



Progress Towards Reducing Disparities: A Report for San Diego County Mental Health Five Year Comparison FY 2001-2002 to FY2006-2007

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG)
and CASRC (JRR, BG, SC), and SDCMHS

Table of Contents

Title	Page
Table of Contents	2
Executive Summary	3
Introduction	5
Comparison of Distribution of Target Population to Mental Health Clients	14
Adult'/Older Adult System of Care Distribution Rates	15
Children's System of Care Distribution Rates	16
Key Findings	18
Comparison by Age Groups by Race/Ethnicity	22
Adult/Older Adult Penetration Rates (Access)	35
Children and Youth Penetration Rates (Access)	37
Adult/Older Adult Retention Rates (Engagement)	39
Children and Youth Retention Rates (Engagement)	41
Disparities in Types of Services Utilized (Adult)	45
Disparities in Types of Services Utilized (Children and Youth)	47
Diagnosis	50
Workforce Diversity	56
Research Article Summaries	60
Race/Ethnicity Determination	64
Glossary of Terms	66

Executive Summary

The purpose of the *Progress Towards Reducing Disparities* report is to report improvements in reduction of disparities across racial/ethnic groups and age groups that have occurred in the last five years and note disparities that continue to exist in San Diego County for the 2006/2007 fiscal year.

Disparities were analyzed relative to accessing mental health service (i.e. penetration), engagement (i.e. retention), type of services used (i.e. outpatient vs. emergency), and diagnosis.

Data for this report was obtained from a January 2008 download of INSYST data. When possible data for 2006/2007 were also compared to 2001/2002 to assess changes over time.

Adult/Older Adult System Findings

The most notable finding that demonstrates progress toward reducing disparities for adults/older adults is that access overall for Latino, Native American, and Asian/Pacific Islanders, did increase from 2001/2002 to 2006/2007. Another positive finding was that in 2006/2007 access to services increased slightly among clients age 60 and above compared to 2001/2002.

However there does continue to be disparities. Latino, Native American, and Asian/Pacific Islanders accessed services less than expected. Engagement was lowest among Asian/Pacific Islander and Native American clients. We also found substantial disparities for African Americans, who used the least outpatient services and the most inpatient and jail services. Schizophrenia/ Schizoaffective disorder was the most frequently diagnosed disorder among African American clients, while Major Depression disorder was the most frequently diagnosed disorder among clients within the remaining racial/ethnic groups.

There remain some disparities based on age, most notably the TAY group (18 to 24 year olds). The TAY group access fewer services than expected, have more difficulty with engagement, and use more inpatient and jail mental health services than other age groups.

Children's System Findings

For children and youth findings in the comparison across FYs 2001/2002 and 2006/2007 demonstrate that access for Latino clients increased, but decreased among all other racial/ethnic groups during the same time period. Otherwise, the disparities found for racial/ethnic groups for those who are 0-17 were similar to those found in the adult system. For children, we found that Latinos, Native Americans, and Asian/Pacific Islanders accessed services less frequently than would be expected based on their proportion in the target population. We also found that engagement was lowest for the Asian/Pacific Islander group.

When examining types of services used, we identified several disparities. Most notably, we found that while a majority of clients (85%) used outpatient services, there were several racial/ethnic groups that utilized a disproportionate share of more restrictive levels of service. More Native American clients used inpatient services without receiving any outpatient services than any other group. Additionally, both more African American and Asian/Pacific Islander clients used juvenile forensics services without receiving any outpatient services than any other groups. Furthermore, we found several disparities when examining differences in diagnoses. Oppositional/Conduct Disorders were the most frequently diagnosed disorder among African American clients, ADHD was the most common diagnosis for White clients, and Depressive disorders were the most frequently diagnosed disorder among clients within the remaining racial/ethnic groups. In addition, there were disparities found based on age. The 0-5 age group accessed services less frequently than would be expected based on their proportion in the population, and the 6-12 age group accessed more services. When comparing 2001/2002 to 2006/2007 data, we found that access decreased slightly among 6-11 year olds, and increased slightly among 0-5 and 12-17 year olds. We also found that outpatient services are used the least by clients age 18 and older who continue to be served by children's' mental health services while the same group uses a high number of juvenile forensics services. In summary, access rates differ significantly between different racial/ethnic and age groups. Engagement and types of services used differ widely by age group, but only slightly between racial/ethnic groups.

Introduction

Background:

It is well documented that disparities exist in the use of mental health services by racial/ethnic minorities^{i,ii} throughout the United States. According to the Institute of Medicine, “a disparity is a difference in health care quality not due to differences in health care needs or preferences of the patientⁱⁱⁱ.” This definition implies that disparities may be a consequence of limited access to health care as well as a lack of culturally appropriate care.

Research on racial/ethnic disparities in access and use of mental health services has shown that racial/ethnic minorities have less access to mental health services, are less likely to receive care, are less likely to be engaged in services, and are more likely to receive poor-quality care when treated than their white counterparts. There are many factors that may contribute to such disparities. For example, low utilization of mental health care among persons with mental illness from racial/ethnic minority groups may be due to a variety of reasons including stigma, a lack of health insurance which limits their access to services, lack of accessible services with short wait times, limited incomes, and/or lack of information about available services. However, even when controlling for differences in access, disparities in use still persist^{iv}. Low utilization may also be due to cultural factors, such as perceived origin of mental illness, perceived helpfulness of mental health care, and/or culture-bound syndromes^v. Additionally, a lack of culturally appropriate care may prevent racial/ethnic minority groups from utilizing mental health services. Research has shown that diagnostic disparities are present as well. For example, there are gender differences in the mental health diagnoses of children. ADHD is more likely to be recognized in boys, who tend to exhibit externalizing symptoms (i.e. disruptive behavior), than in girls, who are more likely to exhibit internalizing symptoms (i.e.

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health inattentive behavior),^{viii} and gender has been acknowledged as a barrier to appropriate diagnosis in ADHD^{ix}. Even for adults, research has shown that across cultures, males are more likely to have externalizing problems than females^x. In addition, depression is more prevalent in women than in men^{xi,xii}. Another example is that African American youth are more often diagnosed with disruptive behavior disorders^{vi}, and several studies, including a Veterans Administration study involving over 100,000 veterans, found that Bipolar disorders are under diagnosed in African-Americans^{vii}. A final example is national data on the onset of mental health disorders that shows significant age differences. The median age for onset of ADHD is 7 years, while the median age of onset for an anxiety disorder is age 11^{xiii}. Schizophrenia often first appears in men in their late teens or early twenties, while women are generally affected in their twenties or early thirties^{xiv}. Symptoms of many mental health disorders begin in childhood and adolescence, resulting in calls for increased prevention and early intervention efforts for children.

Progress Towards Reducing Disparities



Unfortunately, although efforts to decrease barriers to mental healthcare among racial/ethnic minorities and age groups have been a focus for SDCMHS for many years, significant disparities persist. A comparison of the San Diego County target population to those receiving mental health services (pages 14 and 15) demonstrates that disparities continue. Most notably for Latino Adults. Latinos comprise 59% of the target population but only 22% of the adult clients receiving mental health services. While these numbers are much better for children, 70% of the population compared to 49% of the clients receiving mental health services, there is still significant room for improvement.

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

It is important to note that while disparities still exist, the key findings from this study indicate that improvements have been made in reducing disparities. Although Latino/a, Asian American/Pacific Islander, and Native American individuals were less likely to access services than expected, their access rates have increased over time. These findings are a promising indication that disparities are being reduced over time.

A summary of key findings for adults and children is included below. For more detailed information on pages 18-58 this report provides several analyses including a of analysis of each major racial/ethnic group by age, an examination of penetration and retention rates by age and by race/ethnicity, a study of variations in service utilization by age and by race/ethnicity, differences in diagnosis by age and by race/ethnicity, a review of workforce diversity, and a listing of relevant research articles completed by staff of the contracted research centers.

Summary of Key Findings:

An analysis of access, engagement, use of services and variances in diagnosis demonstrated the following key findings:

By Race/Ethnicity:

- Latinos:
 - Adults/Older Adults:
 - Were less likely to access services than expected. However, rates have gone up slightly over time.
 - 13% had only one visit to an outpatient program.
 - Children and Youth
 - Had the lowest access rates among racial/ethnic groups in FY01-02 however, rates have gone up over time.
 - 30% had fewer than 5 visits.
- African Americans:
 - Adults/Older Adults
 - Were more likely to use only inpatient/emergency (18%) and only jail services (27%), and less likely to use outpatient services than the other racial/ethnic groups.
 - Have a higher rate of being diagnosed with Schizophrenia or Schizoaffective disorder.
 - Children and Youth
 - Were more likely to use juvenile forensics services without using any other types of less restrictive services than other racial/ethnic groups.
 - Were also more likely to use Day Treatment Services.
 - 13% had only 1 visit.

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

- Asian/Pacific Islanders:
 - Adults/Older Adults
 - Had moderate to low access rates compared to the other racial/ethnic groups, indicating they were moderately likely to access services. However, rates have gone up slightly over time.
 - Children and Youth
 - Had low access rates compared to the other racial/ethnic groups, and access rates have gone down slightly over time.
 - Had the lowest rate engagement, and were most likely to discontinue services after 1 visit.
 - 16% had only 1 visit.
- Native Americans:
 - Adults/Older Adults
 - Had the second lowest access rates among racial/ethnic groups, indicating they were less likely to access services. However, rates have gone up slightly over time.
 - Children and Youth
 - Had the lowest access rates among racial/ethnic groups in FY0607 and there was a slight decline from FY0102.
 - Were more likely to use inpatient only services than other racial/ethnic groups

By Age:

- Age group 0-5:
 - Had the lowest access rates among age groups, however, access rates have increased slightly over time.
 - Had the lowest engagement rates among age groups, indicating they were less likely to continue services past 10 visits.
 - Were more likely to use outpatient services than clients ages 12 and older.
- Age group 6-11:
 - Access rates have gone down slightly over time.
 - Were more likely to use outpatient services than the other age groups.
- Age group 12-17:
 - Had the highest access rates among age groups, indicating they were more likely to access services. Further, access rates have increased slightly over time.
 - 24% used juvenile forensics services only.
- Age group 18 and older:
 - Were least likely to use outpatient services and most likely to use juvenile forensics services.
- Age group 18-24 (Transitional Age Youth):

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

- Had the lowest access rates among age groups. Further, their access of services has gone down slightly over time.
 - Had the lowest engagement rates among age groups, with 31% having fewer 3 or fewer visits.
 - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to use outpatient services than the other age groups.
- Age 60 and older (Older Adults):
 - Had moderate to low engagement rates compared to other age groups and were somewhat less likely to continue services past 8 visits.

Conclusions

Areas of success and needed improvement for each age group by race/ethnicity are shown in the tables below.

Table 1 clearly demonstrates need for improvement for both TAY and Older Adults, as well as targeted improvement for African American, Latino, Asian/Pacific Islander and native American.

Table #1

Adult Areas of Success (+) and Areas that Need Improvement (*) for Age and Racial/Ethnic Disparities

	Age/Racial/Ethnic Group							
	18-24	25-59	60+	White	African American	Latino	Asian/Pacific Islander	Native American
Access	*	+	*	+	+	*	*	*
Change in access over Time	*	+	+	+	+	+	+	+
Engagement	*	+	*	+	+	+	+	+
Use of restrictive levels of service	*	+	*	+	*	+	+	+

Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG) and CASRC (JRR, BG, SC), and SDCMHS

Table 2 clearly demonstrates need for improvement for 0-5 and Asian/Pacific Islander as well as targeted improvement for age groups 6-11, and 18+, and racial/ethnic groups of African American, Latino, and Native American.

Table #2

**CMHS Areas of Success (+) and Areas that Need Improvement (*)
Age and Racial/Ethnic Disparities**

	Age/Racial/ethnic Group								
	0-5	6-11	12-17	18+	White	African American	Latino	Asian/Pacific Islander	Native American
Access	*	+	+	+	+	+	*	*	*
Changes in Access over Time	+	*	+	+	+	+	+	*	*
Engagement	*	+	+	+	+	+	+	*	+
Use of less Restrictive Services	+	+	+	*	+	*	+	*	*

Next Steps

While the results of the report indicate that progress has been made, there is still much to do to reduce disparities in San Diego County. The Institute of Medicine (IOM) has recently made several recommendations for further eliminating health care disparities which are applicable to mental health care. Specifically, their *Unequal Treatment* report suggests that health care systems proactively improve minority access to care.

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

Several steps health care systems could take to improve minority access and help eliminate disparities in engagement, service utilization and diagnosis are to increase the diversity in the mental health workforce, as well as to provide culturally appropriate education for providers.

A greater diversity in the mental health workforce is an important factor for improving health disparities. Increasing the proportion of racial/ethnic minorities would likely provide more culturally appropriate treatment. Additionally, increased diversity of mental health providers would offer language skills to match those of patients.

One way San Diego County will increase the diversity in the mental health workforce is through the Workforce Education and Training (WET) component of the MHSA. WET will provide funding for San Diego County to “build the capacity of our current and prospective public mental health workforce.” Specifically, WET funding will include educational, training and counseling programs that are designed to recruit and prepare individuals for entry into a career in the public mental health system. Programs will address opportunities and equal access for underrepresented racial/ethnic, cultural, and/or linguistic groups.

Culturally appropriate education for providers is another promising direction in eliminating racial/ethnic disparities. Cultural competence is especially appealing in that it may aid in reducing health disparities by recognizing and adjusting qualities of healthcare delivery to reflect patient culture. In fact, the Surgeon General’s report from 1999 suggested that fundamental components of effective mental health service delivery include “culturally sensitive service.” In recent years, researchers have explored a variety of areas for the purpose of enabling greater implementation of multicultural competencies. These areas include the adequacy of psychological services and treatment interventions for culturally diverse populations^{xvi}; multicultural counseling training^{xvii}; examination of multicultural curricula in graduate programs^{xix}; counselors' self-awareness regarding cultural identity, heritage, and values^{xx}; the use of multicultural training videos^{xxi}; and the influence of racial/ethnic identity on counselor training^{xxii}.

The next steps in reducing disparities for San Diego County Mental Health Services based on the findings in this report are to:

- 1) conduct further examination to determine the root cause of the disparities,

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

- 2) assess the effectiveness of current strategies to increase awareness of mental health issues and services in minority populations,
- 3) continue to identify and improve strategies that appear to be effective in reducing disparities in access, engagement, service utilization and diagnoses,
- 4) analyze new and innovative strategies that have been successful in other communities and implement in San Diego,
- 5) utilize effective methods to evaluate the cultural sensitivity of providers and services,
- 6) ensure that service planning groups have information about disparities,
- 7) work with client and family representatives of all racial/ethnic groups, targeted age groups, and other cultural groups to identify barriers to quality improvement.
- 8) consider analyzing additional cultural factors such as client and caregiver language, the impact of the family on treatment decisions, level of acculturation, religious differences, and cultural differences within currently aggregated racial/ethnic groups such as Asian / Pacific Islanders. Other cultural distinctions that might be important to investigate include sexual orientation, religion, and other important cultural groups.

- ⁱ Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: National Academy Press; 2003.
- ⁱⁱ U.S. Department of Health and Human Services. *Mental Health: Culture, Race, and Ethnicity—A Supplement to Mental Health: A Report of the Surgeon General*. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2001.
- ⁱⁱⁱ Breslau, J. et al., (2006). Specifying race-ethnic differences in risk for psychiatric disorder in a USA national sample, *Psychological Medicine*, 36(1), 57-68.
- ^{iv} Dobalian, A., Rivers, P., (2008). Racial and ethnic disparities in the use of mental health services. *The Journal of Behavioral Health Services & Research*. 35(2), 128-141.
- ^v Gilmer, T., Ojeda, V., Folsom, D., Fuentes, D., Garcia, P., & Jeste, D. (2007). Initiation and use of public mental health services by persons with severe mental illness and limited English proficiency. *Psychiatric Services*, 58(12), 1555-1561.
- ^{vi} Mak W.; Rosenblatt A. Demographic Influences on Psychiatric Diagnoses Among Youth Served in California Systems of Care. *Journal of Child and Family Studies*, 2002, 11(2): 165-178.; DelBello MP, Lopez-Larson MP, Soutullo CA, Strakowski SM: Effects of race on psychiatric diagnosis of hospitalized adolescents: a retrospective chart review. *J Child Adolesc Psychopharmacol* 11:95-103, 2001; Fabrega, H., Ulrich, R., & Mezzich, J. Do Caucasian and Black adolescents differ at psychiatric intake? *Journal of the American Academy of Child and Adolescent Psychiatry*, 1993, 32(3): 407-413.
- ^{vii} Blow FC, Zeber JE, McCarthy JF, Valenstein M, Gillon L, Bingham CR. Ethnicity and diagnostic patterns in veterans with psychoses. *Soc Psychiatry Psychiatr Epidemiol*. Oct 2004;39(10):841-851. Bell, C. C. & Mehta, H. (1980). The misdiagnosis of black patients with manic depressive illness. *Journal of the National Medical Association*, 72, 141-145; Bell, C. C. & Mehta, H. (1981). The misdiagnosis of black patients with manic depressive illness: Second in a series. *Journal of the National Medical Association*, 73, 101-107; Mukherjee, S., Shukla, S., Woodle, J., Rosen, A. M., & Olarte, S. (1983). Misdiagnosis of schizophrenia in bipolar patients: A multiethnic comparison. *American Journal of Psychiatry*, 140, 1571-1574.
- ^{viii} Biederman J, Mick E, Faraone SV, Braaten E, Doyle A, Spencer T, Wilens TE, Frazier E, Johnson MA. Influence Of Gender On Attention Deficit Hyperactivity Disorder In Children Referred To A Psychiatric Clinic. *American Journal of Psychiatry*. 2002 Jan;159(1):36-42.
- ^{ix} NIH Consensus Statement. Diagnosis and treatment of attention deficit hyperactivity disorder (ADHD). 1998;16:1-37. Available at <http://consensus.nih.gov/1998/1998AttentionDeficitHyperactivityDisorder110html.htm>
- ^x Crijnen AA, Achenbach TM, Verhulst FC. Problems reported by parents of children in multiple cultures: The Child Behavior Checklist syndrome constructs. *American Journal of Psychiatry*, 1999; 156: 569-574.
- ^{xi} Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *Journal of the American Medical Association*, 2003; Jun 18;289(23):3095-105.
- ^{xii} Nguyen L, Huang LN, Arganza GF, Liao Q. The influence of race and ethnicity on psychiatric diagnoses and clinical characteristics of children and adolescents in children's services. *Cultural Diversity and Ethnic Minority Psychology*; 2007, 13(1): 18-25.
- ^{xiii} Kessler RC, Berglund PA, Demler O, Jin R, Walters EE. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*. 2005 Jun;62(6):593-602.
- ^{xiv} Robins LN, Regier DA, eds. *Psychiatric disorders in America: the Epidemiologic Catchment Area Study*. New York: The Free Press, 1991.
- ^{xv} Cook et al., "Measuring Trends in Mental health Care Disparities, 2000-2004."
- ^{xvi} Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist*, 616-24.
- ^{xvii} Pedersen, P. (1988). *A handbook for developing multicultural awareness*. Alexandria, VA American Association for Counseling and Development.
- ^{xix} Ponterotto, J. G., & Casas, J. M. (1987). In search of multicultural competence within counselor education programs. *Journal of Counseling & Development*, 65,430-434.
- ^x Cayleff, S. E. (1986). Ethical issues in counseling gender, race, and culturally distinct groups. *Journal of Counseling & Development*, 64, 345-347.
- ^{xxi} Pope-Davis, D. B., Reynolds, A. L., & Vazquez, L. A (1992). *Multicultural counseling: Issues of ethnic diversity*. A training video. Iowa City, IA: Audiovisual Center, The University of Iowa.
- ^{xxii} Sabnani, H. B., Ponterotto, J. G., Borodovsky, L. G. (1991). White racial identity development and cross-cultural counselor training: A stage model. *The Counseling Psychologist*, 19, 72- 102.

Comparison of Distribution of Target Population to Mental Health Clients

Adult/Older Adult System of Care Distribution Rates

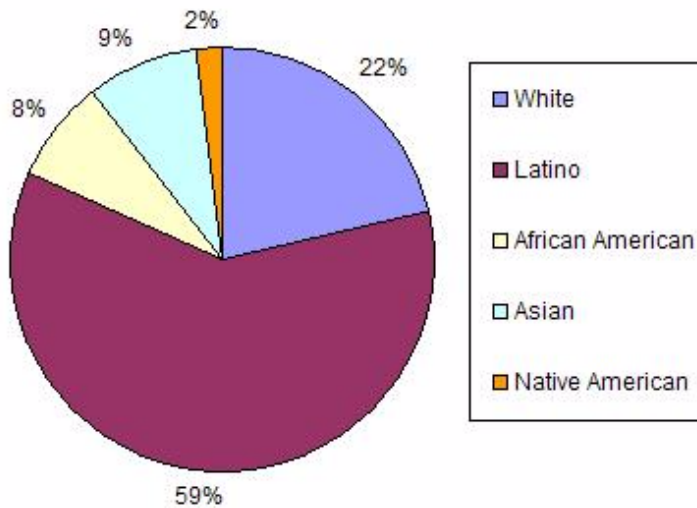
Target Population versus Actual Mental Health System Clients for

Adult/Older Adult System of Care:

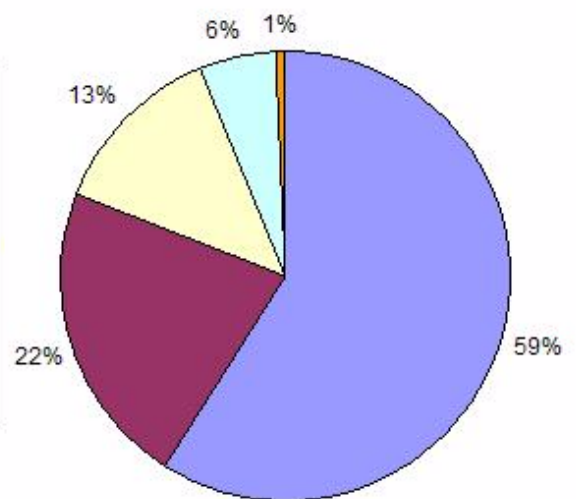
FY 2006-2007

	2006-07			
	Eligible Clients		Actual Clients	
	San Diego County Uninsured or Medicaid under 200% FPL		A/OAMHS Clients	
	Number	%	Number	%
White	69,892	22%	20,460	59%
Latino	195,290	59%	7,692	22%
African American	24,819	8%	4,499	13%
Asian	28,284	9%	1,917	6%
Native American	6,413	2%	218	1%

Potential Clients: San Diego County Uninsured or Medicaid under 200% FPL (06-07)



Actual Clients: A/OAMHS Clients (06-07)

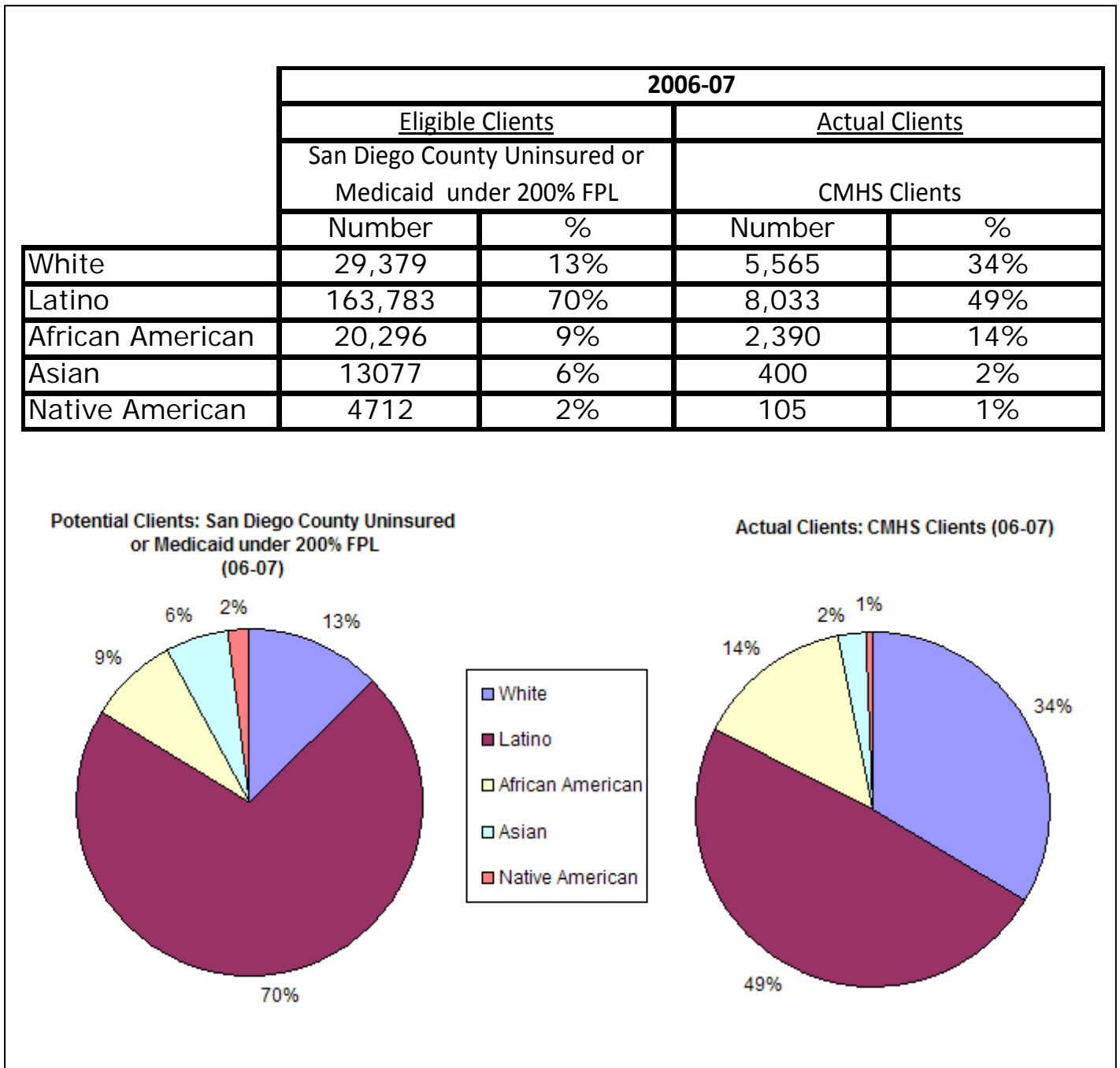


Children's System of Care Distribution Rates

Target Population versus Actual Mental Health System Clients for

Children's System of Care:

FY 2006-2007



Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG) and CASRC (JRR, BG, SC), and SDCMHS

Key Findings

Key Findings on Adult/Older Adult Groups Receiving Services

An analysis of access, engagement, use of services and variances in diagnosis demonstrated the following key findings of disparities for Adults/Older Adults:

By Ethnicity/Race:

- Latinos:
 - Were less likely to access services than expected. However, rates have gone up slightly over time.
 - 13% had only one visit to an outpatient program.
- African Americans:
 - Were more likely to use only inpatient/emergency (18%) and only jail services (27%), and less likely to use outpatient services than the other racial/ethnic groups.
 - Have a higher rate of being diagnosed with Schizophrenia or Schizoaffective disorder.
- Asian/Pacific Islanders:
 - Had moderate to low access rates compared to the other racial/ethnic groups, indicating they were moderately likely to access services. However, rates have gone up slightly over time.
- Native Americans:
 - Had the second lowest access rates among racial/ethnic groups, indicating they were less likely to access services. However, rates have gone up slightly over time.

By Age:

- Age 18-24 (Transitional Age Youth):
 - Had the lowest access rates among age groups. Further, their access of services has gone down slightly over time.
 - Had the lowest engagement rates among age groups, with 31% having fewer 3 or fewer visits.
 - Were more likely to use inpatient/emergency services (24%) and jail services (26%) and less likely to use outpatient services than the other age groups.
- Age 60 and older:
 - Had moderate to low engagement rates compared to other age groups and were somewhat less likely to continue services past 8 visits.

Key Findings on Children's Groups Receiving Services

An analysis of access, engagement, use of services and variances in diagnosis demonstrated the following key findings of disparities for children and youth:

By Ethnicity/Race:

- Latinos:
 - Had the lowest access rates among racial/ethnic groups in FY01-02 however, rates have gone up over time.
 - 30% had fewer than 5 visits.
- African Americans:
 - Were more likely to use juvenile forensics services without using any other types of less restrictive services than other racial/ethnic groups.
 - Were also more likely to use Day Treatment Services.
 - 13% had only 1 visit.
- Asian/Pacific Islanders:
 - Had low access rates compared to the other racial/ethnic groups, and access rates have gone down slightly over time.
 - Had the lowest rate engagement, and were most likely to discontinue services after 1 visit.
 - 16% had only 1 visit.
- Native Americans:
 - Had the lowest access rates among racial/ethnic groups in FY0607 and there was a slight decline from FY0102.
 - Were more likely to use inpatient only services than other racial/ethnic groups.

By age:

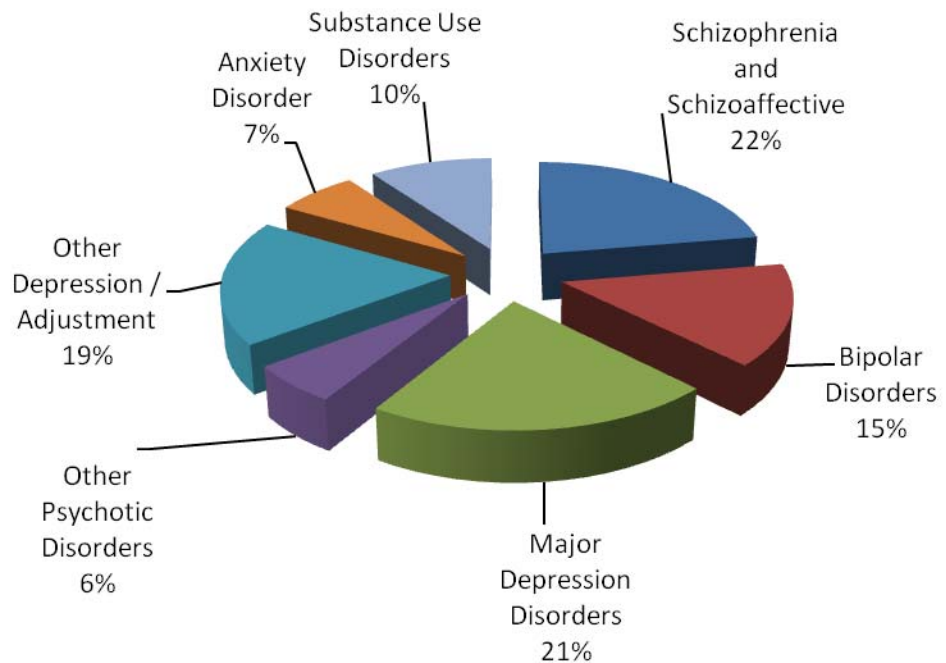
- Age group 0-5:
 - Had the lowest access rates among age groups, access rates have increased slightly over time.
 - Had the lowest engagement rates among age groups, indicating they were less likely to continue services past 10 visits.
- Age group 6-11:
 - Access rates have gone down slightly over time.
- Age group 12-17:
 - Had the highest access rates among age groups, indicating they were more likely to access services. Further, access rates have increased slightly over time.
 - 24% used juvenile forensics services only.
- Age group 18 and older:
 - Were least likely to use outpatient services and most likely to use juvenile forensics services.

Comparison of Age Groups and by Race/Ethnicity

White Adults and Older Adults

- 19,716 White adult clients were served in FY0607.
- 98% of White adult clients identified English as their preferred language.
- Age:
 - <18-24: 11%
 - 25-59: 79%
 - 60+: 9%

White Diagnosis Distribution



- Gender:
 - Female: 48%
 - Male: 51%
 - Unknown: 0.3%

- Top 3 diagnoses:
 1. Major Depression disorders
 2. Schizophrenia and Schizoaffective disorders
 3. Other Depression/Adjustment disorders

- Access (Penetration rates):
 - FY0102: 34%
 - FY0607: 29%

- Engagement (Retention rate):
 - <8 visits: 44%
 - 8+ visits: 56%

- White adult clients were less likely to be seen by Fee For Service Providers than the overall AOAMHS population (22% vs.26% respectively).
- White adult clients were more likely to utilize EPU services than the overall AOAMHS population (24% vs.22% respectively).
- White adult clients are more likely to be uninsured, as compared to the overall AOAMHS population (51% vs. 46% respectively).

White Children and Youth

- 4,590 White children and youth clients were served in FY0607, of which 30% were new clients.

- Age:
 - 0-5: 10%
 - 6-11: 29%
 - 12-17: 57%
 - 18+: 5%

- Gender:
 - Female: 39%
 - Male: 60%
 - Unknown: 1%

- Top 3 diagnoses:
 1. ADHD
 2. Depressive disorders
 3. Adjustment disorders

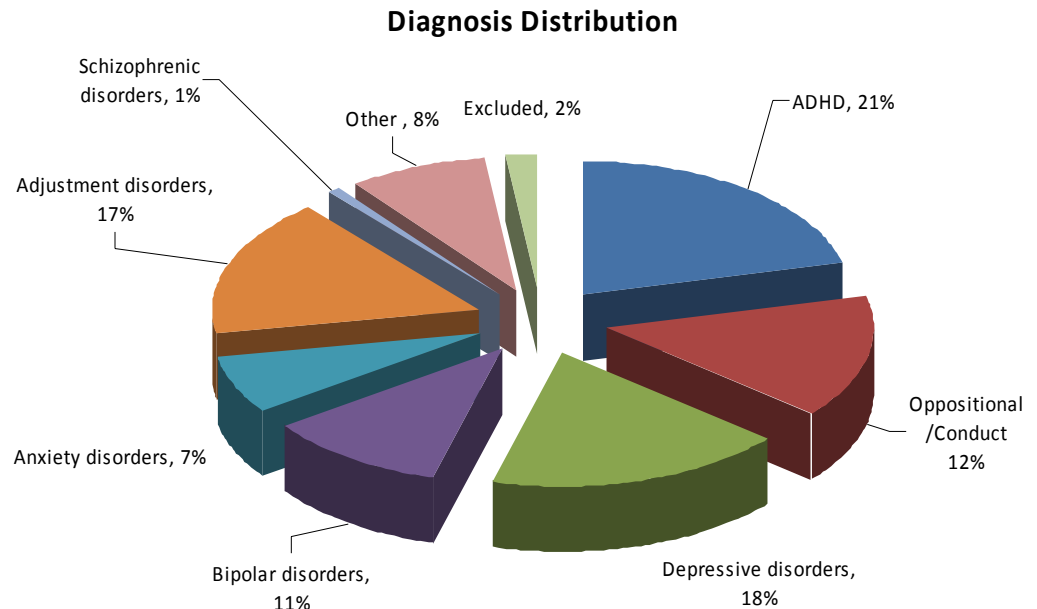
- Penetration rates (White and Other combined):
 - FY0102: 27%
 - FY0607: 20%

- Retention:
 - Mean visits: 32.7
 - Median visits: 16
 - 10% of White clients had only one visit during FY0607

- White children and youth clients were more likely to be seen by Fee For Service Providers than the overall CMHS population (37% vs. 30% respectively).

- White children and youth clients were less likely to be seen by Juvenile Justice related providers (15% vs. 20% overall).

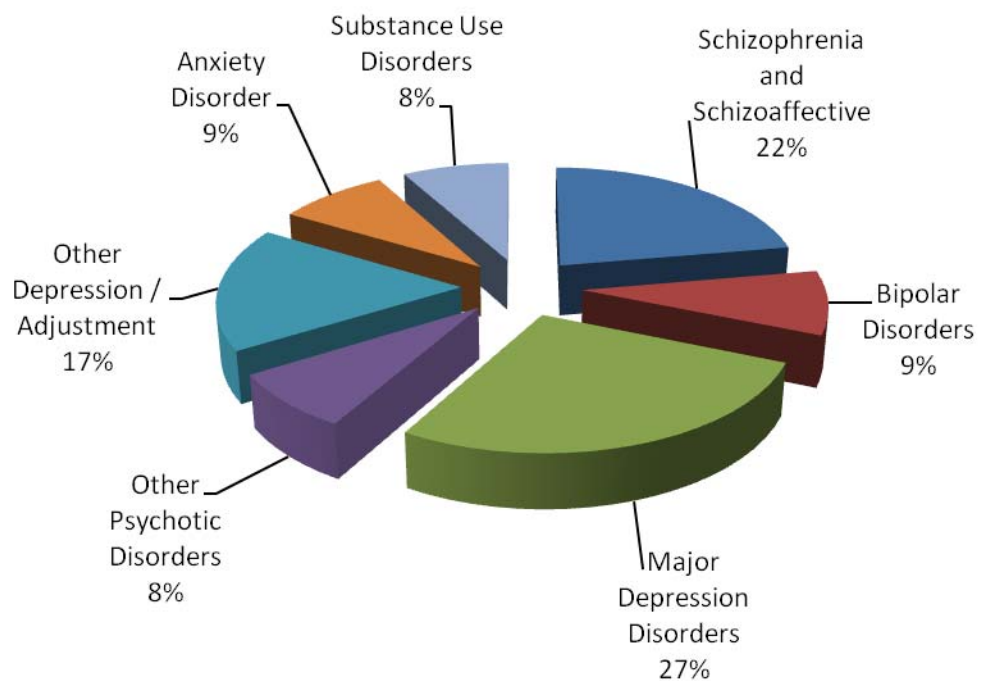
- White children and youth clients are less likely to have Medi-Cal (79%) and more likely to have private insurance or be uninsured (9% and 12% respectively, as compared to the overall CMHS population).



Hispanic Adults and Older Adults

- 8,242 Hispanic adult clients were served in FY0607.
- 31% of Hispanic adult clients identified Spanish as their preferred language.
- Age:
 - <18-24: 19%
 - 25-59: 75%
 - 60+: 7%

Hispanic Diagnosis Distribution



- Gender:
 - Female: 52%
 - Male: 47%
 - Unknown: 0.7%
- Top 3 diagnoses:
 1. Major Depression disorders
 2. Schizophrenia and Schizoaffective disorders
 3. Other Depression/Adjustment disorders
- Penetration rates:
 - FY0102: 4%
 - FY0607: 4%

Hispanic Subcategories		
Description	N	%
Mexican American/Chicano	5,572	67%
White	1,398	17%
Other Hispanic	505	6%
Other Latin American	208	3%
African American	106	1%
Puerto Rican	89	1%
Other / Unknown	364	4%
Total	8,242	100%

- Retention:
 - <8 visits: 45%
 - 8+ visits: 55%
- Hispanic adult clients were less likely to utilize Forensic services than the overall AOAMHS population (22% vs.26% respectively).
- Hispanic adult clients are slightly more likely to be uninsured, as compared to the overall AOAMHS population (47% vs. 46% respectively).

Hispanic Children and Youth

- 8,354 Hispanic children and youth clients were served in FY0607, of which 42% were new clients.
- Almost 30% of Hispanic children and youth clients identified Spanish as their preferred language.

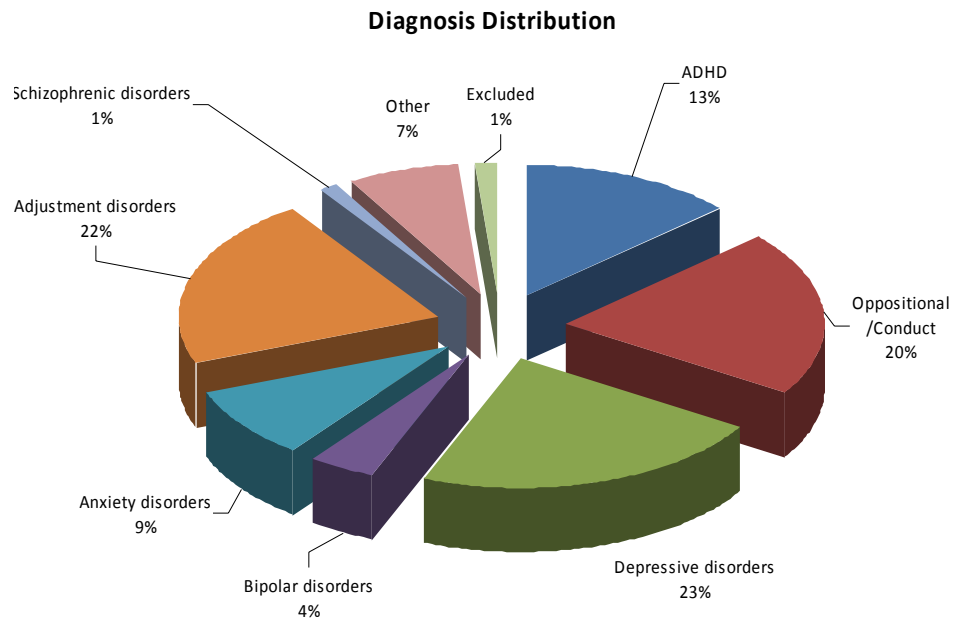
- Age:
 - 0-5: 10%
 - 6-11: 30%
 - 12-17: 57%
 - 18+: 4%

- Gender:
 - Female: 38%
 - Male: 61%
 - Unknown: 1%

- Top 3 diagnoses:
 1. Depressive disorders
 2. Adjustment disorders
 3. Oppositional / conduct disorders

- Penetration rates:
 - FY0102: 3%
 - FY0607: 5%

- Retention:
 - Mean visits: 24.5
 - Median visits: 14
 - 12% of Hispanic clients had only one visit during FY0607



CMHS Hispanic Subcategories		
Description	N	%
Mexican American/Chicano	5,952	71%
White	385	4%
Other Hispanic	156	2%
Other Latin American	121	1%
African American	140	2%
Puerto Rican	17	0.2%
Other / Unknown	1583	19%
Total	8,354	100%

- Hispanic children and youth clients were less likely to be seen by Fee For Service Providers than the overall CMHS population (24% vs. 30% respectively).
- Hispanic children and youth clients are less likely to have private insurance, as compared to the overall CMHS population (3% vs. 4%).

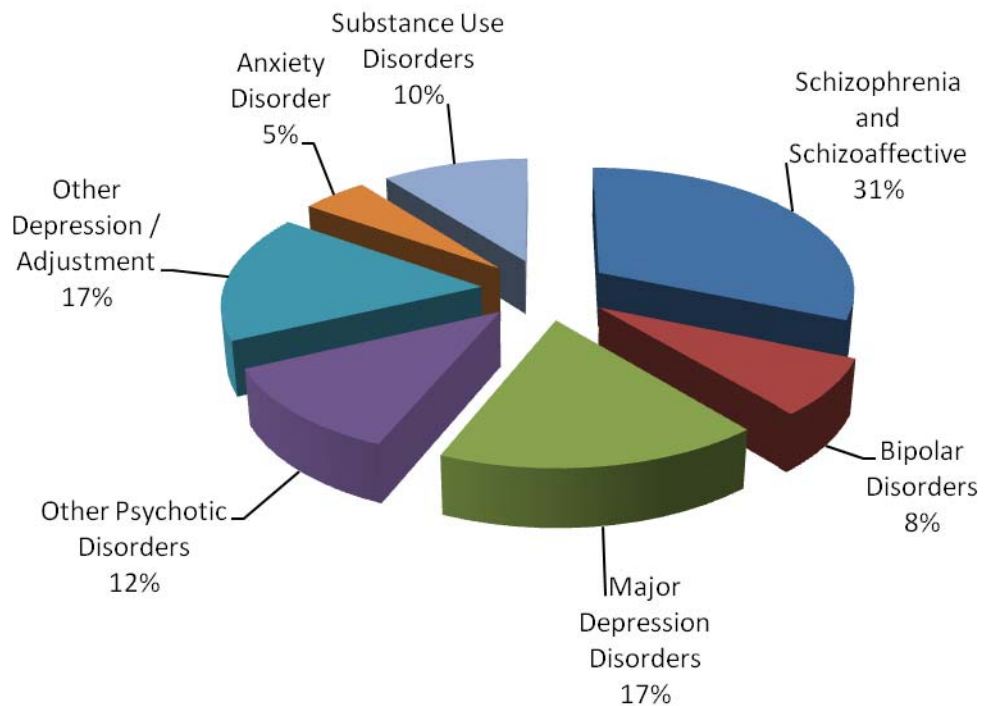
African American Adults and Older Adults

- 4,723 African American adult clients were served in FY0607.
- 98% of African American adult clients identified English as their preferred language.
- Age:
 - <18-24: 13%
 - 25-59: 82%
 - 60+: 5%

African American Diagnosis Distribution

- Gender:
 - Female: 45%
 - Male: 53%
 - Unknown: 0.4%

- Top 3 diagnoses:
 1. Schizophrenia and Schizoaffective disorders
 2. Major Depression disorders
 3. Other Depression/Adjustment disorders



- Penetration rates:
 - FY0102: 18%
 - FY0607: 18%

- Retention:
 - <8 visits: 45%
 - 8+ visits: 55 %

- African-American adult clients were more likely to utilize Forensic services , as compared to the overall AOAMHS population (39% vs. 26% overall).
- African-American adult clients were more likely to utilize EPU services, as compared to the overall AOAMHS population (25% vs.22%).
- African-American adult clients are less likely to be uninsured, as compared to the overall AOAMHS population (44% vs. 46% respectively).

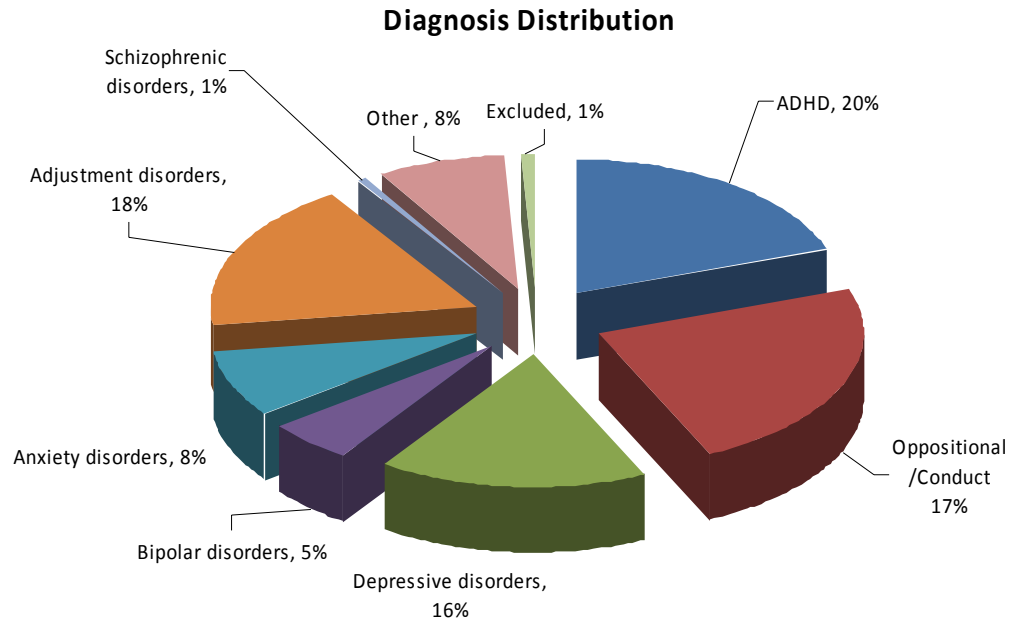
African-American Children and Youth

- 2,515 African-American children and youth clients were served in FY0607, of which 28% were new clients.

- Age:
 - 0-5: 9%
 - 6-11: 29%
 - 12-17: 58%
 - 18+: 5%

- Gender:
 - Female: 38%
 - Male: 61%
 - Unknown: 1%

- Top 3 diagnoses:
 1. Oppositional / conduct disorders
 2. ADHD
 3. Adjustment disorders



- Penetration rates:
 - FY0102: 12%
 - FY0607: 12%

- Retention:
 - Mean visits: 32.4
 - Median visits: 15
 - 13% of African-American clients had only one visit during FY0607

- African-American children and youth clients were more likely to be seen by Juvenile Justice related providers (25% vs. 20% overall).

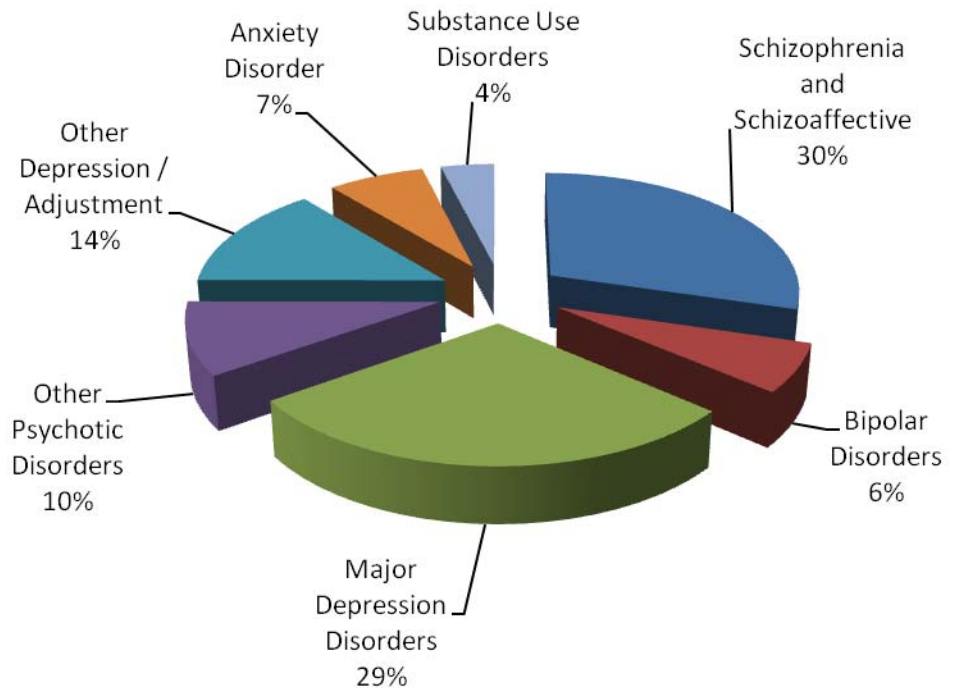
- African-American children and youth clients were more likely to utilize Day Rehabilitation services, as compared to the overall CMHS population (11% vs. 7%).

- African-American children and youth clients are more likely to have Medi-Cal (91% vs. 86% overall) and less likely be uninsured (5% vs. 9%), as compared to the overall CMHS population.

Asian Adults and Older Adults

- 2,106 Asian adult clients were served in FY0607.
- 41% of Asian adult clients identified an Asian language as their preferred language.
- Age:
 - <18-24: 10%
 - 25-59: 75%
 - 60+: 15%

Asian Diagnosis Distribution



- Gender:
 - Female: 54%
 - Male: 46%
 - Unknown: 0.7%
- Top 3 diagnoses:
 1. Major Depression disorders
 2. Schizophrenia and Schizoaffective disorders
 3. Other Depression/Adjustment disorders
- Penetration rates:
 - FY0102: 6%
 - FY0607: 7%

- Retention:
 - <8 visits: 46%
 - 8+ visits: 54%
- Asian adult clients were less likely to utilize EPU services, as compared to the overall AOAMHS population (16% vs.22%).
- Asian / Pacific Islander adult clients are less likely to be uninsured, as compared to the overall AOAMHS population (33% vs. 46%).

Adult Asian Subcategories		
Description	N	%
Vietnamese	731	33%
Filipino	541	24%
Cambodian	177	8%
*Pacific Islander	136	6%
**Other Southeast Asian	124	6%
Amerasian	109	5%
Chinese	102	5%
Japanese	88	4%
Korean	65	3%
Asian Indian	33	2%
Other / Unknown	136	6%
Total	2,242	100%
*Pacific Islander includes Guamanian, Hawaiian Native and Samoan.		
**Other Southeast Asian includes Hmong and Laotian.		

Asian / Pacific Islander Children and Youth

- 420 Asian / Pacific Islander children and youth clients were served in FY0607, of which 40% were new clients.
- While 89% of Asian / Pacific Islander children and youth clients identified English as their preferred language, 3% identified Vietnamese as their preferred language, 0.6% identified Tagalog, and 7% identified another language.

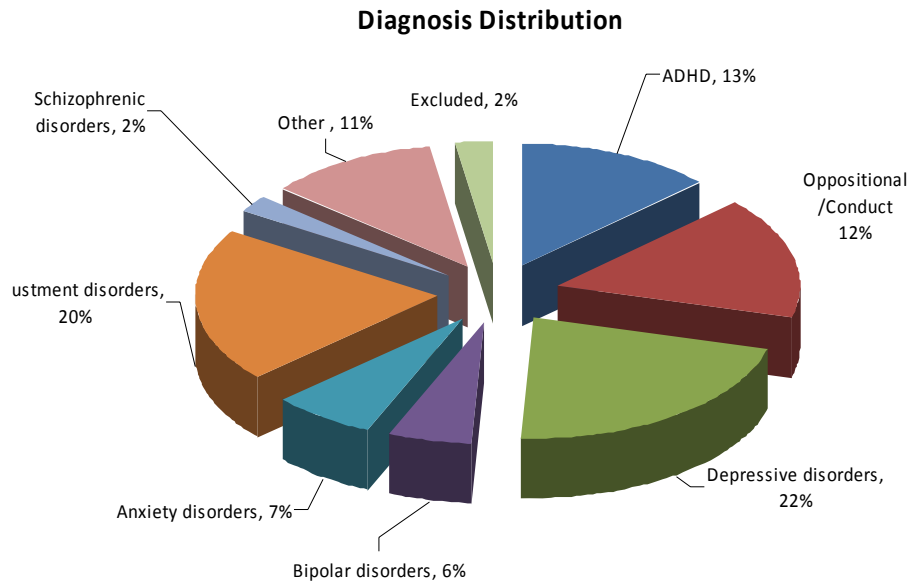
- Age:
 - 0-5: 11%
 - 6-11: 2%
 - 12-17: 59%
 - 18+: 5%

- Gender:
 - Female: 39%
 - Male: 60%
 - Unknown: 0.7%

- Top 3 diagnoses:
 1. Depressive disorders
 2. Adjustment disorders
 3. Oppositional / conduct disorders

- Penetration rates:
 - FY0102: 5%
 - FY0607: 3%

- Retention:
 - Mean visits: 24.2
 - Median visits: 13
 - 16% of Asian / Pacific Islander clients had only one visit during FY0607



CMHS Asian Subcategories		
Description	N	%
Vietnamese	58	14%
Filipino	99	24%
Cambodian	31	7%
*Pacific Islander	59	14%
**Other Southeast Asian	25	6%
Amerasian	61	15%
Chinese	8	2%
Japanese	7	2%
Korean	6	1%
Asian Indian	10	2%
Other / Unknown	56	13%
Total	420	100%
*Pacific Islander includes Guamanian, Hawaiian Native and Samoan.		
**Other Southeast Asian includes Hmong and Laotian.		

Native American Adults and Older Adults

- 227 Native American adult clients were served in FY0607.
- 96% of Native American adult clients identified English as their preferred language.
- Age:
 - <18-24: 13%
 - 25-59: 83%
 - 60+: 4%

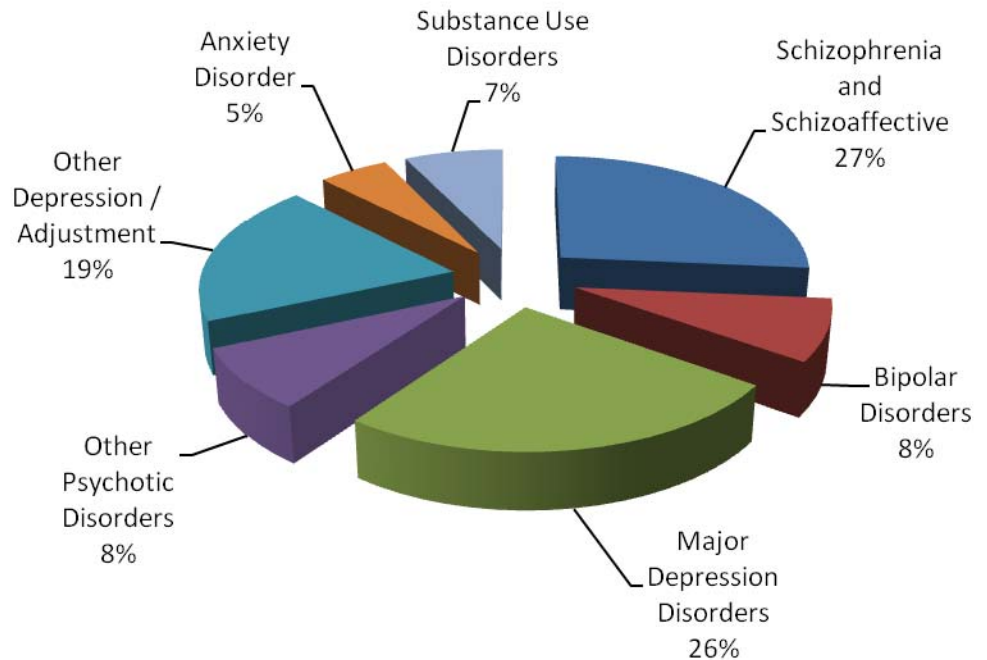
- Gender:
 - Female: 56%
 - Male: 44%
 - Unknown: 0.4%

- Top 3 diagnoses:
 1. Major Depression disorders
 2. Schizophrenia and Schizoaffective disorders
 3. Other Depression/Adjustment disorders

- Penetration rates:
 - FY0102: 4%
 - FY0607: 5%

- Retention:
 - <8 visits: 46%
 - 8+ visits: 54%

Native American Diagnosis Distribution



Native American Children and Youth

- 112 Native American children and youth clients were served in FY0607, of which 30% were new clients.

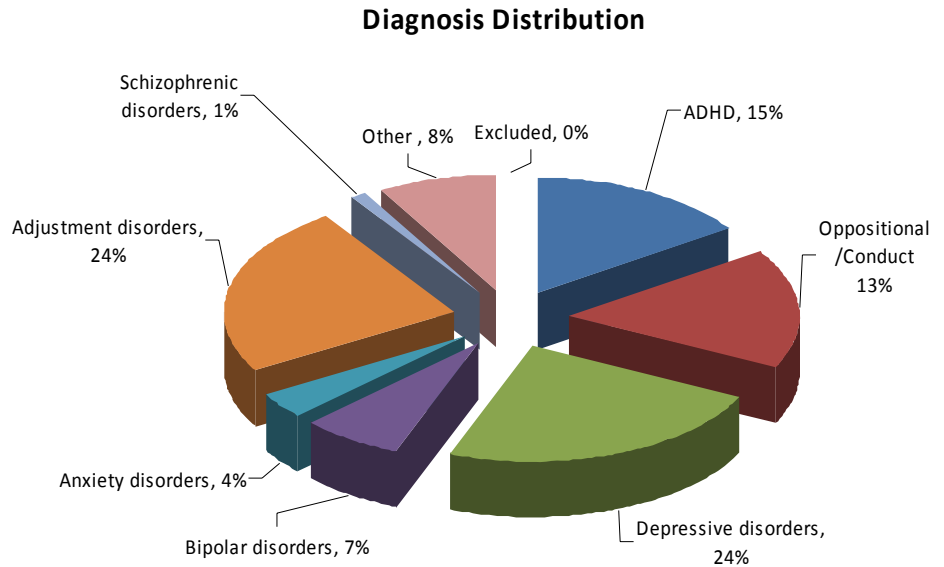
- Age:
 - 0-5: 7%
 - 6-11: 32%
 - 12-17: 54%
 - 18+: 6%

- Gender:
 - Female: 44%
 - Male: 5%
 - Unknown: 1%

- Top 3 diagnoses:
 - Depressive disorders
 - Adjustment disorders
 - Oppositional / conduct disorders

- Penetration rates:
 - FY0102: 4%
 - FY0607: 2%

- Retention:
 - Mean visits: 27.0
 - Median visits: 12
 - 12% of Native American clients had only one visit during FY0607



Disparities in Access and Engagement

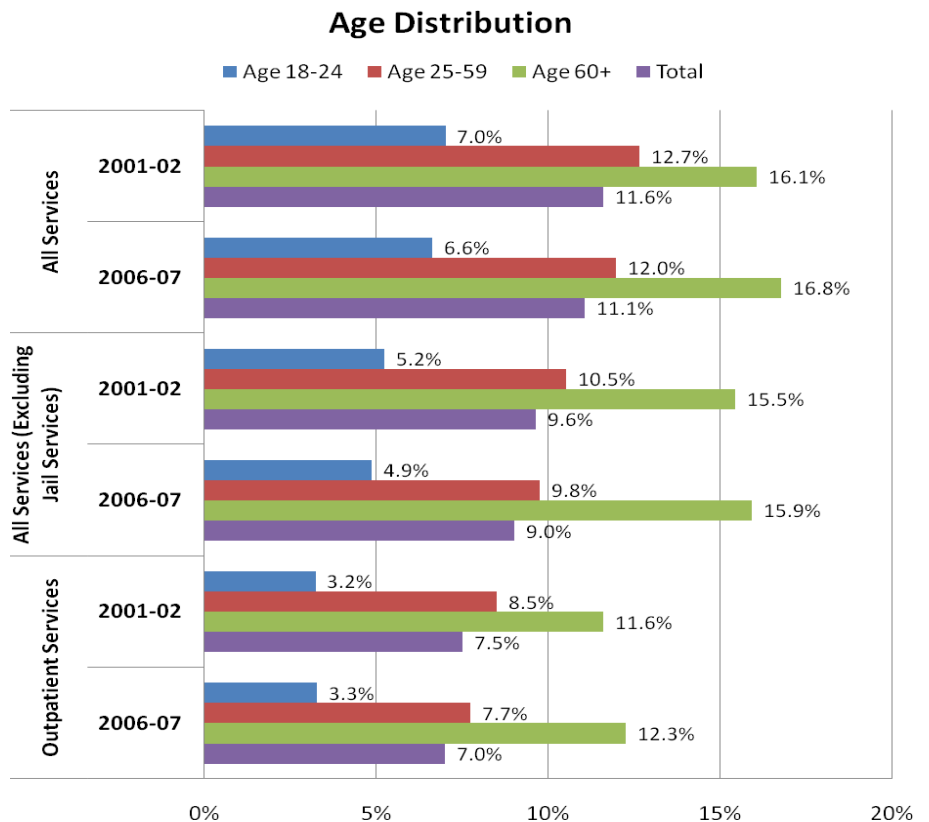
Analysis of Penetration and Retention Rates by Age Group and by Race/Ethnicity

Disparities in access to services were identified by comparing the target population to the number who actually receive San Diego County mental health services (penetration rate). Disparities in engagement were identified by analyzing the percentage of clients who continued services past eight visits for adults and ten visits for children (retention rate).

Adult and Older Adult Penetration Rates by Age

Penetration rates for all services, all services excluding jail services, and outpatient services were examined across three age groups: 18-24, 25-59, and 60+. Penetration rates were calculated as number of actual clients within a specific age group (i.e. 18-24, 25-59, and 60+) who received services (AOAMHS clients) divided by number of potential clients (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries) within that age group (i.e. 18-24, 25-59, and 60+). Differences in penetration rates were examined across years by comparing penetration rates in 2001-2002 to penetration rates in 2006-2007.

- Clients age 60+ had the highest penetration rates for all types of services in 2001-2002 and 2006-2007.
- Clients age 18-24 had the lowest penetration rates for all types of services in 2001-2002 and 2006-2007.
- Penetration rates across all clients age 18+ decreased slightly from 2001-2002 to 2006-2007 for all types of services.
- Penetration rates for clients age 60+ increased slightly from 2001-2002 to 2006-2007 for all types of services.
- Penetration rates for clients age 18-59 decreased slightly from 2001-2002 to 2006-2007 for all types of services.

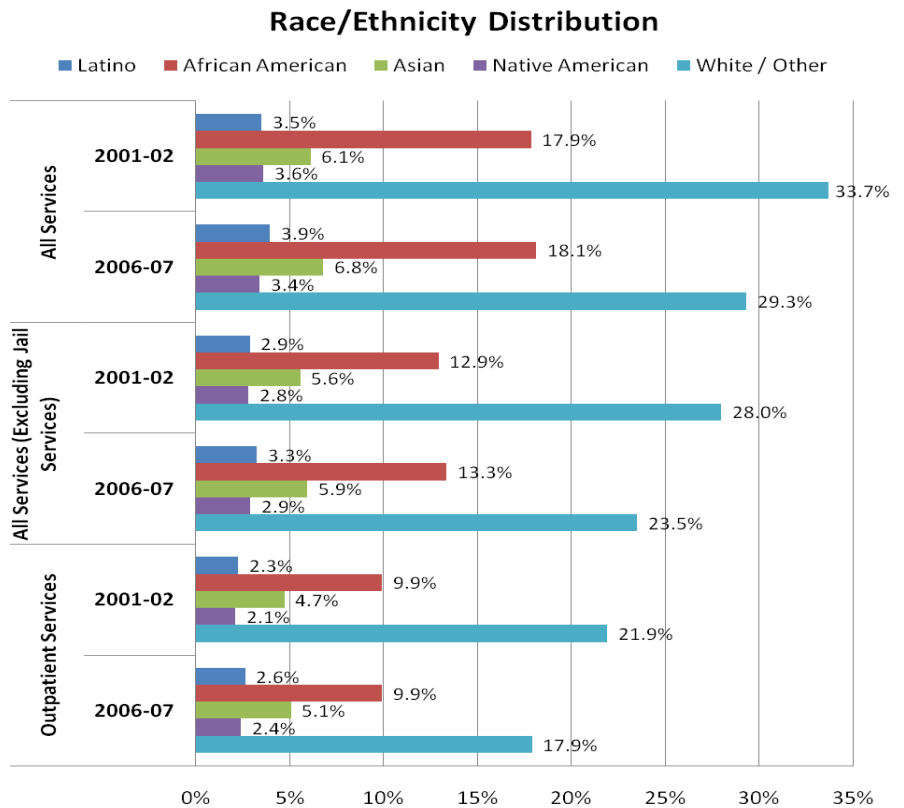


All Services				
	Potential clients		Actual clients	
	San Diego County Uninsured or Medicaid under 200% FPL		AOAMHS Clients	
	2001-02	2006-07	2001-02	2006-07
Age 18-24	74,552	76,425	5,232	5,061
Age 25-59	242,191	248,273	30,651	29,725
Age 60+	19,410	19,897	3,118	3,338
Total	336,154	344,596	39,001	38,124

Adult Penetration Rates by Race/Ethnicity for Clients Age 18-59

Penetration rates for all services, all services excluding jail services, and outpatient services were examined across five race/ethnicity groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Penetration rates were calculated as number of actual clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who received services (AOAMHS clients) divided by number of potential clients (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries) within that racial/ethnic group. Differences in penetration rates were examined across years by comparing penetration rates in 2001-2002 to penetration rates in 2006-2007.

- White clients had the highest penetration rates for all types of services in 2001-2002 and 2006-2007.
- Latino, Native American, and Asian clients had the lowest penetration rates for all types of services in 2001-2002 and 2006-2007.
- Penetration rates among White clients decreased from 2001-2002 to 2006-2007 for all types of services.
- Penetration rates among Latino, African American, Asian, and Native American clients increased slightly from 2001-2002 to 2006-2007 for all types of services.



	All Services			
	Potential Clients		Actual Clients	
	San Diego County Uninsured or Medicaid under 200% FPL		A/OAMHS Clients	
	2001-02	2006-07	2001-02	2006-07
White	68,180	69,892	22,991	20,460
Latino	190,506	195,290	6,660	7,692
African American	24,211	24,819	4,323	4,499
Asian	27,591	28,284	1,686	1,917
Native American	6,256	6,413	223	218

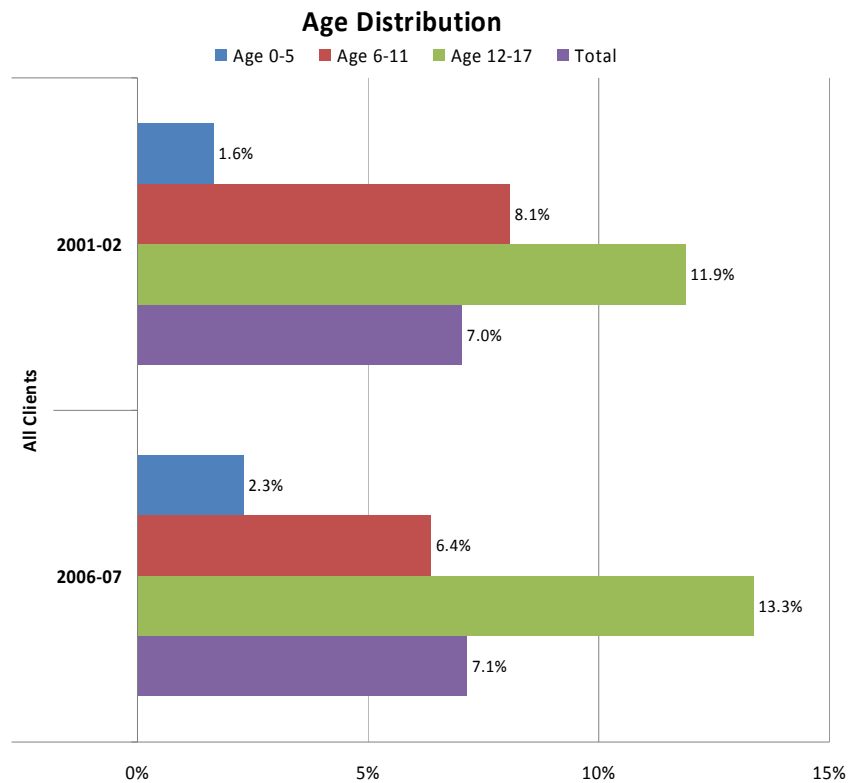
Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG) and CASRC (JRR, BG, SC), and SDCMHS

Children’s and Youth Penetration Rates by Age

Penetration rates for Children’s Mental Health Services clients were examined across three age groups: 0-5, 6-11, and 12-17. Penetration rates were calculated as number of actual clients within a specific age group (i.e. 0-5, 6-11, and 12-17) who received services (CMHS clients) divided by number of potential clients (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries) within that age group (i.e. 0-5, 6-11, and 12-17). Differences in penetration rates were examined across years by comparing penetration rates in 2001-2002 to penetration rates in 2006-2007.

- Clients age 12-17 had the highest penetration rates in 2001-2002 and 2006-2007.
- Clients age 0-5 had the lowest penetration rates in 2001-2002 and 2006-2007.
- Penetration rates for clients age 0-5 increased slightly from 2001-2002 to 2006-2007.
- Penetration rates across clients age 6-11 decreased slightly from 2001-2002 to 2006-2007.
- Penetration rates for clients age 12-17 increased slightly from 2001-2002 to 2006-2007.



All Clients				
	Potential clients		Actual clients	
	San Diego County Uninsured or Medicaid under 200% FPL		CMHS Clients	
	2001-02	2006-07	2001-02	2006-07
Age 0-5	78,728	80,705	1,294	1,850
Age 6-11	76,077	77,987	6,146	4,959
Age 12-17	70,778	72,555	8,410	9,684
Total	225,583	231,247	15,850	16,493

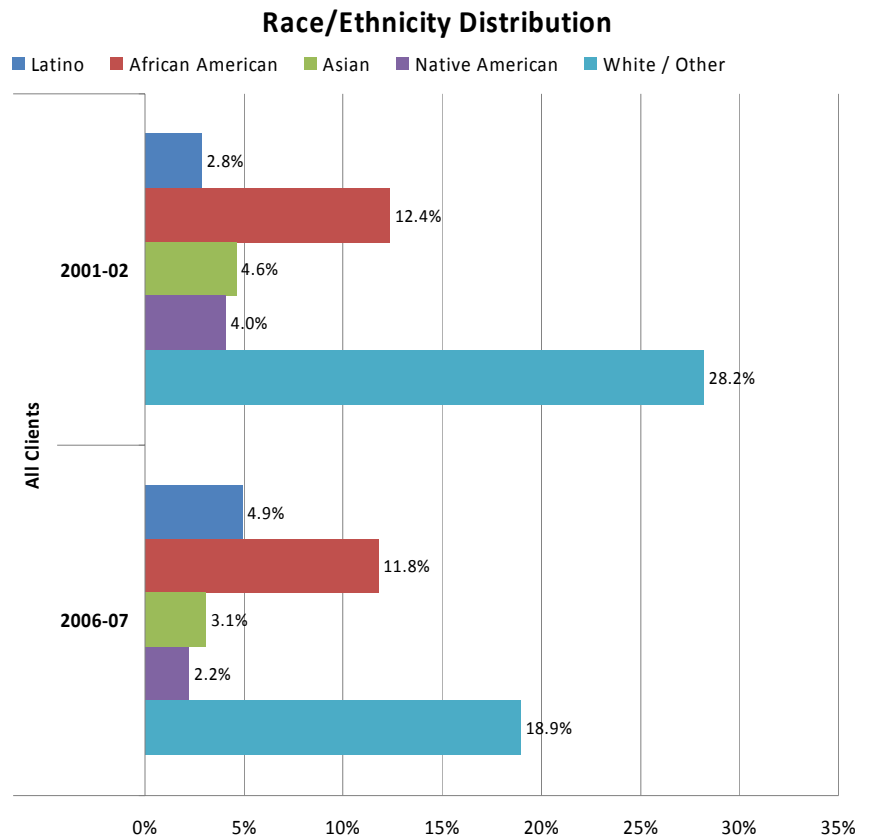
Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG) and CASRC (JRR, BG, SC), and SDCMHS

Penetration Rates by Race/Ethnicity for Age 0-17

Penetration rates for CMHS clients were examined across five race/ethnicity groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Penetration rates were calculated as number of actual clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who received services (CMHS clients) divided by number of potential clients (San Diego County residents under 200% FPL who were either uninsured or Medi-Cal beneficiaries) within that racial/ethnic group. Differences in penetration rates were examined across years by comparing penetration rates in 2001-2002 to penetration rates in 2006-2007.

- White clients had the highest penetration rates for all types of services in 2001-2002 and 2006-2007.
- Latino, Native American, and Asian clients had the lowest penetration rates in 2001-2002 and 2006-2007.
- Penetration rates among Latino clients increased from 2001-2002 to 2006-2007.
- Penetration rates among White, African American, Asian, and Native American clients decreased from 2001-2002 to 2006-2007.



	All Services			
	<u>Potential Clients</u>		<u>Actual Clients</u>	
	San Diego County Uninsured or Medicaid under 200% FPL		CMHS Clients	
	2001-02	2006-07	2001-02	2006-07
White	28,660	29,379	8,082	5,565
Latino	159,771	163,783	4,549	8,033
African American	19,799	20,296	2,446	2,390
Asian	12,757	13,077	587	400
Native American	4,597	4,712	186	105

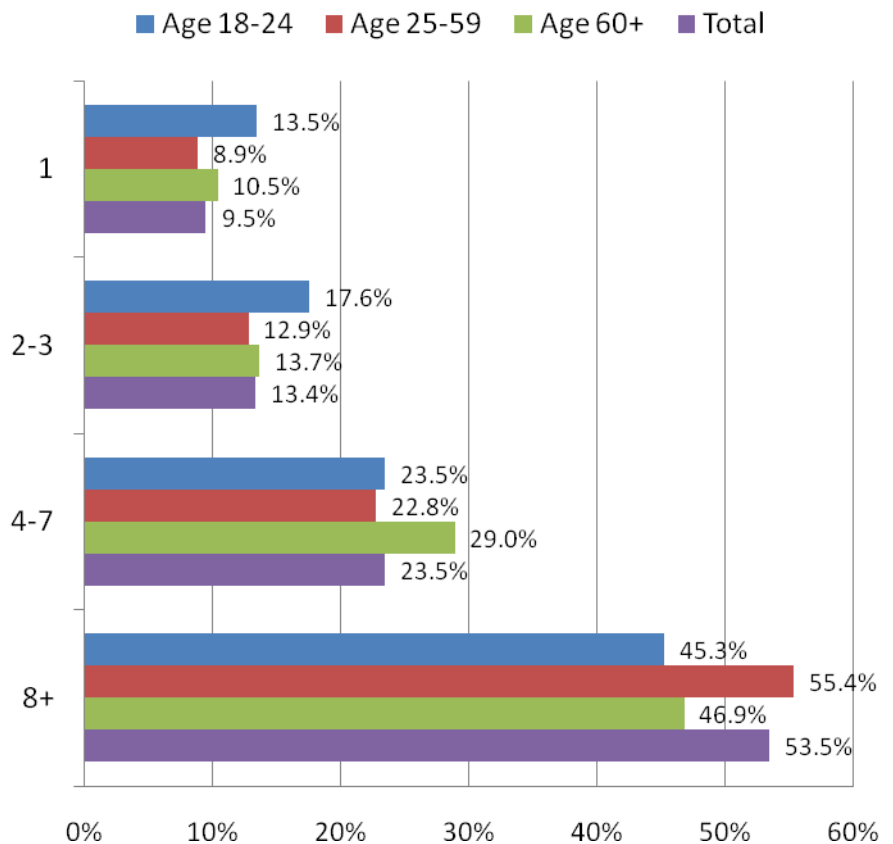
Adult and Older Adult Retention Rates by Age for Number of Outpatient Visits

Outpatient service retention rates for AOAMHS clients were examined in 2006-2007 across three age groups: 18-24, 25-59, and 60+. Retention rates were calculated as number of clients within a specific age group (i.e. 18-24, 25-59, and 60+) who received services divided by number of total clients within that age group (i.e. 18-24, 25-59, and 60+).

Number of Visits by Age

24,103 Unique Clients

- 54% of all clients had retention rates of 8 or more visits.
- Clients age 25-59 had the highest retention rates, and were more likely than the other age groups to continue services past 8 visits.
- Clients age 18-24 had the lowest retention rates, and were more likely than the other age groups to drop services in under 4 visits.
- Clients age 60+ were most likely than the other age groups to drop services in 4-7 visits.



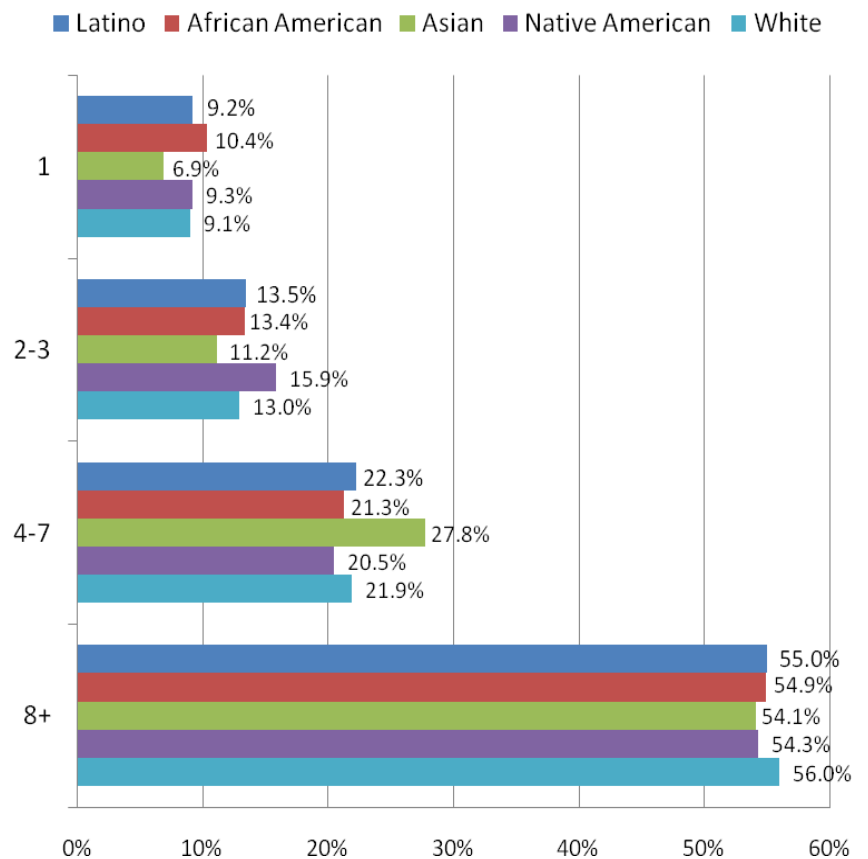
Adult Retention Rates by Race/Ethnicity for Number of Outpatient Visits

Outpatient service retention rates for AOAMHS clients were examined in 2006-2007 across five racial/ethnic groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Retention rates were calculated as number of clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who received services divided by number of total clients within that racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites).

- White clients had the highest retention rates, and were slightly more likely than the other racial/ethnic groups to continue services past 8 visits. However, retention rates of 8 or more visits did not vary significantly between racial/ethnic groups.
- Asian and Native American clients had the lowest retention rates. However, retention rates of 8 or more visits did not vary significantly between racial/ethnic groups.
- African American clients were more likely than the other racial/ethnic groups to drop services after 1 visit.
- Native American clients were more likely than the other racial/ethnic groups to drop services in 2-3 visits.
- Asian clients were more likely than other racial/ethnic groups to drop services in 4-7 visits.

Number of Visits by Race/Ethnicity

19,719 Unique Clients Age 18 - 59



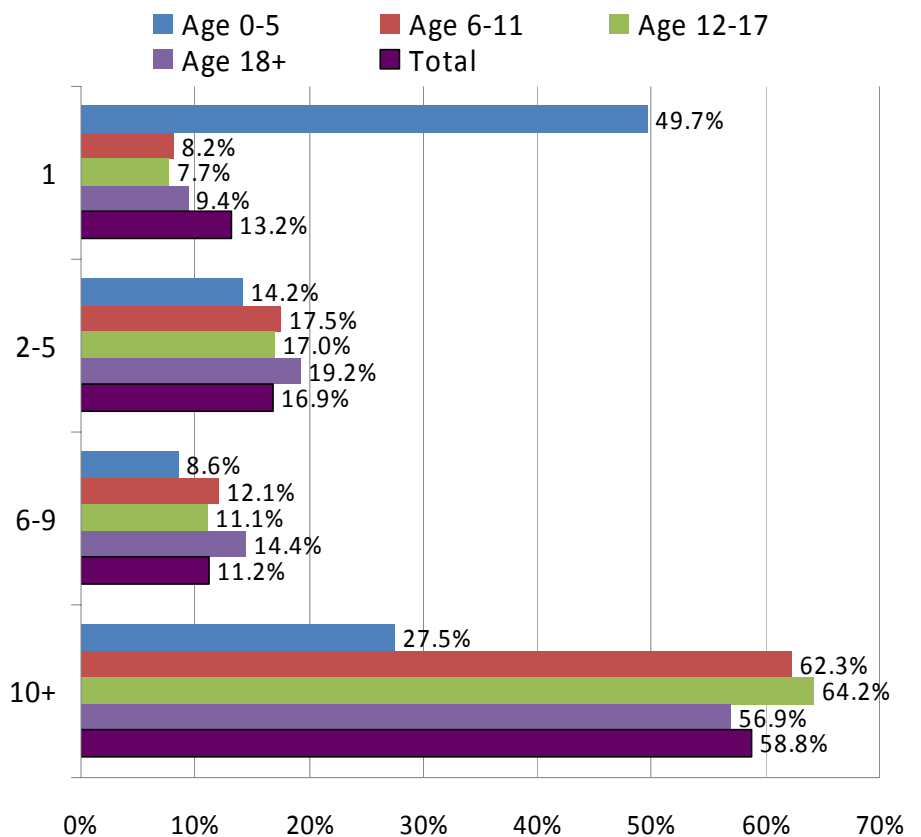
Child and Youth Retention Rates by Age for Number of Visits

Service retention rates for CMHS clients were examined in 2006-2007 across four age groups: 0-5, 6-11, 12-17, 18+. Retention rates were calculated as number of clients within a specific age group (i.e. 0-5, 6-11, 12-17, 18+) who received services divided by number of total clients within that age group (i.e. 0-5, 6-11, 12-17, 18+). Note: Visit data was not available for clients served solely by the JFS and Spectrum programs; these clients are excluded from the figure below.

Number of Visits by Age

14,454 Unique Clients

- Retention rates varied significantly by client age.
- 59% of all clients had retention rates of 10 or more visits.
- Clients age 6-11 and 12-17 had the highest retention rates, and were more likely than the other age groups to continue services past 10 visits.
- Clients age 0-5 had the lowest retention rates, and were much more likely than the other age groups to drop services after 1 visit.



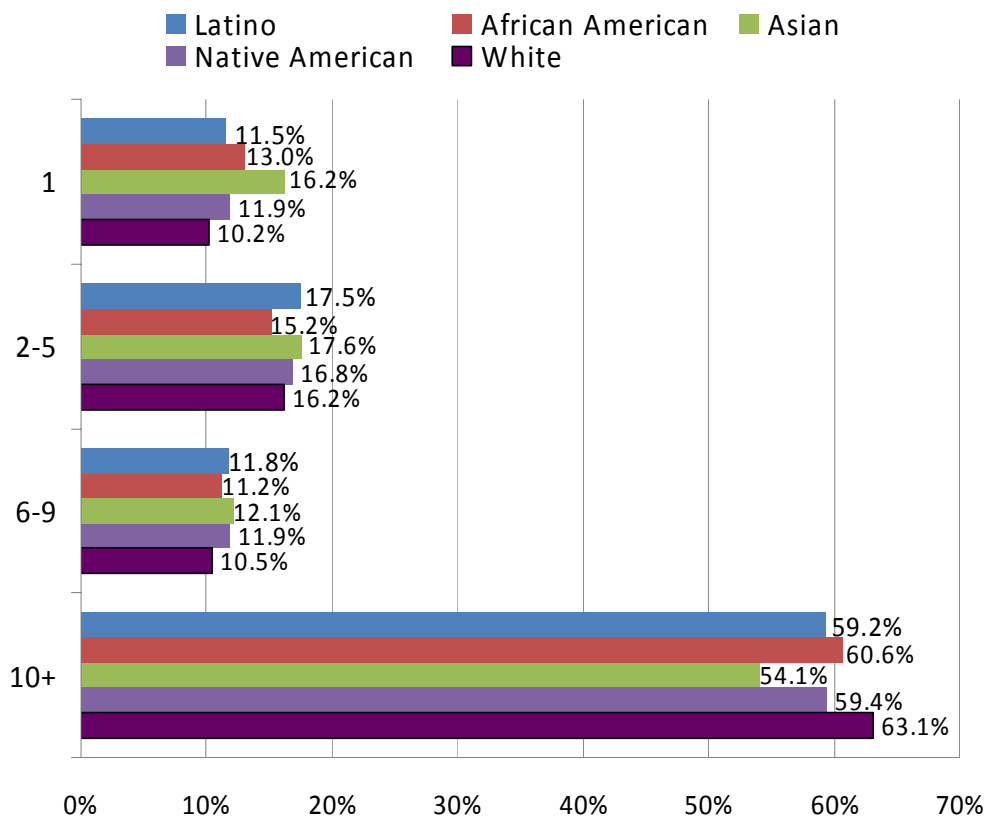
Child and Youth Retention Rates by Race/Ethnicity for Number of Visits

Service retention rates for CMHS clients were examined in 2006-2007 across five racial/ethnic groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Retention rates were calculated as number of clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who received services divided by number of total clients within that racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites). Note: Visit data was not available for clients served solely by the JFS and Spectrum programs; these clients are excluded from the figure below.

- Retention rates varied significantly by race/ethnicity.
- White clients had the highest retention rates, and were more likely than the other racial/ethnic groups to continue services past 10 visits.
- Asian clients had the lowest retention rates and were more likely than the other racial/ethnic groups to drop services after 1 visit.

Number of Visits by Race/Ethnicity

13,579 Unique Clients Age 0 - 18

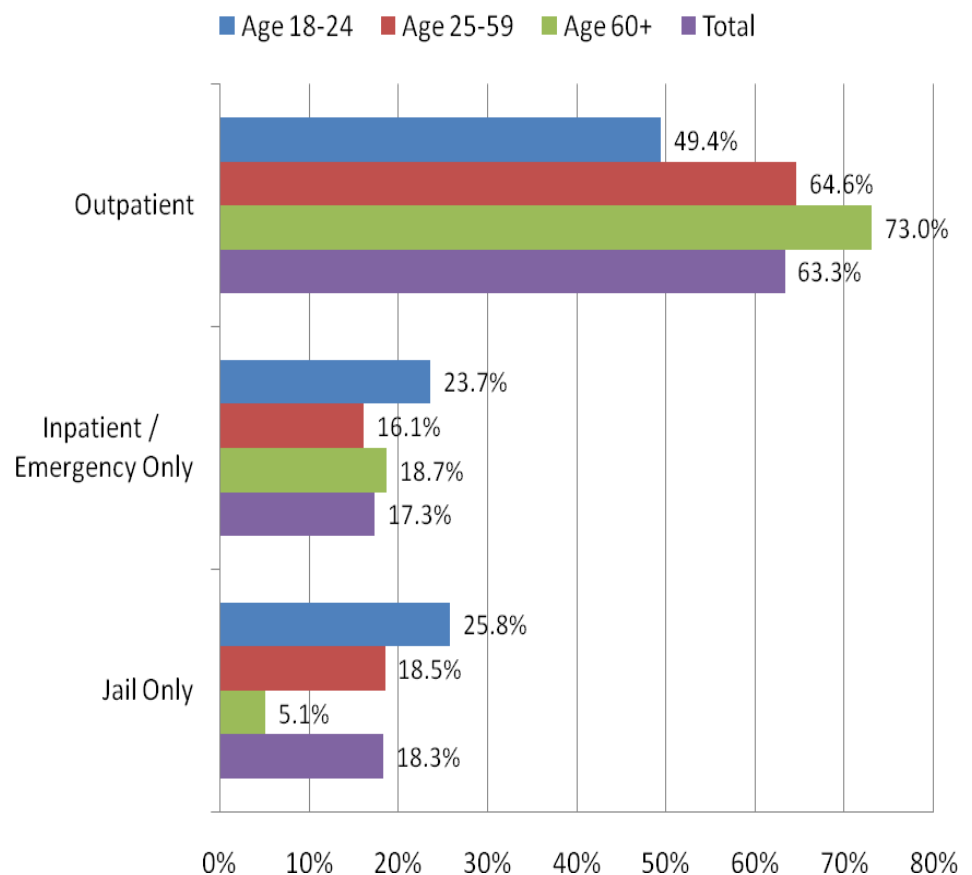


Disparities in Service Utilization by Age and by Race/Ethnicity

Type of Services Used by Age – Adult and Older Adult

A goal of AOAMHS has been to increase use of outpatient services and decrease use of inpatient/emergency services. Types of services used by all AOAMHS clients were examined in 2006-2007 across three age groups: 18-24, 25-59, and 60+. Utilization rates were calculated as number of clients within a specific age group (i.e. 18-24, 25-59, and 60+) who used a specific type of service (i.e. outpatient, inpatient/emergency, and jail only) divided by number of total clients within that age group (i.e. 18-24, 25-59, and 60+).

Age Distribution

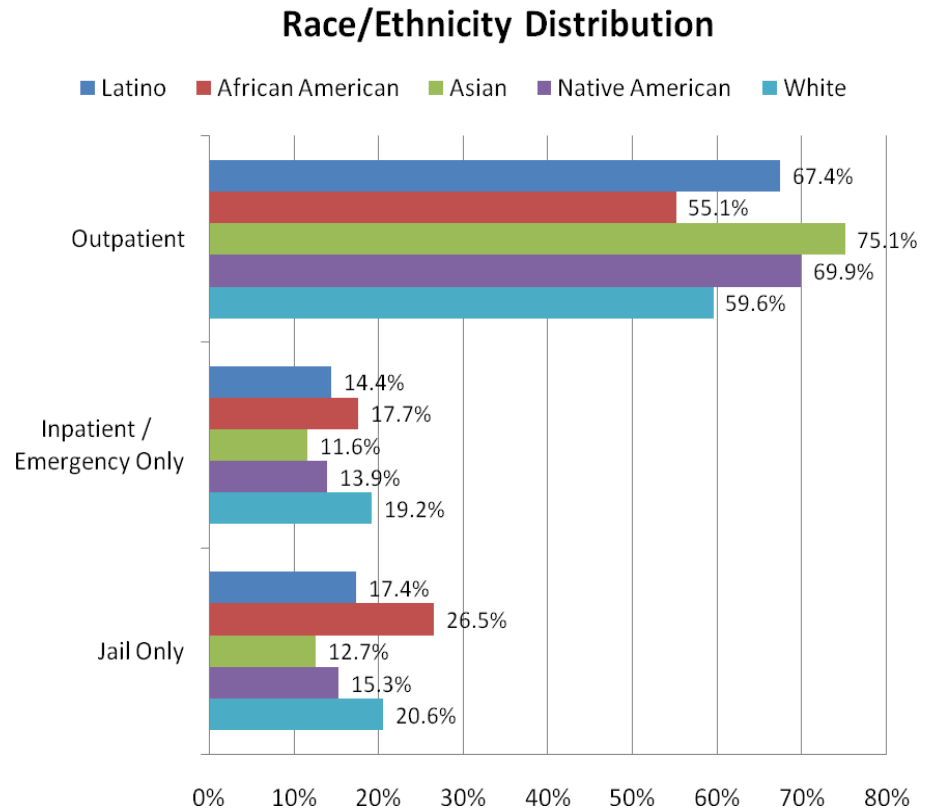


- 63% of all clients use outpatient services.
- Clients age 18-24 used more inpatient/emergency and jail only services and less outpatient services than the other age group.
- Clients age 60+ used more outpatient services than other age group.
- Clients age 25-59 used fewer inpatient/emergency services than other age group.

Type of Services Used by Race/Ethnicity – Adult and Older Adult

Types of services used by AOAMHS clients were examined in 2006-2007 across five racial/ethnic groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Utilization rates were calculated as number of clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who used a specific type of service (i.e. outpatient, inpatient/emergency, and jail only) divided by number of total clients within that race/ethnicity group.

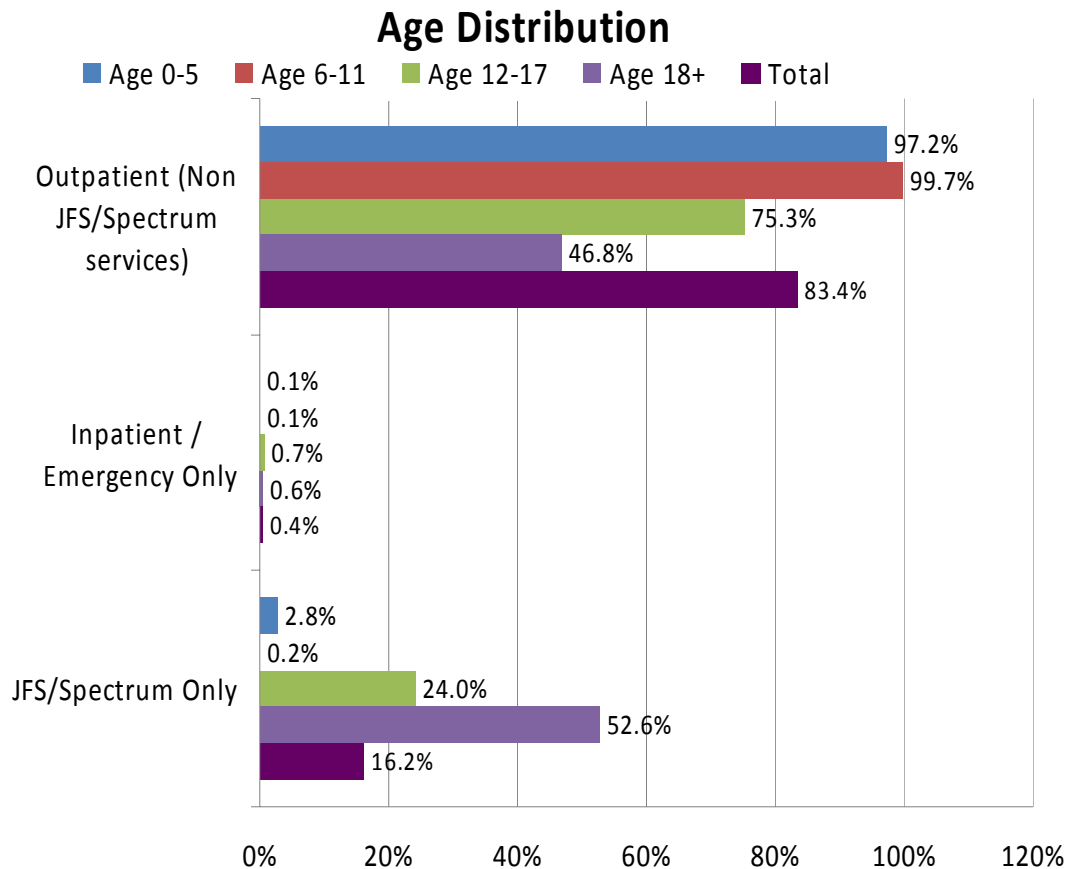
- White and African American clients used more inpatient/emergency and jail only services and less outpatient services than the other racial/ethnic group.
- Asian, and to a lesser extent, Native American clients, used more outpatient services and fewer inpatient/emergency and jail only services than other racial/ethnic group.



Type of Services Used by Age - Children and Youth

A goal of CMHS has been to increase use of outpatient services and decrease use of inpatient/emergency services. Types of services used by all CMHS clients were examined in 2006-2007 across four age groups: 0-5, 6-11, 12-17, 18+. Utilization rates were calculated as number of clients within a specific age group (i.e. 0-5, 6-11, 12-17, 18+) who used a specific type of service (i.e. outpatient, inpatient/emergency only, and JFS/Spectrum only) divided by number of total clients within that age group (i.e. 0-5, 6-11, 12-17, 18+).

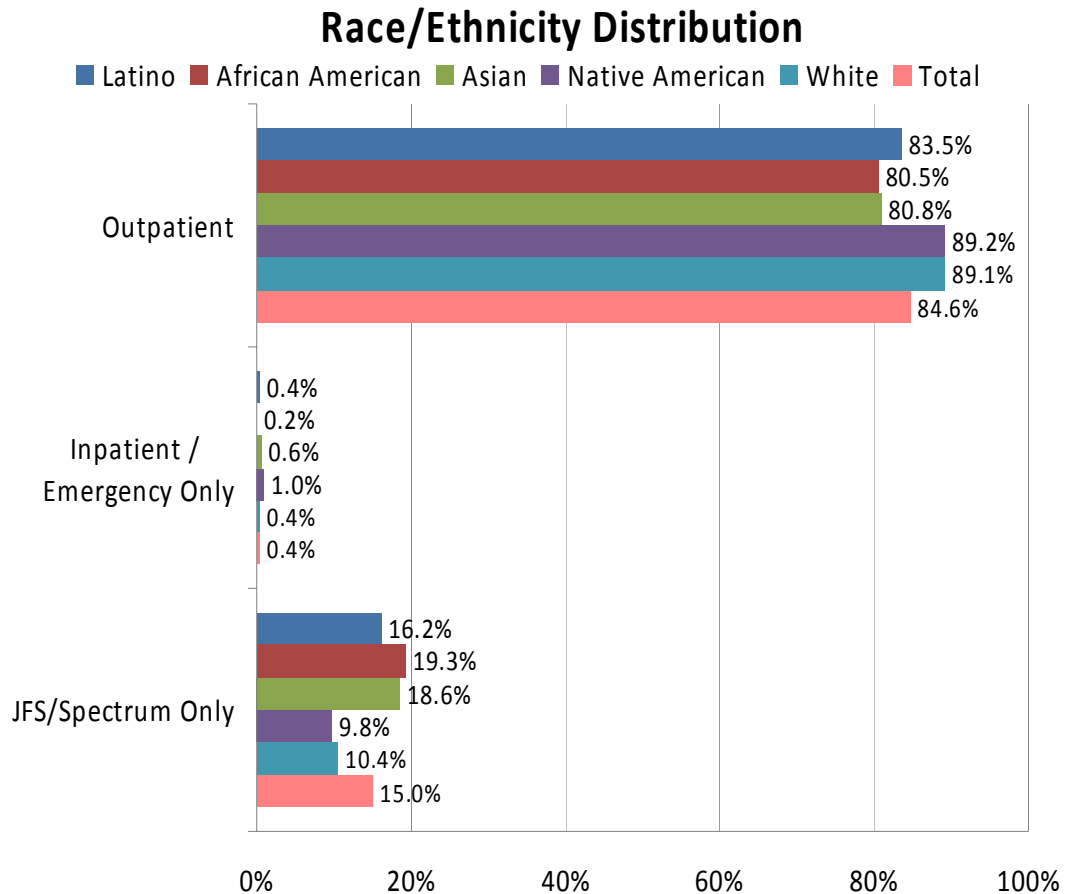
- 83% of all clients used outpatient services.
- Few clients used only inpatient/emergency services during the fiscal year.
- Clients age 12-17 and 18+ used more JFS/Spectrum only services and less outpatient services than the other age groups.
- Few clients under age 12 used JFS/Spectrum only services.



Type of Services Used by Race/Ethnicity - Children and Youth

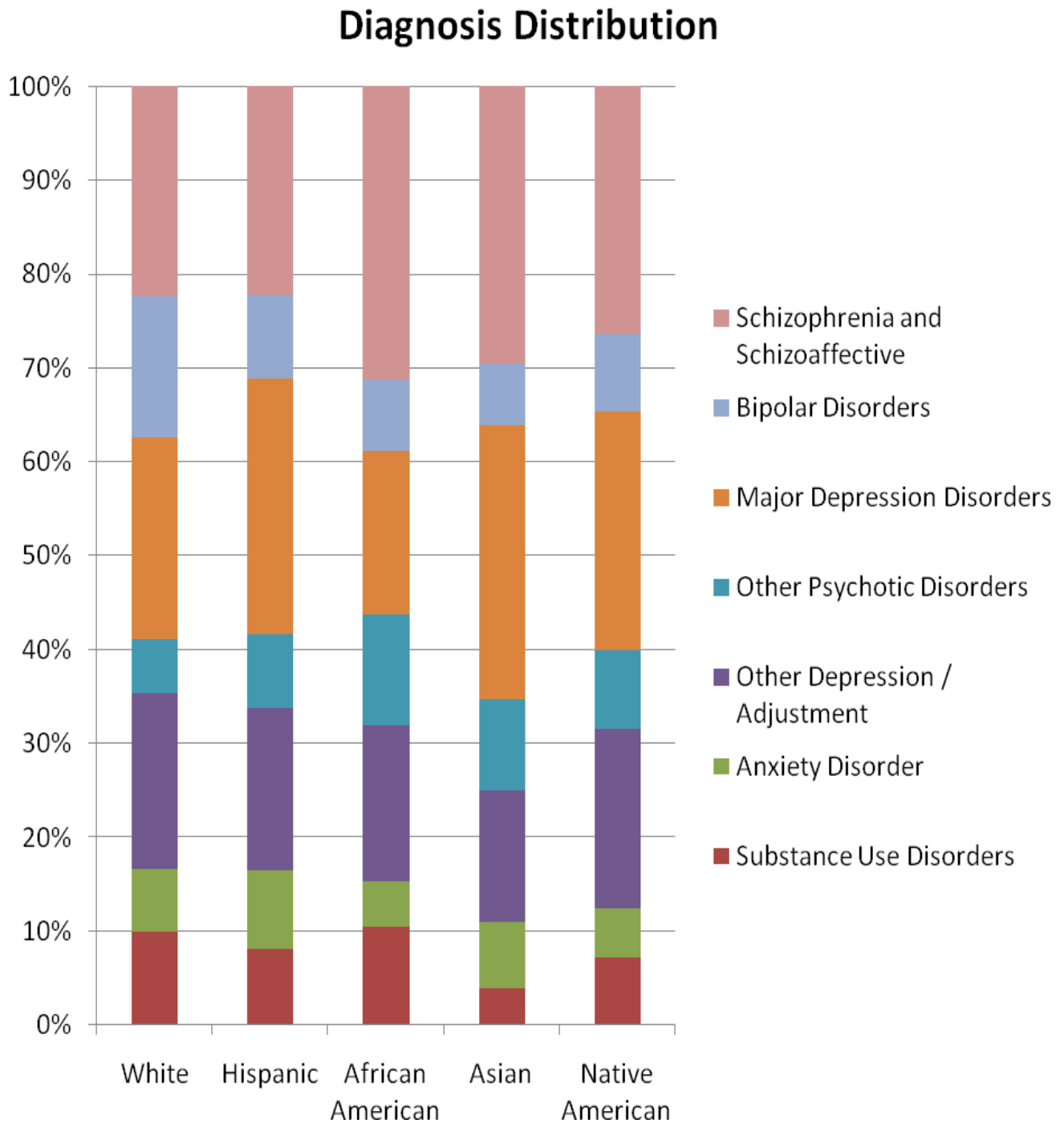
Types of services used by CMHS clients were examined in 2006-2007 across five racial/ethnic groups: Latinos, African Americans, Asians, Native Americans, and Whites/other. Utilization rates were calculated as number of clients within a specific racial/ethnic group (i.e. Latinos, African Americans, Asians, Native Americans, and Whites/other) who used a specific type of service (i.e. outpatient, inpatient/emergency only, and JFS/Spectrum only) divided by number of total clients within that race/ethnicity group.

- The majority of clients used non-JFS / Spectrum outpatient services, while few clients used only inpatient or emergency services.
- African American and Asian clients used more JFS/Spectrum only services and less outpatient services than the other racial/ethnic groups.
- Native American clients used more outpatient services, more inpatient /emergency only services, and fewer JFS/Spectrum only services than other racial/ethnic groups.
- White clients used more outpatient services and fewer JFS/Spectrum only services than other racial/ethnic groups other than Native American.



Disparity in Diagnosis by Age and by Race/Ethnicity

Diagnosis by Race/Ethnicity (Adult)

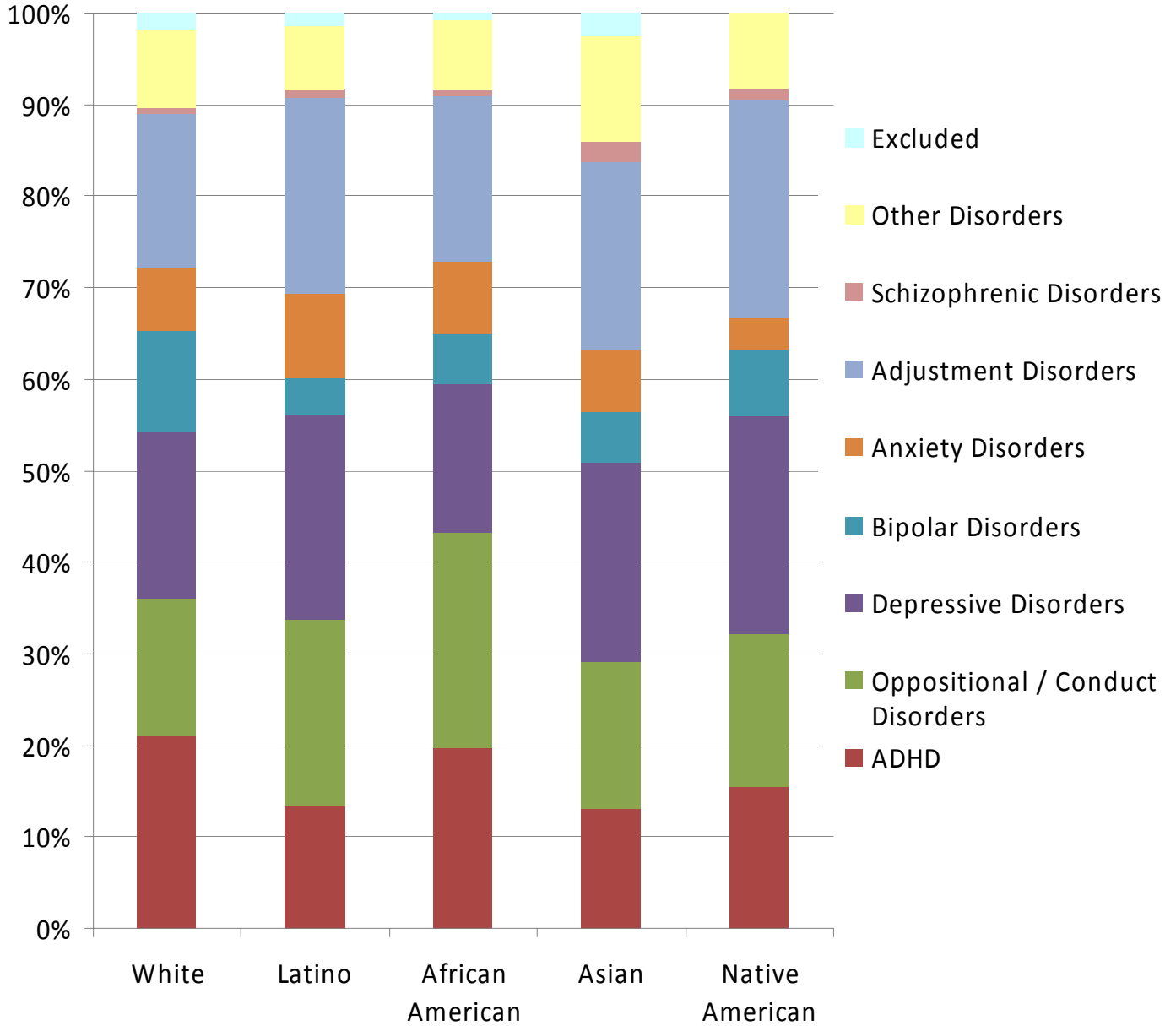


Diagnosis by Race/Ethnicity - Adult- Older Adult

- Schizophrenia/schizoaffective, bipolar disorder, major depression disorder, other psychotic disorder, other depression/adjustment disorder, anxiety disorder, and substance abuse disorder diagnosis rates were examined for five racial/ethnic groups: Latinos, African Americans, Asians, Native Americans, and Whites/other.
- African American clients had the highest prevalence rates of Schizophrenia and Schizoaffective disorders, while Hispanic clients had the lowest prevalence rates of Schizophrenia and Schizoaffective disorders.
- White clients had the highest prevalence rates of Bipolar disorders, while Asian clients had the lowest prevalence rates of Bipolar disorders.
- Asian clients had the highest prevalence rates of Major Depression disorders, while African American clients had the lowest prevalence rates of Major Depression disorders.
- African American clients had the highest prevalence rates of Other Psychotic disorders, while white clients had the lowest prevalence rates of Other Psychotic disorders.
- White and Native American clients had the highest prevalence rates of Other Depression/Adjustment disorders, while Asian clients had the lowest prevalence rates of Other Depression/Adjustment disorders.
- Hispanic clients had the highest prevalence rates of Anxiety disorders, while African American clients had the lowest prevalence rates of Anxiety disorders.
- African American clients had the highest prevalence rates of Substance Use disorders, while Asian clients had the lowest prevalence rates of Substance Use disorders.

Diagnosis by Race/Ethnicity - Children and Youth

Diagnosis Distribution



Diagnosis by Race/Ethnicity - Children and Youth

- White clients had the highest prevalence rates of Bipolar disorders and ADHD, while Latino clients had the lowest prevalence rates of these disorders.
- Asian clients had the highest prevalence rates of Major Depression disorders, while African American clients had the lowest prevalence rates of Major Depression disorders.
- African American clients had the highest prevalence rates of Oppositional/Conduct disorders, and the lowest prevalence rates of Depressive disorders.
- Asian/Pacific Islander clients had the highest prevalence rates of Schizophrenic disorders, while African American clients had the lowest prevalence rates of Schizophrenic disorders.
- Native American clients had the lowest prevalence rates of Anxiety disorders.
- White clients had the lowest prevalence rates of Adjustment disorders

Current Workforce Diversity

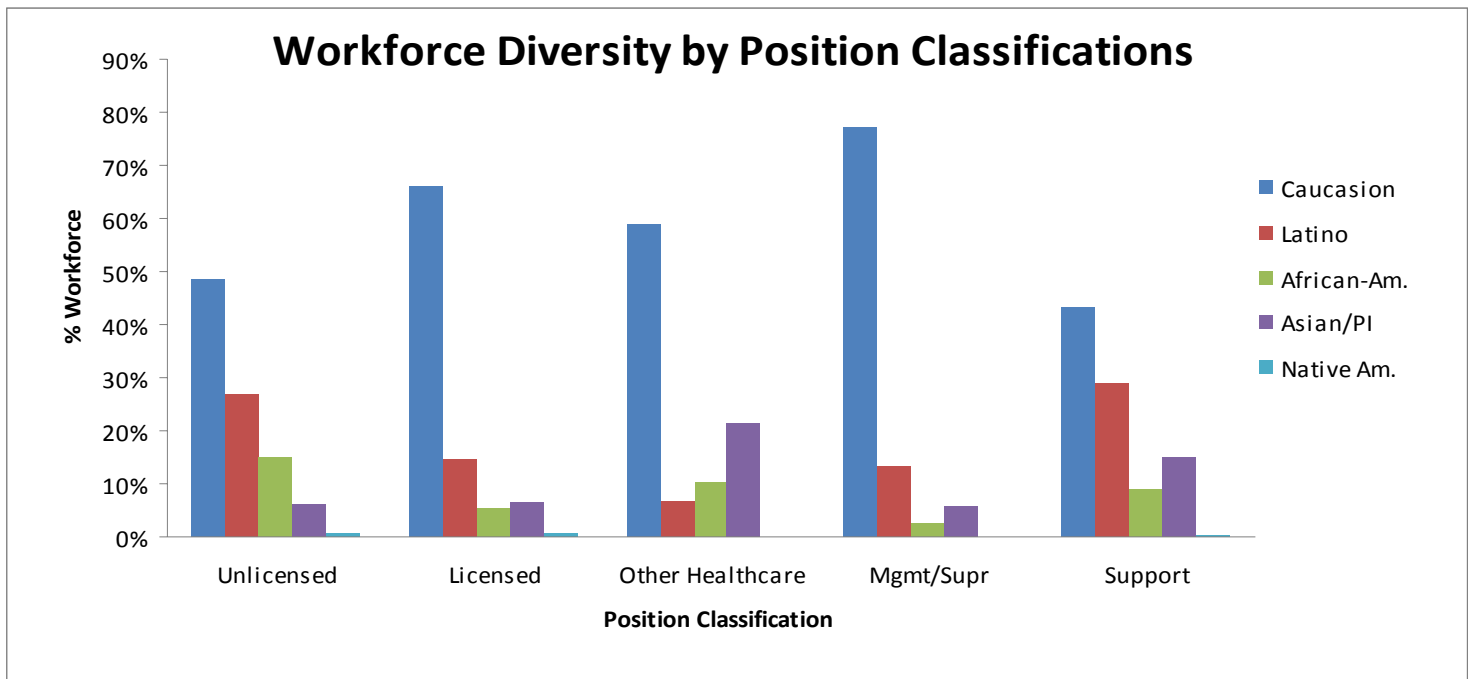
Current Workforce Diversity

Data shows that the overall mental health workforce in San Diego County is considerably diverse. However, the ethnic diversity of the workforce does not mirror that of the mental health population. Future efforts to increase the diversity of workforce may aid in reducing health disparities.

Overall, the workforce is 59% Caucasian, 19% Latino/Hispanic, 9% African Americans/Blacks, 8% Asian/Pacific Islanders, and 1% Native American¹.

An examination of the diversity in the workforce by position classification yields the following additional information:

- Diversity of Managerial and Supervisory Staff is the lowest of all occupational classifications. Twenty-three percent of Managerial and Supervisory Staff are of diverse ethnicities.
- The diversity of Unlicensed Direct Staff and Support Staff are closest to the 56% diversity of those being served in the public mental health system. Diversity of Unlicensed Direct Staff and Support Staff are 51% and 57% respectively.

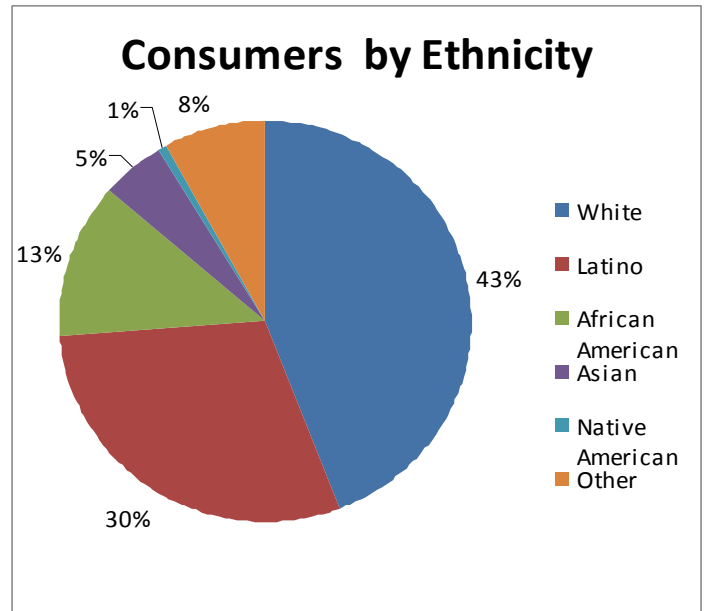
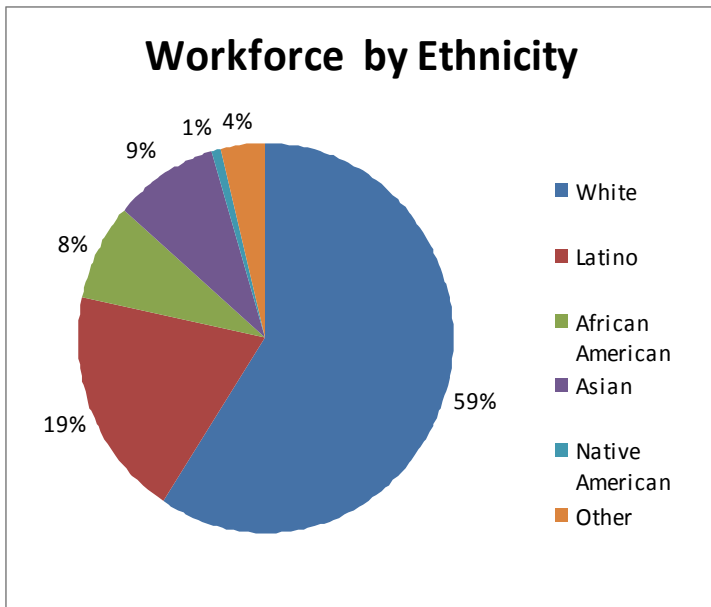


¹ County of San Diego Mental Health Services, "Workforce Employment and Training Needs Assessment," MHA Proposition 63.

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

Provided below is a detailed breakdown of the comparison between diversity in the mental health workforce and the population served.

- Overall, 41% of the workforce is ethnically and culturally diverse, whereas 57% of the population served is ethnically and culturally diverse.
- Caucasians and Asians are overrepresented in the workforce, while African Americans and Latinos are underrepresented.



ATTACHMENTS
Research Article Summary
Race/Ethnicity Determination
GLOSSARY

Research Article Summary

Access to public mental health services among older adults with severe mental illness

Todd P. Gilmer, Ph.D., Victoria D. Ojeda, Ph.D., M.P.H., Dahlia Fuentes, M.P.H., M.S.W., Viviana Criado, M.P.A., and Piedad Garcia, Ed.D.

2008 *International Journal of Geriatric Psychiatry*, published online.

The San Diego County Adult and Older Adult Mental Health Services (AOAMHS) Managements Information System (MIS) was used in this study to examine client data. The purpose of this study was to investigate how older adults first access the mental health system, which could potentially inform intervention strategies.

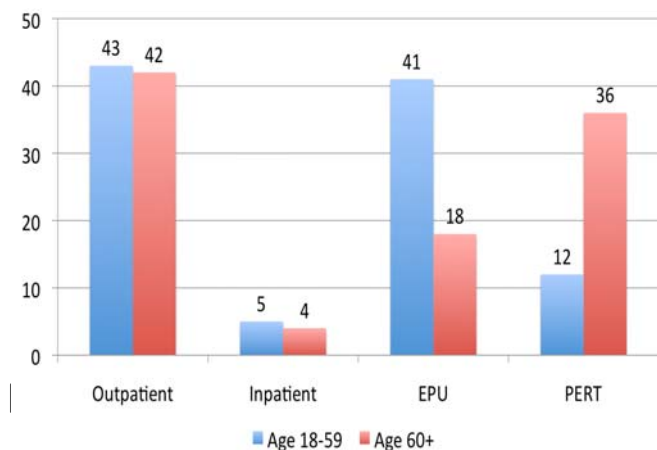
Older adults were defined as those age 60+. Emergency services were separated into EPU (psychiatric emergency unit) and PERT (psychiatric emergency response team). Inpatient services were defined as admissions to acute psychiatric inpatient and crisis residential facilities, and outpatient services were defined as case management, individual or group therapy, and medication management.

Analyses aimed to compare type of services used in older adults vs younger adults, and to investigate which type of service was most likely to be the point of access for older adults: emergency, inpatient, or outpatient services.

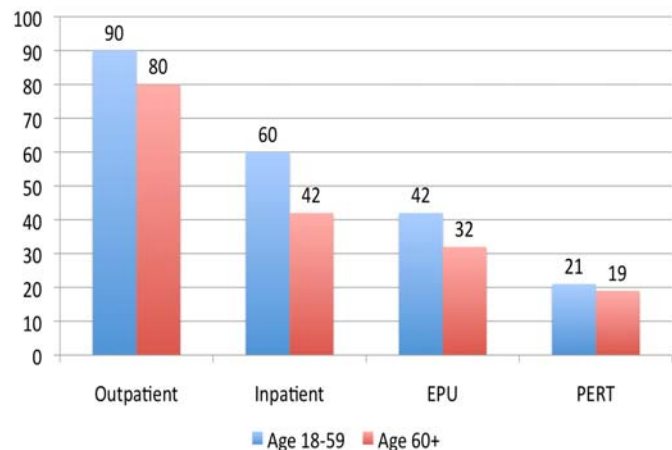
Results indicated that older adults were less likely to use inpatient care as point of contact when compared to younger adults. Older adults were also much less likely to use EPU emergency services as point of contact when compared to younger adults, but much more likely to use PERT response team emergency services. Researchers attribute the increased use of PERT in older adults as being partly due to the decrease in EPU use. However, older adults were also significantly less likely to receive follow up care when compared to younger adults. Additionally, only 48% of older adults compared to 61% of adults age 60 and under used follow up services within 90 days of initial contact.

The researchers suggest that the link between PERT and outpatient providers be improved in order to support older adults to receive follow up care. They also suggest that specific programs and efforts be made at outpatient programs to retain older adults. FSPs (Full Service Partnerships) are suggested as one way to improve these problems.

Percent Initiating by Type of Service



Percent Receiving Any Additional Service
by Type of First Service



Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG)
and CASRC (JRR, BG, SC), and SDCMHS

Progress Towards Reducing Disparities: A Report for San Diego County Mental Health
Initiation and Use of Public Mental Health Services by Persons With Severe Mental Illness and Limited English Proficiency

Todd P. Gilmer, Ph.D., Victoria D. Ojeda, Ph.D., M.P.H., David P. Folsom, M.D., M.P.H., Dahlia Fuentes, M.P.H., M.S.W., Piedad Garcia, Ed.D., and Dilip V. Jeste, M.D.

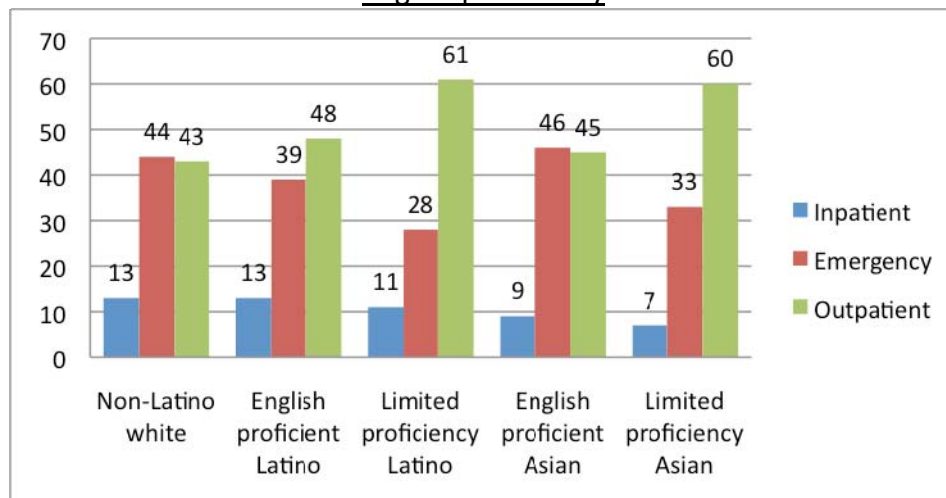
2007 *Psychiatric Services*, 58(12), 1555-1562.

The San Diego County Adult and Older Adult Mental Health Services (AOAMHS) Managements Information System (MIS) was used in this study to examine client data. Asian and Latino clients were identified and compared to Caucasian clients. Asian and Latino clients were also identified as either English speaking, or non English speaking. However, this was simply determined by the client’s preference for language spoken at their provider. The researchers refer to this as “English proficiency vs limited English proficiency”.

The data were analyzed to compare use of emergency, inpatient, and outpatient services between English speaking Asians vs non English speaking Asians, English speaking Latinos vs non English speaking Latinos, and all groups vs Caucasians. The researchers hypothesized that the non English speaking groups would be more likely to use emergency services and less likely to use outpatient services than the English speaking groups. It is important to note that the English speaking Asians and Latinos had a higher prevalence of Schizophrenia and lower prevalence of Depression when compared to the non English speaking Asians and Latinos.

Results indicated that, when looking at point of access and 6 month follow up, non English speaking Asians and Latinos were more likely to use outpatient services and less likely to use emergency services than English speaking Asians, Latinos, and Caucasians. When looking at the 12 and 18 month follow up after initial point of access, there were no statistically significant differences in types of services (emergency, inpatient, or outpatient) used between non English vs English speaking Asians, Latinos, and Caucasians.

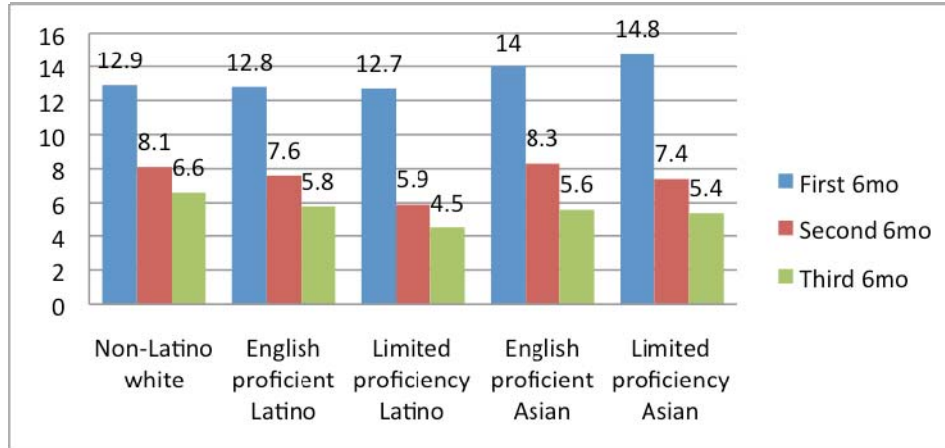
Point of first contact (%) with the mental health system for non-Latino white, Latino, and Asian clients, by English proficiency



When looking specifically at number of outpatient services used, non English speaking Latinos used fewer outpatient services compared to English speaking Latinos, but number of outpatient services used by non English speaking and English speaking Asians did not differ.

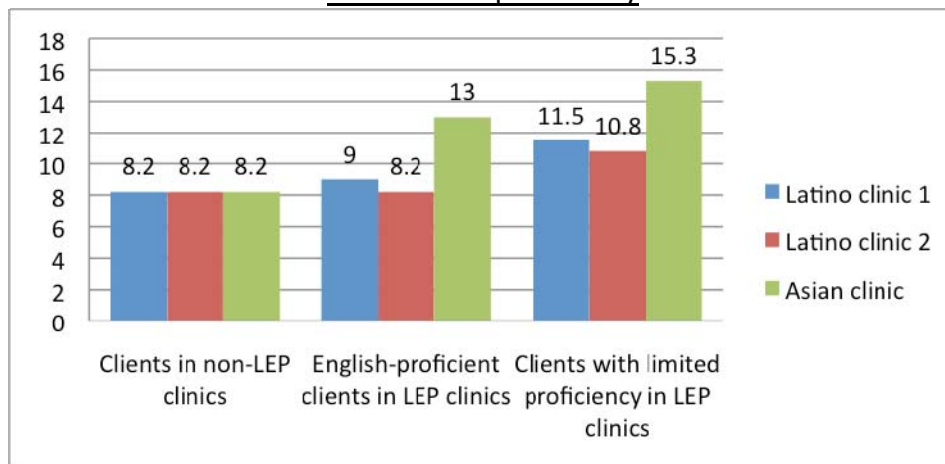
Progress Towards Reducing Disparities: A Report for San Diego County Mental Health

Number of outpatient mental health services visits in three six-month periods after first use of the system among non-Latino white, Latino, and Asian clients who were English proficient or of limited proficiency



Researchers found that 82% of non English speaking Asian clients received the majority of their services from a clinic that specialized in the Pan-Asian community, and that 32% of non English speaking Latino clients received the majority of their services from one of two clinics that specialized in the Latino community. Clients in these clinics, especially those who were non English speakers, were more likely to use outpatient services than clients from other clinics.

Number of outpatient mental health visits at clinics serving large numbers of clients with limited English proficiency (LEP clinics) among 9,243 non-Latino white, Latino, and Asian clients who were English proficient or of limited proficiency



The researchers partly attribute these findings to the theory that non English speaking clients have higher levels of familial and other social support to help direct them to the right type of services (i.e. these bilingual clinics, or outpatient services in general). The researchers suggest that these bilingual clinics are especially successful in supporting underserved clients (and clients in general) to use outpatient rather than emergency type services, and that further funding and research should be directed toward these clinics.

Race/Ethnicity Determination

How race/ethnicity is defined:

Race/ethnicity data were collected from InSyst, which follows the United States Census Bureau definitions of race. The term race/ethnicity reflects a social/cultural definition. The definition of race/ethnicity does not conform to any biological, anthropological or genetic criteria. Hispanic ethnicity is tracked separately than race. People who identify their origin as Spanish, Hispanic, or Latino are classified as Hispanic but may be of any race (i.e. White or African American). See the following website for further information:

<http://www.census.gov/PressRelease/www/2001/raceqandas.html>

How race/ethnicity is determined in InSyst:

InSyst contains two variables that are used to determine race/ethnicity. For each client the RACE variable contains one of 35 possible descriptions. Each description corresponds to a Race/Ethnicity value (see below). If the HISPANIC_ORIGIN variable is set to 1, the race/ethnicity is set to Hispanic regardless of the ethnicity description.

Description in InSyst	Race/Ethnicity Determination in InSyst
African American	African American
Amerasian	Asian
Asian Indian	Asian
Cambodian	Asian
Chinese	Asian
Cuban	Hispanic
Dominican	Hispanic
Ethiopian	Other
Filipino	Asian
Guamanian	Asian
Hawaiian Native	Asian
Hmong	Asian
Iranian	Other
Iraqi	Other
Japanese	Asian
Korean	Asian
Laotian	Asian
Mexican American/Chicano	Hispanic
Multiple	Other
Native American	Native American
Other	Other
Other Asian	Asian
Other Hispanic	Hispanic
Other Latin American	Hispanic
Other Non-White	Other
Other Southeast Asian	Asian
Pacific Islander	Asian
Puerto Rican	Hispanic
Salvadoran	Hispanic
Samoan	Asian
Somali	Other
Sudanese	Other
Unknown	Unknown
Vietnamese	Asian
White	Caucasian

Race/Ethnicity Breakdown FY0607 Number of clients = 55,377		
Description	N	%
White	24,306	44%
African American	7,238	13%
Native American	339	0.6%
Asian	2,662	5%
Hispanic	16,596	30%
Other/Unknown	4,236	8%

Other / Unknown Subcategories		
Description	N	%
Unknown	2,564	61%
Other	789	19%
Iraqi	267	6%
Iranian	211	5%
Ethiopian	169	4%
Sudanese	63	1%
Somali	60	1%
Multiple	113	3%
Total	4,236	100%

Data Sources: UBH (1/2008 download)
Date Revised: 4/28/2009

Source: HSRC (AS, BL, JC, MS, ST, TG)
and CASRC (JRR, BG, SC), and SDCMHS

Glossary

200% FPL – Poverty level requirements to qualify for San Diego County mental health services; annual income for family of 2 less than \$29k.

Access – Having the necessary resources and ability to obtain mental health services.

AOAMHS – Adult and older adult mental health services; acronym for San Diego County adult mental health system.

CMHS – Children’s mental health services; acronym for San Diego County children’s mental health system.

Cultural Competency – Ability to interact effectively with people of different cultures and ethnicities.

Cultural Sensitivity – Awareness of cultural and ethnic differences, without judgments of right or wrong.

Disparities – Differences or inequalities between groups of people.

Emergency Services – One-time use services such as the psychiatric emergency room and psychiatric emergency response team.

Inpatient Services – Acute services, typically in psychiatric inpatient hospitals or crisis residential facilities.

Jail Services – Any mental health services offered to those serving jail sentences.

JFS/Spectrum Services – Services provided through the JFS and Spectrum programs. These services are typically delivered to Probation-involved youth, and are not entered into the INSYST billing system.

Outpatient Services – Services such as case management, individual or group therapy, and medication management.

Penetration –The degree to which services are used.

Racial/ethnic Identity – Identifying with a specific racial or ethnic group.

Retention – The ability to retain clients in services for a desired or necessary amount of time to maximize treatment effects.

Self-Awareness –Being aware of one’s own thoughts and the impact those thoughts or actions derived from those thoughts may have on other people.

Utilization –The manner in which a service is used.

