BEHAVIORAL HEALTH AND RECOVERY SERVICES
A Mental Health, Alcohol and Drug Service Organization

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Behavioral Health Director

800 Scenic Drive, Modesto, CA 95350

June 26, 2014

MHSOAC
1325 J Street, Suite 1700
Sacramento, CA 95814

Dear Colleagues:

This letter is cover for submission of the attached Final Report(s) of six (6) MHSA Innovation Projects that completed in FY13-14. They are being submitted under separate cover due to time and logistical constraints of submitting them within an annual update/three year plan.

We understand, counties must provide the MHSOAC with a final report upon completion of innovation projects and that the final report may be included in the County's annual update or its Three-Year Plan, whichever is due during the year the project is completed; the county does not have to provide, but may submit, a separate report.

Working from the BHRS Vision and Mission, MHSA General Standards, input from stakeholders, and in accordance with state guidelines, these projects were developed in FY10-11. As two (2) year demonstration projects, they were fully and successfully implemented by three (3) community-based organizations and one county agency in Stanislaus County.

An acknowledgement that you have received the document is appreciated.

If you have any questions, please do not hesitate to contact me, or Dan Rosas, MHSA Coordinator, at (209) 525-6225.

Sincerely,

Madelyn Schlaepfer, Ph.D., CEAP
Behavioral Health Director

cc: Dan Rosas

Enclosure

StanUp for Wellness!

Support Mental & Emotional Health

Stanislaus County
Behavioral Health and Recovery Services

Mental Health Services Act

Innovations Final Reports FY 2013-14

June 2014

WELLNESS • RECOVERY • RESILIENCE

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INNOVATION OVERVIEW

The primary goal of MHSA innovation projects is learning and contributing to practice in the mental health and behavioral health system. Services may be delivered as a means to achieve the learning object proposed but Innovation funds may not be used to sustain the service after the learning project is completed.

Innovation funding is unique and intended for projects that will focus on and demonstrate one of the following primary purposes; 1) ways to increase access to underserved groups, 2) ways to increase the quality of services including better outcomes, 3) ways to promote interagency collaboration, or 4) ways to increase access to services. Additionally, innovation projects are expected to contribute to learning in the mental health field by introducing new approaches, making a change to an existing mental health practice or introducing a new application of a promising community-driven approach that has been successful in a non-mental health context.

Innovation projects are developed through input from community planning processes and are reflective of the unmet need identified by inclusive and diverse stakeholder input. Project ideas typically begin with identification of dilemmas, some of which are long-standing, in the behavioral health system. Innovation funding makes it possible to try out new approaches, gather data, define and measure the success of the new approach or practice without taking funds away from other necessary services.

Since January 2010, Stanislaus County has conducted three rounds of community planning for Innovation funding that resulted in the establishment of 12 new projects. The first round of planning resulted in one project with learning goals related to stakeholder and agency partner participation in understanding public funding processes and how these community partners may contribute to decision-making. The project is entitled: Evolving a Community-Owned Behavioral Health System of Supports and Services. Concluding in FY12-13, the final report was submitted to the MHSAOAC in June 2013 and may be viewed at www.stanislausmhsa.com.

Stanislaus' second round of planning for Innovation began with the BHRS leadership team's intention to bring out ideas for projects in behavioral health that are unique to efforts in our county's commitment to community capacity building, increasing protective factors and advancement of non-stigmatizing early intervention approaches. The process began with stakeholder input in the spring of 2010. Input was solicited to identify areas that we (BHRS and our community) could significantly move forward our learning in behavioral health. Broad community participation was ensured through educational workshops conducted throughout the County. An inclusive Request for Proposal bid process resulted in selection and funding of nine (9) new Innovation projects to be operated by six unique community-based organizations and one county agency for two or three years. Six final reports are being submitted from the 2 year projects identified in round two:

- Building Support Systems for Troubled Children
- Civility School Learning Project
- Integration Innovations
- Promoting Community Wellness through Nature and Neighborhood-Driven
- Revolution Project
- Connecting Youth to Community Resources

Three additional projects from round two will complete in FY14-15.

Next steps for Stanislaus:

A third round of Innovation Projects was conducted in FY12-13 and resulted in two (2) new projects: Stanislaus County Wisdom Transformation Initiative and Garden Gate Innovative Respite. The projects were approved in June 2013 and began implementation in FY13-14. The approved project proposals may be viewed by going to www.stanislausmhsa.com.

Round four (4) of Innovation project planning is currently underway in Stanislaus County. Contributing elements to future innovation projects will include, but not be limited to: 1) lessons learned and successes from earlier projects, 2) amount of funds available, 3) emergence of new opportunities to advance learning identified through community input, and 4) health care reform and other legislative influences on the behavioral health care system in California.

Final Report

Building Support Systems for Troubled Youth

Ceres Partnership for Healthy Children

Issue

Building Support Systems for Troubled Youth Project, a 2 year project operated by Ceres Partnership for Healthy Families, focused on increasing the quality of service and creating better outcomes for troubled youth through a family resource center-based mentoring program that integrated schools, community, and family support systems to increase developmental assets in troubled youth ages 7-11 yrs.

Pre-adolescent aged youth who are experiencing behavioral struggles are at risk for higher incidences of involvement in substance abuse and other health/mental health compromising risk behaviors but not necessarily able to access the traditional mental health service system – nor do they necessarily need it. By focusing on building developmental assets early the project demonstrated ways for youth to avoid lifelong involvement with publicly funded systems. Traditional approaches by schools, mental health systems, and juvenile justice systems often take a focus toward forcing compliance, fixing the youth or family, or punishing the youth, and fail to effectively address strengthening of developmental assets.

Through this innovative collaboration, we were able to test whether the combination of program elements produces the outcome we want and need. The project will help support and accelerate county-wide transformation by addressing the learning priority of improving the well-being of children.

Project Description

This purpose of this project was to increase developmental assets of troubled youth through a mentoring program that integrated school, community, and family support systems. The learning aspect of the project was to answer questions about how these support systems integrate to support the development of assets, how long it takes to make a difference in student assets, and whether this approach has a positive impact on youth mental health indicators and the related potential to engage in risky or harmful behavior.

Students and their families participated in the program for 90 – 120 days, with most receiving support services for the 90 days. The most frequent services provided to participating families were mentoring visits with students and parent education visits with families. The mentor visited approximately 4 times per month with the student and an additional 4 times with the family. Consultations with teachers and school staff were conducted regularly throughout the project period.

Another feature of the program was expanding support systems for students and families. The most frequent supports provided were food/shelter provisions and child mental health services. A few children were connected to new role models as well. Overall, however, most families did not receive a

wide array of support connections because of difficulties that arose during the project. (See Changes During Implementation.).

Project Effectiveness

One indicator of how well a program operates is client satisfaction. This project collected feedback from some student participants (N = 10 / 30% of population) and community members with ties to the program (N = 9 / population unknown). In general satisfaction scores were positive, but there is no way to determine if these small groups represent the population as a whole.

Internal and External Developmental Assets

The most compelling evidence of program success was the consistent improvement shown in students' self-ratings of developmental assets and problem behaviors. The Student Assessment Measure (SAM), employed to assess developmental assets and potential for problem behavior, was completed at intake and again at three 30-day intervals.

Even at the start of the program most students rated themselves positively on the SAM, indicating some prior development of assets. Scores improved steadily though the mentoring and parent education process, although it took longer to start the process of building external assets. Students eventually reached high levels in both areas.

Mental Health and Potential for Risky Behavior

Increases in developmental assets were accompanied by a more positive outlook on self and family as well as higher reported control of negative behaviors and situations. Students scored higher on these SAM subscales at the end of the program than at the start. Changes were gradual across the 90-day period, but did not reach the standard for statistical reliability until the exit survey. Initially the larger deficit was in self-management, but by the end of the program, students rated themselves just as strongly in that area as in positivity.

Participating students also rated their parents/guardians as higher in control after completing the program. They said parents were clearer about rules and more likely to stick to the rules they set. These changes were linked to increased respect for parents and confidence in one's ability to change things in life.

Interpersonal Skills

Once per month the case manager rated students on 19 interpersonal skills using a 4-point scale ranging from *must teach* (1) to *mastered* (4). Students reported reliable increases each month of participation. The first rating was 49% of maximum and the final was 70%. There is one limitation that must be considered when interpreting these results. A single case manager completed all ratings and did so with knowledge of how long students had been participants in the program. His expectations could have biased the data despite efforts to be objective.

Changes During Implementation

During implementation a majority of referrals were received from Ceres Unified School District to address behavioral issues. The program hoped to serve as a linkage for families to other services such as food/shelter programs and mental health services however; as a result of parents feeling embarrassed or wanting to remain private, not all students received additional services as planned. There were parents who were reluctant to work with other agencies as a result of not being ready to deal with or address their own personal issues. Not every student in the program needed to be linked to additional services but were in need of guidance to deal with learned behavioral issues.

We became aware of the need to increase parent education and parent support services during implementation. In order to accommodate working parents and their schedules the mentor would work closely with them to allow time for them to meet. Many parents informed the mentor that they were not home very much and relied on other relatives, friends or the after school programs to be the training influences in the lives of their adolescent. Many parents could have received additional services but were not available for the mandated parent participation.

As a result of the positive outcomes we were experiencing with the adolescents we served clinicians began referring adolescents to the program. They were already providing mental health services to these adolescents but required additional opportunities for skill building and developmental assets.

What was Learned

1. One learning question to be answered through this project was what individual service or set of services make the most difference in promoting the growth of developmental assets. The strategy used to answer this question was to focus on change in a set of 14 students with low entry levels of developmental assets. Services received by students who made substantial improvement were compared with those of students who did not. Families whose children showed the most improvement received more parent education/support visits than those in the low improvement group. On the other hand, students in the low improvement group received more child mental health services. Generalizing from the results of a small group of students is always risky. Still, the results suggest that combining parent education with mentoring adds an extra boost to developing student assets.

2. A second question was how long it takes to see improvement in developmental assets. Improvement in internal assets was gradual, with increases evident at each 30-day check-in with students. This suggests that mentoring and parent support have an immediate impact on student personal well-being and the effect grows with increased services, at least for the first 90 days. Increased external assets were more delayed and first became evident after 60 days of services. Further improvement was noted at the 90 day check-in and the final assessment. The results suggest that changing a student's environment takes longer than changing internal attributes, but is equally responsive to mentoring combined with parent support.

3. The final learning question was whether this approach (mentoring and family support) has a positive impact on student mental health and the related potential for risky and harmful behavior. There is clear evidence that this approach had a positive impact. Students expressed more positivity at the end of the program than at intake, with increases noted in self-liking, respect for parents, and positive social behavior. The potential for harmful behavior was reduced as well. Students entered this program with more deficits in self-management than any other area. However, they reported stronger self-management skills after 30 days in the program and continued to improve throughout the 90 day period. Reports of saying no to bad behavior, avoiding risky places, and working our problems peacefully all increased.

Recommendations for Others

This project was a successful learning experience. The approach used had a positive impact because it allowed us to concentrate on increasing developmental assets of troubled youth by providing one-on one mentoring, parent education and family support services. It is important to have age appropriate educational videos which cover anger management skills, social skills, coping and communication skills. These videos should include training guides for the youth as well as a parent education component. It is recommended future implementers create a directory of all local family resources; food banks, housing, clothing and public health services to provide to families in need of additional support.

Developing partnerships with the local school district and school officials to educate them about the program and the referral process is an important key. We recommend future implementers acquire appropriate incentives and set in place a procedure for distribution. Partnerships with local civic groups and businesses can help support the program with the purchase of incentives. Reinforcement incentives when used properly as positive consequences can help build new appropriate behavior in youth.

It is essential for future implementers to plan for patience, present a caring position and practice perseverance.

Continuation of Project

Due to lack of funding we are not able to continue this project. We may be able to serve a few youth per year through our Family Resource Centers family case management services. We will also meet with our partners in education to explore future funding opportunities, considering the positive outcomes of the project.

Reports Developed

An independent program evaluator, Jamie McCreary, Ph.D., designed and analyzed data collection systems for this project. The final report is attached to this document.

Evaluation Report: Building Support Systems for Troubled Youth

Jamie McCreary, Ph.D.
Program and Organization Development Consultant

This report summarizes program evaluation results for an innovative project intended to increase developmental assets of troubled youth through a mentoring program that integrated school, community, and family support systems. The project was sponsored by Behavioral Health and Recovery Services of Stanislaus County and implemented by Ceres Partnership for Healthy Children, a family resource center operated by Center for Human Services. The project was funded to answer questions about how these support systems integrate to support the development of assets, how long it takes to make a difference in student assets, and whether this approach has a positive impact on mental health indicators and the related potential to engage in risky or harmful behavior.

Data employed in this evaluation included student outcome files (N=30), student satisfaction forms (N=10), and community satisfaction surveys (N=9). Information for student outcome files were extracted from case management files with student and family names redacted:

1. Intake interview by Ceres Partnership for Healthy Children staff
2. Stanislaus Comprehensive Family Assessment
3. Monthly progress reports of family and student support services, student behavior, and individual skill level assessment (4 reports per student)
4. Monthly student surveys to assess developmental assets, mental health, and potential for harmful and/or risky behavior (baseline and 3-4 surveys per student)

Contents

Summary of Learning Results

Intensive mentoring and parent support effectively increased developmental assets and interpersonal skills in a group of 30 children who participated in the program. A comparison of group means at the start and conclusion of the program revealed a statistically reliable increase in both internal and external assets. These results were confirmed for the three factors underlying the measure used to assess developmental assets: Positivity about Life, Self-Management Skills, and Perceived Parental Authority. A comparison of monthly assessment of student interpersonal skills by the case manager also revealed steady improvement across the term of the program.

Integration of Support Services. The most frequent services provided to families were mentoring visits with students and education/support visits with parents. Analysis of a small group of children who entered the program with poorly developed assets suggests that increased support to parents enhances the effect of mentoring. The parents whose children showed the most improvement by the end of the program spent more time with the mentor.

Length of Time for Improvement. Improvement in internal assets was gradual, with increases evident at each 30-day check-in with students. This suggests that mentoring and parent support have an immediate impact on student personal well-being and the effect grows with increased services, at least for the first 90 days. Increased external assets were more delayed and first became evident after 60 days of services. Further improvement was noted at the 90 day check-in and the final assessment. The results suggest that changing a student's environment takes longer than changing internal attributes, but is equally responsive to mentoring combined with parent support.

Mental Health/Risky Behavior. There is clear evidence that this approach has a positive impact on mental health. Students expressed more positivity at the end of the program than at intake, with increases noted in self-liking, respect for parents, and positive social behavior. The potential for harmful behavior was reduced as well. Students entered this program with more deficits in self-management than any other area. However, they reported stronger self-management skills after 30 days in the program and continued to improve throughout the 90 day period. Reports of saying no to bad behavior, avoiding risky places, and working our problems peacefully all increased.

Program Evaluation

Who was served by the project?

Thirty students, 26 boys and 4 girls, participated in the mentoring program. Students ranged in age from 7 through 11, with a mean age of 9.1 years (SD = 1.3). Most had parents/guardians living in the home, but more lived with a female parent or guardian (90%) than with a male (50%).[1] All participants lived with other children as well; the mean number of children living in the home with the participating students was 3.0 (SD = 1.3).

The Stanislaus Comprehensive Family Assessment (SCFA) results for participating families are shown in Table 1. The most frequent family concerns were about conflict resolution, school performance and/or attendance, child discipline, and employment/education.

Table 1: Results of SCFA

N=28	Concerns Identified	
	Number of Families	**Percent of Families**
Conflict resolution	21	75.0%
School performance and attendance	11	39.3%
Child discipline	5	17.9%
Employment and education	5	17.9%
Income	4	14.3%
Food and shelter	3	10.7%
Support systems	2	6.7%
Child supervision	2	6.7%
Child's behavior in response to adult intervention	2	6.7%
Substance abuse	1	3.6%

How much did the project do?

The most frequent services provided to participating families were mentoring visits with students and parent education visits with families. Table 2 shows the means number of contacts in each phase of the project, listing only contacts that lasted 30 minutes or longer. Overall, more contacts were made in the first 30 days, approximately one per week. The frequency dropped off to 3 times per month in subsequent time periods.

[1] Very few participants were in foster care (n=1), were being raised by extended family (n=2) or were diagnosed with ADHD (n=2).

Table 2: Contacts with Students and Families				
N=30	Number of Mentoring Contacts		Number of Parent Education Contacts	
	Mean	SD	Mean	SD
First 30 days	4.47	1.33	4.30	1.56
Second 30 days	3.73	1.14	3.63	1.21
Last 30 days	3.63	1.03	3.30	1.18

Another feature of the program was expanding support systems for students and families. Table 3 shows the distribution of support services. The most frequent supports provided were food/shelter provisions and child mental health services. A few children were connected to new role models as well. Overall, however, most families did not receive a wide array of support connections.

Table 3: Support System Connections		
N=30	Support Provided	
	Number of Families	Percent of Families
Food/shelter provisions	9	30.0%
Child mental health services	8	26.7%
Role model (community)	3	10%
Role model (family)	1	3.3%
Family counseling	1	3.3%
Parent mental health services	0	0%
Employment services	0	0%
Child recreational activities	0	0%
Parent substance abuse services	0	0%

How well did the project provide support?

One indicator of how well a program operates is client satisfaction. This project collected feedback from some student participants (N = 10 / 30% of population) and community members with ties to the program (N = 9 / population unknown). In general satisfaction scores were positive, but there is no way to determine if these small groups represents the population as a whole.

Table 4 displays the frequency distribution for the student survey. In addition, total scores were calculated for each student across all questions, weighting the responses 1 through 4 in ascending order. The mean score for student satisfaction was 16.5 (SD = 3.47); this score is 82.5% of maximum.

Table 4: Student Satisfaction Survey Results				
N=10	Strongly Disagree	Disagree	Agree	Strongly Agree
The program helped me do better at home.	-	-	70%	30%
The program helped me do better in school.	-	-	50%	50%
I like spending time with my mentor.	10%	-	40%	50%
I am glad I took part in this program.	20%	-	20%	60%
This is a good program for kids like me.	10%	10%	30%	50%

Table 5 provides a summary of responses to the community survey. The majority of surveys were completed by school staff (n=5) and the remainder by representatives of businesses or partner agencies (n=2), and parents (n=2). All but one respondent said they had at least a moderate amount of contact with the program. Total scores were calculated for each person, weighting the responses 1 through 4 in ascending order. The mean score for satisfaction was 25.1 (SD = 3.44); this score is 89.6% of maximum.

Table 5: Community Satisfaction Survey Results					
N=9	Strongly Disagree	Disagree	Agree	Strongly Agree	Not Enough Information
The program benefits the Ceres community.	11.1%			88.9%	-
The program reaches out to the kids who need help.	-	-	22.2%	77.8%	-
Program staff members are respectful.	-	-	25.0%	75.0%	-
Youth Guide staff members keep me up to date.	-	-	25.0%	75.0%	-
The program was explained to me clearly.			33.3%	66.7%	
This program helps youth behave better.	-	-	44.4%	55.6%	-
This program helps youth do better in school.	-	-	33.3%	66.7%	-

Is anyone better off from participating in the program?

Internal and External Developmental Assets

The most compelling evidence of program success was the consistent improvement shown in students' self-ratings of developmental assets and problem behaviors. The Student Assessment Measure (SAM), employed to assess developmental assets and potential for problem behavior, was completed at intake and again at three 30-day intervals[2]. This instrument presents 17 statements related to social, emotional, and family life and asks the student to rate agreement using a 4-point scale ranging from *strongly disagree* (1) to *strongly agree* (4). Questions were written to assess internal development assets (8 questions), external developmental assets (6 questions) and potential for risky or harmful behavior (3 questions). See Appendix A for a copy of the SAM and Appendix B to see how SAM questions linked to developmental assets.

Internal reliability checks indicated that questions for internal and external assets could be summed to calculate a valid score, but the questions related to risky and harmful behavior could not. Table 6 shows mean scores for developmental assets at intake (baseline), 30 days later, 60 days later, and 90 days later (exit). ANOVA indicated that the program was effective: both internal and external assets grew during

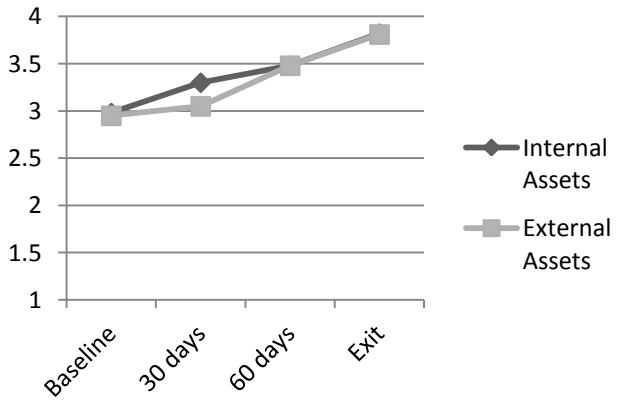
[2] Several students extended their participation to 120 days because of an interruption of services during the summer. In these cases the final survey was used to assess *exit* results instead of the third survey.

the program. Changes were gradual across the 90-day period and reached the standard for statistical reliability in the final 90 days.

Table 6: SAM Developmental Asset Results					
N=30	**Baseline**	**30 days**	**60 days**	**Exit**	**Statistical Differences**
Internal Assets					Exit > Baseline
Mean	**2.98**	3.30	3.48	**3.82**	
Standard Deviation	*0.67*	*0.56*	*0.36*	*0.35*	
External Assets					Exit > Baseline
Mean	**2.95**	3.05	3.48	**3.81**	
Standard Deviation	*0.61*	*0.58*	*0.47*	*0.23*	

Figure 1 shows the process of change in perspective. Mean scores in each area can range from 1 to 4. Even at the start of the program most students rated themselves on the positive end of the scale, indicating some prior development of assets. Scores improved steadily though the mentoring and parent education process, although it took longer to start the process of building external assets. Students eventually reached high levels in both areas.

Figure 1
Mean Scores for Internal and External Assets



Mental Health and Potential for Harmful/Risky Behavior

Examining the outcomes through a different lens provides additional information about the effectiveness of this program. Factor analysis was used to identify the underlying structure of the SAM. This instrument was designed to measure internal and external assets, but the way students answered tells us even more about what changed through participation in this program.

Factor analysis of all SAM data revealed that the scale actually measures three statistically overlapping attributes. (1) Positivity about Life, (2) Self-Management of Negative Behaviors, and (3) Perceived Parental Control. [3] Questions loading highest on each factor are shown in Appendix C.

[3] One item, "I spend time with grownups who are not my parents", did not factor on these three dimensions.

1. *Positivity about Life*, the first and most powerful factor, grouped questions from all three areas targeted during survey design. The common factor underlying this group appears to be positivity about personal, social, and family life.
2. *Self-Management*, the second factor, reflects the ability to manage one's own behavior. It combined questions focused on risky and harmful behavior with internal developmental assets. Optimism about the future also was associated with questions about self-management.
3. *Perceived Parental Control* contains subset of questions designed to assess external developmental assets. Interestingly, one question from the internal assets list also factored in this group. Parental control was associated with having a personal sense of control over things that happen in life.

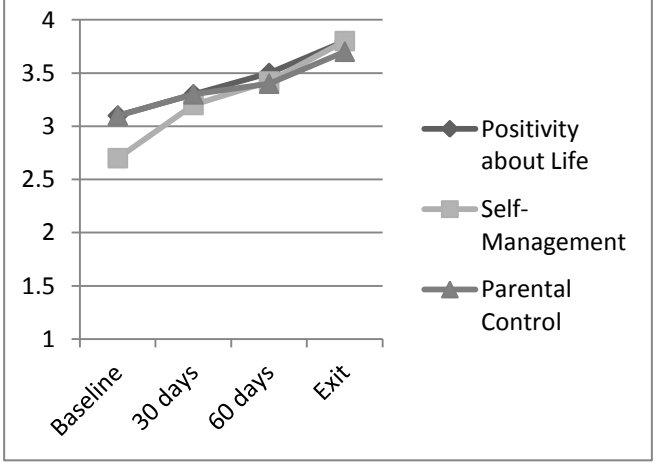
Responses to questions falling into each of these three areas were averaged to yield an overall score for each reporting period. Table 7 shows mean scores at intake (baseline), 30 days later, 60 days later, and 90 days later (exit). ANOVA revealed differences between the baseline and exit scores on all three factors. Changes were gradual across the 90-day period, but did not reach the standard for statistical reliability until the exit survey.

Table 7: SAM Factor Results

N=30	Baseline	30 days	60 days	Exit	Statistical Differences
Positivity About Self And Family					Exit > Baseline
Mean	**3.11**	3.28	3.51	**3.76**	
Standard Deviation	*0.66*	*0.56*	*0.49*	*0.29*	
Self-Management Of Negative Behavior					Exit > Baseline
Mean	**2.69**	3.19	3.42	**3.78**	
Standard Deviation	*0.67*	*0.64*	*0.48*	*0.25*	
Perceived Parental Control					Exit > Baseline
Mean	**3.17**	3.25	3.38	**3.67**	
Standard Deviation	*0.73*	*0.69*	*0.52*	*0.32*	

As seen in Figure 2, participants in this program scored higher in Positivity about Life, Self-Management Skills, and Perceived Parental Control at the end of the program than at the beginning. The largest initial deficit was in Self-Management, but by the end of the program, students rated themselves just as positively in that area as in others.

Figure 2
Mean Scores for SAM Factors



Interpersonal Skills

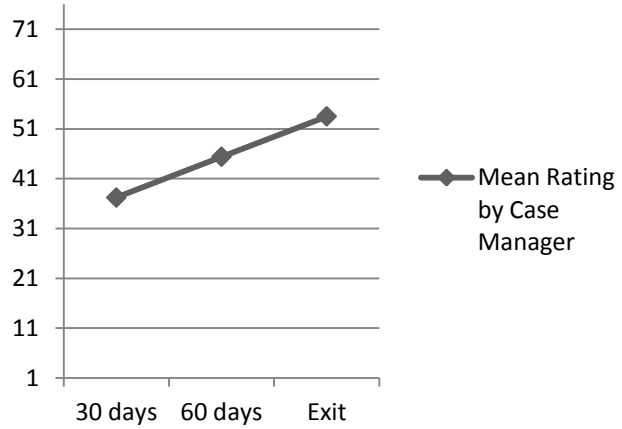
Once per month the case manager rated students on 19 interpersonal skills using a 4-point scale ranging from *must teach* (1) to *mastered* (4). An overall score for each month was calcuated by summing ratings across skill areas. The highest possible score was 76. The skills rated are shown in Appendix D. Table 8 shows mean scores across the three months of the program.

Table 8: Interpersonal Skill Assessment Results				
N=30	**30 days**	**60 days**	**90 days**	**Statistical Differences**
Mean	**37.24**	**45.38**	**53.45**	90 days > 60 days > 30 days
Standard Deviation	*1.95*	*2.11*	*2.06*	

As shown in Figure 3, improvement was steady throughout the course of the program. Students reported reliable increases each month of participation. The first rating was 49% of maximum and the final was 70%.

There is one limitation that must be considered when interpreting these results. A single case manager completed all ratings and did so with knowledge of how long students had been participants in the program. His expectations could have biased the data despite efforts to be objective.

Figure 3
Mean Scores for Interpersonal SKills



What made a difference?

One learning question to be answered through this project was what individual service or set of services make the most difference in promoting the growth of developmental assets. Answering this question presents a challenge for several reasons. First, the number of mentoring visits and parent education sessions far outnumbered the number of other support services. Given the positive results of the project, it seems likely that these services made a difference for students and their families. However, there is relatively little variation in the number of visits across students, making it difficult to quantitatively demonstrate that effect.

Second, the amount of change possible depends on the initial score at intake. For students already at the top of scale, no change can be evident even if the program has positive impact. This was the case for 4 participants in the sample, roughly 13% of the sample. In addition, there is a possible confound at the lowest end of the scale. These students can make the most progress statistically and they also are

the most likely to receive additional support services. A correlation between progress and services may make it appear that services supported the growth, even though that may not be the case.

The strategy adopted as a means of bypassing this problem was to compare at-risk students who made substantial improvement with those who did not. The sample was limited to the 14 students whose mean score across all SAM question was less than 3.00 on a scale of 1 to 4. From that sample the students with less that 1.00 change during the project (n=4) were identified. These participants were matched with students most similar to them in starting scores who had shown substantial improvement in SAM scores over the course of the program (n=5).

Table 9 compares the students selected for analysis to assess the closeness of the match between low and high improvement students. The low improvement group had a reliably higher starting score than the high improvement students, but ended the program with a statistically similar final score. The amount of change across the course of the program (difference between the intake and final SAM scores) was statistically higher for the high performing group.

Table 9: Match Between High and Low Improvement Groups

	Low Improvement Group	High Improvement Group	Statistical Differences
Number	4	5	
Mean Baseline SAM Score	2.91	2.49	Low Group > High Group
Mean Final SAM Score	3.60	3.66	No Difference
Mean Change Score	0.69	1.21	High Group > Low Group

Table 10 compares the services received by the two groups. ANOVA revealed two statistically reliable differences between the groups. Families whose children showed the most improvement received more parent education/support visits than those in the low improvement group. On the other hand, students in the low improvement group received more child mental health services. Generalizing from the results of a small group of students is always risky. Still, the results suggest that combining parent education with mentoring provides adds an extra boost to developing student assets.

Table 10: Services to High and Low Improvement Groups

	Low Improvement Group	High Improvement Group	Statistical Differences
Mean number of mentoring visits	10.5	13.4	-
Mean number of parent sessions	5.0	8.6	High Group > Low Group
Mean number of new family role models	0	0	-
Mean number of new community role models	0	0.6	-
Child mental health services	0.8	0	High Group < Low Group
Family counseling	0	0	-
Parent mental health services	0	0	-
Food/shelter assistance	0.8	0.6	-

Appendix

A. The Student Assessment Measure (SAM)

Please circle one answer on each line to complete the sentence.

I ___ like the way my parents talk to me	Almost never	Sometimes	Often	Almost always
I ___ hand in my homework on time.	Almost never	Sometimes	Often	Almost always
I ___ destroy or harm things.	Almost never	Sometimes	Often	Almost always
I ___ like who I am.	Almost never	Sometimes	Often	Almost always
I ___ spend time with grown-ups who are not my parents.	Almost never	Sometimes	Often	Almost always
I ___ think before I act.	Almost never	Sometimes	Often	Almost always
My parents ___ do the right thing.	Almost never	Sometimes	Often	Almost always
I ___ make new friends.	Almost never	Sometimes	Often	Almost always
I can ___ work things out when I get angry.	Almost never	Sometimes	Often	Almost always
I ___ look up to the grown-ups in my life.	Almost never	Sometimes	Often	Almost always
The future ___ looks good to me.	Almost never	Sometimes	Often	Almost always
I ___ can work out problems with other kids.	Almost never	Sometimes	Often	Almost always
I ___ say no to people who ask me to break the rules.	Almost never	Sometimes	Often	Almost always
My parents ___ set rules for me.	Almost never	Sometimes	Often	Almost always
I ___ avoid places where I might get in trouble.	Almost never	Sometimes	Often	Almost always
My parents ___ stick to the rules they set up for me.	Almost never	Sometimes	Often	Almost always
I ___ think I can change things in my life.	Almost never	Sometimes	Often	Almost always

B. Student Assessment Measure (SAM) Questions and Developmental Assets

Results Areas and Indicators	Survey Questions[4]
EXTERNAL ASSETS	
A. Parents will communicate positively with the child. (DA1)	1. I like the way my parents talk to me
B. The child will receive support from adults other than parents. (DA3)	2. I spend time with grown-ups who are not my parents.
C. Parents will model positive responsible behavior for the child. (DA14)	3. My parents do the right thing.
D. Adults who provide support to the child will model positive, responsible behavior. (DA14)	4. I look up to the grown-ups in my life.
E. The family will develop clear rules for the child. (DA11)	5. My parents set rules for me.
F. The family will develop and enforce consequences for the child's behavior. (DA11)	6. My parents stick to the rules they set up for me.
INTERNAL ASSETS	
A. The child will hand in homework on time. (D 23)	7. I hand in my homework on time.
B. The child will think about decisions. (DA 32)	8. I think before I act.
C. The child will be able to make friends. (DA 33)	9. I make new friends.
D. The child will know how to resolve problems with others without getting in trouble. (DA 36)	10. I can work out problems with other kids.
E. The child will be able to stay away from people likely to get him or her in trouble. (DA 35)	11. I avoid places where I might get in trouble.
F. The child will have a sense of control over the things that happen in life. (DA 37)	12. I think I can change things in my life.
G. The child will have a positive view of the self. (DA 38)	13. I like who I am.
H. The child is optimistic about his/her personal future) (DA 40)	14. The future looks good to me.
POTENTIAL FOR RISKY/HARMFUL BEHAVIOR	
A. The child will engage in safe behavior.	15. I destroy or harm things. (Reverse scored)
B. The child will be able to manage anger effectively.	16. I can work things out when I get angry.
C. The child will be able to "say no" to doing wrong or dangerous things.	17. I say no to people who ask me to break the rules.

[4] Responses: Almost never, Sometimes, Usually, Almost always

C. Underlying Factors of the Student Assessment Measure (SAM)

1. *Positivity about Life*, the first and most powerful factor, grouped questions from all three areas targeted during survey design. This factor appears to measure positivity across personal, social, and family life.

    - I like who I am. (Internal)
    - I [do not] destroy or harm things. (Risky behavior)
    - I make new friends. (Internal)
    - I like the way my parents talk to me. (External)
    - I look up to the grown-ups in my life. (External)
    - I hand in my homework on time. (Internal)

2. *Self-Management*, the second factor, combines questions focused on risky and harmful behavior with internal developmental assets. This factor reflects the ability to manage one's own behavior. Optimism about the future also was associated with questions about self-management.

    - I say no to people who ask me to break the rules. (Risky behavior)
    - I avoid places where I might get in trouble. (Internal)
    - I can work things out when I get angry. (Risky behavior)
    - I can work out problems with other kids. (Internal)
    - I think before I act. (Internal)
    - The future looks good to me.(Internal)

3. *Perceived Parental Control* contains a subset of questions designed to assess external developmental assets. Interestingly, one question from the internal assets list also factored in this group. Parental control was associated with having a personal sense of control over things that happen in life.

    - My parents stick to the rules they set up for me.(External)
    - My parents set rules for me. (External)
    - My parents do the right thing. (External)
    - I think I can change things in my life. (Internal)

D. Interpersonal Skill Ratings

	1 Must Teach	2 Practicing	3 Improving	4 Mastered
Following instructions				
Accepting consequences				
Accepting NO for an answer				
Negotiating				
Making a request				
Problem solving				
Volunteering				
Resisting peer pressure				
Peer reporting				
Getting someone's attention				
Asking for help				
Apologizing				
Greeting skills				
Giving constructive criticism				
Accepting constructive criticism				
Giving compliments				
Accepting compliments				
Conversation skills				
Appropriate disagreeing				

Final Report

Civility Learning Project
Keyes Union School District

Issue

Civility is a key component to the emotional health and well-being of people living and working in groups. It is also something over which we have a great deal of control. Civility is an action and is demonstrated through our choices. Youth develop healthier emotional and social coping skills while in a positive and civil environment. Schools represent a perfect opportunity to impact young people by teaching them about civility. Skills and attitudes learned now turn into habits and community culture later.

In a 2002 Pew Survey 79% of respondents reported a lack of courtesy and respect as a serious national problem and 61% stated it was a worsening trend as time passed. This is despite the fact that civility is regarded as an important aspect of social interactions.

A similar survey found the following:

- 83% reported it was very important to work in a civil environment.
- 25% reported they felt their workplace has become less civil in the last 12 months.
- 37% reported decreased effort at work attributed to working environment.
- 13% used health care / employee assistance benefits due to stress related issues.
- 70% contemplated changing jobs because of incivility in the workplace.

People desire an improved quality of life for all members of their community. Traditional models for providing school-based support for students have a primary focus on “solving the problem” or “fixing the student” with much less focus on connecting the individual to his/her natural support community.

Focusing efforts on deliberate civility is a logical way to improve the emotional health and well-being of young people in our community.

Project Description

The Choose Civility Learning Project was designed to find out if building a culture of civility would increase positive interactions across a school community, and further, if these cultural changes would impact the mental, social, and emotional well-being of youth. The project was implemented by Center for Human Services (CHS) in the Keyes Union School District in rural California. Activities were designed to increase awareness and practice of courtesy, kindness, and consideration among students and school staff.

Improving emotional health and well-being at Keyes Elementary and Spratling Middle School with civility activities and strategies at the student, classroom, parent, and campus level was what the Choose

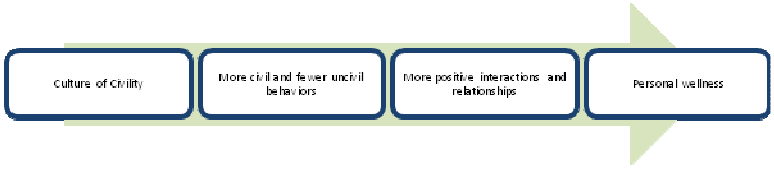
Civility Learning Project set out to do. The project was designed to improve developmental assets and connections for children attending Keyes schools, improve teacher/school personnel productivity and relationships and improve the overall positivity of the campus cultures.

The Choose Civility Learning Project introduced a new approach for building school capacity to promote emotional wellness. A chief goal of the project coordinators was to implement a project that could be replicated in other schools in the county. This was particularly relevant at the county level as the Stanislaus County Office of Education's (SCOE) countywide initiative was focused on civility education at the time.

Strategies used to accomplish the capacity building goal and answer the learning question included training for staff in methods to change the culture on campus and school staff in-service days for feedback gathering, communication of goals, and training in classroom based civility activities. A task force of CHS and school district staff was also established to develop strategies and steer the implementation process. Direct student based strategies included civility themed art projects, classroom presentations, school wide assemblies, formation of campus clubs and one-on-one skill building for individual students on an as needed basis.

Project Effectiveness

The evaluation of this project focused on four variables related to civility. We hypothesized a chain of causality among these variables based on social psychological research. The project impacted the first two stages of cultural change. The results are impressive for a relatively short program.



There is clear evidence of a culture shift valuing civility. Statistically reliable changes were evident on four of seven indicators, with gains of 15 – 20%. Staff rated civility as more important for the school at the end of the first semester and those gains were maintained. They also reported increased attention to civility on campus and more time at campus-wide staff meetings devoted to the issue. Certificated staff became more willing to invest work time in civility activities in the daily routine. Although there is room for continued growth, the foundation has been established for a culture of civility.

As expected, the cultural shift was reflected in social behavior. Uncivil behavior among students decreased through the course of this project. Depending on grade level, students reported reductions in rudeness, argumentativeness, and exclusion of others from activities. There is also tentative evidence of reduced arguing and rumor-spreading among staff.

The positivity of relationships among different groups within the school community did not change over the course of this project. Generally, a reduction in negative behavior sets the stage for developing more positive, cooperative relationships. Building relationships, however, takes many repeated

interactions over time. There likely has not yet been enough time to reap the benefits of the cultural change that occurred.

Still, there is some promising evidence. The perceptions of school staff have shifted in a positive direction. There was a notable change in how many felt respected by other staff and the number who experienced a sense of teamwork with the parents with whom they interacted. Also, middle school students, often a challenging group, showed reliable improvements in how much they like the way adults relate to them at school.

There is no evidence of a one-year change in the wellness of students at Keyes Union School District. Although there was a reduction in reported stress by students in grades 3-5, other measures remained stable. Cultural changes, if sustained, may be reflected in the future wellness of students in Keyes.

Changes During Implementation

When the project began select school staff met with CHS staff to discuss implementation strategies and introduction of the project to school district staff as a whole. It was agreed that a district in-service day (student non-attendance day) would be the best tool to use to engage the entire staff and gather their feedback while also communicating the purpose of the project. With the support of district administration the school board agreed to cancel school for one day to allow time for the in-service, dubbed “Civility Kick-Off” day by project staff. A baseline survey to measure perceptions of civility was administered to school staff as well as students ahead of time and reviewed with staff at the in-service day.

At the Civility Kick-Off, four Focused Conversations were facilitated with over 90 school district staff present. The Focused Conversation Method is a logical process that directs a conversation to flow from surface to depth. A facilitator leads the conversation through a series of questions at four levels to identify facts and emotional responses to situations, as well as define meaning and provide resolution to the discussion topic. Two of these Focused Conversations were also facilitated with parent groups at a later date. These conversations proved essential as they provided all district staff with the opportunity to provide detailed input into the process. It also allowed CHS staff to communicate project goals and strategies to all the staff participants at once.

Results from the Focused Conversations, and the staff and student surveys indicated a need to focus more attention to cultivating a culture of civility in school staff than originally proposed. As a result, select school staff attended a training on effecting culture change on school campuses. A school based relationships expert was engaged to provide training and technical assistance to school staff as they adapted their professional habits towards a culture of civility.

The task force explored strategies that would have a broader, environmental impact on the campuses. Students at both schools participated in Rachel’s Challenge, an interactive assembly style presentation designed to teach kindness and civility goals to students and parents. It is based on the life and journal entries of Rachel Scott, a teen killed in the Columbine massacre. Additionally, elementary aged students

received civility themed presentations throughout the school years and were encouraged to write down acts of kindness or civility on paper chain links and connect their links with others in their class. Ultimately, each class linked their paper "chain of kindness" together, stretching over a mile long, long enough to reach the middle school. Wristbands with the message, "Start a Chain Reaction", were distributed to students, staff and parents.

The Keyes Union School District Superintendent initiated a district-wide book study on the book, Mindset – The New Psychology of Success. The book focuses on the difference between approaching conflict and problems with either a "fixed" or "growth" mindset. In a conversation with the Superintendent, she expressed the goal of having this book study to positively impact the staff/student, staff/parent, and staff/staff relationships on and off campus. Visual reminders reinforcing the concepts of a growth mindset were placed throughout the campuses.

What was Learned

Two of the Choose Civility Learning Project evaluation areas focused directly on learning.

- Learn if building school capacity to promote civility increases positive interactions.
- Learn about the impact of civility on the mental/behavioral/ emotional wellness of children, teachers/staff, and parents.

With these target impact areas identified, project implementation focused on capacity building of students and school staff to improve the overall positivity of their respective campuses.

Introducing civility themed activities and communication does impact the emotional health and well-being of students and staff in a school setting. The Choose Civility Learning Project worked with school staff from the first step in the planning stage to identify strategies they felt would be successful within their district. This method of engagement required great commitment on the part of all participants but was more effective than following a set program or curriculum. Many staff members remarked throughout the planning and implementation process that they did not want this project to become "just another binder", referring to the myriad of programs available to schools to purchase. One staff member involved in the planning task force stated, "If you own the process, you own the outcome." This sentiment demonstrates the enthusiasm for and potential success of a cooperative approach over a purchased "push in" method.

Observed incidents of negative behavior decreased during implementation of the project. The most significant change in observed student behavior occurred after the Rachel's Challenge assemblies. Incidents of observed negative interactions between students decreased and positive interactions increased. These observations, tracked by CHS staff on campus, were corroborated by survey results.

After their Rachel's Challenge assembly experience, students at Spratling Middle School formed a club based on Rachel's Challenge goals. Club participants formed a "Welcoming Committee" and "Special Projects" subgroups to encourage their peers and improve emotional well-being on campus. Although

the club had an adult advisor the projects and activities were student initiated and student led. This demonstrated a measure of success in capacity building.

Reinforcement of the importance of civility activities on campus and attention to civility throughout the school day and in staff meetings helped to maintain awareness of civility as a significant contributor to emotional well being.

Recommendations for Others

This project is recommended to any group of like-minded people who identify as a community. The long term benefits of civility, kindness and altruism to the emotional health and well-being of individuals are worth the effort required to realize them.

During the early stages of project planning facilitators should openly acknowledging the existence of ongoing obstacles. Changing the culture of a school, workplace or community requires time and deliberate effort. In addition to effort, exploring ways to become more civil involves courage. It requires an individual to acknowledge that the system in which they function is imperfect and that they, personally, contribute to that imperfection through their behavior. There were many times during the Choose Civility Learning Project that participants became discouraged, frustrated and overwhelmed. A partner group or individual working closely with participants will benefit the project by offering a more objective perspective and also by championing the project when participants become discouraged.

It is important to keep in mind that many professionals have had the experience of management endorsing one philosophy after another as fads come and go. As a capacity building project focused on a positive culture shift, the project must be presented and developed with a sense of teamwork and cooperation. Participants must be willing to commit to devoting the necessary time and energy to learn skills to become more civil and teach those skills to others. If this commitment is not maintained and nurtured the project will not be successful.

CHS staff reported that over the course of the project they developed a sense of comraderie with the Keyes School District and a genuine respect for the families and staff who comprise that school community.

Continuation of Project

The Choose Civility Learning Project is not continuing under another funding source, however, the Keyes Union School District is continuing some of the practices started during the project.

Reports Developed

An independent program evaluator, Jamie McCreary, Ph.D., designed and analyzed data collection systems for this project. The final report is attached to this document.

Evaluation Report: Civility School Learning Project

Jamie McCreary, Ph.D.
Program and Organization Development Consultant

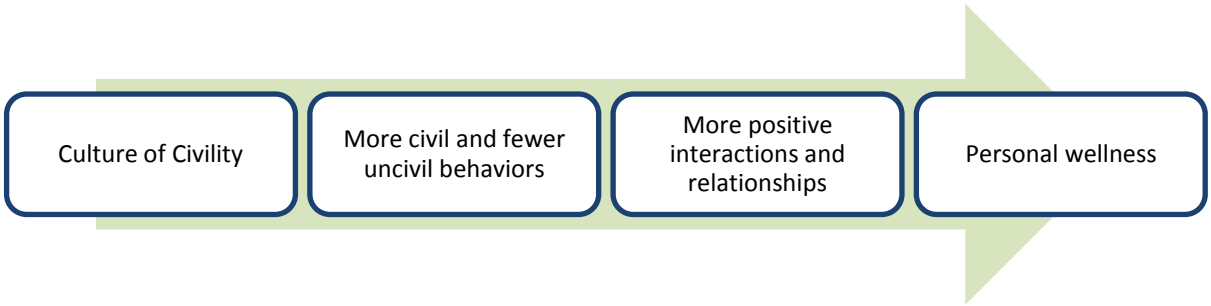
The Civility Learning Project was sponsored by Behavioral Health and Recovery Services of Stanislaus County to find out if building a culture of civility would increase positive interactions across a school community, and further, if these cultural changes would impact the mental, social, and emotional well-being of youth.

The project was implemented by Center for Human Services (CHS) in the Keyes Union School District in rural California. Activities were designed to increase awareness and practice of courtesy, kindness, and consideration among students, and school staff. This report summarizes program evaluation results, addressing the questions below. It complements observations by CHS program staff about what did (and did) not work to accomplish these outcomes. These observations are reported elsewhere.

- Did the Civility project establish a culture of civility ?
- Did the Civility project promote positive interactions across the school community?
- Did the Civility project improve the mental, social, and emotional well-being of students?

Summary of Results

The evaluation of this project focused on four variables related to civility. We hypothesized a chain of causality among these variables based on social psychological research. Of course, it was not possible to fully test this causal chain within the confines of the present learning project.



Did the Civility project establish a culture of civility ?

There is clear evidence of a culture shift valuing civility. Statistically reliable changes were evident on four of seven indicators, with gains of 15 – 20%. Staff rated civility as more important for the school at the end of the first semester and those gains were maintained. They also reported increased attention

to civility on campus and more time at campus-wide staff meetings devoted to the issue. Certificated staff became more willing to invest work time in civility activities in the daily routine. Although there is room for continued growth, the foundation has been established for a culture of civility.

Survey data do not provide clear evidence about whether the school has accepted ownership of the cultural change. While certificated staff increased the amount of time they are willing to invest in civility activities, the amount of time spent on civility issues at grade-level meetings remained the same. Continued commitment by staff is necessary for the cultural shift to be maintained once the grant ends.

As expected, the cultural shift was reflected in social behavior. Uncivil behavior among students decreased through the course of this project. Depending on grade level, students reported reductions in rudeness, argumentativeness, and exclusion of others from activities. There is also tentative evidence of reduced arguing and rumor-spreading among staff.

Did the Civility project promote positive interactions across the school community?

The positivity of relationships among different groups within the school community did not change over the course of this project. Generally, a reduction in negative behavior sets the stage for developing more positive, cooperative relationships. Building relationships, however, takes many repeated interactions over time. There likely has not yet been enough time to reap the benefits of the cultural change that occurred.

Still, there is some promising evidence. The perceptions of school staff have shifted in a positive direction. There was a notable change in how many felt respected by other staff and the number who experienced a sense of teamwork with the parents with whom they interacted. Also, middle school students, often a challenging group, showed reliable improvements in how much they like the way adults to them at school.

Did the Civility project improve the mental, social, and emotional well-being of students?

There is no evidence of a one-year change in the wellness of students at Keyes Union School District. Although there was a reduction in reported stress by students in grades 3-5, other measures remained stable. Cultural changes, if sustained, may be reflected in the future wellness of students in Keyes.

Did the Civility project establish a culture of civility ?

As the culture of a social group shifts, one can observe changes in what people value and prioritize in daily activities. The schools' capacity to move towards a culture of civility was assessed through questions about the importance and visibility of civility activities and about time spent promoting civility on campus. Reports were submitted by teachers, classified staff, and administrative staff.

There is clear evidence of a culture shift valuing civility. Project staff selected 7 indicators to assess progress towards a culture of civility and 4 showed statistically reliable change over the course of the project, showing gains of 15 – 20%.

Figure 1 shows the percent of respondents who gave rated civility as a high priority and saw attention given to it on campus.[1] As the project progressed, school staff rated civility as increasingly important. They also reported increased attention to civility on campus.

Staff were asked how often 10 minutes or more were devoted to civility issues at meetings. Figure 2 displays results. The frequency of discussion increased at campus-wide meetings, but not at grade-level ones.

Figure 1: Culture Change Indicators

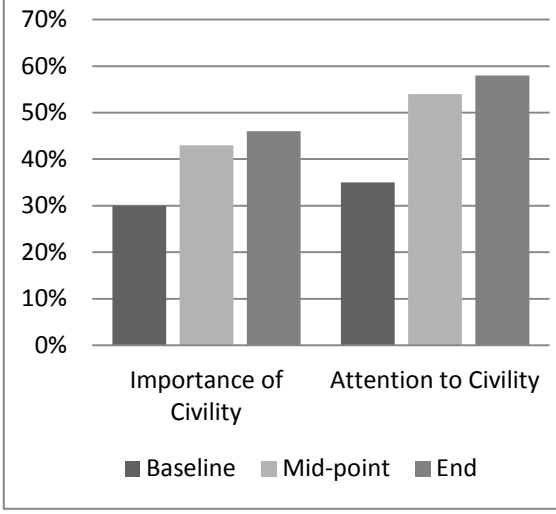
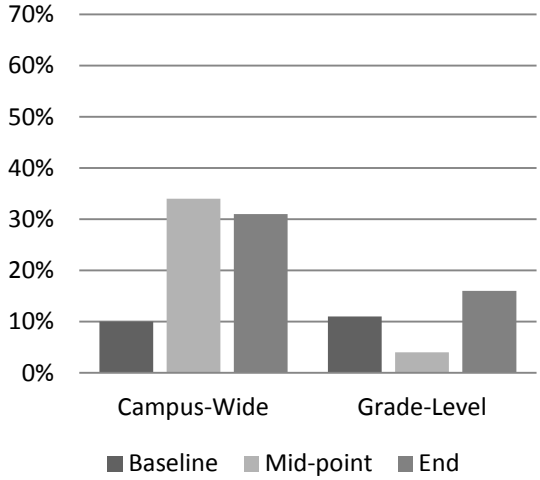
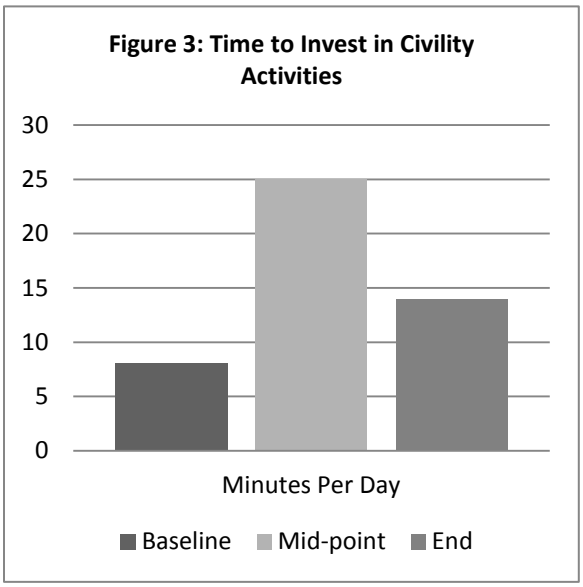


Figure 2: Discussion of Civility



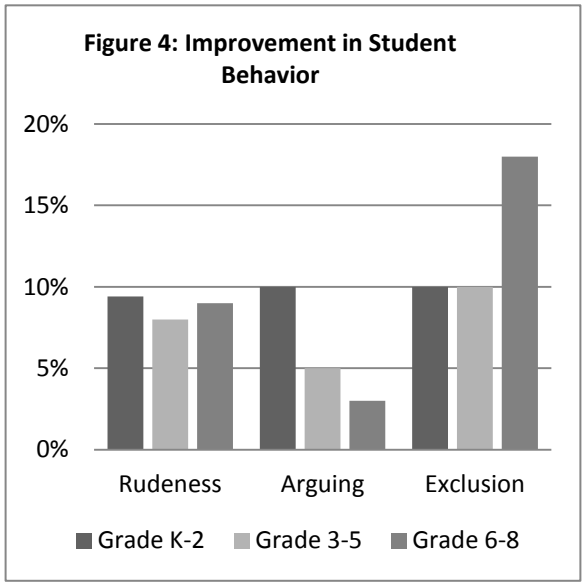
[1] In all analyses, statistical tests were calculated using raw data, not percentage scores. ANOVA was used to identify statistically reliable changes.

Staff members also were asked to write a number on the survey to indicate how many minutes per day they were willing to invest in civility activities in and out of class. Results for certificated employees are shown in Figure 3.



Overall, employees increased their willingness to change over the course of the project. The most change occurred between Baseline and the Mid-point of the project. Even though the number of minutes dropped in the final semester of the program, it still exceeded baseline.

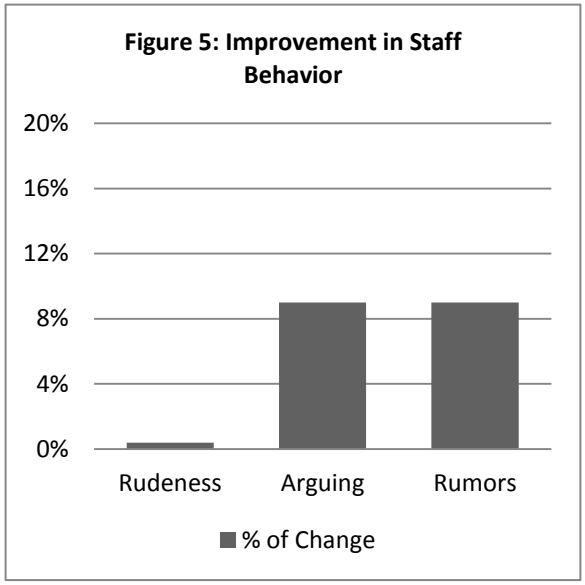
The culture of a social group is also reflected in the behavior of its members. Reports on the frequency of civil behavior (courteous or considerate actions) and uncivil behavior (rude or hurtful actions) were provided by school staff and students. Examples used in the questions for staff and students were age appropriate.



Students

No changes were noted for positive social behaviors among students, with approximately 50% of the children reporting frequent positive behavior. The opposite was true for negative behaviors. Figure 4 shows the results for uncivil (rude or hurtful) behavior by displaying the amount of change in student reports of negative social behavior through the course of the project. Depending on grade level, students reported changes in rudeness, argumentativeness, and exclusion of others from activities. The strongest change was in the frequency of excluding others form activities in grades 6 through 8.

Staff

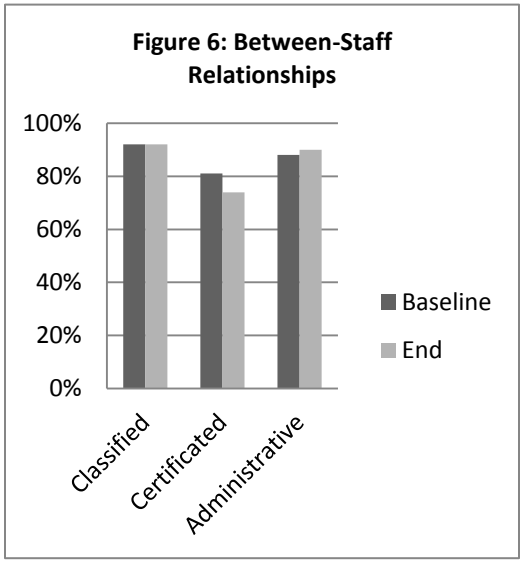


More than 75% of staff reported positive behavior from colleagues and the data showed no change across the course of the project. The picture for negative behavior is more complex. While many people reported changes in negative behavior, others did not. This variability in the data prevented statistically significant results. The raw results show some evidence of change, however.

Figure 5 shows the results for uncivil behavior by displaying the amount of change in how many staff members reported frequent occurrences of the behavior among colleagues . Raw scores show reduced arguing and rumor-spreading among staff. Reports of rudeness were low overall and showed the least amount of change.

Did the Civility project promote positive interactions across the school community?

As a community increases civil behaviors and decreases uncivil ones, relationships become more positive. This outcome was measured through questions about positive relationships between groups. These survey questions were asked of students, parents, and staff. However, variations in composition of the parent samples prevented valid analyses involving this group.



Between Staff Relationships

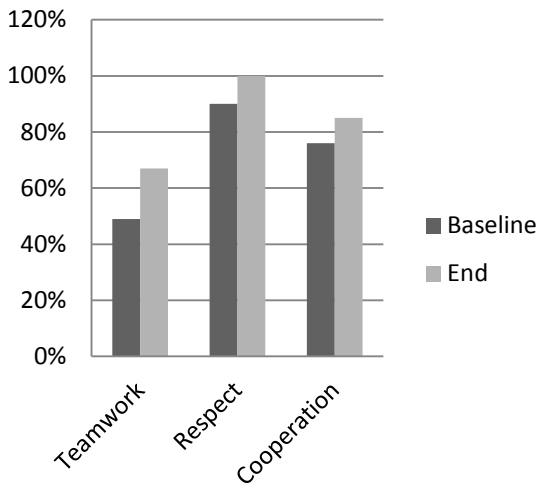
Staff members were asked about their relationships with individuals who hold different positions at the school. Figure 6 shows positivity of relationships with administrative staff, certificated staff, and classified staff. There was no evidence of overall change in these relationships. Reports are overwhelmingly positive and quite surprising given private reports from school personnel on ongoing tension between groups. There may be a self-presentation bias in the survey results.

Staff were also asked about how often they felt respected by others on the staff. Results for this question revealed a shift in perception that may lead to improved relationships in the future. Final results revealed a **13% increase** in the number of staff who felt respected by colleagues. Due to variability in the data the change was not statistically reliable.

Parent-Staff Relationships

Staff were asked about positivity in their relationships with parents on a periodic basis. Figure 7 tracks the percent of staff members reporting respect, cooperation, and teamwork in relationships with parents over the course of the project. Staff reported improved relationships with parents across measures, but only the results for teamwork (p=.06) approached the standard for statistical reliability.

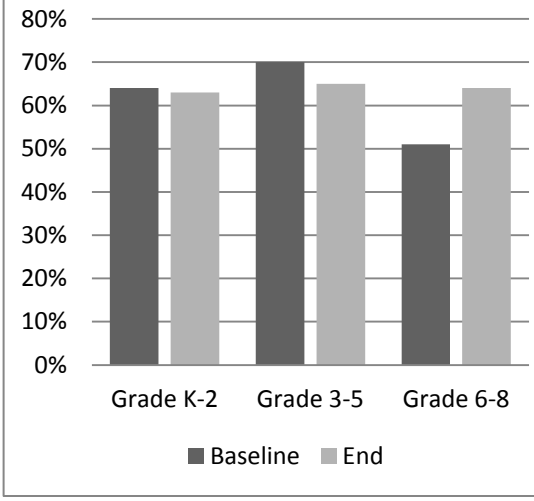
Figure 7: Parent-Staff Relationships



Staff-Student Relationships

Students were asked to describe how much they liked the way the adults they meet at school talked to them. All students were surveyed. Figure 8 shows changes in the percent of children who said they liked the way adults interacted with them. There was reliable improvement among middle school students (grades 6-8.) There appeared to be a decline in grades 3-5, but the difference between groups was not statistically reliable.

Figure 8: Student-Staff Interactions

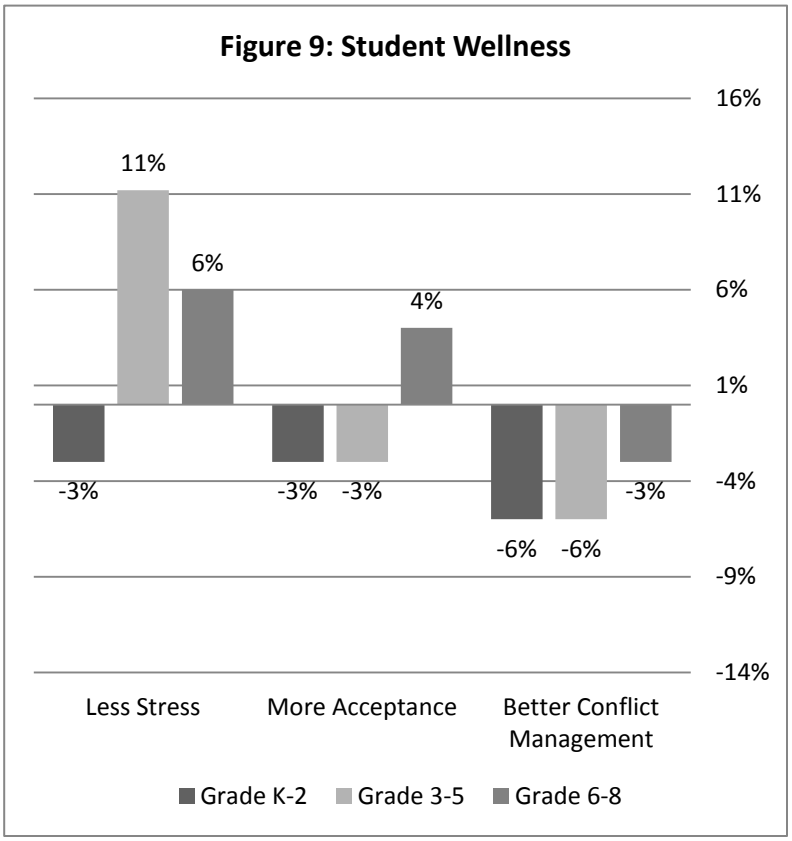


Did the Civility project improve the mental, social, and emotional well-being of students?

We hypothesized that persons who live in a supportive social environment would experience more social, emotional, and mental wellness. Adapted questions from the Short Warwick-Edinburgh Well-Being Scale (SWEWBS) were employed to assess the wellness of students. This instrument instructs the respondent to report on several indicators of wellness, focusing only on the past 2 weeks.

Figure 9 shows the amount of improvement in three indicators of student wellness: feeling upset by things (stress), fitting in with the social group (acceptance), and being able to work out problems with other children (conflict management).

Figure 9: Student Wellness



The only reliable change was in the amount of stress experienced by students in grades 3-5. Scores for feeling upset decreased 11% between Baseline (June 2012) and the end of the next school year (May 2013). There is no evidence of change in acceptance of others or conflict management as a result of the program.

Final Report

Project Revolution

Patterson Teen Center

Issue

Revolution Project was a 2 year project operated by Center for Human Services (CHS) and focused on promoting interagency and community collaboration in the rural, underserved Westside community of Patterson. Traditional models for conflict resolution between youth and adults had a primary focus on "punishing the problem" or "fixing the youth problem" with little to no focus on increasing common ground through communication, increasing developmental assets of youth, and connecting youth to adults in leadership roles in support of their community. In particular, the City of Patterson had been wrestling with challenges related to negative adult and youth interactions in a high profile area where youth normally congregate after school hours. Some business owners felt youth were responsible for vandalism and property damage, threatening other customers, and creating an unwelcome and uncomfortable environment. Youth, on the other hand, felt the culture was not friendly toward youth and they were unfairly judged and generally misunderstood.

This innovative project was intended to attract the interest of youth and adults from diverse cultures and ethnic groups throughout Stanislaus County and create a new model for youth leadership in civic-minded roles as a way to improve the emotional and mental wellness of youth through strengthened relationships.

Project Description

Revolution Project was funded to determine what it takes to resolve existing conflicts, build partnerships, and strengthen relationships between youth and adults in a rural, underserved community. Accomplishing these outcomes was intended to improve emotional and mental wellness of participating youth. The project was implemented at Patterson Teen Center (PTC), a resource for youth in the underserved community of Patterson, CA.

Three key learning strategies were used in order to strengthen connection between youth and the community.

1. **Engage and educate cross-sections of adults about positive youth development practices**
   Community Youth Café (CYC) was developed as a learning group to get parents, business owners, spiritual leaders, educators, youth workers, seniors and youth to build, share, and express knowledge through a process of dialogue and deep reflection around positive youth development and community collaboration. The groups met twice a month during the project to explore different questions regarding youth resiliency and community collaboration. Members

of these groups were key players in conducting fundraisers, recruiting volunteers and helping with community activities.

2. **Build youth assets by supporting and working with youth**
   Another feature of the program was involving youth in developing a new teen center with programming and activities they wanted and needed. Youth also played an active role in designing and carrying out activities in the community. A taskforce, Executive Youth Action Commission, was initiated to build stronger leadership skills among Patterson youth. These members represented their respected school as well as the teen center throughout the City of Patterson. The youth were provided with training and technical support from various community partners.
3. **Community/volunteer engagement**
   Teen center staff created a volunteer recruitment list to identify potential volunteers for teen center events. The volunteer list was comprised of parents, youth, seniors and community leaders. The list was normally collected during outreaching events and community members were asked if they would like to help with programs and/or activities at the teen center. We also outreached to several local colleges to recruit student volunteers. These strategies have been very effective in recruiting volunteers since in FY 2012-2013 we had approximately 100 community members involved in youth activities.

Project Effectiveness

Impact on Youth

Project Revolution had a positive impact on participating youth. Community members reported that Patterson Teen Center (PTC) programs and activities helped students become better people and do better in school. Although adults gave higher ratings than youth, the average scores for both PTC participants and the control group were above the mid-point of the range of possible scores.

Youth who participated in project activities benefitted psychologically from PTC membership. In the first year of the project, participating youth outscored the control group on mental health measures. Regardless of how often they visited the teen center, youth who did so reported higher levels of social and emotional well being and showed evidence of increased internal developmental assets. Differences between groups were less evident in year 2, partly due to improvement in the control group. Since scores of those who participated in PTC programs and activities did not change reliably between years 1 and 2, it is possible that youth in the control group benefitted from other factors in year 2, erasing differences between the groups.

Relationship Improvement

Overall, there was no broad-based change in relationships between youth and targeted adult groups over the course of Project Revolution. There was on exception, however. Engagement in teen programs and activities by employees of nearby businesses increased in year 2 of the project.

One indicator of relationship improvement used in this project was attitude change, shifts in what people believe about the other group and how they feel about them. The results did not show substantial attitude change by youth over the course of the project. Among adults, results were the opposite of expected. There was some decline in positivity about youth between year 1 and 2, particularly among people active at the senior center. Only employees from neighboring businesses maintained stable attitudes across the two years.

Another indicator of relationship change is engagement with members of the other group. This measure confirmed the attitude change results: there was no overall improvement in youth-adult relationships. Levels of engagement for both youth and adults targeted in the program were similar to those in the respective control groups. There was one exception, however. As mentioned above, there was clear evidence that employees of neighboring businesses became more engaged with youth programs in year 2 of the project

Changes During Implementation

Several strategies were used to engage broad cross-sections of adults in the CYC groups. Times, locations, and frequency of groups were changed in order to meet the needs of group members. Most groups were held in the evenings so youth would be able to participate in the meetings. Members met in different locations (mainly school establishments) to ensure equal representation and diversity of youth. This proved to be effective as more youth participated in the meeting during the second year of the project.

Another change of the program was identifying strategies that would help improve emotional and mental health and wellness among teen center participants. These strategies transpired after we received our baseline results and realized that we needed to work on healthy youth development. In order to improve internal assets among teen center participants, objectives were set every month with the youth. The objectives surrounded issues such as trust, respecting others, and confidence. In addition, teen center activities were tailored to support the objective of the month. Also, youth played an active role in designing and implementing events. It was important to allow youth to be part of the designing and implementation process since we wanted them to feel part of their community. A task force was initiated, Youth Action Commission (YAC), in the teen center to allow youth to have an active role and voice in developing services they needed and wanted.

In order to involve and connect community members with local youth, several strategies were used as well. Youth created a video presentation to share their work and accomplishments with their community. One presentation they made was to city council. This proved to be effective as several council members later participated in their events.

Allowing other community members to have an active role in community activities/events was also effective in engaging a variety of people. Different community members (seniors, city officials, parents,

local businesses, etc) were invited to take part of the planning and implementation process of every event.

What was Learned

1. One learning question to be answered through this project was what it takes to resolve conflict and build partnerships between adults and youth in a small community with considerable tension between the groups. Project staff employed many strategies, some of which appeared to have short term results. However, with sustained conflicts such as the ones found in Patterson, the issues were too far ingrained in the culture for short-term changes to make a strong impact in over two years. Inter-group attitudes remained approximately 3 on a scale of 1-5 for both youth and adults. Youth engagement with community adults averaged 3.5 throughout the project as did senior center engagement with youth programs and activities. Adult engagement with youth was somewhat better among city employees and neighborhood businesses (4 out of 5).

2. A related learning question focused on what it takes to improve the mental and emotional wellness of youth. It was hoped that improved relationships would play a part in this process, but that did not develop. However, PTC youth participants did show an advantage on mental health measures, particularly in year 1 of the project. Participation had positive outcomes, even though relationships with adults were not altered.

3. Participation at Patterson Teen Center has a positive impact on youth mental wellness since it meets the needs of the teens. The teen center is able to provide a safe, supervised and enjoyable place for teens to meet with their peers, provides opportunities to participate in fun, meaningful substance free activities, provides an opportunity for youth to have an active role and voice in shaping services to meet their needs, allows youth to explore leadership roles and provide caring adults who want to help teens develop by providing support, resources and inspiration.

Recommendations for Others

Certain challenges are unique to each project and are due to circumstances, staff and development of evaluation approaches. Taking the time to learn how the duration of contact with individuals in this project was found to be critical part of long term success. Long lasting relationships are important for positive relationships to occur. Although many community members were engaged in youth activities, long lasting relationships did not occur. Unfortunately, due to changes in staff, youth were also not able to develop long lasting relationships with staff. For instance, data was collected by Patterson Teen Center staff in April and May 2013. Surveys were completed by 75 youth and 28 adults. Unfortunately, indicators of positive well-being declined 21% compared to Baseline. Many contributors can reveal the emotional shift among the young people during this period. During this period, the City of Patterson experienced several street shootings and fights. Also, challenges transpired as the Center for Human Services began to transition the Patterson Teen Center to the City of Patterson. This created uncertainty among the young people since they were unsure how this new transition would affect them directly.

Many young people were worried about new changes that occur during transitions, which include but are not limited to changes in new staff, changes in the current structure of the teen center, and the long term livelihood of the teen center. We believe that long lasting relationships are essential if we want to create positive relationships and build cohesion among individuals.

A second recommendation is the type of staff working with youth (paid or volunteers) should be youth-friendly, supportive, flexible, experienced, trained, consistent and able to work well with others.

Continuation of Project

The Patterson Teen Center is currently being operated by the City of Patterson. The City of Patterson plans to move the current teen center to a more spacious facility. Opportunities to support the ongoing activities and programming of the teen center are being explored by the City of Patterson and local stakeholders.

Reports Developed

An independent program evaluator, Jamie McCreary, Ph.D., designed and analyzed data collection systems for this project. The final report is attached to this document.

Evaluation Report: Revolution Project

Jamie McCreary, Ph.D.
Program and Organization Development Consultant

Revolution Project was sponsored by Behavioral Health and Recovery Services of Stanislaus County to determine what it takes to resolve existing conflicts, build partnerships, and strengthen relationships between youth and adults in a rural, underserved community. Accomplishing these outcomes was intended to improve emotional and mental wellness of participating youth.

The project was implemented by Center for Human Services (CHS) at the Patterson Teen Center. Activities were designed to increase common ground of youth and adults through improved communication, increased developmental assets for youth, and expanded connections between youth and adults in leadership roles in the community.

This report summarizes program evaluation results, addressing the questions below. It complements observations by program staff about what did (and did) not work to accomplish these outcomes. These observations are reported elsewhere.

- Did the Revolution project support meet the developmental needs of community youth?
- Did the Revolution project improve relationships between youth and adults?
- Did the Revolution project improve emotional and mental health among participating youth?

Summary of Results

Did the Revolution project support meet the developmental needs of community youth?

Community members reported that PTC programs and activities had a good impact on youth. Both youth and adults rated PTC positively, reporting that it helped students become better people and do better in school. Although adults gave higher ratings than youth, the average scores for both PTC participants and the control group were above the mid-point of the range of possible scores.

Did the Revolution project improve relationships between youth and adults?

One measure of relationship improvement is attitude change, shifts in what people believe about the other group and how they feel about them. Overall, the results do not show substantial attitude change by youth and community adults over the course of the project. While there was some evidence of change in youth perceptions in year 2, the effect was not statistically reliable.

Among adults, results were the opposite of expected. There was evidence of some decline in positivity about youth between year 1 and 2, particularly among people active at the senior center. Community events should be investigated to determine potential factors in the decline. Only employees from neighboring businesses maintained stable attitudes across the two years.

Another indicator of relationship change is engagement with members of the other group. This measure confirmed the attitude change results: there was no overall improvement in youth-adult relationships. Levels of engagement for both youth and adults targeted in the program were similar to those in the respective control groups. There was one exception, however. There is clear evidence that employees of neighboring businesses became more engaged with youth programs in year 2 of the project.

Did the Revolution project improve emotional and mental health among participating youth?

Youth who participated in project activities benefitted from PTC membership. In the first year of the project, participating youth outscored the control group on mental health measures. Regardless of how often they visited the teen center, youth who did so reported higher levels of social and emotional well being and showed evidence of increased internal developmental assets. Differences between groups were less evident in year 2, partly due to improvement in the control group. Since scores of those who participated in PTC programs and activities did not change reliably between years 1 and 2, it is possible that youth in the control group benefitted from other factors in year 2, erasing differences between the groups.

Did the Revolution project support meet the developmental needs of participating youth?

PTC activities during the Revolution project supported the developmental needs of youth. Youth and adult surveys in year 2 of the project assessed this issue through a set of questions (shown in Appendix A) accompanied by a 5-point response grid. A high score indicated a positive evaluation of PTC outcomes.

Table 1 shows the results of these assessments. Overall, ratings were positive (above the mid-point of the scale) although adult ratings were higher than those provided by youth. The mean scores for subgroups of youth and adults did not differ statistically from one another.

Table 1: Mean satisfaction scores by role in program					
	Mean	SD		Mean	SD
Youth			Adults		
Control Group (n=23)	3.70	0.99	Neighboring Businesses (n=16)	4.47	0.54
Occasional participants (n=35)	3.34	0.94	Control Group (n=10)	4.31	0.97
Frequent Participants (n=22)	3.15	1.06	Parents (n=19)	4.25	0.59
			Seniors (n=9)	4.13	0.90
			City Employees (n=12)	3.74	1.21

Did the Revolution project improve relationships between youth and adults?

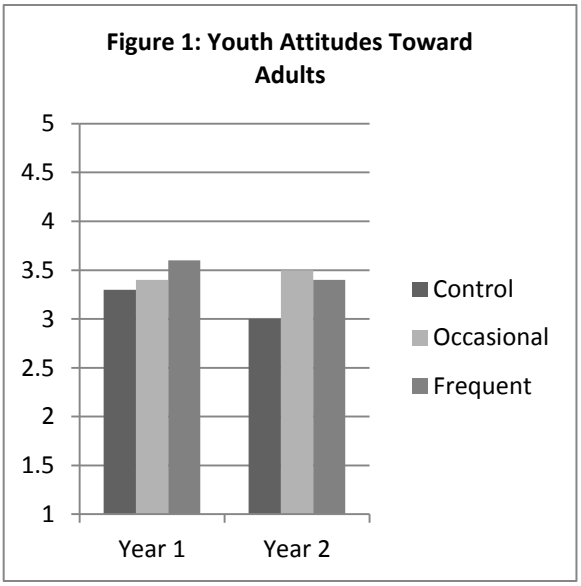
One measure of positive relationships is attitudes about the other group. The level of positivity between youth and adults was measured at 6-month intervals for two years using 5-point attitude questions. A higher score indicated more positive perceptions of the other group. Questions used to assess positivity are shown in Appendix B. Responses to these items were summed to create a single score.

Youth Attitudes

Figure 1 displays mean attitude scores for youth broken down into three groups: frequent participants, occasional participants, and a control group of nonparticipating students.

On the surface it appears that participating youth were more positive about adults than control students in year 2, but the statistical reliability of the difference was suspect (p=.07.) The apparent change can best be attributed to declines in the positivity of youth in the control group, not improvement among PTC youth.

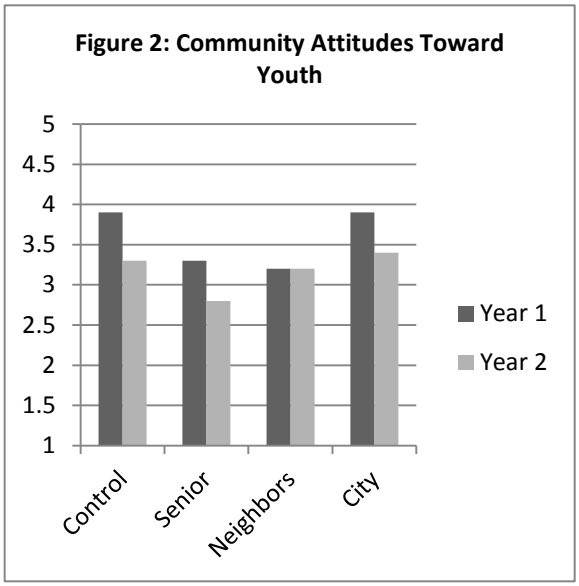
Figure 1: Youth Attitudes Toward Adults



Community Attitudes

Figure 2 shows mean attitude scores for adults in targeted groups for the Revolution project: Senior Center Participants, Neighboring Businesses, and City Employees. Attitudes of a control group (not members of any targeted groups) also are shown.

Overall, seniors had the least positive perceptions of youth and attitudes declined through the course of the project (p=.02). Decline was also evident among the control group and city employees, but differences between years 1 and 2 were not statistically reliable. Attitudes of people working in nearby businesses remained constant across the duration of the project.

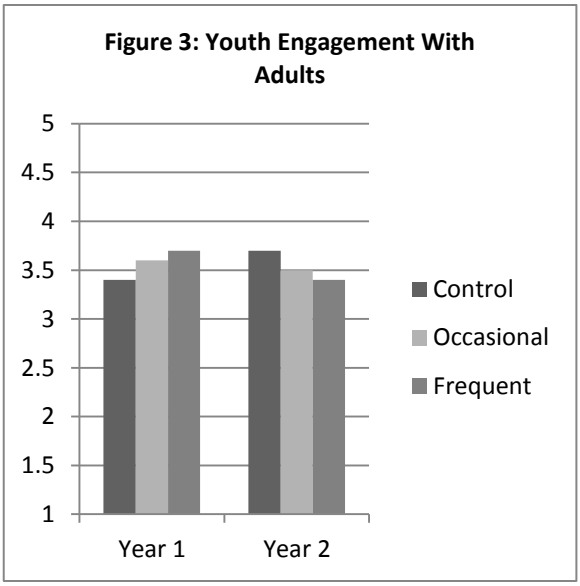


More engagement with the other group is a second, but not independent, indicator of improved relationships. The level of engagement between youth and adults was measured at 6-month intervals for two years using 5-point attitude questions, with a higher score representing a more engagement with the other group. Questions used to assess engagement are shown in Appendix C. Responses to these items were summed to create a single score.

Youth Engagement with Adults

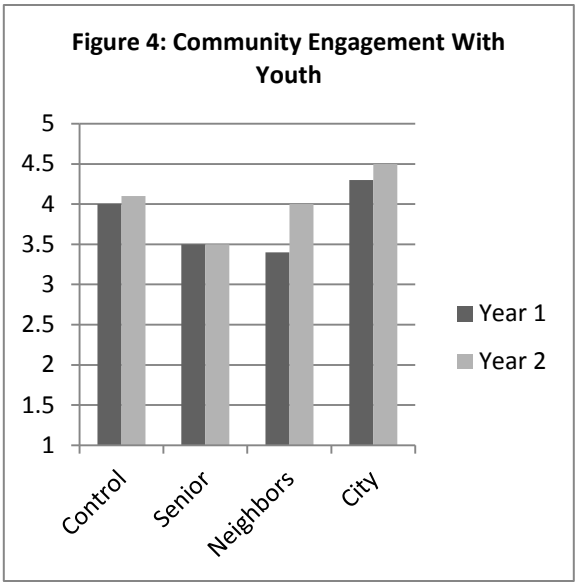
Figure 3 displays mean scores for youth engagement in the community for years 1 and 2. Results are shown for three groups: frequent participants, occasional participants, and a control group of nonparticipating students.

The results do not show improved community engagement among participating youth. While there was marginal improvement among control participants (p=.07), there is no evidence of change in either group of PTC participants.



Community Engagement With Youth

Figure 4 shows mean engagement scores for adults in groups targeted in the Revolution project: Senior Center Participants, Neighboring Businesses, and City Employees. These scores represent engagement with youth programs in the Patterson community. Scores for a control group (not members of any targeted groups) also are shown.



City employees reported the highest level of engagment across all groups tested. Although the mean sengagement score for this group increased from year 1 to 2, the difference were not statistically reliable.

There is evidence of increased engagement by emplyees of businesses near the teen center. Respondents from this group increased involvement with youth in year 2 of the project (p=.008).

Did the Revolution project improve emotional and mental health among participating youth?

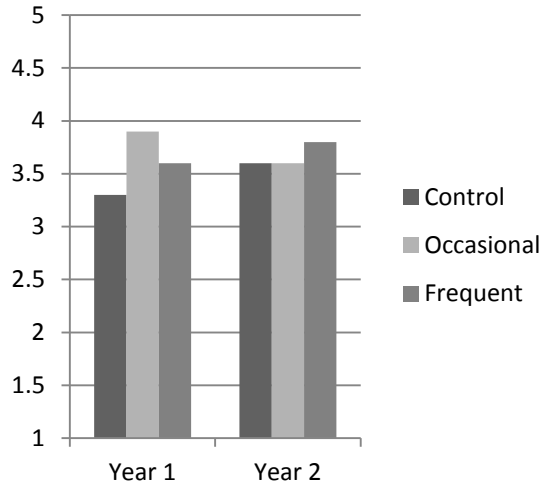
Several measures were used to track social and emotional well-being of youth participating in the project. Assessments were completed twice each year. The Short Warwick-Edinburgh Well-Being Scale (SWEWBS) assessed seven dimensions of positive well-being focusing on the previous 2 weeks. Other self-report questions assessed internal developmental assets focusing on a 3-month period. Since preliminary data analysis indicated that SWEWBS and internal asset questions were intercorrelated, all relevant questions were summed to create a single mental health score (see Appendix D.)

Figure 5 shows mean mental health scores for years 1 and 2 for three groups of students; those who participated in teen center activities occasionally (less than 2 days per week), those who participated frequently (at least two days a week), and a control group who did not participate.

PTC participants scored higher in mental health than the control group in year 1, reporting more indicators of mental, social, and emotional well-being (p=. 03). Although the mean score for frequent participants was also higher than the control group in year 2, differences did not meet the standard for statistical reliability.

The similarity of scores for youth in the control and participant groups is due in part to improvements in the control group. These students scored higher on mental health indicators in year 2 than in year 1 (p=.05), while the other two groups did not change statistically.

Figure 5: Youth Mental Health



Appendices: Subscales of Youth and Adult Surveys

A. Assessment of Patterson Teen Center Outcomes

Youth	Adult
I learn how to be a better person at the teen center.	The PTC helps teens become better people.
The PTC helps me do better at school.	The PTC helps youth do better in school.
I get to meet more adults through the teen center.	The PTC serves the community well.

B. Assessment of Positive Attitudes Between Groups

Youth	Adult
Adults have a good outlook on life.	Teens in my town are easy to talk to.
Adults in my town show respect to youth.	Youth and adults in my town get along well.
Youth and adults in my town get along well.	Teens in my town not disrespect me.
Adults in my town are easy to talk to.	I like the teenagers in my town.
Adults in my town seem to value youth.	Overall, I trust teenagers.
Adults in my town support what youth want to do.	Youth in my town work to make things better.
Adults have a good outlook on life.	

C. Assessment of Engagement Between Groups

Youth	Adult
I spend time with adults who are not my parents.	I can name at least 3 programs for youth in Patterson.
I spend time doing things that help others in my town.	I would like to volunteer at a youth program.
Adults in my town try to make things better for youth.	I should do my part to support youth programs.
I trust adults.	Adults should make a point of showing teens that they are valued.
I feel like I am part of my community.	Teens need community support to grow up well.
I speak up for what I believe in.	

D. Assessment of Youth Social and Emotional Mental Health (Youth Only)

I finish my jobs at home without being told.	I've been feeling useful.
I can work things out with others when I get angry.	I've been feeling relaxed.
I like people from other races.	I've been dealing with problems well.
I like who I am.	I've been thinking clearly.
The future looks god to me.	I've been feeling close to others.
I've been feeling optimistic about the future.	I've been able to make up my own mind about things.

Tuolumne River Trust

Final Report

Promoting Community Wellness

Through Nature and Neighborhood Driven Therapies

Tuolumne River Trust

Issue

Conditions in Modesto's Airport Neighborhood are dire. Orville Wright Elementary School's federal poverty designation is at a staggering 100%; high rates of crime, vandalism and gang activity coupled with a lack of infrastructure and safe play spaces, pose a threat to residents' physical and emotional health on a daily basis. Anxiety, depression, substance abuse, mental illness, obesity and low self-esteem are commonly diagnosed in children and adults. In contrast, the community is surrounded by two of the County's most precious natural resources, the Tuolumne River and the Tuolumne River Regional Park, a source of beauty and serenity as well as physical and mental health at residents' doorsteps.

Traditional approaches to addressing mental wellness issues tend to focus on treating the patient and the symptom without dealing with the physical conditions that often contribute to illness. Yet research tells us that environment, both where we live and how we perceive our surroundings, plays an important role in our overall health.

This project was designed to learn whether a combination of family-oriented outdoor experiences, community-driven neighborhood improvements and capacity-building could be effective as "therapies" to improve the mental and emotional wellbeing of residents in this community.

Project Description

Promoting Community Wellness was funded to explore a new community-based approach that strives to increase wellness through outdoor programming and resident-led neighborhood improvements. The project, implemented by Tuolumne River Trust (TRT), was designed to improve attitudes towards their immediate surroundings as well as a river park located in the neighborhood and to build personal connections with nature as a means of improving physical and mental/emotional health.

A series of community-driven and resident-led activities (therapies) were used to address environmental and social barriers to mental wellness in the Airport Neighborhood on 3 levels:

- Individual – strengthening Developmental Assets in children
- Family – strengthening leadership skills and social competency

- Community – increasing resident engagement and community connectedness.

The activities identified as "therapies" to promote community wellness reflected input from residents, partners and from a growing body of research that show the importance of outdoor play and connection to nature for the mental, intellectual and physical health of kids, families and communities. Activities included but were not limited to:

- The development of a resident-managed soccer field and youth soccer program to provide a safe play area for families, strengthen youth/adult relationships, conflict resolution and character development,
- A family summer camp to link families to the outdoors and leverage the stress-reducing power of nature,
- After school programs for elementary and junior high youth designed to strengthen developmental assets and instill the desire and skills to take advantage of the physical and mental benefits of outdoor and nature-based recreation.
- Year round culturally sensitive family activities and events to strengthen youth/adult relationships and camaraderie among residents,
- Agency (Airport Collaborative) and resident (Community Chats) collaboratives designed to strengthen networks among resident and support organizations,
- Leadership training (adults) and Peacebuilders initiative (adults and youth) designed to address bullying, grow respect and build community,
- Resident-driven neighborhood improvement projects to improve safety and residents' attitudes towards their neighborhood.

Four core programs were analyzed to assess the effectiveness of these "therapies":

Adult Leadership Program – Made up of a core group of residents who participated in leadership classes, community chats, design and implementation of neighborhood improvement projects and family-oriented programming, both in the neighborhood and at the river park.

Get Up and Go Program – An after-school program that provided healthy outdoor recreation and nature-based activities for 3rd through 6th grade youth from the Airport Neighborhood.

Tuolumne River Adventure Club – An after-school program that provided healthy outdoor recreation and nature-based activities as well as monthly field trips for junior high youth from the Airport Neighborhood.

Family Summer Camp – A week-long program for youth ages 6 – 12 and their families designed to teach them how to enjoy the river and river park safely. Two week-long sessions were offered in Year 1 and three sessions in Year 2 of this project.

Tuolumne River Trust

Project Effectiveness

Four core programs sponsored by TRT were examined: the Adult Leadership Program, the Tuolumne River Adventure Club (TRAC), Get Up and Go (GUNG) , and the Family Summer Camp. In the first two of these programs, survey data were collected intermittently throughout the project period. In the others, data were collected by TRT staff in the first month of participation and again at the end of the program. The following outcomes were monitored through participant surveys:

1. Attitudes about the Tuolumne River Regional Park
2. Positive connections to nature and the neighborhood
3. Physical health and mental/emotional wellness

Adult Leadership Program

A small group of community women met regularly throughout the project period to plan events, discuss community issues, and organize neighborhood improvement projects. Many had children who participated in TRT youth programs. Participants were assessed at the start of this project and periodically thereafter for the next 18 months.

Involvement in the adult leadership program was clearly associated with an array of benefits, including more contact with neighbors, feeling more calm when outside, and feeling safer at the river after only 6 months of participation. This group reported mental/emotional health gains, feeling more useful and thinking more clearly, after 9-18 months of membership.

The results for the adult leadership program confirm the framework of this innovative project: Adult participants first made new connections to the neighborhood and nature and then, with extended involvement, began to report mental and emotional growth.

Tuolumne River Adventure Club

Among the youth programs, the Tuolumne River Adventure Club had the greatest potential for impacting students' attitudes toward and connections with nature. Youth participated throughout the year in outdoor activities with an experienced environmental educator. Unfortunately, the small number of students involved and problems with consistent data collection made it impossible to evaluate the outcomes of this program.

Get Up and Go

Get Up and Go, an afterschool program that integrated physical activity and park visits, was evaluated for 4 months in the first year of the project and for an entire school year in the second. Cohort 1 began the program with positive attitudes about the park but expressed some discomfort around the river. Attitudes about the park declined at the end of the semester and students remained wary of the river.

Cohort 2 started the GUNG program with more positive perceptions of the park and more comfort with the river.[1] They maintained those attitudes throughout the year, but did not strengthen them.

Overall, the afternoon program did not have a notable impact on physical and mental wellness as measured through program surveys. This result is consistent with the framework on which this community wellness program was built: since new connections with nature were not built, students did not experience increased wellness.

Family Summer Camp

Summer Camp consisted of a 2-3 week program during which youth enjoyed day-long activities at the park. Youth who participated as Cohort 1 did not experience increased positivity about the park and connection with nature through this experience. In fact, they reported less comfort with the river at the end of the program. They also reported declines in energy and feeling less socially connected to others at the end of the program. These particular results might be attributed to fatigue and disappointment at the end of the program, but there is no way to explore this issue with the existing data.

Results for Cohort 2 were quite different.[2] Students reported feeling more healthy at the end of the program and being better able to work out problems with other children. They did not report new attitudes and connection with nature, however. The program had wellness benefits—but they were not mediated by positive experiences with nature.

Changes During Implementation

Several key changes were made during the project period to address challenges/issues that arose. These changes will be discussed for each core program evaluated.

Adult Leadership Program

At the beginning of this project, most of the recruitment and outreach was done with informational fliers through Orville Wright Elementary School and activities associated with Healthy Start Family Services. While this strategy was successful in recruiting an initial core group of residents, Hispanic women who are either stay-at-home mothers or seasonal workers, it was not successful at growing or diversifying the group. New outreach strategies were tried including door-to-door outreach and the

[1] Cohort 2 included some returning members from Cohort 1 (23%) and one student from the previous Summer Camp.

[2] Some members of Cohort 2 also participated in Cohort 1 (18%).

addition of free Zumba classes which were preceded or followed by Community Chats where activities related to this project were discussed and planned. While door-to-door outreach was not very successful, Zumba did result in an increase in attendance of the Chats but did not result in a more representative mix of the Neighborhood.

Get Up and Go Program

The goal of this program was to provide organized outdoor activities after school at the River and in the Park to try and change youths' attitudes about their neighborhood and the park while improving their overall health and well-being by spending more time outdoors and in nature. Initial program design was classic environmental education with a learning component, outdoor skill development and safety. However, we found that when we took the youth from school to the park they became unruly and destructive. It was clear that while the youth viewed the park as freedom from their normal environment they didn't know how to express it in an appropriate way which resulted in more negative experiences than positive ones. The first adjustment was creating a purposeful transition from the neighborhood and the constraints of the school day to the Park and nature. Snack was followed by 15 minutes of free play on the playground and then an icebreaker and/or teambuilding games. Activities in the park were selected to favor guided exploration and fun rather than education. The school's Peace Builders' Code of Conduct that the youth are familiar with was adapted for the outdoor setting. Behaviors improved and a more positive experience in the park and at the River was achieved.

Tuolumne River Adventure Club

The TRAC program was designed as an after-school outdoor recreation and environmental education program for Junior High youth that included more intense recreational skill development through weekend field trips. The biggest challenge with this program was recruitment and retention of youth. Since most of the adults who were currently being engaged in the project didn't have junior high age children, staff prepared fliers advertising the program in English and Spanish and handed them out at neighborhood functions but with little recruitment success so we decided to start the program with the older youth from the GUNG program for the 3+ months remaining of the school year. The second year most of those youth moved on to La Loma Junior High where we got permission to recruit additional youth. We handed out fliers and collected contact information from interested youth but follow up proved difficult as many phone numbers were disconnected or parents wouldn't answer or return calls. Going door to door wasn't much more successful as most parents wouldn't open the door to strangers. We held a meeting with partners to discuss new recruitment strategies which resulted in two new approaches. First, we realized that we needed to market the program differently for the parents. While youth were attracted by the promise of fishing, canoeing and camping, most parents didn't see those activities as important priorities for their children. So we created a separate flier which included some of the tangible benefits of these activities such as leadership development, conflict resolution, improved

self-esteem and self-worth. We also mentioned how the program could provide educational application, career exploration and would include community service experiences. The goal was to get more buy-in and interest from the parents. Concurrently, we were able to work with guidance counselors from La Loma who "hand-picked" a list of students they thought would be good candidates for the program. While both strategies worked to increase recruitment success, retention of youth still posed a challenge. This was most likely due to a number of factors: the high turnover rate within the neighborhood (families move frequently with little notice), losing youth to openings in the full-time after-school program, because of poor academic performance, seasonal sports and the age of the target audience (teens wanting their independence).

A new activity was added during the second year when we realized that, while we were successfully engaging adults and youth independently, there was not much overlap so we were not engaging many family units. So we added a program, Fun Fridays at the River, designed specifically to get other family members of the youth and adults we were engaging out to the park. Every third Friday evening we had games, crafts, canoeing, fishing and snacks. While, the program was successful in getting women from the Adult Leadership group to come to the park with their children, very few parents of the GUNG or TRAC youth attended. That said, the program was very popular with those who attended.

What was Learned

1. The learning question to be answered through this project was whether involvement with nature and neighborhood play an important role in the health and vitality of community members. Results for adult participants in a long-term leadership group confirmed this connection.

2. Several approaches were used to involve youth with nature and the regional park in the neighborhood. The results indicate that the afterschool program and park summer camp did not change youth attitudes toward and connection with nature as hoped, nor did they have a unified impact on wellness. The one program with the greatest potential for achieving these outcomes, Tuolumne River Adventure Club, experienced data collection problems that resulted in an extremely small sample size. This approach may or may not have impacted youth involvement with nature and thereby increased wellness.

The fact that adults were engaged in a variety of ways and affected positive change in their immediate environment resulted in this project having a positive impact on adults. Leadership training along with support from TRT staff and project partners led to project participants identifying problems and achieving concrete solutions such as: an ally lighting ordinance, building a section of sidewalk and increasing stray dog patrols. As a result, the women felt empowered and more optimistic about their future. Staff from Healthy Start, a project partner, observed that residents demonstrated a higher sense

of social connectedness, increased attendance at other community events and a higher degree of confidence in their ability to access mental health services within their community.

Through exit interviews with key members of the Adult Leadership group, residents reported feeling better both physically and mentally. They said they felt more social connectedness as a result of the project and they reported feeling less stress and more physically fit as a result of Zumba classes and activities in the park. While they expressed feeling more optimistic about the future and more positive about their neighborhood, they said these feelings were short lived because the results of the neighborhood improvement projects were short lived. The leadership group also increased their use and enjoyment of the river and park with their children and expressed feeling happy to see their children playing outdoors and enjoyed getting to know their neighbors through fun activities with their children.

This project showed us that in order to affect change in attitudes and behaviors in youth, parents must be involved. We saw more positive changes in youth whose parents were either directly involved in project-related activities (summer camp, Fun Fridays at the River, Adult Leadership Group) or who verbally expressed buy-in and enthusiasm for the program when their child was present and encouraged regular attendance. That said, observations by staff and volunteers and informal exit interviews with youth from all three programs: TRAC, GUNG and Summer Camp, suggest that time spent at the park and on the river was highly enjoyed, helped youth gain more confidence, provided leadership development opportunities and helped them see the river and park in a new light.

Recommendations for Others

One of the most challenging aspects of this project was the scope and overly ambitious goals. We tried to affect change with multiple groups, at multiple levels and using multiple strategies in a very short period of time. While we were able to complete all learning activities and are excited about the changes we observed, we recommend starting small, working with one target group on long-term solutions to a specific problem. Several milestones were reached in a very short amount of time but very few of them have been sustained.

We did not budget enough for the professional evaluator. While we made a budget modification midway through the project which helped mitigate this problem, we believe the scope of the project and the fact that we were attempting to measure the benefits of spending time in nature in a mental health context resulted in survey development taking longer than anticipated, which caused the initial costs to set up the evaluation instrument to run higher than planned. Having enough funding for the evaluator to be involved in all aspects of data collection and learning for the length of the project is crucial.

The Airport Neighborhood, while relatively low in population and small in geographic size, is very diverse and segregated. The community is solidly divided by race, culture, and City- County boundaries, which makes it very challenging to engage a wide cross-section of the population. Our project reached mainly Hispanic residents from Mexico.

Any future effort to improve the mental wellness of Airport residents must continue to address the issue of safety, the lack of which affects every aspect of these residents' lives. One of our project goals was to help residents identify actions that would make them feel safer in and more positive about their neighborhood. The Adult Leadership group achieved this goal. They attended leadership trainings, identified issues and actions to address them. Two examples include meeting with Animal Services to address the stray dog issue and with County and City staff to address illegal dumping. While action was taken, the results have been short lived and current status unknown. Moving forward, a community liaison from these departments should be appointed to meet with residents to continue to look for solutions to these problems. Living in fear is probably the biggest obstacle to achieving physical and mental wellbeing in these families.

Continuation of Project

Some aspects of this project will be continued at a reduced level of funding. We are in the process of hiring a new Riverside Communities Organizer with funding from private foundations. However, this position will cover riverside communities in general, including but not limited to the Airport Neighborhood. This person will continue to attend both the Airport Neighborhood Collaborative and the Community Chats. We will continue to work with key partners to support initiatives deemed important to helping residents affect positive change in their community. We will also continue to offer programming that gets families out enjoying the park and the river. Ongoing funding will allow us to continue to offer the TRAC program for junior high youth and the Family Summer Camp.

Reports Developed

An independent program evaluator, Jamie McCreary, Ph.D., designed and analyzed data collection systems for this project in collaboration with TRT staff. The final report is attached to this document.

Tuolumne River Trust

Promoting Community Wellness through Nature and Neighborhood Driven Therapies

Case Studies

1. **Irma**

   Irma is a 51 year old Hispanic female who has lived in the Airport Neighborhood for about 4 years. She is a single mother of 4 sons. Irma was a participant in this project as a member of the Adult Leadership group and as a parent to Christian Sanchez and Cristobol Gutierrez who participated in the Get Up and Go and Tuolumne River Adventure Club programs respectively. Irma heard about the project through meetings at Healthy Start and a flier distributed through Orville Wright Elementary School. She said that she was interested in joining the leadership group so that she could meet more residents and get involved in activities/programs that would improve the wellbeing of her family. During the grant period, Irma participated in the Leadership training, the Community Chats, Zumba, Fun Fridays at the River and helped with Neighborhood improvement projects. She also attended Family Summer Camp even though neither of her younger sons were actively involved, simply to take advantage of the socialization at the park with the other mothers.

   Irma reports that one of the most important personal benefits of this project is the camaraderie and support from the friends she has made through the Leadership Group. She said that before becoming involved in this project, she hadn't made many friends since moving to the Neighborhood and was feeling isolated and depressed. She has also enjoyed all the different activities she has been involved in and that receiving the training and being part of efforts to improve the neighborhood has made her feel empowered, increased her feeling of self-worth and made her feel better about her future. Irma has also enjoyed the Zumba classes and the activities in the park. She said that she feels healthier and has lost weight which has made her more confident and boosted her self-esteem. She says that feeling better about herself and having more friends has motivated her to become more involved in other activities in the neighborhood. She says being in the park with the other families makes her feel relaxed

and happy. She says she feels lucky to have the park close by and feels a little safer there than before the project.

As of this interview, Irma is participating in a class on the 40 Developmental Assets taking place at Healthy Start and is considering getting certified in Zumba so that the women who have been attending the exercise class can continue on their own.

2. Brian

Brian is a 9 year old Hispanic youth who attended the second year of the Family Summer Camp. Brian's mother said that she signed him up for the camp because he suffers from anxiety and lacks socialization skills because he feels afraid to go outside and play with others in the neighborhood. As a result he has also become very sedentary and overweight. Brian was very shy the first few days of camp and had to have his mother and older brother with him at all times, but by the end of camp he was much more independent, engaged in all camp activities and played more with the other kids. Being heavy, Brian didn't want to participate in relay races or other more physical activities but by the second week he was participating more, pushing himself more physically and would even run ahead with the other boys instead of walking holding hands with his mom. Where we saw Brian shine the most was on the last day of camp he took his mother and brother out in a canoe with him. His mother said she was totally amazed at the transformation she saw in him during those two weeks of Summer Camp.

Jamie McCreary

Outcome Summary
Innovative Project:
Promoting Community Wellness Through Nature and Neighborhood Driven Therapies

This document summarizes progress towards achieving three outcomes through core programs of the Tuolumne River Trust (TRT) innovative project sponsored by Behavioral Health and Recovery Services of Stanislaus County. Outcomes were assessed through participant surveys developed in collaboration with TRT staff. The outcomes assessed were:

1. Improved attitudes about the Tuolumne River Regional Park among participants
2. Increased positive connections to nature among program participants
3. Improved health and wellness among program participants

Four core programs sponsored by TRT were examined: the Adult Leadership Program, the Tuolumne River Adventure Club (TRAC), Get Up and Go (GUNG) , and the Park Summer Camp. Means for participants who completed both a pre and post test are included in this report. The number of surveys analyzed from each program are shown below. Counts for specific questions are lower in cases where different forms were used or questions were skipped by respondents.

	PRE	POST 1	POST 2	PRE AND POST 1	PRE AND POST 2
Adult Leadership Program	11	8	9	8	9
Tuolumne River Adventure Club	8	5	4	5	4
Get Up and Go Cohort 1	23	17	-	15	-
Get Up and Go Cohort 2	27	20	-	16	-
Park Summer Camp Cohort 1	13	14	-	13	-
Park Summer Camp Cohort 2	16	17	-	16	-

The tables that follow show data disaggregated by program and question. Changes between pre and post groups were evaluated using a paired t-test at a p =.05 level of probability. Changes that were not statistically reliable, but were still notable, are shown in bold print and marked by an asterisk in the change column[1]. Sample sizes for the TRAC program may have been too small to detect patterns in the data. Results for this program should be interpreted with caution.

Results Summary

Adults were assessed periodically throughout the term of the project. Three data points are reported here: Baseline, Post 1 (2-9 months later) and Post 2 (9-18 months later.) Participation in the adult leadership program was clearly associated with an array of benefits, including more contact with

[1] Notable changes had a chance probability of 6-10%.

neighbors, feeling calm when outside, and feeling safe at the river. Participants also reported feeling more useful and thinking more clearly after 9-18 months of membership.

Participants in the Tuolumne River Adventure Club also completed surveys intermittently. The data points reported here include Baseline, Post 1 (2-6 months later) and Post 2 (7-12 months later.) Unfortunately, the small number of students involved and problems with consistent data collection make it impossible to evaluate the outcomes of this program.

Overall there were few differences between pre and post scores for youth participants in short-term TRT programs. Youth participants in Cohort 1 expressed less enthusiasm about the park and river at the end of GUNG and Camp programs and were more likely to say they did not have enough friends. It should be noted that the GUNG afterschool program was offered only 4 months in year 1.

Increased negativity was not evident in the second year of programming. Attitudes about the park and river were stable throughout the year for all programs. Even better, personal growth was evident summer camp participants in Cohort 2. Post scores were higher for feeling healthy and being able to work out problems with peers.

TABLE 1: Adult Leadership Program

Range 1-5	Baseline vs. Post Test 1 (2-9 months later)				Baseline vs. Post Test 2 (9-18 months later)			
	n	**Pre**	**Post**	**Change**	**n**	**Pre**	**Post**	**Change**
Neighborhood Involvement							¤	
I do my part to make my neighborhood better.	7	3.14	3.71	-	8	3.13	3.88	**-**
I get involved with things in my neighborhood.	7	**3.43**	**4.14**	*	8	3.75	4.38	-
I keep in touch with my neighbors	**8**	**2.38**	**3.50**	**Up**	**9**	**2.89**	**4.33**	**Up**
Positive Connections to Nature								
To me, it feels good to be outside.	8	2.88	2.75	-	9	3.00	4.00	-
I feel calm when I am outside.	8	**2.13**	**2.75**	**Up**	9	2.67	3.00	**-**
Attitudes Abut the Park								
I feel safe at the river.	8	2.25	2.63	**-**	9	**2.33**	**4.00**	**Up**
The park is a safe place to play.	7	2.14	2.57	-	8	2.38	2.38	-
I go to the park every week.	7	2.86	2.14	-	8	3.25	3.38	-
Mental and Physical Wellness (past 2 weeks)								
I've been feeling optimistic about the future.	8	3.50	3.88	-	8	3.63	3.88	-
I've been feeling useful.	7	4.14	4.29	-	7	**4.00**	**5.00**	**Up**
I've been feeling relaxed.	7	**3.43**	**3.86**	*	7	3..57	4.14	-
I've been dealing with problems well.	7	3.43	3.57	-	7	3.29	4.14	-
I've been feeling close to people.	7	**3.43**	**4.14**	*	7	3.57	4.29	-
I've been thinking clearly.	7	4.00	3.43	-	7	**3.86**	**4.71**	**Up**
I've been able to make up my own mind about things.	7	4.57	4.86	-	7	4.33	4.71	-

TABLE 2: Tuolumne River Adventure Club

Range 1-4	Baseline vs. Post Test 1 (2-6 months later)				Baseline vs. Post Test 2 (6-12 months later)			
	n	**Pre**	**Post**	**Change**	**n**	**Pre**	**Post**	**Change**
Positive Connections to Nature								
Do you like to play outside?	5	3.00	3.00	-	4	2.75	3.25	-
Do you like to go to the park?	5	2.40	1.80	**-**	4	3.00	2.75	**-**
Do you feel safe at the river?	5	2.40	2.60	**-**	4	3.00	3.00	**-**
How often does your family go to the park?	4	1.75	2.00	**-**	4	2.25	2.00	**-**
Physical Wellness								
Do you feel healthy?	4	3.00	2.75	-	4	3.75	3.75	-
Do you like to keep moving when you play?	4	2.25	3.00	-	4	2.50	3.25	**-**
Do you get tired a lot?	4	3.25	2.25	-	4	2.00	2.00	-
Mental / Emotional Wellness								
Do you think good things will happen in your life?	4	3.25	3.25	-	4	3.25	3.75	-
How often do things happen that get you upset?	4	1.50	1.75	-	4	1.50	1.50	-
Do you have enough friends?	4	2.50	2.50	-	4	3.25	3.25	**-**
Can you work out problems with other kids?	4	2.50	2.50	-	4	3.00	3.00	-

TABLE 3: Cohort 1 Youth Programs[2]

Range 1-4 (except as noted)	Get Up and Go (GUNG)				Park Summer Camp			
	n	**Pre**	**Post**	**Change**	**n**	**Pre**	**Post**	**Change**
TRT Program Satisfaction								
Do you have fun when you go to the park with GUNG ?	na	na	na		na	na	na	
Do you get bored when you go to the park with GUNG ?	na	na	na		na	na	na	
Attitudes About the Park								
Do you like to play outside?	15	3.07	3.29	-	13	2.85	2.92	-
Do you like to go to the park?	15	**3.47**	**2.73**	**Down**	13	3.15	2.92	-
Do you feel safe at the river?	15	2.64	2.71	-	13	**3.38**	**2.54**	**Down**
Is the park important to you?	na	na	na		na	na	na	
Do you talk to your friends about the park and river?	na	na	na		na	na	na	
If you could choose, would you play at the park or at home?	na	na	na		na	na	na	
How often does your family go to the park?	na	na	na		13	2.15	2.38	-
Positive Connections to Nature								
How often do you feel calm at natural places like the park and river?	na	na	na		na	na	na	
How often do you feel nervous at natural places like the park and river?	na	na	na		na	na	na	
River is…cool (range 0-1)	na	na	na		na	na	na	
River is… scary (range 0-1)	na	na	na		na	na	na	
River is… fun (range 0-1)	na	na	na		na	na	na	
River is… dirty (range 0-1)	na	na	na		na	na	na	
In natural places I feel… excited (range 0-1)	na	na	na		na	na	na	
In natural places I feel… bored (range 0-1)	na	na	na		na	na	na	
In natural places I feel… curious (range 0-1)	na	na	na		na	na	na	
In natural places I feel… disgusted (range 0-1)	na	na	na		na	na	na	
Mental and Physical Wellness								
Do you feel healthy?	15	3.25	2.93	-	13	**3.31**	**2.77**	*
Do you get tired a lot?	15	2.46	2.54	-	13	2.38	2.23	-
Do you like to keep moving when you play?	15	3.00	3.20	-	13	**3.46**	**2.85**	**Down**
Can you work out problems with other kids?	15	2.73	2.47	-	13	2.62	2.62	-
Do you have enough friends?	15	**3.57**	**3.14**	**Down**	13	**3.62**	**2.77**	**Down**
Do you think good things will happen in your life?	15	2.87	3.27	-	13	2.85	2.69	-
How often do things happen that get you upset?	15	2.69	2.08	-	13	1.92	2.23	-

[2] **February - August 2012**

TABLE 4: Cohort 2 Youth Programs [3]

Range 1-4 except as noted	Get Up and Go (GUNG)				Park Summer Camp			
	n	Pre	Post	Change	n	Pre	Post	Change
TRT Program Satisfaction								
Do you have fun when you go to the park with GUNG ?	12	3.83	3.75	-	na	na	na	
Do you get bored when you go to the park with GUNG ?	12	1.00	1.08	-	na	na	na	
Attitudes Abut the Park								
Do you like to play outside?	15	3.20	3.00	-	13	3.15	3.15	-
Do you like to go to the park?	15	3.27	3.33	-	12	2.92	3.33	-
Do you feel safe at the river?	15	3.33	3.20	-	13	3.00	3.15	-
Is the park important to you?	12	3.33	3.08	-	na	na	na	
Do you talk to your friends about the park and river?	15	2.67	2.00	-	na	na	na	
If you could choose, would you play at the park or at home?	12	2.92	2.58	-	na	na	na	
Positive Connections to Nature								
How often do you feel calm at natural places like the park and river?	12	3.08	2.83	-	na	na	na	
How often do you feel nervous at natural places like the park and river?	12	1.67	1.67	-	na	na	na	
River is…cool (range 0-1)	12	**0.67**	**0.17**	**Down**	na	na	na	
River is… scary (range 0-1)	12	0.00	0.00	-	na	na	na	
River is… fun (range 0-1)	12	0.67	0.75	-	na	na	na	
River is… dirty (range 0-1)	12	0.17	0.08	-	na	na	na	
In natural places I feel… excited (range 0-1)	12	0.58	0.50	-	na	na	na	
In natural places I feel… bored (range 0-1)	12	0.08	0.08	-	na	na	na	
In natural places I feel… curious (range 0-1)	12	0.50	0.42	-	na	na	na	
In natural places I feel… disgusted (range 0-1)	12	**0.25**	**0.00**	*	na	na	na	
Mental and Physical Wellness								
Do you feel healthy?	15	3.47	3.67	-	**12**	**2.83**	**3.42**	**Up**
Do you get tired a lot?	15	1.80	2.07	-	13	2.46	2.46	-
Do you like to keep moving when you play?	15	3.27	3.20	-	13	3.15	3.15	-
Can you work out problems with other kids?	15	**2.60**	**3.20**	*	**13**	**2.15**	**2.92**	**Up**
Do you have enough friends?	15	3.13	3.27	--	13	2.92	3.38	-
Do you think good things will happen in your life?	15	3.27	3.47		13	2.38	2.00	-
How often do things happen that get you upset?	15	1.93	1.93	-	13	1.85	2.23	-

[3] **September 2012 – May 2013**

SIERRA VISTA CHILD & FAMILY SERVICES

INN 06 Connecting Youth Receiving Services To Community Resources

FINAL REPORT

SUBBMITED TO: Stanislaus Behavioral Health & Recovery Services

DATE: February 14, 2014

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive, Modesto, CA 209-525-6247, fax 209-558-4323

FINAL REPORT

ISSUE ADDRESSED

Current mental health practice does not emphasize activities outside of the clinical setting as an adjunct to mental health services. Similar to the Community Capacity Building research, The 40 Developmental Asset research tells us that having youth involved in youth development programs that they enjoy help them develop into healthy individuals. The Connecting Youth Project will teach us whether or not making the connection to youth development programs improve the mental health outcomes for youth, and what types of practices or activities will get youth engaged outside of the clinical setting. The learning is important to our community because it can significantly change and transform the way a clinician performs and provides mental health services to youth. This could also make a case for these types of youth development activities to become part of the formal treatment plan.

Various elements of the project, often referred to as Connecting Kids, introduced a new application to the mental health system of a promising community-driven practice/approach or a practice/approach that has been successful in a non-mental health context. The "positive youth development" approach was adopted from outside the mental health system and has been successful in a non-mental health context. Positive youth development is the intentional effort of other youth, adults, and the community to provide community-based supports and opportunities for youth to enhance their interests, skills, and abilities. We understand that all young people (regardless of whether or not they are receiving mental health treatment) need support, guidance and opportunities during adolescence. We also understand from research of the 40 Developmental Assets that constructive use of time in creative activities and youth programs help young people grow up healthy, caring and responsible.

What we wanted to learn is: When clinical therapy is combined with a community-based activity that a young person is interested and engaged in, does that shorten the time of treatment and produce a better mental health outcome for that young person? Can this approach result in a mental health practice that includes community-based activities in a treatment plan, that are normally outside of the traditional forms of mental health service delivery, thereby transforming traditional outpatient therapy in the future?

DESCRIPTION OF THE PROJECT

Connecting Youth to Community Supports was a 2 year project operated by Sierra Vista Child and Family Services (SVCFS) and focused on increasing quality of services including better outcomes with a secondary focus of promoting interagency collaboration incorporating recovery and resiliency based approaches and de-stigmatizing community-based activities into treatment, and connecting youth to community based activities that may reduce length of time and intensity of treatment. Youth who were receiving formal mental health services were recruited to participate in the project. Mental Health Clinicians assisted youth in identifying activities they were curious about, interested in, and passionate about. Community Support Specialists connected the youth to the desired activity and monitored participation in the activity. The clinician monitored progress toward recovery including length of time and intensity of treatment.

The project sought to contribute to practice by learning how to assist mental health clinicians in thinking about incorporating community-based activities into treatment may reduce the length of time and intensity of treatment for youth and their families. The project hoped to support and accelerate county-wide transformation by connecting people receiving services to community-based supports and service providers to become more facile in linking their clients to information and support for more holistic approaches to well-being.

The mental/emotional health issue this project addresses is that the current mental health model that our agency utilizes is diagnosis-driven, which historically hasn't emphasized community linkages as a formal part of the treatment plan. Our expected outcome is that youth who are under the care of a clinician AND engaged in our proposed project will successfully complete their treatment plan in less time and with better outcomes than with just clinical sessions alone.

The specific BHRS learning issue that the project addressed is ***Connecting people receiving services to community-based supports***. The questions that our proposal addresses are ***How can people providing services encourage people receiving services to connect with community-based supports that focus on their interests, passions, and strengths instead of their symptoms, illness or diagnosis?*** and ***Does making these connections to community-based supports improve the experience of recovery and decrease the length of time and intensity of needed treatment?***

ANALYSIS AND EFFECTIVENESS OF PROJECT

The program timeline was as follows:

First 90 days

- Project Development - Community Support Specialist coordinated the innovation project, and set up relationships with the agencies in local communities and throughout the county that offer youth development programs.

Month #4

- Community Support Specialist educated the clinicians about positive youth development activities that are available in the community to young people in treatment.

Ongoing after Month #4

- Clinicians provided a baseline assessment of the youth's mental health prior to contacting the Community Support Specialist.
- Clinician and Community Support Specialist worked together to assist the youth in identifying an activity that they are interested and passionate about and develop a participation plan.
- Community Support Specialist engaged the young person and connected them with the program.
- Young person participated in an activity in their community, with participation monitored by the Community Support Specialist.
- Community Support Specialist worked with the clinicians and case managers, so that once learning occurred, the program supports were in place and the referrals could continue.

155 children were referred to the program. Of that number 115 were connected with activities in the community. The other 40 were provided with the opportunity, but did not following through with the linked activity. For the purposes of this report, the data evaluates only those who were fully engaged in the community activity for a minimum for four months. That number is 87 (N = 87).

Types of Activities

Youth were connected with a variety of activities during the project. The total N = 87 consists of youth who participated in their selected community activity for a minimum of four months. Many youth participated for up to six months, with a select few extending beyond six months. Following is a list of activities youth have been linked to during the project.

Gym Membership	Cheerleading	Boxing	Golf
Swimming lessons	Gym-fit	Ballet	Softball
Karate	Modeling classes	Other Dance	Violin
Guitar	Cake decorating	Soccer	Art classes
Voice lessons	Baseball	Football	Piano
Gymnastics	Horseback riding	Bowling	Basketball

Youth Total Time in Treatment

It was hypothesized that the average total time in treatment would be reduced for youth who actively engaged in community activities. This included both time (months) in services and intensity (hours) of services. Data collected during the course of the project demonstrated that children who were connected and fully engaged in community activities remained in treatment *longer* than children who were not connected to community activities. This was true for all programs from which children were referred. Figure 1 illustrates the average length of stay in months for children enrolled in the Attention Deficit Hyperactivity Disorder Clinic (ADHD) and Children's Outpatient Program (COP). Children actively participating in community activities had a longer average length of stay in the program than children not participating in the Connecting Kids Project (CK). Likewise, Figure 2 illustrates the average total number of hours of services per child is significantly higher for those participating in the Connecting Kids Project compared to those in Mental Health (MH) Services only.

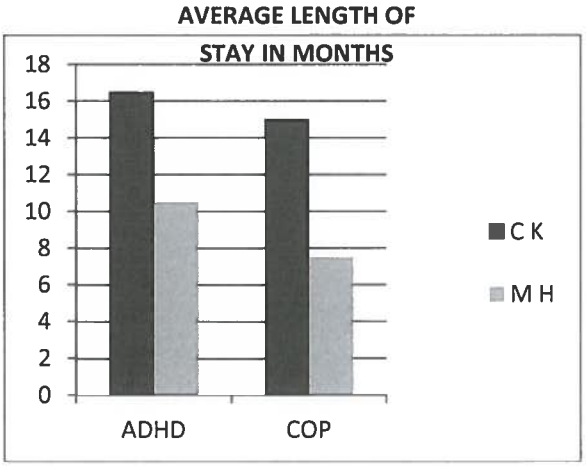


FIGURE 1

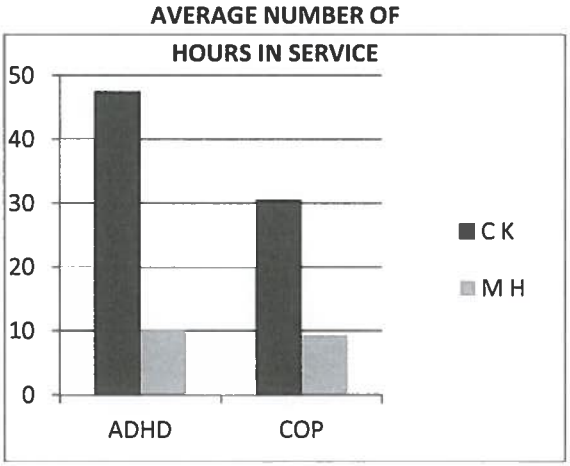


FIGURE 2

Stanislaus County Behavioral Health and Recovery Services
800 Scenic Drive, Modesto, CA 209-525-6247, fax 209-558-4323

It is significant to note that most children engaged in the Connecting Kids Project were participating in their Mental Health Treatment program for a fair amount of time prior to engagement in the Connecting Kids Project. Figure 3 shows the average months of service prior to engagement in Connecting Kids, during engagement with Connecting Kids, and total time in program. Figure 4 shows the same for average hours.

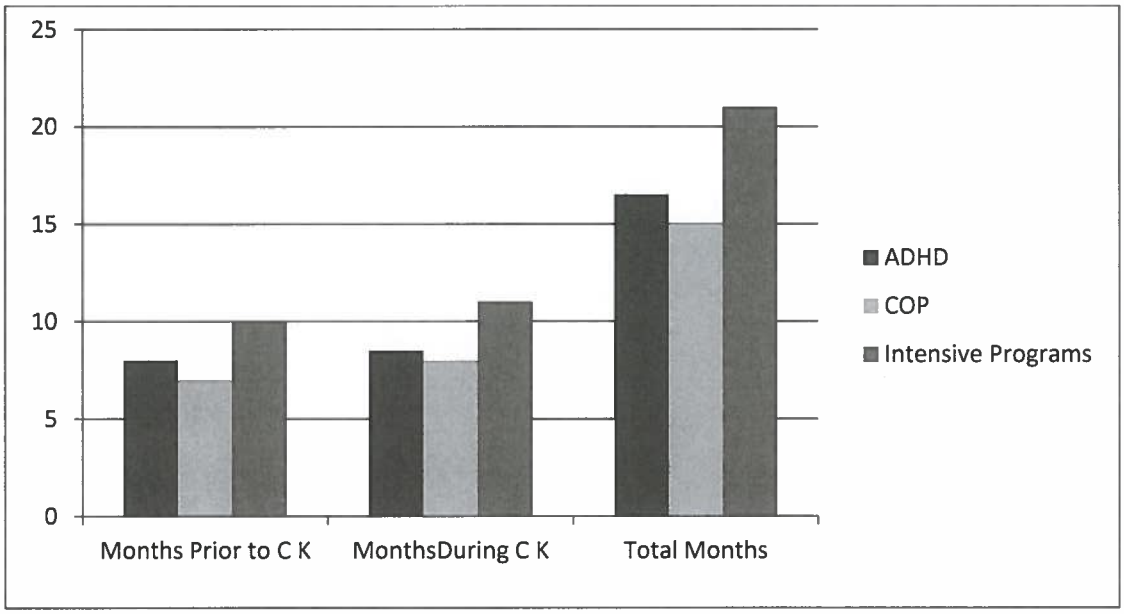


FIGURE 3

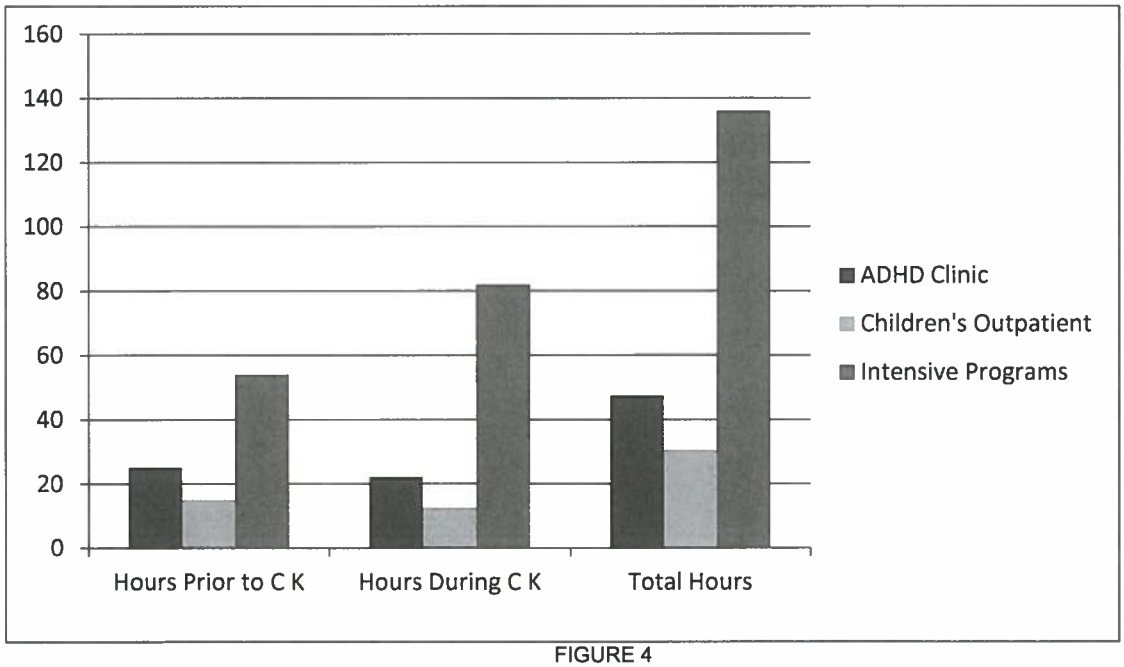


FIGURE 4

Figures 4 and 5 above include children referred from high intensity programs such as the Non-Public School (NPS), Home Based Services (HBS), and the LIFE Path Early Psychosis Intervention Program (EPI). These programs, by design, have multiple contacts per week and may be more than two years in duration. As such, data for time and intensity skews toward the high end. Nevertheless, it is interesting to see how the numbers compare against traditional mental health services. For the purposes of this report, only the period during the Connecting Kids Project is considered. Prior services are not indicated in the figures for those in the NPS or EPI Programs.

Another consideration is to compare the average time during participation in Connecting Kids vs. Mental Health Services only. It should be emphasized again that children participating in the Connecting Kids project are engaged in community activities *and* mental health services. Interestingly, even when factoring out the time in mental health services prior to engagement in the Connecting Kids Program, the children fully participating in community activities had on average more hours of service than those with mental health services only. Figures 5 and 6 illustrate this comparison.

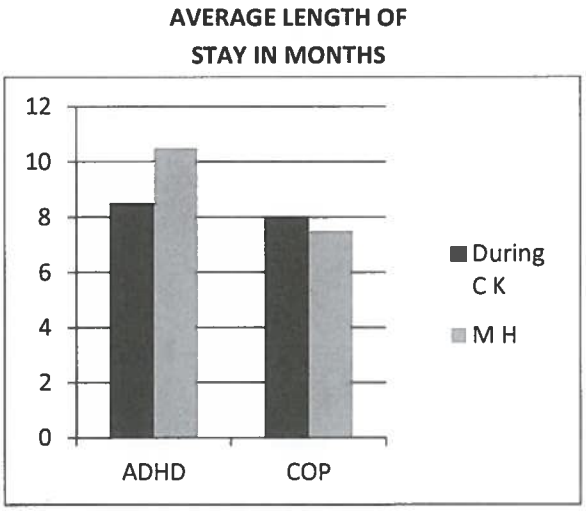


FIGURE 5

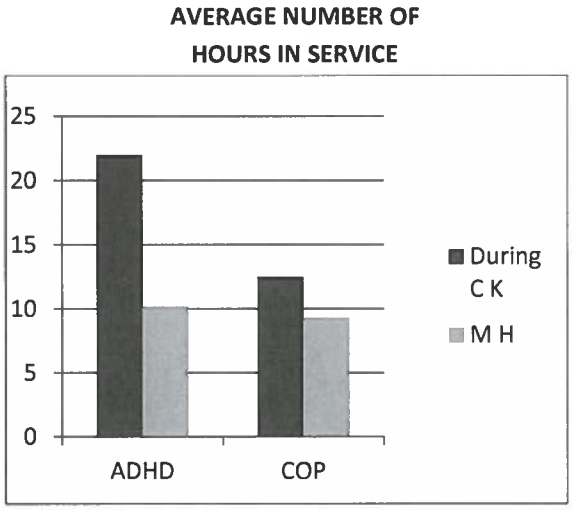


FIGURE 6

Clinician Evaluation of Mental Health Status

Clinicians provided 31 matched sets of pre-post evaluation data. Clinicians responded to a ten item survey using a 5 point Likert scale for each question. Range of total score for each survey was 0 – 50. The average change score between pre and post test was +11.25, or a 45% positive change. Additionally 97% (30/31) of responses indicated participation in the Connecting Kids project improved children's presenting symptoms. N=of matched sets for children. The following table presents results broken down by program.

CLINICIAN SURVEYS	% Improved	% Worsened	% Stay the Same
ADHD (N=15)	14/15	0/15	1/15
COP (N=8)	8/8	0/8	0/8
High Intensity (N=8)	8/8	0/8	0/8
All Programs (N=31)	30/31	0/31	1/31

YOUTH AND CAREGIVER SELF RATINGS

Youth provided 49 matched sets of pre-post evaluation data. Youth responded to a ten item survey using a 5 point Likert scale for each question. Range of total score for each survey was 0 – 50. The average change score between pre and post test was +5.5, or a 15% positive change. It should be noted the children on average had a 38/50 score on the pre-survey. This high average pre-survey score leaves little room for improvement. Yet, 73% of children (36/49) referred from all programs felt participation in community activities improved their mental health symptoms, 2% (1/49) felt their symptoms were worse, and 25% (12/49) felt no change. The following table breaks these figures down by program.

YOUTH SURVEYS	% Improved	% Worsened	% Stay the Same
ADHD (N=19)	13/19	0/19	6/19
COP (N=14)	13/14	0/14	1/14
High Intensity (N=16)	10/16	1/16	5/16
All Programs (N=49)	36/49	1/49	12/49

Parents provided 49 matched sets of pre-post evaluation data. Parents responded to the same survey as their children. Parent pre and post scores were generally lower than clinician's and children's scores. The average change score between parent pre and post test was +8, or a 42% positive change. Of note, the highest ratings generally occurred after the second month of the child's involvement in the community activity, then tapered off and flat lined at the reported rate. 86% of Parents (42/49) referred from all programs felt participation in community activities improved their mental health symptoms, 2% (1/49) felt their symptoms were worse, and 12% (6/49) felt no change. The following table breaks these figures down by program.

PARENT SURVEYS	% Improved	% Worsened	% Stay the Same
ADHD (N=19)	15/19	0/19	4/19
COP (N=14)	12/14	0/14	2/14
High Intensity (N=16)	15/16	1/16	0/16
All Programs (N=49)	42/49	1/49	6/49

Common Themes

In addition to the above data, children, parents and clinicians were asked to respond with short narratives as to the impact of participating in the Connecting Kids Project. Several themes emerged.

Increased Confidence—Increased confidence of children was mentioned by nearly 65% of parents. This was noted in each of the six month reporting cycles for this project. Parents reported that participation in the activities bolstered **self-esteem** and a positive sense of confidence. These children were less anxious and bolder when trying new things. For many this increased confidence was realized across environments, including home and school. Additionally, 85% of responding clinicians also indicated children's confidence increased. This was most notable in the child's presentation during session. Clinicians attributed this directly to participation in community activities, and not to the child simply becoming accustom to the therapeutic setting.

Improved Family Relationships—Improved family relationships was another theme that emerged in the post narrative surveys. Parents and children alike noted an increase in positive interactions in the home environment between parent and child and between the child and their siblings.

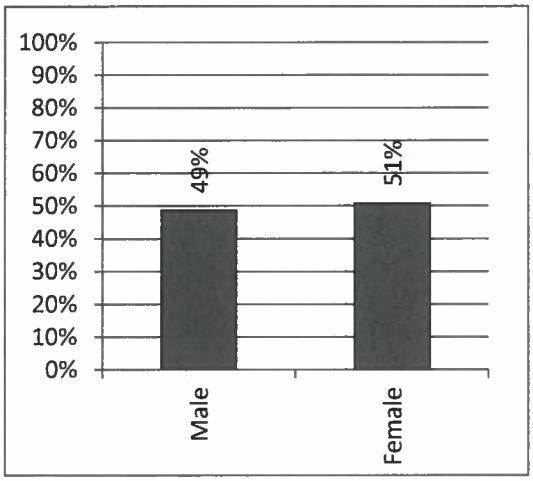
Improved Social Skills—A theme that emerged among clinician responses was that the children developed improved social skills as a result of participation in the community activities.

Improved Engagement in the Mental Health Service—In a separate post survey conducted confidentially via Survey Monkey, many clinicians noted that children became more invested in therapy once they had connected to a community activity. The children were more participatory during sessions. This appeared to be directly related to improving well-being and decreasing symptomology.

Demographics of Children Served

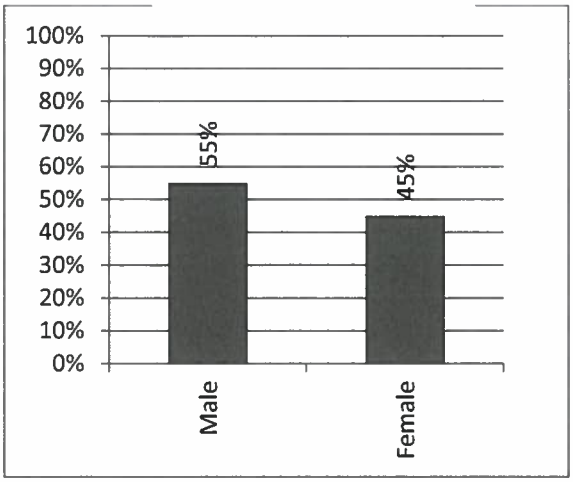
Demographics are presented on the following pages for both total children referred to the program (N=155) and total of children who fully participated in the community activity for a minimum of four months (N=87).

Referred: N=155



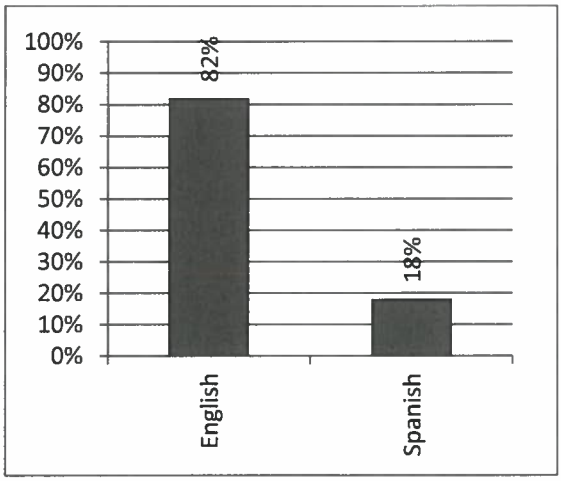
GENDER

Participated: N=87



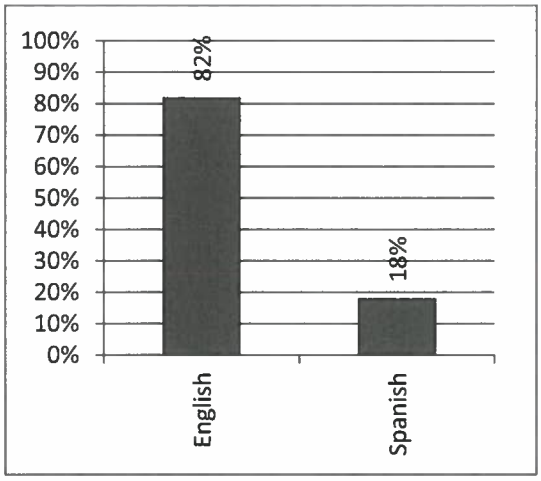
GENDER

Referred: N=155

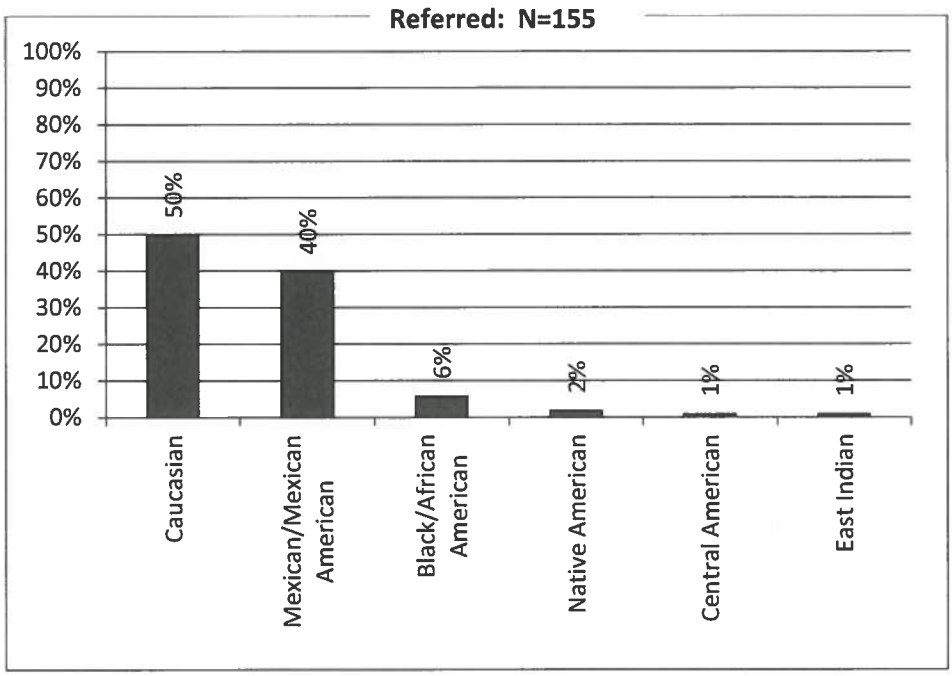


LANGUAGE

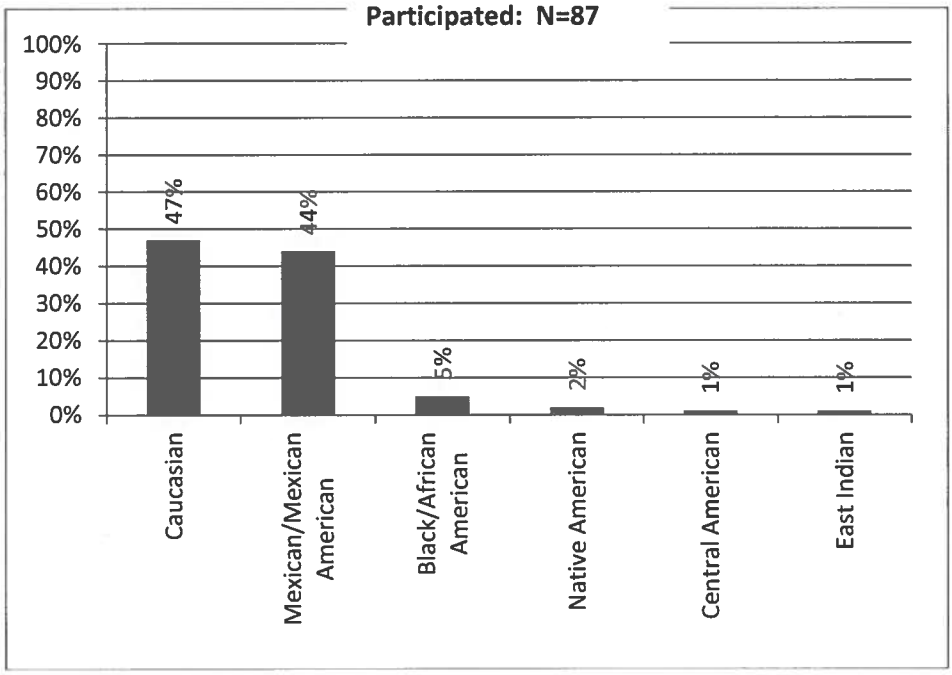
Participated: N=87



LANGUAGE

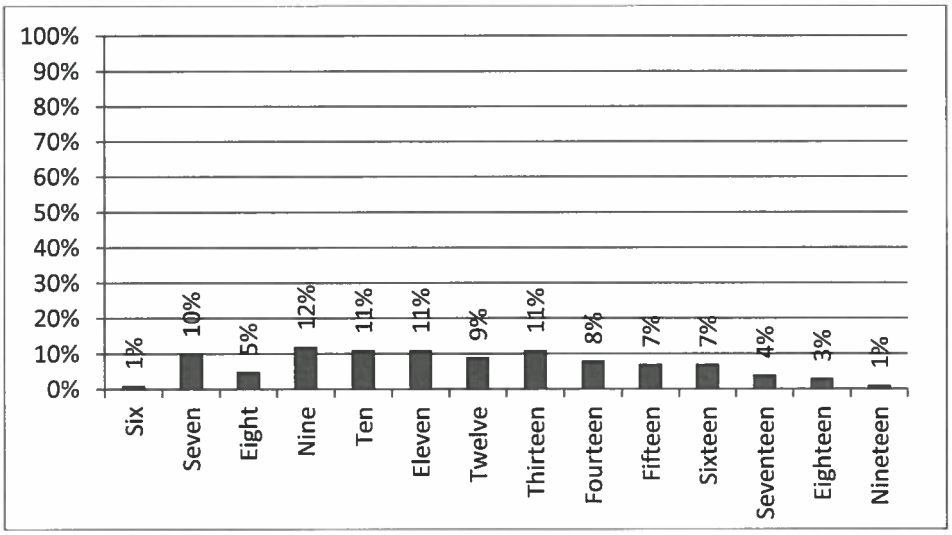


ETHNICITY



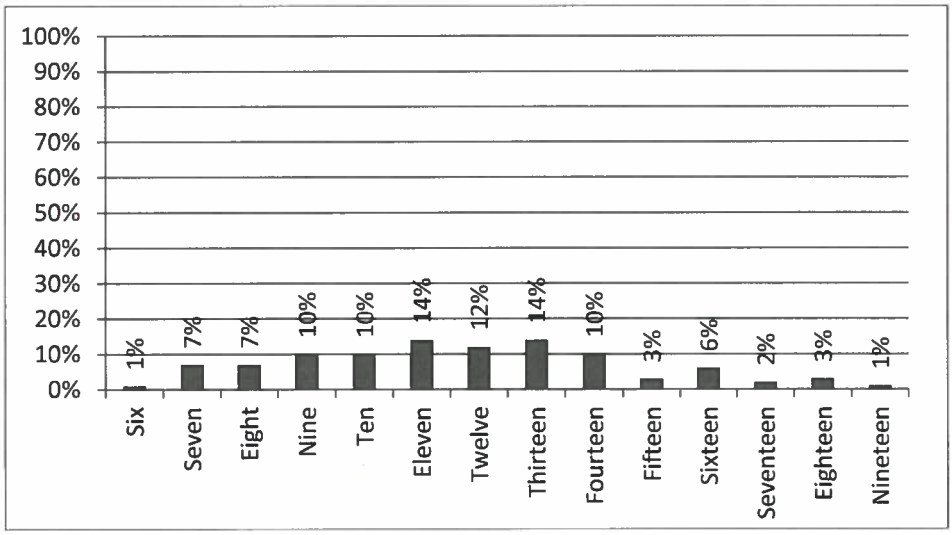
ETHNICITY

Referred: N=155



AGE

Participated: N=87



AGE

In the table below, data is presented in the Results Based Accountability Framework.

RBA Framework : Example of Program Results Shown in RBA Framework	
Examples: • # of unduplicated clients served in FY12-13 • # of classes/groups held	**How Much?**
• 1 fundraiser conducted • 155 referrals received into the program • 115 youth were screened into the program and connected with Community Activities • 87 engaged for a minimum of four months in community activity • 20 community based organizations agreed to offer low or no cost activities	
Examples: • Average length of treatment • Customer satisfaction data • Data addressing hard to reach populations served	**How Well?**
• 93% (69/74) of surveyed Caregivers Surveyed reported Satisfaction with the Program • Average length of treatment 18 months for all programs o ADHD: 16.5 months o COP: 15.0 months o Intense: 21.0 months • Average hours of treatment 39 for all programs o ADHD: 22.0 o COP: 12.5 o Intense: 82.0	
Examples: • Changes in participant skills/knowledge • Changes in participant attitude/opinion • Changes in participant behavior • Changes in participant circumstance	**Is Anyone Better Off?**
• Improved Well Being (decreased symptoms) • Improved Family Relationships • Increased Confidence • Improved Social Skills	

WHAT WAS LEARNED

1. The primary Learning Objective of the Connecting Kids Project was to determine if connecting children who are participating in formal mental health services to community activities that they are interested in would reduce the time and intensity of

Mental Health Service. It was learned that connecting children to community activities in effect increased time and intensity of services. It is hypothesized that participation in healthy activities improves engagement in the therapeutic process leading to more time in service as well as greater benefit in terms of outcomes. The reported feelings of increased confidence and self-esteem may give rise to a greater sense of hope regarding primary referral issues and bolster motivation to capitalize on the therapeutic experience.

2. Parents and children reported ancillary benefits to participation in community activities. Parents noted throughout the project that once children were engaged in community activities their sense of confidence and self-esteem improved. Having "something to do" seemed to increase children's happiness and mood. The parent/child relationship benefited as well as increased positive interaction among the child and their siblings.

3. Clinicians reported that children fully participating in the project developed improved social skills. It seems reasonable social skills would improve as most activities required interacting with others. Many children and parents reported little exposure to community outside the school environment. Perhaps being involved in community activities afforded positive role models as well as increased clear expectations regarding social interactions.

4. Children from both outpatient settings and more intensive programs, such as non-public school, benefit from participation in community activities. By report from clinicians, parents, and children, child clients in the ADHD Clinic may have derived less benefit than their counterparts in other programs. This could be due to the nature of ADHD symptomology being a more enduring than other mental health symptoms such as anxiety and depression. If a child is anxious or depressed, regular participation in activities can often impact his mood in positive ways, and this impact can be seen in terms of improved behavior. ADHD symptomology is present even when a child is regularly participating in activities. Though mood can still be affected positively, impulse control and hyperactivity can still be present, thus giving the appearance of behavior "staying the same."

5. We learned that the community at large is ready and willing to assist children in getting connected to activities. Over the two years of the project donors contributed over $14,000 to help fund activities for needy children. Additionally, there have been 42

distinct organizations that children and youth have been connected to in the community. Twenty of these community entities offered low-cost or no-cost services:

- Ingram's Music Turlock: discounted lessons
- Dale's Guitar: offered us good discounts on their guitars
- Gottschalk Music Center: waived statement fee for an instrument rental
- Juline's School of Dance: offered their services for free
- Robert Taylor's Martial Arts: offered their services for free
- Maddux Youth Center: free
- Modesto Park and Recreation: offered scholarships
- Ceres Park and Recreation: offered scholarships
- Aikido of Modesto: waived registration fee, and offered discount on uniform
- Chinese Martial Arts: was able to waive all start up fees
- Step It Up Dance Studio: was able to waive registration and discount on class tuition
- Art and Day Camp: discounted horse lessons
- Attitude Plus! Dance Studio: discount on class tuition
- Gottschalk Music Repair Shop: would repair most wind instruments for free
- Thomas and Vessel: would repair most string instruments for free
- Ingrams and Brauns: discount on group classes
- Luv 2 Dance: discount on class tuition
- Oakdale Mixed Martial Arts: offered scholarships
- Red Shield Salvation Army: discounted activities
- Yes Company: offers fund raising opportunities, or free

6. 19/19 Clinicians who completed the post survey via Survey Monkey indicated they felt participation in this project helped improved treatment outcomes for their child clients.

7. 18/19 Clinicians believe engaging youth in community activities should be included as part of the formal mental health treatment plan.

Challenges

Some challenges were identified during the evaluation and learning process.

1. <u>Identifying no-cost or low-cost activities.</u> Many families participating in the project report an inability or hardship regarding paying for activities. Though Sierra Vista can assist families via the Fund A Dream donor program, once formal services are concluded, the families are fully responsible for the continued cost of the activities.

Identifying no-cost or low-cost activities becomes critical to sustaining the benefits of these healthy pursuits, be it continuing in current activities or transitioning to new ones.

2. Subsidized Activities. Due to Sierra Vista subsidizing activities, as well as offering full "scholarships" for activities, many families presented for Mental Health Services seemingly with the specific goal of having the Innovations Project pay in full for community activities for children. The motivation to participate in the mental health services may have been compromised for these families. That is, some caregivers expressed interest only in the Innovations component of services, and once children were engaged in community activities did not consistently present children for the formal mental health services.

3. Subsidized Activities. A second challenge with regard to subsidized activities is impact on length of stay. It is possible that the longer length of stay in formal mental health services had more to do with a desire to keep the subsidy and less to do with a greater engagement in services.

4. Turnover. Over the past eighteen months Sierra Vista has experienced significant turn over in clinical positions related to Mental Health Realignment in California. This has impacted securing clinician feedback for the final report.

5. High Intensity Program Referrals. Children referred from high intensity programs such as the Non Public School Day Treatment Program and Home Based Services generally receive multiple services per week during the duration of services. Additionally, children in the non-public school are often in attendance for two plus years. The level of services for this population skews data in terms of time and intensity of services.

Conclusion

The data suggests the program has been successful in promoting the wellbeing of youth and helping to ameliorate presenting symptomalogy. Though participation in the program did not reduce time and intensity of formal mental health services, it did yield positive results with both formal and anecdotal outcomes. Children and parents appeared to engage more fully in services and derive more benefits than those children and families participating in Mental Health Services only. This was evidenced by a greater number of months in treatment and a greater number of hours of service. Even when accounting for the time in mental health

services prior to referral to Connecting Kids, time and intensity of services was still greater for those fully engaged in the community activity. Clinicians reported children and families participating in Connecting Kids derived greater therapeutic benefit. Parents and clinicians also indicated children engaged in community activities developed an increased sense of confidence and improved interactions with family members. Clinicians are embracing this concept of Community Capacity Building and continue to refer to the project. The responses of youth, parents and clinical staff have been so positive Sierra Vista is working to integrate the project into regular practice. At this time, one staff will continue to be a point person for connecting youth to community supports. It is expected that this service will be billed directly via the child's open chart using case management coding.

Recommend this Project to Others?

Sierra Vista would recommend other mental health service providers explore connecting kids to community activities. Children seem to engage better in the therapeutic process and gain benefits both inside and outside of session.

Continue the Project Under a Different Funding Source?

Sierra Vista continues to explore the feasibility of continuing the project via formal Mental Health contract billing. Challenges with accessing Anasazi as well as ensuring proper billing codes and progress notes have slowed the progress of this endeavor. However, Sierra Vista remains optimistic that the Connecting Kids program will remain operational and continue to link children to community activities.

Materials Developed to Communicate Lessons Learned and Project Results

See attached Surveys

Sierra Vista Child & Family Services
Innovations
Parent/Guardian- Post Survey

Program:_____ Date: _____
Clinician:_____ Client:_____

On a rating scale of (1-5), 1 being never, 5 being always, rate each of the following statements on how you believe your child has been feeling this past week:

1	2	3	4	5
				
Never	Once in a while	Sometimes	Most of the time	Always

1. My child is happy. _____
2. My child gets along well with family. _____
3. My child gets along well with friends. _____
4. My child likes to get up and do things. _____
5. My child feels like he/she can do most things. _____
6. My child likes going to school. _____
7. My child is successful in school. _____
8. My child feels calm and relaxed most of the time. _____
9. My child enjoys activities in the community. _____
10. My child feels that things are going well in his/her life. _____
11. This activity has helped my child feel better. _____

Sierra Vista Child & Family Services
Innovations
Client Post Survey

Program:_____ Date: _____
Clinician:_____ Client:_____

On a rating scale of (1-5), 1 being never, 5 being always, rate each of the following statements on how you been feeling this past week:

1	2	3	4	5
 Never	 Once in a while	 Sometimes	 Most of the time	 Always

1. I am happy. _____
2. I get along well with my family. _____
3. I get along well with my friends. _____
4. I like to get up and do things. _____
5. I feel like I can do most things. _____
6. I like going to school. _____
7. I am successful in school. _____
8. I feel calm and relaxed most of the time. _____
9. I enjoy activities in the community. _____
10. I feel that things are going well in my life. _____
11. This activity has helped me feel better. _____

Sierra Vista Child & Family Services
Innovations
Clinician Post-Survey

Program:_____ Date: _____
Clinician:_____ Client:_____

On a rating scale of (1-5), 1 being never, 5 being always, rate each of the following statements on how you believe your client has been feeling this past week:

1	2	3	4	5
				
Never	Once in a while	Sometimes	Most of the time	Always

1. My client is happy._____
2. My client gets along well with family. _____
3. My client gets along well with friends. _____
4. My client likes to get up and do things. _____
5. My client feels like he/she can do most things. _____
6. My client likes going to school._____
7. My client is successful in school._____
8. My client feels calm and relaxed most of the time._____
9. My client enjoys activities in the community. _____
10. My client feels that things are going well in his/her life. _____
11. This activity has helped my client feel better. _____

Clinician Feedback

1. What have you learned as a result of engaging your client in an activity?

2. What has changed as a result of engaging your client in an activity?

3. Do you think engaging our youth in activities should be included as part of the formal mental health treatment plan? If so, why?

The following is the results printout from the Clinician Post Survey conducted via Survey Monkey.

What did you learn as a result of the youth you served being involved in the Innovations Project?

Many children are not able to be involved in most activities based on their parents' financial situations, and the children lose out on having relationships with other children with similar interests, or do not find out what their talents are.

2/5/2014 11:19 AM View respondent's answers

Youth participating in an activity can make a big diffrence in their life. Youth just like adults need things to keep them busy and distracted from the problems they may be facing.

2/4/2014 2:49 PM View respondent's answers

I believe this program should expand to include parents. I have been learning that very often parents need knowledge and mentoring around how to parent. They also would benefit from exploring their interests outside the home. Too many get caught up in taking care of their child instead of themselves.

2/3/2014 5:37 PM View respondent's answers

The importance of holistic care (mind, body, soul)

2/3/2014 3:19 PM View respondent's answers

What I learned was that Innovation Project contributes to my cl reaching his treatment goals and helps cl's increase their learning and decrease their hyperactivity levels.

2/3/2014 1:59 PM View respondent's answers

Client was able to participate in community services and sports with support from innovations.

2/3/2014 1:24 PM View respondent's answers

I learned that Innovations is an extremely important part of Sierra Vista. Our client really need this outlet, and I appreciate all of Megan's hard work to match our clients with their interests. My client's love Innovations, and parents are constantly asking about it.

2/3/2014 1:18 PM View respondent's answers

Client benefit from learning or building on a new skill.

1/31/2014 4:55 PM View respondent's answers

How being involved in an activity can help boost their self esteem

1/31/2014 4:34 PM View respondent's answers

I learned that having the client participate in an extra curricular activity outside of school can create an avenue for improvement.

1/31/2014 2:43 PM View respondent's answers

Child was more motivated to continue attending counseling and had a positive activity to engage in after school

1/31/2014 12:12 PM View respondent's answers

My client has the ability to learn and maintain engaged in an activity that he enjoys.

1/31/2014 11:54 AM View respondent's answers

that mental health treatment can be positively enhanced through the use of viable, engaging, positive community activities and additional supports

1/28/2014 1:46 PM View respondent's answers

I do not feel as if i learned anything specific as result of the program.

1/27/2014 2:14 PM View respondent's answers

I learned that beng involved in an activity helps youth to recover from mental health illnesses and increases their motivation to want to succeed and feel better about who they are.

1/27/2014 10:17 AM View respondent's answers

Even though it did not decrease treatment time, it definitely served as a distraction and a stress reliever.

1/27/2014 9:05 AM View respondent's answers

It gives them something positive to look forward to

1/27/2014 8:49 AM View respondent's answers

The innovations program reiterated the fact that increasing the types of coping skills and creating variation among coping skills is an essential life tool, that these cl's are being introduced to many

coping skills which plants a seed for them to be able to decrease subjective units of distress in their future.

1/27/2014 8:39 AM View respondent's answers

The importance of connections with the community have been helpful in helping the clients have access to opportunities they would not have had.

1/25/2014 6:10 PM View respondent's answ

Do you feel participation in the Innovations Program helped improve treatment outcomes for your clients?

	No	Yes	Total	Average Rating
(no label)	0%	100%		
	0	19	19	2.00

What benefits, beyond specific treatment goals, did your clients experience as a result of participating in the Innovations Program?

Many of the clients would never have had the chance to be involved in many of the activities due to their low SES. This gave them something to talk about with other children who have the resources to be involved in the activities.

2/5/2014 11:19 AM View respondent's answers

It helped my client with her self esteem. It helped her feel happy and distract her from thinking about her problems she was facing.

2/4/2014 2:49 PM View respondent's answers

They got involved with other children (home schooled client), they were able to have other positive adult interactions and I feel their self-esteem was improved.

2/3/2014 5:37 PM View respondent's answers

The clients that had someone walk them through connecting with activities benefited. They seemed happy with the activities which improved their well being. The clients who just received a list of activities, with not much contact and follow through, did not benefit unfortunately.

2/3/2014 3:19 PM View respondent's answers

According to parents and cl's experience with Innovation program, cl has been able to able to learn a new skill that has helped him to increase his self-esteem levels and decrease his hyperactivity and impulsivity levels.

2/3/2014 1:59 PM View respondent's answers

Positive growth and participation in things they would not have had access to or ability to participate in.

2/3/2014 1:24 PM View respondent's answers

My clients made new friends, tried new activities, gained self-confidence, and had an outlet to express themselves.

2/3/2014 1:18 PM View respondent's answers

Increase in self-esteem, increased interactions with other peers and adults, building support outside immediate family.

1/31/2014 4:55 PM View respondent's answers

They learned more about animals and it was something exciting for them

1/31/2014 4:34 PM View respondent's answers

Increased self-esteem; exposure to a new activity; gaining knoweldge of hard work and dedication; being able to form new and healthy relationships.

1/31/2014 2:43 PM View respondent's answers

Client's self-esteem appeared to increase

1/31/2014 12:12 PM View respondent's answers

Increased social skills, due to increased interactions with other children and adults. Client learned Karate, so self-defense increased, along with confidence and willingness to protect younger siblings. Client felt like his progress and engagement in the activity was meaningful and valuable.

1/31/2014 11:54 AM View respondent's answers

self advocacy skills, leadership skills, and how to be a positive role model to others

1/28/2014 1:46 PM View respondent's answers

+ increase self-esteem + increase confidence + Demonstrated increase in social skills

1/27/2014 2:14 PM View respondent's answers

Feeling better of who they are, getting along with others, learning social skills, communication skills and increasing their self esteem.

1/27/2014 10:17 AM View respondent's answers

It served as coping mechanism for consumers. It helped them cope with either anger, depression, anxiety. It served as an out for consumers that might need some time for themselves away from family that may be triggering their behavior.

1/27/2014 9:05 AM View respondent's answers

increased self-esteem

1/27/2014 8:49 AM View respondent's answers

increased self-esteem in the cl's, and the program is an additional tool for parents to see that activity as essential to the mental health, reduction of symptoms and overall health of their children.

1/27/2014 8:39 AM View respondent's answers

The relationship between the caregiver and the client improved due to the caregiver having access to the a community social avenue. The clients interaction with children of similar interests and age group and the caregivers interacted with other caregivers and a support system within the community.

1/25/2014 6:10 PM View respondent's answers

How did client participation in the Innovations Program impact your therapy sessions with the client?

Many of my clients brightened up when discussing their time in the activities. They seemed more interested in talking in session.

2/5/2014 11:19 AM View respondent's answers

Client would attend sessions in a happy mood, she would report how happy she felt.

2/4/2014 2:49 PM View respondent's answers

nothing specifi

2/3/2014 5:37 PM View respondent's answers

It gave more areas to explore with clients. It helped them set goals too.

2/3/2014 3:19 PM View respondent's answers

since cl began his Piano sessions, cl has been able to focus in therapy sessions, able to take turns to play during play therapy, and able to listen to instruction.

2/3/2014 1:59 PM View respondent's answers

Client felt successful and motivated.

2/3/2014 1:24 PM View respondent's answers

It was wonderful to be able to speak with the client about what he/she was doing in Innovations, and it was great to meet with Megan every so often for surveys. It helped me get a better grasp on where the client is, and how else I (and SVCFS) can support the client. Thank you, Megan, for your professionalism and hard work. You are awesome!

2/3/2014 1:18 PM View respondent's answers

Client looked forward to sharing experience and what they were working on. Was able to participate in activity the family would not be able to afford otherwise.

1/31/2014 4:55 PM View respondent's answers

Cl appeared excited and communicated easily in session.

1/31/2014 4:34 PM View respondent's answers

We incorporated the activity into our session.

1/31/2014 2:43 PM View respondent's answers

Client had more energy and was more motivated to open up in sessions.

1/31/2014 12:12 PM View respondent's answers

Client was eager and excited to share about his experiences in his activity. Client always brought forth and excitement in taking his karate classes. This class also helped client realize that he can parttake in an acticvity, maintain engaged, and that he can follow rules, directions and carry out tasks that are asked of him.

1/31/2014 11:54 AM View respondent's answers

positive impact as evidenced by increased attendance for counseling sessions

1/28/2014 1:46 PM View respondent's answers

Clients reported on their innovations involvement and and expressed enjoyment towards their selected activities. In some cases were self-esteem was targeted, treatment progressed at a quicker pace.

1/27/2014 2:14 PM View respondent's answers

I was able to see a change in clients attitude, way of viewing themselves and feeling more energized. This helped my sessions because client wanted to participate more and as a therapist I was able to identify the changes in client and share that with them to make them aware of their improvements.

1/27/2014 10:17 AM View respondent's answers

It definitely gave something to talk about and check in on weekly basis.

1/27/2014 9:05 AM View respondent's answers

He seemed more positive and confident

1/27/2014 8:49 AM View respondent's answers

cl would share their activities resulting in the continual strenfthening of rapport, trust, and increased cl's self-esteem each time that they shared with clinician.

1/27/2014 8:39 AM View respondent's answers

The clients access to the community helped to highlight environments beyond the home life and allowed the client to be open to changes which include interactions with the community.

1/25/2014 6:10 PM View

Please rate the following: I believe engaging youth in community activities should be included as part of the formal mental health treatment plan

- Answered: 19
- Skipped: 0

(no label)
01234

	Strongly Disagree	Disagree	Agree	Strongly Agree	Total	Average Rating
(no label)	5.26% 1	0% 0	26.32% 5	68.42% 13	19	3.58

Final Project Report

Integration Innovations
"Savvy Self-Care"
A Program by Stanislaus County Health Services Agency
For Patients with Co-Occurring Diabetes and Mental Illness

Description of Issue Addressed

The link between mental illness and diabetes is strong (although not fully understood due to the complex relationship between the two). People with mental illness are two to three times more likely to have diabetes than the general population and also exhibit decreased life expectancy. Furthermore, their access to medical treatment for diabetes and other health problems has been found to be more limited and less intensive than treatment available to those without mental illness. Diabetes itself requires considerable emotional and psychological resources for self-management, resources the mentally ill often lack.

Also, people with diabetes are more likely to experience depression and anxiety than their non-diabetic counterparts. It is unclear whether these mental health problems resulted from or contributed to the development of diabetes. Many observers believe both scenarios are likely.

Regardless of the etiology of the disease, people with mental illness (depression, anxiety, bipolar disorder, personality disorders, and psychotic disorders) often have poor outcomes from their diabetes treatment. In Stanislaus County, the recent introduction of Integrated Behavioral Health (IBH) providers in the primary care clinics has resulted in greater awareness of the problem. Diabetes is difficult to manage, at best. For the mentally ill, it can be nearly impossible.

Therefore, in 2011, the Health Services Agency (HSA), which serves low income residents through six family practice clinics (including one pediatrics clinic), applied to Behavioral Health and Recovery Services (BHRS) to undertake an Innovations Learning Project to explore how to effectively serve the population of adults who are dually diagnosed with mental illness and diabetes. Initially, staff members involved with this project were not certain what form the program would take. They knew one thing, however: the traditional didactic classroom approach to diabetic education (focusing almost exclusively on nutrition and exercise) would not likely be enough to achieve significant results with this population.

Description of the Project

"Savvy Self-Care," as the program became known, evolved into a 12-week psychoeducational approach to diabetes self-management for people who also suffer from a mental illness. A curriculum ("Take Action" from Galveston, Texas Health District) touching on relevant self-care issues was identified. This curriculum, which is in the public domain, included traditional topics such as nutrition and exercise, but offered much more than that, including complications of the disease, coping strategies, stress management, medication management, etc. It also included the motivational interviewing model, helping participants to identify their level of readiness for change.

In addition to a strong social support component, the program was originally designed to provide case management, therapeutic services, and psychiatric evaluation and intervention. However, staff shortages precluded the provision of many of these services.

Participants did see a physician (faculty or resident) briefly each week. Emerging medical problems were addressed by immediate referral to the patient's primary care physician. The substantial social support component addressed issues of isolation and demoralization among participants. Partner agencies provided staff and volunteers to meet with participants between sessions, engage them in social activities and problem solving, and assist them in reducing barriers to participation in the program.

Staff expected to see reduced levels of depression and anxiety in participants as well as improved health outcomes—lowered A1c (three-month measure of blood sugar) levels and decreased BMI (Body Mass Index). They also expected to see enhanced perceptions of social support in participants and specific behavioral changes related to self-care.

Program Effectiveness

Program modifications made during implementation. Initially, we thought pairings between a participant and a volunteer could occur naturally in the course of interaction in the program. We found, however, that participants (and some volunteers, for that matter) were too shy to make this an efficient process. So, staff determined the pairings based on several variables (gender, interests, participant needs, etc.).

We also provided some structure to the social support component by asking each pair (volunteer and participant) to shop together, prepare, serve and report nutritional content of a healthy snack during a particular session (instead of just asking staff to provide the refreshments). This created an additional learning opportunity for participants.

As the program progressed, volunteer staff from one of our partner agencies began offering a variety of activities between sessions to engage participants with one another outside of a classroom setting. This strategy helped them to feel more comfortable with one another and seemed to facilitate greater openness in the sessions.

Midway during the two-year project (after conducting two 12-week programs), we realized that participants were having difficulty incorporating exercise into their daily routines. Our social support volunteers began encouraging participation in a variety of physical activities—bowling, walking, going to a gym, etc. This seemed a more effective way of increasing participants' activity levels than simply offering a 90-minute lecture on the subject.

We also changed how clinic patients came into the program. Instead of simply generating a list of potentially eligible patients and having the coordinator contact them, we asked physicians to be more active in the referral process. In a large, busy clinic with many faculty doctors and residents, this was a challenge. Eventually, the doctors' staff would make an appointment for their patients to be seen for intake just as they would make other referrals to specialists in the system.

What was learned. The following "Lessons Learned" are explored in greater depth in the "Savvy Self-Care Operations Manual" produced as a concrete outcome of this learning project.

1. Direct physician involvement in the referral process—beyond just indicating interest for a particular patient—is important for the referral to result in enrollment.

2. All personnel (whether grant-funded or not) with a role to play in a project of this nature should be identified and involved during the early planning process.

3. People who have diabetes (especially those with a co-occurring mental illness) are rarely provided sufficient education about their condition and the medications used to treat it at the point of diagnosis.

4. Savvy Self-Care participants should be viewed as an important resource for ongoing social support, which is critical to program success. They can be utilized as volunteers in subsequent program cycles.

5. It is possible to utilize an existing curriculum developed in another state under different circumstances around which to build a program for HSA clientele. We also learned that we could augment the curriculum with material we considered relevant to the needs of our clientele.

6. Social support activities both within the group sessions and outside of them likely enhanced program attendance, willingness to share and interact, and motivation to adopt healthy lifestyle behaviors.

7. Participants greatly appreciated our professionalism in conducting the informed consent process and the efforts we exhibited (and described to them in writing) to protect their confidentiality.

8. There are strategies staff can employ to facilitate supportive connections between volunteers and participants such as deliberate pairings and routine phone check-ins.

9. Social support opportunities and mental health content embedded in our curriculum are not necessarily enough to adequately address the psychiatric issues presented by participants. The original program design which included a strong treatment component—if implemented—might have improved outcomes.

10. Offering concrete exercise opportunities and encouraging their use (by setting an example, providing transportation, etc.) is a more effective strategy to increase participants' activity levels than simply lecturing or talking about various forms of exercise.

Measurable Outcomes. Through a variety of quantitative and qualitative data collection strategies, the impact of "Savvy Self-Care" on participants was measured and observed. Several standardized instruments were employed: Generalized Contentment Scale (measure of depression), Clinical Anxiety Scale, and MOS (Medical Outcomes Study) Social Support Scale. We utilized BMI (Body Mass Index) and A1c (three-month measure of blood sugar). We also elicited participants' perceptions of the program and its impact on them through a written questionnaire at the end of the program. Several structured interviews were conducted with a few participants to understand their "lived experience."

The following are the most significant findings:

1. **Depression scores** were reduced from a mean of **45.08** (SD=15.51) at pretest to a mean of **34.74** (SD=18.59) at posttest, a statistically significant finding at t=**4.43**; p=**.000**.

2. Nine participants (**30%**) of the 30 who initially scored in the clinically depressed range (30 or above) no longer exhibited clinical depression at posttest. However, 70% remained clinically depressed.

3. **Anxiety scores** were reduced from a mean of **34.81** (SD=19.55) at pretest to a mean of **27.09** (SD=18.83) at posttest , a statistically significant finding at t=**3.18**; p=**.003**.

4. Nine participants (**40%**) of the 22 who scored initially in the clinically anxious range (30 or above) no longer exhibited clinical anxiety at posttest. However, 60% remained clinically anxious.

5. **Perceived social support scores** were increased from a mean of **3.34** (SD=1.03) at pretest to a mean of **3.77** (SD=.97) at posttest, a statistically significant finding at t=**-3.37**; p=**.002**.

6. **Number of close friends/relatives** increased from a mean of **3.94** (SD=4.22) at pretest to a mean of **5.31** (SD=4.58) at posttest, a statistically significant finding at t=**-2.53**; p=**.016**).

7. **A1c levels** were reduced from a mean of 8.91 at pretest to a mean of 8.19 at posttest, a statistically significant finding at t=**3.09**; p=**.004**.

8. **BMI scores** remained unchanged with a mean at pretest of **39.06** (SD=8.72) and mean at posttest of **38.79** (SD=8.08); t=**1.08**; p=**.29**.

9. Participants reported various **positive lifestyle changes** as a result of their involvement in Savvy Self-Care:

   N=36
   Eating better: 97%
   Taking medications as prescribed: 83%
   Exercising more: 78%
   More frequent self-monitoring of glucose: 75%
   Managing stress better: 69%
   Socializing more: 61%

10. Educational sessions were ranked as the **most valuable program component** by participants. Group activities within the sessions (warm-up exercises conducted while the faculty and resident physicians were examining participants one-on-one) and the mini check-ups themselves were also highly valued. The warm-up activities offered an opportunity for significant social interaction among participants, volunteers, and staff.

11. **Least useful program components** were referrals, outside social activities, and grocery card incentives.

12. Several participants credit the program for substantial improvements in their mental status, ability to manage their disease effectively and ability to function effectively in various family, social, and community roles.

Additional Observations. It is important to note that "Savvy Self-Care" was successful in serving its intended population—low income patients from diverse ethnic backgrounds who have difficulties in controlling their diabetes (A1c of 7.0 or more) and exhibit symptoms of mental illness. Approximately 50% of participants were ethnic

minorities. Most participants scored in the clinically significant range for depression and/or anxiety at pretest. About a fourth scored low (below 3.0) at pretest on the MOS Social Support scale, indicating some level of isolation that could make self-management of the disease difficult. Only six participants (15%) did not score in the clinical range at pretest for either depression or anxiety. These participants were admitted to the program because of a history of mental health concerns. Despite their relatively low scores at pretest, most still showed improvement in mental status.

No differences in outcomes (depression, anxiety, social support, A1c) were observed between men and women, between Caucasians and ethnic minorities or due to differences in age or education. The one exception was depression. Ethnic minorities exhibited a greater decrease in depression than Caucasians ($t=2.57$; $p=.015$), dropping an average of 17 points (versus 5.0 for Caucasians), despite nearly equal scores at pretest.

While it is impossible with the data collected to understand exactly why this difference occurred, it is a noteworthy finding, given that ethnic minorities have often been underserved or not effectively served in programs of this nature. The fact that both the Coordinator and Project Medical Director were from ethnic minority groups may have contributed to a sense of comfort and safety among these participants that enhanced their participation and learning.

The following conclusions are suggested by the quantitative and qualitative findings:

1. The program produced a modest reduction in anxiety and depression among participants. However, 70% of participants continued to score above the clinical cut-off (30 points) on one or both variables. More dramatic changes might have been observed had all the components of the program (as originally envisioned) been put in place. Lack of staff (specifically, a psychiatrist and an LCSW) hampered program efforts to provide intensive mental health services.

2. Clearly, the educational and social support components contributed the most to positive outcomes, given that clinical services were minimal. Perceived social support was enhanced after the 12-week program in all cohorts (even

in those with higher social support scores at pretest) and all cohorts ranked the educational component as the most valuable to them.

3. The program could, most likely, operate without outside social activities or grocery card incentives, without impacting results.

4. The most dramatic outcome observed was a reduction in A1c levels—on average, ___ (approximately the same amount one could expect from a medication change with no accompanying behavioral changes). Participants clearly understood the health messages they received and implemented many of the suggested strategies for dealing more effectively with diabetes.

5. BMI (a height to weight ratio) was not impacted by the 12-week program. Obviously, a different approach to weight loss (and probably a much longer program) is needed.

In summary, combining medical, educational, and social support strategies in a primary care setting with a medical residency training program is a viable approach to the needs of those who are dually diagnosed with mental illness and diabetes. While resulting changes in health and mental status were modest for some, they were life changing for others.

Recommendations regarding replication. Based on the findings of this learning project, the following recommendations are made to other primary care organizations wishing to impact the health behaviors of their dually diagnosed (diabetes/mental illness) population:

1. Develop a logic model with intended outcomes clearly defined to guide program development; review periodically and revise, as needed.

2. Offer a 12-week psychoeducational program (or similar curriculum), inclusive of key diabetic self-management components in addition to nutrition and exercise.

3. Introduce participants to the model, “Stages of Change” so they can assess what changes they want to make, if any, how motivated they are to make them, and how confident they are that they can succeed. Refer back to this model frequently so that participants can evaluate their own progress.

4. Limit enrolled program participants to 12, but include others who can provide support (family and friends, clinic staff, program "graduates," outside agency staff and volunteers, as available). Develop an informal "we're-all-in-this-together" environment in which learning can take place, reducing self-stigma and isolation.

5. Involve medical staff who are knowledgeable about diabetes, motivated to teach the material, personable, and nonjudgmental. The content should be provided in interactive, rather than strictly didactic fashion. A little humor will help a great deal!

6. Combine the group education with individual "mini check-ups" by a physician and/or resident to closely monitor patient progress and learning. Refer any medical issues back to the patient's primary care physician.

7. Provide opportunities for continued socialization and learning outside of the group sessions, such as a support group for people with diabetes and mental illness, walking group, nutrition/cooking classes, information on programs that provide low-cost locally-grown vegetables, etc.

8. Assess participants for substance abuse and mental health issues prior to and during the program (it may take some participants time to be comfortable revealing problems they are experiencing in these areas). Offer individual therapy, support groups, and/or referrals to address these issues.

9. Offer "warm-up" activities at each meeting while the mini check-ups are being performed to engage participants in interaction with one another and prepare them for the day's topic.

10. Provide healthy snacks and assign participants responsibility for providing them, if possible.

11. Communicate with patients' primary care physicians to increase participants' motivation to adopt healthy behaviors and improve diabetic and psychiatric outcomes.

12. Conclude the program with a "graduation" ceremony and provide a certificate of completion to each participant.

Program continuation. Perhaps the best gauge of the value an organization places on a new program are the efforts made to continue it past a specific funding period. The Health Services Agency successfully submitted a proposal for a "Song-Brown" grant (through the medical residency program) to continue funding for "Savvy Self-Care" and to keep all the essential components in place (social support, money for healthy snacks, faculty MD and resident time, etc.).

Also, while conducting interviews with medical students applying for Family Practice Residency with HSA, faculty were surprised to find considerable interest in "Savvy Self-Care" from many applicants who had read about the program on the Residency web site. They wanted to know more about how the agency addresses diabetic care and patient education and expressed interest in being part of this program.

These two unexpected outcomes from the learning project could cement "Savvy Self-Care" as a unique service and training feature of the Family Practice Residency with potentially widespread effects as graduating residents move out into the larger community to practice.

Materials Developed to Communicate Lessons Learned and Project Results. This report is a brief synopsis of a much more detailed description of the HSA Innovations project, "Savvy Self-Care." A 140-page operations manual (not counting the actual curriculum materials themselves) has been prepared. In addition to quantitative and qualitative findings from the evaluation, this manual describes personnel and material resources needed to conduct a program of this type, warm up activities for each session, lessons learned during planning and implementation, and recommendations for replication.

"SAVVY SELF-CARE"

A Program By Stanislaus County Health Services Agency
For
Patients with Diabetes and Mental Illness

Operations Manual
with Evaluation Results
Prepared under an MHSA Learning Contract
With Stanislaus County
Behavioral Health and Recovery Services

By
Christine Bitonti, PhD, LCSW
Evaluator
Yolanda Travis, MS, CAS-S
Coordinator

This manual contains information about personnel, supplies, curriculum, and other resources needed to conduct the "Savvy Self-Care" Program in a primary health care setting along with outcomes and lessons learned over 2-1/2 years of program operation. It was developed through an Innovations Program learning contract between Stanislaus Behavioral Health and Recovery Services and the Health Services Agency (contractor) under the Mental Health Services Act. The learning project took place from January, 2012 through June, 2014 (including a six-month start-up period).

In addition to the Evaluator, Christine Bitonti, and the Program Coordinator, Yolanda Travis, who prepared this manual, the following people were instrumental in the development and/or implementation of this program:

Dr. Juan Lopez-Solorza, Project Medical Doctor
Dr. Del Morris, HSA Medical Director
Greg Diederich, Contracts Management
Dr. Marlene Cohen, IBH Consultant
Patricia Trevizo, Paradise Medical Office Manager
Karryn Unruh, McHenry Medical Office Manager
Susan DeSouza, NAMI Volunteer Coordinator
Emmanuel Elizondo , Liaison, West Modesto King-Kennedy Neighborhood Collaborative

Throughout the manual, *Lessons Learned* are identified as they relate to various planning and implementation issues. Additional lessons that didn't easily fit a category in the manual are identified at the end.

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Rationale for Project

The link between mental illness and diabetes is strong, although not fully understood due to the complex relationship between the two. People with mental illness are two to three times more likely to have diabetes than the general population and also exhibit decreased life expectancy. Furthermore, their access to medical treatment for diabetes and other health problems has been found to be more limited and less intensive than treatment available to those without mental illness. Diabetes itself requires considerable emotional and psychological resources for self-management, resources the mentally ill often lack.

Also, people with diabetes are more likely to experience depression and anxiety than their non-diabetic counterparts. It is unclear whether these mental health problems resulted from or contributed to the development of diabetes. Many observers believe both scenarios are likely.

Regardless of the etiology of the disease, people with mental illness (depression, anxiety, bipolar disorder, personality disorders, and psychotic disorders) often have poor outcomes from their diabetes treatment. In Stanislaus County, the recent introduction of Integrated Behavioral Health (IBH) providers in the primary care clinics has resulted in greater awareness of the problem. Diabetes is difficult to manage, at best. For the mentally ill, it can be nearly impossible.

Therefore, in 2011, the Health Services Agency (HSA), which serves low income residents through six family practice clinics (including one pediatrics clinic), applied to Behavioral Health and Recovery Services (BHRS) to undertake an Innovations Learning Project to explore how to effectively serve the population of adults who are dually diagnosed with mental illness and diabetes. Initially, staff members involved with this project were not certain what form the program would take. They knew one thing, however: the traditional didactic classroom approach to diabetic education (focusing almost exclusively on nutrition and exercise) would not likely be enough to achieve significant results with this population.

They proposed that the program have a clinical component (weekly “mini check-ups”), a psychoeducational component (curriculum involving traditional nutrition and exercise content plus topics related to disease self-management, psychological coping

and stress management), and a significant social support component (one-on-one and in-group support for motivation and problem-solving). During the six months of program start-up, a Logic Model (see Appendix A) was created to guide program development and evaluation, and an existing diabetes curriculum (described below) was identified. Developing a curriculum from the ground up would have been too time-consuming and well beyond the scope of this project.

This project was distinguished from a similar program operated by BHRS, "High Risk Health" in a number of ways. First, the primary care providers and behavioral health staff are all co-located in one setting. PCPs and clinicians discuss clients' needs/progress in person, allowing medical and/or psychiatric issues to be identified and addressed quickly. The proposed Innovations Program was to be offered on-site by staff with whom participants might already be familiar, increasing the likelihood of their participation. Peer support would be integrated into the project, and the environment created would be supportive and interactive to maximize learning and encourage mutual support.

Preparation and Needed Resources

Recruitment of Participants

Obviously, it is important to have sufficient participation in order for the program to be viable. Within a clinic serving over 15,000 patients per year, it seemed, at first, that it would be an easy task to enroll 10 to 12 people with co-occurring mental illness and diabetes into the program. A list of about 245 people with an A1C of 7 or greater who had been seen by an IBH provider was generated for the first cohort. These names were given to the Coordinator, who called them to arrange assessment appointments. Physicians were provided the names of their patients on the list, as well, so that they could encourage participation.

Lesson Learned: *Direct physician involvement in the referral process—beyond just indicating interest for a particular patient—is important for the referral to result in enrollment.* The Coordinator who called prospective participants found out that few knew about the program or had been coached by their PCPs on the importance of attending. The original list of 245 was quickly whittled down to only 23 who actually showed up for the assessment (and only 10 of those actually came into the program). There were a few who didn't meet the eligibility requirements (usually because they did not have a mental illness), but most of those who were eligible simply did not have sufficient motivation to follow through.

Having learned this lesson after recruitment of Cohort 2, staff began assertively reaching out to physicians to increase their involvement. Insufficient coordination time was the reason this strategy was not employed earlier. The original staffing plan had called for a half-time Coordinator, but the person hired for this position left after a few months and remaining staff did not have the time available for physician contact.

The following are strategies that were eventually put in place to encourage patient participation:

1. The Clinic Manager was enlisted to speak directly to physicians regarding referred patients who did not follow up with intake/assessment appointments.
2. The Coordinator sent emails to physicians with updates on the status of their referred patients' enrollment in the program.

3. The participating faculty physicians were encouraged to speak to their residents about the importance of talking with patients about the program prior to referring.

Allocation of Staff and Supplies

In the original application for project funds, the positions of Coordinator, Evaluator, and Substance Abuse Counselor were named along with a certain amount for physicians' and residents' time. But, other key players (who were not written into the proposal) were not identified. For example, the PMO Clinic Manager (in charge of clinic operations at the first site where the program was offered) was not sufficiently involved in the planning process and had to get "up to speed" quickly once the program was about to start. She was able to do so and provided invaluable support, guidance, and decision-making to insure the program's success. More time to plan would have helped her with personnel and materials needs and allowed the project to benefit earlier from her expertise and problem-solving abilities.

Lesson Learned: *All personnel (whether grant-funded or not) with a role to play in a project of this nature should be identified and involved during the early planning process.* If there are individuals inhabiting these key roles, they should be invited to review proposals and plans and to provide input appropriate to their roles, even if frequent planning meetings are not possible due to time constraints. The evaluator recommends that at least one or two meetings with all salient personnel present be conducted so that everyone can see who else has a role to play in program development and implementation.

The personnel required to conduct "Savvy Self-Care" include:

A. The **Coordinator**, whose role it is to identify and enroll eligible patients, prepare the room and materials for each session, broker and/or provide mental health services for participants, work with social support volunteers, communicate with medical and IBH staff regarding patient needs.
B. The **Project Medical Doctor**, whose role it is to conduct weekly medical check-ups with participants (including the supervision of a resident helping with the clinic) and conduct the educational group session with help from the resident and other staff, as available.
C. The **Clinic Manager**, whose role it is to allocate staff and supplies for the weekly clinics, assist with case-finding activities, and supervise ancillary staff assigned to the project.

D. The **Resident** (usually a different one every one to two weeks), whose role it is to conduct medical check-ups and assist the Project Medical Doctor in providing the educational session.

E. The **Medical Assistant**, whose role it is to weigh patients, measure vital signs, and help with clinic logistics.
F. The **Evaluator**, whose role is to collect and analyze data related to patient outcomes, to develop survey questionnaires as needed, to record observations of the group process to incorporate into a narrative of the results, and to prepare reports for the funding source. In ongoing service delivery (rather than a learning project such as this), the evaluation role may be more limited and could be fulfilled by other staff members (e.g., someone who can compare pre and post A1C levels).

Volunteers who provided one-on-one and in-group social support were obtained through contracts with two community organizations: the local chapter of the National Alliance on Mental Illness (NAMI) and the West Modesto King-Kennedy Neighborhood Collaborative (WMKKNC). During the life of this project, 20 individuals from these two organizations provided support for Savvy Self-Care participants. They spent over 300 hours in telephone and face-to-face contacts with participants. Several volunteers participated with every Savvy cohort.

These are some of the activities with Savvy participants that volunteers arranged and conducted:

- Telephone contacts to arrange meetings and provide support
- Meal planning, food shopping, and preparation of healthy snacks for Savvy sessions
- Nutrition classes outside of Savvy sessions
- Potluck meals outside of Savvy sessions
- Support group held at NAMI office
- Transportation to sessions and other activities
- Movie excursions
- Lunches and picnics (one-on-one and/or group)
- Walking, bowling, and gym activities

Some of the Savvy Self-Care participants became volunteers in the program (through NAMI) after completing it. This was an unanticipated positive outcome and

suggests a way for HSA to continue the social support component after the learning project has ended.

Lesson Learned: *Savvy Self-Care participants should be viewed as an important resource for ongoing social support, which is critical to program success.* Former participants who were active in their cohorts and benefitted from participation should be recruited to attend Savvy sessions and engage with current participants for mutual support.

The supplies that are needed to conduct Savvy Self-Care medical check-ups are those one would expect to be available in a regular clinic setting: glucometer, gloves, hand sanitizer, antiseptic wipes, cotton balls, progress note forms, etc. For Savvy Self-Care, a plastic tote was prepared with these items and stored in the project office for easy retrieval each week. The M.A. brought a portable scale, thermometer, and blood pressure cuff to the conference room to weigh patients and obtain vital signs.

Conducting Savvy Self-Care

Physical Space Requirements

Each Savvy Self-Care meeting is divided into two parts: medical clinic where mini medical check-ups occur followed by the educational/support session. A large conference room is needed where "warm-up" activities can be conducted while the check-ups are taking place. At Paradise Medical Office (PMO), the conference room can be divided in half with an accordion-style door that was pulled nearly shut (with an opening for people to go back and forth. At McHenry Medical Office (MMO), a small room off the conference room and a divider were used to provide privacy for the check-ups.

At PMO, one-half of the conference room was set up with three tables in a "U" formation (but not connected), one of which served as the medical assistant's station with charts, supplies and a place for him/her to sit and record information. Two additional tables on either side of the M.A.'s table (with two chairs each) served as the physicians' stations—one for the supervising M.D., the other for a resident.

The other half of the conference room was set up in a large square or rectangle (rather than classroom style), accommodating as many chairs as possible. This configuration allowed all participants to see each other clearly, facilitating interaction. About 20 to 24 chairs were placed around the perimeter. Enrollees, volunteers, and staff were inter-mingled. Two chairs at the head of the table (nearest the dry erase board) were reserved for the physician and resident to use when they had finished their clinic and joined the group.

One or two additional tables were placed near the entrance to the conference room. These tables were used for sign-in sheets, name tags, session materials, brochures about diabetes, and water and snacks for the session.

Clinic Procedures/Schedule

Patients begin arriving at the clinic at about 8:00AM. They check in at registration and are directed to the conference room where the program is conducted. They take a seat around the large rectangle of tables after signing in and picking up the

day's handouts. The M.A. assigned to the project calls each, in turn, to take vital signs and weight. Then, they sit back down and wait to be called for their check-up.

The supervising physician and resident arrive around 8:30AM and begin conducting the mini physicals. Care is taken to provide as much privacy as possible for these sessions (room divider is always drawn nearly shut), although everyone involved in the program knows they were taking place, of course. No one is ever asked to disrobe in the public area. If needed, the doctors find a private room to conduct the exam.

Classroom Procedures/Schedule

While the check-ups are taking place, the coordinator leads a warm-up activity in the "classroom" area once most participants (including the volunteers) have arrived. Each 20-30 minute warm-up is carefully chosen to coordinate with the topic of the day. For example, on the day nutrition is discussed, participants might be asked to form a small group and review the nutritional chart from a fast food restaurant, making selections that would comprise a healthy, diabetic meal (possible, but fairly difficult to do, they soon discover).

Prior to the session on complications of diabetes, participants look at and describe pictures of various organs such as liver, kidney, and pancreas, learning the functions of each one and how they impact diabetes. Before the session on stress management, a relaxation exercise is conducted, and so on. See Warm-up Activities (Appendix B).

After the warm-up, the team that has been assigned to provide the snack for the day, presents recipes and nutritional information to the entire group. Volunteers distribute samples of the dish around the table. This activity requires about 15 minutes.

The project M.D. and resident join the large group after the check-ups have been completed. They present the content for the day and answer questions from group members. This component takes about 90 minutes.

Curriculum Materials

Savvy Self-Care utilizes a curriculum developed by the Galveston Health District under a grant from the Robert Wood Johnson Foundation. The curriculum is called "Take Action" and includes twelve educational sessions with lesson plans and

participant materials (all available in the public domain). This curriculum was selected because it had been utilized in a public program serving low income patients and contained specific content relevant to the needs of people with mental health problems. It was also far broader than just a nutritional approach, addressing a variety of self-management topics.

The twelve topics are:

1. Why Should I take Control of my Diabetes?
2. Ready for Change (based on the Motivational Interviewing model)
3. My Action Plans
4. High Blood Sugar, Low Blood Sugar
5. Complications of Diabetes
6. Sick Days
7. Nutrition
8. Coping with Diabetes
9. Diabetes and Stress Management
10. Exercise
11. Oral Medications
12. Insulin

For each session, a lesson plan had been created, including Learning Objectives, Behavior (what participants can do to improve self-management), and Learning Method and Materials. See Appendix C for the complete set of lesson plans and Appendix F for participant handouts.

Additional materials were added to the curriculum to enhance the mental health content, specifically, the "Thoughts-To-Action" model and "How to Change a Thought" (Appendix G). This model links types of cognitive interpretations of major and minor life events to emotional states and demonstrates how to turn a perceived threat, harm, or loss into a challenge (or alter a specific stress-producing thought), thereby transforming negative emotional states.

Lesson learned: *It is possible to utilize an existing curriculum developed in another state under different circumstances around which to build a program for HSA clientele. We also learned that we could augment the curriculum with material we considered relevant to the needs of our clientele.*

It is important to note that program participants uniformly reported that they had received little of the information provided in our program over the years since being diagnosed with diabetes. Many did not begin learning about self-management

until they had been living with diabetes for 10 or more years. Some participants had already encountered severe complications like ketoacidosis, coma, amputations, and blindness. It is not surprising that they were all experiencing at least moderate mental illness (mostly depression and anxiety) and had difficulty managing their physical and psychological symptoms.

Participating physicians acknowledged that most family practice doctors have insufficient time to provide diabetic education to patients and their families. Even if the patient comes prepared with a list of questions and issues, there is rarely enough time to address them all. And, many patients take a very passive approach to their own care, rarely advocating for themselves and expecting the doctor to provide an easy solution to their problems.

Role of Project Medical Doctor

While the "Take Action" curriculum from Galveston, Texas was originally delivered by trained para-professionals in the Robert Wood Johnson project, it is delivered by an M.D. in Savvy Self-Care for several reasons. First, it contains very detailed clinical information that we believed would raise many useful questions (which it does!) requiring a physician to answer.

Also, we hoped that having participants interacting each week with a primary care physician would empower them to communicate more directly with their own doctors and take a more active role in clinic visits. Many reported that their participation in the program had this effect.

In addition to teaching, answering questions, and encouraging patient involvement in their own treatment, the Project Medical Doctor and HSA Medical Director who substitutes now and again supervise a resident each week who assists in conducting the mini check-ups. The project M.D. is also responsible for insuring that participants obtain the follow-up care they need as a result of the check-ups.

Role of Family Practice Residents

The Family Practice Residents who participate in Savvy Self-Care are placed at Paradise Medical Office through a residency program at U.C. Davis. Most have graduated from medical schools outside of the U.S. They are at the clinic for three years and participate in all aspects of family practice. A schedule is created for each

12-week round of Savvy Self-Care with a different resident assigned to the project each week or two.

The residents are given the curriculum materials relevant to their assigned sessions to study in advance. Each participates in the entire session, working alongside the attending physician to conduct the "mini check-ups" and helping to lead the educational component. Several residents made unique contributions to their session. For example, one brought in various props to illustrate portion control during the unit on nutrition. He demonstrated that what people often think is a one-cup container is actually much larger.

Many of the residents commented after their involvement that they had appreciated the opportunity to participate in a group educational approach to disease management. They echoed the attending physician's comments about the insufficiency of patient education during individual office visits.

Role of Social Support Volunteers

When the Innovations project was proposed, we knew that social support would be an important component of the program. However, we did not have a specific model of support in mind. We had two community-based organizations willing to partner with us on this project and develop the model as we went along.

At the conclusion of each Savvy round, volunteers/liaisons (who had not done so before) were asked to comment on what they had done and what seemed to help participants the most (see Appendix E, "Survey Questionnaires"). Volunteers and liaisons (20 in total over the course of the program) provided similar services. Liaisons were designated by their agencies to participate; volunteers were recruited from the community.

Social support staff commented most frequently on their one-on-one role of supporting the participant/s to whom they were assigned. They provided this support by listening, problem solving, and just being available when participants needed them.

They often made phone calls just to "check in" with participants. They shared their own struggles (with depression, diet, exercise) and provided motivation for participants to attend group sessions and change lifestyle behaviors. Some provided transportation and went grocery shopping with participants. They also accompanied them to outside social activities. In general, they tried to provide a sense of community and a caring, compassionate learning environment.

The social support staff ranked program components similarly to how participants ranked them. They saw the educational sessions as the most important, followed by the mini medical "check-ups." They tended to see peer support as more important than participants saw it and group activities in the sessions as less important. Like participants, however, they did not see the grocery card incentives or referrals as particularly important.

Lesson learned: *Social support activities both within the group sessions and outside of them likely enhanced program attendance, willingness to share and interact, and motivation to adopt healthy lifestyle behaviors.*

Role of Coordinator

The Coordinator of Savvy Self-Care is the pivotal position, since intake, assessment, and coordination of care are time-consuming tasks. Also, the Coordinator leads warm-up activities during the first part of each session and communicates with participants' physicians as well as staff and volunteers from the two partner agencies.

The original plan for Savvy coordination called for half-time (20 hours/week) by a full-time clinical social worker who would have regular IBH duties the rest of the week. When the person hired for the position left soon after the program started, a void was created. It was quickly filled by the evaluator (an LCSW) and a psychology intern assigned part-time to the program. However, the evaluator worked only one-day per week (and had her own tasks to accomplish), and the intern was assigned to the program only eight hours per week.

It soon became apparent that the intake/assessment tasks (in which the evaluator already participated) and tasks associated with conducting the 12-week psychoeducational component took precedence over case management and other coordination tasks (e.g. communicating with physicians and making referrals to other support programs). While waiting for a new coordinator to be hired, the two remaining staff members did their best to keep the program running and collect the data for the evaluation. Despite "limping along" for months, things got done and the groups were conducted.

When it became apparent that a new staff person would not likely be hired in time, the intern was designated the coordinator, although her hours stayed the same (eight per week). Out of necessity, at the program's onset, the evaluator's role shifted to one of "participant-observer" due to her increased involvement with participants.

This shift (discussed later under "Evaluation Design") actually proved beneficial to the evaluation component.

A major task for the coordinator is conducting the assessments necessary to assure that participants are clearly dually diagnosed with diabetes that is not well controlled (based on an A1c of 7.0 or more) and have mental health problems, as well. The standardized instruments help determine clinical levels of anxiety and depression. However, a few participants whose scores fell below the clinical cut-off score of 30 on these instruments were, nonetheless, included due to histories of psychiatric problems.

Snacks and Incentives

Diabetics develop a complex relationship to food, often feeling deprived, fearful, or powerless around food. In our culture, food plays an important role in fostering social interactions. Staff and volunteers wanted participants to learn to relax around food, to be thoughtful in choosing and preparing it, and to enjoy social interactions involving food.

Snacks and water were available at every session. During Cohort 1, NAMI volunteers took responsibility for buying and preparing healthy snacks (fruits, vegetables, yogurt, low-fat cheese sticks, almonds, etc.).

As the program evolved, participants and the volunteers with whom they were paired provided more elaborate snacks which they created themselves (sometimes even hot food). They would tell the group members what ingredients (with corresponding nutritional information) went into the preparation and also provide recipes. For some, it was a revelation that vegetable dishes, brown rice, whole wheat pasta, and low-fat meats could taste good.

Having food available did seem to foster interaction as group members talked among themselves about the ingredients, how well they liked the dishes and ways they were changing their shopping and food preparation habits at home.

Each enrolled participant who attended a session received a $10 gift card for a local supermarket. At first, program planners thought they would tie the incentive to completion of a particular homework assignment each week, but that approach seemed like it would be too punitive and we worried that it might actually discourage people from attending (if they didn't have their homework finished). So, the cards were left as an attendance incentive, which was ranked fairly low in importance by most participants, suggesting it may not be needed at all.

Evaluating Learning and Outcomes

Logic Model

Savvy Self-Care began as a vague notion about addressing the needs of Health Services Agency patients with co-occurring diabetes and psychiatric disorders. The process of articulating the Logic Model (see Appendix A) guided the planners in developing both the program and evaluation strategies described in this manual.

First, the problem situation was defined: People with co-occurring mental illness and diabetes often have poor outcomes in both areas—more acute psychiatric episodes and more negative health consequences. This statement formed the first "box" on the Logic Model chart. Then, the desired short and longer-term results were articulated. The short-term results were expected to contribute to longer-term outcomes (not all of which could be measured in the time frame of the evaluation). Both sets of outcomes are at the far end of the Logic Model chart.

In the center of the chart are the Inputs and Outputs, which flesh out the actions and activities that were to take place during the learning project. Inputs are the resources required to undertake the project. Outputs are what we expected to do with the resources and whom we would reach.

The Logic Model provided a guide for articulating evaluation questions—both *process* ("Did we do what we said we would do?") and *outcome* ("What impact did we have on our target group?"). Our actual evaluation questions are more specific than these and guided selection and development of standardized instruments and survey questionnaires included in Appendix E.

The Logic Model chart also provided a guide for "mid-course corrections" as we developed our interventions. We could look at our lessons learned in light of the projected inputs/outputs/outcomes and make modest changes as appropriate. One proposed change was to increase the hours for the Coordinator, whose role in this process was critical. Unfortunately, her hours were not increased and her scope of practice (for individual sessions) was narrowly defined (drug and alcohol issues only). This circumstance greatly hindered the project's ability to respond effectively to observed mental health concerns of participants—one of the major objectives of the program.

Evaluation Design

This learning project employed a "mixed" design, including both quantitative and qualitative approaches. The evaluation of outcomes involved a pretest/posttest, one group design. Participants served as their own controls. Having access to the medical charts of participants, the evaluator could observe health-related variables prior to involvement in Savvy Self-Care and again after program completion. For mental health-related variables, pre/post-testing was required.

Survey instruments were designed to capture the perceptions and experiences of those involved (mostly participants and volunteers) utilizing open-ended questions. One attempt to gather perceptions from referring physicians was not successful—they simply didn't respond. Content analysis procedures were utilized to examine the responses to these questions in light of overarching research questions.

The following are key research questions that guided inquiry regarding participant outcomes:

1. To what extent, if any, do program participants experience a decrease in symptoms of depression and anxiety after three months of program involvement?
2. To what extent, if any, do program participants exhibit improvements in average glucose level (measured by A1C test) and body mass index (BMI) after three months of program involvement?
3. To what extent, if any, do program participants report an increase in perceived social support after six months of program involvement?
4. Is any observed increase in social support related to improved health and mental health outcomes?
5. Are positive health and mental health outcomes related to level of program involvement?
6. What behavioral changes related to health and mental health outcomes do participants report after three months of program involvement?
7. Which components of the program were most helpful to participants in achieving their wellness goals?
8. In what percentage of participants is risk of alcohol and/or drug abuse identified? How was this risk addressed and with what results?

The evaluator of Savvy Self-Care adopted a participant-observer role, which was useful in several ways. First, by attending nearly all of the weekly psychoeducational

sessions, the evaluator was able to observe directly the level of participation and interaction that occurred in each cohort. Also, she frequently reminded staff and participants of the learning focus of this project. Hopefully, her participation helped participants feel more comfortable filling out the various instruments and questionnaires important to the evaluation.

Informed Consent

While an informed consent process was not required of the learning projects under the Innovations Program, Savvy Self-Care staff determined that the nature of data collection in this evaluation (conducted in a medical setting) did necessitate such a procedure. To forego informed consent would have constituted a violation of ethical conduct for the agency and the licensed professionals involved in the project (see Appendix D).

A straightforward description of the evaluation component of Savvy Self-Care was developed, including the purpose of the evaluation, confidentiality guarantees, participant responsibilities, benefits and risks, rights to refuse or withdraw, cost and compensation, and contact information for questions/concerns. This three-page document was provided to program candidates at the intake/assessment session. They were asked to sign the form (if they wanted to participate), and were provided a copy. While some people chose not to enroll in Savvy Self-Care (for various reasons), no one who wanted to join ever refused to sign the informed consent document. Many expressed gratitude for the opportunity to contribute to helping the agency learn how best to meet their needs and the needs of others with similar concerns.

Lesson learned: *Participants greatly appreciated our professionalism in conducting the informed consent process and the efforts we exhibited (and described to them in writing) to protect their confidentiality.*

Measurement Instruments

The **SBIRT** (Screening, Brief Intervention, and Referral to Treatment) process was conducted utilizing two screening tools: the **AUDIT** (Alcohol Use Disorders Identification Test) and the **DAST-10** (Drug Abuse Screening Test). See Appendix E

for instruments. These are short form instruments that provide a measure of risk for substance abuse and potential need for specialized intervention.

In the case of the AUDIT, a score of 7 or below suggests a need for alcohol education only. From 8-15, advice may be indicated; from 16-19, counseling and monitoring are indicated; and from 20-40 referral for diagnostic evaluation and treatment is needed.

In the case of the DAST-10, a score of 0 indicates "No problems reported" with no response required. From 1-2, a low level of risk is suggested with monitoring and reassessment at a later date. From 3-5, moderate risk is suggested with the need for further investigation. A score of 6-8 suggests a substantial level of risk with assessment required; 9-10 indicates severe risk with assessment and treatment needed.

SBIRT was provided to each person referred to Savvy Self-Care. Few had immediate alcohol/drug abuse treatment needs (many had them in their past), and those who did were seen by the program coordinator who is a certified addiction specialist. The measures utilized in the SBIRT process were not part of the pre-post evaluation. They were in the public domain, requiring no special permission for use.

To observe changes in mental health status among Savvy Self-Care participants, two instruments were selected from the WALMYR Assessment Scales or WAS scales (see Appendix E). These scales are not in the public domain and were purchased from the publisher for use in this evaluation. The scales are "Generalized Contentment Scale" or **GCS** (a measure of depression) and "Clinical Anxiety Scale" or **CAS** (measuring anxiety as the name suggests).

These scales were selected for several reasons. They are short (although longer than the SBIRT screening tools) and easily administered. They have good reliability and validity. They can be utilized with the same individual on repeated occasions without "response decay," and they are easy to understand and interpret. They also have a clinical "cutting score." Above a score of 30, most individuals have a clinically significant problem; below 30, they are generally free of such problems.

Both scales are self-report assessment tools designed to measure the magnitude of a separate problem. They have the same format and structure with 25 items rated

on a likert scale—from 1-7 in the case of the GCS and 1-5 for the CAS. They are scored using the same formula which yields a score from 0 to 100.

To observe changes in participants' perceptions of social support, the Social Support Survey Instrument from **MOS** (Medical Outcomes Study) was utilized (see

Appendix E). This instrument is in the public domain, requiring no special permission for its use. It was developed and tested in a health setting, which made it a good fit for this evaluation.

The instrument is comprised of two sections—19 items scored on a likert scale from 1-5 and a simple question, "About how many close friends and close relatives do you have—people you feel at ease with and can talk to about what is on your mind?"

Surveys and Other Data Collection Methods

Several survey questionnaires were developed by the evaluator to capture the perceptions of participants and volunteers regarding their experiences with Savvy Self-Care. A third instrument—directed at residents—was simply not returned by them.

At the conclusion of each 12-week program, participants answered questions about the relative importance to them of each component of the program and how the program had impacted them. Volunteers provided data about their perceived role in the program and observations they had made regarding how the program had impacted participants. (See Appendix E).

In order to provide a fuller, more narrative view of program outcomes, the evaluator conducted interviews with several participants clearly helped by the program. See Appendix E for the Case Study Interview format.

Project Outcomes and Implementation Lessons Learned

Savvy Self-Care Participant Outcomes

In this section, each evaluation question is addressed, in turn, with statistical findings reported for all participants combined. Descriptive data is shown for each cohort, but sample sizes were too small for comparisons of means (pre to post) to be meaningful.

Since it was important for this program to serve a diverse (and largely underserved) clientele, demographic data are provided, suggesting that Savvy Self-Care did, indeed, serve its intended population. As the figures below show, only five more women than men participated and more than 50% of participants were non-Caucasians. Ethnicity data from the official Modesto city web site mirror these findings with some differences. The city data suggest that 4.4% of the population is African-American or Black compared with 15% of Savvy participants, suggesting that this typically underserved population was well-represented. In Modesto, 6.7% of the population is Asian compared with 7.7% of Savvy participants; 1.3% are Native American compared with 2.6% in Savvy. Hispanics seemed to be underrepresented in Savvy (23% versus 31.7% in the population) and Caucasians were overrepresented (48.7% versus 32.8%).

Age of participants ranged from 34 to 67; education ranged from 9 years to 15 years, indicating that even younger clients and those with limited secondary education made use of the program.

Gender (N=39)

	N	Percent
Male	17	43.6
Female	22	56.4

Ethnicity (N=38)

	N	Percent
African American	6	15.4
Asian American	3	7.7
Caucasian	19	48.7
Hispanic	8	23.1
Native American	1	2.6
Other	1	2.6

Age (N=38)

Mean	S.D.	Minimum	Maximum
51.51	8.214	34	67

Education (N=35)

Mean	S.D.	Minimum	Maximum
12.57	1.316	9	15

Question 1: *To what extent, if any, do program participants experience a decrease in symptoms of depression and anxiety after three months of program involvement?*

Program participants experienced a statistically significant decrease in symptoms of depression (p=.000) after three months of program involvement (see chart below). All cohorts exhibited some change in the hypothesized direction, although sample sizes for the cohorts were too small to allow in-group pre-post comparisons. Of 30 participants who were clinically depressed initially (and for whom we had post-test data), a total of 9 participants (30%) reduced their depression scores below a clinically significant level (score of 30 or more). Twenty-one (70%) remained clinically depressed, despite improvements.

Generalized Contentment Scale

	n=9 Cohort #1	n=8 Cohort #2	n=8 Cohort #3	n=6 Cohort #4	n=7 Cohort #5
Mean, Pretest	**42.14**	**53.08**	**38.82**	**51.89**	**43.05**
S.D.	12.92	15.39	14.81	8.11	20.02
Mean, Posttest	**35.63**	**44.42**	**25.75**	**40.56**	**26.67**
S.D.	18.27	13.81	22.83	15.41	17.93

N=37 (all groups combined)
Mean, Pretest= **45.08** (SD=15.51)
Mean, Posttest=**34.74** (SD=18.59)
t-value=**4.43** (df=36); p=**.000**

Program participants also experienced a statistically significant decrease in symptoms of anxiety (p=.003) after three months of program involvement (see chart below). Every cohort exhibited some change in the hypothesized direction. Changes in anxiety scores were more modest than those for depression, however, because they were much lower at the beginning. Of 22 participants who were clinically anxious initially (and for whom we had post-test data), a total of 9 participants (40%) moved from clinical to non-clinical levels, while 13 (60%) remained clinically anxious.

Clinical Anxiety Scale

	n=9 Cohort #1	n=8 Cohort #2	n=8 Cohort #3	n=6 Cohort #4	n=7 Cohort #5
Mean, Pretest	**34.67**	**42.25**	**34.33**	**30.50**	**31.43**
S.D.	9.85	22.36	20.33	14.94	27.22
Mean, Posttest	**33.43**	**33.79**	**23.88**	**19.67**	**20.33**
S.D.	20.82	20.66	18.50	11.36	19.28

N=37 (all groups combined)
Mean, Pretest=**34.81** (SD=19.55)
Mean, Posttest=**27.09** (SD=18.83)
t-value=**3.18** (df=36); p=**.003**

Question 2: *To what extent, if any, do program participants exhibit improvements in average glucose level (measured by A1C test) and body mass index (BMI) after three months of program involvement?*

Findings in this area were mixed. A1c levels decreased dramatically (p=.004) by nearly three-quarters of a point (.72)—about the same amount that could be expected in three months with a medication change alone with no accompanying behavioral changes (.6 to 1.0 point). Again, all cohorts except number five exhibited a positive reduction in glucose levels, although pre-post comparisons could not be done due to small sample sizes. The negative results for the fifth cohort were likely impacted by a medication reduction for one member due to excessive weight gain.

A1c (Three-Month Average Glucose)

	n=8 Cohort #1	n=7 Cohort #2	n=8 Cohort #3	n=4 Cohort #4	n=6 Cohort #5
Mean, Pretest	**9.70**	**9.23**	**9.31**	**8.48**	**7.23**
S.D.	2.24	1.66	1.74	1.59	0.55
Mean, Posttest	**8.28**	**8.33**	**8.63**	**8.23**	**7.32**
S.D.	1.27	1.35	1.01	.95	0.82

N=33 (all groups combined)
Mean, Pretest=**8.91**

Mean, Posttest=**8.19**
t-value=**3.09**; p**=.004**

Body Mass Index scores changed very little. The small reduction in these values was not statistically significant, suggesting that the program had no impact on this variable.

BMI (Body Mass Index)

	n=9 Cohort #1	n=7 Cohort #2	n=9 Cohort #3	n=6 Cohort #4	n=7 Cohort #5
Mean, Pretest	**35.72**	**38.81**	**38.37**	**41.19**	**43.78**
S.D.	5.71	8.24	6.68	11.19	12.03
Mean, Posttest	**35.56**	**37.59**	**38.83**	**39.58**	**43.39**
S.D.	5.37	7.74	6.27	9.98	11.25

N=37 (all groups combined)
Mean, Pretest=**39.06** (SD=8.72)
Mean, Posttest=**38.79** (SD=8.08)
t-value=**1.08** (df=37); p=**.29**

Question 3: *To what extent, if any, do program participants report an increase in perceived social support after six months of program involvement?*

Program participants experienced a statistically significant increase in perceived social support (see chart below) after three months of program participation. The increases in scores seem very small (for example, 3.41 to 3.65 for Cohort #1; to overall), but that is because the maximum score possible was 5.0.

Number of close friends and relatives increased, as well, for the total sample and all cohorts. Again, statistical significance was obtained for the sample as a whole.

MOS (Medical Outcomes Study) Social Support Scale

	n=9 Cohort #1	n=8 Cohort #2	n=8 Cohort #3	n=6 Cohort #4	n=7 Cohort #5
Mean, Pretest	**3.41**	**2.70**	**4.02**	**3.12**	**3.34**
S.D.	1.09	1.28	.95	.56	.87
Mean, Posttest	**3.65**	**3.30**	**4.42**	**3.66**	**3.83**
S.D.	.96	1.12	.77	1.04	.78

N=37 (all groups combined)
Mean, Pretest=**3.34** (SD=1.033)
Mean, Posttest=**3.77** (SD=.97)
t-value=**-3.37** (df=36); p=**.002**

MOS (Medical Outcomes Study) Social Support Scale (Number of Close Friends/Relatives)

	n=9 Cohort #1	n=7 Cohort #2	n=8 Cohort #3	n=6 Cohort #4	n=7 Cohort #5
Mean, Pretest	**3.78**	**4.57**	**6.00**	**2.50**	**2.43**
S.D.	2.82	7.46	4.50	1.05	.79
Mean, Posttest	**5.78**	**4.75**	**9.00**	**3.50**	**2.83**
S.D.	2.54	6.50	5.40	2.26	.98

N=36 (all groups combined)
Mean, Pretest=**3.94** (SD=4.22)
Mean, Posttest=**5.31** (SD=4.58)
t-value=**-2.53** (df=34); p=**.016**

Question 4: *Is any observed increase in social support related to improved health and mental health outcomes?*

Bivariate correlations were performed on the amount of change in social support and each of the main outcome variables that were statistically significant from pre to post: depression, anxiety, and A1c. No statistically significant findings were observed,

most likely because of the small sample size. Qualitative data reported below indicate the importance to participants of social support in the program. And, overall, perceived social support (as measured by the MOS) was enhanced from pre to post assessments. It is highly likely that this aspect of Savvy Self-Care did contribute to positive outcomes, even if the relationship cannot be quantified.

Question 5: *Are positive health and mental health outcomes related to level of program involvement?*

As it turned out, there was little variability in the amount of program involvement observed. Most participants attended at least nine sessions, and many (especially in Cohort #5) did not miss a session. Therefore, statistical analysis (correlation) would not be meaningful. It is possible to conclude, based on these findings, that if someone decided to enter the program and came at least twice (several people left after the first session), they would likely finish it and experience the benefits described above.

Question 6: *What behavioral changes related to health and mental health outcomes do participants report after three months of program involvement?*

Participants were given two opportunities to respond to the question about physical health outcomes—one in a closed format, the other in an open-ended format. Data for mental health outcomes were analyzed from an open-ended question only, since responses varied widely and could not be categorized so easily. The closed format question consisted of six behaviors that the first cohort had generated in response to the open-ended question, “Please list what you are doing now (or doing better) to manage the disease” (to which they responded if they had checked “Yes” to the previous question of whether or not their self-management of diabetes had improved as a result of involvement in “Savvy Self-Care”). Subsequent groups were offered this list and simply checked all that applied to them in addition to giving their own open-ended responses.

Here are the results of the tabulation:

N=36
Eating healthier: 97%
Taking medications as prescribed: 83%
Exercising more: 78%
More frequent self-monitoring of glucose: 75%
Managing stress better: 69%

Socializing more: 61%

Ninety-seven percent of respondents (N=37) believe their self-management of diabetes improved as a result of the program. Their open-ended responses could be categorized into "medical management of the disease," "lifestyle changes," "attitudinal changes," and "education." The behaviors listed above (from the closed-ended questions) fall into the first two categories. There is little question that the majority of participants changed how and what they eat, altered other aspects of their lifestyle, and started taking their physician's instructions seriously. A number of people also noted attitudinal changes, like paying more attention to their disease and making the decision to gain control.

Ninety-seven percent of respondents (N=37) also experienced positive changes in mental status. Mental health benefits noted were more idiosyncratic than those for diabetes self-management, but fell into three general categories: "attitudinal/self-esteem changes," "improved personal skills," and "improved social skills." "Managing stress better" and "being more positive about one's life" were frequent comments. Participants also noted greater ability to deal with anger ("thinking before I act"), losing weight (which improved self-esteem), going out and having fun more often, and being more comfortable with themselves.

Question 7: *Which components of the program were most helpful to participants in achieving their wellness goals?*

Some differences among the cohorts were observed in how each group ranked the eight components of the program (educational sessions, group activities within sessions, grocery card incentives, individual counseling, peer support, referrals, social

activities outside sessions, and mini medical check-ups). For example, most groups ranked "grocery card incentives" very low. However, one group with a number of economically disadvantaged participants ranked it somewhat higher. Also, some groups appreciated the social support and outside social activities more than others (which may have had to do with the amount of support available to them at home).

In general, "educational sessions" were the most helpful to participants, since most joined this program looking for information to manage their diabetes better. The "mini medical check-ups" were also highly valued as were "group activities within the sessions" (the warm-up exercises conducted while the faculty and resident physicians

saw each participant briefly one-on-one). "Referrals" were least helpful, because only a few participants actually needed or utilized this service. Several members of the fourth and fifth cohorts did join the Community-Supported Agriculture Program of WMKKNC; some participated in NAMI-sponsored support groups; others received help with SSI applications. Outside social activities and the grocery card incentives were also ranked lower. "Individual counseling" and "peer support" were ranked in the middle, valued by some, less so by others.

Based on these findings, a program of this nature could probably operate successfully without referrals, outside social activities and monetary incentives. However, peer support, particularly within sessions, was a valuable component that should be maintained along with educational sessions and frequent physician monitoring.

Question 8: *In what percentage of participants is risk of alcohol and/or drug abuse identified? How was this risk addressed and with what results?*

Of the 39 participants who completed Savvy Self-Care, one (2.6%) scored "at risk" for alcohol problems and 4 (10.3%) scored "at risk" for drug problems on the SBIRT screening tools (described earlier in this report). Interestingly, the Certified Addiction Specialist (CAS) assigned to the project saw a total of 14 patients to discuss AOD issues. Many of these participants reported past abuse (but no current use) or discussed their concerns about the substance abuse of a family member. A few simply provided inaccurate information at pre-test and were, indeed, at risk (identified as such through counseling).

The CAS employed a variety of therapeutic approaches in her work with these participants: psychotherapy, cognitive-behavioral therapy, assessing stages of change (motivational interviewing), and behavior modification. She worked with clients to build coping skills to combat internal and environmental triggers, enhance awareness of triggers, improve impulse control, and prevent relapse.

All clients who saw the CAS received drug and alcohol education, learning about the effects of substances on the brain, heart, liver, and other organs and, in particular, the effect of AOD use on diabetes. She also emphasized the negative effect of chronic marijuana use on memory and provided information about alternatives to chronic pain management, such as mindfulness and relaxation techniques.

Most participants were receptive to the information provided. Only one actually demonstrated clear behavioral change as a result of this component of the program. This individual stopped drinking and using substances and continues to engage in more positive activities such as volunteering and helping family members.

Additional Statistical Findings

Analyses were conducted to compare outcomes between men and women, between Caucasian and ethnic minority participants and by age and education. There were no statistically significant differences in levels of depression and anxiety, perceived social support, number of close friends, or A1c observed between men and women either at the beginning or end of the program. Both groups benefitted equally from the program. With respect to age, no statistically significant correlations were observed between age and changes in depression, anxiety, perceived social support, close friends, or A1c.

To examine the impact of the program on Caucasians and ethnic minorities, the variable "Ethnicity" was recoded into Group 1 (Caucasians) and Group 2 (Ethnic Minorities). On all of the outcome variables except one, no differences were observed between the two groups. The exception was change in depression. Ethnic minorities exhibited a greater decrease in depression scores than did Caucasians (by about 12 points), although the two groups were nearly equal in depression scores at the beginning of program participation.

Generalized Contentment Scale
(By Ethnicity)

	N=18 Ethnic Minorities	N=19 Caucasians	
Mean, Pretest	**45.67**	**45.30**	
S.D.	15.73	14.66	
Mean, Change	**-16.70**	**-5.00**	
S.D.	13.30	13.61	t-value=**2.57** (df=33); p=**.015**

While it is impossible with the data collected to understand exactly why this difference occurred, it is a noteworthy finding, given that ethnic minorities have often been underserved or not effectively served in programs of this nature. The fact that both the Coordinator and Project Medical Director were from ethnic minority groups may have contributed to a sense of comfort and safety among these participants that enhanced their participation and learning.

Conclusions From Statistical Results

Clearly, elements of both mental and physical health were impacted in positive ways among participants of Savvy Self-Care. Depression and anxiety levels were decreased. Perceived social support and number of close friends were increased. And, while BMI was not impacted, A1c levels dropped significantly—about the same as could be expected from a change in medication with no accompanying behavioral changes.

The positive outcomes were most likely due to the educational sessions, weekly attention by the faculty and resident MDs, and by social support provided in all aspects of the program.

While statistical significance was achieved in pre to post scores on the major outcome variables, levels of depression and anxiety remained high for many participants. Since little direct intervention (chiefly, psychiatric consultation, case management, and psychotherapy) was provided due to lack of staff, these results are not surprising. What is noteworthy, however, is that the remaining interventions—

education and social support—appeared to contribute to positive changes by themselves. That so many participants remained at clinically significant levels of depression and anxiety is troubling, however. A truly integrated behavioral health approach (which this project originally aimed to test) might have achieved many more positive outcomes.

Case Studies

While statistical data were important to collect in determining outcomes of participation in “Savvy Self-Care,” qualitative data were collected from a few participants who appeared to have benefitted from the program and agreed to be interviewed. While not all participants achieved these results, it is important to hear the stories of those who found this approach especially helpful in attaining their personal goals.

Calvin. Respondent is a 56 year-old, single, African American male with three grown children. He lives next door to one daughter and her young son and helps them out as best he can. Calvin (not his real name) worked in engineering for a Silicon Valley manufacturing company for almost 30 years and was laid off just shy of eligibility for a full pension, which "really crushed my spirit." Due to his deteriorating health, he has been unable to work for many years. It was ten years ago when he had a "severe collapse"—an episode of extremely high blood sugar (over 600) that landed him in a hospital with blurred vision. He didn't even know he had diabetes at the time.

In retrospect, Calvin describes himself as "a mess…just about in despair" when his doctor at PMO suggested he attend the Savvy Self-Care Program. He was fighting depression due to his "basket" of health problems (high blood pressure, high cholesterol, diabetes). He was confused about his health conditions. He did not understand the severity of his diabetes (he didn't even know what an A1c reading represented). After living with the disease for ten years, he had never been given any information on self-care beyond a few brochures. In particular, he had no idea how to eat properly, including how to shop and prepare food.

Prior to participating in Savvy Self-Care, Calvin drank alcohol excessively to deal with stress and to help get to sleep at night (something he no longer does). But, when he woke up, the stressors would still be there. He heaped guilt upon himself for eating poorly and not taking care of himself in other ways. But, he really didn't know what to do instead.

Calvin credits Savvy Self-Care with a host of improvements to his physical and mental health. With an A1c of around 8 points at the start of the program, he is proud of the fact that "I'm just about ready to crack 7!" He has lost 20 pounds. Most importantly, he feels better about himself. "I have the ammunition I need to fight this war with diabetes."

Calvin's greatest need upon entering Savvy was to understand how to eat and, just as importantly, how to shop. "The hardest thing is shopping…it's a battlefield out there!" Calvin learned how to read labels and to understand the relative nutritional merits of various foods. Today, he has eliminated highly processed foods from his diet and eats brown rice and whole grains instead of white rice and white bread. He also checks his blood sugar frequently (which he didn't do before) "so I can stay on track."

Another indirect consequence of participation in the program is that he now has Social Security Disability. Twice before, he had been turned down and didn't know where to turn. A Savvy Self-Care support person from West Modesto King-Kennedy

Neighborhood Collaborative helped him get to DRAIL, an organization for disabled people. The staff there supported his re-application process, which was successful this time. With a steady income, he can buy higher quality food, and his stress level is greatly reduced. He is now a volunteer for the WMKKNC and will be providing outreach to the community to inspire others to take advantage of various health-promotion programs.

When asked what had helped him the most about SSC, Calvin did not hesitate. "It was knowing there was a doctor there giving us information to verify our knowledge. I could trust the information. That was a big thing." He also benefitted from the camaraderie in the large group sessions. "People could speak up and share what was on their minds."

The outside social activities were less important to Calvin, although he sometimes participated in them. Focusing on himself was his intention in participating in SSC—something he knew he needed to do to overcome his depression and redirect his life onto a healthier path. "I just wanted to get back to being the person I knew I could be!"

Graciela. Respondent is a 47 year-old, single, mother of two (ages 13 and 10) who is in the process of becoming the legal guardian of her three granddaughters (ages 6, 4 and 3). At the time she entered Savvy Self-Care, Graciela (not her real name) was living with her mother and her 24 year-old daughter (the mother of the three girls), in addition to the five children. Since then, her daughter abandoned her three girls, leaving them in Graciela's care.

Graciela is Caucasian and Puerto Rican. She grew up in Southern California and has nine siblings. At age 2, she was diagnosed with Type I diabetes, which she has been managing for 45 years. She moved to the Modesto area to help her mother care for her dying father. After his death from diabetic-related kidney failure, she decided to stay.

Graciela worked in a shop making prosthetic feet, but couldn't continue to work after she developed carpal tunnel syndrome and neuropathy (the latter related to her diabetes). She was eventually granted Social Security Disability.

For many years, Graciela was addicted to methamphetamines. Eventually, her daughter started using drugs, as well. As a result, the daughter lost her children to Child Protective Services, and they ended up in foster care. It was then that Graciela realized that she, too, could lose her children if she didn't get clean and sober. She also knew that her grandchildren would need a stable influence in their lives. So, she went

into recovery and continues to attend AA meetings and talk with her sponsor. She has been clean and sober for three years.

When she joined Savvy Self-Care, she was somewhat skeptical, having had many diabetes education classes before. She was motivated, though, as her years of addiction had taken a toll on her health. She simply had not managed her disease carefully and her A1c (three-month measure of blood sugar) had risen to 10.8 at one point (it was already about one point lower when she started the program). Knowing that she had not taken care of herself well also contributed to a clinical depression.

Graciela found Savvy Self-Care to be a very different approach to diabetic education than the one and two-day classes she had attended in the past. She benefitted from seeing a doctor each time she came to class (he helped her get into her own PCP once when an acute medical issue was identified). Also, she could ask questions much more freely than in the other programs. And, each subject was explored in much greater depth. Even after all the education she has had over the years, she still learned a great deal in Savvy Self-Care.

Megan. Respondent is a 42 year-old Asian/Caucasian single woman, ("Megan") who lives in a small apartment with her grown son who has mental health problems. His Social Security check is their only income. Prior to moving in with him, client was homeless and unable to continue her job as a security guard due to "health problems" (mostly depression). She had been living with her ex-boyfriend and his mother, but couldn't continue this arrangement because of the strained relationship with the ex.

Megan couldn't make car payments, and her car would have been repossessed if her ex hadn't gotten it impounded. So, it was returned to the bank and she was able to get some money, which allowed her to get housing and pay a few bills. She told her son, however, that he would have to stay on his psychotropic medications if the two lived together (which he has done).

Megan claims she has been clean and sober for one year after intermittent use since her 20s. She had a seven-year period of being clean (probably when working), but relapsed when her living conditions began to deteriorate. "Using drugs didn't help, but I didn't know what else to do."

At the beginning of "Savvy Self-Care," Megan was very skeptical about the program. "I felt like s__t, and I didn't think anyone or anything could help me. I was negative about everything." She was indifferent about her diabetes diagnosis and about living in general. She was not actively suicidal, but "I didn't care if I got run over by a car." Her blood sugars were fluctuating between 200-300; she was constantly

thirsty and urinating so much at night that she needed diapers (something she no longer needs). She simply hadn't been taking care of herself.

Even the supervising physician of "Savvy" questioned at first whether the program would be able to help her, a fact he has shared with her. At the graduation ceremony at the end of the 12-week cycle, he told the entire group just how much he has seen her change in a positive way.

The turning point for Megan was seeing that others really do care about her. She knew she had her son's support, but her mother was constantly negative and demeaning toward her. With the support of new friends developed in the program, she was able to confront her mother and have an honest conversation with her. Her mother told Megan that she does love her and doesn't want to see her die.

In describing how she has benefitted from the program, Megan proclaims proudly, "I changed the way I think, talk, and act. I'm more outgoing and confident. I can talk with people now and I realize that they really do care."

During the 12-week program, Megan lost 11 pounds and her blood sugars dropped dramatically (partly due to a medication change she advocated for herself). This morning, the reading was 139, much better than the 200s she had been experiencing.

The social support component obviously helped Megan tremendously. She enjoyed the in-group interactions and participated in NAMI-sponsored activities between sessions. She also found the educational component helpful and began incorporating what she learned into her daily routine. About the program, she commented, "It really does change your life if you want to change."

Megan hopes that she will be able to volunteer in the next cycle of "Savvy," although transportation remains a problem for her. She has a friend with diabetes (who owns a car) who may want to volunteer as a support person, as well. They could drive together to meetings and other activities.

Megan has changed her eating habits, choosing whole grains over processed ones and watching her carbohydrate intake. She is a role model for her son and other family members as they see her paying attention to food labels and portion sizes. Summing up her experience with "Savvy," she states, "I like myself now!"

Additional Implementation Lessons Learned

Each cohort of six to nine people who completed the Savvy Self-Care Program taught us something about implementing this model. When we observed a problem or something about the program that wasn't working as well as we would have liked, we made adjustments in our approach and observed the results. By the fourth cohort, we had a model that seemed to be working well.

From **Cohort 1** and **Cohort 2** we learned that *there are strategies staff can employ to facilitate supportive connections between volunteers and participants*. Originally, we thought it would be best to allow relationships to form "organically" (without our intervention). Participants were told that the volunteers were present to help them and support their learning. We encouraged them to talk with the volunteers and find someone with whom they felt comfortable to connect.

Well, that approach didn't work so well. Both participants and volunteers seemed shy and did not connect as readily as we had hoped. We decided that for the second cohort, we would engineer the connections. In consultation with the volunteer coordinator from NAMI and liaison from WMKKNC, we paired each participant with a volunteer with whom we thought they would be compatible. We also gave the pairs an assignment—to go shopping together (with grocery cards we provided) and prepare a healthy snack for a particular session.

This approach worked much better. Cohort 2 became very cohesive and rated social support activities both within and outside the group sessions much more highly than did the first cohort. Lesson learned!

From **Cohort 2** and **Cohort 3**, we learned that *social support opportunities and mental health content embedded in our curriculum are not necessarily enough to adequately address the psychiatric issues presented by participants*.

For example, one of the benefits of greater group cohesion in Cohort 2 was the willingness of participants to share more in the group sessions regarding their mental health concerns. They talked more about depression and anxiety and their struggles with family life. We realized toward the end of the 12-week session, however, that we had not been adequately addressing these concerns.

Having lost the psychiatrist assigned to our program (she left the county and had not been replaced at that point) and having so few hours of time assigned to our coordinator, very little direct mental health intervention had been provided to participants in the first two cohorts. Indeed, while their depression and anxiety scores

were reduced from the beginning to the end of the program (at a statistically significant level), about 65% continued to score above the clinical cut-off of 30 points on one or both measures, suggesting that more needed to be done in this regard.

We tried, unsuccessfully, to get the coordinator's hours assigned to the project increased from eight to 14, which would have allowed her more time for individual counseling sessions with participants and time to staff each incoming cohort member. The increased hours would have enabled staff to determine who needed extra attention to address mental health difficulties, including referral back to their PCP for psychotropic medications and, in rare cases, referral to Behavioral Health and Recovery Services for more intensive services than those available in a primary care health setting.

From **Cohort 3** and **Cohort 4**, we learned that *offering concrete exercise opportunities and encouraging their use (by setting an example, providing transportation, etc.) is a more effective strategy to increase participants' activity levels than simply lecturing or talking about various forms of exercise.*

"Bottom Line" Lesson Learned

People who have diabetes (especially those with a co-occurring mental illness) are rarely provided sufficient education about their condition and the medications used to treat it at the point of diagnosis. Savvy participants repeatedly told us that it took up to 10 years for them to receive the information that could be truly helpful to them in self-management. For many, this program offered their first real education beyond a basic nutrition course. They need information regarding: 1) defining and understanding diabetes and its impact on organs and systems in the body, 2) medications (oral and insulin)—what they do, why they are prescribed in various combinations, side effects, etc., 3) high and low blood sugar (especially, how to manage both conditions), 4) complications and their prevention, 5) what to do when sick with a cold or flu, 6) the role of physical exercise and stress management in controlling diabetes.

Based on the findings of this learning project, the following recommendations are made to other primary care organizations wishing to impact the health behaviors of their dually diagnosed (diabetes/mental illness) population:

1. Develop a logic model with intended outcomes clearly defined to guide program development; review periodically and revise, as needed.

2. Offer a 12-week psychoeducational program (or similar curriculum), inclusive of key diabetic self-management components in addition to nutrition and exercise.

3. Introduce participants to the model, “Stages of Change” so they can assess what changes they want to make, if any, how motivated they are to make them, and how confident they are that they can succeed. Refer back to this model frequently so that participants can evaluate their own progress.

4. Limit enrolled program participants to 12, but include others who can provide support (family and friends, clinic staff, program “graduates,” outside agency staff and volunteers, as available). Develop an informal “we’re-all-in-this-together” environment in which learning can take place, reducing self-stigma and isolation.

5. Involve medical staff members who are knowledgeable about diabetes, motivated to teach the material, personable, and nonjudgmental. The content should be provided in interactive, rather than strictly didactic fashion. A little humor will help a great deal!

6. Combine the group education with individual “mini check-ups” by a physician and/or resident to closely monitor patient progress and learning. Refer any medical issues back to the patient’s primary care physician.

7. Provide opportunities for continued socialization and learning outside of the group sessions, such as a support group for people with diabetes and mental illness, walking group, nutrition/cooking classes, information on programs that provide low-cost locally-grown vegetables, etc.

8. Assess participants for substance abuse and mental health issues prior to and during the program (it may take some participants time to be comfortable revealing problems they are experiencing in these areas). Offer individual therapy, support groups, and/or referrals to address these issues.

9. Offer “warm-up” activities at each meeting while the mini check-ups are being performed to engage participants in interaction with one another and prepare them for the day’s topic.

10. Provide healthy snacks and assign participants responsibility for providing them, if possible.

11. Communicate with patients' primary care physicians to increase participants' motivation to adopt healthy behaviors and improve diabetic and psychiatric outcomes.

12. Conclude the program with a "graduation" ceremony and provide a certificate of completion to each participant.

Additional Unanticipated Program Outcomes

Prior to the availability of the final "Savvy Self-Care" evaluation results, the Health Services Agency administration had already observed positive outcomes from the program. They decided to apply for funding to continue "Savvy" in its present format through the Song-Brown Program (funding source associated with the Residency Program). The grant proposal submitted was accepted with $120,000 funding for two years anticipated to begin in July 1, 2014.

Also, in the Fall of 2013, a number of medical students being interviewed for Family Practice Residency positions in 2014 surprised panel members when they inquired about "Savvy" (after reading about it on the Residency Program's web site). They were specifically interested in knowing more about the agency's group approach to diabetic care and patient education and possibly working in "Savvy" if accepted into the Residency program.

These two conditions—obtaining funds through Residency Program resources and the interest of incoming residents in the group care approach—could cement "Savvy Self-Care" as a unique service and training feature of the program.

For the Appendices mentioned in this report, please contact the Stanislaus County MHSA office at (209) 525-6247.