Conclusion: Lessons Learned

The AB 2034 initiative provided funding for 53 mental health programs operating in 34 counties and cities throughout California. These programs provided services to a target population whose needs previously went largely unmet, individuals with a mental illness who had been previously homeless or incarcerated. At the height of the AB 2034 initiative, these programs were serving almost 5,000 individuals through recovery-oriented mental health services that followed a harm reduction model and also provided supportive housing.

AB 2034 Program Outcomes and Evaluation

Summary

The AB 2034 initiative had a strong focus on accountability and was expected to demonstrate both its effectiveness and ability to reduce institutional costs for its participants. Through the tracking of all the AB 2034 programs’ outcomes, it was found there were significant reductions in hospitalizations, incarcerations and homelessness. These outcomes included a:

- 67.90% decrease in the number of participants in psychiatric hospitals
- 47.54% decrease in the number of hospital admissions
- 64.6% decrease in the number of hospital days
- 74.92% decrease in the number of participants incarcerated
- 67.75% decrease in the number of incarcerations
- 81.25% decrease in the number of incarceration days
- 82.7% decrease in the number of participants who became homeless since enrollment compared to the number of participants who were homeless prior to enrollment
- 76.41% decrease in the overall number of homeless days experienced by participants.

Additionally, increases were found in AB 2034 participants’ engagement in employment and educational activities. These outcomes included a:

- 71.71% increase in the number of participants employed part-time
- 119.44% increase in the number of full-time employment days
- 247.47% increase in the number of part-time employment days
- 43.48% increase in the number of persons engaged in educational activity.

These outcomes indicate the state-funded AB 2034 program produced significant savings at the local level, via reductions in local jail and emergency medical and psychiatric costs. It is estimated that for an average cost of $11,000 per participant, the average cost savings (over the six years of participation in the programs) would be $8,788 per person per year. This estimate only takes into account the savings.
Lessons Learned from California’s AB 2034 Programs

from reduced hospitalizations and incarcerations and does not include any cost reductions resulting from lowered emergency medical or psychiatric care. Thus, the overall cost of helping program participants obtain basic needs (housing, clothing, food) and improve their overall quality of life (as indicated by the performance indicators of decreases in hospitalizations and increases in employment and education) is estimated to be less than $2,212 per person per year.

Lessons Learned

• Track a wide range of performance indicators to demonstrate program effectiveness and efficiency. In addition to the psychiatric hospitalization, incarceration, housing, employment, and education outcomes collected for the AB 2034 initiative, it is recommended future programs track emergency medical and psychiatric visits.

• Establish a mechanism for “bottom-up” participation from local program participants in any performance measurement system. For the AB 2034 initiative this was accomplished via the Data Committee. This committee included representation from all regions of the state and ensured that participating counties had input into both the performance indicators and outcome measures that were selected as well as the means by which they were implemented. This “bottom-up” process played a significant part in the initiative’s success by promoting ownership of the program at the local level.

• Ensure timely and ongoing feedback is provided about program and statewide outcomes. AB 2034 programs were given monthly feedback about their own performance and were provided with tools to compare their own performance to that of other counties and programs. These outcomes were also used by the statewide leadership to establish benchmarks for the AB 2034 programs’ performance.

• Have an independent entity validate the accuracy of the data collected. The AB 2034 evaluator had dedicated staff who reviewed the data that were submitted by the programs for accuracy. Without this independent third-party review, it would be extremely difficult for local program staff to ensure data accuracy, thus undermining the very basis of the measurement feedback system. This has enormous implications for the data collection system established by the State of California for the Full Service Partnerships (FSPs) under the Mental Health Services Act. These programs have no independent evaluator fulfilling this function and are instead relying on local efforts to ensure data accuracy. It seems unlikely that individual FSPs will be able to find the resources to ensure data accuracy and this ultimately may call into question the effectiveness of these programs.
AB 2034 Implementation by Statewide Leadership

Summary

The biggest challenge to the AB 2034 implementation was the need to change an underlying culture, attitudes, and values in order to provide recovery-oriented and harm reduction intervention strategies to AB 2034’s un-served and underserved target population. In addition to this, multiple changes were needed to local infrastructures that would allow organizations to adopt the service delivery model envisioned by the drafters of the AB 2034 legislation.

The State Department of Mental Health (DMH) was charged with identifying the program and performance standards by which local programs would accomplish this goal. The program standards initially ensured the target population was being identified and enrolled quickly through outreach, that participants were being provided with immediate housing, and that local programs were offering recovery-oriented and integrated services - provided in an outpatient (preferably field-based) setting, with program staffing available after-hours. Additionally, these standards established that personal service coordinators (PSCs) would be an integral part of multidisciplinary, culturally competent teams. Local programs were also required to establish community collaborations with law enforcement and housing providers, and to establish fiscal structures that would allow service providers to quickly access flexible funding on behalf of program participants. Drawing upon the AB 2034 Steering Committee’s recommendations, the DMH developed additional performance standards for service delivery and staffing. These performance standards clarified that there would be 24/7 availability of AB 2034 program staff and expanded the recommended staffing to include consumer providers, housing, and employment specialists.

In addition to issuing program and performance standards, the DMH leadership recognized that local mental health programs had faced significant challenges in previous years in terms of fiscal resources, staff resources, community support, and local politics. As a result of these factors, local mental health systems were in different stages of development with regard to understanding and believing in the values and philosophy of recovery, as well as the goals and benefits of providing AB 2034’s integrated comprehensive services which (while intensive) were not necessarily focused on mental health treatment. Therefore the DMH also saw its goal similarly to the goal for AB 2034 program staff: to assess each program served in terms of its stage of recovery or development, and to provide the meaningful supports necessary to improve program performance.

The DMH accomplished this in multiple ways. First, it established the AB 2034 Steering Committee which helped to identify programs’ needs, newly emerging evidence-based practices, and statewide training needs for both the AB 2034 initiative and local programs. This committee met often, with the regular participation of policy staff from the DMH as well as staff from the California Institute for Mental Health (CiMH), in order to identify what had and had not worked in the pilot implementation, what was and was not working in the current AB 2034 statewide implementation, and why. The committee applied their observations in determining training and technical assistance needs for all AB 2034 programs. The committee
also focused on methods that supported fidelity to the initiative’s mission in all AB 2034 counties. The Steering Committee actively sought existing and emerging models of program design and implementation that could be integrated into existing AB 2034 local program structures - remaining faithful to the initiative’s original principles and strategies, while also encouraging experimentation.

Training and technical assistance needs were also identified through the Regional Coordinator Meetings and Line Staff Meetings established early in the AB 2034 implementation by the AB 2034 Steering Committee. These collaborative meetings provided a mechanism for continuous quality improvement at both the state and local level.

**Lessons Learned**

- **Establish a leadership role for multiple levels of initiative partners.** In the AB 2034 initiative this was accomplished by establishing the AB 2034 Steering Committee, which had representation from managers responsible for the successful AB 34 pilot programs. These committee members drew upon and applied their implementation experience with similar program models. Throughout this statewide initiative, this committee’s unique interface and close connection to county and program staff made it possible to move through a performance improvement cycle (plan, do, study, act) in a quick and effective manner. The dynamics of the interface that emerged made for one of the key elements to the success of the AB 2034 statewide initiative.

- **Have statewide leadership model a balanced approach of optimism, pragmatism, and caution when preparing for the implementation of large-scale initiative involving local programs.** While maintaining an attitude of collaboration in order to foster and sustain collaborations, the DMH also provided program and performance standards that clarified the service delivery models for local programs.

- **Create a mechanism for “bottom-up” participation from local program participants in assessing emerging program and training needs.** For the AB 2034 initiative this was accomplished via the triumvirate of the AB 2034 Steering Committee, Regional Coordinator Meetings, and Line Staff meetings. The DMH leadership promoted the emergence of collaborative relationships within these groups and demonstrated a commitment to allowing problems to emerge and be solved within these groups.

- **Pay close attention to and quickly address concerns expressed by local program and county staff.** Have leadership provide answers as quickly as possible; supplement with training and technical assistance tailored to the local concerns. In the AB 2034 program this was achieved by the CiMH’s participation in both the AB 2034 Steering Committee as well as the Regional Coordinator Meetings. The CiMH was able to capitalize on this first-hand knowledge in developing and providing the statewide AB 2034 trainings.
AB 2034 Implementation of Local Programs

Summary

Interviews with program managers, team leads, providers, and participants suggest the various AB 2034 programs shared a common philosophy, which was expressed by the teams’ recovery-based cultures and the providers’ use of recovery-oriented interventions. The majority of AB 2034 programs also provided similar staff positions on their team(s), including a team lead, PSC(s), psychiatrist, consumer provider(s), and housing specialist(s).

While it appears the local AB 2034 providers shared philosophies and interventions, the survey data indicate there was considerable variability in the providers’ availability to participants (as demonstrated by the varying participant to provider ratios). AB 2034 program managers and team leads also ran their teams differently across the state. For example, the survey and interview data found the following:

- **Field-Based Services**: As the DMH had intended, ninety-six percent of responding AB 2034 programs reported that at least 56% of contact with participants took place in the community. Engagement in these natural settings reduced the provider-participant power imbalance, increased the feeling of connection, and often introduced the participants to parts of the community they wouldn’t have felt comfortable entering by themselves.

- **24/7 Availability**: When interviewed, AB 2034 managers, staff, and participants attested to the benefits of 24/7 availability. While many programs attained the ideal of 24/7 availability of a PSC who was known to the consumer, all did not achieve it. Yet, even many small counties and county-run programs did find a way to provide 24/7 coverage, overcoming barriers of union contracts or small size. Having trained team members available 24/7 who already knew the program participants enabled staff members to de-escalate situations that traditionally would have resulted in a participant’s eviction, arrest, or involuntary hospitalization. This 24/7 availability also increased participants’ confidence in their providers’ desires to help them and was thought to have reduced attrition from the program.

- **Flexible Funding**: All managers, service providers, and participants interviewed for this report agreed that having flexible funds they could easily access and use to aid a person’s individual recovery was one of the most important aspects of AB 2034 service delivery. The bulk of programs’ flex fund dollars were spent on housing (such as rental deposits, partial or full rent subsidies, and motel rentals), clothing, and food. AB 2034 programs implemented different methods of allocating flex funds (per participant, as needs arose, or a combination of both methods) and had different mechanisms for authorizing the use of flex funds (decisions by a team lead, an entire team, an individual staff, or several of these methods of flex fund authorizations). Team leads and managers understood flex fund spending was to be viewed a mental health intervention, with the aim of restoring a person’s function or aiding the person’s recovery.
• **Multidisciplinary Teams:** While some AB 2034 programs consisted of a single treatment team, larger AB 2034 programs operated multiple treatment teams. Regardless of their number, teams were usually comprised of professionals and paraprofessionals who brought different levels of clinical training and experience, including licensed and/or unlicensed PSCs, employment and housing specialist(s), psychiatrist(s), and consumer provider(s) – all coordinated by the treatment team lead. Based on interview data and the responses to our AB 2034 survey we found:

1. **Outreach** - 62% percent of AB 2034 programs were able to provide outreach and engagement services for three months or more before enrolling an individual in the AB 2034 program.

2. **PSCs** - The relationship between the PSC and participant was described as the most critical aspect that aided individual recovery. Both participants and service providers described the same three characteristics they believed service providers needed to have in order to help in recovery: 1) a demonstrated desire to follow the participants’ goals, 2) never giving up, and 3) doing what they said they would do.

3. **Consumer Providers** - The presence of consumer providers within AB 2034 was believed to contribute to the reduction of stigma. Consumer providers’ life experience was also found to be a valuable resource for both participants and other staff. Despite concern about the high level of training needs and frequent turnover of consumer providers, overall it was felt that consumer providers were an essential part of a recovery-oriented program. However, less than half of the programs responding to the survey reported consumer providers were included in their team meetings, suggesting that full inclusion of these team members was not universally obtained.

4. **Specialist Staff Members (psychiatrist, nurse, employment and housing specialist)** – At least seventy-percent of the responding programs reported they had consumer providers, dedicated psychiatrist, nurse (or nurse practitioner), housing and/or employment specialists on their teams. Of these staff, the employment specialists were the least represented on teams. Almost 70% of nurses and psychiatrists were reported to have participated in AB 2034 team meetings.

Despite an early challenge in providing team leads and line staff with training, the interview data suggests the continuous offering of original and evolving training (along with technical assistance provided through the Regional Coordinator Meetings and Line Staff Meetings) led to the widespread dissemination of a recovery-oriented philosophy and the providers’ use of related interventions.

**Lessons Learned**

The AB 2034 statewide initiative provided local programs with several key elements that might have allowed the initiative to be described as an effective practice. These included:

• a practice philosophy (recovery-oriented, harm reduction)
Lessons Learned from California’s AB 2034 Programs

- core team training (coordinator meetings, line staff meetings, Harm Reduction, Housing First, Employment First, Co-occurring disorders, and Motivational Interviewing)

- standardization of team composition (these were provided via the DMH established performance standards of multidisciplinary teams that included a team lead, PSC(s), housing specialist, employment specialist, consumer provider, and psychiatrist)

- standardization methods of service delivery (also provided via the DMHS established performance standards that included outreach, 24/7 coverage, and field based service provision)

- measurable participant outcomes (as identified by the AB 2034 Data Committee and evaluated by Mental Health America of Los Angeles (MHALA))

However, there were several key elements missing from the AB 2034 initiative that resulted in being unable to document it as a replicable effective practice:

- standardized tools (including standards and examples of clinical documentation and a client services plan)

- team implementation structures (such as caseload distribution and management, team meeting and supervision structures)

- establishment and use of fidelity measurements that documented actual program implementation of the philosophy, trainings, team composition, and methods of service delivery (as well as team implementation structures, and tools - had they been developed)

Based on the information presented in this report (as well as the accompanying “Resource Manual” of diverse materials collected from AB 2034 programs across the state) it would now be possible to create and pilot a new AB-2034 inspired program that have all the necessary structures in place to study its effectiveness and replicability as a practice.
Concluding Thoughts

As noted in the introduction, the AB 2034 initiative was a perfect storm of a compelling issue and a funding source that were matched by dedicated leadership at the state and local levels, determined to deliver the best and most effective services possible. In retrospect, it was fortuitous that the state leadership and majority of program managers were visionaries and quick to grasp the potential of this initiative. However this was a somewhat unnatural phenomenon, which would need to be accounted for in the implementation of similar large-scale behavioral health endeavors. It is hoped this report provides a foundation from which an AB 2034-inspired program design and implementation model could be developed in the future. If so, there were many "lessons learned" that would be valuable to apply.

Perhaps the most significant lesson to be drawn from the AB 2034 initiative is that it designed, implemented, and followed effective collaboration and accountability structures at both the local and state levels. The program outcomes provided the primary method of accountability for individual programs and also for the overall AB 2034 initiative. Additionally, at the state leadership level, the AB 2034 Steering Committee and Regional Coordinator meetings served both collaboration and accountability functions. The DMH staff in these groups clearly defined and modeled that leadership's primary function was to support the programs from the "bottom up" - beginning with the participant and next taking into account the line staff members' needs. It was stated and understood that the local and state leadership's primary responsibility was to support participants and line staff in their work, setting up the structures and supports that would be necessary for both groups to take the risks necessary for recovery and program outcomes. These groups focused on identifying the barriers that were preventing recovery-oriented service delivery at both the state and local levels, and then set about removing, or finding creative ways around, these barriers.

At the local level, there was group "norming" that took place for program managers and line staff that participated in the Regional Coordinator and Line Staff meetings, however there were no negative repercussions that resulted from candid disclosure. Thus these groups primarily served a collaborative not accountability, function. In fact, while program and performance standards were developed by the DMH, to a large extent it was, and still is, not entirely known how many AB 2034 programs actually delivered services in the way that their program plans were written. Indeed, as the limited survey showed, there was some variability in program's adherence to the performance standards (24/7, using effective practices, caseload sizes).

Given these and other reported findings, if the "lessons learned" from AB 2034 were to be applied to future program development and implementation, we recommend such initiatives establish and follow performance standards for both local programs as well as the overall program leadership. The key components of the state leadership model described within this report could be used as a template for future leadership performance standards. This would ensure the presence of a strong, yet collaborative and flexible, leadership that focuses on fostering program implementation that will result in the desired participant outcomes.
Additionally, the key AB 2034 program performance standards already identified by the DMH, and implemented by the majority of programs, could easily be adopted as future program standards. What would still be required is the development of fidelity measures for program operation that would provide additional clarity for implementers as well as an accountability tool.

Retaining a method of data collection that provides detailed outcomes results is also recommended, as one (but not the only) method of accountability. Additional methods of program review would be desirable, not only at the program level but also for the leadership, to assure that leadership follows the performance standards as developed. It would, however, be essential to isolate the program implementation and program review functions, as the type of successful collaboration modeled within the Regional Coordinator meetings would only be possible if leadership, managers, and line staff remain free to openly discuss both successes and barriers to implementation within the group. A logical next step would be to implement and study these practices, via pilot programs at multiple sites, in order to determine whether the "lessons learned" from AB 2034 can be translated into an effective practice.

The AB 2034 programs were extremely successful in moving individuals out of homelessness and providing the necessary supports to foster participants’ recovery journeys. The flexibility of funding provided under the AB 2034 legislation enabled counties and cities across California to provide a comprehensive array of services necessary to meet the multiple needs of the population it served: outreach, mental health, housing assistance, and employment services. The positive outcomes achieved by these AB 2034 teams significantly altered perceptions of community-based programs’ sustainability and cost efficiency, while showing mental health systems’ capacity to positively impact the lives of individuals with a mental illness who had been previously homeless or incarcerated.