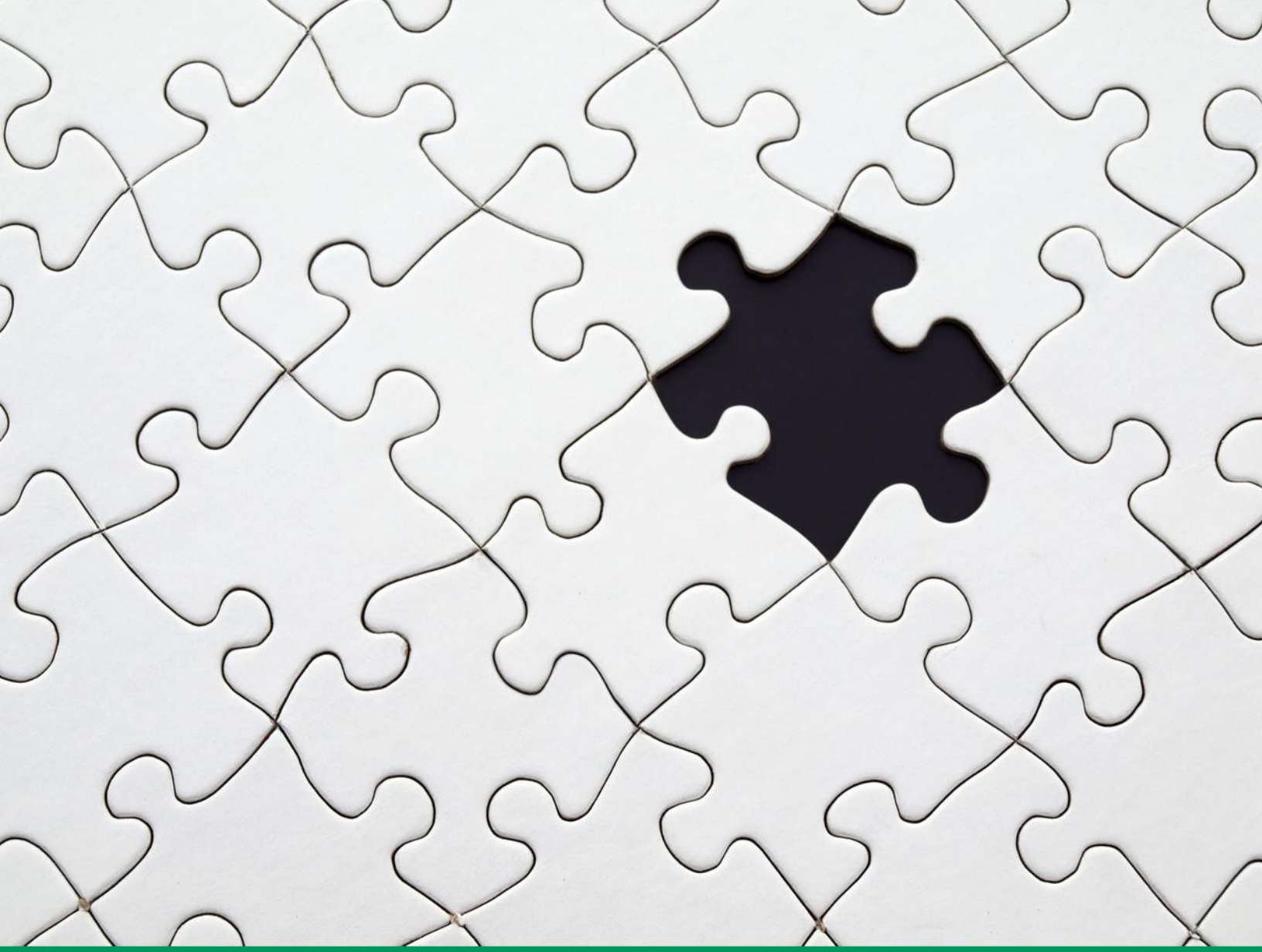

Alameda County Behavioral Health's In-Home Outreach Teams Program Evaluation

Fiscal Year 18/19

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

MENTAL HEALTH SERVICES ACT · PROPOSITION 63 · CALIFORNIA
WELLNESS • RECOVERY • RESILIENCE

Alameda County Behavioral Health | Mental Health Services Act Division | December 2019

Acknowledgements

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- Abode
- Bonita House
- La Familia
- Stars

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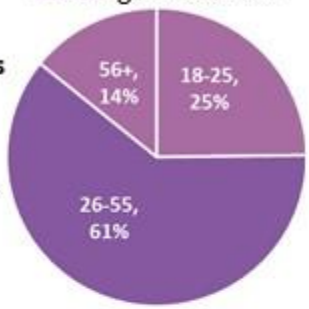
Alameda County Behavioral Health's In-Home Outreach Teams Program

Evaluation Summary Fiscal Year 18/19
December 2020

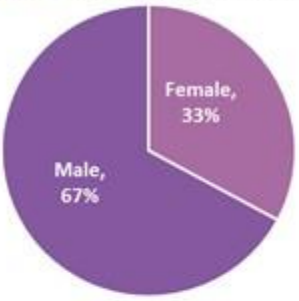
How Much Did We Do?

The IHOTs served **395 duplicate partners** during the fiscal year. When comparing the race/ethnicity of IHOT partners to ACBH Outpatient Beneficiaries the IHOTs served a higher percentage of **Asians**, **Hispanics/Latinos**, and **Whites**.

61% aged 26 to 55



67% identified as Male

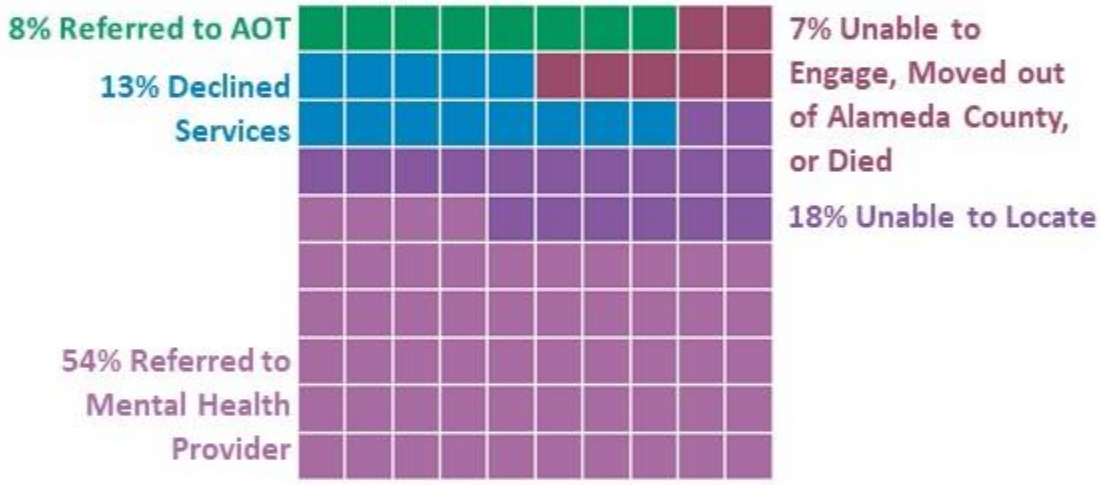


91% spoke English

How Well Did We Do It?

There were **384 partners discharged** during the fiscal year, the chart to the right shows the discharge outcomes of 169 partners (44%). The other 56% of discharged partners had unclear outcomes and have been excluded from the chart to the right.

62% of IHOT partners were successfully engaged

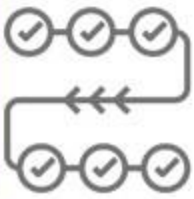


The main goal of the IHOTs is to connect clients to mental health services, either a new one or re-connect with a previous provider, and community-based services. Successful engagement means that partners trust and have a rapport with the IHOT. Through 13 one-on-one interviews with family members and current or former partners revealed how IHOTs built trust and rapport with partners.

How IHOTs Build Trust with Partner

Listening to the partner

Navigating a complex system to connect partners to wanted/needed services



Being persistent and consistent

How IHOTs Build Rapport with Partner

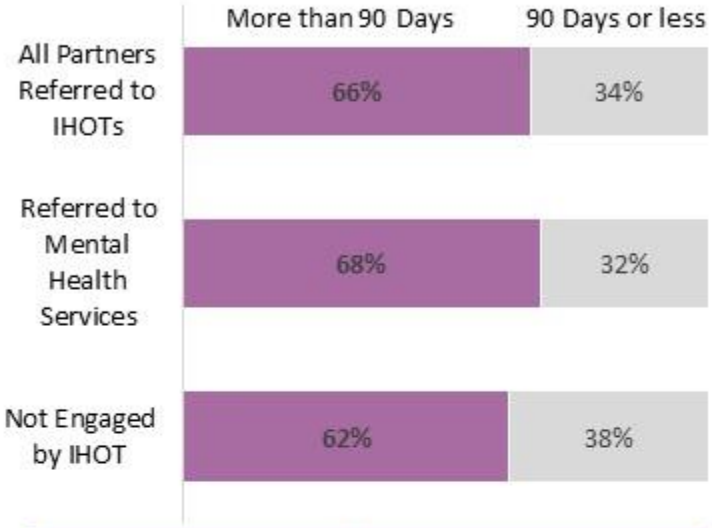
Facilitating goal setting

Becoming like family or a support system

Demonstrating care for the partner

How Well Did We Do It?

Of the 169 partners that have clear discharge outcomes, **more than half were open for longer than 90 days**. There is not a significant difference between the length of time partners are open and whether they are subsequently referred to mental health services.



Areas of Concern

Partners and family members spoke about how the IHOT, mental health, and community-based services could be improved. The areas of concern the interviewees spoke about that can harm the relationship with the IHOT and decrease the perceived quality of the services received are:

1. **Time it takes to link to services**
2. **Not enough time each week with the client**
3. **Staff turnover throughout the ACBH system**

Is Anyone Better off?

The connection to community-based services, mental health services, and the IHOT improved the partners' and family members' lives in the following ways:

Being more recovery oriented

"I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year." – Partner

Asking for help

"One thing that changed was that [the partner] was at least willing to talk about getting help. The IHOT was at least talking about getting psychiatry so then [the partner] was agreeing to it. So at least that opened the door for us to get [the partner] to it." – Family Member

Accomplishing goals

"I enrolled in classes in Merritt College." – Partner

Improving hygiene

"I think that was first and foremost, [the partner] started taking care of [their] health better, taking more showers, getting [themselves] cleaned up." – Family Member

Life saving

"They saved our life. They saved [my child's] life, they saved my life." – Family Member

"I truly believe that the IHOT team saved my [child's] life." – Family Member

Recommendations for Program Improvements during FY 20-21

1. Continue to improve data entry quality, collaborate to build a data dashboard, and explore the logic model outcomes for appropriateness with the IHOT teams.
2. Expand the language diversity of IHOT partners using a brochure created for the IHOTs.
3. Increase the amount they connect with families, including having a conversation to set expectations about what the IHOT will reasonably accomplish. The brochure could facilitate the expectation setting conversation.
4. ACBH Program Specialists will work with IHOT and ACCESS to figure out a workflow to best link partners to the level of care that the partners need.

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The full report is available at www.acmhsa.org.

Introduction

Program Background

Alameda County Behavioral Health's (ACBH) In-Home Outreach Teams (IHOTs) provide outreach to adults and transition age youth (TAY) over 18 that are living with the most serious mental health diagnoses and who struggle to engage with services. These individuals can have a cycle of repetitive psychiatric crises, resulting in hospitalizations, incarcerations, and homelessness. ACBH launched their IHOT programs in July 2016 based on a model implemented in San Diego that showed a reduced use of psychiatric emergency services and a demonstrated increased use of ongoing outpatient mental health treatment among individuals who engage in IHOT services, as compared to before engagement[1]. The goal of the Alameda County's IHOTs is to engage referred individuals and link them to community-based and mental health services.

The IHOTs are funded by the Mental Health Services Act (MHSA), which funds mental health services in California through a one percent tax on personal annual incomes that exceed one million dollars. It is designed to expand and transform California's mental health systems to better serve individuals with and at risk of serious mental health issues and their families. Locally, ACBH's MHSA Division is the agency that administers the MHSA funding.

Evaluation Rationale

ACBH's IHOTs were last evaluated at the end of their first year of program implementation. In September 2019, the MHSA Division hired a Management Analyst to perform program evaluations of their funded services. The aim of this FY 18/19 evaluation was to:

1. Create a logic model for the IHOT programs through engagement with stakeholders and establish program outcome measures (See Appendix A).
2. Utilize the logic model and the Results Based Accountability (RBA) framework to gather available data and measure the outcomes created for the programs.
3. Conduct and analyze interviews to deepen the understanding of the family and client experience and to use this understanding to create a product for outreach.

The RBA framework uses a simple iterative process to help organizations assess current performance, identify strategies to improve, and facilitate rapid implementation of action plans. It uses the following questions as their framework:

1. How much did we do?
2. How well did we do it?
3. Is anyone better off?

Since 2014, ACBH has been utilizing RBA in various capacities to monitor program performance and assess impacts on the clients who come into contact with the department and/or contracted services.

Stakeholder Identification and Engagement

The primary intended users of this evaluation include the ACBH Program Specialists that manage the IHOTs, the Assistant Director of Adult/Older Adult System of Care, the MHSA Division Director, and the IHOT programs. This evaluation will be used to inform ongoing program development and improvement

[1] Source: https://www.sandiegocounty.gov/content/dam/sdc/hhsa/programs/bhs/TRL/2014-15%20Updates/Section%206%20Docs/Innovation%20Evaluation%20Report%20rev5.11.16.pdf Retrieved: 10/16/2020

and reporting to funders at Alameda County and the State of California. Below are the evaluation components and the stakeholder groups that were engaged (**Table 1**).

Table 1. Evaluation Components and Stakeholder Group Engaged

Evaluation Component	Stakeholder Group
Logic Model	➢ ACBH Program Specialists that manage the IHOTs ➢ ACBH Assistant Director of Adult/Older Adult System of Care
Interview Guide	➢ ACBH Program Specialists that manage the IHOTs ➢ ACBH Assistant Director of Adult/Older Adult System of Care ➢ IHOT Providers
Interview Recruitment	➢ IHOT Providers ➢ ACBH Family Dialog Group*

*Family Dialog Group out of the Office of Family Empowerment is composed of family members of people who have received services in the ACBH system of care.

Program Description

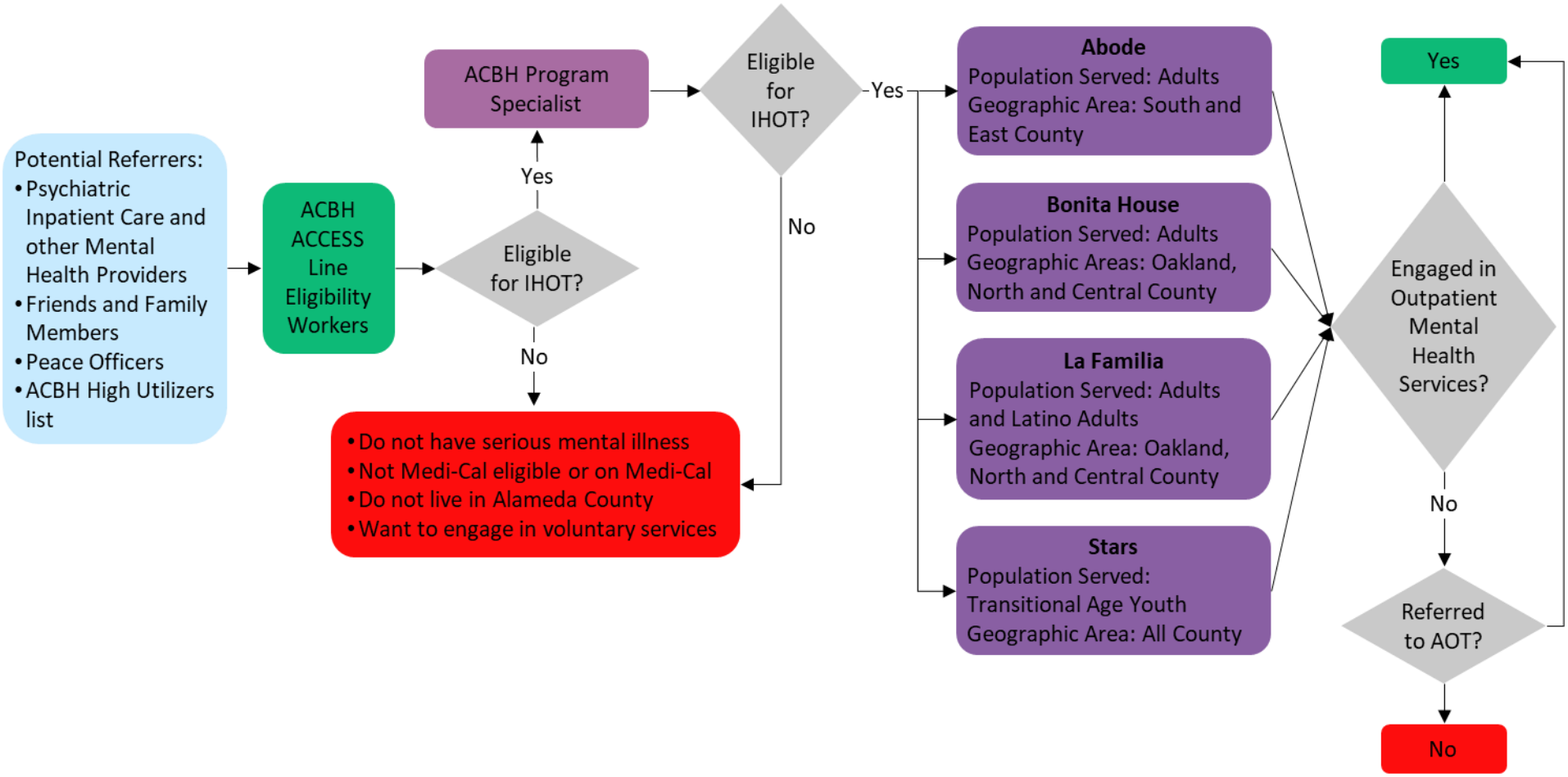
Referrals to ACBH's IHOT programs are through the ACCESS phone line, eligibility workers screen and evaluate those referred for medical necessity and then refer to appropriate providers in the ACBH system. Referrals can come from psychiatric inpatient care, friends, family members, peace officers, and the ACBH High Utilizers list. Initial eligibility is determined using the following criteria: those who are suspected to be living with a serious mental illness; have or are eligible for Medi-Cal; live in Alameda County (including those experiencing homelessness); and people that are reluctant to engage in outpatient mental health services. One of the ACBH Program Specialists that manage the IHOTs reviews the list and confirms eligibility, then distributes the potential partners to the appropriate IHOT or directly to Assisted Outpatient Treatment (AOT). AOT is different from IHOT in that it is a statute driven program (AB 1421), which uses the assertive community treatment (ACT) model and is connected to a court process that determines eligibility for the program and compels individuals to participate in services. Once referred to an IHOT, the team is responsible for using the referral information to try to contact and engage the partners. The referral flow is shown in **Figure 1**.

There are four community-based IHOT providers, each of which has a specific cultural and/or geographic focus, as shown in **Figure 1**. Each IHOT provider employs culturally relevant and age-specific mobile outreach strategies to build trust and rapport with referred individuals and their families, in order to connect them to voluntary specialty mental health services and community-based services. To be successful at employing these strategies, the IHOT maintains the following team:

1. Clinician
2. Peer Advocates (Two)
3. Clinical Lead
4. Family Advocate

If at any time during the IHOT outreach and engagement process individuals that are not engaging in voluntary services and appear to meet AOT eligibility criteria, they may be referred to AOT.

Figure 1. Referral Flow of IHOT Partners



Evaluation Methods

Design

The evaluation utilizes a mixed-methods approach of quantitative and qualitative data to assess program outcomes. These evaluation methods were chosen to best ascertain how referrals to community based and mental health services were distributed by IHOTs and used by partners and their family members. The quantitative components came from reports in the electronic health record (EHR) and the qualitative data came from interviews with former and current partners and family members. **Table 2** below describes the data elements and sources.

Table 2. Data Elements and Sources

Data Element	Data Source
How many people assessed for eligibility by IHOT Program Specialist	Clinician's Gateway
How many IHOT partners referred to AOT	Clinician's Gateway
Demographics of IHOT partners	Clinician's Gateway
First outreach attempt made within three business days of referral	Clinician's Gateway
Referred partners are found by IHOT (contact is made with partner)	Clinician's Gateway
At least 50% of partners are successfully linked to outpatient mental health services or rehabilitation and recovery services within the first 90-days of referral.	Clinician's Gateway
Referred partners' family members, friends, and others engaged to help find partner	Interviews with former and current partners and their families
Trust with partner established	Interviews with former and current partners and their families
Rapport with partner established	Interviews with former and current partners and their families
Partner linked to community-based services	Interviews with former and current partners and their families
Partner linked to mental health services	Clinician's Gateway Interviews with former and current partners and their families
Support groups provided to partner's family members	Interviews with family members
Overall length of services 90-days or less	Clinician's Gateway

Data Collection, Processing, and Analysis Procedures

Qualitative Data

A series of 13 one-on-one interviews with family members and current or former partners were conducted to gather data. Initially, the evaluation was going to include a focus group made up of the Family Dialog Group, but scheduling constraints and the Shelter-in-Place due to COVID-19 lead to shifting to one-on-one interviews. This type of interview allows for more in-depth information, unlike focus-groups, which have multiple people sharing information with a limited amount of time.

Additionally, there is minimal influence on responses, the interviewer is the only possible source of influence to the responses of the interviewee.

The interview guide used was fairly structured with possible probes. The areas covered in the interview guide included: outreach by IHOT, how trust and rapport is built with the partner, linkage to community-based and mental health services, and the quality of the services the partner was connected to. The guides ask slightly different questions depending on whether they were a family member or a client (see guides in Appendix B).

Interviewees were chosen by the IHOTs and most family members were participants of the Family Dialogue Group. However, if the management analyst had interactions with the family members of a partner being interviewed then she offered the opportunity to interview the family member. Incentives of $20 gift cards were used for the interviews. Potential participants were deemed eligible if they were at least 18 years of age and either had a family member that had previously or were currently receiving services from IHOT or a current or former IHOT partner.

The Management Analyst read the questions aloud and answers were recorded digitally. An evaluator-administered interview limits misunderstood questions, inappropriate, and incomplete responses. Demographic information of race/ethnicity, age, city of residence, gender identity, and whether they (if partner) or their family member were currently receiving mental health or substance misuse treatment services were also voluntarily collected (see survey Appendix C). Demographic data was not reported in this report due to the small numbers, but will be kept for reference for planning future interviews and focus groups.

There were a variety of ethical concerns going into this evaluation. First, was to make sure that the participants all had informed consent. An informed consent document was either given to each participant or read aloud prior to the start of the interview. They were all offered a copy to keep or mailed a copy if it was a phone interview. Another concern was that of risk assessment and more specifically psychological stress of the participants. During the interview, each potential participant was informed that the interview was completely confidential, voluntary, they could stop the interview at any given time, and they were also given information of who they could contact in case of any psychological stress.

The largest ethical issue with any interview is confidentiality, to protect this the names of the participants, their gender, and the name of the IHOT team that provided services are not reported. To ensure confidentiality, identifying information was changed when quoting interview participants including the gender of the partner. The data is stored on a password protected computer and the recordings were destroyed a week after the interview. The rest of the data (transcripts, coded transcripts, and field notes) will be maintained on the same pass-word protected computer for a year and then destroyed. These terms were agreed upon by all participants via the informed consent.

The Management Analyst transcribed all interviews and used qualitative coding software called Taguette to code the data. The management analyst reviewed all answers and categorized them into common response themes. Thematic analysis was chosen to analyze this data, it proved useful in finding the common experiences that the IHOT partners and their family members shared and allowed for the use of patterns to build themes in the analysis.

Quantitative Data

The quantitative data was entered into the EHR by the ACBH Program Specialists and members of the IHOTs. ACBH's information systems pulled two different reports from the EHR and provided them to the Management Analyst. They included the information listed in **Table 2** above. One report had the demographic information of the partners, referral information, and the opening and closing dates. The other, called the Referral Tracker, was used to keep track of all of the interactions they had with either the partners or their families.

The data were analyzed using Excel. Prior to analysis, the Management Analyst reviewed the data files for errors, duplicates, and omissions. The analysis involved case-wise deletion, meaning that any data coded as missing or non-applicable was not included in the individual analysis, which resulted in different sample sizes. Due to limitations set forth by the Health Insurance Portability and Accountability Act (HIPAA), groupings of less than 10 individuals are not explicitly reported or are combined with other groups to make them larger than 10.

Data Synthesis

The quantitative and qualitative data were synthesized to create the evaluation findings. Throughout the evaluation process, the Management Analyst collaborated with ACBH Program Specialists and the IHOT providers to vet analytic decisions and findings. This was done both formally through presentations and informally through conversations with ACBH Program Specialists and the IHOT providers. Findings from qualitative content analyses were integrated with the quantitative data throughout the report and both were used when creating recommendations. Discussion of results with IHOTs informed the explanation of the qualitative themes and the evaluation recommendations.

Limitations

As is the case with all real-world evaluations, there were important limitations to consider. Data for pre-enrollment time periods compared to post-enrollment time periods for partners in each program were currently unavailable. Additionally, there was high variability in the amount of data entered by IHOT providers into Clinician's Gateway; in many instances the location, number of interactions, and outcome of each encounter could not be determined. This may reflect that many IHOT partners are challenging to engage and providers may be struggling with how to meaningfully communicate the results of the encounter in the EHR.

Due to the sensitive nature of the services, interviews with participants and families aimed to maximize participation and build trust between the outside evaluator and interviewees. However, there are several compromises involved in the use of an evaluator-administered interview for sensitive topics, such as use of mental health services. Participants may be reluctant or unwilling to discuss sensitive questions with outside evaluators. Also, respondents' answers may be subject to social desirability biases, as respondents may wish to give the 'correct' response or hide/minimize certain behaviors. This may result in evaluation findings that do not truly reflect respondent behavior (for example, potential over-reporting of use of community-based services or under-reporting need for mental health services).

Another limitation of the interviews is that it relies on a convenience sample – that is, participants are selected based on being readily available to participate, and not by random chance. Accordingly, the responses of the partners and family members who agree to participate in the interviews may differ from those of users who refuse to participate and/or who were not asked to participate.

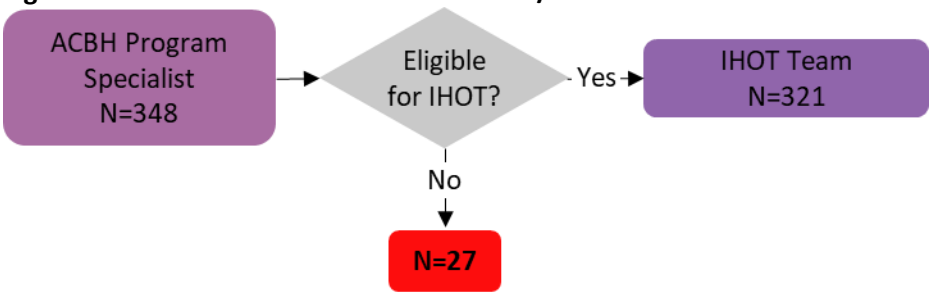
Finally, the sample itself is limiting, originally the goal was to find IHOT partners or family members of IHOT partners that are currently receiving or having received services in the last year from the time of the interview, because they would have better recall of their experiences. However, some of this sample of family members is made up of family members that have received services more than a year from the interview. This means that the data gathered might not be as detailed as it could have been due to the time that has passed. Also, the interviews were originally going to be in-person to facilitate trust and rapport building, but due to locations of partners and the COVID-19 Shelter-in-Place orders in California about half of the interviews were conducted over the phone.

Findings – How Much Did We Do?

Referral Flow of those Referred to IHOT

During FY 18/19, there were 745 cases open in the electronic health record, these include those referred from the ACBH ACCESS line to the Program Specialist, all partners that received services from IHOTs during that year, and contain duplicates. There were 395 duplicated partners that were served by IHOTs. All IHOTs served more than their contracted number of clients with the percent of open partners ranging from 20%-29%. There were 20 cases opened prior to FY 18/19. **Figure 2** below, describes the flow of episode referred during FY 18/19.

Figure 2. Referral Flow of IHOT Clients FY 18/19

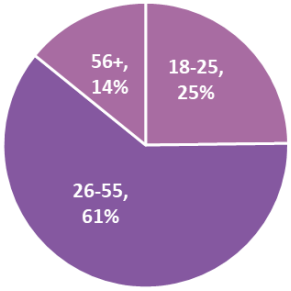


During the interviews, most of the family members stated that they were already connected to the ACBH system of care when they learned about the IHOTs and were referred by an ACBH contracted provider.

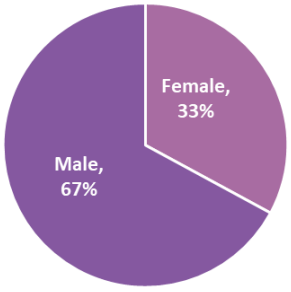
> "…I got a phone call one day and hearing about the services and they asked if I would be willing to and I said yes. I was trying to get all the help that I could get at that time for my [child]."
> –Family Member

Partner Demographics

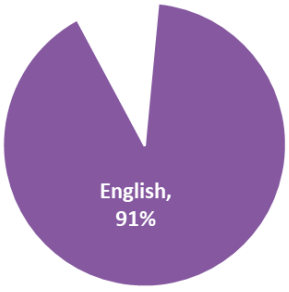
61% were between the ages of 26 to 55.



67% identified as Male.



91% spoke English.

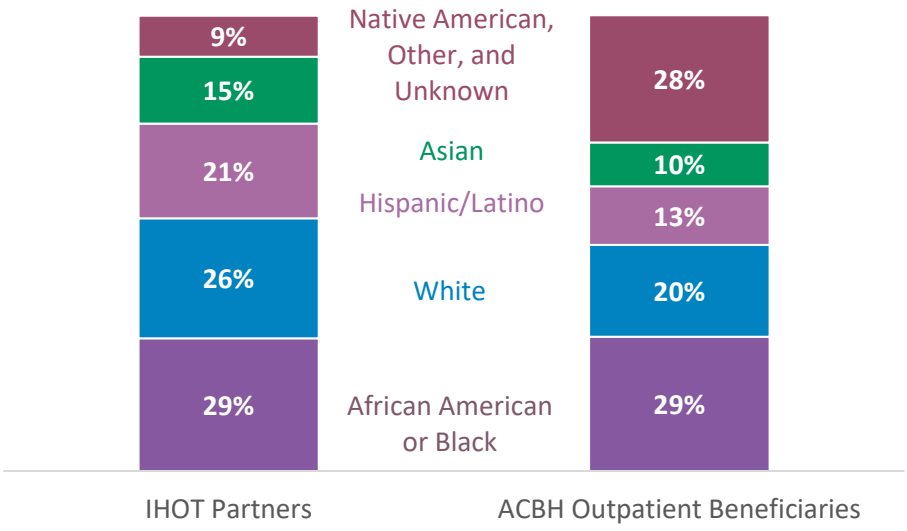


The demographics above are of the 395 duplicated partners open to the IHOTs during FY 18/19. Even though over 90% of partners spoke English, clients spoke a variety of languages. The next highest served language was Spanish at 4% and the rest served spoke Arabic, Cantonese, a Chinese Dialect, a Filipino Dialect, Korean, Mandarin, Other, Unknown/Not Reported, or Vietnamese.

When comparing the IHOT clients to the demographics of the ACBH outpatient population, which includes those that are not in crisis stabilization, subacute, hospital, jail or juvenile justice. Adults 26-55 are represented in the IHOT population at about the same percent as the outpatient populations (61% vs 60%). Whereas, TAY are overrepresented in the IHOT population (25% vs 18%) and Older Adults are underrepresented (14% vs 22%). Male identified IHOT partners are overrepresented (67% vs 47%). English speaking IHOT partners are overrepresented when compared to the outpatient population (91% vs 86%).

Figure 4. Race and Ethnicity of Engaged IHOT Partners

IHOTs served a higher percentage of **Asian**, **Hispanic/ Latino**, and **White** partners compared to ACBH Outpatient Beneficiaries.



While most clients spoke English the race and ethnicity of the clients was across many different groups. IHOTs served more Asian, Hispanic/Latino, and White partners than the ACBH outpatient providers.

In speaking with the IHOT teams, they had the following thoughts on the racial/ethnic differences between IHOTs and ACBH Outpatient Beneficiaries:

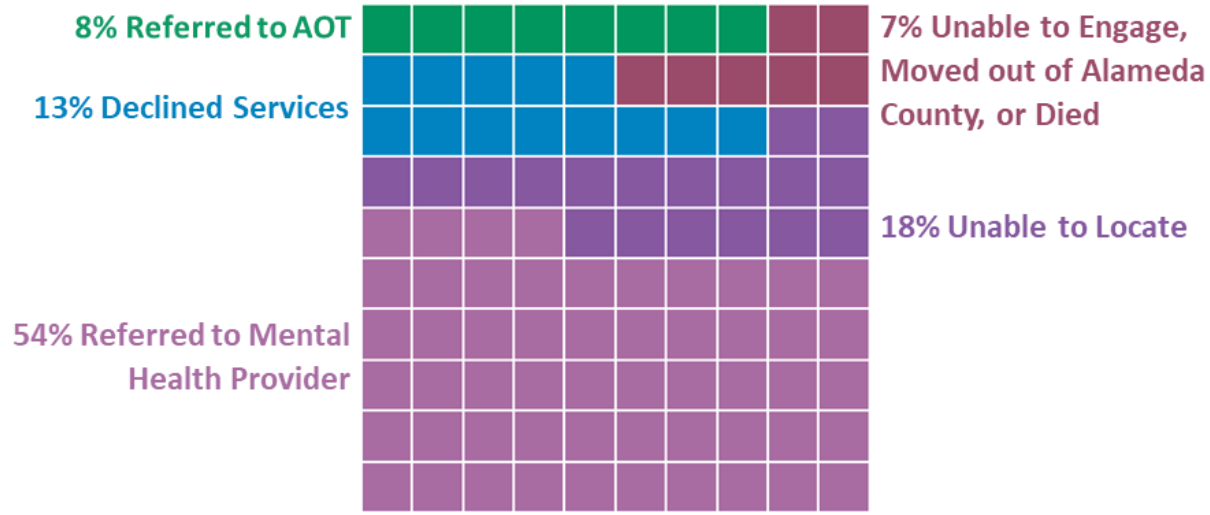
1. Men may be overrepresented because they are more likely to have the police called on them and have a more outwardly expressed symptoms, whereas women's symptoms may not be as obvious or threatening to the family. So, the women may have less interaction with this part of the ACBH system of care.
2. English-speaking patients already have more interaction with the system and have more non-family member referrals so the system already knows if they are reluctant to engage in treatment. Those that do not speak English as their first language or have limited English proficiency are often not engaged in the system and are referred by family members.
3. Asian patients were engaged by the IHOTs at a higher percentage because a provider that serves a lot of Asians has very few case managers that go out in the field and they use the IHOTs to get their partners reconnected to care.

Findings – How Well Did We Do It?

Partner Discharge Outcomes

The IHOTs are asked to try to connect with new clients within three business days. Of the 161 referrals made during the FY 18/19 that were tracked in the Referral Tracker database, 55% (n=88) were contacted within three days. The rest had first contact more than three days after the referral date. There were 384 partners discharged during the FY 18/19, 56% (n=215) of the discharge codes used were not clear so they have been excluded from the following results. Below are the discharge outcomes of the 169 partners that had clear discharge codes.

Figure 5. Referral Outcomes



Unsuccessful Engagement

According to the interviews, client's and family's first impressions varied by how involved they were with the referral and lead to varying levels of knowledge about the IHOT team trying to contact them. Those that were less involved did not always have a positive first impression and therefore could be harder to engage.

"…I didn't, like it was just an onslaught you know…I didn't know what he was talking about, where he was going, what he knew." – Partner not involved

"…they didn't know what they were doing." – Family member less involved

According to the conversations with IHOT teams, those less involved family members could be out of state and it is neighbors or mobile crisis that are engaging with and referring these clients.

Clients and families that were involved with their referral, generally had a positive first impression of the team.

"…that they were very friendly. [That] if they could help in any way they would." – Partner that advocated for themselves to receive services

"Well she was just a warm, caring person. It was nice to know that there were people fighting to get my [child] the help that [they] desperately needed. It was a relief knowing that I wasn't in the struggle by myself." – Family member more involved

However, depending on the severity of their mental illness family members might not be able to prepare the person referred for meeting the team.

> "Yeah, I was in not a good condition I was paranoid about their services at first but once I got working with [the IHOT] …I had a good experience with them." – Partner

> "The other thing was [the partner] stopped [their] meds. So, [they were] severely depressed, [they] didn't move. That's why you couldn't engage [them]." – Family Member

Additionally, it might be hard to engage or even locate clients because families and potential clients did not have a network of people that could help connect the client to the services.

> "First, I heard it through my parents. They said that they were going to contact me and then I received a phone call or text message." – Partner

> "My [child] doesn't have any friends, [they are] still very, very sick… [They have] no friends, no brothers, no sisters so it was just me and the team." – Family Member

Successful Engagement

The main goal of the IHOTs is to connect clients to mental health services, either a new one or re-connect with a previous provider, and community-based services. While first impressions of the IHOT were not always positive, successful engagement with IHOTs means that partners trust and have a rapport with the IHOT. The tables below discuss what was revealed in the interviews about how the IHOTs built trust and rapport with partners.

How IHOTs Build Trust with Partner

Listening to the partner

"I'm hard to listen to sometimes and so with that in mind, actually, she did a very good job as far as active listening." – Partner

"She listened to me when I was talking about my parents…and kind of just listened to what I had to say and asked very intellectual, very helpful questions." – Partner

Navigating a complex system to connect partners to wanted/needed services

"I like that she got involved… I think they were able to get to the higher people in [a Community-Based Organization] and stuff like that to get things done. Because I was having problems with [them]." – Partner

"And they help you get to the place you want to be. Like they've gotten me so much further in my housing then I would have done by myself…They pulled out resources that I didn't even know existed." – Partner

Being persistent and consistent

"Trying to have conversations with [the partner] was very difficult in the beginning. [They] did not want to engage but [they] came around and it didn't take too long…But [the IHOT] kept showing up." – Family Member

"Having consistency in [the partner's] life that [they] knew that every Wednesday [they] would hear from [the IHOT] …the structure is important for people with mental health issues and that is what they provided for [the partner]." – Family Member

Listening icon created by Vectorstall, navigating icon created by IconPai, and persistent and consistent icon created by Becris. All icons downloaded from the Noun Project.

How IHOTs Build Rapport with Partner

Facilitating goal setting

"Just, you know, build me up with what I did, my work experience and what I could do or accomplish. And gave me some good advice." – Partner

"I think one of the goals was [they] really wanted to go back to work. Work was really, really important to [them] so [the IHOT] would set a goal [for the partner]." – Family Member

Becoming like family or a support system

"I'm just glad we were just there to talk like family and [the] outreach team is wonderful." – Partner

"It was like going to lunch with your family…They would ask [the partner] questions without focusing so much on the mental health." – Family Member

Demonstrating caring for the partner

"She's also asked me like what am I doing, how's it going what I'm doing, how my relationship with my parents is it fruitful." – Partner

"Everything that she does is with care." – Partner

Goal setting icon created by Adrien Coquet, family or support system icon created by Made x Made, and caring icon created by shanthagawri. All icons downloaded from the Noun Project.

Linking to Community-based Services

There was a combination of ways that the IHOT helped the partner find and connect to community-based services. The services ranged from housing to nutrition assistance to addiction remission services. If the client was willing and able they would connect themselves to community-based services. However, the IHOT was there to advocate for them when needed.

> "She helped me get around and she worked on making sure I wasn't going to be on the streets… They were able to get me into a hotel for like a month or something. She fought for that." – Partner

> "It's mainly, she'll give me information about a facility and then I'll call them and set up an appointment." – Partner

While IHOTs cannot refer to mental health services, they can help the client call the ACCESS line to get referred to outpatient mental health services. They would also advocate on the partner's behalf, regardless of whether they were previously or newly connected to mental health services.

> "No, [the partner] wasn't on medication and the [IHOT]…put the fire up under [Mental Health Provider] but I wasn't actually getting stuff that I know that I could get…I would say that they were very much instrumental in getting [Mental Health Provider] to kind of get on the ball." – Family Member

> "So, I know they did speak to the doctor there in the hospital to let them know, "Hey this is what's going on with this young man," and that helped get him a lengthier stay and help, too." – Family Member

Persuasion to Engage in Mental Health Services

Building trust and rapport with partners is important to empowering them to agree to be connected to mental health services. Partners and their family members spoke about why the partner decided to engage in mental health services.

Partners often reported that they knew they needed mental health services, which is how they were persuaded to connect to these services.

> "Yes, so I needed to, I knew I couldn't go forever without the meds. Even though I'm pretty good at it, it's better to get the meds...When I found out that there were psych appointments I said good I'll take one."

However, family members felt that the IHOT teams were instrumental to enabling the partner to want to connect with mental health services.

> "I think that once [they partner] had [an] interaction with this person it started to make [them] think [they] wanted to get better. [They] definitely began to consider recovering because [the partner] was interacting with somebody else besides just us… [the IHOT] definitely got [them] opened up to mental health recovery."

> "I think by the time [the IHOT] left [the partner] was aware that [they] needed more than the IHOT was created to provide. [They were] aware that [they] needed more."

After discussing with the IHOTs, they reported that they are successful at connecting people to mental health services because of their experience decreasing barriers to care. However, IHOTs often felt like they could not advocate enough to help partners get hospitalized, especially for hard to reach patients. Family members also mentioned the importance of hospitalization. Partners spoke about being hospitalized, but did not comment on their feelings about it.

IHOTs felt that families might decrease their success connecting partners to mental health services because they might be create barriers to successful engagement and take it out on the IHOT staff when the partner does not get dramatically better. An effective solution found by an IHOT was asking family members, "what are you expecting the IHOT to do?" and then telling the family what is reasonable to expect. Also, speaking with families about the longevity of mental illness and that the partner will be living with it for the rest of their life. Another area that could be clarified for families and others that refer partners is that IHOT is "outreach only" and do not respond to crises. As such, IHOTs are encouraged to discuss resources with families upfront to deal with crisis, such as calling Alameda County's Mobile Crisis Unit.[2]

Family Supports

Not only are the IHOTs expected to provide services to their clients, but they are expected to also provide support groups to the family members as well. Family members reported varying levels of support and referrals to groups from the IHOT teams.

> "Yes. And they have contacts for me also to get into groups…They're going to come here to meet with me."

[2] Currently, all Crisis Services clinical staff work primarily out in the field, which increases community-based crisis prevention and early intervention services, thereby ensuring clients are referred to the appropriate type of mental health services. More information can be found in the MHSA Plan # OESD 5 at https://acmhsa.org/wp-content/uploads/2019/12/19-20-MHSA-Plan-Update2.pdf

> "No, once the first interview was over we pretty much didn't have any family support…they didn't send us information about family support groups or anything. It was very weird."

> "They would say, 'If you need help you can go to this and this and that.' I would say that I'm a trained [mental health] facilitator and this had nothing to do with IHOT…and it is hard there is not a support group for facilitators."

IHOT teams reported that the amount of support varied depending on whether the family wanted it and the severity of the partner's illness. Additionally, they felt that there are not a lot of resources in the county for families. Families might not know how they are influencing the partner's ability to get services and do not necessarily want anything to do with referring them to mental health services. Some IHOT team members felt that the family and the partners both need to heal and work intensely to assist the families.

Time Open by IHOTs

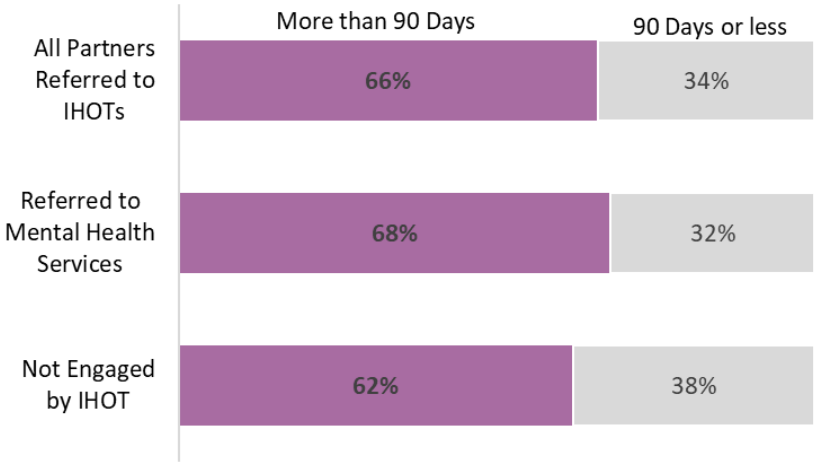
The IHOTs are expected to follow-up with the partner once the client has begun to participate in outpatient mental health services for up to 90 days or three months. Additionally, the length of stay shall not be extended beyond six months or 180 days without approval and those that the IHOTs are unable to locate for 90 days despite their attempts to contact those referred or if the referred consistently declines treatment despite their attempts to engage the client. Clients and family members varied in remembering a conversation about how long they were expected to be worked with. However, they did explain the purpose of their work.

> "She didn't say, 'I am going to be working with you for this long' but yes, she explained what they do and how they can help." – Partner

> "IHOT made it very clear to me that this was their work, this is what we do, we want to make certain that [the partner] is stable and we won't leave until [they are] stable. I don't remember them saying 'We are only going to be here for two months, if [they are] not stable at two months we're gone.' I don't remember that." – Family Member

Of the 169 partners that had a known discharge outcome, more than half were open for longer than 90 days. There is not a significant difference between the length of time partners are open and whether they are subsequently referred to mental health services (**Figure 6**). Among the 106 partners referred to mental health services or AOT, 67% were open for less than six months. However, this does not reflect how long partners were opened once they were engaged in services.

Figure 6. More IHOT Partners were Open for 90 Days



The IHOT teams feel that the 90-day time limit is too restrictive because they are a hard to engage population and, as previously mentioned, the time it takes to connect partners to services. Engaging IHOT referrals versus getting them ready to get them to treatment can take longer. Additionally, trying to connect the partner to mental health services does not always succeed. There are partners that may agree to treatment versus those that sign a treatment plan.

Areas of Concern

Partners and family members spoke about how the IHOT, mental health, and community-based services could be improved. What can harm the relationship with the IHOT and decrease the perceived quality of the services received are: the time it takes to link to services, not enough time spent each week with the partner, and staff turnover throughout the system.

Time it takes to link to services was mentioned as a frustration to getting services, not just services the IHOT was trying to connect the partners to, but also the subsequent services.

> "But then there's been inconsistencies with how that is handled in a timely fashion." – Family Member

> "We kept wondering when [the partner] was going to get a psychiatrist. The [IHOT] would sort of pass along and talk briefly about the possibility of seeing a psychiatrist and [the partner] got on board." – Family Member

> "But see the only thing that was maybe a problem is just the sheer amount of time it was taking to do these things." – Partner

> "And, um, they ended up supposedly this was supposed to help with finding SLEs [sober living environments] and all this stuff…with the rehab…I didn't find out till like a week or two at the end but there was no help at the rehab and I couldn't get help anywhere on any type of housing or anything." – Partner

After discussing these findings with the IHOTs they said that this was also their biggest concern. They mentioned that the speed with which referrals are completed and "at the mercy of whoever is over the program." When referrals do not go through, then the partners can fall through cracks. The other concern the IHOTs mentioned was that the partners might not meet county criteria for services because the system is built to "fail-up" to higher levels of care. Oftentimes, because these individuals have been reluctant to engage in services then they do not have enough interaction with the ACBH system to justify a higher-level of care. They are also frustrated with a lack of services for co-occurring disorders.

Partners and family members also felt like that they did not get enough time. They wanted more time and more frequent contact with the IHOT team. However, partners can be rereferred to IHOT if needed.

> "But as far as there's really nothing other than it needs to be more. But not uniformly, more because of the fact that the service is actually really helpful and they need more people. So that they're not as bogged down." – Partner

> "Once a week was nowhere near enough to keep anything going at all. If [the partner] had had more meetings a week [they] might have pulled [themselves] out. But if [they] only had to pull it together for an hour a week, [they were] unconscious the rest of the week so there was no progress." – Family Member

The 161 referrals that were in the Referral Tracker had 3,615 contacts with the IHOTs, which averages to 22 contacts per referral, a mean of 16, a min of one contact, and a max of 103. Because the amount of

contact varied this probably influences how many services they were connected to or if they were successfully engaged. This does not measure the length of time or quality of each contact. This may also be why clients decline services or do not engage. However, increasing the number of contacts per week might create outsized expectations for the care they will get with other providers. Additionally, some of the partners might need a higher level of care that they might not have access to when being discharged from IHOT.

This area of concern is also positive because partners and families want more time. After speaking with the IHOTs, they spoke about how there was a lot of intention to connect with the person because of the 90-day limit (explored above). The IHOTs want to give their partners a lot of care during the time they have, because the partners are often in crisis and there is a need to create relationships quickly.

Most clients only had one or two IHOT team members that they worked with consistently. However, staff turnover was often the reason for working with multiple people and it would take time for the partners and the team to create a relationship with a new IHOT member and with others within the ACBH system of care.

> "I think part of it has been there was turnover in staff a lot. That instability for [them] was not great. There was not much communication with me at all." – Family Member

> "We know for sure it was staff turnover they had told [the partner] that. The first person shared with [the partner] that she was leaving and even shared some of her reasons why she was leaving and then had one session where she brought the new person in to introduce [the partner] to the new person…Anyway, like I said it was pretty clear that team was struggling right then." – Family Member

The frustration with staff turnover carried through to the services that they were referred to.

> "To start therapy and two months later they're gone. And they've only had maybe three sessions an intro…but not enough." – Family Member

The staff turnover for the IHOTs has decreased after FY 18/19. The IHOTs agreed that a warm hand-off is important among transitioning team members and they would like this also for when the IHOTs refer to another agency. They felt that the transition between IHOTs and other agencies could be better if the teams reached out to debrief and work collaboratively to engage with partners.

Findings – Is Anyone Better Off?

The connection to community-based services, mental health services, and the IHOT improved the partners' and family members' lives. Once connected to services the changes in partner's lives included being more recovery oriented, asking for help, accomplishing goals, improving their hygiene, and having their life saved by the IHOT.

Partners and family members spoke about how the services made the partner more recovery oriented. For mental health services they reported the following:

> "I got some stuff off my chest. I learned about myself speaking about things." – Partner

> "[The partner] had you know someone else to talk to in the whole scheme of things and someone else to go over things with, which is what [they] need." – Family Member

> “Because I wasn't there for it but I saw an upswing in [the partner’s] behavior. A lot more happiness and a lot more abilities to do things.” – Family Member

Being connected to community-based services also helped them become recovery-oriented:

> “I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year.” – Partner

> “They kept me off the streets I mean they helped a lot. They helped me not get stuff taken or stolen when I wasn't around and let me have a secure place where I could leave my stuff and go out. It made me feel secure.” – Partner

Specifically, family members spoke about the partner being willing to ask for help with their mental health.

> “One thing that changed was that [the partner] was at least willing to talk about getting help. It actually opened [them] up to being willing to get help. The IHOT was at least talking about getting psychiatry so then [the partner] was agreeing to it. So at least that opened the door for us to get [the partner] to it.” – Family Member

The partners’ time with IHOT also helped them accomplish goals, which is important for self-determination.

> “I enrolled in classes in Merritt College.” – Partner

> “It's more easygoing, I mean I quit drinking altogether and I haven't relapsed or anything. I'm feeling better now that I don't get too depressed and so but I'm taking medication.” – Partner

Even small, but important, changes to the partners’ daily routines were commented on by family members, such as increase in hygiene.

> “I think that was first and foremost, [the partner] started taking care of [their] health better, taking more showers, getting [themselves] cleaned up.” – Family Member

> “It was interesting, once [the partner] started taking [their] meds all of the other stuff like combing [their] hair and taking a bath, all of those things came naturally to [them].” – Family Member

Many family members spoke about how the IHOT ultimately saved both their life and the partner’s life.

> “They saved our life. They saved [my child’s] life, they saved my life.” – Family Member

> “I truly believe that the IHOT team saved my [child's] life.” – Family Member

When speaking with the IHOT teams they said that feedback like this is what keeps them going. Hearing the appreciation for their work.

Summary and Recommendations

Summary

This evaluation was undertaken to create a logic model, measure outcomes created for programs, and deepen the understanding of the family and client experience. The goal is to use this understanding to create a product for outreach. IHOTs served a racial and ethnically diverse population of mostly men, adults, and English speakers. Discharge data from the IHOTs was not complete, with over half (56%) of the discharged partners were missing a clear discharge code. Of those that did have a clear discharge code 62% were referred to mental health services or to AOT. In order to successfully link partners to services, IHOTs need to build trust and rapport with the partners in a variety of ways, including being persistent and consistent with outreach and becoming a support system for the partner. Families conveyed that they wanted support and referrals to services, but varied in whether they received that support. From the interviews the respondents were concerned about the time it takes for things to get moving, the limited amount of time with the IHOTs, and staff turnover throughout the system. Partners were better off because they were working towards recovery, asking for mental health help, accomplishing goals, increasing hygiene, and that the IHOT was life-saving for the partners and the family.

Recommendations

Considering these findings, this evaluation has demonstrated the IHOTs value to the Alameda County Behavioral Health system of care. The IHOT's current services appear to be accomplishing the goal of connecting those with serious mental illness to community-based and mental health services. These findings suggest that the services are both needed and valued by the partners and their family members. To continue to provide and improve upon the services, the following recommendations are made for the IHOTs and the ACBH Program Specialists:

1. Improve data quality:
    a. The Program Specialist provides guidance to the IHOTs to improve destination codes in Clinician's Gateway – this is already in progress.
    b. ACBH's Program Specialists, Management Analyst, Information Systems, and the IHOTs collaborate to build a dashboard to review data during the FY 20-21 fiscal year. At minimum, the dashboard will include incarceration, hospitalization, and psychiatric emergency use data for pre- and post-enrollment time periods and IHOT discharge destinations.
    c. Explore the logic model outcomes for appropriateness with the IHOT teams, particularly the 90-day time limit during FY 20-21.
2. Increase IHOT Partners' language diversity and set expectations for family members using a brochure created for the programs (Appendix D). The brochure will be used for the following:
    a. Outreach to diverse communities. The Program Specialist has already scheduled a meeting with providers that focus on underserved ethnic and language communities in March 2021.
    b. Use when meeting clients/families for the first time, which could include mailing them to families after referral.

3. IHOTs increase the amount they connect with families, including having a conversation to set expectations about what the IHOT will reasonably accomplish. The brochure could facilitate the expectation setting conversation. This is because of family member's desire for support and the IHOT's recognition that families influence the recovery of the partner.
    a. During FY 20-21, the ACBH Program Specialists will set aside at least one IHOT Collaborative meeting to discuss working with family members and develop a workplan for increasing engagement. This may include reminding the referrals sources that IHOT is "outreach only" and that they do not respond to crises. IHOTs will be encouraged to discuss resources with families upfront to deal with crisis, like calling Alameda County's Mobile Crisis Unit.
4. ACBH Program Specialists will work with IHOT and ACCESS to figure out a workflow to best link partners to the level of care that the partners need. Since IHOT and the interviewees expressed concern over the difficulty it can be to connect partners to Mental Health Services.

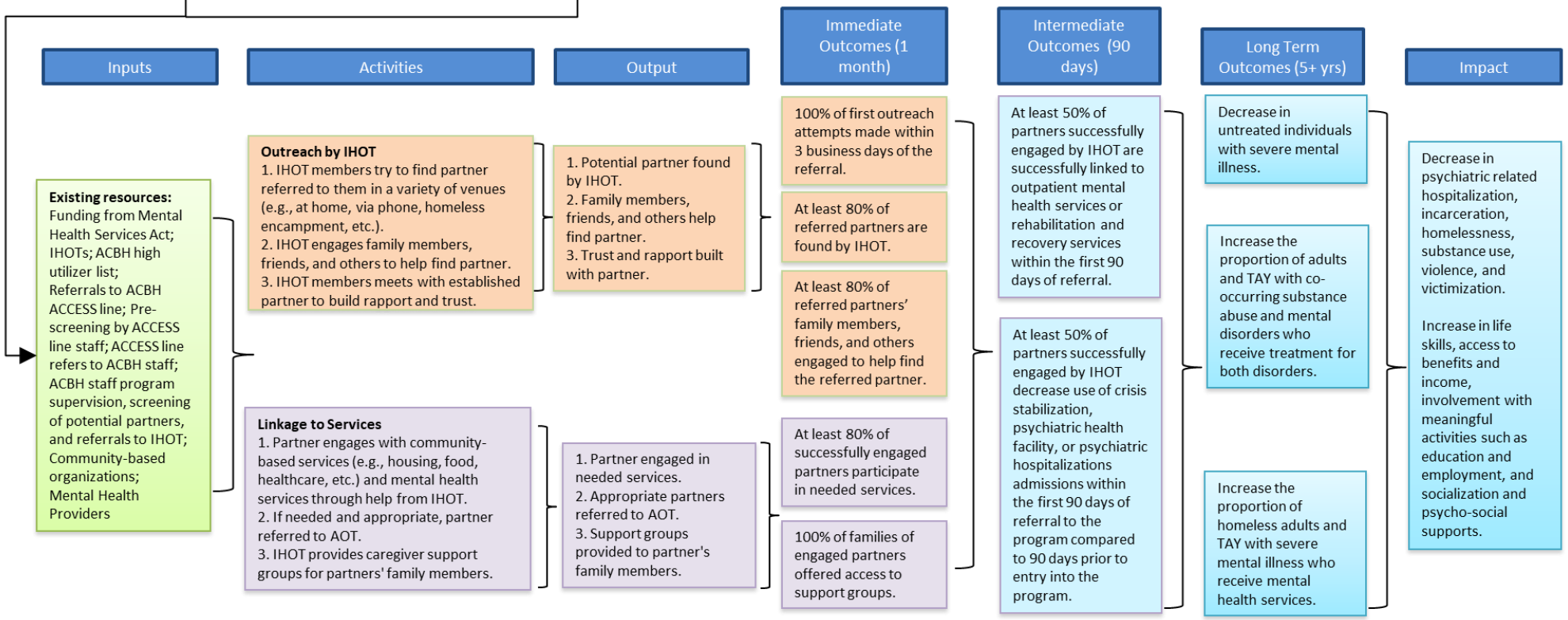
Appendix A

Logic Model Alameda County Behavioral Health's (ACBH) In-Home Outreach Teams (IHOT)

Problem Statement: Adults and TAY over 18 with the most serious mental health problems who struggle to engage in services can have a cycle of repetitive psychiatric crises, resulting in hospitalizations, incarcerations, and homelessness.

Rationale:
Data from the San Diego program indicate a trend toward reduced use of psychiatric emergency services and increased use of ongoing outpatient mental health treatment among individuals who are referred to and engaged in IHOT services, as compared to before IHOT engagement.

Assumptions:
1. The IHOTs can serve at least 65 unduplicated individuals in a year.
2. The IHOTs caseload is 15-20 partners at a time.
3. The IHOT maintains a team of one FTE clinician, two FTE peer advocates, one clinical lead, and a family advocate.



Appendix B

Individual Interview Guide – In Home Outreach Teams FY 18/19 Evaluation

Introduction

Thank you for agreeing to be interviewed. My name is Carly Rachocki, I am a Management Analyst for Alameda County Behavioral Health and I work on evaluating programs. Today we are going to spend the next hour talking about the In-Home Outreach Teams or IHOT. The purpose of this discussion is to help ACBH understand the quality of the services we are providing.

The consent form needs to be signed before we begin. Please take time to read it over, but the main points are that this interview is voluntary, you do not have to answer any questions that you do not want to, and you can stop participating at any time. We will be reporting the results of the interviews to a variety of different groups but will not be using any names when reporting so your answers will remain confidential. Do you have any questions?

Great. Please complete the consent form and return them to me.

I am going to start recording now.

Outreach by IHOT

1. IHOTs (Agency Name or Team Member they are familiar with) provide outreach and engagement to people with the intention of connecting them to mental health care and community supports. When and how did you first hear that the IHOT was trying to contact you?
    a. What was your first impression upon meeting them?
2. What other experiences do you have working with the IHOT (**probe:** did they spend time talking to you/your other family members about mental health symptoms; explain the purpose of their work and the length of time they were expected to work with you)?

Linkage to Services

3. Describe the ways that the IHOT tried to build trust with you (**probe:** were they empathetic; used active listening; communicate; recognized you as an individual; or met you where you were at)?
    a. Which of those worked at building trust? Why?
    b. Which of those did not work at building trust? Why?
4. Describe the ways that IHOT tried to build rapport or a relationship with you (**probe:** did you work with the same person over and over or were there multiple people; holding silence when productive; using laughter; or setting attainable goals)?
    a. Which of those worked at building rapport? Why?
    b. Which of those did not work at building rapport? Why?
    c. Follow-up if they speak about the same person working with them or multiple people: How did that go?

5. What community-based services did the IHOT connect you with (**probe:** health insurance; housing; food; jobs; social security; substance use; disability services; general assistance)?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist you to connect with these services (**probe:** educating you about services available; providing you with the application; helping you to fill out the application; helping you get to appointments)?
6. What mental health services did the IHOT connect you with?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist you to connect with these services?
    d. What persuaded you to connect with mental health services?
7. After engagement with IHOT how did your life change?
8. Is there anything else about the IHOT or your experience receiving services that you want to add?

Closing

Thank you for your time. Please fill out this questionnaire to tell me a little bit about yourself. Do you want a copy of the consent form?

Focus Group Guide – In Home Outreach Teams FY 18/19 Evaluation

Introduction

Thank you for coming. My name is Carly Rachocki, I am a Management Analyst for Alameda County Behavioral Health and I work on evaluating programs. Today we are going to spend the next 45 minutes talking about the In-Home Outreach Teams or IHOT. The purpose of this discussion is to help ACBH understand the quality of the services we are providing.

I am passing out a consent form that needs to be signed if you agree to participate. Please take time to read it over, but the main points are that this focus group is voluntary, you do not have to answer any questions that you do not want to, and you can stop participating at any time. We will be reporting the results of this focus group to a variety of different groups but will not be using any names when reporting so your answers will remain confidential. Do you have any questions?

Great. Please complete the consent form and return them to me.

In order to help me facilitate, can you go around an introduce yourselves? Thank you.

I am going to start recording now.

Introduction questions

9. IHOTs (Agency Name or Team Member they are familiar with) provide outreach and engagement to people with the intention of connecting them to mental health care and community supports. They receive referrals from a variety of places, including family members. How did you hear about IHOT and the services they provide?

Outreach by IHOT

1. What was your experience working with the IHOT to connect your family member?
    a. What was your first impression upon meeting them?
    b. Tell me about other people that they engaged to help connect your family member? What was their role in helping find them?
2. What other experiences did you have working with the IHOT (**probe:** did they spend time talking to you/your other family members about mental health symptoms; explain the purpose of their work and the length of time they were expected to work with you)?

Linkage to Services

3. Describe the ways that the IHOT tried to build trust with your family member (**probe:** were they empathetic, used active listening, communicate, recognize the individual).
    a. Which of those worked at building trust? Why?
    b. Which of those did not work at building trust? Why?
4. Describe the ways that the IHOT tried to build rapport or a relationship with your family member (**probe:** did they work with the same person over and over or were there multiple people; holding silence when productive; using laughter; or setting attainable goals)?
    a. Which of those worked at building rapport? Why?
    b. Which of those did not work at building rapport? Why?

    c. Follow-up if they speak about the same person working with them or multiple people: How did that go?
5. What community-based services did the IHOT connect your family member with (**probe:** health insurance; housing; food; jobs; social security; substance use; disability services; general assistance)?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist your family member to connect with these services (**probe:** educating you about services available; providing you with the application; helping you to fill out the application; helping you get to appointments)?
6. What mental health services did the IHOT connect your family member with?
    a. How did these services help?
    b. In what ways could these services have been better?
    c. How did the IHOT assist your family member to connect with these services?
    d. What persuaded your family member to connect with mental health services?
7. After engagement with IHOT, how did you family member's life change?
8. Tell me about your experience learning about the support group provided by IHOT.
    a. If you chose to attend the support group, what was your experience with it?
    b. If you did not choose to attend it, tell me why you chose not to.
    c. Describe the other family supports that they referred you to.
        i. What was your experience with those supports?
9. Is there anything else about the IHOT or your experience receiving services that you want to add?

Closing

Thank you for your time. I am going to pass around a questionnaire to tell me a little bit about yourself and so that I know who is participating in the focus group. While you are filling that out is there anyone that wants a copy of their consent form?

Appendix C

Demographic Survey Individual Interviews

Please let us know a little bit about yourself by filling out this survey. *Your participation is voluntary and will not affect your ability to receive program services.* Alameda County Behavioral Health will use the results of this survey when reporting to stakeholders. Information shared with us will be anonymous because it will be combined with other surveys before sharing the results.

1. What is your race/ethnicity? _____

2. What is your age? _____

3. What is your gender identity?

☐ Male

☐ Female

☐ Female-to-Male (FTM)/Transgender Male/Trans Man

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Genderqueer, neither exclusively Male nor Female

☐ Additional Gender Category/ (or Other),

Please specify: _____

4. What city do you live in? _____

5. Are you currently receiving mental health services?

☐ Yes
☐ No

6. Are you currently receiving treatment for substance abuse?

☐ Yes
☐ No

Demographic Survey Focus Group

Please let us know a little bit about yourself by filling out this survey. *Your participation is voluntary and will not affect your ability to receive program services.* Alameda County Behavioral Health will use the results of this survey when reporting to stakeholders. Information shared with us will be anonymous because it will be combined with other surveys before sharing the results.

4. What is your race/ethnicity? _____

5. What is your age? _____

6. What is your current gender identity?

☐ Male

☐ Female

☐ Female-to-Male (FTM)/Transgender Male/Trans Man

☐ Male-to-Female (MTF)/Transgender Female/Trans Woman

☐ Genderqueer, neither exclusively Male nor Female

☐ Additional Gender Category/ (or Other),

Please specify: _____

4. What city do you live in? _____

5. Did you have a family member that received IHOT services?

☐ Yes
☐ No

6. Is your family member currently receiving mental health services?

☐ Yes
☐ No

7. Is your family member currently receiving treatment for substance abuse?

☐ Yes
☐ No

"I truly believe that the IHOT team saved my [child's] life."
-Family Member

The organizations below provide IHOT services.

ABODE SERVICES
Because everyone should have a home.

Bonita House INC

LA FAMILIA

STARS Community Services
Respect • Compassion • Trust • Positivity • Inspire Wholeness •

"I'm not there, but I can see myself getting healthy. I can see myself passing a college class. I can see myself getting back to work before the end of the year."
-Client

Funding for these programs provided by the Mental Health Services Act or Prop. 63. For more information visit Alameda County's MHSA Website at www.acmhsa.org. Please call the multilingual ACCESS hotline 24 hours a day/7 days a week at 1-800-491-9099 to refer someone for services.

MENTAL HEALTH SERVICES ACT PROPOSITION 63 CALIFORNIA

WELLNESS • RECOVERY • RESILIENCE

alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

Alameda County Behavioral Health's In Home Outreach Teams

Linking People To Mental Health and Community-based Services

In Home Outreach Teams (IHOT) work with the most vulnerable Alameda County residents.

IHOTs outreach to adults and transition age youth (TAY) over 18 living with the most serious mental health diagnoses who struggle to engage in services. These individuals can have a cycle of repetitive psychiatric crises that result in hospitalizations, incarcerations, and homelessness. IHOTs **do not provide treatment** but they do work with individuals and their loved ones to help link these individuals to needed community-based and mental health services.

IHOTs work with participants and their families to:

- Explain what services are available in the community to fit their needs, including information about specialty mental health care.
- Teach skills in order to engage with services in the community and mental health.
- Work towards improving their mental health and quality of life.

"It was nice to know that there were people fighting to get my [child] the help that [they] desperately needed. It was a relief knowing that I wasn't in the struggle by myself."
-Family Member

Someone is eligible for IHOT Services if they:

- Are suspected of having a serious mental illness.
- Have Medi-Cal or are eligible for Medi-Cal.
- Live in Alameda County, including those experiencing homelessness.
- Reluctant to engage in outpatient mental health services.

Anyone can refer someone to IHOT.

- Clients do not have to refer themselves to IHOT services. Members of the community can refer to IHOT, including, but not limited to family, caretakers, law enforcement, and mental health providers.
- If you or someone you know would benefit from IHOT services **please call the multilingual ACCESS hotline 24 hours a day/7 days a week at 1-800-491-9099.**