

MHSOAC Evaluation Interpretation Paper:  
Evaluation of Early Intervention Cluster Programs



**Evaluation Interpretation Paper**

**Interpretation of UCLA PEI Contract #MHSOAC-12-007  
Deliverable 2: Evaluation of Early Intervention Program Clusters**

**July 2014**

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As part of its Welfare & Institution Code (WIC) Section 5845 oversight responsibilities, and consistent with the vision of the Mental Health Services Oversight and Accountability Commission (MHSOAC) Evaluation Master Plan, the MHSOAC entered into an evaluation-focused contract with researchers at the University of California, Los Angeles (UCLA) Center for Healthier Children, Youth, and Families on June 26, 2012. The contract required the researchers to evaluate the Prevention and Early Intervention (PEI) component of the Mental Health Services Act (MHSA).

This contract comprised two primary facets. The first major report (Deliverable 1) completed via this contract, titled “Prevention and Early Intervention: California’s Investment to Prevent Mental Illness from becoming Severe and Disabling”, assessed the service populations and MHSA expenditures for prevention and early intervention efforts during fiscal year 2011/12. The results of this evaluation are detailed within the report and associated Executive Summary that was presented to the Commission in January 2014. These findings are also discussed and interpreted by the MHSOAC in a previous Evaluation Interpretation Paper (also presented to the Commission in January 2014).

The second set of reports (Deliverable 2), titled “Evaluation of Early Intervention Program/Efforts” assessed the impact of three specific “clusters” of early intervention programs on consumers’ MHSA-defined mental health outcomes. The results from the cluster reports were completed in Spring 2014. This MHSOAC Evaluation Interpretation Paper focuses on these reports. Below, we provide a high-level summary of the findings for each cluster and describe issues that the MHSOAC may wish to consider based on the study findings.

### ***Summary***

#### Overview of Clusters & Inclusion Criteria

Three clusters of early intervention programs were chosen for evaluation. The following populations were served by each of the three clusters:

- *Cluster 1:* Children and youth displaying emotional disturbance as a result of trauma.
- *Cluster 2:* Youth, transition-age youth, and younger adults with prodromal symptoms or experiencing first onset of psychosis.
- *Cluster 3:* Older adults experiencing early onset of depression symptoms.

Among all of the early intervention programs that served these target populations, four inclusion criteria were used in order to identify which specific programs to include in this evaluation.

These four inclusion criteria are as follows:

1. *Early Intervention Programs:* Selected programs served individuals with early onset of a mental illness or emotional disturbance. Programs that also included prevention services were eligible, but the primary focus of this evaluation was on the early invention services provided by the program.

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2. *PEI Funding*: Early intervention services provided by programs were at least partially funded by MHSA PEI funds.
3. *Consumer Population Defined by Clinical Assessment*: The early onset populations being served were identified via systematic assessment with clinical cut-offs (i.e., participants displayed a “clinical level” of symptoms of early onset of a mental illness or emotional disturbance).
4. *Program Components and Implementation*: Programs provided promising or evidence-based treatment components found in peer-reviewed research to be effective for the target population being studied (i.e., the population specified for each cluster). Programs also implemented these program components with fidelity.

Using these criteria, two programs being implemented across eight counties were selected for Cluster 1: Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) and Cognitive Behavioral Intervention for Trauma in Schools (CBITS). Three programs being implemented across eight counties were selected for Cluster 2: Prevention and Recovery in Early Psychosis (PREP), Portland Early Identification and Referral (PIER), and Sacramento Early Diagnosis and Preventative Treatment (SacEDAPT). For Cluster 3, three programs being implemented across ten counties were selected: the IMPACT program, Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors), and Program to Encourage Active Living for Seniors (PEARLS).

The intention of the identification of coherent clusters of early intervention programs was to assess the overall ability of such programs to achieve MHSA-defined goals on a statewide level. As such, analyses were conducted to determine whether the individual clusters of programs had any positive impact on the seven negative outcomes associated with untreated mental illness or other outcomes that the MHSA identifies for the PEI component. In the end, specific outcomes examined for each cluster depended on the available data. Despite general intentions to focus on MHSA-defined outcomes, outcome measures varied highly across programs and counties, making it challenging to draw strong conclusions for full clusters of programs. Results of these cluster evaluations are summarized below (detailed reports of all analyses are available in the final cluster reports).

#### Summary of Results: Cluster 1

Overall, Cluster 1 programs (TF-CBT and CBITS) showed evidence of reducing the severity of mental illness for children and youth displaying emotional disturbance as a result of trauma. In particular, TF-CBT was associated with improvement in functioning and movement into the “nonclinical” range on some outcome measures post-intervention. This pattern of improvement held across participating counties, and among underserved racial groups. In addition, findings from Cluster 1 also indicated improved access among traditionally underserved demographic groups. Specifically, almost all of the Cluster 1 counties were found to be serving gender and

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racial/ethnic groups at rates proportional to each demographic group's estimated need for service in their county (i.e., no particular group stood out as being "underserved" in this particular cluster of programs). This promising pattern may be related to the explicit focus on serving traditionally underserved groups that is shared by many of these programs.

Summary of Results: Cluster 2

For Cluster 2 programs targeting youth, transition-age-youth, and younger adults with prodromal symptoms or experiencing first onset of psychosis (PREP, PIER, and SacEDAPT), there was some evidence that these early intervention programs had a positive impact on mental health outcomes. With regard to preventing mental illness from becoming severe and disabling, participants in all three Cluster 2 programs displayed decreases in depression and improved mental health functioning on average. In addition, there were reductions in incarcerations, school drop out, unemployment, and homelessness among these participants, although the sample sizes available for these individual outcomes were too small to draw definitive conclusions. Similar to Cluster 1, Cluster 2 programs also served traditionally underserved racial groups at rates proportional to each group's estimated need for service. Again, this suggests that these programs' increased focus on meeting the needs of underserved populations might be effectively increasing rates of service for these groups.

Finally, UCLA also examined whether counties participating in Cluster 2 programs displayed reduced rates of mental health service initiation compared to all other California counties. This was explored based on the notion that counties with these Cluster 2 programs might be effectively preventing individuals from needing full-fledge mental health services and rather treating individuals early on at the first sign of symptoms, as early intervention programs are intended to. Unfortunately, Cluster 2 counties differed significantly from other California counties with regard to mental health service initiation rates even *before* the intervention period began. Thus, it was difficult to conclusively determine whether or not Cluster 2 early intervention programs had a unique impact on rates of service initiation in Cluster 2 counties relative to other California counties.

Summary of Results: Cluster 3

Cluster 3 early intervention programs serving older adults experiencing early onset of depression symptoms (IMPACT, Healthy IDEAS, and PEARLS) also showed evidence of efficacy. Findings indicated significant improvement in depression, anxiety, and functioning from pre- to post-intervention across all three programs, although sample sizes for some programs were too small to draw definitive conclusions. In addition, some counties served traditionally underserved groups in relative proportion to, or at even greater rates than, their estimated need for services (e.g., Black participants were "over-served" relative to their estimated need in some counties). However, a few counties continued to serve relatively low rates of participants from some underserved groups (e.g., some counties served the female population at a relatively higher rate

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than the typically underserved male population, and some counties continued to underserve Hispanic populations). Finally, Cluster 3 programs showed promising findings with regard to reduction in suicidal thoughts and behaviors. On average, these reductions were statistically significant across these early intervention programs.

***Issues for the MHSOAC to Consider***

Across all three clusters, findings from this evaluation indicate that many early intervention programs are yielding promising patterns of improvement in mental health outcomes across California. This overall pattern of improvement is consistent with findings from prior evaluations of these early intervention programs conducted in other contexts, suggesting that successful implementation of these programs within California's diverse counties is indeed achievable and likely to yield positive outcomes. Although the findings from this evaluation indicate an overall positive pattern, the results are based on small numbers of clients within only a handful of programs that met inclusion criteria for each of the three clusters. In order to more fully understand the impact of various clusters of PEI programs, as well as the PEI component overall, stronger evaluations and more systematic data are needed on PEI programs. The proposed PEI Regulations that were recently adopted by the Commission are designed to provide counties with guidance that should ultimately lead to stronger evaluations and more systematic data.

Current guidelines provided by the Department of Mental Health require that the counties only evaluate one of their PEI programs and focus on any MHSA-defined outcomes that apply to those programs. Counties are also expected to identify methods to measure those outcomes on their own and are not provided with any guidance or recommendations. These issues contributed to challenges encountered within this evaluation. Overall, findings from this report must be interpreted with caution, as they may not stem beyond particular programs and, in some cases, particular programs being offered with single counties. Below is a summary of some of the primary problems that were encountered within this project and recommendations for how those issues could potentially be overcome. Please note that most of the recommendations have been put into motion within the proposed PEI Regulations that were adopted by the Commission.

High variability in data collection methods that prohibits drawing conclusions beyond the individual program level. Counties currently have the freedom to choose which PEI programs they would like to administer. They are also currently required to evaluate only one of their administered PEI programs. The MHSA provides a list of seven negative outcomes associated with having an untreated mental illness that are intended to be reduced via specific PEI programs, in addition to broader goals that are applicable to all programs (e.g., improve timely access to un/underserved individuals; reduce the duration of untreated mental illness). All counties are required to identify relevant outcomes that may change as a result of their particular programs, although they are only required to actually evaluate those outcomes for just one PEI program. No explicit guidance is provided regarding how those outcomes should be measured.

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This general autonomy has led to high levels of variability in the data collection methods used across counties, and even across programs with highly comparable foci.

- Variability in what outcomes to focus on. In some instances, no programs/counties collected any data that pertained to some of the MHSA-defined outcome (e.g., reduce stigma and discrimination associated with being diagnosed with a mental illness), which led to the inability to evaluate whether that goal was being achieved at the program, county, or statewide level. Another broad-based goal (i.e., improve timely access to services for underserved populations) could not be directly assessed because actual access (versus a lack of access) to services was not routinely tracked; nor was the length of time that it took for an individual seeking services to gain access to those services. As a proxy indicator of timely access, UCLA examined each underserved groups' enrollment in program services, relative to that group's estimated county-wide need for services. While this proxy provides some useful information, it is not a true measure of underserved populations' "timely access" to early intervention services.
  - Recommendations: Make PEI evaluation goals and expectations more explicit. If ambiguity exists regarding interpretation of PEI goals and how/if achievement of such goals should be measured, provide recommendations or requirements that would make expectations more concrete. Provide counties and providers with assistance that will support them in their ability to properly understand and implement evaluation goals, and meet the State's expectations. These recommendations would be achieved via final approval of the adopted proposed PEI Regulations, coupled with provision of training and technical assistance to the counties.
- Variability in how to measure outcomes. Although all included programs/counties had collected data on some MHSA-defined outcomes, the evaluators encountered a lack of consistently identified outcomes to focus on, and a lack of consistently defined/used measures to assess those outcomes. Similar programs within the same cluster did not always collect data on the same outcomes. When programs within clusters were collecting data on the same outcome(s), different indicators were often used to assess those same outcomes (across different programs/counties). For example, to measure possible reductions in justice system involvement, some counties collected arrest rates while others measured incarceration rates. This made it difficult to assess the cumulative impact of early intervention services on specific outcomes across multiple programs, even within single clusters.
  - Recommendations: The MHSOAC should place greater emphasis on the importance of addressing MHSA goals, as well as the value of collecting program-level data in order to assess whether those goals are being achieved. Standardize or provide recommendations for how counties should measure all MHSA-defined goals that

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pertain to PEI. This recommendation would be partially achieved via final approval of the adopted proposed PEI Regulations (i.e., the proposed PEI Regulations provide guidelines for measuring some of the MHSA-defined outcomes); this recommendation could be further achieved via training and technical assistance provided to the counties. Develop a standardized and automated reporting mechanism through which counties routinely submit PEI data, including data on outcomes, to the State. This recommendation will be partially achieved via the adopted proposed PEI Regulations, which provide reporting requirements for PEI evaluations and outcomes. This recommendation could be further achieved via development of an automated system through which this data is submitted to the State. The UCLA report includes several suggestions for how data standardization might be achieved:

- Determine a specific set of indicators that all programs must track/measure (e.g., program type and goals, target population, demographics, pre/post dates of service utilization, etc.).
  - Establish specific outcomes (consistent with MHSA's seven negative outcomes of untreated mental illness) that must be measured both pre- and post-intervention.
  - When possible, encourage the use of standardized tools for measurement of these outcomes.
- Variability in other data collection methods. Beyond choice of measure/indicator, the evaluations included within the scope of this project used highly divergent methods to assess the efficacy of their programs. For example, across all program participants, very few provided pre- and post-intervention reports of outcomes, which resulted in very small sample sizes in analyses that focused on change in outcomes as a result of program participation. In other cases, important data that could potentially be used toward assessment of some outcomes (e.g., client race/ethnicity) was not routinely collected.
- Recommendations: Develop ways to support counties in their evaluative efforts, especially during the planning and implementation phases. Provide counties with training and technical assistance that will help them to strengthen their PEI evaluations. Identify system-level challenges that may prohibit counties from designing and implementing stronger evaluations, consider ways that those challenges could be overcome, and work to implement possible solutions (e.g., changes in policy).

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Many counties may not be using clinical criteria to determine diagnoses or offering programs with demonstrated effectiveness. UCLA identified four basic inclusion criteria to decide which programs to invite to be part of each cluster. Many counties' programs were excluded from inclusion in the clusters due to the following inclusion criterion: use appropriate clinical criteria in determining diagnoses. This criterion highlights aspects of the MHSA that are applicable to appropriate target populations for PEI programs.

- PEI programs are intended to serve individuals who are at risk for mental illness or are showing the early signs and symptoms of mental illness, with early intervention programs focusing on the latter. Individuals with full-scale mental illness that is beyond the first break or initial symptoms should be treated with other clinical interventions that are funded via the Community Services and Supports (CSS) component, rather than PEI. Individuals identified via PEI-funded outreach efforts that are not considered to be in those initial stages are to be referred to relevant programs outside of PEI. Use of clinical criteria to determine diagnoses may be helpful in trying to understand an individual's needs and place them into services most appropriately. The limited number of counties that are using clinical criteria to determine diagnosis may create challenges regarding the accuracy of client placement into appropriate services, including into PEI versus CSS programs.
  - Recommendations: Take steps to ensure that counties are using adequate methods to identify client needs and properly place them into appropriate services (e.g., PEI, CSS, or otherwise). Identify ways to strengthen county ability to properly assess and identify client need so that clients are placed into the most appropriate services. Work with the counties to overcome barriers that prohibit this.

By taking the steps outlined above, the MHSOAC has the opportunity to continue to strengthen the use of PEI funds to prevent mental illnesses from becoming severe and disabling, and to improve timely access to services for underserved populations. In addition, the MHSOAC has the opportunity to ensure that counties and the State have ample information about the quality and success of specific types of early intervention programs being implemented across the state, which could help facilitate quality improvement efforts, fund allocation, and implementation of prioritization of future programs and services. These recommendations are in line with the MHSOAC-adopted Logic Model that specifies oversight and accountability strategies that the MHSOAC should be using, including ensuring collecting and tracking of relevant data/information, ensuring that counties are provided with appropriate support, ensuring that MHSA funding and services comply with relevant statutes, and use of evaluation results for quality improvement purposes. The recommendations are also consistent with recently adopted proposed Regulations for the MHSA PEI component.