COUNTY OF SAN DIEGO – HEALTH AND HUMAN SERVICES AGENCY
BEHAVIORAL HEALTH SERVICES

Mental Health Services Act Innovation Projects

Evaluation 2015

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COUNTY OF SAN DIEGO HHSA HEALTH AND HUMAN SERVICES AGENCY | LIVE WELL SAN DIEGO

Innovation Projects Evaluation
Developed by the County of San Diego Behavioral Health Services,
Behavioral Health Division, Quality Improvement Unit

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Introduction

The Mental Health Services Act (MHSA), Proposition 63, was approved by California voters in November 2004 and became effective January 1, 2005. The MHSA provides funding for expansion of mental health services in California. As required by the law, the County of San Diego, through the Health and Human Services Agency (HHSA) Mental Health Services Division, has completed the MHSA Innovation Program and Expenditure Plan. The MHSA Innovation Plan outlines proposed MHSA-funded programs and services to be provided locally. Innovation programs provide services that are novel, creative, and/or ingenious mental health practices/approaches that are expected to contribute to learning. These Innovation programs were developed within communities through a process that is inclusive and representative, especially of unserved and underserved individuals.

The County's MHSA Innovation Plan will be updated annually based on funding revisions and other program considerations. New programs will be added based on funding availability. The MHSA provides access to services for identified unserved/underserved clients in new or expanded programs, but may not replace or supplant existing services. Services provided through MHSA support the County's adopted Live Well, San Diego! vision by enabling participants with behavioral health needs and the general public to access necessary resources and thereby lead healthy and productive lives.

In accordance with the MHSA ***Vision Statement*** and ***Guiding Principles***, services are designed to adhere to the following principles:

- Cultural and linguistic competency
- Promotion of resiliency in children and their families, and recovery/wellness for adults and their families
- Increased access to services, including timely access and more convenient geographic locations for services
- Services that are more effective, including evidence-based or best practices
- Reduced need for out-of-home and institutional care, maintaining clients in their communities
- Reduced stigma towards mental illness
- Consumer and Family participation and involvement
- Increased array and intensity of services
- Screening and treatment for persons with dual diagnoses
- Improved collaboration between mental health and other systems (education, law enforcement, child welfare, etc.)
- Services tailored to age-specific needs
- Address eligibility gaps by serving the uninsured and unserved

HHSA and BHS Vision, Mission, and Guiding Principles

All Innovation Projects are in alignment with the HHSA and Behavioral Health Services' vision, mission, and strategy/guiding principles.

County of San Diego, Health and Human Services Agency

Vision: Healthy, Safe, and Thriving San Diego Communities.
Mission: To make people's lives healthier, safer, and self-sufficient by delivering essential services.
Strategy:

1. **Building a Better System** focuses on how the County delivers services and how it can further strengthen partnerships to support health. An example is putting physical and mental health together so that they are easier to access.
2. **Supporting Healthy Choices** provides information and educates residents so they are aware of how choices they make affect their health. The plan highlights chronic diseases because these are largely preventable and we can make a difference through awareness and education.
3. **Pursuing Policy Changes for a Healthy Environment** is about creating policies and community changes to support recommended healthy choices.
4. **Improving the Culture from Within**. As an employer, the County has a responsibility to educate and support its workforce so employees "walk the talk." In order to make a positive impact on those served throughout the County, the workforce needs to be on the same page.

Behavioral Health Services

Vision: Safe, mentally healthy, addiction-free communities.
Mission: In partnership with our communities, work to make people's lives safe, healthy, and self-sufficient by providing quality behavioral health services.
Guiding Principles:

1. Support activities designed to reduce stigma and raise awareness surrounding mental health, alcohol and other drug problems, and problem gambling.
2. Ensure services are outcome driven, culturally competent, recovery and client/family centered, and innovative and creative.
3. Foster continuous improvement to maximize efficiency and effectiveness of services.
4. Maintain fiscal integrity.
5. Assist employees in reaching their full potential.

Mental Health Services Act Innovations Projects
INN-01 Wellness and Self-Regulation for Children and Youth Evaluation 2015

Program Name: **Wellness and Self-Regulation for Children and Youth**
Program Start Date: **October 15, 2010**
Program End Date: **October 14, 2013**

Purpose

1. **Purpose:**
   The Wellness and Self-Regulation for Children and Youth Innovations Project was an MHSA funded program. It was awarded to both New Alternatives Incorporated (New Alternatives Inc.) for adolescents, ages 12 to 18 in the Rate Classification Levels (RCL) 12 and 14, and to San Diego Center for Children for children ages 6 to 13 in RCL 12. The goal of this program was to address the specific physical, emotional, and relational challenges faced by these children and youth. Given their circumstances, these children and youth are more likely to face health challenges such as obesity, diabetes, depression, anxiety, post-traumatic stress, and other life challenges.

2. **Explanation of Purpose:**
   The Wellness and Self-Regulation Program offered these youth an array of alternative, holistic interventions to produce a positive impact on their mental and physical health. These alternative treatment strategies focused on teaching youth multiple ways to re-regulate functioning in the following areas: arousal level, mood, physical health, mental health, social functioning, sleeping patterns, eating habits, family wellness, frustration management, and sense of self.

Learning Objectives

1. **Learning Objective (#1): Impact of Nutrition on a Child's Health, Weight, and Behaviors.**

What We Hoped to Learn: Would implementing a healthier school lunch menu improve a child's health and weight management and decrease negative behaviors?

What We Learned: A lot was learned and observed during the implementation of this program. First, this program highlighted the importance of a proper nutritional base. The first change implemented to one of the campuses was the menu. The menu changed from a standard school lunch to a menu based on the Mediterranean diet created by the Kitchen Manager and a consulting Clinical Nutritionist. This menu maximized nutrition while minimizing sugar intake. After implementing this lunch menu, staff noticed an increase in weight management and a decrease in negative behaviors by the children.

2. Learning Objective (#2): Impact of Motivational Interviewing

What We Hoped to Learn: Would training staff on Motivational Interviewing produce more positive interactions with the youth?

What We Learned: As part of the Wellness and Self-Regulation program, the staff were properly trained to implement Motivational Interviewing through a program known as Why Try. This technique trained and encouraged staff to interact with the youth in a more effective way. Overall, power struggles were avoided and the youth were empowered. This resulted in a more effective and positive relationship between the staff and the children. Also, the use of Motivational Interviewing helped create a more positive campus climate.

3. Learning Objective (#3): Medication Tracking to Monitor Client's Use

What We Hoped to Learn: Did a youth's involvement in this program result in a decrease in their medication use?

What We Learned: Medication use is a complex and multifaceted issue; therefore, different methods for tracking medications were discussed prior to implementation. It was agreed to track the number of medications per category, such as antidepressants and antipsychotics. Overall, an average of 15.6 percent of discharged teens experienced a decrease in medication use per diagnostic category. However, there was no overall significant decrease in psychotropic medication use. Although, possibly due to a better diet and a slight decrease in the use of psychotropic medication, there was a noticeable decrease in the use of other medications used to help counteract the psychotropic medication side effects.

4. Learning Objective (#4): Administration of Mood Surveys to Youth

What We Hoped to Learn: Did youth's involvement in this program positively impact their mood over time?

What We Learned: Mood surveys were administered to measure feeling happy, sad, calm, or angry. The initial plan was to administer the surveys daily; however, survey administration changed to weekly to avoid the youths' frustration with the survey frequency. Despite this change in frequency of administering the survey, the youth still became frustrated. It was concluded that mood surveys did not accurately measure the intended goal. Although, it was learned that psychological assessments provided a valid and reliable method for measuring psychological health and therefore, it can be used as a better tracking system of a youth's overall functioning in the future.

5. Learning Objective (#5): Monitoring a Youth's Cholesterol, Blood Sugar, and Blood Pressure

What We Hoped to Learn: Did the implemented wellness interventions positively impact a youth's cholesterol, blood sugar, and blood pressure?

What We Learned: Overall, the large majority of youth had normal cholesterol, blood sugar, and blood pressure levels, thus there was no significant change observed. However, some teens (average of 10 throughout the program) with high cholesterol or who were pre-diabetic or diabetic experienced improvements in these areas. In the future, these measurements can be reserved for the youth who specifically experience or express concerns with cholesterol, blood sugar, or blood pressure. Also, these measurements could be obtained at intake or if concern arises, and then monitored quarterly. This approach would be less intrusive and overall more cost-effective.

6. Learning Objective (#6): Monitoring a Youth's Heart Rate

What We Hoped to Learn: Did the implemented wellness interventions positively impact a youth's heart rate?

What We Learned: The Wellness Licensed Vocational Nurse (LVN) obtained the youth's heart rate measurements weekly. The participants' heart rate measurement changes were insignificant. It was very difficult to obtain this measurement at the same time each week, and many teens refused, thus creating a fluctuation in readings and deeming the data invalid. Overall, monitoring a youth's heart rate did not show to be necessary for tracking physical health improvements.

Analysis of Program Effectiveness

1. Changes or Modifications during Implementation:

The Wellness and Self-Regulation contract required some modifications to its required elements in order to improve its effectiveness, efficiency, and to better coordinate with programs already in place such as mental health clinics and schools.

Initially, the contract required five wellness activities to be offered per day. At New Alternatives Inc. wellness activities were between 45 and 60 minutes in duration making it difficult to achieve five activities after school in a day. Therefore, the requirement for daily wellness activities was adjusted to three to five activities per day and allowed for more flexibility to schedule activities. Next, mood surveys were intended to be administered to youth daily. However, due to dissatisfaction among the youth, the mood survey administration was changed from daily to weekly.

Lastly, in order to take a deeper look at the psychological impact of the wellness and self-regulation program, the directors suggested adding valid and reliable psychological assessments to the outcomes data. Thus, the assessments were implemented upon intake and discharge, and at

six-month intervals, as needed, to ensure a pre and post score. Within the psychological assessments, three clinically validated assessments were chosen to measure anxiety, depression, and post-traumatic stress (RCMAS, CDI, UCLA-PTSD Index).

2. **Impact on Participants:**

   The implementation of a healthier lunch menu appeared to have positively impacted participants by improving weight management and reducing negative behaviors. The use of Motivational Interviewing by staff also resulted in a positive campus culture as it empowered the youth and improved relationships between the staff and the youth.

3. **What Was Learned:**

   Implementing a healthier lunch menu at the school appeared to have a positive impact on youth's physical and mental health. In addition, the use of Motivational Interviewing improved the youth's resilience and empowered them in decision making. The tracking of mood, cholesterol, blood sugar, blood pressure, heart rate, and medication proved to be more of a stressor on staff and the youth; therefore, it will not be recommended to track for continued program management or future program implementation.

4. **Recommended for Replication? YES**

   Although the MHSA Wellness and Self-Regulation contract ended October 14, 2013, the wellness program at New Alternatives, Inc. has continued. The Wellness Director assembled a team of Wellness Leaders to assume the responsibilities of the wellness program and developed a built-in sustainability plan. The team of Wellness Leaders lead daily wellness activities, provide nutrition education, model healthy behaviors, and educate the youth and staff about wellness issues. To allow for more flexibility, each unit on campus designed their own unique schedule of wellness activities based on the interests of the teens.

   In addition, the program implemented sensory integration through a sensory room. The use of sensory integration to promote healthy self-regulation in teens has been effective and congruent with the trauma-focused nature of the wellness program. Sensory integration education allows teens and staff to identify warning signs and initiate sensory interventions and coping skills to prevent escalation of behaviors.

5. **Lessons Learned in Implementation:**

   This experience determined what elements would be beneficial for future wellness programs and what elements are not necessary. It was learned that the weekly mood surveys should be eliminated from the program. Also, quarterly blood draws along with heart rate and blood pressure measurements should be administered to specific youth with health concerns. Lastly, although medication tracking is difficult to track for this population, specific medication tracking

measures identifying type, dose, and times per day, may be helpful in gaining more insight into the wellness program's effect on medication use. However, this would require adequate staffing to track this information on a more formal and consistent basis.

6. **Program Cost-Effectiveness:**

   Professional wellness consultants were an integral part of this contract, and their expertise in wellness benefitted all involved. Unfortunately, the cost comparisons surrounding the wellness activities that required an individual with a licensed certification or training to lead were not tracked during this contract term. In order to improve cost effectiveness it is recommended to analyze and determine which wellness activities require Wellness Leaders who possess professional certificates compared to those who do not.

Next Steps/Recommendations

Program has been discontinued; however, effective elements have been incorporated into existing programs since the philosophy of the program is well aligned with *Live Well! San Diego*.

Mental Health Services Act Innovations Projects

INN-02 HOPE Connections Evaluation 2015

Program Name: **HOPE Connections Peer and Family Engagement Project**
Program Start Date: **July 1, 2011**
Program End Date: **December 31, 2014**

Purpose

1. **Purpose:**
   HOPE Connections offered support to individuals experiencing mental health challenges and their family members from the unique perspective of "someone who has been there." HOPE Connections utilized peers, clinicians, nurses, and family members to assist clients in navigating the County of San Diego's behavioral health system. Specifically, they assisted clients particularly during significant life transitions such as the initial engagement with behavioral health services. Additionally, HOPE Connections aimed to reduce the need for hospitalization, reduce stigma, and foster independence in clients while they navigate behavioral health services.

2. **Explanation of Purpose:**
   HOPE Connections offered peer support and family engagement to clients and their families in three levels of care throughout San Diego County's Behavioral Health Services (SDCBHS): the County's Emergency Psychiatric Unit (EPU), the County of San Diego's Psychiatric Hospital (SDCPH), and designated outpatient mental health clinics. Culturally and linguistically competent support staff offered referrals, side-by-side coaching, assistance with reintegration into the community, linkages to appropriate mental health services, and help with navigating both behavioral and primary health care systems in an effort to encourage outpatient service utilization and recovery. HOPE Connections also developed an educational curriculum to train peer specialists and family members to serve as an effective bridge between primary health and behavioral health care.

Learning Objectives

1. **Learning Objective (#1): Determine the Impact of Peer Engagement**

What We Hoped to Learn: Did having Support Specialists at the clinic site produce better client recovery outcomes?

What We Learned: Overall, it was found that by having a presence of a Peer Specialist in the EPU and at clinic sites increased utilization of Outpatient services for enrolled participants from 28 percent to 60 percent. Even for individuals who were just contacted by Support Specialists in the EPU ad not enrolled in HOPE reported an increase in utilization of services from 25 percent to 40 percent.

2. **Learning Objective (#2): Determine if Peer Specialists Build Trusting Relationships with Clients and Family**

What We Hoped to Learn: Were Support Specialists able to build trust with clients and families and make them feel less overwhelmed?

What We Learned: The program implemented "warm hand-offs" by having Community Specialists meet and engage with a client prior to the client's discharge from the hospital. This was found to create a positive relationship between the staff and client. However, it was recommended to collect satisfaction data in the future to evaluate how well peer and family staff were able to engage and assist clients and their families.

3. **Learning Objective (#3): Understand the Service Patterns of Clients Engaged at EPU**

What We Hoped to Learn: Did initial client engagement by peers and family at the EPU lead to improved access and utilization of behavioral health services?

What We Learned: Preliminary data suggests that involvement with the program's peer specialists may have increased the utilization of outpatient mental health services at a higher rate than clients who did not have support through the HOPE program following the services received at EPU or SDCPH. Unfortunately, due to various reasons and entry points to access mental health services, this measure was not formally tracked throughout the program's existence.

4. **Learning Objective (#4): Detect the Role of Family Involvement in EPU Outcomes**

What We Hoped to Learn: Did an effort to include the family members of clients contribute to better outcomes in the EPU?

What We Learned: Increased family involvement served as an alternate source in reconnecting with clients post discharge and an important tool in utilizing the clients' natural resources in the community. However, this was not formally tracked within the program. While family involvement seemed to be very helpful for both staff and clients, it is recommended for future programs to collect data in effort to establish a link between family involvement and better outcomes in the EPU.

5. **Learning Objective (#5): Understand the Relationships Between EPU Engagement and Client Retention**

What We Hoped to Learn: Did effective engagement and linkage by the HOPE Connections team within the EPU result in greater client retention in behavioral health services?

What We Learned: The use of Community Specialists to drive patients to their initial clinic appointment immediately after discharge helped increase the clients' access to and utilization of services. Also, HOPE Connections ensured that established transportation services for future appointments were in place to help effectively engage clients to continue the use of needed behavioral health services. It was noted that patients often did not accept a ride to an appointment directly after being discharged from the hospital due to the desire to return home.

6. **Learning Objective (#6): Identify the Relationships Between Peer/Family Support and Long-Term Recovery**

What We Hoped to Learn: Did the use of peer and family supports result in positive long-term recovery outcomes for clients?

What We Learned: Various metrics regarding increased linkages to care, employment status, and living situation were not collected consistently throughout the program. It was learned to collect this information to track if peer and family support positively impacted clients and their long-term recovery outcomes.

7. **Learning Objective (#7): Determine the Effectiveness of Client-Centered, Recovery-Oriented Services within the EPU and Outpatient clinics**

What We Hoped to Learn: Did voluntary, recovery-oriented, client-driven services successfully change staff attitudes toward recovery within the EPU and outpatient clinic environments?

What We Learned: Through the use of peers and family, HOPE Connections was able to educate and support clients, their families, and the community in accessing resources. The program followed up with clients referred to mental health clinics to help create positive relationships and effective communication with the staff at mental health clinics. Also, the program assigned Community Specialists to be present at clinics during a specific time frame within walk-in hours to help establish relationships and set up meetings for the clients.

8. **Learning Objective (#8): Determine the Effectiveness of Peer Engagement Strategies within Age, Ethnic, and Cultural Groups**

What We Hoped to Learn: Were peer engagement strategies effective with certain age, ethnic, and cultural groups? Were these results strong enough to inform practice for this program and other programs in San Diego County?

What We Learned: Basic demographic information was not collected and analyzed to indicate whether peer engagement strategies were particularly effective within one group or another. However, the program did match the patient with a Community Specialist who had similarities in

regards to culture and age in effort to create a more positive relationship, especially surrounding a client's preferred language.

9. **Learning Objective (#9): Determine the Generalizability of the Program Model for other San Diego Emergency Departments**

What We Hoped to Learn: Is this program model generalizable to other emergency departments in San Diego County hospitals to provide support and linkage to clients and families?

What We Learned: With adequate funding, this model may be generalized to other emergency departments in San Diego hospitals. Preliminary evaluation results demonstrate that providing support and linkage to clients and families by peer specialists and family specialists are promising practices that may support increased utilization of outpatient treatment and a reduction in unnecessary hospitalizations.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   On June 30, 2013, the .5 full-time equivalent (FTE) community registered nurse (RN) position was increased to 1.0 FTE to better meet the needs of the clients.

2. **Impact on Participants:**

   With the implementation of Community Specialists, who were peer and family specialists, the program was able to coordinate and communicate the needed services for clients once they were discharged from the hospital. This helped clients become aware of how to access and use the services in their community. Clients often provided positive feedback to staff in regards to the positive impact peer support specialists had on their own life.

3. **What Was Learned:**

   The increase in RN hours to the HOPE Connections team enhanced effectiveness by providing additional support that other members could not provide. The community RN assisted in connecting clients who were not accepted into mental health clinics by linking them to Primary Care Physicians (PCP). The PCP prescribed necessary psychiatric medications, or linked them to a primary care clinic with a psychiatrist on staff who could prescribe psychiatric medications. Lastly, the RN was able to dedicate a large portion of time to the clients with multiple physical health problems. The nurse would work hard to get the clients connected with the health care specialist and accompany the clients to their appointment.

4. **Recommended for Replication? YES**

The HOPE Connections program established itself as an important intervention for clients in SDCPH's Emergency Psychiatric and Crisis Residential Units. This peer-based model has provided several promising indicators regarding service utilization and has led to its inclusion in the current Next Steps program.

5. **Lessons Learned in Implementation:**

Community Specialists were a huge success in creating a positive transition for clients from the hospitals to the community through: warm hand-offs in the hospital, setting up client's transportation to future appointments in the community, coordinating with Crisis Houses, and involving the family of clients to help clients through the transition. It was observed to be beneficial to match Community Specialists with clients with similar cultures, ages, and languages. Lastly, by having Community Specialists at the mental health clinics during walk-in hours was beneficial to help assist in the walk-in process, ensure acceptance into the clinic, and provide proper referrals for clients.

HOPE also facilitated an increase in coordination and communication with the client's assigned Social Worker on the inpatient units prior to discharge. This helped foster positive and proactive relationships with staff at mental health clinics. Also, implanting HOPE Connections helped better understand the nuances of each mental health clinic site operations and how it is vital in maximizing the assistance to clients when navigating the system. Lastly, by implementing the HOPE Connections Community RN, clients were able to get assistance with being referred to a PCP and managing all their health care needs. Also, the community RN can assist in connecting clients who were not accepted into the mental health clinic to a PCP who could prescribe psychiatric medications or another clinic that had a psychiatrist.

6. **Program Cost-Effectiveness:**

During the three year period that this program was implemented, 17 clients were assisted in the mental health clinics, 483 were assisted in the SDCPH, and 500 were assisted in the EPU. Overall, a total of 1,000 clients were assisted. Also, a budget of $4,810,000 was used for the three year contract term of this program, which resulted in a $4,810 cost per client.

Next Steps/Recommendations

Based on lessons learned through this project, successful elements of the program were incorporated into a Request for Proposals (RFP) that builds on the strengths of the Support Specialist model. This new program includes an emphasis on connecting clients to substance abuse and physical health services in addition to mental health services. Through the RFP, HOPE Connections became part of a larger program known as Next Steps. Next steps merged main aspects from ICARE, HOPE Connections, and the University of San Diego (UCSD) Bridge to Recovery. The overall purpose of Next

Steps is to combine the needed programs to coordinate care for individuals with serious mental illness and/or substance abuse issues within the mental health clinics, the psychiatric hospitals, primary care, and services within the community. The main aspects of HOPE Connections used within Next Steps is to continue to provide a better transition and coordination of care for clients being discharged from psychiatric hospitals into the community. This is done through community-based teams and Community Specialists. Next Steps had an initial contract term from January 1, 2015 to June 30, 2015 with a contract amount of $1,250,000. Next Steps has an option for six more contract years beginning July 1, 2015 and ending June 30, 2021 for $2,500,000 each additional year. The contract obligations are to screen 200 clients per month at the EPU and Crisis Recovery Unit (CRU), enroll 150 clients per month at the EPU and CRU, and contract with 100 family members per month.

Mental Health Services Act Innovations Projects
INN-03 Physical Health Integration Project Evaluation 2015

Program Name: **Physical Health Integration Project/ICARE**
Program Start Date: **January 10, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   ICARE (Integrated Care Resources) was an innovation pilot designed to create person-centered medical homes for individuals with serious mental illness (SMI) in a primary care setting. The goal was to enhance overall mental and physical wellness by increasing access to a physical health care for individuals with SMI.

2. **Explanation of Purpose:**
   ICARE was one of five MHSA components designed to foster new approaches to increasing knowledge about serving the mental health needs of San Diego County communities. The goals of all Innovation Projects were to use novel approaches to increase service access to underserved groups, increase quality of services, promote interagency collaboration, and increase service access for the mental health community. The focus of the ICARE program was to enhance mental and physical wellness through a holistic and collaborative continuum of care across primary care and mental health clinics.

Learning Objectives

1. **Learning Objective (#1): Determine the Interagency Collaboration between Community Health Centers and Mental Health Providers**

What We Hoped to Learn: Did this program promote interagency collaboration between community health centers and Mental Health service providers? Also, did this program increase access and quality of services for those individuals with an acute illness, who we were previously unable to be served adequately due to an overburdened Mental Health System?

What We Learned: After the end of the program, the evaluation results indicated that Federally Qualified Health Centers (FQHC) and mental health clinics had an increase in interagency collaboration and promoted both access and quality. 227 participants were enrolled over the program duration of three years. Overall satisfaction scores from clients increased by 5 percent between baseline and after six months, and were 5.8 percent higher (98.3% compared to 92.5%) when compared with the aggregate scores of other County mental health programs.

2. **Learning Objective (#2): Identify the Improvement in Overall Outcomes for Older Adult Population**

What We Hoped to Learn: Did this approach meet the mental health and physical health needs of the older adult population? Also, did this program improve the overall outcomes of the older adult population?

What We Learned: Overall, 102 individuals over the age of 50 were enrolled in the program, accounting for 45 percent of the total sample. Although the older adult population made up a majority of the client group, no further analysis was done specifically for this population. It was learned that due to the large representation of older adults within this program, more future data collection and analysis can be done surrounding this population.

3. **Learning Objective (#3): Identify the Underserved and Refugee Community Outcomes**

What We Hoped to Learn: Did this approach benefit and meet the mental health needs of those in the underserved and refugee communities who typically present in primary care settings with physical complaints?

What We Learned: At the end of the program, only 4.3 percent of participants' initial visits were from a primary care setting. This may be because this program and the SmartCare psychiatric consultation program provided a great deal of support to primary care to treat individuals with higher level mental health needs. Also, ICARE had a contractor who specifically treated mental health for refugee populations. Therefore, if refugees were identified and referred, it may have occurred outside this project.

4. **Learning Objective (#4): Clarify the Recognition, Referral, and/or Treatment of Underserved Communities**

What We Hoped to Learn: Did a systematic investment in the competence of primary care providers to recognize and manage mental health needs increase their recognition, and referral or treatment of this otherwise poorly served community?

What We Learned: Staff's overall satisfaction with the integrated provided services for clients, which was measured through focus groups and surveys of providers, was high. Data from the psychiatric consultation program (separate from this program) indicated that the clinics that participated in ICARE were some of the more frequent users of the service. This result may indicate an increased awareness and willingness to serve the SMI population. Overall, there was an increase in providers feeling confident in their own ability and the clinics' ability to serve these communities in need.

5. **Learning Objective (#5): Identify the Mental Health Outcomes when Clients Receive Physical Health Services**

What We Hoped to Learn: Was there an improvement in mental health outcomes when clients with SMI received ongoing physical health care services and/or treatment in a primary care setting?

What We Learned: ICARE participants were among SDCBHS clients whose outcomes were measured previously at mental health clinics. To evaluate overall improvement in mental health outcomes, the client's previously recorded mental health data was used to compare ICARE participants' mental health recovery before and after ICARE participation at baseline, 6-month, 12-month, and 18-month follow-up assessments. At the ICARE 6-month and 12-month follow-up, participants significantly improved their mental health recovery since their last assessment at the mental health clinic across all participant and behavioral health specialist perspectives. There was also a significant improvement in recovery from the mental health clinic to 18 months in ICARE. Overall, ICARE participants showed mental health recovery improvements through enrollment in the program compared to their previous mental health clinic scores.

6. **Learning Objective (#6): Reduce the Stigmatization of SMI Clients with Primary Care Physicians and Staff**

What We Hoped to Learn: Did adapting the Behavioral Health Consultant (BHC) model, which has shown to be effective for less serious mental illness, assist primary care providers in serving the behavioral health needs of their patients with stable SMI? Also, did this role also help reduce the stigmatization of SMI clients within the Primary Care staff?

What We Have Learned: At follow-up, participants showed improvements by reported decreases on almost all perceived stigma items, indicating that they felt less stigmatized as a result of their mental health condition. Also, average stigma scores slightly decreased from baseline to six months (2.80 to 2.52) and then remained fairly constant at 12 and 18 months (2.57 to 2.59). However, these changes in average stigma scores were not statistically significant.

7. **Learning Objective (#7): Clarify the Needs of Refugee and Immigrant Populations in Primary Care Setting**

What We Hoped to Learn: Did this behavioral health integrated approach meet the mental health needs of refugee and immigrant populations at the primary care setting?

What We Have Learned: ICARE had a contractor who provided mental health services specifically for refugee populations and they were not part of this current innovations project. Therefore, if refugees were identified and referred, it may have occurred outside this project and were not tracked to show ICARE's ability to meet the needs of this population in the primary care setting. However, it is not sure that having this contactor in place led to more services being provided to this population.

8. **Learning Objective (#8): Determine the Utilization Rates of the Emergency Department**

What We Hoped to Learn: Did the number of emergency department (ED) visits decrease among individuals with SMI who received ongoing physical health care compared to the current rate for clients in the Mental Health System?

What We Have Learned: Overall, a reduction of ED visits were reported for those with SMI who engaged in this project. This was evaluated with a percentage of participants reporting zero emergency room (ER) visits in the last six months for any reason decreased from a baseline of 78.3 percent to 71.7 percent at six months. Results increased to 78.3 percent to 12 months and then increased to 89.1 percent at 18 months.

9. **Learning Objective (#9): Understand the Coordination of Clients with SMI from Mental Health Clinics to Primary Care Provider Settings**

What We Hoped to Learn: Did the coordination of stable SMI clients from the health clinic into the primary care setting help the county serve more severe SMI clients?

What We Have Learned: Surveys of the ICARE staff at baseline and at the completion of the program resulted in an increase in providers' satisfaction with their ability to coordinate and arrange services for less stable SMI clients. There was an increase from 57 percent to 86 percent in staff's reported ability to communicate between Primary Care providers and Behavioral Health providers. Also, staff's reporting of the ability for Behavior Health and Primary Care settings to provide integrated services to help clients increased from baseline to the completion of the program.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   During the course of implementation, project staff discussed the possibility of expanding the site where the program was offered to include the south region. This was due to a large number of clients in this area who met the criteria for participation and a health clinic was located nearby. Therefore, an exam room was built at the South Bay Guidance Center to accommodate the nurses' physical exams for clients. Also, Chula Vista Family Health Center site was added to the list of participating locations for the ICARE program.

   Secondly, the staff explored the idea of utilizing the LVN as the Nurse Care Coordinator instead of an RN. It was determined that the LVN would be more cost-efficient and would provide the health information and scheduling assistance that was needed to continue to make the project successful.

2. **Impact on Participants:**

The addition of the South region site had a positive impact on the program and its participants. The site became a steady source of referrals. Participants at both mental health sites were able to choose to receive their health care at Chula Vista Family Health Center if that location better met their needs. Other choices include Logan Heights, North Park, and the Downtown clinics. The clients who had access to this program received all of the services available for the ICARE participants at the Areta Crowell Center: physical health screenings and on-site scheduling assistance; substance abuse screening and counseling; peer assistance in transitioning to the Family Health Centers' services; and support from BHCs during the process.

3. **What Was Learned:**

Overall, participants' physical health had no significant changes throughout the program. However, there was an increase in medication adherence scores and an overall increase in the number of clients reporting zero hospitalizations for physical health reasons. Therefore, there was no significant impact directly on a client's physical health, but there was an increase in positive behaviors relative to physical health.

Throughout the program, there were very high satisfaction scores from both providers and clients with the overall communication, access, and coordination of services provided. This was shown through significant improvements in the behavioral health specialist's perspective of participant's mental health recovery measures. Also, participants reported significant improvements in their own mental health recovery. These significant improvements traversed from the mental health clinics through ICARE follow-ups. Furthermore, ICARE participants improved greater than outpatient clients in some aspects of mental health recovery.

It was also learned that the older adult population represented a large portion of clients served in this program. It is recommended to create more focus on tracking this population to better fit their needs if replicated.

4. **Recommended for Replication? YES**

Yes, this project is recommended for replication. While the program could be run successfully as is, the County has chosen to use elements from this program in combination with other projects to create a new program.

4. **Lessons Learned in Implementation:**

In addition to providing services in an area where the ICARE program was clearly needed, the ICARE expansion showed us how participants in different regions respond to the model. Staff found that clients from Areta Crowell Center, who are a more transient population, were relatively

amenable to the idea of needing to access their mental and physical health care at a new location. However, the clients in Chula Vista were more resistant to this idea. Staff noted this could be due to a difference in demographic make-up between the two client populations each site served.

To meet this challenge, BHCs began to spend more time at the mental health site so that clients would get to know them better before they transitioned to the health clinic for their services. By building this relationship from the front end, clients were then greeted by a familiar face when they made their first appointment at the new clinic. The BHCs provided the clients with more detail regarding the building and the process at the new clinic, which made the transition smoother.

6. **Program Cost-Effectiveness:**
   An increase in funding for the program provided additional services that were previously unavailable. ICARE supplied a Nurse Care Coordinator onsite at the mental health clinic that performed physical health screenings and direct appointment scheduling at Federally Qualified Health Centers. An Alcohol and Other Drugs (AOD) counselor was also available for screenings, groups, and follow-up support. Peers helped transition clients to the new health center, provided follow-up with clients regarding appointments, and also helped clients obtain necessary eligibility paperwork. BHCs provided necessary, therapeutic support as clients transitioned from the mental health clinics to the Federally Qualified Health Center sites.

Next Steps/Recommendations

Based on lessons learned through this project, successful elements of the program were incorporated into a Request for Proposals (RFP) to create a new program. This program builds on the strengths of the peer specialist model and includes an emphasis on connecting clients to substance abuse and physical health services in addition to mental health services. Through the RFP, ICARE became part of a larger program known as Next Steps. Next Steps merged main aspects from ICARE, HOPE Connections, and the University of San Diego (UCSD) Bridge to Recovery. The overall purpose of Next Steps was to combine the needed programs to coordinate care for individuals with severe mental illness and/or substance abuse issues within the mental health clinics, the psychiatric hospitals, primary care, and services within the community. The main aspects of ICARE used to help coordinate the care for people from mental health clinics to primary care services. Next Steps had an initial contract term from January 1, 2015 to June 30, 2015 with a contract amount of $1,250,000. Next Steps has an option for six more contract years beginning July 1, 2015 and ending June 30, 2021 for $2,500,000 each additional year. The contract obligations are to screen 200 clients per month at the EPU and Crisis Recovery Unit (CRU), enroll 150 clients per month at the EPU and CRU, and contract with 100 family members per month.

Mental Health Services Act Innovations Projects
INN-04 Mobility Management in North San Diego County Evaluation 2015

Program Name: **North County Transit District: Mobility Management Program**
Program Start Date**: August 1, 2011**
Program End Date: **June 30, 2014**

Purpose

1. **Purpose:**
   Mobility Management Program (MMP) was developed to increase access to underserved groups. MMP was a peer-based transportation program designed to improve the availability, quality, and efficient delivery of transportation services as well as increase participant access to services and activities. It was also meant to minimize barriers to transportation for seniors, people with disabilities, and low-income residents in North County. The primary components of the program included travel training and transportation coordination. Transportation Coordinators educated service providers and consumers on transportation resources in the North San Diego County region. Mental health consumers who preferred to receive training in a group format were able to participate in group travel training courses facilitated by the Transportation Coordinator. Similar to the one-on-one mentoring referred to as a "Travel Trainer", group classes focused on educating consumers on how to navigate the transit system safely and confidently throughout the local community. Consumers learned how to use the Rider's Guide to map routes to and from their desired destinations, understand the ticket vending machines, on-line resources, transit center locations, and amenities. The final component of the group training process included planning and implementing a field trip utilizing public transportation to a location selected by the class members.

2. **Explanation of Purpose:**
   It is a well-established fact that current systems of transportation in San Diego County do not meet the needs of the people who must rely on public transit or private transportation (Full Access & Coordinated Transportation, Inc.). Numerous stakeholders have expressed this need throughout the MHSA Community Planning Process. Stakeholders have stated that a peer-based transportation program could increase self-sufficiency, provide more access to patient services, and lead to fewer appointments missed. Other benefits that the stakeholders identified were opportunities to build relationships with peers while sharing rides, the reduction of family's stress because they will know that transportation assistance is available, and the reduction of isolation because clients will need to get out and talk with peers in order to get to their appointments.

   Studies clearly demonstrate that older adults are underserved by community mental health systems for a number of reasons. One significant cause is the inability for individuals to access adequate services. In addition, changes in regional demographics and land use patterns require new approaches for providing transportation services, particularly for underserved adults and

older adults in North San Diego County. North San Diego County consists of a geographic region larger than the state of Rhode Island, and over half of the area is rural. Historically, due to low population numbers, these areas have consistently struggled with securing adequate resources to provide comprehensive health and social services to community residents.

According to the findings of the study, "Transportation Concerns and Needs of Mental Health Client Populations in North San Diego County," residents have limited knowledge of available transportation resources. Evidence suggests that a small number of consumers are reaching out and effectively connecting with public transit options.

Transportation plays a critical role in providing access to employment, health care, education, community services, and activities necessary for daily living. The importance is underscored by the variety of transportation programs created in conjunction with Health and Human Services programs and the significant federal investment in accessible public transportation systems, United We Ride.

Learning Objectives

1. **Learning Objective (#1): Understand the Utilization of the Transit System**

What We Hoped to Learn: Did MMP participants utilize the transit system more frequently and rely less on family and friends for transportation? By reducing various barriers to utilizing public transportation, were participants more confident and independent, thus improving their overall social functioning and satisfaction?

What We Learned: At the end of the program, 70 percent of travel trainees reported utilizing transit more often than they did prior to participating in the travel training program. Also, 58 percent reported receiving rides less frequently from friends or family for the purpose of attending appointments or activities. Overall, this revealed how MMP positively impacted participants and their families.

2. **Learning Objective (#2): Understand Participant's Engagement with Health and Medical Appointments**

What We Hoped to Learn: Did implementing MMP increase the number of health and/or medical appointments scheduled for participants?

What We Learned: Overall, 69 percent of participants who reported on the pre-test that they avoided scheduling health and/or medical appointments due to transportation barriers reported an increase in the number of appointments they now schedule. Also, 77 percent of participants completed the post-test reported an increase in the number of health and/or medical appointments they could not attend, compared to the pre-test. Lastly, 83 percent of consumers who completed

travel training reported on the post-test that they use public transit to participate in social activities. All of these findings reveal how the MMP helped participants feel more comfortable with utilizing the transit system for various reasons.

3. Learning Objective (#3): Identify the Outcomes for Peer Volunteers and Participants

What We Hoped to Learn: By recruiting peers as volunteer drivers for the Ride Share component of the program, did both the volunteer and participant enhance their social skills, did the participant increase mobility, and did the family members feel less of the responsibility of transporting the participant?

What We Learned: The objective of the Ride Share program was to reduce barriers and increase mobility for the targeted population. Though well received and desired, the Ride Share component was discontinued for several reasons. One of the reasons was a difficulty recruiting a sufficient number of volunteer drivers, especially surrounding the potential liability for these drivers. Another reason was a high volume of administrative requirements that were necessary to provide services responsibly and safely. Lastly, most consumers preferred the advantages of Ride Share services over using transit, even if they possessed transit skills. This created a more frequent utilization of the program's service which was not sustainable due to lack of volunteer drivers.

Analysis of Program Effectiveness

1. Changes or Modifications During Implementation:

The Ride Share component was discontinued due to low number of volunteer drivers and the high level of liability and administrative process needed for these drivers.

2. Impact on Participants:

Overall, consumers developed a better social network and resources in regards to accessing services in the area. However, due to the program being discontinued, those who were receiving rides no longer had that option available. All other components of the program remained.

3. What Was Learned:

The program successfully exceeded the contract goal and engaged 463 individuals. It was learned that offering incentives, providing group travel training services, and marketing on the BREEZE Buses were successful outreach efforts to recruit participants. Overall, consumer engagement increased access to services and activities and helped develop friendships among the participants. The peer-based service model was successful and helped program volunteers stay committed. Also, several consumers were very active in encouraging their peers to enroll. Lastly, the program was successful in developing and strengthening partnerships with Clubhouses, hospitals, and many of the mental health provider agencies.

A major issue for this program surrounded the difficulty in recruiting volunteer drivers. There was a high volume of administrative requirements necessary for volunteer drivers to provide services responsibly and safely, along with a potential liability of the drivers. This resulted in a very limited number of transportation options, especially in the rural communities. Lastly, most consumers preferred the advantages of Ride Share services over using the transit system, even if they possessed transit skills. This created a more frequent utilization of the program's service which was not sustainable due to lack of volunteer drivers.

Another issue was access and engagement in the program. Most mental health service providers had large workloads. This made it difficult for many of them to dedicate the time and effort needed to facilitate consumer access to the MMP. It was also noted that private practitioners were difficult to engage within the program. Also, the stigma associated with mental illness was a barrier to enrollment for many, particularly among the older adult population. Lastly, consumers were not able to readily identify "recovery skills".

4. **Recommended for Replication? NO**

While the program had some success with some mental health clients, it is not recommended for replication due to its low priority for the limited funding resources available. Transportation issues in the North County Regions, particularly in the rural areas and for adults with mobility issues, cannot be significantly improved by this program.

5. **Lessons Learned in Implementation:**

Due to the difficulty surrounding the recruitment and administrative processes needed for volunteer drivers, the program was unable to significantly improve the mobility issues in the North County regions. However, the client satisfaction and the benefit from the program were very high. It was also learned which outreach efforts were beneficial in recruiting clients for the program. Overall, the program was not the most cost-effective way to improve the transportation barriers for individuals to access needed services.

6. **Program Cost-Effectiveness:**

There was an increase in the number of participants who were able to utilize the transit system and this increased both social and health-related interactions. This program utilized Volunteer Travel Trainers and volunteer drivers, which improved the cost-effectiveness of the program. However, due to limited priority and limited funding resources available, the expansion to recruit and the liability to cover more volunteer drivers in the program were not sufficient.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-05 Positive Parenting for Men in Recovery Evaluation 2015

Program Name: **Positive Parenting for Men in Recovery**
Program Start Date: **July 1, 2010**
Program End Date: **June 30, 2013**

Purpose

1. **Purpose:**
   The Positive Parenting for Men in Recovery was a voluntary program which offers a culturally integrated approach to education that incorporated parenting skills, mental health wellness, substance abuse education, and violence/trauma prevention for fathers who were in Alcohol and Other Drug (AOD) treatment and had co-occurring disorders. This program worked to enhance parenting and coping skills for these fathers and address negative issues that arise from trauma, mental illness, substance abuse, and violence in order to produce better outcomes for them and their children. The program design was composed of a 13-session group program with four objectives:
   i. Increase Positive Parenting skills
   ii. Improve mental health wellness
   iii. Reduce substance abuse risk factors and/or stressors
   iv. Reduce/prevent violence and trauma (directed at children or self and others)

2. **Explanation of Purpose:**
   This project provided opportunities for clients to learn behavior and management skills that focused on teaching self-regulation, thus enabling recovering males to gain better control of their lives and reduce dependence/reliance on illicit substances. We hoped to be proactively addressing how child abuse affects parenting patterns and provide the tools necessary to prevent future generations from struggling with emotional, mental health, and/or substance abuse issues. This was a voluntary group program for men in the following target population:
   i. Transition age youth (TAY) , ages 18-25
   ii. Enrolled in non-residential AOD treatment programs at six Regional Recovery Centers (RRCs)

Six Regional Recovery Centers had equal funding and objectives, noted in the table below:

Contract	Contractor	RRC	3-Year Funding	3-Year Caseload Objective	Documented Graduates	Pre- and Post-Tests	Surveys	Comments
534111	MITE	SOUTH	$105,000	75	16	8	17	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534112	MITE	EAST	$105,000	75	41	20	27	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534113	MHS Inc.	CENTRAL	$105,000	75	66	51	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534154	MHS Inc.	NORTH INLAND	$105,000	75	17	0	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
534155	MHS Inc.	MID-COAST	$105,000	75	0	35	24	REPORTED 32% AVERAGE INCREASE IN POST-TEST SCORES
534156	MITE	NORTH COASTAL	$105,000	75	49	23	0	SPECIFIC KNOWLEDGE INCREASE NOT REPORTED
TOTALS			$630,000	450	189	137	68	

Learning Objectives

1. Learning Objective (#1): Determine the Impact of Positive Parenting Skills

What We Hoped to Learn: Were both target populations able to produce measureable improvements in positive parenting skills as measured by pre- vs. post-tests?

What We Learned: A small portion of motivated or court-ordered clients experienced an improvement in parenting skills through a non-clinical therapy. In a relaxed group setting led by experienced clinicians. An improvement was found when the therapy group incorporated an enhanced parenting curriculum within the sessions. All of these aspects were also very effective for the men already receiving mental health services. However, pre- and post-test improvements were not measured formally in all cases. Therefore, significant increases in positive parenting skills were unable to be determined.

2. Learning Objective (#2): Understand the Impact of Mental Health Wellness

What We Hoped to Learn: Did this program help male clients to learn more about mental health wellness and additional treatment resources as well as child and family trauma/violence prevention issues?

What We Learned: This program found that a relaxed "non-clinical" tone or setting allowed the participants the time and comfort to be open and to engage in the group, bond with other members, and be receptive to the instructor and curriculum. Some of the main topics that clients felt were helpful included: mental health resources in the community, self-monitoring and awareness for signs of mental health problems, and where to go for medication management support. It was also learned that providing refreshments, like snacks and soft drinks, for the male TAY population was highly recommended to encourage participation and retention.

3. Learning Objective (#3): Understand Substance Abuse Risk Factors and/or Stressors

What We Hoped to Learn: Did helping clients identify life stressors related to parenting issues and provide additional tools for reducing risk factors for relapse, create positive outcomes for this population?

What We Learned: Through implementation, many effective approaches for this population resulted in positive outcomes. First, the approaches of redirecting anger to acknowledge and adopting positive parenting behaviors best suited for their child were effective for clients. Also, meditation and visualization techniques were taught to clients as stress reduction tools. Lastly, it was observed that clients in the Strength-Based Regional Recovery Centers who benefited from the group chose to continue the group outside the contract setting.

4. Learning Objective (#4): Determine the Impact of Violence and Trauma Prevention

What We Hoped to Learn: Did the contractor's use of "trauma-informed" approaches recognize the vulnerabilities of trauma survivors, and avoid inadvertently re-traumatizing clients, while also facilitating client participation in treatment?

What We Learned: It was learned that a large majority of the TAY fathers in AOD programs have experienced some form of trauma, neglect and/or abuse as children. Therefore, clients benefited from increased knowledge about trauma and how it impacts negative and positive approaches to parenting. Also, role playing and discussing a model of healthy parenting were perceived as being beneficial to most clients in a group setting.

Analysis of Program Effectiveness

1. **Changes or Modifications During Implementation:**

   No changes or modifications were made throughout the implementation of this program.

2. **Impact on Participants:**

   Overall, 189 documented clients in the program graduated. Of the 189, 68 clients completed satisfaction surveys and 70 percent of surveys had very positive satisfaction ratings Also, there were 137 clients who completed both the pre-and post-program tests. An average of 49 percent of post-tests results showed improvement. Unfortunately, this was below the benchmark expected outcome of 70 percent.

3. **What Was Learned:**

   Overall, creating age-based parenting sub-groups with some level of shared experience fostered comfort and openness within the clients. In addition, sub-groups of differing perspectives and cultural backgrounds learned improved parenting skills from each other by dialoguing in the group setting and sharing successful strategies. Finally, it was learned that improving parenting skills appeared anecdotally to promote increased sobriety and social competence of formerly substance-abusing, male parents.

4. **Recommended for Replication? NO**

   The high cost per client was a main contributing factor to discontinuing the program; however, components and aspects of this model can be incorporated into existing AOD services or Prevention and Early Intervention programs with similar benefits to the client population and their children.

5. **Lessons Learned in Implementation:**

   The program revealed that positive parenting resources for men in AOD treatment are in a supply deficit. This target population would benefit from specific curriculum, in group sessions, within established contracts, and using existing staff. Also, providing separate, non-treatment oriented parenting groups allowed clients to focus on parenting skills taught by the instructor and curriculum, while supporting AOD treatment goals. Lastly, it is recommended that TAY treatment

participants be screened to see whether they need anger management services as a supplement to substance abuse treatment.

6. **Program Cost Effectiveness:**

   The cost per client was determined by taking the total dollar budget ($630,000) and dividing by the number of graduates in the program (188), resulting in $3,807 per person. However, it should be noted that the actual cost was less due to some contractor underspending. Overall, there was an increase in level of services as these services formerly did not exist and the staff to client ratio was 1:7.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-06 After-School Inclusion Program Evaluation 2015

Program Name: **MHSA Innovations After-School Inclusion Program**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   The purpose of the MHSA Innovations After-School Inclusion Program was to increase access to after-school programs for youth with social-emotional and/or behavioral issues. The program provided opportunities for students, previously stigmatized and/or precluded from participating, to be integrated with their peers by utilizing Inclusion Aides. Inclusion Aides provided behavioral support and taught the participating youth pro-social and functional skills. The program introduced a community defined approach to the behavioral health system that has been successful in a non-mental health context. Additionally, the Inclusion Program educated after-school staff, families, and other community members on how to help youth with behavioral issues thrive in their environment with the intent of building in sustainability of concepts in after school programs. The Inclusion Program measured the impact of the benefit derived from behavior interventions and access to after-school programs on youth with behavioral issues.

2. **Explanation of Purpose:**
   Research has shown a community need for services to provide interventions for youth who are exhibiting social-emotional and/or behavioral issues while in the care of after-school providers. Often after-school providers are not equipped with the knowledge and/or training to work with these youth. Therefore, these youth are at risk of being precluded or discharged from the after-school program. When youth do not have the opportunity to participate in after-school programming, stressors may occur in the family which can lead to further issues in the community. Often, families do not have the resources and/or knowledge to access available services for their children. Inclusion Program staff who were working with these youth were able to provide appropriate support aligning with the behavioral health system in a nontraditional mental health setting. Inclusion Program staff offered one staff-per-client behavioral support to the youth and taught the after-school staff how to work with these youth through both formal and informal training.

Learning Objectives

1. **Learning Objective (#1): Understand Students' Self-Esteem, Social Competence, and Healthy Behavior**

What We Hoped to Learn: Did Inclusion Aides increase participating youth's self-esteem, social competence, and healthy behavior?

What We Learned: Based on a self-reported youth survey at the beginning of the program and at the end, results showed that youth's perception of their behavior increased significantly after participating in the program. Also, both parents and staff reported a significant improvement in the youth's exclusion, hyperactivity, aggression, anxiety, and anti-social and pro-social behaviors after their participation in the program.

2. **Learning Objective (#2): Determine the Impact of an Individualized Behavior Intervention Plan**

What We Hoped to Learn: By developing an Individualized Behavior Intervention Plan, did participant's social connectedness and self-worth increase?

What We Learned: Social connectedness was measured by assessing youth's perceived levels of social acceptance and self-worth when they entered the Inclusion Program compared to when they exited the program. Results showed a significant increase in youth's perceptions of their social acceptance and self-worth from the program entry to program exit.

3. **Learning Objective (#3): Understand the Impact on Parents or Guardians Stress Levels**

What We Hoped to Learn: Did a youth's participation within the Inclusion Program decrease a parent's or guardian's stress level?

What We Learned: Parent's stress levels were measured by a self-reported measure at their child's entry into the program and exit from the program. Results revealed that parent stress levels decreased significantly after their child participated in the Inclusion Program.

4. **Learning Objective (#4): Identify the Use of Gatekeepers Referrals to Appropriate Services**

What We Hoped to Learn: Did the Inclusion Program model properly educate after-school staff (Gatekeepers) to improve their ability to support youth with social-emotional and behavioral challenges?

What We Learned: Overall, 95 percent of Gatekeepers agreed or strongly agreed that the trainings they received from this program helped them increase their knowledge of the topics covered. Also, Gatekeepers provided feedback and reported they felt that Inclusion Aides practiced open communication with staff and taught staff new approaches on how to best support youth. However, a constant turnover rate with after-school staff made the sustainability of the program knowledge challenging. Also, it was observed that site supervisors and staff varied on levels of openness and utilization of all the interventions and strategies given to them by Inclusion Aides. The after-school

program sites and staff with more participation resulted in fewer behavior issues among the children in the after-school program.

5. Learning Objective (#5): Determine the Effectiveness of Referrals to Community Resources

What We Hoped to Learn: Did program participants and families in need of external resources get successfully connected to community resources?

What We Learned: Not all families were interested in receiving information about other programs and services at the time of intake. It was learned that Inclusion Aides often had more success with providing referrals during the course of services rather than at the beginning or end. Some families took advantage of the external resources given to them. When families were able to connect with resources and outside referrals, positive change within the family system was observed.

Analysis of Program Effectiveness

1. Changes or Modifications During Implementation:

During the course of the program, the Inclusion Program made modifications programmatically, administratively, and fiscally. There were some programmatic changes surrounding trainings implemented over the three years. First, the Inclusion Program developed standardized training curricula on a wide variety of topics that fit the need of the after-school program and participant issues. The program's delivery model was changed and implemented to these standardized trainings quarterly at after-school program staff meetings. The Inclusion Program also implemented training at camp site facilities, while providing support for participants at camp. Second, the Inclusion Program set standards for productivity, such as requiring Inclusion Aides to meet with after-school staff for at least 30 minutes per week, meeting with school staff monthly, working with participants at a high rate, and meeting with families regularly. Also, Inclusion Aides were given the opportunity to pick one to two trainings to attend that were specific to issues at their site and the participants' behaviors.

There were also a few changes in regards to meetings and supervision that were implemented. First, the program's full-time staff met regularly with the branch coordinators and directors to discuss program challenges and successes. Also, additional components of supervision were added where the Lead Inclusion Aides provided individual and group supervision, as well as went out and monitored school sites.

Administrative changes surrounded hiring a fifth Lead Inclusion Aide to help facilitate the training process and develop training curricula, as well as monitor school sites. Also, an Advocacy Coordinator was hired to help with community outreach, recruitment, and program development.

Fiscal changes to the Inclusion Program included 15 additional Inclusion Aides, two Data Entry staff, and one Receptionist added to the program's staff on a temporary basis. The program

Research Associate began as a part-time position but switched over to a full-time position for the remainder of the fiscal year. Beginning July 1, 2013, the position went back to part-time and as of October, has been eliminated and replaced with an Independent Subcontractor for the outcome analysis. The program Office Administrator started as a 30-hour per week position and at the end of the program was a full-time position. Also, the Inclusion Program contracted with Harder & Company to do data analysis.

2. **Impact on Participants:**

The Inclusion Program implemented a positive change model for working with youth. Participating youth reported high satisfaction rates along with improved outcomes. Parents and Gatekeepers involved with the program also reported high satisfaction rates and noticeable behavior changes of the youth in the program.

3. **What Was Learned:**

During the implementation of the program's first year, the Inclusion Program learned many different lessons. In the area of staff supervision and training, the addition of the fifth Lead Inclusion Aide helped improve program development and sustainability. Also, having a tiered system of supervision was important because Lead Inclusion Aides provided a wealth of knowledge and guidance to Inclusion Aides in their region. Staff was attracted to the Inclusion Aide position as a stepping stone to other professions within the field of behavioral health. This led to a difficulty in retaining staff and keeping continuity within the after-school program needed to make the program more effective. Lastly, it has been difficult to find bilingual staff, which was ideal to serve the client population at certain schools.

Communication was a key aspect to this program. It was critical to consistently reach out to school districts to ensure collaboration. There were different types of after-school programs, such as non-licensed programs (free) versus licensed programs (parents pay for services). There were different regulations and requirements for each program. Also, it was integral for the Inclusion Program to have constant communication with the YMCA branches to ensure collaboration and increased referral numbers.

The Inclusion Program also learned through trauma-informed care that the majority of the participants had mental health issues and/or experienced trauma in some way. More participants than the program originally thought have been or were involved with the child welfare system, were exposed to substance abuse, have had incarcerated parents, and exhibited different mental health diagnosis. This led to the realization that the best way to train the after-school staff was to have standardized training curricula that could be used across the county to educate staff on a wide range of topics and behaviors.

Overall, it took not only a large amount of time, effort, collaboration, drive, and passion to set up the infrastructure of a brand new program. In order to produce quality data, a specialized evaluator and system were critical.

4. **Recommended for Replication? YES**

   The Inclusion Program was very successful throughout its first year. We learned what were our limitations, challenges, and capabilities. The biggest difficulty for the program was sustaining staff for part-time positions. For the continuity and stability of the program, it would be helpful to have the Inclusion Aide position be full-time, but due to after-school program hours, having full-time Aide positions were not practical or cost-effective.

5. **Lessons Learned in Implementation:**

   While implementing the Inclusion Program we have learned about all the available resources in the community and the best practices for reaching out and linking participants and families to appropriate services and resources. Also, the Inclusion Program learned that staff consistency was very important and integral to the success of the youth and families. Lastly, after-school programs and/or districts were not always run the same; therefore, it is hard to hold staff accountable to the same standards. For example, sports were not offered in all after-school programs. Also, youth were in the after school program until 6:00 p.m., Monday through Friday, and on the weekend parents did not always have resources to get the participants involved in recreational activities and sports.

6. **Program Cost-Effectiveness:**

   Throughout the first year of programming, there was an increase in the amount of schools and participants. Inclusion was able to provide the adequate services and hire 15 additional Inclusion Aides on a temporary basis due to the budget allotted. This gave Inclusion the capability of working with more participants, families, and training more after-school staff.

   Over the contract term, $3,453,047.83 was used and a total of 797 youth were served. Therefore, $4,332.56 was spent per youth. The program ultimately fell short of their goal of 300 youth per fiscal year, which would have brought down the cost per client. This compares to an estimated target cost per client of $3,000 in the Children, Youth and Families outpatient system; however, the premise was that if preventive work is done on the front end, there are savings not only in dollar terms, but also in the long-term impact of preventing youth from entering the behavioral health system. Also, a potential one-staff-per-client behavior coaching service through Therapeutic Behavioral Services can cost on average $5,000. This program was proven to be cheaper than other forms of interventions.

Next Steps/Recommendations

Program to be discontinued; however, effective elements to be incorporated into existing programs.

Mental Health Services Act Innovations Projects
INN-07 Transition Age and Foster Care Youth Evaluation 2015

Program Name: **TAY Academy**
Program Start Date: **July 10, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   The goal of TAY Academy was to enhance life skills, increase self-sufficiency, and self-esteem, improve behavioral and mental health conditions, and improve overall wellness for its target population. TAY Academy attempted to increase access to Transition Age Youth (TAY) and Foster Youth by providing solutions to the challenges, problems, and barriers identified by these populations. Also, this program established five regionally-based TAY Academy Centers that integrated coaching, mentoring, and teaching strategies for the TAY and Foster Youth. TAY Academy worked towards a successful transition to independent living and increased the number of youth/TAY who transition out of the Children, Youth, and Families System into the Adult and Older Adult System of Care.

2. **Explanation of Purpose:**
   TAY and a prominent subset of current and former Foster Youth often have difficulty in transitioning from the Children, Youth, and Families System into the Adult and Older Adult System of Care. There is a noted struggle in this area due to a lack of overall support and access to care. Subsequently, these TAY are at an elevated risk for mental illness compared to their peers of the same age.

Learning Objectives

1. **Learning Objective (#1): Determine the Impact of Individualized Goal Plans**

What We Hoped to Learn: By creating individualized goal plans, did the participants' engagement in other services increase?

What We Learned: There were an overall 1,134 youth served through the TAY Academy. Around 169 of these individuals served created an individualized vision plan to address their needs and reduce their problems and barriers. It was then found that of these individuals who created individualized goal plans, 95 percent demonstrated intensive engagement for a period of at least six months by accessing Connections coaching and Seeking Safety curricula, vocational training, and/or short-term stabilization housing. Also, 87 percent of the youth with individualized goal plans demonstrated progress towards meeting one or more life plan goals in the areas of Safety, Health and Wellness, Education, Employment, Self-Sufficiency, and Stability. Lastly, 108 youth out of the 169 youth (64 percent) demonstrated sustained or increased productivity by enrollment in school, college, training program, community service program, or employment.

2. Learning Objective (#2): Determine the Impact on Transitioning Foster Youth

What We Hoped to Learn: Did the TAY Academy increase the engagement and retention rates of Foster Youth in supportive transitional activities?

What We Learned: Overall, 131 out of 1,134 (11.6 percent) of youth were current or transitioning Foster Youth from the Foster Care System. Activities performed with this former Foster Youth surrounded creating vision plans, accessing connection coaching, and increasing their engagement in supportive transitional activities. However, data was not directly recorded to measure an increase in the engagement and retention of these 131 youth transitioning from the foster care system.

3. Learning Objective (#3): Identify the Impact of Community Integration Programs on TAY Outcomes

What We Hoped to Learn: By implementing a community integration program, like TAY Academy, were TAY outcomes improved?

What We Learned: There was a positive impact on TAY youth in regards to employment outcomes. Overall, 34 youth out of 50 TAY youth (68 percent) were accepted into the Eco-Eventerprise or Naval Supply Systems Command (NAVSUP) Programs. These are programs that provide career opportunities and resume building skills for youth. Of the 34 youth, all completed initial training for Eco-Eventerprise or NAVSUP and 41 percent were employed after six months. Also, 35 percent received vocational training. In conclusion, there was a major success in providing 180 TAY youth with housing by the end of the program.

It was also learned that 124 youth out of 160 TAY youth (77.5 percent) who had an elevated risk for mental illness showed improvement in areas that support reduced engagement in the of the Children, Youth, and Families System or the Adult and Older Adult Mental Health Systems of Care such as: Self Care behaviors, Healthy Development, Protective Mechanisms, and Resiliency. Lastly, 81 percent of this at-risk youth also showed improvement in five relational competency areas: empathy, social conduct, expression of emotion, impulse control, and insight.

4. Learning Objective (#4): Understand the Effectiveness of Healthy Behaviors

What We Hoped to Learn: Did the TAY Academy increase positive, healthy behaviors for participants?

What We Learned: Overall, 234 youth were connected to a medical home and received medical check-ups and/or physicals. In addition, numerous youth engaged in classes, groups, or programming that actively engaged youth, thus increasing healthy behaviors. Also, while only 40 were required, 324 youth out of participated in leadership and youth development activities. Lastly, 50 youth out of 52 participants who had prior legal system involvement demonstrated reduced criminal activity.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   The program did not expend their full start-up budget, and as a result, funding was reduced during the first Fiscal Year in the amount of $207,607. This changed the program's annual contract amount from $1,812,706 to $1,605,099.

   Policies and procedures were developed and revised throughout the duration of the contract surrounding the review of meeting notes and manager logs to collaborate in addressing safety and discipline concerns. Also, the initial concept of Youth Advisory Councils, as a way of engaging youth in decision-making, was not implemented as designed. This was due to inconsistent attendance and inability of most youth served to make long-term commitments to volunteer. Instead, sites switched to a "Clubhouse-type" model in which all members were invited to take part in monthly Youth Advisory meetings. This proved to be successful and popular with youth and allowed them the ability to share their voice on issues of concern.

2. **Impact on Participants:**

   The youth who were surveyed noted that they strongly agreed or agreed with the statement "TAY Academy staff understands how to work with youth". The youth reported that they felt they were heard, respected, and valued. Also, youth were involved in making decisions about activities, felt free to share their opinions and ideas about the Academy with staff, and there was a culture of acceptance for differences at the TAY Academy.

3. **What Was Learned**:

   Overall, current and former Foster Youth gained support through the Extended Foster Care Units (AB 12). Also, the drop-in model appeared to not lend itself to support a consistent engagement and sustained impact over time. Unfortunately, the model did not have the capability to track the TAY life goals, needs, and long-term well-being overtime. Although, it was also learned that leading from behind and allowing the youth to be the experts of their own experience was a successful approach in working with this population.

   During Fiscal Year of 2013-2014, transitional housing funding was reduced by 50 percent due to a decrease in utilization. Also, sites were consolidated to save money. TAY Academy changed the service delivery model to more effectively engage Extended Foster Care (EFC) youth by redirecting the Eco-Eventerprise (vocational training) component to another model. Lastly, it was learned of the importance to having a tracking system in place to gather needed learning information and/or contract with another evaluator.

4. **Recommended for Replication? YES**

   This program structure was successful for engaging homeless TAY for a short period of time. The recommendation would be to replicate the program with the addition of a housing support specialist to effectively link homeless youth to housing and community resources over a longer period of time to track effectiveness. In addition, the recommendation is to provide services that

target high risk EFC youth, to prevent homelessness, and assist in a successful transition to adulthood.

5. **Lessons Learned in Implementation:**

   One barrier in the program was housing, and this portion of the program was not implemented until four months into the program. The main issues causing this was the length of time to get approved from the renting agency and the process in identifying which youth would live there. It was also found to be difficult to monitor the housing portion of the program. In the end, the housing utilization rate was approximately 53 percent.

   The employment component (Eco-Eventerprise) experienced several unanticipated challenges during implementation. First, youth could not access the training or classes due to transportation difficulties. Second, there was a large portion of youth who dropped out or reported low attendance. Lastly, youth did not consistently access all programs at the expected volume and, consequently, the outcomes were difficult to achieve.

   Measuring outcomes and performance was also an issue for the TAY Academy program. The database was not operational until six months into the first year of contract. Additionally, data was tracked inconsistently and did not produce the consistent measurements or results.

6. **Program Cost-Effectiveness:**

   TAY Academy had a total of 1,134 unduplicated youth attend five TAY Academy sites and 20.38 Full-Time Employee (FTE) direct-staff positions which is a direct staff-to-TAY ratio of 1 to 56. It should be noted that the unduplicated youth goal for Fiscal Year 2012-2013 was 200, which would have been a direct staff-to-client ratio of 1 to 11. Cost per client was $1,469.14 ($1,666,000.07 for 1,134 youth).

Next Steps/Recommendations

Program evaluation outlined the need for additional learning with modifications to the current program design.

Mental Health Services Act Innovations Projects
INN-08 Independent Living Facilities Evaluation 2015

Program Name: **Community Health Improvement Partners – Independent Living Facilities**
Program Start Date: **July 1, 2012**
Program End Date: **June 30, 2015**

Purpose

1. **Purpose:**
   Community Health Improvement Partners were working to promote the highest quality Independent Living (IL) home environment for adults with serious mental illness (SMI). The goal was to promote support, wellness, and recovery to IL residents. The Independent Living Association (ILA) represents the core of the Independent Living Facilities (ILF) Project. The ILA includes criteria for membership, rating levels for facilities based on adherence to ILA quality standards, education for IL owners and residents, membership development, and a focus on sustainability.

2. **Explanation of Purpose:**
   There was an increasing trend for individuals choosing the unlicensed ILF as a housing option. While ILFs can be a key resource for people with SMI to develop and sustain wellness and recovery, there was some concern that the ILFs lack consistent standards supporting their residents. This project addressed the identified issues by providing appropriate and reliable housing resource coordination, education, and standards. Also, this program strived to have an increased transparency and accountability for ILFs. It encouraged consumers and community participation in the process and was expected to result in improvements in resident and tenant services, and in the quality of life for ILF residents. Also, ILA was a free, voluntary membership organization for IL owners with membership benefits.

Learning Objectives

1. **Learning Objective (#1): Determine the Impact of a Set of Quality Standards for IL Homes**

What We Hoped to Learn: Was the standard of living increased for IL residents if IL owners became ILA members and adopted a baseline level of quality standards?

What We Learned: Overall, there were 46 active members and several more who were going through the membership process. IL owners worked to successfully collaborate with other community organizations, law enforcement partners, hospitals, and behavioral health partners. Having established standards has been critical to the program's success. Owners universally commented on the increased number of referrals as a result of joining the ILA, which they attributed to being a member.

2. **Learning Objective (#2): Understand the Utilization of an ILA Online Directory**

What We Hoped to Learn: Did behavioral health consumers, family members, and the larger community utilize a searchable online database that provided a centralized resource to find information about the quality of the IL options in the county? Also, did ILA members utilize the online directory to provide marketing opportunities and referral sources for owners?

What We Learned: The online directory was successfully being utilized according to its design. Website traffic continued to increase over time with a 48 percent increase in website traffic over the last year, ending on June 30, 2015. According to the Google Analytics data the site had 14,727 sessions. From these 14,727 sessions, 59.5 percent were first-time visitors and 40.5 percent were returning visitors.

3. **Learning Objective (#3): Develop a Peer Review Accountability Team (PRAT)**

What We Hoped to Learn: By creating a PRAT, were outcomes improved for IL residents and their families?

What We Learned: The ILA quality standards (developed by the ILA work team) developed a foundation for ensuring transparency and consistency in the process of determining which IL homes qualify to be ILA members. PRAT was made up of owners and residents, and served to ensure that all ILA members adhered to the quality standards and provided ongoing feedback. In Fiscal Year 2014-2015, there were 54 PRAT inspections (including follow-up visits). Of these 54 inspections, 22 homes met the quality standards on the first inspection and 24 homes were advised and coached on changes needed to be made to meet ILA Quality Standards. PRAT was able to provide support to the homes that did not meet the standards. Constant review and comparison of inspections helped PRAT standardize inspections and make improvements on the current inspection process.

4. **Learning Objective (#4): Understand the Impact of Education and Training for IL Owners and Residents**

What We Hoped to Learn: By providing education and training on an ongoing basis for both IL owners and residents, did the standards of IL homes improve and promote high quality facilities?

What We Learned: The training programs were designed to increase knowledge about IL homes, ILA Quality Standards, and other topics that contributed to increasing the quality of IL operations for owners and residents. In Fiscal Year 2014-2015, the ILA conducted 17 formal training courses for participants, which included 321 owners, 122 residents, and 319 community members. Results from the pre- and post-tests indicated positive results and exceeded the contract's outcome objectives.

Based on evaluations, training participants indicated that they were very satisfied with the course content and trainers.

5. Learning Objective (#5): Identify Areas of Advocacy and Systems Change

What We Hoped to Learn: Were advocacy and systems change components focusing on educating policy makers and community members effective in reducing discrimination and ensuring the rights of IL owners were protected?

What We Learned: The ILA analyzed all of the relevant municipal and county codes that applied to shared living environments to better understand how code enforcement interacted with ILFs. ILA staff and community partners also worked closely with the City of San Diego and the College Area Community Planning Group. This partnership worked to stop the exclusion of shared housing in single family zoned areas of the city and created new shared housing options through a proposed Ordinance. In addition, materials were developed as a result of several trainings focused on communicating the legal basis for ILFs.

Analysis of Program Effectiveness

1. **Changes or Modifications during Implementation:**

   The inspection process used by the PRAT was constantly changing to adapt to the environment. Also, new training materials were developed after working with City of San Diego and College Area Community Planning Group.

2. **Impact on Participants:**

   The program seemed to have an overall positive impact on participants. It was reported that higher referrals were being made and received due to the program. Also, the online directory was being used by a new population of users.

3. **What Was Learned:**

   This program exemplified the need for standard living standards for ILFs. It was also learned that many participants were more appreciative of the new program due to the increase in referrals, along with the PERT team as a resource to help coach and support them to meet the needed standards. Lastly, the online directory was successful in reaching a larger population of users and being a helpful resource.

4. **Recommended for Replication? YES**

The program was successful at improving the standardization of ILFs and positively impacted IL residents and owners. The program received a six month contract extension and anticipates receiving a new contract with an RFP for services coming in 2016. With the extension and new contract, the program is no longer funded under Mental Health Services Act Innovations funding and will be funded through Prevention and Early Intervention.

5. Lessons Learned in Implementation:

The PRAT's inspections revealed the need for the ILA Quality Standards when almost 60 percent of houses inspected did not meet standards. This led to a constant review and improvement of the process to try and make it more time efficient. Also, many trainings and educational aspects were developed through lessons learned as the program was implemented.

6. Program Cost-Effectiveness:

In the final year of the program, the staffing levels were altered based on the needs for the program. The changes included removing a Director of Finance and Director of Strategic Outcomes and adding an additional assistant and coordinator, which as a result, decreased the program's expenses. Overall, the program has had positive outcomes and is planning to implement more data collection methods to accurately measure the program cost-effectiveness if the contract is extended.

Next Steps/Recommendations

The program extended the current contract for six months. The program is currently working on an Request for Proposal to extend the program and services. The anticipated new contract will begin on January 1, 2016.

Mental Health Services Act Innovations Projects
INN-09 Health Literacy Evaluation 2015

Program Name: **Health Literacy- Implementation on Hold**
Program Start Date: **N/A**
Program End Date: **N/A**

Mental Health Services Innovations Projects
INN-10 In-Home Outreach Teams (IHOT) Evaluation 2015

Program Name: **In-Home Outreach Team Program**
Program Start Date: **January 2, 2012**
Program End Date: **December 31, 2014**

Purpose

1. **Purpose:**
   The purpose of the mobile In-Home Outreach Teams (IHOT) was to provide in-home outreach and engagement services to individuals with Serious Mental Illness (SMI) who are reluctant to seek outpatient mental health services, and to their family members or caretakers. IHOT provided in-home assessment, crisis intervention, short-term case management, and support services (including information and education about mental health services and community resources; linkages to access outpatient mental health care; and rehabilitation and recovery services among others) to individuals with SMI and their family or caretaker, as necessary. These services were expected to increase family member satisfaction with the Mental Health System of Care, as well as reduce the effects of untreated mental illness in individuals with SMI and their families.

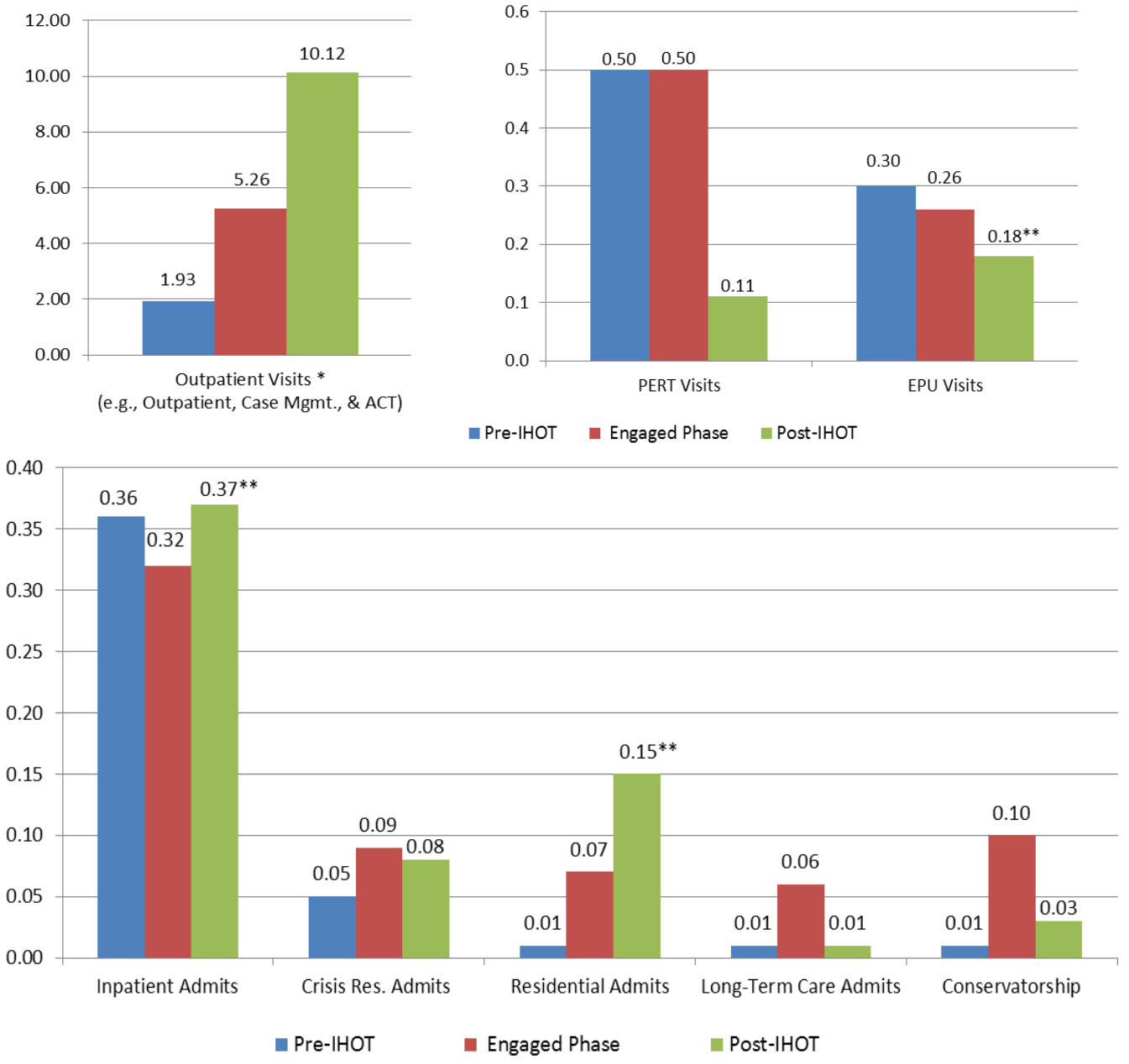
2. **Explanation of Purpose:**
   The project's framework was developed based on community concerns about individuals with mental illness who are seen in the jail system or access emergency services. Often this population resists efforts to be linked to ongoing mental health care and other supportive services. As a consequence, these individuals utilize higher levels of care repeatedly without good recovery outcomes. Therefore, IHOT implemented home based outreach efforts with peer/family and clinical staff to build relationships with the client and their family members and to strengthen a client's engagement outcomes.

Learning Objectives

1. **Learning Objective (#1): Impact of IHOT on Individuals with SMI**

What We Hoped to Learn: Were participants in IHOT more likely to access or accept outpatient mental health services and reduce unnecessary hospitalization and/or criminal justice interaction?

What We Learned: The service utilization patterns suggested that participation in IHOT was associated with the desired trends of increased outpatient mental health treatment and reduced utilization of the high severity, high need services, such as Psychiatric Emergency Response Team (PERT), Emergency Psychiatric Unit (EPU), and hospitalization as noted in the charts below.



* Per person averages of service utilization provide a useful measure for assessing overall trends; however, as in the case of outpatient visits it is important to note that averages may differ from "typical" client experiences when the data include some large values. Overall, more outpatient visits occurred during and especially after IHOT participation than before IHOT participation, but the averages were heavily influenced by the high frequency service users. For example, after removing the five (5) highest outpatient service users from the calculations the Pre-IHOT, Engaged Phase, and Post-IHOT averages reduced to 0.88, 3.06, and 4.51 visits, respectively.

** Average was heavily influenced by one high service utilizer. Analyses conducted with the respective high utilizer removed resulted in the following revised Post-IHOT averages: EPU Visits=.11, Inpatient Admits=.27, and Residential Admits=.03.

2. Learning Objective (#2): Impact of IHOT on Family Member Knowledge

What We Hoped to Learn: By providing these outreach and education services, did family members of IHOT participants have a better understanding of the mental health system and how to best support IHOT participants?

What We Learned: Overall, the satisfaction information was not consistently captured during this time period. From the available information, 66.6 percent of IHOT participants (n=36) and 89.1 percent of family members (n=37) indicated they were highly satisfied with services received. Data collection procedures have been changed for the program's current expansion to increase the satisfaction questionnaire response rate and provide greater confidence in representation of the responses.

Analysis of Program Effectiveness

7. Changes or Modifications during Implementation:

After implementation and according to the workloads, it was determined that an additional 1.0 Full-Time Employment (FTE) data analyst was needed to track the data provided by the field staff.

8. Impact on Participants:

With the addition of the data analyst, staff time was freed up to allow more time in the field interacting with participants. Also, clinical staff had more time for necessary case consultation and supervision with staff about participant and family situations. Lastly, on average there was an overall decrease in the utilization of PERT, EPU, or hospitalizations among IHOT participants.

9. What Was Learned:

The program services were very well received in each of the regional catchment areas. Knowledge of the IHOT services became widespread, with over 30 percent of incoming referrals coming from outside of the program's catchment areas. It was evident that there is a need for these services to be available in all County regions.

The overall 60.7 percent of all IHOT participants were males. Caucasian was the most common racial/ethnic category at 60.4 percent. Almost three quarters of the IHOT participants (71 percent) were between 25-59 years old, with some representation among both TAY and older adults. Schizophrenia/Schizoaffective Disorder represented the most common diagnosis for the IHOT participants at 50.4 percent, followed by Bipolar Disorder at 17.3 percent. Also, 47.8 percent were identified as likely having a substance abuse related disorder. Referrals came from many sources, but referrals from family members were most common (63.8 percent). The leading external referral sources were Housing Assistance (10.9 percent) and Mental Health Outpatient Services (9.3 percent). This information provided good knowledge to help address the client

population and build better services for the program when expanded into other regions of the county.

10. Recommended for Replication? YES

The program would benefit from an additional 1.0 FTE licensed clinician to be available for face-to-face screening should a participant be eligible and amenable to receiving services. Services should also be available Countywide.

11. Lessons Learned in Implementation:

After implementation, it was learned that there was a need for another licensed clinician to handle the workload produced by the program's success. Also, family members were an important part of the majority of client's progress. It was found that family members were the major source of referrals to the program and a majority of clients resided in a family member's house while in the program. Unfortunately, there was no formal tracking of metrics surrounding family members. It is recommended to implement and track this information in the future.

12. Program Cost-Effectiveness:

It was determined that an additional data staff was needed to maintain the expected scope. In addition to administrative staff, there were three IHOT, each consisting of a case worker, a peer staff, and a family coach. Moving forward, there will be an additional licensed clinician to provide the face-to-face screening of those deemed eligible. Unfortunately, the number of family members served was not tracked in the initial year of the program, only the identified participants who were referred, accepted for outreach, and engaged. Therefore, the metric for the initial year of the program (dividing budget by number of participants) is not inclusive of everyone served. At the end of the Innovations contract, 341 participants were accepted into the program. The contract budget for this time frame was $3,098,342.50, resulting in $9,086 dollars per participant on average.

Next Steps/Recommendations

IHOT expanded to three new regions within San Diego County. Two new contracts were developed. One was developed for the Northern regions and included North Coastal, North Inland, and North Central. The goal of this contract was to serve a minimum of 200 unduplicated participants and family members each year in each region, totaling 600 per year for the Northern Regions. The second contract was made for the South regions, which included Central, East, and South. The goal of this contract is to serve 80 participants and their family members each year within each region, totaling 240 served each year for the Southern regions.