Evaluation Findings from the Massachusetts Department of Public Health's Non-Traditional Mental Health Pilot Programs

Final Report

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Introduction

Recent advances in the treatment of HIV/AIDS have slowed AIDS death rates and the progression of disease for many individuals. This opportunity for improved health presents new challenges for people living with HIV and AIDS, as individuals must maintain strict adherence to complicated treatment regimens in order to benefit from the new therapies. However, adherence to treatment can be supported by a relatively stable lifestyle, a good understanding of the impact of different medications, and strong life management skills. Adherence is also enhanced by the ability to adapt to changes that arise as a result of medication side effects, other health issues, or challenging social and personal circumstances.

For some individuals living with HIV or AIDS, mental health problems stand directly in the path of seeking treatment to begin with, or adhering to treatment once prescribed. The availability of mental health and support services can have an important impact on the ability to access and adhere to complicated treatment regimes. At the same time, there is a growing recognition, documented by local and national needs assessments, that mental health services constitute the largest growing area of unmet need among people living with HIV and their families.

There are multiple barriers to appropriate mental health care for people living with HIV/AIDS. At the top of the list are the lack of insurance coverage, the absence of private payment resources, and language barriers. However, even for English-speaking, insured individuals, there are numerous roadblocks to mental health care.

Many people with HIV and mental health disorders do not recognize or acknowledge their mental health needs. Thus they are unlikely to seek out traditional mental health treatment. At the same time, mainstream health insurance (both private and public) rarely covers the outreach, collateral work, and support services that are essential to bring these individuals into care.

Furthermore, a large percentage of individuals with significant mental health issues also have a substance abuse disorder. Traditionally trained mental health clinicians generally are not able to address the needs of this triply diagnosed population – people with HIV/AIDS, mental health disorders, and substance abuse disorders. For example, many mental health clinics and clinicians require that an individual be substance-free before providing treatment for the mental health issues.

Recognizing these barriers and the importance of addressing them, the HIV/AIDS Bureau at the Massachusetts Department of Public Health (hereafter the Bureau) funded five mental health/HIV pilot projects in 1998. These pilot projects were designed to offer non-traditional mental health services to people living with HIV and AIDS. The goal was to provide clinically appropriate and culturally sensitive mental health services that would assist individuals in alleviating the impact of mental health stressors on physical health status, increase their ability to access and adhere to complicated treatment regimes, and better enable them to negotiate changing life circumstances.

These programs were specifically directed to:

- Support capacity not reimbursed by Medicaid and other insurers;
- Engage hard-to-reach clients;
- Show alternative, creative approaches to providing mental health services to people living with HIV and AIDS;
- Provide short-term mental health supports rather than long term mental health services;
- Use trained, master's-level mental health clinicians to provide care;
- Demonstrate a flexible delivery model and provide care in a wide range of settings;
- Link to existing HIV services in the community; and
- Develop a referral capacity for services beyond the immediate or short-term interventions of the programs.

The Medicaid Working Group at the Boston University School of Public Health was hired to conduct an evaluation of the pilot mental health programs to determine if these objectives were met. This report presents the results of our evaluation.

Description of the DPH Non-Traditional Mental Health Pilot Programs

The non-traditional mental health programs operated in five different areas of the state. Although all the programs were designed to meet the needs of individuals living with HIV who are underserved, some programs also targeted a specific subset of this population. Below we provide a snapshot of each program:

The ReachOut Program (Programa Alcanzar) was part of Health and Education Services (HES), a licensed mental health agency serving the Merrimack Valley Area. The target population was HIV positive men being released from the Essex County House of Correction. One mental health clinician, bilingual in English and Spanish, staffed the program. There were no subcontract agencies.

The *AIDS Project Worcester Mental Health Pilot* (APW) program provided services to individuals living in the cities of Worcester and Southbridge, as well as in the smaller towns of southern and northern Worcester County. The program built upon the existing service capacity of the AIDS service organization (ASO). The program targeted APW's current clients as well as individuals who frequented the People's Inebriate Program (PIP), a 24-hour "wet" shelter. Three mental health clinicians and three graduate student interns staffed the program. Planned subcontractors included Community Health Link and Great Brook Valley Health Center.

The *Boston Mental Health Pilot* (BMHP) was a collaboration of three agencies: Justice Resource Institute (JRI), Boston Living Center (BLC), and Bay Cove Human Services. The program targeted HIV positive individuals who received meals and wellness services at the BLC and those who attended JRI's Wayne Wright Resource Center (WWRC), a drop-in center for youth. Services were provided at both sites, with a mental health clinician staffing each site. There were no subcontractors.

Cape Cod Human Services (CCHS), a licensed mental health clinic, led a collaborative mental health pilot program serving Cape Cod and the islands of Nantucket and Martha's Vineyard. The program was designed to focus specifically on both gay men and persons with substance abuse issues. Subcontracting agencies included Provincetown AIDS Support Group (PASG), Upper Cape AIDS Network (UCAN), and Cape AIDS Resource Exchange and Services (CARES), as well as mental health providers on Nantucket and Martha's Vineyard. A mental health clinician or clinicians was planned for each subcontracted site.

The *HIV/AIDS Mental Health Program* of the Home Health VNA (HHVNA) served homebound individuals living in Merrimack Valley and Southern New Hampshire. The mental health pilot intervention targeted the Latino population in particular. The model included the hiring of seven fee-for-service social workers, some of whom were bilingual and/or bicultural. There were no subcontractors.

There were several common links among the programs:

- All were designed to meet the needs of individuals living with HIV and AIDS with mental health and support service needs that are not well met by the traditional mental health system.
- Each program was designed to increase mental health capacity and provide services that are not reimbursable through standard health insurance.
- All of the programs featured either interagency collaborations and/or linkages between mental health agencies and HIV services within their communities.
- All were willing to participate actively in an evaluation of their service delivery models.

The following services were offered by each of the programs as appropriate, either on or off-site:

Table 1: Services Offered by Pilot Programs

Service Type	**Description**
Aftercare planning	Planning, with client, for services and supports upon termination of services in the pilot program
Client advocacy visit	Accompanying the client to appointments, court appearances, interviews, etc., to assist and advocate
Clinical telephone intervention	Clinical intervention by telephone
Collateral contact	Phone or face-to-face contact with other providers involved with client
Daily task assistance	Assistance rendered to the client with daily tasks, such as errands.
Engagement/trust building	Contact with clients for the purpose of establishing trust and strengthening the clinician /client relationship
Family mental health counseling	Family mental health session
Group mental health counseling	Group mental health session
Individual mental health counseling	Individual mental health session
Intake	Initial meeting, non-urgent, for assessment and planning
Mental health care coordination, post-release *(from correctional facility)*	Post-release care coordination sessions (community-based)
Monitoring, pre- or post-discharge	Visits or phone calls with the purpose of verifying client's physical and mental health status before or after discharge from the pilot program
New client outreach	Phone calls, visits or other activities designed to recruit potential clients for the pilot program
Provider coordination	Coordination of medical and/or mental health care
Referrals— mental health/substance abuse	Referrals to reimbursable mental health or substance abuse services
Referrals— supports	Referrals to supportive, legal and other services
Transportation	One-way ride provided by a mental health program clinician
Urgent assessment	Clinical intervention in a crisis situation

Evaluation Methodology

The evaluation was designed to determine whether or not the programs met the Bureau's criteria discussed above and to identify successful models of care and lessons learned. To complete the evaluation, we employed several different methods:

1. Group meetings with program staff at program inception and at interim stages throughout the pilot. We conducted an initial meeting with each of the program directors and program staff from the pilot programs, as well as with Bureau staff. During this meeting, we focused on getting to know each program and describing the evaluation. We also obtained input on the evaluation plan in order to conduct the participatory evaluation. Subsequent meetings focused on interim results.

2. Key informant interviews at each agency understand how each of the pilots fit into their broader organizational context and how the agency envisioned the pilot would fill unmet needs. A structured interview protocol was developed to guide the interview process and ensure comparability of information. After completing the interviews, we summarized each and developed an integrated summary report.

3. Development of data collection tools, training on their use at program sites and collection of data on a monthly basis. The data were inputted into an SPSS database and analyzed using standard statistical techniques.

4. Development and administration of consumer satisfaction surveys to clients after their fourth visit and at termination. The results were inputted into an SPSS database and analyzed using standard statistical techniques.

5. Qualitative analysis, using a semi-structured interview guide, of a non-random sample of clients based on clinician report to learn more about client disposition after program discharge.

6. Regular meetings with Bureau staff to discuss progress on the evaluation.

Below we present our findings. It is important to note in interpreting the findings that data were analyzed both in the aggregate and by program. Moreover, two programs were subanalyzed by site: the Boston Mental Health Pilot was broken into the Wayne Wright site and the Boston Living Center site, and the Cape Cod Human Services pilot was subdivided into the Provincetown site and the Upper Cape and Islands sites.

Findings

Program Start Up

Programs required a fair amount of start up time, ranging from three months to ten months. APW began serving clients during September 1998, while CCHS was unable to enroll any clients until March of 1999. Barriers to start up included:

- hiring issues- certain programs wanted to hire bilingual clinicians and/or clinicians of color, but had difficulty attracting them;
- salary issues- some of the programs' salaries for clinical staff were not competitive; and
- subcontracting issues- implementing subcontracts took more effort and negotiation than expected, and sometimes fell through completely.

Numbers Served

Through the end of the funding cycle (June 2000), we obtained demographic, clinical and service utilization information on 368 people served by the five programs.

Programs served varying numbers of clients. Some programs, such as ReachOut and HHVNA were designed to serve small, specific populations, while programs such as APW, BMHP and CCHS were expected to serve larger populations. The following table shows the breakdown of clients served by program and program site:

Table 2: Number of Clients by Program

Program	***Number of Clients Served***
AIDS Project Worcester	53
Cape Cod Human Services	Total: 71 Upper Cape and Islands sites: 25 PASG: 46
Health and Education Services	69
Home Health VNA	55
Boston Mental Health Pilot	Total: 120 BLC: 76 WWRC: 44
Total	368

Across all programs, 10% of those served were affected others. However, this varied considerably by program. APW served the highest proportion of affected others (30%), while affected others made up no more than 5% of any other program's client population.

Demographics of Populations Served

Gender

Table 3 provides a gender breakdown by project:

Table 3: Gender by Project

Program	***Male***	***Female***
AIDS Project Worcester	62%	37%
Cape Cod Human Services	Total: 82% Upper Cape and Islands sites: 52% PASG: 98%	Total: 18% Upper Cape and Islands sites: 48% PASG: 2%
Health and Education Services	94%	6%
Home Health VNA	38%	62%
Boston Mental Health Pilot *(3% missing)*	Total: 78% BLC: 74% WWRC: 84%	Total: 21% BLC: 24% WWRC: 16%
Total *(1% missing)*	73%	26%

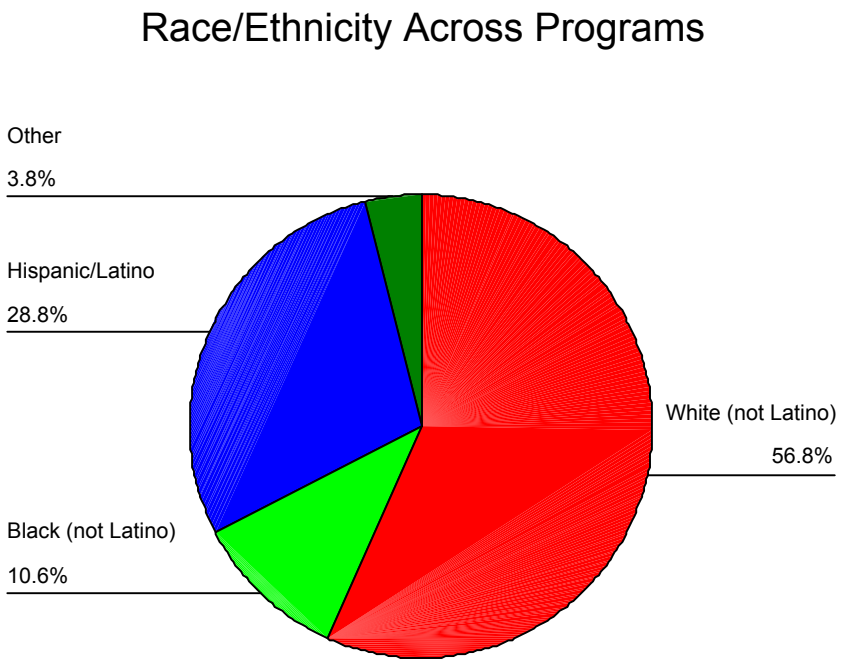
Age

The mean age for all clients across programs was 39.6. This age was consistent across all programs. At the Wayne Wright site, the clients were slightly younger (mean age = 36) than the clients at the other programs. At CCHS, the mean age was slightly higher at close to 42.

Race/Ethnicity

Chart 1 displays the ethnic/racial composition across all programs.

Chart 1:



There was variation among programs. This is due in part to two programs targeting the Latino population. In addition, it was difficult for programs to reach African Americans. Table 4 details the ethnic/racial makeup of each program's clients.

Table 4: Race/Ethnicity by Program

Program	***Race/Ethnicity***
AIDS Project Worcester	57% White, 26% Latino, 13% Black, 4% Other
Cape Cod Human Services	Total: 93% White, 4% Black, 1% Latino, 1% Other; Upper Cape and Islands sites: 96% White, 4% Black; PASG: 91% White, 4% Black, 2% Latino, 4% Other
Health and Education Services	59% Latino, 29% White, 10% Black
Home Health VNA	73% Latino, 20% White, 4% Black, 4% Other
Boston Mental Health Pilot	Total: 68% White, 17% Black, 1% Latino, 1% Other BLC: 65% White, 18% Black, 9% Latino, 8% Other WWRC: 73% White, 14% Black, 9% Latino, 4% Other

Employment Status

Overall, 23% of clients reported full or part time employment, while the remaining 77% reported being unemployed. Reason for lack of employment is not known, as this was not a data element that we collected. Unemployment was highest at HES at 90% and lowest at CCHS at 55%. However, within CCHS there was significant variation between sites, with 72% unemployment at the Upper Cape and Island sites and only 46% unemployment at PASG.

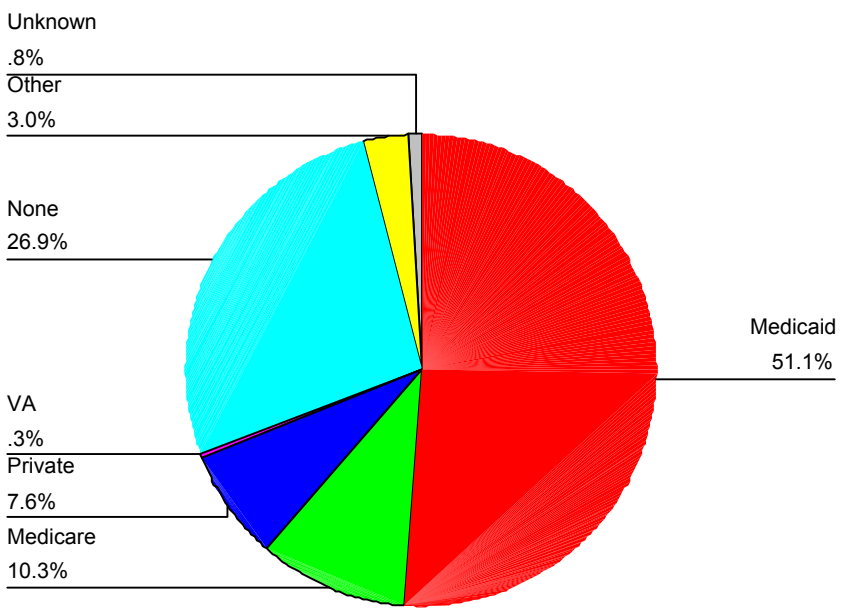
Household Income

Overall, the population served was poor. Although the mean household annual income reported was just over $13,000, the median income of $7,596 is likely a more accurate reflection of the financial status of the population, as the mean is skewed by two individuals who reported household incomes over $200,000. In fact, 16% of the population reported no income, while only 4% reported annual household incomes of greater than $40,000. Median income across programs ranged from $0 at HES to $13,000 at CCHS. In addition, more than half of the PASG clients were employed, when data was analyzed there was no significant difference between their incomes and the incomes of other clients, indicating that for those who work, earnings are low.

Insurance Status

Medicaid was the most common (51%) form of health insurance for this population, followed by Medicare at 10%. 27% of all clients overall are uninsured. Chart 2 displays the distribution of insurance type across programs.

Chart 2:



There is much variation in receipt of Medicaid benefits and in the percentage of uninsured between programs and program sites. Receipt of Medicaid benefits was highest at HHVA and lowest at CCHS, specifically at PASG. Only 1% of clients at BLC were uninsured, while almost two-thirds of those in the ReachOut program had no insurance.

Table 5 shows percentages of Medicaid coverage and percentages of uninsured by program.

Table 5: Percentages of Clients with Medicaid Coverage and Clients without Insurance, by Program

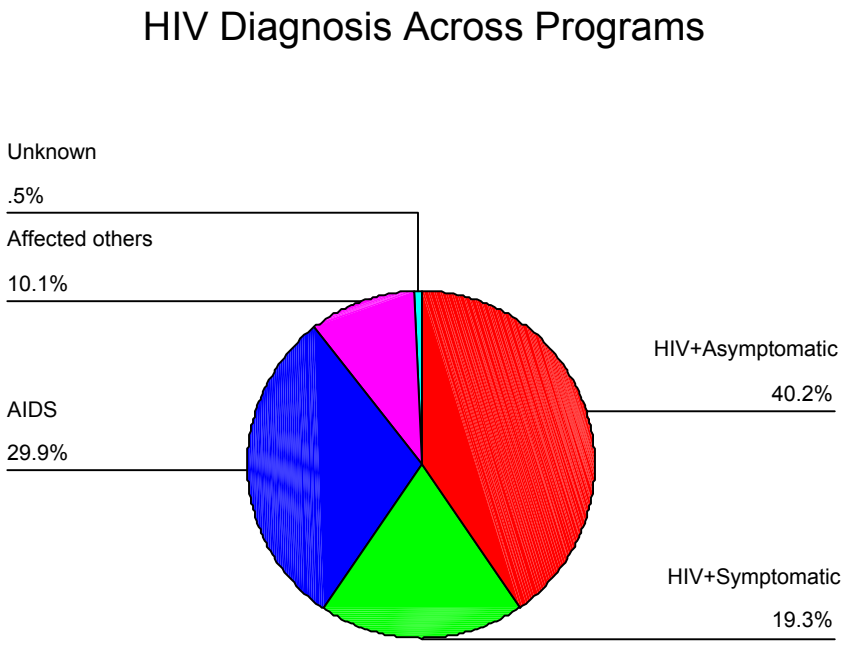
Program	% on Medicaid	% without insurance
AIDS Project Worcester	47%	15%
Cape Cod Human Services	Total: 27%; Upper Cape and Islands sites: 56% PASG: 11%	Total: 48%; Upper Cape and Islands sites: 24%; PASG: 61%
Health and Education Services	35%	65%
Home Health VNA	89%	6%
Boston Mental Health Pilot	Total: 59%; BLC: 67%; WWRC: 46%	Total: 8%; BLC: 1% WWRC: 18%

HIV Clinical Information

30% of all clients served had an AIDS diagnosis by the end of the pilot, up from 25% at the end of the first year, indicating either that clients' disease stage progressed or that an increased number of clients beginning services at the later stage of the pilot had an AIDS diagnosis. However, overall, almost half of all clients were HIV asymptomatic.

Chart 3 displays the distribution of HIV diagnoses across programs.

Chart 3:



There was a significant difference across programs in the percentage with an AIDS, rather than HIV, diagnosis. Table 6 details these differences.

Table 6: Percentage of Clients with an AIDS Diagnosis by Program

Program	**% of Clients With AIDS Diagnosis**
AIDS Project Worcester	22%
Cape Cod Human Services	Total: 45% Upper Cape and Islands sites: 56% PASG: 39%
Health and Education Services	6%
Home Health VNA	42%
Boston Mental Health Pilot	Total: 33% BLC: 33%; WWRC: 32%

For individuals living with HIV or AIDS (90% of those served overall), the most common HIV transmission category reported was injection drug use (37%), followed by men who have sex with men (36%). The same two categories were most common across programs.

Mental Health Clinical Information

Diagnostic information was collected on all five DSM-IV axes. Axis I describes a person's mental health disorders or conditions which may be a focus of clinical attention; Axis II details any personality disorders or developmental disabilities that a person may have; Axis III provides information about general medical conditions; Axis IV details psychosocial and environmental problems that the person may be experiencing; and Axis V is the Global Assessment of Functioning (GAF) score, which measures overall level of life functioning.

The most common primary Axis I diagnoses at intake included substance abuse disorders, including alcohol-related disorders; depressive or dysthymic disorders, adjustment disorders, or anxiety disorders. There was almost no change in diagnosis at visits 12 or 20, the two other points at which we reviewed diagnostic data.

V codes are DSM-IV diagnostic codes used on Axis I that indicate conditions that may be a focus of clinical attention, but are not disorders *per se*. Examples of V code diagnoses include bereavement and noncompliance with treatment, which are important issues for this population. However, few individuals treated through the mental health pilots (less than 4%) had primary V code diagnoses. This may be because clinicians tend not to use these codes on a regular basis, as insurers will typically not pay for treatment for V code diagnoses.

Only 20 individuals, or 5% of the population served, were ever given an Axis II diagnosis. For those with an Axis II diagnosis, most common were dependent personality disorder, antisocial personality disorder, and mental retardation.

Not surprisingly, AIDS or an HIV symptomatic or asymptomatic illness was the most common primary Axis III diagnosis at all time periods. The most common secondary Axis III diagnoses were hepatitis C (17%), followed by asthma (7%) and cancer (4%). These diagnoses also did not change over time.

Axis IV provides information about other stressors in an individual's life. Most common psychosocial stressors included medical problems (19%), homelessness or an unstable living situation (17%), unemployment or economic problems (12%), legal problems (14%), and relationship problems (8%). These issues also remained fairly constant over time, with some minor decreases in homelessness and economic concerns.

Axis V, the Global Assessment of Functioning (GAF) score, measures a person's level of functioning. A score between 1-50 indicates severe impairment; 51-60 indicates moderate impairment; and 61-100 indicates mild to no impairment.

Table 7 details mean GAF scores at different points within clients' therapeutic experience.

Table 7: Mean GAF Scores at Intake, Visit 12, Visit 20, and Visit 30

Intake	Visit 12	Visit 20	Visit 30
53	57	55	58

There was a statistically significant change between intake and visit 12, from visit 12 to visit 20, and from visit 20 to visit 30 for the 17 individuals who had 30 visits in the database. However, the direction of the change was confounding. GAF scores increased between intake and visit 12, decreased between visit 12 and visit 20, and increased again between visits 20 and 30. This was the case across all programs except the HHVNA, where there was no change between visits 12 and 20.

Service Utilization

When the evaluation of the pilot programs began, it was assumed that each client would receive, on an average, 12 service units or fewer, and the understanding was that individual counseling sessions would comprise the bulk of the service utilization. However, as time progressed, we realized that the clinicians were providing many other therapeutic and support services besides traditional counseling sessions.

Four out of five programs provided 13 or fewer services per client on average. In contrast, the ReachOut program provided an average of 39 units of service. It is likely that the clients in this program had higher levels of utilization due to the need for supports upon release from the correctional facility.

Overall, the number of service units received per client ranged from 1 to 211. A large portion of these services were not face-to-face client contacts, but instead collateral contacts made with other service providers on behalf of the client, or, less traditional client-centered services such as telephone intervention or supportive services.
The most commonly used services are listed below in Table 8:

Table 8: Most Commonly Used Services Across Programs

Service Units (across programs)	*Number of Units*	*Percent of All Services*
Collateral contact	1398	24%
Individual MH counseling on site	1387	24%
Clinical telephone intervention	769	13%
Individual MH counseling off site	681	12%

Surprisingly, some services that were expected to be used frequently at the time of program development, such as urgent mental health assessment and family or group counseling were used infrequently; instead, a significant amount of time was spent on services such as coordinating care, making referrals to a wide range of services, and on

client advocacy.

Disposition

As of August 2000, we received disposition information on 302 clients. Table 9 lists the most common dispositions.

Table 9: Disposition Across Programs

Disposition	***Percent***
Continued services within the same program/agency	37%
Other (i.e., moved out of service area, in jail)	20%
Continuing mental health treatment at different location	19%
Lost to follow up/unknown	15%
Additional treatment recommended, but client refused	9%

There was significant variation in disposition trends by program. This is closely related to both the way in which each program is structured as a short-term program to make referrals, and/or whether clients are willing or able to obtain care elsewhere.

Specifically,

- 76% of APW clients continued mental health treatment either at APW or at a different location. Of these, 62 percent were continuing to obtain their care at APW rather than at another mental health agency, despite the fact that APW is not a licensed mental health clinic.

- Of the total CCHS clients, 59% continued to receive mental health services, equally split between that agency and another agency. There was a higher percentage of outside referrals made by the PASG site than by the other Cape sites, as well as a higher percentage of clients deemed ineligible because they are insured (12%).

- Almost 80% of HES clients continue to receive services, mostly through the ReachOut program, which continues to be funded from a new grant. Surprisingly, this population had the lowest rate of refusing additional mental health treatment when it was suggested (only three individuals).

- HHVNA clients either are continuing services through the same program or a different location (45%). Although this agency made numerous referrals, a high percentage refused additional mental health treatment (18%).

- 41% of BMHP clients are continuing mental health treatment, about twice as often within BMHP as at another agency. By site, the BLC clients were more likely to receive their care at another agency while the WWRC clients were more likely to continue at JRI Health, usually at the Sidney Borum clinic. 11% of clients refused additional mental health treatment, most of these clients being from the WWRC population. This agency lost the highest

percentage of clients to follow-up or was unaware of their disposition (close to 30%), again most often from the WWRC site.

In addition to collecting disposition data monthly with our data collection tool, we also collected some qualitative outcome data through follow-up interviews with clinicians. These interviews concerned the dispositions of selected clients who received 12 or more service units. The majority of the clients discussed have experienced improvements in their quality of life as a result of participating in the mental health intervention, although in several cases their situations in general may have become worse because of their disease progression, life circumstances, or substance use. The entire follow-up report is included in Appendix A.

Consumer Satisfaction

We received 89 responses to our consumer satisfaction survey for a 32% response rate overall. Surveys were distributed to program staff to hand to clients after the 12th visit. During the first year of the program, the consumer satisfaction response rate was 40%, compared to only 25% during the second year. However, the tenor of the responses has remained unchanged. The consumers who returned the survey reported extremely high satisfaction with the pilot programs. Over 90% of all respondents have agreed with the following statements:

- My counselor helps me with my problems.
- Talking with my counselor helps me handle my daily life better.
- The counselor I see spends enough time with me when I see him/her for services.
- I feel like my counselor understands me.
- I am able to see a counselor who speaks my own language.

However, although satisfaction was still very high in these areas, consumers were not so apt to agree with other statements, such as:

- Talking with my counselor helps me stay on my medication. *(74% agree; 11% said that this statement was not applicable to them.)*
- If I am in crisis, my counselor sees me quickly. *(77% agree; again, 11% said this was not applicable.)*
- I can see my counselor as often as I need to. *(72% agree)*
- When I need to talk to someone, my counselor will come to where I am. *(72% agree)*

Other comments from the satisfaction survey included:

- "They help me obtain programs to help my health."
- "We trust him a lot, he is very important in our life."
- "I can trust her much more than any of my most trusted family members."
- "She is both great at her job and a wonderful person as well. She has been so

supportive and her guidance has made it possible to get my life back on track."

- "Without my counselor's help, I can honestly say that I would have committed suicide from all of the confusion in my life."
- "I wish we had more time here and there."
- "My counselor speaks Spanish and English very well."
- "She not only helps me, she is like a social worker, case manager, mental health professional all in one."
- "Thank you, your program was incredibly helpful and appreciated."
- (*Paraphrased):* I have to go to him, I cannot be seen anywhere else.

The negative comments tended to relate to having to see their counselor at the agency site and having a limit to the number of sessions.

Discussion and Issues for Future Consideration

From this evaluation, several important findings emerge for future consideration. These findings concern:

- the role of health insurance;
- alternative models of care, including thinking differently about both service mix and the role of the mental health clinician;
- measuring outcomes;
- managing subcontracts and collaborations;
- clinician hiring and stability; and
- triple diagnosis programs.

The Role of Health Insurance

Not surprisingly, the role of the insurer is a key issue. First, a significant portion of the clients enrolled in the programs is uninsured and it appears that many will remain uninsured even with Medicaid eligibility expansion through the new waiver. Although some of our income data was estimated and some is missing, based on the data we have, if Medicaid eligibility is expanded to 200% of the federal poverty line, only about 4% of the programs' total population would newly qualify for benefits. Even for the Provincetown program--where the expectation has been that the waiver would have a major impact--the income data we have received indicates that only 9 individuals, or less than 13% of their population, would become eligible for Medicaid. Some clients have been discharged after the pilot funding ended due to lack of health insurance. Alternative funding streams are critical.

However, two-thirds of the clients served by these do receive Medicaid benefits. Collateral work and non-reimbursable services were important aspects of these programs. More than half of the service units provided under the mental health pilots are not reimbursable through traditional insurance, including Medicaid. Furthermore, one entire pilot program (HHVNA) existed solely because Medicaid does not cover social work in

the home. It is critical to consider the role of the Medicaid program and negotiate with the Department of Medical Assistance and the Massachusetts Behavioral Health Partnership to incorporate some of these non-reimbursable services into their benefit packages. In the interim, it may be useful to consider whether some agencies can link their models and collaborate to secure insurance payments, and for the Bureau to develop a funding mechanism to subsidize only for those services or those clients not covered by insurance.

Alternative Models of Care

At the time the pilot projects were conceived, the Bureau called for alternative, creative approaches to providing mental health services to people living with HIV and AIDS. However, because the pilots had not yet evolved, it was not clear what form these alternative approaches would take. The only explicit directives included locating services in a non-mental health clinic setting where people might be more likely to access services and providing transitional care with a visit limit. As the pilot projects evolved, two important themes around "alternative approaches" to care emerged. The first was the recognition of the diverse scope of services needed to engage clients in care and keep them in care, which included a combination of outreach, collateral, and support services in addition to standard counseling. The second was the role of the mental health clinician, which included both the professional skills of a licensed therapist, as well as advocacy, support service, and care coordination roles. In these programs, the mental health clinician's job has been more demanding than that of a traditional office-based mental health clinician. The programs have taken the bold step of allowing a broad definition of what a mental health clinician can do. They also have raised the possibility of developing a new team approach to care that would integrate mental health and social services by complementing the mental health clinician with a case manager.

The programs that were most successful in enrolling clients and sustaining a high level of consumer satisfaction had some common elements. Included among these were programs that targeted very specific populations, incorporated strong outreach components, broadened the role of the clinician, and provided services at sites that were not mental health-specific.

Measuring Outcomes

When the Bureau conceptualized the mental health pilot, there was an expectation that individuals would receive no more than twelve mental health visits and that a successful disposition or outcome would be a quick transition to longer-term mental health treatment. As it became clear that the scope of services required modification, it also became clear that the visit limit was artificial, often mimicking the role of the traditional insurer, and also did not fit into the model of care or meet client needs. Clients who were unable to be easily transitioned to other mental health services often had a high level of need, were often unable or unwilling to obtain care elsewhere due to past experiences with more traditional mental health programs, or had made a positive connection with a

provider that was important to sustain. It became clear that measuring success should take into account more than just early transitions to other providers.

In addition to transitions, the other measure that was conceived of as an outcome was an increase in Global Assessment of Functioning, or GAF, score. As stated in the results section, GAF scores did show improvement after 12 visits. However, for the 38% of clients who received more than 12 visits, there was a decrease in GAF score between visits 12 and 20. There are many potential explanations for this finding, but it should not be taken to mean than individuals are more likely to function poorly as they receive more treatment. Rather, it may be that clients showed a "honeymoon effect" during the earlier period of treatment or that those who received more care had more significant and extraordinary needs. It is also important to note that for the 15% of clients who had 30 visits, GAF increased at the 30th visits. This finding has implications for considering the utility of the GAF score as an outcome measure for this population, as well as for thinking about arbitrary visit limits. In the future, we recommend an increased emphasis on defining and tracking outcomes that are good indicators for this population. This will be useful in making program decisions, and if positive, negotiating with other payors.

It is also important to note client preference for these non-traditional models and satisfaction with them, based on the patient satisfaction surveys. The Bureau takes seriously consumer satisfaction, and we believe that this should continue to be considered an important program outcome measure.

Managing Subcontracts and Collaborations

A major barrier to successful program implementation involved subcontractual relationships. The difficulty in implementing subcontracts significantly impacted program size, start-up and innovation. For example, the APW program ultimately served small numbers and never implemented their innovative shelter-based program because they were not able to implement a working subcontract with Community HealthLink. Subcontract issues also dramatically slowed the implementation of the entire CCHS program, and had an effect on the number of clients served by these sites as well. However, subcontractual relationships can work once they are implemented. In the instance of the CCHS program, once the subcontract with PASG was finally in place, this program was able to access a key target population and enroll many clients within a short time period. Our results suggest that if programs are going to provide care through subcontracts, letters of commitment from the subcontracting agencies should be required before any funding decisions are made. These subcontracts should be in place before funding begins.

Collaborations also posed some related, although less serious, difficulties. The Boston Mental Health Pilot, as a three-agency collaboration, relied on a single individual who conceptualized the program and acted as the spokesperson for all of the agencies. This individual left the agency during the early stages of the pilot, and each of the other collaborating partners experienced management staff turnover as well. This led to some frustrations around ownership and responsibility. We suggest that this be averted in the

future through a higher level of involvement of all funded partner agencies.

Clinician Hiring and Stability

In addition to finding models of care that work, the clinicians were key to the success of the programs. It was difficult for some programs to hire and retain qualified staff who were excited about and open to working in a non-traditional model of care. Sites that were able to hire skilled clinical staff quickly were most readily able to implement their programs. Additionally, programs or sites that maintained a high degree of clinician stability throughout the life of the pilot had the most success in terms of outreach, enrollment and consumer satisfaction. Although it is impossible to control staff retention completely, it is important that agencies recognize the enhanced role of the clinician and compensate accordingly to ease both staff hiring and retention.

Triple Diagnosis

As discussed in the results section of this report, a significant proportion of the clients served in these programs have a diagnosed substance abuse disorder. In reality, these programs serving clients who are confronting three major health issues—HIV/AIDS, a mental health disorder, and a substance abuse disorder. It is critical for the AIDS Bureau and the Bureau of Substance Abuse Services at the Department of Public Health to reevaluate their individual roles in funding these services and consider collaborative funding and programming. Given limited dollars, this may be a method to increase capacity and decrease duplication. We also recommend that the AIDS Bureau examine these programs in light of existing mental health/substance abuse treatment capacity across other services funded by the AIDS Bureau, as well as those funded by other areas of the Department.