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Evaluation of Outcomes of Fresno County's Mental Health Prevention Programs

California's Proposition 63, which was signed into law as the Mental Health Services Act (MHSA), levied a 1-percent tax on personal income in excess of \$1 million, with the funds intended to be used for mental health services and supports. The MHSA specifically indicated that 20 percent of this funding should be dedicated to prevention and early intervention (PEI) services. California's PEI programs have various aims, with the following program categories: (1) prevention, (2) early intervention, (3) outreach for increasing recognition of early signs of mental illness, (4) stigma and discrimination reduction, (5) access and linkage to treatment for individuals with serious mental illness, (6) improving timely access to services for underserved populations, and (7) suicide prevention.

The state's PEI regulations state that county departments of behavioral health should measure appropriate outcomes and indicators for these PEI program types (California Code of Regulations, Title 9), but they do not provide specific guidance on which outcomes to measure and how to measure them. Many counties have struggled to measure PEI outcomes, in part because prevention programs often do not use electronic health records to capture participant data.

To address this challenge, the Fresno County Department of Behavioral Health (DBH) engaged

our RAND research team to design a web-based data collection tool for its prevention programs. We began by interviewing staff from Fresno County DBH's PEI programs to gather data on what the staff saw as the key outcomes they were trying to affect and the methods they were using to evaluate their programs. We used this information to identify core domains to measure in the prevention

KEY FINDINGS

- The participating county prevention programs serve a diverse population that experiences serious challenges with mental health and life functioning.
- Youth and adults alike experienced challenges in various domains: They had low self-efficacy, high perceived stress, low social support, and low overall life satisfaction.
- Adults served also reported low mental health knowledge and difficulty functioning in their day-to-day lives because of emotional issues.

outcomes tool, which included self-efficacy, perceived stress, emotional functioning, social support, and life satisfaction for both youth and adults; school attendance and classroom behavioral engagement for youth only; and resilience, general mental health knowledge, knowledge of how to seek or give help, attitudes about help-seeking, and stigma toward individuals with mental illness for adults only.

We identified brief, reliable, and valid measures for each of these outcome domains (described in the next section) and integrated them into youth and adult prevention outcome surveys. We then programmed a web-based tool that Fresno prevention programs could use to input demographic and outcomes data. In this report, we summarize initial results from early data collected via this new tool from four prevention programs that piloted it.

Methods

PEI Programs and Client Populations

Four PEI service providers representing four different PEI programs participated in the early-adopter data collection:

- **Culturally Based Access and Navigation Support (CBANS).** CBANS combines elements of peer support interventions, community health worker interventions, and culturally inclusive community services to provide access and linkages to treatment for individuals with serious mental illness who are members of diverse cultural groups. In particular, the CBANS program included in this report predominately serves an older adult (ages 60 and older) refugee population. Fresno Coun-

ty’s CBANS programs aim to build relationships with underserved communities, reduce the stigma associated with talking about mental health, reduce stress associated with navigating complex resource systems, increase social support, and reduce overall distress. CBANS falls under the following PEI program categories: (1) **improve timely access to services for underserved populations** and (2) **outreach for increasing recognition of early signs of mental illness.**

- **Holistic Cultural Education Wellness Center.** This program aims to help people live well-balanced lives in mind, body, and spirit through a wide variety of activities, such as support groups in various languages, mindful body movement classes, nutrition classes, healing garden classes, dance classes, healing arts and crafts activities, cross-cultural education workshops, and others. The program serves individuals of all ages, although clients are primarily adult women. It is a **prevention** program.
- **Peer Wellness Center.** The Blue Sky Wellness Center is a peer-run recovery support program for adults age 18 and older who experience mental illness. The goals of the peer wellness center program are to promote mental health recovery and life functioning, and to increase feelings of hope, freedom of choice, and self-determination. It is a **prevention** program.
- **Youth Empowerment Center.** This program aims to help youth develop life skills, skills to identify early signs and symptoms of mental health problems, and positive coping skills. Youth empowerment services include organized activities and events, as well as a drop-in center. The center serves children and transition-aged youth ages 10–24, including some youth experiencing homelessness. **The program addresses prevention and outreach for increasing recognition of early signs of mental illness.**

Overall, these prevention programs serve at-risk populations; some individuals served have serious mental illness and others are at risk for mental illness.

Abbreviations

DBH	Department of Behavioral Health
MHSA	Mental Health Services Act
N/A	not applicable
NIH	National Institutes of Health
PEI	prevention and early intervention
PROMIS	Patient-Reported Outcomes Measurement Information System
SD	standard deviation

Measures

We identified a set of core outcome measures that are relevant to the PEI service population and can be used to inform provision of care. PEI providers and DBH can use these standardized measures to track outcomes over time for the individuals they serve. We reviewed the goals and reporting requirements for PEI programs; conducted interviews with PEI providers to understand their existing programming, goals, and data collection methods; and reviewed research literature to identify outcome measures. In selecting the measures, we considered various factors, such as available data on reliability and validity, brevity (shorter measures were greatly preferred in order to increase feasibility), use in similar populations, and inclusion in repositories of well-researched assessments (such as the National Institutes of Health [NIH] Toolbox and Patient-Reported Outcomes Measurement Information System [PROMIS] item bank). The final set of outcome measures include measures that are specific to age category as well as measures that apply to all individuals served by PEI providers regardless of age.

Youth Measures

Table 1 summarizes the seven measures selected for youth participants (ages 8–17). They include measures of self-efficacy, psychological stress, impairment in functioning as a result of emotions, social support, and satisfaction with life, as well as brief measures of school functioning. Five of the measures are sums or averages of responses to component items coded on a 5-point Likert scale. One measure is the number of days in the past 30, and one is a yes-or-no response. The last column provides a clinically meaningful interpretation of the scores for each measure based on the literature for that measure. The sums for self-efficacy and perceived stress can be converted to t-scores that norm the raw scores to a population distribution. More detail on the measures, including the component items, is provided in the appendix.

Adult Measures

Table 2 summarizes the ten measures selected for adult participants (ages 18 and older). Nine of the measures are sums of responses to items coded on a

5-point Likert scale. One measure is the number of days in the past 30 days. As with the youth measures, the last column provides a clinically meaningful interpretation of the scores for each measure. The sums for self-efficacy and life satisfaction can be converted to t-scores that norm the raw scores to a population distribution. The details of each measure are included in the appendix.

Web-Based Tool for Data Collection

We built a web-based tool to collect outcome measures for individuals served by PEI providers. We created input forms for each measure as well as a form that collects demographic data on each individual. Information entered into each form is stored in a JSON database. The tool is hosted by RAND on Amazon Web Services GovCloud. Access to each service provider's data is restricted to the service provider and RAND project staff.

Although the web-based tool was designed for direct data entry by either program participants or providers, participating providers commonly printed out copies of the demographic questionnaire and survey instrument relevant to their population, gave the survey to the individuals they serve, and then entered the data from the paper instruments into the web tool. We requested that providers survey the individuals they serve at six-month intervals. The demographic data were collected at the initial survey. Each participant received an individual identification in the tool, and multiple surveys could be entered for each participant under their individual identification.

Analysis

We summarized demographics and each of the outcome measures for the earliest survey available for all individuals served. We summarized non-missing values for each measure after dropping individuals with surveys that included missing values for all of the scale items of a measure. We also summarized the change in values for each measure between the earliest and the most recent survey for individuals with multiple surveys, and we tested for the significance of any changes using t-tests. We excluded surveys with missing data.

TABLE 1
Outcome Measures for Youth Participants (Ages 8–17)

Measure	Source	Components ^a	Score Range	Clinical Interpretation
Self-efficacy	NIH Toolbox Fixed Form V2–Self Efficacy ^b	Ten items: 5-point Likert scale, never to very often	5–50	The score can be converted to a t-score (mean = 0, standard deviation [SD] = 1). Values of 1 SD or more above the mean are considered high self-efficacy; values of 1 SD or more below are considered low self-efficacy.
Perceived stress	PROMIS item bank–Psychological Stress Experiences–Short Form 4a ^c	Four items: 5-point Likert scale, never to always	4–20	The score can be converted to a t-score (mean = 50, SD = 10). 1–2 SD above = high. > 2 SD above = very high. 1–2 SD below = low. > 2 SD below = very low.
Emotional functioning	Functioning item, Teen Depression Awareness Project ^d	One item: number of days out of 30	1–30	Higher number means worse functioning.
Social support	Sarason Social Support measure (adapted by Ragavan et al.) ^e	Three items: 5-point Likert scale, none of the time to all of the time	3–15	12 or higher = higher social support.
Life satisfaction	Brief Multidimensional Students’ Life Satisfaction Scale–Peabody Treatment Progress Battery ^f	Six items: 5-point Likert scale, very dissatisfied to very satisfied	1–5	> 4.5 = high satisfaction. 3.3–4.5 = medium satisfaction. < 3.3 = low satisfaction.
School attendance	National Survey on Drug Use and Health ^g	One item: yes/no attended school	Yes/no	N/A
Classroom behavioral engagement	Student Engagement Scale ^h	Four items: 5-point Likert scale, never to all the time	1–5	Scores of 4 or above indicate high engagement. Scores between 3 and 4 indicate moderate engagement. Scores below 3 indicate low engagement.

NOTE: N/A = not applicable.

^a Likert scales are converted to numbers corresponding to each level of the scale 1 (lowest) through 5 (highest).

^b HealthMeasures, undated-b.

^c Bevans et al., 2018a.

^d Jaycox et al., 2010; Jaycox et al., 2009.

^e Ragavan et al., 2020.

^f Bickman et al., 2010; Athay, Kelley, and Dew-Reeves, 2012.

^g Substance Abuse and Mental Health Services Administration, 2015.

^h Fredericks et al., 2005.

TABLE 2
Outcome Measures for Adult Participants (Ages 18 and Older)

Measure	Source	Components ^a	Score Range	Clinical Interpretation
Self-efficacy	PROMIS Short Form v1.0–General Self-Efficacy 4a ^b	Four items: 5-point Likert scale, not at all confident to very confident	4–20	Scores can be converted to t-scores (mean = 50, SD = 10). A higher score or higher t-score means higher self-efficacy.
Resilience	Brief-Resilient Coping Scale ^c	Four items: 5-point Likert scale, does not describe me at all to describes me very well	4–20	17–20 = high resilience. 14–16 = medium resilience. 4–13 = low resilience.
Perceived stress	Perceived Stress Scale (PSS-4 ^d)	Average of four items: 5-point Likert scale, never to very often	0–4	A higher score means higher stress.
Emotional functioning	Functioning item, National Comorbidity Survey Replication ^e	One item: Number of days out of 30	1–30	A higher number means more days of poor functioning.
Social support	Behavioral Risk Factors Surveillance System, Social Support item ^f	One item: 5-point Likert scale, never to always	1–5	A higher score means higher social support.
Life satisfaction	NIH Toolbox Item Bank v2.0–General Life Satisfaction (Ages 18+)–Fixed Form B ^g	Five items: 5-point Likert scale, strongly disagree to strongly agree	5–25	A score can be converted to a t-score (mean = 50, SD = 10). Values of 1 SD or more above the mean are considered high life satisfaction. Values of 1 SD or more below are considered low satisfaction.
General mental health knowledge	Mental Health Knowledge Schedule (MAKS) ^h	Five items: 5-point Likert scale strongly disagree to strongly agree	5–25	A higher score means more knowledge.
Knowledge of how to seek or give help	RAND CaIMHSA surveys ⁱ	Two items: 5-point Likert scale, strongly disagree to strongly agree	1–5 (each)	Each item is scored individually. Scoring is simplified to any agreement (yes or no).
Attitudes about help-seeking	General Help-Seeking Questionnaire ⁱ	Nine items: 7-point Likert scale, extremely unlikely to extremely likely	9–63	A higher score indicates higher help-seeking intention.
Stigma/attitudes about individuals with mental illness	RAND CaIMHSA surveys, other surveys ^k	Four items: 5-point Likert scale, not at all to very much	4–20	A higher number means greater stigma.

^a Likert scales are converted to numbers corresponding to each level of the scale: 1 (lowest) through 5 (highest) for all scales except the Perceived Stress Scale (PSS-4). The levels for PSS-4 are converted to 0 (lowest) to 4 (highest) as directed by the documentation for this scale.

^b Kupst et al., 2015; PROMIS, 2017a.

^c Sinclair and Wallston, 2004.

^d Cohen, Kamarck, and Mermelstein, 1983; Vallejo et al., 2018.

^e Kessler et al., 2006; Shearer, Ebener, and Burnam, 2018.

^f Strine et al., 2008.

^g HealthMeasures, undated-a.

^h Evans-Lacko et al., 2010.

ⁱ Collins et al., 2021.

^j Wilson et al., 2005.

^k Rüsck et al., 2014; Stuart and Arboleda-Flórez, 2001; Kobau et al., 2009; Burnam et al., 2014; Brown and Wyllie, 2010.

Results

Vendors entered data for 274 surveys (27 youth surveys and 247 adult surveys) between September 2021 and May 2024. Twelve adults completed follow-up surveys; no youth completed follow-up surveys. Because there are no follow-up surveys for youth, we were unable to assess changes in their outcomes over time.

Individuals Served

Table 3 summarizes demographics from the initial survey for individuals surveyed by PEI providers. With respect to race or ethnicity, the majority of individuals served were non-White, with Hispanic or Latino individuals the largest racial or ethnic group served by Fresno County DBH's prevention programs. The majority of those served were adults ages 26–59. Programs appeared to serve more male individuals than female, though 28 percent of respondents did not provide gender information, making it difficult to accurately assess the gender distribution. Three individuals identified as transgender or another gender identity. The majority of individuals served identified as heterosexual or straight, and 6 percent identified as another sexual orientation. Again, we encountered a large amount of missing data. Only 2 percent of those surveyed identified as veterans.

Youth Measures: Mental Health and Life Functioning of the Individuals Served

Table 4 summarizes the average values and provides clinical interpretation for the youth outcome measures. The clinical interpretation provided in the table is based on the interpretation levels described in Table 1. None of the youth served have more than one survey, so only baseline data are provided. For some, this information was collected at the start of the individual's participation in the program, but our data may also include information from individuals who had already been participating.

When examining this population in relation to scoring interpretation guidelines provided in the research literature (summarized in the final column of Table 1), we find that, overall, the youth

served experience challenges in various domains, as expected for participants in prevention programs. The majority of the youth surveyed had low self-efficacy, and none had high levels of self-efficacy. The average t-score for self-efficacy was -1.2 , significantly below the population average of 0. More than one in three youth served reported high levels of perceived stress, most did not have high levels of social support, and the average t-score was 57.3, significantly higher than the population average of 50. The overwhelming majority of surveyed youth had low life satisfaction, and none had high satisfaction with their lives. However, school engagement was more varied, with about one in three reporting low classroom engagement but similar numbers reporting high classroom engagement.

Adult Measures: Mental Health and Life Functioning of the Individuals Served

Table 5 summarizes the adult outcomes at the time participants took their first survey (for some individuals, this was at the start of program participation, but others had already been participating in the program at the time of the assessment). We assessed changes in each outcome between the earliest and latest surveys for those who had more than one; none of the changes were statistically significant. This may be a result of the small number of individuals who filled out multiple surveys (12) preventing us from identifying actual changes or it could be because there were no actual changes in outcomes. The median time between baseline and final follow-up surveys was 12 months but varied from 1 to 30 months. Three individuals had more than two surveys, and the times between the first and second surveys varied from less than one month to three months. Note that this reflects the data entry date, which may be delayed from the data collection date.

Similar to youth served, the adults served, overall, experienced challenges in various domains of mental health attitudes, knowledge, and functioning when compared with interpretation guidelines based on the research literature (summarized in the final column of Table 2). The average self-efficacy was significantly lower than the population average (the

TABLE 3
Demographics of Individuals Served

Demographic ^a	Number of Individuals Served	Percentage of Individuals Served
Race or ethnicity		
American Indian or Alaska Native	8	3
Asian	7	3
Black or African American	33	13
Hispanic or Latino	64	25
White, non-Hispanic	46	18
Native Hawaiian or other Pacific Islander	2	1
Other	7	3
More than one race	2	1
Declined to respond	12	5
Missing	73	18
Age		
0–15 (youth)	39	15
16–25 (transition-aged youth)	20	8
26–59 (adult)	145	57
60+ (older adult)	28	11
Missing	22	9
Gender at birth		
Female	68	27
Male	113	44
Declined to respond	2	1
Missing	71	28
Current Gender		
Female	69	27
Male	110	43
Transgender	2	1
Another gender identity	1	0.4
Missing	72	28
Sexual orientation		
Heterosexual or straight	149	59
Bisexual	6	2
Gay or lesbian	5	2
Queer	2	1
Questioning or unsure of sexual orientation	1	0.4
Another sexual orientation	2	1
Declined to respond	15	6
Missing	74	29
Veteran status		
Yes	6	2
No	174	69
Declined to respond	2	1
Missing	72	28
Total individuals	254	100

^a Demographic categories and grouping within each category are based on state reporting requirements for PEI programs. Youth have missing data for all demographic measures except Age Category.

TABLE 4
Youth Outcome Measures

Measure	Mean Score (95% Confidence Interval)	Clinical Interpretation ^a
Self-efficacy (sum)	25.3 (22.9–27.7) t-score: -1.2 ^b (-1.5, -1.0)	59% low self-efficacy 41% average self-efficacy 0% high self-efficacy
Perceived stress (sum)	10.0 (9.0–11.0) t-score: 57.3 ^c (54.8, 59.7)	37% high stress 56% average stress 7% low stress
Social support (sum)	7.6 (6.6–8.5)	93% average or low social support 7% high social support
Life satisfaction (average)	2.6 (2.3–2.9)	85% low life satisfaction 15% average life satisfaction 0% high life satisfaction
School attendance (percentage)	100.0% (N/A)	N/A
Classroom behavioral engagement (average)	3.3 (2.9–3.6)	30% low classroom engagement 40% moderate classroom engagement 30% high classroom engagement

NOTES: *N* = 27. All 27 have values for all measures. No emotional functioning data were submitted for youth.

^a Based on values of outcomes described in the clinical interpretation column of Table 1.

^b Normative mean t-score = 0.

^c Normative mean t-score = 50.

average t-score was 41.5 compared with the population average of 50). A majority of adults (68 percent) had low life satisfaction, and the average t-score was 41.7, significantly lower than the population average of 50. They perceived their stress levels as high, and they had low levels of social support to draw on to help them cope. Along similar lines, they were unlikely to seek help from others. On average, they reported being unable to function because of emotional issues for about seven out of every 30 days. Their resilience was mixed, with about one-fourth reporting high resilience, about one-half having average resilience, and a little more than one-fourth being low in resilience. On average, they had low general mental health knowledge and low specific knowledge of mental health resources and of how to be supportive of people with mental illness.

Conclusion

Fresno County prevention providers piloted the use of a new web-based tool for collection of outcomes

data. The data indicate that the county’s prevention programs serve a diverse population that experiences serious challenges with mental health and life functioning. Youth and adults alike experienced challenges in various domains: They had low self-efficacy, high perceived stress, low social support, and low overall life satisfaction. Adults served also reported low mental health knowledge and difficulty functioning in their day-to-day lives because of emotional issues.

However, these findings should be viewed with caution because of small sample sizes and high missing data for some measures. The small number of follow-up surveys meant that the evaluation did not have adequate power to detect changes in outcomes over time. This was the first time multiple PEI providers were asked to provide the same set of measures for the individuals they serve, using a web based tool. Some providers encountered challenges accessing the tool because of technical issues at their end and RAND’s end or because of staffing issues that meant delays in collecting and entering the data. The provider that entered the most data,

TABLE 5
Adult Outcome Measures

Measure ^a	Mean Score on First Survey ^b (95% Confidence Interval)	Clinical Interpretation ^c
Self-efficacy (sum) <i>n</i> = 203	10.0 (9.1–10.8) t-score 40.5 ^d (38.6–42.5)	On average lower self-efficacy than the population average (mean t-score of 50)
Resilience (sum) <i>n</i> = 247	12.2 (11.4–13.0)	30% low resilience 45% average resilience 25% high resilience
Perceived stress (average) <i>n</i> = 200	1.3 (1.2–1.4)	On average, high perceived stress among individuals served
Emotional functioning (days) <i>n</i> = 32	6.8 (3.5–10.0)	On average, unable to work or carry out usual activities seven days a month
Social support (average) <i>n</i> = 200	2.0 (1.8–2.2)	On average, rarely gets needed social and emotional support
Life satisfaction (sum) <i>n</i> = 200	12.0 (11.0–12.9) t-score: 41.7 d (40.0–43.5)	68% low life satisfaction 26% average life satisfaction 6% high life satisfaction
General mental health knowledge (sum) <i>n</i> = 198	11.1 (10.1–12.2)	On average, low general mental health knowledge
Attitudes about help seeking (sum) <i>n</i> = 247	15.9 (14.7–17.1)	On average, unlikely to seek help from others
Knowledge how to find info (percent agree) <i>n</i> = 247	10.1% (6.4%–13.9%)	On average, low knowledge of how to find mental health information or resources
Knowledge how to be supportive (percent agree) <i>n</i> = 247	12.1% (8.1%–16.2%)	On average, low knowledge of how to be supportive of people with mental illness

^a This column lists the name of the measure, a description of the type of number reported, and the sample size with non-missing values for the measure for the only survey for individuals with one or the earliest available survey for individuals with multiple surveys.

^b Information in this column is based on only surveys for individuals with only one (*n* = 234) and on earliest available survey for individuals with multiple surveys (*n* = 12).

^c At baseline, material in this column is based on relative values of outcomes described in the clinical interpretation column of Table 2. This includes the mean t-score (95-percent confidence interval) for self-efficacy and life satisfaction. Percentages are for the respondents with no missing data for the measure. No stigma data were submitted for adults.

^d Normative mean t-score = 50.

Kings View, already had experience collecting its own data and had existing staff with experience collecting assessment data. However, collecting this set of measures repeatedly for the same individuals was new to Kings View. It is unclear whether the low number of follow-up surveys is the result of challenges with collecting repeated assessments or

of high turnover in the population of individuals served. If the tool is broadly adopted, programs can work on consistency in data collection and implementation of regular follow-ups to ensure complete data and availability of follow-up data for those individuals who return to their programs.

APPENDIX

Outcomes Measures

Core Measures: Youth

Self-Efficacy

Please read each sentence and decide how true it is of you in general.

1. I can always manage to solve difficult problems if I try hard enough.
2. If someone tries to keep me from getting what I want, I can find a way to get what I want.
3. It is easy for me to stick to my goals and reach them.
4. I am confident that I could do a good job dealing with unexpected events.
5. Thanks to my talents and skills, I know how to handle unexpected situations.
6. I can solve most problems if I try hard enough.
7. I can stay calm when facing difficulties because I can handle them.
8. When I have a problem, I can find several ways to solve it.
9. If I am in trouble, I can think of a solution.
10. I can handle whatever comes my way.

Source: NIH Toolbox Fixed Form V2—Self Efficacy (Youth 8–12 and 13–17) (HealthMeasures, undated-b)

Response options: 5-point Likert scale: 1 = never, 2 = almost never, 3 = sometimes, 4 = fairly often, 5 = very often

Scoring instructions: The value of each question is summed. This table can be used to convert the score to the theta score and t-score.

Rules for missing data: Unknown

Scoring interpretation: The higher the t-score, the greater the self-efficacy. A score of 1 SD or more below the mean is considered low self-efficacy; a score of 1 SD or more above the mean is considered high self-efficacy.

Perceived Stress

In the past seven days . . .

1. I felt stressed.
2. I felt that my problems kept piling up.

3. I felt overwhelmed.
4. I felt unable to manage things in my life.

Source: PROMIS item bank—Psychological Stress Experiences—Short Form 4a (Bevans et al., 2018b)

Response options: never, rarely, sometimes, often, always

Scoring instructions: Summed response values converted to t-score (PROMIS, 2017b, p. 7). Recommend using HealthMeasures Scoring Service or automatic calculation tool (PROMIS, 2017b, p. 2).

Rules for missing data: If a participant skips a question, use Health Measures Scoring Service to generate score (PROMIS, 2017b, p. 2). “If two or more responses are marked by the respondent, and they are next to one another, then a data entry specialist will be responsible for randomly selecting one of them to be entered and will write down on the form which answer was selected If two or more responses are marked, and they are NOT all next to one another, the response will be considered missing.”

Scoring interpretation: T-score of 40–60 (average stress); 60–70 (high); 70 and above (very high); 30–40 (low); below 30 (very low)

Emotional Functioning

1. In the past 30 days, for how many days were you totally unable to do your usual activities or school work because of emotional problems?
 - a. Response option: Number of days: ___/30

Source: Functioning item, Teen Depression Awareness Project (Jaycox et al., 2010; Jaycox et al., 2009)

Scoring instructions: Report days out of 30 that youth was unable to function at usual activities because of emotional problems.

Rules for missing data: Exclude if missing.

Scoring interpretation: The greater the number of days, the worse the emotional functioning.

Social Support

1. Do you have someone who cares about you?
2. Do you have someone who makes you feel better?
3. Do you have someone on whom you can depend?

Source: 3 items adapted from the Sarason Social Support measure (Ragavan et al., 2020)

Response options: 5-point Likert scale: 1 = strongly disagree to 5 = strongly agree

Scoring instructions: Calculate the mean of the three items.

Rules for missing data: Not specified

Scoring interpretation: A mean equal to or greater than 4.0 indicates a presence of social support.

Life Satisfaction

How satisfied or dissatisfied are you with:

1. Your family life?
2. Your friendships?
3. Your school experience?
4. Yourself?
5. Where you live?
6. Your life overall?

Source: Brief Multidimensional Students' Life Satisfaction Scale – Peabody Treatment Progress Battery (BMSLSS-PTPB: Youth) (Athay, Kelley, and Dew-Reeves, 2012)

Response options: 5-point Likert scale: 1 = very dissatisfied, 2 = somewhat dissatisfied, 3 = neither satisfied nor dissatisfied, 4 = somewhat satisfied, 5 = very satisfied

Scoring instructions: Sum up the response values and take the average of them (by dividing by number of items).

Rules for missing data: When there are missing data, take the average of the values of the completed responses. It's up to the measure administrator to decide when there's too much missing information.

Scoring interpretation: 3.3–4.5 (medium satisfaction); higher than 4.5 (high); lower than 3.3 (low)

School Attendance

1. Have you attended any type of school at any time during the past 12 months? By “school,” we mean elementary school, junior high or middle school, high school, or a college or university. Please include home schooling as well.

Source: National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration, 2015)

Response options: No (If you answered No, skip to the next section), Yes

Scoring instructions: N/A

Rules for missing data: N/A

Scoring interpretation: N/A

Classroom Behavioral Engagement

Behavioral Engagement subscale:

1. I pay attention in class.
2. When I am in class, I just act as if I am working.
3. I follow the rules at school.
4. I get in trouble at school.

Source: Student Engagement Scale (SES) (Fredericks et al., 2005)

Response options: 5-point Likert scale: 1 = never, 2 = on occasion, 3 = some of the time, 4 = most of the time, 5 = all of the time

Scoring instructions: Question 2 and 4 should be reverse scored. No other instructions specified.

Rules for missing data: Not specified

Scoring interpretation: Not specified

Core Measures: Adults

Self-Efficacy

For the next set of questions, please read each sentence and rate your level of confidence in managing various situations, problems, and events.

1. I can manage to solve difficult problems if I try hard enough.
2. I am confident that I could deal efficiently with unexpected events.
3. If I am in trouble, I can think of a solution.
4. I can handle whatever comes my way.

Source: PROMIS Short Form v1.0—General Self-Efficacy 4a (PROMIS Health Organization) (Kupst et al., 2015; HealthMeasures, undated-b)

Response options: 5-point Likert scale: 1 = I am not at all confident, 2 = I am a little confident, 3 = I am somewhat confident, 4 = I am quite confident, 5 = I am very confident

Scoring instruction: Sum up the scores. Use the Short Form Conversion Table (PROMIS, 2017a, p. 11) to convert the raw score to a t-score. The guidebook

recommends using the HealthMeasures Scoring Service (Assessment Center, undated) over manual scoring, however see PROMIS (2017a, p. 3) for more.

Rules for missing data: All items should be answered. If the participant does not answer all questions, then the HealthMeasures Scoring Service needs to be used (Assessment Center, undated).

Scoring interpretation: The greater the t-score, the greater the self-efficacy.

Resilience

1. I look for creative ways to alter difficult situations.
2. Regardless of what happens to me, I believe I can control my reaction to it.
3. I believe that I can grow in positive ways by dealing with difficult situations.
4. I actively look for ways to replace the losses I encounter in life.

Source: Brief-Resilient Coping Scale (Sinclair and Wallston, 2004)

Response options: 5-point Likert scale: 1 = describes me not at all to 5 = describes me very well

Scoring instructions: Scores are summed.

Rules for missing data: Unknown

Scoring interpretation: Low resilient copers (4–13 points), medium resilient copers (14–16 points), high resilient copers (17–20 points)

Perceived Stress

In the last month, how often have you . . .

1. Felt that you were unable to control the important things in your life?
2. Felt confident about your ability to handle your personal problems?
3. Felt that things were going your way?
4. Felt difficulties were piling up so high that you could not overcome them?

Source: Perceived Stress Scale (PSS-4) (Cohen, Kamarck, and Mermelstein, 1983; Vallejo et al., 2018)

Response options: Never, almost never, sometimes, fairly often, very often

Scoring instructions: For questions 1 and 4, code such that never = 0, almost never = 1 . . . very often = 4. Reverse code the positive items, questions 2 and 3 (Never = 4 . . . very often = 0).

Rules for missing data: Unknown

Scoring interpretation: Higher scores indicate more stressful life situations. There are no cut-off scores, but scores are compared with normative scores. A representative sample of 2,387 U.S. adults from 1988 provides normative data (the mean score was 4.49 with a standard deviation of 2.96).

Emotional Functioning

1. In the past 30 days, for how many days were you totally unable to work or carry out your usual activities because of emotional problems?

Source: Functioning item, National Comorbidity Survey Replication (Kessler et al., 2006)

Response options: Number of days: ___/30; Don't know

Scoring instructions: N/A (this is a single survey item)

Rules for missing data: N/A (this is a single survey item)

Scoring interpretation: The greater the number of days, the worse the emotional functioning.

Social Support

How often do you get the social and emotional support that you need? Please check only one box.

Source: Behavioral Risk Factors Surveillance System, Social Support item (Strine et al., 2008)

Response options: Never, rarely, sometimes, usually, always, don't know

Scoring instructions: N/A

Rules for missing data: This is part of a larger survey, so N/A.

Scoring interpretation: This is part of a larger survey, so no cut-off points.

Life Satisfaction

Indicate how much you agree or disagree:

1. My life is going well.
2. My life is just right.
3. I wish I had a different kind of life.
4. I have a good life.
5. I have what I want in life.

Source: NIH Toolbox Item Bank v2.0—General Life Satisfaction (Ages 18+)—Fixed Form B (HealthMeasures, undated-a)

Response options: 5-point Likert scale: 1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree

Scoring instructions: Sum scores across items and use conversion table to convert to t-scores (HealthMeasures, 2020, p. 20).

Rules for missing data: For this particular use case, contact help@healthmeasures.net for further consultation on dealing with missing data.

Scoring interpretation: The greater the score on a particular item, the greater the individual's general life satisfaction. A t-score of 50 is the mean for the general U.S. population. A t-score ≤ 40 suggests low life satisfaction and a score ≥ 60 suggests life satisfaction. "T-scores ≤ 40 may warrant heightened surveillance or concern" (HealthMeasures, undated-a).

General Mental Health Knowledge

1. Most people with mental health problems want to have paid employment.
2. If a friend had a mental health problem, I know what advice to give them to get professional help.
3. Medication can be an effective treatment for people with mental health problems.
4. Psychotherapy (e.g., counseling or talking therapy) can be an effective treatment for people with mental health problems.
5. People with severe mental health problems can fully recover.
6. Most people with mental health problems go to a health care professional to get help.

Source: MAKS Mental Health Knowledge Schedule (Evans-Lacko et al., 2010)

Response options: Agree strongly; agree slightly; neither agree nor disagree; disagree slightly; don't know

Scoring instructions: Strongly agree = 5 . . . strongly disagree = 1. "Don't know" is scored as 3. Question 6 is reverse coded. Sum across all items.

Rules for missing data: Unknown

Scoring interpretation: Higher score means more knowledgeable.

Knowledge of How to Seek or Give Help

1. I know how to find information or resources to help if I or someone I know experiences a mental health problem.
2. I know how I could be supportive of people with mental illness if I wanted to be.

Source: RAND CalMHSA surveys (Burnham et al., 2014; Collins et al., 2021)

Response options: For each item, the extent of agreement is measured on a 5-point scale (strongly agree to strongly disagree).

Scoring instructions: Responses were recoded to reflect any agreement (agree or strongly agree) versus no agreement (all other response options).

Rules for missing data: N/A, they are used as single items.

Scoring interpretation: Interpret as agreement (yes or no)

Attitudes About Help-Seeking

If you were having a personal or emotional problem, how likely is it that you would seek help from the following people?

1. Intimate partner (e.g., girlfriend, boyfriend, husband, wife, de' facto)
2. Friend (not related to you)
3. Parent
4. Other relative/family member
5. Mental health professional (e.g., psychologist, social worker, counselor)
6. Phone helpline (e.g., Lifeline)
7. Doctor or general practitioner
8. Minister or religious leader (e.g., priest, rabbi, chaplain)
9. I would not seek help from anyone.
10. I would seek help from another not listed above (please list in the space provided).

Source: General Help-Seeking Questionnaire (GHSQ) (Wilson et al., 2005)

Response options: 7-point Likert scale: Anchors 1 = extremely unlikely, 3 = unlikely, 5 = likely, 7 = extremely likely

Scoring instructions: Sum the scores across the items. Reverse score item 9.

Rules for missing data: Unknown

Scoring interpretation: Higher scores indicate higher help-seeking intention.

Stigma/Attitudes About Individuals with Mental Illness

1. Would you feel ashamed if you had a mental illness?

Source: Rüsich et al., 2014

Response options: 1 (not at all) to 5 (very much)

Scoring instructions: Unknown

Rules for missing data: N/A (only one question measuring this construct)

Scoring interpretation: Higher scores indicate greater likelihood of feeling ashamed and greater stigma.

2. If someone in your family had a mental illness, would you feel ashamed if people knew about it?

Source: RAND CalMHSA surveys (Burnham et al., 2014; Collins et al., 2021)

Response options: Definitely not, probably not, probably, definitely

Scoring instructions: Unknown

Rules for missing data: N/A (only one question measuring this construct)

Scoring interpretation: Unclear if there is an interpretation beyond the literal meaning of the response.

3. I believe a person with mental illness can eventually recover.
4. People who have had a mental illness are never going to be able to contribute much to society.

Source: RAND CalMHSA surveys (Burnham et al., 2014; Collins et al., 2021)

Response options: Strongly agree, moderately agree, neither agree nor disagree, moderately disagree, strongly disagree

Scoring instructions: N/A (not scored)

Rules for missing data: Unknown

Scoring interpretation: Unclear if there is an interpretation beyond the literal meaning of the response.

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About This Report

California's prevention and early intervention (PEI) regulations state that county departments of behavioral health should measure appropriate outcomes and indicators, but these regulations do not provide specific guidance on which outcomes to measure and how to measure them. Many counties have struggled to measure PEI outcomes, in part because prevention programs often do not use electronic health records to capture participant data. To address this challenge, the Fresno County Department of Behavioral Health (DBH) engaged a RAND evaluation team to design a data collection tool for its prevention programs. This report summarizes initial results from early data collected via this new tool from four prevention programs that piloted it.

Funding

This research was funded by the California Mental Health Services Authority (CalMHSA) and carried out within the Access and Delivery Program in RAND Health Care.

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CalMHSA

CalMHSA is an organization of county governments working to improve mental health outcomes for individuals, families, and communities. Prevention and early intervention programs implemented by CalMHSA are funded by counties through the voter-approved Mental Health Services Act (Prop. 63). Prop. 63 provides the funding and framework needed to expand mental health services to previously underserved populations and all of California's diverse communities.

Acknowledgments

We are grateful for the support and guidance of Fresno County Department of Behavioral Health staff, especially Erinn Chan-Golston. We thank Fresno prevention program staff for their participation in the evaluation and CalMHSA staff for their support. We also thank our peer reviewers, Joshua Breslau and Donna Farley, for their helpful feedback on a draft of the report.

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