Connections to Care (C2C)

The Perspectives of Leaders at Community-Based Organizations That Are Integrating Mental Health Supports

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Key findings

- As of August 2017, community-based organizations (CBOs) have begun to implement the Connections to Care (C2C) program, including training and coaching staff and providing mental health services to clients.
- Interviews with CBO leaders from participating organizations show that, even in the early stages of the program, cultural attitudes toward mental health and approaches to clients have shifted within CBOs.
- CBO leaders observed that proactively addressing CBO staff concerns and clearly defining roles between CBOs and mental health providers are factors that facilitate C2C implementation.
- Addressing some commonly endorsed challenges, such as perceived burden on CBO direct service staff, mental health stigma, and client logistical needs, could facilitate the implementation of C2C.

SUMMARY ■ The mental health system often does not reach all individuals who need mental health services. The Connections to Care (C2C) program, a $30 million public-private partnership under the federal Social Innovation Fund, with oversight from the C2C Collaborative, aims to address this problem and reach up to 40,000 New Yorkers over five years by encouraging formal collaborations between community-based organizations (CBOs) and mental health providers (MHPs). In the C2C task-shifting model, mental health specialists equip nonspecialist direct service staff at CBOs with the skills to deliver nonmedical mental health services while also facilitating referrals for more intensive care, if needed. By the end of the first year of C2C implementation, CBOs had contracted with MHPs, and together they developed operational plans and delivered C2C services to over 4,000 CBO clients. The RAND Corporation is evaluating the results of the C2C program from three vantage points: the effect of C2C on participating clients, relative to a comparison group of New Yorkers not receiving C2C services (impact); the program's implementation across different CBOs; and the effects of the program on government and CBO spending. The purpose of this brief research report is to present preliminary key findings from interviews with CBO leadership, conducted between June and August of 2017, which focused on CBO leaders' experiences launching C2C at their organizations. We share these findings to support CBOs and additional stakeholders in decisionmaking for C2C during the implementation phase. Other findings from the evaluation will be released as data become available.

BACKGROUND

Not all individuals who need mental health services can easily access them in the current mental health system. This may be especially true for individuals with low incomes, who may not be aware of or have access to resources and supports (e.g., psychotherapy, psychiatric medication management) to address their needs. Stigma around mental health services, a lack of widespread accurate information on such services, and a shortage of accessible providers often exacerbate these unmet needs. In response to these challenges, policy leaders and researchers have asked, Could mental health needs be better met by bringing mental health services to low-income populations through community-based organizations (CBOs) already serving them? Can we expand the mental health workforce by training CBO staff to recognize unmet mental health needs, deliver evidence-based interventions, and promote access to stepped-up care for people who need it? And will doing so help them achieve other health and social goals through underlying CBO services?

The C2C program aims to answer these questions. In C2C, CBOs partner with traditional mental health providers (MHPs) to integrate a range of mental health supports into the everyday work of CBOs. This $30 million public-private partnership under the federal Social Innovation Fund,[1] with oversight from the C2C Collaborative,[2] will reach up to 40,000 New Yorkers over five years by encouraging formal collaborations between CBOs and MHPs.

The C2C program serves clients from three target populations of low-income New Yorkers: parents/caregivers who are expecting or who have children up to the age of four; young adults ages 16 to 24 who are not in school and are not employed; or adults age 18 or older who are not employed or are underemployed. CBOs provide a wide range of services to these populations, including workforce development, youth-oriented programming, immigration services, HIV testing, early childhood education, homeless shelters, and domestic violence interventions. In C2C, CBO staff receive training, ongoing coaching, and support from an MHP to implement four core C2C mental health services (hereafter, "C2C services"): mental health screening, mental health first aid, motivational interviewing, and psychoeducation. In this task-shifting model, mental health specialists equip nonspecialists with the skills to effectively deliver nonmedical mental health services. CBOs and MHPs also develop pathways to facilitate referrals for more intensive care, if needed, and participate in regular service coordination meetings.

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The RAND Corporation (RAND) is evaluating the results of the C2C program from three vantage points: the effect of C2C on participating clients, relative to a comparison group of New Yorkers not receiving C2C services (impact); the program's implementation across different CBOs; and the effects of the program on government and CBO spending. For more detailed information on the program and its evaluation, see our January 2017 brief on Connections to Care (RAND Corporation, 2017).

Data collection for the evaluation began on June 1, 2017. The purpose of this brief research report is to present preliminary key findings from interviews with CBO leadership, particularly around their experiences launching C2C at their organizations. We share these findings to support CBOs and additional stakeholders in decisionmaking for C2C during the implementation phase. Other findings from the evaluation will be released as data become available.

METHODOLOGY

From June to August 2017, RAND conducted in-person site visits with CBOs and their MHPs that included key informant interviews and focus groups with leadership, staff, and clients. RAND developed interview guides using questions tested in previous evaluations and adapted for C2C. Interviews took place approximately 15 months after the C2C program began. A majority of the CBO sites devoted the first year of C2C participation to creating and refining implementation plans and training CBO staff members. At the time of the interviews, all sites had begun delivering at least two (screening, mental health first aid) of the four core C2C mental health services. Through these site visits, RAND collected qualitative information on implementation experiences, training in mental health services, delivery of C2C mental health services, management of crisis situations, collaboration between CBOs and MHPs, client engagement in C2C, and client perspectives on C2C experience, quality, and satisfaction.

RAND used a mixed-method software environment (Dedoose) to conduct thematic analysis and identify recurring patterns in the data ("themes"). A team of four coders, all of whom participated in data collection, engaged in iterative rounds of data analysis to inform the development of a hierarchical code tree consisting of key themes, and held frequent coding reconciliation meetings to establish a robust shared sense of how the code tree represented the data and to ensure that coding was consistent.

This brief research report focuses on key findings from interviews with 35 CBO leaders from across the 15 CBOs (e.g., CBO chief executive officers, CBO C2C program directors). These CBO leaders oversaw the launch and implementation of C2C. Any identifying information has been redacted from quotes to preserve interviewee anonymity. Analyses of data from other key informant interviews (MHP leadership, CBO staff, CBO clients) are ongoing, and comprehensive results will be presented in a forthcoming report.

FINDINGS

Perceptions of C2C Program Implementation

Challenges

CBO leadership encountered several challenges within the early implementation phase. These challenges arose at the organizational, staff, and client levels.

Key themes that emerged in a majority of interviews included *administrative challenges*, such as reporting burden, data systems creation (e.g., to track delivery of C2C services), and difficulty coordinating and scheduling C2C trainings and ongoing C2C supervision and coaching sessions. For example, "Finding the time to train enough people at one time was difficult."

Most interviewees also raised *staff concerns about C2C implementation (i.e., from direct service staff feedback) affecting their buy-in*, including additional responsibilities associated with C2C training and service delivery, confidence/ability to deliver C2C services to clients experiencing a mental health issue, and staff turnover. For example, one CBO leader stated,

> There are still certain staff who are resistant. . . . Really it's because they feel it's additional work. . . . Some remain resistant because it comes with a lot of tracking [and they] feel like they're supposed to sign up for training every month: "When do I see clients if I'm doing either training or admin work?"

Another CBO leader discussed concerns that had been raised by direct service staff members regarding their ability to provide mental health support to clients:

> In the beginning, it was a little scary [for staff] . . . some would say "We're not a mental health organization." I don't want to say pushback; it was more like fear. Because here we're about [providing regular CBO services]. . . . But since we've had [MHP support], staff know if they're overwhelmed [with a client mental health issue], [the MHP] can provide them with support and instruction. That allows us to have that mental health conversation.

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Several sites also reported challenges associated with *client barriers to engaging in C2C*, including concerns about privacy and mental health stigma. For example, "There have been people who've declined screening due to concerns about confidentiality and privacy." Another interviewee cited client stigma as a barrier to accessing care through C2C referrals: "I would say there's definitely some resistance around going for treatment. There's stigma so we try to make [the referral process] as comfortable as possible."

Many interviewees also acknowledged client logistical barriers to completing mental health care referrals (e.g., insurance-related issues, child care needs, travel/location considerations, and scheduling conflicts). CBO sites, in many cases, have already taken steps to overcome some of these challenges. For example, one CBO lead stated,

> One thing we found . . . was that [clients] would want the services and might not have insurance. So, one of the things we've done is take a look at our population, some are undocumented, or have no insurance, or even can't afford transportation to the clinic so we developed a partnership with [additional outside] providers and the agency itself has partnered with programs to set dollar amounts in terms of services they provide and we have taken on the responsibility of providing that for [clients] as well as metro cards for transportation. That in and of itself is a big thing because what we're seeing is it's not just isolated at [this CBO]."

Facilitators

CBO leaders identified a number of factors that eased the initial rollout of C2C at their organizations. A majority of these interviewees cited *efforts to support staff buy-in to C2C* as helpful to program implementation at both the organizational leadership and direct service staff levels. CBO leaders cited responsiveness to staff perspectives and needs as one approach:

> It helped us to be responsive to the staff's comments, to hear their feedback and suggestions for what worked and didn't work, and that helped us to continue to get their buy-in.

CBO leaders noted that developing clear messages that explain the intended goals of C2C to CBO staff (e.g., to help improve clients' lives; to help staff navigate client mental health issues that may arise in the course of providing standard services) encouraged staff participation and acceptance of C2C at this early implementation stage. One interviewee said,

> [We have been] conscious about making this a value added to staff, so they don't just feel like [C2C] is just additional work. They feel like it's something that will really benefit the clients and the community.

Several interviewees emphasized the importance of strong collaborative relationships between CBOs and MHPs. Many viewed frequent communication and openness *between CBOs and MHPs* as a critical part of C2C implementation. One leader said,

> It has been very collaborative—[CBO and MHP leaders] meet a lot and there is always a lot of time to share and keep each other up to date. People are very willing to collaborate and point out what works and what doesn't.

Many CBO leaders also highlighted the importance of designating *clear roles and responsibilities*, including the respective roles of the CBO (e.g., coordinating training activities, tracking delivery of C2C services) and the MHP (e.g., training and coaching staff in the delivery of C2C services). Leaders also voiced the importance of having specific team members at both the CBO and the MHP dedicated to maintaining the relationship and coordinating communication between the two organizations, particularly regarding client referrals:

> Having someone designated specifically as our C2C coordinator and someone specifically as the designated intake person at the [MHP] being the main connection has allowed much more fluid communication. From the [MHP] side, they really like getting to know more about [the CBO] and our clients, so it has provided them more context on our clients too, whereas before the C2C program, there wasn't as much of an interface between the counseling center and our agency. It just feels like there is more communication around the clients' referrals and whether or not they followed up.

Some also acknowledged the importance of having a *staff member who maintains a regular physical presence at both the CBO and MHP* as an important facilitator of C2C implementation.

Perceived Impact of C2C

CBO leaders commented on several ways in which C2C had positive effects on their organizations and clients. Interviewees from nearly all sites identified the improvements in *CBO culture surrounding mental health* as helping to achieve organizational goals (e.g., client housing placement, job placement and retention, educational attainment, health and wellbeing). Many interviewees also commented on the *development of a "common language" for staff when discussing and attending to client mental health issues*. For example, leadership at one site noted,

> I'd say with motivational interviewing, we are developing a shared language around and through our programming. It comes up in common conversations now; it is becoming a part of us and something we often refer to.

Most interviewees acknowledged C2C's positive effect on *staff members' ability to effectively deliver regular, non-C2C CBO services*. C2C services helped staff see a "bigger picture" context for working with clients, improved CBO-client relationships, and bolstered staff members' confidence and competence to navigate a range of challenges, especially with clients who struggle with a mental health problem that may interfere with their ability to engage in CBO services. One CBO leader said,

> Whereas before the staff might just have shut down or thought, "The client is being rude to me today" or "they just don't listen," there is a sense that when staff come out of training, they can respond better to the client, they are able to make a better connection to how and why the client responds a certain way. . . . [I]t helps them be more present and engaged with the client.

Similarly, some sites noted an increased awareness of and *commitment to the role that direct service staff members can play in supporting clients with mental health issues*. For example, one CBO lead stated,

> There is definitely a collective commitment to providing C2C services and supports. I can see the [C2C training] growing our staff's awareness and confidence that they can play a role [in supporting client mental health] even if they are not social workers.

A handful of sites also commented on initial successes connecting clients with needed mental health treatment. In some instances, interviewees commented on perceived global improvements in client functioning following successful engagement in mental health services. For example, one CBO leader reported,

> Sometimes it might take up to ten years for someone with mental illness to address that. We've found that we can cut some of that time for people we service. For example, there was an individual who couldn't complete the program because anxiety always got the best of her. . . . [Now the client] is going to [see the MHP] consistently and her life has really taken off.

CONCLUSION

Early analysis of data collected during the initial phase of C2C program implementation points to overall positive perceptions of the program and some initial changes in organizational culture surrounding the approach to client mental health issues. Interviews with CBO leaders show that CBO staff and leaders have been both engaging with the program and willing to participate in training and provision of C2C services. Moreover, at this stage in the implementation process, many CBO leaders have already begun to identify critical factors that facilitated the roll-out of C2C at their organizations. Many have also identified barriers to C2C implementation and have begun to address challenges. The data collected provide an opportunity for the CBOs and MHPs to address areas that may warrant focused improvement, such as burden on direct service CBO staff, as well as mental health stigma and logistical barriers that

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may impede clients' follow-through on mental health referrals. But the anecdotal positive feedback may also renew enthusiasm among CBOs that may be less confident in their implementation progress.

A complete report on the findings of the key informant interviews with CBO and MHP leadership, CBO staff, and CBO clients will be released in 2018. Additional evaluation activities for this project include a staff survey on experiences with C2C training and services delivery, a C2C participant survey assessing impact of C2C on clients' well-being and access to care, and a cost study. Findings from these data collection efforts will be shared in future reports.

Notes

[1] The Social Innovation Fund (SIF), a program of the Corporation for National and Community Service, received funding from 2010 to 2016. Using public and private resources to find and grow community-based nonprofits with evidence of results, SIF intermediaries received funding to award subgrants that focus on overcoming challenges in economic opportunity, healthy futures, and youth development. Although the Corporation for National and Community Service made its last SIF intermediary awards in fiscal year 2016, SIF intermediaries will continue to administer their subgrant programs until their federal funding has been exhausted.

[2] The C2C Collaborative, comprising the Mayor's Fund to Advance New York City, the Mayor's Office for Economic Opportunity, and the New York City Department of Health and Mental Hygiene, oversees the C2C initiative. For more information, please see RAND Corporation, 2017.

Reference

RAND Corporation, Connections to Care (C2C): Evaluating an Initiative Integrating Mental Health Supports into Social Service Settings, Santa Monica, Calif.: RAND Corporation, CP-857, January 2017. As of October 25, 2017: https://www.rand.org/pubs/corporate_pubs/CP857-2017-01.html

About This Report

This work was performed as part of a five-year evaluation of the Connections to Care (C2C) program in New York City. For more information about this project, please see www.rand.org/pubs/corporate_pubs/CP857-2017-01.html. A RAND Corporation team has been working with New York City government partners to assess the cost and impact of C2C and whether and how the program is being implemented effectively and efficiently. This research report provides early insights into the implementation of C2C from the perspective of leaders at the community-based organizations participating in C2C as they begin the second year of the three-year project.

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