COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH DEPARTMENT

MENTAL HEALTH SERVICES ACT (MHSA)

INNOVATION

FISCAL YEAR 2016-2020

INNOVATION PROJECTS EVALUATION REPORT

WELLNESS RECOVERY RESILIENCE

COUNTY OF SAN LUIS OBISPO

CAL POLY
Political Science
COLLEGE OF LIBERAL ARTS

COUNTY OF SAN LUIS OBISPO HEALTH AGENCY
BEHAVIORAL HEALTH DEPARTMENT
Mental Health Services Act
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October, 2020

It is with great pride and excitement that the County of San Luis Obispo's Behavioral Health Department present this evaluation of Mental Health Services Act (MHSA)-funded Innovation programs for the fiscal years of 2016-2020. This evaluation has been conducted (and reported herein) by faculty and students from the Master of Public Policy program at California Polytechnic State University (Cal Poly) at San Luis Obispo. The Behavioral Health Department has benefitted from a long relationship with Cal Poly's "MPP" program, and was fortunate to have the leadership of Drs. Martin Battle and Elizabeth Lowham (and an outstanding team of graduate students) oversee the evaluation of the four projects described in this report.

"Innovation" is the most unique of MHSA *components*, offering counties the opportunity to work with its communities and develop new, original, best practices for the public mental health system. An Innovation project is designed mainly to contribute to learning, rather than simply providing a service. It was fitting, then, for the County to partner with a local institution of higher education to examine the efficacy and results of these four projects.

Along with our gratitude for Cal Poly and its MPP program for its excellent evaluation and report, we would also like to thank Nestor Veloz-Passalacqua who served as the County's Innovation Coordinator in ushering these projects all the way from their early stages of implementation to completion. Mr. Veloz-Passalacqua worked with the providers of each project , and the evaluators, to stay focused on the learning objectives and collect the data necessary to "tell their story."

And, thank you for your interest in the County's Innovation projects for 2016-2020! Enjoy the report.

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Part 1: Executive Summary

This report has been produced by a team of faculty and students affiliated with the Master of Public Policy program at California Polytechnic State University—San Luis Obispo, as part of our 'Learn by Doing' philosophy. The team is led by Drs. Battle and Lowham. We won a competitive bid to review San Luis Obispo County's INNovation projects.

In this report, we examine the success of four projects that ended in the fiscal year 2019-2020. We use a mixed-methods approach, examining primary and secondary data.
We find that:

- All projects created new knowledge—which is the goal of the INNovation component of the MHSA
- All projects were successful in the set goals
- Each provider worked well with San Luis Obispo County
- The providers showed great adaptability in dealing with unforeseen issues and obstacles
- There were some issues with data collection and analysis (although none of these relate to security or HIPAA issues)

We recommend that:

- The results of the INNovation projects should be widely shared
- Future projects should include self-care training
- Future projects should set up explicit comparison groups or specific measures of success
- Data collection and management training should be made available to future providers

Part 2: MHSA INNovation Projects: Introduction & Historical Background

Context

The Mental Health Services Act (MHSA) was enacted in November of 2004 with the passage of Proposition 63 by California voters. The implementation of the MSHA saw the creation of new regional mental health service initiatives, known as "INNovation Projects" that are administered by county governments and financed by the MHSA.[1] In the years since the Act's passage, a broad array of community health projects gained shape, and many have become important nodes within the mental healthcare networks of their respective counties. Due to the experimental nature of these programs, third-party evaluations were required to offer insights on the efficacy of different treatment models. Such independent evaluations may help improve efficiency within, efficacy of, and appropriate dispersion of innovation programs.

Funding for MHSA derives from a 1% tax on individuals with an annual income in excess of $1 million. The tax has generated approximately $15 billion in state government revenue since its official beginning on January 1, 2005.[2] The MHSA budget has made it possible for counties to innovate and enact continued positive changes in the healthcare system. The MHSA INNovation budget is 5% of the annual budget for the entire suite of programs, compared to 73% for CSS, 16% for PEI, 5% for Capital Facilities & Technological Needs, and 1% for WET.[3] Funding is available for all counties, but counties must follow a process to access the funds. To apply for MHSA funding, a county must submit a *Three-Year Program and Expenditure Plan* to the Mental Health Services Oversight and Accountability Commission (MHSOAC). The plan is developed for accountability purposes and outlines the stakeholder engagement, public planning sessions, and a narrative on how the specific INNovation project will operate (Mental Health Services Act Proposed Guidelines for Innovation Component of the County's Three-Year Program and Expenditure Plan, 2019). The *Three-Year Program and Expenditure Plan* highlights the county's community input, includes formulated programs that will meet community needs, and requests funding for implementation.

San Luis Obispo County's Behavioral Health Department INNovation projects first received funding in fiscal year 2012-2013, with $767,529 going towards the eight initial Innovation projects.[4] After the initial set of eight projects, the next INNovation programs came four years later, bringing the total number of INNovation projects executed in San Luis Obispo County to twelve. The four new INNovation projects were implemented as part of San Luis Obispo

[1] The MHSA has various components, such as Prevention and Early Intervention (PEI), Community Services and Support (CSS), and Workforce Education and Training (WET) which were initially developed to deliver needed services, while serving as experiments in different treatment models.
[2] (Mental Health Services Oversight & Accountability Commission, 2019).
[3] (San Luis Obispo County Behavioral Health Department, 2016).
[4] (Mental Health Services Oversight and Accountability Commission, 2015).

County's 2016-2017 Annual Update to the Three-Year Program and Expenditure Report to the MHSOAC (San Luis Obispo County Behavioral Health Department, 2016).
Funding continues for the duration of each project, which ranges from 24 to 36 months.[5] The County has enacted programs to assist many groups who typically experience less access to mental health services, including veterans, children, young adults, adults, elderly, and marginalized groups such as Latinx and LGBTQ persons.[6] At the end of the project, counties can continue to fund the project, although it can no longer be funded via the INNovation funding. In many ways, the INNovation funding supports the proof-of-concept testing of an idea, which can then be continued, adapted or ended, depending on a particular county's needs.

This report evaluates the results of four recently completed INNovation projects: Transition Assistance and Relapse Prevention (TARP), Creating Opportunities for Latinas to Experience Goal Achievement (COLEGA) Late Life Empowerment and Affirmation (LLEAP), and Not For Ourselves Alone (NFOA), and assesses their outcomes and processes to improve future services.

[5] (SLO Co. INN Plan Final 2011).
[6] (MHSOAC Innovation Evaluation Project, 2015).

Part 3: Information & Contexts of INNovation Projects Funded During 2016-2017 Fiscal Year

Transition Assistance and Relapse Prevention

Transition Assistance and Relapse Prevention (TARP) was designed and implemented in the tradition of the Full-Service Partnership (FSP) model of recovery with an emphasis on supported recovery. Full-Service Partnership is a "24/7," wrap-around service that includes support for rehabilitation, medical, vocational, and substance abuse, as well as goal-setting educational materials for clients in mental health recovery. FSP aims to help clients create strong self-care foundations to facilitate transitioning from intensive care to independent living, with the skills to manage symptoms independently. The Transition Assistance and Relapse Prevention program mimics the Full-Service Partnership model and adds an additional layer of support in the form of peer mentorship. To assist with transitioning to self-supported care, TARP places a peer mentor with experience in mental health related issues with a FSP client, who is set to move on from FSP services within 90 days. The FSP model of care has been used to reduce traditional recidivism in persons transitioning back to society from incarceration or addiction recovery.

Creating Opportunities for Latinas to Experience Goal Achievement

Creating Opportunities for Latinas to Experience Goal Achievement (COLEGA) was a county government initiative with resources contracted through *Stand Strong*, a local resource and support organization for domestic violence survivors. COLEGA provides group counseling sessions for Latina/x women who are, or who have been, subject to domestic violence and who stand to benefit from mental health service and education. Each group is led by one Latina/x peer counselor in a process known as *peer mentoring*, wherein participants are acquainted with and educated on concepts like abuse, depression, self-care, and mental health in general, and encouraged to engage in self-reflection regarding if and how these concepts may apply to their own circumstances.[7] Each session leader can be described using one of these three levels of relevant lived experience: Latina/xs without lived mental health experience, Latina/xs with lived mental health experience, and Latina/xs with a history of domestic violence and lived mental health experience.

Not For Ourselves Alone

Not For Ourselves Alone (NFOA) provided practical tools that participants could use in their daily work based in principles of trauma-informed care, though the principle goal of trauma-informed care is somewhat broader. More generally, trauma-informed care training attempts to change the way that people understand and interact with each other, applying

[7] Whitney, D. et. al. 2011. Modeling Factors of Natural Mentoring Relationships, Problem Behaviors, and Emotional Well-being. *Mentoring and Tutoring: Partnership in Learning.* Vol. 19 Issue 1.

a new lens through which to think about human behavior. In the words of one facilitator of the INNovation program, trauma-informed care is "something you live, not something you do." To produce results on this level, NFOA staff developed and implemented a series of trainings called the Customer Awareness Response Effort (CARE) for county employees and offices. Each CARE Program entailed a four-part training series that took place over the course of twelve months. During these trainings, facilitators aimed to *educate* participants on trauma-informed care, as well as to assist in the *application* of the material learned.

Late Life Empowerment and Affirmation Project

Implemented by Wilshire Community Services, Inc., the *Late Life Empowerment and Affirmation Project* (LLEAP) aimed to provide older adults with mental health services and tools to help them become head of their own household and feel self-empowered after the loss of a spouse. The LLEAP team consisted of a Case Manager and Program Director who also served as the licensed Marriage and Family Therapist. LLEAP focused on improving mental health by providing tools that helped participants feel empowered and confident, while reducing risk factors associated with mental illness and/or severe mental illness, such as isolation and depression. LLEAP's goal was to provide a skills-development approach to engage widows and widowers socially and create a setting where they could find comfort and affirmation among peers (MHSA, 2019-2020). The team presented the program to strategic partners they identified as potential referrals, allowing the LLEAP team identify possible gaps in service, and modified eligibility to include individuals who were recently bereaved or struggling with anticipatory grief (i.e., individuals who had a spouse with a terminal illness).

Part 4: Methodology

We used a sequential mixed-methods approach to collect data from each of the four projects. To gain a holistic view of the projects, we wanted to use both quantitative and qualitative data, if available. We reviewed quantitative and qualitative data collected by each provider, in addition to carrying out interviews with providers.

Each evaluation began by examining the data collected by each provider as part of their regular and routine operation as a MHSA INNovation Project. This took many forms (see Table 1). After this analysis of secondary data, we used semi-structured interviews with individuals involved in the provision of services to help us understand, contextualize, deepen, and fill in gaps in knowledge.

Table 1: Methodology used for each for each INNovation project

	Primary Data Collected	Secondary Data Collected
TARP	Interviews with staff	Annual Reports Outcome data collected by TMHA Self-assessment data
NFOA	Interviews with staff	Annual Reports CARE Assessment and CARE Survey
COLEGA	Interviews with staff	Annual Reports PHQ-9
LLEAP	Interviews with staff	Annual Report PHQ-9 Intake assessment and exit surveys

Part 5: General Findings on Project Outcomes and the INNovation Process

Before we examine each INNovation project in turn, we draw attention to some general points about the success and failures of the projects in general, as well as about the overall INNovation process. First, we note that the SLO County Behavioral Health Department was very helpful in our evaluation. County employees were helpful in introducing our team to the providers and in arranging for data to be shared with us. General findings that apply across projects are:

- All the INNovation projects evaluated increased knowledge in many ways. The goal of the INNovation work is to increase the understanding of mental health issues and to test new, innovative programs. Each of the programs successfully met this broad goal. While there seems to be variation in the level of success, they all undoubtedly experimented and produced new knowledge from which future programs and providers can learn.
- Each provider appeared to work well with the SLO County Behavioral Health Department. This is not unexpected in some projects (e.g., the SLO County Behavioral Health Department was the provider in one case), but seems to be generalized to all providers. Many of the providers mentioned their collegial relationship with the SLO County Behavioral Health Department. We feel that this can only be viewed in a positive way (we will discuss why below).
- The INNovation projects showed great adaptability that helped them deal with unforeseen issues and obstacles. The very nature of INNovation Projects and the creation of new knowledge required participants to respond to unexpected situations. In many cases, they seemed able to pivot with these challenges. This adaptability seems partly helped by the good relationships the providers had with the SLO County Behavioral Health Department.
- Importantly, we note that, many, if not all, of the INNovation projects had data collection, maintenance, and assessment issues. We feel that these issues can be dealt with (see Recommendations) and should not necessarily be viewed as problems with either the project, providers, or the SLO County Behavioral Health Department. In many ways, the issues of data are not inherently bad and may be partially linked to the nature of the INNovation projects. For example, a number of the projects proposed a large number and wide variety of testable outcomes and do not measure all of them. Proposing to evaluate projects with many possible outcomes is rational, particularly in cases where providers suspect that adaptability or pivoting the project might be necessary. But there does seem to be a pattern of the providers not being equipped to collect and manage data across the breadth of their proposed measures and outcomes, particularly in response to the adaptability described above.
- Hiring and retention of staff seems to have been an issue in some cases.

- A number of projects noted the importance of self-care training, either for participants and/or staff and providers.

In the interest of brevity, we have excluded many Tables and Figures relating to INNovation projects. Please contact us if you would like to see these.

Part 6: Individual Project Evaluation

Transition Assistance and Relapse Prevention

Recommendations

1) Prioritize data collection and management.
2) Develop more robust measures and/or include control groups to better assess success or failure.

TARP Participant Data

Of all measures in the TARP client report, we analyzed the only two measures without missing data: *days in program*, the total number of days in the TARP program, and *total contacts*, the total number of contacts participants had with TARP staff. As shown in Table 1 and Figure 1, the range between minimum and maximum values is large. *Days in the program* ranges from 1 to 762. *Total contacts* range from 2 to 93. Median values found for days in program is 543 and total contacts is 18.5.[8] Pearson's R analysis, shown in Table 2, shows a positive correlation between the two measures. This is not surprising, as the more time a participant has in the program, the more contacts with TARP staff they would have.

Two critical measures, relapse back to FSP and hospitalizations after leaving FSP services, had incomplete data. TARP did not have data for eleven participants for relapse back to FSP. Because of this incomplete data, we cannot determine if clients relapsed. However, is it reasonable to assume that some of these clients likely relapsed. TARP did not have data on hospitalization after leaving FSP services for ten clients. Again, in these cases, we can make no determination as to whether these clients were hospitalized or not after FSP, although we can again assume that some clients were hospitalized. For recidivism, because 100% of the participants did not recidivate, we could not conduct analysis on whether the program impacted recidivism.

TARP Surveys

Findings from the TARP client survey indicate positive self-assessment outcomes from the program. In eight out of nine questions, the majority of respondents responded favorably (either *agree* or *strongly agree*) in regard to having positive feelings on their opportunities and recovery. The one statement that received the most positive response was "I know the resources in my community that I can access to help with my wellness and recovery." Eight out of nine respondents agreed or strongly agreed and one respondent disagreed.

The one question that did not receive a majority of favorable answers was "I feel able to achieve my own personal goals." Four out of nine respondents agreed or strongly agreed, four responded neutral, and one responded disagree.

[8] The median is used as it is unaffected by outliers.

TARP mentor survey results also indicate positive movement between pre-TARP answers and post-TARP answers. No mentor's evaluation showed negative results when comparing pre- and post-TARP survey results. For example, the mentors believed there was a real positive effect of being a mentor on their employment opportunities. Across all measures, TARP mentors responded that results were *better* or *stayed the same*.

Process Evaluation & Recommendations

Interviews with service providers resulted in a wealth of information on the program's history and processes. All interviewees mentioned different aspects about the human experience and human interactions involved in TARP, which they all believed helped mentors to better feel that they were able to manage their own wellness and recover. Providers believed that mentors helped alleviate the anxiety around moving to self-managed care for FSP participants and graduates. While the human experience can be positive in terms of outcomes, it can also identify potential improvements and challenges. One respondent believed that some participants may report their experience as negative because of not connecting with their TARP mentor. Another respondent believed that the human aspect of helping others increased stress on the mentor. All believed that communication with the County was good.

Other findings of the interviews show that the TARP program was an ongoing experiment and providers continued to make changes. One respondent said that since the program was new, the mentors were test subjects themselves in the process. As a response to the recognition of this, for example, TARP developed formal training for peer support to aid in the mentors' own self-care. Additional changes included moving the mentor position from part time to full time; creating a new database that is being used to track outcomes; and updating the program billing structure to bill Medi-Cal to help with financial stability.

The program was designed from the beginning to be administered by TMHA. There was no request for proposals from other agencies to administer TARP. TMHA worked with the County and community to both design the structure and outputs. This made it relatively easy to integrate TARP into TMHA's existing network of programs efficiently. TMHA was already administering the FSP program, as well as other TMHA programs in behavioral health. TMHA had the expertise and experience to develop the program and training internally and could adapt to changing circumstances easily, such as integrating a mentorship interest training for current FSP clients.

Most of our recommendations with regards to the future of TARP are related to data collection and methodology. First, we recommend that TARP explain and clarify which data is collected and why. Some data specific to TARP is hard to collect, e.g., relapse back to FSP can only happen if there is an open bed in the FSP program. Reduction in relapse and recidivism can be hard to measure, too, because participants can have those outcomes when they are out of the county. These instances would not be available or known to TARP staff or

providers. Second, we recommend that TARP find ways to more effectively track some of the outputs and outcomes that are easier to measure—i.e., a measure of client stress (which could be measured by a survey given to a client) rather than relapse (which is hard to measure). Third, in the future, we propose that TARP either explicitly develops or tracks control groups to aid in the analysis of comparative outcomes or that TARP set performance goals based on findings learned from previous studies. Finally, programmatically, based on our interviews and analysis, we also recommend TARP create additional mentor positions – especially for a non-male mentor.

Creating Opportunities for Latinas to Experience Goal Achievement

Recommendation

1) Provide self-care training to support clients.
2) Revise self-assessment questionnaire with more culturally appropriate questions.
3) Develop initial workshop to introduce clients to concepts and work.

Outcomes Evaluation & Recommendations

Based on both the interviews with the providers at *Stand Strong* and the surveys given to the clients, it is evident that the COLEGA project was well received by both the clinicians who ran the program and by the clients themselves. As noted in the contract between the county and *Stand Strong*, the cultural competency of all who worked in COLEGA was a crucial element of this success. Hiring not only bilingual but also bicultural COLEGA clinicians was critical to this project's success because, to paraphrase one provider, it helped to undermine the stigma related to mental health treatment in the Latinx community and set the participants at ease.

Our evaluation yielded three primary recommendations. First, we suggest including a self-care section in every session. This will build a toolbox for clients to use in their daily lives to help destress and relax and will continue the program's work to decrease stigma and put clients at ease.

Second, we suggest that the county work with the provider to develop a self-assessment that is more accessible for clients (i.e., review the pre-post tests and adjust words/sayings as deemed culturally appropriate). This would include training new staff and retraining current staff annually to ensure everyone is up to date on the importance of these changes. Lastly, we recommend the creation of a pre-COLEGA workshop that introduces participants to the topics covered in the program, definitions of relevant mental health terms, and similar concepts that will help establish baseline comfort with discussing and working with these topics. As evidenced by the Patient Health Questionaire-9 (PHQ9) results, many clients described themselves as less depressed than when starting the program, yet the clinicians had only given a cursory introduction of the concepts like depression and self-care. The true effect size may in fact be larger than that observed in our sample of 51 PHQ-9 forms, and this could likely be determined by instituting more in-depth conversations about mental health concepts at the beginning of the program.

Process Evaluation & Recommendations

Culturally competent therapists and peer mentors are key to the success of this program. Many of our respondents stated the need for not only bilingual therapists, but also Latina/x therapists as well, due to cultural competency. One respondent discussed the stigma in Latinx culture around discussing mental health, and that clients who can relate to a person with a similar cultural background would allow for more openness about current and past mental health problems. For example, a non-Latinx therapist interrupted a client by pausing

the client to take down notes. A Latinx peer mentor reported that, had the therapist been more culturally competent, they would have let the client finish.

The centering of cultural competence also meant that many of the tools used to assess clients were tweaked. For example, two respondents advocated making changes to the surveys or process of administering them so as to be culturally competent. One mentor would read the questions out loud to the participants for the clients who were not literate. Many of the clients were confused by the usage of certain words as in the Latinx culture the words have a different meaning than the word does in American English. For example, countless clients thought that their peer counselor was their therapist and were understandably confused by simple but important words and/or phrases used for assessment. Traditionally in the Latinx culture, women have been taught self-sacrifice over self-care, with the focus on being a mother and caregiver to others. Several respondents suggested adding self-care education to the program to allow each client to leave the program with tools to use outside in their daily lives. Respondents believed that breathing techniques would allow clients the ability to calm down and relax the brain and body and to reduce stress, for example. The *Stand Strong* team followed the contract with the County of San Luis Obispo very closely, and realized the need to do so, as this innovation grant is welcomed in the Latina/x community as a much-needed resource in the fight against domestic violence and to ensure personal growth.

Recommendations

1) Increase involvement of managers with the development of a tailored CARE 100.
2) Decrease size of training groups.
3) Modify future scheduling to more closely resemble the schedule of Group D.
4) Develop and distribute the CARE Workbook.
5) Pre-test survey to collect data.

Evaluating NFOA Objectives

SLOBHD (2016) describes three objectives to measure the success of NFOA, focusing on customer satisfaction, rates of training, and awareness. For the purposes of this report, the goal related to awareness was further divided into two parts, resulting in four distinct areas of measurement. Table 2 displays the program objectives as we reviewed them for this report and outlines the methods used for measuring each area. SLOBHD (2016) includes some basic guidelines on how they intended to measure these objectives, and this report follows those guidelines where possible. Some of the metrics mentioned in the proposal (e.g., incident reports and consumer surveys) were not provided, thus are not used in this assessment.

Table 2: NFOA Objectives

OBJECTIVES	OUTCOME MEASURES
Objective 1 **By the end of the project County mental health consumers' satisfaction rates with services received by participating county agencies will increase by 20%.**	Question #3: I feel/believe that at least 50% of SLO county residents who come into our office are satisfied with the information and services provided. & Question #19: I feel the CARE principles and tools I learned will help me increase satisfaction rates of my consumers/customers/ patrons when using my department's services.
Objective 2 **By the end of the project 30% of targeted County employees and agencies will have received TIC training.**	Review of participation data

Objective 3.1 **By the end of the project there will be a decrease in the stigma related to mental health consumers.**	Question #8: I am familiar with the stigma related to mental illness in the county.
Objective 3.2 **By the end of the project there will be an increase in awareness of mental illness in the community.**	Question #16: After the CARE Program, I now have an increased awareness of mental illness and its prevalence in our community.
Process Evaluation	Q 13: Please rate the usefulness of each CARE training session. & Q 20: I feel the CARE trainings program would be more useful if in the future attendees only took CARE 101.

CARE Assessment

The CARE Assessment was developed to serve as the primary tool for measuring progress toward the program objectives. The assessment measured participants' understanding of public services and mental health in SLO County. The assessment consists of ten questions on a five-point Likert scale, to be answered from *strongly disagree* (1) to *strongly agree* (5). Using a repeated measures design, participants completed the CARE Assessment at multiple times during the training. At CARE 101, participants completed the assessment prior to the start of the training (Entry Assessment), then again afterward (Post-101 Assessment). Individuals who continued with the program through CARE 104 were given the assessment a third time (Post-104 Assessment).

CARE Survey

The CARE Survey was a tool for participants to provide feedback regarding their subjective experience of the training and was administered after CARE 101. It consisted primarily of Likert-style questions on participant satisfaction with specific components of the training, with each question including a space for other comments. The CARE Survey also included open-ended questions regarding the most and least useful parts of the training, potential areas for improvement, and two major takeaways from the training.

Program Evaluation

This survey was sent to participants via email sometime after the completion of CARE 104. The Program Evaluation examined items from the CARE Survey, demographic questions, and other questions related to the program objectives.

Workbook Satisfaction Survey

Later in the implementation of NFOA, providers identified a need to compile many of the tools and exercises used into a single location. This led to the creation of the CARE Workbook. Late-stage participants completed the CARE Workbook prior to the start of the fourth CARE-101 training and used it as a reference. At that time, it was also distributed to individuals from the previous groups. The Workbook Survey was given to those who received the workbook to collect feedback on the usefulness of this tool.

Significance Testing

We evaluated Objective 1 (satisfaction) and Objective 3.1 (stigma) using significance testing. Two of the items on the CARE Assessment were specifically created to measure progress toward these objectives. CARE Assessment item #3, *"I feel/believe that at least 50% of SLO county residents who come into our office are satisfied with the information and services provided,"* was designed for measuring progress toward Objective 1. Question #8, *"I am familiar with the stigma related to mental illness in the county,"* was created for Objective 3.1. SLOBHD laid out benchmarks as a percentage change in the dependent variable (e.g., increasing consumer satisfaction rates by 20%). We used t-tests (sometimes called difference-of-means tests) to determine whether or not the difference in scores are statistically significant. Generally, a t-score that is greater than 2 is unlikely to happen randomly.

We used three t-tests to measure the effects of the different components of the training. First, we used a t-test to determine an overall effect of the program on participant responses using data from the Entry Assessment and Post-104 Assessment. Because more participants attended CARE 101 than completed the entire program, more Entry Assessments were completed than Post-104 Assessments. For this reason, independent samples t-tests were used instead of paired tests. If this test found overall effect, we used two more t-tests to evaluate the effectiveness of the *education* (CARE 101) and *application* (CARE 102-104) components of NFOA separately. In these cases, we used a paired t-test to measure the effect of CARE 101 using the Entry Assessment and the Post-101 Assessment. We evaluated CARE 102-104 using Post-104 Assessment and using the Post-101 Assessment as the control.

Program Evaluations

We used results from all of the surveys in identifying important trends in participant feedback. However, we focused on four questions from the Program Evaluation in evaluating NFOA. Two of these questions assisted in measuring the objectives, and are similar in wording to the CARE Assessment, but allowed participants to provide their subjective experience and opinion. Question #19, *"I feel the CARE principles and tools I learned will help me increase satisfaction rates of my consumers/customers/patrons when using my department's services,"* referred to Objective 1. Question #16, *"After the CARE Program, I now have an increased awareness of mental illness and its prevalence in our community,"* referred to Objective 3.2. The other two questions inquired about the overall usefulness of the CARE trainings. A list of the questions garnering extra focus in this paper can be found in Table 2.

Staff Interviews

We interviewed three participants regarding the successes and challenges of implementing NFOA. The interviews covered a wide range of topics including the course design, participant recruitment, tracking of the program objectives, discussion of themes identified in survey data, and staff's recommendations for improvement.

Results

Objective 1: Consumer Satisfaction

Generally, the staff who attended CARE sessions think the training had a positive impact on client satisfaction. After the training was implemented, most people replied that they 'Strongly Agreed' that at least 50% of residents were satisfied with information or services. This was unlikely to be an artifact of the training, as this increase was not seen in the pre- and post-test survey of CARE-101 (which took place on the same day, so the training would not have been put into practice—see Table 3), but only after staff returned to their jobs and implemented the training. Table 3 shows that there was a statistically significant effect of the entire training and the CARE-101 to CARE-104 training.

Table 3: Difference of Means Tests for Satisfaction and Stigma

Objective	Test	Pre-Test Assessment (Mean)	Post-Test Assessment (Mean)	Difference of Means
Satisfaction	Overall Effect	Entry 3.91	Post-104 4.45	0.54*
	CARE-101	Entry 3.91	Post-101 4.08	0.17
	CARE-102 to CARE-104	Post 101 4.08	Post-104 4.45	0.37*
		Entry	Post-104	

Stigma	Overall Effect	3.87	4.45	0.58*
	CARE-101	Entry 3.87	Post-101 4.2	0.33*
	CARE-102 to CARE-104	Post 101 4.2	Post-104 4.45	0.25*

* p<.05

Objective 2: Targeted Employees

By the conclusion of the program, the total attendance in NFOA was 543, including 210 unique individuals. Participants came from 16 County Departments, as well as one non-County public agency (Regional Transit Authority), and two private non-profit organizations (Peoples' Self-Help Housing and SLO Foodbank). Using these data, in addition to CARE 104 Satisfaction Survey data, it can be estimated that between 66% and 74% of attendees fall into the category of SLO County non-health, non-social service employees.

Objective 3: Stigma and Awareness

Staff responses to stigma awareness showed a positive effect of the training, with the median response increasing for Agree to Strongly Agree after the training. Table 3 shows that these changes are significant. The independent samples t-test on CARE Assessment question #8 showed a significant increase from the Entry Assessment to the Post-104 Assessment. As opposed to the findings for Objective 1, both the education phase and the application phase also showed significant results. This result suggests that both phases of the CARE program were helpful in increasing participants' awareness of stigma surrounding mental illness.

Responses to Question #16 of the Program Evaluation suggest that participants felt that the program was valuable in increasing their awareness of mental illness in the community (Median = *Agree*).

Process Findings and Recommendations
CARE 101

Participants reported highly positive feedback for CARE 101 (Q13 of Program Evaluation Survey, Mean = 4.53, Median = *Extremely Useful*). In response to the open-ended prompt about the most useful part of the training, a majority of respondents said CARE 101 or discussed a specific component from within CARE 101. Specific components of the CARE 101 training that were highlighted were the ACEs study, identifying stress, promoting self-care, the secondary effects of trauma, and the window of tolerance. Survey respondents noted how CARE 101 changed their perceptions of trauma in the context of their work and also in their own lives, suggesting that this training was successful in promoting a new lens through which to think about the impacts of trauma.

CARE 102-104

Feedback from existing surveys and our interviews suggest that participants' opinions of CARE 102-104 were more mixed. Overall, program evaluations were still positive overall but showed a higher proportion of negative or neutral responses for CARE 102-104 (24.3%) than for CARE 101 (10.5%). However, respondents also reported that the training would be *more* useful if future attendees only took CARE 101 (Q20C Program Evaluation, Figure 3). These seemingly contradictory results may be interpreted in multiple ways, but we believe they are likely due to the variable nature of these trainings. The success of CARE 102-104 was dependent on the dynamics within individual groups. Interviewees pointed out that office politics, level of leadership support, department policies, number of employees within an office, and individual personalities of participants all played a large part in determining the success of these trainings. This dynamic may help explain further feedback from participants suggesting that some groups struggled to identify purpose in these sessions and/or failed to create substantive change due to constraints within their department. Interviews echoed this dynamic, stating that the effectiveness of CARE 102-104 varied from group to group. Providers noted that groups from smaller departments (less than 100 staff) tended to be more productive than groups from larger ones, possibly due to a structure that is more bureaucratic and constrained.

In open-ended questions, the most commonly discussed challenge to the effectiveness of CARE 102-104 was a lack of involvement from management-level staff. The application component of CARE was intended to allow employees an opportunity to identify challenges within their workplace and to work toward some solutions. However, without the inclusion of decision-makers or management, plans for improvement sometimes stalled. Staff suggest that one of the most important ways to improve the program would be to find a way to better integrate leaders into the CARE trainings. Some suggested this may be done with a "CARE 100" training exclusive to management staff in which they learn about trauma-informed care through the lens of both manager and employee and start to identify areas of improvement within their organization. This may encourage supervisors, managers, and directors to better integrate the goals of their employees into the workplace.

Scheduling and Recruitment

During the implementation of NFOA, staff made some minor adjustments to the training schedule. One challenge noted by both participants and staff was that the CARE sessions were too far apart. This led to many participants forgetting material and/or neglecting action items between sessions. NFOA providers suggested that there should be no more than two months between training components and made adjustments to the schedule for Group D to a positive effect according to staff. NFOA staff also added second 101 session for each Group midway through the program. Because CARE 101 was required before staff could meaningfully participate in the later sessions, staff who were unable to attend 101 would be required to wait another six months before getting another opportunity to participate. By

offering two introductory sessions for Groups C and D, staff could accommodate more schedules, which allowed for increased participation. Including more 101 training could also benefit participants who would like to take the course again as a refresher.

Materials

Feedback from the Workbook Surveys show that participants viewed the CARE Workbook to be very beneficial. More specifically, respondents felt that the workbook was beneficial in providing an additional format for understanding the principles discussed during the training. Many noted that the material presented was both comprehensive and concise, as well as relevant both at work and in their personal lives. This suggests that the addition of charts, tips, psychometric tests, worksheets, and other visuals is helpful in solidifying the principles of trauma-informed care into everyday practice.

Training for Trainers

Some participants noted their desire to share the principles they learned with others but lacked the resources to do so. This may have been addressed in part by the addition of the CARE Workbook, though multiple responses on the Workbook Survey acknowledged that the workbook is less useful without an initial understanding of trauma-informed care. NFOA staff suggest that adding a component on how to extend trauma-informed care to others would be beneficial in creating systemic change in the workplaces of public employees.

Late Life Empowerment and Affirmation Project

Recommendations

1) Develop a smoother transition out of program or referral to other programs for support.
2) Offer program support to clients before death of partner.
3) Expand program to younger clients.
4) Provide training to deal with data collection.
5) Create of clearer, measurable goals.

Outcomes Evaluation & Recommendations

LLEAP served a total of eighty-one participants over three fiscal years from November 2016 through December 2019. Sixty-five of the eighty-one participants (80.2%) completed and returned the surveys. The program served approximately four cohorts per year with six to eight clients in each cohort. The secondary data collected included quantitative scores from clinical assessments and surveys with before, during, and after results. The scores included data for the following categories: Depression, Anxiety, Isolation, Mental Health Status, Stress Management, and Emotional Distress.

Reduction in Depression Rates as Evidenced in PHQ-9 Screenings

Each participant completed a Patient Health Questionaire-9 screening test for depression at the beginning, middle, and end of the program (see Figure 1 for a boxplot of PHQ-9 scores). We input all data and conducted a multiple regression test to allow for the control of client age and gender. We found that LLEAP participants saw a significant decrease in depression compared to those who did not participate in LLEAP (see Table 4).

Each participant completed an anxiety screening survey at the beginning, middle and end of the program (see Figure 2 for a boxplot of anxiety scores). Results of the multiple regression showed that LLEAP participants had about a 1.3 unit decrease in their anxiety score compared to those who did not participate in LLEAP, and this was statistically significant. See Table 10 for details.

We conducted similar analyses for specific outcomes related to loneliness and anxiety (see Figures 3 for isolation scores). Findings indicate that LLEAP had variable impact on these two outcomes. Each participant completed a "UCLA Loneliness Scale Version 3" to measure how isolated they felt at the beginning and end of the program. We conducted a multiple regression test finding no significant difference in feelings of isolation between LLEAP participants and those who did not participate in LLEAP. See Table 10 for details.

Other goals (such as reduction in symptomology and increased capacity to manage day-to-day tasks) could not be evaluated quantitative, as data was collected with staff's interaction.

Table 4: Regression Outputs for LLEAP Treatment

Variables	Depression	Anxiety	Isolation
Treatment	-0.878 (.35)*	-1.32 (.000)*	0.979 (1.236)
Age	0.053 (.018)*	0.027 (.849)	-0.067 (.065)
Female (or not)	-0.477 (.409)	-0.682 (.215)*	0.549 (1.443)
Constant	-7.417	-2.546	-7.978
R^2	.109	.345	.014
Number of Observations	145		

* p<.05

Figure 1: Boxplot of PHQ-9 Scores

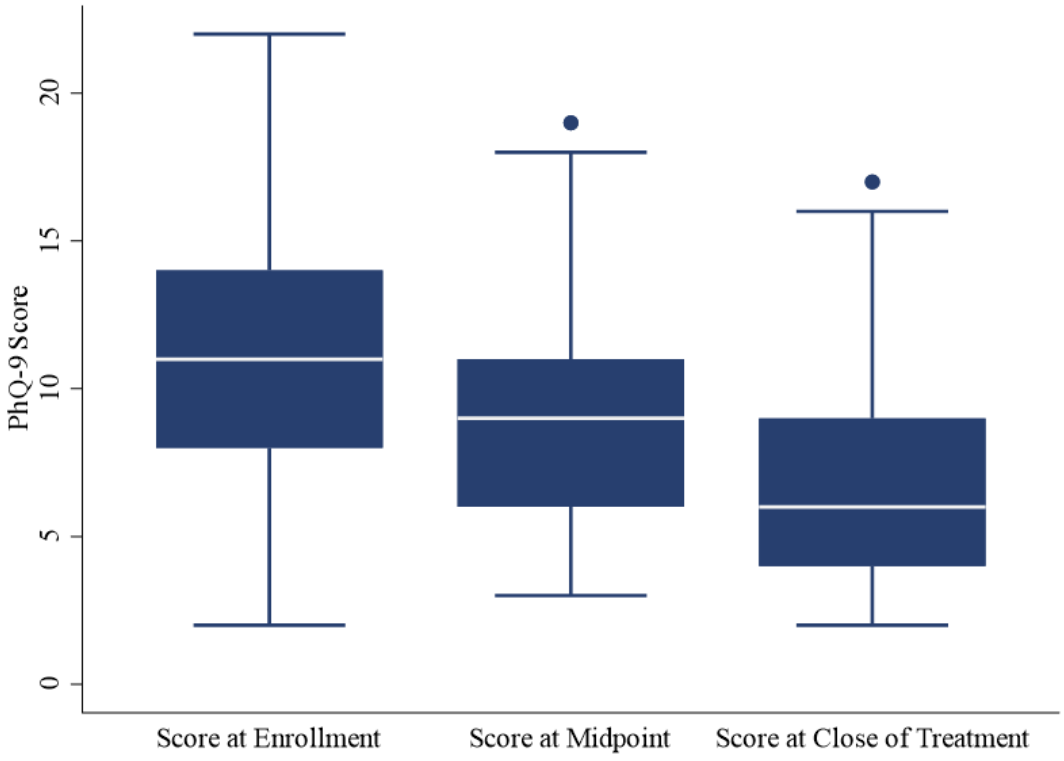


Figure 2: Boxplot of Anxiety Scores

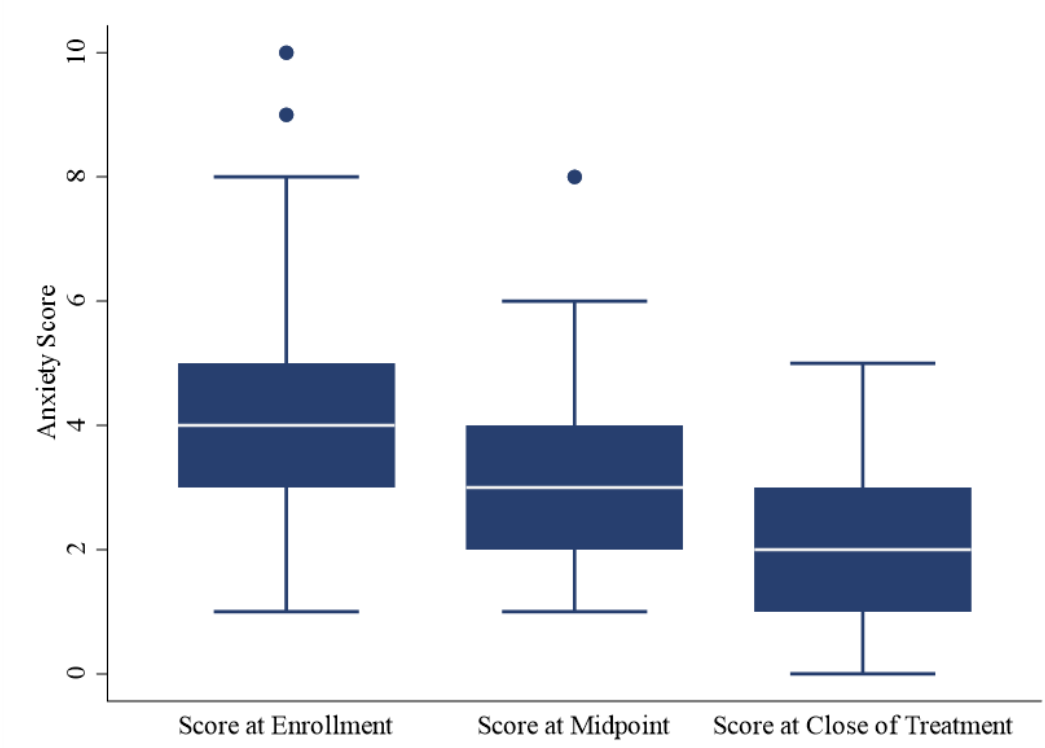
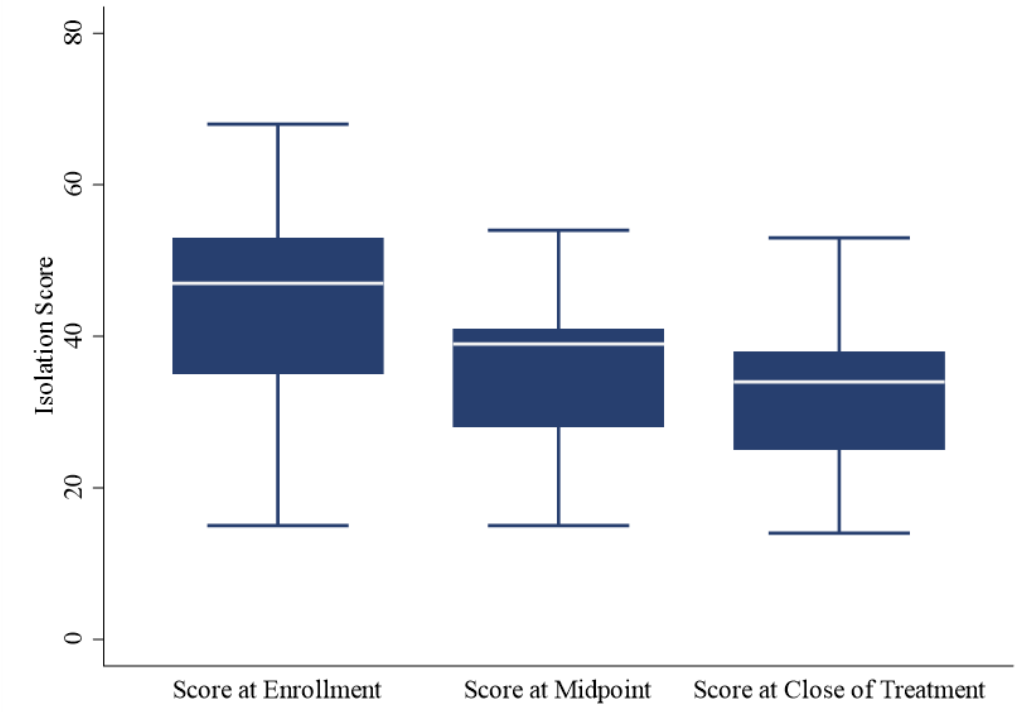


Figure 3: Boxplot of Isolation Scores



Process Evaluation & Recommendations

Part of our evaluation included separate in-person semi-structured interviews with LLEAP providers. Findings from interviews revealed several challenges and areas for improvement:

- High staff turnover during the program may have affected the ability to effectively serve the clients.
- One respondent noted that clients had a harder time transitioning out of the program, which created an unintended reliance. At the end of the program, we recommend developing a smoother transition for closure or referral to another program if needed.
- Respondents felt that communication with the County was good.
- One respondent noted that the team was ill-equipped to properly record and measure the data, recognizing the need for data training so that the data are collected and measured so as to correspond to the stated goals.

Recommendations

Our analysis of program-collected data and interviews lead us to the following recommendations, some of which focus on data collection and some of which focus on program operation. For LLEAP, we recommend:

- Developing a smoother transition of LLEAP and referrals to other programs.
- The creation and adherence to clear, consistent, and measurable goals.
- Broadening of clientele criteria to consider those who are not elderly and those who are losing somebody that they depend on, regardless of the status of their relationship with that person (i.e., the program should serve not only surviving spouses , but anyone who is losing a life partner or support system; age should not be a factor).
- Changing the time frame for when clients should be referred. Instead of 6 months to 1 year after life partner passes, services might also be offered 6 months before the anticipated death of a partner (to the partners of those who are in hospice care, for instance). It was often difficult to take the necessary time to go through the curriculum while processing the death of the deceased. These needs are immediate, and clients want quick answers and immediate help.
- The project is in need of someone to review the data they are collecting. The data does not convey which activity or service resulted in a client feeling less depressed, etc. We recommend data training for the staff or the hiring of a data professional.

Part 7: General Recommendations

In this section, we offer general recommendations that could support both this set of INNovation projects and also those that may be forthcoming. First, we note that all projects demonstrated some success in achieving their broad goals, particularly related to the goals of creating and testing new programs. Certainly, we are not in a position to make specific recommendations about maintaining specific projects and/or in what form. These decisions must be made with a wider view toward county mental health goals and resources. But we would like to point out that all projects were successful, to varying degrees, in achieving both their primary mission and in creating new knowledge.

In addition, we recommend several specific courses of action in support of future INNovation projects:

1) Share the outcomes of the INNovation projects broadly and specifically with future providers and INNovation project proposers. While independent evaluation is required by the state, we believe that these projects findings may be of use other projects across the state and future projects within the county. This is particularly the case with recommendations and findings regarding data collection and analysis.
2) Future INNovation projects may want to include self-care training for both clients and for providers. More than one of the projects we evaluated concluded that such training was necessary for clients and/or providers. Certainly, in part, this could be partially related to ideas of self-care entering common lexicon and usage. However, we also believe that because of the innovative nature of the projects, self-care can help support the sustainability and effectiveness of the program by supporting providers as well as clients. The creation of a simple self-care training module by the County (which could easily be distributed to providers), would be one avenue to streamline such inclusion. The County could approach one of the providers which developed self-care training or develop the training themselves.
3) Encourage future proposals to be explicit about the creation of comparison groups or outcomes. Methodologically, we consistently noted that we had trouble drawing conclusions about the magnitude of effect or outcome because of the lack of a control group or expected outcome without intervention. There is a delicate balance between providing enough ambiguity or flexibility to allow for the adaptability required by projects like this and the need to be able to evidence or support findings with data. Control groups, explicit outcomes, and or a process to formally identify changes in data collection or goals might support both aims and needs.
4) Develop standard recommendations and requirements for data. The collection and management of data is of great importance, particularly given the intent of the program to evaluate and test different innovations in mental health services.

We recommend development of a data collection training that could be offered to all current and future providers. It could include:

a) A module on data collection
b) A module on data management (for example, training in Excel or Google Sheets, both of which are easily accessible)
c) Survey design
d) Focus group training
e) Reporting practices.