Specialized CIT for Young Adults (SCYA)

Final Evaluation Report

December 30, 2016

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I. INTRODUCTION and PROGRAM OVERVIEW

This study was an evaluation of an early diversion program called Specialized Crisis Intervention Teams (CIT) for Young Adults (SCYA). SCYA was federally funded through a three-year grant from SAMHSA, the Substance Abuse and Mental Health Services Administration, to the Connecticut Department of Mental Health and Addiction Services (DMHAS). Connecticut was one of three states who received this Early Diversion grant, in what was intended to be a pilot of promising programs. All three awarded programs utilized CIT, but in different ways. The primary distinguishing features of the CT program were that it focused on the young adult population and also that it was state-wide instead of covering one metropolitan area, as the other grantees did. The SCYA program was designed to provide alternatives to arrest for young adults exhibiting or at risk of behavioral or mental health problems, while the other states included adults of all ages. The overall SCYA program goals were to reduce arrest and incarceration, and to increase access and utilization of community services for young adults.

In addition to DMHAS, several other agencies were responsible for different components of the project. The other main agencies were ABH, NAMI, CABLE and UCONN. (More details are described below.) A work group, functioning as a steering committee, was established early in the project and met regularly through to the end. The Workgroup included people representing all of the above-mentioned agencies.

DMHAS contracted with Advanced Behavioral Health (ABH) to conduct project management, coordinate with the project sites, and to provide direct clinical and support services. A full-time clinician at ABH was assigned as the SCYA project manager, who was also expected to provide services to young adult (YA) clients referred to her from the CIT program sites. ABH also set up a 24 hour hotline with contracted clinicians in the off-hours for SCYA referrals. In the course of the project, there was virtually no usage of the hotline, so eventually it was dropped.

The SCYA program was implemented in Hartford, New Haven, Norwich, Bridgeport, Waterbury and Stamford, where state-operated CIT programs already existed. Although under the oversight of the DMHAS Forensic Unit, and following the general goals and structure of the CIT model, there were some differences in how the various sites operated. Clinicians at most of the sites either followed police calls on the radio and made their own decisions to go out to mental health related incidents, or were called in by the police for assistance. In two sites, clinicians would do ride-alongs with the police. In one site, the police and clinicians went out on visits together only as follow-ups to the initial police contact. In most locations, if no clinician was available for the initial call, the police would send the clinician a report or referral later for follow-up. It should be noted that in all locations, there were only one or two CIT clinicians total. Some back-up

was provided by Mobile Crisis clinicians, but CIT clinicians were also expected to provide some non-CIT services to the mental health agency they were assigned to.

During the course of the SCYA project, attempts were made to help relieve the CIT clinicians of other duties so they could focus more on CIT, especially for young adults and SCYA. The sites were also encouraged to be more structured in following up on initial contacts, and all were asked to provide common documentation of both initial and follow-up contacts for the project. All of these efforts were at least somewhat successful, but were not maintained over time, especially after the agencies had to deal with staff cuts in the spring of 2016.

Midway through the project, when it was clear that the program was not exactly working as planned, it was decided (in addition to starting regional meetings and several other outreach strategies) that the best use of the ABH clinician's time would be to directly support a limited number of CIT clinicians at their program site. Based on feasibility and the local CIT YA numbers, it was decided that Hartford would be the first enhancement site. The ABH clinician assisted the CIT clinician in both initial and follow-up client contacts and with paperwork. The NAMI peer coordinator also participated in client outreach. All involved felt that this arrangement worked well. After several months, Waterbury became the second enhancement site, although they did not choose to utilize the extra help offered as much as in Hartford, at least not initially.

Another important component of the SCYA program was providing young adult-specific training both to the CIT clinicians and police officers. Two psychiatrists, one from Yale University and one from the Hartford-based Institute of Living (IOL), who specialized in young adults and emerging psychosis, were engaged to create a training module to include as part of the regular CIT training conducted by CABLE on an on-going basis. They also provided training specifically with the CIT clinicians early in the project, and were available for further consultation. A representative from the CT Alliance to Benefit Law Enforcement (CABLE) served on the SCYA Workgroup, and provided input from the police viewpoint, including direct communication with the police chiefs when needed.

In addition, the CT chapter of the National Alliance on Mental Illness (NAMI) was centrally involved in the SCYA project. A Young Adult peer support coordinator who had lived experience with the mental health and law enforcement system was hired to work on the project. In addition to being part of the Workgroup and fully engaged in the decision-making and planning process, the peer support coordinator provided training to other YA facilitators and set up YA peer groups in several locations across the state for them to run. Initially, it was expected that the peer group participants would at least somewhat be populated by clients referred by SCYA clinicians, and that the police would also hand out information about the groups to YAs. However, this referral path was unfruitful, and the groups ended up receiving referrals from other sources.

The evaluators for this project were from the UCONN School of Social Work. The evaluation of the SCYA project was primarily the responsibility of Eleni Rodis, M.S.,

Acting Director of Research for DMHAS, and Research Associate in the School of Social Work at the University of Connecticut (UConn).   The DMHAS Research Division was created over two decades ago through a unique arrangement with the University of Connecticut. Research Division staff are hired through UCONN and considered faculty and professional staff at the School of Social Work, but collectively serve as a DMHAS unit. As such, the DMHAS Research Division was well-positioned to interact with the SCYA agencies. In addition to Ms. Rodis, several research assistants and data personnel were involved in the project.   Three RAs successively took on the daily evaluation management (e.g. communicating with program sites, assigning and conducting interviews, helping in report preparation, etc.), and one data manager/analyst who took responsibility for data oversight and reporting. Other RAs were involved in interviewing and data entry.

In addition to the Workgroup meetings, local site visits were held. Usually the ABH project manager, the CIT manager from the Forensic unit, someone from the evaluation team, and the peer coordinator would visit the program sites to meet with the CIT clinicians and their supervisors. Sometimes the DMHAS project director and Mobile Crisis representatives would also be present.

II. EVALUATION OVERVIEW

All study procedures and documents were reviewed and approved by the Department of Mental Health and Addiction Services (DMHAS) Institutional Review Board (IRB). There is an agreement between the DMHAS and UCONN IRBs whereby the UCONN IRB is informed of and accepts the determinations of the DMHAS IRB for Research Division investigators.

As originally proposed, the evaluation involved both quantitative and qualitative components, including:

> 1) confidential interviews with program participants;
> 2) collection of program information from CIT, ABH and NAMI staff;
> 3) administrative data from DMHAS and other agencies if needed; and
> 4) focus groups with participants and staff.

For the most part, all these components were included in the final analyses. Earlier in the evaluation, DMHAS administrative data was checked for information on CIT clients, and it was discovered that many cases either weren't entered at all or at a long delay, so different data collection methods were set up to get client and service information. Also, most of the YA CIT clients didn't seem to have a history of incarceration and weren't generally arrested or incarcerated, so it was decided that obtaining and matching data from the Department of Correction wouldn't have been a valuable investment of time and resources.

Evaluation Activities: Reports on the progress of recruitment by program site were regularly prepared and shared with stakeholders. Baseline and follow-up interviews were

conducted. Interview and tracking data were entered in local databases and SAMHSA's data platform (TRAC), and reports of follow-ups due were utilized. In the final project year, several focus groups were conducted by evaluation personnel. At least one person from the evaluation team attended all project meetings and conference calls with stakeholders and program staff for purposes of project monitoring, documentation, and process evaluation. The research assistant regularly wrote up minutes from meetings and these were shared with work group participants. The evaluation staff contributed sections to the quarterly reports that were sent to SAMHSA, and participated in the federal level site visits, conference calls, and meetings. As the evaluation team collected process observations and client-level data, this information was shared with the project director, project manager, workgroup members, clinical teams, and other relevant stakeholders in order to guide project implementation. The evaluation team documented the developments and decisions of the project as they were being made, and tracked the proposed and executed implementation changes.

If a client agreed to be a part of the evaluation (asked by the CIT clinician), a signed referral form was faxed to the research office or to the program manager at ABH. After receiving permission to contact the clients, a research interviewer described the evaluation and conducted informed consent with willing participants. The goal was to recruit approximately 225 clients for the evaluation. Each participant was invited to complete 3 interviews: one at baseline, one at 3 months, and one at 6 months. Participants received $15 for each completed interview, and were eligible for $5 bonuses for keeping their first scheduled appointments, resulting in the possibility of earning a maximum of $60 for interview participation.

Recruitment: One of the biggest challenges for this project was recruitment, both for the program itself as well as for the evaluation. Although many people were seen by CIT clinicians, the majority did not receive enhanced services offered by SCYA. Out of 703 clients who were reported to have had contact with the SCYA CIT clinicians, only 93 agreed to sign a study referral form, a response rate of 13%. Only fifty-five (55) baselines out of the 93 referrals were completed over the course of the project, resulting in representation of only about 8% of the CIT clients. Both the initial agreements to be contacted and the agreements to do baseline and follow-up interviews were at rates markedly lower than we have had for all other studies we have done.   We theorize that part of the reason for this is due to the clients' initial contact being during a time of crisis, negative feelings about their police experience, and partly perhaps also being due to the young adult population. (Additional details on these are in the results and discussion sections.) A great deal of effort was expended by the evaluation, management, and program staff to try to increase recruitment numbers, with only limited effect.

The evaluation team made multiple attempts to contact the people who agreed to be contacted. We extended interview windows for months, and had multiple interviewers try to contact the clients if the first interviewer was unsuccessful. As always, the client was met in a safe location that was convenient for them at a date and time they chose. If interviews could not be completed, we obtained basic demographic data in order to enter into TRAC. To allow for additional avenues of contact, the evaluation team amended the

IRB to allow for texting of the clients by the evaluation team prior to study consent, phone referrals by the clinicians to the evaluation team, and for clinicians to give wallet cards containing the evaluation team's information so the clients could refer themselves. The evaluation team continued to reach out through all avenues possible to encourage participation. Additional materials and meetings had been provided to the clinicians in order to try to improve engagement, including input from the peer coordinator and from DMHAS staff experienced in working with young adults. We attempted to reach participants until close to the end of funding in order to try to obtain complete data. We also obtained program information from the clinicians for all participants.

The original plan had been for CIT clinicians to invite all Young Adult program participants (18-25 year olds) to hear about the evaluation from a member of the research staff. Given that the number of referrals had been much lower than expected, several changes to the program were implemented. The SCYA client age-range was expanded from 18-25 to 18-29. All the program participants within the expanded age range were eligible for the enhanced SCYA services and were invited to be a part of the evaluation. In addition, the evaluation aimed to recruit a comparison group of CIT clients age 30 and over. However, most of the study referrals received were still within the 18-25 age range, and only three clients over 30 agreed to participate.

In addition to expanding the participant age range, the pool of clinicians who could refer was also expanded. Because potential SCYA clients could have contact with Mobile Crisis clinicians who responded to police calls, these clinicians were instructed to also make referrals to the SCYA program and evaluation. This addition did not lead to an increase in referrals for several possible reasons. At some sites, there were no Mobile Crisis services. At others, Mobile Crisis and CIT were not well integrated, which inhibited the sharing of information regarding SCYA. And at other sites, CIT clinicians were also the Mobile clinicians; thus there was no expansion in recruitment source.

By the end of the project, a total of 93 study referrals had been received. Fifty-five baseline interviews had been completed (52 young adults and 3 aged 30 or over). Although referral rates had improved after various modifications, there were continuing problems with recruiting clients into the program. There were 698 total refusals to be contacted. About half of what the clinicians were labeling as refusals were situations where the clinicians did not actually ask their clients to participate because it was deemed inappropriate to do so. For example, clients were noted as refusing to participate in the evaluation because they were too paranoid, floridly psychotic, in need of acute medical care, intoxicated, "actively slashing their wrists," confused, etc. In these cases, ideally, clinicians should have engaged in three good faith follow-up attempts to obtain permission to be referred to the study. However, because of a lack of consistent documentation regarding these cases, it was not clear that this was occurring in some cases. When asked why this is so in the quarterly regional meetings, clinicians stated that they are unable to get enough information during the initial encounter to be able to follow-up; clients were in severe crisis and were not able to provide a phone number or address. Most of these clients were admitted to the emergency room. Upon discharge,

most of the CIT programs were not notified by the hospital nor were they given information with which the clinicians could use to follow-up.

The final recruitment numbers can be seen below.

Location	Signed Eval. Referral Form	Did not agree to be contacted	Interview Pending	Signed but did not do interview	Completed Baseline Interview	TRAC cases without interview	Goal	Total	% to goal
Hartford	20	99	2	8	**10**	32	38	42	111%
New Haven	23	5	0	11	**12**	24	38	36	95%
Southeastern	23	193	2	7	**14**	25	38	39	103%
Bridgeport	5	12	0	1	**4**	36	37	40	108%
Stamford	18	43	1	4	**13**	14	37	27	73%
Waterbury	4	351	0	2	**2**	55	37	57	154%
Total	93	703	5	33	**55**	186	225	241	107%

III. DATA COLLECTION

Participant Interviews: Participants were interviewed at baseline/program intake, and 3 and 6 months after intake. The evaluation interviews were separate from program involvement. That is to say, even people who dropped out of the program were interviewed if they agreed. (Conversely, they could still receive services from the program even if they did not want to participate in the evaluation.) Participants were asked about their personal characteristics, employment and income, substance use, social support, living conditions, legal involvement, and mental health, including trauma symptoms and overall functioning.

Measures: The structured interviews consisted mainly of the required SAMHSA measures that make up the GPRA/NOMS tool.   We added some brief measures that we thought would capture important information more specific to the YA population: the Youth Empowerment Scale (Walker et al, 2010) and the Hemingway Measure of Late Adolescent Connectedness (Karcher & Sass, 2010). We also added a measure of client perception of the relationship with the CIT clinicians, the Client Feedback Questionnaire II (Ulaszek et al, 2012). Items from these measures can be seen in **Appendix 1**.

Administrative Data: Secondary data on service utilization was received from ABH and the SCYA program sites. Over the course of the project, a brief intake form with information on client characteristics, type of contact, service referrals made, etc., was developed. A form to track follow-up attempts was also developed. These forms were collected by the ABH clinician and entered into a database.

Focus Groups and other qualitative data: On an on-going basis, the researchers kept track of general project development, including meeting notes, emails, decisions that were made by the oversight committee, etc. At least one person from the evaluation team attended all project meetings, conference calls and webinars with stakeholders, the federal funders and program staff for purposes of project development, documentation, and process evaluation. Minutes from meetings and trainings were written up by evaluation staff and shared with the workgroup and others as appropriate. The lead evaluator participated in decision-making, and provided data to help with this process. Towards the end of the project, the evaluators also conducted 5 focus groups, one with young adult staff and peer group facilitators, one with SCYA staff, one with CIT clinicians, one with peer young adult support group participants, and one with peer young adult support group facilitators.
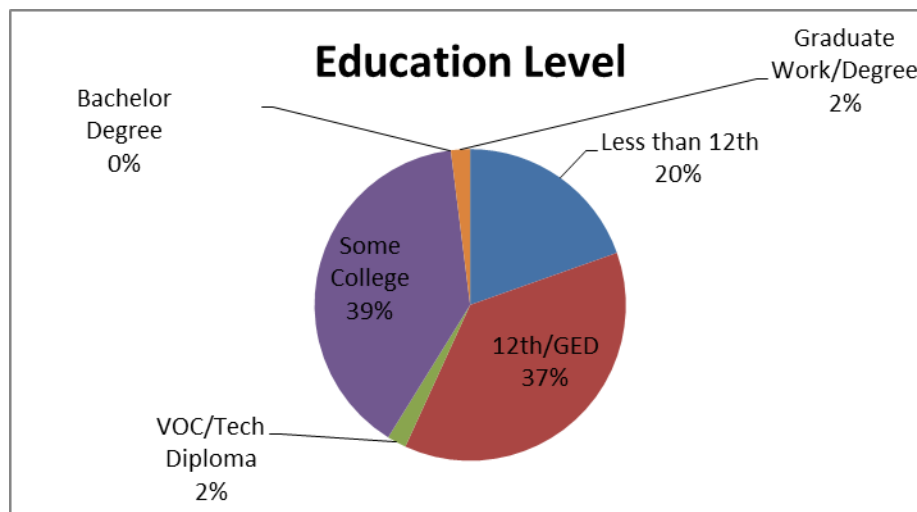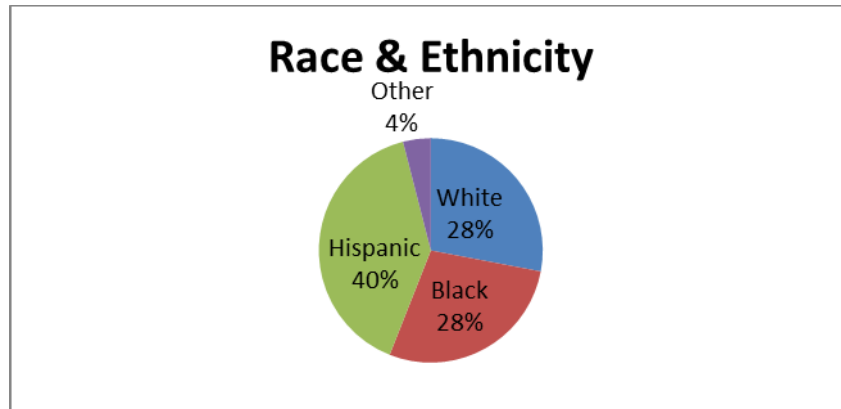
IV. RESULTS

Quantitative Data

In total, there were 1089 SCYA cases included in the evaluation; 55 interview cases (52 young adults and 3 who were 30 or older) and 1034 non-interview cases (37.9% young adults and 62.1% who were 30 or older). 236 cases (the young adults) were entered into TRAC. The non-interview cases represented clients served by SCYA but who did not agree to be interviewed, either because they weren't asked to do so by the clinicians, they declined to be contacted by the evaluators, or the interviewers weren't able to reach them for a baseline interview.
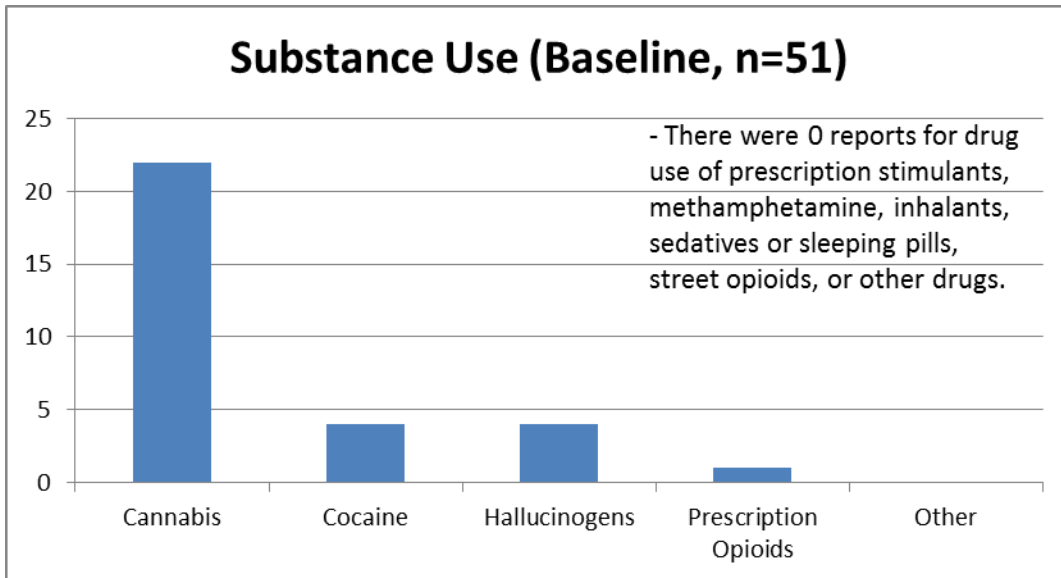
Interview Results:

Due to the small number of follow-up interviews, 28 that completed 3-month interviews and 20 that completed 6-month interviews, out of 52 baselines, significance tests were not run. However, descriptive statistics from all time points are provided below. The three comparison participants (those 30 years old or older) were dropped from the interview reports since there weren't enough to make up a comparison group. Due to the low overall recruitment and low follow-up rates, any observations should be viewed with caution. They are not likely to be representative of the larger population.

Baseline interview data indicated that the SCYA evaluation participants were 51% male, 40% Hispanic/Latino, 28% Black, 28 % White and 2% Other. Sexual orientation was reported as 86% heterosexual, 6% gay/lesbian, and 8% bisexual. In addition, 37% had finished high school or earned their GED at baseline. Just over 41% reported at least some college attendance.

Race & Ethnicity

- Other 4%
- White 28%
- Black 28%
- Hispanic 40%

Education Level

- Graduate Work/Degree 2%
- Bachelor Degree 0%
- Less than 12th 20%
- Some College 39%
- 12th/GED 37%
- VOC/Tech Diploma 2%

Of note, 74.5% of the interview participants reported having experienced trauma in their lifetimes. Of this group, 92% reported at least one PTSD symptom currently, and 16.6% reported having been hit, kicked or otherwise physically hurt in the last 30 days.

Looking at substance use, alcohol was the most frequently used substance reported. At baseline, 54.9% reported any alcohol use and 21.6% reporting using until intoxicated in the last 30 days. 62.7% reported using tobacco, which is very significantly higher than the overall percentage in the general CT population. The next highest substance of use was marijuana, at 43.1%. Other substances were reported used at much lower rates, resulting in an overall usage of illegal/non-prescribed substances at 45.1% in 30 days (not including alcohol).

Substance Use (Baseline, n=51)

- There were 0 reports for drug use of prescription stimulants, methamphetamine, inhalants, sedatives or sleeping pills, street opioids, or other drugs.

Regarding items that we have both baseline and follow-up data for, there is an indication of improvement on some variables over time, although in some cases, there was a larger improvement at 3 months that was reduced at 6 months, but was still higher than at baseline.

In terms of employment, those employed (either full or part time) at baseline made up 23.5%, at 3-month 37.6%, and at 6-month 27.8%. Those enrolled in school started higher at baseline (29.4%) and decreased at subsequent time points – 19.2% at 3 months and 22.3% at 6 months. When employment and school rates are combined (either in school or employed), the rates are fairly steady across the time points, although slightly higher at 6 months than at baseline.

In terms of living situation, those living in independent housing were as follows: 37.3% at baseline, 38.5% at 3 months, and 33.8% at 6 months. Conversely, 3.9% reported being homeless most of the past 30 days at baseline, 3.8% at 3 months and 0 at 6 months.

Education & Employment
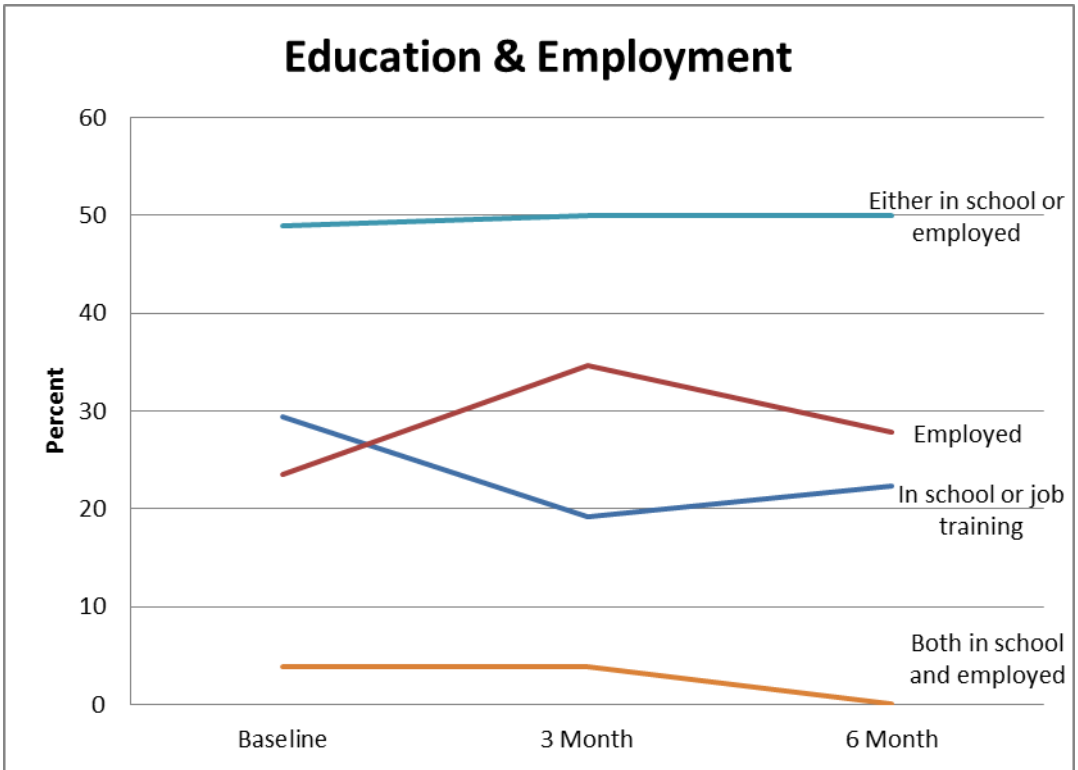
In terms of inpatient psychiatric involvement, improvement over time is also suggested. Being in a hospital for mental health treatment was 23.5% at baseline, 3.8% at 3 months and 0 at 6 months. Going to the emergency room for psychiatric reasons was 45.1% at baseline, 23.1% at 3 months and 0 at 6 months.

Those who reported having been arrested in the last 30 days also indicated improvement: 11.8% at baseline, 3.8% at 3 months and 5.6% at 6 months. However, those reporting having been incarcerated in the last 30 days showed a different pattern – none at baseline, 7.7% at 3 months and 5.6% at 6 months. It should be noted that these percentages all represent just 1 or 2 cases.

Experiences in past 30 days
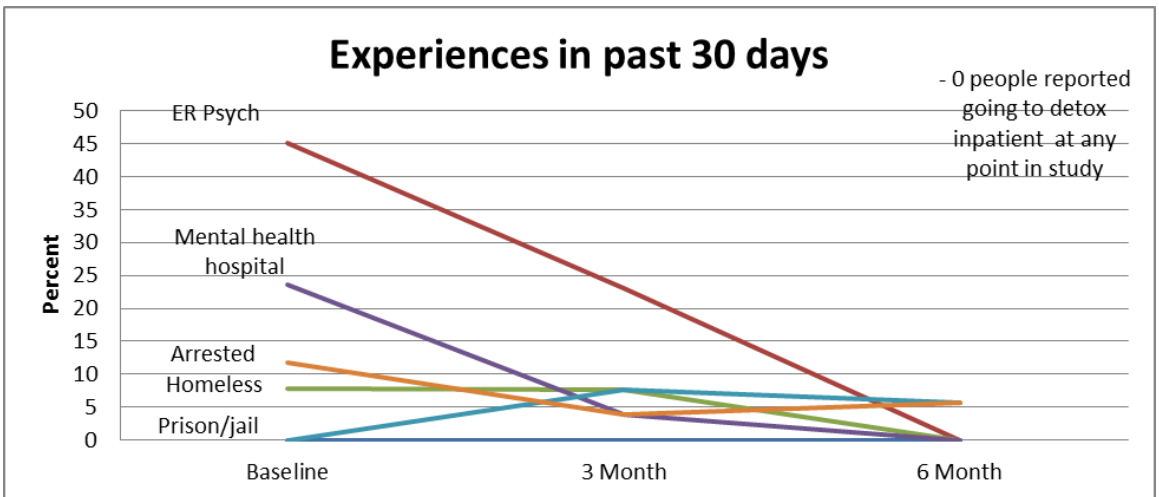
For measures of health, symptoms and functioning, generally some improvements over time seem to be suggested, although not necessarily of large clinical significance. (The items below were reverse-scored.)

Feelings Scores
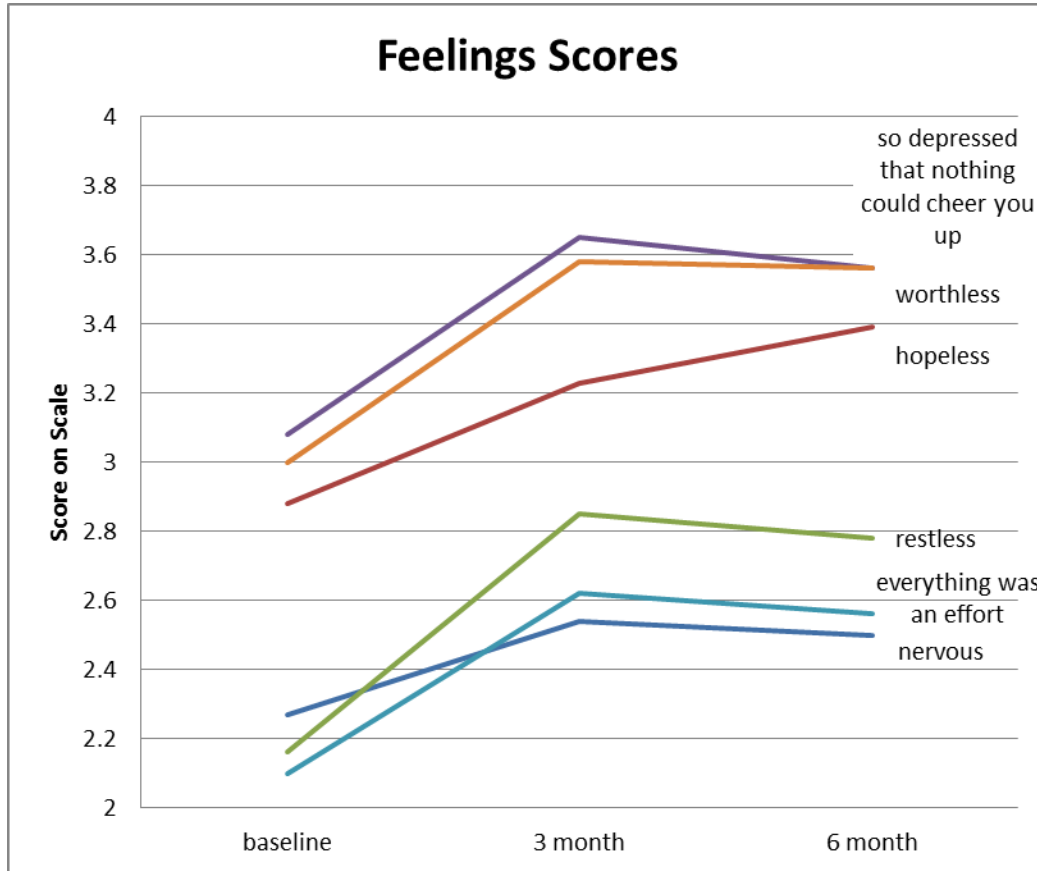
The Hemingway and Youth Empowerment scales did not show a consistent pattern of change over time, with baseline and follow up scores within .2 points of each other.

Administrative Data:

As previously mentioned, the clinicians involved in SCYA were asked to keep track of their client contacts, especially for the young adult CIT clients. Clinicians who reported on their contacts included the CIT clinicians, Mobile Crisis clinicians who worked on CIT cases, and the full-time project manager clinician hired through ABH. All these contact sheets were sent to ABH and entered there into an Access database developed by the evaluation team's data manager. In this way, a great deal more cases were able to be included in the evaluation than participated in the interviews, but the data was more limited than would have been in the interview.

After cleaning out duplicates and other inappropriate cases (e.g. those that weren't diverted), there was a total of 585 intake forms and 351 contact forms included in the

ABH database. The clinicians reported on all the CIT/SCYA cases, including both those in the YA group and those 30 and over.   Intake data indicated that the SCYA clients were 52.1% male, 23.6% Hispanic/Latino, 23.9% Black, 48.7% White, 1.2% American Indian and 2.6% Mixed.
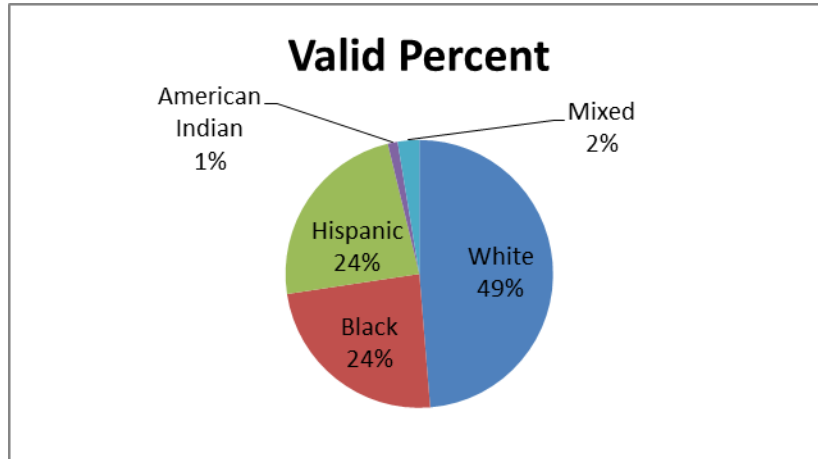
In terms of how the clinicians became involved in the police contacts, 27.4% were called by the police, 25.9% responded based on listening to the police radio, 18.5% received a follow up request, 12.7% resulted from a ride-along, and approximately 15% were other or missing.
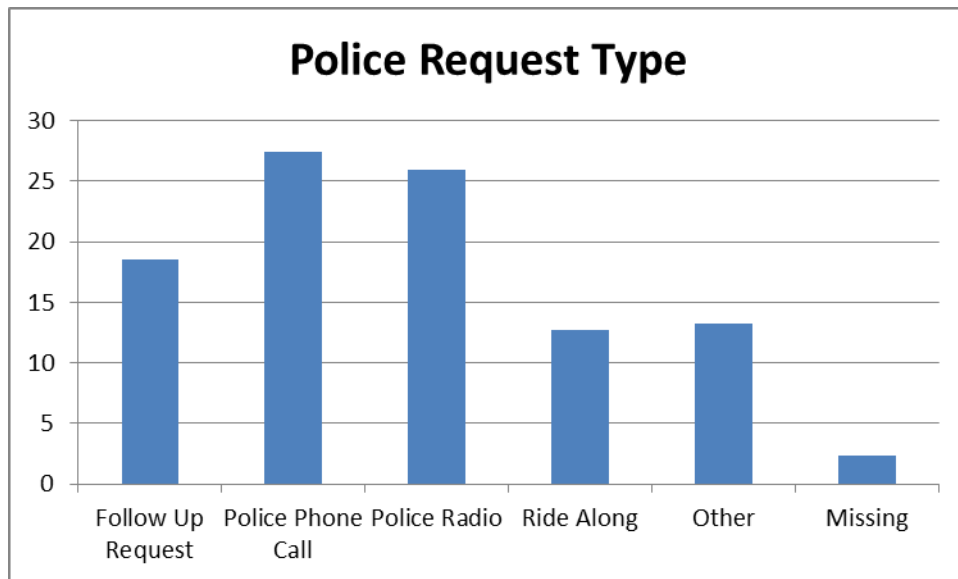
Over 62% of cases resulted in the client being taken to the emergency department. Over 69% of clients spoke with the CIT clinician but only 28.2% said that they were interested in help. The YA group seemed more likely to go to the ED, somewhat less likely to speak with the clinician, but more interested in help.
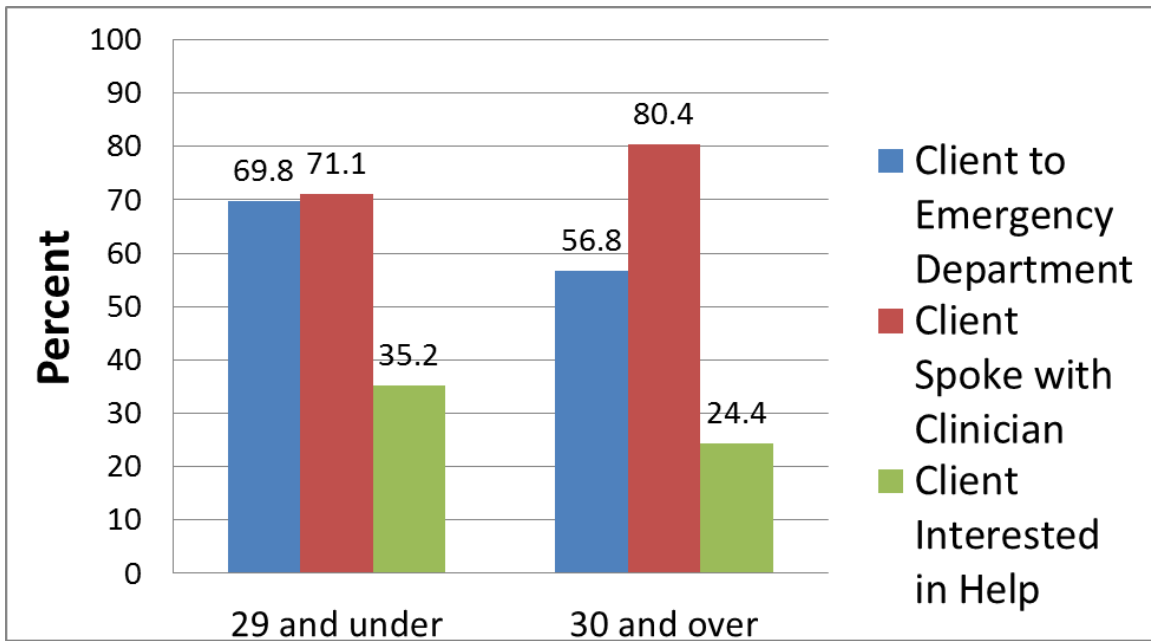
A large proportion of the clients were referred for mental health treatment (63.7%). Much smaller percentages were referred to other services, the largest being 8.9% to case management, 7.8 to other, 6.1 to medical and 4.9 to Young Adult Services.

After making follow-up attempts, the clinicians reported not being able to reach 30.7% of the CIT clients, but being able to reach and engage 51.4% of them.

Qualitative data

Qualitative data was collected throughout the course of the project, both in terms of process observations and directly through focus groups and meetings with key staff. In terms of the process evaluation, the implementation of the project illuminated the differences between sites in implementing CIT, program drift from the model over time, and how decentralization has led to communication and coordination challenges. SCYA spurred some changes in these regards, requiring the involvement of the DMHAS commissioner and the CEOs at each LMHA, as well as other central office leaders. We have also learned that young adults in crisis are particularly difficult to engage, resulting in strikingly lower participation rates than other populations we have worked with, including older adults who were homeless, criminal justice involved, and have mentally illness and/or substance use disorders. Although in many ways, the SCYA project did not roll out as planned and anticipated, it yielded rich information on CIT and the mental health system in CT, as well as invaluable experience with the young adult population.

Focus Groups

In the final year of the project, several focus groups were held with representatives of different populations involved in the study. They included CIT clinicians, the ABH

clinician, young adult peer group participants, and YA peer group facilitators, who also have lived experience with mental illness and often the criminal justice system themselves. Below are descriptions of the themes that emerged from the focus groups.

SCYA Client Population Description

In all of the focus groups, the participants were asked to describe the clients in their programs especially as it pertained to SCYA.

The **CIT clinician perspective** was that many of the clients they see are too psychotic and/or distressed to do more than assess imminent risk. They feel that the clients may resent the clinicians after police contact or being in hospital or jail as a result of the police/CIT contact and therefore resist follow-up contact. They have also observed that opioid overdoses have been affecting YAs badly in recent years. Many of the calls they see involve attempted suicides. They shared that YAs often don't have anywhere to go or to get basic needs met.

NAMI peer group participants generally were described as having had many mental health problems since childhood, especially as related to trauma. Most have a history of and are currently in other mental health services. Referral sources for the groups included: Meetup.com, the NAMI website, community agencies, word of mouth, parents, friends, flyers (at mall), therapists or other MH staff. The main needs of the participants are: jobs, education, support while in school/college, independent housing, advocacy, knowledge of rights, help getting in door to services

Peer Group Descriptions

Generally, the peer group format started out with a more structured protocol, but became less formal in practice in response to participant preference and facilitator experience. They usually start the groups with a check-in about the week with all the members. The facilitators utilize many creative activities, e.g. art projects, games, ice breakers, taking walks, journal writing, yoga, and meditation. While engaging in these activities, free-flowing conversation follows. The participants describe their experience in the groups as feeling less alone, feeling that the group is like a family, and that they support each other.

Quotes re Peer Groups:

- "…we do have deep conversations about what we're going through and they definitely, everyone puts in their opinion on how maybe you can better that situation, or maybe it's a toxic situation for you, so you need to step out. And we'll give words of encouragement to everybody. In here, it's never anything bad, like if somebody gets triggered by a lot of things, then they can walk out and recollect theirself. It's a very nice environment and it's safe for a lot of people. So I like it a lot."
- They always leave with hugs. All of the participants seem to like this unwritten rule: "I think hugs make things better."

- "It's like we just poured our hearts out to everybody and we're family, and you're coming back to us next week."
- "It's definitely something I look forward to in the week. Like you definitely have the choice to come, but it's definitely something I'd rather have more often than just once a week."
- "Some of us hang out outside of group. I would say that a lot of people I'm pretty close with, I met in this group."

Barriers evidenced in the SCYA program and/or YAs accessing services in general

The clinicians observed the following as being barriers to the above:

- Lack of releases
- Being able to reach clients
- Program restrictions
- Negative experience with police
- May not make the connection between the crisis and the follow-up
- Nowhere to take them if don't need ER
- Increasing needs and lessening resources

The young adults were more likely to identify stigma as a barrier to receiving mental health services:

- Parents often don't understand mental illness
- Fear of stigma often prevents YA from getting help or talking about what is happening
- Less stigma in younger generations
- "It's just a diagnosis. It doesn't mean you are that person; you just live with it."
- "For me, I consider my [mental illness] experience as one small chapter of my whole book."

Experiences and Perceptions

Young adult focus group participants described their perceptions and experiences with the police, mental health providers and different types of treatment. Regarding the police, they described a range of experiences from positive to neutral to negative. Generally, the positive experiences were with officers who treated them with respect and didn't make assumptions that they were bad. They also described a gamut of experiences with MH providers and different treatment modalities. All seemed to have had experiences with services they disliked and with ones they liked, including having found MH professionals they both trusted and didn't. Many expressed appreciation for receiving trauma-specific services. Generally, they wanted their preferences to be heard and solicited and for assumptions and cookie-cutter recommendations not to be used, e.g. based solely on diagnosis. Although some found relief for their symptoms with medication, they didn't want medication to be assumed to be the best course of treatment.

There was a strong preference for non-traditional/non-medical approaches such as yoga and meditation.

Specific SCYA Project Feedback

Both YAs and clinicians were asked for SCYA feedback but the YAs generally had little awareness of the SCYA project specifically, so most of the feedback reported here is from the clinicians. They felt that there wasn't enough police or clinician input into the project design in the planning stage. They felt that it was too difficult to try to cover the whole state, especially since each area is different, including the way CIT is conducted. They complained about too much paperwork being required, especially since they were overextended as it is. There was confusion about the role of ABH, so their help was underutilized until late in project. They felt that younger clients (teens) should have been eligible for SCYA.

The clinicians felt that what was really needed was more resources, including the following:

- Case management, housing, basic needs
- Access, drop-in, respite centers
- EAP model where could be seen within 24 hours for 6-8 times
- Family and community education
- Work with people in the hospital
- More police training
- Bilingual staff
- 24 hour coverage
- Have ABH clinician more integrated with CIT & EDs
- Someone to do follow-ups and referrals
- Peer involvement

Recommendations from YA participants generally included the following.

Regarding the police:

- Need to be trained to de-escalate, nonviolent communication and how not to traumatize the YA
- All should get Mental Health First Aid & trauma-informed training
- Police need self-care & support -- If police don't respect support enough for themselves when they're in need of it, then they are not going to respect the need for someone else.
- Basic empathy, try to understand what YA experiencing, listening skills, validation
- Body language – sit down with them
- Have police do role plays with YAs

Regarding providers/services:

- All staff in the agency should have MH training
- More YA support groups across state
- Don't judge YA on what they're capable of based on their worst day/s
- Don't assume peer staff are always ready to disclose & delve into personal issues
- "Whenever we are ready for treatment, providers should be sure to make that a safe place and considering all available options, including other avenues aside from taking medication."
- Parent education/training

Regarding schools/the education system:

- Do mental health education & training for all staff and all children
- Teach emotional intelligence
- "So I think school … we can get all of the kids in one place, and this is something we have to take advantage of… And that is really such a great opportunity; I don't think that can be stressed enough. Because it's going to create a wave of difference, and that's really gonna have an effect."

V. DISCUSSION

There were definite and important limitations to the evaluation that affect the ability to draw conclusions from the project, but this is somewhat to be expected from pilot programs. The main limiting factor to the evaluation was the low recruitment resulting in a small number of interviews being conducted. Those that were done were suggestive of some improvements over time for the participants, but it wasn't clear whether the interview participants were representative of the CIT YA population. In fact, feedback from the clinicians indicated that the people who agreed to and were able to participate in the interviews were likely higher functioning than those who were not. We were able to include program data reported by the clinicians on a much larger sample of the CIT population, and also gathered a wealth of qualitative data that provided much food for thought.

In a way, the fact that the SCYA project was not implemented as planned provided more of an opportunity to learn than it would have otherwise. This project shed a light on how CIT was being implemented in Connecticut, how it interacted with other crisis services, and generally on the state-run mental health system in our state. It also provided information on the interaction of the law enforcement system with the mental health system, and the needs and preferences of the young adult population.

More specifically, our experiences with poor implementation and recruitment revealed several factors influencing all these systems as well as the idiosyncrasies of the YA population. Although the Connecticut mental health system has always been on the forefront of best practice, it is currently struggling with a reduction in resources, both in

terms of staffing and programming. The evaluator hypothesizes that a relative lack of active guidance in the unit overseeing the CIT program may be exacerbating this problem. Each local mental health agency has been able to run CIT at their locations as they felt best fit their situation, and there seemed to have been limited central oversight or accountability. Although some freedom to deal with site-specific conditions is necessary, some sites drifted a bit from CIT model fidelity. And the general lack of coordination or consistent expectations seemed to make sharing resources or even common problem-solving difficult. The SCYA project forced greater awareness of what was happening with CIT and also Mobile Crisis, and what seemed to be an overdependence on taking clients to emergency departments. This was deemed as especially problematic since everyone agreed that often the EDs didn't provide much more than a short-lived "cooling off" space with little if any follow up care. Nevertheless, it was clear that there is no lack of extremely dedicated clinicians and administrators who are making incredible efforts to serve people with great needs. Like Sisyphus pushing his heavy rock uphill over and over, there is a fear that the clinicians may not be able to keep up as they have been, and may break under the constant pressure if structural changes are not made.

Based on the observations from the SCYA implementation, DMHAS central office leadership has been supporting the development of several different initiatives and applying for grants that can support some restructuring of crisis services. They are funding the placement of peer recovery specialists in several emergency departments to assist with engagement and service linkage. They are participating in early intervention, suicide prevention and workforce development initiatives. Our experiences with SCYA also informed the development of the CT Strong program, which is also a SAMHSA-funded initiative under the Now IS the Time Healthy Transitions grant.

VI. RECOMMENDATIONS

In a time of constricting resources, the dedicated people at DMHAS and its collaborating agencies must come up with creative ideas to help both their clients and their staff to serve them. Based on feedback from the focus groups and the process evaluation, one recommendation is for peers to be more involved in most, if not all, programs, but especially diversion and those that focus on young adults. DMHAS has already been utilizing peers to a great extent and is pushing for more. Although there are challenges with this, it seems to be the best way to engage these populations, which should eventually reduce the demand for crisis and criminal justice services. Existing resources should be leveraged by coordination across program sites within DMHAS, and also across agencies and systems. For instance, further strengthening of the coordination between the adult and child mental health systems and the education system holds promise for better service provision and reducing the likelihood of people in need falling through the cracks between systems. As eloquently expressed in the YA focus groups, there is a need for further training in mental health and de-escalation techniques for the police. The YAs recommend that all police receive CIT, Mental Health First Aid and trauma-sensitivity training. That truly would be wonderful, but police departments are also dealing with limited resources and low staffing levels, especially in the larger urban

areas. However, if these types of trainings, as well as mental health support for the officers themselves, could be instituted, it's likely that many community improvements would follow. At the least, the YA and emerging mental illness components begun under SCYA have been retained in the regular CIT training for the police, and psychiatric staff from IOL have volunteered to continue to provide it, at least for the time being.

Both clinicians and young adults involved in the project strongly recommended having non-clinical alternatives to help young adults in CT. The need for more drop-in centers where YAs can engage in various activities and get some basic supports, including just a safe place to hang out, was expressed multiple times. Our experience indicates that YAs tend not to respond well to a direct approach of offering mental health services, but are more likely to engage if they can get involved in other less threatening activities that are valuable to them, like yoga, games, job help, etc.

In terms of research, it is recommended that the young adult population be further explored, especially as it relates to mental health, complementary approaches, and peer involvement. The data we already possess has only just begun to be explored, and further data should be collected. In terms of regular data collected and reported by various state and other agencies, oftentimes, data on the age group of interest (18-25 or 29) is not available as such. The CT police departments don't seem to track age much at all, unless they happen to note when minors or the elderly are involved. Although some agencies do have age data, they don't tend to report on the YA or transition-age clients as a separate group. Doing so would be an invaluable first step in further exploring the needs of this group.

VII.   REFERENCES

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