AN EVALUATION OF A FOUNDATION’S COMMUNITY-WIDE INITIATIVE TO IMPACT MENTAL HEALTH OUTCOMES

A Dissertation by

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AN EVALUATION OF A FOUNDATION’S COMMUNITY-WIDE EFFORT TO IMPACT MENTAL HEALTH OUTCOMES

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To my husband, John, to my parents and siblings, and to my family and friends: I have the greatest support network in all of you who make life so wonderful each and every day.
ACKNOWLEDGEMENTS

First, to the funder of this mental health project: You have made an immeasurable difference in so many lives (although I have tried to capture this difference to some extent!). Without your influence, policies would have stayed the same, community partnerships may not have formed, and some greatly needed services never would have been provided. To the organizations that provided mental health programs and services in the community: Thank you for your willingness to share your stories and passion for the work you do. It is truly inspiring and overwhelming to see organizations work together to alleviate a myriad of problems, and you do it so well day-in and day-out.

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ABSTRACT

This exploratory study was focused on mental health, broadly defined, as part of a larger community assessment research project. The primary goals of this study were to determine how a mental health initiative impacted the perceived care provided by the mental health-serving organizations and also to identify promising practices of grantees. Because the goal of this study was illumination and understanding, as opposed to prediction or causal determination, the data collected were qualitative, coming from open-ended questions and archival data obtained from the agencies. Organizations reported many strengths and successes, such as improved client outcomes, partnerships and collaboration among agencies and community members, as well as having a committed board, staff, administrators, and volunteers. Challenges for organizations included measuring outcomes, securing adequate staffing levels, and securing adequate funding. Overall, mental health-serving organizations reported positive changes in the community, but could benefit from longer granting periods, capacity building activities, improved client access to services, greater community awareness and reduced stigma associated with mental illness.
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CHAPTER 1

INTRODUCTION

Mental illness is a major health issue in the United States. More than one out of every five adults in the US has a diagnosable mental disorder in any given year (Bourdon, Rae, Locke, Narrow, & Regier, 1992). With so many people suffering from mental illness’ debilitating effects, countless efforts are in place to alleviate its distress and get to the core of the problem. These efforts include traditional mental health care, community-oriented care, and mental health consumer-based care. One of the arms of the nonprofit world deals exclusively with mental health issues in any given community. This research project examined 52 nonprofit organizations that provide mental health services, in part, funded through a special initiative during fiscal year 2007. As part of a larger study which identified mental health as one area of great need, this study focused on mental health efforts alone. Funding was to be used exclusively on enhancing the capacity of the organizations to address mental health issues with each organization’s respective target population. This exploratory study uses a qualitative approach to ascertain the extent of the foundation’s mental health funding on the system of care within the community. This study also aims to identify the promising organizational and programmatic practices present in mental health grantees.

To provide a conceptual and theoretical framework, the epidemiology of mental disorders in the United States is discussed. Two major epidemiological studies have been conducted nation-wide to determine the incidence and prevalence of mental disorders. The Epidemiological Catchment Area study found one-year prevalence for any given mental disorder to be 21.7% in the general population. Lifetime prevalence was 32.7%. In the National
Comorbidity Study, it was found that almost half of all adults had lifetime prevalence for at least one disorder. Current epidemiology of mental disorders is the last part of this section.

Because of the great needs surrounding mental illness in the US, the next section discusses the three main types of care that are available to address ill mental health. These services include: traditional care, consumer-driven services, and community-based services. All three are necessary components used to address mental illness in a very complex system of care. The system itself, while providing essential services, is a loosely-coupled system, and coordination among agencies can be seen as an ongoing issue.

One of the three main types of mental health services provided in a setting is community-based mental health services, which are typically provided by nonprofit organizations. The organizations included in this study mainly provided community-based mental health services. Because of this, nonprofit organizational capacity is the next topic included. The theoretical framework, best practices, and barriers to implementing capacity building in nonprofit organizations are addressed in this section. A Midwestern foundation provided financial and other support for this initiative with the hope to impact mental health outcomes. The foundation itself was young and recently formed from a settlement.

Epidemiology of Mental Disorders in the United States

The attempt to measure psychological disorders began in the 1950s with data from the Midtown Manhattan study (Srole, 1962). Checklists were used as a way to measure depressed affect, psychological distress, and dysfunction. Validity for the checklist scales was achieved by comparing clinical and nonclinical populations. Unexpectedly, rather than simply measuring
mental dysfunction, it was more likely that symptoms were confounded by low socioeconomic status (Link & Dohrenwend, 1980).

**Epidemiological Catchment Area (ECA)**

There were two classic studies that have estimated the incidence and prevalence of mental disorders in the United States. The first, and most well-known, is the Epidemiological Catchment Area (ECA) project funded by the National Institute of Mental Health (NIMH; or, more specifically, the Center for Epidemiologic Studies of NIMH) in the early 1980s. Using NIMH’s Diagnostic Interview Schedule (DIS), information was collected via field surveys in five areas around the nation: New Haven, Connecticut; Baltimore, Maryland; St. Louis, Missouri; Piedmont area of North Carolina; and Los Angeles, California. The aims of the study were to estimate incidence and prevalence of mental disorders, to search for etiological information, and to assist in the planning of future health care services. Never combined before this study, the ECA used five methodological aspects: 1) “emphasis on specific diagnoses, 2) the integration of community surveys with institutional surveys, 3) the collection of prevalence as well as incidence data, 4) the systematic linkage of service utilization data with other epidemiologic variables, and 5) the multisite comparative-collaborate aspect” (Eaton, Regier, Locke, & Taube, 1981, p. 319). Diagnoses were based on DSM-III criteria for mental disorders.

From the 18,571 household and 2,290 institutional residents aged 18 and older, one-year prevalence for any DIS disorder was 21.7%, meaning that one out of five people 18 and older suffered from a diagnosable mental disorder in that year (Bourdon, Rae, Locke, Narrow, & Regier, 1992). Lifetime prevalence was found to be 32.7% for one or more disorders. Lifetime
prevalence for two or more disorders was 11.3%, and, for three or more disorders, 4.7%. Men were found to have higher rates of substance use disorders and antisocial personality disorder, whereas women had higher rates of affective, anxiety, and somatization disorders. Equal rates for men and women were reported for schizophrenia and manic episodes. Fewer adults than expected ever sought outpatient and/or inpatient services for mental health reasons. Co-morbid adults were more likely to seek these services compared to those suffering from one disorder alone. See Table 1 below.

Table 1

Percentages of Adults Aged 18 and Older Who Used Outpatient and Inpatient Services for Mental Health Reasons, by Number of Disorders

<table>
<thead>
<tr>
<th>Services</th>
<th>No disorder</th>
<th>1 disorder</th>
<th>2 or more disorders</th>
</tr>
</thead>
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<tr>
<td>Outpatient mental health or general medical in past 6 months</td>
<td>4.6</td>
<td>13.7</td>
<td>29.1</td>
</tr>
<tr>
<td>Inpatient hospitalization in past year</td>
<td>0.4</td>
<td>1.4</td>
<td>7.5</td>
</tr>
<tr>
<td>Any outpatient or inpatient services</td>
<td>4.7</td>
<td>13.9</td>
<td>30.8</td>
</tr>
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*Note. Adapted from Bourdon, Rae, Locke, Narrow, & Regier, 1992.*

National Comorbidity Survey (NCS)

The National Comorbidity Survey (NCS) was mandated by Congress and was conducted from 1990-1992 using DSM-III-R diagnostic criteria to study the prevalence of mental disorders
and the subsequent services used. Over 8,000 people, ages 15 to 54 years, in 48 states responded to the household survey. Respondents were asked questions from a revised version of the World Health Organization’s Composite International Diagnostic Interview (CIDI) by trained lay interviewers. Results show that almost half of those who responded had a lifetime prevalence for at least one disorder (Kessler, McGonagle, Zhao, Nelson, Hughes, Eshleman, Wittchen, & Kendler, 1994). Almost 30 percent reported a disorder in the past year. Those who were highly co-morbid (having three or more disorders) made up over half of all lifetime disorders and were in the majority of those who suffered severely. Less than 40 percent of those with lifetime prevalence for any disorder had ever received professional treatment. Women had higher rates of affective and anxiety disorders, whereas men were found to have higher rates of substance use disorders and antisocial personality disorder. Prevalence of most disorders declined with both age and higher socioeconomic status. The NCS was revised and replicated from 2001-2003 (Kessler, Chiu, Demler, & Walters, 2005).

**Current Epidemiology**

The Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute of Mental Health (NIMH), both branches of the U.S. Department of Health and Human Services, have the most current data regarding mental disorders in America.

**Adults.** SAMHSA’s 2007 National Survey on Drug Use & Health (NSDUH) used the K6 Scale, a set of likert-item questions related to six symptoms associated with psychological distress, to screen for mental illness on a national level (Substance Abuse and Mental Health Services Administration, Office of Applied Studies, 2008). The K6 tool, like other psychological
tools to evaluate mental illness on a broad scale (Poulin, Lemoine, Poirier, & Lambert, 2005), though not a diagnostic tool, has been shown to be associated with serious mental illness (Swartz, 2008). It has been shown to be an excellent screening instrument, especially due to the low burden it places on respondents (Cairney, Vedhuizen, Wade, Kurdyak, & Streiner, 2007) and due to its psychometric properties (Kessler, Andrew, Colpe, Hiripi, Mroczek, Normand, Walters, & Zaslavsky, 2002).

The survey revealed 10.9 percent of adults (24.3 million) experienced serious psychological distress (SPD; having a score of 13 or higher on the K6 scale) in the year prior to time of assessment. Rates for 2004 and 2006 were 12.2 percent and 11.3 percent, respectively. For percentages of adults with SPD by age group, see Table 2, below. As the table shows, rates of SPD varied by age category; those in the youngest age group (ages 18 to 25) were found to have the highest rate of SPD, while those above 50 had the lowest rate.

Of those who experienced SPD in the previous year, 44.6 percent (10.8 million) received mental health services during the same year. There is a negative correlation between age and the likelihood that one with SPD received mental health services. That is, even though young adults ages 18 to 25 had the largest percentage of adults with SPD, they were less likely to receive mental health services compared to those ages 26 to 49 and 50 or above. See Table 2.
### Table 2

Percentages of Adults with Past Year Serious Psychological Distress Who Received Mental Health Services in the Past Year, by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
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<th>Percent with Past Year Serious Psychological Distress Who Received Mental Health Services</th>
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<tr>
<td>18 to 25</td>
<td>17.9%</td>
<td>29.4%</td>
</tr>
<tr>
<td>26 to 49</td>
<td>12.2%</td>
<td>47.2%</td>
</tr>
<tr>
<td>50 or older</td>
<td>7.0%</td>
<td>53.8%</td>
</tr>
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*Note. Source is SAMHSA, 2007 NSDUH.*

Of those with SPD who received mental health services, 34.6 percent received prescription medication only, 43.3 percent received prescription medication and outpatient services, and 6.9 percent received prescription medication, outpatient services, and inpatient services. Rates of SPD were associated with levels of previous year substance abuse or dependence. Among all adults with SPD, 22.1 percent (5.4 million) were dependent on or abused illicit drugs or alcohol (those without SPD had a rate of 7.6 percent). Of those with SPD and substance abuse or dependence, 46.5 percent received mental health care or specialty substance abuse treatment. This was the breakdown of treatment for co-occurring disorders: 10.4 percent received both types of service, 33.3 percent received mental health care only, and 2.8 percent received specialty substance abuse treatment only.
Seven and a half percent (16.5 million) of respondents experienced one or more Major Depressive Episode(s) (MDE) in the previous year. Of those, 64.5 percent received some form of treatment, which was lower than the 2006 rate of 69.1 percent. Those who experienced an MDE were more likely than their counterparts to be dependent on or abuse illicit drugs (8.8 versus 2.1 percent) or alcohol (17.0 versus 7.0 percent).

When asked if their mental health needs were being met by the available resources, 4.9 percent (10.9 million) of adults responded that they had an unmet need for mental health care in the past year. An unmet need included: not receiving any care at all, a delay in care, or a perceived lack of care. Several barriers to care were also reported in the study (See Figure 1). The study concluded that new strategies were needed to engage and treat those who suffer from mental health problems.
Figure 1

Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with an Unmet Need for Mental Health Care Who Did Not Receive Mental Health Services, 2007

- Could Not Afford Cost: 43.2%
- Could Handle Problem without Treatment at the Time: 29.3%
- Did Not Know Where to Go for Services: 18.1%
- Did Not Have Time: 16.7%
- Health Insurance Did Not Cover Enough Treatment: 11.3%
- Concerned about Confidentiality: 11.1%
- Did Not Feel Need for Treatment: 9.6%
- Treatment Would Not Help: 9.3%
- Might Cause Neighbors/Community to Have Negative Opinion: 8.7%
- Might Have Negative Effect on Job: 8.6%

*Note: Figure is from SAMHSA, 2007 NSDUH.*
The National Institute of Mental Health (NIMH) has recently estimated that 26.2 percent of American adults suffer from a diagnosable mental disorder yearly (National Institute of Mental Health, 2008). About 6 percent are estimated to have a serious mental illness. Many (45 percent) who suffer from a serious mental illness have co-morbid disorders. Out of all of the disorders, anxiety disorders are the most common, affecting 18.1 percent (approximately 40 million) American adults in any given year. Anxiety disorders have been estimated to cost $63 billion a year in direct and indirect costs, including things such as decreased productivity, lost jobs or wages, missing work, suicide, and disruptions in social networks (Langlieb & Kahn, 2005). Anxiety disorders often co-occur with depressive disorders and/or substance abuse. Mood disorders affect 9.5 percent (around 20.9 million) American adults in a given year, and are estimated to cost $83 billion a year (Langlieb & Kahn, 2005). About 1.1 percent of the population is afflicted with schizophrenia, which affects men and women equally. Attention Deficit Hyperactivity Disorder is estimated to affect 4.1 percent of adults in any one year.

Children. The prevalence of childhood mental disorders is not as well documented as for adults. With that said, it is estimated that about 20 percent of children have symptoms of DSM-IV mental disorders with mild impairment. Five to nine percent of children ages 9 to 17 have Serious Emotional Disturbance (SED), a legal term describing severe impairment due to a mental disorder (U.S. Public Health Service, 2001). Mental health problems in children are seen across all social classes; however, children who suffer from physical problems, intellectual disabilities, low birth weight, poverty, abuse or neglect, or a family history of disorders are at greater risk of developing a mental health disorder (U.S. Public Health Service, 2001).

Autism, which is four times more common in males than females, has a prevalence of 3.4 cases per 1,000 children (National Institute of Mental Health, 2008). When girls have autism,
they disproportionately suffer more severe symptoms and greater cognitive impairment (National Institute of Mental Health, 2008). Attention Deficit Hyperactivity Disorder (ADHD) has a median age of onset of 7 years and can persist into adulthood. ADHD is one of the most common mental disorders diagnosed in children and teenagers (National Institute of Mental Health, 2008).

In 2007, 8.2 percent of youth ages 12 to 17 had a major depressive episode (MDE; not to be confused with major depression). Five and a half percent of this age group had MDE with severe impairment in at least one role domain (SAMHSA, 2008). Adolescent females had more than twice the rate of MDE in 2007 compared to adolescent males (11.9 versus 4.6 percent). Adolescent females were also more likely than adolescent males to experience MDE with severe impairment (8.2 versus 3.0 percent; SAMHSA, 2008). Adolescents who experienced MDE in the previous year were more likely than their counterparts to use illicit drugs (35.5 versus 17.2 percent; SAMHSA, 2008). Of the adolescents suffering from MDE, 38.9 percent received treatment for depression. This is the breakdown of treatment for this group: 20.5 percent saw a medical doctor or other professional only, 2.5 percent used prescription medication only, and 15.6 percent received both types of treatment. In 2007, 12.5 percent of youth ages 12 to 17 received treatment for behavioral or emotional problems in a mental health setting; 11.5 percent received services in the educational setting; and 2.8 percent received services in the general medical setting; and 5.1 percent of youths received care in multiple settings (SAMHSA, 2008).

Racial-ethnic Differences. Mental disorders are present in all groups of people, regardless of race or ethnicity (U.S. Public Health Service, 2001). That is, actual rates of mental illness are similar for racial minority and majority groups; however, minorities are oftentimes over-diagnosed, especially with regard to more serious disorders. What is different between groups is the environment of inequality that persists in our communities. Racial and ethnic minorities face
a complicated set of issues, such as greater exposure to racism, discrimination, violence, and poverty (U.S. Public Health Service, 2001). In fact, living in poverty has the greatest observable impact on mental health: Groups in the lowest level of income, education, and occupation are two to three times more likely to suffer from a mental disorder than those in the highest level (U.S. Public Health Service, 2001). When one controls for the socioeconomic status of all racial-ethnic groups, rate differences disappear.

Mental illness symptoms are expressed in various ways depending on one’s cultural background, and this culture influences the type of services sought for treatment. Cultural misunderstandings or communication barriers prevent minorities from seeking and receiving proper care (U.S. Public Health Service, 2001). Although stigma of mental illness and substance abuse is greater than stigma for any other condition (Mechanic, Schlesinger, & McAlpine, 1995), the stigma around mental illness in minority groups is greater than attitudes held by whites, which discourages treatment (U.S. Public Health Service, 2001). Mistrust of clinicians is also another factor that could prevent minorities from seeking care (U.S. Public Health Service, 2001). These barriers prevent minorities from seeking care until problems are very severe (U.S. Public Health Service, 2001). This becomes evident when African Americans’ overrepresentation in inpatient psychiatric care is observed: their rate of utilization is practically double that of whites (U.S. Public Health Service, 2001). Also, it has been observed that African Americans are more likely than whites to use the emergency room for mental health problems, perhaps an extension of African Americans’ reliance on the emergency room for general health problems which is linked to poverty. This is also due to a scarcity of health care providers in minority communities or lack of insurance coverage for this racial group (U.S. Public Health Service, 2001).
Asian Americans, as a group, are distinguished from other groups due to their lack of seeking out mental health care in specialty settings. This group is less likely than African Americans, Hispanic Americans, and whites to seek care: Asian Americans are a quarter as likely as whites, and half as likely as African Americans and Hispanics, to seek outpatient specialty care, and are less likely to receive inpatient care (U.S. Public Health Service, 2001). There are many possible reasons for this: stigma within the culture, limited proficiency in the English language for some recent immigrants, different cultural explanations for mental illness, and the difficulty in locating culturally competent services (U.S. Public Health Service, 2001).

Several epidemiologic studies have found that Hispanic Americans’ rates of mental illness are comparable to those of whites in America. The prevalence of specific mental health problems, how symptoms manifest themselves, and help-seeking behaviors among the subgroups of this population needs further research. For example, multiple studies have shown that Mexican American and Puerto Rican women with symptoms of depression are underrepresented in mental health specialty care, but overrepresented in general medical care (U.S. Public Health Service, 2001).

Native Americans have not been studied as much as other groups in relation to mental health. However, it is known that depression is a problem for many Native American communities. Rates have been shown to be notably higher than the general population in epidemiologic studies. Alcohol dependence and abuse has also surfaced as an issue faced by this group: Rates are about twice the rates seen in the general population. Related, suicide also occurs at abnormally high levels. Post-traumatic stress is more prevalent in this group compared to whites. Native Americans are overrepresented in inpatient care compared to whites.
Gender Differences. Results from the 2007 NSDUH study reveal that women have a higher prevalence of Serious Psychological Distress (SPD) compared to men (13.4 percent versus 8.2 percent; SAMHSA, 2008). Major Depressive Disorder is found in women more often than men, and is the leading cause of disability in the U.S. for those ages 15 to 44 (National Institute of Mental Health, 2008). Major Depressive Disorder affects 6.7 percent (14.8 million) American adults in any given year (National Institute of Mental Health, 2008). Among adults who experienced a Major Depressive Episode (MDE) in 2007, women were more likely than men to receive treatment for depression (68.0 versus 57.8 percent, respectively), though this rate for women was lower than the 2006 rate of 73.7 percent (SAMHSA, 2008).

Schizophrenia affects both males and females in equal numbers, although the age of onset for women is generally later than for men (National Institute of Mental Health, 2008). Females are more likely than males to harbor an eating disorder, which include Anorexia Nervosa, Bulimia Nervosa, and binge-eating disorder (National Institute of Mental Health, 2008). Females account for 90 percent of all eating disorders, which have the highest mortality rate of all mental health disorders (Keel & Herzog, 2004). Autism is four times more common in males than in females (National Institute of Mental Health, 2008).

Mental Health Services

A number of services have been developed and are available to address the needs of those suffering from mental illness. These services fall into three main types: traditional services, consumer-driven services, and community-based support. Historically, traditional care was the primary type of care provided between 1880 and 1950, signified by the marked increase in the
number of asylums and granting of bare necessities to patients in these settings. Failures of asylum care (e.g., ill treatment, isolation, loss of life skills, and the high cost) lead to deinstitutionalization (Fakhourya & Priebea, 2007). Community-based services followed, with a range of services provided to clients within community settings. Balanced care, which blends community treatment with sometimes-necessary hospital treatment, is the preferred approach to mental illness today.

**Traditional Mental Health Services**

Traditional mental health service was the main type of care provided to patients before the recovery movement in the 1960s. Those suffering from mental illness often were treated long-term in a hospital or asylum setting, and the medical model, which limits patient input, was the basis for treatment (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). See Table 3 for more on the medical model. Today, traditional mental health services are oftentimes provided by psychiatrists, therapists, psychologists, nurses, mental health counselors, and others who have been trained and licensed to work with the mentally ill population in an inpatient or hospital setting. Traditional mental health agencies include psychiatric hospitals, private clinics, and family service agencies. These mental health organizations provide a range of services, including: partial hospitalization, inpatient care, 24-hour emergency service, consultation, and pharmacological, psychological, and social interventions (Thornicroft & Tansella, 2003). Types of therapy can range from behavioral, cognitive, and biomedical therapies to psychodynamic, group, interpersonal, and electroconvulsive therapies (SAMHSA, 2003). If
traditional medical care is provided off campus – such as in a clinic – it should be easily accessible to the population being served.

There is no research that supports the idea that a hospital-only approach is preferable for those suffering from mental illness, but hospitals can provide an important role if community services are unsuccessful for an individual (Thornicroft & Tansella, 2003). For example, those who require immediate assistance, urgent medical care, and/or suffer from severe conditions, disturbances, or tendencies need to have accessible and available acute or long-term inpatient care/hospitalization. With that in mind, there are available alternatives to acute and long-term inpatient care. Acute day hospitals provide day treatment for those with severe psychiatric problems and have been shown to be an appropriate alternative for 25%-33% of individuals who would have been admitted to a hospital. Day hospitals have the added benefits of faster improvement and are less expensive than acute care. Crisis homes are staffed by mental health care professionals and provide housing in a community setting for otherwise-admitted patients. Home treatment and crisis resolution teams assess individuals during a crisis and then provide tailored intensive treatment at the individual’s home to reduce hospital admission. Residential care, which can be provided just during the daytime, around the clock, or with reduced levels of staff support, is a type of community care used to reduce long-term psychiatric hospitalization (Thornicroft & Tansella, 2003).

Because of the various types of treatment modalities, the World Health Organization supports a balanced-care approach to mental health, where hospital-based services, consumer-run services, and community-based services are combined to provide comprehensive care, stating that neither type of service alone can provide the complete care individuals need (Thornicroft & Tansella, 2003). For the balanced-care approach to be effective, hospital stay should be as brief
as possible, organized immediately when the problem arises, and used only when necessary (Thornicroft & Tansella, 2003). For this balanced-care approach to work, organizations in all sectors of the mental health field (public, non-profit, and for-profit) need to be aligned and in constant communication with one another.

**Consumer-based Mental Health Services**

Consumer-based services were originally seen as complementary to traditional mental health services. Until the mid-1900s, traditional mental health services were the main type of care provided for those suffering with mental illness. Even though overcrowding and unsanitary conditions were a major problem in asylums (Fakhourya & Priebea, 2007), it wasn't until the 1950s that a shift in treatment actually occurred. New medications were introduced and accepted as a treatment option, and their use became widespread, allowing many individuals to function in a community setting instead of an asylum (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). The 1960s and 1970s were a time of civil rights advocacy, which further aided the recovery movement. President Kennedy’s sister, Rosemary, suffered from a mental disability, perhaps influencing his support of federal policies in the treatment of those with mental illness (Stroman, 2003). Due to the combination of: criticisms of public mental hospitals, the role of new medications, the federal government’s shifted responsibility for mental health care costs (as opposed to the state’s), and President Kennedy’s support for mental health research, the shift to consumer- and community-based mental health care was the most logical approach at the time (Stroman, 2003).
Today, consumer-based services advocate for individuals to live in the least restrictive environment and participate as an active consumer in the mental health treatment process. It allows people to live in their communities and receive care close to home. The importance of consumer-based services in aiding in the recovery of those with mental illness has been well-recognized by the government: In 2002, President Bush established the New Freedom Commission on Mental Health, stating that Americans deserve excellent mental health care. The Commission urged that government authorities must encourage consumers and families to participate in their treatment and recovery from mental illness: “The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority. Consumers and families… have a key role in expanding the mental health care delivery workforce and creating a system that focuses on recovery. Consequently, consumers should be involved in a variety of appropriate service and support settings” (President’s New Freedom Commission on Mental Health, 2003, p.37).

Consumer-based recovery services include such things as: self-help groups, consumer-run organizations, peer support, and employment services (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). Self-help groups are support groups made up of those suffering from a specified illness or addiction. Some self-help groups follow specified models of support, whereas the organization of other groups is left to the decision of its members. Technically, self-help group members all share the same condition or concern and are self-run, whereas groups that are facilitated by a professional are termed support groups, which are often linked to a specific agency (Kurtz, 1997). There should be respect between professionals and those who participate in self-help groups, with both groups realizing how beneficial the other can be. There is a saying in self-help groups which demonstrates the
complementary nature between consumer-based and professional mental health care: “Doctors know better than we do how a sickness can be treated. We know better than doctors how sick people can be treated as humans” (Moeller, 1999).

Consumer-run organizations (CROs) are nonprofit organizations that are run entirely by and for mental health consumers. CROs are also known as self-help agencies (Segal & Silverman, 2002) or consumer-run drop-in centers (Mowbray, Robinson, & Holter, 2002). CROs provide a host of services, ranging from skills development and hosting support groups to operating a drop-in center and/or providing education and public awareness, but, above all, CROs are mainly focused on building relationships among their members with mental illness. A national survey conducted in 2006 discovered that there are a large number of community-based consumer-run services (Goldstrom, Campbell, Rogers, Lambert, Blacklow, Henderson, & Manderscheid, 2006). Results showed that, in 2002, there were 7,467 groups, organizations, and services run by and for those with mental illness. In contrast, there were 4,546 traditional mental health organizations in 2000 (Miller, 2008).

Peer support is another type of consumer-based service. Peer support services are oftentimes provided at CROs, but can also occur outside of CROs because peer support, in general, is about sharing one’s experiences with someone who has insight into that experience. There are, however, certified peer specialists, who obtain certification to serve as role models for other consumers as part of a continuum of available mental health services. They perform a wide range of tasks to help others recover from mental illness. Certified peer specialists share insights into how they recovered and reveal tools they used along the way as well as provide skill training in regard to symptom management (Reifer, 2003).
Those with mental illness oftentimes have a difficult time finding and securing employment. In fact, the President’s New Freedom Commission on Mental Health (2003) found a 90% unemployment rate among adults with serious mental illness – the worst unemployment rate of all disabilities. Many of the unemployed indicate that they want to work and could work with moderate assistance (President’s New Freedom Commission on Mental Health, 2003). Because of this, employment services are found and provided to mental health consumers in some community settings (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). Employment programs include services such as: resume preparation, benefits counseling, skills training and job coaching (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). An innovative community support program called Individual Placement and Support (IPS) is a model that emphasizes a “place and train” approach so that individuals are placed in a work setting with direct support rather than the traditional model which emphasizes training before placement (Thornicroft & Tansella, 2003; President’s New Freedom Commission on Mental Health, 2003). An assessment of the program revealed a 60-80% employment rate, demonstrating how effective such a program can be (Drake, Becker, Clark, & Mueser, 1999).

Unlike traditional mental health services, which operate from a medical model standpoint, consumer-driven services operate on the principle that people can help themselves and learn from others who have shared experiences (The National Mental Health Consumers’ Self-Help Clearinghouse, n.d.). Known as the “Recovery Model,” for mental health treatment, the ideology embraces the strengths of consumers and posits that they can and do recover from mental illness. Recovery is the process by which individuals with mental illness are able to participate as fully as possible in their communities (President’s New Freedom Commission on Mental Health, 2003). In the Recovery model, consumers are active participants in their
treatment regimen and take responsibility for recovery through education and advocacy (Reifer, 2003). To compare the medical and recovery models side-by-side, see Table 3.

**Table 3**

A Comparison of Mental Health Treatment Approaches: The Medical and Recovery Models

<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Recovery Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Established Practices:</td>
<td>Emerging Practices:</td>
</tr>
<tr>
<td>Harsh restraint methods</td>
<td>Consumer and family education</td>
</tr>
<tr>
<td>Sheltered workshops</td>
<td>Consumer-run initiatives</td>
</tr>
<tr>
<td>Long-term hospitalization</td>
<td>Community-based care</td>
</tr>
<tr>
<td>Massive doses of medications</td>
<td>Medication to suit the individual</td>
</tr>
<tr>
<td>Staff-directed treatment</td>
<td>Consumer participation in treatment</td>
</tr>
<tr>
<td></td>
<td>Self-help groups</td>
</tr>
<tr>
<td>Established Task:</td>
<td>Emerging Task:</td>
</tr>
<tr>
<td>Stabilization</td>
<td>Education</td>
</tr>
<tr>
<td>Custodial care</td>
<td>Involvement</td>
</tr>
<tr>
<td>Established Beliefs:</td>
<td>Emerging Beliefs:</td>
</tr>
<tr>
<td>Will never be able to function in society</td>
<td>Can function well in society with supports</td>
</tr>
<tr>
<td>Impaired judgment &amp; can’t trust thinking</td>
<td>Can make a positive contribution to society</td>
</tr>
<tr>
<td>Has something wrong with them that someone else needs to fix</td>
<td>Can learn ways to cope with symptoms</td>
</tr>
<tr>
<td>Do not understand their own needs</td>
<td>Can use experience of mental illness as a source of knowledge</td>
</tr>
<tr>
<td>Will not recover</td>
<td>Can learn from and teach other consumers</td>
</tr>
<tr>
<td>Established responsibility of provider:</td>
<td>Emerging responsibility of provider:</td>
</tr>
<tr>
<td>Will provide appropriate custodial care based on staff wisdom and input</td>
<td>Provide an environment that is based on consumer wisdom and input</td>
</tr>
<tr>
<td>Established responsibility of consumer:</td>
<td>Emerging responsibility of consumer:</td>
</tr>
<tr>
<td>Be obedient and learn to comply</td>
<td>Self-advocacy and dialogue with the system about what is and is not helpful</td>
</tr>
<tr>
<td></td>
<td>Take responsibility for one’s own recovery</td>
</tr>
<tr>
<td></td>
<td>Use self-help</td>
</tr>
</tbody>
</table>

*Note: Source of table is Reifer, 2003.*
Recipients of consumer-driven services do not seek to abolish traditional care, but, rather, to gain knowledge about the system and learn to operate within the system in order to receive the best care possible. Consumer-based services can be empowering for participants, especially if participants are engaged and attend regularly (Rogers, Teague, Lichenstein, Campbell, Lyass, Chen, & Banks, 2007). Also, community-based services can reduce the probability of 30-day re-hospitalizations over time and can also reduce length of stay in hospitals (Hyun, Nawka, Hang, Hu, & Bloom, 2008).

Cost-effectiveness studies show that quality of service provided in the community settings is positively correlated with amount of spending, and services provided in the community, generally, can cost about as much as services provided in a hospital setting (Thornicroft & Tansella, 2003); however, allowing an individual to function in the community as fully as possible, as opposed to in a hospital, has immeasurable benefits to a person’s well-being.

Nonprofit Community-based Care

The third main type of service for those with mental illness is community-based care, oftentimes provided by nonprofits. The public and nonprofit sectors are intertwined and mutually dependent: nonprofits receive revenue and other assistance from the government to create and implement programs, and the government relies on nonprofits to deliver social services to citizens; hence, they rely on each other for resources (Saidel, 1991; Smith & Lipsky, 1993). Nonprofits play critical roles in aiding their service recipients, and they primarily exist to serve their consumers’ well-being (Ben-Ner, 2006). Unlike the business sector, nonprofits are mission-driven rather than profit-driven (Cryer, 2008). There is great diversity in the target populations of
nonprofit care. Not only do nonprofits serve runaway youth, serve as shelters for the battered, provide child welfare, serve educational and religious purposes, and serve a political function, they also attempt to alleviate the suffering caused by mental illness and other social problems (Smith & Lipsky, 1993). While nonprofits do rely on volunteers and charity for their revenues, over half of the revenue for most nonprofits comes from government support. For example, in 1988, mental health agencies affiliated with a local United Way of America chapter received 64 percent of their income from the government (Smith & Lipsky, 1993). When a nonprofit has multiple sources of income, including government aid, it must adhere fully to the government’s contractual requirements in providing services, even if the government aid covers only part of the program. Also, the boom in the number of nonprofit agencies has led to stiff competition among agencies for grants from foundations and private donations (Smith & Lipsky, 1993).

The government, or public sector, has always been actively involved in aiding those with mental illness, often providing services directly or in partnership with nonprofits. As mentioned previously, in the mid-1800s, state-run hospitals were responsible for the care of chronically mentally ill patients. In the 1960s, community mental health centers (CMHCs) were first established under a federal initiative to provide care. These CMHCs were a basic form of managed care because they provided services within a budget to a subset of the population. Ever since deinstitutionalization, there has been a trend to move mental health services to the community. The ensuing cost-shifting to patients, families, professionals, and the community can be hard to bear (Mechanic, Schlesinger, & McAlpine, 1995). Most mental health services today fall under a managed care approach, which means treatment decisions are determined by an organization, not the individual receiving care. There are three types of managed care approaches: prepaid health plans, utilization management, or high-cost management (Mechanic,
Schlesinger, & McAlpine, 1995). With prepaid health plans, the cost of care is lower, partly due to reduced hospitalization and by using less intense outpatient services. Cost savings with utilization management approach are due to a reduced number of hospitalizations, especially for groups that had previously incurred a lot of cost before having this type of plan. In some cases, it makes more sense to use a managed care approach instead of unjustifiably expensive treatments. Quality of care, a complicated and ever-changing concept, is something that needs to be monitored continuously when using these approaches (Mechanic, Schlesinger, & McAlpine, 1995).

Many nonprofit agencies exist to serve underprivileged groups or society in general. The individuals who receive assistance from nonprofits are oftentimes individuals who live in an unstable environment, are transient, have multiple chronic health conditions (MCC), and/or are on public support. This is truly a poor and ill group that is supported by the nonprofit and public sectors.

For example, Leventhal and Brooks-Gunn (2003) used a randomized controlled design in New York City to show that there is a link between the type of neighborhood dwelling in which one lives and mental health outcomes. In their experiment, baseline mental and health measures were collected, and then a randomized group of families living in public-assisted housing in poverty-stricken neighborhoods received special assistance to move into private housing in near-poor or non-poor neighborhoods. Three years later, mental health outcomes of this group were compared to the subgroup of families who had remained in public housing. Significantly less distress and anxious/depressive symptoms were found three years later in the group that had been living in low-poverty neighborhoods. The experimental group received not only publicly-funded Section 8 housing vouchers, but also special assistance that was made possible by local nonprofit
organizations. Assistance included help with locating units, help with overcoming obstacles to obtaining housing in low-poverty areas, and assistance in working with landlords unfamiliar with Section 8 housing vouchers.

Calling attention to the mental health needs of the homeless population, Koegel, Sullivan, Burnam, Morton, & Wenzel (1999) analyzed data from interviews with 1,563 homeless individuals. The researchers hoped to gain prevalence of mental health and substance abuse problems and to attempt to predict mental health and substance abuse treatment among a community-based probability sample of homeless adults. Sixty-seven percent of interviewees reported chronic substance dependence (alcohol or drug), and twenty-two percent met criteria for chronic mental illness. Seventy-seven percent of those with chronic mental illness were also chronic substance abusers. Only twenty percent of those with chronic mental illness or substance abuse received treatment in the previous sixty days. Utilizing mental health services was predicted by need factors, such as diagnosis or acknowledgement of a mental health problem.

The U.S. Department of Health and Human Services (HHS) has over 50 current initiatives focusing on the improvement of lives of those suffering from multiple chronic conditions (MCC). One of these conditions is mental health, and others include arthritis, diabetes, hypertension, and heart conditions. It is estimated that 75 million Americans suffer from two or more concurrent chronic conditions, while 145 million – almost half of the population – suffer from one chronic condition (Anderson, 2010). Six percent of all females and four percent of all males have five or more chronic conditions (Anderson, 2010). Conditions are classified as chronic when they last a year or more, require constant medical attention, and/or limit daily functioning. MCCs can have many adverse outcomes if left untreated and place great burden on physicians, the service delivery system, and the community at large. A staggering 85
percent of all health care money in the US is spent on individuals with chronic health conditions. Many collaborative efforts are in place among public agencies and nonprofits to coordinate efforts at addressing these chronic health conditions that affect so many people and with great cost to society.

As mentioned previously, the nonprofit sector includes many varied types of agencies, one of which is mental health organizations. Mental health nonprofits exist to ease the suffering associated with living with a mental illness. Some nonprofit organizations serve only one purpose, while others serve multiple aims. The same is true with regard to mental health nonprofits. Some, such as community mental health centers or mental health associations, serve only those suffering from mental illness. Many more mental health nonprofits serve mental health consumers along with other functions (e.g., housing, domestic violence, and child maltreatment).

Mental health organizations’ service to the poor can be broken into two types of care: in-patient and out-patient, as well as the three types of facilities – the three main sectors: for-profit (business), nonprofit (private/voluntary), and government (public). In the case of the proportion of poor being served by mental health organizations, the proportion of poor in the inpatient category in for-profit facilities is 6.7%, compared with 38.6% in nonprofit facilities and 62.8% in public facilities. The outpatient category is quite different, where the proportion of poor is 76.5% in for-profit facilities, 56.0% in nonprofit facilities, and 74.0% in public facilities (Ben-Nur, 1994). See Table 4. It is customary for patients in the nonprofit facilities to be referred to other programs when the limits on their Medicaid coverage are attained (Ben-Nur, 1994).
Table 4

Proportion of Poor Clientele Served by Mental Health Organizations in the Three Sectors: For-profit, Nonprofit, and Public

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Category</th>
<th>Outpatient Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>For-profit facilities</td>
<td>6.7%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Nonprofit facilities</td>
<td>38.6%</td>
<td>56.0%</td>
</tr>
<tr>
<td>Public facilities</td>
<td>62.8%</td>
<td>74.0%</td>
</tr>
</tbody>
</table>

There is also a connection between source of funding and target of aid: the more government and United Way funding provided to a nonprofit, the more likely it is to serve poor clientele versus nonprofits that receive less government funding (Ben-Nur, 1994). Ben-Nur (1994) suggests that policies be aligned such that a certain portion of nonprofit revenues be made to serve pro-poor activities so that more charitable activities exist within the nonprofit realm, along with their already-existing ability to fill a niche where businesses and the government can’t.

Serving the poor is not always as easy as it seems, depending on the reaction of those needing aid. When welfare reform was passed in 1996 (Personal Responsibility and Work Opportunity Reconciliation Act; PRWORA), it shifted responsibility for needy families from the federal government to states. The assumption was that local private nonprofits and governmental entities would provide aid to the needy. This shift to relying more on private nonprofits perhaps didn’t take into account how the poor react to receiving aid from nonprofits. It has been shown that decisions to use public aid versus private help is impacted by stigma, information, practical
impediments (e.g., hours of operation, ability to travel), and perceived need (Kissane, 2003). In fact, oftentimes, the poor are likely to seek out friends and family for help in lieu of nonprofit aid (Kissane, 2003). Lack of information was one of the main reasons given for using public help instead of private aid. Those interviewed in Kissane’s (2003) study said they didn’t know where to go to obtain nonprofit help, even though agencies existed within a few blocks of most interviewees. Even though some interviewees had extensive social networks, it didn’t predict their knowledge of nonprofits, which seems counterintuitive, but those with large social networks could rely on those connections for in-kind support (instead of information) – a safety net of sorts.

The stigma of receiving aid prevented discussion of nonprofits among friends and family at times (Kissane, 2003). For example, one interviewee said she felt comfortable sharing information about a parenting support group she liked, but not about the housing, food, job, and energy assistance she knew about or received. Some refused nonprofit aid, saying welfare was an entitlement, whereas nonprofit use was charity. Along with stigma, some feared for their safety in the nonprofit’s location, some cited time constraints, and others admitted they didn’t like how they were treated by a nonprofit in the past, all of which could not compensate for the amount of aid received by the nonprofit. All of these explanations given by the interviewees align with Lester Salamon’s (1987) ideas about the four failures of the nonprofit sector: philanthropic insufficiency (inadequate resources to provide services), philanthropic particularism (tendency to target certain subgroups), philanthropic paternalism (those with resources define community needs), and philanthropic amateurism (insufficient approaches to solving problems).

Many of the agencies that responded to the foundation’s request for proposal to enhance their services fit into this broad description of community-based services for mental health.
These auxiliary services provide a wide range of assistance to the mentally ill, with advocacy for patient rights at the forefront of awareness.

One must keep in mind that regardless of treatment type, in order to benefit, patients have to obtain and follow treatment, which some shy away from due to the stigma surrounding mental illness. Public knowledge regarding mental disorders is lacking, and some people hold very negative beliefs about medication for disorders (Jorm, Angermeyer, & Katschnig, 2000). In fact, members of the public, as compared to clinicians, lack understanding regarding the proper treatments or origins of mental illness, which can have dire implications for patients who do not believe in the treatment plan given by their doctors (Jorm, 2000). Other barriers to treatment exist as well. The type of treatment that is available in any given community depends on the resources available. Thornicroft and Tansella (2003) state that communities with limited resources may be able to access care from a primary care health setting only, whereas highly-resourced areas could provide more differentiated and specialized treatment. As the President’s New Freedom Commission on Mental Health (2003) points out, even though much progress has been made in the area of mental health and recovery, there is still much work to do. As the Commission discusses in their report to the President, the mental health system as it stands today is fragmented and disconnected, often frustrating for those who have to navigate it. Disjointed policies and reforms have resulted in a piecemeal system, thus adding more burden and frustration to an already cumbersome system. Much is yet to be done in the area of mental health in order to fully provide easily-accessible and complete services to those who need it.
Loosely Coupled Systems of Care

Weick (1976) was one of the first researchers to discuss loosely coupled systems, stating that coupled events “are responsive, but that each event also preserves its own identity and some evidence of its physical or logical separateness” (p.3). In loosely coupled systems, elements affect each other “suddenly (rather than constantly), negligibly (rather than significantly), indirectly (rather than directly), and eventually (rather than immediately)” (Weick, 1982, p.380). Weick (1976) likened loosely coupled systems to educational organizations. To use educational imagery, Weick states that a counselor’s office is loosely coupled to a principal’s office in that the two are somehow attached, but each retains its own separateness and identity. Their attachment could be weak or unimportant, infrequent, or slow to respond. Loose coupling also carries the connotation of “impermanence, dissolvability, and tacitness (sic), all of which are potentially crucial properties of the “glue” that holds organizations together” (Weick, 1976, p.3). Weick is quick to state that loosely coupled systems can be advantageous or a liability, depending on potential functions associated with loose coupling.

For example, loose coupling might allow some portion(s) of an organization to persist, such as a tradition. Also, loose coupling could provide a “sensitive sensing mechanism” (Weick, 1976, p.6) in that loosely coupled systems know their environments better than more tightly coupled systems which have fewer external and independent elements. In a loosely coupled system, one element can be modified without affecting the entire system, such that a problem in one element of the system will not directly affect another element of the system because the stability within the system buffers it from outside influences (Orton & Weick, 1990; Weick, 1976). These systems can adapt quickly to an environment if needed, and if a breakdown occurs, it can be isolated such that other portions of the organization are unaffected. Individuals
participating in a loosely coupled system have a sense of efficacy and function with autonomy, which may be limited in a tightly coupled system. Lastly, these systems should cost less money and time because coordination takes much effort.

Loose coupling is difficult to “observe” unless one uses methodology that provides rich contextual detail (Weick, 1976). For example, if people are spending time in Activity A, they are not devoting time to Activity B. More likely to be noted, however, is that people are spending time doing Activity A, whereas lack of time spent on Activity B is not likely to be noted. The idea is that tight coupling in one activity (Activity A) precludes loose coupling in another activity (Activity B). Both exist in a system, but both are not equally observed. Hence, loose coupling can be thought of as the “glue” holding elements of organizations together. What makes an “organization” is “clusters of events that are tightly coupled within and loosely coupled between” (Weick, 1976, p.14). This works in organizations because everyone in the organization knows roughly what is going on.

In any given community, one can find a network of mental health services and organizations (including for-profit, non-profit, consumer-driven, and public services). Mental health-serving organizations within the community can be seen as loosely coupled systems because they are both determinate entities – searching for certainty – and indeterminate entities, realizing and expecting the unexpected and uncertain (Orton & Weick, 1990). The level of loose coupling in the system varies by number and strength of interdependence among the parts. Spontaneous changes might occur in one element while stability is evident in another part. In essence, in loosely coupled systems, an organization can operate on a technical level, which is closed to outside influence (producing stability), while concurrently operating on an institutional level, which is open to outside influences (producing flexibility; Oreck & Weick, 1990). This is
how the mental health-serving organizations in this study operate: operating with stability (distinctiveness) while still being open to outside forces (responsiveness). See Table 5.

Table 5

A Comparison of the Four Types of Systems

<table>
<thead>
<tr>
<th></th>
<th>Is Responsiveness Present?</th>
<th>Is Distinctiveness Present?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Noncoupled System</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tightly Coupled System</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Decoupled System</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Loosely Coupled System</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Note*. Created from Oreck & Weick, 1990.

This loosely coupled system of services for mental health may or may not be easy to navigate, but it does exist in most communities; however, with that said, there are still a lot of gaps in services provided. Also, it can be challenging for consumers and their families to know about or locate available resources; even the most skilled and persistent mental health case managers sometimes have great difficulty navigating an urban mental health system because, while pockets of collaboration between agencies do exist, typically, the system is not well-coordinated. While there are nonprofits that provide some of the same services, arguably, there is little to no duplication of services as the needs of consumers greatly outweigh the available services provided.
Because many of the organizations that were included in this study were community-based nonprofits, the next section on nonprofit organizational capacity gives a glimpse into the needs of nonprofits that serve the mentally ill population. Nonprofits, in order to best serve their clients, must be able to operate in a way that is efficient and best aligned with their missions.

Nonprofit Organizational Capacity

While communities increasingly turn to nonprofits to provide vital services, nonprofits, faced with decreased funding, are turning to strategies known to help achieve their missions in the most efficient manner. What makes a nonprofit effective, according to Grantmakers for Effective Organizations, is the “ability of an organization to fulfill its mission through a blend of sound management, strong governance, and a persistent rededication to achieving results” (Connolly, 2000, p.2). Organizational capacity building has been used for years to strengthen nonprofit organizations and increase their effectiveness in serving vulnerable populations. While it can be difficult to directly link capacity building with achieved outcomes, capacity building is key to high performance of nonprofits (Letts, Ryan, & Grossman, 1998). As Paul Light explains in his book, *Sustaining Nonprofit Performance: The Case for Capacity Building and the Evidence to Support It*, capacity building is important because “no matter where the organization might be in time and place, capacity building is a potentially high-yield, low-cost investment that can improve program success dramatically” (Light, 2004, p.174).

There are many definitions of capacity building because organizations are multidimensional, but, most simply, it is “building the capacity to fulfill an organization’s mission” (Jacobs, 2001, p.1). Capacity building entails modifying “some aspect of an
organization’s existing environment, internal structure, leadership, and management systems, which, in turn, should improve employees’ morale, expertise, productivity, efficiency, and so forth, which should strengthen an organization’s capacity to do its work, which should increase organizational performance” (Light, 2004, p46). It means that an organization will have the ability to deliver a program, expand it, and adapt to change as needed (Letts, Ryan, & Grossman, 1999). This is in contrast to a focus solely on building new programs or keeping administrative costs low; capacity building is aimed at strengthening the structure of an organization so that it can deliver effective programs to the community (Venture Philanthropy Partners, 2001). Hence, the focus is on the organization, which, when strengthened, in turn, will strengthen programs. Because programs always operate within the confines of an organization, great programs need great organizations in which to operate in order to succeed. Employees of nonprofits recognize the importance of capacity building for their organizations’ effectiveness, with roughly three-quarters of 1,140 survey respondents in 2001 indicating that capacity building involving strategic planning improves organizational outcomes (Jolley, Wituk, Gregory, Thomas, & Meissen, 2010).

Backer, Blag, and Groves (2004) performed an environmental scan to better understand who is doing nonprofit capacity building and what strategies are employed to build an organization’s capacity. The types of people and organizations who provide capacity building to nonprofits are broad and varied, including: intermediaries, foundations, academic centers, faith-based organizations, government, independent consultants, management support organizations, community-based nonprofits, and researchers. The researchers found that unexpected groups of people are emerging as providers of capacity building services as well, which include peer-to-peer networks (nonprofit managers providing capacity building services to one another), organizations that provide capacity building to rural areas, comprehensive capacity building
centers (organizations that provide multiple capacity building services in one location), and even individual philanthropists.

Generally, there are three types of capacity building services that are provided by capacity building providers (Backer, Blag, & Groves, 2004). Assessment is the first type, which is the process of using questions and/or tools to determine the needs and assets of an organization and determining whether the nonprofit is ready for capacity building. The assessment results inform future work with the organization, and as such, needs to be thorough and take into account the environment in which the organization operates. The second type of capacity building is technical assistance and organizational development consultation. Technical assistance can be offered in a workshop style format and is usually a hands-on process with staff. It is often aimed at shaping the organization’s direct operations, although it can include mechanical (installing new technology) or skill-building (training to use new technology to improve services) themes. Organizational development consultation is usually offered to staff or board members and usually involves self-examination and/or larger organizational themes. Direct financial support is the third type. This entails providing funds for such things as direct operating expenses or equipment purchase. Many capacity building activities stemmed from the inability of nonprofit organizations to achieve program objectives due to lack of capacity (Backer, Blag, & Groves, 2004).

More findings from the environmental scan (Backer, Blag, & Groves, 2004) included eleven approaches or strategies that are emerging and becoming mainstream in the capacity building field: (a) capacity building grant-making by individual philanthropists, (b) combining capacity building services with funding related capacity building purchases, (c) commercial vendors providing capacity building services, (d) promoting collaboration among service
providers to enhance capacity building, (e) offering capacity building through for-profit sector consulting firms oriented to the nonprofit market, (f) offering capacity building through academic nonprofit centers, (g) offering field-specific capacity building, (h) creating “second generation tools” for capacity building, (i) creating flexible, responsive funding for capacity building, (j) building capacity by changing the community environment, and (k) building capacity through organizationally focused coaching for nonprofit leaders (Backer, Blag, & Groves, 2004).

**Theoretical Framework for Nonprofit Organizational Capacity**

Any organization, large or small, can benefit from capacity building activities (Venture Philanthropy Partners, 2001). Ricket (2000) gives four basic steps to building organizational capacity: 1) “diagnosing what is missing or needed in the organization, 2) planning strategies to change the situation, 3) educating personnel to carry out change, and 4) evaluating results. As an organization engages in these activities it acquires new knowledge about organizational actions and outcomes. Organizational capacity expands when learning goes beyond solving a specific problem to gaining the skills and knowledge to solve future problems.” Of course, capacity building is not easy. It may or may not take much money to do capacity building, but it does take dedication from staff, and, oftentimes, it can be stressful for those involved (Light, 2004).

Connolly (2006) provides nonprofit organizations with a theoretical model so board members and executives can be proactive and informed about their organizations and anticipated growth and change. The Nonprofit Organizational Lifecycle Model includes multiple capacities that effective nonprofits possess, including physical resources, relationships, culture and
activities/services that the organization provides. It describes capacities that organizations should have to be effective in four different capacity areas: Adaptive, Leadership, Management, and Technical. The Nonprofit Organizational Lifecycle Model recognizes that nonprofit organizations each have a lifecycle, which includes five stages: start-up, adolescent, mature, stagnant, and defunct. A nonprofit can move back and forth between stages throughout its lifecycle, and each stage requires the right mix of the four capacities in order to function well and maintain the organization. The four capacities help the nonprofit move throughout the lifecycles and make smooth transitions between stages.

According to the Nonprofit Organizational Lifecycle Model (Connolly, 2006), there are four specific organizational proficiencies that high-performing nonprofits have in common: Adaptive, Leadership, Management, and Technical capacities. Using this model, it is possible to determine a nonprofit’s effectiveness along these four core organizational capacities, each described below:

*Adaptive Capacity.* Adaptive capacity is “the ability to monitor, assess, respond to, and create internal and external changes” (Connolly, 2006, p.6). It involves being inquisitive and constantly attuned to the organization’s surroundings so that the organization can quickly identify and adapt to changes, opportunities, and ideas. Adaptive nonprofits are always learning, improving, and continually expanding their capacity to achieve desired results. This involves being proactive, rather than reactive, to potential problems.

*Leadership Capacity.* Leadership capacity is the ability of all organizational leaders to create and sustain a vision, inspire, model, prioritize, make decisions, provide direction, and to innovate – all in order to achieve an organization’s mission (Connolly, 2006). An organization
needs good leadership in order to manage its work well and function in the long-term. Leadership and adaptive capacities are interrelated in that a leader needs knowledge about the organization and outside environment in order to perform well.

**Management Capacity.** Management capacity is the ability to use organizational resources effectively and efficiently (Connolly, 2006). It includes hiring, training, and assessing staff, as well as providing incentives for performance, solving internal problems and facilitating clear communication. An organization that has management capacity uses financial information to ensure that organizational decisions and financial resources are aligned with the organization’s mission. Management capacity depends on leadership capacity because leaders manage an organization’s functions; if leaders make poor decisions, it will negatively affect the organization’s management capacity.

**Technical Capacity.** Technical capacity involves performing key operational functions and providing programs and services (Connolly, 2006). It includes having the resources (e.g., skills, experience, knowledge, tools, facilities, and technology) needed to implement all programmatic, organizational, and community strategies. This capacity is more independent from the other three capacities. If an organization knows what it needs in order to perform well, but can’t deliver a desired performance, it would have poor technical capacity.

All of the four core capacities operate within an organizational culture, meaning each organization has a unique history, language, structure, and values that affect staff behaviors (TCC Group, 2009). When all four capacities are aligned with each other – that is, each capacity is at the strength appropriate to its lifecycle stage – the organization can perform well, being more centered in its overall strategic culture and enabled to achieve its mission (Connolly, 2006).
Out of the four core areas, adaptive and leadership capacities are the areas of greatest need for most nonprofits; however, most tend to focus on management and technical capacities (Connolly & York, 2003). Although it is possibly the least known of the four capacities, adaptive capacity is the most crucial capacity needing focus because nonprofits need to be resilient, innovative, and able to flexibly adjust to internal and external changes with ease (Connolly, 2006; Connolly & York, 2003). Adaptive capacity is also one of the three capacities identified by Letts, Ryan, and Grossman (1998) as essential for a high-performance nonprofit. Despite its high priority, oftentimes, adaptive capacity is not the center of attention during capacity building activities (Backer, Bleeg, & Groves, 2004, p39). This may be because adaptive work is difficult, oftentimes causing hidden conflicts to emerge (Heifetz & Linsky, 2002). Because of the tension that can sometimes surface when the status quo is challenged, leaders need to challenge people and ask difficult questions, but also realize when tension may be counterproductive and act with reassurance. Heifetz and Linsky (2002) propose that there is a productive range of distress within which adaptive work can occur. Too much uncertainty can cause distress, while not enough can cause complacency. In between the two is where adaptive challenge occurs.

Through an analysis of 684 nonprofit organizations that took the Core Capacity Assessment Tool (CCAT) – the assessment tool that is used by TCC Group to measure the four types of capacity – TCC Group found that the keys to nonprofit sustainability are: 1) financial and programmatic adaptability, 2) decisive, strategic, and accountable leadership, and 3) the resources to deliver core programs (York, n.d.). Using regression analysis, it was found that many nonprofit organizations are not financially sustainable. Twenty-eight percent of organizations found themselves to be “strong” in regard to organizational resource sustainability, whereas 42% rated themselves as “satisfactory” and 30% found themselves to be “challenged” in
trying to attain sustainability of resources. Organizations that have leaders who are mission-centered, focused, inspirational and motivational were significantly more sustainable than those without such leadership. Only about one-quarter of surveyed organizations scored highly in leadership categories. Fundraising and financial management might even predict whether an organization will be sustained (York, n.d.).

Best Practices in Organizational Capacity Building

Jacobs (2001) conducted a literature review and interviewed 38 expert providers of capacity building services to determine what separates average capacity building practices from exemplary capacity building practices. Nineteen interviews were conducted with recipients of the expert capacity building services as well. It was found that exceptional capacity building is not just a set of actions between an organization and provider, but, rather, it involves a quality relationship between the two and a competent provider who operates with a set of core principles. Expert providers of capacity building have the applicable knowledge to work with a specific organization and are continually learning and growing professionally. Expert providers should be able to refer clients to other experts when applicable and are proactive about seeking advice from clients about what they want out of the capacity building services. The following nine principles of capacity building were found to be indicative of successfully implemented services:

1. *Every organization is capable of building its own capacity.* Providers can work with organizations to achieve their goals, but, ultimately, the organization is in charge of building their own capacity.
2. *Trust between the organization and the provider is essential.* Trust between the two parties ensures open communication and progress.

3. *An organization must be ready for capacity-building.* Some qualities that might indicate readiness include: openness to change, clear description of organization’s mission, belief in capacity building’s potential, and a commitment of time and resources.

4. *Ongoing questioning means better answers.* Capacity building providers should use their skills to determine what organizations really need and, after encouraging feedback, apply those skills to the situation at hand. An environment of questioning should be encouraged.

5. *Team and peer learning are effective capacity-building tools.* When multiple people are involved in the process and learning from one another, it builds momentum that is necessary for change.

6. *Capacity-building should accommodate different learning styles.* Because people learn best in different ways, an effective provider will adapt to the needs of the group by using varied methods of communication and activities.

7. *Every organization has its own history and culture.* The better the provider understands the organization, the better the service given to the organization will be. The effective provider will truly listen, communicate, and understand the organization’s context before moving forward.

8. *All people and all parts of an organization are interrelated.* Any change that is to occur is more likely to be accepted if it involves members from all levels of the organization.

9. *Capacity-building takes time.* Capacity building is a process that occurs in stages and which, eventually, becomes ingrained in the organization’s work.
Barriers to Implementing Capacity Building

Even though research points to the beneficial results of capacity building efforts, many nonprofits neglect capacity building in favor of developing and implementing programs (Venture Philanthropy Partners, 2001). In some ways, it makes sense that nonprofits are program-focused. After all, nonprofits oftentimes begin with a motivated individual or group who promotes a new idea to address a social need. Also, capacity building involves a long-term commitment, and many nonprofits hope to achieve their missions in the near future. With the investment of time and money that is required for capacity building, many managers would prefer to put their resources toward programs instead. Various reasons why nonprofits choose not to implement capacity building initiatives in their organizations include:

- Programs are favored because of motivated individuals or pressing social issues in the community.
- Capacity-building can consume a lot of time, energy, and resources in the short-term.
- Nonprofits elevate programs, not “office work.”
- Planning for capacity building might distract from day-to-day work.
- External funding is often earmarked for program use, not capacity building expenditures.
- There is no shared approach that can be applied to every nonprofit.
- Establishing the link between capacity building and social impact has been difficult to capture (Venture Philanthropy Partners, 2001).

Financial cost is a primary reason why organizations choose not to implement capacity building services (Jacobs, 2001). Underlying beliefs and attitudes about capacity building has contributed to the lack of funding for capacity building (Jacobs, 2001). Some organizations cited
lack of access to capacity building as a reason why it was not used (Jacobs, 2001). Networks of providers can help alleviate the problems associated with access to capacity building services.

Environmental Scan Results

In 2004, an environmental scan was conducted in a large urban Midwestern city where the present study was also conducted. This environmental scan was conducted to identify the current health needs of the surrounding residents. Using local and state data in the scan, many trends were found, and among them was mental health as a serious health issue. The local mental health arena gradually had been receiving reduced funds, while, conversely, the demand for mental health services rose 20% in the past three years. State funding for one of the mental health centers, for example, had been cut 25%, and, in general, services aimed at children with mental health needs was particularly lacking. Three of the counties saw the number of children with serious emotional disturbances (SED) receiving care double between 2000 and 2002.

Results from public health reports and a focus group revealed that mental health, just behind high blood pressure and dental problems, was a major health concern for the area’s residents. The availability of mental health services, especially for children, was described as inadequate in meeting the needs of the region. Inadequate funding, lack of cultural competence, professional shortages, and the need for additional substance abuse treatment programs and inpatient mental health facilities were all described as areas on which to focus due to their great impact on the day-to-day lives of residents. Out of those areas, inadequate funding was found to have the most immediate impact on mental health due to the effects it has on other sectors, such
as emergency room visits, contact with law enforcement agencies, incarceration, homelessness, and public safety.

Foundation Defined Grants (FDGs) were awarded to address certain health priorities determined by the foundation. Because of the findings of the environmental scan in 2004, currently, there are three funding priorities of the foundation, one of which is mental health. The current study solely addresses this mental health arena and the organizations that received the foundation’s mental health funding in fiscal year 2007.

Current Study

The current study is an exploratory study focused on mental health, broadly defined, as part of a larger community assessment research project. The primary goals of this study are to determine how funding impacted the care provided by the mental health-serving organizations and also to identify promising practices of grantees.

Aim 1

To discover to what extent funding led to perceived enhancement of services provided by the funded mental health-serving organizations.

Aim 2

To assess promising practices and organizational capacity of grantees to impact mental health outcomes.
CHAPTER 2

METHODS

Participants

Not-for-profit Organizations

Fifty-two organizations had programs that were funded by a large, urban, and Midwestern grantmaking foundation during fiscal year 2007. All of the organizations were not-for-profit 501(c)(3) tax-exempt organizations, two of the organizations also were labeled civic and community organizations, and five were additionally categorized as education-based. Most (36) of the organizations had been established for over 20 years, 10 were less than 20 years old, 4 were less than 10 years, and 2 were less than 5 years old. Average amount of funding requested by each organization for the mental health projects was $167,065.87 (Median was $124,275.00, and the range was $25,500.00-$801,578.00). Average amount of funding provided to each organization was $134,663.42 (Median was $100,000.00, and the range was $25,500.00-$489,527.00). The average operating budget for the organizations was $21,178,852.73; however, 16 of the organizations had a budget of less than one million dollars, 28 organizations had budgets between one million and ten million dollars, and 8 organizations had budgets of over ten million dollars, with the highest organizational budget being over $465 million, and the lowest organizational budget at $13,000. The median budget was $2,580,030.00. Of those organizations that were funded, 34 organizations (65.4%) requested a 12-month grant period. Fourteen organizations (26.9%) requested a 24-month grant, and 3 (5.8%) requested a 36-month grant. One organization (1.9%) requested a 19-month grant. See Table 6 for financial information of each funded program.
All of the 52 organizations were located in the Greater Kansas City area, with the exception of one, which was located in Iola, KS. Twenty-two of the projects were conducted only in Missouri, 6 projects took place only in Kansas, and 24 projects took place in both Missouri and Kansas. Organizations primarily served the following races: 51.0% Caucasian, 39.2% African American, and 9.8% Hispanic/Latino. Also, 48 organizations (92.3%) served primarily both males and females, whereas 3 organizations (5.8%) served females only, and 1 organization (1.9%) served males only. Over half (58.8%) of the organizations primarily serve those below the federal poverty level (FPL); two organizations (3.9%) mainly serve those up to two times the federal poverty level (2X FPL), and 2 organizations (3.9%) primarily serve those up to three times the federal poverty level (3X FPL). About a third (31.4%) of the organizations did not capture the socioeconomic status of their clients. Please see Table 7 for information regarding the organizational characteristics of the funded agencies in fiscal year 2007.

Organizations mainly served populations in 4 different counties as well as the entire Kansas City, Missouri area. Below is a description of each of the 4 main counties included in this study, with data for each county gathered from the United States Census Bureau.

**Jackson County.** Jackson County, located in Missouri, was named after the country’s seventh president in 1826. Geographically, Jackson County consists of 605 square miles of land, with persons per square mile being 1,082. Jackson County’s population in 2009 was 705,708. Of those, 120,542 reported a disability. Caucasians made up 73.2% of the population, African Americans made up 22.4%, 8.2% were Hispanic, 1.6% were Asian, and 0.6% reported being Native American. Median household income in 2008 was $47,284, with 14.4% living below the poverty threshold. In 2000, 62.9% of the population reported being homeowners.
**Johnson County.** Johnson County, located in Kansas, was officially organized in 1857 and named after Reverend Thomas Johnson, who was a Methodist minister who created a mission among the Shawnee Indians in 1829. Shawnee was the original choice of a name for the county, with Johnson County actually being the second choice. Johnson County consists of 477 square miles of land, with persons per square mile being 946. Johnson County’s population in 2009 was 542,737. Of those, 48,627 reported a disability. Caucasians made up 89.5% of the population, Hispanics made up 6.3%, 4.5% were African American, 4.0% were Asian, and 0.5% reported being Native American. Median household income in 2008 was $76,250, with 4.6% living below the poverty level. In 2000, 72.3% reported being homeowners.

**Lafayette County.** Lafayette County, located in Missouri, was founded in 1820 and named for Marquis de La Fayette, who was a French aristocrat and military officer. Settlers came mostly from Kentucky, Tennessee, and Virginia. Lafayette County consists of 629 square miles of land, with persons per square mile being 52. Lafayette County’s population in 2009 was 32,572. Of those, 5,843 reported a disability. Caucasians made up 95.4% of the population, African Americans made up 2.5%, Hispanics accounted for 1.6% of the population, 0.4% were Native American, and 0.3% reported being Asian. Median household income in 2008 was $46,394, with 13.1% reported being below the poverty line. In 2000, 75.4% reported being homeowners.

**Wyandotte County.** Wyandotte County, located in Kansas, is the smallest county in the state and is named after the Wyandot Indians. Wyandotte County consists of 151 square miles of land, with persons per square mile being 1,046. Wyandotte County’s population in 2009 was 155,085 with 35,384 reporting a disability. Caucasians made up 69.1% of the population, African Americans made up 26.2%, 23.2% reported Hispanic origin, 2.0% were Asian, and 0.8%
reported being Native American. Median household income in 2008 was $39,208, with 19.2% living below the poverty level. In 2000, 62.9% reported being homeowners.

Key Personnel: Program Directors and Staff

Key personnel from each of the 52 organizations were asked to participate in on-site interviews in spring 2009. A total of 76 key personnel from 40 organizations completed interviews. Personnel who did not complete interviews either could not be reached by repeated attempts at telephone or email communication (n=11), or refused participation in the interview process (n=1). Personnel from 12 organizations did not complete interviews; however, all organizations were included in the document review.

Instruments

Key Personnel Interviews

The interview instrument consisted of three areas in which the foundation required data: (a) information about the organization, (b) the foundation-funded program, as well as (c) suggestions for the foundation. More specifically, interviews consisted of questions regarding:

- strengths and challenges of the organization,
- how the organization supported the funded program,
- what long-term impact they would like to see (or did see) because of the program,
- population served by the program (beyond those they had intended),
- other activities as part of the program (beyond those initially identified),
- unexpected outcomes,
- the evidence base for the program (or lack thereof),
• impact funding had on the program and organization,
• what worked well and challenges in the program, and
• suggestions for the foundation in supporting programs and mental health in general.

Domain one of the interview instrument contained four questions regarding information about the organization in which each program operated. The first question was an ice breaker. Interviewees were asked to tell the interviewer about the organization and when it was founded. Next, interviewees were asked what the mission of the organization was. This was asked to see if the program’s activities matched the organization’s mission. Next, interviewers asked what strengths existed in the organization, and, lastly, what challenges the organization faced.

Domain two contained the most questions of the three domains of the interview. Broadly, this section had 14 questions regarding the foundation-funded program. During this section, interviewers used the logic models that were previously created in order to personalize the questions about each individual program. For example, using a logic model, the interviewer reminded the program staff of the target population that was served by his/her program. The interviewee was then asked if that was correct and if any others were served by the program as well. This was done in order to see if any population that received the program’s aid was missing from the reports that the program personnel submitted to the foundation. Logic models were also used to ask about the program itself, the program’s activities, and its outcomes. Other questions asked during this section of the interview were with regard to length of funding, whether the program was new or already established, how many people were served (and whether that amount was more or less than the number served before the grant – if applicable), how the grant changed the program’s services or activities (if applicable), how outcomes were measured, whether there were any unintended outcomes, what long-term impact they would like to see
because of their program, what worked well, challenges faced (and how they were addressed), and whether the program completed a logic model. All of these questions were asked in order to gain in-depth information regarding the programs that perhaps was not included in the original grant proposals and reports submitted to the foundation.

In domain three, the final section, interviewees answered four questions regarding suggestions that they might have for the foundation so that the foundation can improve its support of mental health-serving organizations in the future. Program personnel responded to a question regarding how funding has helped, specifically, the program and, more generally, the organization. Interviewees were asked for ways the foundation could better support grantees and what the foundation should do to support mental health in the future. Lastly, grantees were asked if the program that was funded in FY 2007 was currently in existence. If so, they were asked how the program is funded and what the program’s plans are for sustaining the program (if any).

Questions from all three domains were open-ended in order to allow participants to answer freely instead of predetermined ways. See Appendix A for the interview instrument.

Procedure

Data collection included reviewing grant proposals and reports from each of the 52 funded organizations and on-site interviews with the funded organizations.

Document Review: Grant Proposals and Reports

All of the 52 organizations responded to a Request for Proposal (RFP) from the foundation in the form of completing a Foundation-defined Grant (FDG) application. Upon receiving mental health funding from the foundation, each of the organizations was required to
complete an interim report six months after initial funding, and then a final report at the end of the grant period. Because 18 organizations (34.6%) requested a grant period of longer than 12 months, they were not required to complete a final report at the end of the 12-month period, and, hence, were not included in the review. The other 34 organizations (65.4%) completed final reports at the end of the 12-month period, which were included in the document review.

Even though all of the organizations received mental health funding from the foundation, program target audiences and activities varied widely from program to program. Because of the uniqueness of each program, each of the documents submitted (52 applications, 52 interim reports, and 34 final reports) was reviewed by researchers at Wichita State University’s Center for Community Support & Research (CCSR) in an attempt to understand the programs across the following dimensions: an overview of the services provided by each organization, the problem or need that funding would help address, an overview of the project (such as target population, the project’s purpose, the approach to be taken to address the problem, project activities, collaboration, staffing, outcomes, and evaluation), progress made toward intended outcomes, and lessons learned from the project.

**Outcome Knowledge Assessment**

The initial document review illuminated inconsistent definitions of outcomes by the organizations. Therefore, researchers performed an assessment after reviewing each organization’s documents as a way to evaluate whether organizations understood outcomes and how to measure them. The evaluation assessed whether the organizations: (a) followed the foundation’s grant proposal template, (b) correctly identified outputs and outcomes, (c) identified measures for outcomes, and (d) reported achieved outcomes (through interim or final reports) as
well as intended outcomes (through the application). This was done to see if and in which key areas programs needed help in determining whether a result is an output or an outcome. See Appendix B for the assessment tool.

**Key Personnel Interviews**

In the spring of 2009, requests for on-site site visits/interviews were made to key personnel from each funded program. Representatives were assured that the site visit was not intended as an evaluation of the program, but as a way to gather further information about the successes and challenges of the funded program and the overall impact of the funding. In short, the interviews were intended as a way to allow program representatives to add qualitative information beyond the reports submitted to the foundation during the funded year. Representatives were assured that their comments during the interview would be kept confidential and that their responses would not affect their current or future funding. When researchers contacted each organization to schedule on-site interviews, representatives were told that interviews would last approximately 45 minutes to an hour and a half and that the three main interview topics were: information about the organization, the foundation-funded program, as well as suggestions for the foundation.

Forty out of fifty-two organizations (76.9%) completed interviews with CCSR staff, beginning in mid-February 2009 until the end of April 2009. When initially contacting the organizations, CCSR researchers requested interviews with those persons who were most familiar with the program. CCSR offered to schedule interviews with more than one person or to include multiple people in each interview if appropriate. None of the 40 organizations scheduled multiple interviews, but 19 (47.5%) included more than one person in their interview. Most
interviews (21; 52.5%) included only one key person in the interview; eleven interviews (27.5%) included two key personnel; five interviews (12.5%) included three key people, and the remaining 3 interviews each had five, six, and seven interviewees present. Those organizations that did not complete interviews either could not be reached by repeated attempts at telephone or email communication (n=11), or refused participation in the interview process (n=1). Many key personnel who could not be reached were no longer with the organization in which the program operated due to the lapse in time between program operation/completion (Fiscal Year 2007) and the requested interview (Spring 2009).
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CHAPTER 3

RESULTS

The results include information regarding how funding from the foundation impacted the perceived level of care provided by the mental health-serving organizations, as well as information regarding the extent to which mental health-serving organizations in this study had the capacity to impact mental health outcomes.

Perceived Improvement of Services

The first aim of this study was to discover to what extent funding led to perceived improvements in services provided by the mental health-serving organizations. Results were gathered using document review of organization’s proposal, as well as interim, and final reports. Interviews were conducted with key personnel from 40 of the participating not-for-profit organizations as an additional source of information. The following information is (a) Program activities, (b) Achieved outcomes, (c) Organizations’ perceived changes in knowledge, attitudes, and behavior, (d) Desired long-term impact, (e) Negative unexpected insights and outcomes, and (f) Positive unexpected insights and outcomes.

Funding provided by the foundation in the area of mental health actually covered many program activities that were not necessarily associated with the narrow use of the term “mental illness.” Because of this, primary service areas of the funded organizations could be categorized as follows: co-occurring disorders (i.e., someone who has both a drug/alcohol problem as well as
a psychiatric disorder), depression/anxiety, family/domestic violence, and child maltreatment. See Table 8 for more information.

Table 8
Primary Service Areas for Funded Organizations

<table>
<thead>
<tr>
<th>Primary Service Area</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression/Anxiety, or Other Mental Health Disorders</td>
<td>21 (40.4%)</td>
</tr>
<tr>
<td>Co-occurring Disorders</td>
<td>13 (25.0%)</td>
</tr>
<tr>
<td>Family/Domestic Violence</td>
<td>10 (19.2%)</td>
</tr>
<tr>
<td>Child Abuse</td>
<td>8 (15.4%)</td>
</tr>
<tr>
<td>All Primary Service Areas</td>
<td>52 (100.0%)</td>
</tr>
</tbody>
</table>

Establishing Categories and Inter-rater Reliability

Wave One. In order to achieve inter-rater reliability, two raters independently themed one-fourth (25%) of the responses to the questions, followed by discussion to reach consensus on the major themes. That is, each of the two raters themed a quarter of the data independently and then came together for discussion regarding the data. Hence, the first “wave” of analyzing the data proceeded through a three-step process (after independent theming of the first quarter of the data by each rater took place). First, one rater recorded the themes each rater assigned independently to the first 25% of the data. Next, the same rater identified cases where there was
agreement between raters and cases where agreement was lacking in the first 25% of the data. If there was agreement between the two raters, the cases were entered into a database. If agreement was not reached independently, raters would discuss each case not in agreement until consensus was reached for each case. Finally, if consensus could not be reached, the two raters would consult an outside senior researcher for a final determination. No cases had to be arbitrated during this wave because consensus was reached upon further discussion of the cases previously not in agreement.

Wave Two. The second “wave” of analyzing the data was much like the first in that, again, this was a three-step process. During the second wave, two raters independently themed the second one-fourth (25%) of the data. The raters again met to reach consensus. If there was agreement between raters, the cases were entered into a database, and if agreement was not reached independently, raters would discuss each case not in agreement until consensus was reached for each case. Finally, if consensus could not be reached, the two raters would consult an outside senior researcher for a final determination. In this research project, no cases had to be arbitrated because consensus was reached upon further discussion of the cases previously not in agreement. During this second “wave,” inter-rater reliability was calculated for all of the data analyzed thus far. Inter-rater reliability was calculated during this second wave; inter-rater reliability was not calculated during the first wave because the purpose of the first wave was to indentify major themes.

The Final Wave. There are many methods for estimating inter-rater reliability. In this study, Cohen’s kappa, $\kappa$, was used to determine inter-rater reliability. Fleiss (1981) has determined that, where reliability coefficients are used (such as Cohen’s kappa, $\kappa$), $\kappa < 0.40$ is poor agreement, $0.40 \leq \kappa \leq 0.75$ is good agreement, and $\kappa > 0.75$ is seen as excellent agreement.
The last “wave” of analyzing the data involved having one researcher independently theme the remainder of a given question’s responses if the inter-rater reliability achieved during the second “wave” for that question was $\kappa \geq 0.60$. The other researcher would independently theme the remaining responses to the next question, and so on, until every other question’s responses were themed. This was done so that each researcher would not have to analyze every response, but rather, once inter-rater reliability was achieved, only one researcher would continue analyzing a question’s responses. This was done until all of the questions’ responses were analyzed. If inter-rater reliability was not high enough ($\kappa < 0.60$) during the second “wave,” researchers would continue to consult one another after analyzing the data independently until inter-rater reliability could be achieved. If inter-rater reliability was high enough ($\kappa \geq 0.60$), only one researcher would continue analyzing a question’s responses. Thus, it was possible that the two researchers could continue to consult each other throughout an entire set of responses for a question; however, this was not the case for any of the data analyzed during this study as kappa was always greater than or equal to 0.60 during this study.

Table 9 lists the observed kappa for the following questions: (1) What long-term impact would you like to see or perhaps did see because of the program? and (2) Were there any unexpected/unintended outcomes as a result of the program?
Table 9

Observed Cohen’s Kappa for Impact and Unintended Outcomes Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Observed Kappa</th>
<th>Standard Error</th>
<th>.95 Confidence Interval</th>
</tr>
</thead>
<tbody>
<tr>
<td>What long-term impact would you like to see or perhaps did see because of the program?</td>
<td>0.715</td>
<td>0.152</td>
<td>0.416 - 1.00</td>
</tr>
<tr>
<td>Were there any unexpected/unintended outcomes as a result of the program?</td>
<td>0.636</td>
<td>0.165</td>
<td>0.314 - 0.959</td>
</tr>
</tbody>
</table>

Program Activities

Program activities varied depending on the funded organization, so activities were themed in order to better understand the organizations’ use of funding. Program activities across the 52 organizations included one or more of the following 10 areas, and are themed as follows, beginning with services most provided by organizations: (a) mental health services, (b) expansion of services, (c) community collaboration in mental and physical healthcare, (d) services to the uninsured, low-income, or hard-to-reach populations, (e) staff and volunteer training, (f) public knowledge expansion/media campaign, (g) services to children suffering from child abuse or neglect, (h) culturally sensitive services, (i) services to domestic violence survivors, and (j) physical healthcare.

*Mental Health Services.* A number of agencies (n=41) received funds for services provided to those with psychiatric issues, co-occurring disorders, and/or alcohol/drug addictions alone, such as: screening and assessment of mental health issues, counseling or individual
therapy, group counseling or therapy, family therapy and support, education provided to clients 
and/or families, dispensation of medication and follow-up to ensure compliance, case 
management, community advocacy, and referral to community services.

*Expansion of services.* Some of the funds provided for capacity building and expansion in 
34 organizations, including dollars for the following: hiring additional staff for existing 
programs, improvements to current services, incorporation of best practices research into 
trainings and interventions, and updates to guidelines and protocols.

*Community collaboration in mental and physical healthcare.* Some organizations (n=23) 
obtained grant funding for collaborative activities, including: coordination of services; 
development of partnerships and collaborative activities among agencies, schools, and other 
service providers; and collaborative planning for community betterment.

*Services to the uninsured, low-income, or hard-to-reach populations.* Underserved 
populations have mental health needs, including: shelter, basic needs provisions, mental health 
and medical services, and referral to community services, which 18 organizations addressed 
using foundation funding. Hard-to-reach populations, for example, included the geriatric 
population, homeless men and women, as well as youth in the juvenile justice system.

*Staff and volunteer training.* Targeted mental health training was provided to staff and 
volunteers in some organizations (n=17). Appropriate interventions and treatment options were 
included in the training. In some cases, training was given to persons other than staff or 
volunteers of the funded agency (e.g., hospital staff and community members) in order to 
 improve overall services to the populations in the funded agency.
Public knowledge expansion and media campaign. Informational and promotional materials were developed, public and professional presentations or forums were made, presentations were given to schools, and media was involved (e.g., press releases or conferences) in 15 organizations to provide the public with knowledge regarding the area of concern.

Services to children suffering from child abuse or neglect. Thirteen agencies received funds to address child maltreatment. Services included advocacy, education for staff and volunteers regarding specific needs and practices when dealing with this population, home placement within a reasonable time frame, low levels of future maltreatment and recidivism, as well as parent or caregiver training and treatment. Functional family therapy and individual therapy were often included in services.

Culturally sensitive services. Cultural sensitivity was frequently incorporated into already-existing programs at 10 organizations. This included trainings for staff and volunteers regarding specific racial/ethnic background of clients, hiring bi-lingual staff/therapists, and providing culturally sensitive therapeutic interventions and tools.

Services to domestic violence survivors. Dollars to enhance services to eight agencies that served domestic violence survivors included: shelter, crisis intervention, health and mental health services to domestic violence survivors and their children, awareness trainings, and trauma recovery services.

Physical healthcare. Healthcare was a stand-alone activity for four organizations. This included visits with a healthcare worker, lab work, and medication.
Program Outputs

From the many varied services provided by funded organizations to the populations at hand, organizations reported to the foundation the resulting outputs and outcomes. Outputs are the products of program activities (such as the number of clients served, number of meetings held, and number of distributed brochures). Outputs provide assurance that services were delivered in the appropriate “dosage” and to the intended recipients. Outcomes, on the other hand, provide a measure of whether the provided service created the intended change. Short-term outcomes often include changes in knowledge, attitudes, skills or motivation. Intermediate outcomes typically are changes in individual behavior, and long-term outcomes are systemic, community, or social changes. Understandably, few organizations were able to report long-term outcomes due to the short length of the granting and reporting period (i.e., one year in the majority of cases). Many organizations had difficulty accurately identifying outcomes and instead offered outputs only.

In this study, the output regarding the number of people served is important because it shows the impact foundation funding had on client access to essential services. Responses from 40 organizations during interviews indicate that more people were served during the grant year (i.e., fiscal year 2007) than the year before. More specifically:

- Nineteen of 40 organizations reported serving more people than the year before.
- Six of 40 reported serving about the same number of people.
- Three of 40 reported serving fewer people.
- Twelve organizations did not track differences between years.
- The total number of people served with FY2007 grant funds was 29,521.
Achieved Outcomes

Outcomes provide a measure of whether the provided service created the intended change. In their reports, organizations reported what was achieved by their programs. Subsequently, the listed achievements were confirmed during face-to-face interviews. Tables 10-13 list achieved outcomes by the four focus areas – mental health, co-occurring disorders, family or domestic violence, and child abuse – rather than looking at outcomes across all organizations (due to the differences among the types of agencies). Achieved outcomes within the tables are categorized by the types of change that occurred (i.e., changes in knowledge/attitude, changes in behavior, and changes in policy, community conditions, or individual long-term changes).
<table>
<thead>
<tr>
<th>Changes in Knowledge and Attitudes</th>
<th>Increased knowledge of healthy ways to cope with problems</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Knowledge of mental health issues and stigma</td>
</tr>
<tr>
<td></td>
<td>Understanding of depression (including late-life depression)</td>
</tr>
<tr>
<td>Changes in Behavior</td>
<td>Improved Global Assessment of Functioning (GAF) scores and/or depression scale scores and/or COPAS Life Satisfaction scores</td>
</tr>
<tr>
<td></td>
<td>Patients follow through on referrals to appropriate mental health services</td>
</tr>
<tr>
<td></td>
<td>Decreased depressive symptoms</td>
</tr>
<tr>
<td></td>
<td>Increased coping (as evidenced by reported decreased stress, parents better able to handle child’s mental health issues, etc.)</td>
</tr>
<tr>
<td></td>
<td>Improved behavior (i.e., anger management)</td>
</tr>
<tr>
<td>Changes in systems, policy, community conditions, or individual long-term change</td>
<td>Early diagnosis and treatment of depression</td>
</tr>
</tbody>
</table>
Table 11
Achieved Outcomes Reported by Funded Co-occurring Disorders Organizations (n = 13)

<p>| Changes in Knowledge and Attitudes          | Improved interpersonal communication skills                                      |
|                                         | Improved knowledge about Oxford House model                                    |
|                                         | Increased knowledge of substance abuse and mental health issues                  |
| Changes in Behavior                      | Sustained drug/alcohol abstinence                                               |
|                                         | Increase in life skills                                                         |
|                                         | Low recidivism rate (decreased incarceration, conviction, or new charges)        |
|                                         | Sustained medicine compliance                                                   |
|                                         | Increase in GAF score                                                           |
|                                         | Received medical care when referred                                              |
|                                         | Decreased symptoms of depression                                                |
|                                         | Connections to community resources                                             |
| Changes in Systems, Policy, Community Conditions, or Individual Long-term Change | Obtainment of permanent housing                                                 |
|                                         | Gains in employment or the ability to be employed                               |
|                                         | Collaboration among agencies                                                    |</p>
<table>
<thead>
<tr>
<th>Changes in Knowledge and Attitudes</th>
<th>Improved understanding of clients’ legal rights</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Improved awareness and understanding of healthy relationships</td>
</tr>
<tr>
<td></td>
<td>Increased self-esteem and confidence</td>
</tr>
<tr>
<td></td>
<td>Increased awareness and knowledge of mental health needs</td>
</tr>
<tr>
<td>Changes in Behavior</td>
<td>Reduced isolation</td>
</tr>
<tr>
<td></td>
<td>Gains in mutual support and self-empowerment</td>
</tr>
<tr>
<td></td>
<td>Reduced symptoms of anxiety or depression</td>
</tr>
<tr>
<td></td>
<td>Increase in GAF score</td>
</tr>
<tr>
<td></td>
<td>Increased coping behaviors</td>
</tr>
<tr>
<td></td>
<td>Filed a protection order</td>
</tr>
<tr>
<td></td>
<td>Improved communication skills</td>
</tr>
<tr>
<td></td>
<td>Reduced levels of conflict among family members</td>
</tr>
<tr>
<td></td>
<td>Drug-free at discharge</td>
</tr>
<tr>
<td>Changes in Systems, Policy, Community Conditions, or Individual Long-term Change</td>
<td>Client safety</td>
</tr>
<tr>
<td></td>
<td>Children shielded from abuse and are not abused</td>
</tr>
<tr>
<td></td>
<td>Changed practices in two hospitals, including the addition of a domestic violence task force and added signage</td>
</tr>
</tbody>
</table>
Table 13
Achieved Outcomes Reported by Funded Child Abuse Organizations (n = 8)

<table>
<thead>
<tr>
<th>Changes in Knowledge and Attitudes</th>
<th>Increased knowledge about abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Better understanding of staff/volunteer’s role</td>
</tr>
<tr>
<td></td>
<td>Improved communication skills</td>
</tr>
<tr>
<td>Changes in Behavior</td>
<td>Better access to community resources</td>
</tr>
<tr>
<td></td>
<td>Improved stability</td>
</tr>
<tr>
<td></td>
<td>Increase in GAF score</td>
</tr>
<tr>
<td></td>
<td>Reduced behavioral problems</td>
</tr>
<tr>
<td>Changes in Systems, Policy, Community Conditions, or Individual Long-term Change</td>
<td>Gains in permanent housing placement within 18 months</td>
</tr>
<tr>
<td></td>
<td>Reduced incidence of abuse and neglect</td>
</tr>
</tbody>
</table>

Perception of Knowledge, Attitude, and Behavior Change

In order to gain information that wasn’t provided in the document review, organizations were asked during the interviews to provide their perception of whether the program had created changes in knowledge, attitudes, or behavior as intended (short- and intermediate outcomes). This question was asked to see if organizations measured these outcomes. Responses from the 40 organizations were scored according to a 0, 1, 2, or 3 scale, as explained below:

- A score of (0) means that negative changes were identified by the organization
- A score of (1) means that no changes were identified by the organization
- A score of (2) means that positive changes were identified, but not measured
- A score of (3) means that positive changes were identified and also measured
Table 14

Frequency of Coded Responses to Outcomes Questions

<table>
<thead>
<tr>
<th>Question</th>
<th>Frequency of responses (organizations)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative changes identified (0)</td>
</tr>
<tr>
<td>Were there changes in knowledge because of this program?</td>
<td>1</td>
</tr>
<tr>
<td>Were there changes in attitudes because of this program?</td>
<td>1</td>
</tr>
<tr>
<td>Were there changes in behavior because of this program?</td>
<td>1</td>
</tr>
</tbody>
</table>

From Table 14, knowledge and behavior changes were more likely to be noted and measured than changes in attitudes. Based on the frequencies in the table, organizations reported achieving positive outcomes, but some had difficulty measuring those outcomes. In the case of attitude change, organizations were more likely to have noticed change, but not measure it, whereas with knowledge and behavior changes, organizations were more likely to have recognized as well as measured those changes. One organization reported negative changes in each of the three areas due to the impact that transitioning to a new facility had on its clients and the inability to implement the program as desired.
Desired Long-term Impact

During interviews, key personnel were asked to state the intended impact of the program ("What long-term impact would you like to see or perhaps did see because of the program?") in order to gather a clearer picture of their desired long-term impact than would have been captured in reports only. Organizations were also asked whether they actually achieved their intended impact. From the responses, 2 organizations (5.0%) did not specify an intended impact, 30 organizations (75.0%) identified their intended impact, and 8 (20.0%) reported that they achieved their intended impact, such as changes in the community or system as a whole. For example, one organization was able to form a collaboration with similar organizations in which they took their services into the community to meet clients where they were (e.g., on the streets, in homeless shelters). Providing services in this way represents a shift in systemic practices. The intended impacts from the interviews are themed below, with the most frequent or powerful themes listed first.

Clients become empowered to lead responsible and productive lives in the community.

Organizations wanted to help their clients attain and maintain employment, gain an education, and become involved in the community as citizens, and as such, provided services to help clients achieve those goals. “We see clients obtain jobs and care for their families. Some got an education.” One child abuse organization provided services in the present in order to achieve distant long-term outcomes: “Over time, we hope that the increased quality of services enable the children to transition into regular child care programs and become more valuable citizens in the community as they learn to overcome challenges associated with child abuse and neglect and learn more effective coping skills.” One organization partnered with the local community in order to increase awareness and to purchase vacant lots to create new housing opportunities for
their clients in order that clients will learn to empower themselves to lead productive lives. One
organization hoped that after services were provided, clients would live “in permanent housing
and be employed.”

Mental health stabilization. Programs sought to increase the overall well-being of clients,
including working through their mental health issues via therapy, case management, and
medication management so that higher levels of coping and functioning could be achieved. One
organization summarized a client’s case as such: “A female patient with depression was unable
to work. After treatment, she was able to care for her family and go to work.” Many
organizations provided accounts such as this one, where individual clients benefitted from the
services they received in order to combat individual mental health issues. One organization
wanted to provide the resources necessary “to help children develop coping skills as they face
future challenges associated with mental health issues.”

Improved access to services. Programs sought to remove barriers to services and provide
more accessible services to clients who lacked the knowledge or money to afford services in the
community. Programs sought to connect clients to services they would not have otherwise
known about or received (e.g., mental health services, educational placement, physical healthcare
resources). One organization sought to provide “more foster children with a stable caring adult
advocate while going through the court system.” Another organization stated that “individuals…
were connected with care that they would not have secured without the program.” Many
organizations stated they wanted to increase opportunities for access to services for their clients
in order to create a functioning and better community.
Permanent housing. Programs sought to help those living in transition (e.g., the homeless, those without permanent addresses) move from a shelter or on the streets into permanent housing. Some organizations provided a safe location for their clients who needed refuge from their current situation. One organization summed up their desired long-term goal, stating they wanted to see “people in permanent housing and employed.”

Physical health improvement. Programs sought to increase clients’ life span and quality of life by improving physical health, not just mental health. One organization’s objective was “for patients to be free of pain and infection and to be able to care for themselves.” Another organization wanted their clients to secure health care because “good health is a large step toward… breaking the cycle of domestic violence.” Another respondent suggested that mental health and physical health services be provided in conjunction with one another, making organizations a one-stop shop for those needing an array of services. As such, “obstacles to healthcare would be removed” and clients would have everything they need at their fingertips.

More partnerships in the community. Programs sought to create and build on partnerships with schools and primary care physicians, county coalitions, domestic violence shelters, health departments, etc., because it was oftentimes much more feasible to tackle any given problem or issue with multiple organizations’ involvement. Many stated that having more people on board eased the burden in accessing the targeted population, presenting referrals, and providing services. “Individuals were connected with care they would not have otherwise received.” One organization stated that they would like to see systems change by having whole communities partner with hospitals so that people can gain access to needed care during small windows of opportunity. Organizations wanted to continue meeting with each other after the granting period ended because they recognized the benefits that collaboration had on their clients.
**Greater community awareness.** Organizations sought to improve the general public’s view of mental illness and to reduce mental illness’ stigma. Some sought to demystify suicide and increase awareness of mental health and other targeted issues so as to increase support for services. For example, one organization wanted to provide a curriculum and a program to other organizations to increase awareness from within organizations. With that knowledge, organizations could then inform their clients and the community. One respondent mentioned that the organization’s staff wanted to become advocates or change agents. Others noted changes they’ve already observed in the community: “We have seen an acknowledgement that returning offenders have mental health needs.” One organization mentioned that they were using the media to spread awareness. Many organizations remarked that if the stigma surrounding mental health and suicide could be de-mystified, their clients would be more likely to seek services.

**An end to social problems.** Programs sought to reduce or alleviate violence, substance abuse, child abuse and neglect through therapy, prevention, or early intervention. One organization hoped for a “decrease in crime” and “some increase in productivity.” Some organizations reported that their clients have left their violent situations. One organization’s hope was “that domestic violence stops within individual families.” Another’s was that “women and children feel safe and secure.” For children, many organizations hoped they could prevent abuse or substance abuse within this population. One organization hoped they could prevent future occurrences of substance abuse and other problems by providing youth with the “best possible services… so they don’t experience a secondary problem because of the initial services they received.”

**Stable family environments.** Organizations wanted to increase positive parenting skills, increase bonds and attachments between parent and child, provide parent education, increase
resources to parents living with personal challenges (e.g., addiction, domestic violence, mental illness) and teach families better communication skills in an effort to increase family stability by promoting family sharing, understanding, and bonding. “We have seen more stable family environments. Many children and families participated in treatment.” One organization stated, “parents now come by and are more involved [which] helped with retention and attendance… and open communication.” Because of the grant, organizations reported youth and families were engaged in therapy services, which allowed them to “learn better communication skills, improve parenting skills, and reduce conflict.”

_Improved staff outcomes._ Staff received education on key issues and attended educational or skill-based trainings due to the grant. One organization reported that their interpreters were more aware and confident in their training than before. For another organization, “stability among advocates was high. Advocates were more well-prepared, and we had longer-term volunteers.” One organization stated that staff members “are becoming more prepared and more able to address mental health issues and provide mental health services.”

_Unexpected Insights and Outcomes_

During the interviews, key personnel were asked, “Were there any unexpected/unintended outcomes as a result of the program?” Responses were themed and then categorized as either “negative” or “positive” insights. Table 15 displays both negative and positive themes that emerged, beginning with the most frequent or powerful themes.
Table 15
Unexpected Insights and Outcomes

<table>
<thead>
<tr>
<th>Negative Unexpected Outcomes</th>
<th>Positive Unexpected Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surprise among staff at how many clients needed mental health services</td>
<td>Partnerships with other organizations were enhanced</td>
</tr>
<tr>
<td>Staff members were surprised at how many clients needed physical health services</td>
<td>Funding led to other opportunities</td>
</tr>
<tr>
<td>Difficulties for clients wanting to access services</td>
<td>Community support was surprising</td>
</tr>
<tr>
<td>Staff hiring and turnover</td>
<td>Improved treatment compliance</td>
</tr>
<tr>
<td>The importance of having innovative recruitment strategies</td>
<td></td>
</tr>
</tbody>
</table>

Negative Unexpected Insights and Outcomes

The following are the negative unexpected themes that emerged from the interview responses to the question, “Were there any unexpected/unintended outcomes as a result of the program?” along with illustrative examples as appropriate.

Surprise among staff at how many clients needed mental health services. Many of the programs noted that the demand for services was far greater than their program’s ability to provide needed services, even when they took into account the impact of foundation funding on their program. One of the mental health-serving organizations stated, “(We)… didn’t realize how
many kids were on medication and the overall incidence of mental health issues in the population; had more clients than anticipated.” In some instances, organizations had to turn away clients because they didn’t have the resources to meet needs: “[We] had more clients than anticipated and that [we] were able to handle.”

Staff members were surprised at how many clients needed physical health services. While some clients needed basic care, there were a number of clients who had severe physical health problems that needed to be addressed. Grantees thought the main concern for clients would be mental health care; however, they realized the needs of the population also included physical health care services, not just mental health; however, they underestimated the level of care needed. Oftentimes, in such cases, clients had to be referred elsewhere because the organizations could not provide the necessary level of physical health care. For example, a domestic violence shelter was given funds to support a women’s advocate; however, in the future, they would like to receive funds to obtain physical health care for the women at the shelter. At the time, women had to be referred elsewhere because the shelter did not provide such services. Another organization noted, “The need for medical and dental care was striking.”

Difficulties for clients wanting to access services. Even though some potential clients knew about the services available to them, there were a number of barriers to access. Some organizations noted a lack of transportation as a contributing factor to difficulties in providing services. One organization noted cultural and lingual challenges in trying to reach youth and the Hispanic population because of the difficulties engaging these populations. Some potential clients’ personal challenges outside of the program (such as lack of childcare or transportation) made it difficult for organizations to respond to their needs. In some cases, there were cultural
and gender barriers that impeded potential clients from accessing services (i.e., fear of disclosure, stigma).

**Staff hiring and turnover.** Other comments pointed to the difficulty in attracting and retaining high quality staff as well as staff who specialized in a given area. This was especially an issue for organizations that indicated they had few resources (e.g., funding, time, few staff to begin with) in order to attract and retain high quality staff members. One organization tried to hire someone they thought could relate to their clients, but that idea backfired: “We tried to hire someone who was a previous abuser, but that didn’t turn out well.” Other organizations mentioned that the one-year granting timeline hindered the hiring process, which would often take many months to find the right person for the job. One respondent stated, “I hired program director who was connected in the community and [the program director] couldn’t deliver. That surprised me. It takes special people to work with this population.” Staff turnover was frequently mentioned as both a challenge and an unexpected complication.

**The importance of having innovative recruitment strategies.** Organizations noted that, even with increased funds, it was challenging to reach potential clients. This reality caused many organizations to adapt to new partnerships, approaches, and practices in order to reach clients. “(It was)… difficult to reach our target audience.” Organizations confirmed the importance of having many varied approaches for recruitment of clients and volunteers, including word of mouth, brochures, and media involvement. One respondent mentioned that it is extremely important to “engage the potential volunteer on a personal level. Email is not personal enough,” noting the importance of face-to-face contact and following-up after initial contact has been made.
Positive Unexpected Insights and Outcomes

Partnerships with other organizations were enhanced. Many organizations entered into partnerships with other service providers, sometimes because of the necessity to overcome obstacles and leverage resources in order to provide the best services possible to clientele. “New partnerships have been formed to better serve clients.” Because of these partnerships, some organizations obtained data or information they needed to better inform their program planning and implementation to better serve client needs and tackle bigger issues that one organization working alone most likely could not handle. “Our partnership shaped our approach to providing services ‘outside the box’ to people who wouldn’t typically show up at our office. It also created internal diversity, and the committee was able to make sure that services truly met the needs of survivors and families of all types.”

Funding led to other opportunities. Many organizations found that their programs were modified or expanded in ways that they hadn’t expected. This expansion also set the stage for other projects to take place currently and in the future. For instance, one organization realized the great need for the type of service they provided, and, hence, they plan on continuing to provide those services in the future. For one organization, their target population shifted; they ended up serving families and not just women. In some instances, community awareness led to other prospects, such as outside organizations contacting funded organizations for training or services. “Others are using this as a model program” and “[We] plan to do more trainings with other organizations” were two comments made during interviews.

Community support was surprising. Organizations tied community support to improved services provided to clients, noting that communities realized the good work they were providing
and wanted to be a part of it. “The community has been very supportive,” and “The community has participated and supported and joined in ways that we never would’ve expected” were comments given during interviews. Some organizations planned activities for the community, such as a community dinner every Wednesday night. “People wanted to hop in and dovetail on what we’re doing,” so organizations adapted to better involve the community.

*Improved treatment compliance.* As stated by organizations, improved compliance with the treatment plan was thought to be associated with improved services provided by the program to its clientele. Organizations were quick to note that they were constantly improving their own education and treatment processes in order that clients might best be served, and, hence, comply with suggested treatment. “Compliance with medication was much improved.” Another organization noted, “Change happened more quickly than planned – in a good way.”

**Promising Practices and Organizational Capacity**

The second aim of this study was to assess promising practices and organizational capacity of grantees to impact mental health outcomes. Results were gathered using document review of organizations’ proposals, as well as interim, and final reports. Interviews were conducted with key personnel from 40 of the participating not-for-profit organizations as an additional source of information.
Establishing Categories and Inter-rater Reliability

Inter-rater reliability was established in the second aim the same way it was established in the first aim. Two raters independently themed a portion of the data and then met to discuss categories. During the second wave of data analysis, inter-rater reliability was calculated using Cohen’s kappa, $\kappa$. Once Cohen’s kappa was greater than or equal to 0.60, one rater completed the analysis of the remaining data for each question.

Table 16 lists the observed kappa for the following questions: (a) What is this organization’s top strength? (b) What is this organization’s top challenge? (c) Overall, what worked well in the program? (d) What was the most difficult challenge in implementing the grant? (e) In what ways has the foundation’s funding helped this program? (f) In what ways did the organization support the program that was funded through the foundation grant for FY2007? (g) How did the organization decide to provide this program? (h) Suggest ways that the foundation can be more effective in achieving its mission. (i) What are two things the foundation could do to better support grantees in general? and (j) What is the most important thing the foundation should do to support mental health?
### Table 16

Observed Cohen’s Kappa for Aim 2

<table>
<thead>
<tr>
<th>Question</th>
<th>Observed Kappa</th>
<th>Standard Error</th>
<th>Lower Limit</th>
<th>Upper Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is this organization’s top strength?</td>
<td>0.667</td>
<td>0.215</td>
<td>0.245</td>
<td>1.00</td>
</tr>
<tr>
<td>What is this organization’s top challenge?</td>
<td>0.778</td>
<td>0.148</td>
<td>0.487</td>
<td>1.00</td>
</tr>
<tr>
<td>Overall, what worked well in the program?</td>
<td>0.883</td>
<td>0.114</td>
<td>0.660</td>
<td>1.00</td>
</tr>
<tr>
<td>What was the most difficult challenge in implementing the grant?</td>
<td>0.847</td>
<td>0.147</td>
<td>0.559</td>
<td>1.00</td>
</tr>
<tr>
<td>In what ways has the foundation’s funding helped this program?</td>
<td>0.714</td>
<td>0.187</td>
<td>0.347</td>
<td>1.00</td>
</tr>
<tr>
<td>In what ways did the organization support the program that was funded through the foundation grant for FY2007?</td>
<td>0.600</td>
<td>0.179</td>
<td>0.249</td>
<td>0.951</td>
</tr>
<tr>
<td>How did the organization decide to provide this program?</td>
<td>0.700</td>
<td>0.113</td>
<td>0.479</td>
<td>0.921</td>
</tr>
<tr>
<td>Suggest ways that the foundation can be more effective in achieving its mission.</td>
<td>0.883</td>
<td>0.114</td>
<td>0.660</td>
<td>1.00</td>
</tr>
<tr>
<td>What are two things the foundation could do to better support grantees in general?</td>
<td>0.820</td>
<td>0.172</td>
<td>0.483</td>
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<tr>
<td>What is the most important thing the foundation should do to support mental health?</td>
<td>0.602</td>
<td>0.206</td>
<td>0.199</td>
<td>1.00</td>
</tr>
</tbody>
</table>

### Organizational Strengths

Key personnel were asked during interviews about the top strengths of the organization as a way to determine organizational capacity (i.e., “What is this organization’s top strength?”).
Their responses have been themed into categories. Explanation of categories is provided along with pertinent quotes from interviews.

*Culturally competent and dedicated staff, board, and volunteers.* Many organizations reported that their key personnel were strengths for the successful operation of programs. Having high quality staff, board, and volunteers not only made for effective programs, but also was critical to the organization’s long-term sustainability. “Our staff is experienced,” and “Diversity of people working here. [Our staff] have different levels of education, difference experiences and backgrounds… everyone has something to bring to the table” are examples of comments given by many organizations. One respondent said, “[We have] a very broad volunteer base, consisting of professionals and consumers, who have a huge voice in the community.” Another said they have a “100% supportive board.” Organizations were grateful to have dedicated individuals working toward the same mission.

*Solid community partnerships through reputation/history.* Forty-six of the 52 organizations (88.5%) in this study had been in existence for 10 years or longer. Respondents communicated the advantage this had on their work: their strong history and connections in the community had been built over time and were valued by both clients and partners. Some reported that their involvement in collaborative projects (because of the foundation’s funding) had added to their status in the community. “The organization is well-known in the community. We are involved in the homeless services coalition, and we have a relationship with the Veterans Administration and intensive mental health care services for homeless veterans.” One organization stated how vital their partnerships were: “We work closely with different organizations in the community to provide services. [We] connect patients with other community
resources, such as housing.” Community partnerships were enhanced due to organizations’ history and reputation.

**Comprehensive care for clients.** Being able to respond to clients’ needs, as well as provide services in a respectful, committed manner was something many respondents listed as a key strength of their organization. Focusing on clients’ strengths, instead of their deficits, while providing the best care possible, was expressed many times throughout interviews. The ability of staff to follow up on outcomes and needs assessments, as well as keep up with technological changes and research also helped support the best care possible for clients. “Patients know they are safe coming to [us]. They feel good about coming here. The immigrant population knows that they will not be turned in; we help them stay healthy… [which] consequently keeps the community healthy.” One organization stated, “[We provide] a true continuum of services, wrap-around services.” Another said, “We focus on individual needs and tailor programming to fit client needs.” Organizations provided client- and strengths-focused, comprehensive care.

**Ability to solve problems.** Many respondents cited their ability to solve problems as a strength of the organization. “We look at the problem from different sides.” Many were proud of their organization’s ability to create alliances with other organizations, find funding when needed, adapt to clients’ needs or community conditions, and put into place innovative programs as the need arose. “Providers are qualified professionals with great diagnostic skills [who are]… dedicated to the patient population. Patients respect them.” Another stated, “[We have] a strong sense of responding to the needs of service recipients [because we] use data from needs assessments and focus group surveys… We have an innovative and visionary CEO.” Being able to respond to problems in an effective manner was important for organizations.
Administrative backing/support. Respondents were thankful for the support provided by administrators within the organization, which led to the implementation and sustainability of effective programs. Administrators were often cited as taking care of things such as fundraising and secretarial support in order to provide a strong foundation for the organization’s sustenance. “[The organization] provides administrative support and helps with purchasing to help maintain the budget.” Administrative support from directors and managers, as well as administrative assistants, was highly valued and listed as a strength by interviewees.

Location. While some organizations listed location as a barrier to access for clients, some listed it as a strength. For example, one organization listed the fact that they had satellite sites as a strength which allowed them to serve clients throughout the community, not just one location. Others said they were located close to the clients who could or do use services. Organizations that operated multiple locations were most likely to list location as a strength.

Organizational Challenges

Key personnel were asked during interviews about the top challenges of the organization as a way to determine organizational capacity (i.e., “What is this organization’s top challenge?”). Their responses have been themed into categories, and selected quotes are provided.

Funding issues exacerbated by the economic downturn. Securing adequate funding was cited by almost all of the respondents as a major challenge for meeting the needs of clients. The poor economy also made it difficult for organizations to provide services at a time when clients need services more than ever. “Keeping the doors open. We are seeing a decrease in philanthropic dollars. We are writing more grants for fewer dollars,” and “Funding, particularly
support for operating expenses. We struggle to secure general operating support which is necessary to implement programming” are examples of commonly cited challenges. The political climate and state of the nation’s economy were mentioned by some as a barrier to care because of their presumed connection to funding. “The change in political structures. Although the changes will likely be positive ultimately, it is a difficult transition.” Handling funding issues is always tough, but the economic downturn magnified the challenges faced by agencies.

Meeting clients’ needs. Respondents cited a great demand for services by clientele. It was a challenge to provide suitable and high-quality services to all who requested them, which was often related to funding concerns. Some organizations mentioned that it was particularly difficult to meet the needs of hard-to-reach populations, such as the homeless, those without transportation, or clients in transient living situations. In some cases, organizations had difficulty convincing the target populations to utilize services. “Growth… Client need is beyond the capacity of the center. [We] can’t admit as many clients as we would like to… There are more needs than resources available to meet those needs.” Another said, “The economic downturn has put additional stress on clients. There is an increased level of need with a decreased amount of resources. More clients are uninsured and without insurance to help cover costs.” Providing services to clients, especially hard-to-reach populations, was difficult at a time when demand was great and resources were low.

Concerns related to administration and/or board of directors. The board of directors was listed as both a strength and a challenge for some organizations. There was concern that, in some cases, board members perhaps did not fully understand or could not advocate for the issue or related program. In some cases, there was disagreement between the board or administrators and the staff over how to best alleviate client needs. “The board does not understand the current
needs of the clients and how best to serve them. They are clueless, old school, and just focus on the bottom line.” One organization stated that they’ve had challenges with their board, especially in the past. Others cited difficulties between administrators and staff regarding how to best implement programs. These difficulties made it difficult for the organization as a whole to move forward.

**Concerns related to staffing.** Recruiting and retaining high-quality, committed staff was listed as a challenge. This was especially difficult in cases where specific training or skill was involved (e.g., medical doctors, counselors). Other concerns were related to the inability to offer competitive salaries and benefits, a high rate of staff turnover, providing sufficient staff training, and difficulty recruiting staff who were willing to work with the target population. “We have fewer staff to address increased needs.” Another noted: “Keeping pace with growth, being able to keep qualified direct services staff and not having so much turnover… to fulfill responsibilities.” Another simply didn’t have the staff to fill necessary roles: “We do not have a development officer.” One mentioned that several of their staff members will be retiring within the next five years, and they haven’t planned for the transition. Organizations had difficulty finding and keeping high-quality, skilled staff appropriate for the available positions.

**Community awareness and education.** A lack of awareness in the community about the issues and related programs available to address the issues was an ongoing challenge. Organizations stated that the stigma attached to mental illness, addictions, and homelessness made some community members hesitant in accessing available services. “The stigma of sexual violence [has been a challenge in] getting to underserved and unknown populations.” A lack of awareness by policy makers was listed as an obstacle in receiving enough funding to continue to provide appropriate services. In some cases, the inability to keep a website updated (or other
technology challenges) led to reduced community awareness and education. “Making sure the community is fully aware of the services the organization provides and the capacities of staff. [They] need to be kept informed.” Another stated, “education regarding the truth is important; misconceptions [abound, which] impacts funding.” If awareness and education in the community could be increased, organizations and clients would benefit greatly.

Facility complications. There were challenges regarding the facility or space that was available in which to provide services. In some cases, facilities needed repair, there wasn’t enough space for staff and/or clients, or there wasn’t the right kind of space for the services provided. Some expressed safety concerns with the location of the facility (i.e., facilities in certain neighborhoods), which could make clients reconsider accessing services. “The facility is old and in need of repair,” and “The state of our facilities. Competitors have newer digs. The environment sets the stage for a lot” were comments concerning challenges organizations faced.

Clients with severe personal challenges. Organizations stated it was a challenge to work with clients who came from a personal background of strife, such as gang violence, limited relational/familial support, or unsafe, very distressed urban environments. Many clients live in vulnerable situations and, in some cases, have no control over that situation, which complicates providing services. “Sometimes children don’t have homes to go to. Parents may not be receptive. This causes behaviors to deteriorate. [There are] lot of issues that disrupt.” Another mentioned, “The environment is tougher for urban children. [They have to deal with] gang violence and no family support.” At the same time, these extraordinarily difficult clients are those who are in the greatest need, hardest to reach, and those for whom greater resources are needed to serve.
**Family and parental support.** Some organizations listed challenges in getting families or parents involved in the programs. This was disappointing to organizations because of the potentially therapeutic effects that family involvement can have on clients, both children and adults. This concern is related to accessibility issues, such as families having trouble getting to the facility or not being available at the time(s) services are delivered, but the main concern was that families may not understand or care about how crucial their involvement is. “Parent involvement” and “no family support” were listed as challenges to providing the best care possible. “Family systems are more complex.” Having all family members on board with treatment would allow for smoother treatment processes and possibly faster recovery.

**Successes/What Worked Well**

In order to determine key successes of the funded programs – and not just the strengths of the organizations as a whole – interviewees were asked to respond to the following question: “Overall, what worked well in the program?” Respondents also provided this information during grant reports when respondents were asked to provide strengths/supports for the program. It was found that themes from the document review and interviews were consistent with each another.

**Client outcomes.** All organizations reported positive outcomes for their clients. Most comments regarding client outcomes involved increasing knowledge (for example, coping mechanisms or knowledge regarding various community resources), and/or alleviation of the presenting problem (such as depression, substance abuse, or behavioral problems for youth). Respondents noted that increased resources allowed them to provide more immediate or better services for those in need and allowed for better relationships with clientele. “I think clients who
were able to recognize the value of the services received tremendous help from it.” Another respondent mentioned their service “approach has helped [clients] find living arrangements.” One noted that their immediacy of consultation for people in crisis has been a huge success for the program: “We have an excellent mental health therapist, so she does a great job of assessing and then following people who need rapid services. One person who was suicidal we got in the hospital in two hours.” Clients greatly benefitted from program offerings.

**Partnerships with other organizations.** Many organizations stated that if it weren’t for the funding, they would not have been able to form key collaborations – intended or unintended – with other organizations. Specifics included developing partnerships with large local hospitals to provide more comprehensive care to those in need (e.g., domestic violence survivors), collaborations as a better way to leverage available resources, and convening meetings with other organizations to address challenges and share ideas. “The ability to collaborate” and “cultivating partnerships” were mentioned often by interviewees. One respondent mentioned that it was beneficial to have partnerships in order to “spread the burden of the training” to more than just one organization. Collaboration was important to organizations both at the time of the program and in looking ahead to future projects.

**Human resource outcomes.** Comments related to this theme included appreciation for the existing board, staff, and volunteers, or appreciation for being able to secure quality staff and volunteers due to the increased funding from the foundation. Many noted that they were able to hire new or more qualified staff, which, in turn, provided better services for clients. Training for the board, staff, and volunteers was another benefit of increased funding. “Overall the volunteers are more prepared” and “training staff… has enabled [us] to more effectively identify treatment approaches that would fit each child and their unique circumstances” were comments given by
respondents. Many organizations listed names of individuals who were integral to the project’s implementation and success due to their involvement and/or passion.

**Enhanced program components.** Organizations reported that they were able to implement enhanced or new program components due to increased funding. This included such things as using best practices research and activities to which they may not otherwise have had access. Organizations were able to tweak their programs in areas that allowed for greater effectiveness. Some organizations shared that the grant-funded programs are now being used as models in other organizations. “[The foundation]… has enabled this organization to be recognized as an evidence-based care center.” Others are continually tweaking the program components that they know work: “Our model worked well for what we needed at the time. I’m excited about the creation of the new model where we use more linkages of services. We are meeting and are all on the same page.” Program components were greatly improved due to increased funding.

**Community outcomes.** Not only did funding help clients; it helped the community as well, respondents said. Most organizations did not formally measure community outcomes, but felt that schools, neighborhoods, and communities benefitted from the work that was being done to provide healthier and more productive children and families. Organizations felt that expanded programs made it possible for them to stay in tune with the community, thus allowing for more effective programs in line with what the community needs. One respondent was grateful that their grant allowed for in-home and community-based services: “This enabled us to engage families, to see family dynamics, and meet them on their turf.” Another noted: “One of our outcomes was building the relationships and to build that bridge… Schools also benefit because they see the results of our program. The direct impact helps us keep a pulse on the community.”
Having a relationship with the local community allowed for greater impact within the community, due to greater acceptance of programs.

*Organizational supports.* Even though organizations stated that their top priority for use of funds was to help clients, they noted that it was helpful that the grant allowed them access to capacity building as well. One interviewee noted that it was extremely rare that a grant would allow for organizational support and not just program implementation. Others stated they were glad to have funding that allowed them to enhance their capacities in the following areas: record-keeping/accounting, planning, gathering input from stakeholders and other areas that provide quality assurance and organizational stability. “The social marketing piece of changing attitude is a huge piece because it’s not a billable thing. It’s crucial for changing attitudes. The grant allows someone to dedicate their time even though it’s not billable to Medicare.” Funding was used to help clients and organizations achieve their goals.

*Credibility.* Respondents noted that receiving funding enhanced both credibility and visibility due to the positive reputation of the foundation itself. Funding also allowed them to expand their credibility by allowing programs to implement evidence-based practices and enhance the quality of their programs. In some cases, funding was used to increase organizations’ visibility with potential clients and the community as a whole. “[We] gained a lot of experience through doing this the ‘right way,’ [which] has brought national attention.” Credibility was enhanced by furthering visibility within the community.

“All worked well.” Remarks such as this were commonplace when responding to this question. Many organizations expressed their gratefulness to the foundation for making their programs possible. “Everything has worked well. The data collection has given us marvelous
typologies. The training has been gratifying, and now we are having partners open to the
process.” Others had been operating their program for a while: “It all works well. We’ve had a
long time to turn this into a well-oiled machine.”

Challenges/What Did Not Work Well

After asking about program successes, respondents were asked to provide challenges they
faced when implementing the program: “What was the most difficult challenge in implementing
the grant?” The themed responses from both interviews and reports are included below.

Client challenges. Recruitment and retention of clients was listed as an issue for service
providers (e.g., difficulty retaining families and individuals as they move across programs,
challenges with parents of youth receiving services). Oftentimes, clients’ needs would exceed the
current capacity of service providers (e.g., the inability to offer user-friendly services). Mobility
and drop-out were issues when clients would change addresses and/or phone numbers or not
attend regularly. Some clients were homeless and difficult to reach for that reason. Sometimes it
was difficult to adapt a program to meet the unique needs of clients (e.g., tailoring the program to
fit in with school needs, focusing only on clients with certain mental health needs). “Phone
numbers changed, making it hard to maintain communication with parents. Addresses also
changed.” One noted, “Although attendance has improved, it is still not good.” It is difficult to
provide services to individuals who cannot be reached; these individuals need services where
they are instead of requiring them to come to organizations.

Staff challenges. Many organizations reported staff-related issues, such as: not having
the correct staff to sufficiently provide the desired program, problems with attracting and hiring
specialized staff (e.g., a substance abuse specialist, bilingual therapists and case managers, staff with cultural competence and expertise), a lack of desired personnel due to restricted funding, a need for more administrative support so adequate staff could be hired, an inability to retain recruited staff or volunteers, and on-going concerns about staff training (e.g., a need for up-to-date training, but little time or resources to offer those opportunities). “Staff turnover led to increased training and decreased caseloads.” One organization noted their challenges in hiring appropriate staff: “Finding someone who wanted to work part-time nights, and was bilingual and culturally competent was difficult. The job was posted for six months.” Staff turnover was an ongoing challenge for many organizations.

Program challenges. Specific challenges regarding implementation, adjustment, and evaluation of the program were mentioned. More specifically, challenges included difficulties in: adapting a curriculum to meet explicit needs, handling documentation and procedures required to implement the program, complying with the timeline for implementation (due to such things as training incompletion because of staff change and low enrollment of clients, for example), location and structural conditions (e.g., failure of lights and difficulties with water system), tracking outcomes (e.g., lack of staff, evaluator resignation, redesign of the survey or tool, a low response rate on surveys, and distinguishing between mental health outcomes and other outcomes), and tailoring the program to diverse populations in need (e.g., the homeless or adjudicated youth). “[We had] staff turnover, a lack of referrals, and low response rate to surveys that were meant to measure the outcomes. Other sources of data had to be used.” Another noted: “There isn’t a lot of space here, and having group activities can become difficult. We keep finding ways because our goal is being responsive to client needs.” Program challenges made it difficult to implement the program as envisioned.
Lack of resources. Challenges were present in organizations simply because there was a paucity of resources available at their disposal. Needed resources included: financial, transportation, childcare to support attendance of service recipients, location (that is, the organization was located in an area with low demand), medication, and other healthcare services. In some cases, organizations reported that they overspent in certain areas (e.g., client medications) in order to meet demand, but that, in doing so, they were unable to provide services in other areas. “[We are] short of people and time. We would like to do more services, but we need people dedicated specifically to this program. As with most organizations, we are stretched to our limits.” Another noted their difficulty in “finding the people, getting the information, and the challenge of distances for everyone to get together.” One simply said, “I didn’t feel like my timeline was realistic.” In order to operate as efficiently as possible, organizations requested more resources to be made available at their disposal.

Internal challenges. In some cases, the organizational culture impeded organizational practices and procedures. Examples included a lack of support from administration for maintaining consistent service delivery to specific groups, inadequate marketing of events and/or issues, and internal barriers related to the culture of the organization. “Staff tends to be territorial and a new program needs to fit into the existing culture.” Another stated their “largest barriers were internal and related to the culture of the organization.” When internal challenges were present, it was difficult for personnel to work together to provide for client needs.

Community partnerships. While many stated that community partnerships were beneficial, some said it was challenging at times for organizations to collaborate with other organizations due to lack of communication in general. This also included a lack of referrals to programs, unsuccessful collaboration efforts, and difficulties in connecting service recipients
with community resources. “Not getting buy-in from certain hospitals, but it’s getting better as
time goes on. Even if they were open, they had a limited view. They are always hesitant to allow
trainings.” Another organization noted their challenge was “making sure we keep
communication open among agencies.” More thoughtful collaboration and communication
would allow organizations to work together to achieve client outcomes.

*External challenges.* Challenges in this area included the gap in service delivery at the
community level, specifically for those with co-occurring disorders, the need to change public
policies in order to be most effective, and the high number of people with multiple needs (e.g.,
homeless individuals with co-occurring disorders, youth with mental health needs in the juvenile
justice system). For example, “Running away was a coping strategy for many youth, resulting in
alternative placements to ensure their well-being. Disruptive behaviors linked to mental health
disorders were also prevalent, resulting in police involvement and/or youth being hospitalized
and placed in more restrictive placements to meet their mental health and safety needs.” External
challenges mentioned were oftentimes connected to other challenges mentioned already, such as
demand exceeding availability, difficulty adapting services, and a lack of collaboration among
agencies.

**How It Was Decided to Provide the Program**

During interviews, organizations were asked, “How did the organization decide to
provide this program?” and “Is the program based on an existing model or program or did you
develop the program within the organization?” These questions were asked in order to ascertain
whether organizations used evidence-based practices when determining either a program or
program components, and also to determine if the program used best practices research if the program was, in fact, adapted to best fit the needs of clientele. Responses were themed into the following categories:

- **1st category**: The organization developed the program themselves.
- **2nd category**: The organization developed the program, but based it on previously established approaches (e.g., used by other similar organizations, adapted from a previous program).
- **3rd category**: The organization based the program on clearly identified best practices or an evidence-based program.

Fifteen organizations developed their program without using previously established approaches as a model (the first category). Ten developed the program themselves, but based it on previously established approaches (the second category), and 15 based the program on identified best practices or evidence-based programs (the third category). Programs that used established practices, such as cognitive therapy or brief interventions, were put into the last category, even if they had not adopted a complete evidence-based program (e.g., QPR, Functional Family Therapy). Some examples of best practices/evidence-based models reported, included:

- **QPR, “Question-Persuade-Refer” emergency mental health intervention for the prevention of suicide**
- **DELPHI instrument for evaluation of hospital-based domestic violence programs and Department of Health and Human Services Best Practices guidelines for domestic violence services**
CCISC, “Comprehensive, Continuous, Integrated System of Care” model for arranging services for individuals with co-occurring disorders (CCISC is also known as the “Minkoff model”)

• SAMHSA recommendations for substance abuse and mental health evidence-based practices

• Dialectical Behavioral Therapy

• PCIT, “Parent-Child Interactive Therapy”

• CBT, “Cognitive Behavioral Therapy”

• FFT, “Functional Family Therapy”

• National Children’s Advocacy Center model programs

Many of these best practices would not have been feasible without these one-year grants.

How Funding Has Helped the Program

In order to gather the organization’s perception of how funding has helped the program, representatives were asked, “In what ways has the foundation’s funding helped this program?” The following are the themed responses given during interviews.

Organizational benefits. Respondents stated that receiving funding and technical support from the foundation helped their organization with organizational credibility and growth potential, which came from being chosen to receive the grant. That is, they felt the foundation trusted in their competence to carry out the program, which the foundation expressed to them by being chosen for the opportunity. “They’ve been so awesome. The beauty is that they trust us
enough to know where the need of our population is. They are supportive of what we are trying to do.” By extension, organizations felt that others would trust them as well. “It took our organization to the next level because we were able to establish the program.” Many felt that the credibility gained from the foundation’s funding would open doors for future opportunities as well – something organizations were grateful for.

*Increased organizational resources.* Respondents were thankful that the foundation allowed them to use money to develop the capacity of programs and the organization, not just for clients. Examples of this included allowing organizations to use the media to recruit volunteers (thus strengthening the program and organization), purchase equipment and other resources, and provide formal training to increase the staff’s capacity to do their work. “It strengthened our program through improved volunteer training, provided resources for media to recruit more volunteers, and provided case supervision in Jackson county.” Another said funding helped “with staff, purchasing equipment and seed, and getting needed resources to help prepare the land.” Funding provided resources that would not have otherwise been made available to programs.

*Expansion of services.* Interviewees constantly expressed that there was great need for services within the community. Because of this high demand, respondents were grateful that the grant allowed them to not only maintain current services, but also expand their current services to more individuals and families. Those who might not have otherwise had access to services (i.e., the underserved and/or hard-to-reach populations) were assisted due to funding. “The [foundation] has helped our program tremendously by allowing us to serve a population that we were not able to serve prior to the grant due to lack of financial resources.” Another said funding “basically supports the programs in other organizations, so it has allowed the expansion throughout the metro area.” When services were expanded, more clients were served.
Built partnerships. It was frequently mentioned that the foundation cultivated collaborations by bringing together grantees for networking and informational meetings. Besides foundation-planned meetings, many organizations had written into their grants that they were planning on partnering with other organizations in order to achieve their stated goals. In some cases, unplanned partnerships developed throughout the course of the granting period. Comments regarding planned and unplanned collaborations from the grant were exceedingly positive. “[The grant] created a foundation for collaboration” and “It helped strengthen community partnerships to better serve clients” were comments given by respondents. Collaboration and partnerships were often cited as something that would continue beyond the granting period.

Impact on client outcomes. Even though organizations struggled to identify or measure outcomes from an evaluation standpoint, they expressed a strong sense that funded programs were impacting clients’ lives. They noted that funding helped them increase the quality and accessibility of their programs, which translated into meeting the needs of clients and improved outcomes. “It helped us serve the needs of the whole child” and “It helped to expand and improve treatment for clients; [we’re] treating more of the whole person” were some of the comments provided.

Sustainability Plans for Programs

In order to attempt to determine the possible sustainability of programs, interviewees were asked whether the program existed prior to the foundation’s funding and in what ways the organization currently supports the program. Based on responses during the 40 interviews, it was
found that 13 of the funded programs were new (that is, not previously implemented by the organization) and 27 were already in existence to some degree in the organization. Responses to the question, “In what way did the organization support the program?” were coded according to the level and type of support provided by the organization to the program. Thirty-eight of the 40 organizations offered responses to this question. Table 17 displays the coded responses.

Table 17

Coded Responses to the Question, “How Did the Organization Support the Program?”

<table>
<thead>
<tr>
<th>Response Code</th>
<th>Frequency (N=38)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The foundation was the sole funder for the project.</td>
<td>2</td>
</tr>
<tr>
<td>The organization provided resources (e.g., facilities, supplies), but no additional staff.</td>
<td>16</td>
</tr>
<tr>
<td>The organization provided resources and additional staff.</td>
<td>14</td>
</tr>
<tr>
<td>Non-specific support from the organization (e.g., “The agency felt that what we wanted to do was important” and “the organization is very supportive because they realize how important the program is for our success”).</td>
<td>6</td>
</tr>
</tbody>
</table>

Organizations’ Knowledge of Outcomes

From the document review of the grant proposals and progress reports, outcomes from the programs were garnered. These outcomes were themed in order to determine what kind of impact the programs provided for clients, organizations, and the community as a whole. Because
initial review of the documents illuminated discrepancies in the definition of “outcome,” a fidelity assessment was completed after reviewing the documents associated with each organization. This fidelity assessment evaluated whether organizations (a) followed the foundation’s grant proposal template that was provided to them, (b) correctly identified outputs and outcomes, (c) identified measures for their outcomes, and (d) reported intended and achieved outcomes.

Outcome knowledge assessment forms were completed for each program after reading submitted proposals, interim reports, and final reports in order to determine how accurate programs were at reporting their activities. The purpose of the assessment form was to capture how well organizations understood how to measure and report the impact of their programs. It was found that organizations varied a great deal on the identification, measurement, and reporting of results regarding their activities. Most organizations reported outputs (the products of activities, such as the number served or number of hours of service) rather than actual outcomes (the measures of impact). Forty percent of organizations did not report outcomes at all, and another 10% didn’t measure their targeted outcomes. When organizations do not (or are not able to) measure their outcomes, it limits an evaluator’s ability to measure the impact that funding had on mental health issues.

Another concern that emerged while performing this assessment was that organizations would include outputs or outcomes that apparently were not measured or simply were not mentioned after the proposal/application. In Table 18, one can see that the majority of organizations were deemed as connecting their proposal to the interim and/or final reports; however, this is a loose interpretation. If programs connected only a few outputs or outcomes between the proposal and the reports, it was deemed that they connected the reports. When
organizations did try to organize their program’s outputs and outcomes, many programs were lacking continuity between intended and achieved outputs or outcomes. Results from the outcome knowledge assessment are included in Table 18.

Table 18
Outcome Knowledge Assessment Questions and Coded Categories

<table>
<thead>
<tr>
<th>Questions</th>
<th>No</th>
<th>Yes, But</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did the organization correctly identify outputs?</td>
<td>23</td>
<td>9</td>
<td>20</td>
</tr>
<tr>
<td>Did the organization correctly identify outcomes?</td>
<td>21</td>
<td>5</td>
<td>26</td>
</tr>
<tr>
<td>Did the organization use appropriate measures for their outcomes – short, intermediate, and long-term?</td>
<td>20</td>
<td>n/a</td>
<td>32</td>
</tr>
<tr>
<td>Did the organization connect their grant proposal to the interim and/or final report(s)?</td>
<td>6</td>
<td>n/a</td>
<td>46</td>
</tr>
</tbody>
</table>

Suggestions for the Foundation in Order to Achieve Its Mission

The foundation was very open to receiving suggestions and feedback from organizations that received their funds, and, as such, they provided many opportunities for organizations to provide such feedback. Suggestions were gathered from interim and final reports, as well as
interview questions. Even though confidentiality was assured, organizations rarely had anything negative to say about the foundation and still expressed great satisfaction and appreciation for all that the foundation did for them and the community. Themed responses to the statement, “Suggest ways that the foundation can be more effective in achieving its mission” are provided below.

*Continue providing opportunities for networking.* Organizations were thankful that they could network with other funded organizations because of the foundation’s ability to provide grantee meetings. Many expressed that these meetings were extremely helpful for collaboration and education purposes. “We look forward to future foundation-sponsored gatherings in order to continue networking with other foundation-supported service providers.” Another said, “we appreciate… meetings with other grant recipients that allow us to exchange information and possible opportunities.” Organizations recommended that the foundation keep providing these beneficial meetings in the future.

*Educate grantees about evidence-based best practices.* Respondents requested assistance from the foundation in order to find and implement evidence-based practices, particularly in their area of focus. Organizations counted on the foundation to be a capacity builder, and they proposed that the foundation could share their resources and information on best practices research in order to have the most effective programs possible. “Bring in national speakers who can inform us about new ideas or report on evidenced-based practices” and “Continue to support this organization with educational opportunities and information about successful interventions being used with similar populations. Opportunities to enhance knowledge are very welcome” were some of the suggestions provided by respondents.
Continue providing financial and technical assistance. Again, interviewees were thankful for the foundation’s support of their mental health programs and requested that the foundation continue to provide support to mental health organizations via financial and technical assistance. Organizations called for unrestricted funding for services and infrastructure from the foundation, if possible, and asked that the foundation continue to be open, available, and engaging. “Provide financial support and leadership directed toward the health of [local area] residents. Continue to provide mental health support.” Another stated that the foundation’s help allowed them to “expand programming to include innovative projects and support for agency planning.” In one way or the other, organizations asked that the foundation continue to provide their support for mental health programming.

Be a leader in the community. Respondents suggested that the foundation take a focus on community and systemic-level changes to support mental health services in the community. They identified the foundation as having the potential for being a major catalyst on mental health issues in the area. The foundation was seen as being in an unique and prime position to advocate for the voiceless and dispossessed with elected officials and others holding influence in the community. It was suggested that the foundation provide an annual summit for the community to focus on mental health needs and available services, with the caveat that the foundation be very well-informed about issues before advocating for a particular approach. “Broadening their advocacy role would also be great” and “[The foundation] has been amazing. Perhaps they could use their influence to encourage all the youth organizations to discuss best practices and look for opportunities to collaborate to maximize our efforts for all the youth of our communities” were comments given. Organizations saw the foundation as being in a unique position to focus on and advocate for mental health issues on a broad scale.
Consider funding other areas. Even though organizations expressed their thankfulness for mental health funding, some saw a need for other services and suggested the foundation be willing to support other target areas (e.g., exploratory work and planning, identification and/or development of best practices, executive leadership program for executives and program directors). “I would suggest that [the foundation] broaden its emphasis.” “[The foundation could] sponsor professional development and community education opportunities, as well as seek input from healthcare providers and consumers, and government agencies.” In lieu of funding another area, one respondent suggested that the foundation encourage a practice where “community providers go to where the clients reside instead of vice-versa, which may result in improved engagement, more efficient use of resources, and improved effectiveness of services.” One grantee suggested that the foundation focus solely on mental health issues instead of the other three areas of domestic violence, child abuse, and co-occurring disorders.

Multiple-year funding. Multi-year funding was available at the time of application, however, the default length of funding was one year. Some suggested that multi-year funding should be the norm when applying for grants, not the exception, especially considering that some mentioned they felt like they had just begun to see positive results before funding ended. “Multiple-year funding for programs would be more effective for everyone.” Those who did receive multi-year funding expressed their gratefulness to the foundation.

Improve access and quality of healthcare. Respondents suggested that the foundation should devote resources to healthcare issues because of the many barriers present for those seeking healthcare. More specifically, many community members seeking care lacked insurance – this was especially an issue for mothers and children. “Improve access and quality of health for medically indigent and underserved by strengthening the agencies that serve these
populations.” Another encouraged the foundation “to continue to support organizations that provide mental health services to underserved populations.” Providing clients with improved access to health care was one suggestion to the foundation.

*Improve grantee-funder contact.* Organizations were thankful for the ability to meet with one another and even asked for more such meetings; however, they also asked for more contact between program officers and organizational staff. Specifically, organizations wanted to be advised of their respective program officers as soon as possible, such as when award notices are given. In some cases, it was suggested that the assistance given to applicants be improved: “Program officers should be more comfortable in giving suggestions for programmatic and operational improvements when they do site visits.” Another recommended that grantees be provided written feedback on proposals. Improving communication between granter and grantee in some form was suggested to the foundation.

**How the Foundation Could Better Support Grantees**

Themed responses to the question, “What are two things the foundation could do to better support grantees in general?” are provided below:

*Continued and multiple-year funding.* Respondents expressed that one-year granting periods allowed them to begin providing services, only to have to cut them off at the end of the grant, just when people were beginning to find out about their services in some cases. Sometimes, because of the grant, services were free during the granting period, but not afterward, which had an adverse effect on some clients. “When it’s a one-year grant, we only have time to get the word out, and then cut off services the following year. People are still
coming to us wanting free services, but they are no longer free.” Multi-year grants would allow more time for organizations to serve clients instead of lagging behind each time a granting period begins (due to start-up time cutting into the first part of the year).

Be flexible in how money is spent. Again, respondents were thankful for the flexibility already in place by the foundation; however, they also requested that the foundation consider allowing funds to be used for things such as transportation, primary prevention, and general operating expenses. “One would be to be flexible in their budgeting to allow for infrastructure that can facilitate the creation and delivery of the services. Secondly, funding for transportation and primary medical care access should be provided within the funding” was one comment. Another said, “fund primary prevention through education; a penny upfront will save $1,000 later on. Primary prevention should be funded at a significant level.” One respondent wanted the foundation to stay on board knowing that things change: “Funding in one area may be needed one year and funding in another may be needed the next… The [foundation] needs to have a better understanding of the changing environment in which their grantees work.” Flexibility in spending was one way the foundation could better support grantees.

Provide opportunities for growth. Specifically, grantees asked that the foundation provide grantee meetings more often and at times that were flexible with their varied schedules. Respondents sought to learn, grow, and collaborate with one another. They requested additional technical support and trainings about specific subject matter. “Provide grantee meetings more often and at different times” and “Longer quarterly meetings among grantees may provide more opportunities for learning and sharing” were two of the comments shared. Organizations often sought to improve their services, which is something the foundation could help inform.
**Assistance with evaluation.** Interviewees shared that they needed help evaluating their programs; specifically, they wanted help understanding and utilizing evaluation results. This includes providing evaluation tools, providing assistance or training on determining outcomes, and requiring an evaluation plan for organizations receiving funding. “Share simple evaluation tools” and “some additional training in evaluation so that outcomes align with activities, so they are measurable” were two comments given by respondents. Respondents were eager to learn from the foundation how best to do evaluation work.

**They are already doing a good job.** Most of the respondents indicated that there was nothing the foundation could do to better support grantees because they were very pleased with the foundation’s assistance and support. They commented on the foundation’s ability to be engaged, available, and open while providing helpful feedback to grantees. “[The foundation] is already very supportive,” and “they do a really good job already” were just a few of the many compliments the foundation received from organizations in response to this question.

**Organizations’ Perception of How the Foundation Might Improve Mental Health Support**

Themed responses to the interview question, “What is the most important thing that the foundation should do to support mental health?” are provided below.

**Provide trainings and knowledge development opportunities to grantees.** Those interviewed stated that they would like knowledge of various capacity-building topics, such as board development, evaluation, collaboration, and knowledge regarding evidence-based practices. “Bring experts in for training when it isn’t available locally,” “help us identify gaps,” and “provide capacity-building, such as board training” are some examples provided from
interviews. Another asked that the foundation “support training around evidenced-based therapies” because training in that area is so expensive. Organizations were eager to learn from the foundation’s expertise or assistance.

*Continue to focus on mental health.* Respondents were thankful for the foundation’s awareness of the need for mental health programming and indicated that maintaining mental health programs in the community was incredibly important. “Mental health affects everything” was one respondent’s answer, thus emphasizing the importance of the foundation’s continued efforts to “keep doing what they’re doing; keep funding services” in this area. Others simply asked that the foundation retain their current support of mental health efforts: “Continue to help mental health providers… If mental health clients improve, they obtain employment, the crime rate decreases, etc.” By continuing to focus on mental health in the years to come, grantees were sure that the foundation would be serving a community in great need of those services.

*Educate and advocate in the community.* Because the foundation is regarded as a well-respected and credible organization, respondents wanted them to take a more active role in influencing public opinion and shaping public policy. Interviewees wanted the foundation to be a voice for the dispossessed, be more involved in civic efforts, and advocate to help address funding and low-cost housing issues. Respondents also wanted the foundation to educate the general public on mental health issues in order to reduce the stigma surrounding mental illness. “Educate patients that mental health is not a weakness; it’s no different than any other medical condition. Take the shame out of it” and “keep focusing on mental health. Keep the community informed on what mental health is and why it is important” were two of the comments given. Another asked that the foundation “educate people in the community who know little about
mental illness and addiction.” By educating the community, respondents stated that stigma would be reduced, and more people who need services would seek them.

    *Increase access to behavioral and physical healthcare.* As already mentioned, respondents indicated that there is great need for physical, as well as behavioral, healthcare. These should be areas of focus for the foundation, with many saying how important it is to work to increase access to both mental and physical health services. “Improve access to services beyond medication.” Another noted, “Because of the stigma related to mental health, the access to care is a huge issue, and this strikes at the quality of care.”

    *Provide support for prevention and protective factors.* Although respondents were likely to ask for more funds in general to support current programs, many asked the foundation to support prevention efforts as well. Thus, the foundation would be providing support in all areas of the mental health services continuum (i.e., prevention, intervention, and treatment). One respondent simply asked that the foundation “be open to new ideas.” Another simply asked that the foundation “support prevention efforts for creating protective factors – early prevention, not just intervention.” Prevention is not usually an area of focus for agencies, so the fact that some organizations mentioned this was encouraging. A focus on protective factors would greatly benefit the community at large and makes long-term financial sense.

    *Stay connected to what is happening in the community.* Respondents both supported the foundation’s efforts, but also had some concern over whether the foundation would become disconnected from the communities it serves as well as the organizations receiving funding. Specifically, one interviewee urged the foundation to continue to fund rural programs. Others urged the foundation to be aware of other efforts in mental health so services are not duplicated.
One respondent urged the foundation to become better educated about issues before “taking sides” on mental health efforts. One said, “Keep [mental health] high on the radar because it is one of the least popular things. Keep the connectedness to legitimize it as a wellness matter.” Overall, organizations urged the foundation to know what is happening in the community so that appropriate services that fit the community would be provided.
CHAPTER 4

DISCUSSION

The results of this study examined the impact of a community-wide initiative by a local foundation on the perceived level of care provided by the mental health-serving organizations, as well as information regarding the extent to which mental health-serving organizations in this study had the capacity to impact mental health outcomes.

Perceived Improvement of Services

Results showed that the initiative did have an impact on the perceived level of care provided, with organizations reporting positive outputs and outcomes. Organizations reported positive changes in knowledge, attitude, behavior, policy, community conditions, and individual long-term changes. Changes in knowledge included such things as: increased understanding of mental health issues, improved knowledge regarding substance abuse and healthy relationships. Others reported increased self-esteem or confidence. Changes in behavior included: increases in Global Assessment of Functioning (GAF) scores, patient follow-through, and decreased symptoms, as well as a lower recidivism rates and reduced isolation. Changes in policy, community conditions, and individual long-term changes included such things as: increased permanent housing, gains in employment, collaboration among agencies, reduced indicators of abuse or neglect, and changes in hospital practice. Regarding outcomes, organizations were more likely to report knowledge and behavior changes than attitude changes. Regardless, many organizations had difficulty measuring outcomes. Only one organization reported negative outcomes.
When asked what long-term impact organizations wanted to achieve, 2 organizations did not specify an intended impact, 30 identified their intended impact, and 8 reported that they achieved their intended impact. Most of the intended impacts were client-centered. For example, organizations wanted to see their clients lead responsible and productive lives, have stable mental and physical health, obtain jobs and permanent housing, and have stable family environments. Other intended impacts were broader in focus and included: improved access to services, more community partnerships, and greater community awareness of mental illness.

Unexpected outcomes, both positive and negative, were also reported. Positive unexpected outcomes included: enhanced partnerships, funding led to other opportunities, community support, and improved treatment compliance. Negative unexpected outcomes included such things as: many more clients needed mental and physical health services than previously thought, difficulties for clients wanting to access services, staff hiring and turnover, and the importance of having innovative recruitment strategies for both volunteers and staff.

Promising Practices and Organizational Capacity

In addition to gathering information regarding perceived improvement of services, organizations were asked to provide information in order to assess their capacity to impact mental health outcomes. Organizational strengths reported included: cultural competence, community partnerships, client-based services, the ability to solve problems, administrative support, and location. Challenges organizations faced included: lack of funding, meeting clients’ needs, challenges with the administration or board of directors, staffing issues, community
awareness, facility complications, clients with severe personal challenges, and lack of parent or family support.

Organizations also reported what worked well for them, and what didn’t work as well. Key successes included positive outcomes for clients and the community, partnerships with other organizations, enhanced program components, organizational supports, increased credibility, and enhanced board, staff, and volunteer outcomes. Despite these successes, challenges in implementing the program were present. For example, sometimes it was hard to recruit and/or retain clients. Sometimes staff challenges were present, such as not having the correct staff to provide the program or difficulties attracting and/or retaining qualified staff. Program challenges (e.g., implementation, adjustment, and evaluation) and lack of resources were mentioned as challenges, as were internal challenges (e.g., lack of support, inadequate marketing of the program) and problems with community partnerships. External challenges included such things as the need to change public policies and the high number of individuals with multiple needs.

To determine if organizations used evidence-based research and practice, organizations were asked how they decided to provide their program and if the program was based on an existing model or did they develop the program within the organization. It was found that 15 organizations developed the program themselves based on no established model or program. Ten developed the program themselves, but based it on previously established approaches, and 15 based the program on identified best practices or evidence-based programs. Considering this was a one-year grant, the number of new best practices implemented is impressive. Not only does this indicate a high level of organizational sophistication, but also what a one-year grant can accomplish that takes an organization to the next level.
Organizations were quick to say the initiative helped their programs in many ways. Respondents shared the organizational benefits of being a grantee, such as organizational credibility and growth potential. Organizations used funding to increase organizational resources to improve the capacity of the program and organization, to expand services provided in the community, and to build partnerships. Organizations also expressed a strong sense that their programs were impacting clients’ lives and allowed for increased quality and accessibility of programs.

In order to determine the possible sustainability of programs, interviewees were asked whether the program existed prior to the initiative, and in what ways the organization currently supports the program. Thirteen of the funded programs were new, and 27 were already in existence to some degree in the organization. The organizations supported the programs by providing resources, but not staff (n=16), and by providing resources and additional staff (n=14). In 2 cases, the foundation was the sole funder of the project, and in 6 cases, there was non-specific support for the program from the organization. Hence, in most cases, there was some form of support from the organization for the program, indicating future sustainability of programs was likely for those receiving support.

Regarding outcomes, it was found that organizations varied a great deal on how well they understood how to measure and report the impact of their programs. For example, some organizations reported outputs (the products of activities, such as the number served) rather than outcomes (the measures of impact, such as a decrease in depression indicators). Surprisingly, 40 percent of organizations did not report outcomes at all, and another 10 percent didn’t measure their targeted outcomes. This limits the ability to assess the community-wide impact that the initiative had on mental health issues. Another issue that emerged was that organizations would
include outputs or outcomes that apparently were not measured. In some cases, the proposal and later reports were only loosely connected, and many programs were lacking continuity between intended and achieved outputs or outcomes. This is an area for continued capacity building for many organizations.

Suggestions were given by organizations to the foundation in order to better achieve its mission. Suggestions included continued opportunities for networking, education regarding evidence-based practices, continued funding and technical assistance, being a leader in the community, and funding multiple years of service. Organizations were extremely grateful for the assistance the foundation provided. Some ways the foundation could better support grantees included: continued and multiple-year funding, flexibility in how money is spent, opportunities for growth, and evaluation assistance. Many indicated that the foundation is already doing a good job supporting grantees. Respondents provided suggestions for how the foundation could improve mental health support: provide trainings and knowledge development opportunities to grantees, continue to focus on mental health, educate and advocate in the community, increase access to behavioral and physical healthcare, provide support for prevention and protective factors, as well as stay connected to what is happening in the community.

Mental Health Needs

This study’s findings reflect the great needs in the area of mental illness, echoing the data found during the Epidemiological Catchment Area (ECA) study, the National Comorbidity Survey (NCS), and the current epidemiology of mental disorders in the United States. The Substance Abuse and Mental Health Services Administration’s (SAMHSA) 2007 National
Survey on Drug Use & Health (NSDUH) found that less than half of individuals with serious psychology distress (SPD) received services for that distress. The findings from organizations’ representatives confirm that there is a great need for services; however, they found that even more individuals and families than originally anticipated needed services and were not receiving the care they need. Along the same lines, the 2007 NSDUH study found that 22.1% of those with SPD were dependent on or abused illicit drugs or alcohol, and, again, less than half of those received the care they needed. This study reflects those findings in that there are many individuals who have co-occurring disorders who need services to address both their mental illness and substance abuse. Not receiving care for mental illness or co-occurring disorders could be due to one or many reasons (SAMHSA, 2008). For example, there is major stigma involved with receiving mental health care. Some view seeking help for mental issues as a sign of weakness or that one’s problems are imaginary or will dissipate with time. For others, they may lack education about where to seek services they need. Some may have barriers in place that limit their ability to access care, such as lack of transportation and cost of services. The majority of people who have an unmet need for mental health care, but do not receive services, report cost as the number one reason why they do not seek services (SAMHSA, 2008).

Challenges also included recruiting and retaining clients for programs. Mobility and drop-out were also issues. Some clients were homeless and difficult to reach. The findings of this study support that client needs often exceed the capacity of the service providers to meet those needs. For example, service providers reported greater capacity community-wide would help them meet the demand of their clients, such as financial support to clients, transportation, childcare to support attendance of the service recipients, medication, and other healthcare services. Many mentioned that it was difficult to provide the needed services because specialized
staff who could provide those services were difficult to recruit and/or retain. Staff mentioned that they were surprised by how many people needed assistance not only with their mental health issues, but also their physical health problems. Mental illness is an area that needs great attention and services aimed at treating the whole individual within his or her community.

Mental Health Services

Although there was a mix of traditional, consumer-based, and community-based services among agencies, the majority of mental health services provided were from community-based nonprofits. Despite that these organizations exist to serve a great diversity of target populations, they all needed mental health services. In this study, service recipients included children who have been maltreated, those suffering from family or domestic violence, and those with co-occurring disorders. Program activities varied as well and included: mental health services, resource expansion, community collaborations, services for the underprivileged, training, public knowledge expansion, services to maltreated children, services to domestic violence survivors, and physical healthcare.

Organizations reported many strengths regarding the provision of mental health services. Respondents were proud to have culturally competent and dedicated staff, board members, and volunteers, and solid community partnerships that had evolved with time and reputation. They reported that when care was provided, it was focused on the client’s strengths and was as comprehensive as possible. Others were pleased to report their ability to solve problems as a strength. Administrative support and a being in a good location were listed as strong points as well.
Despite these strengths, there were also many challenges faced by service providers, specifically regarding the provision of mental health services. Funding was a major concern, especially for mental health services. The overall economy and steep competition for existing funding were mentioned as major challenges by almost all of the organizations. Even with increased funding from the foundation, organizations struggled to reach the poorest of the poor. Nonprofits struggled with the high demand for services and the inability to provide for all who needed or requested care. Organizations mentioned how heavily they rely on volunteers to reach their goals and charity for their revenue. They also mentioned that recruiting and maintaining staff with the necessary, up-to-date skills and applicable knowledge to do the work needed was sometimes a challenge.

Nonprofits’ problems are complicated, especially when their recipients have more than one condition needing attention. Those who truly needed care the most – those living in an unstable environment, those who are transient, those who have multiple chronic health conditions, and those who are on public support – are oftentimes those who are the hardest to reach. Reaching out and meeting these populations where they are, instead of requesting that these populations come to the organization, might be one step organizations could take to serve these underprivileged groups. For example, it has been found that improved coping skills and having social support impact the homeless population in a positive manner (Stein, Nyamathi, & Zane, 2009).

Many of those needing services suffered not only mental illness, but also substance abuse, physical illness, or other problems. Many reported the challenges in caring for this specialized group. Organizations needed more resources in order to fulfill the needs of their clients who had multiple conditions. The need for physical health care surprised some of the
service providers, however, maybe it should not have been so surprising: the U.S. Department of Health and Human Services (HHS) estimates that 75 million Americans suffer from two or more concurrent chronic conditions, including both mental and physical health conditions (Anderson, 2010). Being able to provide care or referrals for this group is crucial, but can be a huge burden for organizations that are ill-equipped to handle these situations. When clients in nonprofit facilities reach the limits on their Medicaid coverage, it is not uncommon for them to be referred elsewhere (Ben-Nur, 1994).

Regardless of the type of treatment provided, clients first need to access treatment, which can be hindered due to the stigma of receiving help, especially help for mental illness. This was confirmed during interviews of key personnel: While many stated that it would be great if the foundation could continue to focus on mental health, some were more specific with their requests, asking that the foundation educate the community about the origins, causes, and types of treatment available for mental illness. The foundation could assure the public that mental illness is not a weakness, it is no different than any other medical condition, and it can be treated. Getting the word out about help and where to receive it, however, is easier said than done.

Loosely Coupled Systems of Care

As the President’s New Freedom Commission on Mental Health (2003) states, much progress has yet to be made in the area of mental health. Services need to be easily accessible for clients as well as affordable and complete. However, many nonprofits operate in a system that is loosely coupled. Each nonprofit operates with a certain amount of stability or distinctiveness while being open to outside forces, meaning each is responsive to what is going on in the
community and their field at a national level. The organizations included in this study listed partnerships with other organizations as something that was greatly valued; however, at times, such organizational collaboration was not without problems. In fact, some worried that the foundation itself might become disconnected and unresponsive to the community’s needs with time.

The initiative allowed organizations to partner with other organizations with which they would not have otherwise collaborated. These partnerships were key for leveraging resources and knowledge sharing. However, not only was it difficult for service providers to maintain open communication with clients, it was also difficult for some to collaborate with other organizations because of failed communication, lack of referrals to programs, and difficulties connecting recipients with community resources. In order to best serve clients, open lines of communication are key. If agencies cannot work together and share knowledge, it hurts not only organizations, but clients as well.

Nonprofit Organizational Capacity

Organizational capacity building helps strengthen nonprofits, and includes assessment, technical assistance, and direct financial support. Organizations rarely have all the tools or resources necessary to carry out their missions, achieve program successes, and best serve clients. In order to enhance effectiveness, nonprofits can build strengths in four capacity areas: adaptive, leadership, management, and technical.
Adaptive Capacity

Adaptive capacity is the “ability to monitor, assess, respond to, and create internal and external changes” (Connolly, 2006). Being proactive, responsive, and flexible are key aspects of adaptive capacity. This capacity is one of the greatest needs for most nonprofits, along with leadership capacity. It is crucial for organizations to be flexible, resilient, and to adjust to internal and external changes, including those in this study.

Organizations stated that they face many challenges, both internally and externally. Internal challenges included an organizational culture that hindered practices and procedures. At times, there was little support from administration for maintaining consistent quality and level of services to specific groups. Some stated there was a lack of fit between the staff or program and the overall culture of the organization. External challenges included a lack of collaboration with other agencies, demand exceeding availability, difficulty adapting services, and a gap in service delivery. Many believe that small and large changes in public policies are needed to better accommodate the difficult issues related to the capacity of mental health organizations. Overall, adaptive capacity is an area of great need for many nonprofits, but creating the needed changes is a challenge because of the large amount of work involved in creating that change. Before that change can occur, organizations first have to acknowledge that it is an area needing attention. Increasing adaptive capacity is the most crucial area on which to focus to create more high functioning nonprofits (Backer, Bleeg, & Groves, 2004; Connolly, 2006; Connolly & York, 2003).
Leadership Capacity

Leadership capacity is the ability of all organizational leaders to create and sustain a vision, inspire, model, prioritize, make decisions, provide direction, and to innovate (Connolly, 2006). Along with adaptive capacity, leadership capacity is one of the areas of greatest need for nonprofits (Connolly & York, 2003). Organizations reported that they had the support of administrators, who take care of such tasks as fundraising, secretarial support, and budgeting. One organizational representative stated during interviews that they had an “innovative and visionary CEO.” Another mentioned that they had a “100% supportive board” of directors. Some mentioned key staff members who were skilled in providing leadership for the program as well as qualifications, credentials, knowledge, and/or experience. Many respondents could name the specific person or persons who had a lot of passion and dedication regarding the work they do, however, this person was not necessarily someone in a leadership position (e.g., a co-worker or program facilitator).

With that said, many reported that this is also an area for improvement. For example, some detailed how there was disagreement between the board of directors or administrators or staff in regard to how to best serve client needs or implement the program. In some cases, staff reported that the board or administrators did not fully understand the program or could not advocate for the issue at hand. Some noted that it would have been helpful if organizational leaders got the word out about their programs. Others mentioned that the overall culture of the organization needed to be revised so that the program would fit better with the overall structure which needed leadership to achieve. If there is a breakdown in leadership in any organization, it cannot successfully achieve its mission, which can lead to more problems.
Management Capacity

Management capacity is the ability to use organizational resources effectively and efficiently (Connolly, 2006), which includes hiring, training, assessing staff, and facilitating clear communication. Some organizations stated they had high quality staff; however, others listed hiring qualified staff as a challenge, especially for organizations seeking staff with specific training or skills. For those who already had high quality staff, retention was sometimes an issue. At times, location played a part in being able to attract staff, with those in rural areas stating it was more difficult to obtain the type of staff they were seeking. Providing sufficient training for staff was another challenge (i.e., a need for up-to-date training, but little time to offer those trainings), as was being able to provide a competitive salary/benefit package. Staff turnover was common for many. One organization knew that several staff members would be leaving soon, but they had made no plans for the transition at the time of the interview. Communication within and outside of the organization could have been improved at times.

Despite all of this, there were many organizations who complimented the management ability of staff, administrators, and the board of directors.

Technical Capacity

Technical capacity involves performing key operational functions and providing programs and services (Connelly, 2006), including having the skills, experience, knowledge, tools, facilities, and technology needed to implement the program. Organizations reported that their staff, board, and volunteers were culturally competent and dedicated to the work they do. Funding allowed for additional training so that staff could gain the necessary technical skills
and/or knowledge to perform key tasks. Staff turnover and retention were problems at times; however, many organizations reported they had highly qualified staff who had plenty of experience with the issues at hand.

A lack of funding was listed as a challenge for almost every organization, which impacted resources available to carry out programs or serve a certain number of clients. Some listed that it has been a major battle trying to secure funding for general operating support to carry out programming. When clients did access services, some cited that there were challenges in regard to the space available to serve clients. Some said they needed more physical space in order to serve the amount of clients coming through their doors or that the space they were provided was not appropriate. Others had challenges with the facility, which was old or in need of repair. At times, it was mentioned that some had challenges with technology, such as keeping a website updated, which could lead to reduced community awareness and education.

Implications

Perceived and Real Positive Impacts of the Initiative

This initiative provides great encouragement in the area of mental health. Funding a mental health initiative is not typical for many foundations because mental health is oftentimes seen as secondary to physical health or other social services (e.g., housing and food assistance). This had a noticeable effect on the perceived improvement of services provided by organizations. Overall, organizations reported that funding helped them provide improved services for clients and serve more clients than they otherwise would have been able. For some organizations, new programs were offered to clients because of the funding.
Organizations may have difficulty identifying and measuring outcomes. Perhaps the foundation can provide organizations with direction in capacity building activities, such as basic evaluation. Also, the foundation could further help grantees by being more specific regarding outcome measurement and requirements on future grant applications and reports. Organizations need capacity building services, and the foundation is one resource where they could go to receive that assistance.

With that said, even though it was difficult for some agencies to track their outcomes, many individuals who would not have received services did get help. As stated, 29,521 individuals received services from the funding provided by this community-wide initiative, thus elevating the level of care provided community-wide.

**Difficulties in Hiring and Retaining Staff**

One year was a short time frame for organizations to work with. Getting a program up and running once funding was received was difficult and took more time than many organizations realized, especially if hiring new staff was part of that process.

Securing adequate staffing levels was an ongoing challenge for many organizations. Not only was recruiting difficult at times, but also retaining high-quality staff. Staff with the required skill set or with the desired specific training (e.g., substance abuse or bilingual therapists, cultural competence) were difficult to attract and/or retain. Staff turnover was a constant threat to achieving program goals. When planning for the future, such as timed transitions (e.g., retirement, filling key roles), capacity building would be beneficial in aligning staff with proper roles, resources, salary/benefits, and training.
Funding allowed for additional training of staff and allowed many to expand their pre-grant staffing levels to include qualified professionals. Respondents indicated that this had a direct impact on clients and allowed for more efficient and enhanced services. Many also expressed their thankfulness for having such dedicated and passionate individuals within their organizations.

**Sustainability**

Results showed that, despite the great help provided by organizations, the needs of the communities being served far outweighed the organizations’ resources and abilities to reach populations that needed services the most. The overarching challenges related to this were organizations’ difficulties related to funding and/or securing resources, such as employing qualified staff. This was exacerbated by an economic downturn, which made securing financial resources easier said than done. Difficulties were especially apparent for hard-to-reach populations, such as the homeless, those without transportation, or clients in transient living conditions.

Sustainability of programs could also be a focus of capacity building efforts, as grantees were vague or noted continuing reliance on the foundation as their plan to sustain their programs. In fact, some organizations did not even respond to the question about sustainability, which is a concern. Many respondents indicated they would be grateful for any assistance they could receive to make their program better or more efficient.

Some programs had a low chance of continuing on after funding from the foundation ended, as shown by how they responded (or by the lack of response) to the sustainability
questions. In fact, it is possible that the unreachable individuals who were being contacted for interviews were no longer available because their programs ended after the initiative ended. With many organizations receiving modest grants for one year for mental health services, it is difficult to sustain unless it is followed up with a concrete plan for extended funding for those who were most promising.

**Collaboration among Agencies**

Organizations reported many strengths and successes, including increased or improved partnerships and collaboration among agencies or community members. Because of the initiative, collaboration and partnerships with other organizations were formed. This was one of the key benefits of the initiative. Many agencies stated that they would not have otherwise made these key connections had they not been involved in the initiative. Collaborations were helpful because they provided education and idea-sharing and made leveraging available resources possible. As a result, more comprehensive and efficient care was provided to clients.

Partnerships were not only beneficial for the length of the granting period, but also beyond. Organizations anticipated that building connections and networking with other organizations who served similar populations during the grant period could only be beneficial for knowledge building and sharing, as well as connecting clients with community resources in the future. Collaboration was also useful to ensure that services were not duplicated and to spread the burden of providing care to more than just one organization.

The partnerships that were formed make up the domain that will be sustained over time, including the partnerships with the foundation, even if services will not be sustained.
Limitations of the Current Study

This was an evaluation of a community-wide initiative to enhance mental health in an urban community. One limitation of this study was that the pool of subjects was grant-funded. Because of this, the results are not representative of all mental health-serving organizations within the community. Also, not all of the organizations that were part of the community-wide initiative to enhance mental health capacity were interviewed. Fifty-two organizations received funding and completed proposal, interim, and final reports; however only 40 of those organizations were interviewed. Two of the 52 organizations (3.8%) refused participation in the interviews. Ten (19.2%) could not be reached for interviews despite multiple emails and phone calls, or the person mainly involved in the project at the time of funding was no longer with the organization. This is somewhat understandable, given that interviews were conducted almost two years after the project’s completion, and some projects’ sole funding source was the foundation.

The method of data collection was primarily self-report from organizations, using data that organizations provided in their proposals, interim, and final reports, as well as face-to-face interviews. The nature of this type of data allows for the collection of rich qualitative information, allowing for insight into organizations that would be difficult to capture with quantitative data alone. The type of data that was collected also had much to do with gathering information that the funders wanted. It would have been more insightful to have a longitudinal study and more quantitative data to allow for even greater understanding, but this was beyond the scope of the current study. The current data were collected at a single point in time, and it would be beneficial if data could be collected over time, which would allow for deeper analysis of the organizations’ capacity to impact mental health.
Future Research

In the future, it would be helpful if a longitudinal study was conducted, where data could be collected to see what type of impact capacity building efforts have on a community at large. The current study could not capture long-term impact data from programs because the granting period was only one year. If another study followed organizations over time, data could be collected regarding how funding impacts capacity building efforts and mental health outcomes over multiple years. This would allow for insight into what works and what doesn’t, which could be applied to future work with mental health providers.

It would be beneficial if future research focused on ways to help build the capacity of mental health providers to offer services in the best and most cost-efficient, non-duplicative manner. One route to helping providers is through foundations that offer funding. Foundations could require that grantees are educated on how to measure and report outputs versus outcomes, how to complete a logic model, and how to provide services that best fit the community. Foundations could provide staff who can answer providers’ questions as well as trainings on capacity building for grantees, which would allow for organizational and programmatic growth.

Also, focusing on how to reach out to special needs populations, such as the homeless or those with multiple chronic conditions, and improve access to care would be advantageous. Oftentimes, these populations will not come to service providers for care. They have to be contacted and offered services, which leads to the next area of future research: overcoming the stigma of reaching out to receive mental health services. Many people avoid seeking services for mental health issues because they are worried that others will view them negatively for reaching out for help. They should not wait until the problem gets worse to seek help. As a society, we
need to better educate individuals about mental illness and break down the barriers to care that exist within communities. Research on the best ways to overcome stigma within communities while reducing barriers to access could benefit individuals needing services and lead to better care.

Conclusion

Overall, mental health serving organizations believed the initiative positively impacted mental health in the communities they served; however, one-year funding was not sufficient for most organizations to achieve the goals outlined in their proposals. Funding helped to increase the number of individuals receiving services as well as implement new programs or make improvements to already-existing programs, but long-term, sustained change should be the focus of future efforts.

Mental health agencies are underdeveloped, especially with regard to adaptive and leadership capacities. Organizations in this study faced challenges in being able to respond to changes, both internally and externally. There needs to be greater fit between the organization’s culture and the staff or program. Also, being able to respond to the needs of the community or adapt services to best serve clients were listed as obstacles for organizations. Adaptive capacity is one of the most difficult capacities to develop; however, it is also one of the most crucial as it leads to enhanced organizations and outcomes (Connolly, 2006). Organizations could also benefit from greater leadership capacity. While many reported that they had visionary leaders or a supportive board of directors, just as many reported that this was an area that could be improved. At times, there was disagreement among members in regard to how to best implement
the program or advocate for an issue to the wider community. Others wished their organization could benefit from having leaders who would market their programs. Leadership capacity could help inform board development, executive leadership development, and leadership transitions (Connolly, 2006). Overall, the capacities of mental health-serving organizations could be greatly improved, especially if they focus on adaptive and leadership capacities.

Educating the community and raising awareness regarding mental illness and its implications are extremely valuable. The stigma of mental illness prevents many from attempting to access services. One way around that is by better educating the community at large. Mental illness should receive the same amount of attention as any physical illness, instead of being seen in a lesser light. Those from racial or ethnic minorities are even less likely to seek services, viewing mental illness as a weakness and/or a personal problem. Others have misperceptions regarding treatment and think they can better handle the problem on their own. Until stigma is addressed, many who would receive helpful services are not beginning the process leading to recovery.

Overall, this initiative was a bold and courageous undertaking for a local foundation. It is impressive that the foundation wanted to focus on mental health as they viewed it as compared to many other individual problems. One of the biggest benefits for organizations was that a respected foundation thought enough about the system of mental health care that they tried to do something to improve it. It is possible that the undertaking was so courageous that other funders will emerge.
REFERENCES
REFERENCES


APPENDIX A

INTERVIEW INSTRUMENT

Foundation 2007 Mental Health Grantee Site Visit Questions

Reminder to interviewer: Be very clear that the following questions refer to the mental health grant they received for fiscal year 2007 from the foundation. This evaluation will not determine whether they will or will not receive future funding from the foundation.

1. Name of Organization and Program: ________________________________
2. Name of Interviewee(s): __________________________________________
3. Interviewee’s Position(s): _________________________________________
4. How long has he/she been at the organization: ________________________
5. Name of Interviewer: _____________________________________________
6. Date of Interview: ________________________________________________

Organizational Information

The following questions are being asked to gain knowledge about the organization in which your program operates.

1. I would like to find out more about your organization. When did this organization start?
   ____________________________________________________________________
   ____________________________________________________________________

2. What is the organization’s mission?
3. Currently, what are the strengths of this organization?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

a. What is this organization’s top strength? _________________________________
   ______________________________________________________________________

4. Currently, what challenges does this organization face?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

a. What is this organization’s top challenge? _______________________________
   ______________________________________________________________________

Program Information

The next questions are about the program that was implemented and received foundation funding in FY 2007.

1. (Remind them about the program for which they received funding ) In your own words, tell me about the program that was specifically funded through the Foundation mental health grant for fiscal year 2007.
2. In what ways did the organization support the program that was funded through the Foundation mental health grant for fiscal year 2007? __________________________
______________________________________________________________
______________________________________________________________

3. Was the program funded for one year or was it a multi-year grant?

______________________________________________________________

4. Was this a brand-new program or did the program already exist?

______________________________________________________________

   a. How did this grant change the program’s services or activities? __________
       ________________________________________________________________

5. How many people (unduplicated) were served through the 2007 grant?

______________________________________________________________

   a. Was this more than, less than, or about the same number of people served in the year before this grant?
       ________________________________________________________________

   b. How many people were served in the year before this grant?
       ________________________________________________________________
6. Is the program that was funded by the Foundation in fiscal year 2007 currently in existence?

   a. How is the program currently funded?

   b. What are your long-term plans for sustaining the program (if any)?

7. Currently, how many staff members are in…

   a. This program?

   b. This organization?

8. In fiscal year 2007, how many staff members were in…

   a. This program?

   b. This organization?

9. In fiscal year 2007, what was the total budget for… (an approximation is fine if he or she doesn’t know the exact amounts)

   a. This program?

   b. This organization?

10. What long-term impact (i.e., changes in the community, changes in social situations, etc.) would you like to see – or did see – because of your program?
11. Based on your application and reports, ________ (interviewer fills in target population) is the population you served with this grant. Is that correct?

a. Are there others who were served as well through this grant that have not been identified?

12. Based on your application and reports, ________ (interviewer fills in activities) are the activities that we understand as being a part of your program. Is this correct?

a. Were there other activities in the program that I have not identified?

13. How did the organization decide to provide this program?

14. Is the program based on an existing model/program OR did you develop the program within the organization?
a. What program or model did you use?
________________________________________________________________________

b. What did you use to develop the program?
________________________________________________________________________

15. What were the goals or intended outcomes of the program?
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

16. In terms of results, were there any changes in the following areas because of the grant-funded program?
   a. Knowledge?
      ________________________________________________________________
   b. Attitudes?
      ________________________________________________________________
   c. Behaviors?
      ________________________________________________________________
   d. Did you measure these changes?
      ________________________________________________________________
      ________________________________________________________________

17. Were there any unexpected/unintended outcomes as a result of the program?
________________________________________________________________________
151

a. What were the unintended outcomes?

________________________________________________________________________
________________________________________________________________________

18. Overall, what worked well in the program?

________________________________________________________________________
________________________________________________________________________

19. Did you face any challenges in implementing the grant?

________________________________________________________________________
________________________________________________________________________

a. What was the most difficult challenge?

________________________________________________________________________
________________________________________________________________________

b. If you had any additional challenges, please explain.

________________________________________________________________________
________________________________________________________________________

20. Part of the grant proposal for the foundation included an optional logic model of the program. Did you complete a logic model for the grant proposal?

________________________________________________________________________

a. What was the experience like for you?

________________________________________________________________________
________________________________________________________________________
b. Did completing the logic model help you organize your grant proposal?

__________________________________________________________________

__________________________________________________________________

c. Please explain why you chose not to complete a logic model.

__________________________________________________________________

__________________________________________________________________

Suggestions for the Foundation

The next questions are being asked in order to provide the Foundation suggestions so that the foundation can improve its support of mental health-serving organizations like yours.

1. In what ways has the Foundation’s funding helped this program?

__________________________________________________________________

__________________________________________________________________

2. In what ways has the Foundation’s funding helped this organization?

__________________________________________________________________

__________________________________________________________________

3. What are two things the Foundation could do to better support grantees?

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________
4. What is the most important thing the Foundation should do to support mental health?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

End of interview. Be sure to thank the interviewees for their time.

Additional comments from interviewer:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
APPENDIX B

Outcome Knowledge Assessment

While completing this form, please include applicable page numbers and identify which report(s) (interim, final, or grant proposal) to which you are referring.

Organization and Program: _______________________________________________________

1. Did the organization follow the Foundation’s grant proposal template? YES NO
   • If no, provide specific details about what was missing or what wasn’t followed.
     __________________________________________________________________________
     __________________________________________________________________________

2. Did the organization provide an interim report? YES NO
   • If yes, did the report contain all necessary information? YES NO
     • Please explain.________________________________________________________________
     __________________________________________________________________________

3. Did the organization provide a final report? YES NO
   • If yes, did the report contain all necessary information? YES NO
     • Please explain.________________________________________________________________
     __________________________________________________________________________

4. Did the organization correctly identify outputs? YES NO YES, BUT NOT MEASURED
   • If applicable, please explain in detail.__________________________________________
     __________________________________________________________________________
5. Did the organization correctly identify outcomes?  YES  NO  YES, BUT NOT MEASURED
   • If applicable, please explain in detail.

6. Did the organization use appropriate measures for their outcomes (short, intermediate, and long term)?  YES  NO
   • If applicable, please explain in detail.

7. Did the organization connect their grant proposal to the interim and/or final report(s)?  YES  NO
   • If applicable, please explain in detail.

8. Is there anything else worth noting that was not captured above?  YES  NO
   • If so, please explain in the space below.