherwise qualify for public specialty mental health services.

Another barrier to the receipt of mental health services is that some people do not realize that they have a mental health problem that might be helped by receiving services. An inability to meet CalWORKs work-related activity requirements may cause some

participants to see the need for services for the first time and/or the referral process may provide easier access to services than was available previously.

About 60% of clients were receiving a mental health service for the first time ever, while 27% had multiple episodes during the study period.

Staff members reported that for 64% of their discharged clients this had been the client's first treatment episode. A total of 58% of the current clients said this was their first time receiving a mental health service. The data also suggest that those who used mental health services for the first time were less severely impaired than those who were repeat users.¹⁵

Statewide data has shown an underutilization of specialty mental health services by ethnic minorities, particularly Latinos. The Los Angeles Department of Mental Health's CalWORKs program has made notable progress in their efforts to reach out to ethnic minorities. This is evidenced by the fact that Asian/Pacific Islanders and Latinos are significantly more likely to be receiving mental health services for the first time (67%). Also, for the current client sample, outreach to the *Spanish-speaking* Latino population appears to have been particularly effective: 34% of the first-time users were Spanish speaking, compared to 18% of those who had used mental health services before.

Both because many mental health problems are episodic in nature and because of the impermanence of housing for many CalWORKs participants, we would expect that some clients would receive services more than one time. We obtained data on all treatment episodes¹⁶ for the discharged clients occurring in FY02-03 or July 03-March 04). Of the 299 clients, 73% had only one CalWORKs-funded episode, 22% had two, and 4% had three or four episodes.

PART 3: ENGAGEMENT

Keeping clients engaged in services is a critical but challenging goal of mental health supportive services.

One of the most important findings from the first year Outcome study was that those participants who completed treatment had better clinical and work outcomes. The second Outcome study devoted more attention to both the objective and subjective reasons why the system might have difficulty in retaining clients in treatment services. Unless the treatment system understands why it is not being successful and is able to organize its services to address these reasons, client engagement will remain relatively low. We have looked more closely at some of the objective challenges that must be overcome to assist clients in attending services as well as some of the reasons why clients themselves say they end services.

¹⁵ Co-occurring domestic violence and substance abuse problems were reported less frequently by 1st time users, and 44% of the 1st time users said that they did not need help with work-related problems, compared to 28% of the repeat users.

¹⁶ An episode comprises a distinct opening and closing of a case.

The service system must be particularly responsive to factors in the lives of MH service recipients that make their regular attendance in treatment difficult if not properly understood and addressed.

The following characteristics of the population receiving mental health services highlights the challenges that the service system must address if it is to provide services that are truly responsive to its clients.

Language diversity. The discharged MH cases sampled by DPSS listed the following as primary languages: Armenian, Cambodian, Cantonese, Chinese, English, Farsi, Gujarati, Korean, Lao, Mandarin, Spanish, and Vietnamese. A list of the primary language among all open mental health CalWORKs clients in January includes in addition Afghan, Hmong, Japanese, Tagalog, and Tonganese. Of currently open mental health CalWORKs clients, 61% have English, 23% have Spanish, and 16% have other languages recorded as primary. This creates a considerable challenge for the mental health system since therapy depends on subtlety and clarity of communication.

Large families. A total of 21% of the current MH cases sampled had four or more children. If the children are not in school, finding child care while attending services, or arranging transportation is a major undertaking for single mothers with several children. If children are in school it limits available appointment times. For those clients who work or go to school themselves, large families make logistics doubly difficult.¹⁷

Co-occurring disorders. In recent years, service agencies are recognizing that substance abuse, mental health issues and domestic violence often occur together. Co-occurring disorders require different professional skills, philosophies and resources.¹⁸ Only a few CalWORKs programs around the state have established integrated services that can serve any combination of these problems.¹⁹ In our discharged mental health client sample, for example, 15% were diagnosed as also having a substance use disorder and 16% had domestic violence issues as a focus of treatment.

Homelessness. Being homeless makes carrying out appointments, indeed any planned activity, extremely difficult.²⁰ Current mental health clients were asked in our survey if they had been homeless within the past year: 13% had.

Consequences of having MH problem. Attending and participating in services require many of the same activities that are required by work or training—such as time management, arranging child care, and using public transportation. So, the very problems that necessitate treatment or services may make it difficult to engage clients. Current

¹⁷ While CalWORKs pays for job-related transportation, it does not pay for transportation to take children to school.

¹⁸ A summary of what is known is the federal *Report To Congress On The Prevention And Treatment Of Co-Occurring Substance Abuse Disorders And Mental Disorders*. (2002). From <http://www.samhsa.gov/reports/congress2002/index.html>

¹⁹ In Los Angeles, the ProtoTypes and the Shields for Families residential programs are among these.

²⁰ DPSS will remove sanctions from anyone who is homeless in recognition that carrying out welfare-to-work activities is virtually impossible without a stable home.

clients were asked the number of days out of the prior 30 days in which they were “totally unable” to work or do daily activities as a result of the problems for which they sought treatment. A total of 37% of the mental health clients indicated being totally unable to carry out daily activities at least 15 days of the prior 30, with another 35% indicating this level of disability from one to 15 days a month.

Program challenge or client hurdle? There are a few programs in the state that are capable of responding to all of these obstacles—through provision of child care and transportation, use of integrated services with bilingual and bicultural staffing, and use of outreach case management²¹. However, this is often not the case in Los Angeles. Engagement failure is, in part, a consequence of programs that are not designed or funded to meet these challenges.

While services were easily accessible for the overwhelming majority of current clients, location or time may be problematic for up to 25%.

A total of 82% of the current mental health clients said that services were available at times that were good, and 82% said that the location was convenient. Taken together, however, 25% of the current mental health clients said that either the times or the location of services was inconvenient for them. Services must be offered at both convenient times and locations in order to continue to more successfully engage clients.

Satisfaction With and Participation in Services

Three-fourths of the current mental health clients are very satisfied with the services they are receiving.

A total of 96% of current clients expressed some degree of satisfaction with their services. Perhaps more telling is that 299 respondents reported they were treated with respect; only one did not (7 did not respond). In addition, 93% said they trust the main person with whom they work, and 96% of current clients said they would recommend the program to a friend. These rates are even higher than last year. Such high rates this year are especially impressive, given that considerable care was taken this year to obtain representative samples of current clients.

In general, Latino clients appeared to be the most satisfied. However, the fact that 22% of the African American clients said either that they would not or were not sure they would recommend the program to a friend requires attention.

²¹ See the CalWORKs Project description of “best practices” in: Meisel, J., D. Chandler, et al. (2002). The Second CalWORKs Project Six-County Case Study Project Report. Sacramento, California Institute for Mental Health, 2030 J. Street, Sacramento, CA 95814.

Mental health providers said that 45% of their discharged clients attended most or virtually all of their scheduled service visits.

Table 5 shows providers' ratings of the level of participation in treatment of their discharged clients. The data confirms the difficulties in sustaining regular attendance for about half of the clients.

Table 5: Provider Ratings of Client Level of Participation in Treatment

Rating	Description	MH N=362
VERY GOOD	Participation in virtually all sessions	12%
GOOD	Participation in most sessions	33%
POOR	Participation sporadic	35%
MINIMAL	Participation rare	20%
TOTAL		100%

About two-thirds of the mental health clients remain in treatment for at least six months.

While participation rates may not be consistent, 63% of the mental health clients remain in treatment for at least six months. (See Table 6.) The mean cost for serving each category of clients is shown in the second column.

Table 6: Discharged Client Time in Treatment (N=277)²²

Time in Services	Percent	Average Cost
Under Two Months	4%	\$1,364
Between Two and Six Months	33%	\$2,364
Six to Nine Months	19%	\$3,106
Between Nine and 12 Months	13%	\$4,153
12 Months or More	31%	\$5,466
TOTAL	100%	\$3,681

Reasons For Terminating Services

We are refining our data collection procedures to better understand the reasons why mental health services are ended prematurely.

The first report utilized the treatment provider’s rating of the reasons why mental health services ended. In 2004 we repeated this asking even more detailed reasons from the mental health service providers. We also collected the end codes entered by the GAIN caseworker in the DPSS welfare-to-work data system (GEARS) that describes their understanding of the reason why the mental health service component ended.

Each of these data sources has its own advantages and disadvantages. While the mental health service provider may know the client better, they will not know the full story of why someone stops coming for treatment since they have basically lost contact with the person. The GAIN worker has the advantage of seeing the client after the end of mental health services, but may not know the real reasons why services ended.

We have generally used the information from the GAIN worker “end codes” in the information that follows, but note, as appropriate, where we have used the treatment provider ratings or where the findings from the treatment providers support the general conclusions.

Data based on GAIN staff reporting shows 20% of the clients completing their mental health episode.²³

Determinations by the GAIN staff recorded for the discharge sample categorized 20% of the discharge sample as having completed their MH supportive service component;

²² Duration of services and costs both have some missing values.

²³ For this year’s discharge sample, mental health clinicians rated successful completion for 14% of the discharged sample, compared to last year’s 12%

another 27% did not complete the service but were working at the time of termination.²⁴ A few clients (3%) terminated MH services due to moving or leaving CalWORKs. Almost half (49%) dropped out (including those who were sanctioned) without employment being noted.²⁵

The percentage of completed mental health supportive services components is similar in the population data from 1998-2001. When open cases are excluded,²⁶ 19% of the 5,247 referrals to mental health services during this time were completed, 37% of referrals ended in a drop out and 17% of referrals ended as no-shows. A variety of other reasons accounted for the remaining 27%. If we disregard no-shows (to make this information more comparable to our survey sample), the percentage of those completing was 24%.

Population data from 1998-2001 show that a higher percentage of mental health clients complete supportive services in the long-run than complete any given service episode.

The 1998-2001 population data show that a higher percentage of *persons* complete the mental health supportive service they were referred for (22%) than complete specific episodes (19%). In other words, some participants entered and left services more than once during the study period and were successful on at least one attempt. The outcomes recorded for the surveys *understate* the extent to which successful outcomes are achieved over time. This is because they focus only on one service episode while a significant number of participants require more than one episode to complete a supportive services component.

Sanctions after referral to a supportive service were low in the population 1998-2001 data.

Overall 2.8% of those referred to a mental health supportive service had a record showing a sanction occurring after the referral. However, sanctions over the entire four-year period, which may have occurred prior to the mental health referral, were much more frequent. Of persons with a MH referral, 22% had at least one financial sanction recorded. These sanctions may later have been “cured;” they just indicate problems with compliance with CalWORKs requirements.

Those who dropped out had somewhat higher rates of sanctions than did those completing. We hypothesize that whatever factors contribute to lack of compliance resulting in sanctioning may also interfere with follow-through of supportive services.

²⁴ GAIN staff explained that “The component end code ‘Component Not Completed-Participant Entered Employment’ is used when participant stopped participating in the activity due to employment...”

²⁵ Note that clients recorded as “no shows” were not included in the DPSS data matched to the discharge sample. This eliminated 31 persons who, according to the mental health system, *had* received services.

²⁶ A total of 30% of all MH/SA/DV service episodes had no “end code” entered to indicate what happened after a referral was made. We were able to check this in the aggregate with mental health administrative data. The number of mental health with no end code almost exactly matched the open cases at the time the study ended; we conclude that virtually all of these referrals were still open at the time the data collection was completed.

Factors Associated With Completing Services

Multivariate analysis points to both service and client characteristics as important determinants of completing treatment.²⁷

Multivariate analysis is a statistical method of determining which of many possible factors combine to predict an outcome. In this case, the outcome is completing the mental health CalWORKs service component.²⁸ The only personal variable associated with completing services is also having a domestic violence problem—mental health clients with DV problems are 2.3 times as likely to complete the component (all other factors held constant) as those without such a problem. Clients who do not have a partner are 2.9 times as likely to complete treatment as those who do. Another, surprising, factor associated with completion of treatment is having been a CalWORKs recipient over three years. Long-term recipients, so defined, are three times as likely to complete the component as those with shorter stays on CalWORKs. Persons with a positive change in global assessment of functioning rating of 10 or more are also highly likely to complete services. Finally, compared to those receiving services less than six months, those who were in treatment between six months and a year were 2.5 times as likely to complete while those receiving treatment a year or more were 7.9 times as likely to complete the component.

The population data from 1998-2001 indicate limited English does not preclude successful engagement. Overall, 27% of clients referred to mental health supportive services in the population data had a DPSS “flag” to denote a CalWORKs participant with limited English ability. Contrary to expectations, the clients in MH services were somewhat more likely to complete services if their English was limited. (The length of time in treatment is also higher for Spanish and Cambodian languages in current mental health clients.) This suggests that specialized programs for cultural and linguistic subpopulations are doing a good job at engagement.

PART 4: MENTAL HEALTH TREATMENT OUTCOMES

Treatment outcomes (that is changes in symptoms and functioning) were assessed from the perspective of both the clients and the service providers. The client ratings are from the sample of clients currently receiving services while the provider ratings are for the set of clients who have been discharged.

Virtually all clients reported receiving help to improve their situation or deal with their problems; at least 70% of current clients rated the mental health services as helping “a lot or some” in five other areas of functioning.

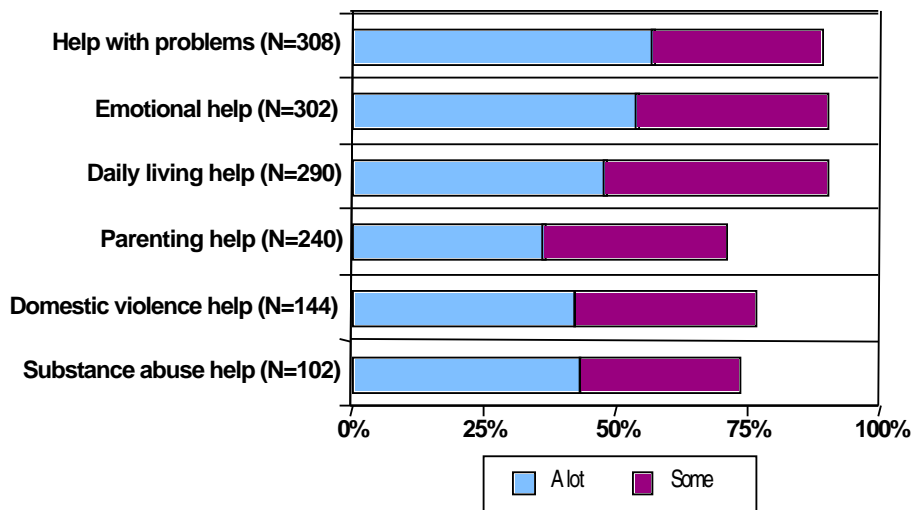
²⁷ Here we present the GAIN staff definition of completing treatment rather than the clinical definition. However, we ran the analyses for both groups (which overlap but are not the same) with similar results except that substance abuse negatively affected results in the clinician ratings and being over 40 and having four or more children positively affected the outcome.

²⁸ These likelihoods are the odds ratios from a multiple logistic regression model.

As shown in Figure 5, help improving their situation or solving their problems was reported by almost all of the clients (57% said “a lot,” 32% “some” and 9% “a little”). Asian/Americans were most likely to rate highly the help they received; African-Americans were least likely to do so. And the extent of reported help received increased linearly with the length of time in services. The amount of reported help also was related to age, with 43% of the 18- to 25-year-olds saying they were helped a lot, compared to 65% of those over 45 years of age.

The graph below shows the amount of help that current clients said they had received from their MH services in dealing with their emotional problems, in dealing with their daily lives, and in their parenting. Help for domestic violence and substance abuse issues was rated almost as high, though more clients said for each that it was “not a problem” (46% said DV was an issue, and 33% said substance abuse was). Only help for emotional problems was associated with a longer duration of treatment. Latinos were more likely than other ethnic groups to give higher ratings for help with emotional problems, parenting, and daily living.

Figure 5: Percent of MH Clients Reporting "A lot" or "Some" Help



Approximately two-thirds of the discharged clients were rated by staff as having made positive change in dealing with their emotions, their children and problems of daily living.

Staff ratings of change were virtually the same for each of the three domains of functioning: approximately 14% were rated as having made strong positive change, and 50% as having made some positive change. These ratings indicate that significant progress can be made even when all treatment goals are not achieved prior to discharge. However, clients who completed services were rated as having strong positive change in 44% of the cases (94% had some positive change) while those known to have dropped out or had

been non-compliant had strong positive outcomes in only 4% of the cases (48% has some positive change). Of those whose status at discharge was uncertain, 17% had strong positive change, and 65% had some positive change.

Staff members also were asked to rate the global functioning of clients at discharge using the 100 point GAF scale described earlier on which ratings of under 50 indicate severe impairment. These ratings were compared to the GAF rating given to the client at admission (or the earliest admission if there were more than one). For 39% of the clients the GAF scores increased by at least five points from admission to discharge. For an additional 15% the GAF score increased from 1 to 5 points and for 36% there was no change. The discharge GAF was lower for 9% of the clients. Those clients who completed treatment showed a greater positive change in GAF scores—57% showed an improvement of at least five points, compared to only 37% of these who terminated before completing goals.

PART 5: EMPLOYMENT-RELATED OUTCOMES

Staff and Client Views of How Services Affect Employability

Mental health services had positive effects on current clients' judgment of their capacity to work.

Current clients were asked, “How much have the services you have gotten here helped you with work problems?” A total of 29% said they received “a lot” of help, and another 43% indicated they received “some” help. These figures are comparable to the ratings of the sample of current clients on the previous report.

A higher percentage of first-time users of mental health services reported receiving “a lot” of help with work problems (44%) than repeat mental health service users (28%). No relationship existed between the amount of help with work problems and length of time in services, or ethnicity, or age.

According to provider ratings, at least half of the discharged clients had positive change in their capacity to look for, find, and retain work.

Mental health staff rated 15% of their clients as having made strong positive change in their capacity to look for, find or retain work. They rated another 37% as having made some positive change.²⁹

The amount of positive change was strongly associated with the time receiving services. Strong positive change took place rarely (7%) in less than six months, and was more likely than average when services lasted at least a year (26%). However, there is a much stronger association with whether or not services were completed. If they were completed, then 47% of mental health clients were rated as making strong improvement.

²⁹ A total of 4% of the staff didn't think capacity to work was relevant, and another 10% said they felt they didn't have enough information to judge. The percentages in the text exclude these.

Employment and Work Activity While Receiving Mental Health Services

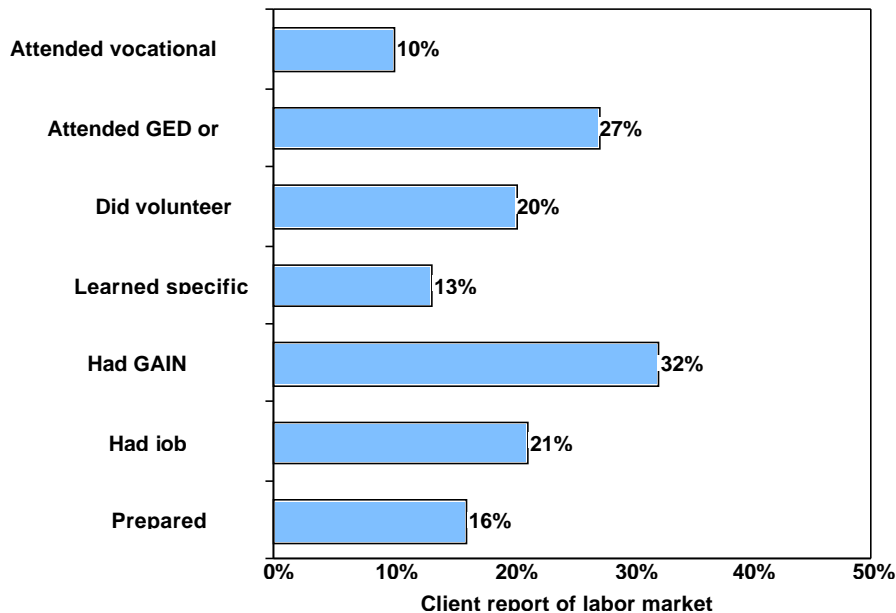
A total of 20% of current CalWORKs mental health clients report they are working while they attend services; at least two-thirds are engaged concurrently in some employment-related activity.

Because clients are already beginning to “time off” of welfare, the sooner that the participant receiving supportive services can *also* participate in welfare-to-work activities the better. We look first at actual employment. A total of 20% of current mental health clients said they had worked in the last three months

While actually holding a job is the most important measure, other work-related activities in the prior three months included: going to a job interview, writing a resume, getting training in specific skills, such as operating a computer, having a GAIN employability assessment, doing volunteer work, attending a vocational training program, or attending a GED program or going to school.

Overall, 64% of mental health clients either worked or participated in one or more of the other employment-related activities in the three months prior to the survey. Figure 6 shows the percentages in each category (one person might appear in several categories).

Figure 6: Current MH Client Participation in Employment-Related Activities (N=293)



Employment and Work Activities at End of Mental Health Services

Multivariate analysis emphasizes the importance of completing treatment but leaves much unexplained.

We attempted to predict³⁰ which clients would be employed at the end of their service episode using multivariate analysis to take account of the overlapping effects of several different variables. Staff view that treatment had been completed was very important, as was the global functioning scale at admission and the amount of change in global functioning from beginning to end of the treatment. However, a number of factors we might have expected to be important were not, including the number of months in treatment, the cost of the service episode, whether the client had an AOD problem, and whether or not the client had four or more children. Only 9% of the variability around employment was explained by these factors combined—which means that most of what affects whether or not people get employed is *not* predicted by either the length or cost of service or personal characteristics of clients that we were able to measure.

About one-fifth of the discharged sample worked in the month in which mental health services ended, and half of the discharged sample either worked or participated in education or training during that same period.

According to DPSS data, 21% of the discharge sample worked in the month in which their mental health supportive services ended. In addition to those working, 23% received post-employment or enhanced³¹ post-employment services, 14% received training or education, 14% received vocational services, 11% received remedial education, and 6% were involved in volunteer work. A total of 43% had at least one of these work-related activities, and 21% had multiple activities. A total of 50% were either working or engaged in a work activity in the month in which their MH supportive services terminated.

Earnings³² were low for those who worked in the month in which mental health services ended.

Table 7 shows the earnings of those who reported earnings in the month in which their mental health services ended. The monthly earnings of most working participants would not be sufficient to support a family. Only 40% of those working made \$900 a month or more, and only 9% of those working earned \$1,500 or more.³³

³⁰ In this case “predict” is used to mean that *had we known in advance* the information used in the statistical model, we could have predicted to some extent who would end up employed. Thus, prediction is hypothetical for this particular population, but presumably the factors found important here could be used to predict employment in other samples of MH clients.

³¹ A special program providing more post-employment services.

³² Information on earnings is collected by those in CalWORKs, or Food Stamps or Medi-Cal programs. We computed the percentage who worked in any month as equal to the percentage reporting any earnings.

³³ Earnings of \$1,500 a month equate to \$18,000 a year. Poverty-level income for 2004 for a family of three is \$15,670 and for four is \$18,850. (<http://aspe.hhs.gov/poverty/04fedreg.htm>) Clients in this sample had an average of 2.84 dependents.

Table 7: Monthly earnings for those employed during the month in which the mental health service terminated

Monthly Earnings	Number	Percent
\$1 – 300	14	25%
\$301-600	7	13%
\$601-900	11	20%
\$901-\$1,500	18	33%
>\$1,500	5	9%

A higher percentage of the discharged individuals who completed mental health services were employed or engaged in volunteer, education, or training activities after their mental health services ended than were those who did not complete services.

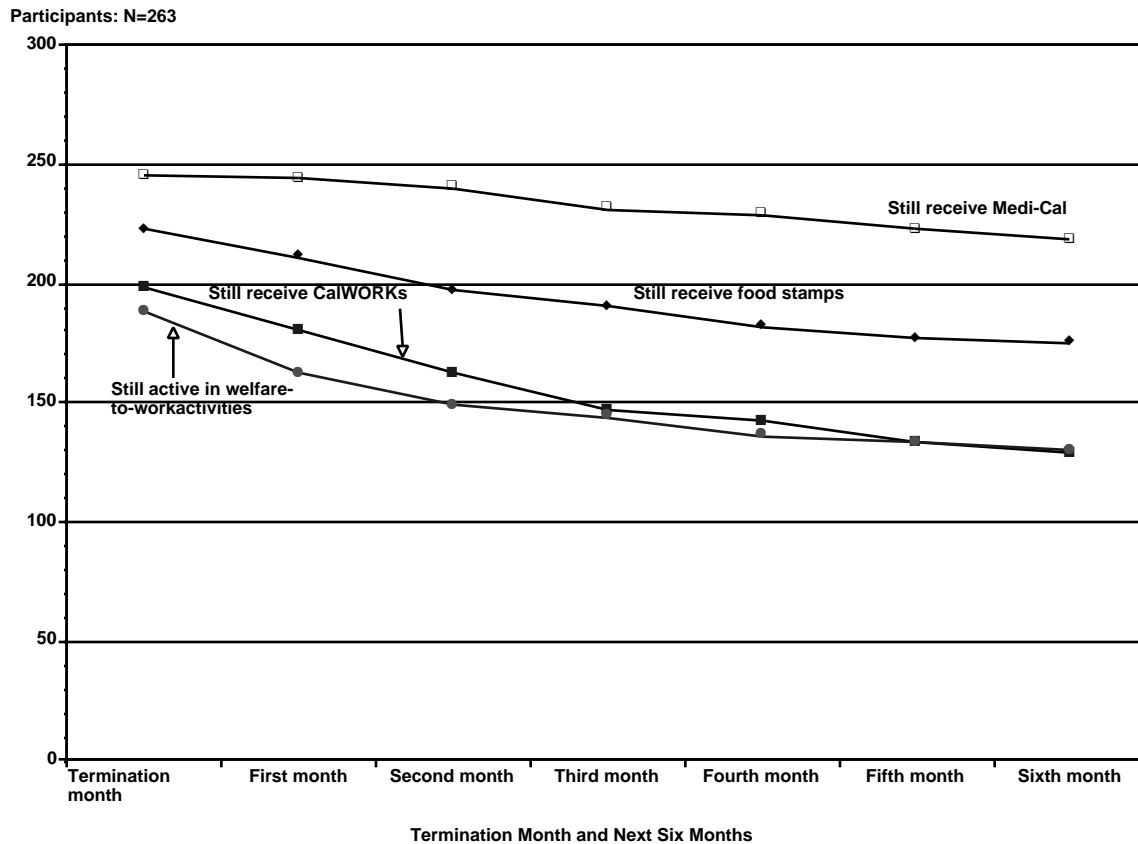
In the month of termination of the MH supportive service, 30% of those who completed the component were employed vs. 19% of all others. Likewise, in the month of termination of the MH supportive service, 68% of those who completed the component were involved in a work activity (other than employment itself) versus 36% of all others.

CalWORKs Eligibility, Employment, and Work Activities Following End of Mental Health Services

CalWORKs receipt for the discharged sample declined almost 50% in the six months following the MH service termination month; Medi-Cal participation remained much higher.

As shown in Figure 7 during the month in which MH supportive services ended, CalWORKs receipt dropped from 263 to 198. Participation in welfare-to-work activities was somewhat lower (primarily due to exemptions), while participation in Medi-Cal remained very high. Use of food stamps was intermediate.

Figure 7: Receipt of CalWORKs, Medi-Cal and Food Stamp programs during the month in which mental health services ended and in the six following months



Over the succeeding six months, all measures of service receipt went down so that by the seventh month, only 129 of the 263 clients in this sample remained on CalWORKs or GAIN.

The percentage of persons working and their average monthly earnings did not change appreciably over the six months following the end of the mental health episodes.

The percentage of persons working in the overall discharge sample did not change much overall nor did they change within the subgroups (i.e. “no longer CalWORKs eligible,” “CalWORKs eligible but not on GAIN,” and “CalWORKs eligible and on GAIN”). The fact that about 70% of those *who had left CalWORKs* reported no earned income is a matter of concern—both in this sample and nationally.³⁴

³⁴ Nelson, Sandi, and Sheila R. Zedlewski. 2003. “Qualitative Interviews with Families Reporting No Work or Government Cash Assistance in the National Survey of America’s Families.” Assessing the New Federalism Discussion Paper no. 03-01. Urban Institute, Washington, D.C. Available at <http://www.urban.org/urlprint.cfm?ID=8331>

Similarly, the average *earnings* per month for those who worked did not change much over the six months following the end of mental health services.

Individual client employment was, however, only moderately stable across months.

While the average number of persons working each month (about 55) remained fairly stable across the seven months (termination and the six following months), a total of 77 persons worked during the time period, so there was a fair amount of turnover within that group. Thirty-three persons (47%) had earned income in all seven months, but 12 earned in five or six months, 18 earned in three or four months, and 14 earned in only one or two months.

Effect of Mental Health Issues and Services on Employment in the Population Data From 1998-2001

We present this data separately since it confirms the above findings about the positive impact of completion of mental health service episodes on employment and earnings using the data on the entire population of CalWORKs mental health clients between 1998-2001. The information shows the general negative impact of mental health issues on employment and the remediation of these impacts by mental health services if the episodes are rated by GAIN workers as successfully completed.

Population data from 1998-2001 show that persons referred for supportive services are less likely than the general CalWORKs population to find employment.

Epidemiological studies have found significant effects of MH status on employment,³⁵ but no studies to date have analyzed long-term effects for the population actually referred to MH/SA/DV supportive services.

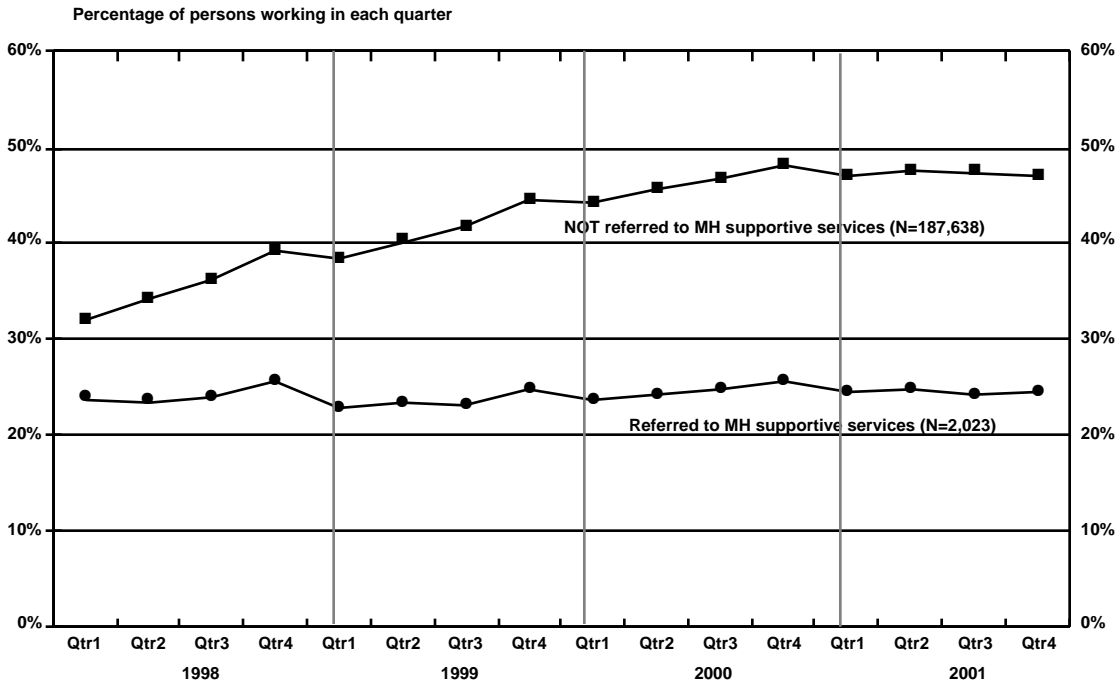
Persons who were given a mental health supportive services referral at some time between the first quarter of 1998 and the fourth quarter of 2001 were much less likely to have earned income, compared to persons in GAIN not referred for a mental health service.³⁶ In 1998, the differential is less than 10%, but by the end of 2001 those with a mental health service referral are only half as likely to have earned some income (24% vs.47%).³⁷ (See Figure 8.)

³⁵ The CalWORKs research on this issue is presented in Chandler, D., & Meisel, J. (2002). *Alcohol & Other Drug, Mental Health, and Domestic Violence Issues: Effects on Employment and Welfare Tenure After One Year*, from www.cimh.org/calworks. Other studies are cited in these documents.

³⁶ The same pattern applies to persons with SA or DV referrals.

³⁷ It would be more revealing to show the percentage working before, during, and after receiving services. With these data, this was not possible.

Figure 8: Referred to MH supported services vs. not referred: percentage with earned income in each quarter³⁸

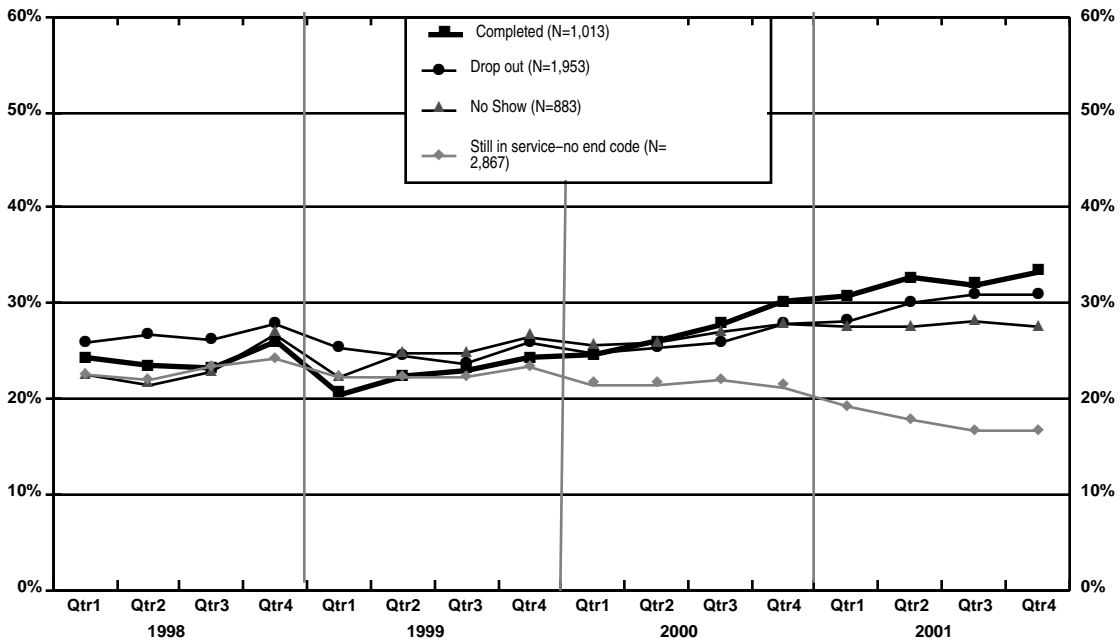


The population data from 1998-2001 show that a higher percentage of persons referred to mental health services work if they complete the service.

As shown in Figure 9, the virtually flat line in Figure 8 for those with MH service referrals, hides very important differences among subgroups. The overall increase over time for those completing a MH service is encouraging. By the end of the study period, 33% were working (vs. 47% of those with no MH health services). Those who start services and then do not complete them (which may be after months or even years of service) also show an overall increase though not quite as high as those completing services. Persons who “no show” to the referral manifest somewhat less gain than do drop outs. And as would be expected, those who are still receiving services are not doing as well, with a *decreasing* percentage working over time. Although we do not know how long these participants have been receiving their services, this does provide evidence that those in on-going treatment may be more impaired in their capacity to work.

³⁸ Note that the referral to supportive services may have come at any time in the four years. It was not possible to show earnings “before” and “after” supportive services referrals.

Figure 9: Change over time in percentage with earned income: subgroups of those referred to MH supportive services 1998-2001



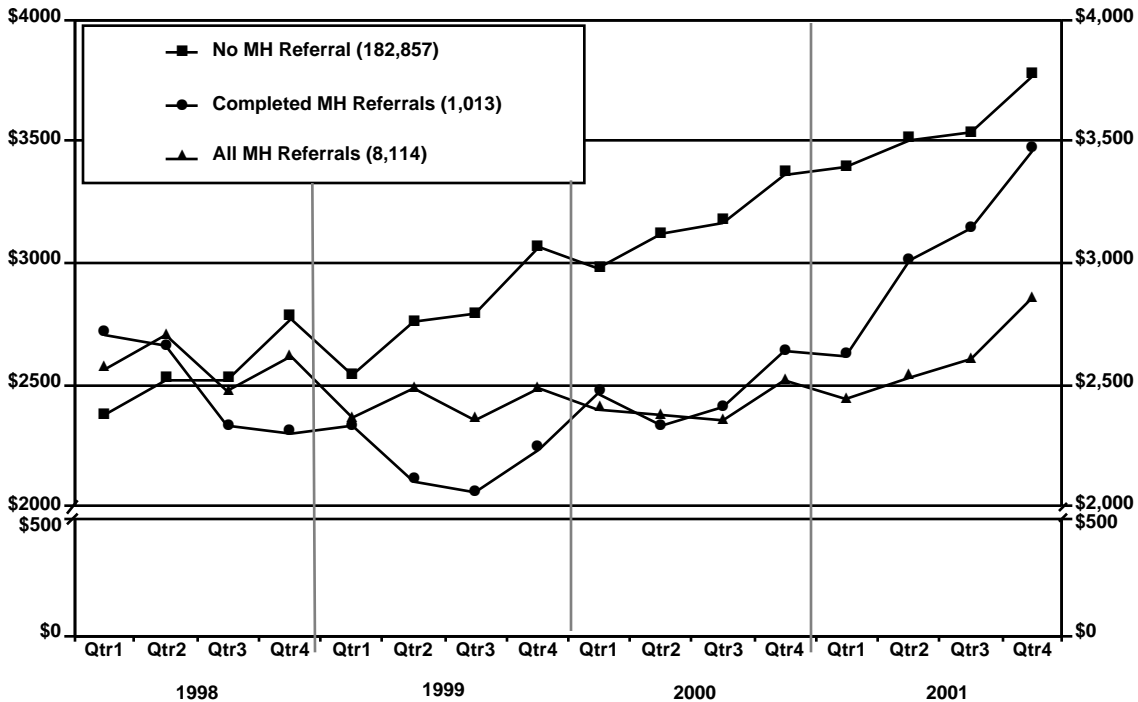
Among clients in the population data who do have earned income, earnings in 1998-2001 for those completing a mental health service are not appreciably below earnings of those with no supportive service referral.

The figures above show the percentage of different groups who worked at all during each quarter. A second question is: for those who *do* work, are earnings different depending on whether they receive a mental health supportive service?

Figure 10 shows the quarterly earned income for three different groups of CalWORKs participants (with persons who did not work omitted). The top line is the persons who were active in CalWORKs at some time during this period of time (1998-2001) who did not have a supportive services referral. Below them appears the income of those who were referred to a supportive service and completed it. By the fourth quarter of 2001 there was little difference between these groups: \$3,766 for those with no MH referral vs. \$3,460 for those completing the service. The bottom line shows the earned income for all those who were referred to supportive services.³⁹

³⁹ Although not shown, the average in the final quarter for those with no recorded end code (that is, still receiving MH services) is only \$2,858 per month, compared to the \$3,460 of those who completed. Those who dropped out or were no-shows were in between (\$2,858 and \$3,043, respectively).

Figure 10: Quarterly earned income for those with some earnings: by supportive service status (Population 1998-2001)



Although those completing mental health services do much better than others referred to but not completing services, without a controlled study, we are not able to say whether that is due to the effects of treatment or that this group differs—in ways related to their earnings—from those who don't complete services.

Length and Costs of Services

Discharged clients who completed treatment received services longer and at a higher cost than persons terminating early.

The length of MH supportive service treatment episodes as recorded in the GAIN data system indicated longer episodes for those who completed the service (14.1 months) than those who terminated early but were employed at the time (8.6 months), or those who dropped out (7.8 months). Correspondingly, average costs per episode (from the DMH administrative data for the same persons) were higher for those completing treatment (\$5,159) than those who did not complete services but who were employed (\$3,254), or those who dropped out (\$3,631). This data suggests that the effort to engage clients until they complete services may result in higher average costs per episode. The consistently better clinical and employment outcomes for those clients who complete treatment, however, may well outweigh these added costs.

SUMMARY

- The percentage of CalWORKs recipients identified and referred for mental health services appears to be leveling off at about 5%.
- CalWORKs continues to provide access to mental health services for a population that has needed help but for the most part has not gotten it in the past. We consistently see a number of first-time users of MH services who have some serious problems that interfere with their daily lives.
- Engagement and retention in treatment continue to be challenging. Having a domestic violence problem, not having a partner, or having been a CalWORKs recipient over three years are factors positively associated with completion of treatment. Additionally, those who remained in treatment a year or more were more likely to complete treatment than those receiving services for shorter periods of time. More investigation is needed in this area, if we are to increase the percentages of participants successfully completing treatment.
- Nonetheless, current clients report a very high level of satisfaction with services. Virtually all of them reported being helped with their MH symptoms and a large majority reported help with other areas of functioning, such as daily living and parenting.
- For discharged clients, staff reported about two-thirds made positive changes in functioning whether or not they completed treatment. Staff also indicated that over half of the discharged clients improved in their global functioning scores; those who completed treatment made more improvement than those who did not.
- Finally, those who completed treatment did better on employment-related outcomes than those that the service provider felt terminated prematurely.
- Data covering all CalWORKs mental health service recipients from 1998-2001 show:
 - a) Employment of persons identified and referred for MH services is much lower than among the general CalWORKs population—indicating that MH is an extremely important barrier to meeting CalWORKs goals.
 - b) The rate of employment is higher for those who have completed their MH service than for dropouts or no-shows, or those still in treatment, but lags significantly behind those not referred for MH services.
 - c) For those who do work, however, the average monthly earnings for persons who completed services are very nearly equal to those who were never referred for MH services.

In summary, although identification and engagement can be improved, CalWORKs mental health supportive services address a real need and do so in ways that have helped clients improve their functioning and achieve their employment-related CalWORKs goals.

Methodological Appendix

Sampling Methods

A major change between the first year's study and this one was in sampling methodology. For both the sample of clients whose services had already ended and the current client sample extensive efforts were made to define samples representative of the populations described above.

Clients whose services had ended

The Research, Evaluation and Quality Assurance Division of DPSS (using GEARS data management system) identified 665 participants who had ended a mental health supportive service between October 2003 and the end of February 2004. The Department of Mental Health selected a random sample of 368 from 66 providers. However, 69 of these clients continued receiving mental health services provided with other funding. These clients are included in the descriptive information about the discharge sample, but are not included in the clinical and employment outcome sections of the report.

Data from the DPSS eligibility and GAIN data systems was then matched to the 299 clients in the discharge sample who were not continuing in treatment. A match was not found for 33, and an additional three did not have a MH episode closing date resulting in a sample of 263 for the employment outcome analysis that used DPSS data.

Clients currently receiving MH/SA/DV services

In the first year's study, current clients were sampled randomly at the participating agencies on several consecutive days. Because this method could potentially bias the sample—if clients who are less satisfied with services attend less regularly—we made extensive efforts this year to select a representative sample. Because of different data systems in the MH/SA/DV agencies, the method of sampling varied to some extent.

- The Department of Mental Health generated a list from its MIS of all CalWORKs clients currently open. From this list a random sample of 400 was drawn, resulting in a final sample of valid cases of 310 drawn from 65 providers.
- Survey forms were available in English, Spanish, and Cambodian.

1998-2001 Population Data

The persons included in this analysis are 11,548 individual parents, who were active in Los Angeles GAIN 1998-2001. "Active" means having one or more referral to any kind of GAIN component, such as Job Club, Job Training, Supportive Services, etc. Information on GAIN services, particularly supportive services (MH/SA/DV) is matched with Unemployment Insurance data on number working, and earnings, in each quarter during the 1998-2001 period. This information was available for the entire time period regardless of how long the person received GAIN services. For employment and earnings analyses, the participants referred for supported services are contrasted with all participants *not* referred, a total of 178,113 persons.



California Institute
for Mental Health
2030 J Street
Sacramento, CA 95814
(916) 556-3480
www.cimh.org

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