

Innovation Work Plan Narrative: INN-12

Work Plan Name: Family Therapy Participation Engagement

County: San Diego

Purpose of Proposed Innovation Project (check all that apply)

- INCREASE ACCESS TO UNDERSERVED GROUPS
- INCREASE THE QUALITY OF SERVICES, INCLUDING BETTER OUTCOMES
- PROMOTE INTERAGENCY COLLABORATION
- INCREASE ACCESS TO SERVICES

Briefly explain the reason for selecting the above purpose(s).

It has been documented that parents who are engaged in the treatment of their child(ren) are a crucial component to positive outcomes and lasting change (Cunningham & Henggeler, 1999; Liddle, 1995; Szapocznik et al., 1988; Coatsworth, Santisteban, McBride, & Szapocznik, 2001). The County of San Diego has set a goal that 80% or more of clients in treatment for serious behavioral health issues shall receive a minimum of one family therapy contact per month with the client's biological, surrogate or extended family member. This goal is not being consistently met throughout our system. Literature and anecdotal reports tell us that parent expectations predict subsequent barriers to treatment. Existing practice of therapists and professional case managers educating and encouraging family participation in treatment has not led to desired level of parent involvement in care. This adapted Innovation Project would utilize specially trained Parent Partners in first establishing a relationship with the families of clients and then using motivational interviewing techniques to overcome barriers to involvement in treatment and activating change. There is no established literature that details the success of Parent Partners trained in motivational interviewing in mobilizing families to participate in family therapy services. We expect this project will allow treatment providers to learn about perceived barriers to involvement and will increase family therapy participation, thereby increasing the quality of services in the following ways:

- Hogue, Liddle, Dauber, and Samuolis (2004) point out, rigorous empirical studies have shown that family-based therapy can produce engagement and retention of drug users and their families in treatment (Henggeler et al., 1991); reduction or elimination of drug use (Liddle et al., 2001; Waldron, Slesnick, Brody, Turner, & Peterson, 2001).
- Family involvement in treatment leads to decreased involvement in delinquent activities (Henggeler, Melton, Smith, Schoenwald, & Hanley, 1993).
- Family involvement in treatment leads to improvement in multiple domains of psychosocial functioning such as school grades, school attendance, and family functioning (Liddle et al., 2000).
- Stakeholder input has identified a model of utilizing Parent Partners to join with caregivers in effort to increase parents understanding of value and therefore increase commitment to consistent participation in family therapy.

Project Description

Describe the Innovation, the issue it addresses and the expected outcome, i.e. how the Innovation project may create positive change. Include a statement of how the Innovation project supports and is consistent with the General Standards identified in the MHSa and Title 9, CCR, section 3320.

- Due to low parent involvement in therapy, a systematic approach to increase caregiver participation in family therapy for existing client treatment would be implemented.
- The new practice would employ a Parent Partner whose primary role will be to engage the client's guardian in family therapy to enhance positive and sustainable gains from treatment.
- Currently Parent Partners are utilized to engage with families in a broader role and offer rehabilitative and case management services, but this would shift to a focal objective of engagement in family therapy.
- Priority efforts shall be made to engage underserved populations such as Latinos and African Americans.
- Significant predictors of low expectancy for therapy services include low SES, severity of the child's dysfunction, ethnic minority status and parental stress and depression (Nock, et al 2001).
- Parent expectations predict subsequent barriers to treatment including participation, treatment attendance and premature termination from therapy (Nock, et al 2001).
- Parent engagement will include education on the importance of authentic family participation in the child's treatment.
- Engagement will explore the reasons for lack of parent participation. It will allow the parent partner to establish a rapport with the family, to hear their concerns about their child and discuss the family's hopes for the future. Next the Parent Partner will help the client's family focus on what habits or behavioral patterns the family hopes to change. The Parent Partner will evoke the family's motivation for change. Finally the Parent Partner will support the family in developing steps they can use/be involved in that will facilitate change.
- Parent Partner will provide information about increased effectiveness of treatment outcomes when parents are involved in family therapy as true change agents for the youth's behaviors.
- Existing strategies to reduce stigma associated with behavioral health services shall be utilized, but offered by a Parent Partner who is able to engage the family from a nontraditional system approach, with emphasis of individualizing the approach specific to the information provided by the family and their experience.
- Education will be offered to ensure that misperception parents relate to our providers that professionals are able to foster meaningful and lasting change without the active problem solving on the part of the family unit will be explored.
- The intent is to clarify, teach, and motivate the caregiver the value of their involvement in treatment and how it will directly support the success and outcomes for the family unit.
- The Parent Partner will be trained in Motivational Interviewing which is traditionally utilized by clinicians, and work with the parent to overcome identified barriers and assist the multidisciplinary team to better accommodate the family needs in order to foster participation.

- Training Parent Partners in Motivational Interviewing techniques is a new use of Motivational Interviewing.
- The Parent Partner would act as the program's "change agent" to work with the program staff on solutions that would foster caregiver involvement.
- Active engagement of families in treatment provides an opportunity to establish effective patterns of communication between family members.
- Stronger problem solving skills within a family unit leads to improved stability.
- A cohesive family unit leads to more stable and thriving communities.
- Each full time Parent Partner would engage a minimum of 40 caregivers per fiscal year.
- Each of the six regional treatment programs will extend the services to a minimum of 80 caregivers annually for a total of 480 families impacted.
- Two full time Parent Partners would join the clinical team of a program.
- One of the two Parent Partners in each program shall be bicultural and bilingual.
- The BHS workforce would be enhanced with 12 additional full time Parent Partner positions, with an additional emphasis on cultural competence.
- Parent Partners will meet the BHS-CYF definition of Family Support Partner as being an individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families and who is employed full or part time to provide direct (potentially billable) services to a child, youth, or family receiving behavioral health services.
- Each of the six regional programs shall employ an analysts/research assistant to create tracking systems, analyze the data and prepare a best practices report out on the findings.
- One program shall be enhanced with a research position that will oversee and pull all six programs data collection into an annual report that trends the findings.

This project is consistent with the General Standards identified in the MHSA and Title 9, CCR, section 3320.

Community Collaboration: Members of the Children's System of Care that have experience with Parent Partners recognized the benefit to utilizing this resource in identifying barriers to treatment and establishing greater involvement in treatment. Increasing involvement of Family/Parent Partners has been presented as an emerging practice and program that utilize this resource have provided feedback to the group about the benefit of adding these members to the treatment team. The County of San Diego Children's System of Care represents multiple sectors including public, private, education, and family and youth.

Cultural Competence: As defined in CCR, Title 9, Section 3200.100, this program demonstrates cultural competency and capacity to reduce disparities in access to mental health services and to improve outcomes for unserved and underserved children and youth with mental illness. It is anticipated that Parent Partners will largely represent the racial/ethnic, cultural, and linguistic populations that our programs serve. This representation will further allow programs to ensure equal access to services, identify and measure disparities in services including bias, racism and other forms of discrimination, and allow treatment providers to have an increased understanding of diverse belief systems concerning mental illness, health, health and wellness. Working alongside Parent Partners, it is anticipated that programs will develop a greater awareness of diversity on all levels- from the administrative level to the direct service provider.

Client Driven and Family Driven Mental Health System: This program includes the ongoing involvement of clients and family members in roles such as, but not limited to, implementation, evaluation, and future dissemination. Ultimately, the program strives to create healthier families in our community. Families may feel better able to connect with Parent Partners and may, in addition to taking a more active role in their own family's care, be better equipped to provide educational information to their community.

Wellness, Recovery and Resilience Focus: This program increases resilience and promotes discovery and wellness for children and youth with serious mental illness by increasing access to services. The goal is to strengthen the overall family to allow for a more stable and resilient family system with strength to sustain wellness.

Integrated Service Experience: This program encourages access to a full range of services provided by community resources, multiple agencies, programs and funding sources for family members.

Number of Participants to be Served

- Each full time parent partner would engage a minimum of 40 caregivers per fiscal year.
- Each of the six regional treatment programs will extend the services to a minimum of 80 caregivers annually for a total of 480 families impacted.

Total Funding

Note: The 3rd year of proposed Innovation funding will occur in FY 2017-18, which is outside of the time frame for this Three Year Plan.

Annual Program Cost	\$1,077,412	3 Year Program Cost	\$3,232,236
Evaluation Cost (4.4% of Total)	\$49,588	3 Year Evaluation Cost	\$148,764
Total Annual Innovation Funding	1,127,000	3 Year Grand Total	\$3,381,000
Inclusive of estimated MHSA costs only (estimated administrative costs are not included).			

Contribution to Learning

Describe how the Innovation project is expected to contribute to learning, including whether it introduces new mental health practices/approaches, changes existing ones, or introduces new applications or practices/approaches that have been successful in non-mental health contexts.

The learning objective is to determine if the utilization of Parent Partners (defined as an individual with experience as a parent/caregiver of a child/youth that has or is currently receiving services from a public agency serving children/families) to provide outreach to families through motivational interviewing engages the family unit in family therapy services. Furthermore, we hope to learn what are the specific strategies and best practices that family partners can utilize to successfully assist caregiver see the value of consistently participating in family therapy. We

want to know if the use of a Parent Partner to do this targeted work will be more successful in persuading caregivers to be involved in family therapy than the traditional model of the clinician outreach to the family. We intend to review if repeated engagement efforts correlated with successful engagement into family therapy.

Timeline

Outline the timeframe within which the Innovation project will operate, including communicating results and lessons learned. Explain how the proposed timeframe will allow sufficient time for learning and will provide the opportunity to assess the feasibility of replication.

Implementation/ Completion Dates: 07/15 – 06/18 **NOTE:** Program design to be developed from competitive process. The dates identified below are a projection of implementation, actual datelines to be determined by winning proposal.

- By 6/15 Amend regional contracts to include innovative component
- 7/2015 Innovation component goes into effect. Contractors will be allowed up to 6 week start-up time to recruit, hire and train Parent Partners.
- 7/2015 Hire an independent evaluator to initiate the data analysis process. A research and data collection outline to capture effectiveness of Parent Partner will be established. Clear measure of family participation and attitudes about participation will be determined
- 9/2015 Parent Partner services begin. Parent Partners initiate the process of engagement with families.
- 9/2015 Begin ongoing data collection and evaluations
- 1/2016 The first semi-annual report will be due 30 days after the second quarter of the project. This report will include all data elements year-to-date, analysis of the barriers and success of the projects and recommendations based on lessons learned thus far
- 8/2016 The first annual report will be due 30 days after the end of the first year of the project and will follow the outline of the first annual report but also include results of a consumer survey, as well as any new data elements and/or additional analyses recommended by the first
- 1/2017 Follows same format as 1/2016
- 8/2017 Follows same format as 8/2016
- 1/2018 Follows same format as 1/2016
- 8/2018 Provide final program assessment and outcome with recommendations.
- 8/2018 Report to be made available for review by other counties. Best practices shall be assembled into a document that will be share across the CYF

System of Care Evaluation by Behavioral Health Services to determination of efficacy and feasibility or replication with other funding, dissemination of results.

An evaluation component will be embedded within the programs with quarterly data reporting, annual reports and recommendations with a final project review to determine program effectiveness and identify the most successful practices from the implementation phase and measure system impact. This will also allow for review of new and adapted strategies that may increase the feasibility of the program for future replication. Focus will be on data that relate families perceived barriers to participating in treatment, data from Parent Partners detailing what they deemed to be helpful in engaging families, and data around actual family participation in treatment and impact on the child's clinical course of treatment.

Project Measurement

Describe how the project will be reviewed and assessed and how the County will include the perspectives of stakeholders in the review and assessment.

- Each contractor will identify recommendations based on what they implemented for best practices to engage caregivers in family therapy. The independent assessor will determine the best modality to gather data to make these recommendations. This may include surveys of the child, caregivers, Parent Partners, gathering data that reflects the number of family therapy sessions, length of treatment, outcome measures, etc.
- Data will be compared to baseline data available detailing participation in family therapy sessions.
- Data will be compared across the 6 individual programs that participate in this Innovations Project and will be reviewed collectively.
- Best practices shall be assembled into a document that will be shared across the Children, Youth and Families (CYF) system of care.
- The contract shall be monitored and evaluated in the following ways:
 - Quarterly Status Reports by program.
 - Data elements that will be tracked and monitored by the program.
 - Independent Evaluator shall complete annual reports and final evaluation of effectiveness of the intervention.
 - Independent Evaluator shall compile data into a Tool Kit to be made available to CYF System of Care.

Leveraging Resources (if applicable)

Provide a list of resources expected to be leveraged, if applicable.

Contractor shall be tasked with exploring leveraging opportunities. Although it is expected that six contracts will be amended to add the parent partner component, all will be set up to benefit from one external evaluation provider who can help implement a consistent evaluation methodology across programs.

NOTE: Actual budget to be determined by winning proposal from competitive process. The following are proposed guidelines:

NEW ANNUAL PROGRAM BUDGET – YEAR 1					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$930,000	\$930,000
2.	Operating Expenditures			\$7,500	\$7,500
3.	Non-recurring Expenditures			NA	NA
4.	Contracts (Training Consultant Contracts)			\$50,000	\$50,000
5.	Work Plan Management			\$139,500	\$139,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$1,127,000	\$1,127,000
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
C. TOTAL FUNDING REQUESTED					
				\$1,127,000	\$1,127,000

BUDGET NARRATIVE

Provide a detailed budget narrative explaining the proposed annual program expenditures for each line item.
1- Personnel: 1 FTE for Family Partner at approximately \$60,000. 12 FTEs For 6 contracts = \$720,000. Research Analyst cost approximately \$70,000 for 1 FTE. Additional 3 FTEs (approximately .5 FTE for each contract) for 6 contract= \$210,000. Total Personnel cost = \$930,000.
2- Operating Expenditures: Anticipate additional \$1,250 needed for Operating expenses (supplies, computers, etc. for additional staff). Total Operating Expenses for 6 contracts = \$7,500.
3- Non-recurring Expenditures: Enhance existing contract by adding the Family Therapy Participation component. Therefore, no Non-recurring expenditures needed.
4- Contract (Training Consultant Contracts): \$50,000 for consultant to provide data analysis and dissemination for evaluation purposes.
5- Work Plan Management: \$139,500 is 15% indirect cost from Personnel cost (\$930,000 X 15% = \$139,500)

NEW ANNUAL PROGRAM BUDGET – YEAR 2					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$930,000	\$930,000
2.	Operating Expenditures			\$7,500	\$7,500
3.	Non-recurring Expenditures			NA	NA
4.	Contracts (Training Consultant Contracts)			\$50,000	\$50,000
5.	Work Plan Management			\$139,500	\$139,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$1,127,000	\$1,127,000
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
C. TOTAL FUNDING REQUESTED				\$1,127,000	\$1,127,000

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3- Contract (Training Consultant Contracts): \$50,000 for consultant to provide data analysis and dissemination for evaluation purposes.
4- Work Plan Management: \$139,500 is 15% indirect cost from Personnel cost (\$930,000 X 15% = \$139,500)

NEW ANNUAL PROGRAM BUDGET – YEAR 3					
A. EXPENDITURES					
	Type of Expenditure	County Mental Health Department	Other Governmental Agencies	Community Mental Health Contract Providers/ CBO's	Total
1.	Personnel			\$930,000	\$930,000
2.	Operating Expenditures			\$7,500	\$7,500
3.	Non-recurring Expenditures			NA	NA
4.	Contracts (Training Consultant Contracts)			\$50,000	\$50,000
5.	Work Plan Management			\$139,500	\$139,500
6.	Other Expenditures			NA	NA
	Total Proposed Expenditures			\$1,127,000	\$1,127,000
B. REVENUES					
1.	New Revenues				
	a. Medi-Cal (FFP only)				
	b. State General Funds				
	c. Other Revenues				
	Total Revenues			\$0	\$0
C. TOTAL FUNDING REQUESTED				\$1,127,000	\$1,127,000

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3- Contract (Training Consultant Contracts): \$50,000 for consultant to provide data analysis and dissemination for evaluation purposes.
4- Work Plan Management: \$139,500 is 15% indirect cost from Personnel cost (\$930,000 X 15% = \$139,500)