WELLNESS • RECOVERY • RESILIENCE

Innovation

Evaluation of San Luis Obispo County Mental Health Services Act: Innovation component activities, 2011-2014

Submitted by Becca Carsel, M.S., May 2015

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EXECUTIVE SUMMARY

The Innovation component of MHSA is the most unique. An Innovation project is one that contributes to learning, rather than providing a service. Innovation projects must be new and creative, and not duplicated in another community. Innovation funding was created for the purpose of developing a new mental health practice, testing the model, evaluating the model, and sharing the results with the statewide mental health system. Innovation projects are similar to pilot or demonstration projects and are subject to time limitations to assess and evaluate their efficacy.

The development of the County's original Innovation plan was overseen by an Innovation Stakeholder group, which was responsible for guiding the planning process, analyzing community input, and selecting projects in accordance with community priorities. The MHSOAC approved the plan in March of 2011.

Following, is a summary of the eight Innovation projects as originally proposed, and evaluated herein. The County's 2011 Innovation plan can be viewed via the web link below:

http://www.slocounty.ca.gov/Assets/MHS/SLO_County_+Innovation_2_11.pdf

System Empowerment for Consumers, Families, and Providers (Work Plan #1) creates and approach to mutual learning and enhanced collaboration among consumers, family members and mental health providers. Key elements of this program include a trust building retreat followed by mutual development of a core training program and curriculum for participants within the public mental health system. Behavioral Health also expects the pilot to initiate policies that enhance the training and education of mental health providers.

The Atascadero Student Wellness Career Project (Work Plan #2) was initiated by San Luis Obispo County high-school students, and intends to engage high school youths' interest, capacity, and skills to provide mental health supports to peers. The Atascadero Student Wellness Career Project will create a peer counseling model with a public health emphasis that includes a youth-directed stigma reduction campaign and exposes students to behavioral health education and careers. By placing a public mental health system provider on the Atascadero High School campus and training peer counselors to use the Screening and Brief Interventions tool, this wellness project is unique to other known models.

Older Adult Family Facilitation (Work Plan #3) aims to create forward-looking solutions that enhance choice, safety, comfort, support, and well-being for older adults. The Older Adult Family Facilitation model will combine elements from Child Welfare Services' Family Group Decision Making (FGDM) and Elder Mediation, with emphasis on creating meaningful connections to a broad range of community resources and supports for older adults and their families. This Innovation project intends to fill service gaps between existing MHSA Older Adult programs.

The Nonviolent Communication SM (NVC) Education Trial (Work Plan #4) adapts a communication method, now used in business, education, juvenile justice, and mediation settings, as an early intervention practice for transition-age youth with serious mental illness and their families. The model

will include education and support groups which focus on youth identified as not amenable to treatment and challenged in recovery because of aggression, conflict, and/or difficulties communicating.

Wellness Arts 101 (Work Plan #5) was developed by and created for college students with mental illness. This program is a for-credit community college course on expressive art for students who have been engaged in or referred for mental health services. The course, to be offered in partnership with Cuesta College, combines academics with the opportunity to develop social and life skills while participating in a therapeutic activity.

Warm Reception and Family Guidance (Work Plan #6) will adapt Stanford's "Cancer Concierge Services" model to serve Behavioral Health clients. The intention is for clients newly referred to the mental health system and supporting family members, to feel safe, secure, informed, and supported so that they may focus on treatment and recovery. The model uses elements of peer-based system navigation, and blends new intake procedures with supportive activities. The goal of this innovation is to create a coordinated "any door" policy among key mental health ports of entry and staff; to offer warm guidance to help link clients to the appropriate provider.

Operation Coastal Care (Work Plan #7) leverages resources by embedding a licensed mental health therapist within an existing local rehabilitation program for veterans and other high-risk individuals. The Operation Coastal Care mental health therapist will assess and respond to participants' mental health issues such as depression, anxiety, addiction, and PTSD, both on-site during program events and through follow-up assessment and treatment in comfortable, confidential environments. MHSA funds only support mental health aspects of the program which will also be made available to participant's family members.

Multi-Modal Play Therapy Outreach Trial (Work Plan #8) pilots an innovative approach to a parent-led, multi-modal, attachment-focused play therapy delivered in home and community settings. The proposed program is designed for children and their parents currently not engaged by the public mental health system, with emphasis on providing services for families in rural and remote areas of the county. As parent and caregiver input and feedback is at the core of this approach, therapists will not identify the first modality or its progression until parents have had the opportunity to experience all three therapy models and provide input to their child's treatment plan. Parents participating in the trial will have an opportunity to learn about and be referred to resources and supports throughout the community.

The learning curve was steep, as the concepts of Innovation had to be approved by local leadership, and policies surrounding these unique projects had to be developed. The Board of Supervisors approved funding for the Innovation projects in June 2011, and project development began in July 2011. SLOBHD worked with Human Resources, County Counsel, and Purchasing in order to develop recruitment, procurement and contracting procedures specific to the unique nature of these projects.

Because the individual projects are diverse and possess unique challenges, and each project operates on a separate timeline, implementation of each project was staggered. This was a result of various factors including project scope, staffing requirements, and other unexpected barriers to implementation. In July of 2013, SLOBHD provided the MHSOAC with an updated timeline which includes the adjusted starting and ending dates for all projects; this includes time for evaluation and wrap up.

SLOBHD provided extensive technical assistance to community and in-house providers in areas such as: project development, measurement of learning and data collection. SLOBHD also developed an Innovation Learning Collaborative as a way for providers to share common themes among the projects and help one another overcome common barriers to implementation of the testing phase.

An external evaluator, Becca Carsel, M.S., was selected via county procurement processes, and the evaluation of the Innovation projects is now complete. Highlights of the evaluation include the following key findings per project:

System Empowerment for Consumers, Families, and Providers (Work Plan #1)

- *Following the retreat, almost everyone used superlatives like "excellent" and "wonderful," to describe the retreat and "hopeful" and "encouraged" to describe their own feelings. One peer said that their favorite part was: "Getting to hear everyone's ideas for a change. Please let's do this again."*

The Atascadero Student Wellness Career Project (Work Plan #2)

- *Students who used the Wellness Center frequently (at least three times for supportive services during 2013-14) reported large increases in knowledge of resources and how to handle their own mental health issues.*

Older Adult Family Facilitation (Work Plan #3)

- *According to client self-report in a retrospective survey (n=14), overall levels of emotional distress fell from a mean of 4.1 on a scale of 1 (low distress) to 5 (high distress) to a mean of 3.7. Sense of well-being increased from a mean of 3.1 to 3.6 exit on a scale of 1 (low) to 5 (high).*

The Nonviolent Communication SM (NVC) Education Trial (Work Plan #4)

- *According to both Youth Treatment Program (YTP) residents and staff, NVC activities at YTP were able to improve partnerships between many of the resident youth and their staff caregivers.*

Wellness Arts 101 (Work Plan #5)

- *Eight of the nine students interviewed reported at least one improved school outcome that they attributed directly to having taken the Wellness Arts class. Four students thought that the class had helped their grades.*

Warm Reception and Family Guidance (Work Plan #6)

- *Family members indicated in interviews that they also felt more self-sufficient and able to navigate the behavioral health system. Clinicians responded that clients have taken steps toward self-sufficiency as a result of the program.*

Operation Coastal Care (Work Plan #7)

- *In post-event surveys, participants reported that they had become more informed about behavioral health resources and also reported a high level of likelihood that they would access those resources as a result of the increased knowledge acquired at the events.*

Multi-Modal Play Therapy Outreach Trial (Work Plan #8)

- *Positive changes were seen for aggressive children, with decreases in aggression over the course of therapy. The children who were most aggressive initially had the largest decrease from entry to exit.*

SLOBHD has applied the lessons learned during the first round of Innovation to streamline, properly plan, and better implement, timelines for future projects. Community planning for future innovation plans is currently underway, and the submittal of a new Innovation plan is anticipated to follow the evaluation in 2015-2016.

SYSTEM EMPOWERMENT FOR CONSUMERS, FAMILIES, & PROVIDERS

During the County's initial Innovation planning process, a focus group consisting of clients and families indicated that lack of understanding prohibits communication between those seeking mental health services and those providing services. The family members who often act as first responders for mentally ill loved ones feel that they are left out of treatment plans, consultations and are generally excluded from the decision-making process. For their part, providers are often bound by regulations, ethics constraints and time limitations which do not allow for gathering and sharing information with family members. As a result, family members and loved ones often feel isolated and removed which increases their frustration with providers, thereby reducing the potential for positive and progressive communication.

The Innovation here created a three-step model to develop and deepen trust; train all current and future providers and family members; and develop sustainable training and accountability measures for County mental health programs. This family-driven project addresses the paradigm which limits communication between providers and family members/loved ones of local consumers. A facilitated retreat was held to build trust and increase communication between the providers, family members, and consumers. The retreat yielded a training group made up of representatives from each group to develop an interactive learning experience for current and future providers and family members entering the mental health system. The Innovation would test whether consumer and family literacy of the provider process -and provider literacy of the consumer/family process - will increase when activities are held which deepen trust and understanding between these key partners.

Outputs:

- One retreat with approximately 40 participants representing consumers, family members, caregivers, service providers, and community support programs.

Outcomes:

- A Retreat measurement tool will measure self-reported attitudes toward mental illness, clinicians, consumers, family members, and community support programs. This will include an indicator of trust between consumers and family members and system providers, with the assumption that rates will improve after the Retreat. The tool will assess participant beliefs about the goals of treatment and recovery.
- A participant survey will be conducted after the retreat to determine satisfaction with the process and whether those in attendance would recommend the process for future collaborations amongst consumers, family members, and County and community behavioral health providers.
- Surveys of both retreat participants and subsequent training attendees will attempt to determine if the method of holding a collaborative retreat amongst consumer, family, and provider partners was an effective tool for developing the training.

SERVICE DELIVERY

San Luis Obispo County Behavioral Health Department (SLOBHD) staff led a retreat planning committee, consisting of County and community providers, consumers, and family members. The "empowerment" began before the retreat happened, as this was a first ever opportunity for planning committee participants to work with the County and get paid for their lived experience and expertise. All planned activities were conducted with the unique needs and similarities of all participating groups in mind. A venue (Camp Ocean Pines), facilitator (Creative Mediation), guest speakers, and panelists were selected via the County's procurement processes, and policy surrounding retreat participation was developed.

At the same time as the retreat, the California Mental Health Services Authority (CalMHSA) launched the stigma reduction campaign, Each Mind Matters. The retreat planning committee maximized this resource and made Each Mind Matters the theme of the retreat. There was a double meaning, indicating that each opinion and perspective also matters. Attendees were identified as Change Agents.

SLOBHD staff and Transitions Mental Health Association (T-MHA) partnered to recruit, coordinate, and supervise retreat participants. The online application process (Appendix A1) was essential in capturing the hope and excitement as well as the concerns and reservations the potential participants were feeling. The committee also hosted several Q&A and educational sessions prior to the retreat (Appendix A2) in order to address any reservations or concerns of any of the participants. SLOBHD staff also met with participants individually, as needed or requested.

The retreat was held August 9th - 10th, 2013. The keynote speaker, Helena Ditko, represented all three roles, as she herself began her journey as a family member, then a provider, and a recipient of services. Facilitated discussions and team building exercises continued for the duration of the retreat. The keynote presentation on the second day included a panel presentation from a provider, client, and family member; all sharing their personal side of the same story (see Appendix A3 for a list of the panel presentation questions).

A total of 62 people participated in the retreat. Of these, 53% identified as peers, 26% as family members, and 47% as providers. Totals add to over 100% because people identified as multiple roles.

Following the retreat, a Curriculum Committee was created. It was comprised of nine members who had participated in the retreat (three from each role) and met monthly for four months to develop training recommendations based upon the lessons learned and discussions during the retreat. Non-participants were nominated by the larger retreat group to participate. Non-County staff participants were interviewed formally and contracted by the County as consultants for the four- month period, being compensated at a rate commensurate with County staff.

During the retreat and the subsequent curriculum committee, it was determined that three distinct needs were needed throughout the county. The first identified need was privacy training for families and clients regarding privacy laws, advanced directives, and release of information. Clients and their families generally receive this information in a time of crisis and through the filter of the provider. In addition, system navigation skills were very strong in the client and family groups but providers were much less aware of all of the community-based resources available to clients. Finally, the panel presentation was widely received and valued by all participants, and recommended to be delivered countywide.

The health information privacy training that was conceived by the Curriculum Committee was created and delivered by a local health consultant hired by T-MHA. Trainings were conducted in North, Central, and South County (see Appendix A4 for HIPAA Training Flyer). A survey was modified from an existing T-

MHA training survey to capture data specific to the project outcomes (Privacy Training Survey instrument in Appendix A5). An initial training was held for County staff as a pilot, and a longer survey instrument was used for this training to ask more in-depth questions about how the training could be improved. HIPAA training attendee numbers are summarized in Table 1.1:

Table 1.1 HIPAA Training Attendee Numbers

	Number of Attendees	Number of Attendees indicating Agency Affiliation
Central Region (San Luis Obispo)	18	17
Northern Region (Atascadero)	13	12
Southern Region (Arroyo Grande)	15	15

Agencies represented at the Privacy trainings included T-MHA, SLOBHD, Community Action Partnership of SLO County, CASA, Long-Term Care Ombudsman, Community Health Centers of the Central Coast, Department of Social Services, ECHO Homeless Shelter, North County Connection, Child Abuse Prevention Council of SLO County, Allan Hancock Community College, 5 Cities Homeless Coalition, Public Health Department, Hospice of SLO County, and T-MHA's Lompoc ACT program. The Southern Region event was attended by at least four staff from neighboring Santa Barbara County (possibly more, as six T-MHA staff were not identified by location and could have been from either county).

DATA COLLECTION

Pre and post surveys (non-matched) were utilized to assess effects of the retreat.. Surveys used Likert-type items, asking participants to rate statements on a 1 to 5 scale. Participants assessed their attitudes toward other roles (peer, family member, provider), understanding of others and feeling of being understood, ability to communicate with others, and feelings of empowerment within the mental health system. Post-surveys also asked respondents about new learning they gained at the retreat. Open-ended questions were used to obtain qualitative data about participants' initial hopes and concerns, whether those were addressed, favorite part of the retreat, biggest challenge, and other comments.

Survey data was analyzed using descriptive statistics, comparing means for each item from the pre-survey (n=35) to those of the post-survey (n=38) and disaggregating by role (see Appendix A6 for Retreat survey instruments).

After the Curriculum Committee completed their work, in-depth interviews of Curriculum Committee members were conducted using a semi-structured interview format. The interviews helped to gain insight into whether the process increased their understanding of advocacy and empowerment, and how the process impacted their life. Eight of the nine committee members were interviewed: all three peers, all three providers, and two of the three family members. An interview was also conducted with the project coordinator to learn more about the process (see Appendix A7 for interview guide).

A document review was also conducted to further inform the evaluation. Documentation collected during the process included the retreat flyer, in-depth retreat agenda, retreat facilitator minutes,

breakout session minutes, retreat planning committee agenda, Curriculum Committee training outcomes grid, and Curriculum Committee peer sub-committee resource planning grid.

LEARNING OUTCOMES

Retreat Outcomes

Seven survey questions were asked at the beginning and end of the retreat to measure whether the retreat had an effect on participants' attitudes and understanding. Due to the small number of family members, results are not disaggregated for this group of participants.

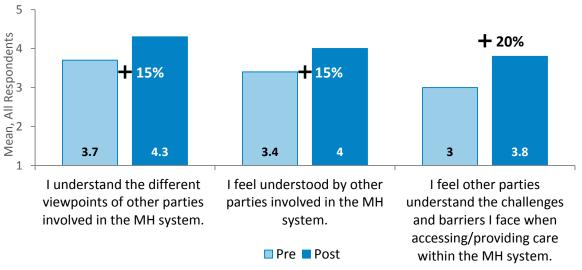Three of the seven questions showed large changes in mean scores from pre to post (Figure 1.1).

Figure 1.1 Comparative Analysis from Pre/Post Scores

Small increases in the mean of all respondents between pre and post were seen for the remainder of the statements:

- I am confident in my ability to communicate well with other parties involved in the mental health system.
- I feel supported in my role (as a peer, family member, or provider).
- I feel empowered to make a difference and promote positive change within the mental health system.
- I understand the challenges and barriers other parties face when accessing/providing care within the mental health system.

Overall, peers were more likely than providers to rate themselves highly at entry, with smaller increases at the end of the retreat (Figure 1.2). The biggest increase between pre and post survey for providers was in feeling understood by peers and families (Figure 1.3). It was also one of the largest changes for peers.

Figure 1.2 Comparative Analysis of Peer and Provider Responses: Others Understand Challenges

I feel other parties understand the challenges and barriers I face when accessing/providing care within the mental health system.
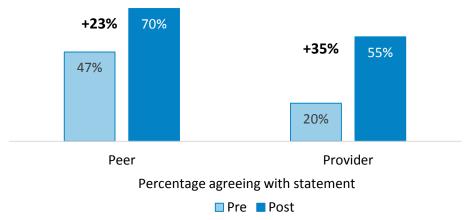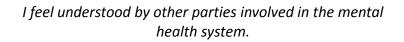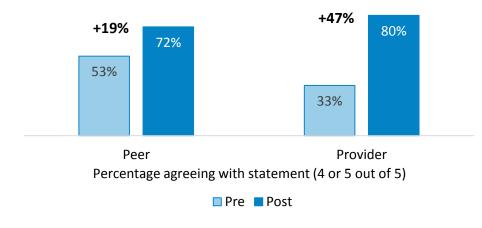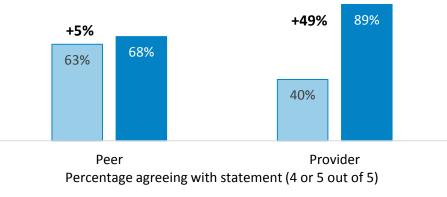

Percentage agreeing with statement

Peer: +23% (Pre 47%, Post 70%)
Provider: +35% (Pre 20%, Post 55%)

■ Pre ■ Post

Figure 1.3 Comparative Analysis of Peer and Provider Responses: Understood by Others in Mental Health

I feel understood by other parties involved in the mental health system.

+19%   72%
53%

+47%   80%
33%

Peer   Provider
Percentage agreeing with statement (4 or 5 out of 5)

☐ Pre ■ Post

Providers also reported a better understanding of others' viewpoints after the retreat (Figure 1.4).

Figure 1.4 Comparative Analysis of Peer and Provider Responses: Understand Different Viewpoints

I understand the different viewpoints of other parties involved in the mental health system.

+5%   68%
63%

+49%   89%
40%

Peer   Provider
Percentage agreeing with statement (4 or 5 out of 5)

☐ Pre ■ Post

When asked on the survey how they were feeling about attending the retreat, participants mainly felt excited. A few peers expressed nervousness and a few providers were "hopeful.". Participants' biggest concerns, regardless of role, were whether they would see results and whether change would happen. "Can we really make a difference?" A few people were concerned about everyone being heard. Several peers hoped that they would gain knowledge, skills, and resources, while a few wanted specific

programs to be implemented as a result of the retreat. Providers and other peers talked more generally about hoping for change and increased communication.

Following the retreat, almost everyone used superlatives like "excellent" and "wonderful," to describe the retreat and "hopeful" and "encouraged" to describe their own feelings. One peer said that their favorite part was: "Getting to hear everyone's ideas for a change. Please let's do this again." Family members were the only group (n=5) who were not so satisfied, expressing that their concerns were not always addressed. They appeared to have different expectations of the retreat. They were also more likely to have physical limitations that effected their participation in the two-day event.

Participants listed a wide range of favorite aspects of the retreat. Themes included hearing others, connecting with others, brainstorming, and the panel and keynote speaker. Many people praised the event and expressed thanks. Fewer challenges were listed by participants. Peers noted challenges such as staying open-minded, contributing, and listening attentively. Provider challenges included sitting for long periods, staying focused, and too much information on the second day. Several people, including three of the six family members, said that the acoustics and noise was their most significant challenge. Comments included:

> *I went back and forth on how transparent I should be as a provider in my sharing and I decided to go with being honest, vulnerable, and speaking my truth. It felt good!*

> *[My favorite part was] coming together as a community to brainstorm about what we can do to make improvements.*

Curriculum Committee Outcomes

The goal for the Curriculum Committee was to develop trainings and resources that facilitated increased understanding between peers, family members, and providers and increased system navigation abilities. Three resources were developed from their recommendations (see Table 1.2).

Table 1.2 Resources

Educational Need	Target Audience	Training/Resource to Address Need	Trainer
Understanding of HIPAA	Family members and peers	HIPAA trainings in the community	Local Health Consultant, T-MHA staff
Empathy training	All: Family members, peers, providers	Replicate "The Rest of the Story" panel from the retreat, with a peer, provider, and family member on the panel.	To be recruited by T-MHA

Awareness of local resources	Providers	Resource training for County staff	System Navigator, County Behavioral Health

Curriculum Committee members were interviewed by the outside evaluator to learn more about the impact of the committee and the retreat on their lives. Interviewees were selected by contacting everyone on a list provided by the facilitator. All three peers, all three providers, and two of the three family members on the list were interviewed (the third family member did not respond).

All of the peer participants thought that the Curriculum Committee experience was very empowering on a personal level. It led them to want to become more involved in the mental health area. For one peer it was transformative. The experience inspired him to move from his janitorial job with T-MHA to become a peer assistant, with plans to be a mental health advocate.

> *It was a really wonderful thing… I felt very empowered in the process that took place at the retreat and the [committee].*
>
> *-Peer Participant*

> *It sparked a fire for me to do everything I can to learn about the mental health community. [Participating on the Curriculum Committee] left me with my hair standing up, I just felt so important... It really gave me a self-esteem boost.*
>
> *-Peer Participant*

The two peers for whom the project had the largest impact felt sad that the committee ended and missed being involved; they were clearly struggling to figure out what to do next with their new insights.

When asked whether the process was transformative, one peer said:

> *I feel like I have the right to question more than ever before. I have the right to say, "Wait a minute, why is it this way when it could be this way? Why are these funds going toward this when they could go toward that?" (Peer)*
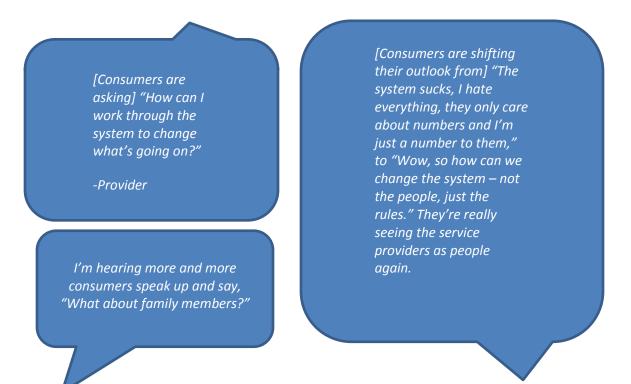
One peer saw the process as support more than advocacy, focusing on learning about what resources are available, but felt that this knowledge was empowering. This person talked about how the process promoted collaboration and awareness:

> *I enjoy seeing the relationship transpire between Transitions and the County [staff], it's great to see that relationship unfold… they're working together on coming to some agreement as to how they can best serve clients… They did a lot of work together that I don't think would have happened otherwise. (Peer)*

Of the two family members interviewed, one thought the Curriculum Committee process was effective while the other had mixed feelings. For both of them, the new information about negotiating the mental

health system was the most empowering, along with learning more about providers' and peers' perspectives.

One T-MHA staff member saw that peers who participated were more empowered, with more awareness of family and provider points of view. This person reported that this understanding is spreading, with more peers asking how they can change the system instead of feeling that the system is doing something to them. As a result of the retreat, two clients have been proactive and became representatives on boards. Staff members generally felt that:

> [Consumers are asking] "How can I work through the system to change what's going on?"
>
> -Provider

> I'm hearing more and more consumers speak up and say, "What about family members?"

> [Consumers are shifting their outlook from] "The system sucks, I hate everything, they only care about numbers and I'm just a number to them," to "Wow, so how can we change the system – not the people, just the rules." They're really seeing the service providers as people again.

A T-MHA staff member suggested replicating the retreat at a T-MHA potluck, noting what a beneficial effect it has had on peers and their relationships with their family. Another suggestion was that mental health providers should have an annual retreat to have a time for collective fun.
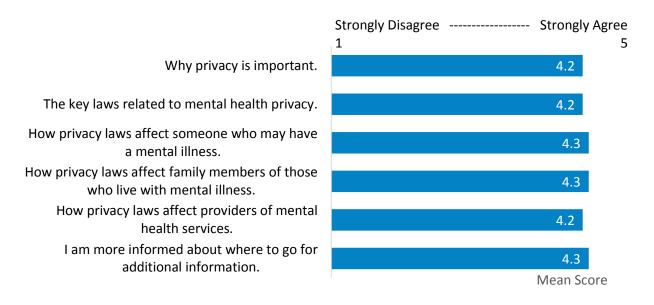
There was some confusion over what the final product of the Curriculum Committee would be, according to representatives from each background. In the interviews, they were initially unsure of what they had achieved, but were appreciative when shown the written outcomes. Everyone thought that the resulting plan would promote collaboration and trust among consumers, providers, and families.

Training Outcomes

"UNDERSTANDING OF HIPAA" TRAINING

Participants completed a post-training survey to determine whether outcomes had been achieved. People commented that the training was very informative. They particularly enjoyed the role play element. Mean scores on survey questions were high: 4.2 – 4.3 on a scale of 1 to 5, with no participants rating any aspect at a 1 or 2 (Figure 1.5).

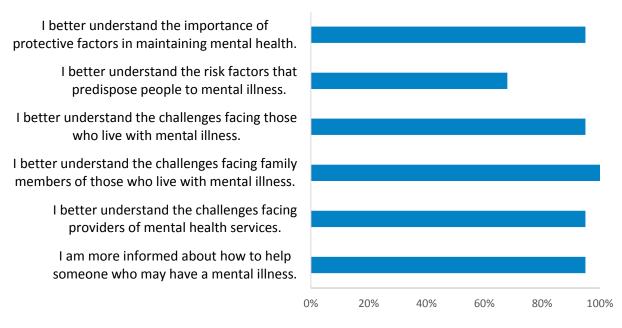**Figure 1.5 HIPAA Post-Training Survey**

"REST OF THE STORY" PANEL PRESENTATION

Twenty-nine people attended a Perspectives Panel presentation at Cal Poly in February of 2015. This panel included a peer, a family member, and a provider. A survey was administered following the presentation with regular Likert-type items and retrospective items. Nineteen people submitted survey responses. All but one were young adults, ages 16-25. Ten respondents identified as having had or currently having a mental health challenge. Sixteen have or had a family member with a mental health challenge. One was a mental health provider. None said that they did not know anyone with a mental illness.

Nearly all respondents (95% to 100%) said that as a result of the presentation, they better understood the importance of protective factors to maintain mental health, how to help someone, and the challenges facing those with mental illness, family members, and providers (Figure 1.6). Somewhat fewer respondents (68%) said that they better understood risk factors that predispose people to mental illness.
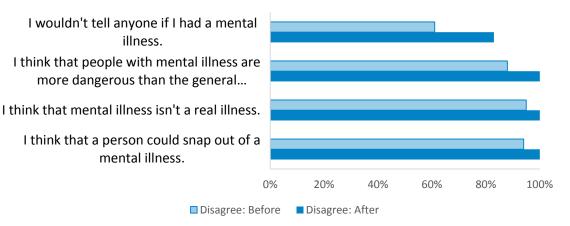
Figure 1.6 Panel Presentation Responses

Nearly all respondents reported an increased understanding of mental health issues.

I better understand the importance of protective factors in maintaining mental health.

I better understand the risk factors that predispose people to mental illness.

I better understand the challenges facing those who live with mental illness.

I better understand the challenges facing family members of those who live with mental illness.

I better understand the challenges facing providers of mental health services.

I am more informed about how to help someone who may have a mental illness.

0% 20% 40% 60% 80% 100%

The retrospective portion focused on stigma. Most people indicated a lack of stigma already, but small improvements were seen (Figure 1.7).

Figure 1.7 Panel Presentation Stigma Responses

Reduced stigma: More participants disagreed with stigma statements after the training.

I wouldn't tell anyone if I had a mental illness.

I think that people with mental illness are more dangerous than the general…

I think that mental illness isn't a real illness.

I think that a person could snap out of a mental illness.

0% 20% 40% 60% 80% 100%

☐ Disagree: Before ■ Disagree: After

When asked what they liked most about the presentation, people wrote:

- The openness of the speakers' perspectives and stories.
- The depth of the stories.
- Knowing more people struggle with similar things.
- It was very personal – a low barrier between presenters and audience.

- The topic in general. Mental illness is something that is not spoken about enough.
- Hearing about overcoming difficulties was very inspiring and helpful.
- It showed me that I need to be more open about my issues.

Suggestions for improvement included having a male speaker, adding resources for help, talking about confidentiality, more information about mental illness, and more interaction.

LESSONS LEARNED

Setting Expectations

Setting appropriate expectations is critical to the retreat process. Many family members appeared to have very different expectations than the retreat organizers and they ended up feeling that their concerns were not heard. They may need very clear goals outlined. Also, some people were not as interested in team-building activities and may have benefited from a greater awareness of the agenda. One retreat planning member suggested in retrospect that the retreat could be just about getting to know each other, while the people who really wanted to be heard could participate in a separate event. Another Curriculum Committee provider member suggested being more clear (in the recruitment materials) that a goal of the retreat would be to develop a curriculum.

Staffing

Retreat organization involved a great deal of negotiation. Recruiting and scheduling participants, fielding participant concerns and issues, and the general need to accommodate three very distinct populations led to some "burnout" on the part of the organizer. To prevent this, the duration could be shorter, multiple people could be in charge of the implementation, a complaint time could be established, and/or more attempts to set participant expectations appropriately could be made.

Facilitating the Curriculum Committee took a high level of skill and effort to keep it on track, while redirecting frustrations and negotiating conflicts. This was also a difficult experience that could be made easier by hiring more outside facilitators to assist.

STRATEGIES FOR REPLICATION

For other Behavioral Health Departments interested in replicating this model, learning recommendations include:

- Be very clear about setting expectations. Someone with a clear understanding of this should speak at each gathering of potential participants, and recruitment materials should be very explicit about the goals and what will and will not be taking place at the gathering.
- Consider shorter, more focused events for relationship-building activities.
- The resulting trainings are being enthusiastically received and could be replicated without the planning process.
- After being as clear as possible about expectations, goals, and outcomes, go over it again.
- Involve alcohol and drug program staff as well as mental health providers.

SUSTAINABILITY

To continuously deepen literacy for consumers, family, and providers about each of the three roles through increased trust and understanding, the project created the privacy training and a powerful short video based on the panel at the retreat. The "Rest of the Story" Panel features the viewpoints of consumers, family and providers as a live conversation. This panel has been embedded in T-MHA's offerings to the mental health community and the larger community and will continue to be offered.

ATASCADERO HIGH SCHOOL STUDENT WELLNESS CAREER PROJECT

Stigma toward those facing mental health challenges is tremendously damaging in high school. Innovation stakeholders, including high school students themselves, also identified this stigma as a barrier to engaging youth to pursue careers in the behavioral health field.

The Atascadero High School Student Wellness Center created a peer counseling model that included a youth-directed stigma reduction campaign and exposed students to behavioral health education and careers. By placing public behavioral health staff providers on campus, this wellness project was unique from other known models. A mental health provider and youth development specialist were embedded on the campus to train peer counselors to use screening and brief intervention tools, while training other student leaders to conduct stigma prevention campaigns.

Using a youth development strategy, the Atascadero Wellness Center tested an expanded, public behavioral health system approach to a peer based student counseling model with the intent of learning. Would combining prevention strategies, peer counseling, and behavioral health career development have a greater impact on stigma reduction and increase student pursuit of college behavioral health education than traditional peer counseling models?

The proposed primary purpose of this Innovation was to increase the quality of services, including better outcomes. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- Behavioral Health staff will be placed on the Atascadero High School campus to train and support students by providing prevention and early intervention counseling for students who are referred or request help in dealing with emotional problems, peer relation issues, stress, anxiety, or depression.
- The counselor and student team will create a warm, safe, and receptive space on campus for students to find support, respect, and freedom to express themselves.
- 50 students per year will access services through the Wellness Center.
- A minimum of 200 students per year will also be provided training and education regarding stigma and mental health issues from the Peer Student Wellness Center Counselors.

Learning Outcomes:

- Students will demonstrate increased knowledge of mental health issues and resources, reduced levels of negative attitudes and stigma, and interest in pursuing education and careers in behavioral health fields.
- Peer Student Wellness Career participants will demonstrate increased capacities for providing support for peers by receiving training in Screening and Brief Interventions and performing the practice with fidelity.
- Atascadero students will demonstrate increased interest in pursuing education and careers in substance use treatment and prevention and mental health fields.

SERVICE DELIVERY

The Atascadero High School Wellness Center opened its doors in February 2012. The center served approximately 335 students for peer counseling during the evaluation period (Fall 2012 through Spring 2014), far more than originally anticipated. Demand was very high for peer mental health services. During the first school year (2012-13) staff tracked peer counseling and also counseling services
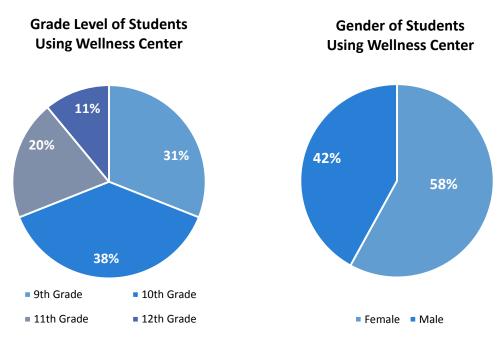
provided by Wellness Center staff. Partway through the year, a "peer to peer" category was added to count students coming in to counsel each other. For the 2013-14 school year, students who came to the Wellness Center because they needed a supportive place on campus (but were not receiving counseling) were also tracked. Students who came to the center during study hall to do their homework rather than using the main study hall area were counted separately to acknowledge the potentially different way they were using the center. These numbers are duplicated counts as they tracked service incidents (Table 2.1).

Table 2.1 Services, By Year

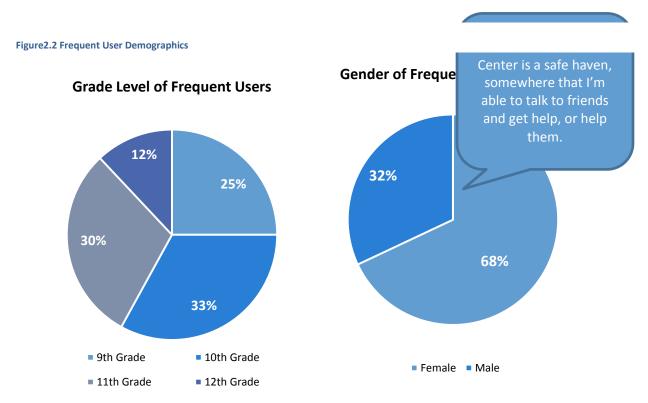|	Peer Counseling	Staff Counseling	Peer to Peer	Safe Space	Study Hall
2012-13	160	246	157	--	--
2013-14	175	330	439	487	427
Total	**335**	**576**	**596**	**487**	**427**

Student demographics, according to three point-in-time surveys during the 2013-14 school year, were as follows (Figure 2.1):

Figure 2.1 Student Demographics

Grade Level of Students Using Wellness Center

- 9th Grade: 31%
- 10th Grade: 38%
- 11th Grade: 20%
- 12th Grade: 11%

Gender of Students Using Wellness Center

- Female: 58%
- Male: 42%

A total of 38 student interns were trained as peer counselors and worked directly providing supportive services for their fellow students. The Wellness Center and interns also sponsored anti-stigma, wellness, and career events on campus. Events included anti-bullying campaigns, body image and self-harm forums, suicide prevention behavioral health career fair and guest speakers, freshman transition camp, and Love Out Loud. Wellness Center interns also promoted statewide efforts by partnering with NAMI for Ending the Silence presentations, and bringing Each Mind Matters to campus and community events.
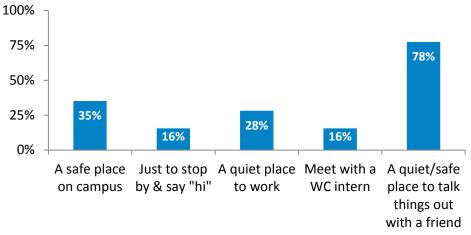
Frequent users were tracked in 2013-14 to learn more about this demographic. They were defined as students who used the Wellness Center at least three times for support services during the 2013-14 school year. A total of 66 frequent users were identified: 60 of these were surveyed for demographic and outcome data. Given the choice to select all that apply, 75% identified as white, while most of the remainder indicated that they were Latino or both white and Latino (32% Latino). Frequent user demographics, such as grade level and gender, were collected (Figure 2.2).

Figure2.2 Frequent User Demographics

Grade Level of Frequent Users

- 9th Grade — 25%
- 10th Grade — 33%
- 11th Grade — 30%
- 12th Grade — 12%

Gender of Frequent Users

- Female — 68%
- Male — 32%

> Center is a safe haven, somewhere that I'm able to talk to friends and get help, or help them.

All students who came into the Wellness Center were asked what they liked about the center, and nearly 20% of students wrote that they liked that it is a safe place. They said it was welcoming, they can be open, people don't judge you, and it is confidential. Another 20% of students wrote that they valued the quiet. Respondents also described the Wellness Center as relaxing, calming, (having) good energy, and a nice place to chill (Figure 2.3)
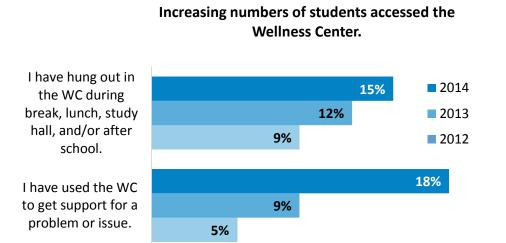
Figure 2.3 Students' Reasons for Visiting the Center

In focus groups, interns reported that the Wellness Center was a comfortable, safe environment.

Students' Reasons for Visiting the Center, 2013-14

Reason	Percentage
A safe place on campus	35%
Just to stop by & say "hi"	16%
A quiet place to work	28%
Meet with a WC intern	16%
A quiet/safe place to talk things out with a friend	78%

Responses to the annual school wide survey showed that an increasing number of students used the wellness center for support and to feel safe (Figure 2.4).

Figure 2.4 Comparative Student Access

Increasing numbers of students accessed the Wellness Center.

Statement	2014	2013	2012
I have hung out in the WC during break, lunch, study hall, and/or after school.	15%	12%	9%
I have used the WC to get support for a problem or issue.	18%	9%	5%

Output and outcome data were collected via staff logs of numbers served, project evaluator observations, school records, and the following evaluation activities (Table 2.2):

Table 2.2 Data Collection Methods

Evaluation Activity	Time Period	Population	Sample Size
School-wide survey	Annually each spring	All AHS students	777-1077

Point-in-time survey	Dec., March, May 2013-14	All students using the Wellness Center	74
Retrospective survey	Spring 2014	Frequent users of the Wellness Center	60
Event survey	2013-14	Students at events during the 2013-14 year	117
Teacher survey	Fall 2013, Spring 2014	All AHS teachers	Fall: 36 Spring: 52
Intern survey	June 2014	Wellness Center interns	13
Intern and student mentor focus groups	Spring 2014	Wellness Center interns, AHS student mentors	Interns: 10 Mentors: 9
Key informant interviews	Fall 2013, periodic	Administrative team, project staff	10

The school-wide survey (Appendix B1) was developed by Behavioral Health staff and administered annually in the spring of 2012, 2013, and 2014. All teachers were asked to administer the survey during a specific class period. Response rates were 53% for the 2012 survey (792 of 1,485), 76% for the 2013 survey (1077 of 1,410), and 61% in 2014 (777 of 1,273).

Student surveys were developed by behavioral health staff and the project evaluator (Appendix B2). Point-in-time surveys were given to all students who came into the Wellness Center three times during the 2013-14 school year: December 11 and 12 (13 surveys), March 20 and 21 (28 surveys), and May 12 and 13 (33 surveys). Students who frequently used the Wellness Center were surveyed in May 2014 to determine whether they experienced changes in their mental health status and related outcomes as a result of Wellness Center services.

Career and anti-stigma events in 2013-14 included a survey at the end of the event to measure career interest and stigma reduction (Appendix B3). Events included the Love Out Loud activity in May 2014, a body image event in March 2014, and a career exploration event in October 2013.

Wellness Center staff created a survey to capture intern feedback at the end of the 2013-14 school year (June 2014). Thirteen interns completed this survey (eight seniors, three juniors, two declined to state). All answers were in the form of qualitative responses.

An initial teacher survey was conducted at an AHS staff meeting in September of 2013 and a follow-up survey was administered via online survey in June 2014 (Appendix B4).

Interviews were conducted in September and October of 2014 with the principal, assistant principal, the three school counselors, and a school psychologist. Results of these interviews and the teacher surveys were used to inform staff and make mid-course corrections to program components.

Wellness Center interns participated in focus groups in May 2014 (Appendix B5). Focus groups with freshman mentors (students who are placed in freshman health classes to mentor students) were also conducted to compare experiences and gather additional information.

School records for frequent users was obtained from the Atascadero High data technician, who provided information on GPA, attendance, and credits attempted and completed for both the school year that students were noted as a frequent user (2013-14) and the previous year. Note that the intensity of use by students in the previous year is unknown.
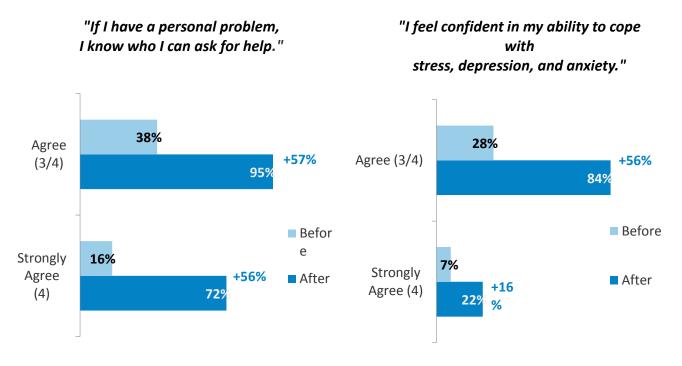
LEARNING OUTCOMES

Increased Knowledge of Mental Health Issues & Resources

Students who used the Wellness Center frequently (at least three times for supportive services during 2013-14) reported large increases in knowledge of resources and how to handle their own mental health issues.

Students were asked to rate on a 1-4 Likert scale whether they disagreed or agreed with the statements regarding coping skills both before and after their use of the Wellness Center. Responses were analyzed for changes in the percentage of students rating their agreement at a "4-strongly agree" and the percentage who agreed at either a "3-agree" or a "4-strongly agree" on the 1-4 scale. Students agreed with both statements at a much higher rate following Wellness Center use (Figure 2.5 and Figure 2.6).

Figure 2.5 Comparative Pre/Post Responses

"If I have a personal problem, I know who I can ask for help."

"I feel confident in my ability to cope with stress, depression, and anxiety."

Students were asked about how often they engaged in specific negative behaviors, both before and after their Wellness Center use. No change was reported in the number of days that students cut class. A reduction in other negative behaviors was seen for up to 23% of students.

School records were analyzed to determine whether gains were made by 66 frequent users in attendance, credits completed, and GPA. Since it was not possible to create a matched comparison group to compare outcomes, frequent user data for the current year (2013-14) was compared to the
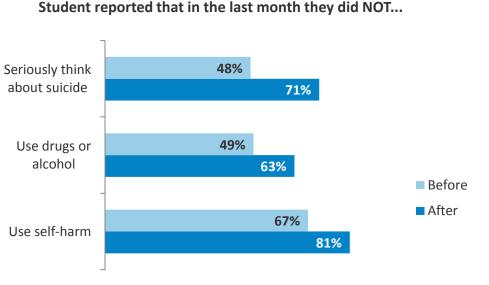
Figure 2.6 Student Responses

Student reported that in the last month they did NOT...

prior year (2012-13) and to the general population.

Prior year data was not obtainable for the 23 ninth graders and six other students, so comparisons for GPA and credits completed were only made for 37 students. It is more likely that gains would have been detected had the frequent user data been compared

to the following year (2014-15) but this timeframe extended beyond the scope of the project.

Average attendance did not change for frequent users from year to year and remained similar to that of the school as a whole (95% for the whole school, 93% for frequent users during the treatment year and 94% during the prior year).
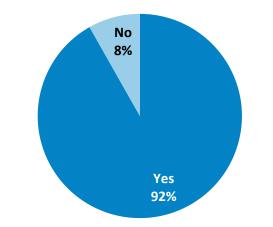
The percentage of credits completed dropped for frequent users during their year of Wellness Center use as compared to the previous year. According to interviews with the behavioral health staff, thishis may be related to the crisis they were experiencing that led them to the Wellness Center. Completion rates for all students enrolled in Atascadero High were analyzed by grade level to check whether students overall completed fewer credits as they progressed to higher grade levels. This was not the case for the school as a whole, only for frequent users of the center.

Mean GPA similarly dropped for frequent users during the year of their Wellness Center use (note that second semester mean GPA is typically lower because it is more difficult to fix problems during the summer). For comparison, mean GPA for all students in the school also dropped. While this analysis primarily demonstrated that frequent users of the Wellness Center were also struggling students, it is worth noting that their attendance remained similar to that of the school as a whole. Further research could determine whether having the Wellness Center on campus helped them to attend school regularly and how to improve course completion and GPA.

Students were surveyed at career and stigma reduction events to determine effects of the events on attitudes, beliefs, and knowledge. At the Love Out Loud event, students (n=42) reported mental health and stigma reduction benefits:

- 81% were more aware of mental health disorders
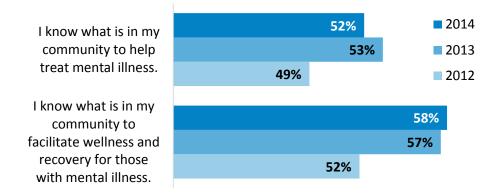- 88% were more aware of positive ways to deal with stress.

At the student forum on body image and eating disorders, students (n=48) reported increased knowledge of body image and eating disorder issues (Figure 2.7).

Figure 2.7 Eating Disorder Response Rate

Are you more aware of symptoms of eating disorders?

Responses to questions about knowledge of mental health issues on the school wide survey changed little from year to year. Each year, between 93% and 94% of students agreed with the first question concerning knowledge of emotional and mental health issues (responses of "agree" or "strongly agree"). Between 86% and 88% of students agreed that they knew the signs of mental and emotional illness. Small increases in agreement were seen in the questions about community resources (17%-19% of stu

Figure 2.8 Comparative Longitudinal Responses

Students reported increases in their knowledge of community resources (% agreeing with statement).

Students were also asked two open-ended questions to survey knowledge of mental health issues:

1) What causes mental illness?
2) How do you cope with emotional problems?

Responses to these questions were coded to determine whether students had positive coping strategies and whether they could provide a cause of mental illness. As indicated in the Innovation plan and as part of the intern learning experience, coding was done by student interns under the direction of the Wellness Center staff. The data lacked inter-rater reliability and a stable coding system because the

students were using the data collection as a learning activity and there was a high turnover rate of both students and staff from year to year. These results should be interpreted with caution (Table 2.3):

Table 2.3 Survey of Participant Knowledge

Desired Response to Question	2011-12	2012-13	2013-14
Knew a cause of mental illness	n/a	71%	73%
Positive coping strategy	58%	67%	55%

Wellness Center interns reported increased knowledge of mental health issues. On year-end survey responses, 77% (10 of 13) talked about how the experience changed them or how much they learned.

In focus groups, interns felt strongly that they had gained extensive knowledge through training and ongoing support. They easily articulated what they learned in their training, from maintaining confidentiality to referral resources to using silence, listening, and asking questions instead of judging.

> *The Wellness Center has definitely had a huge impact on my life. It gave me the proper tools and skills to mentor, counsel, and just listen to those around me.*

> *It's helped me care more. Not that I didn't care about mental health, but I didn't think it was a problem.... Seeing all these kids who have their own issues make me really care about it and think it was important. More people should think mental health is important and mental illness is a very serious thing.*
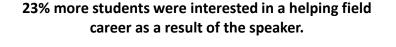
They said that they received training all year through an initial retreat, ongoing meetings, speakers, hearing from each other, talking with the Wellness Center staff, being taught about community resources, and taking the first semester interactive final. They appreciated the training and how it helped to improve their skills.
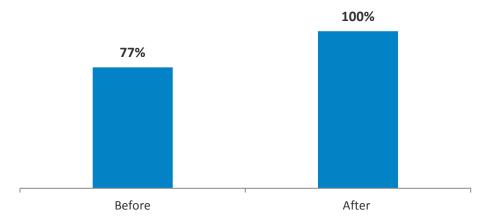
The students who participated in the intern focus groups reported enormous personal benefits to their participation. They related that it changed their attitudes toward others, making them more open-minded, caring, and appreciative. Interns enjoyed being able to work with their peers. They saw themselves as more sympathetic, less judgmental and more open-minded, more grateful, less stereotyping of others, more understanding of others' mental health problems, and able to see commonalities in different people. They said that they had improved their communication skills and their ability to connect with others.

Interest in Pursuing Education and Careers in Behavioral Health Fields

A career exploration event was held in October of 2013, with Frank Warren, a manager with the Behavioral Health Department presenting about careers in the field. According to student surveys, the event increased the number of students interested in entering a helping field career (Figure 2.9).

Figure 2.9 Pre/Post Results for Career Interest

23% more students were interested in a helping field career as a result of the speaker.

A student forum on wellness issues was held in March, 2014. Speakers and activities focused on body image and eating disorders. Students were asked whether hearing these speakers increased their interest in going into a helping field (Figure 2.10)
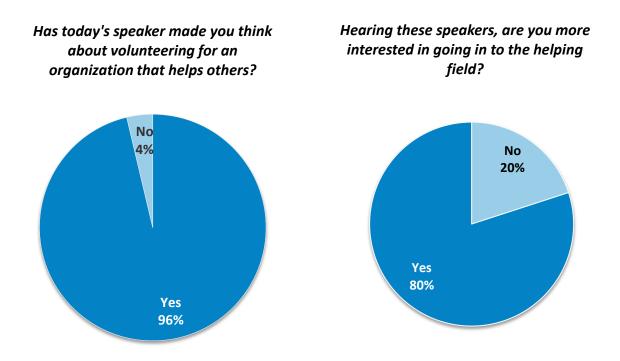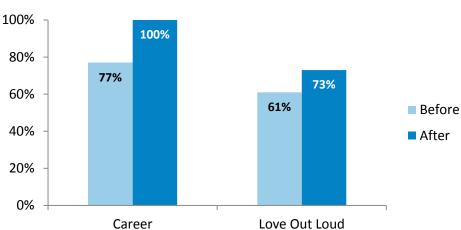
Has today's speaker made you think about volunteering for an organization that helps others?

Hearing these speakers, are you more interested in going in to the helping field?

Figure 2.10 Participant Responses

During Mental Health Awareness Week, in May, 2014, the Wellness Center sponsored a series of events under the campaign title "Love Out Loud." Cal Poly's Peers Understanding Listening Supporting Education (PULSE) students visited campus and spoke to students about mental wellness and healthy lifestyles. Atascadero High students shared their stories and discussed positive coping skills. On post-event surveys, there was a 12% increase (from 61% to 73%) in students considering going into the helping professions. In addition to an increase in career interest, 76% of respondents were now thinking of volunteering for an organization that helps others.

When compared to the career exploration event held in October of 2013, fewer students at the Love Out Loud event reported an increased interest in helping careers. However, the students at the Love Out Loud speaker event were not specifically attending a career event, did not start out as likely to be interested in a helping career, and were more likely to be younger and male compared to those at the career event. It would appear that a different segment of the student population was reached by this event (Figure 2.11).

Figure 2.11 Comparative Participant Responses, By Event

Interest in a helping career, October 2013 career event versus Love Out Loud event

Students reported in focus groups that they chose to be a Wellness Center intern because they were curious about mental health careers. For the most part, those who were more certain initially that they wanted to enter the mental health profession still wanted to by the end of the year, while those who were not sure initially were still unsure. The internship appeared to act as a testing ground for their career aspirations rather than as a recruiting mechanism. When compared to freshman mentors, interns were more likely to have been sure they wanted to enter a mental health profession when they applied and were more likely at the end of the year to want to pursue a mental health career.

Four of the ten Wellness Center interns who participated in focus groups wanted to go into a mental health profession prior to becoming an intern and they still had this career goal at the end of the internship. One of these students also planned to continue with similar work in his college wellness center.

Three of the interns in focus groups were not sure what type of profession they will choose but thought that the experience had

I feel really accomplished to be able to be leaving high school … knowing that I've been involved in that. It feels good to have been able to help people throughout high school.

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focused them more on a "people" profession. Of the remaining three interns, two students had thought they wanted to work in mental health but by the end of the internship they no longer wanted to: one because she acquired a new interest and the other because she decided it wasn't a good fit, though she still wanted to work in a related field. The last student had not been interested in a mental health career and was still not interested, but she felt she gained a lot socially from the experience.

On a year-end survey in June 2014, the interns were asked whether their experience helped to guide them into a helping field. Seven of the thirteen interns (54%) surveyed responded affirmatively, with three saying that they are going into a helping field, three specifying that their Wellness Center experience had an impact on their choice, and one saying that the experience confirmed their choice. Two interns said that it might impact their choice of career, while four interns said that they planned to go into a different direction professionally.

In the Spring and Summer 2014, behavioral health staff conducted a follow-up survey with all former interns. Any former interns who could be contacted were asked what their college major or career interest was and what community service they were involved in. Of the 28 former interns contacted, 18 reported "helping profession" majors or interest areas. Twelve of the twenty-eight reported a major or interest area directly related to behavioral health (e.g.: psychology, neuroscience, cognitive sciences, biopsychology, child development). Four of the former interns had participated in additional community internships or leadership activities: two interned with the San Luis Obispo County Behavioral Health Department (SLOBHD); another was a mental health peer educator in college; and a fourth hosted a mind and body care event at her college. Another was considering starting an Active Minds chapter at her university.

> *[When the Wellness Center first opened] people would be embarrassed about it... like, 'We don't want to talk about those things'... But now it's more like, 'Oh yeah, the Wellness Center!' They're not so shy about it. It's not seen as a bad thing anymore to go there .*

> *I think it helps people feel more comfortable if they're having a problem, they don't have to sit in class, being uncomfortable around other people. They can just go there. Before, there wasn't an option. You just had to say, 'Oh I don't feel well' and they'd send you to the Nurse's office.*

Decreased Stigma

Student comments on the point-in-time survey of all Wellness Center users indicated an appreciation for the lack of stigma at the Wellness Center. Several students listed 'not being judged' or 'accepting' when asked what they liked about the center.

At the Love Out Loud event, 81% of students surveyed were more aware of mental health disorders as a result of the event. At the body image event, student written responses to the question, "Why do these events help students?" indicated an awareness of a need for less stigma.

In focus groups, Wellness Center interns thought that the level of stigma about mental health issues at school has declined since they have been at Atascadero High. They believed that the visibility of the Wellness Center has been a major factor. Interns cited teachers' increased willingness to send students to the Wellness Center and students feeling more comfortable using the Wellness Center as evidence of declining stigma.

Wellness Center students entered the statewide "Directing the Change" student anti-stigma competition. Their film *Be The Person* won the third place regional award in the stigma reduction category.

Figure 2.12 AHS Student Film, *Be The Person*

Freshman mentors who participated in focus groups as a comparison group to the Wellness Center interns were divided about stigma reduction, with one focus group thinking that awareness has increased and the other saying that students are still very uncomfortable talking about mental health issues. The focus group that thought awareness had increased were not sure that all students would agree with them; they said that that it could just be their experience because they are very involved in activities or because they are older now. This group thought that having the Wellness Center on campus has helped to increase awareness and that students are comfortable accessing the Wellness Center.

Before, [teachers would] be like, just get over it and stop faking it. But now teachers are starting to see that it's important so they'll offer to send you to the Wellness Center. They see that it's just as important as physical health.

The other freshmen mentor focus group was uncertain about the meaning of stigma at first. Ultimately they thought that talking about mental health issues is still very uncomfortable for students, both because it is very personal and because students may encounter ridicule. They did note that students use the Wellness Center without ridicule.

The school wide survey asked students whether they were comfortable around someone with mental illness. No change was seen in students' responses from 2012 to 2014. Mean scores were 3.9 out of 5 (on a scale of 1=strongly disagree to 5=strongly agree)

every year, with 76% of students agreeing (selected "agree" or "strongly agree") in 2012, 79% in 2013, and 78% in 2014. Overall, students rated themselves as comfortable around people with mental illness.

On the school wide survey, students were asked one open-ended question regarding stigma:

1) What would you feel and do if you discovered your friend had been diagnosed with a mental illness?

Responses to this questions were coded to determine whether students had a positive response to others. The coding process was also part of student intern learning; these results should be interpreted with caution (Table 2.4):

Table 2.4 Participants Response to Peer (Measuring Stigma)

Desired Response to Question	2011-12	2012-13	2013-14
Positive response to peer	58%	66%	64%

The Wellness Center was a tremendous help after the death of a well-known student in the Fall of 2013. Administrators and teachers stated that without the Wellness Center, the school would not have had the capacity to deal with the demand for services, and some students would likely have remained at home. It was widely agreed by students, staff, and teachers that during the crisis there did not appear to be any notion of stigma connected to using the Wellness Center as a place to grieve and heal.

In one focus group, interns emphasized that their diversity was central to the Wellness Center's success. Interns explained they are a diverse group, selected from many different "groups" or types of students on campus. They said that they changed their attitudes toward other groups of students by working with one another, including becoming less judgmental and less likely to stereotype others. And because they spread the word about the Wellness Center in each of their groups, students from all groups now use the Wellness Center.

> *I used to be super judgmental, like 'wow, she looks like this so therefore she's this and this and this.' But then you talk to those people who you thought you had those judgments about and it completely changes. And you see them as a real person as opposed to just a stereotype.*

> *I expected it to just be all the ASB and peer students... I was terrified because I'm a nerdy choir kid that watches Netflix and reads comic books. But then I got there and it's so diverse. There are people from literally every different clique on campus.... It's a weird quirky family. It's nice, it's really diverse*

They also thought that students from all groups were more likely to feel comfortable in the Wellness Center because of the intern diversity that reflected student backgrounds. In a comparison focus group, a freshman mentor also brought up how many different groups of people used the Wellness Center. Interns were emphatic that this was key to acceptance of a Wellness Center on campus.
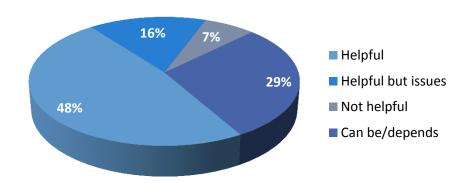
LESSONS LEARNED

Teacher Perceptions

Teachers continue to have generally positive feelings about the Wellness Center. On both the initial teacher survey and the follow-up survey, approximately one-quarter of teachers reported referring students to the Wellness Center at least monthly. Around half of teachers said they referred students less than monthly and 25% had never referred a student (note that some respondents did not work with the general student population).

In the June 2014 survey, nearly all teachers said that the Wellness Center can be a helpful resource but half of respondents had reservations (Figure 2.13).

Figure 2.13 Teacher Responses

93% of teachers think the Wellness Center can be a helpful resource for students

Teachers who referred students more frequently were more likely to have favorable opinions about the Wellness Center and were more likely to list the Wellness Center as an option that they would consider if they encountered a student with a mental health issue. Conversely, those who did not refer students also wrote that they would refer students with mental health issues to the counseling office. A few teachers did not think that this kind of support was necessary ("*I don't think we have many students with legitimate mental health issues*") indicting a need for education and awareness activities among staff.

The issue of students leaving class to go to the Wellness Center was the primary reason for teachers having reservations about the Wellness Center. Nearly three-quarters of teachers who completed the written questions commented on this issue. Comments ranged from thinking that a few students were taking advantage of leaving class to believing that many students were using it as a way to avoid tests, challenging assignments, and repercussions for not being prepared for class (e.g.: forgot P.E. clothes, didn't do homework). Sixteen percent of teachers commented positively on this topic, saying that the situation regarding missing class has been improving.

This issue continues to be a challenge for Wellness Center staff, who have been working to improve communication with teachers and educate teachers on common misperceptions, including reminding teachers that it is their choice to release a student during class and that there is always a qualified adult available to help students if a peer is not appropriate.

STRATEGIES FOR REPLICATION

For other communities interested in replicating this Innovation project, learning highlights include:

- Coordinating closely and communicating frequently with the school counseling department and teaching staff is important to create acceptance among school staff for an on-campus Wellness Center. Consider setting up the center within the school counseling department. This would also support behavioral health career events.
- The campus community needs to understand when it is appropriate for a student to go to the Wellness Center and when to go to a school counselor.
- Be prepared that as stigma reduction and knowledge of signs and symptoms increases, more students will come seeking help. This means that more adult counselors must be on staff to work with students with needs beyond the scope of peer interns. Referrals to off-campus providers are not usually followed through; therapists need to be on campus to effectively help teens in crisis.

SUSTAINABILITY

San Luis Obispo County Behavioral Health staff are currently meeting with Atascadero High School to develop a sustainability plan.

OLDER ADULT FAMILY FACILITATION

During the Innovation community planning process, stakeholders determined that gaps in services continued to exist for Older Adults (ages 65 and older) in San Luis Obispo County. Older Adults who suffer from severe mental illness may be served by a single Full Service Partnership (FSP) through Community Services and Supports (CSS). Depression screening, Transitional Counseling, Senior Peer Counseling, and Caring Caller programs were expanded through Prevention and Early Intervention (PEI). Older adults with behavioral health challenges that go beyond early intervention, but are not severe enough for FSP programs are often underserved and "fall between the cracks". Stakeholders hypothesized that this was due to a lack of integration among providers.

Wilshire Community Services was selected to conduct the Older Adult Family Facilitation project which aimed to create forward-looking solutions that enhance choice, safety, comfort, support, and well-being for older adults. This two-year pilot project was created to fill service gaps between existing Older Adult programs. This project blended two approaches successful with children (Family Group Decision Making) and older adults (Elder Mediation), and addressed the need for integrating system supports when engaging seniors in mental health care.

The original Innovation design was a community-based, multidisciplinary team of older adult care professionals, and individuals chosen by the client to participate in their wellness plan. The care team meetings were to be facilitated by a professional mediator and a licensed therapist to act as a case manager. This client-centered early intervention approach aimed to ensure that the client is actively involved in their wellness plan and that their definition of a quality life is respected and maintained. Each care plan considered the six recognized dimensions of wellness: emotional, intellectual, purposeful, physical, social, and spiritual.

The proposed primary purpose of this Innovation was: to increase the quality of services, including better outcomes with a secondary purpose of promoting interagency collaboration. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- Serve at least 15 older adults and families per year, engaging approximately three other entities serving older adults per case.

Learning Outcomes:

- Will participants and caregivers demonstrate increased satisfaction with services and increased perception of being cared for?
- Will participants report increased factors of wellness, health, and overall happiness?
- Will the project provider, community partners, staff, and volunteers report an increased feeling of satisfaction and rates of success?

SERVICE DELIVERY

The project started with a beta test, during which Wilshire Community Services (the selected provider) learned that four key areas of the projects needed to be addressed and refined in order to ensure the

best possible outcomes for each participant: engagement of community providers, appropriateness of client for services, caregiver mental health needs, and increased self-care skills. In response to these issues, staff adopted a new model with a stable, specialized team that reviewed each case, rather than building a new team for each client. This team consulted monthly and made recommendations for referrals and resources. The therapist functioned as the coordinator and brought cases to the meetings, and the mediator acted as the family facilitator.

Figure 3.1. Map of Client Locations

Demographic information was provided for all 25 clients. The mean client age was 77 with an age range from 60 to 95. Six clients were male and 19 were female. All but one reported having a low monthly income of $800-$2,500 per month. Clients were located throughout the county, with one-third in San Luis Obispo, one-third in South County, and one-third in North County and on the Coast (Figure 3.1).

Clients entered the program with a number of severe health issues, from cancer and COPD to

Parkinson's to early Alzheimer's. Every client had mental health issues at entry. Most had depression and/or anxiety; three were bipolar, one experienced paranoia, and one had a history of psychotic episodes. Two clients had known substance abuse issues. When health and mental health issues were looked at in terms of chronic problems, eight clients had chronic health problems, twelve had chronic mental health problems, and two had chronic family conflict. Three clients died while their cases were open.

Clients' family support ranged from extensive, with several children involved, to non-existent. Some clients had other resources involved at intake, including Wilshire Caring Callers, friends, Hospice, and their church. Only two had a spouse or significant other involved. Six clients had family caregivers in residence, while 11 clients had no local family involved in their lives. Two clients did not have Medicare coverage because they were not yet 65 years old. Seven clients were on both Medicare and Medi-Cal.

There were a total of 25 adults over the two years of the project. Ten clients were served in year one, as a smaller case load was used to initially refine the model. Fifteen clients were served in year two. An additional 35 family members were also supported.

Most clients were connected to three (n=12) or four (n=10) resources; and all clients were provided with at least two resource connections (n=3). Resources included Caring Callers, Senior Peer Counseling, Clearings therapy, Care Coordination, Resource Connection, Home Health, Hospice, family and caregiver support, and family meetings.

Innovation project staff engaged an average of 1.32 outside resources per case. These were primarily family and friends of the client, but also included in-home caregivers, in-home supportive services, mental health professionals, the client's church, Al-Anon, and an attorney. In 13 cases, staff engaged

with one outside resource. Eight cases had two outside resources, one case had four outside resources, and three cases had no outside resources.

DATA COLLECTION

Project staff collected output and outcome data through intake assessments, administration of mental health scales at intake and exit, satisfaction surveys at exit, and staff tracking of resources provided for each client and gaps in resources remaining at discharge. Detailed demographics were also reported for each client. The project evaluator conducted key informant interviews with staff and analyzed all mental health data.

Two clients dropped out of the program and did not have discharge assessments; their data is not included in project outcomes.

Four instruments were used to measure participant and caregiver wellness:

- Patient Health Questionnaire-9 (PHQ-9) Depression Screening published by Pfizer Inc.
- Anxiety Screening, developed by Wilshire Community Services Senior Services Division;
- Caregiver Stress Test, developed by Wilshire Community Services Senior Services Division; and
- Case Management Level, designated by staff based on client need, as determined by client assessment.

These four instruments were administered at intake and discharge to the clients enrolled in the Older Adult Family Facilitation Project and their caregivers. Data on all four measures was reported for each of these 23 clients. The PHQ-9 and Anxiety Screening were self-reported by the client. The Caregiver Stress Test was self-reported by the client's caregiver. The Case Management Level was determined by staff.

As indicated in the original evaluation design, Wilshire provided a convenience sample comparison group of 15 clients who received only Senior Peer Counseling (SPC) services through the County's PEI programs. Due to the screening process for SPC, clients in this program were expected to have fewer mental health issues and to need fewer services than those in the Innovation project.

LEARNING OUTCOMES

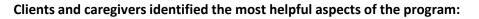### Satisfaction with Services

Clients and caregivers completed a retrospective survey about general satisfaction and changes in well-being (Table 3.1). Both clients and caregivers reported similar levels of satisfaction. Fourteen clients and eleven caregivers (both live-in and not in residence) completed surveys. When asked how well the program met their needs, satisfaction was lower, perhaps because so many clients were still facing significant health and income problems that were beyond the scope of the program. (See Lessons Learned for more discussion of these issues.)
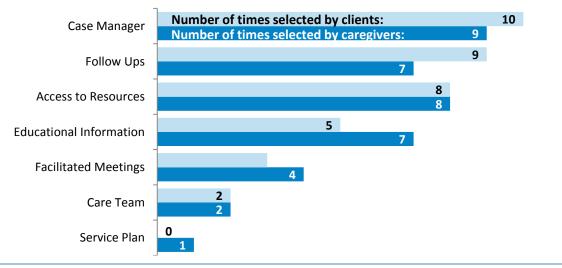
Both clients and caregivers indicated that the top three most helpful aspects of the program were: having a case manager; continued follow up; and access to resources (Figure 3.2).

Table 3.1 Retrospective Survey Results

Average rating, scale of 1 (lowest) to 5 (highest)	Clients	Caregivers
How would you rate the quality of service you received?	3.7	3.6
Would you recommend the program to a friend?	3.6	3.5
How satisfied are you with the amount of help you have received?	3.7	3.5
Overall, how satisfied are you with the service you received?	3.6	3.5
Did you get the kind of service you wanted?	2.8	2.9
To what extent has the program met your needs?	3.1	3.1
Have the services helped you to deal more effectively with your problems?	3.1	3.1

Figure 3.2 Comparative Rankings of Helpful Program Aspects

Clients and caregivers identified the most helpful aspects of the program:

Number of times selected by clients:
Number of times selected by caregivers:

Aspect	Clients	Caregivers
Case Manager	10	9
Follow Ups	9	7
Access to Resources	8	8
Educational Information	5	7
Facilitated Meetings		4
Care Team	2	2
Service Plan	0	1

Health and Wellness Factors

Staff reported that participants had many chronic health and mental health issues that could not be alleviated through a family facilitation process. However, mental wellness factors, including anxiety and depression, did improve substantially over the course of services.

According to client self-report in a retrospective survey (n=14), overall levels of emotional distress fell from a mean of 4.1 on a scale of 1 (low distress) to 5 (high distress) to a mean of 3.7. Sense of well-being increased from a mean of 3.1 to 3.6 exit on a scale of 1 (low) to 5 (high). They saw little change in their coping skills (3.4 to 3.6) and overall quality of life (3.5 to 3.6). However, when asked to rate their capacity to achieve quality of life on each of the six dimensions of aging, clients identified improvements

in the emotional, social, and intellectual domains. Small improvements were noted in the purposeful and spiritual domains, while no change was seen in the physical domain (Figure 3.3).
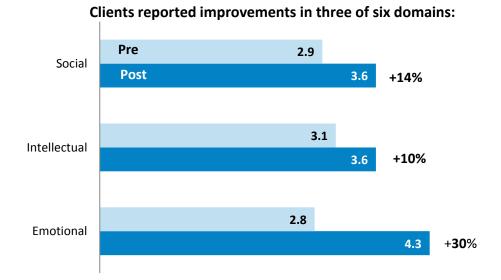
Figure 3.3 Client Reports of Improvement

Clients reported improvements in three of six domains:
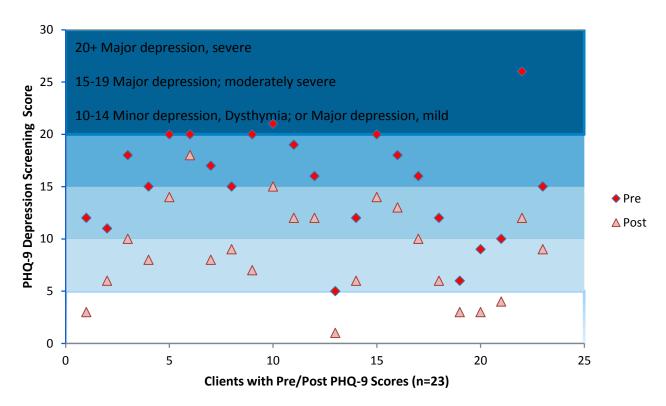

In a retrospective survey, caregivers (n=11) reported a reduction in emotional distress for clients, from a mean of 4.3 on a scale of 1 (low distress) to 5 (high distress) at entry to a mean of 3.2 at exit. Oddly, they reported a decrease in clients' sense of wellbeing, from a mean of 3.7 to 3.1. At the same time, they reported an increase for clients in the emotional domain, from a mean of 2.6 to 4.0. They also reported small increases in wellness in each of the other domains.

When asked whether the program increased their feeling of connection and their confidence to self-advocate, client responses averaged in the mid-range (connection: 2.8; confidence: 2.7, on a scale of 1 [low] to 5 [high]). They were more positive about the program expanding their knowledge of and access to resources (3.4). Caregivers reported slightly higher levels of improvement for clients. Clients reported that their risk of losing housing remained largely unchanged, from a mean of 2.5 at entry to 2.3 at exit on a scale of 1 (low risk) to 5 (high risk).

REDUCTION IN DEPRESSION

The PHQ-9 depression screening instrument was scored on a scale of 1 to 27 (see Appendix C1). A score of 0-4 indicated no symptoms, while a score of 5-9 indicated minimal symptoms. A score of 10-14 indicated minor depression; dysthymia; or major depression (mild). A score of 15-19 indicated major depression (moderately severe) and a score of 20 or higher indicated major depression (severe). Innovation client scores on PHQ-9 depression screenings at intake and discharge showed high initial levels of depression and a decrease in depression for 100% of clients. Note that the colored bands indicate the PHQ-9 severity level, explained along the right column (Figure 3.4).

Figure 3.4 Clients with Pre/Post PHQ-9 Scores

Of the 15 clients with moderately severe or severe major depression (PHQ-9 score of 15+) at intake:

- Five clients exited with only minimal symptoms (PHQ-9 score of 5-9)
- Eight clients exited with mild symptoms (PHQ-9 score of 10-14)
- Two clients exited at a moderately severe level (PHQ-9 score of 15-19), dropping from a severe level.
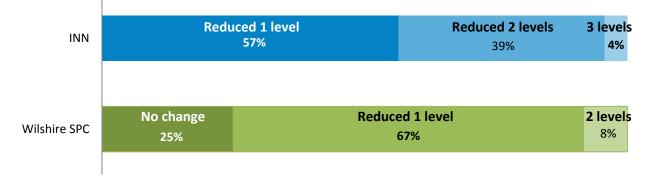
All clients reported a reduction in depression symptoms of at least one severity level (Figure 3.5). A comparative analysis showed that INN clients had greater depression symptoms level reductions than their Wilshire SPC peers (Figure 3.6).

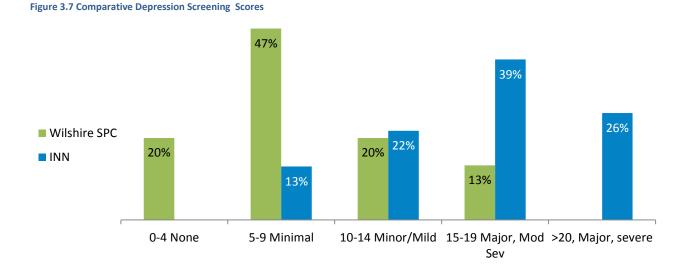**Figure 3.5 Reduction in Depression Symptoms at Discharge**

Reduction in Depression Symptoms at Discharge

- -3 levels: 4%
- -2 levels: 39%
- -1 level: 57%

Figure3.6 Comparative Reduction in Depression, By Levels

Reduction in Depression by Number of Levels. Percentage of Clients at Discharge.

INN
- Reduced 1 level 57%
- Reduced 2 levels 39%
- 3 levels 4%

Wilshire SPC
- No change 25%
- Reduced 1 level 67%
- 2 levels 8%

At intake, Innovation clients scored much higher on depression index than SPC clients (figure 3.7).

Figure 3.7 Comparative Depression Screening Scores

Legend:
- Wilshire SPC
- INN

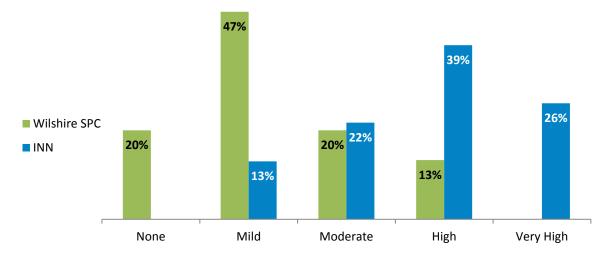| Category	Wilshire SPC	INN
0-4 None	20%	
5-9 Minimal	47%	13%
10-14 Minor/Mild	20%	22%
15-19 Major, Mod Sev	13%	39%
>20, Major, severe		26%

REDUCTION IN ANXIETY

Anxiety levels of Innovation clients and a comparison group were measured at intake and discharge using an Anxiety Screening tool. The Anxiety Screening tool was scored on a scale of 1 to 10 (see Appendix C2). A score of 1-2 indicated mild anxiety, and a score of 3-5 indicated moderate anxiety. A score of 6-8 indicated high anxiety, while a score of 9-10 indicated very high anxiety.

Sixty-five percent of Innovation clients had "high" or "very high" levels of anxiety at intake. Only one client had no anxiety at intake. In the comparison group of 15 Senior Peer Counseling (Wilshire SPC) clients, four clients had no anxiety at intake and no clients presented with "high" or "very high" levels of anxiety.

Overall, Innovation (INN) clients scored much higher on the anxiety screening at intake than Wilshire SPC clients (Figure 3.8).

Figure 3.8 Comparative Anxiety Screening Scores

Higher Anxiety Screening Scores at Intake for INN Clients.

Over three-quarters of Innovation clients reported a reduction in anxiety symptoms of at least one severity level (Figure 3.9).
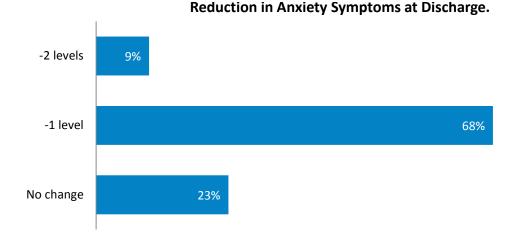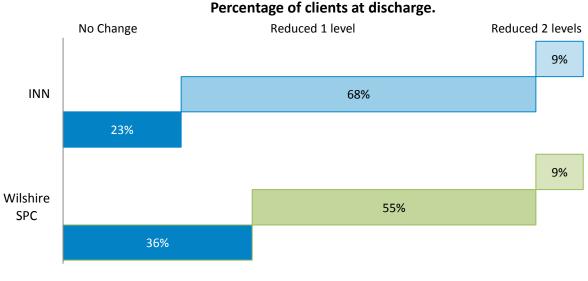
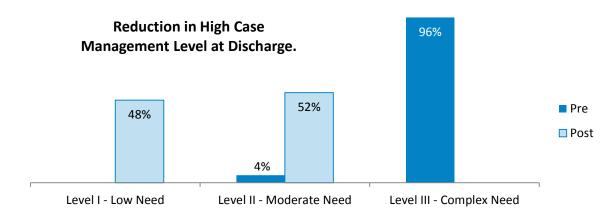**Figure 3.9 Comparative Reduction in Anxiet y By Levels**

Reduction in Anxiety Symptoms at Discharge.

- -2 levels: 9%
- -1 level: 68%
- No change: 23%

Figure3.20 Reduction in Anxiety Symptoms at Discharge

Reduction in anxiety by number of levels.
Percentage of clients at discharge.

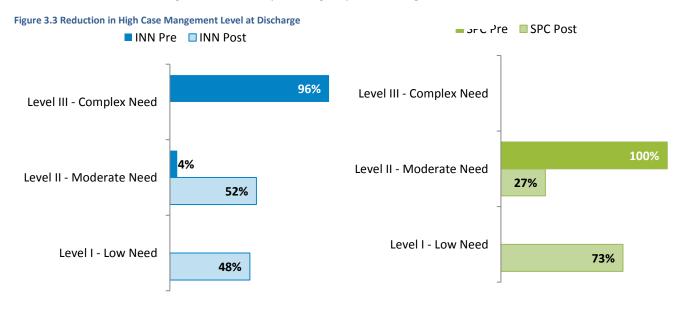|	No Change	Reduced 1 level	Reduced 2 levels
INN	23%	68%	9%
Wilshire SPC	36%	55%	9%

REDUCTION IN CASE MANAGEMENT NEEDS

Project staff determined a case management level at intake and discharge for each Innovation client, as well as for the comparison group of Senior Peer Counseling clients. Case management levels were determined using a rating scale that took into account client functioning, existing support, psychological and medical needs, other resource needs, and intensity of case management required (see Appendix C3 for rating scale). Level 1 indicates a low need, Level 2 describes a moderate need, and Level 3 is a complex, or high, need. Among Innovation clients, nearly every individual was rated at the highest need

Reduction in High Case Management Level at Discharge.

	Pre	Post
Level I - Low Need		48%
Level II - Moderate Need	4%	52%
Level III - Complex Need	96%	

level (Level III, Complex Need) at intake. By discharge, 100% of clients had a reduction in case management need level and none remained at the highest level.

Compared to Wilshire SPC clients, case management needs were much higher at intake for Innovation clients (3.11). No clients remained at the highest need level, but more Innovation clients still had moderate needs at discharge than did comparison group clients (Figure 3.12).

Figure 3.3 Reduction in High Case Mangement Level at Discharge

INN Pre / INN Post / SPC Pre / SPC Post

INN	INN Pre	INN Post
Level III - Complex Need	96%	
Level II - Moderate Need	4%	52%
Level I - Low Need		48%

SPC	SPC Pre	SPC Post
Level III - Complex Need		
Level II - Moderate Need	100%	27%
Level I - Low Need		73%

CLIENT EXAMPLE

Innovation project staff provided this case study of a typical client. Note that only the client's name and other identifying information has been changed in this description:

Tom is a senior living by himself with few local social contacts who started to feel depressed, not just from falling but also from getting older. Tom sought help through Senior Peer Counseling with Wilshire Community Services which not only addressed his emotional concern, but discovered other needs as well. The Senior Peer Counselor brought Tom's case to the Director of Senior Services who discovered that Tom also had a primary care physician, a neurologist, a home health agency, and a personal care agency. In

spite of the resources available to him, Tom was still missing doctor's appointments, not eating, and was experiencing hopelessness and loneliness. It seemed none of his resources were communicating with one another to prevent this. With Tom's authorization, Wilshire Community Services acted as a liaison between the different service providers which greatly reduced Tom's depression symptoms.

LESSONS LEARNED

Care Team

The care team concept proved to be challenging to implement. Staff had a difficult time getting professionals to participate. Doctors worried about confidentiality and did not have time to attend meetings. Often, resources simply didn't exist. A few people from outside organizations did attend the care team meetings, including a social worker, a minister, and an Alzheimer Association representative.

In response to these issues, staff adopted a new model with a stable, specialized team that reviewed each case, rather than building a new team for each client. This team consulted monthly and made recommendations for referrals and resources. Wilshire acted as the coordinator and brought cases to the meetings, and the mediator acted as the family facilitator.

The Case Manager position was created to step in and fill the gaps that the care team was unable to address. The Case Manager contacted professionals individually and often, and worked with clients to learn to advocate for themselves and improve their ability to navigate the health care and social service systems.

Appropriateness for participation

As clients began participating in the program, staff realized that criteria needed to be established to enroll those clients who would most benefit from the approach. The following criteria were established based on staff experience and found to be effective:

- The client must be 65 years or older
- The client must present with a mental health diagnosis that is primarily treatable through counseling and other non-institutional interventions (appropriate diagnoses would include depression and anxiety which are the most commonly reported mental health issues in older adults).
- The client must be willing and able to participate in the care plan.

Despite targeting participants who were willing and able to do self-care, staff found that it was difficult to transition clients out of services because clients became reliant on care team members rather than building their own skills for system navigation. At the same time, family members who were not caregivers frequently expected staff to solve the client's problems rather than participating in solutions.

As a result of these challenges, the Case Manager increased the engagement with clients to ensure their participation in accessing services. The Case Manager worked to build client ability to self-advocate and be in charge of their own care, increasing the educational component of the project. Even with this increased support, clients still reported that they were unsure of what to do once on their own and sometimes began having more crises after exiting the program. Staff recommended that future

iterations of the project include a slower exit (for example, moving from monthly to quarterly meetings, then phone calls quarterly, etc.).
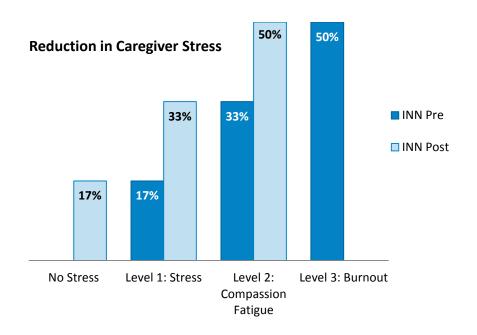
Caregiver mental health needs

For clients with a family caregiver in residence, staff found that caregivers often had high levels of stress and little support. Resources outside the family were needed to maintain the wellness of both the client and the caregiver. Staff also found that care plans needed to address the needs of caregivers, both those who lived with the client and those who lived nearby, as well as the needs of the client for the plan to be successful. They observed that when caregivers were supported, outcomes for clients improved. It should be noted, though, that only six clients had caregivers in residence. Eleven clients had no local family involved.

Caregiver stress was defined as: a condition of exhaustion, anger, rage, or guilt that results from unrelieved caring for a chronically ill dependent. Caregiver data was very limited, with six caregiver stress surveys completed for Innovation clients and four caregiver surveys for the comparison Senior Peer Counseling clients. Due to the extremely small sample size, comparison data is not reported for this measure.

The Caregiver stress instrument was scored on a scale of 1 to 11. A score of 1-4 indicated caregiver stress. A score of 5-8 indicated compassion fatigue, while a score of 9-11 indicated burnout (see Appendix C4 for instrument and rating scale). Of the six Innovation client caregivers, 50% reported the highest level of stress and burnout at intake. All but one caregiver reported reduced stress at the end of the family facilitation process (Figure 3.13). No caregivers reported having the highest level of stress at discharge.

Figure 3.53 Comparative Pre/Post Results in Caregiver Stress
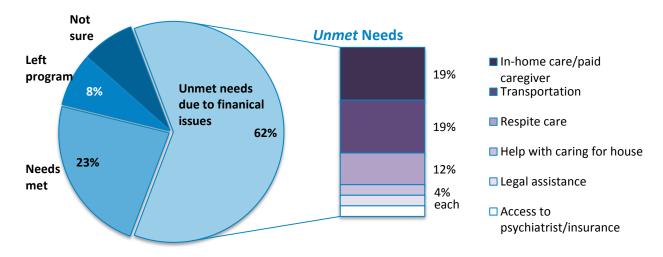

Community Resource Gaps

An unexpected need that became apparent to project staff was that there are large gaps in community resources. Following discharge, staff evaluated whether they believed the client's needs had been fully met. One-quarter of clients had their needs met, while over 60% had unmet needs (Figure 3.14). Unmet needs were all seen to be due to gaps in community resources for those with limited funds (or conversely a lack of finances on the part of the client). Unmet needs included a paid caregiver/in-home care, transportation, respite care, help with caring for their house, legal assistance, and access to medical care (Figure 3.15). According to the Project Director:

"Perhaps the most significant challenge faced in the implementation phase was the gaps in services available to older adults. Often times, the identified problems could not easily be addressed due to a lack of available resources. Many of the clients served during the testing phase lacked the financial resources to secure necessary services and public assistance programs either did not exist or the client did not qualify."

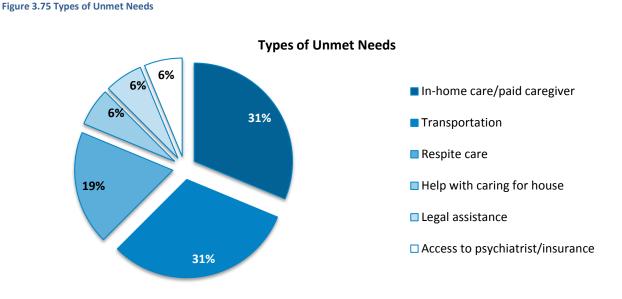**Figure 3.64 Comparison Between Clients' Needs Met and Ongoing Unment Needs**

Percentage of clients who had needs met vs. ongoing unmet needs

Staff comments about clients' unmet needs included:

- She desperately needed in-home care to provide a respite for her daughter, her only caregiver. They didn't qualify for respite care because the daughter was a paid caregiver through IHSS.
- She needed help with her yard, organizing her home, and major home repairs but she did not have financial resources.

The Project Director did point out that clients seemed to feel some relief despite continuing gaps, not only from the services that they were able to put in place but also from being validated that they were in a difficult situation and from being able to vent their frustrations.

Figure 3.75 Types of Unmet Needs

Types of Unmet Needs

- In-home care/paid caregiver
- Transportation
- Respite care
- Help with caring for house
- Legal assistance
- Access to psychiatrist/insurance

For staff, this was a difficult issue because they saw how many gaps remained for clients and became discouraged that they weren't able to provide enough help. When they reviewed the outcome data showing large improvements in their clients' mental wellness, staff morale increased substantially.

An administrator within the program noted that, "We also had very high expectations of ourselves." A realistic view of how much can be changed in challenging circumstances would reduce staff burnout.

Other Lessons Learned

Staff reported several other lessons learned from the Innovation project:

- With many services for older adults, project staff found that they needed an integrated case management system to track clients' demographics and outcomes. For example, they had a client with five different files because five separate projects had worked with her.
- Mental health supports are helpful but other supports are also needed for low-income older adults and their caregivers.
- The project began using a "Six Dimensions of Wellness" model that worked towards positive aging on the following dimensions: Emotional; Intellectual; Purposeful; Physical; Social; and Spiritual. However, staff found the needs of clients to be so urgent that they found themselves "triaging" instead. They were focused on the immediate issues such as caregiver respite, financial resources, family conflict, and pressing health and mental health needs and did not find the Six Dimensions model relevant for this population.
- Many older adults have no local family support. This can be compounded by their mental health issues, which can lead to estrangement from family members.

STRATEGIES FOR REPLICATION

For other communities interested in replicating this Innovation project, learning highlights include:

- Careful screening of potential clients is important to ensure that clients are able to participate in their care plan.
- Intensive case management, with or without a dedicated care team, is critical.
- Care plans and case management must include caregiver support.
- The program should have a clear philosophy of family empowerment and include a substantial self-advocacy skill-building component
- Anticipate that clients with multiple needs and chronic conditions will present with depression and/or anxiety.
- Consider partnering with other non-profit agencies or for-profit businesses willing to help clients as needs arise that require funding sources (e.g.: home repairs, medical transportation, and caregiver respite)

SUSTAINABILITY

Through the Older Adult Family Facilitation project, San Luis Obispo County Behavioral Health and Wilshire Community Services learned much about the gaps in services existing for Older Adults, and applied the lessons learned to their existing older adult programs. Wilshire now offers a version of the Innovation project in the form of the Navigating Options for Wellness (NOW) program.

Wilshire is working to build collaborative relationships with private sector businesses which provide critical services (eg: personal care, transportation, respite care). Wilshire is currently exploring ways to address the gaps in community resources that exist locally for low-income older adults. They have a much higher awareness of the needs of older adults with mental health challenges, as well as of the needs of caregivers.

San Luis Obispo County Behavioral Health has presented the findings of the Innovation project to stakeholders and will prioritize closing the service gaps for older adults during the upcoming community planning and request for proposal processes for CSS and PEI.

NON-VIOLENT COMMUNICATION (NVC) EDUCATION TRIAL

Consumers, family members, and providers expressed a serious need for alternative methods and a change in approach for communication methods system wide. This was especially communicated by providers and families of Transitional Aged Youth (TAY) clients. Angry and abusive communication reduces the capacity for recovery.

Nonviolent Communication (NVC) workshop trainings have been utilized throughout San Luis Obispo County for several years. Having reached hundreds of individuals and families (including parents and teachers) NVC helps many people heal and recover from emotional challenges. NVC is more than a communication skill set; it is a cognitive framework for interpreting the world. It teaches people to express themselves and respond to others in a non-judgmental way, reframing interactions to focus on empathy and compassion.

Recognizing this, the Nonviolent Communication Education Trial was developed as part of Innovation to adapt NVC principles for TAY experiencing mental and/or emotional difficulties, exhibiting anger, aggression and conflict with parents, teachers, or caregivers. In testing the NVC methods with TAY, this innovation studied conflict resolution methods when engaging TAY in their recovery.

The United Way of San Luis Obispo County was selected to administer the NVC Education trial. Classes were taught at two different continuation high schools and the curriculum was adapted to best meet the needs of the students. The adapted curriculum focused on giving TAY empathy, modeling listening skills, and teaching NVC concepts through activities and direct instruction. The curriculum was also provided for the teens and staff of **Transitions-Mental Health Association's** Youth Treatment Program (YTP).

The proposed primary purpose of this Innovation was to increase the quality of services including better outcomes. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- 96 individuals will participate in NVC training.

Learning Outcomes:

- Participants in NVC will be surveyed using pre and post scales and staff will track and monitor participant and family member outcomes, including:
    - Reduced feelings of anxiety, hostility, and violence towards self and others.
    - An increase in empathetic connections with what others are feeling and needing.
    - Reduction in negative behaviors, including incidents of violence, running away, etc.

SERVICE DELIVERY

Classes

United Way staff investigated several different avenues for connecting with high-need TAY through local agencies. They first offered a class to Independent Living Program (ILP) teens and outreach to Bakari Program (gang-exposed teen) participants, but logistics were challenging for these groups. Next they taught a class at Grizzly Academy. Although Grizzly Academy offers a variety of electives to cadets it was not an ongoing recruitment source. Outreach to ten different agencies was conducted during this time period.

In the Spring of 2013, the NVC facilitators began offering classes through Pacific Beach Continuation High School in San Luis Obispo. This was a better logistical match, with students already present for classes and able to receive credit for course completion. In the Fall of 2013, United Way staff reached out to Lopez Continuation High School and offered classes for their students through Winter of 2014. At Pacific Beach, students were referred by the school counselor in the spring and a teacher in the fall (due to the loss of their school counselor). At Lopez, students were referred by the school counselor.
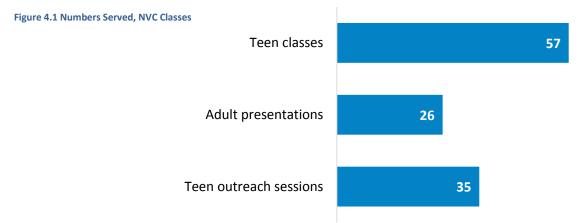
A total of eight classes were offered to various high-risk teen populations; six of these were at continuation high schools (Table 4.1):

Table 4.1 Populations Served

Population Served	Level	Date
Independent Living Program	Beginning	Summer 2012
Grizzly Academy	Beginning	Fall 2012
Pacific Beach Continuation High	Beginning	Spring 2013
Pacific Beach Continuation High	Intermediate	Spring 2013
Pacific Beach Continuation High	Beginning	Fall 2013
Lopez Continuation High	Beginning	Fall 2013
Lopez Continuation High	Intermediate	Winter 2014
Lopez Continuation High	Beginning	Winter 2014

A total of 57 teens participated in NVC classes. In addition to the classes, teen outreach sessions were

Numbers Served, NVC Classes

Figure 4.1 Numbers Served, NVC Classes

conducted with ILP, Grizzly, and Pacific Beach teens to recruit for classes. Adult presentations were made to Youth Services staff and ILP staff (Figure 4.1):

ADAPTATIONS

Several adaptations were made to the original NVC curriculum. One adaptation involved integrating Alternative to Violence Project (AVP) activities into the curriculum. AVP is a program developed to address violence in prisons using interactive exercises, games and role-plays. Bringing AVP tools to the NVC curriculum for both teens and staff increased interaction and perception of "fun," and appeared to help participants better understand NVC principles through more experiential engagement.
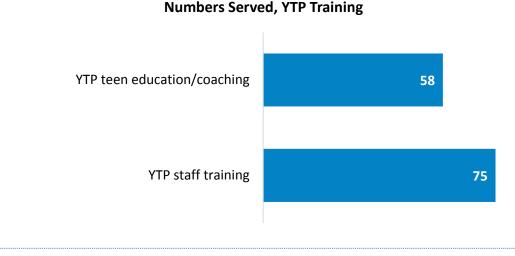
Other adaptations included slowing down the curriculum and beginning with more modeling for participants of listening and empathy; reduced direct instruction about NVC theory; and separation of the group into two groups when indicated. Facilitators also learned that a high level of curricular flexibility was needed to respond to students' specific needs.

Youth Treatment Program (YTP)

NVC Innovation project staff worked with San Luis Obispo County Behavioral Health Department (SLOBHD) staff to offer NVC education to Youth Treatment Program (YTP) **teens and their caregiver staff. This partnership emerged in the first months of the project through a connection with a YTP therapist. YTP staff have been transitioning the residential home** to a trauma-informed care orientation **and NVC training supported this philosophy.**

NVC facilitators engaged both YTP residents and staff in trainings and coaching. Teens had weekly education in support groups and more frequent coaching and support on the "floor," the living areas of

Figure 4.2 Numbers Served, YTP Training   for additional support.

Numbers served were counted by quarter, resulting in duplication (Figure 4.2):

Numbers Served, YTP Training

Category	Number
YTP teen education/coaching	58
YTP staff training	75

ADAPTATIONS

Initially, much of the NVC education for teens was presented during therapy group sessions, with some follow-up by the facilitator on the "floor" each week. Overall, the teens were reluctant to engage in the learning during group sessions. A second facilitator took over in the fall and spent several evenings each week on the floor interacting with teens, building trust and seeking teachable moments for NVC learning.

When teens at YTP break a rule, they are written up and have to talk it through at a later date with the appropriate staff member; often they receive some kind of consequence at this time. This state of waiting to talk it through is called "being on repair," because they have damaged a relationship and need to repair it. A white board in the office is used to track who is on Repair, which corresponds to reduced privileges, versus who is not (called RO, or Restoring Order). Both facilitators participated in structured "repairs" between staff and teens, modeling NVC communication for the youth and their caregivers.

After introducing NVC to YTP staff through a series of monthly staff workshops that were adapted from the original curriculum, YTP staff told NVC facilitators that they wanted more concrete skills and tools. The facilitators further adapted the curriculum, developing weekly small group trainings to address this need, as well as more in-depth all-staff workshops that focused on the skills and tools being requested.

DATA COLLECTION

Classes

All continuation high school students were interviewed prior to beginning any classes and then again after each session. The pre/post closed interview series was utilized to provide insights into any changes that occurred in students' thinking as a result of the class. Oral interviews were chosen to reduce barriers for students who struggled with writing (see Appendix D1 for pre and post interview scripts). Students also completed a post-class survey.

YTP

Staff workshops at the Youth Treatment Program (YTP) were assessed via post-workshop surveys which were administered one to two weeks after workshops to gather data about whether staff were able to apply learning to their interactions with residents. Small group assessments were collected orally each session by the facilitator as a class exercise. Both staff and teen residents at YTP were interviewed at six-month intervals using a semi-structured protocol and responsive interviewing technique (see Appendix D2.)

Six staff were interviewed in December 2012 and January 2013, including one full-time floor staff, one part-time floor staff, three managerial staff, and a mental health therapist. Four of the six had not been trained in NVC prior to the start of this project. Additional floor staff could not be interviewed due to their scheduling constraints.

In May and June of 2013 five more staff were interviewed, including four floor staff and one mental health therapist, and a focus group was conducted with the management team (see Appendix D3 for management team focus group protocol). Five staff were interviewed in January of 2014; these were primarily full-time staff (four out of five) who were more engaged with the NVC project.

In January, 2013, six teens were interviewed. Five of the six had been there since the NVC facilitator started his work at YTP; the sixth had been there for a couple of months. Then in June 2013, five teens were interviewed. Their length of stay at YTP ranged from multiple years to starting closely after the NVC facilitator. Three of the five had been interviewed during the first set of interviews. In February 2014, five teens were interviewed, only one of whom had been interviewed previously. All the residents who were interviewed had been there since the second NVC facilitator started at YTP.

LEARNING OUTCOMES: CLASSES

Learning outcomes are being reported only for the six classes at Pacific Beach Continuation High School and Lopez Continuation High School, as the first two classes, through the Independent Living Program and Grizzly Academy, involved pilot evaluation strategies.
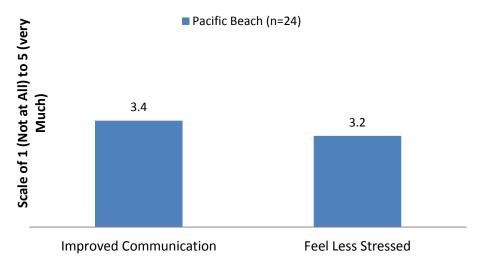
Reduced Anger, Increased Expression of Feelings and Needs, Greater Empathy

Class surveys were submitted by every student who completed the course. Students were asked to what degree they agreed with the following statements (1=not at all; 5=very much):

- This class has helped me communicate better in my life.
- I feel less stressed overall because of this class.
- I would recommend this class to a friend or family member.
- I would like to continue taking NVC classes in the future.

Mean scores for the first two statements around student outcomes included all continuation high school students (Figure 4.3).
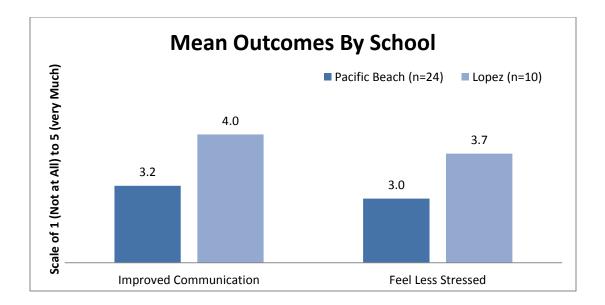
Figure 4.3 Mean Outcomes, All Continuation High School Students

Mean Outcomes, All Continuation High School Students

Lopez students rated the class as more effective than Pacific Beach students (Figure 4.4):

Figure 4.4 Mean Outcomes, By School

Mean Outcomes By School

Scale of 1 (Not at All) to 5 (very Much)

■ Pacific Beach (n=24) ■ Lopez (n=10)

Improved Communication: Pacific Beach 3.2, Lopez 4.0

Feel Less Stressed: Pacific Beach 3.0, Lopez 3.7

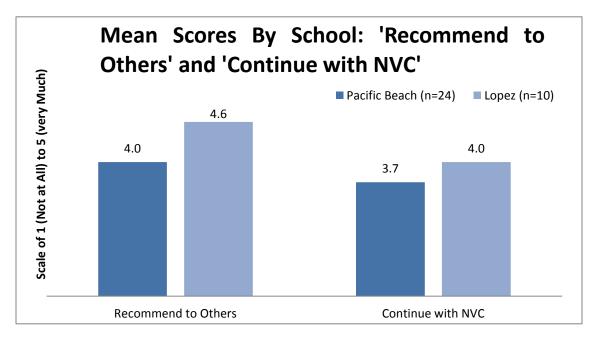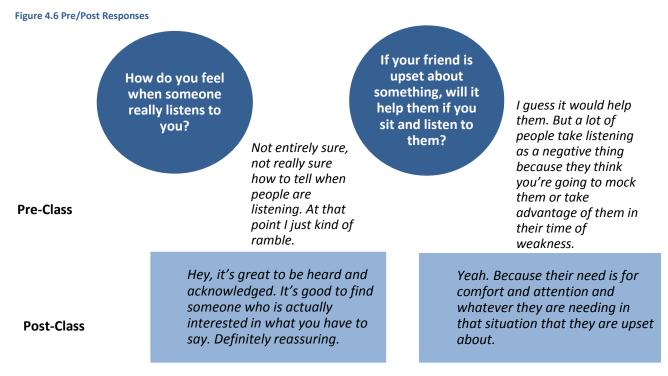Students at both schools were interested in more classes and would recommend it to others (Figure 4.5):

Figure 4.5 Mean Scores By School

When asked what they liked most about the class, few of the Pacific Beach students talked specifically about what they learned. They appreciated the communication, listening, honesty, and atmosphere. Only one student wrote an answer that indicated a change in their own understanding.

Comments from Lopez students were more specific about how the class has affected them and what they valued. Five of the ten Lopez students (50%) listed changes in their own understanding, including not jumping to conclusions and controlling their anger. Identical questions were asked in pre and post interviews and the quality of answers increased, with students better able to express their feelings, needs and the importance of being heard (Figure 4.6).

Figure 4.6 Pre/Post Responses

How do you feel when someone really listens to you?

If your friend is upset about something, will it help them if you sit and listen to them?

Pre-Class

Not entirely sure, not really sure how to tell when people are listening. At that point I just kind of ramble.

I guess it would help them. But a lot of people take listening as a negative thing because they think you're going to mock them or take advantage of them in their time of weakness.

Post-Class

Hey, it's great to be heard and acknowledged. It's good to find someone who is actually interested in what you have to say. Definitely reassuring.

Yeah. Because their need is for comfort and attention and whatever they are needing in that situation that they are upset about.

Students in the Lopez classes appeared to be more receptive to the type of learning and change being offered in the NVC classes. While few Pacific Beach students could express clear reasons for taking the class, most Lopez students talked about specific reasons, including having anger issues, difficulty communicating with family members, and being overwhelmingly frustrated in their life. Students in the Lopez High classes were much more likely to report specific positive shifts in their behavior and mental health. Students reported reduced anger toward others and themselves, an increased ability to express their feelings and needs, and greater empathy for what others are feeling and needing. Overall, the class appeared to have a strong impact on the emotional wellbeing of the Lopez students.

During the last two sets of post-class interviews, a question was added to ask Lopez students directly whether the class had changed anything for them at home, school, work, or in other relationships. All students responded with specific information about how the class had improved their lives. TAY

… [NVC} decreased my depression a lot. And disturbing thoughts went away.

Besides, like, saving, my life? And that's not an exaggeration either

I stopped having suicidal thoughts because of this class.

I am now able to stay aware when I get angry…If it weren't for this class I would be in jail.

I would have been kicked out [of school] if I wasn't in that [NVC] group.

participants reported to the evaluator and instructors:

The evaluation of this portion of the project was structured as a case study to gain a deeper understanding of project effects and themes in this new venue. Data was triangulated through staff interviews, teen resident interviews, staff surveys, a management team focus group, document review, and NVC facilitator interviews.

Because the management team was simultaneously continuing to educate staff around a trauma-informed care orientation and align policies and procedures to this orientation, it was difficult to separate the effects of NVC education from the effects of the shift to trauma-informed care. For individual residents, it was also difficult to evaluate specific effects of NVC, as a variety interventions take place with residents during their stay. The stability of the overall environment was also highly variable depending on the mix of residents at the time and their level of need. Despite the difficulty evaluating effects of NVC, it was clear to all participants that NVC supported trauma-informed care, with many staff seeing it as the verbal language that they needed to clearly express the trauma-informed care philosophy during specific interactions.

Reduced Anger, Increased Expression of Feelings and Needs, Greater Empathy

For some residents, the NVC framework helped them to reduce their anger and increase their ability to express their needs. Factors that appeared to play a role in the efficacy of NVC included whether the teen was able to be self-aware, was receptive to change, had ongoing family trauma in their lives, the nature of their mental health and medication issues, and the interpersonal dynamics between the particular personalities (including reactivity and aggression) of residents at the time and between residents and staff. Staff noted that learning NVC skills increases the teens' understanding about how to resolve conflict after the initial anger had passed:

> The last couple weeks, we've had some conflict in the house between kids…I've been really impressed by their ability to come back to it a little while later and openly name and express the need to talk, to resolve this conflict in a way that both parties can feel safe. …People have conflicts, we can come to this in a safe way – is really a powerful thing. That's a hard skill. A lot of grownups don't have that skill.

Improving Partnerships Between Youth and Caregivers

According to both YTP residents and staff, NVC activities at YTP were able to improve partnerships between many of the resident youth and their staff caregivers.

Providing education was a key component to improving caregiver/youth partnerships. The educational trainings helped caregivers improve their interactions with youth. At YTP, staff spent their time in close

quarters with highly volatile teens who had mental illnesses and a history of trauma and could be physically threatening. Resident teens, conversely, were accustomed to not being heard by adults and expected power struggles rather than communication. The NVC trainings and coaching helped the adults to both better hear the teens and to better express the fact that they were hearing them. At the same time, the residents were often better able to accept that they were being heard by staff.

STAFF PERCEPTIONS

All staff reported seeing positive changes in the teens and in the teens' interactions with staff, which they attributed to the NVC training and coaching. The staff said that the teens feel more respected and are beginning to trust that staff is on their side. The teens seem to feel more connected to the staff and have greater awareness of when they are being disrespectful to the staff. A County therapist who works with the teens was also interviewed and reported that some residents are processing more deeply and have grasped the NVC concepts. Another therapist reported that residents are expressing themselves more, rushing less to anger and judgment, and seeking less negative attention for themselves.

The staff had clearly learned from the NVC facilitators and are better able to support the mental health of the teens. One of the mental health therapists reported that floor staff appeared more resilient and more confident about setting limits, engaged in fewer power struggles with teens, and documented their "repair manual" notes more often in ways that translate the needs behind the behaviors rather than blaming the teens.

According to one staff member, there is a greater "sense of doing it as a team, for the teens to be successful." Based on interviews with YTP staff, the NVC project has been successful in beginning to shift the perspective and communication skills of staff to one of increased respect and empathy for the teens in their care. This is a necessary first step to teens being able to act on the NVC strategies being taught and modeled for them.

Staff members articulated that they are now thinking much more about what the teen needs when he or she is acting out.

> I think it really helps staff to have that framework so that we can come from a place of deepened empathy which allows for greater co-regulation. Because if I see a kid who doesn't have a need met, versus a kid who's "acting out" or "misbehaving," I'm able to connect to their need and feel more regulated myself. I don't see them as doing anything wrong, I just see a need being expressed. So I stay more regulated and I do my job better.

The small group work initiated in the Fall of 2013 supported YTP staff in their own mental wellness, enabling them to support the residents and decreasing caregiver burnout. The NVC facilitators learned that this was an important component to offer, as emotionally fatigued staff are not able to partner with and support struggling teens.

TEEN PERCEPTIONS

Teens interviewed during the first round of interviews in January 2013 were most likely to see the changes brought by the NVC facilitators, as they had been there prior to the beginning of the project. Not every teen saw changes, but many did and they appreciated the increased feeling of partnership. TAY reported staff asking them what they need and how to make it work better more frequently.

Another teen, who commented on how much he had learned from the NVC facilitator, said, "How I respond isn't the best, but how he handles it is really helpful." The teen explained that the staff member uses NVC to help him calm down. The staff member takes a breath, waits, and then asks him, "What are you really needing?"

CULTURAL AND STRUCTURAL CHANGES

One overall effect of the project at YTP has been to shift the culture of the facility in a positive way. When teens break a rule, they are written up and have to talk it through at a later date with the appropriate staff member; often they receive some kind of consequence at this time.

Rather than waiting days to make a repair, the NVC facilitator introduced the concept of using NVC to make repairs "in the moment," meaning before the appropriate staff member's shift ends. He challenged staff and teens to increase the number of repairs made in the moment and therefore reduce the number of teens on Repair, a negative status that limited their privileges.

As a result of these efforts, the management team reported that all residents were on RO - a positive status that includes all privileges - for five days at the beginning of June. Team members said that it has been nearly a year since all teens were on RO for even one day, and no one could remember all teens being on RO for five days. This builds a climate where both staff and teens believe that they are doing something right.

Another effect the project has had on YTP is that managers have made substantial revisions to the repair log that staff fills out when teens are assigned a repair (see Appendix D4 for original and revised logs). The original log simply documented that the teen on repair had an assignment they needed to complete. The revised log asks what the teen was needing and what was learned. The new log reminds staff that the behaviors are rooted in needs, helping them to remain connected to the teens. While a change in logs was something that management wanted to do as part of their shift to a trauma-informed care orientation several years ago, they attributed the actual change to the NVC project, which prepared staff for the transition and made it more obvious that this was needed.

LESSONS LEARNED

Project Launch

Initially, United Way staff began by reaching out to several different agencies to find the appropriate teen audience for NVC classes. Transportation and coordination were huge logistical issues amongst the many agencies since teens did not routinely gather as a group. Once staff connected with the continuation high schools, they found that these were ideal venues for NVC classes. Many students fit the criteria of experiencing emotional difficulties and being at risk for serious mental health problems, and counselors were able to identify these students and offer them this class for high school credit. Support from school counselors was vital to identify students receptive to this type of learning, and

support from an administrator was important in order to set up a quiet indoor space, offer course credit, and schedule class times.

Project Design

Transition aged youth are a challenging group to offer NVC to as a stand-alone class (as opposed to part of a full-time treatment program). It is a critical period in their lives where NVC can provide benefits, but they are often withdrawn and reluctant to open up in a group of peers. Facilitators spent a lot of time and energy trying to adapt their curriculum to engage teens who were not motivated to be there. Once facilitators began working with more motivated teens, they could see that motivation was the critical factor for success.

The learning modality is very important for this audience. For high-need teens, direct modeling in real life situations appears to be more effective than more structured learning. At YTP, direct modeling was also very helpful for staff who wanted to know how to use NVC in specific situations.

The size and composition of the group is also important. At YTP, teens were resistant to discussing communication issues in their peer group; individual and very small group interactions were more effective. Peers could be a factor in the high school classes as well, and one class separated into two groups could mitigate these concerns.

It is clear from interviews with YTP staff that the success of the project was based on providing education simultaneously to both staff and teens. When both residents and staff see that they are all learning on a shared journey, the benefits seem to be magnified. It is essential to align learning so that staff and residents have a shared understanding.

Innovation staff faced many challenges in bringing NVC training to YTP from outside of their organizational structure. It may be easier to align NVC trainings with other initiatives such as trauma-informed care training, communicate with staff, find time for trainings, make mid-course corrections, and plan for sustainability if the project is managed from within the facility. Mid-course corrections were particularly difficult to enact due to the external nature of the project.

Staffing and Staff Training

A lack of NVC facilitators locally was a key limiting factor to this project. Once continuation high school students were identified as a key audience, additional classes could not be offered simultaneously at other schools due to a lack of trained facilitators. In retrospect, the project may have benefited from a lengthier planning period that included training additional facilitators who already were experienced in working with teens.

Barriers to extensive NVC training within YTP included a lack of additional YTP staff training hours beyond what was already in use. Staff asked for more time to practice and often struggled to immediately use NVC language with residents. An initial multi-day workshop for staff, along with time for ongoing training and substantial training for new hires would be ideal.

NVC and Trauma-Informed Care

The model which has been created at YTP, coaching and training both TAYs and the adults with whom they interact daily, has the potential to be a replicable innovation with great success for the most at-risk TAYs in the mental health system. It is not meant to be a stand-alone component, but rather a way to teach both residents and staff the language behind the "trauma-informed care" philosophy.

NVC is a valuable tool to complement trauma-informed care training and floor staffing. Ideally, a program would hire an additional floor staff person with extensive experience working with NVC and youth with histories of trauma who would be responsible for supporting communication between residents and between residents and staff.

NVC is meant to offer a way to deepen and repair trust and connection over time, helping teens to feel safe and heard. But other systems must be in place to ensure safety so that people feel safe enough to use and hear words. At times it appeared that staff wanted more of these basic safety systems and were disappointed that NVC could not provide this.

STRATEGIES FOR REPLICATION

An NVC Teen Series Toolkit was created by project staff for other NVC Facilitators to use when working with transition aged youth (see Appendix D5). It includes tips for facilitators new to working with teens, a sample curriculum guide, ground rules, a reproducible booklet with the essentials of NVC, and facilitator contact information.

For other communities interested in replicating this NVC project, learning highlights include:

- For teen classes, facilitators should consider adapting their adult NVC curriculum to include the use of Alternatives to Violence Project activities, increase modeling for participants of listening and empathy, reduce direct instruction about NVC theory, and separate the group into two groups when appropriate. A high level of curricular flexibility is needed to respond to students' specific needs. Co-facilitation is necessary, preferably with one facilitator who has prior experience with teens who live in traumatic situations.
- For both teen and adult classes, NVC is much more effective for those who truly want to be there. Those who do not want to be there undermine the quality of learning for the rest, so it is important to screen for willing participants. The ideal student has a clear reason to be in the class, the verbal ability to talk about their feelings, and an openness to change.
- Whenever possible, house NVC facilitators within the facility or organization where the training is taking place to leverage the institutional knowledge, logistical support, and increased likelihood of buy-in.
- Regions that lack a sufficient number of NVC facilitators interested in working with teens should be prepared to train or recruit facilitators. Facilitators with prior experience working with teens, particularly teens with trauma backgrounds, should be recruited.

SUSTAINABILITY

YTP is working to hire the NVC facilitator who has been working on the floor with the teens and helping teens and staff to conduct repairs. It is anticipated that he will be hired soon and will continue to work on NVC skills with residents several evenings each week. While a funding mechanism for sustained classes in schools has also not been identified, United Way continues to seek out funding for this purpose. Project learning has helped United Way staff to determine next steps, including working on

increasing the number of NVC facilitators in the community. United Way has since piloted an NVC curriculum in a middle school, in collaboration with students at California Polytechnic State University, San Luis Obispo.

WELLNESS ARTS 101

During the Innovation planning process, local college students and educator stakeholders described difficulties for consumers on college campuses. Depression and anxiety manifest, or are exacerbated, during the transition to college, especially for the first time or re-entry student. In addition, few on-campus supports (i.e. NAMI, support groups, Active Minds, etc.) existed on community college campuses, leaving those students with behavioral health struggles especially vulnerable. The Wellness Arts 101 program was designed to serve students identifying as having a behavioral health challenge at all stages of recovery in a for-credit academic setting.

Cuesta College was selected to partner with San Luis Obispo County Behavioral Health Department (SLOBHD) and offer Wellness Arts 101, the first ever for-credit college course targeted specifically for students with behavioral health barriers to education. Cuesta College's Wellness Arts Coordinator (a licensed Marriage and Family Therapist) and County Behavioral Health worked hand in hand to develop the curriculum which used a combination of lecture and lab components. During course development Cuesta solicited and received input and feedback from numerous partners and stakeholders, including peers, family members, service providers, college and high school counselors, and private therapists.

The Wellness Arts Coordinator and an Art Instructor team-taught Wellness Arts in order to properly keep students engaged and meet the variety of emotional and educational needs in the classroom. A stigma free enrollment process was developed. Individual meetings between the students and program coordinator were used to evaluate their current emotional functioning, as well as their reflections about the course and progress in school. These meetings served not only as a check-in, but also as a way to refer students to additional supportive services that they may need. In addition, Cuesta College learned that engaging higher functioning students to act as mentors to those who are not as far along in their recovery improves overall success for all participating students. This unexpected approach has become a key component of class success.

Cuesta College continued to leverage additional resources and increase capacity of testing and refining the model, and expanded the course to Cuesta College's North County Campus in Paso Robles. The class has also received the support of the media; in September 2014 the news outlet KSBY had a feature about the class.

The proposed primary purpose of this Innovation was to increase the quality of services, including better outcomes. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- Two Wellness Arts courses held during each project year.
- A minimum average of 20 students engaged per session.

Learning Outcomes:

- Will consumer students attending community college have improved academic outcomes by participating in a credit course designed specifically for them?
- Will participating students have improved wellness outcomes?
- Will an on-campus course designed for students identifying as having a behavioral health challenge reduce feelings of stigma and increase the sense of belonging?

SERVICE DELIVERY

The Wellness Arts class was originally targeted to transitional-aged youth (TAY), but considering the average age of a Cuesta College student is 28, it was not surprising to discover that students of varied ages were interested in taking Wellness Arts. The class was marketed for students experiencing a behavioral health challenge, but not listed in a course catalog as one strictly for students with a diagnosis. In order to ensure that the target population was enrolling in the class without labeling or stigmatizing them, Kelsey Kehoe, LMFT (the project coordinator) scheduled meetings with each student prior to enrollment. Later, the class was moved to the Work Experience Department, where most enrollments are done by referral and most general students do not see marketing for the targeted population. Referrals are now processed through Disabled Student Programs and Services (DSPS), college counselors, word of mouth, flyers posted around campus, campus-wide emails, and community mental health programs.

Based on student and teacher feedback, re-entry students who have not succeeded academically in the past appear to be the students who thrive most in this class. Younger students are also a good fit when they are ready for this type of a class; however, younger students seemed to be less prepared to identify as facing a behavioral health challenge and thought the class was too "touchy-feely". One instructor pointed out that no matter what age they are, students in this class tend to feel isolated and lonely, like they don't fit in. As part of a group focusing on wellness and self-expression, they flourished.

Few students dropped the class each semester. Instructors followed up with students to ask why they dropped and found that students most often left because they were psychology majors for whom the class was not a good fit; they had ongoing mental health issues that precluded regular class attendance; the class was too big for their anxiety level (particularly one semester when they started with 24 students); they already knew the strategies being offered or weren't yet open to them; or the class is too stressful and they are not yet ready for any level of college experience.

Eight classes were conducted over six semesters with a total of 145 participants (Table 5.1). More students than expected were re-entry students (ages 26 and over) who had previously had their education interrupted due to a myriad of life challenges including: substance use disorders, anxiety, panic attacks, trauma, divorce, job loss, ADHD, self-harm, bipolar disorder, depression, PTSD, and chronic health conditions.
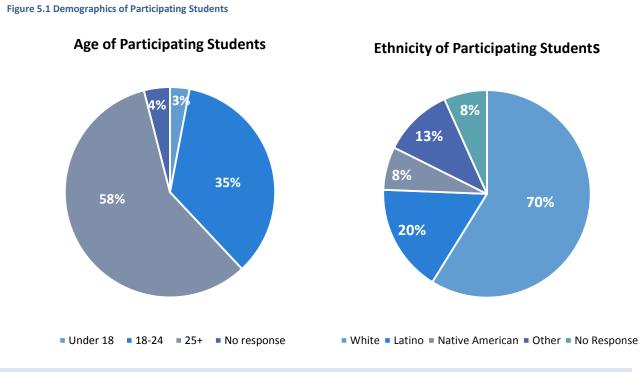
Table 5.1 Breakdown of Participants, Class By

Semester	# of Students	#of Re-Entry	% Re-Entry
Spring 2012	16	13	81%
Fall 2012	24	14	58%
Spring 2013	28	15	54%
Fall 2013 (SLO/North County)	33	15	45%
Spring 2014	18	12	67%
Fall 2014 (SLO/North County)	26	Not available	
TOTAL	145	69 (of 119)	58%

Seventy-one percent of students from both campuses had DSPS status during the class, with 50% of students designated DSPS prior to the class and 52% after the class. Fewer North County students had DSPS status during the class (43%), but a higher percentage of North County students became DSPS

students after the class: 14% were designated DSPS prior to the course; 50% were DSPS after the course, demonstrating how instrumental the class itself was to link students with other services and supports.

A sample of the first five semesters indicated that 34% of respondents were male, 61% were female, and 5% declined to state. Ages and race/ethnicity of respondents are displayed in Figure 5.1.

Figure 5.1 Demographics of Participating Students

Age of Participating Students

Ethnicity of Participating Students

- Under 18 - 18-24 - 25+ - No response

- White - Latino - Native American - Other - No Response

DATA COLLECTION

A retrospective student survey was created to assess students' mental wellness, academic readiness, and use of art as a tool for wellness (see Appendix E1). For this report, student survey data was analyzed for the first five semesters of classes and results were compared by gender, race/ethnicity, and age. Students were asked to choose a support person close to them and the retrospective survey was administered to the identified individuals. Data from four semesters of the support person responses were analyzed (Appendix E2).

In-depth interviews using a semi-structured interview format were conducted with nine former Wellness Arts students to gain insight into how the class may have affected their mental health and school performance. Seven women and two men were interviewed, with a range of ages, length of school attendance, and personal challenges (see Appendix E4 for the student interview summary). Interviews were also conducted with three course instructors (including the project coordinator) and the Director of Workforce Economic Development and Community Programs.

The evaluator and project staff worked with Cuesta College Institutional Research associates who analyzed student data in the Summer of 2014 to determine whether the class had an impact on student grades, students' ability to complete classes, and the number of units they were able to take each semester (unit load). Within-subject tests analyzed student GPA, unit load, and retention before and after the Wellness Arts class. A between-subject (matched-pair) analysis of Wellness Arts students and
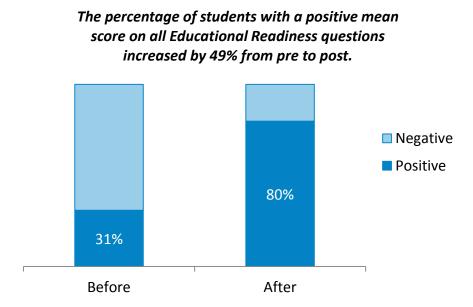
similar students who were not enrolled in Wellness Arts was also conducted. The between-subject analysis compared academic data for 48 Wellness Arts students (those who took other classes at Cuesta College in the semesters immediately prior to and following the Wellness Arts class) with comparison group students to determine whether the class had an effect on GPA or course load. The comparison group was created using propensity score matching that accounted for age, gender, race/ethnicity, disability, and DSPS status. Data was analyzed for the first three semesters of Wellness Arts.

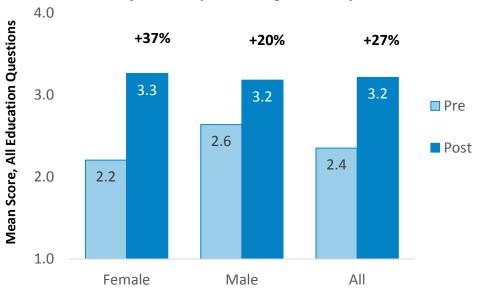## LEARNING OUTCOMES

Academic Impact

Academic outcomes were self-reported by participants and their designated support people via a retrospective survey. A subscale for Educational Readiness was created by combining questions related to this topic (Questions 1-7, 9-11). The intent of these subscales was to provide a snapshot of ratings from a lengthy survey. Items were rated on a Likert scale of 1-4, with 1 = Disagree and 4 = Agree. Responses were collapsed into two categories, Agree (3-4) and Disagree (1-2) (Figure 5.2).

Figure 5.8 Comparative Pre/Post Educational Readiness Scores

The percentage of students with a positive mean score on all Educational Readiness questions increased by 49% from pre to post.

Data was analyzed by demographic variables, including ethnicity, gender, and age range. No differences in mean scores were found for the Educational Readiness subscale between white and Latino students, or between students under age 25 and students 25 and older. However, some differences were found when data was examined by gender: females reported larger gains than males, starting with a lower mean score and ending with a higher mean score (Figure 5.3).
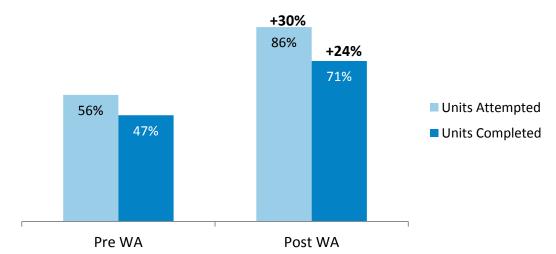
Figure 5.3 Educational Readiness, By Gender

While all students reported improvement in Educational Readiness, females reported the greatest improvement.
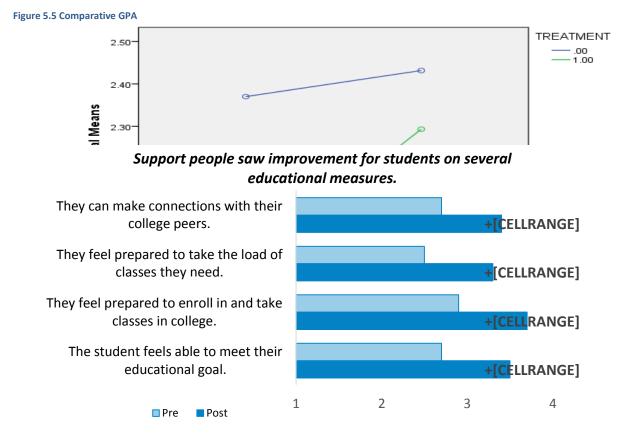

According to the Institutional Research Department's analysis, more students attempted and completed units following participating in Wellness Arts than prior to Wellness Arts. A total of 71% of Wellness Arts students completed at least one class in the following semester, an increase of 24% (Figure 5.4):

Figure 5.4 Comparative Analysis of Units Attempted and Units Completed

This post-class completion rate is much higher than the retention rate for the college as a whole (retention rates for students who began studies in Fall 2012 and returned to take classes in Fall 2013 were 64% for full-time students and 34% for part-time students).

A greater increase in GPA was seen for the Wellness Arts cohort than for the comparison group. In Figure 5.5 (below) the top line (.00) represents the comparison group and the lower line (1.00) represents the Wellness Arts sample.

Figure 5.5 Comparative GPA

Support people saw improvement for students on several educational measures.

However, this analysis was not statistically significant at the .05 significance level. This was true for both within-group and between-group analyses of GPA and for analyses of student load. Student load was examined based on the percentage of units completed before and after the class. No statistically significant relationships were found (*p*>.05).

Each student selected a parent, guardian, family member, case worker, or other support person to

Figure 5.6 Support Peoples Measurement of Improvement, By Educational Measures

complete a retrospective survey about the student at the end of the class. Mean scores for support person surveys indicated an improvement for students from before the class and after the class on all measures (Figure 5.6)

Eight of the nine students interviewed reported at least one improved school outcome that they attributed directly to having taken the Wellness Arts class. Four students thought that the class had helped their grades. Three students said that it helped them to stay in school, and talked about being able to take more difficult classes as a result of Wellness Arts. One student reported that it helped them to succeed in the classes that they were already taking. Many students also reported that the class created a support network for them, which has helped them to succeed in school (see Figure 5.7 for student quotes).

Students were asked whether the class helped them to feel more comfortable talking in front of the class or working with a group. Nearly every student said that they were more comfortable working in

groups as a result of the class and three students increased their confidence talking in front of the class. Students appreciated the opportunity to practice these skills in a safe, supportive environment, with people they could connect to.

Figure 5.7 Student Quotes

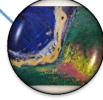*I got an A on a test! I don't remember the last time that happened!*

This class makes you feel safe. If you don't feel safe in [another] class, it gives you the tools to help you feel safe.

I'm a C, D, F student because of my anxiety. I love history but I have a hard time comprehending a lot of stuff. I went to the History class and I got a B in that class! That's from that self-esteem, that confidence from Wellness Arts. I feel like without the teachings and without (Wellness Arts), I probably would have gotten a D.

It helped me build confidence to where I could take another class. I actually took two other classes besides Wellness Arts the next semester.

If someone would have told me 'You're going to go to college and you're going to really like it.' I would have laughed and said, 'Forget it!' And I like it a lot now!
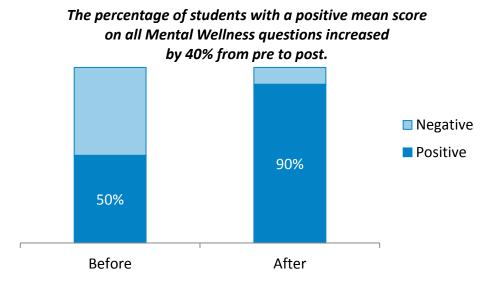
I enjoyed school for the first time in 15 years. Because of Wellness Arts.
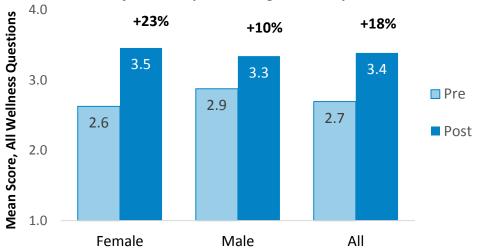
Wellness Impact

The Mental Wellness questions of the survey were averaged to examine overall increases or decreases in reported mental wellness. As with the Educational Readiness subscale, the Mental Wellness subscale was created by combining questions that related to this topic (Questions 12-14, 17-22). In Figure 5.8, responses were collapsed into two categories, Agree (3-4) and Disagree (1-2).

Figure 5.8 Comparative Scores, Pre/Post

The percentage of students with a positive mean score on all Mental Wellness questions increased by 40% from pre to post.

As with the Educational Readiness subscale, the Mental Wellness subscale was analyzed by demographic variables, including ethnicity, gender, and age range. No differences were found for means between white and Latino students or between students under age 25 and students 25 and older. However, some differences were found when data was examined by gender: females reported larger gains than males, starting with a lower mean score and ending with a higher mean score (Figure 5.9).
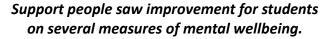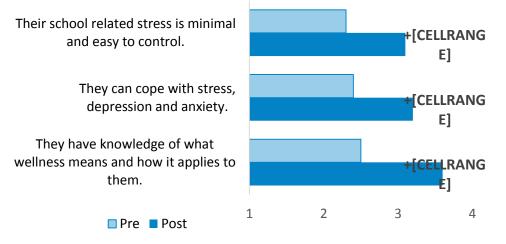
Figure 5.9 Comparative Scores, By Gender

While all students reported improvement in Mental Wellness, females reported the greatest improvement.

Mean scores from the support person surveys indicated an improvement for students from before the class to after the class (Figure 5.10).

Figure 5.10 Support Peoples Measurement of Improvement, By Mental Well-Being

Support people saw improvement for students on several measures of mental wellbeing.

Their school related stress is minimal and easy to control. +[CELLRANGE]

They can cope with stress, depression and anxiety. +[CELLRANGE]

They have knowledge of what wellness means and how it applies to them. +[CELLRANGE]
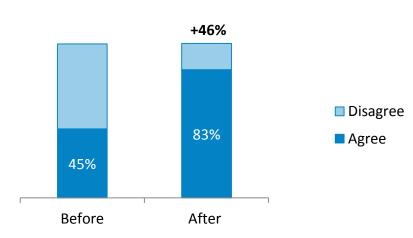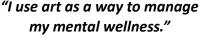
☐ Pre ■ Post

The surveys also examined whether art had become a mental wellness strategy for students. Most students (83%) reported that they used art as a way to managed their mental wellness at the end of the class. Similarly, 85% of support people reported that their student used art as a tool to manage their wellness by the end of the class (Figure 5.11).

Figure 5.11 Comparative Pre/Post of Student Responses

"I use art as a way to manage my mental wellness."

+46%

☐ Disagree
■ Agree

45% 83%

Before   After

In a focus group several students spoke about how they enjoyed the artwork and particularly appreciated the focus on process. They appreciated that no one judged the artistic merits of their products. They also enjoyed the calmness, confidence, fun, and sense of mindfulness that creating art gave them, both in the class and on their own.

All interviewees cited improved mental health as a result of the class, and all said it helped them to manage their emotions. Specifically, interviewees reported that the class helped them to: reduce fear and anger, lower anxiety, become more calm, and lower stress.

Every student explained tools and strategies they learned for relaxing during classes, tests and studying. Students described doodling, carrying art supplies, scribbling before tests, deep breathing, meditations, and many other techniques. They talked about how these strategies reduced their anxiety and helped them to succeed in the classes they took after Wellness Arts.

Stigma and Social Support

…Especially going to class and knowing you're not the only one. Part of the stigma is that everybody thinks that they are the only one.

There did not appear to be any change in levels of stigma overall (from 51% to 52% of students not feeling stigmatized), as per the survey question, "I feel stigmatized by my mental health issues." However, interviews indicated that the students interpreted stigma in different ways. Some talked about the external stigma of someone else's negative reaction to their behavioral health challenge or negative portrayal of mental illness in the media. Others discussed their own internal stigma (or self-stigma) as a negative voice telling them that they are not capable of succeeding in school. This was compounded for re-entry students who felt additional age related stigma.

It made me feel like I can do this, there's nothing wrong with me. I'm just as OK as everybody else. I belong in school.

Many interviewees tied the question of whether the class reduced stigma for them to their increased connections with others and how they no longer felt alone as a result of the class. They explained that the class reduced stigma by increasing their understanding that they are not the only ones dealing with these issues and by giving them the skills and confidence to address the challenges.

One unanticipated and important benefit of the class was the social support network it created for students who otherwise felt isolated on campus, particularly re-entry students. This theme was incorporated into the interview protocol after the interviewees spontaneously talked about it. Six of the nine interviewees reported gaining a support network from the class and said their network functioned both during the class and for years afterwards.

I had my own stigma about myself. I don't have that anymore.

The project coordinator launched the first Active Minds chapter on campus as a result of the class. The success of Wellness Arts also allowed Cuesta to receive additional grants for mental health resources. This increased capacity allowed for an online training and faculty training; the grants also funded a behavioral intervention team, suicide prevention and mental health awareness events. In addition to Wellness Arts, Cuesta has a robust menu of Behavioral Health programs and services for students.

There's not one day that I'm on campus where I don't see somebody that was in class. It makes campus friendlier.

LESSONS LEARNED

Approval Process & Departmental Oversight

The approval process to adopt the course as a for-credit college class was lengthy and required continual curricular revisions and flexibility around which department would be most appropriate. The project staff who were based in the Work Experience & Community Programs department wrote the initial Wellness Arts curriculum and looked to Academic Support for a departmental designation for the class. Note that the Art department was not an option because students in art classes are graded on the quality of the art they produce, which would have been detrimental to students in the Wellness Arts class.

The class ran as a trial for three semesters as an Academic Support Special Topics class. Curricular revisions were made each semester based on student and teacher feedback. Next, project staff took the class to the Curriculum Committee for approval as a stand-alone class (rather than Special Topics). Due to the curricular revisions that had been made in response to student needs, the Curriculum Committee decided that the class did not have enough academic content to be classified as an Academic Support Department class. Please see Appendix E4 for the syllabus and one activity; the full course reader is available upon request.

Disabled Student Programs and Services would have been a good fit, but no longer offered classes as a department. So the class became a part of the Work Experience Department and was approved for non-transferable credit. The project coordinator and instructors continue to measure student learning outcomes, student success, and satisfaction each semester, changing course outline and deliverables as appropriate in response to input.

The DSPS counselors who stepped forward to co-teach the class helped enormously with recruitment, instruction, and providing during-class and follow-up services to support students in maintaining their progress. The project staff still hope to move oversight of the class to DSPS if it becomes an option.

Staffing

Course instructors worked to keep the focus of the class on college success rather than on mental health issues. To do this successfully, instructors emphasized how critical it was that they were well-trained, familiar with mental health issues and disabilities, able to teach to different learning styles, and also culturally sensitive (two instructors were DSPS Specialists, one of whom was previously a rehabilitation therapist with art rehab training; another was a MFT specializing in art therapy). Faculty worked to manage the diversity of the class, with students of widely varying backgrounds (including students with severe social anxiety, schizophrenia, personality disorders, bipolar, PTSD, autism, etc.).

Faculty also thought that having two teachers was important to the success of the class. They were able to work as a team to model problem solving and collaborative work. To keep the class feeling safe, students' emotions need to be contained and managed. At times, this can mean that one instructor continues talking to a student in private while the other proceeds with the class. In addition to assisting one another with student interactions, instructors also balanced one another's knowledge and skills. One instructor, typically the mental health therapist, managed the art projects, setting up materials and leading the projects, while the other prepared accompanying lectures and brought experience as a classroom instructor, including classroom management skills.

Instructors saw that classes should be limited to 18 students so that each student can participate and instructors can manage shifting dynamics. However, they frequently admitted at least 20 students to account for those who would drop the class.

STRATEGIES FOR REPLICATION

For other colleges interested in replicating this Wellness Arts project, learning highlights include:

- Creating a safe space is crucial for the class. Build group support into the lessons and art projects. Students were very supportive of each other and appreciated the atmosphere of support. Mixed learning modalities also offer everyone a way to participate and feel safe.
- The success of the class is a combination of good instruction (containing the personal dynamics), structure, and content. Timing of art projects can be tricky, and instructors should have a back-up plan in case a project is completed quickly. Students can be trained to add in detail. For those who want to take too long, instructors taught that learning to stay within a timeline is a skill for school success.
- Combining an instructor with a therapy background with one with a DSPS and classroom background created a synergy that maintained a safe environment while encouraging learning and challenge.
- For art to be a lifelong mental wellness tool, students need to make it a habit. Therefore, the class does a lot of art, not just a few big projects. The length of the class is important for this also; a short workshop would not be enough for students to pick up the habit of creating art.
- To successfully recruit for this class, a partnership with DSPS is vital. Ideally, the class would be integrated into DSPS supports for students, supported by the DSPS department.

SUSTAINABILITY

The Wellness Arts class has been institutionalized into the Cuesta College course offerings, funding one teacher and ensuring the continuation of the class. To address the needs of the student population taking this class, a second instructor is also needed. Staff are exploring ways of providing this instructor, including a volunteer MFT intern/trainee or other community resource. As a result of the success and media attention the class has received, many community members and students have expressed interest in helping with this course.

SERVICE ENHANCEMENT PROGRAM

The Service Enhancement Program (originally titled Warm Reception and Family Guidance) was created to infuse customer service practices into the behavioral health system. Stakeholders wanted all clients and their family members to feel safe, secure, informed, and supported so that they could focus on treatment and recovery.

The County planned to adopt Stanford's Cancer Center "Cancer Concierge Services" model to serve Behavioral Health clients utilizing three key elements: beautification of the lobby, peer support and system navigation services, and adapting a patient organizer. Soon after project approval, the Hearst Cancer Center was opened at French Hospital in San Luis Obispo. Numerous attempts to meet with the Stanford's Center staff were unsuccessful. San Luis Obispo Behavioral Health Department (SLOBHD) staff were able to meet with the Hearst Cancer Center staff to discuss the barriers, challenges, and best practices of the program. Stakeholders agreed adapting the local model was more appropriate considering the clients, geographic location, resources and size of the facility were more comparable.

Stakeholders also selected the North County clinic as the testing site as it served all ages. SLOBHD staff provided the project oversight and acted as project coordinator and Transitions-Mental Health Association (T-MHA) provided peer support staff. Launched in the summer of 2012, the Warm Reception and Family Guidance Project was the first ever on-site resource navigation and peer support partnership in the County. After a clinic-wide contest, the project was re-named the Service Enhancement Program (SEP).

The proposed primary purpose of this Innovation was to increase access to services, with a secondary purpose to increase the quality of services, including better outcomes. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:
- One project coordinator and a partner peer navigator will be located in the County Mental Health office.
- A consumer care organizer will be developed and adapted from the Cancer Center Organizer model.
- Environmental enhancements to make the clinic more inviting and welcoming.

Learning Outcomes:
- Improved access for consumers entering and remaining in the public mental health system when guided to the most appropriate agency.
- Overall increases in consumer and family satisfaction with behavioral health services, and as a result, increased retention of consumers in consistent and continuous treatment program.
- Increased feelings of self-efficacy and evidence of self-sufficiency from consumers and families participating in the program.
- Reduced anxiety, confusion, and frustration around system navigation.

SERVICE DELIVERY

SEP served 401 unique clients and family members at the Atascadero clinic from October 2012 through October of 2014. A small number of clients were served prior to that time, but the project tracking system had not been fully developed and functional until October 2012. Additional behavioral health staff and anonymous callers were assisted with one-time requests but were not tracked as part of this
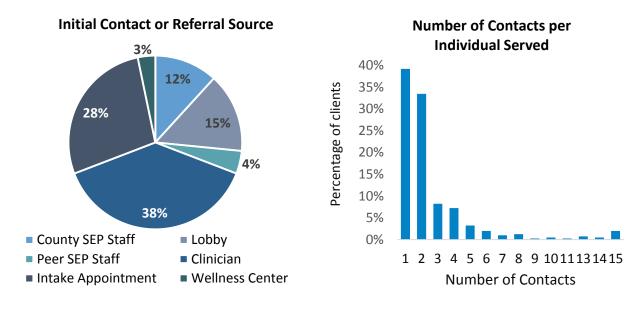
Innovation project. Clients were primarily consumers, 11% were family members and a small number were supportive friends accessing services for consumers (Figure 6.1).

Figure 6.1 Demographics

Category of Individual Served

■ Consumer   ■ Family member   ■ Friend

MHSA Special Populations Served

Individuals Served By Gender

■ Female   ■ Male

Individuals Served By Age

■ Child   ■ Transition-Age Youth
■ Adult   ■ Older Adult

Many clients entered the program through outreach to the community provided by County and peer staff. For others, an initial referral to the SEP came from clinicians or partner agencies (Figure 6.2). The number of contacts that clients had with SEP staff ranged greatly, with three-quarters of clients having one or two contacts (n=291) and one-quarter of clients having three to 15 contacts (n=110). Family and friends were more likely to have fewer contacts with SEP staff. All but three family members had between one and three contacts, with most (80%) having one or two contacts.

Figure6. 2 Referrals and Number of Contacts

Initial Contact or Referral Source

Legend:
- County SEP Staff
- Lobby
- Peer SEP Staff
- Clinician
- Intake Appointment
- Wellness Center

Number of Contacts per Individual Served

DATA COLLECTION

Several evaluation activities were conducted to measure the effects of the SEP program on clients and the clinic as a whole (Table 6.1):

Table 6.3 Data Collection Methods

Evaluation Activity	Time Period	Population	Sample Size
Satisfaction surveys	December 2013	All SEP clients	23
Outcome surveys	February 2014 – April 2014	SEP clients with 3+ contacts	13
Clinic staff phone interviews	December 2013-January 2014	All clinic staff who consented	13
Family member phone interviews	July 2014	SEP clients who were family members	5
Client organizer phone interviews	November 2014	SEP clients who received organizers	8
Missed appointment data	2012, 2013	All North County Clinic clients, SEP clients	105, 114
Observation rating scale	Oct 2014 – Nov 2014	North County Clinic and two comparison clinics	3 clinics

Satisfaction surveys were distributed to all SEP clients and were anonymously deposited in a box at the reception desk. Thirteen clients completed an anonymous outcome survey for frequent clients.

Clinic staff and family members were interviewed to learn more about client outcomes and program successes and challenges. Interviews were conducted for each staff member who completed a consent form at a staff meeting. Adult and child therapists, supervisors, front desk and records staff, and co-located staff were interviewed. Family members were interviewed to ask whether the program had an effect on their loved one's access to care and retention; and on their own self-efficacy and mental

wellness. Family members were called from a list provided by SEP staff of all whose permission they were able to obtain. Interviews were conducted using a semi-structured format with an interview guide (Appendix F1).

Clients who received organizers were interviewed to learn more about any effects the organizer may have had in their lives. Interviewees were selected using a systematic sampling method from a list of all those who received the organizers (n=42). Two names were then substituted to preserve gender ratios. Of the 14 clients, the project evaluator was able to contact eight for interviews.

Missed appointment data was extracted from the Anasazi system by the San Luis Obispo County Behavioral Health administrative staff. Some issues with this data were noted, likely due to the fact that it was a relatively new system with a staggered implementation and not all staff were using it in 2012 and 2013. Data was obtained for the North County Behavioral Health Clinic for the months of July through December in 2012 and for the months of July through December in 2013 as a comparison.

A "Clinic Reception Area: Welcoming Environment" Observation Rating Scale was developed to rate the reception area after the beautification process (Appendix F2). Due to the project evaluator joining the project after it started, a rating prior to beautification was not possible. Instead, two other county behavioral health clinics were also rated to provide comparison data. The instrument was developed based on research into similar types of instruments and reception area best practices, feedback from stakeholders, and pilot tests at private clinics and hospitals. The rating scale included two subscales, "Environment" and "Resources," to measure both the physical environment and access to community resources.

In addition to these outcome data measures, project staff collected demographic, output, and outcome measures through intake assessments and tracked referrals and resources provided.

LEARNING OUTCOMES

Clinic Beautification

The first adaptation created a more welcoming physical and cultural environment at the clinic. This strategy was considered effective by nearly everyone surveyed and interviewed. Clients and clinician stakeholders played an active part in all aspects of clinic improvements. Weekend painting and planting parties were held to improve both clinic appearance and strengthen relationships with clients, families, and providers. A mural designed by the project's peer navigator and painted by clients, families, and providers stands as visual reminder of increased collaboration and trust.

A "share corner" was developed for clients, staff, and families to both donate and have access to essential everyday items (clothing, coats, food, books, blankets, etc.). Simple, updated, clean furniture was added to the lobby and comforts such as puzzles, plants, and outside waiting areas were created. The peer navigator was located in the lobby and kept all resource materials updated while a slide show of other peers in recovery and local wellness events played on a digital picture frame.
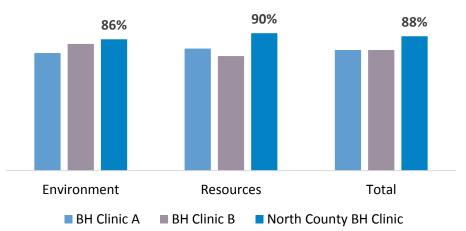
> *The focus is now on people feeling welcome instead of feeling like they're coming and asking for help and feeling bad about that... Before they were feeling ashamed... Now they feel like it's their life, their place. – Clinic Staff Member*

> *The beautification is immediate, ongoing, and consistent. No doubt about it that the place is warmer. The people who come in say, "I like what you've done with the place." – Clinic Staff Member*

Results of the "Clinic Reception Area: Welcoming Environment" Observation Rating Scale indicated that the beautification strategy resulted in a welcoming environment with a high level of access to local resources. The physical environment subscale ("Environment") included 11 items and the access to community resource materials subscale ("Resources") included 7 items. Total scores are the mean of the two subscales (Figure 6.3).

Figure 6.3 Comparative Environment Subscale and Resources Subscale

Clinic beautification resulted in high scores for both Environment and Resources.

The environment rated highly on overall appearance, stigma reduction, signage, appropriate seating, uncluttered decorations, reading materials, and safety for young children. Of special note were the hand painted murals created by clients and staff. Resources were extensive, well organized, easily visible, and covered a wide range of community services. Clients were observed looking at resources. Resources were available in multiple formats, on the wall and in a binder. Written resources in Spanish were available, however quantities were limited.
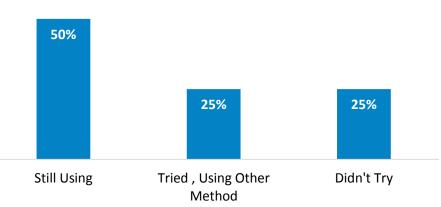
While the evaluator was unable to rate the reception area at the start of the project, "before" photos (Appendix F3) clearly show that the reception area's welcoming atmosphere has been greatly enhanced. Most clinic staff interviewees thought the clinic beautification project was effective and helped to reduce clients' anxiety about being at the clinic, again generally in proportion to the number of clients that they had referred. One recounted having a client who had previously been seen at other clinics say that she felt much safer at the North County Clinic, and that it was a more welcoming environment.

Client Organizer

A client organizer was developed and adapted from the Stanford and Hearst Cancer Center organizers. Clinician and client stakeholders took part in each aspect of development, from content to design. A group of 25 clients volunteered to use the organizer for a period of six months and provide feedback on the efficiency of its use. A tracking system was developed to maintain client privacy, and policy was developed on what to do in the event the organizer was lost. The result was a much simpler version as compared to the Hearst and Stanford models, and a large scale roll out of the organizer was implemented in March of 2014 (Appendix F4).

An additional 42 client organizers were distributed between March and August of 2014. Clients who received organizers and agreed to participate were interviewed by telephone to learn more about whether and how they were using it. Six of the eight clients had tried it and four were still using it (Figure 6.4):

Figure 6.4 Participant Utilization of Organizers

**75% of clients interviewed tried the organizer;
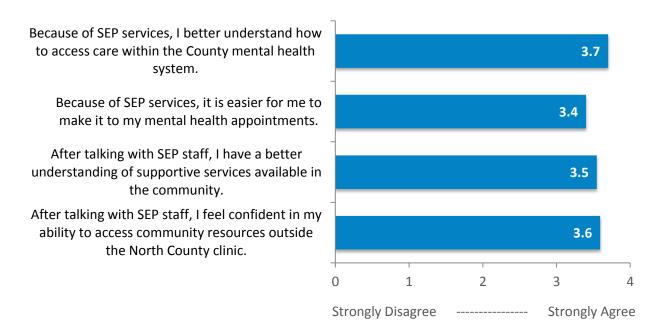50% of clients are still using it after 2-7 months.**

All six clients who tried the organizer liked it and four of them have been using it extensively. One client changed the dividers and put in her own, turning it into an organizer for all her health needs. A second uses it for all her medical and behavioral health appointments. Another uses it daily for business cards, notes, paper, and other storage, while another expanded it for use with Drug & Alcohol services also, adding clear plastic protector sheets.

The two clients who did not continue to use it both decided to use other organizational tools. One used her organizer twice and appreciated it but felt she was already very organized on her phone. Another was using the calendar in the organizer but he started using a day planner. Another didn't look at it because of various issues she was having, but she kept it easily accessible and looked through it during the interview.

Increased Access

Responses on the client outcome survey that indicated improved access also spoke to an increased sense of self-efficacy and long-term skills for accessing future care (Figure 6.5):

Figure 6.5 Response Rate for Increased Ability to Access Resources Independently

Statement	Rating
Because of SEP services, I better understand how to access care within the County mental health system.	3.7
Because of SEP services, it is easier for me to make it to my mental health appointments.	3.4
After talking with SEP staff, I have a better understanding of supportive services available in the community.	3.5
After talking with SEP staff, I feel confident in my ability to access community resources outside the North County clinic.	3.6

Strongly Disagree   ----------------   Strongly Agree

Family members indicated in interviews that they also felt more self-sufficient and able to navigate the behavioral health system. Clinicians responded that clients have taken steps toward self-sufficiency as a result of the program.
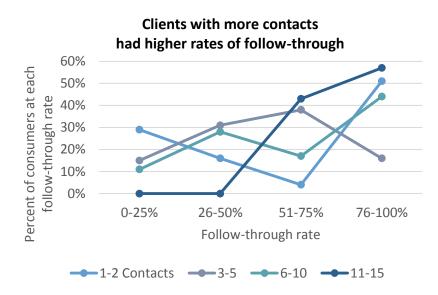
IMPROVED CLIENT RETENTION AND FOLLOW THROUGH

Missed appointment data from 2012 and 2013 was compared to see whether "no-shows" (clients who missed the appointment and did not call to cancel or reschedule) decreased as a result of SEP activities. No difference was seen between the two time periods. However, due to the staggered implementation of the new electronic health record system during those years, the Atascadero Clinic data is considered to be unreliable. Clinic and support staff perceived that the program did decrease the missed appointment rate.

The support my clients got helped them to become housed and to take care of some of their legal obligations, and they've continued to do well since… they've received that help. - Clinician
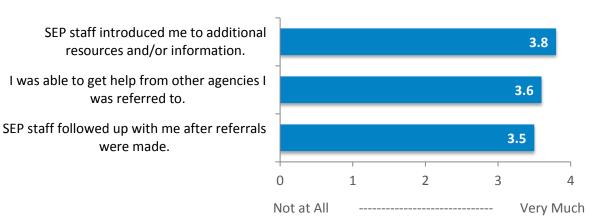
The Project Coordinator documented follow-through on referrals. Clients who exhibited follow-through remained engaged in the behavioral health system by maintaining attendance at the clinic for therapy, psychiatric, and case management services. For the 71% of consumers who had one or two contacts with SEP staff, follow-through rates were lower overall, though follow-through may have been more difficult to track. As the number of contacts rose, overall follow-through increased (Figure 6.6).

Figure 6.6 Client Rates of Follow-Through

Clients with more contacts had higher rates of follow-through

Y-axis: Percent of consumers at each follow-through rate (0% to 60%)
X-axis: Follow-through rate (0-25%, 26-50%, 51-75%, 76-100%)

Legend: 1-2 Contacts 3-5 6-10 11-15

Clients surveyed indicated that SEP staff helped them learn about community resources. As a result, they received help from other agencies. They also received follow-up support from SEP staff to help with retention in behavioral health services (Figure 6.7).

Figure 6.7 Client Access to Community Resources

SEP helped clients access community resources

SEP staff introduced me to additional resources and/or information.	3.8
I was able to get help from other agencies I was referred to.	3.6
SEP staff followed up with me after referrals were made.	3.5

Scale: 0 to 4

Not at All ---------------------------- Very Much

the number of clients they had referred to the program. Clinicians valued being able to directly hand clients to in-house staff with current knowledge of community resources. They noted that clients could use therapy time more effectively because they weren't needing assistance from the therapist in meeting basic needs. Also, when basic needs were met and a level of security achieved, clients were more able to focus on and benefit from therapy.

The large majority of SEP clients (72%) engaged in one or two contacts with staff to assist with forms, provide referrals, and problem solve. Another 18% of clients had

> *It should be part of the mental health work-up. Step 1, go see John. Because that's a viewpoint and candidness that is precious and hard to come by.* — Family Member
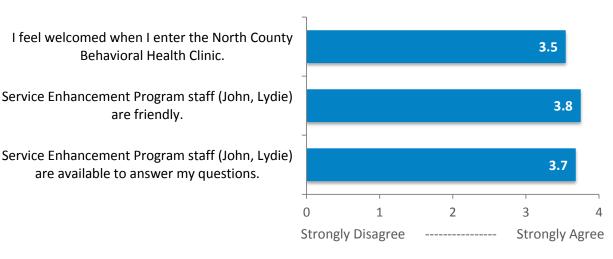
three to five contacts. For clients with one to five staff contacts, the most frequent resource referrals were for housing, community groups, employment, the Wellness Center, and County services.

Increased Client and Family Satisfaction

Clients did not refer to the program by name; they just knew the peer and County staff as "John and Lydie," who were in the lobby when they needed them. Satisfaction survey results indicated clients felt welcomed upon entry and believed that SEP staff were friendly and accessible (Figure 6.8). Outcome survey comments also spoke to satisfaction among those who used the SEP program. In interviews with family members, all of those contacted were very satisfied with the services. Clinicians also reported that the project has been helpful to clients for connecting them to resources and navigating the behavioral health system.

Figure 6.8 Clients Response Rate to Feeling Welcomed

Clients felt welcomed in the North County clinic.

I feel welcomed when I enter the North County Behavioral Health Clinic. **3.5**

Service Enhancement Program staff (John, Lydie) are friendly. **3.8**

Service Enhancement Program staff (John, Lydie) are available to answer my questions. **3.7**

0 1 2 3 4

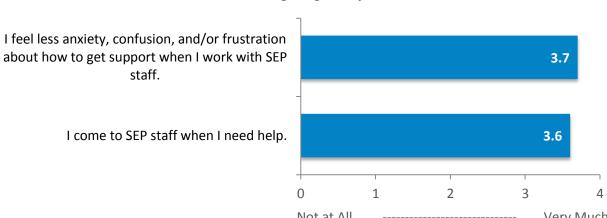Strongly Disagree   ----------------   Strongly Agree

Reduced Anxiety, Confusion, and Frustration

In addition to feeling welcomed, clients and family members interviewed also experienced reductions in anxiety, confusion, and frustration. They reported that this was due to both the access to information and the knowledge that someone was listening and available to help. The caring, connection, and hope provided by SEP staff was seen by family members as very important to their mental health. Survey data indicated that the program did make clients and families feel better and more able to access support (Figure 6.9).

Written comments reflected both the support consumers received from SEP and also the reduced anxiety they felt knowing that help was available if they needed it (Figure 6.9). One clinician also shared

Clients experienced reduced anxiety, confusion, and/or frustration when navigating the system.

I feel less anxiety, confusion, and/or frustration about how to get support when I work with SEP staff.	3.7
I come to SEP staff when I need help.	3.6

0   1   2   3   4

Not at All   ----------------------------   Very Much

that in connecting clients with SSI and other resources, "[SEP services have] a huge impact on reducing anxiety. … It took away a lot of stressors that clients had that interfered with their recovery."

LESSONS LEARNED

The large majority of SEP clients (72%) engaged in one or two contacts with staff to assist with forms, provide referrals, and problem solve. Another 18% of clients had three to five contacts. A small group of clients (7%, n=34) engaged in a high number of contacts (6-15 contacts), indicating a need for two types of services (or additional case management services, if services were already being provided). The most frequently referred resources were similar to those for clients with fewer contacts with the exception of employment. Consumers with a high number of contacts were less likely to be referred for employment, possibly because their particular issues were preventing employment. The need for community resource information and assistance was much larger than anticipated and demand was high for these services.

Based on this data, the SEP coordinator position could potentially be configured as two positions, one to provide resource navigation assistance and another to provide more intensive services by appointment. In addition to helping clients with community resource navigation, SEP staff were also able to increase clinic staff knowledge of community resources. This further increased the opportunities to support clients.

STRATEGIES FOR REPLICATION

For other communities interested in replicating this Innovation project, learning highlights include:

- Having concierge-style staff and resources accessible to consumers and family members is a powerful strategy for increasing access to resources, increasing satisfaction with clinic services, and supporting consumers in improved mental health outcomes.

- The concierge model requires adaptation to the specific needs, strengths, and resources of each clinic. Retaining the key elements while being flexible about the specific implementation strategies was vital to attaining the goals of the project.
- The personalities and skill sets of the staff members are critical to the success of this type of program. Careful selection is advised, and considerations may include the ability to work with minimal supervision, an outgoing nature to approach new clients, friendliness toward clients and clinic staff, and the organizational skills to present and update large amounts of community resource information.
- Initial buy-in from clinic staff would greatly ease the transition to a program like SEP. Consider creating the program in collaboration with clinic staff and in response to concerns that staff express.
- SEP staff should have a desk area of high visibility in the clinic lobby and a private desk area away from other clients in the event a more intensive discussion is necessary.
- Updated resource materials should be posted on boards within the lobby, in binders, on designated shelves, or in filing cabinets with regular announcements and connections made to clinic staff at routine staff meetings.

SUSTAINABILITY

Stakeholders and behavioral health management agreed that SEP should be sustained and expanded to other clinics. The program will be moved to the Community Services and Supports Program 5, Client and Family Wellness and part of the Managed Care services. The focus will be on replicating the beautification aspects of the project as well as providing peer based navigation and supportive services. The organizer is less of a priority for stakeholders and will be transitioned into helping consumers understand concepts of organization in a way that works for them (technology, reminder calls, calendars, support system, etc.)

SEP program implementation at each clinic will be based upon each clinic's general overall needs, uniqueness of clientele, space limitations, and regional resources.

OPERATION COASTAL CARE

Although mental health services are available through the military for returning veterans, stigma attached to those services prevented veterans and their families from accessing them. Rehabilitative physical activities targeted at veterans are popular (eg: AmpSurf) with the general acceptance that improved physical capacity improves mental health and wellness. This new model adapted the Johnny Miller Foundation's "Wounded Warriors;" which uses "Ocean Therapy" programs to support Marines at Camp Pendleton. Like that program, this model utilized a cadre of volunteers and staff to assist participants in physical activities, and mental health therapists to process their experiences.

This adaptation tested the activity-based model within community settings (opposed to military environments) with the goal of increasing access to veterans and their families. The Operation Coastal Care project embedded a mental health therapist to provide services to participants, both on-site during outdoor events and other non-military, non-clinic settings. The therapist conducted initial briefings and process with participants at the point of the intervention, and provided follow-up assessment and treatment in comfortable, confidential environments. The therapist also provided linkage and referral for participants and their families to the support available throughout the public mental health system.

Operation Coastal Care was originally designed to partner with existing AmpSurf and other local Veteran centered events. Soon after approval, the frequency of local AmpSurf, and other similar rehabilitative outdoor activities, declined. An absence of events in the community made testing the model impossible. San Luis Obispo County strategized with the Innovation Stakeholder Group, to address the lack of events available. The role of a project coordinator was taken on by a Prevention and Outreach Specialist who partnered with the therapist to test the model. Despite these process changes, both the learning goals and target populations remained the same.

The proposed primary purpose of this Innovation was to increase access to the underserved veteran population. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- Provide screening to approximately 50 individuals annually
- Provide treatment for approximately 20 individuals annually
- Participate in 10 events annually

Learning Outcomes:

- Will veterans participating in the program feel less stigmatized? and (as a result)
- Demonstrate an increased rate of accessing mental health services?
- Will participants demonstrate improved mental wellness outcomes?

SERVICE DELIVERY

Once project staff were hired, Operation Coastal Care was more aptly renamed Veterans Outreach. The Prevention Specialist provided outreach and education, and partnered with over 350 local organizations in order to host free events for veterans and their families. This strategy proved successful and served the dual purpose of not only creating a vehicle for testing the model, but it also increased community collaboration surrounding veterans' issues. Agencies that hosted and supported events felt empowered

to give thanks to veterans in the community and continue to support veterans outside of the Innovation project. The Outreach team also educated the community and increased awareness surrounding mental health issues specific to veterans.

An initial challenge was developing strategies to outreach to the target population without the expected draw of an established activity such as AmpSurf. The Coordinator connected with a variety of veterans groups, partnered with California Polytechnic State University and Cuesta College, created a Facebook page, advertised in local newspapers, posted flyers, spoke at Camp San Luis Obispo and Camp Roberts, and set up a booth at Thursday night Farmers' Market to promote the veterans events. Word quickly spread (see Appendix G1 for a sample flyer). A total of 13 events were held between the evaluation period of August 2012 and June 2014. Participants included 244 veterans (including several active duty members) and 183 family members/guests (see Figure 7.1 for participant demographics).

The events were very popular and proved an effective therapeutic environment for veterans, as many of them lacked peer engagement in an environment of acceptance, belonging, and fun. Project staff deliberately provided a mix of activities, with some that were less physical and some that were more adventurous. This was appreciated by participants, who sought out activities at their level (see Figure 7.2 for events). Demand was highest for activities that are generally more costly to access, such as zip lining, horseback riding, and kayaking. There was also positive feedback about simpler events such as
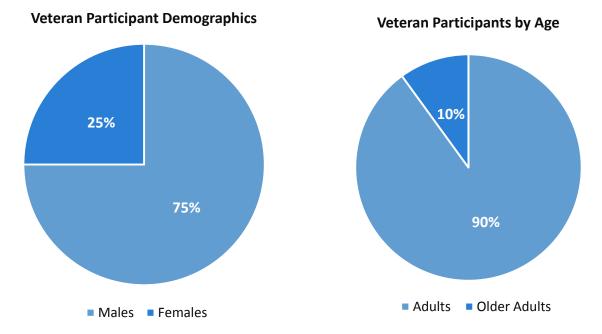
Figure 7. 1 Participant Demographics

hiking and scavenger hunts, with participants enjoying working as a team and having a structure that facilitated them getting to know one another.

In addition to increasing collaboration surrounding events, the prevention specialist assisted the Veterans Outreach therapist during rehabilitative activities in connecting veterans and their families to extended community services and resources. San Luis Obispo County Behavioral Health (SLOBHD) partnered with the Veteran's Services Office (VSO) to provide space for the Veterans Outreach Therapist. This led to many contacts with veterans directly through outreach and services provided at the VSO (e.g. veteran benefits, legal assistance, military records, etc.) which also became an additional referral source for the Veterans Outreach events.

An analysis of activity logs shows that 149 unique veterans participated in events, with 99 (66%)

Figure 7.2 Veteran's Outreach Events

attending one event and 50 (34%) attending more than one event. The mean number of events attended was 1.63, with a standard deviation of ±1.14. The original project therapist left the program in

Climbing Wall 08/2012 & 3/2013

Bishop Peak Hike 09/2012

Zipline 10/2012

Kayaking 1/2013 & 1/2014

Crossfit 03/2013

AmpSurf 3/2013 & 4/2014

Horseback Riding 08/2013 & 3/2014

Mud Mash 10/2013

Montana de Oro Hike 03/2014

summer of 2012, so the therapist data focuses on the second therapist who began in October of 2013 and is still active in the program today.

The therapist counseled 95 clients outside of events through August 2014. Of these, 88 were assessed and referred to appropriate services and resources (including the therapist) depending on many factors such as specific diagnoses and needs, insurance status, eligibility for medical or veteran's benefits (Figure 7.3).

Figure 7.3 Various Ways Clients were Served
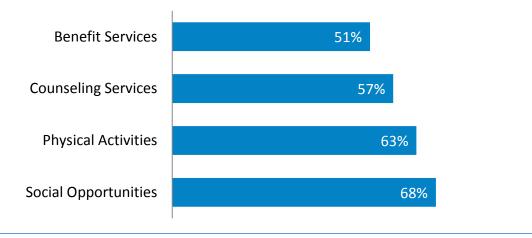

DATA COLLECTION

Rosters and sign in sheets were maintained by the Prevention Specialist. Surveys were administered to every participant at the end of each activity. An initial satisfaction survey was developed by staff and administered at five of the first eight events, from August 2012 through September 2013. This survey was then modified in October 2013 to also collect outcome data; it was used for the subsequent five events. A total of 161 participants completed surveys: 74 using the first survey and 87 using the second survey.

In the spring of 2014, phone interviews with 12 participants were conducted to learn more from participants regarding outcomes (see Figure 7.4). Those who were contacted tended to be at least middle-aged (eight of the twelve) and involved in veterans or military groups, either through work or as volunteers (five of the twelve). One of these participants was still on active duty. All had been connected with mental health resources. Interviews were coded for themes and types of benefits were categorized. In a report for staff, quotes from the interviews were used to provide deeper insight into the qualitative categories (Appendix G2).

Therapy clients and outcomes were tracked utilizing electronic health records, and clinician chart reviews.
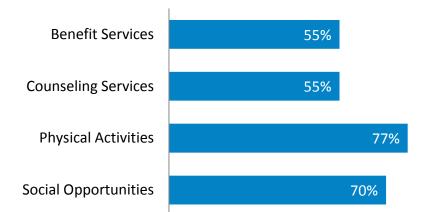
LEARNING OUTCOMES

Figure 7.4 Increased Rate of Informed Participants

Percentage of respondents who said they were now more informed about this resource:

Resource	Percentage
Benefit Services	51%
Counseling Services	57%
Physical Activities	63%
Social Opportunities	68%

Increased Access

In post-event surveys, participants reported that they had become more informed about behavioral health resources and also reported a high level of likelihood that they would access those resources as a result of the increased knowledge acquired at the events (Figure 7.5). Project staff provided resource connections both at the events and during follow up activities.

Figure 7.5 Likelihood to Access Resources

Percentage of respondents who said they were now more likely to access this resource:

Resource	Percentage
Benefit Services	55%
Counseling Services	55%
Physical Activities	77%
Social Opportunities	70%

All of the participants interviewed thought that it was a good idea to have a mental health therapist at the events. Those who had been to more events were more aware of the therapist. They reported a wide range of contact with her, from extensive support to passing conversation. Every interviewee sounded comfortable with the level of contact they had made. Having the mental health therapist at events, and her involvement in the planning of events, helped them to be therapeutic in nature for participants.

> *Personally for me it has [helped]. I've talked to [the therapist] before, during the events. She kind of knows your issues, what you're going through, how hard it is. There's a sense of peace that you can go to her; that she's there at the event.*
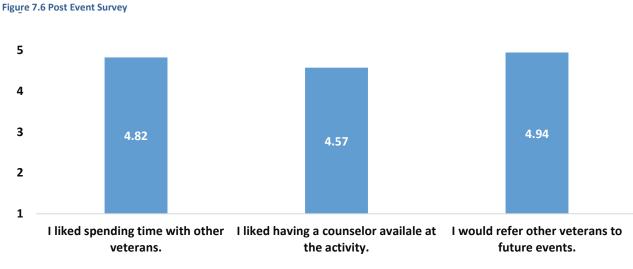
> *It's really hard for people to go to therapy. Like for me, I know I need it but I connect with nature instead. But sometimes you need that individual to talk to. It's perfect to have someone who puts herself out there instead of you having to go find her*

One example of a successful linkage was a male veteran who followed up with the therapist after they talked at an event. He had co-occurring mental health and substance use disorders and had been homeless in the past. The therapist worked with a treatment center and was able to get the Veterans Affairs (VA) to pay for him to attend a residential program. He got VA medical benefits for the first time in his life, despite having served in the military approximately 30 years ago.
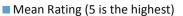
Another male veteran followed up after an event by asking the therapist about volunteer opportunities. She assessed him and found that he struggled with PTSD and depression, along with marital issues. In the nine months he has been seeing her for therapy, she reports that he has become more confident and independent, has higher self-esteem, and was able to get a job.

Reducing Stigma

When asked on the post-event survey whether they liked having a counselor at the event, participants were overwhelmingly positive about this Innovation. They also responded very positively to spending time with other veterans in this setting and felt strongly that they would refer other veterans to future events, again indicating that they were comfortable with the addition of a mental health professional to the event. These responses appear to indicate that the event reduced mental health stigma and made veterans comfortable with the idea of addressing mental health issues (Figure 7.6).

Post-Event Survey

Figure 7.6 Post Event Survey

I liked spending time with other veterans.	I liked having a counselor availale at the activity.	I would refer other veterans to future events.
4.82	4.57	4.94

■ Mean Rating (5 is the highest)

In participant interviews, veterans were asked whether the events helped to reduce stigma around using mental health services. They had widely varying answers to the idea of mental health stigma including internal stigma and the benefit to them of being with others who deal with the same issues they do. Several thought that stigma was more of an issue for active duty members. Everyone agreed that in a broad sense, the events help with stigma reduction.

Is there still stigma?

- *In some areas yes, absolutely. Especially the active duty population.*

- *There's a stigma about mental health – nobody wants to think they need help. When you get out there, you start to realize you have a problem. All this outreach does help, a lot.*

Do the Veteran's Outreach events reduce stigma?

- *Absolutely yes. Everyone's out there having a good time, smiling, laughing, sharing their experiences.*

- *Yes, the events are a good thing because they're very positive about mental health.*

Project staff reported that their own comfort level at explaining that the event was sponsored by SLOBHD had increased substantially. They did not see any negative reactions from participants when

this was explained at each event. Based on survey comments, participants appreciated that the project was actively trying to support their mental wellness
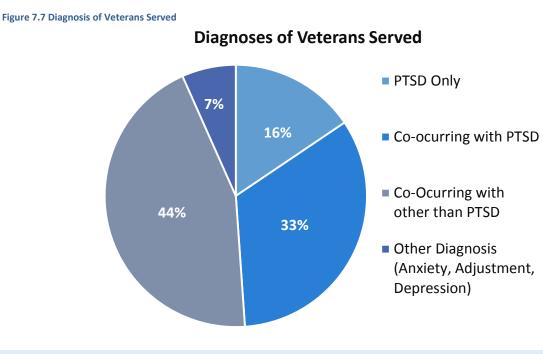
IMPROVED MENTAL WELLNESS

During key informant interviews project staff wondered, based on their observations, whether the events themselves are a form of therapy which provide their own mental health benefits. Every interviewee believed that engaging in the physical and social activity made a positive impact on their emotional well-being. Categories of the benefits of the program included: getting out of the house, reducing social anxiety, connection to resources, strengthening family connections, providing a sense of purpose, and integration of military branches.

According to participant surveys, interviews, and project staff interactions, participants stressed the importance of family involvement in the events. When asked how much they liked being able to bring guests to events, the mean response on all surveys was 4.9 out of 5 (very positive). Some veterans reported that the participation with their families improved the overall wellness of the entire family. Others made friends and became supports for each other, creating a much-needed sense of family.

The therapist provided direct service (beyond assessment) to 45 veterans who would have been underserved or inappropriately served. Fourteen veterans would have been unserved altogether as they only received services from the therapist. Services included transitional therapy, group therapy, couples therapy, and individual therapy.

This project filled several gaps in community resources for veterans. There is not a full VA hospital in San Luis Obispo, only a small clinic. Combat veterans suffering from PTSD take priority for services and receive mostly medical management but not counseling services. The therapist served many non-combat veterans, or provided secondary individual and group therapy to combat and non-combat veterans and their families. In addition 77% of the clients assessed by the Innovation therapist were diagnosed with a co-occurring disorder, and the therapist provided much needed counseling support in connection with Drug and Alcohol Services (Figure 7.7). The Innovation therapist also provided early intervention transitional therapy for vceteran's while they transitioned into services with the VA, private therapist, or a hospital. Fourteen veterans had ongoing therapy with the Innovation Therapist because they did not qualify or were not appropriate for any other mental health resources.

Figure 7.7 Diagnosis of Veterans Served

Diagnoses of Veterans Served

- PTSD Only
- Co-ocurring with PTSD
- Co-Occurring with other than PTSD
- Other Diagnosis (Anxiety, Adjustment, Depression)

LESSONS LEARNED

Having prevention staff plan and implement the events in partnership with a mental health therapist was seen by both participants and staff as a successful staffing arrangement. Participants appreciated the presence of licensed clinical staff while also enjoying the bond that formed with prevention staff. Project staff suggested that in the future, recruiting volunteers to handle set up and registration would allow staff greater engagement with participants.

The personality of the therapist is important to consider. The County originally assigned a therapist to the project who was also a retired, high-ranking military officer. When launching the project this experience was valuable, although the therapist may not have been comfortable with the many shifting structural changes that occurred in the project's development. A new therapist, a military family member, was assigned to the project and adapted quickly to the model. The project therapist should be a either a family member or a fellow veteran who is very aware of military culture. As the data collected from the therapist is limited to the timeframe in which the second therapist was working on the project (2013-2014), it can be assumed that the total number of veterans engaged in relation to veterans who attend the events would be much higher if replicated.

STRATEGIES FOR REPLICATION

For other communities interested in replicating the Veteran's Outreach project, learning highlights include:

- Pairing a clinical staff with prevention professionals brings the prevention framework to the behavioral health context, creating a new paradigm for outreach and activities for behavioral health populations.
- This project demonstrates that a community-based activity can be therapeutic; people don't have to enter an office setting to receive mental health benefits.

SUSTAINABILITY

Stakeholders approved sustaining the therapist through Community Services and Supports, and the prevention specialist through Prevention and Early Intervention funding. Based upon frequent participant feedback, project staff are currently looking at a model that will engage veterans to act as a planning committee for events, and create a fee based model for the events themselves, removing some of the barriers for local businesses to sponsor the events. Engaging volunteer peer veterans will increase the capacity of the project and allow the Prevention Specialist to focus on more education, community collaboration, and expansion of the project.

MULTI-MODAL PLAY THERAPY OUTREACH TRIAL

During the Innovation community planning process, stakeholders identified barriers prohibiting many families from accessing services for young children (ages 0-5). San Luis Obispo County is a large geographic area with several rural communities, presenting a challenge to access services due to the lack of transportation options. Families from the northern and southern parts of the county face a two hour public commute to access services at the centrally located children's assessment center, Martha's Place. Another (and equally prohibitive) challenge for parents is the resistance which occurs when services appear to be invasive, overwhelming, or complicated. Assessments and treatment for children may involve a variety of observations, interactive sessions, physical exams, and questions from therapists. Some parents are reluctant to bring their child to Martha's Place due to anxiety around navigating future appointments and ongoing treatment regiments, or simply the fear of having a child diagnosed with a mental illness and the stigma surrounding such diagnosis.

The Multi-Modal Play Therapy Outreach Trial piloted a parent-led, multi-modal, attachment-focused play therapy delivered in home and community settings. The intention of the trial was reducing parental resistance and improving play therapy treatments to better engage parents and caregivers, while increasing access and maintenance of services. The Community Action Partnership of San Luis Obispo County (CAP-SLO) was selected to test the Multi-Modal Play Therapy Outreach trial with focus on families in rural and remote areas of the county. Services were offered in homes, pre-schools, family resource centers, and elementary schools, as well as on evenings and weekends.

This multi-modal strategy used three evidence-based practices: Theraplay, Filial Play Therapy, and Non-Directive Play Therapy. Parent and caregiver feedback was at the center of this approach. The program's trained therapist did not identify the first modality or its progression until parents or caregivers had the opportunity to experience all three therapy models and provide input into their child's treatment plan. Participating parents and caregivers had the opportunity to learn about and be referred to resources and supports throughout the community.

The proposed primary purpose of this Innovation was to increase access to services, with a secondary purpose to increase the quality of services, including better outcomes. Estimated outputs and learning outcomes determined at program initiation were:

Estimated Outputs:

- Serve a minimum of 24 new clients per year.

Learning Outcomes:

- Will parents have reduced resistance to behavioral health services for their children, indicated by decreased missed appointments ("no-shows") and increased maintenance of services?
- Will parents experience improved satisfaction by indicating acceptance of therapy strategies and potential for self-sufficiency?
- Will children receiving services demonstrate symptoms of attachment disorders and increased wellness in comparison to clients receiving singular-modality play therapy?

DEMOGRAPHIC SUMMARY

The project therapist assessed children from 48 families over the two year pilot period. Children were then placed in the program based on a qualifying diagnosis or referral from other services. In some cases, parents did not respond following the intake. A total of 32 children completed at least five treatment appointments. Services were focused on rural, isolated areas in north and south San Luis Obispo County (Figure 8.1) and children were referred from a variety of sources (Table 8.1).
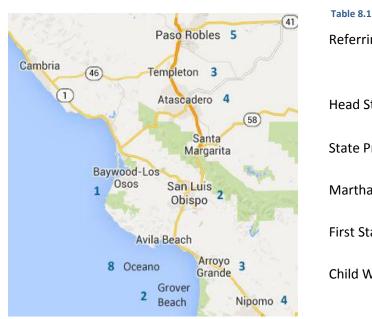
Figure 8.1 Map of Clients Locations

Table 8.1 Source of Child Referrals

Referring Agency	Number of Referrals
Head Start	9 (8 families)
State Preschool	4 (4 families)
Martha's Place	7 (7 families)
First Start	5 (5 families)
Child Welfare Services	7 (4 families)

Of these 32 children, the primary location for treatment was the home for 12 clients (31%) and schools (Head Start, State Preschool, other preschool, or elementary school) for 17 clients (53%). The remaining three clients (9%) were seen at a Community Counseling Center office. Secondary treatment locations included Services Affirming Family Empowerment (SAFE) offices and rehab treatment. According to the caregiver report, the mean age of children at entry was 52.8 months (4 years, 4.8 months).

Of the 26 children for whom pre-surveys were collected, the mean age of the child when parents first began having concerns was reported as 27.3 months, with a mean span of 23.7 months between first concern and entry into the program. According to caregivers, nine children had previously received behavioral health services while fifteen had not (two had no response).
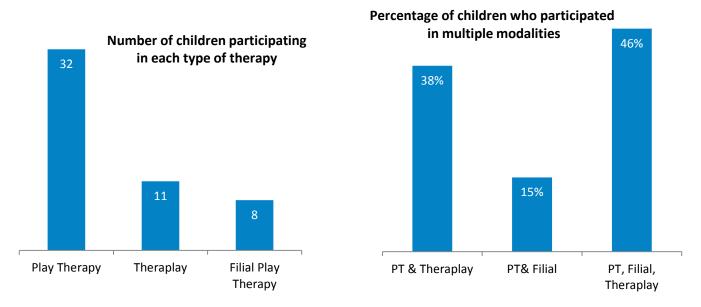
Most caregiver participants were parents, often in a single parent situation. Several children had grandparents as their primary caregiver, either in a temporary or permanent caregiver role. Of the 32 children treated by the therapist, all but three (91%) had current or previous Child Welfare Services (CWS) engagement. Nearly one-third (10 of 32) had open cases. Over one-third of clients had been assessed by Martha's Place. Four families were homeless.

Number of Clients Participating in Each Modality

The type of treatment and length of treatment varied depending on the needs and capacities of the family members:

- All 32 children participated in Non-Directive Play Therapy; 40% percent of the children also participated in an additional modality with their caregiver (Theraplay and/or Filial Play Therapy).
- Eleven children and their parent/guardian participated in Theraplay and eight parents engaged in Filial Play Therapy.
- Two of the parents who participated in Filial Play Therapy did not participate in Theraplay; the remaining six Filial Play Therapy participants also participated in Theraplay (Figure 8.2).

Figure 8.2 Enrollment Numbers for Each Type of Therapy and Participation in Multiple Modalities

Number of children participating in each type of therapy

Play Therapy	Theraplay	Filial Play Therapy
32	11	8

Percentage of children who participated in multiple modalities

PT & Theraplay	PT& Filial	PT, Filial, Theraplay
38%	15%	46%

The total number of therapy sessions varied considerably from family to family (Table 8.2):

Table 8.2 Number of Sessions by Type of Therapy

Number of Sessions by Type of Therapy	Mean	Median	Mode	Range
Non-Directive Play Therapy	14.9	15	20	4 – 28
Theraplay	7.2	7	8	3 – 10
Filial Play Therapy	5.8	4.4	4	2 – 10
Total Sessions – All Modalities	18.8	20	20	5 – 33

DATA COLLECTION

Surveys were administered to caregivers at the beginning and end of therapy, with post-surveys mailed to caregivers. When post-surveys were not returned, a three-question "brief" post-survey was mailed. If

those were not returned, the brief post-survey was conducted as a phone interview by the therapist when possible. Demographic and access data was collected on both pre and post surveys. Satisfaction surveys were also given to and mailed to caregivers at the conclusion of services (Appendix H1).

A total of 26 pre-surveys were collected. Sixteen full post-surveys and eleven brief post-surveys were obtained from twenty-one caregivers. Six caregivers returned both full and brief post-surveys, while five caregivers only returned brief surveys. One child had two sets of data collected three months apart while two children, siblings, had no data. Staff attempted to administer a Parent Stress Index as well, but only three parents completed a post-Index.

Project staff attempted to obtain Ages and Stages Questionnaire: Social-Emotional (ASQ-SE) screening data from Head Start programs for those children enrolled in Head Start during therapy. Unfortunately the Head Start programs did not conduct follow up ASQs so there was no pre/post data. However, teacher notes in children's files were reviewed. Caregivers and teachers were interviewed as available, with a lack of caregiver permission limiting access.

LEARNING OUTCOMES

Missed Appointment Rates

A comparison of the missed appointment, or "no-show," rates for the Play Therapy project and County Behavioral Health clients (ages 0 through 5) was conducted for the same time frame as the pilot project.

The Play Therapy project had a much lower rate of "no-shows" (Table 8.3), likely because the therapist saw many children in community or school settings, and because he called to confirm prior to driving to each appointment. Advance cancellation rates were slightly higher, again likely due to the therapist calling to confirm appointments and cancelling them at that time as indicated.

Table 8.3 Comparative Rate of "No-Shows"

County Behavioral Health no-show rates were 350% higher than those of the project:

County MH No-Show	INN Project No-Show	County MH Advance Cancellation	INN Project Advance Cancellation
9%	2%	14%	17%

Decreased Symptoms

The Innovation play therapist developed rating scales for "Aggression in Therapy" and "Attachment to Therapist" and then reviewed each child's case notes to rate levels of aggression and attachment at entry and exit. Aggression was rated on a scale of 1 to 5, with 1 being least aggressive. A category of 0 for avoidant was established, but no child met this criteria. Attachment was rated on a scale of 0 to 5, with 0 being avoidant of the therapist (Appendix H2). Notes from the child's first 3-5 visits were used to create a composite entry rating, as some children started out very cautious but quickly became more aggressive as they felt safer with the therapist.

Of the 32 children enrolled in the project, 19 were assessed using these scales. The remaining children either had very few play therapy sessions (4 to 7), or exited prior to post assessment.

Aggression in Therapy

When the play therapist began working with one boy, he attempted to break all of the toys into pieces by stomping on them. During the course of Non-Directive Play Therapy, the boy began playing in less aggressive and less destructive ways. When he began playing more calmly and in a less chaotic fashion, the play therapist invited the mother (a teenager), who had been observing the play therapy each week, to participate in the play therapy process with her son. As she learned, the play therapist took a back seat allowing her to play with her child on her own. The play therapist introduced Theraplay activities into the treatment to increase the level of secure bonding between child and mother. Upon completion of sessions, the mother shared: "Before the therapist started meeting with us, all I knew how to do was 'be mean' to my child." The young mother explained that prior to the Innovation, she was more interested in getting her son to behave than she was in connecting with him.

Positive changes were seen for aggressive children, with decreases in aggression over the course of therapy*. **The children who were most aggressive initially had the largest decrease from entry to exit.** The children who did not exhibit change from entry to exit were never highly aggressive. All highly aggressive children (rated 4 or 5) moved at least two points down on the rating scale, ending at a 3 or lower (Figure 8.3).
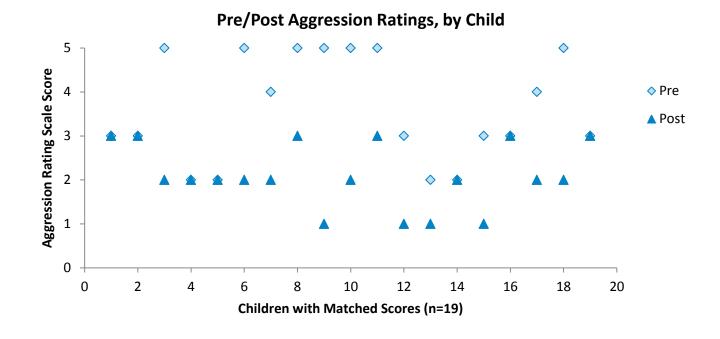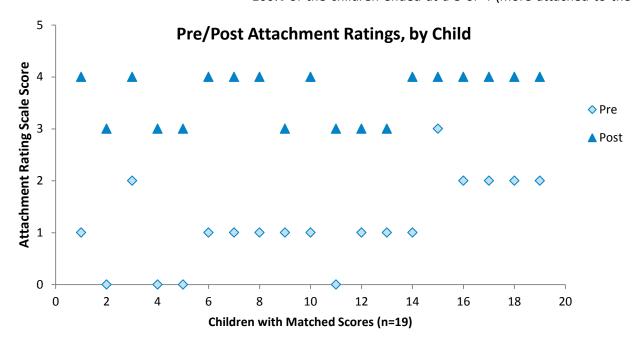
Figure 8.3 Pre/Post Aggression Ratings by Child

ATTACHMENT TO THERAPIST

Positive changes were seen for all children in their attachment to the therapist (Figure 8.4). **The children who were the least attached initially made the largest gains**. According to the therapist, children on the Autism spectrum were less likely to show a change in attachment.

Figure 8.4 Pre/Post Attachment Ratings by Child

While 95% of children (18 of 19) entered therapy at a 0-2, 100% of the children ended at a 3 or 4 (more attached to the

Pre/Post Attachment Ratings, by Child

therapist).

CAREGIVER PERCEPTIONS

Sixteen caregivers completed both the pre and post survey in its longer form. Caregivers were asked identical questions on both the pre and post-survey. Questions were presented as Likert items using a ten-point scale. All caregivers reported a reduction in negative behaviors and an improvement in positive behaviors (Figure 8.5).

It is possible that the ten-point scale may have presented too many options, blurring the difference

Reductions of Self Destructive Behavior and Frequency of Anger

50% **+25%**

Figure 8.5 Reductions of Self Destructive Behavior and Frequency of Anger

between points. To explore this possibility, the scale was collapsed into two categories, "positive" and "negative," each comprising one half of the 1-10 point scale. Using this method of analysis, a greater shift could be seen for some items.
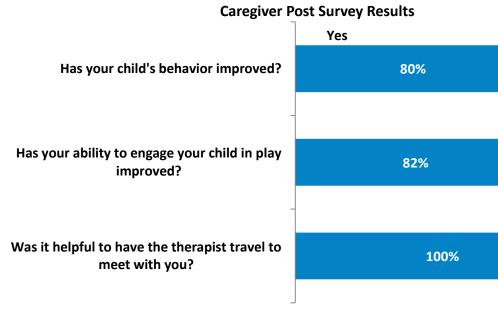
When asked about whether their child showed affection for them and how well they engage in play activities with their child, caregivers rated both very highly at entry and exit. They also included very positive comments about the bond they had with their child at entry. Given that families were selected for this program based on an attachment disorder diagnosis and that almost every family had Child Welfare involvement, the high number of positive comments about their bond at entry may be due to rater bias on the part of the caregiver completing the survey. Caregivers may have considered their play ability and child's level of affection to be high until they learned more from the therapist, or they may have been concerned about how they presented initially.

Comments regarding their bond with their child on the post-survey included:

- He's loving again. I have my son back.
- I've been reading the parenting info you sent, it was very helpful to meet with you and my child to do play activities.
- Much closer than we were but his behavior got worse since started I working out of the home.
- Our bond has improved. He is more open to talk about everything and listens to what I have to say.
- I love it. More words and less melt downs now.

Eleven caregivers completed the brief post-survey. Of these, 80% reported seeing improvements in their child's behavior, and a similar percentage reported improvements in their own ability to play with their child (Figure 8.6.).

Figure 8.6 Caregiver Post Survey Results

Caregiver Post Survey Results

Yes

Has your child's behavior improved? **80%**

Has your ability to engage your child in play improved? **82%**

Was it helpful to have the therapist travel to meet with you? **100%**

Comments on the brief post-survey about child behavior improvements included:

- She is less bossy and less resistive to following directions.
- Thanks (*Play Therapist Name*). He really felt comfortable with you.
- Not so much an improvement in behavior, but things came out through play therapy to help communicate.
- Very much! Able to stay and focus in the Kindergarten classroom!
- Fewer/less severe tantrums

It is important to note that many children had highly disruptive home environments that did not change over the course of therapy. These environments included ongoing domestic violence, mothers being placed in jail and rehab, homelessness, parents with mental illness, and children being left with multiple caregivers.

Comments about whether caregivers were better able to engage their child in play included:

- Yes we have been playing a lot of board games.
- The activities we did together were very helpful!
- Wanted child's dad to attend but he didn't want to. It would have been good if he did.
- I can tell she has been developing a healthy imagination.

Parents were contacted for interviews to learn more about whether and how the program helped their child and family. One father related that the therapy was not about his child's behaviors but about bringing him and his child closer. He said that this goal had been accomplished and that he still uses the techniques he learned for bonding. The father appreciated the therapist's scheduling flexibility and that the sessions took place at his child's school. He felt that the therapist exceeded expectations by also providing information about other services and helping him to organize an inter-agency team to handle his child's behaviors. He also appreciated the short intake process and that counseling started quickly. The father wished that the relationship with the therapist could have been continued.

PRESCHOOL STAFF PERCEPTIONS

Two Head Start teachers were interviewed by telephone. Each was asked about the effects of the therapy on a child who had been in their class. Teachers were selected based on parent permission and project staff knowledge of who to contact. One of the teachers was unsure of the effect of the intervention, while the other teacher believed that the intervention directly improved the child's behavior.

The first teacher reported that the child was ambivalent about participating in therapy because it was being offered during outside play time and he wanted to join the outside play. This timing was necessary to create private space for therapy at the school. The teacher reported that the child's behavior did improve and the child was able to express himself more positively and follow directions more often. His relationship to teachers improved to some degree, though the teacher was not sure whether it was due to therapy or length of time at the preschool. The teacher noted that the child's family dynamic was so chaotic that it was difficult to help the child without working with the family as a whole. He added that the project was worthwhile and that he has seen other children benefit from therapy too.

The second teacher, reporting on a different child, said that the project "worked amazingly." She thought that having therapy at the preschool helped the child to feel comfortable. This child was in the Head Start classroom for a total of three years. At first he displayed many negative behaviors in the

classroom and was in the Innovation program for several months. The teacher saw a "night and day difference," noting improvement in interactions with peers, family, and teachers. She thought that the therapy helped the child to calm himself down and deal with his anger. "It gave him coping skills. ... We could really see drastic changes." The therapist also gave teachers suggestions for how to work with the child, which they found very helpful. Overall, the teacher said: "We need more of that style of intervention, where children are comfortable and where it works."

The Head Start Preschool at Cuesta College referred a child who had been abandoned by his mother. He was having frequent tantrums, throwing tables and chairs, causing the teachers to evacuate the other children from the classroom. The Innovation play therapist provided extensive behavioral planning to both the grandparents and the preschool staff and he met regularly with the boy for months to follow providing Non-Directive Play Therapy. Along with the efforts of the preschool staff and the grandparents, the therapist was able to successfully provide that child with a therapeutic venue for him to express what he was carrying inside of himself and his behaviors significantly diminished. Recently his mother had come out of rehab and returned to his life. His behavior escalated upon her return, and the Innovation play therapist has been working with him and his mother. After providing Theraplay activities (to rebuild secure bonds with his mother) this young boy has begun to relax and accept his mother back into his life.

MULTI-MODAL ANALYSIS

Children's scores on the aggression and the attachment rating scales were analyzed by the number of modalities in which they participated. The project hypothesis was that participation in more than one therapy modality would improve outcomes for children. All children received Non-Directive Play Therapy alone with the therapist. The two additional modalities, Theraplay and Filial Play Therapy, both involved parents in direct play with the child. Filial Play Therapy also provided parents with instruction for home activities.

Exploratory analysis of the data revealed little difference between the pre and post levels of aggression and attachment for children who only engaged in Non-Directive Play Therapy versus those who also engaged in Theraplay and/or Filial Play Therapy with a caregiver. Table 8.4 lists the average change from entry to exit for those children who engaged in one modality and those who engaged in two to three modalities.

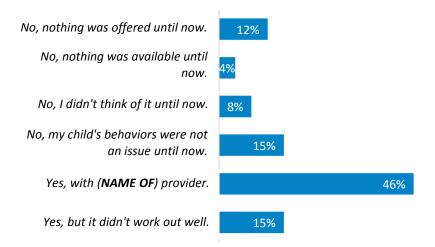**Table 8.7 Comparative Average Change from Entry to Exit**

Aggression	Mean Change	Attachment	Mean Change
Play Therapy Only	1.56	Play Therapy Only	2.33
Theraplay &/Or Filial PT Also	1.50	Theraplay &/Or Filial PT Also	2.60

As discussed in the Decreased Symptoms section above, a clear division can be seen between children who started therapy as highly aggressive versus those with more moderate aggressiveness, with ratings for the highly aggressive children more likely to decline. The same holds true for children with very low attachment levels. This appears to be the dominant theme of the data, rather than the modality of therapy. It may be that the therapist's ability to select the most appropriate modalities for each family

was the reason for the decreased symptoms seen in these very severe cases. Due to the small overall size of the population (n=19) and possible selection bias due to caregivers self-selecting into participatory therapy, statistical analysis of this data is not appropriate.

Parent Satisfaction: Reduced barriers to access

Parents/caregivers were asked whether, prior to participation in the Innovation, they had attempted to access therapy for the child in the last six months. Responses to a multiple-choice set of responses were as follows:

Figure 8.8 Attempted Access to Therapy Responses

Have you attempted to access therapy for your child in the last six months?

Response	Percentage
No, nothing was offered until now.	12%
No, nothing was available until now.	4%
No, I didn't think of it until now.	8%
No, my child's behaviors were not an issue until now.	15%
Yes, with (**NAME OF**) provider.	46%
Yes, but it didn't work out well.	15%

Transportation

When asked whether transportation had been a prior barrier to accessing therapy previously, 14 caregivers responded that it had. Of the closed-choice transportation barrier options, five selected the option that services were too far away; five marked the choice that gas was too expensive; and five marked that they did not have a reliable vehicle (one selected two choices). When asked on the post-survey whether the project removed a transportation barrier, 10 caregivers identified specific transportation barriers that had been eliminated. Comments on the brief post-survey about transportation included:

- That was very helpful.
- Transporting him to/from Martha's Place was too much with all our other appointments for our other children and our own health concerns (from Oceano to SLO).
- Very helpful.
- Very much. I'm a working mother. Scheduling is very difficult.

Ease of Access

Caregivers answered on the post-survey that the project removed an insurance barrier for them. One selected that it solved the issue of being too expensive to pay out of pocket; three said it solved the issue of finding a therapist who took their insurance, and one said that it solved the issue of their co-pay or deductible being too high. Respondents also indicated that the project had removed paperwork barriers, with two caregivers saying it addressed the issue of intake forms being too long or confusing and one caregiver responded that it addressed the issue of forms not being in Spanish.

STIGMA REDUCTION

Three caregivers indicated that they had encountered a barrier around previous therapist access. One of these could not find a therapist who worked with "very young" children and two could not find a therapist who worked with "young" children. Four caregivers did not want to go to a public clinic. Two caregivers selected that they did not want their child labeled, and two selected "the stigma of going to a mental health clinic." Following therapy, one caregiver selected that the project "had resolved the issue of no bilingual therapist being available." Two respondents said that the project resolved the issue of not wanting their child to be labeled, and one said that it "resolved the issue of stigma around going to a mental health clinic."

Maintaining Play Therapy Practices

When asked how motivated caregivers were to continue play therapy activities at home after therapy ended, 88% of caregivers chose a positive response (>5 out of 10) to the question. This question was asked on the full post-survey, with 16 of 28 parents responding.

> I got everything I needed out of all of my sessions. It was amazing.
>
> Parent

Nearly two-thirds (63%) of respondents rated their motivation as very high (at an eight, nine, or 10 out of 10). Eighty-two percent of caregivers who responded to the brief post-survey indicated that their ability to play with their child has improved. It is hoped that these caregivers will maintain play therapy practices.

88%

Parent Satisfaction: Decreased Resistance

Satisfaction surveys were completed by 15 of the 28 caregivers. The surveys consisted of 14 statements with a rating scale of Strongly Agree to Strongly Disagree and a Not Applicable selection. An open-ended question asked for suggestions for improvement. The surveys were a standard client evaluation survey for work with a therapist; they were not designed specifically for this project.

Parents responded very positively to the therapy services. All statements had a mean score of at least 3.4 (Table 8.5).

Table 8.5 Parent Satisfaction Survey Responses

Statement (1-4 Scale, 4=Strongly Agree)	Mean	Agree/ Strongly
I was treated with courtesy and respect.	3.9	100%
The services I received helped me.	3.6	93%
My therapist referred me to other services I needed.	3.4	93%
My therapist took time to answer my questions.	3.7	100%
If I had a complaint, it was handled well.	3.7	100%
Overall, I was satisfied with my therapist.	3.6	93%
I felt comfortable with and trusted my therapist.	3.7	93%
My therapist and I worked together to set goals for my family.	3.5	93%
My therapist was sensitive to my culture and/or religion.	3.6	100%
My therapist and I periodically discussed the progress my family was making.	3.6	93%
My therapist helped me identify my strengths and my challenges.	3.4	93%

LESSONS LEARNED

Project Launch

Of all of the Innovation project providers, CAP-SLO was able to launch the program with the fewest barriers. Due to existing relationships between the provider and the community (family resource centers, schools, child care centers, and Head Start) families immediately trusted the CAP-SLO therapist. This unexpected outcome made enrolling children in the trial easier.

The primary barrier to implementation was hiring a bilingual therapist. Through a very robust and collaborative recruitment process in partnership with San Luis Obispo County Behavioral Health, CAP-SLO was unable to identify a bilingual therapist who was trained in all three modalities, was licensed (rather than an intern), and wanted to work in this setting. Eventually an individual was contracted to work with the monolingual families.

Project Design

Project staff saw that having a therapist with the capacity to use each of the three modalities as needed, customized to each family's situation, worked well for this very high-need population. The therapist's ability to involve parents through Theraplay and Filial Play Therapy seemed to decrease parental

resistance, at least for the short term. They noted that this project would likely benefit young children with any mental health issue rather than only those with attachment disorder.

Screening for appropriate families involved weighing the likelihood that the caregiver would participate in the therapy with the child's need for the therapy. Some grandparents were caregivers but were not interested in doing attachment work because they didn't want to consider themselves the parent. Families experienced turnover in caregivers as parents came in and out of the picture due to jail, rehab, current drug use, etc. At the same time, these were all reasons for the children's attachment issues that needed to be addressed.

The project staff chose to keep the child in services as long as possible under the condition that benefits were being achieved, even if this meant that the parent stopped participating. Other caregivers were reluctant to participate in the therapy process from the outset. In retrospect, staff thought that it might be advantageous to require a set number of parent appointments, taking into account that later work may just be with the child. Alternatively, it could be considered a strength of the project that it worked for families regardless of whether the caregiver was ready to participate in therapy.

As noted in the Caregiver Perceptions section, many children were experiencing ongoing trauma over the course of therapy. According to the therapist, "Many of these children need more therapy and may require ongoing therapy throughout their childhood. The reality of 4-6 months of treatment, which was the initial plan, didn't fit all the children and the realities in their families." It became clear that many children with attachment disorder have parents who are similarly attachment challenged (for example, one mother had never kissed her child). With over 90% of children having current or previous CWS contact, this project targeted some of the highest-need children in the county. It made progress with both the children and their parents, but clearly additional mental health supports are needed for many of these families, including mental health therapy and parenting education for the parents.

STRATEGIES FOR REPLICATION

For other communities interested in replicating this Multi Modal Play Therapy Outreach project, learning highlights include:

- Having a male therapist seemed to be very helpful for children who lacked positive male involvement in their lives. Consider expanding the model to having both a male and female bilingual therapist, a case manager, and full integration into the agency's CWS programs, including in-home parent education.
- At a minimum, a separate staff person to conduct pre and post testing and make appointment reminders would be helpful
- In more rural areas, bilingual therapists with multi-modal training may not be available. Projects could extend the planning timeline to allow time for staff training or recruitment from other regions.
- Try different methods for obtaining post-therapy data, including incentives, inter-agency cooperation, and additional staff focused on data collection.

SUSTAINABILITY

The First 5 of San Luis Obispo's Health Access Training Project has expressed interest in advocating for the continuation of this program. Martha's Place and the First 5 Health Access Training Project are currently engaging in discussions to develop a sustainability plan.